

Witness Name: William Vineall
Statement No.: 6
Exhibits: 7
Dated: 17 April 2025

THIRLWALL INQUIRY

SIXTH WITNESS STATEMENT OF WILLIAM VINEALL

I, William Vineall, Director of NHS Quality, Safety and Investigations at the Department of Health and Social Care, 39 Victoria Street, London SW1H 0EH will say as follows:-

1. I make this statement on behalf of the Department of Health and Social Care (“the Department”) in response to a Rule 9 request dated 31 March 2025. 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. Within this statement I provide:
 - a. A response to a request pursuant to Rule 9 for information arising from a decision taken by the North Central London Integrated Care Board and NHS England London region Specialised Commissioning to consolidate the maternity and neonatal services in North Central London into four sites and eventually close the maternity and neonatal units at the Royal Free Hospital. In preparing this statement, the Department has, with the Chair’s consent, shared the Rule 9 request with NHS England.
 - b. Further information about the use of BadgerNet by Trusts and the interoperability of the systems used.
 - c. Clarification of the arrangements which should be made by the Inquiry in light of the recent announcement that NHS England is to be abolished.

Response to the Rule 9 request of 31 March 2025

4. The Inquiry has referred to a decision by North Central London Integrated Care Board and NHS England London region Specialised Commissioning to consolidate the maternity and neonatal services in North Central London into four sites and eventually close the maternity and neonatal units at the Royal Free Hospital. This was described in a press release by NHS England on 25 March 2025 (exhibit **WV/2**). The Department is asked a series of questions arising from this. INQ0108956

5. The Department and NHS England have shared but distinct legal responsibilities in relation to service change and therefore a collaborative approach has been adopted by the Department and NHS England in responding to the Inquiry's request. NHS England remains the responsible statutory body for specialised commissioning (including neonatal critical care services) and also provides assurance and oversight of service change including for live cases. As such, and with the Inquiry's consent, the Department has shared the Rule 9 request with NHS England who have assisted in providing considerable information used within this statement. I have therefore relied upon Department officials and NHS England input to provide this response.

6. Following the introduction of the purchaser/provider split in 1991, and the subsequent establishment of Primary Care Trusts in 2002 as the local responsible body for all NHS commissioning (with this later being led by Clinical Commissioning Groups and NHS England, and now Integrated Care Boards ("ICBs") and NHS England), there has been a long-established split between operational decision-making in relation to service change and scrutiny and oversight, with Secretary of State as the ultimate arbiter of a reconfiguration.

7. This split in responsibilities remains in place today and is reflected in the statutory framework. Under the National Health Service Act 2006 ("NHS Act 2006"), NHS England exercises more than one function, such as:
 - a. a commissioner of healthcare services (the capacity in which NHS England was involved in relation to the Royal Free decision);
 - b. the assurance body in relation to ICBs; and
 - c. preparation and dissemination of national guidance to the healthcare system to support and improve the quality of service change and share best practice.

8. The Secretary of State has largely remained removed from day-to-day management and decision-making on service change, as the reconfiguration of services is a matter for the

relevant NHS organisations. The current legislation, however, retains the Secretary of State as ultimate arbiter and provides a framework through which the Secretary of State can become involved through a decision to call-in a reconfiguration proposal. There is no time limit as to when a call-in request can be made, but once the Secretary of State has decided to call-in a reconfiguration, he must make a decision within 6 months and indeed it can be exercised so as to re-take a decision already made.

9. The Secretary of State can choose to seek additional expert advice in relation to NHS reconfigurations from the Independent Reconfiguration Panel (IRP). The IRP is an advisory non-departmental public body sponsored by the Department. The role of the IRP is to provide independent advice to Ministers on matters relating to reconfigurations and changes to NHS services in England. The IRP chair is supported by a panel of up to 15 members made up of senior clinicians, NHS managers and lay representatives. Their role includes providing impartial, expert and clinical advice to help the Secretary of State to determine whether to use the call-in power and provide advice on any called-in NHS reconfiguration proposals.
10. Informal advice continues to be available to any interested party from the IRP, who will support anyone, to determine if a call-in request is appropriate or to seek support to resolve issues with a proposal locally. This informal service is managed by the IRP Chair, Chief Executive and the secretariat in the Department.
11. The Inquiry is asked to note that the North Central London service change remains a live case and through the respective functions of NHS England and the Department, either body may make subsequent decisions on it. The provision of this statement does not fetter the discretion of either body to make such decisions.

DHSC's (or NHS England's) policy on the closure and/or consolidation of maternity and/or neonatal units

12. The reconfiguration of services, including for example, the closure and/or consolidation of maternity and/or neonatal units is a local decision that should be informed by clinical best practice following appropriate engagement with patients and stakeholders. All service changes should be based on clear evidence that they will deliver better outcomes for patients.
13. Responsibility for the delivery, implementation and funding decisions for services ultimately rests with the appropriate NHS commissioning body. Substantial planned

service change should be subject to a full public consultation and meet the Government and NHS England's 'tests' to ensure good decision-making.

14. The Government's four tests of service change are:
 - a. Strong public and patient engagement.
 - b. Consistency with current and prospective need for patient choice.
 - c. Clear, clinical evidence base.
 - d. Support for proposals from clinical commissioners.

15. NHS England introduced a new test applicable from 1 April 2017, which means that hospital bed closures arising from proposed major service reconfigurations will in future only be supported where a new test is met that ensures patients will continue to receive high-quality care.

16. The Department introduced new statutory powers on 31 January 2024 giving the Secretary of State increased oversight and powers to intervene in reconfigurations. There is a high bar for the use of these powers. Further information is set out within the statutory guidance 'Reconfiguring NHS services – ministerial intervention powers' (exhibit **WV/3**) **INQ0108957**

NHS England assurance role

17. Prior to public involvement and consultation, NHS England will assure proposals for substantial service change (see NHS England's 'Planning, assuring and delivering service change for patients' guidance (exhibits **WV/4** and **WV/5**)). NHS England has a role both to support and assure the development of proposals by commissioners. Assurance will be applied proportionately to the scale of the change being proposed, with the level of assurance tailored to the service change. **INQ0108958**
INQ0108959

18. For any service change requiring public involvement and consultation which also requires capital funding, NHS England will assess any proposals to provide assurance that they do not require an unsustainable level of capital expenditure and that they will be affordable in revenue terms.

Consultation with the local authority

19. Regulation 23 of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 ("the LA Regulations 2013") specifies that where a commissioner is considering a proposal for substantial development or substantial

variation of the health service in the area of a local authority (“LA”) they must consult with the LA, provide the LA with the proposed date by which they intend to make a decision, the date by which the LA can make any comments, inform the LA of any changes to the dates, and publish the dates.

20. Consultation requirements do not apply where the commissioner is satisfied that a decision needs to be taken without allowing time for consultation because of a risk to safety or welfare of patients or staff, however the commissioner must notify the LA of the decision taken and the reason why no consultation has taken place.
21. If a LA makes recommendations to the commissioner and the commissioner disagrees, the commissioner must notify the LA that they disagree, and the commissioner and the LA must take steps as reasonably practicable to reach agreement.

Consultation with the public

22. Public involvement and consultation duties are set out in section 13Q of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) for NHS England and section 14Z45 for ICBs. All NHS commissioners must make arrangements for people who receive the services to be involved (whether) by being consulted or provided with information or in other ways in planning, developing and considering proposals and decisions affecting operation of the service. NHS Trusts and NHS Foundation Trusts have similar duties under section 242 of the NHS Act 2006.

Notifying Secretary of State

23. Under Schedule 10A of the NHS Act 2006 (in relation to intervention powers in relation to the reconfiguration of NHS services), if an NHS commissioning body proposes a notifiable reconfiguration it must notify the Secretary of State. A notifiable reconfiguration is defined in Regulation 2 of the National Health Service (Notifiable Reconfigurations and Transitional Provision) Regulations 2024. A reconfiguration is notifiable where the nature of the proposal means the commissioner is obliged to consult with a local authority under Regulation 23 of the LA Regulations 2013.

Reconfiguring NHS services – ministerial intervention powers

24. The Health and Care Act 2022 included new powers in the NHS Act 2006, giving the Secretary of State increased oversight of, and earlier Ministerial involvement in, the reconfiguration of NHS services. These powers were commenced on 31 January 2024.

The Department published statutory guidance on the new powers on 9 January 2024 setting out how call-in requests will be considered (exhibit **WV/3**). **INQ0108957**

25. Under Schedule 10A of the NHS Act 2006, the Secretary of State can give an NHS commissioning body a direction 'calling in' any proposal by the body for the reconfiguration of NHS services. This allows the Secretary of State to intervene in NHS service reconfigurations at any stage where a proposal exists and take or re-take any decision that could have been taken by the NHS commissioning body within 6 months. The decision to call-in a reconfiguration would take into account clinical evidence including seeking advice from the IRP where appropriate.
26. Anyone can request that the Secretary of State calls in a proposed reconfiguration, but the Secretary of State is not obliged to act on them.
27. In circumstances where the Secretary of State has decided to call-in a proposal, Schedule 10A of the NHS Act 2006 specifies:
 - a. the NHS commissioning body can make representations regarding the Secretary of State direction calling in the proposal.
 - b. the NHS commissioning body must not take further steps in relation to the proposal except to the extent the direction allows.
 - c. the NHS commissioning body must, once notified, give effect to any decision of the Secretary of State in relation to the proposal.
28. All NHS commissioners, NHS Trusts and NHS Foundation Trusts must give the Secretary of State any information or other assistance that the Secretary of State requires it to give for the purposes of carrying out any functions under the Secretary of State's intervention powers in relation to the reconfiguration of NHS services. This would include consideration of any clinical evidence base in relation to the proposal as appropriate.
29. By Schedule 10A to the NHS Act 2006, NHS commissioning bodies, NHS Trusts and NHS Foundation Trusts must have regard to any guidance the Secretary of State publishes for NHS commissioning bodies, NHS Trusts and NHS Foundation Trusts about:
 - a. the exercise of their functions under the Secretary of State's intervention powers in relation to the reconfiguration of NHS services; and

- b. how the Secretary of State proposes to exercise the Secretary of State's functions under the Secretary of State's intervention powers in relation to the reconfiguration of NHS services.
30. NHS England has provided a separate and full response to the Inquiry's Rule 9 questions as it is currently responsible for assuring NHS service changes, including for live cases. NHS England's response is set out in an annex to this statement. The response from NHS England explains in greater detail its role in the North Central London service change and is presented as a separate annex to make clear the distinct but complementary responsibilities of the Department and NHS England (exhibit **WV/1**).

INQ0108955

BadgerNet

31. Frontline digitisation of the NHS is a Government priority with well documented benefits. However, the NHS does not mandate which Electronic Patient Records ("EPR") supplier Trusts should procure.
32. BadgerNet Neonatal (owned by System C) is the market leader for neonatal data services and has been well embedded in neonatal services over a long period of time. BadgerNet Neonatal is used for direct patient care (primary data) as well as a number of key data flows (secondary data) which, via the System C spine, provides the data for the National Neonatal Audit Programme.
33. There are other neonatal EPR providers procured by a minority of Trusts for use within neonatal units which has resulted in data interoperability issues in relation to secondary data collection via the System C spine. In short, data from non-BadgerNet systems cannot flow/transfer directly to the System C spine where it is then extracted for the National Neonatal Audit Programme.
34. System C currently has in place a short-term work around that allows data to be sent from non-BadgerNet sites into the System C Spine for national reporting purposes, this includes an element of manual data entry. System C is developing an application programming interface ("API") (which is sometimes referred to as 'a patch'). This would allow the other neonatal EPR providers to submit data for the secondary data collection. For the solution to work, the relevant Trusts would need to commit to submitting data via this new route and purchase the API from System C.

35. There are also data interoperability issues between BadgerNet Neonatal and wider EPR systems regarding primary data collection. There is a specialist neonatal data working group led by Dr Ngozi Edi-Osagie currently considering Neonatal data issues.
36. To deliver interoperability between systems, the Government has introduced regulations to Parliament which will commence section 95 of the Health and Care Act 2022. This will establish the process for preparing and publishing information standards, which will be mandatory for public and private health and adult social care providers.
37. The current Data (Use and Access) Bill will in addition make information standards mandatory for the IT suppliers in the health and care system and provide enforcement powers for promoting compliance.
38. These measures will provide the framework for future interoperability between IT systems by creating a legal framework for mandating adherence to common standards, allowing for information to be shared in real time between organisations that use different systems.

Handling of recommendations

39. Following the Prime Minister's announcement of the abolition of NHS England on 13 March 2025 the Chair has requested clarity on where responsibility would lie for recommendations directed to NHS England once it is abolished. As set out in our oral closing submissions, the Department, with NHS England, has considered the status of any recommendations that may be directed to NHS England and the appropriate way forward would be for any recommendations which the Chair may wish to address to NHS England, as currently constituted, also to be addressed to the Department. NHS England will then take forward any such recommendations during the period in which it remains in existence, with responsibility for any outstanding work then passing to the Department, as co-recipient. This will ensure that there is no ambiguity, or shortfall, in accountability if there is work that remains to be done in respect of any of your recommendations after NHS England ceases to exist.
40. As the Sponsoring Minister, the Secretary of State will receive the Inquiry's report and will have responsibility, through the Department, for overseeing all its recommendations, regardless of their assignation, in the usual established way. The delivery of those recommendations specifically assigned to NHS England will additionally fall to the

Department given the abolition of NHS England. I am the Department's Senior Responsible Officer for the implementation of the Inquiry's recommendations.

41. The merger of the Department and NHS England remains at an early stage and we will provide further updates with respect to recommendations of inquiries relevant to the Department/NHS England as and when new information is available.

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: 17.04.2025