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Sheffield Health and Social Care NHS Foundation Trust
Sheffield Teaching Hospitals NHS Foundation Trust

Sheffield Accountable Care Partnership (ACP) Board

Reviewing the Chair Arrangements and Interface between the ACP Board and the Health and Well-Being Board

Date: 31/10/2018

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Date	23rd October 2018

1. Purpose

The purpose of this paper is to explore the relationship between the HWB and ACP Board and to explore options around alternative chairing arrangements, following feedback from the CQC in their recent Local System Review.

2. Introduction / Background

Sheffield was criticised by the CQC for having the same chairs for both the Health and Well-Being Board and the Accountable Care Partnership Board. Both are chaired by the CCG Chair and the Cabinet Member for Health and Social Care. The CQC saw the Health and Well-Being Board as accountable for the Local System Review and therefore the experience of Older People in Sheffield. The CQC acknowledged the role of the ACP in delivering the overall action plan to address the criticisms of the Local System Review. They stated the HWB should be holding the ACP accountable for the delivery of the LSR Action Plan. They felt this responsibility was difficult to execute effectively due to both bodies have the same chairs.

This paper therefore proposes a set of options to consider around chair arrangements in the context of the wider interface between the ACP and HWB Board.

This paper is presented in the context of a Terms of Reference review that the HWB Board is undergoing, with final outcomes from this wider review expected in December 2018.

3. Is your report for Approval / Consideration / Noting

Consideration

4. Recommendations / Action Required by Accountable Care Partnership

Members of the ACP Board are asked to provide views on:

1.1.1 Any recommendations on the interface between the ACP and Health and Well-

Being Board in terms of the wider Terms of Reference about to take place.

1.1.2 Comment specifically on the accountability relationship between the ACP and HWB in light of the CQC comments.

1.1.3 Which option around chair arrangements should be taken forward to address the recommendation made by the CQC**:**

Alongside views from ACP Board members, the Health and Well-Being Board was consulted on 25th October 2018. Following this:

- Chairs will consider the information received and determine a way forward. This may need some liaison with individual partner boards.

5. Other Headings

N/A

Are there any Resource Implications (including Financial, Staffing etc.)?

If the option to appoint an independent chair for the ACP is chosen, there will be salary resource implications.

ACP Board – 31/ 10/ 2018

Reviewing the Chair Arrangements and Interface between the ACP Board and the Health and Well-Being Board

31st October 2018

1.0 SUMMARY

1.1 Sheffield was criticised by the CQC for having the same chairs for both the Health and Well-Being Board and the Accountable Care Partnership Board. Both are chaired by the CCG Chair and the Cabinet Member for Health and Social Care. The CQC saw the Health and Well-Being Board as accountable for the Local System Review and therefore the experience of Older People in Sheffield. The CQC acknowledged the role of the ACP in delivering the overall action plan to address the criticisms of the Local System Review. They stated the HWB should be holding the ACP accountable for the delivery of the LSR Action Plan. They felt this responsibility was difficult to execute effectively due to both bodies have the same chairs.

1.2 This paper therefore proposes a set of options to consider around chair arrangements in the context of the wider interface between the ACP and HWB Board.

1.3 This paper is presented in the context of a Terms of Reference review that the HWB Board is undergoing, with final outcomes from this wider review expected in December 2018.

1.4 Additionally other attendees of both Boards have suggested an overlap in areas of responsibility and some comparative information is provided to prompt debate. This paper will be presented to both the Health and Well-Being Board and the ACP Board with members of both boards are asked to provide views on:

1.4.1 Any recommendations on the interface between the ACP and Health and Well-Being Board in terms of the wider Terms of Reference about to take place.

1.4.2 Comment specifically on the accountability relationship between the ACP and HWB in light of the CQC comments.

1.4.3 Which option around chair arrangements should be taken forward to address the recommendation made by the CQC?

2 WHAT DOES THIS MEAN FOR SHEFFIELD PEOPLE?

2.1 Gaining better clarity around chair arrangements and the HWB/ ACP interface will

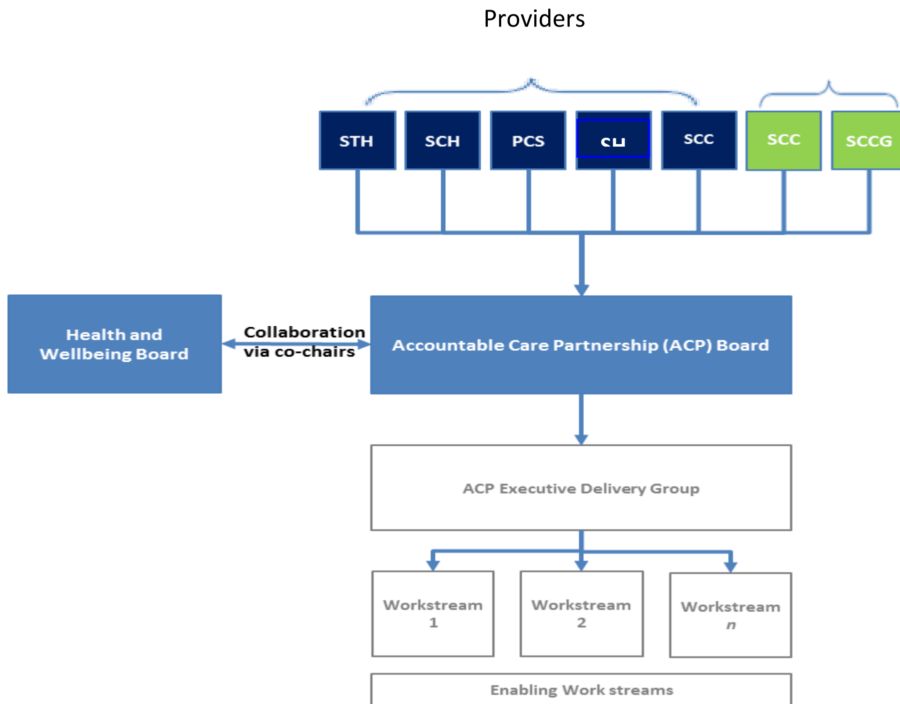
2.1.1 Improve understanding for the public and indeed for wider health and care staff across Sheffield

2.1.2 Improve effectiveness of meetings – which in turn will help progress the health and well-being and ACP place agenda for Sheffield.

2.1.3 Clarify the expectations of the accountability relationship between the HWB and the ACP.

3 BACKGROUND

3.1 In the ACP governance documentation, the relationship between the two bodies is described as one of collaboration, and this has been important to a number of the co-chairs – they explicitly haven't seen the HWB as "the peak" of a hierarchy. In this respect, locally, we have assumed a different relationship to the one the CQC assumed. This collaborative relationship is demonstrated by the organogram in the MOU for the ACP covered below.



N.B: This diagram pre-dates the decision for VCSE to join the ACP partnership – therefore they are not shown as a partner- this requires refreshing when formal documentation next reviewed. This diagram also does not reflect the role of the Oversight and Scrutiny Committee, formalised since the ACP MOU was finalised.

3.2 The decision to have the same chairs for both bodies arose from good intentions from the joint chairs to ensure arrangements between the two bodies were joined up.

3.3 **The CQC LSR has necessitated a review of this decision and a need to review the assumptions around accountability. We formally need to clarify this understanding between the boards, and chair arrangements.**

4 COMPARATIVE INFORMATION AND OPTIONS - SUMMARY

4.1 Firstly some background is provided to help contextualise the discussion around chair arrangements.

4.1.1 At Appendix 1 a comparison of functions between the ACP Board and the Health and Well-Being Board is provided

4.1.2 At Appendix 2 a review of arrangements in other places is attached to provide comparative information.

4.1.3 At Appendix 3, the pros and cons of each chairing arrangement is outlined.

4.2 From Appendix 1 we can reflect:

4.2.1 There is some overlap between HWB and ACP terms of reference, but overall the Health and Well-Being Board has a broader focus. The Health and Well-being Board more fully engages with the wider determinants of health where the ACP is more focused on the health and care system. However, it must be stated that the ACP states as its vision “a desire to improve health and wellbeing for Sheffield’s residents” with a focus on population health as part of the triple aim. Therefore this stated vision is sometimes at odds with the narrower focus the ACP has assumed.

4.2.2 It is important the HWB Board and ACP Board connect effectively to ensure the ACP’s strategic approach is positioned within the HWB’s overall strategy.

4.2.3 The HWB has a set of statutory responsibilities, including encouraging integrated working. The ACP Board does not have any statutory responsibilities and effectively refers decisions of significance to its partner Boards or equivalent. The HWBB is a sub-committee of full council and therefore arguably has the capacity to exercise more power than it does currently.

4.2.4 We should also note the role of the Oversight and Scrutiny Committee and its responsibility to consider the work of the ACP Board as part of its wider duties around the scrutiny of the health and care system. A 6 monthly review has been agreed.

4.2.5 The membership of the HWB and ACP Boards has some overlap, but overall, the membership of the ACP Board has a greater level of seniority than the HWB, with a number of individuals attending the HWB that report to Chairs or CEOs on the ACP Board. Therefore the CQC’s stated understanding of the HWB holding the ACP Board to account for the delivery of the CQC Local System Review is problematic. It should be noted that the HWBB was purposefully set up this way – to bring specific skill and knowledge sets into the Board to better understand and critique approaches to improving health and well-being.

4.3 Appendix 2 provides a brief review of the relationship between Health and Well-Being Boards and their equivalent Accountable Care Partnership Boards in other footprints. A number of SYB Places are compared, alongside two wave 1 ICS footprints (which are comparable in population terms of Sheffield) and a few other sites around the country. From this we can conclude:

4.3.1 There is not one “better” way of this relationship working, and much is down to local history and relationships.

4.3.2 Chair arrangements differ significantly across different place footprints, based on different historical rationale, or particular strengths of individuals within patches. No other place surveyed had the same chairs for HWB and ACP Board, and in this respect Sheffield was an outlier.

4.3.3 Some patches have brought in independent chairs, to bring particular skill-sets, challenge or to seriously signal a different approach to prevention, integration or the relationship to local communities and the voluntary sector.

4.3.4 Some patches do see their ACP-equivalent “reporting” to the HWB, some report little relationship and others report a more collaborative arrangement, such as the one assumed for Sheffield. Most individuals surveyed stated the accountability relationship in their place between HWB and ACP-equivalent was unclear. A number were also similarly raising the question about what the relationship should look like.

4.3.5 One or two patches (notably Bradford) were much clearer about there being a deliberate strategic connection between the overall HWB strategy and supporting strategies (such as their equivalent ACP arrangements).

4.4 Appendix 3 sets out options to be considered by both the Health and Well-Being Board and the ACP Board around chair arrangements. These are summarised below. Pros and Cons of each option are laid out in Appendix 3.

Option	**Notes**
A. Merge both boards	Subsume ACP Board into HWB Business and fully refresh HWB membership. This would demonstrate the genuine commitment of the ACP to the full wider determinants of health.
B. Put both meetings under the HWB umbrella but with dedicated meetings to each agenda	For example, 1 month “HWB (as stands)” alternated with “HWB – ACP”. This would clarify the link, reduce overlap but still have dedicated agendas for each meeting.
C. Cabinet Member chairs the HWB and CCG Chair chairs the ACP Board.	Both sit on each other’s board to ensure connection (as per Rotherham, Dorset). Cleaner relationship, more natural fit of Cabinet member to chair HWB and CCG Chair to chair ACP Board
D. Nominate an alternative chair from partner organisations to the ACP Board.	This could be rotated between organisations but key risk of organisational conflicts of interest.
E. Appoint independent chair of ACP Board	Look for specific skills/ expertise in the appointment (as per Bassetlaw, Oldham, 2 Surrey ICPs)
F. Do nothing	Review of other places indicates many places have an unclear relationship, and in this respect Sheffield is not unusual. But alongside CQC recommendation, locally it is also felt the arrangements could be improved – and this option would fail to recognise that.

5 ASSUMPTIONS

Regardless of the option on chairing chosen, the authors are assuming:

5.1 Connection is crucial. The ACP should be positioned within the overall HWB strategy

5.2 Strategy development of the refreshed HWB and the ACP Place Plan should be developed in tandem and is noted this has been achieved in Bradford and in Doncaster.

5.3 Practical planning of the meetings (perhaps through a shared Steering Group) should be connected to ensure reduced duplication.

6 QUESTIONS FOR THE BOARD

6.1 Members of the Accountable Care Partnership Board are asked to provide views on:

6.1.1 Any recommendations on the interface between the ACP and Health and Well-Being Board in terms of the wider Terms of Reference about to take place.

6.1.2 Comment specifically on the accountability relationship between the ACP and HWB in light of the CQC comments.

6.1.3 Which option around chair arrangements should be taken forward to address the recommendation made by the CQC?

7 NEXT STEPS

7.1 Alongside views from the Accountable Care Partnership Board, Health and Well-being Board members were consulted on 25th October 2018. Following that:

7.1.1 Chairs will consider the information received and determine a way forward. This may need some liaison with individual partner boards.

Appendix 1: HWBB & ACP LINKS & COMPARISONS

	HWBB	**ACP**
Why established	Health and Social Care Act 2012. Role of Board Terms of Reference (revised February 2017) "The Board will develop and maintain a vision for a city free from inequalities in health and wellbeing, taking a view of the whole population from pre-birth to end of life. The Board will be the system leader for health & wellbeing, acting as a strong and effective partnership to improve the commissioning and delivery of services across the NHS and the Council, leading in turn to improved health and wellbeing outcomes and reduced health inequalities for the people of Sheffield."	Part of Sheffield's response to the NHS Five Year Forward View, focused on how the NHS & social care system in Sheffield functions. The 7 partners 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"*
Frequency & Public Transparency	The Board meets every quarter in public, interspersed with engagement events and private strategy development meetings on a monthly basis. Meeting held in public quarterly with time for questions from public. Papers for public meeting published on SCC website.	Meets quarterly Public session of each meeting with time for questions from public. Papers for public session published on partner websites.
Membership	Cabinet Member for Health & Social Care (SCC), Cabinet Member for Children, Young People & Families (SCC), Chief Executive (SCC), Director of Adult Social Services (SCC), Director of Children's Services (SCC). Governing Body Chair (SCCG), One other Governing Body GP (SCCG), Accountable Officer (SCCG), Medical Director (SCCG), Director of Strategy (SCCG)	4 x NHS Chairs, 4 x NHS CEOs, Chair of PCS, CEO of PCS, Cabinet Member for Health and Social Care from SCC, CEO of Council, CEO of Voluntary Action Sheffield, Director of Public Health, Sheffield ACP Programme Director. **Chaired jointly by CCG Chair and Cabinet Member for Health and Social Care.**

	NHS England senior representative (as commissioner) NHS Provider – Clinical Representative (David Throssell, Medical Director, STHFT) Non-Executive Representative (Jayne Brown, Chair, SHSC), VCF Provider (Clare Mappin, CEX, Burton Street Foundation) Blue Light Service representative (Stuart Barton, Sheffield District Commander, SYP), Housing Association representative (currently vacant) Independent voices: Chair of Healthwatch Sheffield (Judy Robinson), Director of Public Health, Academic (Professor Laura Serrant) **Chaired jointly by CCG Chair and Cabinet Member for Health and Social Care.**	
Main interest?	Responsibility is for the health & wellbeing of the Sheffield population, and its interest is in all the areas that can have an impact on this. Range of “systems” that are part of this. Centre of gravity of NHS / Social care delivery system.	Vision indicated aims around prevention: *“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”* Compared to the Health and Well-Being Board, the ACP Board is more focused on health and care specifically, although discussions do move into the wider determinants of health and indeed one programme is the “Communities, Well-being and Social Value” workstream.
Main areas of focus / scope	Health and wellbeing in its broadest sense: for any system within the city, consider the potential delivering for improved health and wellbeing through that system	NHS and Social Care system
Parent body / accountability	Full council	Boards of NHS Bodies & PCS, SCC cabinet, VAS Board
Parent to	None There is a relationship with BCF related bodies, such as Executive	Set of programme boards, designed to bring stakeholders together to execute vision for better

	Management Group.	integrated NHS and Social Care system and greater prevention orientation.
Statutory duties	Specific statutory responsibilities to: • Develop an understanding of the health & wellbeing needs of Sheffield residents, through the production of a Joint Strategic Needs Assessment • Develop a strategy for improving the health & wellbeing of Sheffield residents, based on what the JSNA reveals • Maintain an understanding of the demand for pharmacies in Sheffield, to support NHSE in its commissioning role, through production of a Pharmaceutical Needs Assessment • Encourage integrated working between NHS and social care commissioners, which takes its most visible form in the requirement for HWBBs to agree Better Care Fund proposals, as set out in the BCF Guidance (though formal budgetary signoff rests with the LA and CCG)	There is no statutory basis for the ACP: it is a coalition of willing partners, focused on making the system function better, in order to support better outcomes for people and to deliver sustainability for services.
Powers	Powers to encourage close working between commissioners of health related services and itself, and between commissioners of health-related services and of NHS and social care services (health-related services is broadly defined and could reasonably apply to much of what an LA does)	No formal powers –see above.
Main strategy	Joint Health & Wellbeing Strategy	Place Based Plan – Shaping Sheffield
How does it work?	Strategy development through enquiry – refreshed Strategy due April 2019 (with collaboration between ACP Director and PH Director to ensure a joined up approach) Engagement with public and relevant bodies to support this Oversight of strategy implementation inc. holding partner organisations to account	ACP Board oversees the Executive Delivery Group which drives a broad set of programmes comprising the overall plan. Place strategy development through enquiry – refreshed plan due April 2019 (with collaboration between ACP Director and PH Director to ensure a joined up approach)

		Engagement with public and relevant bodies to support this Oversight of strategy implementation inc. holding partner organisations to account – but on collaborative basis
Links to other bodies	Relationship with scrutiny – scrutiny will be interested in HWBB decisions e.g. JHWBS, BCF, but HWBB could potentially work with scrutiny in holding to account Unanswered questions about how HWB link with a number of partnership boards including: Sheffield City Partnership Board, Public Service Reform Leadership Group & Community Safety Partnership in particular, Plus wider range of other partnership boards with narrower focus either in terms of topic of interest or population of focus. Various efforts have been made to rationalise over the years.	Scrutiny has a responsibility to consider the work of the ACP Board as part of its wider duties around the scrutiny of the health and care system. A 6 monthly review has been agreed. Links to SY &B Integrated Care System via CEO colleagues who attend both ACP and ICS Board. No clear accountability framework at this time. Unanswered questions about how HWB link with a number of partnership boards including: Sheffield City Partnership Board, Public Service Reform Leadership Group.

Appendix 2: Relationships between HWB and ACP Board and Chair Arrangements

	Relationship between HWB and ACP Board	**Chair arrangements of HWB and ACP Board**
Bassetlaw ACP	The chair of the ACP Board meeting will be accountable to the Health and Wellbeing Board for delivery of its strategic health and well-being priorities	Ms Catherine Burn chairs the ACP Board – Director, Bassetlaw Community and Voluntary Service. HWB is chaired by an elected member (with a GP background). HWB is described as having influence, on ACP, although whether the ACP is "accountable" to the HWB is unclear.
Barnsley ACP	The ACPB report on a regular basis to member organisations' sovereign Boards/ relevant decision making bodies. The ACP Delivery Board (which reports to the ACP B) also provides regular updates to the HWB, but the ACP is not typically described as being held "to account" by the HWB.	CCG Chair chairs the ACP Board. HWB is chaired by the Leader of the Council, with the CCG Chair as vice chair.
Doncaster ACP	The ACP is one of four strands of the Borough Strategy reporting to the "Team Doncaster" Board which involves the CEOs of all organisations, including fire, police, education and housing. The "Caring Strand" of this work is the ACP. The HWB holds the Doncaster Integrated Care Delivery Board (ACP) to account for delivery of the agree health and wellbeing outcomes for Doncaster.	The HWB is chaired by Cabinet Member and Portfolio Holder for Adult Social Care, Rachael Blake. Mayor Ros Jones chairs the "Team Doncaster" Board and Jackie Pederson, AO of the CCG chairs the Integrated Care Partnership Board responsible for delivering the Caring Theme of the Borough Strategy (effectively the Doncaster's Place Plan).

	Commissioning Governance and accountability for spend Governing Body Cabinet Joint Commissioning Membership Board (JCMB) CCG Council Strategic steer, direction and holding to account Team Doncaster (Caring) Health and Wellbeing Board (HWBB) Doncaster ICPB Provider Alliance Partnership Doncaster ICPDT Task and Finish Groups	
Rotherham ACP	In Rotherham, the HWB is described as overseeing strategy and deliver for healthcare. The ACP Place Board is accountable to the HWB for the delivery of the Place Plan.	Councillor Roach who holds the Adult Services portfolio is chair, with the CCG Chair the vice chair. The Place Board is chaired by Chris Edwards (CCG AO) and Sharon Kemp (Council CEO). The chairs act as lay members on each other's board to ensure connection and scrutiny.
Bradford (included as quoted by CQC as exemplar in terms of Local System Review)	HWB here has made the decision to have a stronger focus on the wider determinants and as a result widened membership to include Director of Place, Police, Fire and social housing. They do cover all aspects including health and social care integration. HWB included all CEOs of Providers. Place Board includes HWB membership plus Director leads etc. Director of Public Health (DPH) describes that all strategies genuinely feed in an overall HWB vision and Place strategy was developed in tandem with the HWB strategy. Each strategy and leads will be scrutinised about how their strategy helps deliver	The HWB is chaired by Leader of the Council. The Place Board is chaired by CEO of Council.

	overall HWB aims. Greater alignment achieved between HWB and Place.	
Oldham Place		ACP chaired by independent chair (Sam Jones (former New Care Models Programme Director @ NHS England). HWB is chaired by Councillor Jenny Harrison.
Surrey Heartlands (one of “ten first wave” ICSs)	Three equivalent ICP “Places” exist in Surrey Heartlands. The Integrated Care System and 3 places historically have all sat outside the Health and Well-Being Board arrangements, with governance just through individual partner board arrangements. This is starting to be re-considered by the respective HWB Boards. At ICS level, complex geography with 3 STP patches falling within the ICS.	The three ICP boards have different chair arrangements. Surrey Downs has opted for an independent chair, North West Surrey as considering an independent chair and the remaining ICP has no plans as yet. The 2 independent chairs are borne largely from a rationale around connecting differently with local communities.
Dorset ICS (one of “ten first wave” ICSs)	Dorset ICS is covered by 2 HWB, 1 covering Poole and Bournemouth and 1 covering Dorset. The ICS is governed by the “System Partnership Board” chaired by a councillor, with CCG Chair as Vice Chair. There is no clarity of relationship between the HWBs and the System Partnership board although the ICS provides a report for information to the HWB. HWB Chairs sit on System Partnership Board. Similar governance conversations are taking place across this ICS footprint.	The ICS “System Partnership Board” chaired by a councillor (who has no executive role), with CCG Chair as Vice Chair. Cabinet members with health related portfolios chair the two HWB.
Leeds	Leeds Health and Well -being Board covers all agendas. Within the Health and Well Being Strategy there is a Health and Care Plan which is focused on NHS/care.	

Appendix 3: Options for Consideration – HWB and ACP

	Rationale & notes	Pros	Cons
A. Merge both boards, and subsume ACP Board into HWB Business.	Overlap significant, would have to retain HWB as the statutory body. This would require review of membership, currently some members of HWB report to ACP Board.	1. Fully aligns agendas & reduces duplication. 2. Saves time for members and chairs. 3. Eliminates issue of "shared" chairs and blurred accountability relationship (CQC issue). 4. Underlines the real commitment of the health & care system to moving to a preventative system. 5. Could prompt significant overall review to restate how the bodies work give them more system ownership/ teeth.	1. Significant agenda of both existing boards – is this realistic? 2. Danger of HWB becoming more "operationally" focused on health and care due to pressing operational issues such as DTOC. 3. Realities of relative NHS/ council "ownership" of each body – may lose health ownership in merger. 4. Risk of losing seniority of membership of ACP Board in current set up – real asset having chair/ Cabinet Member and CEO membership from each partner. 5. Would prompt significant overall review of "governance" rather than action. This issue and possibility can always be revisited in the future – need to focus on making progress. Both HWB and ACP have had recent governance reviews.
B. Put both meetings under the HWB umbrella but with dedicated meetings to each agenda – 1 month "HWB (as stands)" alternated with "HWB – ACP"		1. Retains dedicated agenda for each meeting. 2. Addresses blurred accountability arrangement (CQC issue) – joint chairs still fully responsible for both agendas, but better aligned, joint planning for both bodies (through Steering Group). 3. Makes the alignment of agendas more evident and explicitly identifies ACP as	1. Still potential for duplication due to significant overlap between bodies. 2. Not significant change – would this really address key issues raised by CQC? 3. Misses the opportunity for a wider review 4. Reduces time for HWB meetings (loses 1 strategy meeting per quarter, replaced by

		needing to be positioned in HWB Strategy. 4. Further consolidates joint working across NHS/ LA in Sheffield. 5. Would reduce some total meeting time – HWB would meet 2 months in every 3, rather than current monthly meeting. Meeting cycle would be HWB/ HWB/ **HWB- ACP**/ HWB/ HWB/ **HWB- ACP**. HWB members who also attend ACP board would have 1 less meeting per quarter. 6. Is pragmatic approach and helps streamline arrangements.	ACP Board) – but this may be saved by reduced duplication. 5. Labour party nationally not supportive of ICS (and ACP by extension), reality of political context may get in way of ACP progress.
C. Cabinet Member takes ownership of the HWB and CCG Chair takes ownership of the ACP Board. Both sit on each other's board to ensure connection.	Cleaner relationship, more natural fit of Cabinet member to chair HWB and CCG Chair to chair ACP Board	1. Addresses blurred accountability arrangement (CQC issue) whilst still ensuring a connected approach. 2. De-politicises the ACP in terms of chair arrangements (can be deemed either advantage or disadvantage). 3. Means HWB can better scrutinise work of ACP, due to separate chairs.	1. Reduces democratic mandate of ACP Board. Potentially dilutes local political ownership demonstrated by having Cabinet Member of Health and Social Care as chair of ACP. 2. Potentially weakens local organisational and "population" focus by not having joint local chairs from CCG and SCC Cabinet. 3. Potentially impacts on the "equal partnership" arrangement of the ACP with one partner chairing each body, although natural fit due to SCC and CCG population focus. 4. Does not take the opportunity to bring external challenge/ push to think differently.
D. Appoint independent chairs of ACP Board	Independent chair with right attributes would need to be headhunted (i.e. with experience from leading integration footprints, national	1. Addresses area of criticism by CQC & appoints chair. 2. Means HWB can better scrutinise work of ACP, due to separate chairs. 3. Provides opportunity to find chair with highly relevant experience of new models of care/	1. Potentially dis-aligns connection between HWB and ACP Board by having different chairs (original arrangement was to encourage close working). 2. Reduces democratic mandate of ACP Board. Potentially dilutes local political ownership demonstrated by having Cabinet Member of

	new models of care experience, strength of local community connection etc.)	new system reform to push Sheffield forward. Oldham, for example, have appointed Sam Jones (former New Care Models Programme Director @ NHS England). We could search for a specific skill-set for an independent ACP chair. 4. May further challenge Sheffield to think differently, demonstrates a serious commitment to integration and prevention orientation, and a different relationship with communities. 5. Enables easier challenge and "holding to account of constituent partners" as chair not drawn from partner organisations themselves. 6. De-politicises the ACP (can be deemed either advantage or disadvantage).	Health and Social Care as joint chair. 3. Potential weakens local organisational ownership by not having local chairs from CCG and SCC Cabinet. 4. Salary cost of chair – although relatively small across partnership.
E. Nominate an alternative chair from partner organisations to the ACP Board. **This could be rotated between organisations.**		1. No additional cost 2. Rotational arrangements would build further ownership of all partners in agenda 3. May enable a less traditional arrangement- i.e. chair from voluntary sector (as per Bassetlaw) 4. Improves accountability relationship between ACP and HWB accepting CQC's criticism in terms of accountability for LSR.	1. Conflict of interests between organisational and system role. 2. Some organisations have more of a population focus, rather than providing specific types of healthcare – hence may be more "natural chairs" for this agenda. 3. Potentially impacts on the "equal partnership" arrangement of the ACP.
F. Do nothing	Retain status quo, justify position to CQC and re-state position that whilst ACP works within HWB space, it is not	1. Varying views on how large this problem is. Some would argue there are conflicts or lack of clarity in many places – we just need to manage those conflicts through collaboration. 2. Retains strong signal of collaborative	1. Many people feel this is a real issue that needs to be addressed. 2. Reputational Damage: Sheffield could be perceived as not listening to the CQC reports and its recommendations, health economy

	accountable to HWB Board and therefore scrutiny role of HWB not an issue.	working between HWB and ACP by having shared chairs	has accepted the findings of the report. 3. Loses opportunity to better position relationship of ACP and HWB.