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NIHR Policy Research Unit in Health and Social Care Systems and Commissioning (PRU HSSC)

Report: *Procuring health care services under the Provider Selection Regime: understanding experiences of Integrated Care Systems*

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Research Team

Dr Dorota Osipovic (London School of Hygiene and Tropical Medicine)

Dr Christina Petsoulas (London School of Hygiene and Tropical Medicine)

Professor Pauline Allen (PI) (London School of Hygiene and Tropical Medicine)

Dr Marie Sanderson (London School of Hygiene and Tropical Medicine)

Contact: Dr Dorota Osipovic (Dorota.Osipovic@lshtm.ac.uk)

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MANCHESTER 1824 The University of Manchester

LONDON SCHOOL of HYGIENE &TROPICAL MEDICINE

University of Kent

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Executive Summary

Study aims, objectives and methods

The Health Care Services (Provider Selection Regime) Regulations 2023 (SI 2023/1348) (PSR) came into force on 1 January 2024. The PSR regulations govern how the relevant authorities (Integrated Care Boards (ICBs), NHS England, NHS trusts, NHS foundation trusts, local authorities and combined authorities) procure health care services in England. The PSR was introduced because the old rules encouraged competitive tendering as a preferred procurement mechanism, which often conflicted with the policy goal of fostering collaboration and system working.

The PSR replaced the previous legislative framework with a sector-specific regime governing the procurement of health services. The aims of the PSR included increasing flexibility for commissioners, reducing unnecessary competitive tendering and administrative burden, improving transparency and supporting the development of "stable collaborations between providers" (EM 2023/1348, point 7.4). The PSR introduced five procurement routes (including direct award and competitive processes) available to the relevant authorities when selecting service providers. Under the PSR, relevant authorities must, among other things, document their procurement decisions, publish transparency notices, and handle provider complaints locally.

In 2025, the Department of Health and Social Care (DHSC) commissioned the NIHR Policy Research Unit in Health and Social Care Systems and Commissioning (NIHR PRU HSSC) to conduct a responsive, qualitative study to explore how the ICB commissioners and health services providers view and apply the PSR regulations. The study aimed to address the extent to which some of the intended goals of this legislation were being realised as perceived by commissioners and providers, in particular with regard to increasing transparency and flexibility in procurement decision making, reducing bureaucracy in administering procurements and facilitating partnership working.

The study was guided by the following research questions:

1. What are the ICBs', NHS trusts/FTs' and independent providers' views of the new Provider Selection Regime?
2. How and by whom are the decisions about an appropriate procurement route made in ICSs? How does this vary with the type and scale of health services being commissioned?

3. How does the PSR differ from the previous procurement regime in aspects such as the amount of flexibility, administrative burden, exposure to potential procurement disputes and ensuring provider sustainability?
4. How does the PSR align with the strategic approach to commissioning pursued by the ICBs and the national policy goal to increase collaboration across the system?

We conducted 16 semi-structured, in-depth interviews with senior and middle level managers in three ICBs and selected NHS and non-NHS provider organisations supplying health services to these ICBs. The fieldwork took place between May 2025 and September 2025.

Summary of findings

1. *What are the ICBs', NHS trusts/FTs' and independent providers' views of the new Provider Selection Regime?*

Overall, there was a favourable reception of the PSR regulations by interviewed commissioners and providers, with most participants perceiving the PSR as delivering improvements on the previous framework. However, there were different views as to how the regulations should be applied in particular circumstances, due to the high flexibility of the PSR and divergent organisational interests of commissioners, public and private sector providers.

ICB interviewees liked the wide range of options and less emphasis on competition allowed by the PSR. However, they perceived there was an increased administrative burden due to the strengthened transparency and due diligence requirements and localised dispute resolution processes, as well as the lack of financial thresholds exempting small value procurements. Providers noted a lot of variation in the way that commissioners interpreted the legislation, in areas such as the requests for information to accompany direct award processes or interpretations of key criteria for procurement. Independent providers welcomed the new procurement regime, praising the increase in transparency of commissioning decisions, enabling fair competition and reducing non-compliance compared with the previous regime. However, they also noted that there was a wide scope for misinterpretations and misunderstandings around the application of the new rules.

2. *How and by whom are the decisions about an appropriate procurement route made in the ICSs? How does this vary with the type and scale of health services being commissioned?*

The ICBs, as statutory commissioners, were the organisations making the majority of procurement decisions in their footprints. The involvement of providers in procurement decision making was minimal. Some providers (such as mental health NHS trusts) were also trying themselves in the new role as 'micro-commissioners' of services for which they had a form of delegated responsibility through lead provider contracts but were finding this new role quite challenging.

The ICB structures and processes governing procurement decision-making were locally determined and thus varied between the three ICBs. The three ICBs varied in terms of staff resources and the maturity of the internal structures and processes. All three ICBs relied on external support from the Commissioning Support Units (CSUs) or similar organisations. We also found that in addition to the administration of the PSR, the same staff within the ICBs were also in charge of the two separate, resource-intensive processes, interfacing with the PSR – non-NHS provider accreditation under the patient choice regulations and the application of the Procurement Act 2023. All this together put considerable pressure on the ICBs' commissioning, procurement and contracting staff, which in practice often comprised a small core team of individuals.

Although the ICBs varied in terms of their internal processes governing procurement decisions, all health services procurements, regardless of the type and scale of health services being commissioned, were subject to these internal processes, as all health services fell under one of the PSR procurement routes. This was seen as one of the positive aspects of the PSR, which removed grey areas around procuring large NHS contracts, which now had to be reprocured using direct awards.

3. *How does the PSR differ from the previous procurement regime in aspects such as the amount of flexibility, administrative burden, exposure to potential procurement disputes and ensuring provider sustainability?*

The PSR represents a significant change in the regulation of health services procurement compared with the previous legal framework under the Public Contracts Regulations 2015 and the Procurement, Patient Choice and Competition Regulations 2013. The participants noted greater flexibility under the PSR for making procurement route decisions, increased transparency and audit trail requirements, a changed dispute resolution process and a greater experienced administrative burden of the PSR compared with the previous framework.

The views of commissioners about the flexibility and discretion allowed by the PSR were generally positive, but not consistent. PSR was seen as clearer than the previous regime and better aligned with a full spectrum of commissioning activities and the commissioning cycle. However, whilst flexibility was on the whole welcome, it was sometimes seen as a double-edged sword. Some interviewees were concerned that, in comparison to the previous regime, the greater flexibility and local discretion under the PSR could lead to uncertainty, multiple interpretations of the rules, and unwarranted variation in commissioning practices. Providers mentioned that the increased flexibility and discretion in applying the PSR rules translated into inconsistent commissioning and procurement approaches for similar services in different geographical areas. Some providers suggested that more standardisation in the interpretation of the rules, definitions and approaches may be required. At the same time, some interviewed providers observed that commissioners were not yet sufficiently utilising the flexibilities of the PSR.

Many ICB interviewees noted a higher administrative burden under the PSR, which was not anticipated, and which put a great strain on limited ICB resources at the time of the proposed cuts to the ICBs. The higher administrative burden was discussed in the context of such aspects as a lack of thresholds for small value contracts, transparency notice requirements, greater emphasis on evidencing provider performance and local dispute resolution process. The increased administrative burden was borne by the existing staff in the ICBs, which in some cases led to a decrease in professional development opportunities. The views on increased, unforeseen administrative burden associated with the PSR were echoed by NHS and independent providers who felt that commissioners raised more extensive and speedier requests for information.

Participants held nuanced views on the increased transparency requirements of the PSR. Some thought that the transparency requirements decreased the risk of procurement disputes, increased market engagement and promoted the development of markets in services. Others thought that transparency requirements increased the risk of challenges, especially by the more commercially aggressive providers, questioning who is benefiting from the increased transparency. The publication of transparency notices was complicated by the lack of PSR-specific notice templates.

ICB interviewees were concerned about the ease with which the providers could raise representations and about the possibility of raising them multiple times. The PSR rules did not specify the grounds for challenging commissioning decisions. This was seen by the ICB interviewees as imbalanced. On the other hand, some providers stressed that they were reluctant to challenge procurement decisions to avoid reputational damage and because it was difficult to change the substantive outcomes of those decisions. Some private providers also commented on the Independent Patient Choice and Procurement Panel's advisory role and a lack of power to direct commissioners.

Some interviewed providers felt that, in comparison to the previous regime, the greater flexibility and local discretion embedded in the PSR made it harder for providers to 'read' and respond to commissioners' intentions. The latter was crucial to providers as the PSR's impact on provider sustainability was indirect and depended largely on commissioners' behaviour rather than the procurement rules per se. The PSR was seen as a powerful tool in the hands of commissioners. This made some providers, in particular smaller providers, concerned that their sustainability would be adversely affected by the unfavourable commissioners' decisions.

4. *How does the PSR align with the strategic approach to commissioning pursued by the ICBs and the national policy goal to increase collaboration across the system?*

Since the inception of this study, there have been some significant national policy shifts. In particular, the NHS 10 Year Health Plan published in July 2025 emphasised the ICBs' role as "the strategic commissioners of local healthcare services" (UK Government, 2025: 12), while stressing individual organisational accountability of providers. The Strategic Commissioning

Framework (NHSE, 2025a) reiterated that strategic commissioning, defined as "a continuous evidence-based process to plan, purchase, monitor and evaluate services over the longer term", will be "the central purpose of the ICBs of the future". The change in the national policy direction also set in motion a turbulent period for the ICBs as local health service commissioners, with many features of the commissioning system architecture subject to amendment or abolition, creating uncertainty as to the future remit and role of the ICBs, which may impact the ICBs' overall approach to commissioning services.

Notwithstanding this, we found that the Provider Selection Regime aligned well with the ambition for the ICBs to embrace the strategic commissioners' role. This is because of the same set of pre-requisites in the form of strong commissioning and contracting functions, which are required to administer the PSR and to fulfil the strategic commissioning role. However, we also found an insufficient local commissioning capacity and capability, and many competing demands on that capacity relating to the PSR and other factors, which prevented commissioners from making full use of the PSR's flexibilities and which curtailed their role as strategic commissioners.

Furthermore, the 10YHP appears to emphasise more transactional, contractual mechanisms to encourage provider collaboration, as opposed to promoting deeper commissioner provider partnerships as part of the Integrated Care System infrastructure, which was the focus of the previous national policy plans (see e.g. NHSE, 2014). However, despite the 10YHP signalling a turn towards more transactional commissioning by the ICBs, the ability of ICBs to "work in partnership" and deliver "system goals" continued to be stressed in other policy documents such as the Strategic Commissioning Framework (NHSE, 2025a). Thus, it is not at all clear whether increasing commissioner provider collaboration within the ICB footprints remains a national policy priority or not.

Regardless of this, we argue that due to the inherent flexibility of the PSR rules, the current procurement framework can accommodate the shifts in the national policy and any oscillations between competition and cooperation. The ambitions expressed in 10YHP so far lack clear delivery mechanisms, whilst the previous ways of working continue in practice. This suggests the persistence of hybridity in the national policy making in the immediate future. Overall, many participants deemed the wider policy context extremely unsettling and were unable to draw long-term predictions for their organisations.

Discussion of findings

The PSR regulations were long-awaited and generally welcomed by the commissioners and providers. However, as the PSR regulations gave the commissioners substantial flexibility, the participants reported a considerable variation in how the rules were being applied. The interviewees had divergent interpretations of the rules and often mismatched expectations of what the regulations should deliver for their organisations and interests, exposing the divergent visions of commissioning in the NHS and disagreements between commissioners and providers.

The PSR was seen as a powerful tool in the hands of commissioners, but it was seen as a largely neutral tool enabling a wide range of commissioners' actions. Given high local discretion, ensuring high professional and ethical standards of public procurement processes was seen as crucial by some interviewees. Furthermore, many participants noted that strengthening the capacity and capability of commissioning organisations was necessary to unlock the creative use of the PSR and its extensive flexibilities. Participants noted that applying the PSR was an ongoing learning process for commissioners and providers. Some interviewed established providers were concerned about the potential return to a more transactional commissioning and its implications for provider sustainability. The implementation of the patient choice policy, which was separate from but interfaced with the PSR, was particularly problematic for commissioners and affected some providers. The limited levers available to commissioners in this area contrasted with the general flexibility of the new procurement framework.

Compliance with the PSR required appropriate commissioning expertise, including skills in contract management and deep knowledge of the provider landscape and provider performance. These were also the skills required for strategic commissioning. However, we found that operational pressures that ICBs were under, combined with an ongoing reorganisation of commissioning function, presented risks to achieving the ambition of ICBs becoming capable strategic commissioners and, in turn, to utilising the full range of flexibilities of the PSR. Nevertheless, we found the PSR regulations, per se, to be an enabler of strategic commissioning, providing appropriate infrastructure, with constraints stemming from factors external to the PSR.

Limitations

The aim of this study was to provide a rapid insight into the PSR views and experiences of the ICBs and selected providers. This was achieved by adopting a case study approach and conducting a limited number of targeted in-depth interviews in three ICB systems with which we had an ongoing research connection at the time. However, this approach has some limitations. As the study design involved interviews with commissioners in three out of 42 ICBs which existed at the time of the fieldwork, and a small selection of providers operating within these ICB areas, it was not possible to make generalisations to the whole NHS, to capture the full range of experiences of the PSR by the ICBs and providers, or to cover all aspects of the PSR regulations. Furthermore, as originally planned, this study explored the experiences of only one type of relevant authority which is required to apply the PSR when commissioning and procuring health services – namely the ICBs. In addition, we have also explored the views and experiences of a limited number of NHS and non-NHS providers, supplying services to the ICBs in our three case study sites. However, the views and experiences of other relevant authorities, such as NHS trusts, NHS FTs and local authorities, which are required to follow the PSR in their capacity as commissioners of health services, have not been explored, but remain an important research gap.

Policy implications

Although the participants found the rules on the whole well-drafted, some called for certain clarifications, for instance, with regard to the scope of the PSR or dispute resolution procedures. Many participants called for a review of the patient choice policy and guidance, which is separate from but interfaces with the PSR. Some participants also called for better operational support of the PSR, which may reduce the administrative burden.

In light of the findings, we draw several policy implications relevant for how the health services commissioners and providers apply the PSR, pointing out:

- *Importance of support from the centre.* Both commissioners and providers were still learning how to use the new regulations appropriately and effectively. The commissioners and providers should continue to be supported centrally through updates to guidance and resources to promote shared views on how the rules should be applied. Better operational support to the ICBs may reduce the experienced administrative burden associated with the PSR and streamline data collection about the procurement processes at the national level.
- *Administrative burden associated with the PSR.* The costs of compliance with the PSR on commissioners and providers should be fully mapped out and acknowledged, taking into account all aspects of the PSR, including dispute resolution, procurement of services subject to patient choice, administration of competitive and direct awards and transparency requirements.
- *Application of the PSR requires robust commissioning capacity and capability.* The ICBs must have the appropriate commissioning capacity and capability and/or third-party support to ensure compliance with the PSR and to make full use of the flexibilities of the new regime, ensuring the right commissioning skillset is on hand. This also applies to any providers taking on the 'micro-commissioner' roles.
- *PSR dispute resolution process lacks clarity*. We found that the dispute resolution procedure was at times unclear and posed challenges for the commissioners and providers. It may benefit from a review and further clarification in the guidance.
- *Challenges in the broader policy environment*. The ICBs operated in a challenging broader policy environment which had implications for the administration of the PSR. These challenges included ICB restructuring as well as non-PSR processes, such as implementation of patient choice, which competed for scarce commissioning resources. As the custodians of the local health systems, the ICBs should have effective levers to better balance the competing priorities inherent in the commissioning function.

Implications for future research

Given the relative newness of the PSR regulations and the ongoing reorganisation of commissioning function, it is important to monitor how the Provider Selection Regime is being used in practice as a commissioning lever. The important aspects to probe include the type and frequency of procurement processes used by different types of relevant authorities subject to the PSR and the type of services procured through different PSR processes; the balance between competitive and non-competitive processes and their implications for commissioners and providers; and the process and outcomes of the procurement disputes at the local and national levels. It is also important to understand how the PSR interplays with other key factors, including pricing and payment mechanisms, complex contractual arrangements, provider competition and collaboration, patient choice framework and commissioner-provider relationships. Qualitative, organisational case studies focusing on the commissioning, contracting and procurement functions offer linked research opportunities in this regard.

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Glossary

10YHP (Fit for the Future: 10 Year Health Plan for England, 10 Year Health Plan) – a government strategy for the development of the NHS in England over the next ten years published in July 2025

AQP (Any Qualified Provider) – a type of NHS contract which allows local commissioners to commission a service from locally accredited providers who offer local patient choice in that service

Blended payments - a holistic blended payment model comprising a fixed element with a quality/outcomes based element, a risk sharing element and/or a variable payment to encourage providers and commissioners to adopt cost effective, joined up approaches

Block contract - the NHS payment system under which a healthcare provider receives a lump sum payment to provide a service irrespective of the number of patients treated

CCG (Clinical Commissioning Group) - the statutory body responsible for planning, organising and buying health and care services for their population prior to the establishment of statutory ICBs

CHS (Community Health Services) – in this report denotes a provider of Community Health Services

CMH (Community and Mental Health) – in this report denotes a provider of Community and Mental Health Services

Commissioner – in this report refers to the Integrated Care Board (ICB) unless stated otherwise

CPV (Common Procurement Vocabulary) - standardised codes used in the UK public procurement to classify goods or services by sector and type

CQC (Care Quality Commission) - the independent regulator of quality of all health and social care services in England

CS (Case Study) – in this report refers to the ICB footprint corresponding with the Integrated Care System

CSU (Commissioning Support Unit) – an NHS organisation which provides business support for a range of organisations including ICBs, LAs and NHS trusts

DHSC (Department of Health and Social Care) - the Ministerial department of the UK Government responsible for developing health and social care policy

FT (Foundation Trust) - NHS trusts which were created in April 2004 and were given more autonomy over capital borrowing, selling of assets, retaining annual surpluses, and developing their own systems for managing and rewarding their staff

FTS (Find a Tender Service) – the UK public procurement portal used for publishing and searching public sector contract opportunities and notifications

GP Federation - a group of general practices or surgeries forming an organisational entity and working together within the local area

ICB (Integrated Care Board) - a statutory body responsible for planning and funding nearly all NHS services in its area

ICS (Integrated Care System) – a local partnership of organisations that come together to deliver four objectives: improvement of health and care outcomes, tackling inequalities, enhancing productivity and value for money, and supporting broader social and economic development. There is one ICB in each ICS area.

IHO (Integrated Health Organisation) – a new organisational model for delivery of health services signalled in the 10YHP envisaging providers holding health budgets for defined local populations

IPCPP (Independent Patient Choice and Procurement Panel, Independent Panel) – an independent expert panel established by the NHSE to advise on the application of the Provider Selection Regime and the provider qualification process under the patient choice regulations in cases of provider complaints

Lead provider contracting – a contractual configuration where one provider organisation holds a service contract with NHS commissioners and subcontracts part of its performance to other organisations

LA (Local Authority) - an administrative body in local government

MH (Mental Health) – in this report denotes a provider of Mental Health Services

NHSE (NHS England) – executive non-departmental public body of the Department of Health and Social Care. Responsible for overseeing the funding, planning, delivery, transformation and performance of NHS healthcare in England

PA (Procurement Act) – Procurement Act 2023 governs public procurement of goods and services in the UK. It came into force on 24 February 2025 replacing a number of statutory instruments, including the PCR 2015

PCR (Public Contracts Regulations) - The Public Contracts Regulations 2015 (SI 2015/102) (revoked)

PPCC (Procurement, Patient Choice and Competition) Regulations - the National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013 (SI 2013/500) (revoked)

Provider Collaboratives - non-statutory partnerships of two or more NHS provider trusts to work at scale to deliver care

PSR (Provider Selection Regime) - The Health Care Services (Provider Selection Regime) Regulations 2023 (SI 2023/1348) govern procurement of health services in England and came into force on 1 January 2024

Social enterprise - a business-like entrepreneurial organisation with primarily social objectives

1. Introduction

The Health Care Services (Provider Selection Regime) Regulations 2023 (SI 2023/1348) (PSR) came into force on 1 January 2024. The PSR regulations govern how the relevant authorities (Integrated Care Boards (ICBs), NHS England, NHS trusts, NHS foundation trusts, local authorities and combined authorities) procure health care services in England. The PSR aims to increase commissioners' flexibility over procurement processes and their transparency, to reduce bureaucratic burden and the use of unnecessary competitive tendering, as well as to support the development of "stable collaborations between providers" (EM, 2023/1348, point 7.4).

In 2025, the Department of Health and Social Care (DHSC) commissioned the NIHR Policy Research Unit in Health and Social Care Systems and Commissioning (NIHR PRU HSSC) to conduct a responsive, qualitative study to explore how the PSR regulations are viewed and applied by NHS commissioners and providers and to interrogate stakeholders' views on the extent to which the intended PSR policy aims are being realised. The NIHR PRU HSSC study was carried out between March 2025 and February 2026. This report presents the findings from this study.

1.1 Policy background

Competition and cooperation are the two fundamental mechanisms of commissioning health services within the NHS (Allen et al., 2017). Commissioning decisions utilising competitive or cooperative mechanisms are transposed into the formal purchasing decisions via the procurement processes. The purpose of the procurement regulations in the public sector is to ensure that the procurement processes are executed fairly and transparently, and with a view to securing optimal outcomes from the point of view of the taxpayer. The policy solutions for achieving the latter are complex and often change. In particular, the NHS commissioning policy over the last two decades is characterised by the alternating preferences for either competitive or cooperative mechanisms of commissioning services, as the ones believed to deliver the optimal results. The procurement regulations usually reflect the policy preferences in this respect.

Competition in the NHS is realised through two broad models. Competition 'for the market' is a result of competitive tendering processes whereby different providers compete to deliver a particular service sought by the commissioner, and a winner takes the whole market in that service. In contrast, competition 'within the market' exists when several providers are accredited to provide a particular service and they compete to attract patients (Osipovic et al., 2020a). It is important to distinguish between these two models of competition as their conditionalities and impacts vary. Cooperation in the NHS refers to a broad range of interorganisational relationships, structures and behaviours involving providers and commissioners of health services, such as provider collaboratives and alliances, clinical networks, partnerships, or system working. It implies the functional coordination of separate but interconnected components to perform a shared task or achieve a common goal (Kodner

and Spreeuwenberg, 2002). Cooperation between different organisations may involve sharing of the resources, risks, information or new markets, whilst working towards mutually beneficial goals. Cooperating partners should have a shared understanding of policy and rules for such a partnership to be successful. In practice, competition and cooperation are not mutually exclusive and co-exist in both commissioning practices, whereby commissioners are managing the local systems through balancing them, and in the provider relationships, whereby providers cooperate and compete simultaneously (co-opetition) or sequentially (Allen et al., 2017). Both competition and cooperation attract their own transaction costs.

Rationale for a legislative change

Since the publication of the NHS Five Year Forward View (NHSE, 2014) many stakeholders called for a reform of the health services procurement regime to bring it in line with the policy turn towards cooperative mechanisms of commissioning and system-based partnerships, and to better support the bulk of commissioning practices, which relied mainly on cooperative mechanisms and partnership working, using competitive tendering sparingly (Allen et al., 2017). At the time, the procurement processes for health services were governed by the National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013 (SI 2013/500) (PPCC 2013) and the Public Contracts Regulations 2015 (SI 2015/102) (PCR 2015). Although complex and allowing some exceptions, these provisions, in essence, implied that competitive tendering is to be a preferred method of procuring health services (Osipovic et al., 2020b).

The tension between policy and practice on one hand, and the formal rules on the other hand, resulted in the limited enforcement of the rules by the sector economic regulator (NHS England and NHS Improvement at the time) in cases of procurement disputes (Osipovic et al., 2020b). However, as the procurement of health services was part of the general public procurement regime governed by the PCR 2015, many providers were choosing to challenge the procurement processes through the court system, resulting in substantial juridification of disputes, signalling an increasing reliance on the legal routes for dispute resolution as opposed to using sector specific mechanisms as part of the hierarchical ‘command and control’ or executive discretion (Osipovic et al., 2020b). In commissioning practice, empirical evidence indicated a certain degree of non-compliance and use of various workarounds, such as single tender waivers, to circumvent the formal procurement rules’ inclination towards competitive tendering and to avoid high transaction costs associated with it (Osipovic et al., 2017). An NHS England 2021 engagement exercise cited in the PSR Impact Assessment found that 79% of respondents agreed with the proposal to revoke the PPCC 2013 and the PCR 2015 regulations (IA 2023/9616: 7). The results of the 2021 NHSE formal consultation on the proposed set up of the new procurement regime provided further arguments for a legislative change (NHSE, 2021).

Aims of the PSR

Both national policy direction and commissioning reality on the ground were increasingly at odds with the legal framework governing the procurement of health services. To remove the imperative for competitive tendering, the Health and Care Act 2022 repealed the National Health Service (Procurement, Patient Choice and Competition) (No 2) Regulations 2013. Subsequently, the PSR put in place new, sector-specific regulations for procuring health care services by removing the relevant health services from the scope of the Public Contracts Regulations 2015.

According to the Explanatory Memorandum accompanying the PSR, the regulations aim to offer procuring authorities greater flexibility in how providers are selected, support the development of "stable collaborations between providers" and remove the imperative for "unnecessary use of competitive tendering" (EM 2023/1348, point 7.4). It is assumed that this should support the "more joined-up patient care pathways and better outcomes" (EM 2023/1346, point 7.1). According to the PSR statutory guidance issued by NHS England, the PSR aims to offer flexible and proportionate processes for selecting providers, increase capability for "greater integration and collaboration", increase transparency around procurement decision making and reduce the bureaucratic burden and transaction costs of procuring services associated with the previous rules (NHSE, 2023a).

The PSR Impact Assessment document offers another insight into the policy aims behind the introduction of the PSR. It states that the three main intentions of the new regulations were to

- "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.
- 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.
- 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" (IA 2023/9616: 14).

The Impact Assessment document acknowledges many caveats which may complicate the achievement of these aims and reflects uncertainty around the best mechanisms for delivering the desired policy outcomes. Firstly, it acknowledges that the fulfilment of these broad policy intentions depended in large part on the commissioners' ability and willingness to use the flexibilities that PSR offers in the way policy intended. The reduction of administrative burden was linked to the removal of "wasteful legal and administrative costs" associated with

unnecessary competitive tendering (IA 2023/9616: 9). However, the overall administrative burden of operating PSR was difficult to estimate. Whilst taking away the competitive tendering imperative, the policymakers were also mindful of any potential adverse effects on prices, service quality and supply of services (IA 2023/9616: 14). At the same time, there is an acknowledgement that the benefits of competition in health services remain unclear (IA 2023/9616: 64) and, rather than procurement regulations per se, other important factors, such as provider payment mechanisms (e.g. national tariffs, block and blended payments etc.), affect pricing as well as quality and quantity of NHS services and the way competition manifests itself in the NHS (IA 2023/9616: 64-65).

1.2 Key features of the Provider Selection Regime

The PSR regulations govern how the relevant authorities (ICBs, NHS England, NHS trusts, NHS foundation trusts, combined authorities and local authorities) procure health care services in England. The PSR applies to all procurements of the relevant health care services, irrespective of their value. The definition of relevant health care services is aided by the provision of the relevant Common Procurement Vocabulary (CPV) codes (PSR, Regulation 2(1), Schedule 1), which are standardised codes used in the UK public procurement to classify goods or services by sector and type. Ultimately, however, whether a particular procurement falls within the scope of the PSR is decided by considering the regulations, guidance and the facts of each case.

The PSR introduced five procurement routes available to the relevant authorities when selecting service providers: Direct Awards A, B and C, Most Suitable Provider (MSP) and Competitive processes. In all cases, the procuring authorities must keep records of their decision making when selecting service providers. In all cases, the commissioner must also publish transparency notices on the Find a Tender Service (FTS) public sector procurement portal, but the notice requirements vary depending on the process being followed (see Table 1). In relation to Direct Award C, MSP and Competitive processes, the commissioner must also observe standstill periods.

Table 1. Transparency notices that require publication under PSR processes (NHSE guidance)

process	decision-making processes					framework agreements		
	direct award processes			the most suitable provider process	the competitive process	establishing a framework agreement	contracts based on a framework agreement without competition	contracts based on a framework agreement following competition
	A	B	C					
Making intentions clear in advance								
Publishing the intended approach in advance				✓				
Publishing a notice for a competitive tender					✓	✓		
Communication of the decision								
Publishing the intention to award notice			✓	✓	✓	✓		✓
Confirmation of the decision								
Publishing a confirmation of award notice	✓	✓	✓	✓	✓	✓	✓	✓
Contract modification								
Publishing a notice for contract modifications	✓	✓	✓	✓	✓	✓	✓	✓

Source: NHSE PSR statutory guidance, Annex B: Transparency, https://www.england.nhs.uk/long-read/the-provider-selection-regime-statutory-guidance/

With regard to three processes (Direct Award C, MSP and Competitive), the PSR (Regulation 12) put in place a dispute resolution process, which is initiated by an aggrieved provider making a written representation to the relevant authority within the standstill period[1]. Any aggrieved provider that believes that there has been a failure to comply with the PSR may make a representation. The standstill period is triggered by the publication of the intention to award transparency notice and lasts eight working days. The relevant authority "must not enter into contract (…) before the end of a standstill period" (Regulation 12(1)).

The PSR (Regulation 23) also provided that independent expert advice may be sought or received on compliance with the PSR from a body endorsed by NHSE. Subsequently, NHSE has established the Independent Patient Choice and Procurement Panel, which considers escalated provider complaints. The Independent Panel's role is to review the procurement process and issue recommendations to the relevant authority on the next steps. However, the Independent Panel cannot direct the relevant authority. The ultimate option available to an aggrieved provider is a judicial review.

The PSR (Regulation 25) introduced an annual reporting requirement on the use of the PSR by the relevant authorities. The relevant authorities must publish an annual summary of the PSR application and contractual activity concerning health services, disclosing, among other

[1] Under the PSR there is no requirement to observe the standstill periods when following the Direct Awards A and B. However, the relevant authority must publish transparency notices to confirm an award and in case of contract modification. The process for raising representations with regards to Direct Awards A and B is not outlined in the PSR.

things, the number of contract awards under each process and the number of provider representations received.

Each of the five procurement processes introduced by the PSR has a specific set of conditions and requirements. The NHSE (2023a) statutory guidance states that "if the criteria are met to follow direct award process A or B, then these processes must be followed to award the contract. A competitive process must be used to award a framework agreement. In all other circumstances, each relevant authority must identify which provider selection process is appropriate for the particular situation and ensures best outcomes for their patients."[2]

Direct Award A process must be used when there is an existing provider, and they are the only capable provider "due to the nature of the relevant health care services" (Regulation 6(1)). There are no standstill periods to observe, but the relevant authority must keep the record of their decision making and publish a confirmation of an award notice.

Direct Award B process must be used when "a patient is offered a choice of provider" with regard to the health service which is being procured, and the number of providers is not restricted by the commissioner (Regulation 6(4)). The relevant authority is required to offer a contract through the Direct Award B process to any provider who meets the qualification criteria. According to the PSR guidance, examples of services subject to patient choice which must be arranged using Direct Award B include but are not limited to "elective services led by a consultant or mental health care professional where the ICB or NHS England has a legal duty to provide patients with a choice of provider" (NHSE, 2023a)[3]. The scope of services subject to patient choice is defined nationally, whilst the provider accreditation process is run locally by the relevant commissioner. Similarly to the Direct Award A, in relation to awards made under the Direct Award B process, there are no standstill periods to observe, but the record keeping and transparency notice requirements apply.

It is important to note that the scope of services subject to statutory patient choice and the provider accreditation process are not governed by the PSR but by the separate patient choice regulations and guidance. The provisions governing patient choice in the NHS are dispersed and complex. These include the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) (Amendment) (No. 2)

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[2] Competitive process is mandated when the commissioner seeks to procure a framework agreement, "an agreement between one or more relevant authorities and one or more providers", which allows for establishing a contractual framework with multiple suppliers for the term of up to 4 years (Regulation 16). Framework agreements are contractual arrangements that involve a pre-approved set of suppliers and set out the terms and conditions (e.g. price, quantity etc.) in advance for the whole duration of an agreement. This allows purchasers to access the services quickly during the term of this agreement.

[3] Direct Award B also applies if the local commissioner decides to open up a service to patient choice locally ("for which patients do not have a legal right to choice"), and the number of providers is not restricted by the commissioner. Examples of services which may be open to local patient choice may include "mandatory eye health services, audiology, podiatry services, NHS continuing healthcare services, and public health services such as over-40 health checks" (NHSE, 2023a).

Regulations 2023 (SI 2023/1105), which came into force at the same time as the PSR, and the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012 (SI 2012/2996) (Part 8. Standing rules: choice of health service provider). The rules governing patient choice in the NHS are summarised in the NHSE patient choice statutory guidance, last updated in December 2023 (NHSE, 2023b).

Whilst interfacing with the PSR through the Direct Award B process, patient choice regulations have important implications for commissioner and provider behaviour. According to patient choice regulations, a provider may approach a commissioner with a request to be assessed for the provision of the services subject to patient choice, and the commissioner must run the provider accreditation process. The successfully accredited providers must be offered an NHS Standard Contract, which is procured under the PSR through Direct Award B. However, the provider is required to hold only one qualifying contract (reflecting local terms and conditions) with at least one relevant commissioning body (an ICB or NHSE) to become a choice for patients anywhere in England, even if there is no explicit contract in place between a particular commissioner and the provider who holds a qualifying contract elsewhere (EM 2023/1105: 3).

Provided the commissioner is not required to use Direct Award A or B, and they are not seeking to procure a framework agreement, for the three remaining processes (Direct Award C, MSP and Competitive) the commissioner has some discretion over which process to use, subject to some further specific conditions.

Direct Award C process may be used when the relevant authority seeks to reprocure an existing contract through a direct award, provided the terms of the new contract do not constitute a "considerable change", and the current provider is performing in the existing contract and likely to continue to perform "to a sufficient standard" (Regulation 6(5)). The considerable change is tested via a two-part test assessing both substantive and financial changes to the contract. The commissioner following this process must publish the intention to award notice, which triggers a standstill period.

Most Suitable Provider process may be used when the relevant authority is "likely to be able to identify the most suitable provider" taking into account all available information and all likely providers for the service (Regulation 6(6)). The commissioner must publish a notice of intention to follow an MSP process and carry out an appraisal of potential providers to find the most suitable one. In contrast to the competitive process, this appraisal does not require any interested providers submitting formal bids but relies entirely on the commissioner's knowledge of the market to make a judgement on the suitability of the provider. Upon selection of the MSP, the commissioner must publish an intention to award notice and observe a standstill period.

Competitive process may be used when the relevant authority prefers to test the market to select a provider for a particular service. Except for framework agreements, the relevant

authorities have some discretion over whether to use a competitive process or any of the alternative processes, if these apply. When following a competitive process, the commissioner must evaluate the providers against the "basic selection criteria" and decide on the weights of the five "key criteria" outlined in the PSR (Regulation 5 and 19(3), Schedule 16). The commissioner must publish a notice for a competitive tender setting out the terms of tender and inviting providers to bid. Following the assessment of the bids against the criteria and selection of the successful provider, the commissioner must publish an intention to award notice, which triggers a standstill period.

The PSR mandates that the commissioners must act "transparently, fairly and proportionately" and with a view to securing the needs of service users as well as improving service quality and efficiency (Regulation 4). In addition, when following Direct Award C, MSP and Competitive processes (and only these processes), relevant authorities must apply the basic selection criteria and must decide on the weights of the key criteria when appraising potential providers. The basic selection criteria refer to provider's (1) suitability to deliver a particular service, (2) their economic and financial standing and (3) technical and professional ability. The key criteria are specified as (1) quality and innovation, (2) value, (3) integration, collaboration and service sustainability, (4) improving access, reducing health inequalities and facilitating choice, and (5) social value. Whilst the commissioner must apply the three basic criteria and is expected not to award contracts to providers who cannot meet those, they have a high degree of discretion in how they weigh the importance of each of the five key criteria in a particular procurement. The PSR guidance states: "the relative importance of the key criteria is not predetermined by the Regulations or this guidance and there is no prescribed hierarchy or weighting for each criterion. Relevant authorities must decide their relative importance for each decision they make under this regime, based on the proposed contracting arrangements and what they are seeking to achieve from them" (NHSE, 2023a). The only limitation imposed on the commissioners in how they prioritise the key criteria stems from other statutory duties, which sit outside of the PSR, such as a minimum 10% net zero and social value weighting applicable to all NHS procurements (NHSE, 2025b). The commissioners must make and keep a record of the criteria that they used in a particular procurement.

1.3 NHS England guidance

The PSR procurement regime introduced many new features and processes compared to the previous framework. To facilitate the application of the PSR by the relevant authorities, NHS England ran a series of webinars prior to the PSR coming into force, published extensive guidance and a toolkit containing supporting materials such as flowcharts, slide decks, Find a Tender Service guide, and end-to-end process maps. NHSE also has a dedicated email for the

PSR-related queries. The guidance and toolkit are being regularly updated and are available on the NHSE website[4].

1.4 Need for research

Following the introduction of the new legal framework, it is important to interrogate how the PSR regulations are understood and applied by the ICBs and providers, and how the procurement rules impact organisational behaviour in practice alongside other factors, as well as gauge the extent to which the assumed aims and benefits of this legislation are being realised. This research study aims to provide insights into the early stages of implementation of the PSR regulations. Moreover, it provides evidence on how the procurement legislation interplays with several key policy issues, in particular provider competition and cooperation, and the strategic commissioning role of the ICBs.

1.5 Study aims

DHSC commissioned NIHR PRU HSSC to conduct a rapid, responsive study to explore the experiences of ICBs and health services providers operating under the PSR. The study aims to investigate how the ICBs and health services providers view the PSR regulations and how the ICBs apply the regulations. The study aims to address the extent to which some of the intended goals of this legislation are being realised as perceived by the commissioners and providers, in particular with regard to increasing transparency and flexibility in procurement decision making, reducing bureaucracy in administering procurements and facilitating partnership working.

1.6 Research questions

We set out to address the following research questions:

- What are the ICBs', NHS trusts/FTs' and independent providers' views of the new Provider Selection Regime?
- How and by whom are the decisions about an appropriate procurement route made in ICSs? How does this vary with the type and scale of health services being commissioned?
- How does the PSR differ from the previous procurement regime in aspects such as the amount of flexibility, administrative burden, exposure to potential procurement disputes and ensuring provider sustainability?
- How does the PSR align with the strategic approach to commissioning pursued by the ICBs and the national policy goal to increase collaboration across the system?

[4] https://www.england.nhs.uk/long-read/the-provider-selection-regime-statutory-guidance/; https://www.england.nhs.uk/publication/provider-selection-regime-toolkit-products/

1.7 Structure of the report

This report is structured as follows. The next section outlines the study design and methods of data collection and analysis. The findings section is organised thematically and includes a discussion of general views of the PSR, governance of the PSR processes within ICBs, commissioner and provider experiences of different procurement processes, comparative views on the key features of the PSR (flexibility, transparency, dispute resolution process) in the light of the perceived differences between the current and past procurement frameworks, views on the NHSE guidance and implications of the PSR for strategic commissioning and the provider landscape. The discussion section addresses the findings in the light of the four research questions and the study limitations. The final section contains conclusions as well as policy implications and suggested areas of further research.

2. Study design and methods

This rapid, responsive, qualitative project was carried out between March 2025 and February 2026. We used a case study approach (Yin, 2009) to investigate how the ICBs and selected service providers to these ICBs understood and applied the new procurement regime. We chose a case study research design as the most appropriate for our study, an approach which we have used successfully in our previous research projects. We selected three ICB case study sites in England. Due to the short timescales, we used the same case studies, which were part of another ongoing NIHR PRU HSSC project (Petsoulas et al., 2025). Our rationale for selecting the case study sites originally (in 2019) was that they varied in health and local authority boundaries configuration, presence or absence of independent provider partners within the system and concentration of providers. We also sought to identify case study sites based in three different NHSE regions.

We conducted semi-structured in-depth interviews with relevant staff members and documentary analysis (e.g. national policy guidance, local documents from our case studies) in three ICB case study sites. Our research questions focused on finding out what commissioners and providers (NHS and independent) thought about the new procurement rules and how they applied them in practice.

Between May and September 2025, we conducted 16 interviews with commissioners and providers in three ICB areas in England. In addition, in order to interrogate the policy rationale and to inform the fieldwork and data analysis, we conducted three interviews with the national PSR and patient choice policy leads from DHSC and NHSE.

2.1 Selection and role of case studies

For this fieldwork, we approached the three case study sites of ICBs, where we were engaged in a separate research project. All three sites agreed to take part in this study. This enabled us to meet the short timelines of this project and ensured familiarity with the wider context in which our participants operated. The case study sites were situated in different parts of England, belonging to three different NHSE regions. The Case Study 1 system covered mainly urban population of around 1.2 million and had four unitary local authorities. Case Study 2 covered a mixed rural and urban population of around 1 million and shared near coterminosity with the county council. Case Study 3 covered an urban population of around 1.8 million and was coterminous with five unitary local authorities.

Situating the interviews within the case studies of three ICBs, with which we had an ongoing research connection, allowed for quicker access to potential interviewees and provided a local organisational and commissioning context, aiding the analysis of the interviews. Although the case studies were used to select and target particular provider organisations, which supplied services to the case study ICB, all providers in our study had relationships and procurement experiences with multiple ICBs. These multiple relationships were relevant to our research

questions. In that sense, the individual organisations, rather than the case studies, were our main unit of analysis in this study.

2.2 Ethical approval

NHS research governance approval from the HRA was granted on 4 April 2025 (IRAS ID 350422/ REC reference 25/HRA/1257). We participated in a streamlined NHS research governance approval process due to the low burden nature of this study and the seniority of the research participants. The study was also granted ethical approval by the London School of Hygiene and Tropical Medicine internal ethics committee on 7 May 2025 (Ref: 32199).

2.3 Timeframe of the research

The fieldwork lasted from May 2025 until September 2025.

2.4 Data collection

Our intention was to interview a small number of ICB and provider staff in each case study site (c. 5 per site). In each ICB, we approached a senior member of staff in the commissioning team, sharing a project summary in which we outlined the rationale for conducting research in the same sites, the purpose of the research and the time commitment that was required (i.e. a small number of interviews lasting up to one hour, conducted remotely). We also requested access to any relevant local documents about the application of the procurement rules.

In addition, we selected three to four providers (NHS and non-NHS) in each case study site to approach with a request for an interview. The targeted providers included a mix of NHS and independent providers delivering a mix of acute, community and mental health services. In particular, we targeted providers active in the community and mental health services provision, as these sectors were historically more exposed to competition 'for the market' (Osipovic et al. 2020a), as well as providers which operated services subject to competition 'within the market'. All targeted providers had some experience of procurement processes under the PSR. This was ascertained during the interviews with ICB staff or by using publicly available information, such as notices published on the Find a Tender Service portal.

Within each commissioner and provider organisation, we identified senior or middle level managers responsible for the implementation of the procurement regime. We approached each participant individually with a request for one-hour interview, sending them a summary of the research project. After they agreed to take part, we sent them a participant information sheet and a consent form to sign.

We conducted semi-structured in-depth interviews with senior and middle-level personnel responsible for procurement, such as ICB commissioning, contracting, commercial or procurement directors and managers; as well as chief executives, director or associate director level managers from NHS (acute, community, mental health) and independent (private and third sector) providers. In one instance, we also interviewed a procurement

manager from a Commissioning Support Unit (CSU) providing procurement support to the case study ICB. The mix of staff interviewed was comparable between three case study ICBs.

The interviews explored a range of issues relevant to our research questions, including the ICB structures and processes involved in the administration of the PSR; how participants viewed the PSR rules in particular with regard to such aspects as administrative burden, flexibility, transparency and risk of disputes; how participants used the PSR rules in the local context and with what effect; how the PSR rules compared with the previous procurement framework; how the procurement rules aligned with the approach to commissioning services that the ICBs were pursuing and how they impacted provider competition and cooperation.

Alongside the interviews, we examined publicly available, relevant documents published on the case study ICBs' websites (such as the ICB Board papers, policies and procedures, governance documents etc.) and on the Find a Tender Service portal to build a fuller picture of the way procurement processes were carried out in the particular system. In addition, some ICBs provided internal documentation associated with the procurements, such as documents outlining their PSR-related policies and procedures. The documentary data was used to inform the interviews and data analysis.

The interviews were conducted by two members of our team (DO and CP). We conducted 16 interviews with ICB and provider staff. Some of the conducted interviews were joint interviews with multiple participants present. Table 2 contains a breakdown of the interviews by case study site and type of organisation.

Table 2. Interviews by the ICB case study (CS) site and type of organisation.

Organisation	**Case study 1**	**Case study 2**	**Case study 3**	**Total**
ICB	2	3	2	**7**
CSU	1	-	-	**1**
NHS Trust/FT	1	1	2	**4**
Independent provider	-	3	1	**4**
Total	**4**	**7**	**5**	**16**

In addition, to aid data analysis and to gain a better understanding of the rationale of the procurement regime and how it sits within the relevant policy context, we conducted three interviews with national PSR and patient choice policy leads. These interviews do not form part of this report but were used to inform the analysis of ICB and provider interviews, in particular, by aiding the distinction between intended and unintended policy impacts and articulating the general theory of change underpinning the PSR.

2.5 Data analysis

DO and CP agreed on the thematic framework for data analysis, combining the themes derived from the research questions and those emerging from the data. DO and CP conducted the thematic analysis and drafted the report. To increase the anonymity of individual participants, we decided to reference participants' quotes in a generic manner (e.g. 'CS2, ICB, Commissioning Director').

In this report, the term 'commissioner' is used interchangeably with the 'ICB' to refer to the Integrated Care Board organisation and its function as a commissioner of health services, unless stated otherwise.

3.1 General views of the PSR

We found that ICB and provider interviewees had an overall positive view of the new procurement regulations. However, there was a lack of consensus as to how the regulations should be applied in particular circumstances. Divergent interests of commissioners, public and private sector providers came to the fore. Below, we present a selection of general views of the PSR expressed from different perspectives, which are explored in more depth in the later sections.

3.1.1 Commissioners' views

The ICB interviewees noted some challenges as well as opportunities and new ways of working instigated by the new procurement regime, "the good and the bad" (CS3, ICB, Business Director), "pros and cons, as with any kind of policy initiative" (CS3, ICB, Strategy Director). The positives included the introduction of the direct award routes, when it was possible to select the provider without testing the market. The challenges included a perception of increased audit trail and reporting burden, determining which services fall in the scope of the PSR, ease of challenging the procurement decisions, dealing with representations locally and a lack of value thresholds for the PSR, which made even small procurements subject to the PSR.

ICB interviewees were overall positive about the purpose behind the PSR rules, i.e. to increase flexibility in the choice of procurement processes and to reduce the imperative for competitive tendering.

> *I think the premise of the PSR is probably right, in terms of what they're trying to do. So, you know, in terms of having a bit more of an emphasis on the flexibility and continuity of care and less probably emphasis on open competition, as there was in the PCR regs*. (CS1, ICB, System Associate Director)

ICB interviewees thought that the rules in general worked well and were well-balanced.

> *I think the procurement framework is generally helpful. I think it balances flexibility with, you know, an ability to use the market competitively where you need to, to keep business with a supplier if you think it's the right thing to do and to, you know, sort of use your various capable provider options where you're doing something a bit more innovative or you need collaboration across parties and some of those sorts of things.* (CS2, ICB, Commissioning Director)

The extent to which ICB interviewees were exposed to the challenging aspects of the PSR depended on the type of services and processes used to procure them. The CS3 ICB director observed that the PSR has been affecting different services in different ways, by impacting the service-specific markets and the way these markets function. They also linked the perception of the heightened administrative burden to the lack of financial thresholds for

procurements. The latter meant that the transaction costs of the PSR were proportionately higher for the small-value contracts.

> *I think it's advantageous in some of the more complex integrated…you know, areas where you need integration of services and, yeah, jury probably still out on some of the simpler processes*. (CS2, ICB, Commissioning Director)

The ICB interviewees welcomed increased local discretion and flexibility introduced by the new regulations, but noted the trade-offs between flexibility and standardisation, and the resulting variability in the way different commissioning organisations will choose to apply the regulations.

> *The element of discretion is welcome, but there's not necessarily going to be consistency in its application.* (CS2, ICB, Contracting Director)

3.1.2 Providers' views

Most interviewed providers (both NHS and independent sector) had relationships with multiple commissioners (ICBs, LAs and NHSE), and thus were at the sharp end of experiencing the variability in the way the PSR rules were applied by different commissioning organisations, even with regard to the same type of services. They noted a lot of variation in the way that commissioners interpreted the legislation.

> *There's a lot in PSR that's open to interpretation by the commissioner, by the decision-making authority or the ICS or whoever it might be. And therefore…you know, so, for example, if we're operating mainly in three ICSs, we see that each one of those has a slightly different way of interpreting PSR. (…) I suppose a lot of it maybe comes down to risk appetite of the individual commissioner.* (CS3, Provider NHS, CMH)

Interviewed providers observed that some commissioners were more comfortable with using direct awards to commission or recommission large community contracts, whilst others were more risk averse, and chose market testing and market engagement. One provider mentioned that the PSR regime gave commissioners many options, but in practice a lot of commissioners defaulted to using the competitive procurement route. Another provider interviewee mentioned that the legal advice given to ICB commissioners was to test the market just to be safe.

> *The rules are actually very complex, they're actually quite open to challenge by litigious private sector firms, and therefore the legal advice that [commissioners] get is basically that really it would be safe only if you go and test the market*. (CS2, Provider NHS, MH)

Independent providers, on the whole, stated that the new procurement regime was welcome. They praised the increasing transparency and visibility of decisions, the equalisation of the playing field, the clarification of some of the grey areas and reduction of non-compliance. Many commented that as a set of rules, the PSR were well-drafted and fit for purpose.

> *The generic thing is that PSR is a good thing, and I think that that's the message. It closed quite a lot of loopholes, it's simple, it's very simple in its application and there's good guidance to support it. So in that sense, really good. If I were to start with a blank piece of paper, I wouldn't do much differently. The areas I'd probably strengthen is the, well, if something goes wrong, what do you do? I think I would strengthen that element, but as a paint-by-numbers, step-by-step guide, how to commission a service, it works really well.* (CS3, Provider Independent, CHS)

The PSR were also seen as a welcome update to the PCR 2015. One private provider operating in the community services market noted that the PSR exposed the past workarounds and non-compliance, which characterised the previous regulatory regime, stating that "PSR is now digging up some of the skeletons from the PCR scenarios" (CS3, Provider Independent, CHS), referring to the frequent use of the single tender waivers under the PCR.

However, the independent providers also noted that there was a wide scope for misinterpretations and misunderstandings around the application of the new rules. Many independent providers stated that the parties often disagreed about the understanding and application of the PSR in specific cases.

> *I think where it falls down is in the application, the people applying the rules don't understand them at all. (...) I think that there is a distinct lack of ability to be able to understand and then apply the rules, and that's not the best thing in itself to us now. (...) So is it good? Yes, it is. Is it being applied properly? No, it isn't.* (CS3, Provider Independent, CHS)

Some private providers attributed the perceived misunderstandings to the initial learning curve, as both commissioners and providers were still learning how to operate the new regulatory regime. Some hoped that the common understanding of the rules would improve in time.

> *We see now that commissioners are learning. So they do something, they realise it's not quite right, they take steps to address that, which is laudable and that's a good thing. That's what we should all do. (...) It will get better.* (CS3, Provider Independent, CHS)

Summary

ICB interviewees liked the range of options and less emphasis on competition allowed by the PSR. However, they noted the increased administrative burden and the lack of financial thresholds for small value procurements. Providers noted a lot of variation in the way that commissioners interpreted the legislation and the disconnect between the way the PSR was intended to work and how it worked in practice. Independent providers welcomed the new procurement regime, praising the increase in transparency of commissioning decisions, equalising the playing field and reducing non-compliance. They also noted that there was a

wide scope for misinterpretations and misunderstandings around the application of the new rules, attributing this in part to the initial learning curve after introducing the rules.

3.2 Structures and processes governing the PSR procurements in the ICBs

In order to discharge responsibilities associated with operating the PSR, the ICBs had to put in place some locally determined structures and procedures, governing procurement decision making, oversight and dispute resolution. As the specific architecture through which the ICBs ensured compliance with the PSR was largely left to local specification, the ICBs varied in their internal structures and procedures.

The procurement function was closely related to commissioning, contracting and corporate business functions of the ICBs, with several ICB interviewees working across these functions or collaborating closely with colleagues from these areas. There was a variation between our three case study ICBs in how such functions were structured internally. There was also an apparent variation in staff resources devoted to these functions.

With regards to the governance of the provider representations, the national NHSE guidance mandated only that when reviewing representations "relevant authorities should, where possible, ensure that decisions are reviewed by individuals not involved in the original decision. Where this is not possible, relevant authorities should ensure that at least one individual not involved in the original decision is included in the review process." (NHSE, 2023a).

3.2.1 Case Study 1

In Case Study 1, the procurement team was overseen by the ICB's contracting department, with a senior contracts manager holding overall responsibility for procurement. The ICB's Director of Finance was the senior responsible officer for procurement at the ICB board level. The ICB contracted with a CSU for procurement advice and to carry out end-to-end procurements, which was delivered by a small team within the CSU.

The ICB procurement team reported into both the ICB's finance and governance committees. The ICB had also set up an internal procurement oversight group to oversee and review the procurement processes to make sure the ICB was following the correct procedures. This group made recommendations to the ICB's commissioning and finance committees. A strategic commissioning committee of the ICB made the decisions about which services would go out to procurement. CS1 ICB stood up internal panels on an ad hoc basis to review any provider representations and make recommendations.

3.2.2 Case Study 2

In case study 2, the procurement proposals went to a commissioning and contracting committee. The proposals were checked and signed off, and then sent to a governance forum, chaired by the Director of Finance, which recommended the proposals to the ICB board for a final decision.

CS2 did not yet have an internal panel to deal with provider representations at the time of the fieldwork. Both the procurements and representations were managed by a small team within the ICB with some support from the CSU. The CS2 contracting director was concerned about

the pressure this put on their small team and about maintaining the independence of a potential internal panel. They were not confident that commissioning colleagues had sufficient knowledge of the regulations to handle the procurement reviews following provider representations.

> *So, if one of us designs, delivers the process, with the CSU more recently, then one of us can't, because we might need to be capable of managing a representation. So that kind of, you know, that's a challenge for us; (…) I went to any one of my colleagues and said can you review the representation, can you confirm whether you think we've made the right decision? And [they are] not very well equipped in understanding the guidance, the regulations, the compliance, what process looks like, I don't know how we could be confident that they gave a genuine robust review of whether or not things were done as they were advertised to have been done.* (CS2, ICB, Contracting Director)

When the responsibilities and requirements placed on ICBs for handling provider representations became more apparent, the CS2 contracting director suggested that pooling resources and procurement expertise at the regional level or larger footprint may be required, as the ICB lacked capacity and capability to handle representations appropriately.

> *When we (…) started to understand what we believe to be the PSR versus what our organisation believes to be a likely requirement of it, we suggested that there be some sort of regional, so sharing of expertise to convene [provider representation] panels. And I still think that might be the right thing.* (CS2, ICB, Contracting Director)

3.2.3 Case Study 3

CS3 ICB's commissioning function was discharged through six teams, each covering a separate service area (e.g. primary care, complex care, population health, etc.) and managing its own portfolio of contracts. The commissioning teams were supported by three contracting teams split between primary care, continuous healthcare and the remaining services. The ICB also had an internal procurement team headed by a business director, which offered in-house, first-hand procurement advice on all contracts. In addition, the ICB also bought contracting and procurement advice and administration from a regional commercial services hub, a former CSU.

The relevant commissioners developed business cases for executive approval. In line with standing financial instructions, different executives and committees were involved in approval depending on the type and value of the service. The business cases were also reviewed by the procurement oversight group, chaired by the ICB's Director of Finance. The procurement oversight group scrutinised and approved the procurement routes for a given business case but did not have any say over the financial or substantive matters associated with a particular procurement. The CS3 ICB often relied on the commercial services hub when running competitive processes.

To process provider complaints, the CS3 ICB assembled a bespoke, internal provider representation panel for each complaint it received. The ICB also sought third-party advice from the regional commercial services hub organisation, representatives of which were also members of the internal panels created to manage representations. To comply with NHSE policy guidance, the ICBs within the region agreed to offer mutual aid in terms of providing independent members for their internal provider representation panels.

Concurrently with administering the PSR, the ICBs had to navigate other resource-intensive processes, governed by separate regulatory frameworks, which 'competed' with the administration of the PSR for the same contracting and procurement ICB staff pool. Specifically, the ICB participants mentioned the administrative burden associated with the non-NHS provider accreditation process governed by the patient choice legislation which interfaced with the PSR Direct Award B (see Section 1.2) and the application of the Procurement Act 2023 (PA 2023) governing the procurement of all goods and services with the exception of health services. The same teams within the ICBs were responsible for the non-NHS provider accreditation process and the application of the two new procurement frameworks – PSR 2023 and PA 2023, as well as residual application of the old PCR 2015 framework, where it still applied. This was a complex backdrop within which procurement teams operated on the ground.

Summary

To discharge their responsibilities under the PSR, the ICBs had to set up internal processes and structures to govern procurement decision-making, oversight and provider representations. The organisation of these functions was largely left to the ICBs' discretion, and we found considerable variation between the ICBs. The case study ICBs varied in terms of staff resources and the maturity of the internal structures and processes, with the largest ICB CS3 appearing to be better resourced compared with the other two ICBs. All three case studies relied on external support from the CSUs or similar organisations. We also found that in addition to the operation of the PSR, the same teams within the ICBs were also running other resource-intensive processes such as non-NHS provider accreditation under the patient choice regulations and the application of the Procurement Act 2023 – alongside other commissioning work, such as service reviews. All this together put considerable pressure on the ICBs' commissioning resources.

3.3 Experiences of the PSR procurement processes

This section describes in detail the ICBs' and providers' views and experiences of applying the PSR regulations in practice, and using the five specified procurement processes – Direct Award A, Direct Award B, Direct Award C, Most Suitable Provider and Competitive processes. We start by outlining the challenges of deciding whether the PSR applies in particular circumstances, before discussing factors influencing a choice of a particular procurement route under the PSR and the experiences of the five PSR procurement processes.

3.3.1 Establishing the scope of PSR

The ICBs came across some challenges when deciding which procurement route to follow in a particular case. One problematic aspect was establishing whether the procurement falls within the scope of the PSR or the Procurement Act. The PSR applied to the procurement of "relevant health care services" which were supported by the CPV codes, yet some procurement managers found the CPV codes insufficiently well defined when trying to apply them in practice.

> *We have 67 CPV…that in theory tells us what is a healthcare service, but they don't have definitions of each of these codes. For example, mental health contracts, usually, commonly, we use interchangeably the word 'counselling' and 'psychology', so psychology is PSR, counselling is Procurement Act. And a psychologist can be providing counselling, or a counsellor cannot be providing psychology services…? So you need to get into the depth of the definition of the service to understand what it is. Then if it's a healthcare professional, it doesn't translate exactly if it's a healthcare service. So I feel there is lack of definition or we need more granular definition about what is a health service.* (CS3, ICB, Business Director)

Establishing whether the procurement falls under the PSR required deep engagement with the specifics of the services and the extent to which it involved clinical input. This set the PSR apart from the previous procurement regime, where distinguishing between health and non-health services was not necessary.

> *Some services feel clinical but actually are governed by the Procurement Act, and some services are clearly, or feel a bit less clinical, but actually are governed by the Provider Selection Regime.* (CS2, ICB, Contracting Director)

Another challenging aspect was deciding whether the health services input was sufficiently high to warrant conducting mixed procurements under the PSR. The latter refers to joint procurements where health services are procured jointly with goods or other non-health services, such as social care services. Procuring different public services jointly is a distinct policy aim appearing in many government policies. The CS3 Commissioning Director noted that navigating the route to procurement has become more complex under the PSR and remains challenging.

I think where it causes a bit of confusion and challenge is when you are procuring…and this is coming up a lot with new policy initiatives, so Get Britain Working Again, that White Paper, where you're actually trying to procure employment support but also social care support alongside that or psychological support services as part of that. And then when you're, kind of, getting into that more integrated space where there's a big component of it that is not health and care, I think it just becomes a bit more complex to navigate. (CS3, ICB, Commissioning Director)

3.3.2 Factors influencing choices of procurement routes

Once the commissioners were satisfied that a particular procurement was in scope of the PSR, they had to choose an appropriate procurement route. They had to use Direct Award A and Direct Award B in certain circumstances, but had more flexibility in terms of deciding between Direct Award C, MSP and competitive routes. Commissioners appraised the particular requirements and flexibilities of each of the five processes against their commissioning needs and resources.

Cost-effectiveness and the opportunity to make financial savings were factors influencing the commissioners' choice of procurement routes. The financial considerations pertained to both the cost envelopes for services as well as transaction costs associated with the procurement. Other issues that commissioners took into account when considering procurement routes included provider performance, the presence or absence of a market, and the risk of challenges.

It's literally, is the provider performing adequately and are we really satisfied with them, and if we're not then there is no alternative, we'll go out to competition. Or it's a market that you know is particularly litigious or there's lots of providers and there's no rationale for staying with the people that we've got now.' (CS2, ICB, Procurement Director)

The considerable flexibility over the choice of the commissioning approaches and procurement processes meant that the same service could be procured through multiple procurement routes. This particularly applied to the community and mental health services, both historically and under the PSR, where services could be procured through any of the five existing routes (including Direct Awards A and B, which were mandated in some circumstances). Providers perceived high variability in commissioning approaches and certain hesitancy from commissioners when having to decide on the preferred procurement route. For instance, the CS2 social enterprise provider of community services observed that a few ICBs, with which they had a relationship, struggled to identify a preferred procurement route for a service.

We're going along this Direct Award C but actually you need to prepare a bid because we might run in parallel a competitive process, and we were like hang on a minute, no way, you're going to make a decision one way or the other. So I think the decision

> *making around the route was tricky I think for the ICS would be my reflection.* (CS2, Provider Independent 2, Social Enterprise, CHS)

Below, we outline commissioners' and providers' views and experiences of specific procurement processes.

3.3.3 Direct Award A

Direct Award A must be used when there is an existing provider, and the commissioners are satisfied that they are the only capable provider for the required service. ICB interviewees welcomed Direct Award A as a straightforward route which removed the grey area around tendering large services contracts. This improved transparency and compliance around large essential health services contracts, compared with the previous regulations, which were equivocal as to whether such contracts were subject to the same procurement requirements as other contracts.

> *I kind of welcome the Direct Award A, for essentially acute services, because if we think about it acute provisions have always been in a grey area, they have never been subject to competition, (…) and if you look at the public contract regs we should have been making a justification, a determined decision upon, you know, a competition; clearly infrastructure prohibits competition for [these contracts](…). So, it's welcome that there is now a formal decision-making, publicly announced, decision making for Direct Award A, that's over there, it is compliant, it is acknowledged, it's recognised.* (CS2, ICB, Contracting Director)

In addition to using this procurement route to procure acute provider contracts, CS3 ICB used Direct Award A to procure the main contracts with local community and mental health NHS trusts. The latter approach was not uniform, as some ICBs (such as CS2) relied on the Direct Award C or competitive processes to commission their main community and MH contracts. The CS3 commissioner justified using Direct Award A, even though there were several existing providers of community and mental health services in the system, by pointing to the specific combination and integration of service portfolios that made the provider's offer unique.

> *It was the combination of the variety of services together and the fact that there was an integration element in there*. (CS3, ICB, Strategy Director)

NHS community and mental health providers who were awarded the contracts through Direct Award A welcomed the stability, "a settled perspective" (CS3, Provider NHS CMH) that it offered. At the same time, they worried that in future some ICBs may decide to market test their community services contracts or consolidate them in their local community trusts, "their native providers" (CS3, Provider NHS CMH) rather than retaining the diverse provider landscape in community services provision, which was a legacy of past commissioning decisions.

3.3.4 Direct Award B

Under the PSR, the Direct Award B process must be used for services where a statutory right to a patient choice of provider applied, and the number of providers was not restricted by the relevant authority. In practice, this meant that the Direct Award B had to be used by ICBs to procure services subject to national patient choice regulations following a successful outcome of the provider accreditation process administered by the ICBs. Direct Award B had to be used also if commissioners wanted to open certain services to patient choice locally, whilst seeking not to restrict the number of providers.

ICB interviewees understood the rationale behind Direct Award B (i.e. to offer patient choice), appreciated a dedicated procurement route for the competition 'within the market', and found the PSR requirements for the Direct Award B relatively clear and straightforward. In contrast, many participants found the operationalisation of the patient choice policy in the ICBs, in particular the non-NHS provider accreditation process, problematic. Some participants also tended to conflate the challenges of administering patient choice policy with the administration of the Direct Award B as part of the new procurement regime, potentially because two key sets of regulations governing these processes came into force at the same time and because of the way non-NHS provider accreditation process interfaced with the Direct Award B (see Section 1.2).

Some ICB interviewees acknowledged that challenges around B were "a consequence of right to choose, patient choice regulations" (CS2, ICB, Contracting Director) and not of the procurement regulations per se, but in practice there was some conflation of these two policy areas.

> *I think what it's opened up for us though is a real tricky situation, particularly around the Direct Award process B and choice. So, it's led to a flurry really, well, more than a flurry, a flood, a flood of providers who want to be accredited under Direct Award process B for elective services, in particular. And the amount…I think nobody could have imagined the amount of work that that has created and creating for ICBs, which we're just simply not…haven't got the resource to do effectively really*. (CS1, ICB System Associate Director)

It is important to re-emphasise that problematic aspects reported by the participants in relation to the Direct Award B did not stem from the provisions of the PSR regulations, but pertained to the implementation of patient choice guidance in the ICBs. The provisions governing patient choice in the NHS are complex and the analysis of their implementation by the ICBs falls outside of the scope of this study. Nevertheless, it is important to note that the overall impact of the PSR regulations on commissioning organisations cannot be understood in isolation from other key policy areas, and thus investigating these other interfacing policy areas, such as patient choice guidance, remains an important area for future research.

3.3.5 Direct Award C

Commissioners praised an option of Direct Award C, which offered a procurement route in situations where there was no material change to the contract, and the commissioners were satisfied with the provider's performance. In practice, commissioners frequently relied on Direct Award C to secure short-term contracts with the incumbents, where the service reviews were ongoing with a view to redesigning the services in the long term. For instance, CS3 ICB utilised this route frequently to procure one-year contracts from existing providers to allow for more time to complete the service reviews. CS3 ICB was aiming to review and standardise provision across a large number of contracts to move away from fragmented commissioning inherited from the CCG era. However, such service reviews were very resource-intensive to complete, so Direct Award C was effectively buying the commissioners more time.

> *We are constantly reviewing our offering and currently we are going through a range of strategic commissioning reviews. So, we are reviewing, for example, all the [community-based] service provision. This comes from when we were five CCGs to one CCG, now to one ICB, so we are understanding what is the offer in the five [places], the service specs, so to carry out this work, we need time. So we don't want to go to procure services without a standard offering across the ICB, so that's why we have been using quite a lot of the Direct Award C.* (CS3, ICB, Commercial Director)

The CS2 ICB Contracting Director welcomed an option to re-award a contract to well-performing providers. They saw it as a means of investing in providers and enabling service improvements. They described this route as the promised "holy grail" of the PSR due to flexibilities it offered to commissioners (CS2, ICB, Contracting Director). Yet there were also a lot of misconceptions around this process. Some contracting colleagues in CS2 were talking about the need to "educate" commissioning colleagues in the proper use of Direct Award C. To comply with C, the commissioners had to show that the service was performing well and meeting or exceeding expectations, not just use it as an automatic contract extension to ensure the continuation of service provision. This required strengthening of contract management skills and capacity within the ICBs. CS2 contracting and procurement interviewees were concerned that some commissioning colleagues tended to use C as a shortcut to an automatic contract extension, which went against the spirit and the letter of this process. They stressed that robust justifications were required to support the use of Direct Award C.

> *Direct Award Cs. I suppose I feel like that was the holy grail, the promise that the provider selection regime was supposed to bring about, which was no longer the automatic need to compete services when their contract term ended, expired. And, yes, it offers that, but, my God, it's a hoop to jump through. (…) The application then of the key criteria, so evidence why we believe the provider is doing well and will do well, I think we will all have to hone our skills on that because what I see across my*

> *colleagues is a nuance of saying why they need the service, not why the provider fulfils the contract in a way that is satisfactory, but why we need to continue the service. And so I think there is a need for us all to develop skills and capabilities to seek the evidence (…) about performance and quality and patient experience, and feedback and improvement. (…) So, we're constantly teaching, educating, and I think, you know, we'll all get better at that over time* (CS2, ICB, Contracting Director)

Some CS2 ICB contracting staff noted that their commissioning colleagues often underestimated the administrative effort required to comply with the Direct Award C. In their view, the due diligence required as part of this process was comparable to running a competitive tendering process. It was not as easy as the label of 'direct award' implied and not as straightforward as using single tender waivers under the previous regime, and "that's a tough lesson for a lot of our commissioners" (CS2, ICB, Contracting Director).

Providers praised the Direct Award C route for its potential to strengthen the financial sustainability of well performing providers and enable long-term planning without going to the market.

> *The mechanism to leave a contract with someone who is deemed to be performing well seems to be a good idea.* (CS2, CEO, GP Federation)

However, in CS3 the independent provider of community services echoed some commissioners' concerns that Direct Award C should not be used for the automatic rollover of contracts but should be seen as an opportunity to assess providers' performance and retain the best providers. The CS3 independent provider challenged the CS3 ICB commissioners on their use of process C, asking for the records detailing their assessment of the incumbent provider's performance and decision-making.

> *Now in my mind, C was a useful tool to retain best in class providers, rather than conducting new procurement. (…) Direct Award C held ICBs to account in so much as they can no longer just roll over a contract, because that's what PCR sort of allowed them to do, and there was too much of that going on. It was lazy commissioning.* (CS3, Provider Independent, CHS)

The importance of good record keeping to be able to demonstrate the decision making on the Direct Award C was particularly crucial in services with an active independent provider market and characterised by the previous use of single tender waivers, past disputes or a history of experimentation with service delivery models. These circumstances led to heightened expectations amongst some potential providers of market testing, which were dashed as a result of perceived 'automatic' contract reprocurements from incumbent providers through Direct Award C.

> *There is no real evidence gathering per se, that's the key bit. So they're supposed to gather the evidence to make the decision and it seems like at the moment a lot of ICBs are using the decision as a way and then trying to backfill in the evidence gathering,*

> *which seems to be a key aspect of what we've come across in CS3 ICB. (…) There was never a formal procurement on the contract [the incumbent provider] currently have.* (CS3, Provider Independent, CHS)

However, the CS3 independent provider admitted that they can both gain and lose from such circumstances, as in areas where they were an incumbent, they benefited from such automatic contract rollovers. This, however, did not preclude them from challenging the commissioners in areas where they were losing out under such arrangements.

The CS3 independent provider also questioned whether the requirement of "satisfying the existing contract (…) to a sufficient standard" as stated in the PSR (Regulation 6), was stringent enough to enable innovation and ensure quality in care delivery. At the same time, they noted that commissioners often did not possess the necessary information to be able to assess providers' performance. This provider was approached by the commissioners from one ICB, which is not one of our case study sites, asking them to supply such information.

> *The ICB in and of itself doesn't necessarily have that information recorded, even though we've been running contracts in those areas for up to a decade. So, we recently had to go through several scenarios in the [Region of England] where we had to do a PSR B data packet for a PSR C scenario.* (CS3, Provider Independent, CHS)

The CS2 independent provider observed a large variation in how different ICBs approached recommissioning the incumbent providers through Direct Award C, some requiring extensive information akin to a competitive process, "taking a belt and braces approach" (CS2 Provider Independent 1, CHS). They also noted that Direct Award C processes can be administratively burdensome for providers because of information requests and due diligence requirements.

> *It's fascinating, (…) we've had direct awards for existing contracts that have been more burdensome than if we were going for a tender. (…) Because the commissioners have essentially asked…basically, used a whole bid…what would be a tender range of questions and a new financial modelling, so to achieve the direct award, it was more burdensome, or as burdensome, as if it was a competitive process.* (CS2 Provider Independent 1, Private, CHS)

Using Direct Award C to offer a short-term contract did not suit the CS2 social enterprise provider of community services (CS2, Provider Independent 2, Social Enterprise, CHS), who was disappointed that the promise of a longer contract, which would have provided some stability, did not materialise. The provider was disappointed that the commissioners had not yet committed to the long-term relationship with the provider. They felt that the commissioner was too cautious in their use of direct awards, preferring instead 'safer' options of short-term contracts and competitive tendering.

3.3.6 Most Suitable Provider

The Most Suitable Provider process, alongside direct awards, presented an alternative to the competitive process. Yet in practice, commissioners found this process problematic. This is

because commissioners found it difficult to gather sufficient evidence, which would enable them to pick a provider. Commissioners in two of our case study sites (CS1 and CS2) found it unfeasible and "unusable" (CS1, ICB, Contracting Manager), and had to abandon the MSP process, switching to other routes (Direct Award C and competitive).

> *Well, it is proving difficult because actually proving that it's the Most Suitable Provider is the tricky bit. So, we've had a couple of…so we've looked at a couple of MSPs and ended up doing them as Cs really*. (CS1, ICB, System Associate Director)

> *So again, no one uses MSP…because no one really understands how it should work, and we can't even get the advice on MSP to see how it should work properly.* (CS1, ICB, Contracting Manager)

As no formal bids from interested providers are required as part of the MSP process, the ICBs found it difficult to assess if a provider was the most suitable. The MSP relies heavily on the commissioner having a prior, extensive knowledge of the providers in the service area it intends to procure. The PSR statutory guidance states that the commissioner may "approach providers and ask for information at any point in the process as necessary but must take a fair and proportionate approach" (NHSE, 2023a). The guidance also states that "the nature of the contract that the relevant authority plans to award will normally be the biggest influence on how familiar it is with potential suitable providers and whether the most suitable provider process is the most appropriate option" (NHSE, 2023a). As commissioners are required to publish notices at three stages of this process (notice of intended approach, of intention to award, of confirmation of award), the visibility and transparency of the MSP process was high and invited scrutiny of the decision making from other providers interested in and capable of providing the service, making the MSP process an "easily challengeable area" (CS2, ICB, Contracting Director). Due to the high chance of challenges and difficulties of collecting evidence for provider appraisal, the MSP was seen as not delivering for commissioners as an alternative to the competitive process. Instead, it was seen as likely to require a switch to a competitive or other processes.

> *How can you decide if a provider's the most suitable provider without actually speaking to them and seeing what they can deliver? The other issue of course is you're almost chancing your arm, you're putting in a notice saying, yes, this is the most suitable provider but if another provider comes along and goes, no, actually we can deliver that, you then have to go, okay, well, we've changed our mind then, we'll go down a competitive process. But by the time you've done that, you might as well have just done a competitive process anyway, you know?* (CS1, ICB, Contracting Manager)

One CS3 ICB interviewee noted that the MSP process needed "maturing" (CS3, ICB, Business Director). Akin to the Direct Award A, some ICB participants saw a potential use of MSP to commission complex contracts, such as IHOs and integrated services, provided a

clear rationale could be articulated. Others have observed its merits for gauging the supply landscape.

> *We put a Most Suitable Provider notice and we had ten expressions of interest, so yes, that's that, isn't it? And maybe it's positive that we are aware of other alternative providers that we weren't aware before. (…) [Then] you need to find out if they are really capable and if they are really interested with further information, because the information that they are basing their interest is a bit superficial, it's a bit basic.* (CS3, ICB, Business Director)

Using the MSP process appropriately depended on a robust market engagement function and a very good understanding of the market (risks, pressures) and capabilities of individual providers. Some commissioners noted that these functions – market engagement and management – suffered during the era of policy emphasis on collaborative system working, so the ICBs' capacity in this area needed to be built up. Market engagement worked reactively in some specific instances, such as during pre-market engagement for competitive processes, but not as an ongoing independent activity that ICB commissioners did proactively as part of their commissioning role. In CS2, the contracting director was trying to convince the ICB executives to invest in the market management capacity. This function was seen as facilitating a better operation of the PSR, in particular assessments against five key criteria for the purpose of the Direct Award C, MSP and competitive processes.

> *I would be more comfortable to use Most Suitable Provider when I have got my programme of proactive and reactive market engagement sorted.* (CS2, ICB, Contracting Director)

In CS3, the NHS specialist acute provider interviewee reflected that the MSP process could be useful for procuring specialist services, over larger footprints, requiring cooperation between different providers. However, they concluded that commissioners did not yet possess the advanced commissioning skills and expertise to make use of the possibilities that the MSP offered.

> *I think where you want to get to with some of the Most Suitable Provider is really highly complex services where you're trying to do something different about population health management type stuff, or something else, you can actually use that. And I think that the commissioners are a way away from being able to do that articulately at the moment* (CS3, Provider NHS, Specialist Acute)

3.3.7 Competitive process

The competitive process largely operated in similar ways as under the previous framework. Competitive process was perceived as a good option in the situation "when you don't know the market", and other alternatives were not available (CS3, ICB, Business Director). Some ICB interviewees commented that discretion over specific weights applied to five key criteria can be both advantageous and disadvantageous. Commissioners were obliged to assign a

minimum 10% weighting for social value and net zero (NHSE, 2025b), whilst having a wide discretion in how they weighed other criteria. Calibrating and finding "the right balance" between key criteria in each particular case was seen as complex (CS2, ICB, Contracting Director). Some commissioners were concerned that this discretion may introduce some unwarranted variation in how different ICBs applied key criteria in respect of similar services and appraised provider capabilities.

CS1 ICB commissioners found the competitive process worked well up to the point of representations, as they had to pause the contract award process when unsuccessful providers made representations.

> *So up to the decision and the notification of the intention to award, that was fine in terms of working that through. It was the bit after the representation bit that has proven really difficult*. (CS1, ICB, System Associate Director)

The representations received during the standstill periods were slowing down the completion of contract awards. Commissioners were not able to award the contracts whilst the representations were being considered locally or by the Independent Patient Choice and Procurement Panel, which could create long delays. Furthermore, as there were no limits to the number of queries a provider could make in relation to the same procurement, commissioners noted that they could be caught in a loop of continuous representations and requests for disclosure of information, which "has a potential to endlessly extend standstill" (CS1, CSU, Procurement Manager).

> *The other issues which are just starting to emerge as well as we do more competitive procurement under the PSR is the fact that it's very, very easy for providers to bring representations. So, there's no barrier to that anymore, which is leading to increased representations being brought, slowing of procurement and actually quite significant difficulties in terms of finishing things off in some instances*. (CS1, CSU, Procurement Manager)

Providers, on the whole, felt that the competitive process remained fairly similar to the one under the previous framework. Some providers commented that commissioners still tended to overuse competitive process, even though alternative procurement routes were available. They felt that competition should be used as a last resort option or to procure innovative services, and not as a default.

> *I think the viable alternatives are there, but when I talk to the commissioners, their advice is always, we need to go to competition, even when they know what they want to buy.* (CS3, Provider NHS, Specialist Acute)

In contrast, other providers, such as a large private provider, felt that the competitive process was not used frequently enough.

Several providers operating in the community services sector commented that the competitive processes were often used to squeeze financial envelopes for services. This made providers consider the viability of such contracts more carefully.

> *There's an envelope and we scrutinise the service specification, we build an operational model, to achieve the requirements of the service specification, and the KPIs that are within that specification and then we cost the delivery of that up. And we determine whether or not we can deliver it and there are some occasions where we feel the budget isn't commensurate with the requirements of the specification and the KPIs, so we back out.* (CS2, Provider Independent 1, CHS)

Similarly, the CS2 social enterprise provider decided on one occasion not to bid for a contract which they thought was not priced correctly, and reflected on the difficulties of defining value in non-tariff based community services.

> *We did have lots of conversations about value. Value for money, social value, all of that. What constitutes for community services value for money, because there's no tariffs, no reference costs, and I think when we were thinking about the other procurement (…) it really was a 'can we deliver the quality of service we want to deliver within the envelope'. That was the basic question.* (CS2, Provider Independent 2, Social Enterprise, CHS)

One large private provider noted that they were able to respond to the squeezed financial envelopes by offering more innovative and efficient service delivery models. However, smaller independent providers were concerned that only the large providers would be able to respond to such tenders, and this would eventually eliminate smaller providers from the market. Commissioners were also concerned about picking up future costs from the potential provider failure, if providers were unable to deliver on their promises. It is important to note that participants' experiences of these issues were not directly related to the way competitive process was structured in the PSR regulations but pertained to the wider challenges associated with the use of competition in commissioning health services.

Summary

We found a range of views on and experiences of applying PSR processes in practice. Commissioners noted some difficulties in establishing whether a particular procurement falls within the scope of the PSR and then finding an appropriate route for the procurement. There was a range of views and experiences of five processes, with Direct Award B and MSP being the most problematic for commissioners, whilst Direct Award A and C were seen as the most useful, and the competitive process as the least changed compared to the previous regime. The administrative burden associated with the direct awards under the PSR was something that many participants did not anticipate but it was becoming more apparent as the PSR became more embedded. The ease of raising representations was another prominent feature of the PSR, which posed issues for commissioners. Overall, the flexibilities and discretion that commissioners had under the PSR presented some advantages and disadvantages, such as

giving commissioners a wide range of tools for their commissioning approaches but potentially introducing unwarranted variation in commissioning and procurement practices and putting pressure on local administrative resources. Providers, having relationships with multiple ICBs, found themselves at the sharp end of such a variation in procurement practices. Both commissioners and providers operated in the context of financial constraints, carefully considering the cost implications of their procurement decisions and actions for their organisations. The independent providers, in particular, scrutinised the financial viability of certain contracts, whilst the commissioners were concerned about the squeezed budgets.

3.4 Comparing the perceptions of the current and past procurement regimes

The Provider Selection Regime represents a considerable change in the regulation of health services procurements compared with the previous legal framework. This section presents commissioners' and providers' comparative views on the key features of the PSR, such as local discretion and flexibility, transparency requirements and dispute resolution process in the light of the perceived differences between the current and past regulations. It also considers the participants' views on the administrative burden generated by the PSR and how the current experienced administrative burden compares with their experiences under the previous framework.

ICB interviewees noted many differences between the Provider Selection Regime 2023 and the past regime, which operated under the PCR 2015 and the PPCC 2013, commenting that the two sets of regulations had very different characteristics and implications. The participants noted greater flexibility under the PSR for making procurement route decisions, increased transparency and audit trail requirements, a changed dispute resolution process and greater administrative burden of the PSR compared with the PCR framework. The participants observed that some operational efficiencies have been achieved compared with the old framework as a result of the introduction of routes to address previous grey areas (such as Direct Award A) and through shortening standstill periods. However, new grey areas have emerged, in particular with regard to establishing the scope of the PSR.

One ICB interviewee observed that the PSR shortened the time between making and enacting commissioning decisions, due to the shortened standstill periods characterising the PSR, streamlining the enactment of decisions and reducing the need for workarounds.

> *The speed of turnaround on the PSR is so much better. So, whereas previously we had to rely quite heavily on single tender waivers because there was such a long lead time between making a decision and being able to enact it, now we can enact it in a couple of weeks, through the PSR.* (CS3, ICB, Commissioning Director)

In particular, the Direct Award C was commended for speeding up the implementation of commissioning decisions.

> *Waiting times, eight working days for a Direct Award C, you know? As opposed to waiting for 30 days [under the PCR]. So the fact is we can issue a notice today and in less than two weeks, it's approved and we're ready to go.* (CS3, ICB, Commissioning Director)

As noted previously, the introduction of Direct Award A to procure large essential contracts was welcome and removed a grey area around the procurement of such contracts. The new regime was described by one independent provider as representing "an improvement in all areas" (CS3, Provider Independent 1, CHS), reflecting the generally favourable views of the new regulations amongst the interviewees.

However, PSR had introduced several new grey areas which were not present under PCR. The new regulations, for example, were vague in comparison with PCR about the timing for replies to representations from providers.

> *The other thing as well with that process is it's not very black and white. For example, timescale, it [PSR] only references something being dealt with in a timely manner, whereas on PCR, it gave you very much you've got to respond within 30 days, you've got to respond within ten days, this has got to be done within…there's none of that under PSR. That's those grey areas I was mentioning earlier*. (CS1, ICB, Contracting Manager)

Furthermore, many ICB interviewees noted that previously, all types of public procurements were conducted under one regulatory framework, and the distinctions between goods and services, or clinical and non-clinical services, were not as consequential. As already mentioned in the previous section, the PSR regime devised specifically for health services procurements introduced complexity when it comes "to identifying the right legislation under which we should be acting" (CS2, ICB, Contracting Director). This could only ultimately be determined based on the facts in each case. Some ICB procurement staff mentioned that distinguishing what was in and out of scope of the PSR was challenging (CS2, ICB, Contracting Director).

> *I don't like the two regimes, that's a head-blowing moment.* (CS2, ICB, Contracting Director)

3.4.1 Flexibility and local discretion

ICB interviewees welcomed the greater flexibility of the PSR, enabling the more effective commissioning of services, especially in cases where the procurement exercises were straightforward, and the commissioners had clarity over whom they wanted to commission.

> *I suppose one of the opportunities and flexibilities that the PSR regime has unlocked is, where you've got straightforward procurements where there is no other, kind of, capable provider in the market just makes it very simple and straightforward. (…) But it doesn't stop people…(…) challenging that even, but it's quite easy to defend. And so, it, kind of, means that from an ICB perspective, you're probably spending less time doing procurement for known outcomes. So that's a positive.* (CS3, ICB, Commissioning Director)

One commissioner observed positive implications of the increased flexibility in the new regime, in that it was more coherent and clearer than the previous framework, gave procurement teams more responsibility and reflected a better understanding of the whole commissioning cycle.

> *I think it all makes perfect sense, and it's far less confusing I think than it was prior. I think there's more work for the organisation, but in that regard I think from a procurement perspective I think it's really helped the procurement team because it's*

made people take on more responsibility, and they have to understand the whole commissioning cycle and they have to recognise that they've got a role in being able to support justifications for certain processes. (CS2, ICB, Procurement Director)

Yet some ICB interviewees also noted the other side to the greater flexibility observing that the previous PCR framework was better defined and gave commissioners more certainty. The PSR was too vague and could lead to a lot of uncertainty and different interpretations. So, ICB interviewees held diverse views as to the overall effects of flexibility.

I think the problem we have is where PCR was (...) very descriptive and it was almost procurement by numbers, you had a canvas to work against, but you had guidance to follow, whereas under PSR, you've got the canvas but it's too blank…it's almost like, well, you ask somebody to paint a tree and everyone's interpretation of a tree is different, isn't it? (CS1, ICB, Contracting Manager)

The interviewed providers also noted greater flexibility in the choice of procurement processes that commissioners have at their disposal compared with the old framework. This resulted in greater variation in how the rules were being applied by the commissioners. The flexible rules, almost by definition, contained more "grey areas" (CS3, NHS CMH) where the commissioner had more decision space. Some providers commented that more flexibility made it harder for the providers to 'read' the commissioners' intentions and to predict commissioners' behaviour than in the previous system, as if there was no common framework or the framework was "opaque" (CS3 Provider NHS CMH).

[Under PCR] people would have their individual kind of approaches to risk and their commissioning strategies and things, but they would work very clearly within a common framework. (...) under PSR, you have lots of different, similar, but slightly different versions of that framework, depending on the commissioner. (CS3, Provider NHS CMH)

I think if [the PSR regulations] are applied properly and they're considered properly and the decision making around what process you're going to follow, as long as that's justified or recorded I don't think there's much issue with [the PSR rules]. I think if they're not fully understood and corners are cut and decision making isn't clear, that flexibility isn't fully understood either. (CS1, Provider NHS MH)

Thus, the variation in commissioning approaches may be perceived as both warranted and unwarranted. It made it harder for providers to understand individual ICBs' approach to commissioning or how the ICBs want to run their systems, so the providers could respond accordingly. One provider described the situation as feeling "very opaque" and reflected on difficulties of dealing with different risk appetites and strategies of commissioners (CS3, Provider NHS, CMH).

That's entirely down to the commissioner and how they want to play it. (...) I think it can sometimes feel for us that there's, kind of, more ambiguity. From a

> *commissioner's perspective, I guess it gives them more latitude to choose the approach that they want to take.* (CS3, Provider NHS, CMH)

Providers stressed the importance of reducing the scope for "opaque local interpretation" of the rules (CS3 Provider NHS CMH) and for commissioners to provide clear justifications for their decisions. Some talked about the importance of achieving the right balance between standardisation and local discretion, as well as between doing the right things at the right level – national, regional, system and local.

Some providers commented that whilst the PSR offered more flexibility, the commissioners, in their perception, were still reluctant to use it (CS2, Provider Independent 2, Social Enterprise, CHS). One provider felt that the PSR framework was not yet fully embedded in the practices of commissioners (CS3, Provider NHS Acute Specialist). An independent provider felt like the ICBs were still working under the previous framework rather than following PSR, despite clear guidance (CS3, Provider Independent 1, CHS). They called for more training directed at commissioning organisations to improve the understanding and application of the new rules.

> *The ICBs are still hiding, they're still hiding, they're still working under PCR, if you like. That's how it feels. And that could be through a lack of understanding. (…) if there had been better training at the onset, then the understanding would be better now and the application of what is a decent set of rules for us all to follow, that would have been much better. At the moment, it seems like we're learning on the job.* (CS3, Provider Independent 1, CHS)

3.4.2 Transparency

The ICB interviewees agreed that transparency requirements increased compared with the previous framework, in particular in relation to the publication of notices and responding to provider representations. However, they also expressed a variety of nuanced views on the impact of greater transparency. Most ICB interviewees noted positive aspects of increased transparency, but also noted additional administrative burden created by the more stringent requirements. A CSU interviewee commented on the lack of appropriate central infrastructure to streamline the publication of notices under the PSR, in particular the lack of PSR-specific Find a Tender Service notice templates, which made it difficult for inexperienced ICB staff to fulfil such simple administrative tasks.

> *What is pretty evident to me though is that [ICBs] are not equipped to do this necessarily. The notices which are available are basically adaptations of former OJEU notices and they don't fit. The guidance doesn't fully cover what needs to be put in what box. The contracting staff who are meant to be doing it have never done it before. And in some instances, the forms simply don't do what they need to do*. (CS1, CSU, Procurement Manager)

ICB interviewees reflected that due to the absence of thresholds in the PSR the same transparency and information disclosure requirements applied to small value contracts, which were taking a disproportionate amount of managerial time.

> *I think the publishing notification every time you renew a contract or award a contract, again I think is new and I don't think it's necessarily a bad thing. I think the risk I can see with it is that …if you have to continuously respond to challenges which from your point of view might not be significant priorities… So, if you're managing a several billion pound portfolio but you're getting loads of challenges about a 100 grand contract somewhere, and suddenly you've got to pivot some managerial time to go and deal with that… Because, you know, you don't have big teams, you don't have lots of management bandwidth*. (CS2, ICB, Commissioning Director)

Furthermore, the CS3 ICB director noted that whilst previously the audit trail and strong rationale were needed only for competitive routes, under the current regime these apply to all procurement decisions. The greater transparency resulted in "creating more of a market to manage. (…) Whereas (…) in the PCR world, you engaged with the market as you needed to" (CS3, ICB, Strategy Director). The greater transparency around the number and types of procurement decisions and contracts managed by the ICB increased "understanding about the range of services ICBs commission" (CS3, ICB, Strategy Director).

> *It's gone up, the transparency, it's much more transparent than it was previously, particularly for smaller procurements. So for us, we've got something like, I don't know, 40 contracts, predominantly NHS contracts and then we've got about 500 small contracts, and all of the small contracts, the vast majority of them used to be almost invisible to the market as to what we did. Now they're not.* (CS3, ICB, Commissioning Director)

The greater transparency aided the formation of markets in health services. The ICB interviewee also noted the effect of greater transparency on the gradual opening up of the markets in services through market engagement. The transparency notices offered the commissioners an opportunity for market engagement and discussion, potentially avoiding the recourse to external legal advice.

> *We have to make sure that we're doing everything right from the beginning so that you have got the confidence when it comes to that that you can justify all of your reasoning… It's much better than going to formal legal recourse immediately. At least you've got the opportunity to discuss it, and maybe this market engagement stuff will potentially allow us to address some of those things that maybe we hadn't appreciated at the time…* (CS2, ICB, Procurement Director)

Some ICB interviewees noted that transparency requirements minimised the risk of receiving representations by making commissioners focus on the clear rationale for their decision, whilst others held an opposite view, believing that greater transparency requirements

increased the risk of representations by inviting greater scrutiny of procurement decisions, especially from more commercially aggressive providers.

> *I would suggest [risk of disputes] it's higher because we have to tell the world what we're doing, whereas, for example, in the old world with a single tender waiver, unless somebody came and actually checked your…you know, did a Freedom of Information request, they would rarely know that you'd actually issued a single tender waiver. Here, we're actually going out and saying to the world, we've done this, or we're thinking of doing this, please complain.* (CS3, ICB, Commissioning Director)

The CS3 ICB director, whilst acknowledging that more transparency was desirable, at the same time questioned who is primarily benefiting from this increased transparency and whether this is in line with the original policy intentions. What was transparency aiming to deliver in the first place – greater public accountability, improved quality of care or marketisation of provision? In their view, currently, the transparency mainly benefited the providers, rather than patients or the public directly, as procurement decisions are more visible to providers, which leads to the gradual opening up of the market opportunities.

> *[PSR] opens up the provider market, it creates more bureaucracy and the requirement to keep a very robust audit trail, et cetera. But equally, it has, like, a level of transparency. But we need to understand who is the transparency benefiting.* (CS3 ICB, Strategy Director)

Some providers reflected on the deeper meaning of transparency under the current framework. The majority of interviewed providers viewed the PSR transparency notices as "helpful" (CS2, Provider Independent 2, Social Enterprise, CHS) and "useful" and welcomed "seeing quite clearly articulated intentions and decisions in relation to Provider Selection Regime" (CS2, Independent Provider 1, CHS). However, one participant felt that there was less transparency under the current system. They claimed that whilst the procurement decisions were communicated transparently, the rationale behind some of the decisions often remained hidden and was not easily deducible for the providers.

> *In some ways it's become more akin to the commissioner does what they want to do and then you find out (…) so, it's transparent in that I can see that happening. It's not always transparent as to their true rationale behind that. And I think sometimes the rationale you get, you, sort of, think, well, I'm not sure I agree with that. I think there is, sort of, an intention behind this but I'm never really going to get clarity around that. So, I guess it can make…as a provider, it can make you a bit cynical about it because you know when you're getting just, sort of, a bit of a wall rather than a clear rationale and, you know, real transparency.* (CS3, Provider NHS CMH)

3.4.3 Dispute resolution

PSR introduced a two-stage process for challenging procurement decisions consisting of a local dispute resolution stage and a judicial review. The local dispute resolution stage involved an investigation by the relevant authority itself with a possibility of escalation to the

national Independent Patient Choice and Procurement Panel for independent advice. As a result, the risk of procurement disputes pursued through the court system diminished considerably under the PSR compared with the PCR. ICB interviewees thought that the new process was preferable to going "straight to court" and valued the national Independent Panel's decisions as they offered further guidance on how to apply the rules (CS2, ICB, Procurement Director). One CS1 CSU manager observed that there was still a "huge fear" of the ICB's decision making being subjected to detailed scrutiny by the national Independent Panel (CS1, CSU, Procurement Manager).

Despite preferring the current dispute resolution process, ICB interviewees in all three case studies were, nevertheless, very vocal about the challenges that it posed for them. The first challenge pertained to the ease with which providers could raise a representation. The PSR rules did not specify the grounds for challenging commissioning decisions, the process was open to all aggrieved providers (not limited to unsuccessful bidders), the costs to providers of making representations were low (it was free to make a representation), whilst the burden of devising and administering the procedures for managing provider representations locally and the cost of consulting legal experts fell on the local ICB. This was seen by ICB interviewees as imbalanced.

> *So we've spent a lot of this week going backwards and forwards with legal trying to understand how we deal with the three representations that we've had. When we talk about increased administration burden, there's an increased administration and legal burden from that perspective, because new regs, a lot of uncertainty, not really great guidance as well from the centre on how we should deal with things at a very high level. And when you start getting into the minutiae of how you should deal with the representation, it's very difficult, because there's a lot less structure around how you should progress it, like I say, just from a simple perspective of timescale*. (CS1, ICB, Contracting Manager)

> *We can get a representation very easy from any provider, and for us to defend ourselves, it is quite burdensome. We have to invest quite a lot of time and unfortunately it seems like there is no clearcut…presently, we are going through a representation now and we are pretty much stuck with that, and every time that we respond, the provider comes back and challenges again, and we are obliged to do an [internal] panel to respond. So it is very lengthy and is quite challenging, the process.* (CS3, ICB, Business Director)

> *Representations is an interesting space because if you're the provider and you didn't get it, why not make a representation? It cost me nothing but time.* (CS2, ICB, Contracting Director)

At the time of the fieldwork, CS1 had received three representations, CS3 had received three representations, and CS2 had received one representation from aggrieved providers, most of whom were from the independent sector. In each case, the ICB stood up an internal panel to

review the representations and was unable to conclude the procurement process while the representations were considered. One CS3 ICB interviewee remarked that, given the large number of contracts procured through the PSR to date by the ICB (mainly using the Direct Award C route), the number of representations that they received was relatively small. However, several ICB interviewees expected that as everyone gets more accustomed to the new regime, the volume of representations will increase.

> *I have said to our executive board, I anticipate that there may be one for every competition that we run.* (CS2, ICB, Contracting Director)

> *I see a lot more things getting challenged.* (CS3, ICB, Commissioning Director)

Others thought that the ease of making challenges under the PSR may be counterbalanced somewhat by providers' reluctance to jeopardise good relationships with commissioners.

> *It's a balance because I think at the same time most people who are looking to enter the market don't want to irritate people who then make decisions about whether they get contracts or not*. (CS2, ICB, Commissioning Director)

The CS2 Contracting Director noted that whilst there should be a mechanism through which providers can appeal and challenge procurement decisions, the bar for making representations was set too low. They perceived some of the provider requests as "ill-informed" and not grounded in a "manifest error", but requiring commissioners to dedicate precious managerial resources to responding to such requests (CS2, ICB, Contracting Director).

> *What I think is dangerous though is the manner in which representations can be made by anybody, at any time, without a reliance on material error, for, you know, the benchmark is so low, to come back and say I don't like the decision you've made.* (CS2, ICB, Contracting Director)

> *Unfortunately, when everybody gets used to this process more and more, I believe that providers are just going to try their luck and do representations without even having very solid grounds, and that is what I'm saying, there needs to be a threshold to raise a representation.* (CS3, ICB, Business Director)

Another issue related to providers making repeated representations, which could delay the award of contracts. Two of the case study ICBs received multiple, repeated requests for clarifications and information from providers relating to the same procurement process, slowing down the procurement and precluding contract awards. In CS1, for example, the commissioners could not award the contract to the winners of two competitive bids because they were receiving continuous representations from the unsuccessful bidders. One of the unsuccessful bidders was the incumbent provider, so the commissioner had to go back to them and ask them for an extension of the existing contract until they sorted out answering the representations. The CS1 ICB interviewee also felt that rebutting provider representations was more difficult under the PSR than under the PCR rules (CS1, ICB, System Associate Director).

Most of the interviewed independent providers had positive views of the dispute resolution process. The CS2 social enterprise provider perceived the process as "very reasonable" and noted that they were monitoring the Independent Panel's decisions. They saw it as a welcome change compared with the past, stemming the costly litigations through courts occurring under the PCR. Another provider noted that the decisions of the Independent Panel were well-balanced and a useful guide for actions to commissioners and providers on the ground.

> *I've read most of the findings that they had, you know, summary level rather than full detail but they seem to be very balanced and considered. And I like their process whereby they consider if there has been something that they aren't happy about, they don't necessarily just say the whole thing is scrapped, they will consider at what point you need to go back in the process, not restart but to pick up…And I think the panel provides quite clear evidence that people can see and learn from.* (CS2, Provider Independent 3, GP Federation)

In contrast, one private provider voiced some dissatisfaction with the dispute resolution process under the PSR. They commented on the lack of effective sanctions that the ICBs can be subjected to following the Independent Panel's decision (CS3, Provider Independent, CHS). The stage after an Independent Panel's review was described by one provider as "no man's land" (CS3, Provider Independent, CHS) as the Panel's recommendations were of an advisory nature and the final decision still lay with the original commissioner. This was seen as a drawback of the current regime, which, in their opinion, may potentially result in some procurement decisions being challenged in the judicial review process. In CS3, the independent provider called for tightening the enforcement of the rules and for the introduction of a third party with powers of direction over relevant authorities in cases where the rules have been breached.

> *Where an ICB gets flagrant with the rules, the IPCPP doesn't have the powers to really bring them back in line. (…) effectively it sort of goes into no man's land at that point because the IPCPP can't get themselves involved, the service is still running in the background, even though it's not technically awarded (…) So the only thing I would say about PSR is it's a really good system, we do think it is better for the NHS, but there are limitations of how people can get ICBs back on track when things aren't quite right, and I think that's something worth considering.* (CS3, Provider Independent, CHS)

> *If a decision is made and it's incorrect, and it's recognised by, say, the IPCPP [Independent Panel] as incorrect then the agency to correct it shouldn't probably be given back to the person who made the wrong decision, and then went through several challenges to be told that, because that is just going to then…we're going back round in a circle. There needs to be a step change effectively where someone else has to get involved and the decision needs to be reviewed in a different light. And I think that's what we're missing from the current PSR.* (CS3, Provider Independent, CHS)

NHS providers were cautious about raising procurement complaints, seeking to preserve good relationships with the commissioners, which they have built in the years of collaborative system working. For instance, one community and mental health services provider was mindful "not to burn your bridges" and did not want to jeopardise established collaborative relationships by resorting to a transactional approach (CS3, Provider NHS CMH). However, the same provider admitted that they looked after their organisational interests through other means such as in contractual negotiations with the commissioner.

> *There have occasionally been cases where…or situations where we've, I don't know, negotiated hard, like properly hard around aspects of contracts, i.e., refuse to sign contracts until we've properly, kind of, agreed the right answer with our commissioners and so on. But that's slightly different to, you know, appealing against a decision.* (CS3, Provider NHS CMH)

Others were approaching the commissioners informally, seeking to influence the commissioning decisions, treating formal challenges as a last resort option. For instance, the CS3 NHS provider of specialist acute services approached some commissioners to challenge their plans for an MSP award, to let them know that they were also a suitable provider for this type of service and that they should be considered for an MSP award or the process should be open to full competition.

> *Almost first conversations will be informal between our contracts leads and our directors and their staff. So it very rarely goes up to the level of we will have a formal dispute. So I think we're relatively unique in that position and we've written a couple of letters recently in relation to procurements that have or haven't taken place to another ICB. But that's been chief exec to chief exec letter, saying, you said you were going to tender this service, you didn't tender this service and now you appear to be commissioning it out through a different provider through the backdoor. Can you stop that?* (CS3, Provider NHS Specialist Acute)

Some interviewed providers also commented that engaging in challenges was not worthwhile, as it was difficult to overturn the substantive decisions, and the challenge mainly related to the procedural errors. Overall, the NHS providers were significantly invested in the system working, and their sustainability depended on the trusted relationships with commissioners.

> *I would imagine there are organisations out there who are much more, kind of, hawkish about this and use those sort of processes liberally. I think we use it very sparingly but it's because, to be honest, we're only really as strong as the trusted relationships that we have in each of our patches and with our commissioners.* (CS3, Provider NHS CMH)

Although independent providers' relationships with commissioners were more transactional than those of NHS providers, some expressed similar reservations about using the formal complaint route. One large private provider of community services mentioned that some providers may be reluctant to challenge procurement decisions in order to avoid reputational

damage and because it was increasingly difficult to change the substantive outcomes of such decisions (CS2, Provider Independent 1, CHS).

> *So even when we feel the feedback is perhaps unfair or inaccurate, the assessment of our bids is inaccurate and even when we feel we don't have…I think it's fair to say that many organisations do not have confidence that that will change the outcome and that it will only cause further harm, potentially reputational harm, to the provider. So most providers will be very, very, very reluctant to challenge, because of the repercussions, reputationally, if they do that.* (CS2, Provider Independent 1, CHS)

3.4.4 Perceptions of higher administrative burden of operating the PSR

In general, participants perceived that the administrative burden under the PSR had increased compared with the previous framework. The increased flexibility and discretion, increased transparency, due diligence and audit trail requirements, lack of thresholds exempting small procurements and largely localised dispute resolution process were perceived as contributing to the perception of heightened administrative burden of operating the PSR for ICBs. In addition, non-PSR related processes, such as non-NHS provider accreditation and procurement of goods and services under the Procurement Act 2023, administered in the ICBs within the same procurement and contracting teams, were adding to the perception of heightened administrative load. The administrative burden manifested itself in various ways including extra workloads, a lack of staff with appropriate expertise and lower productivity due to general unfamiliarity with the new processes. The higher administrative burden was largely not anticipated by the ICBs, who were instead expecting administrative efficiencies as a result of the expansion of the direct award options and removal of the imperative for competitive tendering.

Some ICB interviewees perceived the administrative burden associated with the PSR in a positive light, attributing it to the tightened requirements for good contract administration. Whilst using the PSR procurement processes, including direct awards, the commissioners had to compile, appraise and record evidence on provider performance, which was seen as a more stringent due diligence requirement than hitherto. Commissioners observed that under the PSR more justification was needed to support decision making.

> *I think [PSR] it's added a greater level of bureaucracy, a greater level of scrutiny, a greater need for absolutely documenting, recording, auditing; we always did that but I mean through the lifecycle of a contract now. So, a greater need for good contract administration, for all of the organisation to be cognisant of the need to consider rationale and evidence, and justifications, and what good looks like.* (CS2, ICB, Contracting Director)

The PSR was described as requiring more effort to operate but also enabling a greater range of actions than the previous framework, one participant describing it as "it takes more to do more" (CS2, ICB, Contracting Director). However, the extra transparency and due diligence

requirements, especially for notices and justifications of commissioning decisions relating to small-value contracts, were seen as creating more friction than in the previous regime.

> *Bizarrely, for some of the more straightforward transactional elements, I think sometimes it can perhaps cause more work than it is worth in terms of the new notification processes and the justifications and some of those sorts of things for stuff that has been…historically would've been quite straightforward*. (CS2, ICB, Commissioning Director)

ICB interviewees observed that the transparency notices increased in both volume and complexity of information that needed to be disclosed, which had an impact on administrative resources. The commissioners had to present a clear rationale for their decision making and were always mindful of potential challenges. Furthermore, the issuing of appropriate notices on the Find a Tender Service platform was complicated by the lack of PSR-specific notice templates and other IT issues, creating more administrative friction.

Similarly, managing provider complaints locally added to the administrative burden on the ICBs. One CS2 ICB interviewee reflected on the ease of raising representations under the PSR and a lack of a quick route to deal with representations which could be deemed unreasonable, trivial or having no grounds. Furthermore, ICB interviewees were concerned about the high workload required to adequately deal with each representation, as well as anticipating the growing volume of challenges in the future.

> *It's very easy for a provider to put a complaint and that makes us to stop, so even if we are correct, we have to stop, review and we have to involve a big amount of time for a big amount of people to address something that we could think they have no reasons to raise it, but we still need to deal with it.* (CS2, ICB, Contracting Director)

In the view of some ICB interviewees, the higher administrative burden they were experiencing created a case for expanding the contracting staff, which was difficult to deliver in the ICBs facing mergers and staff cuts. In practice, the extra administrative burden generated by the PSR was borne by the existing staff.

> *And these issues are quite hidden, because a lot of them have been absorbed by people who are already in roles, so they've just increased their workload, they're working much longer hours to achieve…So I'd say from an administration perspective on the ICB, there's a lot of hidden increase, but we'd quite easily be able to employ two more members of staff to manage the administration process*. (CS1, ICB, Contracting Manager)

The additional administrative pressures had a negative impact on procurement professionals within the ICBs, who felt in danger of deskilling as they had to devote more time to routine admin tasks and less time to honing their wider strategic purchasing skills. One procurement manager referred to their current workload as being "a glorified post-box for notices" (CS1, ICB, Contracting Manager).

> *It's almost deskilled the profession, if you like. Whereas before you'd use procurement professionals, now you'd probably need a lot more administration posts to post the notices that basically just say we've awarded it on this basis. (…) I feel with PSR it's retrograded that back to being more of an administration process rather than being used strategically. We haven't got enough capacity at the moment, and things might change, but at the moment we haven't got enough capacity within the system to do the process element of it and be more strategic and look at how we take that forward*. (CS1, ICB, Contracting Manager)

One CS2 ICB interviewee suggested that pooling of resources and expertise over wider geographies may be required to ease the administrative burden in some areas. They perceived the process of restructuring the ICBs as an opportunity to review the administrative workloads, but were also concerned that it may result in a potential loss of the right expertise (CS2, ICB, Contracting Director).

> *As ICBs are further slashed then we will have to look at operating more collectively, and that definitely… So, I've suggested that Direct Award B certainly is done across the region, so that we have some synchronicity in our assessments and judgements, and our forms of contract award, et cetera, and specifications; and I think there's an opportunity there. I think there's an opportunity in looking at representation management across broader geographies as well, because of that there'll be a paucity of subject matter expertise as we start to strip back ICBs.* (CS2, ICB, Contracting Director)

Some participants thought that the ICBs may get better at operating the PSR, which may reduce the administrative burden in the future, viewing it as "transitional" (CS2, ICB, Commissioning Director), but others felt that the increased administrative burden was a more permanent feature of the new regime rather than a temporary effect associated with the learning curve.

> *I think we'll get better at using it, which will make it much more intuitive, and to sort of be knowing, and knowing what the evidence looks like, what does good look like? How do I prove that these are the right providers for these services? What should I be gathering? What can I point to? I think we'll get better at doing that and keeping records and documenting that throughout the term of the contract*. (CS3, ICB Commissioning Director)

Interviewed providers felt that the administrative burden under the PSR has either remained the same (CS2, Provider NHS MH; CS3, Provider NHS CMH) or somewhat increased. The latter was related to more extensive and speedier requests for information from commissioners. The providers felt that the promise of simplification of procurement under the PSR did not materialise. One provider (CS3, Provider NHS CMH) was glad that they did not disband their business development team, as they found the requests for data from commissioners increasingly burdensome. The variability in commissioners' approaches

enabled by the PSR required providers to devote more administrative resources to tailor their offers to different commissioners. One provider illustrated the issue with an example of different interpretations of social value (one of the five key criteria for assessing a provider's offer) by different commissioners. They argued that instead of leaving it to local discretion, a standardised view and a consensus on what constitutes social value in community services provision would have been more efficient. Whilst buying into the principle behind social value, in practice, they found the lack of common understanding of it and its multiple interpretations "quite bamboozling" (CS3, Provider NHS, CMH).

> *If what social value looks like for every different commissioner is slightly different, it makes it much harder for us to deliver a coherent, joined up offer, which is social value or community value and so on. Because what we find is that for every different contract, it will be a very localised kind of interpretation of what that means, almost to a community level. And that can be really tricky.* (CS3, Provider NHS, CMH)

As noted previously, several providers commented on the variation in the way commissioners interpreted requirements for Direct Award C, with providers finding that some direct award processes can be as administratively burdensome as large competitive contracts. Whilst commissioners were requesting quick turnarounds, providers needed more time to scrutinise the financial viability of the terms for each contract, which added to the administrative pressure.

Overall, participants appreciated that there were interdependencies and trade-offs between different features of the PSR, such as between greater flexibility and greater transparency at the cost of greater administrative burden. Some viewed this as a reasonable position to be in.

> *I think the legal framework around procurement I think does have flexibility in it and doesn't cause us problems. I think actually, you know, there's slightly more paperwork to do but, as I say, I think that's a transitional bit. I think actually the range of tools you have are probably quite helpful*. (CS2, ICB, Commissioning Director)

For others, the greater administrative burden was not sufficiently offset by the newly gained flexibility. This may be due to the non-compliance with the past framework, considerably reducing the felt administrative burden associated with the past regime and heightening the perception of the current burden. It may also be because of the problematic aspects of some of the processes introduced by the PSR itself, complicating the overall appraisal of the utility of the new regime. In particular, Direct Award B created a lot of uncertainty for commissioners, and the MSP was difficult to use in practice.

> *I think the way PSR was sold to everybody, I think it should have provided that flexibility, but I think if you had Direct Award Process A, C and competitive only, I'd have said yes, it would have worked well. But with the complexities that B's brought about, and the capacity that's taken to facilitate and manage, and the grey areas of MSP, in particular, I think it's rendered large parts of it unmanageable or just unusable*. (CS1, ICB, Contracting Manager)

Summary

Participants noted many differences between the way they operated under the current and past procurement regulations. The participants noted greater flexibility under the PSR for making procurement route decisions, increased transparency and audit trail requirements, the changed dispute resolution process and higher administrative burden of the PSR. Compared with the previous procurement regime, ICB interviewees observed improvements in the PSR rules, for example, shortening the standstill periods and streamlining the enactment of commissioning decisions through the options of the different direct awards. Some commissioners, however, felt that the PSR regime introduced new grey areas, like a lack of clarity about the timing for replies to provider representations and difficulties in distinguishing what was in and out of scope of the PSR. In that sense, the PSR represented 'a tale of two halves'.

The views of ICB interviewees about the flexibility and discretion allowed by the PSR regime were generally positive but not consistent. ICB interviewees welcomed the greater flexibility of the PSR enabling the more effective commissioning of services. Yet some participants were concerned that, in comparison to the previous regime, the greater flexibility and discretion under the PSR could lead to uncertainty and multiple interpretations of the rules. Others thought that PSR was clearer than the previous regime and gave procurement and contracting teams a better understanding of the whole commissioning cycle. Providers mentioned that the increased flexibility and discretion in applying the PSR rules translated into inconsistent commissioning and procurement approaches for similar services in different geographical areas, which made it harder for providers to 'read' and respond to commissioners' intentions. At the same time, some interviewed providers observed that commissioners were not yet utilising the flexibilities of the PSR in practice. Some providers suggested that more standardisation in the interpretation of the rules, definitions and approaches may be required.

Interviewees held nuanced views on the increased transparency requirements of the PSR. Some thought that the transparency requirements decreased the risk of provider representations, increased market engagement and promoted development of markets in services. Others thought that transparency requirements increased the risk of challenges, especially by the more commercially aggressive providers, questioning who is benefiting from the increased transparency. The publication of transparency notices was complicated by the lack of PSR-specific notice templates.

ICB interviewees were very vocal about the ease with which the providers could raise representations. The PSR rules did not specify the grounds for challenging commissioning decisions, the process was open to all aggrieved providers, the costs to providers were low (it was free to make a representation), whilst the administrative burden of dealing with representations and the cost of legal advice fell mainly on the local ICB. This was seen by ICB interviewees as imbalanced. Some were concerned that the ease of raising representation and the possibility of raising them multiple times might be exploited by some providers. On

the other hand, NHS and third sector providers sought to gain insights or influence over commissioning decisions through their longstanding collaborative relationships with commissioners, avoiding the formal complaint route. Some private providers also stressed that they were reluctant to challenge commissioning decisions to avoid reputational damage and because it was difficult to change the substantive outcomes of those decisions. They referred to the Independent Patient Choice and Procurement Panel's lack of power to enforce its decisions on commissioners.

Many ICB interviewees noted increased administrative burden under the PSR, which was not anticipated, and which put a great strain on limited ICB resources at the time of the proposed cuts to the ICBs. The higher administrative burden was discussed in the context of such aspects as a lack of thresholds for small value contracts, transparency notice requirements, greater emphasis on evidencing provider performance and local dispute resolution process. The increased administrative burden was borne by the existing staff in the ICBs, which in some cases led to decreasing professional development opportunities. The views on additional, unforeseen administrative burden were echoed by NHS and independent providers who felt that commissioners raised more extensive and speedier requests for information.

Overall, participants commented on the interdependencies and trade-offs between different features of the PSR, such as between greater flexibility and greater transparency at the cost of greater administrative burden, reflecting on the complexities of the new regime.

3.5 Views on the PSR NHSE guidance

The introduction of the PSR was supported by extensive guidance published by NHSE in October 2023 and subsequently updated (NHSE, 2023a). The guidance contains a range of supporting materials such as flowcharts, end-to-end process maps and frequently asked questions. NHSE also ran webinars prior to the PSR coming into force and provided a dedicated communication channel for raising PSR related queries. In this section we review participants' views on the availability and clarity of the PSR guidance.

3.5.1 Commissioners' views

Overall, ICB interviewees found the NHSE guidance on the PSR quite clear. One ICB interviewee remarked that it was sufficiently clear for a non-procurement specialist to understand, which facilitated the workflow between commissioning and procurement colleagues within the ICB.

> *I mean, regarding PSR, apart from those two issues that I raised earlier [scope of services under PSR and ease of raising complaints], I think it's fine. We've been working with it, it's quite clear, we have discussed it with other departments, so people, even that they don't have experience in procurement, they do understand the differences [between processes] and when [the PSR] can be applied.* (CS3, ICB, Business Director)

> *I think the whole PSR to me is so much more simple and easier to understand than the Procurement Act, and the way in which it's been authored and the fact that everything about a subject is in one place generally. It's in appropriate chapters...So yes, I think it's really good. And the templates are really good, the flow charts are really helpful.* (CS2, ICB, Procurement Director)

One ICB director, however, thought that the support from NHSE around the application of regulations to real-life situations was absent and that the ICB had to resort to expensive legal advice. This interviewee suggested that there should be a national support team for PSR queries, such as the national contracting team that commissioners can contact for support.

> *So, my example of that would be in the contracting world, if I had a problem in terms of the application of the rules of the contract, there is a national contracting team that I could go and talk to…I don't get a sense and I don't think we've seen the same, sort of, support in terms of the PSR regs from NHS England that's helped us work our way through it. And I think that's evidenced by the stuff that we're going through at the moment around representation and all the stuff that we're having to do with lawyers rather than with NHS England*. (CS1, ICB System Associate Director)

One ICB contracting director noted that one needs to read the statutory instrument, guidance and any other PSR toolkit materials together to understand a particular position. Flowcharts, in particular, were seen as providing more categorical answers where guidance left space for interpretations, so they were seen as particularly helpful.

> *The guidance is okay. I think you have to read everything together though, to fully understand it. So, you have to read the statutory instrument as well as the guidance, as well as review on the flowcharts. And only that way do you genuinely get full understanding.* (CS2, ICB, Contracting Director)

Some areas mentioned where guidance could be improved included determining whether a procurement falls within the scope of the PSR; tightening grounds for raising representations; informing other bidders about the extension to the standstill period due to the received representation, and whether or not other bidders can launch their own representations during the extended standstill period.

ICB interviewees were confident that the guidance will be tested and improved over time with more examples and scenarios provided.

> *So there will be tests that then enhance the guidance as we go through time, I'm absolutely sure about that.* (CS2, ICB, Contracting Director)

Some participants commented on an interface with other sets of relevant NHSE guidance, in particular that of patient choice. The guidance in relation to services subject to patient choice was seen as contradictory.

> *So, now the guidance is a little bit, sort of, bipolar really. So, on the one hand it will say, people can do unlimited activity and everyone has to pay for it, and then on the other hand it will say, but you're not allowed to bankrupt the NHS and people need to work together to agree plans that are sensible. And it just goes into quite a grey area of how that works so you're relying on people to work within the spirit of agreements*. (CS2, ICB, Commissioning Director)

Many ICB interviewees called for a wholesale review of the patient choice policy and guidance, some pointing out potential adverse implications of the current policy set up for the quality of services subject to patient choice. The main concern related to a lack of capacity and capability at the ICB level to deliver robust and consistent quality assurance and oversight processes of independent providers who were using the patient choice policy as a route to market entry.

3.5.2 Providers' views

Similar to ICB interviewees, providers held broadly favourable views of available guidance. However, one specialist acute provider found the guidance "too ambiguous" (CS3, Provider NHS Specialist Acute). They noted that guidance leaves a large room for local interpretation, which had practical implications. They were calling for a situation where "at least 80 or 90 per cent of cases should be easy to put into boxes," and one did not need to seek external advice (CS3, Provider NHS Specialist Acute). In their view, underspecification, especially in circumstances of resource constraints, may increase risk-aversion of ICBs, which in this case

was interpreted as avoiding direct awards and using unnecessary competitive processes, and may hinder innovation and more thoughtful commissioning.

> *We write policy in such a way at NHS England that we don't provide guidance, we leave everything up to local decision and we leave so much ambiguity in it that actually people who are at under capacity don't have enormous amounts of confidence in the decisions they're going to have to make with the very short amount of time they've got to make those decisions, and the relatively poor information that they've got to make decisions, will just tend to make the simplest thing for [the commissioners], which is very rarely the intention of the policy.* (CS3, Provider NHS Specialist Acute)

> *I do feel that PSR rules are a bit like that, in that it's quite simple, it's quite straightforward in some ways, it actually reads quite ambiguously in a lot of ways. It's all up to local decision. And actually, therefore, there's a real incentive for commissioners to just skip the Direct Awards and the Most Suitable Provider options and go straight into competition.* (CS3, Provider NHS Specialist Acute)

Another provider observed in a similar vein that PSR guidance was "complicated but clear" (CS2, Provider NHS MH). However, they could not comment on how it impacts commissioners because, as a provider, they were not "making the commissioning decision" and "facing any potential liability" based on this guidance (CS2, Provider NHS MH).

In CS2, the social enterprise provider appreciated that the PSR guidance and toolkit, such as FAQs, were being continuously updated, providing more detail, which made it easier to interpret the legal briefings and Independent Panel reviews. Another participant mentioned that the guidance needed to be continuously updated with the learning from the ongoing application of the rules.

> *So I think the guidance when it first comes out is fine, it helps, but then once you apply it there is going to be some variation because people interpreted things different ways, and then as long as it's updated with any learning that's been identified it's fine*. (CS1, Provider NHS MH)

Independent providers praised the available PSR guidance, perceiving it as "straightforward" (CS3, Provider Independent, CHS) and "clear", "easy to find" (CS2, Provider Independent 1, CHS). However, despite praising an adequate and clear guidance, some were also flabbergasted as to why many commissioners "get it wrong" (CS3, Provider Independent, CHS) or were not yet able to act on it (CS2, Provider Independent 2, Social Enterprise, CHS).

> *I would just say that it's not just the PSR that's good, that it's nice and straightforward, the guidance that supports it is extremely good. You can't get it wrong, and so many people do, and that's I think the biggest issue that I would have.* (CS3, Provider Independent, CHS)

Summary

ICB interviewees found the NHSE guidance on the PSR generally clear, but some felt they needed more support around the application of the rules to real life situations because they frequently had to use expensive legal advice. They suggested regular updates with the learning from the ongoing application of the rules and an ongoing national support team for operating PSR, similar to the one offered by the national contracting team. Some ICB interviewees noted the impact of other NHSE guidance, particularly on patient choice, which was seen as problematic.

Some NHS providers found the PSR guidance too permissive and ambiguous in certain areas, with lots of room for interpretation, which, in their view, could result in risk-aversion by commissioners and the use of unnecessary competitive processes instead of using more direct awards. Independent providers were generally positive about the rules and the available guidance. Some independent providers, however, complained that commissioners, in their view, did not always apply the rules appropriately.

3.6 Implications of the PSR for strategic commissioning and provider landscape

The 10 Year Health Plan reemphasised the ICBs' role as "the strategic commissioners of local healthcare services" (UK Government, 2025: 79). The ICBs will be expected to "draw on a deep understanding of population need, and to make long-term decisions in the interests of improved outcomes and financial sustainability", utilising a range of commissioning tools, including market management, procurement and contracting (UK Government, 2025: 79).

In this section, we draw some implications of the PSR for the ICBs' role as strategic commissioners, as well as reflect on implications for providers, in particular on the way providers compete and cooperate.

3.6.1 Alignment of the PSR with the ICBs' role as a strategic commissioner

The Provider Selection Regime was seen as a powerful tool in the hands of commissioners, as it offered flexible tools to commission complex contracts such as lead provider arrangements. One ICB interviewee mentioned that the PSR regulations could be a very useful tool for strategic commissioning in future, which could enable long-term provider-commissioner relationships, unlocking investments in staff, infrastructure and well-performing service models. Yet at the time of the research, the regime was still new, and ICB resources were limited, so case study ICBs did not have the resources to take full advantage of the rules and were resorting to short-term fixes.

> *We are in this, sort of, transitional phase…I think we're probably using a lot more Direct Award C just to sort of roll stuff over, because we haven't had enough time to really consider the portfolio as holistically as we would like, and that'll sort of catch up over the next couple of years…But (…) we're probably not making the most of all of the tools at the moment because we're … Direct Award B is quite time-intensive and (…) you've only got so much managerial time in a given year, you can only target so many big areas of work.*' (CS2, ICB, Commissioning Director)

One CS2 ICB interviewee praised the PSR for enabling long-term investment in services through the use of Direct Award C, in particular. However, they noted that such approaches could only be executed "within the limitations of the way in which you let your contract initially", which required one to be "very intelligent about scoping that contract from day one" and thinking strategically (CS2, ICB, Procurement Director). At the same time, they worried that longer contracts may not please all providers, as they may limit the market and provider competition.

Many NHS and third sector providers noted that the commissioners were lacking in commissioning skills and not yet making full use of existing flexibilities under the PSR. They advocated for greater use of alternatives to competitive process, as well as for the procurement of longer contracts and more innovative commissioning to facilitate provider collaboration, for instance, commissioning provider collaboratives to deliver clinical triage of referrals. Longer and larger contracts were welcome from the point of view of unlocking

provider investment in services, however they carried a risk of market concentration adversely impacting smaller providers. However, other participants did not yet see the PSR having an impact in such ways, stating that commissioners do not yet have the bandwidth to exercise their strategic commissioning role properly, which would require dealing with a complex legacy of fragmentation of contracting and provision dating back to the CCG era.

> *Commissioners and procurement teams in ICBs are not strong, they lack skills, they lack expertise, they lack time, more than anything. There's very little development for them and there's very little legal support. And as soon as the first legal letter comes in from another provider, whether it is warranted or not, they go straight back out to competition, because actually they don't feel confident enough to face down providers who may be putting in fairly speculative legal challenges in order to open up the market.* (CS3, Provider NHS Specialist Acute)

Similarly, the CS2 social enterprise provider thought that the PSR has lots of potential, but its realisation comes across skills and capacity gaps in commissioning.

> *I do think that the legislation's got loads of potential, it's needing that skill base and a stable skill base in commissioning to really drive the value out.* (CS2, Provider Independent 2, Social Enterprise, CHS)

> *I think the legislation does give the flexibility, it's the execution, and I think it's having the confidence and the courage to do the right thing for patients and the population rather than a well, we need to cut costs or we're worried that X company over there will then sue us for millions and stuff like that. So it is the skill, the capability. And hopefully with the refocusing of ICS roles and responsibilities there is more emphasis on that contracting procurement, that strategic commissioning that will change, but I don't think in the short term it will, and I think ICSs will continue to be risk averse in what they're doing.* (CS2, Provider Independent 2, Social Enterprise, CHS)

As noted in section 3.4.1 on local discretion, some providers voiced frustration with commissioners' risk aversion and hesitation to make full use of the flexibility that the PSR rules allow and with defaulting to the competitive process, instead of showing a bit more "courage" (CS2, Provider Independent 2, Social Enterprise, CHS).

> *I think the lack of a very clear strategic direction by the [CS2] ICS underpins the decision making. Because in other systems I think they're much clearer about where they want to go in terms of provision. I think the 18 months [contract] is because in [CS2 ICB] there are four different community providers in the four places, all of whom had different contract durations, so they're trying to line us all up. (...) So we've heard one provider, two providers, vertical integration, horizontal integration and all of that, and they don't know what they want.* (CS2, Provider Independent 2, Social Enterprise, CHS)

One CS2 NHS mental health provider described commissioners as still fearful of potential litigation, even though the risk of litigation through courts (as opposed to the risk of challenges through an internal process) has diminished considerably compared with the PCR framework. They observed that the level of evidence required to provide a rationale for procurement decisions under the PSR was high, potentially compounding commissioners' risk aversion towards using alternatives to competitive process and fear of challenges.

> *What I experienced as the genuine fear of a commissioner saying, oh we'd like to do it, but we don't think it's safe. So, as I said, it still feels like if it's gone to market once, PSR isn't enough to stop it going to market again. (…) They [commissioners] seem to be saying that though the rules allow it, they need to be able to assure themselves a number of things are true, and that those things are quite difficult to evidence, and therefore you still open yourself up to litigation.* (CS2, Provider, NHS MH)

In contrast, private providers had a different outlook to the NHS or established third sector providers in that they preferred more procurement to be open to competition to increase their market share or chances of market entry and stressed the importance of robust pre-market engagement exercises feeding into the tendering processes. The CS2 private provider of community health services expressed their concern that some of the procurement processes did not appear "genuine", were not preceded by genuine market engagement, where the outcome was likely predetermined or were not executed to the highest standards. This was perceived as contrary to the public interest. In particular, they deemed it a "dereliction of duty" (CS2, Provider Independent 1, private, CHS) when commissioners used direct awards to procure services from the underperforming NHS providers.

> *If you're genuine about wanting the best for the public, you really want to get to know who the potential suppliers are going to be, or the providers are going to be, and you want to excite them about the opportunity and inform them, so that they can put forward their best proposition.* (CS2, Provider Independent 1, private, CHS)

The CS2 private provider saw the current ICB structures as "conflicted" and commented positively on the ambitions of the 10YHP and strategic commissioning turn, of potentially reasserting the purchaser provider split.

> *The role of the ICBs is becoming strategic commissioners is going to be crucial for the implementation of the new Provider Selection Regime (…) I think the current structure is conflicted. The current structure, where you've got commissioners and providers on a decision making board, we lose a sense of objectivity. I don't think that the issues are being confronted all the time and it's very hard to do something about poor performance, (…) I think the separation of ICBs, from the providers, and separation of strategic commissioners is good for the public, is good for service quality. And certainly good for financial viability.* (CS2, Provider Independent 1, private, CHS)

The same private provider commented on the inconsistencies in the way different commissioners discharged their roles as advocates of public interest and stewards of taxpayers' money. They emphasised that the commissioners have a responsibility towards the public and a powerful tool in their hands in the form of the PSR. They advocated for the introduction of commissioning standards and for strengthening the accountability of procurement decision makers. They emphasised the importance of not just simply following the processes, but also upholding the principles of fair procurements, which, in their experience, was variable.

> *Rules are rules, it's about who is executing those rules and what ethical, moral standards they're applying.* (CS2, Provider Independent 1, CHS)

> *What I didn't see, when [PSR] was implemented, was anything about the behaviours, expectation, obligation, etiquette, commitment of the staff responsible for the execution of it. (…) I can't emphasise that enough. It's just that, for me, this is a huge res…when I see the commissioners, when I meet with them, I say you've got an honourable privileged position to be using an exercise that selects the best and most suitable provider for the public on behalf of the public, that's a huge responsibility. And they…you've got to execute that from the highest possible standard of objectivity of fairness of, you know, I just don't see…I guess my concern is that's the bit that I see missing from the exercise. The process I don't have a problem with.* (CS2, Provider Independent 1, CHS)

In contrast, some NHS providers, who were developing collaborative relationships over the last decade or so, were worried about the possible transactional turn in ICB commissioning practices. For instance, in CS3, the NHS community and mental health services provider that took advantage of opportunities for market expansion during the internal market phase and subsequently built collaborative relationships in multiple ICBs during the system working phase, was now worried that some of these ICBs may try to move those contracts to their 'anchor' local community providers. The provider was focusing mainly on working with commissioners to improve services, for instance, by tackling unwarranted variation in community services provision, which was in itself a legacy of fragmented commissioning from the CCG era, and preventing established contracts from going to the market.

> *Historically, [we] have been a trust that has grown a lot and been very successful competing with other trusts, but we, over the last sort of, five, six years, have very much thrown in…ourselves into a world of collaboration, of relationships, of partnership and so on. And, therefore, we now struggle a bit where we have a commissioner who wants to go back to…takes a very old-school approach to this. But, you know, that's their prerogative I guess and I do wonder whether the new NHS regime and the world of the 10-year plan and so on will shift the dial a little bit back to…slightly more towards that, sort of, competitive position. And probably not as it was 15, 10 years ago or whatever, but I think it is shifting the dial at least more to the*

centre of the scale, if you like, between competition and collaboration. (CS3, Provider NHS, CMH)

ICB interviewees were cautious in drawing long-term implications of the PSR for the ICBs, due to the ongoing staff cuts and reorganisation of the ICBs. The future functions of the ICBs were not yet clear, and the commissioners were concerned about their ability to deliver the expanded contracting and procurement capacity within the £18.76 per head of population administrative management allowance by Q3 of 2025/26 (NHSE, 2025c).

The transparency of the PSR exposed the existence of a large number of legacy contractual relationships, many dating back to the times of the Clinical Commissioning Groups. The ICBs were only just beginning to scope programmes of work required to standardise the fragmented service provision in their footprints, especially in community services, before being subjected to another round of reorganisation. For instance, the CS3 ICB had the ambition to review all of its commissioned services by the end of 2025/26. The requirement to cut 50% of its running costs made this target unrealistic. ICBs were worried about the capacity to deliver these reviews. Thus, although PSR was seen as having the potential to incentivise more effective commissioning practices, in practice, at the time of the fieldwork, this potential was not yet realised due to the resource constraints in the ICBs and ongoing restructuring of the commissioning function.

The ICB interviewees also acknowledged that they needed to build up the commissioning skills, including in contract negotiation and management, specification, costing and pricing of services, and provider performance management, which were somewhat blunted during the system working policy emphasis. The policy turn refocusing the ICBs on strategic commissioning, coupled with the ICBs having to comply with the PSR framework, may lead to strengthening of commissioning skills and capacity in the future. In that sense, the PSR rules were aligned with the strategic commissioner role that the ICBs were meant to take on, as both the rules and the role required similar high-level commissioning competencies. Yet the establishment of the necessary internal processes for evidence gathering and routine oversight of providers was endangered by the destabilising reorganisation of the ICBs.

The ICBs over more recent years have shed their contract management, their performance and quality management teams, the oversight, because we have moved into collaboration and integration, which is absolutely the right thing to do, but then with an emphasis that we don't put the checks and balances and the measures and the oversight in place, because that felt uncomfortable whilst forming collaborative and integrated relationship. (...) I think there's a paucity to some degree of evidence to support the rationale and justification [of procurements], which is what is proving itself challenging. (...) We need to build our foundations of market intelligence, understanding of capabilities, understanding of price, and, you know, all of those other things. (CS2, ICB, Contracting Director)

A specialist provider reflected that commissioners may not have sufficient clinical expertise to specify and monitor some contracts effectively, and manage the market in certain clinical areas, particularly those with an active private provider landscape. The effective market management in specialised areas of provision required specialist knowledge which sat in providers rather than commissioners. They also felt that such market shaping was best done centrally to avoid ICBs duplicating efforts and spreading the expertise thinly.

> *A lot of the commissioners are also doing at least three or four other specialties, so they're doing [specialty X] on a Tuesday morning once a week, they don't have the capacity. And actually, what you need is a critical mass of expertise in order to manage those contracts effectively, manage that market, manage the stability of that market. And as we have so much additional capacity [in specialty X], to drive up standards as far as you can, you don't necessarily want to choke off supply but you do also want to try and get rid of the cheap and cheerful ones and start getting people competing on quality across the pathways.* (CS3, Provider NHS Specialist Acute)

One independent provider commented about the lack of clinical and financial expertise amongst commissioners, which was necessary to specify and cost the contracts accurately. The CS3 private provider of community-based services noted that in practice, commissioners often relied on historical trends in spend to cost services and expected providers to supply the necessary information for service specification and costing. This was seen as challenging and prone to misunderstandings.

One NHS provider advocated that commissioners need to be supported at the national or regional level to build up their "confidence" in using the PSR flexibly and in their commissioning and procurement skills. The provider hoped that if commissioners felt more supported, they would be less risk-averse, which in this case meant less reliant on the competitive process.

> *I think that what really needs to be is almost people need to have confidence instilled in them so that actually they can do this, it will be fine. That there is some sort of regulatory air cover, at least some slightly more vexatious cases will just be pushed aside or dealt with. Whereas actually very much the NHS England position is, it's up to local determination, sort your own issues out.* (CS3, Provider NHS Specialist Acute)

One CS2 independent provider expressed concern that the ICBs' ability to conduct fair and thorough procurements might be jeopardised by the organisational 'upheaval' (CS2, Provider Independent 1, CHS) due to cuts and mergers that ICBs are undergoing. Also, in CS2 the social enterprise provider worried that ICB restructuring might result in the loss of experienced procurement and contracting staff. All three case study ICBs bought some procurement support from third-party organisations, either the CSUs or bodies which were created on the basis of the former CSUs. Due to the administrative resource squeeze, some commissioners foresaw an increase in joint procurements executed jointly with other ICBs, at

the regional or national levels. Yet the ICB interviewee thought that such procurements were also more likely to be challenged.

> *So, I think we're doing a lot more collaborative procurement so entering into national and regional procurements which is sort of…it's good really, you know, there's a lot of sense to it and you can use technical expertise once. And in theory you should get some economies of scale, but actually in reality I've never really seen that. I don't think we do financially better out of doing larger geographical procurements. But what is definitely true is that they are challenged legally with much greater frequency than if we run our own local procurements, because you're aggregating up big bits of business. And then if you've got organisations who are losing those bits, so suddenly they're losing big chunks of their business at a national level and that means they are much more motivated to go down for litigation and for legal challenge and everything else*. (CS2, ICB, Commissioning Director)

One CS2 ICB contracting director noted that the nature of the PSR heightened expectations of commissioning staff involvement in procurements. This is because procurement can no longer be easily compartmentalised as "someone else's problem" but instead has become "everybody's business right now" as the PSR "covers everything" (CS2, ICB, Contracting Director). Another commissioner reflected that additional administrative capacity required to comply with the PSR was incompatible with the desire for slimmer ICBs expressed in the government policy. They were concerned that the high expectations put on the ICBs, which go beyond the ICBs' current capacity, may lead to their failure.

> *Are we creating a situation where we're maybe setting [the ICBs] up to fail by introducing a whole bunch of new providers to the market, requiring them to contract with more providers that they don't have the capability or capacity to manage any longer as strategic commissioners? So how do they become good at the role of strategic commissioner whilst managing all the various, kind of, technical, legal requirements of the PSR?* (CS3, ICB, Strategy Director)

Some interviewees noted other important tools that sit outside of the PSR, which impact and enable strategic commissioning actions. The CS3 NHS specialist acute provider reflected that the commissioners have a range of other tools to redesign the services, which largely bypass procurement, such as service development through provider collaboratives, setting up Advice and Guidance services, or modifying payment mechanisms and incentives. They also emphasised that the PSR requires robust and coherent economic regulatory tools in payment and contracting to achieve the service improvements and support innovation.

> *PSR is just one plank in a suite of economic regulatory tools. So the tariff, the national standard contracting and the broader economic regulation and commissioning are all part of this. Every improvement you make in PSR is great, but actually until you make commensurate improvements in all the other areas… And the national standard contract is probably one of the stronger areas, but the other areas*

are pretty weak. Until you make commensurate improvements in the rest of the stuff, you are not going to get a really robust procurement regime which supports innovation and service transformation. (CS3 Provider NHS Specialist Acute)

Finally, patient choice policy was one area which sat outside of the PSR, which ICB interviewees found particularly problematic, and which had major implications for commissioning capacity and capability. ICB interviewees were concerned about the weak commissioning levers over the activity and spend in the services subject to patient choice, provider-driven processes and open market entry routes in a wide range of services subject to patient choice. ICB participants were also concerned about unwarranted variation in the way the non-NHS provider accreditation process was managed by different ICBs, alignment with the services commissioned through the main NHS contracts, as well as potential negative implications for the quality of care. The full appraisal of the implications of the patient choice policy on the ability of the ICBs to carry out their strategic commissioning roles remains an important area for the future research.

3.6.2 Implications of the PSR for the provider landscape

Commissioners' actions under the PSR have important consequences for the provider landscape, in that they shape provider behaviour and the way the providers compete and cooperate with each other. Commissioners' actions can also impact long-term provider sustainability. In this section, we will examine the views of ICB interviewees and providers on how the PSR may influence provider organisations.

ICB interviewees perceived the PSR as a largely neutral tool in terms of impacting provider sustainability and provider collaboration.

I don't think it makes any difference. We do have quite a strong collaboration with providers, I mean, we need the providers, the providers need us, and we work a lot with them, but I don't think that has made any difference to that. (CS3, ICB, Business Director)

I don't think it particularly does influence [collaboration]. Either you're working together and then you find the appropriate process or you're not.' (CS2, ICB, Procurement Director)

Providers concurred and observed that long-term investment in services is, first and foremost, a commissioning decision. Procurement rules were just a neutral enabling tool for such decisions. In that sense, except for complications of the Direct Award B stemming from the patient choice regulations, the PSR regulations were seen as agnostic as to the best ways of commissioning services, and what commissioning mechanisms (competitive or cooperative) should be used.

I don't think PSR of itself generates long or short term contracts, that's for the commissioners to decide how frequently they want to go to market really, isn't it?' (CS2, Provider NHS MH)

Unlike the previous framework, which favoured competitive tendering processes, the PSR does not push the commissioners into one or another direction, but is flexible enough to support any commissioning decisions and enable a wide range of commissioners' actions. This flexibility and power given to commissioners by the PSR were the reasons why it was seen as crucial that the PSR operated on a sound commissioning foundation. It was also the reasoning behind some providers' concerns about how such powers would be used by the commissioners and the impact on provider sustainability. One provider stated that their future ultimately depended on the commissioners as "all our highest risks are related to the ICB's decision-making and behaviour" (CS2, Provider Independent 3, GP Federation). Those providers who hoped for longer contracts to unlock investments and create more certainty for their organisations did not yet see this reflected in the commissioning practices.

Implications for providers competing 'within the market'

Some interviewed providers were particularly exposed to the competition 'within the market' which under the PSR is procured through Direct Award B. In services subject to patient choice, such as audiology, ophthalmology, mental health, diagnostics and others, markets were operating or developing with many competing providers and "a lot of money to be made" (CS1, Provider NHS MH).

> *I can see the market becoming a lot more competitive, so I think you're seeing a lot more new organisations trying to get into the market. I think the Direct Award B process and some of the guidance that goes with that creates more of a pathway for new entrants into the market. And I think that can…yeah, I think that can create competition that might impact market share.* (CS2, ICB, Commissioning Director)

The CS3 independent provider, which took part in both competition 'for the market' and 'in the market', had a strong belief in the market's ability to provide checks and balances on providers in areas where strong competition from multiple providers was present, and the patients were able to exercise their right to choose the provider. They felt that when there was limited competition, the checks and balances became problematic.

> *If the market says something is possible, we don't have a leg to stand on in terms of if we wanted something extra from it or the market says it's appropriate and applicable, then we work within the market. So I think where it's done right, it's a great balancer, because it also checks unreserved power from a provider perspective. It's when it's not done right, when it's only done on a limited scope instead of evidence, that it starts becoming a problem*. (CS3, Provider Independent, CHS)

The CS3 NHS specialist provider, operating in a market with a strong presence of independent providers and competing both 'for the market' and 'in the market', was concerned about losing out on activity and qualified staff to the independent sector in services subject to patient choice. They were also concerned about independent providers cherry-picking "the profitable bits of a pathway and leaving the unprofitable bits, and we're the people who pick up the unprofitable bits" (CS3, Provider NHS Specialist Acute) and about

some referral, marketing and subcontracting practices employed by independent providers, which they deemed dubious. There were also knock-on effects for the NHS providers in terms of deskilling and lack of training opportunities for the NHS staff in services heavily targeted by the independent sector, and in terms of missed opportunities for cross-subsidisation of more expensive services by the more profitable ones. The NHS provider had activity caps imposed by the commissioner, so it could not easily grow their market share. They also offered help to other NHS providers through the mutual aid process. The providers which operated in the tariff-based services were feeling a financial squeeze.

> *The problem has come from two areas, one in which basically, essentially, the tariff prices are starting to see scaling in order to offset unmet efficiency by the providers. And the second part of this is, as activity shifts out of providers, there are stranded costs they haven't reconciled.* (CS3, Provider NHS Specialist Acute)

The provider called for "coherent market regulation" in certain markets, such as high volume low complexity procedures, which were posing challenges for the NHS providers. However, they stressed that these challenges have not been caused by the PSR "in and of itself" (CS3, Provider NHS Specialist Acute).

According to one ICB interviewee, a consequence of a more competitive environment in services subject to patient choice may be that the NHS providers would have to become more efficient and commercially minded in order to compete successfully with the independent providers.

> *I think the NHS has to be a lot more competitive in terms of its offer against the wider market. I think there is a bit of complacency around that. And I think, yeah, if you put it in just a really cold purchasing sense, you know, so things like ophthalmology for example where a private provider can deliver, yeah, cataract surgery at much higher productivity, much lower price, incentivise their clinicians differently to make it more attractive, you know, the NHS shies away from some of those things and as a result it delivers a worse offer to patients. It's less competitive and it's going to have to sort itself out on that sort of thing*. (CS2, ICB, Commissioning Director)

Implications for providers competing 'for the market'

With regards to the competition 'for the market' share, the CS2 contracting director stressed the importance of striking the right balance between competitive and direct award processes. They believed in keeping the market entry options open for private providers who were seen as bringing "capital investment and infrastructure" (CS2, ICB, Contracting Director).

> *[In the past] it was default competition which was a bad thing, I don't want it to be default Direct Award C, because that can be a bad thing. We need to maintain the balance of those opportunities through the regime; so use the longevity arrangements under Direct Award C where that makes sense, but still bring about fresh, and*

innovation, and investment, and wherever that's needed. (CS2, ICB, Contracting Director)

Many interviewed providers of community services operated business models which relied solely on the competition 'for the market' share and did not take part in the competition 'within the market'. This included some established independent providers, such as the CS2 private provider of community services, which solely relied on the publicly funded services as its main income stream. Thus, the ability to maintain and scale up their existing NHS and LA funded services and enter new local markets was crucial to them. Some of the views expressed by such independent providers resembled those of the NHS providers. For instance, the CS2 private provider commented on the fragmentation of commissioning around certain services (such as those falling within the public health remit) and was advocating for a wider use of longer-term contracts in services and areas where it was an incumbent.

Any provider, NHS, independent, third sector, any provider will say that a longer term contract is better, when it comes to financial planning and investing in, you know…So, I guess, flip it over and think of the opposite of what I'm saying. So if a contract comes out for two years, I'm not going to get funding to invest in technology, I'm not going to get funding to do a workforce modernisation review, I'm not going to get funding to build a new estate that meets the needs of the public. So it's the opposite, so you're going to just have a stagnant service. Or you've got a long contract, you can see that you can get the return on that upfront investment. (CS2, Provider Independent 1, CHS)

This independent provider similarly believed that strong provider competition 'for the market' will have a quality-enhancing impact on the community services provision.

I would like to see community providers delivering community services, I guess, and I would like to see services that aren't performing at the level required, whether it be both on efficiency, productivity and quality being improved. (…) And the best way to do that is to test the market and get the best provider in and hold them to…you know, choose the best provider and hold them to account. (CS2, Provider Independent 1, CHS)

Interviewed independent providers had contractual relationships with multiple ICBs. The variation in commissioning approaches meant that the providers had to navigate a complex matrix of commissioning relationships, some working to the provider's advantage and some creating disadvantages for the provider, depending on the approach that commissioners take. Furthermore, as commissioners often relied on the providers to supply service level expertise to specify and cost the services, it was not entirely clear in some instances who was ultimately shaping the market in a particular service area – commissioners or providers. For instance, in CS3 an independent provider was actively horizon scanning for new opportunities that matched their existing portfolio of services and engaging with commissioners.

> *So there's a lot of work at our end in making sure that people understand what the clinical requirements are, understand the market's changing and sharing innovation as much as possible, because it's very different in a lot of places, and so we're constantly passing phone numbers, if you like, between commissioners about this commissioner did this and it was a good idea, talk to them about how you would like to roll that model into yours, things like that. And so basically our aim is to make sure that our commissioners are informed as much as possible on how the service not just works now but how it should potentially look going forward to meet their needs, so when procurements happen, it's an easier process for them and it's an easier process for us.* (CS3, Provider Independent, CHS)

Pre-market engagement exercises were seen as important by providers, as they served as a first opportunity to test commissioners' plans against what providers were prepared to deliver, with inevitable disagreements on pricing envelopes and preferred commissioning approaches. Many providers used pre-market engagement as an opportunity to voice their objections. The CS2 independent provider signalled to one ICB that they would be withdrawing from the procurement if it was advertised on a lead provider basis, as this was "financially unattractive to us" (CS2, Provider Independent 2, Social Enterprise, CHS). Similarly, the CS3 community and mental health provider commented that the margins on the planned contracts were becoming tighter, and they were not able "to generate a surplus or generate a comfortable overhead", making the provider consider whether to step away from such opportunities (CS3, Provider NHS, CMH). Such signals from providers about potential exit from the market increased commissioners' hesitation as to the right commissioning approach, with some ICBs exhibiting a distinct lack of strategic direction.

> *[In another ICB], we see signs of struggle I would say in that they are doing repeated market engagement processes, saying that they're going to launch a procedure, which I think will be a competitive procedure, and then getting feedback from providers which essentially is like well, we're not going to be able to do it for that, we're not going to be able to deliver it in that way, we're unlikely to be interested, so then they get cold feet, and then we'll launch another market engagement exercise. So we're wasting a lot of time, I think, doing these pre-procurement engagements, to the point where I think we're quite deterred now from participating, as are other partners, because it's brought us together with other partners, but almost brought us together in a consensus that this isn't really going to work for any of us.* (CS2, Provider Independent 2, Social Enterprise, CHS)

> *Part of the dealmaking that goes on around a direct award is a commissioner saying, okay, we will go down this route with you but we need you to be able to take a haircut of this or we need you to be able to deliver this much more but within the same envelope and things. And that's part of the deal. And then our business assurance process needs to be able to look at that quite rationally and say, can we still make this stack up?* (CS3, Provider NHS, CMH)

Some NHS providers commented on the private providers' apparent greater ability to accept the squeezed envelopes for services. They noted that this sometimes makes the private providers overpromise to secure the contract and then underdeliver. They noted examples where the NHS provider had to step in to build back a service which had been underinvested. However, they also emphasised that private providers' practices fell within the "spectrum of business practice" and "perfectly clear and legal" (CS3, Provider NHS, CMH).

> *I think [private providers] often have the ability to come in from the outside of a system and go low and go big and bold because they have less of the baggage of perhaps an incumbent NHS provider who actually takes a more realistic view but it's less attractive to the commissioner. I would say that because I'm an NHS provider, of course.* (CS3, Provider NHS, CMH)

Implications for NHS providers as emerging 'micro-commissioners'

The PSR came into force at a time when many NHS providers were trying themselves in the new roles as emerging 'micro-commissioners' of certain services. Whilst performing a commissioning role, the NHS trusts and foundation trusts must comply with the PSR. Such 'micro-commissioner' roles emerged as part of the cooperative commissioning approaches, often in an attempt to tackle fragmentation and to pivot financial and quality performance risks associated with the provision of such services towards providers, using mechanisms such as lead provider contracts and subcontracting relationships. The 'micro-commissioner' roles were particularly prevalent in mental health services. As 'micro-commissioners', providers were exposed to the same dilemmas and challenges of commissioning services under the PSR as the ICBs, including challenges of managing competition and patient choice, and stimulating provider cooperation in the service areas they were responsible for. Interviewed 'micro-commissioners' saw both opportunities and challenges associated with this new role.

The CS3 NHS CMH provider saw this model as one way to tackle competition from private providers.

> *We're integrating with [the private providers] as a commissioner rather than a competitor. Sometimes we compete, but I think I certainly wouldn't see it as a huge risk, I would probably say that there is as much an opportunity in there as a risk. But equally, if I then think about [the CMH trust] as a commissioner, I'm thinking, you know, we need to make sure that they are, in terms of the quality, in terms of the assurance, governance, et cetera, that they are as robust as an NHS.* (CS3 Provider NHS CMH).

The CS1 ICB had a lead provider contract with the mental health trust through which the mental health trust was acting as a commissioner for the majority of mental health services in the system (apart from services subject to patient choice and procured through Direct Award B). As a lead provider and in their commissioning capacity, the provider noted that they were

not planning any big competitive tendering processes and were looking to identify savings by consolidating the current provision.

> *We're trying to see if there's cost savings involved. So we're not looking at any big tenders for any big services at the moment. We're trying to look at what we can effectively save on rather than put out*. (CS1, Provider NHS, MH)

Impact on smaller providers

Some ICB interviewees noted that the smaller providers may be somewhat disadvantaged by the procurement decisions made under the new regime. ICB interviewees commented that removing thresholds may have taken away the incentive to commission through smaller contracts, which could be kept 'under the threshold', which may adversely impact smaller providers. Furthermore, commissioners responded to the financial risks created by the patient choice policy by erecting "*more bureaucratic barriers to entry",* which could affect smaller providers more severely (CS2, ICB, Commissioning Director).

The CS2 social enterprise provider, whose business model relied solely on the competition 'for the market', expressed similar concerns. They reflected that being a well performing provider did not translate automatically into the longer contracts and more favourable procurement approaches, notwithstanding the rhetoric surrounding the PSR. Furthermore, as commissioners showed more preference for consolidation of multiple contracts into lead provider arrangements, this provider was worried about potential market concentration in the community services. As a smaller provider, they were concerned if they would be pushed out of the market by larger providers more able to take on the risks associated with such contracts and more able to absorb the squeezed financial envelopes and transaction costs (being "a very slick bidding machine") associated with such procurements (CS2, Provider Independent 2, Social Enterprise, CHS). They argued that the market concentration in the community services would be detrimental to patient care. In particular, the CS2 social enterprise provider commented that such large providers' bids differ considerably from what is delivered in reality, and that commissioners are "quite scared of the consequences of not awarding to a provider that could have a large legal machine behind them" (CS2, Provider Independent 2, Social Enterprise, CHS). The provider had hoped that the PSR would be used as a leverage "to protect this variety in the market" (CS2, Provider Independent 2, Social Enterprise, CHS).

> *We're trying to push back on that and saying that's not creating a good market for yourselves. This desire to just have one contract, which then might be loads of subs underneath, just for the sake of simplicity, will be driving providers like us out of the market because really only the big boys can bid for that. They might talk the right talk about having social enterprises and smaller providers as partners, but when it comes to it, you'll end up with monopolies growing, and that's an issue for the NHS as a whole across the nation.* (CS2, Provider Independent 2, Social Enterprise, CHS)

The social enterprise provider hoped that they would be well placed to take advantage of opportunities that may emerge during the implementation of the neighbourhood health model

and shift from sickness to prevention and hospital to community care in the NHS 10YHP. However, the provider felt that the overall outlook was uncertain due to ongoing restructuring of the NHS authorities and local government, which affected commissioners' ability to plan and act strategically. Despite this, the provider hoped that some of the benefits of the PSR would materialise, as the PSR provided the right infrastructure for that.

> *[The PSR] is absolutely a step in the right direction. It's dependent on how things are locally though. The infrastructure's really good, the drive from the centre's been really good. (…) It's just really maximising the benefits and hoping that that will start to happen a bit more quickly than our experience has felt like.* (CS2, Provider Independent 2, Social Enterprise, CHS)

Summary

The PSR offered a powerful and flexible tool to commissioners, which aligned well with the ICBs' pivoting towards a strategic commissioner's role. The PSR was seen as largely a neutral tool by both interviewed commissioners and providers, as it did not push commissioners towards any preferred course of action, but instead enabled a wide range of them. This was why many participants stressed the importance of strengthening the capacity and capability of commissioning organisations, which would enable the creative use of the PSR and its extensive flexibilities. The PSR was seen as a tool "to good strategy and good delivery" (CS3, Provider NHS, CMH), but it was merely a tool, and there was a variation in how it was being used.

Compliance with the PSR required skills in contract management, record keeping, and deep knowledge of the provider landscape and provider performance. Using the PSR well depended on investment in appropriate commissioning expertise – in areas such as data analytics, performance monitoring, financial probity, change management, contracting, procurement, and market management. Thus, there was a potential for PSR to incentivise good commissioning practices, as the latter were often a precondition of compliance with the former. However, we also found that operational pressures that ICBs were under, combined with an ongoing reorganisation of commissioning function, ICB budget and staff cuts, and planned abolition of the CSUs, presented risks to achieving the ambition of ICBs becoming capable strategic commissioners. This, in turn, presented a risk to using the full range of flexibilities of the PSR and ensuring full compliance. Nevertheless, we found the PSR regulations per se were an enabler of strategic commissioning, providing appropriate infrastructure, with constraints preventing the realisation of such ambitions nested in external factors of financial constraints and organisational upheaval.

Providers noted a lot of variation, inconsistencies and some hesitation in the way different commissioners were applying the PSR. They also noted that this was an ongoing learning process and behaviours of both commissioners and providers were changing as everyone learned more about the new regulatory framework and its potential.

There was a variation in the degree and nature of NHS providers' exposure to the provider competition. The position of providers was shaped to a large extent by commissioners' preferences towards competitive or collaborative mechanisms for commissioning services. It also differed depending on the type of business model that the provider pursued and which specific specialities and services they were operating in, as well as the presence or absence of competitors. In particular, some NHS providers were more impacted by the competition 'for the market', others 'within the market', or a mix of both. Some noted that NHS providers must become more competitive in the current landscape, but there were lots of problematic aspects in the way competition affected the NHS and established providers.

Furthermore, over the last decade or so, NHS providers were building collaborative relationships within the systems they operated. The potential turn to more transactional commissioning, enabled by the wide flexibilities of the PSR, provoked some anxieties amongst established providers, as their position depended to a great extent on commissioners' actions. NHS providers and some established independent providers were mainly focusing on maintaining and strengthening their current contracts with the commissioners and preventing them from being market tested. Some providers were engaged in horizon scanning for new opportunities, but these were relatively limited. Providers were often faced with a dilemma of having to respond to the squeezed financial envelopes for services, requiring careful consideration of the viability of such contracts. Some mental health providers were trying themselves in the new role as 'micro-commissioners' for certain services but finding themselves at the sharp end of the commissioning and procurement challenges.

The private providers welcomed the transactional turn in commissioning, stating that the previous era was characterised by the lack of transparency and overuse of direct awards to incumbents to the detriment of market testing. They held strong beliefs in the regulating effects of competition and choice principles on the market in health services. Ensuring high procurement standards, clarity around rules of the game, transparency, fairness, and open avenues of market entry were all important aspects of the new procurement regime to private providers. The smaller community services provider was concerned about the tendency to consolidate services into large lead provider arrangements, as they were not able to bid for such contracts and were worried about ultimately being pushed out of such markets.

Overall, many participants deemed the wider policy context as extremely unsettling and thus were unable to draw long-term predictions about the future of their organisations. Despite noticing policy signals towards transactional commissioning, the overall policy direction was hard to read and not at all clear, as the importance of provider collaboration was also stressed in the new policy. The ambitions expressed in the 10YHP lacked clear and coherent delivery mechanisms, suggesting that both commissioners and providers will have to accept and deal with the underlying contradictions in the commissioning policy in the immediate future. This made it harder for providers to read commissioners' intentions and respond to them accordingly.

4. Discussion

In this study we investigated the application of the new Provider Selection Regime utilising a case study approach. We analysed the views and experiences of interviewees from three NHS Integrated Care Boards and from selected NHS and independent organisations which supplied services to the three ICBs. The study interrogated how different features and processes of the Provider Selection Regime were applied in practice and the extent to which the new procurement framework impacted commissioner and provider behaviour. The research was guided by the following four research questions, which we will address in turn.

4.1 What are the ICBs', NHS Trusts/FTs' and independent providers' views of the new Provider Selection Regime?

Overall, there was a favourable reception of the PSR regulations by interviewed commissioners and providers, with most participants perceiving it as delivering improvements on the previous framework. However, there were different views as to how the regulations should be applied in particular circumstances, due to the high flexibility of the PSR and divergent organisational interests of commissioners, public and private sector providers.

ICB interviewees liked the wide range of options and less emphasis on competition allowed by the PSR. However, they noted the increased administrative burden and the lack of financial thresholds for small value procurements. Providers noted a lot of variation in the way that commissioners interpreted the legislation, in areas such as the requests for information to accompany direct award processes or interpretations of key criteria for procurement. Independent providers welcomed the new procurement regime, praising the increase in transparency of commissioning decisions, enabling fair competition and reducing non-compliance compared with the previous regime. However, they also noted that there was a wide scope for misinterpretations and misunderstandings around the application of the new rules, attributing this in part to the initial learning curve after introducing the rules.

4.2 How and by whom are the decisions about an appropriate procurement route made in the ICSs? How does this vary with the type and scale of health services being commissioned?

The ICBs, as statutory commissioners, were the organisations making the majority of procurement decisions in the ICS footprints. The involvement of providers in procurement decision making was minimal. Where it occurred, it was limited to informal lobbying for a particular route or trying to influence commissioners' actions through informal conversations, networks or as part of more formal market engagement exercises. Some providers (such as mental health trusts) were also trying themselves in the new role as 'micro-commissioners' of services for which they had a form of delegated responsibility through lead provider contracts but were finding this new role quite challenging.

The ICB structures and processes governing procurement decision-making were locally determined and thus varied between the case studies. The case study ICBs varied in terms of staff resources and the maturity of the internal structures and processes. All three ICBs relied on external support from the CSUs or similar organisations. We also found that in addition to the administrative burden associated with the operation of the PSR, the same small teams of staff within the ICBs were also in charge of the two separate, resource-intensive processes interfacing with the PSR – non-NHS provider accreditation under the patient choice regulations and the application of the Procurement Act 2023. All this together put considerable pressure on the ICBs' commissioning, procurement and contracting teams, which in practice often comprised a very small core team of individuals.

In the studied ICBs, the commissioning staff engaged in reviews of service lines and proposed recommissioning models. Subsequently, commissioning colleagues worked together with procurement and contracting colleagues to identify the most appropriate procurement route under the PSR through which the service can be recommissioned. At this point in more complex cases, procurement advice was often sought from CSU or another third-party organisation. Such procurement proposals were then submitted to different ICB committees for approval and sign-off. The ICBs varied in terms of the internal processes they deployed to identify and oversee procurement decisions. The same internal processes were largely applied to all procurements, regardless of the type and scale of health services being commissioned, as all types of health services fell under one of the PSR procurement processes. This was indeed seen as one of the positives introduced by the PSR of removing grey areas with regard to commissioning large NHS contracts, which could now be reprocured using Direct Award A or other routes.

4.3 How does the PSR differ from the previous procurement regime in aspects such as the amount of flexibility, administrative burden, exposure to potential procurement disputes and ensuring provider sustainability?

The Provider Selection Regime 2023 represents a significant change in the regulation of health services procurement compared with the previous legal framework under the Public Contracts Regulations 2015. Some of the key features of the new regime as reflected by the participants included greater flexibility and transparency, alongside a perception of a higher administrative burden and an expectation of an increase in local procurement disputes, the administrative costs of which would be borne out largely by the ICBs themselves. Thus, the participants accepted that the PSR regulations involved inevitable trade-offs, some of which were intended by the way the policy was set up. For instance, the greater flexibility for commissioners came with greater local accountability for procurement decision-making and local dispute resolution processes, which required robust administration and audit trails and thus attracted higher administrative costs. However, many interviewed ICB participants were caught off guard by the higher administrative costs of operating the PSR, given the publicised aim of reducing transaction costs and bureaucracy associated with the unnecessary

competitive tendering that the PSR was meant to deliver. Furthermore, in practice, commissioners on the ground experienced lower administrative costs under the previous framework, due to various workarounds, such as the use of tender waivers. Such workarounds minimised the use of administratively costly competitive tendering. The previous framework was also seen as characterised by less stringent transparency, audit and reporting requirements. This is why the higher administrative burden of the PSR was perceived as a somewhat unexpected feature of the new regime by the commissioners and providers in this study.

Whilst flexibility was on the whole welcome, it was sometimes seen as a double-edged sword. Some interviewees thought that, in comparison to the previous regime, the discretion that commissioners have under the PSR could lead to more uncertainty and unwarranted variation in commissioning practices. Some participants noted that the greater flexibility and transparency do not offset the greater administrative burden under the PSR sufficiently. Others thought that PSR was clearer than the previous regime and gave procurement and contracting teams a better understanding of the whole commissioning cycle. The PSR was also seen as better aligned with a full spectrum of commissioning activities.

The greater transparency under the PSR rules, regardless of the type or value of the contracts, may have increased the likelihood of complaints by unsuccessful providers. However, some observed that as the nature of the dispute resolution under the PSR has shifted towards being a sector-specific process, the risk of costly litigations through courts characterising the previous regime has been minimised, despite the overall frequency of disputes potentially increasing. Arguably, as the dispute resolution process is handled locally by the commissioner and the national Independent Panel does not have the power of direction, the position of the commissioner in the disputes has been strengthened compared with the previous framework. However, at the same time, the commissioners bore the administrative costs of local dispute resolution processes, which were absorbed within the existing procurement, contracting and commissioning teams within the ICBs, putting an extra strain on their stretched resources.

Operationally, compared with the previous procurement regime, commissioners observed some improvements, for example, shortening the standstill periods and streamlining the enactment of commissioning decisions through the options of the different direct awards. Some commissioners, however, felt that the PSR regime introduced new grey areas, like a lack of clarity around the provider representation process and ending the standstill periods, and difficulties in distinguishing what was in and out of scope of the PSR. There were also ongoing, unresolved issues around implementation, such as a lack of PSR tailored Find a Tender Service notice templates.

Finally, some providers felt that, in comparison to the previous regime, the greater flexibilities and local discretion embedded in the PSR made it harder for them to predict commissioners' behaviour. The ability to read commissioners' intention was crucial to providers as the PSR's impact on provider sustainability was indirect and depended largely

on commissioners' behaviour rather than the procurement rules per se. In that sense the PSR rules made it harder to predict commissioners' behaviour due to being more permissive than the previous framework. The PSR did not encourage or discourage competition 'for the market'. It mandated the use of Direct Award A for services which can be delivered only by a sole capable provider, such as essential NHS services, and offered non-competitive procurement alternatives in other cases. The PSR supported competition 'within the market' through the Direct Award B, but the levers for managing this type of competition lay in the separate regulations and guidance. Overall, the PSR gave commissioners considerable flexibility and enabled a wide range of actions. This made the PSR a powerful tool in the hands of commissioners. It also made some providers, in particular smaller providers, concerned about how the commissioners' decisions would affect their long-term organisational sustainability. In light of this greater commissioner power, some independent providers were calling for greater accountability of the commissioners for their decision making and for raising the professional and ethical standards around procurement processes.

4.4 How does the PSR align with the strategic approach to commissioning pursued by the ICBs and the national policy goal to increase collaboration across the system?

Since the inception of this study there have been some significant national policy shifts. In particular, the 10 Year Health Plan published in July 2025 emphasised the ICBs' role as "the strategic commissioners of local healthcare services" (UK Government, 2025: 79), while stressing individual organisational accountability of providers. The plan also refocused on the more transactional, contractual mechanisms to encourage provider collaboration as opposed to the deepening commissioner provider partnerships as part of the ICS infrastructure. The ICBs will be expected to "draw on a deep understanding of population need, and to make long-term decisions in the interests of improved outcomes and financial sustainability", utilising a range of commissioning tools, including market management, procurement and contracting (UK Government, 2025: 79). The Strategic Commissioning Framework (NHSE, 2025a) reiterated that strategic commissioning, defined as "a continuous evidence-based process to plan, purchase, monitor and evaluate services over the longer term", will be "the central purpose of the ICBs of the future".

In this study, we found that the Provider Selection Regime was seen as a powerful tool in the hands of commissioners. Strong commissioning and contracting functions were necessary conditions for the administration of the PSR and were also required for the operationalisation of the vision of ICBs as strategic commissioners. In that sense, because of the largely similar set of pre-requisites, the PSR rules aligned well with the strategic commissioning ambition for the ICBs. However, we found that the commissioners were not yet making full use of the PSR's flexibilities due to the insufficient local commissioning capacity and capability, and many competing demands on that capacity relating to the PSR and other factors. Furthermore, commissioners operated in a complex policy environment, which sometimes

pushed down the search for solutions to key policy dilemmas from the central authorities to the local purchasing organisations. This, coupled with the ongoing restructuring of the commissioning function in the English NHS, stretched local administrative resources and increased the risk aversion of commissioners rather than enabling their role as strategic commissioners. Finally, due to the flexibility of the PSR rules, the current procurement framework can accommodate the shifts in the national policy and its oscillation between competition and cooperation. The co-existence of contradictory principles of competition and cooperation and simultaneous statutory requirements to pursue both principles characterised the internal market era of the English NHS in the late 2000s and early 2010s (see e.g. Sanderson et al. 2017; Osipovic et al., 2020b). Following the publication of the 10YHP, the preference for an optimal mix of competitive and cooperative elements in the national policy is difficult to discern. Despite the 10YHP signalling a turn towards more transactional commissioning by the ICBs, the ability of ICBs to "work in partnership" and deliver "system goals" continued to be stressed in other policy documents such as the Strategic Commissioning Framework (NHSE, 2025a). The ambitions expressed in 10YHP so far lack clear and coherent delivery mechanisms, whilst the previous ways of working continue in practice. This suggests that both commissioners and providers will have to deal with the ongoing, underlying hybridity in the national policy making in the immediate future. Overall, many participants deemed the wider policy context extremely unsettling and were unable to draw long-term predictions for their organisations.

4.5 Limitations

The aim of this study was to provide a rapid insight into the PSR views and experiences of three ICBs and selected providers to these ICBs. Situating the interviews within the case studies of three ICBs, with which we had an ongoing research connection, allowed for quicker access to potential interviewees and provided the longitudinal knowledge of a local organisational and commissioning context, aiding the analysis of the interviews. The semi-structured, in-depth interviews are the most appropriate data collection technique to identify the factors impacting the implementation of the new procurement regime in everyday practice at a local level. Evidence from the interviews cannot be easily obtained from surveys, routine administrative data or documents and can complement other research in this area.

However, this study has some limitations. As the study design involved interviews with commissioners in three out of 42 ICBs which existed at the time of the fieldwork, and a small selection of providers operating within these ICB areas, it is not possible to make generalisations to the whole NHS, and to capture the full range of experiences of the PSR by the ICBs and providers. Furthermore, as the findings reflect the aspects of the PSR which formed part of the topic guide as well as issues that participants themselves brought up during the interviews which depended on their particular experiences, not all aspects of the PSR regulations were covered in this report. In particular, the issues around mixed procurements, contract modifications, use of urgent awards and framework agreements have not been explored in this study.

Due to the quick reporting timelines and resource limitations, the study had a specific, limited scope which was agreed in advance. It was agreed at the outset that the study would be limited to exploring experiences of only one type of relevant authority which is required to apply the PSR when commissioning and procuring health services – namely the ICBs. In addition, we have also explored the views and experiences of a limited number of providers, supplying services to the ICBs in our three case study sites. However, the views and experiences of other relevant authorities, in particular the NHS trusts and FTs, and local authorities which are required to follow the PSR in their capacity as commissioners of health services, have not been explored, but remain an important research gap.

There were other important aspects of the administration of the PSR which were not interrogated in this study. Namely, the issues such as assessing the frequency and patterns of the use of specific procurement processes under the PSR by relevant authorities, the scale and impact of local dispute resolution processes and the impact of the decision making by the national Independent Patient Choice and Procurement Panel. These areas remain worthy of further investigation using different study designs and methods.

5. Conclusions

The new health services procurement regulations were long-awaited and generally welcomed by the commissioners and providers. This was due to the perceived drawbacks of the previous framework, including the in-built imperative for competitive tendering, juridification of dispute processes and regulatory grey areas with regard to procurements of certain types of services. However, as the PSR regulations give the commissioners substantial flexibility, the participants reported a considerable variation in how the rules were being applied. The interviewees had divergent interpretations of the rules and often mismatched expectations of what the regulations should deliver for their organisations and interests, exposing the divergent visions for commissioning in the NHS and disagreements between commissioners and providers.

Although the participants found the rules on the whole well-drafted, some called for certain clarifications, for instance, with regard to the scope of the PSR or dispute resolution procedures. Many participants called for a review of the patient choice policy and guidance, which is independent of but interfacing with the PSR. Some participants also called for better operational support of the PSR, which may reduce the administrative burden. This could include the provision of the PSR-specific transparency notice templates on the Find a Tender Service and streamlining some processes.

The clarity around the PSR rules is important, as the rules influence the commissioner and provider behaviour. Yet the impact of the PSR on organisational behaviour should not be viewed in isolation. Other crucial influencing factors include provider payment mechanisms, pricing and capital investment structures, different types of contractual arrangements, workforce and staffing issues, and other relevant and interfacing incentives and policies. As the PSR rules are generally permissive, other factors may have greater influence in steering commissioning decisions than the PSR rules per se.

Due to their relative permissiveness, the PSR rules were seen as a powerful commissioning tool as they supported and enabled a wide range of commissioners' actions. The PSR rules lack a clear preference for competition or cooperation, veering towards neutrality, permissiveness and supporting a mix of options rather than prescribing one preferred mechanism. Arguably, the PSR rules reflected the policy intention of moving procurement decision making to the local level to enable better tailoring to the local circumstances, to extract better value of the procurement processes locally, and to avoid unnecessary competitive tendering (IA 2023/9616). Whilst the neutrality and flexibility of the PSR transferred more power to local commissioners, the case study ICBs have not yet been able to take full advantage of the greater flexibility in procurement rules due to capacity and capability constraints. Furthermore, some providers were concerned that the relatively permissive nature of the PSR may result in heightened uncertainty for providers trying to read commissioners' intentions and may affect their long-term organisational sustainability.

The study found that there were some exceptions to the overall perception of permissiveness of the PSR procurement rules. One such exception comprised a lack of flexibility over procurements of services subject to patient choice which the ICB interviewees found problematic. The patient choice policy is a complex policy area governed by separate legislation and guidance, interfacing with the PSR through a dedicated Direct Award B process (see Section 1.2). We found this to be a departure from the overall flexibility that the PSR offered to the local commissioning organisations. This was also a departure from procurement as a predominantly commissioner-led process to a process that was largely provider-led, with weak levers within the patient choice policy available to commissioners to act strategically.[5]

Another aspect which participants in this study found challenging related to the perception of higher administrative burden of operating the PSR processes compared with the previous procurement framework. The perception of administrative burden and the transaction costs associated with the PSR were related to some of the key features of the new regime, including greater transparency and audit trail requirements, local dispute resolution process and strengthened due diligence in relation to direct award processes. Many participants found the higher experienced administrative burden of the PSR unexpected, given the preceding rhetoric of simplification and reducing bureaucracy. Some commissioners signalled that the perception of higher administrative burden may reduce somewhat in time as the PSR processes become more embedded in everyday practices.

The perception of a higher administrative burden of the PSR could be partially explained by a degree of non-compliance with the previous framework, which was reducing the administrative load on the ICBs and their predecessors CCGs in the past. One of the aims of the PSR was to reduce the use of "unnecessary" competitive tendering and therefore save on associated transaction costs. The IA predicted cost savings to providers and commissioners in cases where direct awards can be used instead of unnecessary competitive procurement (IA 2023/9616: 3). However, it is difficult to ascertain how frequently the competitive tendering was conducted "unnecessarily" under the previous framework. The evidence from our past studies shows that competitive tendering was used sparingly, and the bulk of commissioning was done using cooperative mechanisms without testing the market, signalling a degree of non-compliance with the past framework (Allen et al., 2016; Osipovic et al., 2017).

Furthermore, this study found that direct awards attract their own administrative burden, due to better governance and transparency requirements, which was the intention behind this legislation. The estimated higher administrative costs associated with the direct awards compared with the previous framework were noted in the PSR Impact Assessment (IA 2023/9616: 22-23). The perceived higher administrative load can also be viewed as a

[5] For examples of commissioning challenges associated with the operation of the patient choice policy, see e.g. HSJ, 2026a; 2026b; 2026c; 2025a; 2025b.

consequence of a policy intention to move more control with accompanying accountability to the local level. This may be reduced somewhat as the new PSR processes become more embedded and streamlined. However, as the perceived administrative burden was mostly associated with the key features of the PSR, including transparency and dispute resolution, rather than its newness, it is unlikely that it will be reduced substantially in the immediate future.

We found that largely due to the PSR's in-built flexibility and similar pre-requisites, the PSR rules aligned well with the strategic commissioning ambitions for the ICBs. At the same time, some commissioners were not yet making the most of the flexibility that the PSR offered, instead defaulting to what was considered locally as a 'safer' option, due to insufficient commissioning capacity. The PSR requires the robust contracting and procurement teams, which proactively engage in contract monitoring, gather knowledge about providers and periodically test the market with regard to all service lines which they commission, to operate effectively. These activities are resource intensive and require an appropriate skillset. This study found that the ICBs lacked the capacity and capability to carry out these activities for all services and had to be selective in how they prioritised scarce commissioning resources. If the ICBs were to fulfil the ambitions of the strategic commissioner role and act as independent purchasers, strengthening the ICBs' commissioning capability and capacity is likely to be needed.

Overall, we found a variation in the degree and nature of the providers' exposure to different types of competition ('for' and 'within' the market) and in the robustness of their collaborative relationships in the systems. The private providers welcomed a potentially more transactional turn in commissioning practices, whilst it provoked some anxieties amongst the established NHS and third sector providers who invested in maintaining their existing contractual relationships and sought to secure them long term. Smaller providers looked forward to the potential opportunities on the back of the planned shift of services from hospital to community but were also worried that unfavourable commissioners' decisions may jeopardise their long-term organisational sustainability. Some participants observed that the lack of value thresholds in the PSR may disproportionately affect the smaller providers, as they have a lower ability to absorb the transaction costs associated with the procurements. The tendency to consolidate fragmented commissioning and multiple contracts into large contractual arrangements which transfer the risks to providers may also disadvantage smaller providers, which have a lower ability to take on larger, more risky contracts.

Since the commissioning of this study at the beginning of 2025, there has been a considerable shift in the national policy goals with the announcement in March 2025 of the planned abolition of NHS England and the publication of the 10 Year Health Plan in July 2025 (UK Government, 2025). This also set in motion a turbulent period for the ICBs as local health service commissioners, with many features of the commissioning system architecture subject to amendment or abolition, creating uncertainty as to the future remit and role of the ICBs. The ongoing ICB clustering, mergers and staff cuts, the planned abolition of CSUs, and the

removal of provider partners from the ICB boards are examples of the organisational changes affecting ICBs, which may impact the ICBs' overall approach to commissioning services. The full implications of the Provider Selection Regime, how it will be used by the ICBs and how it will affect the providers, remain to be seen.

5.1 Policy implications

Overall, this study found the PSR to be well-suited to the period of policy uncertainty and able to accommodate many different commissioning approaches. However, whilst expressing the overall satisfaction with the rules, some participants called for some amendments and clarifications of the PSR and found the application of the rules at times challenging and causing disagreements.

In light of the findings, several policy implications relevant for how the health service commissioners and providers use and apply the PSR can be pointed out.

- *Importance of support from the centre.* Both commissioners and providers were still learning how to use the new regulations appropriately and effectively. The commissioners and providers should continue to be supported centrally through updates to guidance and resources, e.g. through dissemination of the Independent Panel reviews, provision of real-life examples and better specification of processes, to promote shared views on how the rules should be applied. This is especially important in areas which some participants found unclear, such as the scope of the PSR and dispute resolution process. The stronger consensus around the application of the rules is important for building effective relationships between commissioners and providers.

  The existing dedicated PSR inbox, enabling an open communication channel between NHSE/DHSC and PSR users, is one way of gauging whether any amendments to the regulations and guidance may be needed in the future. There is also an opportunity to offer better operational support to the ICBs, such as through the provision of the PSR-specific transparency notice templates and standardisation of annual reporting requirements, which may reduce the experienced administrative burden locally and streamline data collection about the procurement processes at the national level.

- *Administrative burden associated with the PSR.* The costs of compliance with the PSR on commissioners and providers should be fully mapped out and acknowledged, taking into account all aspects of the PSR, including dispute resolution, procurement of services subject to patient choice, administration of competitive and direct awards and transparency requirements. Opportunities to streamline the most burdensome processes, for instance, through reduction of duplication and unwarranted variation or through increasing standardisation of solutions and approaches in commissioning and procurement practices should be explored.

- *Application of the PSR requires robust commissioning capacity and capability.* Making use of the flexibilities of the PSR and ensuring compliance with the PSR require a robust commissioning function. The ICBs must have the appropriate commissioning capacity and capability and/or third-party support in this area to ensure the right commissioning skillset is on hand. Investing in the right commissioning expertise is also key to achieving the strategic commissioning ambition for the ICBs. Similarly, the providers who are taking on the 'micro-commissioner' and lead provider roles need to have the right commissioning expertise. This finding has implications for the ongoing restructuring of the commissioning function locally, regionally and nationally.
- *PSR dispute resolution process lacks clarity*. This study found that there was some dissatisfaction with the way certain aspects of the dispute resolution process worked for commissioners and providers. The dispute resolution procedure was at times unclear and posed challenges for the commissioners and providers, especially in relation to multiple representations relating to the same case, clarification of endpoints for standstill periods and the interplay between local and national processes. The dispute resolution process may benefit from a review and further clarification in the guidance.
- *Challenges in the broader policy environment*. The ICBs operated in a challenging broader policy environment which had implications for the administration of the PSR. These challenges included ICB restructuring as well as non-PSR processes, such as implementation of patient choice, which competed for scarce commissioning resources. As the custodians of the local health systems, the ICBs should have effective levers to better balance the competing priorities inherent in the commissioning function.

5.2 Implications for future research

Given the ongoing reorganisation of commissioning function in the English NHS, it is important to continue exploring how the ICBs and other types of relevant authorities, including providers acting as 'micro-commissioners', use the flexibilities of the PSR. The important aspects to probe include the type and frequency of procurement processes used by different types of relevant authorities subject to the PSR and the type of services procured through different PSR processes, the balance between competitive and non-competitive processes and its implication for commissioners and providers, and the extent to which the disagreements over how the rules should be applied are diminishing.

The PSR has strengthened transparency and reporting requirements around procurement decision making. This presents an opportunity to obtain a clearer, national picture of the prevalence and patterns of procurement processes for health services by different relevant authorities from administrative data returns. However, the quality of such administrative data needs to be consistently high and easily accessible to enable such an analysis. Better

operational support to the users of the PSR may facilitate both the consistency of the returns and the research in this area.

It is also important to trace how the PSR will support the innovative commissioning mechanisms such as complex contractual arrangements underpinning provider collaboration, including Integrated Health Organisations, single neighbourhood and multi-neighbourhood providers and other organisational changes planned in the 10YHP. As the functions of commissioning, contracting and procurement are linked in practice, the qualitative organisational case studies focusing on one of the functions offer linked research opportunities.

Another area of potential future research centres on the process and outcomes of the procurement disputes at the local and national levels. Many participants in this study voiced their concerns about some of the aspects of the dispute resolution process at the local level. There is also a growing portfolio of national Independent Panel reviews. It is important to find out the extent to which the disputes are being resolved locally or escalated to the national level, and what happens in practice following a local or national review decision, what consequences such decisions have for different stakeholders and service provision. Such a focus will provide a better understanding of the parameters of the dispute resolution process and its role in the PSR framework, as well as give a further insight into the problematic aspects of the application of the PSR itself.

Last but not least, this study found that the use of the Direct Award B process was seen as problematic for commissioners and some providers, due to the challenges of implementation of patient choice regulations and guidance. A study of how the ICBs implement patient choice policy in selected specialty areas would improve the understanding of its interface with the PSR and of the wider commissioning challenges. What local solutions do commissioners implement to manage this type of competition, what role does the PSR Direct Award B play in this, and how does the competition 'within the market' impact the financial sustainability of local health economies, quality of care and patients' ability to exercise choice?

Given the relative newness of the PSR regulations which need time to become embedded in the commissioning practices and the ongoing reorganisation of commissioning function, it is important to monitor how the Provider Selection Regime is being used in practice as a commissioning lever, and how it interplays with other issues including pricing and payment mechanisms, complex contractual arrangements, provider competition and collaboration, patient choice framework and commissioner-provider relationships.

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