



House of Commons
Committee of Public Accounts

The provision of the out-of-hours GP service in Cornwall

Fifteenth Report of Session 2013–14

*Report, together with formal minutes, oral and
written evidence*

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Committee of Public Accounts

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Committee staff

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Summary

Out-of-hours services provide urgent primary care when GP surgeries are closed. In early 2012 whistleblowers raised concerns that the out-of-hours service in Cornwall was short staffed and that the contractor, Serco, had lied about its performance by altering data. Serco provides the service under a £32 million five-year contract with the primary care trust, NHS Cornwall and Isles of Scilly, until 31 March 2013, and since 1 April 2013 with Kernow Clinical Commissioning Group.

The primary care trust and the strategic health authority did not demonstrate they had the appropriate skills to negotiate effectively with private providers and hold them to proper account for poor performance. Serco, as a large provider of public services is able to win public sector contracts but has not in this instance proved capable of delivering a good service on the ground.

Evidence has confirmed that what the whistleblowers in Cornwall were saying was substantially true. However, Serco appears to have had a bullying culture and management style which inhibited whistleblowers from being open in the patients' interest. The company responded to stories placed in the press by whistleblowers in a heavy handed way, launching internal investigations and searching employees lockers when issues were raised, and staff were fearful of raising concerns. Serco initially denied the concerns raised by whistleblowers and it was only after reports appeared in the press that it started to accept that things were wrong. Most concerning was the fact that Serco staff altered data on 252 occasions, resulting in Serco overstating the performance it reported to the primary care trust. Serco could not explain what motivated the two staff concerned to act in this way. These two staff were not paid a bonus, but Serco conceded that the contract manager had been paid a bonus which was linked to performance. The staff have since left the company. The terms of their departure included confidentiality agreements, but Serco offered no convincing explanation of why this was necessary.

The quality of the service being provided by Serco in Cornwall is not good enough. People rely on out-of-hours services when they need urgent medical care in the evenings, at weekends and on bank holidays when regular GP surgeries are shut. Serco has struggled to ensure enough staff are available to fill all its clinic and car shifts, although it has increased staffing levels in recent months. It has consistently failed to meet the national quality requirements relating to the responsiveness of out-of-hours services and performance is still falling short. However, it is difficult to assess how Serco's performance compares with other out-of-hours services, because benchmarking data is incomplete and performance against the national quality requirements, that all out-of-hours services are expected to meet, is not collated nationally.

Serco's performance declined dramatically in the middle of 2012 following the introduction of a new system called NHS Pathways. The system allows call handlers to make an initial clinical assessment as soon as patients call the service. Serco underestimated the number of staff needed to operate the NHS Pathways system and performance against the national quality requirements for answering and assessing calls dropped sharply. There

was also a substantial rise in the number of calls passed to the local ambulance service.

The primary care trust did not scrutinise Serco's performance effectively. When these issues came to light, it did not penalise Serco, withhold payment or terminate the contract. The incentives in the contract were only loosely linked to achieving the national quality requirements, although the primary care trust could terminate the contract in the event of repeated failure to meet the requirements. Serco was one of only two bidders when the contract was let in 2011. Other potential bidders dropped out as they could not stay within the cost ceiling set by the primary care trust. Serco told us that it is currently making a loss on the contract.

On the basis of a Report by the Comptroller and Auditor General,¹ we took evidence from Serco, the former strategic health authority, the former primary care trust and the clinical commissioning group on the provision of the out-of-hours GP service in Cornwall.

Conclusions and recommendations

1. **This inquiry validates concerns we have raised previously about the framework for devolved local services.** In particular, evidence about the out-of-hours service in Cornwall raises issues about the capability of the NHS to contract effectively with private providers. We are concerned about the robustness and availability of performance information, the strength of local accountability mechanisms, and the quality of oversight of a contracted service. We are also concerned that large private providers are emerging who are extremely skilled in negotiating and securing contracts but then fail to deliver a good, value for money service. Responsibility for this particular service now rests with the local clinical commissioning group. However, NHS England is accountable for the proper functioning of the commissioning system as a whole. On this basis, we would welcome NHS England's observations on the following points and on what assurance it has that these issues are not replicated elsewhere in the commissioning system.
 - i. **The primary care trust was deeply ineffective and employed limited levers to manage Serco's performance and did not use those it had effectively.** The contractual incentives were not linked closely enough to the achievement of the national quality requirements for out-of-hours services. This meant that the primary care trust made some bonus payments despite the fact that Serco's performance was falling well short of what was required. Even when it knew that Serco had falsified performance data, the primary care trust did not fine the contractor or terminate the contract. NHS England must also give clear guidance and respond promptly to requests for advice from clinical commissioning groups about whether services should be put out to tender.
 - ii. **The primary care trust needed to challenge Serco's performance much more robustly.** NHS bodies need to be commercially shrewd in dealing with major contractors like Serco so that contracts have the right framework and obligations and that performance is rigorously scrutinised. The new clinical commissioning groups will need access to adequate procurement skills and advice when they put services out to tender to make sure contracts are well designed and secure value for money for the taxpayer.
 - iii. **Serco's culture and management style discouraged whistleblowing.** The concerns about the out-of-hours service in Cornwall only came to light because of the intervention of whistleblowers. Serco failed to investigate thoroughly when concerns were first raised and the way management responded made whistleblowers feel threatened and fearful of raising further concerns.
 - iv. **It is unclear why Serco felt it necessary to use confidentiality agreements.** The terms of the severance agreements with the two members of staff who manipulated performance data included confidentiality clauses. We can see no justification for this practice, which runs counter to the culture of openness the Secretary of State has said he wishes to see in the NHS.

2. **Serco's performance on this contract has not met national standards.** For example, 20% of calls were abandoned after 89 seconds against a national standard of 5% or fewer. Even where it has increased staffing it still has insufficient staff to fulfil clinical shifts.
3. **Serco underestimated the number of staff needed, especially to operate NHS Pathways. Its performance in dealing with calls declined dramatically after the system was introduced.** We heard evidence that NHS Pathways is a good system, but it needs sufficient numbers of properly trained operators to work successfully. The new 111 services, which are starting to be introduced across the country, will also be using NHS Pathways. There is a risk that these services will experience the same problems as Serco did in Cornwall. NHS England should seek assurance from all 111 service providers that they have fully assessed the likely impact of NHS Pathways, that they are confident they have sufficient staff in place, and that they have contingency plans in case staffing levels prove to be insufficient so that there are no adverse effects on patients.
4. **The lack of comparable data means it is not clear whether Serco is providing a better or worse service than other providers of out-of-hours services.** The Department has not mandated that local NHS bodies publish comparable performance data on this area. Because the current benchmarking exercise is voluntary it is incomplete, and the information is out-of-date. This makes it impossible for local people to know how their out-of-hours service compares with others. NHS England should require clinical commissioning groups to publish comparable data, in a common format, showing local performance against the national quality requirements to support transparency and accountability.

1 The quality of the out-of-hours GP service in Cornwall

1. Out-of-hours GP services allow people to see a doctor when they need to in the evenings, at weekends and on bank holidays, when GP surgeries are closed.² In Cornwall, Serco runs the out-of-hours GP service. Until 31 March 2013, the service was provided under a contract with Cornwall and Isles of Scilly Primary Care Trust.³ With the abolition of the primary care trust under the Health and Social Care Act 2012, responsibility for the contract passed to Kernow Clinical Commissioning Group on 1 April 2013.⁴ Clinical commissioning groups are accountable to NHS England, which is responsible for the commissioning system as a whole.⁵ We have emphasised before that regardless of what public money is spent on, or which bodies are spending it, it must be spent properly with due regard to value for money.⁶

2. Cornwall is Serco's only out-of-hours GP service in the UK.⁷ It has provided the service since 2006. The current contract, which is for five years, started in October 2011 and is worth £32 million in total, about £7 million a year. Serco estimates that for 2012 it will make a loss on the contract of about £1 million.⁸ It did not expect to make a loss when it bid for the contract, and does not believe that the primary care trust set the cost ceiling for the contract too low. But two potential bidders decided they could not submit a bid within that limit.⁹

3. Serco has consistently failed to meet the national quality requirements for the responsiveness of out-of-hours services set by the Department of Health.¹⁰ In January, February and March 2013, Serco did not meet the requirements for answering telephone calls quickly, making clinical assessments, or carrying out face-to-face consultations promptly.¹¹ In March 2013, Serco answered just 52% of calls within 90 seconds (against a standard of 100%), and 20% of calls were abandoned after 89 seconds (against a standard of 5% or fewer).¹²

4. Serco is struggling to improve performance in the face of rising demand for the service. Demand increased by 20% in the six months from September 2012.¹³ Demand for out-of-

2 C&AG's Report, para 1.1

3 C&AG's Report, para 1.2

4 C&AG's Report, para 1.9

5 Q 241

6 Report by the Committee of Public Accounts, Accountability for public money, twenty eighth report of Session 2010-11, HC 740

7 Q 162

8 Qq 16, 169; C&AG's Report, para 1.2

9 Qq 55-57, 104, 174-175, 271; C&AG's Report, para 3.21

10 C&AG's Report, para 8

11 Qq 85-87, 301; Ev 30

12 Qq 142-146; Ev 30; C&AG's Report Figure 6

13 Qq 114-115

hours care is inevitably unpredictable, but Serco does not understand the reasons for the sharp increase. It is working with local commissioners to work out how demand might be reduced.¹⁴

5. Performance against the national quality requirements declined significantly following the introduction of NHS Pathways in May 2012. NHS Pathways is a computer-based triage system, which staff answering calls from patients use to make an initial clinical assessment. It is the system which will be used nationally for the new 111 services for urgent care which are being introduced from April 2013. Serco told us that the benefit of NHS Pathways is that it allows a non-clinician, who would normally just take a patient's address and date of birth, to deliver care straightaway.¹⁵

6. NHS Pathways is risk averse. The number of calls passed to the local ambulance service increased sharply after the system was introduced, and 12% of calls resulted in either an ambulance being sent, or people being told to go to a hospital emergency department. That level of demand on emergency departments was not sustainable or appropriate, so Serco has implemented an additional clinical assessment stage to make sure people get the right care. The proportion of calls which result in an ambulance being sent or people being told to go to an emergency department has since fallen to 5%.¹⁶ Serco does not know, however, whether the additional stage is causing delay, but is working to measure the impact.¹⁷

7. The out-of-hours service in Cornwall was the first to implement the NHS Pathways system in full. At the outset, Serco had insufficient call handlers to deal with peaks in demand, but has since increased the number of call handling staff.¹⁸ It now has 63 call handlers and is training more. It takes a year, however, for a call handler to become completely proficient.¹⁹

8. Whistleblowers raised concerns about short staffing in the out-of-hours service.²⁰ Serco needs to have staff available in clinics and in cars to visit patients at home. During 2012, it regularly had insufficient staff to fill all clinical shifts. For example, most shifts in the last three months of the year were not fully staffed.²¹ In the first three months of 2013, the proportion of scheduled car hours that were unfilled was 7.6% in January, 6.4% in February and 6.3% in March 2013.²² Serco told us that since June 2012 it had increased actual clinical hours by 13.5%.²³ It has also agreed a minimum baseline staffing level with the primary care trust and the clinical commissioning group. Since then, staffing has never dropped below the baseline. However, because rotas typically provide for staffing levels around 15%

14 Qq 55, 66, 102, 161

15 Qq 66, 180, 252

16 Qq 66, 74

17 Q 81

18 Qq 55-57, 66

19 Q 151

20 C&AG's Report, paras 2.16-2.19

21 C&AG's Report, paras 5, 2.19 and Figure 5

22 Qq 88-94; Ev 30

23 Qq 98-100

above the baseline, it is possible for Serco to meet the baseline and still have unfilled shifts.²⁴

9. The limited benchmarking data that exists indicates that the out-of-hours service in Cornwall is better than the service available in many other parts of the country.²⁵ However, the benchmarking is voluntary and local services do not have to provide data. The benchmarking does not therefore give a complete or consistent picture of the performance of all out-of-hours services.²⁶

24 Qq 97-98

25 Q 251; C&AG's report, paras 2.35-2.36

26 Qq 251, 255-256

2 The changes made to Serco's reported performance data

10. Whistleblowers raised concerns that Serco staff were altering data with the result that performance reported to the primary care trust was overstated.²⁷ Serco initially denied allegations of data manipulation when they were first reported. However, it subsequently carried out a detailed forensic audit covering the first six months of 2012, which found that two members of staff had made unauthorised data changes on 252 occasions. The changes resulted in Serco's performance against the national quality requirements being overstated in seven instances in reports to the primary care trust.²⁸ The primary care trust told us that Serco had admitted that it was likely that changes had also been made to performance data in 2011, although this period had not been reviewed.²⁹

11. Serco told us that the data changes were difficult to detect. The unauthorised changes were not identified by routine management controls or by an earlier review by the primary care trust's internal auditors.³⁰ Serco told us that it had subsequently strengthened data protocols, and restricted access to the system.³¹

12. In October 2012 the primary care trust commissioned PricewaterhouseCoopers to validate Serco's forensic audit. PricewaterhouseCoopers had not reported in full at the time of our hearing, but the primary care trust told us that the three key findings were that: the staff who carried out the forensic audit were properly qualified and suitably independent; there was no material difference between PricewaterhouseCoopers' audit and the audit Serco undertook; and no further changes had been found in data relating to the six months from July 2012.³² The clinical commissioning group is committed to publishing the results of PricewaterhouseCoopers' review as soon as possible.³³

13. Serco stressed that changing data in this way was wholly unacceptable.³⁴ The two employees concerned were suspended and have now left the company.³⁵ However, the individuals' motivation for changing the data remains unclear.³⁶ Serco told us that there had been no financial gain to the two individuals or the company as a result of the changes that had been made; Serco also claimed that management had not sanctioned or condoned the changes. The staff were not, for example, eligible for performance bonuses but the contract manager was. His bonus depended in part on financial performance. Serco conceded that if performance was reported as being more successful because data had been

27 C&AG's Report, para 3.1

28 Q 126; C&AG's Report, paras 11-12

29 Q 212

30 Qq 130-131

31 Q 58

32 Q 58

33 Qq 202-209; C&AG's Report, para 3.10

34 Q 120

35 C&AG's Report, para 3.12

36 Qq 120, 122, 127-129

manipulated, the contract manager would be more likely to get a bonus. Serco confirmed that they had asked the individuals concerned for an explanation for their behaviour but they had provided “absolutely no reason whatsoever”.³⁷

14. The two staff who left signed severance agreements, which included confidentiality clauses.³⁸ Serco told us that this approach provided a simple mechanism for removing the individuals swiftly, but it did not provide a convincing explanation as to why the confidentiality clauses were needed.³⁹

15. Responsibility for managing the contract for the out-of-hours service rested with the primary care trust until 31 March 2013. It should have scrutinised Serco’s performance more closely.⁴⁰ Out-of-hours services were not part of the national performance framework which the strategic health authority used to oversee the primary care trust’s performance.⁴¹ The strategic health authority became involved only by exception, if the primary care trust alerted it to difficulties.⁴²

16. The contract used by the primary care trust was a standard framework contract that was developed nationally. It allows for contract termination as the remedy for breach or repeated failure to comply.⁴³ The contract does not include provisions to fine Serco. The primary care trust said that it considered withholding payment from Serco, but decided not to do so after taking account of performance in the round, including the positive feedback from patients.⁴⁴

17. The contract includes five key performance indicators but only one is linked to performance against the national quality requirements, which the data changes affected. Serco’s behaviour did not affect the amount of money the primary care trust paid to Serco.⁴⁵ Serco received some but not all of the bonus payments it was eligible for in 2012.⁴⁶

18. The clinical commissioning group has put in place more robust contract and performance management arrangements, in light of the recommendations in the Comptroller and Auditor General’s Report. It is looking at what further options are available to help it manage the contract effectively,⁴⁷ including the possibility of more nuanced contractual incentives so it can impose penalties without terminating the contract. The strategic health authority told us that the NHS needs better contract management and the levers to deliver it. The culture has traditionally been not to levy fines and penalties.⁴⁸

37 Qq 120, 122

38 Qq 33-34

39 Qq 38-41

40 C&AG’s Report, para 3.14

41 Qq 185-187, 251

42 Q 251

43 Qq 221, 224, 238

44 Qq 191-196, 239, 262

45 Qq 214, 235; C&AG’s Report, para 3.18

46 Qq 305-306

47 Qq 223, 228-230, 242-246, 303-306

48 Q 251

3 Protecting whistleblowers

19. Whistleblowers played a key role in surfacing concerns about the out-of-hours service in Cornwall, despite fearing the consequences of speaking out.⁴⁹ Serco told us that its staff can raise concerns with an external organisation and 135 employees had used this service in the past year. Employees are able to raise concerns anonymously if they choose to do so. Serco told us that concerns are investigated and action taken where they are substantiated. Serco asserted that there are no reprisals against staff who use the service.⁵⁰

20. Policies and processes on whistleblowing are not sufficient on their own. In a healthy organisation, leaders must be seen to be accountable and promote an open culture.⁵¹ However, in response to whistleblowers passing information to the press, Serco's local managers in Cornwall launched an internal investigation that included reviewing staff email accounts and unannounced searches of staff lockers.⁵² Serco accepted that local managers had communicated to staff in a way they would not condone.⁵³ When concerns came to light, Serco sent experienced managers to talk to staff in Cornwall to understand how things were being run. They found examples of inappropriate leadership styles. Serco has since changed the senior team in Cornwall, including strengthening the clinical leadership, and believes that the ethos and culture in the service has improved significantly.⁵⁴

21. To encourage staff to feel comfortable about raising concerns, Serco wrote a joint letter with the primary care trust to staff, and also provided staff training, to reiterate how concerns can be raised and what protection is available. An employee engagement survey, carried out for Serco by an external organisation, found that 79% of staff said they felt comfortable that they could raise issues with their line manager, an increase of 3% since Serco started these initiatives.⁵⁵

22. The Department of Health confirmed that whistleblowing legislation covers private sector, as well as public sector, employees. The Department agreed that the way in which Serco handled the whistleblowers was strongly counter-productive in terms of creating an open culture where people feel confident speaking out.⁵⁶

49 C&AG's Report, paras 4.1, 4.5

50 Qq 54, 134; Ev 30

51 Qq 59-60

52 Qq 42, 50

53 Qq 43, 51

54 Q 59

55 Qq 63-64

56 Qq 311-313

Formal Minutes

Monday 24 June 2013

Members present:

Mrs Margaret Hodge, in the Chair

Mr Richard Bacon
Guto Bebb
Jackie Doyle-Price
Chris Heaton-Harris
Meg Hillier

Mr Stewart Jackson
Fiona Mactaggart
Nick Smith
Justin Tomlinson

Draft Report (*The provision of the out-of-hours GP service in Cornwall*), proposed by the Chair, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 22 read and agreed to.

Conclusions and recommendations agreed to.

Summary agreed to.

Resolved, That the Report be the Fifteenth Report of the Committee to the House.

Ordered, That the Chair make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

Written evidence was ordered to be reported to the House for printing with the Report.

[Adjourned till Monday 1 July at 3.00 pm]

Witnesses

Monday 22 April 2013

Page

Valerie Michie, Managing Director, **Jeremy Stafford**, Chief Executive Officer UK & Europe and **Dr Louis Warren**, Contract Director, Serco

Ev 1

Sir Ian Carruthers OBE, former Chief Executive, NHS South of England, **Gavin Larner**, Director of Professional Standards, Department of Health, **Steve Moore**, Chief Executive, Cornwall and Scilly Isles Primary Care Trust and **Joy Youart**, Managing Director (Accountable Officer), Kernow CCG

Ev 18

List of printed written evidence

1 Serco

Ev 30

List of Reports from the Committee during the current Parliament

The reference number of the Government's response to each Report is printed in brackets after the HC printing number.

Session 2013–14

First Report	Ministry of Defence: Equipment Plan 2012-2022 and Major Projects Report 2012	HC 53
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Oral evidence

Taken before the Committee of Public Accounts on Monday 22 April 2013

Members present:

Margaret Hodge (Chair)

Guto Bebb
Jackie Doyle-Price
Chris Heaton-Harris
Meg Hillier
Mr Stewart Jackson

Fiona Mactaggart
Austin Mitchell
Ian Swales
Justin Tomlinson

Amyas Morse, Comptroller and Auditor General, **Gabrielle Cohen**, Assistant Auditor General, and **Laura Brackwell**, Director, National Audit Office and **Marius Gallaher**, Alternate Treasury Officer of Accounts were in attendance.

REPORT BY THE COMPTROLLER AND AUDITOR GENERAL

Memorandum on the provision of the out-of-hours GP service in Cornwall (HC 1016)

Examination of Witnesses

Witnesses: **Valerie Michie**, Managing Director, Serco, **Jeremy Stafford**, Chief Executive Officer UK & Europe, Serco, and **Dr Louis Warren**, Contract Director, Serco, gave evidence.

Q1 Chair: Thank you for agreeing to give evidence this afternoon. I will start with you, Mr Stafford, as the chief executive officer. I have three questions. To give some context to the consideration of the contract in Cornwall, how much business does Serco currently do with the public sector? I would define that as including work for central Government, health authorities and local government and schools. How much work across the piece? How much is all that public sector work worth in terms of turnover to your company?

Jeremy Stafford: Today that turnover is around £2.4 billion.

Q2 Chair: £2.4 billion?

Jeremy Stafford: If you put it all together.

Q3 Chair: And what is that as a percentage of all the business that you do as a company?

Jeremy Stafford: A little less than half.

Q4 Chair: Is the rest of your business public sector contracts abroad or other business in the UK?

Jeremy Stafford: We are a global business, so the majority of that is abroad. A small portion is private sector business in the UK.

Q5 Chair: And that is facilities management and that sort of thing?

Jeremy Stafford: That is correct.

Q6 Chair: What proportion of that £2.4 billion is in the health sector?

Jeremy Stafford: The health sector is about £300 million.

Q7 Chair: And growing? Are you bidding a lot in health?

Jeremy Stafford: Yes, we are.

Q8 Chair: And what were you two years ago in health? Do you know?

Valerie Michie: It would have been around £200 million to £250 million about two years ago.

Q9 Chair: Thank you. For the last financial year, what were your pre-tax profits overall as a company?

Jeremy Stafford: They were £287 million.

Q10 Chair: And your top directors' salaries and bonuses?

Jeremy Stafford: Our chief executive earns just over £700,000.

Q11 Chair: And then a bonus?

Jeremy Stafford: He will have a bonus on top of that.

Q12 Chair: How much?

Jeremy Stafford: I can't recall that number off the top of my head, but I am happy to come back to you with that answer.

Q13 Ian Swales: In our notes, it says that Mr Stafford is the chief executive officer. Is that a mistake?

Jeremy Stafford: I am the chief executive officer of UK and Europe, and Chris Hyman is the chief executive officer of the group.

Q14 Chair: Are you prepared to tell us what is your salary and bonus?

Jeremy Stafford: Of course. I earn £325,000.

22 April 2013 Serco

Q15 Chair: And your bonus?

Jeremy Stafford: I am eligible for a bonus on top of that, and 50% is my target bonus for the year.

Q16 Chair: Thank you very much indeed. This contract is worth £32 million. Are you able to share with us your pre-tax profit expectations on this contract?

Jeremy Stafford: The total contract value over the years is £32 million, so it is about £7 million a year turnover. In 2012, we will make a loss on it of about £1 million.

Q17 Chair: You will make a loss of £1 million in 2012, so how will you turn that round in 2013?

Jeremy Stafford: I doubt whether we will turn it round in 2013. We are very focused on making sure that we deliver a good service to the citizens and meet our commitments to the commissioners. From the commentary in the Report, you will be aware that we had a number of things to address in 2012, such as the introduction of the Pathways system. We have also had a significant increase in usage: currently about 20%, but annualised at about 10%. At the moment, we are very focused on making sure that we deliver a good service. If that means that we make a loss, so be it.

Q18 Chair: When do you expect to make a profit?

Jeremy Stafford: We would like to make a profit in 2014, but we do not know how long that will take. If you look at the contracts that we deliver in other parts of the public sector, where we have issues, we stay with them as long as it takes to get them fixed.

Q19 Chair: Out of this £7 million—actually, you are making a loss as you are spending £8 million in the current year—how much of that is staffing? What proportion of that goes on people?

Jeremy Stafford: Valerie, perhaps I could ask you to pick that up.

Valerie Michie: I do not have the exact percentage, but it would be the vast majority of the cost on the contract.

Q20 Chair: So, what—85%?

Valerie Michie: Yes, or higher, probably.

Dr Warren: It is just under £600,000 a month, so it works out across the year as the lion's share of the operational costs.

Q21 Chair: Six hundred thousand pounds a month. And are you now fully staffed on healthcare advisers? You said that you would have 61 in post by the end of March, so have you got that?

Dr Warren: We have 63 health advisers—

Q22 Chair: In post?

Dr Warren: In post. Two are awaiting CRBs, but they are fully trained and ready to start work.

Q23 Chair: Are all of them full time?

Dr Warren: There is a range of times that they work. On average, they tend to work about 15 to 20 hours, but the manning profile, which is in the NAO Report

and discussed by the CQC, is based on that, and that 61 was the projected number of staff that we needed. Given the fact that we are dealing with a 20% uplift in demand, we are working with our commissioners and health providers to understand that demand and make sure that we can robustly deal with it and give the best level of care, so we will be recruiting even more beyond the 63 that we have in place at the moment.

Q24 Chair: And doctors?

Dr Warren: We have four times as many GPs employed as we did at the time of the first CQC visit. In terms of our staffing across the board, we have a mix of staff, but we are delivering a very high level of care with that extra staffing. Indeed, that is replicated with our patients' surveys; the last two of which have shown a greater than 95% in terms of—

Q25 Chair: Thank you very much for that full information. There are two areas that we want to concentrate on: one is whistleblowing, and we also want to talk a little bit about the quality of the service delivered in Cornwall. I will start generally with whistleblowing: just for my information, as a private contractor delivering a public service, are you covered by the whistleblowing legislation?

Jeremy Stafford: Yes we are, and we take our responsibilities there very seriously. We have benchmarked whistleblowing systems within the business and they are used extensively.

Q26 Chair: Can you explain the two people who fiddled the figures? I understand that you believe that they were mavericks. What was the financial or other incentive for them to cheat?

Valerie Michie: There was no financial gain to them or the company for the changes that they made. We have reflected on their motives. I can only assume that they wished to portray a better view of the performance of the service. As you can see from the data in the Report, not all the changes that they made actually improved the sort of dashboard of the service.

Q27 Chair: It seems odd to me to want to manipulate data if there is no incentive to do it. I want to ask a question of all three of you, if you can answer it. Can you assure me—because it is not what I have heard from the whistleblowers—that neither of those individuals received any instruction from anybody in Serco to manipulate or in any way alter the data for any purpose?

Valerie Michie: Yes, categorically. We performed a full investigation. We were concerned about the repeated concerns that were raised around data performing and reporting. Although two previous external audits, one by Tenon and one by the CQC, had not found any issues, none the less, we were still concerned and put in place our own very detailed forensic audit, which allowed us to uncover the changes that were happening that were low-level but highly concerning to us.

When we did uncover that, we immediately carried out a thorough investigation, which also involved looking at whether those changes were known,

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sanctioned or condoned elsewhere within the organisation. We found absolutely no evidence of that whatsoever.

Q28 Chair: It seems very odd to anybody from the outside that they should manipulate data without there being an instruction for them to do so. You are telling me categorically, Ms Michie, that there was no such instruction?

Valerie Michie: I am, yes.

Q29 Chair: Do you agree with that, Mr Stafford?

Jeremy Stafford: I do.

Q30 Chair: Anywhere in the organisation?

Jeremy Stafford: I absolutely agree with that.

Q31 Chair: And Dr Warren?

Dr Warren: Yes, completely. There is absolutely no way—

Q32 Chair: Were any of you around at the time?

Dr Warren: I was and I worked for the service clinically. I worked both as a self-employed doctor and I came on as an employed doctor in the middle of last year, and now run the service as a GP and still work.

Q33 Chair: Have the two individuals signed severance agreements?

Valerie Michie: They have, yes.

Q34 Chair: Is there a confidentiality clause in that severance agreement?

Valerie Michie: The agreements do contain confidentiality clauses. However, they make it explicit that that does not prohibit people from making protected disclosures or from whistleblowing. That is standard in all our employment contracts and compromise agreements.

Q35 Chair: Why sign a confidentiality agreement then?

Valerie Michie: It was a simple and effective way for us to remove them from the service.

Q36 Chair: But it is your choice to make it confidential, not theirs. I can understand that you wanted a severance agreement but why put a confidentiality clause in it?

Valerie Michie: When we had the conclusion of the Report, we started an investigation process. The individuals concerned were immediately suspended on receipt of the evidence that we had. At that point, the individuals decided that they wished to leave, and we accepted that. This was the easiest and swiftest way.

Q37 Chair: Why put a confidentiality clause in it?

Valerie Michie: It was something they wanted as well. They were operating within a—

Q38 Chair: Why did you want it?

Valerie Michie: It wasn't a factor for us. What we wanted was a simple exit for the individuals.

Q39 Chair: You don't need a confidentiality clause for that. You could just agree a severance payment, without a confidentiality clause.

Valerie Michie: We could, but it is a standard way of agreeing an exit.

Q40 Chair: But why?

Valerie Michie: Partly because we hadn't finished the employee process, which could have taken quite some time. The investigation itself took us quite some time and quite intensive effort. What we wanted to do was address this quickly and move on, and this provided a swift mechanism to do that.

Q41 Chair: That is not a very convincing response, if I am honest with you.

Valerie Michie: It is the honest response.

Q42 Chair: I am going to ask two more questions and then I am going to Mr Jackson, Fiona Mactaggart and Austin Mitchell.

I have here a copy of an e-mail that a Mr Alan Tooth sent to loads of people—you've probably seen it—in which he says: "I am writing to inform you that, as stated in the recent team brief, an investigation will begin over the coming week due to the recent inaccurate information"—that is his view—"that has been sent to the local and national press. Serco will be conducting a thorough investigation and will be working with third parties, such as Cornwall IT Services, for information related to Serco e-mail accounts, and any content of e-mails deemed appropriate, to establish the facts related to any false information being passed to others within the organisation or externally to the business." Why did you undertake this sort of exercise to try to inhibit whistleblowing?

Valerie Michie: There are two responses there. One is to point out that Mr Tooth is no longer in our employment and is one of the individuals who has—

Q43 Chair: Everybody seems to have acted without instruction from above. Mr Tooth, at the time—I haven't got a date on this I'm afraid—sent this out. This was just at the time when the whole issue was hitting the press. You wouldn't be here if it wasn't for the press and the whistleblowing.

Valerie Michie: To respond to the question: the reason that that investigation was carried out, although I absolutely accept that that e-mail is worded in a way that we would not condone, was because part of the information that was given included patient-identifiable data and we have a legal and moral responsibility to ensure that patient-identifiable data isn't put in the public domain and it was, which is something that as a responsible healthcare provider we have to investigate properly.

Q44 Chair: So you are trying to get us to believe that you did this not to protect Serco's reputation, because it had been undermined by the whistleblower talking to the press, but to protect the confidentiality of information for the patient? Is that what you are trying to make me believe?

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Valerie Michie: First, we welcome the fact that the points that were brought to light were brought to light. They were raised with both the regulator and the press. We hope that we can demonstrate today, and also that the Report shows, that we responded swiftly and decisively to the points that were raised. We have a responsibility to follow up patient-identifiable data being put in the public domain. Some of the information that was put in the public domain was incredibly sensitive, were it to be made public, to the individuals concerned. That is something that we have to allow to happen. However, I would accept that the wording of that e-mail is less than satisfactory.

Q45 Chair: Can I ask you then, did Karl Cole, regional director at Serco Health, make verbal threats to call handlers or health advisers over whistleblowing?

Valerie Michie: Not that I was aware of. As I said, every—

Q46 Chair: Again, it has been in the public domain. Have you checked whether it is true?

Valerie Michie: Multiple allegations have been put to us through different mechanisms at different times. Each and every single allegation we have thoroughly investigated—

Q47 Chair: So did Karl Cole make those verbal threats to call handlers or health advisers over whistleblowing?

Valerie Michie: We found no evidence on that specific allegation.

Q48 Chair: He denied them to you, did he?

Valerie Michie: We found no evidence to support that allegation.

Q49 Chair: What does that mean? Did he deny them? Did you interview him and he said he did not do it?

Valerie Michie: I cannot comment specifically. I would need to go back and check how that was investigated, whether we interviewed him or the individuals. I would not want to give you the details inaccurately. However, we did not find any evidence to support that allegation.

Q50 Chair: There are two more incidents that I have come across. Did Serco undertake unannounced staff locker searches?

Valerie Michie: We did, yes.

Q51 Chair: Why?

Valerie Michie: Again, the individual who instigated that is no longer—one of the things we did and in response to the type of e-mail that you've highlighted, and immediately on having these concerns raised, we brought in managers from outside Cornwall, initially to work alongside the team in Cornwall, until we could get a very clear picture of what was specifically going on both through the day-to-day management and running of the service, but also through the detailed investigations of the specific items raised around data. One of the things that those managers,

who are experienced and trusted within our organisation, did was to sit down with all the staff—both the call handlers and those in cars—to get a picture of the style and tone and whether they were happy with the way in which things were being run. The data manipulation was, to us, completely unacceptable, and we dealt with it quickly, and we also made changes to the leadership of the service in Cornwall. We felt that strengthening the clinical leadership was appropriate—hence Louis was appointed to run the service—because we found examples of leadership styles that we felt were inappropriate.

Q52 Chair: I will ask one more question. I think it is best to get it on the table, then other Members can play with it. A whistleblowing GP told the PCT in August 2011 that he was concerned about inadequate staffing levels. Did the company call that person in and warn him that he would not be allowed to work for Serco again if there was any further whistleblowing?

Valerie Michie: If that is the same allegation that was put to us some time ago, it was also specifically investigated. Again, no evidence was found to support that allegation.

Q53 Chair: So the GP was not telling the truth?

Valerie Michie: This is the difficulty in investigating the multiplicity of things that were raised to us. Sometimes you end up with a source who understandably does not want to be named and who makes allegations against another person. That is the reality of investigating. However, where we found clear evidence—the regulator noted the staffing levels and the data reporting—we made changes to the leadership. We took on board quickly the key themes that came out, and we responded when we were able to substantiate them. This is a good, safe service, which continues to be highly regarded by the residents of Cornwall in external surveys.

Q54 Chair: We will come back to whether it is a good service today. Can I put to you, Mr Stafford, what we have established so far? In a six-month period in 2012 there were 252 instances of the wrong data being put in. We will question the PCT about why on earth they did not look at 2010 and 2011 when it was rife by 2012 and you knew there were problems; one assumes that there was less lying in 2012. You got rid of two staff, but you put a confidentiality clause in their severance agreements. You accept that Alan Tooth sent an e-mail saying that he was doing an investigation to find out who was a whistleblower. You accept that Serco undertook an unannounced staff locker search, which was, again, to look for evidence of whether anybody was whistleblowing. You have not established whether the GP was telling the truth when he was threatened, and you have not established whether Karl Cole ever made verbal threats. But you have established enough to leave me with the strong feeling that the culture within your company was one where, for some reason or another, people felt that they had to cheat, and did not feel comfortable telling the truth about the levels of

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service that were being offered by your company. Do you agree with that?

Jeremy Stafford: What I can say quite clearly is that is not the company I know. I hear very clearly the points you raised. We take whistleblowing very seriously as an organisation. We use a third party called The Network to provide an objective service. In the past year, that service was used by 135 of our employees to raise concerns. When those concerns are substantiated, they come to the appropriate level of the organisation and to me. We investigate them and support the individual, and we make sure that actions are taken to drive the high-quality services that we are committed to.

What I hear you describe in the Cornwall out-of-hours service is not the company that I recognise, and I have been very taken aback by some of what has come to light through press coverage. Rest assured that we take this most seriously, and we are taking a whole series of steps to ensure that this could not happen again in the future.

Q55 Mr Jackson: Mr Stafford, may I just take you back a bit to a more fundamental series of questions, which follow on from the Chair's original questions? We often say on this Committee that organisations such as yours are good at bidding for public sector contracts, but not very good at carrying them out. There does seem to be some evidence that it could be argued that this contract package was used as a sort of loss leader. Is your business model in Serco to expand market share in the public sector, or actually from day one to make a profit? I think I understood you to say that you were making a loss in at least one financial year.

The reason why I ask that is because you will see in paragraph 3.21 of the Report that two of the four bidders dropped out. The bigger question I am asking is: are you, effectively, almost a monopoly? You have the economies of scale to outbid anyone else, and the corollary of that, of course, is that you cannot compete at the end of it, because the cost package is unsustainable financially, and therefore you cannot deliver the service you promised. The question is: are you overbidding because you can—because you have got a good mechanism for winning a contract, but not carrying it through?

Jeremy Stafford: I entirely understand your question. We are certainly not a monopoly. We are absolutely committed to delivering good services, and in the broad range of services that we deliver, we will sometimes have service issues. We are very focused, when that happens, on seeing through our commitments to our commissioners. Valerie, is there anything that you would like to add on that, particularly in terms of health?

Valerie Michie: I was just going to say that there is no incentive for us to do that, because the commissioners we work with in Cornwall, for example, talk—the NHS structure knows and understands each other very well. As we illustrated at the beginning, health is a growth area for us, so there is no incentive for us to loss lead to grow market share, because we are incentivised to deliver from day

one on each and every single contract otherwise we would not continue to be successful in the sector.

In this particular circumstance there were two assumptions that we made that in hindsight proved to be inaccurate. The first was around the staffing model, particularly in light of post-Pathways. We assumed the delivery of a staffing model based on the best data available to us from Pathways and more generally but, in hindsight, when we implemented the system, we have augmented that staffing model significantly. The other is, as my colleagues mentioned earlier, demand, which has in the last six months, for example, increased by 20%. We did not anticipate either of those factors, which are the main drivers of the financial performance, but we did not bid for it to be a loss-leading contract.

Q56 Mr Jackson: Cornwall is not quite unique, but it is different in many ways from most of the United Kingdom. It is mainly rural, there are lots of older people, there are pockets of poverty and it is very large. To what reasons would you ascribe the fact that two of the four bidders dropped out? What did they know that you did not know?

Valerie Michie: I do not even know who the two bidders were that dropped out, I am afraid, so I could not give you an educated view as to what their reasons were.

Q57 Mr Jackson: So from your point of view, there was not an element of just winning this contract for market share to support the business model. You wanted to make a go of it, but what both of you are saying in your answers is that you made assumptions that were flawed.

Valerie Michie: Yes. We wanted to make a go of it, and we did not bid to make a continued loss, but it has transpired that two of those assumptions, in hindsight, were not proven to be what we had thought at the time, and that is what is contributing to the financial performance. As Jeremy said, having set out to deliver the service, we will do everything to ensure that we deliver a good service.

Q58 Mr Jackson: Perhaps you can answer a final question. Given what you have said, what procedures have you put in place in terms of learning from the experience in ongoing working with Kernow Commissioning Group?

Valerie Michie: Specifically in Cornwall, data was one of the areas we quickly responded on. We put in place data protocols and an external review by PwC has validated externally that there have been no further changes since we put them in place. We have a much more regular and improved scrutiny process, which Louis can perhaps elaborate on. We have restricted system access and we have improved the clinical leadership of the contract. We worked very closely with the PCT, and now with the CCG, to respond to the continuing needs of the community, as well as to the points that have been raised in various formats over the past period.

Q59 Fiona Mactaggart: I want to ask about two things: one is whistleblowing; and the other is the

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impact of NHS Pathways and the effect on standards. Thinking about whistleblowing, I went to look at personnel publications. In *Personnel Today*, I read a quote from Sian Thomas, who was a director for NHS employers and has been an HR director in private and NHS companies. She said: "It's more of a leadership issue that we should be focusing on. If the leadership creates the right culture where people are not afraid to speak out, then everyone becomes accountable. Accountability needs to be built into the culture at all levels." Mr Stafford, what have you done to do that?

Jeremy Stafford: I would wholeheartedly agree with that point. You have to take accountability for the services you are responsible for. In doing that, it becomes normal within the business that we step up and step forward. I was keen to attend this hearing today, because although you invited one of our team—Paul Forden, who is currently delivering a project for us in Australia—I felt that it was important to be here to discuss these issues. You get a healthy environment if, as a leader, you are seen to put yourself up front and to put a high value on having an open culture and ensuring that people can hear what the business is struggling with, as well as if you are seen to address challenges directly, when you meet them. Perhaps I could ask Dr Warren to come in, because he joined the organisation to deliver service in the front line and he is now responsible for leading the service in Cornwall, and that gives him a unique perspective.

Dr Warren: The first thing I would say is that, as a clinician and a GP, I work for the service as well as having the director role. The importance of medical management has been recognised—it was part of the reason why I was offered the position. There are good processes in place on whistleblowing, which have been verified by our unions, which have recommended them and guaranteed how good they are in terms of policy and in terms of the processes that our staff can use.

What is more important is that the ethos and culture within the contract has improved significantly. I meet staff daily. I get e-mails and phone calls, and from the bottom to the top, we have an employee communication forum for staff members to put their views forward. There are several different mechanisms that have been made more robust to ensure that relationship with our staff. We are delivering care and it is easy to lose sight, with the events and challenges of the past year—you mentioned NHS Pathways—of the fact that we are delivering very good care. While there have been issues with the contract, our patient surveys in the past six months have shown that 95% plus of people rate the service as fair to excellent. That is way above the national average. We benchmark in the top quartile.

Chair: We are talking about whistleblowing, Dr Warren.

Q60 Fiona Mactaggart: You say it has got better, but I want to know what you do differently from when it was not better.

Dr Warren: It is the realisation that while you have got policies and processes, you need to work and engage with your staff to ensure that there is proper understanding.

Q61 Fiona Mactaggart: But how do they get that understanding? I am trying to make you name some very practical things that mean that data handlers and call handlers know that they are personally accountable and should speak up. I have not heard any yet.

Dr Warren: Well, we now have an extended leadership team, which is very much a team in which policy, procedure, learning and change practice get divulged down and fed back up as well. I mentioned the employee communication forum. We have just developed SharePoint access for anyone working not just in our call centre, but in our external sites—we run 11 clinics around the county as well. It has not been implemented, but that is just an IT issue. We plan to do that so that wherever they are—you must realise that some of these staff are part time, and maybe do just the odd shift here and there—we can try to encompass them within the whole ethos and culture. So there are steps and they are having an effect. The reality is that, as a clinician working for the service, I can see that effect every day. Patients tell me that they are getting a good service.

Q62 Chair: How long have you worked for the service?

Dr Warren: I have done several roles. First, I worked as a self-employed doctor early last year. I then came on under contract as an employed doctor.

Q63 Chair: You have been there since 2012.

Dr Warren: Yes, exactly. Since 2012.

Valerie Michie: Specifically, on what we have done on whistleblowing, as the Report notes, we reiterated our processes through communications channels and so on. We wrote a joint letter with the PCT to reiterate the responsibility and the ways in which things could be raised, and also the protection for individuals who had issues to raise. We have also run comprehensive training, and not just in Cornwall—although, actually, when I was in Cornwall last week, we were running the training there—around how to deal with raising all types of issues, and specifically protected disclosures. Finally, we do an employee engagement survey right across the group worldwide. If I look at the results for Cornwall, I can see that 79% of the staff say that they feel very comfortable that they can raise issues with their line manager. That is an external survey carried out by Aon Hewitt. The global benchmark for that is 70%, so we have very strong external data that say things are moving in the right direction.

Q64 Fiona Mactaggart: What did it say before you started these initiatives?

Valerie Michie: It was actually still quite a high percentage. I can provide the specific number, but I think that it was still in the seventies.

Jeremy Stafford: It was 3% lower.

Valerie Michie: Yes, it was 3% lower. We have reiterated the various mechanisms available to people and the protection that is available. As Louis says, we have put in place lots of—

Chair: So when people found it difficult to whistleblow, it was only 3% lower.

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Q65 Fiona Mactaggart: I also said that I wanted to look at NHS Pathways, because the Report says that you have not met national quality requirements for out-of-hours services. Indeed, on the requirement that “immediate life-threatening conditions should be identified and passed to the ambulance service within three minutes”, paragraph 2.29 suggests that although Serco’s performance was originally 100%, and sometimes failing to reach that only 3% of the time, performance fell to a low of one in seven not reaching the standard in September 2012. Having read the Report, it seems that Serco believes that that is a consequence of NHS Pathways. Is that why it fell so suddenly?

Dr Warren: Just to be clear—sorry—are we talking specifically about the national quality requirement for ambulance call times?

Q66 Fiona Mactaggart: No, I am using that as an example. What I am concerned about is that NHS Pathways seems to have had a very significant impact on your ability to provide a responsive service. I am interested in that. Do you think that that means we should be worried about other services that are planning to use NHS Pathways, such as the 111 service in Berkshire, which has just been deferred? I want you to tell me what it is about NHS Pathways that led to this crashing decline in your performance.

Dr Warren: There are pluses and minuses to everything in life but, actually, the really good thing about NHS Pathways, which has been recognised by the Department of Health, is that it is a definitive care assessment. That essentially means that a non-clinician can answer the phones—the same person who would normally just take your address and date of birth can actually deliver care through an IT system. That is an incredibly good thing for patients, and patients like it.

The issue, particularly with our service, was that although we conducted an impact analysis and worked closely with the NHS Pathways team—and indeed there were a couple of out-of-hours providers who had the Pathways system, but they had not implemented it fully; they ran other systems alongside it—we were in new territory in terms of the fact that we were the only out-of-hours service to implement it fully and take calls. Unfortunately, the effect that that had was that the number of call handlers—the capacity to deal with those peaks and spikes in demand—wasn’t as good as it should have been. That is why we have worked very hard and recognised what was said in the CQC and NAO Reports about our call handling capacity not being sufficient. We have responded robustly. We have 63, which is above what we said we would have, and we are training even more.

So the issues and the complexities of the system have been a bit of a learning process. The 111 launch that has happened nationally has had some similar effects. In Cornwall, we have learned from those and put in some additional steps. You mentioned ambulance calls, and we have put additional clinical triage in, in agreement with our commissioners, because the risk-averse nature of the Pathways system meant that more ambulances and people were being told to go to emergency departments. That was not sustainable or

appropriate, and we recognised that very quickly, so we implemented an extra level of clinical triage so that those more risky calls, or the patients who were deemed to be more unwell, had that extra step to make sure that they were getting the right care. The effect of that has been that although in the initial phase of Pathways being implemented our ambulance and ED dispositions—where the patients ended up—went up to 12% of total calls, since we put that step in place, it is back down to 4% for ambulance calls and 1% for ED attendances. The 18-month benchmark is above that, so that extra step—that extra learning—has had a big effect on our local health economy.

We have been working with NHS Direct, which has the 111 contract that is due to be launched next month, and that learning has, I hope, been transferred across to it. We will continue to work with it, and we will constantly analyse how things progress and change as that happens. But this is also in the setting of a 20% uplift in demand, and that is not completely understood at the moment. There are likely to be many factors that have caused that, whether it is the winter, whether it is 111 or Pathways, whether it is changed behaviour, or whether it is because, bizarrely, in the NHS sometimes you get a step-wise lift in service usage that is not always completely clear.

Q67 Chair: Dr Warren, I am stopping you there because you are going on and on, and we have lots to do. This is one of the areas where, again, it appears to me, reading yet another *Guardian* story on this—by Felicity Lawrence, who seems to have done a lot of very good work exposing what is happening—that you had as a KPI, or key performance indicator, not having too many people getting on to ambulances. You put out—this appears to be when you were around—an instruction to staff, which I will quote from the article: “Please be aware that once the disposition screen for a 999 response is reached, we have three minutes in which to close the call and phone South Western ambulance service trust...If the call remains ‘open’ for longer than this three-minute window we fail on our KPIs”—your obsession with KPIs rather than care—“If you do not want/cannot close the call immediately...please click back to the previous screen and ‘change answer’ as this in essence stops the clock”. So you, or somebody else in the organisation with which you were then working, put out an instruction deliberately not to get people to an ambulance as quickly as possible, when those people need it, simply to meet your KPI. It is outrageous.

Dr Warren: It is not true, I am afraid, and I will come back with an explanation, because it is quite a complex system.

Q68 Chair: Can you do it briefly, please?

Dr Warren: Okay. We ring an ambulance every time it is appropriate to do so. That memo was poorly written, perhaps, but the aim of it—

Q69 Chair: Everything is somebody else’s fault in this. You have sometimes got rid of the somebody else, but it is somebody else; it is never the three of you.

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Dr Warren: I think mistakes are made. How that e-mail was written and what transpired afterwards was regrettable.

Chair: So mistakes were also made previously by all these other guys who have tried to stop whistleblowing? Everything is a mistake. What does that say?

Q70 Ian Swales: Who wrote the e-mail?

Dr Warren: It was written by one of our middle managers, and they were acting in the best interests of the wider health economy.

Q71 Chair: Or in the best interests of Serco.

Dr Warren: No, in the best interests of patients. I can say this very clearly as a GP: what we are doing—

Q72 Chair: Delaying an ambulance is in the best interests of patients?

Dr Warren: I must be completely clear on this: we were not delaying an ambulance. More importantly—

Q73 Chair: You were. You were stopping the clock.

Dr Warren: No. It is very important that we get this exactly right factually: there was no delay to an ambulance, because at that stage—

Q74 Chair: “This in essence stops the clock.”

Dr Warren: No. What that memo was trying to do was make sure that we accurately reported when we were ringing ambulances. I can categorically say that we fulfil that outcome, in terms of the national quality requirements. As I have described, that step was linked to the extra clinical triage to make sure that the right people were getting the right care at the right time.

Q75 Chair: An extra clinical triage is stopping the clock.

Dr Warren: No, it is not stopping the clock. The clock has not started, because that clinical assessment is still ongoing.

Q76 Chair: I see, but you have stopped the clock because you have created a new clinical assessment. It must take longer. Let’s have a bit of common sense. Take away the technical thing and have a bit of common sense. You were sending too many people in ambulances—the point that Fiona Mactaggart raised. You were worried that that did not meet your KPI—Serco’s interest, not the patient’s interest—so you introduced a new protocol that cuts the number of people who require an ambulance but also delays them.

Dr Warren: I think you need to recognise that, actually, the national quality requirements were not designed for the Pathways system. That is something on which we are working with our commissioners, and indeed the Department of Health is fully aware of that and is looking to renew them. They are national, so it is not something we can do locally, but the reality is that those national quality requirements do not understand the Pathways system.

Q77 Fiona Mactaggart: Do you think the national quality requirements are wrong?

Dr Warren: No, they are not wrong; they are just not designed to work with the Pathways system. For example, one of the previous outcomes, on a historical model of running the out-of-hours service, was an urgent disposition within 20 minutes—they had to speak to a GP within 20 minutes. That no longer exists for the Pathways. There is no outcome with Pathways for 20 minutes. That is an example.

The other example is speaking to a GP within an hour. Pathways has got an hour, four hours, six hours and 12 hours. As we have the national quality requirements, which are contractual, which we are measured against, and which are a national thing, if Pathways does a definitive care assessment and it says that a patient needs to speak to a GP within 12 hours, we are still doing it at the moment, and being measured within an hour, so there is an example that shows that perhaps the system needs to change. With specific reference to 999 and ambulances being called, it does not recognise the additional step, which is clinically the right thing to do, of having ambulances called for people who need them, rather than because a system is slightly risk-averse. The clinical step that has been put in place, which has been agreed with our commissioners and is the right thing to do—it is the thing that we are continuing to do—unfortunately the system does not understand.

To report accurately, we had to put this process in place. It was written badly, and it gave the phrase “stop the clock,” which gives all the wrong connotations of data changing, but the facts are what they are. It is the right thing to do. We have not changed any data. We are ringing ambulances in the right time for the right people.

Q78 Fiona Mactaggart: Has it taken longer than it used to for the people who do get ambulances to get them?

Dr Warren: Sorry, is it taking longer?

Fiona Mactaggart: You were saying that we are calling the ambulance less frequently than we did immediately following the introduction of the NHS Pathways. For those fewer people who have an ambulance called, what is the time for an ambulance to arrive when it is required under your present system, compared to what it was previously?

Dr Warren: That would be a question for South Western Ambulance Service NHS Foundation Trust.

Q79 Chair: You must know. Don’t tell me that you do not know.

Dr Warren: I do not know how long it takes for an ambulance. I would not know the timed response periods.

Valerie Michie: We know when we call an ambulance, not how long it takes to get there.

Q80 Chair: You know how long your process takes.

Dr Warren: As a clinician—I am often around call-handling in the call centre—when that decision is made to ring the ambulance, the ambulance is rung straight away.

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Chair: No, that is not the question Fiona asked. Do you want to ask it again, Fiona?

Q81 Fiona Mactaggart: You were saying that the national standards are effectively wrong, and that they are going to be subject to change. I want a very simple answer. You have inserted this extra process in NHS Pathways that you are prepared to justify clinically. What impact has that had, when an ambulance is called, on how long it takes someone to get that ambulance? That seems to me to be very relevant. You are calling fewer, because you assert that that is the right thing to do, but how long does it take for the right ambulances to be got for people in Cornwall now?

Dr Warren: It is a good question, and we are working on that. That addition to what we want to measure—we are working with our commissioners on it—is whether that clinical triage is causing any delay. The reality is that at the moment the systems are not there to monitor and give a time, although we are working with the software provider to do that. We listen to a variety of calls, and on a monthly basis we audit a whole selection of calls, specifically when the clinical floorwalker is used—the extra clinical triage for those emergency calls. We vet, verify and assure that it is being used appropriately and is not causing untoward delay. It must also be recognised and taken as part of the background picture that in the historical model, when a nurse or doctor rings in a GP practice or otherwise, they go through a list of questions that from a professional perspective are the right things to ask to ensure that an ambulance is right. It is very difficult to tell how long that will be, and our experience from listening to those calls is that the ones that are delayed are normally because people are refusing an ambulance, and you have to talk to people and assess how they are. That gives a bit of background.

Q82 Fiona Mactaggart: Are you currently meeting the standards that you think should be changing?

Dr Warren: We are meeting the standards—

Q83 Fiona Mactaggart: You are? You can assure us that you are currently meeting the NHS quality standards?

Dr Warren: The national quality requirements around ambulance calling—

Q84 Fiona Mactaggart: For all out-of-hours services?

Dr Warren: For all services, so—

Q85 Fiona Mactaggart: For all out-of-hours services? There is a series of national quality requirements for out-of-hours services that is consistently referred to in this Report. Are you meeting those standards now?

Dr Warren: We routinely meet 10 out of 13 of them, and we are improving in all the others. Importantly, as a doctor—

Q86 Chair: What are you not meeting?

Dr Warren: As the CQC and the NAO Report identified, and as we have discussed already, the call-handling capacity. We are uplifting that, and I am happy to say that on Saturday last weekend, when we had 36 call-handlers on—that is the busiest time of our week, and I was working clinically—we met that target 96.9%. We are going in the right direction, but the reality is that we have had to be reactive in terms of call-handling. We are not meeting it, but I do not believe that that is impacting on the care we are giving.

Q87 Chair: What else are you not meeting? You said there are three you are not meeting.

Dr Warren: The other area is NQR 9, which is essentially to speak to a GP within an hour. For the reasons I mentioned, the Pathways system lumps them all together, so that has presented a challenge. I can happily say that before Christmas we were meeting it. The 20% uplift in demand since September has had an effect, but I am happy to say that we are improving in that area as well.

Q88 Chair: How many unfilled shifts were there in January this year?

Dr Warren: I can tell you the stats for unfilled shifts last Saturday.

Q89 Chair: No. I want to know what the unfilled shifts were in January, February and March this year.

Dr Warren: Again, it is important to recognise that unfilled shifts—

Q90 Chair: Just answer the question, Dr Warren. What were the unfilled shifts?

Dr Warren: In terms of non-clinical or clinical? A range of staff work for our service, so we have—

Q91 Chair: Define them however you want, but answer the question.

Dr Warren: Unfilled shifts, which were recently highlighted in the media, are not an accurate way to measure care delivery in an out-of-hours service—*[Interruption.]*

Chair: You are off-camera. You are very lucky.

Dr Warren: If I can give an example of why, looking just at the rota—

Q92 Chair: No. I just want one way in which you can measure performance. All these things are very difficult. You tell me care is all right; I do not know, and it is a very difficult thing to measure. It is pretty easy to measure whether your staffing levels are right. It is one thing to have people in post and another to fill shifts. I have got in front of me, you will be surprised to hear, pages and pages of unfilled shifts every month.

Dr Warren: If those were the data that were given to the media, they were not correct either. Importantly, I can give you an example of why I am looking at—

Q93 Chair: Just tell me how many unfilled shifts there were in January.

Dr Warren: I do not have that information to hand.

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Q94 Chair: Have you got it?

Laura Brackwell: No. Figure 5 shows the proportion of clinical hours that were unfilled in October to December, and what the Chair is interested in is what the profile is like, or what the average is in January, February, and March.

Chair: Everything is getting better. What is it in January, February, and March?

Dr Warren: I do not have those data to hand right now, but I can easily provide them.

Q95 Chair: Why not?

Dr Warren: For the very reason that I am going to explain now. In terms of our—

Q96 Chair: You do not want us to know the data because they might embarrass you.

Dr Warren: No, I have absolutely no problem with that, because the importance of an unscheduled care provider is that flexibility. We have a range of clinicians and, importantly, in terms of our employed staff, we have significantly upped them. We have four times as many employed GPs as—

Q97 Chair: There is no point in having employed GPs if they are not working. What I am interested in is how many people—*[Interruption.]* I am really sorry about this noise.

Dr Warren: In terms of the actual staffing, importantly that was discussed after Dr Colin-Thomé's report last year, and a baseline of staffing was agreed, and the three GPs. Importantly, our actual staffing levels have been way above that.

Q98 Chair: I am not interested in staffing levels. I have asked you a really simple question. We can all have staffing levels, and people talk about staffing levels, but how many people have you got actually providing? How many times do you not fill the shifts to the level that you yourself have determined is appropriate to meet the service?

Valerie Michie: I am sorry, we do not have the detail with us on unfilled shifts. We will happily provide it; we are not seeking to withhold it. We have been transparent with the NAO and everyone else with all the data. What I can give you information on, and what we do measure, is the percentage increase in hours. Since June 2012, we have increased clinical hours on the contract by 13.5%. As Louis also highlighted, in order to respond to the concerns around baseline levels of clinical staff, we agreed a minimum baseline with the commissioners and key stakeholders. We have never dropped below that minimum baseline since then and, in actual fact, we staff typically around 15% to 16% more than that minimum baseline, so we staff not just for a safe service but to deliver a good service in line with the national quality requirements.

Q99 Chair: I am sorry to say this to you, but I have got probably three pages of unfilled shifts for each of January, February and March. I could tot up the figures: March is seven and a half pages of unfilled shifts.

Valerie Michie: It is really important to recognise that the actual staffing levels are the most important measure, and actual staffing levels have continued to increase. The CQC's report in December said that it recognised the increase in staffing levels of clinicians; its only recommendation was around increasing resources for health advisers and, as Louis pointed out, we are further ahead in the recruitment plan for—

Q100 Chair: Ms Michie, the whole point is that staffing levels can go up, and you can put people on your books, but are they doing the job on the day? That is the important thing.

Valerie Michie: I am talking about actual hours data, not staffing levels. The 13.5% increase is in actual hours, and the 16.5% increase is actual hours above the minimum baseline.

Amyas Morse: I am sorry if I am being slow on the uptake here, but the Chair has what looks like a copy of records of your activity. How could you have unfilled shifts—in other words, people not able to carry out the shifts—and, at the same time, have a greater availability of hours? Is this the 20% growth rate, or what is it? What is the explanation of it? Talking frankly, there must be an answer to this. It is not a conundrum. Is it possible for them both to exist, or what? What is happening?

Ian Swales: It used to be worse.

Valerie Michie: I think it is difficult to respond to data that we do not have in front of us. We have been open and transparent with all the people who come in to look at the service, to provide them with all the data—

Q101 Chair: Dr Warren will have the data. You have the data. These are not surprise data put together by one of the whistleblowers.

Valerie Michie: We have had data provided to us that have been wholly inaccurate and have not represented the actual staffing levels that were achieved.

Q102 Chair: These are not data put together by whistleblowers. These are data put together by Serco.

Dr Warren: I know that you do not want me to give my example, but you have to understand how we roster out of hours. You have to understand that it is an unscheduled care environment. That demand can happen anywhere. On any one night, I might get 10 calls in Penzance. If I've got every other car and every other clinic in Cornwall filled, my ability to treat those 10 patients is still not good, so the flexibility of delivering that care and the rostering—

Q103 Chair: Of course, but the basic would be you determine—nobody else—how many staff you need. Obviously, there are peaks and troughs, as there are in any public service, but you determine how many staff you need. What the documentation shows is that, even with your higher determination, you are getting a load of unfilled shifts.

Dr Warren: What is required to run this service, in terms of a baseline—that is not what we aim for—was discussed with, or brought to our attention by, Dr Colin-Thomé's independent report on the service, and our discussions with our commissioner stemmed from that. A baseline was agreed, and the baseline was:

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what actual hours are delivered? The rota system is a different aspect of that. You will recognise that we deal with a lot of self-employed, and a temporary work force. We cannot have a rota system where a doctor goes away skiing for a couple of weeks and we are just not providing care to a certain area of Cornwall, so the roster is way and above what is actually required, and way above what that actual baseline is. If you look at that roster and look at unfilled shifts, you will get a misleading interpretation of our staffing. Those are the facts.

Q104 Austin Mitchell: I want to return to a point raised by Stewart, because paragraph 3.21, as he said, states that there are four preferred bidders for a contract and two withdrew because they could not submit a bid within the cost ceiling set by the primary care trust. That suggests to me that the cost ceiling was set too low. Do you agree?

Jeremy Stafford: I do not think that the cost ceiling was set too low. I think there was an opportunity to deliver the service in the way that it was designed, and with the increase in usage and with the adoption of the Pathways system, we have found that we have a disconnect between the costs of operating the service and what we anticipated. We are therefore currently making a loss, but we do not expect that to be the case indefinitely.

Q105 Austin Mitchell: What made you think that you could fit within that cost ceiling, where two others could not?

Jeremy Stafford: We often have that situation. Take the example of the prisoner escorting competition, which took place a couple of years ago: we were substantially to change the way that service operated, take 19% out of the costs of that service, still make a return for the investors and bring considerable benefit to the service as a result. We often find that through transformation and re-engineering, we can significantly reduce the cost base.

Q106 Austin Mitchell: And you could do that without compromising the service quality?

Jeremy Stafford: That is what we would always seek to do. Indeed, we would seek to improve the service, wherever we can.

Q107 Austin Mitchell: As you told us at the start, you lost a million quid last year on it. Have you attempted to renegotiate the contract?

Jeremy Stafford: Valerie, I think you have had conversations with the commissioning group about how the service is performing. I am not party to those, but perhaps you could pick that up.

Valerie Michie: Yes. Our focus and the conversations with the commissioners have been around responding quickly to the challenges that have been outlined in this Report as to how we navigate forward. That has not been the focus of the dialogue. We have got a new customer in the clinical commissioning group, who have been in role literally only since 1 April. We have been working with them on the recommendations of this Report. As Louis has outlined, the system in

Cornwall is under significant pressure. That has been our sole focus.

Q108 Austin Mitchell: Have you asked them to put up any more money?

Valerie Michie: We have said to them that it is a difficult situation for us to continue, and we have offered some suggestions as to how we might be able to resolve that. For example, as 111 is introduced locally, that will impact on not only our service but the urgent care system. We have been working with the commissioners to make sure that, as one of a number of parties in the urgent care system, we all respond to the changes that are necessary in the system.

Q109 Chair: The question was: are you asking for more money?

Valerie Michie: That has not been our focus, no. We have said to them that we are in a difficult financial position, but our focus has been—

Q110 Austin Mitchell: You are asking them to modify part of the service. Could you not ask them for more money?

Valerie Michie: Equally, they are asking us to modify part of the service as well, so 111 will pick up some of the call-handling. There will be changes to the way in which urgent care needs to be delivered, not just in Cornwall but more broadly. We are working together to make sure that we do that, to respond to the needs of the local community.

Q111 Austin Mitchell: So you are asking for the terms of a contract that might be too onerous to be relaxed?

Valerie Michie: That is absolutely not what we have been focused on.

Jeremy Stafford: It is quite normal for us, over a multi-year contract, to stay close to the commissioners—the clients—and make sure that the contract stays in step with what the service users demand. There will be a series of change notices, which allow the contract to stay aligned to what is required.

Q112 Austin Mitchell: Just one more question: I do not know to what extent you rely on local GPs joining your service, or to what extent you bring in your own medical people, but North Cornwall probably has a lot in common with Grimsby, except of course Grimsby is more beautiful. The problem is the remoteness, which makes it very difficult to attract medical skills, talent and quality. Is that part of your problem in North Cornwall?

Jeremy Stafford: Having grown up outside Grimsby, I can only agree with you that it is more beautiful. However, in terms of the specifics that we have in the service and in Cornwall, I will ask Doctor Warren to pick that question up.

Dr Warren: Regionally, obviously in Cornwall there are some challenges geographically, in where patient's homes and the GP cover lie, and indeed in where minor injuries unit cover lies, and where it is in relation to the acute hospitals. In the area you bring

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to our attention—North Cornwall—we have worked very closely with the patient focus group there, because we recognise that they are geographically further away, and we have made headway. Indeed, there is a car there. Recently, we have got 4x4s.

Q113 Austin Mitchell: You say the problems are geographical, rather than to do with an inability to attract people to a remote area.

Dr Warren: There is not really an issue with getting the staffing there. It is making sure that the level is appropriate, to make sure that if people are unwell they can get to a hospital or a clinic. We have got two 4x4s that have been implemented this year, and that kind of change has come about through working with our staff, and indeed with patient focus groups.

We are looking to, and have started dialogue with, the Devon out-of-hours provider as well, in terms of getting better operational control and care to the patients that lie on the border between both our providers, because often they will end up going to the Devon hospital—to Derriford—as opposed to Royal Cornwall.

In terms of our approach, and just going back to your last question, in terms of the difficulties with funding based on the fact that we have acted first, and we are addressing this demand issue, and we are absolutely committed—

Q114 Chair: How much has demand gone up? By what percentage has it gone up by?

Dr Warren: It has gone up by 20% since September.

Q115 Chair: What do you mean, September? That is one month.

Dr Warren: No, no. Since September to the present, our demand level has gone up 20%, and—

Q116 Chair: In the last six months?

Dr Warren: In the last six months, yes. There are many reasons for that. Pathways will be one of those, but we are working with our commissioners and they have recently provided a significant amount of demand—

Q117 Chair: Pathways is not a reason for increased demand. If more people ring you up, it is not because of Pathways.

Dr Warren: Yes, but Pathways may have changed behaviours. A lot of what we deal with out of hours now, or a good proportion of it, is what perhaps you might determine as alternative care, so not traditionally what would have been seen out of hours. There are many reasons why that might come about. We are working with our commissioners and looking at proper demand analysis and trends to work a solution for that. But what is important is that we have acted first. We have resourced, we are staffing and we are delivering a very high level of care.

In terms of working to a long-term solution, as part of the unscheduled care programme we are working with the commissioners and all the other health providers to work a solution and adapt our services so that they integrate properly and we can address whether the demand will be ongoing. We can also

look at solutions cross-border and operationally so that people get the right care at the right time wherever they are, depending on which hospital they end up at. We are trying to work horizontally, to integrate it and improve future care as a long-term solution, rather than just plugging the gap with extra funding.

Q118 Jackie Doyle-Price: Mr Stafford, you were very frank earlier with regard to your reward package, and you said some positive things about leadership and the fact that you have to lead from the front. I want to go back to the question the Chair asked earlier about why individuals felt they ought to be manipulating the figures, which brings to light questions about culture. Was anybody in connection with this contract on a bonus of any kind?

Jeremy Stafford: In terms of this contract, I am not aware of our exact arrangement. Valerie, can you answer that?

Valerie Michie: Yes, I think the contract manager would have been, but not the two individuals who were found to have been changing the data.

Q119 Jackie Doyle-Price: What would be the criteria for that individual—the contract manager—to attain their bonus?

Valerie Michie: There are a range of measures for that individual, and right across the business. One relates to increasing employee engagement, measured externally, as we talked about earlier. One relates to customer and patient satisfaction. Another relates to safety and having a strong reduction in clinical safety rates. The other is on financial performance, but it is equally weighted to those four indicators.

Q120 Jackie Doyle-Price: So when we look at the fact that performance was overstated in seven instances because of false reporting, that would have had an impact on this individual's bonus, presumably. If his performance was reported as being more successful because of the manipulation of figures, he would be more likely to get a bonus.

Valerie Michie: I think in a minor way. There is a difficulty in trying to understand the motivation. It is completely unacceptable that it happened and we apologised to the people of Cornwall and our commissioners at the time, but when the commissioners and the performance group looked at the restated data and the actual data, their view was that they would not have taken any different actions or perspective over performance with both sets of data. The very difficult fact is they did change data, which is wholly unacceptable. However, it was not to a material impact, even to the individual's performance bonus.

Q121 Jackie Doyle-Price: That is all fine, but what I am trying to get my head around is whether behaviour is being encouraged by performance management within the organisation that is encouraging some of your employees to behave in this way. That is what I am trying to get at. It comes back to the point about leadership. When you have a company such as yours that relies heavily on public

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sector contracts and is going out and getting lots of them, how can we be confident that you are actually focusing on good outcomes in terms of public services and not just ticking boxes to keep your contract?

Valerie Michie: If you look at those four measures, the changes that were made did not impact on the employee engagement and the service. In fact, arguably, that is an indicator of where we might see cultural challenges and where we need to focus strongly. The patient satisfaction data are externally benchmarked and gathered, as is employee engagement, so they did not influence that.

Similarly, the clinical reporting is independently verified, and has been verified by the regulator. It did not impact the financial performance either. On reflection, my own view is that when they went to the monthly meetings they wanted to present a more green dashboard than was actually the case. But it does not impact on the way in which we measure them as an organisation.

Chair: Two people want to come in, because we are so astounded by that.

Q122 Guto Bebb: Jackie has touched on the crux of the issue as far as I am concerned. It looks as if the number of changes that were made was something like 0.2% of all the interventions of Serco, but they actually affected 14% of the performance indicators. The figure here is that 20 of 152 separate performance measures were actually affected. That is about 14%. Quite clearly, therefore, those changes were made for a specific purpose. Whether there was financial reward for the individuals concerned, I think Jackie's point is crucially correct. Were they massaging the figures for a purpose?

Chair: Let's take Amyas's view as well and then you can answer the two together.

Amyas Morse: It is not really in the same field. I want to make sure I have really understood this. You were not in post at this time but you were, Valerie.

Valerie Michie: Yes.

Amyas Morse: You strike me as a very switched-on, capable individual. You gave these people a package of some kind to let them go, yes?

Valerie Michie: We paid them their notice.

Amyas Morse: They must have explained this to you. Don't tell me you let them walk out of the door. You need to fix this; you need to fix the system. You can't have let them walk out of the door. However inadequate the explanation must have been, somebody in your organisation must have spoken to these people and said, "Whatever made you do this?" Can you tell us in words of one syllable what they said?

Valerie Michie: Of course we did that. It does not give me any satisfaction or pleasure to be able to sit here and not explain to you. It is something that you would—

Amyas Morse: What did they say when you asked them?

Valerie Michie: They gave us absolutely no reason whatsoever [Interruption.] I can only tell you what they said to us.

Q123 Chair: When did they leave?

Valerie Michie: They left in August.

Q124 Chair: In August. On 29 May 2012, you wrote a letter to *The Guardian*, in which you said, "We are well aware of a substantial number of the allegations considered by *The Guardian*; these have been raised before, fully investigated by us and by a number of independent bodies, and found to be false and without foundation." When did you change your mind? "There was no substance to any allegations of altering figures or manipulating data."

Valerie Michie: That is right. That was based on the external audit that was done by RSM Tenon.

Q125 Chair: You changed your mind between the end of May and when?

Valerie Michie: As I said previously, when we saw the draft report from the CQC, which had likewise also looked at data reporting, it said equally that it had not found any inappropriate changes but it was concerned.

Q126 Chair: When did you change your mind, Ms Michie?

Valerie Michie: Then, on the basis on the ongoing concerns, I instigated our own internal forensic audit, which as you have been able to see is incredibly detailed, to go through 107,000 transactions to be able to find the 252.

Q127 Chair: A six-month audit when everybody knew it was going on anyway. Go on.

Valerie Michie: The first time that that audit gave specific evidence that there had been data changes was on 5 July. That was the first date that I was given specific evidence that there had been data changes. When that audit had then progressed enough to be able to identify where they had been made, as soon as we understood that, we suspended the individuals concerned and concluded the investigations.

Amyas Morse: They never gave you an explanation of why they did it.

Valerie Michie: No, they didn't. In fact, they—

Chair: We just don't believe this. All I would say is that I hope you are telling us the truth because that is the basis on which you are giving evidence. It just doesn't sound credible. You can see round the table that this is not a partisan view.

Q128 Guto Bebb: The concern I have is that the changes that were made were a very small percentage of the overall transactions but they specifically affected a significant proportion of the performance measurements. If there was no financial gain for the individuals concerned, the question is surely, why did they do it?

Valerie Michie: The further illogic, which I'm afraid does not help my position but exacerbates it, is that of the changes that they made, which as you rightly say affected 20 indicators, only actually changed the colour, which is what the performance was focused on, of seven of the 20. So you kind of wonder why they made the majority of them and why they did not make them better. I completely accept that it is entirely illogical, and I am sorry that I cannot give you a better explanation, but I am absolutely telling

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the truth about the investigation and the reasons that they gave us.

Q129 Jackie Doyle-Price: So I presume that you have had a full and frank discussion with your contract manager for this contract about all this?

Valerie Michie: Absolutely.

Q130 Jackie Doyle-Price: Why then did their management controls not pick this up?

Valerie Michie: I think that, again, if you look at the level with which these changes were made, they were very, very difficult to detect. Two previous external audits had not detected them; it took a full forensic audit to detect them. To help to explain that, there was a process that we undertook with the commissioners whereby valid changes were made, and what actually happened was that we found out that the changes—the 252—were invalid changes. For example, if we sent a GP out to do a house visit, and the individual was not in their house—this is an example given in the NAO Report—that was a valid non-failure of the quality requirement as a “patient-caused delay.” We had a process with the commissioners whereby we said, “This is the dashboard and these are the changes that have been made for patient-caused delay.” So in actual fact, in the six-month period, 23 valid changes and 253 invalid changes were made.

Q131 Jackie Doyle-Price: So 10% were valid. Or less than 10%.

Valerie Michie: Exactly. But I think that part of what made it very difficult to detect was that there was an accepted change process for valid reasons that was being used for invalid reasons. Because it was such a small number of such a high level of transactions, it was very difficult for us to find.

Q132 Jackie Doyle-Price: I have one final question. Did the contract manager for this contract receive their bonus?

Valerie Michie: They did not receive a full bonus.

Q133 Jackie Doyle-Price: They did not receive a full bonus, but they received a bonus.

Valerie Michie: I do not know categorically. I do not think that they received a full bonus, but I think that they did receive a bonus.

Q134 Ian Swales: May I return briefly to the whistleblower question? Mr Stafford, you said that you have had 135 cases in the past year. How many of those 135 people are still working for Serco?

Jeremy Stafford: Of the ones who came through the formal process, I cannot give you that number here and now, but I would be very happy to come back to you with it. We are very clear that if people use the process, which is designed to protect the individual and the confidential information that we are party to, there will be no reprisals. So I can be absolutely clear that there will have been no reprisals. I would have to check whether some of them have chosen to leave the organisation.

Valerie Michie: I do not know that we would know, because we would not be given the identity of the individuals, would we?

Jeremy Stafford: We would not know the identity, but I am sure that we can inquire from our third-party provider.

Q135 Chair: So you would not do again what you did last time, which is deny the allegation in the way that Ms Michie did in *The Guardian*?

Jeremy Stafford: In terms of the whistleblower process, we are very actively using that to elicit information from around the operations to ensure that we surface issues. If a whistleblower chooses to go outside that process, obviously you have complications associated with that.

Q136 Chair: What does that mean? What happened in this instance is that they got so frustrated that they ended up going public, so you then deny them. But if they had not gone public, we would not be having this hearing and you would not know that people were acting wrongly in your organisation.

Jeremy Stafford: So I am pleased that this has come to light—

Q137 Chair: Ms Michie denied it up to a month before it was established by years of it being told. It does not hold true.

Jeremy Stafford: Can I just pick up that point, because it is very important? As Valerie said, there were two external audits of the service, one by RSM Tenon, which took 80 cases. Of the 80, it identified one case for concern, which was examined in detail and seen not to be of any importance. So that audit confirmed that there was not an issue. Then the CQC conducted their investigation, and they came back and said that they could not find any cause. It was only when we did the forensic audit—the 107,000 transactions—that this came to light, and as soon as we discovered there was an issue, we acted swiftly and decisively.

Q138 Ian Swales: The only reason why I ask the question is that I think there is a much wider question, not just in Serco but in the NHS generally, where week after week we see professionals effectively having their careers ruined because they have decided to blow the whistle. I would like to be sure that the culture of your organisation is such that you treat those as learning experiences and not ones that result in that person being victimised in some way—it may not be obvious, but I would say that if people leave the company voluntarily shortly after such an event, you have got to ask why.

Jeremy Stafford: I can give you an absolute commitment that we see whistleblowing as a very important part of running the complex services that we are responsible for. Only last week, I had one that came through the “Tell Chris” channel, which runs in parallel with the external provider, which raised real concerns. We are now looking into those, but we will look after the interests of the individual.

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Q139 Ian Swales: Can you let the Committee have an answer to my question? Of the 135—it was your number—how many of those are still with Serco? Of the ones that have left, have any been fired or have they gone voluntarily? That would be helpful, to help us nail that down.

My main question is about figures 7 and 8, which we have touched on but not spoken about specifically. Figure 7 shows call handling, and it shows an absolutely shocking deterioration in the middle of last year. I know that we keep talking about NHS Pathways, but the data show there is a far higher number of abandoned calls and far longer on the phone. If you just compare the start of the year and the end of the year, as shown on that graph, the total number of calls is not wildly different but the response of your organisation is wildly different. Can you tell us what the position is now, three months on from this graph?

Jeremy Stafford: The reasons for the call handling performance—it does drop off, as you will see from the graph, Pathways starts—

Q140 Chair: Can you just answer the question, Dr Warren? What is the performance now?

Dr Warren: The performance now is improving. I can say from Saturday that we got 96.9%—

Chair: No, not just one day. One day is hopeless. You had a good day on Saturday, and you were coming to the Committee on Monday; I bet you staffed it up to the hilt.

Q141 Ian Swales: If I said March, for example—I do not know whether you have got that data yet. Do you have the data for calls answered within 90 seconds, calls after 90 seconds and abandoned calls? Do you have that information?

Dr Warren: We do have that data. I do not have the exact numbers for you now, but we meet with our commissioners twice monthly at the moment to discuss those—

Q142 Chair: What is it?

Dr Warren: I do not have the exact figures, but I can get them to you.

Q143 Ian Swales: If I were in your position—this is national quality requirement No. 8. Isn't that data that you would have? Have you got any idea of what it is?

Q144 Dr Warren: I think it is roughly around—it is Easter as well, which is significant. We managed 15,000 calls, which is unprecedented.

Q145 Ian Swales: In March?

Dr Warren: Yes, we received over 15,000 calls, which is unprecedented. Obviously, Easter weekend was in there, when we had 4,700 calls presented to the service. That is a very high number. I think it is about 70%, and I think it is important to recognise—

Chair: 70%?

Dr Warren: 70% within 90 seconds.

Q146 Ian Swales: And what proportion were abandoned?

Dr Warren: Abandoned is about 8%. I can get the exact numbers to you.

Q147 Ian Swales: I accept the fact that there is a higher number of calls, but the performance of your service is still substantially worse than it was in the first half of last year. Would you agree with that?

Dr Warren: No, I would not, because I think our performance is not worse. Our ability to handle calls—

Q148 Chair: Performance on this is worse.

Dr Warren: Yes, but you cannot compare the two, because with this people are getting a definitive care assessment when they get through to us, and they are answered—I think very importantly—immediately. So we no longer have had any engaged calls since January, since the new phone system was put in. Not a single person who has rung our service gets an engaged tone. They all get through. They all get answered.

Chair: They don't—8% or 9% don't.

Q149 Ian Swales: You have just said that 8% were abandoned. Why would they be abandoned?

Dr Warren: They get through to our service, the call is answered, and initially they listen to a message, which signposts them if they have an emergency or were trying to access the service for something else; we signpost them to a provider for something like dentistry. After that—the majority of the time, within 30 seconds—our call handlers give them a definitive care assessment. The important thing to acknowledge is that that definitive care assessment—that call time—takes between five and seven minutes. The old system, before Pathways implementation, took about one to two minutes. It is very difficult to compare the performance before and after Pathways because they are completely different processes.

Q150 Ian Swales: Can you send the Committee your actual data for March, on a basis that you think is sensible? Similarly, there is figure 8, which is on national quality requirement No. 9—again, from the middle of last year. I think this is actually more shocking, because here we are talking about what is probably in some cases literally life or death. When you look at the deterioration in the service around clinical assessments, what is your answer to that, and what is the performance now in this regard?

Dr Warren: There are two things being measured in figure 8: the emergency face-to-face within an hour and—sorry, that's wrong; it is the urgent cases triage, which is within 20 minutes. As I said earlier, those cases are not urgent cases: it is a system used for non-clinical staff to pull off things like prescriptions to be highlighted and given to a practitioner. That particular NQR—the green line on figure 8—does not equate to patients trying to get through to the service with an outcome of 20 minutes response time, because that particular national quality requirement outcome does not exist with the Pathways system. Since May last year, which is when you can see it dropping off, there are about 10 calls a month, and they are picked out. We have discussed this with the commissioner. They

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are not urgent patients. That is misleading. It is not ideal, but we are working to get that resolved in our monthly meetings.

Q151 Ian Swales: You are saying that the data prior to the middle of last year are different data?

Dr Warren: Exactly, yes.

Laura Brackwell: Going back to figure 7, I think you said that the position in March was that about 70% were answered within 90 seconds. That is essentially the same performance as you had in November. It has not improved since then.

Dr Warren: No, but we have had a 20% uplift since September. We have uplifted our call handlers, and now we have 63, but it also needs to be recognised that it takes a year for a call handler to be completely proficient. There is a lead time. It affects call-handling ability in two ways, really: it affects it because they will offload the call and do what we term an early exit, which means that they exit the system because they can't get the pathway they need and it will go for a clinical triage, or alternatively the call will take them a long time. That changes as the year progresses. Importantly, despite the uplift in call handlers—

Q152 Chair: The uplift is winter. What you really have to look at is the whole year.

Dr Warren: Even taking that into consideration, it is way above previous years.

Chair: Well, you can send us data to prove that. At the moment we are just looking at winter.

Q153 Ian Swales: Going back to figure 8, what should we be looking to measure? If you say that it has different data on the left-hand side and the right-hand side, what should we be looking at? You have a national quality requirement; what is the performance that you have to deliver?

Dr Warren: I was talking specifically about the pale green line—the urgent calls triaged. The routine triage, as you can see, dips down and back up. It has been hovering around 90% for the past few months.

Q154 Ian Swales: Are you trying to tell us that routine is more serious than urgent?

Dr Warren: No. Routine is within one hour; as I said, the urgent no longer actually correlates with the Pathways system. That is not measured any more. The routine still exists, and calls that fall into that particular outcome are not just calls that ought to speak to a GP within an hour, but all the other pathways—speak to a GP and other dispositions—which is one hour, two hours, six hours and 12 hours.

Q155 Ian Swales: You don't measure your response to urgent calls any more. Is that what you are telling us?

Dr Warren: This is speaking to a clinician. With the Pathways system, there is no disposition less than an hour. The 20 minutes no longer exists.

Q156 Ian Swales: Even in urgent cases, you only have to make an hour. Is that what you are saying?

Dr Warren: The Pathways system is designed such that it does not give an hour outcome to an out-of-hours provider. We are constrained by the system that we are using—

Q157 Ian Swales: Sorry, I did not understand that last comment. Run that by me again. In urgent cases that were measured against 20 minutes, are you saying now that the measure is only an hour because they are lumped in with non-urgent cases? Is that what you are saying? That is what I am hearing.

Dr Warren: That, or they are signposted to other providers, so that they are either signposted as an emergency or they are dealt with in the one hour. The shortest time line for an out-of-hours GP provider with the Pathways system, in terms of an outcome from that system that requires a GP contact to speak to a GP, is an hour.

Q158 Ian Swales: I am really quite surprised, but that is obviously not your issue; it is something we will need to take up with others.

I have a final question. In order to make this contract profitable, one of two things has to happen: you have either to get more money or take out resource—either amount or quality of resource. What are you going to do? Sorry, the third thing is to stay loss-making. What are you going to do?

Dr Warren: At the moment, we are absolutely committed, as a commission—

Q159 Chair: At the moment, what are you going to do?

Dr Warren: We are going to maintain what we are doing, which is providing a high level of care, and we will react to that and not necessarily the financials. Now we need to work with our commissioners to help resolve some of those issues going into the long term—

Q160 Chair: We do not understand—it is gobbledegook. Are you going to cut the service, put the price up or what?

Dr Warren: We are not going to cut the service—

Q161 Chair: You are not going to cut the service, you are not going to put the price up—

Valerie Michie: The factor that he did not mention, and that we are primarily focused on working on with the commissioners, is trying to reduce demand, which is a challenge for the service, not just for our service but for the NHS overall. We are actually looking at what is driving people into our service and other urgent care services, and at how can we work with the other services to try to—that is not just a challenge for us but a challenge full stop. Our prime concern is to try to work out how to reduce that demand. That is the main thing we think we will see with the contract.

Q162 Meg Hillier: I have to say, Chair, that last exchange seems to be a good advert to other potential providers not to bid for the contract.

Briefly, I want to address three areas: one, the contracts that you have already won; two, some staffing issues; and thirdly, your general approach to

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tendering. I will be as quick-fire as I can, Chair. First, may I ask, Ms Michie, how many other out-of-hours care services Serco runs in the UK?

Valerie Michie: We don't have any other out-of-hours services. We provide a range of other services, including—

Q163 Meg Hillier: Not GP out-of-hours services? Okay. Did you have a presence at all in Cornwall before you bid for this contract?

Valerie Michie: Not in terms of health, no.

Q164 Meg Hillier: Was the previous director of the out-of-hours service—before Dr Warren took over—a medical doctor?

Valerie Michie: No, but we have always had a clinical director on the service, alongside the operational director. In fact, we still have the same clinical director. Regardless of whether the overall responsible leader is a clinician or not, we obviously have a clinical leader—

Q165 Meg Hillier: Now you have two doctors at the top, effectively, instead of just the one.

Valerie Michie: They have very different functions. The clinical directors' functions are around clinical assurance, and obviously dealing with doctors and also reporting into the overall clinical governance structure in the business.

Q166 Meg Hillier: So Dr Warren's is more of a managerial role, even though you are a clinician, Dr Warren?

Dr Warren: Yes.

Q167 Meg Hillier: Was Dr Warren appointed because of his clinical background?

Valerie Michie: Yes. In actual fact, Dr Warren was the deputy clinical director on the contract before being appointed to his operational role.

Q168 Meg Hillier: That was a deliberate decision, in order to bring more medical input into the contract?

Valerie Michie: It was part of what we have been trying to do—to seek to recover the confidence of commissioners and users of the service, and we felt that having a local clinician in charge was part of that response.

Q169 Meg Hillier: Which perhaps goes back to the points made right at the beginning about companies that bid for contracts but do not necessarily have the staff team in place before they get the contract, because presumably you have brought in staff from Cornwall who were not previously Serco employees.

Laura Brackwell: Can I add that they have actually been running the service since 2006?

Meg Hillier: But pre-2006 you did not have any people in Cornwall working for Serco? They were then taken on for this contract.

Valerie Michie: What happens when we take on a contract is that the existing staff on the contract transfer to us—

Q170 Meg Hillier: Under TUPE?

Valerie Michie: That is right. We also augment that. Between myself and Louis, the individual in my team who runs our clinical services, we have many years' experience of operations within the NHS. We make sure that we have a mix of staff, not just those who transfer across with the contract, but experienced operators within our business, who we typically bring in from the health service.

Q171 Meg Hillier: They have all previously worked in the health system in one way or another?

Valerie Michie: Yes.

Q172 Meg Hillier: Do you ring-fence each contract? You are making a loss on this, so presumably you cross-subsidise across your business. I don't know which of you wants to answer. You are able to make a loss on one contract because you have large amounts of business—a £2.4 billion turnover in the public sector in the UK alone.

Jeremy Stafford: I am responsible for a very substantial portfolio of services. With that breadth of portfolio, you will normally have challenges in some of the services. We choose to see our commitments through to make sure that when the service stabilises we make a profit from it in the future—a modest profit, being Serco. But we will tolerate a period when we make a loss because we are committed to getting things right.

Q173 Meg Hillier: Presumably you could choose to walk away from the contract if you so chose—I am not suggesting that you do so. Or is there a clause that says you cannot walk away from it?

Valerie Michie: I am not sure whether we technically can or cannot, but we wouldn't.

Q174 Ian Swales: Did you know that it would be loss-making at the start?

Jeremy Stafford: No.

Valerie Michie: No. That goes back to the previous two points.

Q175 Ian Swales: You didn't bid knowing that you would make a loss. Is that right?

Valerie Michie: No. We got two of the assumptions.

Q176 Meg Hillier: You don't provide any actual subsidy? On your book you maintain a loss in some areas, you make a profit in other areas, and overall it balances out. You couldn't make a loss across all contracts because you would lose your job, Mr Stafford, among other things.

Jeremy Stafford: You get changes—as we have in this one—with supply and demand. You get changes when you bring in, with the best of intentions, new technology to allow the service to become better and more efficient in the future. Quite often when you do that, there is unexpected cause and effect. We have learned over the years that you should navigate your way through that difficult period and get to the point where you are able to deliver what you anticipated.

Q177 Meg Hillier: Perhaps I should direct this question to Dr Warren. Do you find that clinicians and

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health advisers want to do this work? We all have issues in our own areas about the number of willing GPs these days. I am the daughter of a former GP, so I know that the old days when everyone got up in the middle of the night are gone and people do not want to do that now. Do you have problems recruiting?

Dr Warren: As Colin-Thomé stated in his report—this is in the NAO Report—there is an ongoing challenge with clinical staffing. We, as an unscheduled care provider, have witnessed that and deal with it on a day-to-day basis. What is important is that the actual staffing delivers a safe and effective service. While we constantly need to work with and engage with that work force, it does not present an issue at the moment, and we are delivering a very high level of care.

Q178 Meg Hillier: When you say that you constantly engage with the work force, is the pay per shift market-dependent? When you negotiate, is it about pay levels for both the clinicians and the broad-brush health advisers, whatever their clinical or non-clinical background?

Dr Warren: Certainly pay is one issue. We have reviewed the pay of both our self-employed work force and our contracted doctors.

Q179 Meg Hillier: Upwards?

Dr Warren: Upwards. We were never out of the scope of the national norm, but it is probably higher now than it was. We did that in response to the fact that it had not been reviewed for a period of time, and it was due.

Q180 Meg Hillier: You mentioned technology and IT, Mr Stafford, but there is another point that I want to pick up. When you develop IT services for a system—this was the first time you had run an out-of-hours service, and you developed Serco's IT system—is it your intellectual property, or if anyone bid for the contract in the future, would they take over that system?

Valerie Michie: We have run the service since 2006, and the system we put in is NHS Pathways. It is not

our system; it is the system that is used nationally in the 111 implementation.

Q181 Meg Hillier: On the general approach to tendering, the head of the NHS said on 18 March that across the board there is not a requirement to competitively tender for services. On 26 March, the Deputy Prime Minister, in answer to a question from a colleague of mine, said, "Clinical commissioning groups are not forced to open services to competition unless they think it is clinically justified in the interests of patients to do so." You run this contract now. But if in the future the current clinical commissioning group that has just taken responsibility decided not to tender but to award the contract to someone else—I think your contract finishes in 2016—would you consider a legal challenge to a non-tendering process that did not choose you as the supplier?

Valerie Michie: Sorry. I am not sure I understand the question.

Q182 Meg Hillier: When the contract comes up for renewal, if the clinical commissioning group, as the Deputy Prime Minister and the head of the NHS say very clearly, does not have to tender and chooses not to tender it to open competition but to give it to another provider, whoever that provider might be, would you automatically consider a legal challenge?

Valerie Michie: No. Absolutely not. I cannot think of any circumstance where we have challenged any tendering process in the health sector.

Q183 Meg Hillier: That is helpful to know. Do you have a budget for legal challenges if you felt there was ever any reason to launch one?

Valerie Michie: No, we do not have a separate budget for that.

Chair: Thank you very much. We have kept you longer than I intended. Apologies for that.

Examination of Witnesses

Witnesses: **Sir Ian Carruthers OBE**, former Chief Executive, NHS South of England, **Gavin Larnar**, Director of Professional Standards, Department of Health, **Steve Moore**, Chief Executive, Cornwall and Scilly Isles Primary Care Trust, and **Joy Youart**, Managing Director (Accountable Officer) Kernow CCG, gave evidence.

Q184 Chair: My sincere apologies for keeping you all waiting. We needed to go through those issues and I think it was right to do them separately. I don't know who to ask this question. I think Gavin Larnar is here just to talk about whistleblowing. Sir Ian, maybe you could start on this. When does something become a systematically unsafe service? How do you define it?

Sir Ian Carruthers: It is a judgment, obviously. It has become systematically unsafe when there are repeated incidents of similar types that are not corrected and we do not learn from them.

Q185 Chair: How many times did Serco have to—use whatever language you like—manipulate, alter, or

perhaps lie about what they were doing before one begins to decide that there is something fishy going on here?

Sir Ian Carruthers: You could come to your own judgment. For me in my role speaking for the SHA, if you are looking at the performance management of it, out-of-hours is something we do not manage. It is the responsibility of the PCT and they are accountable for that.

Q186 Chair: To you?

Sir Ian Carruthers: Yes, but out-of-hours is not part of the national performance framework.

Chair: Sorry, say that again.

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Sir Ian Carruthers: It is not part of the national quality measures for the routine performance framework.

Q187 Chair: So you don't judge a PCT on how it manages its out-of-hours services contracts. Is that what you are telling me?

Sir Ian Carruthers: We don't. It is managed by exception. The PCT would have to alert us to difficulties that they were having and then, of course, we would intervene, which is what happened in this case.

Q188 Chair: Mr Moore, how often did they need to lie to you before you felt that you ought to perhaps refuse to pay them, which you did not even do?

Steve Moore: As Sir Ian said, there is a judgment call in all this. Our job is to ensure that we are robust and even-handed in how we deal with all our providers and to ensure that we are proportionate in all of the issues going on.

Q189 Chair: How often do they need to lie for you to judge that they should not get paid?

Steve Moore: I am not sure I could put a number on it. Clearly any factual inaccuracies, whether in the data or anything else, from any provider is something that we would be deeply concerned about.

Q190 Chair: It was 252 in the six months when they knew everybody was looking at them.

Steve Moore: What I would say on that is that we were picking up some concerns through all the various interactions—

Q191 Chair: Why was 252 lies in six months, when everybody knew that they were being looked at—by that time, *The Guardian* and everybody were on to them—not enough for you to think that you should stop paying them?

Steve Moore: It was considered, because clearly we expect our providers to give us honest information.

Q192 Chair: Why was it not enough?

Steve Moore: Because when you take a rounded view of all the performance of the contract and the impact of those particular changes, it is—

Q193 Chair: So 252 lies was not enough?

Steve Moore: In terms of the impact they had on the quality measurements of the contract, they changed seven of the 252—

Q194 Chair: Just say yes or no: 252 lies was not enough for you, in your judgment.

Steve Moore: One lie is too many, but it is how you deal with it.

Q195 Chair: But they never got a penny less.

Steve Moore: But, at their own expense, they had to put the systems right and make sure that—

Q196 Chair: Yes, but they lied 252 times and they never got a penny less.

Steve Moore: No, they did not.

Q197 Chair: When I look at this, there are two things. One is that you looked at only six months in 2012—you didn't, but they did; you never did a separate independent audit. Here was a company that had lied—you heard them say, "It was this individual" and "It was that individual"—but you never did an independent survey. Why not? And why, despite all the whistleblowers telling you, did you not look at the years when the whistleblowers said that things were much worse, which were 2011 and 2010? By 2012 everybody was on to them and they were being a bit more careful.

Steve Moore: Of course, we were picking up concerns around the data issues back at the beginning of 2012 and we sent our own auditors in. Our audit committee, which is a sub-committee of the board—

Q198 Chair: When did you send them in?

Steve Moore: We sent them in March 2012. They did a sample audit, which is a normal practice—

Q199 Chair: This is the 80?

Steve Moore: Yes. They could find no examples—

Q200 Chair: Useless auditors.

Steve Moore: Well, I do not think that they were useless; they went in to do what we asked them, which was to check that we could rely on the accuracy of the data that was being reported to us in the NQRs. They do sample audits in those things. I think it is a measure of the size of the data changes—the 0.2%—that I think it would have been very difficult, in hindsight, to see.

Q201 Chair: You have not answered the two questions I asked, so let me ask them separately. When it was clear that things were going wrong, why were you happy to depend on Serco's own audit given that you knew they had lied?

Steve Moore: Of course we did not do that, because we sent in our own auditors after the event. Serco agreed with us that because there was some general level of concern—

Q202 Chair: I have not seen any evidence of your survey. Where is your survey?

Steve Moore: We sent in PwC to have a look at this—

Q203 Chair: But they have not reported yet.

Steve Moore: They are in the last stages of reporting. But they went in to do two things—

Q204 Fiona Mactaggart: This Report says that their report was due in March 2013 and we are now in April.

Steve Moore: It has been a bit slower than we thought. I was keen to try to get that reported to our board in full in March, but that did not happen. It will be picked up—

Q205 Chair: I bet they've done it; I bet you're sitting on it.

Steve Moore: No, what we reported back to our board were three key findings that they were able to tell us at the time. The detail is still being worked through.

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One is that the Serco's staff, who they brought in to do the audit, were properly qualified and suitably independent. The second is that they found no material difference in their audit from the one that Serco undertook themselves, which was the key issue for me and the board. The third is that, from 6 July 2012, there were no further instances; they looked at a further six months of data at that forensic level—

Q206 Chair: Hang on a minute; there are two or three things. Has PwC reported to you?

Steve Moore: No, the report was not finalised by the time—

Q207 Chair: Has it reported to you? You may be negotiating the wording—I know how these things work; I did them—but has it reported to you?

Steve Moore: I have had the executive summary, which was in draft, before the PCT came to an end—

Q208 Chair: You have had it, and now you are fiddling and playing around with the content, because that is what happens.

Steve Moore: It is a very detailed audit, and some of that needs to be gone through. The CCG has committed to publishing—

Q209 Chair: You are negotiating, with them, the content.

Steve Moore: The CCG has now taken that on, because it is committed to publishing it as early as possible.

Q210 Chair: It is deeply unsatisfactory that the report is not out. The second thing that is unsatisfactory, and on which you still have not answered, is this: you have checked on its audit, but why have you not done your own audit, and why did you not look at 2011 or 2010? This is public money that you are playing around with, Mr Moore.

Steve Moore: In terms of the second six months' worth of data, it looked to assure us that the changes had happened—

Q211 Chair: No. Obviously, after the event, we paid out public money to a company for providing a service and, when it knew that the spotlight was on it, you still found 252 instances where it lied. You did not do your own check to see whether that was right, and you did not look at the previous year, though the whistleblowers had told you that it was where the real problems were—and had told you, Sir Ian.

Sir Ian Carruthers: I have never seen any correspondence or contact with the whistleblowers.

Q212 Chair: Okay. Apologies for that.

Steve Moore: It was clear from the forensic audit that we signed off with Serco that there were data changes. They were also clear with us that there were likely to be data changes that went back to 2011. On ensuring that we did the right thing, in terms of the public purse and other things, I wanted to ensure both that its audit could be relied on and that there were no further instances of data being changed following the end of the audit.

Q213 Chair: Why did you not look at 2011?

Steve Moore: Because the focus of our audit was on ensuring that what it had audited itself was reliable.

Q214 Chair: You paid it for 2011. Why did you not check that you had paid it for what it said it had done? I do not get it.

Steve Moore: Again, the other issue here is that the NQRs—the national quality requirements—which the data affected, did not change the amount of money that Serco was paid, either in 2011 or in 2012.

Q215 Chair: That is another shocking bit of your contracting. If a company lied about the stats—you are being told by whistleblowers that it was much worse in 2011 and 2010—for you to ignore that just seems unacceptable.

Steve Moore: I do not believe we ignored anything that was coming through to us.

Q216 Chair: You did. You did not do anything about it. You did not check.

Steve Moore: Well, we ensured that the issue had been picked up. While the size of the data changes were relatively small, the worry for me was that it was possible to do it at all. That is what we wanted to ensure that Serco had fixed, going forward.

Q217 Chair: Answer me something else: how on earth did you ever write a contract that enabled it to have PIs and lie about them, with no penalty? I do not think that you monitored it properly. I do not understand how you wrote that contract. You have said, "It was not worth checking, because this would not have impacted on the money we paid it." How did you write a contract like that?

Steve Moore: The contract is clear about what we expect, in terms of behaviour from providers. We do not expect providers to manipulate their data—any provider.

Q218 Chair: It did, but you never took money away from it.

Steve Moore: That was not a problem with the contract itself, in terms of the expectations. We had moved the contract on—

Q219 Chair: It was not a problem with the contract?

Steve Moore: In terms of expecting providers' behaviour to be such that there would be no changes to data.

Q220 Ian Swales: So it is in breach of contract, then. Whatever those clauses say, Serco is in breach of its contract. Why have you not extracted some financial penalty for the taxpayer, when it is in breach of the contract that you agreed?

Steve Moore: Certainly, what we have learned from all this, among many things, is that we need to look again at the financial incentives.

Q221 Ian Swales: If it was a private sector company and the public sector had breached the contract in some way, you would find yourself in court, so how come we have not done anything?

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Steve Moore: The contract, similar to many others, and the APMS auspices under which this was written, allows for contract termination as the contract remedy.

Q222 Ian Swales: Exactly. And with the threat of contract termination, surely you could have extracted some benefit from that for the taxpayer.

Steve Moore: One of the things that we have learned is that that is a significant tool at our disposal that needs to be used carefully and in proportion.

Q223 Ian Swales: How carefully? If the boot was on the other foot, you would have found yourself with a big bill, through a court process. I am absolutely sure you would.

Steve Moore: One of things the CCG would now like to look at is having more nuanced incentives in the contract, so that we can penalise, rather than go for the termination option up front, given all the other things that were going on with this contract and how it is embedded in the local system.

Q224 Ian Swales: Who advised you on drawing up this contract? What sort of expertise did you have? How much NHS national experience was there, or did you just make it up locally on the day?

Steve Moore: We used the standard APMS contract, which is developed nationally. We also had a set of local experts, not just local to Cornwall. About 38 people were involved in the assessment of this contract, from procurement experts to local GPs and so on.

Q225 Ian Swales: From your experience of that contract, do you think that we could be facing pretty much the same situation somewhere else in the country, because the national advice was inadequate? Is that what I take from that?

Steve Moore: It is difficult to comment on what other contractual arrangements are in place.

Q226 Ian Swales: But you used a national framework.

Steve Moore: We did, yes.

Ian Swales: And the national framework did not help you to set this sort of thing out properly.

Q227 Chair: Where is the risk to Serco in this?

Steve Moore: In terms of all the issues that came out, it has a significant risk around its reputation.

Chair: I don't think it is doing too badly: it has two point something billion quid-worth of contracts.

Q228 Ian Swales: Has the question of penalties ever been discussed, either internally in your organisation or with Serco?

Steve Moore: In the light of the NAO Report, something is now being actively discussed with Serco. My view about fining is that it can be a relatively blunt tool to get the change that you need. We do need to ensure that the first focus is that providers do the right thing and, when that fails to be the case, that we hold them to account for correcting the systems. That is something that we do with all our providers.

Q229 Ian Swales: First, this Report is nearly two months old, so I do not know when you are actually going to do something. You say "in the light of the NAO Report". Secondly, I do not know if you were in the earlier hearing, but I do not think Committee members were that convinced that the culture or performance of Serco has gone from north to south, as it were—in other words, that you are never going to have this kind of problem again. I do not think any of us around this table would put our shirts on that. Don't you need to get a bit tougher with people with that kind of contract, and with those providers?

Steve Moore: I agree that lessons are to be learned from all this. Active discussions are going on now with the CCG in the light of the NAO Report, and I think are being taken forward.

Q230 Ian Swales: When you say that discussions are going on now, is that with a view to some sort of penalty?

Steve Moore: The recommendation was to look at the financial incentives, including penalties, within the contract.

Q231 Chair: So are you getting out of the contract? Did you work for the PCT before?

Joy Youart: No, I worked in NHS London, and I was the chief development officer for the clinical commissioning group.

Q232 Chair: Had you written this national contract then?

Joy Youart: No.

Q233 Ian Swales: To finish my point, clearly you want to have a good working relationship with Serco and to continue improving the service, but if it was in default to this degree last year—and, as the Chair said, probably in the previous two years—it is one thing to look forward, but should you not also look back at the way it performed previously, when you are talking about penalties and contracts?

Steve Moore: Certainly the focus for 2012 was to ensure that Serco put right all the unacceptable things that went on, whether that was in its culture or in the data manipulation, for example. I think we have been holding it very much to the fire on all that, to ensure that it delivers a service that is worthy of the people of Cornwall, whom it serves. However, I do accept that there are things we can learn, in terms of contract levers that will enhance that in future.

Q234 Ian Swales: A final point from me: there are issues about breaching the contract by providing false data. Are you saying, in answer to what the Chair said earlier, that it does not matter what level of performance it provides, because there are no penalties? Is that the case?

Steve Moore: No, absolutely not. We have a performance management process that involves local GPs as well as managers and patient reps, which every month looks in a great deal of detail at every aspect of the service.

Q235 Chair: Why didn't you fine these people? This is just incredible. Why didn't you withdraw money from them?

Steve Moore: The contract did not allow for that.

Chair: So there isn't a process. Jackie.

Q236 Jackie Doyle-Price: I've seen this too much in the NHS. When things go wrong, it is, "Oh dear, how terrible," but when we look at sanctions, the view is generally taken that it would be more damaging to patients' interests than if we just carried on as we are. Does that not give a signal to companies like Serco that the moment they win a contract, they are just laughing all the way to the bank?

Steve Moore: I do not think Serco is in any doubt about the need to sort out the issues that it had last year with the service. We have been very clear with it.

Q237 Chair: It was not last year.

Steve Moore: And before that, sorry.

Q238 Jackie Doyle-Price: With repeated failure to comply, ultimately you could terminate the contract?

Steve Moore: Yes.

Q239 Jackie Doyle-Price: On what basis did you take the decision not to?

Steve Moore: As I said at the beginning, it is about taking a proportionate approach to all of that. I think you have hindsight, and people can question you about that. It is a judgment call, not just for me but for the board of the PCT. This was a provider that was getting very positive patient feedback, and the only provider in Cornwall that we were required to survey all the time. It had things that were unacceptably wrong in its service. We needed to take a rounded view to ensure that that was improved.

Q240 Jackie Doyle-Price: Let's not hide behind patient feedback here. In my experience, patients have pretty low expectations and will take what they are given. Really, the question for you, Mr Larner, is what this teaches us about broader contract performance, because there is an issue here. We have companies that are good at winning public sector contracts, and when they have got them, it is "Get what you're given."

Gavin Larner: My responses relate to whistleblowing, rather than to general contract management in the NHS, but I am happy to take those points back.

Q241 Jackie Doyle-Price: I did notice you have all the difficult issues on your desk, to be frank. There is an issue here. If we are to rely more on contract management to deliver services in the NHS, there must be some established standards that the Department and the NHS nationally hold some of these commissioning groups to, because Serco is taking candy off a baby.

Gavin Larner: NHS England, now established, will want to look at the quality of commissioning, and to see that CCGs are taken forward. Not only will it support them in the development of that, but where

there are problems, it will take the necessary steps. As I said, it is not my area.

Ian Swales: There is irony in all this. If a new fast-on-their-feet company comes along in Cornwall and says, "We can provide this service; we have all the people" and so on, the NHS will say, "No, we want to go to a company with the size and reputation of Serco", regardless of past performance. The Committee finds it very irritating that repeated contract failures by organisations do not seem to have any impact on the future awarding of contracts.

Chair: We have three minutes left before the vote.

Q242 Meg Hillier: I want to ask a quick question. You are in charge of the CCG, which will be responsible for re-tendering this contract, if you choose to re-tender it. We have had clear evidence—I do not know whether you were in for the earlier session—from the head of the NHS and from the Deputy Prime Minister that you do not have to put a contract out to tender. It is early days. You are having fortnightly meetings with this lot. Is it a consideration that you would not bother to go through the tender process?

Joy Youart: With any of the contracts, we review them. We have put a much more robust contract and performance mechanism in place on the back of the recommendations, and we have to look at every contract on its merits.

Q243 Chair: Are you thinking of terminating this contract?

Joy Youart: It is one of the areas that we are considering, yes.

Q244 Chair: And when are you taking a decision?

Joy Youart: All the decisions are going to our performance management group.

Q245 Chair: When are you taking a decision on this contract?

Joy Youart: We are pulling together at the moment all the information. I cannot give you a date. We are going to explore every avenue that we have available.

Q246 Meg Hillier: In exploring every avenue, you will presumably have to consider whether there are other potential companies or social enterprises ready to tender. Have you looked at that so far?

Joy Youart: We are looking at every avenue open to us. Our main issue is to make sure that we have an out-of-hours provider in Cornwall.

Q247 Meg Hillier: There is one thing that alarms me. I have had issues in my area. You can hardly benchmark Hackney and Cornwall—they are very different areas—but this is saying that if you are a big company, you can tender and take the risk. If you are a small organisation, or any organisation, you can keep upping the pay of the doctors, clinicians and health advisers, because everyone has got the message now that it is a bit of a mess in Cornwall. They can almost come in and bid at whatever price they want. How will you guard against that on the one hand and the poor service that you have been receiving on the

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other? It seems that GPs and others are saying, “We don’t want to do this at that price,” so it is not good value for money for the taxpayer, either.

Joy Youart: Those are all things that we have to consider. GPs are involved in the procurement of contracts now. We have excellent contract managers—

Q248 Chair: I do not think you have excellent contract managers. I think they are rubbish.

Amyas Morse: On private sector negotiating, perhaps I can offer a contribution. If you have the power to terminate a contract, you do not need someone specifically saying, “You can take penalties.” If Serco were to offer you some penalty to help you in your considerations, would you take it into account?

Joy Youart: We have to take everything into account around the contracts. We have to look at every aspect.

Amyas Morse: If you have got the power to terminate a contract, you can very reasonably say to any provider, not particularly just Serco, “You are in breach, but I will take into consideration any proposals that you want to make to help me in thinking about what I should do about that breach.” You do not need something specific that says you can get penalties. If they are in breach, you can decide how to negotiate it for yourself. Isn’t that right?

Joy Youart: That is the discussion we are now having with Serco.

Ian Swales: As long as that is not tied to renewal.

Q249 Meg Hillier: Presumably, Dr Youart would also commission, as a GP—

Joy Youart: I am not a doctor.

Meg Hillier: Sorry, it says on our papers that you are a doctor. Well, they do not say “a doctor”; they say “Dr”. You are in charge of a CCG that is made up of GPs, but GPs could also bid to run this contract in future, so there is an interesting issue there. Do you have Chinese walls or anything between the GP members of the CCG and any who might be involved in any consortium in future?

Joy Youart: Yes, we have clear guidelines in terms of conflicts of interest, and at each of our governing body meetings they have to declare any interests. We keep a register of those interests.

Q250 Meg Hillier: But they are privy to a lot of internal information.

Joy Youart: They are, but a clinical commissioning group is made up of clinicians and managers. We have put those things in place to ensure that those interests are declared at every meeting and that we have a register of those interests. In fairness, when we have been in those meetings, they have declared those, and they have excluded them from the discussions. *[Interruption.]*

Chair: We have two votes, apparently, so I suggest that we reconvene at 6 pm.

*Sitting suspended for Divisions in the House.
On resuming—*

Q251 Chair: Jackie and Guto are definitely coming back, but we will start because that is in everyone’s interests, as it is getting late. Sir Ian, you have listened to the conversation across the piece, and you have

a broader perspective of the NHS. This looks pretty shambolic to me, but I do not know what your view on it all is.

Sir Ian Carruthers: Let me couch the question as “What would I learn from this?” I want to make two preamble comments, and one relates to performance management. The contract is between the PCT and the provider, and because there is no national framework to performance manage it, it is left to local management all the time. Therefore, the SHA, while we were there, only managed this by exception, because we concentrated on the national quality measures, which relate to A and E, ambulance services and so on. It is important to put that in context.

If you are asking me what lessons we can learn from this, I think the answer is a number of things. First, the National Audit Office Report makes a good stab with the six conclusions, and I support them all, but out-of-hours care is a very important service to the public. However, you only have to look at the benchmark data to realise the fluctuation in satisfaction ratios. I take the point that the public may say one thing, and may be very generous, but if you look at the data, it is clear the public are not wholly satisfied. The first thing I would do would be to include those data in the overall performance management process with the national quality measures. To do that, you would need to collect the national performance data set consistently, because the benchmark data are pretty hopeless—people can choose whether or not to submit those data, so you cannot get a proper picture. You cannot performance manage anything if you do not have that basic data, or comparisons, and you certainly will not improve performance without effective benchmarks.

We should make the data more up to date, and conduct regular benchmarking. We should also publish the data quarterly, so that they are transparent, because I am not quite sure how the public are able to make a judgment on the service.

On top of that, there are things that we could learn about Pathways. I certainly think that we need strong performance management and stronger contract management. We were just chatting during the break about the national contract, which does not provide for penalties, although to pick up on what the Comptroller and Auditor General said, you can have a discussion about that, and Steve Moore may want to comment. We need better contract management, and the levers to deliver that. For a host of reasons, it has been our culture in the NHS not to levy fines and penalties, because in hospitals, for example, it often causes more problems by taking money away from places that are struggling, so there is a cultural point about fines. I know you will come on to whistleblowing, but personally I believe that we should attempt to create healthier organisations in which issues are addressed early, people are very open and we all work together for the same thing: the patient. I think we need to do that and it is possible.

I believe out-of-hours needs to be given greater priority until the standards are met. A review of out-of-hours services should be conducted to put all this on the same footing as some of the other key

parameters that the NHS measures day to day. In my view, measuring A and E performance is very important, but I do not see how you can do that when another part of the emergency system—urgent care system—is dealt with on a completely different basis. I do not have a magic wand, but I think this needs to be raised in the highest possible way, because this is the first contact that most people have with the NHS. One last thing is that while you may be appalled by what you have heard today, according to the benchmarked criteria, it is fair to say that the services being supplied are actually better than many of your individual constituencies, from the data I have looked at.

Chair: Really? Sugar!

Sir Ian Carruthers: The data, the satisfaction ratios and so on suggest that there is only one that is better. I have the data here, showing that the performance data that you are seeing today is at the top-performing end of out-of-hours services, atrocious though you might think that is. That is why I think we need to look at this a bit more.

Amyas Morse: I found that very helpful. I would just respond by saying that before today's session, the NAO health team came to the conclusion that we may need to do a much wider study on out-of-hours care. I make a commitment to the Committee that we will do that. We will get that moving, and we will no doubt get some advice from Sir Ian and others. That is the first point. The second goes back to the advice that Ian Swales gave earlier. I do not speak for the Committee but, if I may make a suggestion, I am sure we would be very interested to hear the result of the more vigorous and engaged negotiations that you are having.

Dealing with a very large, powerful organisation that is all over the public sector is a bit different. This is not to say that there is anything wrong with it, but when dealing with such an organisation, you probably need to be pretty robust in the way you defend your interests. You need to ensure that if you are entitled to anything or you have a point of leverage, you use it to the full. I think that is terribly important. I suggest that as you go through these discussions and start bringing this point to bed, I am sure that the Committee would be very interested in how you have got on. I do not know whether it would be useful, Chair, if we bring it back.

Chair: That would be really, really helpful.

Amyas Morse: I am sure they would love to hear from you about how you get on in your negotiations.

Q252 Fiona Mactaggart: I am anxious that this is one of the top-performing out-of-hours services, and I am anxious about what we were hearing earlier regarding the changes to the quality of requirements. I suppose my big anxiety is that we are using, as I understand it, NHS Pathways, which Serco blames for its collapse in meeting national quality standards, in the 111 service that is being rolled out around the country. Is there a problem with Pathways that needs remedying? What are the implications for the 111 service? Let us start with those two.

Steve Moore: The first thing to say about Pathways—and I am not an expert on it as a tool—is that it is

certainly something that has a great deal of clinically based evidence behind it. It was designed by clinicians nationally and is seen as good practice. It has been used by ambulance trusts around the country for some time now, so it is a tool that is seen to work. I think it comes down to how you implement it and ensuring that you are planning for what the effects might be, because it is an algorithmic model. There are certainly lessons from what happened in Cornwall in June when we implemented it. It was the first place in the country, I believe, to do it for an out-of-hours contract, so that brought its own challenges with finding out about it and having a reasonable impact assessment. I can see that going through into the national 111 roll-out.

Q253 Fiona Mactaggart: I am not sure that I got an answer I understood. Perhaps Sir Ian could talk to me about what it means for the 111 service throughout the country?

Sir Ian Carruthers: First, I have left the NHS. I was involved in the preparation of 111, where we had to go through check lists, check points and so on, so I do not know—other than what I have read in the press—how the performance has continued since it has been introduced. The point I was going to make about Pathways is that it is the nationally designed part of the system, and it has good intent behind it. However, I am not quite sure, as Steve has just said, that the drops in performance that actually occurred can be attributed to Pathways. My guess is that if we examined them across other areas where 111 has been introduced—I know that 111 is yet to be introduced in Cornwall—I think that you would perhaps find that some areas are functioning quite well on Pathways without this drop.

Q254 Chair: Well, Pathways seems to be sensible. It is like when you ring NHS Direct and you get taken through a series of questions. It is the most wonderful service.

Sir Ian Carruthers: Chair, there is a question of whether Pathways and the standards cohabit together. This is why I think there needs to be a review. On top of that, we have no data to prove what is happening anyway, because a lot of organisations do not actually return the data on the quality requirements.

Chair: I think dumping on Pathways in the way Serco tried to do was wrong. Anyway, it knew it was coming and it should have prepared. It had had months to prepare but, particularly when Ian asked them, it had not even improved its performance on responding to telephone calls.

Q255 Fiona Mactaggart: So it is not Pathways. I was slightly worried, Sir Ian, about you saying that lots of people are not providing quality data at all.

Sir Ian Carruthers: My colleagues in the National Audit Office may correct me on this, but it is my understanding that the benchmarking information that is available nationally is done on a voluntary basis.

Laura Brackwell: That is correct.

Sir Ian Carruthers: And there is no formal connection at the level of PCT to do that. It was in the year when we really wanted to decentralise and

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create local autonomy. That is absolutely correct, but with that should come transparency—

Q256 Chair: Hear, hear. And accountability.

Sir Ian Carruthers: And accountability, which that will bring about. If I am PCT A, I could just choose not to give my data.

Laura Brackwell: About two thirds of PCTs have bought into the benchmarking service, so a third have not.

Q257 Fiona Mactaggart: We keep being told that we learned about this apparently excellent service—among the top in the country, which was based on some fibs, at least; let's call them fibs, and not anything more dramatic—because people broke the rules, the whistle blew, and so on. If you are saying to me, Sir Ian, that this is one of the best in the country, should that give us any anxiety that, all over the country, many other frightening things are happening?

Sir Ian Carruthers: I am saying it on the basis of the data that are volunteered to the benchmark club, because I am not sure that you actually could draw those conclusions as there is not a complete dataset.

Q258 Chair: But the benchmark data that Serco supplied were the fiddled data.

Sir Ian Carruthers: Yes, you can say that, but—

Chair: It's true.

Sir Ian Carruthers: But it is a question of how material that was in the percentages. That is why I think that out of hours needs a far greater look-at—that is why I feel that it is there. What would be my other criteria for testing about Cornwall? It is the number of serious untoward incidents we have had, which are about the safety of care. In the past 18 months¹, I think that we have had eight, all of which have been investigated and all of which have been signed off. When you think of the number of transactions and given the data that we have—

Q259 Chair: Eight where—in Cornwall?

Sir Ian Carruthers: Yes. Serious incidents—untoward incidents—that people want to put in the learning and reporting system. All of them have been signed off and dealt with, but that is another indicator saying that when you look at the transactions over an 18-month² period, it would be nice to know whether eight was a good mark or not. The truth is that we do not really know.

Q260 Ian Swales: Who puts them in—Serco?

Sir Ian Carruthers: The provider does, but the PCT and the CCG will be monitoring this. These are like the never events of hospitals.

Q261 Fiona Mactaggart: If you look at paragraph 3.18, it tells us that in terms of the bonus payments linked to the performance indicators in this contract, “only one of these relates to achieving outcomes”. Only one of them seems to be about quality in relation to the patient. It seems to me that if we had a

contracting system that put the quality of service to the patient at the top of the system, we would get the kind of transparency and quality of information that I think the Committee and you, Sir Ian, require. Why did that not happen?

Sir Ian Carruthers: I don't know, but the truth is that the logical thing is to pick up the NAO Report and link, in fact, the payments to what are the very serious and key quality requirements. That was why I began by saying that if I look at learning lessons, the first thing to say is that I think all six of the recommendations are very pertinent, but it needs to go further.

Q262 Chair: Why was it not in your contract? Was it because it was not a national contract?

Steve Moore: It was not part of the national contract, yes.

Q263 Meg Hillier: I want to make an observation about patient surveys in my local hospital a few years ago. It is now slightly out of date, but in the patient survey results, there was a higher number of people who had had episiotomies than the hospital had actually carried out, including three men. That perhaps suggests that there is something to do with the patient survey data as well, so when we look at some of this, maybe we need to look at how on earth the data could ever be audited.

You talk about benchmarking, and I am interested in the benchmarking club being voluntary. Some of us sat on the pre-legislative scrutiny Committee on the draft Local Audit Bill, and there was a real gap in health services. You were in a senior position in the NHS. Was there any discussion about how to improve that and any agreement, or was it just done in such haste that—

Sir Ian Carruthers: On out-of-hours?

Meg Hillier: Generally. Is it just out-of-hours that is voluntary—

Sir Ian Carruthers: The thing I was talking about was really that the Department of Health, I understand, pays a contribution to an individual club that supplies the data. The data are collected on a voluntary basis.

Q264 Meg Hillier: That is just for out-of-hours, so in other areas, it is much more robust.

Sir Ian Carruthers: Yes.

Q265 Meg Hillier: Was there any discussion among out-of-hours providers or commissioners about the inadequacies of that, and any pressure on the NHS centrally?

Sir Ian Carruthers: No. I could also argue about what data are put in the public domain about the GP contract and performance on that, for example.

Q266 Meg Hillier: We would want more rather than less, I think.

Sir Ian Carruthers: I think they are all linked. It comes from a time when people were saying, “We want to be light touch on this.” I am all for light touch, and I think the future direction of the NHS will be fine, but there are certain things on which, if we want to secure improvement, transparency is the way to do

¹ Note by witness: should read since December 2008

² See footnote 1

it—it does not have to be command and control—but to do that you have to have the basic data set.

Q267 Meg Hillier: Sir Ian, you chime with the Committee on that, because transparency is one of the pillars of our work

Turning to Steve Moore, you set a contract for a tender. Four bidders came in, but two dropped out because the price point was too low a cost for them to continue. Can you tell us a bit more about those bidders and why they dropped out?

Steve Moore: I can tell you that we set a cost envelope for this contract as part of the procurement. It is recognised in the David Colin-Thomé report that the amount we pay for out-of-hours services generally for Cornwall is quite high.

Q268 Meg Hillier: It was £1 million more, roughly—£7.2 million and £6.7 million, wasn't it?

Steve Moore: But in terms of benchmarking it as far as we are able to across the NHS, and given some of the comments Sir Ian has made, we can see that we spend relatively high amounts on out-of-hours services.

Q269 Meg Hillier: And that was factoring in that Cornwall has rather different geography from, say, Hackney or Redcar?

Steve Moore: That is part of the problem. In Devon, for example, it is about £10 per patient and in Cornwall it is about £13 per patient that we spend. Cornwall covers 1,374 square miles. It is very challenging.

Meg Hillier: I once went to a wedding there and it took me five hours to get across.

Steve Moore: We set a financial envelope within the procurement process that reflected how much we were currently spending, assessed with that our expectations of efficiency, which of course we expect from all our providers, and then went to test the market.

Q270 Meg Hillier: But four came in at that point.

Steve Moore: Yes.

Q271 Meg Hillier: Can you tell us a bit more about the two that pulled out? I am aware it could be confidential, but it was a long time ago now, so could you tell us a little about why they pulled out?

Steve Moore: At least one of them—I don't know about both—pulled out because it was not able to get under the financial envelope, which is a pass-fail within the rules.

Q272 Meg Hillier: And were they all private sector companies?

Steve Moore: No. It was a mix of social enterprise and private sector, with some NHS.

Q273 Chair: It was only four. Of the two that fell out, one was private.

Steve Moore: There were a number of partnerships. For example, the ambulance trust was a bidder with a social enterprise in Devon, as a single bidder. There

were a number of different entities as part of that procurement process.

Q274 Meg Hillier: Perhaps I can turn to Joy Youart—Ms Youart, not Dr Youart—on the issue around legal challenge. In my own area, the previous local commissioner, before the CCG came in, decided that it needed to tender a contract. It advised GPs locally to bid—sorry, the PCT advised GPs to bid—a year ago. In January, the commissioning board decided that it needed to tender the contract. The reason was that it was fearful of legal challenge. Is that one of the considerations? Before the Division bell went, you talked about considering many things in the round: is the consideration of legal challenge by losing bidders, or companies that are not asked to tender, one that your CCG will be taking into account in future?

Joy Youart: Yes, contractually and legally.

Q275 Meg Hillier: Serco said—on the record, which may be helpful to you—that they would not consider a legal challenge, so we and others can hold their feet to the fire on that—I am sure local MPs would—if it were to change. However, that does tend to mean that if you had a small social enterprise bidding to run the contract—I say small; it is big, because it is Cornwall, but it could be a small entity—you would know, because it is common sense, that they would not have the money to mount a legal challenge, but the big companies have a big wallet of money that they can put on the table. You are then actually more inclined to worry about the legal challenge from the big companies, and the little guys go to the wall. Is that going to happen?

Joy Youart: No, I don't think that is the case. Clearly, there are procurement rules we have to follow. They are laid down in the NHS. We have to look at the local circumstance we are sat within. We are very keen at the moment that with out-of-hours and other services we look at a whole-system approach. If that affects patient care, that is the way we have to look at things.

Q276 Meg Hillier: But trying to prove that in a court of a law could take a very long time and could be very expensive for you. That is what the decision was made on in my area: it was cheaper to tender than to risk a legal challenge against tender.

Joy Youart: That is clearly the judgment we have to make.

Q277 Meg Hillier: I point out again that on 18 March, the head of the NHS, Sir David Nicholson, said: "There is not a requirement to competitively tender for those services"—that was services in general. On 26 March, the Deputy Prime Minister said that, "Clinical commissioning groups"—such as yours—"are not forced to open services to competition unless they think it is clinically justified in the interests of patients to do so." However, that has not yet been challenged in court. I could paraphrase what you are saying as, basically, that you are going to take an "in the round" but cautious approach to that legal threat. Is that a fair summary of what you said?

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Joy Youart: It is. Because we have clinicians and managers working together, we can look at it from the perspective of all those aspects of care and also the wider system that we are working within.

Q278 Meg Hillier: Although Serco said that they will not make a legal challenge, it seems to me that that gives carte blanche to any company, whether or not it is currently bidding for or running anything in Cornwall, to make a legal challenge if you decided to go with either Serco or a local social enterprise.

Joy Youart: And we would look to the procurement advice that we have as part of the CCG. Part of that is the legal advice to us in terms of those contracts.

Q279 Meg Hillier: You are looking at the clinical expertise and legal expertise.

Joy Youart: Absolutely. That is the balance we have to make.

Q280 Chair: Is it right that you are not taking account of the performance of the contractor?

Joy Youart: We would absolutely take that into account.

Q281 Chair: Because the Report says, somewhere, that you are not taking account of that. Help me, Laura.

Laura Brackwell: It says that in assessing the bids, the PCT could not take account of Serco's performance—

Joy Youart: I think we can only look at contracts going forward. We are only authorised—

Q282 Chair: No, you are looking at the performance of this contractor.

Meg Hillier: In terms of patient care.

Joy Youart: Yes.

Q283 Meg Hillier: If you are not convinced that they are doing a good job now, surely you could take that into account?

Joy Youart: The revised technical working group and performance management group that we now have in place look at all those indicators. We look at the clinical, and we triangulate patient experience, quality and safety of the service and performance on resources.

Q284 Chair: Past performance?

Joy Youart: Past performance and present performance.

Q285 Meg Hillier: Maybe you can comment on this, Sir Ian, although please tell me if you do not feel that you can. Let us consider a rapacious private provider with deep pockets, bidding or not bidding for a contract, whether or not it has any interest in running a contract in Cornwall or anywhere else. It seems to me that if you give the contract to one organisation—private, public, social enterprise or whatever—one rapacious private company could go around the country picking off and legally challenging the fact that you did not tender. Even if the CCG made a settlement in the end, that company could go away

with loads of money. From what I am hearing, there is nothing that stops that happening, which seems extraordinary. Am I wrong in my interpretation, Sir Ian?

Sir Ian Carruthers: I think that it is a matter for the CCG to decide what they want to do in this instance—

Q286 Meg Hillier: The threat is there, isn't it?

Sir Ian Carruthers: Obviously private sector companies will make their own judgments about how they do their business. In essence, I think you have to be cautious about competition, because it is not an end in its own right. However, equally, we should not think that things have not improved because of it as well. The private and public sectors have lived together in the NHS for many, many years, and will continue to do so. I do not think that demonising one rather than the other—

Q287 Meg Hillier: Sorry, I am not demonising; I am simply saying that, factually, the threat of legal challenge is very present.

Sir Ian Carruthers: Yes.

Q288 Meg Hillier: It could come from any quarter if a CCG decides to take a non-tendering route. It could come from a social enterprise.

Sir Ian Carruthers: Yes is the answer.

Q289 Ian Swales: One of the things that we are all seeing as constituency MPs is the effects of A and Es being swamped by lots of people, which is causing cancellation of elective operations, pressure on the ambulance service—it cannot get people out of the vehicles—and so on. Paragraph 2.31 of the Report says: "Serco considers that the NHS Pathways system is relatively risk adverse and so is more likely to instruct a health adviser that an ambulance should be called." We can all see that happening, so there could be a problem with Pathways, but are providers such as Serco, in thinking about their resources, incentivised to choose one pathway or another? In terms of how they deal with people, are they better off if they can get this to happen rather than that?

Steve Moore: I do not believe that is the case. Certainly, the number of calls to an out-of-hours service that gets transferred to a 999 service is relatively small in relation to the number of calls that they get in total. I do not think there is any obvious incentive for an out-of-hours provider to shift work.

Q290 Ian Swales: Let me give you an example. In the old days, you might well have sent a doctor round to somebody's house, and we want to see more care in the community. Is there any difference for Serco in saying, "We will get a doctor round to see you," or "We will get you an ambulance and get you to A and E"? Is there any financial difference for them in those two pathways?

Steve Moore: I do not believe there is. There are a couple of other control mechanisms in place, one of which is that all the providers in the urgent care network, including Serco—that brings together the acute trust and the ambulance—regularly get together in the resilience forum. If any particular provider was

seen to be doing something like that, it would be held to account.

Q291 Ian Swales: You may not even want to answer this, but I ask you to think about it: the real point is that we are seeing stresses and strains because budgets are held in different places, and if you can push your work to somebody else's budget, whether it is health, social care or whatever, you win the game. I even had an example last week of the police being asked to act as ambulances because of a shortage of ambulances. I wonder whether there are any games that Serco can play that you can see as a result of this contract. If there are, they will.

Steve Moore: I think it would be very marginal and would be picked up very quickly.

Q292 Chair: I think we are all astounded by this. If you are Serco, if you can shove the work on to the ambulance service it saves you people and money.

Ian Swales: Does it? That is my question.

Chair: It must do.

Laura Brackwell: It does in the sense that Serco do not pay for the ambulance service and they do pay for the GPs, so in that sense it does.

Q293 Ian Swales: Why didn't you answer the question?

Steve Moore: Apologies; what I tried to say is that it is a relatively marginal part of the 137,000 calls.

Q294 Ian Swales: How can it be? Now we are hearing partly why A and Es in hospitals are being swamped, because providers like Serco have an incentive to send you to A and E rather than get a GP. Is that right?

Steve Moore: I do not believe that that is happening.

Chair: You do not believe it, but it must be.

Q295 Ian Swales: They have a financial incentive. Believe me, companies like Serco sit every day looking at how they can chisel more money out of the contract. If they have an incentive, they will be doing it. It is naive to imagine that they will not be. Surely you do not actually believe that, do you? If you do, you should not be dealing with rapacious companies like Serco. They will be doing it, believe me.

Steve Moore: I can accept that it is a risk, and certainly something that we would be very alerted to, if it was happening.

Ian Swales: Well, go back and look, because that will be one of the problems you have got, I am sure.

Chair: I have to ask you all to be really brief. Jackie wants a very brief question, Austin a really brief one, and then I just want to ask about whistleblowing before we stop.

Q296 Jackie Doyle-Price: A very brief question to Ms Youart. The Report explains how the contract was re-tendered in 2011, which was obviously when the landscape was changing, and it says that the CCG was involved in that process. Are you satisfied that you had enough influence over the contract for the new contract to be issued?

Joy Youart: The CCG was not authorised at that point in time, but what we did have was a GP who was involved in the contract. It was very early on in our development as a CCG. They were there as clinical advisers with the PCT working through that contract.

Q297 Chair: So the answer is no.

Joy Youart: Not as an authorised CCG.

Q298 Chair: The answer is no? You didn't have enough influence or you did have enough influence?

Joy Youart: Well—

Sir Ian Carruthers: The Report says the answer is yes.

Q299 Jackie Doyle-Price: I think the conclusion is that it came at the wrong time in the life cycle of the CCG.

Joy Youart: It did. It was very early on in the life cycle of the CCG.

Q300 Austin Mitchell: Like Ian Swales, I believe you are dealing with nasty capitalist organisations—good to know that that is a Liberal point of view as well. Why didn't you include penalty clauses in the contract for failing to meet national service requirements?

Steve Moore: As I said earlier, we were working with a national contract, and that does not allow for fining to be formally clearly set out, although we take the point made by the Comptroller and Auditor General that it is now actively being looked at.

Q301 Austin Mitchell: Are Serco now meeting national quality requirements?

Joy Youart: No.

Q302 Austin Mitchell: What are you going to do about it?

Joy Youart: We have a technical working group and a performance management group, which are looking at all those performance standards. At the moment, we are looking at what we have within the contract that we can use as leverage. We have made no other bonus payments in terms of that to Serco, and that information will come back to our performance management group.

Q303 Austin Mitchell: Are they going to be penalised?

Joy Youart: Partly what we are looking at the moment is what is within the contract—

Q304 Austin Mitchell: I think you said penalised in part earlier on.

Joy Youart: We are looking at what options are available to us.

Q305 Chair: What is the bonus system? Are there bonus payments to Serco from the PCT/CCG?

Steve Moore: There are KPIs that sit beyond the national quality requirements that we talked about.

Q306 Chair: You told us that you paid partial bonuses in 2012, and you are looking at whether you

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withdraw all bonuses for 2013 because they are not reaching their performance standards.

Joy Youart: Yes, exactly. That is one of the considerations for our performance management group.

Q307 Chair: One very quick question—I want us to finish. Why didn't you specify minimum staffing levels in the contract?

Steve Moore: It is something that is being actively debated. There is always a balancing act between specifying these things, with the clarity that brings, and—

Q308 Chair: Do you regret not having specified it?

Steve Moore: It is something that is being looked at in the light of what has happened.

Q309 Chair: Are you going to specify minimum staffing levels?

Joy Youart: That is an area we are exploring with Serco. We need to consider not just the minimum staffing levels; as you heard, the care system in Cornwall has peaks and troughs in demand, and the clinicians are looking at that as well.

Q310 Chair: Did any of the staff responsible for monitoring the contract, either in the PCT or the CCG, work for Serco?

Joy Youart: No.

Q311 Chair: Can I ask two or three questions on whistleblowing? Are private contractors who work for the NHS covered by the legislation on whistleblowers?

Gavin Larner: Yes. The Public Interest Disclosure Act is a piece of general employment law that covers both public and private sector employees.

Q312 Chair: Does the duty of candour cover admin staff?

Gavin Larner: I think, as it stands at the moment, the duty of candour contractually relates to organisations rather than to individuals, so it does not fall on individual members of staff. The Secretary of State said that he wants to wait for the outcome of the review that Don Berwick is conducting into safety in the NHS so that he understands how sanctions on individuals might impact on the culture of the organisation. There is a risk that if you put too much on individuals you create a culture of fear, rather than a culture of openness. He wants to see what Don Berwick has to say before he makes a judgment about whether criminal sanctions or other sanctions should be applied to individuals.

Q313 Chair: What is your view of the way Serco handled the whistleblowers?

Gavin Larner: From what I have heard today, it sounds like the instances you have referred to, if they are true, are strongly counter-productive in terms of creating an open culture where people feel confident speaking out.

Q314 Chair: Why didn't you listen to the whistleblowers?

Steve Moore: We did.

Q315 Chair: They don't think you did.

Steve Moore: We wrote to all their staff to reiterate our support.

Q316 Chair: They don't think you did, Mr Moore. They say the only reason they went to *The Guardian* is that you were one of the people not listening to them.

Steve Moore: There was certainly a lot of noise coming through both to us and to our local MP.

Q317 Chair: Noise? So what did you do about it?

Steve Moore: We sent in our auditors to have a look at their processes and policies, and then we wrote to all their staff jointly with Serco management.

Q318 Chair: When did you do that?

Steve Moore: We did that in June 2012.

Q319 Chair: But that was after it had been blown in the papers. You didn't do it in 2010–11 when people started to worry about staffing levels and the quality of the service, did you?

Steve Moore: No.

Q320 Chair: Although they were talking to you at that time.

Steve Moore: The culture changed very significantly at the beginning of 2012. That was when we started to get—

Q321 Chair: Your culture changed?

Steve Moore: No, Serco's culture. We started to get worries from—

Q322 Chair: You don't know—I am going over the same ground—because you did nothing about looking at performance in 2010–11, so you have no idea. The whistleblowers told me that it was worse in 2010–11. Right, thank you so much. My apologies for keeping you so late. My thanks to Committee members for staying with us.

Written evidence from Serco

Q12—*Global Chief Executive's remuneration*

Mr Christopher Hyman's bonus last year was £812,250.

Q93–98, Q150, and Q152—*All relating to continuation for January-March 2013 of performance data-sets cited in NAO Memorandum*

Please see the attached data-sets and charts which provide a continuation of each of the relevant figures in the NAO Memorandum to bring the data up to March 2013 as requested.

Q134 and Q139—*Use of externally provided whistle-blowing service*

Of the 135 individuals who used the whistle-blowing service externally provided by "The Network" 34 chose to remain anonymous. Therefore, we are unable to say how many of the 34 anonymous callers have left the company and how many remain with Serco. Although Serco does have the names of the remaining 101 individuals who reported matters through The Network, neither Serco or The Network record those employees personal identifiable information (such as the individual's employee number) in sufficient detail to permit the Company to correlate the individual using the whistle-blowing process with its employee database. With so many of our employees throughout the company having the same name, and given the fact that employees change positions due to internal reorganisations or to pursue other opportunities within the Company, we are unable to determine how many of the 101 employees remain with the company at this time. We can confirm that there have been no complaints of retaliation received by those who have used our "speak up" process.

We believe that this and the attached provide the information requested, however please let us know whether the Committee have any further requests for information following this letter, or if further clarification of the attached data is required, and we will endeavour to provide it.

Valerie Michie
Managing Director, Serco Health

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