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".

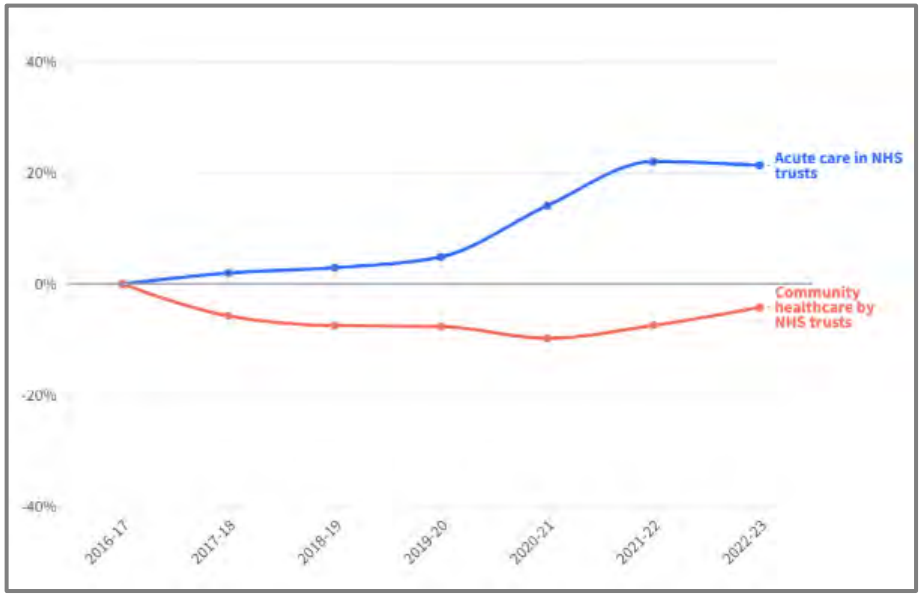
Between 2006 and 2021, Darzi notes:

"…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

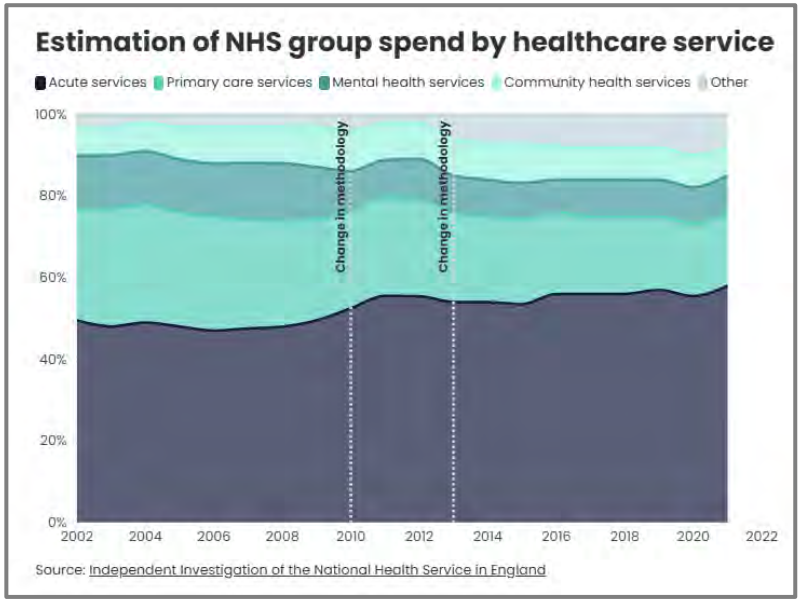
Expanding the supply of care in general practice is a crucial part of this puzzle and yet the NHS has made little progress in rebalancing funding towards non-hospital parts of the system.

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.

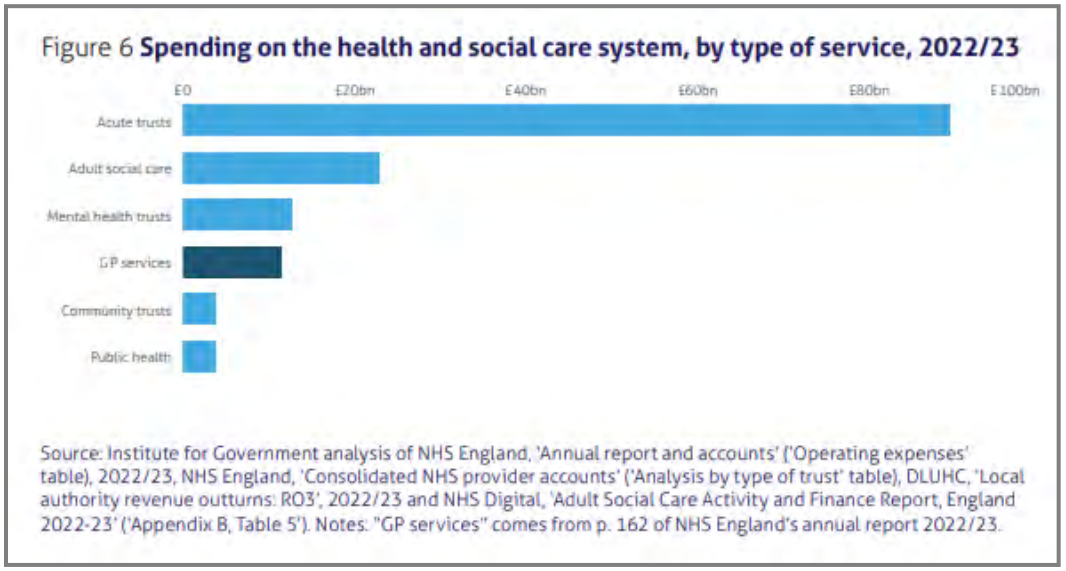
The RSCH through its 2018 ‘acquisition’ of the cottage hospitals in Haslemere, Cranleigh and Milford has laid down a lot of the model. It shares the hub and spoke vision:

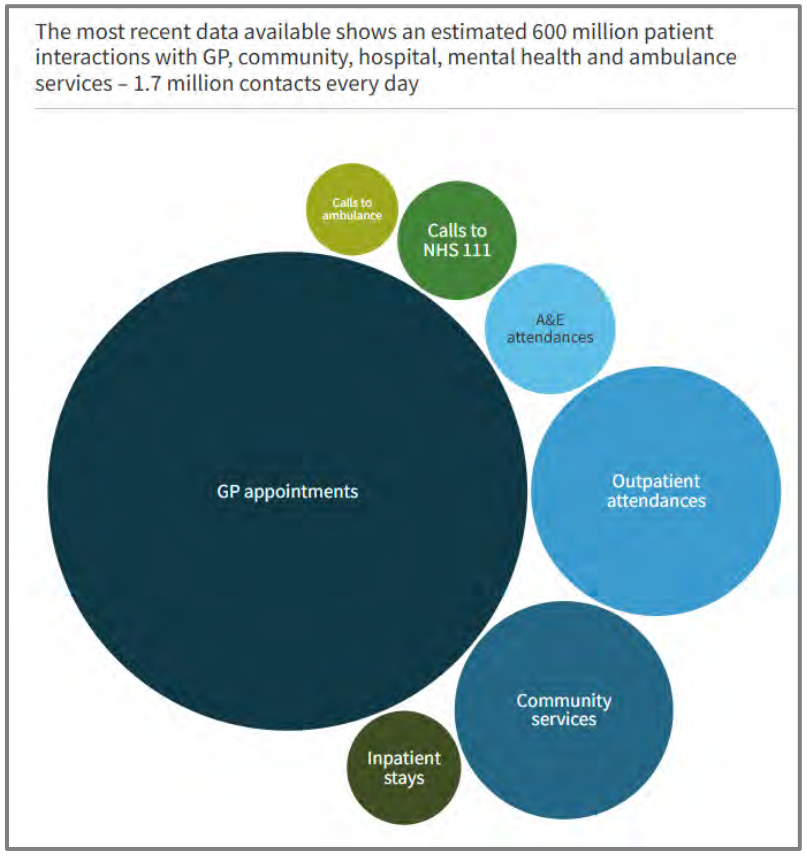
‘We are delighted that our bid to secure additional diagnostic capacity through our Community Diagnostic Centre, located at Milford Community Hospital, was approved in 2022. This £15m hub will provide MRI, CT and X-Ray services and has been designed in collaboration with our primary care colleagues with 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



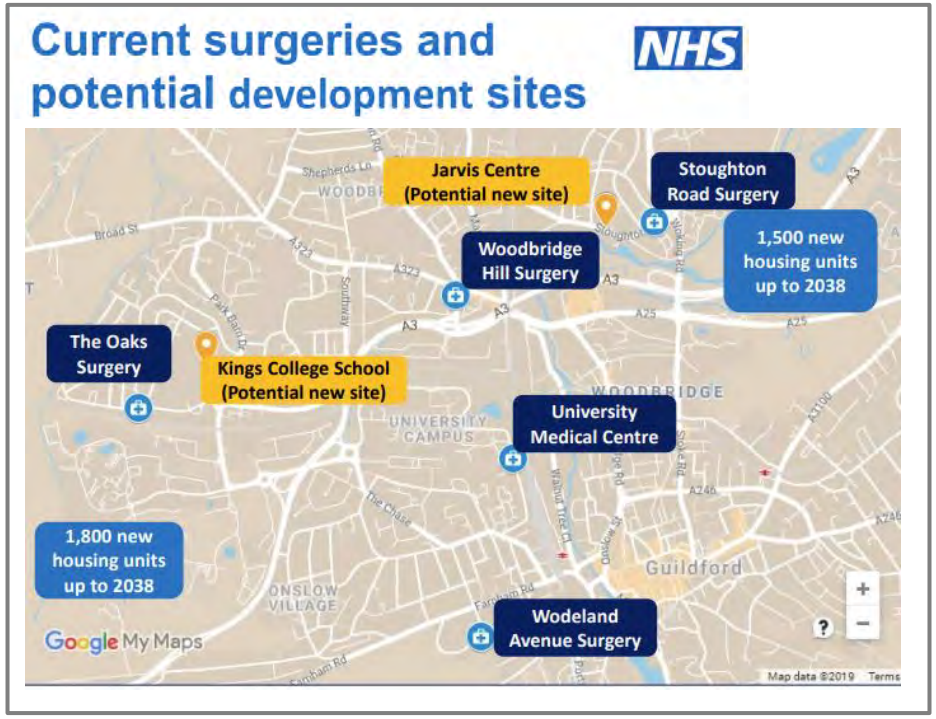


The King's Fund, June 2024.

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.

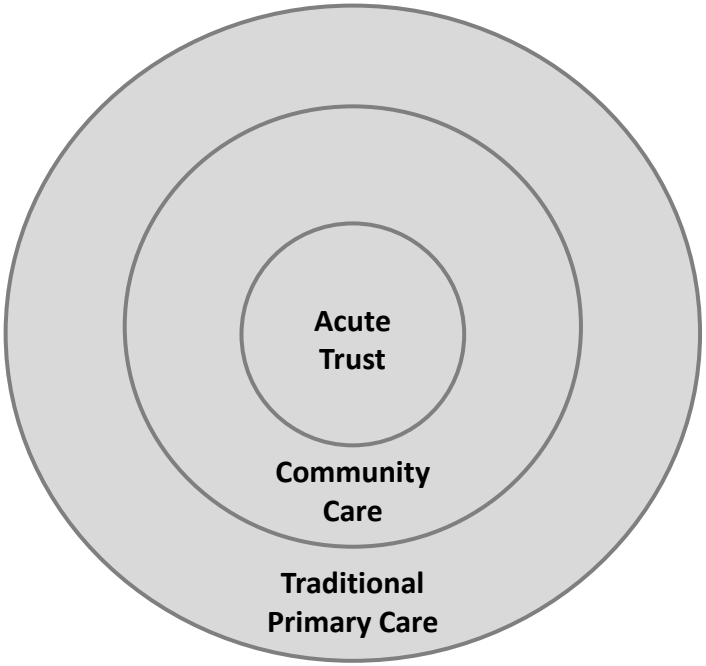
How does the ICB prioritise?

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?

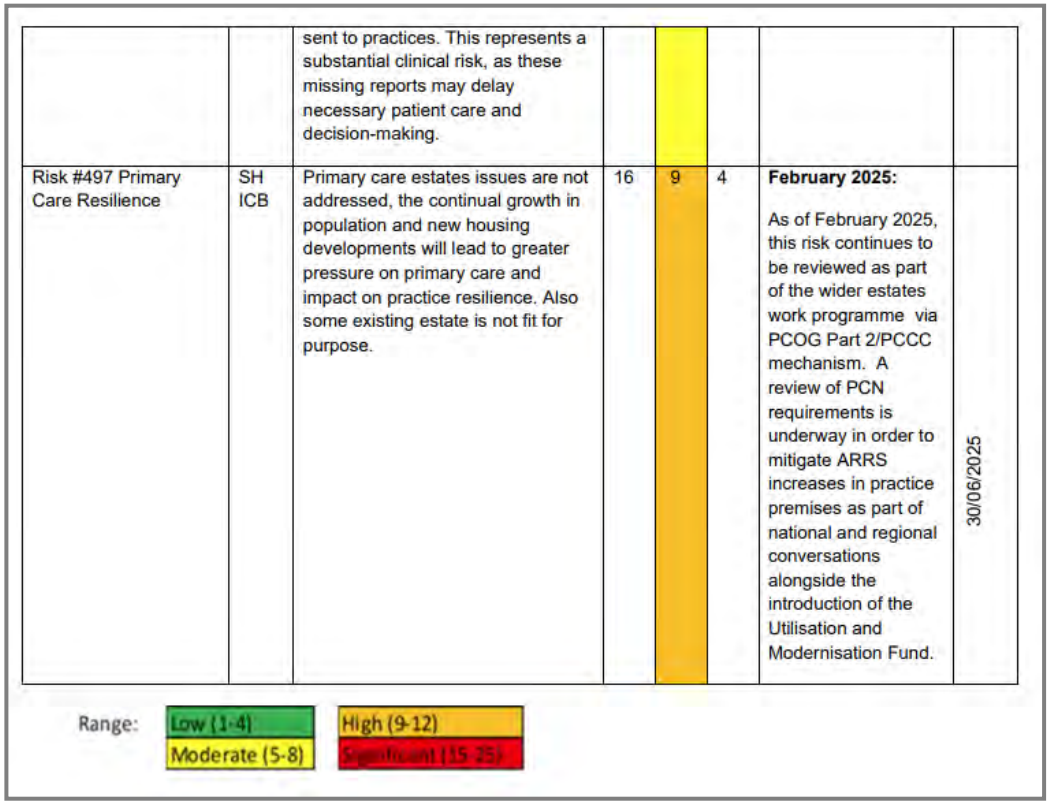
The ICB says current primary care premises are ‘High Risk’.

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

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..

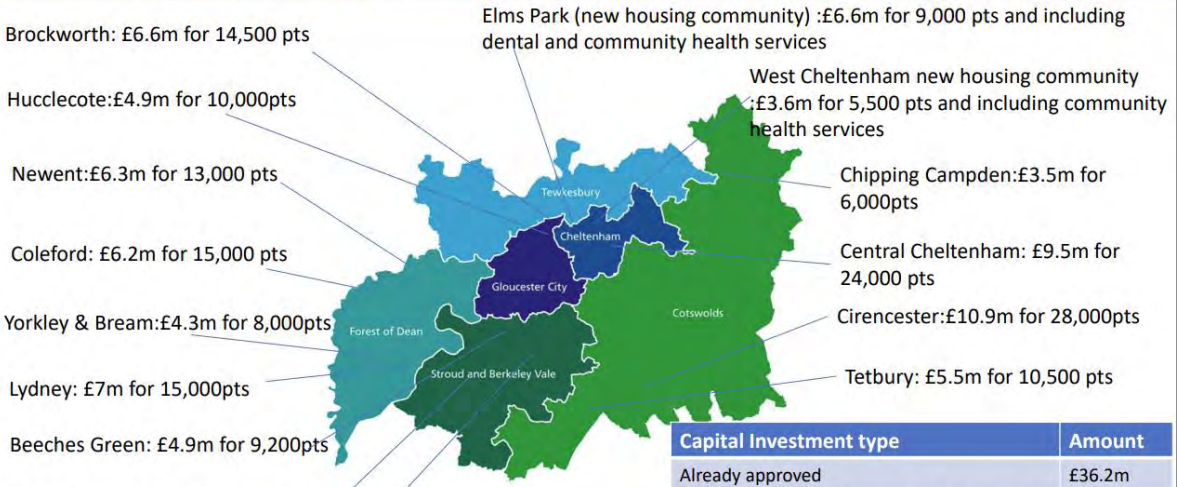
All practices in Gloucestershire are eligible to bid for an IG in line with national guidance and governance arrangements, regardless of whether the premises are owned by the practice or leased:

- 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 COUNTY COUNCIL

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

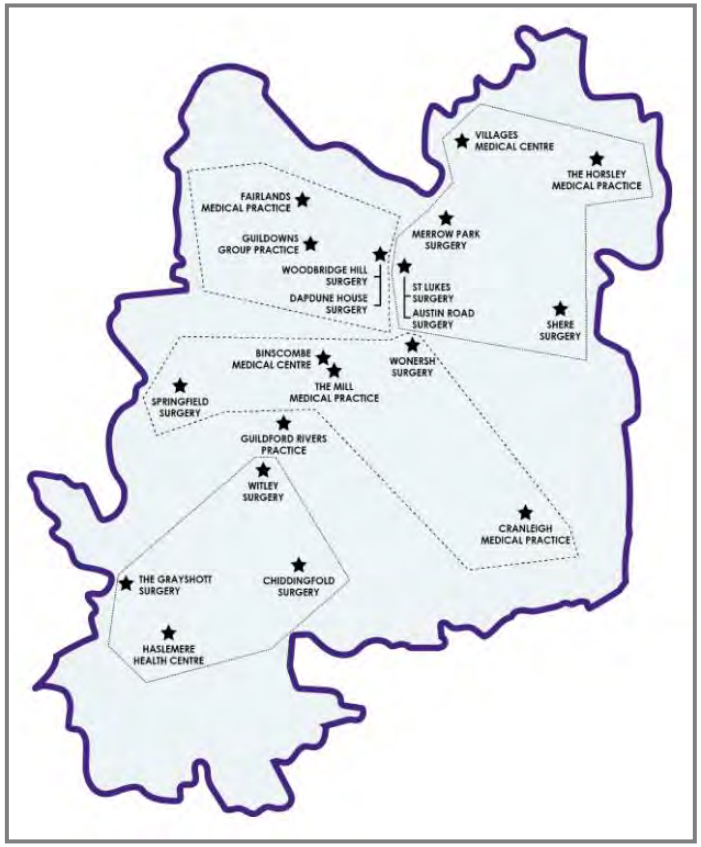
- Is there enough provider appetite (interested parties) to provide additional services?
- Can any new service be provided within financial sustainability limits?
- Will any other local services experience any destabilisation?

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.

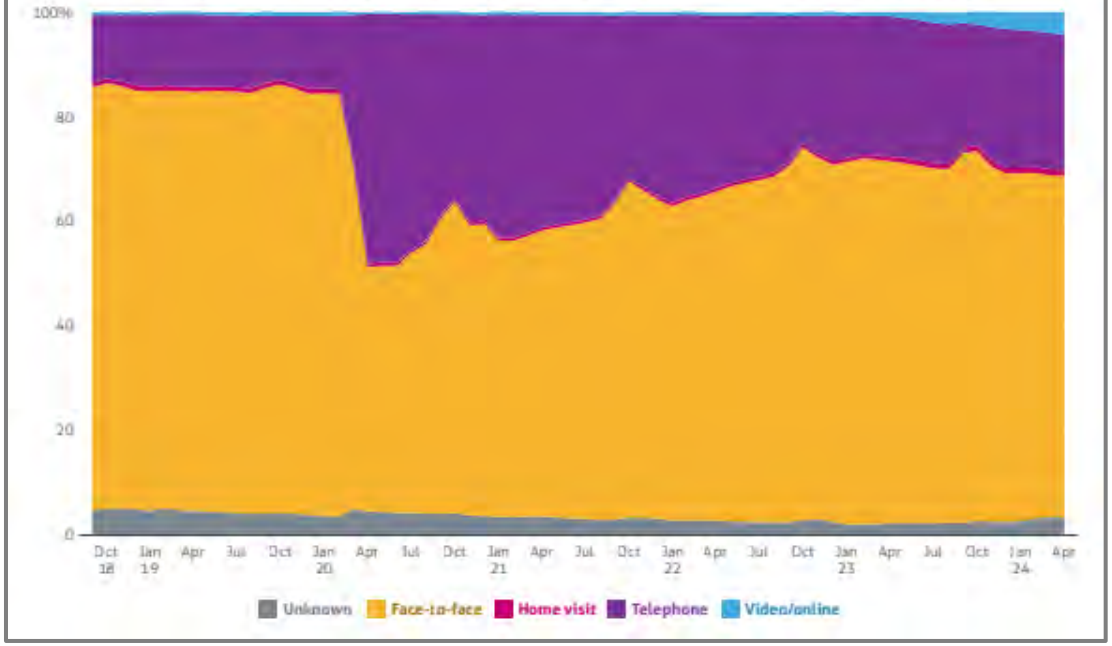
Most visits are made by the elderly. They are accustomed to the status quo.

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.