Witness Name: William Vineall

Statement No.: 3

Exhibits: 10 **[WV3/1 - WV3/10]**

Dated: 30/08/2024

THIRLWALL INQUIRY

THIRD WITNESS STATEMENT OF WILLIAM VINEALL

Introduction

1. I make this statement on behalf of the Department of Health and Social Care ("the Department") in support of the Department's written opening statement to the Thirlwall Inquiry. I am authorised to make this statement on behalf of the Department.

2. I am Director, NHS Quality, Safety and Investigations at the Department. I have held that post since 2020. Further details of my role and employment history are set out in my first witness statement to the Inquiry dated 5 April 2024 [INQ0015468].

3. Since my first witness statement to the Inquiry, a new Government was elected on July 4, 2024 and a new Secretary of State for Health and Social Care appointed.

4. Ahead of the oral hearings and in support of the Department's written opening statement, there are a number of developments by the new Government on which I wish to update the Inquiry:
    i. Review into the operational effectiveness of the Care Quality Commission ("CQC")
    ii. Independent Investigation of NHS performance
    iii. Martha's Rule
    iv. Manager regulation
    v. Duty of Candour – public servants
    vi. Medical Examiners
    vii. Information sharing between DHSC and NHS England ("NHSE")

Review into the operational effectiveness of the CQC – Dr Penny Dash

5. In May 2024, the former Government commissioned Dr Penny Dash to undertake a review into the operational effectiveness of the CQC. The review was established under the Cabinet Office public bodies review programme. The review programme was a rolling programme of reviews to evaluate the governance, accountability, efficacy and efficiency of existing arm's length bodies. The terms of reference for the CQC review were to examine the suitability of the Single Assessment Framework methodology for inspections and ratings, including for local authorities and integrated care systems **INQ0107942** [INQ].

6. In July 2024, the new Secretary of State requested that an interim report be published, which was delivered on 26 July. The interim report summarised five key findings, with corresponding recommendations **INQ0107918**]. The key findings were:
    i. Poor operational performance.
    ii. Significant challenges with the provider portal and regulatory platform.
    iii. Considerable loss of credibility within the health and care sectors due to the loss of sector expertise and wider restructuring, resulting in lost opportunities for improvement.
    iv. Concerns around the single assessment framework.
    v. Lack of clarity regarding how ratings are calculated and concerning use of the outcome of previous inspections (often several years ago) to calculate a current rating.

7. The five corresponding recommendations made in line with the findings above were:
    i. Rapidly improve operational performance.
    ii. Fix the provider portal and regulatory platform.
    iii. Rebuild expertise within the organisation and relationships with providers in order to resurrect credibility.
    iv. Review the single assessment framework to make it fit for purpose.
    v. Clarify how ratings are calculated and make the results more transparent particularly where multi-year inspections and ratings have been used.

8. Responding to the interim report, the Secretary of State recognised that it exposed serious failings, and outlined four immediate steps that the Government would take with the CQC [INQ]. Those steps are:

   i. The appointment by the CQC of Professor Sir Mike Richards to review the single assessment framework and its implementation, with an initial primary focus on its use in the NHS and independent healthcare (including primary and secondary care, mental health, community and ambulance). The findings from this initial phase will inform the approach of reviewing the single assessment framework and its implementation in other areas. This is an important step in addressing the concerns Dr Dash raises about the single assessment framework. Sir Mike is an eminent and highly regarded clinician who was the CQC's first chief inspector of hospitals.

   ii. Improving transparency in terms of how the CQC determines its ratings for health and social care providers. This will include being clearer about what evidence has been considered in reaching the ratings, as well as setting out clearly the dates of the inspections that a rating is based on. This is a first step to bring in greater transparency, but more work will be required as the CQC looks in more detail at its assessment framework.

   iii. Increasing the Department's level of oversight of the CQC, including the frequency and seniority of that oversight, to ensure that the recommendations in the interim review are acted upon. This arrangement will continue once the final report is published. The Secretary of State has requested firm assurance from the chair that effective and credible appointments are made for a permanent chief executive and chief inspectorate of healthcare.

   iv. Asking Dr Dash to undertake further work and make recommendations on how to maximise the effectiveness of all patient safety organisations. Terms of reference will be determined in due course.

9. Dr Dash's final report is due to be published in the autumn of 2024.

Independent Investigation of NHS performance – Lord Darzi

10. The Secretary of State has commissioned Lord Darzi to undertake an independent investigation of NHS performance, with the terms of reference published on 11 July 2024 [**INQ0107915**]. Lord Darzi's investigation will examine patient access to healthcare, the quality of healthcare being provided and the overall performance of the health system. The investigation will consider the available data and intelligence to provide an independent

and expert understanding of the current performance of the NHS across England and the challenges facing the healthcare system. The investigation will report in September 2024, and findings will feed into the Government's 10 year plan for health.

Martha's Rule

11. The introduction of Martha's Rule in the NHS in 2024-25 is taking place through a phased approach. Adult and paediatric acute provider sites that offer 24/7 critical care outreach capability were asked to formally register an expression of interest in being part of the first phase with NHSE. The first phase introduction of Martha's Rule began implementation in April 2024 at 143 provider sites. This initial phase will inform the development of wider national policy proposals for Martha's Rule [INQ0107943 **(Exhibit WV3/3)].**

Manager regulation

12. In the light of the events at the Countess of Chester Hospital, there has been a renewed focus on whether additional measures are required to enhance the accountability of senior managers and whether extending regulation to senior managers would be an effective means of ensuring patient safety.

13. The new Government has committed in its manifesto to introducing professional standards for, and regulation of, NHS manager[**INQ0107944**].

14. Detailed work will be required to determine the most appropriate and effective means of regulating senior NHS managers, but options that have been suggested previously are set out in my first witness statement [INQ0015468] at paragraph 253.

Duty of Candour – public servants

15. The King's Speech in July 2024 announced the Government's intention to legislate to introduce a duty of candour for public servants to promote a more open and accountable culture (sometimes referred to as a "Hillsborough Law") [**INQ0107945**]. Further information on this will be available in due course.

Medical Examiners

16. In my previous witness statement, I set out progress made so far for introducing medical examiners on a non-statutory footing **[INQ0015468**]. Since then, Regulations introducing changes to the death certification process were laid before Parliament on 15 April 2024

[INQ0107946]. These regulations will come into force on 9 September 2024 alongside the publication of relevant guidance [INQ0107947 / [INQ0107948] / [INQ0107949]]. The introduction of medical examiners is part of a broader process of reform to the death certification, registration and coronial processes in England and Wales. Under these reforms, all deaths will become legally subject to either a medical examiner's scrutiny or a coroner's investigation.

Information sharing between DHSC and NHSE

17. It is the Government's policy that NHSE and the DHSC's working relationships should be closer to promote greater information sharing.

18. DHSC and NHSE officials continue to work together to identify opportunities to ensure critical information flows to the Department and to Ministers work as effectively as possible. Over the last 18 months, NHSE has strengthened and matured system structures that support escalation of operational and strategic issues. NHSE is currently consulting on a new 'NHS Oversight and Assessment Framework' which describes their revised approach to the oversight of ICBs and Trusts [INQ INQ0107923]. The framework sets out the processes by which ICBs and providers will be held to account for delivering high-quality care for patients and how NHSE will identify and diagnose problems, with necessary support or intervention provided to address challenges. Where a system or provider is in NHSE's Recovery Support Programme, NHSE and DHSC have regular discussions on the challenges and improvement support being provided.

Statement of Truth

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Signed: Personal Data

Dated: 30/08/2024