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Report of:	*Chief Executive*
Report to:	*Cabinet Member for Health and Social Care*
Date of Decision:	*20 September 2017*
Subject:	*Sheffield Accountable Care Partnership*

Is this a Key Decision? If Yes, reason Key Decision:-	Yes		No	X
- Expenditure and/or savings over £500,000				
- Affects 2 or more Wards				
Which Cabinet Member Portfolio does this relate to? *Health and Social Care* Which Scrutiny and Policy Development Committee does this relate to? *Healthier Communities and Adult Social Care*				
Has an Equality Impact Assessment (EIA) been undertaken?	Yes		No	X
If YES, what EIA reference number has it been given? *(Insert reference number)*				
Does the report contain confidential or exempt information?	Yes		No	X

Purpose of Report:

This report sets out recent national and local developments in relation to the planning and delivery of health and care services. It is particularly focused on the development of an Accountable Care Partnership (ACP) for Sheffield, of which Sheffield City Council will be a member. The report draws the Cabinet Member's attention to a number of challenges to be resolved during the establishment of the ACP, but seeks endorsement of the overall approach being taken, subject to a number of caveats set out in the paper.

Recommendations:

It is recommended that the Cabinet Member:

- Notes the establishment of the South Yorkshire and Bassetlaw Accountable Care System

- Notes the development of the Sheffield Place Based Plan

- Endorses the establishment of the shadow Sheffield Accountable Care Partnership Board subject to the following principles:
    - That the Cabinet Member for Health and Social Care should co-chair the board
    - That a formal relationship should be created between the Health and Wellbeing Board and the ACP Board to ensure appropriate oversight of its work
    - That the ACP Board is provided with appropriate officer support from across its membership to allow it to make rapid progress
    - That other health and social care transformation programmes should be absorbed into the work of the ACP to avoid the potential for duplication, overlap and wasted resource.
    - That the ACP Board should focus on the wider transformational change required within the health and social care system, in line with the Sheffield Place Based Plan, and should commission activity in line with this.

- Continues to progress the Accountable Care Partnership through arrangements and agreements consistent with the principles above.

- Notes that a further executive report will be presented to formally establish the Accountable Care Partnership Board following its 'shadow' period

Background Papers:

1. Kings Fund briefing note on Accountable Care Organisations: https://www.kingsfund.org.uk/topics/integrated-care/accountable-care-organisations-explained
2. Local Government Association briefing note on 'Next Steps on the Five Year Forward View': https://www.local.gov.uk/sites/default/files/documents/NHS%20England%2C%20next%20steps%20on%20the%20NHS%20%20Five%20Year%20Forward%20Plan.pdf
3. South Yorkshire and Bassetlaw Sustainability and Transformation Plan:

https://smybndccgs.nhs.uk/download_file/167/159

4. Shaping Sheffield (Sheffield Place Based Plan): http://www.sheffieldccg.nhs.uk/Downloads/Get%20informed/SheffieldPlaceBasedPlanFinalVersion.pdf

<table>
<tr><th colspan="4">Lead Officer to complete:-</th></tr>
<tr><td rowspan="4">1</td><td colspan="2" rowspan="3">I have consulted the relevant departments in respect of any relevant implications indicated on the Statutory and Council Policy Checklist, and comments have been incorporated / additional forms completed / EIA completed, where required.</td><td>Finance: Liz Gough</td></tr>
<tr><td>Legal: Andrea Simpson</td></tr>
<tr><td>Equalities: Adele Robinson</td></tr>
<tr><td colspan="3">Legal, financial/commercial and equalities implications must be included within the report and the name of the officer consulted must be included above.</td></tr>
<tr><td>2</td><td colspan="2">EMT member who approved submission:</td><td>Chief Executive</td></tr>
<tr><td>3</td><td colspan="2">Cabinet Member consulted:</td><td>Cllr Cate McDonald</td></tr>
<tr><td rowspan="3">4</td><td colspan="3">I confirm that all necessary approval has been obtained in respect of the implications indicated on the Statutory and Council Policy Checklist and that the report has been approved for submission to the Decision Maker by the EMT member indicated at 2. In addition, any additional forms have been completed and signed off as required at 1.</td></tr>
<tr><td colspan="2">Lead Officer Name:
James Henderson</td><td>Job Title:
Director of Policy, Performance and Communications</td></tr>
<tr><td colspan="3">Date: 30 August 2017</td></tr>
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Sheffield Accountable Care Partnership

Purpose of Report

1. This report sets out the basis for a new approach to health and social care in the city. This approach will be based upon a clear focus on prevention and reducing health inequalities and will be taken forward by a new Accountable Care Partnership. In particular, the revised approach will see much greater integration between health and social care budgets and commissioning activity to achieve agreed outcomes. This report identifies those outcomes and seeks agreement to key principles for further work including entering into revised partnership arrangements.

Background and Context

2. The Sheffield Joint Health and Wellbeing Strategy identifies the key mission of the Sheffield Health and Wellbeing Board, a committee of the City Council jointly chaired by the Clinical Commissioning Group (CCG), as the following:

    - *Tackle the main reasons why people become ill or unwell and in doing so reduce health inequalities in the city.*

    - *Focus on people – the people of Sheffield are the city's biggest asset. We want people to take greater responsibility for their own wellbeing by making good choices. Services will work together with Sheffield people to design and deliver services which best meet the needs of an individual.*

    - *Value independence – stronger primary care, community based services and community health interventions will help people remain independent and stay at or close to home.*

    - *Ensure that all services are high quality and value for money.*

3. Although part of the strategy, achieving this mission has proven challenging. Some of the key challenges that have been identified are as follows:

    - A lack of integration within the current health and social care system which prevents resources flowing to the area of greatest impact and need

    - A lack of flexibility in allowing new approaches

    - Although the Health and Wellbeing Board brings together the CCG, primary care, the Council, and Healthwatch it has until recently not included the key

providers within the city and therefore a truly system wide focus has not been developed.

- A general lack of resources in the system, particularly in the face of the government austerity programme, for both on health and social care, although this impact has been greater for social care budgets

- A lack of a system-wide approach to workforce development, including investment in the skills and knowledge that staff will need to work and thrive in a new context

4. Beyond the immediate challenges set out above, health outcomes for people in Sheffield are not as good as they should be. We have seen a flattening out in both life expectancy and healthy life expectancy over the last few years when other developed economies have continued to increase; there are substantial and stubbornly resistant to change health inequalities[1] in the city; and we continue to perform below the national average on a wide range of population health measures. And at a national level, we have a system that has arguably focussed too much on structural reform as a route to improving outcomes for people.

5. Recognising the challenges facing the NHS and the wider health and care system, in October 2014, NHS England published the Five Year Forward View[2] in October 2014. This set out a number of possible models for the future planning and delivery of health and care in local areas, aimed at improving the quality and sustainability of current provision. The Forward View explicitly recognised that all areas were different and that there should be no one size fits all approach, and instead solutions had to be based on local needs and circumstances. Notwithstanding this, since that time, one of the models described (the 'accountable care' model[3]) has gained most traction.

The Concept of Accountable Care

6. The concept of accountable care is being presented within this paper as an opportunity to tackle some of the challenges that have impeded progress. It needs to be said at the outset, that the accountable care approach may help to make better use of current resources but does not deal with a fundamental challenge of a lack of resources within the system at this stage.

[1] This refers to the wide variety of health inequalities seen in the city, between different geographical areas, between different communities of identity, and different communities of interest
[2] https://www.england.nhs.uk/publication/nhs-five-year-forward-view/
[3] Described in the Five Year Forward View as 'Primary and Acute Care Services'

7. The concept is one that has developed internationally over the last decade. There are a number of formal definitions available, notably the Kings Fund definition[4]. At the heart of the definitions is the need for focused effort to rebalance care delivery towards the needs of people and populations and away from service specific priorities. Often within this is a network of providers with a shared goal and aim, a single shared set of outcomes, and sometimes a single budget.

8. If fully implemented the concept of accountable care will represent a fundamental change to the way in which health and care services have been planned, commissioned and delivered to date. However, it should be noted that the present plans for a Sheffield Accountable Care Partnership, as described below, do not envisage putting all features of the wider model in place at this stage – particularly the use of contractually defined population health outcomes and objectives.

9. Notwithstanding this, an accountable care approach has to be based upon collaboration, flexible use of resource, an unremitting focus upon agreed outcomes, and a willingness to embrace initiatives from all parts of the system both statutory and voluntary. The development of this model of working has fundamental implications for the nature of commissioning and implies a more collegiate and collaborative arrangement between the commissioner and a provider network.

Impact

10. Although the move to develop a more integrated approach to health and social care is designed to create conditions for greater success in achieving the city's priorities, experience suggests that an absolute clarity of required outcomes will also be necessary. Agreement to these outcomes is still "work in progress". For the Council it is suggested that these must include:

    - City-wide life expectancy greater than the national average
    - City-wide healthy life expectancy greater than the national average
    - A narrowing of the health inequality gap driven by accelerated improvements in the health of citizens in key localities
    - Sustained outcomes for those receiving early health and care interventions

11. It is acknowledged that the outcomes described above do not adequately capture a single measure of the overall wellbeing of the population, although this is challenging with current data sources. It is also acknowledged there is further work to do on engagement.

[4] https://www.kingsfund.org.uk/topics/integrated-care/accountable-care-organisations-explained.

Place-based Plans and the Sheffield Accountable Care Partnership

12. SCC has been involved in the CCG led Sheffield Place-based Plan, known as Sharing Sheffield (formerly Shaping Sheffield). This sets out a number of priority areas for the health and social care system in Sheffield (see Appendix A), and identifies the broad themes around which the Accountable Care Partnership for Sheffield may shape its thinking and delivery.

13. There is, at the current time, no desire for organisational change within Sheffield. It is expected that the responsibilities of the current legally constituted organisations will remain, with no expectation of new organisations being created or existing organisations being disbanded. As a result the concept of an Accountable Care Partnership (ACP) for Sheffield has gained traction, based on the accountable care principles described in paragraph 7 above. The principal purpose of the ACP should be to bring commissioners and providers together to plan services, taking a population and outcomes based view and driving transformation in delivery. It is also expected there will need to be a fundamental redefinition of the role of commissioning in the NHS which, when combined with an alliance of providers and functions within SCC will form the ACP.

14. Thus the task for the emerging Sheffield ACP is to develop a partnership of existing organisations with a clear common purpose, and to reshape the way in which those organisations operate in response to that purpose.

15. The Accountable Care Partnership for Sheffield will involve the various local NHS provider organisations (including Sheffield Teaching Hospitals; Sheffield Children's Hospital; Primary Care Sheffield, and Sheffield Health and Social Care Foundation Trusts), the Clinical Commissioning Group, and Sheffield City Council. It is intended to deliver integrated care across Sheffield, by bringing together commissioning and service delivery arrangements across the various organisations involved. The stated aims of the shadow Sheffield ACP are:
    - Delivering tangible improvements in local health and wellbeing
    - Tackling persistent inequalities in health and wellbeing
    - Improving public engagement and empowerment
    - Ensuring the sustainability of the Sheffield health and care economy
    - Supporting a motivated and high-performing workforce

16. Achieving these aims will require us to take a population-wide health and wellbeing management approach, with a focus on prevention and early intervention within safe, strong, and resilient communities in which people are supported to live independently. Where care is needed, it should be focused, as far as possible around local neighbourhoods, and should be integrated between providers across end-to-end pathways to reduce fragmentation. Access to high quality, high intensity should be

available when required, delivered at the appropriate scale. And resources should be targeted on the basis of population need and where they will have the most impact, with investment and disinvestment decisions made to deliver ACP outcomes.

17. In addition to these principles it will be important to ensure that the inequality agenda is built into the heart of the approach, and that the focus on prevention[5] is built in across the whole of the agenda and not seen as separate. As well as becoming the planning mechanism for health and care delivery the ACP Board will have a fundamental role to act as the mechanism to redefine commissioning, workforce development, payment reform and ensuring our system is flexible enough to meet future challenges.

18. It is being proposed that an Accountable Care Partnership Board for Sheffield should be established and this has been convened in shadow form. This board is co-chaired by Cllr Cate McDonald and Dr Tim Moorhead (Chair of Sheffield CCG), and comprises the Chairs and Chief Executives of Sheffield Teaching Hospitals, Sheffield Children's Hospital, Primary Care Sheffield, Sheffield Health and Social Care Foundation Trust, Sheffield City Council, and Sheffield CCG. It is proposed the ACP Board is supported by an ACP Executive Delivery Group, comprising the Chief Executives and relevant Executive Directors.

Rationale for SCC involvement in the Accountable Care Partnership

19. The development of Accountable Care as a concept offers significant opportunity for the people of Sheffield. If implemented effectively, it could mean a health and care system that fully focuses on outcomes for the population as a whole, rather than focusing on organisations, services, funding streams, and pathways. It could also result in a health and care system that works better for people, supporting them to stay healthier for longer and out of hospital, and that, in time, saves money (or at least stops costs rising as quickly).

20. With our adults' and children's social care commissioning responsibilities, alongside our public health role, Sheffield City Council is a critical partner within the ACP. It has become increasingly clear over the last few years that there will be no solution to either social care sustainability or NHS healthcare sustainability without considering the health and social care system as a whole. The focus will be on the way that the system as a whole operates, rather than what is in the individual interests of each organisation within the system.

21. Furthermore, it is likely that future additional Government funding for health and social care services will be dependent on the establishment of mechanisms such as an ACP that more closely integrate the planning and delivery of health and social care

[5] Although, as noted above, a focus on prevention does not obviate the need for high quality, responsive and timely healthcare services for people who are in need of support

services. This is a trend that has already begun with the Better Care Fund and additional social care funding announced by the Government in 2016. Areas that do not make rapid progress may find it less easy to secure additional resource or be granted freedoms and flexibilities from nationally set policies and programmes, which may hinder our ability to deliver the quality of health and social care that we aspire to for the people of Sheffield.

22. The advantages of being involved in the ACP are clear, and include:

- The potential to shift the focus of the health and care system from treating illness to preventing people from becoming ill in the first place, promoting wider population health[6]
- The ability to shape and flex services in the city according to local need
- The opportunity to focus the attention on the long-standing and pervasive health inequalities that are a feature of Sheffield, and to use resources and influence to help shift this picture
- Recognition that future Government funding decisions (and therefore service sustainability) are likely to be tied to the effectiveness of integrated working arrangements
- An ACP may represent a mechanism to resolve some of the long-standing 'boundary issues' between the NHS and local government (e.g. delayed transfers of care or Continuing Health Care payments)
- The potential to use the ACP to deliver broader service transformation across SCC and NHS services that we know will be required to meet changing public expectations.

23. Emerging experience from Greater Manchester, where accountable care arrangements have been in development for longer than in Sheffield, suggests that the key positive lessons from high-level partnerships include: ensuring that success and failure is owned as a system, not organisation; ensuring that the relationship with regulators and other national bodies is clear; and focusing on a 'can-do' transformational culture – backing ideas but with careful evaluation.

24. The lessons learned include: the difficulties of a model where there are a large number of organisations[7] with dispersed leadership and fragile mechanisms to hold it all together; a tendency to assume a tiny "central team" will solve problems (underscoring the need for all partners to have ownership with strong political and officer leadership and an appropriately resourced central team with capacity to make things happen); and a failure to engage the public and frontline workforce in the change, leading to cultures and working practices not changing in line with the overall vision for the ACP.

[6] However, there will continue to need to be an absolute focus on providing the highest quality healthcare services for people who do need them

[7] Greater Manchester's arrangements include over 40 separate NHS and local government bodies, significantly more than proposed for Sheffield's ACP

25. It should also be noted that involvement in the Accountable Care Partnership will mean that the Council will have a more direct role than it has ever had before in ensuring that national quality standards within the NHS are maintained, and in supporting decision making around the development and delivery of NHS services (although formal decision making will continue to rest with the responsible organisation).

Wider Context

26. The Sheffield Placed-based Plan and the ACP has been developed in the context of wider work led by NHS England (NHSE). This has created a comprehensive series of areas – referred to as footprints – across the country. For Sheffield, we are within the South Yorkshire and Bassetlaw footprint. These arrangements have primarily involved NHS providers and commissioners. Each footprint was required to produce a plan – a Sustainability and Transformation Plan (STP), and following this a South Yorkshire and Bassetlaw Accountable Care System has been established, involving commissioners and providers from across the STP footprint area. The STP process has attracted criticism as lacking transparency and being overly focussed just on the sustainability of the current system.

27. The work at the South Yorkshire and Bassetlaw level[8] identified three gaps in the current system. These can be summarised as:

- wide variations in quality of care
- variation in outcomes for people
- a gap between available resources and demand

28. Concurrent to this, and in part as a response to those gaps, the development of the Sheffield Place-based Plan has taken place. Each authority in South Yorkshire has done similar.

29. The ACP in Sheffield will therefore be focussed on the Sheffield plan. As a local authority, it is recommended that SCC fully engages with the shaping of the delivery of that plan whilst reserving the right to take an independent view on any consultation about proposed changes to the NHS services and provision.

Issues and challenges

30. Notwithstanding the opportunity that the ACP represents for Sheffield, and as highlighted in the experience of Greater Manchester (set out at paragraphs 19 and 20

[8] https://smybndccgs.nhs.uk/ and https://smybndccgs.nhs.uk/download_file/167/159

above), it is also undoubtedly a complex piece of work, with a number of fundamental challenges that will need to be overcome. The key issues that the board will need to consider as it becomes operational are set out below:

31. Timeframes: the ACP is intended to become fully operational by April 2019. From April 2018 to 2019, the ACP will operate in shadow form alongside the current commissioning and delivery arrangements. The period to April 2018 will be used to design and develop the ACP. As such it represents a challenging timescale, given the breadth of activity the ACP will have in scope and the scale of ambition that the partnership has set out.

32. Existing planning mechanisms: The Board will have to determine firstly how to rationalise the various partnership forums that already exist and ensure they service a common mission, and secondly, how the various planning processes internal to each organisation are harmonised and aligned around the goals for the Accountable Care Partnership.

33. Scale: There is an overall lack of clarity about what the relationship between the two 'footprints' (i.e. South Yorkshire and Bassetlaw ACS, and Sheffield ACP) should be, and which should be mainly responsible for the change needed within the system. Sheffield City Council's view to date has been that whilst both footprints are important, it is imperative that the more local footprint must be responsible for the bulk of what is delivered – it is at this level that effective progress towards more preventative services can be made and at which service delivery between organisations can best be integrated around the needs of individuals. There will be some specialised services[9] which it will make sense to plan and deliver over a larger geography (i.e. South Yorkshire and Bassetlaw), it is not anticipated the ACP will be responsible for specialised services. However, most accept that in general terms the principle of subsidiarity should apply – services should be delivered at the lowest practical level. In effect this would mean neighbourhoods as the default building block for delivery and Sheffield as the default planning footprint. This means that the Sheffield ACP should take primacy in the planning and delivery of services, with the SY and Bassetlaw ACS acting in a support role to the ambitions of the ACP for the residents of Sheffield.

34. Business as Usual: Because of the current pressures across the system there is a risk that the ACP becomes focused on business as usual and solving the latest challenge to face the system (for example delayed transfers of care or 4 hour waiting times in A&E). Whilst these are important issues, an over focus on day to day challenges could serve to derail the ACP from its primary task which is to fundamentally reform the way in which health and care is delivered across the various organisations. A far

[9] For example renal dialysis, neurosurgery, cardiac surgery. Such specialised services have historically been planned across large geographies. SCH and STH both provide specialised services to people across South Yorkshire and beyond, it represents a large share of their service offer.

greater focus on cultural change, as opposed to contractual relationships, will be needed. This is happening now at the frontline, the challenge for the Board is to ensure that same change is reflected at strategic level. Whilst much of health and social care is delivered by statutory service providers, other organisations, particularly in the voluntary and community sectors, also have important delivery responsibilities. For the changes set out in this report to succeed, these non-statutory organisations will need to be fully involved in the proposed accountable care arrangements.

35. This type of longer term, more transformational work could get 'squeezed out' by the day to day operational requirements. Therefore, although it features as a workstream within the ACP, it is imperative that work already underway within SCC on public service reform (PSR) runs through all aspects of how the ACP operates. The principal function of PSR in this area is to ensure that challenge around all aspects of transformation is put into place across the whole of the work of the Board, not being only set within an individual workstream. Crucially, this involves the freedom not to be constrained in our thinking by the current accepted norms of the system/organisational thinking

36. Measuring Progress: It will be vitally important that the Accountable Care Partnership can assess how it is progressing towards its stated ambitions. A dashboard of indicators for the ACP Board is currently in development. This is likely to set out so-called Tier 1 and Tier 2 measures – Tier 1 are long-term outcome based indicators (e.g. on healthy life expectancy), which are likely to move only slowly over time; Tier 2 are shorter term outcome or process measures, which will provide an indication of progress towards the overall ambitions. However, alongside these measures about how outcomes are changing, it will also be important that the board is able to assess progress on the development of the partnership itself, including through the development and use of 'gateways'.

37. Capacity: As it stands, the ACP is lacking in capacity to take forward the ambitious agenda set out above. Consultancy support is currently being provided. To be effective, support will need to be established to take forward activity on the individual workstreams and to coordinate the work of the ACP as a whole. Clearly the board has a strategic leadership role around shaping the delivery of health and social care services across the city. This role will need to be supported by dedicated capacity to help them fulfil this role, directly to the ACP Board and Executive Group, and needs to include, as a minimum, the following skills:

    - Operational leadership [what does this mean for different groups of staff and professional disciplines, and how can those groups work together to realise the change needed]
    - Programme management [for rigour and discipline about finances, risks, project resource allocation]
    - Clinical leadership [engagement with workforce, regulators, etc.]

- ‘Functional’ leadership (HR, IT, finance, legal, analysis, communications) [addressing specific challenges about how we work together as organisations]

38. Each organisation that forms the ACP should contribute resource to enable this team to be established. We will need a set of officers across the organisations in the partnership who are tasked with working on it, as a partnership. This would give all organisations collective responsibility for the success of the ACP.

39. Approach to commissioning: It is clear that commissioning arrangements across the health and care system will have to change: this is being considered as part of the commissioning review cited above. Nevertheless, the concept of accountable care fundamentally challenges the ‘commissioner-provider split’. There is merit in establishing a principle that commissioning should:

    - focus on strategic goals and not service level detail
    - should be undertaken with a place based geography as a default
    - should increasingly be a joint and equal approach between the NHS and SCC
    - increasingly commissioning should take an explicitly preventative focus
    - enable decision-making where it is most appropriate, supporting roles that span commissioning organisations as appropriate.

40. Governance: although the shadow ACP Board and Executive Group are now in place, there are a number of unresolved governance challenges that remain. These include how the ACP is accountable to local people through democratic structures, and how other joint health and care programmes currently in existence (for example, the Health and Well Being Board (HWBB), the Better Care Fund and Executive Management Groups) should relate to the ACP. The role of the HWBB might also be developed as one of promoting engagement within constituent organisations, with a wider range of bodies in the development of the ACP.

41. In particular, there is a great deal of overlap between the HWBB and the ACPB in terms of organisational representation and some of the named members of both boards. We have refreshed the membership of the HWBB so there is greater plurality of constituencies represented, and a greater clinical and professional input. The input of the HWBB to the work of the ACPB should be strategic and should focus on setting the broad mission of the ACPB and the broad expectations around achievement. This should also ensure that the work of the ACP is clearly located in the Health and Wellbeing Strategy, the Joint Strategic Needs Assessment, and the broader role of the HWBB.

42. It is proposed that:

- The broad mission and level of ambition for the Accountable Care Partnership Board should be set by the Health and Well Being Board. The Cabinet Member is asked to note that some changes to current partnership arrangements may be needed to take into account the need to streamline with the mission established.

- As the ACP develops, the governance arrangements will need to be kept under review, including whether it will be necessary to establish a mechanism to delegate specific SCC functions to new joint arrangements. This is not within the scope of this paper.

- In the leadership of this, the co-chairs should be clear and mindful that meaningful change will not come from changes in governance, but changes in culture and ways of operating.

Has there been any consultation?

43. The CCG has facilitated consultation on the Sheffield Place-based Plan (now known as Sharing Sheffield, formerly Shaping Sheffield). This has consisted of a number of consultation events (held on 21 April 2016, 29 September 2016, and 9 March 2017) with invitees from across the public, private and voluntary sectors in Sheffield. In addition to this, the CCG has supported a twitter conversation using the hashtag #shapingsheffield. Full details of the consultation, including the participants, key themes emerging, and how this was used to shape the plan can be found on the CCG's website at http://www.sheffieldccg.nhs.uk/our-projects/shaping-sheffield.htm. The plan has also been discussed by the Sheffield Health and Wellbeing Board on multiple occasions, including substantively in September 2016, and again in January 2017 to consider feedback from the consultation undertaken to that point. In its revised terms of reference the Health and Wellbeing Board has indicated that it should have ownership and oversight of strategic planning across its remit, which would include oversight of the Sheffield Place Based Plan. Transformation, behavioural and cultural change could be helped by engaging with patients and citizens in design, delivery and governance/ management of services.
    It is acknowledged that further work is required to make the process more transparent and accountable to the people of Sheffield. This needs to be explicitly picked up by the ACP Board.

44. There has not been consultation on the establishment of the ACP Board itself, but this has followed as a direct consequence of the development of the Place-Based Plan.

Equality of Opportunity Implications

45. As a Public Authority, we have legal requirements under Section 149 of the Equality Act 2010. These are often collectively referred to as the 'general duties to promote equality'. To help us meet the general equality duties, we also have specific duties.

We have considered our obligations under this Duty in this report and found that there are no direct equality of opportunity implications arising as a result of this report.

46. Clearly however, the development of Accountable Care arrangements for Sheffield could have profound implications for the planning and delivery of health and care services, and, as this report has noted, could have an impact upon health inequalities in the city. Specific proposals arising from the Accountable Care Partnership will be subject to formal decision making in line with the governance arrangements of each of the partners. As such, and because the ACP partners are all public bodies, decisions on any specific changes to service delivery or policy will include the consideration of equality implications, to continue to ensure the Council and our partners fulfil our statutory obligations.

Financial and Commercial Implications

47. There are no financial or commercial implications arising directly from this report. Any financial or commercial implications that arise from the formal establishment of the ACP Board or the relationships between the partners will be addressed in a further report.

Legal Implications

48. NHS bodies and local authorities have a duty under section 82 of the National Health Service Act 2006 to co-operate in exercising their respective functions in order to secure and advance the health and welfare of the population. The proposals outlined in this report comply with this duty.

49. Further legal implications may arise should the relationships within the ACP become more formal or the delegation of functions to joint arrangements needs to be considered as the ACP develops. These will be addressed in a future report to formally establish the ACP Board.

50. The Health and Wellbeing Board is a committee of the local authority established under the provisions of Part 5 of the Health and Social Care Act 2012 and consisting of members and senior officers of the local authority, representatives of the CCG and of the local Healthwatch organisation, and such other persons or representatives as thought appropriate by the local authority or the Board. It has a statutory duty to encourage persons who arrange for the provision of any health or social care services in the area to work in an integrated manner for the purpose of advancing the health and wellbeing of the people in the area. Having strategic oversight of the work of the ACP is consistent with this duty.

Alternative options considered

51. The only other option open to the Council at this time would be not to participate in the shadow Accountable Care Partnership. Were the Council to decide to pursue this option, it is likely that the ACP would be established in any event (although without SCC participation). In this scenario, it is likely that the Council would still have to be responsive to the ACP, but with much reduced influence and control over the direction of travel. It is also possible that funding opportunities (particularly for social care) might be lost either because of non-participation or because of a perceived weakening of partnership working in the city. For these reasons, this option is not recommended.

Reasons for Recommendations

52. The recommendations contained in this report would, if implemented, provide a starting point for the development of a new approach to the planning and delivery of health and care services across Sheffield, with the potential to have a significant impact on health outcomes for people across the city.

53. Given Sheffield City Council's social care and public health responsibilities, and the interdependencies that we have with services commissioned and provided by NHS organisations in the city, it is appropriate that the authority is heavily involved in the development of the ACP, as recommended by this report.

54. It is also important that sufficient safeguards are placed around the Council's participation in the ACP, given the developing nature of the partnership, including the recommendation that a further executive report is presented before the formal establishment of the ACP board following the completion of its 'shadow' phase.

Appendix A – Sheffield Place Based Plan priorities (2017-19)

- We will empower parents, families and carers to provide healthy, stable and nurturing family environments
- We will have midwife led care in every community
- We will Implement a new services that helps grow and nurture life chances
- We will Increase the proportion of children and young people who are school and life ready
- We will recognise the link between employment and physical and mental health and help more people into work
- We will design our services to support improved emotional wellbeing and mental health for children, young people and adults
- We will agree a single risk stratification process for our population and agree how we use this so that we can then target our resources so we can help those most at risk
- We will invest heavily into the development of neighbourhood working
- We will work with our staff and teams to promote flexibility, to promote patient centred services and to promote a culture in Sheffield where staff across organisations are enabled to resolve difficult issues which impact on patients and communities
- We will tackle inequalities head on by making disproportionate investments in effort and resources into those communities with most need
- We will collectively support implementing the Sheffield Tackling Poverty Strategy

These priorities are in support of a broader set of aims over the lifetime of the plan

- Develop Sheffield as a healthy and successful city
- Increase Health and Wellbeing
- Reduce Health Inequalities
- Provide children, young people and adults with the help, support and care they need and feel is right for them
- Design a Health and Wellbeing System that is innovative, affordable and offers good value for money
- Be employers of caring and cared for staff with the right skills , knowledge and experience and supported to work across organisational boundaries
- Deliver excellent research, innovation and education
- To develop and expand specialised services for children and adults across the region

The Sheffield Place Based Plan is available to download at:
http://www.sheffieldccg.nhs.uk/Downloads/Get%20informed/SheffieldPlaceBasedPlanFinalVersion.pdf

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