

Health and Social Care Committee

Oral evidence: Pre-appointment hearing for the position of Chair of NHS England, HC 743

Wednesday 26 February 2025

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Watch the meeting

Members present: Layla Moran (Chair); Ben Coleman; Dr Beccy Cooper; Josh Fenton-Glynn; Andrew George; Paulette Hamilton; Joe Robertson; Gregory Stafford.

Questions 1-84

Witness

[I](#): Dr Penny Dash, government's preferred candidate, Chair NHS England.

Written evidence from witnesses:

- [Add names of witnesses and hyperlink to submissions]

Examination of witness

Witness: Dr Penny Dash.

Chair: Welcome to today's session, which is a pre-appointment hearing for the new chair of NHS England. Welcome to your first session with us, Dr Penny Dash. Thank you so much for coming; it is much appreciated. We will start with the first question from Paulette Hamilton.

Q1 **Paulette Hamilton:** Good morning, Penny. My first question comes after reading your CV. You talked about the health systems that you have supported around the world to deliver improvements, and you also talked about supporting major reform programmes in the NHS over the last 25 years. How do you feel that this experience will assist your chairing, considering that things are changing so fast? You are looking at devolution and things being broken off, and you are looking at decentralisation. How do you feel that will that assist you in your new role as chair?

Dr Dash: Do you mean how will the things that I have done in the past assist?

Paulette Hamilton: Yes, absolutely.

Dr Dash: First off, good morning and thank you for inviting me along today. I am very pleased to be here. I have done a lot of things, as I said, in quite a lot of places, but I am continually learning. That is one of the things that keeps me going and keeps me energised. I am continually learning because it is a continually changing world, exactly as you say. The world is changing at the moment; it is changing very quickly. All sorts of things are happening, including many things that none of us can fully predict into the future.

My general approach is to say, "Where are we now?" When I come into any role, any place or any organisation, I say, "What is the starting point?" We are very fortunate in healthcare in this country: we have lots of data and we have, generally, quite a lot of cohesion about what we are trying to do. We also have lots of thoughts, ideas and experiences of what some of the potential things are that we could be doing. As well as that, we have a lot of people who are interested in looking at what is happening in other parts of the world, as well as what is happening in other industries and other parts of our lives.

Q2 **Paulette Hamilton:** Let me focus you a little bit. Your CV is excellent: it talks about all the wonderful things that you have done around the world. But in the UK, you seem to have centralised, predominantly in London and the surrounding areas. I am from Birmingham, and some of the people here are from further afield, so the other bit of my question is: how well do you understand the challenges that the NHS is facing to deliver in other parts of this country?



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Dr Dash: While my employed roles have been largely in London, the work that I have done, partly in consulting and partly in some of those roles, has very much been around the whole country. As I think I put in there, I have worked in all seven of the NHS regions and I have worked in most of the current ICS footprints. Actually, Birmingham is a place that is a bit of a gap, as I said to you, so I have been reading up on that. I have done a lot of work in Manchester, and I have done a lot of work in Dorset—I say those deliberately, because they are very different parts of the country with very different infrastructures.

I have done quite a lot of work in Hampshire and on the Isle of Wight. I have done a lot of work in the midlands, across Bedfordshire, in Milton Keynes and so on. I come from Stoke-on-Trent and I started my career working as a night nurse in the hospitals there. I actually did some of my medical school training in Stoke, and I then went on to do quite a big piece of work following Mid Staffs to look at work across that area.

Q3 Paulette Hamilton: My colleagues will dig deeper, but could you give us an example, before I ask my last question, of something that you are really proud of that you have done across the UK?

Dr Dash: One of the proudest things I have done was the work on stroke care. I started off working in London, doing a lot of analysis of the quality of stroke care. A lot of my work has started with quality of care—that is one of my big passions and I am happy to talk more about that. Currently, I am doing some work on that, as you may know.

The stroke work started by looking at quality of care. We looked at all 31 hospitals in London and at the quality of stroke care in them all. We did a lot of work with leading clinicians, working in stroke units in particular, but also in primary care and in social care. We came up with some proposals that were then implemented in London with significant improvement. The latest research says an estimated 96 lives a year were saved but also far more morbidity from that. I then worked with the central team to take that across the country, and we went to every part of the country.

I had a very memorable piece—which I have referred to, because it really stuck, and this is from about 10 years ago or more—which happened to be in Birmingham, with a representative group from society. One quite elderly lady there said to me when I was presenting—Ara Darzi was leading some of this work, but he could not go, so I was presenting it—“How did you let this happen?” That was the variation in quality of care. That has always stuck with me.

From that, I have really had this strong passion and energy to take the work that happened in London around the rest of the country. That, indeed, did happen, and we now have some excellent stroke care across the country. It still needs to improve, because the treatments for stroke care have evolved and moved on, and so on and so forth, but that is an example of something that I very much did.

Q4 Paulette Hamilton: Moving on, Penny, in your CV—that is what I am



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going by—you have a small number of digital healthcare start-ups for which you do advisory work, and you mention two venture capital organisations. You have said that you will give some of those up, but I would like to ask whether you think it is appropriate to continue to hold some of the other investments, the other things that you are not giving up, and especially with your involvement with the Cambridge Health Network, which you co-chair. How do you see your relationship with Cambridge Health Network changing? Could it not be seen as a conflict of interest?

Dr Dash: On the digital start-ups, I have invested in some of those—a small amount, but I have still invested in them—and I have gone through them with the Department of Health and Social Care. Ultimately, the permanent secretary will take a view, and so on and so forth. I am very happy to divest any of the ones that I feel, they feel, are a conflict. I am with you—I do not want there to be any perception of conflict of interest. I have agreed with the Department that we look at each of them individually, and I will divest my ownership stake in any of the ones that we feel are close. One of them is a clinic in Kenya, so I do not think that that is a conflict, but it is a bit about going through some of them.

The Cambridge Health Network is an interesting one. I co-founded that 20 years ago with a colleague. We have had lots of fantastic speakers—we have Andy Burnham coming to speak tonight, up in Manchester, so I am heading up there. He is going to speak about some of the work they are doing on employment and health, and so on. It is a great way of staying connected, through the speakers and the people who come along. At the moment, I get paid for my time in setting up those events, but I am very happy to step back from that. I would still like to be able to go to the events and to participate and so on, but I am very happy—I have discussed this with my co-chair—to move away from any remuneration, to avoid any conflict of interest.

Paulette Hamilton: Thank you, Penny.

Q5 Andrew George: You commented on the 10-year plan, which is not published yet, and the three shifts. You have been critical about the lack of progress that has been made on the three shifts. Obviously, they have only just been announced, but there has been an underlying desire to achieve those three shifts. Unarguably, they are desirable. With regard to, for example, the shift from acute hospital care to the community, what do you see as the primary impediments to actually achieving that kind of shift? It has been a mantra for some time, so what needs to be unblocked?

Dr Dash: That is a very good question. I think there are a few things. One is that, as many GPs would say at the moment, there is quite a bit of frustration among the primary care community—the primary care community is obviously much wider than GPs, but there is frustration around levels of investment in that. You can look at what has happened in terms of the money over the last five or 10 years. We have ended up spending more money in the hospital sector than in the primary care



sector and the community sector, and I think that needs to be reversed. Obviously you cannot do that overnight, but slowly, over time, that needs to happen and we need to come more in line with other countries that we would probably aspire to look a bit more like—the Nordic countries, for example.

There is definitely a bit about changing some of those investment patterns and doing that. Of course, that is not straightforward to do. That is going to require quite a lot of changes in terms of both local care—I do not particularly like the term “out-of-hospital care”—and hospital-based care. So one thing is changing the patterns of investment.

The second bit is around redesign of that local care. There is a lot of talk at the moment about neighbourhood care, integrated neighbourhood teams and so on. To a degree, it means different things to different people. I think more clarity on that will come out through the 10-year plan. But on the concept of having multidisciplinary teams that work effectively together, where that is working well across the country, it is really impressive. There are some fantastic examples in this country of that already happening. So there is a bit about making that more common, taking the best of the rest—there is a big need to do more of that—and really helping people to see what some of the examples of best-practice care are and to work out how they start to implement those locally. That does require a whole host of changes—to workforce planning, to estate planning and so on. I am sure we will come on to some of the productivity opportunities, particularly in the acute sector.

Q6 Andrew George: Right. But you know that the pressure at the moment is very much on acute care, with substantial delayed discharges, corridor care and ambulances queuing outside emergency departments. There will be a lot of resistance to any suggestion that the leadership of NHS England is going to withdraw still further resources from the acute sector, so don't you think your leadership will be required to press the case for, if you like, double running, at both ends, for a transitional period, to achieve these kinds of outcomes?

Dr Dash: I am very aware that this is challenging. I am also very aware that there are limited funds, so it is not easy to say we are going to double running at the moment. Those are real constraints. At the same time, if you look across the country, we do have big differences in, first of all, how many people turn up at the front door of a hospital. There are big differences across the country, so again, how do we take what is happening in some of the better places and seek to replicate that? That is not about stopping people going to hospital deliberately. It is about providing better care so that they do not need to go into hospital. So there is a piece at the very front door.

There are then really interesting examples looking at what happens when people—particularly people with long-term conditions and so on—do fall sick. Again, there are some very different models around the country for rapid response services, bringing together community services, social care



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services, ambulance services, paramedics and so on to intervene early and find alternatives to hospital admission.

There is then some work, which I think is much needed, looking at flow through hospitals. Many people talk about that. I speak to a lot of chief execs around the country—there is a lot written on it. How do we get back to some of the flow—which was better, I think it is fair to say, 10 years ago—through A&E and through the rest of the hospital? There is then the discharge element. How do we make that smoother and easier? I am sure I will be asked, so I will say this now: this is not just hospital versus social care; it is both. We have to get the whole bit working better together.

Q7 **Andrew George:** There are challenges ahead.

Dr Dash: Lots of challenges.

Q8 **Andrew George:** Can I move you on to your experience and an area of political contentiousness that certainly bedevils debate here—that is, the role of the private sector? You had 19 years in McKinsey; one may say that is coming from the dark side into the NHS. To what extent do you recognise the potential risks of the way in which the independent sector might interface with the public sector? Do you think it can be managed in such a manner that it does not simply allow the private sector to cherry-pick the profitable bits and leave the NHS with the difficult stuff, to put it bluntly?

Dr Dash: Absolutely. That is a spot-on question. First, to reiterate what I put in the questionnaire, the concept of a single payer, funded through taxation, is a fantastic asset for us. I say that having looked at other countries. If you go to many other countries in the world, they can only dream of having a concept where you have that single payer, able to take lifetime risk for a population, able to balance risk across such a large population, able to use data and the concept of the registered lists that we have, and so on. The funding, if I look internationally at all the data and analysis, is an excellent model and we should stick with that. I am happy to say that.

On provision, there is already a lot of private sector provision in the NHS—everything from, of course, GPs as private providers to private provision of all the scanners and bits of kit. There is already a lot of that. I am not an expert in procurement, but if I look and read about that, many people talk about opportunities for better procurement of all those things, from bits of kit to drugs and so on—the list goes on.

When it comes to what you refer to, bringing in private providers for different kinds of care—cataracts and hip replacements are obvious examples—where there is capacity and a waiting list, the pragmatic bit is to use it. The crucial bit, as you say, is to ensure that you are paying an appropriate price for the level of service provided. That means getting the tariff, procurement and contract right. It also means getting the contract assurance right—all of those bits.



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We are in a fortunate place now, in that we have lots of data—way more data than we have ever had before. There is a real ability now to have far more variation in tariffs to take into account case mix. That would be true in terms of money flows around the NHS as well as into private providers. If we could do that much more effectively, that would negate the concerns about cherry-picking that you refer to.

- Q9 **Andrew George:** This is almost parallel to the question that Pauline asked earlier. For providers who have a foot in both camps, providing both elective care in the NHS and private care, do you think that that can be managed? There is certainly a lot of unease in the system about how that is currently handled and managed, both ethically and in how one ensures that the public sector is properly protected.

Dr Dash: I think we must have a robust tariff system, robust contracting and robust assurance. That is certainly a point I have been pushing where I am at the moment in North West London. How do we know that we are getting what we paid for?

Andrew George: Thank you very much.

- Q10 **Chair:** I will take you up on the suggestion that we should ask you a bit more about social care. What role do you see social care playing in helping to deliver what the NHS priorities?

Dr Dash: Social care is clearly a critical element, particularly with an ageing population and people with more complex needs, and there is a real opportunity for more joint working. There are some fantastic examples around the country, including North West London, and should I be appointed, I am keen to see what is happening in different parts of the country. I hear a lot about it; I have not yet witnessed all of it, but there is certainly a lot of talk about some fantastic examples of joint working, not just across the NHS and social care, but involving wider aspects of Government, the voluntary sector, and so on.

There is some good work already happening, which, as I say, I would like to see myself, particularly in looking after people proactively—pre-empting care, pre-empting needs and so on. Even in my own patch, we have things like work on early frailty and support with simple things like going into people's homes and making sure that there is a rail, or that there are not rugs to fall over and so on. There is a lot of work to be done.

There are opportunities around joint teams. Looking more at domiciliary social care, people talk about things like having social care staff going out to visit people in their own homes, and then the district nurse coming half an hour later; could they do more joint working there, and so on? There are lots of opportunities. Then, in terms of home-based social care—particularly care homes and so on—as you probably know, I have been looking at the role of the CQC and I am now looking at the wider quality landscape. I think there are opportunities to get more data on quality of care in social care.

- Q11 **Chair:** You are talking about the wider landscape, and this Committee is



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very interested in that—in fact, we have an inquiry on it—but what about your role specifically? What would you personally do to help to bridge the gaps you are describing?

Dr Dash: I talk quite a lot about the principle of “empower and enable”. I think a lot of that work is down to local systems; I do not see it as my job to tell local systems what to do. I do see it as my job to make sure that we have high-calibre, capable leaders in every system, but then it is up to those local systems to work effectively together.

There are things that we can do from the centre to enable that local working. For example, I noted Ben pushing Julian Kelly on some of the modelling work; that is the sort of work that I would like to see more of. I would like to see more analysis of where the opportunities I was just talking about are. What could that look like? What would the opportunities be? What are the different options for what we could be doing? That is the work that we could do more of—once, nationally—rather than have each local system replicate different pieces of work.

That is my answer: setting out some of the principles, doing some of the modelling analysis behind it, asking questions—I am very keen on that—and trying to work with each system in a more collaborative way, to a degree.

Q12 **Chair:** Do you feel that is not happening currently?

Dr Dash: Yes and no.

Q13 **Chair:** We are trying to get to the nub of how it is going to be different under you.

Dr Dash: I like the principle of “board to boards”, which you might have heard a few people talk about. The concept, which I would like to do—these are aspirations, and, obviously, I have not started yet—

Chair: Yes, but we are after vision today.

Dr Dash: And obviously there is a new chief exec now, so there is a whole load of moving parts. What I would like to do is move to a world where the centre is not sitting in some central place, be that in Leeds or in London, but is out there working with every bit of the country, almost saying, “How can we help?”

We clearly have an assurance role as well. You cannot let everyone go off and do completely wacky things; we have to make sure that things are moving in the right direction. We will have a 10-year plan, and so on, but I am keen to have this dialogue, because the benefit of being in a national role is that you can see different things around the country; you can invest in, say, analysis, thinking, modelling work, and so on, that could help people locally.

I would like to build a model wherein we have challenging conversations, saying things like, “Show us your plan. Be clear about what you are trying to do,” and, “We’re not quite sure you are doing enough here, and you are



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not doing enough there,” but also saying, “This bit is great. Can I take this bit, and take it to other parts of the country, to use as a best-practice example?” That is the kind of ethos.

- Q14 **Chair:** Thank you. You told us, and we do not disagree, that aligning NHS England against the functions it is required to deliver will involve “a major turnaround of one of the largest organisations in the world.” You have spoken a bit about your vision, but I am curious about the roles you have had in the past. This is a massive job, and the turnaround is huge.

Dr Dash: Yes.

Chair: Can you give us concrete examples of where, in previous work, you have made changes this large—or at least approaching this large, because I accept that this is its own unique challenge? Point us the way; what is your record of delivery before this job?

Dr Dash: Exactly as you say, you would be hard pressed to find something of this scale and magnitude anywhere globally and we do need to recognise that. I apologise in advance for coming back to this, but I take hope from the fact that I have done a lot of work in a lot of systems, including across the whole of this country and in other bits of the world with, not as big as this—

- Q15 **Chair:** Can you be specific? Other bits of the world? Which, when and how?

Dr Dash: I referred in one example to doing some work in Malaysia, with a population of 32 million. All the pieces of work start with asking what the population need is. We must always start with the population need. The great thing here is that we know more or less of the population need. We have lots of data on health needs. There has obviously been the big conversation happening over the last six months, so there have been lots of opportunities to have community conversations locally and to speak with people locally. My experience of doing that has been really going bottom up, getting out there, speaking to people, looking at the data, looking at the analysis and so on, then pulling that together to say what sort of things we could and should be providing—much of which will, I hope, come through in the 10-year plan—and being very clear about that and why we are doing it. I have done that across very large populations and I hope that I will be able to replicate that here.

- Q16 **Chair:** How did you do it in Malaysia? Is that the example you are using here?

Dr Dash: Exactly the same sort of principles as you would find here, but the good thing is that we have way better data here.

- Q17 **Chair:** I am looking for specifics. You said that you went to talk to people. What does that mean? What concrete steps were taken by you in order to make that happen?

Dr Dash: Let me give you examples from here then, because in some ways that is the best thing. Examples from here would be all of those



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places I have spoken about, different bits in different parts of the country, and then doing national work. You start off with bringing together members of the public in a room, move through big public facing events, including everything from flip charts all around the walls showing people what is happening in their area. The flipcharts have data from their area, as well as what is happening in other parts of the country. They are asked about what they are looking for, what they would like to see, what matters to them, and so on. Another example is similar events with clinicians, putting out lots of data about how they are doing, as often people have not seen that data.

Q18 Chair: And this was the North West London ICB specifically?

Dr Dash: No, I have done this in many places. I used lots of data and had really difficult conversations—it often does not go down too well, putting stuff on the walls about outcomes and saying, “You are not doing particularly well on this compared with other parts of the country.” Again, bringing in these different examples. People often have not seen what they have not seen. If the information shows how it’s being done 50 miles down the road or 5,000 miles away, take a look at it and have a think about how it could apply here locally.

I use different forms of media to share some of those examples, such as videos. I take all the outputs of all those different things and then start to develop different options. So, what are the sorts of things you would like to do here? What could work and what could not work? Then I lay out those different options for different service models, whether it is down at an individual speciality level, such as how you might organise cardiology here, through to how you might organise integrated care in the community. We then turn that into tangible options, options with analysis behind them, and determine the evaluation criteria that matter to the local public, local politicians and local staff in evaluating those different options.

Q19 Chair: We are looking for a big change. What you said about stroke services was taken, but it is quite specific. Can you give us one example where you applied this model, which you have clearly developed in several parts of the country? Where best could we go and look at your work in delivery—not just analysis of the problem, which you are clearly very good at, but the delivery of the solution—that then made things better for patients?

Dr Dash: First of all, it is not my work. I am a conduit, an enabler, and a supporter. The work is always done by the frontline teams and that would be true in this as well; that is a crucial bit about the role of the chair. For a tangible example, I could point to some great stuff happening at the moment down in Dorset. I referred to that earlier. They are close to opening a new shiny emergency department in Bournemouth, and they have built a very impressive elective centre at Poole hospital, all on the back of some absolutely fantastic new models of primary care down there. They already had some very good models, but they have built on them, spread them more widely and so on, so that is a particular place that I would refer to.



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There is some good work in Manchester. They still have a lot more to do, but there are some really interesting models and more integrated care. North Manchester is a very good example of not just bringing together acute hospital care, but vertically integrating with community care, and there are plans in place for building a new integrated hospital.

Q20 Chair: When was the work in Manchester done?

Dr Dash: Probably about 10 years ago. Dorset has actually been very quick—one of the quickest. The work was initially set out in 2014, and they are literally building now. In many places, changes in hospitals in particular can take quite a long time to come through.

One of the first examples a big piece that I did was in Hertfordshire. Yesterday, I met the chief exec and the incoming chair there; they talked me through many of the things they have done, building on some work from 20 years ago. It is still work in progress, but they have made a lot of improvements there.

One of the most tangible examples in hospitals is Trafford hospital in Manchester. About 10 years ago, Central Manchester university hospital NHS foundation trust took over some of the responsibility for Trafford, which was really struggling as a site. They got really good data and analysis, which took them a few years to do—these things never happen quickly—but there was a real improvement in standardised mortality rates. The norm is 100, and it went from 120, which is a high standardised mortality rate, not good, down to something like 92, very good, and there was a significant improvement in operating costs too. Those are a few examples.

Chair: Thank you very much. I appreciate it.

Q21 Gregory Stafford: Good morning, Dr Dash. In your submission, you told us that one of your priorities for your first year as chair would be to “clarify the relative roles of NHSE, ICBs and providers”. What changes do you want to make to those groups?

Dr Dash: At the moment, it is not up to me. There is a working group that is looking at exactly that question, and that work will be fed into the 10-year plan. I am part of that working group—there is actually another meeting of it this afternoon.

Q22 Gregory Stafford: Yes, but, just to clarify, in your statement you said that is what you want to do. From your point of view, what would that look like?

Dr Dash: I want to see clarity, because at the moment I do not think it is clear enough. The bit that I want to see is clarity, and the 10-year plan process will come out with proposals. I can input into those proposals, but I can’t say more.

Q23 Gregory Stafford: Okay, so what are you inputting into those proposals that you would like to see?



Dr Dash: A few things specifically—it is quite a long conversation. One is that we need to be clear on ICBs. At the moment, the Secretary of State's view seems to be that we are sticking with ICBs, and I am supportive of that, but then we need to be very clear on what their function is. Are they strategic commissioners? Absolutely, but they do not necessarily have the skills and capabilities to do that at the moment, so there is a real need to build skills and capabilities in strategic commissioning. I am happy to talk more about that. That is a recognised need, and it absolutely needs to happen. That is quite a significant one.

The second is the relationship between ICBs and individual providers—GPs and wider primary care, mental health trusts, acute trusts and so on. We need to be clear what that relationship is. At the moment, we have a bit of a mix of a contractual relationship—Andrew referred earlier to contracting with the private sector—and a managed relationship, which is about optimising provision and so on across a geographical area. It is crucial to clarify where we use contracts and where we manage the system. At the moment, it is not entirely clear, and one of the things that I hear from people is that they want that to be made clearer. Those are the sorts of things I am alluding to.

There is another bit. As I say, I have been doing this wider review of quality, which will be published in a couple of weeks, and one of the big things in that is the need to be much clearer about the role of boards, which is fundamental to getting high-quality care. Ensuring high-quality care needs to be the role of boards, whether it is the board of an ICB or the board of a provider. What are their responsibilities? What do we expect them to do? What does really good look like? What are we going to hold them to account for? In turn, they have a role within their organisations. They are managing very big organisations that are quite complicated in a number of cases. How do they work with the individual directorates, teams and individual clinical staff? All that needs work.

Q24 Gregory Stafford: You said in another part of your submission that you were going to look to significantly improve the governance and accountability, which is presumably the bit you just touched on. What do you think is currently not working about governance and accountability, and what tangible things would you like to see changed so that it does work for you?

Dr Dash: I would like to see a much greater focus on quality and productivity. Those are two of the key things. I think we could help from the centre in looking at what the core metrics are in that. Again, we have the luxury as a country of having lots of data. We have some really good schemes. For example, the Getting It Right First Time—GIRFT—scheme has some very good data in it; it is clinically led and really good on clinical outcomes. Are the boards looking at that data in their core board meeting? Do they know which bits of their hospital are providing high-quality care in line with some of the best in the country, and which bits are not and therefore need a bit of focus and attention? The same will be true in mental health care and in community care. We do not have the equivalent of that board structure in primary care, so that is where the ICBs come in.



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How are they looking at quality of care there? All of that is supported by a stronger CQC. That is an area that I would like to see greater focus on, as well as some of the productivity metrics.

- Q25 **Gregory Stafford:** You know how to push my buttons by talking about GIRFT, so well done on that. I should declare that I used to work for the Getting It Right First Time programme.

How would you achieve that without significant change and top-down reorganisation? You have said that ICBs are likely to remain, but you seem to be advocating for quite a fundamental change. How do you manage that without top-down reorganisation? As the chair, what do you see as your role in ensuring that the boards you talk about actually produce the things you want? If they do not, what sanctions do you feel you should have as chair to be able to impose or depose people?

Dr Dash: I do not think anyone wants to do a major restructuring. That would not win many brownie points at the moment. That seems to be the view of the Secretary of State as well. It is about working with the system, rather than throwing everything up in the air. That is the first bit.

It is a mixture of things. I have referred to that in my submission, under the question about working with NHS England, but the same things apply. One is role modelling. I spoke a bit about board to boards. One of the reasons why I like board to boards is that it is a good opportunity for role modelling. If I ask questions of another board, I would hope that that then gets them to think, "Okay, are we asking those questions ourselves?" There are some more formal mechanisms—for example, being very clear on the metrics that matter and the sorts of things we would look at, but also supporting people to look at some of those things themselves locally.

On your final question, which was about what the sanctions are, I think we do need a better balance of positive incentives as well as negative. There seems to be a tendency to jump to the negative sanctions rather than the positive things. I do not want to pre-empt it, because there are a lot of conversations happening in the 10-year plan accountability working group on exactly the things you are asking about, but I do not think they would mind me saying that those are the things people are talking about—what are the ideas and thoughts on both positive incentives for change and less positive ones? I do not want to go into more detail, because they are working on that.

- Q26 **Gregory Stafford:** I understand; thank you. You just said that you do not want a big top-down reorganisation, but Amanda Pritchard hinted at this very strongly when she was in front of us a few weeks ago, and it has been announced in the papers today that there is going to be quite a lot of restructuring between NHS England and the Department of Health and Social Care. Given that it seems the Government's intention is to take increasing control over NHS England, how will you, as chair, ensure that the organisation maintains its operational and clinical independence?

Dr Dash: First, the Secretary of State has gone on record saying that he does not want to do a major restructuring in terms of changing legislation and so on. To a degree, I know what you know from the papers and so on,



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because I am obviously not in post yet. What I think is needed, which I referred to earlier, is clarity on what functions are needed from the centre. This needs to be built bottom-up. We need to say, to do all the things we have been talking about so far, to help local systems—not to tell them, but to help them—“What are the things that could usefully be done once at the centre?” I would like to start with that.

Q27 Gregory Stafford: When you say the centre, do you mean NHS England or the Department?

Dr Dash: I think it is both. There are differential roles. Clearly, there are things that the Department does that NHS England does not do, and there is a lot that NHS England does that the Department does not do, and so on. There are also some areas that work very closely together already. It is about building that bottom-up and then being very clear, in order to support the NHS to deliver the sorts of things I have been talking about, what functions, skills and capabilities you need in NHS England, what needs to be done in statute—we need to recognise that—and what the Department needs to do, and how you put all that together coherently so that groups of people can work effectively together.

Q28 Gregory Stafford: Are you saying that, under your chairmanship, the distinct line between the Department and NHS England will blur and become—let’s be positive—more collaborative than it is currently? I am trying to get a handle on what the Secretary of State seems to be doing, and how comfortable or otherwise you are with that.

Dr Dash: I am very comfortable with the concept, which seems to be being set out at the moment, of closer collaboration. If that is the direction of travel, I do not have a problem with that. But it is hard for me to know more because I am still outside the ring.

Q29 Gregory Stafford: On that point of being outside, how many meetings, conversations or discussions have you had with the Secretary of State in the last six months? You do not need to give a precise figure, but just a rough ballpark.

Chair: You can write to us if you want to check your diary.

Dr Dash: I will check my diary. Finger in the air, around 10, but I can check my diary and tell you.

Chair: Sure. Thank you.

Q30 Gregory Stafford: In terms of your application to this role, were you tapped up or spoken to by the Secretary of State or anyone within the Department to do the role, or did you just put this forward yourself?

Dr Dash: Absolutely.

Gregory Stafford: I suppose the concern that I have is that given that the Secretary of State essentially sacked the outgoing chair, for whatever reason, I want to be confident that you will not just be a mouthpiece for the Secretary of State and the Department. What reassurance can you



give me on that?

Dr Dash: I am a strong person. I have lots of thoughts and ideas. I have written a lot. I am very well networked in the system. I go back to data—data, data, data. The reality is that you are working within wherever the current ministerial and political team is, so I need to work with the system, but I would not describe myself as a mouthpiece for someone else.

Q31 **Gregory Stafford:** I would hope not, but I wanted to hear you say it.

For my final question, let me go back to where I started. In your application, you said that you wanted to “clarify and simplify” the relationship between NHSE and the Department, and that “the interface between NHSE and DHSC should be better utilised”. To a degree, you have described what you meant by that. I support what I want to understand is this. Do you say that because you know that is where the Secretary of State is going or because you fundamentally believe in that change of relationship?

Dr Dash: I think I said the first thing that you just quoted, not the second. I said it partly because in the last 10 months, I have been doing this work on reviewing the CQC and looking at the wider quality landscape. I have been working very closely with DHSC on that. They provided me with a small team and helped me with quite a lot of the data and setting up meetings and so on. I have also been working with NHS England, which also has data on quality of care. At that tiny, tiny little level, there is some duplication.

Gregory Stafford: Thank you very much.

Q32 **Josh Fenton-Glynn:** Thank you, Dr Dash. One of the big parts of your job will be enabling the delivery of the three key shifts. I looked at something that you said in an interview with the Institute for Government. It is a slightly abridged quote, but you said that we could roll out neighbourhood care “within probably a few weeks in North West London...but we’ve got to be willing to do it, and we’ve got to tackle some vested interests.” What vested interests do you need to tackle?

Dr Dash: Lots. We have got to the place where we are over many, many years. I have already referred to the fact that at the moment we put a relatively high amount of money into our hospitals. Hospitals are not at the moment standing up, throwing money back at the ICB and saying, “Please spend more on primary care,” even though they themselves would absolutely say that they would like to see a better-functioning model of neighbourhood care. But that requires changes to be made, which is going to take time to do, and that is going to take a lot of working through with local teams.

Q33 **Josh Fenton-Glynn:** Forgive me, but you are talking around the subject. You are essentially saying that we need to pull money out of hospitals and put it into the community.



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Dr Dash: If we want to change the relative balance, we can, first, make differential investment decisions as the amount of money in the system goes up. But in a world where we are not anticipating vast increases in the amount of money going into the system, that would mean starting to transfer funds. Exactly as I said earlier, that is not easy or straightforward to do, and it will take time. That is one bit.

The second bit is that in bringing together integrated neighbourhood teams, there are multiple players. The term is “integrated teams”, so it is teams from social care, community care, the wider voluntary sector and so on. All those people are, quite rightly at the moment, focused on their own organisations, so it will take time to bring them together. The bit I was talking about is that on paper you can set that out, but to do it in reality will take time and there will be work to do with all those people.

- Q34 **Josh Fenton-Glynn:** You have talked about hospitals and about trying to bring people together. Do you think there are other vested interests you will have to overcome to deliver the three shifts?

Dr Dash: In some ways, if I talk about people working outside hospital and people in hospitals, that covers the workforce. There are obviously also politicians, both national and local, who rightly take an active and interested view in what is happening locally. There are some of the big unions—the BMA and so on. All these organisations have an interest in what is happening, so it is a complicated landscape.

- Q35 **Josh Fenton-Glynn:** What kind of challenge do you expect from the BMA?

Dr Dash: I do not know any more than I have already said. I read the stuff and you read the stuff. I have no conversations other than bits that you would have seen in the press. My sense is that if you look at what the GP community is saying, it is crying out for change.

- Q36 **Josh Fenton-Glynn:** Parts of it will cry out for change, but I am curious as to what you think the difficult conversations are going to be.

Dr Dash: I genuinely do not know, because I have not had those conversations and it has not yet been laid out in the 10-year plan and so on. It is still quite high level. I support the three shifts—I think most people do—but it is quite high level, and a lot of it is about getting into the detail of that. It is hard to know until you see the detail, to be honest.

- Q37 **Josh Fenton-Glynn:** In your role as chair, which is obviously different from the chief executive role, your job is to enable the chief executive to make those three shifts. In terms of your leadership position, setting the vision and enabling them to do it, what do you foresee as the big challenges?

Dr Dash: For the chief exec?

Josh Fenton-Glynn: No, for you as chair. What will you have to do to enable the chief exec?



Dr Dash: I put in the questionnaire “to support and challenge”—those are the kind of terms I would use. I absolutely see the role of the chair as doing both of those. It is about supporting the chief executive—to be there as another pair of hands, to a degree, who is able to help in whatever way. A lot of that depends on the personality of the chief exec. We can work in different ways depending on that. It is about bringing both sets of skills and strengths and so on to it. There is a lot about being a good sounding board, someone to speak to, someone to bounce things off, and so on. There are lots of things in that supporting role.

In the challenging role it is about saying, “Are we doing the right things? Are we being ambitious enough? Are we challenging other bits of the system enough? Are we putting the investment in the right areas?” To be honest, they are many of the questions you are asking. “Have we got the right sorts of people in the right places working in the right way to deliver on this agenda?”, and so on. The trick is getting the balance right. If you go too much on the support or too much on the challenge, that is where you start to get a bit of a difficult relationship.

Q38 Josh Fenton-Glynn: I feel a bit like in your answers either you go very operational and talk about things that you have seen on an ICB level, or you pull back and you are quite general and then say, “Well, the 10-year plan isn’t in yet.” For the chair of this organisation—the person who is going to deliver the change—I am almost looking for something in the middle: “What am I practically going to do in order to open up the NHS for the three shifts?” If you wanted me to take one message away when thinking about what you are going to be like—the personality of Penny Dash as chair—what would that be? What is the thing that you would bring to it that would make a difference?

Dr Dash: *The Guardian* called me a reforming zealot and a “no-nonsense character”. I thought, “Where have they got those from?” That is probably a reasonable description. I am ambitious. I am ambitious for change. I have spent a lot of my life working on these topics and I care deeply about them. I care deeply about equity. I care deeply about quality of care. It is unacceptable that some people get some sort of care and other people do not. I do care deeply about making good use of resources—I think that is a fundamental obligation.

We have a fantastic opportunity at the moment to make some real, tangible changes and shifts, and I will absolutely be holding the chief exec and the whole exec team to account on that: “Are you going far enough, fast enough?” We can get into a lot more of the detail of that—I am not sure we have the time for it today—but I do also want to respect the 10-year plan work and all the people who are involved in that. I think we need to give that time to come out and then take it, and then I would like to get into, as you say, that level—

Q39 Josh Fenton-Glynn: And then run with it as the reforming zealot that you are.

Dr Dash: Yes, absolutely.

Josh Fenton-Glynn: Fantastic. Thank you very much.

- Q40 **Joe Robertson:** Good morning. You have talked about ensuring that there is an effective executive team in place, and of course you will get to appoint a new chief executive, as Amanda Pritchard is standing down. What are the qualities you are looking for in a new chief executive to help deliver all this reform and change?

Dr Dash: I believe, but I have not been fully party to it, that Jim Mackey is going to do this for the next one to two years, so I do not think it is an instant decision. I think he has agreed to come in as an interim to do that. I know Jim. He has obviously done some very positive things in the past. I should also say I have a lot of respect for Amanda. She has been leading the system through some very difficult times over the last few years, and I thank her for that.

What do we need to do now? We absolutely have to do the sorts of things I set out. I am applying to be only the chair, not the chief exec, so I need first of all to have conversations with the chief exec to build that alignment. We will not be in completely unified harmony. It would be a bad thing if we were. We will have some differences and some different ideas, but what I would be looking for is someone who shares the passion and commitment for change, because otherwise that would be quite hard to do; someone who has some of the insights, and the experience and the expertise and the knowledge and so on; someone who is very comfortable with data and analysis, particularly around those big topics of quality, productivity and so on; and someone who has a good sense of what is happening in the wider world. Obviously, some of the things around tech are big—there are potentially massive opportunities—so the ability to look out as well as to look in is crucial. The final bit, but by no means the least, is someone who can work very effectively with people.

- Q41 **Joe Robertson:** Thinking about the executive team, rather than the chief exec per se, I want to invite you to reflect on where we maybe have not achieved or delivered as we would have wanted to in the last few years, and where you would like to see the new, refreshed team deliver on. I think it would give the public confidence if you could reflect on some of the weaknesses—for want of a better word—in recent times.

Dr Dash: I am not sure they are weaknesses; in some ways, they are more outcomes of circumstance, to a degree. What are the things that I would like to see? If I look forward, with tech we are in a very interesting time, and some of the things that are bubbling through are amazing. As many people have said, though, we also have to get the basics right. If you still have staff who cannot even switch on their computer—I mean, it is just ridiculous. People are saying that they come into work and it takes them half an hour to log on, and they have five different logins and so on. That is crazy. I would like to see the basics absolutely resolved, as well as then some of the stuff that is coming through now.

Some of the things that are coming in are fascinating. The ambient voice technology seems to be having a very positive impact, very quickly, on



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both quality and productivity. I have seen a couple of mock-ups, and people demonstrating some of that, and it is phenomenal. Some of the other things that are coming through on the tech side are amazing, as well as some of the data and analytics—things like using predictive modelling tools to do better scheduling of operating theatres. You could do that for out-patient work; there is the potential to take a big chunk of out-patients and use digital tools to redesign the processes and have them work better for patients and staff.

I do not know whether you have read the report that the King's Fund did with Healthwatch and National Voices a couple of weeks ago, but it found that two thirds of people in the country had experienced administrative errors. Certainly, that would be in line with my personal experience—getting wrong letters to the wrong address at the wrong time, and so on. All those things would be really big. The issue comes back to differential investment. You obviously have to invest in those things—you have to invest to save—but I would like to see far bigger investment in the technology to do those things.

Then there is the bit that was referred to earlier, which I thought you were going to mention and I spoke about at that event, which is operational management. We have lots of people working on improving operations, in terms of the operational functioning of the system, but there is still a way to go on that. That is where I would go big.

Q42 Joe Robertson: Just thinking about that good example of technology, but getting the basics right—not running before you can walk—to what extent is not managing to get the basics right so far the responsibility of the executive team? Is there some accountability lower down in the system? For example, having five logins does not necessarily look like an executive team accountability issue; it is somewhere lower down. How are you going to ensure that that accountability is felt?

Dr Dash: Yes, I am asking myself that. I do not know—that is why I keep asking myself.

Joe Robertson: If you can achieve that, you will achieve a huge amount, if I may say so.

Dr Dash: Exactly, because you think, “You mustn’t need to run that from NHS England—that must be a local thing.” I honestly do not know, but I am asking myself the same questions.

Joe Robertson: It is not about my opinions, but I think that is probably a major issue within the NHS. It is such a big organisation; how do you ensure the accountability at lower levels and not just at the top?

Dr Dash: Absolutely.

Q43 Chair: Can I ask about the board itself? We have talked about the executive team, but as chair of the board you will be responsible for that. Do you envisage making many changes to the board in terms of structure or specialties?



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Dr Dash: There are two non-exec vacancies coming up, so there is a process at the moment. The applications closed last week, and if I am appointed, I will join the interviews, which will be at the end of March.

Q44 **Chair:** Is there a glaring gap you can see that you are hoping will get filled?

Dr Dash: I have looked at the current board, and then at some of the people coming through. One gap that has been flagged—a number of people have said this—is around primary care and neighbourhood care. That is definitely one. It strikes me that that is a gap at the moment in terms of the non-exec team, so we will see where we get to with this round of interviews. There is a lot on mental health, particularly children and young people's mental health, which is obviously a big topic. Simon Wessely is there already, so we will see where that is. I also come back to the point about technology, which is obviously a big area; there are people on the board with expertise in that.

The other thing, which we have not spoken about much—I realise I did not write about it much, which was a bit of an error—is some of the out-there stuff, in life sciences, genomics and so on. There are some amazing things happening; how are we working with partnerships to make sure that we remain at the leading edge globally in terms of some of those things? They are challenging in terms of their enormity, but potentially quite exciting and interesting.

Q45 **Chair:** As an Oxford MP, I will admit that that gets me excited too.

Dr Dash: For example, I am going to see the Ellison institute in Oxford in a few weeks. That is really interesting. How do we make sure we maintain enough contacts and connections with things like that?

Q46 **Chair:** You set the culture for the board. How interventionist do you feel it is appropriate for a board to be? What is your style? Every chair is different.

Dr Dash: Every chair is different. I get asked that question a lot, and I think about it a lot. I have also spent a bit of time speaking to lots of other chairs—I am quite interested in that—and reading as well; quite a lot has been written about different types of chairs. I learned a lot from going and speaking to people, and it made me think quite a bit.

Q47 **Chair:** Are these recent conversations you had in preparing for this?

Dr Dash: No, over the last five years. One big thing that comes up is that it is circumstantial. If you are chairing some of the digital start-ups, early SMEs and so on, that is a different dynamic from something like North West London on the NHS side. It is definitely circumstantial: different sorts of organisations require different roles. As we were talking about before, there is something about the different dynamics between the chief exec and a chair, and trying to get the best of both—so, moderating the style, depending on the sort of person it is.



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I probably cannot get away from the fact that, as you will have picked up, I am interested in lots of things and look at lots of things. I like running quite a lot of the numbers myself and so on. Not all chairs do that. So I would say I am probably—my current chief exec would raise his eyebrows at this point—a little bit more of an interventionist.

Q48 **Chair:** You run the risk of stepping on a few toes.

Dr Dash: I definitely run the risk, so one of the big things is stepping back. I would say that I have been trying, and I would like to believe that I have got better at doing that. I have got better at saying, “These are the things I will get more involved in, and these are the things I absolutely will not; I will assure myself, but I won’t dig into the real detail on that. I will leave that to the executive team to do.”

Q49 **Dr Cooper:** As you have just said, you have an interest in lots of different parts of healthcare systems. I want to focus your attention on your chair role in North West London and your interaction with NHS England. It would be helpful if you could reflect a bit on how you see the culture of NHS England from that role.

Dr Dash: We have had very positive relationships, but I am aware, through conversations with some others, that the dynamics are different in different places. That is something I am quite interested in.

Q50 **Dr Cooper:** When you say “positive”, what are you experiencing from NHS England that leads you to believe that that is a positive culture for you?

Dr Dash: NHS England is both regional and national. In terms of the region, we have a good level of interaction. I get support, which is crucial. With the regional directors I have worked with, I have had a lot of support. I can pick up the phone and say, “We are a bit stuck with this,” “Could you help with that?” or “What do you think about this?” We have had a lot of support, and that has been really helpful. We have had good conversations about what we think we could do jointly and how we get the balance right between what we do at the ICB level versus what we do at the regional level. Those have been good conversations. I would not say we have necessarily always agreed on them, but they have been good, balanced conversations.

Q51 **Dr Cooper:** That all sounds positive; that is great. If I look at what you said earlier to one of my colleagues, one thing that you are interested in is around decentralisation and having less of a focus at the centre. It is great that you have had a positive relationship with NHS England, but as the incoming chair, if you are successful in this appointment, you will help to set the culture of NHS England. Do you foresee the devolution—possible decentralisation—of NHS England as a positive move for that culture, or are there issues that you foresee coming forward?

Dr Dash: Largely positive, because there is a set of things that do come from NHS England. I have given you the positive, but some of the things that will come more from the national rather than the regional I don’t think should be coming. Others have spoken about that. Patricia Hewitt went into quite a lot of detail about that in her review.



Q52 **Dr Cooper:** So you generally agree with the Hewitt review—

Dr Dash: I definitely think there is more latitude for people to decide locally. There is quite a lot of telling that I am not sure is necessarily the most constructive. So, I am definitely supportive of that. At the same time, as I alluded to earlier, I do think there are things that could be better done once. I think, for example, of the principles of healthcare value. How do we really understand? What is the potential impact? What is the return on investment of different healthcare interventions? Where should we be putting our money? What could an optimal cost structure look like? And so on and so forth. It does not make sense to do that 42 times, and we definitely do not have the skills and capabilities to do that 42 times.

There are quite a lot of things that could be done. In the whole public health field, there are quite a lot of things that we as a country have done really well by doing it nationally and so on—getting the evidence base, the understanding, the analysis, and doing that once. But how do you deliver that? How do you develop the priorities? How do you decide what you are going to do in these particular streets or this particular neighbourhood and so on? You cannot do that nationally; that absolutely needs to be done locally.

Q53 **Dr Cooper:** It sounds to me as though you are saying that on balance there is too much centralisation currently, and that you would be supportive of seeing a more decentralised NHS, and therefore a more streamlined approach to NHS England as a sort of central function.

Dr Dash: Many people, including NHS England—not necessarily me—say they would like to see more things decided locally. I have had a go at starting to lay out some of the things. It is quite interesting if you get into the detail—

Q54 **Dr Cooper:** If you are successful in this appointment you will be the chair, and part of your role will be to drive forward the cultural change. And you would be supportive of that.

Dr Dash: Yes. We absolutely need to say, these are the things that could and should be done locally, and these are the things that could and should be done nationally. We should have a sensible conversation and debate about that, based on the principles of subsidiarity.

Q55 **Dr Cooper:** One final question from me. You have done a lot of things and have a lot of interests. As the Chair rightly pointed out, there are different types of chairs in terms of interventionist. How comfortable do you feel about moving from that more operational sort of approach? I know you are an ICB chair, but I have seen what you have done. You have been pretty hands on. How do you feel about moving to a more strategic role where you are looking at that bigger picture? I guess my final question is: if you are successful in this appointment, in 10 years' time what might you say that your input has been that will mean I will be able to say, "Dr Dash was the chair of NHS England and in 10 years that strategic vision has come through"? How would you want me to see that?



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Dr Dash: I think you are asking two different questions. In terms of the strategic vision, if we could deliver those three shifts, hallelujah. But we have to be clear on what that actually means. Over 10 years, it is not just about going three shifts—ta-da!—we’ve done it. That then has to translate through into better health outcomes, better life expectancy, better quality of life, better access and so on. So there is quite a lot in that.

Q56 **Dr Cooper:** Just to be clear, your contribution towards that 10-year-vision—

Dr Dash: Is then your second question, which is what would my role be as the chair as part of that. First, I work within the framework that is set by the Government of the day, so I want to be clear on that. It then comes back to me working hand in glove with the chief exec, the exec team and the whole of the workforce—we have not spoken that much about the 1.5 million people—to deliver these changes. I absolutely recognise the specific role of the chair, which I come back to as being a support function, a challenge function, bringing clarity, being a good communicator, being a conduit listening to people and picking up what they are saying, and so on. It is absolutely not being operational. It is more about how to get that balance right.

Dr Cooper: Thank you.

Ben Coleman: I should begin by declaring that Dr Dash and I know each other. I had the pleasure of serving on the integrated care board for North West London while she was Chair, until I was elected.

Dr Dash: I still am.

Q57 **Ben Coleman:** She is still the chair. Maybe I am one of the vested interests you referred to, Penny. Would that be the case?

Dr Dash: No. No vested interests.

Chair: Be honest. In fact, we encourage you to be.

Dr Dash: Vested interests are not necessarily individuals, are they? They are groups.

Q58 **Ben Coleman:** Okay. I would like to come back to the relationship with the NHS and local authorities. Perhaps that would be a better way to enter that. I will pick up on this. You noted that I tried to probe a bit with Julian Kelly about hospitals. Prevention is what I would like to start by talking about. Prevention has been seen largely in terms of the resources given for public health, which is hugely important, of course. But there is a role for lots of other bodies in the NHS to support prevention, and it is not very well defined at the moment.

I was trying to probe with Julian Kelly a little about the role of hospital trusts in that. My feeling was that he was coming back to me saying, “Well, hospitals don’t have any incentive to support social care particularly, because as soon as you get someone out of hospital, you’ve got another person waiting on a long waiting list for an operation.” What is



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the role, as you see it, of hospital trusts in prevention, and how could we incentivise it?

Dr Dash: There are a few things in that question. I will take prevention first in terms of primary prevention, and then come on to secondary prevention. There is a crucial difference, even though they overlap at times. Primary prevention would be smoking, obesity, breastfeeding and so on, as well as the wider determinants of health, which we have done lots on. I do not think it is the role of a hospital per se to be running a big smoking cessation campaign or working with local authorities to look at ways of getting easier access to healthy food and so on. Hospitals can do what hospitals do. What I think hospitals could do are some of the prompts around that.

To come back to the technology, there are some really good examples in other parts of the world. If you've got a good electronic health record or great data system, you turn up in A&E and if you have not had your HPV vaccine or flu vaccine, it comes up in flashing lights on that electronic health record. Even if you are in A&E with a broken arm, they will get that flu vaccine in you, if you are due one. I think we could do a much better job on that. We are one system, we have single patient data records and so on. We ought to be able to do that in a much more impactful way. That is an example of hospitals' role in primary prevention.

In terms of social care, you are coming more to secondary prevention, particularly for people with greater needs. That is more about everyone working together as a system. That comes back to some of the questions Greg was asking about: the role of ICBs versus providers and so on. We do not want to make it too separate. You want everybody to work together, to be able to ask where the opportunities are for us to fundamentally redesign this system. It is in no one's interests to keep admitting people to hospital who do not need to be there. How do we all work together to understand how to do that?

Q59 **Ben Coleman:** Hospitals do, by and large, a brilliant job, but no one in the system is perfect. Hospitals do not have a direct incentive to keep people out of hospital, or to keep people supported by social care at home so that they can live independently and so that any hospital entry is delayed by, perhaps, a decade. How can we incentivise hospitals differently?

Dr Dash: Or how can we incentivise the system, because it might not necessarily be that you want to incentivise the hospitals for that; you might want to incentivise someone else for that. I worked with the NHS Confederation about a year ago to write a report on payment reform. We looked at some of the different models that exist in other parts of the world—particularly risk-based models for out-of-hospital care and for bringing together teams including social care, primary community mental health care and so on—and at taking on more of the risk for managing that community and that population. Looking at those incentives is really interesting, and looking at what is the best way of funding that. That is a really crucial topic. Again—I am pointing a lot to the 10-year plan—I hope



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that the 10-year plan will do some good work on that, and that we will come out with something good on it, so I think that is one thing.

In answer to the question, what do we want to incentivise hospitals for, I think we want to incentivise them for doing all the great things that we need our hospitals to do, such as really high-quality care, good throughput, good productivity and so on. We need to think about how we get those incentives right—even when everyone is doing everything. People talk about things like moving to more lead provider models, for example. It is a very complicated world, but I think there are some really good examples from other places, and indeed things that people have looked at here, which could be done.

Q60 Ben Coleman: That is interesting. I guess I was coming from a different place from where I have the impression that you are coming from. It was in terms of the potential for hospitals to do more in the community. However, as we move towards the focus being on community and primary care, that obviously needs funding. There is a lot of discussion about double running. How are we going to fund it? Are we going to take money from hospitals now—and many of them already need repairs, which are being delayed by decades—or are we going to do double running, in which we continue to fund hospitals properly, as they are funded now, and also find the money needed to start the improvements in primary and community care? What is your view? Should we double run or not?

Dr Dash: In an ideal world, you need to build up different bits and so on, but—I keep coming back to this—I do not see that magic money tree at the moment. I cannot see where there is suddenly going to be a big influx of money to do that, so we need to be pragmatic. What I do see, and I alluded to it before, are some amazing opportunities that are bubbling up to deliver the same care at lower cost, and that is where I think we should go.

Q61 Ben Coleman: The same care in a hospital or in a primary situation?

Dr Dash: Particularly in a hospital, but some of that would apply in other settings as well.

Q62 Ben Coleman: So you would make hospitals more efficient, save some money there, take that money and spend it in primary and community care. Is that right?

Dr Dash: Yes.

Q63 Ben Coleman: If the hospitals did not become more efficient, would you shift money from hospitals—cut hospitals' funding—in favour of primary and community care anyway?

Dr Dash: I have asked that question and I am obviously wrestling with it myself, somewhat. We need to look at the entirety. We need to look at where there are opportunities to do things differently. We need to say, "What could we put in place to enable every single bit of the system to do things differently and better?" On your point—what if it does not work and what if we cannot do that?—we know some places are already doing



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things and we know there is a big variation, so if we get to a place where even with the most interventions in the world, and all the rest of it, that place still is not doing something, then—

Q64 **Ben Coleman:** The place being what?

Dr Dash: Well, it could be anything. It could be a community trust, a mental health trust, an acute trust, or it could be a department within it. We can see already, at the moment, that we do have a big variation in terms of, essentially, the unit cost of delivering the same activity.

Q65 **Ben Coleman:** Forgive me, but I guess I am pressing you on this because it is a particularly live issue. I am declaring my interest because in North West London, Andrew Lansley brought out a document, which I know you are familiar with, called “Shaping a Healthier Future”. It would have closed the A&E in Ealing hospital and Charing Cross hospital, and would effectively have got rid of most of the sites, in order to fund improvements to primary and community care. As you are fully aware, that did not happen, because of the campaigns I was involved in. However, is that the only way we are now going to get funding for community and primary care—by taking it away from hospitals—or would you hope that you can find other sources of funding? If not, is that the route we have to go down again?

Dr Dash: First, there is a lot more money in the system than there was back then. Secondly, there is a lot more technology and a lot more focus on the opportunities of technology. What I would like to see is some really good modelling that actually sets that out. I do not think this should be a hypothetical question; I think we have enough data and analytical capabilities that we could make it a real one. At the moment, this is hypothetical. I want to see the data that allows us to see what we think we could do, and that then allows you to see what some of the choices are.

Q66 **Ben Coleman:** I talked about double running because, in meetings with Members of Parliament, Ministers at a very senior level in the Department of Health have said that they believe in double running. Are they perhaps being a little optimistic, given the situation in which we find ourselves?

Dr Dash: I do not know, because I have not seen the data and the analysis.

Q67 **Ben Coleman:** Right. So, they might be being optimistic, but you do not know?

Dr Dash: I do not know.

Q68 **Ben Coleman:** And that is because you do not know the money in the system?

Dr Dash: We know the money in the system—that is a known. We know the population, and we know the money in the system, but we also know an awful lot about what are good interventions. We have a lot of data, research and best practice examples. What I am looking to see is the



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population times by the interventions and the best practice models, times by either an optimised unit cost or a realistic unit cost—you never fully get to a fully optimised one. Then, we need to say what that means. If we could do that analysis—that is what is referred to in the zero-based reviews that are meant to be happening or that are happening—that would give us the data we need so that these cease to become hypothetical conversations, and become real conversations that allow us to see—

- Q69 **Ben Coleman:** Zero-based budgeting is, of course, a good way to go in any system, but the NHS is obviously a system unlike any other, because the size and complexity make it more difficult. I get the feeling that you are saying that there is more money in the system than there was when the previous Government felt it was necessary to close two hospitals to fund primary and community care. You think there is another way—the idea of double running, where you would fund community and primary care to get stronger. If they took the pressure off hospitals, and fewer people went into hospitals, of course you would not have the same need as you have today. But until that happens, both would continue to be funded—

Dr Dash: I honestly do not know.

- Q70 **Ben Coleman:** So it might lead to cuts in hospital funding?

Dr Dash: I do not know, because I have not seen that analysis.

- Q71 **Ben Coleman:** Okay, that is helpful. Thank you. Coming to local authorities, the person spec for the job talked about having an understanding of the “contribution local authorities make to delivering positive health outcomes.” When the Secretary of State came to see the Committee, he said he did not think that local government feels “like an equitable partner around the table with the NHS”. How well do you think the NHS understands and works with local authorities, and vice versa, and what can we do to strengthen that relationship?

Dr Dash: I am a bit more positive, but you may tell me otherwise. I think we have had some good conversations and done some good work together in North West London. Is there room to improve? Absolutely, there is room to improve. As I said earlier, I hear a lot about some very positive examples around the country, and I am interested to go and see those, and see what the view is of those, because I am absolutely sure that it will not be the same across 153 local authorities. It will be very different.

- Q72 **Ben Coleman:** It will be different. My contention, which we have discussed in the past, is that the NHS broadly does not understand social care, and social care does not understand the NHS as well as it could, but understands it better. The Committee recently made a visit to the Isle of Wight, which was very interesting, because there was a real gap in how the ICB approached the social care team, not to mention the third sector team. There was a real space there in terms of understanding and ability to work together. From your experience, how can the NHS be helped to understand social care and get more out of it?

Dr Dash: And vice versa?



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Ben Coleman: And vice versa, as I said at the beginning.

Dr Dash: I think that would be through relationships and dialogue; it strikes me that that is usually the best way to go. What I hear from the places that do feel they have a better relationship is that it is because they have got that. That is the bit—I have already said it—that I am very keen to go learn and see more about. People do speak very passionately about some of the examples where people have made a lot of progress on those areas; I want to go and see that and understand those different elements.

Q73 **Ben Coleman:** Do you think that the national care service, which is much discussed, should be left to local authorities or should it be run out of the Department of Health and Social Care?

Dr Dash: I think Louise Casey is going to tell us.

Q74 **Ben Coleman:** What do you think?

Dr Dash: You are doing your own inquiry as well.

Ben Coleman: But just to help inform that.

Dr Dash: I listened in to some of that. I will leave it to the people who have been asked to give a view on that.

Q75 **Ben Coleman:** Do you think there might be some argument for taking it from local authorities?

Dr Dash: I will leave it to the people who have been asked to give a view on that; it is not my decision.

Ben Coleman: That is fair enough. You talked about growth but I am going to move on to something else, which is very interesting.

Chair: Before we do, we will hear from Paulette Hamilton. Then we will come back to your question.

Q76 **Paulette Hamilton:** I was really interested in what you said. I want to go from what Ben was saying back to your role at NHSE. With all the changes that are going on at NHSE and you going in as the chair, do you feel that NHSE is agile enough? What would be the two things you would do as the new chair to encourage the new chief exec to make it a more agile organisation and not so cumbersome?

Dr Dash: There are two bits on how you get an agile organisation—three bits. The first is to have the right functions, which I talked about earlier. There is a need to say that, in the light of where we get to in the 10-year plan, what are the functions that we need in NHS England? We have to be clear about that.

We need to build from the bottom up, whereas at the moment we tend to be a bit top down. What are the functions that we actually need and what are the skills and capabilities and so on to do that? That is the first bit: to get those right people working the right roles in the right place to do that.



The second, which quite a lot of people talk about, is culture. I tend to say that culture does not happen by accident; it is a deliberate outcome of lots of things. That is about putting in place very clear role descriptions for people—what you expect from them in their work, being clear on the values that you recognise, the purpose; it is about good support and development for people, ways of working, performance appraisals, incentives and so on and so forth. There are a whole set of things around culture, as well as, crucially, role modelling. I will come back to role modelling—it is a big thing about the way in which the leadership of any organisation works, which then dictates and ripples through organisations. There is an awful lot in that culture bit.

Then in the “agile”, which is the term you use—an interesting one that a lot of people have written on, around what an agile organisation is and how you get to that. There are quite a lot about things like sprints—all these buzzy, buzzy management words—but people doing fast sprints and working in different teams and ways around the organisation. I would be interested to explore that. I do not know whether any work has been done on that, but I think that would—

Q77 Paulette Hamilton: I am not asking about work that has been done. My specific question is that you are going in as chair. I have read all about you. I have read that you are, on paper, a very dynamic person. I would like to see a more agile NHSE. What are the two things that you would like to see to make that organisation more agile? Come on, Penny, show us who you are!

Dr Dash: It is probably not just NHS England—it is actually across the whole system—but I will start there because that is my remit.

I share your enthusiasm. I think it is a bit about starting from the top; people talk a lot about hope at the moment, and I hope I can bring some of that. I think that it is about being clear on what it is that we are trying to do and sharing some of those examples to say that it is possible—there are some really great examples out there—and being very clear on what everyone’s individual role is and how we recognise and support every individual. It is those sorts of things; that is what I read and see and have been part of in other places.

Paulette Hamilton: Thank you.

Q78 Ben Coleman: I have just a couple more things, but you will be glad that we are bouncing along. We are talking about getting enthusiastic, and growth is always a very exciting subject to talk about, because the country desperately needs it. It is also exciting to hear about the opportunity that the NHS can play in stimulating and encouraging growth. You touched on life sciences, and in my part of London hospitals are working very closely on trying to develop them. How do you see NHS England’s specific role in supporting and developing growth?

Dr Dash: We can go a bit parochial and talk about White City—for people who have not been there, I would definitely go and look, because it is absolutely fascinating. First, it is a really interesting example of urban



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development. Secondly, if you go there—it is in west London—there is everything from some really big companies to a whole host of start-ups there. It is very dynamic; it reminds you of start-up culture in other parts of the world. Of all the companies there, 70% have some involvement in healthcare, either directly or indirectly. At the same time, we have a world-leading university and a world-leading medical school there, and all sorts of research and so on. There is also a population that ranges literally—this is classic London—from the plush flats within 30 yards of where the BBC was, through to the council estate with a high proportion of people who came as refugees from Somalia. All of that is in one geography.

How do you use this inward investment—which is essentially what this is—in very dynamic, high-growth industries, many of which are in healthcare, to stimulate local employment and local economic growth, and also benefit the local healthcare services?

Q79 Ben Coleman: That is a great question. How does NHS England take a role in that?

Dr Dash: First, by calling it out. Secondly, by doing things that you can do nationally; that is a very local example, but it is the things that you can do nationally that really endorse and support that.

Whoever came up with the fourth objective for ICSs, which is that economic and social development, that was great. I will try to take that with me, because, interestingly, that is not in the objectives of NHS England, although it is in the objectives of ICBs and ICSs. So that is quite an interesting one. Let's take that, because it is a great one.

But, then, we should also make it really practical. There are some practical examples. I am going to Manchester after this meeting, and this is going to be a big topic there. They are very proud of what they are starting to do in Manchester on some of these same things, and there is a lot of economic development around the health agenda. The health innovation network up there is very much at the forefront of that, trying to drive a lot of it, and working very much with local government, universities and so on.

We have examples around the country, so how do we take them and say, "What are the things that we could do really well?" To take one I really like, there is a start-up that has come out of Imperial. You put a little mouse on your chest, and it does an automated reading of the ECG straight on to an iPhone. That is now in all the GP practices in North West London, which is a big productivity gain for them and for the system, and it is way better quality care, because it does an AI readout, rather than a human eyes readout.

Q80 Ben Coleman: It is good to see your enthusiasm for that, and thank you for your praise for what is going on in North West London—it is very exciting.

I am going to ask you a completely different last question. We have



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bombarded you with questions here; some have been tougher, and some have been easier. However, you and I have also worked together; I sometimes felt very frustrated at some of the things that happened in the local NHS, and I think you shared that at times. It will be quite challenging being the head of the whole system; there will be a lot of frustrations about how the system operates and some of the people in it—whether they have vested interests, or they are stick-in-the-muds or whatever they are. How do you think you will deal with the frustrations that you will experience as the chair of NHS England?

Dr Dash: I would like to say that there is a wonderful thing about getting to a certain age in life. I was even more of a zealot when I was younger, but that is another story. I have learned a lot through the years, and I would like to believe I am balanced. Certainly, although I have not really had an opportunity today, I have become a good listener; I am actually quite quiet a lot of the time, which is not my natural style. So I have become much better at listening; I really try to hear different perspectives and to understand where different people are coming from. People do not take positions on things—well, occasionally they do, but not in general—just because they have woken up that morning and decided to. Usually, there are very valid reasons behind the many interests that people take.

Understanding and listening to those, and so on, is a crucial thing, as is remembering the north star—what are we all here for? We are here for the population. We have not spoken much about inequality, but that is key. How do we improve things for everyone? It is about keeping hold of the fact that someone somewhere is doing something fantastic. We need to take that and spread it—that is the hope, the bit that gives me hope, and keeps me energised and going. Ultimately, that is my role. My role is not to be there and to be frustrated, but to keep going.

Ben Coleman: Thank you very much.

Q81 **Chair:** Right. I have a couple of rounding-off questions—we could well have ended there, as it would have been a good place to end, but there are a couple of points that we need to touch on. Workforce has been a bit missing from our conversation thus far.

Dr Dash: It has, yes.

Chair: I wondered whether you wanted to give us your thoughts on the importance of the NHS workforce, and in particular of the workforce plan—how it might need to change in the context of the big ambitions that we all share.

Dr Dash: I was about to say to Ben's question that the other thing is that I am not by myself—I will not be working by myself. The 1.5 million employees, and any number of people in local authorities, the voluntary sector and the private sector—this is a very big world. I think there is a bit about drawing support from all those people, as well as working with people.



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On the workforce, at the moment there are challenges around, to a degree, and in some places—I do not think everywhere—some disillusionment, frustration, change fatigue, and so on and so forth. I come back to that word “hope”—I think it is a good word—and getting more of that out there. Some of the things in the Gordon Messenger and Linda Pollard review about different management styles need looking at.

There is a big thing about more development opportunities for people. Appraisals happen, but I do not see appraisals happening in the way I would like to see them happening, which is by understanding what someone wants to do and where they want to go to, and helping them on that journey and providing support to do that. A lot of things around the workforce offer could be developed and could change, and I would like to see that. Again, that comes back to the bit of hope.

On the workforce plan, I believe that is due for a refresh, I think, this summer, if I am correct. I believe that there is a commitment coming out of the 10-year plan to do that refresh. I will take a very active interest in that. I am very interested to see that that is done well.

Q82 Chair: You spoke about personal development. The next steps are that we get to write a report about this, which we turn around with very short shrift. What are the developmental points that you need in your role as chair? You mentioned that working with the sheer complexity and scale of the whole NHS and central Government was an area that you want to develop. Expand on that. What do you need? Help us to help you succeed.

Dr Dash: First off, you have asked spot-on questions. I agreed with all your questions.

Chair: Thank you; we try.

Dr Dash: This is hard, so support is a big one, to be honest.

Q83 Chair: What does that look like for you?

Dr Dash: Constructive dialogue—challenging and constructive. It has been a bit one way. We could have some other conversations.

I come back to what Ben was pushing me on, this bit. There are choices. They are not easy choices; they are really hard choices. I would hope and, to a degree, commit—I hope I am not promising too much—that we can get more of that data, analysis and so on, and be clear on what that means for the hard choices. That is another bit.

I recognise primacy of Parliament, and all the MPs with everything else—the balance between representing your constituencies—but there is a bit about having that shared view of what the choices are here, almost. What are the challenges? What are the choices? That for me is quite a key thing that will be required—whether it is at the NHS England level, the Department of Health and Social Care level, with Ministers, or the wider Parliament level—being very clear on what the choices are facing me. That is a big thing.



Q84 Chair: And the bit about data? You spoke earlier about going out, learning more about local authorities and seeing more around the country. There is a tension there, of course, between the learning and the doing. How are you going to find that? This is a job for two or three days a week, but that is a lot. In terms of your time commitment and getting going, can you envisage what that looks like in the next few months?

Dr Dash: I put that a bit in the questionnaire. At first, I said I would do a listening exercise and then I thought, "Oh my goodness, no! People are going to think, 'She is going to be doing this listening exercise for the next three years', but they want me to do something", but I think you can parallel-process, by the way.

I definitely think that a lot needs to happen, and some of that needs to happen very quickly. You have alluded to some of the things, but the 10-year plan will come out, and hopefully that will give a clear sense of direction. It will be turning that into real, tangible things, getting going on day one, and keeping the show on the road—we have not really spoken about that. In-year stability is a big thing.

People are starting to use the word "turnaround", which is probably a reasonable term to use. It is a mixture of keeping things going in the immediate future and building those very clear plans for the future from the 10-year plan, asking, "What does this mean? What are we going to do?" It is getting out around the country and seeing what people are doing, not only as a listening exercise, but also sharing some things. I will be kept very busy from 1 April in doing those three things.

Chair: I suspect you may be. That is as good a place as any to end. Thank you very much, Dr Penny Dash, for joining us this morning.