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‘Transforming Services Together’: what does East London’s plan for health services imply for East Londoners?

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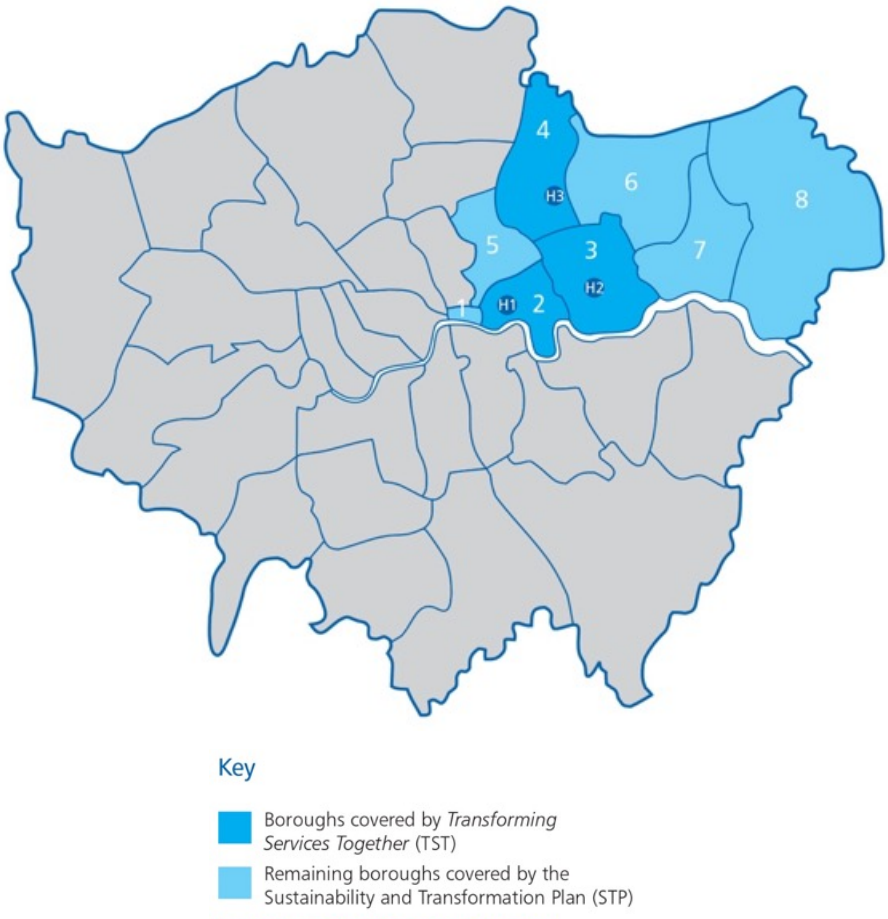

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Executive Summary

1. Transforming Services Together (TST) is a five-year plan to radically reconfigure health services in the London boroughs of Newham, Tower Hamlets and Waltham Forest. The draft plan was drawn up between 2014 and 2016, at a cost of £3.49m for external consultants alone. It now appears to form part of the draft Sustainability and Transformation Plan (STP) for the wider North-East London area or 'footprint'.

2. This report reviews the changes proposed by the TST plan and assesses the impact on East London's patients and whether they are likely to work. It asks the following questions:

- What problems is Transforming Services Together seeking to address?
- What is the planner's solution to closing the funding gap?
- If all goes ahead as planned what will this mean for patients?
- Are the plans based on realistic assumptions?
- What will it mean for patients if the planner's assumptions are wrong and the plans cannot be achieved?

3. The primary driver behind the plan is the fact that the government's spending plans announced in 2015 mean that the NHS in the TST area will not have enough money to continue to provide the range and quality of health services that it does now. By 2020/21 the planners forecast that there will be a deficit of £398m, an over threefold increase from the £108m deficit in 2015/16.

4. Over the next fifteen years East London's population is projected to increase by some 270,000 (30%), while government spending on health services per head is set to fall. The main hospital provider in the area, Barts Health, has the biggest deficit of any hospital trust in England. So the area's Clinical Commissioning Groups (CCGs) are being required to move away from reliance on hospital-based services to providing much more care in the community.

5. The community in the TST area has very high healthcare needs. Newham and Tower Hamlets have two of the highest rates in the country for older people living in income-deprived households (41% and 49.7% respectively), and 39.3% of children in Tower Hamlets live in income-deprived families, the highest rate in the country. As a result life expectancy rates are low and there are higher than average rates of hospital stays for alcohol-related harm and acute sexually transmitted diseases. Rates of childhood obesity are high and there are also very high levels of mental illness. Additionally, over 50% of residents in the three boroughs are from minority ethnic groups, and the population is also exceptionally transient – 281 people per 1,000 move in or out of one of the boroughs every year, making continuity of care particularly difficult.

6. On top of this it is very difficult to recruit and retain NHS staff in East London. In 2015 Barts Health was short of 730 nurses (13%) and 100 doctors, and 15% of staff were leaving every year. Furthermore, many staff in the lower pay bands are below the minimum income threshold for living in London with an average commute of 15 miles.

7. To deal with the expected shortfall in funding the TST plan proposes (a) to improve the way the 20% of higher-risk patients who account for 80% of NHS spending are treated, through improved integration between hospital and non-hospital provision; (b) to shift a large part of the care for lower-risk patients out of hospitals into a radically-changed system of care in the community, and (c) to encourage self-care (i.e. many more patients maintaining their own health than are doing so at present). Patients seeking care will be expected to ring a NHS 111 telephone line first to book appointments for community-based urgent care.

8. A quarter of all the work that is now done in emergency departments will in future be done in GP practices and community healthcare facilities. In addition many more patients at the end of their lives will be enabled to die at home supported by palliative care workers; and many more mothers will give birth at home, assisted by midwives. Instead of needing a new 550-bed hospital by 2025, under the new system the area will need only 26 more by 2021 and 240 more hospital beds by 2025.

9. At the same time primary and community care services will be radically changed. The planners predict a need for 195 additional GPs by 2025 but by then there will be a third fewer GPs than at present down from 600 to 400. Instead much of the work now done by GPs will be done by nurses, physician associates (science graduates with a two-year postgraduate diploma) and pharmacists leaving GPs to deal with only the most serious cases. These arrangements are expected to provide patients with better care than they get now, as well as saving money.

10. The plans rest on several crucial assumptions. They assume that it will be possible to recruit the additional lower-paid physician associates, nurses, pharmacists, midwives, and palliative care workforce needed to staff the new system in place of GPs, and that they will have the skills needed to provide a much greater volume of care, some of it also of greater complexity, diverted from hospitals. The plans also assume that the existing hospital and primary and community care staff will be able and willing to make the necessary changes to the division of responsibilities and working patterns whilst covering for the ongoing 13% of unfilled posts and 15% turnover rate.

11. Given the high turnover of residents (28% a year), high levels of English as a second language and low internet access levels for over 60s it is unlikely that the projected 90% of patients will be comfortable accessing the urgent care available using the NHS 111 telephone system or online. Furthermore, the blanket 6.2% cut to public health budgets in Newham and Tower Hamlets lowers the likelihood of patients successfully improving their health through self-care. And the planners assume that a total of £72m will be available from external sources for the necessary £173m investment in training, electronic patient records and physical facilities to support the new model of care provision over the next five years.

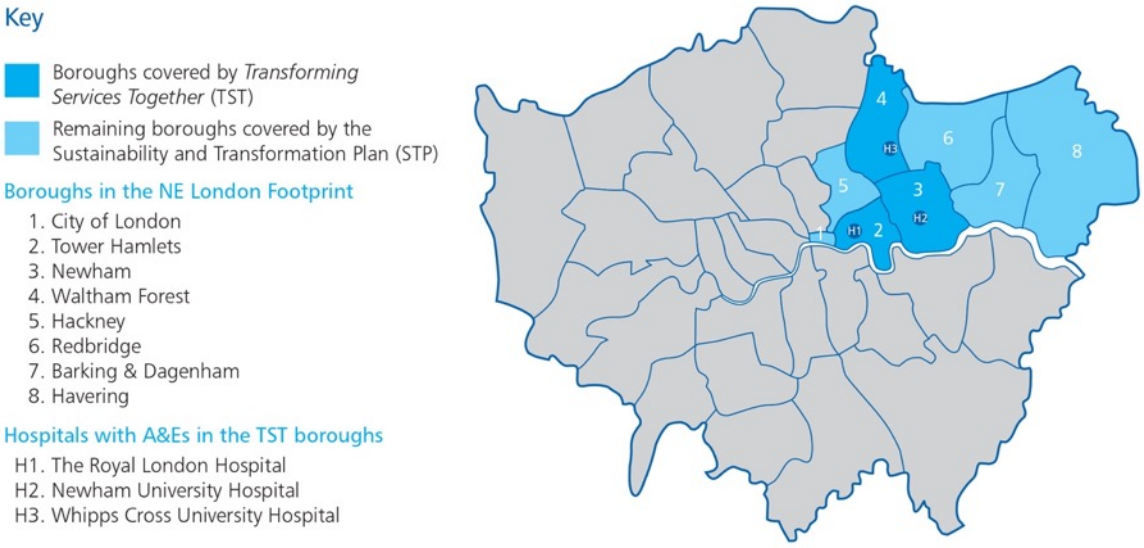
12. There is a strong case for action given the issues the TST area faces. If the planners' assumptions are correct the TST plan may provide as good, or even better health services than East Londoners receive at present, though in radically altered ways. However, these are all heroic assumptions which the plan itself recognises often cannot be relied upon. The existing staff shortages make radical changes in working practices difficult to bring about without compromising patient care. It is unlikely that the needed

additional staff can be recruited and retained. And it is very unlikely that all of the £173m investment needed to make the new model work effectively will be provided.

13. But if the plan is put into practice without all the conditions for it being met, health care in this part of East London will be in serious trouble. If cuts and changes are made without the corresponding investments delivering as expected, a Frankenstein Framework of new and old systems would emerge confusing both patients and medical practitioners. Care will be rationed and those who do get care could get a worse quality.

Background

1. Transforming Services Together (TST) is a five-year plan to radically reconfigure health services in the London boroughs of Newham, Tower Hamlets and Waltham Forest. The draft plan was drawn up between 2014 and 2016 and now appears to form part of the draft Sustainability and Transformation Plan (STP) for the wider North-East London area or 'footprint'.



2. The TST draft plan prefigures the thinking behind STPs. The TST plan has cost the three boroughs £3.49m for external consultants alone (i.e. not counting the input from NHS or local authority personnel) between April 2015 and July 2016.[1]

What problems is Transforming Services Together seeking to address?

a) A gap between the amount of money needed to provide healthcare and the amount of money given by government

3. The primary driver behind the plan is the fact that based on the government's spending plans announced in 2015 the NHS in the TST area will not have enough money, over the next five years, to continue to provide health services in the same way that it does now. In 2015/16 the health organisations in the TST area (the hospitals and the commissioners of services) spent £108m more than they received in funding from the government to meet the healthcare needs of their population.[2] This was driven by a deficit of £134.9m at the hospital trust for the area, Barts Health NHS Trust, which was partly offset by the combined £27m surplus from the three Clinical Commissioning Groups (CCGs) in the TST area.[3]

4. Barts Health is now in 'special measures' in relation to both care standards and its financial position. However, the financial problems of the East London healthcare system are expected to worsen. By 2020/21 the gap between the income received from the government for health care and the cost of providing healthcare services in the TST ar-

ea will rise to £398m, 61% of the predicted overall £655m deficit for the entire North East London footprint in 2020/21.[4] It is important to note that the £398m TST area funding gap by 2020/21 does not include the existing deficit at Barts of £134.9m for 2015/16. Adding this increases the TST's predicted funding gap of £398m by 34% to £533m*.[5,6]

5. The calculations involved in predicting the size of the financial gap that the plan is meant to close, and seeing how the plan is expected to close it, are complicated. A more detailed explanation is included in the footnote below.†

b) The challenge of providing healthcare to an economically deprived and transient population

6. The TST plan identifies a number of major problems confronting health services in East London which affect the finances and the quality of health care: deprivation, and consequently an exceptionally high level of ill health; significant staff shortages; and an unusually high level of population growth.

7. The burden of deprivation in the area is acute. Newham and Tower Hamlets have two of the highest rates in the country for older people living in income-deprived households (41% and 49.7% respectively), and 39.3% of children in Tower Hamlets live in income-deprived families, the highest rate in the country.[7] There is a clear link between poor health in the area and poverty, for example: poor life expectancy, higher than average rates of hospital stays for alcohol-related harm and acute sexually transmitted diseases, childhood obesity, and very high levels of mental illness, with a high need for child and adolescent mental health services.

8. Additionally, 61%, 69% and 48% of residents in Newham, Tower Hamlets and Waltham Forest respectively are from minority ethnic groups. The population is also exceptionally transient – 281 people per 1,000 move in or out of one of the boroughs every year. As the TST says, 'This can cause difficulty in providing continuity of care. At some emergency departments as many as 30% of those attending are not registered with a GP'.[8]

c) A shortage of healthcare staff

9. Hospital staff shortages in both the TST area and wider North East London footprint are severe. In 2015 there was a shortfall of 730 full time nurses (13%), and 100 doctors at Barts Health, plus a shortfall of 250 non-medically qualified clinical personnel, chiefly

† To explain this in more detail, the predicted cost of meeting the healthcare needs of the local population (£676m by 2020/21) will not be matched by the funding received from government (£327m by 2020/21). This gap of £349m will be made even greater by the fact that Barts Health is expected to have to spend £49m more over the next five years than it will get in income.[4] Together these figures equate to a gap of £398m by 2020/21. As noted above the £49m accumulated overspend for Barts Health does not include its existing deficit of £134.9m in 2015/16. This deficit for 2015/16 was partly accounted for by a PFI payment of £145.4m, a recurring annual charge which will rise to £164.6m by 2020/21.[5]

physiotherapists and occupational therapists. Staff turnover rates were over 15% a year.[9] As a result the total spend on temporary staff was £146 million across the North East London area in 2014/15, £40 million higher than the cost for a comparable number of permanent staff.[4] Both the shortages and the turnover rates were and are strongly influenced by the high cost of housing in London. In 2015 salaries for most staff in the five lowest bands of pay were below the minimum income standard threshold needed to live in London.[10]

10. A major crisis in GP services is also looming. In 2013 over a third of all the male GPs in Newham and Waltham Forest were over 60, and many of them were looking to reduce their working hours in the next five years. In Newham 6% of male GPs are single-handed (i.e. they work alone in their own practice) and so have no colleagues to continue their practice when they retire, and little prospect of being replaced by anyone new.[9] By 2021 it is estimated that an extra 125 GPs will be needed, and almost 200 more by 2025/6.[11] But the plan concedes that 'this [additional GPs] will be impossible given the national shortages and high retirement rates'.[10] Instead the number of GPs is expected to fall by a third from 600 in 2014/15 to 400 by 2024/5.[12]

d) A growing population in East London

11. On top of these problems, the area faces a projected population increase in the next 15 years of 270,000, or 30%, particularly due to the redevelopment of the area surrounding the Olympic Park.[8] This increase will be compounded by the expected reconfiguration of The King George Hospital's emergency department in Redbridge which will lead to an extra 92,000 people going to Whipps Cross or Newham hospital instead.[13] With the counter-measures of the TST plan only 240 more hospital beds will be needed by 2025/6 and only 26 more by 2020/21.[14] It is not clear from the plan, however, where these reduced numbers of additional beds will be created, or even that they will be.

What is the planners' solution to closing the funding gap?

12. The plan put forward to address this funding gap is based on one central idea: instead of providing care in hospitals more care will be provided in less expensive community settings. It notes that 20% of patients account for 80% of the overall amount of spending on healthcare, and aims to find more cost-effective ways of providing healthcare to this 'high risk' group of patients, and less expensive ways of providing it for the 80% who are at lower risk. Providing more health care in community settings will reduce the number of emergency hospital patient admissions, attendances, readmissions, and the length of stay in hospital for those who need to be admitted.

13. These measures are projected to reduce the number of additional hospital beds needed at Barts Health by 2020/21 from 306 to 26.[15] The plan also aims for a 20% reduction in spending on non-elective (i.e. emergency) hospital treatments. This will be achieved by providing better integrated care (i.e. which links in-hospital and non-hospital care) for people with long-term conditions, a 50% reduction of emergency admissions of patients needing end of life care, and a 20% reduction in hospital-based outpatient appointments.[16]

14. Shifting activity from hospitals to the community is thus central to the plan. To summarise, this involves:

> i) creating 'Urgent Care Hubs' at the area's three emergency departments to ensure that patients who attend A&E but do not require a hospital stay are treated at an urgent care centre instead;
>
> ii) shifting a large proportion of end of life and urgent care from hospitals to general practices and other forms of community-based care, principally pharmacies and social care;
>
> iii) reorganizing primary care on the basis of much larger GP practices and federations of smaller practices, with a limited number of primary care 'hubs' offering a wider range of services, while radically altering the skill-mix in primary care;
>
> iv) having fewer hospital births
>
> v) patients will be expected to ring a NHS 111 number, explain their symptoms and then be directed/triaged to the appropriate community or hospital care location and discouraged from just turning up at a hospital, clinic or urgent care hub.

Reducing pressure on emergency departments

15. Under the plan 26% of the work currently done every year in emergency departments will be distributed to other providers as follows:[17]

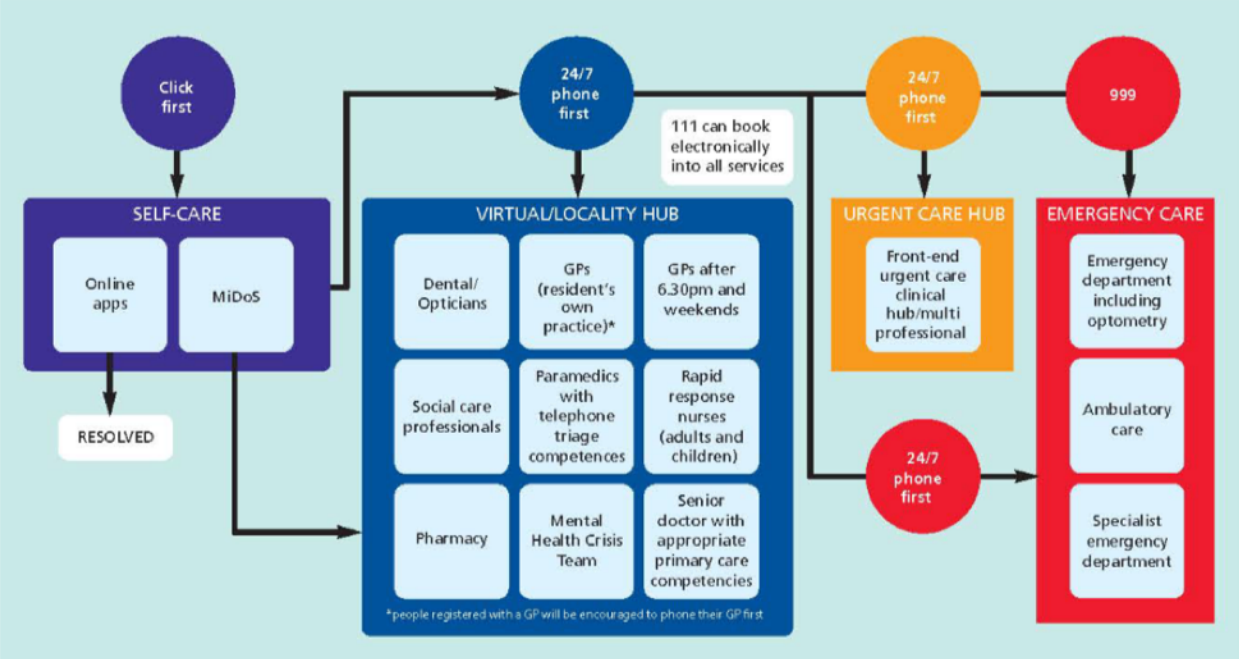
-'Urgent Care Hubs', based in the hospital and staffed by a range of medical staff who will deal with patients who do not need a hospital bed: 34,037 cases p.a. (21% of the total redistributed)
-'Clinical Locality Hubs', based outside of hospital and potentially across multiple sites, combining GPs, pharmacists, dentists, opticians, and community care: 69,707 cases (44%)
-GPs: 34,731 cases (22%)
-Pharmacies: 11,556 cases (7%)
-'Self-Care': 9,971 cases (6%)

16. I.e. two-thirds will be handled by reorganised primary and community care provision (Clinical Locality Hubs 44%, and 22% GPs). Multi-specialty Community Providers (larger GP practices or federations of smaller practices) with 30,000 patients each will provide a wide range of services, including minor surgery, and GP surgeries will become larger, or form larger 'networks' or federations, with multi-disciplinary primary care 'hubs' each catering for 10-15,000 patients. But there will be fewer GPs – the number is expected to fall by a third, from 600 to 400 – offset by an increase in allied health and social care staff such as pharmacists, physician associates (science graduates with a two-year postgraduate diploma), nurses, and administrators.12 It is proposed that these staff will take on much of the work currently done by GPs, who will be freed up to deal with the more serious cases. And despite population growth and the extra work to be undertaken, only a minimal overall increase in primary care staff is projected over the next ten years.

Self-care

17. The plan also aims to reduce work for both primary care (GP and initial diagnosis) and secondary care (hospital/clinic based advanced medical investigation) by getting patients to lead healthier lifestyles. It states that 'We aim to change the culture of over-reliance on medical/hospital services to one where prevention of ill health gets greater priority, and people take more responsibility for their own health,'[18] and that 'The development of capacity in the third sector and the realisation of a culture of self-care will enable shifts of unnecessary activity from primary and community care.'[19] Six per cent of the work presently done by emergency departments, and 10% of attendances at surgeries, is expected to be replaced by improved self-care, while early identification and prevention is thought capable of reducing outpatient referrals by five per cent.[20]

The proposed re-arrangement of and access to medical services under the TST plan.



18. Taken together, the planners expect that the TST initiatives, documented above, will lead to a £165m net saving by 2020/21.[21] A further £173m is projected to be spent on upgrading buildings and facilities (i.e. capital), of which £72m will need to come from outside the local health economy.[22]

If all goes ahead as planned what will this mean for patients?

19. If all the planned transformations are successful patients will benefit from greater choice over the location of care and better access to out of hours medical treatment (i.e. weekdays 6:30pm-08:00am, all weekends). There will however be challenges with a NHS 111 telephone triage system to navigate, a different skill mix of professionals providing medical care to deal with, and more self-care required for many.

20. For end of life patients there will be 24-hour palliative care and pharmaceutical services so that they can die in a location of their own choosing.[23] Currently 22-29% of

East London patients die at home, compared with the 50-70% across London who say they would like to.[24] The aim is to decrease the number of patients in need of palliative care who die after emergency admission to a Barts Health hospital from the 600 such patients in 2014-15 to 300 a year, by enabling them to die at home or in voluntary sector facilities (such as hospices).[25]

21. Better integration of care aims to bring appropriate treatment for patients faster. Primary care hubs will bring together doctors, dentists, GPs, pharmacists, opticians, and community services working as one team, but not necessarily in one location. They aim to bring improved accessibility by providing walk-in services and 24/7 rapid response and mental health crisis teams.[26] Urgent care hubs staffed with a mix of professionals (including prescribers and mental health specialists), and equipped with diagnostic facilities, will aim to give 95% of patients a clinical decision in 90 minutes.[26] Together the primary care and urgent care hubs will reduce the number of patients in emergency departments allowing them to meet the A&E 4 hour target.

22. The way patients access care will change to a 'click first' and 'phone first' NHS 111 triage system. The 'click first' approach involves patients logging on to a website which will tell them what services are available, or enable them to either deal with their problem themselves, get it dealt with at a pharmacy, or phone NHS 111.[27] The NHS 111 phone line will become the avenue to access all forms of care: by 2020 90% of the access to community-based urgent care systems will be through NHS 111.[26] Walk-in patients will be discouraged in favour of triage and booking via NHS 111.

23. Treatment and diagnosis will be carried out by a different mix of professionals compared to currently. NHS 111 will direct patients with minor illnesses to pharmacies instead of to GPs. They aim to increase by 50% the use of pharmacies for minor ailments.[26] In primary care and also in secondary care more diagnosis and treatment will be carried out by physician associates instead of by GPs or hospital doctors. They are estimated to be capable of taking over 83% of primary care visits without direct supervision by a doctor.[28]

24. In East London the planners note that 80% of the healthcare costs were accounted for by 20% of the patients.[29] These patients will be given case management or care coordination plans (where a GP or other medical professional provides the patient with a plan for managing their condition and is responsible for its supervision and review). More of the remaining 80% of patients will be expected to take responsibility for their own health than is the case now. This will entail more reliance on what the plan describes as 'community-based approaches', such as 'social prescribing' (i.e. getting support from local activity groups), and accessing information digitally.

Are the plans based on realistic assumptions?

25. The TST plan is ambitious in scope and rests on many questionable assumptions. The targeted reductions in spending on hospital provision rest on evidence that resources are not at present efficiently used. For example, up to 21% of people who attend emergency departments and are not admitted to hospital require no significant treatment, and a further 5% have a mental health condition.[30] The case for providing alternative ways of treating such cases is clear.

26. What is not clear is that the planned alternative models of provision will both save money and provide good care. In the first place, while focus groups of stakeholders may think they will do this, no evidence is provided that the models have been successfully tested. It appears to be assumed that they will work and save money too. The planners' focus on new ways of providing care tends to see patients as automatic receivers of whatever is going to be offered, without undertaking any systematic analysis of what the new arrangements will mean for them in practice. And second, it is assumed that the resources of capital and trained people needed to make them work will be forthcoming.

Workforce

27. The plan aims to reduce the need for new hospital beds by shifting care to primary care and self-care.[16] To deliver the predicted increase in activity under the existing arrangements they estimate that by 2025 East London would need 195 extra GPs.[31] However, it is assumed that GP numbers will actually fall from 600 in 2014/15 to 400 in 2024/25, mostly due to retirement. It is assumed that this shortfall of 395 GPs will be offset by an increase in allied health and social care staff. By 2025 this will include: 106 pharmacists, 38 physician associates (science graduates with a two-year postgraduate diploma), 238 nurses, and 130 administrators.[12] These staff will then take on much of the work of GPs and thus compensate for the expected shortfall.

28. This assumption has two potentially fatal flaws. First, the plan registers some doubt that the physician associates, practice nurses and other non-medical staff that the plan calls for can be found. It rates the possibility that not enough providers will have enough staff to implement the new arrangement of medical care as both 'highly likely' and 'catastrophic' (i.e. fatal to the plan), adding that 'work is underway to assess the market and numbers of providers who will be able to fulfil the remit'.[32] This difficulty is exacerbated by the relatively lower pay of nurses and physician associates compared to GPs, at about half an annual GP's salary. The high cost of living means that the five lowest bands of pay (including nurses) are below London's minimum income threshold.[10] Shifting to reliance on these lower paid staff will heighten the existing difficulties of recruitment for primary and community care.

29. Second, even if enough staff can be found, there is a risk that their training will not be to a level that will enable them to handle the more complex care needed by some of the patients moved from hospital to primary and community care. Whether this new skill-mix of staff will be able to provide adequate care has, however, 'not been accounted for in the modelling' carried out by the planners.[33] It is also important to note that the new profession of 'physician associates' is as yet unregulated, unlike doctors and nurses who are bound by professional rules and safeguards governing the range of duties that they can safely perform.

30. A further question is how a workforce under high stress, with 13% of posts unfilled and a 15% turnover rate (with 2,800 staff leaving the area's hospitals each year), can be motivated and retrained to implement radical changes to their responsibilities and work patterns.[34] This is particularly problematic because the amount of funding earmarked for 'transformation' in the Sustainability and Transformation Fund, provided by government to enable radical changes to the design of NHS medical care, already looks too small to incentivise large-scale changes. The TST plan sometimes acknowledges this. For example, it recognises that the Urgent Care hubs planned for the three hospitals

depend on major reorganisations of staff roles: 'There will also need to be changes to the way community staff work with on-ward recovery nursing, occupational therapy and physiotherapy, together with dementia speciality nursing, local authority social services, ambulance liaison and pharmacy/enhanced prescribing. Some of these resources may present a challenge, given skills shortages within professions both nationally and locally.'[35] But although the problem of implementing changes while continuing to provide a vital service is acknowledged, the plan does not offer convincing reasons for thinking that it can be solved without risk to the safe provision of care.

Population and patients

31. Any measures to prevent ill-health are welcome. But, as mentioned before, the TST plan is, on the whole, a plan with the planner's priorities in mind without much analysis of what the new arrangements will mean for patients in practice. For example, by 2020 it is expected that 90% of access to community-based urgent care will be through the NHS 111.[26] For the 80% of the population considered to be at low to medium risk of needing medical care greater self-care is expected via the use of online resources. Both of these are expected to save a significant amount of money. However, the uptake of these services is likely to be low, given a 28% rate of population turnover, many residents with English as a second language, and only 42% of over 60s having internet access.[8,36] Often these groups are the most deprived and in need of health care, but also the least able to adapt to new models of diagnosis and treatment. Furthermore, the high turnover of residents reduces the effectiveness of any care plans for patients moving to, or from, other areas.

32. The potential for a significant shift from care to self-care is also reduced by the recent severe cuts to mental health and public health budgets. Cuts to Child and Adolescent Mental Health Service budgets are leading to large reductions in the number of referred children being seen;[37] Waltham Forest's Healthy Child Programme has had its budget cut, and the blanket 6.2% cut to public health budgets has cost Newham and Tower Hamlets £1.9m and £2.2m respectively this year.[38] In the light of all these factors the projections of savings to be obtained from self-care look optimistic, with the risk that the savings are made but patients who need care may not get it.

Co-ordination of different medical professionals

33. The Health and Social Care Act (HSCA) 2012 separated the purchasing and provision of healthcare in order to foster competition amongst healthcare providers. The solutions adopted by the TST planners, in line with the NHS Five Year Forward View, reverse the main thrust of the Act by encouraging greater co-ordination between both hospital and primary care providers. However, the Act's legal structure and incentives to compete remain in force and hospitals are expected to balance their books whilst improving patient safety.[39] The risk is that the providers covered by the plan will, at times, be forced by the profit-maximising incentives built into the Act to act in their organisation's narrow interest instead of following the plan.

34. For patients most at risk of hospital admission the main risk foreseen by the planners is that 'providers do not have sufficient confidence in other elements of the system to make changes to their own services'.[40] This is to be mitigated in part by investment in 'GP networks [also described elsewhere in the plan as federations] and

provider networks in all three boroughs'. Yet another risk is seen as being that 'GP federations are not mature enough to enable negotiation with other providers'.[40] Nonetheless a net saving of between £4.2m and £6.6m over a five year period is predicted from better integrated care for these patients.[41]

Financial

35. The TST plan is now being subsumed into the Sustainability and Transformation Plan (STP) for the North East London area. The primary aim of the STP is to achieve financial balance in the local health economy, which requires eliminating the deficit at Barts Health. Barts Health had the largest provider deficit in the country in 2015/16 (£134.9m) and this was largely due to a PFI payment for that year of £145.4m, which will rise to £164.6m a year by 2020/21.[5,6] The financial projections in the TST do not include the existing (carried forward) deficit at Barts Health. Including this deficit makes it hard to see how the TST or the STP will achieve financial balance without significant cuts to services.

36. The plan calls for current spending of £33.2m and capital investment of £173m to achieve net revenue savings of £165m up to 2020/21.[21,22] The £173m of capital investment required will be spent primarily on Barts Health and a redesign of the Whipps Cross hospital site. This is compared to the estimated £352m of capital investment which would be required up to 2020/21, if the TST programme was not adopted, to provide the additional 550 beds required to meet future population need. The planners estimate that of the £173m capital cost £72m will need to be raised from outside their forecast income.[22‡] However, there is little prospect of significant additional funding from government, with only £0.5bn of the £2.1bn 2016/17 Sustainability and Transformation Fund available for transformation, the rest having to be spent on lowering existing hospital deficits.[42] £0.5bn works out at an average of £11.4m per STP footprint, well short of the total needed in the first year of the TST plan. There is little prospect that later STF funding will come near to meeting the TST's needed total of £72m.

What will it mean for patients if the planners' assumptions are wrong and the plans cannot be achieved?

37. The planners make it clear that 'most importantly, these changes will reset the system on a path towards financial sustainability' with Barts Health's deficit representing the biggest obstacle to achieving this.[43] With financial balance being the key driver behind the TST plan, if the predicted savings are not achieved cuts will have to be made to patient services and the quality of care. Given that the quality of care in East London is already below standard in several areas, with, for example, Barts Health rated 'Inadequate' by the Care Quality Commission and 40% of respondents unable to see a GP of their choice, a further deterioration in services could be disastrous.[43] If the plan is only part-implemented due to funding shortfalls patients in East London risk being faced with a Frankenstein Framework of new and old models of care. Without a full implementation

‡ It should be noted that the plan appears to defer to the five years following 2020/21 a far greater amount of needed capital investment of £463m (over 2.5 times the figure for the previous five years).[22]

of the plan the projected benefits of the TST will not be realised and instead a disorganised system will be in place, harder for patients to navigate, offering poorer quality of care for all and even no care for some, and imposing greater burdens of unpaid care on family members, mainly women.

Conclusion

38. If the planners' assumptions are correct the TST plan may provide as good, or even better health services than East Londoners receive at present, though in radically altered ways. If the existing hospital, primary care, and community care staff work together to rapidly adopt the changed ways of working; if patients readily adapt to the new ways of accessing treatment and are willing and able to care for their own health in the ways called for; if there is enough transformation funding to provide the £72m investment called for by the plan; if the needed additional workforce can be recruited and retained; then it is possible that East Londoners will continue to receive good care.

39. However it looks as if many of these conditions will not be met. In this case, the services available to Londoners in the TST area will be in serious trouble. Health providers will not be able to provide a comprehensive health service or one of adequate quality. Care will be rationed and those who do get care will get a worse quality.

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