Delivering the Prime Contractor approach to NHS services:
“Command and control” or “accountable care provider”? 
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1. **EXECUTIVE SUMMARY**

1.1 The NHS has gone through wide ranging changes in its commissioning structures following the Health and Social Care Act 2012. The reconfiguration this introduced in April 2013 is now starting to settle down, with CCGs in many areas looking to introduce new and innovative approaches around contracting and finance in order to drive greater change.

1.2 There is no one single approach to meeting the challenges of integration against financial austerity, reduced resources, lost corporate knowledge from some organisations and the refined procurement and competition regime. CCGs are member based organisations which do not follow a set “governance” structure or constitution (whilst there is a model this was not uniformly adopted) and therefore there are CCG models which (for example) will have differing approaches to GP engagement and commissioning support.

**New Prime Contracting models emerging**

1.3 There is strong support nationally to adopt new approaches to contracting such as the prime contractor model to bring in closer provider integration across both health and social care. The increasing role of CCGs in this process is only likely to expand further with the advent of co-commissioning of primary care by them.

1.4 The development of new contractual models has also been accelerated through a greater freedom to make changes to the NHS Standard Contract in some key areas:

1.4.1 CCGs may determine the duration of the contract they wish to offer, within the framework of national guidelines and regulations on procurement, choice and competition; this gives an option of longer contract terms than previously to assist in transformational approaches;

1.4.2 in agreement with providers, move away from rigid national prices, using the Local Variation flexibility set out in the National Tariff guidance, potentially developing different payment models based more on quality and outcomes and less on activity; and

1.4.3 utilise innovative contracting approaches such as offering contractors compensation on termination.

1.5 Increasing numbers of CCGs have now started high profile/high value pathway based procurements to seek to impose a more radical system reconfiguration (generally in the areas of MSK and community services) especially through the route of appointing a prime contractor (see Staffordshire, Bedfordshire and Cambridgeshire). The impact of the changes appears to be that we are now seeing larger higher value contracts with longer contract terms. This increases the pressure on the processes which CCGs are running as the risk to providers who lose out on these “super contracts” is much greater.

1.6 In effect there is in some cases a “winner takes all” position if you are offering a 5 or 10 year contract for a wider package of services, so the providers who fail to win the contract are likely to suffer significantly as a result. This will mean that these processes will be both complex and highly sensitive to challenge (this is more so than for previous short term and lower value procurements). So in reality it is not unexpected to see issues arising and some challenges coming up in these new processes.

1.7 The current number of “prime contractor” approaches to procuring a wider range of health and social care pathways / population groups have come under some criticism (“Prime Contractor model looks old before its time – HSJ November 14”) due to the problems in implementing them, but there was always likely to be some issues in looking to move away from the established health and social care models.
1.8 The prime contractor model should not be seen as a quick fix to commissioners’ issues through pushing responsibility, cost and risk onto the provider. Commissioners will benefit from carrying out an early wider assessment of the approach against other models. The process should build in time to engage the market to be ready to adopt an alternative approach and ideally facilitate closer working arrangements through current arrangements or new overarching contracts so that change is managed collaboratively over time in the context of both commissioner and provider concerns.

1.9 However, it is not always possible to have the time to develop the model fully and there is often (with the current financial imperatives) a need to implement change quickly. Whilst in some areas it may be felt that disruptive innovation is required, it does increase the risks to commissioners both in terms of the risk of challenge from bidders in the process and also in achieving an end result that is capable of delivering change in outcomes and efficiency rather than just a change in the name of the provider organisation(s).

1.10 If the commissioners see the prime approach as a way to simply shoebox a wider package of services together for a reduced budget without provider-side buy in to the process then the approach is essentially a kind of enforced provider roulette. Providers are driven to bid competitively for core services and are unlikely to have sufficient time for appropriate development of their wider offering (especially if it has to be developed following a procurement notice) rather than as developed through a strategic alliance approach. These circumstances are likely to see a response of a traditional command and control sub-contracting approach with supplier induced demand and “like it or lump it care” as described by Simon Stevens. If the desire is to change the model then there needs to be engagement and buy in from the provider side to deliver services in a different way.

1.11 Previously, larger prime contractor based models have been criticised for sidelining SMEs. Without careful consideration in these models the rise of third sector health providers, such as social enterprises, voluntary groups and charities (which may offer the more innovative and reactive solutions), may be hindered by their inability to take key roles within prime contractor arrangements where they are effectively side lined as minor partners. A complaint that has often been made is that they are engaged to win the tender but that once the contract has been secured the services will go through the prime and the core contractors rather than other parties who may be better placed.

1.12 There are also issues if selecting a sole provider could effectively remove competition for services leaving the commissioners with reduced options on the expiry of the initial term. Commissioners (and providers) also need to be cogniscent of the risks in introducing a prime contractor/lead provider model with a higher value/longer term contract to avoid embedding in some of the current issues and behaviours. There are new flexibilities in how NHS commissioners can contract and these can incentivise a different type of performance and a real change to services if they are used in an appropriate manner.

2. UNDERSTANDING THE PRIME CONTRACTOR MODEL

2.1 This paper firstly explains the basic structure of how a prime contractor arrangement may work and then provides an analysis of the legal and commercial issues and risks in using it to deliver more sophisticated approaches to NHS services.

2.2 A “Prime Contractor” (or “Lead Provider”) will be an entity that has overall responsibility for the management and delivery of all the contracted requirements under a commissioning contract with a commissioner.

2.3 In a health sector context, the Prime Contractor would contract directly with either a CCG or other commissioning body for the provision of health services for the term of the contract. The Prime Contractor could be an organisation which provides elements of the services itself (this would be the usual arrangement) but it is also possible that
it could be a new entity set up for the purpose of the contract which sub-contracts the service provision to a defined chain of sub-contractors.

2.4 By way of example the Prime Contractor could be a Foundation Trust, a joint venture organisation spun out of Foundation Trusts or a private sector organisation. It may provide some services directly and/or sub-contract some services to other organisations. It would also manage payments to sub-contractors and bear responsibility for their performance as it holds the ultimate contract with the commissioner.

Features of the Prime Contractor model

2.5 A Prime Contractor will need to have project management capability, technical competence, financial standing and supply chain arrangements, with an increasing emphasis being placed on their willingness to share risk.

2.6 Once a Prime Contractor is chosen and the sub-contracting arrangements are finalised, the commissioner is still likely to have a Contract Manager overseeing the Prime Contractor’s management of the services. While the object of the model is to pass responsibility for management of the provision of services to the Prime Contractor, the commissioner may wish to retain a degree of control, for example, an ability to veto through refusal of consent to the Prime Contractor’s decision to change/terminate a particular sub-contractor or to have a direct agreement with a key sub-contractor.

2.7 Although funding arrangements between the Prime Contractors and the sub-contractors is a matter for them to decide, the commissioner will often look for evidence that all sub-contractors are aware of their roles and that payment arrangements, for example payment terms have been agreed for the flow down of funds.

2.8 There is also the very real possibility of providers being involved in multiple prime contractor models for different services/areas in a variety of guises and this will present logistical and practical challenges for providers in managing this involvement – especially if different approaches to prime contractor are being taken for different services by commissioners.

Considerations in adopting a prime contracting structure

2.9 The majority of the benefits of the prime contractor model tend to show up in the commissioners’ side of the ledger in terms of reduced numbers of contractual arrangements to manage, reduced administration, greater integration of contractual arrangements and more manageable cost. However, the commissioners should also consider the impact of their approach on the provider side and how fair and equitable it is to expect the providers to introduce a new system and take on management of wider services from day one at a significantly reduced margin and substantially increased risk profile. There are a number of questions which the commissioners should consider at an early stage to avoid a disconnect between the model and the potential providers, including:

2.9.1 whether the providers are used to working together in this way (which services are operating in the desired way to be held up as evidence of what the commissioners want to achieve)?

2.9.2 will the approach bring a “winner takes all” procurement which would destabilise other providers as opposed to the Prime Contractor (and lead to a significant lessening of competition)?

2.9.3 would the Prime Contractor be in a position to shore up its own services at the cost of smaller third sector providers whose services were swept up into a larger prime contractor arrangement?
2.9.4 is the change in patients’ best interests and in compliance with the Procurement Patient Choice and Competition (No.2) Regulations?

2.9.5 how long in duration will the contract need to be for the providers to be able to introduce substantive changes and what flexibilities in the financial structure for payments would incentivise this behaviour?

3. LEGAL AND CONTRACTUAL ISSUES WITH THE PRIME CONTRACTOR MODEL

Using the NHS Standard Contract as a Prime Contract

3.1 Under the NHS England Technical Guidance\(^1\) the NHS Standard Contract must be used by CCGs and by NHS England where they wish to contract for NHS-funded healthcare services (including acute, ambulance, patient transport, care home, community-based, high-secure, mental health and learning disability services). The only exceptions to this in the guidance are:

3.1.1 primary care services commissioned by NHS England;

3.1.2 any primary care improvement schemes commissioned by CCGs on behalf of NHS England (which would be effected through the primary care contracts held by NHS England); and

3.1.3 any out-of-hours primary medical services commissioned by CCGs on behalf of NHS England, for which an APMS contract must be used.

3.2 If (as would be likely) the prime contractor model includes elements of secondary, community and primary care and requires one contract in place to deliver services in an integrated system then an NHS Standard Contract (made compliant with the APMS Directions through the addition of terms to make it compliant with the APMS Regulations) may be the optimal model for use. There is more flexibility around the duration (term) of the NHS Standard Contract and this has been used in a number of procurements to offer terms of 5 years and more.

3.3 Also there is greater flexibility under the current tariff rules to introduce new local financial arrangements into the contract through agreement, therefore the contract has become much more adaptable to meet the requirements of a prime contractor model and new outcomes or year of care financial models.

NHS Standard Contract flow down

3.4 A contract for NHS services between the CCG and the Prime Contractor is likely to be required to be the NHS Standard Contract. The model would then envisage the Prime Contractor accepting liability to the CCG for its defaults as well as those of any of its sub-contractors.

3.5 Consequently, the Prime Contractor will be seeking to flow down to the fullest extent possible the obligations and liabilities contained within the NHS Standard Contract to the sub-contractors. The division of responsibility and each party’s share of risk and liability would usually be a contentious issue (and this is what we have seen in our experience where similar models have been adopted). As an alternative model the Prime Contractor may be a new legal entity such as a limited company which has been established for the purpose.

Flow down of risk under the contract against smaller sub-contractors

3.6 The major issue for the Prime Contractor is the assumption of the risks within the NHS Standard Contract and the responsibility for sub-contractors providing the services.

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3.7 The Prime Contractor would need to relinquish control over the provision of those services to the sub-contractors. Flowing down the contractual responsibilities to sub-contractors may protect the Prime Contractor but may also in turn impose too great a risk on sub-contractors without providing sufficient reward. Combined with possible limited liability of the Prime Contractor, a sub-contractor may consider the potential cost to their organisation of becoming a sub-contractor in these circumstances is too high.

**Procurement with a new prime contractor entity**

3.8 If the relationship between the commissioner and the Prime Contractor is through a tender exercise then the pre-qualification stage is likely to require some financial security and performance data from the participants on the new vehicle so there may need to be guarantees from the sponsoring body to the commissioner which would obviously reduce the benefit of protection from having a separate legal entity. However the Prime Contractor body would still potentially be able to limit its liability to the sub-contractors.

3.9 In addition, if the parties are to work together during a procurement exercise, they may also require a memorandum of understanding/bidding agreement setting out the parties' respective responsibilities during that process and tying down key principles/costs.

3.10 Agreements between the Prime Contractor and the sub-contractors will have to determine the consequences of an insolvency of, or other material breach or non-performance of obligations by, the sub-contractor as the Prime Contractor would still need to complete the performance of the main contract with the commissioner.

**Sub-contract requirements**

3.11 The Prime Contractor would want to include its requirements in its contract with the sub-contractor at the outset. The sub-contracts should allow the Prime Contractor to:

3.11.1 Monitor the overall level of spend under the contract.

3.11.2 Operate a contractor governance arrangement with the other providers, including managing performance issues centrally.

3.11.3 Agree any variations centrally and flow down to the sub-contractors.

3.11.4 If appropriate, recover a management fee from the other contractors for its management costs.

3.12 Prime Contractors would want to ensure that they are not exposed under the payment profile of the contracts, e.g. they do not have to pay the sub-contractor if there is a dispute with the CCG over payment for those services and that there is a clear dispute process in place to manage multiple contractors.

3.13 As stated above, the Prime Contractor may incur a substantial management burden here. To mitigate this, the Prime Contractor can build this cost into any tender and also seek to levy a proportion of this charge down to the sub-contractors.

3.14 Termination provisions in the NHS Standard Contract will need to be reflected in the sub-contracts by the Prime Contractor. The Prime Contractor will want the right to terminate a sub-contract for poor performance before it causes issues with the main contract. A specification may need to be agreed setting out key performance indicators that will trigger staged remedies depending on the severity of any performance failure. One remedy may be for a right to step-in to deliver services by the Prime Contractor or partial termination/suspension.

3.15 The model could also look to allow some flexibility for the removal of underperforming parties before their default caused material issues with the main commissioning
contract. The Prime Contractor will need to be aware of its responsibility for the ultimate provision of the services in these circumstances.

**Management of information flow from complex supply chains**

3.16 The assumption of management by the Prime Contractor adds an extra stage in the flow of information from provider to commissioner. There could be difficulty in the Prime Contractor collating information from each of the sub-contractors and reporting to the commissioner in a timely manner. This may have implications for the perceived responsiveness and cost of the Prime Contractor model.

3.17 Information flow will be vital to the operation of the prime contractor model which cuts across commissioners and a variety of provider organisations through the Prime Contractor. As the responsible party under the contract the Prime Contractor will want to set out standards in its sub-contracts and drive the reporting and information flows it needs from the supply chain.

**Competition Law**

3.18 Operation of the prime contractor model may raise competition law concerns. Competition law refers to entities fixing prices or anti-competitive agreements. The Prime Contractor may also be in a dominant position in the local healthcare market for a particular service. Commissioners will need to ensure that the Prime Contractor manages the provision or sub-contracting of services in a way that does not constitute abuse of that dominant position. To minimise the chance of a breach of the competition rules, Prime Contractors should monitor procurement exercises, review the terms of their agreements (to ensure that they are not anti-competitive) and sub-contractors’ behaviour.

**TUPE**

3.19 The TUPE liabilities incurred when a sub-contractor is terminated and another appointed will need careful consideration especially as employment costs are likely to be a major factor in the price of the sub-contract. These considerations will need to include TUPE in at the start of the contract and TUPE out at its end.

**Conflicts of Interest**

3.20 Any potential conflict of interest between the commissioner role and contractor/sub-contractor role would need to be openly declared and carefully managed within the Prime Contractor structure. There is nothing to stop GP practices being part of provider-side integrated care arrangements so long as there are appropriate safeguards as to how the services are commissioned and NHS England has provided guidance to CCGs on dealing with Conflicts of Interest.

4. **KEY CONSIDERATIONS IN DEVELOPING A PRIME CONTRACTOR PROCESS**

**Allowing providers to work more effectively across organisational boundaries**

4.1 If you are not wanting to create a scenario with one large provider effectively taking on the prime role and controlling the supply chain to its own order then the providers will need to ensure that there are effective governance and information systems in place within the prime arrangements to support the desired way of working across the provider organisations.

4.2 For the providers, this could include the formation of a new joint venture vehicle with a shareholders or members agreement setting out the structure, information sharing agreements between providers or alliancing agreements.

4.3 Procurement and competition concerns should be considered at an early stage to determine if there are any particular issues which could be addressed through the way the structure is formed and the documentation – for example, protocols as to
what information can be shared and what information sharing between the providers would be prohibited can be very helpful. Early informal engagement with appropriate advisers and/or Monitor may also avoid significant issues around competition emerging later.

4.4 One of the main issues which can derail more collaborative approaches is what form will the leadership of the prime provider group take. If it is to be one organisation leading and hosting then it will require careful structuring of the arrangements to avoid falling into the command and control model whilst also managing the risks that the “lead” will take on as prime. This is where the joint venture/alliance model can provide a more palatable solution as the structure and documents can offset the influence of a large organisation to facilitate a more collaborative approach to risk sharing.

4.5 It may well be that provider organisations take on differing roles across a number of prime contractor networks depending on the services involved and their own specialisms. This will be challenging and a move away from the current market practices and may involve NHS Trusts becoming more collaboratively focussed taking a lead in the development of prime contractor responses or becoming part of the wider network of provision as and where appropriate.

Diagram 1: possible commissioner integrated commissioning of a Prime Contract

Commissioner support for the development of closer provider working

4.6 Ultimately, the commissioners will determine whether to procure services and what shape that procurement will take. They obviously have a fundamental role to play which will influence the “shape” the providers may need to adopt to respond to their commissioning activities.

4.7 Commissioners who adopt the prime contractor model should (as has already been mentioned) resource the process of procuring/ selecting the model and conduct an options appraisal as to whether the model is likely to meet their aims. It is often said that form should follow function and in this instance the contractual and procurement
route should follow the commissioners’ desired outcomes and specification rather than the other way round. The commitment in time and expense of adopting a new approach of this type should not be underestimated, especially if a route such as a competitive dialogue is chosen for a procurement, and we would recommend that early specialist advice is sought to help with the options appraisal and sculpt any procurement process from the first stage.

4.8 It is important for the commissioner to understand who the likely providers are and whether they have the capability to adapt to the new services and payment models which the commissioners may want to introduce. The risk of destabilisation and pushing organisations into financial (and service) difficulty becomes greater the wider the breadth of services/population are included, the longer the term of the contract and the higher the value.

4.9 Also there should be an assessment of the current collaborative partnering between the local providers (and those who may need to collaborate to deliver the desired model). If the area and the services have a track record of collaborative working then this could be assessed to see what can be delivered under current structures within the confines of the Procurement rules.

An Outcomes based approach within a Prime Contractor model

4.10 Currently nearly all contracts used by CCGs with providers are based upon activity - inputs and outputs. Moving to a prime contractor model with a wider scope of services commissioned provides a possible route to move to an outcomes-based approach which might change the shape of service provision due to being able to allocate a specific budget for a specific population group or care pathway (initially the majority of examples appear to be focussing on frail and elderly (over 65s) and diabetes).

4.11 Whilst on the surface the outcomes approach would appear to be well suited to a prime contractor model through the bundling together of a pathway/population budget and service provision under one contract, the complexities are increased in terms of dealing with how this risk and gain flows through to the supply chain level.

4.12 This is especially the case in respect of the costing of the services across a group of providers where the outcomes will be overarching and not due to any one clear defined action from a party. There is then a need to define a mechanism for how any payments/penalties from meeting outcomes are shared across the supply chain members.

4.13 If a significant proportion of the contract is to be based on outcomes then this could support a case for an overarching agreement between the supply chain members working together as an alliance or a joint venture vehicle as the prime contractor within which a mechanism for flowing the outcomes-based payments across the supply chain can be documented to prevent the position being distorted through the management of one prime contractor. From the providers perspective this will need to flow from the main contract and will need to have the flexibility to change in line with the outcomes set out in it. It will also need to have a review mechanism to adjust out any potentially perverse results affecting the supply chain if the outcomes are not operating as anticipated.

4.14 The quality of and availability of information (financial and clinical data) around the specified population/pathway will also be a critical consideration for the commissioner and the provider in moving to the outcomes-based model. It is important to be able to define the budget (and for the supply chain to be able to understand the costs underpinning their elements of delivery of the outcomes), the providers (due diligence on the existing contracts – seeing how activity has been treated,double counting) and then have appropriate datasets recorded to measure the outcomes (for sub-contracts will be needed with the different providers involved). This is likely to come into the contract negotiations in terms of which party is better placed to manage the risks of
the financial and clinical data being inaccurate (for example inconsistent coding of data leading to incorrect assumptions of resourcing and demand).

4.15 The option of introducing an alliance/overarching contract approach to the providers supply chain is shown in diagram 2 below. This may also be achieved by the providers forming a joint venture and introducing the alliance principles in their arrangements within the new vehicle. It is important to note that the NHS Standard Contract can only be executed by one provider so any “alliance” would need to consider how it would contract (whether through a new vehicle or a member acting as host (taking on the risk with indemnities from the other parties.

Diagram 2: Prime Contractor: Alliancing Model

4.16 CCGs might consider introducing this method of working on a phased basis (for example through using overarching contracts over existing contractual arrangements with providers) to give providers the time and opportunity to learn to work together in this way prior to procuring the prime contractor.

*Contract penalties and reward systems need to fit in with the desired model of performance and avoid double jeopardy reversion to the old methods*

*Developing from Prime Contractor into Accountable Lead Provider?*

4.17 One suggested route which is a variant on a straightforward subcontracting/command and control model is the Accountable Lead Provider model which has been proposed by Dr Steven Laitner and others.

4.18 In this approach the commissioners use the whole health care budget for a particular care group or population as the basis for procuring a provider who is willing and able to deliver an integrated set of services to meet the needs of the group or population.

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2 Professor P Corrigan and Dr S Laitner —The Accountable Lead Provider, July 2012 (Right Care Casebook)
4.19 This “accountable lead provider” is envisaged as being a health care provider in the centre of the pathway (between primary care and hospital inpatient care) rather than a navigator or implementer who is not actually a provider in the system. The accountable lead provider doesn’t have to deliver the whole pathway of care themselves but takes accountability for the delivery of the contracted services that are then integrated across the whole pathway.

4.20 Importantly the accountable lead provider is not acting as a commissioner of services, they are acting as a combination of provider, integrator and programme manager, who will both deliver and sub-contract for healthcare where required to do so.

**Using the contract measures and mechanics to support improvements in quality and outcomes which providers will need to work together to achieve**

4.21 Both commissioners and providers should work together to define and agree the appropriate contract measures (both for reporting and performance indicators/outcomes) which are not overly complex and burdensome.

4.22 From a positive perspective setting a smaller number of indicators which involve all parties and which the parties can agree upon would help to develop a more collaborative approach. Where there are hundreds of KPIs or targets the administrative burden is greater and the focus of the service change can be dissipated.

5. **CONCLUSIONS**

5.1 The success of the prime contractor model in the NHS appears to date to have been mixed. However, there needs to be a realistic assessment of what the model can achieve and when it is best used to deliver benefits to the system.

5.2 It is one of the tools for commissioners which can help to deliver more integrated care and can allow the use of a more outcomes or values based approach where it is used appropriately. This being said there is a need for the commissioners to resource the process of procuring/selecting the contractor – and the commitment of this should not be underestimated especially if a route such as a competitive dialogue route is chosen.

5.3 Much then hinges on ensuring that the likely bidders have the capability to manage budgets and services and to bring about a more collaborative partnering approach between the providers who will need to collaborate to deliver the services. This will require having a contract structure which provides the right incentives and targets to press the prime contractor and its supply chain to act differently and deliver the services in a new way. Some of the key considerations in this have been explored above.

5.4 The underlying objectives for commissioners to save money and improve quality through greater integration under a prime contractor model can be best achieved if the prime and supply chain work together to take responsibility and deliver services for their population, focusing on care co-ordination and access. To just introduce pure supply chain management principles to the model will just replicate the previous structure with the Prime also taking on the role of the Commissioner.

5.5 The opportunity to create and define the supply chain structure presents an opportunity for the prime contractor and its partners to create a different approach to delivery.

5.6 This is especially the case if we are looking at different payment models such as outcomes based contracts as opposed to an activity model - without flowing down the incentives and structure to the supply chain the incentives for a different way of working will stop at the level of the prime contractor which will put the prime at risk.
5.7 So how do you flow down a system wide outcome measure and payment across a wide and complex supply chain? This will involve a different model of sub-contracting rather than just a straight flow of the prime contract down the chain – solutions could include overarching arrangements entered into between the supply chain and the prime – formally defining the common aims and forums for the supply chain and prime to interact and work more closely – and setting out (in a quasi-alliance approach) how the outcome will be delivered and the shared responsibilities between the parties.

5.8 There is also a risk that this is the commissioner seeking to delegate elements of their commissioning function to the prime contractor by process so commissioners need to be wary of how they set up and manage their prime contractor to ensure that they are fulfilling their statutory duties.

5.9 There is with the new and emerging models a need to develop more collaborative forms of governance with improved co-ordination of the supply chain (obvious elements such as electronic health records and joint location/teams come to mind though as mentioned above any approach should also be considered against its impact under competition law prior to implementation).

5.10 So there are a wide variety of approaches to the Prime Contractor model and providers and commissioners need to be aware of the variances and understand how the models work and the benefits and downsides of them. Just having assurance that you have a large NHS trust as a prime contractor should not prevent a more detailed analysis of the approach to the supply chain and how it will facilitate better integration and patient care.

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