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?

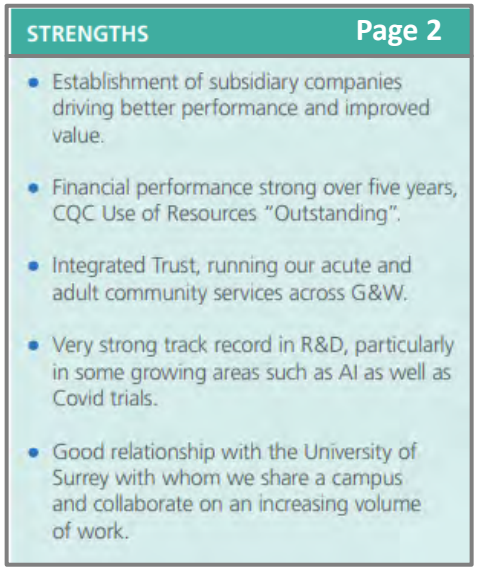
Certainly, the cancer-related margins should benefit from being on the Specialised Commissioning tariff.

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.

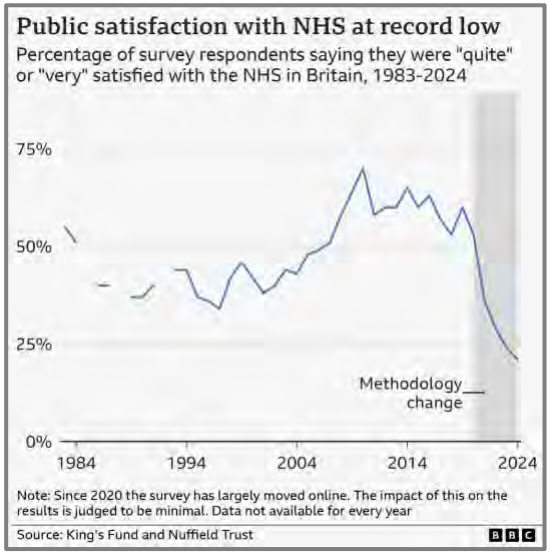
Its local reputation is currently good, but this might change if there are circumstances which create excess demand.

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.

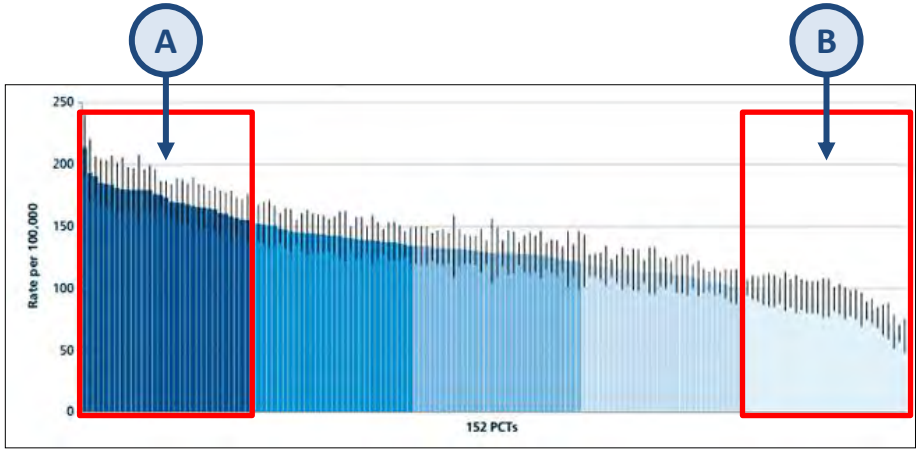
Are all medical specialties being adequately resourced?

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.

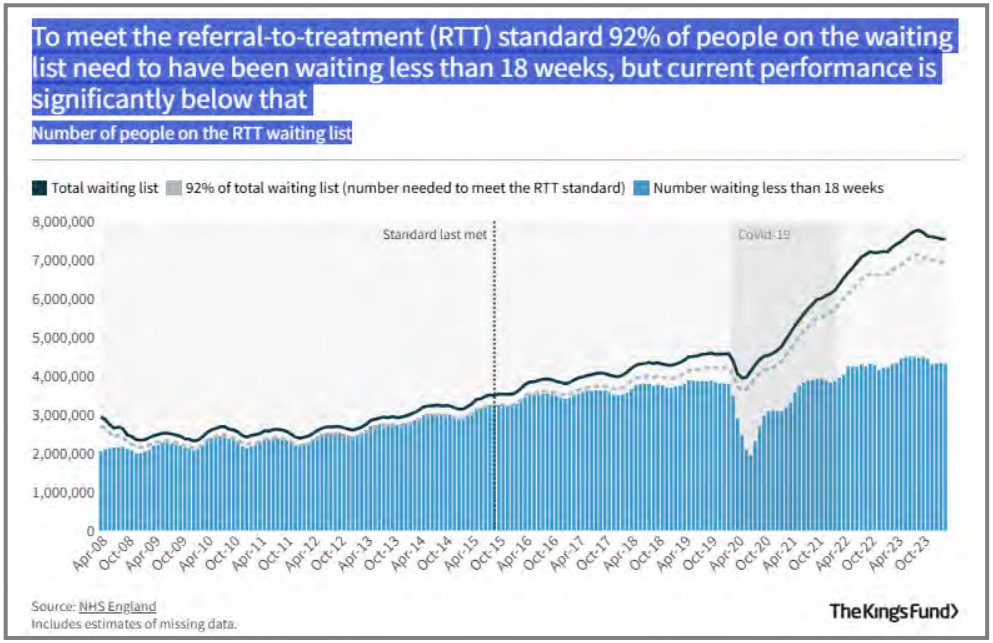


Map TT.1: Rate of hospital-admitted procedures for benign prostatic condition per population by commissioner.
NHS RightCare Atlas.

RSCH performance: meeting the referral-to-treatment (RTT) standard is an NHS Constitution standard

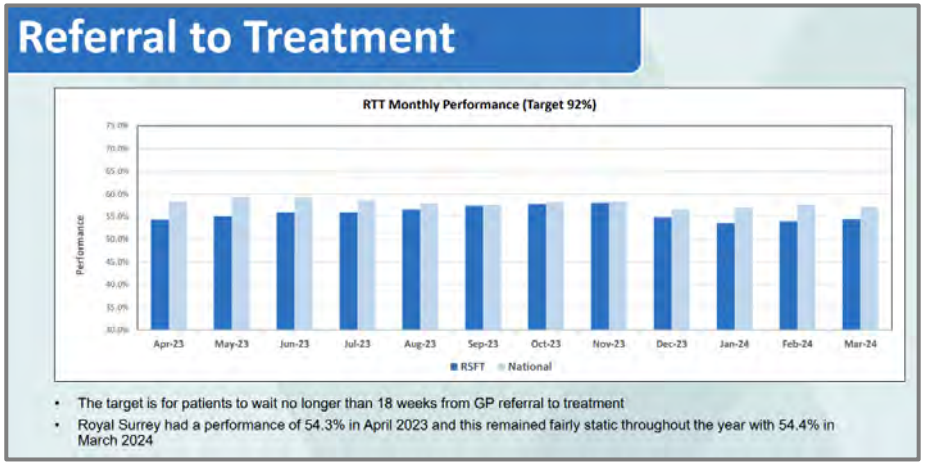
The NHS Constitution sets a standard that 92% of people waiting for elective (non-urgent) treatment (such as cataract surgery or a knee replacement) should wait no longer than 18 weeks from referral to their first treatment. This standard was last met in September 2015. Since then, performance has declined 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.

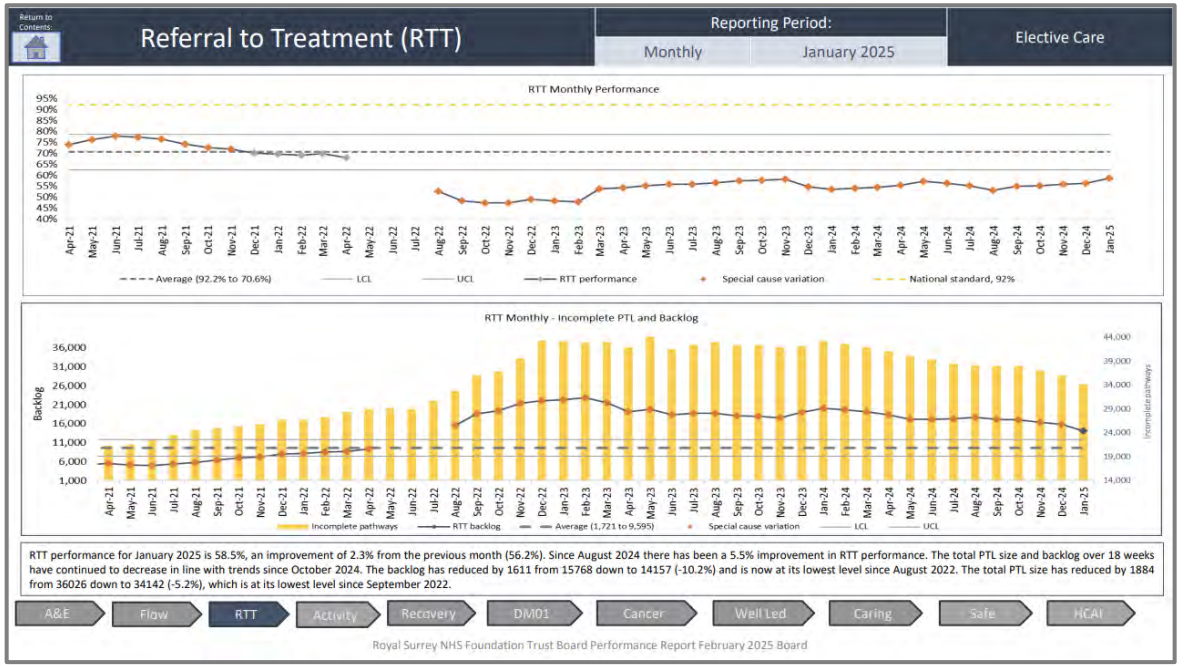
To meet the referral-to-treatment (RTT) standard 92% of people on the waiting list need to have been waiting less than 18 weeks, but current performance is significantly below that.



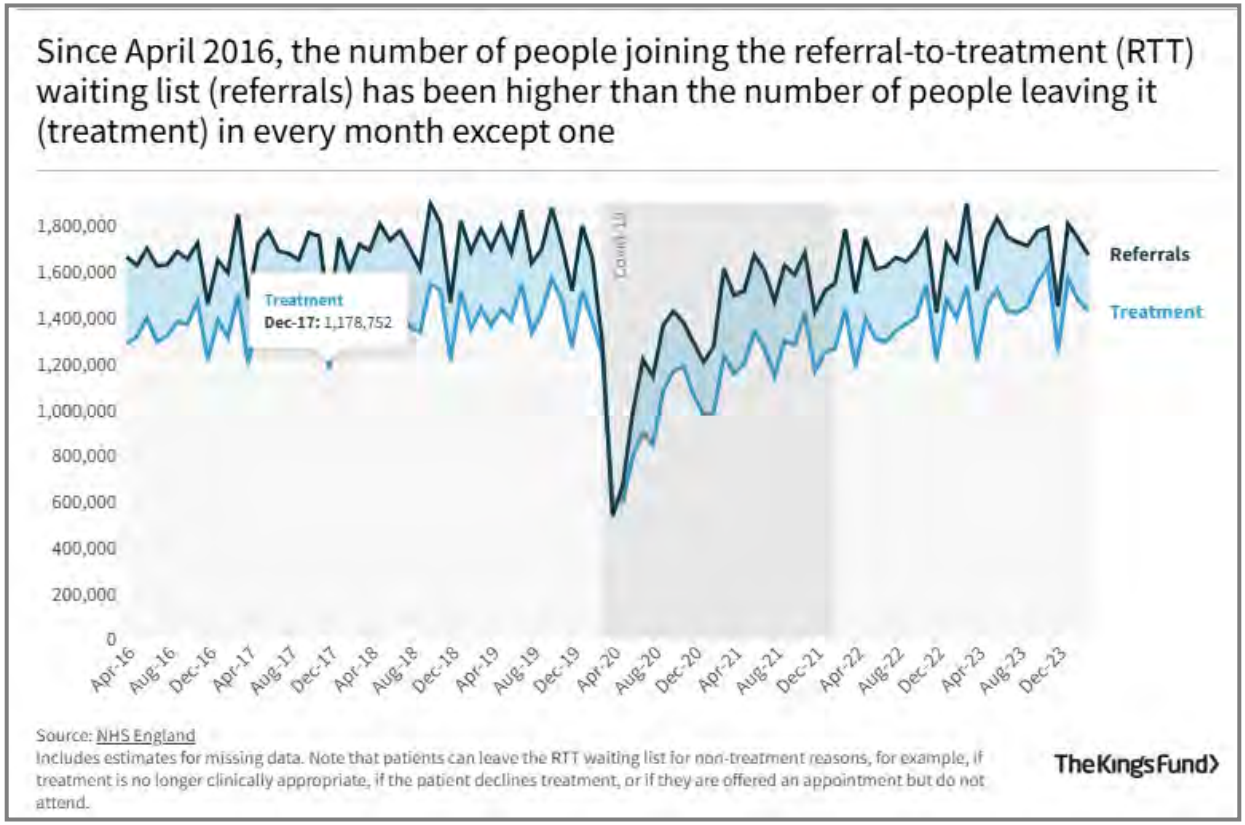
RSCH waiting time performance is improving – but it will take a long time to get close to the government target

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

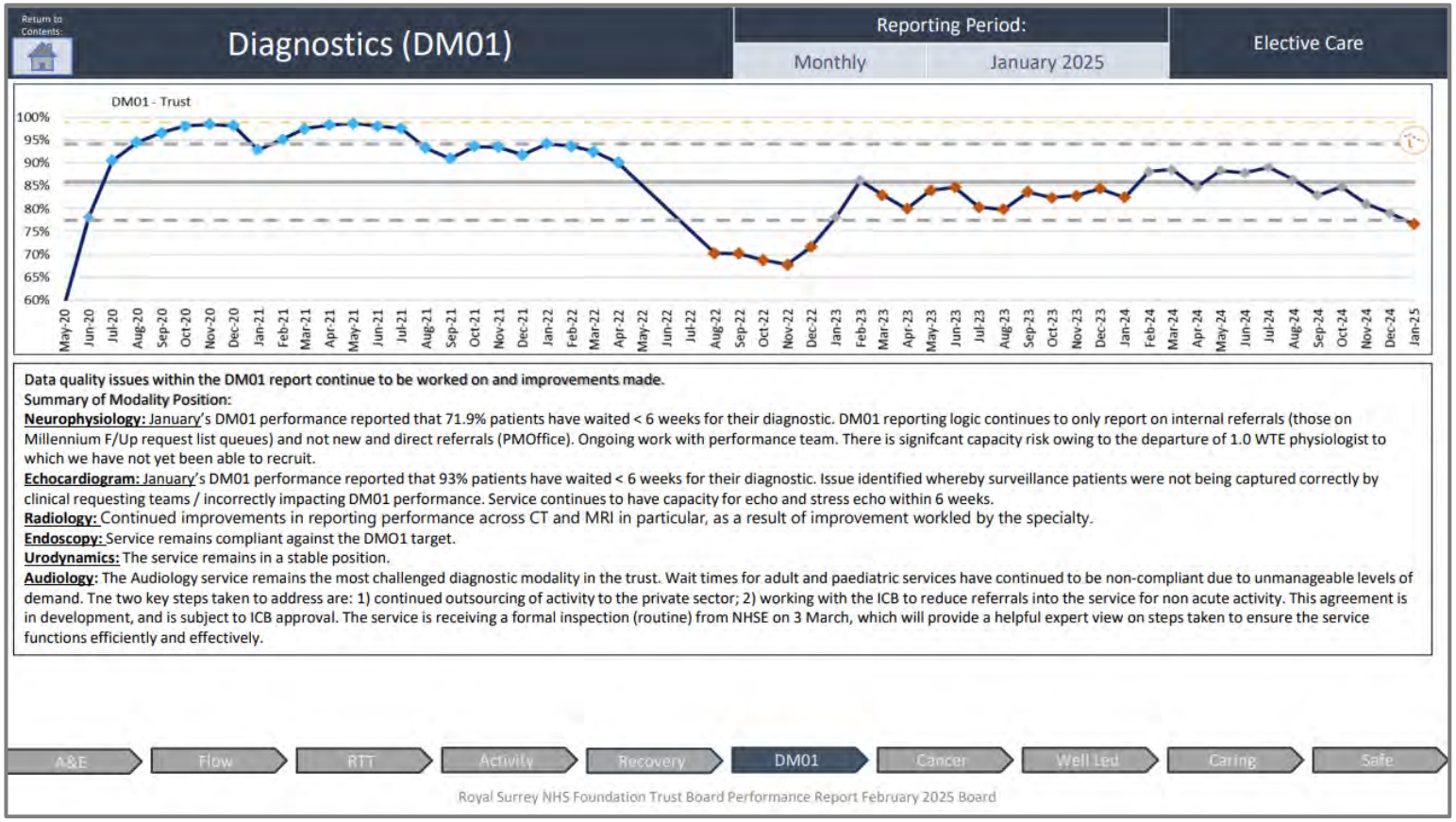


RCSH diagnostics metrics are on a downward trajectory. Many could be undertaken in community locations.

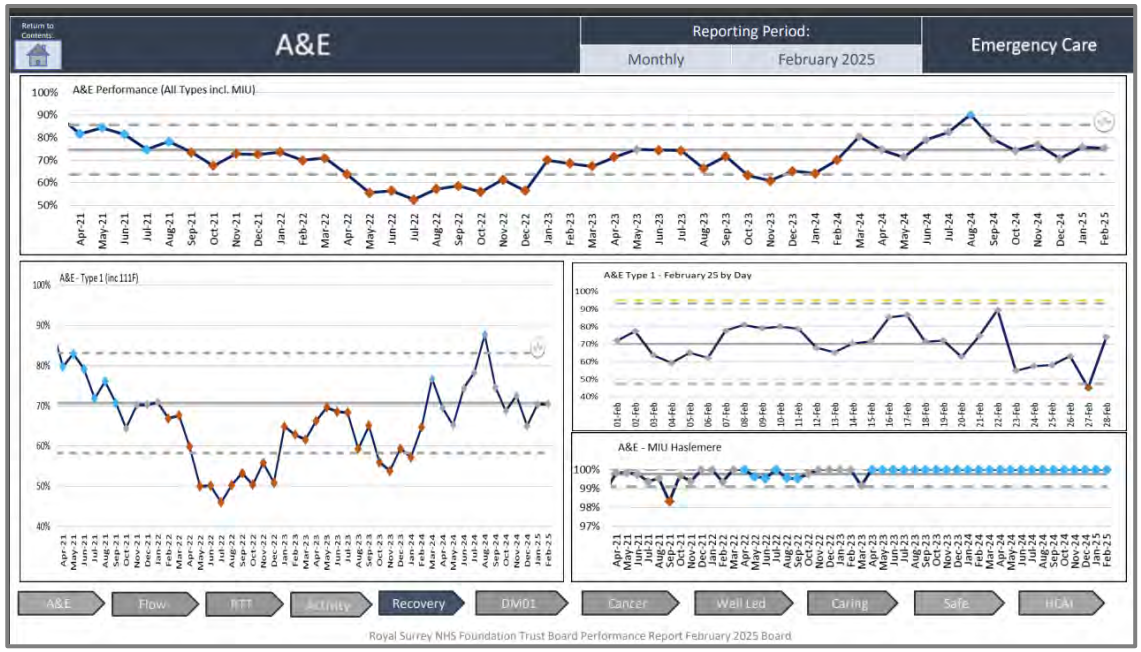
Will the opening of the Milford CDC make a difference?

How will the two locations be co-ordinated?

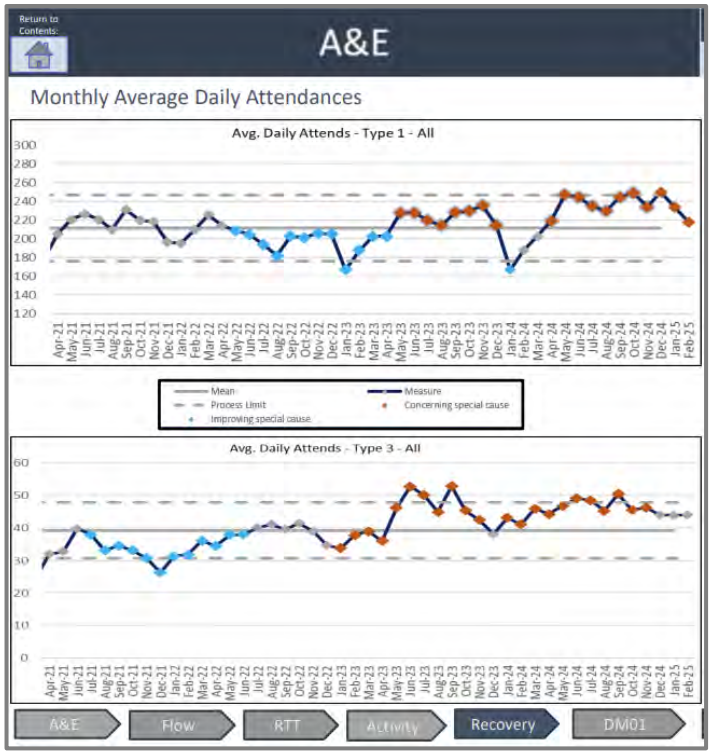
Which patients will go where?



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.

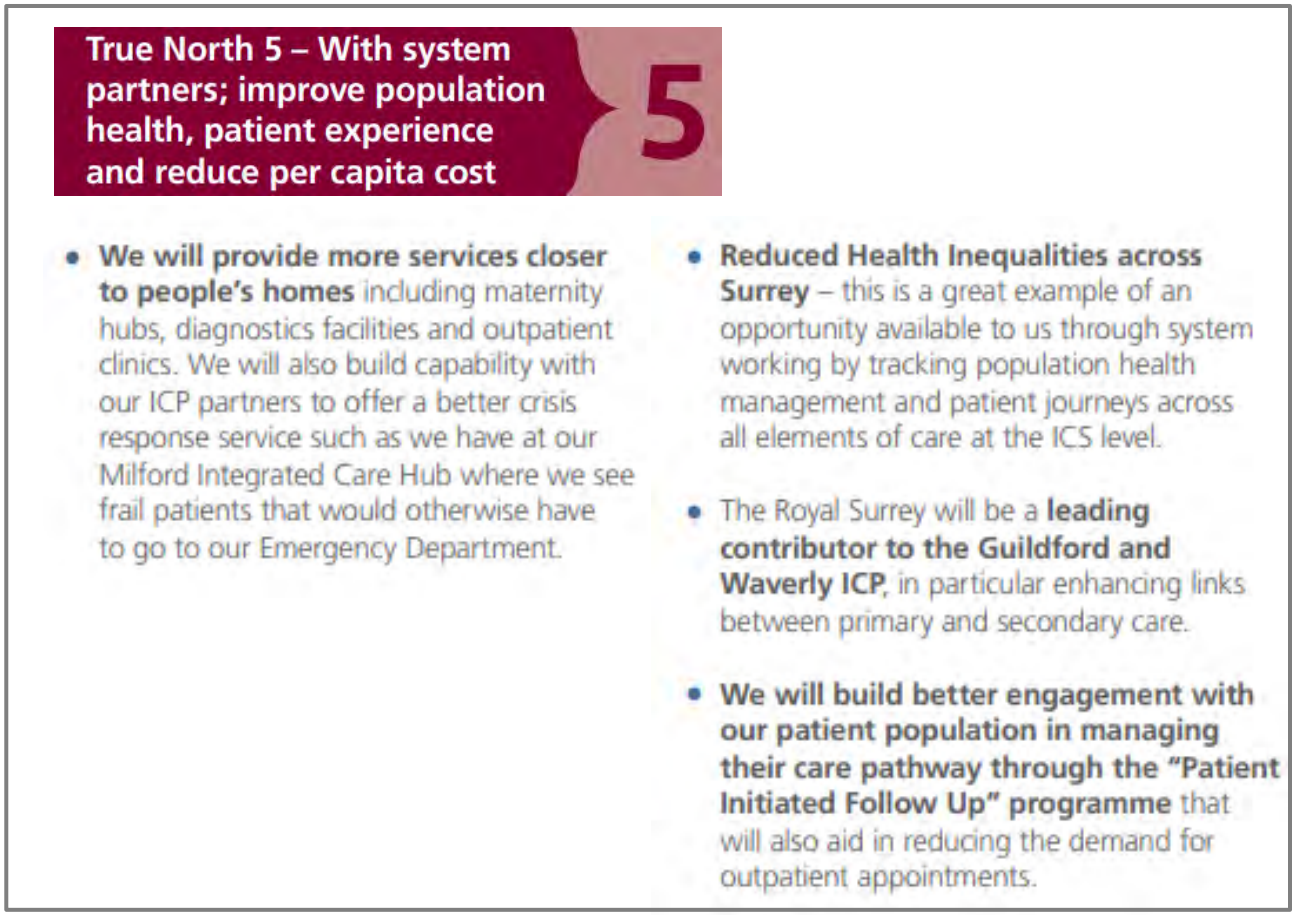
Service improvement: Subcos can provide a renewed or different focus on specific services, securing change more quickly and allowing for the introduction of new expertise.

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.

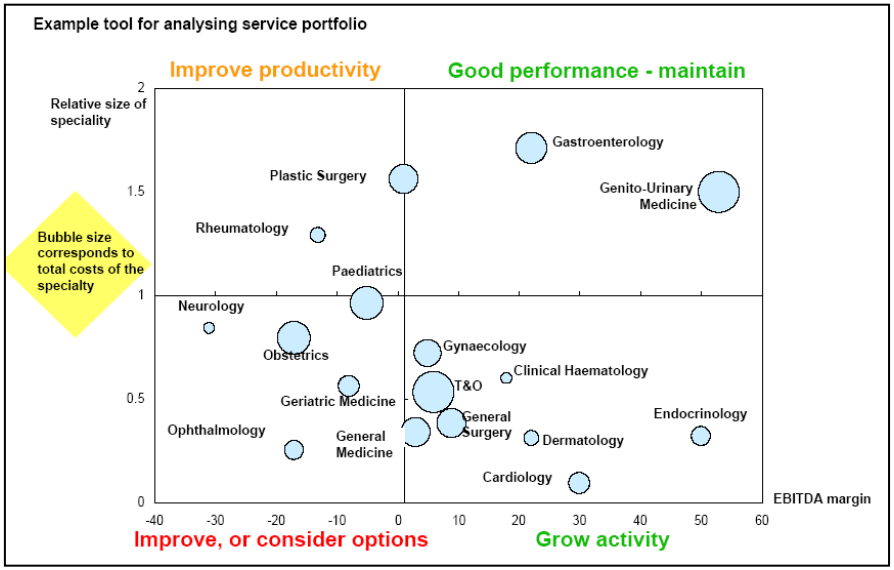
Which procedures/episodes of care make a profit and which a loss?

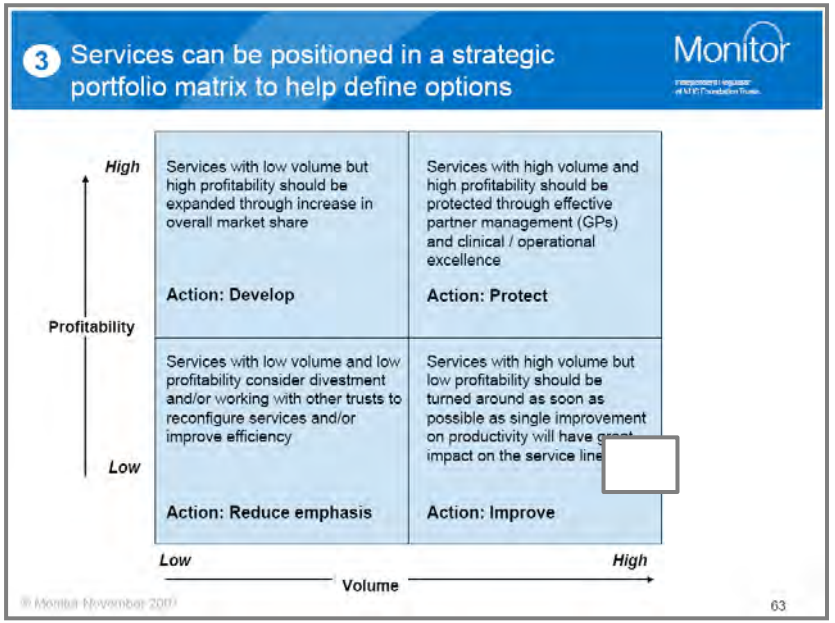
This technique, SLM – introduced by NHS Monitor - has been used across FTs.

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.

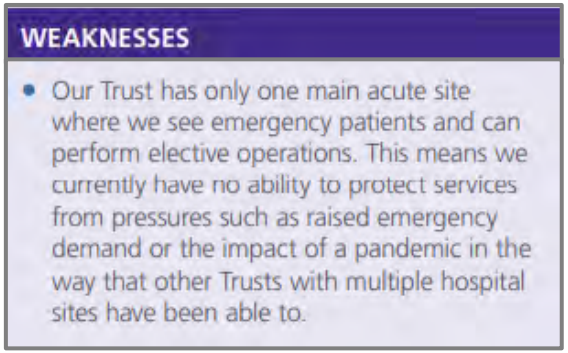
But is expansion of the district general hospital at risk to the continuous development of the cancer centre.

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.

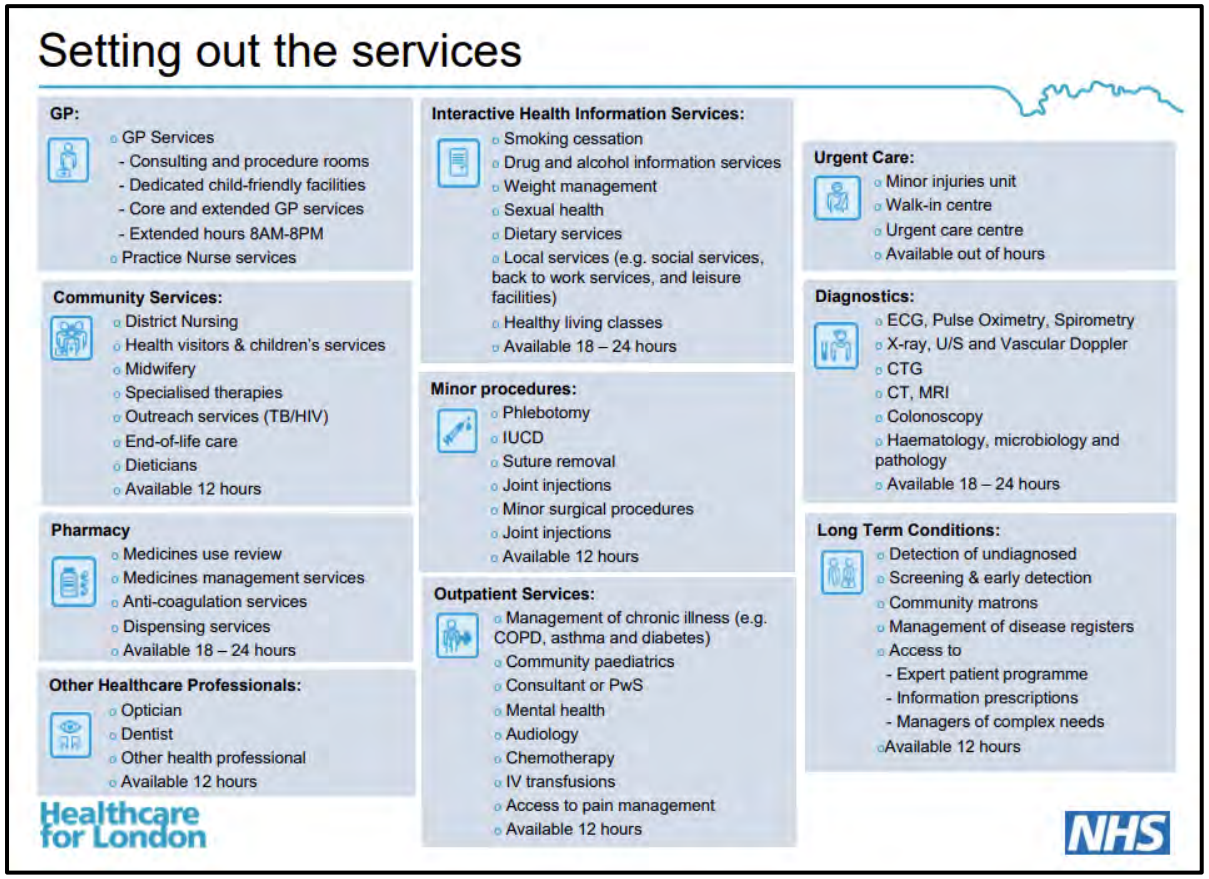
The RSCH has proven expertise in financial engineering and would find the most effective funding solution for this site.

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.