Witness Name: Tom Bell
Statement No: One
Exhibits: Three (TACB/1, TACB/2 & TACB/3)
Dated: 15th April 2024

THIRLWALL INQUIRY

WITNESS STATEMENT OF Thomas A C Bell

I, Tom Bell, will say as follows: -

1. My name is Tom Bell, I'm an author, business consultant, speaker, trainer, and former NHS manager who lost my job after whistleblowing. I use my unique mix of learned, lived, and professional experience to help health and care organisations provide safer services. I'm a regular speaker at the annual Patient Safety Congress and in the wake of the Lucy Letby case I was invited to comment on NHS culture for Newsnight and LBC. I've sat on numerous steering groups contributing to nationally significant topics including Open Government, the Justice System, and NHS leadership. I believe improvement begins with understanding and our ignorance is the greatest enemy we face. I help individuals, teams, and organisations understand, identify, and address wilful blindness, ethical fading, and sub-optimal cultural conformity. I've authored two books; *Lions, Liars, Donkeys and Penguins - The Killing of Alison* (2020), a critically acclaimed true story of the events preceding the suicide of my sister following her abuse by a nurse in an NHS mental health hospital, and *No Wealth But Life – What's Gone Wrong with Healthcare in Britain & How We Can Save the NHS* (2023). The text contained in Exhibit TACB/1 **[INQ0017830]** is taken directly from this book. I had considered submitting selected extracts to the inquiry but on reflection I felt it might be useful to include the chapter in its entirety so readers can gain some sense of the context and I cannot be accused of cherry picking what I thought might be better received. Though it is not written in the style of text I imagine is normally submitted to an inquiry, I genuinely feel it offers a useful additional view which might not otherwise be made available to the inquiry. I am an AQUA (Advancing Quality Alliance) Associate and NHS Leadership Academy Facilitator. I've extensive knowledge of NHS culture and a wealth of expertise in the factors and context surrounding speaking-up, whistleblowers and whistleblowing, in the UK and internationally. I am currently

working with an NHS Trust helping them with patient safety. I was commissioned by the Institute of Health and Social Care Management to develop an accredited online masterclass, *Speaking Up Safely*. I have worked with the board and operational teams of the PHSO. I contributed to the fifth edition of the UK National Action Plan for Open Government published in early 2022. I contributed to a 2020 report by Justice.org.uk entitled *When Things go Wrong*. In 2019 following my experience as a whistleblower, I was asked to submit information to the NHS England *Kark Review* into standards for NHS Directors. I have initiated and led local, regional and national projects relating to the implementation of technology and the appropriate use of data to increase patient safety and reduce risk in NHS settings. I am a Fellow of the Institute of Management. I have an MBA, an MSc, a PgCert in Digital Healthcare and numerous diplomas. I was a former steering group member of the Northern Leadership Academy.

2. Please find the following observations and related appendices to support the work of this important inquiry. Though exhibit one may seem lengthy, I would encourage the reading of it in full to extract the numerous insights it contains that I think are highly pertinent to the events at the Countess of Chester Hospital and the culture of the wider NHS. There is a lot in it I feel will aid the inquiry. If the inquiry would like more information from the full text in question, then please let me know and I will forward further relevant sections for the inquiry to consider.
3. **Observations and thoughts in relation to point 28** - *Whether recommendations to address culture and governance issues made by previous inquiries into the NHS have been implemented into wider NHS practice? To what effect?*
4. Most previous review efforts (Cumberledge, Francis, Jones (Bishop), Kark, Kirkup, Messenger, Ockendon, Smith (re Shipman) etc.), and post-incident/post-inquiry recommendations for culture change in the NHS are rooted in legalistic approaches or the traditional mechanical sometimes motherhood and apple-pie style models of management, i.e., those widely taught to private sector businesses and then inappropriately applied to tackling issues in public service organisations. The one report into NHS leadership and how to improve it which many feel could have had an impact (Better Leadership for Tomorrow, Lord Rose, 2015) was kicked into the long-grass and the simple and logical recommendations it made were never implemented. Culture is without doubt the most significant challenge facing the NHS, yet the creators of most post inquiry reports refer to it in passing as a nebulous thing that must be referred to, but which it is clear they do not fully understand. There has not been a set of post-

inquiry recommendations that has paid the issue of culture change the significant and candid attention it warrants.

5. In relation to the efficacy of previous inquiry recommendations, it could be (has been) credibly argued that the impact of most inquiries relating to the NHS is stymied before they are even published because of the limited scope of the initial inquiry remits. These being restricted to what is understood to be relevant at a point in time and often undertaken by people who although well respected are so immersed in the system they are unable (not unwilling) to see beyond their present paradigm. In short, most inquiries fall into the trap Einstein so eloquently verbalised as trying to solve the problems facing them with precisely the same thinking that created them. This generally means that the broader out of scope systemwide issues that impact on the activity of the institutions in question, including the external generation of demand, and the forces that influence the behaviours of staff at every level, are often ignored. Contrast this approach with the planning and strategy formulation adopted by many large private sector organisations, and the lack of systemic thinking and analysis becomes obvious.
6. Of course, there are many within the NHS who will say that the impact of this or that set of recommendations was useful to some degree, but in truth the question is not rightly theirs to answer. And most of those willing to express a public view recognise they exist in organisational and institutional cultures that will not reward them for saying anything contrary to the accepted party line. The NHS is not known for its tolerance of alternative points of view. It is the patients, service users and staff who are best placed to answer questions about the efficacy of previous recommendations, unfortunately their views are not sought as frequently (or welcomed) as they should be.
7. What healthcare policy makers and senior NHS staff appear exceptionally poor at acknowledging is that the opportunity cost of striving to demonstrate (not to be confused with enacting in practice) implementation of all the various directives they have been served over the years, is huge. The old adages that whoever chases two rabbits catches neither and when everything is a priority then nothing is a priority remain as true today as ever, yet the simple guiding principles behind these maxims remain largely ignored. I recall working in a middle management post in an NHS Trust when the Francis Report was published in 2013. With its almost three hundred recommendations, directors and managers didn't know where to start and I can say with confidence the impact of the report on the Trust I worked for was negligible.

8. In pockets of the NHS the proposed implementation of the fit and proper persons requirement (November 2014) caused such consternation it led to services being less safe after its introduction. Many directors felt (logically if morally questionably) that if they could be deemed unfit for not acting on information they received (one of the criteria), the safest option would be to close the channels by which they might receive such information and duly did so.

9. **Observations and thoughts in relation to point 29** - *What concerns are there about the effectiveness of the current culture, governance management structures and processes, regulation and other external scrutiny in keeping babies in hospital safe and ensuring the quality of their care? What further changes, if any, should be made to the current structures, culture or professional regulation to improve the quality of care and safety of babies? How should accountability of senior managers be strengthened?*

10. I think this question might just as appositely be expressed as *keeping people in hospital safe and ensuring the quality of their care*. A safe hospital is a safe hospital,? Nurse Letby could have had just as devastating an impact upon vulnerable adults or those with multiple morbidities. It should also be acknowledged that if the board and senior managers were unaware of (as some doubtless would have been) and also and more worryingly prepared to dismiss such significant concerns as those that had allegedly been raised, then the likelihood of other incidents of harm and/or inappropriate conduct and management behaviours occurring in other parts of the same NHS Trust, are high.

11. The bulk of my response to this point is contained in appendix one (exhibit [INQ0017830] TACB/1). However, in relation to how to strengthen the accountability of senior managers, it is my view that the recently relaunched fit and proper persons test for senior NHS staff should be amended to include the possibility of sanctions and barring for senior staff who are found to be unfit. It is absurd that a director of a small private sector company can be found to be unfit to hold the post of director following poor behaviour or judgement when engaged in the business of selling widgets or non-essential services, yet no such sanctions can be used in relation to publicly funded managers and directors employed in the vital business of running the National Health Service.

12. **Observations and thoughts in relation to point 30** - *Would any concerns with the conduct of the board, managers, doctors, nurses and midwives at the Countess of Chester Hospital have been addressed through changes in NHS culture, management and governance structures and professional regulation?*

13. *Re conduct being addressed by changes in culture* - in relation to references to culture, it should be noted by the inquiry that the NHS contains a multitude of overlapping sometimes competing, sometimes reinforcing, and often highly defensive and protective cultures. Any talk or recommendations considered in efforts to drive culture change will require significant preparatory and even longer implementation time as well as unwavering high-level commitment and long-term focus. "Culture will always eat strategy for breakfast" – **Peter Drucker**
14. *Re conduct being addressed by changes in management governance and professional regulations* - I believe new guidance and reporting criteria and perhaps methods, such as the provision of nationally coordinated online reporting/whistleblowing platforms in line with current EU legislation, should be applied NHS wide. These could align with existing Freedom to Speak Up Guardian activity and encourage (ensure) that staff, clinical and non-clinical, raise and escalate genuine concerns. In appendix one (exhibit TACB/1), I have highlighted the practice said to have been adopted by many BUPA care locations in relation to their stance on reporting issues directly to the police prior to seeking approval of local/regional management; i.e.,, the breaking (real or suspected) of the law takes precedence over management hierarchy, as many feel it should.

[INQ0017830]

15. Though on one level I think it is incredibly sad that such guidance on reporting life threatening issues to the relevant authorities should be needed, the reality is that the culture of the NHS has become so insular and fearful that I cannot see how people can be adequately encouraged and enabled to do the right thing by any other means in the short to medium-term. It is quite simply not adequate for NHS employees to walk away from serious concerns saying they "did their bit" by merely raising concerns to senior directors and managers when they suspect harm has occurred and lives are at risk. The fact that senior intelligent people did not raise their concerns with the local constabulary on matters of such grave significance is a clear and worrying indicator of how insular and insulated the culture of COCH and parts of the wider NHS was/is. There were doubtless issues of behavioural science at play (i.e., *Dingwall's Rule of Optimism) which should be considered when viewing and interpreting the non-actions of the senior clinicians on the ward as well as the response they allegedly received from senior management. **Some things are genuinely too terrible for us to contemplate and so we subconsciously dismiss the possibility of their occurrence using the rationale that, such things couldn't possibly be happening to people on the ward or in the hospital I work in, manage in, or lead etc., etc.*

16. Other observations, thoughts and experiences that I think may be relevant to the inquiry:

17. Shortly after the conclusion of the Lucy Letby trial I attended a meeting of leaders hosted by the Northwest NHS Leadership Academy. A representative from the Countess of Chester Hospital was present. Following the opening panel discussion attendees were invited to ask questions of the senior directors present. I asked a challenging question which I felt in light of recent events in the region was relevant. You could have heard a pin drop. Throughout the remainder of the day, I was approached and thanked by numerous other attendees for asking a question they had wanted to but were fearful of doing. I asked why they were fearful, they all replied that to ask a challenging question of a senior regional director or commissioner could damage their career. It is alarming that in the wake of the COCH tragedy in a confidential discussion amongst NHS leaders in what should have been a safe space, that current and aspiring NHS leaders and managers still felt unable to ask probing questions of those in positions of leadership because of fears about the potential repercussions. Culture change in my view is without doubt the number one challenge to patient safety facing the NHS.

18. In the course of researching my second book, as well as looking at the topics of discussion outlined on agendas and in the minutes of COCH board meetings, I noted the frequency of COCH board meetings. I found it concerning the board of any organisation using such significant resources and tasked with such vital work in a challenged operating environment, were only meeting six times a year. I have highlighted this in appendices two and three (exhibits TACB/2 **[INQ0017831]** & TACB/3 **[INQ0017832]**). The practice of holding six bi-monthly full meetings of the board each year has been a consistent historical feature of the leadership practice at the Countess of Chester Hospital. In my professional view this frequency of meeting would be inadequate to support good governance and oversight at the best of times.

19. In relation to the need for joined-up technology and the production of visible data. Had basic joined-up technology been in place and its findings available to view on screen and in real time by clinicians, managers, and directors, at the Countess of Chester Hospital, the pattern of deaths and harms that Lucy Letby was causing on the neonatal ward would have become almost instantly visible to anyone with access to the system. The shift rota reveals at a glance that her presence is the one consistent factor each time an unexplained death occurred, or an

unexpected harm was inflicted. There is no justifiable reason why in the era in question such joined-up systems were (are) not in place across the entire NHS.

20. The recent call from parliament for evidence in relation to the inquiry about the relationship between leadership in the NHS and performance/productivity as well as patient safety, will surface some common themes and ideas which could be of great value to this inquiry. I would also take this opportunity to highlight the upcoming review into the duty of candour and the recently undertaken review of the coronial system, both of which might be explored to be aligned with and add to the impact of this inquiry.
21. Lastly, I would like to offer my services to the inquiry team should someone be needed to look at and analyse COCH board reports and accompanying papers from the periods in question. I have no interest in being compensated for this activity, I currently offer the service to healthcare providers as the process can be very useful in revealing what the focus, the knowns and unknowns that an organisations' board is dealing with, paying attention to or unaware of etc., and the high-level strategic rhetoric versus operational reality. The inquiry may find this helpful in establishing and confirming context re the role of the board in creating appropriate culture.
22. I hope what I have submitted is useful. I am happy to be put on any contact list (email in footer) to be kept informed and updated and I am happy to provide further information if required.

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: 15-04-2024