Lancashire and South Cumbria Integrated Care Board

Integrated Care Board

Date of meeting	5 November 2026
Title of paper	Thirlwall Inquiry – Board consideration
Presented by	Jane Scattergood, Interim Chief Nurse
Author	Margaret Williams, Interim Deputy Chief Nurse
Agenda item	9
Confidential	No

Executive summary

As we set out the ICB Board consideration of the Thirlwall inquiry our thoughts remain with the families affected, who have experienced unimaginable loss and pain, and an NHS that repeatedly failed them. The care, safety, and safeguarding of all patients is the principal duty of all of us, and this is why we must all act with the urgency, curiosity, and openness to ensure that the learning from this Inquiry is translated into clear action.

The Thirlwall Inquiry published 15th September 2026 has significant implications for NHS leadership, safeguarding and governance beyond neonatal services. Upon publication the Chief Nursing Officer for England and Chief Operating Officer for NHSE have asked every NHS Trust and ICB Board to consider the Inquiry findings.

The central question posed is “Can the Board be assured that, if similar warning signs arose within ICB-commissioned services, they would be recognised, connected, escalated and acted upon early enough to prevent harm?”

The primary ICB Board requirement is to consider whether the wider failures in safeguarding, professional curiosity, speaking up, escalation, leadership and governance could occur elsewhere within the system, and whether current ICB assurance arrangements would identify and respond to warning signs early enough.

This sits alongside specific Inquiry recommendations and actions requiring delivery by relevant Providers. Assurance will be sought by the ICB’s quality assurance architecture for commissioned Providers and reported through the ICB Quality Outcomes Committee.

Public and Stakeholder Engagement

Work is underway to redesign the Maternity and Neonatal Voice Partnership model working with People First with the aim to improve how we hear experiences from women and families across Lancashire and South Cumbria.

Recommendations

The ICB Board is asked to:

1. Note the findings and recommendations arising from the Thirlwall Inquiry and recognise the relevance of the wider learning beyond maternity and neonatal services.
2. Endorse the proposed Lancashire and South Cumbria ICB and system assurance oversight framework, recognising that the approach will continue to develop and mature.
3. Support the ICB, in its role as strategic commissioner, in obtaining proportionate provider assurance in relation to:
    a. organisational culture and speaking up;
    b. safeguarding governance and escalation;
    c. application of the Insightful Provider Board framework;
    d. implementation of the National Bereavement Care Pathway;
    e. compliance with the Getting it right first time (GIRFT) Neonatology Guide to Safe Insulin Use; and
    f. Sudden unexpected death in childhood (SUDIC) arrangements.
4. Endorse the application of the wider learning across ICB governance and assurance arrangements, including Board and committee development, safeguarding assurance and quality surveillance, with particular consideration given to services caring for children and vulnerable people.

Which Strategic Objective/s does the report relate to:		Tick
SO1	To improve population health and reduce inequalities through effective strategic commissioning.	✓
SO2	Commission high quality, safe and accessible services that deliver better and more equitable outcomes and patient experience.	✓
SO3	To develop and sustain the workforce, leadership and organisational capability required to operate as an effective strategic commissioner.	✓
SO4	Improved financial sustainability through directing available resources to deliver the greatest possible value.	✓
SO5	To deliver agreed national and local outcomes through a balanced focus on performance, improvement and long-term system resilience.	✓

Implications

	Yes	No	N/A	Comments
Associated risks	✓			
Are associated risks detailed on the ICB Risk Register?		✓		
Financial Implications	✓			Potentially for providers which may require ICB commissioning consideration

Where paper has been discussed (list other committees/forums that have discussed this paper)

Meeting	Date	Outcomes
ICB Quality and Outcomes Committee	28 October 2026	Received, discussed, endorsed approach to Quality Governance and Assurance.

		Paper to be presented to (dates to be confirmed): - Child Death overview panels - All Children Safeguarding Partnership Boards - Medicines Optimisation System Group.

Conflicts of interest associated with this report
Nil to note at time of writing.

Impact assessments				
	Yes	**No**	**N/A**	**Comments**
Quality impact assessment completed		✓		
Equality impact assessment completed		✓		
Data privacy impact assessment completed		✓		

Report authorised by:	Jane Scattergood, Interim Chief Nurse

Integrated Care Board – 5 November 2026

Thirlwall Inquiry – Board Consideration

1. Introduction

1.1 The Thirlwall Inquiry, chaired by Lady Justice Thirlwall, examined events at the Countess of Chester Hospital between 2015 and 2018 and the response of the Trust and wider health system to an unexplained increase in neonatal deaths and concerns that babies may have been deliberately harmed. It published a report on 15th September 2026 (appendix 1).

1.2 This paper aims to support the Board to review the recommendations and appraise the actions required. This sits alongside specific Inquiry recommendations and actions requiring delivery by relevant providers and assurance that will be monitored via ICB Quality and Outcomes Committee. A paper was received and discussed at ICB Quality and Outcomes Committee on the 28th October 2026, with plans to discuss at Child Death Overview Panels, Adult and Children Safeguarding Partnership Boards and the Integrated Medicines Optimisation Committee.

1.3 The recommendations of Thirlwall are stated at appendix 1, these have been summarised and grouped to support presentation of this paper and Board consideration.

1.4 The central question asked is “can the Board be assured that, if similar warning signs arose within ICB-commissioned services, they would be recognised, connected, escalated and acted upon early enough to prevent harm?”

1.5 The Board is asked to consider whether the wider failures in safeguarding, professional curiosity, speaking up, escalation, leadership and governance could occur elsewhere within the system, and whether current ICB assurance arrangements would identify and respond to warning signs early enough.

2. System-wide expectations for the ICB Board

2.1 ***Board leadership and assurance***
Ask: Reflect on whether Board and committee discussions consistently demonstrate curiosity, constructive challenge, openness to dissenting views and a willingness to seek additional or independent assurance where evidence is incomplete.
Current position and evidence: The ICB has established governance and assurance arrangements. Thirlwall provides an opportunity to test whether these arrangements consistently enable sufficient curiosity, constructive challenge, and escalation where assurance is incomplete or conflicting.

Proposed ICB approach: Use the actions required by the Inquiry findings to test the quality of Board and committee debate, the balance between compliance and impact, and whether additional or independent assurance is sought where evidence is incomplete or conflicting.
Next steps: Build into Board and committee development activity. Self-assessment against recognised benchmarks.

2.2 ***Strengthening collective intelligence***

Ask: Bring together information from mortality reviews, safeguarding, patient safety incidents, complaints, Freedom to Speak Up, workforce indicators, coronial processes and correspondence, medical examiners products, Child Death Overview Panels (CDOP), and the experiences of women and families to identify patterns and themes that may not be visible through a single reporting route.
Current position and evidence: Maternity and Neonatal Voice Partnership feedback provides a source of lived-experience insight. The ICB quality governance and assurance oversight structures at appendix 2 visually demonstrate the connected formal and informal points across the organisation, providers, partners and networks.
Key themes currently identified: The Maternity and Neonatal Voices Partnership have undertaken an annual review with family feedback predominantly positive this is a key source of intelligence for the ICB. The ICB operating model with be a driver to refresh and review current arrangements. Quality governance and assurance structures are in place.
Next Steps: Implementation of the target operating model and review of quality governance assurance framework, folding in National Quality Board guidance on quality assurance and improvement, sequentially as that guidance is released. Test our thinking and implementation with regulators such as NHS England. Benchmark our framework and implementation with other ICBs and seek feedback.

2.3 ***Learning from challenge and escalation***

Ask: Examine whether staff, clinical leaders, patients and families understand how to raise concerns, whether concerns are heard and acted upon, and whether escalation routes remain effective where there is professional disagreement or uncertainty.
Current position and evidence: The Inquiry reinforces that patient safety must remain the overriding priority and that organisations should act on concerns and suspicion rather than wait for certainty, particularly where deliberate harm may be possible.
Areas for assurance: Freedom to Speak Up arrangements; safeguarding escalation; professional curiosity; clinical and reflective supervision; routes for clinical disagreement are in place with evidence of processes in action.
Next step: Continue to build matrix working approaches, culture of openness and connectivity. Continue to ensure review of safety intelligence, audit findings, learning from cases and independent challenge. Raise awareness of Safeguarding, Freedom to Speak Up, complaints processes.

2.4 ***Listening to families***

Ask: Use the redesign of the Maternity and Neonatal Voice Partnership arrangements to strengthen how the experiences of women and families inform commissioning, oversight and improvement.

Current position and evidence: The ICB works with People First to support independent maternity and neonatal voices. Feedback indicates that families value kind, respectful care and involvement in decisions, but experience is diminished by inconsistent communication, unclear care plans, limited updates, accessibility barriers and practical issues for partners.

Proposed ICB approach: Ensure family experience is routinely triangulated with incidents, complaints, safeguarding, mortality, coronial correspondence, workforce and speaking-up intelligence, with clear feedback to communities on what has changed as a result.

Next Step: Continue to strengthen Maternity Neonatal Voices Partnership Mode (and other ICB engagement, listening fora), note representation and inclusion arrangements, measure impact of improvement action and approach to closing the feedback loop for commissioning improved outcomes and experience.

2.5 ***Embedding wider organisational learning***

Ask: Apply the learning beyond maternity and neonatal services, and incorporate it into Board development, committee-effectiveness reviews, safeguarding assurance and quality-surveillance activity.

Current position and evidence: The Inquiry highlights wider themes of culture, governance, safeguarding, escalation, professional curiosity, speaking up and Board assurance. These themes are relevant across NHS-funded services, not only maternity and neonatal care.

Proposed areas of application: Continue to develop the ICB approach to Inquiry learning across Board and committee effectiveness, safeguarding and quality assurance, professional curiosity and escalation, Freedom to Speak Up, workforce culture, patient and family voice, and the triangulation of quality, safety and safeguarding intelligence.

Next Steps: Undertake a systematic review of the wider Inquiry learning against existing ICB governance, safeguarding and quality-surveillance arrangements; identify any gaps in oversight, escalation and assurance; incorporate relevant learning into Board and committee development and effectiveness reviews; and establish appropriate mechanisms for embedding and monitoring the learning across commissioned services.

3.0 Provider requirements requiring ICB oversight and Assurance

3.1 For the ICB, as strategic commissioner, the priority is to obtain appropriate assurance that Providers have considered the Inquiry findings, assessed the relevance to their organisations and services, and taken appropriate action where required. This should be supported through existing safeguarding, quality surveillance and Provider assurance arrangements, with escalation through established governance routes where gaps or concerns are identified.

3.2 The ICB Quality and Outcomes Committee will oversee and gain assurance of provider implementation of the Thirlwall recommendations. A paper was

received and reviewed at the meeting 28th October 2026, with the approach to the quality governance assurance oversight being reviewed, considered and endorsed.

3.3 The current ICB quality governance assurance framework (appendix 2) links organisations, partnerships and networks, professionals and voices that support the collective approach to information sharing, intelligence, engagement and points of escalation.

4.0 Specific provider requirements

4.1 ***Leadership, Culture and Speaking Up***
Providers have effective arrangements which enable staff to raise concerns, challenge practice and escalate risks without fear of detriment, and that Boards actively review intelligence from Freedom to Speak Up, safeguarding, incidents, complaints and workforce indicators.

4.2 ***Safeguarding governance***
Safeguarding is given appropriate prominence within Provider governance structures. Safeguarding training compliance is maintained and referenced in contracts of employment and staff understand how and when concerns should be escalated.

4.3 ***Insightful Provider Board Framework***
NHS England specifically references the Insightful Provider Board guidance and expects provider boards to ensure they receive, triangulate and use safety, quality, safeguarding, mortality, workforce and speaking-up information effectively. The Board should seek Provider self-assessment against the framework and evidence of actions arising. NHS England » The insightful provider board

4.4 ***National bereavement care pathway***
Maternity and neonatal providers are implementing the National Bereavement Care Pathway and providing compassionate, consistent support to families experiencing stillbirth, neonatal death or pregnancy loss, as required through national planning guidance. NBCP England | Sands

4.5 ***GIRFT Guide to safe insulin use in neonatal services***
Relevant providers gain assurance regarding implementation of the GIRFT (Getting it Right First Time) Neonatology Guide to Safe Insulin Use, including access controls, storage requirements and associated security measures within the timescales mandated by NHS England. GIRFT-guide-to-safe-insulin-use-in-neonatal-services-FINAL-January-2026.pdf

4.6 ***SUDIC compliance***
Providers with neonatal services have reinforced awareness and compliance with the Sudden Unexpected Death in Childhood (SUDIC) process and have communicated requirements to all relevant clinical staff and Boards

5. Conclusion

5.1 The Thirlwall Inquiry provides significant learning for the NHS that extends beyond maternity and neonatal services. The findings reinforce the importance of effective leadership and governance, a culture in which concerns are heard and acted upon, strong safeguarding arrangements, professional curiosity, effective escalation and the ability of Boards to triangulate intelligence to identify emerging risks.

5.2 Obtaining assurance that Providers have considered the Inquiry findings, taken appropriate action and can evidence effective governance, with concerns escalated, will be through established quality and safeguarding arrangements with ICB Quality and Outcomes Committee oversight and assurance.

5.3 The wider learning should also inform the ICB's own Board and committee development, safeguarding assurance and quality-surveillance arrangements, ensuring that intelligence from patients and families, staff, safeguarding, incidents, complaints and workforce information is considered collectively and that emerging concerns and themes are recognised and acted upon.

6. Recommendations

The ICB Board is asked to:

1. Note the findings and recommendations arising from the Thirlwall Inquiry and recognise the relevance of the wider learning beyond maternity and neonatal services.
2. Endorse the proposed Lancashire and South Cumbria ICB and system assurance oversight framework, recognising that the approach will continue to develop and mature.
3. Support the ICB, in its role as strategic commissioner, in obtaining proportionate provider assurance in relation to:
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    c. application of the Insightful Provider Board framework;
    d. implementation of the National Bereavement Care Pathway;
    e. compliance with the GIRFT Neonatology Guide to Safe Insulin Use; and
    f. SUDIC arrangements.
4. Endorse the application of the wider learning across ICB governance and assurance arrangements, including Board and committee development, safeguarding assurance and quality surveillance, with particular consideration given to services caring for children and vulnerable people.

Margaret Williams

29 October 2026