Title: **Extension of Any Qualified Provider** **Lead department or agency:** Department of Health **Other departments or agencies:**	**Impact Assessment (IA)** **IA No:** 2026 **Date:** 14/07/2010 **Stage:** Final **Source of intervention:** Domestic **Type of measure:** Other

Summary: Intervention and Options

What is the problem under consideration? Why is government intervention necessary?

Comparisons with other countries suggest NHS outcomes in some areas of healthcare are not as good as they could be, for example rates of amenable mortality, mortality rates of respiratory diseases, acute complications of diabetes and incidence of MRSA infection rates. The NHS also scores relatively poorly on being responsive to the patients it serves and lacks a genuinely patient-centred approach. We know that patients want choice and control over the health care they receive. By amending the guidance for the commissioning process to extend choice to any qualified provider across community services, patients will be able to choose services that suit them best – creating incentives for providers to drive up standards, increase innovation and improve efficiency.

What are the policy objectives and the intended effects?

The policy objectives and intended effects are to:

i) improve outcomes for patients from health interventions;

ii) improve responsiveness of services to patient preferences; and

iii) increase patient choice and control.

This will be achieved through making healthcare services contestable; streamlining the procurement process; and giving patients a wider choice of providers for a larger number of services

What policy options have been considered, including any alternatives to regulation? Please justify preferred option (further details in Evidence Base)

- **Option 1**: Do nothing – patient choice of any qualified provider to continue to be available for services procured under the NHS Standard Contract for Acute Services
- **Option 2**: Extend patient choice to any qualified provider for all services procured under all NHS Standard Contracts with phased implementation, initially to a small number of priority community and mental health services with central support to commissioners
- **Option 3**: Extend patient choice of any qualified provider to services procured under NHS Standard Contracts with discretion of local commissioners as to which services are within scope. No central support.

Option 2 is the preferred option

Will the policy be reviewed? It will be reviewed. **If applicable, set review date:** Month/2012 **What is the basis for this review?** PIR. **If applicable, set sunset clause date:** Month/Year	
Are there arrangements in place that will allow a systematic collection of monitoring information for future policy review?	Yes

SELECT SIGNATORY Sign-off For final proposal stage Impact Assessments:

I have read the Impact Assessment and I am satisfied that (a) it represents a fair and reasonable view of the expected costs, benefits and impact of the policy, and (b) the benefits justify the costs.

Signed by the responsible Minister: Date: .....

URN 10/1268 Ver. 2.0 12/10

Summary: Analysis and Evidence

Policy Option 2

Description:

Implement extension of patient choice of provider to additional health service areas

Price Base Year 2011	PV Base Year 2011	Time Period Years 5	Net Benefit (Present Value (PV)) (£m)		
			Low:	High:	Best Estimate: 13.0

COSTS (£m)	Total Transition (Constant Price)	Years	Average Annual (excl. Transition) (Constant Price)	Total Cost (Present Value)
Low				
High				
Best Estimate	0		1	4.7

Description and scale of key monetised costs by 'main affected groups'

The total cost reflects the extra resources required to provide central support to commissioners. The total costs figure shown comprises Exchequer costs of £4.7m. Opportunity cost adjustments have not been made, but would increase this figure by 2.4 times. The policy proposals affect the procurement process operated by commissioners. Commissioners already conduct procurement. They will be expected to switch to the new procurement arrangements and use existing procurement teams.

Other key non-monetised costs by 'main affected groups'

There is a possibility that healthcare professionals may need to dedicate some additional time advising patients on the wider options which will be available. This could result in a time cost being incurred, however this cannot be quantified because of a lack of evidence.

BENEFITS (£m)	Total Transition (Constant Price)	Years	Average Annual (excl. Transition) (Constant Price)	Total Benefit (Present Value)
Low				
High				
Best Estimate	0		3.5	17.7

Description and scale of key monetised benefits by 'main affected groups'

The change to the new procurement arrangement is expected to be less resource intensive as commissioners will be encouraged to cooperate and pool knowledge and resources. The monetised benefits are made up of these cost savings. As for costs above, these presented figures have not been adjusted for opportunity costs which would increase the benefits by 2.4 times.

Other key non-monetised benefits by 'main affected groups'

Over time health care services are expected to evolve to be more innovative and efficient as patients choose the services that best meet their needs. These benefits are not included in the monetised benefits above, although a quantified illustration is given in the evidence base.

Key assumptions/sensitivities/risks — **Discount rate (%)** 3.5

For the cost savings from the new procurement arrangements to be materialised, commissioners will have to embrace the proposals for cooperating and pooling procurement resources between themselves.

A key assumption for the delivery of innovative services and greater efficiency is that the proposed policy reforms will create credible threats of new providers contesting existing healthcare services.

Direct impact on business (Equivalent Annual) £m):			In scope of OIOO?	Measure qualifies as
Costs:	Benefits:	Net:	No	NA

Enforcement, Implementation and Wider Impacts

What is the geographic coverage of the policy/option?			England		
From what date will the policy be implemented?			01/04/2012		
Which organisation(s) will enforce the policy?			Department of Health		
What is the annual change in enforcement cost (£m)?			zero		
Does enforcement comply with Hampton principles?			Yes		
Does implementation go beyond minimum EU requirements?			N/A		
What is the CO_2 equivalent change in greenhouse gas emissions? (Million tonnes CO_2 equivalent)			**Traded:** N/A	**Non-traded:** N/A	
Does the proposal have an impact on competition?			Yes		
What proportion (%) of Total PV costs/benefits is directly attributable to primary legislation, if applicable?			**Costs:** N/A	**Benefits:** N/A	
Distribution of annual cost (%) by organisation size (excl. Transition) (Constant Price)	**Micro** N/A	**< 20** N/A	**Small** N/A	**Medium** N/A	**Large** N/A
Are any of these organisations exempt?	No	No	No	No	No

Specific Impact Tests: Checklist

Set out in the table below where information on any SITs undertaken as part of the analysis of the policy options can be found in the evidence base. For guidance on how to complete each test, double-click on the link for the guidance provided by the relevant department.

Please note this checklist is not intended to list each and every statutory consideration that departments should take into account when deciding which policy option to follow. It is the responsibility of departments to make sure that their duties are complied with.

Does your policy option/proposal have an impact on...?	**Impact**	**Page ref within IA**
Statutory equality duties[1] Statutory Equality Duties Impact Test guidance	Yes	EIA
Economic impacts		
Competition Competition Assessment Impact Test guidance	Yes	27
Small firms Small Firms Impact Test guidance	Yes	27
Environmental impacts		
Greenhouse gas assessment Greenhouse Gas Assessment Impact Test guidance	No	
Wider environmental issues Wider Environmental Issues Impact Test guidance	No	
Social impacts		
Health and well-being Health and Well-being Impact Test guidance	Yes	all
Human rights Human Rights Impact Test guidance	No	
Justice system Justice Impact Test guidance	No	
Rural proofing Rural Proofing Impact Test guidance	Yes	27-28
Sustainable development Sustainable Development Impact Test guidance	No	

[1] Public bodies including Whitehall departments are required to consider the impact of their policies and measures on race, disability and gender. It is intended to extend this consideration requirement under the Equality Act 2010 to cover age, sexual orientation, religion or belief and gender reassignment from April 2011 (to Great Britain only). The Toolkit provides advice on statutory equality duties for public authorities with a remit in Northern Ireland.

Summary: Analysis and Evidence

Policy Option 3

Description:

Price Base Year 2011	PV Base Year 2011	Time Period Years 5	Net Benefit (Present Value (PV)) (£m)		
			Low:	High:	Best Estimate: 7.5

COSTS (£m)	Total Transition (Constant Price)	Years	Average Annual (excl. Transition) (Constant Price)	Total Cost (Present Value)
Low				
High				
Best Estimate			0	**0**

Description and scale of key monetised costs by 'main affected groups'

The total costs are expected to be zero. The policy proposals affect the procurement process operated by commissioners. Commissioners already routinely conduct procurements. They will be expected to switch to the new procurement arrangements using existing procurement teams.

Other key non-monetised costs by 'main affected groups'

There is a possibility that healthcare professionals may need to dedicate some additional time advising patients on the wider options, which will be available. This could result in a time cost being incurred. This has not been quantified due to a lack of evidence.

BENEFITS (£m)	Total Transition (Constant Price)	Years	Average Annual (excl. Transition) (Constant Price)	Total Benefit (Present Value)
Low				
High				
Best Estimate			1.5	**7.5**

Description and scale of key monetised benefits by 'main affected groups'

The change to the new procurement arrangement is expected to be less resource intensive as commissioners will be encouraged to cooperate and pool knowledge and resources. The monetised benefits are made up of these cost savings. No adjustment has been made to reflect opportunity costs of cost savings which would increase the benefits by 2.4 times.

Other key non-monetised benefits by 'main affected groups'

Over time health care services are expected to evolve to be more innovative and efficient as patients choose the services that best meet their needs. These benefits are not included in the monetised benefits above, although a quantified illustration is given in the evidence base.

Key assumptions/sensitivities/risks — **Discount rate (%)** 3.5

A key assumption for the delivery of innovative services and greater efficiency is that the proposed policy reforms will create credible threats of new providers contesting existing healthcare services.

Direct impact on business (Equivalent Annual) £m:			In scope of OIOO?	Measure qualifies as
Costs:	Benefits:	Net:	No	NA

Enforcement, Implementation and Wider Impacts

What is the geographic coverage of the policy/option?			England		
From what date will the policy be implemented?			01/04/2012		
Which organisation(s) will enforce the policy?			Department of Health		
What is the annual change in enforcement cost (£m)?			zero		
Does enforcement comply with Hampton principles?			Yes		
Does implementation go beyond minimum EU requirements?			N/A		
What is the CO_2 equivalent change in greenhouse gas emissions? (Million tonnes CO_2 equivalent)			**Traded:**		**Non-traded:**
Does the proposal have an impact on competition?			Yes		
What proportion (%) of Total PV costs/benefits is directly attributable to primary legislation, if applicable?			**Costs:** N/A		**Benefits:** N/A
Distribution of annual cost (%) by organisation size (excl. Transition) (Constant Price)	**Micro** N/A	**< 20** N/A	**Small** N/A	**Medium** N/A	**Large** N/A
Are any of these organisations exempt?	No	No	No	No	No

Specific Impact Tests: Checklist

Set out in the table below where information on any SITs undertaken as part of the analysis of the policy options can be found in the evidence base. For guidance on how to complete each test, double-click on the link for the guidance provided by the relevant department.

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Economic impacts		
Competition Competition Assessment Impact Test guidance	Yes	27
Small firms Small Firms Impact Test guidance	Yes	27
Environmental impacts		
Greenhouse gas assessment Greenhouse Gas Assessment Impact Test guidance	No	
Wider environmental issues Wider Environmental Issues Impact Test guidance	No	
Social impacts		
Health and well-being Health and Well-being Impact Test guidance	Yes	all
Human rights Human Rights Impact Test guidance	No	
Justice system Justice Impact Test guidance	No	
Rural proofing Rural Proofing Impact Test guidance	Yes	27-28
Sustainable development Sustainable Development Impact Test guidance	No	

[1] Public bodies including Whitehall departments are required to consider the impact of their policies and measures on race, disability and gender. It is intended to extend this consideration requirement under the Equality Act 2010 to cover age, sexual orientation, religion or belief and gender reassignment from April 2011 (to Great Britain only). The Toolkit provides advice on statutory equality duties for public authorities with a remit in Northern Ireland.

Evidence Base (for summary sheets) – Notes

Use this space to set out the relevant references, evidence, analysis and detailed narrative from which you have generated your policy options or proposal. Please fill in **References** section.

References

Include the links to relevant legislation and publications, such as public impact assessments of earlier stages (e.g. Consultation, Final, Enactment) and those of the matching IN or OUTs measures.

No.	Legislation or publication
1	
2	
3	
4	

+ Add another row

One In One Out (OIOO)

The proposals for extending patient choice of provider do not require primary or secondary legislation. The lever for bringing about choice is the guidance issued by the Department of Health to commissioners (statutory bodies). Any obligations on providers (public sector, private sector, or civil society organisations) are terms and conditions of contractual agreements to provide NHS funded services. By virtue of applying to the public sector or being contractual obligations, the proposals for increased patient choice of provider are out of scope of the one-in-one-out process.

Obligations fall on the public sector

The guidance for *Extending Patient Choice of Provider* and the impact assessment falls on NHS commissioners (public sector) and covers NHS funded activity under the standard NHS contracts.

Evidence Base

Ensure that the information in this section provides clear evidence of the information provided in the summary pages of this form (recommended maximum of 30 pages). Complete the **Annual profile of monetised costs and benefits** (transition and recurring) below over the life of the preferred policy (use the spreadsheet attached if the period is longer than 10 years).

The spreadsheet also contains an emission changes table that you will need to fill in if your measure has an impact on greenhouse gas emissions.

Annual profile of monetised costs and benefits* - (£m) constant prices

	Y_0	Y_1	Y_2	Y_3	Y_4	Y_5	Y_6	Y_7	Y_8	Y_9
Transition costs	0	0	0	0	0					
Annual recurring cost	1	1	1	1	1					
Total annual costs	1	1	1	1	1					
Transition benefits	0	0	0	0	0					
Annual recurring benefits	0.9	4.6	4.6	4.6	4.6					
Total annual benefits	0.9	4.6	4.6	4.6	4.6					

* For non-monetised benefits please see summary pages and main evidence base section

Evidence Base (for summary sheets)

Introduction

1. This impact assessment covers the White Paper *Equity and Excellence: Liberating the NHS*[1] commitment to extend patient choice to any willing provider[2]. It accompanies the guidance document *Extending patient choice of provider* and follows the consultation process which started with the issuing of the document, *Liberating the NHS: Greater Choice and Control*[3] on the 18th October 2010. It reflects the outcome of the listening exercise and recommendations made by the NHS Future Forum.
2. The Choice consultation document, *Liberating the NHS: Greater Choice and Control*, contained a number of commitments to increase the ability of patients to make choices about the healthcare they receive. The Government has elected to implement different commitments to different timetables. Subsequent impact assessments will be published on a timeline to match the implementation of the other choice commitments.
3. The consultation contained four questions on the implementation of patient choice of any willing provider. These were on the areas of health care that should be prioritised for early implementation (Q2); the approach for establishing a provider's fitness to provide services (Q41); whether the approach to establishing fitness should be applied uniformly to all providers (Q42); and the establishment of a directory of providers who have received accreditation (Q43).
4. In response to the views received during the consultation and what we heard during the listening exercise, the implementation of patient choice of provider is set out in the guidance document, *Extending patient choice of provider.*
5. The policy to extend choice to any qualified provider would give commissioners the means by which they can procure services that enable patients to choose from a wider range of qualified providers. These providers will have to meet the necessary quality requirements and price (either national tariff or locally set price) in order to be qualified. Services procured through this route will not give providers guaranteed minimum volume levels. Nor would it allow a provider to have a single tender contract which in effect grants a local monopoly.
6. Most NHS funded services in England are commissioned using one of four standard contracts (acute hospital services; mental health and learning disabilities; community services; and ambulance services). Services procured through the NHS standard contract for acute services are already subject to the principles that prices for services are fixed and that providers must seek to attract patients on the basis of quality without receiving minimum guarantees of volumes of patients treated. This will not change. The proposals set out here see these principles extended to services under other contracts through a phased implementation starting with community services.
7. Some community and mental health services will be the first areas to which these principles will be extended. Many other community and mental health services also have the potential to benefit in the future. Other areas, e.g. designated services like A&E, are expected to remain beyond the scope of patient choice of provider.

What is the problem under consideration?

8. Comparisons with other countries suggest NHS outcomes in some areas of healthcare are not as good as they could be, for example rates of amenable mortality[4], mortality rates of respiratory diseases[5], acute complications of diabetes[6] and incidence of MRSA infection rates[7]. The NHS also

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[1] http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_117794.pdf

[2] "Any willing provider" has been renamed "any qualified provider" to clarify the policy. It forms part of a suite of policies designed to increase patient choice of provider. From here on this document will use the term any qualified provider, except when referring directly to the consultation document *Liberating the NHS: Greater Choice and Control*

[3] http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_120613.pdf

[4] Nolte, E., McKee, C. M., *Measuring the Health of Nations: analysis of mortality amenable to healthcare* BMJ 2003; 327:1129 (2003)

[5] Eurocare-4 www.eurocare.it

[6] OECD, *Health at a Glance* 2009

[7] European Antimicrobial Resistance Surveillance System (EARSS) incidence of MRSA per 100,000 patient days (2008)

scores relatively poorly on being responsive to the patients it serves and lacks a genuinely patient-centred approach where patients are often expected to fit around services[8,9] . We also know that patients want choice and control over the healthcare they receive[10].

9. Part of the reason for poor outcomes is that some services are not as responsive to patients as they might be because they operate in near local monopoly conditions. The proposed changes to the procurement guidance should increase the range of healthcare providers from which patients may choose and consequently should increase the degree of responsiveness from the providers. This could be new providers entering the market to meet a perceived gap in current provision, existing providers expanding or adapting their services in response to patient needs and poor performers improving their services or exiting provision of those services.

10. At present, the procurement mechanisms of volume and cost contracts or block contracts create a barrier to entry for potential new providers. Tendered contracts allow incumbents to maintain patient volumes and revenues over the lifetime of the contract for want of alternatives for patients to choose. New providers can only offer services to patients if they win the contract when a commissioner decides on a new procurement round.

11. Positive incentives for improvements to efficiency and responsiveness result from services being contestable, i.e. where entry and exit conditions are straightforward and transparent. The expansion of patient choice of provider through any qualified provider by enhancing procurement policy is designed to increase contestability by limiting scope for de facto monopolies in local services. Instead, any provider that meets the qualification requirements will be allowed to register with the local commissioner and offer their services to patients. Patients will then decide which provider best meets their needs for a given clinical need and their GP would refer them accordingly.

12. The number of providers offering any given healthcare service would depend on the characteristics of the service. Some services will naturally be able to support more providers than others depending on the potential economies of scale available. The important element that the proposed change in the procurement guidance brings to commissioning is that services become more contestable even where only one provider initially offers services to patients. The changes to local provision of services will evolve over time to reflect the choices made by patients. This could take the form of existing providers offering a wider range of services or expanding existing services to a larger geographical reach or through a bigger number of locations, as well as wholly new providers electing to offer services.

Rationale for Government Intervention

13. Government is best placed to introduce the enhancements to procurement policy because the NHS is a public service funded by the taxpayer. Further, it is responsible for the design of standard NHS contracts. Through the issuing of guidance it can influence the implementation of the policy across England so that it is as fair and equal as possible.

14. The proposed reforms give patients more control over the healthcare they receive by extending the range of services to which the procurement arrangements that facilitate patient choice of provider may be applied. They make it easier for new providers to offer services to NHS patients by removing actual and perceived barriers to entry. The principles of patient choice of any qualified provider means that no provider in the market will have guaranteed volumes and all providers will compete at the same agreed price (either national tariff or locally set price).

15. The extension of patient choice to any qualified provider will take place within the context of the tighter financial environment ahead. The government has protected the NHS in England in the Spending Review settlement, with cash funding growth of £11.5bn (over 10%) by 2014/15. By comparison with other departments, this is a generous settlement, though by NHS historical standards still extremely challenging. Over the next spending period (2011/12 – 2014/15) the NHS will face significant additional demand for services arising from the age and lifestyle of the population

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[8] The Talinn Charter, *Health Systems for Health and Wealth* Draft Charter , World Health Organisation (2008)

[9] *Is the NHS becoming more patient centred? Trends from the national surveys of patients in England2002-2007* Picker Institute (2007)

[10] British Attitude Survey, NatCen http://www.natcen.ac.uk/study/british-social-attitudes-25th-report/our-findings (2009)

as well as the need to fund new technologies and drugs. This policy is intended to help achieve the necessary efficiencies to help achieve the QIPP objectives.

16. Local decisions about how money is spent makes a big difference to the types of services available to local communities. The extension of patient choice to any qualified provider along with Payment by Results where money follows the patient, will allow patient preferences as indicated by which provider patients chose to be referred to, to influence local services.

17. This proposed reform builds upon, and strengthens, the choice policies introduced to date. Patient choice has been introduced incrementally in specific areas since 2004. The proposals in the consultation document *Liberating the NHS: Greater Choice and Control* (2010) are designed to change the impact of patient choice on services to move accountability in the NHS closer to those who deliver the service and to increase the control patients have over their care. The extension of patient choice to any qualified provider through enhancements to procurement policy forms part of these wider proposals.

What are the policy objectives?

18. The policy objectives and intended effects are:

    - to improve outcomes for patients from health interventions;
    - to improve responsiveness of services to patient preferences; and
    - to increase patient choice and control.

    This will be achieved through:

    - more contestable markets for healthcare services;
    - a more efficient procurement process; and
    - a wider choice for patients of a range of providers for a larger number of services

What are the underlying causes of the problem?

19. In 1776, Adam Smith warned of the dangers of monopolies, '...monopoly... ...is the great enemy of good management'[11]. Yet many structures in the NHS retain the form of monopoly provision which may in part contribute to the poor outcomes discussed above. This section sets out the evidence base that demonstrates the advantages of more competitive arrangements. It also discusses the academic papers that investigate the effects of the reforms that introduced choice of elective acute services in April 2006.

20. There is a rich academic literature that has investigated the relationship between market structure and the outcomes, productivity and innovation in those markets. Some of this was covered by the impact assessment published in January 2011 by the Department of Health to accompany the Health and Social Care Bill 2011. As annex B of the Health Bill impact assessment acknowledges, some of the most frequently cited studies are:

    - Nickell (1996) finds that firms which face more competition have significantly greater productivity growth than those facing muted competition. He estimates that up to 40% of productivity differences between Organisation for Economic Cooperation and Development (OECD) countries is accounted for by the level of entry and exit by firms;
    - Djankov and Murrell (2002) finds that, in transition economies, the degree of competition has a significant impact on economic performance;
    - Ahm reviews a large number of studies on the link between competition and innovation and concludes that competition encourages innovation activities and has a significant impact on long term productivity; and
    - The Office of Fair Trading (OFT) commissioned a study by Frontier Economics on choice and competition in public services. They concluded that "supply side flexibility around entry, exit and expansion is critical"

[11] Smith A. *The Wealth of Nations* Chapter XI Part 1

21. A number of studies were published during 2010, that looked at the impact of earlier reforms to introduce patient choice of provider in elective care. These studies build on academic literature from a number of countries, notably the US, which discusses competition in healthcare services.

    - Cooper at al (2010a, 2010b) found that following the introduction of choice in 2006 "... that in markets with fixed-prices, hospital competition can improve patient outcomes.";
    - Bloom et al (2010) also used the introduction of choice in 2006 to investigate the impact of competition on management and outcomes. They conclude that '... our measure of management quality was robustly associated with better hospital outcomes...[and]... more hospital competition appears to cause improved hospital outcomes.'
    - Gaynor et al (2010) is a third paper that uses the introduction of choice in 2006 to investigate the impact of fixed price competition. Their findings corroborated those of Cooper, and they state in their concluding remarks '...that competition is an important mechanism to enhancing the quality of care patients receive. Monopoly power is directly harmful to patients, in the worst way possible – it substantially increases the risk of death.'
    - Both Bloom and Gaynor found that the volume of patients that moved from one hospital to another was not large and that the viability of the hospitals was not called into question. Nevertheless a significant improvement in quality was observed.

22. In summary, there is clear evidence that more competition in service provision can lead to more efficient delivery of goods and services in all sectors of the economy. Further, the controlled fixed price competition introduced so far to some areas of the NHS has had positive effects in terms of both efficiency and outcomes for patients. There is every reason to believe that rolling out similar arrangements to other areas of the NHS will have similar effects on them.

What policy options have been considered?

Option 1: Do nothing

23. At present the policy for commissioning NHS funded services are set out in *The Procurement Guide for Commissioners of NHS Funded Services*[12] , published in July 2010. This document sets out the different procurement routes open to commissioners and anticipated the impact of a move to "any willing provider" principles for an increased range of services.

24. The do nothing option sees the procurement processes run by commissioners continuing as set out in *The Procurement Guide*. Any qualified provider arrangements already apply to the procurement of elective acute services from hospitals.

25. For other services, commissioners commonly use contract management and tendering. The process for awarding contracts through tendering is shown in figure 1. There are three phases to the process. Phase 1, analysis, and phase 2 investigation are common for both the tendering process and the any qualified provider process. Phase 3 is specific to tendering.

26. Under the tendering process, phase 3 begins with the service specification being advertised to prospective providers using the mandated NHS procurement portal, *NHS Supply2Health*[13]. The process is:

    - The advertising commissioner issues through the portal a pre-qualification questionnaire which is evaluated upon return.
    - The commissioner then issues an invitation to tender to those candidate providers that satisfy the requirements of the pre-qualification questionnaire.
    - In turn, the returned invitation to tender documents are assessed and commissioner hold negotiations with the preferred bidder to finalise the terms of the contract.
    - Finally, the contract is awarded to the successful bidder and unsuccessful candidates are informed by letter.

[12] http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_118219.pdf

[13] http://www.supply2health.nhs.uk/default.aspx

27. Phase 3, which is specific to the tender process, takes considerable commissioner resource as they sift through the bids and decide how to proceed. This is discussed in more detail in the cost section below. If the proposals to extend the application of any qualified provider are not adopted, the lengthy commissioning process will remain and the benefits through cost savings to the administration budget set out below will not be realised.

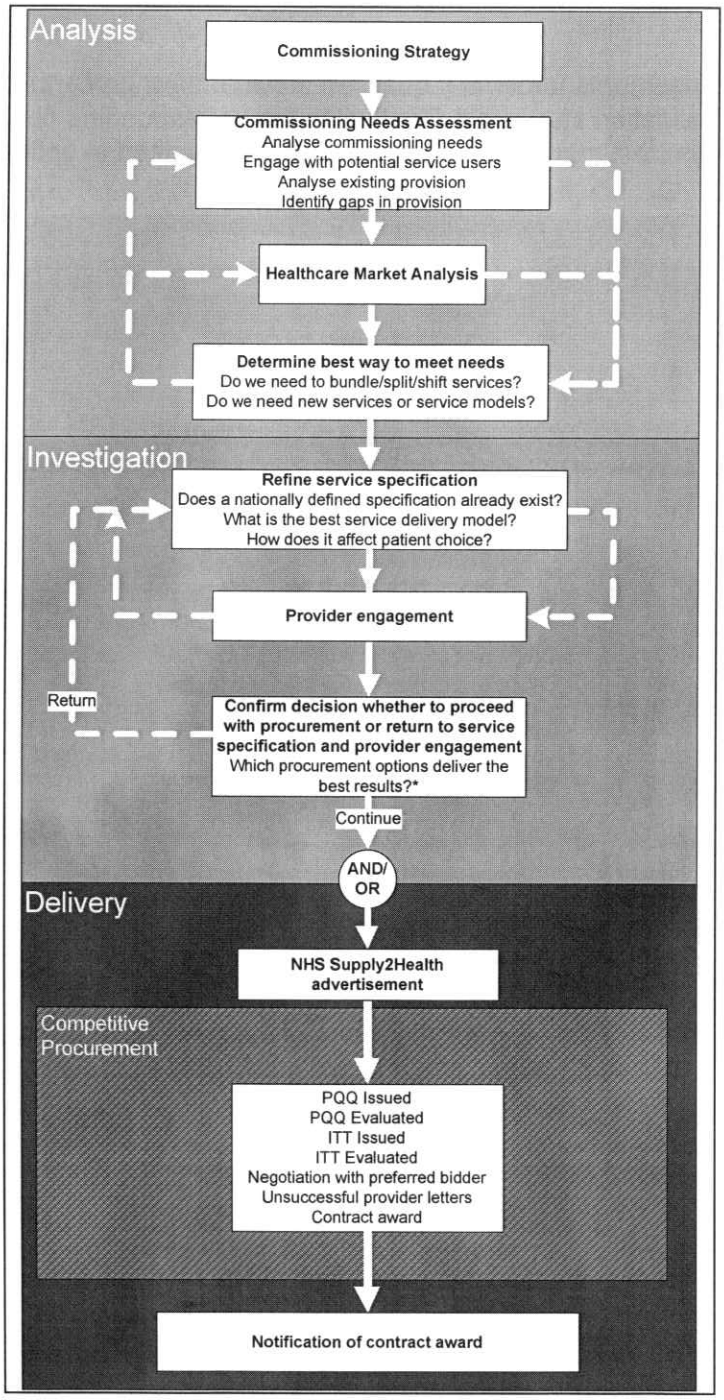

Figure 1: The Contract Management and Tendering Process

Option 2: Expand patient choice of provider through amendment of procurement rules to increase the range of services to which any qualified provider will apply with central direction to phased implementation and with central support for local commissioners.

28. The proposed policy is that the any qualified provider procurement principles will be applied beyond elective acute hospital services to other areas of community and mental health services from April 2012. This will be done with a phased approach, first encompassing the service areas shown in table 1.

The commissioning process

29. Key elements of an any qualified provider procurement are that:

- No provider will receive a guaranteed minimum volume of patients;
- All providers of the service will do so at the same fixed price (either national tariff or locally set price)
- A provider must be registered with both the Care Quality Commission and Monitor
- A provider must be registered with the commissioner for payment purposes

30. The procurement arrangements under any qualified provider arrangements are shown in figure 2. The analysis and investigation stages are identical to the corresponding phases in the procurement arrangements under contract management and tendering described in option 1. The only change is the delivery stage.

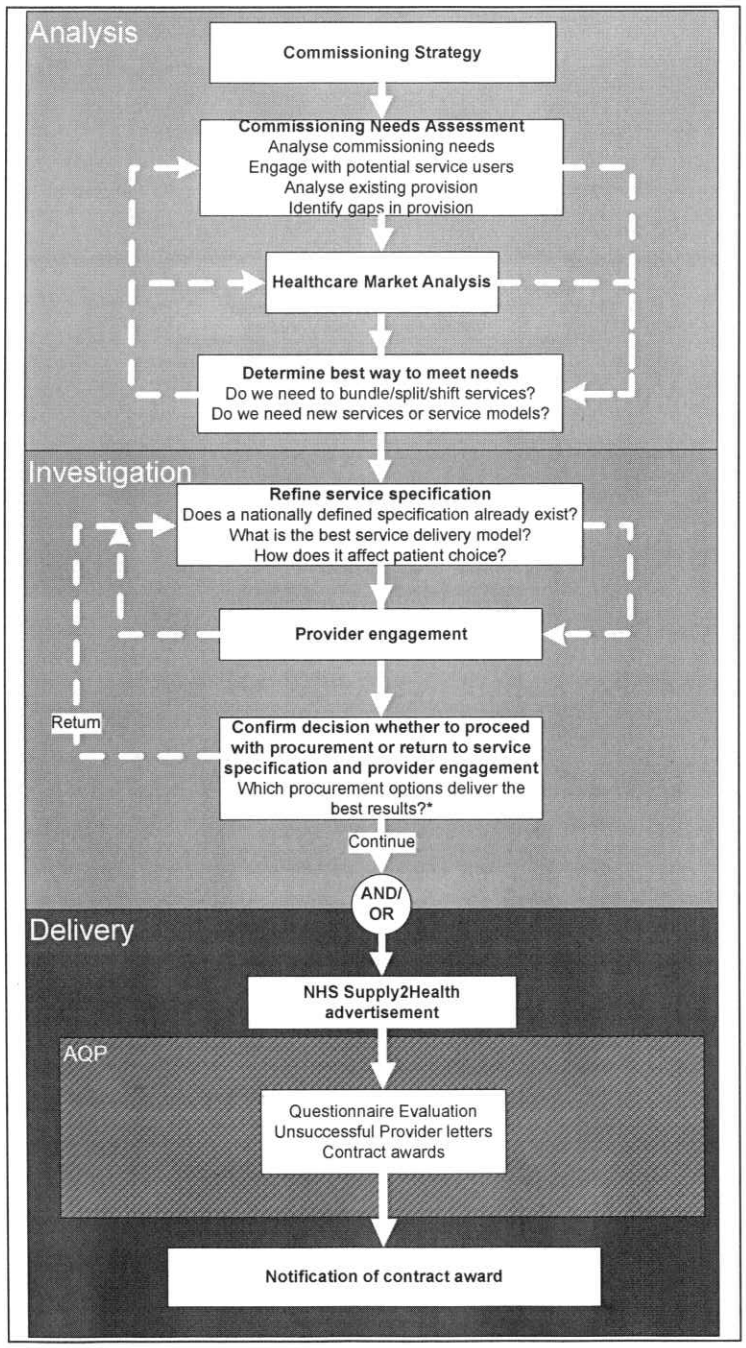

Figure 2:The Any Qualified Provider Procurement Process

31. The change occurs following the advertisement of the service on the NHS Supply2Health portal. At this stage, questionnaires are issued and evaluated on return. All providers that successfully provide the assurances that they meet the requirements are qualified and placed on a directory of providers. The advantage of the any qualified provider model is that the commissioner does not have to

evaluate competing bids in order to decide which is the best one. They can simply accept all bids that meet the requirements.

32. The qualification process has four steps:
    - The commissioner advertises AQP opportunities via NHS Supply2Health
    - Providers apply to be qualified by completing a questionnaire
    - Qualified Providers maintained in a central directory
    - Commissioners register qualified providers
33. The qualification process will be supported by central team funded by the Department of Health. The team will include **qualification** staff and technical staff to support choose and book and maintain the directory. This is one incentive for commissioners to adopt the any qualified provider principles. Others are discussed in the section on impacts of option 2 on commissioners, below.

Changes to the delivery of healthcare services

34. Under this option the Department of Health nominates a list of health service areas that should be given priority for the adoption of the any qualified provider principles. Local commissioners, supported by PCT clusters would select three or more services for implementation in 2012/13 although they may go beyond three or choose alternative services with a higher local priority, if there is a clear case to do so based on the views of service users and potential gains in quality and access.
35. Nominated services are shown in table 1, below, along with the volumes and expenditure at national level for context.

Table 1: List of DH nominated services

Service	**Expenditure (£m)**
Adult hearing services	197
Continence services and supplies	112
Direct access diagnostic imaging (X-rays, MRI scans etc)	141
Community musculoskeletal services (inc back pain)	230
Podiatry	177
Psychological therapies (IAPT)	173
Leg ulcer wound care	200
Wheelchair supply and maintenance	100
Total	**1,193**

Source: DH and reference cost data 2009/10[14]

36. The immediate change to these services, as stated above, is that once the procurement process is implemented, the contracts awarded to providers will not be to provide all of that service to the commissioner population. No volumes will be guaranteed and the provider will be paid depending on how many patients choose to be referred to it. Depending on the response from candidates to the invitation to tender process, more than one provider may be accredited to deliver services in each service area.
37. Consequently, one cannot say for sure how the structure of services will evolve with time. However, the procurement structure is designed to make services more responsive to patient choice as the principle of money following the patient is extended to community services increasing the incentives for services to attract patients. Some providers may choose to extend the range of services they offer, some may choose to extend the geographical range of existing services and /or the number of locations from which they are delivered. New providers may choose to begin offering services. Thus some services may develop a wide variety of providers, while for other services the provider

[14] expenditure figures refer to only the community delivered parts of the respective services and not to all NHS spend in England for the respective service

base may remain more concentrated, albeit subject to greater discipline through increased contestability.

38. Elective acute services are already procured by commissioners using any qualified provider principles. This gives patients in England a free choice of contracted hospitals when referred for first outpatient appointments. The remaining paragraphs in this section sets out the data on the utilisation by patients of NHS funded services at non-NHS hospitals for context.

39. Chart 1 shows the volumes of NHS funded activity performed in non-NHS hospitals. 1st outpatient referrals (upper blue line) have risen to between 30,000 to 35,000 per month, peaking at 35,300 in March 2011 following a steady rise since the introduction of choice in 2006.

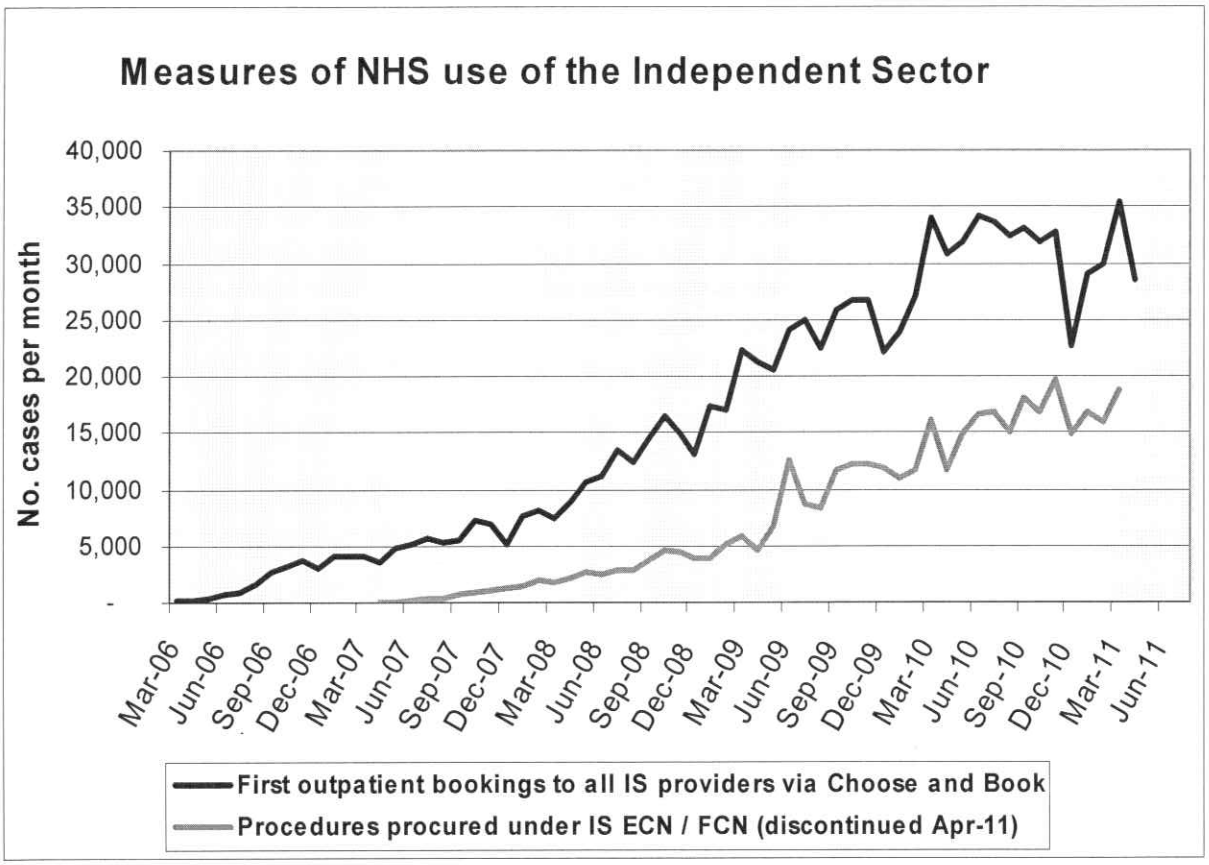

Chart 1: measure of NHS use of the independent sector

40. The red lower line shows the number of procedures invoiced by the independent sector via the extended choice network. This peaked at 19,600 in November 2010. To put that into context with all NHS funded activity, the average monthly referrals by GPs to 1st Outpatient Appointments was 920,000 in 2010/11.

41. Chart 2, which shows the proportion of patients being referred to non-NHS providers, adds further context. Between April 2010 and March 2011, the proportion remained broadly steady at 3.5%. This suggests that referrals to non-NHS providers have risen in line with the general increase in demand for NHS services. As overall demand for NHS services is expected to continue to rise in the coming years, there is scope for non-NHS providers to expand into community services without compromising the viability of NHS providers, as has been achieved in elective acute services to date.

Option 3:Expand AQP through amendment of procurement guidance with implementation at the discretion of local commissioners

42. This option is very similar to option 2 above. However, instead of the Department of Health specifying which service areas should be given priority, local commissioners would decide which services they apply the revised procurement guidance to without central support. This would have the advantage of allowing commissioners complete flexibility, with the benefit that they can pick the services to prioritise that will deliver the biggest improvements to their local communities.

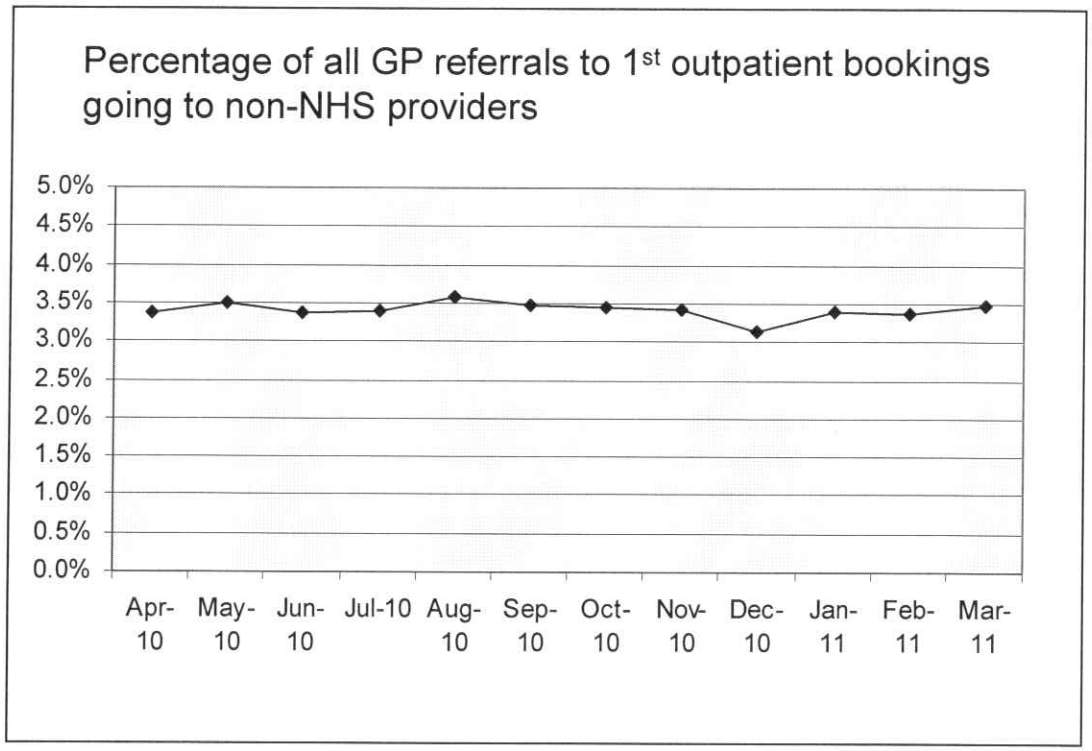

Chart 2: Percentage of all GP referrals to 1st outpatient bookings going to non-NHS providers

43. But there is also a potential downside. If each commissioner were to act without a clear steer on which services to prioritise, the choice offer in neighbouring communities could start to look quite different. This has the potential to cause confusion to local people as some people would be able to exercise choice for some services while others would not.

44. This approach would not enable the benefits that can be achieved through delivering the qualification process at scale (see option 2). Under option 2, gains can be made through use of standardised guidance on currencies and service specifications for certain services. For example, procurement by one cluster or region on behalf of others can reduce the need for providers to apply to each commissioner to deliver the same service. This process is facilitated by support from a central team. Under option 3 there would be no central support and scope for co-operation between commissioners would be reduced, therefore these benefits would be foregone.

Impacts of Preferred Option 2

45. The analysis identifies two main areas of impacts. The first is that the change in guidance leads to a change in the procurement process and as such will have an impact on the behaviour of commissioners. The second is the impact on services to which patient choice of provider is extended.

On Commissioners

46. Commissioners will be encouraged to collaborate during the procurement process to minimise duplication of effort. This will necessitate one commissioner acting as lead commissioner for a specific service. Once a provider has been added to an approved list, it will not need to be accredited again by a second commissioner in order to be added to their approved list.

47. Additionally, the lead commissioner will be responsible for monitoring a provider and ensuring they fulfil the terms of the contract. This is additional to the requirements of meeting the clinical standards required by CQC and the economic regulation of monitor, but is comparable to the level of monitoring currently required from commissioners under extant tendering arrangements.

48. Commissioners will use the guidance to procure services as contracts come up for renewal. Commissioners need only assess whether a bid meets the requirements rather than identifying the best candidate and then entering in detailed discussions with them. Therefore, AQP is less

resource intensive than previous procurement models. This should provide an incentive for commissioners to adopt AQP principles as it will help them meet their own efficiency targets for administration and support QIPP objectives.

49. A further incentive is provided under this option by the establishment by the Department of Health of a central team to provide support for AQP procurement. This is additional to any support Strategic Health Authorities (SHAs) will also be offering.

50. A final mechanism to promote take up of the AQP principles is that performance management of commissioners by SHAs will include their compliance with the Procurement Guidance. In future years, it is anticipated that clinical commissioning groups will be held to account by the National Commissioning Board (subject to parliamentary approval) in a similar manner.

On services

51. The other area of impact will be on the services that are selected for the extension of patient choice to any qualified provider. Providers that have been qualified will be placed on a list of qualified providers from whom patients may choose services. In practice, for many this will mean that they place slots on the Choose and Book electronic booking system. For other providers, alternative referral mechanisms may be more appropriate. Volumes of patients seen/treated by any one provider will not be guaranteed. Providers will be paid depending on the number of patients they attract. In the short term, this should generate incentives for providers to be more responsive to patients. In the longer run, this should lead to innovation and productivity improvements. This is discussed in more detail below.

Benefits

Procurement Cost Savings

52. The first area of benefits relates directly to the change in the procurement process. The guidance encourages greater cooperating between commissioners when procuring services from providers. The table below shows representative costs for a commissioner for the different stages of the procurement process.

	Year 1	Year 2	Year 3	Year 4	Year 5
Analysis (weeks saved)	0	4	4	4	4
Investigation (weeks saved)	0	2	2	2	2
Delivery (weeks saved)	2	4	4	4	4
Total hours saved in procurement	11.2	56	56	56	56
Cost per hour	£181	£181	£181	£181	£181
Total Savings (constant prices)	£2,024	£10,120	£10,120	£10,120	£10,120
Total Savings (discounted)	£2,024	£9,778	£9,447	£9,128	£8,819

Table 2: Saving from AQP per commissioner per project

53. From the table 2 we can see that in year 1 commissioners only realise time savings in the delivery phase. This is achieved by a quicker bid evaluation process as the procurement team only has to determine whether each bid meets the advertised specification and not which is the best one with which to proceed. In future years, procurement teams also realise time savings in the analysis and

investigation phases as they collaborate with each other by pooling expertise and sharing service specifications. The cost savings from extending patient choice of provider are the result of reduced administration time for a commissioning team in a typical primary care trust (PCT). Table 3 shows savings aggregated for the 151 PCTs in England, assuming the savings apply to **3 procurement exercises per year**, per PCT.

	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Total Savings per project England (discounted)	£0.3m	£1.5m	£1.4m	£1.4m	£1.3m	£5.9m
Total Savings for all projects England (discounted)	£0.9	£4.5m	£4.2m	£4.2m	£3.9m	£17.7m

Table 3: Total Savings from AQP for England

54. The savings rise from £306,000 in year 1 to £1.3 million in future years as the process becomes more embedded and the time savings in each of the three phases are realised. Saving occur at all phases as the commissioners can reduce the resources needed to draw up service specifications when they share existing specifications for an increasing range of services drawn up in previous years. In other words there are savings through learning by doing and from sharing expertise.
55. We have assumed that the cost savings to the procurement process are not cash releasing, however there is a chance that in the future, as greater savings are realised, cash could be released and invested elsewhere in the health system. This is discussed further in the risks section.

Improved efficiency of Provision

56. As the coordinating document for the impact assessment that accompanied the Health and Social Care Bill 2011 makes clear, the benefits from choice and competition are linked to the reform package of the Bill and it is difficult to attribute quantified benefits to individual policies.
57. Nevertheless, as noted above, Nickell (1996) suggests that up to 40% of efficiency gains in OECD countries are as a result of the ability of firms to enter and exit markets. Therefore, reforms that make it easier for firms to enter and leave the health care sector can be expected to increase efficiency.
58. Since 2006/07, the tariff for acute services has included a efficiency requirement. This has ranged from 2.5% to 3.5%[15]. If, expanding the procurement arrangements to facilitate entry and exit to other services achieves this level of efficiency gain, then it has the potential to deliver between £10 million and £14 million[16] of savings per year on every £1 billion worth of services to which it is applied.
59. With AQP principles being expanded to community-based services, where the threat of entry and exit will bring either greater contestability or competition to these services, one would expect to see increased efficiency. This is corroborated by Bloom et al (2010) who found that the quality of management was correlated to the level of competition for services.
60. Community Services account for approximately £10bn of expenditure. Initially the extension of patient choice to any qualified provider will apply to about £1,193m worth of services. Applying the convention of 2.5% to 3.5% efficiency savings, as seen in acute care, and 40% efficiency gains due to entry and exit, the expected level of efficiency savings is estimated to be between £12m and £17m per year. The evidence of Gaynor and Cooper suggests that a vast expansion of alternative providers is not required to achieve these efficiency gains - only a genuine increase in contestability for these services.

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[15] Department of Health *A simple guide to Payment by Results* 2011) p41
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_120254.pdf

[16] efficiency saving = £1bn * 0.025 * 40% = £10m; and = £1bn * 0.035 * 40% = £14m

61. The efficiency gains could fall to either the provider or commissioner. For the commissioner to receive a share of the efficiency gain, they would need to consider applying an efficiency component to the locally set price, along the lines of the national tariff. As this policy proposal does not have an explicit mechanism to extract the potential efficiency gains, the efficiency gains calculated above are based on assumptions and are purely illustrative. They therefore have not been included in the calculation for the net present value on the summary pages.

Costs

Procurement costs

62. The reduction in the administration costs for a commissioner by adopting AQP in place of procurement through more traditional tendering process is identified as one of the benefits of the policy proposals. The table below shows typical administration time and costs for the two procurement processes.

	Year 1		Year 2		Year 3		Year 4		Year 5	
	Tender	AQP	Tender	AQP	Tender	AQP	Tender	AQP	Tender	AQP
Analysis (weeks)	8	8	8	4	8	4	8	4	8	4
Investigation (weeks)	8	8	6	4	6	4	6	4	6	4
Delivery (weeks)	6	4	6	2	6	2	6	2	6	2
Total weeks	22	20	20	10	20	10	20	10	20	10
Total hour on procurement	123.2	112	112	56	112	56	112	56	112	56
Cost per hour	£181	£181	£181	£181	£181	£181	£181	£181	£181	£181
Total Cost (constant Prices)	£22,264	£20,240	£20,240	£10,120	£20,240	£10,120	£20,240	£10,120	£20,240	£10,120
Total Costs (Discounted)	£22,264	£20,240	£19,556	£9,778	£18,894	£9,447	£18,255	£9,128	£17,638	£8,819

Table 4: Running cost to commissioning organisation of a procurement team per procurement project

63. As can be seen from the table above, in each year, the cost of procuring services per project using the new arrangements is lower than existing arrangements. Consequently, there are no additional costs from this part of the procurement process.

64. The cost savings are entered as benefits. The cost of funding the teams that undertake procurement within commissioning organisation will be met from existing budgets.

Cost of central support for qualification and of directory of qualified providers

65. For the purposes of costing, it is expected that the Department of Health will establish a central team to support local commissioners with the qualification process. The make up of the team is yet to be decided but is likely to consist of up to 14 whole time equivalent members of staff (including a director of commissioning and project managers) at cost of up to £1million per year. The funding will be met from existing central funding. If the Commissioning Board receives parliamentary approval, this function will become the responsibility of the Board and the cost will be met by the Board's budget.

66. The table below shows the cost over 5 years at constant prices and discounted at 3.5%

	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Cost of central team (constant prices)	£1m	£1m	£1m	£1m	£1m	£1m
Cost of central team (discounted)	£1m	£0.97m	£0.93m	£0.90m	£0.87m	£4.67m

Table 5: Cost of central support team

Cost of monitoring contracts

67. Once providers have been registered and have started providing services, commissioners will need to monitor the provision to ensure the terms of the contract are being met. This is equally true of the current situation where commissioners must monitor the contracts awarded through tendering. Therefore the cost of this part of the commissioners functions are not expected to increase.

Resource costs for services selected for Patient Choice of *Any Qualified* Provider

68. The services selected for the first phase of implementing the extension of patient choice of provider are shown in the table1. Volumes of activity and cost of the services are not expected to rise above trend as a result of the extensions to patient choice of provider. The only change is that patients will have the choice to receive any service on the list of qualified providers that have appointment slots on the Choose and Book system. Referral behaviour by general practitioners again is not expected to change. Therefore there should not be any impact on expenditure for these services as a result of increased patient choice of provider. Although volumes of referrals are not expected to rise, there is a risk that they might. This is discussed below.

Cost of additional staff time

69. As patient choice of any qualified provider is extended, it is possible that some patients will require extra advice when making choices. There is a possibility that healthcare professionals may need to dedicate some additional time advising patients on the greater choice of providers which will be available. This could result in an additional time cost being incurred. It is not known what proportion of patients will require additional time for this purpose, or how much time will be required. Equally, there is no evidence that it will necessarily rise. As such this potential cost has not been quantified.

Risks

Budgetary uncertainty

70. One of the central tenants of the patient choice of any qualified provider principles is that the contracts will not contain guarantees on the volume of activity that will be supplied by each provider. This means that commissioners will not know in advance the number of appointments, procedures and interventions for which they will be invoiced by individual providers although the total quantum can be estimated. Any uncertainty could make commissioners reluctant to adopt these principles or to impose additional contractual requirements to manage demand. However, it should be emphasised that this policy will not introduce any greater uncertainty over total referrals that already exists.

No new providers enter the market

71. The lack of guaranteed volumes and income may also deter new providers. To enter provision of any given service, a provider may incur certain investment (fixed capital outlay) costs. If the prospective provider does not believe it can make a return on that investment, then it will decide not to take the risk. While guarantees is a way of over coming the risks, business in many sectors of the economy make investment decisions every day with no guarantee of a return. A bigger risk may be whether new providers believe they face a level playing field in terms of patients being offered the choice of their services. This point is covered by one of the roles of Monitor to ensure that a level playing field for all providers is maintained.

NHS funded transport

72. The NHS has two schemes to assist patients with transport to and from appointments:

    - The Patient Transport Service provides transport for patients with a medical need for the transport.
    - The Healthcare Travel Cost Scheme provides reimbursements of public transport costs to some patients who qualify, e.g. for low incomes.

73. There is a risk that if the patient choice of provider policies lead to more providers offering services from a range of locations, the cost of the patient transport scheme could rise. This is because these services are commissioned by commissioners under contracts. Providers of transport services believe current terms of the contracts only cover transport to existing providers. If new providers offer services transport providers may seek to renegotiate contracts to cover the additional costs of taking patients to a larger number of destinations.

74. The cost of the HTCS should not rise as a result of the policy proposals. Although the options of location of services for patients should increase as a result of the policy proposals, the number of patients being referred should remain the same. Further, the proposals are aimed at community services, hence services are expected to be located at venues that are more convenient for patients, e.g. on the high street. Therefore the number of patients qualifying for HTCS should remain the same and the distances travelled should not increase, so the cost of HTCS should not rise as a result of the policy.

Private Transport

75. The impact on travel patterns for treatment is unknown. Extending patient choice of any qualified provider could result in some patients choosing providers that are located further from where they live, which they would not do under the status quo. However, in this case, patients would implicitly assess if the benefits from going to the provider of their choice outweighs the additional journey time. Conversely, as the initial phase of extending any qualified provider focuses mainly on community services, it is possible that many patients will be required to travel less than they would be under the status quo, and therefore their travel cost could be reduced under option 2.

Fragmentation of services

76. There is a perceived risk that the introduction of choice and a wider range of providers could lead to a fragmentation of services. This need not be the case if services are well specified and they fit clearly within the pathway. At present, different parts of the NHS provide the services that make up the patient pathway and patients must move between them. In reality, the pathway for patients is already fragmented, and while the introduction of any qualified provider will not necessarily contribute to a direct reduction in fragmentation, more development of service specifications could have positive impact in this regard. Overall, integration of services that improves the patient experience is considered best achieved through good management rather than vertically integrated providers.

Duplication of provision and spare capacity

77. Another potential criticism of the expansion of choice to any qualified provider is that it could lead to duplication of services across providers and unnecessary spare capacity. Whether this is an issue will depend on the economies of scale of a service. A service with high fixed costs does require large volumes to have low average costs. Not all health services fit this model. Those community services prioritised for the phased implementation of extension of patient choice of any qualified provider, such as hearing tests and hearing aid fittings or podiatry, can be delivered on a relatively modest scale. Therefore there is the potential for multiple providers to co-exist efficiently in the market for these services. Duplication of provision might occur if a commissioner insists on any qualified provider meaning a large number of providers for its own sake rather than designing a healthcare market tailored to the particular service. Ultimately, this will be a consideration for providers in deciding whether or not to compete for services and they will implicitly form an assessment of this risk.

Viability of Services and rising unit costs

78. A final risk sometimes raised is that some NHS services, e.g. audiology, provide both specialist services and routine services in the same unit. If patients choose to go to a new provider for the routine services then the specialist service will become unviable and will be lost. This will not be the case under these policy proposals. Commissioners are required to ensure provision of a wide range of services to meet the needs of their populations. Specifications for different services, e.g. specialist and routine, should be defined separately and the prices or tariffs set for full cost recovery. Therefore the viability of specialist services should not be threatened, although some service providers may shrink while others expand depending on patient choices.

79. All services have some fixed costs and as the volume of activity at one provider falls so their unit costs will rise. However, the services listed for priority implementation have relatively small fixed costs so should not suffer particularly from large rises in unit costs if the scale of activity falls. Any rises in unit costs for a given provider may be off-set from increases in efficiencies as providers innovate to attract patients. Over time, as commissioners apply the principles of AQP to service areas beyond the list, they will need to be mindful of the type of service they are procuring. The objective of any qualified provider is not to get more providers offering services for its own sake, but to generate genuine contestability to ensure providers deliver services that are efficient. In theory, this could mean that the service only has one provider so long as the service is open to new providers should they wish to enter.

Upside Risk: Cash Release of Savings

80. When quantifying the benefits which arise from cost savings, we have assumed that the savings are not cash releasing i.e. commissioners will make time savings which release pressures elsewhere however this will not have an impact on their budgets and therefore cash is not released back into the system. There is an upside risk that in the future, as savings to commissioners are realised, that cash will be released back into the healthcare system. For every £1 of cost saved it is assumed that there is an opportunity cost saving of £2.40. This is because it is estimated that the government foregoes the purchase of a Quality Adjusted Life Year, a QALY, or a benefit of equivalent social value, for each £25,000 cost, and that QALYs have an assumed monetary value of around £60,000 to the public. If we were to assume the savings were cash releasing, the benefits would be 2.4 times larger than they currently stand.

Impacts of Option 3

81. The core proposal of option 3 is the same as option 2 with regard to the expansion of any qualified provider principles into the procurement guidance. However, under option 3 there is no nominated list of services for commissioners to prioritise and the Department of Health does not establish a central team to support local commissioners in carrying out procurement activities.

Benefits

Procurement Cost Savings

82. As with option 2, under option 3 the guidance encourages greater cooperation between commissioners when procuring services from providers. However, without direction on which services to prioritise it is likely that commissioners individually choose which services they wish to apply the amended procurement procedures to. As a result, it is likely that the anticipated cost savings from cooperation and pooling of procurement resource will not materialise. Therefore the realised cost savings in the first 5 years would be lower. The table below shows the cost savings that could be achieved if commissioners only get the benefit during the delivery phase of the procurement process from the simplified evaluation stage.

	Year 1	Year 2	Year 3	Year 4	Year 5
Analysis (weeks saved)	0	0	0	0	0
Investigation (weeks saved)	0	0	0	0	0

Delivery (weeks saved)	2	4	4	4	4
Total hours saved in procurement	11.2	22.4	22.4	22.4	22.4
Cost per hour	£181	£181	£181	£181	£181
Total Savings (constant prices)	£2,024	£4,048	£4,048	£4,048	£4,048
Total Savings (discounted)	£2,024	£3,911	£3,779	£3,651	£3,528

Table 6: Saving from AQP per commissioner per project

83. It is possible that some savings in the resources used to procure services would be possible in later years as the volume of services using the revised procurement process increases and the opportunity for collaboration also increases. However, this option provides no mechanism to facilitate that.

	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Total Savings per projected England (discounted)	£0.3m	£0.6m	£0.6m	£0.6m	£0.5m	£2.6m
Total Savings for all projects England (discounted)	£0.9m	£1.8m	£1.8m	£1.8m	£1.5m	£7.8m

Table 7: Total Savings from AQP for England

84. The aggregated England level saving in table 7 follow the same calculations as for option 2. First the savings from table 6 are aggregated across the 151 primary care trusts. Then it is assumed that each PCT undertakes 3 procurement projects per year.

Improved efficiency of provision

85. So long as the new procurement process are implemented correctly, they should be as effective under option 3 at delivering improved efficiency from providers as under option 2. Therefore, the benefits are estimated to be between £11 million and £16 million per every £1 billion of NHS funded activity[17].

Costs

Procurement costs

86. Unlike for option 2, option 3 does only generate reductions in administration costs for commissioners during the delivery phase of procurement process. Therefore, as with option 2, the costs of procuring services under AQP can be done by commissioners with existing resources. Thus the amount entered into the cost summary for this section is zero. The cost saving is entered as a benefit.

[17] See paragraph 57 for derivation.

	Year 1		Year 2		Year 3		Year 4		Year 5	
	Tender	AQP	Tender	AQP	Tender	AQP	Tender	AQP	Tender	AQP
Analysis (weeks)	8	8	8	8	8	8	8	8	8	8
Investigation (weeks)	8	8	6	6	6	6	6	6	6	6
Delivery (weeks)	6	4	6	2	6	2	6	2	6	2
Total weeks	22	20	20	16	20	16	20	16	20	16
Total hour on procurement	123	112	112	89.6	112	89.6	112	89.6	112	89.6
Cost per hour	£181	£181	£181	£181	£181	£181	£181	£181	£181	£181
Total Cost (constant Prices)	£22,264	£20,240	£20,240	£16,192	£20,240	£16,192	£20,240	£16,192	£20,240	£16,192
Total Costs (Discounted)	£22,264	£20,240	£19,556	£15,644	£18,894	£15,115	£18,255	£14,604	£17,638	£14,110

Table 8: Running cost to commissioning organisation of a procurement team

Cost of central support for accreditation and of directory of accredited providers

87. Under option 3, there is no proposal to provide any central support to commissioners for the procurement process. Therefore the costs are zero.

Risks

88. The risks under option 3 are the same as under option 2, see discussion in preceding sections.

Summary and Weighting of Options

89. Using the evidence presented, we estimate that the cost of option 2 over 5 years, at constant prices will be £5m, which is £4.7 million in present value terms. The estimated benefits from option 2 on an equivalent basis are £17.7m from savings to administration costs for commissioners. Therefore the net benefits based on quantified, monetised costs and benefits are £13.0m. There are additional costs and benefits which haven't been monetised as discussed above.

90. To account for the opportunity cost (i.e. If the additional costs had instead been spent directly on providing extra health care) it is convention to apply an adjustment of 2.4 to the monetary costs of the policy option which leads to an estimated opportunity costs of £11.2 million[18]. However, the benefits are cost savings and so the adjustment should apply equally to the benefit side. For simplicity, we have presented the figures without the opportunity cost adjustment as the analysis is unchanged.

91. The evidence for option 3 estimates that the cost to implement the policy of extend any qualified provider without central support, or phased priority to services, over 5 years is £0. This is because commissioners will meet costs from existing budgets by transferring resources from current procurement programmes and activities. The estimated benefits are £7.5m from administrative cost savings to commissioners.

92. For both option 2 and option 3, the discussion above estimates benefits from efficiency savings in the delivery of services through any qualified provider procurement. As these benefits are based solely on assumptions they have not been included in the summary table below. By way of illustration, if these efficiency savings were realised they would be of the order of £12m to £17m per year for every

[18] The Department of Health technical guidance on Impact Assessments states that it should be assumed that the opportunity cost of £1 of exchequer funding is £2.40.This is because it is estimated that the government foregoes the purchase of a Quality Adjusted Life Year, a QALY, or a benefit of equivalent social value, for each £25,000 cost, and that QALYs have a monetary value of around £60,000 to the public.

£1bn of services procured using any qualified provider principles. This would make the case for AQP more compelling.

93. On the balance of the evidence, both options have a net present value greater than zero and offer value for money. Option 2 offers the better value and is the preferred option.

Table : Costs and benefits and other factors associated with the short listed options							
OPTIONS (against Option 1)	COSTS (£)		BENEFITS (£)		NET BENEFITS (£)	Equality/ Other Impacts	QIPP Compliance
	Central	Worst	Central	Worst	Central		
Option 2: ***	£4.7m	n/k	£17.7m	n/k	£13.0m	See EQIA	Yes
Option 3: ***	£0m	n/k	£7.5m	n/k	£7.5m	See EQIA	yes

Note: presented figures have been discounted; opportunity cost multiplier of 2.4 hasn't been applied but applies equally to the costs and benefits (cost savings) so results of the analysis are unaffected.

Assumptions

The cost per hour of a procurement team within a commissioner is based on discussions with the NHS and is shown in the table below.

Cost of team members	Salary	Whole Time Equivalent on Procurement	Cost
Director of Commissioning	£80,000	0.4	£32,000
Director of Finance	£85,000	0.2	£17,000
Head of Commissioning	£40,000	1	£40,000
Head of Finance	£40,000	0.2	£8,000
Project Manager	£30,000	4	£120,000
Administrative Staff	£18,000	2	£36,000
			£253,000

The team does not spend all its team on procurement projects. Below are the assumptions used to calculate the hourly cost for procurement

Cost per week*	£6325
Cost per hour**	£181

* based on staff working 40 weeks per year after annual leave = £253,000 / 40 = £6325

** based on a 35 hour week = £6325 / 35 = £181

Annexes

Annex A: Post Implementation Review (PIR) Plan

A PIR should be undertaken, usually three to five years after implementation of the policy, but exceptionally a longer period may be more appropriate. If the policy is subject to a sunset clause, the review should be carried out sufficiently early that any renewal or amendment to legislation can be enacted before the expiry date. A PIR should examine the extent to which the implemented regulations have achieved their objectives, assess their costs and benefits and identify whether they are having any unintended consequences. Please set out the PIR Plan as detailed below. If there is no plan to do a PIR please provide reasons below.

Basis of the review:. The AQP guidance is expected to be reviewed in future years and any updates will require a futher impact assessment to be carried out. That will provide an opportunity to review the implementation of the policy
Review objective:. The objective of the review is to ensure that the costs savings estimated here have been delivered and that the policy is net beneficial.
Review approach and rationale: Carry out further Impact assessment.
Baseline: The baseline is the information set out in this Impact Assessment document.
Success criteria: n/a
Monitoring information arrangements: information on the costs associated with carrying out any qualifiied provider procurement.
Reasons for not planning a review: n/a

Annex B: Specific Impact Test

Competition

The Office of Fair Trading has published screening questions to help determine whether a policy is likely to have an impact on competition. These are:

Would the proposals directly limit the number or range of suppliers?

The proposals are expected to increase the number or range of suppliers. The proposals are intended to amend procurement guidance to make it easier for suppliers to enter and exit service provision. The proposals also amend arrangements so that more than one provider can hold concurrent contracts for the same service.

Would the proposal indirectly limit the number or range of suppliers?

For suppliers to be able to offer NHS-funded services they must meet the requirements of the standard NHS contracts. The enhancements to procurement policy are intended to keep the burdens on candidate organisations bidding for contracts as low as possible.

Would the proposals limit the ability of providers to compete?

The proposals to amend the procurement guidance are not expected to limit the ability of suppliers to compete. The proposals will allow more than one supplier to hold concurrent contracts for the same service allowing patients to choose from which supplier they receive the service. Notwithstanding this all holders of NHS contracts will have to register with the Care Quality Commission and with Monitor. The proposals here do not change those requirements.

Small Firms

The proposals aim to encourage small firms to be able to provider many NHS funded services, particularly community services. Therefore, one would expect the policy to have a positive impact on small firms.

Environmental Impacts

There is no reason to expect any significant environmental impacts

Human Rights

There is no reason to expect any significant impact on human rights

Justice System

There is no reason to expect any significant impact on the justice system

Rural Proofing

Extending choice of provider could potentially have an impact on those living in rural areas. People living in these areas may have different priorities and therefore different considerations when making choices than those living in urban or sub-urban areas, and may face greater difficulties in exercising choice.

While 19.1% of the population in England live in rural areas, only 11.1% of hospitals are located in these areas. This relative under-provision of hospital services in rural areas can be explained by a lack of critical mass of population, which limits the potential to exploit economies of scale and therefore makes healthcare services relatively more expensive. Services are therefore more likely to be located in areas with greater population density, where average costs can be minimised. The proposals to change the procurement process to extend choice to any qualified provider are designed to make it easier for new providers to offer services and to be more responsive to patients. However, with rural areas having higher costs, the change in rural provision of health services may be small.

Despite the barriers to choice that exist in rural areas, research from the Kings Fund (2010) found that respondents living in small towns and villages or in rural settings were significantly more likely to be aware of choice, to be offered a choice and to choose a non-local hospital than those in cities, large towns or suburbs.

This impact assessment covers the commitment to extend patient choice of provider by amending the procurement guidance to cover services under additional NHS contracts. Access to information about choice can be an issue for people living in rural areas, whether that is from a library, directly from healthcare providers or by computer via the internet connections. It is not expected that the expansion of choice of provider is not expected to disadvantage rural patients, but they might not benefit as much a patients in urban areas.

Annex C Bibliography

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