Title: Provider Selection Regime Impact Assessment
IA No: 9616

RPC Reference No: NA

Lead department or agency: DHSC

Other departments or agencies: NHS England

Impact Assessment (IA)

Date: 16/10/2023

Stage: Final

Source of intervention: Domestic

Type of measure: Secondary legislation

Contact for enquiries:
Policy Lead: Richard.Corbett@dhsc.gov.uk
Analytical Lead:
Daniel.jones@dhsc.gov.uk

Summary: Intervention and Options

RPC Opinion: Not a regulatory provision

Cost of Preferred (or more likely) Option (in 2020 prices)			
Total Net Present Social Value	**Business Net Present Value**	**Net cost to business per year**	**Business Impact Target Status**
£183.4m	NA	NA	Not a regulatory provision

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

NHS commissioners, NHS England and local authority commissioners have reported that current rules on procurement for healthcare services under the Procurement, Patient Choice, and Competition Regulations (PPCCR) 2013 and the Public Contract Regulations (PCR) 2015 are not well suited to the effective arrangement of healthcare services in England. For many healthcare services, the choice of service provider is constrained by the nature of the service and its interdependencies with other services. Current regulations have generated expectations that competitive tendering should be used to arrange services even when there is no overall value in doing so. Commissioners have reported that reliance on competitive tendering creates barrier`s to collaboration and the effective integration of services as well as reducing certainty for providers which leads to inefficient use of resources. It also creates unnecessary administrative costs. Government intervention is required to change the law but the evidence on potential impacts of reducing competition in public procurement is mixed when it comes to health care services.

What are the policy objectives of the action or intervention and the intended effects?

Introducing a new regime to govern the arrangement of healthcare services through regulations can provide relevant authorities with a more flexible decision-making framework than is currently available. The intention is that these changes would lead to improved healthcare services for patients, including through increased integration of services, service sustainability, and more joined-up care. The objectives of this intervention are:

1. To encourage increased collaboration between commissioners and providers and to promote better integration of services and more joined-up care.
2. To give providers more certainty in order to promote longer-term investment, more opportunities for partnership and collaboration with other providers, and to reduce staff turnover.
3. To enable more efficient use of resources by reducing unnecessary bureaucracy.

The indicators of success will be linked to the outcomes that NHS England, Integrated Care Systems (Integrated Care Boards), Local Authorities, and NHS Trusts and Foundation Trusts deliver for patients, the taxpayer, and the population by utilising the flexibility provided by the Provider Selection Regime (PSR) when commissioning healthcare services. DHSC intends to commission a research programme to understand the different ways that Integrated Care Systems and system partners come together to design, commission, and deliver services, and their potential impacts and outcomes – including assessment of the role of the PSR.

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

- Business as usual – This would not remove the barriers to integration and collaboration identified by commissioners.
- Option 1: Our preferred option is to introduce a new procurement regime (PSR) to provide statutory NHS bodies and local authorities with a flexible decision-making framework when arranging healthcare services, which would facilitate integration and collaboration across the healthcare system.
- Option 2: We considered limiting the use of a new procurement regime (PSR) to services commissioned by NHS bodies, meaning that health services commissioned by local authorities would still be arranged under the PCR.
- Option 3: We considered exempting NHS-to-NHS health service arrangements from the PCR which would allow NHS commissioners to commission services from NHS providers without competition. All healthcare services arranged by local authorities or services arranged by NHS commissioners with independent providers (including private, VCSE and small businesses) would still be subject to the PCR.
- Non-regulatory option: We considered alternatives to regulation, whereby relevant authorities continue to arrange healthcare services under the PCR whilst maintaining the aims of integration of services and better joined up care under the ICS structure.

Will the policy be reviewed? It will not be reviewed. **If applicable, set review date:** Month/Year

Is this measure likely to impact on international trade and investment?		No		
Are any of these organisations in scope?	**Micro** Yes	**Small** Yes	**Medium** Yes	**Large** Yes
What is the CO_2 equivalent change in greenhouse gas emissions? (Million tonnes CO_2 equivalent)		**Traded:**	**Non-traded:**	

I have read the Impact Assessment and I am satisfied that, given the available evidence, it represents a reasonable view of the likely costs, benefits and impact of the leading options.

Signed by the responsible Minister: Will Quince Date: 17th October 2023

Summary: Analysis & Evidence

Policy Option 1

Description: Regulations introducing a new procurement regime – Provider Selection Regime (PSR), for relevant authorities to use when selecting providers to deliver healthcare services for the purpose of the healthcare service in England. Relevant authorities include: an ICB; a local authority in England, a combined authority, NHS England, an NHS Trust, or an NHS Foundation Trust.

FULL ECONOMIC ASSESSMENT

Price Base Year 2023	**PV Base Year** 2023	**Time Period Years** 10	**Net Benefit (Present Value (PV)) (£m)**		
			Low: -15.2	**High: 751.2**	**Best Estimate: 233.6**

COSTS (£m)	**Total Transition** (Constant Price)	Years	**Average Annual** (excl. Transition) (Constant Price)	**Total Cost** (Present Value)
Low	4.0	1	1.2	**14.2**
High	26.5		3.9	**59.9**
Best Estimate	14.4		2.4	**34.7**

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

We have estimated familiarisation costs to commissioners and providers of health care services in England of £14.4m in the first year of implementation. The main recurrent costs come from the introduction of an independent review panel (£20.3m over the appraisal period). There is also a small cost associated with the additional transparency requirements (£0.05m over 10-year appraisal period). We have not provided an estimate for private businesses because the PSR regulates the procurement practices in the public sector and NHS organisations, and therefore has no direct costs and benefits for businesses, although there may be indirect impacts for businesses. Costs of potential litigation activity have been included in our sensitivity analysis but not in our central estimate due to the uncertainty of these impacts.

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

There are potential impacts of the PSR on competition levels in the long-term on health care service markets, which could affect efficiency, innovation, number of providers or price of contracts.

BENEFITS (£m)	**Total Transition** (Constant Price)	Years	**Average Annual** (excl. Transition) (Constant Price)	**Total Benefit** (Present Value)
Low	NA	NA	5.5	**44.7**
High	NA		93.7	**765.4**
Best Estimate	NA		32.8	**268.3**

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

The only monetised benefit identified was the cost saving to providers and commissioners of the reduced administrative burden associated with using direct award in scenarios where competitive procurement is currently being used unnecessarily. Benefits from a potential decrease in litigation activity have been included in the sensitivity analysis but not our central estimate. These benefits carry high uncertainty which is reflected in the range provided.

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

Most of the benefits of the PSR relate to the flexibility it offers relevant authorities in the NHS and across local government and the opportunities for integration and collaboration that it provides. The key benefits are that a long-term focus for providers may encourage innovation, which may improve quality of service and value for money; and greater collaboration between commissioners and providers, which may enable greater integration of services in the best interests of patients.

Key assumptions/sensitivities/risks	**Discount**	3.5

There is a lack of specific and robust data relating to health care procurement in England; assumptions have been used where evidence is missing **Our estimates have been developed based on 20% of data coverage from the data source. This is a key driver of the large sensitivity range and the values presented in this IA**; the best estimates provided in this summary table are based on the midpoint between the maximum and minimum estimates. Modelling results also rely upon the following further assumptions ordered by importance: (i) that direct awards under the PSR will solely be used in situations where one bid was received; (ii) that full adoption of PSR guidance is expected within five years; (iii) that procurement costs under the PSR are proportionate to total contract value; (iv) that commissioners will face familiarisation costs to retraining staff to ensure guidance is adhered to; (v) that future litigation costs under the PSR may increase or decrease**. Competition –** there are potential risks to competition in allowing more flexibility to commissioners through the PSR including fairness, promoting competition, and realising the benefits of competition.

BUSINESS ASSESSMENT (Option 1)

Direct impact on business (Equivalent Annual) £m:			**Score for Business Impact Target (qualifying provisions only) £m:**
Costs: NA	**Benefits:** NA	**Net:** NA	NA

Summary: Analysis & Evidence

Policy Option 2

Description: The new procurement regime would be introduced for NHS organisations to use when selecting providers to deliver healthcare services for the purpose of the healthcare service in England. Initially, engagement for the changes that the PSR entails was led by NHS England and therefore was only considered for the arrangement of services by statutory NHS bodies. Non-NHS bodies are excluded from the PSR under this option.

FULL ECONOMIC ASSESSMENT

Price Base Year 2023	**PV Base Year** 2023	**Time Period Years** 10	**Net Benefit (Present Value (PV)) (£m)**		
			Low: 1.5	**High: 496.5**	**Best Estimate: 177.5**

COSTS (£m)	**Total Transition** (Constant Price)	Years	**Average Annual** (excl. Transition) (Constant Price)	**Total Cost** (Present Value)
Low	2.7	1	0.8	**9.1**
High	10.2		2.5	**31.3**
Best Estimate	6.2		1.5	**19.2**

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

We have estimated familiarisation costs to NHS commissioners and providers of health care services in England of £6.2m in the first year of implementation. The main recurrent costs come from the introduction of an independent review panel (£12.9m over the appraisal period). There is also a small cost associated with the additional transparency requirements (£0.004m over 10-year appraisal period). Costs from a potential increase in litigation activity have been included in our sensitivity analysis but not our central estimate. We have not provided an estimate for private businesses because the PSR under this option regulates only NHS organisations and the way in which they can procure their healthcare services, and therefore has no direct costs and benefits for businesses, although there may be indirect impacts for businesses. Costs of potential litigation activity have been included in our sensitivity analysis but not in our central estimate due to the uncertainty of these impacts.

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

There are potential impacts of the PSR on competition levels in the long-term on NHS health care service markets, which could affect efficiency, innovation, number of providers or price of contracts.

BENEFITS (£m)	**Total Transition** (Constant Price)	Years	**Average Annual** (excl. Transition) (Constant Price)	**Total Benefit** (Present Value)
Low	NA	NA	4.0	**32.8**
High	NA		61.9	**505.7**
Best Estimate	NA		24.1	**196.6**

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

The only monetised benefit identified was the cost saving to providers and NHS commissioners of the reduced administrative burden associated with using direct award in scenarios where competitive procurement is currently being used unnecessarily. Benefits from a potential decrease in litigation activity have been included in the sensitivity analysis but not our central estimate. These estimates carry high uncertainty which is reflected in the range presented.

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

Most of the benefits of the PSR relate to the flexibility it offers NHS commissioners and the opportunities for integration and collaboration that it provides. The key benefits are that a long-term focus for providers may encourage innovation, which may improve quality of service and value for money; and greater collaboration between NHS commissioners and providers, which may enable greater integration of services in the best interests of patients.

Key assumptions/sensitivities/risks	**Discount rate**	3.5

There is a lack of specific and robust data relating to NHS procurement in England; assumptions have been used where evidence is missing but our assumptions around the behaviour of NHS commissioners under the PSR may be incorrect. **Our estimates have been developed based on 20% of data coverage from the data source. This is a key driver of the large sensitivity range and the values presented in this IA.** The best estimates provided in this summary table are based on the midpoint between the maximum and minimum estimates based on our central assumption/medium savings scenario. There are risks that direct award would be used more than estimated, leading to the loss of benefits from competition when it could have led to better outcome for patients. Other modelling assumptions about procurement procedures and key impacts are identical to those described in Option 1 above. **Competition –** there are potential risks to competition in allowing more flexibility to commissioners through the PSR, including fairness, promoting competition, and realising the benefits of competition.

BUSINESS ASSESSMENT (Option 2)

Direct impact on business (Equivalent Annual) £m:			**Score for Business Impact Target (qualifying provisions only) £m:**
Costs: NA	**Benefits:** NA	**Net:** NA	NA

Summary: Analysis & Evidence

Policy Option 3

Description: The PSR would only be applicable for NHS commissioners commissioning services with NHS providers. In effect, NHS commissioners would be able to directly award contracts to NHS providers outside of the PCR. For services where private providers or voluntary organisations are being considered in the procurement process, commissioners would likely go through a competitive tendering process via the PCR.

FULL ECONOMIC ASSESSMENT

Price Base Year 2023	**PV Base Year** 2023	**Time Period Years** 10	**Net Benefit (Present Value (PV)) (£m)**		
			Low: 11.2	**High: 238.6**	**Best Estimate: 94.6**

COSTS (£m)	**Total Transition** (Constant Price)	Years	**Average Annual** (excl. Transition) (Constant Price)	**Total Cost** (Present Value)
Low	2.2	1	0.002	**2.2**
High	6.5		0.006	**6.6**
Best Estimate	4.2		0.004	**4.3**

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

We have estimated familiarisation costs to NHS commissioners and NHS providers of health care services in England of £4.2m in the first year of implementation. There is also a small cost associated with additional transparency requirements (£0.003m over 10-year appraisal period). Costs from a potential increase in litigation activity have been included in our sensitivity analysis but not our central estimate. We have not provided an estimate for private businesses because this option only applies to NHS organisations, and therefore has no direct costs and benefits for businesses, although there may be indirect impacts for businesses. Costs of potential litigation activity have been included in our sensitivity analysis but not in our central estimate due to the uncertainty of these impacts.

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

There are potential impacts of the PSR on competition levels in the long-term on NHS health care service markets, which could affect efficiency, innovation, number of providers or price of contracts.

BENEFITS (£m)	**Total Transition** (Constant Price)	Years	**Average Annual** (excl. Transition) (Constant Price)	**Total Benefit** (Present Value)
Low	NA	NA	2.2	**17.7**
High	NA		29.5	**240.8**
Best Estimate	NA		12.1	**98.8**

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

The only monetised benefit identified related to health care services may be arranged 'in-house' in the NHS without reference to a procurement regime; if NHS commissioners are able to directly award contracts to NHS providers outside of the PCR it reduces their administrative burden. Benefits from a potential decrease in litigation activity have been included in the sensitivity analysis but not our central estimate. These estimates carry high uncertainty which is reflected in the range presented.

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

This proposal may have the advantage of promoting collaboration, integration and open problem solving between NHS commissioners and NHS providers and improve certainty for NHS providers in order to encourage long-term investment in services, better staff retention and long-term expertise.

Key assumptions/sensitivities/risks	**Discount rate**	3.5

There is a lack of specific and robust data relating to NHS procurement in England; assumptions have been used where evidence is missing but our assumptions around the behaviour of NHS commissioners may be incorrect. **Our estimates have been developed based on 20% of data coverage from the data source. This is a key driver of the sensitivity range and the values presented in this IA**; the best estimates provided in this summary table are based on the midpoint between the maximum and minimum estimates based on our central assumption/medium savings scenario. Other modelling assumptions about procurement procedures and key impacts are identical to those described in Option 1 above. **Competition -** Given less coverage of this option, competition risks are likely to be significantly lower, though there are some potential risks to fairness, promoting competition and realising the benefits of competition.

BUSINESS ASSESSMENT (Option 3)

Direct impact on business (Equivalent Annual) £m:			**Score for Business Impact Target (qualifying provisions only) £m:**
Costs: NA	**Benefits:** NA	**Net:** NA	NA

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Evidence Base

Problem under consideration and rationale for intervention

1. Healthcare services are currently arranged under the Public Contracts Regulations (PCR) 2015 and the Procurement, Patient Choice and Competition Regulations (PPCCR) 2013. NHS England's 2021 engagement exercise[1] found that these competition and procurement rules are not well suited to the way healthcare is arranged, with 79% of respondents agreeing or strongly agreeing with NHSE proposals which involved revoking these regulations[2].

2. Having taken forward the recommendations from this engagement and NHS England's subsequent consultation in 2021, the Department has legislated on the basis that the current regulations governing the procurement of healthcare services are found to unnecessarily and disproportionately require competitive tendering when arranging healthcare services. Stakeholders reported that the current regulations created an expectation to go to tender when commissioning healthcare services even when there is relatively little value in doing so when considered against a variety of factors, such as interdependencies between services, a single most suitable provider being easily identifiable, the role of patient choice, value for money, quality of services and patient outcomes.

3. Between 2014/15 and 2019/20, DHSC gross procurement totalled approximately £380bn[3]; however, this includes healthcare and non-healthcare contracts. Following implementation, the procurement of healthcare services will follow PSR guidance. The best available data to understand the procurement activity of healthcare services is published contract data by the European Commission, recorded on Tender Electronic Daily (TED). The core analysis and estimate of the Net Present Value in this impact assessment uses TED data from 2014/15 to 2019/20. We have explored the 20/21 TED data and opted to exclude it from the core analysis due to the substantial variation in that year's data as a result of the Covid-19 pandemic. We have instead used the 20/21 data as a sensitivity scenario to help understand what would happen to the estimated benefits if this data was applied. This is discussed in detail in **annex 1.** 21/22 data has been excluded as it was incomplete due to the end of UK data reporting to TED following the exit of the European Union.

4. According to TED data on healthcare procured in England between 2014/15 and 2019/20 totalled £75bn in value. Whilst this is the best available data source, only contracts above specific cost thresholds need to be advertised as per EU Directives. Therefore, only a fraction of all healthcare contracts are included in this sample. Given the large uncertainty around the exact volume of funding that would be captured under the PSR (estimated to be between £75bn-£380bn for the period between 2014/15 and 2019/20), we have produced a sensitivity analysis, considered within the risks and assumption section (**paragraphs 212 - 217**).

5. Common Procurement Vocabulary (CPV) classifications and codes offer a standardised vocabulary of procurement services, allowing procurement contracts to be classified consistently. CPV codes are 8-digits in length, with healthcare codes starting with '851'. A review of procurement contracts recorded on TED between 2014/15 and 2019/20

[1] NHS England, The NHS's recommendations to Government and Parliament for an NHS Bill, Annex 1: Implementing the NHS Long Term Plan: Public Engagement on Proposals for Possible Changes to Legislation, 2019. [Online]. Available from: PowerPoint Presentation (england.nhs.uk)

[2] B0706-NHS-Provider-Selection-regime-response-to-consultation.pdf (england.nhs.uk)

[3] HMT Public Expenditure Statistical Analyses (PESA) - GOV.UK (www.gov.uk)

discovered 3,263 contracts with at least one CPV code beginning with '851', totalling 5,810[4] healthcare codes. Preliminary analysis found that 43.4% of codes were classified as either "Health Services", or "Miscellaneous Health Services". Excluding these two CPV codes, which fail to provide much information on the object of contracts, 11 classifications across a revised sample of 3,288 codes, are responsible for 55.7% of total codes, as detailed below:

Table 1: Most common CPV classifications across Tender Electronic Daily (TED) tender sample*

CPV classification	% of total CPVs in revised sample (4,546 codes)
Medical practice and related services	7.4%
Dental practice and related services	7.2%
Pharmacy services	5.4%
Pathology services	5.1%
Surgical hospital services	5.0%
Medical hospital services	5.0%
Oxygen-therapy services	4.5%
Paramedical services	4.5%
Hospital and related services	4.0%
Medical imaging services	4.0%
Residential nursing care services	3.5%
Total	**55.7%**

6. Analysing the responses of DHSC's 2022 consultation[5], which takes in the views of partners across the health and care system including providers, DHSC has also identified that NHS commissioners find that the current procurement rules sometimes disrupt or prevent opportunities for increased collaboration, greater integration, and open problem-solving. A common response to the 2019 NHS engagement exercise was that current competition and procurement rules necessitating frequent tendering of contracts to arrange healthcare services can create barriers to integrating care and disrupt the development of stable collaborations.[6] The current rules also reduce certainty for providers, even in situations where there is only one feasible provider, which has an impact on opportunities for long-term investment, the establishment of effective partnerships which deliver a system-wide approach to healthcare including better integrated services, and staff retention.

7. Similarly, engagement with local authority commissioners has identified that the necessity to regularly retender public health services is not practical as there is often an identifiable single most suitable provider to deliver the required services.

[4] A single contract can include several CPV codes because the contract may include many services, that is why, the number of CPV codes (5,810) in our sample is larger than the number of contracts (3,263)

[5] Provider Selection Regime: supplementary consultation on the detail of proposals for regulations - GOV.UK (www.gov.uk)

[6] NHS Provider Selection Regime: Consultation on proposals, 2021. Available from: B0135-provider-selection-regime-consultation.pdf (england.nhs.uk)

8. Groups representing healthcare provider interests such as NHS Provider, the Independent Health Provider Network, and Social Enterprise UK have welcomed the aims of the PSR; that competitive procurement should be used only where it helps promote the interests of patients, the taxpayer, and the population; and support the desire to make it easier to integrate services and enhance collaboration to improve health and care outcomes. However, provider representatives have also reiterated the need for transparency and a potential route for the independent review of decisions made under the new regime and the Department and NHS England have incorporated these features into the PSR.

9. The Government is best placed to address these barriers to integration and collaboration by using regulations to change the rules for the procurement of healthcare services in England to provide greater flexibility.

10. DHSC has consulted on the proposed changes[7] and expects that the successful implementation of the PSR will free up resources from the NHS spent on running resource intensive open and non-open tendering processes that would be diverted to designing and planning more integrated healthcare services (as enabled by the flexibility offered to commissioners by the PSR) and other supporting activity such as spending on monitoring contract performance. This supports NHS bodies and local authorities in their statutory duties to deliver good quality healthcare whilst managing costs, and driving and delivering better outcomes for patients and its population.

11. DHSC has found that competition under the current regulations can generate unnecessary bureaucracy for relevant authorities and providers, with wasteful legal and administrative costs in some scenarios. In the 2021 NHS engagement on proposals for a new procurement regime, a large number of responders appreciated the benefit of the proposed regime as it would reduce unnecessary costs and bureaucracy associated with running competitive tendering exercises when arranging healthcare services.[8]

12. There is a significant body of evidence exploring the role of competition in health; the results of which are mixed, implying that competition is not relevant in all scenarios relating to health care. The literature seems to suggest that competition works better in some areas of health care than others and this suggests that competition should not be used as a default in every scenario.

13. There is some evidence that competition in health care markets can lead to better health care outcomes, for example:

    a) Following a year-long study, Civitas (2010)[9] found many examples of the market having significant positive impacts on quality, efficiency, innovation, and patient-focus.
    b) The Audit Commission (2008)[10] details case studies of competition in the healthcare market highlighting a scenario in which the competitive process achieved its object of a better provision of care for patients at a lower cost.

[7] Provider Selection Regime: supplementary consultation on the detail of proposals for regulations - GOV.UK (www.gov.uk)

[8] NHS provider selection regime: response to consultation, July 2021. Available from: B0706-NHS-Provider-Selection-regime-response-to-consultation.pdf (england.nhs.uk)

[9] Refusing treatment: the NHS and market-based reform by Civitas, October 2010

[10] Is the treatment working? Progress with the NHS system reform programme, Health National report June 2008, Audit Commission

c) After the introduction of competition, quality improved, as measured by AMI[11] or all-cause mortality rates, for patients who lived in more competitive markets (LSE 2010[12]; Gaynor et al. 2013[13]; Cooper et al. 2011[14]; Bloom et al. 2011[15]). The introduction of competition can be an important mechanism for enhancing the quality of care of patients without increases in expenditure per patient. This shows that hospital competition in markets with fixed prices can lead to improvements in at least some measures of clinical quality.

14. However, there is also research which shows that competition can have either no impact or an adverse effect in some health care markets. For example:

a) Feng et al. (2015)[16] found no statistically significant association between hospital market concentration and patient reported outcomes following hip or knee replacement surgery and Moscelli et al. (2021)[17] found that competition led to an increase in possible emergency readmissions following hip and knee replacements, so competition had no positive effect on this measure of quality.
b) It is difficult and costly to monitor all aspects of health care performance so competition involving negotiated prices may reduce quality, as providers could skimp on unobserved aspects in order to lower their costs (Allen, 2013)[18].
c) In response to competitive pressures on costs, hospitals cut services that affected AMI mortality rates, which were unobserved, in order to increase other activities which consumers (patients) could better observe; hospitals facing competition had significantly shorter average waiting times for elective treatments (Propper, Burgess, & Gossage, 2008[19]; Bevan & Skellern, 2011[20]).
d) Civitas (2010)[21] found that collaboration sometimes suffered as a result of competition and high-quality care was undermined by organisational self-interest when a health care market was created. Contracting in the NHS is associated with high transaction costs (Marini & Street, 2007[22]), and has been seen to foster adversarial relationships (Deakin & Walsh, 1996[23]).
e) Competition is not appropriate for implementing large, long-term service transformation programmes and it can be seen as a confrontational method of commissioning which can damage relationships between commissioners and providers (Allen et al. 2016[24]).

[11] Acute Myocardial Infarction (heart attack)

[12] Cooper, Gibbons, Jones and McGuire. Does Hospital Competition Save Lives? Evidence from the NHS Patient Choice Reforms. Working Paper 16/2010. LSE Health. January 2010

[13] Death by Market Power: Reform, Competition, and Patient Outcomes in the National Health Service by Martin Gaynor, Rodrigo Moreno-Serra, and Carol Propper, American Economic Journal: Economic Policy 2013

[14] Does Hospital Competition Save Lives? Evidence from The English NHS Patient Choice Reforms, Zack Cooper, Stephen Gibbons, Simon Jones and Alistair McGuire, The Economic Journal, 121. August 2011

[15] Bloom N, Propper C, Seiler S, Van Reenen J. The impact of competition on management quality: evidence from public hospitals, 2011.

[16] Association between market concentration of hospitals and patient health gain following hip replacement surgery by Yan Feng, Michele Pistollato, Anita Charlesworth, Nancy Devlin, Carol Propper, and Jon Sussex, Journal of Health Services Research & Policy 2015

[17] Hospital competition and quality for non-emergency patients in the English NHS by Giuseppe Moscelli, Hugh Gravelle, Luigi Siciliani, The RAND Journal of Economics: Vol 52. May 2021

[18] Allen, P. (2013) 'An economic analysis of the limits of market based reforms in the English NHS' BMC Health Services Research 13

[19] Propper, S Burgess, D Gossage (2008) "Competition and quality: evidence from the NHS internal market 1991-1996" Economic Journal

[20] Does competition between two hospitals improve clinical quality? A review of evidence from two ears of competition in the English NHS by Bevan and Skellern, BMJ Clinical Research, 2011

[21] Refusing treatment: the NHS and market-based reform by Civitas, October 2010

[22] Marini, G., & Street, A. (2007). A transaction costs analysis of changing contractual relations in the English NHS. Health Policy, 83(1),

[23] Deakin, N., & Walsh, K. (1996). The Enabling State: the role of markets and contracts. Public Administration, 74

[24] Allen et al. Commissioning through Competition and Cooperation Final Report, Policy Research Unit in Commissioning and the Healthcare System, June 2016

15. Additionally, some studies identify other risks when introducing competition in health care commissioning. For example:

    a) Transaction costs can be significant and therefore can limit the extent to which competition can increase efficiency (Williamson, 1985[25]). Health care has a number of features that increase transaction costs between purchasers and providers, including the difficulties of specifying the quality of services and monitoring whether quality standards have been met (Mays, Jones & Dixon, 2011[26]), both of which may therefore limit the efficiency benefits of competition in health care markets. In our engagement with stakeholders, the issue of how costly it is to run these competitive processes was widely reported.

    b) Allen et al. (2016[27]) found that a large call on resources was needed to carry out a procurement process, with NHS commissioners describing the process as cumbersome, time consuming and complex[28]. Competition was still seen as an important tool for commissioning if it was not enforced top-down, and instead commissioners were able to determine when they believed that competition added value to the procurement process.

    c) Competition in health care markets is geographically based; some areas face greater competition than others due to the number of service users, therefore, procurement processes which involve competition are more appropriate for certain contracts in certain areas than others (Propper et al. 2008[29]; Petsoulas et al. 2011[30]).

    d) There are few studies which analyse the long-term effects of competition in the NHS so it is difficult to draw conclusions about what the long-term impacts of the new regulations will be. This is because the development of commissioning in the NHS has been characterised by regular, structural change (Mays, Jones & Dixon, 2011[31]).

    e) The right to legal challenge that competitors hold under the PCR provides opportunity for providers to use the legal challenge process to delay contract awards and to disrupt justifiable and sound arrangements. Fear of legal challenge was cited as a reason behind why NHS commissioners wouldn't use more cooperative commissioning methods in the Policy Research Unit in Health & Social Care Systems and Commissioning's (PRUComm) 2017 report[32], even if they believed that this would be the best method of strategic planning and commissioning.

16. Based on the mixed findings from the literature, we cannot conclude that competition, will always necessarily lead to better outcomes in health care services as it may do in other sectors or industries due to high monitoring and transaction costs and the need for collaboration between providers and commissioners when arranging health care services. Competition may be able to stimulate and challenge existing providers out of complacency and can be useful to force providers to improve services. However, it's

[25] Williamson, O.E. (1975). Markets and Hierarchies: Analysis and Antitrust Implications. New York: Free Press

[26] Mays N., Jones L. and Dixon A. (eds) (2011) 'Understanding New Labour's market reforms of the English NHS' King's Fund

[27] Allen et al. Commissioning through Competition and Cooperation Final Report, Policy Research Unit in Commissioning and the Healthcare System, June 2016

[28] Allen et al. Commissioning through Competition and Cooperation Final Report, Policy Research Unit in Commissioning and the Healthcare System, June 2016

[29] Propper, S Burgess, D Gossage (2008) "Competition and quality: evidence from the NHS internal market 1991-1996" Economic Journal

[30] The use of standard contracts in the English National Health Service: a case study analysis. Christina Petsoulas, Pauline Allen, David Hughes, Peter Vincent-Jones, Jennifer Roberts, May 2011 Social Science Medicine 73(2)

[31] Mays N., Jones L. and Dixon A. (eds) (2011) 'Understanding New Labour's market reforms of the English NHS' King's Fund

[32] Allen et al., Next Steps in Commissioning through Competition and Cooperation (2016-2017), Dec 2017. Available from: Mar 2018: Next steps in commissioning through competition and cooperation (2016-2017) - Policy Research Unit in Commissioning and the Healthcare System (prucomm.ac.uk)

clear that, while competition can lead to improved outcomes in some commissioning scenarios, it can be equally damaging in others.

Rationale and evidence to justify the level of analysis used in the IA (proportionality approach)

17. This IA captures the impacts of secondary legislation introducing the details of the Provider Selection Regime (PSR). The IA for the primary legislation introducing the powers for the implementation of the PSR can be found in the Health and Care Act 2022 core measures Impact Assessment. The previous IA did not attempt to quantify the impacts of this intervention as the details had not been developed yet.

18. While we cannot estimate for certain the amount of public funds that would be subject to the PSR, it will certainly be substantial. According to PESA[1], the gross current procurement in DHSC budget in 2019/20 was £66.7b (due to the impact of the Covid-19 pandemic on procurement we have excluded 20/21 data from this analysis). None of the metrics available capture accurately the scope of the PSR but we know that the room for impacts is large.

19. We have therefore taken the following approaches to estimate the costs and benefits in this IA:

    a. Quantitative analysis: Analysis of NHS procurement is very complex due to poor availability and consistency of data on tendering and other commissioning mechanisms[2]. There are two main data sources we have explored: Contract Finder (CF) and Tenders Electronic Daily (TED). Both tools allow public access to contracting activity by public bodies. More detail on our process to obtain a dataset for this IA can be read in **Annex 3**.

    b. Literature review: While quantitative analysis on NHS commissioning is limited, we have explored a wide range of different sources to help with our modelling of crucial assumptions. Details of key sources can be found in **Annexes 3, 4 and 5**.

    c. Stakeholder engagement: This IA takes into account the responses from the supplementary consultation on the detail of proposals for regulations and the call for evidence that DHSC launched on 21st February 2022. These responses have helped us to develop credible assumptions in the absence of data or reliable evidence. Key summary findings from this consultation can be found in **Annex 2**. We have also engaged with NHS England as part of the process to develop appropriate assumptions and cost estimates.

    d. Scenario modelling and sensitivity analysis: Despite our best efforts to build a robust evidence base, there are still significant uncertainties around data gaps and behavioural responses from both commissioners and providers to the new regulations. We have therefore, prepared a number of different scenario and sensitivity analyses to capture these uncertainties. **Annex 6** captures a summary of these.

20. The key drawback of our data is the lack of specific and robust data relating to health care procurement in the UK. We think that the range of evidence we have used is suitable as it draws from a wide range of literature; where possible, we have obtained data from NHS organisations to use as the basis of our assumptions, and where this has not been possible, we have taken data from studies with robust methodology, that match the range provided across the literature and have large sample sizes if available.

[1] Public Expenditure Statistical Analyses 2021 (publishing.service.gov.uk)

[2] Allen et al., Commissioning through Competition and Cooperation, PRU Comms, June 2016

Policy objective

21. The three main objectives of this government intervention are to:

    i. Increase collaboration and open-problem solving between commissioners and providers in order to improve health care services for patients and the population whilst managing costs, for example by better integrating services and delivering more effective and better joined-up pathways.

    ii. Improve certainty for providers in order to encourage long-term investment in services, better staff retention and long-term expertise. Providers may then be enabled to collaborate and form partnerships with other providers to facilitate integration of services.

    iii. Provide better value for money for commissioners and providers by ensuring a more efficient use of government resources through reducing wasteful administrative costs. Commissioners should focus their time on improving service provision and tailoring it to local health needs rather than using resources on unnecessary tendering processes.

22. The policy aims to meet these three objectives, while not negatively impacting on price, quality, or supply of service provision. This can be measured through the reduction of resources used by commissioners on procurement processes; the price of contracts remaining constant; and the quality of contracts and patient experience improving due to the integration of services.

23. The indicators of success will be tied to the actions of commissioning functions of NHS England, Integrated Care Systems (Integrated Care Boards) and system partners (such as Local Authorities and NHS Trusts and Foundation Trusts) and the outcomes that they deliver for patients, the taxpayer, and the population by utilising the flexibility provided by the PSR. DHSC intends to undertake a research programme to understand the different ways that Integrated Care Systems and system partners come together to design, commission, and deliver services, and their potential impacts and outcomes – including assessment of the role of the PSR. More information on how we plan to understand whether these objectives have been achieved can be found in the Monitoring and Evaluation section (**paragraphs 256 - 260**).

Description of options considered

Option 0: Business as usual

24. If no new regulations are made, then relevant authorities will have to continue to follow current regulations when arranging healthcare services. As NHS commissioners have reported that current rules create barriers to integration and collaboration, this would not align with the wider changes that are being brought in under the Health and Care Act 2022. Competitive tendering is still a tool under the PSR which commissioners may use when wishing to test the market for a supplier who can deliver better outcomes. Continuing to arrange services under the current regulations may enforce greater use of competitive tendering which could increase the opportunity for identifying new suppliers that could deliver better outcomes. However, it would also continue to present the same barriers to collaboration and integration of services identified by stakeholders as well as create a continued sense of uncertainty for providers, leading to an inefficient use of resources in some scenarios.

Option 1: Provider Selection Regime (preferred option)

25. We intend to make regulations introducing a new procurement regime – Provider Selection Regime (PSR), for relevant authorities to use when selecting providers to deliver healthcare services for the purpose of the healthcare service in England. Relevant authorities are defined in section 79 of the Health and Care Act 2022 as: an ICB; a local authority in England, a combined authority, NHS England, an NHS Trust, or an NHS Foundation Trust. The intention is to provide a flexible framework that aligns with the integrated and collaborative approach to commissioning that is intended for new Integrated Care Systems. The PSR would provide relevant authorities with a flexible, transparent, and proportionate process for decision-making when arranging healthcare services.

26. The PSR would not be used to arrange social care services. However, in circumstances where health care and social care services are arranged together under a single contract, they may be arranged under the PSR. This would only apply in circumstances where the main subject matter of the contract remains the delivery of health care service to individuals, and, in the view of the relevant authority, procuring the relevant health care services and the other goods and services separately would, or would be likely to, have a material adverse impact on the relevant authority's ability to act in accordance with the procurement principles.

Option 2: PSR only applies to NHS commissioners

27. The new procurement regime would be introduced for NHS organisations to use when selecting providers to deliver healthcare services for the purpose of the healthcare service in England. Initially, engagement for the changes that the PSR entails was led by NHS England and therefore was only considered for the arrangement of services by statutory NHS bodies.

28. Since 2015, the responsibility to commission health services (including the Healthy Child Programme, substance misuse services and sexual and reproductive health services) has been undertaken by local authorities in England. This option would exclude local government commissioners, and therefore essential health services, from the scope of the PSR.

29. However, stakeholder engagement with commissioners and representatives from local government has demonstrated that local government commissioners face the same challenges as NHS commissioners when using the PCR to arrange health services, such as barriers to integration and instability of services.

30. The definition of health care services in the NHS Act 2006 includes health care services arranged by local authorities, therefore, when introducing procurement regulations for health care services, local authorities should be included in the scope.

Option 3: Services arranged between NHS commissioners and NHS providers are exempt from the PCR.

31. Under this option, government would look to exempt services arranged between NHS commissioners and NHS provides from the scope of the PCR. This would mean that health care services may be arranged 'in-house' in the NHS without reference to a procurement regime. NHS commissioners may still arrange services with the independent sector, but would have to follow the rules set out in the PCR. As such, services provided by VCSEs and small businesses would have to be arranged under current procurement and competition rules through the PCR. This would give commissioners greater discretion when commissioning services with NHS providers than with other providers.

32. In effect, NHS commissioners would be able to directly award contracts to NHS providers outside of the PCR. For services where private providers are being considered in the procurement process, commissioners would likely go through a competitive tendering process.

33. However, it was determined that the same rules need to apply to all providers, as the main issues and barriers to integration that arise from the current rules on competition under the PCR apply irrespective of the type of provider. Maintaining a requirement on competitive tendering for certain sectors and not statutory NHS bodies would likely heavily incentivise the statutory NHS bodies, and have a detrimental impact on certain sectors where competitive tendering is required, including SMEs and the VCSE sector.

34. Additionally, this proposal could not be extended to local authorities, who would have to continue to use the PCR to arrange health care services. This would not resolve the issues reportedly faced by local authorities as referenced above.

Non-regulatory options

35. In this option, we would not introduce any new legislation on the procurement of healthcare services. This would mean that decision-making bodies continue to procure healthcare services under the PCR. As with the 'Business as usual' option, this would mean that the concerns of commissioners and providers, that the current rules prevent the establishment of stable collaborations, integration of services, and the delivery of more joined-up care, would not be addressed.

36. Guidance without legislation would not be sufficient to achieve the aims of the PSR. For example, NHS England would only be able to issue guidance which is in keeping with current rules set out in the PCR and this would not achieve the aims set to be established by the PSR to give decision-making bodies more flexibility of how to arrange services including when it adds value to run a competitive exercise.

37. We have disregarded non-regulatory options. This is because regulations are required to remove the application of the PCR from the arrangement of health care services and to establish separate bespoke regulations specifically for the arrangement of health care services.

38. A summary of the scope of the different regulatory options presented in this section is included in **table 2** below. The table captures when commissioners will be allowed to use the PSR to commission healthcare services and what type of providers will be eligible under each option. It can be noted that the different options that have been analysed considered which organisations should be in scope of and eligible for the PSR, acknowledging that it is a more advantageous procurement procedure, allowing for more flexibility for commissioners and enhancing collaboration and integration.

Table 2: Summary of different regulatory options considered in this impact assessment

	Type	Option 0	Option 1	Option 2	Option 3
Commissioners	NHS	PCR	PSR	PSR	Direct Award
	LAs	PCR	PSR	PCR	PCR
	Other	PCR	PCR	PCR	PCR
Providers	NHS	PCR	Eligible	Eligible	Eligible
	Independent	PCR	Eligible	Eligible	Not eligible

Summary and preferred option with description of implementation plan

39. The Health and Care Act 2022 provides powers to revoke the Procurement, Patient Choice and Competition Regulations (PPCCR) 2013, and for the Secretary of State to make new regulations on procurement. We intend to use these powers to introduce the Provider Selection Regime (PSR) through regulations (Option 1), which will set out new arrangements for relevant authorities to follow when arranging healthcare services in a way that facilitates the integration and collaboration intended to be delivered by provisions set out in the Health and Care Act 2022. These Regulations will also make consequential amendments to the Public Contracts Regulations (PCR) 2015 to remove healthcare services from the scope of the PCR.

40. The PSR would be used to arrange healthcare services, provided that the services are for the purpose of the health system in England, and the services are provided directly to individuals to secure improvement in the physical and mental health of the people of England and in the prevention, diagnosis and treatment of physical and mental illness. The service must also be arranged by a relevant authority, which is defined as: a combined authority; an Integrated Care Board; a local authority in England; NHS England; an NHS Trust; or an NHS Foundation Trust. In circumstances where a service is subcontracted, then the subcontracting body would be able use the PSR to arrange the service only if they are listed as a relevant authority.

41. There are five routes to make a contract award in the PSR. These are:

    1. **Continuation of existing arrangements:** in circumstances where there is limited or no reason to seek to change provider, relevant authorities may re-award

contracts to, or extend contracts with, the incumbent provider(s). There are three instances where this is permitted:

a) **Direct Award Process A –** The type of service means there is no realistic alternative to the current provider/group of providers

b) **Direct Award Process B –** People have a choice of providers and the number of providers is not being limited by the decision-making body.

c) **Direct Award Process C –** The incumbent provider/group of providers is judged by the decision-making body to be doing a sufficiently good job and can continue to do so, and the service is not changing considerably.

For the latter of these circumstances, the decision-maker must be transparent in its decision-making including publishing its decision and taking representations from providers during a standstill period before the contract is awarded.

2. **The Most Suitable Provider Process (MSPP) – for identifying the most suitable provider for new or considerably changed arrangements:** for circumstances where existing arrangements need to change considerably; or where the incumbent is no longer able/wants to provide the service; or where the decision-making body wants to use a different provider. And the decision-making body considers it can identify a most suitable provider without running a competitive procurement process. The decision-maker must be transparent in its decision-making including publishing its decision and taking representations from providers during a standstill period before the contract is awarded.

3. **Competitive Process –** 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 to test the market using a competitive process.

42. In Direct Award Process C, MSPP and the Competitive Process, relevant authorities must justify decisions against the following Key Criteria: quality and innovation; value; integration and collaboration; access, inequalities and choice; and service sustainability and social value.

43. More detail about the award processes can be found in **Annex 7.**

Monetised and non-monetised costs and benefits of each option (including administrative burden)

44. Before discussing the options in detail, this section presents the methodology used to estimate each of the impacts in isolation. When looking into the different options, figures will change due to the different scopes covered by each of the options, but the methodology will remain broadly the same. **It is important to note that year 1 impacts are part year impacts due to expected implementation in December 2023**. Year 1 recurrent costs have been scaled down to reflect this, transition costs are assumed to occur in year 1. To help readers follow this and understand the different scenarios produced, **table 3** includes a summary of each of the impacts.

Table 3: Summary of impacts analysed in this IA

Impacts	Familiarisation	Litigation	Procurement changes	Transparency	Independent Panel
Key decisions modelled	Number of staff and time spent familiarising with the new regulations	Number of informal challenges faced by commissioners after PSR implemented.	Number of contracts that would be awarded using different types of procurement procedures due to the change in rules.	Number of staff and time spent complying with the new transparency rules imposed by the PSR	Estimated based on cost of other previous review panels in healthcare, in consultation with NHS England.
Main assumptions	Only current staff require re-training Training PSR for new staff will involve no additional costs	No change in progress from informal to formal challenges from counterfactual. 14% of informal challenges progress to Court. Average legal fees £50,000 of formal challenges. Unsuccessful part pays 65% of legal to the winner. If provider is successful, commissioners will have to pay on top of that, 0.8% the value of the contract.	Number of contracts increase with growth in gross DHSC budget for procurement. Procurement costs account for approximately 1.4% of overall contract value Commissioner costs account for the other 25% of the overall procurement cost (0.3% of contract value). The cost to individual providers is 70% of the cost faced by commissioners.	Current processes are similar, so no re-training of commissioning staff is required. Commissioners keep a procurement decisions log throughout the year, so information required is readily available.	For the high estimate - The previous Co-operation & Competition Panel (CCP) as part of Monitor is partly analogous to the proposed PSR independent review panel. For the low estimate we adjust the cost of the CCP panel-based estimate to one third based on the fact that procurement decisions was one of three responsibilities of this panel.
Uncertainties / sensitivities	Using arithmetic average on wages due to unknown distribution and low risk	Unreliable data on ICS litigation activity and missing data from LAs. Unclear behaviour from providers about their litigation activity post-PSR. Scenario 1: Litigation activity remains constant Scenario 2: Litigation activity reduced by 25% Scenario 3: Litigation activity increased by 25% Assumption 1: No change in success rate for providers. Assumption 1b: Decrease in success rate for providers. Immediate adoption of changes Linear adoption of changes Gradual adoption of changes	Unclear behaviour from commissioners about their procurement decision post-PSR. Low savings scenario: 50% of open and non-open procedures with only 1 bid would now be issued via direct award. Medium savings scenario: 100% of open and non-open procedures with only 1 bid would now be issued via direct award. High savings scenario: The number of open and non-open procedures will be reduced by 25% and instead issued via direct award. Immediate adoption of changes Linear adoption of changes Gradual adoption of changes Additional sensitivity in **annex 1** using insights from 2020/21 data to understand impact on analysis of Covid-19 pandemic.	Using midpoints of estimates of time required per notice to calculate average resources across procurement types. Using arithmetic average for higher band wages. Modelled same low, medium and high savings scenarios as for procurement changes, with a linear adoption of changes.	We do not have data on the number of reviews that this panel will see and therefore estimates are uncertain. LOW SCENARIO In absence of detail, assumes that one third of CCP activity was linked to independent review of procurement decisions in high scenario. The CENTRAL SCENARIO is the mid-point of costs between the higher cost of the CCP and the lower adjusted cost. The HIGH SCENARIO may be an overestimate given it is based on a panel that had a wider responsibilities.

Monetised costs

Familiarisation costs

45. We anticipate that all three options will generate familiarisation costs to commissioners of health care services in the first year following implementation. Failing to comply with the new guidance, could risk commissioners being challenged on their procurement decisions. Providers will also be required to familiarise themselves with the PSR regulations before partaking in procurement processes, although their familiarisation costs will likely be lower than the costs faced by commissioners. Respondents to DHSC's consultation indicated that commissioners and providers could face short-term costs from training staff on the details of the PSR, as well as updating existing materials and procedures to align with the new regime.

46. We understand that this system is no more complex than the current one so commissioners and providers will only face retraining costs for current staff; there will be no additional costs of training new staff in the future, even if they operate under two procurement systems. Different options considered in this IA will have different familiarisation impacts associated as they cover different providers and/or commissioners.

47. As part of the transitional arrangements, NHS England are involved in preparing materials to explain the PSR to NHS organisations and local authorities, including summary documents of the PSR and workshops to ensure understanding. For this implementation work NHS England have told us that they have a £150k budget which they expect to spend in the first year of implementation. NHSE are also responsible for the training and implementation costs of the new independent review process; they have indicated that they expect to spend £100k on this process.

48. We have estimated the transition cost for commissioners based on the following assumptions and data:

    a. 50 people in each commissioning body will need to be aware of the new Provider Selection Regime based on responses to the DHSC consultation.

    b. One full day (7.5 hours) per commissioning staff member in NHS and local authorities to attend the required training and reading relevant materials.

    c. Gross hourly wage for NHS commissioners in 2023/24 of £29.257[1] and £28.74[2] for commissioners in Local Authorities.

    d. CCGs (106), Las (164), NHS Trusts (213) & Regional NHS England branches (7).

49. We have estimated the transition cost for providers based on the following assumptions and data:

    a. 40 people in each provider organisation will need to be aware of the new Provider Selection Regime based on responses to the DHSC consultation.

    b. 2 hours to familiarise procurement staff with the new regulations.

[1] Information from NHSJobs indicates that NHS procurement staff fall within band 5 and band 8a (23/24 values). We have used the midpoint of these pay grades, uplifted by 34.5% to account for employer non-wage labour costs, such as NI contributions, in line with RPC guidance.

[2] We have calculated the local authority wage in the same way and inflated to 2023/24 values, based on the median hourly wage for the regulations of activities providing health care from the 2022 Annual Survey of Hours and Earnings (ASHE)[2]. The local authority adjusted commissioner wage is £28.74.

c. Gross hourly wage for key procurement staff in provider organisations in 2022/23 of £23.67[3].

d. 4,647 businesses[4] that would need to familiarise with the new regulations.

Transparency requirements

50. The regulations detailing the PSR will include additional transparency requirements to the current regime. Depending on the type of award process used, there will be additional notices providing information on the intended approach of the procurement process, the intention to award the contract, and a confirmation of the award notice that commissioners are required to publish.

51. We have assumed that it will be the same staff members as currently that are completing the notices, knowledge of the process of completing and publishing the notices is the same, and, whilst the information required to be published is different under the PSR, the information required is similar to current processes so there will be no additional training required.

52. We have estimated the transparency costs for commissioners based on the following assumptions and data:

a. Gross hourly salary of £34.65[5] [6] for 23/24.

b. The distribution of contracts in our dataset by procurement type.

c. The following times required for each type of procurement procedures based on input from the procurement specialists in an NHS Commissioning Support Unit. These figures are estimates and it is likely that the level of resources required will vary depending on the complexity of the procurement process, the number of providers involved, the number of lots etc.

Table 4: Average time taken in minutes for notices and summaries by procurement type

	PPCCR (current requirements)	PSR
Open	50	50
Non-Open	50	50
Direct Award[7]	20	55

53. Based on these estimates, we have estimated direct award contracts under the PPCCR to cost £11.55 and all other contracts to cost £28.88. Under the PSR, we estimate that

[3] To calculate the wages of key procurement staff in provider organisations, we have used the median wage for those employed in human health activities from the 2022 ASHE including employer on-costs and inflated to 2023/24 values.

[4] We do not have exact data for the number of businesses involved in providing healthcare services specifically, however, we do have information on the total number of bids received for contracts each year between 2014-2020 in our data. 4,647 is the average number of bids received between 2014-20. There are risks of double counting as providers may bid for more than one contract and our data does not capture all contracting activity that occurs relating to health procurement. To account for this uncertainty, we have produced two additional scenarios using the highest and lowest number of bids received for contracts in scope of the PSR per year in our data.

[5] Based on NHSE engagement with a small group of commissioners about what pay band the employees involved in completing the required notices for contracts would be in. Responses varied but there was a consensus that it would be staff at the higher end of the pay bands (between band 6 and 8b) that would be responsible for completing transparency notices. We used the mid-point of these pay grades, converted to current prices, and uplifted for non-labour costs to get an hourly wage of £34.65.

[6] Taken from Pay scales for 2023/24 | NHS Employers

[7] Direct award could be used in multiple decision-making circumstances which involve different notice requirements and therefore different levels of resources. We have taken an average across circumstances based on the reported estimated costs as we have no evidence for the amount that each circumstance will be used under the PSR.

the notices required for direct award will cost £31.76 and all other contracts will cost £28.88. These figures are averages as costs will vary depending on the size and complexity of the contract and what award process is used under the PSR.

54. Currently, under the PPCCR, commissioners are required to publish a record of the contracts awarded in the reporting year. The PSR also contains a similar requirement to compile and collate information on the number of contracts procured under the different circumstances and information about providers into a single document each year. The content of the documents differs under current and proposed regulations, however, Arden and Gem CSU estimated the time taken to complete the yearly notice under both the PPCCR and the PSR as 7.5 working hours, with the assumption that commissioning bodies keep a decision-making log of all the procurement decisions over the year.

Competition impacts

55. The PSR introduces potential risks around fairness, promoting competition and realising the benefits of competition associated with changes to the procurement regime. The following section discusses the existing evidence on competition in healthcare, and outlines mitigating factors against the risks posed from providing commissioners with more flexibility to use direct award processes. The impact is uncertain, and we acknowledge the risk that there could be a larger reduction in any existing competition than intended. However, these risks (if realised) may be counterbalanced by the regime's intended aims to deliver greater collaboration and integration across the health and care services – which are themselves intended to deliver benefits for patients and the taxpayer.

56. A lot of the evidence available on competition in health care evaluates the impacts of local hospital competition and the level of patient choice, rather than directly assessing the impact of competition in the procurement process. Procurement policy is one of the mechanisms for driving competition in the provision of NHS services so this evidence may still be relevant, however findings are mixed, so it is difficult to draw a robust conclusion on the role of competition in health care markets.

57. There are many studies that demonstrate that more competitive markets with fixed prices can deliver better results for consumers.[8] However, there are some valid criticisms of the methodology of these studies[9], including the fact that a lot of studies do not account for the role of new entry and exit of incumbents[10] and many do not provide any causal mechanism by which choice of provider for elective care could have affected outcomes[11]. Some studies conclude that competition in healthcare procurement isn't always beneficial.[12]

58. When prices were fixed, many studies have shown that quality, as measured by mortality rates from AMI, increased. Where there was both price and quality competition in the NHS, studies show that observable quality, measured by indicators such as waiting times, improved and non-observable measures, such as hospital mortality rates, were adversely affected. The literature seems to suggest that competition works better in some areas of health care than others.

[8] See Gaynor et al. 2010, 2011, 2013; Bloom et al. 2015; Cooper et al. 2011

[9] Feng et al., 2015. Available from: Association between market concentration of hospitals and patient health gain following hip replacement surgery (sagepub.com)

[10] The Office of Health Economics Commission on Competition in the NHS (2012). Available from: 366 - Report OHE Commission Competition Jan 2012.pdf

[11] Pollock et al. 2011. Available from: Lancet_2011_Pollock_NoEvidence_Cooper.pdf (allysonpollock.com)

[12] See OHE, 2012; Civitas, 2010; Audit Commission, 2008; Allen et al., 2016; Allen et al., 2017; Goddard, 2015

59. The aim of the PSR is to address the scenarios where competition does not currently appear to deliver any benefits to patients. The central assumption of our model is that procurement contracts which receive multiple bids will continue to be procured in the same way, leaving the level of competition unaffected. Taking this assumption, we have explored the possible effects of competition on price in the healthcare market, using the number of offers contracts received as a proxy for competition. We found that there was not a statistically significant difference in price between contracts with competition (>1 bid) and without competition (1 bid) overall, and that this relationship was only significant in two regions and for contracts containing four certain CPV codes. The results of our analysis are detailed in the wider impacts section (**paragraphs 225-243**).

60. Our central assumption – that under the PSR only contracts where there is a low level of meaningful competition will be directly awarded – is underpinned by the behavioural assumption that commissioners will adhere to PSR guidance as intended. However, it is possible that in some cases commissioners may behave adversely and award contracts directly despite there being multiple appropriate bidders, with this reducing competition. **Paragraph 242** summarises our conclusions on the available evidence around the impact on competition.

61. Moreover, whilst our findings suggest that competition does not significantly affect price in the short term, it is not possible to say if this will hold in the longer term once the PSR is implemented. There is a possibility that over time the PSR will reduce competition, leading to unintended effects on quality, the number of service providers, and contract prices. As the evidence cannot explore the long-term relationship between competition and price due to regular system changes, it is difficult for us to predict these impacts in detail.

62. At the same time, Government and NHS England have designed the regime to include checks and balances that seek to mitigate the risks to fairness across providers of healthcare services and commissioners' ability to deliver high-quality and good value for money services. These are:

    a. Transparency – the PSR contains greater transparency than its predecessor procurement regime. To ensure transparency, a sequence of notices must be published under each of the procurement processes. This ensures that information on how procurements are processed and how decisions are made is publicly available. Relevant authorities also have a duty to record information relevant to their decision and to manage conflicts of interest in decision-making.

    b. Standstill (local resolution) – Where the relevant authority follows Direct Award Process C, the Most Suitable Provider Process or the Competitive Process, it must not enter into the contract or conclude the framework agreement before the end of a standstill period. The standstill period gives an opportunity for a potential provider for the proposed contract, who is aggrieved by the decision and believes that there has been a failure to comply with the PSR to make written representations to the relevant authority. The relevant authority must afford each provider that made representations further opportunity to explain or clarify their representations and provide any requested information which the relevant authority has a duty to record to such provider. Once the relevant authority has considered the representations it must then make a further decision either to award the contract as intended, repeat steps in the procurement process, or abandon the procurement (see below). The PSR states that five working days must elapse before the standstill period can close and the relevant authority can take action on its decision.

c. Standstill (panel review) – a five working day period is left so that, if the aggrieved provider still believes that there was a failure to comply with the PSR, it may request a review of the procurement decision from the panel so that the relevant authority can seek or otherwise receive independent expert advice, if appropriate. The panel may then provide recommendations to the relevant authority and will be published online. The relevant authority may then make a subsequent further decision, replacing its previous decision.

63. In summary, the provisions in the regulations and further explanation in the statutory guidance on transparency, recording of information, management of conflicts of interest and the standstill period work together to encourage that relevant authorities make effective decisions when operating under this procurement regime.

Litigation impacts

64. There may be litigation if providers feel that they were treated unfairly or that there were irregularities in the procurement process. If a provider is unhappy with the process, they are able to make a representation to the decision-making body (contracting authority) who led the procurement process. If providers are unhappy with the outcome of this initial representation and wish to escalate beyond this, they may then escalate the representation to an independently chaired panel. This panel will be equipped to determine whether the representation warrants further review and, if so, review the decision-making of the relevant authority before providing advice and recommendation to the relevant authority. The Department intends that the introduction of this panel will allow more heavily contested decisions made under the PSR to reach resolution without proceeding to the courts.

65. However, if the provider remains unsatisfied with the local or independent panel review processes, then they can make a formal legal challenge against the decision through Judicial Review.

66. Challenges are often raised in relation to allegations of unfairness in evaluating tenders, including providers claiming that decision-making bodies haven't disclosed their evaluation criteria or haven't evaluated tenders properly. Providers are more likely to challenge if they have made a substantial investment in the tender process and are therefore seeking to recover some or all of these costs.[13]

67. If involved, the courts will review the actions of the commissioning body to determine whether the relevant rules from the Public Contracts Regulations (PCR) 2015 and the Procurement, Patient Choice and Competition Regulations (PPCCR) 2013 have been complied with and that the provider has suffered a loss as a result, including the loss of a chance of obtaining the contract.

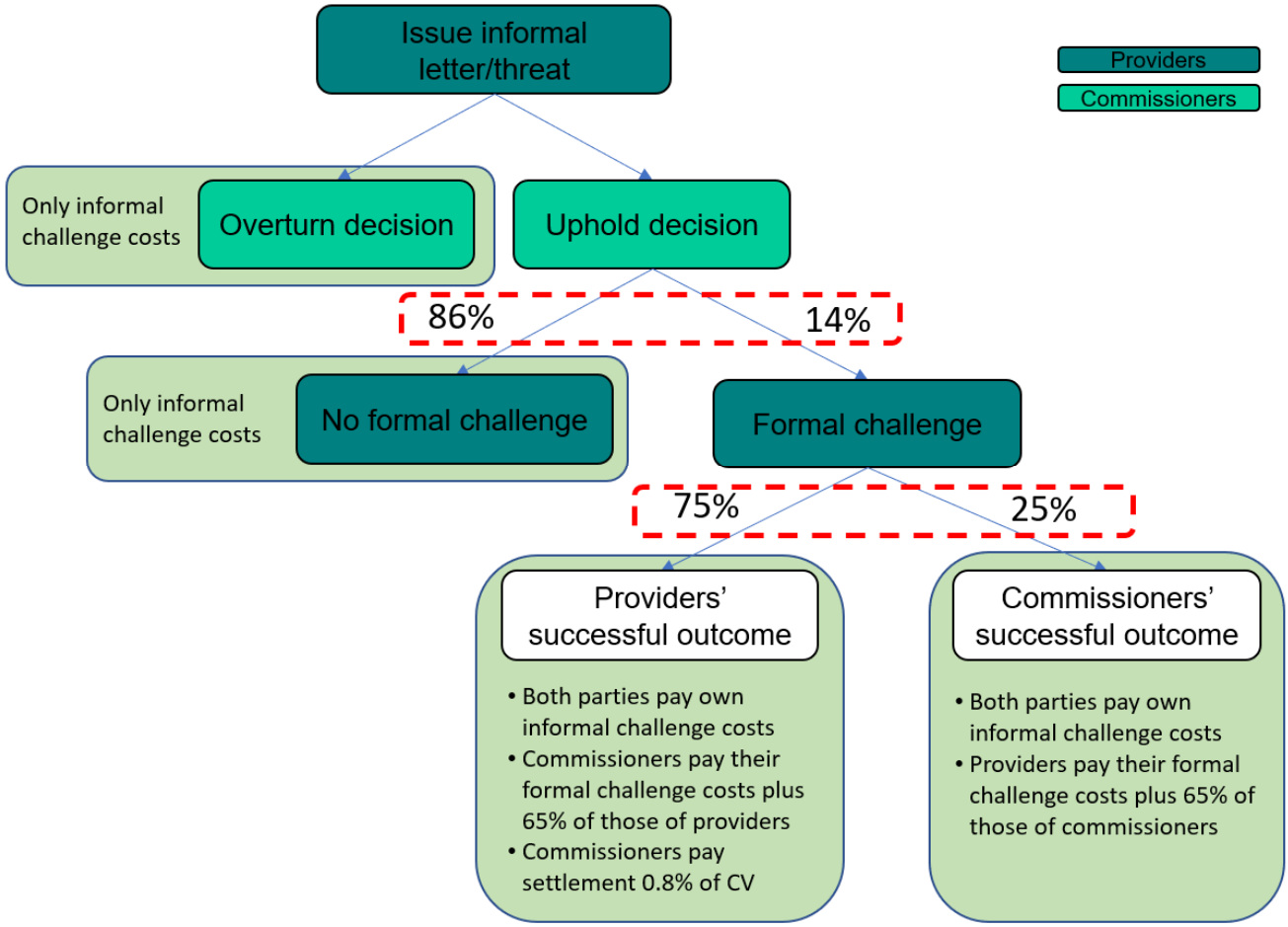
68. It is uncertain how litigation activity will differ once the PSR has been implemented. It is possible that the PSR will lead to a reduction in litigation activity as it may reduce uncertainty for decision-making bodies and providers on when competitive tender is necessary (under the new regulations) and therefore promote better compliance with the regulations.

69. However, it is also possible that providers may challenge decisions more often after the implementation of the PSR due to their exclusion from the process of a contract, that would have previously been awarded via open procurement, is now directly awarded to a provider, meaning a loss of potential revenue to health care providers. If so, providers will have to challenge these decisions on the grounds against the new regulations.

70. **Figure 1** below summarises the litigation process and includes % of cases that end in a formal challenge and the outcome. These percentages are based on the available evidence on litigation the litigation process and inform our assumptions for the cost estimates produced in this section. Note that this does not include the newly introduced independent review process which is described from **paragraph 78**.

[13] Challenges to procurement decisions: The issues and the pitfalls. Sharpe Pritchard, Solicitors and Parliamentary Agents. Briefing – Spring 2014.

Figure 1: Diagram outlining stages of the litigation process (excluding the new independent review option)



a) Initial letters and threats

71. We do not have any data on the level of resources (both time and monetary) required for commissioners or providers to submit and respond to initial letters regarding a procurement process they want to challenge. The time required for the preparation of informal challenges and their corresponding response will vary.

72. We have estimated the cost of a commissioner dealing with an initial representation as £145.27 based on the following assumptions and data:

    a. 5 hours[14] to gather the details regarding their decision-making process and respond to the provider's letter.

    b. Gross hourly wage[15] of commissioners of £29.05.

73. We have estimated the cost of a provider submitting and initial representation as £217.76, based on the following assumptions and data:

[14] We could not find any available data on the length of the informal challenge process; this figure is an estimate based on engagement with NHS stakeholders.
[15] To calculate the cost of a commissioning body dealing with an informal legal challenge we have calculated the weighted average wage from procurement teams in local authorities and NHS organisations (£29.05) as explained in Annex 5.

c. 8 hours[16] in total to i) read all the relevant documents provided by the commissioner to then draft and submit their response (4 hours) and ii) to read through the response they receive from commissioners and the time taken to then decide on their next steps (4 hours).

d. Gross hourly wage of a provider challenging a procurement decision as £27.22[17].

Table 5: Estimation of costs per initial representation

	Commissioners	Providers
Hours required per initial representation	5	8
Gross hourly wage	£29.06	£27.22
Estimated cost per initial representation	£145.27	£217.76

b) Challenges escalated to the court – formal challenges

74. We have estimated the cost for commissioners and providers dealing with a formal legal challenge based on the following assumptions and data:

a. 14% of informal challenges lead to subsequent legal action as reported by the Health Service Journal[18] and other relevant literature[19].

b. £50,000 as a fixed cost of dealing with a legal challenge based on the relevant range of costs from the literature (£10k - £100k) and evidence from CCGs in HSJ[20] (2019).

c. The losing litigant is generally required to pay 65% of the other party's legal costs, in addition to all its own legal costs.

d. 75% of unsuccessful outcomes in Court for the commissioners based on evidence for HSJ[21] and other relevant literature[22].

e. If the commissioning body is unsuccessful, on top of point d above, they will be forced to pay, on average a settlement of 1% of the contract value[23].

75. We have used the median value of contracts in our TED dataset to find the average figure for settlement costs. The median contract value is £1,270,000, so 1% of the median contract value is approximately £13,000.

76. Table 6 shows the estimated cost per legal challenge based on assumptions b. and c. above. The successful party only pays 35% of their legal fees (full cost estimated at £50k), whilst the unsuccessful party pays 100% of their own legal fees (£50k) plus 65% of the successful parties legal fees. The commissioning body cost if unsuccessful is higher due to assumption e. above.

[16] We could not find any available data on the length of the informal challenge process; this figure is an estimate based on engagement with NHS stakeholders.

[17] Given we do not know the distribution of provider type of potential bidders, we have calculated the cost of providers by multiplying the average wage across the NHS, LAs and businesses as estimated in Annex 5.

[18] The CCGs with the most procurement challenges revealed | Expert Briefing | Health Service Journal (hsj.co.uk)

[19] Craven, R. and Arrowsmith, S. (2016) Public procurement and access to justice: a legal and empirical study of the UK system. Public Procurement Law Review, 6.

[20] The CCGs with the most procurement challenges revealed | Expert Briefing | Health Service Journal (hsj.co.uk)

[21] The CCGs with the most procurement challenges revealed | Expert Briefing | Health Service Journal (hsj.co.uk)

[22] The Law Reviews - The Government Procurement Review

[23] This is a rounded estimate based on data from the HSJ: The CCGs with the most procurement challenges revealed | Expert Briefing | Health Service Journal (hsj.co.uk)

Table 6: Estimation of costs per formal legal challenge

	Providers	Commissioners
Successful	£17,500	£17,500
Unsuccessful	£82,500	£95,500

c) Volume of litigation activity

77. Data on the number of challenges and procedures brought forward against commissioners for their procurement practices is limited to CCGs and not very reliable. We assume that merging CCGs into ICSs will not impact the level of appealing activity. One could argue that more challenges may occur due to merging contracting activity at a higher level as ICSs will be dealing with more contracts than an individual CCG does currently however, the number of contracts will not be changing following this merge.

78. We have estimated the number of legal challenges providers and commissioners face based on the following assumptions and data:

a) The Health Service Journal reports that between 2013-14 and 2017-18 CCGs faced 57 procurement challenges in total; this is based on a 70% response rate of all UK CCGs and may underreport the number of initial representations CCGs actually face.[24]

b) One study reports that, between 2009 and 2015, local governments faced an average of 70 public procurement disputes in total; this is based on an 83% response rate of all UK local governments and relates to all public procurement, not just health.[25]

c) Discussions with NHS England procurement experts indicate that these studies hugely underestimate the amount of challenges decision making bodies who procure health services face. Based on discussions with stakeholders we believe that an estimate of 100 initial representations a year seems more reasonable, however, the lack of substantial data on this must be acknowledged.

Table 7: Summary of assumptions regarding litigation activity

Number of representations made to a decision-making body during the standstill period in a year	100
Number of formal legal challenges	14
Number of formal legal challenges won by providers	10 (75%)

Additional Independent Panel Review Process

79. NHS England set out proposals for oversight and challenge of decisions made under the PSR in their consultation which ran from February to April 2021. Under these proposals, a standstill period would run from the point at which the decision-making body publishes their intention to award a contract to a selected provider (unless the nature of the service means there is only one provider or patients have a choice of providers that is not limited by the decision-making body). During the standstill period, providers who have been impacted by the decision may make a representation to the decision-making body. If so, the decision-making body would be obliged to review the decision, share information with the aggrieved provider(s), and conclude whether the process had been followed correctly before confirming the contract award. This could

[24] The CCGs with the most procurement challenges revealed | Expert Briefing | Health Service Journal (hsj.co.uk)

[25] Clear, S & Cahill, D 2021, 'An Empirical Study of the Frequency and Distribution of Judicial Review in Resolving Public Procurement Disputes: Proposals for Legal and Policy Reform', European Public Law, vol. 27

lead to the decision-making process being revisited (with potential to select a different provider) or to uphold the original decision.

80. Following this process, an aggrieved provider would still be able to pursue a claim through Judicial Review of the decision-making process if they do not accept the outcomes of the decision-making body's review. It is also possible that an aggrieved provider may not make a representation to the decision-making body during the standstill period and could proceed straight to Judicial Review instead.

81. In the DHSC PSR Consultation[26] some stakeholders raised concerns about the lack of opportunities for independent review (i.e., a review undertaken by persons outside of the original decision-making body) asides from undertaking a legal challenge through Judicial Review. At the same time, there was concern that legal challenges are expensive, burdensome and time-consuming for decision-making bodies and providers alike (and most notably smaller providers who may have limited resources to undertake a legal challenge).

82. Considering this feedback, the PSR statutory guidance now allows for a means to introduce independent review through the establishment of an independently chaired panel.

83. We intend that this process will be used as a last resort when local resolution only between the decision-making body and aggrieved provider(s) is unlikely to resolve the dispute (which will continue to be the de facto approach to resolving disputes under the PSR). This may be because the relevant decision is unusually complex or controversial. The intention is that the work of the panel to review decisions made under the PSR will be limited to a small number of cases where it is necessary and proportionate.

84. More detail on the role of this panel and the process can be found in **annex 8**.

85. The cost estimate for this element has been based on previous panels performing a similar role in the past. Given the high uncertainty we have with this estimate we provide two approaches below. The Department will work with NHS England to evaluate the estimated costs of the independent review panel going forward.

86. We have also included an additional estimate for costs to commissioners and providers in responding to and preparing for an independent review.

Cost of the Independent Review Panel

High Scenario

87. The basis of our cost estimate is a previous panel that was part of Monitor, the Competition & Co-operation Panel[27]. The scope of this panel included independent review of procurement decisions. The 2009 annual report outlines the full scope of this panel:

> *"the Panel's advice will cover mergers and acquisitions, the conduct of providers (for example potentially restrictive agreements between providers) and consideration of appeals from strategic health authorities on procurement and advertising."*

[26] Provider Selection Regime: supplementary consultation on the detail of proposals for regulations - GOV.UK (www.gov.uk)

[27] Monitor Annual Report 2009 HC621 (publishing.service.gov.uk)

88. In terms of cost, the 2012/13 Monitor annual report stated the budget for the CCP, received as a grant from the DHSC due to Monitor taking over sponsorship of the CCP, as £3.1m (2012/13 prices)[28]. Inflating this to 23/24 prices gives a cost estimate of **£3.8m per annum**. We use this as the basis of our high-cost estimate for the proposed independent review panel.

89. The costs for 23/24 have been adjusted for part-year implementation and are estimated at £1.3m.

Low-cost Scenario

90. The high-cost scenario above assumes that the PSR Independent panel would have the same scope as the previous Competition & Co-operation panel. However, given the much broader scope of this panel, to arrive at a low estimate we have applied a scaling factor of 33.3% to this costing because appeals on procurement and advertising is stated as only one of three main responsibilities of this panel (see **paragraph 87** above). We accept that this is a broad assumption to make, and that it implies equal cost weighting of the three responsibilities. However, we do not have any better information to narrow down this estimate and we believe it is a prudent estimate as:

    a. The appeal function also included advertising and as such was not just a procurement appeals function

    b. Under the PSR only some procurement processes would be eligible for referral to the new Independent Review Panel.

91. As a result of this adjustment our low annual estimate of costs for the Independent Review Panel is **£1.3m** per annum (23/24 prices).

92. The costs for 23/24 have been adjusted for part-year implementation and are estimated at £0.4m.

93. Please note that learnings from the early operation of the panel may identify that these estimates are conservative, and that we require more time than anticipated from panellists and case workers depending on the complexity of the cases received, and/or that the panel receives more than the estimated range of requests for review.

94. We have consulted NHS England on these costings, and the information we received from them support the approach we have taken in this impact assessment.

Cost to commissioners & providers

95. The impact on commissioners and providers of responding to and preparing for an independent review are uncertain. We do not have data for this and rely on assumption-based analysis.

96. As this process is to be seen as a last resort and is not an automatic right. We have therefore estimated that the number of challenges being independently reviewed will be approximately double the number of challenges that end up in Court (i.e., 28% of challenges made at the local resolution level).

[28] Monitor Annual Report and Accounts 2012-13 HC 489 Session 2013-2014 (publishing.service.gov.uk)

97. We have estimated the cost of a provider in the independent review process as £204.15, based on the following assumptions and data:

    a) 7.5 hours of work[29] to begin the process, agree terms with the decision-making body, extend the standstill period, and decide next steps following the judgement.

    b) Gross hourly wage of providers of £27.22[30].

98. We have estimated the cost per review to a commissioner (decision making body) in the independent review process as £217.98 based on the following assumptions and data

    a) 7.5 hours of work[31] to agree terms with the provider, extend the standstill period, and liaise with the independent review panel

    b) Gross hourly wage of commissioners of £29.06[30].

Monetised benefits

Procurement changes

99. In the NHS PSR Consultation[32], commissioners reported that in some cases competitive tender can lead to a waste of unnecessary time and resources. When the PSR is implemented, we assume that there will be an increase of direct award processes as a result of the new regulations. Therefore, under the PSR, there could be a reduction in the overall cost of procurement processes, but this will depend on the type of procurement procedures that are used instead of open procedures.

100. Accurate data on the costs of procurement procedures, especially in the UK healthcare market, is very limited. The majority of the existing evidence related to the cost of procurement procedures is of limited relevance to draw robust conclusions. In **Annex 3**, we have identified the key sources of information we have used to make assumptions in this section.

101. We have estimated the cost for commissioners and providers (**table 8**) of running/participating in a procurement process by procurement type based on the following assumptions and data:

    a. Procurement costs account for approximately 1.4% of overall contract value. Commissioners bear 0.3% of the contract value. This is based on a report prepared by PwC for European Commission in 2011[33] and aligned with findings from other studies[34] [35] [36] reviewed. Estimates for the overall cost of procurement procedures range from 0.4% to 3% of contract value in median terms, rising to 6.6%-8.1% when it comes to small purchases.

    b. We have estimated the cost to individual providers as 70% of the cost faced by commissioners. This is based on the average costs reported in the EC and CEBR

[29] This figure is an estimate based on engagement with NHS stakeholders.

[30] Given we do not know the distribution of provider type of potential bidders, we have calculated the cost of providers by multiplying the average wage across the NHS, LAs and businesses as estimated in Annex 5.

[31] This figure is an estimate based on engagement with NHS stakeholders.

[32] https://www.england.nhs.uk/publication/nhs-provider-selection-regime-consultation-on-proposals/

[33] Public procurement in Europe: Cost and effectiveness, A study on procurement regulation. Prepared for the European Commission, March 2011. Microsoft Word - EC PROC PwC cost and effect FINAL.docx

[34] Olga Balaeva, Andrei Yakovlev, Yuliya Rodionova & Daniil Esaulov (2020): Public procurement transaction costs: a country-level assessment, Public Money & Management

[35] Pavel (2013) in J. Nemec, M. Grega & M. Orviska, Over-bureaucratisation in public procurement: purposes and results, 2019, JEL: H57 https://doi.org/10.3326/pse.44.2.5

[36] Carbonara, N., Costantino, N. and Pellegrino, R. (2016), "A transaction costs-based model to choose PPP procurement procedures", Engineering, Construction and Architectural Management, Vol. 23 No. 4, pp. 491-510. https://doi.org/10.1108/ECAM-07-2014-0099

papers where the typical cost providers pay is 69% and 72.5% of commissioners' costs.

c. Mean average contract value and number of offers from our TED dataset, by procurement type.

102. The process of developing the cost assumptions across the different types of procurement in **table 8** below is discussed in more detail in **annex 4**.

Table 8: Procurement cost estimates for commissioners and providers, by type of procurement

Type of procurement	Cost to commissioner (0.3% of average CV)	Cost to each provider (70% of commissioner costs)	Total cost of running procurement process
Open procurement	£64,100	£44,900	£109,000
Direct award	£45,500	£31,900	£77,400
Other non-open procurement	£178,400	£124,900	£303,300

103. We do not have any information on how procurement practices will change following the implementation of the new regulations. Therefore, there are high levels of uncertainty around the assumption of the change in procurement procedures under the PSR. We have produced 3 different scenarios on the proportion of procurement procedures that could occur as a result of the new regulations in steady state.

- **Low savings scenario:** 50% of open and non-open procedures with only 1 bid would now be issued via direct award.
- **Medium savings scenario:** 100% of open and non-open procedures with only 1 bid would now be issued via direct award.
- **High savings scenario:** 25% of all open and non-open procedures will instead be issued via direct award.

104. The medium savings assumption is our best estimate for commissioners' behaviour following the implementation of the new procurement regulations. We believe that this is a reasonable estimate for the proportion of contracts that are currently going out to competitive tender unnecessarily. **Annex 1** provides additional sensitivity analysis on these costs using insights from the 20/21 TED data, discussed in **paragraph 3,** however due to the unique nature of 20/21 data this is not included in our NPV calculations.

105. Procurement specialists in commissioning bodies should have an idea of the feasible providers for a service in their area and will undertake some form of market engagement before going out to tender. Commissioners retendering a service may know from experience that there is only one feasible provider in the area for a particular service or for a contract with a particular scope.

106. There is a risk that in some scenarios commissioners may be unaware of interested and feasible providers in the market and may cut out more competition than intended. Allen et al. (2020)[37] highlighted the necessity of testing the market prior to issuing a formal

[37] Allen, P., Moran, V., Checkland, K. and Peckham, S. (eds) (2020) 'Commissioning Healthcare in England: evidence, policy and practice. Evidence from a national research programme' Policy Press

invitation to tender in order to ascertain provider interest and avoid the situation of going through a costly tendering process to end up with the same or a worse quality provider.

107. We have assumed a linear transition with an initial large increase**.** Following engagement with NHS stakeholders we are aware that there are contracts coming up for renewal and some commissioners will wait for the new regulations to be implemented to put them out to tender. Therefore, we have assumed an initial increase of 40%, followed by a linear increase until steady state is reached 5 years after implementation.

Table 9: Linear change in proportion of procurement procedures under the PSR until steady state

Year	**Y1**	**Y2**	**Y3**	**Y4**	**Y5**
Yearly change	40%	15%	15%	15%	15%
Cumulative change	40%	55%	70%	85%	100%

Option 1: Provider Selection Regime (Recommended option)

108. In this option, relevant authorities will be able to use the new PSR regulations to select providers when the following three conditions are simultaneously met:
    a. They are used to deliver healthcare services for the purpose of the healthcare service in England.
    b. The services subject to procurement are provided directly to individuals.
    c. The contracting entity is one of the following: an ICB; a local authority in England, a combined authority, NHS England, an NHS Trust, or an NHS Foundation Trust.

Familiarisation costs

109. In this option, both NHS and local authority commissioners will need to familiarise themselves with the new PSR regulations, as well as healthcare service providers of all types. The materials and workshops prepared and delivered by NHSE will also be available to the relevant local authority staff.

110. We have used the method detailed in **paragraphs 45-49** to calculate familiarisation costs to commissioners. The total estimate of familiarisation costs to commissioners is captured below and is approximately £5.6m.

Table 10: Familiarisation costs to commissioners under option 1

	NHS commissioners in ICSs	NHS commissioners in Trusts	NHS England	Local Authorities
Number of organisations	106	213	7	164
Key procurement staff who need to know regulations in detail **(per organisation)**	50	50	50	50
Familiarisation time required (in working hours)	7.5	7.5	7.5	7.5
Budget for PSR implementation (,000)			£250	
Gross wages per hour	£29.25	£29.25	£29.25	£29.25
Commissioners' one-off cost (,000)	**£1,163**	**£2,336**	**£327**	**£1,768**

111. We have estimated the familiarisation cost of option 1 for providers (**table 11**) based on the following assumptions and data:
    a. 4,647 providers. This is obtained as the average number of bids per year between 2014/15-2019/20 on our TED dataset. This is not a perfect figure as it is possible for providers to bid for multiple contracts within the same year and our data doesn't capture all health service contracting activity.
    b. 2 hours, on average, for businesses to familiarise with the PSR. Providers will likely consult the PSR when needed and this can be factored into the normal cost of a procurement process as individuals will learn the process properly as they go through it.

c. The size of the procurement team in each business will also vary, as will therefore, the number of staff required to familiarise themselves with the new regulations. From the DHSC consultation we know that the average response from providers was that there were approximately 40 key procurement staff who needed to be aware of the Provider Selection Regime.

112. The total estimate of familiarisation costs to providers is captured below and is approximately £8.8m.

Table 11: Familiarisation costs to providers under option 1

Number of providers	4,647
Key procurement staff who need to know regulations in detail	40
Familiarisation time required (in working hours)	2
Gross wages per hour	£23.67
Total one off cost (£,000)	£8,800

113. To account for some of the uncertainty surrounding the assumptions made we have completed a sensitivity analysis around the number of hours required for commissioning staff members and the number of providers that are required to familiarise with the new regulations. More specifically we've looked at:

a. Changing the required time to familiarise commissioning staff from 7.5 hours to either 3.75 (-50%) or 11.25 (+50%); the familiarisation costs would range between £2.9m and £8.3m for commissioners.

b. Changing the number of providers impacted based on the minimum and maximum number of bids received in a year between 2014/15 – 2019/20 from 4,647 to either 585 or 9,620 the familiarisation cost would range between £1.1m and £18.2m for providers.

Table 12: Summary of familiarisation cost ranges (in £m) in option 1 by scenario

£m	Commissioners	Providers	Total
Low	2.9	1.1	4.0
Central	5.6	8.8	14.4
High	8.3	18.2	26.5

114. Our central estimate the overall one-off cost of implementing the PSR to both providers and commissioners is approximately £14.4m.

Transparency requirements

115. There will be additional notices providing information on the intended approach of the procurement process, the intention to award the contract, and a confirmation of the award notice that commissioners are required to publish as part of the PSR. As explained in **paragraphs 50-54**, the number of notices, and therefore the level of resources required, varies by type of procurement process being used.

116. Using the cost estimates from procurement specialists in an NHS Commissioning Support Unit (detailed in **paragraphs 50-54**), we have calculated additional transparency costs to be £23,000 across the first 10 years of the PSR being implemented. This calculation is based on the medium savings assumption and a linear transition for procurement process changes (detailed in **paragraphs 103 - 107**).

117. We have completed a sensitivity analysis in line with the possible change in behaviour of commissioners regarding the proportion of different procurement procedures used. We have calculated the costs of additional transparency requirements in the low, medium, and high savings scenario (detailed in **paragraph 103**):

Table 13: Summary of transparency costs to commissioners (in £m) in option 1 by scenario

£,000	Cost to commissioners (£,000)
Low scenario	19
Medium scenario	22
High scenario	26

Procurement changes

118. Using competitive procurement procedures when there's only one viable provider that could win the contract, adds no value for commissioners and increases the cost for both commissioners and taxpayers. It also increases tension and uncertainty with the existing provider unnecessarily. It is not possible to ascertain exactly which contracts were published in which only one feasible candidate existed. However, we have used contracts which received a single bid as a proxy.

    a. In our data from TED, 14.8% of contracts ran via non-open procurement procedures, and that fall under the scope of the PSR, only have one bid recorded in the contract data. That is, 14.8% of all non-open contracts identified under the scope of PSR received only 1 bid.

    b. In our TED data, 14.4% of contracts ran via open procurement procedures, and that would fall under the scope of the PSR, only received one bid for the contract. That is, 14.5% of all open contracts identified under the scope of PSR only received 1 bid.

Table 14: Distribution of contracts that received only 1 bid under the PSR, by procurement type

Scenario	Non-open procurement procedures	Open procurement procedures
Proportion of contracts under PSR scope within open/non-open procurement procedures which received only one bid	14.8%	14.4%

119. **Chart 2** outlines the flow of contracts between different procurement types in the medium savings scenario, assuming no growth in contract number for simplicity.

120. **Table 15** captures the estimated impacts of changes in procurement procedures in the low, medium and high savings scenarios, showing the % of contracts that fall under the different procurement types under each scenario (detailed in **paragraphs 99-107**). Based on the medium savings scenario where we assume a linear transition, we estimate that there will be an overall saving of £110 million within the first 10 years of the PSR being implemented. The full range of estimated savings based on the 3 scenarios is presented in **table 16**.

Chart 2: Change in contract awards between procurement types in medium savings scenario (yearly average) – no contract growth

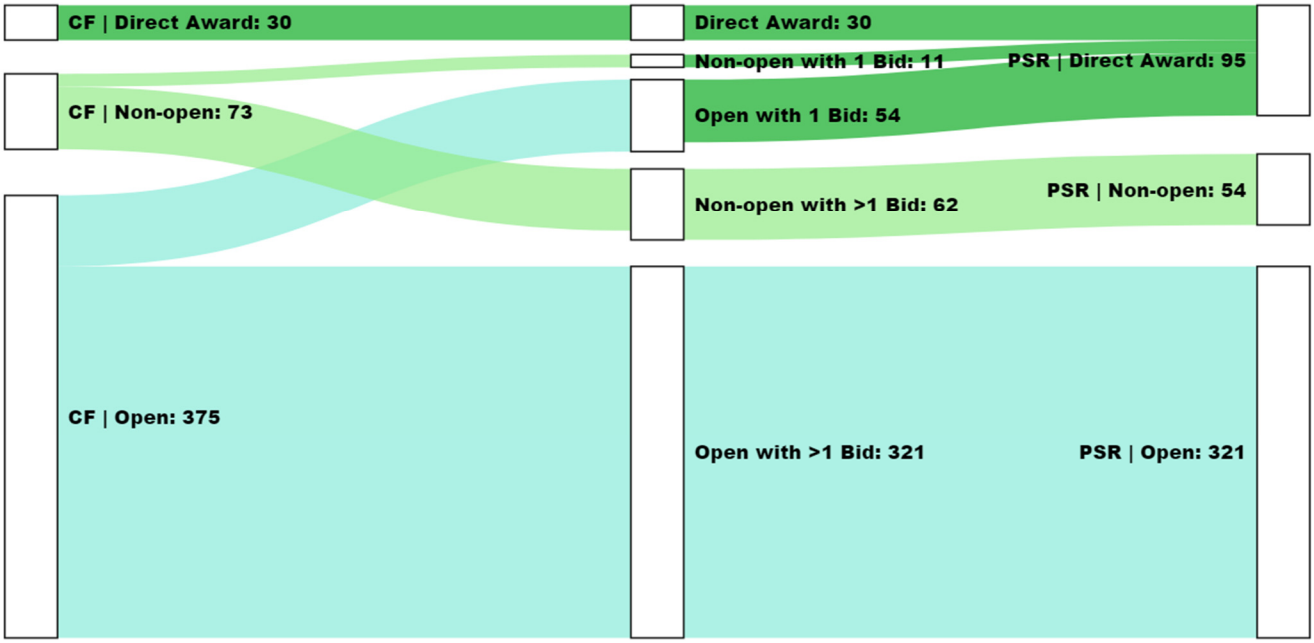


Table 15: Contract distribution under different scenarios, by procurement type

Scenario	Non-open procurement procedures	Open procurement procedures	Direct Award procedures
Counterfactual / BAU	15.3%	78.5%	6.2%
Low savings	14.2%	72.8%	13.0%
Medium savings	13.0%	67.2%	19.8%
High savings	11.5%	58.9%	29.7%

Table 16: Summary of procurement change savings ranges (in £m) in option 1, by scenario

£m	Commissioners	Providers	Total
Low	32.2	22.5	54.7
Central	64.4	45.1	109.5
High	110.0	76.9	186.9

**values may not sum due to rounding*

Litigation impacts

121. When the PSR is implemented, there are a few possibilities regarding what will happen to the number of legal challenges that commissioners face over procurement decisions. We do not have any data on how the level of litigation will change after the PSR is implemented. Due to this, we have considered different scenarios regarding appealing activity under the PSR.

    a. Scenario 1: Litigation activity remains constant under the PSR: The PSR may not lead to any changes in litigation activity. In this scenario the only change would be the introduction of the independent review stage (impact detail from **paragraph 126**); we have assumed that cases would increase in the first year to 28 and remain constant with litigation activity.

    b. Scenario 2: The volume of litigation activity decreases by 25% when the PSR is implemented: We have assumed that when the PSR is implemented there will be more contracts awarded via direct award, therefore, there will be fewer providers

involved in a procurement decision. The new regulations also clarify the rules regarding when it is appropriate for commissioners to use different procurement processes; this could make commissioners less vulnerable to legal challenges, especially with the increased transparency requirements.

c. Scenario 3: The volume of litigation activity increases by 25% when the PSR is implemented: As we are assuming that open contracts will be reduced, it may be the case that providers feel as though they have missed out on opportunities and therefore the number of challenges may actually increase as a result of the PSR. We have estimated a scenario where there is a 25% increase in the number of informal legal challenges when the PSR is implemented.

Table 17: Change in number of legal challenges under the PSR

Scenario	Informal legal challenges	Change in informal legal challenges	Formal legal challenges	Change in formal legal challenges
Counterfactual	100	NA	14	NA
Scenario 1: No change	100	0	14	0
Scenario 2: 25% decrease	75	-25	11	-3
Scenario 3: 25% increase	125	25	18	4

122. In terms of the proportion of legal challenges won by providers under the PSR we have considered two key scenarios:

a. No change in providers' success rate: The PSR may not affect the success rate of providers in formal legal challenges. How successful providers are in legal challenges is mainly determined by the behaviour of commissioners and their compliance with the procurement regulations.

b. 25ppts reduction in providers' success rate: The success rate for providers of the procurement cases that do go to court may decrease as the rules should be clearer and less complex regarding when contracts should be arranged through different procurement types. It will be easier for commissioners to comply with the new rules and could also reduce the likelihood of losing any potential legal challenges they face. If providers realise that they are less likely to be successful with a challenge, they may also be less likely to challenge in the future.

Table 18: Change in proportion of legal challenges won by providers under the PSR

Scenario	**Formal legal challenges won by providers**	**Formal legal challenges won by commissioners**
Counterfactual No change in providers success rate	75%	25%
25ppts reduction in providers' success rate	50%	50%

123. The transition to the new steady state will mirror the changes in procurement procedures (linear transition). We have assumed that if there is a change in the success rate to providers, it would happen instantly, as this change is due to the new rules providing greater clarity and flexibility to commissioners so will occur when the new rules are in place. It will take some time for providers' behaviour to adapt to the PSR rules and the number of challenges will change as providers get used to the new regulations and observe the behaviour and outcomes of other providers who are deciding whether to challenge or not.

124. As formal challenges are calculated as a percentage of informal challenges, they will also increase/decrease at the same rate. **Tables 19** and **20** present the estimated savings and costs under the two scenarios. The savings and costs in year 1 are scaled for a mid year implementation, expected to be December 2023.

Table 19: Cumulative savings of 25% reduction in litigation activity and no change in providers' success rate at legal challenges (Undiscounted)

	Y1	Y2	Y3	Y4	Y5	Y6	Y7	Y8	Y9	Y10
Informal challenges	90	86	83	79	75	75	75	75	75	75
Formal challenges	13	12	12	11	11	11	11	11	11	11
Yearly savings to commissioners (£,000)	£32	£115	£115	£212	£212	£212	£212	£212	£212	£212
Yearly savings to providers (£,000)	£2	£90	£91	£96	£97	£97	£97	£97	£97	£97
Total Savings (£,000)	**£35**	**£205**	**£206**	**£308**	**£309**	**£309**	**£309**	**£309**	**£309**	**£309**

Table 20: Cumulative costs of 25% increase in litigation activity and no change in providers' success rate at legal challenges (Undiscounted)

	Y1	Y2	Y3	Y4	Y5	Y6	Y7	Y8	Y9	Y10
Informal challenges	110	114	118	121	125	125	125	125	125	125
Formal challenges	15	16	17	17	18	18	18	18	18	18
Yearly costs to commissioners (£,000)	£97	£193	£211	£212	£308	£308	£308	£308	£308	£308
Yearly costs to providers (£,000)	£7	£12	£95	£96	£101	£101	£101	£101	£101	£101
Total Savings (£,000)	**£104**	**£205**	**£307**	**£308**	**£409**	**£409**	**£409**	**£409**	**£409**	**£409**

125. We estimate that the savings from changes in litigation activity across the first 10 years of the PSR may fall approximately between £2.6m and -£3.3m, as captured in **table 21.** Given the uncertainty around providers' and commissioners' behaviour to the changes, we do not provide a central estimate or include these calculations in our NPV. The maximum savings would require the volume of litigation activity to decrease by 25% and success rates in legal challenges for providers to stay the same when the PSR is implemented. The minimum savings would require the volume of litigation activity to increase by 25% and success rates in legal challenges for providers to stay the same when the PSR is implemented.

Table 21: Saving ranges due to changes in litigation activity due in option 1 (Undiscounted)

£,000	Maximum	Minimum
Commissioners	£1,747	-£2,494
Providers	£861	-£814
Total	**£2,608**	**-£3,308**

**Note values may not sum due to rounding*

Introduction of a PSR Independent Review Panel

126. The underlying detail of these estimates is in **paragraphs 79 to 98**.

127. Central bodies will incur a direct cost of running a new Independent Review panel. We have based the range for this costing on a previous or panel to provide a sense of scale. The Department will work with NHS England to fully understand and evaluate the costs estimated for the Independent Review Panel going forward. As a result, these estimates carry high uncertainty and are subject to further development following implementation of the PSR.

Low Scenario

128. The low scenario is estimated at **£1.3m per annum** based on published information from the Independent Reconfiguration Panel annual review.

High Scenario

129. The high scenario is estimated based on published information from a previous panel that was part of Monitor, the Co-operation and Competition Panel. The resulting cost estimate is around **£3.8m per annum** based on the reported costs of this panel.

Central Scenario

130. We have taken the mid-point as our central estimate given the lack of available detail on the volume of cases this panel will review. This gives us a central estimate of around **£2.6m per annum** for the panel itself.

Table 22 below, summarises the estimated impact on NHS England under the low, central and high scenario over the 10 year appraisal period.

Table 22 – Independent Review Panel Cost Estimates Over 10 Year Appraisal (Undiscounted)

£,000	Total Cost
Low Scenario	**11,818**
Central Scenario	**23,815**
High Scenario	**35,813**

131. We also include an estimated impact on commissioners and providers in responding to and preparing for an independent review. We have had to use assumption-based analysis here as there is no available data, as such these estimates are to provide a sense of impact and do not represent an exact estimate of the number of cases that we expect to be referred to independent review. We do not include this estimate in our central estimate of total costs but have included them in the sensitivity costs. The impacts on commissioners and providers are summarised in **Table 23** below. The estimated number of independent review cases is linked to scenario 1 and 2 of the litigation cost estimates where in scenario 1 we see a small decrease in the number of litigation cases, and scenario 2 we see a small increase. Costs in year 1 are part year costs due to December 2023 implementation.

Table 23 – Estimated Impact of Independent Review on Commissioners & Providers (Undiscounted)

		Y1	Y2	Y3	Y4	Y5	Y6	Y7	Y8	Y9	Y10
Scenario 1 - 25% decrease in litigation cases	No. Independent Reviews	8	24	23	22	21	21	21	21	21	21
	Cost to commissioners	£1,817	£5,232	£5,014	£4,796	£4,578	£4,578	£4,578	£4,578	£4,578	£4,578
	Cost to providers	£1,701	£4,900	£4,695	£4,491	£4,287	£4,287	£4,287	£4,287	£4,287	£4,287
	Total cost	£3,518	£10,131	£9,709	£9,287	£8,865	£8,865	£8,865	£8,865	£8,865	£8,865
Scenario 2 - 25% increase in litigation cases	No. Independent Reviews	10	32	33	34	35	35	35	35	35	35
	Cost to commissioners	£2,253	£6,975	£7,193	£7,411	£7,629	£7,629	£7,629	£7,629	£7,629	£7,629
	Cost to providers	£2,110	£6,533	£6,737	£6,941	£7,145	£7,145	£7,145	£7,145	£7,145	£7,145
	Total cost	£4,362	£13,508	£13,930	£14,353	£14,775	£14,775	£14,775	£14,775	£14,775	£14,775

132. Under these scenarios, over the 10-year appraisal period we estimate total costs of around £85k to £135k for commissioners and providers of responding to and preparing for independent reviews.

Non-monetised impacts

133. The PSR will provide decision-making bodies (including ICBs, NHS England, Trusts and Foundation Trusts, local authorities, and combined authorities) with a more flexible set of rules to follow when arranging healthcare services. The PSR has been designed in consultation with commissioners and provider of healthcare services to account for the idiosyncrasies of the health and care system to provide clarity to relevant authorities on how to make decisions with regard to specific circumstances and also provides relevant authorities with more discretion for when to award a contract for healthcare services directly without running a competitive tender exercise.

134. The intended benefits of the PSR relate to each of the award processes available under the PSR. More detail on these award processes can be found in **Annex 7**.

135. The overarching intended benefit of Direct Process A and Direct Award Process B is to provide clarity to relevant authorities for when undertaking procurement processes on top of existing protocol and accreditation of providers is not necessary and would only be disruptive. Additionally, it will remove unnecessary bureaucracy by empowering relevant authorities to (where appropriate) direct award contracts instead of running competitive tendering processes.

136. One of the intended benefits for Direct Award Process C and the Most Suitable Provider Process (MSPP) is that relevant authorities will have greater flexibility to design and deliver well-coordinated systems to deliver more joined up care and unlock opportunities to innovate through increased collaboration and integration of services. Additionally, it will give providers more certainty of their position in the system, and may enable longer-term investment in service improvement, improved staff retention (and morale), and more opportunity and confidence to enter into effective partnerships and integrate services within the system.

137. The move away from competition to collaboration is also intended to promote a cultural shift in which commissioners and providers work together to deliver overall system outcomes rather than competing with each other to win contracts for modulated services. By contrast, if relevant authorities have to run tendering exercises for each separable service across the system on a periodical basis this may obstruct efforts to build a well-coordinated system by introducing multiple adversarial processes with uncertain outcomes. This may also have the benefit of removing unnecessary bureaucracy associated with running competitive tendering processes that do not add overall value.

138. Finally, with the exception of Direct Award Process A and Direct Award Process B (which refer to specific types of service) a decision-maker may always opt to run a competitive tendering exercise to select the best provider to deliver a healthcare service. Additionally, if the circumstances required to use Direct Award Process C or MSPP do not apply then competitive tendering will remain the default. The benefit of this approach is to continue to promote the use of competition where it may add value against the key criteria set out in the PSR regulations and guidance.

139. Furthermore, proposed rules for mixed procurement will also allow for provisions outside of healthcare (such as social care) to be arranged under a single contract under the PSR so long as the main subject matter of the contract is the delivery of health care. This will help make sure that contracts can be arranged which benefit patients who require multiple services and allow for joined-up care.

140. There is a possibility that, as the PSR may reduce competition levels, it could lead to a more inefficient service. If the risk of losing a contract is diminished and the threat of competition is reduced it is possible that it may actually reduce the incentive for excellence and innovation for providers, which would have negative impact on patients through a reduction in the quality of services provided. If competition is inadvertently reduced by commissioners, this may have a long-term impact on the number of providers, which in turn could allow complacency within incumbents as their contract isn't necessarily dependent on the quality or price of their service if there are no alternative service providers.

141. The key mitigation to this risk is to establish a regime under which relevant authorities will continue to use competition when it has the potential to add overall value to patients, the taxpayer, and the population. The provisions of the PSR make clear when relevant authorities should and cannot not use a tendering process (i.e., the nature of the service means there is only one provider or competition is achieved through patient choice of accredited providers). Outside of these specific scenarios, provisions also make clear the conditions under which a decision-maker may consider awarding a contract without competition (as per Direct Award Process C or the MSPP) above). As such, competitive tendering of contracts remains the default option if these conditions are not met or the decision-maker wishes to run a competitive tendering exercise.

142. Compliance with these provisions by decision-makers is essential so that the benefits listed above are achieved and direct award and competitive tendering are utilised to best effect for patients, the taxpayer, and the population. To this end, the PSR also contains provisions for transparency (which are greater than required in current regulations), a standstill period following the selection of a provider under Direct Award Process C, the MSPP, and the Competitive Process so that other providers may make representations against the decision and local resolution can be undertaken, and the option to introduce an independent reviewer into the local resolution process if necessary. Additionally, the PSR regulations also make provision that 'Quality and Innovation' are used in the key criteria used when selecting providers which will drive performance in the arrangement of healthcare services. On balance, we believe that the risks are outweighed by the proposed benefits listed above.

Summary of impacts under option 1

143. We estimate that the impacts of this option will result in a net present value saving between -£15m and £141m with a central estimate of £55m net savings (**table 24**). These savings are driven mainly by a reduction in the use of open and non-open procurement procedures when commissioners issue a contract when there's only one bid and an increase in the use of direct award. In all scenarios, savings are higher for commissioners than for providers (**table 24**, where a negative value represents a net cost). It should be noted that, as flagged in **paragraph 125**, litigation impacts have not been included in our central estimates as there is too much uncertainty about future behaviour around legal challenges. As it can be observed, slight changes in assumptions used can have a big impact over saving estimates.

Table 24: Net savings for commissioners and providers of option 1, by scenario (undiscounted)

£,000		Y1	Y2	Y3	Y4	Y5	Y6	Y7	Y8	Y9	Y10
Yearly net savings for commissioners (£,000)	Low	-8,080	941	1,533	2,274	3,044	3,474	3,901	4,331	4,758	5,187
	Medium	-5,154	2,284	3,506	4,987	6,722	7,582	8,436	9,296	10,150	11,009
	High	-2,141	4,009	6,094	8,720	11,682	13,149	14,607	16,075	17,533	19,000
Yearly net savings for providers (£,000)	Low	-18,067	781	1,124	1,642	2,243	2,544	2,843	3,143	3,442	3,743
	Medium	-8,492	1,599	2,453	3,490	4,703	5,305	5,902	6,504	7,101	7,703
	High	-583	2,813	4,272	6,047	8,119	9,146	10,166	11,192	12,212	13,239
Yearly net savings for central bodies (£,000)	Low	-1,283	-3,851	-3,851	-3,851	-3,852	-3,852	-3,852	-3,852	-3,852	-3,852
	Medium	-851	-2,552	-2,552	-2,552	-2,552	-2,552	-2,552	-2,552	-2,552	-2,552
	High	-426	-1,276	-1,276	-1,276	-1,275	-1,275	-1,275	-1,275	-1,275	-1,275
Yearly total net savings	Low	-27,430	-2,129	-1,194	65	1,435	2,166	2,892	3,622	4,348	5,078
	Medium	-14,497	1,331	3,407	5,925	8,873	10,335	11,786	13,248	14,699	16,160
	High	-3,150	5,546	9,090	13,491	18,526	21,020	23,498	25,992	28,470	30,964

**Values may not sum due to rounding*

Table 25: Net Present Value of option 1, by scenario

£m	NPV (£m)
Low savings scenario	-15.1
Medium savings scenario	54.8
High savings scenario	140.7

Option 2: PSR only applies to NHS commissioners

144. Under this option, the new procurement regime would only be introduced for NHS organisations to use when selecting providers to deliver healthcare services for the purpose of the healthcare service in England. This would exclude local authorities from being able to arrange services under the same procurement regime when contracting the same health care services.

145. Regulating only NHS commissioners would reduce the number of organisations and people who will have to adapt to the change in regulations for the arrangement of health care services as local authorities would continue to arrange health care services under the existing regime. Local authorities would then continue to use a single regime for all public procurement (whether health care services or otherwise) and this may be considered simpler.

146. To calculate the costs of this option we have used the same methodology and assumptions as for our preferred option, with our TED data filtered to exclude contracts that were not commissioned by NHS organisations.

Familiarisation

147. Familiarisation costs of this option are lower than option 1 as there will be fewer commissioning organisations who will be required to familiarise themselves with the new regulations. It is only NHS commissioners in ICBs (currently CCG staff), NHS commissioners in Trusts and Foundation Trusts, and NHS England who we need to calculate familiarisation costs for.

148. The total estimate of familiarisation costs to commissioners is £3.9m and is captured in the table below.

Table 26: Familiarisation costs to commissioners under option 2

	NHS commissioners in ICSs	**NHS commissioners in Trusts**	**NHS England**
Number of organisations	106	213	7
Key procurement staff who need to know regulations in detail	50	50	50
Familiarisation time required (in working hours)	7.5	7.5	7.5
Budget for PSR implementation (£,000)			£250
Gross wages per hour	£29.25	£29.25	£29.25
Commissioners' one-off cost (£,000)	£1,163	£2,336	£327

149. As there will be fewer contracts under the scope of this option, there would also be fewer providers affected by the PSR; some providers may only provide health care services to local authorities. The mean average of the total bids received for contracts each year between 2014/15-2019/20 in the scope of the PSR under option 2 is 1,256, compared to 4,647 in option 1.

150. The total estimate of familiarisation costs to providers is £2.4m and is captured in the table below.

Table 27: Familiarisation costs to providers under option 2

Number of providers	1,256
Key procurement staff who need to know regulations in detail	40
Familiarisation time required (in working hours)	2
Gross wages per hour	23.67
Overall one off cost	£2,378

151. To account for some of the uncertainty surrounding the assumptions made we have completed a sensitivity analysis around the number of hours required for commissioning staff members and the numbers of providers required to familiarise with the new regulations. More specifically we've looked at:
    a. Changing the required time to familiarise commissioning staff from 7.5 hours to either 3.75 (-50%) or 11.25 (+50%) the familiarisation costs would range between £2m and £5.6m for commissioners.
    b. Changing the number of providers impacted based on the minimum and maximum number of bids received in a year between 2014/15 – 2019/20 from 1,256 to either 327 or 2,436 the familiarisation cost would range between £0.6m and £4.6m for providers.

Table 28: Summary of familiarisation cost ranges (in £m) in option 2 by scenario

£m	Commissioners	Providers	Total
Low	2.0	0.6	2.7
Central	3.8	2.4	6.2
High	5.6	4.6	10.2

**Values may not sum due to rounding*

152. This suggests that the overall one-off cost of implementing the PSR to both providers and commissioners is approximately £6.2m in year one.

Transparency requirements

153. The additional cost of transparency requirements under the new procurement regime will be lower when it is only applied to NHS commissioners because there are fewer commissioners who need to complete the record of contracts that year and fewer contracts under the scope overall.

154. Based on the estimated costs presented in **paragraphs 50-54**, the medium savings assumption and a linear transition for procurement process changes presented in **paragraphs 99-107**, we have calculated total additional transparency costs to be approximately £17k over the 10 year appraisal period This cost is only applicable to commissioners.

155. We have completed a sensitivity analysis in line with the possible change in behaviour of commissioners regarding the proportion of different procurement procedures used. We have calculated the costs of additional transparency requirements in the low, medium and high savings scenario:

Table 29: Transparency requirement costs (£,000) in option 2 by scenario

£,000	**Cost to NHS commissioners (£,000)**
Low scenario	15
Medium scenario	17

High scenario	19

Procurement changes

156. When we only analyse contracts commissioned by NHS decision-making bodies the number of contracts in our TED dataset, is reduced which will reduce savings for both providers and commissioners:
    a. 16.2% of contracts ran via non-open procurement procedures, that would fall under the scope of the PSR, and that were commissioned by NHS organisations, only received one bid for the contract. That is, 16.2% of all non-open contracts identified under the scope of PSR option 2 received only 1 bid.
    b. 16.4% of contracts ran via open procurement procedures, and that fall under the scope of the PSR, only have one bid recorded in the contract data. That is, 16.4% of all open contracts identified under the scope of PSR option 2 received only 1 bid.

Table 30: Distribution of contracts with only 1 bid in option 2, by procurement type

Scenario	Non-open procurement procedures	Open procurement procedures
Proportion of contracts under option 2 within open/non-open procurement procedures which received only one bid	16.2%	16.4%

157. We assume that when the PSR is implemented, NHS commissioners will procure contracts which only receive one bid through direct award procedures in order to ensure resources are not wasted. We have modelled the same three scenarios due to the uncertainty surrounding this assumption.

Table 31: Summary of contract distribution by procurement type under different scenarios

Scenario	Non-open procurement procedures	Open procurement procedures	Direct Award procedures
Counterfactual / BAU	16.6%	75.8%	7.6%
Low savings	15.1%	69.6%	15.3%
Medium savings	13.9%	63.4%	22.7%
High savings	12.5%	56.8%	30.7%

158. Based on the medium savings scenario where we assume a linear transition, we estimate that there will be an overall saving of £80mwithin the first 10 years of the PSR being implemented.

159. We have completed a sensitivity analysis around the procurement behaviour of commissioners under the option 2 based on the 3 scenarios listed in **paragraphs 103** - **107** above:

Table 32: Summary of procurement change savings ranges (in £m) in option 2 by scenario

£m	Commissioners	Providers	Total
Low	23.6	16.5	40.1
Central	47.2	33.0	80.2
High	72.6	50.8	123.4

**Totals may not sum due to rounding*

Litigation impacts

160. The BAU scenario which we compare against to determine the impact of changes in litigation, is lower under option 2 as fewer commissioning bodies in scope means fewer contracts and therefore fewer challenges.

161. We have modelled the same two scenarios due to the lack of certainty surrounding what the impact of the PSR will be on litigation activity.

Table 33: Change in number of legal challenges in option 2

Scenario	Informal legal challenges	Change in informal legal challenges	Formal legal challenges	Change in formal legal challenges
Counterfactual	64	NA	9	NA
Scenario 1: No change	64	0	9	0
Scenario 2: 25% decrease	48	-16	7	-2
Scenario 3: 25% increase	80	16	11	2

162. The cost to providers of dealing with an informal legal challenge is the same as under our preferred option as the type of provider is not limited in the scope. Our estimate for the cost to NHS commissioning bodies dealing with an informal legal challenge uses the average wage from procurement teams in NHS organisations (£29.25). This makes the estimated cost of a commissioner dealing with an informal legal challenge £146.25.

Table 34: Summary of costs per informal challenge in option 2

	Commissioners	Providers
Hours required per informal challenge	5	8
Gross hourly wage	£29.25	£26.46
Estimated cost per informal challenge	£146.25	£211.68

163. We have modelled an instant change in the success rate and a linear change in the number of challenges for both a 25% increase and a 25% decrease due to the high levels of uncertainty surrounding how the PSR will impact litigation activity. The impacts of these scenarios are shown in the **tables 35 and 36** below. The savings and costs in year 1 are scaled for a mid year implementation, expected to be December 2023.

Table 35: Cumulative savings of 25% reduction in litigation activity and no change in providers' success rate at legal challenges

	Y1	Y2	Y3	Y4	Y5	Y6	Y7	Y8	Y9	Y10
Informal challenges	58	55	53	50	48	48	48	48	48	48
Formal challenges	8	8	7	7	7	7	7	7	7	7
Yearly savings to commissioners (£,000)	£32	£97	£192	£192	£193	£193	£193	£193	£193	£193
Yearly savings to providers (£,000)	£2	£7	£12	£13	£13	£13	£13	£13	£13	£13
Total Savings (£,000)	**£34**	**£103**	**£204**	**£205**	**£206**	**£206**	**£206**	**£206**	**£206**	**£206**

Table 36: Cumulative cost of 25% increase in litigation activity and no change in providers' success rate at legal challenges

	Y1	Y2	Y3	Y4	Y5	Y6	Y7	Y8	Y9	Y10
Informal challenges	70	73	75	78	80	80	80	80	80	80
Formal challenges	10	10	11	11	11	11	11	11	11	11
Yearly costs to commissioners (£,000)	£6	£19	£114	£115	£115	£115	£115	£115	£115	£115
Yearly costs to providers (£,000)	£28	£84	£90	£90	£91	£91	£91	£91	£91	£91
Total costs (£,000)	**£34**	**£103**	**£204**	**£205**	**£206**	**£206**	**£206**	**£206**	**£206**	**£206**

164. We believe that the savings from changes in litigation activity may fall approximately between £1.8m (saving) and -£1.8m (cost) over the 10 year appraisal period. The table below summarises the range of savings we believe the changes in litigation may generate. Given the uncertainty, we do not provide a central estimate. The maximum savings would require the volume of litigation activity to decrease by 25% and success rates in legal challenges for providers to remain the same when the PSR is implemented. The minimum savings would require the volume of litigation activity to increase by 25% and success rates in legal challenges for providers to remain the same when the PSR is implemented.

Table 37: Saving ranges due to changes in litigation activity in option 2.

£,000	Maximum	Minimum
Commissioners	£1,670	-£944
Providers	£111	-£836
	£1,781	-£1,780

Introduction of a PSR Independent Review Panel

165. The detail of these estimates is discussed in **paragraphs 79 to 98** above.

166. Central bodies will incur a direct cost of running a new Independent Review panel. We have based the range for this costing on a previous or panel to provide a sense of scale. The Department will work with NHS England to fully understand and evaluate the

costs estimated for the Independent Review Panel going forward. As a result, these estimates carry high uncertainty and are subject to further development following implementation of the PSR.

167. The cost impact in option 2 compared to option 1 is lower because there are fewer contracts captured by PSR due to having fewer commissioners in scope. From TED data we identified that 64% of the contracts captured in option 1 would be captured under option 2. The assumed independent review costs are reduced proportionately.

Low Scenario

168. The low scenario is estimated at **£0.8m per annum** based on published information from the Independent Reconfiguration Panel annual review.

High Scenario

169. The high scenario is estimated based on published information from a previous panel that was part of Monitor, the Co-operation and Competition Panel. The resulting cost estimate is around **£2.4m per annum** based on the reported costs of this panel.

Central Scenario

170. We have taken the mid-point as our central estimate given the lack of available detail on this panel. This gives us a central estimate of around **£1.6m** per annum for the panel itself.

171. **Table 38** below, summarises the estimated impact on Central Bodies under the low, central and high scenario over the 10-year appraisal period.

Table 38 – Independent Review Panel Cost Estimates Over 10 Year Appraisal (Undiscounted)

£,000	Total Cost
Low Cost Scenario	7,532
Central Cost Scenario	15,178
High Cost Scenario	22,824

172. We also include an estimated impact on commissioners and providers in responding to and preparing for an independent review. We have had to use assumption-based analysis here as there is no available data. We do not include this estimate in our central estimate of total costs but have included them in the sensitivity costs. The impacts on commissioners and providers are summarised in **Table 39** below. The estimated number of independent review cases is linked to scenario 1 and 2 of the litigation cost estimates where in scenario 1 we see a small decrease in the number of litigation cases, and scenario 2 we see a small increase. Costs in year 1 are part year costs due to December 2023 implementation.

Table 39 – Estimated Impact of Independent Review on Commissioners & Providers (Undiscounted)

		Y1	Y2	Y3	Y4	Y5	Y6	Y7	Y8	Y9	Y10
Scenario 1 - 25% decrease in litigation cases	**No. Independent Reviews**	5	15	15	14	13	13	13	13	13	13
	Cost to commissioners	£1,170	£3,291	£3,291	£3,071	£2,852	£2,852	£2,852	£2,852	£2,852	£2,852
	Cost to providers	£1,058	£2,977	£2,977	£2,778	£2,580	£2,580	£2,580	£2,580	£2,580	£2,580
	Total cost	£2,228	£6,267	£6,267	£5,850	£5,432	£5,432	£5,432	£5,432	£5,432	£5,432

Scenario 2 - 25% increase in litigation cases	**No. Independent Reviews**	7	20	21	22	22	22	22	22	22	22
	Cost to commissioners	£1,463	£4,388	£4,607	£4,826	£4,826	£4,826	£4,826	£4,826	£4,826	£4,826
	Cost to providers	£1,323	£3,969	£4,167	£4,366	£4,366	£4,366	£4,366	£4,366	£4,366	£4,366
	Total cost	£2,786	£8,357	£8,774	£9,192	£9,192	£9,192	£9,192	£9,192	£9,192	£9,192

173. Over the 10-year appraisal period we estimate total costs of around £50k to £85k for commissioners and providers of responding to and preparing for independent reviews.

Non-monetised impacts

174. The non-monetised intended benefits and risks of option 1 include those benefits and risks listed under option 1. Namely, that adopting the PSR for relevant authorities in the NHS to arrange healthcare services will help drive clarity, reduce unnecessary bureaucracy as well as promote collaboration and integration of services across systems. These are for the same reasons detailed under option 1.

175. The distinction is that the benefits stemming from Direct Award Process C, MSPP, and the Competitive Process , would be smaller under option 2 as it only applies to NHS commissioners, therefore excluding health care services arranged through local authorities and reducing consistency and collaboration across commissioners in the wider health and care system compared to option 1. Services will still be joined up in the best interest of patients to provide efficiency and continuity when accessing health care services, but it will not be possible to provide joined-up health care services on the same scale as if local authorities were also operating under the PSR.

176. The risk of reduced competition levels leading to a less efficient service is smaller than under option 1 (for the same reason that it would not apply to the arrangement of healthcare services by local authorities). However, the risk would remain for services arranged by NHS decision-making bodies for the same reasons as outlined in option 1. The mitigations listed under option 1 would remain valid and the same for this option.

Engagement with local authorities and the NHS has identified that placing NHS commissioners and local authority commissioners on the same statutory footing when arranging health care services is in the best interests of commissioners, providers, and patients to ensure that the benefits of the PSR can be maximised, commissioners of health care services are subject to the same rules regardless of whether they are NHS or Local Government, and integration and collaboration across the NHS and Local Government can be preserved and promoted.

Summary of impacts under Option 2

177. We estimate that the NPV of this option will range between £1.5m and £93m, with a central estimate of £46m net savings (**table 41**). These savings are driven mainly by a reduction in the use of open and non-open procurement procedures when commissioners issue a contract when there's only one bid and an increase in the use of direct award. These savings are less than we estimate for option 1 due to the exclusion of local authority commissioners from the new procurement regulations. **Table 40** below shows the undiscounted net savings estimates for commissioners, providers and central bodies, where a negative value represents a net cost.

Table 40: Net savings for commissioners and providers of option 2, by scenario (undiscounted)

£,000		Y1	Y2	Y3	Y4	Y5	Y6	Y7	Y8	Y9	Y10
Yearly net savings for commissioners (£,000)	**Low**	-5,460	812	1,165	1,707	2,344	2,656	2,970	3,285	3,599	3,911
	Medium	-3,504	1,672	2,569	3,655	4,930	5,553	6,183	6,812	7,441	8,065
	High	-1,511	2,666	4,142	5,813	7,774	8,734	9,702	10,670	11,639	12,598
Yearly net savings for providers (£,000)	**Low**	-4,529	497	805	1,184	1,630	1,848	2,068	2,288	2,508	2,726
	Medium	-2,153	1,170	1,798	2,557	3,449	3,885	4,326	4,766	5,207	5,643
	High	-271	1,804	2,775	3,944	5,316	5,987	6,665	7,342	8,020	8,691
Yearly net savings to central bodies (£,000)	**Low**	-818	-2,454	-2,454	-2,455	-2,455	-2,455	-2,455	-2,455	-2,455	-2,455
	Medium	-542	-1,626	-1,626	-1,626	-1,626	-1,626	-1,626	-1,626	-1,626	-1,626
	High	-271	-813	-813	-813	-812	-812	-812	-812	-812	-812
Yearly total net savings	**Low**	**-10,808**	**-1,145**	**-484**	**436**	**1,519**	**2,049**	**2,583**	**3,118**	**3,653**	**4,183**
	Medium	**-6,198**	**1,216**	**2,741**	**4,586**	**6,752**	**7,812**	**8,882**	**9,952**	**11,022**	**12,081**
	High	**-2,054**	**3,657**	**6,103**	**8,944**	**12,278**	**13,909**	**15,554**	**17,200**	**18,846**	**20,477**

**Values may not sum due to rounding*

Table 41: Net Present Value of option 2, by scenario

£m	NPV (£m)
Low savings scenario	**1.5**
Medium savings scenario	**46.4**
High savings scenario	**93.2**

Option 3: Services arranged between NHS commissioners and NHS providers are exempted from the PCR

178. Under this option, government would look to exempt services arranged between NHS commissioners and NHS providers from the scope of the PCR. This would mean that health care services may be arranged 'in-house' in the NHS without reference to a procurement regime. NHS commissioners may still arrange services with the independent sector, but if so would have to follow the rules set out in the PCR. Under this option, government would introduce a new procurement regime for relevant authorities to use when selecting providers to deliver healthcare services for the purpose of the healthcare service in England. In this option, we would instead limit the use of the PSR to services provided by statutory NHS bodies, meaning that services provided by VCSEs and small businesses would have to be arranged under current procurement and competition rules through the PCR

179. This proposal may have the advantage of promoting collaboration, integration and open problem solving between NHS commissioners and NHS providers and improve certainty for NHS providers in order to encourage long-term investment in services, better staff retention and long-term expertise.

180. However, it was determined that the same rules need to apply to all providers, as the main issues and barriers to integration that arise from the current rules on competition under the PCR apply irrespective of the type of provider. Maintaining a requirement on competitive tendering for certain sectors and not statutory NHS bodies would likely heavily incentivise the statutory NHS bodies, and have a detrimental impact on those certain sectors where competitive tendering would more likely be required, including SMEs and the VCSE sector. Additionally, the absence of a procurement regime (such as the PSR or PCR) for transactions between NHS bodies may lead to a loss of transparency when arranging services, loss of opportunities for independent providers and reduction of provider diversity, and less incentive for NHS providers to deliver the best possible service.

Familiarisation

181. Familiarisation costs of this option are similar to option 2 as it is only NHS commissioners who we need to calculate familiarisation costs for; the only difference in option 3 is that NHS England's budget for implementation doesn't include the extra £100,000 allocated to setting up the independent review stage.

182. The total estimate of familiarisation costs to commissioners is £3.7m and is captured in the table below.

Table 42: Familiarisation costs to commissioners under option 3

	NHS commissioners in ICSs	NHS commissioners in Trusts	NHS England
Number of organisations	106	213	7
Key procurement staff who need to know regulations in detail	50	50	50
Familiarisation time required (in working hours)	7.5	7.5	7.5
Budget for PSR implementation (£,000)			£150

Gross wages per hour	£29.25	£29.25	£29.25
Commissioners' one-off cost (£,000)	£1,163	£2,336	£227

183. Familiarisation costs to providers will be lower than in the other options as this option is only applicable to NHS providers. We have calculated the cost using the current number of NHS Trusts and Foundation Trusts in England.

184. The total estimate of familiarisation costs to providers is £0.5m and is captured in the table below.

Table 43: Familiarisation costs to providers under option 3

Number of providers	213
Key procurement staff who need to know regulations in detail	40
Familiarisation time required (in working hours)	2
Gross wages per hour	£29.25
Overall one off cost (£,000)	£498

185. To account for some of the uncertainty surrounding the assumptions made we have completed a sensitivity analysis around the number of hours required for commissioning staff members and the numbers of providers required to familiarise with the new regulations. More specifically we've looked at changing the time required by 50% either way, for both commissioners and providers.

Table 44: Summary of familiarisation cost ranges (in £m) in option 3 by scenario

£m	Commissioners	Providers	Total
Low	1.9	0.2	2.2
Central	3.7	0.5	4.2
High	5.5	1.0	6.5

**values may not sum due to rounding*

186. This suggests that the overall one-off cost of implementing the PSR to both providers and commissioners is approximately £4.2m.

Transparency requirements

187. Exempting NHS-to-NHS commissioning of healthcare services is not the same as establishing the PSR and it is unclear what transparency requirements would be necessary under this regime. However, some form of transparency to understand the nature of commissioning activity and keep stakeholders (as well as the independent sector) abreast of commissioning activity would likely be required under any policy proposal. As such, we have assumed for the purposes of the following analysis that provisions for transparency the same as those set out in the PSR would be established for NHS-to-NHS commissioning under this option.

188. The additional cost of these transparency requirements will be lower when only applied to NHS commissioners arranging services through NHS providers because there are fewer contracts under the scope overall.

189. Based on the estimated costs (**paragraphs 50-54**), the medium savings assumption for option 3 (presented in **paragraph 192** below) and a linear transition for procurement process changes (**paragraph 107**), we have calculated total additional transparency costs to be £13,000. This cost is only applicable to NHS commissioners.

190. We have completed a sensitivity analysis in line with the possible change in behaviour of commissioners regarding the proportion of different procurement procedures used. We have calculated the costs of additional transparency requirements in the low, medium and high savings scenario**:**

Table 45: Transparency requirement costs (£,000) in option 3 by scenario

	Cost to NHS commissioners (£,000)
Low savings scenario	-12
Medium savings scenario	-13
High savings scenario	-14

Procurement changes

191. Under option 3, health care services may be arranged 'in-house' in the NHS without reference to a procurement regime. Therefore, NHS commissioners are able to directly award contracts to NHS providers outside of the PCR. Our assumption under option 3 is that NHS commissioners will be likely to directly award contracts to NHS providers, no matter the number of bids it currently receives.

192. Due to the uncertainty surrounding these assumptions we have completed a sensitivity analysis around the main assumption. The scenarios we have modelled under this option are different to option 1 and 2:

- **Low savings:** 50% of all health care service contracts that are currently won by NHS providers will be directly awarded to NHS providers, regardless of the number of bids.
- **Medium savings (central assumption):** 75% of all health care service contracts that are currently won by NHS providers will be directly awarded to NHS providers, regardless of the number of bids.
- **High savings:** 100% of all health care service contracts that are currently won by NHS providers will be directly awarded to NHS providers, regardless of the number of bids.

Table 46: Summary of contract distribution by procurement type under different scenarios under option 3

Scenario	Non-open procurement procedures	Open procurement procedures	Direct Award procedures
Counterfactual / BAU	17.4%	61.7%	20.9%
Low savings	11.0%	39.0%	50.0%
Medium savings	5.5%	19.5%	75.0%
High savings	0.0%	0.0%	100.0%

193. These changes may seem large, however, by including only contracts for services arranged by NHS commissioners through NHS providers, the scope of contracts in our dataset reduces by almost 92%. Under this option, most health care service contracts will continue to be arranged under the PCR.

194. Based on the medium savings scenario where we assume a linear transition, we estimate that there will be an overall saving of £40,900,000 within the first 10 years of option 3 being implemented.

195. We have completed a sensitivity analysis around the procurement behaviour of commissioners under option 3 based on the 3 scenarios listed above:

Table 47: Summary of procurement change savings ranges (in £m) in option 3 by scenario

	Commissioners	Providers	Total
Low	12.9	9.1	30.0
Central	24.0	16.8	40.9
High	35.2	24.6	59.7

** Values may not sum due to rounding*

Litigation impacts

196. The BAU scenario which we compare against to determine the impact of changes in litigation, is significantly lower under option 3 as fewer commissioning bodies in scope means that there are also fewer contracts in scope and therefore fewer numbers of challenges are likely to be affected. As there are only 8% of the number of contracts that would be captured under the PSR under option 3 compared to option 1 this would reduce the estimated litigation and independent review costs significantly. However, we have included these estimates here for completeness.

197. We have modelled the same two scenarios as under the previous options due to the lack of certainty surrounding what the impact of these regulations will be on litigation activity. Because this option allows for health care services to be arranged 'in-house' in the NHS without reference to a procurement regime, there would be no independent review stage established under this option.

198. It may be the case that, because there are fewer contracts under the scope due to only contracts provided by NHS organisations being included, there will be a smaller impact on litigation activity. However, we do not have enough data on the proportion of challenges that come from NHS providers compared to independent providers so we have modelled the litigation impacts on all available litigation activity data due to the lack of certainty surrounding what the impact of these regulations will be on NHS litigation activity specifically. These figures are therefore likely to be an overestimation of the cost of litigation activity changes, with the actual cost being much smaller.

Table 48: Change in number of legal challenges in option 3

Scenario	Informal legal challenges	Change in informal legal challenges	Formal legal challenges	Change in formal legal challenges
Counterfactual	8	NA	1	NA
Scenario 1: No change	8	0	1	0
Scenario 2: 25% decrease	6	-2	1	0
Scenario 3b: 25% increase	10	25	18	4

199. Our estimate for the cost to NHS providers submitting an informal legal challenge uses the average wage from procurement teams in NHS organisations (£24.77). This makes the estimated cost of a provider dealing with an informal legal challenge £146.25. The cost to providers is calculated using the same NHS wage, making the estimated cost of a commissioner dealing with an informal legal challenge £234.

200. We believe that the savings from changes in litigation activity may fall approximately between £6k (saving) and -£6k(cost), The table below summarises the range of savings we believe the changes in litigation may generate. Given the uncertainty, we do not provide a central estimate. The maximum savings would require the volume of litigation activity to decrease by 25% and success rates for providers to stay the same when option 3 is implemented. The minimum savings would require the volume of litigation activity to increase by 25% and success rates for providers to stay the same when option 3 is implemented.

Table 49: Saving ranges due to changes in litigation activity in option 3.

£,000	Maximum	Minimum
Commissioners	£2	-£2
Providers	£4	-£4
Total	**£6**	**-£6**

Introduction of a PSR Independent Review Panel

201. We have not included costs for an independent review panel under option 3 as the independent review panel would not be applicable in this scenario.

Non-monetised impacts

202. This option involves a much simpler process for NHS commissioners arranging health care services through NHS providers, which provides them with much more flexibility. NHS commissioners will benefit from more discretion in the decision-making process when procuring services in-house in the NHS.

203. This option would generate greater certainty for NHS providers who provide services to NHS commissioners. This will strengthen the retention rate of NHS provider staff, having a positive impact on staff morale as NHS providers who perform well have an opportunity to retain their contract over the long term, which will benefit the workforce.

204. This long-term focus may also incentivise investment and innovation to improve the quality of care provided by NHS providers. Therefore, long-term service provision plans encouraged by option 3 could lead to a better quality of services for patients.

205. By excluding all non-NHS commissioners and providers from option 3, the non-monetised benefit of a more integrated provision of services will be reduced significantly, with communication and collaboration only being encouraged within NHS organisations rather than across the whole system. Services will still be joined up in the best interest of patients to provide efficiency and continuity when accessing health care services, but it will not be possible to provide joined-up health care services on the same scale as if non-NHS organisations were also operating included in this option.

206. This option would exclude local authorities from this ‘in-house’ arrangement and healthcare services arranged by local authorities would still be subject to the PCR. In engagement with local authorities and the NHS, and providers we are content that placing NHS commissioners and local authority commissioners on the same statutory footing when arranging health care services is in the best interests of commissioners, provides, and patients to ensure that the benefits of the PSR can be maximised, commissioners of health care services are subject to the same rules regardless of whether they are NHS or Local Government, and integration and collaboration across the NHS and Local Government can be preserved and promoted.

207. Maintaining a requirement on competitive tendering for certain sectors and not statutory NHS bodies may have a detrimental impact on the independent sector where competitive tendering to arrange services under the PCR would still be required, this includes SMEs and the VCSE sector. There will be reduced opportunities for non-NHS providers to bid for and win contracts which have been put out to competitive tender. This could have adverse impacts on market diversification for healthcare services and prevent relevant authorities from being able to collaborate as effectively with independent providers as NHS providers. This could disrupt relevant authorities' efforts to design well-coordinated systems and integrate services with reference to the full breadth of provider who may offer value to patients, the taxpayer, and the population.

208. Under this option, the NHS are able to arrange services without reference to a procurement regime; this may lead to a large reduction in the level of competition involved in NHS contracts as NHS commissioners would effectively be able to directly award contracts to NHS providers outside of the PCR.

209. There is a possibility that this reduction in competition could lead to a more inefficient service as it may actually reduce the incentives for excellence and innovation for NHS providers as they no longer have to compete with private providers for a vast majority of their contracts. This would negatively impact patients through a reduction in the quality of services provided.

Summary of impacts under Option 3

210. We estimate that the NPV of this option will range between £11m and £46m with a central estimate of £29m net savings (**table 51**). These savings are driven mainly by an increase in the use of direct award between NHS organisations. These savings are less than we estimate for option 1 due to local authority commissioners and services provided by non-NHS bodies remaining under the PCR.

Table 50: Net savings for commissioners and providers of option 3, by scenario (undiscounted)

£,000		Y1	Y2	Y3	Y4	Y5	Y6	Y7	Y8	Y9	Y10
Yearly net savings for commissioners (£,000)	Low	-5,427	454	694	984	1,336	1,501	1,667	1,845	2,010	2,176
	Medium	-3,565	845	1,291	1,829	2,484	2,791	3,099	3,430	3,738	4,045
	High	-1,703	1,236	1,888	2,675	3,632	4,081	4,531	5,015	5,465	5,915
Yearly net savings for providers (£,000)	Low	-936	318	486	689	935	1,051	1,167	1,291	1,407	1,523
	Medium	-386	592	904	1,281	1,738	1,953	2,169	2,400	2,616	2,831
	High	-85	865	1,322	1,872	2,541	2,856	3,171	3,509	3,824	4,139
Yearly Net Cost to Central Bodies (£,000)	Low	-	-	-	-	-	-	-	-	-	-
	Medium	-	-	-	-	-	-	-	-	-	-
	High	-	-	-	-	-	-	-	-	-	-
Yearly total net savings	Low	**-6,364**	**772**	**1,180**	**1,672**	**2,271**	**2,552**	**2,833**	**3,136**	**3,417**	**3,699**
	Medium	**-3,951**	**1,437**	**2,195**	**3,110**	**4,222**	**4,745**	**5,267**	**5,830**	**6,353**	**6,876**
	High	**-1,787**	**2,101**	**3,210**	**4,548**	**6,173**	**6,938**	**7,702**	**8,525**	**9,289**	**10,053**

Table 51: Net Present Value of option 3, by scenario

£m	NPV (£m)
Low savings scenario	11.2
Medium savings scenario	28.7
High savings scenario	46.0

Direct costs and benefits to business calculations

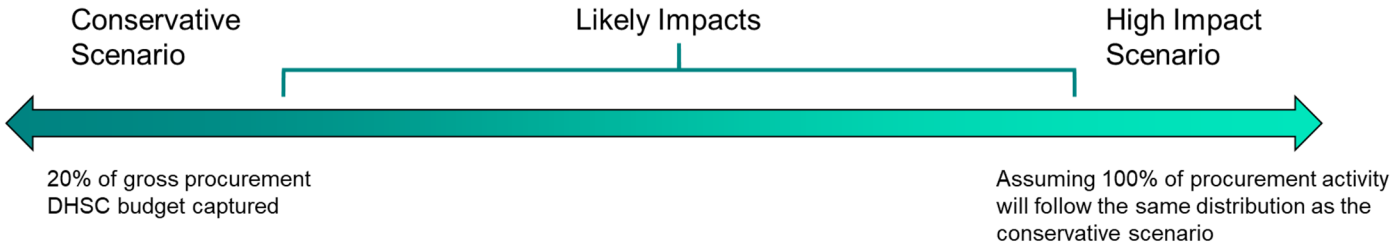
211. The PSR does not involve regulating businesses activity, it is NHS legislation which involves the regulation of the public sector and NHS organisations and the way in which they can procure their healthcare services. **It is therefore not a regulatory measure for businesses** as per the Better Regulation Framework guidance, and therefore has no direct costs and benefits for businesses.

Risks and assumptions

212. As detailed in the proportionality approach, our data only captures about 20% of DHSC's gross current procurement budget from 2014/15 to 2019/20. We are uncertain as to why this is the case but further interrogation on this issue is provided in **Annex 6**. We are therefore unable to accurately estimate the impacts of this policy on all contracting activity.

213. We believe that the impacts we have presented under the three options above show the minimum impacts of the new proposed procurement regime; that is, a very conservative scenario. We have completed a sensitivity analysis to illustrate how these impacts would differ depending on how the missing data is distributed. The costs from the additional transparency requirements and the savings from changes in procurement processes are calculated based on our data; it is these impacts that will be affected by this change.

214. We have modelled a high impact scenario, making assumptions on the missing 80% of our data to show an estimate for the maximum impact we believe the PSR could have. It is extremely unlikely that all of the missing contracts that are not captured in our data have the same characteristics e.g., distribution of procurement procedures, commissioning bodies and contract values, however, this calculation could provide us with a range which represents the possible impacts of the PSR. This is because procurement activity that is published is different and by definition less dynamic, more bureaucratic and more competitive.



215. For the high impact scenario, we have modelled costs in the same way as detailed for our preferred option, with the assumption that the number of contracts has increased by 80 percentage points. This scenario is modelled under the assumption that all the missing contracts behave in the same way as the contracts in our dataset, with the same average contract value, average number of bids, split of commissioning bodies, and proportion of procurement procedures. We acknowledge that this is a non-feasible scenario but presenting for illustrative purposes.

Table 52: Maximum and minimum estimate of NPV of option 1 in the high impact scenario

	Minimum NPV (£m)	Maximum NPV (£m)
Low savings scenario	-15.1	163.8
Medium savings scenario	54.8	412.5
High savings scenario	140.7	751.2

216. It is unlikely that the maximum NPV is an accurate estimate for the impacts of this intervention as much of the contracting activity not represented in our data will happen below the EU threshold of £663,540 (as detailed in the 2015 PCR) and therefore are likely to be cheaper on average, less likely to be issued via open procurement and less complex in nature. It is also unlikely that the minimum NPV is an accurate estimate for the impacts of the PSR as it is we know our dataset does not capture all of the contracts that will be eligible and therefore impacted by the PSR. Therefore, we believe costs to be somewhere within this range, but given the large number of assumptions that would be required to model the 80% of missing data based on no evidence, we find this will add no value to this IA.

217. For each of our options, where we have provided a best estimate, we have used the midpoint between our maximum (costs based on extrapolating to the other 80% of contracting activity) and minimum (costs based on just our TED data) estimates based on the medium savings scenario. This gives us a **best estimate NPV of £233.6m** over our 10-year appraisal period. We have produced additional sensitivity analysis based on the 2020/21 TED data in **annex 1** but due to the atypical nature of this data we have not included it in the NPV calculations.

Risks concerning competition

218. Potential risks concerning the establishment of the PSR and the role of competition in delivering positive outcomes is discussed in **paragraphs 137-142**. As discussed, we are expecting these risks to be managed by the checks and balances of the PSR which includes provisions relating to the circumstances under which direct awards can be made, the continued use of competitive procurement processes in the Regime, the criteria for assessing providers, transparency, the opportunity for providers to challenge decisions during the standstill period in the PSR, and the independent review process (**see paragraph 62 – 63)**. Additionally, relevant authorities which commission services under the PSR are held accountable in legislation to deliver positive outcomes. For example, the conditions of the Public Health Grant which funds the commissioning of healthcare services by local authorities and the statutory duties in NHS Act 2006 on the discharge of the commissioning functions of Integrated Care Boards. The wider impacts relating to competition are discussed further in **paragraphs 225-243.**

Impact on small and micro businesses

Winning and bidding rates in TED data

219. Within the contracts that were awarded to SMEs, the proportion of procurement procedures used for contracts awarded to SMEs is similar to the proportion of procurement procedures used for all contracts in scope of the PSR. We have assumed that when the PSR is implemented the proportion of contracts that are open and non-open will be reduced as any contracts which received only 1 bid will likely be organised via direct award under the PSR. As the proportion of open and non-open contracts awarded to SMEs looks quite similar to the overall proportion of open contracts, we can

assume that contracts held by SMEs will not be affected more than other larger organisations.

Table 53: Proportion of contracts awarded to SMEs by procurement type in our data

Type of procurement	Number of contracts awarded to SMEs	Proportion of contracts awarded to SMEs	Procurement procedures across PSR
Open	766	79.5%	78.5%
Non-open	154	16.0%	15.3%
Direct award	43	4.5%	6.2%

220. Of the open contracts awarded to SMEs 11.5% (88 contracts) received only one bid; we have assumed that these contracts will be organised via direct award when the PSR is implemented, which will mean these SMEs will see savings when arranging these services. This is a smaller proportion than the proportion of open contracts with one bid across all contracts (14.4%) so SMEs may face slightly less savings than average, but they should not face increased costs as a result of the PSR. Similarly, 11.7% of contracts awarded via non-open procurement (16 contracts) received only one bid. These contracts will also be arranged via direct award when the PSR is implemented, providing savings to those SMEs.

221. We have observed in our partial data that SMEs tend to bid more for and be more successful in more competitive contracts which attract more bids than the average number of bids across our counterfactual contracts. The mean bids across all contracts in scope of the new regulations is 9.7 and within that, for contracts awarded to SMEs it is 16.2; this is 6.5 bids more than the overall mean. This implies that, whilst contracts awarded to SMEs use a similar proportion of open procedures as overall, the contracts that SMEs win tend to be more competitive, as measured by the mean number of offers received per contract.

222. In conclusion, under the PSR, competitive procedures will still take place when commissioners consider it appropriate, therefore these contracts will be procured via similar processes. Whilst we cannot be certain exactly how the introduction of PSR will impact the process, we do not expect SMEs to be affected more than larger organisations due to currently being involved in more competitive contracts. Even if commissioners invertedly cut out more competition than intended, the characteristics of contracts awarded to SMEs are similar to other provider organisations, therefore, we would not expect them to be disproportionately affected.

<u>Contract values in TED data</u>

223. Contracts that are awarded to SMEs also have a mean value approximately 40% lower than the mean contract value in our PSR dataset. This means that they face higher fixed costs as a proportion of contract value when preparing and submitting bids for a tender exercise, whether successful or unsuccessful. When the PSR is implemented some of the contracts currently held by SMEs may be directly awarded to them when it is time to renew the contract as, under the new PSR rules, contracts can be directly awarded to the incumbent provider if they are providing a good service. This is a potential cost saving that will have a bigger impact on SMEs than other larger providers due to their higher costs as a proportion of contract value.

224. In our data, we find that the overall average proportion of contract value awarded to SMEs is 22.7%. This figure does vary quite significantly year on year as no contracts were awarded to an SME in our data in 2014/15 and only 12 were awarded in 2015/16. If we were to exclude these anomaly years, the average would be 30.2%. This figure is

higher than the 18.4%[1] we see in DHSC's spend with SMEs, but this difference may be explained by the fact that the DHSC figure is overall procurement spending and does not reflect procurement spending with SMEs specifically on healthcare services, like our data shows.

Table 54: Proportion of spend with SMEs in TED data

Year	PSR value	Number of contracts awarded to SMEs	SME value	Proportion of spending on SMEs
2014/15	£3,399,277,832	0	£0	0.0%
2015/16	£7,893,280,893	12	£20,918,281	0.3%
2016/17	£8,393,914,214	122	£1,162,753,116	13.9%
2017/18	£7,914,038,266	207	£1,566,811,108	19.8%
2018/19	£5,327,025,767	378	£1,264,400,660	23.7%
2019/20	£12,422,389,247	244	£6,285,467,741	50.6%

[1] CBP-9317.pdf (parliament.uk)

Wider impacts

Competition impacts on prices

225. As presented in **paragraphs 11-15**, there has been a lot of research on the effects of competition on various markets. Much of economic theory and quantitative research shows that more competitive markets can deliver better results for consumers. If firms must satisfy the needs of consumers or face business failure, they have a powerful incentive to provide products and services that meet these needs at the lowest possible price and innovate to ensure that they continue to meet consumer preferences through providing a good quality service.

226. The evidence on the benefits of competition in health[1] is generally more unclear. Also, little research has been done into the effects of competition on the commissioning side of healthcare so there is no clear evidence on the effect of competition in the market affected by the PSR. This is especially the case because of how the national tariff affects prices in this market (detailed in **paragraphs 230-231** below).

227. The existing evidence on the effects of competition are detailed below. While it is widely accepted that competition does lead to some benefits for consumers there is some debate in the literature about when competition is appropriate and whether it always leads to the best possible outcome.

228. One of the most recent studies by Goddard (2015)[2] argues that the complexity and diversity of competitive markets means evidence on their impact is conflicting and non-generalisable beyond the specific context in which the evaluation has taken place. Competition isn't necessarily good or bad; it can work better in some aspects of health care than others.

229. Allen et al. (2016)[3] details four in depth case studies from various CCGs aimed to investigate how commissioners managed the interplay of competition and cooperation. Competition was able to challenge existing providers and combat complacency so was a useful tool to improve services when not enforced top-down. However, competition isn't appropriate for implementing long-term service transformations as it was too confrontational; collaborative planning was preferred in this scenario. Due to the poor quality of routine data available it is impossible to understand the extent and nature of the use of competitive commissioning across the NHS.

230. National prices were introduced in the Health and Social Care Act 2012. This intervention set the price a commissioner must use as the basis for paying a provider for a service specified in the national tariff. National tariff prices are traditionally based on the average cost of services reported by NHS providers in the annual reference costs collection.

231. However, there has been a move away from these national prices in recent years. Blended payments became the default payment for emergency care, adult mental

[1] See for example: Gaynor, Moreno-Serra and Propper (2010, 2013); Bloom et al., (2015); Gaynor et al., (2011); Cooper et al., (2011); Feng et al., (2015); Pollock et al., (2011); Propper, Burgess and Gossage (2008);, Bevan and Skellern (2011); Civitas (2011).

[2] Competition in Healthcare: Good, Bad or Ugly? By Maria Goddard, Int J Health Policy Manag. 2015

[3] Allen et al. Commissioning through Competition and Cooperation Final Report, Policy Research Unit in Commissioning and the Healthcare System, June 2016

health services, outpatient attendances and most maternity services in the 20/21 National Tariff. Blended payments are a fixed payment plus at least one of: a quality- or outcomes-based element; a risk sharing element; and/or a variable payment[4]. The aim is to encourage improved partnership working between commissioners and providers.

232. The NHS Payment Scheme gives NHS England more discretion to set and vary the pricing structures for the purpose of payment for healthcare services.[5] This is designed to encourage a move towards blended and block payment approaches, which will allow for local variations in pricing. Providers and commissioners are required to locally agree their aligned payment and incentive fixed element.[6] So, whilst providers and commissioners have increasingly more flexibility in agreeing payment prices, they are still bound by national price guidance and local pricing. This may mean that this market is affected by levels of competition differently.

Competition analysis in our data

233. When the PSR is implemented, we have assumed that there will be a change in the proportion of procurement types, reducing the proportion of open and non-open contracts arranged under the PSR. Instead, these contracts will be directly awarded to providers. While this may seem like it would decrease competition, only contracts not currently arranged via direct award that received 1 bid, have been assumed to be awarded through direct award under the PSR. This should mean that contracts which capture a good level of competition, with at least more than one offer, will be organised through the same processes as they are currently, therefore not having a significant effect on competition.

234. These assumptions are uncertain and there is a risk that commissioners may directly award contracts to providers, despite there being more than one feasible provider for a service. If this reduction in the level of competition occurs under the PSR, there is a risk that the price of contracts will increase due to a long-term reduction in competition. We have done some analysis on the contracts in our dataset to understand how competition currently affects prices and therefore whether prices will be impacted because of the PSR.

235. **Note that the results from this analysis should be considered as <u>indicative only</u> because the TED data the analysis is based on only captures 20% of healthcare procurement spend.**

236. Most of our analysis is done with Kruskal-Wallis tests, which is the alternative non-parametric test to a one-way ANOVA. A Kruskal-Wallis test is used to determine whether there are statistically significant differences between two or more groups of an independent variable on a continuous or ordinal dependent variable. The reason we do not use a normal one-way parametric ANOVA is because our data does not fulfil the assumptions required to carry one out: our data is not normally distributed, and the samples do not have equal variance. A Kruskal-Wallis test is designed to account for these issues.

237. **Based on partial data, we found that there was not a statistically significant difference in price between the average price of contracts with competition (>1**

[4] 2020-21 NT Understanding and using the national tariff (england.nhs.uk)

[5] HCB 2021 procurement competition briefing Sep 2021.pdf

[6] Consultation on the 2021/22 national tariff (england.nhs.uk)

bid) and without competition (1 bid) for all contracts between 2014/15 and 2019/20 with 'Health' as their main activity. We performed a Kruskal Wallis rank sum test on contract prices by the number of bids received. We believe that the number of offers is a good proxy for competition, however, the number of offers will likely also be affected by the type of procurement process used to award the contract. This does not mean, however, that the lack of competition does not impact outcomes through channels other than price, such as quality or quantity. These findings do not necessarily imply that this relationship will continue to hold once the PSR is implemented, or that unobserved impacts on quality or quantity may not happen.

238. **Based on partial data, we found that the relationship between price and competition (measured by 1 bid and >1 bid) was only significant in 7 scenarios[7] when analysing our data broken down by CPV code[8] and region.** Competition in health care markets is geographically based, as competition may be affected by the number of service users varying by region (Propper et al. 2008[9]). We therefore broke our data down into each of the 9 regions in England to measure whether the level of competition has a bigger impact on price in some areas more than others. It is also likely that the object of a contract is likely to have an impact on the price; for example, some services may entail more specialist equipment or personnel or have a larger scope and are therefore more expensive than other services. We therefore analysed the relationship between price and competition within CPV codes.

239. Where there is a significant relationship, the correlation between price and number of bids is inconclusive. In one scenario[10], there was a strong positive correlation, and in two[11], there were moderate negative correlations. We would expect price to decrease as the number of bids increase, in line with economic theory. However, we do not observe this consistently in our data.

240. It may be the case that the number of offers a contract receives is linked to price in other ways. In our data there are some contracts that are awarded to multiple providers, for example, contracts with multiple subcontracts or framework agreements. If contracts have multiple awards, they are also likely to have multiple offers recorded and also may have higher contract values as they are being awarded to multiple providers. Alternatively, the complexity of the contract may influence the procurement procedure used, which will subsequently impact the number of bids received; complex contracts with a larger scope, which are therefore more expensive, may be more likely to be procured via a non-open process such as negotiated without a call for evidence or competitive dialogue[12]. These processes allow a discussion between providers and commissioners about proposals to complex issues within the contract; these processes will receive fewer bids as only a few providers will be selected by commissioners and invited to submit a bid. This implies that it is possible that the impact of the number of offers on price may not be directly causal as the relationship can go both ways and be

[7] '. 'Health services' (85100000) in the West Midlands; 'Medical practice and related services' (85120000) in Yorkshire and the Humber'; 'Medical practice services' (85121000) in the South East; 'Dental practice and related services' (85130000) in Yorkshire and the Humber; 'Miscellaneous health services' (85140000) in the North West and in Yorkshire and the Humber; and 'Pharmacy services' (85149000) in the North West.

[8] CPV (Common Procurement Vocabulary) codes categorise contract notices in order to make them easier for suppliers and contracting authorities to find. There are more than 9,000 CPV codes defined.

[9] Propper, S Burgess, D Gossage (2008) "Competition and quality: evidence from the NHS internal market 1991-1996" Economic Journal

[10] 'Medical practice services' (85121000) in the South East

[11] 'Medical practice and related services' (85120000) and 'Dental practice and related services' (85130000), both in Yorkshire and the Humber.

[12] In our data overall mean value is £18.9m; competitive dialogue mean value is £112.8m; negotiated with a call for competition mean value is £255.1m

influenced by other variables such as procurement type, region, and CPV code, as we have explored in our analysis.

241. Economic theory predicts that a reduction in competition may lead to an increase in the cost of contracts. However, our analysis has found that even if the PSR reduced the level of competition, this does not seem to be a significant risk in this health care procurement market as, **based on partial data we did not find a statistically significant difference in the price of contracts with and without competition for most of the contracts in our dataset. However, we cannot be certain that this relationship will continue to hold once the policy is implemented.**

242. There is still a risk that the PSR may have a negative impact on the price of contracts faced by commissioners when procuring health care services. Our analysis implies that there isn't a significant risk of an impact on price in the short term, however, it is still possible that, if commissioners cut out more competition than intended, this could negatively impact price in the long term. If commissioners directly award contracts with high levels of competition, it may lead to the number of providers decreasing over time, which may have longer-term impacts on the price of contracts. However, we have decided to balance this risk against the potential benefits (including for resource efficiency stemming from better joined up services) which enabling greater integration of services may generate. Additionally, many NHS prices are controlled by the NHS Payment Scheme – which sets out payment mechanisms which will help NHS bodies control prices and secure value for money for many relevant healthcare services.

243. **Paragraph 62** discusses the checks and balances the new regulations and guidance put in place, that seek to mitigate the risks to competition.

Delivering Outcomes for Patients, the Taxpayer, and the Population

244. Decisions under the PSR which require the selection of a provider (i.e., using Direct Award Process C, the Most Suitable Provider Process (MSPP) or the Competitive Process) will be subject to an assessment against statutory key criteria set out in the PSR regulations and expanded in the statutory guidance. The intention of this is to ensure that providers and the healthcare services they offer are in the best interests of patients, the taxpayer, and the population with a much wider reference to achieving positive outcomes that can be achieved through an assessment based more narrowly on the best economic value. The key criteria are:

    a) **Quality and innovation:** Ensures that decision-making bodies seek to maximise the quality of services and the performance of providers, and to innovate and improve services so they are fit for the future.
    b) **Value:** Ensures that decision-making bodies seek to maximise the value offered by a service in relation to the cost, by selecting the option with the best combination of benefits to individuals in terms of outcomes and to the population in terms of improved health and wellbeing; and brings value to taxpayers by reducing the burden of ill-health over the lifetime of the arrangement.
    c) **Integration, collaboration and service sustainability:** Ensures that decision-making bodies seek to maximise the integration of services for patients to improve outcomes, that decision-making bodies give due consideration to how their decisions may affect the stability and sustainability of services over time across providers, and that their decisions are consistent with local and national

plans around integrating care and joining up services for patients and service users.

d) **Access, inequalities and choice:** Ensures that decision-making bodies seek to maximise the choices available to patients, and that services and treatments are offered and accessible to all individuals who need them, with a particular focus on tackling health inequalities.

e) **Social value:** Ensures decision-making bodies seek to maximise the social value created by the arrangements, recognising the role the health service plays in local communities, including their leadership role in achieving a net zero carbon footprint.

Potential international trade implications

245. Our data implies that the PSR will not have significant impacts on imports of healthcare services as we have observed very few services procured from international providers between 2014/15 and 2019/20 in our dataset (detailed below in **paragraphs 250-252**).

246. However, the share of non-UK providers in the market presented below may not be exhaustive. For example, there are limits to the evidence on the extent to which international trade is a feature in the procurement of health care services. Our data also doesn't capture providers who have established a commercial presence in the UK but have foreign ownership. It is also worth noting that the PSR scope only applies to England, whereas the trade data in TED only highlights UK or non-UK based providers.

247. The new procurement regulations do not prevent the use of competition in all scenarios; there will still be scenarios where competition will add value to the procurement process and therefore the PSR will not impact every contract in our dataset, even if it is in scope of the PSR.

248. As detailed in **paragraphs 223-224**, we do not expect the PSR to have an impact on the contract value of the services being procured under the PSR in the short term at least. Therefore, we do not expect the PSR to have a significant effect on the value of overall trade.

249. Overall, while the market share of non-UK providers may be slightly larger than presented below, we still believe that the PSR is unlikely to affect imports of health care services as it is unlikely to change the market significantly anyway. The impact is therefore limited.

Number of contracts awarded to non-UK providers in our dataset

250. In the counterfactual, only 30 contracts/contract lots were awarded to providers from countries outside of the UK. Of these, 25 were awarded to only a non-UK provider and 5 were awarded to multiple countries including non-UK countries.

251. In the PSR, only 21 contract lots were awarded to providers from countries outside of the UK[1]; 11 of these are unique contracts. Of these, 19 were awarded to only a non-UK country and 2 were awarded to multiple countries including non-UK countries. Only the contracts that would be under the scope of the PSR have a possibility of being affected by the new regulations.

Table 55: Contracts awarded to providers from non-UK countries in our TED data

	Number of contracts overall	Number of contracts awarded to a non-UK provider	Percentage of contracts awarded outside of UK
Counterfactual	3263	30	0.92%
PSR	2862	21	0.73%

252. We have estimated that our data only captures approximately 20% of contracting activity relating to health services in England so the actual number of contracts awarded to providers from non-UK countries is likely to be higher than the figures presented in **table 55**. Whilst our data does not capture all procurement activity related to health services, due to the low numbers of contracts being awarded to non-UK providers in our

[1] The providers from countries awarded contracts that were under the scope of the PSR were United Arab Emirates, Australia, Belgium, Guernsey, Ireland, Netherlands, Finland, and United States.

dataset, it is unlikely that the PSR will have a significant impact on international trade or investment.

Content of contracts with non-UK providers

253. **CPVs:** In the PSR, 6 out of the 11 unique contract IDs awarded to non-UK companies (54.5%) were procured via mixed procurement. Within the contracts awarded to SMEs there are 261 unique CPV codes. The most common is 'Medical hospital services', which appears 12 times (57.1% of contracts, 4.6% of all CPV codes). There are 19 CPV codes which appear 11 times – 13 of which are types of medical equipment; 4 are other types of medical services; and 2 are types of pharmaceutical products.

254. **Contract value:** The contracts that are awarded to non-UK countries tend to be cheaper than the average price of contract award in our dataset.

Table 56: Average contract values of UK v non-UK contracts in scope of the PSR

Contract group	Mean contract value	Median contract value
PSR UK	£ 15,740,319	£ 1,138,540
PSR non-UK	£ 12,250,999	£ 847,421

255. **Procedure used and offers received:** Under the PSR, 17 of the contracts awarded to non-UK countries are procured via open procurement processes (81%) and the rest are procured via non-open procedures. The average number of offers is slightly higher than the overall average, with a mean of 12.5 and a median of 8, (compared with 9.7 and 3 in the PSR). Most of these contracts won't be affected by the PSR as they have high levels of competition and will therefore continue to be procured via open procurement procedures; only 2 contracts awarded to non-UK countries have 1 bid and will therefore be likely to be arranged via direct award under the PSR. Even if our behavioural assumptions regarding commissioners are incorrect, the number of contracts affected by the PSR that are awarded to non-UK organisations is very low and therefore not a significant risk to international trade.

Monitoring and Evaluation

256. As part of the Health and Care Act 2022 evaluation programme the aim is to understand the different ways that ICSs and system partners (at system, place, and neighbourhood level) are coming together to design, commission and deliver services, and fulfil their duties, and the potential impacts. The PSR will form part of the Post Implementation Review of this Act.

257. Government has also committed to evaluate the PSR between 1 & 2 years after implementation and to review the policy (including considering amendments to the regulations and guidance) if that evaluation demonstrates that there is merit in doing so.

258. Understanding how the PSR affects commissioning will be an integral part of that evaluation. The PSR is an important enabler of collaboration and integration and while we are not planning to evaluate the impacts of the PSR in isolation, the research will help us to understand the experiences of local arrangements for delivering integrated care.

259. The aim is to capture learning to identify how positive changes may have been achieved, the obstacles to this (and how these can be avoided), and to disseminate that learning across the system.

260. This evaluation will be a mixed methods and multi-phased study taking approximately 3 years to complete. Research outputs (including interim reports) will be produced and disseminated with systems, facilitating the spread of lessons learnt and best practice with systems.

Annex 1: Analysis of 2020/21 TED Data

The purpose of this annex is to outline why 2020/21 TED data is not included in our core analysis and produce some sensitivity to the estimated net benefits based on high level insights we can draw from the 2020/21 data. The overall insight from this data is that the scope for estimated net savings is likely lower based on 2020/21 data alone. Whilst this is a useful sensitivity exercise, we are cautious in taking concrete conclusions from the 20/21 data due to the likely atypical nature of procurement activity during the covid-19 pandemic.

Why have we excluded 20/21 TED data from our core analysis?

During 2020/21, the Covid-19 pandemic resulted in significant differences in total value of contracts, mean value of contracts, mean number of bids received, the frequency they were procured by central bodies, and the frequency in which they were awarded directly, when compared to contracts procured between 2014/15 and 2019/20. The significant scale of this is outlined in Table 1 below, where the column titled "Increase Ratio" outlines how different the selected indicators were in 2020/21. As a result of this exploratory analysis, we decided that the nature of the 20/21 data would skew the analysis for the purpose of the core analysis in this Impact Assessment and we excluded the data from our analysis.

Beyond this we also do not know how reporting habits changed because of Covid, i.e., the types of contracts reported to TED during the pandemic may have differed to the types of contracts typically reported under pre-pandemic conditions.

Table 1: Summary of Data Exploration Comparing 2014/15 to 2019/20 TED Data (Core Analysis) with the 2020/21 TED Data – Based on preferred Option 1

	2014/15 to 2019/20 TED Data	2020/21 TED Data	Increase Ratio
Average Annual Number of Contracts in Data	477	577	1.21
Average Aggregate Annual Cost of Contracts in Data (£bn)	7.6	42.2	5.59
Mean Contract Value (£m)	15.8	73.2	4.62
Mean Number of Offers (bids) per Contract	9.74	39.89	4.10
% of Awards Issued as Direct Award	6.2%	13.2%	2.12
% of Contracts Procured Via NHS England	12.2%	52.0%	4.26

What is the purpose of producing some additional insights using the 20/21 data?

We have produced the following section to make use of the data and from the covid-19 pandemic and how it would impact the potential net benefit estimated in our core analysis. This insight is not necessary for the core analysis but provides some additional sensitivity and rigour based on a real-world extreme example. Given the likely atypical nature of procurement activity during the pandemic we would recommend caution in interpreting this data. In the following section we only comment on the likely direction of savings estimated as opposed to providing exact cost/saving estimates.

Analysis of the 20/21 Data

Procurement Benefits

Values in this section are all based on the preferred option 1 from the main impact assessment. **Table 2** below outlines the difference in the % of direct award issued in the TED data, the % of competitive contracts that only had one bid, and the resulting central assumption this generates for the % of contracts that would be issued as Direct Award under the PSR and thus result in a cost saving. The baseline of % of direct awards is higher in 2020/21 data at 13.2% compared to 6.2% in 2014/15 to 2019/20 data. The proportion of competitive contracts with only 1 bid is also lower in the 2020/21 data at 22.1% when compared to 29.2% in the 2014/15 to 2019/20 data. The result is the difference between the % of direct award in our central assumption and the % of contracts currently issued as direct award is around half that based on the 2020/21 data analysis as it is in the 2014/15 to 2019/20 data analysis. As such we would expect that the scope of estimated savings would reduce by at least 50% using the 2020/21 data.

Table 2 – Scenarios of % of Awards that would be issued as Direct Award under our central assumption based on 2014/15 Data compared to 2020/21 data – based on preferred Option 1

	2014/15 to 2019/20 Data	**2020/21 Data**
Total Contracts in TED data	2,862	577
% of Contracts Currently Issued as Direct Award*	6.2%	13.2%
% of Competitive Contracts with Only 1 Bid*	29.2%	22.1%
Central Assumption % Direct Award Under the PSR*	19.8%	20.1%
Difference Between Central Assumption & % of Contracts Currently Issued as Direct Award	13.6%	6.9%

See table 15 in the main body of the Impact Assessment.

Impact on costs

The estimated costs in the core analysis of this impact assessment are unaffected by the % of contracts that are issued as direct award. We anticipate that familiarisation costs, and costs of independent review would be unchanged as the same regulatory changes apply.

There may be some risk that where more direct awards are issued (as they were in 2020/21) that there may be a higher number of referrals to the independent panel to be reviewed. This risk could also be reflected in litigation impact; however, we do not have any data or evidence to base scenarios on.

If the analysis was purely based on 2020/21 data, then the net present value benefits would likely reduce by over 50%. This means under our central scenario we would still anticipate a net benefit. However, as stated above this is shown as an extreme example for transparency purposes. We don't recommend using this data for the reasons set out above and therefore overall net benefit figures based on this data don't feature in the range of costs and benefits set out in the IA.

Annex 2: Key Summary of Responses to DHSC Consultation

DHSC published a consultation which ran from 21 February 2022 to 28 March 2022, which sought views and evidence from the system to understand anticipated costs and savings for commissioners and providers related to the establishment of the PSR.

DHSC received 124 responses to this consultation. A summary of the key findings on anticipated costs and savings associated with the PSR are listed below:

Establishing the PSR:

- 65% of respondents anticipate that more than 50 people in their organisation will need to be aware of the new PSR. This is higher for commissioners (80% for LAs, 75% for CCGs and 100% for CSUs). Some NHS Commissioners stated that they have already begun preparation to enable them to establish the new regime.
- Only 4% of respondents disagree/strongly disagree that their organisation will be able to successfully transition to the PSR. Some local authority commissioners voiced concern that it will be difficult to manage the PSR alongside using the PCR for other services.

Short-term costs:

- Overall, 62% of respondents agree that their organisation would incur short-term costs. This figure was higher for commissioners (70% for LAs and 80% for CSUs), compared with only 25% for providers. The main reasons for short-term costs listed by both commissioners and providers include: staff training; updating existing materials; and updating procedures/processes.

Operational costs and savings:

- However, only 28% of respondents agree that they will incur increased operational running costs. Again, this figure was higher for commissioners (59% for CCGs and 40% for CSUs), compared with only 8% for providers. The main reasons for increased operational costs listed by commissioners include: increased bureaucracy relating to transparency requirements; training; and additional staff. The main reasons for increased operational running costs listed by providers include: more proactive stakeholder engagement; and increased running costs due to lack of competition.
- Only 15% of respondents anticipate that their organisation will realise operational savings. However, 44% don’t know. The main reasons for operational savings listed by commissioners and providers related to the reduction in competitive tendering. However, some commissioners also noted non-monetised savings including: improving/maintaining quality of care; utilising innovation; and improving patient outcomes.

Annex 3: Data sources explored on health service contracts

1. There are two main data sources we have explored: Contract Finder (CF) and Tenders Electronic Daily (TED). Both tools allow public access to contracting activity by public bodies. CF is a national dataset based on gov.uk, whereas TED is published by the European Commission. Public entities based in the UK are not expected to continue using TED from the start of 2021, but because our analysis covers 2014-2020, we have a rich amount of data form this source.

2. Despite publication thresholds being lower for CF than they are for TED, we found that the availability of data in TED was much larger in size and better in quality. However, despite being the best available data source, our data only captures about 20% of the gross current procurement in DHSC budget from 2014/15 to 2019/20. Commissioners only need to publish their contracts in TED when their costs are above a certain threshold. Once we filtered our data, we found approximately 3000 contracts that contain CPV codes that are related to health with data on price, bids, commissioning body and provider. It may be the case that not all health service contracts that are published on TED are included in this data if the contracts have been misclassified or are missing information that is required for meaningful analysis.

3. The reason why the percentage of budget captured by our data is so low could be for two main reasons: either most contracting activity happens below EU threshold and therefore it does not require to be published or commissioners are not complying with transparency and publication rules. We cannot determine which one it is as there is no UK data on procurement activity below the EU threshold, but a study in public procurement practices in Spain estimated that 90% of the total number of contracts awarded were below the EU threshold, accounting for 20% of the total expenditure in public procurement[1]. Therefore, it would seem unlikely that 80% of all DHSC procurement budget was spent in contracting activity below EU threshold.

4. We believe that our data and analysis will not capture all the impacts of the PSR, as much of the contracting activity impacted by the PSR will happen below the EU threshold. However, we have absolutely no evidence or data to make estimations of what the distribution of procurement procedures and contract values, mainly because it is radically different in nature: more dynamic, less complex, and less expensive. After exploring different options, we determined that modelling the distribution of 80% missing data based on unevidenced assumptions could be misleading, strongly skewing the results, and not appropriate for the value it would add. Please, see **paragraphs 212-217** for the sensitivity analysis around this.

[1] Sanchez-Graells, Albert, Public Procurement Below Thresholds in Spain (July 15, 2011). Available at http://dx.doi.org/10.2139/ssrn.1888186

Annex 4: Evidence base on procurement costs

a. **Non-open procurement is more costly than open procurement, with the exception of direct award**. Open procedures take relatively less time to complete than most non-open procedures as they involve fewer stages. They also generally involve less negotiation between providers and commissioners, which can be important for more complex procedures, but also very time consuming.

b. **Multi-stage procedures lasted the longest and therefore required the most resources from commissioners**. These include procedures where providers are either invited to join the process following a pre-selection stage by commissioners or are involved in an additional stage of dialogue after the initial bids are received from providers. Restricted procedures were approximately 30% more expensive than open procedures, which may be due to the two-stage evaluation process which implies a delay in the contract award. Negotiated procedures and competitive dialogue procedures also took a long time to complete.

c. **Direct award is reported to be the least resource intensive procurement process for commissioners** (EC, 2011[2]). For direct award, the median number of days spent on the procurement process is 18 for commissioners and 20 for providers. For commissioners, this is 14% lower than open contracts and 28% lower than non-open contracts.

d. **Procurement costs account for approximately 1.4% of overall contract value**; this is based on average salaries from OECD and Eurostat data across 30 European countries, detailed in a report by PwC for the European Commission in 2011. They report that **75% of these costs (1.1% of contract value) are faced by suppliers**, including unsuccessful bidders. Other literature provides a range of 0.25-5%.[3] [4] [5]

e. **Costs are likely to be larger as a share of contract value for contracts at the lower end of the range**. At the lower threshold of €125,000, total costs can reach between 18-29% of contract value.[6] [7]

f. **Commissioner costs account for the other 25% of the overall procurement cost** (0.3% of contract value). The higher total costs for suppliers can be explained by the fact that several bids are prepared and submitted for each tender, so the overall cost is split amongst those providers who bid for a contract.

[2] Public procurement in Europe: Cost and effectiveness, A study on procurement regulation. Prepared for the European Commission, March 2011. Microsoft Word - EC PROC PwC cost and effect FINAL.docx

[3] Olga Balaeva, Andrei Yakovlev, Yuliya Rodionova & Daniil Esaulov (2020): Public procurement transaction costs: a country-level assessment, Public Money & Management

[4] Pavel (2013) in J. Nemec, M. Grega & M. Orviska, Over-bureaucratisation in public procurement: purposes and results, 2019

[5] Carbonara, N., Costantino, N. and Pellegrino, R. (2016), "A transaction costs-based model to choose PPP procurement procedures", Engineering, Construction and Architectural Management, Vol. 23

[6] Public procurement in Europe: Cost and effectiveness, A study on procurement regulation. Prepared for the European Commission, March 2011. Microsoft Word - EC PROC PwC cost and effect FINAL.docx

[7] Olga Balaeva, Andrei Yakovlev, Yuliya Rodionova & Daniil Esaulov (2020): Public procurement transaction costs: a country-level assessment, Public Money & Management

Annex 5: Estimating costs of litigation impacts of commissioners and providers

Initial representations

1. To calculate the cost to NHS commissioners of dealing with these informal legal challenges we will use the 2023/24 NHS Agenda for Change hourly pay grades.[8] Through analysis of procurement roles on NHSJobs[9], all adverts were within band 5 and band 8a, so we will use the midpoint of these grades as an estimate of wages. This wage needs to be uplifted by an additional 34.5% to account for employer non-wage labour costs, such as NI contributions, in line with RPC guidance, , to get £29.25. Note the 34.5% on-cost is likely an overestimate as it assumes 100% of staff are pension scheme members.

2. For local authorities, we have used the median hourly wage for the regulation of activities providing health care, taken from the 2022 Annual Survey of Hours and Earnings10, again uplifted by 34.5% (assuming the same on-costs as NHS) and adjusted for inflation to 23/24, to get £28.74. We are aware that the hourly wage will vary by council and grade, this is an average estimate.

3. We have then calculated a weighted average wage for commissioners, based on the fact that 64% of contracts are commissioned by NHS bodies and the other 36% by local authorities, of £29.05.

4. It is difficult to estimate the hourly cost to providers as this includes private businesses as well as NHS organisations and local authorities, some of which will also be part of the VCSE sector who are likely on lower wages. To work out the cost of a provider submitting and dealing with an informal legal challenge to a procurement decision, we will use the average wage across NHS organisations (£29.25), local authorities (28.74) and businesses (23.67) to get an estimated average wage of £27.22. The hourly wage for private providers is taken from the 2022 ASHE data as the median hourly wage for those employed in human health activities (plus a 34.5% on-cost adjustment and inflation adjustment).

Formal challenges: key sources used

The CCGs with the most procurement challenges revealed | Expert Briefing | Health Service Journal (hsj.co.uk)

An Empirical Study of the Frequency and Distribution of Judicial Review in Resolving Public Procurement Disputes: Proposals for Legal and Policy Reform - Bangor University

(PDF) Public procurement and access to justice: a legal and empirical study of the UK system (researchgate.net)

The Government Procurement Review - The Law Reviews

[8] Pay scales for 2023/24 | NHS Employers

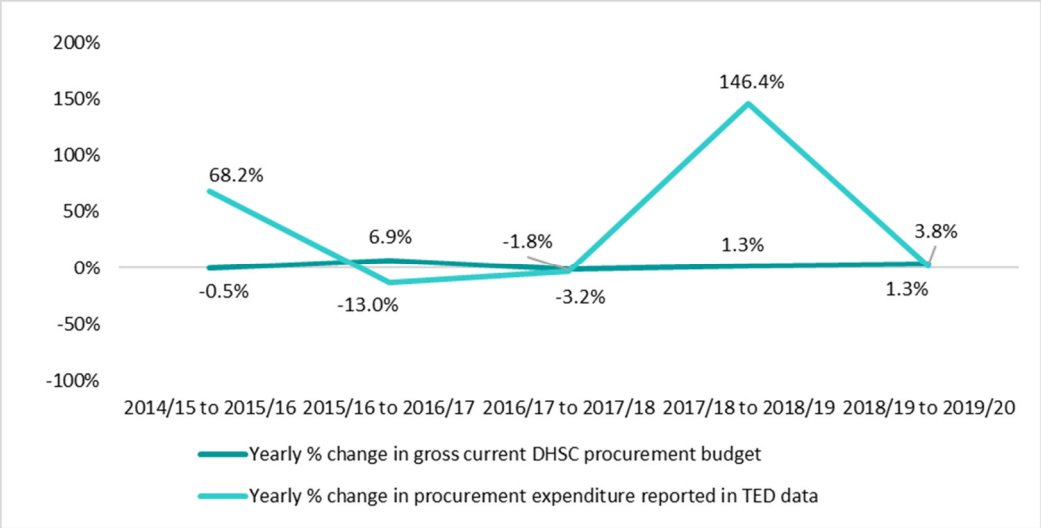
[9] NHSJobs.com: Supplies and Procurement vacancies | trac.jobs

[10] Earnings and hours worked, industry by four-digit SIC: ASHE Table 16 - Office for National Statistics (ons.gov.uk)

Annex 6: Scenario modelling and sensitivity analysis

1. Another big uncertainty in our modelling is the future trend of contracting activity. We explored different methods to forecast future contracting activity. We investigated the amount spent in healthcare services procurement 2014/15 to 2019/20 (chart 1) but variation between years it's too volatile so it's difficult to extract conclusions. We have instead assumed that the expenditure will grow in line with the growth experienced in gross current procurement in DHSC budget[11] over that period, that is 1.9%. We have then translated that into volume of contracts by using average contract prices.

Chart 1: Trends in growth rates 2014/15 to 2019/20 – gross current DHSC procurement budget and procurement expenditure reported in TED



2. There are multiple procurement procedures. More specifically, in TED we find 6 different types of procurement procedures. However, for the sake of this analysis we've categorised them in 3 main groups: open contracts (O), non-open contracts (NO) and contracts issued via direct awards (DA). The table below summarises the distribution of contracts awarded by different procurement procedures. While we believe there are significant differences between the types of procurements, we understand that it overcomplicates the analysis and adds little value when broken down in more than 3 groups.

Table 57: Distribution of contracts by procurement type and aggregation for this IA

Type of procurement (TED)	Contracts (N)	Contracts (%)	Type of simplified procurement	Contracts (N)	Contracts (%)
Award without prior publication of a contract notice	109	4%	Direct Award	178	6%
Negotiated without a call for competition	69	2%			
Competitive dialogue	48	2%	Non-open	438	16%
Negotiated with a call for competition	54	2%			
Restricted	336	12%			

[11] These figures are for the whole department and therefore not broken down into health services specifically. These figures represent procurement in budgets in England, rather than actual spending, this makes it easy to compare with TED data but does not really capture how much commissioners spend on health services. We explored other options, including gross current expenditure on health or DHSC material expenditure. However, we believe the gross current procurement in DHSC budget is the best comparator as our data does not capture how much commissioners spend on health services, the only data we have is on contract award value which tend to significantly differ from actual spend.

Open	2246	78%	Open	2246	78%
Total	3169	100%	Total	2862	100%

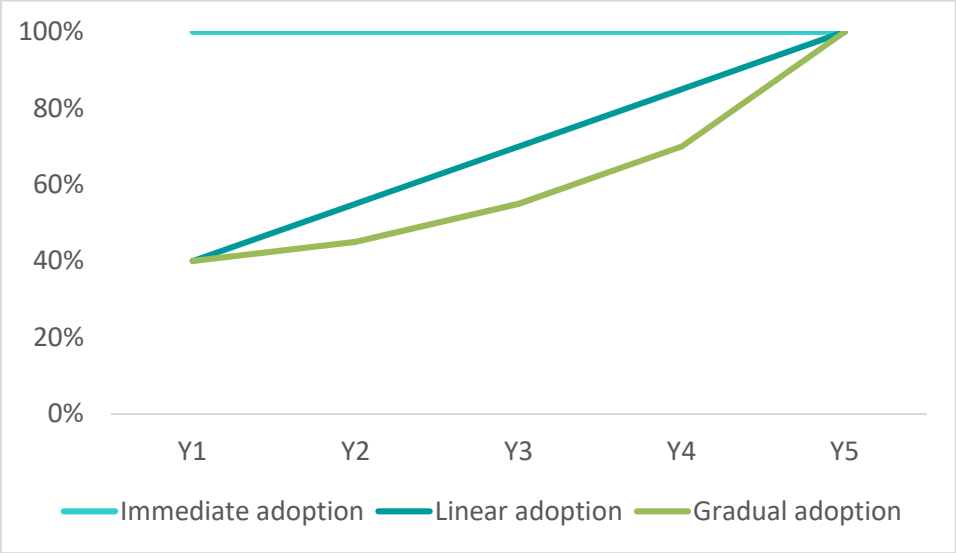
3. We assume that when the PSR is implemented, commissioners will benefit from the additional flexibility and award all of these contracts via direct award, which would generate savings for commissioners and providers. As this assumption is uncertain, we have produced the following scenarios.
    a. Low savings scenario: 50% of open and non-open procedures with only 1 bid would now be issued via direct award.
    b. Medium savings scenario: 100% of open and non-open procedures with only 1 bid would now be issued via direct award.
    c. High savings scenario: The number of open and non-open procedures will be reduced by 25% and instead issued via direct award.

4. The time profile of the changes in the proportion of procurement procedures that would occur as a result of the PSR in steady state, could significantly modify the policy impacts over the span of analysis. Based on extensive engagement with stakeholders, we have introduced an assumption that there will be a spike in year 1 when the PSR is first implemented, when all the contracts that have recently expired are retendered. We are uncertain when the impacts of the PSR will be felt, so we have considered 3 possible scenarios across the different impacts.
    a. Immediate adoption: 100% of all changes happen immediately after implementation, achieving steady state in FY 2023/24
    b. Linear adoption: We assume that it will take some time to reach steady state, as commissioners learn how the new system works and contracts end and require retendering. We assume that the impacts will be split evenly across years 2-5 following implementation.
    c. Gradual adoption: Again, we assume that impacts are not felt in full immediately after implementation. Learning takes time so adoption may be smaller in the first couple of years but will then catch up in the following three years.

Table 58: Summary of time profile scenarios for the impacts in this IA

		Y1	**Y2**	**Y3**	**Y4**	**Y5**
Immediate adoption	Yearly change	100%	0%	0%	0%	0%
	Cumulative change	100%	100%	100%	100%	100%
Linear adoption	Yearly change	40%	15%	15%	15%	15%
	Cumulative change	40%	55%	70%	85%	100%
Gradual adoption	Yearly change	40%	5%	10%	15%	30%
	Cumulative change	40%	45%	55%	70%	100%

Chart 2: Cumulative change of different time profile scenarios



Annex 7: Understanding Award Processes

Direct Award Process A

A relevant authority may only use Direct Award Process A when the nature of a service means there is no alternative provider (for example, Type 1 and Type 2 emergency services) the decision-maker may arrange this service directly with the sole provider without encountering unnecessary bureaucracy.

Direct Award Process B

A relevant authority may only use Direct Award Process B when arranging services for which patients have a statutory right to choice or if the relevant authority otherwise offers patients a choice of provider and does not limit the number of accredited providers from delivering the service. That is, the decision-maker must award a contract to a provider who is accredited to deliver that service without adding additional unwarranted process or bureaucracy. This may prevent confusion of how to arrange these services with providers and may prevent unnecessary barriers to providers for whose services patients have a right to choose from. Relevant authorities will be obligated to follow these rules when these specific scenarios apply.

Direct Award Process C

A relevant authority may use Direct Award Process C to re-award a contract to the incumbent provider when that provider is doing a sufficiently good job and the value of the contract has not changed beyond a threshold.. This process provides relevant authorities flexibility for when to re-award a contract which may prove helpful in a variety of circumstances. For example, this may be the best route to award because the incumbent plays a pivotal role in overarching health system design which cannot be replicated by another provider without introducing severe disruption which would outweigh any benefits obtained through retendering the contract. Additionally, the provider may be the sole provider who can provide specific healthcare services in a given geography or system.

The Most Suitable Provider Process (MSPP)

The MSPP gives relevant authorities flexibility to award a contract directly to an identifiable single most suitable provider. Again, this recognises that there are circumstances in which an identified provider should be awarded a contract either because of partnership working with other (collaboration), the interdependence of their services with wider services (integration), or because circumstance (rather than the nature of the service as above) means that they are the only suitable provider (e.g., a geography with a limited market of provider(s) who can deliver a certain service across a defined footprint).

The Competitive Process

Relevant authorities will continue to be able to use competitive tendering to arrange many health care services.

Annex 8: Provider Selection Regime, Independent Review Panel

Overview

1. The Provider Selection Regime (PSR) Independent Panel will provide a route for providers (including independent sector providers) to challenge decisions made under the PSR.

1. This panel will offer providers of healthcare services a single focal point for raising concerns over procurement and will be combined with the enforcement mechanism on patient choice.
2. We have designed this panel to help ensure that:
    a. procurement processes are fair, enabling both NHS and independent sector providers to compete for contracts
    b. providers are not unfairly excluded from offering services to patients on the NHS
    c. in respect to patient choice legislation – that patients' right to choices are respected
3. It has been agreed that:
    a. The panel will be chaired by an independent person.
    b. The panel will be empowered to look at both procurement (under the PSR) and patient choice issues.
    c. The panel's recommendations will be published online. This will give commissioners the incentive to reconsider their procurement decisions if they are recommended to do so. If the circumstances warrant it (e.g., if a commissioner is failing, or is at risk of failing, to carry out its commissioning functions effectively), then NHS England could intervene in its regulatory capacity to improve the commissioner's performance.
    d. A single chair will preside over the panel's functions and the outward facing aspect of the panel will present a single focal point for providers to raise their concerns – whether related to patient choice or procurement. This will help ensure a simple platform for providers to raise concerns to help win the confidence of the system.
    e. The panel will not charge providers or commissioners to review provider concerns.
    f. The panel will have a set of acceptance criteria which will determine whether a provider concern is legitimate and will be reviewed by the panel. This is to protect from specious claims. Government will work with NHS England and the eventual chair of the panel to produce these criteria. However, we agree that there should be no value threshold to determine which concerns may be escalated to the panel.

Recommendations

4. The panel will be able to recommend to commissioners to restart or return to an earlier stage of the procurement if the commissioner has not complied with the requirements of the PSR (including acting in line with the procurement principles and processes in the PSR regulations) or if a commissioner is failing, or is at risk of failing, to carry out its commissioning functions effectively.
5. The panel will make recommendations (after accepting a complaint from a provider) to commissioners *before* a contract is awarded. This will allow the commissioner to revisit its procurement processes and decisions before a contract award is made. A commissioner would retain the right in how to respond to the recommendations of the panel. However, we

expect commissioners to act in the interests of reducing risk and to therefore accommodate the panel's published recommendations wherever possible.

6. As an example, a commissioner may have decided to use the Most Suitable Provider Process to award a contract directly to a provider – but has not provided a justifiable reason in its statutory published notices which explains why direct award was used in this circumstance. A provider may then be concerned that the commissioner has taken the direct award process for reasons that run counter to the achievement of the procurement principles or to the effective exercise of its commissioning function (e.g., to save time or because they are under resource pressure). In doing so, the commissioner may have missed an opportunity to best achieve its duty to exercise its commissioning functions effectively and in keeping with the procurement principles. This may especially be the case if the service can be delivered by any suitable provider (not especially complex or with complex integration requirements) and there are genuine choices in the market.
7. In this scenario, the provider, having already undertaken efforts to resolve concerns with the commissioner through the local resolution process, may raise its concern with the panel. The panel would then review the decision and may, if merited, advise that the commissioner should have done things differently to achieve the best outcomes. This may come in the form of a recommendation for the commissioner to go back to the beginning of its decision-making and consider whether competition or direct award is most likely to achieve the best outcomes for patients and the taxpayer.

<u>The Process</u>

8. The future process would be:
    a. A provider makes a representation to the commissioner during the standstill period i.e., before the contract is awarded.
    b. The commissioner reviews the representation locally (as per the original proposals for the PSR) including by establishing a dialogue with the provider and by sharing all information it has a duty to record (including reasons for the decision) with the provider. This review should include individuals not involved in the original decision in appropriate positions to preserve the integrity of the review.
    c. The commissioner shares their decision with the provider.
    d. If the provider remains unsatisfied, the provider can then ask for the PSR decisions to be reviewed by the 'panel'. The standstill period will be extended to allow the panel to complete the review.
    e. The panel, supported by a central secretariat, would compile evidence (as necessary and proportionate) to review the decisions made by the commissioner and to establish whether the commissioner followed the regime appropriately – including whether the procurement principles set out in the regime were best achieved by the commissioner's approach and whether the commissioner carried out its commissioning function effectively.
    f. The panel would provide its recommendations to the commissioner and publish them online. The panel would also alert NHS England and DHSC to the recommendations.
    g. The commissioner responds to the recommendations and decides whether to revise its procurement processes or decisions.