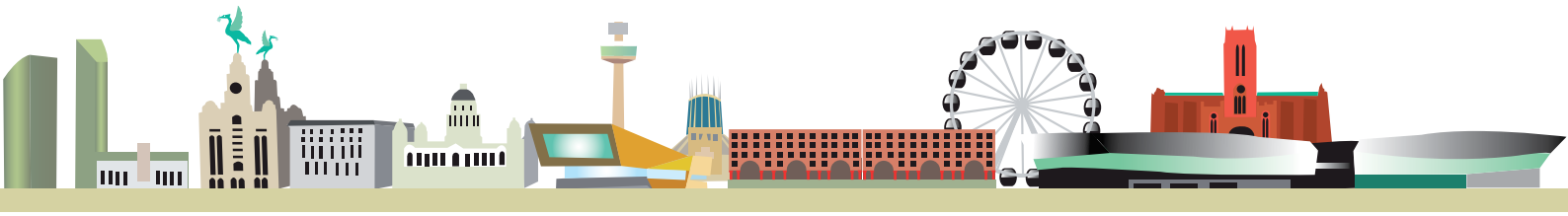
Liverpool City Council

The Mayoral Health Commission

ALL CHANGE

- the platform to a healthier Liverpool



2020 Decade of Health & Wellbeing

MAYOR OF LIVERPOOL

Contents

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Foreword

It is undoubtedly a challenge in challenging times to produce a report on the future of health and healthcare in the city of Liverpool when resources are being withdrawn from local authorities and NHS funds are at best capped at current levels. However, it did not feel that way because, without exception, all parties from whom we took evidence agreed that the task was important, indeed essential and urgent, and expressed willingness and enthusiasm to embrace radical change. Hence, the importance of using the 'burning platform' as the metaphor came through strongly. This came from all sectors, including public health, social services, primary and secondary care, voluntary organisations and, most importantly, patients.

We have produced ten recommendations – a '10-point plan'- the first three being overarching principles and the remainder how these might be achieved. Now the challenge is to take these ten recommendations of the report and mobilise the enthusiasm that we experienced to bring about practical change. This will require some new partnerships and a fresh start for some existing ones. We start from a position of strength, for example, with strong primary care organised around neighbourhoods and some world-class bioscience. We have a Clinical Commissioning Group with a strong vision, expressed in 'Healthy Liverpool', that puts well-being and prevention of disease at the centre of its plans. However, we have to acknowledge also that we have some of the poorest health outcomes and widest health inequalities in the country. We have new opportunities to tackle these as public health now forms an essential bridge between health and social care, between local authority and NHS.

I appointed commissioners largely from outside the city, in part to bring their experience from other parts of the country to us and in part as national advocates on our behalf so they might join us on the important journey that Liverpool is embarking on. I am grateful to them for their time and effort. I am also grateful to the local steering group, which comprised hard-working local professionals in the field, for being so generous with their time and expertise. Finally, I am grateful to the Mayor, Joe Anderson, and his team for setting me this challenge and giving me an opportunity to leave this proud city, which I have served as a hospital doctor for more than 30 years, with a legacy that should deliver better health and wellbeing for its citizens for decades to come.

Conclusions, Recommendations and the Way Forward

Conclusions

In 2012 the directly elected Mayor of Liverpool, Joe Anderson, invited Professor Sir Ian Gilmore to lead a Commission to determine how best to support and improve the health and well-being of the people of Liverpool. After a year of wide-ranging consultation and subsequent analysis of the information gathered, this work is complete. The result is this report: the conclusions are set out below.

As a city Liverpool has made major achievements in the last 20 years in the areas of urban and economic regeneration. It has exceeded public health targets and narrowed some measures of heath inequalities: and it has been left a strong primary care legacy by the PCT. However, Liverpool shares the national and international challenges of delivering ever-more expensive specialist care through new drugs and other technologies at a time when people are living longer, working and paying higher taxes for a shorter part of their lives, and are developing the degenerative co-morbidities of longevity.

The city also has particular challenges, despite the success of its public health programmes, as it remains at the bottom of the league for most indices of deprivation, and many of its citizens have a history of poverty, unemployment, and social exclusion. As a city Liverpool has been particularly badly hit by cuts in central funding for social services and for local government and will be disadvantaged further if proposed changes in the formula for allocation of health and social care funding favouring age over deprivation are introduced. So, although there are many successes to build on, there is a sense that the finishing line recedes faster than the city can run.

From evidence put before it the Commission concludes that there is sufficient willingness to participate, expertise, experience and resources available in Liverpool to create a far-reaching and visionary plan to improve the health and well-being of its people. This combined with the widely expressed view from witnesses that something radical must be done, and that they and their organisations are ready and willing participants in this, leaves the way clear for change.

But minor modifications in the existing healthcare system will not be enough to meet the challenges Liverpool faces. The city must use the current 'burning platform' to bring about the radical shift required. Inevitably, this will create tensions and there will need to be resolution of some key issues before any plan can be put into action, let alone accomplished.

One of Liverpool's strongest assets is its human capital, and it is famous for its community spirit and resilience. However, there is also a culture of over-reliance on hospitals for all medical treatment. To effect the changes required, this attitude to healthcare will need to be changed and the people of Liverpool will have to have a greater awareness of the range of alternatives to hospital, which in their turn need to be more accessible, including over the 24/7 period.

People need real practical support to be able to live more independent and healthier lives. Grasping the importance of self-determination with respect to health and well-being, and then acting on it, is governed by factors well outside the remit of the NHS: factors such as poverty; educational attainment; employment prospects; family cohesiveness; and a general investment in life that often only comes with being fully engaged with society in a positive and meaningful way. Change cannot be achieved without the commitment and understanding of the people, and those engaged in commissioning services and providing care will need to recognise the breadth of issues they will be dealing with.

Specialist staff will continue to require specialist education and training and there will be a level of professional expertise in all the partnering organisations that can only be acquired through time spent 'in post' working with staff who have gone through similar education and training. However, the people receiving services do not come neatly packaged and,certainly in the domains of health and social care, present increasingly with complex and multiple problems. The vision for Liverpool

should acknowledge this dimension and in the same way that service provision and delivery will need increasingly to be innovative, the people delivering it will require broad and flexible skills.

In the past, a significant barrier to true integration of care has been the failure to integrate information systems, to use new technologies appropriately, and to share data across agencies. Success of many of the Commission's recommendations will rest heavily on overcoming these barriers.

In order to free up resources for modern healthcare, there must be a combination of: reducing requirements through improved population health; increasing individual responsibility for health and self-management; shifting more care out of hospitals into the community where it can be most cost-effective; and reducing wasteful duplication of services or unnecessary competition.

Greater integration of care across the whole system is the only feasible way to achieve these aims. Any plan will need to strike a balance between where the boundaries of agencies lie; boundaries defined not only in geographical terms but also by what is in the best interests of people and patients. This is likely to result in some unusual and innovative pairings and partnerships, of which we have already seen many signs in the city. For example, the fire service joining with social care; business collaborating with public health; doctors and nurses working with musicians, artists, and footballers. Community pharmacies have the potential to be invaluable partners too.

There is unanimous commitment across the health and social care landscape in Liverpool to embrace more integrated care but there are significant barriers to this in practice, such as perverse funding incentives, and over-prescriptive national scrutiny of financial targets rather than population needs. Tackling these will require imaginative commissioning of both secondary and tertiary services by commissioners, and strong leadership to influence national agendas.

Liverpool's primary care structure is already well-developed around 18 neighbourhoods these have the potential to bring together other agencies around the needs of individuals and their communities. The Commission saw great opportunities for meaningful integration around a neighbourhood model of care provision that brought together all relevant health, social care, and other resources within a defined area, but recognised that this would at the same time raise issues about funding, accountability, leadership and sustainability.

Developing and putting in place a comprehensive system of health and well-being for Liverpool will require not only the cooperation and collaboration of partners but also a large measure of political will to see through the necessary changes. It will also require a realistic time scale for implementation and resolution, what is envisaged is not the relatively simple task of identifying 'problems' and listing 'priorities'. What the leaders of this enterprise will be required to do is effect a major change in behaviour both in partners and in the people of Liverpool.

While many of the Commission's recommendations will take years to implement fully, there is an urgency to start and to seek short-term as well as long-term gains. In this respect there are several reasons why the Commission's report is timely:

- The central university hospital, the Royal Liverpool, is about to be rebuilt as a state of the art hospital and will create the environment for a new Bio-campus;
- The hospitals in the city are already working with the University of Liverpool in a body called Liverpool Health Partners, which is committed to jointly fostering the highest standards of clinical service, education and biomedical research in the city;
- The award from the Department of Health of the North West Coast Academic Health Science Network and the Collaboration for Leadership in Applied Health Research and Care with a focus on applying research findings to spread innovation and to tackle health inequalities;
- The proposed development of the Liverpool Biomedical Research Centre in Personalised Health within Liverpool Health Partners; and
- The Commission is reporting to an elected mayor, the first of any UK core city, with local and national influence.

Change needs to happen in the context of the city region and surrounding North West of England, where there are close interdependencies of the constituent parts. Similar challenges are facing all cities in the UK, but Liverpool is well placed to exert some of the levers identified here and should seize the opportunity to become an exemplar for others to follow.

It is clear that the Commission's vision for Liverpool will need strong and easily identifiable leadership, backed up by political will. Authority will be required to resolve the competing priorities that will inevitably result from the prospect of radical change. It is likely also that this authority will need to extend beyond Liverpool if negotiations are required with national bodies, including with government.

The written submissions received by the Commission in response to its seven questions contain a wealth of detailed, sound, practical and thoughtful suggestions and actions, and provide an excellent platform to go forward. The Commission commends them.

The report recommendations are a starting point for change. The first three are over-arching and strategic, and set the vision in broad terms:

1: It is recommended that all the key partners in Liverpool (including the City Council, Liverpool Clinical Commissioning Group, NHS England (Merseyside), NHS Trusts, Liverpool Health Partners, the Academic Health Science Network, and the voluntary sector) formally sign up to the principle of seeking to create a pioneering, high quality, sustainable Integrated Health and Social Care System for Liverpool, and undertake together to lead, manage, and fund the transformation of the health outcomes of the people of Liverpool.

2: It is recommended that prevention and self-care become the primary focus in the transformation of the health outcomes of the people of Liverpool, and within this a focus on young people and the elderly should be priorities. This will require tackling the social determinants of health and directly engaging the citizens of the city.

3: It is recommended that the system be stimulated by a major new initiative to integrate out of hours services across primary, community, secondary, tertiary, mental health and social care, commissioned by Liverpool Clinical Commissioning Group, NHS England (Merseyside), and Liverpool City Council, and so become a national exemplar.

The further seven recommendations makeup the Commission's 10 Point Integrated Health and Social Care System recommended to the Mayor include Coproducing the Integrated Plan; Developing the Neighbourhood Model; Creating the NHS Workforce for the future; Leadership based on Research and shared Information and; the wider role of the city.

Achieving the vision set out in these recommendations will require strong operational over-sight and support from a number of individuals, organisations, and other sources. The urgency of action cannot be emphasised strongly enough and it is essential that there is oversight and scrutiny of the ten-point implementation plan.

Recommendations

The Commission heard abundant evidence from a wide variety of organisations in Liverpool about the resources, skills, vision, and, above all, the willingness of those organisations to engage in a single, unified plan to transform the health of the people of Liverpool.

Such is the extent of the poor health outcomes of the people of Liverpool, and the relentless drive on budgets and resources, that only a wholesale comprehensive approach to their transformation is likely to succeed.

The Commission's vision is an Integrated Health and Social Care System for Liverpool, with prevention and self-care at its core. To achieve this there is a 10-point plan. The first three are over-arching recommendations that set the vision:

1: It is recommended that all the key partners in Liverpool (including the City Council, Liverpool Clinical Commissioning Group, NHS England (Merseyside), NHS Trusts, Liverpool Health Partners, the Academic Health Science Network, and the voluntary sector) formally sign up to the principle of seeking to create a pioneering, high quality, sustainable Integrated Health and Social Care System for Liverpool, and undertake together to lead, manage, and fund the transformation of the health outcomes of the people of Liverpool.

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Achieving the vision set out in these recommendations will require strong operational over-sight and support from a number of individuals, organisations, and other sources. Therefore the Commission further recommends the following:

Co-producing an Integrated Plan

4: It is recommended that a single unifying strategic plan is developed, based on the City's Joint Strategic Needs Assessment bringing together the local commissioning plans of the Clinical Commissioning Group, the City Council, the Health and Well-being Strategy of the joint Health and Well-being Board, and NHS England (Merseyside).

5: It is recommended that national bodies such as NHS England, Health Education England, Monitor, the Care Quality Commission, the NHS Trust Development Agency, Public Health England, and Health Watch be kept fully informed of the strategic plan, to allow space for the reduction of duplication and unnecessary competition (particularly in secondary care), and for the restructuring of primary, community, secondary, and tertiary services to improve the patient pathway and quality of care. Support from these bodies is critical for the realisation of the strategic plan.

6: It is recommended that locally Liverpool Health Partners and the North West Coast Academic Health Science Network play a key part, through research-based input from the academic community and their links to industry, in helping primary, community, secondary, and tertiary providers to 'act as one' and to work together across traditional boundaries.

Co-producing this integrated plan with wide-ranging partnerships will require:

- Building a coherent joint leadership and management structure founded on an ethos of collaboration;
- Developing integrated provision for health and care in the community;
- Implementing a strong sustained communication and marketing plan to enable the people of Liverpool to understand the scale of the challenge and the role they can play;
- A commitment to the pace and scale required to initiate this transformation as well as to the need for continuing change over a decade;
- Using intelligent and proactive commissioning to prioritise collaboration over competition and to overcome fragmentation, gaps, and silo mentality in health providers;
- Exploring ways of working with the whole system to invest more in budgets for prevention and to free up resources for improving community well-being and resilience;
- Developing pooled budget initiatives and exploring alternative funding models around capitation;
- Targeting early years and pregnancy as investment for the future so that children receive the best start in life; and
- Implementing a family service approach, for example using antenatal care as an opportunity to assess and influence maternal, child and family health.

Developing the Neighbourhood Model

7: It is recommended that a Neighbourhood Model be the key way of implementing the proposed Integrated Liverpool Health and Social Care System.

This will include:

- Building on Liverpool's current primary care Neighbourhood Health Centre structure and network;
- Ensuring that primary care, community health, mental health, secondary care, and public health interventions and resources are aligned wherever possible at neighbourhood level;
- Building into neighbourhoods close links with the social care and voluntary sectors, and local community assets;
- Bringing multiple services to common neighbourhood sites, for example housing, benefits, Citizens' Advice, debt management, etc;
- Working towards true co-terminosity between agencies, for example between the police, the fire service, social care, and community health;
- Linking with schools, adult, and further education, and Sure Start Centres to align with the neighbourhood model approach; and
- Developing and aligning the current range of community health staff (for example health trainers, community health ambassadors, health promotion and social inclusion teams etc) into a more coherent and larger cohort of Community Health workers, based in neighbourhoods and interfacing between clinical staff and the community.

Creating the NHS Workforce for the future

8: It is recommended that the workforce strategy needed to deliver a high quality, integrated 24/7 service, and to transform the health outcomes of the people of Liverpool includes the development of new roles, where needed assisting existing staff to work differently, giving young people access to new opportunities and supports wherever possible the recommendations of the Mayor of Liverpool's Education Commission.

This will include:

- Developing new well-trained generic care practitioners across health and social care, and, working with local Higher Education Institutions, Health Education England (Local Workforce Education Group), and providers of health and social care to develop new qualifications to bridge NHS and Social Services;
- Working with Health Education England, Liverpool City Council, the Local Enterprise Partnership, and the Academic Health Science Network to develop enhanced NHS initiatives for apprenticeships, local employment, and back to work schemes that target people from disadvantaged communities;
- Developing and expanding NHS cadetships and schemes for young people to experience health services particularly in the community, and working with the Healthy Schools' team and the Schools' Parliament to grow a 'Health Champion' role in every secondary school in the city;

- Encouraging the Liverpool Learning Partnership to add 'health' as a crucial component of the Liverpool Local Curriculum, proposed by the Mayor of Liverpool's Education Commission, bringing health and social care role models into schools.

Leadership based on research and shared information

9: It is recommended that the transformation of the health outcomes of the people of Liverpool through the Integrated Health and Social Care System is research and evidence-based.

It is further recommended that priority be given to improved data sharing across the whole of health and social care and to an integrated electronic record, to the benefit of direct patient care, innovation and research.

This will include:

- Encouraging the close collaboration between Liverpool Health Partners, the Academic Health Science Network, the Comprehensive Local Research Network, and the North West Coast Collaboration for Leadership in Applied Health Research and Care to support evidence-based research and evaluation of the Commission's proposals; to oversee translation of research into innovation and action; and to speed up the implementation of proven successful change for the benefit of patients;
- Working with the Academic Health Science Network, the national Technology Strategy Board, the Local Enterprise Partnership, Liverpool Vision, and the Mi(Dallas) initiative, to promote the City Region as a Centre of Excellence for Assisted Living New Technology; and
- Working with the Local Enterprise Partnership, Liverpool Vision, Liverpool Health Partners, and the Academic Health Science Network to position Liverpool as an international centre for the life-sciences, including personalised medicine, pharmaceutical trials, and the exploitation of 'big data'.

The wider role of the City

10: It is recommended that the City of Liverpool and all its organisations commit to the transformation of the health outcomes of the people of Liverpool by tackling the wider determinants of health and facilitating the healthy choices in food, alcohol, smoking, exercise, and transport.

This will include:

Health is Wealth

- Recognising that 'Health is Wealth' and that a healthy city will attract funds, business, and visitors for the benefit of the city, its businesses, and its people;
- Celebrating Liverpool's unique capabilities, a range of high quality institutions, strong partnerships, a tradition of health leadership and innovation, and strong specialist services to achieve the transformation required;
- Inspiring the people of Liverpool to engage wholeheartedly in the transformation, and creating an inclusive, stream-lined and equitable Integrated Health and Social Care System that is understandable and accessible to the whole population; and
- Each organisation validating its activities to ensure it makes the healthy choice, the easy choice.

Corporate citizenship and sustainability

- Ensuring all local employers, including NHS trusts, adopt the Workplace Well-being Charter, developed in Liverpool and now the national NHS standard, and build compliance with this standard into supply-chain contracts;
- Encouraging the NHS and all local organisations to prioritise local procurement in the City, making use of the Public Service (Social Value) Act 2012 with its commitment to the improvement of social, economic, and environmental well-being;
- Supporting the NHS to develop more sustainable transport, energy and natural environment policies, such as the local NHS Carbon Collective and further improvements in cycling facilities; and
- Urging all NHS organisations, along with other major employers, to seek to pay the Living Wage as recommended by the Liverpool Fairness Commission.

Engaging the Community

- Working with the voluntary sector to mobilise community action to bring about sustainable large scale change, including innovative participatory funding for local action, and enhancing partnerships to maximise the effect of the Liverpool pound;
- Building on community engagement through projects such as: the football clubs' community programmes; arts projects (for example the Royal Liverpool Philharmonic Orchestra's 'in harmony'); green environmental projects (for example Natural Choices and Live-ability for the elderly population); and
- Working with the Mayoral Lead Voluntary and Community Sector Champion and key local voluntary sector organisations to increase volunteering in the NHS by developing a new accredited role, recognised by the Mayor, of 'Health Champion' building on initiatives such as the Mi/Dallas champions, the Black and Minority Ethnic Champion network, and the Football Clubs' Champions. For some participants this might be a first step into employment as well as a voluntary role.

Enhancing health promotion; preventing ill health

- Continuing to invest in prevention initiatives around smoking, diet, exercise, drugs, alcohol, and sexual health, and combining these in a more 'joined-up' 'wellness service', to prolong a healthy life as well as prevent premature death;
- Continuing the 2020 Decade of Health and Well-being's innovative Public Mental Health promotion of the New Economic Foundation's 5-ways to Well-being – Connect, Keep Learning, Be Active, Take Notice, Give (CLANG);
- Targeting for extra support the most vulnerable groups and those most at risk through social, economic, or racial disadvantage, and acting with partners on the wider determinants of health to ensure healthy and sustainable places and communities across the whole city;
- Promoting the development of Liverpool-Active City as an international exemplar for mass participation in physical activity, especially for young people and the elderly;
- Liverpool becoming an exemplar city for the reduction of alcohol-related harm by building on partnerships that have developed in this field between the local authority, police, the NHS and employers; and
- Supporting the commitment of the City Council to work across the Liverpool city region to implement the 50 pence minimum unit price for alcohol, as well as using its licensing powers to curb off licences and fast food outlets near schools.

The Way Forward

All of the Commissions' 10 recommendations will require continuing work, monitoring, and evaluation. Some will require Task and Finish Groups, for example in delivering the recommendation to create the NHS workforce for the future; others such as developing the Neighbourhood Model will benefit from a high profile city-wide conference involving all the parties. It is vital that this further work on all recommendations is undertaken urgently.

The Commission acknowledges the valuable role the Mayor of Liverpool has played in convening a regular Health Summit attended by all the key local health and social care organisations, and this has been an important step in encouraging partnership working. It is vital that there is clear leadership in the way forward.

The Commission believes that the future of the city depends on its people, and the Mayor and City Council are well placed to continue to monitor the progress of the various health and social care organisations in the coming months and years. It believes that implementation of these recommendations is urgent and encourages the Mayor to:

- Invite all key partners to sign up to the recommendations the report
- Use it as a springboard for establishing a formal review mechanism for ensuring that action is taken.

1.Overview of Liverpool

1.1
During the coming months and years, the people of Liverpool face considerable challenges to their health and well-being. Some of these are rooted in what are termed the 'social determinants of health'; others are looming, for example, financial pressures linked to a number of factors, increased demand competing with decreased resources. The need for a solution is critical. This report sets out Liverpool's challenges in some depth and proposes a way forward.

1.2
Liverpool is home to 466,415 people living in 206,515 households[1] making it the fifth largest of the eight core cities. 86.2% of the population describes itself as 'white British and Irish' a rate which is higher than the national rate of 81.4%. There is, however, a long-standing Liverpool-born black community, as well as long-standing Chinese and Somali communities (see table 1). Liverpool's population is a relatively young one with a significantly higher proportion than the national average aged 15 to 35 years. The average age in Liverpool in 2011[1] was 35.4 years compared with 38 years in England. However, as in many other parts of the country, the resident population is an aging one with an increasing proportion aged 80-plus years, a section of the population which is forecast to increase by over one third during the next 20 years, bringing the total in this age group to 85,000 (see figure 1).

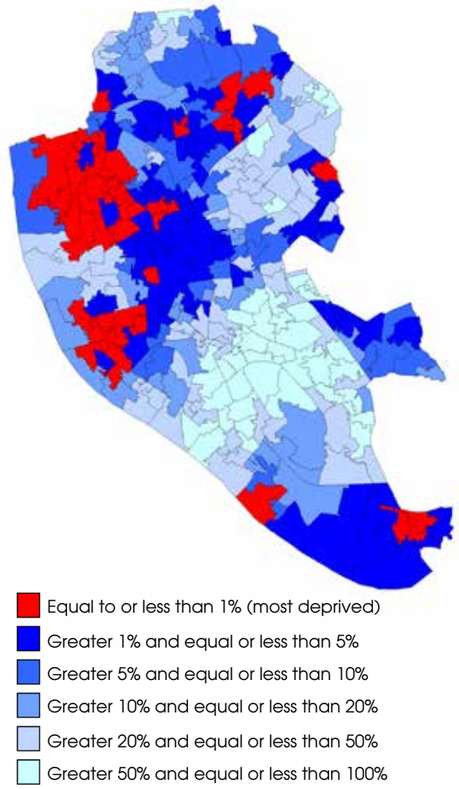
Table 1: Liverpool Population by Ethnic Group

Ethnic Group	Liverpool	England
White • British • Irish • Other	88.9 % 84.8 % 1.4 % 2.6 %	86 % 80.5 % 0.9 % 4.4 %
Mixed/multiple ethnic groups	2.5 %	2.3 %
Asian/Asian British	4.2 %	7.8 %
Black/African/ Caribbean/Black British	2.6 %	3.5 %
Other ethnic group	1.8 %	1.0 %

ONS Census 2011

1.3
The Index of Multiple Deprivation 2010[2] identifies Liverpool as the most deprived local authority in England, with the most severe deprivation concentrated in the north of the City (see map 1): the extent of deprivation is by far the greatest issue facing health in the City. While inequalities in life expectancy between Liverpool and England are decreasing, there remains a significant gap. Within Liverpool, males in the more deprived areas of the City die over 10 years sooner than their counterparts in the most affluent areas; for females the variation is just over 7 years (see figure 2).

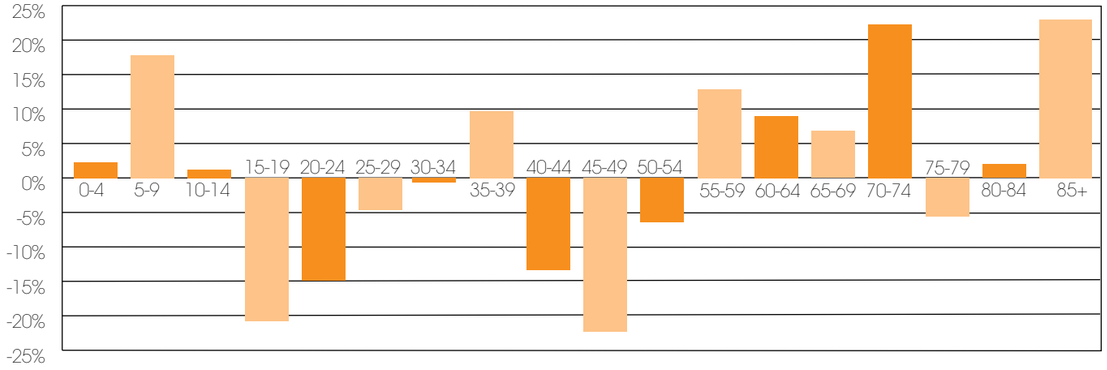
Map 1 Levels of Deprivation in Liverpool



IMD 2012

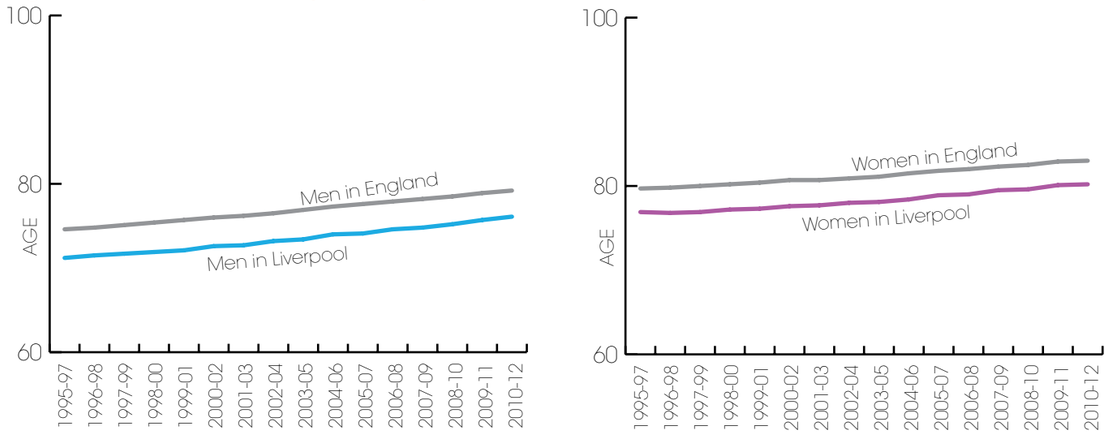
1.4
One in three Liverpool children live in poverty compared with one in five children in England. Figures show that there were around 32,200 (15%) lone parent households at the time of the 2011 Census[1], with 21,200 containing dependent children. This compares to 10.7% nationally[1]. Almost one in three of the

Figure 1:Projected population change in Liverpool between 2012 - 2021



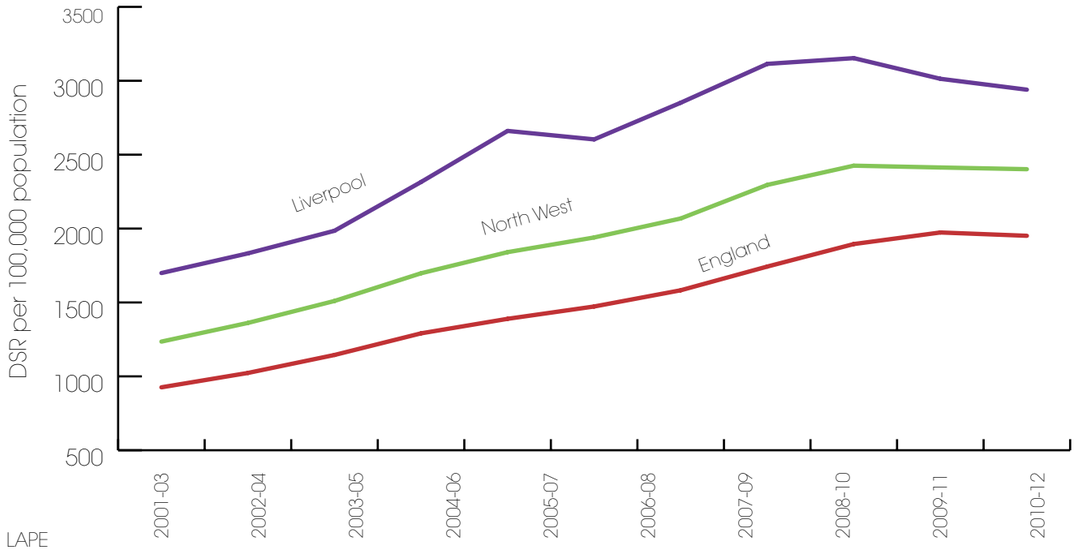
ONS Interim 2011 subnational population projections for England and 2012 MYE's

Figure 2: Trends in Life Expectancy



ONS 2011

Figure 3: Trends in Admission Episodes for Alcohol-related Conditions Directly Standardised Rates per 100,000 population , all ages



LAPE

population experiences poor mental health, compared to around one in six across the North West. Mental illness is associated with reduced life expectancy of between 15 to 20 years[3]
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1.5
The negative impact of alcohol amounts to a burden of expenditure on the City of more than £228 million per year, representing an average spend of £512 for every man, woman and child. For those under 18 years of age in Liverpool, cannabis and alcohol remain the key "problem substances" and evidence from the National Treatment Agency for Substance Abuse[4] suggests that those who use these are doing so more intensively than ever. Specialist services are effective for those that engage with them and help to prevent them from becoming the problem drug and alcohol users of the future. A report from The Centre for Social Justice[5] put Liverpool fifth in a list of local authorities in England for opiate and/or crack use in 2010-11, with 17.42 per 1,000 adults affected.

1.6
Alcohol related harms are increasing in Liverpool despite overall population levels of consumption reducing nationally. Nationally, girls aged 15-16 years report binge drinking and drunkenness more than boys. Binge drinking is also a key factor in teenage pregnancy, another major problem for Liverpool and girls are also more likely than boys to be admitted to hospital for alcohol related harm. Evidence suggests a strong association between heavy episodic binge drinking and violent youth offending. Underage heavy episodic binge-drinking, defined as consuming five or more drinks on one occasion, is associated with a range of negative health and social outcomes including accidents, physical and mental health problems, poor school performance, anti-social behaviour and violence. The National Offending, Crime and Justice Survey found that underage drinkers who drank at least once a week commit a disproportionate number of offences, particularly violent offences[6].

1.7
A report by the UK Department for Children, Schools and Families[7] estimated that approximately 1,245 young people attend hospital emergency departments weekly for alcohol-related treatment, the equivalent of 64,750 visits per year. However, only 6% of emergency departments in the UK offer alcohol harm-reduction interventions to patients aged 16 years or under. The Centre for Social Justice put Liverpool sixth amongst local authorities in England for alcohol-attributable admissions to hospital in 2010-11, with 31.53 per 1,000 adult males admitted[5].

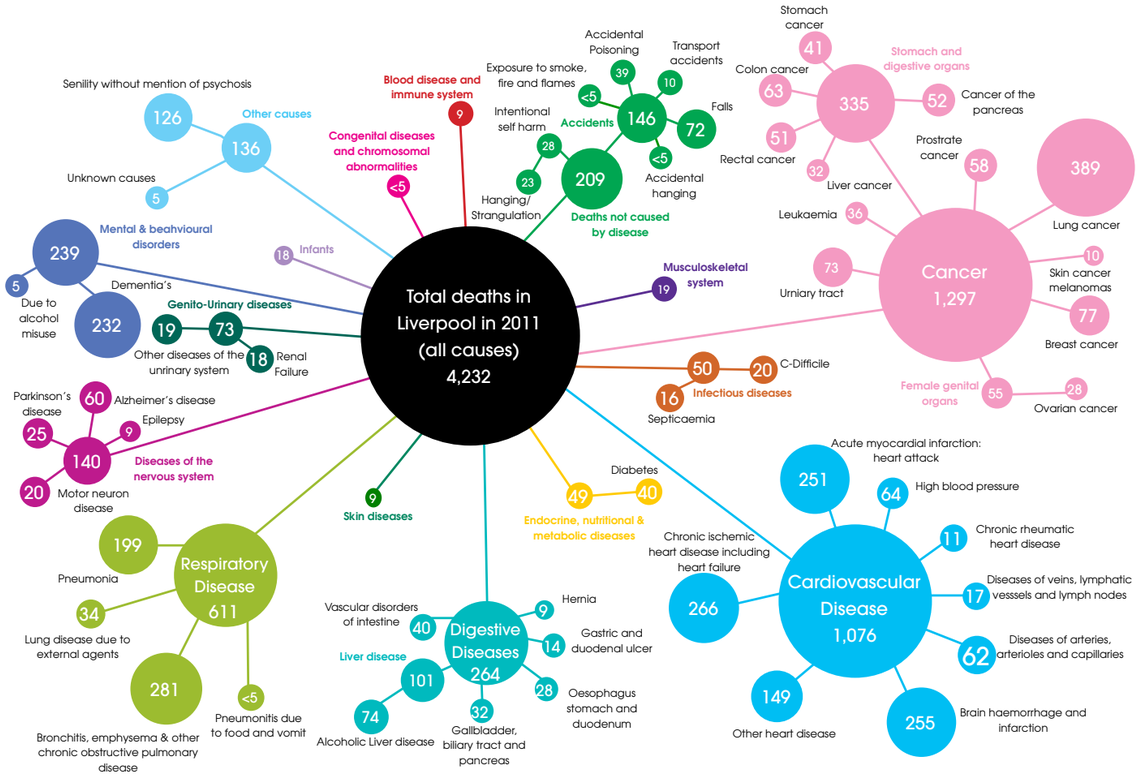
1.8
The incidence of cancers is significantly higher than the national rate and has increased at twice the national rate over the last decade. Approximately 2,500 Liverpool residents are diagnosed with cancer each year, 438 more than would be the case if the local incidence rate equalled the national average. The incidence rate for lung cancer in Liverpool remains at twice the national average.

1.9
Levels of worklessness in the City are well above the national average, with 22% of working age adults claiming out of work benefit compared to 12.5% for Great Britain[1]. Liverpool has the second lowest average household income of the eight core cities. 28% of Liverpool's population are believed to live in a Housing Association property[1].

1.10
Of the 14,000 people using adult social care services during the course of a year, 68% are over the age of 65 years. The most common primary need group is physical disability, followed by mental health, inclusive of dementia. Forecasted trends indicate that by 2030 demand for social care will have increased by more than a fifth, a potential increase of 3,000 service users[8].

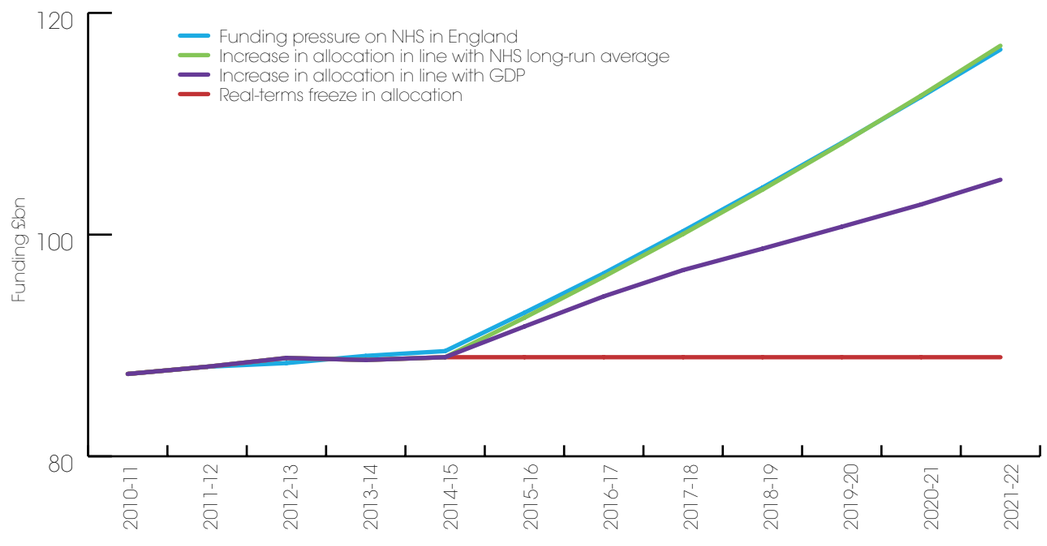
1.11
But along with this there have been improvements. Since 2001 Liverpool has seen the second largest reduction in premature mortality among the eight core cities in England, falling by almost a quarter from 496.6 per 100,000 to 374.9 per 100,000 between 2001 and 2011. There have also been marked improvements in lifestyle. In particular the prevalence of smoking fell from 35% among adults aged 16+ in 2005 to 26% in 2011, and there is some evidence of a levelling off in

Figure 4: Main Causes of Death in Liverpool



Liverpool JSNA 2013

Figure 5: Funding Pressures on NHS Services 2015/16 to 2021/22



Nuffield Trust

alcohol related hospital admissions[8] (See figure 3).
An overview of the main causes of death in Liverpool can be seen in figure 4.

1.12

The City's financial situation also needs consideration. Although health spending was protected in real terms in the 2011–2015 Comprehensive Spending Review, the clear expectation is that, as a consequence of people living longer, many with a limiting health condition, together with increased patient expectation and advances in medical technology, NHS expenditure will continue to increase in the future. This will inevitably give rise to acute financial pressures across the NHS system and demand for further efficiency gains. Whether these are deliverable is debatable, as the efficiency and throughput of the NHS is heavily dependent on those services which wrap around it, including social care.

1.13

Liverpool City Council's controllable resources will be cut by half between 2010 and 2016 as there will be a real terms government grant reduction from 2010/11 to 2016/17 of 50%, with a budget gap of £156 million over the next three years (see table 2). This is against a background of increases of nearly 12% in the number of older people and 8% in the number of children by the end of the current decade. Both of these age groups place significant demands on health and social care support.

Table 2: Liverpool City Council Budget Cuts 2014/2017

Year	Budget Cut (£millions)
2014/15	£45m
2015/16	£63m
2016/17	£48m
Total	**£156m**

1.14

Additionally, the new NHS funding formula is likely to have adverse impact on Liverpool Clinical Commissioning Group's resources in the future. On current, provisional, figures, Liverpool CCG's allocation could be cut by 7% if resources are realigned with targets over time, although this pace of change is likely to be slow.

1.15

The combined impact of NHS resources frozen in real terms and continued increases in demand is demonstrated in Figure 5, compiled by the widely respected Nuffield Trust. This identified a potential shortfall of £28 billion across the NHS by 2021/22, which would, if evenly distributed, result in a funding gap of around £300 million for Liverpool. The analysis assumes that no mitigating actions are taken over this period and is, therefore, theoretical, but it does demonstrate the scale of the challenge facing the NHS in the City.

1.16

Notwithstanding the improvements set out in paragraph 1.11, given the scale of the financial pressures set out above, it is clear that the City faces considerable challenges, many of which the City's Health and Well-being Board is seeking to address through its statement of priorities. The statistics and comparators described above are just a sample of the challenges that the City faces: more information is available within the City's Joint Strategic Needs Assessment. However, it provides a useful backdrop to the work of the Mayoral Commission on Health and illustrates why in 2012 the Mayor announced this important initiative to identify how best to support and improve the health and well-being of the people of Liverpool, giving particular attention to the needs of the elderly and to the potential for targeting the health and well-being of young people. In addition the Mayor asked the Commission to consider the contribution that the NHS can make to the overall enhancement of Liverpool in terms of investment, jobs, research, education and sustainability. Together with aspects of health and well-being, these economic factors represent the 'health and wealth' of Liverpool.

2. The Mayoral Commission on Health

2.1
The Mayoral Commission on Health (the Commission) took place in the middle of some of the biggest changes in the organisation of the NHS since its inception in 1948. These include: the setting up of new Health and Well-being Boards; Clinical Commissioning Groups with their new ways of commissioning health services; and in line with national policy the transfer of responsibility for the City's public health from the NHS to the local authority. At the start of formal Commission evidence gathering, the Primary Healthcare Trust (PCT) ceased to exist and was replaced by the Liverpool Clinical Commissioning Group (CCG), as well as by the other organisations which collectively have taken on the PCT functions.

2.2
This, together with some of the worst health and deprivation statistics in the country, is the context within which the Commission undertook its work. Liverpool is a city with a much higher than national average prevalence for factors known to have a negative impact on health and well-being, set in a landscape of national change and local transition. The organisations which serve the City, and on which it can draw to realise the vision set out in this report, comprise its 'asset-base' and resources. These are described according to their relevance to the work of the Commission in Chapter 3.

2.3
In considering the material put before it, the Commission has identified nine areas for further comment, where the direction of travel to improve the health and well-being of the people of Liverpool should be focussed. These are:

- The people of Liverpool
- Prevention and health promotion
- Integrated care
- Incentives
- Organisations to deliver the plan
- Workforce and skills
- A healthy economy
- Evidence and research
- Technology and health.

Each area is discussed in Chapter 3. A summary of recommendations and the way forward follow in Chapter 5.

2.4
Throughout its work, the Commission was struck by a readiness on the part of all those providing evidence to commit themselves and their organisations to improving the health and well-being of the people of Liverpool. There was universal willingness expressed amongst witnesses to work in partnership with each other to achieve this, and recognition that improved outcomes for patients are more important than organisational needs. The Commission applauds this, but recognises that willingness and commitment alone are not enough. Change on the scale set out in this report will require strong leadership and those taking responsibility will need to act with some urgency.

3. The City of Liverpool's Assets and Resources

3.1
Liverpool as a city has experienced enormous ups and downs in its history. Growing its wealth from the slave trade it developed a Georgian architecture unrivalled outside London and aspired to be the 'Athens of the North'. It became the 'second city of Empire' with the confidence to build St George's Hall, the largest neo-classical building in Europe, and the Three Graces on the Waterfront. Huge wealth co-existed with enormous poverty, deprivation, and ill-health, all of which inspired the appointment of the first director of public health in the country, the visionary Dr Duncan. The City still shows some scars of its key role in World War II. A huge port-based work force was gradually diminished with a new manufacturing base emerging, which itself declined by the 1980s. By the turn of the millennium, after a difficult period marked by inner city riots and a controversial city council, Liverpool started on the road to renewal, with the European Capital of Culture year of 2008, a symbolic turning point in the City's new history which has also seen a new Conference Centre and Arena on Liverpool's stunning waterfront, a major new shopping centre Liverpool ONE, and a totally refurbished Central Library.

3.2
The following paragraphs describe briefly the current Liverpool landscape in terms of the organisations that provide its healthcare (in the City and wider); the services and networks linked to these; and bodies not linked organisationally but which make a major contribution to their wider work. They constitute the assets and resources that Liverpool will be able to draw on to realise the vision set out in this report. Some are new and emerging; others are well established. Together they represent significant capital, human and material, with enormous experience and expertise to improve patient services and outcomes. With their courage, resilience, tenacity and humour, the people of Liverpool are arguably its greatest asset. Their pivotal role in improving the City's health is discussed in Chapter 4.

Map 2: Local Clinical Commissioning Groups

Healthcare

3.3
In Merseyside there are six Clinical Commissioning Groups (map 2); four acute trusts; three specialist trusts; two community trusts; one mental health trust; one children's trust; and 1,050 general practitioners in 248 general practices. Thus the people in the City region have access to a wide range of high quality clinical services, ranging from the 'every day' care provided from general practice to care from facilities with a world-wide reputation for excellence. There has been considerable recent investment in physical assets with new development planned around Aintree, Alder Hey, the Royal Liverpool hospitals and Mersey Care NHS Trust. With the proposed Bio-campus there is potential for the Liverpool City Region to be a world-class centre of excellence in the life sciences and healthcare.

Public health

3.4
Following the Health and Social Care Act 2012[9], Liverpool's public health function now resides with the local authority, the body that is also responsible for the provision of social care services. Public Health in Liverpool has provided a strategic direction for health and well-being for several years and, in spite of revised working arrangements and re-organisation, this remains unchanged and as committed as ever before. The strength of Liverpool's public health function is added to by the academic public health departments at Liverpool and Liverpool John Moores Universities. Public Health in Liverpool is playing a key part in the work of the CCGs, Health and Well-being Boards, and the development of the joint strategic needs assessments referred to in paragraph 3.7.

Clinical Commissioning

3.5
In April 2013, Liverpool NHS PCT ceased to exist and, in line with national policy, was replaced by NHS Liverpool CCG and the other new organisations mentioned below. The contribution made by the PCT to improving the health and well-being of the people of Liverpool is set out in its public health directorate Health Improvement 2002-2013 document[10] which describes the PCT's considerable achievements in reducing health inequalities in Liverpool. This is a remarkable legacy on which the City can now build.

3.6
The NHS White Paper[11] handed over commissioning responsibility on 1 April 2013 to general practitioners through local CCGs and to NHS England. Thus, the newly created Liverpool CCG has assumed responsibility for improving health outcomes for the people of Liverpool, around half a million of them, registered with 95 general practices, grouped in turn into 18 neighbourhoods. The 95 General Practices in the City are all commissioned to deliver the Liverpool General Practice Specification, which sets out standards of care over and above those required in the national contract. Building on the work of the PCT, the CCG has adopted an approach designed 'to secure a sustainable model of care which promotes health and offers value and service quality' and has embarked on a programme of work to achieve the aims of its approach by 2020 aspiring that '(by 2020) health outcomes for people within Liverpool will have improved relative to the rest of England and health inequalities will be narrowed'. Support for the CCG in its commissioning role has been available from the Merseyside and Cheshire Commissioning Support Unit, a body that emerged from the NHS reforms and which is currently hosted by NHS England.

3.7
In addition to these changes, public health responsibility and leadership was moved to local government. Health and Well-being Boards, based in local authorities, are the means of bringing together NHS commissioners and others with the purpose of coordinating the local public health agenda. Under the 2012 Act[9] Local Authorities and CCGs are required to develop 'joint strategic needs assessments' as the basis of a joint health and well-being strategy. In Liverpool this work is well underway and involves many of the partner organisations from which the Commission took evidence.

NHS England (Merseyside)

3.8
Formerly established as the Local Area Team of the NHS Commissioning Board in October 2012, NHS England is an independent body, at arm's length from the government. Its main role is to improve health outcomes for people in England. In this respect, the interests of the people of Liverpool are incorporated into the work of NHS England (Merseyside), which has wider responsibility than for Liverpool alone, but which includes Liverpool CCG and a number of acute, specialist, and community NHS trusts all serving the health needs of the people of Liverpool. Work to address these needs has started in earnest and NHS England (Merseyside) is working with patient, professional and other partners to shape a vision for primary care.

The voluntary sector and independent charities

3.9
The voluntary sector in Liverpool is a vibrant one with more than 2,000 grassroots organisations as well as charitable organisations operating on a regional or national basis. The umbrella body for the non-profit sector in Liverpool is Liverpool Charity and Voluntary Services but informal links exist between several of the voluntary organisations and statutory bodies with arrangements in place between them for the provision of patient and carer support services. Some, for example Health at Work, are specifically focussed on health and well-being; others operate on a small scale and reach out to individuals and communities with practical and personalised solutions to a range of issues that impact negatively on health and well-being.

Partnerships and networks

3.10
Over the recent months some notable partnerships and networks have been established, or are being planned, to further support Liverpool's health and well-being and social care systems. Liverpool Health Partners (LHP) is a strategic partnership creating an Academic Health Science System for the City Region and beyond, delivering excellence in research, healthcare delivery and clinical education, and ultimately translating bio-medical research to direct clinical benefits for patients.

3.11
The Northwest Coast Academic Health Science Network (AHSN), which covers Liverpool, is one of 15 such NHS bodies being established nationally. Their function is to spread innovation at 'scale and pace' which means the implementation of new treatments or health technologies, or the application of existing treatments and technologies in new ways.

3.12
The Northwest Coast Collaboration for Leadership in Applied Health Research and Care (CLAHRC) has been established recently with a £9.5 million grant from the Department of Health. Although extending beyond Liverpool the work of the CLAHRC is focussed on health inequalities, which is particularly relevant for the city. The CLAHRC will deliver innovative applied health research to improve the quality of care, focussing on chronic disease and public health, linked to implementation. It is hosted by the Liverpool CCG and interfaces directly with the AHSN and LHP.

3.13
The Comprehensive Local Research Network has a mandate to deliver Department of Health National Institute of Clinical Research approved research into 25 NHS trusts within the Cheshire and Merseyside area. In the coming year the area will enlarge to bring in South Cumbria and Lancashire and will be hosted by the Royal Liverpool Hospital. The network has a strong record in recruitment to and delivery of major trials that shape healthcare and outcomes. The role of the network is expected to evolve with a greater emphasis on patient and public

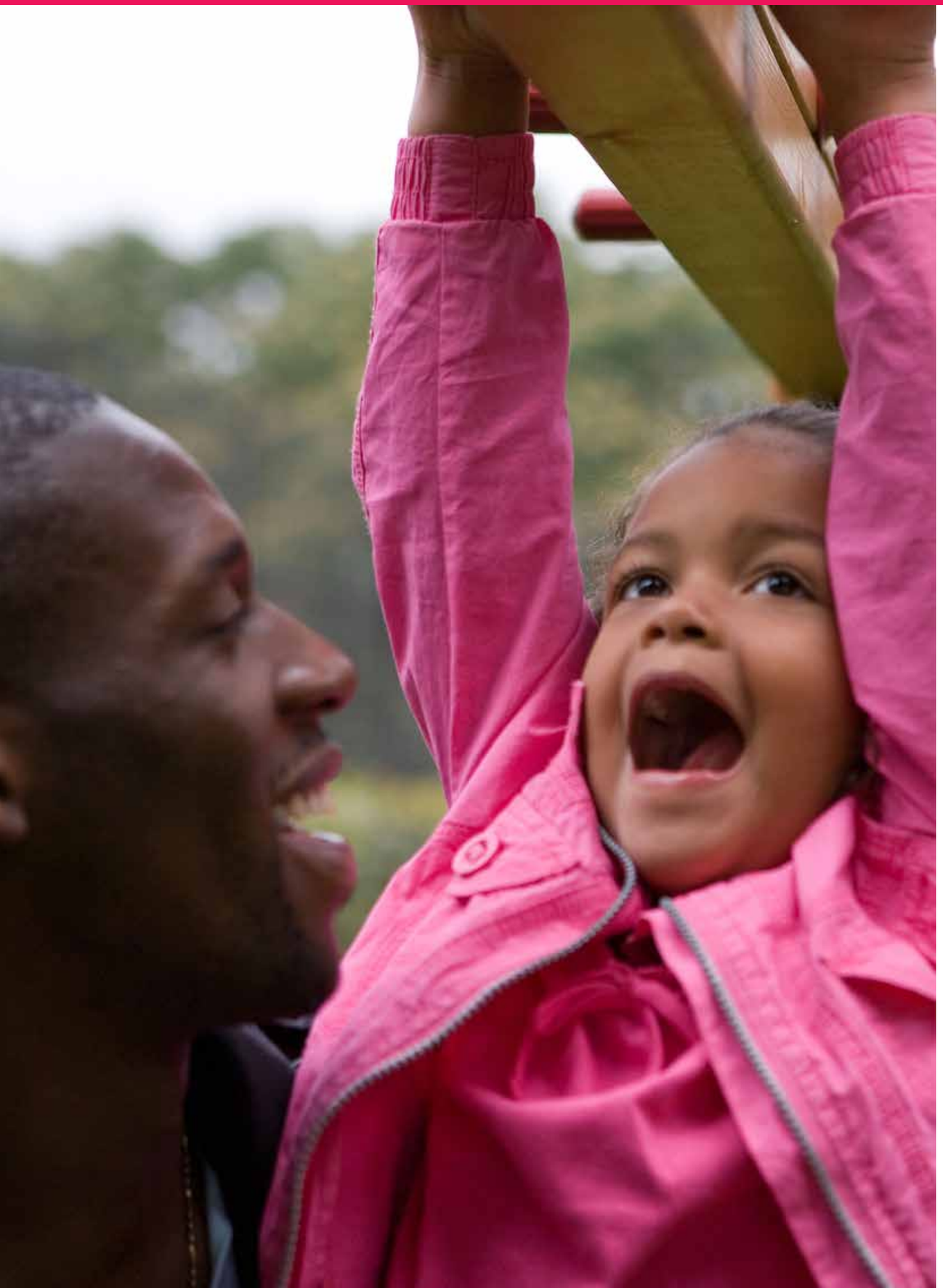
engagement in research, liaison with health commissioners, and closer working to build research capacity within the geographical footprint.

3.14
The Liverpool and Sefton Health Partnership, the Local Improvement Finance Trust (LIFT) for Liverpool and Sefton, was formed in 2004. LIFT is a government initiative designed to assist in the delivery of improved primary and community health infrastructure. In Liverpool this has been particularly successful and Liverpool is regarded as one of the major success stories nationally. There are now 18 neighbourhood health centres across Liverpool, 12 of them new builds, delivering a range of services close to people's homes, with capacity to extend its influence in terms of the facilities and the innovative solutions they can accommodate.

Education and training

3.15
The quality of staff charged with delivering health and well-being and social care to the people of Liverpool will be critical to the success of any health improvement plan. Developing the strategy needed to deliver the workforce to support the NHS in the future and to commission the education and training of staff locally is the responsibility of the Cheshire and Merseyside Local Workforce and Education Group (LWEG) which is part of Health Education Northwest (the largest Local Education and Training Board (LETB) in the country). The remit of LWEG includes doctors in training, student nurses, midwives, allied health professionals, healthcare scientists and unregistered workforce including apprenticeships. The Cheshire and Merseyside LWEG is made up of representatives at board level of all the providers of healthcare as well as local universities, primary care and public health.

3.16
Although not all the health and social care workforce will be 'home grown', Liverpool City Region's universities provide first class education and training opportunities in health and social care that put the City in an excellent position to populate its health and social care system with locally educated talent.



4. Findings

A common agenda

4.1
There was clear recognition by all witnesses of the urgent need to address and transform the health of the people of Liverpool. Some witnesses emphasised that not taking major action to improve health would, inescapably, guarantee ever-increasing demands on health services that simply could not be met within a context of declining resources and increasing costs.

4.2
This recognition was matched by an equally strong willingness among all witnesses to commit their organisations to work in partnership for the common cause and a shared vision to transform the health of the people of Liverpool, even though they understood this might mean gains and losses for each of them. Despite those consequences they were willing to unite on a common agenda including playing their part in defining the vision and subsequently implementing it.

4.3
Witnesses saw clearly the part the health community in Liverpool could play in creating not only a healthier population, but also adding value to the overall health and wealth of the Liverpool economy.

What the vision needs to be

4.4
The challenge of transforming the health of the people of Liverpool is enormous. Witnesses repeatedly noted that the vision and actions would need to be radical, broad-reaching and comprehensive. Tinkering with parts of the system will not achieve the magnitude of change required.

4.5
The vision must put people and patients at its heart and be informed by and respond to their expressed needs. The focus of the vision needs to be on service user benefit rather than on service reconfiguration for the sake of it. Resources need to be managed around the patient rather than managed round the budgets of each participating organisation.

4.6
It was abundantly clear that health and well-being are dependent on a wide range of factors outside the direct remit of the NHS including housing, debt, education, social care, lifestyle options, the environment, proliferation of fast food outlets, bicycle tracks, city infrastructure etc. Further information about the social determinants of health can be found in Professor Sir Michael Marmot's report on health inequalities in England [12].

4.7
Transforming the health of the people of Liverpool necessitates the broadest possible approach that includes the whole range of relevant agencies and services whose contribution to the well-being of the citizen may at times outweigh any direct contribution from a healthcare provider. This could involve making housing and employment advice, and debt counselling available at sites where primary healthcare services are also delivered. It could involve a City-wide approach to countering the harm caused by smoking, obesity and alcohol misuse, delivering public health messages in a consistent, coordinated and imaginative way to every individual. It was clear that solutions may at times be more non-clinical than clinical. The Commission heard of many local innovative examples to tackle the underlying determinants of ill health such as the Healthy Homes programme, the Liveability Active Aging project and the Natural Choices environmental programme, as well as many city-wide health campaigns.

4.8
Across the whole of Liverpool and in all circumstances, the 'healthy choice has to become the easiest choice'.

4.9
This, in turn, necessitates an unprecedented degree of integration, common agenda, shared vision and shared planning between the wealth of agencies involved in all aspects of a person's life. Services must be designed around the needs of patients rather than around existing systems. Today there are a large number of independent organisations

each having to deliver against their own challenges. Throughout the evidence sessions, the Commission heard the acknowledgement by NHS trust leaders that more collaboration, more specialisation, and a better division of labour, were essential to make the best use of diminishing resources; to improve quality and outcomes; to avoid duplication; and to fill gaps in provision.

4.10
The Commission heard that there have been successes in collaborative work including under the Quality Innovation Productivity and Prevention Framework[13]. These have included the consolidation of maternity services and breast surgery; concentration of vascular and upper gastro-intestinal care; plans to relocate some of the Clatterbridge cancer service to a city-centre site adjacent to the new Royal Liverpool Hospital; coordination of trauma services; and the concentration of rehabilitation services.

4.11
Given the scale of the challenge, the vision must be long term, perhaps a minimum of ten years, as some of the changes will take that long to deliver their benefits. But long term does not mean slow. The vision and its implementation plan need to proceed at a rapid pace. There is an imperative to move quickly with financial pressures looming, the need to improve quality of care, an aging population, the continuing escalation of healthcare costs, and the demand for a 24/7 NHS.

4.12
The barrier is not the inability of organisations to take a longer term perspective, nor a lack of leaders who are capable of doing this. But current, largely financial, pressures force them to take decisions based on short term priorities. The truth is that individual players recognise the benefit of closer working, acknowledge its power, but to date no truly far-reaching and practical method has been found to achieve this for Liverpool. It should be noted also that many of the barriers are imposed externally through national organisations such as Monitor, the Care Quality Commission (CQC) and NHS England where structures and systems have created these unintended barriers for Liverpool. Central support will be required to overcome these barriers.

4.13
The vision will need creativity and a willingness to take risks. There is no pre-existing blueprint.

4.14
Making these changes requires the building of trust between partners and will require strong leadership. This means leaders who are supported and who have sufficient authority to implement change where this is needed: and who protect participating organisations from duties, responsibilities, and expectations laid down by national bodies, where these factors constrain and inhibit local change. The whole system needs to think about how this will be achieved and 'it may not necessarily rest in one place; it might be a collection of champions and leaders who together are recognised as the leadership'.

4.15
The scale of the problem is so immense that all of Liverpool's agencies and organisations cannot transform Liverpool's health by themselves. The people of Liverpool must be encouraged and facilitated to aspire to a healthier life, therefore, the vision must inspire the people of Liverpool to believe that they can achieve better health through their own actions with support from the broad range of services available on a city-wide basis.

4.16
Creating the right kind of culture, the right kind of ethos, and the desire to make things happen; to engage all people in that process, is the most sustainable agent of change. Sometimes structural change actually inhibits progress.

4.17
In order to bring about change, all parties involved in this will need an environment where conversations, which may at times be difficult, can take place to create a common vision; where decisions can be made and where actions can be taken forward, creating a sense of inclusivity between participants.

4.18
Building on the previous work of the PCT and in partnership with the City Council and on the new Healthy Liverpool programme currently being developed by the Liverpool CCG, the City needs to develop a unified approach to the development and provision of a collaborative and coordinated plan to transform the health of the people of Liverpool that:

- Is committed, radical, comprehensive, creative, sustainable, and long term;
- Engages every individual in Liverpool;
- Puts patient needs and quality services at its heart and is informed by and responds to patient and public expressed needs;
- Facilitates a cultural change to health and healthcare;
- Is underpinned by a comprehensive communications plan;
- Draws on combined expertise and experience from all across the City;
- Builds on partnerships, and encourages collaboration between stakeholders;
- Develops new models of care, integrating the diversity and multiplicity of existing services and taking account of the need to rationalise some services where there is duplication;
- Has a coordinated campaigning approach;
- Speaks with one voice to deliver consistent messages;
- Develops a commonality of protocols and procedures which will have an impact on procurement, incentives and aspects of sustainability; and
- Recognises and exploits research potential.

4.19
One witness spoke about civic pride and civic responsibility; building a compelling vision for Liverpool around the creation and maintenance of good health.

'I would like to enable Liverpool to be seen as a beacon for best practice so that other people could come to Liverpool and see how we have done it. To see how we have created an environment where people can live healthier for longer.'
That may well be the vision.

The factors

Engaging the people of Liverpool

4.20
The people of Liverpool need to be involved in acquiring for themselves a clearer understanding about how to use more effectively the services that impact on their health and well-being. They also need support to access these services more easily, and on a 24/7 basis.

4.21
Therefore, if the people of Liverpool are to be engaged then their voices must be heard so that services are designed and delivered around patient and public needs and priorities; and, importantly, they must become active participants in improving health outcomes.

4.22
Big organisations tend to consult about what they have already decided. 'We have got a strong view that some of these things fail because we approach them from a professional's view and we think we know what is right'.

4.23
The Commission heard that it is unlikely that an individual will make an investment in their health unless they themselves have an investment in society. Therefore, the vision needs to find ways of tapping into people's sense of belonging in order to support them to lead healthier lives. Factors which will assist this and which will likely lead to a reduced demand for statutory services, include education and employment opportunities, debt counselling, safe and warm housing, access to a green environment, digital inclusion and an improved financial base. Thus one of the solutions to improving health and well-being in Liverpool will be to invest more in community life and local institutions; to enhance a sense of connection to society amongst its citizens, and to look for the 'reasons behind the reasons' when things break down.

4.24
Wherever possible services need to address the 'reasons behind the reasons' for poor health choices, be they poverty, unemployment, housing problems, debt, domestic violence, alcoholism etc. in a deliberate, systematic way to remove as many barriers as possible to people making healthy choices.

4.25
Any plan needs to encourage a personal investment in a healthier lifestyle to effect a

cultural change to health and well-being. This involves an 'asset-based' approach where people are seen 'for the things they can do and are looked at in the round, rather than a deficit approach that looks at the things people cannot do and sees them as a series of conditions or problems'. This would involve a whole-system approach where social inclusion, education, leisure, finance, housing and the environment are considered in one piece. It also means creating a new language whereby health and well-being are described in terms and using levers that have meaning for the individual.

4.26
Such an approach is a radical one requiring vision and leadership. It will necessitate a clear, compelling and consistent set of messages across all Liverpool agencies. The media, housing advisers, debt counsellors, mental health professionals, social workers, arts organisations, football clubs, supermarkets, restaurants, firemen, teachers, policemen, community champions and next door neighbours must all say the same things as each other about smoking, alcohol and exercise etc. and imperatively the same things as the NHS. This must be a Liverpool-wide campaign building on the previous city-wide campaigns and partnerships such as Smokefree Liverpool[14]; Lose a Million Pounds, Liverpool's Challenge[15]; and the current 2020 Decade of Health and Well-being[16]. These campaigns have already built a culture of collaboration involving a wide breadth of agencies working with the NHS on health improvement programmes and projects – as the Commission witnessed from a range of organisations involving the arts, the environment, housing, fire service, police, education, sports, the voluntary sector and business. For those in employment, the workplace itself is an ideal place to promote health and well-being messages.

4.27
The approach needs to include all the relevant topics around managing expectations, managing demand, self-empowerment, self-care, self-reliance, managing one's own well-being, supporting others, taking preventive actions and seeking services appropriately, underpinned by the clear commitment from Liverpool's leaders to do everything within their power in support through services designed to meet people's expressed needs that are well-publicised and easy to access on a 24/7 basis. Such an approach needs to recognise the real barriers faced by many sections of the population living in acute poverty in Liverpool and facing increased hardship as a result of local authority cut-backs, benefits reduction, and limited job opportunities.

Prevention and Health Promotion

4.28
Several witnesses felt that acute services were prioritised over prevention. They sought equal priority between prevention, cure and care.

4.29
Whilst the pressures and problems of the NHS are widely articulated, they tend to focus on institutions rather than on the communities they serve. The focus must be on the person, with well-planned and well-articulated health promotion activities at its heart, supporting networks of social capital with health and well-being services supporting and intervening as required.

4.30
The Commission heard a proposal that investing in prevention should become an incentive for secondary care, which would inevitably mean looking at a whole system, whole population approach.

4.31
It was put to the Commission that such a focus could reduce demand on acute services where in the opinion of one witness fragmentation may have resulted in over-investment. The Commission recognised that there needs to be a shift in funding away from the 'clinical treatment of the problem' to 'prevention' but appreciated that this would be challenging when the urgency of illness take precedence.

4.32
The Commission heard that a shift of resources into prevention may allow individuals to lead longer, healthier, lives, but may not necessarily be cost-effective when the inevitable end-of-life co-morbidities and dependencies are factored in. However, an effective strategy of prevention may reduce these co-morbidities and costs, and this remains an active debate. Certainly managed care organisations in the USA such as Kaiser Permanente predict savings from active intervention.

4.33
In support of a coordinated approach, the Commission heard persuasive arguments about the potential power of engaging the public at large, not just patients, in health-promoting behaviour, recognising that messages about health and well-being should be delivered across the board and not just to those with defined health need. Such an approach would facilitate a move away from a reactive model of health and healthcare to a more proactive one, employing devices such as 'risk profiling' and 'risk stratification' that would enable more appropriate targeting of interventions and advice. Those classified 'low risk' would receive health information and messages that 'would allow the right choices to be made as easily as possible'; those at higher risk would receive bespoke messages and would be engaged more directly in a programme of self-care.

4.34
The Commission heard conflicting views on how active health service staff themselves should be as promoters of good health and providers of health advice. On one hand it is perhaps unreasonable to expect someone who works long hours in the system to then continue this work informally when off duty. On the other hand health service staff in particular should be exemplars of a health-promoting life style. Where responsibility begins and ends is unclear, but what is certain is that unless a person fully embraces concepts of good health and how to obtain and retain it they are unlikely to be effective ambassadors in any context. Certainly NHS employers have a responsibility to invest in the health of their staff, such as participating in the Workplace Well-being Charter (of which 392 organisations in Liverpool are accredited, including some NHS trusts, with a further 125 in the pipe-line for March 2014) or the Health Promoting Hospital initiative, and supporting events such as the North West NHS Games.

4.35
There are already examples in Liverpool of community health staff acting as a link between clinicians and community, including health promotion staff, the social inclusion team, health trainers, and community health ambassadors. The Commission heard support for these initiatives along with the suggestion that these needed to be on a larger scale, better coordinated, and organised more systematically and intensively on a neighbourhood basis (for example, currently there are 20 Health Trainers and four Community Health Ambassador Teams for the whole of Liverpool).

Integrated care

4.36
There was unanimous agreement among witnesses of the need for integrated care. This was seen to be better for patients and more cost-effective for the 'system' through reducing duplication of resources and multiple attendances by patients at different agencies for overlapping problems. According to one witness integrated care is a 'person-centred planning approach'. That does not necessarily mean bringing together people in one organisation, but does mean that the orientation of service provision is biased to the user. Another witness stated, 'integrated care should have the same leadership/management and deliver from the same budget pool'.

4.37
As is recognised nationally, integration of 'health' and 'social services' was regarded by many witnesses as a priority. Because the challenge to transform the health of the people of Liverpool is immense, no available relevant resource should be left unused. The Commission heard that integration also means bringing in resources from other key players such as education, police, fire, ambulance, the arts organisations, the environmental sector, the social housing sector, and critically the voluntary sector.

4.38
Witnesses recommended that there should be a strong emphasis on the way in which education can be used to improve life chances and through this to improve health. The Commission heard of Liverpool's strong Healthy Schools programme, and the Mayor of Liverpool's

Education Commission provides further opportunities for linking health to the proposed Liverpool Local Curriculum.

4.39
The Commission believes that the voluntary sector should have a much greater recognition for the importance of its role in the co-ordination and delivery of services to service users than is currently the case. The effectiveness of the work carried out by the voluntary sector comes about through generating trust and spotting need at individual and at neighbourhood level and then brokering simple, flexible solutions.

4.40
Witnesses set out a range of initiatives, some with a recognisable focus on health and well-being (walking and cycling schemes), but many where opportunities present themselves in the course of their routine work (the work of fire prevention officers) that could be used to add value to population health and well-being. Although many of the activities discussed did not come with a label 'health improvement' on them, it was clear that these diverse initiatives contribute hugely to population health and well-being, most particularly through community engagement, empowering, and confidence building and should clearly be recognised and included in integrated care.

4.41
The Fire Service was emphatic that they walked through more front doors than any other agency in Liverpool, and knew from their own records which houses contained the frail and vulnerable, because they had to know this when prioritising actions in the event of fire or flood. Given the magnitude of the task of transforming Liverpool's health all available resources should be considered. There exist already some strong initiatives to build on such as the nationally acclaimed Healthy Homes programme, which has reduced the number of winter deaths in the city.

4.42
Key organisations in Liverpool would need to work together and take responsibility for setting the agenda, building on existing good practice, for example the already-established network of 'health champions', and revitalised NHS estates. Relationships would need to be formed that worked across organisational and geographical borders with participants 'behaving as they would if they were one organisation'. In addition a method of information sharing would need to be found 'without it being an issue'.

4.43
Integrated care will require a breakdown of the silo mentality, the root of which is the separateness of organisations. Professional boundaries need to become much more flexible and professional protectionism needs to be surrendered so that the 'end-user' is the key focus of care.

4.44

Witnesses spoke about ways to rationalise existing services including identifying what is duplicated; about organisations being very open about what is working and what is not and gaining a level of agreement on what should sit where. One witness stated ***'I do not think there is enough collaboration and too much duplication from what I see, too much competition that I do not think is particularly healthy'.*** Another ***'I would not start from a position of 'let us reorganise the trusts in the city'. I would seek to use levers that enable organisations to be more aligned with integrated care and whatever the consequence of that is comes as a result of the reorganised care, of health and social care coming together across primary, secondary and tertiary care'.***

4.45
However, it was acknowledged that there were huge practical difficulties in aligning services in the city; in particular the requirement for financial stability among individual foundation trusts, and the degree of central control imposed on them by the regulator organisation Monitor, and by the CQC.

4.46
One witness spoke of the need for a much more joined up approach with a single agency having ownership of the whole patient pathway including: preventing patients coming into hospital; treating them appropriately when they are in hospital; and discharging them quickly back home. Others spoke of the need to think through the pathway of patients on discharge to include follow-up as locally as possible. The Commission believes that in some parts of the country this is happening already[17].

4.47
Liverpool already has pilots for delivering care closer to home, thereby empowering patients to be more involved in their follow up. These pilots are seeking to work out the most effective and cost-effective way to deliver care. Thus new models need to allow services to be delivered in ways that are not constrained by hospital structures in the way in which care is delivered.

4.48
All witnesses recognised that integrated care necessitated a re-orientation of funding mechanisms. One of the inhibitors to health and social care integration is the way in which these services are currently funded, which is independently, whilst simultaneously organisations are expected to provide a streamlined service. One of the solutions to this put to the Commission was to adopt a population-approach to service commissioning. The Commission heard that certainly, in financial terms, lack of integration could result in trade-offs between systems, placing them in opposition rather than collaboration.

4.49
Further challenges to integration were seen as:

- No existing forum where all the key players come together;
- No clear 'lead' agency to take overall responsibility for strategy and delivery;
- The need for some partners to relinquish roles and responsibilities in some contexts;
- The current lack of co-terminosity of organisational boundaries; and
- The risk that reducing the number of agency contacts for the individual may increase social isolation and possibly remove valued contact.

4.50
Another significant barrier to integration is the lack of common IT systems and data protection protocols. These are addressed below under Technology.

Incentives

4.51
There are currently several incentives for health and other services that run counter to the shared vision of integrated care for Liverpool.

4.52
One of the paradoxes with the new Health and Social Care Act[9] is that it is setting up perverse incentives for organisations to deliver services in a certain way by virtue of the fact that they are a foundation trust and they must, therefore, ensure and protect their income. The Commission recognises that organisations have obligations placed on them that are required to ensure their sustainability. However, it would be preferable if organisations could be incentivised around holistic and integrated care.

4.53

One witness stated `***The way that we are regulated, the performance targets, the statutory duties that we have, often work against our real wishes and desires for developing and changing healthcare and somewhere we have to create the room and the space to have safe conversations where leaders in the system can leave their baggage behind and actually talk together in a trusting environment about how do we get from A to B'.*** Another said ***'…. and the strengths are really just about recognising where we and the other partners bring added value and then bringing those services together'.***

4.54

Another witness stated, ***'It is also about making sure that we move away from our traditional way of counting value in health. The contract that we have is a block contract with elements of it depending on quality outcomes, things like returning people to work after a myocardial infarction within a set period of time. That framework has really sparked interest, motivation, and alignment amongst our social care colleagues. They can see how they can make a difference when they are not encumbered by activity count or income going to separate organisations; there is a commonality that is happening around the patient'***.

4.55
In addition to meeting the demands of local commissioners, many organisations must also meet the demands of national organisations. For example, for foundation trusts this includes Monitor for whom the trusts have things they must do to 'keep them off our backs'. Thus national priorities may conflict with local needs. Witnesses noted that, if there were a plan in Liverpool that was robust enough, it would allow organisations to be freed from some of the imposed perverse external incentives.

4.56
An integral part of realigning these perverse incentives would be intelligent and intuitive commissioning. Currently organisations have different incentives and priorities. There need to be clear commissioning intentions that are patient-focussed and service-focussed. At some point organisational form will follow function.

4.57

Witnesses stated that they would be prepared to work to create a vision and a 'business case' not only to align the different boards of the statutory organisations but also to take the vision to Monitor, the CQC, and NHS England, and to the NHS Trust Development Agency. They noted that sometimes problems come via the regulators and the obligation imposed on them by these bodies to meet externally imposed targets. However, there would be no actual bar to presenting the regulators with a clearly articulated strategy for planned change, one that acts in the best interests of patients. ***'You should not worry about Monitor if we are all working together'***.

4.58
Procurement deserves a special mention. Witnesses felt that procurement could be used to better effect. Historically NHS managers went through competitive tendering which often resulted in services being sent out of the area, including abroad. While there may be short-term financial gains to an organisation for procuring from outside the area, local procurement ensures that the investment stays in the city and supports the local population.

4.59

From the perspective of the voluntary sector a bias towards purchasing 'NHS branded' services disadvantages smaller local organisations. In the opinion of the sector, procurement is not weighted enough to local services and some mechanism needs to be found that legitimately biases procurement to local agencies. Smaller, local providers are more likely to have a long-term commitment to an area. One witnesses stated ***'In terms of procurement wherever possible we try to procure locally to keep the money local'*** indicating it can be done. The Carbon Collective of Merseyside NHS Trusts has done some useful work on energy efficiency, the 'Simple Actions' project. It was pointed out that the new Public Services (Social Value) Act 2012[18] is a mechanism that can be used to encourage procurement for local social benefit.

4.60
A witness with extensive procurement experience noted that the NHS in the North West does not have the building blocks in place to run efficient procurement, including helpful electronic systems. It was stated that the NHS performance and standard order systems are archaic compared to that of business. NHS North West procurement is putting in place a system to develop their procurement staff to a standard where they are 'professionals' and not just 'supplies officers'. It is also developing collaborative procurement approaches to get clinicians to sign up to the same products, the same approach, and to a level of standardisation.

Organisations to deliver the plan

4.61
Liverpool has a rich set of assets at its disposal to meet the challenge of transforming the health of the people of Liverpool. These have been outlined in Section 4.

4.62
Services, whether commissioned by health, social services or other bodies, or jointly in support of integrated care, will inevitably have clearly defined remits, deliverables and measures. But their clear remits also limit their flexibility and responsiveness to changing and evolving needs and challenges. By contrast the voluntary sector can be 'messy, disorganised and fluid' yet is extremely effective and outstanding value for money. The strength and effectiveness of Liverpool's voluntary sector rests in part on its ability to take an holistic approach to the needs of the community it serves. The commission heard compelling evidence that tackling a health issue in isolation when there are multiple problems affecting a troubled individual or family is likely to be ineffective. Only by attending to the person in the round can progress be made towards better health and improved well-being.

4.63
Paradoxically the strength of the voluntary sector is also its weakness. It is strong because it gets to the heart of the matter at a local level, is flexible and can respond quickly, it brings diversity and can 'think differently'. It is weak because it is ill-defined, exists on a financially precarious basis and is dependent on loose connections. However, it is described as 'the warp and weft of society' and because it is seen as independent of local and national government is often trusted more than statutory provision.

4.64
The Commission heard that the voluntary organisations wish to enter into equal partnership with health and social services, and with other statutory providers. However, seeking to systematise such an amorphous and informal, but functionally effective, sector excessively could lead to a considerable weakening of its effectiveness on the ground. The success of many voluntary organisations is often contingent on the efforts and commitment of a very small group of people, even of a single person. This enables bespoke solutions to unique problems, which, because of their relevance to the individual, engenders trust between 'recipient' and 'provider'. Voluntary organisations are able to apply a sensitivity and insight in a way that statutory organisations are sometimes unable to achieve. Voluntary organisations can play a vital role in developing further the voluntary health champion role that has been spreading across the city, including black and minority ethnic champions, Everton and Liverpool Football Club champions, and the 150 champions associated with the Mi/Dallas project working particularly, but not exclusively, with the elderly population.

4.65
One of the key enablers of the effectiveness of the voluntary sector is that it functions locally, fully integrated with the local community. Witnesses spoke of replicating this effectiveness for the statutory services – a neighbourhood model – where the skills and experience of a number of partners join together within a locality to improve health and well-being.

4.66
The advantages of adopting such a model include:

- Existing, well-recognised and trusted roles;
- Considerable experience;
- A shared desire for improvement; and
- Diverse and innovative approaches to identifying and tackling 'problems'.

4.67
Adopting a neighbourhood model would need to find a way to combine the best of what each individual organisation would contribute – without losing individual identity and the power inherent in their separateness. This could involve making services such as housing, employment advice, debt counselling, and social care, and some secondary health services and health improvement interventions, all available at sites where primary healthcare services are delivered, making it possible for the user to combine access to all these services at one time rather than making several visits.

4.68
Aligning boundaries, social services, health, police, fire, education etc. would be a valuable enabler. Moving financial resources from commissioned services to the voluntary sector could increase the reach of the voluntary sector but impose challenges of accountability and performance monitoring.

Work force/skills

4.69
Delivering the Commission's aim of transforming the health of the people of Liverpool will require action by trainers, educators, employers, research organisations, community activists, and service commissioners to ensure that the health and well-being workforce is fit for purpose: it will also need to use all the human,

structural, and networked resources available in the City to bring this about.

4.70
There was recognition by all witnesses of the necessity for integrated care as a cornerstone of future health services in Liverpool. Therefore, finding the right level of skill and knowledge to work effectively within integrated care is critical.

4.71
One of the approaches brought to the Commission was the integration of aspects of health and social work training into one qualification. The positives of this are clear, if care is to be provided in an integrated fashion then the skills of the person providing that care need also to be integrated. Such integration might be a way of getting around the problem identified to the Commission of recognising when to call an ambulance to, for example, a care home; having enough health and social care knowledge combined to take appropriate action. On the other hand how much knowledge is 'enough' and can the qualities required be compressed into a three-year training course? Diversification clearly enables more flexibility within the system, but this needs to be quality controlled. Progression within a chosen field is also vital. The Commission heard that, currently, it is not possible to progress social work training on a part-time basis in Liverpool, and this is a pity.

4.72
NHS apprenticeships and cadets already exist in Liverpool: there were just under 600 apprentices and cadets across Cheshire and Merseyside for the period 2010-2013, with over half of those in Liverpool. Entrants are trained to work across a variety of clinical and non-clinical settings, and the Commission heard that these roles could be enhanced still further to help increase employment opportunities for more disadvantaged sections of the population and to open up a ladder of progression within the NHS, as well as providing additional community-based staff to help navigate the interface between NHS clinicians and the population of Liverpool. For the registered professions training across disciplines is more difficult because curricula are set by the regulators of each profession.

4.73
The Commission heard that a great deal can be done through continuing professional development to take, for example, people who were trained as hospital nurses and give them additional skills, or give them skills which are more orientated towards fostering and maintaining the independence of the 'user'. One example given to the Commission was work with paediatric nurses with mainly hospital experience who were given experience in community paediatric care. It was pointed out that a single visit from a support worker with generic skills will be more efficient and cost-effective than visits from multiple agencies. However, it should be recognised that elderly and isolated people might value the increased contact from apparent duplication of visits.

4.74
It was recognised, that whatever happens about workforce training and development, it has to be done through partnerships. It has to remove disciplinary and professional boundaries; the focus must be on the person receiving care and who needs support, not on organisational structures, or on 'professional' demarcation.

4.75
Evidence from the Cheshire and Merseyside LWEG stated that it is engaged in cross-organisational work force planning where different organisations get together around a particular care pathway and do not rely on single silo plans. This is important in moving away from organisational work force plans to health economy work force planning.

4.76
One witness noted that in the past much workforce development has been exclusively focussed on acute NHS organisations. The witness felt that there were many other service providers that had different workforce development needs and that these should be brought more strongly into the equation.

4.77
Witnesses strongly supported the view of employing local people wherever possible, both to empower them as individuals and to help the Liverpool economy. Witnesses also agreed that more could be done in this area through greater collaboration. Apart from supporting the economy, education is the most effective change agent in improving the life chances of individuals.

4.78
It was noted that health and education needed to work much more closely together and the Commission was an ideal opportunity to express this. Although there has been a marked year-on-year improvement in school achievements in Liverpool, some of the aspiration levels of some of Liverpool's children leaving school are quite low[19]. There is an opportunity for the Commission to work with Headteachers across the city to talk about the range of employment opportunities available in the NHS and to ask the question 'how do we target these youngsters' for future employment prospects? Health could be built into the Liverpool Local Curriculum: the new Liverpool Lifesciences University Technical College (opening in September 2013) is another opportunity to promote the NHS as a great profession for Liverpool students and citizens to aspire to, helping to create the NHS staff and the scientists Liverpool needs for the future.

4.79
There is a need to have more flexible approaches for education and training on how people enter into health and social care career paths; how they exit them; and how they re-direct themselves to other areas of work if aspirations are not met. There are ways into education for young people other than through formal schooling. Using community services and community youth focussed projects could be a valuable alternative.

4.80
Witnesses were committed to the idea of taking people from local communities to become health leaders and health promoters. One witness stated, ***'We try to bring people from Liverpool on to our courses because they then tend to come with a commitment and a passion to their community but not at the expense of appropriate standards'.*** It is about enrolling the local population to be part of the solution.

4.81
Witnesses also noted the need to harness the power of health staff as these people live in the community and through word of mouth can make a significant contribution.

4.82
There was also clear recognition of the contribution the public can make. ***'We have masses of people who want to volunteer for us. As money becomes tighter there are people out there who want to help us'.*** One witness described a volunteering system, funded from lottery money some years ago in which they invested significantly. ***'The volunteers are all over the place, in our out-patients, our A&E serving coffee to people; they do a lot of equality and diversity work as well. What we are finding now is that children at school, not just the A level students, but local children are coming in to do that work. We have recently demonstrated some back to work success in that. That sort of model and in a planned way across the economy would be good'.***

4.83
Work force changes cannot be achieved overnight. Change is measured in years not months. It needs long-term strategic planning and it needs commitment and vision from the whole of the health community to drive that change.

4.84
Service commissioners need to be clear what outcomes they are seeking in order for providers to develop an appropriate workforce in partnership with local institutes of education.

A healthy economy

4.85
Transforming the health of the people of Liverpool will require all the resources that Liverpool can muster. So the transformation needs both to involve Liverpool and benefit Liverpool, including its general economy, environment, and appeal.

4.86
It is often said of enterprise that its 'people' are its biggest asset and this is no less true for Liverpool. Maintaining and improving health and well-being is one aspect of protecting

this precious resource, and in this respect a focus on safeguarding the health and well-being of Liverpool's children is imperative: not only from the perspective of the well-being of the young people themselves but also for the city's economic future. In the same way that the report of the Mayor's Commission on Education raised the bar for educational attainment, a similar case should be made to invest in improving the health and well-being of generations to come. This is not just a long-term investment: support for parents and young children, particularly in the most deprived areas, can produce early savings in health and criminal justice costs, in addition to those lifetime benefits.

4.87
As noted before, making the healthy choice the easiest choice will be a critical component of transforming Liverpool's health. The environment can play its part in this by reducing the proliferation of fast-food outlets and off-licences and replacing them with outlets for fresh, healthy food, not just on the high street but in hospitals, care homes, schools, offices and institutions. Improving the environment includes more and better linked cycle routes, enhancing the city's green spaces, and commissioning and designing buildings and landscapes to promote walking, (possibly through planning regulations). It includes making the promotion of health a core component in all relevant policy areas. Some of the impact of these changes will be long-term but without them the whole programme will be undermined.

4.88
Improving health in Liverpool will need greater coordination and a much better interface with innovation, particularly with the private sector. The present government is encouraging a plurality of care providers, and public-private partnerships. Liverpool needs to find a system that works for the people of the city and which allows entrepreneurialism and enterprise to flourish.

4.89
In 2014 Liverpool will host the International Festival for Business, ***'the biggest business event the UK has put on since 1951'.*** One week of the 60-day programme will be devoted to science and technology, and Liverpool Health Partners is brokering a programme on health and healthcare. This will provide a unique opportunity for the City to demonstrate on a global scale its potential as a leader in healthcare and related science and technology. Liverpool has a unique constellation of top quality specialist trusts and services, together with world class life sciences research in its universities and higher education sectors on which to go forward.

4.90
The collaborative approach to health and well-being discussed earlier in this chapter could play a part in this, emphasising once again the need for a comprehensive strategy, delivered in a way that brings together all the partners. It could also provide an opportunity to redress some of the negative images of Liverpool that exist outside the City that will need to be countered if significant inward investment is to be made into the economy.

4.91
The Commission heard that decisions made by major companies to invest in specific parts of the country are often finely balanced and influenced not only by government inducements but also by human factors. Therefore, Liverpool needs to position itself as a place where health and well-being are a top priority; where the population understands the contribution that good health makes to a thriving economy; where all the partners involved in creating a healthy community work together; and where education and training bear a direct relationship to employment opportunities. On the last point, it is imperative that high value jobs are created in Liverpool and the health technology and bio-science sectors could provide such an opportunity... ***'if we remain a low wage economy in the private sector we will export our population or retain our population in a difficult situation'***.

4.92
The reduction in public sector employment in Liverpool has inevitably had an impact on those people caught up in redundancy, and cuts are set to continue. The issues for public and private sector employers are no different with respect to maintaining a healthy workforce, although the internal resources to deal with this are different. It was put to the Commission that, in some instances, public sector occupational health departments need a stronger focus on staff health and well-being. A coordinated and comprehensive approach to health and well-being applies equally in all workplaces. As one witness stated: ***'An active workforce is a more productive workforce and will be likely to stay with you longer'.*** Wider use of the Workplace Well-being Charter pioneered in Liverpool and now the national standard would help this process.

4.93
However, redundancy and unemployment have wider implications than for the individual involved. People live in units, families, and communities. Employment and employment opportunities are inextricably linked to better health and improved life chances, not just for the individual, but for their immediate and wider associates. A coordinated and collaborative approach to health and well-being should bear in mind all these linkages.

Evidence and research

4.94
Witnesses recognised the importance of evidence-based actions and research not only in transforming the health and well-being of the people of Liverpool but also in making Liverpool a sought after and attractive place to work and live.

4.95
To meet the challenge of transforming the health and well-being of the people of Liverpool, it will be essential to use the very best ways and means and these should be based on evidence. Liverpool needs to ensure that its clinicians are enabled to deliver the very best care based on the best and most up to date evidence which must necessarily form part of their on-going professional education and development. This should include engaging the providers of care and patients jointly in understanding what quality care is and how they can access it.

4.96
Where there is no evidence it must be derived. There will be many areas of uncertainty in the transforming of Liverpool's health and well-being and these represent important areas for new research. The research institute established after the Health is Wealth Commission by Liverpool PCT in partnership with the University of Liverpool, the Liverpool Institute for Health Inequalities Research (LivHir), has taken valuable steps in seeking to bridge the gap between research and local policy and action: the new CLAHRC will be building on this work in supporting action research to have an impact on health inequalities. This is a promising development.

4.97
One of the difficulties, for example, in promoting the role of voluntary organisations is lack of research and evaluation into its role and effectiveness. This is being countered through collaboration between grass roots organisations. For example, the Commission heard in the area of post natal depression ***'there is a lot of research and we are making sure that we are firmly in the middle of it'***. The commission heard that when contracts for services are awarded funding has not always been included explicitly for evaluation. This has made it difficult subsequently to decide which projects to replicate and which to abandon.

4.98
Commissioners and funders need to recognise the vital importance of evaluation to inform next steps. If the stakeholders are engaged in the research process from the beginning, they will be carrying out research that is more relevant to the questions that need to be answered. It is important to empower commissioners and clinical leads in the CCG to understand how research can better inform what it is that they are commissioning and to give them the means to challenge providers; as Liverpool CCG, the partner of LivHir and the host of the CLAHRC, has already demonstrated a tangible commitment to build on.

4.99
The proposed Bio-campus will be a major focus in positioning Liverpool as a national and international centre of excellence for health science and technology. The Commission heard that Liverpool has the potential to establish itself as such a centre and is already leading the way in some areas, particularly around personalised medicine. Developing research and education will contribute hugely to raising Liverpool's profile on the health research agenda.

4.100
One of the factors in attracting companies and getting them to stay in an area is access to relevant expertise in terms of scientists, medical expertise and opinion leaders; bio-banks for access to samples for their research and development priorities; access to patient groups; and having a streamlined process for getting ethics approval for their studies. Having a 'one stop shop' would enable them to acquire the relevant expertise and advice in one place. Liverpool Health Partners is making the establishment of a Joint Research Office a priority. Coupling this with the added benefit of a market for their product in the immediate health economy creates a strong proposition for inward investment.

4.101
Ways need to be found to market the science sector by collaboration between LHP, the AHSN, Liverpool Vision, and the Local Enterprise Partnership. Developing areas where Liverpool could lead nationally would open doors for funding and attract inward investment. In order to do this, Liverpool needs ***'a critical mass of university knowledge, provider knowledge, company knowledge, all feeding amongst each other and creating a honey-pot approach'.*** The best places around the world are those that are globally connected and are ***'smart at making their local interface international'.*** Liverpool needs to arrive at a place where its health economy and its leaders are recognised nationally and internationally, but in the words of one witness this is likely to require some ***'heavy lifting'*** where competing priorities and negative behaviours are set aside for the greater good. The positive commitment to collaboration that the Commission heard from the AHSN, LHP, Liverpool Vision and the Liverpool Enterprise Board, is a hopeful sign that a strong partnership will emerge from these new organisations. Liverpool is already a national and international leader in certain areas, such as personalised medicine, but there needs to be real investment in success to spread this depth more widely.

4.102
Supporting research creates inward investment, including local building and construction initiatives employing local labour as has happened with the Lift buildings and as is planned for the new Alder Hey and Royal Liverpool Hospitals and the Aintree and Merseycare developments. Healthcare engaging with industry is hugely valuable. Streamlining processes and finding ways to simplify the healthcare landscape for companies so that they have easier access to the excellent researchers, clinicians, patients, and the facilities that Liverpool offers will itself bring investment to the region and will encourage businesses to bring opportunities to the City.

Technology and health

4.103
Many witnesses emphasised the critical importance of sharing data within organisations, between organisations, and with patients, and identified the need for a comprehensive IT solution to underpin this. Several witnesses called for personal health records for patients themselves to empower them and as an aid to self-care.

4.104
Another common theme was 'data and information' sharing, which is problematic. Where this was relevant, organisations expressed a willingness to share data, and confirmed the willingness of their clients for them to share information about them. However, they consistently identify health as an impediment to this, with health organisations citing patient confidentiality as the reason. This is clearly an area that needs discussion and there is no simple solution.

4.105
The Commission heard the well-known tension between privacy and sharing data. However one witness called for a reassessment of the risks of data sharing by noting that there had been very few deaths and injuries resulting from sharing too much data but many from sharing too little. In the plan to transform Liverpool's health and well-being, this tension will need to be examined. The government's recent response to the Caldicott Review[20] will be helpful in this respect.

4.106
Liverpool needs a clear informatics strategy for a healthcare system that builds on what has already been achieved locally and allows primary and secondary care, and all the other organisations involved in delivering integrated care, to be linked together for improved patient care and outcomes.

4.107
When speaking of integrated care, witnesses noted the need for a whole pathway approach, which would require a technical solution across multiple organisations to underpin it. These pathways would need to be developed with the participating agencies working together. Hospitals, for example, would be required to work differently in terms of supporting other practitioners to manage people out in the community. One witness felt that multiple organisations can get in the way of progress on this front and believed that one organisation should be responsible for the whole pathway, particularly for some of the chronic diseases.

4.108
The Commission heard that home monitoring, tele-health, and tele-medicine are sometimes seen as ends in themselves whereas they are enablers and need to be backed up by services that respond appropriately to the information received.

4.109
To manage patients in the community more effectively, expert opinion must be provided. Currently if this is required it is mostly by means of an out-patient referral, or if it is more urgent it is via an ambulance and admission. Technology ought to enable access to expert opinion much earlier in the pathway before deterioration occurs that requires a patient to be admitted to hospital. The Commission heard much reference to the Dallas/Mi (More Independent) initiative as a potentially ground-breaking partnership between the health, housing, voluntary, and private sectors, to make more radical use of new technology to support people in their homes. Pathways should be encouraging self-care unless it is essential that people go into hospital, at which point they get the best possible care. New technology can be particularly helpful in assisting the elderly population to remain at home, when aligned with appropriate face-to-face support.

4.110
In terms of integrating and sharing information, technology is probably under-utilised, and this is a business opportunity that Liverpool could exploit. With the collapse of the National Program for IT, Liverpool need not wait for national initiatives or have national dependencies. It can strike out on its own.

5. Summary of Recommendations and the Way Forward

The Commission heard abundant evidence from a wide variety of organisations in Liverpool about the resources, skills, vision, and, above all, the willingness of those organisations to engage in a single, unified plan to transform the health of the people of Liverpool.

Such is the extent of the poor health outcomes of the people of Liverpool, and the relentless drive on budgets and resources, that only a wholesale comprehensive approach to their transformation is likely to succeed.

Recommendations

The Commission's vision is an Integrated Health and Social Care System for Liverpool, with prevention and self-care at its core. To achieve this there is a 10-point plan. **The first three are over-arching recommendations that set the vision:**

1. It is recommended that all the key partners in Liverpool (including the City Council, Liverpool Clinical Commissioning Group, NHS England (Merseyside), NHS Trusts, Liverpool Health Partners, the Academic Health Science Network, and the voluntary sector) formally sign up to the principle of seeking to create a pioneering, high quality, sustainable Integrated Health and Social Care System for Liverpool, and undertake together to lead, manage, and fund the transformation of the health outcomes of the people of Liverpool.

2. It is recommended that prevention and self-care become the primary focus in the transformation of the health outcomes of the people of Liverpool, and within this a focus on young people and older people should be priorities. This will require tackling the social determinants of health and directly engaging the citizens of the city.

3. It is recommended that the system be stimulated by a major new initiative to integrate out of hours services across primary, community, secondary, tertiary, mental health and social care, commissioned by Liverpool Clinical Commissioning Group, NHS England (Merseyside), and Liverpool City Council, and so become a national exemplar.

Achieving the vision set out in these recommendations will require strong operational over-sight and support from a number of individuals, organisations, and other sources. Therefore the Commission further recommends the following:

Co-producing an Integrated Plan

4. It is recommended that a single unifying strategic plan is developed, based on the City's Joint Strategic Needs Assessment bringing together the local commissioning plans of the Clinical Commissioning Group, the City Council, the Health and Well-being Strategy of the joint Health and Well-being Board, and NHS England (Merseyside).

5. It is recommended that national bodies such as NHS England, Health Education England, Monitor, the Care Quality Commission, the NHS Trust Development Agency, Public Health England, and Health Watch be kept fully informed of the strategic plan, to allow space for the reduction of duplication and unnecessary competition (particularly in secondary care), and for the restructuring of primary, community, secondary, and tertiary services to improve the patient pathway and quality of care. Support from these bodies is critical for the realisation of the strategic plan.

6. It is recommended that locally Liverpool Health Partners and the North West Coast Academic Health Science Network play a key part, through research-based input from the academic community and their links to industry, in helping primary, community, secondary, and tertiary providers to 'act as one' and to work together across traditional boundaries.

Developing the Neighbourhood Model

7. It is recommended that a Neighbourhood Model be the key way of implementing the proposed Integrated Liverpool Health and Social Care System.

Creating the NHS Workforce for the future

8. It is recommended that the workforce strategy needed to deliver a high quality, integrated 24/7 service, and to transform the health outcomes of the people of Liverpool includes the development of new roles, where needed assisting existing staff to work differently, giving young people access to new opportunities and supports wherever possible the recommendations of the Mayor of Liverpool's Education Commission.

Leadership based on research and shared information

9. It is recommended that the transformation of the health outcomes of the people of Liverpool through the Integrated Health and Social Care System is research and evidence-based.

The wider role of the City

10. It is recommended that the City of Liverpool and all its organisations commit to the transformation of the health outcomes of the people of Liverpool by tackling the wider determinants of health and facilitating the healthy choices in food, alcohol, smoking, exercise, and transport.

The Way Forward

All of the Commissions' 10 recommendations will require continuing work, monitoring, and evaluation. Some will require Task and Finish Groups, for example in delivering the recommendation to create the NHS workforce for the future; others such as developing the Neighbourhood Model will benefit from a high profile city-wide conference involving all the parties. It is vital that this further work on all recommendations is undertaken urgently.

The Commission acknowledges the valuable role the Mayor of Liverpool has played in convening a regular Health Summit attended by all the key local health and social care organisations, and this has been an important step in encouraging partnership working. It is vital that there is clear leadership in the way forward.

The Commission believes that the future of the City depends on its people, and the Mayor and City Council are well placed to continue to monitor the progress of the various health and social care organisations in the coming months and years. It believes that implementation of these recommendations is urgent and encourages the Mayor to:

- invite all key partners to sign up to the recommendations of the report
- use it as a springboard for establishing a formal review mechanism for ensuring that action is taken

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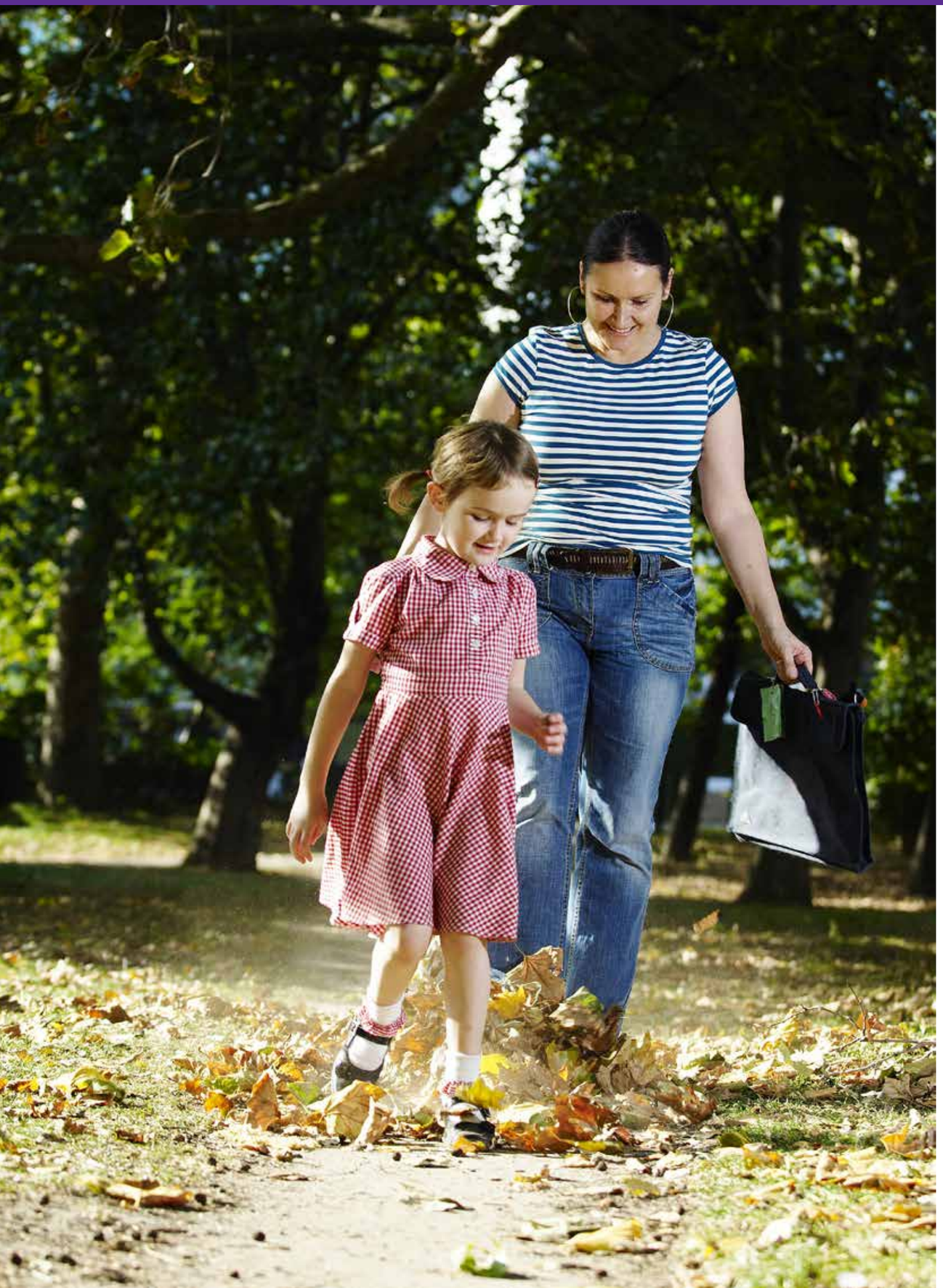

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Appendix A

Method of working and gathering the evidence

In order to gather material to write this report, the Mayoral Commission on Health adopted a comprehensive method of consultation, beginning in January 2013 and finishing in November 2013. During this time, the Commission took oral evidence from 77 witnesses (most of whom also provided a written submission), received an additional 15 responses to a set of questions relating to its terms of reference, and, with the support of Liverpool Health Watch, convened a workshop to obtain the views from a panel of 11 local patient representatives. The Commission also received a submission from the Mayoral Action Group on Poverty.

Those who attended meetings and provided oral evidence are set out in Appendix A. Questions relating to the terms of reference that all contributors (oral and written) were asked to address are set out in Appendix B. The names of the 15 people who submitted written evidence only, which formed part of an additional method of evidence gathering, are at Appendix C. In order to streamline the report text explanation of technical terms has been minimised. More information can be found in the glossary at Appendix D.

With the permission of the individuals and organisations providing them, answers to the Commission questions are published separately in the form of a technical supplement to the Commission report. The technical supplement includes submissions from those listed in Appendix A, and a summary of the written responses from those listed in Appendix C. The Commission is particularly grateful to the contributors for the care and effort that went into the production of these submissions and commend them for their sound, practical and thoughtful content.

There was also much experience of Liverpool health and healthcare over 30 years represented in the local steering group: membership included specialists in primary and secondary care, community and mental health, public health and commissioning. In addition, particular attention was paid to previous reports and commissions. These are listed in the reference and additional sources section (Chapter 6).

Within the report, the Commission has selected quotations from its witnesses to illustrate and amplify points made and conclusions drawn. The Commission believes that its report is a true reflection of the evidence put before it and that it can be used with confidence by the Mayor in taking forward his important agenda to improve the health and well-being of the people of Liverpool.

Terms of reference

1. To identify how best to support and improve the health and well-being of the people of Liverpool through:

- Considering the opportunities for improving access to high quality health and healthcare, through:
    - Closer working between agencies across health and social services; to provide more appropriate, targeted health and social care for older people
    - Better integration of patient care pathways that encourage independent living and self-care
    - Better use of new technologies to give people more choice and control over their lives and increase their independence
    - Assessing the current health profile of the city. Including the impact of factors such as obesity, smoking, alcohol, and drug misuse on peoples wellbeing
    - Making Liverpool a world leader in bioscience that attracts the best to join us.
- The Commission will give particular attention to the needs of the elderly and to the potential for targeting the health and wellbeing of young people.

2. The Commission will make recommendations that will facilitate delivery of this ambitious programme of change.

Those who attended meetings and gave oral evidence (2013)

Tuesday 16 April

Liz Mear, Chief Executive
Stuart Moore, Director of Strategy and Planning
The Walton Centre NHS Foundation Trust

Raj Jain, Chief Executive
The Liverpool Heart and Chest NHS Foundation Trust

Kathryn Thomson, Chief Executive
Gail Naylor, Director of Nursing, Midwifery and Operations
Liverpool Women's NHS FT
Julie McMorran, Trust Secretary (in attendance)

Andrew Cannell, Chief Executive
Peter Kirkbridge, Medical Director
Clatterbridge Centre for Oncology

Catherine Beardshaw, Chief Executive
Aintree Lodge, Aintree University Hospitals NHS Trust

Aidan Kehoe, Chief Executive
Robert Sutton, R&D Director
Royal Liverpool University Hospital

Louise Shepherd, Chief Executive
Ian Lewis, Medical Director
Alder Hey Children's NHS FT

Wednesday 1 May

Rosalind Way, Director of Operations
Liverpool Health Partners
Mark Gabbay, Professor of General Practice, Head of Department
Jane Cloke
Liverpool Health Inequalities Research Unit

Philip Dylak
Director of Transition, **NW Coast Academic Health Science Network** and
Research Associate, Advancing Quality Alliance

Munir Pirmohammed, Clinical Academic lead,
University of Liverpool

Kathryn Thomson, Chair, **Local Workforce Education Group**
Chris Jeffries, Acting Chief Executive, NWLETB

John Cater, Vice Chancellor
Seth Crofts, Pro-vice Chancellor and Dean
Edgehill University

John Brinkman, Dean Faculty of Health Sciences
Michael Lavalette, Professor of Social Work
Liverpool Hope University

Wednesday 15 May

Alan Lewis, Chief Executive
Liverpool Charity and Voluntary Services

Lesley Dixon, Chief Executive
Julia Purvis, Health and Wellbeing Manager
Personal Service Society

Dil Daly, Chief Executive
Age Concern

Steve Hawkins, Chief Executive
Ursula Bell, Domiciliary Care Project
Local Solutions

Robin Ireland, Chief Executive
Nicola Calder, Food and Nutrition Lead
Health Inequalities Group, Heart of Mersey

Andrew Lynch, Development Officer
Kathy Hull, Executive Officer
Dorcas O Akeju OBE, Interim Chair,
Michelle Cox
Healthwatch Liverpool

Tuesday 11 June

Maurice Smith
NHS Liverpool Clinical Commissioning Group
(CCG) Governing Body Member
Liverpool CCG Executive Lead for integrated Care Programme
Chair Mi (Dallas) Programme

Graham Pink, Chief Executive
Liverpool and Sefton Health Partnership

Jenny Stewart, Chief Executive
Liverpool Chamber of Commerce

Max Steinberg, Chief Executive
Liverpool Vision

Derek Campbell
Immediate past Chief Executive, Liverpool PCT

Alan Welby
Executive Director for Key Growth Areas
Liverpool City Region Local Enterprise Partnership

Thursday 27 June

Bob McGowan
Sector Manager, North Sector, **Northwest Ambulance Service, Cheshire and Merseyside area**
Stephen Tiffany
Senior School Improvement Officer, Healthy Schools Initiative

Chief Superintendent Jon Ward
Chief Superintendent Ngaire Waine
Merseyside Police

Phil Garrigan, Deputy Chief Fire Officer
Merseyside Fire and Rescue Service

Donna Kelly, Divisional Director of Housing,
Mike Coates, LHT Board champion for health and well-being
Liverpool Housing Trust

Carole Carroll, Head of Policy
John Smith, Policy Officer
Mersey Travel

Richard Nutter, LARC/Thrive Programme
Michael Eakin, Chief Executive, **Royal Liverpool Philharmonic**

Lindsey Fryer, Head of Interpretation and Education, **Tate Liverpool**

Kathryn Dempsey, Head of Collaboration Programme, **Foundation for Art and Creative Technology**

Wednesday 3 July

Paula Grey, Director of Public Health
Sandra Davies, Associate Director of Health Improvement
Liverpool City Council

Katherine Sheerin Chief Officer
Simon Bowers, Vice Clinical Chair
Liverpool Clinical Commissioning Group

Clare Perkins, Deputy Director
Centre for Public Health and North West Public Health Observatory

Kate Johnson, Dean of the Faculty of Health and Applied Social Sciences and the Faculty of Education, Community and Leisure
Liverpool John Moores University

Tim Andrews, Managing Director
Carol Hill, Head of Corporate Affairs
Merseyside and Cheshire Commissioning support unit

Rob Barnett, Secretary
Liverpool Local Medical Committee and BMA representative

Frances Molloy, Chief Executive
James Dunningham, Operations Director
Health at Work

Thursday 11 July

Helen Lockett, Executive Nurse and Director of Operations
Liverpool Community NHS Trust

Friday 12 July

Mark Haig, Head of Operations, **Liverpool FC Foundation**

Simon Bowers, General Practitioner and Vice Clinical Chair, **Liverpool CCG**

Dave Horsfield, Mi Programme Manager,
Liverpool CCG

Steven Blackall, **Liverpool FC Foundation Men's Health Course**
Messages of support from: Lucas Leiva (First team player and Liverpool FC Foundation Ambassador), Iqbal Zaffar (First Team Doctor)

Members of the Commission's patient reference group
John Bruce, Anja Anwar, Mavis Morgan, David Lloyd, Moira McLoughlin, John Roberts, Anne Gorton, Lesley Davies, Kathy Jull, Andrew Lynch, Inez Bootsgezel

Tuesday 23 July

Nicola Headlam
Heseltine Institute of Public Policy and Practice,
University of Liverpool, Management School

Ian Wray
Department of Geography and Planning,
University of Liverpool

Ray Walker, Executive Director of High Secure Services and Nursing
Dr Faizal Mohamed, Clinical Director Addictions
Dr Sakib Shamas-ud-din, Clinical Director Rebuild
Mersey Care NHS trust

Clare Duggan, Director,
NHS England (Merseyside)

Kenneth Wilson, Clinical Director
National Institute of Health research Cheshire and Merseyside Comprehensive Local Research Network

Appendix B

Commission questions

The commission is intent on finding ways to improve the health and well-being of the people of Liverpool, and importantly on finding innovative ways to do this. This will be achieved through closer working between health and social care providers and commissioners, in partnership with the population of Liverpool that they serve. In order to identify better ways of working and to develop models of care for the future, the Liverpool health commission will look at in detail some key conditions, but not exclusively, to identify issues integral to their prevention and management, focussing on the need for self-care allied with a better understanding of how to maximise individual's potential for a healthy life. The conditions that the commission is focussing on are obesity, diabetes, rehabilitation after a period of illness, living with one or more long term condition, and dementia. The Mayor of Liverpool has identified the elderly and young people for particular consideration. From an analysis of evidence received the commission will recommend a way forward for the city.

Commission terms of reference follow this section. This review takes place in the context of many major improvements and health gains in the city of Liverpool, including some narrowing of the vital gap in health outcomes between the richest and poorest. At the same time there are in Liverpool major cuts to local authority funding and welfare benefits, the tightening of NHS finances, and a total restructuring of NHS commissioning. Particular attention will be paid to other recent reviews of health and wealth in the area.

We would very much like you to contribute to the debate by sharing your views on all or some of the questions set out below, and by adding any further thoughts of your own.

Questions

1. In order to make the biggest improvements in health and healthcare in Liverpool, we will need:

a) citizens to value their health and wellbeing and to take greater responsibility for them;
b) the public to look first to primary care for their health needs, freeing up hospitals to look after the sickest patients;
c) patients to become more expert partners in managing their own long-term conditions; and
d) patients supported by appropriate help to stay in their own homes.

How can these aims be best achieved; what are the barriers; and how can they be overcome?

2. Many of the causes of poor health are related to factors beyond the immediate control of the NHS, such as education, housing and a healthy environment. How can local government in Liverpool work with others to influence these factors?

3. What do you understand by integrated care and what needs to change to allow it to happen in Liverpool?

4. If you were asked to design a system to improve the care in Liverpool of any of the conditions set out in the introduction, what would it look like?

5. How can we harness the current healthcare work force, the largest in the city, to be champions for health and healthcare in their communities? What more can the NHS in Liverpool do to encourage local people into training and employment in the NHS at all levels, and to use its procurement powers in a more local and sustainable direction?

6. The UK leads the world in many aspects of health technology, but the uptake into the daily delivery of healthcare is often slow or patchy. What steps could Liverpool take to ensure that it becomes a national leader in the adoption of new technologies that promote health and encourage self-care?

7. What more can we do to attract the best national and international life scientists to work in our expanding Liverpool bio-campus?

Appendix C

The Commission would like to thank the following people who sent in a written response to the Commission questions:

John Ashton, President Elect, Faculty of Public Health
Michael Salla, Everton Football Club
Jenny Cottrell
Alison Petrie-Brown, Liverpool City Council
Justine Andrew, KPMG
Rachel Panizzo, British Medical Association
Paul Nolan, The Mersey Forest
Krishna Chinthapalli, Royal College of Physicians
Lynn Perry, Barnados
Jackie Roberts
Benedetta La Corte, Royal College of Obstetricians and Gynaecologists
Kieran Murphy, Medical Director, Cheshire, Warrington and Wirral CCG
Kathleen Charters, Sathir House
Chris Holcombe, Clinical Lead, Merseyside and Cheshire Cancer Network.
Sean Oliver, HMP Altcourse

Appendix D

Glossary

Academic Health Science Networks
AHSN's develop solutions to healthcare problems and get existing solutions spread more quickly by building strong relationships with their regional scientific and academic communities and industry. The designated AHSNs are: East Midlands, Eastern, Greater Manchester, North East and North Cumbria, North West Coast, Imperial College Health Partners, Oxford, South London, South West Peninsula, Kent, Surrey and Sussex, UCL Partners, Wessex, West Midlands, West of England, Yorkshire and Humber.

Care Quality Commission
The Care Quality Commission (CQC) is a non-departmental public body established in 2009 to regulate and inspect health and social care services in England. This includes services provided by the National Health Service (NHS), local authorities, private companies and voluntary organisations - whether in hospitals, care homes or people's own homes.

Clinical Commissioning Groups
Clinical commissioning groups (CCGs) are NHS organisations set up by the Health and Social Care Act 2012 to organise the delivery of NHS services in England. They replace primary care trusts (PCTs)

Core Cities Group
Core Cities are a unique and united local authority voice to promote the role of our cities in driving economic growth. The groups represent the councils of England's eight largest city economies outside London. These are: Liverpool, Manchester, Newcastle, Leeds, Birmingham, Nottingham, Sheffield, and Bristol.

Health
World Health Organisation: Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

Health and Well-being Boards
Health and wellbeing boards are statutory bodies which were introduced as part of the NHS reforms outlined in the Health and Social Care Act 2012. According to the Act, each upper-tier authority in England is required to form a health and wellbeing board as a local authority committee.

Healthy Homes Programme
The Healthy Homes Programme (HHP) is run by Liverpool City Council. It aims to prevent ill health and injury resulting from poor quality housing conditions.

Integrated care
World Health Organisation: The organisation and management of health services so that people get the care they need, when they need it, in ways that are user-friendly, achieve the desired results and provide value for money.

Joint Strategic Needs Assessments
The Joint Strategic Needs Assessment is a document which describes the health, care and well-being needs of people in Liverpool, both now and in the future.

Kaiser Permanente
Is an integrated managed care consortium, based in Oakland, California, United States, founded in 1945 by industrialist Henry J. Kaiser and physician Sidney Garfield. Kaiser Permanente is made up of three distinct groups of entities: the Kaiser Foundation Health Plan and its regional operating subsidiaries; Kaiser Foundation Hospitals; and the autonomous regional Permanente Medical Groups. As of 2006, Kaiser Permanente operates in nine states and the District of Columbia, and is the largest managed care organization in the United States

Liveability Active Aging Programme
This is a nurse led service which promotes the health and independence of people aged 50 and over

Liverpool – the city/city region/Merseyside
The Liverpool City Region is an economic and political area of England centred on Liverpool, which also includes the local authorities of Halton, Knowsley, Sefton, St Helens, and Wirral. The six authorities come together to deal with strategic policy areas such as economic growth, transport, tourism, culture, housing, and physical infrastructure.

Liverpool Health Partners
A strategic partnership for creating health gain pursuing excellence in healthcare delivery, research and clinical education.

Liverpool Vision
Liverpool Vision is the Mayor of Liverpool's economic development company, governed by a Board of two Directors: Mayor Joe Anderson (Chairman) and Councillor Malcolm Kennedy. The Board sets the Company's business plan and budget, and is supported by a small advisory group including other Councillors, a representative of the private sector, and the Chief Executives of the City Council and Liverpool Vision.

Local Enterprise Partnership /Board
The Liverpool City Region LEP is a private sector led Board with political leaders representing the six local authority areas of Halton, Knowsley, Liverpool, Sefton, St Helens and Wirral.

Mi/Dallas
The Liverpool Mi More Independent Programme is a project being run by Liverpool CCG with the aim of improving the health of people within the city. The group were successful in securing a £7.7million grant from the Technology Strategy Board as part of their 'Delivering Assisted Living Lifestyles at Scale' programme (DALLAS).

Monitor (making the health sector work for patients)
Monitor is the sector regulator for health services in England. Its job is to protect and promote the interests of patients by ensuring that the whole sector works for their benefit. Monitor exercises a range of powers granted to it by Parliament: these include setting and enforcing a framework of rules for health sector providers and commissioners, and are implemented in part through a system of licencing.

Natural Choices
The Mersey Forest has helped nearly 40 community groups to deliver health and wellbeing benefits to people across Liverpool, as part of the Natural Choices for Health and Wellbeing project.

NHS England
NHS England is an executive non-departmental public body of the Department of Health. It oversees the budget, planning, delivery and day-to-day operation of the NHS in England as set out in the Health and Social Care Act 2012.

NHS Trust Development Authority
The NHS Trust Development Authority provides support, oversight and governance for all NHS Trusts on their journey to delivering what patients want; high quality services today, secure for tomorrow.

Strategic Clinical Networks
Launched by the NHS Commissioning Board in 2012, Strategic Clinical Networks are national networks to improve health services for specific patient groups or conditions. They have been established in areas of major healthcare challenge where a whole system, integrated approach is needed to achieve a real change in quality and outcomes of care for patients. It is intended that Strategic Clinical Networks will help commissioners reduce unwarranted variation in services and will encourage innovation.

Workplace Well-being Charter
The Workplace Wellbeing Charter is an opportunity for employers to demonstrate their commitment to the health and well-being of their workforce. The positive impact that employment can have on health and wellbeing is now well documented. There is also strong evidence to show how having a healthy workforce can reduce sickness absence, lower staff turnover and boost productivity - this is good for employers, workers and the wider economy.

Acknowledgements

The development of this report was greatly enriched by the evidence received, both oral and written, from many witnesses who gave their time and wisdom generously to assist the Commission with its work.

In addition to these witnesses, the Commission would like to thank the following:

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Barry Lewis for technical support.

Michelle Cox, Andrew Lynch and Kathy Hull, for their help in bringing in the views of local patient group representatives.

Phil Wadeson, Director of Finance, NHS Merseyside; Becky Hellard, Director of Finance and Resources, Liverpool City Council; and Chris Williamson, Lead Public Health Epidemiologist, Liverpool City Council: for checking and providing some of the factual content contained in sections 1 and 2 of the report.