Moving to prevention

Moving from treatment to prevention is the third government strategy shift

‘The NHS should prioritise and optimise prevention through community engagement, system alignment, and incentivised investment. This includes supporting evidence-based prevention programs, such as those addressing smoking, obesity, and alcohol intake, alongside initiatives like the NHS Diabetes Prevention Programme.

Here's a more detailed breakdown:

Prioritise and Optimise Prevention: The NHS Long Term Plan emphasises a shift from solely treating illness to also preventing it, aiming to save lives and reduce demand on healthcare services. This involves proactively addressing health risks and promoting healthy lifestyles.

Engage Communities: Community-based initiatives and collaborations with local authorities are crucial for delivering integrated and seamless care. This includes reaching out to those who may be underserved or face barriers to accessing care.

System Alignment and Incentivised Investment: The NHS needs to work across different systems, including local authorities and public health agencies, to create a cohesive approach to prevention. Incentives for prevention efforts can help drive investment and support the development of new programmes’.

Google AI.

There are powerful incentives to invest more in prevention, but it never happens

‘Ill health is not just a health problem; it has major economic consequences too. Increasing numbers of people are out of the workforce due to ill health and more still see their productivity in work reduced as a result of illness, stifling economic growth.

All this is set to worsen as our population ages and our health needs become increasingly numerous and complex.

The ‘size of the prize’ for prevention is huge. It is estimated that applying known, evidence-based preventative interventions earlier and more broadly could add 20 more healthy days per person, per year, in the UK - a 33% reduction in ill health - unlocking a $401 billion (around £320 billion) rise in GDP over 20 years.

Upstream, preventative health interventions have proven cost-effectiveness and are known to be more efficient than downstream care. The ubiquity of digital technology means we are now able to do prevention in a personalised way and at scale.

Central to the success of this transformation in approach will be a new social contract for health - one where responsibility is shared between government and the people.

To make prevention everyone’s business will require a shift from a ‘do to’ to a ‘do with’ mentality - something we are already seeing in parts of the healthcare system.’

Mobilising the full range of programmes across organisations to deliver a community approach would probably be the best shot’.

‘Making prevention everyone’s business: a transformational approach to personalised prevention in England’, DHSC, May 2024.

There is another integration opportunity – collaborating with public health organisations

‘Section 82 of the NHS Act 2006 requires NHS bodies and local authorities to co-operate with each other ‘to secure and advance the health and welfare of the people of England and Wales’. In England local strategic partnerships (LSPs) have been used to help achieve this aim.

Where they are in place, LSPs operate at a strategic level and are led by local authorities. LSPs are non-statutory, non-executive, multi-agency bodies that are designed to bring together different parts of the public sector (including the NHS) as well as the private and voluntary sectors at a local level, so that initiatives and services can support each other and work together.

The 2012 Act placed a duty on ICBs and local authorities (through the HWB) to consider how to make best use of the flexibilities when drawing up the JSNA and JLHWS. To reinforce this duty, NHS England has a duty to promote the use of these flexibilities by ICBs’.
HFMA.

The Healthy Surrey and Wellbeing Strategy says, ‘Our Strategy has an increased focus on working together with communities which will be crucial to our success. Making the most of our strengthened system partnerships that have worked together so effectively during the pandemic will help us deliver outcomes in the key neighbourhoods and communities that experience the poorest health’.
Healthy Surrey, 2022.

The website gives no information about progress around the installation of its many programmes or its updating, ‘The community vision for Surrey describes what residents and partners think Surrey should look like by 2030 (a review is currently underway).’
Healthy Surrey, 2022.

A lot of community needs could be advanced by a stronger ‘retail’ presence from public health providers

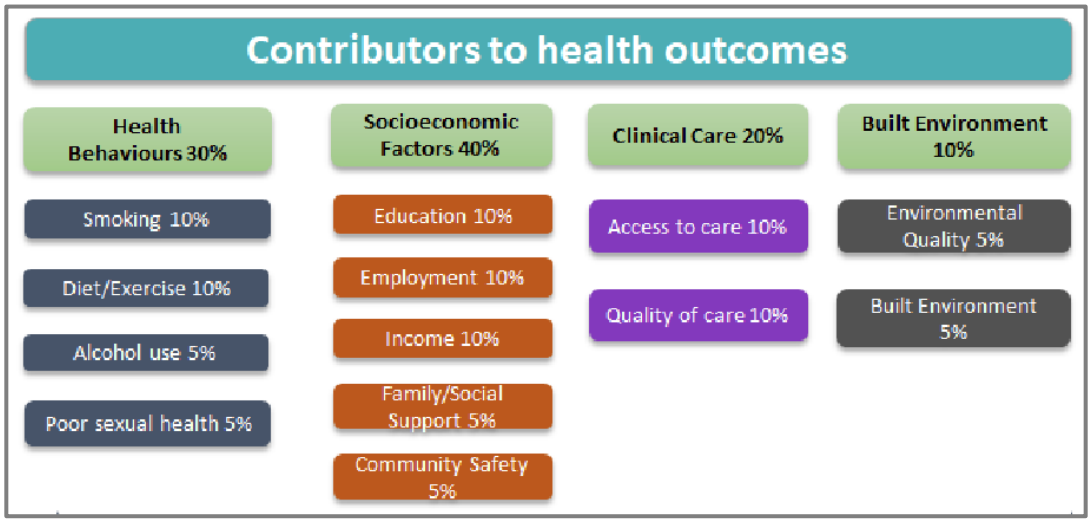
Clinical care may contribute only to health outcomes, there other factors as well, those associated with ’health behaviours’, see chart below.

Installing community health centres are a proven way of improving health behaviours which would tackle the further 20%.

These premises become the ‘anchors’ for attracting a range of health-related services.

A stronger community retail hub can be used flexibly by LA social services, voluntary organisations and health charities, which have been depleted in recent years.

Part of the fix of community care will be ensuring the better co-ordination of public health initiatives.



Surrey Heartlands ICS 5 Year Strategic Delivery Plan 2019 - 2024
A Partnership approach to transforming local health and care services

Surrey CC has a lofty vision for community action

Principles for working with communities

Through the process of refreshing the Strategy, the Health and Well-Being Board recognised the need for and committed to starting more collaborative and creative work with those communities in the geographic areas of deprivation with the poorest health outcomes. This commitment was based on the strong evidence that in order to achieve lasting change in communities, improve community safety and reduce health inequalities, it is essential that communities themselves participate and lead. Organisations need to be open to new types of collaboration where power sits more firmly with the communities we serve.

The Health and Well-Being Board has adopted the following principles (the Four Cs) for working with communities to guide this commitment across the system:

Community capacity building: 'Building trust and relationships'

Co-designing: 'Deciding together'

Co-producing: 'Delivering together'

Community-led action: 'Communities leading, with support when they need it’

Surrey County Council website.

‘Highlights’ seem to spend most time on intent, rather than delivery. The budget is small and shrinking

March 2025 (Surrey CC) Highlight Report

‘These Highlight Reports are published on the Healthy Surrey website after being reported to and discussed at the quarterly, public combined Surrey Health and Well-Being Board/Surrey Heartlands Integrated Care Partnership meetings.

They provide an overview of a selection of projects and programmes which directly support the delivery of the Surrey Health and Well-being Strategy with the priority populations. The reports also include the latest relevant data and insights, along with examples of collaboration to support communities experiencing the poorest health outcomes. They highlight the most recent opportunities for and challenges to the Surrey system. Lastly, they include an update on the progress of the Joint Strategic Needs Assessment (JSNA) and prevention communications.

The budget allocation is £36.6m per year. (That is equivalent of £55.66 of annual Council Tax for a Band D property.)’

Or about £4.4m for Guildford including staff and overheads.

https://www.healthysurrey.org.uk/about/highlight-reports/march-2025

If the full AARS staff commitment is taken up, practices can deliver more of the much-needed public health programmes

For many years a significant part of the public health agenda has been contracted to GPs for practices to deliver.

A lot of these services have been curtailed by increased pressures on primary care services.

The AARS opens up new opportunities for increased attention in this area, particularly from designated staff such as social prescribing link workers, health and wellbeing coaches, care coordinators, mental health practitioners, GP assistants and physician associates.

Many of the patients who would benefit from public health programmes have complex needs and often multiple co-morbidities, in particular mental health issues.

They become an opportunity for a truly multi-disciplinary team approach.

Contracts

Community care needs to be put on a more business-like footing

A re-organisation of community care will require a complete review of current activities.

In particular, this should include an audit of all provider contracts.

Commissioners have always struggled to engage with the long tail of providers – charities, voluntary organisations, CICs, etc - who deliver bespoke, one-off services.

There is no published management information about performance standards, KPIs or other metrics.

Terms and Conditions are often invisible, kept in the ‘black box’ of commercial confidentiality.

Most are remunerated on a block contract, usually on a last year plus basis with no resort to performance monitoring.

These organisations have their place in community care, but the quality of delivery and outcomes are not reported to commissioners.

Interruptions to care pathways are more likely as small organisations become stretched.

In such a federated environment, getting contracts right to secure community care delivery is critical

Contract development will become a key competency for those who will supervise the transition.

The first requirement will be to complete a full review of current service standards and delivery.

There is the likelihood that there could literally be hundreds of contracts in the Surrey Heartlands ICB area.

'The PMS contract is another form of core contract but unlike the GMS contract, is negotiated and agreed locally by ICBs with a general practice or practices. This contract offers commissioners more flexibility to tailor requirements to local needs while also keeping within national guidelines and legislation. About 28 per cent of practices held PMS contracts in July 2024'. **BMA.**

'An APMS contract allows services to be delivered by alternative providers, with locally agreed contracts and prices. The APMS contract offers greater flexibility than the other [GP] contract types. The APMS framework allows contracts with organisations (such as private companies or third sector providers) other than general practitioners/partnerships of GPs to provide primary care services. APMS contracts can also be used to commission other types of primary care service, beyond that of 'core' general practice. For example, a social enterprise could be contracted to provide primary health care to people who are homeless or asylum seekers.**'**
King's Fund, June 2020.

GPs will need to be asked about how they intend to operate in a community care re-set

This will start from what services they plan to deliver under their GMS contracts, or not.

How many want to operate new services and under which contract.

How PCNs see the deployment of AARS staff and whether GP practice supervision is the best way to deliver components of community care.

What will be the ongoing role of Procare and how the existing contract needs to be redeveloped.

Hailed as an NHS innovation at its time it may not have progressed as originally envisaged.

Annual reports at Companies House show a substantial reduction in staffing, for example.

What Covid did show was the agility of GPs to respond to a significant organisational and logistics challenge.

Since then, the growth of the AARS workforce has brought additional challenges.

All of the above will mean that the input of GPs views will need to be respected, whoever leads the re-organisation.

If RSCH got control of community care, they would make extensive use of the Head Provider contract

NHS England contracting advice says:

'It is becoming increasingly common for a provider (the "Head Provider") to sub-contract delivery of certain clinical services to a third party (the "SubContractor"). It can be the sub-contracting of an entire service or of delivery of part of a care pathway. It can be an isolated subcontracting by the Head Provider to a single Sub-Contractor, or the sub-contracting of a range of services to multiple Sub-Contractors under a prime contractor/lead provider (these terms are interchangeable) commissioning model.

The APMS contract offers greater flexibility than the other two contract types. The APMS framework allows contracts with organisations (such as private companies or third sector providers) other than general practitioners/partnerships of GPs to provide primary care services.

APMS contracts can also be used to commission other types of primary care service, beyond that of 'core' general practice. For example, a social enterprise could be contracted to provide primary health care to people who are homeless or asylum seekers. In 2018/19, 2 per cent of practices held this type of contract.' **NHS England**

The GPs with Extended Roles programme enables doctors to act independently providing a specialist role

The GPs with Extended Roles programme enables doctors to act independently providing a specialist role

‘A GPwER (formerly known as a GPwSI or a GP with special interest) is a practising GP with a UK licence who takes on a role outside of their primary care duties. The extended role typically occurs under a separate contract outside of your usual setting, enhancing your earning potential. It will be in addition to the care you provide to patients as part of your general practice.’

There are a range of positions that are classed as extended roles, for example:

- Minor surgery
- Dermatology
- Frailty
- Mental health
- Allergy
- Cardiology
- Sports medicine
- Musculo-skeletal
- Women’s health

In order to be a GPwER, you would need to maintain your general practice role’. **GP World.**

The local women's health hub initiative is one model for expanding community care

This programme has all the key attributes of a programme GP-led in the community

'We are a GP-led and GP-provided service, the provider contractually is Shere Surgery, a rural GP practice in Surrey.

We have a team of three GPSIs and run four clinics a week from two GP practices; on average we see 20 to 25 patients a week. We take referrals from all 21 practices in our CCG.

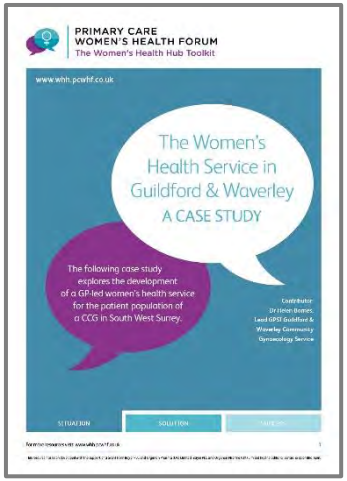
To improve access to women's health services by enabling women, traditionally seen in a consultant-led hospital clinic, to be seen in a GP-led community setting.

To reduce secondary care referrals and as such reduce the burden on the acute trust and improve waiting times.

Whilst we are a separate provider, we are contractually integrated with the local hospital.

The service is funded by the CCG, with the Community Gynae activity being included in the overall funding provision for outpatient gynaecology care. We have agreed tariffs for new and follow-up patients.

Within the service we use several systems including EMIS and Viewpoint [ultrasound software]'.



Combining the elements of many existing NHS policies (with others) would open up a raft of new care services

If a number NHS policies of the past twenty years are conflated, then an opportunity which was never imagined emerges.

Certainly, this opportunity is something which the more entrepreneurial GPs are likely to consider. This is what the individual NHS policies allow:

AARS: an expandable out-of-hospital, GP led base to expand the provision of community care services.

Patient Choice: the statutory entitlement for patients to choose their care.

Personal Health plans: the ability of certain patients to operate a health budget for the NHS to pay for their care.

Referral management: a possible AARS service providing a patient choice and navigation service. Could also offer a second opinion service.

Contracts: GPs can deliver additional NHS services under the PMS contract. The APMS framework allows contracts with organisations (such as private companies or third sector providers).

GPs with Extended Roles (formerly GPwSIs): GPs who wish to deliver specialist clinics.

Consultants working in private practice: many hospital specialists allocate their week into NHS and private sessions.

Combining them would create what is an essentially alternative stream of community delivered care services. It is very likely that independent hospitals and clinics would also want to participate.

Organisation: a new structure is required

Creating a cohesive, integrated system is complicated. The potential players have their own agendas

A transition to a fully-developed community care organisation needs whole system buy-in.

This is seen as the major challenge.

Currently, the parties involved have their own agendas.

FTs are resolutely autonomous.

GPs will do what's best for their individual practices.

Unification of practices in Primary Care Networks isn't always easy.

Community care is delivered by a diverse group of providers.

Negotiated compromises will be necessary.

The ICB will need to take a firm leadership role, using the levers available to it - mostly budget allocations and contracts - to deliver integration and a hub and spoke delivery system.

The RSCH would have to become a much larger system player, if it has the will.

Particularly if the ICB is diminished through the abolition of NHS England.

We have considered many of the options in this presentation. We're certain that others will arise.

To deliver this initiative, stakeholder interests have to be accommodated

You have to consider the players' motivations.

GPs will not see the benefits of strategic change; they will plough their own furrows. They will continue to respond to financial incentives as they always have.

The RSCH seems reluctant to embrace change beyond its own premises. Arguably, its business strategy may be compromising its role as a local district hospital.

The risk averse, only partially engaged, ICB will lose focus as it is disbanded.

So, who will take on the leadership role?

Our recommendation is that The Royal Surrey Hospital becomes the Royal Surrey Hospital *System.*

It goes further in its engagement with GPs in the Procare JV which is re-contracted.

It creates new alliances with PCNs, investing in new support services to deliver seamless care pathway management.

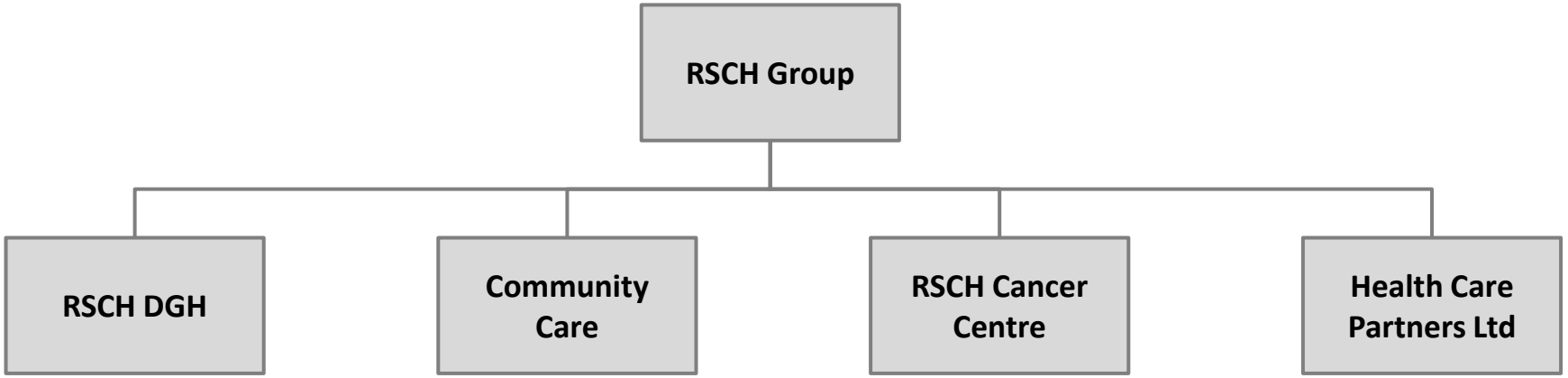
It looks at whole system capability – public and private sector – to create cohesive coverage.

Should Healthcare Partners Ltd expand its role to become a much more important entity in system management.

Reconfiguration is now essential. But existing capabilities must not be lost

That's why we are proposing a repositioning of current resources.

This will give these new business units a sharper focus.



RSCH DGH

An unremitting focus on being the community hospital for its extensive catchment area.
Strengthening its capability to address underprovided specialisms.
Working closely with the Community Care organisation to smooth pathways and extract maximum value for the system.
Being prepared to switch funding 'upstream' to increase its own productivity.
'Clear its decks' to ensure an improvement in RTT and other metrics.

Community Care

Operate in a business-like way, unifying providers to deliver clear objectives.

Collaborate fully with GP practices and PCNs to ensure an integrated delivery capability

Build an esprit-de-corps across participating providers to achieve a common culture

Operate from a purpose-built hub with a full set of back-office functions

Build a base for collegiate MDT working

Invest heavily in systems, data collection and analytics

RSCH Cancer Centre

Continue with existing business plan

Appoint its own leadership team which reports to RSCH Group HQ

Investigate all opportunities to increase prestige and reputation

Work with University and Medical School to attract new R&D funding

Health Care Partners Ltd

Refashion as the data and analytics support centre for all local providers

Work with all relevant stakeholders, viz. Procare to provide support, training for GP practices

Lead on projects to identify discrete population segments

Become a centre of excellence for NHS data, analytics to serve local communities

Which brings us full circle

What we are putting forward is not new. There is usually a solution somewhere in the NHS re-set

‘There are several challenges that providers of primary and community care often need to overcome to work together collaboratively, including:

- a history of poor relationships, different cultures and lack of mutual understanding between secondary and primary care providers
- procurement processes, contract structures and commissioning are still tailored to the GP partnership model rather than facilitating collaboration
- PCNs are still embryonic in some areas. Even with PCNs, navigating the primary care landscape within an STP/ICS footprint can be challenging for secondary care providers given the sheer numbers of GP practices in their patch.
- primary and secondary care clinicians need to be brought along with the integration agenda, often by workforce or technological incentives rather than financial incentives
- the lack of tangible deliverables for integrated health and care services can also be a barrier to collaboration, although increasingly systems are taking the initiative to do this locally
- Despite these challenges, community providers have adapted and reconfigured their existing multidisciplinary structures and workforce arrangements within the new PCN footprints. Given it takes time to develop relationships and an aligned vision for health and care services for the local population, there is a mixed picture of engagement and progress across the country. The case study of integration between primary and community care in Derbyshire shows how investing time and energy in building good working relationships is essential’.

NHS Confederation

Can the RSCH take the leadership role and also resolve the N&W Guildford GP premises deadlock?

Five years have elapsed since the CCG report on future GP premises for North and West Guildford.

The plan was for them to be built by now.

But the stand-off continued. The ICS has had no funding for practice redevelopment and the GPs no intention to redevelop their sites or pay for new ones.

But the world has moved on since 2019. NHS policy has also evolved.

Community hubs probably make more sense than continuous hospital expansion.

They should be the new hubs in a hub and spoke configuration

The Royal Surrey has the money. What we have been trying to do is it help it find the will.

We have spent a lot of time in this presentation attempting to make a case why driving through these innovations makes good business sense for both the RSCH and the local health economy.

And, of course, patients and population, too.

The 2019 CCG report recommended a second site

‘Based on the case for change and the outcome of the option appraisal the recommendation is that the option to develop new premises on the Kings College site in Park Barn and the Jarvis Centre on Stoughton Road is taken forward to the next stage’.

The Kings College, Park Barn site is no longer available.

Would one option be the reconfiguration of the nearby Hive facility, owned by GBC?

A wellbeing hub from which specialist health care MDT members could operate seems like a possibility.

‘Our role is to work with our amazing local communities to build confidence and empower people to enhance their wellbeing. This could be through finding and supporting local groups, connecting individuals with agencies or community facilities, or simply inspiring people to achieve their goals’, say a group based on these premises. Which all seems admirable.

There should be room for a GP practice, or a practice satellite on the site..

We leave the thought with you.