HOUSE OF COMMONS

Health and Social Care Committee

Oral evidence: Pre-appointment hearing for the position of Chair of NHS England, HC 1035

Tuesday 18 January 2022

Ordered by the House of Commons to be published on 18 January 2022.

Watch the meeting

Members present: Jeremy Hunt (Chair); Lucy Allan; Paul Bristow; Barbara Keeley; Taiwo Owatemi; Sarah Owen; Laura Trott.

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Witness

I: Richard Meddings.

Examination of witness

Witness: Richard Meddings.

Q1 **Chair:** Good morning. Welcome to this pre-appointment hearing with the Government's preferred candidate for the position of chair of NHS England, Richard Meddings. Mr Meddings, welcome. Thank you for joining us and for your time.

I will start with a very general question. Why do you want to do this role? What makes you think that you are a suitable candidate?

Richard Meddings: Thank you. I should probably have expected that as an opening question. First, I am delighted to be here to subject myself to the scrutiny of this Committee. It is a really important part of the process. I look forward to the questions and the challenge.

I felt a mixture of being honoured and somewhat humbled to be nominated to this role. I also felt somewhat daunted by it. I have a clear commitment to public service and, like all of us in the room, a desire to make a difference. It probably comes from my family and school background. Members of my family work predominantly in public service. There is a serious job to be done, but I do not underestimate the complexity of it and the level of challenge. In my written submission to you, I tried to think of the best phrase to use. I said that I think that the health service today faces probably the most severe test in its history. That is something to be very thoughtful about.

The NHS is distinctive to the UK. It is an industry, but it is an institution of which we should be massively proud. How a society looks after its population, and in particular the health of its population, marks the quality and fairness of that society. The health service is a clear leading light with regard to that. Delivering health accessible to all, free at the point of delivery, is absolutely core and critical.

I use the health service. My family use the health service. Forgive me if this is slightly mawkish, but my younger sister passed away two years ago after a long illness. I saw very personally how the health service looked after her. My mother passed away just over a year before my younger sister died. The situation was the same—a long illness, and the health service looked after her. My twin brother has just retired as an NHS surgeon, mainly in NHS Scotland, but also, for many years, in NHS England. As twin brothers, he and I have talked a lot over his nearly 40 years in the NHS about working there. My daughter is now a fourth-year medical student. Again, there is commitment to the health service. As I said, I use the service.

Last week I had the privilege of going out on an ambulance shift. I am in London. I went out from 3 pm to 3 am. It actually went slightly longer than that. I saw at first hand what the health service provides to people in our society. It was eye-opening in many ways. I had an expectation of

what I might see, but it was absolutely eye-opening to see the individual patients the ambulance crew engaged with, including a very elderly, frail woman in difficult living conditions and in palliative care for cancer. When you see that, to go back to what I said right at the start, in emotional terms, it is an honour to be nominated to this role, but it is also humbling to be nominated. I am somewhat daunted by the complexity and vastness of the task.

I thank that ambulance crew, John and Olivia—I will call them out—for the 15-minute break that we had when I said that I needed to go to the loo. Other than that, we were on duty and at work for the whole of that 12 to 12 and a half-hour period. This is a call-out for the workforce and staff in the health service overall. It was remarkable to see that work ethic and the stress under which they work.

Q2 **Chair:** How hard do you think people work in the NHS compared with the City?

Richard Meddings: It is a different type of thing. They work hugely hard in the NHS. It is uneven, by which I mean that there must be periods of the most immense stress and intensity. What the NHS is doing is really important. What the City does, in different ways, with different value judgments, can be really important and equally intense, but when one steps back, the NHS is working hugely hard, particularly in the last two years, under real stress and making huge sacrifices. Perhaps that comparison is not the one to make. Aspects of both industries work hard, but the health service is one to be applauded.

Q3 **Chair:** We are going to talk about your background. The reason I asked that question is that your background is in financial services. We will talk about that a bit more later. In your short period of getting to know what is happening in the NHS, what do you identify as the biggest challenges you would like the NHS England board to get its teeth into?

Richard Meddings: There are some immediate challenges and there are the biggest challenges. When I was approached for the role, I thought hard about it. The integrated care system that is being introduced offers a real opportunity for a material uplift in the way the NHS delivers. As I look at it, I think that its underlying motivation, which is collaboration rather than competition, is really important.

The integration with care is absolutely vital. Currently the health service is locked into a boundaried system, which causes real ineffectiveness or inefficiency. We need to work much more closely. Making sure that we are identifying and meeting need relevant to the local community—to place—is really important. Therefore, having flexibility down at place, coming up through the 42 ICSs, is a real opportunity for further improvement.

The most important thing is that it comes from a drive from within the health service, which is something that one sees in any event. It has

emerged partly post the 2012 Act, which seemed to have caused great fragmentation. Actually, you have seen associations and collaborations coming together as the health service tries to agglomerate, which brings that into much more mechanical force.

Q4 **Chair:** In yesterday's *Guardian*, there was a story that one in four doctors are so tired that it impairs their ability to look after patients properly. Is workforce a concern for you?

Richard Meddings: It is. I apologise for being long-winded. I started with the ICS because, when I was approached, that was the thing that struck me mechanically. In the last two to three weeks, having read in and having had a range of different meetings, I think that the No. 1 challenge for the health service is the workforce. I had not seen the statistic that one in four doctors are under such stress and exhaustion that they feel less able to provide service, but the workforce challenge is the benighting challenge to almost everything else we look at in the health service. We can put money into the health service, but if we do not have the staff to deliver it at the frontline that is a real problem.

Q5 **Chair:** This Committee has recommended on numerous occasions that we should have independently verified forecasts of the number of doctors and nurses we should be training for the future, but that has been blocked consistently by the Treasury, where, of course, you used to be a non-executive director. In that particular argument, will you be on the Treasury's side or the NHS's side?

Richard Meddings: Absolutely on the NHS's side, and not because I will have been so fortunate as to have received your support to do this role but because, fundamentally, I think the argument is the right one. In the NHS, it takes a minimum of seven years to train a doctor and then another five or six years before they end up in a particular specialism. It is a long-run industry. It is not a company; it is a whole industry. One has to manage to a long-term horizon. Not managing workforce over that period is very short-sighted. I would wish to challenge, engage and make the case for the health service to the Treasury about the need for long-term planning with regard to the workforce.

In my written submission, in response to a number of the questions that you asked, I said that one of the three themes I would like to think about hard in my first year is the question of capacity. The first part of that capacity question is long-term workforce planning.

Q6 **Chair:** There is one last question from me before I bring in my colleagues. In your written submission, you said that you agreed with us that the NHS had performed magnificently during the pandemic. What are the things that the NHS has not got right in the last few years?

Richard Meddings: Clearly, some of the delivery in parts of the service has not been as effective as we would like. The last two years have been the most remarkably stressful time. It is quite easy to sit outside it and to

comment on aspects of it that have not worked as well as we might have liked, but overall it has done remarkably.

What has it not done as well? I have to be quite careful, as I am an outsider coming in and a fresh pair of eyes. I would question whether the reporting within the health service looks upwards too much, rather than thinking about patient outcomes. I am sure that it means to look at the patient outcomes, absolutely, but when you look at the structures—the regions, the CCGs, the STPs and so on—as you go down from NHSE and across to HEE, NHSX and NHS Digital, all of which we want to bring together, the question is, how does that machine report up and down, to what extent is that effective and to what extent is it efficient, not just in financial terms but in time? Does it allow the frontline to spend enough time dealing with what the frontline should do?

The area that I would probe coming in would be that—the reporting and the bureaucracy. Bureaucracy is good. Good bureaucracy is very important to running proper and sizeable machines. The issue is whether the bureaucracy and the reporting need to be thought about.

Q7 **Chair:** Given that if the NHS were a country its GDP would be about the same size as the GDP of Morocco, are you saying that if you were king of Morocco you would not be an autocratic king but would be pushing power downwards?

Richard Meddings: Absolutely. I hate to draw parallels with my time at Standard Chartered, because they never quite work, but Standard Chartered is a bank that is in over 70 countries, with no large home market. How does one run that from the centre? How does one influence it in terms of group-wide objectives?

The way to run it is to trust and delegate down to the individual business areas in the individual countries. In exchange for that, there are two aspects. One is what my then CEO used to call a pathological collaboration; we must collaborate to make this work. That was between the businesses and the countries. The other was escalation. You trust and delegate down, and you rely on escalation upwards of issues that might emerge. If that dynamic comes about, it can reduce the need for people to say, "Show me, show me, show me," to one layer, which then goes down to the next layer, saying, "Show me, show me, show me." All that reporting and bureaucracy is not necessarily adding to the most effective running of the service overall.

Q8 **Barbara Keeley:** The essential criteria in the person specification for the role include a commitment "to improving health and care outcomes for patients and the public, with an understanding of the strategic challenges and opportunities to deliver improvements," but neither health nor care is mentioned in your background or experience. What makes you think that you have the knowledge and experience to become chair of NHS England at a time of such great difficulty, change and complexity, particularly due to the pandemic?

Richard Meddings: Thank you very much for that question. It was a question that I asked myself when I was first approached. When I was first approached I was apprehensive, but the role is a governance role. It is not a management role. I have over 30 years of FTSE 100 board experience. I have been a chair and a chief executive. I have chaired every type of committee that one sees in running institutions.

There is a clear abundance of talent. It is axiomatic to say that there is an abundance of medical and clinician talent within the senior echelons of and throughout the health service. All of us here come to our roles with different experiences and perspectives. I absolutely recognise that this is not an area I have worked in before and have knowledge of, but I am bringing a different set of skills and experiences to the role of chair.

Q9 **Barbara Keeley:** I did not ask about skills. I asked about knowledge and experience. What knowledge and experience of health and care do you have?

Richard Meddings: When thinking about how to structure the board, it would be really important for me to make sure that around the board table there were strong and independent non-executive directors, some with very good health and clinician knowledge. Clearly, one would have that within the executive. I do not think that everyone who comes to a particular role has to have the perfect match of experience set.

Q10 **Barbara Keeley:** Can I stop you there? You are not answering my question.

Richard Meddings: I am trying to. I apologise if I am not.

Q11 **Barbara Keeley:** It is about what knowledge and experience you have.

Richard Meddings: As I put in my application, I have no direct knowledge of health and care, apart from family experiences and being a patient of the health service, which is quite an important insight.

Q12 **Barbara Keeley:** The role requires "leadership and accountability to…support NHS recovery following the impact of Covid" and to "drive forward further improvement and transformation through the delivery of NHS and social care reform plans." What is your knowledge of the social care sector and the reforms that are needed in social care? That is an important part of moving forward.

Richard Meddings: Your first question would answer the second one. I have very limited direct knowledge or experience of the social care sector.

Q13 **Barbara Keeley:** Do you have any experience of the social care sector?

Richard Meddings: I have experience on a personal basis. I referred earlier—I am sorry to go back to it—to the deaths of my younger sister and my mother. I would say that my older sister was an unpaid carer to my mother for many years before she went into a care home. As a

family, we engaged with the care system to understand what level of support we could get. The same was true of my younger sister, who passed away. Her husband and my niece, her only daughter, were unpaid carers to my sister throughout that period.

I absolutely acknowledge that I do not have any direct experience of being in the management or leadership of the social care system, but I have seen it on a personal basis.

Q14 **Barbara Keeley:** There is a great deal of discussion of the reforms needed to social care. That is where the NHS comes into it. Do you have any experience or knowledge of those?

Richard Meddings: I lost the last bit of your question.

Q15 **Barbara Keeley:** Do you have experience and knowledge of the reforms that are thought to be needed to social care?

Richard Meddings: I have been looking hard at that question for the last two or three weeks, since my nomination. What is most important is that we break down the way we have organised ourselves. Effectively, the health service is boundaried away from the care system. Looking at the underlying statistics, there are 93,000 vacancies in the health service and 105,000 vacancies in the social care system, with a turnover rate of 28.5%. That is my understanding of the pressures on that workforce.

There is an interaction between care, social care and health around workforce. Therefore, it would clearly be wrong not to look at the question that the Chair asked earlier on workforce, for instance, on an integrated basis, to understand the pressures and dynamics that exist in social care and across in health. Have I worked in care or social care before? No. Am I keen to immerse myself and to understand that issue? Absolutely.

Q16 **Barbara Keeley:** You said earlier that you use the health service. Do you have, or have you had, private medical insurance?

Richard Meddings: I have. One aspect of the financial services industry, in particular, is that, probably since I was in my mid-20s, part of the remuneration package has been the offer of private health.

Q17 **Barbara Keeley:** When did you last use that private medical insurance?

Richard Meddings: I had what turned out to be an unprovoked DVT late last year. I started within the health service. I went to my GP, who referred me to scans in the health service. I had a series of scans to find out what the nature of the issue was. It was an unprovoked DVT. I was then referred privately.

Q18 **Barbara Keeley:** Do you think that you are qualified to inform the running of NHS care if, when you had a health problem yourself, you did not trust the NHS?

Richard Meddings: I do not think that is right. I absolutely trusted the NHS, and I still do. My last engagement with the NHS was just before Christmas, when my local GP surgery contacted me proactively and asked me to come for annual blood tests, as part of trying to spot whether anything is going wrong within me. I went in for my blood tests. Eight or nine days later, I was called by the same GP surgery to talk me through the outcomes. Hopefully, they were fine.

I am absolutely a user of the health service. I am passionate in believing in what it stands for and does. I have seen its service to my family. I have to be careful, as it was one isolated visit, but last week I saw the way the ambulance crew dealt with people in significant distress, a number of whom were significantly disadvantaged economically. I absolutely stand—

Q19 **Barbara Keeley:** Can we stick to your own experience? I asked you about your own experience. You have told us that when you had the health issue that you mentioned, you were referred to the private sector and used the private sector.

Richard Meddings: I can give you another example. I am obviously not a great cricketer—that is a different sort of parallel, given the Ashes—but in my early teens I failed to duck to a cricket ball and had my teeth knocked out. I had about 11 operations, two of which were in the private sector and eight or nine of which were in the health service. The last of them—you may smile—was a cosmetic delivery to me in the private sector. I use the health service. I am a passionate believer in the health service and what it stands for.

Barbara Keeley: Apart from when you want to be referred to the private sector.

Q20 **Sarah Owen:** Thank you for coming today. In your answers just now and in your written submission, you mentioned several times the importance of the workforce. How will they be a priority to you?

Richard Meddings: It is a really central question. It is a workforce of 1.24 million people, with 93,000 vacancies and a high degree of absenteeism at the moment, given Covid isolation. In many ways, it is an ageing workforce, so much of the concern is about further pressure. This is not a stable position.

In every aspect of the health service one looks at, the key question has to be, what about the workforce? It is quite easy to start to envisage strategies, priorities and deliveries and to think that that works, but each time one looks at where we are going to spend this money and how we are going to improve that service the question is, what does it mean for the workforce? Without the workforce, these things are not imaginary, but they will not be delivered effectively. It is the central question with almost everything that one asks.

Q21 **Sarah Owen:** I want to drill down into your experience of the NHS

workforce and, in particular, the care workforce. As you mention, you have a number of chairships in your CV and have worked in a number of banks. The banking sector is predominantly white. The NHS and the care service are made up of a very diverse workforce.

Richard Meddings: It is very diverse.

Q22 **Sarah Owen:** It is a proudly diverse workforce, yet you have not mentioned diversity or black, Asian and minority ethnic workforce challenges that the workforce has faced, particularly in the last two years, and the disparities on which the Committee has taken evidence. Why has that not been mentioned anywhere?

Richard Meddings: I think it is mentioned in my written submission, where I talk about the need for huge support for a very diverse workforce and to understand what that means.

Q23 **Sarah Owen:** What is your experience of working with diverse workforces?

Richard Meddings: Standard Chartered was 96,000 people. They were predominantly Indian and Chinese by background. The bank operates in 14 sub-Saharan African countries and has a huge ethnic mix. One of the most brilliant parts of my career was working in Standard Chartered and being exposed to that degree of diversity. It was absolutely wonderful. I was on the board of Standard Chartered for 12 years and worked significantly with populations and different ethnicities all over the world for that period. Every second week, I would be away long haul in different parts of the world.

You make a really serious point. I have only been reading in, and I want to get to understand this, but one of the things that struck me was the statistics around what is called bullying and harassment in the health service. I may get the percentages wrong, but they were stark. One in four of the people in the health service had suffered either bullying or harassment from patients. Eighteen per cent. of the health service had suffered bullying or harassment from peers within the health service. Just over 10% had suffered that from managers.

Why does that happen? I suspect that it is partly due to the sheer amount of stress we put people under, particularly with high attrition and high vacancies. This is a complex problem. It will also be about education, broader understanding and empathy for different people with different backgrounds and experiences. I think there is a very significant workforce challenge beyond the capacity challenge, which is a behaviour challenge requiring investment in skills or behaviours. Without that, we will see a much less good overall performance and we will lose more people. People will not work in an unhappy environment.

Q24 **Sarah Owen:** I have two areas of questioning. The second is around your independence from Government. You have said that you are going to step down from your non-executive director role at the Treasury. Is

that correct?

Richard Meddings: I have done so already, on 31 December.

Q25 **Sarah Owen:** You have done so already. In the paperwork that we have, it still says present.

Richard Meddings: I am sorry.

Q26 **Sarah Owen:** If you were to get the role and were to see that policy direction from this Government and from different Departments was unhelpful to the NHS and to care, how comfortable would you be in pushing back?

Richard Meddings: Significantly comfortable. This is an arm's length body. It is independent. Clearly, the Secretary of State has powers, but the role of the chair is to chair the board of an independent, arm's length body, which happens to be NHS England and all the others. To Ms Keeley's questions about my experience, that independence is right at the heart of making sure that the experienced executive, managers and clinicians within the health service are protected and are able to continue to do what they believe is best for the health service. There is operational autonomy and independence.

As I said, the Secretary of State clearly has powers. The important thing, as we would all say, is to try not to end up with some sort of clash all the time. One of the important roles of the chair is to act as a bridge. Many of us can end up in argument unless we have pre-communicated, discussed and thrashed out the issues.

To your basic question, absolutely I would stand up for and argue on behalf of the health service, but I would hope that, in the emergence of those issues, there would be very good communication, bridging and discussion between the health service, represented by me, the CEO, other executives and the very strong board that I would like to see around me, and wherever pressure was coming from: the Secretary of State, the Department, the Treasury—to the Chair's earlier question—or No. 10.

Q27 **Sarah Owen:** Is there anything that you would have done differently in the last two years to avoid the situation that we are seeing, with one in four doctors saying that they are now too tired to function properly and the Army coming into hospitals to deliver healthcare?

Richard Meddings: I honestly do not know the answer to that. As we all know, it has been quite the most remarkable period. There are lots of criticisms of Test and Trace, for example, but we have built the most scaled Test and Trace system, however it emerged. Then I look at other things. I look at the way that people who had stepped out of the NHS came back. I look at the volunteering, which has been remarkable. The ventilator challenge was outstanding. We had 8,000 ventilators. Another 4,000 were procured, and then something like 14,000 were created by

industry very quickly to provide ventilation. There was a huge amount of fast reaction to a really difficult crisis that swept across us.

Q28 **Sarah Owen:** There is not necessarily anything you would have done differently over the last two years. You would not have suggested anything that could have improved the situation we find ourselves in.

Richard Meddings: I do not know the answer to that. It is a really good question. I know that there is going to be a review of how the pandemic has been handled. That is what it is about. I think there will be real learnings and lessons.

One thing that I wrote in my submission to you is that it is not just about working through the current pressures of this pandemic. Once it becomes endemic, there are some real lessons that we can take away and learn. It will come back a lot to workforce. It will be about how we could have helped the workforce to operate as effectively as possible. They have made the most remarkable efforts themselves, but I suspect that it will be in that area that we find that we could have provided more support or a different approach, but I honestly do not know the answer today.

Q29 **Sarah Owen:** I am curious. One of the positions that you say you will not be stepping down from immediately is the Hastings education opportunity area chair. Is that correct?

Richard Meddings: Yes. Clearly, I want to make sure that I free up the necessary time. The Hastings OA is something I have been honoured and very proud to chair. As you know, it is an initiative that looks to provide support to the 12 areas of England and Wales that have the most difficult educational outcomes.

I have discussed it with them and said that my preference would be to step down. However, what they have come back to me with, which I absolutely get, is that the funding the initiative is overseeing runs parallel with the academic year, and we are in the last year of that. The discussion—this is what I said I would be very happy to do—is that there are three more meetings between now and the end of June. I said that for that period it would be sensible, if they wanted, for me to stay. I said that we need to understand that I probably would not have the same degree of time that I currently have and can give to the between-the-meetings activities that go on. We haven't had time to do this yet, but we need to find and discuss who is going to provide the input that I have historically provided between board meetings. I suspect it will just be to stay for the last three board meetings. Sorry it is a long answer, but I am trying to manage it as best I can.

Q30 **Sarah Owen:** Thank you. I wanted to come back to that, because, obviously, with your banking background there is very little for us to be able to say whether you have been successful or not in that, other than the fact that you have got other jobs.

Richard Meddings: I agree.

Q31 **Sarah Owen:** It is true that we do not have any real assessment of that, but we have with the Hastings education opportunity area. It is one of the opportunity areas that has had very mixed results.

Richard Meddings: I don't think that is right, actually. Key stage 2—

Q32 **Sarah Owen:** In key stage 2 you have.

Richard Meddings: It has been excellent.

Q33 **Sarah Owen:** Key stage 2 has improved, but key stage 4 is one of the three areas that has not improved.

Richard Meddings: The reason for that is that there were four secondary schools and two of the secondary schools have been combined into one in that period. That makes for quite a difficult and different set of circumstances.

I forget now, but there had been significant changes in leadership in those secondary schools. As you and I know very well, the quality of the leadership—we are having that conversation today—matters hugely. In those schools, we have had continuous turnover.

It is also important, when we look at Hastings, to remember—forget about me—that the board of the Hastings opportunity area, and all of the partners, the constituents, whether it is the local council, the local authority or the academy trusts, all of them coming together, can be hugely proud of what they have delivered. You are quite right that at key stage 4 it has not been as good as at key stages 2 and 3, but we have seen a real pick-up in literacy, numeracy, aspiration building and mental health engagement, which are the main four initiatives. We have also seen a pick-up in attendance, which has been really good. That has been a real challenge.

The current work that we are doing, which I am most excited about, is looking at transition. I am always amazed that our children go from primary to secondary and we lose the information about them—

Chair: Thank you. I am sorry. I am going to gently move on. Do you want to ask a last question, Sarah?

Q34 **Sarah Owen:** Yes, I do. I am very interested in the answer that you gave. If we are sat here, with the NHS continuing to have the same challenges that it has now in a few years' time, I would be really disappointed with an answer that takes no responsibility for that failing yourself.

Richard Meddings: No, no, I am not saying that I haven't and that we could not have done it better. I am saying that there are reasons why key stage 4 has not done as well as key stage 2.

Chair: We are going to move on from that with Lucy Allan.

Lucy Allan: Thank you, Chair. I should disclose that I worked at the

same organisation as the candidate at the time he was employed by that organisation.

Chair: Was he your boss?

Lucy Allan: I did not know him in that capacity. I did not know he worked there.

Richard Meddings: I am not sure that is a good answer!

Q35 **Lucy Allan:** It was a very large organisation. Mr Meddings, I also had a background in financial services and then went on to be a non-executive director of an NHS trust board. I can see some of the challenges that will lie ahead for you in that non-executive capacity.

In answer to something that the Chair put to you, you said that bureaucracy is good. Do you want to reflect on that? One of the biggest challenges you will find, moving from the private sector to the public sector, is bureaucracy. Getting things done is incredibly difficult. Getting senior management to be accountable is incredibly difficult. There are no penalties for poor performance. People pop up again in their senior management roles. When they have failed at one trust, they pop up in another one.

I wonder to what extent you see challenges in moving from the private sector to the public sector, when you have not previously had experience of the public sector.

Richard Meddings: I have had some experience of the public sector. I was seven years on the Treasury board—the previous questions were to that point—working alongside the Department for Education with regard to the Hastings opportunity area.

I think what I said about bureaucracy is that good bureaucracy is important. I certainly do not think you can expect sizeable operations to run without any bureaucracy. The problem with bureaucracy is that it tends to be seen as a pejorative description whenever the word is used. I think, on balance, we need institutions that have the necessary levels of information capture and MI reporting. Who does that? It tends to be done in what are seen as the bureaucratic structures.

I think what you are saying is consistent with the fact that when bureaucracy goes wrong, is overburdensome and is for its own sake, it can get in the way of more effective delivery of whatever the particular industry, corporate or, in this case, the health service is delivering. It is important to have standards; to have reporting; to have MI; and to have clear KPIs. They must follow strategic priorities, but if it is overburdensome and you have lots of meetings where people are just passing paper and there is no actual outcome, you have to question whether that is useful enough.

Q36 **Lucy Allan:** You mentioned accountability to patients, to people, and putting that front and centre. It is very easy to say that. Probably

everyone in the NHS will tell you that. My experience as an MP over the last seven years is that, very often, senior management put their interests and the interests of the organisation and staff, which is quite common, before the interests of the patients. They do not see themselves necessarily as patient centred. They will say they are, and the workforce, the people on the frontline, will put patients first, but higher up the chain we do not see that. I found it quite shocking that, whenever something goes wrong in the NHS from a patient's perspective, that patient is not seen as the most important priority.

How do you think you could influence a culture to shift from self-interest to patient interest?

Richard Meddings: Sitting as the chair, one's role on that is partly to make sure that in the discussions that come to the board and in engagement with the executives the question is asked from the patient's perspective—"What does this look like?"—and that, in all communications out to the organisation and the broader constituencies engaged with the health service, that remains a continuous theme.

In the written submission, I purposely finished on the point you make. I finished by saying that keeping the delivery of best outcomes for patients at the centre of our thinking will make for better strategic choices. I made up that last sentence in part, actually, in conversation with my twin brother. He would say to me, as a surgeon in NHS Scotland, that that is the most important thing. Often, we can get captured within what is in the interests of the NHS organisation. One has to have the patient outcome first.

Q37 **Lucy Allan:** Finally, could you give us an example of how you have led change and fundamental reform in your professional career to date?

Richard Meddings: They are all in the financial services sector, obviously. At Standard Chartered, we created and built a significant wholesale banking franchise based on our trade and cash management over a nine-year period. In the Woolwich, back when I first became a finance director, we again transformed the offer to our customers through something called Open Plan, which revolutionised the way the retail banking industry was offering a combination of products to customers. In TSB, partly after the migration, we utterly transformed the way TSB offers services to the customer, both with the offer of technology and in much clearer strategies around customer identification and offering the product that fits.

I have been involved in many acquisitions and many disposals. I have done integration.

Q38 **Lucy Allan:** Could I interrupt you there? Do you think that the NHS needs reform? In what way will you deliver that?

Richard Meddings: It needs reform and transformation, which is not to say that it is bad and therefore needs it. If we look at the challenge that

faces all of us in an ageing population post this pandemic, there is a significant change in the volume of demand. We can also look at how technology has absolutely transformed the way we all live our lives, and make sure that we think about bringing technology to offer better patient outcomes and better delivery that can transform the way we offer service.

Coming back to the workforce, if we do not get the workforce question answered properly, and if we do not ask that question whenever we are looking at an issue, I think we will find that we are not effective.

Q39 **Lucy Allan:** The levy comes into effect in April. How will you ensure that there will be taxpayer value for money in the NHS? That is not something that the NHS has ever typically focused on. Is that on your agenda, and how will you demonstrate that?

Richard Meddings: Yes, it is on my agenda. In many ways, with a budget of just under £154 billion—£2.8 billion of which is spent on NHS England and the regions—one can look at the extra levy of £36 billion or so and the extra £5.4 billion that was put in by Government in September, but actually it is the whole piece, isn't it?

What is really important is to look for efficiencies and savings to reinvest in better delivery and better outcomes. I do not think that people are mischievously mis-spending at all. I just think that we probably have quite a lot of leakage of the money as it goes down through the various structures. Finding how to do that more effectively and efficiently to reinvest in better outcomes and better service is key.

Q40 **Laura Trott:** Mr Meddings, I want to ask about two related areas, the first of which is a little more on outcomes and the second of which is about how the NHS learns from mistakes.

First on outcomes, which you have mentioned numerous times in this session and in your submission, how do you propose to measure whether you have been successful in improving patient outcomes?

Richard Meddings: Me personally, or for the health service?

Q41 **Laura Trott:** For the board and the health service. What will you be looking to target?

Richard Meddings: It is a really good question. One of the challenges of targets is unintended consequences, yet at the same time it is really important to set clear priorities and goals. I know already, if you look at the long-term plan for the health service, that it very quickly goes into a whole range, quite rightly, of more delivery of this intervention and more engagement with that particular illness. That is right and those clear goals and targets should be set.

How one delivers against those is very straightforward in measurement and reporting up through to the board. It is the same thing in constantly guarding against the unintended consequence of saying, "I am going to

purely deliver on how long people wait as they come through to A&E." How that is then delivered is the better question.

I think we will have standard KPI reporting, delivered off the agreed goals and priorities, in terms of a range of interventions across a range of health conditions, and then a continuous question about how that was delivered. Can we just understand that there were no unintended ramifications from that?

Q42 **Laura Trott:** You mentioned ICSs and ICBs.

Richard Meddings: Yes, which I think are really important.

Q43 **Laura Trott:** One of the many questions we, as a Committee, had about those structures was the lack of focus on patient improvements and improved patient outcomes as a result of the changes. How would you make sure that patients were benefited for the better as a result of the changes that are going through?

Richard Meddings: Again, I think it is a really good question. As you look at it, it is a structure. You have a chairman, a CEO, someone representing NHS Providers, someone representing primary care, which is right, and then you have the local authority bringing in other contributions to health, whether that is education, housing or social care. That is very important.

Again, what is really good about them is that they are required effectively to deliver to local community need. Local community need will be defined according to patient outcomes. How does that happen? As you know from your engagement, we have the integrated care boards. Feeding into the integrated care boards we have the integrated care partnerships, which represent a much broader constituency, attached to their community and informed about what the local community need is—community need being "What is the pressure here?" and "What are we seeing among our community for our patients?"

The reason I think it is really good is that it also might allow us to be more responsive to inequality, health inequalities. As a structure it is very good. How does it deliver? I think it is quality of leadership. The Gordon Messenger initiative, looking at leadership more broadly, is really important as an insight. The quality of leadership in the ICSs, particularly in the ICBs, for me is core critical. The engagement of NHS England with those systems as integrated care systems, and the leaders of the systems, the communication, information sharing and the messaging is what will give us some confidence in their potential success.

Q44 **Laura Trott:** How do you see your role as chair in holding them to account?

Richard Meddings: I have had two meetings with Amanda Pritchard. One was familiarisation before the interview process, and there has been one since. So far, I have also had one with Mark Cubbon, the chief

delivery officer, and with Julian Kelly, the CFO. One of the things I talked to all of them about in those meetings was what the engagement is with the ICS, particularly with the ICB chairs and CEOs. I do not have the specific answer, but there should be a regular rhythm of engagement between the NHSEI board and the ICSs as the main delivery point.

Q45 **Laura Trott:** Moving on to patient safety, one of the things we have seen time and again in the Committee is the NHS failing to learn from mistakes. It was particularly true when we looked at maternity safety. Time after time, CQC inspections in the worst performing areas threw up the same issues.

How can you ensure that the NHS learns from mistakes, and that when we have reports and inquiries into things that have gone wrong—as they do—they do not then happen again and cause suffering in numerous families time after time?

Richard Meddings: Mistakes happen. I am a firm believer, when things go wrong, that we are transparent about that. We need transparency and therefore learning.

Perhaps the most recent example—in a financial setting, forgive me—was in Credit Suisse, when it lost a significant sum of money on one hedge fund called Archegos. I led the investigation and review for the board into how that had happened and what had happened. I argued, and the board agreed, that we should publish it. Even though it is very embarrassing that the bank could lose such a sum of money on one hedge fund, I said, and the board agreed, that by publishing it, first of all, we show our investors that we take it really seriously. Most importantly, what happens in a big institution is that someone says, "Oh, it went wrong over there; that's nothing to do with me." Actually, by publishing it one says, "But look at the themes that allowed it to go wrong," lack of escalation or whatever. Then you say, "Now you should take and translate that, talk about it and think about whether you have the same challenge everywhere else in the organisation."

I did the same with TSB with the Slaughter and May report. It was a very awkward and difficult report, but we published it and engaged with it. We need transparency, without a blame culture, so that other people can learn how it went wrong. That is the answer to your question.

Q46 **Taiwo Owatemi:** I start by declaring that my partner works as a consultant for Credit Suisse.

One of the challenges that is facing the NHS is health inequality. The Marmot report shows, for example, that a woman from the wealthiest area of Coventry has lower life expectancy than in other regions within the country. In your role as chair of the NHS, how do you think you can address the health inequalities that currently happen?

Richard Meddings: I see the same. I was brought up in Wolverhampton. My older sister still lives in Wolverhampton. I see the

inequalities, whether economic deprivation in particular areas or other community factors. It is a really important issue. To Ms Keeley's questions about my actual practical knowledge, I do not have a direct answer for you about how I would deal with that, but making sure that we are thinking hard about health inequalities is important.

Again, without making it the cutting of the Gordian knot, the idea of the integrated care system, fed with local knowledge to serve that community, will allow to come up through the 42 integrated care systems direct knowledge about the needs of their local community. In that way, I think we have a chance of very real insight. Instead of top-down delivery, the intervention and the ask is fed from local need.

As I said, the important thing is that the integrated care boards are well led and engage properly with the local authorities, who can explain a lot and give lots of fact-based information about why some of the prevailing conditions are causing a lot of the inequality. The ICPs—the integrated care partnerships—can do the same. That information gives us a chance then to intervene.

Through the ICBs, they have to produce an allocation—a strategy and a resource allocation plan on a rolling five-year basis. The way to engage with it is to say, "We have inequality. Are we weighting sufficiently down through your overall system into the places or the neighbourhoods? To what extent are we weighting the spend or the interventions to those areas that will, hopefully, reduce that inequality? It is a broader question than just health. Health inequality flows from other factors."

Q47 **Taiwo Owatemi:** I want to move on to workforce culture. You said earlier that there are behavioural and workforce challenges, and investment is needed. What do you think can be done to address the current blame culture in the NHS? That is something that we have looked at, as a Committee, time and again.

Richard Meddings: I have been reading quite a lot of the various hearings that you have held. I have read your recommendations. Again, it is partly the answer I gave earlier on transparency and sharing information. It is about education, training and incentives. By incentives, I do not necessarily mean financial incentives but incentives to behave properly.

The question of workforce in all of its manifestations, as I have said two or three times—forgive me for repeating it—has to be the core question that underpins every other question that gets asked.

Q48 **Taiwo Owatemi:** You told us that you wanted to develop a better fact base and a better dataset.

Richard Meddings: Yes.

Q49 **Taiwo Owatemi:** Could you elaborate on that?

Richard Meddings: I was trying to look up all sorts of things. A lot of what I have done has been as a finance director. Here I am saying, let me get the fact base and the set, and depending on what source you ask, you often get a different answer. It is just to make sure that we have clarity when we talk about particular aspects and that we all understand what it is we are talking about. It is more about the precision of the data that we use. It seems to me that there are multiple sources of different answers to what sounds like the same question. I want to make sure, as I approach it, that what I understand to be the shape of the question I am asking about or probing on is actually what everyone else understands.

There are multiple answers to how many hospitals there are in the UK. Define a hospital. Is it acute hospitals? You get different answers to these questions. How many GPs are there? There are 28,000. How many practices? There are 7,000. Is it right that 5,000 of those are individual GPs as opposed to partnerships?

There is a lot of high-level data, but does everybody agree that is what it looks like? That is why I say that it is quite easy to debate a question and suddenly find that three people in the room have a different idea about the magnitude of it.

Q50 **Taiwo Owatemi:** I have a broader data question. What are your views on a move to let private companies use NHS data within the broader NHS goals?

Chair: The last one, Taiwo, if that is all right.

Richard Meddings: One has to be really careful about the confidentiality of customer data, but there is a circle to square. I think I saw Simon Stevens appearing before this Committee answer a very similar question about a year or so ago. It is squaring the circle between the patient's data being, quite rightly, held confidentially and then, if they are in an emergency situation, whether their data immediately available. There are huge amounts of data.

To your question about whether the private sector should be able to utilise it, clearly we have artificial intelligence coming. We have the benefit of algorithms analysis, using that data to better work out how to intervene earlier. There must be a benefit that we should absolutely explore, which is, can we get better outcomes by properly analysing with proper expertise what the data tells us? Can we identify indicators of emerging ill-health earlier by using this data? That is really important. I am for that, but it needs necessary safeguards around it.

Q51 **Taiwo Owatemi:** This is the second part. Do you see any potential conflict of interest between private market involvement where funding is concerned for the delivery of NHS treatments?

Richard Meddings: I think about that question a lot. One of the things that is really interesting about the health service is that so much of it is

private. GP practices are private. You have a lot of private sector engagement in the health service. I think it is important that that gets provided. I step back to what I said right at the start. The thing that is distinctive and absolutely core, and I passionately believe in, is the way the NHS today, and from its very foundation in 1948, is accessible to all and free at the point of use.

Q52 **Paul Bristow:** I have a few very quick questions for you, if I may. If you are successful in this role, what criteria do you think we should use to assess your performance?

Richard Meddings: In my written submission I gave you five criteria, which you will have seen. I suspect your question derives from the fact that a couple of them are slightly broader in their answer.

Paul Bristow: Yes.

Richard Meddings: It will not surprise you that one of them is the integrated care systems being properly implemented. A second is to bring around me a strong and independent-minded board and see it operate well. A third will be the relationship with Amanda Pritchard as CEO. That is a really important relationship that works very well, with constructive challenge and open discussion and, at the same time, partnership.

The broader ones are to what extent you would believe that, as chair, I encouraged very active dialogue with external expert organisations, whether the King's Fund, the Nuffield Trust, the Health Foundation or others. One of the things I want to represent, coming in without direct health or care practitioner knowledge, with a fresh pair of eyes, is to maintain that freshness and to stop the organisation becoming introverted.

One of the things I would like you to test me on is whether I expose the thinking of the health service sufficiently, at board level and at senior management level, to that degree of external challenge. It may go to workforce, in answer to an earlier question, but it strikes me that that would be a very important test of me. That is quite general, but it is quite interesting about behaviours, values and ways of thinking.

The fifth was a series of strategic goals and deliveries, which will be set out, and you can quite clearly see whether the health service has delivered to those.

Q53 **Paul Bristow:** How would you set about embedding a culture of transparency within NHS England? It is not just transparency to patients but transparency in some of the commissioning decisions. NHS England is a huge commissioner, so it would be in some of the commissioning decisions that NHS England makes.

Richard Meddings: I do not know how to answer that question, sitting here today, except that as a principle the commissioners have a statutory obligation to act in the best interests of the patients. I do not want to

make it up; I do not know the specific answer, but in the reviews of commissioning decisions, if one sees challenges, it is about communicating those as lessons learnt.

One of the things that the financial services sector broadly does well is lessons learnt. It does lessons learnt well by actually publishing them within the particular corporate or across the industry. One of the things the financial services regulator does well is to publish findings, sometimes eventually, which show the industry overall how something did not work.

Q54 **Paul Bristow:** How do you think NHS England can embed a culture of innovation and learning best practice in the health service?

Richard Meddings: The health service is an industry—1.25 million people and £154 billion. It is huge, vast and complex. Again, looking from the outside, I need to be careful, but if one thinks about innovation, particularly digital, quite often the mistake that is made is to digitalise the current process. The thing that is needed is a cultural and information change. An attitudinal, cultural shift about the way things operate is needed before you digitalise. If one simply technologically transforms a current process without re-engineering it first, and, secondly, without making sure that the relevant users are suitably educated and have had explained to them why it makes more sense, you will have a crowding into other areas of the system as it does not operate well.

It is probably going to be increasing the level of direct technological knowledge of the board, and then down through the organisation, looking at the degree of priority we give digital and technological transformation. It is cultural and attitudinal as much as it is technological skill.

Q55 **Paul Bristow:** I entirely agree with that. Do you think there is anything the NHS can learn about innovation from FinTechs, for example?

Richard Meddings: I suspect that we can all learn. FinTechs are very interesting as an aspect. They are predominantly front-end customer applications, so they enable the customer directly to engage. We are all increasingly comfortable—not all, but large parts of society—in an online world. Many of us have wearables that give information about attributes that contribute to health. I think that sort of EdTech world is already resonant and quite significant. They could probably learn from each other, actually.

Q56 **Paul Bristow:** I think the biggest challenge the NHS is going to face over the next few years—this is just my opinion—is the financial uplift and whether that money is being well spent. I heard the response to your question from my colleague, Lucy Allan.

One of the biggest challenges for ensuring that our money is well spent is improved productivity in the NHS, in my view. I heard what you said about targets and how sometimes they are perverse and lead to perverse outcomes. I also heard what you said about KPIs and judging people by KPIs. Do you think individual trusts should be held to account for meeting

particular KPIs? What do you think should happen to trusts that do not meet them?

Richard Meddings: Held to account? They will have targets that are measures of their performance. To the extent that they do not meet them, they should be able to explain why they have not met them. One of the great dangers—you see it in the business world—is sometimes to say, "Am I going to set very aspirational targets that are hard to hit but are achievable?" If you do not get that right, you can have, first, apparent failure but it is still operating at a very good level or, secondly, wrong behaviours to get the last five points or 10 points to hit the target.

The answer, to pick up your phrase, Mr Bristow, is to be accountable, but it is as much the explanation of what the target was, why they set it and why—to your question—they did not achieve it in that case. I think they are quite subtle. It is the accountability attribution that one has to be thoughtful about, but you need KPIs. We cannot just wander out there, particularly if we are thinking about the value of spend.

Chair: Last question, Paul.

Q57 **Paul Bristow:** It is, Chair. I promise.

I understand what you mean and I accept your explanation about the need for an explanation if NHS trusts do not reach particular KPIs or measures, but if there is a particular failure that is obviously a failure, what do you think should happen as a result of that failure?

Richard Meddings: At the end, if it is a failure through mismanagement, there have to be consequences for that management.

Q58 **Paul Bristow:** Do you think they should just get more money?

Richard Meddings: No. It depends on what the issue is. If it is a mismanagement issue, you change the management. It depends on what the reason for the failure is, doesn't it? There has to be accountability.

Q59 **Chair:** Thank you. On that note we will conclude the session. We are very grateful for your time this morning. We have had a very wide range of questions. We appreciate your thoughtful and comprehensive answers. We will now discuss in private, if you will forgive us, how we think it has gone so that we can give our decision to the Government. We are very grateful to you for your time.

Richard Meddings: May I just make one, 30-second comment?

Chair: Of course, yes. Please do.

Richard Meddings: Thank you for your questions. If you were to support me and I was nominated, I look forward to coming back as frequently as you would want to engage with you on the questions you have and the issues that we all face. It would be an important part of the dialogue.

Separately, I would be hugely privileged, if I were nominated for this role, to have the ability to work with the health service and the staff and workforce in it. I pay them the tribute I did, or tried to do, at the start. They have been absolutely remarkable in the last two years, and before that, when faced with increasing challenges. It would be a great honour to be able to take this role.

Chair: Thank you very much indeed.