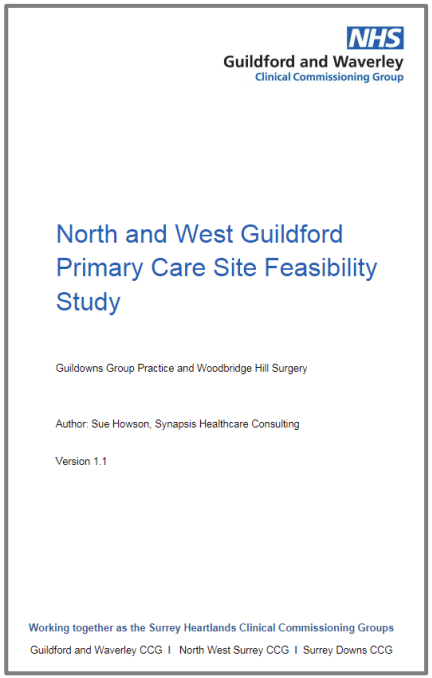
Meeting with Guildford and Waverley Health and Care Alliance

22nd January 2025

Why we are here today

- We want to hear from you about where the ICB is in implementing the 2019 plan for GP premises upgrades in North and West Guildford.
- We have been told that there have been no developments.
- The original timetable saw a completion date of January 2023.
- We'd like to make some proposals for moving the agenda forward.



NHS
Guildford and Waverley
Clinical Commissioning Group

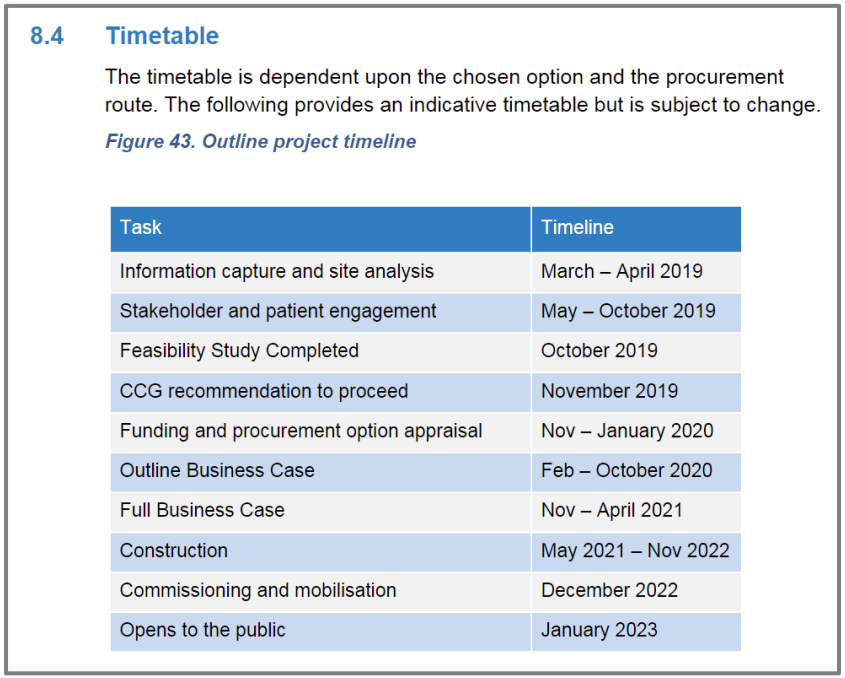
North and West Guildford Primary Care Site Feasibility Study

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



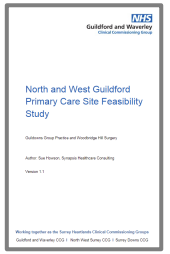
8.4 Timetable

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

Figure 43. Outline project timeline

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

This is what the 2019 report 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’.
- ‘The current delivery model is not sustainable given the current pressures on primary care and the problems with the recruitment and retention of GPs.’
- ‘The current estate is not fit for purpose and with further additional demand in the form of two new planned housing developments at Slyfield and Blackwell Farm, the lack of primary care capacity in north and west Guildford will be further exposed.’
- ‘This study has concluded that the only viable option is to increase capacity through new build options.’
- ‘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.’

Potential development sites were identified

The 2019 report identified redevelopment opportunities:

- ‘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.
- Note: the Kings College, Park Barn site is no longer available.

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 7,400 sqm site with three principal buildings.
- 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.**
- It is a few hundred yards from the Stoughton Road GP surgery operated by the Guildowns practice.
- The Jarvis Centre site is owned by NHS Property Services, obviating the need to purchase a property under private ownership.

The NHS England vision for community diagnostic centres is quite clear. This type of facility would radically reduce pressures on the ‘compressed’ Egerton Road site.

What is this service?

- Community diagnostic centres provide a broad range of diagnostic tests. For example, scans (e.g. MRI), tests (e.g. blood) and checks (e.g. seeing how well your kidneys are working).
- They are often located away from hospitals (e.g. shopping centres), allowing people to access diagnostics closer to home.

Uprating the primary care real estate capability is part of a fundamental NHS England policy change

- There is, finally, an acceptance that depending on GPs to redevelop their premises is not workable.
- The policy change occurred in July 2024 with a restatement in October and November.

Primary care capital grants policy

NHS England

Date published: 24 July, 2024
Date last updated: 25 October, 2024

1. Background

NHS England standing financial instructions (SFIs) allow for capital grants to be made using specific powers under the NHS Act 2006 for Investment into GP Premises in accordance with any relevant legislation.

This grant policy sets out the framework and guidance for application when making any said capital grant noting the requisite legislative powers and conditions that are required to be applied.

3. Premises improvement grant

Powers – NHS (GMS – premises costs) directions 2024

When a contractor identifies the need for improvements such as alterations or an extension to existing premises, this will be governed by the NHS (GMS – premises costs) directions 2024 (PCDs). The PCDs set out the terms and conditions of an improvement grant.

An integrated care board (ICB) can make non-recurrent grants for premises improvements in line with the requirements set out in the PCDs; specifically, part 2, directions 7-13.

Guide to the changes to primary care premises policy

NHS England

Date last updated: 11 November, 2024

Associated with the implementation of The National Health Service (General Medical Services Premises Costs) Directions 2024 ['the Directions']

Key changes

6. The Directions allow commissioners to make larger investments in GP practices in a more flexible way and seek to provide contractors with some reassurance about their premises liabilities. They also deliver some significantly improved terms for contractors, as well as technical updates.

Improvement grants

7. A long-standing restriction on commissioner contribution to premises improvements has been removed. Commissioners can now award GP grants funding up to 100% of project value, where appropriate and subject to business case assessment and local prioritisation. Grant values have been increased, and abatement and guaranteed periods of use have been reduced.

This is how one ICB is implementing the policy

GP Premises Development & Delivery Plan April 2024 to March 2031

Final version
July 5th 2024

iv. Improvement Grants

The ICB recognises the importance of utilising the Improvement Grant (IG) Scheme as defined in 2024 Premises Costs Directions (PCDs) to assist practices expand and/or upgrade their existing premises.

Using IGs to make improvements to primary care premises deliver a direct benefit to patients, e.g. increased clinical capacity, improved access to services and compliance with national standards such as CQC, DDA, confidentiality, etc..

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

- The PCDs provide a prescriptive list of the types of projects that can and cannot be funded.
- The maximum award that can be granted is up to 100%.
- The IG scheme works on a reimbursement basis, meaning practices must pay invoices first; there is no scope for the CCG to reimburse contractors directly.
- If a practice is awarded an IG, the building works need to be completed and all funds spent in the same financial year that the grant is awarded (although exceptions have been made for larger projects).
- The ICB has little flexibility in the application of the rules.

One Gloucestershire

4(vii) – Delivering the plan: confirmed schemes and future ambitions by place including estimated capital costs and number of patients (pts)

Brockworth: £6.6m for 14,500 pts

Hucclecote:£4.9m for 10,000pts

Newent:£6.3m for 13,000 pts

Coleford: £6.2m for 15,000 pts

Yorkley & Bream:£4.3m for 8,000pts

Lydney: £7m for 15,000pts

Beeches Green: £4.9m for 9,200pts

Cam & Wisloe Green:£6.5m for 15,000pts

Minchinhampton: £6m for 9,000pts

Elms Park (new housing community) :£6.6m for 9,000 pts and including dental and community health services

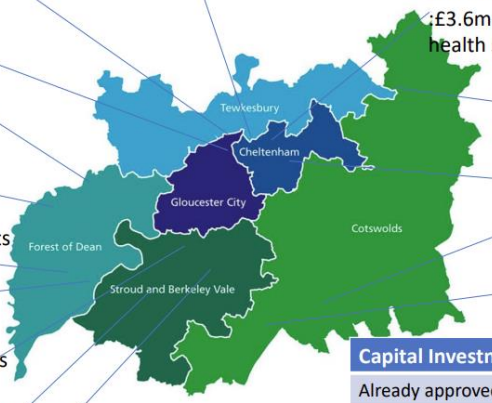
West Cheltenham new housing community :£3.6m for 5,500 pts and including community health services

Chipping Campden:£3.5m for 6,000pts

Central Cheltenham: £9.5m for 24,000 pts

Cirencester:£10.9m for 28,000pts

Tetbury: £5.5m for 10,500 pts



Capital Investment type	Amount
Already approved	£36.2m
Minimum Section 106 contributions needed	£13.6m
New investment	£42.5m
Total	**£92.3m**

We can’t see the same estates plan for Surrey Heartlands GP premises. But plenty of expressions of intent

Joint Forward Plan 2024 Fact File: Estates

Ambition 3: What we need to deliver these ambitions

Estates can be a catalyst for integration, particularly when approaching the delivery of neighbourhood teams and same-day urgent care. As a system, we can develop spaces and establish the conditions for communities to improve their wellbeing, on their own terms, in non-clinical ways.

Case Study

A new community diagnostic centre at Woking Community Hospital will prevent the need for 30,000 hospital visits outside of Woking annually, providing residents with a vibrant, modern health facility.

This project is part of a wider community diagnostic hub programme across Surrey Heartlands, helping to reduce waiting times and expedite treatment for local people.

Improving access to GP services

Ensuring people have access to high quality care and support from their GP practice is a key priority for us – and practice teams continue to work incredibly hard as they continue to see more patients than ever before.

SURREY HEARTLANDS Health and Care Partnership

SURREY COUNTY COUNCIL

NHS

Joining up care across Surrey Heartlands

A summary of our strategy

2 Delivering care differently

Local people have told us they want services that are responsive to their needs and put them at the centre of decision-making. Based on feedback, we have developed two main aims to transform how we deliver care:

- Making it easier for people to access the care they need, when they need it.
- Creating the space and time for our workforce to provide the continuity of care that is so important to our populations.

We will do this through the development of our provider collaborative, the creation of neighbourhood teams, enhanced primary care, social care delivery, mental health support and working with children and families.

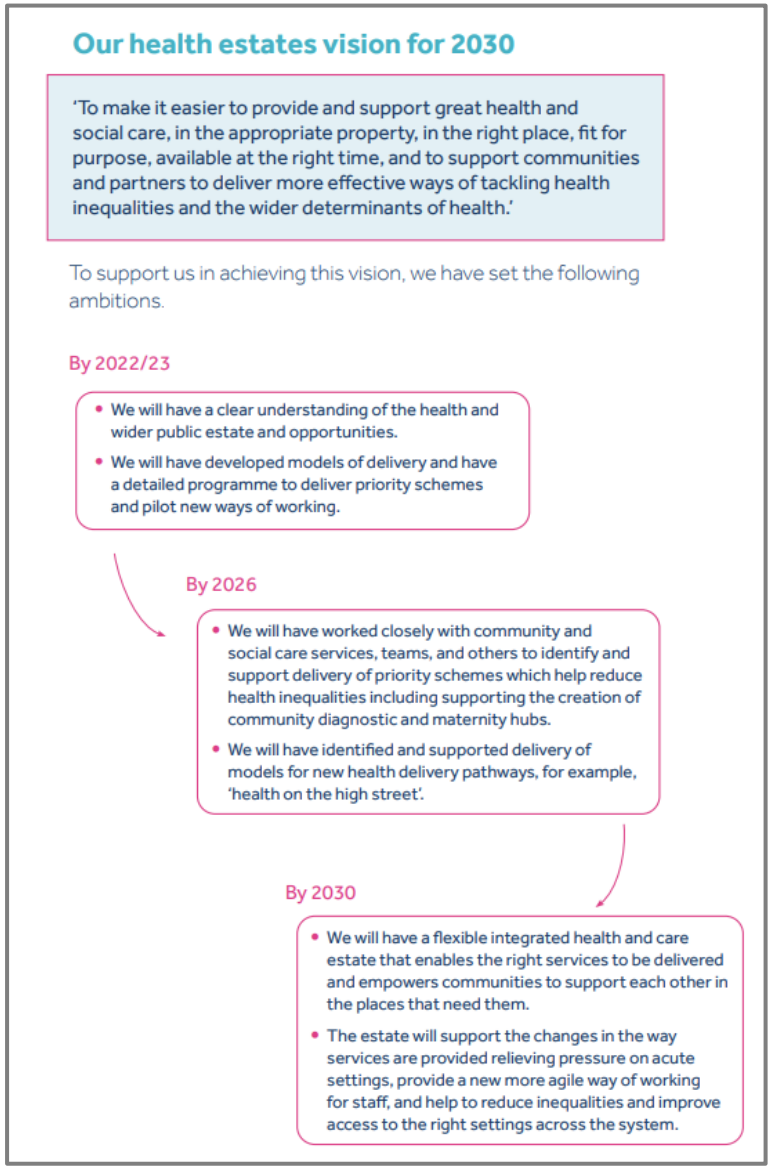
Provider collaboratives

Local providers of health services working collaboratively to consider the best way to deliver some services across a wider geography.

Neighbourhood teams

Teams of different professionals working together to care for people with more complex needs across very local geographies.

There are milestones, but no specific information for individual GP locations



Our health estates vision for 2030

'To make it easier to provide and support great health and social care, in the appropriate property, in the right place, fit for purpose, available at the right time, and to support communities and partners to deliver more effective ways of tackling health inequalities and the wider determinants of health.'

To support us in achieving this vision, we have set the following ambitions.

By 2022/23

- We will have a clear understanding of the health and wider public estate and opportunities.
- We will have developed models of delivery and have a detailed programme to deliver priority schemes and pilot new ways of working.

By 2026

- We will have worked closely with community and social care services, teams, and others to identify and support delivery of priority schemes which help reduce health inequalities including supporting the creation of community diagnostic and maternity hubs.
- We will have identified and supported delivery of models for new health delivery pathways, for example, 'health on the high street'.

By 2030

- We will have a flexible integrated health and care estate that enables the right services to be delivered and empowers communities to support each other in the places that need them.
- The estate will support the changes in the way services are provided relieving pressure on acute settings, provide a new more agile way of working for staff, and help to reduce inequalities and improve access to the right settings across the system.

Delivery Milestones

2024/25

- Support Place based project delivery through access to frameworks, finance options and advice and information.
- Support the collation and review of Capital pipeline in readiness for the NHSE funding round
- Monitor the property CapEx programme and provide ICB with information and context for assurance and decision making
- Maintain data and work with Trusts to support data management and potential central response to requirements such as Estates Returns Information Collection (ERIC) returns
- Continue work on centralised Planning returns and co-ordinated CIL applications for infrastructure funding
- Develop vacant space 'agency' for system

Surrey Heartlands Integrated Care Strategy, December 2022.

- Is this the latest plan?
- Are the 2024/2025 delivery milestones on schedule?
- Where can we find the detail?

A cascade of game changing capability is being constrained by the inadequacy of local GP premises

- Primary care will be transformed only if the resources, principally real estate, are fit-for purpose.
- A bigger GP practice headcount requires a lot more space.
- Technology has changed, and will change premises design further.
- The opportunities include:
  - Leveraging the additional staffing provided through AARS.
  - Better multi-disciplinary team coordination in a collegiate working space.
  - Closer case management coordination with community and social services.
  - Managing ‘Virtual Ward’ patients OOH, taking over more outpatients.
  - Applying IT, digital, data/analytics at a greater scale.
  - Referral Management, delivering Patient Choice options.
  - A Single-Point-of-Access (SPA) for the whole borough?
  - Effective triaging, sharing patient records.
  - Additional ICB contracts delivered by GPs and third parties.

- The Guildowns practice has shown its ability to lead on these developments. Look what might be available if all local PCN capability was merged:

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

What's happening with the GW hub and spoke vision?

'The "hub and spoke" model for health care is where the "hub" is the anchor site for the specialty in that area and the "spokes" are the connecting secondary sites [in the community]. GP sites are the wheel around the circumference of the interlocking, integrated system.' **Google**

- The RSCH through its 'acquisition' of the cottage hospitals in Haslemere, Cranleigh and Milford has laid down a lot of the model, which needs completion. It shares the hub and spoke vision:
- 'We are delighted that our bid to secure additional diagnostic capacity through our Community Diagnostic Centre, located at Milford Community Hospital, was approved in 2022. This £15m hub will provide MRI, CT and X-Ray services and has been designed in collaboration with our primary care colleagues with further diagnostic services being rolled out across GP practices to create a Guildford and Waverley Integrated Care Partnership (ICP)-wide 'hub and spoke' model.' **Royal Surrey Annual Report 2023/24 .**
- The Woking Community Hospital is also part of the local delivery system.
- North Guildford is an obvious gap, particularly given its population's health status.
- Are there any others, particularly with the forecast population growth to the east of the town?
- There is also a need to inventory check primary care premises – see what we say on pages 8 and 9.
- Finally, are the PCNs effectively co-ordinated? The AARS scheme has built headcount and overhead. Is it being used optimally?

We would argue that a lack of investment in primary care has harmed some Guildford citizens

- If the duty of health systems is to protect its people, it could be that Guildford has an imbalance in its delivery system.
- Life expectancy is lower, health status poorer, in the deprived parts of Guildford.
- According to the last CCG survey in 2019, 'the main areas of deprivation in Guildford are within the wards of Westborough and Stoke.'
- These are not areas of total deprivation: 'within Westborough, 12% of the population live within the 10-20% most deprived areas in England (ranked 5726) and within Stoke, 13.3% of residents are within the 20%-30% range (ranked 6889)'.
- '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. **References: ONS ,SCC and GBC**
- The inverse care law applies in Guildford, which states that 'people who need medical care the most are the least likely to get it'.
- Cranleigh, population 12,700; Haslemere, 12,000; and Milford 4,200 are all satellites of the RSCH system. All of these localities have long life expectancy – higher than the national average.
- Yet for the population of the 25,000 people in the three wards north of the A3 has no legacy community hospitals, nor any planned for the future.
- This means that they receive no development money from the RSCH balance sheet.

Quantifying the harm done to people in Guildford

(We feel that somebody could do a better calculation than the one we have included below).

- The population of Guildford is 163,000.
- The population for the three most deprived wards - Stoke, Stoughton, Westborough is 25,500.
- 1.9% of population have 65th birthdays every year, that's 3,100 for Guildford and 485 for the three wards.
- UK life expectancy at 65 is 19.5 years.
- The three wards have a life expectancy of 11.4 years at 65.
- For a single annual cohort 485 x 11.4 years = 5529 years over their collective lifetimes.
- 2019, more than five years ago, was the year the CCG published its Guildford GP premises report.
- 5529 x 5 = 27,645 lost years of life compared with UK average.

Is the ICB delivering on its legal obligations?

'NHS England, Guidance on integrated care board constitutions and governance, July 2024

The Act includes a range of ICB obligations in relation to health inequalities, which should underpin the discharge of functions in each ICB, including:

- the health inequalities duty on ICBs:
  - "Each integrated care board must, in the exercise of its functions, have regard to the need to – (a) reduce inequalities between persons with respect to their ability to access health services, and (b) reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services"
- that the inequality of outcome that must be considered includes, in particular, outcomes in relation to service effectiveness and safety and the quality of the experience of patients, as specified under the duty in relation to improving service quality
- the collection, analysis and publication of information relating to inequalities, in line with NHS England's views set out in the national statement
- the duty to promote integration where this would reduce inequalities in access to services or outcomes achieved
- duties on ICBs in relation to several other areas that require consideration of health inequalities – in making wider decisions, planning, performance reporting, publishing certain reports and plans, annual reports and forward planning

In addition, each ICB is subject to an annual assessment of its performance by NHS England which must include, but is not limited to, how well the ICB has discharged several specific duties including:

- the duty to reduce inequalities of access and outcomes
- the duty to improve the quality of services
- the duty to have regard to the wider effect of decisions (the triple aim)
- the duty to consult patients and the public about decisions that affect them'.

- The Act referred to is the NHS Act 2006, as amended by the Health and Care Act 2022.
- There is plenty of evidence that there is a wide disparity in health provision across the borough.

Is the local funding issue the consequence of the dominant position of the RSCH?

- The ICB and the CCG have followed a line that there has been no money for primary care investment.
- They have been stuck in the failing paradigm that this was a GP practice responsibility.
- Commissioners have failed to drive equity and allocative efficiency in annual contract rounds.
- RSCH has grown richer, often at the expense of other members of the community.
- Some of the business cases seem suspect, Milford Hospital for example which has no patient hinterland.
- Commissioners have failed to fully exploit any negotiating leverage they have.
- The RSCH has to be brought into the plan for delivering local integrated care.
- The ICB has now got to put right an unbalanced local delivery system if it wants to deliver truly integrated care.
- Is the start in this year's contracting round, or will it be another extrapolation of the status quo?

Does everyone recognise the anomaly of the £80+mn of taxpayers' equity sitting on the RSCH balance sheet?

- First, it has to be acknowledged that the Royal Surrey is an exceptional local hospital.
- We should be grateful for it.
- It also has very skilled, probably best in class, financial and project management.
- It's their job to focus on the hospital agenda, which they have done with great vigour.
- But has this impacted local health care delivery as a whole, maybe impeding the move to integrated care?
- We accept that its cash balance has been accumulated by leveraging a wide range of income sources.
- The biggest annual funding allocation comes from the local commissioner (formerly the CCG, now the ICB).
- Prudent management of the government's Sustainability and Transformation Fund (STF) over a number of years has resulted in the growth of RSCH reserves which have been in excess of £100 million.
- The principal qualification for an STF award is achieving a pre-determined 'Control Target', usually to avoid a year-end deficit.
- This can mean regulating the amount of acute care delivered in the year to balance the books.
- We're not sure whether commissioners have factored in STF income in the annul contract round.
- What does the RSCH plan to do with the money?

The STF story has been in plain sight. It's reported in the RSCH annual accounts

- But it takes an almost forensic understanding of NHS finances to see how the money flows, how skilful financial management has built the balance sheet, see the boxes.
- We're not certain if elected RSCH Members and even the Governors (both parts of the hospital governance process) would begin to understand them.
- There is scant coverage of financial matters at annual meetings, just one title page, number 30 of 46 of the Hospital Annual Members meeting. **https://www.royalsurrey.nhs.uk/download/annual-members-meeting-2024-presentation-deckpdf.pdf?ver=68504&doc=docm93jijm4n27647.pdf.**
- Has the ICB seen it? There is no reference to an ICB attendee.
- The 2023-2024 AMM meeting was held on 26 September 2024. The minutes are not yet on the hospital website.

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

RSCH says it is signed up to the NHS Integrated Care strategy. But is it?

- 'The Trust continues to be leading member of Surrey Heartlands Integrated Care System, developing a deeply integrated operational model within the Guildford & Waverley "Place".'
- 'We took over the adult community services in Guildford and Waverley in 2018, making us an integrated Trust, and giving us a step-change in our ability to wrap services around patients outside of the walls of our main hospital site.' **Both quotes from RSCH Reports.**
- Yet, the RSCH Chair sent us an email saying 'the RSCH does not have the resource nor the mandate to get involved in primary or social care'.
- The RSCH is still invested in the Procare Community Health JV? How has it developed?
- Claire Fuller's '5 Year Strategic Delivery Plan 2019-2025' was a great one, an NHS England exemplar (and worth a complete re-read):

'The integration of delivery teams in the OOH space with community teams, hospital discharge and admission avoidance teams with adult social teams will as they become embedded allow a "One Team" approach which will remove some of the barriers in place currently. We will help better manage people in their own homes and take proactive action before a more serious onset of symptoms occurs. The role of the PCNs to become the local organising entity is key. In GW the plan is to not just align the adult community teams to primary care areas but to transfer the staff as well.'

- This plan was written six years ago. But how much has got executed?
- And where is the next one?

Is the RSCH prepared to cooperate in the funding the local Integrated Care Plan – starting with the Jarvis centre?

- The financing of a Jarvis Centre refit could come from a number of different places.
- RSCH could pay for it all or create an entity which is mortgaged with rent charged annually to a range of users. It might jointly fund with the ICB given the recent NHS England policy changes.
- Private sector providers - Assura and Prime - could bring their business models.
- GP surgery rents are paid for by the NHS almost in their entirety. This might be up to 50% of the space.
- RSCH could provide outpatient services, refunded by PbR.
- Community care would be funded by the ICB. The JV with Procare could be expanded or relocated.
- Private sector health providers – diagnostics, dentistry, optometry, physiotherapy, pharmacy, for example.
- ICB might want to run certain admin. service possibly in connection with PCNs.
- Urgent care or walk-in services.
- Specialised clinics could be contracted in by the ICB – take the Women's Health service in Shere as a local example.
- Local authority services - public health and social care.
- Rent from voluntary organisations and charities like Macmillan.
- The RSCH has proven expertise in financial engineering and would find the most effective funding solution for this site.

A move to an integrated care system will require a new approach to budgeting in the local health economy

- Perpetuating the current funding imbalance would frustrate the transition to integrated care.
- 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.
- To enable the new care vision to be delivered, 2025/6 should be Year One, a transitional budget, but the first of a recasting of ICB investment. Is this in progress?
- This will be a complicated undertaking involving the whole health economy.
- We believe that this is a good time to rework all budgets taking a zero-based approach.
- We accept that the RSCH needs to be persuaded that a diversion of funding into the community will be a good investment. There is a canon of work to prove this.

'Zero-based budgeting is a method of budgeting in which all expenses must be justified for each new period. The process begins from a "zero base" and every function within an organisation is analysed for its needs and costs. The budgets are then built around what's needed for the upcoming period regardless of whether each budget is higher or lower than the last one.'
Investopedia.

Going forward, there are big questions which need honest answers

- To what degree does the ICB feel it's delivering the NHS England plan?
- How will it accelerate the Darzi/Sweeting agenda: 'hospital to community; analogue to digital; sickness to prevention'?
- What is the local state of preparedness for each?
- Where is the ICB in negotiations with RSCH over the 2025/26 contract round?
- What's different from last year?
- Is the commissioner using its contracting leverage to move care out of hospital.
- Is it about to extrapolate the present, or is a radical re-structuring envisaged?
- How will it deal with the primary care premises issue?