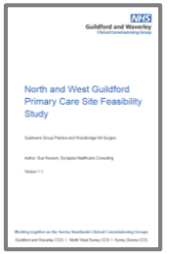
Meeting with Guildford and Waverley Health and Care Alliance, 22nd January 2025

Updated 31st October 2025

Executive summary

- There is a long-held, general consensus that GP premises in north and west Guildford are not fit for purpose.
- A 2019 CCG report recommended two new rebuilds, one in Stoughton and one in Park Barn.
- The report has never been implemented.
- There has been a stand-off between the Guildowns GP practice and the ICB as to who organises the funding. The NHS is now legally able to provide financing.
- NHS England policy is to move patients out of hospital and into communities.
- This can only happen if there is somewhere for them to go, which is not the case for these localities.
- Also, hospital capacity has to be protected from excess demand to enable it to provide urgent and emergency care and treat more complex conditions.
- The Royal Surrey is full every day and will be forever. Its waiting times are longer than the national average.
- Improved primary and community premises can provide a broader range of services and operate as a base for multi-disciplinary teams.
- The 2019 report foresaw a redevelopment of the Jarvis Centre site in Stoughton which is owned by NHS Property Services.
- The £20 million build cost could be funded from a number of sources. The cash rich RSCH could provide the seed capital.
- There are real benefits both for itself and the local system if it took a larger role in providing care in the community.
- Our representations to the ICB have been continuously rebuffed. We question whether it is meeting its legal obligations.
- Commissioning boards are now required to urgently produce strategies showing how the move to community care can be delivered.
- There will be considerable public interest in seeing what turns out. Maintaining the status quo is untenable.

This is what the 2019 CCG report on north and west Guildford GP premises said



- ‘The case for change has identified some key issues that need to be addressed if primary care in north and west Guildford is to be sustainable into the future’.
- ‘A significant proportion of the population it affects is the town’s most needy’.
- ‘The current delivery model is not sustainable given the current pressures on primary care and the problems with the recruitment and retention of GPs.’
- ‘The current estate is not fit for purpose and with further additional demand in the form of two new planned housing developments at Slyfield and Blackwell Farm, the lack of primary care capacity in north and west Guildford will be further exposed.’
- ‘This study has concluded that the only viable option is to increase capacity through new build options.’
- ‘The Guildowns Group Practice has expressed a desire not to hold any freehold property interests as a partnership going forward. For the Guildowns practice, delivering services across four sites further compounds these issues.’

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.

Potential development sites were identified

The 2019 report identified redevelopment opportunities:

- ‘Building new combined facilities at the Jarvis Centre and Kings College, Park Barn would provide the opportunity to address many of Guildford’s most pressing medical needs.’
  - **‘The Jarvis Centre – Stoughton Road**
    The Jarvis Centre is located on Stoughton Road and is owned by NHS Property Services. It is in the northeast quadrant of the registered GP lists included within this study. The site extends to approximately 7,400m2 with three buildings present on the site:
    The main building is a combination of single and three storeys and occupies a footprint of approximately 1,500m2;
    The annex – a small double storey building to the rear of the site with a footprint of approximately 140 m2; and
    The portacabin – a single storey temporary structure.
  - **Kings College – Park Barn**
    The Kings College site is located on the western boundary of the practices’ catchment area.
    The available land is on the site of Kings College.
- ***Note: the Kings College, Park Barn site is no longer available.***
- This will still leave this site and the existing Wodeland Avenue practice, as covered in the 2019 report, as requiring further investigation.
- The overall situation in the North of Guildford is harming patients and requires urgent attention. Proceeding with the Jarvis site, nearly six years on, is now critical.

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

- ‘The location is within one of Guildford’s most deprived localities.
- It is a large 7,400 sqm site with three principal buildings.
- Stoughton Road surgery is a leased property at the end of a row of commercial properties.’
- ‘For the registered list size, the building is significantly undersized offering only 118 sqm, a deficit of 251 sqm.’ **2019 CCG Report.**
- It is a few hundred yards from the Stoughton Road GP surgery operated by the Guildowns practice.
- The Jarvis Centre site is owned by NHS Property Services, obviating the need to purchase a property under private ownership.

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

What is this service?

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

CHANGE NHS Get involved now change.nhs.uk

This is precisely the kind of development that the area needs

- ‘Washwood Heath, a community health clinic was set up in a deprived part of east Birmingham two years ago (2023). Here, hospital doctors, GPs, nurses, occupational therapists, council social care teams, mental health professionals and charity staff work under one roof.
- The £15m three-storey 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.
- The target is the most frequent users of health services - and the aim is to keep them well and out of hospital.
- "We want to work with the 10% of the population that is responsible for 70 to 80% of its use," explains head of Birmingham Community Healthcare NHS Trust, one of the key partners at Washwood Heath. "The NHS cannot meet their needs on its own – it requires partnership working.“
  BBC, 8 April 2025

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

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

Primary care capital grants policy

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

1. Background

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

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

3. Premises improvement grant

Powers – NHS (GMS – premises costs) directions 2024

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

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

Guide to the changes to primary care premises policy

Date last updated: 11 November, 2024

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

Key changes

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

Improvement grants

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

This is how one ICB is implementing the policy

GP Premises Development & Delivery Plan April 2024 to March 2031

Final version
July 5th 2024

iv. Improvement Grants

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

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

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

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

One Gloucestershire

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

Brockworth: £6.6m for 14,500 pts

Hucclecote:£4.9m for 10,000pts

Newent:£6.3m for 13,000 pts

Coleford: £6.2m for 15,000 pts

Yorkley & Bream:£4.3m for 8,000pts

Lydney: £7m for 15,000pts

Beeches Green: £4.9m for 9,200pts

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

Minchinhampton: £6m for 9,000pts

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

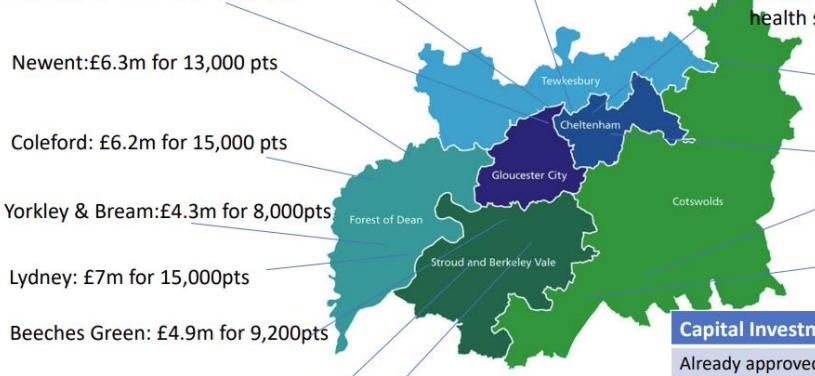
West Cheltenham new housing community :£3.6m for 5,500 pts and including community health services

Chipping Campden:£3.5m for 6,000pts

Central Cheltenham: £9.5m for 24,000 pts

Cirencester:£10.9m for 28,000pts

Tetbury: £5.5m for 10,500 pts



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

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

Joint Forward Plan 2024 Fact File: Estates

Ambition 3: What we need to deliver these ambitions

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

Case Study

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

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

Improving access to GP services

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

SURREY HEARTLANDS Health and Care Partnership

SURREY COUNTY COUNCIL

NHS

Joining up care across Surrey Heartlands

A summary of our strategy

2 Delivering care differently

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

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

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

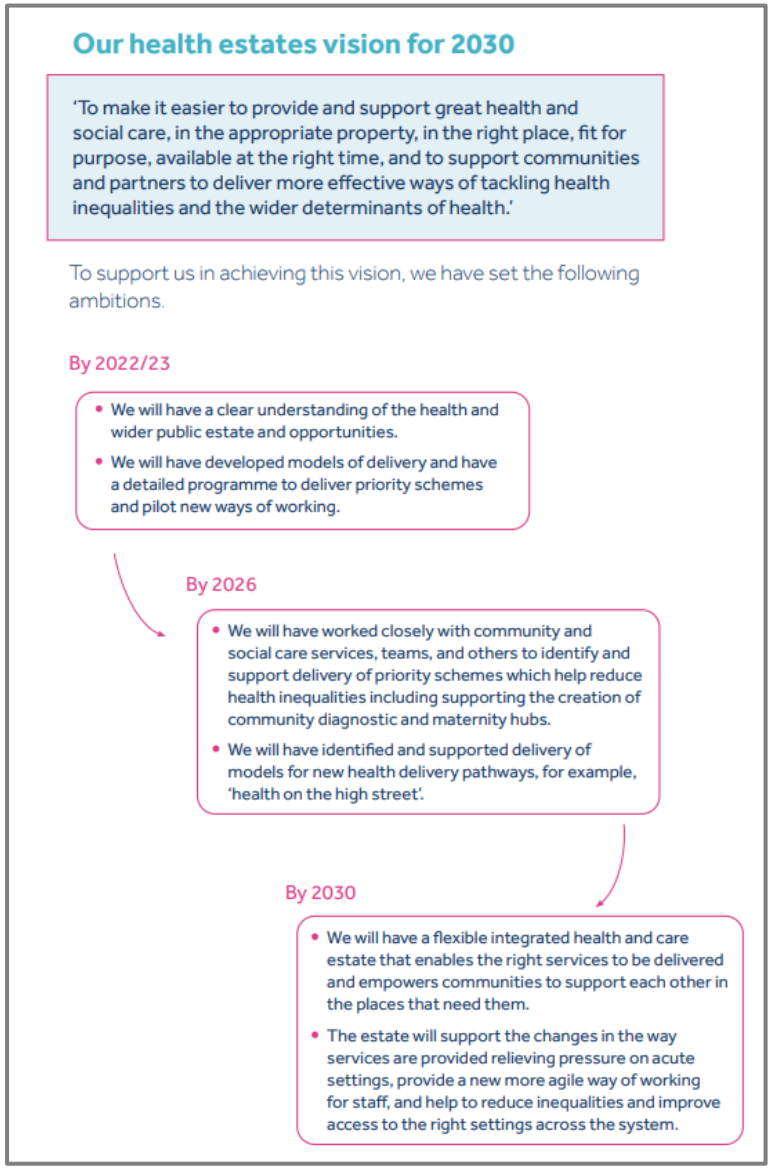
Provider collaboratives

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

Neighbourhood teams

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

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



Our health estates vision for 2030

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

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

By 2022/23

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

By 2026

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

By 2030

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

Delivery Milestones

2024/25

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

Surrey Heartlands Integrated Care Strategy, December 2022.

The shift to investment in community and primary care has to take place in England, Surrey and Guildford, in particular

- In 2022/23, the NHS spent roughly one eighth as much on general practice as on acute hospital trusts (£11.5 billion on the former and £89.5bn on the latter). This is despite the majority of daily NHS activity taking place in primary care'.
- It will be impossible, however, to shift care into the community without an expansion in capacity, which will in turn need a modernised and expanded estate that will facilitate the working of an expanded GP workforce and new MDTs'.
  Institute for Government, Delivering a general practice estate that is fit for purpose, June 2024.
- '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 three to four years as local areas build and expand their neighbourhood health services'. **Fit for the future: 10 Year Health Plan for England. DHSC, July 2025.**

Perpetuating the current funding imbalance would frustrate the transition to integrated care

- The Royal Surrey has an annual income of around £500 million, receiving about half from the ICB.
- Ashford St Peters, £330million, the local mental health trust, £200 million.
- Local GPs receive less than £20 million as capitation fees. Practically no capital allocations.
- Community health services (RSCH is in a joint venture with some PCN partners) about £20 million.
- To enable the new care vision to be delivered, we proposed that 2025/6 should be Year One of a transitional budget. It never happened.
- We wanted the RSCH to accept that a diversion of funding into the community would be a good investment. It later did, see page 27.
- Most capital expenditure allocations by the ICB in recent years have gone to provider units - a new mental health hospital in Chertsey; Community Diagnostic Centres on established sites in Milford and Woking; £9.5m for 'a new centre for higher-volume, lower complexity procedures at Ashford St Peters' (surely a missed community care investment).
- The Royal Surrey has probably received at least £50 million over the past five years, despite having cash reserves in the £75-100 million range. Most are still unused. A large proportion of ICB allocations was spent on developing the RSCH Cancer Centre.
- It is difficult to see the precise position with ICB capex funding through a lack of published data. GPs have received very little.

The last we heard from the ICB - on 19 Sep - was completely non-committal. They still see the development as a GP responsibility

'Further to the recent board meeting last week, firstly our apologies that your request was not acknowledged at the June board meeting as you had expected, and that we hadn't been in touch during the intervening period. We can confirm however that your updated report/presentation has been shared with the Chair and Chief Executive as requested.

In relation to local primary care estates within Guildford and Waverley, the focus of your previous correspondence, as we have said, the ICB is supportive of the need for a new model of estates within primary care in the North and Central Guildford area, the ICB primary care team and local partners are working together to explore this further. The local system partners meet via the Guildford and Waverley (now the West) Alliance Board and the Finance and Resource Committee to approve local health and care delivery plans. Local primary care estates development is also a key part of every Primary Care Commissioning Subcommittee.

The approved approaches to investment and pace of delivery are subject to national and local access to investment and includes the practices' own approaches to their business models. In terms of local engagement, we would expect the practices to keep their Patient Participation Group updated as a key conduit for patient/public engagement and, as you are both members, suggest that you formally request an update at the next meeting.

In recognising your ambition regarding primary care estates development and local health and care services, as indicated at Wednesday's board meeting and the fact that you have already met with the lead Executive for primary care and Place Alliance Chair to discuss these matters we would suggest that the next step would be a more practical meeting that involves the practice. As referenced at the Board your inclusion in such a meeting needs to be initiated by the practice. We will make contact with the practice and update them on the position. With their agreement we would be happy to join a meeting with you and the practice. We hope that this will be a productive opportunity for a more targeted conversation.'

- As of 24-10-2025, the Guildowns practice had received no communication from the ICB.
- We plan to follow up with a further question for the December ICB Board meeting.

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

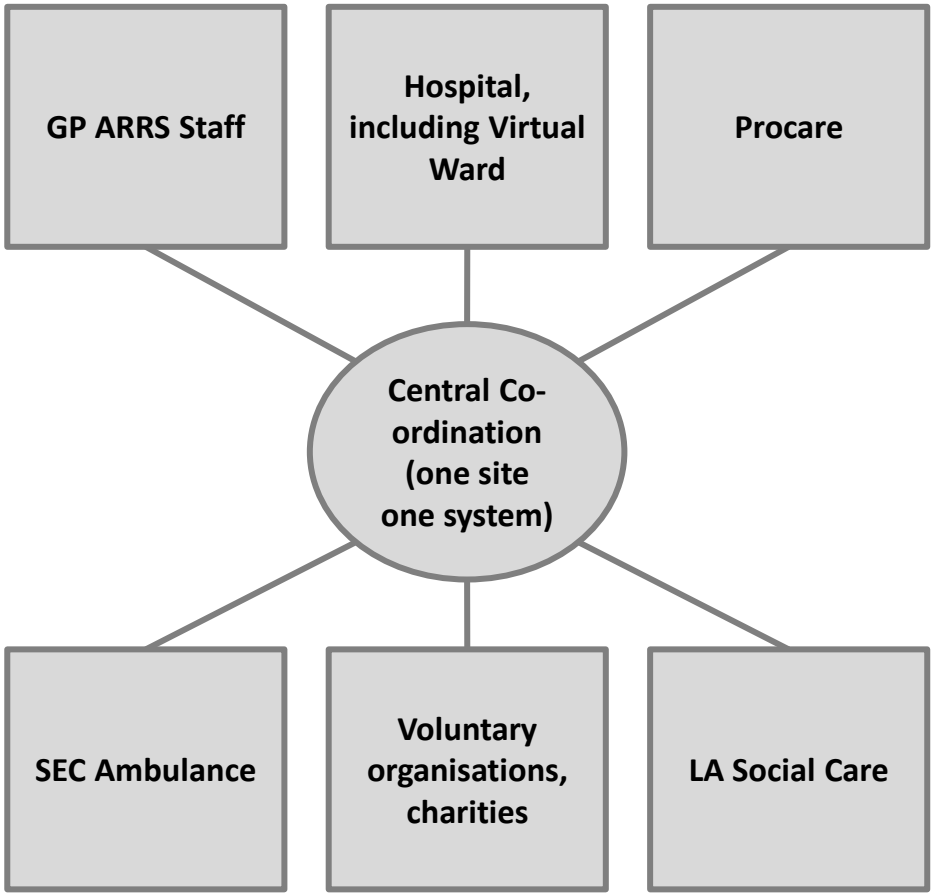
- Primary care will be transformed only if the resources, principally real estate, are fit-for purpose.
- A bigger GP practice headcount requires a lot more space.
- Technology has changed and will change premises design further.
- The opportunities include:
  - Leveraging the additional staffing provided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

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

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

Grouping community health care services to operate from a single site brings many benefits

- There is a much bigger opportunity if you can bring all locally provided community services into a single management system. This is essentially the place where multi-disciplinary teams would be headquartered.
- It would provide an operational base with sufficient space for back-office services, admin and training, for example.
- This might be operated under a single Integrated Health Organisation proposed under the 10 Year Plan.
- The RSCH, as a competent Foundation Trust, would be the firm favourite to be the local Integrated Health Organisation (IHO).
- It should move early to secure the position.



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

- If the duty of health systems is to protect its people, it could be that Guildford has an imbalance in its delivery system.
- Life expectancy is lower, health status poorer, in the deprived parts of Guildford.
- According to the last CCG survey in 2019, 'the main areas of deprivation in Guildford are within the wards of Westborough and Stoke.'
- These are not areas of total deprivation: 'within Westborough, 12% of the population live within the 10-20% most deprived areas in England (ranked 5726) and within Stoke, 13.3% of residents are within the 20%-30% range (ranked 6889)'.
- 'Life expectancy at birth for men ranges from 76.6 years in Stoke to 87.6 years in Godalming Holloway, a difference of almost 10 years. LE at birth for women ranges from 78.8 years (Stoke) to 90.7 years (Blackheath and Wonersh), a difference of 11.9 years.'
- 'The Park Barn and Royal Surrey neighbourhood has the highest level of overall deprivation - with 35.4% of households suffering some type of deprivation. **References: ONS ,SCC and GBC**
- The inverse care law applies in Guildford, which states that 'people who need medical care the most are the least likely to get it'.
- Cranleigh, population 12,700; Haslemere, 12,000; and Milford 4,200 are all satellites of the RSCH system. All of these localities have long life expectancy – higher than the national average.
- Is the health status of people in these localities actually deteriorating? The last report from the now defunct Guildford Health and Wellbeing Board would suggest so: 'despite a positive overall picture, there are however some significant inequalities. For example, life expectancy is 7.3 years lower for men and 3.0 years lower for women in the most deprived areas of Guildford than in the least deprived areas**.' Guildford Health and Wellbeing Board 2017.**

Is the ICB delivering on its legal obligations?

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

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

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

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

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

- The Act referred to is the NHS Act 2006, as amended by the Health and Care Act 2022.
- There is plenty of evidence that there is a wide disparity in health provision across the borough.
- Is the ICB exposed to a Judicial Review on this basis?

Since our meeting with the ICB in January, the government's 10 Year Plan for the NHS has been published. It says

'We will reinvent the NHS through three radical shifts:

- hospital to community
- analogue to digital
- sickness to prevention

These will be the core components of our new care model. To support the scale of change we need, we will ensure the whole NHS is ready to deliver these three shifts at pace through a new operating model:

- by ushering in a new era of transparency
- by creating a new workforce model with staff genuinely aligned with the future direction of reform
- through a reshaped innovation strategy
- by taking a different approach to NHS finances.'

'The Neighbourhood Health Service 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.

We will achieve our goals by harnessing a huge cross-societal energy on prevention. We will work with businesses, employers, investors, local authorities and mayors to create a healthier country together.' **NHS England 10 Year Plan, DHSC.**

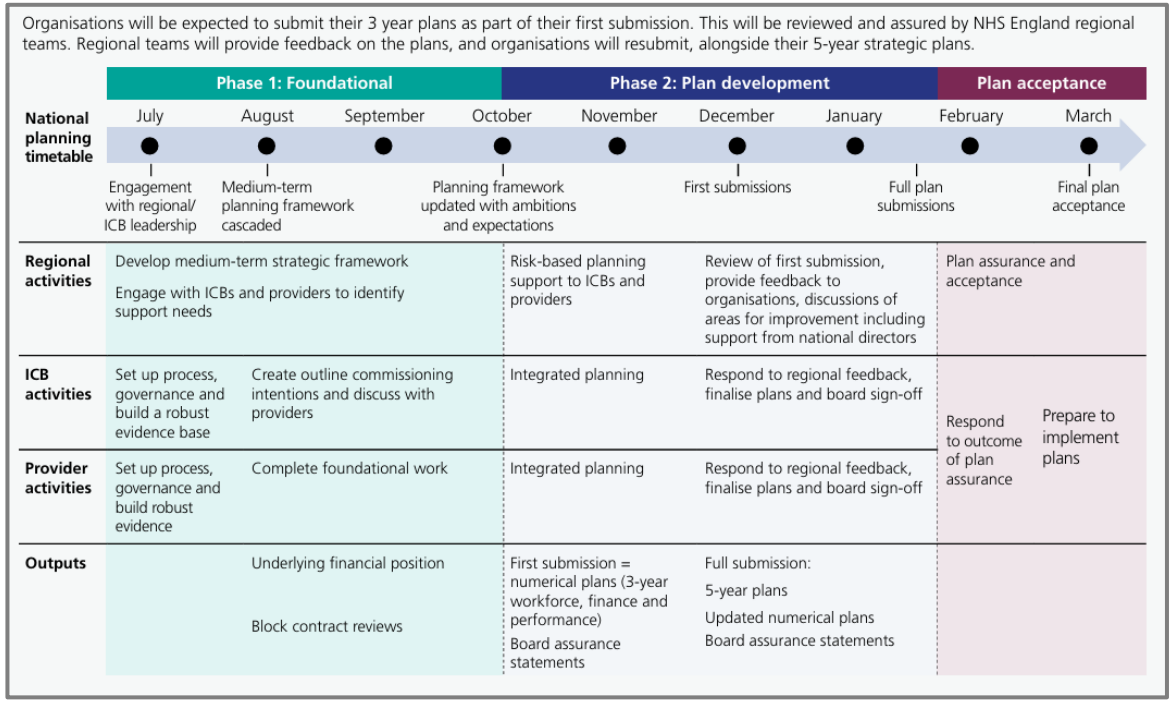
Neighbourhood health is at the forefront of the new Medium Term Planning Framework

- ‘Today’s publication (23 Oct 2025) shows how that reform agenda will drive faster delivery of care now while creating a platform for sustained improvement in the future. It completely rewires how the NHS works, setting out how a new operating model and financial regime.
- Resetting these foundations will enable the NHS to accelerate the delivery of neighbourhood health services.
- This document sets out how we are moving to a new operating model, resetting the financial framework and creating much greater opportunity for local autonomy through [a] new neighbourhood health approach.
- Delivering neighbourhood health at pace is central to returning patient and community trust in the NHS, breaking down siloed working among our staff and finally getting control of improving urgent care by providing more convenient and appropriate services in every neighbourhood in the country’. **NHSEmedium-term-planning-framework-delivering-change-together-2026-27-to-2028-29.pdf**

The planning timeline has been accelerated

‘Timeline and key documents for 2026/27 and beyond

- The following is a breakdown of the planning process for 2026/27 and the subsequent years under the new MTPF:
- October 2025: NHS England publishes the new Medium Term Planning Framework.
- March 2026: Interim targets are set for the end of the 2025/26 financial year.
- 2026/27 onwards: Integrated Care Boards (ICBs) will base their annual planning and commissioning activities on the priorities set out in the MTPF, rather than waiting for annual commissioning intentions.
- March 2029: The MTPF culminates, with ambitious goals expected to be met, such as reducing the number of patients waiting longer than 18 weeks for treatment and improving cancer and diagnostic services.’



Locally, both the ICB and ICP (the HWB) are adrift with their strategy documents

The last strategy from **Surrey Heartlands ICB** was published in December 2022. It will expire in two months time. Readers can make their own judgments about how much has been delivered.
https://www.surreyheartlands.org/download.cfm?doc=docm93jijm4n1371.pdf&ver=1395

The **Health and Wellbeing Board** is at least six months behind with its Plan, see timetable. Their [comprehensive] checklist shows: 'the following related dependencies identify where there are opportunities to ensure consistency and alignment either through new data becoming available or the recent publishing of strategies:

- Devolution & Local Government Reform (including relevant duties for unitary authorities and Mayoral Strategic Authority).
- Current Changes to ICBs/ICSs roles and functions.
- New NHS Ten Year Plan (as yet unpublished).
- The findings of all new JSNA chapters.
- Local community insights collaborative.
- New legislation since 2022 update.
- Surrey Heartlands IC Strategy.
- Surrey Heartlands Clinical Strategy.
- Index of Multiple Deprivation refresh.
- Census 2021 analysis.
- New Surrey EDI evidence base.
- The establishment of the Community Safety and Prevention board.'
  Item 8 - HWBS Refresh - June 2025.pdf

7. Timescale and delivery plan

The following provides a summary of a proposed draft timeline for updating the Strategy during 2025/26.

Action	Jun '24	Jul '24	Aug '24	Sep '24	Oct '24	Nov '24	Dec '24	Jan '25	Feb '25	Mar '25
HWB/ ICP engagement	■						■			■
Review scope of refresh with HWB/ICP	■									
Engagement with programme SROs involved in delivery		■	■	■	■					
Community input through existing channels (incl. VCSE Alliance, Surrey HDRC public involvement panel		■	■	■	■					
First draft of updated Strategy produced						■				
Agree updated Strategy and publish										■

A real issue is that these strategies are input to the NHS Medium Term Planning Framework which requires immediate attention, see previous page.

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

- The ICB and its predecessor CCG have followed a line that there has been no money for primary care investment.
- They have been stuck in the failing paradigm that this was a GP practice responsibility.
- Commissioners' mission is to drive equity and allocative efficiency in annual contract rounds, improving effectiveness and equality locally.
- RSCH has grown richer, often at the expense of other members of the providing community.
- Some of the business cases seem suspect, the Milford Hospital Diagnostic Centre for example, which has no patient hinterland.
- The ICB has now got to put right an unbalanced local delivery system if it wants to deliver truly integrated care.
- Commissioners have failed to fully exploit any negotiating leverage they have with the RSCH.
- The RSCH has to be brought into the plan for delivering local integrated care, given its resources and government plans.
- Will this start in this year's provider contracting round, or will it be another extrapolation of the status quo?
- But NHS England has now (October 2025) launched a new planning system.

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

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

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

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

Note 22 Cash and cash equivalents movements

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

	Group		Trust	
	2023/24	2022/23	2023/24	2022/23
	£000	£000	£000	£000
At 1 April	**83,539**	**108,520**	**80,360**	**108,181**
Net change in year	5,176	(24,981)	6,488	(27,821)
At 31 March	**88,715**	**83,539**	**86,848**	**80,360**
Broken down into:				
Cash at commercial banks and in hand	2,014	3,446	146	267
Cash with the Government Banking Service	86,701	80,093	86,701	80,093
Total cash and cash equivalents as in SoFP	**88,715**	**83,539**	**86,848**	**80,360**
Total cash and cash equivalents as in SoCF	**88,715**	**83,539**	**86,848**	**80,360**

Total cash and cash equivalents as in SoCF

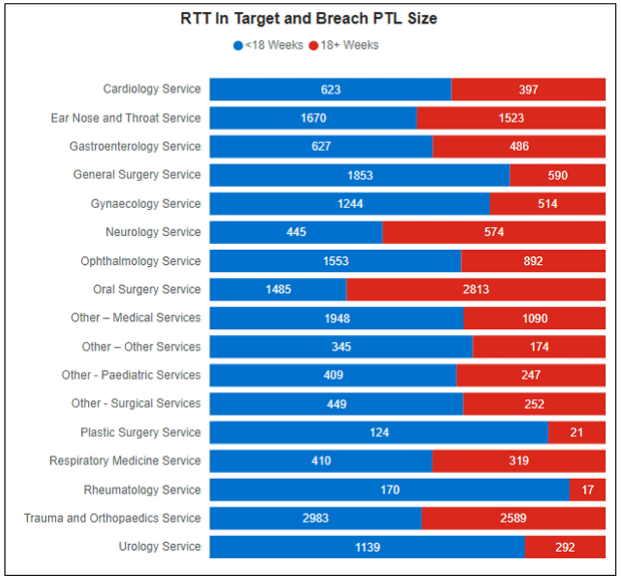
Year ending	£m
2016	4.9
2017	8.4
2018	34.7
2019	58.0
2020	79.5
2021	98.6
2022	108.2
2023	80.1
2024	86.7

The RSCH is suffering from a demand overload. Many patients should be moved out of the hospital

- Delivery performance levels are deteriorating at RSCH.
- Waiting times are worse than the national average.
- The RSCH is full every day and seemingly will be forever.

Elective Care - RTT — **Reporting Period: Aug 25**

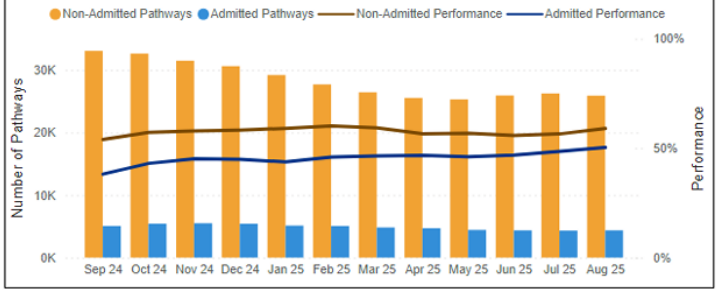
RTT In Target and Breach PTL Size



RTT Performance by Speciality

Specialty	Total Waiting List	Performance	Performance Sparkline
Cardiology Service	1020	61.08%	
Ear Nose and Throat Service	3193	52.30%	
Gastroenterology Service	1113	56.33%	
General Surgery Service	2443	75.85%	
Gynaecology Service	1758	70.76%	
Neurology Service	1019	43.67%	
Ophthalmology Service	2445	63.52%	
Oral Surgery Service	4298	34.55%	
Other – Medical Services	3038	64.12%	
Other – Other Services	519	66.47%	
Other - Paediatric Services	656	62.35%	
Other - Surgical Services	701	64.05%	
Plastic Surgery Service	145	85.52%	
Respiratory Medicine Service	729	56.24%	
Rheumatology Service	187	90.91%	
Trauma and Orthopaedics Service	5572	53.54%	
Urology Service	1431	79.59%	
Total	**30267**	**57.74%**	

RTT Performance of Admitted and Non-Admitted Incomplete Pathways



Elective Care

Metric	Performance	Variance
Clinic Utilisation		↓
DM01 Performance	◆	↑
ERF Achievement Electives	◆	↓
ERF Achievement First Attendances	◆	↓
ERF Achievement Procedures	◆	↓
Overdue Diagnostic Surveillance		↑
RTT Performance	◆	↑
RTT PTL Size		↓
Theatre Utilisation	◆	↑

Urgent & Emergency Care

Metric	Performance	Variance
All Types Attendances		↓
All Types Performance	◆	↑
Ambulance Handovers >60 mins	◆	↓
Bed Occupancy	◆	↑
Corridor Care		↑
Hospital at Home		↑
Type 1 Attendances		↓
Type 1 Performance	◆	↑
Urgent Community Response	●	↑

● Target Met ◆ Target Not Met
↑ Positive Increase ↑ Neutral Increase
↓ Positive Decrease ↓ Neutral Decrease
No Target Set ↑ Negative Increase
No Change ↓ Negative Decrease

Royal Surrey NHS Foundation Trust Board Performance Report

RSCH Integrated Performance Scorecard, September 2025.

The September RSCH Board meeting highlighted current pressures

- ‘Overall, the recent period had presented challenges for operational performance. Recovery plans had been put in place for the areas most affected. These covered the Referral to Treatment (RTT) position and diagnostic standard (DM01). Four specialties (maxillofacial, trauma & orthopaedic, audiology and ultrasound) had recovery plans to resolve these positions by the end of the second quarter of the current financial year. The ICB was engaged with this work.
- The position on the 62-day cancer standard had deteriorated during the current month, although overall performance for oncology remained strong. Whilst urgent and emergency care had performed relatively well during the period reported, there had been some decline in the four-hour standard during the current month.’
- [An NED] referenced the new CQC oversight regime, which had placed the Trust in the third tier for external review. This is a position which is reviewed quarterly.
- The RSCH website continues to refer to the Hospital as rated ‘Outstanding’.

- **CQC ratings (Tier 1 to 4)**
- Under the CQC's performance assessment framework, all trusts and integrated care boards (ICBs) are assigned a tier or segment based on their performance.
- **Tier 1:** High-performing.
- **Tier 2:** Performing well, but requiring monitoring.
- **Tier 3:** Underperforming or showing deterioration.
- A Care Quality Commission (CQC) rating of "Tier 3" or "Segment 3" indicates that a hospital is performing poorly. It signifies that the hospital is not meeting the CQC's expectations and requires significant support and improvement.

How RSCH sees the benefit of neighbourhood health. It recognises the financial savings 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

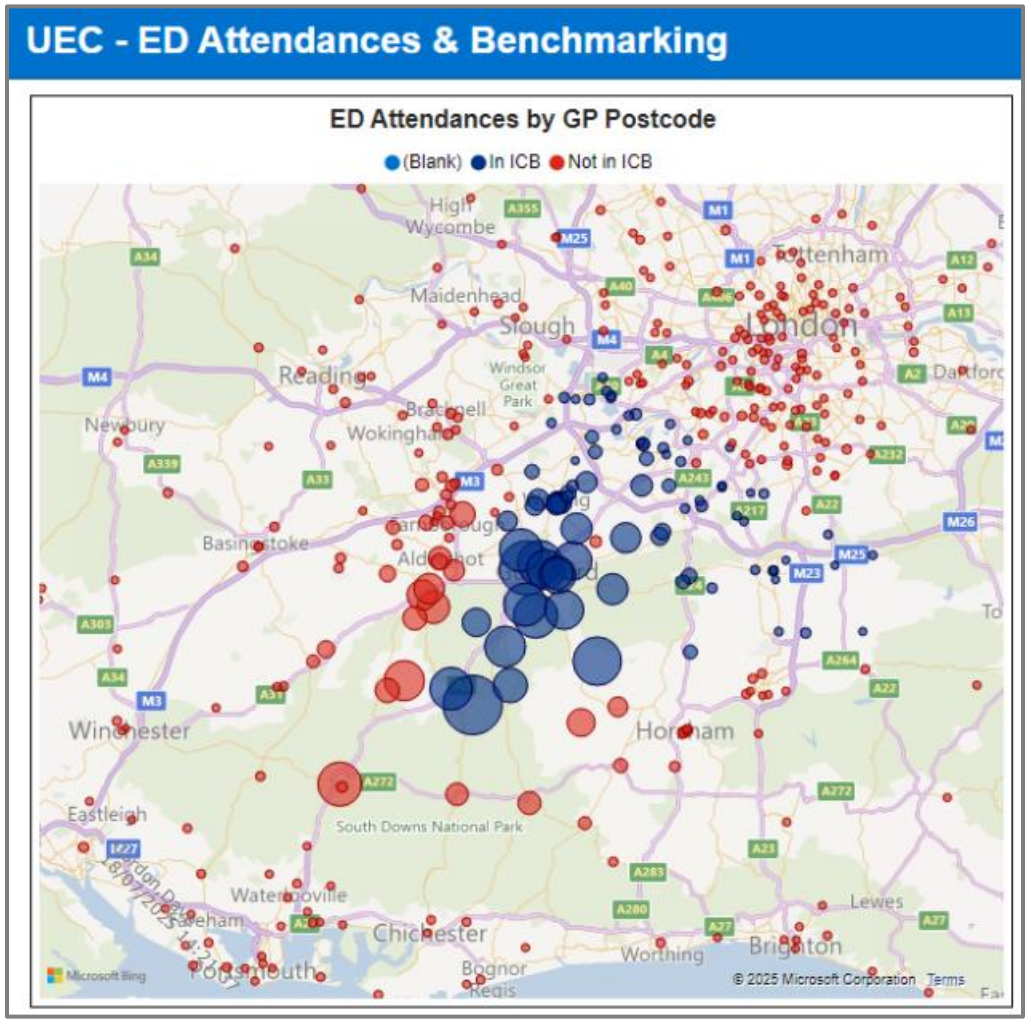
Core requirements

- 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 performance data suggests most ED demand is very local

- The heaviest demand on unscheduled hospital admissions comes from areas with significant levels of deprivation.
- The Royal Surrey's own heatmap for emergency admissions shows a high concentration of people living in Guildford north of the A3.
- Reducing unscheduled demand, moving outpatient care, diagnostics, testing and minor injury care, many services which are now performed in neighbourhood hubs, would free up space at the hospital for more complex treatments.



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

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

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

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

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

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

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

Going forward, there are big questions which need honest answers (updated 27-10-2025)

- To what degree does the ICB feel it can deliver the NHS England 10 Year Plan?
- How will it accelerate the Darzi/Sweeting agenda: ‘hospital to community; analogue to digital; sickness to prevention’?
- What is the local state of preparedness for each?
- Where can we see the strategy and action plans?
- What’s different from last year?
- Where is the ICB in negotiations with RSCH over the 2026/27 contract round?
- Is the commissioner, the ICB, using its contracting leverage to move care out of hospital.
- Is it about to extrapolate the present, or is a radical re-structuring envisaged?
- How much more is to be allocated for primary and community care in Guildford?
- How will it deal with the primary care premises issue?