BOARD OF DIRECTORS MEETING (Open)

Date: 11 October 2017 **Item Ref: 11ii**

TITLE OF PAPER	**Accountable Care Partnership – Statement of Intent**
TO BE PRESENTED BY	**Kevan Taylor, Chief Executive**
ACTION REQUIRED	The Board is asked to confirm the Chairman and Chief Executive are able to sign the statement of intent
OUTCOME	The collaborative working with the other local health and social care providers in Sheffield.
TIMETABLE FOR DECISION	October 17
LINKS TO OTHER KEY REPORTS / DECISIONS	Early discussions at the Board of Directors
LINKS TO OTHER RELEVANT FRAMEWORKS BAF, RISK, OUTCOMES	BAF reference 104ii
IMPLICATIONS FOR SERVICE DELIVERY AND FINANCIAL IMPACT	The development of the ACP will provide a mechanism to evolve and improve future service delivery as part of a whole system approach and create opportunities to aligning services.
CONSIDERATION OF LEGAL ISSUES	Each organisation involved in the ACP holds individual accountabilities and governance constraints and these may take precedence. The ACP documents attached to this paper are not legally binding on the organisation.

Author of Report	Anna Pridmore
Designation	Governance Specialist
Date of Report	6 October 2017

SUMMARY REPORT

Report to: **BOARD OF DIRECTORS MEETING**

Date: **11 October 2017**

Subject: **ACP – Statement of Intent**

Presented by: **Kevan Taylor, Chief Executive**

1. Purpose

For Approval	*For a collective decision*	*To report progress*	*To seek input from*	*For information*	*Other (please state below)*
X	*X*				

2. Summary

The Board has previously received updates on progress against the development of an Accountable Care Partnership (ACP). The Board has also been advised that a statement of intent was being prepared that would be presented to the Board.

Attached to this paper is the statement of intent, a Memorandum of Understanding (MoU) and Terms of Reference (ToRs). The key points to highlight in the papers are:

- The six main health and care organisations in Sheffield have commenced a programme of work to develop an ACP in Sheffield.
- The statement outlines the ACP vision and long term aims with the full benefits of the improvements being seen by 2025.
- The MoU describes the three phases of development of the ACP; currently the ACP is at the development phase.
- The MoU outlines the delivery programme for the ACP during 2017/18.
- The ToRs outline the arrangements for the ACP Board which represents one of the three tiers in the overarching governance structure.
- The agreements that are in place are not legally binding on the Trust.
- The suite of papers provides a framework and mechanisms for all parties to work collaboratively.

3 Next Steps

The Statement of intent requires the Chairman and Chief Executive to formally sign the document.

4 Actions

The Board is asked to confirm the Chairman and Chief Executive are able to sign the statement of intent

5 Monitoring Arrangements

The Board will receive regular reports.

6 Contact Details

Margaret Saunders
Director of Corporate Governance (Board Secretary)

Sheffield Accountable Care Partnership

Statement of Intent

This document sets out the key issues on which the participants in Sheffield's Accountable Care Partnership (ACP) have agreed. It refers to a number of appendices (The ACP board Memorandum of Understanding [Appendix 1] and Terms of Reference [Appendix 2]). For the sake of clarity this document takes precedence over those appendices in the event of any contradictions or misunderstandings.

The participants, who have signed the document as below, recognise that in coming together as an ACP, the individual accountabilities and governance constraints of each organisation must be respected and may take precedence. They also recognise that the operational day to day delivery of health and care will remain within organisations and that this is not the purpose of the ACP. This does not undermine the determination of the participants to seek to effect the beneficial changes which this Partnership is seeking. This document is, as a consequence, not legally binding on the participants.

Parties to the Agreement

The parties to this agreement are:

- NHS Sheffield Clinical Commissioning Group (CCG)
- Primary Care Sheffield (PCS)
- Sheffield Children's Hospital NHS Foundation Trust (SCH)
- Sheffield City Council (SCC)
- Sheffield Health and Social Care NHS Foundation Trust (SHSC)
- Sheffield Teaching Hospitals NHS Foundation Trust (STH)

Vision and Aims

The parties have agreed to work together in:

> *"Improving the health and wellbeing of Sheffield's residents through the promotion of a health and wellbeing culture in all we do and the development and delivery of a world class health and care system"*

This is the ACP vision.

This will be achieved by targeting improvements which by *2025* will see:

- *Healthy life expectancy greater than the national average*
- *Upper decile outcomes for those receiving health and care interventions*
- *A difference in healthy life expectancy lower than the national average between a) the most and least deprived sections of our population, and b) those with mental and physical health disorders*
- *Equity of access to health and social care services for all citizens*
- *Waiting times for Child and Adolescent Mental Health Services lower than the national average*
- *A balance of expenditure against the total resources available to our health and care system*

These are our long-term aims, which will be achieved by maintaining a persistent focus in all our programmes of work on:

1. Delivering tangible improvements in local health and wellbeing
2. Tackling persistent inequalities in health and wellbeing
3. Improving public engagement and empowerment
4. Ensuring the sustainability of the Sheffield health and care economy
5. Supporting a motivated and high-performing workforce

Accountable Care Principles

To ensure that we deliver our vision and aims in ways that are consistent with public-sector values, all partners make a commitment to adhering to the Accountable Care Principles summarised below:

Mutuality

- Accountability to the partnership and to the population of Sheffield
- Working across organisational boundaries
- Working in the best interests of the wider system rather than those of individual organisations
- Leveraging the knowledge, skills and experience of partners in the design and delivery of services
- Ongoing engagement and service co-design with service users and the general public
- Empowering individuals to take greater ownership of their health and wellbeing

Population outcomes

- Adopting a population health and wellbeing management approach
- Focusing on health and wellbeing outcomes rather than traditional service line KPIs
- Shifting the model of care towards prevention and early intervention rather than treatment and cure
- Delivering integrated services focused on the local needs of individuals, their carers, and their families
- Developing a flexible workforce aligned to changing patterns in skills and service demand
- Working with partners to consistently address each of the wider determinants of health

Sharing Risk and reward

- Removing barriers to collaboration
- Ensuring transparency of resources across the system
- Enabling flows of resources across the system to support people's needs, develop services, and tackle health and wellbeing inequalities
- Implementing systems to enable the fair and equitable apportionment of risk and reward across the partnership

Values and governance

- Defining our shared values
- Developing a high-performing shared culture aligned to our principles and objectives

- Creating a culture of greater accountability to service users and the public
- Greater involvement of the public in the configuration and delivery of services within the ACP construct

Operating Model

The responsible Executives from the participating organisations will work together to establish programmes of work which will set organisational structures, work priorities and reporting mechanisms, designed to achieve the ACP aims. These will be dynamic and will be updated / reshaped as required and as priorities evolve in the years ahead.

The ACP will aim to act collaboratively and with pace and will explore organisational mechanisms which facilitate that approach, having regard to the overriding fiscal and fiduciary responsibilities of individual parties.

The initial organisation structures, first phase priorities, operating model, terms of reference and authority limits are set out as appendices to this document.

Signed by:

NHS Sheffield Clinical Commissioning Group (CCG)

Chair: _____

Chief Executive: _____

Primary Care Sheffield (PCS)

Chair: _____

Chief Executive: _____

Sheffield Children's Hospital NHS Foundation Trust (SCH)

Chair: _____

Chief Executive: _____

Sheffield City Council (SCC)

Chair: _____

Chief Executive: _____

Sheffield Health and Social Care NHS Foundation Trust (SHSC)

Chair: _____

Chief Executive: _____

Sheffield Teaching Hospitals NHS Foundation Trust (STH)

Chair: _____

Chief Executive: _____

Appendix 1

Memorandum of Understanding for the Sheffield Accountable Care Partnership

September 2017

Document Control

Title	Memorandum of Understanding for the Sheffield Accountable Care Partnership		
Author			
Target Audience	Sheffield ACP Membership		
Version	V 2.0		
Created Date	17th May 2017		
Date of Issue			
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To be read in conjunction with			
Document History:			
Date	Version	Author	Details
17th May 2017	0.1	Folarin Majekodunmi	Creation of document
22nd May 2017	0.4	Folarin Majekodunmi	
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30th May 2017	0.8	Folarin Majekodunmi	
8th June 2017	1.0	Folarin Majekodunmi	
13th June 2017	1.1	Folarin Majekodunmi	
28 June 2017	1.2	Lucy Cole	Updated with comments at first ACP Board
7th July 2017	1.3	Folarin Majekodunmi	Updated with comments from Cate McDonald
11th July 2017	1.4	Folarin Majekodunmi	Updated vision, aims and objectives
21st July 2017	1.5	Lucy Cole	Incorporating comments from ACP Board
24th July 2017	1.7	Folarin Majekodunmi	Changes to Objectives and Principles
21st August 2017	1.8	Folarin Majekodunmi	Inclusion of SoI and updated objectives
1st September 2017	2.0	Gareth Hartley	Incorporate ACP Board comments and alignment with SOI
Approval by:			

Contents

1. THE MEMORANDUM OF UNDERSTANDING

a. Introduction

We recognise that integrating health and social care is vitally important for improving the efficiency of our public services and delivering improved health and wellbeing for our population. The NHS Five Year Forward View articulates why change is urgently needed, what that change might look like and how it can be achieved. It describes a number of potential models of care which could be provided in the future, and defines the actions required at local and national levels to support delivery.

The six main health and care organisations in Sheffield have commenced a programme of work to develop an Accountable Care Partnership (ACP) in Sheffield, in line with the ambitions outlined in the place-based plan 'Shaping Sheffield'. Each of these organisations brings a different perspective, opportunities and constraints derived from, for example, their form, regulation and membership. However, all six organisations have committed to the development of The ACP.

There will be three Phases in the development of the ACP:

1. **The Development Phase** – cementing partnership working between all provider and commissioner organisations. Decision-making authority for the ACP Board to develop the ACP.
2. **The Shadow Phase** – initial delivery of new integrated models of care within the existing organisational framework. Transition to new joint strategic commissioning arrangements and development of the future model of provision.
3. **The Operational Phase** – fully functional ACP with defined strategic place-based commissioner and integrated provider model, with delegation for some (to be determined) decision-making (albeit with full accountability to organisational boards under the current legislative framework).

b. The purpose of the MoU

This MoU serves as a record of the basis on which all Parties will collaborate to form an Accountable Care Partnership Board during the **Development Phase** of the ACP. It should be understood that some change in arrangements will be warranted in future phases, this will likely necessitate the creation of a new or updated MoU to reflect these arrangements.

This document sets out:

- The Parties' commitment to the ACP's vision, aims, priorities and objectives as organisations;
- Shared expectations relevant to ACP partners
- Expectations relevant to next steps in the development process

c. The parties to the MoU

The Parties to the agreement are those listed in the accompanying Statement of Intent (SoI).

This MoU focuses on the elements of governance and our shared commitment to achieving common goals, through the joint design and transformation of services.

Where possible, all parties agree to act in good faith to support the aims, priorities and objectives of this MoU for the benefit of all Sheffield residents, subject to their specific legal/ statutory obligations and constraints

The parties recognise that in coming together as an ACP, individual accountabilities and governance constraints of each organisation must be respected and may take precedence. They also recognise that the operational day to day delivery of health and care will remain within organisations and that this is not the purpose of the ACP. This does not undermine the determination of the participants to seek to effect the beneficial changes which this Partnership is seeking. This document is, as a consequence, not legally binding on the participants.

All parties agree that the present MoU is not legally binding.

d. Recommended Decision-making arrangements

As the ACP continues to develop and mature, it will be appropriate to shift increasing amounts of decision-making from the partner boards to the ACP Board.

During the **Development Phase,** early decision-making will be relevant to the configuration of the ACP Board itself and will therefore need to be made by partner boards and in some cases organisations' memberships. However, as it develops, the ACP Board will increasingly be in a position where it needs to make decisions about its own future.

The table below provides the recommended division of decision-making for the ACP Board during the **Development Phase**.

	Major Programme Decision Areas	Remains with individual partner boards	Decision-making passed to ACP Board	Indicative Timescales
1	Agreement on the ACP Board Terms of Reference and Memorandum of Understanding			Jul-17
2	Agreement on the structure and function of the ACP Executive Delivery Group			Jul-17
3	Agreement on key ACP objectives	Agree	Recommend	Jul-17
4	Agreement on ACP outcomes framework	Agree	Recommend	Aug-17
5	Agreement on strategic commissioning arrangements	Agree	Recommend	Oct-17
6	Definition of ACP commercial approach e.g. collaboration vs. competitive process in line with public contract regulations and OJEU regulations	Agree	Recommend	Oct-17
7	Agreement on the initial scope of the ACP (i.e. which services will be included)	Agree	Recommend	Oct-17
8	Agreement on the implementation plan and implementation governance arrangements	Agree	Recommend	Oct-17
9	Agreement on conferring decision-making to the ACP board	Agree	Recommend	Nov-17
10	Agreement on the appointment of the programme director			Oct-17
11	Agreement on the mobilisation of resources required to deliver			Apr-18
12	Agreement on the split between strategic and tactical commissioning functions			Apr-18

2. OUR AMBITION – WHAT ARE WE TRYING TO ACHIEVE AND WHY?

a. Our Shared Challenges

There are significant health inequalities in Sheffield, and despite the progress made in improving the health of the population over the last few years the city is behind the national average for health and social care outcomes.

- Life expectancy for men in the most deprived parts of Sheffield is 74.4 years. In the least deprived parts of Sheffield it is 83.1 years. The difference is 8.7 years.
- Life expectancy for women in the most deprived parts of Sheffield is 78.7 years. In the least deprived parts of Sheffield it is 86 years. The difference is 7.3 years.
- The above two facts also illustrate the difference between men and women.
- Infant mortality rates (per 1000 live births) in Sheffield are 5.5 for White British mothers, 10.9 for Black and Black British mothers, and 13.4 for Asian and Asian British mothers.
- Health deprivation and disability is much higher in the central and eastern parts of Sheffield.
- There are nearly three times as many high-risk drinkers in Central Sheffield than in Dore and Totley
- The estimated prevalence of smoking is nearly three times higher in the most deprived deciles compared to the least deprived parts of Sheffield.
- Smoking in pregnancy is strongly related to socio-economic status and the prevalence of smoking around the time of delivery varies from 0% to 40% across Sheffield neighbourhoods
- The incidence of obesity in parts of the East and North East of Sheffield is twice that of Central Sheffield

Although most of these statistics describe adult health issues, children suffer from health inequalities and are, in many instances, less able to take action themselves to address this than adults. **We need, therefore, to pay particular attention to the health of children, particularly in communities with poorer health outcomes**.

All parties have agreed collectively that a different approach is warranted. The starting point is a shared vision, aims, priorities, objectives and a set of principles that shape the way we work together.

b. Our Shared Vision, Aims, and Objectives

The shared vision, aims, objectives of the Sheffield Accountable Care Partnership, along with the principles it will adhere to, are outlined in the accompanying Statement of Intent (SoI).

c. Leadership in the ACP

System working: Commitments

Through the arrangements in the present MoU, all Parties collectively signal their transition away from an 'organisationally focused mindset', in which they act to secure their own individual interests and future to a 'system focused mindset', in which they collaborate with partners to address the challenges and improve the health of the population of Sheffield.

The shift must be led by the leadership and the expectation must be that they will put the needs of the ACP above those of their employer organisation when appropriate, whilst recognising that individual accountabilities and governance constraints of each organisation must be respected and may take precedence.

Leadership of Whole Systems, published by the King's Fund in 2012, makes seven recommendations to leaders about characteristics commonly associated with success in whole systems. These recommendations have been adapted to make the following commitments:

1. Making new connections across the system with current and potential partner organisations.
2. Adopting an open, enquiring mindset, without being constrained by current paradigms.
3. Embracing uncertainty and being positive about change – adopting an entrepreneurial attitude.
4. Drawing on as many different insights and perspectives as possible; leveraging the power of a diversity of opinion.
5. Ensuring that leadership and decision-making are distributed throughout all levels and functions within the system.
6. Establishing a compelling vision which is shared by all partners in the whole system.
7. Promoting the importance of values – investing as much energy into relationships and behaviours as into developing the ACP.

All Parties are committed to working according to these recommendations.

System working: Practical Implications

The commitments summarised above have practical implications on how the ACP Board and ACP Executive Delivery Group function and interact with partner boards. These include:

- All members of the ACP governance structure are expected to champion the vision, aims, priorities and objectives of the ACP.
- All members are expected to be representatives of their organisation to the ACP and representatives of the ACP to their organisation **in equal measure**. This will require ongoing engagement with members, service users and the general public
- All members are expected to be completely transparent in communications, irrespective of organisational type or focus. Full transparency is expected between commissioners and providers

- All members are expected to work collaboratively to find solutions which best support the delivery of the ACP's mission, irrespective of the impact on any individual organisation (where appropriate).
- Where individual partner boards elect not to honour a commitment or ratify a recommendation from the ACP Board, a rationale for the decision should be provided from a "system" perceptive.

d. ACP Membership

All Parties intend that any organisation who is a partner to the ACP agree to:

- The ACP's vision, aims, objectives, principles, and priorities (outlined in the Statement of Intent) and ownership of the system success/failure.
- Acknowledge that the collective delivery of health and wellbeing outcomes is the most important success factor.
- Move towards the adoption of a single capitated budget and acknowledge that all parties have a shared responsibility for the system-wide finances (proportional to their contribution).
- Being part of the ACP at this stage and to engaging with further work to define future governance arrangements (for Shadow and Operational Phases).
- Work towards developing how the principle of proportionality of impact and risk share will operate within the ACP governance and decision-making processes.

During the Shadow and Operational Phases, greater involvement is expected from Independent and Voluntary Sector Organisations (outside of Primary Care Sheffield which is a core member of the Partnership). It is anticipated that these organisations will be associates, rather than direct members, of the ACP with separate agreements.

e. Our Desired Deliverables

The parties within the ACP will ultimately be jointly accountable for deliverables aligned to:

- The priorities for 2017-19, listed in the Sheffield Place-Based (TBC).
- The triple aim of the overarching SY&B ACS

These are set out below. The priorities from place-based plan and will need review and refinement as an initial responsibility of the ACP Board.

2017-19 Priorities (From Sheffield Place-Based Plan)	**Care and quality**
• 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 service that helps grow and nurture life chances • We will Increase the proportion of children and young people who are school and life ready	• Joined-up, high-quality services across hospitals, care homes, general practices, community and other services • Easy and convenient access to services across settings and times of day • Greater availability of services closer to home • Better quality, more specialised hospital-based care • Greater availability and variety of non-health services that enhance people's health

• 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	**Health and wellbeing** • Better support for individuals in relation to physical and mental wellness and prevention • A wider variety of healthy living schemes aimed at all segments of the population • Active networks and links that connect people across communities and provide support • Greater collaboration across the public sector relevant to the wider determinants of health **Finance and sustainability** • High-quality efficient services which provide good value-for-money for tax payers • Reduced waste and greater efficiency in service delivery • Greater use of available funding in enabling individuals to stay well and providing care closer to their homes • A workforce and services that works flexibly to respond to individual needs and how people live locally, ensuring that the right skills and services are present in the right place and the right time

f. Engagement

Parties are collectively and individually committed to sustained and significant public and patient engagement at neighbourhood, ACP and where required ACS level, to support transformation that benefits the population of Sheffield. Building on the key commitments, Parties will work as a Partnership to ensure that all partners including: the public, users of services, carers, health and care commissioners, providers, HWBs, AHSNs and the voluntary sector are involved in shaping the future of health and care across the City of Sheffield.

3. OUR DELIVERY PROGRAMME FOR 2017/18

a. Priority work streams

The focus in the short-term on a number of priority work streams which have been identified and agreed by all parties as requiring a more integrated approach to delivery. These will enable us to begin to address our stated aims and create a stable platform on which to drive further transformation.

The priority work streams, and the key objectives within each are summarised below. These will be dynamic and will be updated / reshaped as required and as priorities evolve in the years ahead:

Priority	Objectives
1) Urgent and Emergency Care	a) Investing in General Practice to offer a consistent 2-hour response for urgent patients through one practice leading across their neighbourhood b) A 2-hour response to General Practice from Community Services accessed through improved SPA; c) Ambulances conveyance to community services not just acute [See and Treat] • Hear and Treat triage at 111 will divert to a local clinical hub to better access City services" d) Ensuring equitable access to urgent primary care across the City, and PMCF hubs, WIC, Urgent Care Centre, GP Collab will provide consistent and reliable offer which the public understand. • A&E will divert appropriate patients into step up community services and be part of this primary care offer. e) Implementing a new Assessment Process (STH): • Those with Ambulatory Care Sensitive Conditions will be treated and their support stepped up to enable recovery at home. • Bookable diagnostic slots for GPs
2) Mental Health and Learning Disabilities	a) Improving the quality of services and the experience of those who use them; b) Reducing reliance on long-term bed based care; c) Promoting preventative person centred care delivered at the earliest opportunity; and d) Delivering £4m financial efficiencies in 2017/18.
3) Planned Care Demand Management	a) Integrating Primary, Community and Secondary Care to support improved self-management b) Developing Primary Care to enable improved demand management c) Developing more efficient and effective Secondary Care services where these are the only alternative
4) Long-Term Condition Management	a) Increasing the use of risk stratification to identify and proactively support the most 'at risk' population segments b) Developing locally responsive neighbourhood models to support the delivery of integrated care to individuals with LTCs c) Improving care coordination, expanding single points of access, step up care and support for self-care
5) Children's Services	a) Improving CAMHS, disability and Special Educational Needs services b) Increasing the focus and support for maternity services and early years, to give our children the best start c) Improving crisis intervention and increasing the availability of treatment closer to home d) Enhancing care for vulnerable groups including Looked After Children
6) Communities, wellbeing and social value	a) Improving health and wellbeing through job creation and other employment opportunities b) Supporting improved educational attainment c) Sharing resources and focusing investment on upstream interventions

b. Building a fit-for-purpose platform (enablers)

Fundamental to the delivery of the priority work streams is the establishment of a number of enablers which will underpin the ACP. During earlier phases a number of barriers to successful transformation were identified, including: finance, payment and contractual mechanisms, workforce and inability to work flexibly (organisational or professional boundaries) and cultural and behavioural barriers to change.

There are two types of enabler:

- Strategic - longer-term strategic development and transition to new models of care within an ACP
- Functional enablers which should be considered as 'task and finish' in nature to provide short-term solution generation to immediate issues and barriers in the system.

The following were agreed to be the initial key enabling work streams of ACP. Again, these will be dynamic and will be updated / reshaped as required and as priorities evolve:

- Neighbourhood development (strategic)
- Commissioning (strategic)
- Workforce (functional)
- Finance, contracts and payment mechanisms (functional)
- Digital and technology (functional)
- Back office (functional)
- Governance (functional)
- Communications and engagement (functional)

c. Development of an Accountable Care Partnership

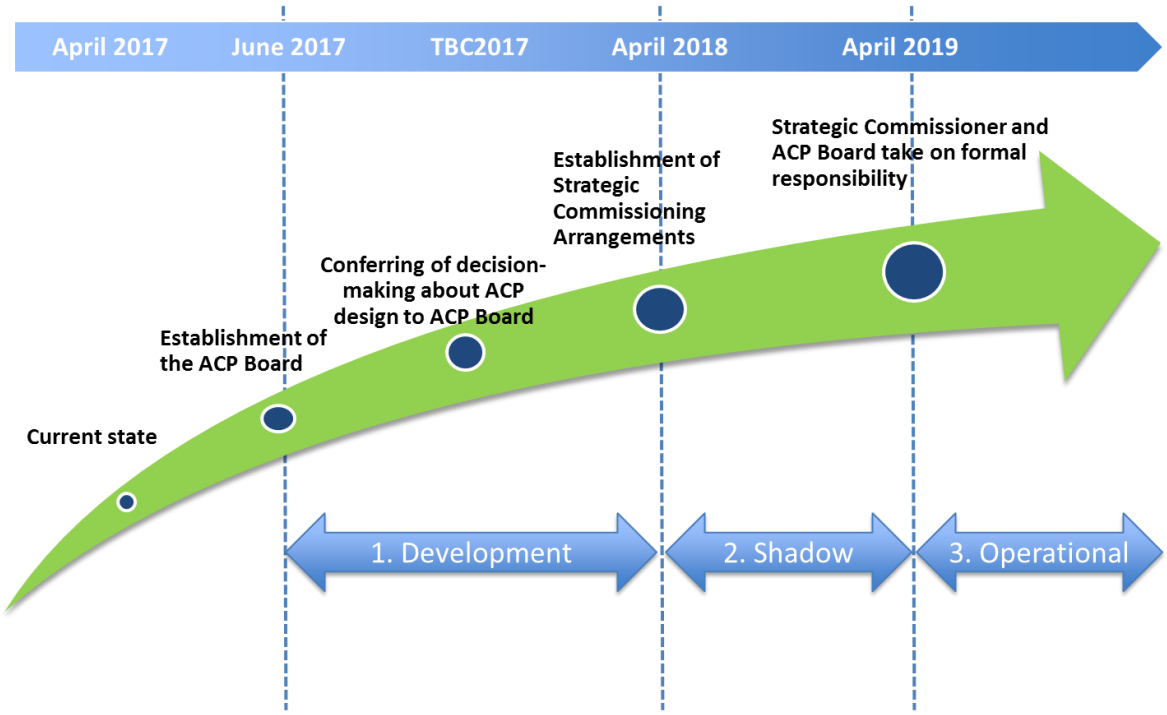
Developing a fully functioning Accountable Care Partnership (ACP) comprising provider and commissioner elements will be multi-stage process.

Each stage will see progressively closer working between partner organisations. This will be supported by appropriate governance arrangements and programme/ project management processes.

Early stages will focus on creating the infrastructure to support the further development of the ACP **(The Development Phase)** and delivering immediate priorities for the system. As the development proceeds, the focus will gradually shift to supporting the delivery of accountable care, under shadow arrangements **(The Shadow Phase)** and finally to supporting the operational ACP **(The Operational Phase)**.

The arrangements outlined in the current document cover the ACP for the **Development Phase**. Partners have made a commitment to reviewing the terms of this document:

- Subject to requests from any partners at any time
- Between phases (Development, Shadow, Operational as part of a gateway process



For all business, outside of the scope of the ACP, governance structures, decision-making and delivery will remain within the remit of the individual organisations.

4. THE DEVELOPMENT PHASE ACCOUNTABLE CARE PARTNERSHIP

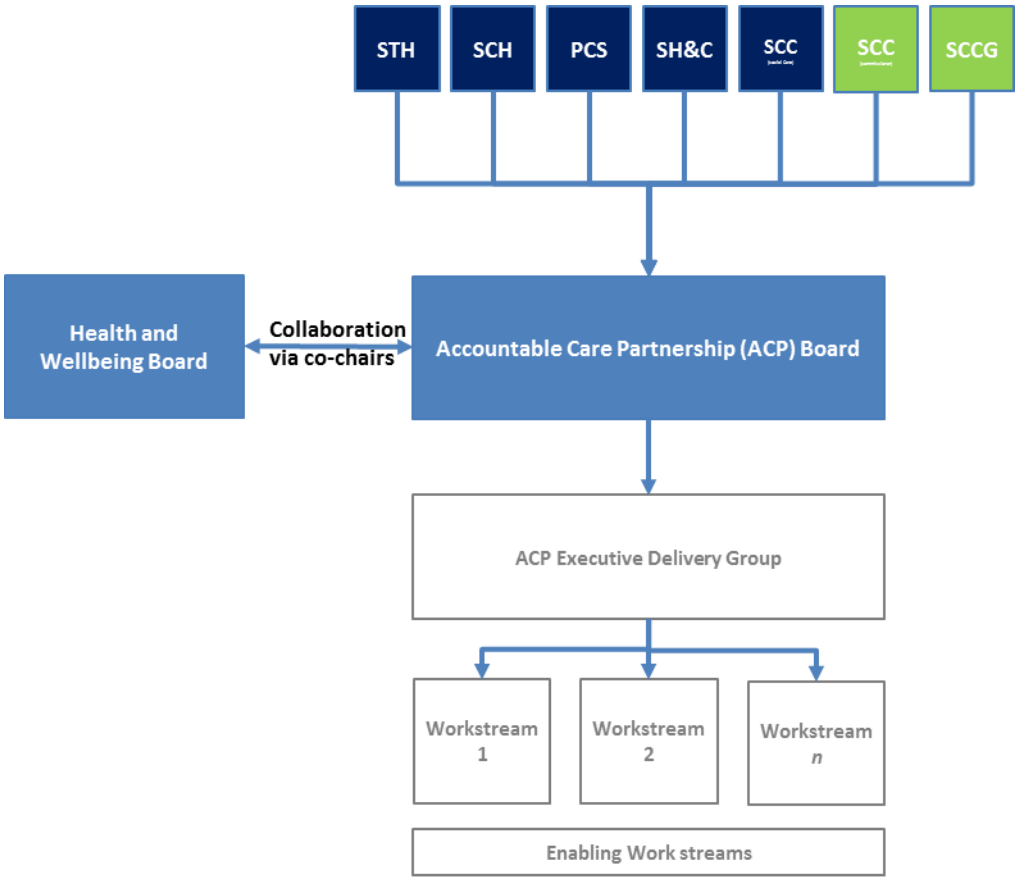
This memorandum of Understanding (MoU) sets out the framework for how the ACP will operate, whilst in the **Development Phase**.

a. Scope and Purpose

The ambition of the Sheffield ACP partners is to create a whole population health system, in which traditional organisational barriers are broken down and care is organised around the needs of service users.

During the **Development Phase** the ACP will not be truly accountable, although it will provide a forum for discussion about the entire system and make recommendations for approval by the boards of its partners. In time, responsibility will be delegated to the board (from member organisations) for the continued development of the ACP, its constituent transformation programme, and all services deemed to be within scope.

The individual components of the governance structure during the development phase is summarised below.



Individual Organisational Boards

At all stages during the development process, individual Organisational Boards retain statutory status (where applicable) and existing accountability. Whilst elements of decision-making may be conferred by partner boards during the **Operational Phase**, within the current legislative framework, actual accountability will remain with member boards.

During the Development Phase, the key task for organisational boards will be to agree what powers will be delegated to the ACP board to provide it with authority to further develop the ACP and to oversee delivery of priority workstreams

The ACP Board

The main focus of the ACP board in the Development Phase will be to support the creation of a fit-for-purpose project structure and to develop new ways of collaborative working. Other responsibilities include:

- Setting the direction of the ACP
- Agree ACP vision, aims, priorities, objectives and the MoU
- Agree system level outcomes
- Oversee development of the ACP
- Oversee delivery of Sheffield Place Based Plan/ agreed outcomes
- Ensure effective partnership working
- Remove organisational barriers or other blockages
- Provide assurance to constituent organisational Boards

- Provide assurance to SYB ACS

The Development ACP Board will:	The Development ACP Board will not:
Provide strategic leadership and oversight of ACP Workstreams	Be a vehicle for leading or managing the delivery of anything that is out of scope or falls under 'Business as Usual'
Oversee the development of, and transition to, new models of care in priority areas / in scope services.	Hold formal accountability for the delivery of operational services.
Make decisions in the context of the shared vision for the Sheffield ACP	Replace decision-making in organisations
Consider investment decisions across the partnership	Share liability for deficit between partners
Collectively hold ACP partners to account for upholding the commitments made in the MoU	Formally impose sanctions against any ACP partner

ACP Executive Delivery Group

The Executive Delivery Group will be responsible for delivery, on behalf of the ACP Board, of the development of an ACP in Sheffield, including (but not limited to):

- Provide oversight, steer and support around the continued development of the ACP (including evolving governance arrangements) for both commissioning and provision
- Development and management of overarching ACP programme plan
- Oversight, steer and support to ACP workstreams
- Ensure timely delivery of ACP workstreams
- Ensure alignment of workstreams and manage interdependencies; with oversight of whole system impact of changes to the model of care
- Prioritise and deploy resources across workstreams
- Remove barriers to bringing together health and care services at an operational level
- Provide assurance to ACP Board

The Workstreams

The workstreams will be responsible for the development and delivery of workstream priorities, this will include the:

- Development and delivery of workstream plans
- Identification of proposed workstream outcomes, measures and targets
- Development and delivery of integrated models of care as per plan
- Ongoing management and monitoring of progress
- Provide assurance to ACP Executive Delivery Group

b. Accountable Care Partnership Governance Framework Development

In the context of our ACP, 2017/18 will be a year of transition, as we look to increasingly formalise arrangements and take greater accountability for healthcare commissioning and provision locally. Over this period, we will by necessity define how partner boards can exercise control over services for which they have accountability, but for which their organisations may no longer be responsible for delivering (shadow phase). There is no single model of good governance in this construct and our collective understanding of what constitutes a suitable arrangement will continue to develop as the ACP approaches its Operational Phase.

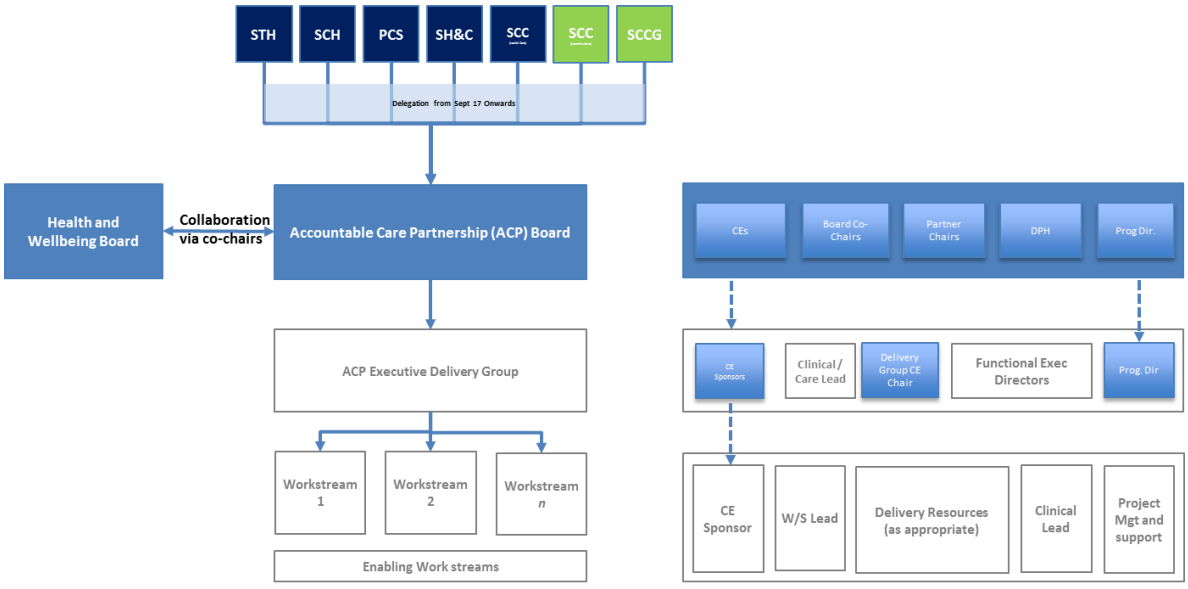
Partners are in agreement that the ACP constitutes a work in progress that will need time to develop its own culture, ways of doing things and internal processes.

As the ACP is in development, legally binding contracts will not be put in place for partners, however this may be done as the ACP enters the **Operational Phase**. During 17/18, the Boards and Governing bodies of the partners will continue to provide assurance oversight through their own board assurance frameworks and governance processes.

c. Our Development Phase ACP Leadership Structure and Development

Governance

The governance structure for the **Development Phase** has been designed to support the ongoing development of the ACP and prepare the system for the **Shadow Phase**. One key output of the **Development Phase** will be determining what mechanism should be used to ensure that the Board (during the Operational Phase) is publicly accountable. Roles and responsibilities within the governance structure have been defined accordingly, as summarised below.



ACP Board

The main aim of the ACP Board during the **Development Phase** is to agree the vision / strategy and oversee the ongoing development of the ACP. Key to this will be supporting partnership working, defining shared outcomes and ensuring that assurance is provided to members' boards (which retain accountability).

As a result, the roles required within this tier of the governance structure can be summarised as follows:

Role	Arrangement	Responsibility
Board Co-chairs	The ACP Board will be co-chaired by the chairs of the Health and Wellbeing Board.	To provide senior input from Primary Care and Social Care partners. To ensure that learnings from HWB inform future integrated working. To maintain continuity of ongoing integrated programmes of work.
Members	**Partner Chairs:** There will be representation from the chairs of the provider organisations **Partner Chief Executives:** There will be representation from the Chief Executive Officers of each of the partner organisations. One of the Chief Executive Officers is also the ACS Lead.	To act as a conduit to their boards/memberships as relates to the progress of the ACP To support system working and ACP outcomes. The ACS lead specifically: To provide a broader context and understanding of the linkage between the ACS and ACP
The Director of Public Health	There will be representation from the Director of Public Health.	To provide leadership and expertise to ensure that the ACP is focused on the development and delivery of improved health and wellbeing outcomes for the population of Sheffield.
Programme Director	The Programme Director will be responsible for the development and ongoing delivery of the ACP Programme in Sheffield.	To coordinate the operation of the Board in conjunction with the Co-Chairs and CEO.

ACP Executive Delivery Group

The **ACP Board** will be supported by the **ACP Executive Delivery Group** made up of partner organisation Chief Executives, workstream leads, with input from clinical leaders. The **ACP Executive Delivery Group** will oversee a centralised PMO function that will provide the support and resource necessary for the development and delivery of the different elements of the programme.

Role	Arrangement	Responsibility
Chief Executive (Workstream) Sponsors	There will be representation from each of the Chief Executive Workstream Sponsors on the Executive Delivery Group.	To ensure progression and delivery in line with ACP outcomes and objectives set by the ACP Board.
Clinical/ Care Lead	There will be representation from the Chair of the Clinical Reference	To provide clinical leadership in the delivery of the ACP programme, ensuring appropriate clinical and user engagement, impact

	Group.	assessment and quality assurance has taken place.
CEO Chair	The ACP Executive Delivery Group will be Chaired by a partner CEO.	To chair and provide leadership to the Executive Delivery Group and ensure cohesion between the Executive Delivery Group and the ACP Board in delivery of agreed priorities and outcomes.
Functional / Enabling Workstream Executive Director Leads	Each functional enabler will have an executive director lead who will represent the functional area on the Executive Delivery Group.	To provide functional representation and system-level executive management to the delivery of the ACP.
Programme Director	The Programme Director will represent the ACP PMO.	To provide dedicated leadership to the delivery of the ACP programme outcomes and objectives. To coordinate the operation of the Executive Delivery Group in conjunction with the CEO Co-Chairs.

The Workstreams

As noted earlier, five workstreams will be set up during the **Development Phase**. The workstreams will be system wide and a key task of the ACP Executive Delivery Group will be to ensure that there is a clear strategic framework for each one, to ensure that there is consistency of outcomes and standards, within which implementation can be delivered.

Key roles within the structure can be summarised as follows:

Role	Arrangement	Rationale
Workstream (Chief Executive) sponsors	Chief Executive level sponsors will hold ultimate accountability for the success or failure of each workstream.	To provide senior leadership and oversight. To ensure that the workstreams are focused on achieving their objectives. To deliver the forecast impact and benefits, and work within accountable care principles. To act as an un-blocker to barriers to change, where this is contrary to ACP commitments. To ensure that the workstream deliverables are of the required quality.
Workstream Leads	Senior managers from partner organisations will lead the day-to-day operations of each workstream.	To ensure an appropriate level of day-to-day workstream management. To enable decision-making outside the Executive Delivery Group.
Delivery Resource	Dedicated delivery resource will ensure that workstreams deliver transformation in line with the vision of the ACP	To provide appropriate resource within key stakeholder organisations to design and deliver sustainable change and outcomes across the system.
Clinical Lead	The Clinical Lead will provide clinical input into all planning and	To provide clinical leadership and expertise to ensure workstreams and enablers are clinically

	decision-making process.	led with wide-scale clinical engagement
Project management support	This will provide dedicated project management support to workstreams and enablers.	To ensure that appropriate administrative support is available, to enable other roles to focus on the most value-add tasks.

5. ROAD MAP AND KEY DATES IN 2017/18

To be confirmed based on Board discussion

Proposed Date	Milestone
TBC	MoU between all partners
TBC	Stakeholders engagement by individual partner organisations
TBC	"Sign-off" of MoU by all partner boards
TBC	ACP leadership team agreed
TBC	Establishment of developmental ACP
TBC	Senior Leadership in Place
TBC	Objectives agreed
TBC	Resources agreed
TBC	Road map for 17/18
TBC	Proposal for next phase ACP
TBC	Service model strategy till 2020

Appendix 2

Sheffield Accountable Care Partnership (ACP)

Accountable Care Partnership Board

Terms of Reference

Version: 1.0

Approved by:

Date Approved:

Author: Folarin Majekodunmi, Project Manager, Sheffield ACP

Date issued:

Review date:

Version Control Sheet

Version	Date	Author	Status	Comment
0.1	31/05/2017	Folarin Majekodunmi	Draft	First draft
0.2	31/05/2017	Lucy Cole	Draft	Updated Content
0.3	01/06/2017	Folarin Majekodunmi	Draft	Amended sections
0.4	13/06/2017	Folarin	Draft	Amended sections

		Majekodunmi		
0.5	28/06/2017	Lucy Cole	Draft	Amendments following first ACP Board
0.6	07/07/2017	Folarin Majekodunmi	Draft	Updated with Cate McDonald comments
0.7	11/07/2017	Folarin Majekodunmi	Draft	Updated vision, aims and objectives
0.8	21/07/2017	Lucy Cole	Draft	Updated with comments from ACP Board
0.9	24/07/2017	Folarin Majekodunmi	Draft	Updated content
1.0	1/09/217	Gareth Hartley	Final	Updated content from ACP Board and alignment with SoI

Sheffield Accountable Care Partnership

ACP Board
Terms of Reference

1. Context

The six main health and care organisations in Sheffield have commenced a programme of work to develop an Accountable Care Partnership (ACP) in Sheffield, in line with the ambitions outlined in the place-based plan 'Shaping Sheffield'. Each of these organisations brings a different perspective, opportunities and constraints derived from, for example, their form, regulation and membership. However, all six organisations have committed to the development of the ACP.

The parties have agreed to work together in:

> *"Improving the health and wellbeing of Sheffield's residents through the promotion of a health and wellbeing culture in all we do and the development and delivery of a world class health and care system"*

This is the ACP vision.

This will be achieved though the following aims:

1. Delivering tangible improvements in local health and wellbeing
2. Tackling persistent inequalities in health and wellbeing
3. Improving public engagement and empowerment
4. Ensuring the sustainability of the Sheffield health and care economy
5. Supporting a motivated and high-performing workforce

Key to delivering this will be the overarching governance framework and the roles and responsibilities across its various tiers. These ToR outline the arrangements for the **ACP Board**, which represent one of three tiers in the overarching governance structure. Separate ToRs exist for the other governance tiers.

Where possible, all parties agree to act in good faith to support the aims, objectives and priorities of this ToR for the benefit of all Sheffield residents, subject to their specific legal/ statutory obligations and constraints.

The parties recognise that in coming together as an ACP, the individual accountabilities and governance constraints of each organisation must be respected and may take precedence. They also recognise that the operational day to day delivery of health and care will remain within organisations and that this is not the purpose of the ACP. This does not undermine the determination of the participants to seek to effect the beneficial changes which this Partnership is seeking. This document is, as a consequence, not legally binding on the participants.

2. ACP development process

There will be three Phases in the development of the ACP:

- The Development Phase
- The Shadow Phase
- The Operational Phase

These terms of reference cover the development phase only. Partners have made a commitment to reviewing the terms of this document:

- Subject to requests from any partners at any time
- Between phases (Development, Shadow, Operational as part of a gateway process

3. Role of the ACP Board

The aim of the **ACP Board** during the development of the ACP is to agree the vision/ strategy and oversee the ongoing development of the ACP. Key to this will be supporting partnership working, defining shared outcomes and ensuring that assurance is provided to members' boards and Sheffield City Council (who retain their existing accountability).

Much of the role of the ACP Board in this phase will be in providing oversight and directing the working of the **ACP Executive Delivery Group**. As ACP development proceeds**,** the main role of the board will be to act as a decision-making forum for the health and social care system in Sheffield, potentially with some delegated authority from the key stakeholders.

In line with the **Memorandum of Understanding**, all board members are expected to shift from an 'organisationally focused mindset', in which they act to secure their own individual and future to a 'system focused mindset', in which they collaborate with partners to address challenges and improve the health of the population of Sheffield. The expectation is that public sector partners will put the needs of the ACP above those of their organisation whilst recognising that individual accountabilities and governance constraints of each organisation must be respected and may take precedence.

The Board is responsible for the deliverables described in section 4. The Board has an agreed membership. Associated meetings / ways of working together will be agreed with all Board members.

4. Key responsibilities

The main focus of the ACP board in the **Development Phase** will be to support the creation of a fit-for-purpose project structure and to develop new ways of collaborative working. Other responsibilities include:

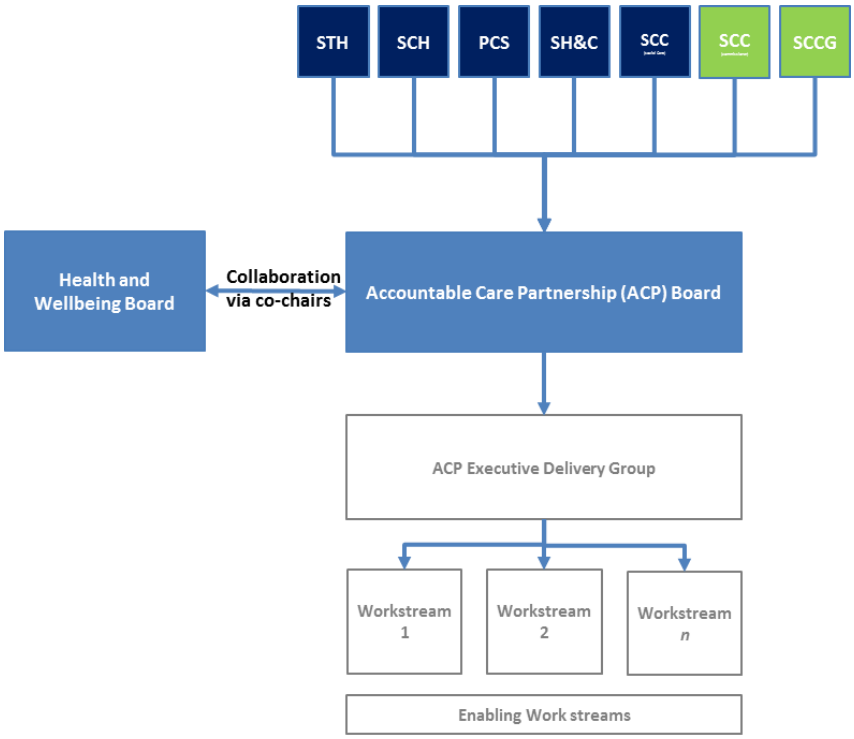
- Setting the direction of the ACP

- Agreeing the ACP vision, strategy, design principles, and the MoU
- Agreeing system level outcomes
- Overseeing development of the ACP
- Overseeing delivery of Sheffield Place Based Plan/ agreed outcomes
- Ensuring effective partnership working
- Ensuring a focus on transformation with an overview of dependent system pressures and business as usual
- Removing organisational barriers or other blockages
- Providing assurance to constituent organisational Boards
- Obtaining the necessary engagement and support from the wider membership of each organisation
- Providing assurance to SYB ACS

*Public accountability will be an important feature of the ACP board in future phases

5. Reporting Arrangements

Initially, the **ACP Board** will report to individual member boards. In time, the ACP Board will hold delegated authority for the development of the ACP in Sheffield, on behalf of its key stakeholder organisations. Reporting into the **ACP Board** will be an **ACP Executive Delivery Group**, which will provide oversight and leadership of the ACP workstreams and enablers.



The **ACP Board** will receive a single, overarching highlight report from the **Programme Director** on behalf of the **Executive Delivery Group** on a monthly basis. The report will contain a progress update and will escalate any risks or issues, as required, to the ACP Board.

6. Membership and quoracy

The membership of the ACP Board will consist of representatives from the six key ACP partner organisations. Other attendees may be invited periodically and when additional expertise or input is required from people other than those identified below this will be agreed via the group as co-opted members.

Name	Organisation	Title	Function
Councillor Cate McDonald **Dr Tim Moorhead**	Sheffield City Council Sheffield CCG	**Co-chairs**	• To provide senior input from Primary Care and Social Care partners. • To ensure that learnings from HWB inform future integrated working. • To maintain continuity of ongoing integrated programmes of work.
Tony Pedder **Sarah Jones** **Jayne Brown** **John Boyington**	Sheffield Teaching Hospitals NHS FT Sheffield Children's NHS FT Sheffield Health & Social Care NHS FT Primary Care Sheffield	**Partner Chair Members**	• To act as a conduit to their boards/memberships as relates to the progress of the ACP • To support system working and ACP outcomes.
John Mothersole **Maddy Ruff** **John Somers** **Kevan Taylor** **Dr Andy Hilton** **Sir Andrew Cash**	Sheffield City Council NHS Sheffield CCG Sheffield Children's NHS FT Sheffield Health & Social Care NHS FT Primary Care Sheffield Sheffield Teaching Hospitals NHS FT	**Partner Chief Executive Members**	
Sir Andrew Cash	Sheffield Teaching Hospitals NHS FT	**ACS Lead**	• To provide input as lead of the South Yorkshire and Bassetlaw ACS, which encompasses the Sheffield ACP.
Greg Fell	Sheffield City Council	**The Director of Public Health**	• To provide leadership and expertise to ensure that the ACP is focused on the development and delivery of improved health and wellbeing outcomes for the population of Sheffield.
To be appointed	NA	**Programme Director**	• To coordinate the operation of the Board in conjunction with the Co-Chairs and CEO.

Each member will need to nominate an appropriate deputy to attend in their absence and changes to the membership must be agreed by the Co-Chairs. Nominated deputies will need to be authorised to act on behalf of the organisation they represent. No single organisation will be permitted to send more than one deputy to any given meeting. The meeting will be quorate only in the presence of a core member (Chair or Chief Executive) from each of the partner organisations.

Members will be responsible for ensuring that appropriate personnel within their own organisation is fully briefed on any group discussions and decisions.

7. Engagement

At this early stage of development, the ACP Board is committed to sustained and significant public and patient engagement at neighbourhood, ACP and where required ACS level, to support transformation that benefits the population of Sheffield. Building on shared principles, the ACP Board will be responsible for ensuring that all partners including: the public, users of services, carers, health and care commissioners, providers, Health and Wellbeing Board, and the voluntary sector are involved in shaping the future of health and care across the City of Sheffield.

8. Decision-making

As agreed in the MoU covering this phase in the development process, the **ACP Board** will not initially have any delegated functions from the Boards/Governing Bodies of its members, which remain separate organisations. All decision-making will be within the scope of services included in the ACP and within the bounds of the Board's remit. All decisions made by the Board will be approved by member boards until such time as there is a formal delegation of responsibilities.

Each member organisation will have a single vote. The board will make decisions by a simple majority of members present, but with the Co-Chairs having a second vote.

9. Record of meetings

A formal record of the meeting will be documented and an action log will be maintained to record actions and outcomes from the meeting, and identify action owners.

10. Frequency

Meetings will take place on a monthly basis.