Delivery models To achieve the left shift from hospital to home

Place partnerships

An existing model

- The commissioning function is held by ICBs.
- There is significant delegation to place, including budgets, convening local partners and responsibility for strategic commissioning for locally determined provision starting with enhanced and transformational resource, not core service funding.
- Governance structure based on collective accountability and delegation of certain decisions from individual organisations to partnership in line with the scope of the 'joint venture'.
- The integrator function could be held by the ICB or shared with providers at place level/at scale.
- **One option would be an alliance approach**, whereby health and social care teams are brought together with an agreed management structure and the ability to hold contracts.
- This approach will require close working with local government and joint commissioning through Section 75 agreements.
- Increased integration of NHS provider and local council teams.

Lead care provider/partnership

An emerging model

- The commissioning function is held by ICBs.
- The integrator function sits within the lead care provider/partnership (this could be providers or provider collaboratives of any kind).
- The provider/partnership holds a risk-based capitated budget focused on improving outcomes for a defined population cohort. The provider/partnership sub-contracts to other providers (including VCSE) at place and neighbourhood.
- Combined delivery of acute, community-based, mental health and GP services with a focus on the latter three service types.
- The provider/partnership takes on the GMS contracts (where there is GP support for this) or sub-contracts providers to deliver care. Most GPs are salaried employees of the provider/partnership.
- Close working with local government as integrated teams that work on the wider determinants of health, enabled by Section 75 agreements.