# Surrey's health care future

**20th August 2025**



Health Care NAVIGATOR

# Author’s note

- The 2012 NHS re-organisation was described as being ‘so large that it could be seen from outer space’.
- We believe that the consequences of the 10 Year Plan, the abolition of NHS England, the mergers of ICBs and the transition to Unitary Authorities, all happening simultaneously, will be greater.
- The move to integrated care means that local systems will be required to develop a more collaborative approach to care design and installation.
- Some Foundation Trusts who have long cherished their independence will find this challenging.
- Also, the planned introduction of Integrated Health Organisations means that there will be winners and losers among participating entities.
- The establishment of the Manchester Local Care Organisation in 2017 provides many insights as to how integrated care organisations develop.
- We expect that the Royal Surrey has begun to strategise its own future role and position.
- We have prepared this document as part of our long-term engagement to see better community care provision in the needy parts of north and west Guildford.

# Two simultaneous reorganisations will redefine health care delivery locally

- A number of important government announcements have been made in recent months which will reshape the health care landscape in England over the next few years.
- The 10 Year Plan establishes new directions for the NHS.
- The abolition of NHS England and the consolidation of ICBs will change commissioning priorities at a local level reflecting the preferences and priorities of new managements.
- The introduction of so-called Integrated Health Organisations, given only passing reference in the NHS 10 Year Plan, will have wide-reaching consequences, particularly for Foundation Trusts.
- Local government reorganisation will also have an impact with the move to Unitary Authorities (UAs) and Mayors.
- This combination of events means that most NHS organisations will need to re-visit their strategies ahead of the 2026/7 financial year.
- Foundation Trusts' jealously-held independence and autonomy will be challenged by these developments.
- Acting quickly to build their position is likely to be the preferred option for acute FTs.

# The plan to move patients for care out of hospital will be the most significant driver of change

- *'The Neighbourhood Health Service is our alternative. It will bring care into local communities, convene professionals into patient-centred teams and end fragmentation. In doing so, it will revitalise access to general practice and enable hospitals to focus on providing world-class specialist care to those who need it.*
- *Over time, it will combine with our new genomics population health service to provide predictive and preventative care that anticipates need, rather than just reacting to it.*
- *At its core, the Neighbourhood Health Service will embody our new preventative principle that care should happen:*
  - *as locally as it can*
  - *digitally by default*
  - *in a patient's home, if possible*
  - *in a neighbourhood health centre when needed*
  - *in a hospital if necessary.'*

**Fit for the future: 10 Year Health Plan for England. DHSC, July 2025.**

# We're not sure whether the authors of the 10 Year Plan have told the whole story about future NHS organisation

- The introduction of Integrated Health Organisations, starting next year, will bring a fundamental reshaping of local NHS systems' management and control.
- *'For the very best NHS FTs - that have shown an ability to meet core standards, improve population health, form partnerships with others and remain financially sustainable over time - we will create a new opportunity to hold the whole health budget for a local population as an Integrated Health Organisation (IHO). If they provide high quality care efficiently, they will be allowed to keep the savings to reinvest in better patient care, new capital projects, digital transformations, new partnerships or even commercial support for start-ups and SMEs with significant promise. Outcomes for patients would be secured through longer-term, capitation-based contracting and the model will be underpinned by both the ICB playing an active part as strategic commissioner and the refreshed FT governance model'.* **10 Year Plan.**
- While the responsibility for budgets and contracts stays with ICBs, they will have considerable influence over future system design.
- Maintaining organisational strength and resilience - and job protection - will be important factors in local power struggles.
- With its current ability to control budgets and contracts, would an ICB want to be the IHO?

# There is no mention here of Foundation Trusts in the trailing of IHOs

- *'Our intention is to designate a small number of these new IHOs in 2026, with a view to them becoming operational in 2027. All new IHOs will be put through a rigorous authorisation process, and will be overseen in a proportionate, rules-based way by their NHS region.*
- *They will be required to support integration, shift resources from hospital to community, focus on population health and tackle inequalities.*
- *They will be free to contract with other service providers, within and outside the NHS.*
- *This approach will help overcome the challenge that, in the NHS, interventions by one provider (e.g. a GP) accrues savings and benefits in another (e.g. a hospital). This means risk and reward is unbalanced, and particularly disincentivises prevention'.*

**Fit for the future: 10 Year Health Plan for England. DHSC, July 2025**

# IHOs are a rebadging of the accountable care organisation which was floated ahead of the introduction of CCGs

- *'Accountable Care Organisations aim to integrate care and bring services together, so people's care is coordinated around them. If introduced, ACOs are designed to help deliver more care in the community and patients' homes, improving access to services and meaning fewer trips to hospital. An ACO is not a new type of legal entity and would not affect the commissioning structure of the NHS. An ACO would simply be the provider organisation which is awarded a single contract by commissioners for all the services which are within scope for the local accountable care model.*
- *The contract holder becomes contractually responsible for improving population health outcomes, rather than simply providing services. The idea behind accountable care is that it brings different organisations from across the health and care system together to work to improve the health of their local population by integrating services and tackling the causes of ill health'.* **Accountable Care Organisations - Government response to consultation on changes to regulations required to facilitate the operation of an NHS Standard Contract (Accountable Care Models), March 2018.**
- There are precedents for NHS commissioners also being a provider organisation – the position with PCGs and PCTs in the early 2000s.
- One future outcome could be a hybridised system with power-sharing between FTs, commissioners and local authorities.
- No organisation has primacy in this configuration.
- It's very much the model adopted for Manchester.

# There are plenty of possible permutations for system design

- Commissioning  will prevail in much the same form for some time, as the 10 Year Plan makes clear.
- There are precedents for NHS commissioners also being a provider organisation – the position with PCGs and PCTs in the early 2000's.
- There is always the possibility that a commissioning organisation can function as a virtual IHO.  There are precedents for an IHO type organisation not being a single Foundation Trust, nor an acute hospital.
- One future outcome could be a hybridised system with power-sharing between FTs, commissioners and local authorities.
- No organisation has primacy in this configuration.
- The installation and development of the Manchester ICB  is a case study which deserves considerable scrutiny.
- Aspects of the model will be introduced across the NHS. At present, we don't know how.

# Will there be significant unintended consequences of new organisational design?

- Health care delivery will become even more politicised as it becomes an issue in local council elections.
- Also, we believe the NHS will become much more accountable to LAs.
- Integrated Care Partnerships, aka Health and Wellbeing Boards, will be much more interventionist in reshaping the design of care than they have in the past.
- We can expect a much deeper involvement by them in strategy development, JSNAs and performance management.
- The NHS which will still have the bulk of responsibility for executing plans will become much more accountable to ICPs.
- Preventive care programmes will receive more prominence – as the third leg of the 10 Year Plan and greater prioritising by ICPs/HWBs.
- Local Mayors will bring a new dynamic, vide Manchester.

# The move to truly integrated care is under way. There are precedents from which NHS organisations can draw

- Manchester is five years ahead of the rest of the NHS in learning how to integrate services. It's a case study which deserves a lot of scrutiny.
- The Combined Authority (CA) and Mayor have became more assertive players, resulting in the health management set-up we see today in Manchester.
- There is the sense that the CA is deeply engaged in the strategy with execution under mostly NHS control.
- The Manchester Local Care Organisation is a much more established provider than is seen in most NHS settings with a high degree of integration – crossover even - between NHS (GPs, hospitals, community care) and LA social services delivery.
- Locally, the prioritisation of projects will also change as the Surrey and Sussex ICBs are merged. A look at their current websites will show their different work styles and culture.
- Which will prevail locally in the new combined commissioning organisation?

# This is just part of the background reading for the Manchester integrated health pilot

‘Manchester Health and Care Commissioning (MHCC) is the primary body responsible for planning and funding health and care services in Manchester, focusing on integrated care and community needs.

**Overview of MHCC**

- Manchester Health and Care Commissioning (MHCC) is a partnership between **Manchester City Council** and the **Manchester Clinical Commissioning Group (CCG)**. Established to streamline the commissioning of health, adult social care, and public health services, MHCC aims to improve health outcomes for the residents of Manchester by integrating various services under a single framework.
- Manchester Community Central

**Key Responsibilities**

- **Commissioning Services**: MHCC is responsible for planning, funding, and monitoring a wide range of health and care services, including those provided by local NHS trusts and community organizations. This includes both health services and adult social care.
- **Community Engagement**: The organization emphasizes continuous involvement of the local community in the commissioning process, ensuring that services meet the needs of residents.
- **Strategic Planning**: MHCC develops strategic plans, such as the **Commissioning Plan**, which outlines priorities and initiatives aimed at improving care delivery and addressing health inequalities in the community.

**Manchester NHS Foundation Trust**

- Manchester TrustStrategy_2024_V12-compressed.pdf
- NHS Reforms Manchester ICB.pdf

**Manchester Local Care Organisation**

- https://www.manchesterlco.org/app/uploads/2024/05/MLCO-Ops-Plan-Summary-2425.pdf
- MLCO-Operating-Plan-2024-25-FINAL.pdf
- MLCO-Ops-Plan-Summary-2425.pdf

**Case Study**

- https://interworks.com/case-studies/greater-manchester-health-service-and-social-care-partnership/

# There are new challenges for the Royal Surrey to consider

- Foundation Trusts' jealously-held independence and autonomy will be challenged by these developments.
- The Royal Surrey (RSCH) has enjoyed a position of relative local strength since becoming a Foundation Trust in 2014.
- In its own SWOT analysis it says 'ICS or national programmes may impact our ability to determine our own future and affect services'. A more collaborative future looks likely for the NHS.
- Most FTs have the upper hand in negotiations with commissioners. The RSCH has been consistently well funded and capitalised.
- Royal Surrey finances have been managed exceptionally well over the past ten years, for example the payments from the Sustainability and Transformation Fund, which have helped it build substantial cash reserves.
- Darzi's 'Right drift' claim argues that hospitals have been disproportionately well funded compared to primary and community care applies as much in Surrey as elsewhere. *'Since at least 2006, and arguably for much longer, successive governments have promised to shift care away from hospitals and into the community. In practice, the reverse has happened'.* **Lord Darzi, 2024.**
- The test for commissioners in the next contract round will be how to begin the shift to neighbourhood health provision.
- There will be no extra money, so something will have to give.

# At the moment, determining what happens next is problematic. What would be the Royal Surrey's best outcome?

- The RSCH management's long-term focus on building the best acute hospital has coincided with an underinvestment in its satellites. 'Our community estate has been significantly under-invested and requires improvement'. **RSCH Annual report, 2023/4.**
- To be a substantial player in neighbourhood health, funds now need to be diverted to out-of-hospital care.
- Envisaged future care models, as presented for Haslemere Hospital, show what needs to be done.
- The RSCH will need to build a case for making a bid to be the IHO for the Guildford and Waverley Place, which will be one component of a much larger future geographic organisation for either west Surrey or the whole of the county.
- This is dependent on the decisions for Unitary Authority boundaries.
- This could threaten the RSCH's much cherished independence. A reference point is the many local Manchester Foundation Trust hospitals' subsidiarity to MUHFT.
- Potentially, the much larger Frimley Park FT, soon to be part of the Surrey Sussex ICS, could have the greater claim to lead.

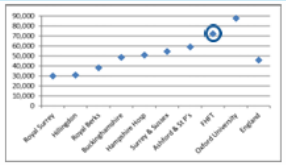
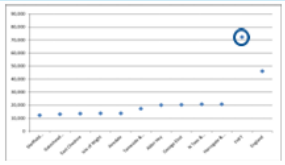
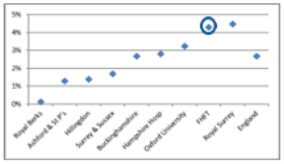
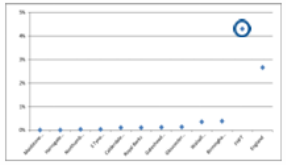
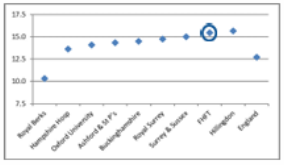
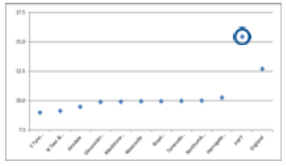
# There will be calls for a merger of west Surrey hospitals. FT status might not give current organisations protection

- Should all Surrey FT hospitals merge to become a single system?
- This now makes more sense with Frimley Park coming into the Surrey Sussex ICB area.
- With the transfer of diagnostics and outpatients into the community, acute hospitals become 'destination' health care locations.
- Google Maps says that all three major sites – RSCH, Frimley Park and St Peters are 20 minutes from each other by car.
- All three offer many of the same services when consolidation would bring more efficiency and cost savings.
- Service gaps could be more easily identified and dealt with. What, for example, would a service line analysis show?
- The RSCH SWOT analysis says *'The Royal Surrey is an important, but not large, Trust in the system and we have some services which rely on small teams and are thus less resilient. Some of our areas of clinical specialism have a national shortage of staff to which we are exposed'.*
- Further, *'our Trust [RSCH] has only one acute site where we see emergency patients and can perform elective operations. This means we currently have no ability to protect services from pressures such as raised emergency demand in the way that other Trusts with multiple hospital site are able to'.*
- The RSCH and St Peters have the same CEO, why shouldn't Frimley Park be included too?
- The overhead could be reduced as well. Shouldn't Finance, HR and Strategy be consolidated for starters?

# Consolidating specialties could even out current performance disparities …

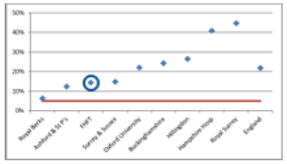
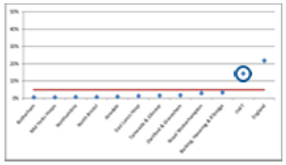
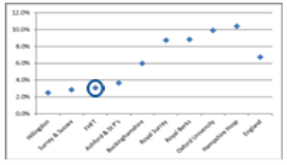
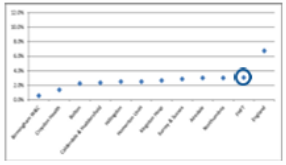
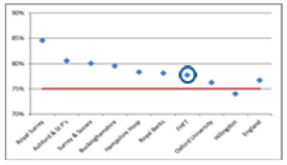
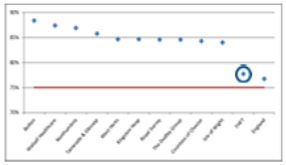
Frimley Health NHS Foundation Trust
PUBLIC BOARD MEETING

## Benchmarking – selected measures

| | Local trusts | Best in class | Rank | Quartile |
|---|---|---|---|---|
| RTT – Total incompletes |  |  | 93/121 | 4th |
| RTT – 52 plus weeks (% of total incompletes) |  |  | 106/121 | 4th |
| RTT – Median RTT waiting time |  |  | 98/121 | 4th |

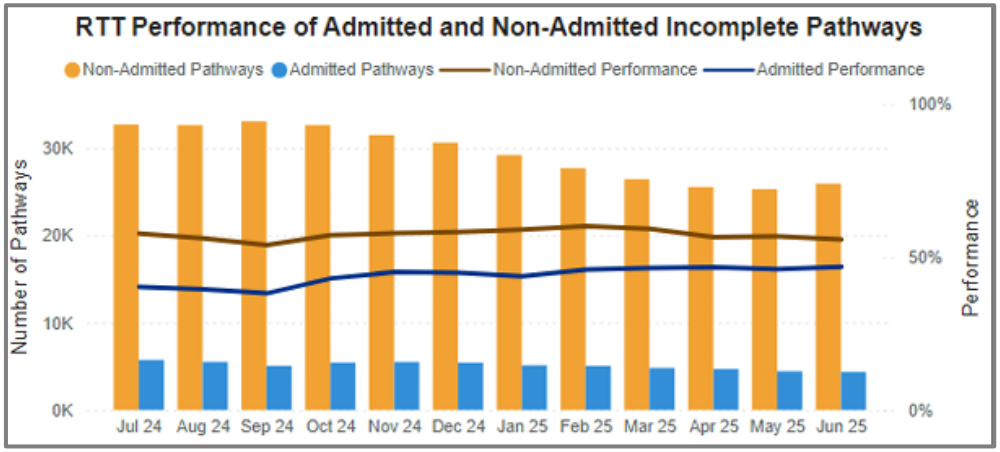
***NOTE** – for each graph, the position furthest to the left is the best performing trust. **Data periods:** RTT = April 2025*
*Best in class peer group has been expanded to include both Acute and Acute & Community trusts so the cohort now includes up to 125 trusts.*

## Benchmarking – selected measures

| | Local trusts | Best in class | Rank | Quartile |
|---|---|---|---|---|
| Diagnostics |  |  | 48/121 | 2nd |
| Cancer – Urgent PTL backlog (proportion waiting over 62 days) |  |  | 11/119 | 1st |
| Cancer – 28-day faster diagnosis |  |  | 58/119 | 2nd |

***NOTE** – for each graph, the position furthest to the left is the best performing trust. **Data periods: Data periods:** Diagnostics = April 2025;*
*Urgent Cancer PTL – proportion waiting over 62 days – position week ending 04 May 2025; Cancer 28-day FDS = April 2025.*
*Best in class peer group has been expanded to include both Acute and Acute & Community trusts so the cohort now includes up to 125 trusts.*

# … and lower RTT wait times across the area




**Public Board**

*Thu 24 July 2025, 09:15 - 12:30*

**Leggett Building**

NHS
Royal Surrey
NHS Foundation Trust

**RTT Performance by Speciality**

| Specialty | Total Waiting List | Performance | Performance Sparkline |
|---|---|---|---|
| Cardiology Service | 1043 | 54.46% | |
| Ear Nose and Throat Service | 3269 | 53.90% | |
| Gastroenterology Service | 1097 | 54.51% | |
| General Surgery Service | 2312 | 69.64% | |
| Gynaecology Service | 1663 | 71.26% | |
| Neurology Service | 1012 | 32.91% | |
| Ophthalmology Service | 2127 | 66.20% | |
| Oral Surgery Service | 4752 | 34.55% | |
| Other – Medical Services | 2867 | 63.86% | |
| Other – Other Services | 453 | 59.16% | |
| Other - Paediatric Services | 653 | 57.73% | |
| Other - Surgical Services | 852 | 67.14% | |
| Plastic Surgery Service | 133 | 86.47% | |
| Respiratory Medicine Service | 772 | 45.47% | |
| Rheumatology Service | 165 | 89.70% | |
| Trauma and Orthopaedics Service | 5777 | 46.51% | |
| Urology Service | 1341 | 78.08% | |
| **Total** | **30288** | **54.48%** | |

# If each of the three hospitals focuses on a specific range of specialties, then a different delivery structure emerges

- Here's one ICB's approach:

## So… What if…?

Traditionally our system, like most others, is defined by our organisational boundaries and governed by the contractual interactions that make up the partnership.
**What if the system financial framework facilitated the means to change the way our system worked?**

What if we used service lines across the system to underpin our ambitions? *It would change the dynamic of the way we view the system and remove organisational boundaries.*

What if we planned prospectively at service level? *We would understand the real cost of delivering care and be able to harness the knowledge and commitment of clinical leaders in a meaningful way.*

What if the accountability at system level was based on service lines?

- *We could align service standards, outcome measures, and common clinical policies to develop improvement plans focussed on delivering patient benefits not just organisational goals.*
- *We could create a culture of improvement across the system that would align with the [LTP} [national improvement] goals and indicators (such as through GIRFT/ Model Hospital and Right Place)*
- *We could develop system management approaches to care pathways*

**To achieve this vision partners across the system would need to adapt organisational financial and governance structures to support System First.**

**ICS stories: Mid & South Essex Service Line Approach, November 2021.**
**https://www.hfma.org.uk/events/ics-stories-mid-south-essex-service-line-approach**

# The envisaged plan is not a trivial undertaking. Intent should be demonstrated to secure IHO candidacy.

- *'The commitment to hospitals taking up a smaller share of the NHS's total spend in future is essential to putting the NHS on a sustainable footing. There are clear and aligned policy measures to help achieve this:*
  - *redeploying staff to primary and community settings through placements and new practice models*
  - *24/7 mental health neighbourhood pilots to bolster out-of-hospital services*
  - *reforming financial flows, with outcomes-based and capitated contracts, including eventually integrated health organisations taking on population budgets.'*
    **NHS Confederation., 3 July 2025**
- Nobody knows how this will happen. If a FT wants to put itself in a strong position to be the IHO, then it should be leading with an agenda which shows moves to deliver the key programmes of the 10 Year Plan.
- Building on community initiatives such as the plans for Haslemere Hospital, Provider-led contracting, collaboration with PCNs and the data aspects of Population Health Management seem to us like good starting points.

# The timetable will move faster than it appears.

- The juggling act will be balancing business as usual with the need to begin the transition to the new operating environment.

| | |
|---|---|
| June 2025 | Government consultation on Surrey local government reorganisation proposals. |
| September/October 2025 | Government decision on local government reorganisation anticipated, which begins statutory process to establish new council(s). If we receive an update before then, we will let you know. |
| January 2026 | Parliamentary process begins to lay Statutory Instruments. |
| May 2026 | Elections to shadow unitary authority or authorities. |
| April 2027 | New unitary or unitaries 'go live'. |
| Spring 2027 or 2028 | Mayoral elections and Mayoral Strategic Authority (MSA) 'go live', with the preparations for the establishment of the MSA taking place throughout 2026 to 2027, or Surrey joins MSA with neighbours. |

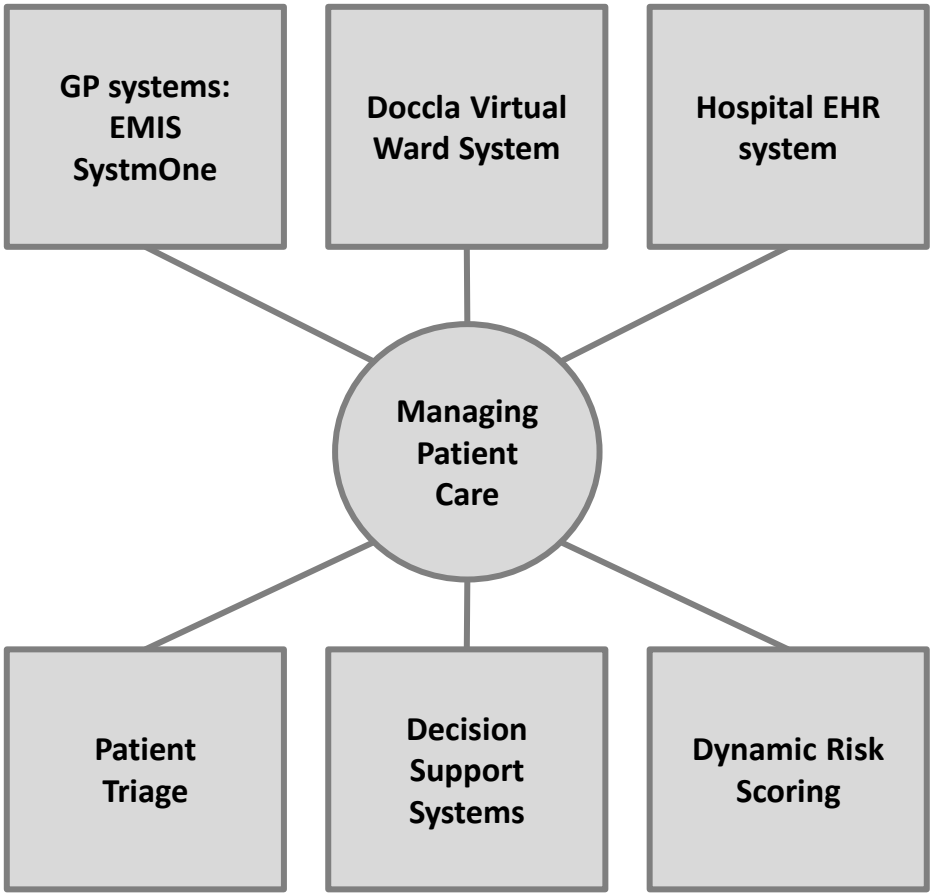
- Not only is it dependent on the formation of new entities, but the people involved – in ICBs and UAs – will be the same ones who are engaged in planning the new organisations.
- This is probably the moment to achieve prime mover advantage.

# IT planning is often the afterthought for NHS organisations. Everything which follows will be impacted by technology

- The NHS has not yet seen the digital disruption which every other industry has witnessed in the last 20 years.
- It's technology which will have the biggest bearing on health care transformation.
- [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.*
- *Connected technology will play a pivotal role with home-based devices such as movement sensors, accelerometers, bluetooth inhalers and pill packs, pulse oximeters and intelligent toilets. Data collated from these devices will be used to identify and predict changes in the behaviour of patients at home. This will underpin early interventions by family or health care services. This will help improve the outcomes and care experience for patients and families and reduce avoidable hospital admissions.'* **EMIS Health, UK's leading provider of GP desktop systems, 2023.**
- A great deal of this is already in place locally but is not yet integrated or deployed strategically.
- The organisation which controls the data will be critical in IHO decision-making.

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

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



# 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.

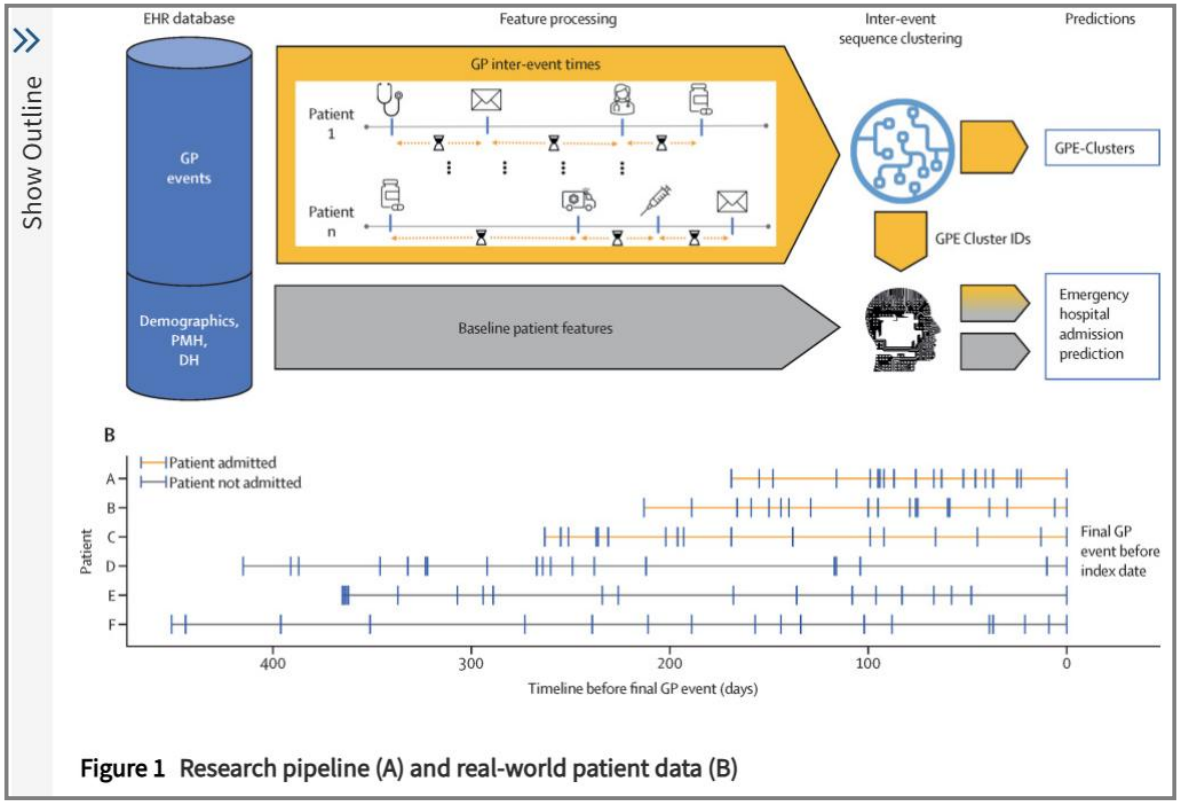
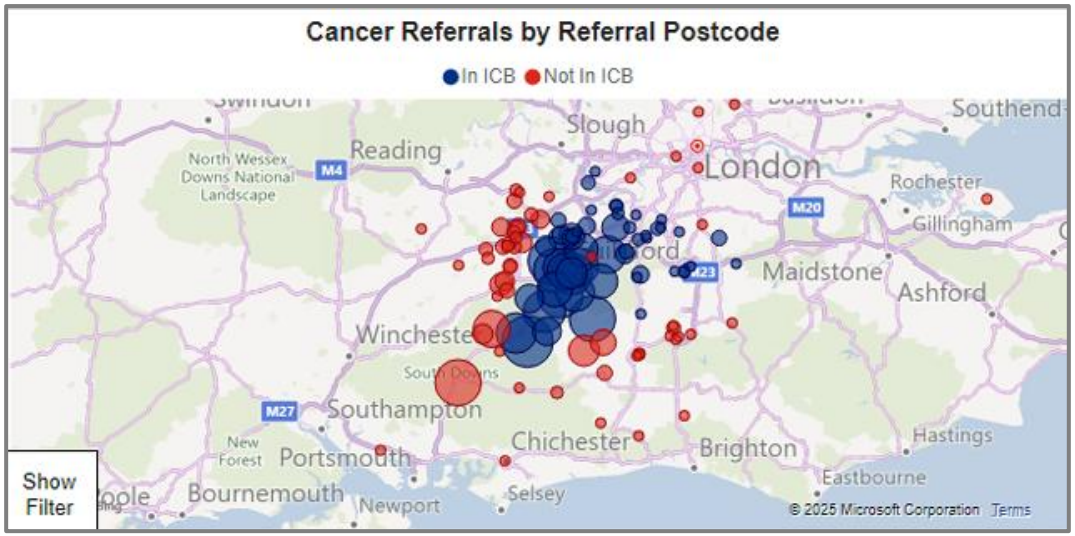



**Figure 1** Research pipeline (A) and real-world patient data (B)

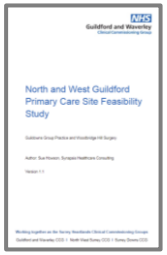
**https://www.thelancet.com/action/showPdf?pii=S2589-7500(24)00254-1**

# There is one ‘elephant in the room’ which needs acknowledgement – the RSCH Cancer Centre

- The Centre is a substantial asset for the RSCH and a remarkable, praiseworthy achievement.
- But is the tail now wagging the dog? Has its DGH role become secondary?
- Cancer surgery is claimed to be 60% of all procedures. Does this mean the reported RTT numbers for general surgery are even worse?
- The RSCH says that it is the country’s fourth largest cancer facility (we don’t know the measurement criteria), operating regionally serving three million people. Does it measure by size of catchment area?
- But the Royal Surrey Performance Scorecard says it’s different, that most patients come from GU postcodes.
- If it is a local cancer centre, then it should form part of a local integrated care strategy.
- If not, then there is an argument for it to be hived off, say as a merger with the Royal Marsden.
- No change would be involved in its development plans. It would still be a Guildford asset.
- The RSCH accounts give no clues as to whether the cancer centre subsidises the DGH, or vice versa. The hospital does receive substantial income from NHSE, presumably for specialised commissioning reimbursement.



# We have already made our agenda clear. We believe that there are many opportunities to advance RSCH interests




- ''To 'form partnerships with others', building relationships with PCNs across the Place is essential.'' **RSCH**.
- Haslemere, Cranleigh and Milford have the benefits of having a physical space operated by RSCH, a base for extending community care.
- What is operating in Haslemere should be the model for other localities.
- Does there need to be similar set-up for other localities? We think so.
- The most obvious starting locations would be north and west Guildford which for many years have been recognised as having poor primary care premises. RSCH should look at the real estate development options in the 2019 CCG Report.
- A more substantial presence in upstream care strengthens the delivery of integrated care and also improves hospital 'supply chains'. The RSCH would have more control over admissions.
- The Procare agreement needs to work across Guildford and Waverley universally, not just in a few PCNs.
- The RSCH Community Co-ordination Centre might also be expanded to create a system-wide single point of access

# Our engagement with this issue is mostly to improve care provision in central Guildford north of the A3

- More than 20,000 people live in the Guildford wards of Stoke, Stoughton North, Stoughton South and Westborough
- This is the part of the town with the highest rates of deprivation (IMD Decile 2) and lowest life expectancy.
- Cranleigh (population 12,700), Haslemere (17,500) and Milford (8,200) all have a completely different demographic but community provision from legacy hospital sites.
- The 2019 CCG proposal to provide new GP premises in Stoughton and Park Barn has never been activated.
- The Jarvis Centre owned by NHS Property Services represents an outstanding opportunity for redevelopment.
- We believe there is a strong business case for RSCH to build a neighbourhood health centre and show its commitment to community engagement. See this case study https://www.bbc.co.uk/news/articles/cn4w2p79v9eo

**From:**

**Jarvis Centre, Stoughton, Guildford**

**To:**

**Washwood Health Community Health Clinic, BBC, 8 April 2025.**

# The RSCH agrees that there needs to be adequate provision in local neighbourhoods


## What we've heard so far, Haslemere Hospital

**Neighbourhood health**

Providing healthcare tailored to local communities With local health and care partners – including the voluntary and community sector

- **Neighbourhood teams**
- **Population health management**
- **Community partnerships**
- **Proactive & preventative care**

**Care for those with long term conditions**

Aim to **improve the quality of life** by enabling people to live well with their condition(s) and maintain their independence.

**Diabetes, asthma and coronary heart disease** are examples.

A long term conditions management hub at Haslemere Hospital would:

- **Integrate services**
- **Promote self management**
- **Focus on preventing exacerbations**
- **Reduce hospital admissions**

**Access Hub for General Practice**

**Urgent Treatment Centre**

**Outpatient rehabilitation**

**Oncology and chemotherapy services delivered locally**

**Frailty 'healthy ageing' hub**

A healthy ageing hub could facilitate community engagement, patient education, guidance and treatment.

Multidisciplinary assessment and care planning.

Targeting people in the earlier stages of frailty, aiming to reverse, halt or slow the progression to moderate/severe frailty

Three key approaches within a healthy ageing hub:

1. **Promotion of healthy ageing**
2. **Completion of Comprehensive Geriatric Assessment (CGA)**
3. **Supporting optimal management of frailty syndromes**

**Increase outpatient services**

High demand from the local population for clinics in:

- **Elderly medicine**
- **Cardiology**
- **Pain management, Anticoagulant, and Neurology**
- **Children's (paediatric) clinics**

# This is the RSCH plan for neighbourhood health. It recognises the financial benefit from moving care out of hospital.

## Neighbourhood Health Opportunities

### 10 Year Health Plan for England - Neighbourhood Health is central

**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)

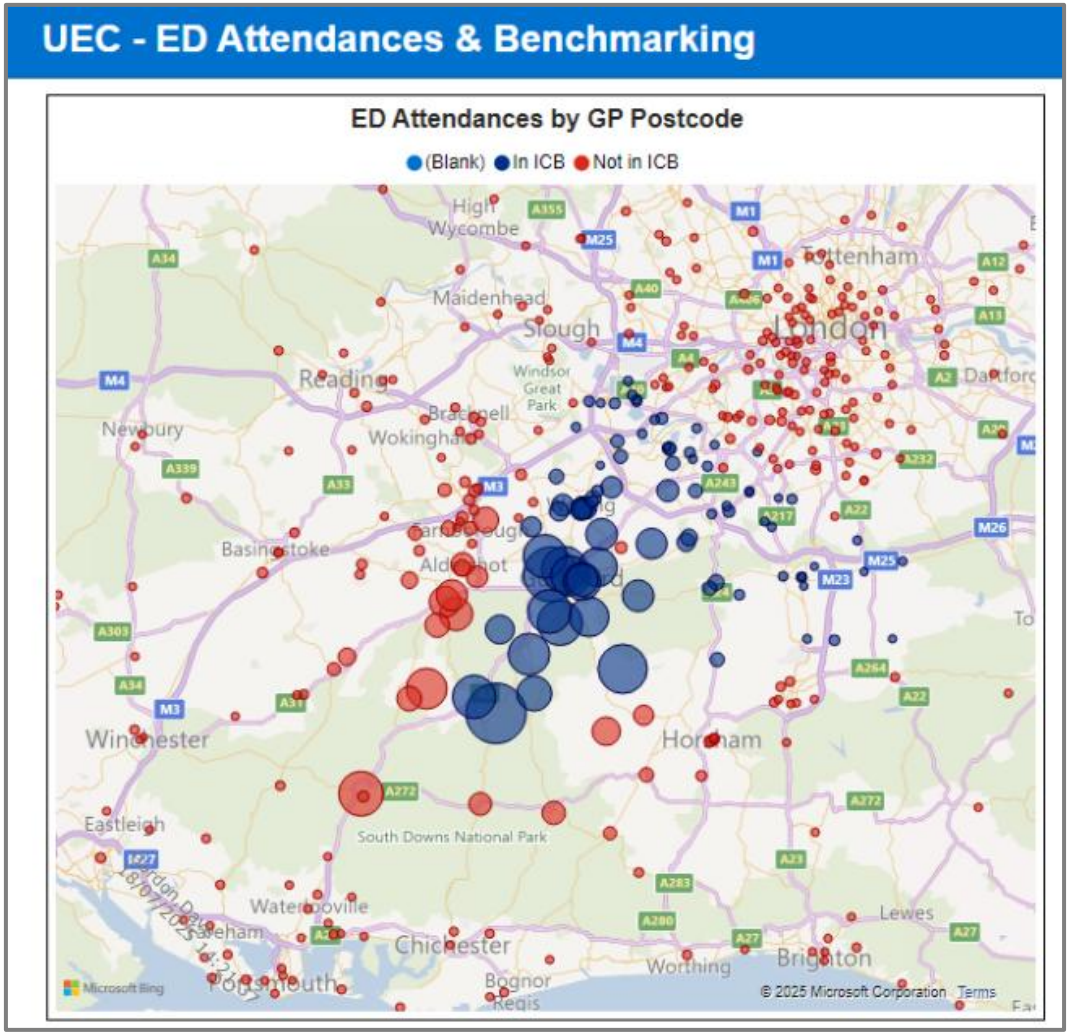
**Systems that invest more in community care see 15% reduction in non-elective admissions and 10% lower ambulance conveyance rates, as well as reductions in Emergency Department attendances**

**Core requirements**

- Partnership working between organisations: RSCH, 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

**'Developing Services at Haslemere Hospital, RSCH, 2025**

# RSCH data says that ED attendances come mostly from town centre postcodes, especially north of A3




- Locally, there seems to be a correlation between ED admissions and the less prosperous parts of the borough

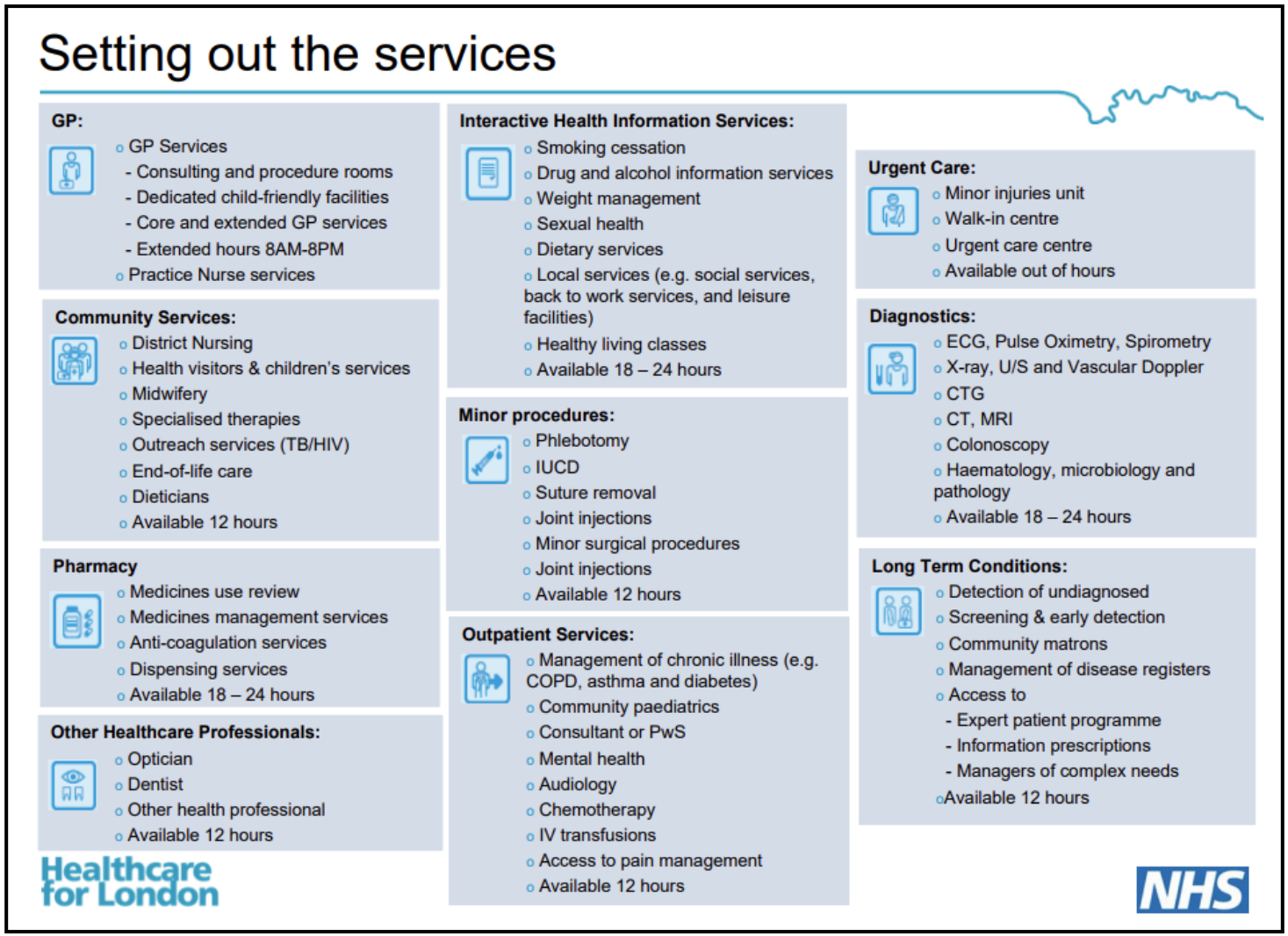
# Given all of the above, would the RSCH be prepared to be the lead funder for the redevelopment of the Jarvis Centre?

The financing of a Jarvis Centre refit could come from a number of different sources:

- RSCH could pay for it all or create an entity which is financed by rent charged annually to a range of users. It might jointly fund with the ICB given the recent NHS England policy changes.
- Private sector providers - Assura and Prime - could bring their business models.
- GP surgery rents are paid for by the NHS almost in their entirety. This might be up to 50% of the space.
- RSCH could provide outpatient services, refunded by PbR.
- Urgent care or walk-in services.
- The JV with Procare could be expanded. MDTs could operate from the site, where there would also be training facilities.
- Better co-ordination with GP ARRS services and some consolidation with other PCNs.
- Rent from voluntary organisations and charities like Macmillan
- Private sector health providers – diagnostics, dentistry, optometry, physiotherapy, pharmacy, for example.
- Specialised clinics could be contracted in by the ICB – take the Women's Health service in Shere as a local example, operated by local GPs. AQP contracts could be awarded by the ICB, see the next slide for possible uses.
- The ICB might want to run certain admin. services, possibly in connection with PCNs.
- Local authority services - public health and social care – to improve integration.

# The developer and operator could look to receive rents and fees from the provider of a wide range services

- Is this essentially a hybrid of polyclinic and department store?



# Financing a community health care centre is a project which is well within the scope of the RSCH.

- The Royal Surrey has proved it is an adept financial engineer.
- In the past three years it has engaged in a complex five-way financing arrangement with Prime plc, Assura, VINCI and GenesisCare.
- This involved the construction of a multi-storey staff car park in an arrangement which also provided the land to build a privately operated cancer clinic and research hub.
- Full details are given in GBC planning application 21/P/00817 approved on **12th January, 2022 7.00 pm (Item PL7)**
- 'The Committee considered the application for 'Full planning permission for a six level multi storey car park to accommodate 598 staff parking spaces and Outline planning permission for a new cancer centre.
- The car park build cost would be c.£7m. This would be 200 additional spaces to the previous surface level provision for 400 cars. The land is freed up for future hospital development.
- The RSCH in press releases said that 'the partnership with GenesisCare via the establishment of the new centre is a further step forward in our ambition to provide patients with the best care possible. Alongside access to world-class technology the facility will enable our team to establish new dedicated training programmes that will expand the hospital's expertise amongst a wider number of clinicians, helping to benefit more patients'.
- Assura plc arranged the £31 million development funding.
- The building is operated by and let to Genesis Cancer Care UK Limited on a 30-year Full Repairing and Insuring lease with annual, index-linked rent reviews.

# The funding of the Jarvis Centre would be completely within the scope of Foundation Trust capital expenditure rules

- Capex projects for this purpose will be fully aligned with the policy to increase neighbourhood health provision.
- NHS England provides guidance on the use of the power to impose limits and manages the overall process for capital investment approval.
- In theory, they can incur any amount of capital expenditure, as long as they can afford it, either through retained surpluses or public dividend capital. The Health and Care Act 2022 includes a clause that enables the DHSC to impose capital spending limits on NHS foundation trusts. This could be enforced where foundation trusts are not considered to be working effectively to prioritise capital expenditure within their system, and risk breaching either the system allocation or the Capital Departmental Expenditure Limit.
- 'Business cases with a financial value of less than £25m can be approved by the provider body's board. Above this level, external approval is required.'
  **UK Government, Health and Care Act 2022 NHS England, Guidance on developing a 10-year infrastructure strategy, updated July 2024. HFMA introductory guide to NHS finance Chapter 14, 2024**.
- Also, it is fully aligned with policy guide changes to NHS England primary care premises funding, updated on 11 November, 2024, see panel.

## Guide to the changes to primary care premises policy

**Date last updated**: 11 November, 2024

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

### Key changes

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

### Improvement grants

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

# The RSCH balance sheet is one of the strongest of NHS FTs, particularly for such a relatively small hospital

- This means that funding the Jarvis Centre site is well within the scope of Foundation Trust funding rules.
- We expect in any case that the capital requirement could be relatively small.
- Other sources of capex are likely to be made available from the ICB, Guildford and Surrey Councils (particularly accumulated s.106 contributions), charities and private sector financing.
- We would urge the RSCH Finance team to look at funding models to evaluate the feasibility. This should include the extra income for the main site which would come from freed-up capacity.

**Note 24 Cash and cash equivalents movements**

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

| | Group | | Trust | |
|---|---|---|---|---|
| | 2024/25 | 2023/24 | 2024/25 | 2023/24 |
| | £000 | £000 | £000 | £000 |
| **At 1 April** | **88,715** | **83,539** | **86,848** | **80,360** |
| Net change in year | (4,291) | 5,176 | (4,018) | 6,488 |
| **At 31 March** | **84,424** | **88,715** | **82,830** | **86,848** |
| **Broken down into:** | | | | |
| Cash at commercial banks and in hand | 2,315 | 2,014 | 721 | 146 |
| Cash with the Government Banking Service | 82,109 | 86,701 | 82,109 | 86,701 |
| **Total cash and cash equivalents as in SoFP** | **84,424** | **88,715** | **82,830** | **86,848** |
| **Total cash and cash equivalents as in SoCF** | **84,424** | **88,715** | **82,830** | **86,848** |

**Statement of Changes in Equity for the year ended 31 March 2025**

| Trust | Public dividend capital £000 | Revaluation reserve £000 | Income and expenditure reserve £000 | Total £000 |
|---|---|---|---|---|
| **Taxpayers' and others' equity at 1 April 2024 - brought forward** | **122,495** | **68,944** | **122,276** | **313,714** |
| Surplus/(deficit) for the year | - | - | (3,912) | **(3,912)** |
| Impairments | - | (10,425) | - | **(10,425)** |
| Revaluations | - | 496 | - | **496** |
| Public dividend capital received | 6,833 | - | - | **6,833** |
| **Taxpayers' and others' equity at 31 March 2025** | **129,328** | **59,015** | **118,364** | **306,706** |

**RSCH Annual Report, 2024-25, Pages 118 and 166.**

**Growth of total cash and cash equivalents 'as in SoCF'**

| Year ending | £m |
|---|---|
| 2016 | 4.9 |
| 2017 | 8.4 |
| 2018 | 34.7 |
| 2019 | 58.0 |
| 2020 | 79.5 |
| 2021 | 98.6 |
| 2022 | 108.2 |
| 2023 | 80.1 |
| 2024 | 86.7 |
| 2025 | 84.4 |

**RSCH Annual Reports.**

# Care funding will need to adapt, or even be changed, to move care out of hospital.

- *'To make this possible, we will shift the pattern of health spending. Over the course of this plan, the share of expenditure on hospital care will fall, with proportionally greater investment in out-of-hospital care. This is not just a long-term ambition. We will also deliver this shift in investment over the next 3 to 4 years as local areas build and expand their neighbourhood health services'.* **'Fit for the future: 10 Year Health Plan for England'. DHSC, July 2025.**
- There is another option, that hospitals follow the patient into the community.
- These might be by personal health budgets, where the patient becomes the buyer.
- In the future other options will open up. What, for example, if the proxy for the patient is a trusted member of an MDT? They already have the care pathway and can control purchasing.
- This is then a Pandora's Box moment for the large acute trust.

# Who wins in the new IHO landscape? Hopefully, the patient

- There are two obvious candidates to become the future Independent Health Organisation, although there are also hybrid options:
  - The West Surrey acute hospital grouping comprising Frimley Park, Ashford St Peter's and RSCH has the strongest management capability and receives the bulk of financing.
  - The ICB-led community health care system, which organises contracts and allocates budgets, could join up with local PCNs.
- The deciding factor might be who controls the delivery of neighbourhood care:
  - The hospital grouping has some history of working with community care organisations, the Procare agreement, for example.
  - GPs through their expanded ARRS teams also have a claim.
  - In addition, there are the local authorities who deliver social care and are involved in strategy development through ICPs/Health and Wellbeing Boards. The Manchester experience is well worth reading.
- It could be the combination of these entities who, with VCSE enterprises, join up to create an expanded multi-disciplinary teams.
- As for most industries, it will be the organisations which control and manage the data who will have the greatest influence on service design and personalisation.
- How the money is allocated will also have a bearing. We see a future where money does follow the patient, particularly the neediest.
- Budgets will then be determined at the individual patient level. If proper Patient Choice programmes are installed, then the nominated patient representative might be an MDT member.
- He or she could then determine the most appropriate provider at each point on the care pathway, paying for treatment from the patient's budget. This could see more GP AQPs working on ICB contracts out of community health centres.