Balancing Guildford's Health Care

A presentation to the Guildford Society

10th June 2024

Health Care NAVIGATOR

Background

- This is a complicated presentation.
- But nothing is straightforward with the NHS with its anomalies, even incongruencies. We know from working for it.
- This means finding a structure for what follows has not been easy for us. We hope we don't lose you.
- We fear that a lot of NHS jargon (and particularly the acronyms) will be a challenge for the layman. This website might be helpful https://www.longtermplan.nhs.uk/online-version/glossary-of-terms/.
- We summarise our findings and recommendations in the next introductory section.
- For more background, please read our earlier presentation – 'Improving Guildford's Health', 10th March 2024.
- We look forward to receiving readers' inputs.

Introduction

Guildford is one of the healthiest towns in the country.

But there are neighbourhoods where people live with poorer health. Their conditions are influenced by a number of factors – relative deprivation, family circumstances, housing and income are just some.

These people live predominantly in three local wards, all north of the A3.

Primary care premises serving these communities were recognised as sub-standard in a 2019 report by the outgoing Clinical Commissioning Group who recommended their re-development.

To date, no progress has been made to change the situation. We are now putting forward some proposals of our own, largely building on earlier recommendations, but which include some redeployment of current resources.

Guildford's health providers have good ratings from their regulators.

The largest organisation by far is the Royal Surrey Hospital – an acute Foundation Trust with an annual income of £500 million.

It is an exceptionally well managed, business-minded, enterprise with a clear strategy. It is financially prudent and has built very large cash reserves.

Apart from its major site, it supports smaller community health centres in former, pre-NHS, cottage hospitals.

GP practices are financed by a mix of partner capital and capitation and other fee income from the NHS. Younger doctors are reluctant to invest in practice development, with the consequence that many of the premises are ageing, cramped for modern primary care and are poorly equipped.

The objective of this presentation is to initiate a discussion about how Guildford's health care capability might be re-balanced, particularly for those living in deprived circumstances

Our objective – in what is a complex, interlocking system – is to offer solutions which have no losers, certainly few compromises, and how local health care provision might be improved from within current resources.

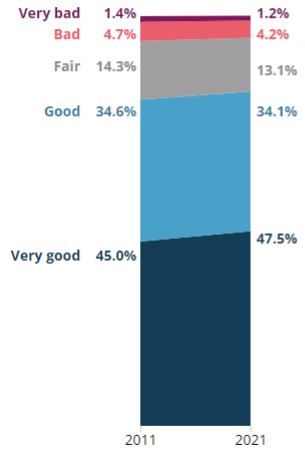
We would like to commend our proposals to you and would very much look forward to having your reaction.

Guildford is a healthy town with highly rated providers

- We should all celebrate that Guildford is a healthy town.
- Its residents are much healthier than the national average.
- ‘People in good/very good health’, Guildford 86.8%, compared with England and Wales 81.6%’, see charts.
- It has excellent primary and secondary care, highly rated by regulators.
- The Royal Surrey says its cancer centre is the fourth largest in the country.
- The town has a vibrant private health sector covering the complete range of treatments and therapies.
- The borough population probably spends more than £50 million annually on out-of-pocket health care and insurance.

But there is one warning: ‘There were only five local authorities where the proportion of people reporting very bad health increased (ranging from 0.1 to 0.3 percentage point increases). These were the Isles of Scilly (0.8%), Guildford (0.8%), Calderdale (1.3%), Mid Devon (1.0%) and South Cambridgeshire (0.8%).’ **ONS, 2023**

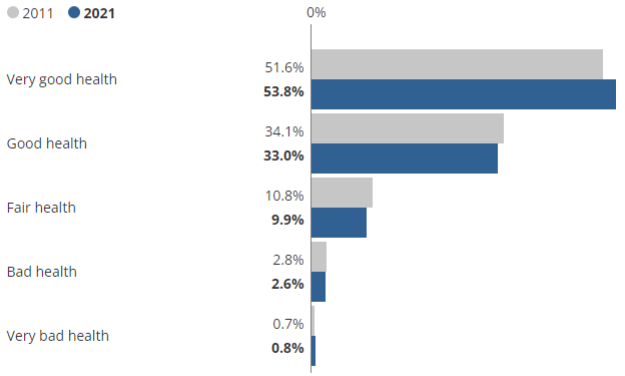
Figure 1: Age-standardised general health, 2011 and 2021, England and Wales



Source: Office for National Statistics – Census 2021

The percentage of people in very bad health in Guildford increased by 0.1 percentage points

Age-standardised proportion of usual residents by self-reported health, **Guildford**



Source: Office for National Statistics – 2011 Census and Census 2021

The move to an integrated care strategy

The current NHS strategy is to improve delivery through a focus on integrated care

The four key aims are:

- Improving outcomes in population health and health care.
- Tackling inequalities in outcomes, experience and access.
- Enhancing productivity and value for money.
- Helping the NHS to support broader social and economic development.'

King's Fund, August 2022

The local Guildford and Waverley Health and Care Alliance sees as its priorities:

- Creating a population health focus.
- Co-designing new models of care with local stakeholders, 'starting with five major programmes'.
- Introducing 'a sustainable community model of care [through] multi-disciplinary teams'.
- 'The integration of delivery teams in the OOH (Out of hospital) space'.
- 'Redesigning care pathways [with] more personalised care'.
- 'Driving integration through newly appointed Reference Groups' to get patient and partner participation.
- Build on 'the machine learning and AI developments of the University of Surrey (the THIM programme)'.

But there seems to be no reference to the outstanding issue of below standard GP premises in North and West Guildford.

Delivering a joined-up care delivery process is an essential prerequisite for a successful healthy economy

- Integration is at the forefront of the Surrey Heartlands ICS plan for Guildford.

Driving Integration

The Guildford and Waverley ICP will achieve its Long Term Vision via a structured and well managed Programme of work; governed by the Guilford and Waverley ICP Board. We are creating ongoing opportunities for our stakeholders to engage and help to continually shape our health and care provision. This includes clinicians and citizens in the newly created Reference Groups, will ensure that the views of all partners in change are taken into account. Our new ways of working together in partnership are:

The **integration of delivery teams** in the OOH space with community teams, hospital discharge and admission avoidance teams with adult social care teams will as they become embedded allow a "One Team" approach which will remove from of the barriers in place currently. We will invest in technology to help better manage people in their own homes and take proactive action before a more serious onset of symptoms occurs. We will build on the machine learning and AI developments in the THIM for dementia work locally working closely with the University of Surrey.

The role of the **PCNs to become the local organising entity** for community teams 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 creates new opportunities to deliver seamless local care.

A **population health management focus** will enable our PCNs to focus on key health and being issues in their localities. We will invest in targeted interventions to help meet those needs better working through a more integrated operationally delivery system. We will also invest more in prevention and independence initiatives to support local people to take greater ownership of their own health and wellbeing. This will involve creative partnerships with community, voluntary and faith based groups. We will use technology to better support people.

An important component of is that more care should be moved out of hospital and into the community

Shifting more care out of hospital and into the community was one of the key improvements outlined in the NHS Long Term Plan. While government health expenditure has continued to rise nearly five years on, the NHS's spend on acute care has grown faster than any other area, increasing in real terms by £10 billion (17 per cent) between 2020/21 and 2021/22, now accounting for over half (53 per cent) of total system spend (see Figure 1). Despite increased resources and prioritisation across the acute sector, A&E pressures have not ebbed and overall performance continues to face challenges.

With the sector working to cultivate system-wide resilience, particularly as winter approaches, there is an opportunity to revisit the goals outlined in the Long Term Plan and accelerate the shift to a sustainable, preventative model. A model that not only views prevention[1] through the lens of reducing hospital and emergency demand, but also better responds to the needs of the population it serves; a model that is good for the nation's health and the wider economy.

Community care is vitally important in its own right. But by investing in upstream, preventative care, a system has greater capacity to treat patients earlier in the pathway, which ultimately mitigates the likelihood that they will become acutely unwell and require more costly care.

"Community services are CCG-funded health services which take place outside of a hospital setting and are not part of the primary medical care portfolio. Community services cover a wide range of service types and different CCGs will commission different sets of services depending on the make-up of their populations and on historical factors affecting service provision in their area."

'Unlocking the power of health beyond the hospital', NHS Confederation, September 2023.

Also, that patients should be treated as near as possible to their home. There are no easy solutions

- This report by NHS Monitor (2016) shows the balanced argument:
- ‘The Moving Healthcare Closer to Home project emerged from conversations between Monitor, the Nuffield Trust and the sector. These revealed questions about the extent to which shifting health care closer to home and away from hospital settings would deliver significant cost savings for local health economies. Evaluating the financial impacts of schemes to shift healthcare closer to home is difficult because understanding what schemes cost and their broader effects is complex. Fluctuations in admissions and length of stay, and the stepped nature of overheads and staff costs in hospitals all mean that the relationship between volumes and cost is far from linear. Our research finds that moving healthcare closer to home will indeed be important in addressing the pressures of future demand and that this may avoid further costs in the longer run.
- That said, our findings caution against expecting too much from a shift away from hospital settings: this is no panacea. Developing schemes to move health care closer to home should sit alongside work on other solutions, such as improving internal processes and decision systems within acute hospitals.’ **Moving healthcare closer to home, Monitor, 2016**
- Acute trusts have always dominated local health systems. The over-arching challenge for ICSs will be to diversify treatment locations, moving care to where the patient’s interests are best served.

There are institutional features which complicate the successful delivery of integrated care

All the players in the local health economy have their own established positions:

- The ICS is charged with bringing the capabilities together and allocating the funding.
- The Royal Surrey has its own financial objectives as a largely autonomous Foundation Trust.
- GPs have their own personal and practice objectives.
- Primary Care Networks are beginning to project their own collective role.
- 'New' organisations like Procare can represent a more commercial stance for PCNs.
- The RSCH/Procare joint venture does present a unique advantage nationally on which it could build.
- A long tail of other providers: voluntary organisations and charities have contracts with the ICS. Many would benefit from a better business footing and more secure contracts.
- Public health services are provided by national NHS agencies and local authorities, principally Surrey County Council. Many patients locally interact with a number of these organisations because of their complex health needs.
- There are many hand-offs between their care providers. Better integration improves outcomes and lowers cost.
- The challenge of the whole health system is to ensure a level, equitable distribution of care for the local population.
- It all has to be delivered within a budget set by the ICS.

The size and direction of NHS investments in the community are key success factors

> **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 ICS 5 Year Strategic Delivery Plan 2019 – 2024. A Partnership approach to transforming local health and care services.

- But the most pressing need is to find an effective solution for Guildford's primary care delivery.
- Can a switch in local NHS investing strategies promote this opportunity?

The Guildford primary care opportunity

NHS England says investing in primary care resources is critical to the success of an integrated care strategy

- ‘For many people, their first point of contact with the health service is through primary care.
- There are almost four times as many patient contacts with these services compared to hospitals. GP practices have specialist knowledge of the areas they serve and the patients they care for, and are usually best placed to improve the health and wellbeing of residents.
- It is important that GP practices are able to build the capacity and capabilities required to meet the needs of their patients, including support to adopt new ways of working and to develop different ways of managing clinical demand.
- The Long Term Plan includes a number of key commitments to support this, including increasing investment in ‘out of hospital’ primary and community health services; investing in more GPs, alongside other roles such as pharmacists, counsellors, physiotherapists and nurse practitioners, to ensure that GPs’ skills are focused on where they can best help patients; and helping practices to embrace new, ‘digital-first’ services, providing convenient access to care and advice.
- GPs and their teams are also being supported to work more closely with colleagues in other practices across an area, forming primary care networks so that they can offer better access, more services and proactive care for patients.’ **NHS England**

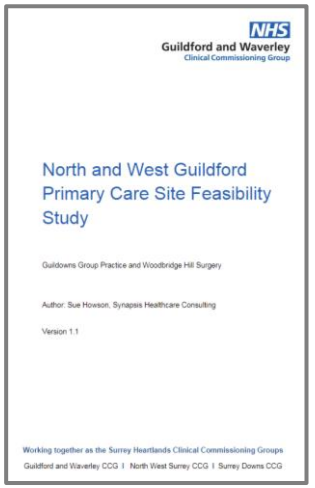
The ICS, since its establishment, has acknowledged that primary care in parts of Guildford needs attention

- ‘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.

A plan was developed by the outgoing CCG in2019

- In 2019, the situation was recognised in the then transitioning CCG's 97 page report which was delivered before the Covid-19 outbreak.
- A significant proportion of the population it affects is the town's most needy.
- It said, 'The current delivery model is not sustainable given the current pressures on primary care and the problems with the recruitment and retention of GPs.
  The current estate is not fit for purpose and with further additional demand in the form of two new planned housing developments at Slyfield and Blackwell Farm, the lack of primary care capacity in north and west Guildford will be further exposed.
- This study has concluded that the only viable option is to increase capacity through new build options.'
- There have been no new proposals from the ICS since 2019, despite this being, arguably, the biggest challenge in Guildford's health delivery.
- But we also see that the framing of the resolution could potentially have a positive cascade impact on the more general health delivery process locally.


NHS
Guildford and Waverley
Clinical Commissioning Group

North and West Guildford Primary Care Site Feasibility Study

Guildowns Group Practice and Woodbridge Hill Surgery

Author: Sue Howson, Synapsis Healthcare Consulting

Version 1.1

Working together as the Surrey Heartlands Clinical Commissioning Groups
Guildford and Waverley CCG I North West Surrey CCG I Surrey Downs CCG

The 2019 CCG timetable said that the programme should have been completed by now

8.4 Timetable

The timetable is dependent upon the chosen option and the procurement route. The following provides an indicative timetable but is subject to change.

Figure 43. Outline project timeline

Task	Timeline
Information capture and site analysis	March – April 2019
Stakeholder and patient engagement	May – October 2019
Feasibility Study Completed	October 2019
CCG recommendation to proceed	November 2019
Funding and procurement option appraisal	Nov – January 2020
Outline Business Case	Feb – October 2020
Full Business Case	Nov – April 2021
Construction	May 2021 – Nov 2022
Commissioning and mobilisation	December 2022
Opens to the public	January 2023

CQC data suggests that people served by all local practices receive good service from their GPs. But could they be better?

‘GP practices in the more deprived areas of England are relatively underfunded, under-doctored, and perform less well on a range of quality indicators compared with practices in wealthier areas.’

‘Practices in deprived areas on average have lower Care Quality Commission scores, lower QOF performance and lower patient satisfaction scores. People who live in areas of high deprivation have on average shorter GP consultations than those in wealthier areas, despite being likely to have more complex health needs.’

‘Access to ‘digital first’ primary care may not be equitable, and new models of ‘digital first’ primary care may not work for many patients with complex needs.’

‘Overall, policy efforts to reduce inequities in the provision of GP services over the past 30 years have not been enough to overcome them.’ **Health Foundation.**

- The gap between the economically most and least fortunate tends to widen.
- This phenomenon also crosses generations if not addressed.

Where Guildford’s primary care needs to be improved

There are pockets of Guildford with residents who are in poorer health often associated with deprivation

- Guildford borough has localities experiencing deprivation with poor health status, particularly north of the A3.
- 'Life expectancy at birth for men ranges from 76.6 years in Stoke to 87.6 years in Godalming Holloway, a difference of almost 10 years. LE at birth for women ranges from 78.8 years (Stoke) to 90.7 years (Blackheath and Wonersh), a difference of 11.9 years'.
- The Park Barn and Royal Surrey neighbourhood has the highest level of overall deprivation - with 35.4% of households suffering some type of deprivation.
- The next most deprived neighbourhoods were Woodbridge Hill (35.2%) and Bellfields, Slyfield and Weyfield (35.1%.)
- Residents of Guildford and Waverley CCG can expect better life expectancy than their counterparts in Surrey. LE is 82.6 years for men and 85.1 for women in Guildford and Waverley compared to 81.3 and 84.5 respectively for Surrey. At age 65 men in G&W can expect to live an additional 20.2 years, and 22.6 years for women. This is considerably higher than the England average for both men (18.6) and women (21.1). Within Surrey, Guildford and Waverley CCG has the highest LE at age 65 for both men and women.'
- The least deprived with Pewley Down and The Mount having a deprivation rate of 26.2%.
  ONS, GBC, SCC, Surrey Heartlands ICB.

- 'Health outcomes for people in Guildford differ depending upon where people live. Local GP services can play a critical role in helping people stay well for longer through proactive care and earlier interventions, but this is proving difficult for these practices.
- Stoughton, Stoke and Westborough are amongst the most deprived wards in Surrey: life expectancy is significantly lower for men and for women compared with other wards in Guildford.'
  Shaping the future of primary care in Guildford, Surrey Heartlands ICS.

The health load in deprived areas is considerably higher

- Although having multiple conditions is often thought of as being related to old age, 30% of people with 4+ conditions are under 65 years of age, and this percentage is higher in disadvantaged areas. Improving care for people with multiple conditions requires action across the NHS and other sectors, not just services targeting elderly people.
- People with multiple conditions have multiple consultations and treatments. We found patients with 4+ conditions had an average of 8.9 outpatient visits across 2.8 different medical specialties. Over the study period, they visited their general practice 24.6 times (or once a month on average) and were prescribed 20.6 different medications. This compares with the 2.8 outpatient visits, 8.8 visits to the general practice, and 5.6 different medications for patients with one condition. However, people with multiple conditions did not seem to have significantly longer GP consultation times despite their more complex needs.
- Our analysis shows that 82% of people with cancer, 92% with cardiovascular disease, 92% with chronic obstructive pulmonary disease and 70% with a mental health condition have at least one additional condition. But clinical strategies to manage care often focus on single conditions.
- Care for those with 2+ conditions accounts for a large proportion of NHS costs, including over half of the costs of primary and secondary care, and three-quarters of the costs of primary care prescriptions. Over the next 5 years, the rising number of people with multiple conditions is projected to increase total hospital activity by 14% and costs by £4bn. Therefore, a sustainable NHS will need to improve both the quality and cost-effectiveness of care for people with multiple conditions.
- Given our findings, long-term planning for the NHS needs to have a clear focus on people with multiple conditions. We suggest six key steps to improve care for this group: supporting those with multiple conditions to live well; developing new models of NHS care for those with multiple conditions; resourcing the vital role of primary care; designing secondary care around those with multiple conditions; using data and sharing information to improve care for those with multiple conditions; and evaluating what works.
- To ensure that everyone has the best opportunity to live a healthy life, urgent cross-government action is needed to tackle the underlying causes of multiple conditions, along with investment in the public services that affect people's health.

The Health Foundation.

The importance of GP premises issues was highlighted

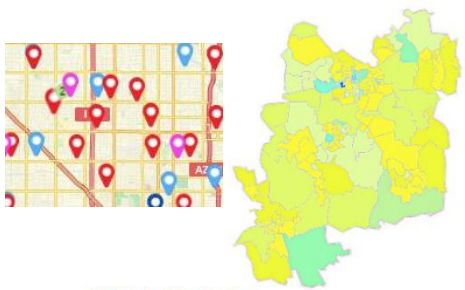
- ‘The main areas of deprivation are located to the north east and north west of the practice populations - Stoke and Westborough.
- The current delivery model is not sustainable given the current pressures on primary care and the problems with the recruitment and retention of GPs.
- The current estate is not fit for purpose and with further additional demand in the form of two new planned housing developments at Slyfield and Blackwell Farm, the lack of primary care capacity in north and west Guildford will be further exposed.
- The Guildowns Group Practice has expressed a desire not to hold any freehold property interests as a partnership going forward. For the Guildowns practice, delivering services across four sites further compounds these issues.
- 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 retention of Wodeland Avenue Surgery needs to be considered in the context of the overall primary care estate strategy for Guildford’.

North and West Guildford Primary Care – Site Feasibility Study, North and West Guildford Primary Care – Site Feasibility Study, October 2019.

Even within wards there are wide differences in the levels of deprivation and prosperity

- According to the last CCG survey in 2019, ‘the main areas of deprivation in Guildford are within the wards of Westborough and Stoke.’
- These are not areas of total deprivation: ‘within Westborough, 12% of the population live within the 10-20% most deprived areas in England (ranked 5726) and within Stoke, 13.3% of residents are within the 20%-30% range (ranked 6889)’.
- What is likely, however, is that within these subdivisions are people with the poorest health conditions and the greatest cost to the NHS.
- This means that probably the best way of looking for those whose health is linked with deprivation is to search at the individual patient level.
- This is entirely possible by reviewing hospital and GP data (HES, SUS, ICD-10, SNOMED-CT) are all available to help build a picture of sickness prevalence at the postcode level.
- It is quite straightforward to literally ‘Pin’ these individuals.

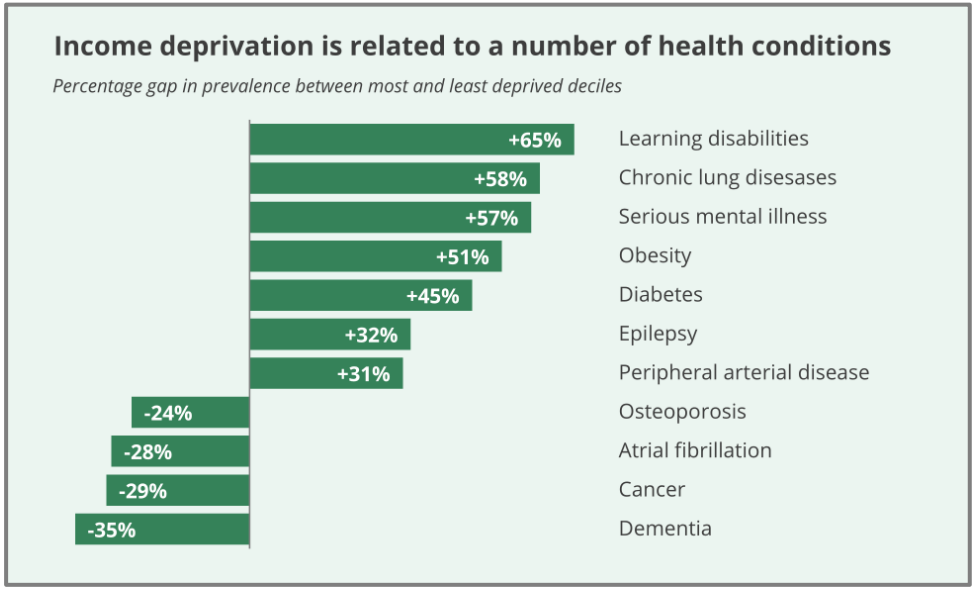
Figure 6. NHS Guildford and Waverley Index of Multiple Deprivation.



Can we attempt to put some of this into numbers?

- The population of Guildford is 163,000.
- The population for the three most deprived wards - Stoke, Stoughton, Westborough is 25,500.
- 1.9% of population have 65th birthdays every year, that's 3,100 for Guildford and 485 for the three wards.
- UK life expectancy at 65 is 19.5 years.
- The three wards have a life expectancy of 11.4 years at 65 = 76.4, a difference of eight years.
- For a single annual cohort 485 x 11.4 years = 5529 years over their collective lifetimes.
- 2019, five years ago, was the year the CCG published its Guildford GP premises report. Nothing has been built.
- 5529 x 5 = 27,645 lost years of life compared with UK average.
- Would the rebuilt GP facilities have made a difference?

Prosperous areas also have their health challenges – linked to longevity



- A positive number on the chart above shows that the condition tends to be higher in areas with high income deprivation than in areas with low income deprivation. For example: in the most deprived areas, one in every 165 people have GP-diagnosed learning disabilities – compared with one in every 272 people in the least deprived areas. This means people living in the most deprived areas are 65% more likely to have a learning disability. By contrast, atrial fibrillation (irregular heart rate) affects 1 in 67 people in the least deprived areas but 1 in 48 people in the most deprived – a gap of -28%.Some conditions, like dementia, are much more common in older people. Areas with older populations also tend to be less income-deprived. This is likely to explain why (for example) dementia is more common in less-deprived areas.

Health inequalities: Income deprivation and north/south divides, January 2019, House of Commons Library.

Do the richer Guildford wards get better health care because their populations demand them?

- Pressure from local resident protest groups can influence local NHS decision-making
- The strength of the middle class lobby has probably caused harm in the past, and may be continuing to do so.
- Has the NHS locally been driven towards making suboptimal decisions with its resource allocation?
- Why has there not been pressure from the wards north of the A3 for a better community health service?

Protesters demonstrate against the threatened closure of beds at Cranleigh Hospital

MP accused of exploiting minor injuries unit fight

Farnham Herald
28th Oct 2019

SHARE

Jeremy Hunt with MIU staff members

The inverse care law

50 years ago, the British GP Julian Tudor Hart first described the 'inverse care law' in a paper in the Lancet. The law states: 'The availability of good medical care tends to vary inversely with the need for it in the population served.'

In other words, people who most need health care are least likely to receive it.

This means that RSCH has to support its legacy medical real estate

- ‘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.’
- We have much to do as we construct the building, hire new staff, and optimise the pathways of patients using the facility. Whilst some services (such as X-ray, echo and ultrasound) are already up and running, the larger development which will see new CT and MRI scans will be ready in late 2024.’ **Royal Surrey Annual Report 2023/4**
- Does the accompanying picture provide any clues?
- Buses only go to Milford Hospital on Tuesdays and Thursdays. It is a 18 minute walk from the Railway Station.
- Is this a case of money being drawn against the Hospital assets, rather by the ICS to support primary care practice?
- Shouldn’t the GW Place ‘hub and spoke’ model include North and West Guildford?

It’s history and NHS reorganisations which have created today’s local care footprint

Why are NHS services distributed unevenly across the Royal Surrey catchment area?

- All health care systems have their own anomalies which can distort both delivery and development.
- NHS England accepts that all health systems are different and allows ICSs to produce their own plans aligned to local circumstances.
- These factors include size, demographics, history, politics and geography.
- There is plenty of evidence of ‘unwarranted variation’, which leads to significant distortions in health service delivery. There is a canon of work on the phenomenon of the Surgical Signature which explains unwarranted variation.
- For example, the creation of the NHS in 1948 was built on a framework of existing medical institutions, many of which are still used today – the hospitals in Farnham Road, Milford, Cranleigh and Haslemere are all local examples.
- Cranleigh, population 12,700, Haslemere, 12,000 and Milford 4,200 are today included as satellites of the RSCH system.
- Yet for the population of 25,000 in the three wards north of the A3, there is no legacy of community hospitals.
- This means that they receive no development money from the RSCH balance sheet.

Care needs to be provided more equitably across Guildford. What funding opportunities are available?

- The reasonable starting place is The Royal Surrey Hospital as the largest operating unit within the local health economy.
- Foundation Trusts produce their own plans and strategies. These are usually mostly aligned with the care needs of the local population.
- But they have other agendas as well – reputation development, revenue growth, financial security, disease specialisation are just some of them.
- All hospitals find themselves in a perpetual juggling mode balancing these and external factors
- Commissioners, nowadays Integrated Care Systems, often find themselves in a complex negotiating struggle with major providers.
- All of this happens in an operating environment which is dynamic, complex and political

It’s meeting the reasonable needs of RSCH which is the key to unlocking transformation

Royal Surrey Strategy

- The RSCH says that [The Hospital] 'provides 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'. **Royal Surrey Hospital Annual Report 2022-3**

'The Royal Surrey is the fourth, nearing the third, largest cancer centre in the country', says Chief Executive of NHS Foundation Trust, Louise Stead.

'The new cancer centre will enable the hospital to treat 7,000 more patients every year.

Royal Surrey is a regional centre for cancer services supporting a population of up to 3 million (around 4.5% of the UK's population).

60% of surgical procedures carried out at the hospital are cancer related.' **RSCH Website**

- A focus on cancer is also likely to attract research and development funding and clinical trials. This higher level of expertise creates the opportunity for greater collaboration with the University, the new Medical School and the Research Park.

The Royal Surrey Hospital is by a long way the dominant player in Guildford's health care

- 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.

Foundation Trust hospitals have enormous scope to pursue their own agendas

- 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 strategy to some degree as the 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.

Acute hospitals do not invest externally to keep people out of hospital. This is the ICS responsibility

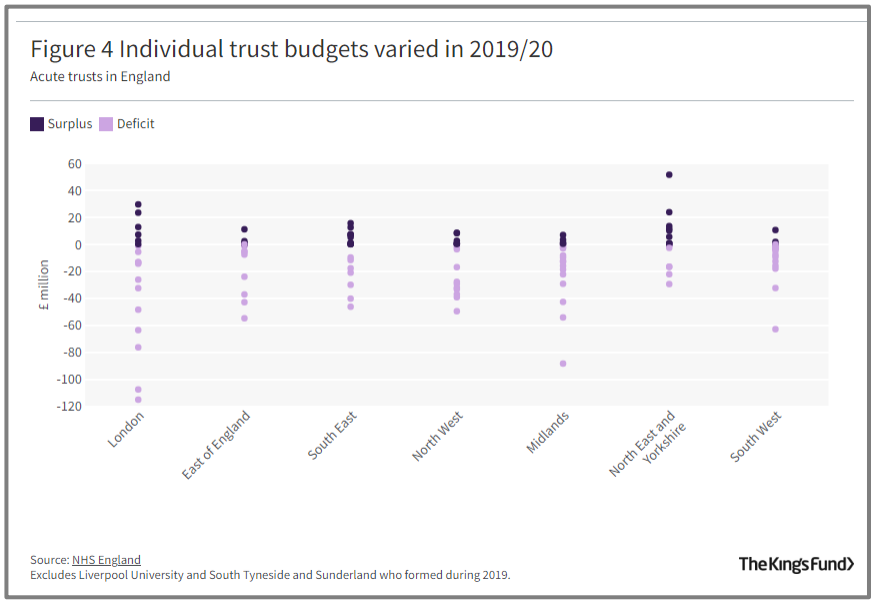
- Acute FTs are the most business-like of all NHS organisations. They are constantly looking to grow. They are loathe to give up revenues.
- Income is relatively predictable, year on year, from a mix of sources.
- ICSs follow DHSC guidelines about the number of episodes of care which should be delivered, particularly for those providers who are remunerated via block contracts.
- This number is capped by the budget. If exceeded, the provider goes into deficit. But the hospital will then extend waiting times.
- Admissions come from two main sources: elected care, normally referred by GPs and set up after outpatient consultations, and emergency cases, many of which are so-called ambulatory care sensitive (ACS) conditions.
- ACS cases are costly, often lengthy in terms of length of stays, This means that if ACS admissions are reduced, more will be able to be spent on higher revenue electives.
- Also, delayed discharges often result from ACS patients, taking up bed space and reducing capacity for acute procedures.
- To a large degree acute hospitals have to deal with what turns up at their door.
- This is why attention to upstream (community) care can change the hospital's financial situation.

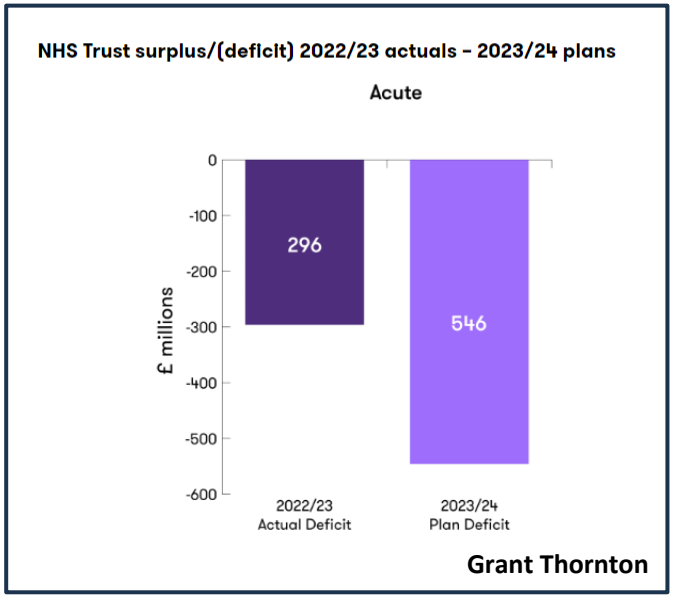
The RSCH is an expert manager of its finances

- The Royal Surrey manages its finances with a high degree of precision.
- Not many not-for-profit enterprises can consistently bring their half a billion pound organisation so close to breakeven.

	Income £m	Surplus £000s
2022/23	529.8	651
2021/22	497.9	1,407
2020/21	467.2	603

- The situation for acute Foundation Trusts across the country puts the RSCH position in perspective:





The Royal Surrey's continuous prudent management has built a significant cash pile over recent years

- Its cash reserves at £80 million at 2023 year end place it close to the very top of acute financial trusts.
- This was the consequence of a strong revenue performance during the period 2018-2021.
- The cash is part of so-called 'Taxpayers' equity', public funds invested in the hospital.
- The responsibility for their spending is solely the responsibility of the Foundation Trust board.

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	
	2022/23 £000	2021/22 £000	2022/23 £000	2021/22 £000
At 1 April	**108,520**	**99,536**	**108,181**	**98,624**
Net change in year	(24,981)	8,984	(27,821)	9,557
At 31 March	**83,539**	**108,520**	**80,360**	**108,181**
Broken down into:				
Cash at commercial banks and in hand	3,446	437	267	98
Cash with the Government Banking Service	80,093	108,083	80,093	108,083
Total cash and cash equivalents as in SoFP	**83,539**	**108,520**	**80,360**	**108,181**
Total cash and cash equivalents as in SoCF	**83,539**	**108,520**	**80,360**	**108,181**

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	80.4

RSCH income sources

- The largest share of RSCH income comes from the Surrey Heartlands ICS, although NHS England and other government health organisations also made a substantial contribution in 2022/23.

	£m	%
Surrey Heartlands	181.1	34.2
NHS England	156.6	29.5
DHSC	13.6	2.6
Health Education England	14.3	2.6
Others (50+ payors)	164.2	31.0
Total	529.8	100.0

- There is no breakdown for NHSE, but based on prior years, we estimate specialised commissioning (mostly for cancer care, presumably) was in the range of £15m-£20m. This represents a substantial growth opportunity for RSCH's oncology unit.
- Surrey Heartlands ICS budget for 2022/23 was £2.14bn. The RSCH received 8.5%. Total commissioning income was £468.7m (88.5%).
- R&D income was about £21 million, the same as the prior year.

The RSCH might look at the Royal Marsden Hospital as a business case it might emulate

- The income of the Royal Marsden Hospital, the UK's leading cancer centre builds through attracting 'imports' of cancer cases from other ICSs and NHS England Specialised Commissioning, plus significant private patient income, see the next slide.
- Consider this quote from the King's Fund - 'In 2018/19, a substantial portion of [income for the Royal Marsden NHS] Foundation Trust came from research and development funding or private patient work, and the income that did come from CCGs or NHS England was drawn from multiple ICS or STP regions outside its 'host' ICS in south-west London.
- 'This may be an extreme example, but not a unique one. Many providers within an ICS will draw substantial income from other ICSs (and therefore depend on the decisions within those ICSs and, indeed, other funders).'
- 'Provider collaboratives may take on some role around mutual aid for their organisations but again, the footprints of providers vary greatly and these collaboratives will be drawing income from many separate decision-makers.' **Reforming the finances of the NHS, Kings Fund, 2020**
- Research and Development funding is also important.
- This income distribution by source has continued over many years.
- The Royal Surrey could follow a similar strategy – maybe cross-subsidising local hospital activity from income from other ICSs and for cancer treatments.

The Royal Marsden finances

- Two thirds of its income comes from ICSs and NHS England, because these would be Specialised Commissioning cases
- Because it attracts a large proportion of private patients (£162m in 2021), it is consistently able to generate significant surpluses.
- Cash balances totalled £166m at year end 2023,'down slightly from the previous year'.

Note: The establishment of the Genesis private cancer centre at the RSCH may, of course, divert some of the potential private patient income.

3. Operating income

3.1 Income from activities by source

	2022/23 Trust	2022/23 Group	2021/22 Trust	2021/22 Group
	£000	£000	£000	£000
Commissioner requested services				
CCGs, ICBs and NHS England	**298,610**	**298,610**	254,448	254,448
Department of Health and Social Care	**11,599**	**11,599**	10,910	10,910
Other NHS and non-NHS	**1,043**	**1,043**	2,066	2,066
Non-commissioner requested services				
Private care	**162,343**	**162,343**	141,612	141,612
	473,595	**473,595**	409,036	409,036

The above analysis classifies income from activities arising into commissioner requested and non-commissioner requested services, as set out in the Group's Provider Licence.

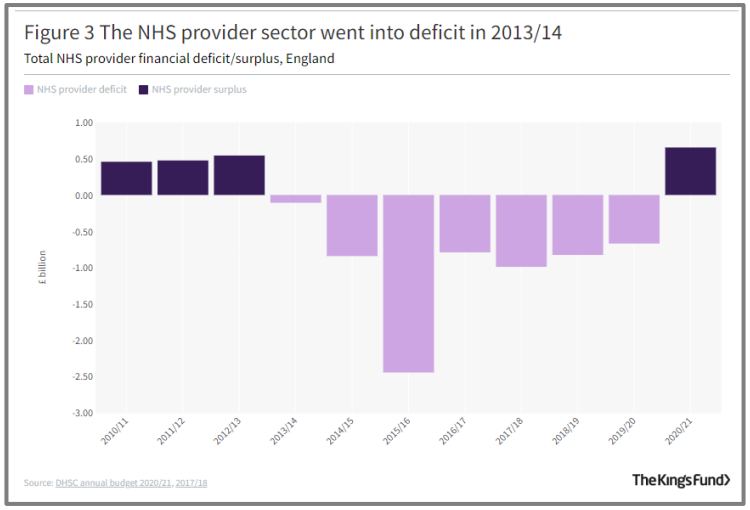
17.2 Analysis of changes in net funds

Group	At 31 March 2023	Changes in cash in year	At 1 April 2021
	£000	£000	£000
Government Banking Service cash at bank	**164,658**	(6,217)	170,875
Commercial cash at bank and in hand	**489**	16	473
Cash and cash equivalents	**165,147**	(6,201)	171,348

Trust	At 31 March 2023	Changes in cash in year	At 1 April 2021
	£000	£000	£000
Government Banking Service cash at bank	**159,778**	(7,445)	167,223
Commercial cash at bank and in hand	**489**	15	474
Cash and cash equivalents	**160,267**	(7,430)	167,697

The Royal Surrey is in a strong financial position compared with its peers; it will resist asset depletion

- Its financial reserves at £80 million at 2023 year end place it at the top of acute financial trusts.
- This was the consequence of a strong trading position during the period 2018-2021.
- Making large surpluses in recent years has been much more challenging for acute trusts.
- ‘The financial performances of Trusts are deteriorating significantly. From the sample of audited bodies analysed, planned deficits (agreed with NHS England) in 2023/24 total £521 million compared to actual reported deficits of £249 million in 2022/23 – a doubling of deficits in one year.’
- The underlying position is considerably worse. It's widely reported that financial plans in 2023/24 are challenging and that Trusts and auditors have identified significant risks with their delivery’. **Grant Thornton, 2024**



‘It’s all about the money’. How a redistribution of funding could meet Guildford’s health challenges

ICSs juggle their finances across their patch. This may not benefit a strongly performing Royal Surrey

- There is nearly always tension between Commissioners and their local acute FT's.
- 'One commonly stated goal of greater system working is that ICSs will manage financial balance in their footprint (possibly sharing this role with other potential ICS-wide relationships, particularly emergent provider collaboratives).
- In theory at least, ICSs have the potential to manage finance across a footprint as they include both commissioners and providers, in contrast to an NHS pre-ICSs, where the commissioner and provider positions were separate.' **King's Fund,2020.**

Across the NHS, Acute FTs dominate local budgets, maybe introducing the ‘Tragedy of the Commons’ syndrome

‘“The Tragedy of the Commons” is where social budgets are dominated by a single organisation, not necessarily for the public good. Is where the self-interest of certain individuals in a group over-rides the collective interest of that group, ultimately to the detriment of all’.
Elinor Ostrom NL.

What Is the Tragedy of the Commons?

A common resource or "commons" is any resource, such as water or land, that provides users with tangible benefits but which nobody has an exclusive claim. The tragedy of the commons is an economic problem where the individual consumes a resource at the expense of society.

If an individual acts in their best interest, it can result in harmful over-consumption to the detriment of all. This phenomenon may result in under-investment and total depletion of a shared resource.

- Acute hospitals, without malice, hoover up local health care budgets.
- The Royal Surrey has a half a billion pound income, local GPs, £20 million.
- This means that GPs have practically no capital for development projects.
- The Procare/RSCH JV – annual budget £19m(?). This could easily be supplemented.

Achieving optimum allocative efficiency is a prime objective of all health systems

- Allocative efficiency is concerned with the way that resources such as funding, staff and medical assets are deployed across a health care system ‘to maximise the net benefits to society.
- There will always be competing demands for resources and in a publicly funded system like the NHS the over-riding mandate is to secure an equitable distribution of spending.
- Local situations are always different and the system controllers have a special responsibility to ensure fairness. But do they take time to re-assess need or consider if the distribution process remains equitable over a period of time?
- Also, they are sometimes working in an environment where there are powerful interests with their own clear objectives and a significant bias to protecting the status quo.
- The result is that in some areas there is over-treatment and in others under-treatment, often not because of patient need, but because of differences in local capability, even hospital preferences.

The ICS should look for allocative efficiency as part of its mandate to deliver equitable care for its population

- It is the responsibility of the ICS to ensure that care is received equitably across its population.
- The starting point is likely to be the current imbalances between patients and across specialties – are some over- and some under-invested?
- The NHS RightCare programme illustrated the many discrepancies.
- Also, there is likely to be instances of expenditure on procedures which are unnecessary or are of low or no medical value.
- Further, are costs being incurred in higher value settings when they could be delivered elsewhere – in a GP practice rather than a hospital outpatients' clinic, for example?
- Are the participants being sufficiently rigorous in hunting down these opportunities?
- Sometimes, there are other motivations to treat.

Opportunity cost needs to be considered: both in financial terms and the consequences for other patients

- External financial analysts would probably categorise the Royal Surrey as an occupancy business.
- Its income derives from re-imbursement for the utilisation of staff, space, equipment and consumables.
- This means the greater the velocity of the throughput, the greater the revenues.
- This puts a premium on maintaining a free flowing stream of patients, particularly those which offer a high margin.
- Low margin occupancy medical cases often represent income lost and also an opportunity cost for the hospital.
- This means reducing the number of ACS cases which result in hospital admissions.
- Elsewhere, we attempt to quantify the cost of unscheduled admissions and delayed discharges which might be many millions of pounds to the Royal Surrey.

Reverting to the 2019 CCG proposal for primary care now looks to be the key imperative

The reasonable starting point would be revisiting the 2019 CCG report

- The recommendation of the 2019 CCG report was to go ahead with the redevelopment of the Jarvis Centre and Kings College.
- Building new combined facilities at the Jarvis Centre and Kings College, Park Barn would provide the opportunity to address many of Guildford's most pressing medical needs.
  - '**The Jarvis Centre – Stoughton Road**
    The Jarvis Centre is located on Stoughton Road and is owned by NHS Property Services. It is in the northeast quadrant of the registered GP lists included within this study. The site extends to approximately 7,400m2 with three buildings present on the site:
    The main building is a combination of single and three storeys and occupies a footprint of approximately 1,500m2;
    The annex – a small double storey building to the rear of the site with a footprint of approximately 140 m2; and
    The portacabin – a single storey temporary structure.
  - **Kings College – Park Barn**
    The Kings College site is located on the western boundary of the practices' catchment area.
    The available land is on the site of Kings College, and is in the ownership of Guildford Educational Partnership (GEP). The land available is approximately 9,750m2 and can be divided into two developable areas as identified in the figure below.
  - **Summary**
    The Jarvis Centre and Kings College site at Park Barn are both capable of [providing] the required accommodation, whether this is configured as one or two sites. The Park Barn site being the larger of the two offers up greater flexibility and also provides the expansion space to incorporate non-GMS services to facilitate a more integrated service offering.'
- This would leave the Wodeland Avenue site as the last critical premises issue for central Guildford.

Primary care services are diversifying quite considerably. Are the local GP practices taking up all of these services?

- The extended PCN model allows each network to recruit several additional roles. PCNs can claim reimbursement of salary costs for these roles through the Additional Roles Reimbursement Scheme, ie at no cost to the practice.
- It is up to each PCN to decide the distribution of roles required, which are:
  - social prescribing link worker
  - clinical pharmacists
  - physician associates
  - first contact physiotherapists
  - pharmacy technicians
  - health and wellbeing coaches
  - care co-ordinators
  - occupational therapists/ dietitians/ podiatrists
  - Paramedics
  - nursing associate
  - mental health practitioners
  - GP assistants
  - digital and transformation lead
  - advanced practitioners.

  HFMA introductory guide to NHS finance,2024

- Space is a big issue The 2019 CCG report on premises said that:
  - 'The primary care estate will need to be developed to facilitate these new ways of working. This means providing appropriate fit for purpose accommodation, sized to meet anticipated demand and flexible in design so that it is adaptable to accommodate changes as they emerge
  - Future sustainability of primary care – the option must be able to provide the range of accommodation required to meet the future changes in the workforce and new ways of working. For example, new primary care professionals such as physiotherapists will require clinical rooms that are of a sufficient size to allow for adequate assessment and treatment, whilst social prescribers and mental health professionals are more likely to work in an interview room style arrangement. Multi-disciplinary working will also require specific accommodation to facilitate joint clinics and case management.'

The pattern of GP consultations has changed. Some adjustment is necessary, but the space requirement may be different.

- People have different access requirements which need to be tailored to their preferences.
- For many people talking to a GP doesn't mean talking to the same GP every time. More immediate access to a GP will meet many people's requirements.
- Not everyone wants to visit their GP practice and for certain people, a telephone or online consultation is preferred for many situations.
- Younger people, on the whole, don't feel they need to see the GP, while for older people, this may be their preference.
- Many people are happy to speak to a nurse, the practice pharmacist or another trained professional if this is appropriate to their condition.
- GP access is under challenge across the NHS. If Guildford is to be an exemplar, it should have common standards and access norms across the PCN. The benefit of a network should be the ability to balance loads through call switching, particularly where the patient record for the callers is available irrespective of the practice location.
- With a move to service lines, for patients on designated pathways, there would be a nominated first responder. Bearing in mind their greater needs, this should involve a reduction in GP demand.

The future premises strategy requires looking at the estate and technology together

- ‘Developments in technology are affecting the NHS estate in different ways. In future, these changes could lead to an estate that is better for patients and staff, smarter and more integrated.
- Technology is likely to result in a different NHS estate, rather than a smaller one, with space being used or configured in different ways
- To maximise their impact, technology and the estate should be brought together as part of wider plans for change. This means developing an overarching vision for how health and care will be delivered in the future and being clear about the role of technology and the estate in delivering it.
- Our research identified a number of factors that can affect the ability of organisations and systems to get the most out of technology and the estate. These include availability of skills, engagement with staff and patients and access to investment.
- Local systems will play a key role in planning technology and the estate across organisations. This includes collaboration across organisations beyond the NHS, and taking advantage of the opportunities that come from working at scale.
- There is also a clear role for the national NHS bodies in supporting this work. They should support common data and technology standards (so that different systems can talk to each other) and facilitate the sharing of learning across the NHS’.

The King’s Fund ‘Clicks and mortar: Technology and the NHS estate’, May 2019

Should Guildford have a showcase health facility in the town centre?

- The Wodeland Avenue GP surgery is acknowledged as a suboptimal option in the reconfiguration of Guildford's primary care services to the west of the town.
- Its current catchment area is likely to be the area to the south and west of the town centre, either side of Portsmouth Road and Farnham Road.
- There is an argument for moving primary and community care and possibly the relocation of some outpatient and diagnostic services into the town centre, which is a walking distance from Wodeland Avenue.
- The facility could also focus on preventative care, health maintenance and act as a healthy living showcase.
- There is an immediate, one-off opportunity to create a purpose built facility within the North Street development, close to the bus station.
- There are other possibilities – the redevelopment of the rear of the closed House of Fraser store, maybe the Telephone Exchange site in Leapale Road or the soon to vacate Police HQ.
- It could also act as an additional retail anchor for the North Street development.
- There is a Section 106 provision in the planning agreement for the North Street development for a GP surgery in Leapale Road. Other s.106 funding is probably available from the Solum, Plaza and Debenhams redevelopments.

GPs' views need to be respected over premises development

- 'The GPs have expressed a wish to move away from an ownership model, which carries financial risks for the partners.'
- 'Sale and Lease Back: the Guildowns Group Practice has expressed a desire not to hold any freehold property interests as a partnership going forward.'
- 'Guildowns Group Practice has had initial discussions with Guildford Borough Council about the local authority acting as the 3PD partner for the Park Barn site. Further detailed discussions will need to be initiated but early indications are that this is a viable option'.
- 'The intention is that the scheme will be procured by the GP partnerships and that they will enter into any required lease agreements with the developers.'
- 'If the retention of Wodeland Avenue Surgery were deemed to be a viable option then the intention of the practice would be to explore a sale and leaseback arrangement with an investment company.'
- [This is the probable show-stopper]: 'However, the GPs will still need to secure legal and technical advice and a project manager to represent them during the development stages of the project and to write the relevant business cases. These pre-project costs are likely to be in the region of £300,000.' **North and West Guildford Primary Care Feasibility Study, 2019**

How do the three new sites get financed?

- We believe that if community health has a significant impact a significant on RSCH operations, then it should take over responsibility for organising the funding to set up the three sites covered in the 2019 review.
- Foundation Trusts have a lot of scope to raise capital. The Royal Surrey is particularly cash rich.
- But there are specialist companies who build medical premises for the NHS who would be likely to undertake the re-fitting and lease the buildings to the Trust. This would keep the capital cost off the RSCH balance sheet.
- If GP surgeries and Procare providing community care occupy some of the space in the new sites, then this cost could be off-set under normal NHS rules.
- Assura PLC says its purpose is 'to create outstanding spaces for health services in their communities. Our business activities involve designing, building, investing in and managing General Practitioner and primary care buildings in the UK'.
- 'The primary care estate accommodates a wide range of NHS services in communities, from general practice to diagnostic and treatment services including x-ray, renal dialysis and MSK physiotherapy; dentistry; acute consultant clinics and other community and social prescribing services.. As at June 2020, Assura's portfolio stands at 565 properties currently serving 5.8 million patients'.

An urgent decision is necessary, given the lead times involved. There needs to be an early public discussion

- The town really needs three new high quality health centres to replace current provision in North and West Guildford.
- Those at the Jarvis Centre and Kings College are essential to address the particular needs of the local communities. The envisaged 'High Street' site to replace the Wodeland Avenue surgery would have a broader role as we set out in this presentation.
- But how will they be managed, funded and operated?
- There seems to be only one best option, that they should become satellites of the Royal Surrey, very much the same as the Farnham Road or Milford Hospitals.
- GPs could then operate out of all three, but only on a tenanted basis.
- Procare could develop its role, maybe becoming the service company for all primary care in Guildford for those GPs who wish to join. They could also run other contracts - medical and non-medical - to provide the necessary skills and practice support.
- What format these changes should take requires an early discussion by the stakeholders.

Moving care to the appropriate location is key

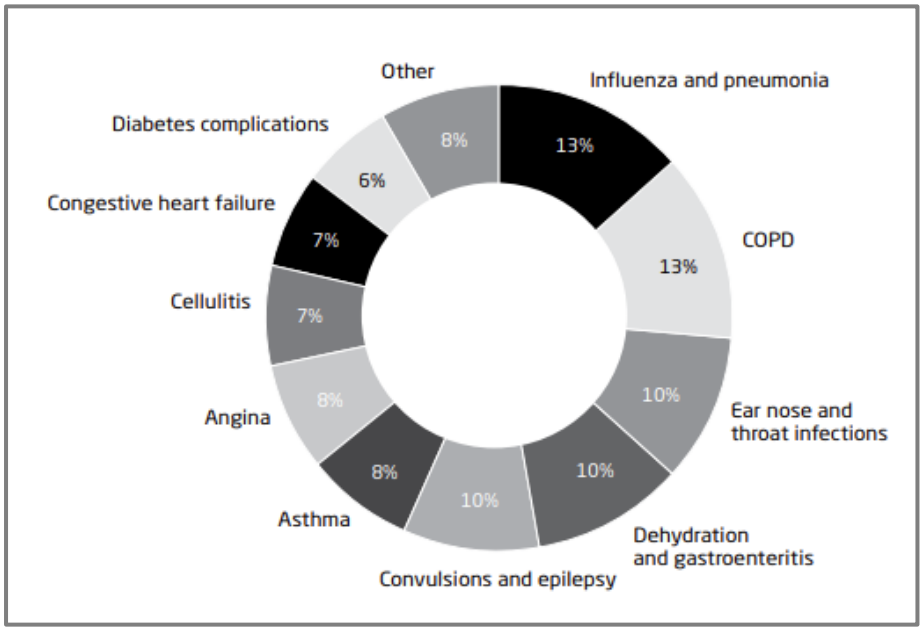
ACS cases represent a consistent cause for hospital admissions when they should be falling

- ‘Ambulatory Care Sensitive Conditions (ACS) account for one in every six emergency hospital admission in England. ACS conditions are a group of conditions where care could be effectively managed outside hospital. Therefore, a high rate of admissions for these conditions may indicate that there is inadequate support to manage these conditions in the community, although other factors such as social and living conditions, poor community support services, and non-response to medication may also result in high levels of admissions’. **NHS England.**
- Overall, rates of emergency admissions are highest for falls, non-specific chest pain, and non-specific abdominal pain. but individual urgent care sensitive conditions have exhibited different trends over time.
- In 2021/22, the rate increased for most conditions where it had fallen due to the pandemic. Emergency admissions related to falls had the highest rate (44 per 1,000 people), followed by non-specific chest pain (41 per 1,000 people) and non-specific abdominal pain (37 per 1,000 people) in 2021/22’. **Potentially preventable emergency admissions, Nuffield Trust, December 2023.**

This is the mix of ACS conditions. Many could be treated out of hospital at the early onset stage

- ‘People in disadvantaged areas are at greater risk of having multiple conditions, and are likely to have multiple conditions at younger ages. Around 28% of people in the most deprived fifth of England have 4+ conditions, compared with 16% in the least-deprived fifth.
- In the least-deprived fifth of areas, people can expect to have 2+ conditions by the time they are 71 years old, but in the most-deprived fifth, people reach the same level of illness a decade earlier, at 61 years of age.’ **The Health Foundation, 2018**

Emergency admissions for ACSCs by condition



The King’s Fund (This slide needs updating).

Tackling ACS admissions could potentially create a number of easy wins for health systems

- It is recognised that investment in community health and primary care reduces ACS unscheduled patient admissions.
- It’s in the hospital’s interest (and the ICS) to lower ACS admissions.
- If a hospital could fund the required interventions these cases, it could probably lower them. But funds are not switched from secondary to primary care to pursue them.
- NHS remuneration systems and silo organisations work against investment in out of hospital resources.
- Also, some acute hospitals see reducing ACS cases as forfeiting revenues.
- There is then a need to look beyond revenue accounting to opportunity cost.
- More throughput of higher value acute procedures, rather than emergency cases would increase hospital productivity and reduce waiting times.

How do you calculate the impact of unscheduled admissions on the Royal Surrey?

- The Royal Surrey loses the income difference between high value elective procedures and unscheduled ACS conditions, both a real and an opportunity cost.
- There are an estimated 15.4m patients with a long term condition in England of which 1.1 million people are undiagnosed. Identifying these people could save the NHS over £3.4m annually.
- ‘Unplanned admissions place a tremendous strain on UK health care resources, accounting for 67% of hospital bed days, costing £12.5 billion annually, and disrupting elective care. In England, they have increased by 47% over the last 15 years, with some arguing that their continued rise threatens to bankrupt the NHS.
- Reducing the number of unplanned admissions is a key priority within the UK. Ambulatory care sensitive conditions (ACSCs) account for one in five unplanned admissions. ACSCs are conditions where GPs can potentially reduce admissions by ensuring that patients receive high-quality disease management, timely treatment, and appropriate referral.
- Substantial inter-practice variation in admission rates for ambulatory care sensitive conditions (ACSC) suggests that decreases might be possible’.
  Opportunities for primary care to reduce hospital admissions: a cross-sectional study of geographical variation, British Journal of General Practice, Jan 2017
- To improve local resource planning, someone needs to make the calculation. The statistical tools are available.

Investing in care in the community is seen as making a positive contribution to NHS finances

'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.

Despite the increased focus on creating better health value and unlocking system productivity, there is currently no relationship between the amount invested by NHS organisations in community care and their population community care needs. The sheer variation in spend perhaps highlights a wider lack of understanding and prioritisation in community care.

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.

Virtual wards are helping redefine community care

- ‘Virtual Wards deliver care for patients who would otherwise have to be treated in hospital’
- Virtual wards are increasingly being used by the NHS to provide care to patients where they live, whether in a care setting or at home. The NHS set targets of 40–50 virtual wards per 100,000 people and to scale up capacity to above 10,000 beds by autumn 2023.
- Care and support is delivered through technology such as apps, technology platforms, wearables and medical devices.
- The technology allows virtual ward teams to monitor a patient’s heart rate, oxygen levels and skin temperature, without the need of being in physical contact with the patient. All of the data is uploaded to the dashboard every few minutes, to allow for the continued monitoring of the patient’s wellbeing. The patient can easily contact the nursing team through the virtual ward technology should they start to feel unwell.
- NHS England says ‘Virtual ward staffing needs to be properly planned. Long-term establishments should be set and regularly reviewed for virtual wards and staffing plans implemented, which provide both permanent and secondment-based opportunities for clinical staff (including from social, community and primary care). This will help reinforce the role of virtual wards as a permanent service which can offer real benefits to career development’.

The SH virtual ward contract could be a breakthrough application in the way that 'at-risk' patients could be monitored

'**Surrey Heartlands ICS awards contract for virtual care digital platform solution**

An award notice has revealed that a £2.975 million contract for a virtual care digital platform solution across Surrey Heartlands ICS has been awarded to Doccla UK Limited, after a procurement process which saw a total of ten tenders submitted.

According to the award notice, the virtual care digital platform solution is required to support the delivery of a patient-centred model, as well as to deliver multidisciplinary and collaborative health services. It's planned to be a clinical pathway agnostic solution, said to be capable of being implemented across an age and care continuum, and be "an agile system with flexibility to respond to evolving technology and operational requirements as these emerge".

In the original procurement notice, the procurement was described as needing to provide an interface between patients and clinicians with the ability to enhance remote monitoring, and as helping to cover an initial 200 virtual ward beds. The notice also stated that Surrey Heartlands would "reserve the right to commission further services from the successful provider", including wearable remote monitoring devices and additional virtual ward beds.

The original notice gave a timeframe of 60 months for the duration of the contract, covering an initial 24 month contract, followed by options to extend up to a maximum of 36 months.'

Health Tec Newspaper, 2 Jan 2024

Those with ACS conditions can be identified easily from their GP and hospital records. So can their costs.

- The health status of every patient can be identified easily from their GP and hospital records
- Everyone's health condition, diagnoses and treatment plans are coded.
- The data can be aggregated to allocate individuals into disease groups.
- It can be stratified and segmented to build cohorts of people with the same condition, asthma or angina, for example.
- Patients can also be given a risk score which is adjustable according to their progress.
- Financial data can be attached to each patient as part of business case development, deploying tools such as PLICS.

GUILDOWNS GROUP PRACTICE

THE OAKS, APPLEGARTH AVENUE, GUILDFORD

	Area	Prevalence	Centile
2023	Coronary Heart Disease	1.7%	7
	Asthma	5.0%	23
2022	Cancer	1.0%	21
	Chronic obstructive Pulmonary Disease	1.1%	25
2021	Hypertension	7.8%	5
	Stroke and Transient Ischaemic Attacks	1.1%	16
	Hypothyroidism	2.0%	13
2020	Heart Failure	0.2%	4
	Diabetes	2.7%	5
2019	Epilepsy	0.4%	15
	Mental Health	0.6%	25
2018	Dementia	0.5%	57
	Chronic Kidney Disease	2.8%	42
2017	Atrial Fibrillation	1.0%	24
	Obesity	5.5%	13
	Learning Disabilities	0.2%	30
2016	Depression Screening	3.9%	7
	Depression ever	8.9%	60
2015	Smoking	18.4%	52
	Depression Incidence	0.3%	21
2014	CHD Prevention	0.5%	8

NHS England QOF database.

Small changes have to be made to RSCH strategy

The RSCH says it provides three integrated types of care Wouldn't true integration be two rather than three?

As is:

[The Hospital] provides 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'. **Royal Surrey Hospital Annual Report 2022-3**

To be:

- What if one and two are merged to create a community health service – essentially the cost centre, delivering the vision of a true hub and spoke operation?
- And three, the cancer centre', becomes the profit centre and also helps build local GVA.

The three sites should include primary care, community health and hospital outpatient services

- GP services would be provided. Practices should pay rent (probably to the Hospital as landlord) following the usual NHS arrangements.
- The Hospital would operate outpatient clinics at tariff rates or outsource them under APMS contracts.
- Community health providers would also pay for their accommodation costs, contributing to the site's running costs.
- Multi-disciplinary teams are also likely to be co-located, as are local authority designated public health staff.
- We are proposing that RSCH underwrites any losses incurred from operating the three sites.
- However, the financial objective would be for the Royal Surrey to at least break even from operating the three expanded primary care sites, putting them on the same financial footing as the locations at Haslemere, Cranleigh and Milford.
- What needs to be brought into the equation is possible gains from freed-up hospital space and the reduction in admissions from these localities which because of their demographics are likely to be higher than for Haslemere, Cranleigh and Milford.

Guildford seems to have complementary systems for managing many classes of care

- An integrated care system could be produced for Guildford which was boundaryless, agnostic of location.
- That the patient should be treated in the place which was most appropriate.
- That preferably was his or her choice.
- There is a significant overlap between local hospital and community care providers, details from their websites:

RSCH Specialty (selection)

Cardiology
Dementia
Diabetes
Gastrointestinal/Hepatology
Maternity
Pain Management
Rheumatology
Sleep Medicine
Urology

Procare Community Care (selection)

Cardiology
Dementia
Diabetes
Gastrointestinal/Hepatology
Maternity
Pain Service
Rheumatology
Sleep Practice
Urology

- Would combining of these resources in a single business unit improve outcomes and lower costs?

There is a need to build on the opportunity of the RSCH/Procare JV

The Procare contract should be developed to diversify care delivery

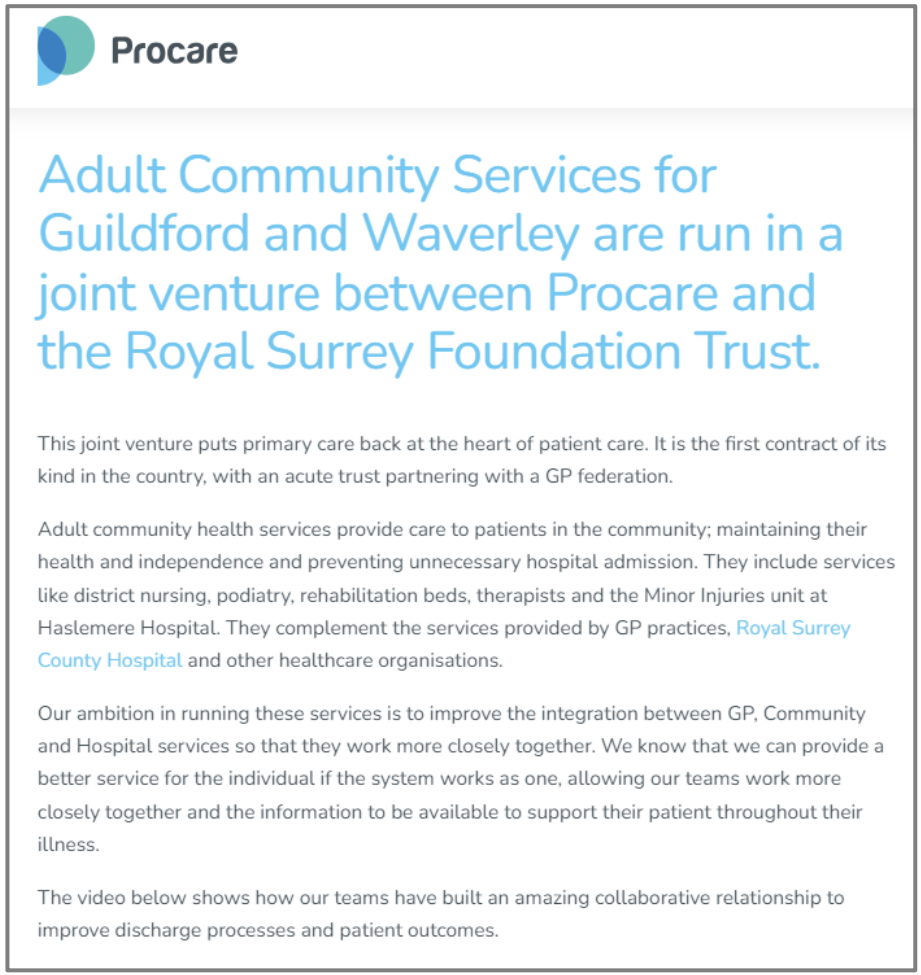
- Already, many GPs provide additional health care services locally via their APMS contracts.

> '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**

- Could these contracts be the vehicles for operating as service lines – with GPs and hospital consultants collaborating in JVs?

We see two unique opportunities for the town. The first is the joint venture contract between hospital and GPs

- This is the first contract between a trust hospital and GP federation to deliver community care.
- ‘All NHS provider trusts are expected to be part of a provider collaborative’. **NHS England**
- The nine year contract duration creates the opportunity for system continuity.
- It should be adequately funded, subsidised even, to ensure sustainability.
- Could it be the basis of a transfer to operating service line management .
- Properly developed, this initiative should create marketable IP for transfer across the NHS.



Procare

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

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

Adult community health services provide care to patients in the community; maintaining their health and independence and preventing unnecessary hospital admission. They include services like district nursing, podiatry, rehabilitation beds, therapists and the Minor Injuries unit at Haslemere Hospital. They complement the services provided by GP practices, Royal Surrey County Hospital and other healthcare organisations.

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

The video below shows how our teams have built an amazing collaborative relationship to improve discharge processes and patient outcomes.

The Guildford community care contract is unique, but it should be seen as just a starting point

- Nowhere else in the country is there a joint venture between the local hospital and the GP PCN network to provide community health services.
- This fits nicely with NHSE guidance that ‘NHS provider trusts will be expected to be part of a provider collaborative’.
- There is a further contract option open to the Royal Surrey. The Integrated Care Provider (ICP) Contract enables commissioners to award a single contract to a provider that is responsible for the integrated provision of general practice, wider NHS and potentially local authority services. This can only be awarded to a statutory body like a foundation trust.
- This arrangement offers additional possibilities for delivering an even broader integrated care proposition.

The importance of the RSCH/Procare joint venture as a launching pad for the future should be recognised

- This partnership represents a unique starting point, possibly for the NHS as a whole.
- Guildford should not give away this hard won advantage.
- That the contract will last for nine years provides the space for continuous development.
- The project should be insulated from any pressures which would obstruct its delivery.
- If necessary it should be funded as an R&D project - which it is.
- Imaginative contract development will be a critical competency going forward.
- No details of the contract seem to be in the public domain.
- Its future financing should not exclude creative solutions. Should the initial-set up be the precursor of future funding rounds?

To move more care into the community, the ICS should look to increase the number of APMS contracts

- We accept that the current venture is probably being underwritten by the hospital, but that is probably to its advantage.
- The ICS should consider what specialities would benefit from being delivered in the community rather than at the RSCH Egerton road site.
- A review of websites shows this overlap between the Hospital and Procare.
- A structured review of opportunities should be carried out next.
- Clinicians should be polled about their interest in participating. These could be from GP practices, the Hospital and elsewhere. These would be stand-alone businesses probably run as Community Interest Companies (CICs), possibly as Procare subsidiaries.
- As for running costs, we are proposing that the joint venture between RSCH and Procare should be extended to these sites.
- Given that it is likely that the RSCH underwrites losses made by the joint venture, shouldn't the RSCH have an equity holding in Procare?

The Procare role should be extended to provide a range of services to support the transition to integrated care

- Procare would have an expanded role – providing the resources to deliver a wide range of clinical roles for both primary and community care. Its GPs could also run a range of local community health care contracts.
- We see it continuing to operate out-of-hours services.
- It will be redefined as ‘the local central control room’.
- It would develop a much stronger involvement in back office services, health record management, data and analytics, maybe in conjunction with Healthcare Partners Ltd and the ICS.
- It should investigate with the RSCH opportunities to introduce a referral management capability.
- It should fully adopt machine learning and AI, looking to develop more innovative approaches to primary and community care service development.

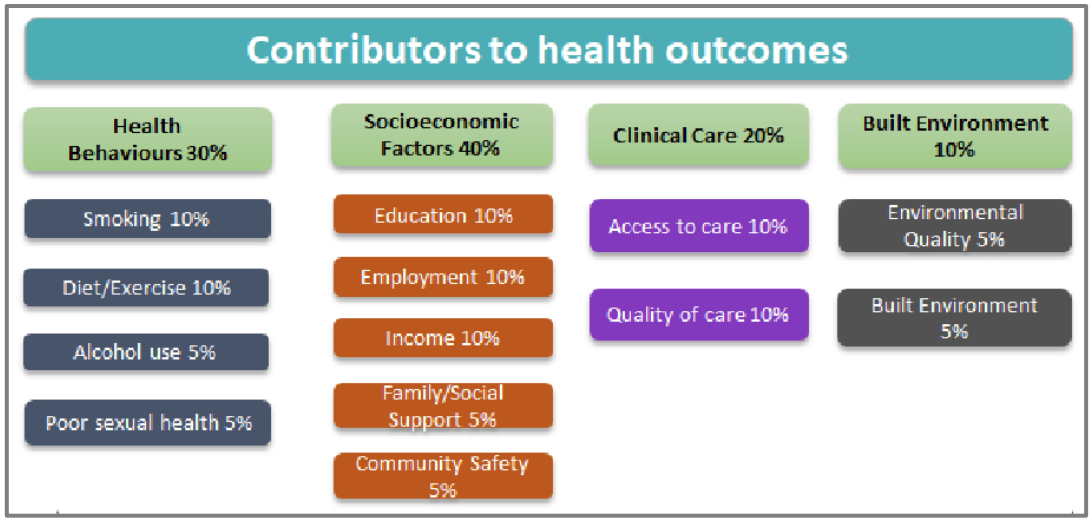
As just one example, the better management of patients in the community would help both the hospital and the ICS

- ‘GPs could play a role in reducing waiting lists. Alongside managing symptoms while patients wait for treatment, they can also support patients who are perhaps equivocal about proceeding with their intervention to look for alternatives to hospital treatment. This might include lifestyle changes such as weight loss and exercises to reduce hip and knee pain, or referral for home aids that enable people to live with their condition. This significant workload will pose huge challenges for practices that were already stretched before the pandemic, which highlights the importance of effective hospital systems that do not drive frustrated patients to their GP for administrative help, or expect GPs to follow up on clinical work initiated by hospital specialists

  Transparent processes with a human touch: the essentials of good waiting list management, Nuffield Trust.
- The introduction of a GP administered referral management centre might be another. This could help co-ordinate APMS clinics and reduce hospital appointments.

Population health condition is, of course, not just a function of the nature and quality of clinical care

- Clinical interventions and treatment contribute only about 20% to an individual's health status.
- Deep-seated social, economic and environmental factors have the most impact.
- Digital exclusion, literacy and English language competence can also make a difference
- This places more responsibility on addressing other aspects of people's lives beyond direct health care.
- Trite as it is, there is a need for an holistic approach to health and wellbeing.
- Regrettably, since Covid , local authority programmes involving population health improvement, changing behaviours and prevention have received less prominence in Surrey and across England.



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

There is one further 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.**

The public health contribution to the communities north of the A3 could be considerable

‘Upper-tier local authorities are responsible for social care and public health services in their ICS area, as well as other vital services such as housing, education, leisure and transport. They must have regard to the ICP’s integrated care strategy when planning and making decisions.

Other partners bring their own unique contribution, including:

- Voluntary, community, faith and social enterprise organisations bring their local expertise in working with people in the communities where they live.
- Social care providers bring expertise in supporting wellbeing and independence for people with disabilities, with mental ill-health and older people.
- Partners from other areas like housing, employment, education, justice and business have a critical role in addressing wider determinants of health and wellbeing for individuals and communities.’

NHS England website.

- Local public health programmes, as described, are highly aspirational, but delivery details are not given.
- Most in any case will be provided by local NHS delivery teams.

Conclusions and next steps

- At the beginning of this presentation, we said that our objective was to propose a re-balancing of Guildford's health delivery system which had no losers.
- Much of this is conditional on The Royal Surrey being prepared to extend its operations to the three new health community centres where it would assume the anchor tenancy role.
- We believe this arrangement would not have any material negative consequences for either its income or capital.
- We see no reason why these proposals to truly integrate care should not have the full support of the ICS.
- We are also recommending extending the scope of GPs' contracts to deliver additional care formats and also to widen their involvement in a number of ancillary and back office services. This would strengthen the PCN capability and the Procare joint venture with the RSCH.
- To deliver these opportunities, we believe that there are unique local opportunities which can be harnessed and leveraged as Guildford builds to potentially become a national exemplar of what NHS integrated care should look like.
- We hope that this contribution can stimulate the debate. We look forward to your response.