Greater Manchester Joint Commissioning Board

Date: 19 November 2019

Subject: Delivering our population health ambition: the role of the Greater Manchester Joint Commissioning Board

Report of: Sarah Price, Executive Lead, Population Health and Commissioning, GM Health and Social Care Partnership

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PURPOSE OF REPORT:

The July JCB considered a detailed update on the implementation of our Population Health Plan. At the September meeting, it was agreed that "Implementation of our overarching ambition to improve the health and well being of our 2.8 million citizens as described in our Population Health Strategy", should be adopted as one of ten core focus areas for the JCB.

This report provides a framework for considering the role of JCB in driving forward a GM ambition to build upon progress made to date and establish a sustainable system-wide Population Health approach which improves health outcomes and reduces inequalities.

A version of the report was considered at the October JCB Executive and it was subsequently agreed that it should be presented to the full JCB given the level of priority we have attached to this issue.

KEY ISSUES TO BE DISCUSSED:

The JCB is asked to consider its' role in the improvement of health outcomes and the reduction in health inequalities across GM with a specific emphasis on the following three areas:

- Health Inequalities
- Investing in Prevention
- Social Value and the role of Anchor Institutions

RECOMMENDATIONS:

The Greater Manchester Joint Commissioning Board is asked to:

- Note the content of this report and review the proposed opportunities for JCB in relation to the development of a sustainable system-wide approach to Population Health in GM which improves health and reduces inequalities.

- Discuss the key areas for consideration set out in 2.11, 3.28 and 4.9 and identify specific opportunities to test new ways of working.

CONTACT OFFICERS:

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SYSTEM ENGAGEMENT

Please complete the information below to outline the discussion with sectoral governance groups prior to submitting to the GM Joint Commissioning Board. If it is not appropriate / deemed necessary for a discussion with a particular group please state why.

PRIMARY CARE ADVISORY GROUP (PCAG)

Has the paper been discussed by PCAG? (Yes/no): **No**
If no please outline the reason: **Initial engagement is with JCBE**
Date of meeting: N/A
Key points to be fed into JCB: N/A

PROVIDER FEDERATION BOARD (PFB)

Has the paper been discussed by PFB? (Yes/no): **No**
If no please outline the reason: **Initial engagement is with JCBE**
Date of meeting: N/A
Key points to be fed into JCB: N/A

WIDER LEADERSHIP TEAM (WLT)

Has the paper been discussed by WLT? (Yes/no): **No**
If no please outline the reason: **Initial engagement is with JCBE**
Date of meeting: N/A
Key points to be fed into JCB: N/A

STRATEGIC PARTNERSHIP EXECUTIVE BOARD (PEB)

Has the paper been discussed by PEB? (Yes/no): **No**
If no please outline the reason: **Initial engagement is with JCBE**
Date of meeting: N/A
Key points to be fed into JCB: N/A

GM CCG DIRECTORS OF COMMISSIONING (DOCS)

Has the paper been discussed by DoCs? (Yes/no): **No**
If no please outline the reason: **Initial engagement is with JCBE**
Date of meeting: N/A
Key points to be fed into JCB: N/A

GM CCG CHIEF FINANCE OFFERS (CFOS)

Has the paper been discussed by CFOs? (Yes/no): **No**
If no please outline the reason: **Initial engagement is with JCBE**
Date of meeting: N/A
Key points to be fed into JCB: N/A

GM LA HEADS OF COMMISSIONING (HOCS)

Has the paper been discussed by HoCs? (Yes/no): **No**
If no please outline the reason: **Initial engagement is with JCBE**
Date of meeting: N/A
Key points to be fed into JCB: N/A

CONTEXT

The July JCB considered a detailed update on the implementation of our Population Health Plan. At the September meeting, it was agreed that "Implementation of our overarching ambition to improve the health and well being of our 2.8 million citizens as described in our Population Health Strategy", should be adopted as one of ten core focus areas for the JCB.

This report provides a framework for considering the role of JCB in driving forward a GM ambition to build upon progress made to date and establish a sustainable system-wide Population Health approach which improves health outcomes and reduces inequalities.

A version of the report was considered at the October JCB Executive and it was subsequently agreed that it should be presented to the full JCB given the level of priority we have attached to this issue.

1.0 INTRODUCTION

1.1. Improvements in Life Expectancy in England have slowed in recent years. The current stagnation is fuelled by continued low life expectancy amongst the most socioeconomically deprived members of our population. This slowing and, in some cases reversal, of life expectancy is unprecedented in modern times and should serve as a significant warning sign.

1.2. The GM Health and Care Prospectus (2018) is unequivocal in its commitment to improving heath and adopting a whole system approach to population health:

"Our big ambition is for our population to both demand better health and have the confidence to change their own lives. To achieve this, we do not want to be restrained by the incremental changes made by small-scale public health projects. And thanks to the range of levers provided by devolution, we do not need to be. Greater Manchester can put health at the heart of every policy and strategy across the whole of the public service."

1.3. There is abundant evidence that when the right social conditions are in place, people lead long, healthy and productive lives.

1.4. Conversely, there is abundant evidence that inadequate social conditions lead to shorter, unhealthier and less productive lives, and that inequalities in health between different social groups are driven primarily by the conditions in which they live, not by their access to health and social care.

1.5. This mirrors the assessment of the challenges and opportunities that exist in Greater Manchester as set out in key strategic documents: the GM Health and

Care Prospectus, the GM Independent Prosperity Review, and the GM Model for Public Services, which have shaped our commitment to establish a sustainable system-wide approach to improving health outcomes and reducing inequalities across GM.

1.6. There is a clear recognition of the complex correlation between health and wealth, and an acceptance that securing a healthier, more equal and more prosperous GM population requires a different conversation which focusses on good health as one of our greatest assets, rather than on ill-health as a burden. In short, good health improves people's wellbeing, their productive capacity and their ability to participate in society. It is a vital contributor to a successful GM economy and a thriving GM society.

1.7. This report builds upon previous reports to the Joint Commissioning Board (JCB) which have set out the Greater Manchester (GM) Population Health transformation programme, progress to date, and proposed next steps.

1.8. It articulates a proposed role for JCB in driving forward a GM ambition to build upon the progress made to date and establish a sustainable system-wide Population Health approach which improves health outcomes and reduces inequalities across GM.

1.9. It focusses on 3 initial priorities:

a. Reducing Health Inequalities

b. Investing in Prevention

c. Social Value and the role of Anchor Institutions

1.10. This aligns with the existing priorities of the JCB as set out in the current business plan and specifically "*implementation of our overarching ambition to improve the health and wellbeing of our 2.8 million citizens as described in our Population Health strategy.*"

2.0 REDUCING HEALTH INEQUALITIES:

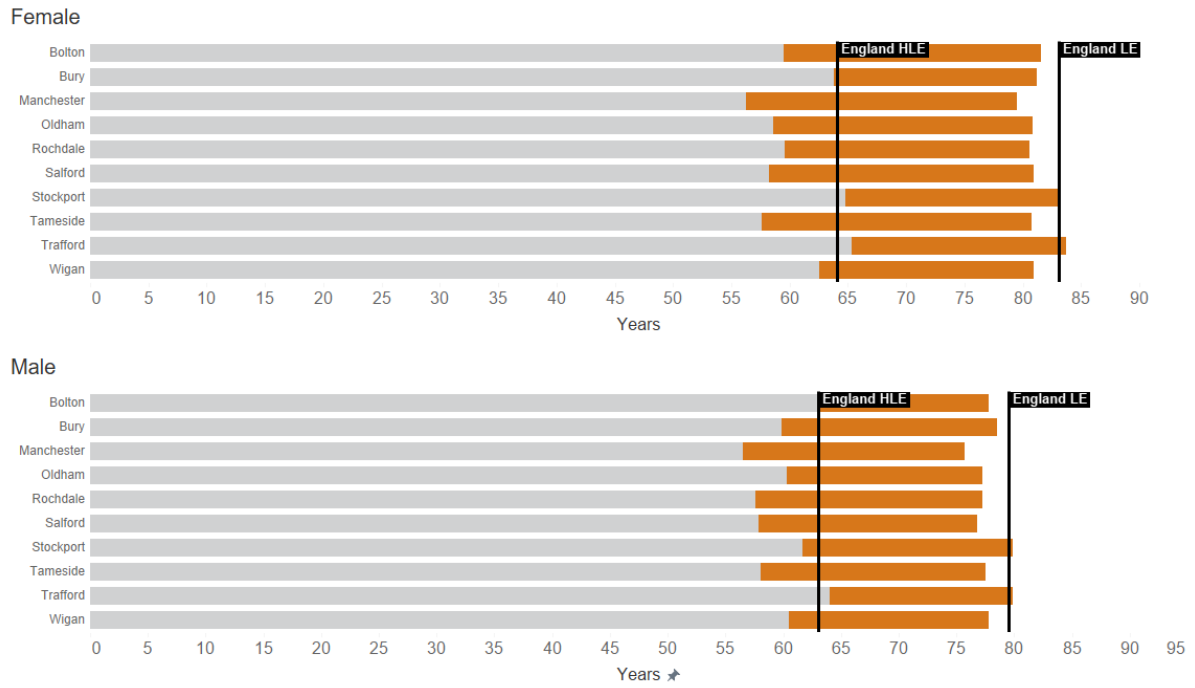
2.1. Within GM we have stark, unwanted and unwarranted variation in health outcomes which affect our population in the most profound ways including how long they live and how much of their life is spent in good health.

2.2. For the purposes of this report, we have specifically considered variation between GM and England; Variation across GM Localities; Variance within GM Localities

2.3. When we compare GM to England there is a significant gap in terms of Life Expectancy (LE) and Healthy Life Expectancy (HLE) and over time, the gap

between GM and England in Life Expectancy at Birth has remained relatively constant:

Figure 1 - Life Expectancy and Healthy Life Expectancy at Birth: GM Localities v England

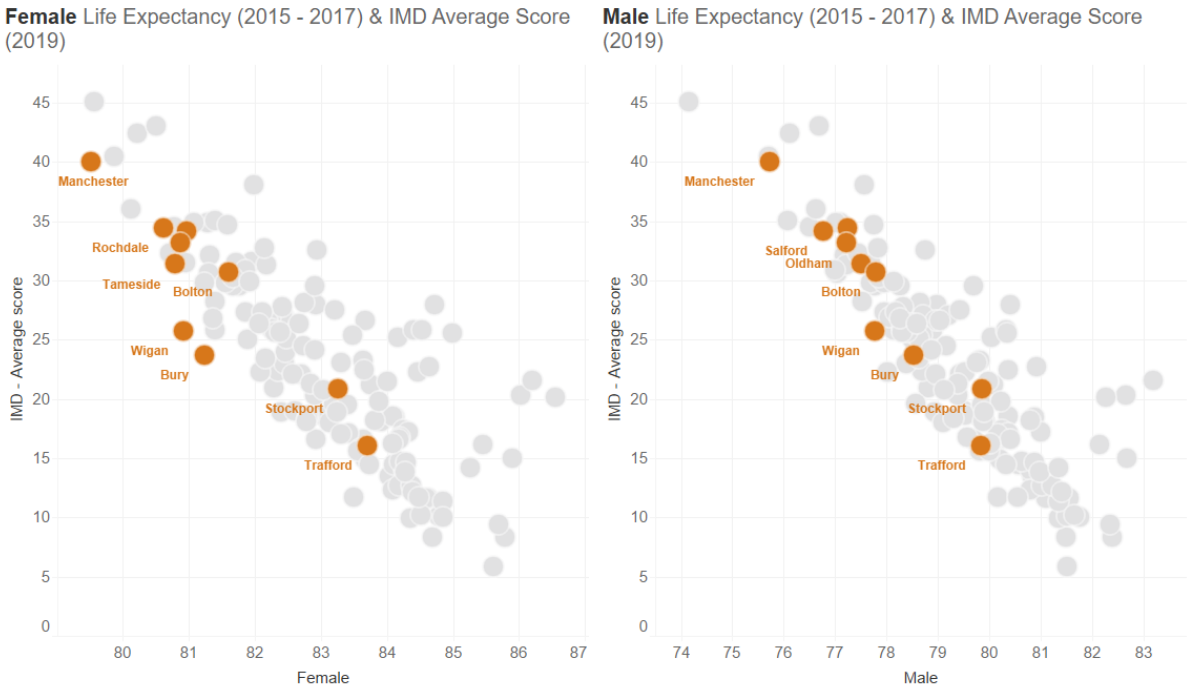


2.4. When we look across GM Localities there are also significant difference in terms of LE and HLE between the 10 areas with a gap from highest to lowest of 4.1 years for Male Life Expectancy at Birth, 3.8 years for Female Life Expectancy of Birth, 7.5 years for Male Healthy Life Expectancy at Birth and 9.1 years for Female Healthy Life Expectancy at Birth.

2.5. In some GM localities the gap between the least and most deprived is in excess of 10 years for Life Expectancy and almost 20 years for Healthy Life Expectancy.

2.6. The 2019 Indices of Multiple Deprivation, when correlated with the 2015-17 Life Expectancy data release, provides clear evidence of the correlation between experiences of multiple deprivation and the impact on Life Expectancy, with the GM areas with the highest deprivation scores also having the poorest life expectancy for male and females:

Figure 2 - Inequality in Healthy Life Expectancy at Birth (Female and Male)



2.7. As set out earlier in this report, the most significant determinants of health relate to the environment within which people are born and live. However, that is not to say that access to universal high-quality health care does not a have an important role to play in reducing health inequalities. The House of Commons Health Committee stated over a decade ago that "*the NHS has the capacity to tackle health inequalities by providing excellent services targeted at, and accessible to those who need them*", reiterated recently in a report on new models of care. Health can be undermined by unequal provision and de facto utilisation of health care, leading to worse survival and recovery in deprived groups compared to affluent ones. For example, cancer patients from deprived areas of the UK have a later diagnosis and worse survival rate compared to their affluent counterparts. A fair and effective health service should respond proportionately to need by segmenting and targeting its services to ensure equitable access and uptake of services across the entire population, with the aim of reducing unwarranted variance and inequalities.

2.8. Three components of health and social care are particularly relevant for reducing inequalities under the principle of proportionate universalism:

- Access to healthcare;
- Health promotion and disease prevention through risk prediction and early diagnosis;
- Strengthening integrated health and social care.

2.9. One example of how this could be modelled in practice is through the emergent GM Health Checks model, currently funded through transformation monies and being tested in Salford, Manchester and Stockport. This model moves away from a universal approach for those aged 40+ within which success is measured on uptake and towards a tiered approach aimed at ensuring continued universal access, with a greater emphasis on identifying and engaging those at greatest risk and providing an integrated response which reduces this risk, and where success is measured in improved individual outcomes and reduced rates of preventable deaths from Cardio Vascular Disease (CVD). Once the model is established and the approach tested, commitment to implementation across GM will be something JCB needs to consider.

2.10. To support this ambition to reduce health inequalities, the GM system is collaborating with Professor Sir Michael Marmot from the Institute of Health Equity and the Health Foundation in his ten year assessment of progress since the publication of 'Fair Society, Healthy Lives' - his seminal analysis of the underlying causes of health inequality. The work is underway to look at the policy approach in GM against the principles set out in 'Fair Society', and the development of key metrics to monitor equity and insight from other areas, both within England and internationally. This is intended to culminate with GM being designated the first 'Marmot-City Region' in early 2020, where GM commits to reducing inequality in outcomes for our citizens. JCB have a role to play in translating this ambition into a tangible reality that places reducing inequalities across our practice, policy and strategy landscape. The initial themes coming out of the work suggest a potential focus on:

- Maintaining health visitor numbers and funding for Family Nurse Partnerships or similar types of support;
- Increased focus on support for school aged children;
- Taking a proportionate universalism approach to skills and employment services;
- Engaging schools more in collaboration and integration,
- Developing programmes to increase employment opportunities for low-skilled workers,
- Working with employers and the VCSE to support health and wellbeing in work places and support for lone parents and carers to stay in work;
- Considering the implementation of universal basic services across GM;
- Working with VCSE organisations to co-design initiatives to reduce social isolation;
- Adopting a Health equity in All Policies approach to ill health prevention to widen the responsibility across sectors and to prioritise early intervention on upstream determinants.

Key Areas for JCB discussion:

2.11. Discuss support for, and the JCB role in:

- Exploring opportunities to reduce variation in access to healthcare through proportionately segmenting and targeting services to ensure equitable access and uptake of services across the entire population.

- Including locality level metrics on inequality and inclusion in planning going forward.

- Committing to programmes that are having an impact on health inequalities, such as Making Smoking History and the GM Health Checks programme over the longer term.

- Contributing to the development of a response to the Marmot review work once it is completed.

- Incorporating specific plans to reduce health inequalities within refreshed Locality Plans.

3.0 INVESTING IN PREVENTION

Why Invest in Prevention?

3.1. In the current context of increasing budgetary pressures in health, social care and other public services, the need to invest in the prevention of ill-health is stronger than ever.

3.2. The Local Government Association (LGA) report *'Prevention: A Shared Commitment'* (2015) found that only 5 per cent of the entire healthcare budget is spent on prevention and contended that:

"if avoidable ill-health could be reduced the savings would be considerable. However, the funds available for prevention are limited. We spend around 20 times as much on treating ill health as we do on direct prevention, yet the relative cost-effectiveness equation sees a reversal of these proportions – primary prevention is likely to be 24-40 times more cost-effective than treatment on a lifetime basis, with a break-even point after as little as two years."

3.3. This report recommended the development of a sustainable Prevention Transformation Fund to make this shift a reality. This recommendation did not advance through national government.

3.4. The fact that the term ‘investment’ is widely used to refer to revenue spending on prevention is itself a clue as to the value of such spending. Most use of revenue in health is referred to as spending rather than investment: it represents the day-to-day running costs, the financial resources deployed to meet demand, or to deliver a project/programme. The term ‘investment’ suggests something different – the use of resources to gain future benefits, as in the case of using capital assets. This is the nature of preventative spend – it is indeed an investment, using resources now to gain future benefits, either by avoiding future financial costs (for example on acute care), reducing demand in the system, improving future financial sustainability or achieving greater health benefits from existing resources.

3.5. The current methodology for determining whether health care spending represents good value for money is to assess how much health the expenditure buys, and whether shifting existing funds to a new intervention results in a net increase in health. This system means that health is viewed as an asset, and something worth spending money on. Prevention on the other hand is often viewed as a method by which to save money. Investment is only seen as worthwhile if it generates savings somewhere else, ideally under the same budget holder’s remit, that completely offset their initial investment. This difference means that despite often being able to generate health at a cheaper cost than in healthcare, prevention is not undertaken, or attracts insufficient investment from a societal viewpoint. Increased scrutiny of the levels of spending on prevention, as well as a more standardised way of evaluating the benefits across the sector, should help bring this unhelpful distinction to the forefront and strengthen the case for such investments.

3.6. The GM Strategic Investment Case for Population Health, agreed by the GM Partnership Executive Board in 2017, concluded that to enhance population health, reduce demand and lower healthcare costs there was a requirement for a more balanced health and social care investment strategy that:

- Recognised the need for a genuinely long-term approach to the economics of prevention.
- Shifted the centre of gravity from a provider driven health care system to a community centred population health system model.
- Provided transformational funding to give prevention the chance to deliver - essentially pump priming initiatives so that we can make a strong case for reinvestment going forward.

3.7. Subsequently £30m of non-recurrent GM Transformation Fund monies were allocated to kickstart this shift and implement the key programmes included within the GM Population Health Plan.

3.8. This has been fully invested and is showing positive impact, but there is a need to revisit the discussions regarding a long-term sustainable investment in Population Health that re-orientates whole system spend towards prevention and early help.

The GM Population Health Plan – Sustaining Success

3.9. Since being allocated £30million in 2017, the budget has been committed to realising the ambitions of the GM Population Health Plan, under the governance and leadership of the GM Population Health Programme Board (PHPB). In many cases this investment has also been the catalyst for additional investment from GM and national partners.

3.10. A Population Health Progress and Next Steps report was provided to the GM Joint Commissioning Board, GM Health and Care Board and GM Combined Authority in July 2019.

3.11. There continues to be an ambition to develop a sustainable model of investment in prevention in GM as part of a whole system approach to population health as set out in the GMHSCP Health and Care Prospectus and JCB can play a pivotal role in the development of this model. However, whilst these ambitions continue to be formed, there is a need to concurrently consider the specific sustainability considerations of the programmes currently underpinned by transformation funding.

3.12. TF investment is non-recurrent and, for the most part, is in place until 31st March 2021.

3.13. The investment for two TF-funded programmes, Focussed Care and Nutrition and Hydration, is scheduled to end on 31/3/2020. In both instances, dialogue has commenced in relation to potential sustainability options and final proposals will be presented to PHPB in January 2020.

3.14. There is a critical role to be played by JCB, in partnership with the PHPB, in assessing the desirability and feasibility of the continuation of, and sustainable models of delivery for, the portfolio of GM Population Health programmes, based upon the evidence that is accrued during this test and learn phase.

3.15. As part of the funding allocation process, a key consideration within all business cases was programme sustainability, with an expectation that programmes had robustly considered future sustainability from the onset. In order to understand the current position in terms of programme sustainability, and any shift from initial plans as set out in business cases, a high-level review has been undertaken by the GM Population Health Transformation Team (PHT), under the governance of the PHPB and in partnership with the leads

for the 14 programmes that received funding for which there is a sustainability consideration.

3.16. This review identified a series of thematic findings which will provide the key lines of enquiry for establishing appropriate sustainability propositions:

- The approach to sustainability will differ across programmes and there is no “one size fits all” option.
- The complexities of implementing some programmes led to delays in achieving full mobilisation which will affect the impact they have within the current funding window. This needs to be understood and considered when reviewing evidence of impact and programme evaluations.
- The system architecture and strategic context of the GM system continues to develop and evolve at pace, and this had created a requirement for programmes to flex their original sustainability plans to mirror this evolution.
- There is an understanding and appreciation of the wider system financial and operational pressures, and a recognition of the fundamental pull that exists between investing in prevention and spending on the “here and now”.

3.17. JCB has a critical role to play in working alongside PHPB to shape and “stress test” sustainability plans for the non-recurrent investments and ensure that propositions are realistic and recognise the evolving GM and local system architecture and strategic context including, but not exclusive to, the implications for integrated commissioning, locality integrated care models, GM-level commissioning, delivery in neighbourhoods of 30-50k (including the role of Primary Care Networks), and the model for public services in GM.

Commissioning for Population Health

3.18. Commissioners within Greater Manchester play a fundamental role in supporting improvements to the health of the population and reductions in health inequalities.

3.19. At a micro level, commissioners have responsibilities for a range of locality and GM functions and services which are intended to improve health, including mandated Public Health functions.

3.20. The recent Health Foundation report, ‘Creating Healthy Lives’ (2019), highlights that the Public Health grant allocation for 2019/20 was 23% lower than when the grant was implemented in 2015/16, and that this will not be redressed with the recent announcement of the increase in the grant for

2020/21. The report highlights incongruence between this reduction in funding and evidence showing that the typical return on investment for local-level public health measures is 14:1 – that is, society benefits by an average of 14 times the initial investment into each intervention.

3.21. JCB have a role to play in ensuring that these services are of optimal quality, evidence based, and delivered at the most appropriate spatial level. Working collaboratively across the system, JCB also has a key role in identifying and responding to unwanted and unwarranted variation in provision and outcomes.

3.22. JCB could seek to test this potential role in some specific areas of business such as Sexual and Reproductive Health or the commissioning of Tier 4 Drug and Alcohol Services (Residential Rehabilitation / In-patient Detoxification).

3.23. At a meso level, by reforming the approach to contracting and incentivisation, there is an opportunity to refocus performance management increasingly towards outcomes, and specifically towards health outcomes. This will require a fundamental rethink of what we prioritise and how we measure success, a realisation of our ambitions to transform the commissioning and delivery architecture within GM, a greater emphasis on how we support those with the greatest needs and poorest outcomes, and how we forge a greater role for the Voluntary, Community and Social Enterprise (VCSE) sector.

3.24. JCB have a role to play in enabling this shift towards outcome based strategic commissioning, incentivisation and contracting and emphasising the importance of improving health and reducing inequalities in outcomes-based accountability frameworks.

3.25. At a macro level, commissioners have responsibilities for a wide range of resources, services and systems that are not health or care-specific, but which could be re-orientated to ensure that they maximise the contribution they make to improving health and reducing inequalities. By adopting this whole-system and placed-based approach it is possible to maximise the extent to which neighbourhoods in GM are conducive to health and contribute to improved health outcomes and reduced inequalities.

3.26. Having a clear understanding of current investment in prevention across the system, both nationally and locally, and an aspiration about what the percentage of total spend should be to improve health and reduce health inequalities, are important enablers of a shift to a greater prevention focus. As part of this, a better understanding of how money is spent on prevention and by whom, and where and when the benefits accrue, is essential in supporting decision-making across the system. We propose to build upon pre-existing approaches from Wales, Scotland and New Zealand to explore approaches to

reviewing our existing system expenditure and developing proposals for developing a targeted approach to investment in prevention.

3.27. JCB have a role to play in ensuring that all locally and GM commissioned services and policies / strategies, whether directly or indirectly health or care-related, are optimised to ensure they contribute to improving health and reducing inequalities.

3.28. JCB have a role to play in exploring the opportunities for developing a targeted and sustainable approach to investment in prevention.

Key Areas for JCB discussion

3.29. Discuss support for, and the role of the JCB in:

- Working alongside the Population Health Programme Board to shape the sustainability proposals for existing GM Population Health programmes.
- Ensuring commitment to the long-term delivery of recurrent prevention activity, including that set out within the Public Health mandate, and ensuring services are of optimal quality, evidence based, and delivered at the most appropriate spatial level.
- Working collaboratively across the system, identifying and responding to unwanted and unwarranted variation in provision and outcomes.
- Enabling the shift towards outcome based strategic commissioning, incentivisation and contracting and emphasising the importance of improving health and reducing inequalities in outcomes-based accountability frameworks.
- Identifying the totality of ‘prevention’ across GM and localities as a global figure and as a proportionate of current spend and developing methodology for the establishment a sustainable and targeted approach to investment in prevention.
- Supporting better decision-making on the use of resources by providing a consistent framework to evaluate the costs and benefits across different organisations.
- Ensuring that all locally and GM commissioned services and policies / strategies, whether directly or indirectly health or care-related, are optimised to ensure they contribute to improving health and reducing inequalities

4.0 SOCIAL VALUE AND THE ROLE OF ANCHOR INSTITUTIONS

4.1. Across GM, the organisations responsible for health and care employ over 127,000 people and spend nearly £16bn per annum. There is an enormous and largely untapped potential for this to provide a platform for transformational change.

4.2. The health and social care system has an important part to play in reducing levels of poor health, advancing social justice and tackling social determinants of health through its role as a direct provider of healthcare, as an employer, as a partner in local systems and as an anchor institution in local communities

4.3. Anchor institutions are large commercial, public and social sector organisations which have a significant stake in a place. Crucially, these organisations can use their commissioning and procurement processes, their workforce and employment capacity, and their real assets such as facilities and land to impact upon economic, social, and environmental priorities, generating what is commonly referred to as social value.

4.4. Traditionally, the application of social value has been most advanced within a local authority environment where there is a clear, broader responsibility for people's economic, social and environmental wellbeing and hence a greater impetus to consider social value. The opportunity in GM, as a result of devolution, is to extend this sense of organisational responsibility to generate social value in a place and align the NHS to the focus on the population and the wider, social determinants of health.

4.5. Work is ongoing across the GMHSCP, GMCA, GM Mayor and localities to fully understand the opportunities that are presented through a more meaningful shared ambition that maximises the Social Value that is generated through GM spending power and through the role of Public Services as 'anchor institutions' and generators of Social Value in their own right. JCB have a role to play in shaping the GM approach to Social Value and anchor institutions to ensure the maximisation of GM spending power and to ensure that Public Services across GM, as 'anchor institutions', are harnessing the contributions that they make to people and communities, health and inequalities.

4.6. As a pre-cursor to this work, and as an NHS Social Value Accelerator site, GMHSCP commissioned the Centre for Local Economic Strategies (CLES) to scope examples of Social Value in action in GM, the potential 'size of the prize', and the steps to be taken to unlock the underlying potential that exists. The key findings of the research were as follows:

- There are good examples of Social Value being used effectively in Health and Care in GM, but they are not consistently applied across the city region.

- If we could unlock the Social Value of health and care spend in GM, the "size of the prize" would be approximately **£760million per annum**.

4.7. Several factors are influencing our current approach to Social Value including:

a. **Skills and capacity** - there is significant variation in the understanding of what social value is and how it should be applied.

b. **Competing institutional priorities** – the pursuit of social value is often in competition with other mainstream priorities and can often end up as a mechanistic tick-box exercise or being ignored completely.

c. **The financial and policy context** – Both local government and the NHS are stretched due to reduced budgets. In this context, the spending of public money is often seen as a commercial market transaction with officer's duty bound to ensure the much prized 'value for money'. Commissioning (a term more properly used to describe the processes of assessing needs and designing ways to meet them) is reduced to a competitive tendering activity, often framed by a rigid set of costed outputs and complex contract conditions.

d. **Lack of a mandate to apply social value** –Public bodies are not mandated to enforce social value. The Social Value Act 2012, by merely requiring public bodies to consider social value, rather than enforcing it, leads to variations in how the Act has been implemented and no consistency of approach.

4.8. To unlock the underlying potential social value in GM there are a series of key steps that are recommended to be taken including:

a. **Asserting the role of GM health and care organisations as key economic agents** - Health and care organisations have significant economic and social impact and have a key role with respect to their wider economic and social impact, which is aligned to local economic development.

b. **Broadening the understanding of what constitutes social value** – Expand the definition beyond the narrow association with commissioning and procurement. A more helpful frame might be to consider the role of social value in Community Wealth Building.

c. **Amplifying the role of GMHSCP as an enabler of social value** – Developing the idea of the NHS as an anchor institution, increase awareness of where social value is being applied well and encourage its up-take elsewhere.

d. **Expanding joint working arrangements at a locality level** - There is potentially much to be gained as a result of the NHS and local government working more closely together, particularly when it comes to advancing social value.

e. **Lobbying for social value to be included within the NHS Future Operating Model (FOM)** - The FOM is a means of leveraging the NHS's purchasing power on a national scale to aggregate demand, centralise purchasing and deliver better value for money for NHS Trusts and the taxpayer. However, it does not currently consider social value. Given its overarching position, GMHSC would be well placed to lobby for this to be changed.

Key Areas for JCB discussion:

4.9. Discuss support for, and the JCB role in:

- Maximising the Social Value associated with Public Services in Greater Manchester and responding to the findings and proposals emerging from the CLES research.

- Exploring the role of Health and Care providers as anchor institutions and identifying the extent to which this is being, can be, and should be progressed in GM.

5.0 RECOMMENDATIONS

5.1. The Greater Manchester Joint Commissioning Board is asked to:

- Note the content of this report and review the proposed opportunities for JCB in relation to the development of a sustainable system-wide approach to Population Health in GM which improves health and reduces inequalities.
- Discuss the key areas for consideration set out in 2.11, 3.28 and 4.9 and identify specific opportunities to test new ways of working.