NHS
Yorkshire
Ambulance Service
NHS Trust

MEETING TITLE Trust Board in Public		**MEETING DATE** 27/04/2021	
TITLE of PAPER	For Discussion: NHS Provider Selection Regime Consultation on proposals (2021)	**PAPER REF**	TB21.017
KEY PRIORITIES	Be a respected and influential system partner, nationally, regionally and at place Choose an item. Choose an item.		
PURPOSE OF THE PAPER	The purpose of the paper is to provide a summary of the NHS Provider Selection Regime Consultation proposals.		
For Approval	☐	**For Assurance**	☐
For Decision	☐	**Discussion/Information**	☒

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DISCUSSED AT / INFORMED BY – include date(s) as		
PREVIOUSLY AGREED AT:	**Committee/Group:**	**Date:**
RECOMMENDATION(S)	Board are asked to **note** the paper and the summary of the proposed Bill Board are asked to **consider** the implications and next steps outlined in the paper Board are asked to **support** the Consultation Question responses and final submission.	

RISK ASSESSMENT	**Yes**	**No**
Corporate Risk Register and/or Board Assurance Framework amended *If 'Yes' – expand in Section 4. / attached paper*	☐	☒
Equality Impact Assessment - *[New]* *If 'Yes' – expand in Section 2. / attached paper*	☐	☒
Resource Implications (Financial, Workforce, other - specify) *If 'Yes' – expand in Section 2. / attached paper*	☐	☒
Legal implications/Regulatory requirements If 'Yes' – expand in Section 2. / attached paper	☐	☒

ASSURANCE/COMPLIANCE	
Care Quality Commission Choose a DOMAIN(s)	4: Responsive 5: Well led

NHSI Single Oversight Framework **Choose a THEME(s)**	1. All

For Discussion: NHS Provider Selection Regime Consultation on proposals (2021)

1. PURPOSE/AIM

1.1 The purpose of the paper is to provide a summary of the NHS Provider Selection Regime Consultation on proposals (2021) which further builds on the publication of the ICS Integration and Innovation: working together to improve health and social care for all (2021), while summarising the aspects of the consultation in this paper which will have direct implications for YAS from a contractual perspective (see section 7)

2. BACKGROUND

2.1 This paper provides further details on the **provider selection regime,** first published in the Integration and Innovation: working together to improve health and social care for all (2021), which provided confirmation of the transition of ICS's towards a statutory footing and further delegation of powers to NHS trusts.

2.2 A key aspect of the White Paper proposals included the intention to replace the current rules for procuring NHS healthcare services with a set of more flexible arrangements that better support the NHS ambition for greater integration and collaboration between NHS organisations and their partners, while reducing administrative bureaucracy.

2.3 In future, NHS England want competitive tendering to be a tool that the NHS can choose to use where it is appropriate, rather than being an imposed, protracted process that hangs over all decisions about arranging services, drives competitive behaviour where collaboration is key and creates barriers where integrating care is the aim.

2.4 The proposed regime therefore provides significantly more flexibility to make decisions about arranging care in a streamlined way, where this can be shown to be in the best interests of patients, taxpayers and the population.

2.5 Key elements of the proposals centre on recommendations to:

- Remove barriers and promote collaboration, supporting decision making bodies to undertake alternatives to formal competitive tendering
- Provide clarity around key criteria to ensure greater transparency, in addition to existing statutory duties

2.6 The **consultation closes on 7 April 2021**; there are a number of consultation questions that can be completed (in section 6), with an opportunity to respond directly via email. The Planning and Development team have developed the proposed response for review and approval via TEG ahead of submission.

3. SUMMARY WHY DO WE NEED A NEW PROVIDER SELECTION REGIME?

3.1 The document covers a range of proposals and considerations; these are set out below. Appendix 1 includes the full NHS Provider Selection Regime Consultation on proposals (2021) document. A three page summary of key points has been created at Appendix 2.

3.2 The creation of statutory ICSs recognises that collective decision-making. between different bodies is the best way to arrange services. NHSE needs to make changes to the law so that the rules around how service arrangements are decided fit with this more collaborative model.

Regime Overview

3.3 The central requirement of the proposed new regime is that arrangements for the delivery of NHS services must be made in a transparent way, in the best interests of patients, taxpayers and the population – the three tests.

3.4 The regime would need to be applied by NHS bodies (NHS England, ICS Boards, NHS trusts and foundation trusts) and local authorities when arranging certain healthcare services for the purposes of the health service. It is important to note that this includes YAS as a 'commissioner' of health care services, via sub-contractor processes; this requires YAS to maintain an ongoing understanding of further detailed guidance and requirements, to ensure the Trust meets and maintains key standards.

3.5 There are broadly three kinds of circumstance that decision-making bodies could be in when arranging services (set out in 4.3). These circumstances dictate the subsequent approach to be followed.

1. Seeking continuation of existing arrangements using the existing provider.
2. Selecting the most suitable provider when a service is new or changing substantially, but a competitive procurement is not appropriate.
3. Selecting a provider by running a competitive procurement.

Applying the Regime

3.6 NHSE proposes preserving and strengthening the rules for providing patient choice currently contained in the regulations to make clear how decision-making bodies should operate the Any Qualified Provider Regime.

3.7 The regime sets out a number of key criteria to be considered when making decisions, in particular in circumstances where services are changing, or competitive tendering is being used. There are also a number of steps that must be taken when applying the regime to provide transparency and scrutiny, and to allow for challenge.

4. Scope

4.1. This regime would apply to the following bodies, in the circumstances described:

Decision Making Body:	Commissioned Services:	
	Healthcare	**Public Health**
ICS Boards	X	X
NHS England	X	X
Local Authorities	Section 75 Partnerships	X
NHS Trusts	X + Sub-contracts	
Foundation Trusts	X + Sub-contracts	

4.2 Decision making bodies must consider this regime when making decisions around the commissioning of healthcare / public health services, including:

- Adherence to the key 'circumstances' for applying the regime (4.3)
- Utilisation of the key criteria that must be considered when making decisions (section 5.2)
- Agreement on joint commissioning / lead commissioner approaches, where appropriate (section 5.10)
- Consideration of approaches to support transparency and scrutiny of decisions and intentions (section 5.13)
- Maintain the 'three tests' of ensuring all decisions are made in the best interests of patients, taxpayers and the population.

Circumstances for applying the regime:

4.3 Continuation of existing arrangements is permitted where the type of service means there is no alternative provision. This includes the following services:

- Type 1 and 2 urgent and emergency services; 999 emergency ambulance services – further clarity is needed around the categorisation of Patient Transport Services within the guidance and being identified as a healthcare service.
- Commissioner requested services / essential services
- Elective services which rely on cross-specialty working and can only be delivered by providers.

4.4 The three circumstances that this regime will typically apply to are:

- **Continuation of existing arrangements**. There will be many situations where the incumbent provider is the only viable provider due to the nature of the service in question, and a change of provider is not feasible or necessary – many NHS services are already arranged in this way. There will be other situations where the incumbent provider/group of providers is

doing a good job and the service is not changing, and there is no value in seeking another provider. In these situations, it needs to be straightforward to continue with the existing arrangements.

- In these cases, decision-making bodies should use the **Key Criteria** (see 5.2 below) and must operate in way that is fully **transparent** (see 5.13)
- **Competitive procurement** – for situations where the decision-making body cannot identify a single provider / group of providers that is most suitable without running a competitive process, or the decision-making body wants to use a competitive process to test the market, **(see 5.4 for further details)**

5. Key Criteria for Identifying a suitable Provider.

5.1. Decision-making bodies must consider the following criteria when making decisions around the selection and provision of healthcare services / providers. These are in addition to existing statutory duties placed on all commissioning bodies; these duties will be transferred into the new legal framework.

5.2. Proposed Criteria Summarised:

- **Quality -** (safety, effectiveness and experience) and innovation – ensuring that decision-making bodies consider the fundamental utility and performance of the service and the quality of the provider generally and seek to maximise these. Ensuring decision-making bodies seek to innovate and improve services delivered by either existing or new providers, proactively developing services that are fit for the future.
- **Value -** ensuring that decision-making bodies seek to maximise the value offered by a service. This is not about choosing the 'cheapest' option, but instead selecting the option with the best combination of benefits to individuals in terms of outcomes and to the community in terms of improved health and wellbeing; and value to taxpayers by reducing the burden of ill health over the lifetime of the arrangement and the cost.
- **Integration and collaboration –** ensuring that decision-making bodies seek to maximise the integration of services for patients to improve outcomes, and that their decisions are consistent with local and national NHS plans around integrating care and joining up services for patients (integrating services does not mean services have to be delivered by the same provider).
- **Access, inequalities and choice –** ensuring that patient choice is promoted and protected, and that the services patients need are available and accessible to all groups, with a particular focus on tackling inequalities.
- **Service sustainability and social value –** ensuring that decision-making bodies give due consideration to how their decisions may affect the current stability and wider sustainability of services over time and/or

in the wider locality; and seek to maximise the social value created by the arrangements, recognising the vital role the NHS plays in local communities and its leadership role in achieving net zero emissions.

Balanced Decision Making

5.3 The breadth and variety of healthcare services the regime applies to removes the ability for the regime to indicate a 'central hierarchy of importance' to the criteria, instead, this places greater focus on decision making bodies to ensure that they:

i. Decide if and how they prioritise and balance the above criteria for each decision they make under this regime, to best reflect their intentions. For example, if an integrated service is what decision-making bodies desire, they may choose to balance the criteria to justify their award of a contract to the provider(s) best able to integrate.

ii. Apply the regime proportionately to reflect the scale, cost and significance of the services being arranged. There is no recommended minimum financial threshold for application of the regime. However, the regime criteria are clear that decision-making bodies should ensure the cost involved in establishing the service is proportionate to the value of the service.

iii. Prioritise the criteria and balance them against each other, ensuring that all criteria are considered in some way and be mindful that other relevant statutory duties may apply, including normal public law decision-making principles. For example, a decision-making body may feel that choice and access are not the central consideration for a given service; however, their statutory duties around patient choice would still need to be met.

Competitive procurement

5.4 The decision-making body may decide when competitive procurement is the most appropriate means to select a provider. Typically this would be under the following initial circumstances:

- The decision-making body is changing a contract / service substantially;
- A new service is being arranged;
- The incumbent no longer wants to or can no longer provide the services; or
- The decision-making body wants to use a different provider

5.5 If the above criteria are met **and** after considering the key criteria (5.2), the decision-making body does not identify a single candidate that is the most suitable provider, and/or concludes that the most suitable provider can only be identified by carrying out a competitive procurement, then it would run such a process. This process would require decision-making bodies to:

i. Have regard to relevant best practice and guidance, for example, HM Treasury's managing public money guidance.

ii. Ensure the process is transparent, open and fair.

iii. Ensure that any provider that has an interest in providing the service is not part of any decision-making process (i.e., when ICS Boards are using this process)
iv. Formally advertise an opportunity for interested providers to express interest in providing the service.
v. Compare providers against the criteria set out in the regime and any other relevant factors, and according to any hierarchy of importance they decide is necessary – which must be published in advance.
vi. Publish their intention to award the contract with a suitable notice period (e.g., 4–6 weeks unless a shorter period is required due to the urgency of the case).
vii. If credible representations are received from other providers about the process, deal with them as per the regime guidance.

5.6. This regime must be applied even-handedly irrespective of the type of provider. Voluntary and independent sector providers currently deliver a range of NHS services that benefit patients, paid at NHS prices. The NHS will still be able to arrange services with voluntary and independent sector providers in future, as now, where this is in the best interests of patients, taxpayers and the population.

5.7 The guidance sets out the importance of supporting innovation; decision-making bodies must not stifle innovation when considering changes.

Arranging Services by Providers

5.8 The guidance recognises that providers also arrange the provision of health services. The guidance is clear that the requirements of the regime also apply to NHS providers when undertaking this role; in the case of YAS, via sub-contract arrangements.

5.9 The expectations are clear around the requirements for clear contracts, contract and performance management by the lead decision making body with the lead provider, and between the lead provider and sub-contractor(s). Focus must remain on achieving the desired outcomes.

Joint Commissioning / Lead Commissioning & Contract Management

5.10 Joint commissioning / lead commissioner roles are recognised in the guidance and clarifies that all decision making bodies retain their responsibility for ensuring that decisions around provision meet the three tests and are compliant with the regime.

5.11 The guidance outlines that decision making bodies must ensure that contracts retain focus on providers and services that meet the needs / best interests of patients, taxpayers and the population. This includes their role in identifying and understanding what those needs are, and that they must align to priorities and strategies at place / system.

5.12 In developing this, they must provide clarity on expected outcomes, which should be reflected in the choice of 'regime' being used. There are clear expectations that contracts need to be developed that achieve these, with appropriate, periodic assessment of the contract and its desired impact - with an ability and expectation that contracts are reviewed, amended, ended where this is not being achieved; to aid this:

- Contracts should have an appropriate length proportionate to the service
- Include review provisions and break points
- Set expectations for extension opportunities

Transparency and scrutiny

5.13 Outcomes of decision-making bodies' decisions reached under this regime are to be made public, with sufficient scrutiny applied to ensure the regime is being followed. Proposals include that decision-making bodies are required to take a number of steps to evidence consultation on proposals and that they have met their responsibilities set out within the new regime.

5.14 The list below applies to all decisions to which this regime applies irrespective of circumstances:

i. Where contracts are being continued or rolled over, or a change in providers is being considered, decision-making bodies must publish their intended approach in advance.
ii. Decision-making bodies must publish a list of contracts awarded along with other relevant information about the contract and its contents. The final guidance for the regime will specify what should be published and where, with the aim of maximising transparency and disclosure.
iii. Decision-making bodies must keep a record of their considerations and decisions made under the regime, including evidence that they have considered all relevant issues and criteria, and that the reasons for any decision are clearly justified.
iv. Decision-making bodies must monitor compliance with this regime via their own annual audit processes, publish the results of annual audit of the regime and address any non-compliance with the regime found via audit.
v. Decision-making bodies must include in their annual report a summary of their contracting activity, including an indication of which contracts were rolled over, where providers changed, where formal tender exercises were advertised, and information about any complaints received in relation to adherence to this regime.

5.15 The right for competitors to legal challenge is being removed and replaced with representations being made to the decision making body, following publication of the decision. Direct Judicial Review would be available for providers that want to challenge the lawfulness of the decision.

5.16. NHSE proposes that decision-making bodies must publish their intention to award the contract to the intended provider, with a suitable notice period (e.g.,

4–6 weeks, subject to any exceptions such as for urgent or patient/public safety cases). If representations objecting to the process or outcome are received from other providers in that time, the decision-making body must:

i. Discuss the issue with the providers or their representatives.
ii. Publish a response to the objections before the award, setting out its decision to either: (a) not to proceed with the contract award as intended and reconsider its process and/or decision; or (b) award the contract as intended and publish reasons for so proceeding as part of the contract award procedure.

5.17 Local authority oversight and scrutiny committees already have powers to scrutinise the activities of certain NHS bodies, as do health and wellbeing boards. These powers will remain and will provide an additional means of scrutiny and another means of oversight of decision-making body decision making.

6 Consultation questions

6.1 The formal consultation has a series of questions; initial draft responses have been included for discussion and review. Responses are rated as Strongly Disagree, Disagree, Neutral, Agree, Strongly Agree, Don't Know:

Consultation Engagement Questions and YAS Response:
1. Should it be possible for decision-making bodies (e.g., the clinical commissioning group (CCG), or, subject to legislation, statutory ICS) to decide to continue with an existing provider (e.g., an NHS community trust) without having to go through a competitive procurement process.
• Strongly Agree • YAS support the ability for commissioners / decision making bodies to continue with existing providers, where agreed quality, performance and patient outcomes are measured and delivered. • Transparency and scrutiny remains fundamental to supporting these decisions. • YAS welcome the proposals to minimise the impact and costs associated with competitive tendering where an existing service provider is well established, providing high quality services within a contractual and service framework that is not changing - focusing on collaborative discussion around performance and delivery is a positive shift. • Risks remain around the pressures on commissioners to test the markets, with options for challenge remaining via publication of intention to award contracts being made available. • YAS welcome the ability for lead commissioning models to continue and the responsibilities of all decision making bodies to understand their role in ensuring the regime is clearly introduced and the three tests are consistently and transparently applied. This should be applied in a collaborative way, reflecting the spirit of the principles based approach within the new regime. • It is necessary to expand upon the criteria and principles set out in the consultation

document to ensure that the burden of evidence for collaborative decision making/direct award is not viewed as more onerous (or inherently riskier) than undertaking a competitive procurement.

- The proposed regime allows for considerable variation in approaches between decision-making bodies. This presents a particular challenge for establishing integrated commissioning arrangements – which must address potentially varying standards across their associate commissioners. Likewise, providers whose footprints span several decision-making bodies, such as the ambulance sector, would be particularly vulnerable to ICSs holding variable standards in their interpretation of the provider selection regime and would reduce opportunities to deliver services that maximise economies of scale.
- Further clarity would be beneficial for current decision making bodies regarding the transition from the current procurement regime to new provider selection arrangements. Whilst acknowledging that this is consultation – commissioners may benefit from clarity / support on how to plan for the change and how to manage any commissioning decisions (particularly decisions to extend or procure existing services) whilst awaiting the formal outcomes of this consultation and the implementation of a new regime

2. Should it be possible for the decision-making bodies (e.g., the CCG or, subject to legislation, the statutory ICS) to be able to make arrangements where there is a single most suitable provider (e.g., an NHS trust) without having to go through a competitive procurement process?

- Strongly Agree
- Ensuring collaborative and broad engagement around the development of new or changing service requirements / specifications will be critical - the role of the ICS and commissioners is vital in determining the key criteria for services alongside effective understanding of providers and markets.
- Where significant changes are required, we would welcome the requirement of commissioners to engage initially with the incumbent in a collaborative way to develop options and proposals for delivery that maximise the three tests around best interest and outcomes for patients, taxpayers and the population.
- There will always be requirements for market testing and competitive tendering - however we will want to see the tests that commissioners will need to apply to minimise these requirements - essentially a value for money / impact analysis assessment that is proportionate to the scale, value and type of service.
- We welcome the focus on innovation and encouraging joint working between commissioners and providers to improve services within existing arrangements.
- Providing the flexibility to continue provision of services with existing providers, alongside an improvement and innovation trajectory will enable the development of future focused services, incorporating new technologies and techniques, for the benefit of patients, taxpayers and the population.
- Clearly defined approaches are needed to manage conflicts of interests – whether in a CCG or ICS context. This is important not just in the context of a competitive process, but in all stages from developing initial intentions through to decisions on

procurement/commissioning route.

- The requirement to consider alternative provision within a relevant area highlights an existing tension between 'primacy of place' and 'system by default'. In a locally commissioned service, there is potential to favour local solutions/place-level provision rather than collaboration with providers operating on a larger (system level or regional level) footprint. Further clarity to ensure local commissioning decisions have regard to a wider range of potential provision options would be welcomed

3. Do you think there are situations where the regime should not apply/should apply differently, and for which we may need to create specific exemptions?

- Agree
- Further clarity will be needed on exemptions to the process - particularly around urgency and patient safety. This must be underpinned by transparency and scrutiny, particularly around conflicts of interest.
- There remains a risk around the direct commissioning of voluntary or independent sector outside of the AQP process - this will need close alignment to conflict of interest and testing against the key criteria to avoid challenge and to ensure the three tests are being satisfied.
- The guidance is not clear around the opportunities for decision making bodies to directly award to independent sector providers outside of the regime; this therefore does represent a risk to the confidence in the approach adopted by decision making bodies.
- Specific exemptions would be beneficial; however we recognise that these cannot be exhaustive. Where urgency is cited, these should be time limited / bound by review periods to ensure ongoing requirements / needs, but with a view that extended periods should then require formal use of the regime process.
- The proposed regime already includes exemptions for 999 Emergency ambulance services, recognising there is no alternative provision. This is positive for clarity of planning and commissioning decision making. Although consideration should be given for whether exemptions can be extended specifically for CAT3 and 4 activity – recognising the potentially de-stabilising effect of this activity being viewed as a distinct cohort subject to different considerations.
- Further consideration is needed to ensure the proposed regime does not create a barrier to the integration of emergency ambulance and patient transport services, or act as a barrier to development/transformation of call handling/ clinical advice services within ambulance services and across systems. The regime makes a brief statement that additional consideration is needed by decision making-bodies in these circumstances- further clarity and a more detailed treatment in the guidance would be desirable to ensure that long term transformation of PTS, clinical advice or call-handling is not impacted negatively.
- The proposals also do not address the disparity between procurement of healthcare services and procurement of social care services. They would appear to make this gap wider – potentially creating a strong disincentive for health to engage in joint

developments with social care.

4. Do you agree with our proposals for a notice period?

- Agree
- Whilst the period hasn't been defined within the guidance, we acknowledge that all providers and other system partners should be made aware at an early stage of intentions to review service models or to change an existing provider, as well as offering notice following a decision on contract award or other commissioning route.
- Consideration must be given to whether a formal standstill (or similar) process is required during the notice period to ensure that systems do not incur mobilisation costs or engage in external communications with patients and the wider population until the conclusion of the mandated notice period. The potential impact of such a standstill on systems must be taken into account when setting the length of any mandatory notice period.
- Whilst the shift towards direct challenge to decision making bodies will reduce the impact on NHS England and **potentially formal legal escalation, there is the risk that decision making bodies may demonstrate defensive or risk averse** behaviours to avoid direct challenge. The regime is helpful in providing key criteria and processes around minimising this risk, however further guidance / clarity may be beneficial to **ensure that competition is not viewed as a safer, default approach.**
- It would be worthwhile considering whether the requirement for a notice period should apply differently depending on the circumstances. Particularly is there benefit in applying a lengthy formal notice period to continue existing arrangements? There is a risk that this step would reinforce transactional behaviors

5. It will be important that trade deals made in future by the UK with other countries support and reinforce this regime, so we propose to work with government to ensure that the arranging of healthcare services by public bodies in England is not in scope of any future trade agreements. Do you agree?

- Agree
- Provider and commissioner confidence in the longevity of the procurement regime (in whatever form it takes) is vital to enable collaborative long term planning. This would be significantly eroded if there was an ongoing risk of substantial change as new trade deals are made.
- Further definition of health care services will be required to provide absolute clarity on what is included within the scope of this regime and any future trade deals.
- Specifically, the provision of NHS Patient Transport Services must be clearly classified as a healthcare service to ensure that it is planned, developed and delivered within this regime.

7. Implications for YAS: Next Steps and Impacts.

7.1 This represents a positive shift for YAS in strengthening positive, collaborative discussion with commissioners on the ongoing development of services, with clear service development trajectories. This is in line with our emerging approach for an Integrated Commissioning Forum. Further consideration will need to be given for engaging our Trust Boards with boards at ICS and ICF level to balance requirements of sovereignty of Trust and System.

7.2 Lead commissioner arrangements can continue, to support regional level discussion around YAS contracts. YAS are in a strong position overall, securing all contracts for PTS and 111 across the Yorkshire and Humber region. However, we must ensure that we take opportunities to demonstrate quality, performance and overall value for money against the three tests. Where locally agreed performance targets are introduced, we must clearly articulate delivery and rationale for any variance against national standards, jointly with decision making bodies. This will require YAS to develop high quality data to support collaborative discussion and ongoing transparency of decisions.

7.3 YAS need to consider the regime requirements for all sub-contracts, in particular private providers within A&E operations and PTS, as part of our ongoing framework and clinical capacity within NHS 111. These contracts have all either been reviewed and renewed recently which may reduce the immediate impact on YAS, however ongoing audit and annual reporting will become a requirement.

7.4 The successful use of the PTS Alternative Provider Framework may minimise the level of challenge faced by local commissioners if decisions to directly award to YAS are introduced. Recent commissioner behaviour for West Yorkshire PTS is contrary to this regime and our anticipated, preferred outcome. The final point in Consultation Question 1 Response seeks to gain assurance from NHSE that support commissioners to make alternative decisions, whilst awaiting the outcome of this regime consultation.

7.5 The focus on innovation is positive, enabling YAS to jointly develop future focused services that meet the needs of patients and communities; this will require improvements in our use of VCS partners and community engagement.

7.6 Further guidance would be beneficial around conflict of interest, as we become a stronger partner in local Health and Care Partnerships – we need to strike the balance of demonstrating intent, interest and influence with our ICS partners, whilst not being seen to interfere with decisions.

7.7 The Trust will need to consider its role and engagement within local Overview & Scrutiny Committees and Health & Wellbeing Boards, to ensure ongoing support and clarity around our role in developing and delivering collaborative agreements.

7.8 The Trust will need to strengthen the approach and use of consultations around the development / commissioning of services to ensure that the needs of local communities is heard and to address the key criteria set out in the regime. This

can be achieved in a collaborative way, drawing on the skills and expertise of current commissioners and their focus on public health.

7.9 The Trust may also benefit from commissioning external reviews (audit or peer) relating to our approach to quality, innovation and our use of funding and outcomes. This would help ensure that we can demonstrate a focus on learning, quality, innovation and value.

7.10 Further risks are around direct award to private providers for aspects of YAS services / contracts, for example, NHS 111 Core CAS being undermined by direct Local CAS contract awards to local providers. Ensuring clarity around outcomes and impact should support discussion around cost / benefit / quality.

7.11 Clarification around the classification of PTS as a healthcare service will be important, to ensure this forms part of the new regime, given the breadth and range of current contracts across Yorkshire. This should be included within the AACE response as a sector.

7.12 The re-introduction of a principles-based approach to commissioning is welcomed but there needs to be a consistent approach to the use of the principles. From a commissioning perspective, there needs to be further detail on why there is a need to prove why they do not need to procure, rather than why they should.

7.13 **'Primacy of place'** features heavily in the DHSC Innovation and Integration White Paper, there needs to be further guidance on where provider collaboratives sit within this new regime. There is detail which advises that irrespective of the type of provider, voluntary and independent sector providers currently need to deliver services that benefit patients.

7.14 YAS welcomes the approach of continuation of existing arrangements for services such as 999 due to the nature of the type of service that is being delivered. The Key Criteria aligns with YAS strategic objectives and those of the ICS.

7.15 This paper incorporates feedback from IUC colleagues and the Programme Lead for Integrated Commissioning IUEC Yorkshire and Humber. Further updates can be shared from AACE once updated – although this may be following final submission.

7.16 The final draft of this paper and the formal YAS response to the consultation will take place on 7 April 2021, ahead of the submission deadline. There is currently no timeline or trajectory set out within the consultation documents for when consultation outputs will be shared or decisions made. The Planning and Development team will continue to review and monitor, providing feedback once available.

8. RECOMMENDATIONS

8.1 Board are asked to **note** the paper and the summary of the proposed Bill
8.2 Board are asked to **consider** the implications and next steps outlined in the paper
8.3 Board are asked to **support** the Consultation Question responses and final submission.

9. APPENDICES

Appendix 1: Integration and Innovation (2021)
Appendix 2: NHS Provider Regime Summary (3 pages)