Delivering integrated care in Guildford

Final Report – April 2025

Author's note

This is the fourth in a series of presentations on local health care delivery produced for the Guildford Society.

The first two were essentially focussed on information gathering and looking at the opportunities for the town from emerging NHS health care policies and the wider perspective of emerging technology.

The third document was about the 'How'. How many of the issues raised previously could be confronted and potential solutions implemented.

This fourth, and last report, consolidates both strategy and tactics. It is much more radical and looks at the current policy positions of the Royal Surrey Hospital, Guildford's major provider and the Surrey Heartlands Integrated Care Board, the commissioner.

We'd like to be seen as a critical friend. We have no allegiances to promote. Our only concern is putting forward suggestions which could result in better health experiences and outcomes for local people.

If we have a bias, it is in the direction of those whose care needs are the greatest. Like most towns, there is a huge gap in the health condition between those who live in the more prosperous parts of town and those who are less fortunate.

Also, these presentations have to make sense to two different audiences – lay people, whose encounters with the health system are mainly as consumers, and on the other side, NHS practitioners and policy-makers who, like us, are deep in the detail.

Readers of the first three documents have pointed out that a number of the pages are repeated. This is for reasons of continuity and emphasis. The same applies to this presentation. These pages, we think, are of sufficient importance in telling the story they need to make another appearance.

Author's note (continued)

All four of the documents are long. But health care delivery is dense, complex and nuanced by politics.

In telling this story, our most difficult challenge has been the structure and flow of this presentation. Health care systems are both multi-dimensional and labyrinthine. Management gurus frequently say that they are the most complex of all ecosystems. We accept that the presentation doesn't always follow a logical route, for which we apologise. But please stay with us.

We start in this presentation in the same place as others – with the longstanding issue of how health delivery in the north of the town is hampered by the poor state of GP premises and how there have been no organisational moves to address the issue, even though these are the facilities which serve the most disadvantaged parts of the town.

We next move to NHS England strategy or more reasonably nowadays, Department of Health and Social Care strategy, as the government has taken control of directing health care policy in England.

Since our last presentation the government has decided to abolish NHSE.

It has been more affirming of the approaches we have long advocated – that the future of health care will be organised around neighbourhood delivery and transforming technology.

The RSCH is the dominant player in local health care, as acute Foundation Trust hospitals are across the NHS. It faces many, diverse challenges which, we believe, it cannot resolve through the continuation of present strategies. Arguably, many never can be – the pressures of demand, for example. But it could make a difference which would be for the benefit of population health.

We believe that most of the solutions lie outside hospitals – in the community. We are advocating, however, that the Royal Surrey takes greater control of these and makes the fullest use of its extensive resources.

This is the central proposition of this presentation.

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Preamble

Guildford is a mostly healthy town. There are pockets of deprivation, however, where health indicators (life expectancy, for example) are well below the national average.

This concentration is in those neighbourhoods to the north of the A3. While the local GP services are rated here as 'Good' by the CQC, a 2019 survey of primary care premises commissioned by the CCG said that 'the current estate [in which they operate] is not fit for purpose' and that 'the delivery model is not sustainable'.

The study concluded that 'the only viable option [was] to increase capacity through new build options.'

Nothing has changed over the past six years. The Guildowns practice has no plans to develop these leasehold premises. The ICB until last year had no funding for practice redevelopment. Nor does it plan to make any allocations in the foreseeable future.

In the meantime, GP premises staffing has more than doubled through the introduction of the Additional Roles Reimbursement Scheme (AARS). There is nowhere for them to go in north and west Guildford.

Government policy is for care to be moved out of hospital into the community. But primary care is overloaded in Guildford and there are no central area community facilities.

The view of the Guildford Society is that something has to give. This presentation explores possible options.

There has to be investment. Government adviser Lord Darzi says that the NHS must 'Lock in the shift of care closer to home by hardwiring financial flows. Financial flows must lock-in this change irreversibly or it will not happen'.

There is a strong candidate as a base to deliver a full range of community health services at the Jarvis Centre in Stoughton, a partly occupied building owned by NHS Property Services.

A rebuild would cost about £20m.

The new community health centre would fill a gap in the ICB's vision for Guildford to have a hub and spoke delivery system.

The logical financier and operator for the recommissioned Jarvis Centre would be the Royal Surrey Hospital which runs community health care satellites in Haslemere, Cranleigh and Milford.

RSCH has sufficient capital to finance the rebuild and has an excellent reputation for financial engineering and project management. This is money (in excess of £80m) which has been accrued at the Trust.

Preamble (continued)

While we are unable to model the project financing, we believe there are multiple risk-free revenue streams which would preserve RSCH capital.

Patient care could be transformed and huge operating efficiency benefits gained as patient pathways are fundamentally reworked. The new posts which have been added by AARS could be combined with existing community health workers, supplemented by social care and public health staff to operate as truly multi-disciplinary teams (MDTs). They would be based in the community in purpose-built spaces which would foster collegiate working.

To deliver these new care combinations the ICB would need to be imaginative with its budgeting and contracting to build around traditional GP GMS contracts.

A conflation of hospital and community care seems inevitable, operated by a single management. We are recommending that Community Care be a brand-new business unit bringing together existing services, managed by RSCH.

In the next five years, care delivery will be transformed by technology. The way information flows will start to blur old boundaries between primary and secondary care.

PCNs would have the room and the technology to be able to provide an expanded range of capabilities to monitor and manage care at the individual patient level. Data collection, processing, analytics and machine learning will help direct patient care from a purpose built back-office located in the community care hub.

This facility should be built as a model office designed flexibly by its users with the aim of providing an open space to foster collegiate working by MDTs.

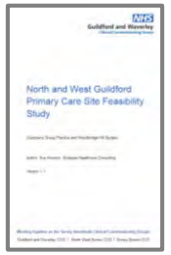
Guildford is particularly advantaged by the range of IT health systems which it has begun to assemble. As a knowledge centre it has the intellectual capital to introduce extraordinary new ways of providing management care.

That's why we envisage the Royal Surrey Hospita*l System* working in the community seamlessly with GP colleagues. This will be important as ICBs lose people, budgets and influence.

We hope that members of the local NHS community will find a way.

Where we started:
GP premises in N & W Guildford

Reprise: A 2019 CCG report said that GP premises in north and west Guildford were not fit-for-purpose



‘The case for change has identified some key issues that need to be addressed if primary care in north and west Guildford is to be sustainable into the future’.

‘A significant proportion of the population it affects is the town’s most needy’.

‘The current delivery model is not sustainable given the current pressures on primary care and the problems with the recruitment and retention of GPs.’

‘The current estate is not fit for purpose and with further additional demand in the form of two new planned housing developments at Slyfield and Blackwell Farm, the lack of primary care capacity in north and west Guildford will be further exposed.’

‘This study has concluded that the only viable option is to increase capacity through new build options.’

‘The Guildowns Group Practice has expressed a desire not to hold any freehold property interests as a partnership going forward. For the Guildowns practice, delivering services across four sites further compounds these issues.’

Future population growth will also increase the pressure on GP services. Guildford's population grew by around 6,500 between the last two censuses, held in 2011 and 2021. But the period up to 2030 will see an acceleration. More than 17,000 new homes are planned to be built in the area in the next five years, potentially adding 50,000 people to the current population of c.150,000.
The locations of the approved developments are shown here
https://www.guildfordsociety.org.uk/Keysites.html
Nearly all of the sites are to the North of Guildford, the area where GP services are most stretched. For details use the zoomable map.

Potential development sites were identified by the report to replace the existing premises

The 2019 report identified redevelopment opportunities:

‘Building new combined facilities at the Jarvis Centre and Kings College, Park Barn would provide the opportunity to address many of Guildford’s most pressing medical needs.’

‘The Jarvis Centre – Stoughton Road

The Jarvis Centre is located on Stoughton Road and is owned by NHS Property Services. It is in the northeast quadrant of the registered GP lists included within this study. The site extends to approximately 7,400m2 with three buildings present on the site:
The main building is a combination of single and three storeys and occupies a footprint of approximately 1,500m2;
The annex – a small double storey building to the rear of the site with a footprint of approximately 140 m2; and
The portacabin – a single storey temporary structure.

Kings College – Park Barn

The Kings College site is located on the western boundary of the practices’ catchment area.
The available land is on the site of Kings College.

Note: the Kings College, Park Barn site is no longer available.

This will still leave this site and the existing Wodeland Avenue practice, as covered in the 2019 report, as requiring further investigation.

The overall situation in the North of Guildford is harming patients and requires urgent attention.

Proceeding with the Jarvis site, nearly six years on, is now critical.

The Jarvis Centre still looks like the only ‘quick-win’ opportunity. Is a transition achievable?

‘The location is within one of Guildford’s most deprived localities.

It is a large 7,400 sqm site with three principal buildings.

Stoughton Road surgery is a leased property at the end of a row of commercial properties.’

‘For the registered list size, the building is significantly undersized offering only 118 sqm, a deficit of 251 sqm.’ **2019 CCG Report.**

It is a few hundred yards from the Stoughton Road GP surgery operated by the Guildowns practice.

The Jarvis Centre site is owned by NHS Property Services, obviating the need to purchase a property under private ownership.

What is this service?

- Community diagnostic centres provide a broad range of diagnostic tests. For example, scans (e.g. MRI), tests (e.g. blood) and checks (e.g. seeing how well your kidneys are working).
- They are often located away from hospitals (e.g. shopping centres), allowing people to access diagnostics closer to home.

This is a much bigger space than a local GP practice would need

This multi-provider hub could be a £20m investment.

The Stoughton GP practice, operated by the Guildowns group, would be a major tenant.

To fund the project, the health hub would also shelter the practice AARS staff, multi-disciplinary teams, multiple community health providers, social workers, dentists, opthalmologists, mental health, ICB and SCC contracted public health services and other providers including hospital services, for example an expansion of outpatient clinics.

All of these will provide rental income, much of it underwritten by the NHS.

There could be a third-party investor like Assura who the RSCH has employed recently.

All of this would take time. We are advocating the use of short-term premises to bridge the transition.

Because of lead times, an early start is essential.

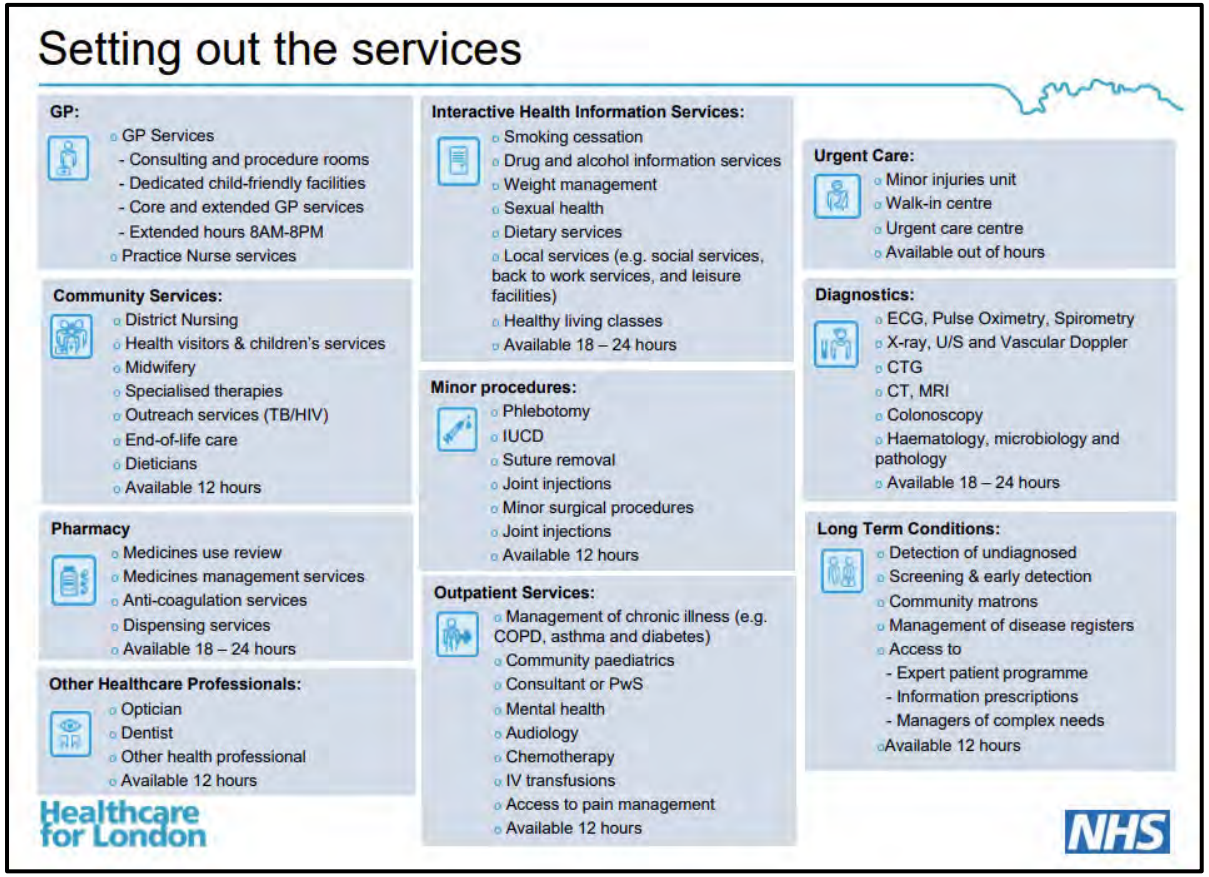
The Jarvis Centre could be sold at any time.

Most of all the project needs an owner. RSCH is probably the only candidate.

Guildford should aim to get the best configuration of services to deliver care in the community

To some degree this might mean looking again at the polyclinic model, proposed by the government about 15 years ago.

There are a significant number of revenue streams. The operation would essentially operate on a 'department store' business model attracting multiple rent paying providers.



'The Polyclinic Service Model', Healthcare for London, May 2008.

The ICB says it wants to address health inequalities. It now needs to take radical action

‘Reducing health inequalities

Health inequalities are unfair and avoidable differences in health between different groups of people. These differences happen because of the conditions we grow up in, live in, and work in. These conditions affect how we feel, think, and behave, and can impact both our physical and mental health.

We want everyone in Surrey Heartlands to have the same chance to live a healthy life, no matter where they live or who they are.

Taking action to reduce health inequalities helps to:

improve people's lives

lower the cost to the NHS and social care by preventing illnesses

support the economy by creating a healthier population’

Surrey Heartlands ICB website, 2025

There is a vast gap in health status between deprived and affluent areas

In 2014 to 2016, the gap in life expectancy between the most and least deprived areas of England was 9 years for males and 7 years for females. The gap for years spent in good health was 19 years for males and females

Source: PHE analysis of ONS mortality data

Has a lack of investment in primary care harmed some Guildford residents?

If the duty of health systems is to protect its people, it could be that Guildford has an imbalance in its delivery system.

Life expectancy is lower, health status poorer, in the deprived parts of Guildford.

According to the last CCG survey in 2019, 'the main areas of deprivation in Guildford are within the wards of Westborough and Stoke.'

These are not areas of total deprivation: 'within Westborough, 12% of the population live within the 10-20% most deprived areas in England (ranked 5726) and within Stoke, 13.3% of residents are within the 20%-30% range (ranked 6889)'.

'Life expectancy at birth for men ranges from 76.6 years in Stoke to 87.6 years in Godalming Holloway, a difference of almost 10 years. LE at birth for women ranges from 78.8 years (Stoke) to 90.7 years (Blackheath and Wonersh), a difference of 11.9 years.'

'The Park Barn and Royal Surrey neighbourhood has the highest level of overall deprivation - with 35.4% of households suffering some type of deprivation.' **References: ONS ,SCC and GBC.**

Guildford's health situation is largely correlated with wealth

The inverse care law applies in Guildford, which states that 'people who need medical care the most are the least likely to get it'.

Cranleigh, population 12,700; Haslemere, 12,000; and Milford 4,200 are all satellites of the RSCH system. All of these localities have long life expectancy – higher than the national average.

Yet for the 25,000 people in the three wards north of the A3 , there is no legacy community hospital, nor any planned for the future.

This means that they receive no development money from the RSCH balance sheet.

Quantifying the harm done to people in Guildford

(We feel that somebody could do a better calculation than the one we have included below).

The population of Guildford is 163,000.

The population for the three most deprived wards - Stoke, Stoughton, Westborough is 25,500.

1.9% of population have 65th birthdays every year, that's 3,100 for Guildford and 485 for the three wards.

UK life expectancy at 65 is 19.5 years.

The three wards have a life expectancy of 11.4 years at 65.

For a single annual cohort 485 x 11.4 years = 5529 years over their collective lifetimes.

2019, more than five years ago, was the year the CCG published its Guildford GP premises report.

5529 x 5 = 27,645 lost years of life compared with UK average.

Equality - is the ICB delivering on its legal obligations?

'NHS England, Guidance on integrated care board constitutions and governance, July 2024

The Act includes a range of ICB obligations in relation to health inequalities, which should underpin the discharge of functions in each ICB, including:

- the health inequalities duty on ICBs:
  - "Each integrated care board must, in the exercise of its functions, have regard to the need to – (a) reduce inequalities between persons with respect to their ability to access health services, and (b) reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services"
- that the inequality of outcome that must be considered includes, in particular, outcomes in relation to service effectiveness and safety and the quality of the experience of patients, as specified under the duty in relation to improving service quality
- the collection, analysis and publication of information relating to inequalities, in line with NHS England's views set out in the national statement
- the duty to promote integration where this would reduce inequalities in access to services or outcomes achieved
- duties on ICBs in relation to several other areas that require consideration of health inequalities – in making wider decisions, planning, performance reporting, publishing certain reports and plans, annual reports and forward planning

In addition, each ICB is subject to an annual assessment of its performance by NHS England which must include, but is not limited to, how well the ICB has discharged several specific duties including:

- the duty to reduce inequalities of access and outcomes
- the duty to improve the quality of services
- the duty to have regard to the wider effect of decisions (the triple aim)
- the duty to consult patients and the public about decisions that affect them'.

The Act referred to is the NHS Act 2006, as amended by the Health and Care Act 2022.

There is plenty of evidence that there is a wide disparity in health provision across the borough.

To rebuild the Jarvis Centre might mean Guildford just asking for the plans.

‘Washwood Heath, a community health clinic that was set up in a deprived part of east Birmingham two years ago when the Conservative government was in power, is a living, working example of what this could look like. Here, hospital doctors, GPs, nurses, occupational therapists, council social care teams, mental health professionals and charity staff work under one roof.

The £15m three-story building combines an urgent treatment centre offering some of the services usually provided by hospitals, as well as a diagnostic service (for MRI scans, X rays and ultrasounds), alongside mental health care and wider social support.

In practice, this allows for addressing social problems such as housing issues, alongside treating physical health conditions, plus arranging support for daily tasks such as washing and dressing.

The target is the most frequent users of health services - and the aim is to keep them well and out of hospital.

"We want to work with the 10% of the population that is responsible for 70 to 80% of its use," explains Richard Kirby, head of Birmingham Community Healthcare NHS Trust, one of the key partners at Washwood Heath. "The NHS cannot meet their needs on its own – it requires partnership working.“ **BBC, 8 April 2025**

NHS England strategy

Government strategy now has three major focuses.

‘We now also have the commitment from the government to three strategic shifts for the NHS, which are:

hospital to primary care and community services

analogue to digital

treatment to prevention.

The government has also committed to the development of a Neighbourhood Health Service, with more care delivered in local communities, supported by a shift in resources. The recent report by Lord Darzi has also supported this strategic direction, highlighting that a more joined-up approach and transformation shift is required to resolve the current fragmented model’.

Integrated health and care, National Director Primary Care and Community Services, NHS England, October 2024

See also: https://www.gov.uk/government/publications/independent-investigation-of-the-nhs-in-england/summary-letter-from-lord-darzi-to-the-secretary-of-state-for-health-and-social-care

Across the NHS in England, the shift of funding out of hospitals into community care is not happening

One of Darzi's telling points was about 'the right drift'.

"Since at least 2006, and arguably for much longer, successive governments have promised to shift care away from hospitals and into the community. In practice, the reverse has happened".

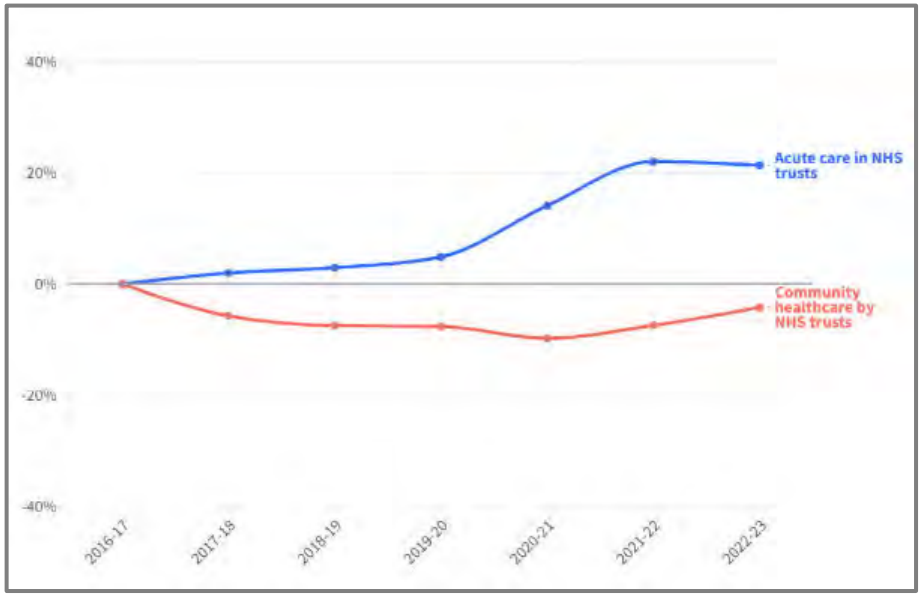
Between 2006 and 2021, Darzi notes:

"…the share of NHS spending on hospitals increased from 47 per cent to 58 per cent…

Between 2016/17 and 2022/23, funding for acute care in NHS trusts grew by 21.4%, while funding for community health care shrank by 4.2%.

Funding for NHS community health care services was cut in real terms in three out of the six years between 2016/17 and 2022/23."

Between 2010 and 2020: the number of community health nurses fell by 7%; health visitor numbers by 29%; and learning disability nurses by 44%. The number of hospital-based specialists increased.



The Strategy Unit, March 2025.

The funding of physical space should support NHS goals. This means a re-focussing on GP and community care premises.

‘The NHS disproportionately funds acute hospitals, despite wanting to move care closer to home

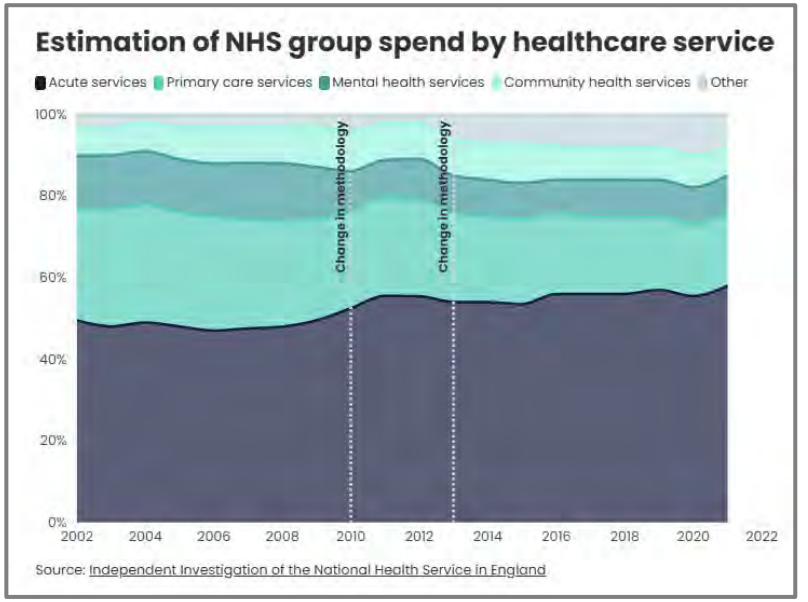
Expanding the supply of care in general practice is a crucial part of this puzzle and yet the NHS has made little progress in rebalancing funding towards non-hospital parts of the system.

In 2022/23, the NHS spent roughly one eighth as much on general practice as on acute hospital trusts (£11.5 billion on the former and £89.5bn on the latter). This is despite the majority of daily NHS activity taking place in primary care’.

It will be impossible, however, to shift care into the community without an expansion in capacity, which will in turn need a modernised and expanded estate that will facilitate the working of an expanded GP workforce and new MDTs’.

Institute for Government, Delivering a general practice estate that is fit for purpose, June 2024.

Not investing in other parts of the upstream pathway - Darzi’s ‘left shift’- will likely lead to diseconomies, worse outcomes and even patient harm.



The local health system will become substantially unbalanced if current funding allocations prevail

‘The Trust continues to be leading member of Surrey Heartlands Integrated Care System, developing a deeply integrated operational model within the Guildford & Waverley “Place”.’

‘We took over the adult community services in Guildford and Waverley in 2018, making us an integrated Trust, and giving us a step-change in our ability to wrap services around patients outside of the walls of our main hospital site.’

Both quotes from RSCH Reports.

RSCH says it is signed up to the NHS Integrated Care strategy. But has it?

The RSCH Chair sent us an email saying ‘the RSCH does not have the resource nor the mandate to get involved in primary or social care’.

The RSCH is still invested in the Procare Community Health JV? How has it been developed?

We suspect that the local health system will become substantially unbalanced if no corrective action is taken..

This will put enormous pressure on the Royal Surrey which is under a number of threats, present and future.

We see no future in horizontal expansion of current operating methods.

The ‘Right Drift’ prevails locally. Perversely, the ICB continues to allocate most of its capex to acute trusts.

This means that the ICB continues with its ‘right drift’, not a left shift: the opposite of NHS stated strategy. As Lord Darzi states:

‘At the highest level, the NHS has had the strategic intention to shift spending from reactive care in hospitals to more proactive care in the community setting – but care has in fact moved in the other direction.

Despite the government’s ambition to move ‘from hospital to community’, the direction of travel remains the same. By removing many ringfences within NHS budgets, the 2025/26 planning guidance will result in a circa four per cent real-terms reduction in spending by many sectors, including community services.

The NHS operating model remains focused on late-stage treatments rather than early intervention or preventing ill health. This approach places a greater burden on NHS resources and does not deliver the best outcomes for patients.’ **NHS Confederation, March 2025.**

This is precisely what is happening locally.

The 2025/6 NHS England Outcomes Framework, essentially its annual plan, sets out ICBs' priorities for the year

It is emphasising a transition to neighbourhood health:

> 'In their role as strategic commissioners, [ICBs] will drive more integrated care through the development of neighbourhood health services, as well as planning the arrangement of acute services to maximise productivity and value.
>
> This year's planning guidance is more focused – setting out a small set of headline ambitions and the key enablers to support organisations to deliver them, alongside local priorities.
>
> 2025/26 is a reset moment, and it starts with the planning process – with more autonomy and flexibility comes greater responsibility and accountability.
>
> Open and ongoing conversations will be needed with staff, the public and stakeholders at organisation, place and system level about what it's going to take to improve productivity, reduce waste and tackle unwarranted variation.
>
> We are asking integrated care boards (ICBs) to take a forensic look at their workforce and what they spend money on.' **NHS England, 2025.**

Neighbourhood health services

1. There is an urgent need to transform the health and care system. We need to move to a neighbourhood health service that will deliver more care at home or closer to home, improve people's access, experience and outcomes, and ensure the sustainability of health and social care delivery.
2. Addressing these issues requires an integrated response from all parts of the health and care system. Currently, too many people experience fragmentation, poor communication and siloed working, resulting in delays, duplication, waste and suboptimal care. It is also frustrating for people working in health and social care. **NHS England.**

The ‘how to’ is nearly always missing from NHS planning guidance. This NHS Confed slide shows what’s necessary

www.nhsconfed.org/long-reads/left-shift-mission-impossible

The current estate configuration cannot enable integration

‘The government wants to better integrate community, primary and social care. The current estate makes this difficult. Partly this is because practices do not have appropriate space for a reimagined workforce. But it is also because the size and placement of practices is largely inappropriate for integrated care.

There needs to be larger spaces that facilitate co-location of primary care, community care, social care and other parts of the health and care system that the government expects to collaborate in an integrated system.

At the same time, to truly understand and address the needs of communities, there should be a range of smaller sites that are closer to the people who use their services’.

Institute for Government, Delivering a general practice estate that is fit for purpose, June 2024.

This corresponds with the local ‘hub and spoke strategy.

The ICB’s preferred estates strategy: hub and spoke

The GW hub and spoke vision

‘The “hub and spoke” model for health care is where the “hub” is the anchor site for the specialty in that area and the “spokes” are the connecting secondary sites [in the community]. GP sites are the wheel around the circumference of the interlocking, integrated system.’ **Google**

The intent of the Guildford and Waverley Integrated Care Partnership (ICP) is ‘to create a system-wide ‘’hub and spoke’’ model’. **ICB.**

RSCH is the hub in the local health system.

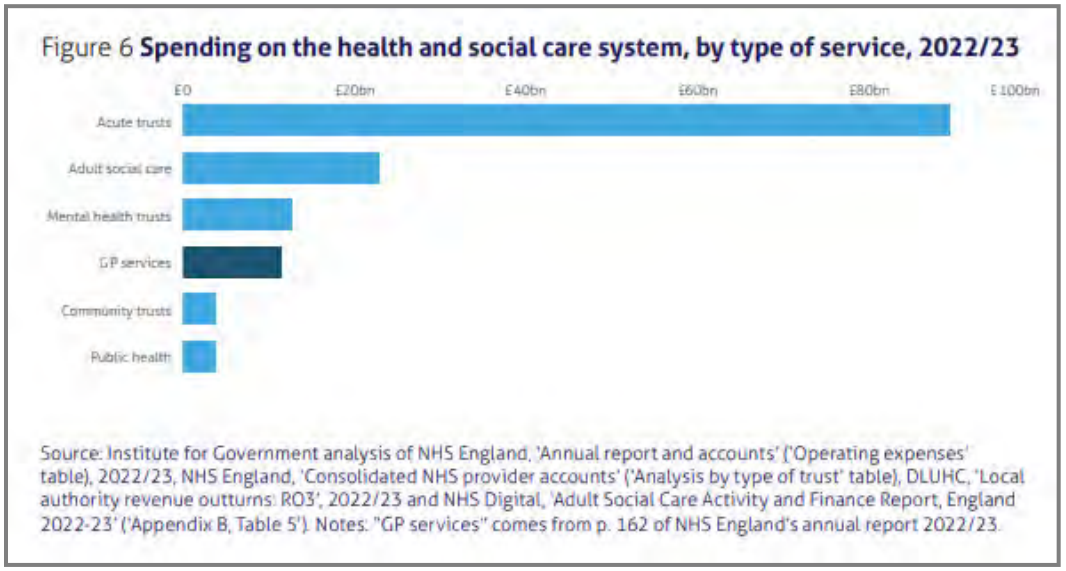
The RSCH through its 2018 ‘acquisition’ of the cottage hospitals in Haslemere, Cranleigh and Milford has laid down a lot of the model. It shares the hub and spoke vision:

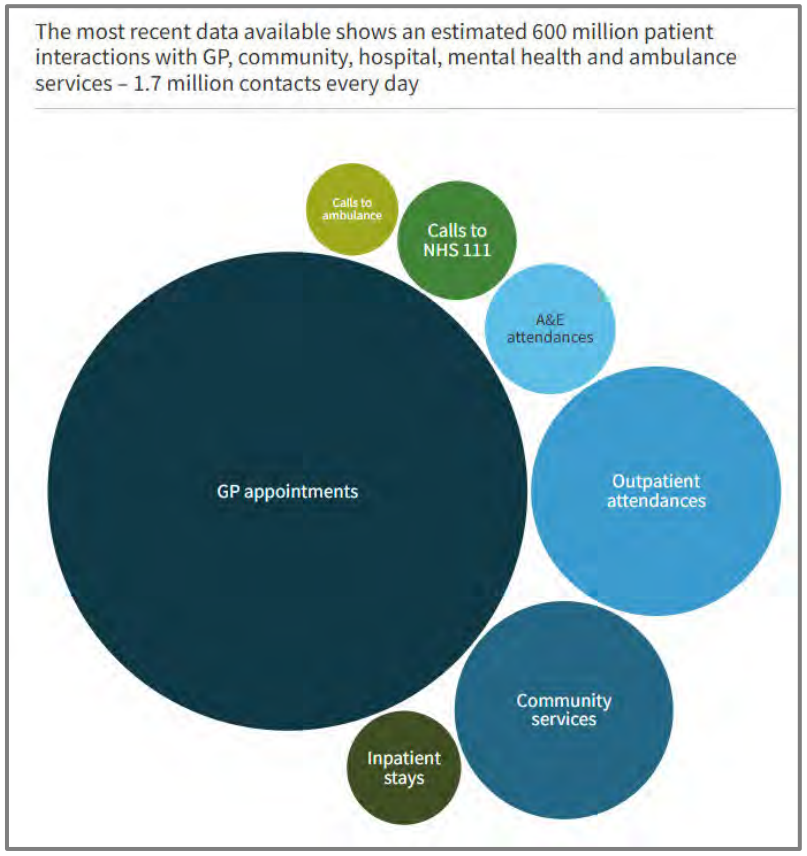
‘We are delighted that our bid to secure additional diagnostic capacity through our Community Diagnostic Centre, located at Milford Community Hospital, was approved in 2022. This £15m hub will provide MRI, CT and X-Ray services and has been designed in collaboration with our primary care colleagues with further diagnostic services being rolled out across GP practices to create a Guildford and Waverley Integrated Care Partnership (ICP)-wide ‘hub and spoke’ model.’ **Royal Surrey Annual Report 2023/24.**

The Woking Community Hospital is also part of the local delivery system.

The ‘rim’ of the wheel is GP practices.

GP contacts make up the bulk of patient interaction with the NHS, yet the cash goes to the hospitals



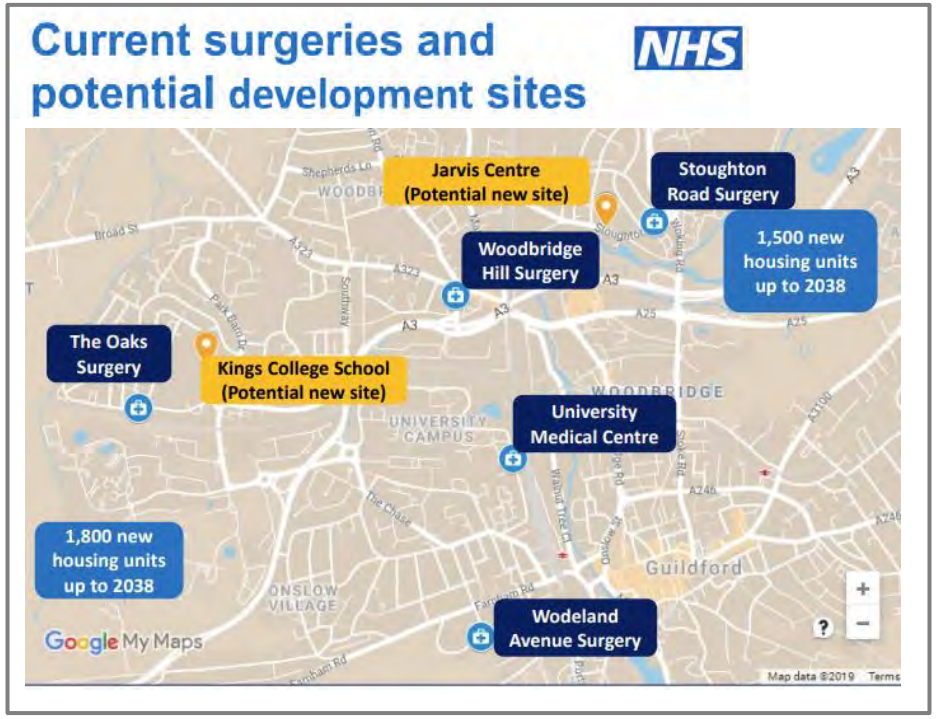


The King's Fund, June 2024.

Our view is that realising the estates strategy is a significant component of the transition to truly integrated care

What would the plan look like:

- The ICB says ‘Decompress’ the hospital site.
- Build and uprate the community hubs network to facilitate neighbourhood services and transfers of care, following government recommendations.
- Make GP practices fit for purpose.
- Create bases for additional staffing through the Additional Roles Reimbursement Scheme (AARS) and its expansion.
- Ensure a purpose-built collegiate space for Multi-disciplinary teams (MDTs).
- Build better back-offices to support an expanded range of PCN services.
- Fill out the ‘hub and spoke’ strategy as necessary.



‘Shaping the future of primary care in Guildford’, Surrey Heartlands, October 2019.

If this is a viable model, there are gaps to be filled

North Guildford is an obvious gap situation, particularly given its population's health status.

Are there any others, particularly with the forecast population growth across Guildford?

This means that a gap analysis and system audit is a priority for future planning.

GP practices are essential components of hub and spoke, yet many of their premises are inadequate.

The AARS scheme has built significant headcount in GP practices, overwhelming many of them and leading to strains on consulting room availability.

There are new, mould breaking, opportunities for PCNs to transform care delivery through strengthened back-office services.

Community care can be provided by a range of NHS, CIC, voluntary and charity organisations operating out of a range of different premises.

Often, there is a need to co-ordinate with social care and public health providers.

A new structure is necessary as care is moved out of hospitals. Their input is critical.

The project management need is therefore substantial.

It’s very difficult to get momentum for a change of strategy if there’s no rallying point for driving the transition

Hospitals have always been the central focus of health systems even if we go back hundreds of years.

These are the centres of excellence where all the challenging medicine gets done.

But, arguably, they are also the manifestation of failure in health care system. For many they are the last place to go in the practice of medicine.

Treatments elsewhere have failed; poor lifestyles have brought on debilitating conditions: while some people just don’t have the right genes.

Hospitals are the last resort, the default position, for their care.

The two most important locations in the hierarchy of medicine have been primary and secondary care. When treatment options in the former run out, the hospital takes over.

That’s fine for acute care. Where surgery takes place followed by a regime of rehabilitation and mending.

But the problem today is the consequence that as people live longer, they get more chronic conditions.

What if many of these people could get intercepted – that a change of health status is recognised much earlier, that corrective, preventive, measures are put in place?

Primary care can’t cope in its present format, there are not enough resources.

So, what if a significantly bulked-up community care system could fill the gap.

Also, hospitals are being re-thought. Technology and MDTs are important drivers. The virtual ward is a prime example

'Hub and Bespoke (from the Economist)

Hospitals are doing more beyond their physical walls. Wards are increasingly virtual. When done well, virtual wards can be safer for patients, relying on wearables to transmit data about vital signs rather than the usual manual checks.

At Addenbrooke's Hospital in Cambridge, a team of five nurses, a pharmacist and two doctors can care for 75 patients at a time out of a back office. Their virtual wards saved 7,900 bed days for the hospital last year. Yet hospitals also seem anachronistic. Dr Iain Goodhart, the scheme's clinical director, reckons at least three-quarters of inpatients could benefit from such care, by delaying admission to hospital or shortening stays.

Partnerships beyond the hospital matter more and more. Dr Goodhart is trying to strengthen links with general practitioners. Ideally, "you should only be in hospital if you need surgery, specialist or intensive care," says Dr Sarb Clare, one of the trust's senior consultants.

As hospitals begin to act differently, they will probably start to look different, too. Some may contain command centres to co-ordinate care; others will function more as campuses, including primary care and clinical-research labs. Staff will rotate more between hospital networks or spend time in satellite hubs: at odds with the new-hospital programme's aims of standardisation.

None of this means that shiny new buildings are irrelevant. Older, sicker populations mean there will be a growing demand for acute care. The evidence for virtual wards remains mixed; cost pressures mean some are likely to be closed'. **Economist, 28 March 2025.**

Community care should stop being the orphan of health systems. It should be given real status.

‘Secondly, we took over the adult community services in Guildford & Waverley in 2018, making us an integrated Trust and giving us a step-change in our ability to wrap services around patients outside of the walls of our main hospital site’. **RSCH annual report.**

Has the RSCH made the promised step change?

What precisely is its articulated plan? We can find little detail.

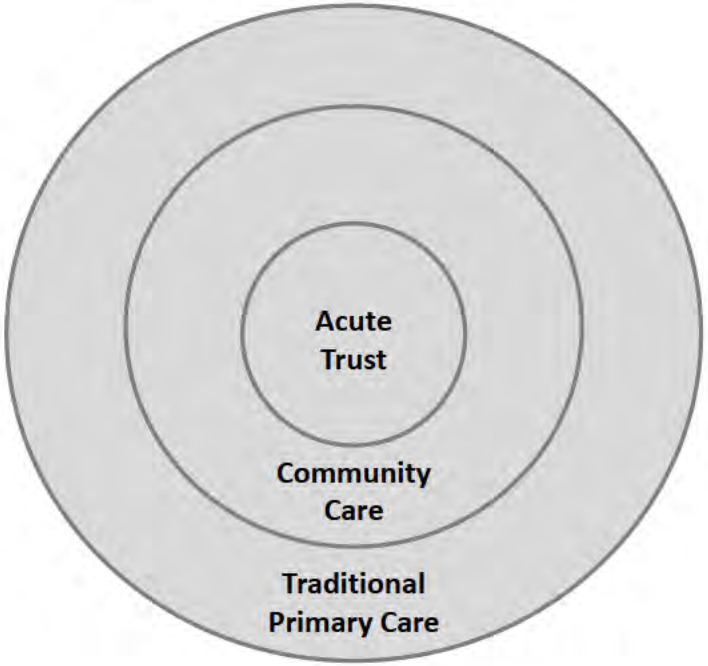
How does the ICB prioritise?

Does community care need a fundamental strategy re-positioning to signal its importance.

Does it become the hub of hub and spoke?

A change of emphasis would fundamentally reposition the importance of community care's status and role

Conventional Hub and Spoke



- Patients enter through GP practices.
- Referred to community care or DGH for diagnosis/treatment.
- Patients returned to GP or under care of community teams

Re-thinking Hub and Spoke

- Hospitals provide a higher acuity service.
- Essentially, community care becomes the hub, with MDTs treating outpatients and patients with LTCs.
- GPs continue as traditional NHS 'front door'.

GP premises

Locally, and nationally, there is general acceptance that GP premises are not fit for current purposes

'Four in 10 GPs are seeing their patients in practice premises that are 'unfit for purpose', according to the latest survey from the Royal College of GPs'.

'Practice teams working in premises they consider ''not fit for purpose'' say that poor conditions such as an insufficient number of consulting rooms (88%), or rooms of adequate size mean that patients are often kept waiting to be seen by a GP or other healthcare professional and that this is now impacting on the standard of care they can deliver. They say that limited space is also making it difficult to train new GPs (66%) and restricting the number of trainee GPs that they can take on (75%), [a particular issue for Guildowns, a training practice], further compounding current staffing shortages and leading to even longer waiting times for GP appointments and higher GP workloads.

Some GP staff reported that they were having to hold consultations in rooms less than a third of the size of the required standard set out by the Department of Health and Social Care'.

RCGP survey, May 2023

Applying the numbers (looking at averages):

Nationally, 40% of 6,280 GP practices means 2,500 are NFP

In Surrey Heartlands, 40% of 140 is 57

In the Guildford and Waverley Place, 40% of 20 is eight.

Which, locally, are they?

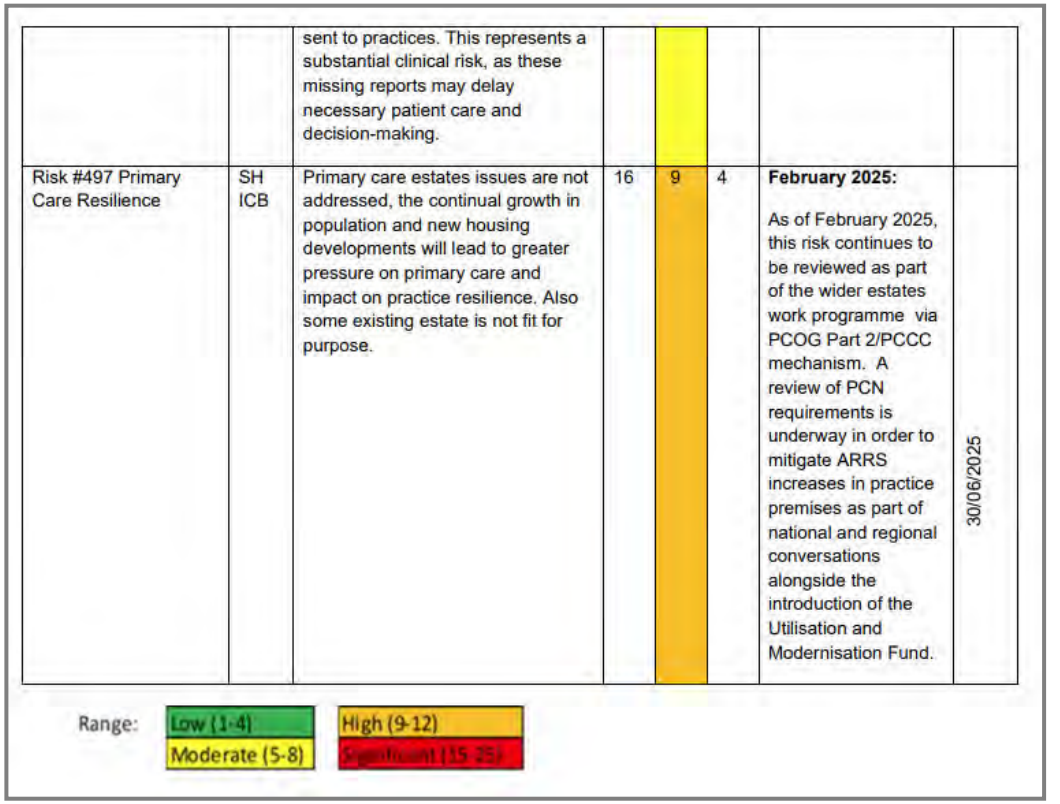
The ICB says current primary care premises are ‘High Risk’.

The ICB has indicated on its risk register that ‘Primary Care Resilience’ is high risk.

This is their assessment of their own situation over which they have control.

They say that local plans need to be developed, but there are none.

We have asked Surrey Heartlands ICB for GP premises funding details, but have been given no information about how it plans to address the issue.



		sent to practices. This represents a substantial clinical risk, as these missing reports may delay necessary patient care and decision-making.					
Risk #497 Primary Care Resilience	SH ICB	Primary care estates issues are not addressed, the continual growth in population and new housing developments will lead to greater pressure on primary care and impact on practice resilience. Also some existing estate is not fit for purpose.	16	9	4	**February 2025:** As of February 2025, this risk continues to be reviewed as part of the wider estates work programme via PCOG Part 2/PCCC mechanism. A review of PCN requirements is underway in order to mitigate ARRS increases in practice premises as part of national and regional conversations alongside the introduction of the Utilisation and Modernisation Fund.	30/06/2025

Range: Low (1-4) Moderate (5-8) High (9-12) Significant (15-25)

Primary Care Risk Register Part 1 PCOG Feb 2025 / PCCC Mar 2025.

https://www.surreyheartlands.org/download/25031204primarycarecommissioningriskregistermarch2025nhssurreyheartlandspdf.pdf?ver=4305&doc=docm93jijm4n2953.pdf

GP resilience and sustainability are questioned. Moving care to the community is 'prevented' by a lack of investment

Yasuda, Hannah	ICB Only - Primary Care Commissioning Committee	Primary care estates issues are not addressed, the continual growth in population and new housing developments will lead to greater pressure on primary care and impact on practice resilience. Also some existing estate is not fit for purpose.	Destabilisation of Primary care, reduced access to primary care, reputational risk. This could lead to a deterioration in primary care estate with fewer GPs willing to become premises owning partners and making the financial commitment. This could result in patients receiving their primary care treatment from premises which may not be fit-for-purpose. If current primary care estates capacity is not increased then this could prevent any work stream aimed at bringing services from hospital to community. The current estates may not support sustainable delivery of services to meet population needs or support the additional roles being recruited in to. This will impact on the ability to grow the workforce.	Lack of primary care estate/ estate not fit for purpose in some areas. Lack of Capital funding. Revenue implications.

Primary Care Risk Register Part 1 PCOG Feb 2025 / PCCC Mar 2025.

https://www.surreyheartlands.org/download/25031204primarycarecommissioningriskregistermarch2025nhssurreyheartlandspdf.pdf?ver=4305&doc=docm93jijm4n2953.pdf

As PCNs take on more staff under AARS, the restricted space will result in reduced patient access and a loss of productivity

1. Developing the Surrey Heartlands estates strategy and prioritising premises needs, developing local practice plans 2.Undertaking review process of existing estate and addressing priority needs identified when they arise via PCOG Part 2 3. Working with local authority planning departments to understand rising risks 4. Utilising Premises improvement grant support for those practices identified as a priority and within the scope of the available funding 5. Bids for resilience from national funding pot to support primary care 6. Working with NHSPS and other stakeholders to resolve estates issues and identify solutions 7. Completing the PCN Estates Toolkit alongside NAPC and local Place teams	1. As PCNs take on additional staff under the ARRS scheme the estate issues continue to grow, and clear guidance is awaited nationally	1. Regular reporting to PCOG and PCCC via Strategic Estates Lead 2. System wide reporting 3. Place based governance and reporting for key projects, such as the Cavell Health Centre development and North Guildford estates programme	1. Funding resource available for major primary care estates improvement (both capital and revenue).

Primary Care Risk Register Part 1 PCOG Feb 2025 / PCCC Mar 2025.

https://www.surreyheartlands.org/download/25031204primarycarecommissioningriskregistermarch2025nhssurreyheartlandspdf.pdf?ver=4305&doc=docm93jijm4n2953.pdf

While the ICB has recognised the GP premises problem, it has provided no solutions. Why?

‘GP practices in different parts of the country now host a wide range of additional health and care professionals, such as physiotherapists, paramedics, pharmacists, and social prescribers, who work alongside GPs and nurses to provide more comprehensive, all-round care and support.

Evidence shows this is better for patients living longer with multiple health conditions. Guildowns and Woodbridge Hill are unable to include these additional roles, that would enhance care, due to limitations in their buildings.

The current space occupied by the two GP practices offers limited opportunity to work in new neighbourhood teams. The services for Guildowns Group Practice are spaced across north and west Guildford, making it challenging for clinical teams to deliver high quality care.

There is not enough space to provide additional services, develop their workforce or adopt new ways of working.

Both GP practices experience problems in attracting and keeping qualified and support staff. The dispersed nature of one practice across four sites and the lack of facilities for training in both practices are known factors that affect the morale of existing staff and the ability of them to attract and keep sought-after highly qualified professionals.’

Shaping the future of primary care in Guildford, Surrey Heartlands ICS.

Despite ICB promises of support, nothing has happened

The GP premises issue is still acknowledged on the Surrey Heartlands website:

'We have worked previously with two GP practices in north and west Guildford to look at how GP services can be provided in the future**.**

Guildowns Group Practice a large training practice that provides GP services from four different sites:

Stoughton Road Surgery, Stoughton Road, GU1 1LL

The Oaks Surgery, Applegarth Avenue, GU2 8LZ

University Medical Centre, University of Surrey, GU2 7XH

Wodeland Avenue Surgery, Wodeland Avenue, GU2 4YP

Woodbridge Hill Surgery operates out of a single surgery located on Deerbarn Road in Guildford.

Both GP practices are independent businesses that have a contract with NHS Surrey Heartlands for the provision of GP services to their registered lists of patients.

We know these Practices face a number of challenges and this programme of work has helped to focus on what factors impact them and their patients. The ICB continues to support these two Practices in how they remain sustainable and continue to offer safe and equitable services to patients.

Changes in NHS England policy no longer constrains the ICBs' inability to provide funding support. So far, the practice has received no new proposals from the ICB. Nothing is included in the 2025/26 ICB capex budget.

The ICB has not funded GP premises redevelopment. For 2023-24, the RSCH received most capex

This is the only reference to capex allocations we can find on the Surrey Heartlands website.

None is for GP premises redevelopment.

RSCH is likely to have received more than £50m over the past two years, plus upgrades at Milford, see over.

'Surrey Heartlands ICB - Joint Capital Resource Plan 2023 to 2024

'The total current planned capital expenditure for Surrey Heartlands Health and Care Partnership ('SHICS') in 2023/24 is £122.2m. This is split by funding type between operating capital of £81.5m (including a £1.7m ICB allocation for GP IT) plus confirmed PDC of £40.7m.

SHICS capital spend by programme 2023/24

Surgery build (RSH) £16.0m (13%)

CDC Diagnostics £12.2m (10%)

Elective Centre (ASPH) £9.5m (8%)

ACU Unit £22.0m (18%)

Medical Equipment £10.4m (8%)

IT £11.6m (10%)

Estates incl GPIT £40.5m (33%)

'Each of the above programmes has an approved business case and an identified source of funding. In aggregate the above infrastructure builds represent £55.6m (45%) of the total planned capital spend in 2023/24'.

The ICB board has provided us with more information. £200k has been allocated for GP practice redevelopment for 2025/6

Our question to the March 2025 ICB Board meeting was:

'Would you please advise the capital expenditure allocated by the ICB for primary care premises for the years 2023/4 and 2024/5 and the budget for 2025/6 in association with the implementation of The National Health Service (General Medical Services Premises Costs) Directions 2024 '.

ICB responses:

'Funding for general practice capital expenditure is provided via annual commissioner capital allocations from NHSE of c£1.7m per year. This capital is required to fund both primary care estates and the refresh of IT equipment within general practice, along with the refresh of corporate ICB IT. The ICB is not delegated to approve capital expenditure as this is a reserved matter for NHSE, so we determine the allocation of funds within the budgets and cover any reimbursable revenue consequences, but ultimately capital schemes are approved by NHSE.

For 2023/24 capital expenditure on general practice estate schemes was £0.5m. This funded a number of schemes including increased clinical space through extensions of existing premises and repurposing of admin space along with infection control improvements.

For 2024/25 capital expenditure on general practice estates schemes was £0.2m, which funded two schemes to provide additional clinical space.

For 2025/26 the total commissioner capital allocation is £2m of which £0.6m has been indicatively earmarked for estates schemes, but the final split between estates & IT spend is currently being finalised prior to the ICBs plan submission on 27th March. The ICB will also have access to a further £1.7m of capital funding for primary care estate through NHSE's Utilisation and Modernisation Fund. This is specifically for enhancing existing space and for schemes that can be completed by March 2026. Initial proposals for utilising this fund have been submitted to NHSE and the ICB is now working through the feasibility of delivering these schemes within the timescales available'.

The Utilisation and Modernisation Fund would on the proposed allocation give Guildford GPs about £250k in total

‘As part of their planning for 2025/26, systems are encouraged to continue developing their plans to adapting their estate to deliver the left shift [from hospital to community]. Systems can use allocations from the new Primary Care Utilisation & Modernisation fund, from BAU primary care capital and from wider system budgets to implement early next steps.

The Primary Care Utilisation & Modernisation Fund was announced during the 2024 Spending Review and provides new capital funding of £102 million to support improvements in the primary care estate. The fund aims to enhance the use of existing infrastructure, create additional capacity for the GP workforce, and increase the number of patient appointments available.

Funding is being indicatively allocated to integrated care boards (ICBs) on a weighted population basis as part of the national allocations planning process, with subsequent adjustments to ensure full fund utilisation based on scheme deliverability. Given the relatively limited availability of capital available in 2025/26, eligible projects include minor estates schemes focused on refurbishing or reconfiguring existing spaces to improve clinical capacity and productivity. The fund excludes technology solutions or the construction of new assets, emphasising the repurposing of underused spaces and adherence to NHS (GMS – Premises Costs) Directions 2024 and statutory standards’. **NHSE Capital guidance 2025/26.**

Surrey Heartlands has chosen to invest in RSCH operated community hubs, but not GP premises

Improving community care facilities could be seen as a reasonable off-set strategy to GP premises investment.

But where GP premises are poor and there is no community heath hub coverage, patients are likely to be more exposed.

Patients in deprived areas are particularly vulnerable as research findings show. No data is available for local practices, so what follows is a generalisation.

'There are significantly fewer GPs per head in the most deprived areas compared to the least deprived. People in the most deprived fifth saw the GP they wanted to see 52% of the time, compared to 59% in the last deprived fifth.

Fewer than 70% of people in the poorest areas said they had a 'very' or 'fairly' good experience of making a GP appointment, compared to over 75% of people in the richest areas.

One in seven people in the poorest areas were unable to get a GP appointment, compared to one in ten in the richest areas.

On key measures of hospital care there is no statistically significant link between deprivation and how long people wait for treatment, either on the four-hour A&E target or the 18 week referral to treatment target.

Emergency admissions were nearly 30% higher in the most deprived fifth of CCGs, compared to the least deprived fifth. **Nuffield Trust**

Funding has also gone to FT hospitals' CDCs

'The four significant capital infrastructure projects in the 2023/24 plan are as follows:

1. Abraham Cowley Unit (ACU) is a 64-bed mental health hospital new build in North West Surrey.
2. Surgical Centre is an expansion of existing theatre capacity at Royal Surrey Hospital ('RSH') designed to increase throughput and meet future elective surgical demand, particular relating to cancer. The expansion of theatre capacity at RSH is separately funded through a bespoke adjustment to the operating capital envelope (total bespoke adjustment is £25m over two years). The surgery build is due to complete early in 2024/25 with £16.0m planned expenditure in 2023/24.
3. The Elective Centre is an expansion of existing theatre capacity at Ashford and St Peters Hospital ('ASPH')) and is due to complete in 2023/24 with the total cost of £9.5m being incurred in 2023/24.
4. Community Diagnostic Centres ('CDCs'- various sites). The system has been awarded £27.0m to fund three multi-year builds for community diagnostics hubs at Woking (North West Surrey), Milford (Guildford and Waverley) and Caterham Dene (East Surrey). Work on the hubs at Milford and Woking started in 2022/23 with Caterham Dean due to start in 2023/24. The hubs are funded through PDC as part of a national programme to move diagnostic capacity away from acute hospital sites into community hubs. The total expenditure on the three CDCs in 2023/24 is currently planned to be £8.1m across the three sites.

'Each of the above programmes has an approved business case and an identified source of funding. In aggregate the above infrastructure builds represent £55.6m (45%) of the total planned capital spend in 2023/24'.

We are asking the ICB for full details for 2024/5 and 2025/6 budget capex allocations. GP funding information is included on the next slide.

Then why was Milford Community hospital the ICB's local choice for a Community Diagnostic Centre?

It doesn't seem to fit the criteria:

'Community diagnostic centres

In October 2021, the DHSC announced that 40 community diagnostic centres would open across England in settings ranging from local shopping centres to football stadiums. Describing these centres as "new one-stop-shops for checks, scans and tests", DHSC said that the centres would help to achieve:

Earlier diagnoses for patients through easier, faster, and more direct access to the full range of diagnostic tests needed to understand patients' symptoms including breathlessness, cancer and ophthalmology

a reduction in waiting times by diverting patients away from hospitals, allowing them to treat urgent patients, whilst the community diagnostic centres "focus on tackling the backlog"

a contribution to the NHS's net zero ambitions by providing multiple tests at one visit, which would reduce the number of patient journeys and help cut carbon emissions and air pollution

DHSC stated that centres would be supported by a £350 million investment from the government and would be fully operational by March 2022. In April 2022, the government reported that 73 centres had already opened and had delivered over 700,000 additional CT, MRI, ultrasound, endoscopy, and ultrasound tests. The government also stated that health and social care funding would help to deliver up to 160 centres by 2025'.

NHS England.

Milford Hospital is a former rehabilitation centre built at the beginning of the twentieth century

‘Milford Community Hospital is a community Frailty Unit with a multi-disciplinary team providing care to older patients.

There are currently 30 beds across two wards. The wards are called Holly and Oak and are situated in Tuesley Unit.

The ward has a team of doctors, nurses, occupational therapists, physiotherapists and healthcare assistants. We have good access to specialist support teams like Dieticians and Podiatry.

The hospital is set in lovely grounds and has a secluded garden much enjoyed by patients and their visitors and also has a diagnostic assessment and treatment centre. We also run specialist clinics to treat multiple sclerosis, podiatry and Parkinson’s.

Our local community hospital in Milford is part of our adult community health service.

The hospital is also home to Royal Surrey's Community Diagnostic Centre, providing MRI and CT scanning. This complements the diagnostic treatments available at Milford including X-ray, ultrasound, echocardiogram and phlebotomy.

A number of specialist clinics are also run from here, including those for multiple sclerosis, podiatry and Parkinson’s.’

RSCH website.

Tuesley, the site, is a hamlet two miles from Milford, with no footfall and poor transport links

Milford Hospital CDC is nearing completion

Published: 9-Dec-2024

Featured companies: MTX Contracts | P+HS Architects | DSSR Consulting Engineers

Design & Build | NHS

MTX and partners have completed the building phase of the new Community Diagnostic Centre at Milford Hospital, part of a broader government initiative to expand local healthcare services

There are 4 ways to get from Guildford to Milford Hospital by train, bus, taxi, or car

Select an option below to see step-by-step directions and to compare ticket prices and travel times in Rome2Rio's travel planner.

Train	BEST	
32 min		£3–8 >
Line 70 bus	CHEAPEST	
38 min		£1–3 >
Taxi		
13 min		£22–27 >
Drive 9.4 mi		
13 min		£3–4 >

Guildford to Milford Hospital by bus and foot

154	38 min	£1
Weekly Services	Average Duration	Cheapest Price

The RSCH continues to do well. These are the 2025-6 allocations. They incorporate incentives which it likes

NHS
Royal Surrey
NHS Foundation Trust

Capital

1.11 YTD Capital spend is £20.7m, against YTD Plan of £31.8m.

1.12 The significant underspend is due to the actual project spend phasing which differs from the plan spend pattern. The Capital programme is forecast to overspend by £0.47m by the end of the year.

1.13 The largest elements of the £30.1m Capital plan are the £10m Surgical Strategy (CASIC) and the £4.01m Diagnostic Strategy (CDC). There has now been £8.2m accounted spend against CASIC in year against an internal plan of £8.3m and a submitted plan of £9.1m. £3.7m has been spent on CDC against an internal plan of £4.3m and a submitted plan of £4.1m.

Risk and opportunity

1.14 The forecast has been adjusted by £1.1m on confirmation of additional funding of £1.0m from the ICB and other minor adjustments. The forecast is now a £2.9m deficit.

1.15 The CNST provision, to cover the funding gap of £2.3m, will crystallise in full in M12.

1.16 However, negotiations with Commissioners (ICB, non-ICB and Spec Comm) continue and there is an opportunity that the position will improve further when final in year negotiations are completed.

2 CONCLUSION

2.1 The Trust is reporting a surplus of (£2.27m) on a Control Total basis, (£2.38m) worse than revised plan.

2.2 The Board is asked to note the analysis of the financial position as summarised above and in the attached detailed pack.

RSCH Board Report, March 2025.

NHS
Royal Surrey
NHS Foundation Trust

Annual Plan 25/26

Annual Plan submission

1. INTRODUCTION

Following discussions with the ICB it has been agreed, subject to Board approval, to submit a breakeven Plan. The ICB have agreed that if the Trust includes a £5.0m stretch CIP it will provide £5.0m of deficit support funding and £0.8m of additional drugs funding to close the gap.

5 CAPITAL

5.1 Operational capital

The operational capital allocation for 25/26 is £16.735m (24/25 £13.595m). There is also an "Estates Safety Fund" of £9.799m and a "Constitutional Standards Fund" of £19.000m available through the ICB.

5.2 Other capital sources

There are no PDC funded schemes.

It should be noted there is no specific capital allocation for CASIC and negotiations remain ongoing with NHSE.

The Trust has been successful in a bid for Radiotherapy Funding, and will receive £2.4m in 25/26 for a new Linac.

A schedule of the ICB capital allocations is include in Appendix 3

6 CONCLUSION

6.1 Recommendation

The Board is asked to approve a final submission of a breakeven Plan inclusive of £25.0m of CIP, £5.0m of which is a stretch target.

Uprating the primary care real estate is now part of an NHS England policy change

There is, finally, an acceptance that depending on GPs to redevelop their premises is not workable.

The policy change occurred in July 2024 with a restatement in October and November.

Primary care capital grants policy

Date published: 24 July, 2024
Date last updated: 25 October, 2024

1. Background

NHS England standing financial instructions (SFIs) allow for capital grants to be made using specific powers under the NHS Act 2006 for Investment into GP Premises in accordance with any relevant legislation.

This grant policy sets out the framework and guidance for application when making any said capital grant noting the requisite legislative powers and conditions that are required to be applied.

3. Premises improvement grant

Powers – NHS (GMS – premises costs) directions 2024

When a contractor identifies the need for improvements such as alterations or an extension to existing premises, this will be governed by the NHS (GMS – premises costs) directions 2024 (PCDs). The PCDs set out the terms and conditions of an improvement grant.

An integrated care board (ICB) can make non-recurrent grants for premises improvements in line with the requirements set out in the PCDs; specifically, part 2, directions 7-13.

Guide to the changes to primary care premises policy

Date last updated: 11 November, 2024

Associated with the implementation of The National Health Service (General Medical Services Premises Costs) Directions 2024 ['the Directions']

Key changes

6. The Directions allow commissioners to make larger investments in GP practices in a more flexible way and seek to provide contractors with some reassurance about their premises liabilities. They also deliver some significantly improved terms for contractors, as well as technical updates.

Improvement grants

7. A long-standing restriction on commissioner contribution to premises improvements has been removed. Commissioners can now award GP grants funding up to 100% of project value, where appropriate and subject to business case assessment and local prioritisation. Grant values have been increased, and abatement and guaranteed periods of use have been reduced.

ICBs, since last year, are able to fund GP premises development

‘Commissioners get long-awaited powers to fully fund GP premises upgrades

The Government has made long-awaited changes to GP premises cost directions, which will allow commissioners to fund 100% of upgrades.

After ‘almost a decade of pressure’ from the BMA, the Department of Health and Social Care published the new PCDs yesterday – cementing changes that were first agreed years ago as part of the five-year GP contract.

The doctors’ union said these were ‘positive steps’ for GP premises owners but warned that there is ‘a very long way to go’ since there is no extra investment for ICBs.

The PCDs regulate how GP premises are funded, and updated regulations now allow for commissioners to give out improvement grants of up to 100% of the project value, where before the limit was 66%.

Commissioners, including ICBs, will now also have ‘new powers’ to better support GP contractors with their premises costs, according to the BMA’.

Pulse, 10 May 2024.

As is always the case for the NHS, different commissioners have different priorities

Other ICBs rate the issue of GP practice capability much higher and have been addressing the issue for years.

This is how one ICB is implementing the policy.

iv. Improvement Grants

The ICB recognises the importance of utilising the Improvement Grant (IG) Scheme as defined in 2024 Premises Costs Directions (PCDs) to assist practices expand and/or upgrade their existing premises.

Using IGs to make improvements to primary care premises deliver a direct benefit to patients, e.g. increased clinical capacity, improved access to services and compliance with national standards such as CQC, DDA, confidentiality, etc..

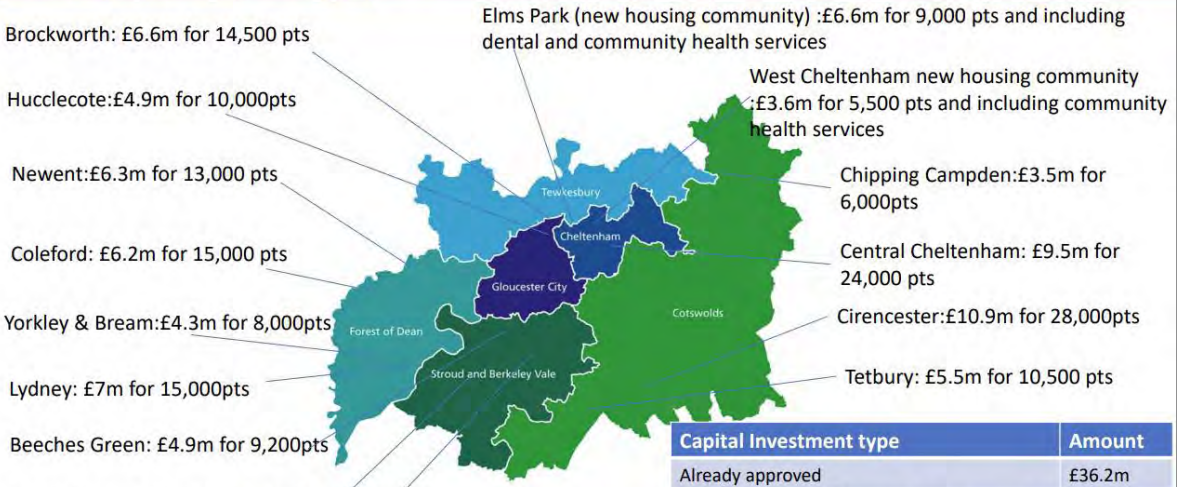
All practices in Gloucestershire are eligible to bid for an IG in line with national guidance and governance arrangements, regardless of whether the premises are owned by the practice or leased:

- The PCDs provide a prescriptive list of the types of projects that can and cannot be funded.
- The maximum award that can be granted is up to 100%.
- The IG scheme works on a reimbursement basis, meaning practices must pay invoices first; there is no scope for the CCG to reimburse contractors directly.
- If a practice is awarded an IG, the building works need to be completed and all funds spent in the same financial year that the grant is awarded (although exceptions have been made for larger projects).
- The ICB has little flexibility in the application of the rules.

One Gloucestershire

GP Premises Development & Delivery Plan April 2024 to March 2031
Final version
July 5th 2024

4(vii) – Delivering the plan: confirmed schemes and future ambitions by place including estimated capital costs and number of patients (pts)



Capital Investment type	Amount
Already approved	£36.2m
Minimum Section 106 contributions needed	£13.6m
New investment	£42.5m
Total	**£92.3m**

Playing catch-up takes years as these extended timescales show.

We can't see the same estates plan for Surrey Heartlands GP premises. But plenty of expressions of intent

Joint Forward Plan 2024 Fact File: Estates

Ambition 3: What we need to deliver these ambitions

Estates can be a catalyst for integration, particularly when approaching the delivery of neighbourhood teams and same-day urgent care. As a system, we can develop spaces and establish the conditions for communities to improve their wellbeing, on their own terms, in non-clinical ways.

Case Study

A new community diagnostic centre at Woking Community Hospital will prevent the need for 30,000 hospital visits outside of Woking annually, providing residents with a vibrant, modern health facility.

This project is part of a wider community diagnostic hub programme across Surrey Heartlands, helping to reduce waiting times and expedite treatment for local people.

Improving access to GP services

Ensuring people have access to high quality care and support from their GP practice is a key priority for us – and practice teams continue to work incredibly hard as they continue to see more patients than ever before.

SURREY HEARTLANDS Health and Care Partnership

SURREY

NHS

Joining up care across Surrey Heartlands

A summary of our strategy

2 Delivering care differently

Local people have told us they want services that are responsive to their needs and put them at the centre of decision-making. Based on feedback, we have developed two main aims to transform how we deliver care:

- Making it easier for people to access the care they need, when they need it.
- Creating the space and time for our workforce to provide the continuity of care that is so important to our populations.

We will do this through the development of our provider collaborative, the creation of neighbourhood teams, enhanced primary care, social care delivery, mental health support and working with children and families.

Provider collaboratives

Local providers of health services working collaboratively to consider the best way to deliver some services across a wider geography.

Neighbourhood teams

Teams of different professionals working together to care for people with more complex needs across very local geographies.

Which are the local GP premises in most need of attention? The Surrey Heartlands ICB has a checklist on its website

Assessing the nature and capacity of existing GP services in the local area.

Explore and understand why additional capacity may be required

- Is there a new housing development leading to an increase in the local population that would need a GP?

Review and forecast the additional capacity required

- What might a potential list size (the number of patients registered at a GP practice) of any new practice be?
- Can surrounding practices provide the GP services required in an effective, safe and viable way?

Work with local people and communities to understand any unmet needs

- Are additional GP services required?

Review local access and transport provision.

Assess the local and wider, competitive market and consider the risks and unintended consequences of new contract arrangements

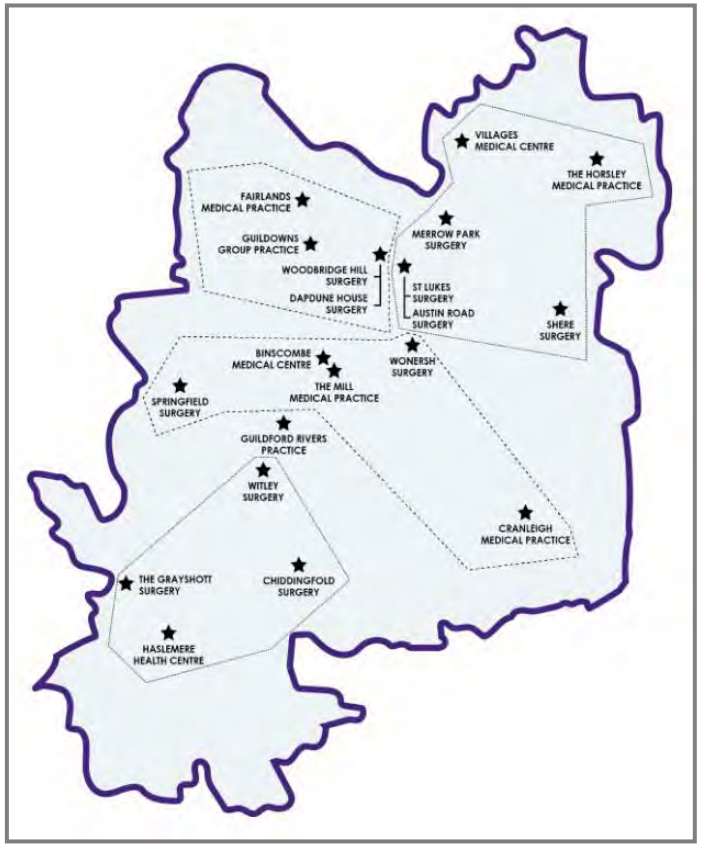
- Is there enough provider appetite (interested parties) to provide additional services?
- Can any new service be provided within financial sustainability limits?
- Will any other local services experience any destabilisation?

Assess the availability of estates (buildings) from which services could operate.

- Are the available buildings appropriate?
- Are there any accessibility issues?
- Can the service afford the costs?

Engage patients and stakeholders at different stages of these actions, including consideration of proposals and next steps.

Consider our responsibilities under the Public Contract Regulations and Procurement, patient choice and competition regulations 2013 and any other legislation and or guidance that may apply.



GP premises need to adapt to changing circumstances – technology, AARS delivered care and government policies

A significant re-development of traditional GP premises might not be the best plan for all of them.

Each has to meet the needs of its practice population, all of which are different.

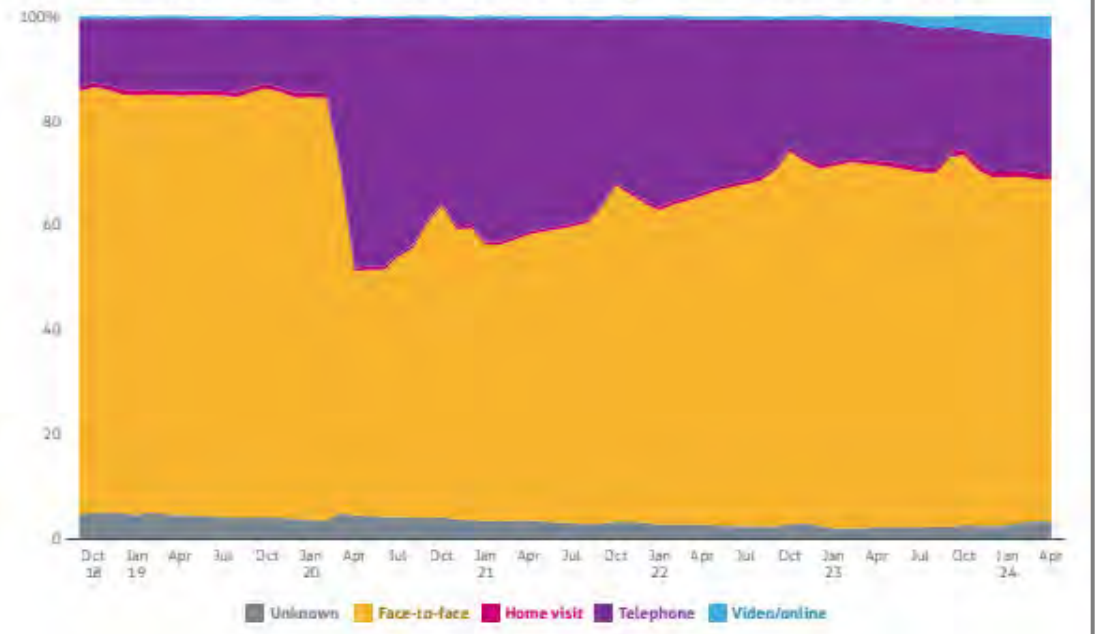
Most visits are made by the elderly. They are accustomed to the status quo.

Frequency is a factor. Four out of ten of consultations at GP practices are reckoned to be frequent attenders, many of which are candidates for MDT care.

There are likely to be patients with mental health and social issues who have special attendance needs.

Most importantly, the mode of contact with the practice's staff has changed substantially since the Covid outbreak.

Figure 1 **GP appointments by mode of delivery, September 2018 to April 2024**



Increasingly, GPs are being seen as the 'wing men' to protect overloaded hospitals. But aren't they as well?

Hospitals to remove 300,000 patients from NHS waiting lists

The shake-up targets pointless appointments and patients who could be treated elsewhere

The Times Apr 9, 2025

A clean up of the NHS waiting list starts this week in efforts to scrap unnecessary appointments

The NHS will remove 300,000 people from hospital waiting lists as part of a "clean up" to scrap pointless appointments.

Hospitals will be paid to review their waiting lists "right away" and take off anyone who could be treated elsewhere or does not strictly need an appointment with a specialist doctor.

Patients with common conditions such as bad backs or cataracts will be contacted and directed for treatment at community services including GPs, physios and opticians, instead of having to wait for a hospital check-up.

The scheme to "validate" the clinical need of millions on waiting lists has been ordered by Sir Jim Mackey, who took over as NHS chief executive this month, as part of a shake-up of the health service led by Wes Streeting, the health secretary.

It is expected to make a significant dent in the NHS waiting list of 7.43 million, and free up consultants to see those most in need while sparing patients pointless trips to hospital.

Internal NHS England analysis has revealed that waiting lists are clogged up with patients who do not need to be there. About 300,000 people have either already been seen privately, had help in A&E, no longer have symptoms, or could be treated in the community.

The NHS has announced funding to prevent 1.2 million unnecessary referrals to the waiting list each year, by nearly doubling the capacity of an "advice and guidance" scheme that enables GPs to discuss cases with hospital specialists without making a formal referral.

It aims to cut out the "middleman" of initial consultations in hospitals, as GPs will be able to get advice about what treatment option is best. Patients with a bad knee, for example, would be booked in directly for a scan or physio instead of needing an appointment with an orthopaedic surgeon first to discuss options.

Professor Sir Stephen Powis, NHS national medical director, said: "We know waiting lists are far too long and as well as bringing down waiting times for patients, it is vital that we also make best use of taxpayer money by working more productively and to avoid unnecessary waste.

"That is why the NHS is set to increase the support available for GPs to help them make the best clinical decision for patients when referring them for specialist care, as well as clinically reviewing waiting lists to identify patients who do not need elective treatment.

"This will not only free up clinical time in hospitals for those who need it most, it will also ensure thousands of patients get the appropriate care they need faster — and avoid joining the waiting list unnecessarily."

Streeting has ordered the NHS to prioritise getting rid of bureaucracy and increasing productivity in order to meet Labour's key election pledge of ensuring all patients are seen within 18 weeks.

NHS England seems committed to shifting the load

Plan for GPs to keep millions out of hospital

Times,17 April 2025

A scheme to help GPs provide care and advice to patients without them joining long NHS hospital waiting lists is being expanded in England, the government has said.

GPs will work more closely with specialists to access expert advice quickly for patients with conditions such as irritable bowel syndrome, menopause symptoms and ear infections.

Backed by £80m of funding, its ambition is to help two million people receive faster and more convenient care in their local community by the end of 2025/26.

Health Minister Karin Smyth said the scheme would "save time and stop masses of people having to head to hospital for unnecessary appointments".

The expanded scheme is part of the government's plan to cut long NHS waiting lists and create extra appointments for patients.

It has pledged that 92% of NHS patients will be waiting less than 18 weeks for treatment after referral to a consultant, by the end of this parliament.

Between July and December 2024, the scheme diverted 660,000 treatments from hospitals and into the community, the government says.

Called 'Advice and Guidance', the scheme links GPs and hospital specialists before patients are referred onto waiting lists, so that tests and treatments can be offered in the most convenient place.

For example, patients with tinnitus and needing ear wax removal often end up being referred to specialists when they could be helped outside hospitals. And women needing advice on types of HRT could be treated in local hubs, rather than waiting to see a gynaecologist.

GP practices are able to claim for each time they use the scheme to shift care from hospital to the community.

A cascade of game changing capability is being constrained by the inadequacy of local GP premises

Primary care will be transformed only if the resources, principally real estate, are fit-for purpose.

A bigger GP practice headcount requires a lot more space.

Technology has changed, and will change premises design further.

The opportunities include:

- Leveraging the additional staffing provided through AARS.
- Better multi-disciplinary team coordination in a collegiate working space.
- Closer case management coordination with community and social services.
- Managing ‘Virtual Ward’ patients OOH, taking over more outpatients.
- Applying IT, digital, data/analytics at a greater scale.
- Referral Management, delivering Patient Choice options.
- A Single-Point-of-Access (SPA) for the whole borough?
- Effective triaging, sharing patient records.
- Additional ICB contracts delivered by GPs and third parties.

Integrating community care: build on the AARS platform?

Building on PCN footprints is the NHS strategy for delivering community care

The NHS Long Term Plan initially set out a requirement for community services to be configured around PCN footprints, with expanded community multi-disciplinary teams providing proactive and anticipatory care to people with more complex needs.

This was further developed in the Fuller report, which set out a vision for integrated multi-professional neighbourhood teams to support people who need proactive care in the community.

The teams bring together staff from across PCN areas, including general practice teams, physical and mental health community teams, secondary care teams, social care teams and care staff. **King's Fund, July 2024.**

AARS was introduced as a novel way of expanding primary care access.

The Additional Roles Reimbursement Scheme (ARRS) was introduced in response to government manifesto commitments to improve access and workforce pressures in primary care. The benefits of the ARRS are evidence that the new roles have a place in the future of primary care.

In 2019 the scheme was launched with the commitment to introduce 26,000 extra staff into primary care practice by 2023/24. Initially, primary care networks (PCNs) could choose from five roles. Over time the list has grown to 17, many of which had not previously been available within primary care. PCNs can recoup the employment costs of these roles from the scheme up to their allocated funding allowance, based on the size of the patient population. The additional staff were intended to see patients who would otherwise have seen a GP but did not require a GP intervention. As a result, GPs would have increased capacity to provide appointments to those patients who required a GP or would benefit from greater continuity of care.

ARRS staff have, enabled the development of new ways of working, such as multidisciplinary working and integrated neighbourhood teams in primary care. Flexibility for local leaders to select the roles they need will be key to the future of the ARRS and the continued development of new services which are tailored to local needs.

NHS Confederation, Assessing the impact and success of the Additional Roles Reimbursement Scheme, Feb 2024.

The existing ARRS workforce has been assured as part of the PCN Direct Enhanced Service which has been renewed indefinitely from 2025.

To compensate for falling GP numbers, the NHS has been adding headcount for specific primary care roles

'The Goals of ARRS

The primary goal of the ARRS is to alleviate the increasing pressures on general practices and improve access to healthcare services for patients. By expanding the clinical and non clinical teams through the reimbursement of additional roles, the scheme seeks to:

Enhance the capacity of primary care services to meet the growing demand for healthcare.

Deliver a broader range of services to patients, thereby improving patient outcomes and satisfaction.

Support the integration of services within PCNs, facilitating a more collaborative and efficient approach to patient care.

Drive forward the shift towards a more preventative approach to healthcare, reducing the reliance on hospital services and promoting community-based care.

The Roles Covered by ARRS

The ARRS roles in primary care are diverse, each contributing uniquely to patient care and the broadening of services offered by PCNs. From clinical pharmacists to first-contact practitioners, these roles are reimbursed through ARRS funding, enabling PCNs to more effectively meet the complex health needs of their communities.

The ARRS roles list is regularly updated, with ARRS roles 2024 introducing new opportunities for PCN ARRS expansion'.

NHS England,2023.

The AARS workforce is diverse delivering a range of primary and community care services

There were 36,862 staff working through ARRS as of 30 September 2024, compared to 37,294 at the end of March.

Primary care workforce, ARRS roles September 2024

NHS England, September 2024.

What's missing from the local line-up? How would AARS services build?

'The intention of the scheme is to grow additional capacity through new roles, and by doing so, help to solve the workforce shortage in general practice. It is not to fill existing vacancies or subsidise the costs of employing people who are already working in primary care, whether funded by a practice, a Clinical Commissioning Group (CCG) or a local NHS provider. Reimbursement through the new Additional Roles Reimbursement Scheme will only be for demonstrably additional people (or, in future years, replacement of those additional people as a result of staff turnover). This additionality rule is also essential for demonstrating value for money'.

Network Contract Directed Enhanced Service Additional Roles Reimbursement Scheme Guidance, NHS England 2019

For 2025/6, there will be an 'Enhancement of ARRS, with GPs and practice nurses added in to the main scheme, minimum GP salary + on-cost reimbursement increased in line with the BMA salaried GP pay range and with no caps on numbers'. **BMA**

Does this mean that there literally is no restriction on the numbers of GPs who could be hired?

What could a 'fully loaded' PCN look like?

What would be the scope and capacity to deliver existing and new individual care services?

What services could then be transferred from hospitals?

How would these services be co-ordinated with traditional local community care services?

It would be interesting to do an inventory check on how many of these positions have been taken up locally, PCN by PCN

Role	PCN 1	PCN 2	PCN 3	PCN 4
social prescribing link worker				
clinical pharmacists				
physician associates				
first contact physiotherapists				
pharmacy technicians				
health and wellbeing coaches				
care co-ordinators				
occupational therapists/ dietitians/ podiatrists				
Paramedics				
nursing associate				
mental health practitioners				
GP assistants				
digital and transformation lead				
advanced practitioners				

If all G&W PCNs were polled, what would coverage look like by Place and PCN

It would be interesting to do an inventory check on how many of these positions have been taken up locally, PCN by PCN

What would be the benefit if all posts were maximised?

Role	PCN 1	PCN 2	PCN 3	PCN 4
social prescribing link worker	X	X		
clinical pharmacists		X	X	X
physician associates	X		X	
first contact physiotherapists		X		X
pharmacy technicians	X			X
health and wellbeing coaches		X	X	
care co-ordinators	X	X	X	
occupational therapists/ dietitians/ podiatrists		X	X	
Paramedics	X			X
nursing associate	X		X	
mental health practitioners		X		X
GP assistants	X	X	X	
digital and transformation lead	X			X
advanced practitioners		X	X	

Role	PCN 1	PCN 2	PCN 3	PCN 4
social prescribing link worker	X	X	X	X
clinical pharmacists	X	X	X	X
physician associates	X	X	X	X
first contact physiotherapists	X	X	X	X
pharmacy technicians	X	X	X	X
health and wellbeing coaches	X	X	X	X
care co-ordinators	X	X	X	X
occupational therapists/ dietitians/ podiatrists	X	X	X	X
Paramedics	X	X	X	X
nursing associate	X	X	X	X
mental health practitioners	X	X	X	X
GP assistants	X	X	X	X
digital and transformation lead	X	X	X	X
advanced practitioners	X	X	X	X

Also, they need not all be located to an individual PCN. What if certain roles were conflated, realising the benefit of scaling?

Co-locating many of these functions would help build multi-disciplinary teams.

MDTs would begin to develop as a unified capability with its own culture.

Should there be a lead PCN coordinator for each of these services across the G&W Place?

Premises then becomes a big issue. Where would they be housed?

Does AARS create complications or opportunities?

But are all the capabilities of these organisations co-ordinated? How are patients' health records shared, for example?

There are significant organisational crossovers between Guildford PCN, GP Federation and Procare.

Then, there is the Procare JV with the RSCH whose Community Hospitals all provide services to patients in their neighbourhoods. The RSCH also runs outpatient clinics.

Charities, voluntary organisations and specialist companies like CSH Surrey also operate in this field.

The object of AARS is to build multi-disciplinary teams, but in PCNs supporting GP practices.

AARS team members could easily have been recruited from local community care operations.

Many of these patients have co-morbidities and will depend on services from different care locations.

Just consider, for example, how many different care providers a diabetes sufferer might see.

How AARS services are co-ordinated with local community care

Most GP practices are not set up to take on a bigger role; taking full advantage of AARS would be a challenge for many

‘Despite PCNs now delivering new services their development has not been uniform, with success often being dependent on local factors. This means that systems have a role to play in promoting integration at place through primary care leadership, providing supporting infrastructure and committing to transformation both in empowering PCNs themselves and in recognising that PCNs – as the ‘building blocks’ of ICSs - are the transformation that underpins all others’.

This becomes a system-wide challenge.

Because the plan is to move patients into the community, hospitals will need to be involved.

Essentially, it would mean creating a new organisation and management structure.

Re-reading the Fuller Stocktake proposals is worth doing.

Integrated neighbourhood 'teams of teams' need to evolve from Primary Care Networks (PCNs), and be rooted in a sense of shared ownership for improving the health and wellbeing of the population. They should promote a culture of collaboration and pride, create the time and space within these teams to problem solve together, and build relationships and trust between primary care and other system partners and communities.'

Next steps for integrating primary care: Fuller stocktake report, May 2022.

The important question is how will they 'evolve'?

The Fuller stocktake has since emphasised the importance of estates and digital (in addition to workforce) as the enablers for creating the capacity for wider improvements led by local decision-making. Increasing the primary care workforce through the ARRS has improved access to general practice, providing over 50 million more appointments in 2023 than in 2019. While demand and pressure remain high, an additional 31,000 roles joining primary care has allowed providers to run additional appointments and extend existing services. The increase in skill mix within primary care teams has also allowed new services to be provided in primary care settings for the first time.

Delivering integrated care: it's local teams which will drive the future NHS

Darzi says that the NHS should 'simplify and innovate care delivery for a neighbourhood NHS'. 'The best way to work as a team is to work in a team: we need to embrace new multi-disciplinary models of care that bring together primary, community and mental health services'.

There is nothing much that is new about care workers operating in multi-disciplinary teams (MDTs). The problem has been unifying staff from different NHS entities and also working with social care organisations and charities.

The ICB is responsible for drawing up the strategy, allocating the funding and promoting delivery.

But none of the NHS provider organisations which would need to combine to deliver integrated care are under its control.

The extra funding for GP practices, properly harnessed, will radically strengthen the building of MDTs.

The ICB must ensure that it is properly financed.

Probably the best way to ensure effective delivery is through contracts with sufficient financial incentives.

NB: a fully functioning teamwork approach has to include the RSCH.

Community health represents a vast bundle of differentiated, highly personalised, medical services

Every day, community health services have about 200,000 patient contacts – about 13% of all daily activity in the NHS.

Community health services cover an extensive and diverse range of activities, and hence can be difficult to define, with the precise range and configuration of services varying between local areas.

They commonly cover a wide range of needs across people of all age groups and are provided by many professional groups. In the NHS the term ‘community health services’ generally excludes specialist community mental health services.

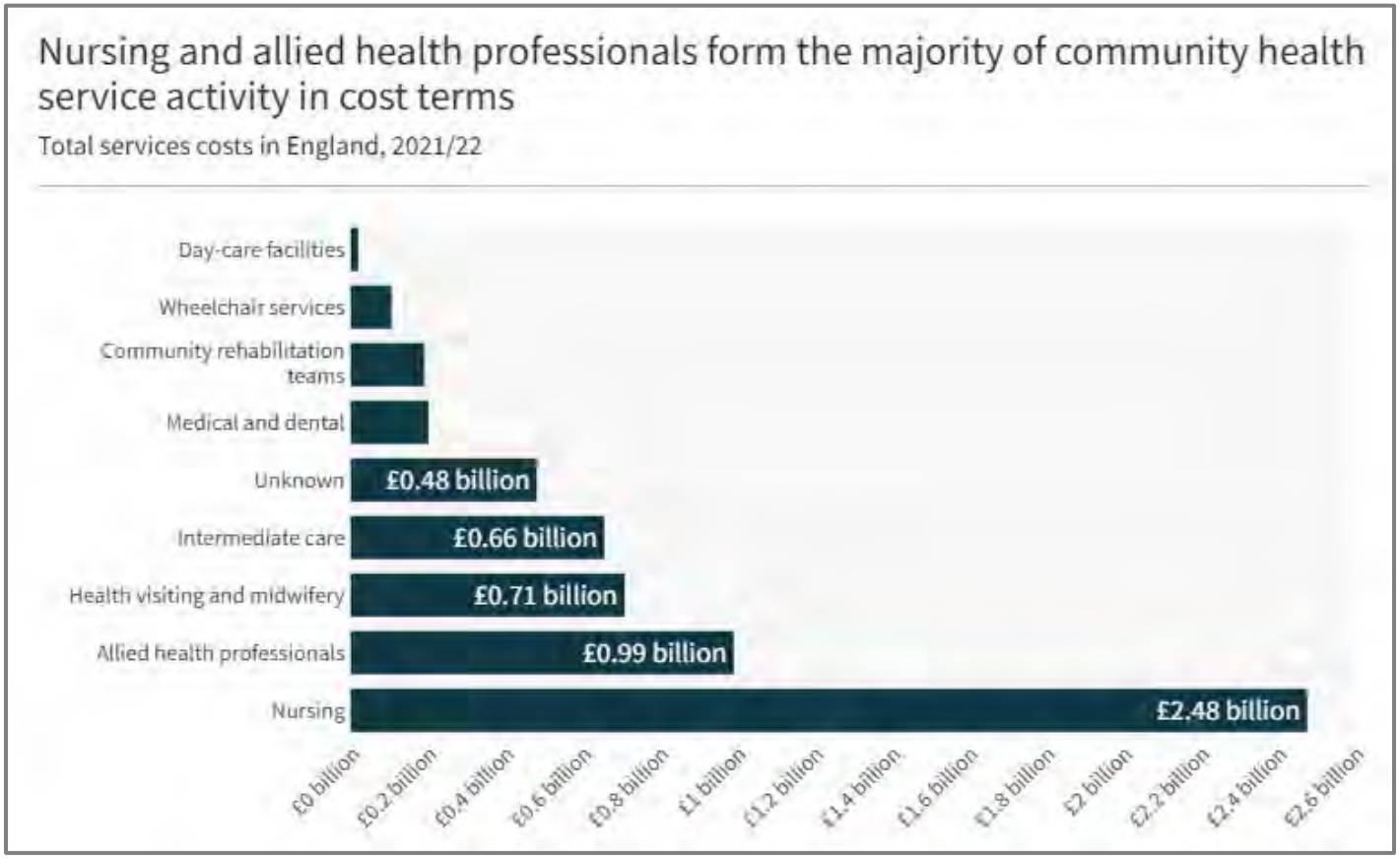
King’s Fund.

Figure 1: Where do NHS community health services fit within systems that support health and care?

Community health services are most often used by children, older people, people living with frailty or with chronic, multiple and/or complex health needs, and/or people who are near the end of their life. Due to this complexity, community services work closely with other parts of the health and care system, such as GPs, hospitals, social care and pharmacies. The increasing numbers of people living with long-term conditions means that more people are likely to need support from community health services in the future.

Services are delivered in a wide range of settings – including people’s own homes, care homes, community clinics, community centres, schools and hospices.

£2.5 billion is spent on community nursing



The King's Fund, June 2024.

We can assume that the same proportions are present locally.

Community health care services are highly fragmented resulting in gaps in patients' care

'In the past two decades, there have been frequent reorganisations to how community health services are structured, resulting in a range of different provider types and sizes; this includes standalone NHS community trusts and combined community and acute or mental health NHS trusts.

It has been estimated that NHS providers hold around half of the total value of community service contracts, with the rest held by providers including community interest companies, local authorities, social enterprises, private providers, GP practices and pharmacies.

A single provider is often responsible for delivering most of the community services in an area, usually alongside other providers that deliver specific services under relatively small contracts.

Community services are delivered by a range of staff, including community nurses, district nurses, allied health professionals (such as therapists) and health visitors. There is limited reliable data about the community workforce, and NHS workforce statistics do not capture in a consistent manner where community-based staff work.

From the data available for community nursing, there are worrying trends that their numbers reduced between 2010 and 2022: community health nurses by 8%, health visitors by 23.5%, and community learning disability nurses by 46%.'

King's Fund.

Locally, there is a very long tail of community care providers. Each ICS may have 20

According to NHS Digital, 'there are over 100 million contacts made with community services each year – these could be a visit from a district nurse at home, a child attending a speech and language clinic, or a patient getting a blood test.

The provider landscape for community health services is made up of approximately 800 providers delivering services in the UK.

NHS England allocates approximately £10 billion annually to community health services,

Community health services are generally made up of physiotherapy, podiatry, nursing, intermediate care, virtual wards, discharge support, musculoskeletal (MSK) and rheumatology programmes, dermatology services.

Unlike the episodic nature of elective and emergency care, community care is often multi-layered and ongoing.

Community care support is often provided over the longer term, and most frequently to children, older people, and those with chronic conditions, or those nearing the end of their lives.

Services are delivered in a multitude of settings, including in people's own homes, community clinics, community centres, schools, and care homes, as well as hospitals.

As many as 70% of community health services are provided by non-NHS organisations, independent providers alongside voluntary groups and social enterprises'.

Community Health Services: what does good look like? Independent Healthcare Providers Network

We have no information as to how well the workforce is co-ordinated locally

‘Community health services employ a broad range of health professionals such as community nurses, district nurses, allied health professionals (including physiotherapists, speech and language therapists, occupational therapists, and podiatrists), health visitors and dentists.

The Nuffield Trust reported that combined community staff make up an estimated one-fifth of the total NHS workforce - 33% are registered nurses, 25% health care assistants and unregistered staff, 21% are allied health professionals, and 18% are other non-clinical staff.

One of the questions which remains about the wider elective waiting lists (over 7.7 million people waiting, Nov 2023), is the extent to which patients could in fact be seen or treated in a community setting’.

There are many case studies at: https://www.ihpn.org.uk/wp-content/uploads/2023/11/IHPN-Community-Services-Report.-22-November-2023.pdf

Given that so many organisations may be involved, we have no information about gaps or overlaps.

This is why having every patient on a risk assessed care pathway is critical.

Prompt interventions by community care staff is likely reduce many avoidable emergency admissions.

‘Based on August 2023 data, over one million people are waiting to receive community health services, with more than 208k waiting more than 18 weeks, and of that, nearly 32k have waited more than 52 weeks.

Approximately, 80% of people are being seen within 12 weeks, although there are problems in some areas - children’s speech and language therapy, where waiting times are far longer’. **IHPN**.

Also, just how well are Adult Community Services integrated with GPs' AARS work force?

'Adult Community Services for Guildford and Waverley are run in a joint venture between Procare and the Royal Surrey Foundation Trust.

This joint venture puts primary care back at the heart of patient care. It is the first contract of its kind in the country, with an acute trust partnering with a GP federation.

Adult community health services provide care to patients in the community; maintaining their health and independence and preventing unnecessary hospital admission.

They include services like district nursing, podiatry, rehabilitation beds, therapists and the Minor Injuries unit at Haslemere Hospital. They complement the services provided by GP practices, Royal Surrey County Hospital and other healthcare organisations.

Our ambition in running these services is to improve the integration between GP, Community and Hospital services so that they work more closely together. We know that we can provide a better service for the individual if the system works as one, allowing our teams work more closely together and the information to be available to support their patient throughout their illness'. **Procare.**

Is AARS effectiveness impared by a lack of space?

‘There is evidence that, so far, those new staff are being under-utilised due to insufficient and inadequate estate space. Traditionally, GPs conduct one-on-one consultations in examination rooms that sit within a practice premises.

MDTs work in different ways. Physiotherapists, for example, generally need more space to work with patients.

MDTs may also work with groups of patients as well as individuals. MDTs also need space to meet each other, co-ordinate care and collaborate.

The current estate is not designed to facilitate those ways of working.’

Delivering a general practice estate that is fit for purpose, Institute for Government, June 2024.

Where will the staff go? GP premises are not designed to house all these people

What are the implications for real estate?

Should there be one major site for the delivery of AARs community-led services?

Multi-disciplinary teams work best in a collegiate environment.

Many of the ARRS personnel need to be grouped in their own discrete spaces, but preferably in a single floor arrangement.

A significant amount of space would be required for a single point of access (SPA) and derivative services, like referral management.

Building a new culture would be a valuable by-product of shared premises.

The AARS scheme is immature and needs a more formal organisation structure

‘Ensure increased ARRS flexibility to allow primary care to determine their workforce needs and the flexibility to contract and deploy where most appropriate.

Greater investment in primary care capital for estate and digital funding to the rest of the NHS to ensure that primary care remains equipped to support a greater shift to out-of-hospital care.

Expand support to commission digital solutions at scale to enable integrated working across the health service and reduce unwarranted variation.

Raising patient awareness of, and confidence in, multidisciplinary primary care is essential.

The scheme currently provides insufficient funding for supervision or training. By tackling workforce recruitment challenges in isolation (without structural enablers such as estates and digital or retainment/professional development) an opportunity for a more thorough intervention was missed.’

Assessing the impact and success of the Additional Roles Reimbursement Scheme, NHS Confederation, Feb 2024.

Logically, NHS community health care could be re-established by building out from the AARS initiative

The AARS programme is the first primary care initiative to invest beyond GPs' capabilities.

This represents a genuine move to reduce pressure on doctors and introduce a wider range of help to address patients' needs.

There are issues – particularly premises - which now need urgent attention.

We put forward a suggestion for consolidating the staffing allocations made for many of these roles to create more scale for the PCNs working within Places.

We identify a number of activities which might then be introduced or strengthened – a Single Point of Access and Referral Management, for example.

The next step would be to look to the ICS to help develop a process for more patients to be moved out of hospital to the community for their ongoing care.

This might mean putting more care under new contracts for which GPs and others might bid.

There might even be joint ventures with RSCH.

A longer-term move would be to consider running many discrete, condition-related care programmes as distinct service lines.

The Women's Hub operated by GPs in Shere might be a model.

Later, we propose a number of ways to strengthen technology to support these initiatives.

Is there true co-ordination between hospital community services and practice AARS schemes?

The RSCH says it delivers the range of community services in the first column.

AARS services, delivered by PCNs and based in GP surgeries are in column two, but local allocations are not known.

How well are the two organisations' services co-ordinated?

Proactive care

- District Nursing
- Proactive Care Service
- Tissue Viability Service
- Multiple Sclerosis Specialist Nurse
- Parkinson's Nurse Specialist
- Heart Failure Service
- Continence Nurse Specialist
- Speech and Language Therapist

Intermediate care

- Urgent Community Response
- Hospital at Home
- Community Therapy Team

Place based care

- Milford Integrated Care Hub (MICHub)
- Musculoskeletal physiotherapy
- Podiatry service

- Clinical pharmacists
- Pharmacy technicians
- The social prescribing link worker
- Health and well-being coaches
- Care co-ordinators
- Physician associates
- First contact physiotherapists
- Dieticians
- Podiatrists
- Occupational therapists
- Nurse Training Associates
- Nursing Associates
- Community Paramedics
- Advanced Practitioners
- General Practice Assistant
- Mental Health Practitioners (Adults and children)
- The Digital and Transformation Lead

The RSCH has a control centre for community care. Does Procare have a separate one?

Community Co-ordination Centre:

'The Community Co-ordination Centre (CCC) is a single referral point for health and social care professionals to refer local residents registered with a GP in Guildford and Waverley.

Once we have received the referral, we will assess each individual and co-ordinate the appropriate community services to support the patient's health and wellbeing to enable to patient to remain in their own home and to prevent any unnecessary admissions to hospital.

To access the service would be through a referral from your GP, health or social care professional or following a discharge from hospital.

You are able to refer yourself by calling the Community Co-ordination Centre on 01483 362 020

When your referral is received either by email or phone, an administrator will ensure we have taken a detailed history of your health concern to enable the clinician to identify the appropriate services to support you.

The identified service will then contact you to arrange an appointment.' **Procare.**

Procare says: 'We provide adult community nursing services 24 hours a day, 7 days a week, 365 days a year.

Our Community Matrons, District Nurses and Community Night Nursing Team provide nursing care, support, advice and treatment for people in their own homes.

To contact the service, your GP or hospital will refer you into the community co-ordination centre.

The referral will then be processed by our team of clinicians and prioritised according to urgency and clinical need.

If you need to contact the CCC please call 0300 303 9513 from 8am - 8pm. Between 8pm - 8am please contact 07771 772180.'

The organisational challenge of community care is that this highly federated business has to be coordinated

Every day, patients in the poorest health are being seen by a wide range of specialist care providers.

Many have complex needs requiring personalised care across a number of conditions.

But how well is the care coordinated and meeting the patient's unique needs?

These people are easy to identify through current NHS systems.

The neediest are about 10% of the local population and represent about £300 million of local health care costs.

This then is a significant, subdivision of the Guildford population.

Their costs are distributed between hospital, community care providers (physical and mental health) and GPs.

As we explain elsewhere in this presentation, it is relatively easy, given current technology and available patient data to build a care pathway for each of them.

The starting point of re-organising their care might be to group them into a single population overseen by a single management.

This would be the basis of a new community care organisation.

An expanded community care capability will need its own organisation

A merger of traditional ‘community care’ and AARS teams seems inevitable, and a good idea.

AARS is expanding under PCN and GP control.

GPs have never been expected to run large, complex businesses.

The main enablers of integrated care [are] the organisational skills of health and social care professionals who [are] actively able to contribute to inter-professional collaborations by bridging task-related gaps and overlaps, and a growing interest in co-production in health care services to improve information sharing and reduce duplication.

‘Despite PCNs now delivering new services, their development has not been uniform, with success often being dependent on local factors. This means that systems have a role to play in promoting integration in Places through primary care leadership, providing supporting infrastructure and committing to transformation both in empowering PCNs themselves and in recognising that PCNs – as the ‘building blocks’ of ICSs - are the transformation that underpins all others’. **NHS Confederation**

But these are operating units with their own limited, separate managements.

Who will bring it altogether and pay for it?

Especially, as ICBs’ future structures are uncertain.

How data becomes the care organiser

It will be data that becomes the health care controller

Health systems are highly fragmented, operating in distinct silos with their own administrative and information systems.

Each part of system (primary, secondary, community care) keeps its own patient records.

There has been practically no interoperability in NHS systems until the arrival of programmes like the Shared Care Record. How extensively is this used by clinicians?

Locally, there have been initiatives, but do they enable the integration/processing of data?

The goal of healthcare interoperability is to allow multiple systems to share patient data, and make it accessible to the providers, patients and those who need to view it.

In the future, the big win is that machines will be able to collate and manipulate the data.

They will have a huge impact on care pathway planning and decision support.

They will operate in real time, alert staff and schedule treatment.

They will change the patient's risk score and prompt interventions and care escalation.

They will monitor interruptions to pathway adherence and collect patient feedback.

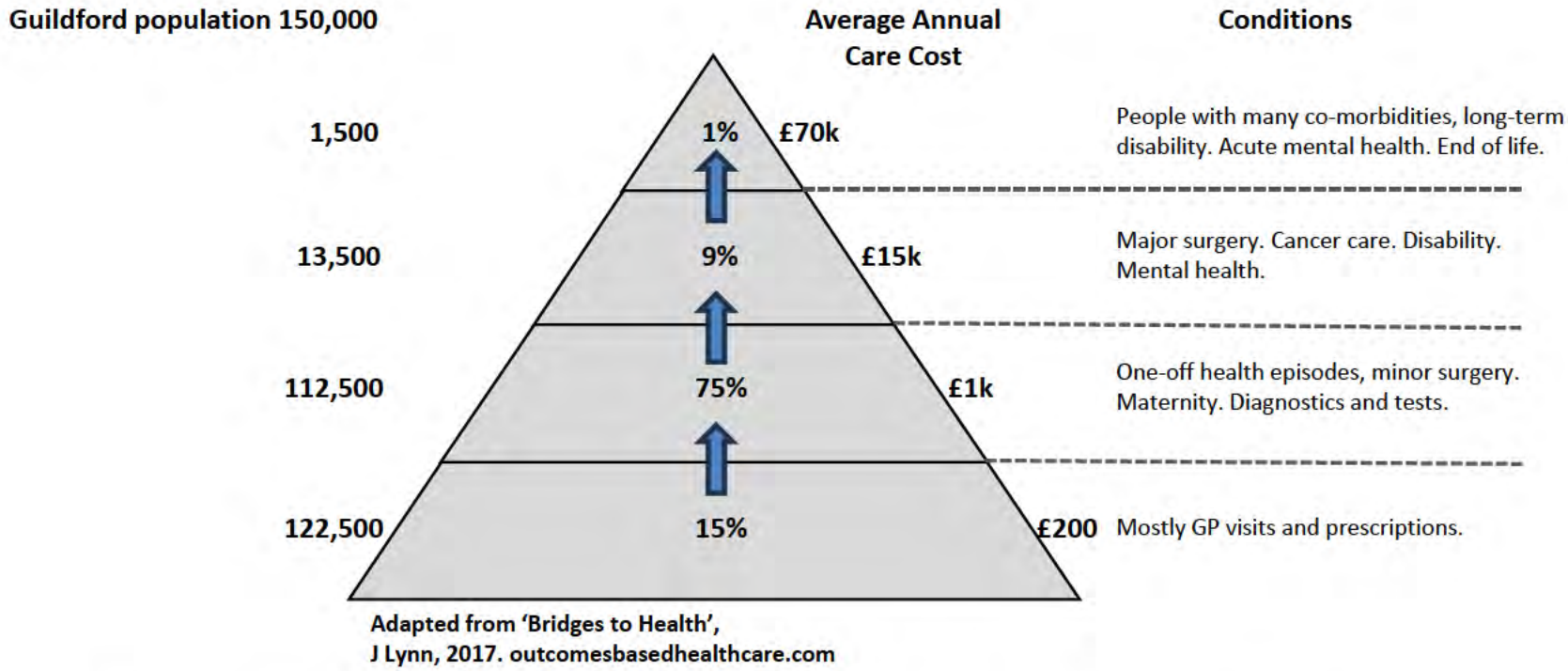
Each interaction will be costed, building a picture of system efficiency and value for money.

A lot of short-cuts become available if all data is copied into the GP record.

After all, the whole population is registered with a GP practice.

Controlling the upward movement in patient morbidity is any system's major challenge, including Guildford's

- Over their lifetimes, most people will inevitably move upwards through this care hierarchy.



- The clear objective of health systems is to reduce this upward movement, to improve population health, slow the rate of morbidity and to lower costs.
- This is how Guildford's £500m health budget is distributed.

The patient risk can be re-calculated with the input of new data

‘EMIS, a widely used electronic patient record system (40+ plus of GPs), facilitates risk scoring and stratification of patients using tools like the electronic frailty index and by integrating with external systems like QRISK for cardiovascular risk assessment, enabling GPs to focus on preventative care.

EMIS Web integrates with other systems to identify vulnerable patients at all ages, including risk stratification tools that can identify the top 2% of at-risk patients.

EMIS Web includes an electronic frailty index that scores patients aged 60 or over against specific criteria for moderate or severe frailty, automatically alerting clinicians if patients meet these criteria.

Information is collected from various sources, including NHS Trusts and the GP practice, and analysed to determine a risk score.

Risk stratification enables GPs to focus on preventing ill health and not just treating sickness, potentially offering additional services to patients at higher risk’. **EMIS website.**

We believe that technology will unify and integrate services

There is real potential for technological developments to support and change how community services deliver care – for example, greater use of remote monitoring of people's health in their own home through wearable devices, or at-home diagnostics and the use of virtual consultations.

Technology can also play a role in facilitating better collaboration between community health services and other partners in the health and care system. For example, more accessible shared care plans and virtual multi-disciplinary team meetings can mean better information flow and communication across organisations, people and places, bringing benefits for both patients and staff (such as fewer tests, saving both patients and staff time).

However, the state of technology in primary and community health and care services is often underdeveloped, reflecting a lack of investment in hardware and software.

Investment will be needed to ensure that the basic infrastructure is in place while giving community health services the opportunity to make the most of technological developments.

King's Fund

Designing care around the person

Managing the patient, rather than the condition, would transform care delivery

‘Overall, patients with no chronic (long term) LTC conditions contributed to 23.3% of the total secondary care costs, patients with one chronic condition to 21.4% of the total costs, patients with multi-morbidities, 55.3% of the total costs.

Hypertension was the most prevalent morbidity recorded in over a quarter of patients (26.5%). Diabetes (11.6%), chronic kidney disease (10.3%), and asthma (9.5%) were next most common.

In terms of costs, patients with hypertension contributed to 41.3% of total costs of secondary care, followed by chronic kidney disease (24.3%), both higher than the total contribution of those with no conditions.’

Multimorbidity combinations, costs of hospital care and potentially preventable emergency admissions in England: A cohort study, Jan 2021.

Managing patients with LTCs in the community will reduce hospitals’ costs.

Treating them in the GP practice would be covered by capitation costs and would disrupt the practice business model.

A new remuneration model will be necessary to ensure that care providers are appropriately compensated.

All the people at the top of the pyramid will have multiple co-morbidities

About one in four adults has a long-term condition

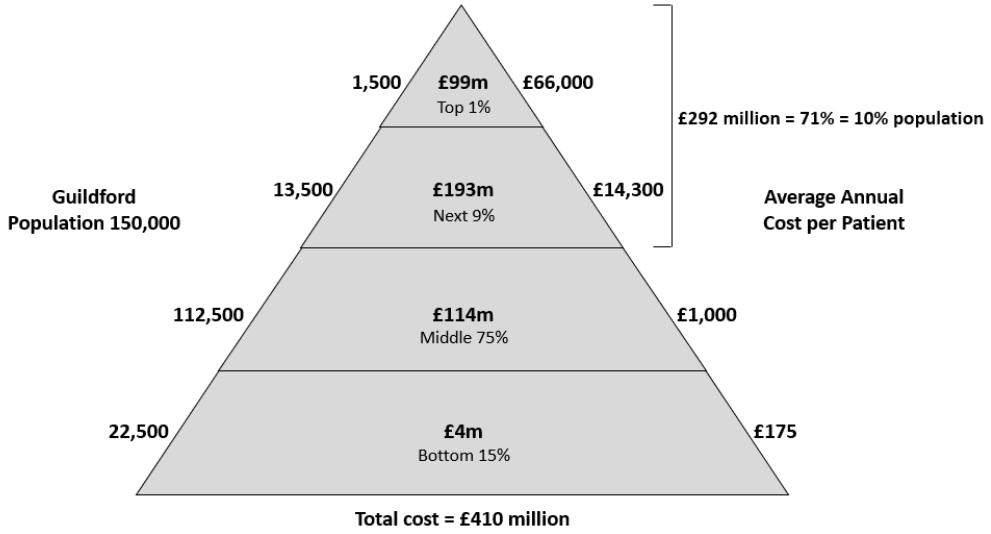
For over 60s , it doubles to 50%

It's two thirds by the age of 75.

For people with co-morbidities, one third have both a physical and mental health condition.

This proportion increases substantially with greater socio-economic deprivation.

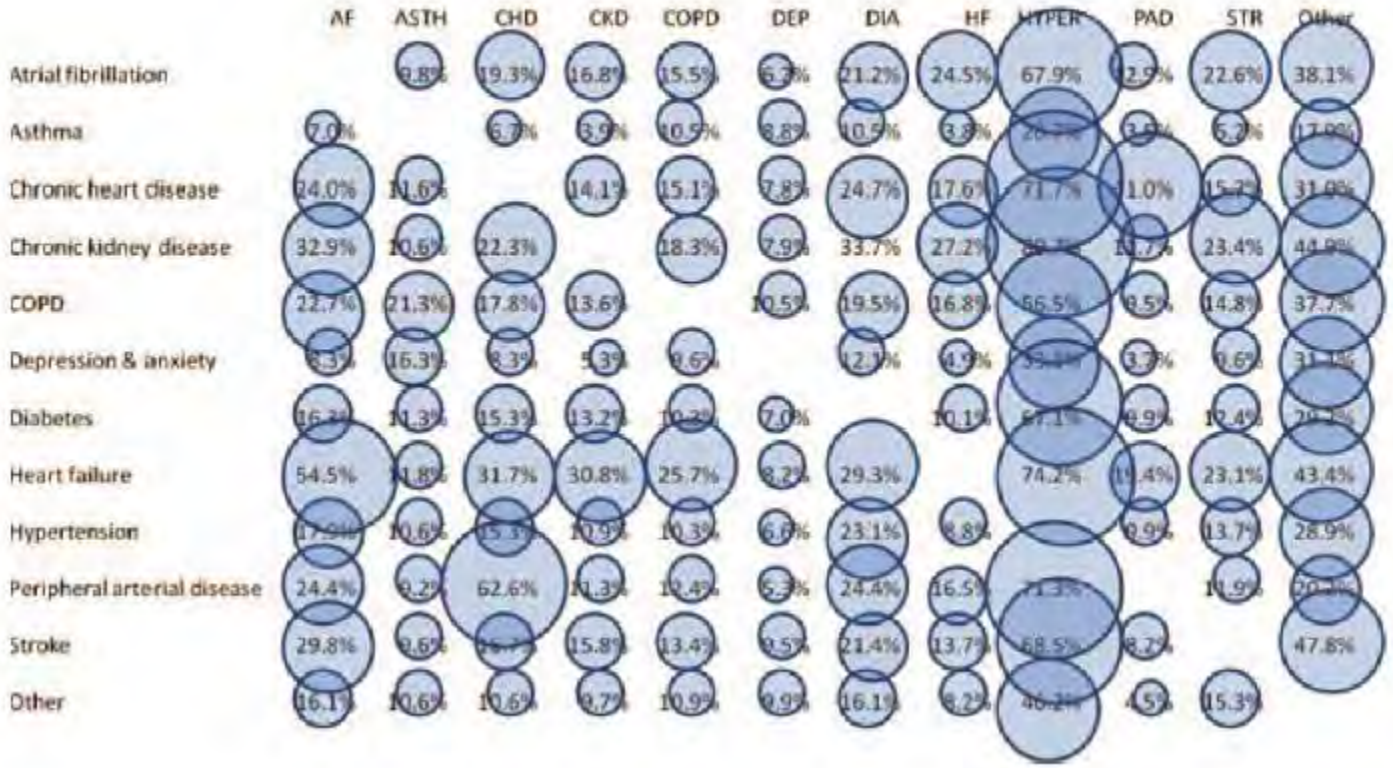
It is a common factor across all health economies that 70% of budgets are consumed by 10% of the population



15 million people out of 57 million in England, more than one in four, have at least one long-term health condition.

The incidence of multiple co-morbidities complicates care management co-ordination

Figure 3 - The percentage of people with a specific LTC (left-hand of figure) who also have another specific LTCs *(selected LTCs only - those where patients demonstrate the greatest multimorbidity)*



Multi-morbidity is increasing and will do so as life expectancy becomes more extended

‘In 2015, 54.0% of people aged over 65 had two or more conditions (multi-morbidity). By 2035 this is predicted to have risen to 67.8%. By age group, the prevalence of multi-morbidity was predicted at 52.8% for people aged 65-74, 75.9% for those aged 75-84, and 90.5% for those above the age of 85.

By 2035, there will be double the number of people aged over 65 living with four or more conditions: 17.0% compared with 9.8% in 2015. People aged over 75 contribute most to this number.

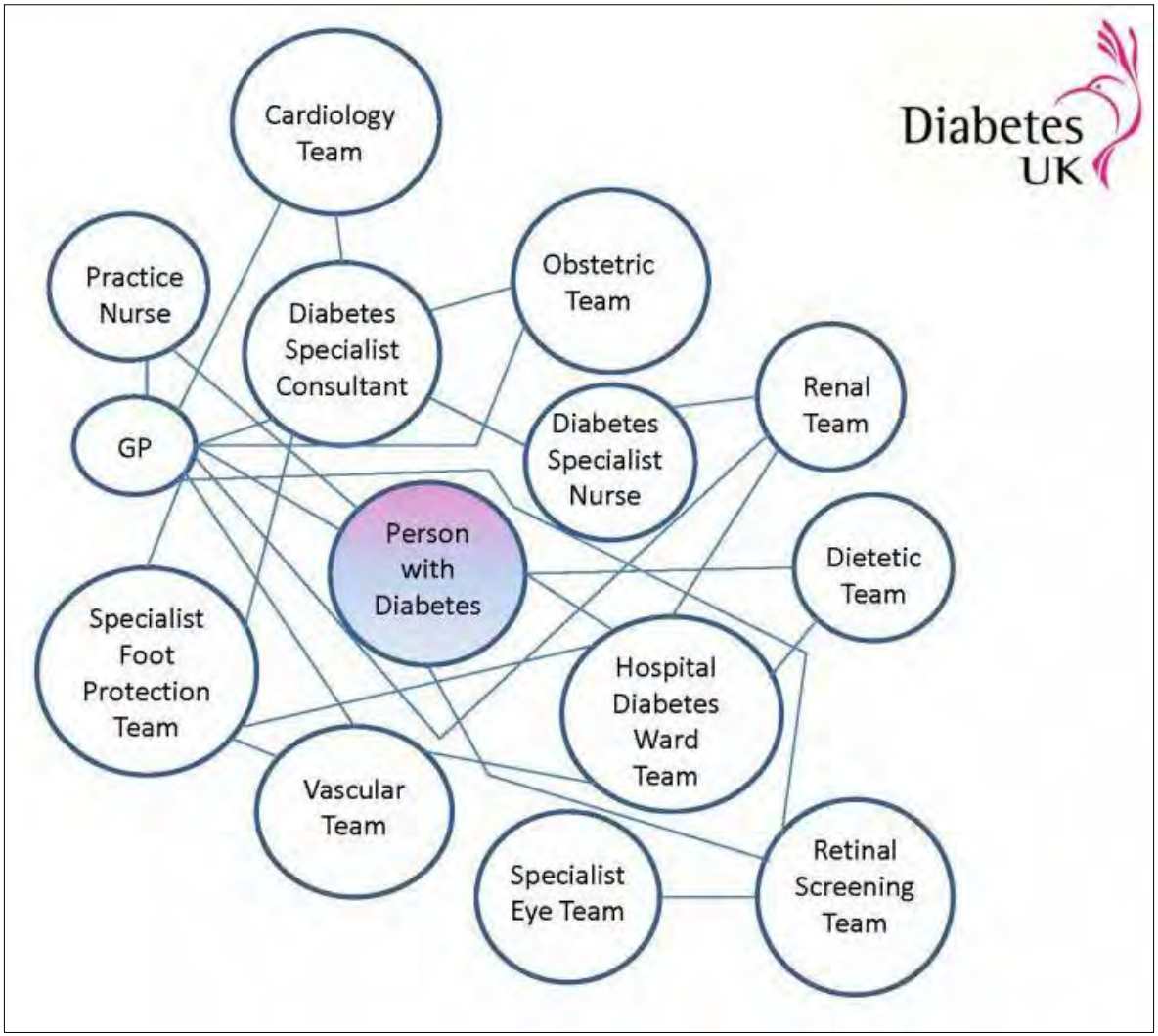
By disease, most people over 65 will be affected by arthritis (62.6%), followed by high blood pressure (55.9%), respiratory disease (24.4%), cancer (23.7%) and diabetes (21.6%). The greatest prevalence increase was for cancer which had doubled from 12.6% in 2015.

The contribution of mental illness (depression, dementia or cognitive impairment) to overall multi-morbidity increases with the number of diseases or impairments. In 2015, 4.1% of people with two or more conditions had mental ill-health, to 34.1% of people with four or more conditions. This pattern is expected to change little by 2035.

Life expectancy is predicted to increase by 3.6 years for men and 2.9 years for women by 2035. This extra life comprises a reduction in years lived with no or only one health condition and an increase in years lived with multi-morbidity’.

Multimorbidity: clinical assessment and management, NICE.

Where there is a focus on condition, rather than the person, there is the chance of discontinuity in care issues, particularly in patient hand-offs



Chris Whitty says ‘stop shunting patients’. Assign an MDT member prime responsibility for the care of an individual?

‘Doctors and NHS services are becoming too specialised to meet the needs of a rapidly ageing population, the chief medical officer (CMO) has warned in his annual report.

Much of the medical profession is organised around single diseases or organ systems ‘in a way that is ill-suited to a future of increasing multimorbidity’ where people accumulate chronic conditions, Professor Chris Whitty said.

It is essential that doctors maintain generalist skills in order to best care for older populations. NHS services and research bodies also need to adapt to the rise of multiple conditions, he added.

Currently older people are ‘shunted around multiple unrelated clinics often with great difficulty to them and their families’, he said, which is ‘bad medicine and bad organisation’.’

NHS England

The GW Alliance will be able to pinpoint local patients who are at risk for unscheduled hospital admission.

They should start with a test area.

Stoughton, Stoke and Westborough are amongst the most deprived wards in Surrey: life expectancy is significantly lower for men and for women compared with other wards in Guildford.

'Life expectancy at birth for men ranges from 76.6 years in Stoke to 87.6 years in Godalming Holloway, a difference of almost 10 years. LE at birth for women ranges from 78.8 years (Stoke) to 90.7 years (Blackheath and Wonersh), a difference of 11.9 years'.

The Park Barn and Royal Surrey neighbourhood has the highest level of overall deprivation - with 35.4% of households suffering some type of deprivation.

The next most deprived neighbourhoods were Woodbridge Hill (35.2%) and Bellfields, Slyfield and Weyfield (35.1%)'. **ONS, Surrey, Guildford data.**

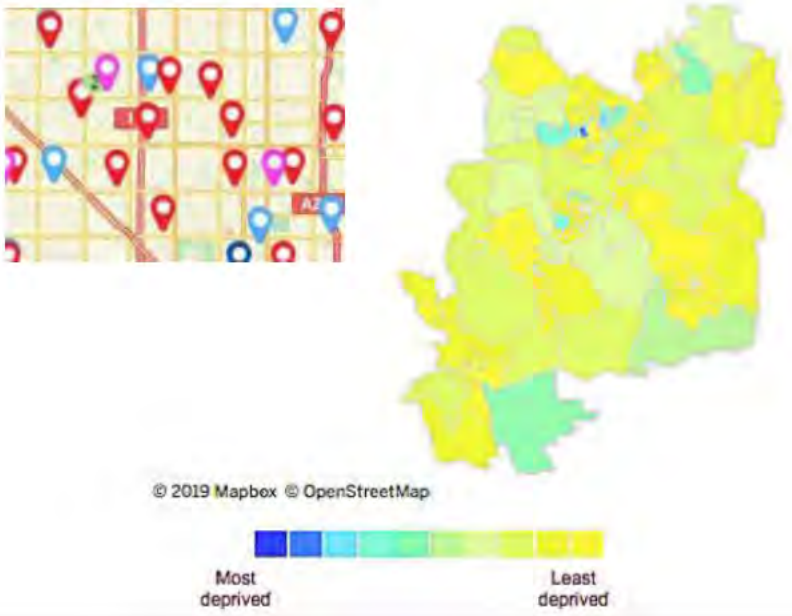
These are localities which, prima facie, present the largest risk of emergency admissions.

HES and hospital EHR data would provide the validation.

This means that every patient has his or her own health record with this degree of data granularity

- This means that probably the best way of looking for those whose health is linked with deprivation is to search at the individual patient level.
- This is entirely possible by reviewing hospital and GP data (HES, SUS, ICD-10, SNOMED-CT) are all available to help build a picture of sickness prevalence at the postcode level.
- It is quite straightforward to literally 'Pin' these individuals.

Figure 6. NHS Guildford and Waverley Index of Multiple Deprivation.



Risk stratification down to a single patient is the target. The data will keep on coming - from a variety of sources

Risk stratification is a method of assessing the potential scale of future adverse events among patients at high, medium, and low risk. By identifying these groups, health planning may be adapted to meet their needs by providing interventions to avoid these adverse events happening.

There are three main approaches to risk stratification. The first two methods of clinical judgement and threshold modelling, are known to have limited effectiveness, this guide focuses on the use of predictive modelling.

Novel concepts for disease-mechanism based patient stratification will address the needs for stratified or personalised therapeutic interventions.

Future analyses will integrate multidimensional and longitudinal data and harness the power of -omics, including pharmacogenomics, systems biomedicine approaches, network analysis and of computational modelling.

Outpatients

Everyone is an outpatient until they are an inpatient

If there are 150,000 NHS beds, then every night, 99.5%+ of the population are not in hospital.

It's the same every day, 365 days a year

Some people are unfortunate that their health condition is such that they either visit or stay in hospitals a lot.

A lot of this happens at the end of life.

'Over half (53%) of public spending in the final year of life is spent on health care (£11.7bn) – or £18,020 per person who died.

Hospital care represents the largest share of health care spending, accounting for 81% of total health care spend (£9.6bn). More than half of this health care spend (56%) goes on emergency hospital care (£6.6 billion).

Put another way, for every £5 of health care spend, £4 was spent in hospital, with £2.80 spent on emergency hospital care'. **Nuffield Trust, 2025**

Beneficial change for the NHS will only occur if long-established conventions are challenged

Progress towards systems redesign can only occur if we move on from old health care conventions.

The care of 'outpatients' is one of these.

Patients, across their lives, are the GP's patients both before and after hospital treatment.

Another way of looking at it is that patients are always outpatients, except when they are in hospital, ie, where they are inpatients.

Many outpatients continue to receive regular hospital appointments even though their care plan could often be delivered in the community.

'The 2019 NHS Long Term Plan highlighted the dramatic rise in outpatient appointments, and pledged to save £1bn a year by stemming the growth in hospital visits. Key to this was a commitment to allow patients to choose virtual appointments, with a five-year ambition to avoid up to 30 million outpatient visits a year.' **The King's Fund.**

NHS England is continuously reframing outpatient care policy, mostly through tightening reimbursement rules. **https://www.england.nhs.uk/outpatient-transformation-programme/**

Outpatient attendances: doing the maths

‘In 2023-24, there were 104.6 million outpatient attendances.

This is an increase of 9.1% from the published figure for the previous year, and an 8.5% increase from the level seen before the coronavirus (COVID-19) pandemic (there were 96.4 million attendances in 2019-20).

Please note that the published number of attendances for 2022-23 are estimated to have been 1.0 million records less than the actual level of activity, as one provider was unable to submit data between June 2022 and March 2023.’ **NHS Digital.**

‘First outpatient attendances.

Where the outpatient attendance has a published unit price, this will form the basis for valuing the activity. Where an attendance does not have a published unit price, a weighted average of attendances with a price is used.

Outpatient follow-up activity is outside the scope of the ERF and forms part of provider fixed payments.’

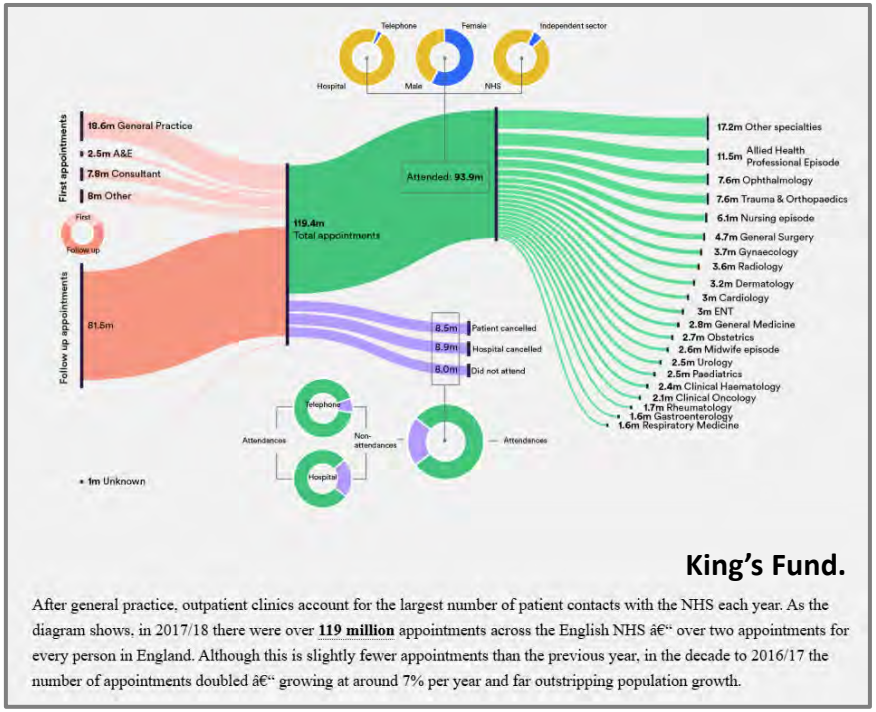
Elective Recovery Fund technical guidance 2024/25.

The transfer of outpatients into community care is impacting the acute hospital business model and funding

‘Each provider and system have been asked to reduce outpatient follow-up appointments by a minimum of 25% by March 2023 compared to 2019/20 baseline activity and go further where possible and re-allocate time, prioritising activities to support elective recovery’.
‘Principles and approach to deliver a personalised outpatient model’, NHS England, 17 May 2022.

The number of hospital outpatient attendances has continued to grow year-on-year. In 2023-4, it was 104.6m compared with 95.9m for the prior year. [NB: Strike action by hospital doctors would have affected numbers].

This a typical view of their care pathways. Where will be patients’ next destinations?



King’s Fund.

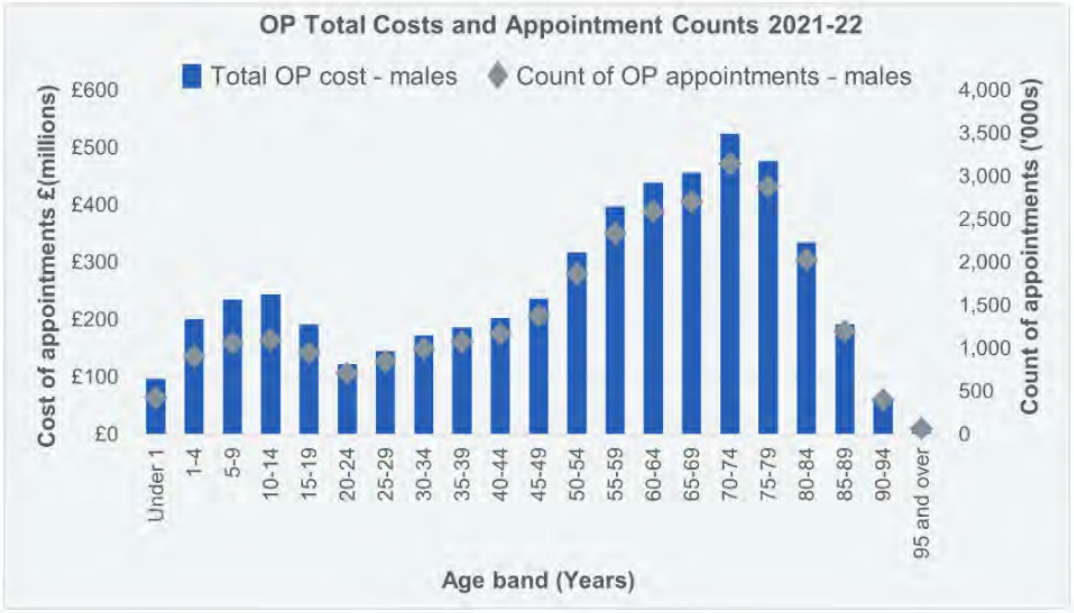
After general practice, outpatient clinics account for the largest number of patient contacts with the NHS each year. As the diagram shows, in 2017/18 there were over **119 million** appointments across the English NHS â€“ over two appointments for every person in England. Although this is slightly fewer appointments than the previous year, in the decade to 2016/17 the number of appointments doubled â€“ growing at around 7% per year and far outstripping population growth.

Over £15bn is spent annually on outpatient care

Outpatients (OP)

A total cost of £14 billion was reported for OP activity. This is summarised by the sex and age value of the HES linked appointment. £1.4 billion (10.4%) of the total cost of OP activity did not link to a HES appointment and is not included in this analysis. Sex or age was unknown or not specified on the linked HES appointment for £2.5 million (less than 0.1%) of reported cost.

The total cost and count of appointments are markedly higher for females in the age groups from 15 to 64 compared to males in the same age groups. Part of this difference is likely to reflect maternity related appointments.



(Fixed) Outpatient numbers are well off plan at RSCH

Total activity is 20% higher than plan, with Fixed 22% higher, for which there is no reimbursement

NHS Royal Surrey NHS Foundation Trust | All Activity | Trust-Wide | SBU: All | February 07/03/2025 12:18:10

Activity

ERF_Type	IM Target	IM Activity	Variance to Target	% IM Variance to Target	YTD Target	YTD Activity	Variance to YTD Target	% YTD Variance to Target
ERF Variable	**16,291**	**18,578**	**2,287**	**14%**	**189,788**	**191,199**	**1,411**	**1%**
Outpatient Procedures	4,786	7,303	2,517	53%	55,758	59,225	3,467	6%
Outpatient	7,652	7,318	(334)	(4%)	89,148	85,363	(3,785)	(4%)
Other	441	603	162	37%	5,143	6,963	1,820	35%
Elective Day case	2,807	2,941	134	5%	32,699	34,379	1,680	5%
Elective	604	413	(191)	(32%)	7,040	5,269	(1,771)	(25%)
Non-ERF Variable	**10,538**	**11,659**	**1,121**	**11%**	**122,763**	**129,093**	**6,330**	**5%**
Other	8,483	9,677	1,194	14%	98,823	106,519	7,696	8%
Direct Access	2,055	1,982	(73)	(4%)	23,940	22,574	(1,366)	(6%)
Fixed	**154,595**	**188,031**	**33,436**	**22%**	**1,801,028**	**2,199,875**	**398,847**	**22%**
Outpatient Procedures	4,151	3,874	(277)	(7%)	48,362	44,859	(3,503)	(7%)
Outpatient	12,771	20,895	8,124	64%	148,779	237,743	88,964	60%
Other	9,110	10,133	1,023	11%	106,132	108,373	2,241	2%
Non Elective	3,690	5,230	1,540	42%	42,994	58,082	15,088	35%
Elective Day case	46	61	15	33%	536	535	(1)	(0%)
Elective	11	4	(7)	(63%)	125	77	(48)	(38%)
Drugs	0	0	0		0	0	0	
Direct Access	117,925	139,172	21,247	18%	1,373,824	1,648,500	274,676	20%
Devices	9	14	5	65%	99	117	18	18%
Critical Care	788	760	(28)	(4%)	9,177	8,146	(1,031)	(11%)
AandE	6,094	7,888	1,794	29%	71,000	93,443	22,443	32%
Total	**181,423**	**218,268**	**36,845**	**20%**	**2,113,579**	**2,520,167**	**406,588**	**19%**

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The above shows activity numbers by type of activity

12

What is the explanation for the difference between Target and Actual? We have none.

RSCH outpatient attendances 2024-25

	YTD 28.02.2025		Full Year Forecast
	Target	**Actual**	
ERF Variable			
Outpatient	89,148	85,363	93,123
Fixed			
Outpatient	148,779	237,743	259,356
Total	**237,927**	**323,106**	**352,479**

RSCH Board Report, March 2025. Our forecast for full year.

Hospitals are being pressured to lower outpatient attendance

‘The financial framework has been set for 2022/23 to support elective recovery and specifically ambitions around personalised outpatients.

Each provider and system have been asked to reduce outpatient follow-up appointments by a minimum of 25% by March 2023 compared to 2019/20 baseline activity and go further where possible and re-allocate time, prioritising activities to support elective recovery’.

Achieving sustained outpatient follow-up reductions will require providers to have in place core operational good practices as a foundation for wider change.

Providers, working across system, should consider patient-initiated follow-up (PIFU), more effective discharge processes and specialist advice where these are clinically appropriate.

In doing so, a personalised outpatient model can offer patients care that is better tailored to individual need and circumstance, delivered through traditional means, when required, but also empowering self-management, remote-monitoring and other alternatives where clinically appropriate’. **NHS England**

To reduce the load on hospitals, patients are being asked to take responsibility for scheduling appointments at RSCH.

‘**Transforming outpatient services for patients**

The NHS is changing how we deliver outpatient services so that patients can be seen more quickly and can access and interact with our services in a way that better suits their lives.

This means giving patients and their carers more control and greater choice over how and when they access care.

We are empowering patients to book their own follow-up care as and when they need it, providing the option of telephone or video consultations where appropriate, and working with GPs to enable access to earlier expert advice’.

Patient initiated follow-up (PIFU) is key to personalising outpatient care, and by enabling patients to have more control over when they receive care, can reduce unnecessary follow-up appointments and make the best use of clinical time’. **RSCH.**

PIFU personalises care, enabling patients to access support when they need it, but not attend routine follow-up appointments when they are well’. **NHS England**

What is a patient initiated follow up PIFU?

'What is patient initiated follow up?
Patient initiated follow up (PIFU) appointments can help reduce unnecessary visits to hospital, reduce patient waiting times and allow healthcare professionals to see more patients in a timely manner. PIFU means you can arrange an appointment for yourself based on your individual symptoms, and receive guidance when you need it. This is an alternative to a routine follow-up appointment, which can be a source of stress and expense, and which you may not always find helpful unless you have a specific concern you wish to discuss withy our healthcare professional.

How does it work?
If PIFU is suitable for you, your healthcare professional will discuss your condition with you and offer you a PIFU. This means instead of being given a routine follow-up clinic appointment, you will be able to arrange a follow-up appointment if you feel you need it. Your healthcare professional will advise on any symptoms you need to watch out for, or the circumstances for which you should make an appointment. This will be documented in the letter you are sent after your appointment, along with how long your PIFU will last.

There are two types of PIFU:

1. PIFU with Clinical Review
   This type of PIFU is suitable for patients who cannot be discharged. It gives you the choice of booking an appointment within the specified period and if you do not need to see the doctor or nurse about your condition during that time, an appointment will be booked for you by the hospital at the end of the specified period.
2. PIFU with Non-clinical Review (Discharge)
   With this type of PIFU, if you do not need to see the doctor or nurse about your condition within the specified period, you will be discharged back to your GP who will re-refer you if you need to be seen again in the future'.

NHS Surrey and Sussex Health.

Nobody seems to be tracking PIFU patients. How many revert to hospital? Or pick up with their GP?

There are, of course, significant financial implications for hospitals if they lose their reimbursement for outpatient care.

Also, the extra load on practices means that it shouldn't reasonably be included within GPs' capitation, should it?

Hospitals often say that there is likely to be a loss of system productivity by moving specialists into the community for out-patient consultations.

But there is an evidence base showing there are better options than sending everyone to hospital for outpatient appointments.

The RSCH website says 'We are empowering patients to book their own follow-up care as and when they need it, providing the option of telephone or video consultations where appropriate, and working with GPs to enable access to earlier expert advice'.

How well is the programme working? Are there any metrics?

There is probably a fine line between patients discharged into Virtual Wards and those in PIFU programmes

- Out-of-hospital patient management might then become something of a lottery.
- Who owns the patient – the hospital, the GP or the community care provider?
- It was always intended that 'the [Virtual] ward [would] be overseen by a consultant, working with therapists, nursing staff and pharmacists'. RSCH.
- There are also operational issues which need resolution.
- Is there one shared patient record? Are updates shared between providers?
- Should the application of the RSCH Doccla software be extended and come under the management of out-of-hospital providers, even MDTs working in the AARS programme?
- Maybe PIFU patients' expreriences should be remotely monitored by the NHS App.
- A junior version of Virtual Ward?

Patient Experience
Pick one icon on each line

How are we doing?	Excellent	Good	Fair	Poor
Care and respect				
Listening and explaining				
Working together				
Reliability and punctuality				

The decanting of hospital outpatients to community care should be managed gradually

Hospital outpatients will be repatriated to community care one by one.

Not all of them are suited to self-monitoring., ie working in PIFU mode.

A proportion of them will be patients with long-term conditions.

Could staff recruited under the AARS programme pick up the most suitable candidates for ongoing out-of-hospital care?

Which patients would they be? What would be the selection criteria?

There is probably already something of a precedent in place with patients who are in the Virtual Ward programme.

In which case, how would practices be remunerated? Would they need to be on a special contract?

The most important driver of change will be technology

Technology will be the resource which changes health care forever. This will challenge a technophobic NHS.

It's technology which will have the biggest bearing on health care transformation.

[By 2030], 'we'll see widespread adoption of genomics, proteomics, lifestyle data collection and psychological data collection. Intelligent algorithms will be used to enable truly personalised health care and medicines, delivered by clinicians and patients themselves, significantly improving outcomes for conditions such as cancer, CVD and diabetes, as well as underpinning improved psychological and physical wellbeing.

Connected technology will play a pivotal role with home-based devices such as movement sensors, accelerometers, bluetooth inhalers and pill packs, pulse oximeters and intelligent toilets. Data collated from these devices will be used to identify and predict changes in the behaviour of patients at home. This will underpin early interventions by family or healthcare services. This will help improve the outcomes and care experience for patients and families, and reduce avoidable hospital admissions.'

EMIS Health, UK's leading provider of GP desktop systems.

For care to be moved to the community, the NHS information technology strategy must deliver there, too

Darzi says in his recent review that there needs to be a 'Tilt towards technology'.

'While there are many excellent examples of technology having an important impact in the NHS—from virtual wards to remote dermatology consultations—it has not radically reshaped services. The NHS remains in the foothills of digital transformation'.

The extraordinary richness of NHS datasets is largely untapped either in clinical care, service planning, or research.

'There must be a major tilt towards technology to unlock productivity. In particular, the hundreds of thousands of NHS staff working outside hospitals urgently need the benefits of digital systems.

There are many possible technologies that would support more efficient, higher quality, safer care in the community. But they are largely absent. Given the shift in the disease burden towards long-term conditions, there is a greater need for information systems that work across different settings'. **NHS England**

Local NHS IT organisations are required to develop interfaces between community and primary care and ensure operability with acute and mental health trusts.

Procare does provide some back office support, but is this essentially maintenance?

Meanwhile, the NHS is about to spend hundreds of millions more on hospitals' IT, building its Federated Data platform to which both the ICB and RSCH seemed to have signed up.

According to the RSCH website, it is already a user of the NHS FDP

‘Federated Data Platform (FDP)

Every day, NHS staff and clinicians are delivering care in new and innovative ways, achieving better outcomes for patients, and driving efficiency. Scaling and sharing these innovations across the health and care system in England is a key challenge for the NHS.

Harnessing the power of digital, data and technology is the key to recovering from the pandemic, addressing longer-term challenges, and delivering services in new and more sustainable ways.

The Federated Data Platform (FDP) is a software ‘data platform’ which will enable NHS organisations to bring together data – currently stored in separate systems – to support staff to access the information they need in one safe and secure environment so that they are better able to coordinate, plan and deliver high quality care.

A ‘federated’ data platform means that every hospital Trust and integrated care board (ICB) (on behalf of the integrated care system (ICS)) will have their own platform which can connect and collaborate with other data platforms as a “federation” making it easier for health and care organisations to work together.’

The Data Platform Contractor, Palantir Technologies UK, LTD is a processor for this Product. RCSH website.

There is no reference to its installation in the 2023/4 RSCH Annual Report which includes a review of ‘Digital developments’ by the CEO.

What benefits is it bringing? What’s the plan to coordinate with primary and community care?

Are all local organisations intent on working off the same data platform? Can it deliver?

What benefits will the FDP bring for primary and community care?

The ICS also has a data strategy, last details of which were published in 2022.

(Why is the SH website never updated. It could become a governance issue?)

Is the reference in the panel (right) about the same programme?

Or is this a much wider data strategy for the ICS?

Does it remain 'a vision'?

The ICS must have an articulated IT and analytics plan which sets out in detail how the various stakeholders connect, together with measurement points.

A move of patients out of hospital will be hampered if the systems to monitor and support them are not in place.

Is this just another example of imbalance in investment between sectors which needs to be addressed in the budgeting process?

Data

Our work to make Surrey a more integrated system has revealed high levels of duplication and difficulty sharing data, which hinders our ability to deliver more integrated services.

Often, individuals need to provide the same information to multiple agencies, increasing the risk of duplication and errors. Collaborative data sharing and analytics presents a unique opportunity to harness the breadth and depth of data which each organisation in Surrey holds, to ensure that the work we do, both individually and collaboratively, to support our residents, patients and communities is integrated.

The Surrey-wide data strategy sets out a vision to support the sharing of data across different systems and partner organisations in Surrey that will help deliver better care/services to local people now and in the future.

We will develop:

- **A system-wide integrated data and digital platform** – this will initially focus on developing a population health-based approach to health and wellbeing, underpinned by integrated finance modelling, and a shared data security and governance framework enabling data sharing agreements and responsibilities between partners.
- **A system intelligence function** (i.e. the data operating model) – this will enable analytical communities to be better connected to provide the integrated insight and analytical capabilities required for the system. The operating model will create Place/Neighbourhood teams, supported by a centralised hub, to work together in an integrated way to share skills, knowledge and experience, as well as helping each other to perform joint insights and analytics for the local populations they serve.

These teams will support a population health management approach. This intelligence function is a framework which any system partner (including the voluntary, community and social enterprise sector) will be able to participate in.

- **A population health hub** – this will enable the wider system to promote, sustain and spread successful interventions and innovations.

There will be no shortage of data

‘Data integration, principally GP records, Hospital EHR systems and social services records will be fed by already available and continuously developed systems .

NHS England’s Palantir Foundry software includes the Improving Elective Care Coordination for Patients Programme (IECCPP) and the Optimised Patient Tracking and Intelligent Choices Application (OPTICA) pilot’.

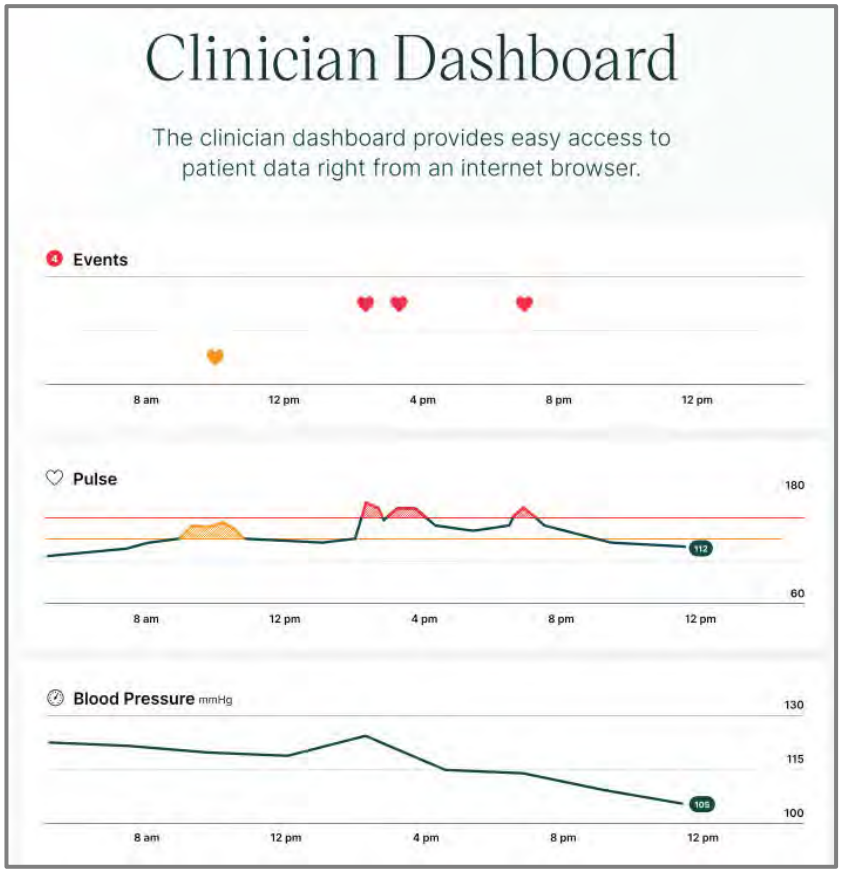
Doccla’s Virtual Ward system is already being used by RSCH.

‘Clinical dashboards that enhance caseload management through holistic views of patient cohorts and visualisations of patient data trends will develop over time.

Integration with electronic patient records to enable flow of coded data from the Doccla dashboard Access to multi-disciplinary clinicians with specialist training in remote monitoring.

New capability is being added continuously.

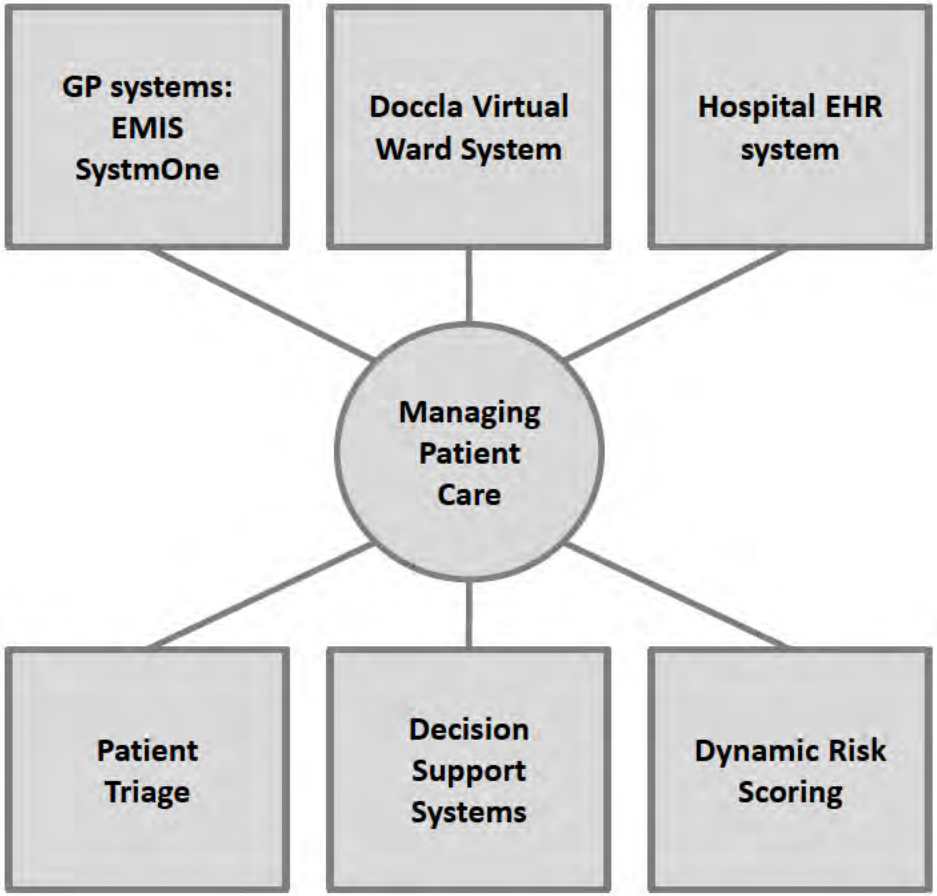
Doccla website



Doccla website.

Much could be achieved by combining the best features of existing locally deployed systems

- Patient management is now supported by a range of digital systems. Locally there are multiple data points in multiple systems:
  - GP patient EHR systems - EMIS and TTP SystmOne - also have many downstream applications to identify at risk patients
  - RSCH operates the Oracle EHR system.
  - Some hospital discharged patients are being managed by the RSCH Virtual Ward Doccla system.
  - A GP triage system is deployed by the Guildowns practice.
  - An expanded primary care back-office capability, linked to a SPA, and operated by a health navigation service, could create a single point of supervision for community-based patients.
- Putting these together will make a real, game-changing difference to patient monitoring.



Technology will monitor health status of patients assigned to MDTs and update risk scores

‘NHS artificial intelligence (AI) giving patients better care and support

The NHS is using AI to predict patients who are at risk of becoming frequent users of emergency services so staff can get them more appropriate care at an earlier stage.

The intervention will ensure that thousands of people get the support they need earlier, while also reducing demand on pressured A&Es.

Over 360,000 patients attend A&E more than five times every year, but now, using data-powered initiatives to identify them, NHS teams are proactively reaching out with support before they walk through the front door of an emergency room.

High Intensity Use (HIU) services use the latest data to find the most regular attendees in their area to identify and resolve the reasons patients are coming forward for care so regularly – often associated with poverty and social isolation.

The NHS has rolled out HIU services to support more than 125 emergency departments across England so far, providing patients with one-to-one coaching support in their own homes to tackle the root cause of why they are visiting A&E.’

NHS England 2024.

People can have their own personal health strategies

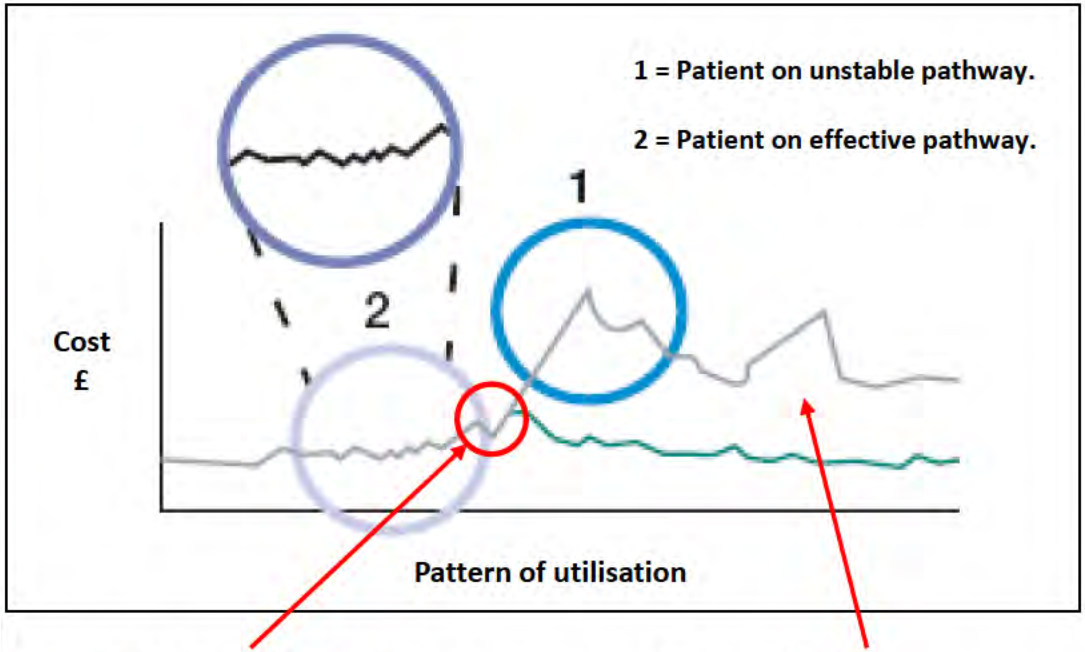
- Health records will be collated, scanned and analysed to create individual risk profiles.
- Those at the top of the pyramid will be managed intensively, usually by MDTs.
- Those lower down monitored to identify emergent risks.
- Systems will send signals to GPs to contact patients.
- Patients missing appointments or not renewing prescription will be identified to enable care pathway adherence.

GUILDOWNS GROUP PRACTICE

THE OAKS, APPLEGARTH AVENUE, GUILDFORD

	Area	Prevalence	Centile
2023	Coronary Heart Disease	1.7%	7
	Asthma	5.0%	23
2022	Cancer	1.0%	21
	Chronic obstructive Pulmonary Disease	1.1%	25
	Hypertension	7.6%	5
2021	Stroke and Transient Ischaemic Attacks	1.1%	16
	Hypothyroidism	2.0%	13
2020	Heart Failure	0.2%	4
	Diabetes	2.7%	5
2019	Epilepsy	0.4%	15
	Mental Health	0.6%	25
2018	Dementia	0.5%	57
	Chronic Kidney Disease	2.8%	42
	Atrial Fibrillation	1.0%	24
2017	Obesity	5.5%	13
	Learning Disabilities	0.2%	30
2016	Depression Screening	3.9%	7
	Depression ever	8.9%	60
2015	Smoking	18.4%	52
	Depression Incidence	0.3%	21
2014	CHD Prevention	0.5%	8

NHS England QOF database.



Identifying these patients is not difficult. The data is there

Harnessing temporal patterns in administrative patient data to predict risk of emergency hospital admission. **Post et al.**

Unplanned hospital admissions are associated with worse patient outcomes and cause strain on health systems worldwide. Primary care electronic health records (EHRs) have successfully been used to create prediction models for emergency hospitalisation, but these approaches require a broad range of diagnostic, physiological, and laboratory values. In this study, we aimed to capture temporal patterns of patient activity from EHR data and evaluate their effectiveness in predicting emergency hospital admissions compared with conventional methods.

Findings Six distinct temporal cluster patterns of primary care EHR activity were identified, associated with varying risks of future emergency hospital admission risk. These patterns were visually interpretable, repeatable at a population-level, and clinically plausible.

For the neediest patients, our vision is for data to be collected and analysed at every point on the care pathway

Patients will be tracked in real time. Each encounter will go into a series of databases which will be read according to need.

Our scheme would factor in previous history from the patient EPR; make an adjusted risk score and begin the aggregation of longitudinal PLICS data.

Patient experience data would also be collected to help understand care outcomes.

This would be additional to the SH data platform and would enable commissioners and providers to make more informed decisions about the effectiveness of the care being delivered at that moment at that care location.

A full clinical decision capability would be incorporated.

'A clinical decision support system (CDSS) is a health information technology that provides clinicians, staff, patients, and other individuals with knowledge and person-specific information to help health and health care. CDSS encompasses a variety of tools to enhance decision-making in the clinical workflow. These tools include computerised alerts and reminders to care providers and patients, clinical guidelines, condition-specific order sets, focused patient data reports and summaries, documentation templates, diagnostic support, and contextually relevant reference information, among other tools. CDSSs constitute a major topic in artificial intelligence in medicine' **Wikipedia**

These models will only get better

‘In this paper, we harness the data-time labels of EHR administrative data, which are automated, low-cost, reliable, ubiquitous, and require minimal data preprocessing.

We aimed to determine the usefulness of the datatime labels using a purpose developed machine learning pipeline (figure 1A) to analyse patient trajectories as manifested in EHRs and read their temporal activity (figure 1B) and show it can enrich the performance of emergency hospital admission prediction compared with a conventional approach.’

Each of these patient interactions produces multiple data points, often collected by different systems.

The win is in their collation, combining Hospital and GP data which is do-able.

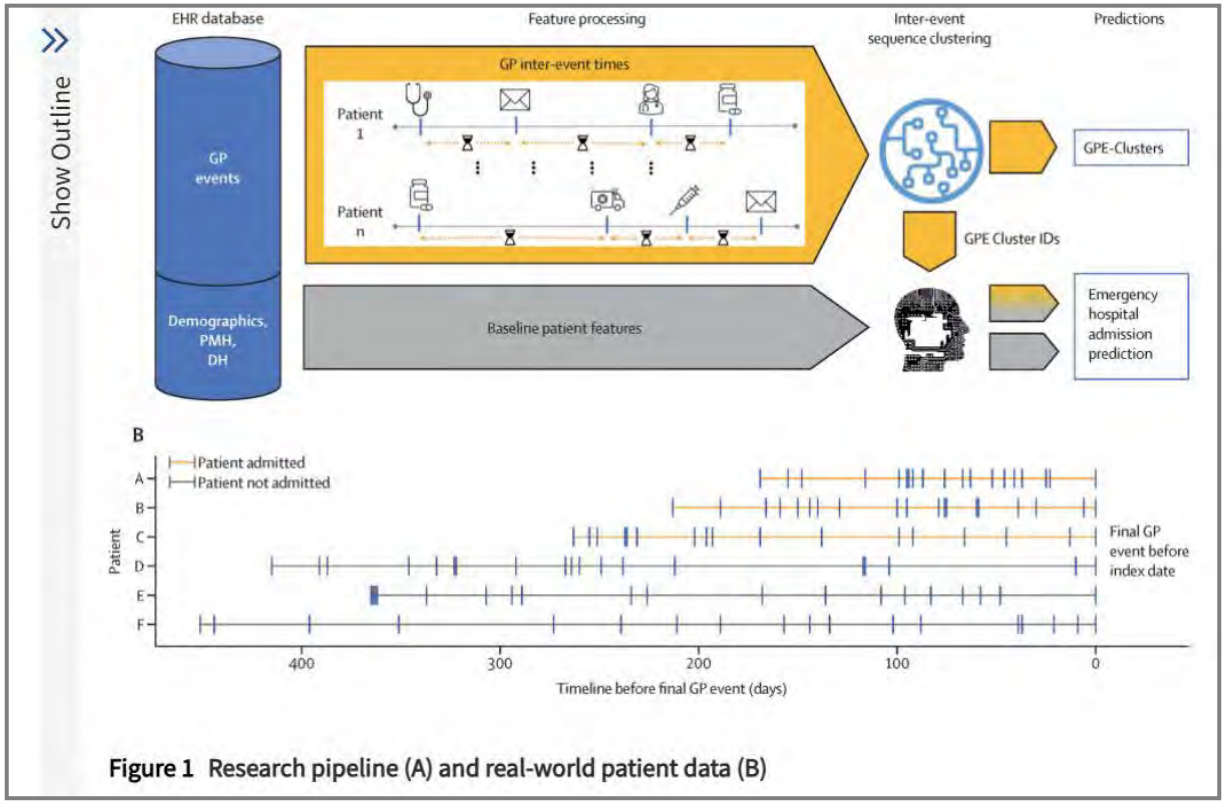
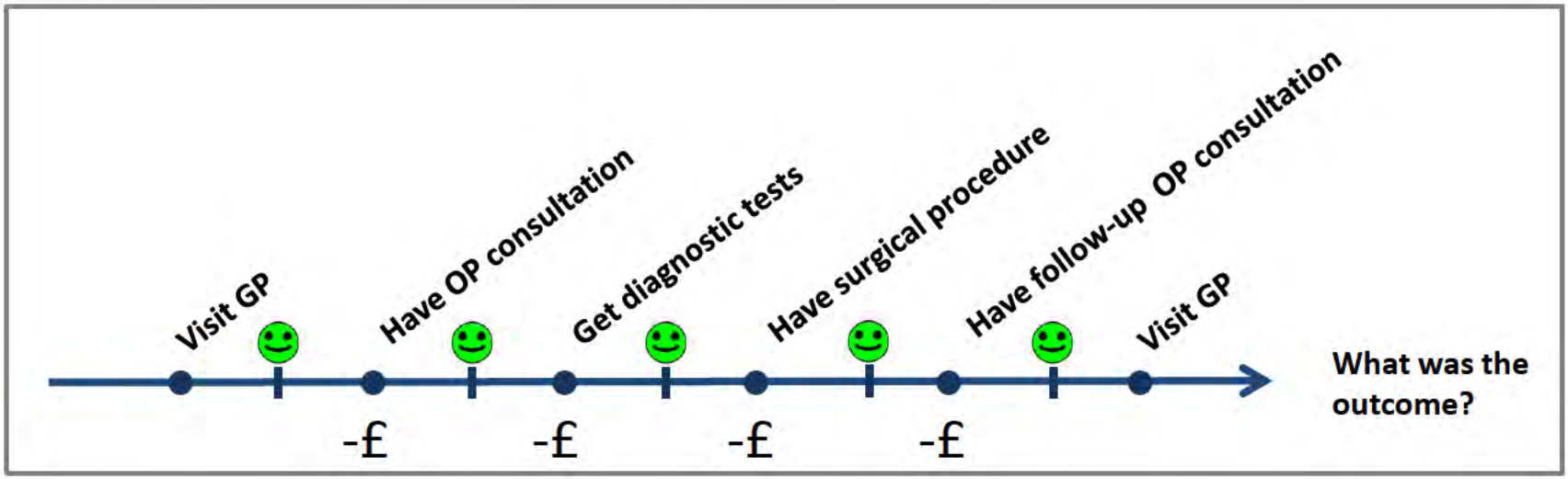


Figure 1 Research pipeline (A) and real-world patient data (B)

https://www.thelancet.com/action/showPdf?pii=S2589-7500(24)00254-1

This is a simplification of the previous slide. All encounters are recorded in granular detail

- Considerably more data is available, also enabling quality and cost information for each episode of care.
- As soon as the care episode is recorded this can update the health record, providing input to a decision support system
- Care staff can then determine the timing of the next scheduled intervention.



Once you record episodes of care it is relatively easy to attach cost details and begin to find real value

- Greater engagement of clinicians in costing and financial decision processes, which empowers them to make decisions in the best interests of patients, being fully aware of the cost implications.
- Improved data quality, in all data feeds, helping national submissions and local commissioning datasets to capture procedures more fully.
- Better understanding of the service area's information, to allow better resource and business planning.
- Better quality data for use in negotiation of local tariffs and variations, or to support business cases for commissioner agreement.

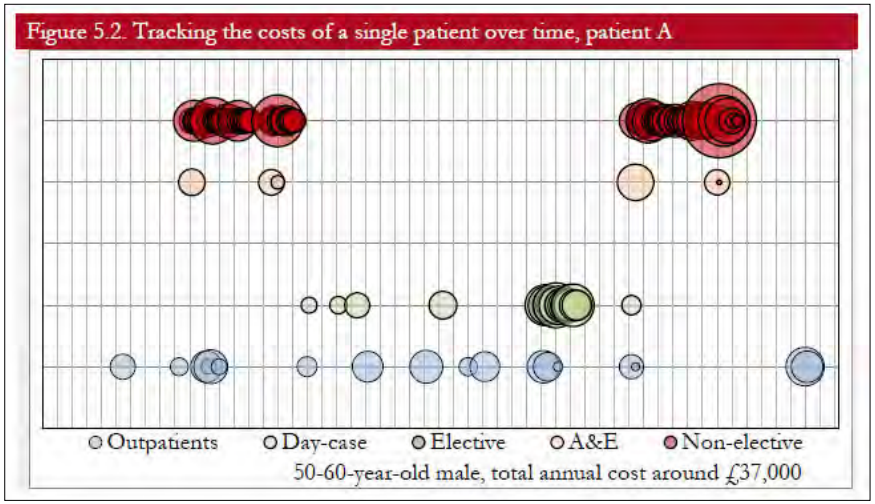
'Patient-level costing: case for change', NHS Improvement, April 2016.

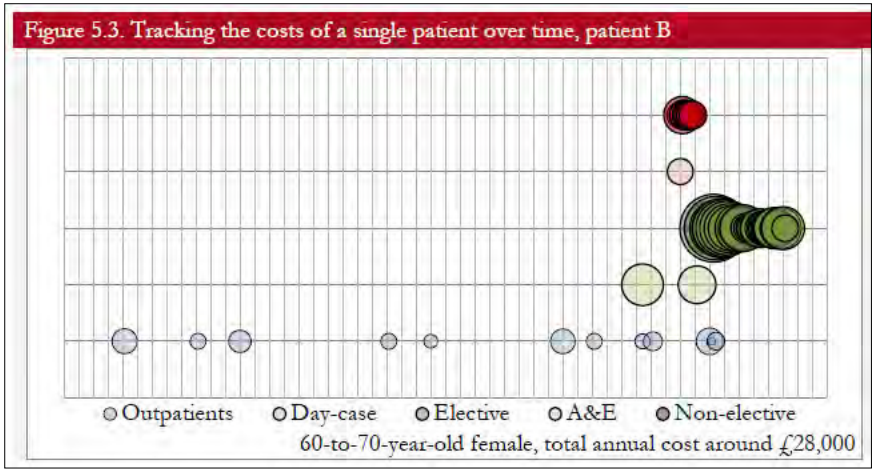
PLICS has been used in community services settings. Technology has been developed that can allocate costs from the individual patient's electronic health record to build a financial history.

For all community activity, the trust's clinicians use the same system to record patient contacts and interventions. To log on, everyone uses a 'smartcard', so that every entry on the system can be tagged with the clinician's 'done by' details (first name and surname).

A reference table can then be used to map each 'done by' to an ESR assignment number. This assignment number can in turn be used to create cost pools from the payroll transactions in the general ledger.

Lincolnshire Community Health services NHS Trust.
'Improving the quality of source information for costing in acute and community services', HFMA, February 2016.





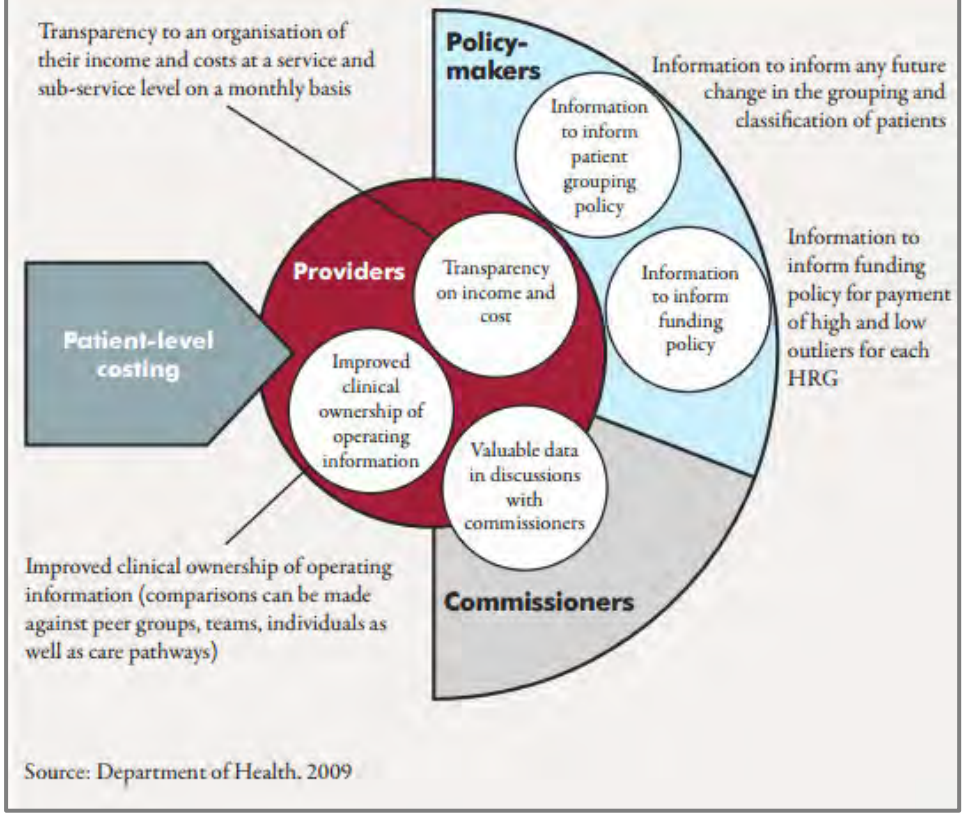
PLICS can provide real insights into individual pathway costs and enable re-design

- PLICS (patient-level information costing **system**) is a system to derive costs at the patient level. It is IT software (and sometimes infrastructure) locally installed and supported by the provider or the provider's preferred supplier.
- Patient-level **costs** (PLC) are an output of the PLICS system.
- Patient-level cost **recording** is the act of providers inputting data into the PLICS system.
- Patient-level cost **collection** is the process of providers submitting data to NHS Improvement on a national basis (taking over from the Department of Health (DH) in 2019).

'Costing transformation programme. Patient-level costing: case for change', NHS Improvement, April 2016

'PLICS allows organisations to identify variation against standardised bundles or pathways of care, between clinical teams, or between different groups of patients. When PLICS is analysed alongside other performance and quality information it becomes even more powerful in understanding the delivery and performance of services.' **NHS England.**

Figure 8: The potential benefits of PLICS, as set out by the Department of Health, showing the main potential beneficiaries



'Patient-level costing: can it yield efficiency savings?', Nuffield Trust, September 2012.

PROMS (Patient Reported Outcomes Measures) should be part of the monitoring system, beginning with high risk patients

'*The national Patient Reported Outcome Measures (PROMs) programme, begun in 2009, collects information from patients about how well the health service is treating them.*

PROMs allows NHS organisations and clinicians to understand the difference that health care interventions make to people's quality of life.

The national PROMs data can enable provider trusts to identify specific areas in which patients feel they struggle/excel during their recovery. This can help trusts to review their care pathway, e.g. to better inform what after-care programmes they might consider introducing.

In choosing to participate in the national PROMs programme, patients complete questionnaires asking about their quality of life before and after surgery'. **NHS England 2015.**

'PROMs provide information of particular salience for quality and performance measurement across five categories: health-related quality of life, functional status, symptoms and symptom burden, health behaviours, and the patient's health care experience.

Many PROMs are intended for use in populations with chronic illnesses. There are a considerable number of PROMs in relation to physical, mental, and social health, particularly for long-term conditions.

Another type of PROM measures functional status, a patient's ability to perform both basic and more advanced (instrumental) activities of daily life. Some may address a very specific type of function (e.g., Upper Limb Functional Index) or be developed for use in a specific disease population (e.g., patients with multiple sclerosis), whereas others may be appropriate for use across chronic conditions'. **National Library of Medicine (US), 2015**

The initiatives we have outlined will need to be validated. There are third party suppliers who can do this.

New health delivery programmes are often treated with suspicion. There is a strong tendency to maintain the status quo.

Change will only be introduced successfully if it is evidence-based.

A progression to service line delivery will need to measure costs and outcomes.

There are established suppliers of these services (other solutions are available).

My Clinical Outcomes

My Clinical Outcomes (MCO) is a patient and clinician-facing web-platform that automates the collection and analysis of Patient Reported Outcomes Measures (PROMs) and Patient Reported Experience Measures (PREMs) in routine clinical practice. The video below gives an overview of what we do.

MCO bring over a decade of experience and expertise to support flexible implementation around existing clinical workflows and ensure ongoing success and high value from launch.

The availability of this information *at scale* will enable users to interrogate databases for their own needs

The micromanagement of the patient becomes possible as more and more data is assembled.

Millions of patients, particularly those with challenging conditions, are today under continuous observation.

The data will provide extraordinary insights to the care provided and its variation.

We will better understand the cost of care for individual patients and cohorts of patients, assisting population health management.

It will address instances of unwarranted variation in care provision, estimated to cost the NHS £billions annually.

All of this is only possible if patients have a combined record of changes in health status, diagnoses and care administered.

Medical practice will be impacted profoundly by the ability of machines to read health information and AI to assist diagnosis

Clinical decision support will be promoted as soon as there is a single coding system in place covering the entire patient health care experience.

Health systems across the world are already seeing how clinical decision support is improved by the machine reading of electronic health data.

This data is being used to modify clinical guidelines and impact pathway design.

The information can be used either as physician support or as an aid for patients whereby the latest information received can be analysed, interpreted and turned into alerts, reminders or follow-ups.

How AI will be applied to health care datasets - an introduction

'The use of Artificial Intelligence can provide unique solutions for health care providers and commissioners.

The process extracts the data available from health service records relevant to the task specified by the requesting health care provider. The output will be a dataset that is used to train a Neural Network.

The health care provider supplies the initial input to the workflow in the form of a specified programme and any pre-defined patient cohort parameters. The specification includes the conditions that are to be screened, along with a definition of the set of patients to be considered. Patient cohort parameters include limitations to be imposed upon the system - such as number of patients or balance of patients within the cohort.

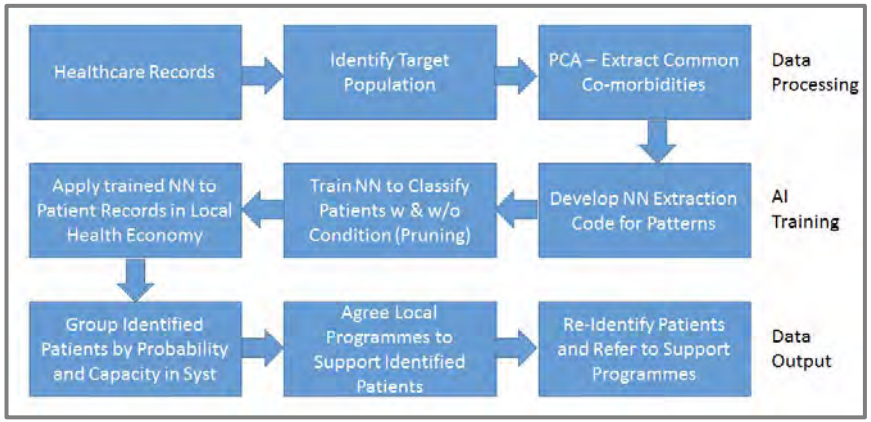
The trained Neural Network then processes the data to provide a business solution for the requester.

Health care records are analysed using the requirements, identifying a target population. Primary Component Analysis is applied to the target population to define the input data set for the neural network.

The workflow diagram shown on the next page covers the stages in producing a patient cohort for screening - from the full patient data set through to provision of a patient cohort to the health care provider.' **i5health**

This is how the AI work flow happens

The workflow diagram shown below covers the stages in producing a patient cohort for screening from the full patient data set through to provision of a patient cohort to the Healthcare provider.



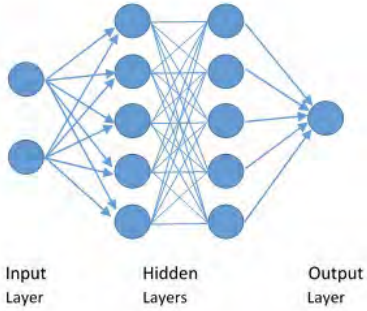
'A neural network is a machine learning programme, or model, makes decisions by using processes that mimic the way biological neurons work together to identify phenomena, weigh options and arrive at conclusions.

Every neural network consists of layers of nodes, or artificial neurons—an input layer, one or more hidden layers, and an output layer. Each node connects to others, and has its own associated weight and threshold. If the output of any individual node is above the specified threshold value, that node is activated, sending data to the next layer of the network. Otherwise, no data is passed along to the next layer of the network.

Neural networks rely on training data to learn and improve their accuracy over time. Once they are fine-tuned for accuracy, they are powerful tools allowing us to classify and cluster data at a high velocity'. **IBM**

Network

The network needed is multi-layered and uses a back propagation algorithm often called a Multilayer Perceptron (MLP).



The training data set is applied to the network. As the training continues, the generalisation data set is used to check the progress of the network training. The stopping criteria is set as the point at which the generalisation error is minimised.

Following training, the network to can be analysed to ensure optimisation. Nodes within the network that do not contribute to the output may be pruned.

The trained network and can then be used to analyse the data for all patients in the target cohort as defined by the healthcare provider.

Our AI is based on **Deep Neural Networks** and is trained and tested on **millions of medical records** and used for screening programmes, hospital optimisation, reducing complications and health and well-being programmes.

i5health

Decision support systems will work off the data fed into patient record systems

Intelligent: CDS systems need to be evidence based and address real-world clinical decisions that would benefit from best practice support. Self-generated data can be used to guide iterative improvement.

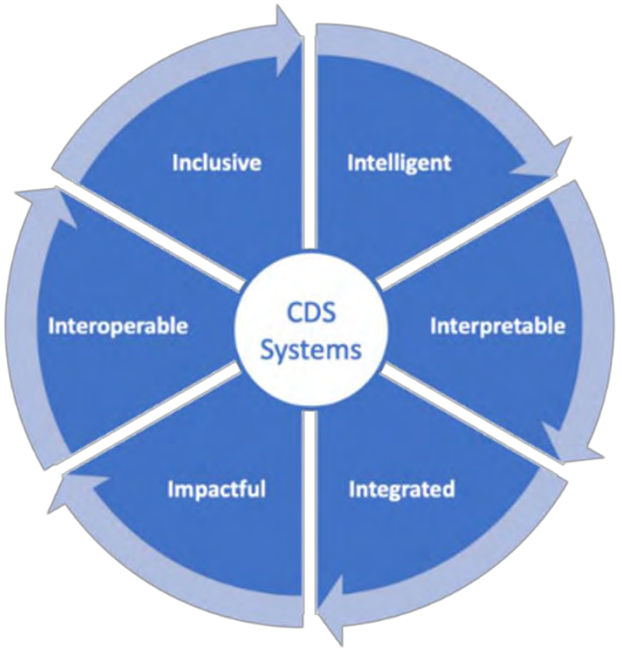
Interpretable: CDS systems need to consider the healthcare professional's knowledge of the topic, use clear and unambiguous content, and demonstrate validity and reliability of recommendations by linking to relevant explanations or evidence.

Integrated: CDS systems need to be designed to complement workflows. Integration with clinical systems can increase impact by embedding decision support in clinical workflows.

Impactful: CDS systems need to consider the experience of users, improve productivity and outcomes, and be clinically safe with mitigations made to reduce potential risks.

Interoperable: CDS systems need to interpret clinical data from systems to minimise manual data entry and present result data within relevant clinical systems by using open application programming interfaces (API) whenever possible. Where a relevant computable knowledge library is available, the CDS system should be configured to import high quality knowledge objects coded using global knowledge standards (Wyatt and Scott, 2020).

Inclusive: CDS systems need to consider a broad range of end users, be based on trusted clinical data that is representative of the target population and help minimise health inequities by standardising care.



'Supporting clinical decisions with health information technology', NHS England.

Knowledge management – Guildford's opportunity

Which local organisation will take the lead in data management and analytics?

‘The lessons from public- and private-sector actors aiming to develop AI in healthcare to date suggest that scale matters - largely due to the resources needed to develop robust AI solutions or make them cost-efficient.

Smaller organisations can benefit from working in innovation clusters that bring together AI, digital health, biomedical research, translational research or other relevant fields.’
McKinsey & Co.

For the whole GW Alliance system to function efficiently and collaboratively it should work off a common data set .

Both the hospital and practices have their own freestanding patient record systems.

Combining the two would deliver quick wins - early identification of at-risk patients in the community, for example. We have covered this in detail in previous presentations.

We understand there have been Surrey-wide initiatives which could provide long term solutions.
https://mycouncil.surreycc.gov.uk/documents/s92184/Item%208%20-%20Appendix%201%20-%20Surrey%20Wide%20Data%20Strategy.pdf

Is there a role for Healthcare Partners Ltd, the RSCH subsidiary?

There are sufficient local initiatives which could lead to combinatorial, marketable, new product opportunities.

With the possibility of Guildford becoming a centre of excellence.

Can Guildford find its own R&D niche? Care pathway analytics might be one of them.

The intellectual wealth of local institutions could create a strong foundation for Guildford's economic development

Is there an opportunity to build on the value added by the University?

RSCH says 'we have a Research & Development strategy which we will deliver to attain "University Hospital" status – an external accreditation which would recognise our expertise in R&D and more closely bind us and our partner University of Surrey'.

'This will increase our attractiveness to staff, enhance our reputation and lead to more research and development opportunities'. **RSCH Strategy 2022-25.**

EXECUTIVE SUMMARY

The Determinants of Regional Innovation Capacity and Economic Competitiveness

The central economic goal for regions should be to attain and sustain a high and rising **standard of living** for their citizens. The ability to earn a high and rising standard of living depends on increasing **productivity**, which in turn depends on innovation. The central challenge then in enhancing prosperity is to create the conditions for **sustained innovation output**.

A critical driver of innovation output, and one not well understood by academics and policy-makers, is the quality of the regional business environment in which firms operate. This environment is embodied in four broad areas that affect the productivity that can be achieved as well as the rate of innovation. (See Exhibit 1 below).

Exhibit 1: Determinants of Regional Productivity

This could see the town make substantial GVA gains

In the academic year 2021/22, the University of Surrey generated:

- £1.1 billion GVA and 14,500 jobs in the Borough of Guildford;
- £1.3 billion GVA and 17,620 jobs in the County of Surrey; and
- £1.9 billion GVA and 25,360 jobs across the UK.

Medical Research

Medical Research generates both health and economic benefits. Not all these benefits can be quantified but those that can are substantial.

The University of Surrey is well regarded for the quality of its health-related research. It ranked 6th in the 2021 UK Research Excellence Framework for research power for health professionals[23] and has a strong track record of working with and on behalf of national charities, research councils, other universities and research institutes.

Adopting a service line approach, operated to best practice by properly funded, equipped and staffed units could create a differentiated, competitively advantaged asset for the town.

Each service line could easily become a new business opportunity. Developing and marketing a best-of-breed model for use across the NHS should attract investors.

Guildford seems exceptionally well-positioned to build this capability as we pointed out before

Organisation	Competences
Royal Surrey County Hospital	Patient care, hospital management, estate planning, contracting, analytics, IT, Surrey Care Record, Doccla Virtual Ward System, NHS Foundry. Surrey Safe Care
Its subsidiary company, Healthcare Partners Ltd https://www.healthcarepartnersltd.co.uk/	Management consultancy, project management, patient pathway design, supply chains, medical device management, clinical support
Surrey Heartlands ICS	Commissioning, care procurement, finance, strategy, estate planning, contracting, IT/Informatics, analytics. Health tech accelerator programme with University of Surrey
Procare https://www.procarehealth.co.uk/about-procare/	Primary care network coordination, community health, out-of-hours service, GP back office services, practice record coordination, management consultancy, IT support, contracting, project management
Guildford and Waverley Health and Care Alliance	Local NHS HQ, system coordination, strategy, finance and budgeting
PCN GP practices	Primary care, patient records, other GMS and PMS services, contracting
University of Surrey School of Medicine	Medical school, AI, Machine Learning, Research, patient risk stratification, hospital management, clinical placements with providers and commissioners
University of Surrey Faculty of Health and Medical Sciences	Undergraduate and graduate programmes –biochemical sciences, clinical and experimental medicine, microbial sciences, nutrition
Surrey Research Park collaborators	Local companies with health care tie-ins including diagnostics, genomics, therapeutics, molecular imaging, cloud solutions
Surrey County Council	Public Health Data. See Surrey-wide Data Strategy, SODA, also Integrated Care System (ICS) strategy

The Royal Surrey County Hospital

The Royal Surrey Hospital is by a long way the dominant player in Guildford health care delivery

Foundation Trusts are truly big businesses, the most skilfully managed in the NHS with all the panoply of professional services (including media relations).

In all local health systems, it is the acute trust (formerly the general hospital) which dominates.

The Royal Surrey has an annual income of around £500 million.

Local GPs receive less than £20 million.

Community health services (of which RSCH is a joint venture partner) about £19 million.

In NHS terms, the Royal Surrey is a smallish general hospital in a small town with the country's 4th largest cancer centre attached.

For its size, the hospital has one of the strongest balance sheets amongst acute FTs.

The Royal Surrey has been a massive beneficiary of the government's Provider Sustainability Fund.

In the past seven years this programme has contributed over £100 million to RSCH reserves through the most skilful business management.

While in its annual accounts the money is described as 'Taxpayers' Equity', the hospital would argue quite reasonably that as it sits on their balance sheet and is rightfully theirs.

But is it morally theirs? It is likely that some patients might have made sacrifices for it to have been secured.

It is on the Hospital's capital account. Throughout this report we make an argument for some of it to be invested on capital projects in the community.

These arrangements need not be dilutive. There is a strong case for the investments to bring a positive return for the Royal Surrey

The RSCH strategy is well articulated. But it now needs to be executed.

The Royal Surrey's strategy

The Royal Surrey is an award-winning organisation and we are proud to be unique in the NHS as we provide three integrated types of care in our organisation. Firstly, we provide acute secondary services – 'normal' hospital services dedicated to the health needs of the local population of approximately 400,000 people across South Surrey. Secondly, we took over the adult community services in Guildford and Waverley in 2018, making us an integrated Trust, and giving us a step-change in our ability to wrap services around patients outside of the walls of our main hospital site. Finally, we are a major tertiary cancer centre offering a range of services for patients across the South East of England for all but the most rare tumour groups.

The Trust was inspected by the Care Quality Commission (CQC) in March 2020 and Use of Resources, Medical Care, and End of Life were rated as outstanding, and Urgent Care as good. The Well Led review was paused and therefore the overall Trust rating has remained unchanged due to the pandemic. The Trust is currently rated as 'Good' overall and 'Outstanding' for responsiveness.

RSCH: Annual Report 2023-24.

Overview of the Trust

The Royal Surrey is an award-winning organisation and we are proud to be unique in the NHS as we provide three integrated types of care in our organisation.

Firstly, we provide acute secondary services – "normal" hospital services dedicated to the health needs of the local population of about 400,000 people across South Surrey.

Secondly, we took over the adult community services in Guildford & Waverley in 2018, making us an integrated Trust and giving us a step-change in our ability to wrap services around patients outside of the walls of our main hospital site.

Finally, we are a major tertiary cancer centre offering a range of services for patients across the South East of England for all but the most rare tumour groups. Currently about 50% of all activity that takes place in the Trust is concerned with the diagnosis, treatment and after-care of patients with, or suspected to have, cancer. Because of these capabilities, we are able to treat patients with cancer more holistically than some other specialist cancer centres (for example if the treatment causes issues with their heart or other organs, we have the specialist doctors onsite able to treat these issues too). The Trust was inspected by the Care Quality Commission (CQC) in March 2020 and Use of Resources, Medical Care and End of Life were rated as outstanding and Urgent Care as good. The Trust is currently rated as 'Good' overall and 'Outstanding' for responsiveness.

RSCH: our strategy 2022-25.

The RSCH has done its own SWOT analysis, which says a lot about priorities and culture. The annotations are ours.

STRENGTHS **Page 1**

- As a tertiary cancer centre we provide surgical and oncology specialist care whose excellence is nationally recognised.
- We are the fourth largest cancer centre in the UK and the second largest provider of robotic surgery.
- Staff satisfaction is top decile, the "Royal Surrey Family" is not a tagline, and it is felt keenly by all our teams.
- Our nursing fill rate is one of the highest in the country, aided by robust overseas recruitment.
- Significant investment in Quality Improvement and transformation teams, embraced by clinical champions.

RSCH: our strategy 2022-25.

The cancer centre occupies the first two bullets of 'Strengths'.

The RSCH doesn't choose to say how good it is as a DGH or recognise departmental strengths (of which there are many).

Are they a secondary priority to being an excellent oncology centre?

Elsewhere, we learn that 60% of its surgery is cancer related.

How good are non-cancer RTTs compared with those for general surgery?

How much does the financial contribution of being a cancer specialist occupy management time and influence decision-making?

What's its net revenue contribution to RSCH?

Which might subsidise which? Is cancer subsidising non-cancer? Has RSCH undertaken a comprehensive Service Line Analysis?

Certainly, the cancer-related margins should benefit from being on the Specialised Commissioning tariff.

What proportion of the capex spend goes to non-cancer activity?

The RSCH doesn't record its robust financial position as a strength, nor its ability to consistently hit targets, both of which are core competences.

Has its pursuit of STF/control targets been in the patient interest?

The RSCH has done its own SWOT analysis, which reveal a lot about priorities and culture. The annotations are ours.

STRENGTHS **Page 2**

- Establishment of subsidiary companies driving better performance and improved value.
- Financial performance strong over five years, CQC Use of Resources "Outstanding".
- Integrated Trust, running our acute and adult community services across G&W.
- Very strong track record in R&D, particularly in some growing areas such as AI as well as Covid trials.
- Good relationship with the University of Surrey with whom we share a campus and collaborate on an increasing volume of work.

RSCH: our strategy 2022-25.

How well is the integrated trust community services JV partnership working?

How has it developed since inception?

How does it measure success? There are no metrics.

Does AI capability development have its own plan? Are data and analytics getting the attention they need?

Is Health Partners Ltd's capability being properly leveraged? What are its priorities/opportunities?

What has any initiative with Univrsity of Surrey delivered to date? What's in the pipeline?

Weaknesses

WEAKNESSES

- We are an organisation, like all those in the NHS, still recovering from the effects of Covid.
- Royal Surrey is an important, but not large, Trust in the system and we have some services which rely on small teams and are thus less resilient.
- Some of our areas of clinical specialism have a national shortage of staff to which we are exposed.
- IT maturity improving but historically under-invested.
- Our community estate (owned by NHS PropCo) has been significantly under-invested and requires improvement.
- Communicating about our achievements and successes.
- Our Trust has only one main acute site where we see emergency patients and can perform elective operations. This means we currently have no ability to protect services from pressures such as raised emergency demand or the impact of a pandemic in the way that other Trusts with multiple hospital sites have been able to.

RSCH: our strategy 2022-25.

Royal Surrey is ‘not large’.

What are its priorities for growth?

Does it plan to grow horizontally or vertically?

Can it do more to insulate itself against emergency demand and other pressures?

There is a compelling argument for strengthening up-stream involvement to regulate demand.

Where does it fit in the hub and spoke strategy? What are its strengths and weaknesses in this set-up?

How will it deal with legacy ‘community’ real estate – refit or rebuild?

Is its financial strategy working to the benefit of stakeholders, including patients?

Should it be concerned about its media coverage

Opportunities

OPPORTUNITIES

- Working with the ICS to improve outcomes, tackle inequalities, enhance productivity and support social and economic development.
- Work with Integrated Care Partnership (ICP) to reduce urgent and emergency care demand with primary and social care through a new Urgent and Emergency Care Strategy.
- Better care for our frail population through an ICP Frailty Strategy.
- We will seek 'University Hospital' status acknowledging that this award is changing to reflect a greater focus on systems in line with government policy.
- Deliver the promise of Surrey Safe Care, our electronic clinical system, to transform the way we use data in care.
- Multiple opportunities to improve cancer diagnosis, treatment and care through new techniques and technologies.
- Better system working will enable us to share data such as scans and records securely across more partners.
- Use system partners to help support any services we have which are small and lack resilience.
- Better working with primary care networks to case manage our population, reducing cost and inequality.
- Working within a provider collaborative will help share best practice and resource to increase resilience.
- Innovative new roles to support medical staffing challenges.
- Opportunities to leverage our partnerships with private providers to enhance our services or increase income (active examples include supporting Royal Surrey with reducing our long-waiting patient list, radiotherapy provision and imaging scans).

RSCH: our strategy 2022-25.

Where's the evidence of the 'joint effort' to tackle equalities?

For Guildford, it should be addressing the neighbourhoods to the north of the A3, but we see no effort to strengthen community care. What are the plans?

Biggest breakthrough will be the ability to identify high risk patients in the community, those likely to be unscheduled care admissions for the hospital. This is the real case management opportunity.

What is the current programme?

Is the provider collaborative only operating at acute FT level?

What about other upstream collaboration opportunities?

Is everyone on board with private sector partnerships? Is the ICB ready with contracts and budgets?

Initiatives to create a greater focus on systems could be advanced without the need to have 'University Hospital' status. We have indicated many in this report.

Threats

THREATS

- Ongoing impact of Covid, new waves or variants, plus a resurgence of flu.
- Growing demand from older, sicker population exceeding local resources.
- ICS or national programmes of work may impact our ability to determine our own future and affect our patients and services.
- Development of ICS could cause duplication in governance and risks distracting senior leaders from their Trust focus.
- New hospital in Sutton run by St George's Healthcare may reduce our activity from that area and may attract staff away from RSFT.
- Unexpected impacts as Britain's future out of the EU becomes clearer.
- Availability of medical workforce in some areas is nationally limited.

RSCH: our strategy 2022-25.

Demand for health care is insatiable, particularly when it is free at the point of demand.

The NHS understands that it will never meet the public's expectations and does its best with funding which in real terms is not increasing nor maintaining parity with developing population and other societal trends.

The Royal Surrey's vulnerability is its relatively small size.

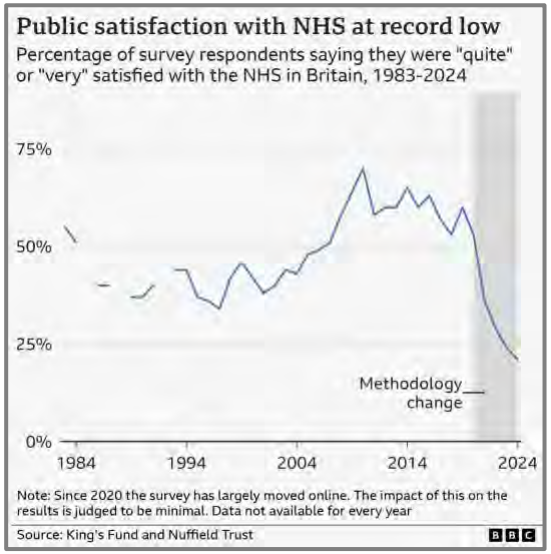
Its local reputation is currently good, but this might change if there are circumstances which create excess demand.

This is most likely to occur when performance standards fall. This will lead in the first instance to reputational damage and media interest.

We believe that this is an exposure for the RSCH as increasingly large numbers of patients will arrive at its doors.

Its current performance metrics are not good.

The panel (left) raises external interference as a threat to RSCH autonomy. Should it be more open?



Another threat? The rebuilding of Frimley Park Hospital is likely to cause some disruption for other local acute trusts

The Chief Executive provided a presentation on the background of Frimley Park Hospital. It was outlined that Frimley Health NHS Foundation Trust ("The Trust") had over 13,000 staff that worked across 10 sites and within patients' homes.

The Trust served a population of around 900,000 people with an annual turnover of £1 billion and was classed as a large NHS Trust.

Modelling showed that the current capacity of the hospital's facilities would not meet future demand. Emergency Department (ED) capacity was 20% greater than in 2019/20 during three peak points in summer 2023.

Frimley Park Hospital currently has 640 beds, which did not meet the current or future demand. The current building was old and not suited for the delivery of the needed clinical model. 64% of Frimley Park Hospital was constructed of RAAC, which was first discovered in 2012 and was widespread throughout the hospital.

Several emergency preparedness sessions had also been run. Frimley Health NHS Foundation Trust had the deadline of 2030, as set by the Department for Health and Social Care to stop using the affected parts of the current hospital site.

Frimley Park Hospital website.

What contingency plans are being developed for RSCH given that it is already at capacity. Where will people go?

The RSCH business plan and funding are set up to deliver and grow the hospital's agenda

The Hospital vision and strategy are well articulated.

The RSCH has by the standard of any acute FT a strong focus on its purpose as a hospital.

The future seems to be about an extrapolation of the status quo.

Its strategy is the board's charter which is self determined.

It has no obligation to participate in any DHSC or NHSE policy changes not directly affecting the hospital – to help with the establishment of a local integrated care plan, for example.

This means that the local ICB has few levers to drive change – the annual contracting cycle, operating budgets and public opinion are the most likely.

There are many instances across the country where the local hospital gets more than its reasonable share of local funding.

However, at the end of the day, the hospital is solely funded by taxpayers' money.

The ICB has a wider duty of care for the general population.

How can the ICB be certain that the current allocation is the best one for the population as a whole?

Should the RSCH become the organiser of a total health care system?

Having a full-blown, discrete community care business unit will enable it deliver many real benefits for the system.

It will reduce the load at the hospital's main site enabling it to focus on the important priorities of being a district general hospital.

But it will also make the co-ordination of resources more flexible, dealing with issues in what are both care pathways and supply chains.

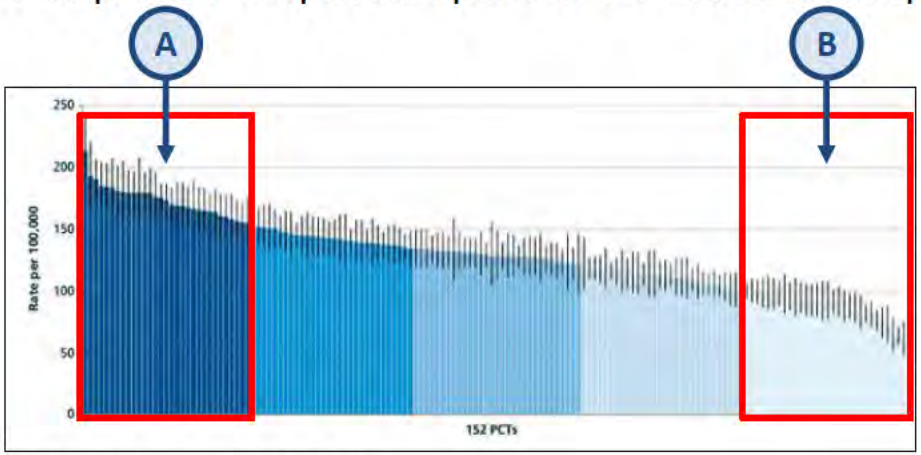
It will operate better as a unified system.

Having the ability to integrate budgets would enable it to invest where there is more benefit – financially and for better outcomes.

We have outlined our proposals for the cancer centre and Healthcare Partners Ltd previously.

Is the answer to attempt to smooth demand, rather tackle the challenge of irreducible waiting lists?

- There is no silver bullet to managing waiting times
- Tackling the NHS waiting list involves a multi-faceted approach focusing on increasing capacity, improving efficiency, and addressing under-resourced parts of the system .
- Key strategies include expanding primary care and diagnostic capacity, utilising technology, streamlining processes, and more effective collaboration across different care settings.
- Are all medical specialties being adequately resourced?
- Has the RSCH identified bottlenecks and is attempting to reduced them.
- How good is the hospital at allocative efficiency – that budgets are being spent equitably? The chart shows how for every condition, across hospitals in the NHS, there is a variation in the number of patients treated in commissioner localities.
- Is it comfortable that is managing unwarranted variation?
- Both are likely to be present in upstream parts of the health care supply chain.

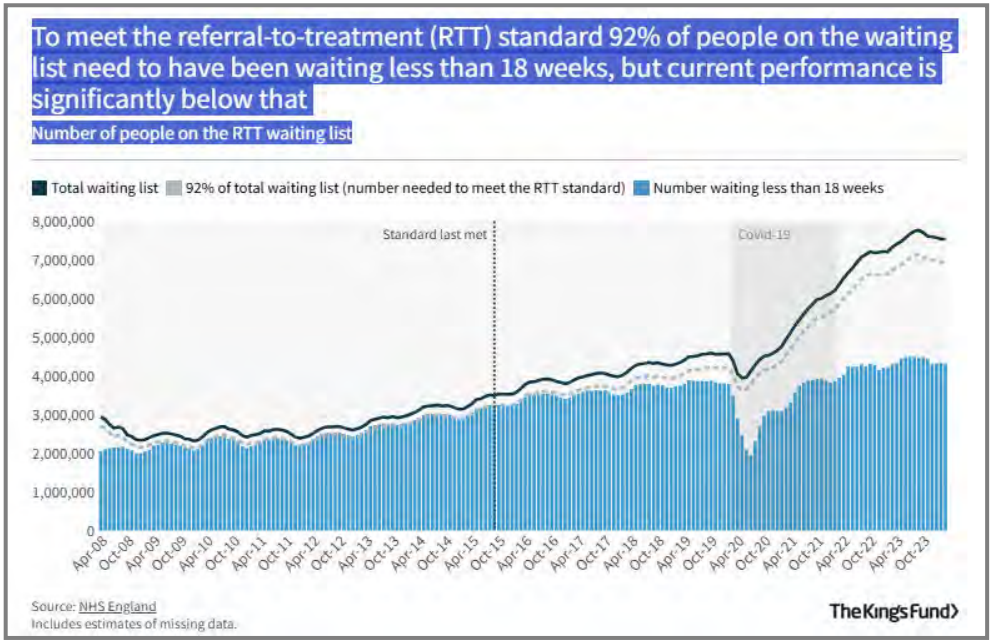


Map TT.1: Rate of hospital-admitted procedures for benign prostatic condition per population by commissioner.
NHS RightCare Atlas.

RSCH performance: meeting the referral-to-treatment (RTT) standard is an NHS Constitution standard

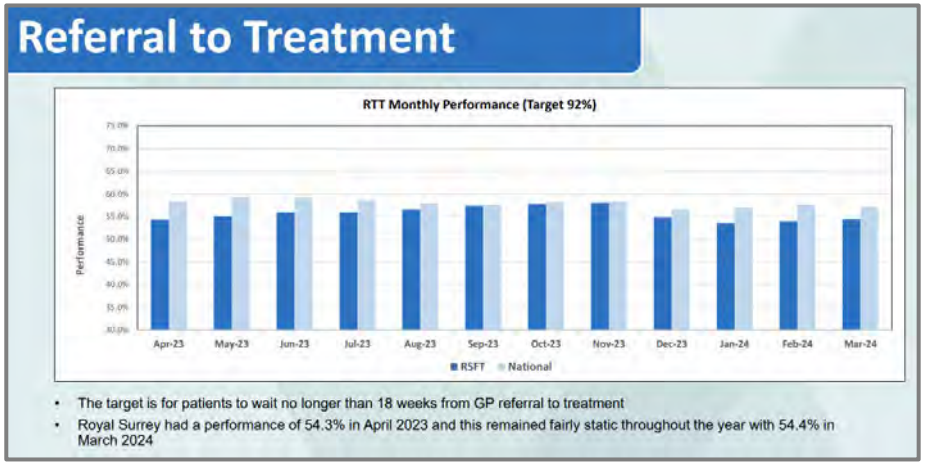
The NHS Constitution sets a standard that 92% of people waiting for elective (non-urgent) treatment (such as cataract surgery or a knee replacement) should wait no longer than 18 weeks from referral to their first treatment. This standard was last met in September 2015. Since then, performance has declined steadily, until the Covid-19 pandemic, when it deteriorated rapidly. Performance has stabilised more recently, but the waiting list remains high, at 7.5 million in March 2024. As some people may be on the waiting list for multiple conditions, this equates to 6.3 million unique patients.

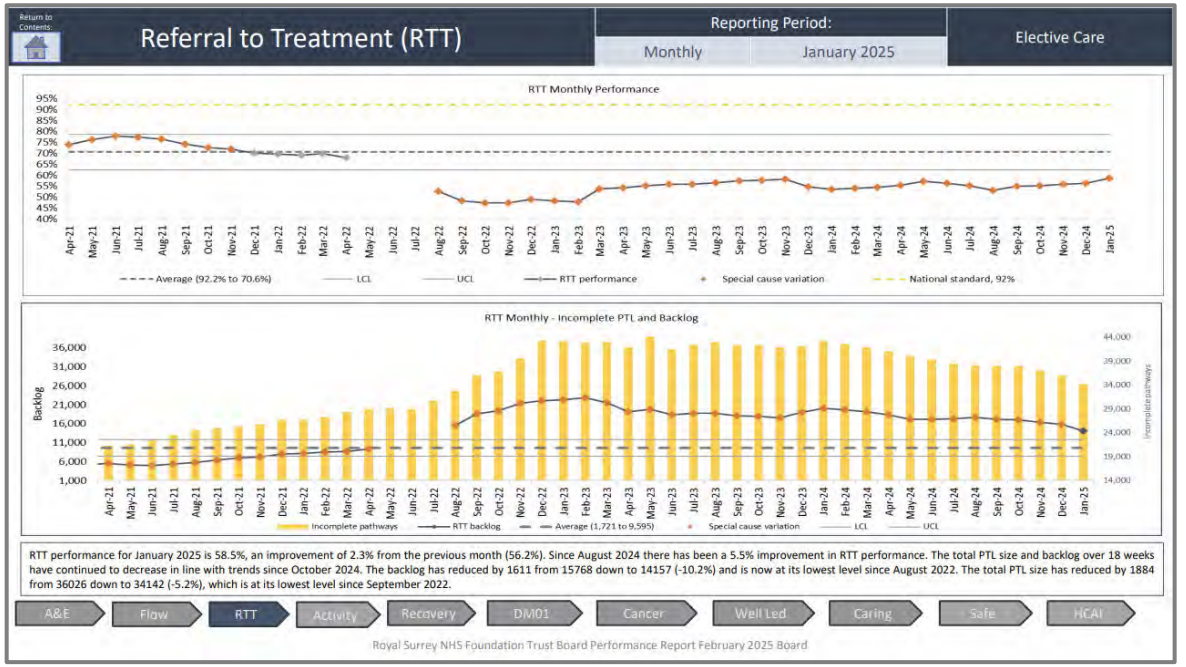
To meet the referral-to-treatment (RTT) standard 92% of people on the waiting list need to have been waiting less than 18 weeks, but current performance is significantly below that.



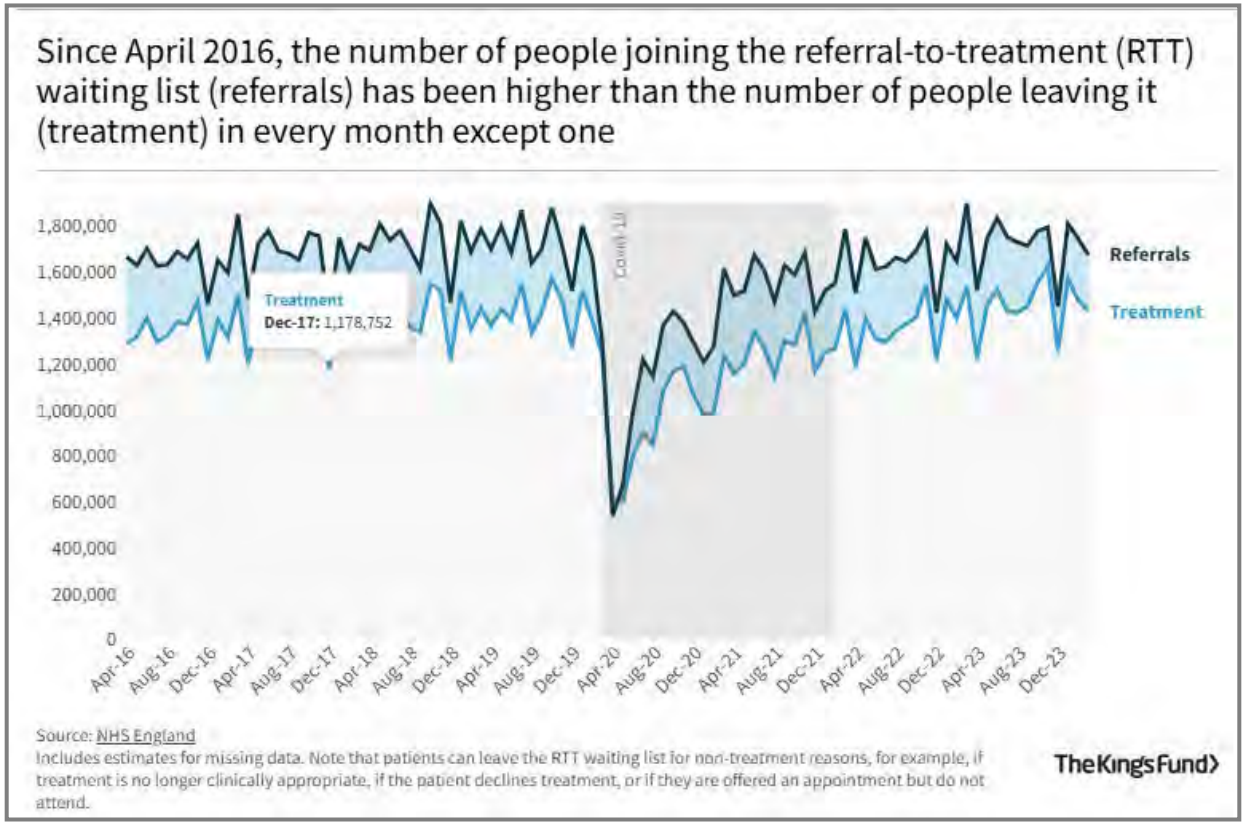
RSCH waiting time performance is improving – but it will take a long time to get close to the government target

The government's elective reform plan pledges to meet the NHS standard that 92% of patients should wait no longer than 18 weeks for treatment by the end of the parliament. This compares with current performance of just 59% at January 2025. The RSCH is behind the national average.





Catch-up will always be hard to do and may be impossible. But there will be a lot of pressure from the government to deliver

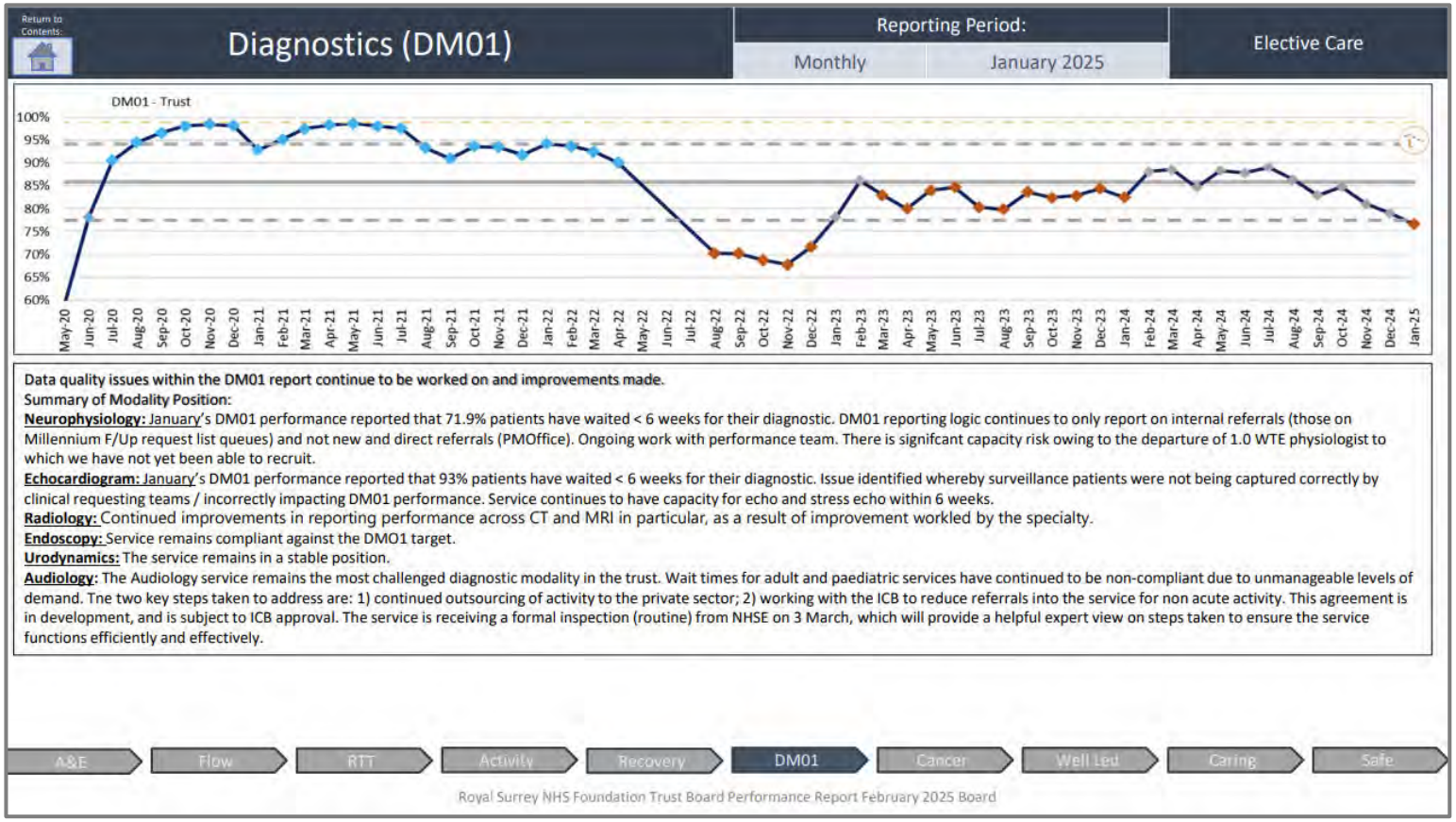


RCSH diagnostics metrics are on a downward trajectory. Many could be undertaken in community locations.

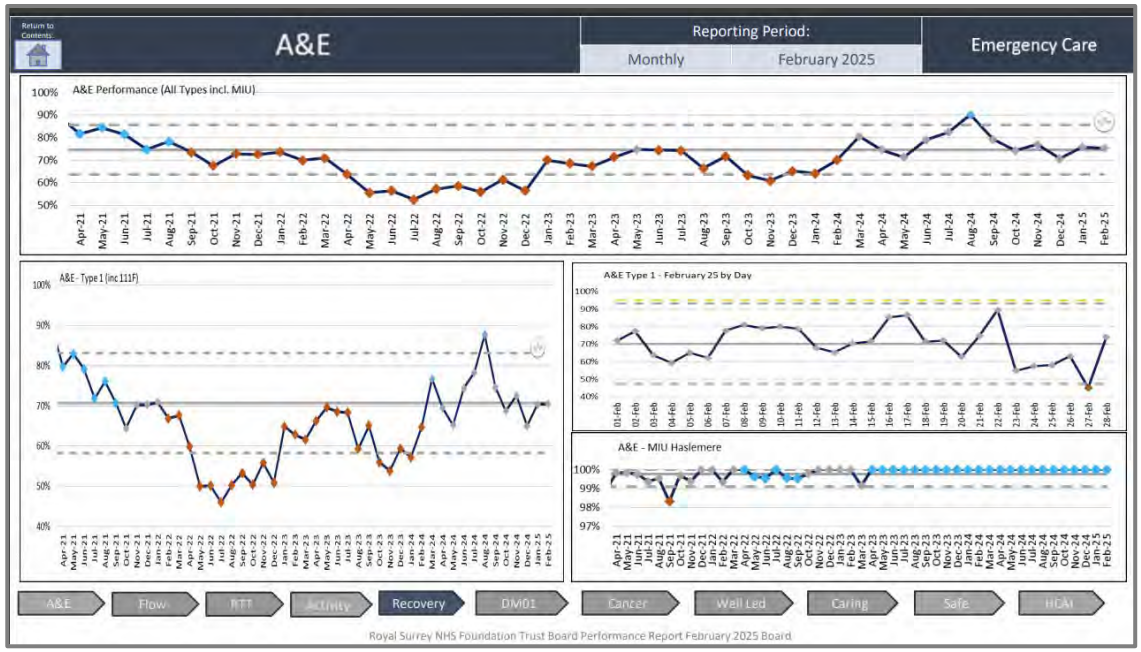
Will the opening of the Milford CDC make a difference?

How will the two locations be co-ordinated?

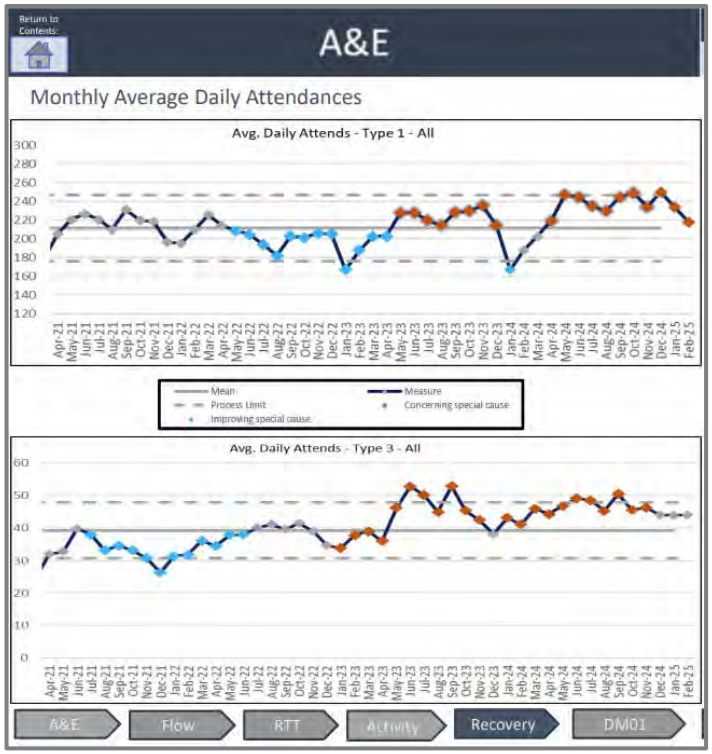
Which patients will go where?



A&E numbers at the main site, always seasonal, are trending upwards



RSCH Board Report, March 2025.



The RSCH balance sheet has been transformed by a government inspired financial manoeuvre

Beginning in the 2016/17 financial year, a £2.45 billion so-called Provider Sustainability Fund was established by HM Treasury to incentivise NHS providers to gradually reduce the overall NHS net deficit. It essentially was a piece of political window dressing.

Cash rewards were given in return for hospitals meeting financial targets.

'Control totals' gave each trust a bottom-line figure for their income and expenditure accounts, essentially to create a result as close as possible to breakeven.

As many as 80 providers (one of which was RSCH) were asked to make real terms spending cuts almost two-thirds bigger than strictly necessary to maintain their own financial health.

This collectively meant that each participant each had to cut their in-year spending by an extra 1.2% beyond the 2% needed to absorb the cost of inflation and thereby balance their books.

We believe one of these was the RSCH. The accounts from 2017 show years of close to break even year end financial results.

The STF story has been in plain sight. It's reported in the RSCH annual accounts

But it takes an almost forensic understanding of NHS finances to see how the money flows, how skilful financial management has built the balance sheet, see the boxes.

We're not certain if elected RSCH Members and even the Governors (both parts of the hospital governance process) would begin to understand them.

There is scant coverage of financial matters at annual meetings, just one title page, number 30 of 46 of the Hospital Annual Members meeting.

RSCH reported 'Cash and Short-term Investments' of £82m in its March 2025 Board Report, up over £3m on the previous month.

Note 22 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	Group		Trust	
	2023/24	2022/23	2023/24	2022/23
	£000	£000	£000	£000
At 1 April	**83,539**	**108,520**	**80,360**	**108,181**
Net change in year	5,176	(24,981)	6,488	(27,821)
At 31 March	**88,715**	**83,539**	**86,848**	**80,360**
Broken down into:				
Cash at commercial banks and in hand	2,014	3,446	146	267
Cash with the Government Banking Service	86,701	80,093	86,701	80,093
Total cash and cash equivalents as in SoFP	**88,715**	**83,539**	**86,848**	**80,360**
Total cash and cash equivalents as in SoCF	**88,715**	**83,539**	**86,848**	**80,360**

Total cash and cash equivalents as in SoCF

Year ending	£m
2016	4.9
2017	8.4
2018	34.7
2019	58.0
2020	79.5
2021	98.6
2022	108.2
2023	80.1
2024	86.7

But whose money is it? Well, it's on the RSCH balance sheet

This is an exceptional amount for what is a relatively small acute Foundation Trust. Deriving maximum advantage from the income opportunities available from a number of different sources requires a high level of business acumen and exceptional financial engineering skills.

This is clearly now the hospital's money, but it has come from the taxpayer and people might wonder if it is working in the best interests of the universe of local patients while locked away in a largely inactive bank account, presumably awaiting some future Hospital capital project.

Taxpayers would reasonably expect that their payments which fund the NHS are working to optimise care for patients across its delivery span. People will want to know that it is being used equitably to deliver the best possible care.

Should, then, this money represents investment capital for the local health system and a significant opportunity for the Royal Surrey to redefine the scope of both its real estate and operations?

RSCH can invest its significant reserves more or less wherever it wants.

As a Foundation Trust Foundation 'not in financial distress', the RSCH would not need to seek approval from NHS England for capital investment and property transaction business cases up to a value of £50m capital cost.

Capital investment and property business case approval guidance for NHS trusts and foundation trusts NHS England, 13th February 2023

Where the RSCH invests in the future will depend on its collective view about its purpose and ambitions.

For example, is this just about growing its main Guildford campus, or does itself look to become a local health system?

What, for example, are its plans to develop the Milford, Haslemere and Cranleigh sites?

The RSCH website says 'Haslemere Community Hospital, Cranleigh Village Hospital and Milford Hospital become part of the Royal Surrey family after the Trust, in conjunction with Procare GP Federation, are awarded the contract to deliver adult community services in Guildford and Waverley'.

Contemporary RSCH annual reports are silent on the financial arrangements.

Foundation Trust hospitals have enormous scope to pursue their own agendas

In 2003, Foundation Trusts, under the Health and Social Care Act 2003, became legally defined as independent public benefit corporations.

Foundation Trusts have a high level of autonomy and are self-governing. They tend to get left to their own devices until a public scandal emerges.

They do not report to the local ICS which can, however, influence their strategy to some degree as the principal budget provider.

NHS foundation trusts are accountable to their local communities through their members and governors, their NHS commissioners through contracts, Parliament and the Care Quality Commission.

'Foundation trusts have freedom to determine their levels of capital spend each year independently; their freedom to invest is constrained only by their ability to finance projects'.

The RSCH annual report on page 3 says it is 'Presented to Parliament pursuant to Schedule 7, paragraph 25(4)(a) of the National Health Service Act 2006'.

The annual accounts say 'The Trust's Ultimate Controlling party is the Department of Health and Social Care.

The ICB understands that in any competition for public approval it would come a poor second to the hospital.

As a Foundation Trust 'not in financial distress', the RSCH would not need to seek approval from NHS England for capital investment and property transaction business cases up to a value of £50m capital cost.

Incidentally, why does the RSCH have Healthcare Partners Ltd, a limited company subsidiary?

The short answer is that you would have to ask them. We asked Google AI:

'NHS Foundation Trust hospitals establish limited company subsidiaries (subcos) to gain greater financial and operational flexibility, potentially allowing them to reduce costs, generate new income, improve services, and offer more competitive employment terms.

Cost reduction: Subcos can help trusts reduce expenditure by providing services such as estates and facilities management, potentially leading to savings through economies of scale and efficient resource allocation.

Revenue generation: Trusts can use subcos to offer services to other NHS organisations or the private sector, generating income that can be reinvested into the trust.

VAT savings: Private companies working for the NHS can claim back VAT, potentially leading to cost savings.

Reinvesting savings: Savings generated by subcos can be reinvested back into the NHS trust, potentially making a substantial impact on cost improvement programmes.

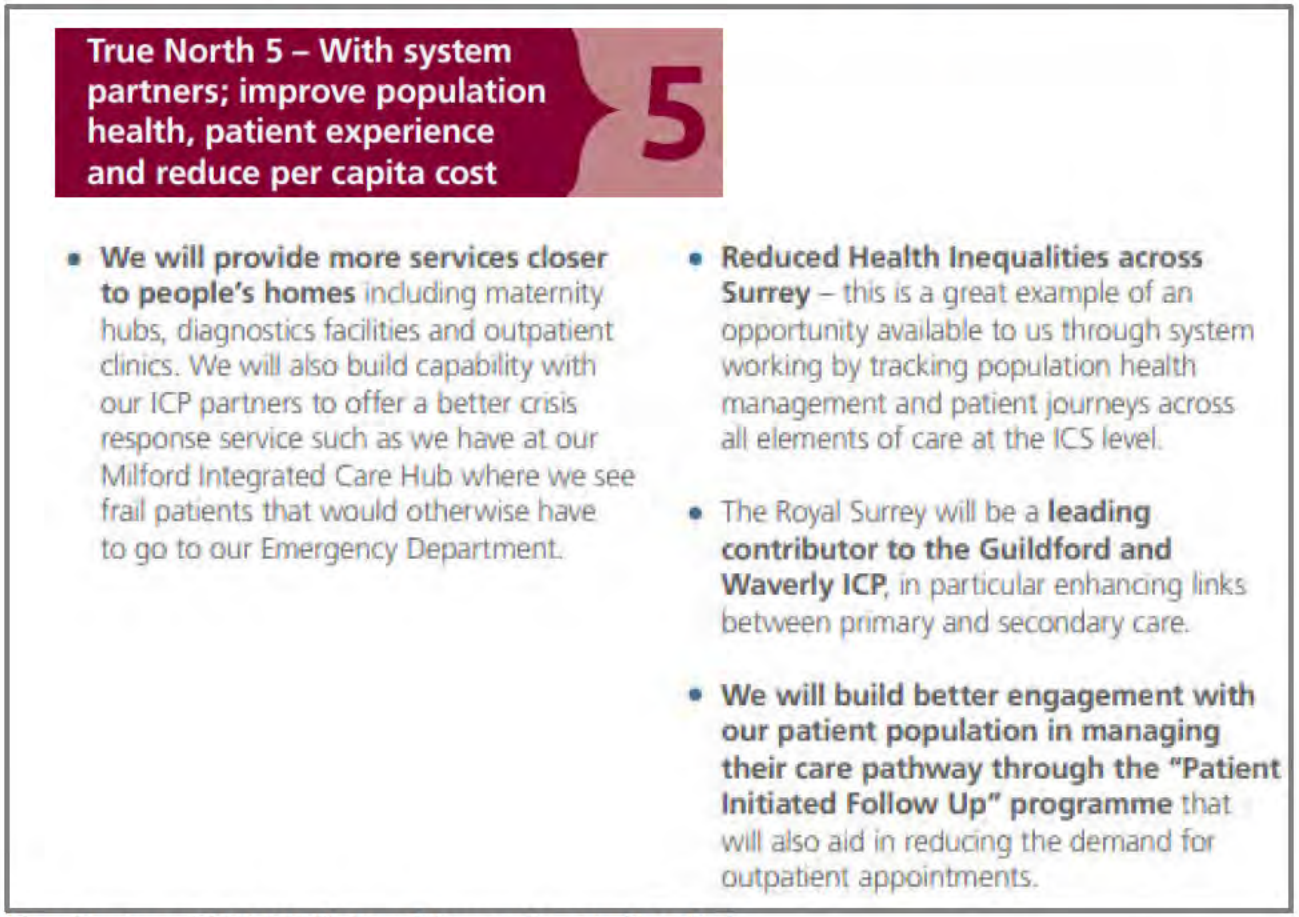
Service improvement: Subcos can provide a renewed or different focus on specific services, securing change more quickly and allowing for the introduction of new expertise.

Staffing: Subcos can offer more flexible employment terms and conditions, including competitive pay and pension benefits, which can help with recruitment and retention, especially for roles that are difficult to fill. Google AI

Cost of Setting Up: Setting up a subco can involve significant costs, including legal advice, consultancy fees, and the establishment of new systems and policies.

Potential for Conflicts of Interest: There is a potential for conflicts of interest if the subco is involved in commercial activities that could compete with the NHS'.

RSCH says it is signed up to the plan to move services out of hospital. But what are the programme details?



True North 5 – With system partners; improve population health, patient experience and reduce per capita cost

5

- **We will provide more services closer to people's homes** including maternity hubs, diagnostics facilities and outpatient clinics. We will also build capability with our ICP partners to offer a better crisis response service such as we have at our Milford Integrated Care Hub where we see frail patients that would otherwise have to go to our Emergency Department.
- **Reduced Health Inequalities across Surrey** – this is a great example of an opportunity available to us through system working by tracking population health management and patient journeys across all elements of care at the ICS level.
- The Royal Surrey will be a **leading contributor to the Guildford and Waverly ICP**, in particular enhancing links between primary and secondary care.
- **We will build better engagement with our patient population in managing their care pathway through the "Patient Initiated Follow Up" programme** that will also aid in reducing the demand for outpatient appointments.

'Our Strategy 2022-2025', Royal Surrey County Hospital.

- We acknowledge that Milford Hospital was the first move. But was this location optimal?

The community care plan needs to be articulated

‘The Trust continues to be leading member of Surrey Heartlands Integrated Care System, developing a deeply integrated operational model within the Guildford & Waverley “Place”.’

‘We took over the adult community services in Guildford and Waverley in 2018, making us an integrated Trust, and giving us a step-change in our ability to wrap services around patients outside of the walls of our main hospital site.’ **Both quotes from RSCH Reports.**

Yet, the RSCH Chair sent us an email saying ‘the RSCH does not have the resource nor the mandate to get involved in primary or social care’.

The RSCH is still invested in the Procare Community Health JV? How has it developed?

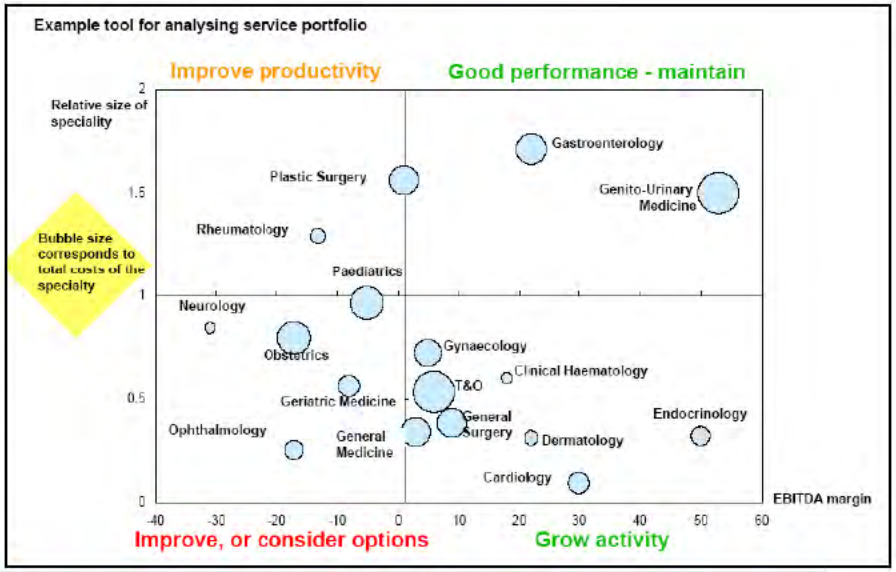
‘The integration of delivery teams in the OOH space with community teams, hospital discharge and admission avoidance teams with adult social teams will as they become embedded allow a “One Team” approach which will remove some of the barriers in place currently. We will help better manage people in their own homes and take proactive action before a more serious onset of symptoms occurs. The role of the PCNs to become the local organising entity is key. In GW the plan is to not just align the adult community teams to primary care areas but to transfer the staff as well.’

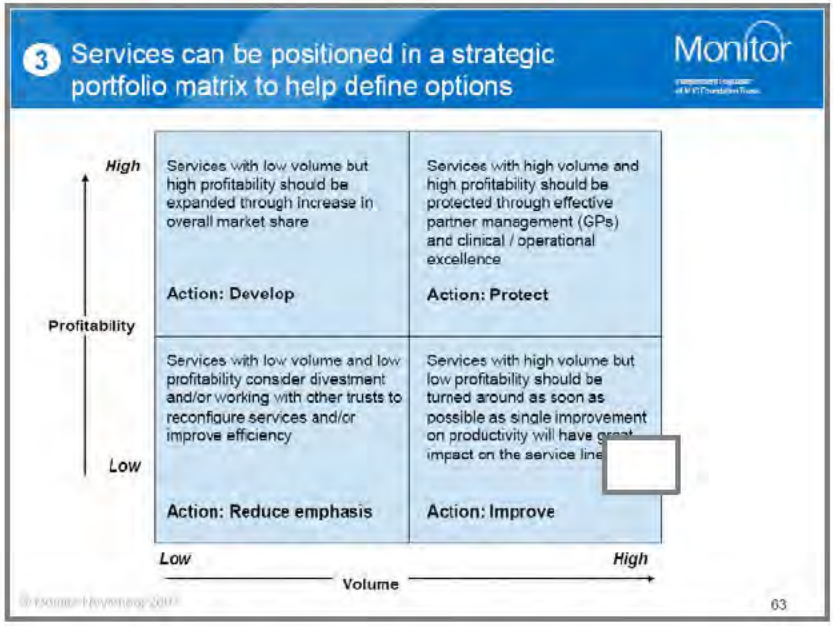
This plan was written six years ago. But how much has got executed?

And where is the next one?

RSCH has a strong grip on maximising its revenue mix. Procedures which are best done in the community should be let go

- For many reasons, many of which are not its fault, RSCH is not optimising its business mix.
- A move to greater participation in local integrated care needn't diminish the RSCH capability to raise revenues. In fact, it could do the opposite.
- Moving low value procedures and care episodes out of hospital would free up space for more complex and therefore more valuable PbR funded activity, particularly for out of area ICSs.
- Which procedures/episodes of care make a profit and which a loss?
- This technique, SLM – introduced by NHS Monitor - has been used across FTs.
- Freeing-up space to deliver more elective care we presume is a major objective
- What would the Royal Surrey want to transfer out?
- Certainly, it would want to reduce ACS conditions





The RSCH need not lose income; it could follow the patients into the community

A ‘boundaryless’ hospital would bring many benefits to local health care.

RSCH has crossed its Rubicon with the Procare JV. But most of this organisation’s staff work independently of the hospital.

In this presentation we proffer suggestions for how a community-based organisation might be built off an expanded AARS capability.

This, however, need not be an either/or proposition.

The hospital could be involved in the community clinics either on a partnership or contractual basis.

Much of a hospital’s income is from GP referrals. Being inside the AARS expanded PCN organisation would strengthen its role in patient direction.

Change will only come about for Guildford's health delivery if the RSCH wants it.

We have explained the motivations of the managements of Foundation Trusts.

Many prefer a business-as-usual approach, believing that integrated care will come to them and will just need bolting on, which might be right.

They will be able to pursue their current agenda and receive better than inflation budget increases forever.

We spend a large part of this presentation developing a rationale for the Royal Surrey, showing how integrated care will not damage its vision of what the hospital will become.

The RSCH is exceptionally well managed. It is good enough to take on the much larger challenge of leading the Guildford and Waverley inclusive care initiative.

It must fully collaborate with the Surrey Heartlands ICB to see it through.

Potential ACS cases represent the biggest opportunity for hospital admission reduction

'ACS conditions are types of conditions where care could be effectively managed outside hospital'.

'Ambulatory Care Sensitive Conditions (ACS) account for one in every six emergency hospital admission in England'. **'Potentially preventable emergency admissions', Nuffield Trust, December 2023.**

They are also long stayers creating an opportunity cost for the hospital to earn extra revenue from higher cost care episodes.

ACS patients at risk are relatively easy to spot. Many aspects of their health trajectory are on a predictable course.

Interventions organised by community teams can significantly reduce emergency admissions.

See our remarks under 'Managing the patient, not the condition'.

Definitions of ambulatory care sensitive conditions (supplement tables 1-5)

ICD list Purdy		
#	Diagnosis	ICD codes
1	Angina	I20, I24.0, I24.8, I24.9
2	Asthma	J45, J46
3	Cellulitis	L03, L04, L08.0, L08.8, L08.9, L88, L98.0
4	Congestive heart failure	I11.0, I50, J81
5	Convulsions and epilepsy	G40, G41, R56, O15
6	Chronic obstructive pulmonary disease	J20, J41, J42, J43, J47
7	Dehydration and gastroenteritis	E86, K52.2, K52.8, K52.9
8	Dental conditions	A69.0, K02, K03, K04, K05, K06, K08, K09.8, K09.9, K12, K13
9	Diabetes complications	E10.0–E10.8, E11.0–E11.8, E12.0–E12.8, E13.0–E13.8, E14.0–E14.8
10	Ear, nose and throat infections	H66, H67, J02, J03, J06, J31.2
11	Gangrene	R02
12	Hypertension	I10, I11.9
13	Influenza and pneumonia	J10, J11, J13, J14, J15.3, J15.4, J15.7, J15.9, J16.8, J18.1, J18
14	Iron-deficiency anaemia	D50.1, D50.8, D50.9
15	Nutritional deficiency	E40, E41, E42, E43, E55.0, E64.3
16	Other vaccine-preventable diseases	A35, A36, A37, A80, B05, B06, B16.1, B16.9, B18.0, B18.1, B26, G00.0, M01.4
17	Pelvic inflammatory disease	N70, N73, N74
18	Perforated/bleeding ulcer	K25.0–K25.2, K25.4–K25.6, K26.0–K26.2, K26.4–K26.6, K27.0–K27.2, K27.4–K27.6, K280–282, K284–K286
19	Pyelonephritis	N10, N11, N12, N13.6

Supplement table 1: ASCS definition by Purdy et al.[1]

bmjopen-October 2017.

The RSCH is running two separate businesses under the same roof. Is the DGH operation prioritised?

All Foundation Trusts hospitals are unique. But the RSCH has grown to become a relatively small district general hospital with a disproportionately large cancer centre sitting beside it.

'The hospital, which is the fourth largest cancer centre in the country, serves a catchment area across south-east England of up to three million people.

The £41.5m development [at the RSCH], expected to be finished by the end of 2025, will house six new operating theatres in modular buildings.

The new centre should allow an extra 7,000 patients to receive surgery every year.'
BBC website, Feb 2024.

A total of 60% of all surgeries currently performed at the hospital are cancer-related.

But has a focus on oncology reduced its capacity to perform more routine surgery?

Its February 2025 Board report said that total activity was 20%, with Fixed [contract procedures, rather than PbR], 22% higher, for which there is no reimbursement'.

Feb 2025 YTD commissioned income was at £470m, £7m higher than budget.

Many cancer episodes of care are priced on Specialised Commissioning tariffs, often with a higher margin. This could offset any 'losses' on non-Cancer activity.

We are unable to separate the two income streams from published data.

Are its RTT waiting time numbers still below the national average?

Should the cancer centre be a ring-fenced RSCH subsidiary?

A new strategy would reflect the changed circumstances.

For example, the cancer centre might become a free-standing, independently financed subsidiary of the RSCH group, essentially the holding company.

The Royal Marsden model might offer some insights. Not only does it provide a world class cancer service but it has found how to create a self-sustaining, one service line business capability, attracting both world class oncologists and research funding.

RSCH's substantial reserves and surpluses provide a base for continuous development.

Would they be larger if there was a closer relationship with the Royal Marsden, even a merger?

RSCH is working hard to compress as many services as possible onto a single site. How much room is left?

Space is always going to be constraint.

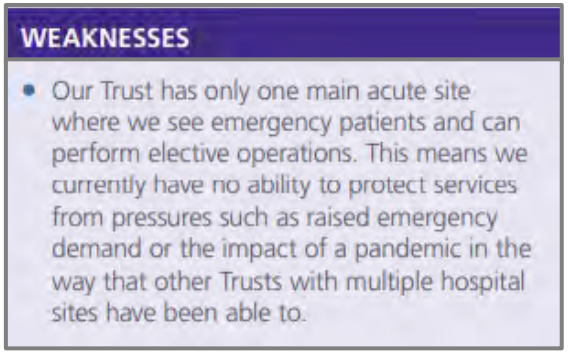
But is expansion of the district general hospital at risk to the continuous development of the cancer centre.

The RSCH understands the risk – see its SWOT analysis.

The £41.5m two-storey development will build on Royal Surrey County Hospital's world-class services in robotic and non-robotic surgery and enable an additional 7,000 patients to receive surgery every year. The investment in new facilities will help Royal Surrey respond to increasing demand for cancer surgery and bring down waiting lists for all elective surgical procedures.

https://www.mtx.co.uk/news/2025/2/11/mtx-to-build-royal-surrey-county-hospitals-state-of-the-art-cancer-and-surgical-innovation-centre

Both the ICB and the Hospitalhave recognised the constraints of the RSCH main site.



WEAKNESSES

- Our Trust has only one main acute site where we see emergency patients and can perform elective operations. This means we currently have no ability to protect services from pressures such as raised emergency demand or the impact of a pandemic in the way that other Trusts with multiple hospital sites have been able to.

RSCH: our strategy 2022-25.

New investments in community teams and new physical assets will enable the acute hospital to decompress from a busy and congested site. Already there have been new investments in diagnostics in the community with Digital X-ray in two community sites enabling more specialist clinics to be completed closer to where people live. Pathology services will be introduced to enhance the local offer further. Initially we will see specialist clinics supporting those with long term conditions being managed closer to home in partnership with local primary care multi-disciplinary teams.

Surrey Heartlands ICB.

All hospitals have a ceiling on their ability to expand. This is why off-site care in the community represents the best opportunity going forward.

Investment in community care delivers good value for money

Keeping people out of hospital is good for the patient, hospital and budget holding commissioner.

This will only happen if there is a system in place to identify and manage patients at risk.

This will require investment in systems and people.

There is no evidence that the ICB has invested in the necessary primary and community located capability. The opportunity cost of keeping people in hospital must be very high

Should the RSCH?

> *'On average, systems that invested more in community care saw 15 per cent lower non-elective admission rates and 10 per cent lower ambulance conveyance rates, both statistically significant differences, together with lower average activity for elective admissions and A&E attendances.'*
>
> *The reduction in acute demand associated with this higher community spend could fund itself through savings on acute activity if a causal relationship were assumed, with an average 31 per cent return on investment and average net saving of £26 million for an average-sized integrated care system (ICS), exemplifying the power and potential of community care at a system level.'*

'Unlocking the power of health beyond the hospital', NHS Confederation, September 2023.

Is the RSCH prepared to cooperate in the funding the local Integrated Care Plan – starting with the Jarvis centre?

The financing of a Jarvis Centre refit could come from a number of different places.

RSCH could pay for it all or create an entity which is mortgaged with rent charged annually to a range of users. It might jointly fund with the ICB given the recent NHS England policy changes.

Private sector providers - Assura and Prime - could bring their business models.

GP surgery rents are paid for by the NHS almost in their entirety. This might be up to 50% of the space.

RSCH could provide outpatient services, refunded by PbR.

Community care would be funded by the ICB. The JV with Procare could be expanded or relocated.

Private sector health providers – diagnostics, dentistry, optometry, physiotherapy, pharmacy, for example.

ICB might want to run certain admin. service possibly in connection with PCNs.

Urgent care or walk-in services.

Specialised clinics could be contracted in by the ICB – take the Women's Health service in Shere as a local example.

Local authority services - public health and social care.

Rent from voluntary organisations and charities like Macmillan.

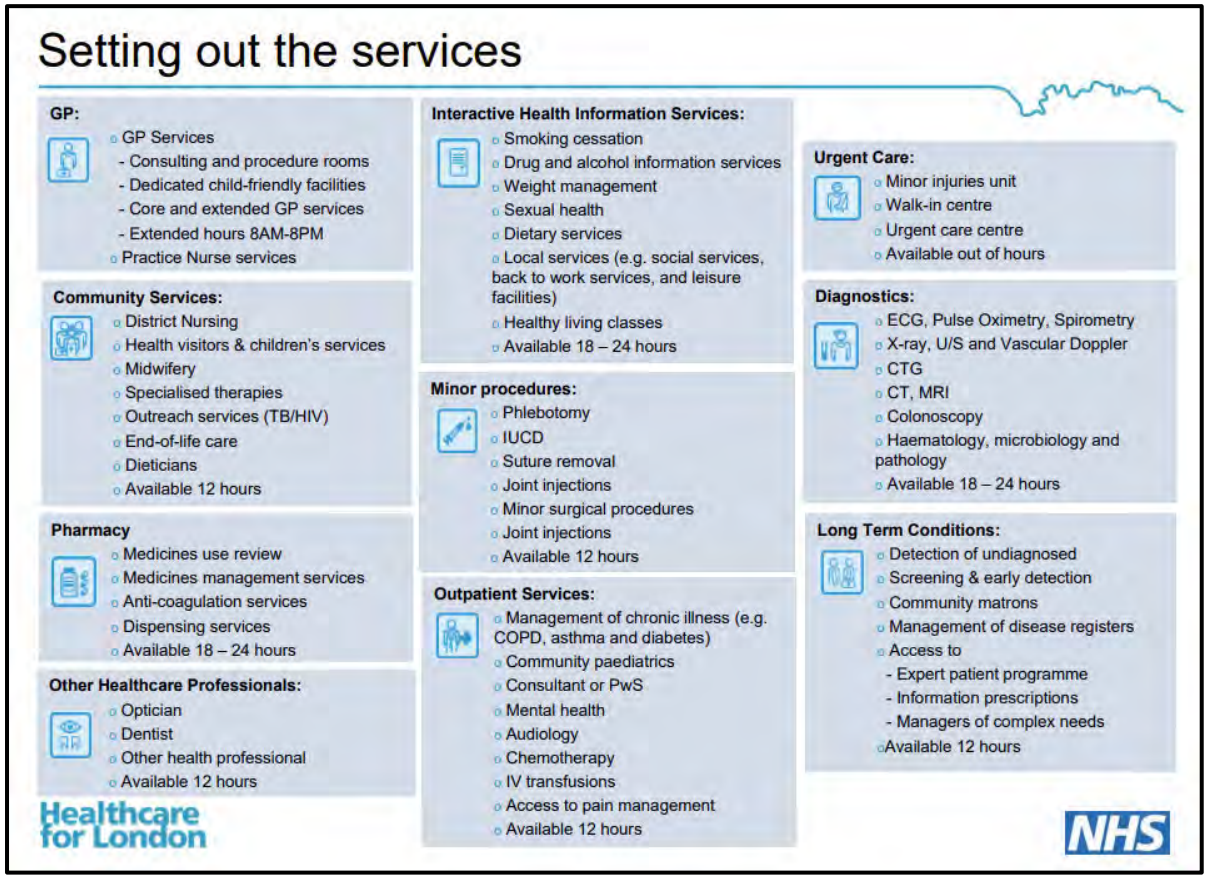
The RSCH has proven expertise in financial engineering and would find the most effective funding solution for this site.

Each of these ‘product lines’ represents an income opportunity for the property operator

Many are risk free, paid through NHS contracts, viz. GP premises rents.

Others can operate under ICB contracts, APMS, for example.

Private sector income is likely to be assured. Many care episodes will be NHS funded.



‘The Polyclinic Service Model’, Healthcare for London, May 2008.

Moving to prevention

Moving from treatment to prevention is the third government strategy shift

‘The NHS should prioritise and optimise prevention through community engagement, system alignment, and incentivised investment. This includes supporting evidence-based prevention programs, such as those addressing smoking, obesity, and alcohol intake, alongside initiatives like the NHS Diabetes Prevention Programme.

Here's a more detailed breakdown:

Prioritise and Optimise Prevention: The NHS Long Term Plan emphasises a shift from solely treating illness to also preventing it, aiming to save lives and reduce demand on healthcare services. This involves proactively addressing health risks and promoting healthy lifestyles.

Engage Communities: Community-based initiatives and collaborations with local authorities are crucial for delivering integrated and seamless care. This includes reaching out to those who may be underserved or face barriers to accessing care.

System Alignment and Incentivised Investment: The NHS needs to work across different systems, including local authorities and public health agencies, to create a cohesive approach to prevention. Incentives for prevention efforts can help drive investment and support the development of new programmes’.

Google AI.

There are powerful incentives to invest more in prevention, but it never happens

‘Ill health is not just a health problem; it has major economic consequences too. Increasing numbers of people are out of the workforce due to ill health and more still see their productivity in work reduced as a result of illness, stifling economic growth.

All this is set to worsen as our population ages and our health needs become increasingly numerous and complex.

The ‘size of the prize’ for prevention is huge. It is estimated that applying known, evidence-based preventative interventions earlier and more broadly could add 20 more healthy days per person, per year, in the UK - a 33% reduction in ill health - unlocking a $401 billion (around £320 billion) rise in GDP over 20 years.

Upstream, preventative health interventions have proven cost-effectiveness and are known to be more efficient than downstream care. The ubiquity of digital technology means we are now able to do prevention in a personalised way and at scale.

Central to the success of this transformation in approach will be a new social contract for health - one where responsibility is shared between government and the people.

To make prevention everyone’s business will require a shift from a ‘do to’ to a ‘do with’ mentality - something we are already seeing in parts of the healthcare system.’

Mobilising the full range of programmes across organisations to deliver a community approach would probably be the best shot’.

‘Making prevention everyone’s business: a transformational approach to personalised prevention in England’, DHSC, May 2024.

There is another integration opportunity – collaborating with public health organisations

‘Section 82 of the NHS Act 2006 requires NHS bodies and local authorities to co-operate with each other ‘to secure and advance the health and welfare of the people of England and Wales’. In England local strategic partnerships (LSPs) have been used to help achieve this aim.

Where they are in place, LSPs operate at a strategic level and are led by local authorities. LSPs are non-statutory, non-executive, multi-agency bodies that are designed to bring together different parts of the public sector (including the NHS) as well as the private and voluntary sectors at a local level, so that initiatives and services can support each other and work together.

The 2012 Act placed a duty on ICBs and local authorities (through the HWB) to consider how to make best use of the flexibilities when drawing up the JSNA and JLHWS. To reinforce this duty, NHS England has a duty to promote the use of these flexibilities by ICBs’.
HFMA.

The Healthy Surrey and Wellbeing Strategy says, ‘Our Strategy has an increased focus on working together with communities which will be crucial to our success. Making the most of our strengthened system partnerships that have worked together so effectively during the pandemic will help us deliver outcomes in the key neighbourhoods and communities that experience the poorest health’.
Healthy Surrey, 2022.

The website gives no information about progress around the installation of its many programmes or its updating, ‘The community vision for Surrey describes what residents and partners think Surrey should look like by 2030 (a review is currently underway).’
Healthy Surrey, 2022.

A lot of community needs could be advanced by a stronger ‘retail’ presence from public health providers

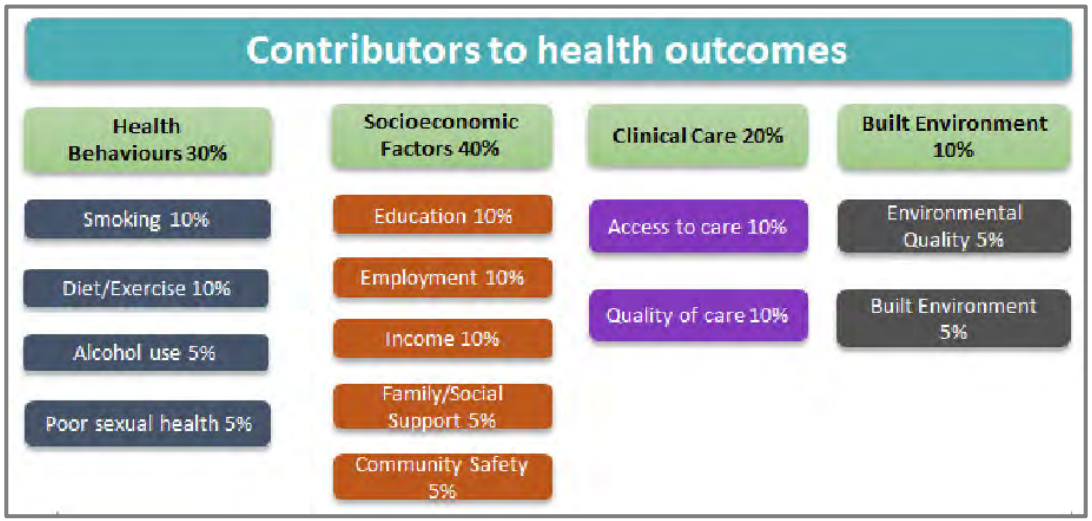
Clinical care may contribute only to health outcomes, there other factors as well, those associated with ’health behaviours’, see chart below.

Installing community health centres are a proven way of improving health behaviours which would tackle the further 20%.

These premises become the ‘anchors’ for attracting a range of health-related services.

A stronger community retail hub can be used flexibly by LA social services, voluntary organisations and health charities, which have been depleted in recent years.

Part of the fix of community care will be ensuring the better co-ordination of public health initiatives.



Surrey Heartlands ICS 5 Year Strategic Delivery Plan 2019 - 2024
A Partnership approach to transforming local health and care services

Surrey CC has a lofty vision for community action

Principles for working with communities

Through the process of refreshing the Strategy, the Health and Well-Being Board recognised the need for and committed to starting more collaborative and creative work with those communities in the geographic areas of deprivation with the poorest health outcomes. This commitment was based on the strong evidence that in order to achieve lasting change in communities, improve community safety and reduce health inequalities, it is essential that communities themselves participate and lead. Organisations need to be open to new types of collaboration where power sits more firmly with the communities we serve.

The Health and Well-Being Board has adopted the following principles (the Four Cs) for working with communities to guide this commitment across the system:

Community capacity building: 'Building trust and relationships'

Co-designing: 'Deciding together'

Co-producing: 'Delivering together'

Community-led action: 'Communities leading, with support when they need it’

Surrey County Council website.

‘Highlights’ seem to spend most time on intent, rather than delivery. The budget is small and shrinking

March 2025 (Surrey CC) Highlight Report

‘These Highlight Reports are published on the Healthy Surrey website after being reported to and discussed at the quarterly, public combined Surrey Health and Well-Being Board/Surrey Heartlands Integrated Care Partnership meetings.

They provide an overview of a selection of projects and programmes which directly support the delivery of the Surrey Health and Well-being Strategy with the priority populations. The reports also include the latest relevant data and insights, along with examples of collaboration to support communities experiencing the poorest health outcomes. They highlight the most recent opportunities for and challenges to the Surrey system. Lastly, they include an update on the progress of the Joint Strategic Needs Assessment (JSNA) and prevention communications.

The budget allocation is £36.6m per year. (That is equivalent of £55.66 of annual Council Tax for a Band D property.)’

Or about £4.4m for Guildford including staff and overheads.

https://www.healthysurrey.org.uk/about/highlight-reports/march-2025

If the full AARS staff commitment is taken up, practices can deliver more of the much-needed public health programmes

For many years a significant part of the public health agenda has been contracted to GPs for practices to deliver.

A lot of these services have been curtailed by increased pressures on primary care services.

The AARS opens up new opportunities for increased attention in this area, particularly from designated staff such as social prescribing link workers, health and wellbeing coaches, care coordinators, mental health practitioners, GP assistants and physician associates.

Many of the patients who would benefit from public health programmes have complex needs and often multiple co-morbidities, in particular mental health issues.

They become an opportunity for a truly multi-disciplinary team approach.

Contracts

Community care needs to be put on a more business-like footing

A re-organisation of community care will require a complete review of current activities.

In particular, this should include an audit of all provider contracts.

Commissioners have always struggled to engage with the long tail of providers – charities, voluntary organisations, CICs, etc - who deliver bespoke, one-off services.

There is no published management information about performance standards, KPIs or other metrics.

Terms and Conditions are often invisible, kept in the ‘black box’ of commercial confidentiality.

Most are remunerated on a block contract, usually on a last year plus basis with no resort to performance monitoring.

These organisations have their place in community care, but the quality of delivery and outcomes are not reported to commissioners.

Interruptions to care pathways are more likely as small organisations become stretched.

In such a federated environment, getting contracts right to secure community care delivery is critical

Contract development will become a key competency for those who will supervise the transition.

The first requirement will be to complete a full review of current service standards and delivery.

There is the likelihood that there could literally be hundreds of contracts in the Surrey Heartlands ICB area.

'The PMS contract is another form of core contract but unlike the GMS contract, is negotiated and agreed locally by ICBs with a general practice or practices. This contract offers commissioners more flexibility to tailor requirements to local needs while also keeping within national guidelines and legislation. About 28 per cent of practices held PMS contracts in July 2024'. **BMA.**

'An APMS contract allows services to be delivered by alternative providers, with locally agreed contracts and prices. The APMS contract offers greater flexibility than the other [GP] contract types. The APMS framework allows contracts with organisations (such as private companies or third sector providers) other than general practitioners/partnerships of GPs to provide primary care services. APMS contracts can also be used to commission other types of primary care service, beyond that of 'core' general practice. For example, a social enterprise could be contracted to provide primary health care to people who are homeless or asylum seekers.**'**
King's Fund, June 2020.

GPs will need to be asked about how they intend to operate in a community care re-set

This will start from what services they plan to deliver under their GMS contracts, or not.

How many want to operate new services and under which contract.

How PCNs see the deployment of AARS staff and whether GP practice supervision is the best way to deliver components of community care.

What will be the ongoing role of Procare and how the existing contract needs to be redeveloped.

Hailed as an NHS innovation at its time it may not have progressed as originally envisaged.

Annual reports at Companies House show a substantial reduction in staffing, for example.

What Covid did show was the agility of GPs to respond to a significant organisational and logistics challenge.

Since then, the growth of the AARS workforce has brought additional challenges.

All of the above will mean that the input of GPs views will need to be respected, whoever leads the re-organisation.

If RSCH got control of community care, they would make extensive use of the Head Provider contract

NHS England contracting advice says:

'It is becoming increasingly common for a provider (the "Head Provider") to sub-contract delivery of certain clinical services to a third party (the "SubContractor"). It can be the sub-contracting of an entire service or of delivery of part of a care pathway. It can be an isolated subcontracting by the Head Provider to a single Sub-Contractor, or the sub-contracting of a range of services to multiple Sub-Contractors under a prime contractor/lead provider (these terms are interchangeable) commissioning model.

The APMS contract offers greater flexibility than the other two contract types. The APMS framework allows contracts with organisations (such as private companies or third sector providers) other than general practitioners/partnerships of GPs to provide primary care services.

APMS contracts can also be used to commission other types of primary care service, beyond that of 'core' general practice. For example, a social enterprise could be contracted to provide primary health care to people who are homeless or asylum seekers. In 2018/19, 2 per cent of practices held this type of contract.' **NHS England**

The GPs with Extended Roles programme enables doctors to act independently providing a specialist role

The GPs with Extended Roles programme enables doctors to act independently providing a specialist role

‘A GPwER (formerly known as a GPwSI or a GP with special interest) is a practising GP with a UK licence who takes on a role outside of their primary care duties. The extended role typically occurs under a separate contract outside of your usual setting, enhancing your earning potential. It will be in addition to the care you provide to patients as part of your general practice.’

There are a range of positions that are classed as extended roles, for example:

- Minor surgery
- Dermatology
- Frailty
- Mental health
- Allergy
- Cardiology
- Sports medicine
- Musculo-skeletal
- Women’s health

In order to be a GPwER, you would need to maintain your general practice role’. **GP World.**

The local women's health hub initiative is one model for expanding community care

This programme has all the key attributes of a programme GP-led in the community

'We are a GP-led and GP-provided service, the provider contractually is Shere Surgery, a rural GP practice in Surrey.

We have a team of three GPSIs and run four clinics a week from two GP practices; on average we see 20 to 25 patients a week. We take referrals from all 21 practices in our CCG.

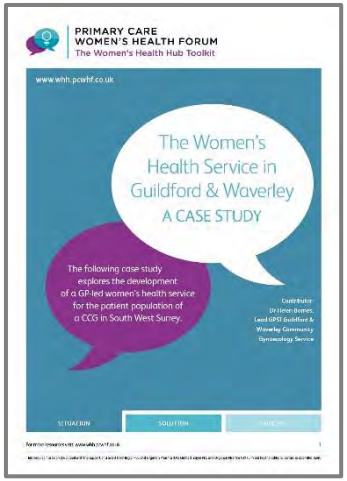
To improve access to women's health services by enabling women, traditionally seen in a consultant-led hospital clinic, to be seen in a GP-led community setting.

To reduce secondary care referrals and as such reduce the burden on the acute trust and improve waiting times.

Whilst we are a separate provider, we are contractually integrated with the local hospital.

The service is funded by the CCG, with the Community Gynae activity being included in the overall funding provision for outpatient gynaecology care. We have agreed tariffs for new and follow-up patients.

Within the service we use several systems including EMIS and Viewpoint [ultrasound software]'.



Combining the elements of many existing NHS policies (with others) would open up a raft of new care services

If a number NHS policies of the past twenty years are conflated, then an opportunity which was never imagined emerges.

Certainly, this opportunity is something which the more entrepreneurial GPs are likely to consider. This is what the individual NHS policies allow:

AARS: an expandable out-of-hospital, GP led base to expand the provision of community care services.

Patient Choice: the statutory entitlement for patients to choose their care.

Personal Health plans: the ability of certain patients to operate a health budget for the NHS to pay for their care.

Referral management: a possible AARS service providing a patient choice and navigation service. Could also offer a second opinion service.

Contracts: GPs can deliver additional NHS services under the PMS contract. The APMS framework allows contracts with organisations (such as private companies or third sector providers).

GPs with Extended Roles (formerly GPwSIs): GPs who wish to deliver specialist clinics.

Consultants working in private practice: many hospital specialists allocate their week into NHS and private sessions.

Combining them would create what is an essentially alternative stream of community delivered care services. It is very likely that independent hospitals and clinics would also want to participate.

Organisation: a new structure is required

Creating a cohesive, integrated system is complicated. The potential players have their own agendas

A transition to a fully-developed community care organisation needs whole system buy-in.

This is seen as the major challenge.

Currently, the parties involved have their own agendas.

FTs are resolutely autonomous.

GPs will do what's best for their individual practices.

Unification of practices in Primary Care Networks isn't always easy.

Community care is delivered by a diverse group of providers.

Negotiated compromises will be necessary.

The ICB will need to take a firm leadership role, using the levers available to it - mostly budget allocations and contracts - to deliver integration and a hub and spoke delivery system.

The RSCH would have to become a much larger system player, if it has the will.

Particularly if the ICB is diminished through the abolition of NHS England.

We have considered many of the options in this presentation. We're certain that others will arise.

To deliver this initiative, stakeholder interests have to be accommodated

You have to consider the players' motivations.

GPs will not see the benefits of strategic change; they will plough their own furrows. They will continue to respond to financial incentives as they always have.

The RSCH seems reluctant to embrace change beyond its own premises. Arguably, its business strategy may be compromising its role as a local district hospital.

The risk averse, only partially engaged, ICB will lose focus as it is disbanded.

So, who will take on the leadership role?

Our recommendation is that The Royal Surrey Hospital becomes the Royal Surrey Hospital *System.*

It goes further in its engagement with GPs in the Procare JV which is re-contracted.

It creates new alliances with PCNs, investing in new support services to deliver seamless care pathway management.

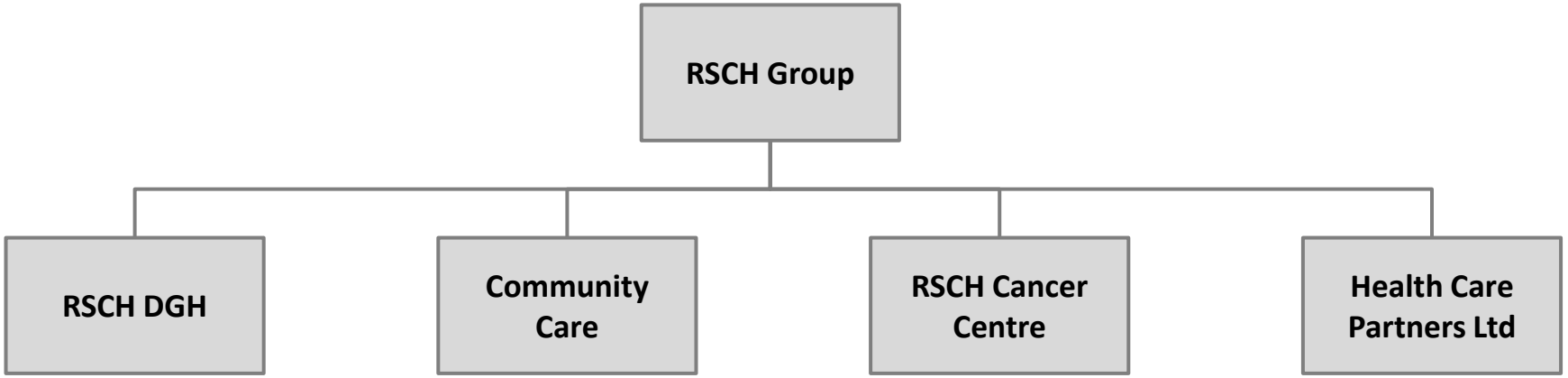
It looks at whole system capability – public and private sector – to create cohesive coverage.

Should Healthcare Partners Ltd expand its role to become a much more important entity in system management.

Reconfiguration is now essential. But existing capabilities must not be lost

That's why we are proposing a repositioning of current resources.

This will give these new business units a sharper focus.



RSCH DGH

An unremitting focus on being the community hospital for its extensive catchment area.
Strengthening its capability to address underprovided specialisms.
Working closely with the Community Care organisation to smooth pathways and extract maximum value for the system.
Being prepared to switch funding 'upstream' to increase its own productivity.
'Clear its decks' to ensure an improvement in RTT and other metrics.

Community Care

Operate in a business-like way, unifying providers to deliver clear objectives.

Collaborate fully with GP practices and PCNs to ensure an integrated delivery capability

Build an esprit-de-corps across participating providers to achieve a common culture

Operate from a purpose-built hub with a full set of back-office functions

Build a base for collegiate MDT working

Invest heavily in systems, data collection and analytics

RSCH Cancer Centre

Continue with existing business plan

Appoint its own leadership team which reports to RSCH Group HQ

Investigate all opportunities to increase prestige and reputation

Work with University and Medical School to attract new R&D funding

Health Care Partners Ltd

Refashion as the data and analytics support centre for all local providers

Work with all relevant stakeholders, viz. Procare to provide support, training for GP practices

Lead on projects to identify discrete population segments

Become a centre of excellence for NHS data, analytics to serve local communities

Which brings us full circle

What we are putting forward is not new. There is usually a solution somewhere in the NHS re-set

‘There are several challenges that providers of primary and community care often need to overcome to work together collaboratively, including:

- a history of poor relationships, different cultures and lack of mutual understanding between secondary and primary care providers
- procurement processes, contract structures and commissioning are still tailored to the GP partnership model rather than facilitating collaboration
- PCNs are still embryonic in some areas. Even with PCNs, navigating the primary care landscape within an STP/ICS footprint can be challenging for secondary care providers given the sheer numbers of GP practices in their patch.
- primary and secondary care clinicians need to be brought along with the integration agenda, often by workforce or technological incentives rather than financial incentives
- the lack of tangible deliverables for integrated health and care services can also be a barrier to collaboration, although increasingly systems are taking the initiative to do this locally
- Despite these challenges, community providers have adapted and reconfigured their existing multidisciplinary structures and workforce arrangements within the new PCN footprints. Given it takes time to develop relationships and an aligned vision for health and care services for the local population, there is a mixed picture of engagement and progress across the country. The case study of integration between primary and community care in Derbyshire shows how investing time and energy in building good working relationships is essential’.

NHS Confederation

Can the RSCH take the leadership role and also resolve the N&W Guildford GP premises deadlock?

Five years have elapsed since the CCG report on future GP premises for North and West Guildford.

The plan was for them to be built by now.

But the stand-off continued. The ICS has had no funding for practice redevelopment and the GPs no intention to redevelop their sites or pay for new ones.

But the world has moved on since 2019. NHS policy has also evolved.

Community hubs probably make more sense than continuous hospital expansion.

They should be the new hubs in a hub and spoke configuration

The Royal Surrey has the money. What we have been trying to do is it help it find the will.

We have spent a lot of time in this presentation attempting to make a case why driving through these innovations makes good business sense for both the RSCH and the local health economy.

And, of course, patients and population, too.

The 2019 CCG report recommended a second site

‘Based on the case for change and the outcome of the option appraisal the recommendation is that the option to develop new premises on the Kings College site in Park Barn and the Jarvis Centre on Stoughton Road is taken forward to the next stage’.

The Kings College, Park Barn site is no longer available.

Would one option be the reconfiguration of the nearby Hive facility, owned by GBC?

A wellbeing hub from which specialist health care MDT members could operate seems like a possibility.

‘Our role is to work with our amazing local communities to build confidence and empower people to enhance their wellbeing. This could be through finding and supporting local groups, connecting individuals with agencies or community facilities, or simply inspiring people to achieve their goals’, say a group based on these premises. Which all seems admirable.

There should be room for a GP practice, or a practice satellite on the site..

We leave the thought with you.

Recommendations

Our recommendations

Introduction

This section is organised around the three strategic shifts for the NHS:

- hospital to primary care and community services
- analogue to digital
- treatment to prevention

(Please note that we do not regard this list as comprehensive. We expect the readers of this report to add their own).

We start from the premise that demand for medical services will always exceed supply. Apart from 'natural' growth in demand - an ageing population for example - Guildford's population could easily increase by one-third over the next ten years, significantly increasing the load on NHS services.

Hospitals will always be full, forever. The Royal Surrey is constrained by its relatively small size and its ability to expand on its existing footprint. Government and NHS England policy is now about 'evening-out' demand across the community, re-locating hospital outpatients and reducing emergency admissions. This is essentially to protect hospitals.

Increasing supply locally care means building capability and capacity outside the Hospital. It's also likely to be quicker to deliver: re-configuring complex medical real estate takes time.

Recommendations

1. Hospital to primary care and community services

The immediate need is for the ICB to undertake a comprehensive survey of current GP and community capacity.

This should include an audit of the state and capability of GP premises. Many existing GP premises are acknowledged as 'not being fit-for-purpose'.

PCNs should also poll practices set about the ambitions of their members for their practices, what they would like to do going forward. This information will help with the re-shaping of both primary and community care.

Our recommendations (continued)

PCNs should provide details of how much of their AARS allocation they have taken up and how this cohort of employees can be co-ordinated with existing community care providers.

Information about case numbers, costs and outcomes would also be helpful.

It will be important to know how this cohort of employees can be co-ordinated with existing community care providers.

There needs to be an understanding of which local neighbourhoods are in deprived areas, in which practice these patients are registered. This will help understand the morbidity load.

The treatment cost of these patients needs to be simulated. To assist with planning, the admission/hospitalisation costs of these patients need to be assessed.

Consideration should be given to our re-envisioning of the 'Hub and spoke' real estate. Our view is that community care should become the new hub, not the DGH, to signal the policy change. What are stakeholder views.

The need to increase/adapt community health care premises should also be evaluated. How well equipped are existing hubs – Cranleigh and Haslemere, - for example? The RSCH says 'our community estate has been significantly under-invested and requires improvement'.

What needs to be done in the short-term to provide temporary accommodation for community care MDTs and back-office support.

Our view is that the Jarvis Centre site should be redeveloped as the de novo model.

Is the Royal Surrey prepared to invest in the rebuild of the Centre to create a community care hub for North Guildford?

The RSCH and ICB should undertake a financial/economic assessment for this project. We believe that the long-term impact on the RSCH balance sheet would be close to neutral.

Our recommendations (continued)

The RSCH should look at different scenarios for its future development as the controller of a number of free-standing business units. We set out details in this paper. We'd be happy to hear stakeholders' views and any alternate proposals.

We believe that RSCH's highly competent clinical and business management of the Hospital is capable of expanding its reach. In particular, we would like to hear its views on our proposal that it takes control of all local community care activities leading to a unified system.

The ICB should amend its community care contracts with all providers – GPs, CICs, voluntary organisations and charities - to establish a reporting line through to the free-standing, RSCH managed, community care organisation. Existing providers' views should be sought.

The care of these patients would then be supervised and delivered, one by one, by MDTs.

The ICB should respect the NHS Patient Choice obligations and also look at the capacity available from independent sector providers.

2. Analogue to digital

We are working on the basis that technology including AI will transform all care delivery within the next five years. This will require a considerable amount of workforce adjustment.

A lot of care will be managed from back offices.

The ICB should seek expert help to set up a system to risk score all members of the local population with a view to creating a register of those at most risk. The ICB should commission a provisional IT system to ensure their effective monitoring.

The system should become the controller for the care of all community care patients, whoever the provider. Each 'at risk' patient would have their own care pathway which would be updated dynamically. This should be supported by decision support systems.

Our recommendations (continued)

The ICB should work with RSCH and PCNs to create an integrated IT capability for patient tracking. This would include components such as the Doccla Virtual Ward system and the NHS Foundry

The IT capability might be developed further by Health Care Partners Ltd which should be reconfigured as the leader in local analytics

We believe that the town of Guildford is, through its local institutions, well set up to take a leadership role in this area. Could it be a new business start-up for the Hospital or University?

3. Treatment to prevention

A lot of preventive health comes from improving access by care workers to local populations and patients.

The move to focus on community care raises the possibility that preventive health care can be re-invented. This would come from strengthened on the ground multi-disciplinary teams, particularly if AARS staff can be integrated with embedded community health providers.

There is the additional opportunity of raising the standard of public health programmes, many of which have been curtailed by reductions in funding. Better coordination on the ground between the NHS and local authorities is necessary. Programmes should be measured more consistently, particularly to understand whether the desired treatment outcomes are being achieved. There is more aspiration than delivery.

The role of social care workers should not be under-estimated. For many people, caring is just as important as care. A way of sharing records is essential. Could GP health records be accessed using mobile devices issued to social care workers?

Next steps

There are, still, big issues which need addressing

Guildford, as a consequence of decisions which have been made (or not made) by the ICB and its predecessors has constrained their options going forward.

Its primary care premises stock is in poor shape. There are no plans to radically change things.

Community care is not co-ordinated. AARS is becoming a missed opportunity.

The local health economy has limited capacity to deliver on new government priorities.

It has probably over-invested in an already well-endowed RSCH.

The only way ahead seems to have been an extrapolation of the past, a sub-optimal application of already scarce funds.

Most of recent investment has failed to address levels on health inequality in certain less prosperous parts of the town.

As is usual in these circumstances, those who will need the most help will get the least.

It’s a time for a correction.

Next steps

This analysis in the first instance is having a very restricted circulation – senior members of the ICB and RSCH only.

We believe we make a compelling argument for how community health care should be expanded in Guildford

What happens next is clearly down to you.

We will be back in touch in a couple of weeks to get your reaction about how your organisations see the way forward for Guildford's health care delivery.

If any of what we have written needs clarification, please let us know.