



Public Accounts Committee

Oral evidence: Whistleblowing, HC 1117

Monday 24 March 2014

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Members present: Margaret Hodge (Chair); Mr Richard Bacon, Stephen Barclay, Chris Heaton-Harris, Mr Stewart Jackson, Austin Mitchell, Nick Smith, Justin Tomlinson

Gabrielle Cohen, Assistant Auditor General, National Audit Office, Paul Oliffe, Director, NAO, and Marius Gallaher, Alternate Treasury Officer of Accounts, were in attendance.

Witnesses: Cathy James, Chief Executive, Public Concern at Work, and Kay Sheldon, Care Quality Commission, gave evidence.

Q1 Chair: Welcome, and thank you both. The first session with the two of you we will try to keep as tight as we can. It is really for you to raise with us the issues that you think we should raise with the accounting officers when they give evidence. To give Kay a minute to settle, I will start with Cathy. If you look at this NAO Report, you think that there are a whole load of pretty good whistleblowing policies out there, yet when I look at the experience of this Committee, we have had a number of cases of whistleblowers, and all of them who have been to us have been ignored or harassed, or have lost their job, or have been paid off. Why, with good policies, is the practice, as we experience it, so poor?

Cathy James: The work of the NAO has meant that Government Departments have looked at their whistleblowing policies more thoroughly in recent times. I would not say that they are sense-checking whether those policies are effective, which is one of the things that came out of some of the work we did when we set up the whistleblowing commission last year. We looked at all sorts of pieces of evidence, and the big factor that came out for us was that three out of four whistleblowers were saying that nothing was done about the concern. Obviously, there is also the fear of reprisal, and the evidence from individuals who have suffered is there and all too evident.

Those two factors are what is really operating in relation to how organisations fail in whistleblowing. They have a policy that might say all the right things. Most of the policies that we look at are really legalistic; they focus on the Public Interest Disclosure Act. That is the wrong end of the stick; that is looking at when the situation has gone wrong. I was at the Health Committee last week. The NHS England policy focused on the Public Interest

Disclosure Act and how you funnel somebody through and whether they have made a protected disclosure or not. That is not why any organisation should look at whistleblowing. They should look at it so that they know about the risks and look after the people who tell them about those risks, because if you are criticising other people, you can sometimes be in a difficult position. Organisations need to recognise that if they want their staff to speak up, and if they want to create a culture where it is safe and acceptable to speak up.

Q2 Chair: So if you were running a Government Department, what sort of things would you do?

Cathy James: We have set out a clear code of practice in the whistleblowing commission: there is a policy that says the right things—that you will not tolerate reprisals and will sanction people if they mete out reprisal against somebody who speaks up. It is rare for somebody who has victimised a person who has spoken out against them to be sanctioned.

Q3 Chair: Has that ever happened?

Cathy James: I am not aware of it ever happening.

Q4 Mr Bacon: You are not aware of it? There was a case in the newspaper very recently. A woman called—

Chair: Against the person who did the victimising.

Mr Bacon: Yes, the person who does the victimising. The person who perpetrates the victimisation.

Cathy James: Against the whistleblower.

Mr Bacon: Then being sanctioned.

Cathy James: It happened in Mid Staffs. I am aware of that in the Mid Staffordshire example.

Mr Bacon: Sorry, I may have misunderstood. You are not aware, apart from Mid Staffordshire, of the perpetrator doing the reprisals and then being sanctioned afterwards.

Cathy James: For meting out the reprisal, yes.

Q5 Mr Bacon: Indeed. Do we know what happened to the chief executive in South Devon? Her name was, or perhaps still is—I do not mean that her name may not have changed, but she may be in post—Paula Vasco-Knight. She is the NHS spokesman on equality and diversity. She hired her daughter's boyfriend, Nico Schenk, in spite of his lack of experience, and then failed to admit the family connection. Two former employees of Dr Vasco-Knight told the tribunal that they had been forced out of the South Devon Healthcare

NHS Trust after complaining about her decision to recruit Mr Schenk. The chairman of the trust has now resigned, but you say you are not aware of, in this case, Dr Vasco-Knight then being forced out, either.

Cathy James: No. Often the accountability comes into play in relation to the wrongdoing, but those around the wrongdoer—the managers who have listened to the wrongdoer and got rid of the messenger—are not made accountable. In Mid Staffordshire, the two nurses who were bullying Helene Donnelly have finally been made accountable and have had fitness to practise hearings against them in the NMC, and they were struck off, so there are rare examples of that sort of action.

Q6 Mr Bacon: Do you think there is a place for the criminal law here? For example, if you destroy data knowing that there is an investigation going on and that the data will be sought, the destruction of those data in those circumstances—when one is aware that they are or may be sought—is in certain circumstances a criminal offence. Do you think there is any role for the extension of the ambit of the criminal law in this area, so that the people who fail to protect whistleblowers, or fail to treat the information properly, or dilute it or suppress it, could be committing an offence?

Cathy James: I think it is very difficult, because there is already no accountability, and there is not a criminal offence. If you then turn it into the criminal law, I am not sure whether it might end up going underground even more, making it even scarier for people to speak up. We have had that around the duty of candour and whether there should be a criminal offence. The problem is that if it feels like people are going to go to prison for having treated a whistleblower badly, it will all get hidden even more than it is now, so I am not sure that that is the answer. There are lots of criminal laws, as you said. If somebody is found to be perverting the course of justice or getting rid of data unlawfully, they should be accountable for those actions, and there should be some accountability around the treatment of whistleblowers.

Q7 Chair: Just go back, Cathy. The policy is clearly not working as well as the Government intended, so what would you do? You have suddenly and miraculously become Cabinet Secretary; say what you would do.

Cathy James: We have made some very strong recommendations around the code of practice—not just looking at the policy.

Q8 Chair: What are the key things there?

Cathy James: It is looking at the review and whether the policies are effective. Then there is oversight in relation to those, so the publication of the results of your review of whistleblowing, and regulators have a really important part to play in this. There are a number of regulators prescribed in law, but they do not have any duty to do anything around that very important statutory responsibility. If there was a code of practice that looked at how organisations deal with whistleblowing, regulators could start to question the licence

arrangements of organisations that are not dealing with whistleblowing well. What we are saying is that the way in which a good whistleblowing policy and good arrangements can be audited and reviewed by regulators should be much more clearly set out.

There is a sense of change in the Care Quality Commission, for example, which has changed the game a little bit. The Care Quality Commission is now looking at how many staff speak up in hospitals, and is taking that as part of its monitoring and red flag process. It is not only that: even if a whistleblower is wrong, if they say that they are suffering, that triggers a review. That means that hospitals have something to lose if they treat whistleblowers badly. They start to look, at board level, at whether their arrangements work in practice or are not worth the paper they are written on. That puts in place accountability around whether whistleblowing arrangements are working properly. It means that the boards of those hospitals start to ask questions, and then things start to change around making it work properly on the ground.

Q9 Chris Heaton-Harris: I believe that Public Concern at Work is doing some work with the Ministry of Defence, or has done so. Do you think that working within a Department like that is going to achieve better results than anything else?

Cathy James: I would like to say yes, but we do not kitemark organisations. What we try to do is help them to get the messaging better, to make sure that they are thinking about the individual who may raise the concern, rather than the organisation reaction to that individual. Obviously, in the Ministry of Defence, they have the most sensitive information around security and they have military personnel, so it was a case of working with them and thinking about how you balance those sometimes competing interests. I hope that we have made a difference to the way that their policy drive is going forward. That was part of a project with the National Fraud Authority to look at attitudes and awareness of staff at the beginning of the process. We did a big survey of Ministry of Defence staff. We have then done some policy work with them. It is up to them to do the work around making sure that people understand it, that it is well promoted, and that it works in practice. The idea is to do a survey at the end of the process to see whether it has made a difference to whether staff trust the process—whether they think that if they raise a concern they will be safe, and the issue will be addressed.

Often the gap is between what is said in the policy and what is happening on the ground. In the NHS survey, 55% of people are saying that they do not think that the concern will be dealt with properly. That is shocking. Surely there is a way for that to be improved. More work can surely be done by those NHS trusts to prove that it is working in practice—by listening, by reacting, by investigating, and by doing the right thing.

Q10 Chair: I am going to turn to Kay. Before Kay starts, I will just say that we tried to get a number of whistleblowers whose evidence has been proven credible to come and talk to us about their experience. Kay was the only one who, in the end, felt brave enough to come. We had somebody from HMRC who would not come, somebody from the MOD who would not come, somebody from local government who would not come, and also somebody

from the police. That shows there is still a culture of complete fear out there, which demonstrates the difficulties that we are facing.

Kay, we are very grateful to you. The idea is that you share with us your experience as a whistleblower—not the details of what you were doing, but your experience of the actual process. Thank you.

Kay Sheldon: I am very pleased to be here. I am very nervous, but I will do my best to describe my experience. Obviously, if there is anything that is not clear, ask me about it.

It was in the middle of 2011 that I started to raise some quite serious concerns about CQC—about the leadership, the management and the culture. I felt that the organisation was at risk of not fulfilling its statutory duties, so they were really quite serious concerns. Unfortunately, because the culture was quite oppressive, those concerns were not well received. The more I tried to get them taken seriously, the more I was subject to inappropriate behaviour, such as being excluded from roles that had been agreed. My mental health was questioned. I am obviously open about the fact that I have had mental health issues, but that was used against me. A secret mental health report was done on me.

As I was really very concerned that the organisation was failing, and failing patients—people who use services—I felt that I had to go outside the organisation. I approached the National Audit Office, the Department of Health and the Mid Staffs public inquiry, and it was the inquiry that responded positively. I was invited to go see them, I gave my evidence, and I was then called to give oral evidence, which I did. After that, unbeknown to me, the chair of the Care Quality Commission wrote to Andrew Lansley asking for me to be removed. I did not know that had happened. I was called into the Department of Health and told that there was going to be an independent review, and I was asked not to attend any further board meetings. It was pretty clear to me that they wanted me out of the picture as fast as possible, so I declined. I said I wanted to continue going to board meetings, which I did. I had someone with me, because I knew that would be necessary.

The review that was set up was not independent; I think that is the thing to say. Frankly, it was a deliberate hatchet job; there is no other way to describe it. I met with the person doing the review for about an hour, and I was told it was going to report within 10 days, but it didn't. It dragged on. I didn't hear anything else, but when I got my personal data, I found out that the person doing the review, the CQC and the Department of Health were in quite a lot of contact. I was completely out of it. I didn't have a voice.

As I said, I still went to board meetings. I felt that I had to do that, because I felt that if I didn't go, it was giving in. I also felt that I needed to continue to make sure that the issues were taken seriously. That is when I started trying to show the impact of my concerns. That is when I looked at Morecambe Bay in more depth. I also looked at Barking, Havering and Redbridge. I particularly focused on Morecambe Bay, and what I discovered was really quite concerning. I had been told it was a robust piece of work, and I was being continually told that there wasn't a problem—that I was the problem. I produced a paper that I sent to the chief executive and the board with questions and concerns, with Morecambe Bay as an example. They would not respond at all. I then sent it to the Department of Health and the Secretary of State. I met with the Secretary of State, but no one would listen or take it seriously. What they wanted to do was, essentially, get rid of me and discredit me.

As you know, I kept going somehow. During the summer of 2012, I happened to connect with a parent at Morecambe Bay—James Titcombe, who now works for the CQC—and he showed me further evidence that made me really concerned that the CQC was potentially trying to cover its tracks. This coincided with the new chief executive coming into post in the CQC. He, to his credit, commissioned an independent review. That was the crucial thing: it was independent. The outcome of the review essentially proved what I was saying, and it also uncovered a particular act of a cover-up.

As a sort of insurance, I lodged a claim with the employment tribunal. My appointment was coming up for review, with a view to its being renewed, and I wanted it to be renewed because I wanted to be part of the future with CQC. When we had the mediation, I said that all I wanted was to be reappointed, but it refused point blank to do that, and essentially paid me off. When the Grant Thornton review was published there was all the media attention and when its back was against the wall it agreed that I would be reappointed. There was resolution, or justice, for me and I am now very pleased to be part of the solution as well as part of the problem, not just in making CQC better and stronger, but in helping to encourage and influence a more healthy culture within services and public life.

Chair: Thank you for that. I know it is really difficult to go through all that traumatic history.

Q11 Chris Heaton-Harris: Thank you again. You are obviously a remarkably strong lady. Now that you are poacher turned gamekeeper—that is the wrong phrase—what are you changing? What steps have you taken to make the CQC a body that someone like you in future will feel confident enough to both come forward to and to know there will be support?

Kay Sheldon: If we start with the board, it has appointed a senior independent member who has particular responsibility for whistleblowing. I was saying to Cathy earlier that there have been a couple of occasions in the last few months when I have had a couple of concerns, but not whistleblowing concerns. I raised them and the response I got was wholly different from that which I got previously and, in fact, actually helped the board to become stronger. There is that in terms of the board.

In terms of wider whistleblowing, as you know, everything is changing in CQC. There are lots of changes, reviews and so on, and we are commissioning two particular reviews. One is to review CQC's own whistleblowing procedures and how it works. The other is to look at how well CQC as a regulator can support and protect whistleblowers who come to us so that we do the best we possibly can in that regard. We have appointed Kim Holt of Patients First who is on secondment to help us with that. There has already been one conversation with whistleblowers, because the key thing is to talk and engage with whistleblowers. They are the experts, by experience.

In terms of our new approach to regulation, one of the domains is what you call the well-led domain and as part of that there is work going on with the King's Fund to look at how we can assess culture in organisations. We will be talking to staff to see whether they feel safe to raise concerns, but that will also feed into how CQC assesses and rates how well an organisation is led.

Q12 Chris Heaton-Harris: CQC is a vital place for whistleblowers to report things to in the first place, so it is all important. I know there have been a number of reviews and that things have changed. Do you now feel confident for someone in your position, if you still had the concerns you had two or three years ago, that they would be dealt with by the senior independent member of the board, or that you would be able to phone up the NAO and get a different answer?

Kay Sheldon: I cannot say that I am convinced that will happen.

Q13 Chair: You are not convinced.

Kay Sheldon: I am not convinced, because of the extreme things that happened—the fact that I did raise some very serious issues and really all they were intent on was to get rid of me. I don't think the Department of Health and the officials there have really taken responsibility for what happened. Personally, I think that if they did—if they did engage with me or other whistleblowers—that would really help to change things, but so far they haven't done it, frankly. We have all the policies and procedures.

Cathy James: There is that disconnect between the Department of Health and the organisations that sit underneath it and the sense that the remedy for the whistleblower is an employment remedy and the Department of Health, the CQC and all the regulators are not employing those people. From past experience, having worked as a kind of advice service for DH, I can say that it was incredibly difficult to get through those barriers. We felt like there were layers of brick walls between us and the trusts, which were obviously in a position of power over all those staff members, so it really needs to come from the organisation that is employing the individual. That is why we are saying that there should be a board champion in every NHS trust looking at whistleblowing. There should be—

Q14 Chair: Well, it goes beyond that, actually. One of our worst cases was the Cornwall out-of-hours service, which is run by Serco. They rifled the lockers to try to find out who the whistleblower was.

Cathy James: There needs to be a huge shift, because for too long whistleblowing has been seen to have been dealt with because we have a law. Well, that's the endgame, not the starting point. There is this work done by the NAO to have a Government lead on whistleblowing—to have leadership from Government on whistleblowing and getting that culture right. That is where the leadership starts across the entire country perhaps.

Q15 Stephen Barclay: I think all of us on the Committee are very grateful for the bravery that you have shown over what has been a very long period of time. You said a number of officials at the Department of Health did not take responsibility for what were very clear concerns. Are some of those still in their post?

Kay Sheldon: Yes.

Q16 Stephen Barclay: Have you had any explanation as to why they are still in their post?

Kay Sheldon: No.

Q17 Stephen Barclay: Would you expect an explanation?

Kay Sheldon: Yes.

Q18 Stephen Barclay: Is it surprising that no disciplinary action has been taken?

Kay Sheldon: I think so, yes.

Q19 Stephen Barclay: Particularly given that your concerns have now been vindicated.

Kay Sheldon: I would expect it, but they haven't done it.

Q20 Stephen Barclay: When you went outside the organisation and raised your concerns with protected bodies such as the National Audit Office, did you get an explanation as to why they did not act?

Kay Sheldon: No.

Q21 Stephen Barclay: Would you expect an explanation?

Kay Sheldon: With the National Audit Office, I knew they had a whistleblowing remit, but they seemed to be saying that what I was raising did not come within their remit, so that was the end of it, but I think if someone was raising such serious concerns, they perhaps should have taken the responsibility to do something.

Q22 Stephen Barclay: So it may be one to pick up in a note, but we need to look at the way the protected bodies are working. Who did the independent review that you described as a hatchet job?

Kay Sheldon: It was Gill Rider.

Q23 Chair: Who?

Kay Sheldon: Gill Rider. She used to be head of the civil service human resources department.

Q24 Mr Bacon: Do you mean the director general of capability in the Cabinet Office as was?

Kay Sheldon: Yes.

Q25 Chair: Which independent review are we talking about?

Stephen Barclay: The review described by Ms Sheldon as a hatchet job.

Kay Sheldon: After I had given evidence at the public inquiry, I was called in to the Department and told that an independent review was going to be done to look at the issues I had raised and how they were responded to. It was Gill Rider who did that, but that wasn't actually what the review was about at all. A few months went by and it was left hanging. I eventually got a letter from Andrew Lansley saying that he was considering removing me and I asked him whether he could fund some legal advice for me, because I'm on tax credits, and he said no, but I went anyway, because I had to, to a legal person—people. Essentially, what the lawyer said was that the review done by Gill Rider was unfair, unlawful and also illegal. *[Interruption.]* Absolutely—all three. I have to say, they backed down immediately. I agreed not to sue Andrew Lansley and he agreed not to remove me. I think, Margaret, you wrote a letter in support, as did Robert Francis.

Q26 Mr Bacon: How soon afterwards did Gill Rider leave the service? She is not there anymore, is she?

Kay Sheldon: She wasn't in post—I think she had left already—when she did this review.

Q27 Mr Bacon: Had she gone back to Accenture, which is where she came from?

Kay Sheldon: I do not know.

Chair: She was appointed as a former civil servant—"former"—so she had already left.

Kay Sheldon: I had an hour's interview with her in December 2011 and there were no further—

Q28 Stephen Barclay: Would you be concerned that perhaps there are conflicts of interest in those coming in to do the reviews?

Kay Sheldon: Yes, absolutely. I was told that it would be independent, because the individual was from a different Department, but it wasn't—absolutely, it wasn't.

Q29 Stephen Barclay: Were there imbalances between the transparency of your evidence and the contacts from others into that independent review?

Kay Sheldon: When I got the letter from Andrew Lansley, I was given the report and something called “working notes”, but I don't know what the other people said exactly.

Q30 Stephen Barclay: So you would not have had transparency over what they submitted about you into the independent review.

Kay Sheldon: No, I didn't.

Q31 Stephen Barclay: So there is scope, whether it happened in this case, for abuse, for people to make unsubstantiated comments in the independent review without you having the opportunity to question those comments?

Kay Sheldon: Yes.

Q32 Stephen Barclay: Do you think that is a procedural failure?

Kay Sheldon: I do. When I got the letter, I was told that I had 10 days to reply, though it was extended. Given the time that had gone from my interview in December through to April/May 2012, all sorts of things were happening that I only found out through getting my personal data. I think that they allowed me 10 days to respond in order to tick a box, so they could say, “Oh, you had the opportunity to respond.”, but they initially denied me legal help and they must have known that what they were doing was not right. They must have known and yet they persisted.

Q33 Stephen Barclay: One final thing from me: when Cynthia Bower, who was the chief executive of CQC—at the heart of the organisation that treated you so badly—left the organisation, she received glowing tributes from Sir David and others. Did you have a chance to read those tributes? What were your thoughts?

Kay Sheldon: I saw some of them, yes. Once I had secured the changes that I wanted, I decided that I was not going to take part in a witch hunt—even though I had been subjected to one. There is this thing that when people are failing, they are allowed to leave and then there are these set phrases that are released by certain people, like Sir David or the permanent secretary or whatever. It is what always happens. I think that most people were aware, to be honest, that they were not exactly accurate. As I said, I did not want to be part of any witch hunt myself.

Q34 Mr Bacon: I would like to add my thanks to those given by the other members of the Committee for the fact that you have come here today. It is not only extraordinarily brave—it should not have been necessary for you to be this brave, but unfortunately it has been, and you have been—but we are all in your debt. You have performed an extraordinary public service. I hope that somebody is going to raise your salary, frankly, because you are much more valuable as a non-executive director for what you have done. I would like to get that on the record and say a big thank you for what you have done.

You did say, which I found extraordinary, that when you raised these concerns, an issue around your mental health was raised. Who did that? Who raised this issue about your mental health?

Kay Sheldon: It was led by the chair of the CQC.

Q35 Mr Bacon: The CQC chair at the time.

Kay Sheldon: At the time, yes.

Q36 Mr Bacon: Can you just—I know that it is David Prior now.

Kay Sheldon: Dame Jo Williams.

Q37 Mr Bacon: This is the sort of thing that used to happen in the Soviet Union. People had their mental health questioned—*[Interruption.]* In all seriousness, this is what used to happen. It happened to you, led by Jo Williams.

Kay Sheldon: Yes, and the Department of Health was also involved.

Q38 Mr Bacon: Who in the Department?

Kay Sheldon: Well—

Chair: You do not have to answer that if you feel uncomfortable. It is up to you.

Kay Sheldon: It was Una O'Brien who—I do not know the extent of the involvement. I have gleaned a lot of the stuff from my personal data, but I know that it was Una O'Brien's office that recommended this private occupational health company. I am quite open that I have had depression and anxiety, which was one reason why I was appointed to the board, and I was a bit stressed, but I was doing my job. I did not have any time off sick or anything like that. There was one incident at a board development day where it was said that if someone does not agree with the rest of the board, they should resign. I was also physically unwell. I had a bit of a panic attack and they ordered a car to take me home. Within a few days, I was fine and I was asked to see the in-house occupational health officer, which I did, and she did not raise any concerns, so I thought that that was the end of it.

When I got my personal data, however—a couple of months later, Jo Williams told me that I had been referred to this occupational health company, Medigold, which I was quite surprised about. I phoned up simply to cancel the appointment and had a 10-minute conversation to say, “I don’t think I need to see a doctor, but a bit of support would be nice.” After that 10-minute conversation with the owner of Medigold, he wrote this three-page letter saying that I probably had paranoid schizophrenia and that he would speak in confidence to the medical director and that my medical notes should be obtained in confidence. I just discovered this in my personal data. I did not know.

Q39 Mr Bacon: It is extraordinary that a potential patient, or someone whom someone thought was a patient, should be referred without their own knowledge. That is very disturbing.

Finally, when you said that you were called in to the Department and told that you would be the subject of an independent review, who were you called into the Department by and who told you that you would be the subject of an independent review?

Kay Sheldon: David Behan.

Mr Bacon: Thank you.

Cathy James: There is one, quite powerful, change that is coming in on 6 April, which is that all MPs are going to be prescribed persons under the Public Interest Disclosure Act 1998. That will add a lot of power to the elbow of somebody in a position such as Kay’s. It was the inquiry that gave her the power. It was a public inquiry where she gave very powerful evidence, which is what hopefully gave her some of the oomph to keep going. Having an independent process, such as your Member of Parliament—it does not have to be your MP. I have seen the statutory instrument that has gone through, and it can be any Member of Parliament in relation to any malpractice proscribed under the law, so it will be interesting to see how that develops. It will really help whistleblowers.

Q40 Chair: Out of interest, Cathy, in a brief pre-meeting, I think I get more whistleblowers than the NAO gets—even now.

Cathy James: The function of the prescribed organisations needs a power boost. If MPs have individuals come to them and then ask those prescribed organisations what they are doing, things will start to change. That would be my hope, anyway. I think it could be really powerful.

Chair: Thank you both. I am conscious of the time. As usual, we MPs are trying to do too much in too little time, but thank you so much, particularly to you, Kay. I know that that was hard to do, but it was lucid and we are very grateful. It really added value to our inquiry, so many thanks.

Examination of Witnesses

Witnesses: **Lin Homer**, Permanent Secretary and Chief Executive, Her Majesty's Revenue and Customs, **Jonathan Slater**, Director General, Transformation and Corporate Strategy, Ministry of Defence, **Chris Wormald**, Permanent Secretary, Department for Education, and **Charlie Massey**, Director General, Strategy and External Affairs, Department of Health, gave evidence.

Chair: I will hand straight over to Chris, because he has to go at half-past 4, and I think that we will be here for a little while. Before he goes, he wishes to raise a number of issues, so let us start there, and then we will come back to other Members with other issues afterwards.

Q41 Chris Heaton-Harris: Forgive me for jumping ahead—I have been whipped to go to a DL Committee at 4.30 pm. I am interested in this because I was a Member of the European Parliament for 10 years and got to deal with a number of whistleblowers there, from Marta Andreasen, who was the chief accountant of the European Commission, to someone at EUROSTAT who nearly brought down the Prodi Commission. I therefore got to know whistleblowers, how they were treated, and how different organisations would try to hide that treatment.

We have just heard some testimony from Kay Sheldon that must be quite hard for the Department of Health, so I guess that I should start with Mr Massey. How much of that did you know?

Charlie Massey: I have not been acquainted with Kay's case. I think that Kay showed enormous courage in coming here today and being so open. Her story is very humbling. I think we still have a huge amount to do across the NHS in getting ourselves into a position, as Cathy was taking about earlier, where staff feel confident that actions will be taken as a result of speaking up. There was a huge moment in the NHS just over a year ago with the Robert Francis public inquiry.

A big part of the emphasis of the response, both from the Department of Health and the whole system, has been around culture change. While there is a lot that the Department of Health and others have done over that year, culture change is not achieved overnight. I am not coming here today to say that I think that 54%¹ of staff feeling confident in speaking up is something that we should be proud about—it absolutely is not. There is a huge amount more that we need to do, particularly to enable staff in front-line operations and providers to feel that the culture and leadership in those organisations is one where they do feel more confident about speaking up.

Q42 Chris Heaton-Harris: In the US Congress and the European institutions, a very good indicator of a department where something is not right is the number of people who have gone on long-term sick leave after having raised a grievance. Do you know the Department of Health's figure for that?

¹ Note by witness: Should have said 71%

Chair: And beyond, to all of its organisations.

Charlie Massey: I do not know that off the top of my head.

Q43 Chris Heaton-Harris: Would you be able to communicate that to us?

Charlie Massey: I am sure that I can find that information and write to you.

Q44 Chair: Hang on a minute. Can you find the information for all the organisations—NHS trusts, private providers and anyone who works from money provided through the Department of Health? Are you telling us that you have got that information, or are you just putting us off?

Charlie Massey: The honest answer to that question is that I don't know what we've got, but I can commit to coming back to this Committee and sharing with you both what we do know and what we don't know, in terms of staff sickness rates.

Q45 Chair: You should know, shouldn't you?

Stephen Barclay: While the NHS is fragmented, each of the bodies have accounting officers in their own right, so one way round that would be to request the information from each accounting officer, or for the NAO to do so. There is a mechanism there.

Charlie Massey: I do know that we used to collect data on a national level, in terms of average sickness rates, but I think the Chair's question was broader, to all those providing NHS services—

Q46 Chair: Funded by the taxpayer. It's our money.

Chris Heaton-Harris: Mr Wormald, can I ask you the same question? Do you know how many?

Chris Wormald: Across the wider education system? No. That is not information we collect.

Q47 Chris Heaton-Harris: Anything in the centre at all?

Chris Wormald: Well, I am sure we could find the information for our own staff, but of course that is an absolutely tiny number of the education work force. We do not collect information at that level for individual schools.

Q48 Chris Heaton-Harris: Even though you—and we, I think—have had people from academies vocally blow the whistle, you do not collate any of that information or have a

policy that you try to spread down? Actually, all academies must have a whistleblowing policy—that is one of the tick-box things—but is there nothing more to it than that?

Chris Wormald: We collect data about the whistleblowing that is done to the Department; I can give you that information. What we don't do is collect data about whistleblowing that happens within an individual school anywhere in the system.

Q49 Chair: Why not?

Chris Wormald: It is not something the Department has traditionally done for any school, and in general we have been trying to reduce the amount of information that we collect from individual schools, rather than increase it. As far as I am aware, it is not something the Department has considered before.

Q50 Chair: Well, it may not have considered it before, but one of the interesting things with the academies is that it is clear that there is a lot of information. In fact, when Peter Lauener was here, he talked about the importance of whistleblowers in providing the first hint of things going wrong. You would think that if that is his view, as the head of the funding agency, it is madness for you, as the accounting officer with ultimate responsibility for all this stuff, not to collect the data and use them intelligently for giving you information about how things are going on the ground and in school. It may not have happened in the last 10 years, but surely it should be happening now, particularly given the fragmentation.

Chris Wormald: It is something that I will take away and think about. As I say, we are trying not to collect large amounts of information from schools.

Q51 Chris Heaton-Harris: That is probably the politest note that this Committee has ever had. However, one of the biggest themes of this Report is the tone from the top of an organisation. If the tone from the top is very nice words but “We’re not really going to bother”, it does not set that tone properly, does it?

Chris Wormald: No, that is not what I said or meant at all. The focus of the Department's activity during the last two years has been to put in place and focus on its own whistleblowing arrangements. We have put a lot of effort—as you say, Peter Lauener has discussed this with you—into ensuring that we have proper and robust processes within the Department, and particularly within the Education Funding Agency, for the whistleblowing cases that come to us. To be honest with the Committee, that is what we have been focusing on. We have not been focusing on the question of wider whistleblowing that happens within individual institutions.

Q52 Stephen Barclay: But how do you know their policies are working if you don't even keep metrics?

Chris Wormald: Well, as I have discussed with this Committee before, what we are seeking to create in the education system is autonomous institutions that are responsible for

their own management. We do not seek to look over the shoulder of individual institutions at that sort of level.

Q53 Stephen Barclay: You wouldn't take that approach to fraud, would you? There is a difference between autonomy and empowering people, and turning a blind eye. You wouldn't say, "Well, there may be a risk of fraud in an organisation, but we will turn a blind eye because it is autonomous." That is a nonsensical argument.

Chris Wormald: I am not saying that at all. We deal with academics—

Q54 Chair: With respect, Chris, you are. You just said it. A lot of this whistleblowing, particularly in the academics, could well be about fraud.

Chris Wormald: Our system is based around an autonomous institution that accounts for its own money, with accounts that are published and properly audited, and a system that allows people to raise concerns directly with us if they feel they have not been dealt with locally. As I say, we do not collect data on issues that are resolved at an individual school level.

Q55 Chair: In the end, you are the accounting officer—I get so tired of saying this—for the whole education budget. We have a fragmented system, and nobody is challenging that, but it is your responsibility as an accounting officer—

Chris Heaton-Harris: You said that they are autonomous, but if it is escalated up to the Department, you record it. What do you do with the bit that is escalated to the Department?

Chris Wormald: The issues are dealt with by the EFA. It has a standard process for doing so and has put a considerable amount of effort into making those processes robust. The chief executive of the EFA showed you last time he was here the card he issues to all his staff about how to deal with complaints when they are received. The EFA has considered at least 45 whistleblowing complaints since it was created. Every single one of them is looked at by EFA staff, who consider whether they raise issues of concern. If they do, we launch a formal investigation—that has happened in 21 cases—which is normally an investigation by forensic auditors of what happened in that institution. When the report is finalised, appropriate action is taken and we publish the results of the inquiry on the EFA website. We put a lot of time and effort into it, and we have robust processes around the whistleblowing done to the EFA to ensure that firm action is taken. I am not in agreement with some members of the Committee on what to do about tracking whistleblowing cases that are dealt with at an individual institution level. That is the difference I was pointing to.

Chair: Steve, do you want to come in with your comment, which I think is pertinent?

Q56 Stephen Barclay: The way you describe it, it seems to be exactly the model that our previous witness, who was a whistleblower, highlighted was not working.

Chris Wormald: Sorry, in what way? We take the whistleblowing cases that come to the Department—

Q57 Stephen Barclay: If the whistleblower reports it to the Department, the Department then goes to the institution. That, in essence, is what you are describing.

Chris Wormald: No. The EFA staff do an initial review of the case to see whether there is a case to be answered. If there is—the vast majority of cases are about financial irregularity—we put in properly trained investigative auditors to get to the bottom of what happened. Clearly, you cannot investigate those cases without going to the institution; it is where the records are kept, and you have to hear its side of the story. As has been borne out by the inquiry reports that we have published—the Committee has asked Peter Lauener and me about this before—it is not simply a case of asking the institution whether it agrees or not. It is a proper investigation of the audit trail, and has frequently resulted in regulatory action.

Q58 Chair: Can I ask two questions about DFE? First, have you any idea whether there are education chains that have more whistleblowing than others? Can you tell us that? We now have a number of education chains that are running a large number of schools. Are there more? Do you know the answer to that? Could you answer that question?

Chris Wormald: Within the individual chains, no, we do not—

Q59 Chair: Could you answer the question?

Chris Wormald: In terms of the whistleblowing complaints that come to the Department, I haven't seen anything of the 57 cases.

Q60 Chair: Do you think you should be able to answer that question?

Chris Wormald: As it has been raised, I will go away and consider it. I cannot give you anything other than an honest answer at the moment.

Q61 Mr Bacon: It sounds like no.

Chris Wormald: I am sorry, but I am being completely open. We do not collect that information at school level. There isn't another answer that I can give you.

Q62 Mr Bacon: I appreciate your earlier answer that the Department is trying to cut down on the amount of information that it seeks, which is perfectly understandable and, in many ways, completely just and right, but if one academy chain has had 87 whistleblowing cases internally within its own procedures, and a lot of them for very good reasons, and another academy chain has had two whistleblowing cases, of which one was completely

unjustified and one had some merit, you wouldn't know that, given what you have said. Surely it ought to be a source of concern to you as the accounting officer that you wouldn't know; it is certainly a source of concern to the Committee that you wouldn't know. That is precisely the sort of thing that ought to flag up to you whether the systems that you, as accounting officer, must attest are working properly are doing so. The answer that you have to give us is, "I don't know."

Chris Wormald: I can only tell you what information we collect.

Q63 Chris Heaton-Harris: In fact, it would be a success, if information was flowing.

Chris Wormald: Having looked at the Reports and considered our systems, one of the things that we want to look at—this was raised by the National Audit Office—is how that information flows around the system. However, I don't want there to be a giant national reporting system for all of this that tries to cover 3,500 academies and 20,000 schools. I can see that there are issues with how we share information around the system, and we will go away and talk about that with the other people involved in the system. In preparation for this hearing, my second reflection on how whistleblowing is working in education was that the picture is quite complicated. One way or another, a lot of bodies are involved. There are local authorities, Ofsted, Ofqual, the Department itself and internal institutions. There is an issue for us on how we spread good practice and share information around the system, which is something that we are looking at.

Q64 Chair: I have one last question before going back to Chris. I have an academy in my constituency, and there are allegations that it is rigging its SATs results. What have I done about that? I have written to Ofsted about it. If the school is rigging its SATs results, which has yet to be established, it would make me wonder what else it is rigging and how else it is using public money. Given the way you currently run the various institutions under your command as accounting officer, I assume that there is no way that Ofsted would talk in that instance to the EFA to share that concern, if I am right. I preface my question by saying that the allegation has yet to be established.

Chris Wormald: I will come back to your specific question on SATs in a moment. Individual cases are discussed, particularly by the Department and Ofsted. We frequently have to decide whether an inspection is the right thing.

Q65 Chair: There is no way of communicating that, is there?

Chris Wormald: No.

Q66 Chair: At the moment there wouldn't be.

Chris Wormald: As I say, what we don't have at the moment—this is something we will go away and look at—is a regular exchange of views on whistleblowing, as such. What we do is discuss individual cases that we are looking at for exactly the reasons that you say. If

an issue is raised on the leadership and management of a school in one regard, it may well go over into other things. SATs results are for the Department to look at because key stage 2 tests are administered by the Standards and Testing Agency, which investigates quite a lot of exam malpractice cases every year and publishes the results on its website. In a way, your comment reinforces one of the things I was thinking about in that area. What we do not provide at the moment—we will look to do much better on it in future—is a route map for people on how they raise issues on particular areas of education. There are a lot of separate bodies involved. That was my second takeaway, having looked at the Report and then at how whistleblowing was working.

Q67 Austin Mitchell: If you do not have any special provision or framework for encouraging, supporting and looking into the cases raised by whistleblowers, how do you get to know what is going on in schools and such a huge sprawling empire? How would you get to know about nepotism or allegations of corruption at Kings school in Bradford without a whistleblower? What happens if I blow a whistle on Kings school in Bradford?

Chris Wormald: If you came to the Department with that, it would be investigated, as was the case.

Q68 Austin Mitchell: It was not. It was passed to the police, and they decided not to investigate.

Chris Wormald: We have discussed that particular issue before.

Chair: We will come back to that, Austin. I will bring in Chris, because he has got to go in a few minutes.

Q69 Chris Heaton-Harris: I want to ask the last two witnesses the same question. Do you know the number of people on long-term sick leave following a grievance in each of the Departments?

Lin Homer: Chair, I know the numbers on people who have whistleblown in the past few years and the breakdown on the proportion of those cases where there is action and the proportion where there is not. There are about 60 to 70 cases each year, and about a third of those are actioned, while two thirds are not actioned. In relation to the case management system, I did not ask whether we know. I am only aware of one case that has followed on with the person leaving the organisation post-whistleblowing. I am conscious of another couple of cases where the issue was only raised as people retired. I am very happy to ask whether that information is kept. We keep detailed case management information, both on the progress of cases and the outcome.

Jonathan Slater: One of the weaknesses that the NAO was right to point out on the MOD's whistleblowing policy was the absence of good quality MI. We simply have to hold up our hands on that. We launch our new policy next Monday, which is associated with a rigorous new system of collecting information. We have asked Public Concern at Work to

work with us to design that, to ensure we get that right. I do not have that information in front of you now, but I would expect to have it in front of you in a year's time.

Q70 Chair: I am going to go back to Lin on the case with one of the whistleblowers who we have worked most with in this Committee, who is Mr Mba. I will not ask about his settlement or any of that, but I want to ask about the process and how you handled him. Do you think it was appropriate to pass on his and his wife's address, two mobile numbers, home number and office number to one of your staff?

Lin Homer: Since I have been in the Department, I have taken the view that we are not clear enough about the procedures we are following and what we are doing to support the whistleblower on one side and what we are doing on the other to investigate the query that has arisen and any other issues. Part of the reason for settling the case as we did was that I acknowledged that the individual was expressing genuinely held concerns and that, as a big employer, we did not follow procedures in supporting that individual as well as I would have liked us to have done.

Q71 Chair: So you think it was inappropriate, in effect.

Lin Homer: I am not happy to talk about the individual.

Q72 Chair: I am asking about process. I have been really careful to ask about process. This man blew the whistle to us, and one needs to go through it. I need to know that it will not happen again, Lin.

Lin Homer: You have my assurance. I have reviewed our procedures to ensure that we are clearer about the roles that individuals are playing internally and clearer about where the individual who has expressed a concern is obtaining support from. There is more we can do in that space, but I am confident that we have improved our practice, including adopting the new civil service procedure.

Q73 Chair: That is a bit waffley for me. I am going to go on. Was it appropriate to review his hard drive, his e-mail traffic, his internet usage and check his departmental telephone contacts, with further interrogation of computer material, look at the itemised billing checks to see what numbers he had rung up and undertake inquiries? Was that appropriate in this instance? In fact, the employment tribunal found that all the information you had given to us and others—the NAO and us—was covered by the whistleblowing legislation. That was the finding, wasn't it? I have the judgment here: it was.

Lin Homer: There was not a judgment, because we settled. But we accepted that he was acting in good faith with a reasonable belief that his concerns deserved investigation.

Q74 Chair: I have to say, the judgment from the court says that it was, if I can find it, under the—

Was it appropriate? It just seems to me that you hounded this man.

Q75 Stephen Barclay: I assume it was a term of the settlement that the Department accepted that he had disclosed in good faith, was it?

Lin Homer: No, I accepted that before we settled, as we prepared for the case. I will say again, if I did not say it clearly enough, that I do not think that all the processes we followed were good enough. I am not prepared to discuss every aspect. One of the issues which I think comes through in the Report, and which we have to be careful about, is that we sometimes owe more than one duty of care and there are times when an investigation has to be undertaken. But I do not believe that we were as careful in supporting this individual as we should have been.

Q76 Stephen Barclay: It is welcome that you have tightened up the procedure. That is good news. What is surprising is that the procedure was not followed in the case of someone disclosing to this Committee, when you would have thought that disclosure to Parliament in that regard was high profile, as we were looking repeatedly at whistleblowing and he had disclosed against that backdrop. It is even more surprising, because this is not a hospital at arm's length that it is harder to have control over; this was probably as high profile a case as you could get.

Lin Homer: It is quite hard for me to stand in a position in history and know what was going on, but I am prepared to say, from the point I was responsible, I had discussions with you, Chair, about taking a personal responsibility as chief executive for the case, and I do believe that we needed to take extra steps to support the individual. We have put those in place.

On reading the Report, I suspect, like my colleagues, there are still things I could do to improve our procedure. I am still concerned that when you access the information we have got available, which is now, I think, clearer, it is still, in the words of your previous witness, quite legalistic: you sort of enter a system that sounds like it is warning you rather than supporting you. My view is that there are probably still some things that I need to do going forward.

Q77 Chair: Let me ask you one other question about the process and how you dealt with him. The thing that shocked me most in the bundle of papers he let me see, some months ago, was that you made a request under the Regulation of Investigatory Powers Act 2000, which in effect is there to deal with terrorism. You used that Act to get information about a whole lot of stuff from other bodies. Again, I have details of that. What I want to hear from you is that you will never do that again where you have a whistleblower. It just shocked me to my bones, really, to see that these very extreme powers being used to try to hound this poor man—there is no other word for it: you hounded him—to the extent that you have

broken him. The Department has broken him and it is awful. I feel personally responsible, because I think we exposed him to a lot of this in using the evidence that he provided to us. Then you go through this saga and see RIPA used—for terrorists—on a whistleblower. I just want to hear from you that you will never, ever do that again to a whistleblower.

Lin Homer: I share your concern. I think we have seen today, in the previous witnesses, the pressure that is placed on an individual if they are not only whistleblowing but having to do so in public. It is one of the wise pieces of advice from a number of sources, including the NAO, that we have a duty of care to try to protect individuals if they wish to raise a concern but not to do so publicly. I think the pressure of being in that public space was very difficult for the individual. I will assure you that we worked very hard to try to balance out that pressure and create an environment in which he felt able to continue.

Q78 Mr Jackson: You haven't answered the question about RIPA.

Lin Homer: I am trying to answer several questions in the last—

Q79 Mr Jackson: Well, get to it. You are giving us a bit of flannel, if I may say so.

Lin Homer: No, I am not.

Q80 Mr Jackson: Yes, you are. You are not on "Money Box" now. Can you get to the point of RIPA? Why did you use that?

Lin Homer: I was addressing what for me is a very serious concern: the exposure of the individual. I have said, and will say again, that I do not believe every decision that was made about the powers that we used was made wisely in this case. I assure you they would be made more wisely. We have a full range of powers, and you know I cannot give you carte blanche assurances for ever more that I will not use—

Chair: On a whistleblower! Where you have got a bona fide whistleblower, I think it is totally and utterly awful that you choose to use these very extreme powers. I was trying to get an assurance from you on that point.

Q81 Mr Jackson: Can I also say this? I think it is rather high-handed for you to sit there and say, "This is what I'm not going to discuss." Your letter says specifically, as I understand it, that there is not a confidentiality clause with regard to these individuals. No one is asking you to divulge any individual or corporate tax information. Given that this is public money, you should be willing to discuss the substantive issues, notwithstanding the court order that has been sealed to stay the proceedings.

Lin Homer: That is another issue, and I believe I owe a duty of care to my previous members of staff. I have indicated to you that I am very happy to discuss that with you in a private setting, but I think the individual is trying to move on, and I wished to respect that. In the same way, I have tried to say very clearly that I acknowledged a genuinely raised

concern. I worked very hard to try to find a solution that would have kept that person within HMRC, but the decision was made by the person not to do that, and I am trying to respect their desire not to—

Q82 Chair: We will come back to the person and how he was treated when he tried to return to work. I want that RIPA question answered. I think you should say that where there are bona fide whistleblowers, it is inappropriate to try to find information about them by using the RIPA powers. It is inappropriate and just wrong.

Lin Homer: I think it was wrong of us not to have greater clarity about which of our powers we were using and when in this case. I am very clear about that, but I do not think I can give you carte blanche for the future, because I have other duties of care, including to Parliament and to individuals. There are requirements around the use of any of our powers. What I have done is put in place much greater scrutiny in any case where those powers are sought to be used that involves a member of staff in this way.

Q83 Chair: Who would have had to authorise the use of RIPA in this case?

Lin Homer: I am clear that it should be right at the top of the organisation. It should be with me when powers like that would be used. I am sorry if it sounded high-handed, but you need to understand that many of our circumstances will involve a member of staff telling us information about another member of staff. These might include criminal activities. It will not always be easy for us, at the beginning of those disclosures, to know which member of staff is telling the truth. Sometimes we will use investigative powers.

Q84 Mr Jackson: That is disingenuous.

Lin Homer: It isn't.

Q85 Mr Jackson: Yes, it is. You know full well it is. In the terms of the settlement, the order that was sealed concluding this action would have contained a full, unambiguous confidentiality agreement, and this doesn't. This only invokes the civil service rules with respect to that individual. It is a different situation. It is not a confidentiality agreement covering tax matters, which I would understand and be more sympathetic to.

Lin Homer: No, there was no gagging clause.

Q86 Mr Jackson: That is my point.

Lin Homer: I have not invoked the Act relating to taxpayer confidentiality. I believe that I owe a duty of care to my ex-member of staff. I wrote, with his agreement, to you in

September informing you about the settlement, and I would be happy to discuss the terms. They do affect his decision.

Q87 Chair: We do not want to discuss it—we are talking about the process.

Lin Homer: That was the question Mr Jackson was asking.

Q88 Mr Jackson: It was about the principle. There was a bit of a discordant tone when you said that you were not prepared to discuss it, yet your letter makes a different point: that you specifically have not got a confidentiality agreement in the order that concluded the proceedings. That was my point—it was about the principle. It is not our immediate business today to find out about the conditions of the order.

Lin Homer: No, and I deliberately chose not to have a gagging clause.

Q89 Chair: May I ask something finally, and then I will stop? I think the Committee has a sense of responsibility—

Lin Homer: I think we share a responsibility.

Chair: The issue is how you treated him. I will use an instance to make a general point, but it is an instance in which we have a particular interest. When he wanted to return to work in November 2011, he got a letter saying that he was not allowed to come back in and had to wait in the foyer of 100 Parliament Street to be collected at 9.50 am. It said, “Do not attend the office earlier than this time or go through the barriers without me being present.” He was not made welcome back to work.

When it was then finally settled that he had to work again, I have seen an exchange of endless e-mails between you, Lin, and Anthony Inglese and others, trying to prevent him returning to his place of work. I will quote from one from 9 November 2012, which I assume came from your private office: “Lin saw the exchange of e-mails between you and Robert. Hm. She is also surprised that OM had been placed in litigation—as to why this is appropriate. May I ask whether OM could be placed in another area?” You tried to prevent him going back to his job. Inglese says, “My people are dismayed by his return to work.”

That is a shocking way for senior management to treat an individual. He had the best of intentions—I do not think there is a bit of malice in this guy; I have never met him, but I have dealt with him through other means—and had the public interest completely at the heart of his actions. That is a shocking way to treat him—preventing him from coming back, so that he has no option but to do a settlement and go off. You have broken his life. Why on earth did you guys treat him like this?

Lin Homer: Chair, as I have said, I would be happy to have a fuller conversation with you. I think that we were trying throughout this period to find a way to minimise the risks to our individual and to the business. Some of the challenges we had at that point—

Q90 Chair: “My people are dismayed by his return to work.” That is the head of law, Inglese, in whose section he was working—“My people are dismayed by his return to work.”

Lin Homer: I would prefer to have a conversation concerning our efforts to bring him back to work with the individual in the room, if he was prepared to come, and in front of you.

Q91 Chair: He is not.

Lin Homer: Well, I am not sure that the offer has been made to him to have a private hearing with you. I think there were many lessons to be learned about the way we supported the individual, and I will say again that I do not think we supported him well enough.

Q92 Mr Jackson: On that, may I make a helpful suggestion? I think we have gone as far as we can on the RIPA issue. Of course, you cannot give an unequivocal undertaking, but are you in a position to say that you have protocols in place for the future treatment of whistleblowers? What legislation might be used to facilitate greater clarity from your point of view?

Lin Homer: Yes, I feel much more confident that there would be a deeper understanding that the organisation has to think about its duty of care to the individual, and its wider duties of care to Parliament and taxpayers. Where there are any decisions that cause conflict between those things, there is a need to escalate and get an opinion that takes both into account. An example of that would be if there are concerns about taxpayer confidentiality, but there is not absolute clarity about how to minimise those concerns. Those were some of the issues that I think were being struggled with, but without sufficient understanding of the need for people to stand above that decision and look across the piece. I am sorry; that is a bit elliptical, but I suspect that those of you who understand my system—

Chair: I have to say—I will move on now, because we have had enough on this—that the final irony of all this is that Dave Hartnett sought permission from the Exchequer Secretary to the Treasury to speak to journalists about the tax affairs of Goldman Sachs, which is what this is all about. You were pursuing him because confidentiality of tax is in the taxpayer’s interest, but at the same time he was in correspondence with the private office of the Exchequer Secretary to the Treasury seeking permission, which he went on to receive, to talk to journalists about a taxpayer’s confidential affairs. That is a shocking example of inconsistent treatment and of the difference between how Dave Hartnett and Mr Mba felt it was appropriate to give the Committee information about it. It is a shocking saga, and I feel really sad that we did not manage it better. Anyway, I have had my say. Can someone come in on something else?

Q93 Mr Bacon: I want to ask Mr Massey about what happens to people who seek to victimise those who make complaints and what the Department of Health now does about that. We heard from Kay Sheldon earlier, and I was thinking of a different case that I raised in our hearing on Wednesday 3 July 2013 on NAO Report HC 477, “Confidentiality clauses

and special severance payments.” I raised the case at length then, so I will just provide a brief précis here.

Essentially, a locum doctor raised concerns about an at-risk child who later died. The concerns were that, had the record keeping been better and had a named doctor been responsible, the case history would have been more thoroughly known and the child might have lived. The child was Baby P, and the action of the primary care trust was to offer the doctor £80,000 to go. When the doctor refused, saying that it wasn’t about money, the trust offered an increased sum of £120,000 with the threat that, if the sum wasn’t accepted, the doctor would be sacked. The doctor was also invited to sign a compromise agreement saying that there were no outstanding issues, which she refused to do. Four years of public money later, the doctor was exonerated and reinstated. What happened to the PCT managers who made that offer to her?

Charlie Massey: I do not know the details of that particular case, but I can—

Q94 Mr Bacon: It is a very famous case—it was Baby P. It was one of the most startling headline-making cases that there has been. One might have expected something to happen to the people who bullied a doctor who expressed entirely legitimate concerns in that way. One might expect there to be consequences for them for having treated a doctor in that way, but you are telling me that you do not know.

Charlie Massey: I don’t know the specifics of that case, but there are three things that I would like to say in relation to victimisation and bullying. First, there is need for candour across the NHS, which is fundamental. Candour is not only about individual clinicians telling patients where something has gone wrong; it is also about fellow professionals being candid where they see other things going wrong. That is why we have done two specific things on the back of the Robert Francis public inquiry. One is that we are introducing a statutory duty of candour for providers so that the CQC can essentially put providers out of business if they are found not to be candid. We are also introducing a professional duty of candour, on which I think the professional bodies will be consulting next month. That will make it clear that professionals can lose their licence to practise—the professional duty of candour will become part of their fitness to practise—if either they are not personally candid or they are not candid about something they see in other professionals.

Q95 Mr Bacon: Does that apply only to clinicians, or does it apply to NHS managers, too?

Charlie Massey: That focuses on the regulated bodies, which cover clinicians. In relation to managers, there is a fit and proper persons test that we are asking the CQC to put in place. The test will ensure that the CQC can essentially keep a register of people who are unfit and improper, which will provide another mechanism.

Q96 Mr Bacon: Do you mean so that the CQC can keep a register of managers who are unfit persons?

Charlie Massey: Exactly. I think that is one important element. Another element is the amendment that was made to the Public Interest Disclosure Act to make employers vicariously liable where co-workers bully an individual who has blown the whistle. That is important for setting a different culture. Essentially, it means that the employers are liable through an employment tribunal.

The third piece you mentioned was around so-called gagging clauses. One thing the Secretary of State did last March was ban gagging clauses across the NHS, and indeed, going further, make sure that all compromise agreements signed henceforth should have in them an explicit clause that says that nothing within the agreement should stop the individual making a disclosure in the public interest. That is important. I recall about a year ago I had a conversation in this Committee about the fact that even if you ban gagging clauses, compromise agreements can still have a chilling effect.

Mr Bacon: Yes. Sir David used those very words.

Charlie Massey: Exactly. None of these issues is, in its own right, a panacea, because it comes back to culture change and leadership.

The other element that is really important is the way in which the CQC goes about its job in terms of inspection. Cathy James spoke a little bit about that earlier this afternoon. The CQC is developing an inspection methodology that brings in the reflections of whistleblowers. Dr Kim Holt has been employed by the CQC to help develop that. That should ensure that complaints and concerns from the public, from patients and from staff are all taken into account in the inspection methodology.

Q97 Mr Bacon: In relation to the Baby P case, can you write to the Committee with information on what happened to the people who were victimising that doctor in that way, and offering public money for her to shut up? Can you write to us to tell us what happened to them?

Charlie Massey: I can write to give you the information.

Q98 Mr Bacon: I think it is appalling. In addition to candour, vicarious liability and gagging clauses, all of which are good points, another point—I think this is often underestimated in the public sector—is the importance of timeliness. That it should have taken four years in that particular case is extraordinary, and of course there was an extra public money dimension because it took so long. There is currently a case involving the chief executive of the South Devon Healthcare NHS Foundation Trust, Paula Vasco-Knight—I mentioned it earlier. She has been suspended after what the media have called a nepotism tribunal. The headline stating that she was suspended was from February 2014. One would hope that it would not take four years to find out the facts. Regardless of what the facts turn out to be, it really should not take four years to find them out, should it? It ought to be possible, in the interests of all parties, to come to a conclusion much more quickly. What are you doing about that?

Charlie Massey: I agree that timeliness is really important. I would make one general point and one specific point. The general point, for me, is that we also need to be clear about the timeliness before something becomes a whistleblowing case. In some ways, for somebody to blow the whistle and seek protection under PIDA is an indication of the system having failed. The open NHS that we want to create, and that Jeremy Hunt has spoken a great deal about in the past year, is one where all providers and organisations welcome concerns that are raised by staff, and see that as an engine of change for their institutions, rather than somebody being forced to blow the whistle. Clearly, when someone does that, it is important that those concerns are investigated properly and that the whistleblower feels they have been listened to properly. The degree of time that that will take will obviously differ from case to case.

I cannot speak about the detail of the Paula Vasco-Knight case that you mentioned, but I know that that hearing is taking place within the next few weeks, after she was suspended on 10 February. I hope that that will reach an earlier point of clarity than the four years that you described.

Q99 Mr Bacon: You mentioned that you did not have the details of the Baby P case to hand. Can you name any case where those guilty of reprisals have faced disciplinary action?

Charlie Massey: I have not come here today prepared with a list of individual cases and the precise details on those.

Mr Bacon: That is a no, then, is it?

Charlie Massey: I have not come here today with a detailed set of cases.

Mr Bacon: Is that a no?

Charlie Massey: It is a no, yes. I don't have that information in front of me.

Q100 Mr Bacon: Well, the word to use, then, is "no". You cannot name any. That speaks volumes in itself, since that is what we are talking about. I would have thought that if the Department was taking this seriously—you talked about the fact that it is about culture change—you ought to be able to say, "There were several famous cases, and there might have been some less famous cases, in which people faced reprisals that they should not have faced because they brought to the attention of the organisation or to others malpractice that should have surfaced and been drawn attention to. As we thought it was right that it was brought to our attention and surfaced, and wrong that there were reprisals, we took action against those guilty of reprisals." I would not necessarily have expected you to be able to name every single case, but the fact that you cannot name any at all is quite illuminating, to be perfectly honest, Mr Massey. It really is. Who will pursue discipline against the people named by Kay Sheldon?

Charlie Massey: Every case is different, in terms of where the appropriate action should take place. In relation to Kay—

Q101 Mr Bacon: I am not talking about every case; I am talking about Kay.

Charlie Massey: I am talking in relation to Kay. I have not come here to speak in detail about Kay's case. What I do know is that David Behan and David Prior, the new leadership of the Care Quality Commission, very much welcomed Kay's reappointment to the CQC board.

Q102 Mr Bacon: Are you sure that is right? Mr Behan, whom we have had in this Committee in the past—in his previous role, I should say; he was at DWP before, I think, a while ago—

Charlie Massey: David Behan was in the Department of Health.

Stephen Barclay: He was also part of the team that did the 12-month review of CQC.

Chair: But he was in the Department of Health.

Mr Bacon: In the past, he has been in front of this Committee as a witness, and I have regarded him as an impressive witness, but Kay Sheldon said that he was the person who called her in and told her she was going to be the subject of an independent review, and moreover that it was very clear that the Department of Health just wanted to get rid of her.

Charlie Massey: That is not true. What David Prior said when Kay was reappointed—

Q103 Chair: No, this is David Behan we are talking about.

Charlie Massey: Well, I am talking about David Prior, and I will come to David Behan—

Q104 Chair: Just answer the question. David Behan was the one who, in the Department, initiated the review and called Kay Sheldon in to tell her that they were going to review whether or not she was a fit person to remain on the board.

Charlie Massey: As I said before, I have not come here equipped to deal with specific questions on any particular individual case.

Q105 Stephen Barclay: No, you are equipped to talk about your policy. How will your policy deal with an issue like the one identified today?

Charlie Massey: So, what—

Q106 Chair: Can you answer that? Just answer it. Don't give us waffle about the policy; just answer the actual specific.

Charlie Massey: Which specific would you like me to—

Q107 Stephen Barclay: We have had evidence today that says that there were reprisals taken against a whistleblower whose account has now been verified. As a matter of policy, who will investigate the people responsible for those reprisals who still work for the Department of Health?

Chair: Or for the CQC?

Charlie Massey: In terms of the policy, as far as I am aware—I may be wrong about this—Kay has agreed to continue on the CQC board and was not seeking further investigation, but I am prepared to—

Q108 Stephen Barclay: Whether she is or not is not the question. The question is about your policy. You have talked about the future, in which you say employers will be vicariously liable. That would not work, moving forward, in an instance like the CQC, because the victimisation—the witness gave evidence on this—was by the chairman and chief executive. They are the people responsible for the organisation. We have had evidence that shows that a whistleblower whose revelations were proved correct was victimised. You have a policy in place on which you have come to give evidence. How will that policy work in that live case?

Charlie Massey: In my view, the CQC leadership under David Behan and David Prior has unequivocally championed the case of the patient and the whistleblower.

Q109 Stephen Barclay: So they are going to investigate people in the Department of Health?

Charlie Massey: David Prior said when Kay was reappointed: “It has taken the courage and determination of men and women like Kay Sheldon...to shine a light into parts of the NHS which have hitherto been shrouded in secrecy.” David Behan has employed James Titcombe, whom we heard about earlier, as a national adviser.

Q110 Stephen Barclay: When will we see work on reprisals? What we are trying to establish, with great respect, is how the policy will work on those guilty of reprisals. That is the issue. In terms of changing culture, that is about having sanctions for those who are found to be guilty. It is very hard to find them guilty in real time, because they have a number of things to their advantage compared with the whistleblower, not least the deep pockets of the organisation, the legal advice that is available, and the ability to bring in independent reviewers, who, actually, are conflicted and not acting in a truly independent sense. It is difficult at the time, but where you find, after the time, that people have behaved wrongly,

you do not seem to be able to articulate from your policy that any sanctions will be taken against those people.

Charlie Massey: Clearly, it will depend on the nature of the issue. If it is clear that there are reprisals that have been absolutely unacceptable, any department has the ability to take disciplinary procedures against any individuals found to have behaved in that way, and it should be absolutely prepared to do so. I am trying not to get drawn in. I do not know the details of this particular case, so it is difficult for me to sit here and say exactly what the appropriate processes should be, whether they are disciplinary processes or not.

Q111 Stephen Barclay: You do not know the details of this case or of the Baby P case. You don't seem to know the details of the highest profile cases on which we are taking evidence.

Charlie Massey: The NAO Report talks about the Department's own policies, and our ability to ensure that whistleblowing through the delivery chain is appropriately taken into account, that organisations have appropriate policies and practices, and that staff know how to raise concerns. Those are issues I have come here prepared to talk about. I do not think it is appropriate for me to talk about—

Q112 Stephen Barclay: Don't you realise that the policy has not worked? We had the protection of whistleblowers in the NHS constitution; the protection of whistleblowers in PIDA; and the chief exec before Sir David gave evidence to this Committee in the previous Parliament. There have been about five or six different attempts at protecting whistleblowers through policy, none of which have worked. The reason they have not worked is because there have not been any sanctions against those responsible for the culture of bullying and victimisation. Until you have sanctions and discipline against often very senior people who are guilty of that victimisation, you will not change the culture.

Charlie Massey: Can I make a couple of comments on that? First, of course the Department of Health should use whatever policy means it can to ensure not only that there are appropriate policies, but that they are properly enforced and the sanctions flow. That is where the points I was talking to Mr Bacon about earlier in relation to candour and gagging orders are absolutely—

Q113 Stephen Barclay: Nigel Crisp sent his guidance note when he was chief exec. He was saying exactly the same stuff you're saying today.

Charlie Massey: All the things I have talked about are things where the Department of Health has taken very specific action over the last period of months, rather than the last period of years. The fact that we are introducing a statutory duty of candour on providers will mean that the CQC will be able to remove members of the board, if those organisations are found to have not been candid with patients where harm has arisen. The professional duty of candour will ensure that for the first time clinicians will be able to have their licence to practise withdrawn through the fitness to practise policies of each of the individual

professional regulators. Those are new things. The whole approach to transparency and inspection that was put into the system is also new. The way in which the CQC is building complaints and whistleblowing policies into its inspection methodology is something that has not happened before. However, all those things that the Department of Health and others are trying to do do not themselves add up to a lever that suddenly changes culture overnight. To change culture, we need a much more determined and sustained approach. I am trying to demonstrate that—

Q114 Chair: Let's ask another specific. What would happen today if Serco was a contractor and a provider, and it rifled through people's lockers to find out who were the whistleblowers? What would happen to Serco today that did not happen two years ago, when this actually occurred?

Charlie Massey: In relation to whistleblowing—

Chair: No. Take that situation, a real-life situation that we had here in the Committee. Again, whistleblowers were too frightened to come to talk to us today. Serco rifled through the whistleblower's lockers to find out who was blowing the whistle about their manipulation of data.

Charlie Massey: As I understand it, what is applied to Serco now that was not at that time is the duty of candour—

Q115 Chair: What would happen to Serco today?

Charlie Massey: They could have their contract withdrawn. Their contractual duty of candour is built into that contract, or would be built into that contract if it happened today. They would therefore be contractually liable for that, as well as the whistleblower being covered by PIDA, which they would not have been two years ago.

Q116 Mr Bacon: When you say that it would be built into their contract if they had a contract today, what about the extant contracts? Is the duty of candour being added to existing contracts with the agreement of the contractors?

Charlie Massey: I forget the precise date, but during 2012-13 there was a duty of candour built into contracts.

Q117 Mr Bacon: I am talking about the old contracts that were extant before the duty of candour was introduced and are still extant today. I understand that the duty of candour would be included as one of the contractual clauses in a new contract, but I am talking about those for which that is not the case: those that were agreed before the introduction of the new duty. How is the duty to be incorporated into those earlier contracts?

Charlie Massey: As I understand it, all of the existing contracts will have been updated to take account of that contractual duty of candour. What I have been talking about

in terms of the statutory duty of candour and professional duty of candour is in addition to that.

That issue of candour is fundamentally important. Essentially, the health system is a very complex system, so it is about—

Q118 Mr Bacon: Just a moment. You said that you understand that they will have been updated. That is great if it is true. Has someone checked that that has actually happened?

Charlie Massey: I would need to come back to you to confirm that, but that is what I have been briefed.

Q119 Mr Bacon: My question is not whether you know the answer, but whether anyone has checked that it has happened? You sound like you do not know if someone has checked.

Charlie Massey: I do not know—

Q120 Mr Bacon: Will you write to the Committee about that?

Charlie Massey: I will, yes.

Q121 Austin Mitchell: I want to pursue one other point. We were talking about Kings school in Bradford and the fact that problems there were brought to your attention. In the highly decentralised system that we now have, with lots of schools and academies being independent, how will you, at the centre, while cutting the Department's staff numbers in any case, know of problems unless you have a framework of supporting, encouraging, sustaining and investigating the cases brought by whistleblowers? Don't you need that in a decentralised system? And have you got it?

Chris Wormald: Yes. That is what we do and that is a responsibility of the EFA. They have put in place, as I was describing earlier, an extensive procedure for dealing with the complaints and whistleblowing that they receive. Every single one is considered and where an investigation is needed, they launch one. That is, as we have discussed—

Q122 Austin Mitchell: They are not just passed on to the police.

Chris Wormald: No. Of the 45 cases of whistleblowing that the EFA has dealt with since its creation, there have been some where the investigation has thrown up matters that need to be passed to the police. I think there have been six—

Q123 Austin Mitchell: How many complaints have you had, and how many have led to an investigation?

Chris Wormald: Every single one is investigated. There are two stages to the investigation. There is an initial assessment by EFA staff of every single one of those 45, and then in 21 that led to a formal investigation, normally by forensic auditors. So just under half of the cases lead to a formal investigation, which leads to a published report.

Then there is a much smaller subset—I think it is six cases—where there has also been a police referral, so it is a very small subset. Half of those police referrals were by the school themselves: they had identified an issue of concern about how one of their people was operating and referred it to the police. Of the other three, two were referred by the Education Funding Agency and one was referred by the Skills Funding Agency, because it was an FE college, so it is a very small number that lead to a police investigation.

Chair: Paul wants to come in.

Paul Oliffe: Chris, presumably you are talking about a small subset of the likely number of whistleblower cases, because you are talking about the ones that directly come to EFA.

Chris Wormald: Yes.

Paul Oliffe: So of the 3,000 of whatever the number is on academies, how many whistleblowing concerns would you expect to be raised? What do you think the total population is?

Chris Wormald: I am sorry, that is the information we were discussing earlier, which we do not collect.

Q124 Mr Bacon: If there were systemic problems, you wouldn't know.

Chris Wormald: Whistleblowing is only one part of our—

Q125 Chair: It is a pretty important part. The one thing I have learned on this Committee, which I did not know before, is how important this is.

Chris Wormald: We agree with you, which is why the EFA has been making a considerable effort to deal well with the whistleblowing that it gets and to publicise that it is doing so. I discussed the issue with the chief executive of the EFA before this hearing, as I am sure you expected me to do, and he always says that the single most important thing it does to promote whistleblowing and to encourage people to come forward is publication of the reports that follow EFA investigations. Certainly he thinks that, as well as training his own staff in how to deal with this, the most important bit of the process is to demonstrate publicly that when concerns are raised with the EFA, they are investigated properly and then accounted for in public. I think he is completely right about that. Those are likely to be a small number of the cases that are dealt with at individual institution level, but it is likely to

be the most serious ones and the ones where people feel that they have not got an appropriate response from the institutions directly.

Q126 Chair: May I ask all of you whether you have an idea of what is systemic? You don't know because you don't have the information, but Mr Massey might be able to. It might come under Lin's, but it will be Jonathan as well. When do you consider it to be systemic? How many would there have to be for us to have a systemic problem?

Lin Homer: I think in our case we wouldn't necessarily get a very large number. I don't think we are as good at sharing the trend information with our audit and risk committee, but our investigative team does look. Sometimes we would not need many cases to be able to say that there is at least a systemic risk, even if there is not evidence that it is yet widely exploited, so we would always review a case to consider whether system changes should happen, even on the back of one case. If you can look in and see a system where one member of staff has had access to our systems to create benefit for themselves or someone they know, you really only need the one case to highlight to you that you need to put some secondary check in. That will happen in our cases.

Q127 Chair: And the rest of you. What is systemic for you, Mr Massey?

Charlie Massey: That is a good question. There are two parts to it. One is that last April, we established quality surveillance groups for local and regional level that brings together CQC, NHS England providers, local Healthwatch and patient advocacy groups. They meet and trigger risk summits if particular issues arise. Those risk summits raise a flag for issues that could be systemic.

The other element is that, separate from the CQC inspection, CQC is now building up a sort of intelligence monitoring model, which will essentially look at a lot of the quantitative data as well as qualitative data, so we will require trusts to publish quarterly information on complaints—

Q128 Chair: That would give you a feel for systemic—

Charlie Massey: That intelligent monitoring should enable us to have a comparable basis of data, which should in turn enable us to be better at identifying systemic risks. I put that in a conditional tense because the intelligent monitoring tool is something the CQC has been building, and we will see over the next six months the degree to which it develops.

Q129 Chair: Mr Slater, what is systemic for you?

Jonathan Slater: As Lin said, one case can identify a system-wide problem. I suppose the particular thing I focus on, which has been helpful in defence, is that the fraud hotline that we have had in place the last couple of years has identified where fraud is happening more than in other areas. Of the 840 cases last year, more than half were in respect of theft, and that helps to inform the work of the Ministry of Defence police and the fraud

team that we have invested in in support. In addition to changes in the control framework, which can be driven by an individual case, getting good-quality data from a fraud hotline—that is only a part of the position; we do not have good MI on the whole, as I said—can inform the work of our police force.

Chair: The reason I raise it was because when we did A4e the DWP Permanent Secretary was unable to define “systemic”. I must have had 50 or 60 letters about A4e. We are trying to get to whether the individual leads to a system-wide failure, or whether it is a particular contractor or particular group of academy chains, which is why we think you should have the information. It is probably a really important bit of work.

Q130 Mr Bacon: Mr Massey, as Mr Slater mentioned the subject of fraud, before we move on, I want to return to the news story today about Mr Jim Gee, the ex-director of the NHS counter-fraud service. He said that there is a figure of £5 billion to £7 billion of fraud in the NHS annually. The Department responded that it did not recognise the figures. Indeed, Mr Gee said that the NHS figures had to be extrapolated, because “the NHS in recent years has stopped measuring its own losses”, only looking at those for dental and pharmaceutical services. First of all, is that true?

Charlie Massey: I do not know. I do not the details of the full piece—

Mr Bacon: It was headline news today. As the director of external affairs for the Department of Health, I would have thought you might have known about it.

Charlie Massey: I do know that we are absolutely determined to tackle fraud. Where there is more fraud potentially is around NHS prescriptions. But we do not recognise the numbers that were mentioned—

Q131 Mr Bacon: What are your numbers then? If you do not recognise the numbers, what are your numbers?

Charlie Massey: I do not have those numbers to hand. I am sorry.

Q132 Mr Bacon: If you do not have the numbers to hand, how do you know that his numbers are wrong? You say that you do not recognise them—it is a phrase that people often use in Departments, and I hear press officers using it regularly. They can almost copy and paste it: “We do not recognise these numbers.” I am sure you have done it yourself—in fact, you did it just now. But it presupposes that you have some other numbers, does it not?

Charlie Massey: I am not responsible for fraud issues in the Department. We may well have—

Q133 Mr Bacon: You are the chief spokesman of this Department. We do not have an accounting officer here, we have you. You are the Director General—which is quite senior—for Strategy and External Relations. I hope I got that right, because I would not want

to misname you. That sounds to me as though you are responsible for corporate communications, among other things. Is that right?

Charlie Massey: Yes, the communications directorate is part of my—

Q134 Mr Bacon: You are the top cheese in communications, so if anyone were going to know about this, I might have thought that you would, especially as it was on the news this morning.

Charlie Massey: I do know that we do not recognise the numbers that were put out. I do not have the precise numbers that we would generate with me this afternoon. I also know that we are determined to stamp out fraud, as is NHS England, and that we are determined to maximise our cost recovery.

Chair: “We have a policy.” I think what we are talking about here is practice, not policy.

Q135 Mr Bacon: It is encouraging that you are determined to stamp it out, I must say. My heart is lightened by the very thought of it.

The issue is that this has been around for a long time. We have heard in the case of the Ministry of Justice, of course, about the contractors invoicing for people who were tagged who did not exist, who were no longer prisoners or who had died. Plainly, pharmaceuticals, the supply of pharmaceuticals and payments for drugs that have not been delivered are one possible issue, but the NHS procures a heck of a lot more than just pharmaceuticals. Are you saying that you do not look at it outside the drugs budget?

Charlie Massey: There are two slightly different things there. One is the question of fraud, the extent of fraud and what we are doing about it. As I said, I do not have in front of me our own numbers on the extent of fraud, but I do know that we do not recognise the numbers that were quoted this morning.

Q136 Mr Jackson: Yes, but you would have been aware, when you were approached prior to this story being in the media this morning, that it was coming, and one would have thought that you would have had a rebuttal that included alternative figures. Wouldn't you think that?

Charlie Massey: Quite possibly. I perhaps took the NAO report and the context of this discussion too literally in terms of—

Q137 Mr Bacon: But the reason that this is relevant is that fraud is precisely the sort of thing that whistleblowers might come forward about. It is a very obvious example of something that people might say: “Did you know that Old Joe's cousin has been invoicing the NHS in such and such a part of the country for services or goods that are not provided?” Then

somebody blows the whistle on it. That is a very obvious example of where whistleblowing might occur, is it not?

Charlie Massey: It is, yes.

Chair: Let's move on.

Q138 Mr Bacon: I want to ask about Mr Slater's Department, because the report says that in the MOD more than half the employees who were surveyed—52%, in fact—who were concerned about serious wrongdoing within the past two years did not raise their concerns and only 40% thought that they would not suffer reprisals as a result of raising a concern. What are you doing about it?

Jonathan Slater: That is a very disappointing statistic, as you say. We hope that we can make a serious change in the perceptions of our staff by the launch of the new policy next Monday, which we have developed with the benefit of support from PCaW. It is just a policy, so—

Q139 Chair: Talk us through it, because the issue before us today is not the policy but the practice. What are you going to do to make what I am sure will read as a perfectly okay policy translate into a change in practice? I have another statistic here. Two thirds of your staff—57%, so not quite two thirds—did not know that anything existed around whistleblowing. What is going to change? What are the three, four, five levers of what you are going to implement that will make life different?

Jonathan Slater: Absolutely. The first crucial thing is to have a very clear policy, signed off by PCaW; it is only the beginning. The second thing is to make sure that people know about it—absolutely—and they need to know about it from the very top of the organisation. So, next Monday they will all be getting a letter from the Permanent Secretary and the Chief of Defence Personnel setting out the policy. The next thing we need to do is to make sure that we are implementing it and that we are telling everybody that we are implementing it, in the way that other members of the panel have referred to and in the way that Chris was describing the importance of explaining to people where whistleblowers have whistleblown and what we have done about it.

We have agreed with PCaW that the right way to start is to produce a quarterly report based on data from the nominated officers who will specialise in dealing with whistleblowing complaints, to identify what action was taken, to identify whether there are systemic things that need to be put right and to publicise the application of the policy in practice. People will need to hear that it is being led from the top, which is why Jon Thompson and I will be taking part in the first training programme that we have designed with the support of PCaW. It is also why we are organising a whistleblowing awareness week that will need to be led from the top of the organisation, with a quarterly report on progress in—

Q140 Mr Bacon: Are you expecting to have to hire in extra temporary staff from the communications department to deal with the blip in whistleblowing or information that is going to come forward?

Jonathan Slater: No.

Q141 Mr Bacon: I am sorry. That was a slightly whimsical question. Just while I have you, Mr Slater, what happens to somebody in MOD who does not treat a whistleblower with due care? Are they sanctioned?

Jonathan Slater: If an allegation was made by a member of staff that they had been suffering reprisals as a result of whistleblowing, I would expect HR or the Permanent Secretary to appoint an investigating officer to identify whether disciplinary action should be taken in the normal way.

Q142 Mr Jackson: Just a quick last question. Do you think there is merit in the idea of having a professional standards governance regime in Government Departments such as health and education, as they do in constabularies and the Metropolitan Police, to oversee the issues around whistleblowing, ethical challenges and other behaviour? It seems to me, listening to the specific examples that we heard today, that it is a bit spatchcock and a bit ad hoc, notwithstanding the legislation, but that if you had a professional standards governance regime it would be clarified, and some of the points put to Mr Wormald would be addressed. You can start.

Chris Wormald: Yes, I thought you might say that. Well, we already have a role in overseeing, as part of the EFA's regulatory functions, whether academies are well governed. We discussed with this Committee before that we act both as the financial regulator and the enforcer of the funding agreements with academies, and we also exercise powers over academies as charities, as an agent of the Charity Commission, so we already have quite a lot of responsibilities about the issue of governance.

I have not considered the model that you propose. I think the question would be what it added to our existing sets of oversights of those institutions. Sorry, that is not a very clear answer, but I do not think it is the kind of question to give you a top-of-the head reaction.

Q143 Mr Jackson: But you will go away and think about it.

Chris Wormald: Well, as I say, I am not going to give you a top-of-the head reaction. I think the question—we look at our oversight of academies all the time, and we ask ourselves whether it is good enough and whether it is dealing with ever-expanding numbers of academies.

Q144 Mr Jackson: Praying in aid the Charity Commission is not actually a silver bullet with this Committee. That is completely useless, as a body generally.

Chris Wormald: I learned that on my last occasion, but just as a matter of fact, unfortunately, we do. We are designated as the agent of the Charity Commission in enforcing charity law, and that is an important part of our regulation of the academy sector. I am not going to comment—as I did not last time—on the Charity Commission, as you have dug into that issue yourselves. Our regulatory functions include that set of powers set out in charity law, as well as the arrangements we have in funding agreements. This will probably be an unpopular answer, but I will give it anyway: I am not always convinced in these cases that centralisation of these issues is the right way forward.

Q145 Chair: We are not talking about centralisation, Chris. We are talking about monitoring.

Chris Wormald: No, the question was about ethical oversight, in the same way as the police. We do think that individual institutions should take responsibility for themselves, as opposed to looking to another body. That is not to say that we do not have very important regulatory functions, around intervening when things go wrong, but the basis of our system at the moment is that institutions are free to run themselves, and we intervene when there is evidence that there is a failure to do so, as opposed to the system that you see in other parts of the public sector, where there is direct oversight of delivery. That is the model we have chosen, and we can debate—and have debated several times—the pros and cons of that model, but at the moment our activity is focused on that question, which we have discussed both today and previously, of how do you spot failure well and intervene, as opposed to a sort of ongoing oversight of everything. I think that is the distinction.

Q146 Chair: I have two final questions. One issue we have not talked about is incentives. Kay Sheldon talked a little bit about that, and I think it is an issue. Do any of you have a budget to support whistleblowers, if they need extra care—if they need legal advice?

Lin Homer: I do not keep a ring-fenced budget, but with a Department the size of ours we can make money available, and we have done all those things that you have said, including payment for independent advice. If I might cheekily just try and suggest an answer to Mr Bacon's question about what you do to make sure policy is seen as effective, I think one of the issues there is to be very clear about the actions that follow, not just in relation to the whistleblower but substantively; so for me one of the questions is, if somebody has raised an issue, even if it is not wholly founded in vindicated concerns, none the less if there are improvements to be made, you make those, and you make it plain that they have come about as a result of the staff opinion.

Q147 Chair: You tell them.

Lin Homer: Yes. We have made some changes to how we deal with big cases. We are more transparent about the number. We continue to have staff sitting in for the decisions of the cases. We give you an annual report. One thing that encourages others is for people to see that whistleblowing has results—

Q148 Mr Bacon: Including perhaps somebody being promoted. It should not have to take someone as brave as Kay Sheldon, hanging on to the truth for grim death, for something to happen.

Lin Homer: I agree, but what will encourage people is to see that the organisation will do something differently as a result of concerns raised, even if they are sometimes painful.

Q149 Mr Bacon: Do you think that should occasionally include people being promoted? There are not exactly many examples at the moment.

Lin Homer: Only some will be as big as some of the ones that we have discussed today, but a series of small changes that people can see are as a result of their action is one thing that raises trust in the system.

Q150 Chair: Do any of you have budgets for supporting individuals?

Charlie Massey: We have the resource. We have focused our resource on signposting and raising awareness among staff across the NHS. The Department of Health funds a whistleblowing helpline, which published just last week a really good piece of guidance for raising concerns—

Q151 Chair: We would expect that. The question was about support to individuals.

Charlie Massey: On specific support, we do not have an earmarked budget, but we would be very clear that we or providers—wherever the whistleblowing takes place—should make funding available.

Q152 Chair: The Americans, taking incentives a bit further, have a regime that enables whistleblowers to be rewarded if there is a significant financial loss to Government. If you look at the US Securities and Exchange Commission, an individual in the Dodd-Frank case was awarded \$14 million. Is anyone thinking about incentives of that nature?

Lin Homer: We do reward. Obviously, our system includes both internal and external whistleblowers. I think we disclosed some figures to you about the moneys that we pay for information that leads to criminals being stopped, but it is not in the order of the US example that you gave. Perhaps fortunately for my budget, the people who whistleblow to us are content with more modest amounts—

Q153 Mr Bacon: A book token.

Lin Homer: It is sometimes more than a book token, but we disclose the amounts in our accounts.

Q154 Chair: I am told that the Home Office is looking at financial incentives for fraud. Is that right?

Paul Oliffe: For fraud? Or are you thinking about asset recovery?

Mr Bacon: You do not mean financial incentives for fraud, do you?

Q155 Chair: No. Incentives to encourage whistleblowers to come forward. I just think it is an interesting issue, but I do not know whether it would work.

Finally—we have not covered this yet, but it is in the Report—what is your view on having a stronger cross-Government capability? Chris will obviously be against it, but what do the rest of you think?

Chris Wormald: You go first, Lin.

Lin Homer: Well, I do not think I heard Chris being against that.

Chair: He hates anything to do with the centre.

Lin Homer: We have certainly benefited from the role that CSEP has played. It is useful and appropriate that we will get asked questions if we are not matching up to best practice. I do think that we are different and the questions you have put to us illustrate that. I do not believe that an absolutely rigid approach would make sense, but we should be asked to comply or explain—to use the private sector model—“Do you follow best practice? If not, why not?” It may sometimes be that your organisation is different or it might be that you are experimenting with what will become future best practice. It is useful, however, that the centre produces that guidance.

Chair: Good. Thank you.