

Health and Social Care Committee

Pre-appointment hearing of Chair of NHS England, HC 1351

Monday 10 September 2018

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Members present: Dr Sarah Wollaston (Chair); Mr Ben Bradshaw; Diana Johnson; Johnny Mercer; Andrew Selous; Dr Paul Williams.

Questions 1 - 58

Witness

I: Lord (David) Prior of Brampton, the Government's preferred candidate for the position of Chair of NHS England.

Examination of witness

Witness: Lord Prior.

Q1 Chair: Good afternoon, Lord Prior. Thank you for coming this afternoon to our pre-appointment hearing for your role as candidate for the chair of NHS England. Can I start by asking you what skills and experience you bring to this role?

Lord Prior: Thank you for having me here. Before I went into Parliament, I had a career in big business at British Steel and in small businesses, so I have a good business background. I was then in politics, so I understand how the political system works. Then in 2002, when I lost my parliamentary seat, I became the chairman of the Norfolk and Norwich University Hospitals. I was chairman there for 12 years. I was chairman of the CQC for two years. I was a Minister in the Health Department for two years. Then I became chairman of UCLH, one of the big teaching hospitals in London. I have had pretty extensive experience of the NHS and of running large organisations, so I think that general background will help.

Q2 Chair: Can you talk us through how you demonstrated your commitment to patient safety and high standards of care in those roles?

Lord Prior: I suppose the obvious role to focus on is at the CQC. The reorganisation of the CQC, which took place when I went there, with David Behan, was largely in response to the Mid Staffs report by Robert Francis, which had shown not just a catastrophic breakdown in patient care and safety at Mid Staffs but that the regulatory system was wholly inadequate. Our response to that and to what happened in the maternity department at Morecambe Bay is pretty strong evidence of my commitment to patient safety.

The lesson I took from that is that good people will do bad things if the culture of the organisation is wrong. If the culture is focused on becoming a foundation trust or purely on finance, it is extraordinary what people will do. Really good, experienced nurses and experienced clinicians will, over a period of time, adopt behaviours, which, if they could look at themselves in the mirror, they would be horrified at, but it does happen and we should always recognise that it can happen.

Q3 Chair: Yes. How did you in your role actually help to drive that kind of culture change, and what will be your leadership style at NHS England as chair? How do you see your role and what will you bring to it?

Lord Prior: One's leadership style has to be fairly chameleon-like. It depends on the organisation and the strengths of the existing organisation. At UCLH, for example, a very strong academic clinician is the chief executive. Although I walk around the hospital, I have total confidence that he and his team are on safety and patient care; it is part of their DNA. I spend relatively less time doing that than I would have done at the Norfolk and Norwich, for example, where probably 80% of



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my time was spent in the hospital visiting wards, talking to people and seeing people, whereas at UCLH I spend more of my time looking at the research agenda, for example, and building relationships outside the hospital.

One's role varies according to the strengths of the organisation you are in. At NHS England, you have a very strong, highly intelligent strategic chief executive, who, as an architect of healthcare systems, is probably unsurpassed. I think my role there is going to be much more on the execution side of the strategy rather than actually developing the strategy.

Q4 Chair: Yes, we would all agree that Simon Stevens has been a very strong leader, but strong leaders can sometimes be difficult to stand up to. Do you see one of the roles of the chair as challenging that?

Lord Prior: Yes. It is strong, constructive challenge, but not negative challenge, because it is quite easy to go over the border between constructive criticism and negative, defensive criticism, which can be very demotivating. You have to come to a modus operandi between you. I know Simon quite well. I never worked with Simon, but I saw him when I was at the Department of Health. He respects constructive criticism from people who he thinks know a bit about what they are talking about.

Q5 Chair: Your previous answer implied that, where you think the leadership is strong, you can take an attitude that they are all over it, they are on it and so you can focus your attention elsewhere. I think people would want to be very clear that you would be prepared to stand up to the leadership of NHS England should you feel unhappy about any of its directions.

Lord Prior: You can be absolutely assured of that.

Chair: Thank you. We have a series of questions, more generally, about independence.

Q6 Diana Johnson: Did you apply for this role or were you head-hunted?

Lord Prior: I think it was a mixture of the two in that Odgers, who were the head-hunters, gave me a call. I thought about it and my initial reaction was not to do it because at the time I felt that probably NHS Improvement and NHS England were going to be merged and that the existing chairman of NHS Improvement would do the combined job. When it became clear that that was not going to happen, I put in my application.

Q7 Diana Johnson: Thank you. The job description states that the primary role of the chair of NHS England is to ensure that NHS England's strategic direction "is aligned to wider Government healthcare policy." Do you think an appropriate description of the main role of NHS England's chair is to align with Government's broader policy on health?

Lord Prior: I think one has a role in helping to shape what that policy is as well. I think the Government would take note of NHS England's views



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about what policy should be. At the end of the day, Parliament has the money, and votes the money, and in the mandate it gives the NHS it is entitled, I think, to set out what its overarching priorities are, whether they be around cancer, mental health or the like. It is then up to NHS England to devise the best ways of delivering those objectives. To that extent, I think that is reasonable.

Q8 Diana Johnson: I was looking at what the BMA said about the politicisation of NHS England. They said that we need an NHS that is run by an independent board, free of party political interference. How do you feel about fulfilling your role as the chair of NHS England and being able to retain the necessary level of operational independence as a non-departmental body? What do you say about that?

Lord Prior: If they had wanted someone who was going to do what they said, they would probably not have picked me, because although I am a Conservative, I am probably about as popular in the Whips Office in the House of Lords as your Chair is popular in the Whips Office in the House of Commons, I believe.

Mr Bradshaw: Hear, hear.

Johnny Mercer: Hear, hear.

Lord Prior: I am independent. When I was at the CQC, I was conspicuously independent there. We produced a number of reports, for example, on social care that made very grim reading from the Government's point of view. I have agonised a bit about whether or not I ought to give up the Conservative party Whip and become an independent or a Cross Bencher. The truth is that I could make the argument both ways, and I would be personally happy with either outcome. Having thought about it a great deal, I thought, is it really credible for someone who has been a Conservative Member of Parliament, who was a Government Minister until six months ago, to give up the Conservative party and become a Cross Bencher? Is that really credible? I thought that it was not, so I decided that it would not be the right way to go, on balance.

Q9 Diana Johnson: You do not think it might be a clear signal of you saying, "I will be operating independently" in this new role if you gave up the Whip?

Lord Prior: It would be symbolic. I hope there will be chances to make a much more substantive statement. There will be times when we disagree with the Government, and that is the point at which to judge me on whether or not I am being independent. But I take the argument—if it was the other way round, I could argue it the other way as well.

Diana Johnson: It is just concerning that both the chair of NHS Improvement and the chair of NHS England will both be taking the Conservative Whip. Thank you.



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Q10 **Dr Williams:** Lord Prior, thank you for coming today. Do you agree that NHS England was created to take the NHS out of day-to-day politics?

Lord Prior: That was certainly one of the purposes of it.

Q11 **Dr Williams:** I would like to come back to the notion of why a politician—because you clearly are a politician—is the right person to be running NHS England.

Lord Prior: I have not been appointed because I am a politician. I think I have been appointed because I have 17 years of experience in the NHS and relevant external experience as well. I have been seen to be independent in that I have voted against the Government on a number of the EU withdrawal Bill provisions, and I have been chairman of the CQC. If you were to talk to your colleagues in the Labour party in the House of Lords, they would regard me as being pretty independent. I just co-authored a report for the IPPR with Ara Darzi, for example. Despite the comment from the BMA, I think I am seen by most parts of the NHS as being independent.

Q12 **Dr Williams:** Do you think this is a more political role than the role you had at the CQC?

Lord Prior: I would say they are equally political, in a sense, but, if anything, it is probably slightly more political than the CQC, yes. I think that is a fair point.

Q13 **Dr Williams:** If there is any health legislation going through the House of Lords, will you be voting on that health legislation?

Lord Prior: No, I would not vote on any health legislation.

Q14 **Dr Williams:** You want to continue to take the Conservative party Whip—you intend to continue to take the Whip for all matters—but you will absent yourself from any legislation relating directly to the NHS.

Lord Prior: Yes.

Q15 **Dr Williams:** Presumably you would vote on Budget legislation that would impact the NHS—the Budget, for example.

Lord Prior: I would vote on the Budget, yes. I think I would. I would have to take it on a case-by-case basis, but I think I would.

Q16 **Dr Williams:** If we get a controversial issue and the Secretary of State is seeking to privately influence you, how will you demonstrate your personal independence?

Lord Prior: I am 63. This is my last job. There is nothing I want from the Government that they can give me. I am more independent and freer now than I have ever been. If there is an issue of principle, you have your argument with the Secretary of State, or if it is an issue of principle on which you cannot agree, you resign.

Q17 **Dr Williams:** There are some big decisions that NHS England has made



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that have been very political decisions in the last few years. One that I can think of in particular is around the allocation of resources and how to apportion resources; there is a funding formula that takes into account deprivation and age, and how you allocate the resources makes a big difference to which parts of the country get more resource. How will you separate your party politics from that decision?

Lord Prior: The decision on how to allocate resources is really a non-political decision. It is done on a formulaic basis. You have to decide how to weight age, deprivation, geography and the like; for example, the market forces factor is under review at the moment, and will have a relative impact on London versus other parts of the country, but I do not see that as a party political matter.

Q18 **Dr Williams:** It is a political decision, because it involves making choices in the way that politics involves making choices, and it probably has an impact on electoral politics because it involves giving more or less resource to different parts of the country.

Lord Prior: I just have to give you my complete assurance that I would never let any party political bias on my account in any way affect that kind of decision.

Q19 **Dr Williams:** Moving to a slightly different matter, what is your opinion of the sustainability of the NHS as a taxpayer-funded system?

Lord Prior: I am 100% committed to a tax-funded NHS. That is the first thing to say. At a time of austerity, as we have had over the last five years, it is extremely difficult to fund the kind of health system we want; when growth in the budget is running at 1% or 1.5% real a year, it is extremely difficult. Now that we have the new five-year deal that has come from the Government—3.4% over that time—it is possible to deliver a decent healthcare system with that budget. My basic philosophical belief is that a free system open to everybody wherever they come from, whatever their genetic inheritance or their background, is of fundamental importance, and of more fundamental importance now, with society as it is at the moment, than it has ever been before.

Q20 **Dr Williams:** Do you think NHS England needs any structural changes? You mentioned before that there had perhaps been some talk of NHS England and NHSI having a joint chair. What is your view of that?

Lord Prior: There is a strong argument for merging at least part of NHS Improvement with NHS England. I say “part of” because I think there is a vitally important aspect of NHS Improvement that does not naturally fit within a regulator, which is the improvement work that Tim Briggs and Tim Evans have done on GIRFT and Model Hospital, and indeed RightCare, which is part of NHS England. I feel that the improvement part of NHS Improvement does not sit happily with the regulatory side. If you were to merge the two organisations, I am not sure you would necessarily merge the whole of both, but certainly there is a lot of scope for the two organisations to work much more closely together.



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Q21 Chair: Can I come back to your comment when you questioned whether it would be seen as credible for you to resign the Whip? We cannot get away from the fact that two of the key roles, chair of NHS England and chair of NHS Improvement, would then essentially be held by people who were holding the party Whip. Can I quote to you from our letter as a Committee to Baroness Harding? We felt rather strongly about this, and in our letter to her, we strongly recommended that she did so. We said that “resignation of the whip would be a practical demonstration that, for the duration of your appointment, you will not be taking instruction from any political party on the way in which you should vote on any issue before Parliament.” Can I put that to you? While I accept what you are saying—your concern is that people will not see it as credible—our response to Baroness Harding on that point as a Committee was that we felt that it was a very important point of principle, for those who were looking at these roles from outside.

Lord Prior: You have a very strong point; it is a very strong argument. I have wrestled with it over the last few days since I knew I was going to get the appointment. I am not going to dispute the strength of the argument you put. I felt, though, not that it would be dishonest to give up the Whip—it would not be dishonest—but that I am a Conservative.

Q22 Chair: Indeed you are, but it is about the discussions with the Whip about how you should vote. That is likely to be central to our discussions. We wrote to Baroness Harding and made that recommendation, and she wrote back to us and said no, essentially. If this Committee were to write to you—we will be sitting in private after this meeting—that, having listened to your arguments, we still felt that you should resign the Whip, would you send us the same response as Baroness Harding, or would you take that into account?

Lord Prior: I would definitely take into account what you say. I would like to think about it, though. I would not like to say now how I would respond.

Q23 Mr Bradshaw: If you were worried, Lord Prior, that you might expose Baroness Harding by having not followed suit if you did the right thing, you could always use the argument that you had been a Government Minister, which I think makes a material difference. That might be helpful, because I can understand that you would not want to embarrass her by doing the right thing when she did not do the right thing.

I am going to ask you a couple of questions about Brexit, but before I do, how would you describe the performance of the Norfolk and Norwich Hospitals while you were chairman?

Lord Prior: Gosh, it was quite a long time ago. We became a foundation trust. That was one measure of success at the time. We hit all our access targets. It is still a very good hospital. I know it is in special measures today, but the clinical care that the Norfolk and Norwich gives, from everything I hear locally, is still very good, but they clearly have financial problems. One of the perennial problems we had was that it was one of



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the first big PFI schemes, and we had a very high unitary charge. When money was slightly easier—I was going to say during the Blair years—we could cope with it. In different times, that unitary charge—

Q24 **Mr Bradshaw:** It is too small, isn't it?

Lord Prior: The Norfolk and Norwich?

Mr Bradshaw: Yes. As a building. That is the impression I got. I have local contacts.

Lord Prior: Any adjustment you want to make to a PFI-funded building costs you an arm and leg. As you know, even if you want to put up a coat hanger or a hook on a wall, it costs you a lot of money in a PFI building. That was always going to be, in the long term, a big issue. It is a big issue for us at UCLH, frankly, but we are a bigger, better-funded hospital.

Q25 **Mr Bradshaw:** It has just had an appalling CQC report and has been put in special measures. Do you think you left long ago enough for you to be sanitised by that period?

Lord Prior: It is over five years ago. I would argue that when I left, although I am not saying it was because of me, it was doing very well.

Q26 **Mr Bradshaw:** I notice that you also chair, or chaired or set up, a number of free schools and/or academies. What has their performance been like?

Lord Prior: Extremely good. There are two free schools and eight academies that have done very well. I think they got "Outstanding" from Ofsted.

Q27 **Mr Bradshaw:** How do you think Brexit is going to impact and, in many ways, is already impacting the strategic priorities that you will want to set the NHS over the next months?

Lord Prior: It is difficult to say until we know what Brexit is. I know "Brexit means Brexit," but it depends a bit on what the deal is. The issues we need to think about are around staffing and access to medicines. Those are the two critical issues in the NHS that we need to have thought about. In terms of access to medicines, already they are putting in an extra six-week supply of all pharmaceuticals. Staffing is an area where I will want to take a very active role with the Government in ensuring that we have proper immigration facilities so that we can get visas for doctors, nurses and other clinicians to come into the country easily.

Q28 **Mr Bradshaw:** Of course, there are implications as well regarding their families.

Lord Prior: And their families, yes.

Q29 **Mr Bradshaw:** I do not know whether you spotted—it was during August when a lot of people were not around—an extraordinary letter from NHS Providers that received widespread media coverage. It was from Chris



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Hopson, the chief executive of NHS Providers, to Simon Stevens and Ian Dalton, and was withering in its analysis of the preparedness of the NHS for Brexit, particularly a no-deal Brexit. It basically said that hospitals and trusts are not being told anything, there does not seem to be any planning and nobody seems to know who is responsible for the planning. It touched on some of the areas you have talked about—concerns about medicines and medical equipment running out, and staff shortages and so forth—and appealed to Simon and Ian to convene a group of trust leaders as a matter of urgency to work through the operational issues they would face should there be no Brexit deal or a hard Brexit. Are you aware of this and, if so, do you know whether anything is happening about it? Would you take a very close look at this and make sure—

Lord Prior: I would. In terms of my short-term priorities, if I were to have this job, Brexit preparedness, along with winter preparedness, would be two things at the top of my list.

- Q30 **Mr Bradshaw:** We, as a Committee, have made quite clear our view that the NHS should publish its contingency planning for no deal and for a hard Brexit, not least because nobody seems to know, and we think that the public have a right to know, what the planning involves. Would you agree with our view?

Lord Prior: Yes. I think that would be reasonable, yes.

- Q31 **Johnny Mercer:** What would be your main priorities going forward? You talked about preparedness for Brexit and things like that, but I want to know about the more strategic things. What is the health service going to look like in five years' time? You say you are committed to a 100% taxpayer-funded NHS. Some would say that might not be possible. What are your thoughts as to where it goes from here?

Lord Prior: The big strategic change that is going to run through the NHS and social care over the next 10 years, and it probably will be over 10 years, is a move away from a fragmented system to a much more integrated, joined-up system. That is going to take quite a long time to do because it requires a lot of change in behaviours, quite apart from organisational change: a lot of change in culture and behaviour. This is bringing together a system that has been fragmented since 1948, in some respects, between social care and healthcare, between primary care and secondary care, and between mental health care and physical care.

Another part of that fragmentation, which has happened more latterly—probably in the last 20 years—is the split between management and clinicians, which is a ludicrous split, but “going over to the dark side” is still talked about by clinicians, as you know. Bringing that back into an integrated system is of fundamental importance. It lies behind the five year forward view. I am sure it will be one of the big things that comes out of the huge engagement process that NHS England is doing at the moment in response to the Government’s five-year funding settlement.



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Q32 Johnny Mercer: How do we look at your performance? What is the metric that your performance is to be judged by? How will the British public, who are ultimately paying your wages, know that you are doing a good job?

Lord Prior: It will be by whether or not they can access GPs more easily, or whether their cancer treatment is as good as anywhere else in Europe. There is a whole range of outcome measures that will surround integrated care systems around population health, which will give a very strong metrics view to judge whether or not an integrated system is delivering a good deal.

Q33 Johnny Mercer: A lot of people could be forgiven for thinking that we have been talking about integrated care ever since anyone can remember. You say it has been fragmented since 1948, and that is clearly the case, but three years ago, and even in 2011, people started to talk about integrated care. We have just combined health and social care budgets in Plymouth, but it is still quite hard to feel a tangible benefit. When will we be able to say that this mission, the direction of travel of combining these things and looking at the NHS as a holistic system, has fundamentally shifted the dial for healthcare in this country?

Lord Prior: It is when your mother or father, suffering from two or three long-term conditions, is able to make an appointment with a GP and the GP will have all their records available, and he will have with him on Skype, or present, a specialist from the hospital at the same time. There may well be a physiotherapist or an occupational therapist, and your mother or father can go to that appointment and leave thinking, "Someone has looked at the whole of my care needs in a joined-up way. I haven't got to explain myself to three or four other people." Then you will know that we have delivered integrated care. I do not think there are many parts of the country where you can do that at the moment.

Q34 Johnny Mercer: What are the key risks in that? You talked a little bit about organisational culture at the beginning. What are the risks that you see to driving through this integrated care challenge?

Lord Prior: The key risk to me is what you touch on in the question, really. I would be careful about using the word "accountable" in this context, but there has to be accountability. It is why they are called accountable care organisations in the States. There has to be clear accountability for performance. We have to be as hard on the outcomes of these integrated care systems as we are at the moment on our foundation trusts, for example.

Q35 Johnny Mercer: Looking at, for example, arm's length bodies in the health and social care sector as a whole, what is the role of NHS England? What is its role in working alongside those partners?

Lord Prior: The primary role of NHS England is as the care and financial architect of the whole system. Bringing integrated care systems into place means changing the whole financial incentive architecture that has



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been developed over the last 25 years. It means fundamental changes to the internal market, the whole provider/commissioner split that has been developed over the last 20-odd years, so it requires a huge, very fundamental change to how we have incentives running around the system. That probably is the single biggest and most important role for NHS England over the next few years.

Q36 Johnny Mercer: What would be your specific role in that?

Lord Prior: My role as chair of NHS England will be to hold the executive management to account; it will be to second-guess what they are doing. The scope for unintended consequences to flow from changes to the financial architecture is huge. The interesting thing about the NHS is that organisations are trained to follow the money. It is counterintuitive in a sense, but actually, particularly in a cash-constrained environment, organisations follow the money and look after themselves. Everything that we have done over the last 20 years has been designed to encourage foundation trusts, for example, to look after themselves and not the system. The more they can treat, the more it makes changes in their favour. That is how it works. That whole psychology has to change.

Q37 Andrew Selous: I want to come to the five year forward view in a second, but before I do, I want to pick up on one or two things you have said. I was very pleased to hear you mention Mid Staffs and Morecambe Bay. Gosport was even worse than those two in terms of the number of people we think lost their life, and it may even have been considerably more than the numbers we heard. One of the things that concerned me at the time was that the data about excess mortality were being sent to the centre and nothing was being done about it. What is your view on that? Do you think that, with stronger knowledge at the centre about what is going on, that sort of thing could not happen again?

Lord Prior: Could it happen again? That is the question that used to keep me awake at night at the CQC. We developed there a series of data—I think we called it Insight—that could reveal real problems happening on the ground, and could be predictive in their nature so that they revealed problems before they became big problems. In reality, we found that we could not do that. You could not rely just on the data; you had to do inspections as well.

Inspections are very heavy-handed. I am being inspected at the moment at UCLH; there are 65 people on the inspection team and it seems like they have been there for weeks. It is massively time-consuming and disruptive, but we found at the CQC that there was no other way you could really get under the skin of the organisation.

Could it happen again? One hopes not. I read very carefully the case of Mr Paterson, the breast surgeon in the West Midlands who operated for many years outside any protocols that he should have used. Scores of clinicians, anaesthetists, breast-care nurses and oncologists knew about that, but did nothing about it.



Q38 **Andrew Selous:** Do you think the duty of candour would make a difference?

Lord Prior: Yes, the duty of candour will help. The freedom to speak out, guardians and all these things will help, but do I think it could never happen again? Probably somewhere in this huge healthcare and social care system, and often in a fairly isolated place, it may happen again. I do not think any system will be infallible. You have to be constantly vigilant. I go back to what I said at the beginning: the tragedy is that good people in a bad environment end up normalising bad behaviour.

Q39 **Andrew Selous:** Do you think the Health Service Safety Investigation Body will be a significant addition to the NHS armoury?

Lord Prior: It will be very significant in learning from where things went wrong, and in learning from where things went wrong it will help change the culture, but they are going to look at a relatively small number of cases in great detail. It is modelled, as you know, on the airlines, and they have a much more open culture than we do in the NHS.

Q40 **Andrew Selous:** You mentioned Tim Briggs and the getting it right first time programme—GIRFT. Tim Briggs and I knocked on doors in the Department of Health for eight years to try to get people to take up GIRFT, and there was a very strong “Not invented here” response to us. Then suddenly everyone wanted it yesterday and it is now across every medical specialism, as far as I can see, extending into primary care as well. What worries me is the fact that the centre is a bit blind to ideas that have not been thought of within the centre. Do you think you could change that mindset?

Lord Prior: I will answer that in two ways. First, the work Tim is doing is fantastic. Trying to reduce unwarranted variation across a whole range of clinical specialties is absolutely terrific—the work he has done there—so I am a huge supporter of his.

The NHS is a devolved structure. There is a limit to what you can do at the centre to mandate trusts, for example, to take up things like GIRFT, so it is not just the “Not invented here” syndrome at the centre; even when they get it in the centre, it is quite hard to get it taken up in Newcastle, Manchester and the like. We are very resistant to change in the NHS. As to how we open up the NHS, I was asked earlier where I would like the NHS to be in 10 years’ time—I would like it to be known as the great healthcare test-bed of the world, where new devices, new techniques, new drugs, new cell and gene therapies and the like would start.

Q41 **Andrew Selous:** We will look forward in a second. Looking at the five year forward view, what is your assessment of how that process has been run from the centre, and what can we learn from it as we now plan for the next 10 years?



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Lord Prior: I reread it recently to refresh my memory. Everything written five years ago is pretty much true today. It was a very perceptive, insightful document, but the clue is in the name. It was a view rather than a plan. It has taken a long time to get to where we are with the vanguards, for example, but I think enough has been done and there is evidence now to prove the case that integrated care has won the argument. Very few people will argue against integrated care, and winning the argument is incredibly important.

The next five years will be all about implementation. As a result of the engagement process that NHS England is doing between now and Christmas, some legislative changes will be required to enable integrated care to develop, and I hope your Committee will have a role in looking at them and maybe helping us get them through.

Q42 **Andrew Selous:** Our sister Committee in the House of Lords looked at the long-term sustainability of the NHS and thought there was a lack of strategic planning in NHS Improvement and NHS England. They thought that that was jeopardising achievements made within the five year forward view. Do you share that assessment and do you have ideas about trying to make sure there is proper strategic planning, which is then implemented on the ground from Newcastle to Manchester, down to Plymouth and so on?

Lord Prior: There is some truth in that. The five year forward view was a vision, if you like. It has proven to be pretty much on the button as far as I can see. It is now a question of implementing it, which is the critical thing over the next five or 10 years. Converting it into a detailed plan and implementation is critical.

Q43 **Andrew Selous:** Looking forward, we have the commitment of a very significant amount of extra money, £20 billion a year by 2023-24, and we are now planning for 10 years rather than five. How do you view that process, and what is going to be your role in making sure it delivers the best possible outcomes for patients throughout the country?

Lord Prior: The engagement process that has been kicked off, which is engaging patient groups, clinicians and the like, is fundamental. This cannot be seen to be Simon's plan. If it is Simon's plan, it will not work, not least because he may not be here in 10 years. At some point, he will leave, so it is no good having his plan if he is no longer there.

Q44 **Andrew Selous:** Picking up on that, is there enough buy-in from GPs in particular at the moment? In the summer, I was in correspondence with every single one of my GP practices, and they are really under pressure at the moment. GPs are very busy people—head down, treating patients—and do not have a lot of time to go to meetings, even the senior ones. Do you feel they have been properly involved in this 10-year planning, where we look forward to seeing the money?

Lord Prior: I will have to find out, but they need to be; if they are not, they need to be. They are a critical part of it. Primary care—the GP



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system—is fundamental to any future for the NHS. If they are not part of the engagement process, they need to be, but I have not picked that up, although I know what you mean; they are busy people.

Q45 Andrew Selous: My impression is that it has been a little bit formulaic. There has been some formal consultation, but I am not sure how much real engagement there has been, given the critical role of primary care.

Lord Prior: Primary practice today, compared with where it was five years ago, has changed quite a lot. A lot more federations have developed and there is a lot more technology being used in primary care. There are a lot more primary care facilities offering a lot more than they used to. Primary care is moving quite rapidly.

Q46 Andrew Selous: Sure. I agree with you when you say that this must not be seen as just Simon Stevens's plan. Do you think we are getting the level of outside buy-in from all the different groups in the wider health community, even the voluntary sector, which has an incredibly important role to play with social prescribing and so on? Do you think we are getting that buy-in? Do you think we are really starting to have a proper conversation?

Lord Prior: There is much more buy-in now on two counts. One is because there is some money. In a time of austerity, there was less buy-in because there was no money for transformation, effectively, and now I think there is more money, so that gets more buy-in. The second thing is that, if you think back to when, for example, STPs came out, or indeed when ACOs were mentioned, there was a feeling—

Andrew Selous: They are now ICPs, I think.

Lord Prior: They are now ICPs or ICSs, or whatever.

Andrew Selous: That means integrated care providers, for anyone listening.

Lord Prior: Or partners. It is one of the two. In any event, in the past people have not felt that they knew what was going on. For example, there was a big scare that ACOs meant Americanisation, meant privatisation. I do not think it ever did, actually. Nevertheless, if things are not done openly and transparently, those stories can run. Ditto with STPs; when they came out, there was a feeling that it was just a guise in which we could explain why we were going to shut this A&E department or that maternity ward, or whatever.

One thing I have learned over the last three or four years is that, however difficult engagement and consultation and the like is, you have to do it in the health service, otherwise nothing will get done. Of all the people who need to be really tied into this, of course, it is the clinicians—the GPs and the hospital doctors as well.

Andrew Selous: Yes, and social care too. Thank you.



Q47 Diana Johnson: I want to ask about prevention, which is obviously a key part of making sure that the additional NHS funding that is going to be made available is well spent. Public Health England is a separate body, but it is really important to you as NHS England. There have been quite a lot of cuts to the budgets for local authorities, who are responsible for public health. What is your take on the relationship between public health and what NHS England can deliver?

Lord Prior: I was asked at the beginning, and I never had a chance to finish my answer, what were the really important things over the next 10 years. Integration was one of them and then we stopped. Of the others, one was prevention and one was technology.

Prevention is absolutely fundamental. The armoury we now have on prevention is getting much greater, particularly with genomics coming on board. If we can address disease much earlier, it will save costs, apart from anything else, apart from vastly improving people's lives. Of all the arm's length bodies that NHS England needs to work with really closely, Public Health England will be absolutely up there.

Q48 Diana Johnson: What about advocating for additional funding for Public Health England?

Lord Prior: Yes. If you look at the two areas that were identified as being vitally important to the five year forward view, one was social care and the other was prevention. In both those areas, not funding them to a great enough extent has had an impact on the performance of the NHS as a whole.

Q49 Dr Williams: Going back to the discussion we were having about accountable care organisations, or integrated care providers, you have already said that you are totally committed to a taxpayer-funded NHS. Do you conceive the contracts to run these new systems being given to NHS organisations, or could you foresee that some of the contracts to run these new large-scale providers could be given to the private sector?

Lord Prior: Subject to what comes out of the engagement process, my instinct is that they should be wholly NHS and put on a statutory basis. They hold the money. This is where the NHS contract with the citizen is going to be held. If there is any question about that—I know there is an issue about whether GPs are NHS or not—I think trust in the whole process will be undermined. Again, I do not want to pre-empt what might come out of the engagement process, and I am very new to this, but my gut instinct is that it needs to be nailed at a very early stage that it is NHS.

Q50 Dr Williams: That is the view of this Committee as well. You mentioned earlier that you were a co-author of a recent IPPR report. That report recommended the setting up of integrated care trusts, as you know, and giving GPs the right to NHS employment in those trusts. I guess that would be a way round the issue of GPs being independent contractors at the moment. Is that something you share?



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Lord Prior: Yes.

Q51 **Dr Williams:** Do you think there is any legislative change that might be needed in order to set the environment for integrated care?

Lord Prior: There is a limit to what you can do with workarounds before you start to undermine the whole base of the existing legislation. The purchaser/provider split has to be addressed, and the regulatory system has to be addressed. At the moment, being responsible for UCLH, I and our team at UCLH are inevitably looking after UCLH, and we are regulated on that basis. If we give—"give" may be the wrong word—if we were to fund a lot of activity in the community for which we got no financial recompense, we would get no thanks from NHS Improvement or indeed the CQC, if it had a knock-on effect on something else that we should have been doing. That has to be addressed.

When foundation trusts came out in 2006-7, whenever it was, I was a supporter of them at the time, but they are islands in the sea now and they will carry on behaving like that as long as that is the way they are regulated and incentivised. We have to break down those barriers before they will become part of the system.

Q52 **Dr Williams:** Do you have a view, either from your experience with the foundation trust or in your new role, on the need to put things out to tender and that process? How does it help or hinder integration?

Lord Prior: There are some things that benefit from being put out to tender. NHS England recently put out a tender, for example, for CT/PET scanning. Four or five people tendered for it and they got a better deal for doing it. Clearly there are always going to be benefits from putting some things out to tender, but the requirement always to put things out to tender when something might be working extremely well is absurd.

There is also the length of the tenders. If you are setting up an ICP, it is no good setting it up for two or three years. They have to take long-term views. If you are going to invest in prevention, for example, the benefits will probably take 10 or 15 years to flow through, so we have to get used to a far greater degree of trust in the system when you are committing to people to provide a service for a long period of time. Clearly you will monitor that service, and, if it deviates significantly, you will have a difficult conversation, but the presumption should be that these contracts are on a much longer-term basis.

Q53 **Dr Williams:** What I am hearing from you is that if there is legislative change—we as a Committee want to invite contributions on that from throughout the health and social care sector—you think the issues that it needs to address are some of the splits between purchasers and providers, and the perverse incentives they encourage, and then, as you describe it, the absurd need for compulsory tender.

Lord Prior: Those would be two areas, but I am not an expert in the field. I think NHS England have made a commitment by next March to



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come back with proposals to this Committee on legislative changes, which you will probably look at before they go further. That seems to make eminent sense.

Q54 **Diana Johnson:** Do you use the NHS?

Lord Prior: Yes, regrettably, I do. I say regrettably because I do not like being ill; I had a skin cancer on my neck this summer, for example.

Diana Johnson: I am sorry to hear that.

Lord Prior: It is nothing serious.

Q55 **Diana Johnson:** I also wondered whether you had private health insurance.

Lord Prior: No, I do not.

Q56 **Diana Johnson:** You don't have private health insurance. In our briefing there was mention, I think, that in 2014 you had some surgery.

Lord Prior: Yes. I did in the past have private health insurance, but I don't any longer.

Diana Johnson: Thank you.

Chair: Does anyone have any further questions?

Q57 **Andrew Selous:** Chair, may I briefly add to Diana's questions on prevention? We have not talked about the child obesity issue. I know it is Public Health England primarily, but it has a massive impact on NHS England.

This Committee did a report on childhood obesity quite recently, and there was a lot of real anger among Committee members about how bad the situation has become. Could we hope to see you being a bit of an activist on the issue across the wider public sector? It extends into all sorts of areas and planning policy, such as the number of takeaways around schools and the behaviour of some of our big food manufacturers who do not have coloured traffic lights on the products they sell, and are really conning parents so that they do not know what sort of food they are buying and do not have proper information.

It is a really big health issue. It is not your direct responsibility, but it has a massive impact on the organisation you are hoping to chair, and a huge impact on your budget—diabetes, strokes and a whole range of issues. As Diana was saying earlier, we cannot have this issue just siloed out to Public Health England and the concern of a few local authorities. It has to be front and centre, doesn't it?

Lord Prior: Childhood obesity is the biggest single public health issue, as big as smoking and alcohol. It is absolutely fundamental. The long-term cost to the whole system is huge, quite apart from the misery to people's lives. You see takeaways just outside school playgrounds, and you see all



the giveaways in supermarkets. There has to be a very broad attack, and I am absolutely with that, yes.

Q58 Andrew Selous: Could we hope to see you perhaps standing up to some of the commercial interests? I do not know if you have seen any of Hugh Fearnley-Whittingstall's programmes over the summer. He commented on WH Smith, for instance, which he nicknamed WH Sugar. He tackled two big food producers in particular. One was Kellogg's, which I think did the right thing, and the other was Nestlé, and I am still waiting to find out what they have done. You are going to be a very prominent public figure as chair of NHS England. Could we hope to see you throwing the authority of your office behind those campaigns to get the food producers, the supermarkets and the takeaway industry to do the right thing?

Lord Prior: Definitely, yes. Obesity is the critical one. I wrote down earlier the three clinical areas that are of most interest to me, and they were cancer, mental health and childhood obesity. They are three really important areas.

Andrew Selous: Excellent. Thank you.

Chair: Thank you very much, Lord Prior. The Committee will sit in private, and we will be writing shortly.

Lord Prior: Thank you. Thank you also for not asking me about the personal issues I have had over the last four weeks, which may have been hard to resist. Thank you for not doing that.

Chair: Of course. Thank you very much, Lord Prior.