Ruth Carnall (Chief Executive, NHS London): Chair, I think you have asked for me and Paul Baumann to talk very briefly about two aspects to this; one, the overall strategy and reconfigurations and, second, is all of this affordable and what is going to happen about money next year and beyond. I think you said five minutes so we are going to try to split it into two very short slots. I will do a very short piece on context and then I am going to ask Paul to talk about money, and then we will field the questions between us in a way that seems appropriate.

Very briefly, you know, because I have spoken to you about it before, that our overall strategy for health and healthcare in London is called Healthcare for London, developed by, in the first instance, Lord Darzi, who has been to your Committees and spoken about that.

We think we are making good progress on implementing that across London. The evidence that I would cite for that is in terms of our overall performance across London against key national matrix. We have improved from being ninth in the queue to currently being third so, in comparison to the ten health authorities in the country, we have gone from ninth to third.

We are doing very much better on financial performance. You will remember when I first came to your meetings we were talking about a deficit overall. We have now got a small surplus overall, but Paul will come on to tell you about the difficulties that we face going forward.

On public opinion of health services in London we are, again, showing a very significant improvement from being, again, tenth in the queue to being around about fourth or fifth in the queue at the moment.

We have made progress on implementing Lord Darzi's recommendations so we now have eight fully functioning heart attack centres in London, so if you have a heart attack in London you get taken to one of eight centres. Over the course of the next financial year, if you have a stroke in London, you will get taken to one of eight hyper acute stroke centres and, from there, transferred, through a care pathway, into properly designated stroke units. If you are unfortunate enough to suffer a major trauma, road accident or similar, you will get taken to one of four major trauma centres in London, all of which will be fully functioning during the course of the next year. So some of Lord Darzi's views about centralising services where it is necessary to deliver safer and better outcomes for patients we are making good progress on. There is more to be done but we are making good progress.

Other end of the spectrum; localising services where possible, developing better primary and community services, more accessible, urgent care services - we have got ten of our polyclinics up and running in London now and we expect to have 30 over the course of the next financial year.

We are making good progress on implementing the key recommendations of that strategy, but it does not remotely represent the complete transformation of services across London in the way that we want to see it. It is a number of incremental changes, all of which are beneficial and will have positive impacts, so the stroke and trauma service changes that I described and that you are familiar with anyway, we expect to save 500 lives a year in London, when they are fully operational. So they are not trivial but they are, nevertheless, incremental. They do not represent the whole transformation.

Our challenge, going forward, is how do we deliver that transformation with much greater pace and ambition than we have been able to do to date? I am conscious that the changes we have made have been relatively narrow and relatively measured. One of the things I want Paul to talk about is the obvious question that gets raised at this point is, "Very interesting, but you developed this plan at a time where you had a lot more money and where there was expectation of more money coming through. Is it still affordable? Can you still deliver all these improvements with the money that you have got or is it simply going to descend into being a series of cuts rather than improvements?" We want to argue that we can still implement healthcare for London and improve the quality of services to Londoners, whilst living within more constrained financial circumstances, but with some very significant challenges about the pace of implementation.

The last point that I want to make is about processes and about reconfiguration which you specifically referred to in your brief for today's meeting. There is only one area of London at the moment where there is a formal public consultation underway, and that is the north east of London around the future of services around the Whipps Cross, King George and Queen's Hospitals. All of the other things that you might read about in newspapers and hear about in petitions and other things are speculative in terms of whether it turns out to be a concrete proposal or not.

One of the dilemmas we have got is Lord Darzi's approach to developing strategy was to engage as many clinicians as he possibly could and to get them to start talking about what the right changes would be and what the options are for the future. I think we have been very successful in doing that and now, across London, you have got groups of local clinicians talking about what changes should be made and, as a result of that, people latch on to the worst possible scenario that they perceive from their perspective, and see that as the thing that is going to happen. I think it is very positive that we have got lots of clinicians engaged but the downside of that is a sort of media stories that you are seeing at the moment.

To be clear about what would be required before any consultation goes ahead and before anything is approved, first and foremost it has to be led by clinicians at a local level, designed and led by them. It has to be built on strong clinical evidence, properly validated, both locally and, where appropriate, nationally and, in some cases, internationally. There is a long and appropriate process of engagement, consultation and discussion. All of that is open to challenge, both legally and through a system that the Department of Health has put in place, of national independent experts coming to review the proposals and, where necessary, being referred to an independent panel prior to any consideration by the Secretary of State. That process takes a very, very long time and has only just started in one part of London which is the outer north east London. All of the other things that you might have read about are at a very, very early stage of discussion with tens, and sometimes twenties, of options being considered.

I am going to stop there and get Paul to speak briefly about is it all still affordable and what will happen if the money runs out question, and then we can take questions across the board.

Paul Baumann (Director of Finance & Investment, NHS London): Thank you very much, Ruth.

(Slide 1) I just want to give you a quick overview of the numbers. There always have to be a lot of numbers. The key message I want to get across, however, is, in the last four years, we have moved in London from a deficit, as Ruth mentioned, £174 million at its peak - and I do recall as I was being recruited into this job, the *Evening Standard* screaming the scandal of that at the masses - to over £300 million of surplus. Just one bit of context though. Neither the deficit that we had then, nor the surplus we have now, is, in its context, significant. In a business of "this size" moving from a 1.6 per cent deficit to a 2.4 per cent surplus is the right side of the dividing line but it is not a massive great cushion with which to look to the future.

As ever in London, the aggregate masks a whole lot of variation within that and so, in some ways, the more important number is not the £174 million going to the £360 million odd; it is the 24 organisations at the bottom of the chart in deficit at the beginning of the process, going down to only six as we speak this year which, again, is a major transformation.

So we have moved from imbalance to balance. We have reduced substantially the number of organisations individually in deficit and perhaps, equally importantly, we have introduced a scheme – which I think we have discussed in this particular place before – whereby the PCTs around London have pooled funds in order to be able to get rid of the historic deficit problem that we have from the past deficits of the huge trusts, so the best part of £500 million has been pooled and in a very rigorous process of assessment of readiness for the future, is being used to wipe out the historic deficits of all trusts around London so that all of them can move, on a level playing field effectively, into the future.

The trusts are the major part of the transformation, in numerical terms, so, of that big deficit we had in the 2005/06 four years ago, £178 million of it was in trusts. They have moved back into surplus. They are now, this year, moderately in surplus of about £4 million. One of the interesting phenomenon of working in the health service is the better a trust becomes the quicker you lose it from SHA management and, therefore, as we get trusts to be more and more in balance and in control of their finances, they move out of the numbers that we are accountable for, so we are left with a reducing number of trusts and they are, typically, the ones who have the biggest and most structurally challenging financial problems.

We have moved out of the period – which you would be able to see up there – of collecting money into the SHA for risk management purposes, so called top slicing, which was a deeply unpopular thing to do when we did it, but was necessary to manage the risk profile back in those dark days. We have passed that money back out to the PCTs as would see in those numbers. They have now invested that. In fact the PCTs, quite rightly, coming out of this year, have a very, very modest level of surplus being taken forward, because the job of a PCT, of course, is to spend its money, not to accumulate big surpluses for its own purposes.

So that is really the historic side of it. You could take the view, based on that, the problem is solved; we have got almost all the organisations back into balance and London's finances are OK etc. There are five important caveats that I wanted to leave you with and then they will form, I guess, a large part of where we might want to go in the discussion. They have been achieved through a lot of hard work but, frankly, they have been achieved at a time of extremely benign economic conditions, so growth in resources going in to the health service over this period has been round about 30 per cent over that four year period. Clearly, we are going into an economic environment, going forward, where there that is going to be very different.

There are still a handful of hard problems to solve. There are four trusts and two PCTs who are in deficit in this year, two of them in quite significant ways. Barking, Dagenham and Redbridge Trust and South London Healthcare Trust. Both of them struggling to get the traction on their cost structure to enable them to get back into balance. We have got a number of hard edged problems to solve.

Most importantly – which is, I think, where Ruth was heading in her introduction – we leave, simple description, imbalance this particular year and, indeed, the current Comprehensive Spending Review (CSR) cycle. As we go into the next two corporate spending review cycles our best estimate is that we will end up with flat funding going forward. Compare that to the 30% of growth that we talked about over the last four years. There is structural cost inflation in the health service, over and above general inflation, of round about 4 per cent per annum, consisting of population growth, demand growth and a kind of built in cost factor. If you take those together,

and flat funding and 4 per cent per annum structural growth in cost, you end up, at the end of the six year cycle that we have modelled going forward, with a deficit which could be anywhere between about £4 billion and £5 billion, based on total allocated resources of about £13 billion.

So you can see the size of the challenge that we have got that we need to address through the actions that we are taking. We will, doubtless, want to talk a bit about what those actions are but they are, essentially, all of the actions, related to Healthcare for London, which I can say a bit more about, if you wish, a little later on.

Nicky Gavron (AM): Sorry, £4 billion to £5 billion by when?

Paul Baumann (NHS London): £4 billion to £5 billion would be the deficit if we did nothing between now and the end of the six year cycle that we have modelled going forward.

Nicky Gavron (AM): The six year cycle.

Paul Baumann (NHS London): So 2016/17, if we did not attack the productivity challenges that we have got, if we did not make the switches into polysystems.

Nicky Gavron (AM): It is an accumulated deficit?

Paul Baumann (NHS London): It is the final year position so it is cumulative in the sense that the problem gets worse and worse and worse.

Nicky Gavron (AM): But it will be an annual one?

Paul Baumann (NHS London): It is an annual deficit against our budget of £13.5 billion, which we think will be held flat, with any luck, in real terms, but that is a hope, not a confidence at this stage.

Richard Barnbrook (AM): This six year. How tightly tied in is that with the public finance initiatives (PFIs)? Are we hamstrung by the PFIs?

James Cleverly (Chair): I think we are running ahead.

Richard Barnbrook (AM): OK. Sorry.

Paul Baumann (NHS London): That was my third caveat, so we are going into a very different economic circumstance and, if we do not do something drastically different from what we have been doing to date, that up to £5 billion of deficit will open up on us.

The big positive is that we do not need to do anything that we were not going to do anyway, in Healthcare for London; we have just got to do it faster and in a more radical way than we might otherwise have done.

The fourth caveat is the trouble has started early. The numbers do not, necessarily, reflect it in full because we have taken action against it. This year, already, there is overheating in the system of terms of activity - nationally; it is not just a London phenomenon.

Richard Barnes (AM): I love the way the finance department says overheating activity, and the doctors would call it treating more patients! Anyway - go on.

Paul Baumann (NHS London): I am commenting on the consequence of that indeed, but there is about £200 million of additional cost this year in the system, unbudgeted, which we have had to deal with, which is a system, I think, of the challenges that we have got in the system.

Certainly, as I look at next year's contracting round between PCTs and trusts, it is probably the most challenging that we have had since I have been around in the last two or three years, as we try to work out how much traction we can get with demand management – which is, again, the accountants' term for doctors finding other ways to deal with people than sending them to hospital! To what extent that can countervail against what I have described as being this strong increase in growth trend in treatment.

So all of that points to a big challenge for us going forward.

Andrew Boff (AM): Yes. It has kind of been answered. Just to be absolutely clear about these figures. All things being equal, with the current level of central funding from government, we are heading for a £4 billion to £5 billion deficit by 2016, but the things that you need to address that are actually programmed, that you are saying we need to do?

Paul Baumann (NHS London): Yes.

Andrew Boff (AM): Is that sufficient? Is that what the plans are? Do you have scenarios you are working to? I know, for example, that in local government departments are being asked to plan for, in some cases, a 25 per cent cut and things like that. Have you got the same processes going and what is the worst scenario you are looking at?

Paul Baumann (NHS London): We have modelled three funding scenarios. The one that I mentioned is the central one, which is flat real funding, so all we get is inflation, which is more than, I have to say, the bulk of the public sector is anticipating, but I think that is a reasonable assumption.

Richard Barnes (AM): Is that the one that leads to the £4 billion to £5 billion.

Paul Baumann (NHS London): That leads to £4.4 billion so it is in the middle of the range that I quoted.

Andrew Boff (AM): By 2016.

NHS London): There is a downside which is that it is flat cash, in other words we do not get inflation funded, for three years, and then, in the succeeding three years, it is slightly more benign. That takes us to the £5.1 billion, to be precise, that I showed at the top of the range. If we were to take a more positive scenario, which is 0.75 per cent of real growth going forward – I will leave you to judge whether that is a scenario we need to spend a lot of time talking about. If you take that benign scenario that takes the deficit down to just below £4 billion.

All of that is assuming our central scenario – because we did do scenarios on growth as well, growth inactivity to come back to our earlier discussion – which, typically, is running at about 4 per cent per annum in pure activity terms, we have done scenarios around that, and that could add another £1 billion to the challenge, if we were to have a continued heating of the growth projections. To keep the analysis straightforward £3.8 billion to £5.1 billion is the range of deficit that would come, depending on what assumptions you take about the Chancellor of the Exchequer and his decisions after the election, into the next couple of CSR cycles.

Richard Barnes (AM): So if you are told, "Cut 10 per cent out of your budget" that would be in addition to the £4 billion to £5 billion?

Paul Baumann (NHS London): Yes.

Richard Barnes (AM): That is significant.

Andrew Boff (AM): In addition to the reforming programmes that you have already got, what else is there up your sleeve to cope with some bad news coming along from the Government?

Paul Baumann (NHS London): The range of outcomes of the strategic actions we are taking is between £4 billion and £6 billion, and that depends really on the degree of radicalness with which we attack them. As we look at the productivity challenges we can make various judgements about how far along the spectrum from good to world class benchmark efficiency we can achieve. Depending on where you get in that spectrum you end up between £4 billion and £6 billion.

If you go back to the figures I talked about, if the flat cash comes about, we have got a £5 billion gap. We have got identified ways of filling the best part of a £6 billion gap so there is thought, at least, as to how we would deal with an even worse situation than that. Frankly, we have not modelled a scenario which is worse than flat cash, nationally as well as in London I should say, so all this is aligned with the modelling that you will have read about at national level.

Navin Shah (Deputy Chair): With the planned cuts, whichever scenarios we look at, what is the likely impact on frontline services? I am concerned, whichever scenario we may face, how are the patients going to be impacted? Can you draw some picture of what the effects will be?

Ruth Carnall (NHS London): Shall I start? There is no part of the system that is going to be left untouched by this; it is too significant. It is not a question of saying to people, "You have to tighten your belts" or, "You have to find a way of doing things more quickly". It is not trivial in terms of asking people to marginally improve what they are doing although, obviously, there are some things we can do like share back office functions and those sorts of things which do not have an impact on the frontline and which we should be pursuing more aggressively than we have done to date.

There are real opportunities with local government that we have started having, I think, some really good conversations with in London about how we might work more effectively together to avoid patients being dropped between stools and between social care and healthcare education and healthcare and so on.

Andrew Boff (AM): Excuse me. Is that the Hammersmith and Fulham model you are thinking of?

Ruth Carnall (CNHS London): Not just. I can come back to that if you want to say a bit more about that, if you are interested in it. It is much more significant than that. No part of the system will be left untouched.

What we have to try and ensure is that we treat patients in the most appropriately treated, in the most effective and the lowest cost setting. Lord Darzi's words, "Centralise where necessary. Localise where possible". So where we can treat people in their own home, more effective prevention, treat people in lower intensity settings, polyclinics in our case, the more we can do that, the better people will get access to services closer to their home.

We have got a huge amount of duplication and fragmentation of hospital services in London, in particular specialist services, and we know that we can save people's lives by centralising those.

All of that implies people being trained to work in different ways and working in different settings, and we are starting to make progress on that. We are starting to think about how we redirect our training resources so that we produce a workforce with a future rather than continue to produce ones at the present.

All of that is a radical change programme requiring completely different care pathways for patients and requiring staff to work in different ways and in different settings. It is all very controversial. Even the things I told you about earlier on about stroke and trauma services, which are very, very well evidenced and where we have had the time and space to put these things into place. We have taken a long time over it. It demonstrably saves people's lives. Even in those cases there is a lot of controversy about it and a lot of anguish on the part of patients about whether they can still access services and so on, so the controversy around some of this will be very significant.

Our challenge is to convince people that this is the right way to receive their healthcare and to implement it quickly. If we can do that then we think that we have got alternative settings of care, alternative care pathways, more effective ways of treating people, more intensive utilisation of the facilities we have got, freeing up estates that we own in London, releasing the resources attached to them, investing that money in better alternatives and so on. We have got a major job to convince people that this is the right way forward.

Ideally we would want to put new models of care in place before old ones are removed. The extent to which we can cope with running any form of service that is duplicative is very, very limited. The pace of change is what, I think, will be the most challenging for us. We could move on from the stroke care to the next one. We could say, "Right. We should do the same thing with vascular surgery. We could convince people about that". So we could carry on doing these things in an incremental way, but we have got to do it much more quickly than that.

Navin Shah (Deputy Chair): Where would accident and emergency A&E provision come, for example, in terms of the duplication or rationalisation that you talked about?

Ruth Carnall (NHS London): At the moment most of the population, I think, believe that behind the sign A&E is a standard offering and that is basically everything you might need in an emergency. That is already not the case in London. As I said to you earlier, if you ring an ambulance for a heart attack you do not go to your local hospital, you get taken to one of eight major centres. If the ambulance thinks you have had a stroke you get taken to one of eight stroke centres in London over the course of the next year. So already we are starting to differentiate between major trauma centres, trauma services and what is, more appropriately called, urgent care.

One of the things we know is that, at the moment, people rely excessively on A&E services and hospital services when, if they had better primary care services, better and more extensive primary and community services, open more hours day and night, in more purpose built facilities, they could have a much better standard and a much cheaper form of care in those places than they can through a standard A&E department.

Our challenge is to be really clear with people about what they can expect to be provided where. What you can expect in a polyclinic - and that has to be the same in Richmond at one end of the town as it is all the way over in Havering at the other - what you can expect when you turn up at a local hospital, what is the offering there, what should you be taken to a major centre for and where are they, and what is the certainty that we have got the ambulance service and the care pathways for patients properly aligned in terms of some of the more serious things that people have got life and death for. The ambulance service is very convincing about the need to get patients to the right place, rather than to the nearest place, and the better outcomes that can be delivered as a result.

One of the things we are going to do over the next year or two is to show those numbers. We can already prove to people that we are saving a significant number of lives from heart attacks in London. Far better outcomes in London than anywhere else in the country, as a result of what we have done, and we will be able to show the same for strokes. Then I think people will start to have more confidence that actually this is something that will save their lives, even if it is 20 minutes further away from home. I am not, in any sense, implying that that journey is going to be an easy one.

Nicky Gavron (AM): You said there nothing has been decided but there is so much concern and anxiety round the closure of the A&E, say the Whittington, and now what you are telling me is that nothing has been decided, so I do not know how it has arisen. There is not a consultation.

Ruth Carnall (Chief Executive, NHS London): One of the things I said earlier was that the way Lord Darzi worked was to try to get clinicians locally engaged in the discussion about what changes are necessary for their patients. We have tried to build on that approach and we have tried to encourage local doctors, nurses and others to engage with people about what the right options for the future are, and they are doing that. So there are discussions in north central London about the future of services there, about the future of organisational configurations and everything else.

The downside of doing that is that people instantly latch on to the fact that one of the options that people are considering is a reduction - there is nobody proposing to close the service there - in the level of emergency care that can be provided in a local setting. In other words, a further extension of what I have described around stroke care, heart attacks and other major emergencies. There are also other options that emphasise the Whittington rather than other places, North Middlesex for example, or Barnet Hospital. So people latch on to the one that they particularly are fearful of, understandably.

I still think it is right to try to encourage local doctors and managers to be talking about these options because, otherwise, we have got a standing start if there is no debate on these things.

I understand the anxieties but also, to be frank, those anxieties are being exacerbated by the current political scenario. There is a whole series of completely spurious things put around about the future of Kingston Hospital which were exaggerated, for reasons that I understand. There is a heightened level of potential for these stories to be exploited which perhaps would not be the case if we were talking about these in July.

Nicky Gavron (AM): Can I just ask one other question though round that which is what it means, the closure of A&Es, for instance, to the actual fabric of the hospital? If you just take that one, which I know quite well, and the neo-natal, other services within the hospital are related to the fact that it is an A&E for a very big area. I am just wondering about then what happens to the status of that hospital and the services within it?

Ruth Carnall (Chief Executive, NHS London): As I have said, we need to completely redefine the term A&E because there will be, in the future, no standard offering of the type that people expect there to be at the moment, and we need to be clear about what the appropriate co-dependencies are for different levels of intensity.

My benchmark with this is, where proposals for change are put forward locally, then I want to know that - in fact, this is set out in a guide that we have now produced for NHS organisations in London taking forward these changes and lessons that we have learned from ones that have not gone well in other times in other parts of London. First of all it has to be developed by local clinicians and there has to be a significant body of clinical opinion locally prepared to represent the changes in the media and with the public and argue, on the basis of the evidence, that they can offer a better and safer quality of care through what it is they are proposing.

If I turn up in a hospital that is proposing to make changes and they cannot put in front of me the six, seven or eight leading clinicians who are prepared to say, "This is a safer and better service for my patients" then it is not something that we would think was supportable.

Nicky Gavron (AM): You are talking about hospital clinicians as well as GPs?

Ruth Carnall (NHS London): Yes, both. Obviously they will have different views and they have to think about the balance of opinion, more in favour than against, and they have to take that change through a process of discussion and consultation, of which the public consultation bit, the formal bit, is actually the shortest bit. The engagement process needs to be much longer than that. There needs to be some form of independent validation. So typically we would use the National Clinical Advisory Team but, in some cases recently, we have used panels of clinical experts from the UK and abroad. So, with the stroke service changes that we made, we used an international panel.

Nicky Gavron (AM): Yes. The other issue is, of course - I do not know if it is what you mean by co-dependencies - all those people who cannot get anything out of hours, dentists etc people use A&E at the other end.

Ruth Carnall (Chief Executive, NHS London): Exactly. The answer to people who are using A&E departments as a substitute for poor primary care and community care is to have the polyclinic model up and running across London, because then you can walk in at least 18 hours a day and in some cases, depending on where it is located, 24 hours a day. You can get dentist, pharmacist, GP, nursing, basic diagnostics, x-ray. We have also specified that every hospital will have a co-located polyclinic.

At the moment if you look at the two polyclinics, one at Hammersmith and one at Charing Cross Hospital, they are demonstrating, in practice, that 60 per cent of the people who previously would have turned up at the A&E department can be more effectively treated in those polyclinics.

I think if people were used to turning up and going to a polyclinic and being seen quickly, getting their blood test and everything else done at the same time, then they will not feel the need to go to the hospital and sit and wait, whilst the team there are dealing with other cases.

In saying that, Nicky, I am not implying that that transition is an easy one. We have got ten examples of polyclinics in London at the moment. That is all. It is nowhere near enough.

Richard Barnes (AM): I am following the fortunes of the one in Harrow. A number of points, Chair. The NHS is notoriously bad at consulting and when you are presented with the preferred option clinicians, on a number of occasions that I have been involved in, have felt dragooned towards that preferred option. I think particularly of the Harefield Hospital and the proposals for change of services there - which was eventually stopped. I would ask you, if you are going to go through the process, have an honest one. You clearly need to reduce the length of time that it take because, at the moment, you can go through a whole Parliament before you change it.

Ruth Carnall (Chief Executive, NHS London): You can go through a lifetime.

Richard Barnes (AM): There is that as well. Cancer services have certainly done that already. I recognise your plea to politicians to show maturity, whichever bench they sit on, on either side of the General Election. I recognise that as well.

The three of you talk about fundamental change. I have not heard fundamental change yet. I understand A&E and the dependencies aer changing. Merging, coming together of PCTs and local

authorities - I am not sure what financial benefit you, Paul, will be looking for. I can recognise the social services and the medical benefits and the care at home benefits that that will lead to, but I do not know what the financial savings of that are. Have you done modelling on what that is likely to be? There are two or three different models of PCT existence, post 6 May - for want of a better date - from either side of the House of Commons.

Finally, Paul, you have been under the cosh for a number of years within the NHS. Funding goes up but you are still expected to find 3 per cent cash savings. Your £5 billion between now and 2016, does that include the 3 per cent savings or are they on top of?

Paul Baumann (NHS London): Let me deal with the easy one first! In the £5 billion, a large part of that is delivering, in cash terms, the sorts of productivity savings you are talking about, so there is not another 3 per cent on top of it. Indeed roughly half, slightly less than half, of that £5 billion that I talked about is going to go up from 3 to 4 per cent, predictably, in the next year or so, but is delivering that 4% in real cash reducing terms.

Richard Barnes (AM): OK. That is already from the previous spending round? That is already built in by the current Prime Minister and the previous Chancellor?

Paul Baumann (NHS London): Yes.

Richard Barnes (AM): So £5 billion really is your minimum figure.

Paul Baumann (NHS London): The only difference is, in the past, a lot of that has been delivered in the context of growing resources, and it is always easier to make 3 per cent or 4 per cent per annum in the context of growth. It is much more difficult to do it when you have not got that growth coming through.

In terms of the savings I think it would be fair to say we have not got a standard model of how to derive savings from PCTs and combinations. We, like the rest of the health service, are required to make 30 per cent management cost savings over the course of the next three years. In PCTs and in the SHA itself.

The way it will be done is we will look at the management costs of PCTs and the SHA at the end of this year. At the end of last year, just to give you a sense of it, it was £250 million for London. We will be expected to show, demonstrate and cash but not in addition to our £5 billion, as part of the £5 billion, the 30% that we are talking about, which is about £75 million, £80 million of saving.

One of the ways - but only one of the ways - in which that will come about is through better cooperation, clearly, with local authorities, between the authorities and PCTs, and the other will be about the way we interact with each other in the health service across London.

Richard Barnes (AM): I tried to do that from the middle of the 1990s onwards. There were some reluctant brides about.

Ruth Carnall (Chief Executive, NHS London): Last week I went to a meeting of London Councils leaders which, in the past, has not been the most comfortable meeting from my part of view, as you can imagine! On this occasion actually I thought it was a very good meeting, from my point of view anyway, in that a very significant number of local government leaders were interested in talking with us about integration of local commissioning, health and social care, health, social and communication.

So what we have agreed to do, jointly, with them, using John O'Brien's (Chief Executive, London Councils) team, is to jointly support a piece of work which is designed to look at what might the

alternative models be for integrating local commissioning at local level, ranging from work better together and models of that, through to what is happening in Hammersmith and Fulham which is a complete integration of the leadership of the PCT and the local authority. I felt that there was significant support for that. Equally, a recognition on their part that the commissioning of, for example, hospital services needs to be scaled up to have the impact that is necessary. So they were, I think, seeing it as a perfectly reasonable deal that much greater integration of commissioning at a local level, with an acceptance that commissioning more specialist services needs to be on for a bigger population.

Merrick Cockell (Chairman, London Councils) was in the Chair and said that he felt that there was a better understanding between us than there had ever been before, and that he thought it was a remarkable outbreak of consensus - or words to that effect - so close to an election. I think they were very positive about the work that we have put in place and at least five or six volunteers for taking forward something akin to what has been done in Hammersmith and Fulham.

Our job, I think, is to make sure that we very actively support those that are willing and enthusiastic so that we give some more examples than just the one. I do not want to just be quoting Hammersmith and Fulham as the only example.

Richard Barnes (AM): Will they control their health economy or will you, on top of that merging, say, "Your A&E's got to go" or, "Your kidney services have got to be transferred to somewhere else"?

Ruth Carnall (Chief Executive, NHS London): We would separate the commissioning of local services, primary and community care and social care from specialist hospital services. Quite where the division would come we would need to work through. So the idea of having five or six pilots that we can work with would enable us to work those issues.

James Cleverly (Chair): I am just conscious of the time. We have still got a fair few questions. My hope to keep a hard and fast segregation between finances and reconfiguration has gone to pot.

Richard Barnes (AM): Chair, we need a separate meeting on this.

James Cleverly (Chair): I am glad that it has actually but I think we might need to get some more detail.

Richard Barnbrook (AM): I would like something clarified. This six year programme of the £4 billion to £5 billion. How tightly is that tied in to this legally binding contract with the private finance initiatives (PFIs) that seems to have gone from £250 million to £400 million? What I am trying to get at here is that obviously it is not just bricks and mortar; it is the whole social politics of how this whole structure is working. I would like to know how tightly tied in are we to these PFI contracts and how much it is costing us overall? I have no love lost with PFIs. I do not think, personally, they work. I think they rip us off; these private contractors. Queen's is an example but I will come back to that a bit later on. I would like to know how much of our money is being tied in to these and for how long and at what cost? What percentage?

Paul Baumann (Director of Finance & Investment, NHS London): The first answer to your question is we are - to use your words - tied in to them. They are a fact. The other fact is they are all facilities we want for the health service and which we must exploit as we go forward.

Richard Barnbrook (AM): But they are putting pressure on us. Suddenly from £250 million to £400 million?

Paul Baumann (Director of Finance & Investment, NHS London): That is not because the cost is increasing because of the PFI; it is simply because we have got schemes which are gradually coming on stream in a variety of places. So they are a fact of the landscape and they will remain so and we are building up other landscapes to make the best use of the real estate that we have got.

They are fully factored into the cost structures that we are planning into this so, to your question, they are not an additional problem that we have got on top of the need to live within that flat funding that we have got; they are part of the cost structure that is factored into that.

Richard Barnbrook (AM): What I am trying to ask here is why - sorry, maybe I am a bit ignorant on this - we need them? For what purpose do we need these PFIs? What I am trying to get at here is that the costings they are putting forward, it seems to us, seem to be slightly escalating and I cannot see justification for why we are using those, when the properties we have under our control at the moment - I am going to take two examples, King George and Saint George. Both are our properties. They work. I realise they are old properties. I know them very well. Havering and Redbridge. Very, very old properties. But they do tend to function. I cannot see why we are having to use considerably large amount of monies.

Let me read this here. There are 25 PFI hospital schemes in London. A recent report stated that repayment costs for PFI contracts are likely to grow - which means we never planned very properly for them in the first case - in the coming year from £250 million, 2009/10, to £400 million in 2014.

Paul Baumann (Director of Finance & Investment, NHS London): The point is not that we have got escalating or unplanned costs; the point is that we have got, for example, the PFIs at Barts and the London which are coming on stream and obviously that adds to the cost of PFI as we go forward. It is not that the costs are escalating; it is simply that we have got more PFIs coming on stream within the 20 that you mentioned.

They are a valid way and a useful way of getting hospitals built. They have been used where that has been the most effective means of doing so. There are stringent tests that we have to perform when we are planning for capital spend in the health service to demonstrate that that is good value for money compared to other ways of doing it. Frankly, if we had not had access to PFI funding, a number of the schemes on which we are absolutely reliant would not have come to fruition because there simply is not the capital funding and, looking forward, there will be even less capital funding to do any building that we need to do.

The number of new PFIs coming on stream now is small, but they are an essential part of the landscape for us.

Richard Barnbrook (AM): I will put it in another direction. There is a more pertinent question to follow on from this. I do not want to make this into a political situation. It is in my back garden. It is the PCT of Havering Redbridge Barking and Dagenham. There is Queen's Hospital. Relatively new. It has been fraught with problems. With the downsizing of both King George and Saint George we have actually physically lost 90 beds in the PCT. Now, obviously, Queen's is - if I am correct, maybe I am wrong but I think I am correct - a PFI project. So that has actually helped the community of Havering, Redbridge and Barking and Dagenham. To downsize two hospitals that seem to work and bringing in a PFI with Queen's Hospital. By reducing the beds in King George and in Saint George, we are 90 beds down. That hospital has been blighted from beginning to end, with floods this, floods that, bugs this, bugs that.

What I am trying to get at here - I think everybody is in line with this - is how can we be assured that the way we are going forward is beneficial to the community, when we are losing rather than gaining?

This comes to the pertinent question which I have requested before. With these four acute trusts we could be in deficit of £85 million by the end of this year, or the next coming years. How does that all work out?

Ruth Carnall (NHS London): OK. There are a lot of things in what you have just spoken about. The first thing to say is, as Paul has said and it is important to emphasise, for a significant period of time the only means of accessing large amounts of capital to build much needed new hospitals has been through a PFI. You might not like it but that is the case.

Richard Barnbrook (AM): Rent of £1 million a year.

Ruth Carnall (NHS London): That has been the only means of getting access to significant amounts of capital. Once you have got it you are tied into a contract to fund the cost of it. Therefore, on occasions, where we look to make changes in services, we have to take into account the fact that there is, essentially, a sunk cost in some of the physical facilities that we have got, and we need to make sure that we exploit their value. Sometimes people will say, "You've only made this decision because you have already got this place up and running" and, to an extent sometimes, that is true. It is a balance between, "We are already investing this money and we are going to have to pay it whether we like it or not and, therefore, isn't it the best use of public money to exploit that asset as best we can?"

If you take the Royal London, which is currently being built - Paul [Baumann] will correct me for getting the numbers wrong now so do not put them in the minutes - the unitary charge associated with that new hospital is something like £100 million per annum. So if we decided it had been built in the wrong place and we wanted to send people somewhere else, we would be paying £100 million before anybody walks in through the door. Therefore, the best thing to do, given that that is a contract that we cannot avoid, is to make the maximum possible use of the investment that has been made, in the interests of good use of public money. So sometimes we are tied into things like that that we then have to exploit.

As to the why are we losing beds and so on? Hospital beds are not always the answer in terms of most appropriate facilities for patients so one of the things we want to invest in, as you know, over the next three years is 100 polyclinics in London. Some of them will be on existing hospital sites but many of them will not, so hospital beds are not the only measurement of facilities that people can use; in fact, quite often, they are not an appropriate measure at all.

In terms of the specifics that you raise about Queen's and other local hospitals, it is true that they face significant financial challenges, hence why PCTs in London, collectively, have put together a sufficient fund of money - not as a top slice from us, but themselves - to help trusts who are in trouble sort out their historic debts. They will only do that on the basis of them putting together a credible plan for the future. In other words they will not chuck good money after bad; they will only put the money in once they are satisfied that they have got a proper plan for the future.

James Cleverly (Chair): Ruth, specifically with regard to the PCTs and acute trusts that are in deficit, one of the concerns - I think you were there actually, at the lunch at the House of Commons probably about a year ago, perhaps it was not - that I raised when we were discussing about this reallocation of funding, the trusts in surplus offsetting the trusts in deficit, was that if the underlying issues which had driven those trusts into deficit were not addressed, then actually what we would do is we would be penalising ….

Ruth Carnall (Chief Executive, NHS London): Chucking good money after bad.

James Cleverly (Chair): Not just chucking good money after bad, which is an important point, but, in practical terms, we would be penalising the hospitals that had been able to deliver and still

generate a deficit which gives a very strong disincentive for the financial managers at trust level to work efficiently. That was one of my real concerns. Has that been addressed? One point. What, at NHS London level, is being done to deal with that deficit and ensure that deficits do not creep forward in what, we have already identified, are significantly tougher economic conditions?

Ruth Carnall (Chief Executive, NHS London): So two parts to your question; one is how do we not throw good money after bad and make sure we only fund things that are viable, and the second is how do we demonstrate fairness to those organisations which have managed their budgets.

James Cleverly (Chair): And incentivise good financial management.

Ruth Carnall (Chief Executive, NHS London): Before Paul came to this meeting he was at the Board that has been set up by PCTs to oversee that process and might be able to talk about how it is doing exactly that; making it fair to people and incentivise the right behaviours, rather than the wrong ones.

Richard Barnes (AM): They have never achieved that in the past and this is not the first time that services had been pooled, or deficits have been pooled.

Paul Baumann (NHS London): Let me give you a couple of examples of where it is beginning to work. To answer your question directly, the Challenge Trust Board, which is the Board which Ruth mentioned, is the group that has the custody of the £500 million of money that has been collected for this purpose and has the ultimate decision making as to whether it goes to the trusts who are applicants for it, to get rid of their historic deficits, or not. It is comprised of seven representatives of PCTs, one from each part of London, and three of the SHA directors who, between them, look in enormous detail at the performance, plans, sustainability and futureproofness of the productivity gains of these particular hospitals, supported by a very extensive process of due diligence.

In a way it is like a trust going through a foundation trust scrutiny or, indeed, the sort of due diligence you do when you are doing mergers and acquisitions, with the express purpose that there is an incentive for people to address all of the issues that you have talked about in terms of why they have got to where they are, and also to have to convince themselves, as well as us, about what they are doing to put the position right.

It is proving much tougher, I think, than most of those trusts thought it was going to be. To date we have made three allocations out of a potential of ten from that Challenge Trust Board fund and they are, perhaps, the easiest of the ten to get back into balance. What is starting to happen is it is driving real difference in behaviour. I can think of at least one trust which has weaned itself off the growth gene, as it were, in terms of always trying to trade itself out of financial difficulty, and is now seriously addressing its cost structure in a way which had not been apparent before and, self-critically, we, as an SHA, had not managed to get it to do before. It is the combination of the SHA intervention, the PCTs sitting round the table, including the ones who are responsible for that health economy, and, obviously, the lure of a substantial financial reward at the end of it, if it can demonstrate the behaviours and the performance that we need.

So that is working. We have got a real test because we have got to get this scheme through by the end of next year, the coming financial year, because that is the undertaking that we made when we founded the fund; that we would, over this two year period, have a) cured the problem of challenge trusts and b) had allocated the money to cure their historic problem. There are two big trusts, the two that I mentioned a little earlier, who are a major part of this, who are taking longer to get sorted out than I would have wished, but it is working, and certainly we are not going to give money to trusts who have not demonstrated real rigorous financial controls.

Richard Barnes (AM): But you can have a runaway acute trust which is causing the PCT problems, because they are failing to manage that runaway acute trust. How are you building that in as well?

Paul Baumann (NHS London): That was the example I gave. There is one trust, of which I am now very fond, which had a history of doing exactly what you just talked about and was part of the health economy in which we have our single biggest PCT deficit at the moment. It has, through this process, seriously readdressed its priorities in terms of doing things differently. There is an attitude to cost efficiency, to productivity and to cost reduction which is manifest in both their submissions to the Challenge Trust Board and its plans for next year, which, I think, we would not have had had we not had this process. It would have continued to trade its way through. Part of the discipline that we have got, which reinforces the strength of commissioners around London, is that no one gets even as far as a serious hearing with the Challenge Trust Board if it has not got its commissioner sitting beside them saying, "The strategy which is being put forward here and the behaviour which is being exemplified here is exactly what we want it to be". It has put commissioners very much in the driving seat about how those problems are cured.

James Cleverly (Chair): Paul, hindsight is a wonderful thing but the question that seems to scream out to me is why did it take so significant a financial deficit for us to get those good management practices in place?

Paul Baumann (Director of Finance & Investment, NHS London): As you say, hindsight is a difficult thing isn't it. The answer is we have finally got PCTs, SHA and trusts working on the same problem with a common purpose. Ruth might have a better answer to why it took us this long to get the courage, I think in part, for the PCTs to be prepared to do this. It was not an easy process, back in 2008, to convince 31 PCTs, of their own volition, to set up a fund to do this. I think, if we tried to do it a year before we did do it, the corporateness of PCTs around London might not have been sufficient to get that agreement. It is a mark, I think, of maturity - and it is on a spectrum I hasten to add, of increasing maturity - of commissioning around London that they were prepared to come together and do this.

When we first started the discussions I was genuinely not sure that we were going to get the proposal through, because there were the usual types of, "Well, should we do it?" and all the things about is it going to encourage perverse behaviour and it is good use of PCT money etc. My reading is it was not possible to do it before then for that reason, and not having the PCTs on board for this would, for reasons I have talked about, have made it much less effective as an influence.

Richard Barnes (AM): They went through a similar round about eight or nine years ago, with deficits and pooling and whatever. What was not there was the fact that the well is now dry. There is nowhere else to go.

Paul Baumann (NHS London): This is not pooling among trusts, to be clear. There is no trust to trust transfer here. This is purely commissioners around London taking responsibility for curing the historic problems of the system, as well as the future.

James Cleverly (Chair): That being the case, how is that this year's deficit is larger than last year's deficit?

Paul Baumann (NHS London): We do not have a deficit.

James Cleverly (Chair): Within that cluster of half a dozen trusts. It has gone from £75 million to £85 million has it not?

Paul Baumann (NHS London): We have got one trust which has a significant increase in deficit, which is South London Healthcare Trust, where we have had issues about cost management through the course of the year, which we have now addressed but it has taken longer than it should have done, and the process of that has increased.

Secondly - and this is where you can take two views of the role of a Finance Director - there are at least a couple of trusts I can think of, in that group of deficits, who have managed, in previous years, for perfectly good reasons, to find non-recurrent - in other words, once off - ways of resolving financial issues in that particular year. Frankly, some of them have now run out of one off things to do and, therefore, we are seeing the real underlying deficit coming through. Frankly, having only four trusts left that are in that position, compared to the 20 odd that we had three or four years ago, strikes me as being a sign of health, not the opposite.

Ruth Carnall (NHS London): The thing that I think is different from the eight to nine years ago is that, in the past, the way that this pooling of resources would have been handled was completely top down so top slice all organisations and, in particular - and most inappropriately in my view - top slice off, for example, mental health trusts who almost always would balance their budget.

When I took this job there was in existence a set of top slices which were done simply on the basis of who had the money. It was done top down by the health authority. What that creates, of course, is a whole set - to your point, Chair - of disincentives. So, if you manage your books well, along comes somebody and takes your surplus away and, if you do not, you get a bail out. It did not encourage any ownership of the problem in the right places.

I think what we have got at the moment is profoundly different from that. It is not imposed by the health authority. It is only PCTs pooling their commissioning funds. It does not affect trusts. There is no money being taken off trusts. Each and every one of them has put it through their own Board as a, "This is the right thing to do to take forward our strategy for London". The incentives, therefore, are much stronger on them to use their own money in the right way to deliver this strategy. The best way to have behaved in the past was to have a deficit. Now, actually, that is not the case. I think it is different in that respect, in terms of where the ownership for tackling the problem is.

Richard Barnes (AM): It engendered hideous resentment and a dreadful blame culture.

Ruth Carnall (NHS London): Yes.

James Cleverly (Chair): I think we are going to have to move on just to tie up a few elements with regard to the reconfiguration, and then draw this section to a close. Nicky?

Nicky Gavron (AM): It seems to me, from listening to this, you are in the middle of a very, very brave plan to reconfigure services and to roll out the local services and the reconfiguration of the hospitals and so on, and all this on a sub-regional basis too. It has come at a time when you are just moving there and there is a lot still in the pipeline and you are coming up against the growth that you talked about, which is immutable, the growth in demand and the growth in population and this £4 billion to £5 billion deficit that is building up. All that is quite separate from the costs of putting in this brave new plan. I am wondering what you can tell us now about the costs of that. I am sure part of it has been done for savings purposes and there will be savings coming out of it.

Paul Baumann (NHS London): To be clear, the change is what drives the savings we are talking about, so they are not in opposition to them. The major sources of positive impact, so how are we going to cope with static funding with the rising demand, is by providing it through the changed landscape that we talked about. Putting in place polysystems, for example, is a source of economy

as well as a source of significantly better quality of care. In other words, it is part of the financial solution.

You are quite right; there are costs of getting there. There are costs of implementing polysystems, there are costs of double running, as you say, and there are costs of inefficiencies whenever you start up any type of new operation. They are absolutely dwarfed by the level of saving that is available if we operate in that way.

Nicky Gavron (AM): The savings are down the line.

Paul Baumann (NHS London): Certainly the relativity is certainly much more beneficial than you think. In terms of setting up a polyclinic, we reckon it costs us between £6 million and £12 million, in terms of start up costs of one sort or another.

Nicky Gavron (AM): For all of them?

Paul Baumann (NHS London): No, for one. Sorry. If you can find a way of doing it for £6 million to £12 million that would be really, really good!

Nicky Gavron (AM): How many are you doing? How many are you rolling out?

Paul Baumann (NHS London): We are doing 100, or thereabouts.

Nicky Gavron (AM): 100 at £6 million to £12 million.

Paul Baumann (NHS London): When you start something up and for the first few months it is operating at less than full efficiency, as we all know from starting anything up. The savings that come out of those polysystems are at least twice the maximum of that, in other words, about £24 million per polysystem which it gets set up. We set it up in a year. It will cost us £6 million to £12 million to get it set up but it will immediately start liberating the £24 million of savings that come against it. As long we can execute with the discipline that is needed, so that from day one it is getting quickly ramping up to the level of activity and the efficiency that it is required to operate at, that all works.

There is a different challenge which is how the hell do we get - excuse me - the capital for all of that because, to the extent that we need capital for polysystems we are running up against capital constraints which are - depending on how you look at it - growing or decreasing, in other words, less capital, more constraint. Clearly the art of that is, as Ruth [Carnall] referred to earlier, wherever possible using buildings that we have already got in our set up, where they can be adapted for this purpose. It is clearly not a question of using wrong buildings for the new purpose.

It is partly liberating the value from our estate. We have got an estate which is conservatively valued at about £6 billion of real estate around London. Now, clearly, there are inefficiencies in any estate portfolio. To the extent we can realise some of that it will help. It is partly about using the funds that are available centrally but they are quite limited. It is partly about private finance initiatives, where appropriate, and it is partly about partnerships with local authorities. In some ways I can see that as being one of the biggest sources of opportunity. Some of the schemes we see coming through at the moment, some of the more imaginative ones, are combinations of local authority and health funding of one sort or another. There is a challenge of capital funding for all this but it is, in my own judgement, a manageable one if we are creative enough about how we do all of that.

Nicky Gavron (AM): You have been concentrating on the polysystem and not so much on the reconfiguration of the acute services.

Richard Barnes (AM): That is where it is needed.

Paul Baumann (NHS London): Yes.

Ruth Carnall (NHS London): If you look at the biggest weaknesses in the health system in London, that is where it is; primary and community services. There is almost a hospital on every street corner. That is not the weakness in our system. The weakness in our system is poor access to primary and community care, in particular for some of the poorer people.

Nicky Gavron (AM): Yes.

Andrew Boff (AM): In the process of reconfiguring the health service, what is your attitude to new GP surgeries being set up?

Ruth Carnall (NHS London): Without having a one size fits all we genuinely have not got some sort of concrete monolith in mind that we put down in every patch. The most important thing is that we make sure that people have access to the range of services that it is possible in the community, so we have a model of care in mind that people should be able to access for significant parts of the day, seven days a week. People should be able to walk into a local facility and get to see a doctor - and do that 7 days a week for at least 18 hours a day, in some cases more - and they should be able to access diagnostic tests, x-rays and, in many cases, appropriate outpatient appointments, especially for those who have got long term conditions. So rather than having to keep going to the hospital, they should be able to get that locally.

That cannot be delivered in small facilities. If you are trying to operate from a single small set of premises you cannot deliver that range of services. So the challenge for us is we need to build new bigger facilities and encourage GPs and their staff and other community and health - not forgetting social services - staff into bigger facilities. In others, where we have got smaller but high quality facilities, connect them to a hub, so that they can continue to provide primary care services and, in some cases, things like district nursing, health visiting and midwifery services, for example, at smaller facilities, but connect them to a central hub where they can provide out of hours services and walk in services.

Try to get a balance between making maximum use of existing facilities, where they are high quality but perhaps not purpose built, but not replicating small single or double handed practices. I certainly would not be supportive of new small single handed type practices. Supporting the ones we have got to connect into a hub, yes. Supporting the use of existing high quality facilities which, maybe, are still not ideally defined, yes. Building new ones, no.

Andrew Boff (AM): Does that not sound a little top down?

Ruth Carnall (NHS London): Every PCT in London is expected to produce their polyclinic plan so, to that extent, it is bottom up. They are expected to do that in partnership with their local GPs so you will get a different network of services in one part of London from another. There are a range of different proposals coming forward, taking account of the local population, their needs, and the sort of facilities that are already there.

If you take Redbridge as an example, I think that the Redbridge polysystem model is built around three major centres. In other places it is a different model. What we are being top down about is what the minimum model of care that patients ought to be able to expect from a polyclinic is. So when proposals come forward, if they can deliver that model of care or better, within the economic constraints that we have got, then fine. If they cannot then we are being challenging about that.

The reason for that is there was a tendency in the early days of this plan for people to say, "X, Y, Z facility locally is a polyclinic and ought to be recognised as such". When we actually scratched the surface of that the local population was not getting the service model that we want to see provided; actually it was something being rebadged and not really changed.

So the top down challenge to PCTs is not about buildings and facilities so much as about can you offer this model of care and could you be more ambitious about that? Could you offer more in the community than you are doing? Could you have it open for more hours of the day? Where is the evidence of integration with local authority services? Have you got wellbeing services there? How can you make sure that your population are able to die at home rather than die in hospital? So challenges of that type, to the model of care, rather than to the building side of it is the top down bit.

Richard Barnes (AM): Are there not two drivers to the polyclinics though? One that you want to stop people turning up at hospitals, probably in A&E, and, two, that the percentage of single practising GPs in London is 25 /30 per cent and most of them will retire over the next five to six years and that, if we do not do something now, by providing polyclinics, there will be a collapse in GP services? Certainly there will be in some of the areas that I know very well because there are no single practising people coming in; (a) no one wanted to live in the poor areas and take over the surgery or, (b), cannot afford to move in to the Northwoods of this world, which also have a crisis, because they cannot afford to buy the premises. Polyclinics are actually a resolution of the, potentially, looming crisis within GP primary care.

Ruth Carnall (NHS London): Those are two important drivers but they are not the only ones so we would hope to see them as a focus for wellbeing services; preventing people becoming ill in the first place, preventing them from turning up at A&E but also preventing repeat admissions. Providing people with long term conditions an appropriate package of care in their community. There is more to it than that but those are two important drivers, yes.

Navin Shah (Deputy Chair): You both have mentioned about a master plan of some 100 polyclinics across London.

Richard Barnes (AM): Can we have a copy!

Navin Shah (Deputy Chair): Indeed. This is what I am coming to; what sort of copy we would have. It is disturbing news that I understand Putney polyclinic, on affordability grounds, has been shelved. That is what I understand. That was in the autumn last year. Is this a sign of financial difficulties, putting at risk that master plan that we have for polyclinics elsewhere? Are the others affected or could be affected accordingly as well?

Ruth Carnall (Chief Executive, NHS London): I do not know about Putney as a specific plan.

Navin Shah (Deputy Chair): But is there a risk of this programme being affected?

Ruth Carnall (Chief Executive, NHS London): To go back to the point about the top down. PCTs are responsible for producing their polyclinic plans for their patch, working with their GPs so, to that extent, the plans are bottom up. Our job is to make sure that they are challenged about whether their proposals will meet the two constraints of does this improve quality of service and access to services for your population, does it give them the model of care that we have described and does it meet the financial challenges? They have got to be able to do both. They cannot meet the financial challenge if they do not offer services of a sufficient scale. So if they come forward with plans that do not properly offer the range of services for the number of hours of the day, seven days a week, then we will be pushing them to do more. In principle, that would be my answer but I do not know about the Putney example.

Paul Baumann (NHS London): It can work either way. As I recall, on the Putney one, actually it was more a question of it was too big and too difficult to get to work in an economic fashion.

Navin Shah (Deputy Chair): If the local PCT puts forward the case that that is the right model for local services, that is the local polyclinic, they would want to develop but if, for financial reasons, they cannot go ahead, is there any mechanism to support those PCTs or is the whole project put in abeyance? How would it work?

Ruth Carnall (Chief Executive, NHS London): Since we have developed an overall model that says we can make what we want to do work with the money, we would want to try to help them find a way of configuring it in a way that would meet the financial challenge. If we thought this was a fantastic set of proposals and really meets what we want to do but they have put forward something that, on the face of it, looked unaffordable, then our job would be to try to help them develop their proposals so that they could be afforded if we thought it was the right model of care.

If your question is more can they expect a subsidy from other parts of London? The answer to that would be no.

James Cleverly (Chair): Right. On that upbeat note I would like to thank you all for coming! I think it has been a very, very interesting meeting. Had time constraints not set upon us we would have tested your patience and probably had you here for a lot longer, but I really do appreciate you coming.