



Provider Selection Regime: consultation on the detail of proposals for regulations

About us

FODO – The Association for Eye Care Providers is the leading national association for eye care providers working in primary and community care settings. Each year our members provide over 18 million eye examinations and offer a wide range of other eye care services across the UK.

We welcome the opportunity to submit our views on the Department of Health and Social Care (DHSC) Provider Selection Regime (PSR) consultation.

Response to consultation questions

In what capacity are you responding to this consultation?

- ☐ An individual sharing my personal views
- ☐ A member of the public
- ☒ On behalf of an organisation

Which of the following best describes the organisation you work for?

- ☐ Civil society Organisation
- ☐ Clinical Commissioning Group
- ☐ Combined authority
- ☐ Commissioning Support Unit
- ☐ Local Authority
- ☐ NHS Foundation Trust
- ☐ NHS Trust
- ☒ Organisation representing healthcare interests
- ☐ Voluntary, community and social enterprise provider
- ☐ Other independent provider
- ☐ Other interested stakeholder
- ☐ Other

Do you represent a small or medium enterprise (SME)?

- ☒ Yes
- ☐ No

Which of the following best describes your role?

- ☐ Procurement specialist

- ☐ Commissioner
- ☐ Legal practitioner
- ☐ Service provider
- ☐ Finance
- ☐ Clinician
- ☒ Other

CPV codes

To what extent do you agree or disagree that the inclusion of a list of CPV codes in the regulations for the Provider Selection Regime would help to clarify the scope of the regime and promote understanding of when the regime applies?

- ☐ Strongly agree
- ☐ Agree
- ☐ Neither agree or disagree
- ☐ Disagree
- ☒ Strongly disagree

Please explain your answer:

We appreciate that procurement specialists have suggested DHSC should add a list of Common public Procurement Vocabulary (CPV) codes to the regulations. CPV codes however were not designed for this purpose. We therefore disagree with CPV codes being listed in the regulations for the following reasons:

- The scope of healthcare services is defined in the Health and Care Bill, other primary legislation (e.g. National Health Service Act 2006) and the DHSC consultation itself. Including CPV codes in the regulations would not add clarity or benefit.
- The Provider Selection Regime (PSR) clearly defines what is within scope and adding CPV codes to regulations might give them a spurious authority which could have unintended consequences – e.g. resulting in some scenarios which fail to promote the interests of patients, the taxpayer and population (a key objective of the PSR).
- CPV codes are a high-level classification system for public procurement; this is not the same as a comprehensive classification system that captures all services that will come under scope of the PSR – e.g. it is recognised that CPV codes do not always describe services and require “contracting authorities [...] to try and find the code that suits their envisaged purchase as accurately as possible” (Reference: <https://simap.ted.europa.eu/cpv>). It is hard to see the benefit of including this in the regulations
- Including CPV codes in regulations would risk ‘locking in’ codes which:
 - do not cover the full range of healthcare services in England - e.g. the CPV system is an international coding mechanism and might not always be generalisable to NHS settings in England (see our response to the next question)
 - would lead to important services where significant benefits can be achieved being subsumed within broader categories and not given the attention they deserve to the detriment of patients, the population and the taxpayer

- would require Regulations to be updated whenever codes are updated, creating an overly bureaucratic process.

Instead of including CPV codes in the regulations, in our view, it would be more pragmatic to set out in the statutory PSR guidance that decision-making bodies should:

- use a CPV code when notifying providers about commissioning intentions and
- where possible include any other descriptor(s) which will help ensure transparency – e.g. enhanced primary eye care services, community optometry etc.
- do this with a view to optimising NHS resources and promoting the interests of patients, the taxpayer and population.

To what extent do you agree or disagree that the list of codes presented in the consultation document accurately represent our aims for defining the scope of healthcare services?

- ☐ Strongly agree
- ☐ Agree
- ☐ Neither agree or disagree
- ☒ Disagree
- ☐ Strongly disagree

Are there CPV codes that you think should be included from the list?

The CPV system is a ‘hit and miss’ classification system for public procurement aimed at standardising the references used by contracting authorities and entities to describe the subject of procurement contracts. It is best used for advertising procurement contracts and is not a comprehensive list of every service that might come under the Provider Selection Regime (PSR).

For example, CPV codes typically describe health care services in an international context, and this explains why there are no separate CPV codes for enhanced primary eye care, optometry etc as standalone models of care. However, in the context of the English NHS, these services are sufficiently important (when considering the health gain and populations served) to have their own ‘code’. It is not clear however that new CPV codes can be proposed in England if they do not fit within the international nomenclature; nor that they would be CPV codes if they were added.

In summary, it seems unnecessary, and potentially unhelpful, to list CPV codes in the regulations. It would be preferable to include them in guidance which advises commissioners to use them with additional detail and other qualifiers to ensure they are used as intended and do not inadvertently mislead or undermine the core purpose of the PSR.

Are there CPV codes that you think should be excluded from the list?

Please see our responses to questions above which set out why, in our view, a list of CPV codes should not be listed in the regulations.

What other types of service (apart from social care) do you think may be arranged in a contract for which the main subject matter is healthcare, which we should be aware of?

We believe the Health and Care Bill, in the context of NHS care in England, defines healthcare and healthcare services sufficiently well. This, read alongside the NHS Constitution, should provide the

necessary information that DHSC, NHS England, ICBs and other decision-making bodies need when thinking about contracts for which the main subject matter is healthcare.

To what extent do you agree or disagree that the list of codes presented under the heading 'Proposals: Mixed Procurement' of the consultation document accurately represent our aims for defining the scope of social care services which may be arranged with healthcare services?

- ☐ Strongly agree
- ☐ Agree
- ☐ Neither agree or disagree
- ☒ Disagree
- ☐ Strongly disagree

Please see our response to questions above which explain why, in our view, CPV codes should not be used in this context.

Are there CPV codes that you think should be included from the list?

Please see our response to questions above which explain why, in our view, CPV codes should not be used in this context.

Are there CPV codes that you think should be excluded from the list?

Please see our response to questions above which explain why, in our view, CPV codes should not be used in this context.

Threshold for 'Considerable Change'

We welcome respondents' views on the suggested formulation of what constitutes a considerable change as set out in the consultation document.

To what extent do you agree or disagree that a threshold for considerable change should require both a change of set amount in contract value and a percentage change in contract value?

- ☐ Strongly agree
- ☐ Agree
- ☒ Neither agree nor disagree
- ☐ Disagree
- ☐ Strongly disagree

Please explain your answer:

There are risks that rigid thresholds will inevitably have unintended consequences in some circumstances. We therefore believe that such risks should be mitigated in the public interest by using statutory PSR guidance to set out:

- more detailed guidance on how to make judgement calls about what constitutes considerable change, even when the variation might be below the stated threshold, and
- when to consider an alternative to decision-making circumstance 1c.

To what extent do you agree or disagree that a change in contract value of over £500,000 is an appropriate threshold when considering what constitutes a considerable change?

- ☐ Strongly agree
- ☐ Agree
- ☒ Neither agree or disagree
- ☐ Disagree
- ☐ Strongly disagree

Please explain your answer:

There are risks that rigid thresholds will inevitably have unintended consequences in some circumstances. We therefore believe that such risks should be mitigated in the public interest by using statutory PSR guidance to set out:

- more detailed guidance on how to make judgement calls about what constitutes considerable change, even when the variation might be below the stated threshold, and
- when to consider an alternative to decision-making circumstance 1c.

To what extent do you agree or disagree that a change in contract value of over 25% is an appropriate threshold when considering what constitutes a considerable change?

- ☐ Strongly agree
- ☐ Agree
- ☒ Neither agree or disagree
- ☐ Disagree
- ☐ Strongly disagree

Please explain your answer:

There are risks that rigid thresholds will inevitably have unintended consequences in some circumstances. We therefore believe that such risks should be mitigated in the public interest by using statutory PSR guidance to set out:

- more detailed guidance on how to make judgement calls about what constitutes considerable change, even when the variation might be below the stated threshold, and
- when to consider an alternative to decision-making circumstance 1c.

Do you have any views on how this formulation may be improved?

- ☒ Yes
- ☐ No

In our view, setting rigid thresholds in regulations will almost certainly have unintended consequences to the disbenefit of patients, and would not be the best way forward. Instead, it would be preferable for decision-makers to be guided by the statutory guidance on the PSR, which should set out the detail about how to decide what constitutes a considerable change with additional safeguards as necessary. This would, in turn, ensure decision-making circumstance 1c is used appropriately and that decision-making bodies do not unnecessarily default to using decision-making circumstance 2 and 3.

We would welcome the opportunity to review the draft statutory guidance on the PSR which, given its significance, we would hope will be consulted on too.

Contract Variations

We welcome respondents' views on the formulation of contract variations, as set out in the consultation document, which would not warrant reapplication of the Provider Selection Regime.

To what extent do you agree or disagree that the list of variations should not warrant the reapplication of the Provider Selection Regime (such as selecting a provider through Decision-Making Circumstance 2 or Decision-Making Circumstance 3)?

- ☐ Strongly agree
- ☐ Agree
- ☐ Neither agree or disagree
- ☒ Disagree
- ☐ Strongly disagree

Please explain your answer:

We agree that, when it is in the best interests of patients, the population and the taxpayer, decision-makers should not have to use circumstance 2 or 3.

Most of the criteria support this aim and this should enable decision-makers to use circumstance 1c with confidence when they choose to do so.

We are not convinced, however, that “changes in contract value which are driven by changes in patient volume” are always “external causes beyond the control of the decision-making body”. In our experience, changes in patient volume are often down to decision-makers’ failure to appropriately assess local needs or discuss these with providers or potential providers in advance.

This is why, in our view, “changes in contract value which are driven by changes in patient volume” should be removed or clarified to ensure it only refers to circumstances that are genuinely beyond the influence of the decision-making body.

The statutory PSR guidance could address all these points. We would be happy to support such guidance and hope to see the DHSC consult on this important guidance in due course.

To what extent do you agree or disagree that a threshold for considerable change for the purpose of contract variations should be subject to both a change of set amount in contract value or a percentage change in contract value?

- ☐ Strongly agree
- ☐ Agree
- ☒ Neither agree or disagree
- ☐ Disagree
- ☐ Strongly disagree

Please explain your answer:

There are risks that rigid thresholds will inevitably have unintended consequences in some circumstances. We therefore believe that such risks should be mitigated in the public interest by using statutory PSR guidance to set out:

- more detailed guidance on how to make judgement calls about what constitutes considerable change, even when the variation might be below the stated threshold, and
- when to consider an alternative to decision-making circumstance 1c.

To what extent do you agree or disagree that a change in contract value of over £500,000 is an appropriate threshold when considering what constitutes a considerable variation for this purpose?

- ☐ Strongly agree
☐ Agree
☒ Neither agree or disagree
☐ Disagree
☐ Strongly disagree

Please explain your answer:

There are risks that rigid thresholds will inevitably have unintended consequences in some circumstances. We therefore believe that such risks should be mitigated in the public interest by using statutory PSR guidance to set out:

- more detailed guidance on how to make judgement calls about what constitutes considerable change, even when the variation might be below the stated threshold, and
- when to consider an alternative to decision-making circumstance 1c.

To what extent do you agree or disagree that a change in contract value of over 25% is an appropriate threshold when considering what constitutes a considerable variation?

- ☐ Strongly agree
☐ Agree
☒ Neither agree or disagree
☐ Disagree
☐ Strongly disagree

Please explain your answer:

There are risks that rigid thresholds will inevitably have unintended consequences in some circumstances. We therefore believe that such risks should be mitigated in the public interest by using statutory PSR guidance to set out:

- more detailed guidance on how to make judgement calls about what constitutes considerable change, even when the variation might be below the stated threshold, and
- when to consider an alternative to decision-making circumstance 1c.

Do you have any views on how this formulation may be improved?

- ☒ Yes
☐ No

If answering 'yes', what changes would you make and why? Please provide specific examples and rationale

In our view, setting these thresholds in regulations will almost certainly result in unintended consequences and disbenefits for patients, the population and the taxpayer. Instead, it would be preferable for decision-makers to be guided by the statutory guidance on the PSR. This could set out the detail on variation and provide opportunities to introduce additional safeguards as necessary. This would, in turn, ensure decision-making circumstance 1c is used appropriately and that decision-making bodies do not unnecessarily default to using decision-making circumstance 2 and 3.

Patient Choice

If establishing lists of providers for non-legal right to choice services for patients to exercise choice, do you think that decision-making bodies would intend to limit these lists to a set number of potential providers?

☒ Yes

☐ No

Please explain your answer:

First, we welcome the Provider Selection Regime (PSR) intention to focus on the best interests of patients, the taxpayer and population, and to cut bureaucracy and costs associated with commissioning in general. It is, however, not clear why decision-making bodies should be encouraged to misapply the concept of AQP as proposed.

When NHS England consulted on the PSR in February 2021, it did not present two alternative AQP models and it is not clear why this duality, which potentially reframes and muddies the concept of AQP, has been introduced or what issue it is seeking to address.

So, although we think that, if it is allowed, some decision-making bodies are likely to limit the number of providers on such lists, it is important to avoid this scenario under the AQP option if AQP is to deliver its intended purpose and benefits. If it is not, then another commissioning option should be used.

The problem described above can be avoided through good guidance and support for decision-making bodies, so that they understand how correctly to apply provider selection options in each circumstance – i.e. either take full advantage of AQP (under circumstance 1b) or transparently use circumstances 2 and 3 to commission care.

Decision-making bodies should objectively understand and assess the benefits of AQP (under circumstance 1b), when considering that using that option. These may include:

- providing a cost-effective and less bureaucratic way to arrange services compared to circumstance 2 and 3
- when applied properly, incentivising providers to improve quality, efficiency, transparency and value for money at a much more rapid rate than will be possible under circumstance 1c, 2 or 3
- not requiring decision-making bodies to pick winners or limit the number of providers, as this will happen naturally with providers not mobilising if they cannot meet the criteria or where there is insufficient patient demand because other providers are already delivering quality and high value care

- incentivising all providers to innovate and invest with a longer-term horizon, as they can focus on long-term service sustainability rather than repetitive tendering on a three or five-year cycle
- sending providers a clear signal about value and sustainability – e.g. if a decision-making body felt there were too many providers under circumstance of AQP1b they would have the ability to engage with all providers to secure the best value in the short and long run.

In summary, the theoretical and improbable risk that there will be an excessive number of providers should not result in decision-makers capping the number of providers on these lists, as this will forego precisely the opportunities AQP was designed to deliver for patients, the taxpayer and population.

It is for these reasons that we would strongly recommend that statutory guidance on the PSR ensures decision-making bodies understand how best to utilise AQP and apply qualification criteria and provider performance to manage capacity, rather than arbitrarily restricting the number of providers and limiting the short, medium and long-term benefits for patients, the taxpayer and population, and thereby undermining the objectives of the PSR and NHS reforms.

We also feel that building in an ongoing bias to the traditional model of consultant-led outpatient care is outdated and counterintuitive, given the NHS Long Term Plan aims to reduce dependence on secondary care and to transform the “outdated and unsustainable” model of outpatients.

This also runs counter to the agreement of health policy experts and the government that the NHS needs to provide more care out of hospital and closer to home, at lower cost and with a greater focus on prevention, if the NHS is to be sustainable. It is therefore vital that the PSR supports and does not inadvertently block this change and impede innovation and moving elective care into non-consultant led community settings where it is safe to do so.

Limiting choice to consultant-led elective care, as set out in the NHS Constitution now a decade old, is anti-innovation and out of sync with the goals of the NHS Long Term Plan, the Health and Care Bill, and the principles underpinning the PSR.

If establishing or altering lists of providers for non-legal right to choice services with a limited number of providers, do you agree or disagree that decision-making bodies should select providers using decision-making circumstances 2 or 3 of the Provider Selection Regime?

- ☐ Strongly agree
- ☒ Agree
- ☐ Neither agree or disagree
- ☐ Disagree
- ☐ Strongly disagree

Please explain your answer:

Further to our feedback on the question above – about the appropriate use of AQP for non-consultant led services – we agree that, if a decision-making body wishes to commission from only a small number of providers, then it should use circumstances 2 and 3 of the PSR.

Transparency

To what extent do you agree or disagree that the notice which states the decision-making bodies intention to award a contract to a provider should also include:

a) A statement explaining the balancing of key criteria which they used to make a decision?

- ☐ Strongly agree
☒ Agree
☐ Neither agree or disagree
☐ Disagree
☐ Strongly disagree

b) A statement explaining the decision-making body's rationale for choosing the successful provider?

- ☐ Strongly agree
☒ Agree
☐ Neither agree or disagree
☐ Disagree
☐ Strongly disagree

Please explain your answers:

We agree with the DHSC that:

- “The principle of transparency in public procurement is central to the integrity and accountability of the system and the fight against corruption. It ensures opportunities are accessible, and processes and decisions can be monitored and scrutinised”
- “The aim of transparency arrangements in the Provider Selection Regime is to ensure that the outcomes of decisions made under the regime are made public and that sufficient scrutiny is applied to ensure the regime is followed in good faith”.

A statement explaining the decision-making body's rationale for choosing the successful provider is a key part of this.

However, we do think more needs to be done to promote transparency and accountability in order to protect the interests of patients, the taxpayer and population. We would therefore like to see more detail on transparency and accountability in the statutory guidance on the PSR. We hope DHSC will hold a public consultation on the guidance as part of the commitment to promoting the principles of transparency and accountability with regard to this important guidance.

Is there other information that you think would be helpful to publish in this notice?

Yes

Please explain your answer including reference to advantages and disadvantages

The PSR understandably aims to challenge bureaucracy and reduce the unnecessary transaction costs in the current NHS commissioning system – aims that we support. We therefore welcome the direction of travel and initial safeguards to ensure decision-makers act in the best interests of patients, the taxpayer and population.

However, when decision-makers opt for circumstance 1c, 2 or 3, it is important that they provide sufficient information to allow stakeholders (e.g. patient groups, providers and others) to objectively

assess the decision making process. We hope this will be set out in statutory guidance on the PSR and we would be happy to contribute to the development of the draft guidance either directly or via consultation.

Annual Summaries

We propose decision-makers must publish a summary of their application of the Provider Selection Regime annually (for example, via the decision-making body's annual reports or annual governance statement). This summary must include:

- the number of contracts re-awarded under decision-making circumstances 1A, 1B and 1C in that year
- the number of contracts let through decision-making circumstances 2 and 3
- the total number of providers contracted with; number of new providers contracted with; number of providers who no longer hold any contract
- the numbers of representations received and the outcome of those representations.

To what extent do you agree or disagree with our proposals around annual summaries?

☒ Strongly agree

☐ Agree

☐ Neither agree or disagree

☐ Disagree

☐ Strongly disagree

Please explain your answer:

In our view, this is an important safeguard for patients, the taxpayer and population. These annual summaries will hopefully provide useful data to help ensure the Provider Selection Regime is working as intended, that best practice is promoted and that unwarranted variation in decision-making is objectively analysed.

Is there any additional information you would suggest for inclusion in these summaries?
Please provide specific examples where possible

It might be helpful for the summaries to include a little more detail viz:

- the number of contracts re-awarded under each of decision-making circumstances 1A, 1B and 1C in that year and the estimated annual value of each contract and overall duration, other than primary care contracts under 1B
- the number of contracts let through each of decision-making circumstances 2 and 3 and the value and duration of each contract
- the total number of providers contracted with; number of new providers contracted with; number of providers holding fewer contracts than the year before; and the number of providers who no longer hold any contract
- the numbers and scale of representations received and the outcome of those representations.

It would also be helpful however if each decision-making body (ICB in most cases) publishes data in a standardised format so that it is possible to compare different commissioners – e.g. decision-making bodies which have had fewer challenges than others etc.

Further questions on establishing the PSR

How many people in your organisation do you anticipate will need to be aware of the new Provider Selection Regime?

- ☐ Less than 10
- ☐ 10 to 20
- ☐ 21 to 30
- ☐ 31 to 40
- ☐ 41 to 50
- ☒ More than 50

What function(s) do these people have? For example, procurement specialists or commissioners or senior leaders

Our response considers people in our organisation and members' organisations. These include clinicians, provider organisations, procurement specialists, and other subject matter experts.

Where possible, we would be grateful if you could state the function and then the number of people who have that function.

NA

To what extent do you agree or disagree with this statement: My organisation will be able to successfully transition from the current arrangements to the new Provider Selection Regime?

- ☐ Strongly agree
- ☒ Agree
- ☐ Neither agree or disagree
- ☐ Disagree
- ☐ Strongly disagree

Please explain your answer:

As a membership body, we will transition to the new Provider Selection Regime and support members and the wider sector (including patient groups) understand and transition to the new way of working.

If applicable, please outline any main challenges you anticipate for implementing the Provider Selection Regime in your organisation.

There are two main challenges:

1. Decision-making bodies (ICBs in particular) will struggle to manage their complex and, at times, vested interests in maintaining financial sustainability unless those on the Board are also committed to reducing the size of their own organisations – as this is key to delivering the Long-Term Plan goal to reduce dependence on the hospital model of care, and especially the “outdated and unsustainable” mode of outpatients care

2. Although we welcome tackling bureaucracy and associated costs in the current commissioning system so that more can be invested in frontline services, we think a major gap is the ability for important stakeholders – e.g. patient groups et al., – to challenge decision-making without the need to revert to judicial review.

The new decision-making structure within the NHS might make it difficult for smaller providers (non-hospitals) that provide important services (those that prevent sensory loss and associated costs) to be heard within the ICB model.

For example, one risk is that large ICBs will have too much to cover and do, and will – given the make-up of the Board – have a bias towards hospital-based models of care.

Where ICBs fail to act quickly – e.g. not moving care out of hospital at pace, which is critical to solving the crisis in ophthalmology – then trusts are likely to remain under financial pressure and ICBs might struggle to shift care because they cannot balance the books without new transformation funding.

If, however, decision-making bodies have clear and comprehensive statutory guidance on the PSR that works in the best interests of patients, the taxpayer and population, and provides mechanisms for stakeholders – e.g. patient groups et al., – to fairly challenge decision-making, this risk can be mitigated.

We therefore hope that:

- the statutory guidance on the PSR will be co-produced and consulted on in the best interests of patients, the taxpayer and population
- DHSC will review the process by which decision-makers can be challenged before having to revert to judicial review.

We would welcome the opportunity to take part in and contribute to the development of statutory guidance on the PSR.

NHS England are currently planning to provide certain tools to support the immediate implementation of the PSR. How useful would each of the following resources be to your organisation?

Webinars (including online questions and answers)

- ☐ A great deal
- ☒ A fair amount
- ☐ Just a little
- ☐ Not at all

Template documents for decision-making bodies to use when making and recording decisions under the PSR

- ☐ A great deal
- ☒ A fair amount
- ☐ Just a little
- ☐ Not at all

Process flow diagrams

- ☐ A great deal
- ☒ A fair amount
- ☐ Just a little
- ☐ Not at all

If you think there any other tools or forms of support that would help your organisation implement the PSR, please provide details.

One major advantage of the new landscape will be that ICBs will be able to tackle unwarranted variation across a larger geographical footprint. Decision-making bodies should therefore be given support to access innovative models of care, best value pathways of care, and advice on how to secure quality services. We, along with sector partners, will continue to work with DHSC and NHSE to help this happen.

After the initial implementation phase of the PSR, if you think there are any other ways that DHSC or NHSE can support your organisation with the successful operation of the PSR in the medium or long term future, please provide details.

We welcome the shift towards collaborative ways of working that focus on the NHS working for patients, the taxpayer and NHS. We would welcome ongoing engagement with DHSC and NHSE as discussed at recent meetings.

If you know of any existing professional networks or communities of practice that you recommend we should engage with on the implementation of the Provider Selection Regime, please provide details.

We would welcome ongoing engagement with:

- Members of FODO – The Association for Eye Care Providers. Our members provide the majority of primary and community-based eye care services in England
- Primary eye care working group, which brings together ABDO, AOP, the College of Optometrists, FODO and LOCSU
- The Clinical Council for Eye Health Commissioning (CCEHC), an independent advisory body representing the leading clinical professions and charity organisations in the eye-care sector in England.

Costs and Savings: Short-term or Familiarisation Costs

Noting that DHSC and NHS England will support the system to help prepare for change, DHSC welcomes views on what other familiarisation costs may be associated with establishing the Provider Selection Regime.

Do you agree or disagree that your organisation would incur short-term costs from the familiarisation of and transitioning to the Provider Selection Regime?

- ☒ Agree, there would be costs
- ☐ Disagree, there would not be costs

☐ I don't know

How do you anticipate these short-term costs would arise?

If possible, please provide a breakdown and estimate of these costs in pounds.

[We will need to support members and the wider sector transition to the new Provider Selection Regime.](#)

To what extent could these costs be accommodated in your organisation's budget?

[NA](#)

Costs and Savings: Ongoing Operational Costs and Savings

Do you anticipate that your organisation will incur any increased operational or running costs when arranging services under the Provider Selection Regime compared with the existing operational costs when arranging services under the current procurement rules?

☐ Yes

☒ [No](#)

☐ I don't know

Please explain your answer and provide specific examples where possible.

[Not after transition, assuming the PSR is refined in the light of consultation and that guidance is consulted on and has the support of providers and the patient groups affected.](#)

Do you anticipate that your organisation will realise any operational savings when arranging services under the Provider Selection Regime compared with arranging services under the current procurement rules?

☐ Yes

☒ [No](#)

☐ I don't know

Please explain your answer and provide specific examples where possible.

[NA](#)

Email consent

Is it okay for the Department of Health and Social Care to contact you by email about your response?

☒ [Yes](#)

☐ No

Would you like to receive updates about other Department of Health and Social Care consultations?

☒ [Yes](#)

☐ No

What is your email address?

Your contact details will not be shared with anyone outside the consultation team

healthpolicy@fodo.com

Feedback

How satisfied are you with the consultation process?

- ☐ Very satisfied
- ☐ Satisfied
- ☒ Somewhat satisfied
- ☐ Disappointed

How did you hear about the consultation?

- ☐ Social media
- ☐ Received an email
- ☐ Word of mouth (family, friend or colleague)
- ☐ Direct communication from third sector organisation or regulatory organisation
- ☐ Broadcast news (TV or radio)
- ☒ GOV.UK or other government website
- ☐ Newspaper (online or print)
- ☐ Website (non-government)
- ☐ Trade magazine
- ☐ Other