Next steps for Guildford's health care

3rd October 2024

Prologue

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

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

All three are long. But health care delivery is dense, complex and nuanced.

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

Readers of the first two documents have pointed out that a few of the pages are repeated. This was for reasons of continuity and emphasis. The same happens with this presentation. Some pages we think are of sufficient importance in telling the story to make another appearance.

However, what is different about this third document is that it is about the 'How'. How many of the issues raised previously can be confronted and potential solutions implemented.

Why are we doing this? Hopefully, to make some difference for those whose health care situation is challenged. But Guildford's position has extraordinary attributes and truly leverageable advantages on which it can build to create a national exemplar for health care delivery.

Contents

Introduction

It would probably be difficult to find anyone who wouldn't agree that integrated systems of health delivery have the best chance of improving the health status of individuals and populations.

Successful integration ensures that each part of the delivery system is co-ordinated seamlessly to achieve the best outcomes at the lowest cost. Tailored to patients' needs it produces the right care at the right place at the right time.

Starting with a clean sheet of paper, designing a system like this would be quite straightforward. Clearly, this option is no more available to the NHS in England than for any other global health care system. All have decades old, legacy formats built on foundations created for different times and circumstances.

The way that care is organised in this country is essentially the same as it was in 1948 when the NHS was founded. For the great majority of people, GPs operating their own practices dealt with their patient's everyday needs and referring more complex cases to government- funded general hospitals.

Today the NHS is a £200bn a year monolith with a workforce approaching 1.5 million. Monolithic as it is, it is composed of literally thousands of separate organisations, established to deliver their own discrete, often highly specific, health care service or range of treatments. Large hospitals can have over 100 departments and multiple sub-specialties.

At the other end of the scale are single purpose clinics and GP practices with only a couple of partners.

All of this is what has to be changed. The aim of integrated care systems according to the recent Darzi review is to 'simplify and innovate care delivery for a neighbourhood NHS: for health practitioners to work in teams, to embrace new multidisciplinary models of care that bring together primary, community and mental health services'.

Guildford is endowed with a good health delivery system. Most local people are satisfied with the care they receive.

But even in this rich town there are pockets of deprivation. For thousands of people, their life expectancy is nine years less than those who live in the most privileged localities. These are the people who would benefit most from community help, where the health infrastructure is poorest, where the inverse care law is starkly demonstrated: that those who need care the most get the least.

This presentation looks at how this situation might be improved. It looks in particular at the key role of the Royal Surrey County Hospital in local care delivery and how the promise of truly integrated care can flourish in Guildford.

Executive summary

‘The NHS in England is under existential threat’ says the new Secretary of State. Earlier this year, Lord Darzi, an eminent surgeon and long time Labour adviser, was asked to undertake a snapshot review of the current NHS situation.

This found a very long list of issues which needed addressing, but few practical solutions. We have yet to see any specific Labour initiatives.

Among Darzi’s principal recommendations were that the government should work to ‘Simplify and innovate care delivery for a neighbourhood NHS. The best way to work as a team is to work in a team: we need to embrace new multidisciplinary models of care that bring together primary, community and mental health services’. Also, that they ‘should lock in the shift of care closer to home by hardwiring financial flows’.

This is our third presentation on the circumstances which combine to produce Guildford’s local care delivery situation. We began them in January this year, reporting in March and June. These are available for anyone who wishes to read them.

Neither we nor Darzi have come up with anything that is particularly new. Global health policy is one of the most well-trodden paths. Also, over its 75 years, the NHS has thought of nearly everything. What we are seeing at this very moment are signals that the new government will reintroduce many initiatives it employed during its last administration.

Where the NHS has underperformed has probably in the areas of sustaining initiatives and seeing them executed across the entirety of the organisation. For many years, there has been a view that it is difficult to run the NHS centrally when the hundreds of localities in which it operates have such a divergence in characteristics and circumstances.

Guildford is nothing like Gateshead or Grimsby. Every town has its own medical signature, based on factors, among others, such as history, politics and economics. The strength of local medical institutions also bring their own bearing.

The result is Guildford, through the wealth of its citizens and the quality of its local health care resources, is a relatively healthy town.

Executive summary (continued)

But it is not universally so. Guildford has significant areas of deprivation with people in chronically bad health and reduced life expectancy.

The most challenged part of the town is north of the A3 in a swathe from Slyfields to Park Barn. A contributing factor we believe is the paucity and quality of GP premises in these localities.

This is what kindled our interest. That despite a clear acknowledgement that all of the buildings used for primary care were not fit for purpose, nothing had been done to remedy the situation. This is an impasse which has now endured for five years.

The issue is that no money is available. The GPs no longer want to invest in premises and the ICB is unable to provide funds. The only chance to expand community care is to find money elsewhere.

The only organisation which might help is the Royal Surrey Hospital. It has one of the strongest NHS balance sheets in the country with nearly £90m of free cash, mostly as a result of government windfalls which it has exploited. We provide a full explanation.

The RSCH has told us that it has no mandate to invest outside the hospital.

Our countervailing proposal is that it extends its operations into the community. It already does that in Milford, Cranleigh and Haslemere, some of the richest parts of the county. So, there are precedents.

But the Hospital has no similar provision to the north of Guildford, areas of relative deprivation. The ICB, as a part of its strategy, sees the town developing a hub and spoke service arrangement which would not be complete until this gap was filled.

Solving the premises issue, we believe, could initiate a cascade of opportunities which would have a profoundly beneficial effect for not only the Guildford neighbourhoods north of the A3, but for the entirety of the Guildford and Waverley Place, and maybe even beyond.

Our proposals, we believe, could be financially positive for the Royal Surrey although it has no duty to make a profit or build its balance sheet.

The starting point is that the RSCH invests in the building of two new community health centres which include expanded GP accommodation in Stoughton and Park Barn. The need, five years on from the CCG report which recommended this solution, is now urgent.

Executive summary (continued)

The Hospital and ICB will have to negotiate a revised activity plan as part of the 2024/25 contract round. But in any case, we see that there could be the beginning of a positive change in the procedure mix which would deliver both financially, and more importantly better health outcomes for the patient.

Every health policy initiative wants more care to be delivered in the community. But there needs to be an operations base and more space is required to house the extra staffing provided under the Additional Roles Reimbursement Scheme who will provide the springboard for an expanded community care operation.

We envisage some consolidation of these PCN staff on a single site as they build multidisciplinary teams.

While there are centrally developed plans to build data platforms, we believe that there is a deployable range of local information systems which can be joined up and used immediately to improve patient care. The Doccla Virtual Wards system and Guildown's triage facility are just two.

We are recommending a gradual repatriation of Hospital outpatients back into the community to be managed by the MDTs. In the future we see an expansion of discrete care service lines, stimulated by ICB contracting. Guildford already has a successful, award-winning precedent with its Women's Health Hub which is an adaptable model.

We put forward a number of ways that patient participation can be widened, particularly in greater shared decision-making and treatment choice.

We are hoping that the Hospital will look to the opportunities for population and patients and itself by a thorough re-appraisal of its role. It is an outstanding hospital both in its care provision and business management. We feel that the latter capability is under-leveraged and that it can move to a leadership role for a Royal Surrey community health system.

We envisage a boundaryless hospital, a potential NHS exemplar, working seamlessly with local providers to deliver truly integrated care.

The need

The NHS is no longer a worldwide exemplar for health care delivery

- For decades the NHS was held up as one of the best health care systems among its global peers.
- The UK's National Health Service (NHS) now compares poorly to other countries by many measures, including:
  - ‘Life expectancy: the UK has some of the lowest life expectancy rates for men and women, and life expectancy has declined particularly since the pandemic.
  - Health care outcomes: the UK performs poorly compared to other countries on health care outcomes, including deaths and life expectancy.
  - ‘Amenable mortality’: the UK is the third-poorest performer among 18 developed countries on the rate at which people die when successful medical care could have saved their lives.
  - The UK placed 8th in the 2022 World Index of Health Innovation for patient-centred care.
  - Factors that can affect a country's health care system include macro-economic, political, legislative, and cultural factors. For example, two countries with similar health spending levels can have different health outcomes if they have different regulatory approaches to promoting healthier life-styles’.
    Commonwealth Fund

It’s hard to see how things will get better: demand for health care will continue to grow faster than government funding

- ‘The next government will inherit a health service in the midst of one of the most challenging periods in its history, with near-record numbers waiting for hospital treatment, people struggling to see their GP and public satisfaction with the NHS at a record low.
- Achieving sustained improvement would require average annual real-terms funding growth of 3.8% over the next 10 years, with a higher rate of growth during the first 5 years, and a lower rate in the remaining 5 years.
- Real-terms funding growth of 0.8% a year would see the total Department of Health and Social Care budget increase to £197bn in 2029/30. This would leave the health care system in England around £38bn short in 2029/30 of the spending we project in our sustained improvement scenario’.

Health Foundation, 2024.

NHS funding faces biggest real-terms cuts since 1970s, warns IFS

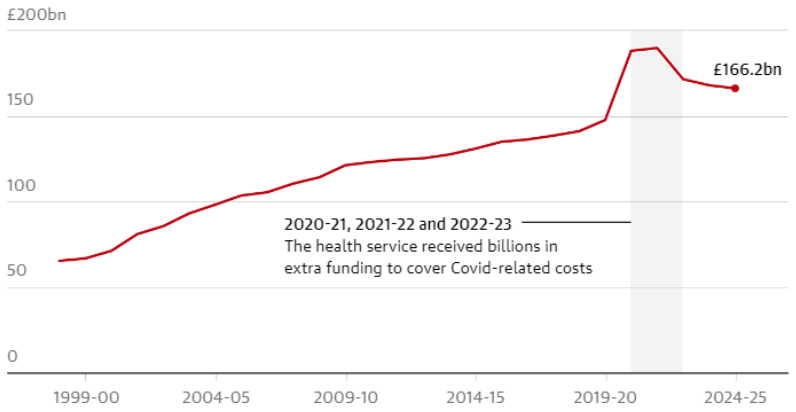
Health spending in England is due to suffer a 1.2% cut - worth £2bn - in the new financial year starting next month, despite the NHS facing extra costs from continuing pay strikes and the expansion of its workforce, according to an analysis by the Institute for Fiscal Studies (IfS).

The health budget, almost all of which the NHS gets, is to go from £168.2bn in 2023-24 to £166.2bn in 2024-25, after adjustment for inflation, in 2022-23 prices.

Without a government rethink the reduction in funding will force the NHS to cut staffing numbers, staff pay, the services it provides to patients or all three, the thinktank warned.

Health spending to be reduced in real terms in 2024-25

Day-to-day (non-investment) health spending



Guardian graphic. Source: IFS

The Guardian, 4th March 2024.

This is the agenda the new government says that it needs to address

- ‘I’m blunt about the fact that the NHS is no longer the envy of the world, not to undermine it, but to reassure people that we’ve noticed.
- I argue that our NHS must modernise or die, not as a threat but a choice.
- The crisis really is that existential.
- When I look at leading health systems across the world, the fundamental problem with the NHS becomes obvious.
- We have an NHS that gets to people too late.
- A hospital-based system geared towards late diagnosis and treatment, delivering poorer outcomes at greater cost.
- An analogue system in a digital age.
- A sickness service, not a health service.
- With too many lives hampered by preventable illness.
- And too many lives lost to the biggest killers.
- So be in no doubt about the scale of the challenge.
- Not just because as waiting lists rise, public confidence falls.
- But because in the longer term the challenge of rising chronic disease, combined with our ageing society, threatens to bankrupt the NHS’.

Wes Streeting, Labour party conference, September 2024.

The government sees NHS transformation through ‘three big shifts for a sustainable future’

- ‘The NHS must undergo three “big shifts” in how it delivers care to ensure a sustainable future’, Wes Streeting has said.
- Speaking at the Financial Times’ Weekend Festival in London, the UK health and social care secretary said the new government would prioritise moving NHS treatment:
  - “from hospital to community”,
  - “analogue to digital”,
  - “sickness to prevention”.
- The three shifts “are absolutely necessary, and actually existential . . . for the future of the NHS”, Streeting said’.
  Financial Times, 7 September 2024.

Our two previous presentations on Guildford's health care development resonate with the Darzi Report

Darzi main recommendations:

- 'Lock in the shift of care closer to home by hardwiring financial flows.
- Financial flows must lock-in this change irreversibly or it will not happen.
- General practice, mental health and community services will need to expand and adapt to the needs of those with long-term conditions whose prevalence is growing rapidly.
- Simplify and innovate care delivery for a neighbourhood NHS. The best way to work as a team is to work in a team: we need to embrace new multidisciplinary models of care that bring together primary, community and mental health services.
- Drive productivity in hospitals. Acute care providers will need to bring down waiting lists by radically improving their productivity. That means fixing flow through better operational management, capital investment in modern buildings and equipment, and re-engaging and empowering staff.
- Tilt towards technology. There must be a major tilt towards technology to unlock productivity. In particular, the hundreds of thousands of NHS staff working outside hospitals urgently need the benefits of digital systems.
- There is enormous potential in AI to transform care and for life sciences breakthroughs to create new treatments.'

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

- Darzi says that the NHS should 'simplify and innovate care delivery for a neighbourhood NHS'. 'The best way to work as a team is to work in a team: we need to embrace new multi-disciplinary models of care that bring together primary, community and mental health services'.
- There is nothing much that is new about care workers operating in multi-disciplinary teams (MDTs). The problem has been unifying staff from different NHS entities and also working with social care organisations and charities.
- The ICB is responsible for drawing up the strategy, allocating the funding and promoting delivery.
- But none of the NHS provider organisations which would need to combine to deliver integrated care are under its control.
- The extra funding for GP practices, properly harnessed, will radically strengthen the building of MDTs.
- The ICB must ensure that it is properly financed.
- Probably the best way to ensure effective delivery is through contracts with sufficient financial incentives.
- NB: a fully functioning teamwork approach has to include the RSCH.

Delivering integrated care - the NHS policy framework

Delivering integrated care: the policy objectives

- The over-arching imperative for ICSs is that they secure the best care for patients.
- 'ICSs have four key aims:
  - 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.'
    NHS England, August 2022
- Locally, the G&W Alliance says its priorities are:
  - '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.

We believe the true measure of success, locally, will be shifting the needle for the underlined objects

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  - ***'Redesigning care pathways [with] more personalised care'.***
  - 'Driving integration through newly appointed 'Reference Groups' to get patient and partner participation.'
- The emphasis is ours.

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 delivered 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. How, the concept of unwarranted variation skewed care between different providers and different patients.
- Also, there are 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 in a hospital outpatients' clinic, for example?
- Is the ICS budget system being sufficiently rigorous in hunting down these opportunities?
- Or will a disproportionate share continue to go to acute hospitals?

ICB responsibility extends to holding providers such as FTs accountable for their programmes and spending

- ICBs are accountable for improving health outcomes for local patients and for getting the best possible value for money from the budgets they receive from NHS England, who require the following information:
  - An overview setting out how the system will use its financial resources to meet the needs of its population and what the system will deliver as well as CCG provider plans.
  - A plan setting out capacity, efficiency and workforce plans, transformation objectives (including clinical and provider strategy), risks to delivery and mitigations.
  - A system data aggregation (activity, workforce, finance, contracting), demonstrating how all individual organisational plans align to the system plan.
  - Activity volumes in plans must be matched to the volumes in their provider plans and vice versa.
- For entities like the Royal Surrey, there is a contract which sets out a delivery plan against the budget for the year. The ICS has very little leverage in managing in year variations, both underspends and overspends.
- Will the ICB be able to resist an RSCH request for an above average budget increase?
- Every pound is needed for the government to deliver its ambition for a shift to community care.

The Royal College of Physicians of England has helpfully set out the agenda

Box 1. Key ingredients for the medical specialist in delivering integrated care in medical specialties.

- Shared vision across organisations and professionals
- Training for integrated working
- Job plan, contracts and person specification to support medical specialists
- Partnerships with primary care and other organisations to connect care
- Effective co-production, co-design and patient engagement
- Shared information systems
- Communication
- Management, governance and administrative support to develop required infrastructure and systems
- Funding (contracts, commissioning, overcoming competition and conflicts of interest)
- Leadership
- Mechanisms to audit and evaluate performance
- Delivering seven-day services and accessibility
- Overcoming unspoken barriers such as:
  - working with different people to develop relationships and mutual trust
  - working with differing organisational hierarchies and professional attitudes
  - working across a number of organisations, regions and services involved over a defined geography
  - lack of intellectual and creative autonomy
  - Unrealistic commissioning expectations
  - lack of focus beyond short-term financial incentives.

'Integrated Care: the Clinicians' view', RCP, 2015.

The challenge

Attempts to ‘Shift the balance of power’ (from secondary to primary care) have dogged the NHS for decades

- The NHS has seen many reorganisations over its history.
- For 35 years it has essentially operated in a state of ‘managed competition’, where purchasers (commissioners) contracted with providers for the care they required.
- There is no power balance, no system equilibrium. The providers have nearly always had the upper hand.
- Foundation Trusts mostly write their own agendas with limited ICB interference.
- Seriously under-capitalised GPs, long disengaged from system politics and investment, plough their own furrow.
- Even within sectors - primary care, for example - there is a wide divergence on priorities and routes forward.
- The funding allocation between the two sectors amplifies the differences.
- Also, how capital is allocated.
- These are the gaps in the system that have to be bridged for sustainable transformation to take place.
- ICBs now have to deal with this polarity. And demands which will exceed supply.

A move to integrated care would require a change in current organisational objectives across the system

- All health systems would find it hard to argue against a move towards a more integrated delivery system.
- The overwhelming canon of evidence is that integrated care systems produce the best results for patients and populations.
- But the parties which have to come together have their own distinctive cultures, roles and responsibilities.
- Real change will come only if organisations can learn to subsume their own objectives into the common good.
- ‘The main enablers of integrated care [are] the organisational skills of health and social care professionals who [are] actively able to contribute to inter-professional collaborations by bridging task-related gaps and overlaps, and a growing interest in co-production in health care services to improve information sharing and reduce duplication. It was noticeable, however that there appeared to be a lack of emphasis on addressing health inequalities. Several factors were found to be involved in bringing about integrated care which, in addition to structural integration, included coherent policies; joint strategies across organisations; and “political, managerial and clinical leadership with a clear and consistent focus on integrated care”.’

Barriers and enablers of integrated care in the UK: a rapid evidence review of review articles and grey literature 2018–2022

Succeeding with integrated care means combining two different delivery formats into a cohesive whole

- The current NHS delivery system is essentially unchanged over its 75 year history.
- Primary and secondary care have always been provided by two organisational entities which have little in common: large-scale, capital-intensive hospitals and lean, partner-owned, independent GP practices.
- This format has operated remarkably successfully with a high degree of symbiosis: what has been described as a two silo system has in fact delivered.
- It is primary care which needs most investment to deliver a wider and more complex range of services.
- But small GP practices do not have a financing model which provides the scope to fund the capital projects required.
- In the past five years NHS England has substantially increased the staffing of practices, but they have little capital to enable them to fully realise the potential of these investments.
- Faced with high refurbishment and redevelopment costs, many want to exit their GP premises.
- Hospitals, particularly those like the Royal Surrey, are however extraordinarily well-endowed.
- To provide the best integrated care this money must move to fund community services.
- As Darzi says ‘financial flows must lock in this change irreversibly or it will not happen’.

This will be the fundamental challenge for all NHS health systems

- Delivering integrated care cannot be achieved without disruption of the status quo.
- Disruptive change - radical transformation - is something that the NHS doesn’t do very well.
- Medicine is conservative about change, reasonably so where patient safety is concerned.
- But it should not be exploited by parties as reasons to protect the status quo.
- All of this creates extended timescales and in the past the likelihood that another policy change would come along before the present one was executed, a particular vulnerability for state-controlled health systems like the NHS.
- But this time, the forces of AI will bring unstoppable momentum.
- The maintenance of legacy cultures, mindsets, political interference will bring jeopardy.
- The existential threat to the NHS which Streeting has set out.

The imperative of the ICB, then, in operational terms, is to set up and execute a massive system change

- ‘Systems thinking is an approach to problem solving which takes into account the overall system as a whole as well as its individual parts.’ ‘It is a framework for seeing interrelationships rather than things, for seeing patterns rather than static snapshots. It is a set of general principles spanning fields as diverse as physical and social sciences, engineering and management. This means that it is a way of exploring and developing effective action in complex contexts, enabling systems change.
- Also, ‘it is a collection of tools and approaches that can help people understand complex systems and visualise data flows within them’. **Peter Senge, The Fifth Discipline, 2006.**

Pivoting to a new community facing health system will mean confronting an embedded position of hospital dominance

- The NHS has for all of its existence been hospital centric.
- These are powerful institutions which have always dominated every local health system.
- Arguably, they have always held real power ahead of governments and successive NHS managements.
- All of this is compounded by the decision to give them Foundation Trust status – in 2002, under a Labour government. They said:
- 'Although run locally, NHS Foundation Trusts will remain part of the NHS family. NHS Foundation Trusts will continue to deliver relevant care for their population, purchased by locally based NHS Primary Care Trusts.
- NHS Foundation Trusts will be set free from central Government control, manage their own budgets and be able to shape the healthcare services they provide to better reflect local needs and priorities.' **Department of Health, 2001**
- Autonomy, self governance and even an isolation from the local NHS commissioners have created institutions increasingly driven by their internal objectives. These are the places where NHS careers are built. Many are billion-pound enterprises with all the panoply of big businesses, including media relations.
- All of this makes the local Foundation Trust almost impossible to challenge.
- 'The Tragedy of the Commons' will continue to be enacted in front of us.

‘The Tragedy of the Commons’ is an established economic phenomenon; we reprise a slide from our first presentation

‘’’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(?) could easily be supplemented.

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Guildford’s GP premises issues

The starting point for our interest was the lack of progress with the redevelopment of local GP premises

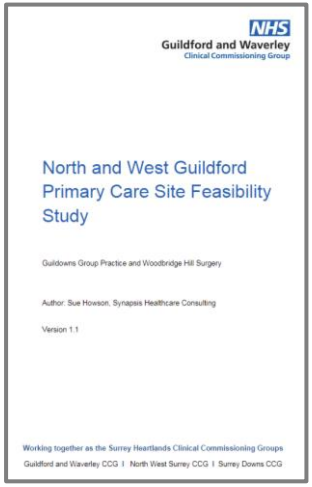
The important GP premises issues

- *'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.

Five years on, the primary care premises situation for North and West Guildford has made zero progress

- As we have pointed out previously, the GP premises situation was recognised in the 2019 transitioning CCG's 97 page report which was delivered before the Covid outbreak.
- It said 'The case for change has identified some key issues that need to be addressed if primary care in north and west Guildford is to be sustainable into the future'.
- 'A significant proportion of the population it affects is the town's most needy'.
- There have been no new proposals from the ICB since 2019, despite this being arguably the biggest challenge in Guildford's health delivery.
- GPs preferences (asking them what they truly want) and dealing with a deteriorating medical estate (which they don't want to own) remain the same.


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

There is still no agreed way forward for a GP premises strategy for N&W Guildford

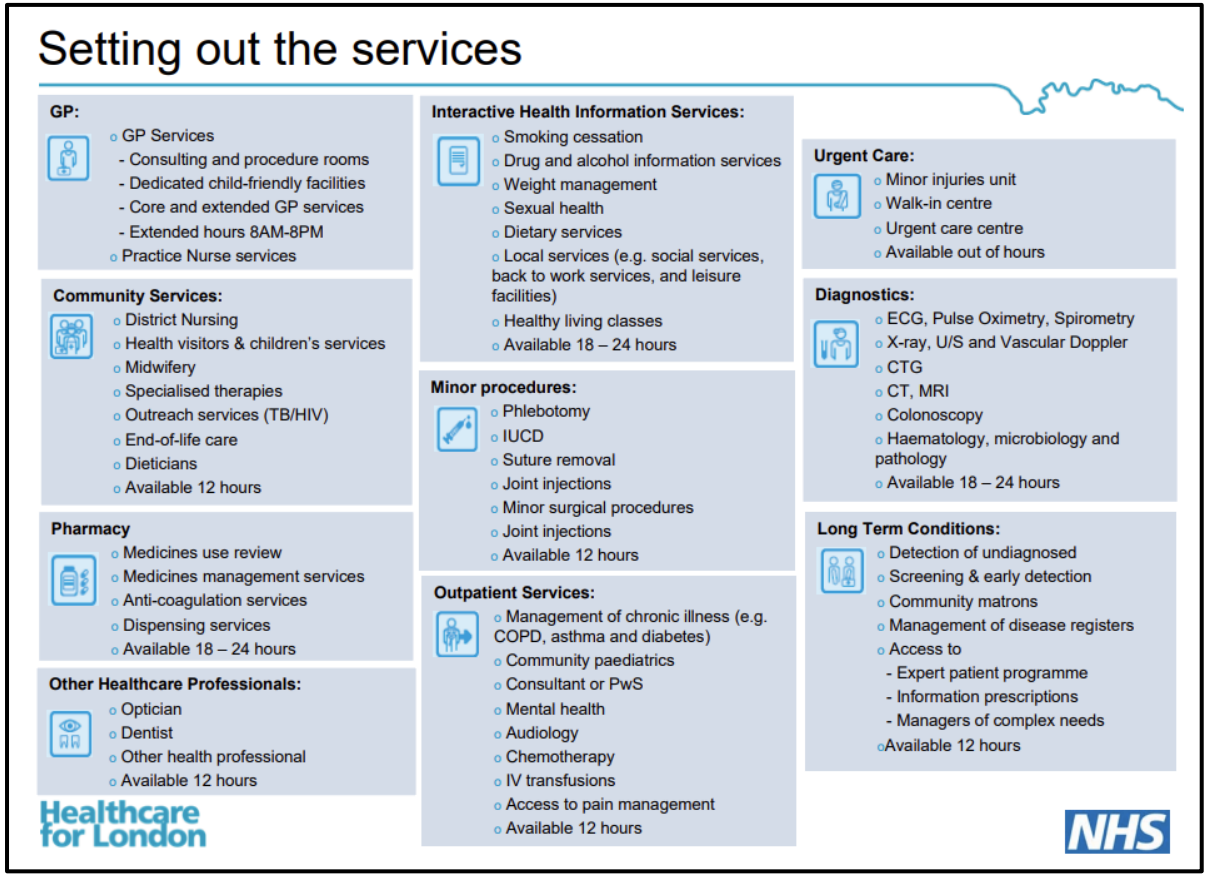
- The recommendation of the 2019 CCG report was to proceed with the redevelopment of the Jarvis Centre and a new build at Kings College.
- It said 'building new combined facilities at the Jarvis Centre and Kings College, Park Barn would provide the opportunity to address many of Guildford's most pressing 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.
  - It is understood this opportunity is no longer available. There is some land adjacent to The Hive which might be usable. This site would most likely operate as expanded GP premises, maybe with an additional focus on mental health/social care.
- This would leave the Wodeland Avenue site as the last critical premises issue for central Guildford.

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

- The location is within one of Guildford’s most deprived localities.
- It is a large 7400 sqm site with three principal buildings.
- It is a few hundred yards from the Stoughton Road GP surgery operated by the Guildowns practice.
- Stoughton Road surgery is a leased property at the end of a row of commercial properties.
  ‘For the registered list size, the building is significantly undersized offering only 118 sqm, a deficit of 251 sqm.’ **2019 CCG Report.**
- The Jarvis Centre site is owned by NHS Property Services, obviating the need to purchase a property under private ownership.
- The ‘main’ building houses services for ‘wheelchair,, ‘children’ and maybe others. Could they be moved elsewhere?
- The breast screening service property could be retained pending possible refurbishment/replacement as the site is redeveloped.
- There would be room to accommodate a centralised enlarged PCN support capability we discuss later.

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

- GP premises are getting larger, better equipped and are sharing space with community care providers and sometimes hospital outpatients departments.
- To some degree this might mean looking again at the polyclinic model, proposed by the government about 15 years ago.



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

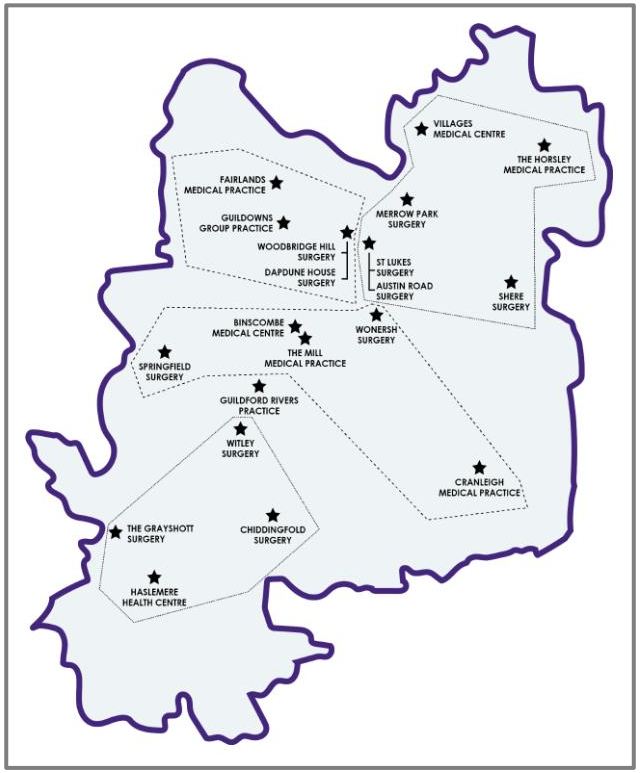
Until a community facility is built, the ICB vision for ‘a hub and spoke’ delivery system around Guildford is incomplete

- The Hospital already has satellites in Milford, Cranleigh and Haslemere.
- These essentially former cottage hospitals came under RSCH control in 2017.
- ‘Community Diagnostic Centre at Milford Hospital enables the hospital to carry out X-Rays, CT scans, blood tests’
- A new Maternity Hub in Haslemere ‘provides care closer to home for women who live in Haslemere, Fernhurst, Chiddingfold and the surrounding communities and saves the time and stress of a journey to Guildford’.
- But the remainder of the wheel is missing.
- The most pressing priority is the area mostly to the North and West of the town.

Building PCN capability

GP practices, members of Primary Care Networks, are grouped to enable services to operate at scale

- Within the Guildford and Waverley (G&W) Integrated Care Partnership Place, there are four Primary care networks (PCNs) made up of 20 individual GP practices.
- These are:
  - North Guildford
  - East Guildford
  - East Waverley
  - West of Waverley



'PCNs typically serve natural communities of around 30,000 to 50,000 patients. PCNs are small enough to provide the personal care valued by both patients and healthcare professionals, but large enough to have impact and economies of scale through better collaboration between general practices and others in the local health and social care system'. **Procare**

Guildford needs to get the best out of its Primary Care Networks

- ‘The benefits of PCNs and of working at scale include:
  - Allowing practices to share resources, expertise, and services.
  - Recruitment of shared staff under the Additional Roles Reimbursement Scheme (ARRS).
  - Improved integration of services across practices and the wider health and care system.
  - The opportunity to build multi-disciplinary teams.
  - Enhanced integration between primary care and community services.
  - Sustainability of smaller GP practices (as they can share resources with other practices within their PCN).
  - Better management of financial pressures and resources, including premises.
  - Forming an entity that can tender to provide additional care services’. **NHS England**

Re-reading the Fuller stocktake proposals is worth doing. It establishes the direction of travel

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

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

PCNs need to be strengthened to act as a counter-balance to the better set up and capitalised hospital services

- Integrated care systems are tasked with driving funding to where it delivers the best outcomes and value, irrespective of location. In a perfect world, funding should follow the patient to the most effective provider for their care.
- This objective will be uppermost as ICBs start to look to allocate funding as part the 2025-26 contracting round.
- More imaginative solutions are necessary to enable the transition to take place. From what the Government is saying, we are now should be entering a phase of fundamental realignment in the way care services across the country and within the G&W Place are delivered.
- NHS England, realising the insufficient long-term investment in GP practices, has introduced 'The Additional Roles Reimbursement Scheme' (AARS) as the means for strengthening primary care.
- Properly managed, we also see it as a springboard for building a much stronger community care capability.
- This is a central plank of this presentation.

A significant expansion of AARS represents the NHS's best chance of moving care into the community

- 'The Goals of ARRS
  - The primary goal of the ARRS is to alleviate the increasing pressures on general practices and improve access to healthcare services for patients. By expanding the clinical and non clinical teams through the reimbursement of additional roles, the scheme seeks to:
  - Enhance the capacity of primary care services to meet the growing demand for healthcare.
  - Deliver a broader range of services to patients, thereby improving patient outcomes and satisfaction.
  - Support the integration of services within PCNs, facilitating a more collaborative and efficient approach to patient care.
  - Drive forward the shift towards a more preventative approach to healthcare, reducing the reliance on hospital services and promoting community-based care.
- The Roles Covered by ARRS
  - The ARRS roles in primary care are diverse, each contributing uniquely to patient care and the broadening of services offered by PCNs. From clinical pharmacists to first-contact practitioners, these roles are reimbursed through ARRS funding, enabling PCNs to more effectively meet the complex health needs of their communities.
  - The ARRS roles list is regularly updated, with ARRS roles 2024 introducing new opportunities for PCN ARRS expansion'.

NHS England,2023.

AARS enables PCNs to staff up, but this should only be the start

- 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 (AARS), 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.

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

- 'The intention of the scheme is to grow additional capacity through new roles, and by doing so, help to solve the workforce shortage in general practice. It is not to fill existing vacancies or subsidise the costs of employing people who are already working in primary care, whether funded by a practice, a Clinical Commissioning Group (CCG) or a local NHS provider. Reimbursement through the new Additional Roles Reimbursement Scheme will only be for demonstrably additional people (or, in future years, replacement of those additional people as a result of staff turnover). This additionality rule is also essential for demonstrating value for money'.
  Network Contract Directed Enhanced Service Additional Roles Reimbursement Scheme Guidance, NHS England 2019

- What could a 'fully loaded' PCN achieve?
- What would be the scope and capacity of its individual care programmes?
- What services would be transferred from hospitals?
- What would the economics and patient satisfaction scores look like?

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

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

If all G&W PCNs were polled, what would take-up look like?

- But what would be the benefit if all posts were maximised?

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

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

- Also, they need not all be located to an individual PCN. What if certain roles were conflated, realising the benefit of scaling?
- Co-locating many of these functions would help build multi-disciplinary teams.
- MDTs would begin to develop as a unified capability with its own culture.
- Should there be a lead PCN coordinator for each of these services across the G&W Place?
- Premises then becomes a big issue. Where would they be housed?

We see the future for community health care by building out from the AARS initiative

- The AARS programme is the first NHSE initiative to invest beyond GPs' capabilities.
- This represents a genuine move to reduce pressure on doctors and introduce a wider range of help to address patients' needs.
- There are issues – particularly premises - which now need urgent attention.
- We put forward a suggestion for consolidating the staffing allocations made for many of these roles to create more scale for the PCNs working within Places.
- We identify a number of activities which might then be introduced or strengthened – a Single Point of Access and Referral Management, for example.
- The next step would be to look to the ICS to help develop a process for more patients to be moved out of hospital to the community for their ongoing care.
- This might mean putting more care under new contracts for which GPs and others might bid.
- There might even be joint ventures with RSCH.
- A longer-term move would be to consider running many discrete, condition-related care programmes as distinct service lines.
- The Women's Hub operated by GPs in Shere might be a model.
- Later, we propose a number of ways to strengthen technology to support these initiatives.

Should the Alliance have a single SPA coordinating care across the G&W Place?

- An ‘NHS Single Point of Access (SPA) is a service that coordinates care for patients and provides information and advice. The SPA can help with a variety of needs, including:
- Triaging referrals: The SPA can triage referrals for routine, urgent, and emergency care.
- Signposting to services: The SPA can help patients find the service that best meets their needs.
- Providing information and advice: The SPA can provide information and advice to patients and healthcare professionals.
- Reducing errors: The SPA can help reduce errors by providing accurate information at the point of care.
- Reducing time wasted: The SPA can help reduce time wasted by collecting and collating information, and by updating IT systems.
- Front-end the Out-of-Hours Service the SPA might be available 24/7, 365 days a year’.
  Oxford Health NHS Foundation Trust

In detail, what might a Single Point of Access do?

- ‘Staffed by a team of experienced clinicians and administrators, the SPA team will:
  - evaluate the patient’s needs using the information provided by the referrer
  - link with the provider services to discuss the referral and an appropriate action plan
  - liaise with the referrer to agree the action plan
  - hold the role of “care co-ordinator” until all referrals have been made and the action plan completed.

- A Single Point of Access is supported by an extensive range of community health services which work to support patients in the community. The types of services that can be accessed via the SPA are:
  - Integrated locality teams
  - Community hospital inpatient care
  - Community Matron Service

- Community Therapy Service, eg: physiotherapy, occupational therapy
  - District Nursing Service
  - Falls Prevention Service
  - Hospital at Home
  - Long term/end of life care
  - Specialist community nursing’

Oxford Health NHS Foundation Trust

Other opportunities should be exploited: a referral management centre, for example

- One local PCN team might act as a referral management unit.
- 'Referral management schemes operate at the interface between primary and secondary care to [manage and] improve GP referrals to specialist care. Generally, referral management schemes are used to check the appropriateness of GP referrals and reduce over-referral.
- Researchers recommend that any referral management strategy should look for under-referrals as well as over-referrals. The objective is to get consistency and reduce unwarranted variation across the patch.
- The King's Fund has identified different approaches for clinical triage and peer review and feedback; potential introduction of financial incentives [revisiting assessment some of the objectives of GP Fundholding]; compilation of a directory of services and use of standard guide-lines.' **The Strategy Unit, Midlands and Lancashire CSU, 2016**
- What the institution of referral units has done in some places has created market places, where new provision by GPs with special interests have opened up specialised clinics under contracts set up by commissioners.
- These enable more patients to be managed in community settings.

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 an AARS administered referral management centre might be another. This could help co-ordinate care from specialist clinics and reduce hospital appointments.

Combining these elements of existing NHS policies (with others) can open up a raft of new care formats

- 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.
  - 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.

There is also significant patient benefit if referrals are supported. Is it happening?

- ‘Every ICB [should] have an established approach to ensure referrals to secondary care are appropriate, including through increased use of advice and guidance (A&G) to avoid unnecessary referrals and allow patients to receive the appropriate advice or intervention more quickly.
- Continue the significant expansion of patient choice at the point of referral, with patients offered a choice of five providers where appropriate, actively encouraging access to non-local NHS providers or the independent sector where this can shorten wait times for patients (measured by patient survey). This will be supported by the introduction of capacity alerts in the NHS e-Referral Service (eRS) to facilitate informed choice for patients.
- How well is patient referral managed locally?

- Guildford and Waverley Referral Support Service was launched in 2019.
- Once your GP has made a referral, a member of the team will call you to discuss where you would like to go for your appointment. You should hear from us within ten working days. If we are not able to speak with you, we will send you a letter in the post instead.
- If it has been more than ten working days since your GP appointment and you have not heard from us, please contact us via:
- phone 0300 561 1333 (9am to 5pm, Monday to Friday)

In our first presentation we looked at a future built around service line management

What if potentially overlapping local care provider organisations could be merged into a single delivery unit?

- If a 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)	Procare Community Care (selection)
Cardiology	Cardiology
Dementia	Dementia
Diabetes	Diabetes
Gastrointestinal/Hepatology	Gastrointestinal/Hepatology
Maternity	Maternity
Pain Management	Pain Service
Rheumatology	Rheumatology
Sleep Medicine	Sleep Practice
Urology	Urology

- Some aspects of SLM were in the past termed disease management whereby pharma companies invested in developing care solutions which incorporated their products or generics. There is a huge canon of work giving details. Google for more information.

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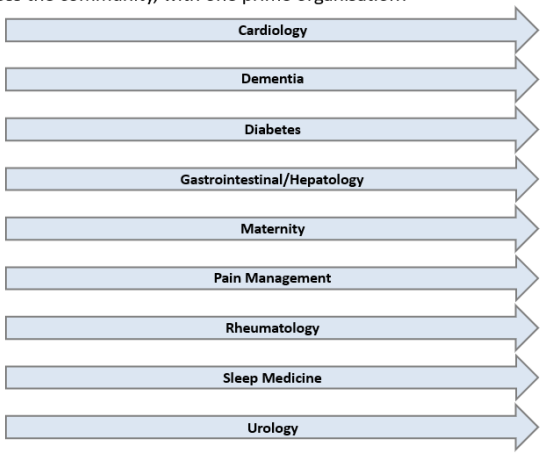
Can the two delivery systems be conflated?

- What might then be achieved if we saw these care categories as service lines, managed locally, across the community, with one prime organisation?



- Is another way of looking at it the creation of the 'boundaryless' hospital or virtual wards?

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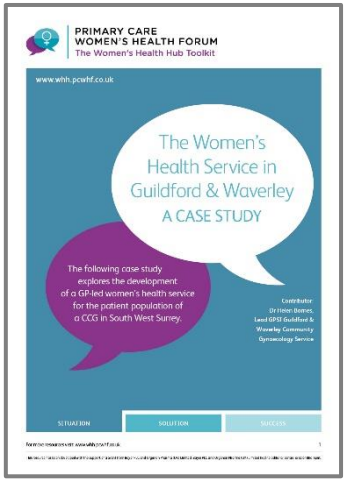
- Is the Shere Women's health hub an example of how service lines might be developed?

The local women's health hub is probably the model for a service line approach to 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]'.



This GPwSI programme could easily be seen as a precedent and pathfinder for local service development

- Purpose
  - ‘We are a GP-led and GP-provided service, the provider contractually is Shere Surgery, a rural GP practice in Surrey.
  - 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’.
- Contracts and funding
  - ‘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’.
  - What is apparent is that a number of Rubicons have been crossed. Why can’t these precedents be extended?

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**

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

- What are the implications for real estate?
- Should there be one major site for the delivery of AARs community-led services?
- Multi-disciplinary teams work best in a collegiate environment.
- Many of the ARRS personnel need to be grouped in their own discrete spaces, but preferably in a single floor arrangement.
- A significant amount of space would be required for a single point of access (SPA) and derivative services, like referral management.
- Building a new culture would be a valuable by-product of shared premises.

Outpatients

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

- Progress towards systems redesign can only occur if we move on from old health care conventions.
- The care of ‘outpatients’ is one of these.
- Patients, across their lives, are the GP’s patients both before and after hospital treatment.
- Another way of looking at it is that patients are always outpatients, except when they are in hospital, ie, where they are inpatients.
- Many outpatients continue to receive regular hospital appointments even though their care plan could often be delivered in the community.
- NHS England is beginning to reframe outpatient care policy https://www.england.nhs.uk/outpatient-transformation-programme/
- There are, of course, significant financial implications for hospitals if they lose their reimbursement for outpatient care.
- Also, the extra load on practices means that it shouldn’t reasonably be included within GPs’ capitation, should it?
- Hospitals often say that there is likely to be a loss of system productivity by moving specialists into the community for out-patient consultations.
- But there is an evidence base showing there are better options than sending everyone to hospital for outpatient appointments.

NHS England's plan is to move outpatients' care into the community. The RSCH buys in, but what are the results?

'**Transforming outpatient services for patients**

- The NHS is changing how we deliver outpatient services so that patients can be seen more quickly and can access and interact with our services in a way that better suits their lives.
- This means giving patients and their carers more control and greater choice over how and when they access care.
- We are empowering patients to book their own follow-up care as and when they need it, providing the option of telephone or video consultations where appropriate, and working with GPs to enable access to earlier expert advice'.
- Patient initiated follow-up (PIFU) is key to personalising outpatient care, and by enabling patients to have more control over when they receive care, can reduce unnecessary follow-up appointments and make best use of clinical time.
- PIFU personalises care, enabling patients to access support when they need it, but not attend routine follow-up appointments when they are well. **NHS England**
- The RSCH website says 'We are empowering patients to book their own follow-up care as and when they need it, providing the option of telephone or video consultations where appropriate, and working with GPs to enable access to earlier expert advice'.
- How well is the programme working? Are there any metrics?

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

- Hospital outpatients could be repatriated to community care one by one.
- There is probably already something of a precedent in place with patients who are in the Virtual Ward programme.
- It was always intended that ‘the [Virtual] ward [would] be overseen by a consultant, working with therapists, nursing staff and pharmacists’.
- We have seen no reports of the scheme’s progress.
- Could the expanded AARS programme pick up the most suitable candidates for ongoing out of hospital care?
- Who would they be? What would be the selection criteria?
- How patients should be ‘accepted’ by GPs is probably a matter for negotiation.
- For example, should a fee be included? And under which contract?
- There are many operational issues. Should the application of the Doccla software come under the management of the community care operation and be merged with the AARS programme?

Patients can only be transferred if there is somewhere safe to send them

- Patients have traditionally been required to attend places of care which can meet their needs.
- The real barrier to transitioning from any current position to a new operating format is the time required in setting up new care infrastructure.
- Historically, this has meant a substantial reliance on hospital real estate and fixed equipment.
- However, new technologies such as digital monitoring and video-conferencing have already made inroads into the number of in-person consultations.
- ‘They are often more convenient for patients, saving them time and money and reducing the stress of travelling to their appointments. This means patients are less likely to cancel or not attend their appointments.
- Video consultations also offer benefits for health care professionals, reducing travel time and stress, and enabling more flexible working, meaning more time to spend with patients.’
  NHS England

True, the transfer of outpatients into community care will disrupt the acute hospital business model and funding

- Hospitals often say that there is likely to be a loss of system productivity by moving specialists into the community for out-patient consultations.
- But there is an evidence base showing there are better options than sending everyone to hospital for outpatient appointments.
- 'Each provider and system have been asked to reduce outpatient follow-up appointments by a minimum of 25% by March 2023 compared to 2019/20 baseline activity and go further where possible and re-allocate time, prioritising activities to support elective recovery'.
  'Principles and approach to deliver a personalised outpatient model', NHS England, 17 May 2022.
- The number of hospital outpatient attendances has continued to grow year-on-year. In 2023-4, it was 104.6m compared with 95.9m for the prior year. Strike action by hospital doctors would have had a bearing.
- In 2023/4 the Royal Surrey had 423,000 outpatient visits. At a tariff price of £120 each, this would be income of £50.76m.
- A 25% reduction of OP appointments would mean a revenue reduction of potentially £12.5m to RSCH.
- But would this figure provide better value for money and no deterioration in patient outcomes if it were invested in community care provision?
- This is the debate which the ICB would need to have with local stakeholders.

Stronger community care would also pre-empt hospital re-admissions, many of whom are long term ‘outpatients’

- Hospital admissions come from two main sources: elected care, normally patients referred by GPs, and emergency cases, many of whom have so-called ambulatory care sensitive (ACS) conditions.
- ACS patients are more likely than average to be frequent hospital attendees, ie. hospital outpatients.
- ACS cases are costly, often lengthy in terms of length of stays. Also, delayed discharges often result from ACS patients, taking up hospital bed space.
- Someone has to look at the business case and ask the important questions.
- Where is the best place for the patients with the greatest health care needs to be treated?
- If ACS admissions were reduced, would the hospital earn more via PbR on higher revenue electives?
- What is the opportunity cost of having these patients as long-term hospital stayers?
- Or is it that the hospital wants to protect its outpatient income, approximately 10 percent of its turnover?

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.

Potential ACS cases represent the biggest opportunity for hospital admission avoidance

- ‘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’. See chart.
- Ambulatory Care Sensitive Conditions (ACS) account for one in every six emergency hospital admission in England. This shows the number of admissions for ambulatory care sensitive conditions per 1000 patients on a GP practice list.
- 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, eight in every 1,000 people in England were admitted to hospital in an emergency with an ACS condition and 22 in every 1,000 people were admitted with an urgent care sensitive condition.
- 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.

Freeing up space at the main RSCH site could lead to a sizeable increase in more necessary hospital procedures

- The ICS already recognises that the ‘acute hospital [needs] to decompress from a busy and congested site’. Moving outpatient care away from the hospital and reducing unplanned admissions would potentially create the space for higher value, faster throughput, elective care procedures.
- It also sees the benefit of operating a hub-and-spoke premises configuration: the main hospital is the hub, community care centres the spokes.
- The hospital is then the hub for neighbourhood GP practices.
- We believe that the Royal Surrey’s business model would benefit if it had more influence over upstream health delivery, the elements of which bring most patients to its doors, either as planned or unscheduled visitors, as is referenced in the 2022-23 Annual Report.

Budgets should be allocated to where they have the best result: some of this will be keeping people out of hospital

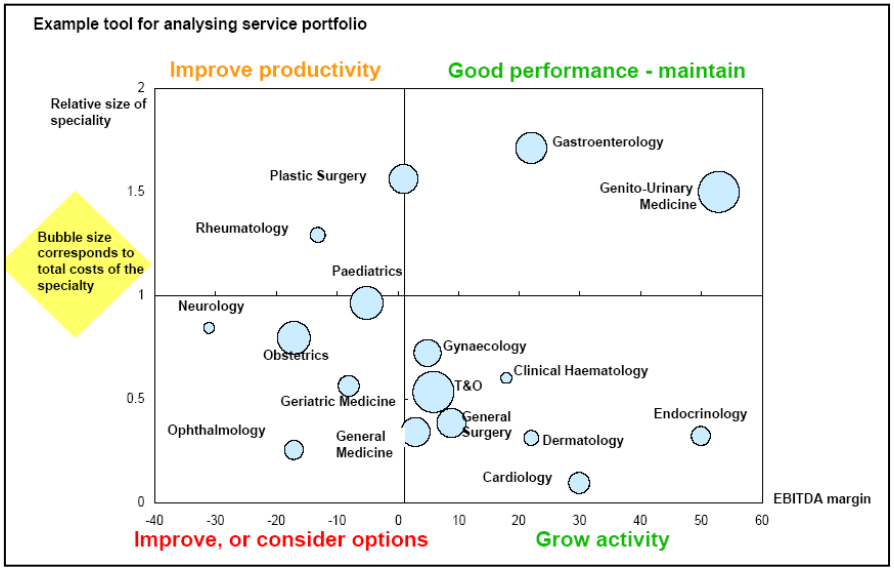
- Every patient should be treated in the most appropriate place
- Investing in what produces the best patient outcomes and value for the entire system are the key objectives
- The bulk of annual funding goes to the local hospital, where it may not be optimised
- The current system works against primary and community provision, even though these are where the best returns can be secured, consider this view:

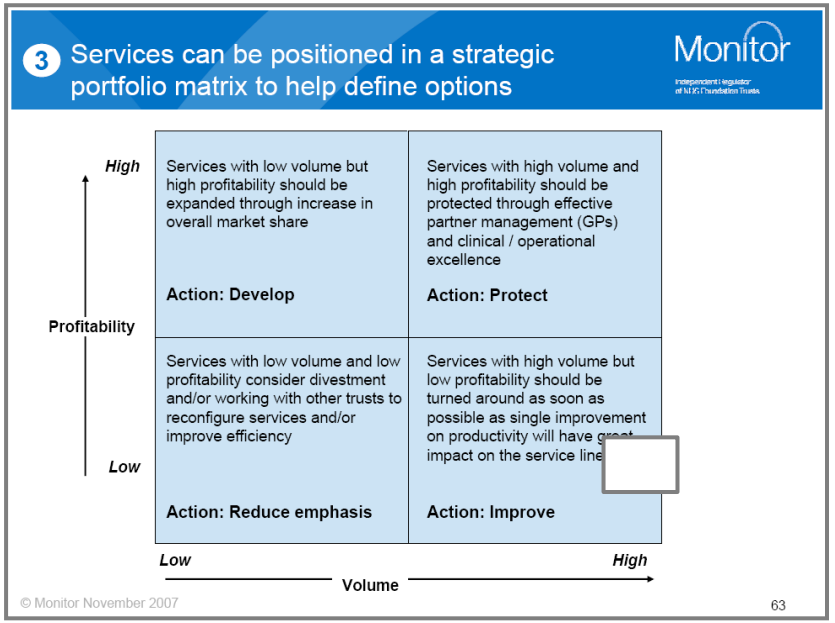
> *'On average, systems that invested more in community care saw 15 per cent lower non-elective admission rates and 10 per cent lower ambulance conveyance rates, both statistically significant differences, together with lower average activity for elective admissions and A&E attendances.'*
>
> *The reduction in acute demand associated with this higher community spend could fund itself through savings on acute activity if a causal relationship were assumed, with an average 31 per cent return on investment and average net saving of £26 million for an average-sized integrated care system (ICS), exemplifying the power and potential of community care at a system level.'*

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

The RSCH has a strong grip on maximising its earning capacity. There are probably more opportunities

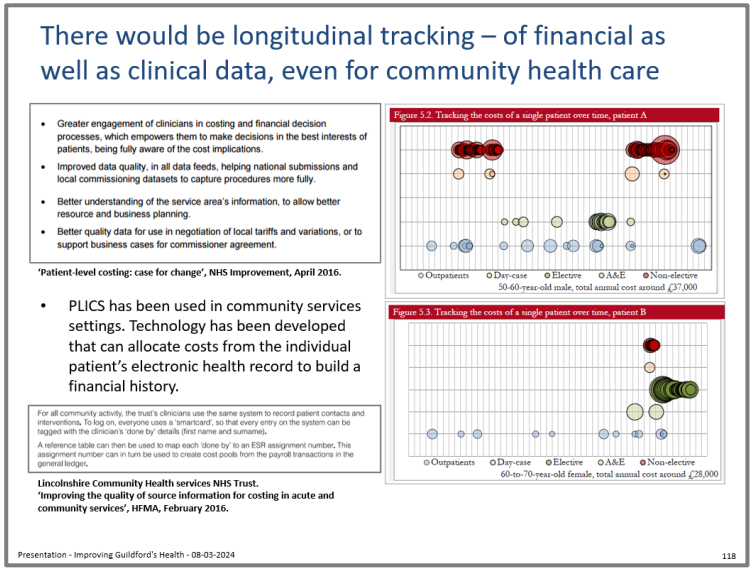
- A move to greater participation in local integrated care needn't diminish the RSCH capability to raise revenues.
- For example, there is probably a lot which it could do to improve its income mix.
- Moving low value procedures and care episodes out of hospital would free up space for more complex and therefore more valuable PbR funded activity, particularly for out of area ICSs.
- Does the RSCH identify costs at the departmental level?
- Which procedures/episodes of care make a profit and which a loss?
- What would a service line analysis reveal? This technique – introduced by NHS Monitor - has been used across FTs.
- What would the Royal Surrey want to transfer out?

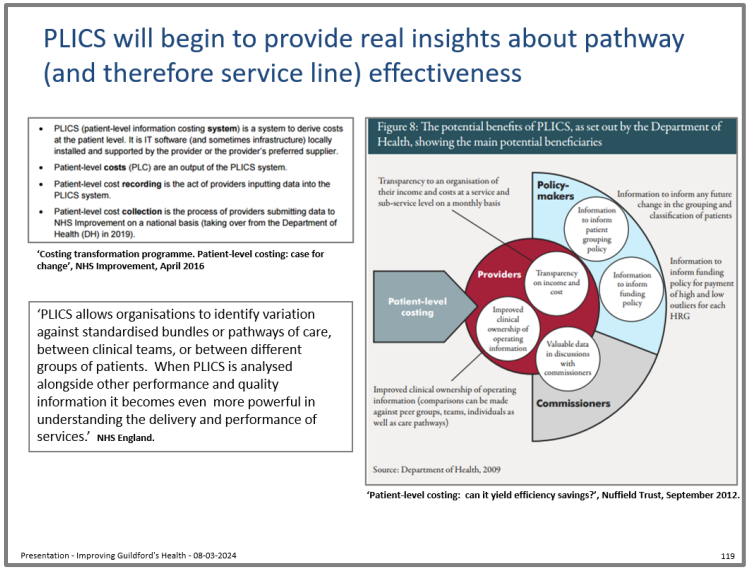




For ICSs to make the right budget allocations, there needs to be system-wide understanding of individual patient care costs

- For years the NHS has said that ‘Money should follow the patient’: but health systems need to have the base data.
- The Darzi review says ‘Lock in the shift of care closer to home by hardwiring financial flows. Financial flows must lock-in this change irreversibly or it will not happen.’
- First, there needs to be a better understanding of how the money for individual patient care flows through the entire local system. This can only be identified by a more granular look at how the current Place business model should be adapted to provide better solutions for local patients’ health care needs.
- Costing patients’ treatment is then essential. The tools are available:





Information technology

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

- Darzi says in his recent review that there needs to be a ‘Tilt towards technology’.
- ‘While there are many excellent examples of technology having an important impact in the NHS—from virtual wards to remote dermatology consultations—it has not radically reshaped services. The NHS remains in the foothills of digital transformation’.
- The extraordinary richness of NHS datasets is largely untapped either in clinical care, service planning, or research.
- ‘There must be a major tilt towards technology to unlock productivity. In particular, the hundreds of thousands of NHS staff working outside hospitals urgently need the benefits of digital systems.
- There are many possible technologies that would support more efficient, higher quality, safer care in the community. But they are largely absent. Given the shift in the disease burden towards long-term conditions, there is a greater need for information systems that work across different settings’.
- But where will the capability to deliver community systems reside - at the ICS or Place level?
- There is no local NHS IT organisation which is set up to develop community or primary care, although PCNs have just received some additional funding.
- Procare does provide some back office support, but is this essentially maintenance?
- Meanwhile, the NHS is about to spend hundreds of millions more on hospitals’ IT, building its Federated Data platform to which both the ICB and RSCH seemed to have signed up.

As might be expected the proposed data platform is hospital centric. But most information is on GP systems

- The Federated Data Platform (FDP) is NHS England's plan for digitising and connecting data to transform health and care.
- 'The FDP will enable NHS organisations to bring together operational data – currently stored in separate systems - to support staff to access the information they need in one environment.
- It will enable trusts and ICSs to make better use of the information they hold, supporting them to work together to understand patterns, solve problems, and plan services for their local populations.
- The NHS FDP is a series of separate data platforms, termed 'instances'. Every hospital trust and ICB will have their own instance of the NHS FDP, called 'local instances'.
- Each local NHS organisation will have the ability to connect and share personal information, for example, to discharge a patient from hospital into a care setting.
- At ICB level (on behalf of the ICSs), the NHS FDP will help bring together data to support population health management, tackling health inequalities and care coordination, enabling ICSs to better understand their populations, supporting a targeted, more effective use of resources and planning services around the needs of their population.
- The National (NHS England) instance of FDP will improve the flow and analysis of reporting data, to assist with strategic and operational planning'. **NHS England**
- NB: the Foundry does not hold GP data, but connections are possible, we are told.

Is the programme really under way? Is this a national vision or a local reality?

- ‘The NHS will roll out new software from spring next year [2024] to deliver better joined-up care for millions of patients, help tackle waiting lists and reduce hospital discharge delays.
- The software will bring together existing NHS data, making it easier for staff to access key information to provide improved and more timely patient care.
- The new tool, known as the Federated Data Platform, will join up key information currently held in separate NHS systems to tackle some of the big challenges the health service faces coming out of the pandemic.
- By bringing together real time data, such as the number of beds in a hospital, the size of elective waiting lists, staff rosters, the availability of medical supplies and social care places, staff can plan and maximise resources such as operating theatre and outpatient clinic time to ensure patients receive more timely care.
- Foundry helps doctors, nurses and other NHS professionals by organising information that NHS Trusts hold on different databases in one place, with accurate, up to the minute information. This enables better decision making that improves hospital efficiency and enables patients to receive treatment sooner.
- For example, a number of NHS Trusts currently use it to combine information they hold such as the condition a patient is being treated for, the status of their pre-operative assessment and the availability of a doctor with the right specialism to treat them. They then use it to book patients in directly for theatre slots.
- This is helping to increase theatre usage while giving patients more notice, reducing last minute cancellations - and ultimately reducing the time people have to wait for the care they need. It does this while rigorously protecting privacy with granular access controls, ensuring professionals only see the information they need to do their job.

NHS England

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

'Federated Data Platform (FDP)

- Every day, NHS staff and clinicians are delivering care in new and innovative ways, achieving better outcomes for patients, and driving efficiency. Scaling and sharing these innovations across the health and care system in England is a key challenge for the NHS.
- Harnessing the power of digital, data and technology is the key to recovering from the pandemic, addressing longer-term challenges, and delivering services in new and more sustainable ways.
- The future of our NHS depends on improving how we use data to:
- care for our patients;
- improve population health;
- plan and improve services; and
- find new ways to deliver services.
- The Federated Data Platform (FDP) is a software 'data platform' which will enable NHS organisations to bring together data – currently stored in separate systems – to support staff to access the information they need in one safe and secure environment so that they are better able to coordinate, plan and deliver high quality care.
- A 'federated' data platform means that every hospital Trust and integrated care board (ICB) (on behalf of the integrated care system (ICS)) will have their own platform which can connect and collaborate with other data platforms as a "federation" making it easier for health and care organisations to work together.'
- The Data Platform Contractor, Palantir Technologies UK, LTD is a processor for this Product. **RCSH website**
- There is no reference to its installation in the 2023/4 RSCH Annual Report which includes a review of 'Digital developments' by the CEO.
- What benefits is it bringing? What's the plan to coordinate with primary and community care?

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

- What benefits will the FDP bring for primary and community care?
- The ICS also has a data strategy, last details of which were published in 2022.
- (Why is the SH website never updated. It could become a governance issue?)
- Is the reference in the panel (right) about the same programme?
- Or is this a much wider data strategy for the ICS?
- Does it remain 'a vision'?
- The ICS must have an articulated IT and analytics plan which sets out in detail how the various stakeholders connect, together with measurement points.
- A move of patients out of hospital will be hampered if the systems to monitor and support them are not in place.
- Is this just another example of imbalance in investment between sectors which needs to be addressed in the budgeting process?

Data

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

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

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

We will develop:

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

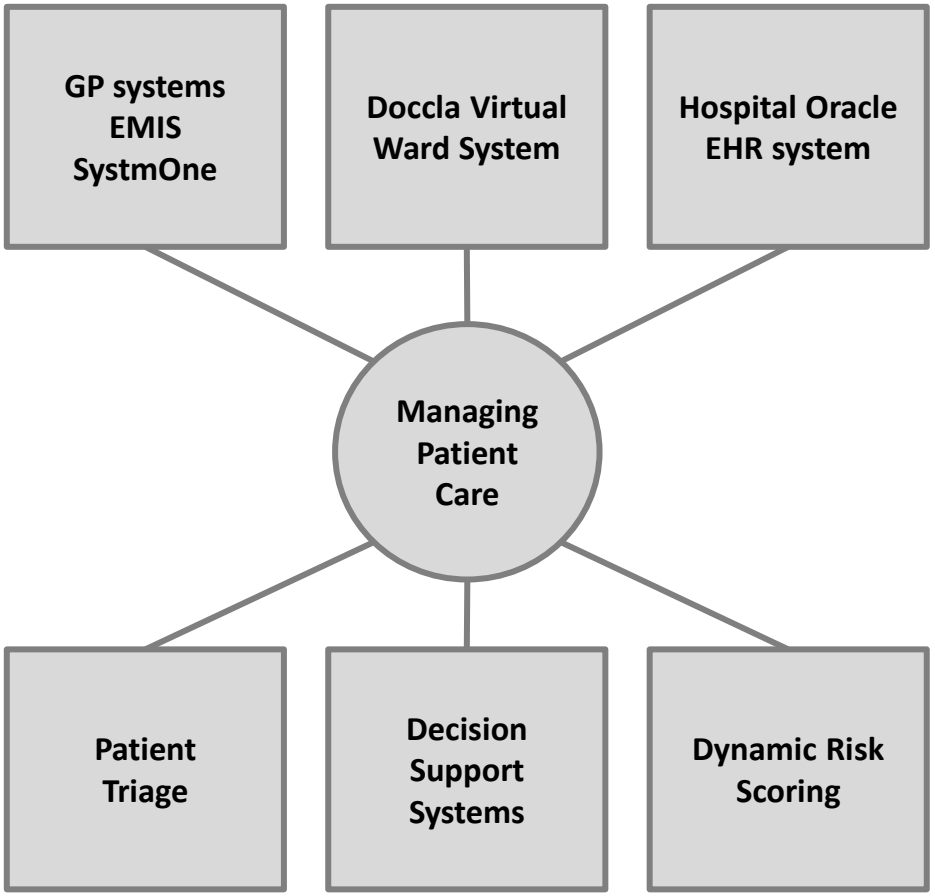
  These teams will support a population health management approach. This intelligence function is a framework which any system partner (including the voluntary, community and social enterprise sector) will be able to participate in.
- **A population health hub** – this will enable the wider system to promote, sustain and spread successful interventions and innovations.

An inclusive digital health record needs to be accessible by all parties - as envisioned by The Tony Blair Institute

- The benefits for delivering this capability are exceptional and would transform local care.
  - Earlier this year, the TBI [Tony Blair Institute] ,published *A New National Purpose: Harnessing Data for Health*; in it 'we advocated for a National Data Trust in the UK to support R&D and drive economic growth. Here we propose a digital health record (DHR) to drive improvements to health and care, and ensure that the NHS is ready for the artificial-intelligence era.
  - Each person's DHR would be the "single source of truth" for their health and care data – data that currently sit in silos across hospitals, GP practices, pharmacies and phones. It would open up a whole new way of generating health and delivering health care in the future.
  - The DHR will have most impact in primary care. Inpatient hospital visits are episodic, with clinical teams able to access relevant personal health data through the hospital record. It is out of hospital where the impact of an integrated, digital, longitudinal health record will be felt. The Fuller Stocktake report describes the three core functions of primary care – access, continuity and prevention – all of which will benefit from a DHR, especially with the advent of AI.
  - Access: For patients with an acute care need, access to a DHR would support services such as 111 to make sure they were seen by the right person, at the right time and in the right place – and that their complete medical record was on hand when they were seen.
  - Continuity: With a DHR, patients with a long-term condition could be empowered to take greater control of their health through apps and digital therapeutics. It would also facilitate care closer to home, with all members of a neighbourhood team able to work with up-to-date information so that care would be safer and more effective.
  - Prevention: A DHR could deliver precision public health, offering tailored advice, investigations and early treatment based on individual risk of ill health.
  - A DHR would also help the NHS prepare for the AI era. Health data are what AI is trained and deployed on – and, increasingly, data are used to regulate AI. A DHR would support the development, adoption and spread of AI technologies in the NHS, supporting the drive to increase productivity.' TBI, 2024
  - Guildford, with the capability we have described, could locally begin to put these components together.

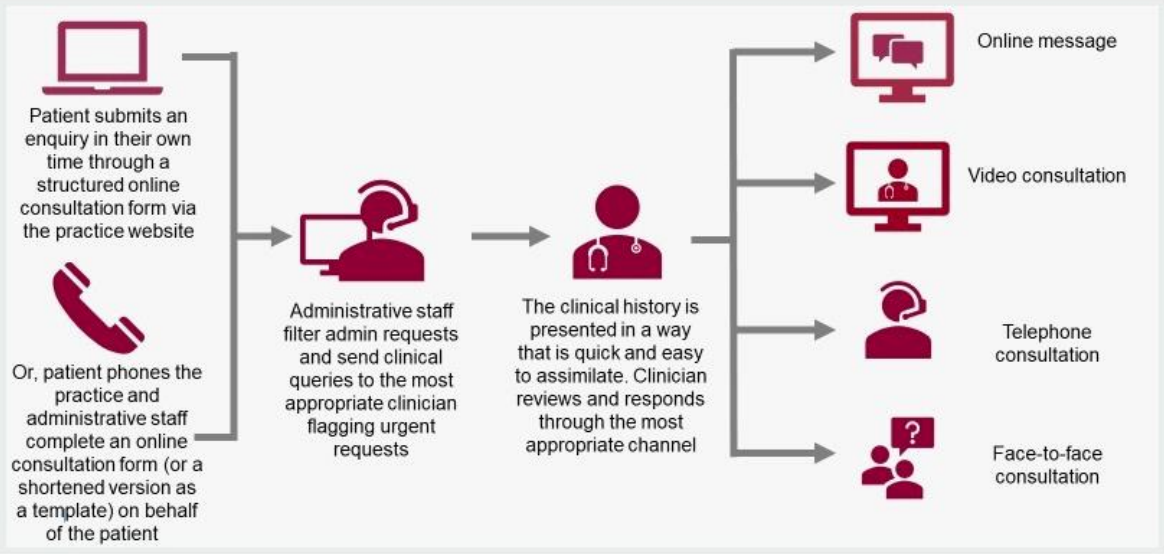
Much could be achieved by combining the best features of existing locally deployed systems

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



The Guildowns practice has implemented a triage system which captures all incoming patient contacts

This is the recommended model for practices to move to, enabling requests to enter through a single workflow and matching the approach for providing care to the person, the circumstance and their needs.



Moving to a total triage model may represent a significant change in how a practice or PCN functions. To deliver any change like this successfully, it is essential to consider organisational culture and to support people through the change process. Resilience resides in teams, particularly in complex and ambiguous times. It is important to remain flexible and supportive of one another in order to realise benefits and build effective new ways of working.

The Doccla Virtual Ward System will bring extraordinary insights to the status of individual patient care

- How Remote Patient Monitoring works
- The RPM process is designed to be seamless and efficient, ensuring that patients receive continuous monitoring and timely care. Here's a step-by-step overview of how RPM works:
- Data Collection:
  - Patients use wearable devices and health applications to collect data on various health metrics.
  - These devices can monitor a range of vital signs, depending on the patient's condition and the type of device used.
- Data Transmission:
  - The collected data is transmitted securely to a centralised system using wireless or mobile networks.
  - This transmission is done in real-time or at regular intervals, ensuring that healthcare providers have up-to-date information.
- Data Analysis:
  - The transmitted data is integrated into a centralised platform where it is analysed using advanced analytics tools.
  - Healthcare providers can access this platform to monitor trends, identify anomalies, and make informed decisions.
- Clinical Intervention:
  - If the data indicates a potential health issue, healthcare providers can intervene promptly.
  - This intervention can range from adjusting medications to scheduling an immediate consultation or hospital visit.
- Patient Feedback:
  - Patients receive feedback and recommendations from their healthcare providers based on the analysed data.
  - This continuous loop ensures that patients are always informed about their health status and any necessary actions.

Doccla website.

- Health organisations will find themselves having to re-design their care delivery systems.
- A real benefit will be the inputs into decision support systems, both human and machine generated.
- How far down into the population should these tools be used- beyond virtual wards, for example.

In our previous presentation we emphasised the criticality of decision support systems

Intelligent: CDS systems need to be evidence based and address real-world clinical decisions that would benefit from best practice support. Self-generated data can be used to guide iterative improvement.

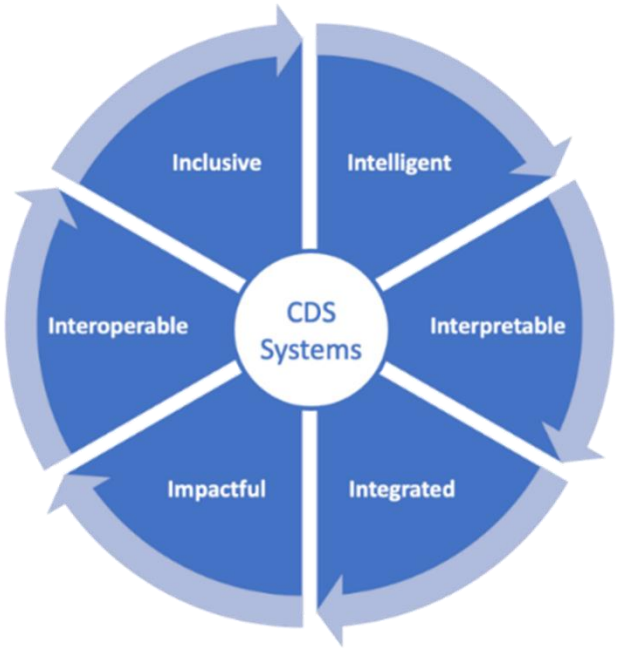
Interpretable: CDS systems need to consider the healthcare professional's knowledge of the topic, use clear and unambiguous content, and demonstrate validity and reliability of recommendations by linking to relevant explanations or evidence.

Integrated: CDS systems need to be designed to complement workflows. Integration with clinical systems can increase impact by embedding decision support in clinical workflows.

Impactful: CDS systems need to consider the experience of users, improve productivity and outcomes, and be clinically safe with mitigations made to reduce potential risks.

Interoperable: CDS systems need to interpret clinical data from systems to minimise manual data entry and present result data within relevant clinical systems by using open application programming interfaces (API) whenever possible. Where a relevant computable knowledge library is available, the CDS system should be configured to import high quality knowledge objects coded using global knowledge standards (Wyatt and Scott, 2020).

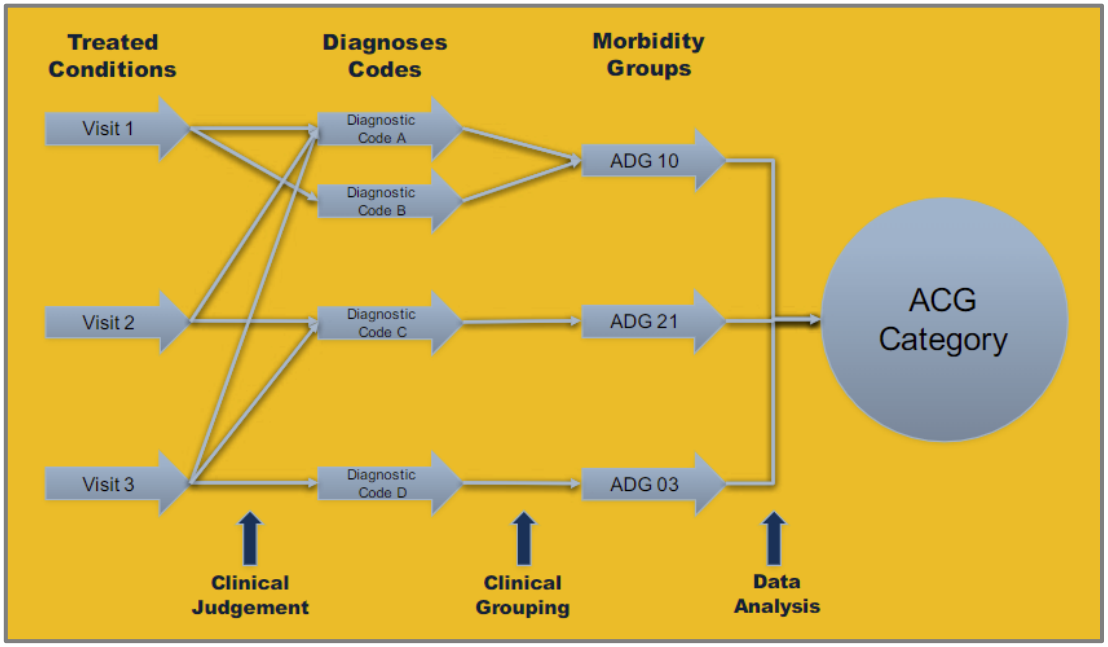
Inclusive: CDS systems need to consider a broad range of end users, be based on trusted clinical data that is representative of the target population and help minimise health inequities by standardising care.



'Supporting clinical decisions with health information technology', NHS England.

Also, how important dynamic risk assessment systems were for patient tracking

- Particularly at the GP level where electronic records have been in place for 25 years.
- The opportunity for data analysis has been under leveraged.
- This may be because hospitals have relied on paper records.
- This is changing, but the GP records are sufficient to guide structural change.



Johns Hopkins ACG System.

The next generation of systems redesign, driven by AI, could come faster than expected

- AI will be the most disruptive force ever to confront health care.
- It is already in progress, coming in multiple waves across the entire spectrum of health sciences and delivery.
- It requires extraordinary amounts of data to work at the most effective levels, but organisations in health care are better endowed with these than for most other sectors.
- Machine driven decision support will make the difference. Not only, for a major event, but through continuous tracking and monitoring.
- The success of these programmes and the extraordinary benefits which are theoretically available depends on the attitudes and behaviours of all involved in assembling the treatment packages which are delivered to patients along their care pathways.

Nobody should underestimate the pace of adoption of AI capabilities

- ‘By 2030, many [enterprises] will be approaching “data ubiquity.” Not only will employees have the latest data at their fingertips, but data will also be embedded in systems, processes, channels, interactions, and decision points that drive automated actions (with sufficient human oversight)’.
- Gen AI agents informed by detailed historical [patient] data will interact with digital twins of those same [patients] to test personalized products, services, and offers before they are rolled out to the real world.
- Clusters of large language models (LLMs) working together will analyse individual health data to derive, develop, and deploy personalized medicines.
- Quantum-sensing technologies, for example, will generate more precise, real-time data on the performance of medical devices, which applied-AI capabilities will be able to analyse to then recommend and make targeted software updates’. **McKinsey and Co.**

This is just one company's (Amazon) vision for health care transformation

- 'Unlock the full potential of your healthcare and life sciences data with AWS.
- Organisations in the heavily-regulated health care and life sciences industries – from biopharmas to health techs to providers and payors – need to accelerate time to diagnosis and insights, increase the pace of innovation, and bring differentiated therapeutics to market faster with an end-to-end data strategy.
- AWS provides a centralised hub for innovation and collaboration on a global level, connecting you with the data and machine learning tools you need, and partners you can trust, all while keeping health and life sciences data secure and private.
- AWS Health Data Portfolio aligns purpose-built AWS Services and AWS Partner solutions to business needs, ranging from secure data transfer, aggregation, and storage to data analytics, collaboration, sharing, and governance.
- With generative AI and purpose-built machine learning services, you can easily integrate cutting-edge technologies into your existing workflows to accelerate innovations and fuel new discoveries.' **Amazon Web Services website.**
- Given their history with IT projects will local NHS units be able to buy into and deliver this kind of vision?
- The NHS has decided to move ahead with its own Federated Data Platform. Downstream organisations will plug in. The plan has not yet been outlined.

What needs to be done? Here's what McKinsey says

- 'Develop a [local] AI strategy for health care, defining a medium - and longer-term vision and goals, specific initiatives, resources and performance indicators.
- Define use cases to support through targeted funding and incentives to enable scaling of AI solutions across the system; ensure these deliver against both clinical and operational outcomes.
- Set standards for digitisation, data quality and completeness, data access, governance, risk management, security and sharing, and system interoperability; incentivise adherence to standards through a combination of performance and financial incentives.
- 'The lessons from public- and private-sector actors aiming to develop AI in healthcare to date suggest that scale matters—largely due to the resources needed to develop robust AI solutions or make them cost-efficient.
- Smaller organisations can benefit from working in innovation clusters that bring together AI, digital health, biomedical research, translational research or other relevant fields.
- Larger organisations can develop into centres of excellence that pave the way for regional and public-private collaborations to scale AI in European [and domestic] health care'.
  McKinsey & Co
- Scale is critical for AI implementation: there has to be a complete Guildford and Waverley dataset. We say elsewhere that Guildford could be an exemplar for delivering a Place based patient management system.

Scale is critical for AI implementation: there has to be a complete Guildford and Waverley dataset

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  McKinsey & Co
- Each practice has analysable patient databases.

GUILDOWNS GROUP PRACTICE

THE OAKS, APPLEGARTH AVENUE, GUILDFORD

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

NHS England QOF database.

In our first presentation, we highlighted Guildford's ability to create a health care knowledge collaborative

Organisation	Competences
Royal Surrey County Hospital	Patient care, hospital management, estate planning, contracting, analytics, IT
Its subsidiary company, Health Partners Ltd https://www.healthcarepartnersltd.co.uk/	Management consultancy, project management, patient pathway design, supply chains, medical device management, clinical support
Surrey Heartlands ICS	Commissioning, care procurement, finance, strategy, estate planning, contracting, IT/Informatics, analytics. Health tech accelerator programme with University of Surrey
Procare https://www.procarehealth.co.uk/about-procare/	Primary care network coordination, community health, out-of-hours service, GP back office services, practice record coordination, management consultancy, IT support, contracting, project management
Guildford and Waverley Health and Care Alliance	Local NHS HQ, system coordination, strategy, finance and budgeting
PCN GP practices	Primary care, patient records, other GMS and PMS services, contracting
University of Surrey School of Medicine	Medical school, AI, Machine Learning, Research, patient risk stratification, hospital management, clinical placements with providers and commissioners
University of Surrey Faculty of Health and Medical Sciences	Undergraduate and graduate programmes –biochemical sciences, clinical and experimental medicine, microbial sciences, nutrition
Surrey Research Park collaborators	Local companies with health care tie-ins including diagnostics, genomics, therapeutics, molecular imaging, cloud solutions
NHS Commissioning Support Units	Commissioning support, business intelligence, analytics, strategy development, procurement, contracting, system design

Which local organisation will take the lead in data management and analytics?

- ‘The lessons from public- and private-sector actors aiming to develop AI in healthcare to date suggest that scale matters - largely due to the resources needed to develop robust AI solutions or make them cost-efficient.
- Smaller organisations can benefit from working in innovation clusters that bring together AI, digital health, biomedical research, translational research or other relevant fields.’ **McKinsey & Co**
- For the whole G&W Alliance system to function efficiently and collaboratively it should work off a common data set (allowing for current data protection and security regulations).
- Both the hospital and practices have their own freestanding patient record systems. Combining the two would deliver the best results.
- It is essentially the easy to achieve early identification of at-risk patients in the community which will have the most important impact on the local system’s effectiveness.
- The previous page outlines the present array of systems.
- There is also probably a need to operate a financial management system which would include cost accounting systems like PLICS to facilitate the best business decisions.
- All of this is we assume is an uncosted function.
- Should the ICS or the hospital bear the cost? Or both?
- Is there a role for Health Care Partners Ltd, the RSCH subsidiary?

The Royal Surrey County Hospital

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

- Foundation Trusts are truly big businesses, the most skilfully managed in the NHS with all the panoply of professional services (including media relations).
- In all local health systems, it is the acute trust (formerly the general hospital) which dominates.
- The Royal Surrey has an annual income of around £500 million.
- Local GPs receive less than £20 million.
- Community health services (of which RSCH is a joint venture partner) about £19 million.
- In NHS terms, the Royal Surrey is a smallish general hospital in a small town with the country's 4th largest cancer centre attached.
- We spend some time in the Appendix detailing how the Royal Surrey has been a massive beneficiary of the government's Provider Sustainability Fund.
- In the past seven years this programme has contributed over £100 million to the RSCH balance sheet through the most skilful business management.
- While in its annual accounts the money is described as 'Taxpayers' Equity', the hospital would argue quite reasonably that as it sits on their balance sheet and is rightfully theirs.
- But is it morally theirs? It is likely that some patients might have made sacrifices for it to have been secured.
- It is on the Hospital's capital account. Throughout this presentation we make an argument for some of it to be invested on capital projects in the community.
- These arrangements need not be dilutive. There is a strong case for the investments to bring a positive return for the Royal Surrey

RSCH activity: volume and cost

- ‘Creating the best value from our £521m turnover, our teams deliver high quality services for our local population. Last year our teams:
  - Saw close to 90,000 patients in our Emergency Department;
  - Delivered 3,000 babies;
  - Performed 34,000 surgical procedures;
  - Completed 82,000 CT and MRI scans;
  - Saw 423,000 outpatients;
  - Treated more than 8,000 cancer patients’.
    RSCH Annual Report 2023-24.
- Each one of these procedures has a price under the NHS Payment Scheme. ‘The NHSPS sets rules for determining the amount payable by a commissioner for the provision of NHS health care services and some public health services’.
- The average payment for a hospital outpatient consultation is £120.
- This means then that the 423,000 outpatients cost about £50m, or roughly 10% of RSCH turnover.
- There were 12.5 OP appointments for every one surgical procedure.
- All GP consultations’ costs are covered within the capitation allowance of about £170pa per patient.
- GP consultations are reckoned to cost about £45 each.

Change will only come about for Guildford's health delivery if the RSCH wants it.

- We have explained the motivations of the managements of Foundation Trusts.
- Many prefer a business-as-usual approach, believing that integrated care will come to them and will just need bolting on.
- They will be able to pursue their current agenda and receive better than inflation budget increases forever.
- This is Wes Streeting's 'existential threat' scenario.
- The status quo cannot deliver his three policy pillars:
  - "from hospital to community",
  - "analogue to digital",
  - "sickness to prevention".
- We spend a large part of this presentation developing a rationale for the Royal Surrey, showing how integrated care will not damage its vision of what the hospital will become.
- The RSCH is exceptionally well managed. It is good enough to take on the much larger challenge of leading the Guildford and Waverley inclusive care initiative.
- It must fully collaborate with the Surrey Heartlands ICB to see it through.

Does the Royal Surrey really understand that it is part of the total local health care system?

- It has said that ‘The Trust is a core partner in the Surrey Heartlands Health and Care Partnership Integrated Care System (ICS)’.
- ‘These organisations have a clear remit to strengthen out-of-hospital services, improve access to the right urgent care services, and align and join up care across Surrey and Guildford and Waverley, thereby reducing inappropriate admissions to hospital.’ **Chair’s Report, 2023-24**
- The Hospital Chair has told us ‘the RSCH does not have the resource nor the mandate to get involved in primary or social care’.
- In annual reports, it is silent about how it plans to participate in creating an integrated care system locally.

The RSCH business plan and funding are set up to deliver and grow the hospital's agenda

- The Hospital vision and strategy are well articulated.
- The RSCH has by the standard of any acute FT a strong focus on its purpose as a hospital
- The future seems to be about an extrapolation of the status quo.
- Its strategy is the board's charter which is self determined.
- It has no obligation to participate in any DHSC or NHSE policy changes not directly affecting the hospital – to help with the establishment of a local integrated care plan, for example.
- This means that the local ICB has few levers to drive change – the annual contracting cycle, operating budgets and public opinion are the most likely.
- There are many instances across the country where the local hospital gets more than its reasonable share of local funding.
- However, at the end of the day, the hospital is solely funded by taxpayers' money.
- The ICB has a wider duty of care for the general population.
- How can the ICB be certain that the current allocation is the best one for the population as a whole?

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.

What financial options does an acute FT need to consider?

- Firstly, it probably wants to stay as close to breakeven.
- It needs to fulfil its contract with its local main commissioner, the Surrey Heartlands ICB. Some of this is under a fixed contract, some through PbR. But this contract is unlikely to grow in value at a rate much higher than inflation.
- Giving up some of the work it does to other providers (probably those in the community) would free up capacity to deliver higher value (potentially higher margin) business. An SLM review would assist with service line selection.
- The extra capacity would also enable it to undertake more work for out-of-area commissioners which would likely be re-imbursed under PbR, again determined by SLM.
- The uprated cancer and cardiac units could probably receive more Specialised Commissioning work remunerated by NHS England.

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.

The RSCH balance sheet has been transformed by a government inspired financial manoeuvre

- Beginning in the 2016/17 financial year, a £2.45 billion so-called Provider Sustainability Fund was established by HM Treasury to incentivise NHS providers to gradually reduce the overall NHS net deficit. It essentially was a piece of political window dressing.
- Cash rewards were given in return for hospitals meeting financial targets.
- 'Control totals', essentially gave each trust a bottom-line figure for their income and expenditure accounts, essentially to create a result as close as possible to breakeven.
- As many as 80 or so providers were asked to make real terms spending cuts almost two-thirds bigger than strictly necessary to maintain their own financial health.
- This collectively meant that each participant each had to cut their in-year spending by an extra 1.2% beyond the 2% needed to absorb the cost of inflation and thereby balance their books.
- We believe one of these was the RSCH. The accounts from 2017 show years of close to break even year end financial results.
- Full details are included in the Appendix.

Much of what we are proposing for integrated care won't happen unless the development capital is available

- As we have explained, the only capital available is with RSCH.
- We have also put forward many reasons why the hospital should invest mostly in practice premises to strengthen both primary and community care.
- There are other non-financial contributions it can make:
  - Management
  - Systems development
  - Premises and real estate management
  - IT, data and analytics
  - Financial management
- But is it leadership that system changes need most.
- We believe that the RSCH is the best equipped organisation to lead the installation of a community care system in the G&W Place.

An alternative business model for RSCH

The Royal Surrey as it currently sees itself

- ‘RSCH strategy has had a three-pronged strategy since 2018:
  - As a ‘normal’ acute general hospital for its local population
  - As a major tertiary cancer centre
  - An integrated trust, as we took over adult community services in Guildford and Waverley’.

  RSCH Annual Report, 2022-3

The Royal Surrey’s strategy

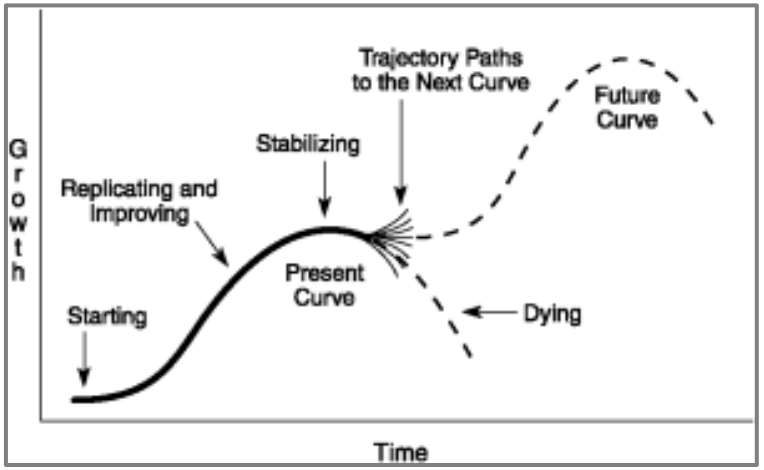
The Royal Surrey is an award-winning organisation and we are proud to be unique in the NHS as we provide three integrated types of care in our organisation. Firstly, we provide acute secondary services – ‘normal’ hospital services dedicated to the health needs of the local population of approximately 400,000 people across South Surrey. Secondly, we took over the adult community services in Guildford and Waverley in 2018, making us an integrated Trust, and giving us a step-change in our ability to wrap services around patients outside of the walls of our main hospital site. Finally, we are a major tertiary cancer centre offering a range of services for patients across the South East of England for all but the most rare tumour groups.

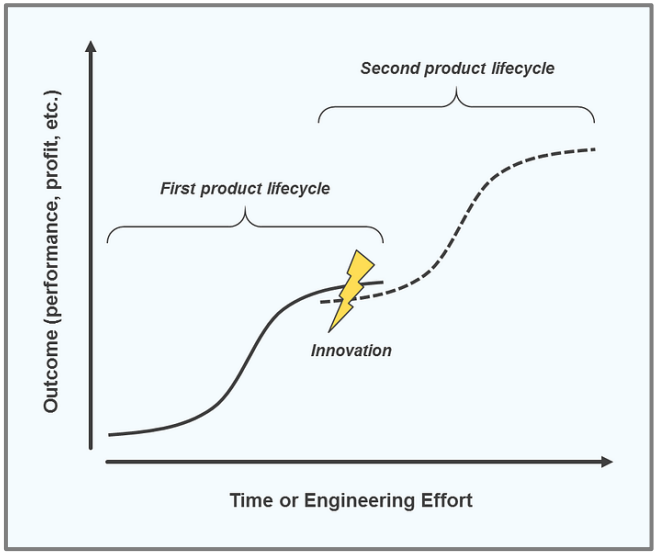
The Trust was inspected by the Care Quality Commission (CQC) in March 2020 and Use of Resources, Medical Care, and End of Life were rated as outstanding, and Urgent Care as good. The Well Led review was paused and therefore the overall Trust rating has remained unchanged due to the pandemic. The Trust is currently rated as ‘Good’ overall and ‘Outstanding’ for responsiveness.

RSCH Annual Report 2017/8

Has the RSCH management reached its S-curve moment?

- The RSCH is now formally recognised by the Care Quality Commission as an outstanding hospital, one that is 'performing exceptionally well'.
- One of the CQC's five tests is that the organisation is well-led: that 'the leadership, management and governance make sure it's providing high-quality care that's based around [the patient's] individual needs, that it encourages learning and innovation, and that it promotes an open and fair culture'.
- The business side of the hospital also demonstrates exceptional financial capability when judged by its peers. Elsewhere in this document we show its precision for balancing its books, year after year. Also, how it has deftly achieved incentive payments offered by the government and built a substantial balance sheet.
- This is a team of people which is at the top of its game
- It is clearly an ambitious management. But it is also which is probably under-leveraged in terms of the capabilities it possesses.
- Should it have a bigger challenge?
- The management theory of the S-curve is that successful entities - people and organisations - eventually achieve mastery of their assignments, that tasks can become increasingly routine and automatic and growth and learning opportunities tighten.
- Eventually, the skills become out of balance with organisational or market needs. This is when it becomes crucial to leap to the next stage of the S-curve, where new challenges are available.





Are there conflicts in the RSCH business model at present which would benefit from clarification?

- What we are proposing might even be seen as a fundamental relook at the Royal Surrey's role and future options. Most NHS operations have just evolved over time rather than followed a plan. The RSCH has adapted to changing circumstances. Nobody ever expected that it would become England's fourth largest cancer centre, for example.
- There are many dissimilarities in the two major hospital operations: one, acting a general hospital serving an essentially local population, and the other a highly focused, single purpose, specialist treatment centre. Their patients are different as are their care and funding models.
- We are even wondering whether this creates an internal conflict for hospital management. How are the two activities balanced? Are there cross-subsidies: do resources switch between them as a consequence of management's own biases?
- What would a comprehensive service line analysis of the two operations show? Might this even lead to a consideration of separating the two entities, equipping them with their own capital and financial structures to create a stronger sense of mission?

Is it worth having a look at the three components of RSCH strategy differently?

- ‘RSCH says it has had a three-pronged strategy since 2018. We are flipping the order of the previous slide:
  1. As a ‘normal’ acute general hospital for its local population.
  2. An integrated trust, ‘as we took over adult community services in Guildford and Waverley.
  3. As a major tertiary cancer centre.

- Let us develop these (in strawman mode). What we are suggesting:
  1. RSCH continues in this role as its core activity. Its principal activities in this are then diagnostics and acute care, with a focus on surgery. It would also deliver a substantial proportion of outpatient care *physically* in the community, particularly patients with long term conditions. Essentially this would mean the merging of 1 with 2 above.
  2. RSCH says that it ‘took over adult community [care] services in Guildford and Waverley’. We are proposing that it should provide both hospital and community care (except for GP services) in a single entity. It would still collaborate in the Procare JV. The effect of the merging 1 and 2 is that this would make the delivery of integrated care programmes organisationally and contractually easier to deliver.
  3. We are proposing that to bring clarity to both businesses, the cancer centre is hived off in a separate entity but still be part of what would be termed the RSCH Group.

The reasonable question might be should the hospital expand to provide more services in the community?

- We’re proposing that a small portion of the capital in the Royal Surrey reserves should be used as the initial investment, the flywheel if you like, to deliver the required new community premises and capital.
- There is a strong business case for the Hospital to take control of the new build projects.
- This has been demonstrated with many recent capital projects – the financing and building of the new staff car parking in conjunction with Genesis, Assura, Prime and Vinci in particular, the Hospital can undertake complex and imaginative projects.
- This would mean that the RSCH as building developer and operator would be both landlord and tenant.

The RSCH need not lose income; it could follow the patients into the community

- A ‘boundaryless’ hospital would bring many benefits to local health care.
- RSCH has crossed its Rubicon with the Procare JV. But most of this organisation’s staff work independently of the hospital.
- In this presentation we proffer suggestions for how a community-based organisation might be built off an expanded AARS capability.
- This, however, need not be an either/or proposition.
- The hospital could be involved in the community clinics either on a partnership or contractual basis.
- Much of a hospital’s income is from GP referrals. Being inside the AARS expanded PCN organisation would increase its role in patient direction.
- Operating via the GP PMS contract or APMS would enable it to protect some of its revenues.

Can the RSCH 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 continues. The ICS has no capital and the GPs have no intention to redevelop their sites or pay for new ones.
- The only potential source of capital is now from the Royal Surrey.
- There is probably no apparent reason why they should help resolve this situation. They would probably make the case that they should not stray from their mandate unless there was something in it for them.
- The Hospital Chair has told us 'the RSCH does not have the resource nor the mandate to get involved in primary or social care'.
- We spend a lot of time in this presentation attempting to make a case why it makes good business sense for both the RSCH and the local health economy.
- And, of course, patients and population, too.

Should the cancer centre be a ring-fenced RSCH subsidiary?

- A new strategy would reflect the changed circumstances.
- For example, the cancer centre might become a free-standing, independently financed subsidiary of the RSCH group, essentially the holding company.
- As we have said before, the Royal Marsden model might offer some insights. Not only does it provide a world class cancer service but it has found how to create a self-sustaining, one service line business capability, attracting both world class oncologists and research funding.
- Its substantial reserves and surpluses provide a base for continuous development

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.
- Might the RSCH even look for a closer relationship with the Royal Marsden, brand sharing or even a merger, increasing the revenue potential of the Surrey site?

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'.

3. Operating income

3.1 Income from activities by source

	2022/23 Trust £000	2022/23 Group £000	2021/22 Trust £000	2021/22 Group £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 £000	Changes in cash in year £000	At 1 April 2021 £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 £000	Changes in cash in year £000	At 1 April 2021 £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

Empowering the Patient

Guildford's health focus should be achieving equity for all patients

- The established health population measures are life expectancy and those who report to ONS that they are in 'very bad' or 'bad' health.
- All localities have their areas of deprivation. As we have pointed out in previous presentations, Guildford certainly does:
- Stoughton, Stoke and Westborough are amongst the most deprived wards in Surrey: life expectancy is significantly lower for men and for women compared with other wards in Guildford.
- 'Life expectancy at birth for men ranges from 76.6 years in Stoke to 87.6 years in Godalming Holloway, a difference of almost 10 years. LE at birth for women ranges from 78.8 years (Stoke) to 90.7 years (Blackheath and Wonersh), a difference of 11.9 years'.
- The Park Barn and Royal Surrey neighbourhood has the highest level of overall deprivation - with 35.4% of households suffering some type of deprivation.
- The next most deprived neighbourhoods were Woodbridge Hill (35.2%) and Bellfields, Slyfield and Weyfield (35.1%)'. **ONS, Surrey, Guildford data.**
- 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) all of which are available to help build a picture of sickness prevalence at the postcode level.
- It is quite straightforward to literally 'Pin' these individuals down to individual households.

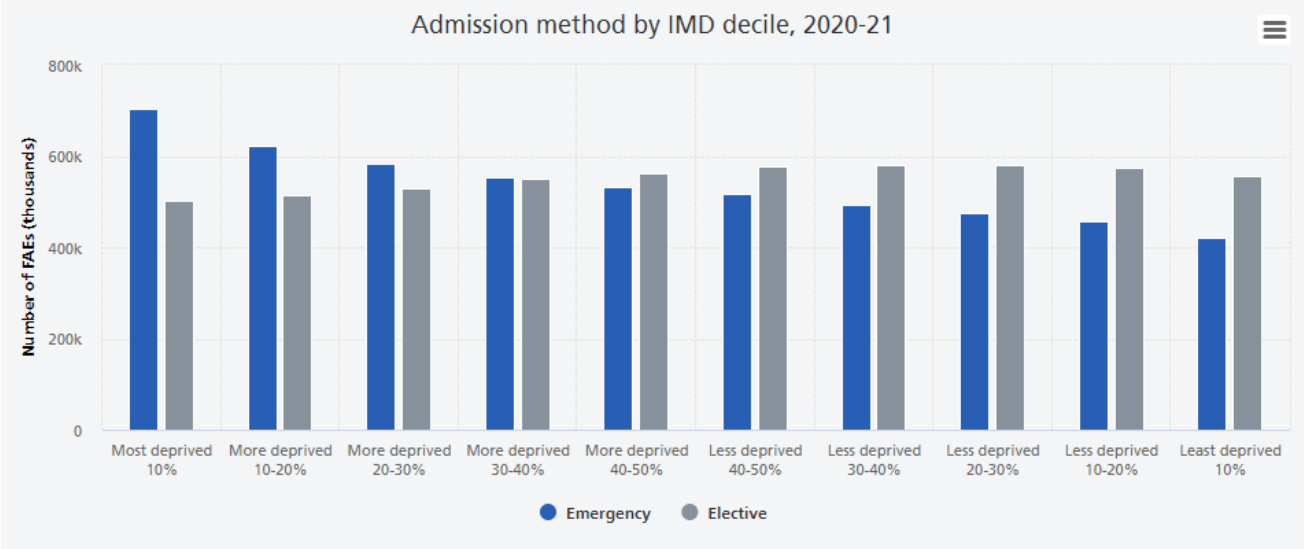
All transformation plans should start with a focus on the patient (in other industries, the customer)

- This is always a big challenge for state controlled, top-down, internally focused institutions.
- They have a tendency to extrapolate from the organisational status quo.
- Also, starting plans at the population level is not good enough; this is the old public health paradigm.
- You have to build from the bottom up, now possible through data ubiquity.
- All patients are different: their treatment preferences should always be acknowledged.
- Clinicians are finding that here are no one size fits all solutions.
- Medicine, for example the use of targeted pharmaceuticals, is becoming exquisitely personalised.
- People's attitudes to their care is also highly individual. Yet the application of techniques drawn from behavioural science and psychographics by the NHS is still sparse.
- Patients have to be engaged for care plans to be optimised.
- Communication methods offer new opportunities for patient dialogue: social media influences the lifestyles of many.
- Securing patient engagement for self-monitoring and self administered treatment have trended upwards for many years. Existing platforms, eg the NHS App have to be leveraged.
- Set against all of this, digital exclusion, particularly among the most needy, means that all life circumstances need to be accommodated.

This slide shows how deprivation impacts hospital admissions

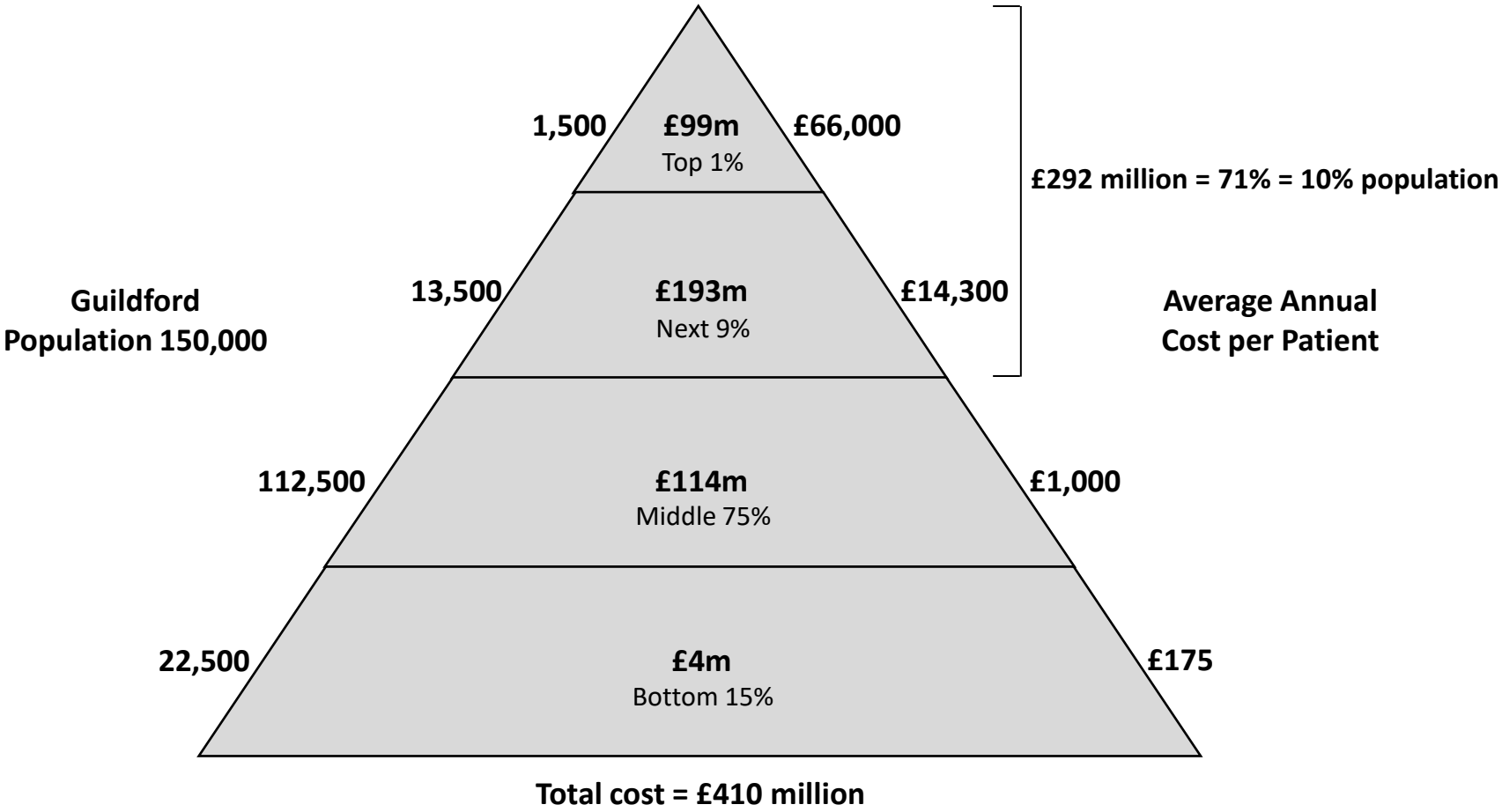
Admission method by IMD decile, 2020-21

We can see in this chart that emergency admissions were more common in the more deprived decile groups compared with the less deprived groups.



- The deprived groups need more emergency hospital admissions.
- In stark contrast, elective care occurs more in the higher deciles because of longer lives which require more acute care.

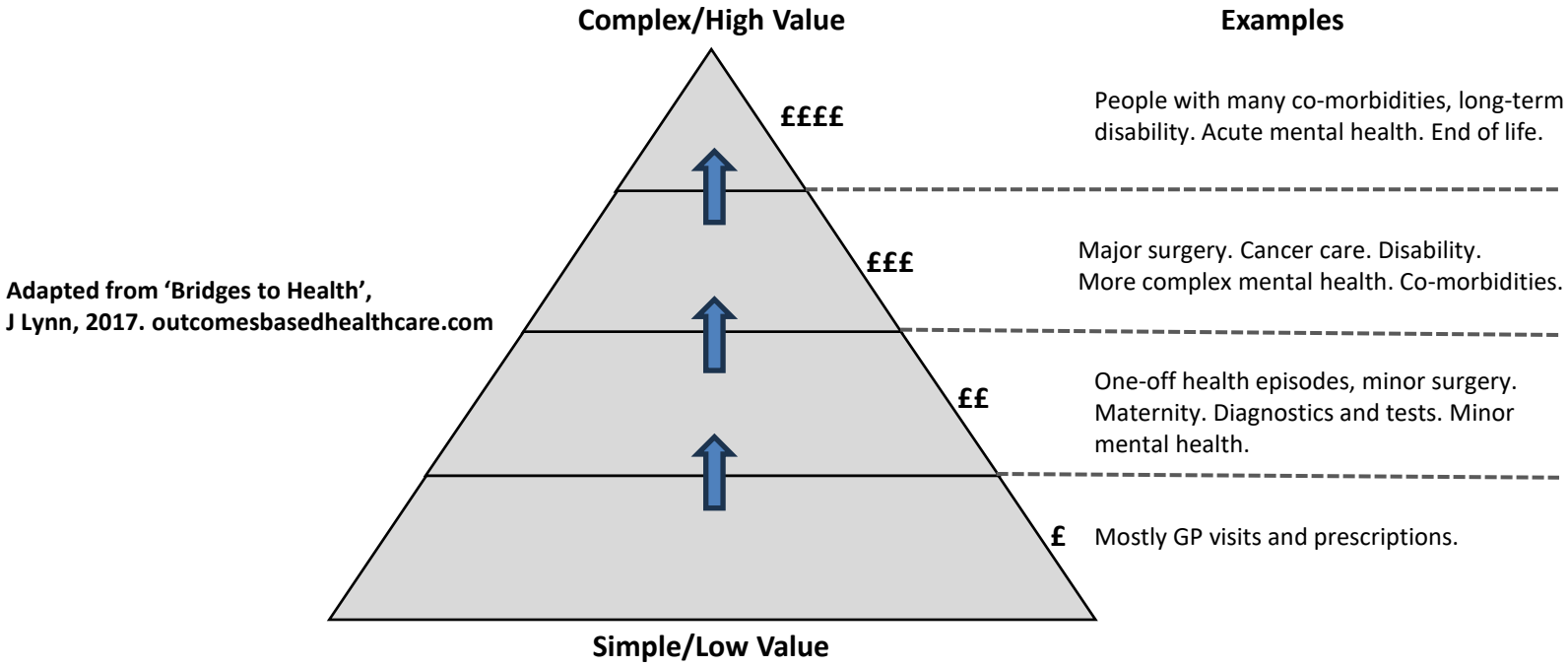
It is a common factor across all health economies that 70% of budgets are consumed by 10% of the population



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

Controlling the upward movement in patient health deterioration is every system's major challenge

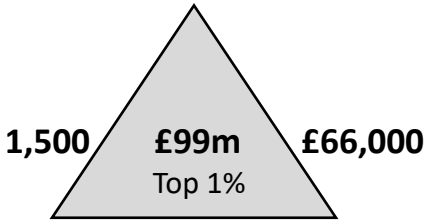
- Over their lifetimes, most people will inevitably move upwards through this care hierarchy.



- The clear objective of health systems is to reduce this upward transition, to raise population health, improve individual outcomes, slow the rate of morbidity and to lower costs.

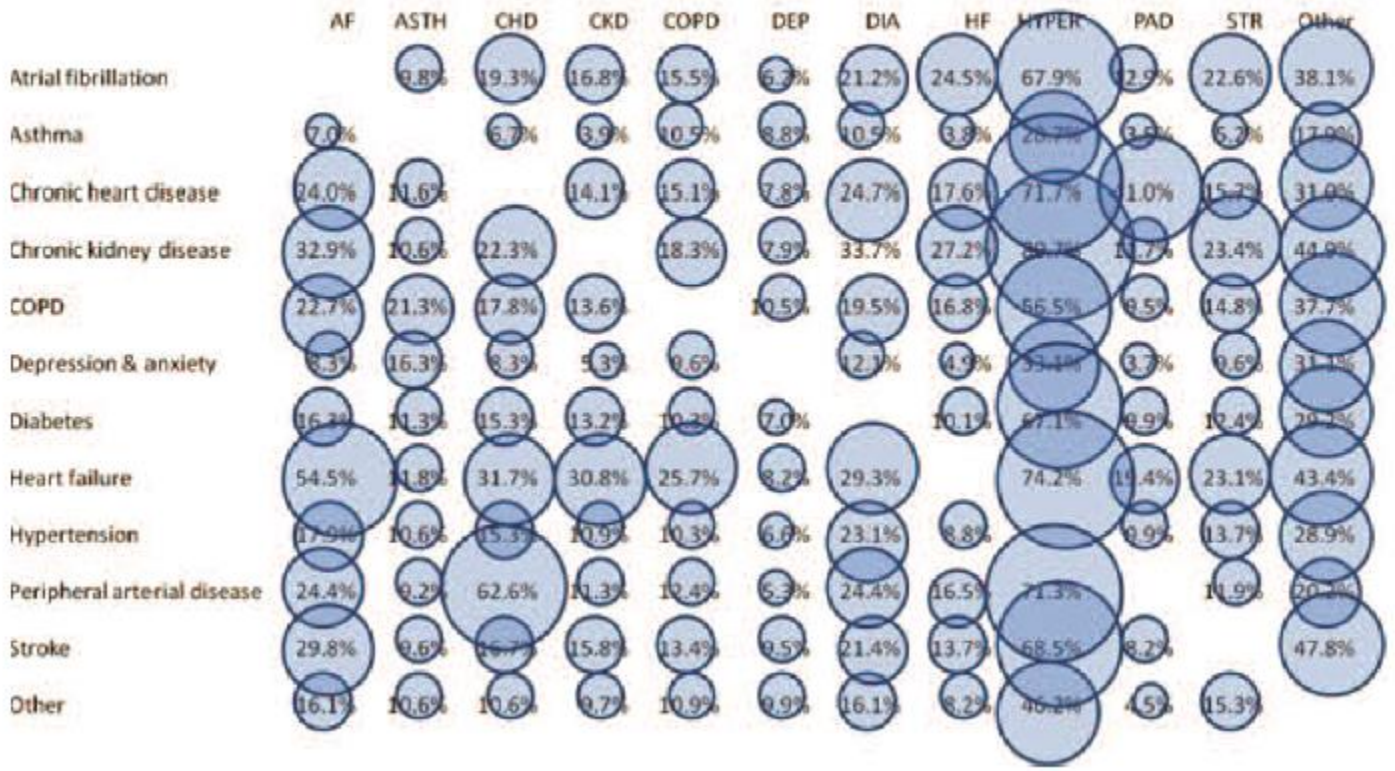
Who are these people? Identifying the most needy is relatively easy, coordinating care delivery, less so

- Data apart, this is relatively easy because these people touch the system most frequently.
- But this will be at multiple points of care for different morbidities.
- Often, information about these encounters is not processed to provide a complete picture.
- This means that for these people many of the opportunities of *integrated care* could fall short.
- Historically, the dominant district general hospital has created patient records around its own needs, often on paper.
- A move to electronic systems can now produce more timely, readable information improving the ability to build a clearer understanding about recent care delivery and the nature of the patient's condition.
- Just who are the 1500 individuals with the most acute care needs? Understanding who they are is the first step in cost improvement and probably achieving better outcomes as well.

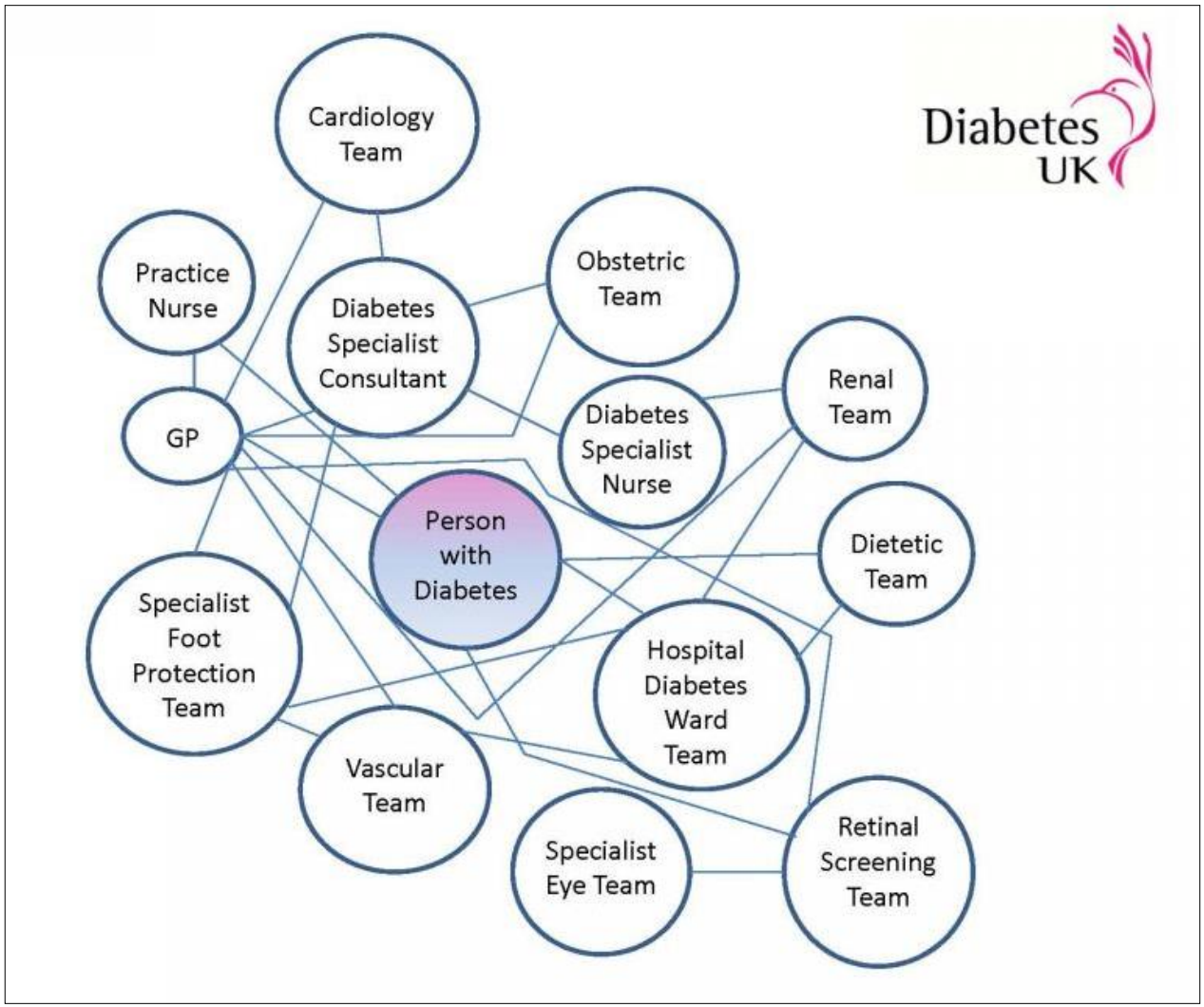


The incidence of multiple co-morbidities complicates care management co-ordination

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

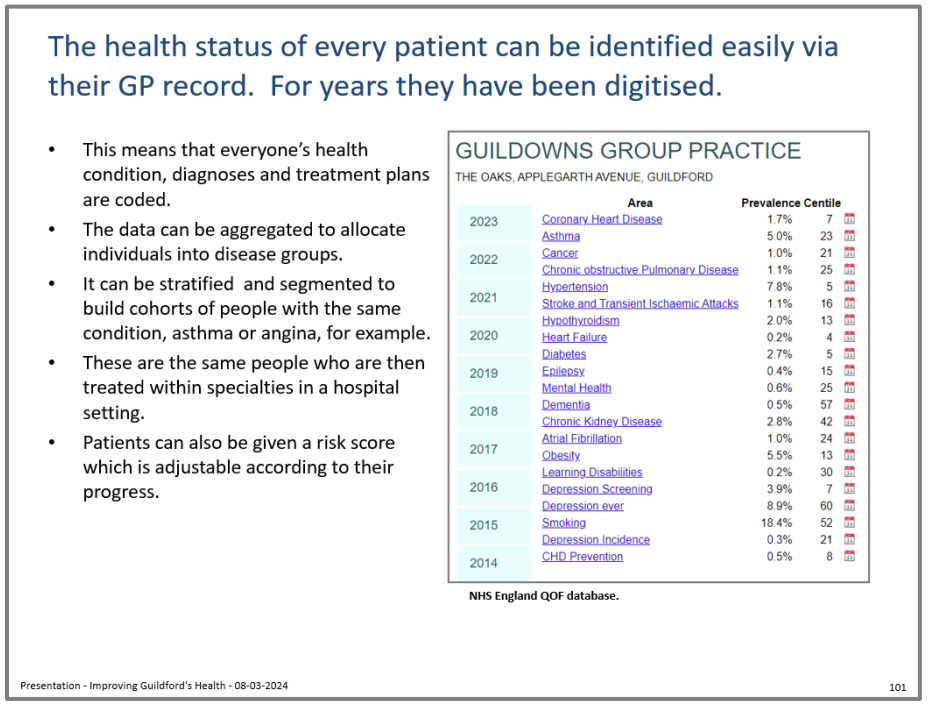


Even a patient with a single condition can have multiple points of care



Patient data is rich and a lot of it is still under-used

- Practitioners need to leverage the data: the patients who need the most help are relatively easy to identify.
- Care plans should be guided by the data.
- Building the initial patient database requires some effort, but is essential.
- It should be a core initiative for all participating organisations.
- After this, it's all about diligent, accurate, timely patient information recording and tracking
- Digitisation is mandatory, as is inter-operability between systems, hospitals and primary care, in particular.
- Analytics will be a big new leading competence for the NHS locally.
- They will drive huge benefits for outcomes and cost containment.
- It will need initial disproportionate ICS funding and management to introduce and embed these new skills.



The health status of every patient can be identified easily via their GP record. For years they have been digitised.

- This means that 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.
- These are the same people who are then treated within specialties in a hospital setting.
- Patients can also be given a risk score which is adjustable according to their progress.

GUILDOWNS GROUP PRACTICE

THE OAKS, APPLEGARTH AVENUE, GUILDFORD

	Area	Prevalence	Centile
2023	Coronary Heart Disease	1.7%	7
	Asthma	5.0%	23
2022	Cancer	1.0%	21
	Chronic obstructive Pulmonary Disease	1.1%	25
	Hypertension	7.8%	5
2021	Stroke and Transient Ischaemic Attacks	1.1%	16
	Hypothyroidism	2.0%	13
2020	Heart Failure	0.2%	4
	Diabetes	2.7%	5
2019	Epilepsy	0.4%	15
	Mental Health	0.6%	25
2018	Dementia	0.5%	57
	Chronic Kidney Disease	2.8%	42
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.

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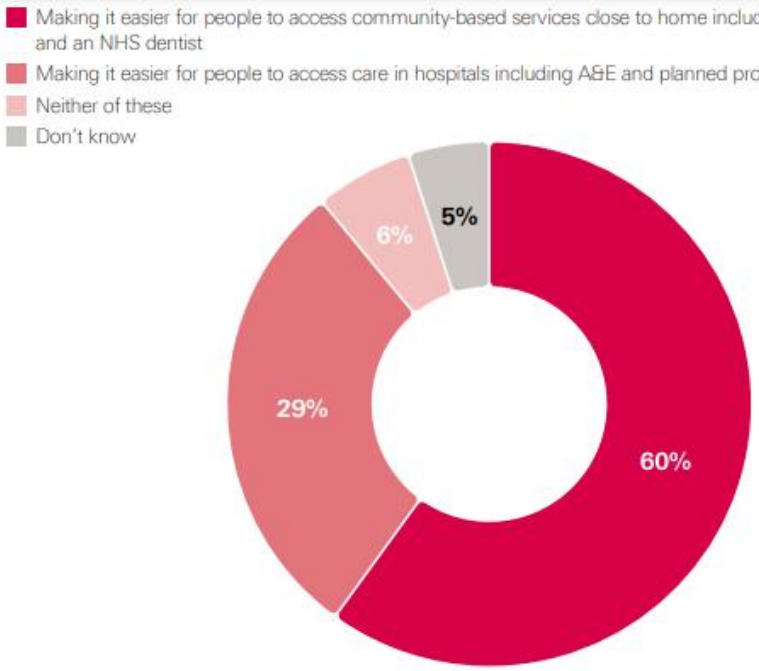
Health systems rarely start their planning with a focus on the patient's needs and circumstances

- The true measure of success will be an unswerving focus on the objectives we highlighted from the ICS's own plan at the beginning of this presentation.
- Knowing the patient's and population's needs, using the information available, is the starting point for care delivery redesign.
- A bottom-up (personalised) rather than top-down (public health) approach is the preferred orientation.
- The desired point-of-arrival is to create a uniquely personalised proposition for the individual concerned.
- It should be the test for every system change that local entities are considering.
- But how often does this happen?
- What needs to be done to ensure its delivery?

Labour sees the need for more consumer engagement. Is this the opportunity to deploy AARS to relocate patients?

- ‘Our reforms will be fundamental and deep.
- We can see the future with the Tories unfolding before our eyes.
- A two-tier health service, where those who can afford it go private and those who can’t are left behind.
- Labour has a different vision for our future.
- Where people have power, choice and control over their own health and care.
- Where the place you’re born or the wealth you’re born into doesn’t determine how long you’ll live.’ **Wes Streeting, Conference speech, 2023**
- It’s possible that Labour will revitalise the patient choice programme which was introduced during their last administration.
- Their belief was that competition reduced hospital waiting times.
- ‘Research shows that giving patients choice can cut up to three months off their waiting time by selecting a different hospital in the same region’. **DHSC website**
- Having a community care option might do better. It is likely that there will be competing offers for diagnostics, for example.

Should Patient Choice be a mandatory PCN offer? It's patients' preferences for their care to be provided out of hospital



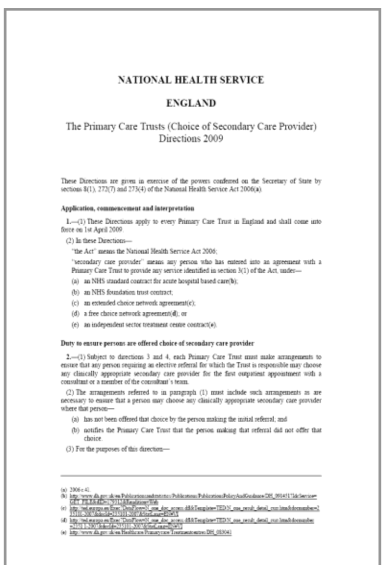
Source: Ipsos survey commissioned by the Health Foundation, Nov 2023

Base: Respondents from England only (1,774), interviewed 23–29 November 2023 via UK KnowledgePanel

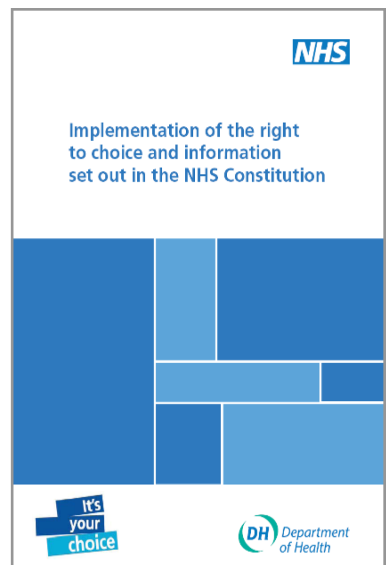
Participants understood that NHS resources are limited and prioritisation is necessary. Most participants, in each location, initially favoured placing greater focus on primary and community care, in line with the polling findings. However, participants were divided over how far to place the focus towards primary and community care, with some thinking it should be slightly focused on these services and others thinking it should be focused on them to a great extent. A few participants in each workshop felt strongly that hospital care should take priority. While there was broad consensus that the focus should shift towards primary and community services, participants found the decision challenging.

Choice of hospital (so long as it accepts the NHS tariff for that procedure) is a legal right for English patients

- Under the NHS Constitution, commissioners are required to offer choice to patients
- Citizens in England now have a legally enforceable right under the NHS Constitution to choose their care provider from an extensive range of hospitals under the NHS Choices scheme.
- **‘Duty to ensure persons are offered choice of secondary care provider:**
  2.—(1) Each CCG must make arrangements to ensure that any person requiring an elective referral for which the Trust is responsible may choose any clinically appropriate secondary care provider for the first outpatient appointment with a consultant or a member of the consultant’s team.’
  The Primary Care Trusts (Choice of Secondary Care Provider) Directions 2009, as amended.



THE NHS CONSTITUTION
the NHS belongs to us all



A PCN AARS unit could create the platform for a Patient Choice offer

- ‘If a GP needs to refer you for a physical or mental health condition, in most cases you have the legal right to choose the hospital or service you'd like to go to.
- This will include many private hospitals if they provide services to the NHS and it does not cost the NHS any more than a referral to a standard NHS hospital.
- You can also choose a clinical team led by a consultant or named health care professional, as long as that team provides the treatment you require. Find out more about choosing a hospital or consultant and choosing a mental health service.
- You can book your appointment via the NHS e-Referral service. It can be done while you're at the GP surgery, or online, using the shortlist of hospitals or services provided in your appointment request letter. The shortlist is selected by your GP, so make sure you tell them about your preferences during the appointment.
- To agree on the shortlist, you and your GP can compare information about hospitals or consultants on this website, including quality outcomes, waiting times, parking and travel. Use the services near you link to make an informed decision before booking. **NHS England**
- Guildowns practice has a designated Care Navigator. Could this be part of their role?

There is the prospect of a digital market developing, an unrealised possibility for many years

Book an appointment using the NHS e-Referral Service

If you've been referred to a specialist through the NHS e-Referral Service, booking your appointment online is easy, safe and secure.

The Start now button will open the NHS e-Referral Service booking website: Manage Your Referral.

You can also use the Start now button to:

check your appointment details

change your appointment

cancel your appointment

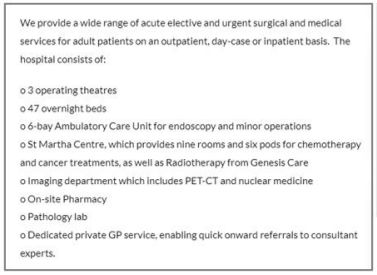
cancel your referral

Choosing your hospital or clinic

You may have more than one hospital or clinic to choose from. But the options will be the same if you book online or over the phone.

The NHS in Guildford should look at local independent capacity as part of its overall acute care capability

- Under the NHS Patient Choice programme, every individual has the right to choose to go to an independent hospital which operates on the NHS tariff.



We provide a wide range of acute elective and urgent surgical and medical services for adult patients on an outpatient, day-case or inpatient basis. The hospital consists of:

- 3 operating theatres
- 47 overnight beds
- 6-bay Ambulatory Care Unit for endoscopy and minor operations
- St Martha Centre, which provides nine rooms and six pods for chemotherapy and cancer treatments, as well as Radiotherapy from Genesis Care
- Imaging department which includes PET-CT and nuclear medicine
- On-site Pharmacy
- Pathology lab
- Dedicated private GP service, enabling quick onward referrals to consultant experts.

Circle Health Mount Alvernia, Guildford.

Key facilities at Nuffield Health Guildford Hospital

Medical cover

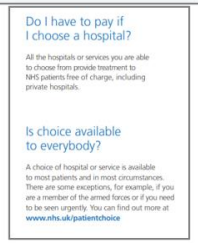
Two 24hr resident medical officers.

Patient accommodation

47 single en-suite patient bedrooms including, nurse call system, TV, radio, direct dial telephones and Wi-Fi.

Theatre and support services

- Four operating theatres (two with laminar flow and one with digital operation)
- Endoscopy theatre
- Four acute dependency beds
- Free on-site parking.



Do I have to pay if I choose a hospital?

All the hospitals or services you are able to choose from provide treatment to NHS patients free of charge, including private hospitals.

Is choice available to everybody?

A choice of hospital or service is available to most patients and in most circumstances. There are some exceptions, for example, if you are a member of the armed forces or if you need to be seen urgently. You can find out more at www.nhs.uk/patientchoice

NHS Patient Choice leaflet.

- This increases Guildford's capacity by 94 beds and eight operating theatres.

- NB: between 15 and 20% of Guildford residents will have private health insurance.

Could Personal Health Budgets be part of the future funding allocation for community delivered care.

- Money would then truly follow the patient. The creative use of PHBs might lead to some interesting new care financing options.
- 'A personal health budget [PHB] uses NHS funding to create an individually agreed personalised care and support plan that offers people of all ages greater choice and flexibility over how their assessed health and wellbeing needs are met.
- This can include a range of things to give people access to care, support and services that are holistic, innovative and build on their strengths.
- Personal health budgets are flexible. They can be used to meet a variety of needs:
  - For ongoing care and support to meet people's assessed health and wellbeing needs,
  - *For one-off budgets to support people to achieve specific goals or outcomes enabling supported self-management eg hospital discharge*, mental health recovery
  - To support children and young people with education, health and care plans
- And they can be:
  - *Pooled to support several individuals to come together to achieve a common health and wellbeing goal*, eg a group health weight management programme for people with a learning disability and/or autism
  - Integrated with social care and/or education personal budgets
  - *Used to target and address wider system priorities such as identified health inequalities.* **NHS England.** NB: our italics for emphasis

Truly personalised care, imaginatively managed, is within reach. How will commissioners react?

- ‘ICBs also have a role in the implementation, promotion, and expansion of personalised care, which may include a personal health budget (PHB).
- A PHB is an amount of money used to support a person’s health and wellbeing needs, planned and agreed between the person and their local NHS team.
- PHBs allow individual patients to decide how to use the money that they are entitled to, to deliver the care they need.
- By enabling individuals to undertake the commissioning role themselves, they have more choice and control in how their long-term health care needs and outcomes are met’. **NHS England**
- Patients also have their standard Choice offer.
- This is the Pandora’s Box option – patients in control of their care choices, navigated by AARS staff, choosing a community destination, maybe operating on an APMS contract.
- Competition rules would mean that private sector providers would also be part of any choice programme.
- GPs can refer patients to the AARS unit for making referrals and onward care arrangements.

NHS England contract policy allows for the delivery of care services by independent providers

NHS England contracting advice says:

- ‘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.’
- Many commissioners have often pushed back on opening up or extending a wider use of contracts.
- Many have been resistant to any change in the status quo.
- But the NHS has to stimulate the supply side to tackle the waiting times backlog.

Arriving at this point sets up the possibility of introducing new models of care funding and contracting

- NHS England says PHBs can be ‘used to target and address wider system priorities such as identified health inequalities’.
- Also, they can be ‘pooled to support several individuals to come together to achieve a common health and wellbeing goal’.
- Might we see a situation where patients with a particular condition amalgamate to create a market for their care?
- Or clinicians, GPswSIs even, come together to ‘market’ a service to these patients?
- Is this where PHBs+Patient Choice could take us – a WhatsApp group of local patients with a common interest?
- This might be particularly applicable for patients with multiple co-morbidities, for whom there are existing support groups or condition specific charities. Could these organisations become care brokers?
- There is probably more options that a care marketplace might offer. For example, could there be NHS funded end-of-life community care/hospice package that patients might buy via a PHB?
- Should the NHS fear this kind of innovation.

Certainly, care delivery must be built around patient preferences which need to be fully understood

- ‘Consumer engagement is a core competency of B2C companies. These companies employ advanced analytics to deeply understand customer needs, develop products and services to meet those needs, and engage (market to) consumers through hyper-personalised messages and content across an array of traditional and digital channels. Retailers, for instance, are now able to provide relevant, personalised recommendations delivered digitally, especially when consumers are in a shopping mode’.
- ‘Our research has shown that health care consumers are no different from retail customers: they want to be good consumers who can make informed choices about the care they receive and expect digital to be a core part of this engagement. Using personalisation techniques pioneered by other industries, health care providers can drive higher engagement and better support the needs of patients’.
  Next generation [patient] engagement on care journey, McKinsey & Co July 23, 2019

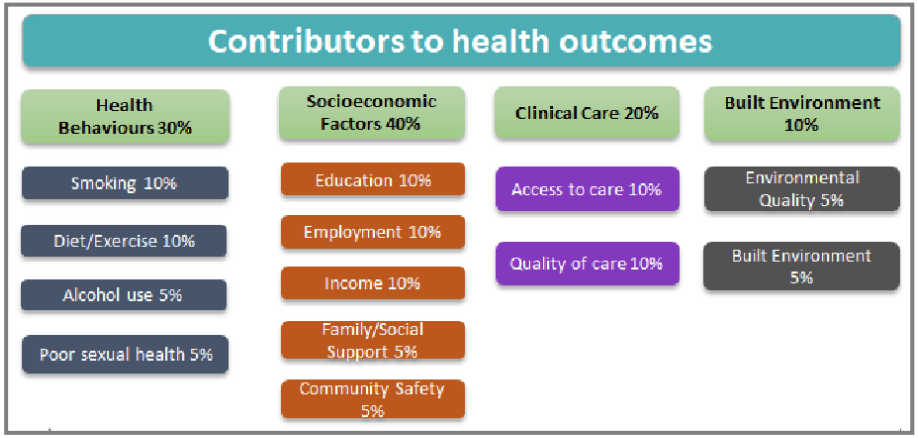
It’s accepted that patient behaviour makes a huge contribution to personal wellbeing and outcomes

- Patient engagement is a critical factor in the achievement of positive health outcomes. Many studies have shown that patients who are actively engaged in their health, wellness and healthcare experience better health outcomes.
- Patients who are active participants in their care and engage health care professionals productively are more likely to pursue regular health screenings and check-ups and exhibit healthy behaviours, such as exercise, proper nutrition and the avoidance of smoking or excessive drinking. Consequently, health issues are detected earlier or avoided altogether, leading to healthier people and less costs to the healthcare system.
- Traditionally, health care has taken a “one size fits all” approach to patient engagement, assuming everyone with the same health condition thinks and acts alike, treating patients like a “walking health condition.” Patients are people, with distinct personalities, values and priorities. Two people may share common characteristics, such as health condition, demographic or socio-economic variables, and they may even behave the same way, but their motivations may be different. If patients’ personalities and motivations are different, an engagement message – whether clinical, educational or marketing – needs to also be different to activate desired behaviours.
- Technology and digital health are playing a greater role in consumers’ health care. Digital health promises to extend providers’ care beyond the walls of the practice and engage patients on their terms. However, while health apps are increasingly available, addressing a spectrum of health, wellness and prevention needs, the majority of patients indicate they do not regularly use a health app on a smartphone or tablet.
- Healthcare providers who engage patients through other digital channels, such as email, typically use the same channels for all patients, further reinforcing a “one size fits all” approach. Some patients may prefer email while other prefer text messages or phone calls. Other patients may still even prefer printed materials. **PatientBond https://www.patientbond.com/psychographics.**
- NB: the NHS already has a health app. We should see this as merely a launch pad. AI will eventually transform its usage.

Public health and prevention

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.
- The needs of people in deprived living conditions cover a wide range of other circumstances, see the slide below.
- Deep-seated social, economic and environmental factors have the most impact, while digital exclusion, literacy and English language competence can also have a bearing
- This places more responsibility on addressing other aspects of people's lives beyond direct health care.
- A better, well equipped community based care function will drive neighbourhood health improvement and is worth the investment.
- Public health programmes can offer some assistance, but require a high level of personalised client support, usually delivered by primary care practices, and often requiring significant time investment by practitioners.
- There are new opportunities which might be harnessed.



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.

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.

Appendix

Well-run Foundation Trusts are excellent financial managers: the RSCH is top of the class

- NHS hospitals don't have to make a profit (or what they call a surplus)
- Probably the optimum result for the financial year is the tiniest of surpluses - which RSCH has achieved consistently over the past few years with extraordinary precision.
- For FTs delivering this position, significant government bonuses have been available for a number of years. This is how RSCH has built the cash pile in its balance sheet.
- A close to breakeven result means that commissioners (nowadays the ICB) know that their delivery expectations are generally being met. The next year's budget will not need to be varied much with regard to volume.
- A large loss can mean overtrading and the threat of special measures.
- A large surplus says that the activity level set by the ICB may not have been achieved. The reasons why will be investigated.
- Some juggling does take place with the different reimbursement methods. Over the years the NHS hospital remuneration system has seen some gaming (read the NAO reports).
- Activity management is always carefully regulated by the most astute FT finance directors.
- Block contract awards and Payment by Results remuneration each need their own separate treatment.
- For example, the provider the objective with block contracts is to ensure that volumes of activity do not deliver a loss.
- The PbR plan is to maximise the number of care episodes which can be delivered where a positive margin is available for that care category.
- So, given all of the above, what financial strategy does the RSCH FD want to pursue?

This is the small print for how the RSCH is remunerated

- ‘The main source of income for the Trust is contracts with commissioners for health care services. Funding envelopes are set at an Integrated Care System (ICS) level. The majority of the Trust’s NHS income is earned from NHS commissioners under the NHS Payment Scheme (NHSPS) which replaced the National Tariff Payment System on 1 April 2023.
- The NHSPS sets out rules to establish the amount payable to trusts for NHS-funded secondary healthcare. Aligned payment and incentive contracts form the main payment mechanism under the NHSPS.
- In 2023/24, API contracts contain both a fixed and variable element. Under the variable element, providers earn income for elective activity (both ordinary and day case), out-patient procedures, out-patient first attendances,[etc]. The precise definition of these activities is given in the NHSPS.
- Income is earned at NHSPS prices based on actual activity. The fixed element includes income for all other services covered by the NHSPS assuming an agreed level of activity with ‘fixed’ in this context meaning not varying based on units of activity.
- The main source of income for the Trust is contracts with commissioners for health care services. Funding envelopes are set at an Integrated Care System (ICS) level. The majority of the Trust’s income is earned from NHS commissioners in the form of fixed payments to fund an agreed level of activity.
- In 2022/23, fixed payments were set at a level assuming the achievement of elective activity targets. Elective recovery funding provides additional funding for the delivery of elective services.
- In 2022/23, elective recovery funding was included within the aligned payment and incentive contracts.
- In 2021/22, income earned by the system based on achievement of elective recovery targets was distributed between individual entities by local agreement and income earned from the fund was accounted for as variable consideration’.

Is the RSCH being slightly disingenuous in reporting its present financial position? It says:

- ‘The other issue is the difficult financial situation we are facing across Surrey Heartlands and at Royal Surrey, as one of several organisations that forms the Integrated Care System (ICS). This is not unique to us locally and [is] a challenge across the NHS.
- As a result, we had expected to report a financial loss for 2023-24, however, due to additional national funding in Q4 we were able to report a small surplus.
- Hospital Trusts are now primarily funded by a block contract, which is a fixed sum that does not change if we see more demand for our services.
- The reality this year is that we have seen a higher volume of patients, many exhibiting higher acuity illness.
- Remaining financially sustainable in this funding environment is challenging and will require a spirit of innovation, delivering productivity gains across our services.’
  Chair, RSCH, Annual Report 2023-24
- Information about how budgets are managed by RSCH is not available for public inspection. It is even unlikely that commissioners have a view about what is spent from which allocation and for what purpose. But they should press for the data to help frame future contracts.

The move away from ‘Block contracts’ to PbR will enable the hospital to be more selective with its delivery choices

- ‘The other issue is the difficult financial situation we are facing ….at Royal Surrey. This is not unique to us locally and [is] a challenge across the NHS. As a result, we had expected to report a financial loss for 2023-24, however, due to additional national funding in Q4 we were able to report a small surplus. Hospital Trusts are now primarily funded by a block contract, which is a fixed sum that does not change if we see more demand for our services. The reality this year is that we have seen a higher volume of patients, many exhibiting higher acuity illness. Remaining financially sustainable in this funding environment is challenging and will require a spirit of innovation delivering productivity gains across our services’.
  RSCH Chair’s Report 2023-4
- [For the 2023-24 financial year, 67% of commissioner income was on a block contract].
- ‘It was 100% for 2022-2023 as the Trust and the wider NHS continued its recovery from the pandemic.
- It was proposed that ‘block’ funding would be provided during the year for non-elective work and this would be supplemented by a variable funding regime designed to incentivise tackling the backlog of elective activity that had amassed during the pandemic.
- The Trust was required to deliver a (£1.6m) deficit for the year as part of a planned (£37m) deficit plan for the ICS’.
  RSCH Annual Reports.

RSCH is expert at managing its ICS funding allocation

- Some juggling does take place with the different reimbursement methods.
- Activity management is always carefully regulated by the most astute FT finance directors
- Block contract awards and Payment by Results remuneration each need their own management approaches.
- For example, the provider objective with block contracts is to ensure that volumes of activity do not exceed allocations and deliver a loss.
- The PbR plan is to maximise the number of care episodes which can be delivered where a positive margin is available for that care category.
- Over the years the NHS hospital remuneration system has seen some gaming (read the NAO reports).
- Clinical coding is never accurate and normally works to the provider advantage.

The RSCH has proved extraordinarily adept at maximising the PSF windfall over many years

- The Royal Surrey has been an exceptional beneficiary of the government's Provider Sustainability Fund. The annual accounts say:
  - '[in 2018-9], 'including the core PSF, the Trust surplus was £10.19m or £12.33m surplus on a control total basis (prior year £9.92m or £9.896m), and £13.98m favourable variance compared to the £1.65m original budget deficit on a control total basis (subsequently increased to a £4.35m control total surplus)'.
  - 'In addition, the Trust qualified for year-end PSF incentive, bonus and general distribution payments [of] £25.890m (prior year £19.878m) due to its better than plan result. Including the 2018/19 core PSF, incentive PSF, bonus PSF and general distribution PSF, the Trust reported a year end surplus of £36.08m or £38.23m on a control total basis (prior year £30.17m or £29.73m respectively)'.
- We have tried to decode this very technical explanation. What we do know is that total PSF payments for the two financial years up to March 2020 totalled £45.8m. The total gross hospital annual surpluses for the three years ending March 2020 were £80.7m

A device to reduce P&L spending became an accrual on the capital account

- Every year between 2017 and 2024, hospital trusts have cut their spending to the level required to balance their books.
- Any resulting surplus reported by these organisations had to sit unspent in their end-of-year accounts, to offset the much bigger gross deficit ran up by the remaining trusts.
- The sustainability cash could in theory spent on anything.
- It was classed a capital expenditure and therefore not charged to the income and expenditure account.
- The question for boards at these providers might have asked themselves was ‘should we agree to spend less on caring for patients?’
- It is almost impossible to work out exactly how many patients would have been impacted or seen a delay in their care.
- The Royal Surrey had a deficit of £8m in the year prior to PSF. What would that have bought in terms of care provided?

The PSF has enabled the Royal Surrey to increase its asset base:

- For example, the Royal Surrey has been an exceptional beneficiary of the government's Provider Sustainability Fund. The annual accounts say:
  - '[in 2018-9], 'including the core PSF, the Trust surplus was £10.19m or £12.33m surplus on a control total basis (prior year £9.92m or £9.896m), and £13.98m favourable variance compared to the £1.65m original budget deficit on a control total basis (subsequently increased to a £4.35m control total surplus)'.
  - 'In addition, the Trust qualified for year-end PSF incentive, bonus and general distribution payments [of] £25.890m (prior year £19.878m) due to its better than plan result. Including the 2018/19 core PSF, incentive PSF, bonus PSF and general distribution PSF, the Trust reported a year end surplus of £36.08m or £38.23m on a control total basis (prior year £30.17m or £29.73m respectively)'.
  - PSF payments for the two financial years up to March 2020 totalled £45.8m. The total gross hospital annual surpluses for the three years ending March 2020 were £80.7m. **RSCH annual accounts.**
- Total cash and cash equivalents, as in SoFP caught our attention, particularly as it grew tenfold from £8m to £80m between 2017 and 2023, having peaked at £108m. This cash, deposited with the Government Banking Service, is a component of what is termed 'taxpayers' equity'.

The Royal Surrey's expert management of PSF has built a significant cash pile over recent years

- Its cash reserves at £86.7 million at 2023-24 year end places RSCH at close to the very top of the richest acute financial trusts.
- 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	
	2023/24	2022/23	2023/24	2022/23
	£000	£000	£000	£000
At 1 April	**83,539**	**108,520**	**80,360**	**108,181**
Net change in year	5,176	(24,981)	6,488	(27,821)
At 31 March	**88,715**	**83,539**	**86,848**	**80,360**
Broken down into:				
Cash at commercial banks and in hand	2,014	3,446	146	267
Cash with the Government Banking Service	86,701	80,093	86,701	80,093
Total cash and cash equivalents as in SoFP	**88,715**	**83,539**	**86,848**	**80,360**
Total cash and cash equivalents as in SoCF	**88,715**	**83,539**	**86,848**	**80,360**

Total cash and cash equivalents as in SoCF

Year ending	£m
2016	4.9
2017	8.4
2018	34.7
2019	58.0
2020	79.5
2021	98.6
2022	108.2
2023	80.1
2024	86.7

But whose money is it? Well, it's on the RSCH balance sheet

- This is an exceptional amount for what is a relatively small acute Foundation Trust. Deriving maximum advantage from the income opportunities available from a number of different sources requires a high level of business acumen and exceptional financial engineering skills.
- This is clearly now the hospital's money, but it has come from the taxpayer and people might wonder if it is working in the best interests of the universe of local patients while locked away in a largely inactive bank account, presumably awaiting some future Hospital capital project.
- Taxpayers would reasonably expect that their payments which fund the NHS are working to optimise care for patients across its delivery span. People will want to know that it is being used equitably to deliver the best possible care.
- Should, then, this money represents investment capital for the local health system and a significant opportunity for the Royal Surrey to redefine the scope of both its real estate and operations?

RSCH now has enormous scope to invest its substantial reserves wherever it wants.

- As a Foundation Trust Foundation 'not in financial distress', the RSCH would not need to seek approval from NHS England for capital investment and property transaction business cases up to a value of £50m capital cost.
  Capital investment and property business case approval guidance for NHS trusts and foundation trusts NHS England, 13th February 2023
- Where the RSCH invests in the future will depend on its collective view about its purpose and ambitions.
- For example is this just about growing its main Guildford campus, or does itself look to become a local health system?
- What for example were the motivations to incorporate the Milford, Haslemere and Cranleigh?
- The RSCH website says 'Haslemere Community Hospital, Cranleigh Village Hospital and Milford Hospital become part of the Royal Surrey family after the Trust, in conjunction with Procare GP Federation, are awarded the contract to deliver adult community services in Guildford and Waverley'.
- Contemporary RSCH annual reports are silent on the financial arrangements.
- Foundation Trust governance arrangements essentially leave all major decisions to their boards.
- Precisely whose interests are they serving?

How the RSCH got rich: 'Having your fudge and eating it'

Sally Gainsbury, Nuffield Trust, Blog 5 April 2019

When is £2.1 billion of funding not actually £2.1 billion of funding? Seemingly when it's awarded to NHS providers in exchange for pulling off £800 million in spending cuts they might otherwise not have troubled themselves with.

The NHS has engineered some **pretty impressive accountancy fiddles** over the last three years, with an **underlying deficit** of over £4 billion in the provider sector massaged down to the slightly more palatable £1 billion mark in the reported accounts. But as ever, the more audacious manoeuvres remain the preserve of Whitehall.

The short history of the £2.45 billion Provider Sustainability Fund looks set to be the latest masterclass in financial trickery. But this isn't just a story of paper-based conjurey to disguise the true disarray of NHS finances. The scale of the trick risks undermining scores of hospital trusts across England, while betraying promises made to patients and clinicians over three years of financial pain.

Control totals and sustainability funds

Starting life in 2016/17 as the £1.8 billion **Sustainability and Transformation Fund (STF)**, then rebadged and uprated to £2.45 billion for 2018/19, the Provider Sustainability Fund has been used to incentivise NHS providers to gradually reduce the overall net deficit in the sector, doing so by doling out cash rewards in return for meeting financial targets.

These targets, known as 'control totals', essentially give each trust a bottom line figure for their income and expenditure accounts. For those organisations deep in deficit, the control total was often a deficit figure, albeit one requiring a real terms spending cut in excess of 4% within the year, as the organisation was dragged slowly out of the red.

But with Treasury impatience what it is, it couldn't all be like that. The requirement for the provider sector as a whole to at least aim for a financial balance meant that, if some were so deep in deficit they would need years to recover, others would need to generate surpluses to at least partially offset the overall bad news.

And so in 2016/17, around a third of provider trusts were set control totals that required them to collectively spend around £270 million less that year than they actually earned – the equivalent to each cutting their spending by an extra 1.2% beyond the 2% needed to absorb the cost of inflation and balance their own books. Put another way: these 80 or so providers were asked to make real terms spending cuts almost two-thirds bigger than strictly necessary to maintain their own financial health.

Incentivising spending cuts

The question for staff and boards at these providers might have been: why should we agree to spend less on caring for patients and employing staff than we can actually afford?

The answer was the £1.8 billion STF, as trusts meeting their control totals were rewarded with cash payments from the fund. The scale of the prize on offer at the start of the year meant that if those trusts held back spending by an extra £270 million, the 'tripartite' of the Treasury, health department and NHS Improvement would almost match that saving again in cash rewards from the STF. It sounded like a no-brainer: one more year of pain in exchange for a significant pile of extra cash.

Further swathes of the STF were also offered towards the end of the financial year, to incentivise spending cuts to go further still. Inevitably not all trusts managed to hit their targets, but by the end of the year, £457 million of the STF was awarded to 77 trusts as reward for them underspending their main income by £200 million.

The catch of course was that the resulting £657 million surplus reported by those organisations had to sit unspent in their end-of-year accounts, as it was badly needed to offset the much bigger gross deficit ran up by the remaining trusts.

It was a similar story in 2017/18. Trusts were again set control totals in an attempt to coax the sector closer to an overall financial balance. On average, those control totals required in-year **real terms spending cuts of 4.3%**.

This time, it resulted in 90 trusts collectively generating £370 million more spending cuts than they strictly needed to break even themselves, for which they were rewarded with £732 million from the STF. Again the resulting £1.1 billion surplus for the year at those 90 trusts had to remain unspent, so to flatter the sector-wide income and expenditure position.

In 2018/19 the fund was increased to £2.45 billion, with control totals yet again requiring average spending cuts in excess of 4% of operating costs within a year. **Based on financial performance to December 2018**, it seems likely that the full financial year will have seen around 75 NHS providers receive around £900 million in sustainability funding, in return for generating another £200 million underspend against their other annual income.

Having your fudge and eating it – continued

For over three-quarters of those providers, 2018/19 was the third year in a row where they cut their spending beyond the level required to balance their own books. They will have done so for the good of the overall sector position and, of course, for their share of the aggregate £2.1 billion in sustainability funding – awarded to a total of 102 separate NHS organisations over the last three years, in exchange for cutting spending by more than they needed to just balance their own books.

So again: what was in it for those organisations?

Delayed gratification

It was of course the promise of spending that sustainability cash in the future. They could in theory spend it on anything, but in a context of control totals – and 2019/20 is the fourth consecutive year of the regime – spending cash earned in a previous year reduces an organisation's ability to meet its control total, as that target is focused on pushing annual spending below the income earned that specific year.

Trust finance directors have always understood this. But the way to get around it was capital expenditure, which is not charged to the income and expenditure account against which the control total is measured, but funded instead from an organisation's cash savings – and the sustainability fund prizes were all in cash.

So the last three years have seen finance directors across NHS providers in England promise their staff and boards that yet another year of additional slog on their cost improvement plans, another year sucking up recruitment freezes, overtime bans and restrictions on purchasing supplies, would be worth it. That another year – 2018/19 being the ninth in a row – of trying to cut operational expenditure by at least another 4% in real terms would pay dividends, not just to the sector financial position as a whole, but to the patients and staff at their hospital in particular.

And the reason it would be worth it – finance directors have stood up and said in both board meetings and to groups of habitually sceptical clinicians – is because the resulting sustainability cash would be spent on buying new kit. New scanners, new monitors, new operating theatre equipment, or alternatively on fixing part of the £3 billion NHS-wide maintenance backlog that poses real risks to patients as it disrupts care or makes it impossible.

That promise was all the more relevant given that the majority of these cash-rich providers were NHS foundation trusts. And they, unlike the more tightly regulated and controlled NHS trusts, are able to invest in capital as they please, without health department sign off.

Treasury spending controls

NHS trusts have never had that freedom, because spending by individual NHS organisations counts against the expenditure limits set by the Treasury for the health department as a whole. The Treasury uses these spending limits to enforce its fiscal framework to hold down government spending in general and, when it comes to capital spending in particular, net borrowing. From the Treasury's perspective, even capital spending funded through an NHS organisation's own cash (rather than a government grant) is troublesome, because if NHS hospitals aren't spending their cash, it sits instead in the Government Banking Service. There it can effectively be recycled and lent out to other parts of the public sector, thus reducing the government's overall need to borrow.

This accounting policy is as true for NHS foundation trust spending as it is for NHS trusts. After all, despite foundation trust freedoms and **political agitation to the contrary**, it has always been accepted that the government ultimately stands behind foundation trusts to protect patients from the risk of financial or organisational failure. That leaves foundation trusts squarely on the government's balance sheet.

Having your fudge and eating it – continued

The fudge

However, since the introduction of foundation trusts in 2004, the perceived benefit of allowing them the freedom and independence to accumulate surpluses (to invest as their boards and governors see fit) has outweighed the health department's concern to keep capital spending within its departmental limit. Until 2010, this fudge was aided by sufficient headroom in the **Capital Department Expenditure Limit (C-DEL)** for health to reassure Whitehall that a sudden foundation trust spending spree was unlikely to seriously threaten a dreaded breach of the C-DEL.

In more recent years, that reassurance has been found in the harsh reality of provider deficits – because organisations in deficit do not go on capital spending sprees.

But as providers slowly start to recover their financial position, and the health department's capital spending allowance remains largely flat and curtailed, Whitehall is getting nervous about foundation trust capital spending ambitions – and the £4 billion of cash sitting on foundation trust balance sheets that could fund it. That cash balance has been boosted, of course, by foundation trusts making up the vast majority – four-fifths – of the 102 organisations awarded a total £2.1 billion in sustainability cash over the last three years.

Eating it

So guess what? A new power for NHS Improvement to limit foundation trust capital spending has now been included in the list of **primary legislative change** sought, apparently because doing so will help implement the recent **Long Term Plan** (and by the way also help the health department stick to its spending limits).

The proposal means the removal of the fudge whereby foundation trusts were both independent of the health department yet the health department remained ultimately responsible for their spending. But it was a fudge that lasted – and ostensibly worked – for 15 years. Without it, foundation trusts would be no longer free to determine what they do with their surpluses, begging the question why should they bother making them at all? And is there a Plan B for driving efficiencies out of NHS providers?

More immediately, however, the proposal means the removal of the fundamental premise motivating most of the NHS providers who delivered a cumulative £800 million additional surplus to the system over the last three years.

Having your fudge and eating it – continued

Costs/benefits

Will those foundation trusts ever recover the trust of the doctors, nurses and support staff who sucked up and delivered more spending cuts than were strictly necessary, on the promise of more kit that may now never materialise? What will the cost of losing that trust be?

So much has been written and enthused over the last decade about the need for more "**clinical engagement**" in the endless quest for NHS efficiency, on convincing clinicians that efficiency is not just about harmful cuts, but rather better outcomes for patients. Yet it appears Whitehall is willing to potentially junk so much clinical trust, rather than contemplate the alternative remedy of seeking a marginal increase to the health department's capital spending allowance to absorb the risk that continued foundation trust freedoms might pose.

Based on the increase in foundation trust cash bank balances over recent years, a one-off increase in the planned capital spending limit of £500 million over the next two years might be sufficient to absorb the risk – the equivalent to less than a 2% real terms increase in the spending limit a year.

Remember that would not be £500 million 'more cash' for the NHS. It would be a £500 million increase to the health department's spending allowance in order to allow NHS organisations to actually spend the £2.1 billion already given to them with some fanfare.

Otherwise, that £2.1 billion cash handed to individual organisations over the last three years will become significantly less than the sum of its parts and take on a strange existence as perhaps a new accounting concept: shadow cash? Money in the bank, earned through blood, sweat and tears and yet which cannot be spent.

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Prior to joining the Trust Sally was an investigative journalist at the Financial Times, working on UK and international investigations spanning public spending, tax avoidance and money laundering. Before joining the FT Sally was chief reporter and news editor at Health Service Journal (HSJ).

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