THE NATIONAL ASSEMBLY FOR WALES
AUDIT COMMITTEE

Report presented to the National Assembly for Wales on 9 March 2006 in accordance with section 102(1) of the Government of Wales Act 1998

Contract for the provision of the out-of-hours GP service in Cardiff

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Summary

In April 2004, Cardiff Local Health Board (LHB) awarded a contract for providing out-of-hours GP services to a newly formed company, Clinical Solutions UK/ Europe (CSUK), following a competitive tender process. Shortly after the service began operating in October 2004, Cardiff LHB awarded CSUK additional funds, which totalled £59,000 over the six months to March 2005, to manage risks to patients' safety caused by unacceptably long call-back times at weekends.

On the basis of a report by the Auditor General,[1] which originated from correspondence from Bro Taf Local Medical Committee, we took evidence on the award and management of the contract from Ms Siân Richards, Chief Executive of Cardiff LHB, Ms Alison Gerrard, Finance Director of Cardiff LHB, and Mrs Ann Lloyd, Head of the Health and Social Care Department of the Welsh Assembly Government.

We also considered a letter sent to the Chair of the Committee from Dr Thompson of Ely Bridge Surgery, challenging one of the conclusions of the Auditor General's report, and the Auditor General's response.

Local Health Boards let and manage a significant number of contracts. Our examination focused on whether there were lessons that other LHBs and the wider public sector could learn from the contract for out-of-hours services in Cardiff. In particular, we considered whether Cardiff LHB had managed the risks associated with awarding the contract to CSUK effectively, and whether Cardiff LHB's decision to award additional funding to the supplier was justified under the terms of the contract.

We concluded:

- there were serious deficiencies in the checks Cardiff LHB carried out to assess the financial and clinical capacity of CSUK prior to awarding the contract; and
- the additional funding of £59,000 awarded to CSUK was unjustified.

Serious deficiencies in the checks carried out prior to awarding the contract

The LHB advertised publicly for tenders, and sought advice and followed Welsh Assembly Government guidance at key stages of the process. Evaluation panels, which included independent representation, scored CSUK's bid the highest against a series of non-

[1] Auditor General for Wales report, *Contract for the provision of the out-of-hours GP service in Cardiff*, 24 August 2005

financial criteria. Nevertheless, there were shortcomings in the process, in particular a lack of clarity about the meaning of the term “integration” in the service specification, and the fact that the decision to award the contract to CSUK was made outside of the full Board. We note recent actions taken by Cardiff LHB to avoid such problems in future.

We found that Cardiff LHB’s management of some of the risks that resulted from its decision to award the contract to CSUK was seriously deficient and fell short of basic standards of commercial prudence. In particular:

a) the background checks Cardiff LHB conducted to verify CSUK’s capacity to deliver clinical services to patients were insufficient to provide that assurance;

b) Cardiff LHB failed to carry out the basic checks needed to verify whether the company was financially sound and capable of absorbing any unexpected costs associated with operating the out-of-hours service; and

c) despite recognising that its decision to award the contract to CSUK involved a number of risks, Cardiff LHB failed to put in place either a documented risk management or contingency plan.

We note that the Welsh Assembly Government has already acted on one of the Auditor General’s recommendations, by issuing a Welsh Health Circular that directs LHBs to existing guidance on background checks and basic due diligence. However, the public has a right to expect that public officials should be competent in exercising a normal level of commercial prudence without needing to refer to detailed guidance. Therefore, as professional commissioners of services, Cardiff Local Health Board officials should at least have been aware of the existence, if not the full detail, of such guidance, and ensured that their handling of this contract reflected that guidance.

The additional funding of £59,000 awarded to CSUK was not justified

The LHB sought to justify to us paying extra money to CSUK on three grounds:

- **increased demand**: both CSUK and the LHB claimed that far more patients were using the service than specified during the procurement of the service;
- **lack of skills and training** amongst CSUK’s nursing staff; and
- **patient safety**: as a consequence of these two factors, CSUK was unable to call back to patients as quickly as the contract specified.

These are spurious arguments; we reject them.

Increased demand could never have constituted grounds for paying CSUK more money: the contract transferred the risk of meeting demand to CSUK. And the evidence clearly shows that, contrary to the flawed logic put to this Committee by Ms Richards, there was no increase in demand above the levels contemplated when the service was being procured.

If it is true that the staff CSUK had inherited from the previous providers of the service lacked the requisite skills, that too was a risk that CSUK had accepted as part of the contract. It was certainly not an argument for paying CSUK more money.

Patient safety might certainly be reason for the LHB to intervene, but we find it incomprehensible that the LHB's chosen intervention was to pay CSUK more money. It was CSUK's obligation, under the contract, to provide a safe service. CSUK's failure to do so is a reason for withholding payment not increasing it.

It is in general a good starting point for a public body to say no when a supplier asks for more money, and particularly if that request comes within weeks of the contract commencing. Far from treating CSUK's request with proper caution, however, the LHB readily paid CSUK what it asked for, in advance of preparing a business case for doing so and without any safeguards should the payment be unjustified (as it was). We note that the LHB's Audit Committee is currently considering whether any of the money can now be recovered from CSUK.

Recommendations

1. Cardiff LHB could have done more at an earlier stage to resolve misunderstandings with a bidder regarding the interpretation of the service specification. **We recommend that public sector bodies should:**
    a) **where appropriate, and being careful to maintain fairness, make pre-tender contact with the market to discuss and clarify the specification, particularly if it is complex or unusual;**
    b) **offer potential bidders opportunities to discuss any potential ambiguity about the interpretation of the service specification before tenders are submitted; and**
    c) **include a glossary in their service specifications that defines any potentially ambiguous terms.**
2. The whole purpose of taking up references is to obtain authoritative, independent confirmation about a company's capacity to deliver. However, Cardiff LHB took up only oral references for CSUK from referees who were, moreover, poorly placed to comment on CSUK's capacity to deliver clinical services and who had potential conflicts of interest. Also, the references were not adequately documented. On the basis of this case, therefore **we recommend that public sector bodies should confirm that referees are in a position to comment authoritatively on the capacity of the company to provide the services being tendered for, that referees have no potential conflicts of interest, and that all references are fully recorded and retained.**
3. It is inexcusable that Cardiff LHB failed to follow good practice in the basic checks it carried out to ensure that CSUK was financially viable and had the capacity to manage any unexpected costs or expenditure. The Welsh Assembly Government recently issued a Welsh Health Circular directing LHBs to existing Treasury and Office of Government Commerce guidance. **We recommend that LHBs, in exercising their duty to apply normal standards of commercial prudence, should be guided by Treasury and Office of Government Commerce guidance on the financial checks that need to be carried out on companies bidding for contracts, with particular reference to the need to verify that new companies have the financial capacity to deliver the service adequately.**
4. An ineffective out-of-hours service could have an adverse impact, not only on the patients directly served, but also on the entire accident and emergency service.

However, despite recognising the importance of the out-of-hours service to patients and that its decision to award the contract to CSUK was inherently risky, Cardiff LHB did not put in place a detailed risk management strategy nor did it have a documented contingency plan. **We recommend that when awarding contracts for patient services to new suppliers, LHBs should develop risk management and contingency plans proportionate to the risks in case of service or financial failure.**

5. Early departure from the terms of a contract in favour of the provider is very risky, should only happen in the most exceptional circumstances and should require a thorough justification. Cardiff LHB did not fully record its original decision to award additional funding to CSUK, but sought to justify its decision on the basis that there had been an unprecedented increase in demand, when, in fact, demand had not risen above the levels set out in the contract. **We recommend that where public sector bodies decide to award additional funding to contractors outside the terms of a contract, they should:**

    a) **robustly assess the evidence that there are exceptional circumstances to justify the funding; and**

    b) **fully record the basis of their decision.**

The contract for the provision of the out-of-hours GP service in Cardiff

There were serious deficiencies in the checks Cardiff LHB carried out to assess the financial and clinical capacity of CSUK prior to awarding the contract

The tender process could have been improved by clarifying definitions in the service specification and the decision-making framework

6. Under the new General Medical Services contract, which allows general practitioners to opt out of their previous responsibilities for the provision of out-of-hours services, from April 2004 responsibility for commissioning out-of-hours GP services fell to Local Health Boards.[2] Ms Richards told us that all GPs in Cardiff had indicated in December 2003 that they intended to opt out of their previous responsibilities. Following discussions with the Welsh Assembly Government, Cardiff LHB decided that it would introduce the new services by 1 October 2004, slightly ahead of the December 2004 deadline, which is known to be a peak time for out-of-hours services.[3] In April 2004, following a three-month procurement, Cardiff Local Health Board awarded a contract for the provision of out-of-hours GP services to CSUK, a recently formed private company.

7. The Welsh Assembly Government had circulated guidance on the steps LHBs should take to secure improved out-of-hours GP services. The Welsh Assembly Government had also organised a series of workshops around Wales to help prepare for the new arrangements.[4] Ms Richards explained that she had attended and spoken at some of the workshops.[5]

8. Ms Richards told us that, in line with Assembly Government guidance and after taking procurement advice, Cardiff LHB decided to adopt a competitive tender process.[6] The LHB issued an invitation to tender for three aspects of the provision of out-of-hours services in Cardiff: telephone nurse triage, clinical assessment and transport. The LHB let a separate contract to provide call handling for the out-of-hours service to Connect 2 Cardiff, Cardiff County Council's call centre.[7]

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[2] AGW report, paragraph 1.1
[3] Q2
[4] Q3
[5] Q4
[6] Q2
[7] AGW report, paragraph 1

9. Cardiff LHB advertised for tenders in the Health Services Journal in January 2004; four bids were received. In March, a multi-disciplinary evaluation panel eliminated two of the bidders, leaving CSUK and Cardiff Integrated Care Consortium (made up of Cardiff Doctors on Call, Cardiff and Vale NHS Trust and the Welsh Ambulance Services NHS Trust) to compete for the contract.[8]

10. A second evaluation panel, which included a representative of the NHS Business Services Centre and a GP, as well as the Vice-Chair of the LHB and senior LHB officials, scored both bids against the following non-financial criteria:

    a) realistic manpower assumptions;

    b) robust recruitment process and accreditation/ training;

    c) potential to meet the targets contained in the service specification;

    d) innovative approach to service delivery;

    e) clinical governance issues; and

    f) accountability arrangements.

    Against these criteria, the evaluation panel scored the CSUK bid 19 per cent higher than the Cardiff Integrated Care Consortium (the Consortium) bid.[9]

11. At the time of the tender and evaluation process, CSUK had a contractual relationship with Clinical Solutions Group, an American software company that produces telephone algorithms to support nurse triage systems, through a reseller's contract. However, Clinical Solutions Group was not a parent company of CSUK.[10] The Auditor General and his staff found no evidence that the information presented at the evaluation panels was inaccurate or deliberately misleading as to the nature of this relationship.[11] Although CSUK made use of the Clinical Solutions Group logo in their presentation, CSUK was entitled to use the logo as part of its contractual relationship with Clinical Solutions Group. The Auditor General also found no evidence that the international experience of Clinical Solutions Group was material to the evaluation of tenders and the decision to award the contract to CSUK.[12]

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[8] AGW report, paragraph 1.3
[9] AGW report, paragraphs 1.4 and 1.5
[10] AGW report, paragraph 1.12
[11] Annex C
[12] Q46 and Annex C

12. CSUK's presentation to the evaluation panels focused on the previous experience of CSUK's senior team who would, if successful, operate the Cardiff out-of-hours service.[13] Ms Richards referred to the importance of this individual experience in the LHB's final decision to award the contract to CSUK.[14] Reference to Clinical Solutions Group's international experience was limited to the use of its clinical decision making support software, which is indeed used in various countries around the world, although Clinical Solutions Group does not provide out-of-hours clinical services in those countries. Further, the criteria used in scoring the bids did not specifically include previous or international experience.[15]

13. Ms Richards assured us that the capacity of bidders to provide clinical services was inherent in the criteria adopted for the evaluation of bids.[16] Although evaluation panel members' written notes identified CSUK's lack of track record as a risk,[17] we consider that the previous experience of the bidders, that could have demonstrated their capacity to deliver clinical services, was not sufficiently explicit in the evaluation criteria. Whilst we recognise the need to avoid unfairly disadvantaging new entrants to the market, we consider that the explicit inclusion of previous experience as one of the criteria against which bids were scored would have encouraged the panel to identify and assess any risks in relation to a bidder's lack of a track record.

14. During the evaluation process it became clear that the LHB and the Consortium had a differing interpretation of the meaning of the term "integrated" used in the service specification.[18] Ms Richards explained that Cardiff LHB had wanted an integrated patient pathway through the out-of-hours system, whilst the Consortium had put together their tender on the basis of a much broader definition of "integration", referring to an integrated emergency care system.[19] The LHB requested that the

[13] Annex C
[14] Q22
[15] Annex C
[16] Q22
[17] Annex C
[18] AGW report, paragraph 1.10
[19] Q6

Consortium revise its bid to remove the additional accident and emergency activity. The LHB also asked CSUK to revise its tender price to reflect an increase of 12 per cent in the activity profile to cover Saturday mornings. CSUK submitted a revised bid but, for a variety of reasons, the Consortium refused to revise its price.[20] The LHB considered that it would have been justified in excluding the Consortium from the process at this stage.[21] Nevertheless, after the second evaluation panel, Cardiff LHB's finance director analysed the Consortium bid on the basis of a common activity profile, to make it comparable on cost grounds.[22]

15. Although Ms Richards highlighted that, of the four bids received, only the Consortium had used the broader definition of integration,[23] the Consortium's interpretation of "integrated" appears reasonable, and we are concerned that Cardiff LHB was not able to resolve this misunderstanding at an earlier stage. We therefore note Ms Richards' statement that, in future, the LHB would endeavour to achieve greater clarity in service specifications by explaining clearly any terms that could be open to interpretation,[24] and would hold formal meetings with bidders before the final evaluation of bids.[25]

16. Notwithstanding these problems of interpretation, we do not consider that there had been any unfair changes in the service specification that would have disadvantaged any bidder. We also recognise that the LHB took steps to treat both bidders equally and to consider both bids on their merits.[26]

17. The final decision to award the contract to CSUK was taken by the chief executive and vice-chair of Cardiff LHB, not the full Board.[27] This was consistent with the LHB's standing orders, which were based upon the Welsh Assembly Government's model standing orders. However, we agree with the findings of the Assembly Government's review, referred to in the Auditor General's report, that awarding this contract outside of a full board decision was "unwise".[28] Ms Richards told us that in future the LHB would be referring such contracts to the Board using a risk

[20] AGW report, paragraphs 1.7 and 1.8
[21] Q6
[22] AGW report, paragraph 1.8
[23] Q6
[24] Q7
[25] Q21
[26] Annex C
[27] AGW report, paragraph 1.11; Q 42
[28] AGW report, paragraph 1.11

assessment model it had developed.[29] And Mrs Lloyd told us that the Welsh Assembly Government was committed to carrying out a comprehensive corporate governance review of local health boards and trusts, which will consider the model standing orders.[30]

Due diligence checks on the financial and clinical capacity of CSUK, prior to award of the contract, were seriously deficient

18. Once Cardiff LHB had selected CSUK as the preferred bidder, it was essential that they carried out full background checks to verify that the company had the financial and clinical capacity to provide the services set out in the tender specification. In particular, it was absolutely crucial that Cardiff LHB firmly established that CSUK was financially sound and capable of absorbing any unexpected costs arising from delivering services to the standards specified. We are concerned that Cardiff LHB did not undertake the basic financial checks needed to investigate the financial standing and viability of CSUK. Ms Gerrard explained that, as a new company, CSUK was unable to provide audited annual accounts.[31] However, guidance from the Office of Government Commerce or equivalent, identifies a number of checks that should be carried out when companies are unable to provide audited accounts.[32] Cardiff LHB did not carry out any of these checks, but did obtain a letter from CSUK's accountants which indicated that their bank account was "well in credit".[33] Ms Gerrard agreed that little assurance could be taken from the letter.[34] It is our view that it was the responsibility of Cardiff LHB to ensure that the basic due diligence checks, required to verify the company's financial standing and viability were carried out. Therefore, we are very concerned that the checks the LHB did carry out were inadequate and unable to provide the level of assurance required when contracting with a new organisation.

19. Ms Gerrard provided us with a detailed explanation of how the LHB had evaluated the financial assumptions underpinning CSUK's tender bid. In particular, Ms Gerrard highlighted that the LHB had compared CSUK's assumptions and tender price with the LHB's own pre-tender estimate.[35] Whist the committee recognises that this is a

[29] Qs 42 and 43; Annex E
[30] Q10
[31] Q31
[32] AGW report, paragraph 1.14
[33] AGW report, paragraph 1.15
[34] Q34
[35] Q31

valuable way of benchmarking bids, we do not believe that the LHB's actions in this regard constitute thorough due diligence. The financial viability, or otherwise, of CSUK could not be verified from the make up of their bid. Further, we note Ms Gerrard's statement that the LHB had gone back to CSUK and advised them to increase their tender price to cover administrative costs, which had been "slightly under-costed".[36] It is highly unusual to encourage bidders to increase their tender price, and this action suggests that CSUK's financial projections were not entirely robust.

20. Ms Richards told us that the LHB knew that CSUK did not provide clinical services anywhere in the United Kingdom, but that its team included individuals with substantial clinical experience.[37] Consequently, it was essential that the LHB carried out robust background checks into CSUK to ensure that this new company, without direct experience of providing out-of-hours services, had the capacity to deliver such a service. As part of its background checks, Cardiff LHB carried out a site visit to an out-of-hours provider in Birmingham where CSUK was providing products as part of a pilot scheme. However, these products were computer software, not clinical services, which the out-of-hours provider in Birmingham did not subsequently commission.[38] Ms Richards accepted that this visit did not show any evidence of CSUK's clinical track record or experience, but that such evidence was provided by further oral references on the company's work elsewhere.[39] However, these further oral references for CSUK came from two other potential customers of software products supplied by CSUK. Such referees were poorly placed to provide any comment on CSUK's capacity to provide clinical services and had a conflict of interest because they were potential future customers of CSUK.[40] The LHB also failed to document the references in an appropriate fashion.[41] We conclude, therefore, that these background checks fell considerably short of the standards we would reasonably expect from a commercially prudent organisation awarding a contract for vital clinical services.

21. Mrs Lloyd informed us that the Welsh Assembly Government had recently issued a Welsh Health Circular in response to the Auditor General's report. This clearly

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[36] Qs 31 to 33
[37] Q14
[38] Qs 13 and 16
[39] Q15
[40] AGW report, paragraph 1.19
[41] AGW report, paragraph 1.19; Q 23

directs LHBs to Office of Government Commerce and Treasury guidance on appropriate background checks and due diligence.[42] Whilst we note the Welsh Assembly Government's circular, we reiterate that it is the primary responsibility of LHBs themselves to carry out basic due diligence procedures, and LHBs should therefore familiarise themselves with the appropriate guidance.

22. Cardiff LHB did take some steps to manage the risks associated with awarding the contract to CSUK. Ms Gerrard told us that the LHB had requested a third party guarantee from Clinical Solutions Group but was unable to secure one because the relationship between Clinical Solutions Group and CSUK was due to be terminated.[43] However, Cardiff LHB did not simply request a third party guarantee; it made a parent company guarantee a condition of the contract award, but could not secure one because Clinical Solutions Group was not a parent company of CSUK.[44] Immediately after issuing the contract offer letter, the LHB was informed that CSUK was a stand alone company with no parent company.[45] Ms Gerrard told us that the LHB subsequently secured a parent company guarantee after shares in CSUK were transferred to Serco in March 2005, six months after the contract was signed.[46]

23. We asked Ms Richards to explain why Cardiff LHB had requested a parent company guarantee if it had known that Clinical Solutions Group was not a parent company of CSUK, and whether, at the time the LHB offered the contract to CSUK, it actually believed CSUK was a subsidiary of Clinical Solutions Group. Ms Richards explained that the LHB was fully aware that CSUK was a stand alone company. She explained that the LHB had requested the parent company guarantee because, at the evaluation panel, and subsequently in writing, CSUK had referred to a certain element of indemnity, of product liability and of financial guarantee as a result of its reseller's agreement with Clinical Solutions Group. She also said that the Chief Executive of CSUK was a vice president of Clinical Solutions Group.[47] This suggests to us that, at the time the contract was offered, the LHB was not entirely clear about the precise nature of the relationship between CSUK and Clinical Solutions Group. In particular, we would have expected the LHB to have been absolutely clear about the relationship between the two companies, and the extent of any financial

[42] Qs 36 to 40; Annex D
[43] Q31
[44] AGW report, paragraph 1.23
[45] Annex C
[46] Q31
[47] Q46

guarantees and indemnities provided by Clinical Solutions Group, before offering the contract to CSUK.

24. Ms Gerrard told us that the LHB took steps to manage cashflow risks by devising a special payment scheme to ensure that CSUK was paid monthly to enable it to meet its outgoings, without compromising government accounting rules prohibiting pre-payments. Ms Gerrard also explained that, as part of the contractual arrangements, the LHB had provided payments to cover costs CSUK had incurred in setting up the service.[48] Whilst we recognise that, in the circumstances, these steps were prudent, we believe that Cardiff LHB, having perceived cashflow as a risk significant enough to warrant a special payment scheme, should have scrutinised CSUK's accounts and cashflow much more closely once the service became operational, in order to monitor and manage the ongoing risks.

25. The LHB also took steps to manage risks associated with CSUK's lack of a track record in providing clinical services. Recognising that the company's clinical experience lay with its senior management staff, the LHB made the award of the contract contingent upon named individuals taking up specific posts in Cardiff.[49] Ms Richards emphasised that Cardiff LHB was effectively commissioning the expertise of these senior staff to lead the out-of hours-service.[50] Whilst we recognise that this did partially address the risks associated with CSUK's lack of a track record, the risk remained that, subsequent to the contract being signed, those individuals could take up employment elsewhere.[51]

26. Although Cardiff LHB took some steps to manage the risks associated with CSUK, we are concerned that these were ad hoc and were neither comprehensive nor proportionate to the high degree of risk involved. Mrs Lloyd told us that the Assembly's review had recognised that, in awarding contracts to companies with no firm track record in the relevant field, risk assessments need to be more robust to cover the increased risk that the organisation may fail to meet its contractual obligations.[52] We are concerned that Cardiff LHB did not put in place a detailed risk management strategy to prevent service failure,[53] nor a contingency plan, detailing the steps the LHB would take should the company prove unable to meet its

[48] Q31
[49] Q50
[50] Q22
[51] AGW report, paragraph 1.25
[52] Q41
[53] AGW report, paragraph 1.22

contractual obligations.[54] In this respect, we note Ms Richards' statement that Cardiff LHB will require fully documented contingency plans for all tenders in the future.[55]

27. We asked Ms Richards why a briefing for the Board, informing them of the decision to award the contract to CSUK, wrongly recorded that the contract had been awarded to Clinical Solutions Group and provided inaccurate information about the international experience of Clinical Solutions Group.[56] Ms Richards explained that the Board briefing had referred to Clinical Solutions Group because CSUK had legitimately used that logo throughout the tender process. Ms Richards emphasised that at the subsequent Board meeting the terminology CSUK was used, to be absolutely clear and to avoid any confusion.[57] Whilst CSUK might have been entitled to use the Clinical Solutions Group logo, and planned to use its software under licence in providing the Cardiff service, we consider that there is little justification for the briefing to lack such clarity.

28. Ms Richards also emphasised that the section of the briefing detailing Clinical Solutions Group's international experience was provided only as background.[58] Nonetheless, the briefing vastly exaggerated the international experience of Clinical Solutions Group, stating that it provided clinical services in a number of countries, when, in fact, it provides clinical software in those countries and does not provide clinical services anywhere in the world.[59] Ms Richards assured us that the briefing had been given in good faith, had not been intended to make a risky decision seem more palatable, and that no Board members had reported feeling misled.[60] However, it further suggests that the LHB were far from clear about the relationship between Clinical Solutions Group and CSUK.

The additional funding of £59,000 awarded to CSUK was not justified

The LHB provided additional funding because of concerns about patient safety which arose from a perceived increase in demand

29. The contract signed by Cardiff LHB and CSUK was based on the model contract issued by the Welsh Assembly Government.[61] The contract was for clinical services:

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[54] AGW report, paragraph 1.27
[55] Q69
[56] AGW report, paragraphs 1.28 to 1.31
[57] Q50
[58] Q50
[59] AGW report, paragraph 1.29
[60] Qs 51 and 53
[61] AGW report, paragraph 2.1; Q4

telephone nurse triage and clinical assessment at a primary care centre or through a home visit, and was based on an indicative annual activity profile of 69,570 cases (the original profile in the service specification of 62,116 plus an additional 12 per cent added in the contract offer letter to reflect demand on a Saturday morning).[62] The contract was for a set fee of £1.9 million and was explicit in making CSUK responsible for meeting any additional or unexpected costs. Therefore, under the contract, risks associated with demand exceeding forecast levels were transferred to CSUK.[63] Because CSUK has no control over demand for out-of-hours GP services, the Auditor General concluded that the contract does not reflect best practice, which suggests that risks should be allocated to those who are best placed to manage them.[64] Mrs Lloyd told us that the Welsh Assembly Government is currently reviewing the allocation of risk in its model contracts, and, through its Welsh Health Circular, has advised LHBs to ensure that risks are appropriately transferred and shared.[65]

30. Regardless of whether the contract followed best practice in allocating risk, CSUK had a responsibility to provide the service to contractual standards for the agreed fee. Those standards included the time taken for patients to be called back to receive telephone advice from a nurse.[66] Ms Richards explained that, within a few weeks of the service commencing, call-back times for telephone advice at weekends were 'unacceptable', with patients waiting on average two and a quarter hours, and up to a maximum of five hours.[67] The LHB believed, and repeated in correspondence and briefings, that the root cause of these delays was an unprecedented increase in demand over the levels forecast, although it had little evidence to support this.[68] In order to manage the risks to patient safety arising from these delays, Cardiff LHB awarded CSUK a total of £59,000 additional funding, initially for a six week period and subsequently extended until the end of March 2005, to hire additional nurses at weekends.[69]

31. Ms Richards told the Committee that nurses employed by CSUK, who had been transferred from the previous provider organisations, had not received ongoing

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[62] AGW report, paragraph 2.11
[63] AGW report, paragraphs 2.1 to 2.5
[64] AGW report, paragraph 9
[65] Qs 11, 59 and 70; Annex D
[66] AGW report, paragraph 2.2
[67] Q55
[68] AGW report, paragraphs 2.10 and 2.12
[69] AGW report, paragraphs 2.7 and 2.8

training and so were taking longer than expected to provide triage services to patients. Ms Richards said this meant that CSUK had to put in place an extensive programme of training for those staff, and that this was an issue over which CSUK had no control.[70] Nevertheless, responsibility for staffing the service to appropriate levels and staff efficiency issues had been transferred to CSUK under the terms of the contract.[71] Further, we are disappointed by this attempt to shift responsibility for CSUK's failure to plan and deliver a safe service for patients in Cardiff to frontline staff and the previous providers.

32. We do not believe that awarding additional funding at such an early stage in the contract was the most appropriate response to CSUK's failure to deliver the service it had agreed to provide, particularly as, under the contract, Cardiff LHB had the right to make deductions from payment should CSUK fail to meet the agreed standards.[72] Ms Richards told us that the LHB had not even considered the option of making a deduction from payments at that time.[73] Instead, she emphasised the LHB's responsibility to manage risks to patient safety, and that this took precedence over considerations of contractual terms and value for money.[74] Ms Richards categorically denied that there was any link between CSUK's financial viability and the need to provide additional funding so early in the life of the contract.[75] Whilst we recognise Ms Richards' ultimate responsibility for patient safety, this should not mean that suppliers should be able to receive additional funding automatically whenever they fail to meet service standards, which could represent a perverse incentive for suppliers to deliver a poor quality service.

Clinical activity did not exceed the levels set out in the service specification

33. In December 2004, CSUK produced a business case to support the provision of additional funding, which claimed that demand had exceeded the contract activity profile by more than 40 per cent. However, there were mathematical errors in the business case and the figures cited were linked to CSUK's own planning assumptions rather than contracted activity levels.[76] Although Ms Richards said that the LHB had rejected the business case,[77] Cardiff LHB did in fact subsequently

[70] Q57
[71] AGW report, paragraph 2.17
[72] AGW report, paragraph 2.3
[73] Q55
[74] Q57
[75] Q58
[76] AGW report, paragraphs 2.9 and 2.10 and Table 2
[77] Qs 63 and 64

provide additional funding to CSUK from December 2004 to March 2005 on the basis that there had been an "unprecedented increase in demand".[78] Cardiff LHB's previous concerns about CSUK's financial projections and cashflow risks, and the use by CSUK of inaccurate figures to claim extra funding, should have led to more robust scrutiny of CSUK's activity to verify the company's claims that it was over-performing against the contract.

34. Cardiff LHB was actually using inappropriate data to verify whether or not CSUK's activity had exceeded contracted levels. The LHB was using the activity rates of Connect-2-Cardiff, Cardiff County Council's call centre that provides call handling facilities for the out-of-hours service, to monitor CSUK's performance against contract and as evidence of an increase in demand of 46 per cent.[79] However, this was an entirely inappropriate measure of CSUK's performance because a significant proportion of the calls handled by Connect-2-Cardiff did not require any clinical response from, and therefore were not passed to, CSUK.[80]

35. In fact, the LHB's own data on CSUK's activity demonstrated that during October and November, the period covered by the initial extra payments, demand did not exceed the monthly or weekend forecasts.[81] Further, over the first six months of the contract, demand was below the contract activity profile.[82] We therefore asked Ms Richards why the LHB had decided to continue providing additional funding to CSUK until the end of March to manage increased demand when the LHB's own figures provided no evidence of such an increase. Ms Richards told the Committee that the decision was based on the issue of patient safety.[83] She also argued that data now available to the LHB shows that, across the whole year, demand has in fact exceeded contractual levels. Ms Richards told us that, in the first year of the contract, only 75 per cent of the calls to the out-of-hours call handling service, operated by Connect-2-Cardiff, had been referred to CSUK because they required a clinical response. She added that, if this is taken into account and the original service specification of 62,116 calls is reduced by 25 per cent, demand is 13 per cent higher than the service specification.[84]

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[78] AGW report, paragraph 2.10
[79] AGW report, paragraph 2.12
[80] AGW report, paragraphs 2.12 and 2.13; Q 68
[81] AGW report, paragraph 2.14 and Tables 3 and 4
[82] AGW report, paragraph 2.15
[83] Q65
[84] Qs 62 and 67

36. We believe Ms Richards' argument that demand has exceeded the levels forecast is fundamentally flawed, because:

    a) it is predicated on monitoring CSUK's performance relative to the activity rates of Connect-2-Cardiff under the terms of a separate call handling contract; Connect-2-Cardiff's call-handling activity has no relevance to monitoring the LHB's contract with CSUK for the provision of clinical services;[85]

    b) although Cardiff LHB had concerns about the historical data used to develop the service specification,[86] once the activity profile in the service specification had been finalised and used as the basis for competitive tenders, there was no reason for bidders or the LHB to assume that the activity profile was anything other than that set out in the service specification;

    c) the 25 per cent reduction in activity claimed is based on figures that were obtained a year after the contract was signed and therefore could not have formed part of the expectations of the parties to the original contract; and

    d) the logical implication of the reduction in the contract activity profile is that the contract price should also fall to reflect the fact that the tender price was based on the activity levels set out in the original service specification.

37. The adjusted activity profile is substantially lower than the profile agreed under the contract, and we are concerned that this new figure is being used by the LHB's out-of-hours monitoring committee to monitor CSUK's activity.[87] Despite the Auditor General's criticism of this approach,[88] it seems that Cardiff LHB is continuing to monitor CSUK's activity inappropriately against the volume of calls handled by Connect-2-Cardiff, and intends to use its adjusted activity profile as the basis for assessing CSUK's performance against contract.[89] We consider this to be totally unacceptable, and raises serious questions about the rigour and effectiveness of Cardiff LHB's monitoring of CSUK's performance.

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[85] AGW report, paragraph 2.13
[86] Q67
[87] Q62
[88] AGW report, paragraph 2.13
[89] Q66

38. We welcome the fact that the LHB's Audit Committee is currently considering whether to seek to recover the additional funding provided to CSUK. However, we are concerned that the LHB told us that it will be considering whether the additional costs absorbed by CSUK over the period of the contract offset the additional payments,[90] as the contract explicitly transfers risk for unexpected costs to CSUK.[91]

[90] Q66
[91] AGW report, paragraph 2.2

Cynulliad Cenedlaethol Cymru
Y Pwyllgor Archwilio

The National Assembly for Wales
The Audit Committee

Dydd Iau, 10 Tachwedd 2005
Thursday, 10 November 2005

Aelodau Cynulliad yn bresennol: Janet Davies (Cadeirydd), Leighton Andrews, Mick Bates, Alun Cairns, Jocelyn Davies, Mark Isherwood, Irene James, Denise Idris Jones, Carl Sargeant, Catherine Thomas.

Swyddogion yn bresennol: Gillian Body, Swyddfa Archwilio Cymru; Jeremy Colman, Archwilydd Cyffredinol Cymru; Paul Dimblebee, Swyddfa Archwilio Cymru; Ian Gibson, Dirprwy Swyddog Cydymffurfiaeth, Cynulliad Cenedlaethol Cymru; Ann Lloyd, Pennaeth yr Adran Iechyd a Gofal Cymdeithasol; Elaine Matthews, Swyddfa Archwilio Cymru; Rob Powell, Swyddfa Archwilio Cymru.

Eraill yn bresennol: Alison Gerrard, Cyfarwyddwr Cyllid, Bwrdd Iechyd Lleol Caerdydd; Gren Kershaw, Prif Weithredwr, Ymddiriedolaeth GIG Conwy a Sir Ddinbych; Siân Richards, Prif Weithredwr, Bwrdd Iechyd Lleol Caerdydd.

Gwasanaeth Pwyllgor: Kathryn Jenkins, Clerc; Ruth Hatton, Dirprwy Glerc.

Assembly Members in attendance: Janet Davies (Chair), Leighton Andrews, Mick Bates, Alun Cairns, Jocelyn Davies, Mark Isherwood, Irene James, Denise Idris Jones, Carl Sargeant, Catherine Thomas.

Officials in attendance: Gillian Body, Wales Audit Office; Jeremy Colman, Auditor General for Wales; Paul Dimblebee, Wales Audit Office; Ian Gibson, Deputy Compliance Officer, National Assembly for Wales; Ann Lloyd, Head of Health and Social Care Department; Elaine Matthews, Wales Audit Office; Rob Powell, Wales Audit Office.

Others in attendance: Alison Gerrard, Director of Finance, Cardiff Local Health Board; Gren Kershaw, Chief Executive, Conwy and Denbighshire NHS Trust; Siân Richards, Chief Executive, Cardiff Local Health Board.

Committee Service: Kathryn Jenkins, Clerk; Ruth Hatton, Deputy Clerk.

Dechreuodd y cyfarfod am 9.31 a.m.
The meeting began at 9.31 a.m.

Cyflwyniad, Ymddiheuriadau, Dirprwyon a Datgan Buddiannau
Introduction, Apologies, Substitutions and Declarations of Interest

Janet Davies: I start by welcoming members of the public, Wales Audit Office staff and committee members to this meeting. Before I turn to the agenda, I would like to outline some housekeeping issues. Many of you will know that the committee operates bilingually, and the headsets can be used to listen to a translation of Welsh contributions and to hear the whole proceedings more clearly. Will everyone please turn off mobile phones, pagers, and all other electronic devices because, in this building, they interfere with the broadcasting and translation systems? In the case of an emergency, leave by the nearest exit, and the ushers will help you to find your way out.

We have not received any apologies for today, except that Alun Cairns will be late arriving because he is at another committee meeting first thing this morning. Do any Members have any declarations of interest to make?

Denise Idris Jones: I just want to mention that I am the Assembly Member for the constituency of Conwy, given that we have Mr Gren Kershaw here today, who is the chief executive of Conwy and Denbighshire NHS Trust, but I do not think that that is really a

declaration of interest.

Janet Davies: I do not think that, formally, it is a declaration of interest, but thank you, Denise. I ask for the witnesses to be brought in for the next item.

Contract ar gyfer Darparu Gwasanaeth Meddyg Teulu y Tu Allan i Oriau yng Nghaerdydd
Contract for the Provision of the Out-of-Hours GP Service in Cardiff

[1] **Janet Davies:** The report about this contract arose from correspondence to the auditor general. It is the first time that the committee has considered a report about an individual local health board. Although the report identifies deficiencies in the letting and management of this contract, we are very keen that coming out of it will be an identification of key issues for all local health boards, and indeed for other Welsh public sector organisations, to improve the letting and management of similar contracts. First, I welcome the witnesses to the meeting and ask them to introduce themselves.

Ms Lloyd: I am Ann Lloyd. I am the head of the Health and Social Care Department at the National Assembly, and the chief executive of the national health service in Wales.

Ms Richards: I am Siân Richards. I am the chief executive of Cardiff Local Health Board.

Ms Gerrard: I am Alison Gerrard. I am the finance director of Cardiff Local Health Board.

[2] **Janet Davies:** I will start by asking Ms Richards the first question. Could you give us some idea of how prepared your local health board was to take over responsibility for the out-of-hours GP services in Cardiff; and could you tell us what steps you took to ensure that the board had sufficient time, staff, skills and experience to let and manage this contract?

Ms Richards: The origination of the need to contract out-of-hours services was as a direct result of the new general medical services contract implemented on an all-UK basis. One of the key elements of that was that general practitioners could opt out of their responsibility to undertake 24-hour care for their patients. As a consequence, the responsibility for commissioning out-of-hours services fell to local health boards. All GPs in Cardiff indicated that they intended to opt out of that responsibility in December 2003. The requirement was to have the new out-of-hours services in place by December 2004. In discussion with colleagues in the Assembly we felt that it was important to implement the service slightly in advance of that deadline because, as I am sure that you will appreciate, the December period is one of the peak times of activity for the out-of-hours services and we felt that there would be a service risk of leaving it until that time. Therefore, we looked to implement the service by 1 October. That was quite a challenging timescale for all local health boards but was not an issue that we had much flexibility about.

In terms of the steps that we undertook, we followed guidance to go through a tendering process to award the service, and the report that you have in front of you outlines the phases of the tendering process that we went through.

On specific skills within the organisation, my finance director and I have extensive experience in previous roles of commissioning clinical services, but it was new to us, and to everyone across the UK, as health commissioners, to commission this particular service. We had access to expert advice, which was available to all LHBs, which enhanced the skills that we had available in our own team. Throughout the process, again as recognised in the report, we utilised expert procurement advice and legal advice.

[3] **Janet Davies:** Turning to Mrs Lloyd, what support did the Assembly provide to help local health boards to commission and manage the new out-of-hours contracts?

Ms Lloyd: We issued guidelines to LHBs in December 2003 detailing precisely what sort of steps they should go through to secure improved out-of-hours services. We also provided them with a model contract, which was rather large, thick and complicated, but had all the clauses that you expect to be covered, and how they should go about doing it. We issued three Welsh health circulars, looking at the new arrangements, public involvement, and the like. We also—because it was new for LHBs, and we wanted to ensure that they could access the sort of advice that they felt that they needed—held several workshops throughout Wales to explain how the contracts might be implemented, what stages they needed to go through, how to evaluate, and so on.

I had two key members of staff on secondment in my department—Stuart Moncur, who was an experienced local health group chief executive, and Ian Jones on the human resources side, because there might be some issues about the transfer of staff. A good proportion of LHBs asked for advice and help, which was readily available. Where we could point them in the direction of procurement advice—we have Welsh Health Supplies, which has good experience of procurement—they were signposted to where they could receive the proper advice and guidance that they would need to do this effectively.

[4] **Janet Davies:** Therefore, did Cardiff Local Health Board ask you for advice?

Ms Lloyd: Yes, I think that it accessed advice when it needed it.

Ms Richards: Yes, we did, throughout the process, and we adopted the model contract. I also spoke at some of the workshops that Mrs Lloyd has just mentioned.

[5] **Janet Davies:** Finally, were there any factors that suggested that Cardiff was in a better or worse position than other LHBs in managing the process?

Ms Lloyd: No, there was nothing on our risk assessment that would suggest that Cardiff had a more difficult set of circumstances. It was not unique in already having two of our providers. As Siân has said, it had been closely involved in the workshops, and it was accessing advice as and when it needed it. Therefore, there was no indication that it would have a greater problem than anyone else.

[6] **Jocelyn Davies:** I have a question for Siân Richards. Given that you had local GPs involved in developing the specification for the contract, why was there such a difference between your understanding of the service specification, and that held by the consortium? Paragraph 1.10 mentions that there was a difference of opinion over the word ‘integrated’. It is a word that we politicians use a lot, and I am not sure whether we know what it means, but when it appears in a contract, it is important that everyone knows what it means. Therefore, why do you think that that difference of opinion existed?

11.30 a.m.

Ms Richards: As you say, the term ‘integration’ seems to be the particular issue. Several workshops were held in the local health board, which, as you say, involved primary care practitioners, and the individual who subsequently became the project manager for the consortium’s bid, who actually developed the tender. The specification utilises the term ‘integration’ to refer to an integrated patient pathway through the out-of-hours system, so that is an integrated service consisting of clinical assessment, visits to primary care, consultation centres, where required, home visits and patient transport. The consortium based its bid on a much broader definition of ‘integration’ and referred to an integrated emergency care system.

This was part of the bid that it submitted to the local health board. At the first evaluation panel, a lengthy debate took place with members of the consortium to clarify the situation and to make quite clear the requirements of our actual specification. I must point out that, of the four bidders at that stage of the process, only one, the consortium, used the broader definition of integration. Following the first evaluation panel, there were a number of discussions between members of the consortium, in particular its project manager, and my nurse director, who was leading on the issue on our behalf. The consortium was asked to price its bid again based on the service that we required. It formally refused to do so. Technically, because it was refusing to meet our specification, we could have excluded it from the process at that stage, but rather than do that, we invited it to the second evaluation panel in order to give it the opportunity to explore the issue with us further.

[7] **Jocelyn Davies:** That does not seem an unreasonable different interpretation. I think that both of you could hold your own interpretations of 'integrated' and stand by that. You are not suggesting that its interpretation was unreasonable, even though it was the only one of four that had taken that interpretation. Should the same situation arise in the future, and you were using the same terminology, how would you avoid the misunderstanding?

Ms Richards: The key learning point for us is that we need to be absolutely explicit in our tender documentation, and in our invitations to tender. Future specifications need to have very clear explanations of terms that could, potentially, be interpreted in different ways. We are currently in the process of developing a specification for prison health services, and that is something that we are very mindful of, and will ensure that, where there are any terms that could be interpreted in different ways, we will either explain them clearly within the text or include a glossary.

[8] **Jocelyn Davies:** Thank you, that is most helpful. Mrs Lloyd mentioned the model contract, the guidance and so on earlier. In retrospect, do you think that those documents were adequate?

Ms Lloyd: They were very comprehensive, but, as you know, we conducted an internal investigation into the setting of this contract, and further guidance has also gone out now as a consequence of the Wales Audit Office report. So, we have clarified the issues that the auditor general has drawn to our attention. However, the documentation—and we were working on this with colleagues from England—was pretty extensive. If there were any concerns about interpretation or missing factors, then I feel sure that they would have been picked up during the discussion that was taking place both in England and Wales as a result of workshops. However, you can always learn from these things, and that is why we have issued further guidance on the way in which contracts might be established in future.

[9] **Jocelyn Davies:** So, are they more comprehensive than they were before?

Ms Lloyd: Yes. In October this year, we issued an additional Welsh health circular, outlining explicitly how to link to the best contract establishment guidance available through the Treasury and other parties.

[10] **Jocelyn Davies:** Have you made any suggestions about the model standing orders?

Ms Lloyd: The model standing orders are being revised anyway. I have asked the principal finance officer of the Assembly to work up a framework for me to look at the whole of corporate governance and the standing orders of local health boards and trusts, as local health boards specifically have been running for two years now. In that way, we can undertake a comprehensive corporate governance review, against that framework, next year. On that basis, we will then look at whether standing orders need to be revised substantively or just on the margins.

[11] **Janet Davies:** As well as being more comprehensive, is the guidance clearer? It is possible for guidance to become so comprehensive that it is difficult for people to find their way through it.

Ms Lloyd: It basically looks at the issue of background checks and the transference of risk. The auditor general has rightly pointed out that risks should be borne by those capable of bearing them, and not universally adopted by one party or another. That has been underlined in the circular. The circular looks at the background checks that should be undertaken by organisations when developing contracts. It highlights the advice that is available on that. We are not trying to make it even more complicated. On the basis of the auditor general's report on additional work that we have undertaken, we will look at model contracts for setting specifications for services again in order to establish whether those need to be amended or adjusted. There will be a number of these contracts over the next few years.

[12] **Mick Bates:** First, Siân, I wish you to confirm that you were the chief executive officer at the time that this took place.

Ms Richards: I was.

[13] **Mick Bates:** Turning to paragraph 1.4 on the evaluation panel and the process involved, Clinical Solutions UK scored highest at the evaluation panel. How did the local health board check that it could back up its claims and plans?

Ms Richards: The assessment was based on a presentation that we received from CSUK. The whole evaluation panel was impressed with the presentation and what appeared to be a highly cohesive team. We checked that out partly by visiting a service in Birmingham where CSUK was providing products. One of the challenges was that CSUK was a new company—we recognised that this would be its first contract in the UK—and that, therefore, we could not observe it operating a service anywhere else. However, what we saw in the Badger out-of-hours service in Birmingham was CSUK working with an established out-of-hours service. We were very interested in looking at how it related to that organisation. We were also able to see a demonstration of the software that it used as part of the clinical-decision support mechanism. That software was one of the impressive parts of its presentation.

On the visit, we also met the medical director of the Wakefield out-of-hours service, where David Holford, the operations director of Clinical Solutions UK, had worked for seven years. The medical director was able to describe to us the successes that David had achieved in that role. In addition to that, we received three further references.

11.40 a.m.

[14] **Mick Bates:** There were many points in your answer. You made reference many times to the computer software that it provided, however, did you also check on the clinical services that it provided to the patients within this evaluation?

Ms Richards: As I have already mentioned, it was a new organisation, so it did not provide clinical services anywhere in the UK, but the individuals making up the Clinical Solutions UK team had a wealth of experience in providing those services. Its medical director, for example, had been the medical director and chief executive of the Glasgow emergency medical service, which is the largest out-of-hours provider in the UK. Its operations director, as I have already mentioned, was the director of the Wakefield out-of-hours service. We realised that we were commissioning the skills of a group of individuals along with the software that it was providing to us.

[15] **Mick Bates:** To go back to the clinical services to patients, during your visit to Birmingham, did you find evidence of any clinical track record?

Ms Richards: No, the visit did not show us that; it was the references that we received on its work in other areas that indicated that, together with annual reports from the Glasgow and the Wakefield services.

[16] **Mick Bates:** Just for the record, what happened to its work in Birmingham?

Ms Richards: Its work in Birmingham was a pilot scheme, and I discovered, only through a recent television programme, that that has not subsequently been commissioned.

[17] **Mick Bates:** So, this was all based on the company's ability to provide computer software—that was the basic evaluation that you undertook.

Ms Richards: No, it was not; it was also based on the vast skills and experience of the individuals making up the Clinical Solutions UK team in working in the out-of-hours environment and in providing clinical care to patients, though not in the entity of Clinical Solutions UK.

[18] **Mick Bates:** Could you briefly explain what risk management you undertook within that evaluation process?

Ms Richards: In the evaluation process, we assessed the bids that we received against a number of criteria, which are set out in paragraph 1.4 of the report. All bidders were asked a set of questions to enable us to score them against those areas.

[19] **Mick Bates:** Computer software is not one of those, is it? However, having heard what you have said, do you now believe that you were just taken in by all the presentational skill that you have referred to?

Ms Richards: No, I do not believe that we were. I believe that the best endorsement is the service that we have up and running in Cardiff. The performance of the service has continuously improved over the 12 months that it has been in operation. The local health board's out-of-hours monitoring committee received a year-end report at its meeting last year, and it was very satisfied with the progress of the service.

[20] **Mick Bates:** Could you clarify that? 'The progress of the service' is obviously not the CSUK service.

Ms Richards: It is the CSUK service, or rather, the out-of-hours service in Cardiff, which is provided by CSUK.

[21] **Mick Bates:** I see. If you were to look back on this and state what lessons you would learn from this bit of the evaluation, what would they be?

Ms Richards: In terms of the lessons, we have already touched on the issue in Mrs Davies's questions about absolute clarity in the specification, because that led to considerable debate in the process. I believe that the process that we adopted was very comprehensive and, indeed, the auditor general's conclusion is that it was robust and fair, but that we could make improvements.

In terms of improvements, if we were to go through a process with several stages in the evaluation, I would probably incorporate an area where the organisation that was going through to the second stage of the process had an opportunity to have a formal meeting,

between the two evaluation stages, to ensure that there was absolute clarity on the specification.

[22] **Mick Bates:** Finally, would you include the capacity to provide clinical services to patients?

Ms Richards: The capacity to provide clinical services is inherent in the criteria that are included, particularly in terms of their realistic manpower assumptions and the potential to meet the targets contained in the service specification. It is important to stress that we were effectively commissioning the leadership of the out-of-hours service and the tools to support it. The actual staff who are to provide the service—nursing staff and drivers in particular—whatever the outcome of the process, would have transferred from the previous providers. They already had the experience and local knowledge, but we were bringing in the leadership for that service and the clinical support decision-making processes.

[23] **Jocelyn Davies:** I was rather surprised by your answer to Mick Bates, in that you did not say that you would take up proper references in the future. Looking at paragraph 1.19, I would not give an office job to someone on the references that you took up. You took oral references, and, according to the auditor general, there was a potential conflict of interest because they were potential customers of Clinical Solutions UK and they were poorly placed to provide an authoritative reference. They were undocumented, as they were oral references—even though you have referred to them twice as being 'received'—and you took informal personal references that were also not documented. I hope that you will definitely take up proper references in the future.

Ms Richards: We would certainly take up written references. We took up oral references, and the outcome of those oral requests was recorded in the minutes of a meeting on 1 April, when my vice-chair and I took the decision to award the tender. However, we would take up written references and we would ensure that they were retained. In my response to the previous question, I was responding specifically on how we would have changed the evaluation panel.

The report contains a number of areas from which we have learnt lessons. We have already taken action to ensure that our existing systems and processes are enhanced. In fact, we began to take that action before the publication of the report. My finance director had, for example, already reviewed our standing orders, and they were submitted to the Assembly for consideration in July 2005, after being approved by my audit committee. The other action that we have undertaken is to develop a risk-assessment methodology, against which we will consider all future contracts to determine whether they should be approved by the full board. If you wish for further detail on that point, my finance director actually developed that methodology. Would you like her to—

11.50 a.m.

[24] **Jocelyn Davies:** I am delighted to hear that you will have a hard copy of a reference in future, and I hope that you will take them up from someone who is authoritative enough to tell you what you need to know, but I think that you are rather missing the point, Mrs Richards.

Ms Richards: We will certainly do that.

[25] **Mick Bates:** Are all evaluation documents in the public domain for the first four bidders?

Ms Richards: The actual submission of tenders—

[26] **Mick Bates:** No. Your evaluation documents.

Ms Richards: They are, yes. They were provided to the audit office, and, more recently, as referred to in the auditor general's recent letter, his team has also looked at the hand-written notes that were written during the process by all of the evaluation team.

[27] **Janet Davies:** I have just one more point on this matter, Mrs Richards. You referred to the process as being robust and fair, and I think it fair to say that the auditor general said that it was overall robust and fair. You also talked about actions that you have taken. Would you agree that those actions were taken to address the deficiencies that he identified?

Ms Richards: The actions will certainly ensure that our procedures are more robust and fair in future. As a local health board, we always welcome reports from the auditor general, whether they are specifically in response to issues in our own organisation or more general, because there is a lot of learning for us and all other health bodies. We hope to continuously develop and improve our systems and processes as a result.

[28] **Alun Cairns:** Picking up on your last point about robustness and fairness, in the letter that the auditor general wrote in response to a letter from—

[29] **Janet Davies:** Sorry, Alun, but we will be discussing those letters at the end, and they will be attached to our report, so I would prefer not to go into them at the moment.

[30] **Alun Cairns:** Okay. That is fair enough.

Mrs Richards, how did you assure yourselves that CSUK was a financially viable company that had sufficient resources to deal with ever-changing and unforeseen needs?

Ms Richards: I will pass that question to my finance director, as she undertook those checks on behalf of the local health board.

Ms Gerrard: As Ms Richards has already mentioned, obviously, we sought specialist procurement advice, as the local health board does not generally enter into contracts of this nature, so we needed to do that. We sought that initially from the Welsh Assembly Government's procurement department, and then later on from trust colleagues on some of the details that we should follow. The report also refers to guidance issued by the Office of Government Commerce, and it is fair to say that I was not personally aware of that information, but, obviously, our procurement advisers would largely be aware of that.

[31] **Alun Cairns:** I am sorry, but I missed that. Who did you say?

Ms Gerrard: Our procurement advisers. With regard to the brand new company, the checks were slightly different to those performed on an established company. With an established company, you have audited accounts, for example, which you can obtain, but we were obviously in a slightly different situation as a brand new organisation. The guidance issued by OGC talks specifically about what we should do in such circumstances. It is clear in pointing out that we need to be mindful of the background checks that are undertaken in these situations so that we do not inadvertently disadvantage new and perhaps innovative suppliers to the market by demanding to see annual accounts, given that they are new companies. So, the guidelines state that we should apply some sort of common-sense rules to looking at those and performing those background checks.

I will now go into some of the details of what we did. The first thing was to try to contact the company's accountants who, although they had not looked at its accounts formally, would

give us some indication, hopefully, of its solvency. The letter that we received was not written in much detail. It basically said that it had not yet carried out any detailed work into its clients' financial viability, but that its bank account was well in credit.

We also looked at some of the detail of the way in which it had put together its tender price. Although we had a tender price of £1.9 million, we needed to ensure that the way in which they had calculated that figure was on a robust basis. So, we had details of how they had made up their price in terms of the medical manpower assumptions, and ensuring that they had built in obvious elements such as national insurance costs, overtime, the proper enhancements of rates of pay at the weekend, nursing costs, administration and so on. So, we had all that detail to look through.

As a result, we went back to the company, because we were slightly concerned about one area, which seemed to be slightly undercosted, certainly in terms of the administration staff and ensuring that there was overnight cover at enhanced rates of pay, for example. As a result, the tender price increased slightly between the two stages. So, we looked at that issue in a lot of detail.

In terms of cash flow, one issue raised by the auditor is that we should have received cash-flow forecasts. Again, it is true to say that that is best practice. We were faced with a difficult situation as to how robust the cash-flow forecasts would be, because the organisation was also going through a separate tender process with other local health boards. In addition, the figures would not be audited, which could potentially have enhanced what it was trying to project to us as cash flow. Instead, we concentrated on looking at the cost that it would be incurring on a monthly basis, and the timing of those costs within the month, and ensuring that the payments that we were providing would provide it with sufficient cash to meet those liabilities.

At the same time, we had to be mindful of the Government accounting rules, in that we are not allowed to pre-pay anyone in advance of service provision. So, we worked out a comprehensive cash-flow statement, which recognised when the liabilities would become due and the costs incurred, supported by detailed evidence that the costs had been incurred in terms of some of the set-up costs before the start of the contract, because, obviously, that period involves quite a lot of work. It also recognised some of the additional payments over Christmas and the new year, for example, when the company would be paying enhanced overtime rates. Part of the contract documentation included the detailed cash-flow projections and the finance that we would be paying to ensure that its liabilities and the cash that we would provide were in tune. So, that was another element that we provided.

Another element that we discussed was whether it would be appropriate, within the guidance, to seek a third-party guarantee. That was one area that has also been raised. Although the Clinical Solutions Group was not a parent company, there was a contractual relationship between it and Clinical Solutions UK. So, we asked whether the Clinical Solutions Group would also provide a third-party guarantee, which would have provided some extra assurances. However, between offering the contract and the contract signature, the relationship between the two parties was due to be terminated, and therefore it was no longer appropriate for the Clinical Solutions Group to provide such a third-party guarantee, although we did obtain a guarantee later when the merger occurred. So, we tried to undertake as many as possible in a sensitive way to ensure that we were not putting undue blockages in place to prevent the company from entering the market place, while at the same time satisfying ourselves that it would be financially viable with sufficient cash to meet its outgoings.

[32] **Alun Cairns:** Normally when a number of tenders come back in a tender process, you are looking to reduce the cost, because there are large profit margins, which is reasonably the case. So, when you went back to them and you had to say, 'Well, hang on a minute, do you want to look again at your administrative staff? You have not included enough costs for that',

did that raise any concerns with you?

12.00 p.m.

Ms Gerrard: It was a very minor issue, which amounted to just a few thousand pounds.

[33] **Alun Cairns:** It is the principle that I am getting at. If it had not covered costs in a certain element, where you did not think that it could realise the obligations, did that not lead you to question the other forecasts and issues presented?

Ms Gerrard: Prior to receiving any tenders, we had also undertaken a pre-tender estimate to give ourselves some idea of what we expected the tender prices to come in at, so that we would already have worked up, for example, what we expected the medical or nursing manpower costs to be, almost as though we were running it ourselves. So, we already had some benchmark costs of what we would expect the prices to come in at, and that was important in terms of developing our financial plan against our financial envelope in terms of the funding. In both those areas, the cost difference between the tender price and our pre-tender estimate was very small.

[34] **Alun Cairns:** The next question is for you, Mrs Richards, but please use Mrs Gerrard if you like. What do you think 'well in credit' means?

Ms Richards: I will ask Mrs Gerrard to respond to that question.

Ms Gerrard: That could mean all things to all men. It was not anything that we could take particular reassurance from, and that is why we worked very closely with the supplier to ensure that the cash that we were providing would meet the liabilities.

[35] **Alun Cairns:** So, that did not carry any credence with you in terms of your tendering process?

Ms Gerrard: No. It was an element that we went through. It was part of what we were advised to do. It did not provide as much information as we would have liked and, therefore, we were not able to use it as an indication of solvency at that point. Therefore, we had to use other measures to test that and to get that assurance.

[36] **Alun Cairns:** Mrs Lloyd, in response to Jocelyn Davies earlier, when she asked whether the advice and guidance to the local health board was adequate, you said that it was comprehensive. However, you have stated that we need to change the model contract, the standing order and the guidance, so does that mean that the support that the Welsh Assembly Government gave was inadequate?

Ms Lloyd: No, it was not inadequate, but the auditor general has pointed out that the issue of background checks needs to be clarified for the service, and that is what we have done. The guidance that the service could have drawn on was already extant then. It was clearly out in the public domain but, because we did our own internal review into this and we have now had the auditor general's review, we wished to issue further guidance.

In terms of model contracts, we have learned from the difficulties that there have been throughout England and Wales in implementing contracts, not just for this but for other things, and it is always prudent to review model contract documentation to ensure that it and standing orders have kept up with legislation. So, the finance director and I will be revising the standing financial instructions for boards in the next year, but not just as a consequence of this; as a consequence of the need for them to be revised and updated regularly.

[37] **Alun Cairns:** I take that point. That is looking forward to the future, but I want to get to the crux of this problem. Granted, standing orders and guidance need to be changed following changes in legislation, but that did not apply in this specific instance, did it? It was new legislation that led to the contracts needing to be in place. There was a model contract, which I assume that the Welsh Assembly Government had developed to work with the local health boards. So I come back to whether it, the guidance and the support were adequate, given all the changes that you are making that have nothing to do with subsequent changes in legislation.

Ms Lloyd: The guidance was adequate. The only problem was that we were not specific enough, neither in England nor in Wales, about the background checks and where those organisations might go to receive the guidance on what you do in background checks. That has been put right.

[38] **Alun Cairns:** Was the model contract adequate?

Ms Lloyd: Yes.

[39] **Alun Cairns:** Mrs Richards, do you think that the support and guidance from the Welsh Assembly Government was adequate?

Ms Richards: I do. We had support throughout the process. Of course, this was a learning process for us, and we are all developing our systems as a consequence. As I mentioned in my first answer, this was the first time that the commissioning of out-of-hours services was the responsibility of the NHS. Previously, it had been the responsibility of individual general practitioners to either provide the services themselves directly or to provide them through a GP co-operative or an independent company.

We all recognised that, in a sense, this was the start of a journey and that, because of other issues that were changing in terms of the primary care environment, we would need to commission very different services from those that had traditionally been provided. That was largely due to the fact that we were well aware that the medical manpower, in the form of GPs who had traditionally provided the out-of-hours service, would not be available in the future. This was one of the key attractions of the contract to GPs, and, therefore, we were in the position of commissioning a new service model across the NHS. We now have a year's experience of commissioning those services, and they will continue to develop over future years.

[40] **Alun Cairns:** I accept what you are saying that yes, it was a major change, but that is why you have guidance and standing orders, and that was the purpose of the model contract. So, Cadeirydd, I am bit confused. We have Mrs Lloyd, with the greatest respect, saying that the guidance, contract, standing orders and support were adequate. We are also getting Mrs Richards saying that they were adequate. However, we are still in this position with this report, in which it appears that something was inadequate, but I still cannot get to grips with what that was.

I accept what you say, Mrs Richards, that it was a major change, but, surely, the logic in terms of any significant change such as this would be to introduce it on a phased basis rather than overnight. Surely, that would have prevented such a problem. The learning curve would then have been smaller, in contrast to the big-bang approach that was taken.

My final question is to Mrs Lloyd. How will you respond to recommendation 1 in the auditor general's report, in which he talks about background checks?

Ms Lloyd: We have already responded to that by issuing a circular in October about the

background checks that should be undertaken.

[41] **Janet Davies:** Mrs Lloyd, I want to take up something that Alun Cairns said. I do not think that a phased approach was available under the legislation that had gone through. I see that you are obviously agreeing with me when I say that. However, do you feel that it would have made the LHB very much more wary of taking on a company that lacked experience? You had a company that lacked experience on the one hand, and a completely new situation on the other, and putting the two together was a big risk.

Ms Lloyd: I think that is slightly different point, if I might say so. I think that there are issues, whether or not you phase it, about how you manage a company that has no firm track record in the field for which its is tendering. As part of the internal review that we undertook, we identified very much that credentials, both in terms of finance and quality, had to be checked thoroughly to ensure that any company could deliver what it says it is going to deliver. Underpinning that, a much more robust risk assessment had to be undertaken by any organisation entering into contracts for contingencies if an organisation failed to meet its contractual obligations. So, I think that other things were learned from this particular instance that are being promulgated to the service.

The phased approach, unfortunately, as you rightly say, was not available to us, which is why so much effort was put into trying to support the local health boards through the changes that were going to be necessary and to share the information and experience that was being gained across England and Wales with this new contract.

12.10 p.m.

[42] **Leighton Andrews:** Ms Richards, this was a new service, a new process and a new contract. You were going to award it to a private company that had never operated in this field before. The incumbent was made up of local GPs; it was bound to be a controversial decision. In that context, therefore, did you not think that you should have taken it to the full board?

Ms Richards: To address one of your statements, there was no single incumbent in Cardiff. The service in Cardiff was provided by two separate organisations, which covered 45 per cent and 55 per cent of the city respectively. So, no status quo option was available to us because we were absolutely clear that we needed to commission the service from one organisation for Cardiff in its entirety. Equally, the two organisations that came through to the second stage were new ones. Clinical Solutions UK, as we have already discussed, was a new company. The consortium was not, in fact, an organisation; it was a new partnership that would have come together specifically to manage this contract, and which did not exist previously.

Moving on to your main point on the board involvement, the board decided to delegate the tendering process and the decision to me and to the chair. The chair's responsibility was subsequently delegated to the vice chair, because the chair is a practising GP in Cardiff and, therefore, used one of the existing services. The board was kept fully informed of this process at every meeting from January 2004 onwards, when the decision was made to delegate this. That continues to be the case to this day. There is a formal board sub-committee, which monitors the progress.

On the decision making, that is one of the clear learning points for us that have come out of the recommendations of the auditor general's report. In response to Mr Cairns's question earlier, I briefly touched on the fact that we developed a risk assessment methodology and we will be using that to look at every contract that we enter into as a local health board to determine whether or not that award should be subject to full board decision making. That looks at a number of dimensions about novelty of service as well as issues such as a change of

a model of care and financial value.

[43] **Leighton Andrews:** It was going to be a controversial decision, whether there was one incumbent, or it was spread between several services. In retrospect, do you think that it should have gone to a full board decision and do you accept that judgment of the Welsh Assembly Government's assessment that it was unwise that it did not?

Ms Richards: I do absolutely accept that recommendation, which is why, as I said, we have developed this methodology to assess future contracts. Through that methodology, this would have been one of the contracts that would go to the full board for decision. The service on which we are going out to tender now is the prison health service for Cardiff, and that will be taken through the full board for decision. In fact, we are presenting the draft specification for that service to the board at our next meeting.

[44] **Leighton Andrews:** Ms Lloyd, what have you done to communicate the judgment that the failure to have a full board decision was unwise to the LHB and to other LHBs in Wales.

Ms Lloyd: LHBs are well aware that the view taken as a result of the internal inquiry was that, although the local health board acted within its standing orders, nevertheless, with a new service such as this—one that would cause much public discussion and therefore would be of great interest to the public—it was unwise not to take it to a full board, because it would be better practice to do that, particularly for new services, and it has been informed of that.

[45] **Leighton Andrews:** Does that have the status of a recommendation now from you?

Ms Lloyd: Yes, as does the whole of that internal report.

[46] **Denise Idris Jones:** Looking at page 15, paragraphs 1.12 and 1.23, the concluding sentence of paragraph 1.23 states:

'the out-of-hours service was provided by a company with no financial track record or parent company guarantee'.

That does not make for pleasant reading. The report says that you were aware that CSUK was a stand-alone company before you awarded the contract, and yet you made a parent-company guarantee from Clinical Solutions Group a condition of awarding the contract. Why did you include a condition that you knew CSUK could not meet? Did you still believe that CSUK was a subsidiary of the Clinical Solutions Group when you awarded the contract?

Ms Richards: We were aware that Clinical Solutions UK was a stand-alone company, hence a number of the checks that Ms Gerrard referred to earlier. The reason that we asked for a guarantee was that, in the presentation made by Clinical Solutions UK to the second evaluation panel and subsequently in writing, the chief executive of that organisation explained that in addition to the relationship with CSG through its resellers agreement—enabling it to use the CSG products and branding as its logo and so on—that it provided an element of indemnity, of product liability and a certain element of financial guarantee. That was the first reason. The second reason was that, at the time of the offer of the tender to Clinical Solutions UK, Andrew Preston, the chief executive of the company, also held a post as vice-president of service development for CSG. It was for those two reasons that we asked for a guarantee. As Ms Gerrard has already explained, between the time of us asking for that guarantee and the contract being signed, the relationship between CSUK and CSG was severed.

[47] **Denise Idris Jones:** Did you not wonder why it had been severed?

Ms Richards: I had a discussion about that with the chief executive of CSUK, and he explained to me that it had always been the intention that, once CSUK had set itself up and established contracts within the services, it would be set adrift from the main company.

[48] **Denise Idris Jones:** It would be able to stand alone.

Ms Richards: Yes, so that it would be able to stand alone.

[49] **Denise Idris Jones:** Did you have a guarantee from Andrew Preston?

Ms Richards: We did not have a parent-company guarantee for the reason that I just outlined. By the time that the contract was signed, that relationship was coming to an end. Clinical Solutions UK was a stand-alone company. We do now have a parent company guarantee because, since that time, the shares of Clinical Solutions UK have been acquired by Serco.

12.20 p.m.

[50] **Denise Idris Jones:** Why were board members told that the contract had been awarded to Clinical Solutions Group? Why was the international experience of Clinical Solutions Group included in the briefing if it was not material to the award of the contract?

Ms Richards: The reason why the Clinical Solutions Group terminology was used in my briefing paper to the board was that, throughout the tendering process, the bid submitted by CSUK was under the branding of CSG. We have confirmed that that was perfectly legitimate through the resellers agreement that it had with that organisation.

The international experience of CSG was not a core part of the brief, but it was at the very end of the briefing as background information. From the point of that briefing, and from the board meeting that followed, the next week, on 7 April, we used the terminology CSUK to be absolutely clear and to avoid any confusion that the contract would be with CSUK. I discussed with the board the fact that this was a new organisation and that was why the body of the report emphasises the skills and experiences of the individuals making up the Clinical Solutions UK team who would be delivering the contract on our behalf. It also explains what the auditor general, quite rightly, points out in his report is perhaps a slightly unusual step, which is that the award of the tender was contingent upon those individuals establishing and implementing the service. We were explicit and named the individuals whom we saw as central to the leadership of the new service.

[51] **Denise Idris Jones:** So, the briefing was not really to make a risky decision seem more palatable to the board members?

Ms Richards: It was absolutely not intended to do that. It was not intended to be misleading in any sense. I gave the briefing in good faith and the audit report accepts that.

[52] **Denise Idris Jones:** But was it though—definitely not?

Ms Richards: That it was not in good faith?

[53] **Denise Idris Jones:** It was in good faith. I believe that you believed that it was in good faith, but when you mentioned the Clinical Solutions Group to the board, was that to make it more palatable for the board to accept the contract?

Ms Richards: That was absolutely not the intention. I was using the branding that the bidders had used throughout the process. We had a very lengthy debate at our April board meeting

about the award of the tender. At our May board meeting, Andrew Preston, the chief executive of Clinical Solutions UK, gave a presentation. If there had been any confusion, that presentation should have provided clarity, because Andrew Preston gave the same presentation to the board that he had given to the two evaluation panels and diagrammatically and verbally explained the relationship. That presentation is referred to in the more recent correspondence from the auditor general that I believe you will be discussing later.

No members of the board have said to me at any point that they felt misled, and they have had ample opportunity to do so. The auditor general's report was presented to a special audit committee meeting of the board the day before its publication, which all board members attended. On hearing the outcome of the report and on reading it, no members of the board have said that they felt misled. In fact, to the contrary, the chair of the local health board's audit committee, who is a lay member of the board, categorically told Mr Dimblebee, who gave the presentation on that day, that she had not been misled.

[54] **Janet Davies:** Before I call Leighton, I am conscious of the fact that we are nearing 12.30 p.m., at which time, I understand, the witnesses would have expected the meeting to finish. On the other hand, if you feel that there are things that you need to say to explain what happened, I do not want to stop you; I am in rather a cleft stick, of time shortage on one hand, but not wanting to cut you off on the other. Therefore, I ask members of the public and the witnesses to be aware of that.

[55] **Leighton Andrews:** I will turn to the provision of the additional funding to deal with clinical risks arising from a perceived increase in demand. Ms Richards, you awarded extra funds to CSUK. At that point, did you consider making any deduction from the payment, or holding some of it back, or threatening to do so, unless CSUK met contractual service standards?

Ms Richards: We did not consider that at the time. The issue facing us was that, within a few weeks of the service commencing, patients were having to wait unacceptably long times for nurse call-back at weekends. The average call-back time on a Sunday morning—the peak time—was two and a quarter hours; the longest call-back time was just over five hours. That was unacceptable, and we had to act immediately to ensure that people could access a safe service. Two weeks into the service, we did not have robust information on contractual performance, but our clear responsibility at that point, and my responsibility as the accountable officer for the contract, was to ensure that patient safety came first.

[56] **Leighton Andrews:** Addressing the issues of patient safety is one thing, but giving a supplier more money is quite another, is it not? Your first port of call when a service is not being delivered is to analyse why that is so.

Ms Richards: Yes. As I say, we were literally two weeks into the service. We analysed why the service was not being delivered—it was because there were up to 80 calls an hour into the system on a Saturday and Sunday morning. This is an emergency service, you cannot reduce demand and those calls had to be responded to. The money that we put into the service was for a fixed period, and was specifically to enable Clinical Solutions UK to employ more nursing staff on a Saturday and Sunday morning to cover the peak periods of demand.

[57] **Leighton Andrews:** My colleagues will discuss the question of hours, but I want to focus on money at present. Was there any danger that the reason that you had to give money to CSUK at this point was because it did not have the proper financial provisions in place, it did not have the right level of cash flow, and it was unable to support the service that it had contracted with you to provide?

12.30 p.m.

Ms Richards: We did not believe that that was the issue. The issue was about having appropriate skills in the organisation to undertake the nurse triaging. The majority of nursing staff who were undertaking this role for Clinical Solutions UK had transferred from the previous organisations. Clinical Solutions UK realised very quickly that these individuals, unfortunately, had not had access to continuous professional development, which meant that, on average, they were responding to three calls per hour, when benchmark activity would show nurse triage specialists responding to eight calls per hour. That clearly required an extensive programme of training for those staff, and we felt that, regardless of the fact that the transfer of risks, technically, according to the contract, fell to Clinical Solutions UK, this was an issue over which it had no control, and that we needed to support it. This was a very difficult decision for us to make; we debated it very rigorously and it was not one that we took lightly. But, at the end of the day, we felt that patient safety had to override issues of a contractual nature and value for money at that point in time. Our key responsibility was to ensure that Cardiff residents had a safe and responsive service.

[58] **Leighton Andrews:** Is it true that there is absolutely no question that you gave money to Clinical Solutions UK because you simply believed that it could not afford to provide the service?

Ms Richards: There is absolutely no question of that.

[59] **Leighton Andrews:** Mrs Lloyd, I think that you have already told us that you are revising the model contract to reflect the balance of risk more sensibly.

Ms Lloyd: Yes.

[60] **Leighton Andrews:** I do not have any further questions on that aspect, but I think that there are break clauses in the model contract. Not every LHB has gone down a three-year route with its provider. That is the case, is it not?

Ms Lloyd: Yes.

[61] **Leighton Andrews:** Do you have any views on whether three years remains the appropriate period?

Ms Lloyd: In order to form a proper working relationship so that you can monitor quality of patient access and the quality of the service provided, three years is the usual period over which contracts are set. However, some LHBs decided that if their ultimate goal was to provide the service themselves, and in order to look at the whole way in which emergency care might be accessed, bringing together the ambulance service, the out-of-hours service, and the accident emergency service, they would set a contract for a shorter period because they would be moving to a different form of service for the future. So, that is a reasonable decision to take.

[62] **Mark Isherwood:** On 8 December 2004, as the report states, a business case was submitted to you to support Clinical Solutions UK's request for an extension in funding, but the figures within that report were completely inaccurate. Did you analyse that business case, or did you just hand over whatever it requested without undertaking that fundamental work?

Ms Richards: We actually rejected that business case because it was for a longer term investment for the duration of the contract. We did not have detail at that point on whether the increased usage in the service, and the calls that it was receiving, would be reflected over the duration of the contract, or whether it was a peak in demand. At the same time, there was pressure across the whole of the emergency system in Wales and the UK, and, as you have

highlighted, that was in December, which is always a very busy time. So, we rejected the business case, which is why we agreed that we would only provide the additional funding on a short-term basis. We now have the benefit of a year's worth of data from the contract, which was presented to the local health board's out-of-hours monitoring committee last week, and what we have seen is that over the whole year, demand has exceeded the contract by 13 per cent. We did not have that information at that point.

[63] **Mark Isherwood:** Had you identified the mathematical error in the business case?

Ms Richards: Yes. We rejected the business case.

[64] **Mark Isherwood:** Having identified that mathematical error?

Ms Richards: There were a number of concerns about the business case, and that was one of them. We did not feel that it was a robust business case. We did not feel that it was justifiable to put the additional money in for the whole period of the contract, as was being requested.

[65] **Irene James:** On page 20, tables 3 and 4 and paragraph 2.14 show us that information was not available to the local health board when it made its decision to award additional funds. Although the report recognises that you did not have the data needed to analyse demand levels when you first awarded additional funding to CSUK, the data would have been available quite shortly afterwards. Therefore, why did you continue to make payments until the end of March to manage increased demand when the figures show that there was none?

Ms Richards: As I have outlined, the decision was based on the issue of patient safety. That was why we awarded the additional funding. We felt that it was necessary until the period at the end of March. Our absolute imperative was to ensure a safe service. The clinical risks were too great not to continue with the funding at that point.

[66] **Irene James:** Will the LHB be looking to recoup any of the additional funding?

Ms Richards: The board is discussing that. It has tasked the audit committee with considering whether we should formally request a repayment of the moneys. The audit committee will be looking at two factors to inform it in that process. The first is the performance over the whole of the first year of the contract, which I referred to briefly. The second is the fact that Clinical Solutions UK has absorbed several additional costs over the course of the year. Those could potentially be perceived to offset that funding. Some of those costs are outlined in the auditor general's report, in paragraph 2.16. The audit committee will formally consider the issue at its next meeting, and it will make a recommendation at the next full board meeting.

[67] **Janet Davies:** Paragraph 2.12 tells us that, in various correspondences, the LHB has repeated the claim that there has been an unprecedented increase in demand. Why was the LHB telling the local medical committee and the public that there had been an unprecedented increase when your own figures show that not to be the case?

12.40 p.m.

Ms Richards: The situation that we inherited, as it were, with regard to commissioning the service, was challenging in that there was a paucity of historic data on which to base the new service. This was largely due to the fact, which we have touched upon on a couple of occasions, that there were traditionally two providers in this area that kept very different data on the services that they provided. They recorded data in very different ways. As a consequence, the only robust data on which we felt we could base the contract was the total number of calls to the services. The figure is quoted in paragraph 2.11 of the report—there

were 62,116 calls. A couple of months before the introduction of the new general medical services contract, the practices that were covered by Cardiff Doctors on Call took the decision to cease their Saturday morning clinics, because, under the new contract, a Saturday morning, for the first time, becomes part of the out-of-hours period. That gave us the information that the activity would probably increase by 12 per cent. However, that was based on just a small number of months, and on just a part of Cardiff. So, the figures from which we were working were quite challenging.

The other point that was not clear at the time of the award of contract, nor was it clear to us at the time that the report was drafted—and we can only confirm this now that we have had the year-end information, as the service has operated for a year—is that, of the total calls received over the year, 75 per cent required a clinical response. If you look at the situation across the whole year, as I mentioned earlier, and consider clinical activity in relation to the total number of calls into the system, you will see that demand is up on expectation by 13 per cent.

[68] **Janet Davies:** It is true, though, that not all calls demand a clinical response. Therefore, should you not have been aware of that before you used those figures?

Ms Richards: We were aware that not all calls required a clinical response, but it was quite unclear in the data that we had received from the historic providers whether they were double-counting figures. This was a significant challenge for us, as I have already mentioned. The pattern of care has become clearer to us over the period of the last 12 months. As I have mentioned, we can now say that, of the total calls received into the service, on average, 75 per cent of calls require clinical activity.

The distinction probably was not quite as pertinent to the previous providers, because they provided both the call-handling element of the service and the clinical activity. The immediate call-handling in Cardiff is handled through the local authority's call-handling service, which is called Connect to Cardiff. That was arranged through a strategic partnership with the local health board.

[69] **Janet Davies:** I find it difficult to accept that, but we must end this session. Ms Richards, you have given us a great deal of information about how you are addressing the recommendation from the auditor general, and perhaps you have given us the full answer, but is there anything that you want to add to what you have said about the way in which you are addressing the recommendations?

Ms Richards: I would just confirm that we submitted an action plan, based on the report's recommendations, to our September board meeting. That was agreed by the full board and, as a consequence, pieces of work are being undertaken by two of the board's formal sub-committees, namely the risk-management committee and the audit committee, to take forward the recommendations. These include the issue, which we have touched on, of whether there should be a repayment of the £60,000. They also include the risk-assessment work to make it clear which contracts should be agreed by the full board in future, and they include the requirement, which we have not touched on during the debate, for fully documented contingency plans for all tenders in the future, in the event of service failure. The full board will continue to monitor the action plan on a regular basis and will receive recommendations from the sub-committees that are taking forward the particular pieces of work. I would like to emphasise that we have taken this report seriously, we have taken its recommendations on board, and I am absolutely sure that our systems and processes will be enhanced as a consequence of that.

[70] **Janet Davies:** Finally, Ms Lloyd, do you want to add anything to what you have already said about how your department will support local bodies in learning the lessons of this report? Again, you may well have given a full reply already on that.

Ms Lloyd: Based on the evidence in the auditor general's report, the service is well aware of these recommendations. Your consequential discussion on it will be extremely helpful and, when we have your report, I will arrange for a workshop to be held for all interested parties in organisations in Wales to go through the issues that arise from the establishment of contracts, particularly the importance of the specification being absolutely clear and the risk management being extremely good, the way in which you have to monitor contracts and where the risk lies for performance against contracts, and how you manage new organisations that come into the field. It has been helpful, and we will hold a workshop to ensure that the lessons can be learnt and that we can build into our latest guidance even more good practice arising from these reports.

[71] **Janet Davies:** I thank the three of you for your very helpful answers. As you probably know, a draft transcript will be produced and sent to you so that you can check it for accuracy before we publish our committee report on the matter. Thank you very much.

I now draw the committee's attention to two letters that we have received, one from Ely Bridge surgery on the auditor general's report and one from the auditor general referring to that. Does anyone have any comments or questions on the letters? They will be appended as annexes to our committee report when it is published. Are you all happy with that? I see that you are.

12.49 p.m.

Cofnodion y Cyfarfod Blaenorol
Minutes of the Previous Meeting

Janet Davies: Does the committee accept the minutes of the last meeting? I see that it does.

Cadarnhawyd cofnodion y cyfarfod blaenorol.
The minutes of the previous meeting were ratified.

Janet Davies: We have two draft committee reports to consider, but before we do that, I will just remind everyone that the next meeting, at the end of the month, will be held in the National Botanic Garden of Wales, near Carmarthen.

Cynnig Trefniadol
Procedural Motion

Janet Davies: At this point we need to bring the public part of the meeting to an end. I ask a Member to propose the appropriate motion.

Carl Sargeant: I propose that

the committee resolves to exclude the public from the remainder of the meeting in accordance with Standing Order No. 8.24(vi).

Janet Davies: I see that the committee is in agreement.

Derbyniwyd y cynnig.
Motion carried.

Daeth rhan gyhoeddus y cyfarfod i ben am 12.50 p.m.
The public part of the meeting ended at 12.50 p.m.

ELY BRIDGE SURGERY

Dr P H Edwards, Dr H M J Charles, Dr Karen Santos, Dr T H R Thompson, Dr Helen Lindsey-Miller, Dr Jane Evans, Dr J A Wakeling
Ely Bridge Surgery, 23 Mill Road, Ely, Cardiff, CF5 4AE
Telephone (029) 2056 1808, Fax (029) 2057 8871
e-mail: elybridge@elybridge.co.uk, web: www.elybridge.co.uk

13/10/2005

Janet Davies A.M.
Chairman Audit Committee
National assembly for wales
Cardiff Bay
Cardiff
CF99 1NA

Dear Ms Davies

Cardiff LHB has informed me that your committee is considering the Auditor general's report into the Cardiff Out of Hours (OOH) service on November 10th.

I am writing as the Chairman of Cardiff Integrated Care Consortium, the organisation that was rejected at the final stage of the OOH tender process. Also as the author of the element of the Cardiff LMC submission to the Auditor General relating to the company status of Clinical Solutions UK Ltd (CSUK).

Whilst the Auditor Generals report is largely welcome there is one aspect that I must disagree with.

The report states in no uncertain terms that the tender process was "Robust and fair". We found this comment surprising, as the submission did not ask the Auditor general to examine the Tender process. Also at no stage were the other agencies involved in the tender process asked for information or opinion.

We feel the Tender Process was unfair and invalid for the following reasons:

1) Information presented during the evaluation process was inaccurate and misleading. This information was critical in the decision process by the panel.

Evidence in my submission, accepted in the report, shows that the claims made by CSUK to be a multinational company with widespread international experience in OOH provision were untrue. These claims were made throughout the tender process and were an integral part of their presentation at the tender assessment meetings.

It is clear from the notes made by the panel members and from the interview with Dr Watkins on the TV program Taro 9 that these claims influenced the decision to award the contract to CSUK. Misleading the panel with information CSUK knew to be untrue must invalidate the tender process.

It is possible that at the time of the initial decision to award the contract to CSUK the LHB Executive were not aware of the true facts. However the tender process cannot be considered finalised until background checks have been made. We know from the report that these checks by the LHB were incompetent, if done at all.
The LHB were informed by CICC that the information regarding CSUK's international & UK experience was incorrect. However they chose to ignore this without checking its validity.

2) Failure to evaluate the credentials of one tendering organisation whilst having full access to information about the other, including accounts and complaints, is unfair practice.

3) The LHB changed the tender specification after the 2nd tender evaluation to the disadvantage of one tendering organisation.

The third area of concern was the change to the Tender Specification following the Second tender assessment meeting.
At this time the LHB requested that C.I.C.C. re-cost our bid on the basis of no activity being transferred from the A&E department to the Primary Care OOH service. The appropriate transfer of patients is essential in an integrated service by any accepted model.
This was a major change to the original specification that called for an integrated service.
Cardiff Integrated Care Consortium consisted of Cardiff & Vale trust, the ambulance trust and Cardiff Doctors on Call (CADOC). Clearly integration and appropriate transfer of patients was integral to our bid and had been clearly indicated throughout the whole process.
Demanding that it be withdrawn and re-costed with no time to look at the implications clearly put our organization at a huge disadvantage.
(I enclose a copy of the letter sent to the LHB at that time)

We felt at the time that this was grossly unfair and made a complaint only to be told there was no mechanism we could appeal to. Dr Allan Jones also wrote to the WAG regarding this issue.

Clearly there are several issues and further information relating to this letter.
If you would like to discuss it further with Dr allan Jones or myself we would be hapy to do so.

Yours Sincerely

Trevor Thompson

Dr. Trevor Thompson

SH-G//

8152
029 2074 8152
Fax 029 2074 2968
Email sian.harrop-griffiths@cardiffandvale.wales.nhs.uk

Mrs A Gerrard
Finance Director
Cardiff LHB
Trenewydd
Fairwater Road
Llandaff
Cardiff CF5 2LD

Dear Alison

Re: Cardiff Integrated Care Consortium – Submission of Tender

I refer to your letter of 23 March requesting that the Consortium submit a revised price schedule which:

- Removes the assumed transfer of activity from A&E services to the out of hours service
- Is based on the UHW out of hours service being open 7 days a week between 6.30 p.m. and 8.00 a.m. only.

I am writing to advise you that following much consideration the Consortium has decided not to submit a revised price schedule on the basis you request.

Our reasons for this are:

- The Consortium is firmly wedded to the establishment of an Integrated Emergency Care Service as outlined in your Service Specification and our tender response. Your new request does not reflect this service model. If you wish a tender to be submitted against this new model a revised Service Specification should be issued.
- The risks associated with the establishment of the Out Of Hours service within the Service Specification are significant; however, our belief is that the tender which we submitted managed those risks to within reasonable limits. We are not prepared to take on the risks associated with your revised service model at such short notice.

We are also concerned to discover that the LHB does not yet have the approval of the Welsh Assembly Government to use the CRI site for the provision of Out of Hours Services from October. The Consortium raised this issue in the tender response and at the first selection panel where we were given a verbal assurance that the Assembly had given this agreement.

The Consortium strongly believes that the service model which we propose in our tender response provides the best possible solution for the population of Cardiff. Any diminution of this would impose significant risks in terms of the Out of Hours service, the remaining NHS services and to the public in Cardiff .

We still wish to be involved in the provision of services in Cardiff if the original Service Specification were adhered to. We would welcome the opportunity to meet with the LHB to discuss how this can be taken forward on a partnership basis between the Consortium and LHB.

I look forward to hearing from you.

Yours sincerely

Siân Harrop-Griffiths
Head of Partnership Development

WALES AUDIT OFFICE
SWYDDFA ARCHWILIO CYMRU

Wales Audit Office / Swyddfa Archwilio Cymru
2-4 Park Grove
Cardiff / Caerdydd CF10 3PA
Direct Tel / Ffôn: 029 20 262 641
e-mail / e-bost: jeremy.colman@wao.gov.uk
PA / CP: Fiona Bashford, fiona.bashford@wao.gov.uk
www.wao.gov.uk

JEREMY COLMAN, AUDITOR GENERAL FOR WALES / ARCHWILYDD CYFFREDINOL CYMRU

Ms Janet Davies AM
Chair - Audit Committee
National Assembly for Wales
Cardiff Bay
CF99 1NA

Date	2nd November 2005
Our reference	JC/0135/fgb
Your reference	
Tel No	029 2026 2641
Fax No	029 2026 2631
E-mail	jeremy.colman@wao.gov.uk
Pages	**1** of **7**

Dear Chair,

Correspondence from Dr Thompson in respect of the Contract for GP Out-Of-Hours Services in Cardiff

Thank you for your letter of 18th October 2005 seeking advice on a letter sent to you by Dr Thompson in respect of the above report, which the Audit Committee will consider on 10th November.

Whilst Dr Thompson's letter largely welcomed my report on the contract for GP out-of-hours services in Cardiff, he disagreed with my conclusion that the tender process was robust and fair, indicating his belief that the tender process was unfair and invalid for the following reasons:

1. information presented during the evaluation process was inaccurate and misleading, and the alleged multinational experience of CSUK was critical to the decision to award the contract to CSUK;
2. failure to evaluate the credentials of one tendering organisation, whilst having full access to information about the other, including accounts and complaints, is unfair practice; and
3. the LHB changed the tender specification after the second tender evaluation, to the disadvantage of one tendering organisation.

Before responding to each of these issues in turn, I think that it would be helpful if I explained the basis and nature of my overall conclusion on the tender process. At the end of my letter I also deal with two more general points about my investigation, raised by Dr Thompson.

My conclusion that the tender process was "robust and fair"

Dr Thompson says 'the report states in no uncertain terms that the tender process was 'robust and fair'. Those words are not an accurate summary of my conclusions on the tender process, which qualify the term "robust and fair" with the important word "overall" and are followed, in the heading for Part 1 of the report, by an additional clause outlining the deficiencies in the LHB's management of key risks surrounding the award of the contract to a new company such as CSUK.

As you know, it is the usual practice in a report such as this from the Auditor General for the language to be measured. In that context the use of the word "deficiencies" is very strong, reflecting the seriousness with which I viewed the weaknesses in the LHB's risk management.

I reached my conclusion about the tender process on the basis that:

a. a sub-group of the LHB General Medical Services Project Board, which included independent stakeholder representation, developed the service specification (paragraph 1.3 of my report);

b. the LHB openly advertised for tenders in the Health Services Journal (paragraph 1.3);

c. two evaluation panels, which included independent stakeholder representatives, assessed and scored the bids against clear non-financial criteria, before considering financial and affordability issues (paragraphs 1.3-1.4);

d. the CSUK bid scored 19 per cent higher than the Consortium's bid against these non-financial criteria, and was £1.2 million cheaper (paragraphs 1.5-1.6);

e. despite the confusion and disagreement about the meaning of the term 'integrated' within the service specification, the LHB took steps to include the Consortium in the evaluation process after the Consortium refused to recost its bid and to compare the bids on the basis of a common activity profile (paragraph 1.7); and

f. I agreed with the findings of an internal review of the tender process by the Welsh Assembly Government regional office, which concluded that "it would not appear that...the process followed by the LHB in the awarding of this contract was flawed in any material way" (paragraph 1.2).

However, following the selection of CSUK as the preferred bidder, there were deficiencies in the LHB's management of key risks associated with the decision to award the contract to a brand new company, particularly the process of due diligence and background checks. These deficiencies are set out specifically in paragraphs 1.12-1.19.

Dr Thompson argues that the tender process cannot be considered finalised until background checks have been made. I agree. Although the background checks fell short of the standard one would expect, I do not believe that that vitiated the process of bid evaluation. My report makes very clear that there is no reason why organisations should not contract with a new company when it is best placed to provide a service, but that there are inherent risks that need to be managed (paragraph 1.13). I therefore concluded that, while the tender process was robust and fair overall, there were deficiencies in the risk management process that supported the contract award.

Information presented during the evaluation process was inaccurate and misleading - the alleged multinational experience of CSUK was critical to the decision to award the contract

My staff reviewed the information provided by CSUK at the evaluation panels and found no evidence that it was inaccurate or misleading. In its presentation, CSUK's slides showed the Clinical Solutions Group logo at the top, but also contained a detailed management structure of CSUK. The presentation said that the Clinical Solutions Group software was used by the NHS, which NHS Wales subsequently confirmed to be true. Other information supplied detailed Clinical Solutions Group's clinical decision making software and its use in various countries. We found that Clinical Solutions Group software was indeed used in these countries, although Clinical Solutions Group did not provide out-of-hours services directly in those countries (see paragraph 1.29 of my report). At the time of the presentation, CSUK had a contractual relationship with Clinical Solutions Group enabling it to sell Clinical Solutions Group software under a reseller's agreement, which gave CSUK the right to use the logo and other stationery.

My staff examined the presentation and supporting literature that CSUK used at the evaluation panels. These make no reference to Clinical Solutions Group having experience of providing out of hours services, although there is reference to the previous experience of the staff CSUK proposed to deploy in Cardiff in providing out of hours services. We saw no evidence that CSUK claimed to be a subsidiary of the Clinical Solutions Group. A diagram in the presentation shows that there were a number of separate "Clinical Solutions" companies in different countries, of which CSUK was one example. Although the diagram does not explicitly spell out the legal nature of the relationship through a reseller's agreement, the presentation makes clear that CSUK had its own structure, Board of Directors, Chief Executive and staff, quite separate from Clinical Solutions Group.

My staff reviewed the LHB's formal notes of the evaluation panel, which summarise the assessments of each panel member. We also spoke to three members of the panel during the course of our investigation and subsequently spoke to the vice-chair of the LHB during the process of clearing my report. None of these records or interviews suggested that there was a need to carry out any further interviews or to examine the notes of individual panel members. The summarised notes of the evaluation panel correctly record the bidder as CSUK and provide no evidence to suggest that international experience was a material factor in the assessment of bids. Indeed, although the summarised notes refer to CSUK's lack of track record in the UK, which clearly suggests that the panel was aware of CSUK's lack of experience, the experience of bidders was not an explicit criterion in the assessment of bids.

Although my staff did not examine the handwritten notes of evaluation panel members referred to in the recent S4C programme, *Taro 9,* and in Dr Thompson's letter, they have now seen these notes and I am satisfied that they contain nothing that should cause me to question the facts and conclusions set out in my report. All members of the panel, besides Dr Watkins, who is referred to in Dr Thompson's letter, scored the Consortium bid more highly than the CSUK bid against the non-financial criteria. Both the LHB's summarised notes and the handwritten notes of individual panel members, from which the summarised notes were drawn, make it clear that the key considerations in evaluating the bids were the proposed models of service delivery, the attitude of the senior management teams and issues relating to clinical governance.

It is true that once CSUK had been selected as the preferred bidder, the LHB asked CSUK to provide a parent company guarantee. This request suggests that there was at this time a misapprehension about the precise nature of CSUK's contractual relationship with Clinical Solutions Group. However, CSUK wrote back to the LHB saying that it had made clear at the evaluation panel that it was a stand alone company, that Clinical Solutions Group was not its parent company and therefore could not provide a parent company guarantee. Consequently, LHB officials were aware that CSUK was a separate, standalone company when they signed the contract with CSUK in September 2004. Paragraphs 1.24 to 1.27 of my report identify the steps taken by the LHB to manage the risks associated with the absence of a parent company guarantee and CSUK's lack of a financial track record, and record my own view that there were deficiencies in the way the LHB managed these risks.

Failure to evaluate the credentials of one tendering organisation whilst having full access to information about the other, including accounts and complaints, is unfair practice

The report highlights the deficiencies in the LHB's background checks into CSUK as a new company. However, where a new organisation is bidding against a more experienced organisation, the organisation letting the contract must review the fuller information available from the more experienced organisation and seek to obtain the sort of information about the new company, outlined in paragraphs 1.15 to 1.19 of my report, which can help it assure itself that service and financial capacity risks will be appropriately managed. My staff found no evidence that information about the Consortium's complaints or financial position disadvantaged it relative to CSUK. By the time the LHB carried out its due diligence checks, the Consortium's bid had already received lower evaluation panel scores than CSUK.

The LHB changed the tender specification after the tender evaluation to the disadvantage of one tendering organisation

During study fieldwork my staff discussed the issue of the service specification with former members of the Consortium and Cardiff LHB. My report confirms that the LHB asked both the Consortium and CSUK to resubmit proposals based on a common activity profile because of differences in the bidders' interpretation of the service specification (paragraphs 1.7-1.8). In its internal review of the

tender process, the Welsh Assembly Government's regional director concluded that there had not been an unfair change in the service specification and that the Consortium's bid was over and above the LHB's requirements, being based on higher activity than the profile in the service specification. I agreed with the conclusions of the internal review by the Welsh Assembly Government's regional director that, in future, there needed to be greater effort at an early stage to resolve any misunderstandings over the service specification. My report shows that the LHB itself carried out an exercise to re-cost the Consortium bid on the basis of a common activity profile, which is further evidence that the LHB took steps to ensure that it could consider both bids on their financial merits and that neither would be disadvantaged. I am satisfied that the LHB treated both bidders equally in dealing with the misunderstanding of the specification, but that the LHB should have done more to ensure that both bidders clearly understood what it meant by the term 'integrated'.

General points

The submission did not ask the Auditor General to examine the tender process.

Dr Thompson's letter claims that the submission did not ask me to examine the tender process. I do not understand the basis of that claim: the original submission of 8 February 2005 from Dr Pierrepoint, chair of the Cardiff Local Medical Committee, explicitly stated that "the tender process adopted by Cardiff LHB might also be flawed and should be investigated by the appropriate authority".

It is, of course, entirely for me to decide the scope of any examination that I perform, so it is hardly relevant to debate whether or not I was asked to investigate the tender process. As it happens I did agree with Dr Pierrepoint's suggestion, and did investigate the tender process.

I must also add that the Local Medical Committee agreed the factual accuracy of paragraph 3 of the report with me prior to publication, which says that the Committee wrote to me, expressing the view that the tender process was flawed.

At no stage were the other agencies involved in the tender process asked for information or opinion

I am surprised that Dr Thompson alleges that my staff did not ask for information or opinion from other agencies involved in the tender process. There seemed little

point in meeting the two bidders who were not short-listed, nor did I consider it necessary to meet CSUK staff to discuss the tender process. My staff did, however, meet LMC members, who had previously been part of the Cardiff Integrated Care Consortium, on 7 April 2005. That meeting included discussion of issues raised in the report, particularly:

a) the baseline CADOC data which the LHB used to inform its service specification;

b) the Consortium's understanding of the service specification and the differing interpretations of the term "integrated"; and

c) how the Consortium was asked to revise its bid after the second evaluation panel.

I trust that this is helpful in addressing the points raised in Dr Thompson's letter in advance of the Committee's consideration of my report on 10 November.

Jeremy Colman
Auditor General for Wales

WHC (2005) 083

WELSH HEALTH CIRCULAR

arc Cathays
aerdydd CF10 3NQ

Cathays Park
Cardiff CF10 3NQ

Issue Date: 20th October 2005
Status: Action

Title: Interim arrangements for amendments to LHB Standing Orders and NHS trust example Standing Orders in advance of revised guidance from the Assembly

For Action by: Chief Executives and Directors of Finance, LHBs and NHS trusts	**Action required** *See paragraph(s)* : See paragraph 2

For Information to: External Auditors

Sender: Dr Christine Daws, Director of Resources Directorate

National Assembly contact(s) : Mr Bob Lawrence, Resource Directorate, NHS Finance Division

Enclosure(s): None

Tel: 029 20825111 GTN: 1208
Llinell union/Direct line: 029 20
Ffacs/Fax: 029 20
Minicom: 029 20823280
http://howis.wales.nhs.uk/whcirculars.cfm

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Dear Colleague,

Interim arrangements for amendments to LHB Standing Orders and NHS trust example Standing Orders in advance of revised guidance from the Assembly

Summary

1. This circular provides guidance on actions needed to be taken by LHBs and Trusts to address shortcomings raised in a recent Wales Audit Office (WAO) report.

2. This circular also draws attention to some amendments that LHBs and Trusts should have already incorporated into their Standing Orders (SOs) due to changes to primary legislation.

3. This Circular provides interim guidance in advance of revised SOs guidance that the Assembly plans to issue by April 2006.

Action

4. LHBs and NHS trusts are asked to note the report findings and address, where appropriate, the report recommendations by:

- revising their Standing Orders;
- revising their tendering and contract procedures;
- ensuring they are always aware of, and follow, guidance, advice and best practice issued by the Assembly, HM Treasury, and other appropriate government departments, such as the Office of Government Commerce (OGC), and where appropriate professional advisors and bodies;
- making sure that arrangements for delegation promote good management and that the delegate is supported by the necessary staff with an appropriate balance of skills: and
- ensure changes to primary legislation are incorporated into their SOs.

Background

5. In August 2005 the Wales Audit Office (WAO) published their report 'Contract for the provision of the out-of-hours GP service in Cardiff'. This report is available via the WAO website: www.wao.gov.uk. The findings that emerged from this report will have an impact on both LHBs and NHS trusts. The recommendations from the report meant that LHBs and Trusts need to review their current SOs.

6. Welsh Health Circulars WHC(2003)021 and WHC(2003)022 enclosed a set of LHB SOs and Standing Financial Instructions (SFIs), respectively. WHC(2003)022 also require LHBs to seek approval from the NHS Wales, Finance Director before any material amendments can be made to these documents.

7. An example set of SOs was circulated to trusts on 31st March 1997 and incorporated into the "Corporate Governance Framework for NHS Wales" document issued on 27th March 1998.

8. The Assembly is currently reviewing LHB SOs and the example SOs for trusts with the aim of issuing revised guidance before April 2006. This interim guidance recommends action by Trusts and LHBs to take account of the recommendations from the recent WAO report and changes to primary legislation in advance of April 2006.

Report Recommendations

Two of the recommendations are targeted at the Assembly, viz.:

9. ***Recommendation a***

Given the relatively limited resources and experience available to LHBs, it would be helpful for the Welsh Assembly Government to direct LHBs to appropriate guidance on the key background checks that need to be conducted in order to verify that a company has the financial capacity and experience to deliver services.

10. Issues:

Health bodies have a duty to ensure they keep up to date with, and follow, guidance, advice and best practice issued by the Assembly, HM Treasury, and other appropriate government departments, such as the OGC; and where appropriate, professional advisors and bodies.

The key background checks recommended by the WAO are basic common sense checks that health bodies should go through as part of their procedures for letting contracts.

11. Guidance issued by the Assembly:

Many strands of guidance have been issued surrounding this matter. Two in particular seem to be relevant, viz.:

The Chief Executive "…. Must make sure that arrangements for delegation promote good management and that the delegate is supported by the necessary staff with an appropriate balance of skills. The latter requires careful selection and development of staff and the sufficient provision of special skills and services (medical, scientific, economic, statistical, accountancy, consultancy, inspection and review, etc)".

[Re: Chief Executives Accountable Officer's Memorandum]

And:

DGM(95)65 enclosed 2 copies of 'Government Accounting (GA)' and advised, the then, health bodies that whilst this document is designed primary for the use of Government departments, the principles outlined for the proper stewardship of public funds apply to all public sector bodies, including the NHS.

Health bodies should note that access to GA is available via the Treasury website: http://www.government-accounting.gov.uk/current/frames.htm and the link in the GA 'Procurement' chapter will take the user to the 'Supplier financial appraisal

guidance' issued by OGC alluded to in the WAO report. This guidance can also be found via the OGC website: http://www.ogc.gov.uk .

12. **Recommendation a – Action:**

It is intended that the revised SOs to be issued by the Assembly will include additional paragraphs that reiterate:

- The need for the organisation to make sure that arrangements for delegation promote good management and that the delegate is supported by the necessary staff with an appropriate balance of skills; and
- The requirement for health bodies to adhere to the principles set out in GA for the proper stewardship of public funds.

The SO section that deals with 'Tendering and contract procedure' will also be amended to include a reference to the document issued by OGC entitled 'Supplier financial appraisal guidance'; and a paragraph covering the following key background checks will also be included:

Inspecting audited accounts,
Reviewing management accounts;,
Profit and loss forecasts,
Company's turnover that relates to the supply of the specific service
Securing a parent guarantee.

These changes will also need to be reflected in the Assembly model contract and/or guidance issued by Community, Primary Care and Health Service Policy Directorate (CPC&HSP Directorate) and this work is being taken forward.

In the interim period LHBs and trusts should amend their own SOs, processes and procedures to incorporate these changes in advance of further guidance from the Assembly.

13. ***Recommendation b***

The Welsh Assembly Government should reconsider the allocation of risk in the model contract and develop contractual provisions for dealing with changes in demand.

14. **Issue:**

The guidance set out in the model contract issued by the Assembly advised LHBs to transfer a number of risks to the supplier without necessarily taking account of the consequences of transferring these risks. It is the WAO view that this advice goes against current best practice, which advocates risks, should be managed by the organisation best placed to do so. The transference of some of these risks was therefore considered to be unreasonable since they were not within the supplier's control.

15. **Guidance issued by the Assembly:**

The WAG model contract issued by CPC&HSP Directorate was based on the English model and it should be noted that this WAO recommendation would have a wider effect on England also.

16. **Recommendation b – Action**

The Assembly is liasing with their Department of Health (DH) colleagues with the view to amending the model contract to take account of this WAO recommendation.

LHBs and trusts should amend their own process and procedures to incorporate this recommendation.

The WAO report also made four recommendations targeted at LHBs as follows:

17. ***Recommendation c***

Local Health Boards should review and, where appropriate, revise their delegations so that Boards are required to approve the award of contracts where the associated risks are significant by their nature, if not by their financial value.

18. ***Recommendation d***

When awarding contracts for the delivery of patient services, LHBs should develop and document detailed risk management and contingency plans that are proportionate to the degree of risk to service continuity.

19. ***Recommendation e***

LHBs should monitor activity levels against those set out in their out-of-hours contracts, and establish robust protocols to assess and evidence claims for additional funds.

20. ***Recommendation f***

Local Health Boards should keep accurate records of all information (including notes of reference, meetings and discussions) that is material to the award, management and variation of contracts.

21. Recommendations c, d, e and f – Action

The principles set out in these four recommendations would, in general terms, strengthen the financial controls that can be applied to all contracts. The Assembly intends to incorporate these principles into the relevant sections of the SOs as part of its current review.

Some amendments to SOs resulting from changes to primary legislation

22. LHBs can now exercise powers under Section 28A of the NHS Act 1977, as amended by the Health Act 1999, to fund projects jointly planned with local authorities, voluntary organisations and other bodies.

23. Revised guidance regarding sponsorship arrangements with the Pharmaceutical Industry has been issued under cover of WHC(2005)016.

24. LHBs and Trusts are reminded that directives by the Council of the European Union, promulgated by the Assembly, prescribing procedures for awarding all forms of contracts shall have effect as if incorporated into SOs.

25. LHBs and trusts should amend their own SOs, processes and procedures to incorporate the WAO recommendations and to incorporate the changes resulting

from primary legislation, in advance of further guidance from the Assembly. It should be noted that the amendments to SOs outlined in this circular do not require the specific approval of the NHS Director of Finance.

Contact point

25. Any queries regarding this circular should be directed to Bob Lawrence (WHTN 1208 3769) at NHS Finance Division, e-mail address: robert.lawrence@wales.gsi.gov.uk**.**

This circular has been issued by:

Dr Christine Daws
Director of Resources

Bwrdd Iechyd Lleol
Local Health Board
Caerdydd
Cardiff

RISK MANAGEMENT COMMITTEE
23 SEPTEMBER 2005

CONSIDERATION OF RISK ASSESSMENT MODEL FOR CONTRACTS AND CONTRACT VARIATIONS

Introduction

This paper has been written to support the deliberations of the Risk Management Committee in considering the practical application of the recommendation in the WAO report on the Out of Hours Contract in respect of delegations for decision making.

Contract types

Contracts can be divided into 5 main types:-

- Non-legal LTAs with other NHS bodies for the provision of health services
- Grants with Voluntary Organisations
- Joint agreements with the Local Authority for health/social care services
- Contracts with independent/private sector providers of health services
- Service Level Agreements with other public sector bodies for the provision of support services.

These can be:-

- Block contracts where there is a fixed price irrespective of activity levels (Fixed)
- Block but with tolerance levels which would trigger a contract variation (Semi-fixed)
- Cost per case or activity unit (Variable)

Contract Variations

Contracts with organisations will set out circumstances for when a contract variation will apply. Most of these reflect financial changes based on actual performance compared to contracted activity levels.

The majority of contract variations issued by the LHB are with Cardiff and Vale NHS Trust and fall into three distinct types:-

- Variations to reflect additional centrally allocated funded from the Assembly for any number of issues. The LHB will receive an additional allocation and the contract is increased commensurately.
- Variations to reflect actual activity levels for a small number of services that are excluded from the main LTA and which are monitored and reimbursed on an actual basis. This includes reimbursement for NICE drugs, scoliosis, ICU services.
- Variations for significant pressures within the main LTA. This variation process is not an exact science and reflects:-
  - actual "bottom line" performance against contracted levels
  - performance in specific "risk" specialties
  - delivery of specific organisational actions to manage activity/demand etc
  - actual additional costs incurred by Trust
  - risk sharing agreements across LHBs and HCW
  - relative financial positions of the organisations and where financial risk can be best managed.

  In essence, this reflects a partnership approach but in light of the NAO report, it could be difficult to demonstrate value for money and this arrangement may now need to be reconsidered. Such variations are seldom considered by the Board and reflect management discussions partly ensuring that we jointly deliver key SAFF and financial targets.

The other main area for contract variations is on GMS contracts particularly in relation to the levels and reimbursement of enhanced services. These can change as a result of:-

- changes to central policy
- response to disease outbreaks
- changes in commissioning arrangements between primary and secondary care
- changes of activity levels on a practice specific basis.

Risk Assessment

Rather than create a new risk assessment tool, developments have been made to improve risk assessment processes throughout the organisation. The area that is most developed is in relation to the risk assessment process around the delivery of the Strategic Change and Efficiency Programme (SCEP).

Applying these criteria to contracts, this risk assessment could be performed as follows:-

Each contract is scored between 0 and 50 against the following criteria:-

a) Corporate Importance – How significant is the contract, in delivering the LHB's objectives for the year. It would be unlikely that any contract would score 0 (no contribution to objectives) or 50 (full contribution to objectives).
b) Corporate Sensitivity – What is the likelihood of external interest affecting the LHB's public image

These two values are summed.

The next stage is to assess the risk of the contract performing to the specification based on two risk factors. Each factor is given a score of between 0-10.

c) Inherent risk – This would include new or changed services, historic issues affecting delivery, non agreement of care models by key parties, contradictory to Government policy, new market providers etc.
d) Control risk – This assessment is based on the level of control that the LHB has in ensuring delivery. High areas of control may include delivery of waiting times which although are delivered by NHS Trusts will be affected by the separate performance management arrangements of the LHB and Assembly and LHB primary care initiatives. Low levels of control may involve mental health contracts when patients are placed through the judicial process.

These two values are multiplied to give a combined score between 0 and 100.

The sum of a)+b) is multiplied by the sum of c) x d) to calculate an overall risk score. This is then divided by 100 to give an overall score between 0 and 100.

Where the risk score is above a certain threshold, then these contracts would require approval by the full Board.

Preliminary Assessment

A preliminary assessment against these criteria has been undertaken of contracts let over last 18 months. The following contracts and contract variations stand out as those that should have been approved by the Board if this risk assessment model was applied. The actual delegation is provided as separate commentary.

Cardiff and Vale NHS Trust	Board considered and approved the Service and Financial Framework. This agreed the marginal changes to the previous years contract.
GMS Out of Hours Contract	Delegated to Vice Chair and Chief Executive
Changes to contracts with voluntary sector organisations	Delegated to panel
Contract variation with Pontypridd and Rhondda Trust re referrals for Breast services	Executive Team
Enhanced Services elements of all GMS provider contracts	Overall strategy and budget approved by Board. Individual contracts agreed by Director of Commissioning/Chief Executive
New mental health contract with Integra	Executive Team
Business Services Centre*	Finance Director/Chief Executive

* Although financial value pre-determined by Assembly.

The Committee is asked to consider whether the use of such criteria would be appropriate given the above preliminary assessment.

Summary

A methodology is proposed for risk assessing those contracts which should be approved by the Board. This would be incorporated into the LHB's scheme of delegation.

The Committee is requested to consider:-

- The suitability of this risk assessment model
- The practical application of the model.

If the Committee approve this model in principle, a full risk assessment will be conducted for all existing and planned contracts.