Agenda item 10

NHS Coventry & Warwickshire ICB
NHS Herefordshire & Worcestershire ICB
Boards 'Meeting in Common'

Wednesday, 18th November 2026 9:30am
held virtually via MS Teams

The Thirlwall Inquiry findings, implications & system quality assurance

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Purpose of paper	☐	Approval	☒	Assurance
	☒	Endorsement	☐	Discussion
	☐	Decision	☒	Information/noting
ICB Applicable:	☒	C&W ICB	☒	H&W ICB
Recommendations	The Boards of NHS Coventry and Warwickshire ICB and NHS Herefordshire and Worcestershire ICB are asked to: • Note the Thirlwall findings and NHS England's expectation that each Trust and ICB Board considers them at its next available public meeting. • Endorse an immediate, risk based assurance exercise for neonatal, maternity, paediatric and safeguarding services, including evidence of actions already due and explicit escalation of any unresolved safety risk, including: o A single Cluster wide inquiry-learning assurance matrix encompassing Thirlwall, Amos and Ockenden, distinguishing direct provider obligations, national actions and ICB commissioning/oversight functions. o Validated exception report through the relevant quality committee to an agreed delivery timetable, with a named owner, timeframe, risk rating and evidence of improvement for each gap. o Family experience, equality, staff speaking-up intelligence, mortality and safeguarding information being triangulated in provider oversight, and not treated as disconnected reports. o Material concerns to be escalated without waiting for a scheduled committee cycle, including to NHS England and statutory safeguarding partners where appropriate.			

Executive Summary

Following the completion of the Thirlwall Inquiry, the Boards are asked to review current assurance processes. Mortality surveillance, safeguarding and provider oversight provide routes to identify and review concerns. Evidence still needs to be checked across the Cluster for the September Sudden Unexpected Death in Infancy and Childhood (SUDIC) communication, neonatal insulin CCTV readiness by 30th November, and safeguarding training and competence.

The Boards are asked to endorse a staged assurance plan and a single Cluster matrix, with a first exception report proposed through the Integrated Quality, Performance & Assurance Committee (IQPAC) in December 2026.

Purpose

The purpose of the report is to present the findings of the Thirlwall Inquiry (15 September 2026), the requirements of NHS England's letter of 21 September 2026, and the implications for the two ICBs' commissioning, safeguarding and system quality leadership responsibilities.

The report sets out an initial, evidence led local response, drawing together the recurring lessons of the Baroness Amos National Maternity and Neonatal Investigation (June 2026), the Ockenden reviews (Shrewsbury and Telford 2022; Nottingham 2026), and Thirlwall. The comparisons are thematic; they do not imply that the reviews have interchangeable recommendations or scopes.

Included within the report are the assurances the ICBs will obtain. It does not claim that individual providers or the ICBs have met requirements before evidence has been reviewed.

Background and National Context

The Thirlwall Inquiry examined events at the Countess of Chester Hospital between 2015 and 2018. It identified serious failures of management, governance and safeguarding, including failures to respond to clinicians' concerns about babies' safety. Its 17 recommendations span surveillance, insulin security, deliberate harm safeguarding, mortality monitoring, bereavement care, accountability, inspection and the auditing of implementation.

NHS England's letter of 21 September 2026 asks Trust and ICB Boards to consider whether similar events could occur locally and whether babies and children are protected in every setting. Immediate actions concern safeguarding training, communication that SUDIC processes apply to babies who have never left hospital, bereavement care and neonatal insulin security. The principal dates are set out in Appendix A.

Thirlwall makes clear that safeguarding action on concerns about possible deliberate harm does not require certainty of guilt. The ICB assurance response will test the timeliness of protective action, professional challenge, escalation and information sharing, as well as the operation of policies and reporting structures.

Relationship with Amos and Ockenden

On 15th July 2026 the Boards considered the Nottingham Ockenden review and the Baroness Amos investigation. This report builds on that work by adding specific tests of whether concerns about possible deliberate harm led to timely protective action, neonatal insulin is secure, and SUDIC is understood and applied when a baby has never left hospital.

The Amos investigation addresses national leadership and standards, family voice, investigations, inequalities and racism, governance, culture, infrastructure and digital systems. Ockenden's reviews address the clinical and organisational determinants of maternity safety, including workforce, multidisciplinary practice, surveillance, learning and engagement with families.

The common concern is whether warnings and learning translate into effective action. Thirlwall's deliberate harm and safeguarding requirements, Amos's explicit focus on racism and inequalities, and Ockenden's clinical safety requirements each need a distinct line of assurance. A common matrix will coordinate the response while preserving these differences and the responsibilities of national bodies, providers and the ICBs.

Implications for the ICBs

Providers are accountable for operational safety, implementation, investigation and corrective action. The ICBs commission safe and equitable services, bring quality intelligence together across organisational boundaries, test evidence, challenge gaps and escalate unresolved risk. NHS England leads national actions and regional oversight.

Shared and distinctive learning from the inquiries

The comparison below is thematic. The table identifies the evidence the ICBs will seek without suggesting that the inquiries have identical scopes or recommendations.

Theme	Thirlwall	Amos / Ockenden	ICB assurance test
Listening and challenge	Concerns about possible deliberate harm require prompt safeguarding and protective action.	Amos: women/families' voices as safety intelligence; Ockenden: listen to families and staff, timely investigations.	The ICBs will trace a sample of concerns from first report through escalation, action and feedback.
Monitoring harm	Board-level death monitoring, MBRRACE reporting, SUDIC, medical examiner input and clear escalation.	Amos: real-time safety data; Ockenden: clinical outcome review and investigation learning.	The ICBs will demonstrate how mortality, incidents, complaints and workforce intelligence are considered together.
Governance and accountability	Board visibility, managerial accountability, external challenge and implementation audit.	Amos: clarified oversight and national standards; Ockenden: executive and clinical accountability for maternity safety.	The ICBs will seek recorded challenge, decisions, accountable owners and evidence of effective action.
Culture and equality	Professional challenge and action on suspicions of deliberate harm.	Amos: anti-racism/discrimination as critical safety matters; Ockenden: multidisciplinary teamworking and safe culture.	The ICBs will consider staff voice, Freedom to Speak Up, discrimination and differential outcomes together.
Clinical and operational safety	Insulin security, monitoring, safeguarding and bereavement pathways.	Amos: safe triage, estates and digital, equitable pathways; Ockenden: safe staffing, escalation, training and neonatal networks.	The ICBs will validate provider-specific actions, delivery dates and residual risks.