First Draft
Work in progress only

Our vision for local health care

The Guildford Society

9th July 2026

Executive summary

Executive summary

The challenge

Medical practice is changing, faster than it has ever done in history.

Demand for health services is growing at an unprecedented pace, driven on the patient side by demographics and consumer behaviour.

Bioscience, the introduction of new treatments, drugs and therapies also expand the range of options and increase cost to the system.

All health systems struggle to adapt quickly. A great deal of the legacy set-up requires significant ongoing financial support, even though it is less efficient. The politics of health care also constrains change. Big business acute hospitals have the ascendancy over small scale primary care, even though it's GPs who create the front-end of supply chains – initiating hospital referrals, for example

State funded systems are full of compromises. Sub-optimal decisions get made for perverse reasons often against what seem like logical alternatives. The allocation of budgets by commissioners is a prime example. GP practices get only a fraction of what goes to hospitals. The government wants to see capital moved to community projects, but 98%+ of the ICB's capex allocations for 2026/7 is going to hospitals.

The current big issue for the government is how does it change the locus of care – investing in neighbourhoods, while the political pressure is to reduce hospital waiting times?

We do not know if, and when, a neighbourhood health centre will be built in north Guildford. If this is not to be for a number of years, then the existential threat to both the local system and patient care will mean that a full range of options needs tobe considered. We discuss these in this proposal.

A major imperative is to reduce pressure on hospitals and, in particular, the Royal Surrey. All patients who don't need to be seen in hospitals should be treated in community settings. The logical place would be their GP surgery or neighbourhood health centre. Currently, local GP premises are mostly full.

Executive summary (continued)

Free up space

GP practice space must be freed up for patient face-to-face consultations. Patients' contact with practices has changed fundamentally since the disruption caused by Covid, with a greater shift to the phone and Internet. The NHS app is the latest driver of change and as the range of its services expands and patient data increases, practice communication will become even less reliant on physical visits and face-to-face contact.

If care is to be moved out of hospital into the community, there must be places for patients to go which meet current standards and can deliver appropriate 21st century health care.

NHS England wants to see the delivery of health care services diversified through the introduction of a range of new providers. '*ICBs will allocate resources in contracting and procuring services, shape and manage the provider market, and have an increased focus on the longer term in their ongoing contractual management of commissioned services.'*

Create an expanded community-based capability through contract proliferation

ICBs and Foundation Trusts should encourage this move by vastly increasing the number of contracts awarded to non-traditional providers, mostly new medical teams sourced from GP practices and hospital specialties.

The initiative will leverage many clinicians' work preferences - their additional interest in a chosen clinical specialty; a more diverse working week; independence and the chance to develop their own businesses.

The process will develop from the longstanding NHS initiative of encouraging GPs, but also hospital consultants, to operate in areas where they have a special interest. This is nearly the full range of clinical services, but one step down from essential hospital care, in for example, dermatology and skin surgery; musculoskeletal; cardiology and respiratory medicine; clinics for heart failure management, hypertension monitoring, asthma and COPD; diabetes; ophthalmology; ENT; minor surgery; women's health; mental health and substance misuse; geriatric care and frailty.

To promote the move, new contracts will have to be sufficiently attractive with most financial risk underwritten by the contractor. ICBs should provide a full range of support services to encourage participation, maybe even within the contract, with the creation of a business establishment template for doctors to use.

Executive summary (continued)

These medical teams will move into the freed-up space in practices which staff recruited under the Additional Roles Reimbursement Scheme (ARRS) and other back office employees will vacate. The ICB will also initiate a search for capacity in other NHS estate, as well as that currently used by local authorities.

Build a Single Point of Access (SPoA)

We foresee a situation whereby every local health system and certainly those which operate at an NHS Place level has a SPoA. Locally, this could be for Guildford and Waverley. Our model sees one established on the Research Park in Guildford.

It would be a joint venture operated by local PCNs and the Royal Surrey Hospital. The accommodation would be rented to avoid capital funding constraints. The ICB and Hospital should work together to develop the business case.

SPoAs act as centralised hubs providing a single digital entry point for patient enquiries, clinical referrals and individual patient care pathway management. They are also the local headquarters for the integrated management teams which provide community health services. This the view of NHS England:

Our model sees the Guildowns practice back office and multi-disciplinary teams located in the SPoA building as the anchor tenants. Next, would be similar staff from other local PCNs. Hospital and community staff from Procare, the company formed by the local GP Federation, would follow. Space should be allocated to promote coordination with third sector Voluntary, Community, and Social Enterprise (VCSE) service providers. Local authority social care staff should also be accommodated to improve patient coordination. Over time, all community patient coordination will operate off a single, AI managed, patient record system.

Executive summary (continued)

Integrate patient data across Guildford and Waverley

In the future we foresee a situation where data becomes the health care controller.

AI will completely transform health care delivery. Every single patient event will be recorded, evaluated, questioned and costed on a personalised automated care pathway. Clinical decision support systems will help guide onward patient care.

We see the Guildowns practice's Medicus as the foundation patient record system. Expert staff from the ICB and RSFT will help with data integration, leveraging the NHS Federated Data Platform.

This will provide a new generation of NHS risk stratification systems enabling the promise of Population Health Management to be delivered.

For legal reasons, all patient data will be under GP control.

Guildford's potential – University, Hospital, GPs, ICB, even Research Park collaborators - as a town which can produce innovative digital solutions to future patient care should be fully exploited.

Executive summary (continued)

Organisation

None of this can happen without a robust management system being in place.

The contraction and merger of the ICB and the creation of two unitary authorities have severely disrupted the development of local health services over the past two years and there is more to come. There has also been the need to adapt to new directions set out in the NHS 10 Year Plan.

More change will happen with the introduction of Integrated Health Organisations and 'Offices of Pan-ICB Commissioning' – OPICS - planned to take "at-scale" commissioning responsibilities previously managed centrally by NHS England from next year, but which could also create more staffing issues for ICBs.

The future structure and scope of the UA-led Health and Wellbeing Boards, possibly under the direction a mayoral strategic authority, will shift power away from the NHS. The appointment of a devolution-oriented Prime Minister could lead to even more complications.

It is vital that institutions now look to quickly and collaboratively plan the way ahead for health care systems which, locally and nationally, will remain challenged.

Finally

This is not a moment for incremental change, for continuing in a business as usual mode.

The Guildford Society welcomes all suggestions as to how this vision might be delivered.

We are available to answer any follow-up questions or provide more detail.

Summary and next steps

For a detailed summary and next steps, go to the back of this presentation, pages 152-155.

Why are we putting forward these proposals?

Our prima facie view is that health care availability and delivery in Guildford, like nearly every other health economy, is not well balanced and as a result is not optimised.

Health care programme effectiveness is measured by how well it achieves its goals, applies its resources and improves patient outcomes.

The aim to achieve allocative efficiency should be paramount, to establish that funds are distributed appropriately, particularly in trade-off situations, for example between preventative care in the community and elective hospital treatments.

We come back frequently in this presentation to demographic disparities where health status differs across ethnicities, social classes and localities.

What is the object of all health programmes? It should be about delivering the best outcomes, patient experiences and quality of care. Population views are important, but for the individual patient it is about how they feel about their health in general and any treatment they have just received; how good is the system in which they live and how satisfactory was the last experience.

As health guru Professor Michael Porter has always made the case - value in health care can only truly be measured by the patient experience. The NHS has always held back on pursuing patient opinions. But programmes like PROMs (Patient-Reported Outcome Measures), assessments by patients about their quality of life, pain levels and activity, before and after an intervention, are essential.

We advocate their universal adoption by the NHS in this presentation. Otherwise, how does it know how good a job it is doing?

Introduction

We don’t pretend to have all the answers in what follows. But we’d like to get the views of interested parties.

- What we are putting forward is a strawman:

> *‘A strawman is a simple draft proposal intended to generate discussion of its attributes and disadvantages to spur the generation of new and better proposals. The strawman is not expected to be the last word; it should be refined until a final model or document is obtained that resolves all issues concerning the scope and nature of the project.’* **Wikipedia.**

- These are the views of the Guildford Society exclusively. They are set up solely to encourage debate.
- The Society has discussed its proposals with representatives of local NHS organisations, but the views expressed are exclusively and entirely its own.

What does all this mean for the local NHS?

- The NHS is under pressure across the country. Guildford is no different.
- Locally, the Royal Surrey is the biggest pinch-point. Demands on it have to be reduced.
- But if we look at each care pathway as essentially a supply chain, then managers will need to look at every patient interaction to see where improvement is possible.
- The Kings Fund estimates that total quantifiable inefficiencies across the NHS sit between £5 billion and £12 billion annually, out of a total budget of approximately £204.7 billion.
- If we take the median to be £8.5bn, then this would be about four percent.
- Our estimate for the budget for Guildford and Waverley is about £780m.
- A four percent saving would bring about £31m
- In this presentation we talk about an investment of £20m (amortised over many years) in a new neighbourhood health centre and about £3m running costs for a Single Point of Access (which excludes staff costs which are already counted, but might even collectively be reduced).
- These are all ballpark numbers, but they help provide some context to the size of the opportunity in relation to the total local NHS budget.
- Because of the way that demand for health services can never be satisfied, we understand that any savings will be diverted to other patient care.
- But what if planned savings were invested along care pathways and additional treatments didn't take place in hospital?
- We'll continue to develop this thinking in this presentation..

Then, there is the promise of what AI might deliver

- *'The IPPR estimated that comprehensive deployment of AI could save the NHS £12.5 billion per year [just] by fully freeing up staff from repetitive administrative time.*
- *Public First said AI adoption could deliver freed-up administrative time equalling the capacity for an extra 3.7 million GP appointments.*
- *Microsoft 365 Copilot saved average staff members 43 minutes per day. translating directly into 'hundreds of millions of pounds' in annual cost savings. Automated voice technology (AI scribes) produced up to £834 million in total staff-time savings.*
- *AI-driven appointment software successfully reduced Did-Not-Attend rates by 30%, generating an estimated £27.5 million in annual savings for a single local trust.*
- *The NHS AI Lab reviewed a specialised clinical decision support tool. Against a project cost of £1.25 million, it generated over £44 million in systemic cost savings by preventing downstream complications.*
- *AI home-care tracking tools showed that early interventions could save the NHS £1.5 million every single day by preventing avoidable emergency hospital admissions.*
- *There is the financial counter-risk: NHS Chief Financial Officers have highlighted the token and cloud compute usage variability. This means that where staff routinely run queries, the underlying cloud compute billing will surge significantly—creating a volatile variable expense that could quickly impact local budgets if not regulated'*. **Google AI, GS edits.**

Strategies are meaningless if they are not executed

- NHS organisations are highly competent producers of strategies.
- But execution is often thwarted because programme implementation takes so long. Changes in government, policies and plans, reorganisations, management and staff turnover often happen in the intervening periods disrupting delivery.
- Guildford's health system hasn't quite reached its moment of existential threat, but it might not be far off.
- In mid-summer, the Royal Surrey is experiencing corridor waits (Board report June 4th, *'the high attendances recorded during the previous winter had remained, with corridor care being required in response at times').*
- Lower down the report, '*Whilst elements such as bed management were part of this [culture change], wider ambitions were required to establish permanent change. Equally, allocating patients to the most appropriate care settings (e.g. community hubs) would reduce the pressure on capacity at Royal Surrey County Hospital*'.
- Changes on the margin might help, but we can see no capacity in the local system, particularly in 'community hubs', wherever they might be.
- Winter pressures could be the tipping point.
- Fundamental, transformational, change is necessary and it must happen now.
- We believe our proposals could help and we commend them to readers.

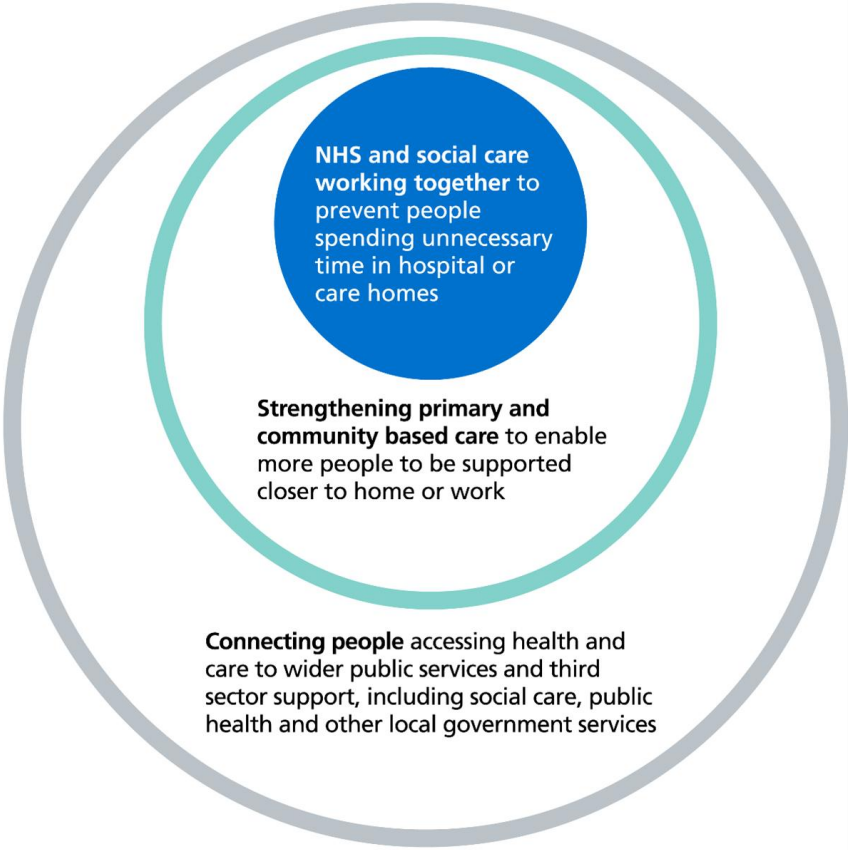
The context

A key pillar of the NHS 10 Year Plan is to shift from hospitals into the neighbourhood

'Why a new approach is needed

- *There is an urgent need to transform the health and care system. We need to move to a neighbourhood health service that will deliver more care at home or closer to home, improve people's access, experience and outcomes, and ensure the sustainability of health and social care delivery. More people are living with multiple and more complex problems, and as highlighted by Lord Darzi, the absolute and relative proportion of our lives spent in ill-health has increased.*
- *NHS and social care working together to prevent people spending unnecessary time in hospital or care homes.*
- *Strengthening primary and community based care to enable more people to be supported closer to home or work.*
- *Connecting people accessing health and care to wider public services and third sector support, including social care, public health and other local government services'.*

Neighbourhood health guidelines 2025/26, NHS England, 25 March 2025



Our view is that North Guildford meets all the tests for being in a ‘clear line of sight’

- *‘NHC estate proposals for upgrading, repurposing or building new centres should build on and be informed by the service changes ICBs are committing to deliver over 2026/27 and beyond in their planning submissions, including improved access to general practice, enhanced support for people with complex needs and the shift of appropriate activity out of acute settings.* ***There should be a clear line of sight*** *between neighbourhood health ambitions, clinical strategies, service redesign plans and the estate solutions proposed to enable them*’. **Neighbourhood health centre guidance for regions and integrated care boards, 16 April 2026.**
- The CCG laid out the programme 2019 for addressing the inadequate premises in north Guildford which should have been finished three years ago, see panel.
- NHS England wants to see decision-making be more evidence-led.
- We would like to see the methodology and recommendations the ICB is employing for its 2026/7 NHC prioritisation.

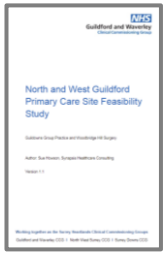
1.7.2 Timetable

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

Outline Project Timeline

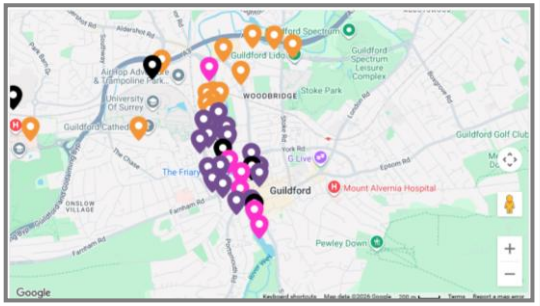
Task	Timeline
Information capture and site analysis	March – April 2019
Stakeholder and patient engagement	May – October 2019
Feasibility Study Completed	October 2019
CCG recommendation to proceed	November 2019
Funding and procurement option appraisal	Nov – January 2020
Outline Business Case (including public consultation)	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

Reprise: The 2019 CCG report said that GP premises in north and west Guildford were not fit-for-purpose



- *'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.'*

Future population growth will also increase the pressure on GP services. Guildford's population grew by around 6,500 between the last two censuses, held in 2011 and 2021. But the period up to 2030 will see an acceleration. More than 17,000 new homes are planned to be built in the area in the next five years, potentially adding 50,000 people to the current population of c.150,000.
The locations of the approved developments are shown here
https://www.guildfordsociety.org.uk/Keysites.html
Nearly all of the sites are to the North of Guildford, the area where GP services are most stretched. For details use the zoomable map.



For the time being, north Guildford's primary care facilities remain in limbo

- Local patient support groups have lobbied for 10 years for GP premises improvement.
- This is a part of Surrey with three of the most deprived wards.
- Nothing has been done while thousands of people have died prematurely.
- The 2019 CCG report recommended new builds in Park Barn and Stoughton.
- Work should have been completed by now.
- Guildford is not a place which connotes poor health status.
- The ICB has given no information about where north Guildford sits in any prioritisation hierarchy for the building of a neighbourhood health centre.
- The ICB CEO said in her most recent Board report that '*ICBs were asked to develop a neighbourhood health centre pipeline, with expressions of interest for national funding (from a £50m pot) submitted to the national team by 28 May 2026. the ICB [has] prepared an initial baseline of proposed locations (across Surrey and Sussex), intended as a starting point for engagement and discussion, reflecting local insight and need, as well as taking account of the most suitable estate approaches in different areas. To prepare our submission, we shared our proposed list with partners for comment to help inform our final submission which also includes a short-list of those locations with the greatest chance of deliverability in-year (2026/27), and which are strongly aligned to demographic need'.*
- In the spirit of transparency, we would like to know where north Guilford figures.

Potential development sites were identified by the 2019 report to replace the existing premises

The 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, having been acquired by another developer in the meantime.

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.

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.

We see the Jarvis Centre as the place to emulate the Washwood Heath NHC

- Watch the video first: 'A virtual visit' at the bottom of this link
- https://communityhealthpartnerships.co.uk/news/washwood-heath-health-and-wellbeing-centre-innovative-utilisation-supporting-productivity/#:~:text=Background,situated%20on%20the%20car%20park.
- Also, A Virtual Visit to Washwood Heath Health and Wellbeing Centre, - Search
- *'Washwood Heath, a community health clinic that was set up in a deprived part of east Birmingham two years ago when the Conservative government was in power, is a living, working example of what this could look like. Here, hospital doctors, GPs, nurses, occupational therapists, council social care teams, mental health professionals and charity staff work under one roof.*
- *The £15m three-story building combines an urgent treatment centre offering some of the services usually provided by hospitals, as well as a diagnostic service (for MRI scans, X rays and ultrasounds), alongside mental health care and wider social support.*
- *In practice, this allows for addressing social problems such as housing issues, alongside treating physical health conditions, plus arranging support for daily tasks such as washing and dressing'.* **BBC.**

A Jarvis Centre redevelopment passes the important test of being an existing building owned by NHS Property Services

NHS England says to ensure estate and financial sustainability:

- *'ICBs must exhaust all avenues to reuse, upgrade, or extend existing NHS properties or civic spaces (like libraries or high street buildings) before proposing a new build.*
- *For upgrades, public capital is utilised. For necessary new builds, a Public-Private Partnership (PPP) model is heavily leveraged, requiring a 20% public capital contribution and an 80% private finance share.*
- *Revenue affordability: the scheme must prove clear revenue viability, demonstrating that its ongoing operational and running costs fit entirely within existing local funding allocations'.*

Redevelopment of the site is estimated to be about £20m. We believe that the 20% public capital contribution - about £4m - is well within local resources of the ICB, Hospital and local authorities.

The Surrey Heartlands Risk Register exposed the issues with unfit GP premises. A new audit is necessary

- SH ICB indicated on its last risk register to be published that ‘Primary Care Resilience’ is high risk.
- This status has remained unchanged over many months, even years.
- We have no evidence that there is any improvement.
- Our view is that to demonstrate good governance, the ICB should continues? with this report.

		sent to practices. This represents a substantial clinical risk, as these missing reports may delay necessary patient care and decision-making.					
Risk #497 Primary Care Resilience	SH ICB	Primary care estates issues are not addressed, the continual growth in population and new housing developments will lead to greater pressure on primary care and impact on practice resilience. Also some existing estate is not fit for purpose.	16	9	4	**February 2025:** As of February 2025, this risk continues to be reviewed as part of the wider estates work programme via PCOG Part 2/PCCC mechanism. A review of PCN requirements is underway in order to mitigate ARRS increases in practice premises as part of national and regional conversations alongside the introduction of the Utilisation and Modernisation Fund.	30/06/2025

Range: Low (1-4) Moderate (5-8) High (9-12) Significant (15-25)

Primary care estates issues are not addressed, the continual growth in population and new housing developments will lead to greater pressure on primary care and impact on practice resilience. Also some existing estate is not fit for purpose.	Destabilisation of Primary care, reduced access to primary care, reputational risk. This could lead to a deterioration in primary care estate with fewer GPs willing to become premises owning partners and making the financial commitment. This could result in patients receiving their primary care treatment from premises which may not be fit-for-purpose. If current primary care estates capacity is not increased then this could prevent any work stream aimed at bringing services from hospital to community. The current estates may not support sustainable delivery of services to meet population needs or support the additional roles being recruited in to. This will impact on the ability to grow the workforce.

Primary care premises remain as ‘High Risk’. Primary care facilities need to be re-assessed as NHCs are planned

- The ICB has indicated on its risk register that ‘Primary Care Resilience’ is high risk.
- They say that local plans need to be developed, but there are none.
- We asked for GP premises funding details, but was given no information about how Surrey Heartlands ICB planned to address the issue.
- There is a need to re-think the role of primary care premises with advances in technology (the role of the NHS app, for example), changing patient preferences and the building of neighbourhood health centres and Single Points of Access.
- An additional important question is what is the split between clinical and admin use.

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Primary Care Risk Register Part 1 PCOG Feb 2025 / PCCC Mar 2025.

Financing a Guildford NCH remains our first choice. You need a very large spreadsheet to look at all the options

- The opacity of NHS finances means that we can only speculate as to how a Neighbourhood Health Centre on the Jarvis Centre site might be funded.
- The current NHSE preferred approach is to create batches of contenders for NHC projects to fill a national pipeline*. 'SR25 provides £426m over four years through the utilisation and modernisation fund, with up to half supporting delivery of 40 to 50 neighbourhood health centres this Parliament through refurbishment of existing buildings'.*
- The ICB produces its own prioritised list. We have not seen it.
- Funding can come from a number of different sources, see the local example of the rebuilding of Weybridge Hospital.
- Community hospitals are often of mixed use with multiple revenue streams – Woking Community Hospital is an obvious example.
- There is a strong business case for the Royal Surrey to fund a new satellite to put it on the same standing as Cranleigh or Haslemere.
- Capital spending is regulated by the local ICB following NHS England and DHSC guidelines to prevent the wider NHS from breaching the UK government's aggregate capital limits.
- The RSFT has a significant cash balance. However, its use is possibly restricted by the Capital Departmental Expenditure Limit (CDEL). This impacts new builds, building repairs, medical equipment, or IT upgrades, if they exceed the ICB's CDEL allowances.
- Does this mean that the RSFT's own cash might effectively be locked out of use if the regional cap is reached?
- We know that the Royal Surrey is an expert financial engineer. Looking back over recent years, it was able to finance the building of a new staff car park by swapping surplus land with a private developer in what might look like a 'no value' capital transfer.

NHS rules present a labyrinth: is this what is derailing Guildford? There may be workrounds

- NHS England Capital guidance 2026/27 to 2029/30 says under 'Capital freedoms and flexibilities' that *'the 10 Year Health Plan sets a clear direction for greater provider-level autonomy. By 2035, all providers are expected to become foundation trusts, retaining surpluses, reinvesting in schemes, and, in some cases, holding budgets for whole populations. Reforms are already in train: delegated limits have risen to £300m, and high performing providers (NHS Oversight Framework segments 1 and 2) can reinvest surpluses more freely. Alongside allocations, new financing models such as Public Private Partnerships are being explored for neighbourhood health centres. While systems and regions will continue to prioritise strategic programmes, the expectation is that providers will take growing responsibility for operational capital'*
- Guildford's needs are more pressing, though. Non-conventional approaches should be investigated.
- Work rounds should be explored to deal with financially constraining devices like CDEL. We believe that the RSFT and ICB financial teams need to look for imaginative, non-traditional, capital free solutions for its redevelopment.
- PPP schemes might be flexed with the GP practice, say through their 'ownership' of a limited company special purpose vehicle, used as the principal business entity to develop the NCH, rather than the hospital - which might be subject to Treasury CDEL rules - acting as owner. Other entities could take some of the equity.
- As rules change, the situation could be regularised with RSFT becoming principal leaseholder. In the case of the Jarvis Centre, the site and building are owned by NHS Property Services. NHSPS might want to look for its own solutions for a building which is not sustainable in its present format, for example an eventual transfer to the RSFT.
- The majority of income streams are essentially risk-free, but all residual risks would rest with the ICB or hospital, not the GP practice. The RSFT would, after all, be the major financial beneficiary as hospital space is released for higher margin procedures.
- A facility such as an NHC is essentially a health care department store with multiple income streams from GP, community, local authority, ICB and private sector tenants. This is income which could be securitised against development costs over a period of time
- The new UA could also be co-opted given its future role in health administration, bringing some of the techniques which local authorities use for project financing.

The Royal Surrey's vision is to reach into the neighbourhood. Part of the solution is tackling upstream demand. It needs a plan

- *'RSFT will continue to address local, place-based, issues collaboratively. We will work jointly with our primary care partners to resolve operational and clinical issues that impact the quality, timeliness and appropriateness of referrals into the acute Trust. This includes supporting consistent referral standards, improving advice and guidance utilisation, and enabling smoother navigation across services.*
- *Work with GPs to co-design and deliver neighbourhood health models of care. RSFT will work closely with PCNs, our GP Federation partners and general practice teams to develop and implement neighbourhood-level models of care that better respond to local population needs. This includes supporting multi-disciplinary working, enabling more proactive and preventative care, and ensuring specialty input is available in ways that strengthen community-centred services, recognising that improved integration delivers better outcomes and a more seamless experience for patients. Identify opportunities for future community-based delivery.*
- *A central part of this transformation is the expansion of virtual wards and the introduction of integrated neighbourhood teams, enabling multidisciplinary professionals to work across organisational boundaries to support patients in their own homes. These models enhance continuity of care, reduce unnecessary admissions, and provide safe, effective alternatives to hospital-based treatment. Expanding our virtual ward capacity and capability will allow patients with higher acuity needs to be monitored remotely using digital tools with regular clinical oversight, facilitating earlier discharge and more responsive care in familiar environments'.* **RSFT Strategy 2026.**

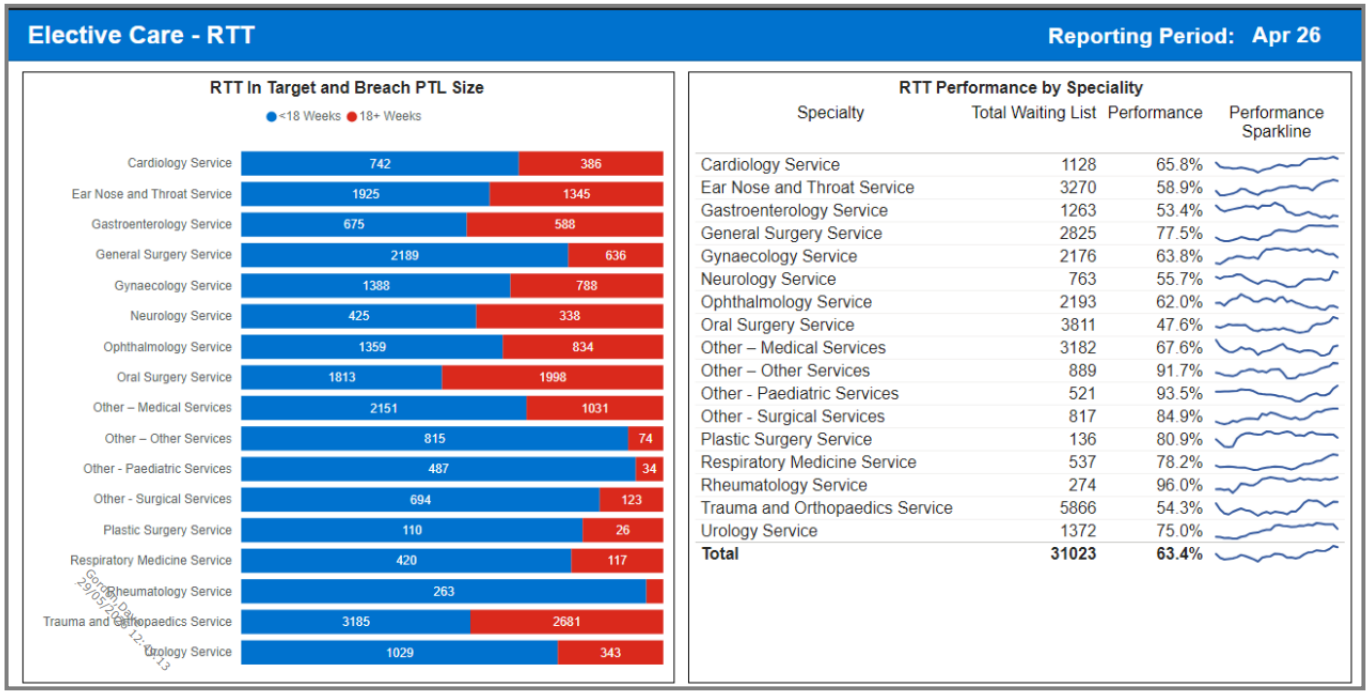
Imperative: protect hospitals

Reducing the exceptional loading on the Royal Surrey is the key priority. Moving care into the neighbourhood is essential

- *'The [RSFT] Chief Operating Officer outlined recent performance, with urgent and emergency care currently running below initial expectations. The high attendances recorded during the previous winter had remained, with corridor care being required in response at times. Inpatient flow was one of the transformation pillars being implemented with Ashford and St Peter's (ASPH), with bed management to be one of the priorities for this work in its initial stages. Elective care had seen its performance improve, with the final position for 2025 – 26 seeing year end targets achieved. This was with the exception of 52-week waiting times on the Patient Tracker List which had been missed by 0.4%. However, a data reporting issue for dental patients had been detected. Radiotherapy reliant on weekend working. This had not led to any identified harms and had since been resolved.*
- *The Chief Operating Officer had reviewed the position at Royal Surrey following guidance issued by NHS England. It was understood that corridor care was a consequence of urgen[t] care pathways not operating as expected, with the ambition to eradicate the practice being agreed by all parties.*
- *Lisa Goldstone asked whether there were any plans to invest at system level on the solutions which would improve the position. The Group Director of Neighbourhood Health responded that primary care was experiencing capacity issues, with these contributing to the Trust's high level of demand.*
- *The Group Director of Strategy was also in dialogue with GPs on digital systems that could support this although interoperability was proving to be an issue in this work'.*

TB1 73.26 OPERATIONAL PERFORMANCE REPORT, RSFT Board minutes, June 2026.

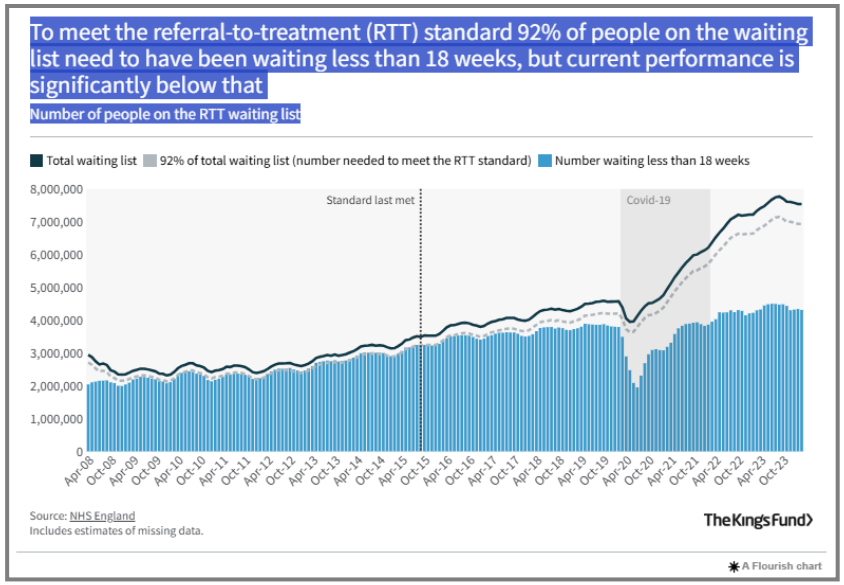
The Royal Surrey is behind the national waiting times performance but has seen a significant recent improvement



RSFT Board minutes, June 2026.

- The comparable composite number was 54.9% in June 2025.

There are doubts as to whether the government will meet its waiting times targets



Target Milestones

- The UK government's flagship NHS pledge is to ensure that 92% of patients wait no longer than 18 weeks from referral to consultant-led, non-urgent treatment by March 2029.
- March 2026 (65%): the NHS narrowly hit its first milestone when 65.3% of patients were seen within the 18-week timeframe.
- March 2027 (70%): next planned target stepping stone towards the final 92% goal.
- March 2029 (92%): final deadline to legally restore the NHS Constitutional Standard.

The RSFT is embattled by a wide range of circumstances which needs a coordinated response to reduce operating risks

- The Neighbourhood Health development is seen as the highest risk with the greatest gap between current and tolerable scores. **RSFT Board minutes, June 2026.**

3 ASSURANCE

Before any controls were applied, the total strategic risk score was 156. Controls in place reduce this score to 121. The overall level of risk has increased by 25% since Board review in January. This has been caused by the addition of a new entry (BAF10) and an increase in the score of BAF9.

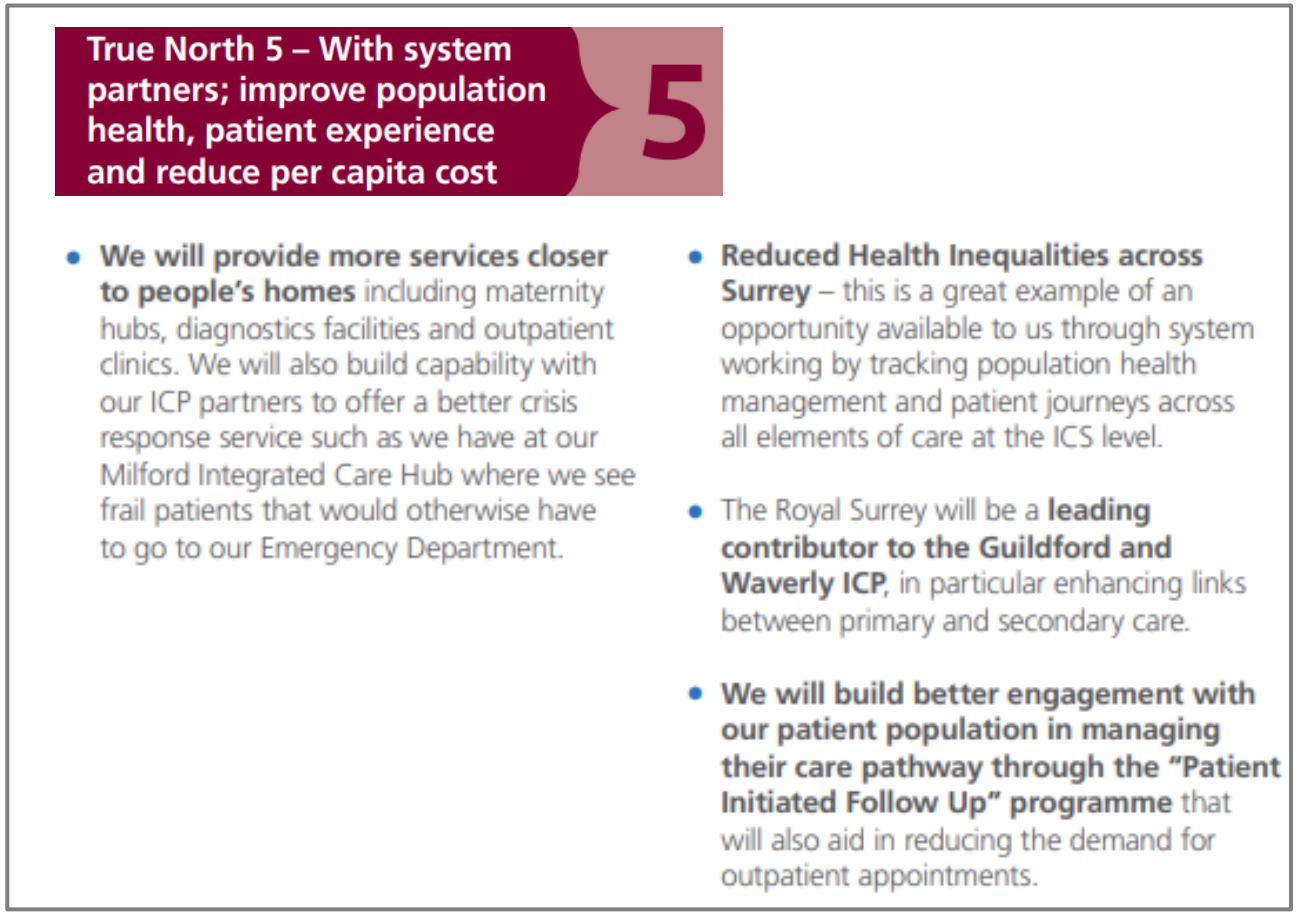
The total tolerable risk score is 51. Therefore, the Trust is currently holding 137% more risk than the Board are comfortable with.

Risk No	Initial Score	Previous Score	Current Score	Tolerable Score	Direction of Score
1 Research	16	6	6	6	⟷
2 Digital strategy	16	12	12	8	⟷
3 Financial sustainability	20	15	15	9	⟷
4 Culture & conduct	9	6	6	2	⟷
5 Workforce	12	12	12	4	⟷
6 Operational performance	16	16	16	3	⟷
7 Infection, prevention & control	16	9	9	4	⟷
8 Data quality	16	9	9	3	⟷
9 External stakeholders	15	12	16	8	↑
10 Neighbourhood health	20		20	4	
Total	156	97	121	51	

Key

RED = considerably higher than tolerable risk score
GREEN = matches or close to tolerable risk score

RSFT says it is signed up to the plan to move services out of hospital. But what are the programme details?



True North 5 – With system partners; improve population health, patient experience and reduce per capita cost 5

- **We will provide more services closer to people's homes** including maternity hubs, diagnostics facilities and outpatient clinics. We will also build capability with our ICP partners to offer a better crisis response service such as we have at our Milford Integrated Care Hub where we see frail patients that would otherwise have to go to our Emergency Department.
- **Reduced Health Inequalities across Surrey** – this is a great example of an opportunity available to us through system working by tracking population health management and patient journeys across all elements of care at the ICS level.
- The Royal Surrey will be a **leading contributor to the Guildford and Waverly ICP**, in particular enhancing links between primary and secondary care.
- **We will build better engagement with our patient population in managing their care pathway through the "Patient Initiated Follow Up" programme** that will also aid in reducing the demand for outpatient appointments.

'Our Strategy 2022-2025', Royal Surrey County Hospital.

Manage the upstream

The summer 2025 Haslemere Town Hall meeting set out the RSFT plans for investing in local neighbourhood health

Neighbourhood Health

- Bringing care to local communities
- Convening professionals into patient-centred teams
- Transforming general practice and restoring GP access
- Offering patients with complex care needs a care plan to support personalised care (reducing hospital admissions)

Systems that invest more in community care see 15% reduction in non-elective admissions and 10% lower ambulance conveyance rates, as well as reductions in Emergency Department attendances

Core requirements

- Partnership working between organisations: RSFT, GPs, Procare, Voluntary, Mental Health and Social Care
- Diagnostics
- Digital capability - involving a Single Patient Record
- Reconfiguration of the existing space within Haslemere Hospital
- Community engagement

Given the critical issues, Guildford can't wait a number of years for a Neighbourhood Health Centre

- Looking at current trends, we cannot foresee an NHC locally in under five years.
- Health care delivery will in any case have fundamentally changed during this period, mainly as a consequence of technology advancement -'genomics, AI, wearable technologies, robotics and joined-up data will have most impact'.
- Patient contact has been transformed since Covid 19.
- It will continue to change particularly as the NHS app plays a greater role.
- All of this is likely to have an impact on real estate configuration.
- The local GP surgery will still have the substantial role in providing patient contact, particularly in localities where there is no NHC.
- Integrated Neighbourhood Teams will focus on discrete patient pathways, each with their own treatment plan.
- This means that freeing up as much practice consulting space is a key imperative.

Practice contact has changed since Covid-19. It will be transformed as the NHS app becomes the centrepiece

- *'Millions of people are using online consultation requests to contact their GP practice each month, as the NHS gives people more choice in how they can safely contact their family doctor.*
- *New figures show 6.5 million online consultation requests were submitted to GPs in September 2025, up half compared to the same period last year [4.4 million in September 2024].*
- *The statistical tipping point where online contact officially overtook telephone calls occurred in Late Summer (August and September) 2025:*
  - *Online (43.3%), includes submitting digital triage forms, requesting repeat prescriptions, or using practice apps.*
  - *Telephone (40.5%), standard voice calls to the reception desk.*
  - *In-Person (14.6%), walking into the physical surgery building to speak with a receptionist.*
- *According to NHS England, roughly three-quarters of the adult population have set up an NHS App account, making it the principal digital gateway to primary health care.*
- *Over 14.8 million distinct users actively log into the app every month.*
- *The platform handles approximately 74.8 million login sessions per year.*
- *Over a rolling 12-month period, 27.3 million unique individuals logged into the app at least once.'* **NHS Digital**

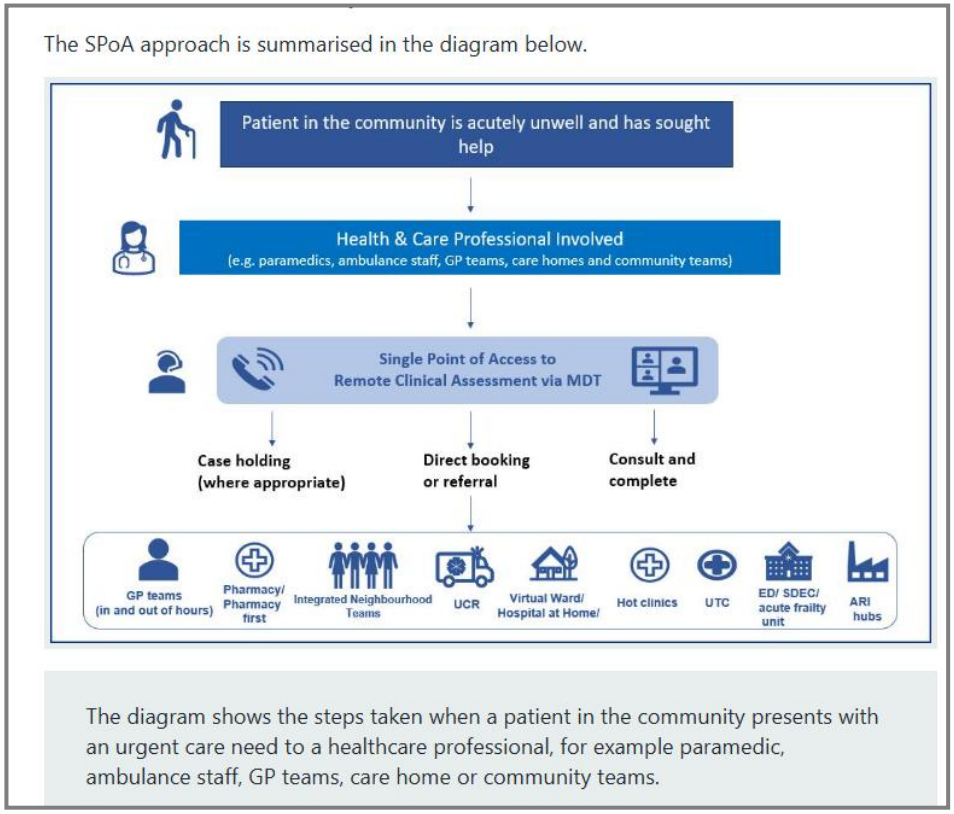
Also, a cascade of game changing capability is being constrained by the inadequacy of GP premises

- Primary care will be transformed, but only if the resources, principally real estate, are fit-for-purpose.
- A larger practice headcount has already required a lot more space, constraining GP service development.
- The opportunities which should not be missed include:
  - leveraging the additional staffing provided through ARRS
  - better multi-disciplinary team coordination in a collegiate working space
  - training space for GPs, MDTs and back-office staff
  - tighter case management coordination with community and social services
  - managing ‘virtual ward’ patients in a community environment
  - taking over more outpatient consultations
  - applying IT, digital, data/analytics at a greater scale
  - facilities to deliver additional ICB service contracts for out-of- hospital procedures
  - closer case management coordination between community and social services
  - a Single-Point-of-Access (SPoA) for the entire NHS Place
  - referral management, also delivering Patient Choice options.

In the interim, building a Single Point of Access (SPoA) seems to us to be the best alternative strategy

- *'A Single Point of Access is a centralised hub that acts as a single contact point for patients, carers, and GPs to access specific health care services.*
- *Instead of navigating multiple different clinics, departments or referrals, all requests for a particular care types of care go through a single coordinated team.*
- *The facility is staffed by experienced clinicians - such as senior nurses, social workers or mental health practitioners who review every incoming call or referral.*
- *The SPoA directly books the patient into the correct clinic, dispatches an urgent crisis team, or refers them onward to community resources.*
- *The purpose of a SPoA is to prevent avoidable ambulance dispatches and conveyances, emergency department attendances and hospital admissions, as a partnership between community, ambulance, primary care, acute services and social care that brings together a multidisciplinary team (MDT).*
- *SPOAs can also help to ensure patients receive hospital-level care at home by increasing referrals to urgent community response teams and the organisation and deployment of virtual wards.*
- *Once the foundation components are in place, systems should look to expand and develop their SPoAs, for example, supporting care homes'*. **NHS England.**

SPoAs are a fundamental keystone of NHS policy. Every local health economy should have one.

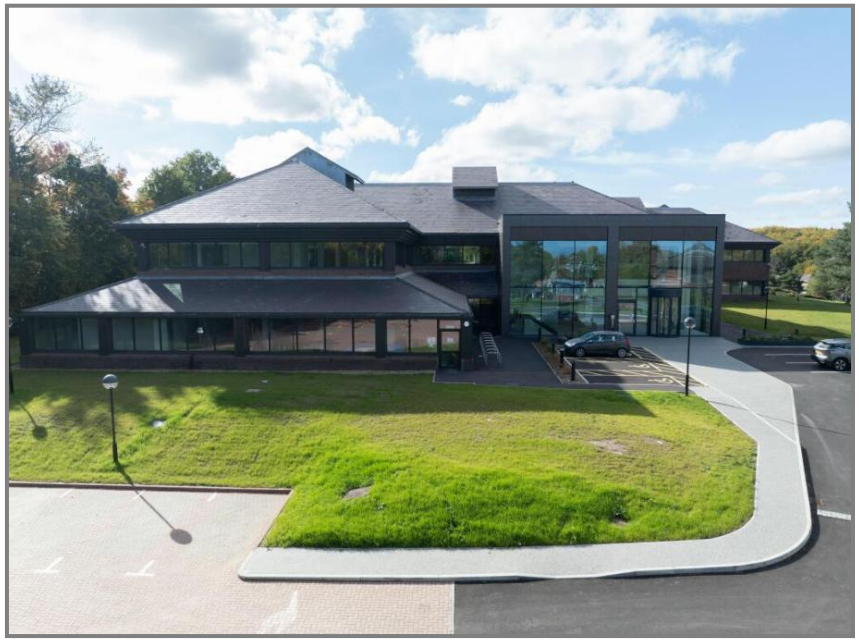


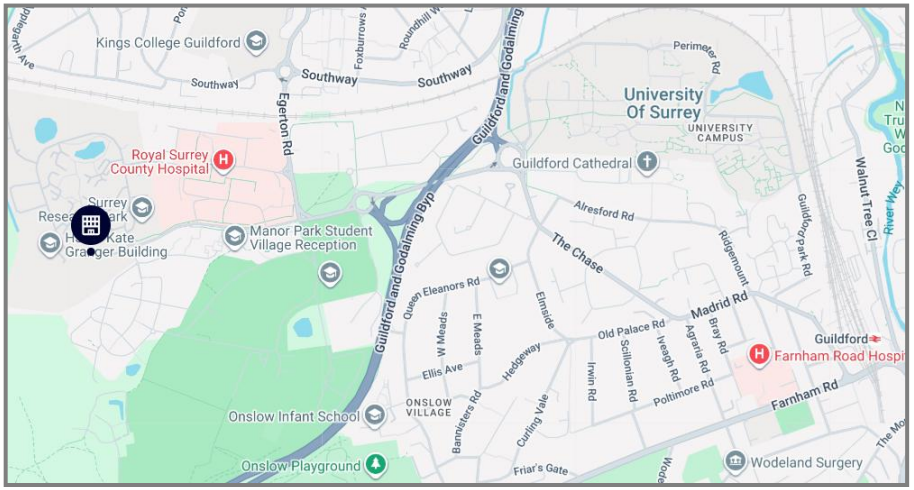
https://www.england.nhs.uk/long-read/single-point-of-access-spoa/

SPoAs are part of the NHS England strategy to strengthen community services

- *'To reduce demand for elective services we are working closely with providers to design a single point of access for elective referrals to enable specialist advice and guidance to be provided earlier in a patient's pathway. This is key to reducing demand in elective services and the number of unnecessary outpatient appointments which currently take place. This approach also focuses on improving patient choice and reducing waiting times for those who do require acute elective care.*
- *Initially we are focussing on 10 specialities with the greatest opportunity for improvement and will be reviewing pathways to ensure we are maximising opportunities to deliver more care in the community. We have allocated digital transformation funding to support the design of the technical solutions which will be key to mobilising this approach at scale and the work.*
- **https://www.england.nhs.uk/long-read/single-point-of-access-spoa/**

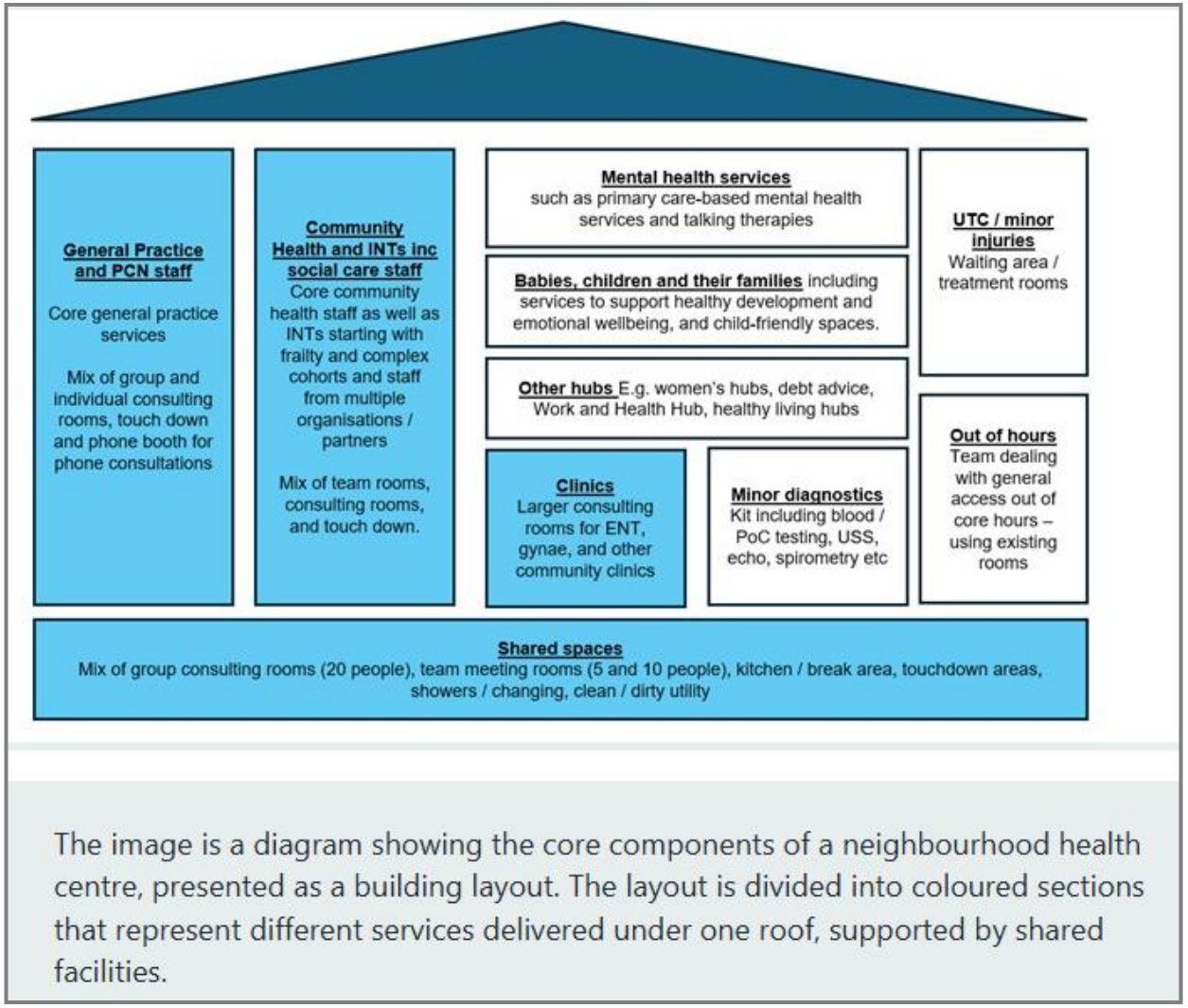
The Guildford Research Park has vacant properties of the right size to accommodate an SPoA





- The Priestley Building, Surrey Research Park, 36,328 square feet, rent £16,458 pcm

What are the components of an SPoA? NHS England says:



The image is a diagram showing the core components of a neighbourhood health centre, presented as a building layout. The layout is divided into coloured sections that represent different services delivered under one roof, supported by shared facilities.

If a fully integrated health system is the aim, then SPoAs could become the place where they come together

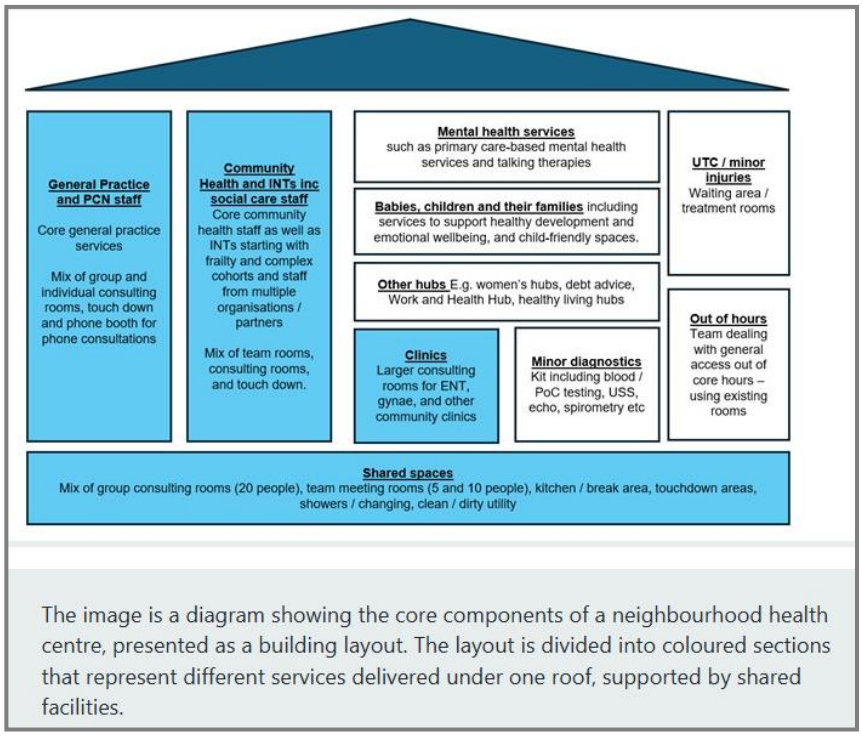
- Integrated health organisations will only succeed if they meet the needs of their participating constituencies.
- GP practices and Foundation Trust acute hospitals have completely different structures and motivations.
- These will need to be balanced. Success will be limited if hospitals see themselves as the dominant, controlling party.
- Yet they have the lion's share of the resources – significant capital, infrastructure and specialist management teams (Finance, IT, HR).
- But what GPs do vitally - if you put health care into an economic framework – is that they control the supply chain, upstream patient care pathways.
- Community health care teams have been positioned as making the greatest contribution to neighbourhood health.
- A new *integrated* organisation should bring together the best features of all participants.
- One of least frequently mentioned benefits of creating an SPoA is that all these constituencies can be united in a single enterprise.

Combining teams in a single physical space is the best way of promoting integration

- *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.

The Fuller stocktake has since emphasised the importance of estates and digital (in addition to workforce) as the enablers for creating the capacity for wider improvements led by local decision-making. Increasing the primary care workforce through the ARRS has improved access to general practice, providing over 50 million more appointments in 2023 than in 2019. While demand and pressure remain high, an additional 31,000 roles joining primary care has allowed providers to run additional appointments and extend existing services. The increase in skill mix within primary care teams has also allowed new services to be provided in primary care settings for the first time.

Eventually, the SPoA and Neighbourhood Health Centre should operate from the same site



The image is a diagram showing the core components of a neighbourhood health centre, presented as a building layout. The layout is divided into coloured sections that represent different services delivered under one roof, supported by shared facilities.

- This would then look very much like the Washwood Heath site described earlier.
- The leased site in the Research Park could then be discontinued, saving an estimated annual outlay approaching £3m.

Our plan would free-up GP practice space by transferring back-office and MDT staff into the new SPoA

- The short-term imperative is to find as much suitable consulting room capacity in primary care. GP practice staffing has trebled in the past five years.
- Multi-disciplinary teams have needed to be accommodated in GP practices but will now be moved out.
- ARRS multi-disciplinary teams would be located in a more communal SPoA space, where eventually most community care staff would come together..
- The secondary function of the facility would be for it also to act as a ‘model office’, providing R&D learning for the future
- These arrangements would eventually grow to become to be the SPoA for Guildford and Waverley along the lines of https://www.england.nhs.uk/long-read/single-point-of-access-spoa/
- This would in the short-term not be a capital project, the premises would be rented.

‘Build it and they will come’. Staff should move in gradually

1. The first movers should be the Guildowns back-office and ARRS multi-disciplinary teams as the anchor tenants.
2. Next, bring in Procare/RSFT estates staff to manage logistics.
3. Install the analytics teams from Procare, RSFT and ICB.
4. In a phased way, bring in the other Guildford and Waverley PCN back-office staff and ARRS teams.
5. RSFT and Procare community care teams are next, grouped with ARRS staff.
6. Add all Virtual Ward staff.
7. Introduce VCSE community staff operating to a new contract.
8. Add County Council social care teams
9. Add relevant ICB personnel.

Face-to-face GP staff with reception teams should be left in place.

Time is of the essence. The project should be developed in real-time, maybe as a ‘skunkworks’ project

- This is not to say that there shouldn’t be a plan and a budget.
- But this should focus on parameters rather than detail. The project can be built as it goes.
- Skunkworks projects are innovative undertakings, usually involving a small group of people who operate outside normal organisational formats. Nowadays they adopt a lean management approach, focussing on maximising customer benefit, optimising processes while minimising wasteful operating methods, leading to improving efficiency and continuous improvement.
- People who have practical experience of project initiation and management should be selected. Hospital real estate and facilities teams and GP business managers seem to be the most likely candidates.
- As for urgency, this project should be seen as one level down from what was built for Covid - 19 and built at pace.
- The business case is mostly about the property investment. Systems and furnishing should in the first instance be staff bringing what they have. In the short term, it doesn’t need to match.
- We see an overwhelmingly positive financial outcome for the entire local health system and a significant patient benefit.

Build an Integrated Team

Community care is a vast industry. But nobody probably knows how effective it really is.

- *'Combined community staff make up an estimated one-fifth of the total NHS workforce. NHS England estimates that, across providers commissioned by the NHS, 33% of community service staff are registered nurses, 25% are health care assistants and unregistered staff, 21% are allied health professionals, 18% are other non-clinical staff, and only 2% are medical.*
- *The numbers of people working in community services are difficult to determine from NHS workforce statistics, which do not capture where staff work in a consistent way. This is a particular problem for staff groups which work across community and acute hospital settings, such as therapists. Even for community nurses who can be identified more easily in workforce data. Staff who work for non-NHS providers are not included in NHS statistics*
- *Health visitors are specialist public health nurses who typically work with families with children under the age of five years.*
- *The number of health visitors has fallen by almost 40% since 2015, when commissioning health visiting services became the responsibility of local authorities.*
- *The fall in numbers of NHS-employed staff may in part reflect a shift from community interest companies or independent sector provision – estimated to be about 10% of health visitors in 2019 - but is also likely to reflect the maintain health visitor levels*'. **NHS Confederation**
- Most of the numbers are considered to be unreliable.

There is a huge amount of activity, but poor record-keeping and little data

- *'Over 100 million contacts are made with community services each year – these could range from a visit from a district nurse at home, a child attending a speech and language clinic, or a patient getting a blood test. People with more complex health needs may need care from several different community services, and in some cases, services are provided by multi-disciplinary teams.*
- *Typically, 60% of all contacts are made with older people and the rest are split evenly between working-age people and children and young people.*
- *Most used services are routine check ups and immunisations, speech and language therapy. Musculoskeletal, children's health, foot care/problems, wound care, blood tests and rehabilitation.*
- *Care providers' contacts with the system [which are highly variable] are meant to be counted in a community services datasets, but currently only a proportion of providers are submitting data returns, and when they do submit data there are very few mandatory fields, leading to incomplete returns.*
- *The data gaps make it difficult to understand not only activity, but also the workforce, spend and quality in community services*'. **NHS Digital, Nuffield Trust 2026.**

The better organisation of community care is very likely to bring substantial benefits

- The numbers of people working in community services are difficult to determine from NHS workforce statistics, which do not capture where staff work in a consistent way.
- Organisations that provide NHS-funded community services are often grouped into a few categories, including trusts (acute, mental health, community and combined NHS trusts), community interest companies, private providers, local government and the third sector. Knowledge about who is providing which services relies on snapshots captured in research studies or unpublished data.
- Information collected by NHS England, obtained by FOI, identified 814 providers of community services in 2020/21, which includes community interest companies as well as for-profit providers. Non-NHS providers outnumber NHS providers, but many are small organisations, and between them they provide about a fifth of services, based on contract value and number of contacts.
- Combined community staff make up an estimated one-fifth of the total NHS workforce. NHS England estimates that, across providers commissioned by the NHS, 33% of community service staff are registered nurses, 25% are health care assistants and unregistered staff, 21% are allied health professionals, 18% are other non-clinical staff.

Locally, there is a very long tail of community care providers. Each ICS may have 40

- According to NHS Digital, '*there are over 100 million contacts made with community services each year – these could be a visit from a district nurse at home, a child attending a speech and language clinic, or a patient getting a blood test.*
- *The provider landscape for community health services is made up of approximately 800 providers delivering services in the UK.*
- *NHS England allocates approximately £10 billion annually to community health services,*
- *Community health services are generally made up of physiotherapy, podiatry, nursing, intermediate care, virtual wards, , discharge support, musculoskeletal (MSK) and rheumatology programmes, dermatology services.*
- *Unlike the episodic nature of elective and emergency care, community care is often multi-layered and ongoing.*
- *Community care support is often provided over the longer term, and most frequently to children, older people, and those with chronic conditions, or those nearing the end of their lives.*
- *Services are delivered in a multitude of settings, including in people's own homes, community clinics, community centres, schools, and care homes, as well as hospitals.*
- *As many as 70% of community health services are provided by non-NHS organisations, independent providers alongside voluntary groups and social enterprises'.*
  Community Health Services: what does good look like? Independent Healthcare Providers Network

For the past five years the NHS has been adding headcount for specific primary care roles in ARRS teams

- ***'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.

ARRS was introduced to expanding primary care capability. It could be a foundation for future community care

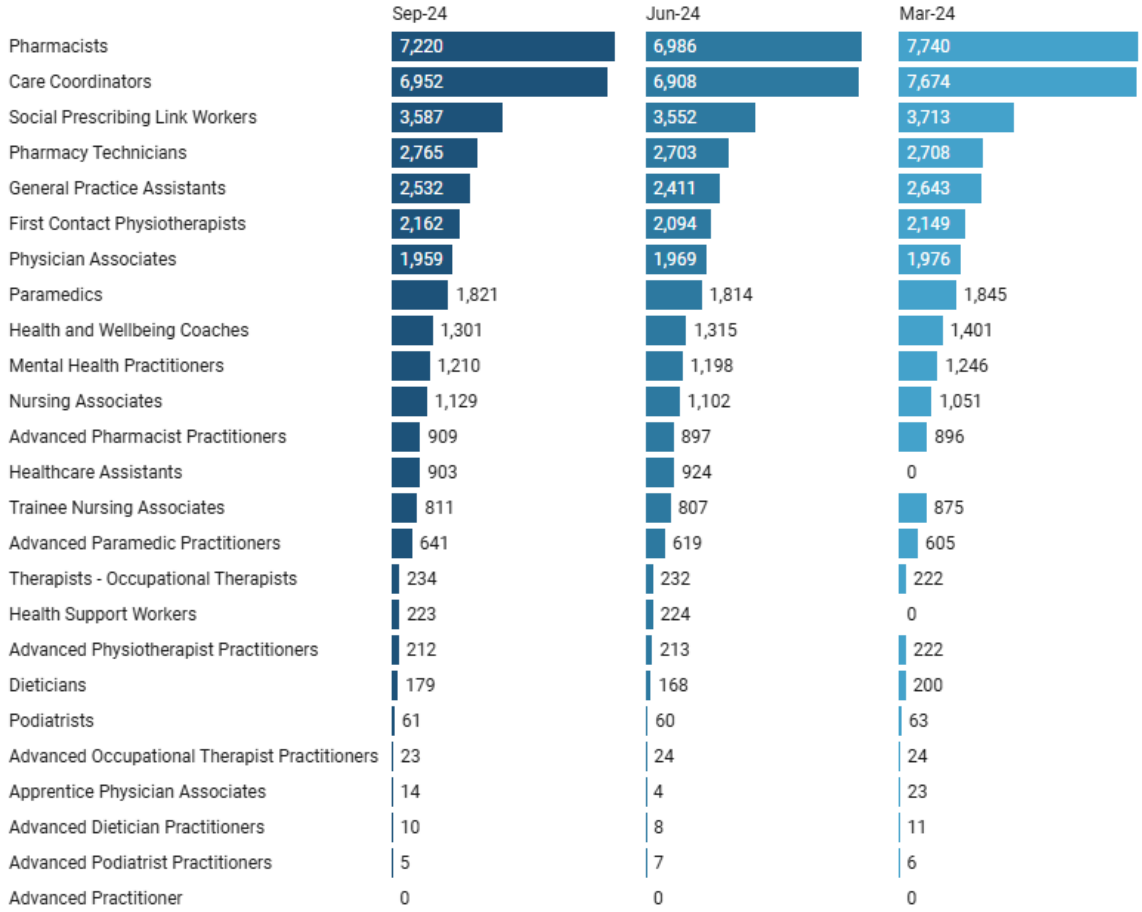
- *'The Additional Roles Reimbursement Scheme (ARRS) was introduced in response to government manifesto commitments to improve access and workforce pressures in primary care. The benefits of the ARRS are evidence that the new roles have a place in the future of primary care.*
- *In 2019 the scheme was launched with the commitment to introduce 26,000 extra staff into primary care practice by 2023/24. Initially, primary care networks (PCNs) could choose from five roles. Over time the list has grown to 17, many of which had not previously been available within primary care. PCNs can recoup the employment costs of these roles from the scheme up to their allocated funding allowance, based on the size of the patient population. The additional staff were intended to see patients who would otherwise have seen a GP but did not require a GP intervention. As a result, GPs would have increased capacity to provide appointments to those patients who required a GP or would benefit from greater continuity of care.*
- *ARRS staff have, enabled the development of new ways of working, such as multidisciplinary working and integrated neighbourhood teams in primary care. Flexibility for local leaders to select the roles they need will be key to the future of the ARRS and the continued development of new services which are tailored to local needs'.*

NHS Confederation, Assessing the impact and success of the Additional Roles Reimbursement Scheme, Feb 2024.

The AARS workforce is diverse delivering a range of primary and community care services

There were 36,862 staff working through ARRS as of 30 September 2024, compared to 37,294 at the end of March.

Primary care workforce, ARRS roles September 2024



NHS England, September 2024.

Is there true co-ordination between hospital community services and practice ARRS schemes?

- The RSFT says it delivers the range of community services, those in the first column.
- ARRS services, delivered by PCNs are in column two, but how much is provided by PCNs is not known.
- How well are the two organisations' services co-ordinated for best outcomes and lower costs?

RSFT delivered community services

- District Nursing
- Proactive Care Service
- Tissue Viability Service
- Multiple Sclerosis Specialist Nurse
- Parkinson's Nurse Specialist
- Heart Failure Service
- Continence Nurse Specialist
- Speech and Language Therapist

Intermediate care

- Urgent Community Response
- Hospital at Home
- Community Therapy Team

Place based care

- Milford Integrated Care Hub (MICHub)
- Musculoskeletal physiotherapy
- Podiatry service

ARRS staff

- Clinical pharmacists
- Pharmacy technicians
- The social prescribing link worker
- Health and well-being coaches
- Care co-ordinators
- Physician associates
- First contact physiotherapists
- Dieticians
- Podiatrists
- Occupational therapists
- Nurse Training Associates
- Nursing Associates
- Community Paramedics
- Advanced Practitioners
- General Practice Assistant
- Mental Health Practitioners (Adults and children)
- The Digital and Transformation Lead

Also, are there overlapping local care providers which might be merged into a single delivery organisation?

- We're looking for a situation in Guildford where the care of patients with complex needs would come under the control of a principal provider.
- There is a significant overlap between local hospital and community care providers, see these details from their websites:

RSFT Specialty (selection)

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

Procare Community Care (selection)

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

- Later in this presentation, we make the case for establishing a Single Point of Access.

The RSFT has a control centre for community care. Does Procare have a separate one?

Community Co-ordination Centre:

- *'The Community Co-ordination Centre (CCC) is a single referral point for health and social care professionals to refer local residents registered with a GP in Guildford and Waverley.*
- *Once we have received the referral, we will assess each individual and co-ordinate the appropriate community services to support the patient's health and wellbeing to enable to patient to remain in their own home and to prevent any unnecessary admissions to hospital.*
- *To access the service would be through a referral from your GP, health or social care professional or following a discharge from hospital.*
- *You are able to refer yourself by calling the Community Co-ordination Centre on 01483 362 020*
- *When your referral is received either by email or phone, an administrator will ensure we have taken a detailed history of your health concern to enable the clinician to identify the appropriate services to support you.*
- *The identified service will then contact you to arrange an appointment.'* ***Procare.***
- *Procare says: 'We provide adult community nursing services 24 hours a day, 7 days a week, 365 days a year.*
- *Our Community Matrons, District Nurses and Community Night Nursing Team provide nursing care, support, advice and treatment for people in their own homes.*
- *To contact the service, your GP or hospital will refer you into the community co-ordination centre.*
- *The referral will then be processed by our team of clinicians and prioritised according to urgency and clinical need.*
- *If you need to contact the CCC please call 0300 303 9513 from 8am - 8pm. Between 8pm - 8am please contact 07771 772180.'*

An expanded community care capability will need coordination and its own organisation

- A merger of traditional ‘community care’ and AARS teams seems inevitable, and a good idea.
- AARS has expanded under PCN and GP control.
- GPs have never been expected to run large, complex businesses.
- *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.*
- *‘Despite PCNs now delivering new services, their development has not been uniform, with success often being dependent on local factors. This means that systems have a role to play in promoting integration in Places through primary care leadership, providing supporting infrastructure and committing to transformation both in empowering PCNs themselves and in recognising that PCNs – as the ‘building blocks’ of ICSs - are the transformation that underpins all others*’. **NHS Confederation**
- But these are operating units with their own limited, separate managements.
- Who will bring it altogether and pay for it?
- Especially, as ICBs’ future structures are also uncertain.

Community care contracts need better supervision and improved KPI monitoring

- Commissioners have always struggled to engage with the long tail of providers- charities, voluntary organisations, CICs ?, etc - who usually deliver bespoke, one-off services.
- A re-organisation of community care would require a complete review of current contracts, many of which do not have
- For the majority of contracts, there is no published management information about performance standards, KPIs or other metrics.
- Terms and Conditions are often invisible, kept in the ‘black box’ of commercial confidentiality.
- Many contracts have been remunerated on a block contract, usually on a last year plus basis with no resort to performance monitoring.
- This practice might transition to a blended payment system (Aligned Payment and Incentive or API) that combines fixed payments with variable, activity-based elements.
- Data on the quality of delivery and outcomes should also be collected by commissioners.
- Individual patient cost data is managed in the PLICS system.

Contract design is a key lever to expand community care

ICBs must take a whole ‘market’ view of their local health economy. All options should be considered

- *‘For ICBs to become sophisticated and intelligent health care payors, they must build capacity and capability across all areas of the strategic commissioning framework. This includes assessing need, applying health care economics (for example, cost per patient per year) to manage markets, and developing expertise in strategic purchasing, contracting, payment design and oversight, utilisation management, resource allocation and evaluation. They will also require commercial skills to support innovative contracting and the management of new provider relationships.*
- *focusing on commissioning for improved quality, defined as improved experience, safety and outcomes as well as equity of access based on population groups and agreed priorities, as opposed to prescriptive operational design, which providers should lead on. This should include horizon scanning to understand new developments and innovations that may help deliver agreed priorities.* **Strategic commissioning framework, NHS England, November, 2025.**

Integration, yes, but NHS England is encouraging more provider diversity, competition even

- Until recently, the NHS England focus was on collaboration as the way to manage markets.
- The 10 Year Plan encouraged ICBs to create a ‘diversity and plurality of providers to drive performance and innovation, and improve quality and value’.
- A diverse provider landscape is seen as a way to ‘encourage innovation and prevent the system from being bound by traditional service arrangements’.
- ICBs have been asked to strengthen their local provider markets by using independent (private) providers, and the voluntary sector, rather than sticking to traditional NHS only models.
- We still see institutional resistance.

The NHS says its objective is to take a market approach, finding the best provider for the required service

- *'Commissioners should also recognise provider diversity – for example, VCSE organisations reliant on grants may need longer-term investment and certainty to modernise. Active management and improvement approaches are required to maximise national primary care contracts (dental, optometry, pharmacy and general practice) for local benefit.*
- *Commissioners must understand contractual and legal frameworks and be able to use the PSR to secure system goals. This may involve contracts that bind providers together, share risk and distribute leadership responsibilities. ICBs also need the skills to actively manage and oversee contracts, applying levers to address quality and performance issues and intervening where necessary to support services to turnaround. ICBs will need to use active management and improvement approaches to maximise the nationally agreed primary care contracts (dental, optometry, community pharmacy and general practice) for best outcomes for the local population. Local procurement strategies should consider how supply chains and small and medium enterprise providers can promote social and economic development, drive inclusive growth and reduce inequalities.'*

NHS England Strategic Commissioning Framework, November 2025.

The ICB should stimulate the market by creating bundles of new community provided contracts

- Moving care out of hospitals into the community could be promoted through the imaginative use of NHS contracts, drawn up by either the ICB or a trust hospital.
- A range of contract formats have been developed by NHS England. All can be adapted to local market circumstances.
- One of these is for GP practices or other organisations to operate under an 'Any Qualified Provider' contract.
- Private and voluntary sector organisations can also bid to deliver elective and community services.
- AQPs must meet NHS quality standards and accept the PbR price tariff for the specific medical service.
- Commissioners have some flexibility to increase contract prices locally, which could be used to improve the incentives required to make moving particular services into the community more attractive to bidders.
- Much as some might resist the description, this could lead to the establishment of a local marketplace for a range of therapies, diagnostics and procedures.

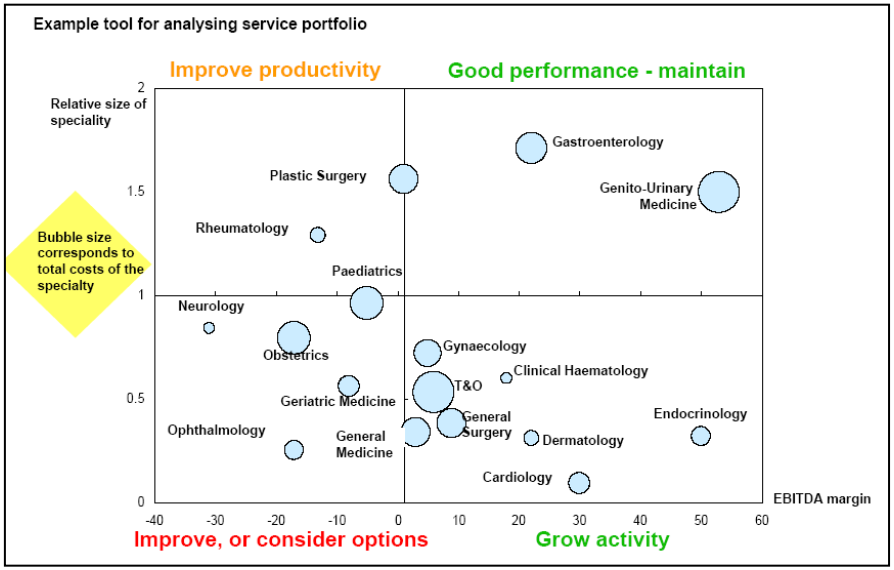
There are an increasing number of contract options which can be used for community care projects

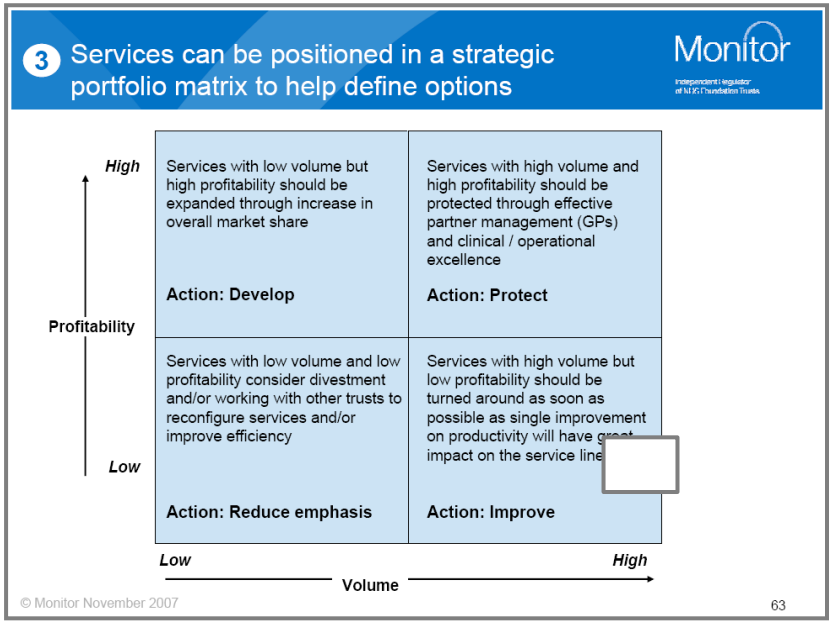
NHS England contracting advice says:

- *'It is becoming increasingly common for a provider (the "Head Provider") to sub-contract delivery of certain clinical services to a third party (the "SubContractor"). It can be the sub-contracting of an entire service or of delivery of part of a care pathway. It can be an isolated subcontracting by the Head Provider to a single Sub-Contractor, or the sub-contracting of a range of services to multiple Sub-Contractors under a prime contractor/lead provider (these terms are interchangeable) commissioning model.*
- *The APMS contract offers greater flexibility than the other two contract types. The APMS framework allows contracts with organisations (such as private companies or third sector providers) other than general practitioners/partnerships of GPs to provide primary care services.*
- *APMS contracts can also be used to commission other types of primary care service, beyond that of 'core' general practice. For example, a social enterprise could be contracted to provide primary health care to people who are homeless or asylum seekers. In 2018/19, 2 per cent of practices held this type of contract.'*

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

- RSFT is probably not optimising its business mix.
- A move to greater participation in local integrated care needn't diminish the RSFT capability to raise revenues. In fact, it could do the opposite.
- 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 ICBs.
- Which procedures/episodes of care make a profit and which a loss?
- This technique, SLM – introduced by NHS Monitor 20 years ago - has been used across FTs to determine 'profitability'.
- What would the Royal Surrey want to transfer out?





GPs deliver services under AQP contracts. So could other entities

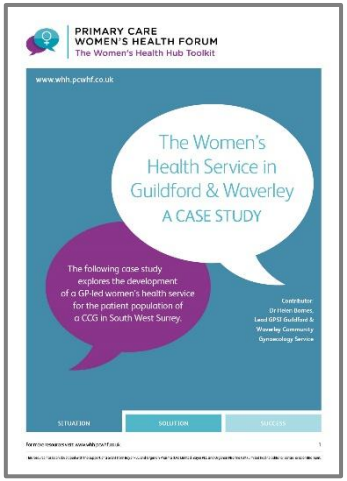
- An Any Qualified Provider (AQP) NHS contract allows non-NHS organisations—including private, third sector, or social enterprises—to provide NHS services if they meet specific quality standards and accreditation.
- Key aspects of the AQP contract system include:
  - Quality assurance: providers must meet pre-defined NHS quality standards and be accredited before joining the provider list.
  - Choice: patients can choose from a range of qualified providers for specific services in community settings (e.g., musculoskeletal care, audiology).
  - This empowers patients to choose their provider, encouraging competition based on service quality rather than price, with providers receiving a fixed, standard tariff.
  - Fixed pricing: there is no price competition; all providers are paid the same contract national or local tariff for services.

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

- 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.'* **Pulse.**
- There are a range of specialties that are classed as extended roles, for example:
    - Minor surgery
    - Dermatology
    - Frailty
    - Mental health
    - Allergy
    - Cardiology
    - Sports medicine
    - Musculo-skeletal
    - Women's health
- The ICB told us in April that *'initially we are focussing on 10 specialities with the greatest opportunity for improvement and will be reviewing pathways to ensure we are maximising opportunities to deliver more care in the community'.*

The Shere women's health hub initiative is probably the model for expanding GP contracts

- This programme has all the key attributes of a programme led by GPs 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]'.* **Practice website.**



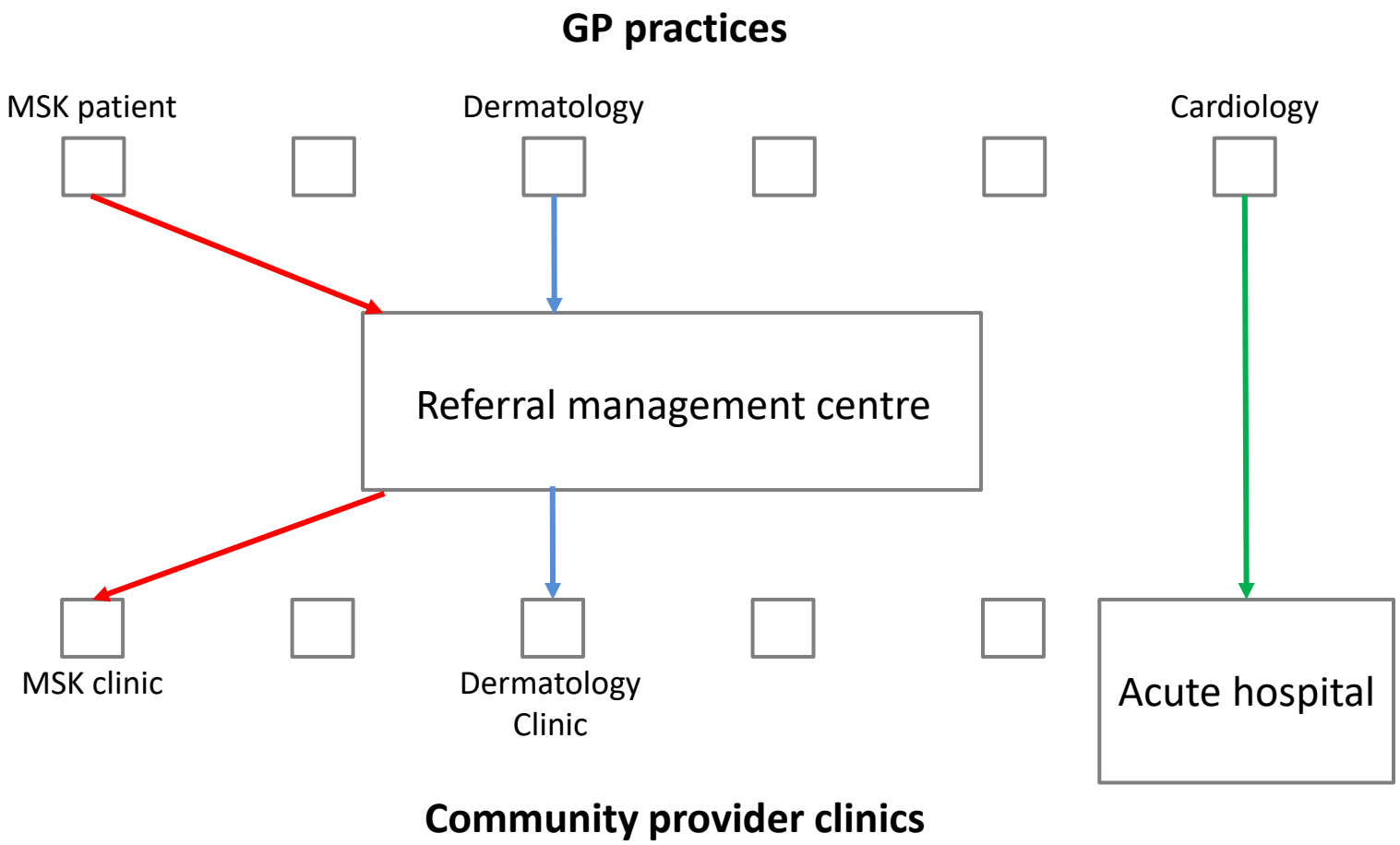
Hospital consultants are also looking for more flexible working options. They can be partners

- *'Almost two thirds of NHS consultants are keen to work for the NHS's online hospital when the revolutionary service launches next year, a new poll has revealed.*
- *Six in ten consultants (60%) said they would be interested in working for NHS Online alongside their current NHS roles – many more than will be needed to run the service.*
- *The survey of nearly 300 consultants and specialist doctors also found that nearly half (48%) would be willing to offer at least four hours a week of their time, with the opportunity to care for patients innovatively, work flexibly and improve patient experience among their top reasons for wanting to sign up.*
- *NHS Online, which will see its first patients next year, is expected to deliver up to 8.5 million virtual appointments and assessments in its first three years – four times more than an average NHS trust.*
- *Earlier this year, the NHS announced that nine common conditions, including menopause and prostate problems, would be the first to be treated by the NHS Online service when it launches.*
- *More patients are now set to benefit as it will also be available to people with recurring urinary tract infections or suspected polycystic ovaries – in addition to the nine conditions previously announced.'* **NHS England, 25 March 2026**

Referral management centres can regulate the flow of patients to hospitals, reducing demand

- RMCs operate as an administrative and clinical filter to manage demand on hospital outpatient clinics.
- When a GP decides a patient needs to see a hospital specialist, the referral is sent via the NHS e-Referral System to the RMC first rather than directly to the hospital.
- This is already a feature of the Medicus system.
- A team of clinicians at the RMC reviews the notes to see if the patient needs a referral to a hospital consultant, or if they could be managed in the community. They also ensure all required blood tests or scans are attached before the hospital receives the file.
- e-RS acts as the electronic gateway into the hospital. Once a referral is successfully booked via e-RS, the patient's data is transferred into the local hospital's Patient Administration System (PAS) to initiate this segment of their care pathway.
- See over.

Protocols determine the routing of patients



Having the SPoA and Referral Management Centre co-located enables the better allocation of care resources

Feature	Referral Management Centre (RMC)	Single Point of Access (SPoA / SPA)
Primary Purpose	To manage, triage, and control the flow of elective (routine) outpatient referrals to hospitals.	To provide a single, simplified entry point for urgent community, mental health, or social care.
Typical Focus	Physical, elective hospital specialties (e.g., orthopaedics, dermatology, physiotherapy).	Mental health services, adult social care, and urgent community response teams.
Pace of Care	Routine and scheduled care. Processing can take days or weeks.	Urgent or crisis care. Often operates 24/7 with rapid turnaround (sometimes 2 to 4 hours).
Key Function	Clinical triage to ensure referrals are appropriate, complete, and routed to the right clinic.	Multidisciplinary triage to coordinate immediate care and prevent unnecessary hospital admissions.
Who Can Use It	Primarily GPs and medical referrers.	GPs, paramedics, police, social workers, and sometimes patients directly (self-referral).

NHS England

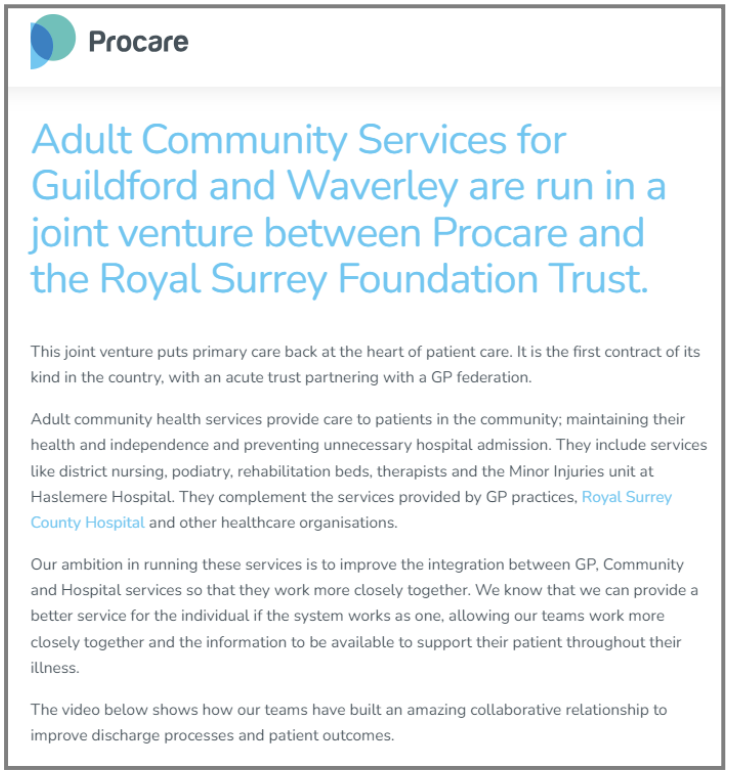
It’s time to relaunch the RSFT/Procare joint venture

We asked Google AI for a review of the Procare joint venture

- *'The Royal Surrey Procare joint venture is a health care partnership designed to integrate acute hospital expertise with primary local care across Guildford and Waverley.*
- *Procare and Royal Surrey now co-manage integrated care for a population of over 220,000 residents across the region.*
- *Formed between the Royal Surrey NHS Foundation Trust and Procare Health (the local GP Federation representing 19 local practices), it represents one of the first times an acute trust and a GP federation co-managed community services.*
- *The Royal Surrey holds the overarching regional contract for community health services. Procare operates via a strategic sub-contract from the hospital to run the adult community nursing division directly.*
- *Community staff are employed under Procare but retain NHS Agenda for Change terms. They also gain dual access to the Royal Surrey NHS Foundation Trust benefits, training, and development pipelines.*
- *Teams of District Nurses, Community Matrons, and Healthcare Assistants manage wound care, palliative treatment, and long-term illnesses at home.*
- *Night Response Service: A dedicated overnight mobile team provides emergency catheter care, injections, and end-of-life comfort to prevent middle-of-the-night A&E admissions.*
- *Care Home Matron Service: Specialist matrons work directly inside local residential and nursing homes to reduce patient falls and avoid unnecessary ambulance call-outs'.* **RSFT website.**

We see the starting point as a reworking of the nine year old Procare/RSFT JV

- This was the first contract between a trust hospital and GP federation to deliver community care.
- ‘All NHS provider trusts are expected to be part of a provider collaborative’. **NHS England.**
- The nine year contract duration creates the opportunity for system continuity and a refresh.
- It should be adequately funded to ensure sustainability.
- There is a further contract option open to the Royal Surrey. The Integrated Care Provider (ICP) Contract enables commissioners to award a single contract to a provider that is responsible for the integrated provision of general practice, wider NHS and potentially local authority services. This can only be awarded to a statutory body like a Foundation Trust.



Procare

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

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

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

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

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

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

- This partnership represents a unique starting point, possibly for the NHS as a whole.
- Guildford should not give away this hard-won advantage.
- That the contract would last for nine years provided the space for continuous development.
- Despite a sterling achievement during Covid, most observers would probably agree that it has failed to deliver its full promise.
- No details of the contract seem to be in the public domain*.
- Its future financing should not exclude creative solutions, combining with other proposals in this presentation.
- Properly developed, the project should create usable IP and learning for transfer across the NHS.

* Was the partnership created under the NHS Standard Contract (integrated Care Provider) Contract which enables GP practices(in a federation or PCN) to collaborate with a lead provider NHS institution like the Royal Surrey?

The Procare experience means that a ‘cold start’ is avoided

- The creation of the RCSH/Procare JV has created the foundation to introduce new ways for delivering Guildford’s health care.
- Our view is that it should be moved on. This would begin with the establishment of a focussed, new legal entity with a clear remit.
- Procare’s ability to mobilise and deliver the Covid-19 vaccination programme shows its potential.
- It has an already built comprehensive support and back office capability.
- This means that it should be able to scale-up operations quickly.
- What now needs to be established is the appetite amongst local GPs – and hospital clinicians – to deliver these solutions.
- We recognise that views will be different across a population which already has limited heterogeneity.
- This means that within subsidiary contracts there should be a range of options for remuneration and trading entities, either for-, or not-for-, profit.
- If necessary, all set-up work should be funded as an R&D project - which it is.
- Imaginative contract development will be a critical competency going forward.

Other commissioners are experimenting with contract design

- *'NHS England has now approved Kent and Medway ICB's request to offer GPs a local variation to the Network Contract Direct Enhanced Service (DES) that will deliver GP-led single neighbourhood care through the existing PCN arrangements.*
- *At the heart of the offer is significant new investment in general practice.*
- *By providing proactive, wraparound care in patients' own homes or usual place of residence, the model aims to improve outcomes and reduce unnecessary hospital admissions.*
- *This is intended to simplify arrangements, reduce fragmentation, strengthen continuity of care and unlock nearly £10 million of new annual investment to support patients with the most complex needs across Kent and Medway.*
- *The initial focus of the new neighbourhood health model will be around 92,000 patients in the most complex care cohorts, including care home residents, people on palliative care registers, and housebound patients living with severe frailty.*
- *Although this group represents around 5 per cent of the Kent and Medway population, they account for around 30 per cent of hospital admissions and often experience longer hospital stays.*
- *For these patients, practices will provide proactive interventions such as:*
  - *advance care planning discussions*
  - *comprehensive geriatric assessments*
  - *structured medication reviews.*
- *It is the first use of this power nationally. The new contract offers retains existing GP core contracts'*. **ICB website.**
  Investing in neighbourhoods - Kent and Medway launches new PCN DES Local Variation contract offer to deliver Neighbourhood Health | News | ICB

Population health management means managing patients one by one

Population health management is central to the delivery of the 10 Year Plan. Individuals make up all populations

Over the past few years, the Society's main concern has been how the health care condition of people living in north Guildford might be raised through the improvement of investment in community health facilities.

But population wellbeing can also be addressed by other actions. We have in mind, for example, how health care services can be better targeted and personalised to meet the specific needs of individuals, particularly those with challenging medical circumstances.

We are in a time of rapid technological transformation. Many industries are being rethought, driven by the sudden ability to access information and processes which significantly change the ways current services are delivered and consumed. We are, of course, referencing AI and machine learning.

Health care is conservative and slow to adopt innovation and new practices. The NHS is also an organisation which is not set up to be a radical leader of change. But the societal pressures on health care systems of having tight finances while needing to meet the more complex needs of an ageing population call for urgent attention.

In this section, we look at how improved data availability and processing can make a fundamental difference.

Later, we will show how well Guildford is set up to exploit these opportunities.

What will NHS England do to drive Population Health Management? It says…

- *'ICBs will use joined-up, person-level data and intelligence (including user feedback, partner insight, outcomes data, public health resource and insight) to develop a deep and dynamic understanding of their local population and their needs now and in the future, and the biological, psychological and social drivers of risk and demand, proactively identifying underserved communities and assessing quality, performance and productivity of all existing provision.*
- *[This will deliver an] in-depth understanding of the population's drivers of risk and demand across biological, psychological and social factors and including health deterioration and inequalities in access to health and care'.*

NHS England, Strategic Commissioning Framework, Nov 2025

Every PCN will utilise population health management to identify patients' needs

PHM can give the NHS the clearest view of the patient load on local systems – the demand side of the health economy. PHM is a data-driven approach involving four key steps:

- understanding the population, using linked data from primary care, hospitals, local authorities and other services to build a comprehensive picture of the health needs of a specific population This helps identify patterns, risk factors and areas of unmet need.
- identifying specific needs: analysing the data to pinpoint specific cohorts of people who would benefit from targeted interventions. This would include individuals at high risk of a certain condition, specific age groups or residents in certain geographical areas facing particular health challenges.
- co-designing and implementing tailored services and support for the identified groups. These interventions are often proactive and preventive, delivered by integrated teams in the community, rather than relying solely on hospital-based care.
- continuously monitoring the impact of the interventions and adjusting the approach based on the outcomes to ensure effectiveness and value for money.

Population health management will promote the decentralisation of patient care

- Historically, the practice of public health has focussed on protecting and improving the health of populations through organised, collective action, rather than the treatment of individuals.
- It has concerned itself with preventing disease in areas such as sanitation, vaccination, health education, and environmental regulation. This is a proactive approach focusing on population-level health rather than reactive medical care for individuals.
- Information has been assembled in a generalised way to address issues at a population level.
- Consequentially, medical care has been organised in a rather centralist, top down arrangement through *general* practitioners and *general* hospitals. This will change as the government drives through its neighbourhood health initiative.
- This is unlike many other areas of consumption, where the starting point for service provision is not at a population level, but understanding the granular circumstances of the individual and crafting a solution for him or her which is as close as possible to matching their particular needs. This is now delivered mostly through social media.
- The NHS understands segmentation and stratification. But only up to a point. What it needs to do is to go down to a segment of one.

Segmentation can take you through different population strata – by disease group, locality, cost and many more

- *Understanding population need is fundamental to service planning but can be daunting when faced with populations of millions of people.*
- *Segmentation is one tool to support improved understanding of population need by dividing the population into more manageable chunks or segments, where each segment has relatively similar healthcare needs and priorities:*
- *The set of population segments must be limited to a manageable number if the healthcare system is to offer a sensible array of integrated services for each segment*
- *The set of population segments should be broad enough to include everyone, that is, at every point in their life, every person should fit into one of these categories, and there should be no individuals who do not fit into a segment*
- *The people in each population segment must have similar health care needs, but each segment must be different enough to justify separate consideration, for example under 5s, and over 80s, are groups which have very specific and different needs*
- *By planning and delivering care that responds to the needs of different segments, and by integrated working, the endeavour is to optimise patient outcomes, improve patients' experiences of services, and reduce costs per patient.*

NHS England, April 2025

Managing the patient, rather than the condition, would transform care delivery. We advocate a segment of one

- *'Overall, patients with no chronic (long term) LTC conditions contributed to 23.3% of the total secondary care costs, patients with one chronic condition to 21.4% of the total costs, patients with multi-morbidities, 55.3% of the total costs.*
- *Hypertension was the most prevalent morbidity recorded in over a quarter of patients (26.5%). Diabetes (11.6%), chronic kidney disease (10.3%), and asthma (9.5%) were next most common.*
- *In terms of costs, patients with hypertension contributed to 41.3% of total costs of secondary care, followed by chronic kidney disease (24.3%), both higher than the total contribution of those with no conditions.'*
  Multimorbidity combinations, costs of hospital care and potentially preventable emergency admissions in England: A cohort study, Jan 2021.
- Managing patients with LTCs in the community will reduce vastly hospitals' costs.
- Treating them in the GP practice would be covered only by capitation costs and would impair the practice business model.
- Care providers should be appropriately compensated.
- Recognising risk and reward will be part of the future renumeration system.

Risk stratification has never been continuously maintained as a commissioner initiative. There are many reasons:

- Predictive accuracy: occurrences of false positives (intervening when not needed) or false negatives (missing at-risk patients) temper engagement and diminish participant confidence.
- Data quality issues: current systems do not rely on semantic searching. GP data entries are converted into code which can be subject to misinterpretation. Entries can also be incomplete, skewing search performance.
- Lack of evidence of benefits: some studies suggest that while these tools find the 'right' people, the subsequent preventive interventions are not always effective enough to reduce overall hospital costs.
- The 'trust deficit': patient confidentiality issues have deterred both commissioners and GP practices from engagement despite rigorous rules oner anonymisation.
- Legal protections: the same stakeholders have taken a view to act defensively rather than becoming involved in time-intensive legal or political action.
- Many commissioners - PCTs, CCGs or ICBs - have never had the internal skillsets to maintain this activity and have relied on NHS Commissioning Support Units. You can read about the process here https://www.ardengemcsu.nhs.uk/services/business-intelligence/risk-stratification/
- Staff turnover, loss of expertise, management priorities are also factors.
- CSUs are being disbanded by DHSC as part of the closure of NHS England.
- Support resources will be is short supply. Guildford and Waverley should understand this and act accordingly.

We see using the tried and tested ACG system as the starting point for GP risk stratification exercises

4.1 Case Finding – Supporting Management of Individual Patients

The ACG System is a patient-centric measure of health status such that each ACG includes individuals with a similar pattern of morbidity and expected resource use. This information can be used to describe how a population is stratified and combined with the outputs of the predictive models, it can be used to find patients who may be suitable for care management programmes such as those targeted at avoiding unplanned admissions.

The ACG System can also be used to identify patients from any level of this pyramid based on user-defined criteria. The following are examples of the type of case finding techniques people are using.

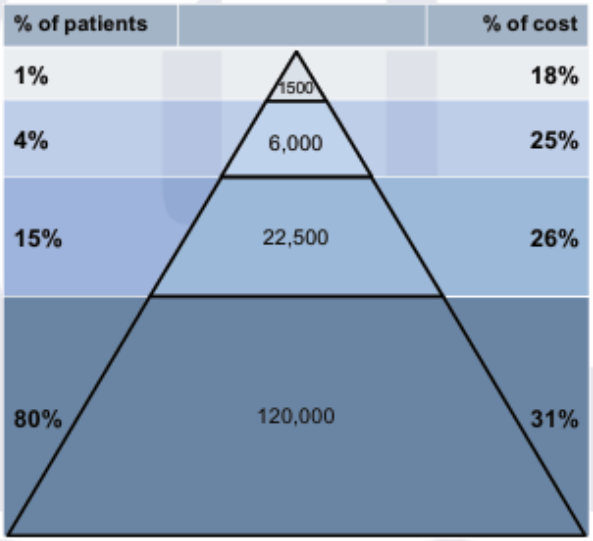
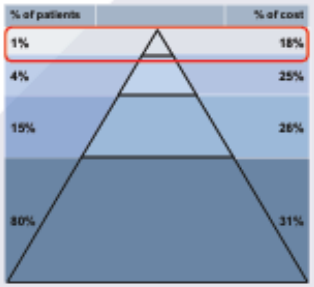


Figure 5 - Risk & Cost Distribution for a CCG

Example 1 – Unplanned Hospital Admissions



Up to 1,200 GP Practices across more than 40 CCGs use the risk of emergency admission predictive model to identify the top 2% of adult patients most at risk of an emergency admission. These patients can then be reviewed at multi-disciplinary meetings and a care plan developed to provide the right health or social care input to prevent admission to hospital.

- The Johns Hopkins ACG System combines data from an array of sources, identifying risk and tracking patients over time. The ACG combines a population-level perspective with patient-level behaviours and conditions.
- The ACG System can handle complex health care information flows, disparate data sources and diverse coding standards. It uses data from individual patients' primary and secondary care records and can incorporate non-clinical data sources, such as socio-economic or functional living status.
- The ACG System's suite of tools uses predictive modelling to identify high-risk patients and potential future health care costs and utilisation.

Both Sussex and Frimley can bring their analytics experience to the new ICB

Frimley ICB's Advanced Population Health Analytics and Tools

'The team already had in place robust population health management analytics to identify patients and had also rolled out remote patient monitoring. They use Graphnet's advanced population health tools to identify and target their most complex and frail patients. Connected Care integrates with the Johns Hopkins ACG® System to provide patient profiling. By using the 'Patient Need Group' (PNG) segmentation tool within the ACG System, the team were able to identify and target high risk patients in the area. The population health analytics solution looks at patient diagnoses and patient needs, enabling the Frimley team to identify and target high risk patients in the top two PNGs that are comprised of the most complex patients.'

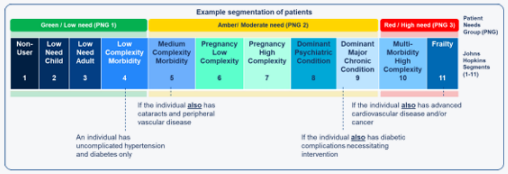
https://www.hopkinsacg.org/wp-content/uploads/2023/07/Use-of-Patient-Need-Groups-PNGs-to-Supportive-Innovative-Care-Programmes-in-Frimley-ICS-July-2023.pdf

Across Thames Valley, we can understand more about our patients' needs and how people use our healthcare services through linking data across our acute, mental health, community and primary care services. This is collated in the Thames Valley and Surrey (TVS) shared care record.

Using the Johns Hopkins ACG (adjusted clinical groups) system we can describe cohorts of patients based on the complexity and acuity of their healthcare needs. This approach is an analytical technique to help understand how disease and morbidity are distributed within a population.

The purpose of the approach is to group segments of a population who share similar needs and will benefit from the similar types of intervention or treatment. The resulting analysis can inform the design of care to help achieve the aims of improved quality, better outcomes and lower cost.

We have understood and modelled our population according to the 11 Johns Hopkins patient needs group (PNG) segments which allows a better understanding of variation and resource use across different points of delivery, and to forecast how healthcare trends could impact future resource need.



What segmentation of our population tells us

- As people get older, their complexity and level of need also both increases as shown by the green, yellow and red groupings shown in figure four.
- Using QOF (Quality and Outcomes Framework) registers it is possible to see this trend more clearly, that people in the higher need groups have greater prevalence of comorbidities and conditions such as hypertension, cancer, coronary heart disease and COPD compared to patients in the Moderate Need group.
- This analysis outlines the case for us to support our Thames Valley population to stay well, and slow the progression of ill health, and where possible develop models of care that provide more proactive, accessible support that reduces people's need for our most acute services.

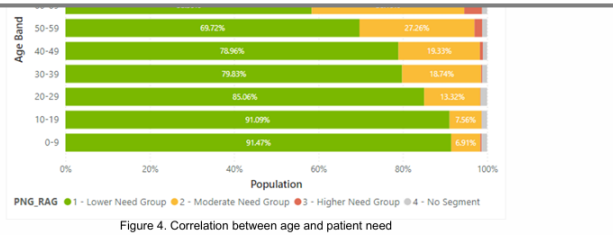


Figure 4. Correlation between age and patient need

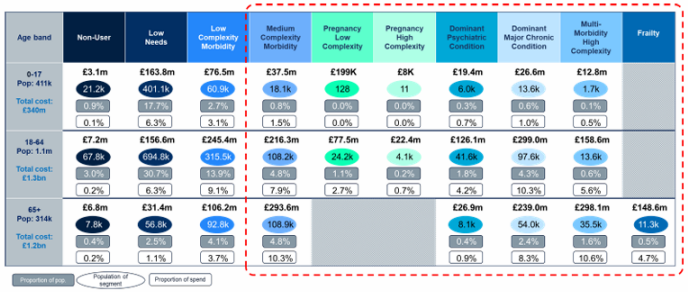


Figure 5. Population profile and resource utilisation baseline as modelled for 2023/24

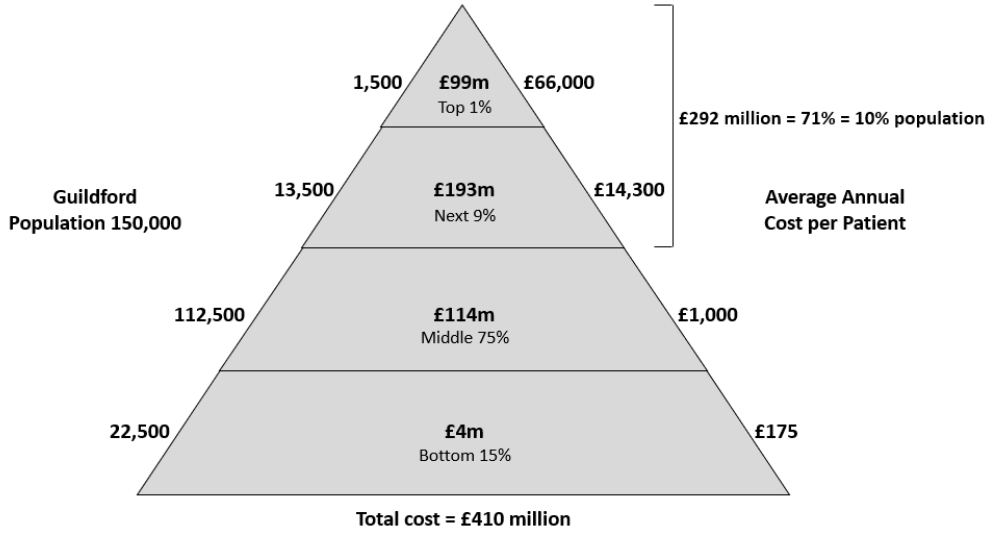
24% of the population who are in the medium and high complexity segments account for **70% of all resource use** in the Thames Valley.

Even more starkly, the **2.7% of the population** who have the most acute needs account for **21% of all resource use.**

All the people at the top of the pyramid will have multiple co-morbidities

- Surrey and Sussex ICB has a budget of £8.32Bn across a population of just over three million, that's an average budget per patient is about £2,750.
- The joint population of Guildford and Waverley is 287,000 producing an estimated total of £790m.
- 16% of patients account for 75% of costs, an average of £12,900 per head.
- About one in four adults has a long-term condition
- For over 60s , it doubles to 50%
- It's two thirds by the age of 75.
- For people with co-morbidities, one third have both a physical and mental health condition.

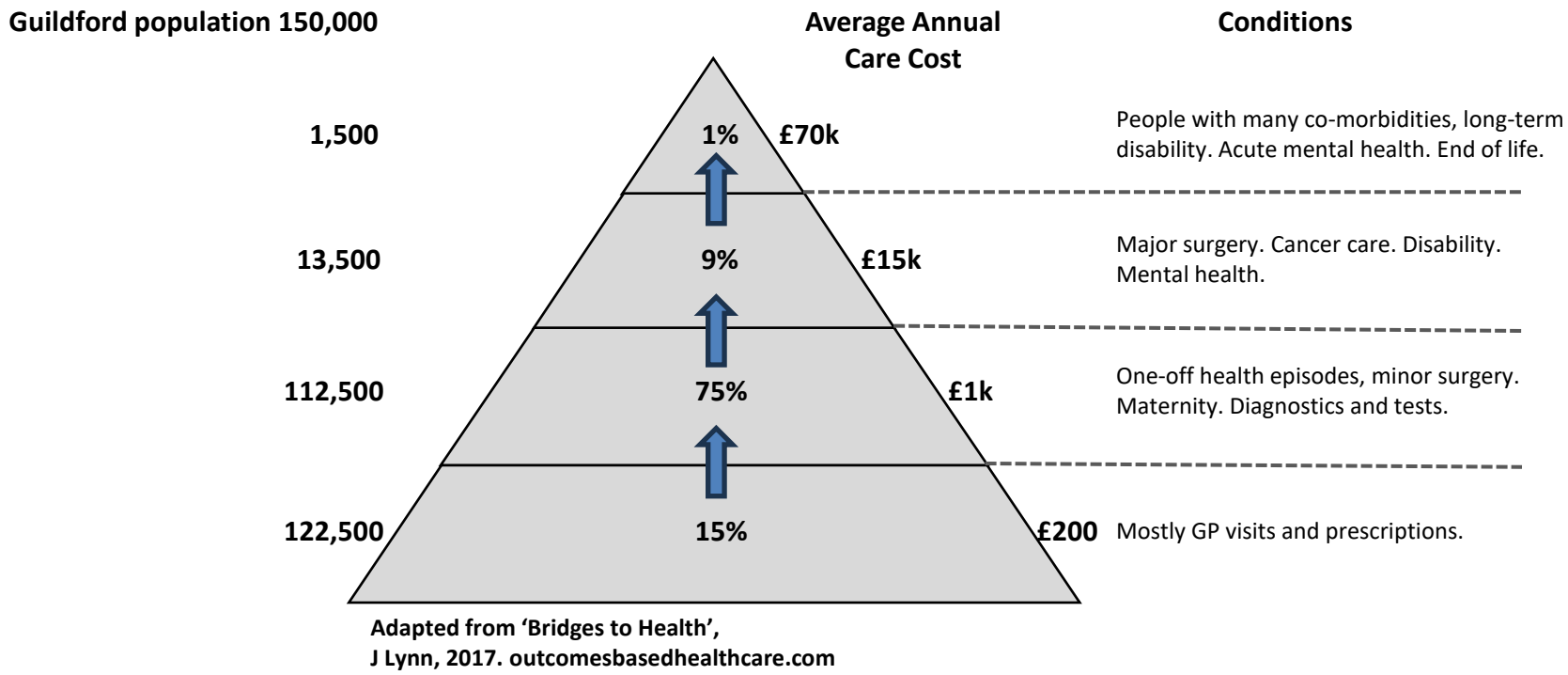
It is a common factor across all health economies that 70% of budgets are consumed by 10% of the population



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 morbidity is any health system's major challenge, including Guildford's

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



- The clear objective of health systems is to reduce this upward movement, to improve population health, slow the rate of morbidity and to lower costs.
- This is how Guildford's c.£500m health budget is distributed.

AI will bring more information, more quickly, to support clinician decision-making

AI assists clinical decision support systems (CDSS) by shifting them from static, rule-based alerts to dynamic, data-driven intelligence.

These systems are able to analyse vast datasets - including medical records, imaging, and genomic data - to provide personalised, real-time recommendations which might reduce human error and improve patient outcomes. through:

- Advanced diagnostics: deep learning models analyse medical images (X-rays, MRIs) and histopathology slides to detect abnormalities, often achieving accuracy comparable to or exceeding specialists in areas like skin cancer classification and lung nodule detection.
- Predictive analytics: machine learning models forecast patient trajectories identifying patients at high risk for events such as stroke and heart failure.
- Personalised treatment: by integrating individual genetic markers, comorbidities, and lifestyle factors, these systems propose tailored treatment plans, rather than relying on one-size-fits-all population averages.
- These systems are able to analyse vast datasets - including medical records, imaging, and genomic data - to provide personalised, real-time recommendations which might reduce human error and improve patient outcomes.

It is the patient data which becomes the new care controller

- Health systems across the world are already seeing how clinical decision support is improved by the machine reading of electronic health data.
- This data is being used to modify clinical guidelines and impact pathway design.
- The information can be used either as physician support or as an aid for patients whereby the latest information received can be analysed, interpreted and turned into alerts, reminders or follow-ups.

'A clinical decision support system (CDSS) is a health information technology that provides clinicians, staff, patients, and other individuals with knowledge and person-specific information to help health and health care. CDSS encompasses a variety of tools to enhance decision-making in the clinical workflow. These tools include computerised alerts and reminders to care providers and patients, clinical guidelines, condition-specific order sets, focused patient data reports and summaries, documentation templates, diagnostic support, and contextually relevant reference information, among other tools. CDSSs constitute a major topic in artificial intelligence in medicine'. **Wikipedia**

Decision support systems can work off the data fed into patient record 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.

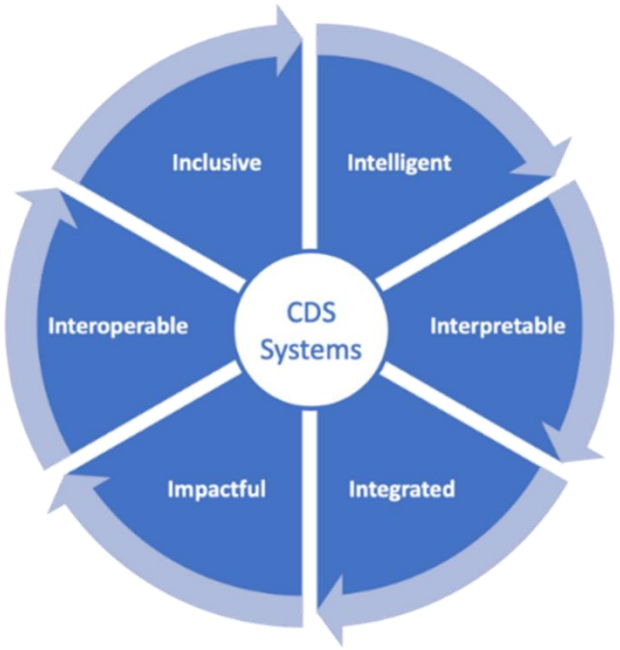
Interpretable: CDS systems need to consider the healthcare professional's knowledge of the topic, use clear and unambiguous content, and demonstrate validity and reliability of recommendations by linking to relevant explanations or evidence.

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.

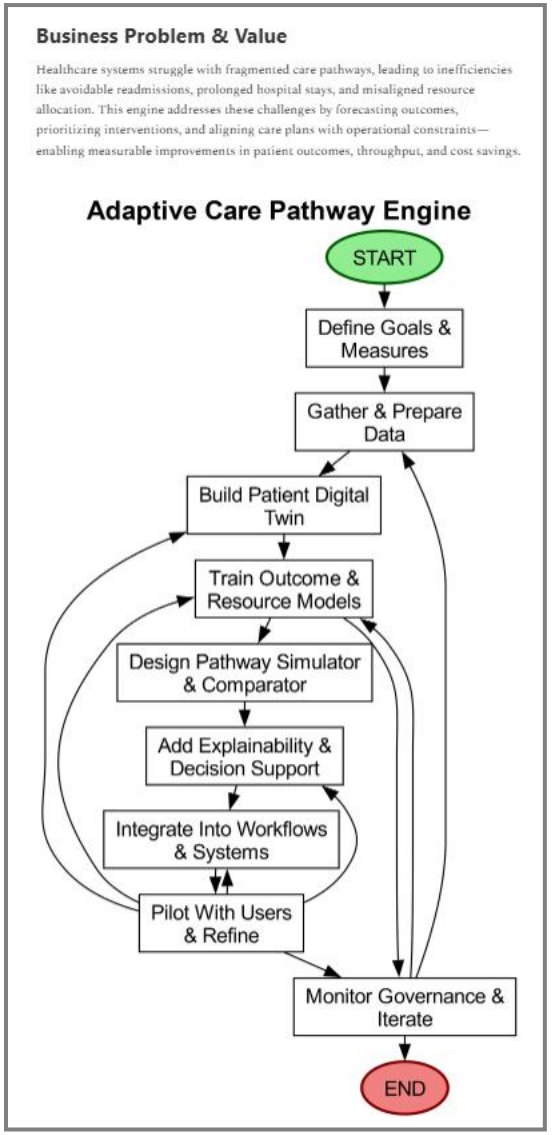
WARNING. AI should never be used on its own for diagnosis or medical decision-making

- AI's diagnostic accuracy varies significantly depending on the task and the type of model used.
- In a major 2025 meta-analysis, AI models performed significantly worse than expert physicians (p=0.007) but were comparable to non-experts and general practitioners.
- Studies using advanced large language models (LLMs) like OpenAI's o1 found they could identify the correct diagnosis in roughly 67% of emergency room cases, compared to 50–55% for physicians when information was limited.
- While specific AI tools often match or exceed human performance in specialised visual tasks like radiology and dermatology, broader generative models still struggle with the complex reasoning required by medical experts
- The highest accuracy is typically achieved when humans and AI work together.
- A ‘human-AI collective’ will compensate for each other's systematic errors, leading to more reliable outcomes than either working on its own.
- AI systems will, of course, only get better.

Every patient pathway is unique

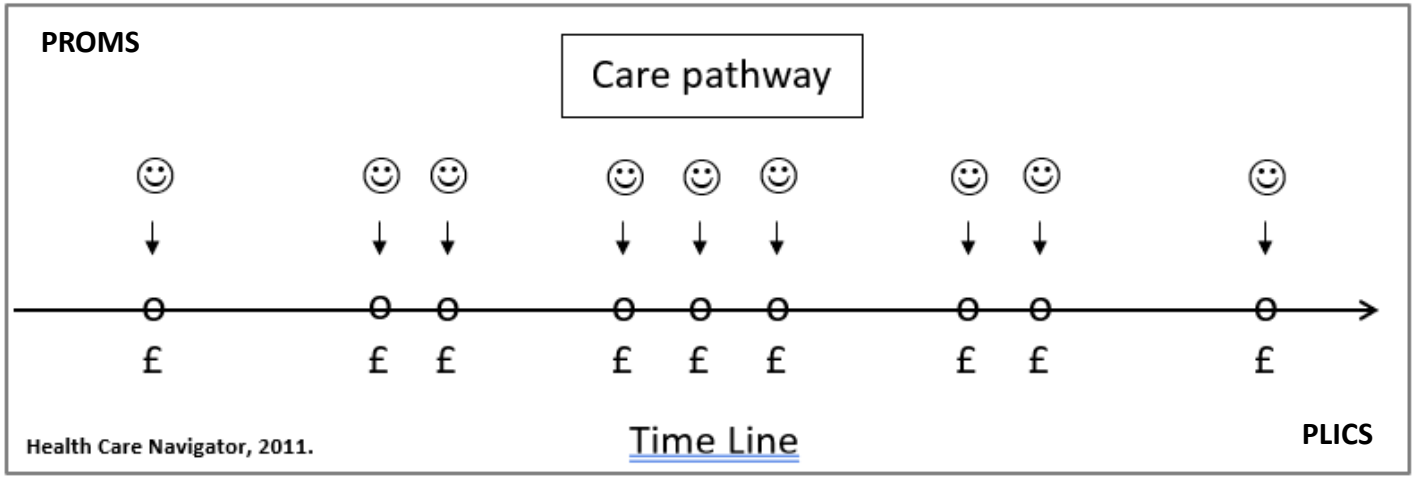
Pathways will become personalised, tailored to the patient's circumstances

- Care pathways detail the essential steps in the care of patients with specific clinical needs.
- Usually, this is an evidence-based process that translates national standards, often developed by NICE, into local delivery programmes.
- Development typically begins with national clinical guidelines from the National Institute for Health and Care Excellence (NICE).
- Local Integrated Care Systems (ICSs), hospital trusts and GP practices can adapt these into operational care pathways.
- Individual patient pathways are then co-designed by a team of GPs, specialists, nurses, therapists and administrators to ensure the plan is feasible across different settings.
- Patients and carers with 'lived experience' are involved to ensure the pathway is person-centred and addresses patients' real-world circumstances.
- *If I look to the future, some of the things that are being developed and coming downstream, like fully automating a care pathway, are phenomenal*'. **Penny Dash, Chair, NHS England, June 2026.**



Data collection and analysis would enable quality and cost to be measured for each episode of care

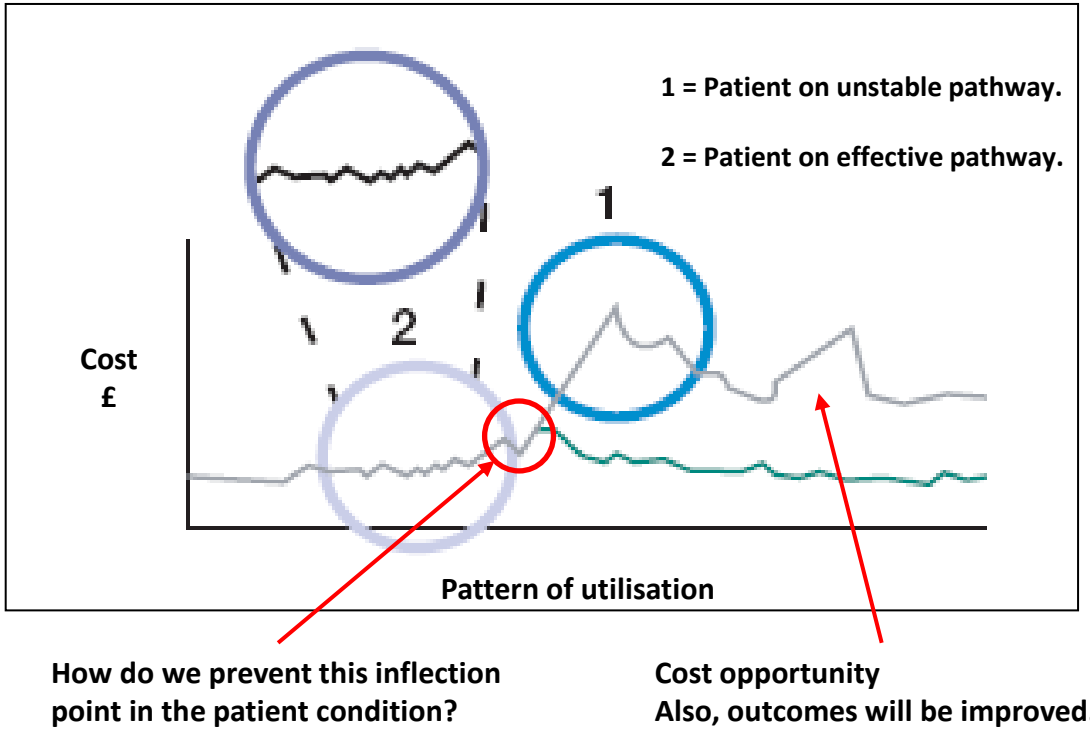
- Everyone is on a health pathway. Each medical event is recorded in the GP held electronic record.
- Current NHS systems can collect cost and patient experience data, episode by episode applying processes such as PLICS and PROMS which monitors outcomes.
- AI will deliver new levels of comprehensiveness and clarity.



PLICS NHS Patient Level Information and Costing System

Progress along care pathways is rarely straightforward. It is easy for them to be disrupted. AI could fix it

- AI health records will be collated, scanned and analysed to create individual care pathways.
- Systems will send signals to GP practices to contact patients.
- Patients missing appointments or not renewing prescriptions will be identified to enable care pathway adherence.



These models will only get better

- *'In this paper, we harness the data-time labels of EHR administrative data, which are automated, low-cost, reliable, ubiquitous, and require minimal data preprocessing.*
- *We aimed to determine the usefulness of the datatime labels using a purpose developed machine learning pipeline (figure 1A) to analyse patient trajectories as manifested in EHRs and read their temporal activity (figure 1B) and show it can enrich the performance of emergency hospital admission prediction compared with a conventional approach.'*
- *Each of these patient interactions produces multiple data points, often collected by different systems'.*
- The win is in their collation, combining Hospital and GP data which is do-able via the FDP.

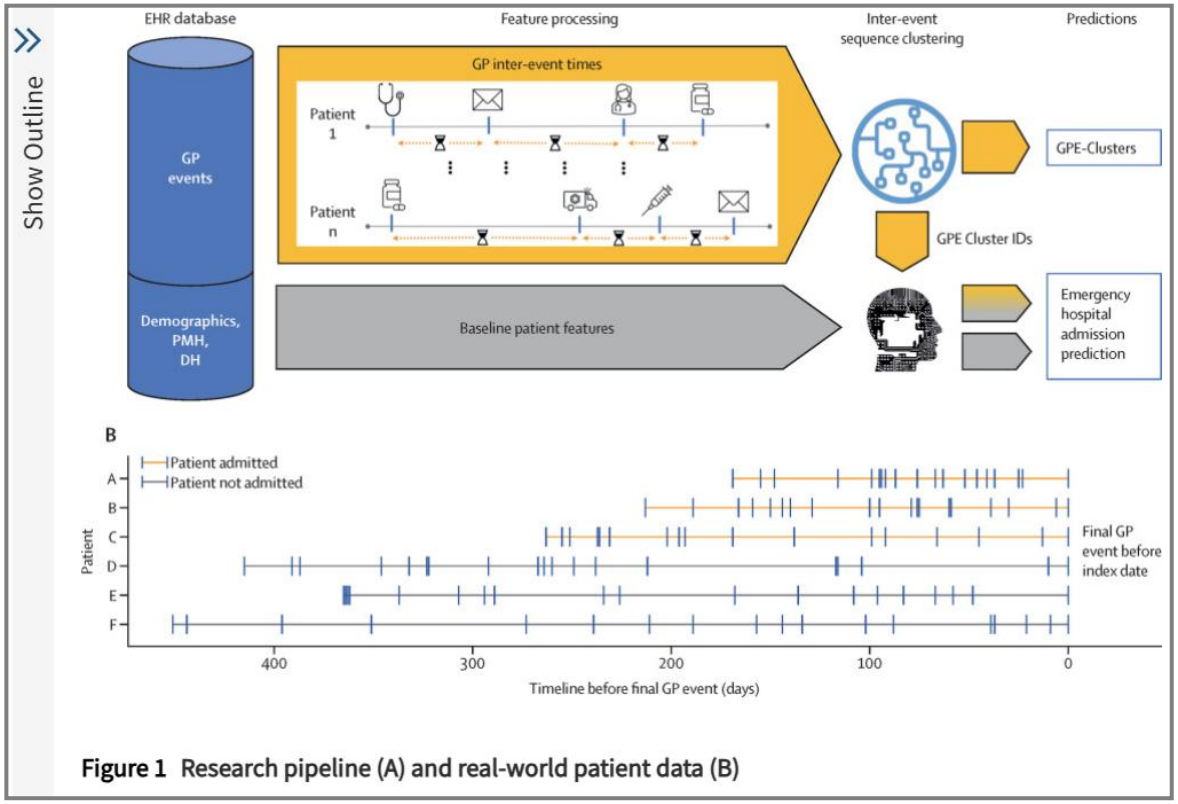
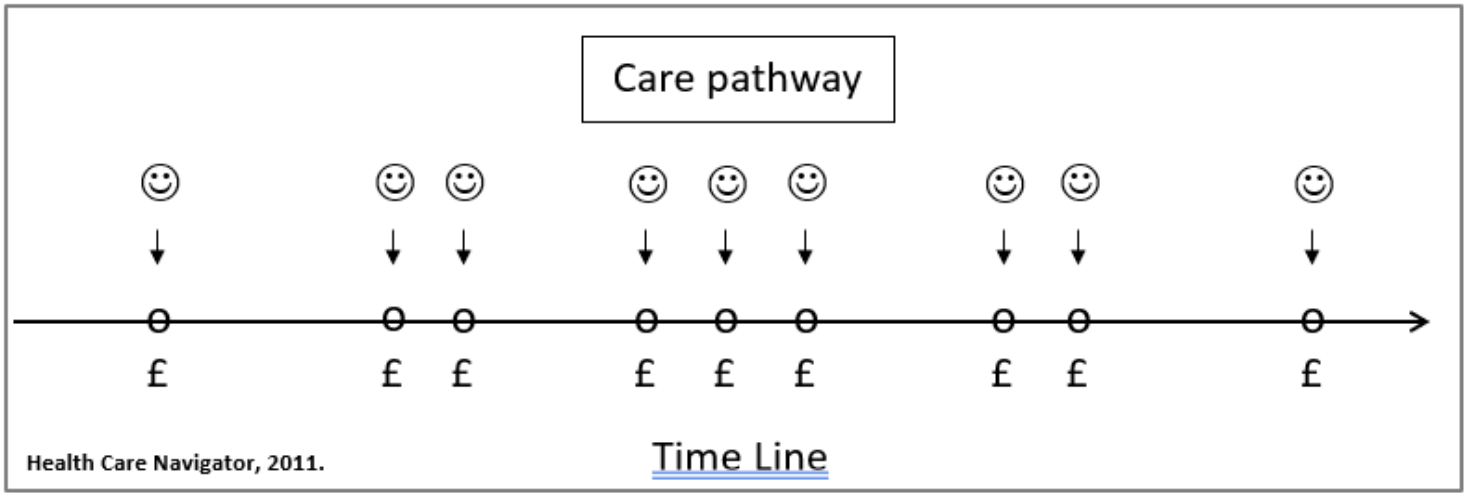


Figure 1 Research pipeline (A) and real-world patient data (B)

https://www.thelancet.com/action/showPdf?pii=S2589-7500(24)00254-1

Soon every patient contact will be monitored by machine



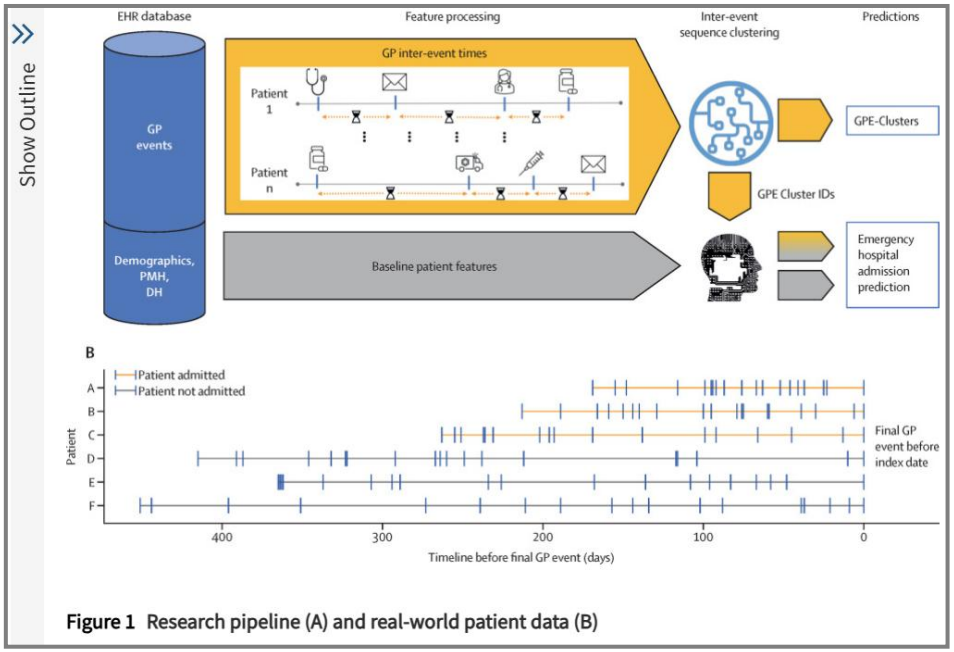
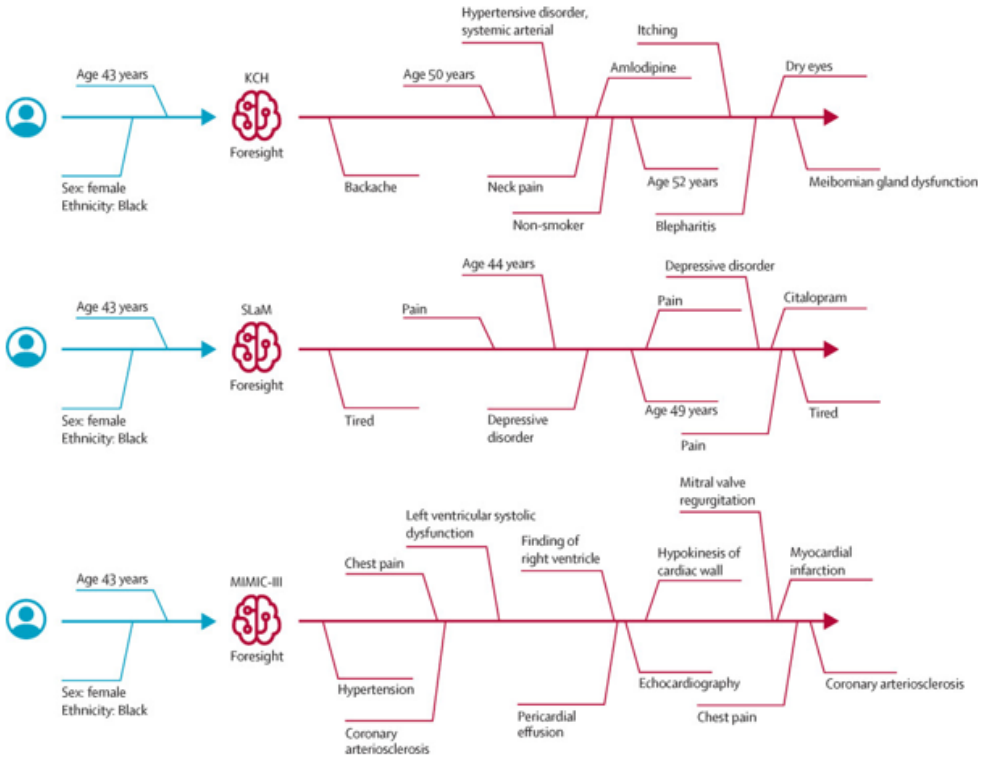


Figure 1 Research pipeline (A) and real-world patient data (B)

The promise of AI goes beyond anything seen before

'Lancet Digital Health in March 2024 published evaluations of our foundation model, Foresight's medical predictions by comparing them to what actually happened to the patients as described in their records. Our Foundation Model can predict the health trajectory of patients by forecasting future disorders, symptoms, medications and procedures. Foresight is trained on real world healthcare data in Kings College Hospital, Princess Royal University Hospital, South London and Maudsley Hospital and MIMIC-III data from Beth Israel Hospital, USA; and uses a deep learning approach to recognise complex patterns in both the structured and textual data of electronic health records to produce predictions'.

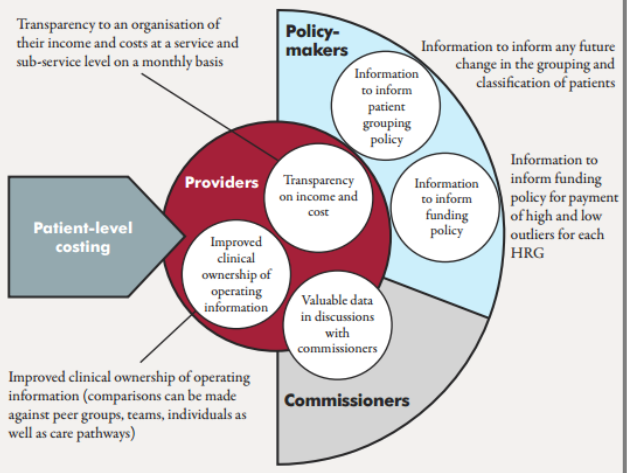


Effective commissioning, value for money and allocative cost efficiency can come from pathway financial data analysis

The NHS England Strategic Commissioning Framework. November 2025 says:

- *'ICBs can build on existing patient-level information and costing systems (PLICS), which capture the cost of each interaction with NHS trusts, allowing analysis by service line, cost type or patient cohort. This enables comparison of costs across providers and within patient groups*'.
- PLICS enables providers to identify where costs can be reduced and efficiencies maximised by detailing the exact cost of care pathways, including staff, drugs, and equipment.
- By highlighting variations in cost for similar patients, clinicians can review pathways to improve quality and reduce waste.
- Benchmarking and performance: Trusts use PLICS to compare costs for similar patient procedures (e.g. hip replacements or outpatient appointments) to identify best practices.
- The detailed cost data helps NHS England set accurate, evidence-based prices for services and understand the relationship between patient characteristics, incidents, and costs.
- Data linking: PLICS data is often linked to national datasets, such as Hospital Episode Statistics (HES) and Mental Health Services Data Set (MHSDS) to provide a complete picture of patient care.
- AI will easily synthesise all of this information.

Figure 8: The potential benefits of PLICS, as set out by the Department of Health, showing the main potential beneficiaries



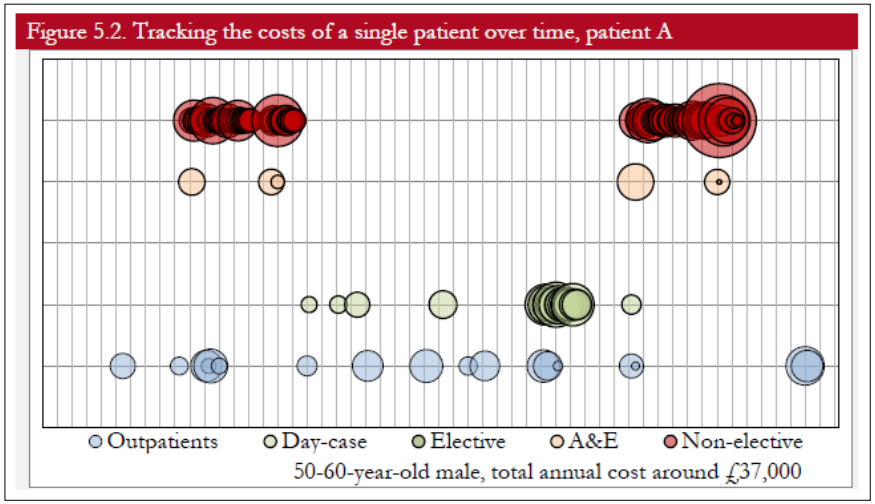
Source: Department of Health, 2009

PLICS can provide real insights into individual pathway costs

- PLICS (patient-level information costing **system**) is a system to derive costs at the patient level. It is IT software (and sometimes infrastructure) locally installed and supported by the provider or the provider's preferred supplier.
- Patient-level **costs** (PLC) are an output of the PLICS system.
- Patient-level cost **recording** is the act of providers inputting data into the PLICS system.
- Patient-level cost **collection** is the process of providers submitting data to NHS Improvement on a national basis (taking over from the Department of Health (DH) in 2019).

'Costing transformation programme. Patient-level costing: case for change', NHS Improvement, April 2016

'PLICS allows organisations to identify variation against standardised bundles or pathways of care, between clinical teams, or between different groups of patients. When PLICS is analysed alongside other performance and quality information it becomes even more powerful in understanding the delivery and performance of services.' **NHS England.**



'Patient-level costing: can it yield efficiency savings?', Nuffield Trust, September 2012.

The NHS has the tools to drive efficiency and productivity. The FDP will facilitate their usage

- Patient-Level Information and Costing Systems (PLICS) should be used in conjunction with the Getting It Right First Time (GIRFT) programme to drive clinical and financial improvements. While GIRFT identifies clinical variations and quality issues, PLICS provides the granular financial evidence needed to validate these findings and secure local "buy-in" from clinicians.
- Using a trust's own PLICS data can provide additional evidence to support GIRFT findings or, in some cases, challenge them.
- Understanding resource variation: GIRFT focuses on reducing unwarranted clinical variation, while PLICS identifies exactly how much that variation costs. Combining them will help trusts see if differences in resource use, a phenomenon of unwarranted variation.
- Robust action plans: Using PLICS alongside GIRFT reviews helps ensure that efficiency-driven action plans are evidence-based. AI will make huge amount of difference.
- Trusts use PLICS, GIRFT, and the Model Health System* together to 'triangulate' information. This helps recognise performance concerns and identifies where services might be operating at a financial loss despite meeting clinical targets.

* '*The Model Health System is a data-driven improvement tool that supports health and care systems to improve patient outcomes and population health. It provides benchmarked insights across the quality of care, productivity and organisational culture to identify opportunities for improvement. The Model Health System incorporates the Model Hospital, which provides hospital provider-level benchmarking. Access to the Model Health System is currently available for all NHS commissioners and providers in England'.*
NHS England.

The most important health care objective is securing the best patient outcome. PROMS are the NHS preferred measure

- ‘PROMs (Patient-Reported Outcome Measures) capture what matters most to the individual rather than just the lab results’.
- These typically short, self-completed questionnaires are measures of a patient’s health status or health-related quality of life at a single point in time.
- Quality of Life measures are prominent, monitoring the patient’s ability to return to daily activities, work and social roles without interference from their condition.
- Patients are offered a questionnaire (often paper-based, but increasingly digital) pre-operatively, once they are passed fit for surgery.
- Post-operative: A follow-up survey is sent to the patient’s home address, typically six months after surgery for hip and knee replacements.
- The NHS PROMs programme measures health gain in patients undergoing procedures such as hip and knee replacement, varicose vein and groin hernia surgery in England, based on patient responses to questionnaires completed before and after surgery.
- Trusts and ICBs can use the data to identify clinical outliers —high-performing units whose practices can be shared, or under-performing units that require investigation. For example, the NEQOS report compares Trust performance on PROMs against others in the North East and North Cumbria, as well as the national average.

PROMS (Patient Reported Outcomes Measures) should be part of the monitoring system, beginning with high risk patients

- *'The national Patient Reported Outcome Measures (PROMs) programme, begun in 2009, collects information from patients about how well the health service is treating them.*
- *PROMs allows NHS organisations and clinicians to understand the difference that health care interventions make to people's quality of life.*
- *The national PROMs data can enable provider trusts to identify specific areas in which patients feel they struggle/excel during their recovery. This can help trusts to review their care pathway, e.g. to better inform what after-care programmes they might consider introducing.*
- *In choosing to participate in the national PROMs programme, patients complete questionnaires asking about their quality of life before and after surgery'.* **NHS England 2015.**

'PROMs provide information of particular salience for quality and performance measurement across five categories: health-related quality of life, functional status, symptoms and symptom burden, health behaviours, and the patient's health care experience.

Many PROMs are intended for use in populations with chronic illnesses. There are a considerable number of PROMs in relation to physical, mental, and social health, particularly for long-term conditions.

Another type of PROM measures functional status, a patient's ability to perform both basic and more advanced (instrumental) activities of daily life. Some may address a very specific type of function (e.g., Upper Limb Functional Index) or be developed for use in a specific disease population (e.g., patients with multiple sclerosis), whereas others may be appropriate for use across chronic conditions'. **National Library of Medicine (US), 2015**

MCO is the sector leading provider of PROMS data

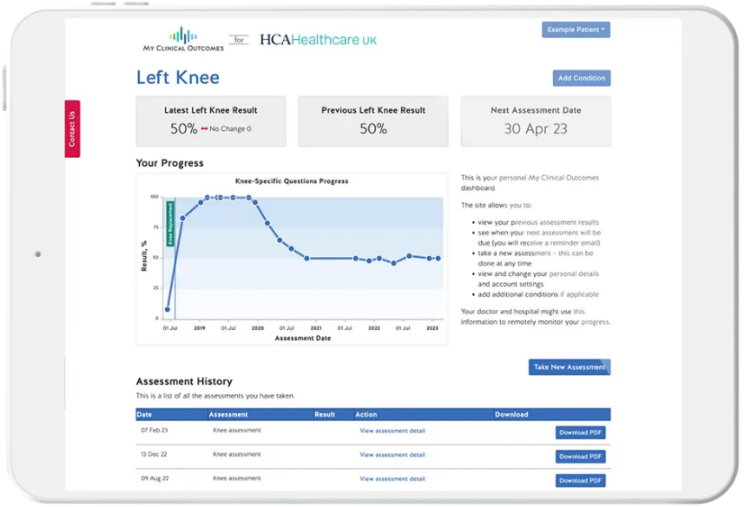
HCA Healthcare UK

Departments Tests & scans Find a consultant Find a location Patient & Visitor Information

How it works

Eligible patients will be sent an email from **hcauk@myclinicaloutcomes.com** to access the MCO platform. This will usually happen after the first consultation but before treatment starts, however it may be at any stage of diagnosis, treatment or follow-up.

The first time patients access the MCO platform, they must verify their identity for information security reasons and can then activate their account. This involves clicking on a button within the email sent by MCO, confirming some details and setting a password. This process will only need to be completed once. Thereafter the tailored PROMs assessment is available to complete, with results available through a personal dashboard that can then be accessed at any time.



AI – the coming wave

We are entering an era where new technologies will fundamentally transform patient care

- [By 2030], *'we'll see widespread adoption of genomics, proteomics, lifestyle data collection and psychological data collection. Intelligent algorithms will be used to enable truly personalised health care and medicines, delivered by clinicians and patients themselves, significantly improving outcomes for conditions such as cancer, CVD and diabetes, as well as underpinning improved psychological and physical wellbeing'.*
  EMIS Health, UK's leading provider of GP desktop systems.
- As for other industries it will be AI which will be the game changer.
- Health systems across the world are already seeing how patient care is improved by the machine reading of electronic health data.
- This transformation shifts the focus from reactive 'sick care' to proactive, continuous health management, where it can be both predictive and preventive.
- All the time, the latest inputs of data can be analysed, interpreted and turned into alerts, reminders or follow-ups.
- We explore these opportunities in this presentation.
- For an independent view of how health care delivery will evolve, go to https://www.pwc.com/gx/en/issues/business-model-reinvention/how-we-care-for-ourselves/global-health-report.html

We know that everything will be different one day

It's hard to see a part of human life which will benefit more from the application of AI than health care.

Its scope is colossal – from the extraordinary strides which are coming from revolutionary experiments in bioscience to the development of a single treatment plan for an elderly GP patient.

NHS England recognises the size and impact of its potential. But it is undoubtedly frustrated by the many circumstances which will hamper front-line adoption. Local health care organisation lags way behind its application in medical settings.

Over their 20 years of existence, there is general acceptance that NHS commissioners have failed to seize the benefits which come from innovating, particularly in the application of information technology.

The future for any kind of fundamental transformation looks poor. The way that control is decentralised to 36 local organisations, Integrated care Boards, all of whom operate semi-autonomously and who are still recovering from a substantial downsizing and consolidation. As such, there little evidence of the capability which is needed to bring in the size of change which is required.

GP practices, with largely fixed funding provided by capitation, have neither the scale nor the technical expertise to drive change. Their IT comes from essentially two large specialist software suppliers. Both have products which are now at least 20 years old and which will struggle to realise the full potential of what AI can deliver.

Locally, in Guildford, we can, however, see real positives and a promising route to the future. There is a range of applications which if unified would create an unparalleled technology stack. This includes a radical, new paradigm GP administration system, now backed by a substantial European health tech company; a Foundation Trust acute hospital with a comprehensive electronic administration system and downstream applications which produce data from remote devices as part of a virtual ward programme.

The game changer is that for the first time there is the potential of all of this information being brought together to produce a singe unified picture of every patient's care. This comes about because of a revolutionary enterprise data operating system which is able to integrate fragmented data, analytics and operations into a single, unified environment. This is possible as a consequence of NHS England's decision to commission a Federated Data Platform, the Foundry bought from controversial US supplier Palantir.

The combined data in the FDP will provide extraordinary insights not only into the care of individual patients, but will also enable inferences to be drawn from many aspects of population health status and management. For the first time the whole population can be dis-assembled down through cohorts of patients, whatever their health status, to a single individual. It can then be dissected and endlessly reorganised to provide hitherto undiscovered learning.

We will better understand the efficacies of care pathways and treatments, how they work for different patients and how programmes might be redesigned. We will learn of how outcomes are produced and how they might be made better. We will have the evidence to understand the precise costs of care programmes, unwarranted variation and allocative efficiency. All of health care delivery comes under unprecedented scrutiny.

The wealth of this capability will only be realised by the execution of sound strategies. This is the NHS's operational challenge. Guildford is exceptionally well-placed. It should seize the initiative.

The Guildford Society is totally aligned with this vision. We can show how it might be implemented in Surrey

Smartphone care, AI and robotics will transform the medical system, says the head of NHS England, who admits the prospect is 'scary'

Penny Dash, the head of NHS England, says patients "don't necessarily need" doctors and nurses as AI technologies advance

The Sunday Times June 20 2026

''The first time patients will meet their surgeon in the future is when they are on the operating table, the head of NHS England has said.

Dr Penny Dash believes advances in technology and artificial intelligence are tearing up the traditional model of providing care, which she said would be almost entirely done through smartphones and online.

At the HLTH Europe conference in Amsterdam, Dash, who trained as a doctor in the NHS before moving into public health and consultancy for McKinsey, said she could see a future where patients would not meet clinicians until much later than they do now, and possibly not at all.

Dash even suggested there could come a point where some patients "don't necessarily need doctors and nurses".

"If I look to the future, some of the things that are being developed and coming downstream, like fully automating a care pathway, are phenomenal," she said.

"That means I would put into my phone that I have got these three symptoms, software would ask me questions, would take a photo and video me lifting my leg or lifting my arm, and the first time you would see a human being would be on an operating table.

"With AI, we could do that for pretty much all health conditions. We don't necessarily need — which will frighten a lot of people — doctors and nurses. You will not want dirty, clumsy hands inside your body. It will all be robotics and non-interventional approaches."

However, the move towards almost entirely digital care has raised concerns among charities for the elderly, which urged the NHS to ensure "no one is left behind".

Dash is spearheading reform of the health service. NHS England is shedding 50 per cent of its staff and being absorbed into the Department of Health and Social Care.

Already technology such as ambient voice technology, where AI software transcribes conversations between doctors and patients, was being widely adopted, Dash said, with "phenomenal impact".

"If we could adopt it, even in its most constrained and limited form, we would probably free up 10 to 20 per cent of the resources we have, which we could then be reinvesting in primary prevention and secondary prevention."

Dash said the NHS would not rush to adopt these changes, but take it "one step at a time", adding: "I passionately believe this would be a way better experience for people, and actually that would be the first step towards a future that might sound scary now, but the car probably sounded scary 100 years ago. So it's about how do we make these small steps — develop a wheel, get used to a cart, and then get to a car." A service called NHS Online, a fully digital specialist hospital trust, will begin next year and offer patients care through the NHS App.

Dash said this sort of approach was what patients wanted: "We know what we need to do, we've just got to be brave enough to do it. Many people think the politicians are the problem. It's not the politicians, it's us in the system."

Caroline Abrahams, director at Age UK, said: "It's clear that technology is set to transform many aspects of our lives for the better over the next decade, including the delivery of healthcare and how we interact with the NHS.

"The potential of the NHS App is truly exciting, but we must also ensure no one is left behind, including the many millions of older people who are not online and who often want and need to use more traditional means of communication, such as telephone and face-to-face."

The NHS recognises the importance in its 10 Year Plan in shifting from an analogue to a digital system

- *'Strategic commissioning is key to enabling the NHS to secure improvements in access, care, quality and greater value for money by delivering the 10 Year Health Plan's three strategic shifts for the NHS:*
  - *from sickness to prevention,*
  - *hospital to community and*
  - *analogue to digital*

  and thereby improve both allocative efficiency - identifying and directing the money to the most clinically appropriate and cost-effective mix of activities - and technical efficiency (enabling providers to undertake the activities more efficiently).'
  NHS England Strategic Commissioning Framework, Nov 2025.

What can we expect from a digital NHS?

- Cataloguing all the benefits is itself a challenging task, but we can expect administrative fragmentation to be replaced by instant data connectivity as patient data, diagnostic scans and clinical monitoring flow instantly across a more unified network.
- Digitisation will reduce unavoidable admissions, improve bed management and raise workforce productivity.
- Predictive data and wearable technology will allow more vulnerable patients to be treated safely in their own homes, intervening long before a health issue turns into an emergency.
- There should also be a reduction in medical errors.

Data - its pervasiveness along with vast gains in processing power - will transform medical decision-making

- Health systems have vast amounts of personal medical data, but they are usually kept in their own distinct silos, which are not interoperable and are under the control of separate organisations.
- This is the case for the information rich NHS which has electronic longitudinal GP records going back for some patients as long as 25 years,
- In the future, the big win is that machines, where allowed, will be able to collate and manipulate the data. This will:
  - have a huge impact on patient care pathway planning and decision support
  - change the patient's risk score and prompt interventions and care escalation
  - operate in real time, alert staff and schedule treatment
  - monitor interruptions to care pathway adherence and collect patient feedback
  - help determine what is best for the patient and system
  - patients will participate more fully in their own care
  - each interaction will be costed, quality assured, increasing system efficiency and value for money
  - individual patients will see a narrowing of the current information asymmetry. This will increase shared decision-making with individuals participating more fully in their own care

Legacy GP systems, not easily AI enabled, are coming to the end of their useful lives. GPs must transition

- *'EMIS Web and TPP SystmOne are transitionally entering the "legacy" category within the NHS strategy, though they still remain the dominant workforce systems' 'Historically, these two platforms held a rigid 90%+ duopoly over UK primary care. However, senior Department of Health and Social Care (DHSC) advisers and NHS England have explicitly labelled the current architecture as "unfit for purpose" and a "barrier to change". They are actively forcing a market shift toward a cloud-first infrastructure.*
- *The GP IT Futures framework, which centrally funded and protected the EMIS/SystmOne ecosystem for years, officially expired. The suppliers themselves recognize that their existing architectures are dated. EMIS is actively driving a multi-year migration strategy away from the classic EMIS Web product, transitioning clients toward its new cloud-based EMIS-X platform. According to current migration schedules, EMIS Web is entering its official sunset phase through 2026–2027'.* **Google AI**
- A real exposure for the NHS is that GP practices will not adopt new systems fast enough to take advantage of the many benefits that become available.
- Unifying on a single new system, possibly by leading with SPoA consolidation, will bring massive benefits.

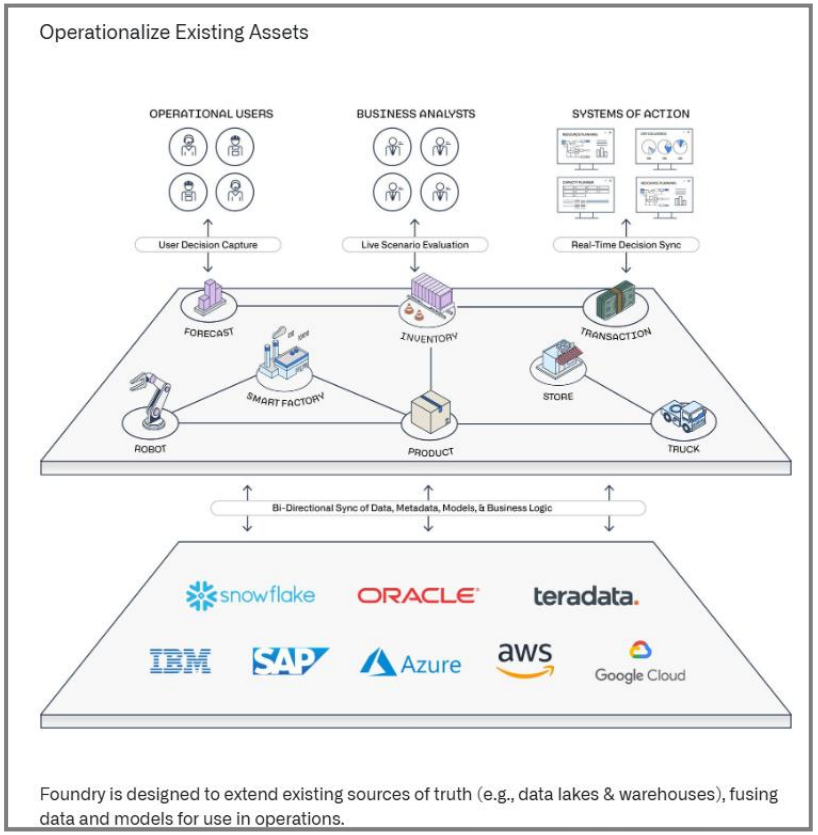
The government is making huge capital investments in world leading systems. The centrepiece is the FDP

- The NHS Federated Data Platform is a national software infrastructure designed to connect fragmented health data across different NHS organisations to improve patient care and operational efficiency.
- It does not replace existing Electronic Patient Record (EPR) systems; instead, it sits on top of them to unify information that is currently siloed in separate IT systems.
- The platform is "federated" because it consists of separate, independent "instances" rather than operating as one giant central database.
- Interoperability: these instances can ‘talk’ to each other only when data sharing agreements are in place and it is legally permitted for direct patient care.
- Every NHS Trust and Integrated Care Board (ICB)is likely to have its own version of the platform.
- There is an over-riding, controlling National Instance. Operated by NHS England, this instance provides the framework for the strategic planning and introduction of new technology.

The FDP Foundry brings together all selected datasets into a single ontology

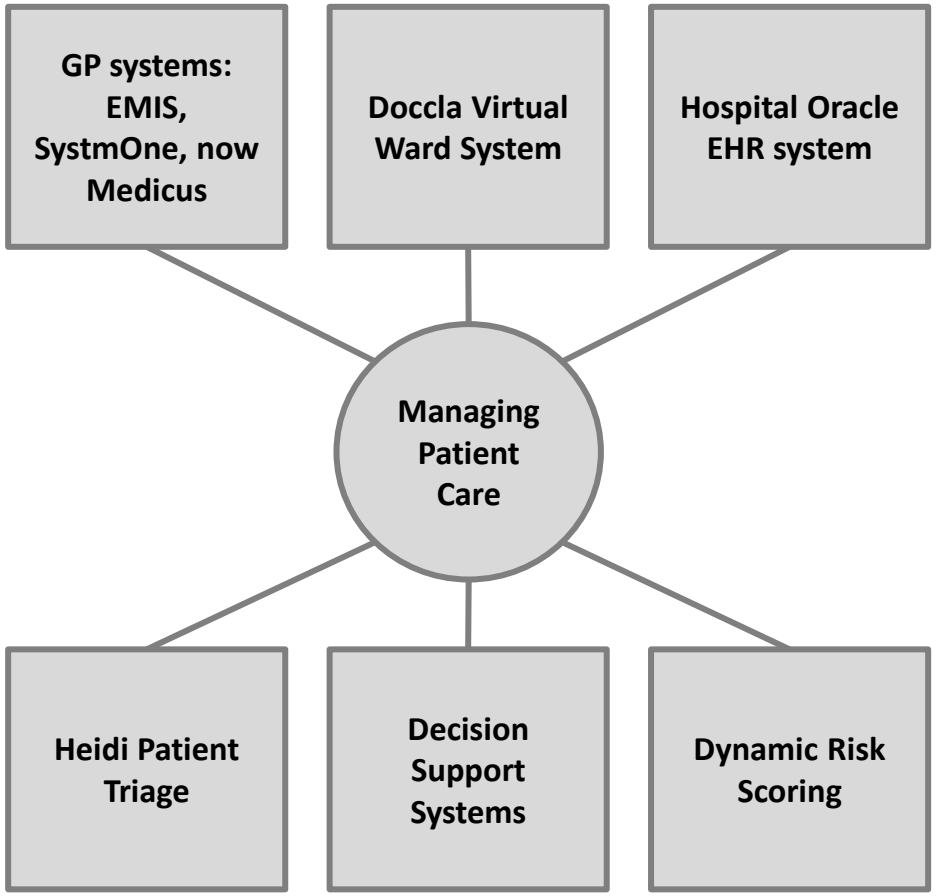
- *The Foundry works as an enterprise operating system that connects, cleans and structures disparate data into a digital twin of an organisation, known as an ontology, turning raw data into actionable objects.*
- *It enables technical and non-technical teams to build AI-powered workflows, run simulations, and drive operational decisions.*
- *Foundry integrates with existing data platforms (e.g., AWS, Snowflake, Azure), allowing for secure, real-time collaboration and 'closed-loop' operations.*
- *Decisions are fed back into enterprise systems to update, for example, hospital activity, patient records, care pathways or financial data with the object of driving continuous improvement.*

Supplier data

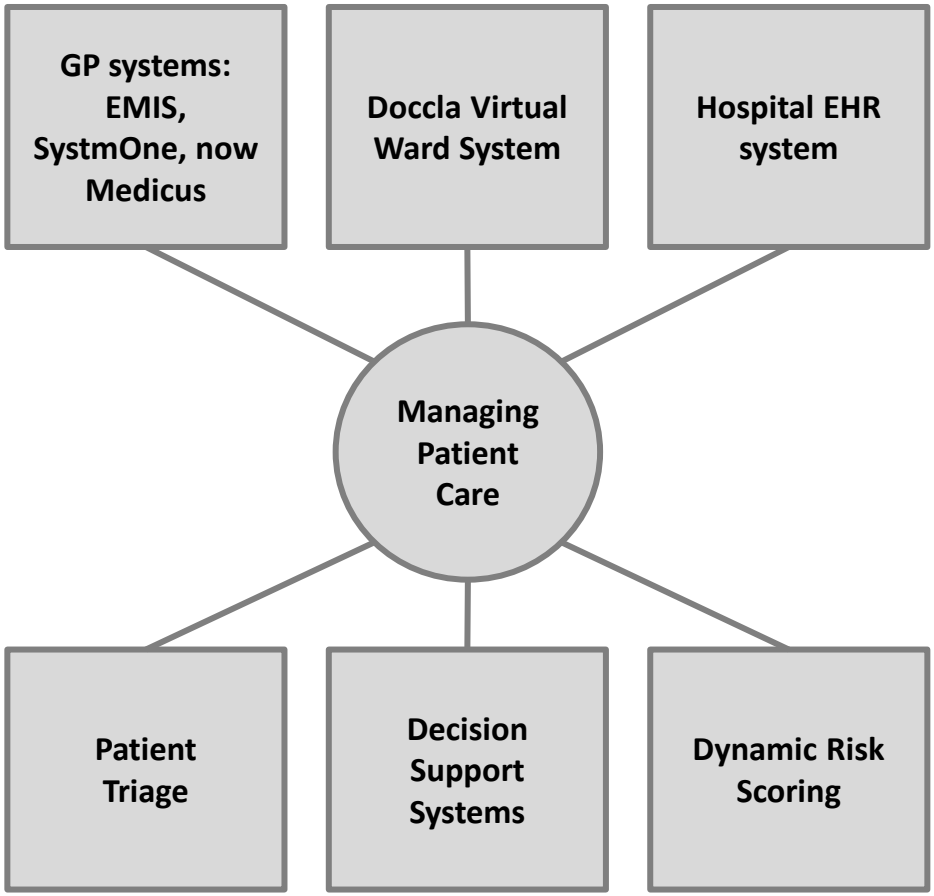


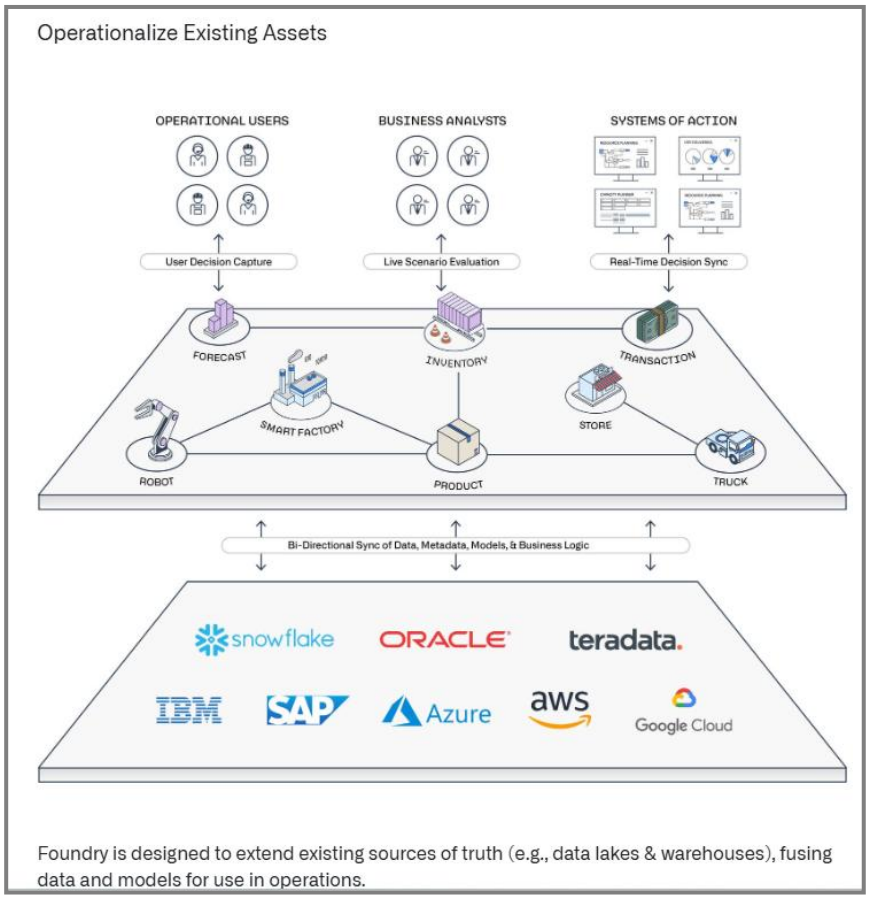
Much could be achieved by combining data from existing locally deployed systems

- Patient management is now supported by a range of digital systems. Locally there are multiple data points.
  - GP patient EHR systems - EMIS and TTP SystmOne – can identify at risk patients.
  - RSFT operates the Oracle EHR system.
  - Some hospital discharged patients are being managed by the RSFT Virtual Ward Doccla system. There are mobile AI systems.
  - An AI powered 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.
- Putting these together will make a real, game-changing difference to patient monitoring.



Then combining this data using an AI system will transform care delivery. This is the killer app.





Who at RSFT knows how to leverage the Foundry?

This is what Google AI says:

- *'Royal Surrey NHS Foundation Trust utilises the Foundry software primarily through its role in the **NHS Federated Data Platform (FDP)**. The platform is listed as part of their Information Governance framework, which details how the Trust manages and secures patient data. [1, 2, 3]*
- *While Royal Surrey was not among the initial 42 pilot sites for Foundry-specific tools like OPTICA (discharge tracking), it is now an active participant in the wider FDP rollout. Its usage focuses on: [1]*
- ***Integrated Care**: Royal Surrey works within the **Surrey Heartlands Health & Care Partnership (ICS)**. Foundry is designed to help Integrated Care Boards understand population needs and target preventative interventions across the county.*
- ***Operational Efficiency**: The Trust uses the platform to securely connect data stored in separate systems—such as theatre management and workforce rosters—to reduce administrative burdens and speed up patient treatment.*
- ***Pandemic Management**: Historically, the Trust used Foundry to manage critical resources, including tracking ventilator availability and medical equipment during the COVID-19 pandemic'.*

The Medicus capability is enabled by a Cloud based system. Guildowns GP practice is one of the first adopters, nationwide

- Cloud-based systems are generally better for AI when scaling, training large models, or requiring rapid deployment, as they provide massive, on-demand GPU power and data storage without upfront hardware costs.
- The cloud allows for rapid deployment of AI-driven solutions and easy integration into existing applications.
- However, local AI (on-premises) is superior for scenarios needing ultra-low latency, strict data privacy, or offline functionality or live captions not needing the Internet.
- Sensitive data that cannot be transferred to the public cloud is better suited for local hosting.
- Cloud platforms like AWS, Google Cloud, and Microsoft Azure offer virtually unlimited computing power, allowing organisations to scale resources up or down based on demand.
- Many organisations now use a hybrid approach, combining the vast computational power of the cloud for training models with the speed and security of local edge computing for running them
- This approach can also split the workload between the cloud and local devices (phone, desktop or tablet).

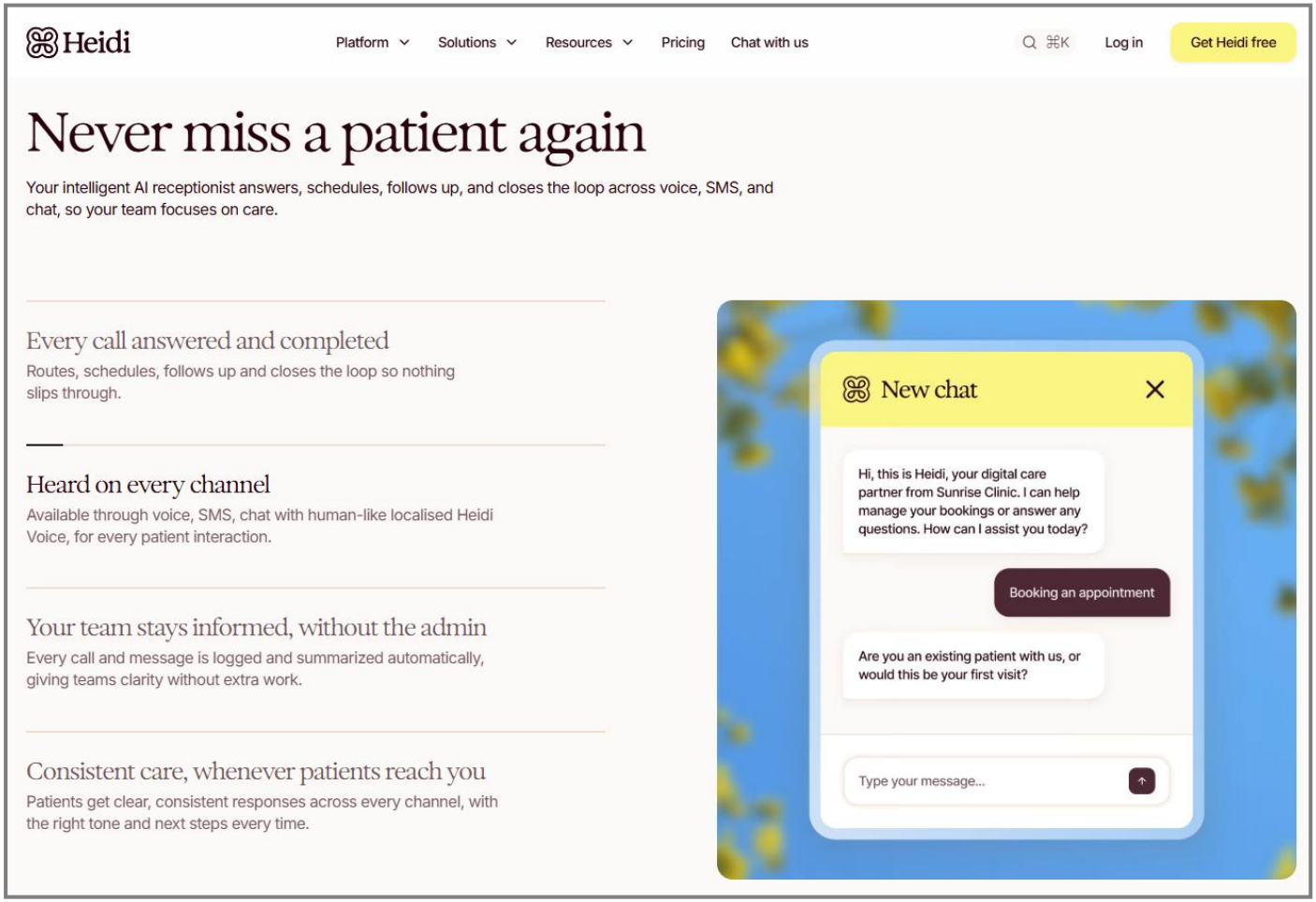
How the AI enabled components can line up in the GP practice environment

- Ambient scribing products, including ambient voice technologies (AVTs), unobtrusively record the patient and caregiver conversation in the background and then convert that dialogue into text and other outputs, requiring minimal user intervention. These technologies utilise advanced speech recognition and integrate powerful capabilities driven by Generative AI and Large Language Models (LLMs).
- Ambient scribing products are designed to support clinical or patient documentation and workflows. So, rather than focusing on the computer screen, keyboard or Dictaphone, the caregiver can focus on the patient in front of them, with confidence that their conversation will translate into an accurate draft summarisation for review and validation after the visit.
- Locally, the Guildowns practice uses Heidi an ambient AI-powered medical scribe and clinical documentation assistant designed to eliminate administrative paperwork for health care professionals
- The Medicus Health GP system is an all-in-one, cloud-based Electronic Patient Record and practice management system
- The Royal Surrey uses the Cerner/Oracle Hospital EHR system https://www.oracle.com/a/ocom/docs/industries/healthcare/ehr-product-brief.pdf

The patient consultation is transformed

- *'Medicus embeds communication tools and data-entry automation straight into a single interface.*
- *The AI listens to the live appointment, drafts structured clinical summaries, extracts relevant medical data and automatically suggests the appropriate clinical code, meaning doctors rarely write notes from scratch.*
- *a medical probabilistic engine determines the safest, most logical next follow-up question to map out their exact history before the GP even opens the file.*
- *The AI ranks and highlights requests based on clinical urgency, allowing receptionists to immediately spot high-risk symptoms.*
- *The AI automatically screens for emergency "red flags," categorises administrative requests (such as sick notes), and ranks clinical queries by urgency.*
- *Medicus utilises natural language processing to read the doctor's typed clinical summary and can automatically map it to the correct local NHS e-Referral Service (e-RS) path.*
- *The platform natively includes patient SMS texting, automated recall campaigns - e.g. inviting eligible cohorts for cervical screenings or flu vaccines*
- *Built-in, live tracking dashboards help practice managers hit Quality and Outcomes Framework (QOF) targets and maintain Care Quality Commission (CQC) regulatory compliance automatically.*
- *GPs can log securely into the full system on any laptop or tablet to safely conduct home visits or work remotely.*
- *This saves an estimated 43 minutes per clinician per day, allowing doctors to look at the patient instead of staring at a keyboard.*
- *When inbound hospital letters or lab results arrive via secure NHS networks, natural language processing automatically parses the text, suggests the correct clinical codes, and flags outliers for the GP.*
- *AI-driven clinical decision support provide automated safety checks, reviewing patient records in the background. It cross-checks new prescriptions against historical diagnoses, active allergies or drug interactions*
- *By highlighting individuals with complex comorbidities whose metrics are slipping, the system prompts the practice to run automated outreach campaigns. This allows clinicians to intervene early and adjust medications, which helps reduce emergency room admissions'*. **Supplier literature**

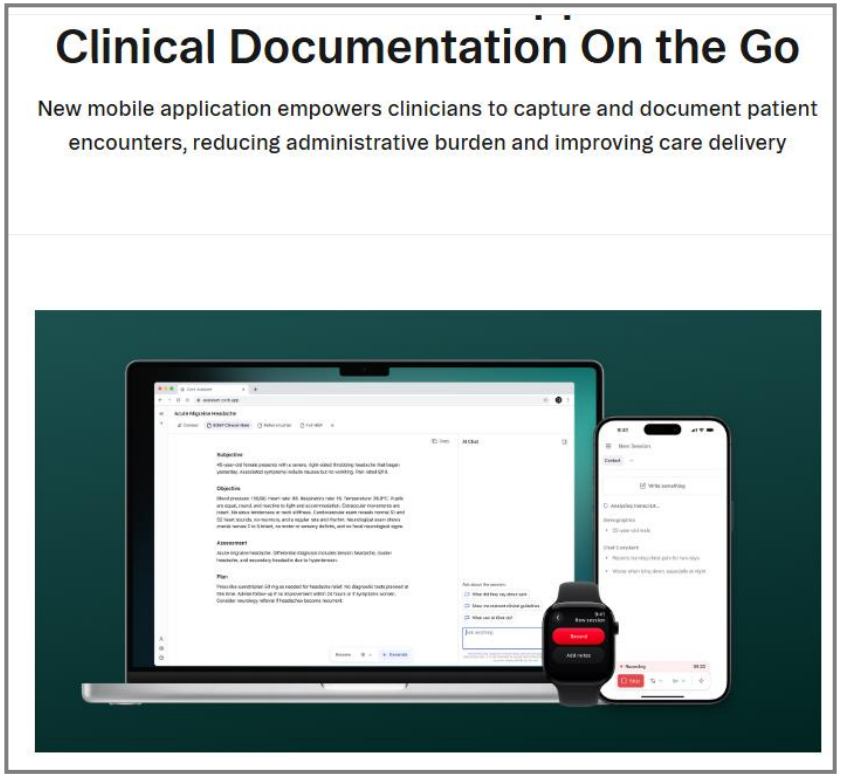
Heidi manages the front door to the Guildowns practice



Medicus provides these in practice capabilities

Mobile AI ambient systems can complete the data collection process

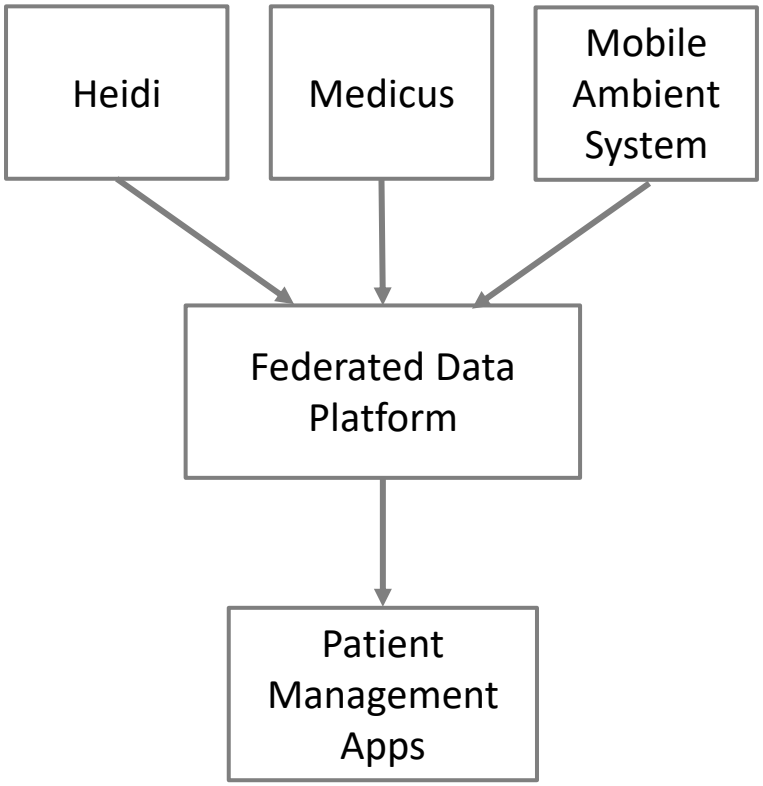
- Community health care staff could use similar systems to record and collect patient data.



This collection of AI systems work together to manage patient care. Clinicians get a seamless view

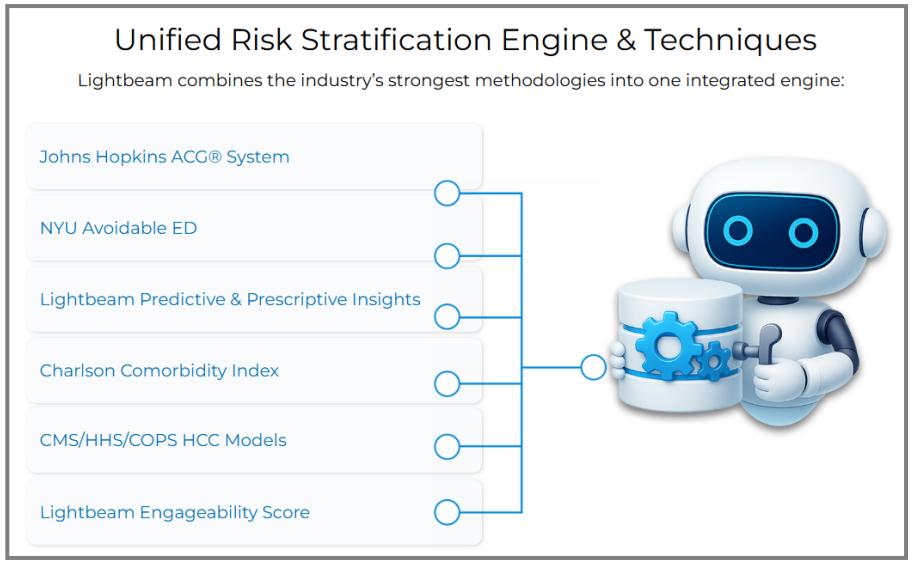
Benefits

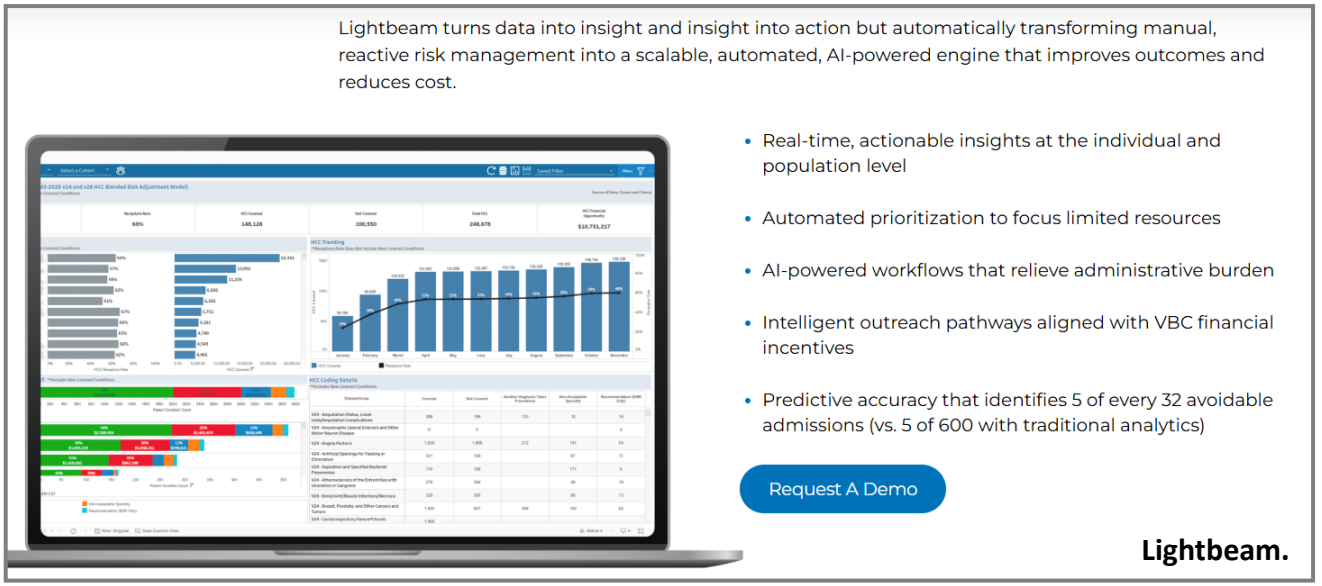
- Clearer, automated information tracking between hospitals and GPs
- Providers can view diagnostic histories automatically
- Better referrals and referral tracking
- Safer community discharge: back into community care managed by GPs
- Smarter outpatient booking systems
- FDP analytical tools to identify local health trends
- Targeted, preventive care pathways.



Finally, in advanced markets, AI is being deployed for risk stratification and segmentation. It takes ACG data

- ‘Lightbeam’s integrated risk management solutions combine real-time data, AI-enabled risk prediction, and automated patient engagement to help organisations intervene earlier, reduce avoidable admissions and manage patient needs across the continuum of care—at scale’.





Now, what if Guildowns' Medicus patient data were merged with patient records extracted from the RSFT Oracle system?

Continuing the Google AI extract:

'Relationship with Existing Systems

- *Foundry does not replace Royal Surrey's core clinical systems but rather overlays them. It integrates data from:*
- ***Surrey Safe Care**: The joint Electronic Patient Record (EPR) system (Oracle Millennium) shared with Ashford and St Peter's Hospitals.*
- ***MyCare**: The patient information portal where individuals can view their own hospital records and appointments. [1, 2, 3]*
- ***Governance & Privacy***
- *Royal Surrey remains the **data controller** for all information processed in their instance of Foundry. This means they decide exactly what data is used and who can see it. Patients can manage their data preferences through the National Data Opt-Out, though this typically applies to secondary research rather than the direct operational improvements Foundry provides. [1, 2]*
- *Are you looking for information on how to **opt out** of data sharing at Royal Surrey, or more details on their **Surrey Safe Care** system?'*

GPs have the best patient data and they are also the legal controllers

- Unlike the more centralised hospital systems being "connected" by Foundry, GP practices use a variety of different software providers (like EMIS or TPP SystmOne).
- Bridging these diverse systems is technically and politically more complex than integrating hospital-based electronic patient records.
- In the legal framework of data protection (UK GDPR), GPs are the "Data Controllers" for their patients' records.
- This means that as contracts are developed, under the present law, GP patient data cannot move to be under the control of any other party.
- There has been considerable pushback over managing GP data in the national Federated Data Platform (FDP).
- Currently, the NHS Federated Data Platform does not include information from GP surgeries at a national level.
- The FDP because the platform is framed as supporting ‘individual care’, rather than secondary research, can be used under GP direction.

The Single Point of Access could become the local command centre for patient care

- A transition to AI systems will enable a sea-change for NHS patient record-keeping.
- GP patient records by law must remain under the control of the practice.
- But other data can be brought in to create a unique local platform. This could be hospital records, data collected in the delivery other services – virtual wards, for example, and community care client engagements.
- We foresee a situation what essentially is a GP operated ‘mission control’ sits inside the SpoA where information is collated and continuously updated to provide a picture of what needs to be the next step or steps in a patient’s care.
- This data would be interrogated by other systems which collect cost and outcome information - PLICS and PROMS for example.
- New ways to design care pathways and deploy resources would inevitably come from the availability of the data and new processing tools.
- This will enable the NHS to embark on a never seen before business transformation, producing exceptionally better patient outcomes and fundamentally lowering costs.

The local opportunity

Guildford in a unique position to innovate in the way that it can manage health data to transform patient care

Data

- The West and North Guildford PCN will have its radically new AI driven Medicus GP system.
- The Royal Surrey hospital is a user of the NHS Federated Data platform
- The RSFT holds patient data which could be cross-referenced to primary care information
- Structured data about certain patients, mostly high users, can come from other associated systems, for example from remote devices used in the virtual ward programme.
- All of this represents a way of building on the NHS Single Patient Record programme. NHS England 'says the Single Patient Record (SPR) will be a digital record that joins patient data together in one secure, easy-to-access place. From 2028, we expect people to start viewing their SPR data through the NHS App. Healthcare professionals will access the patient information they need from one single place too, supporting safer, quicker and more accurate care'.

Participants

- Organisations which have come together to form the new Surrey and Sussex ICB have extensive use of patient risk stratification processes.
- The RSFT is a user of the FDP
- Locally, in Guildford there are other organisations which could lead AI based analytics programmes – the University, Medical School, Surrey County Council and private sector organisations.

Next steps

- The remainder of this presentation sets out how these capabilities might be brought together to build a unique local asset.
- We start with Population Health Management.

Guildford is well-positioned to build on this capability

Organisation	Competences
Royal Surrey County Hospital	Patient care, hospital management, estate planning, contracting, analytics, IT, Surrey Care Record, Doccla Virtual Ward System, NHS Foundry. Surrey Safe Care
Its subsidiary company, Healthcare Partners Ltd https://www.healthcarepartnersltd.co.uk/	Management consultancy, project management, patient pathway design, supply chains, medical device management, clinical support
Surrey and Sussex ICB	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, Medicus and Heidi AI enabled systems
University of Surrey School of Medicine	Medical School. Undergraduate and graduate programmes – biochemical sciences, clinical and experimental medicine, microbial sciences, nutrition. hospital management, clinical placements with providers and commissioners
University of Surrey, The Surrey Institute for People-Centred AI	AI, Machine Learning, research, hospital management. ‘‘Our vision is for the University of Surrey to become the national centre of excellence in people-centred AI research, training and innovation, and its application for the benefit of society
Surrey Research Park collaborators	Local companies with health care tie-ins including diagnostics, genomics, therapeutics, molecular imaging, cloud solutions
Surrey County Council (West Surrey UA from April 2027)	Health and Wellbeing Board. Public Health Data. Surrey-wide Data Strategy, SODA, also Integrated Care System (ICS) strategy

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 ICB system to function efficiently and collaboratively it should work off a common data set.
- Both the hospital and practices have their own freestanding patient record systems.
- Combining the two would deliver quick wins - early identification of at-risk patients in the community, for example. We have covered this in detail in previous presentations.
- We understand there have been Surrey-wide initiatives which could provide long term solutions.
  https://mycouncil.surreycc.gov.uk/documents/s92184/Item%208%20-%20Appendix%201%20-%20Surrey%20Wide%20Data%20Strategy.pdf
- There are sufficient local initiatives which could lead to combinatorial, marketable, new product opportunities.
- Which could result in Guildford becoming a centre of excellence.

Is there a big local opportunity here? Could this organisation be the driver?

- ‘Professor Stephen Jarvis is the President and Vice-Chancellor of the University of Surrey. He formally took up the role in September 2025 and was officially installed as the university's sixth Vice-Chancellor in February 2026.
- He helped establish the UK's national institute for data science and AI, The Alan Turing Institute, serving as a Trustee and non-executive Director.
- A distinguished computational scientist and formerly Provost and Vice-Principal at the University of Birmingham, Professor Jarvis leads Surrey's long-term *Vision 2041* strategy.
- He has received several major grants from the UK Research Councils and from industry, supporting research in areas including data science, robotics and autonomy, aerodynamics and continuum mechanics, networks and distributed systems, computer graphics and visualization, software engineering and computer architectures.

The Surrey Institute for People-Centred AI

- ‘Our vision is for the University of Surrey to become the national centre of excellence in people-centred AI research, training and innovation, and its application for the benefit of society’.
- PAI is spearheaded by visionary academics with a passion for collaboration and co-creation, and a deep commitment to people-centred AI. With this distinctive approach, the academic team builds on Surrey’s excellent track record of collaboration with industry, the public sector, government and other relevant institutions to develop innovative ideas and foster new research directions.

Organisation

Surrey and Sussex ICB will continue to be affected by DHSC organisational development

- Further significant changes are planned for ICBs which will impact commissioning staff. ‘ICBs will be co-ordinated by new regional ‘’OPICs’’ starting in April 2027. The seven regional Offices of Pan-ICB Commissioning are planned to take "at-scale" commissioning responsibilities previously managed centrally by NHS England, transferring the power [for remaining commissioning services] to regional clusters of Integrated Care Boards.
- *‘The primary goal of an OPIC is to serve as a regional "centre of commissioning excellence". Instead of every individual ICB attempting to duplicate complex contracts, the OPIC will act as a single pooled resource to manage large-scale healthcare pathways efficiently across an entire geographic region.’*
- ICBs will be required to learn, import and apply these skills while organisational change continues. How will this help be prioritised? Has Surrey and Sussex begun to assess its own requirements?
- Each of the seven NHS England regions is required to select a single "host" ICB to house their OPIC. These hubs will absorb transferring NHS England regional staff and become fully operational by April 2027’.
- It is not clear what happens in fixing and allocating annual budgets for 2027/28 and the years that follow. Will these responsibilities move in a cascade from Treasury to DHCS to OPICS to ICBs?

Is the plan to reintroduce Strategic Health Authorities (2002-2013), rebadged as DHSC regional offices?

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- Commissioning excellence resources may be in short supply.
- But, won’t many of the commissioning functions already be moving to IHOs?

Control will only get more complicated as other organisations emerge

- NHS England says *'Strategic commissioning and joint procurement involve joint planning, shared accountability and a collective role with local authorities in shaping population health strategies and plans. However, successful co-commissioning is not without challenges. Barriers include navigating complex governance structures, securing sustainable funding models and addressing workforce capacity issues. Overcoming these challenges will be essential to unlocking the full potential of integrated commissioning and ensuring that health and care systems are equipped to respond effectively to local health needs.'*
- The role of the SCC Health and Wellbeing Board will change fundamentally, particularly if they come under the influence of a Combined Authority Mayor.
- The plan is to move most budget-holding into Advanced Foundation Trusts, high-performing FTs, which pass an assessment process. *'The objective is to and benefit from a fundamentally different relationship with the centre, greater strategic and operational autonomy, a capability-based approach to regulation and greater financial flexibilities'.* **NHS England.**
- Integrated Health Organisations, as they transition from being Advanced FTs, will assume new commissioning responsibilities. IHOs are 'a contract-based delivery method to reform how NHS care is funded and delivered in England'.
- One of the admission criteria is that the Trust is in the top two segments of the NHS Oversight Framework for two consecutive quarters. Both RSFT and Ashford St Peters currently fail this test.
- Frimley Park passes.

Under these circumstances what roles are left with the ICB? Are further mergers likely?

- *'The IHO will develop decision-making infrastructure to shift the balance of care, and the balance of existing spend, out of the acute sector and into the community, demonstrating a strong understanding of cost effectiveness, healthcare value and the relationship between cost and outcomes'.*
- *'IHO contract holders will allocate resources and design services to support implementation of new models of person-centred care - including the shift to neighbourhoods - that will improve health outcomes, patient and staff experience and efficacy of care. This will require the designated host provider to work with and contract other providers to deliver services, including multi-neighbourhood providers'.* **NHS England.**

It’s likely that Surrey and Sussex will find itself competing for finite resources. West Surrey often misses out.

- *‘This [reorganisation] process has also included the onboarding of a small number of CSU colleagues, as CSUs prepare to be dissolved by the end of March 2027 and preparation for consultation with colleagues from our digital, data and insight teams. The latter is part of progress towards the creation of a Kent, Surrey and Sussex Digital, Data and Insight Directorate. With some senior appointments already made, the vast majority of digital, data and insight colleagues across Kent, Surrey and Sussex will be part of a full staff consultation on the proposed directorate structure and ways of working, which is expected to launch during June 2026’.* **Surrey and Sussex ICB Board report June 2026.**
- Given its starting position (and maybe even culture issues) the ICB could find itself low in the pecking order. A lot will depend as well on where the Directorate is located. Will this be within the OPIC?
- Guildford is particularly advantaged and we are recommending that it develops its own independent approach to ‘digital and data’, leveraging local assets.

The creation of the West Surrey unitary authority brings another level of uncertainty which has to be managed

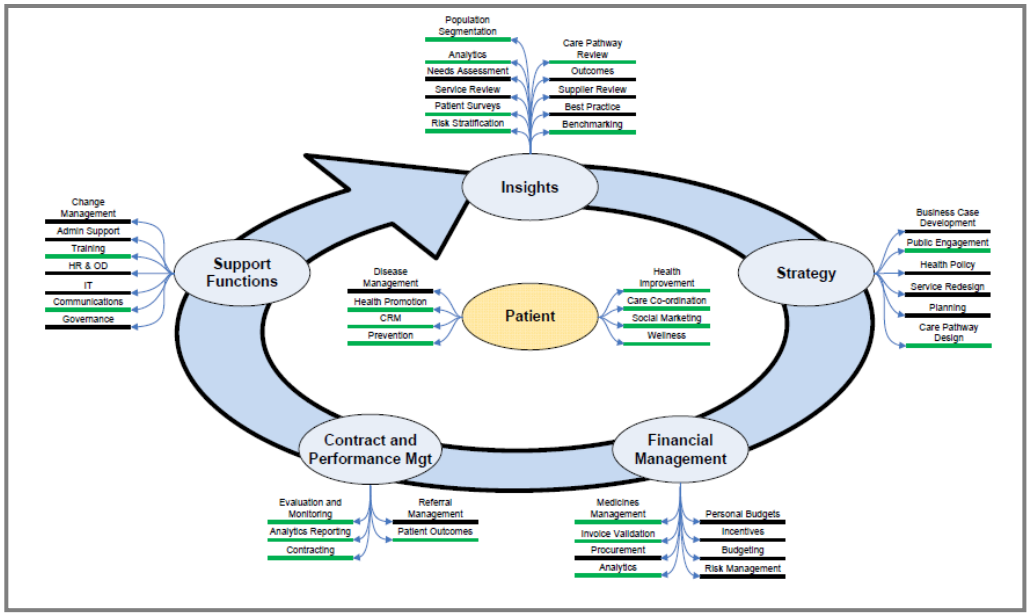
- UA system changes means that the future of West Surrey's health care administration looks potentially problematic at this point in July 2026. There are many issues requiring resolution.
- The HWB risks losing focus as it continues with an unelected council chairman and key cabinet members. There is a very steep learning curve to create a competent new board ready for April 2027. The establishment of a shadow Health and Wellbeing Board is now seen as critical given the size and complexity of the agenda.
- Beyond this there is the substantial work of preparing the West Surrey UA for assuming a much greater responsibility for care commissioning in the years ahead.
- Under the government's 10-Year Health Plan the aim has been to make ICB boundaries contiguous with regional mayoral and strategic local government. The situation for West Surrey at the time of writing seems unclear. The Surrey County Council Health and Wellbeing Board (also known as the Integrated Care Partnership) meets with the Surrey and Sussex ICB while the shadow West Surrey unitary authority is being established.
- If Surrey in the future has a single Mayoral strategic authority, then it seems reasonable to assume that the Health and Wellbeing Board, the Integrated Care Partnership, will prevail.
- If the point of arrival is to foresee a model which exists for Greater Manchester or South Yorkshire, the Mayor's office will then have a more prominent position within the Integrated Care Partnership, working with local NHS leaders to ensure the NHS supports the wider delivery of public services, across the acknowledged determinants of health - housing, employment, social care and transport.
- All of this will take place as ICBs' roles change with the transfer of many commissioning and budget allocation functions to Advanced Foundation Trusts and Integrated Health Organisations.
- The measure of success for all of these bodies will be their ability to provide truly joined-up services for the local population and patients

There is another integration opportunity – collaborating on public health budgets

- *'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.*
  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.

If IHOs take over from ICBs, there is a whole raft of contracting skills which will need to be mastered

- *'ICBs need the skills to actively manage and oversee their markets applying levers to address cost, quality and performance issues to deliver the best outcomes for the local population'.*
- Local procurement strategies should consider how supply chains and small and medium enterprise providers can promote social and economic development, drive inclusive growth and reduce inequalities.
- ICBs will understand and allocate resources in contracting and procuring services, shape and manage the provider market.
- Health care commissioning is a complex industrial process. IHOs will have to develop many of these skills.



Summary and next steps

Summary

For those in NHS management in this part of west Surrey, this is not the moment for the faint-hearted.

The challenges couldn't be greater. The Royal Surrey Hospital is under almost unprecedented demand pressure. The ICB is still putting a new organisation in place with many key posts only just being filled. There are likely to be further constraining issues involving a lack of local knowledge and new relationships having to be built.

There is even the prospect of ongoing re-organisations from the abolition of NHS England, the creation of Integrated Health Organisations and a completely new local authority structure which could in time see a power shift.

Further, a one year old NHS Plan has introduced policy and operational shifts which will be difficult to deliver given previous under--investment and the need for new facilities which can't be brought online quickly.

All of this collides with an unprecedented change in technology which will transform the way in which health care will be delivered. It is very difficult to get a head round its scope and potential. For nearly everyone, each day will bring a new learning opportunity.

All of this comes to an NHS structure and culture which does not change quickly. But given the circumstances, this time there is no business as usual option. We're moving from incremental to exponential.

This presentation puts forward a number of radical ways for confronting the challenges which lie ahead.

Summary (continued)

Delivering the necessary changes will touch nearly every entity in the local NHS ecosystem.

While it can't happen without a full articulation of the plan to stakeholders, the sheer scale of what needs to be delivered is not the kind of undertaking which committees can execute.

Delegation is critical. We believe that in the first instance, covering the launch period, the responsible organisations should be the Royal Surrey and the North and West PCN, the Guildowns GP practice.

They should be fully supported, project funded if necessary by the ICB, beginning with the mobilising event, the creation of a local Single Point of Access. https://www.england.nhs.uk/long-read/single-point-of-access-spoa/

We see this measure as the only one that can bring timely relief from the current pressures on the system.

A fully fledged SPoA requires a significant floor area. Contracting real estate takes time. That's why we are recommending in the first instance there should be a search for any suitable, usable space. The pilot launch team will pragmatically begin to build their operating environment and begin testing of systems.

Scale will come later.

Recommendations

NHS England's policy is for as many patients as possible to be moved out of hospital for their treatment to take place in community settings.

This necessitates there being space and clinicians being available to provide patient care.

We are recommending that the ICB carries out an audit of how much consultation and treatment space is available in GP clinics, NHS properties and the wider public space.

The ICB should simultaneously publish details of contracts it plans to offer to qualifying providers across a number of specialties which are not dependent on hospital facilities.

These should be contracts which are framed to provide risk-free remuneration to attract GP and hospital specialist participation. 'Money should follow the patient'.

A local referral management centre should be established to help with the routing of patients to the most appropriate care destination. This should be co-located with a Single Point of Access which would coordinate local care delivery and provide a collegiate space from which Multi-Disciplinary Teams would operate.

All community staff should be brought together in a federated organisation under the control of a single entity. The existing Royal Surrey/Procare joint venture contract should be re-drawn to set up the management detail. Most practice ARRS and VCSE staff would come within its scope.

We are recommending the building of a neighbourhood health centre on the Jarvis Centre site in North Guildford. We are looking to the ICB to work with the Royal Surrey Hospital and North and West Guildford PCN to create the right financial arrangement. We believe that there is scope locally to find a workable financial solution.

Population Health Management capabilities need to be strengthened, starting with an investment in current programmes focussed on market segmentation and risk stratification. These should be rapidly expanded to include the new generation of AI triage and patient management systems which are presently being adopted.

AI systems will provide a vast array of actionable data for commissioners and clinicians to use to redefine care delivery. In particular, we see these tools being used to transform care pathway management lowering costs and radically improving patient outcomes.

Finally, we see a unique opportunity for Guildford to exploit local assets – Hospital, progressive GPs, University, Medical School and ICB - coming together to create a transforming centre of excellence for next generation health care delivery.

The Guildford Society welcomes all suggestions as to how this vision might be delivered.