PUBLIC ACCOUNTS COMMITTEE

INQUIRY INTO FIONA STANLEY HOSPITAL

TRANSCRIPT OF EVIDENCE
TAKEN AT PERTH
WEDNESDAY, 30 NOVEMBER 2011

Members

Mr J.C. Kobelke (Chairman)
Mr J.M. Francis (Deputy Chairman)
Mr A. Krsticevic
Ms R. Saffioti
Mr C.J. Tallentire

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Hearing commenced at 9.30 am

CAMPBELL, MR DAVID MAXWELL
Chief Executive Officer, Serco Australia,
Level 10, 90 Arthur Street,
North Sydney 2060, examined:

PRINCE, MR ANDREW JAMES
Director, Serco Healthcare Consulting, United Kingdom,
Level 10, 90 Arthur Street,
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CATTERALL, MR TIMOTHY JAMES
Director, Strategy and Business Development, Serco Australia,
Level 10, 90 Arthur Street,
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QUARRIE, MR IAN ROGER
Director, Strategy and Business Development,
Level 10, 90 Arthur Street,
North Sydney 2060, examined:

The CHAIRMAN: Could I start by saying on behalf of the Public Accounts Committee—Tony Krsticevic, Joe Francis, Chris Tallentire, and myself, John Kobelke—I thank you for appearing before the committee today. The purpose of this hearing is to assist the committee as it gathers evidence for its inquiry into the decision to award to Serco Australia the contract for the provision of non-clinical services at Fiona Stanley Hospital. The Public Accounts Committee is a committee of the Legislative Assembly of the Parliament of Western Australia. This hearing is a formal procedure of the Parliament and therefore commands the same respect given to proceedings in the house itself. Even though the committee is not asking witnesses to provide evidence on oath or affirmation, it is important that you understand that any deliberate misleading of the committee will be regarded as contempt of Parliament. This is a public hearing and Hansard will be making a transcript of proceedings for the public record. If you refer to any documents during your evidence, it would assist Hansard if you could provide the full title for the record. Before we proceed with questions we have for you today, I need to ask you a series of standard questions. Have you completed the Details of Witness form?

Mr Campbell: Yes we have.

The CHAIRMAN: Do you understand the notes at the bottom of the form about giving evidence to a parliamentary committee?

Mr Campbell: Yes, we do.

The CHAIRMAN: Did you receive and read the Information for Witness sheet provided with the Details of Witness form today?

Mr Campbell: Yes.

The CHAIRMAN: Do you have any questions in relation to being a witness at today's hearing?

Mr Campbell: We have no questions.

The CHAIRMAN: We have a set of questions and I will lead off; however, I understand you might like to make an opening statement and we would welcome you doing that if you wish.

Mr Campbell: Thank you Mr Chairman. I would like to accept that invitation and thank you and good morning Chair and committee members. We are very grateful to be able to take this opportunity to participate in this inquiry. Serco Australia recognises the privilege and responsibility we have in the vital role in helping to develop and deliver services at the State's flagship health facility, Fiona Stanley Hospital. It is an incredibly exciting project for us. We have entered into this contract confident that we have the experience, expertise and commitment to deliver an outstanding service in partnership with the state government. Supported by fully integrated non-clinical services, Fiona Stanley Hospital will provide an outstanding environment for patients and provide clinical staff with more time to care for their patients. We are confident we can achieve and exceed our goals by utilising our knowledge from successfully delivering public services around the world and by drawing upon our health expertise in THE United Kingdom and our 20 years' experience in Australia, including 16 years' experience in Western Australia. Once operational at the Fiona Stanley Hospital, Serco will directly employ over 1 000 people in the hospital, providing extensive and integrated non-clinical support services including: technical systems; support for telemedicine; teaching and training; internal and external transport; patient record management; management of site utility and energy supplies; catering; cleaning of clinical and non-clinical facilities; procurement and maintenance; medical equipment; and environmental and recycling services.

Our extensive experience in the health sector is vital to laying the foundations of our services at Fiona Stanley Hospital. In the United Kingdom, Serco provides services in partnership with the National Health Service and other health and social care organisations. Through these services more than two million people in a range of primary and community settings, receive healthcare services from Serco. Our success in identifying and delivering integrated health services has been recognised through a number of awards that are testament to our innovative approach and the effective partnership between public and private organisations in public hospital settings. At Forth Valley Hospital in Scotland, Serco and our NHS partners have just won the FM Excellence in a Major Project award from the prestigious British Institute of Facilities Management. Also at Forth Valley, Serco and the NHS have just won the Estate Management Category in the Building Better Healthcare Awards for the use of automatic guided vehicles for services such as waste removal, freeing up frontline staff to work with patients, reducing occupational injuries and improving infection control. Serco is consistently ranked in the top quartile of cleanliness, safety and hygiene at the hospitals we clean. A recent report found that overall the Forth Valley Hospital meets and exceeds the rigorous standard to protect patients, staff and visitors from the risk of foreign infections. Other significant achievements in health include leading and directing changes in waste segregation at Norfolk and Norwich University Hospital, increasing recycling tonnage over 30 per cent in a three-month period; winning eight consecutive gold awards for safety at Wishaw General Hospital—the last three years being awarded the prestigious gold medal from the NHS; and developing the e-porter program in neighbouring hospitals to actively and efficiently manage bed occupancy and patient flow. Whilst it is nice to receive this recognition, we strive for continuous improvement to deliver the best possible service. This commitment to world's best practice is being delivered in Western Australia as well.

The Public Accounts Committee has previously asked how our performance will be measured and managed, and I welcome these questions and we will briefly outline the depth of our accountability. In addition to the competitive tender process, government service contracts deliver a level of accountability that few other organisations face. The accountability measures contained in our contract include key performance indicators; financial and reputational sanctions for failure to meet service levels; independent inspections and audits; and on-site government monitors. Of course, the ultimate accountability for the private sector provider is that we will be replaced should our performance be found to be unsatisfactory. These accountability measures help to ensure the high

standard of service, they drive innovation, they direct the provider's focus to the government's priorities, and they help ensure value for money for the taxpayer. Serco believes that clear and strong accountability is a critical element in successful service delivery, whether it is from the public or private sector.

In the case of Fiona Stanley Hospital, we have signed up to 450 individual key performance indicators. Each of these indicators is a measure of our success. We have been in discussion with the health department to make these KPIs public and I am pleased to be able to inform the committee this morning that both parties have agreed to publish 93 per cent of those KPIs, with only those relating to security being withheld. I believe the department will provide these to the committee this week. We are very comfortable with as much information as possible being made available to the community, and by allowing them to see the depth of our accountability in these performance indicators we are confident that the committee and the community will recognise our significant commitment to the Fiona Stanley Hospital and the people of Western Australia.

Finally, I would like to acknowledge the 75 staff we already have working incredibly hard to development the services at Fiona Stanley Hospital to ensure it is a world-class facility. It has only been four months since we signed the contract with the state and in that short period we have built a team in Western Australia that has quickly formed a productive partnership with the state and is quickly finalising the integrated non-clinical service plans for the future of this outstanding hospital. Thank you and we look forward to your questions.

The CHAIRMAN: I also thank you for the fact that you provided a written submission, which we have made public, and we may refer to that. The way we are structuring the questions is to focus on given areas. They are not tight and members might want to open up issues in slightly different ways, but that way hopefully we will move from one sector to another rather than backwards and forwards too much. I would like to start with getting on the record some of the experience that Serco brings to this contract. Can I start by asking if you could outline Serco's involvement in the healthcare sector in Australia?

Mr Campbell: Certainly Mr Chair. Serco has received this particular opportunity on the basis of not just our Australian experience, but also our—

The CHAIRMAN: No, all I want now is your Australian experience. My next question will be about your UK experience, which I know is more extensive.

Mr Campbell: Our Australian experience in the health services—we have had up to 15 years' experience with supporting the Australian Defence Force providing support service for their pharmaceutical supplies, and engineering support services for medical support equipment. We provide a full suite of clinical services to Acacia Prison in Western Australia, which covers from dental through to psychological services. We provide a similar suite of services at Borallon Prison in Queensland. Those services will be transferred to a new prison at Gatton, which will commence operation in January 2012.

The CHAIRMAN: I take it from that that currently you do not provide any services to private or public hospitals in Australia?

Mr Campbell: We do not provide services to private or public hospitals in Australia.

The CHAIRMAN: So perhaps we can move to the UK where I know you have more extensive background and experience. You have already mentioned in your report five hospitals. Could we go through those and get a brief summary of the nature and the reach of services you provide at Forth Valley, Norfolk and Norwich, Wishaw, Leicester Royal, and Plymouth?

Mr Campbell: Certainly Mr Chairman. We approached this particular project on the basis that we have very significant international experience. To meet the requirements of this committee, we have brought from the UK our colleague Mr Andrew Prince and I will ask Mr Prince to address those specific questions.

Mr Prince: Thank you Chairman. If I can take each of the five major hospitals in turn. We have been supporting Wishaw Hospital in Scotland since 2001. This is a major hospital of some 700 beds where we provide total facilities management services. These range from electrical and mechanical service, building maintenance of the building's fabric, and infrastructure and grounds maintenance. There is 64 000 square metres of property. We also provide what is often termed as soft services; that is, cleaning, catering, portering, help desk, switchboard and a range of other services, which are patient-facing in the hospital. Can I move onto Forth Valley?

The CHAIRMAN: Just briefly, can you follow up on Wishaw. To what extent are those services provided directly by Serco or do you subcontract for all or most of those services?

Mr Prince: All or most of those services are provided directly by Serco.

The CHAIRMAN: What about other non-clinical services at Wishaw? Are there other companies providing some of the non-clinical services or do you have total coverage?

Mr Prince: I am not aware of other companies providing non-clinical services at Wishaw, or indeed any of the other hospitals that we support.

The CHAIRMAN: So the five hospitals that you are going to give us details on, basically Serco covers all of the non-clinical services in each of those hospitals—

Mr Prince: Except for Plymouth where we provide the soft services; that is, cleaning, catering, portering and so on, but not grounds and estate management services.

The CHAIRMAN: If you would like to move through the other hospitals—

Mr Prince: Forth Valley, which is a modern hospital that opened in 2011, is an 860-bed tertiary hospital in Scotland where we provide support for the fabric of the buildings, and electrical and mechanical maintenance support. There we also procure and manage the utilities for the hospital. It is a larger facility, something like 95 000 square feet with, I think I mentioned 860 beds, so quite a substantial hospital, and again we provide the whole range of soft services—hotel services, cleaning, catering, portering, linen, security, car parking and so on. Norfolk and Norwich is a more longstanding contract. Again, it is a large hospital, tertiary, with things like cancer services. It has around 1 000 beds and again there we provide—and have since 2001—the electrical maintenance and building support services for that hospital over the footprint of some 130 000 square metres and again a full raft of soft services—cleaning, catering, help desk, switchboard, portering, linens, security, site security, car parking, grounds maintenance and so on.

The CHAIRMAN: I have two follow-up questions on Norfolk and Norwich. You service a hospital of some standing so you have come in providing those services after the hospital has been running for some years?

Mr Prince: From the beginning with the hard services, and I am not quite sure when the soft services started, but certainly for the last five or six years.

The CHAIRMAN: And you mentioned, I think, 130 000 square metres. Earlier you talked about a hospital and you spoke about square feet. I just want to make sure we are not confused with—

Mr Prince: No I am sorry, both should be square metres. Plymouth, again, is a more recent contract, which was initiated in 2009. There we run the soft services; cleaning, catering, help desk, switchboard and so on.

[9.45 am]

That is for a major hospital—900 beds—in Plymouth called Derriford Hospital and also for a smaller eye hospital, which is also in Plymouth.

The CHAIRMAN: Who provides the hard services?

Mr Prince: I am not able to answer that question.

The CHAIRMAN: You do not know if it is another company or —

Mr Prince: I do not know if it is self-provided or another company. The fifth largest hospital is the Leicester Royal Infirmary, which again is a tertiary hospital with some 1 000 beds in the centre of Leicester in the East Midlands—again, 130 000 square metres or so. There we provide both hard services around electrical maintenance site services and also soft services, including their post room and waste management. Those are the five major hospitals where we provide support services. I might also mention we run Braintree Hospital, which is a smaller hospital in the south of England. We provide both non-clinical and clinical services. So that includes minor surgery, outpatients and radiological diagnostic services.

The CHAIRMAN: At Braintree then, is Serco actually managing the whole hospital?

Mr Prince: It is.

The CHAIRMAN: That is because Serco is the owner or you simply have a contract with the owner?

Mr Prince: We have a contract. It is still managed as an NHS hospital, supporting the NHS, but it is run and managed by Serco.

The CHAIRMAN: In any of those hospitals we have mentioned, has Serco gone in as a partner, as part of a conglomerate or an association as a PFI when they were set up, or have you always come in afterwards to provide the services?

Mr Campbell: With Norfolk and Norwich Serco certainly committed to that from the start and we were part of a consortium from the start on that particular project. To the best of my knowledge in the others we were not part of a consortium.

The CHAIRMAN: Was that a PFI-basis?

Mr Campbell: That was a PFI. We had, if I remember correctly, a three per cent equity involved in the original consortium.

The CHAIRMAN: I think it is evident, but just to get it on the record in these hospitals where you offer a range of services—hard and soft in most except for one in which you provide generally the soft services—do you take on the role of overall management and coordination of services? Is that part of the role that Serco fills as well?

Mr Prince: Of the services we provide? Yes, we do. We provide the coordination across those services.

The CHAIRMAN: What about for all non-clinical services? I am interested in boundary issues that may open up later between the role that you have and the role that other service providers might have—the role that you will have and the role that health will have here in terms of providing clinical services. What I am getting at is the overall coordination to make sure everything works within these hospitals, what is the structure there of actual wider management, not just the services that you are directly contracted to deliver?

Mr Prince: To the best of my understanding, we manage and coordinate the services that we deliver, not a wider set of services, except in the instance of Braintree Hospital, where we provide services across the whole management and yet we may not employ all of the doctors, for example, who may come in to run clinics. So, we provide the service around the clinics for the clinicians to come in and provide the outpatient services.

The CHAIRMAN: Across those hospitals, what is your involvement in IT services or ICT?

Mr Prince: We provide services where ICT is needed to coordinate our services. For example, orders requests and responses are managed with IT, as you would expect. On some sites we manage the helpdesk and switchboard, which again require software support.

The CHAIRMAN: My understanding with Fiona Stanley Hospital is that you will be the head contractor to provide those ICT services.

Mr Campbell: At Fiona Stanley Hospital we are the lead service integrator, that is correct, and prime contractor.

The CHAIRMAN: Does that model exist in any of your UK hospitals?

Mr Campbell: No, it does not. At the appropriate time Mr Catterall can step you through the model that we have in place for Fiona Stanley, which addresses that issue.

The CHAIRMAN: We will come to those things a bit later. Are there any innovations being used at Fiona Stanley Hospital which will be totally new to Australia which perhaps you have brought in from your experiences there?

Mr Campbell: The answer to that is yes. I will ask Mr Catterall, who was directly involved with the preparation of the [inaudible] to go through the innovation that we bring to this project.

Mr Catterall: In terms of innovations that have been brought to the project from the UK specifically, the use of the real-time location facility, handheld devices for the work initiation amongst floor-based staff and asset location tracking are currently implemented at Forth Valley Hospital and will be applied in this environment. At Forth Valley we also use automatic guided vehicles. However, automatic guided vehicles are in use in new hospital projects in Australia. So, as some of the PFI projects are coming online in this marketplace, those types of vehicles are being used. We are bringing on board cleaning methodologies, including microfibre cleaning methods from our UK operations for use over here as well.

The CHAIRMAN: But they are already being used in hospitals in Australia?

Mr Catterall: The methods that we are using, as I understand it, are slightly different to the methods that are currently being used here.

Mr C.J. TALLENTIRE: Just drilling down a bit into the Wishaw Hospital and looking at a report that came out—an announced inspection report, in fact, from September last year—I notice there that there was some quite negative comment when it came to the standard of cleaning services. Can you outline how you have addressed some of the issues there, that range from failure to ensure that sluice rooms were free of dust, ranging to dust under patient's beds and around skirting boards and a whole range of cleaning deficiencies there.

Mr Campbell: I will ask Mr Prince to talk about that in detail. I point out that over the five hospitals we have consistently remained in the top 25 per cent in terms of the audited standards for cleanliness hygiene. There was a single instance, but I will ask Mr Prince to go through that in detail.

Mr C.J. TALLENTIRE: This is just from my research I have so far.

Mr Prince: Mr Tallentire, I am aware of the report that you are referring to relating to Wishaw Hospital and it does report the findings of dust and fluff in place where they simply should not have been. As you would expect with a company of Serco's standing and ambition in terms of cleanliness in hospitals, you would expect it first of all to take situations seriously when they are found and then to respond promptly to remedy the situation, which we did, and action was taken. First of all a review of the situation was undertaken by our own people to substantiate the lapse in performance. The action we took was in areas of staffing in terms of the shift arrangements and training and supervision to make sure that we were aware of the standards being maintained as they should have been, and in terms of the equipment being used. We took every effort to remedy the situation as quickly as possible. I am pleased to say that now the excellent track record that we aspire to and have been maintaining has now been restored.

The CHAIRMAN: Just following directly on from that question, in the submission you provided to us, it says, as Mr Campbell just said, that —

> In the UK Serco, is consistently ranked in the top quartile for cleanliness, safety and hygiene at the hospitals we clean.

Who actually assessed that? Is it an independent body that ranks hospitals in terms of cleanliness, hygiene and safety?

Mr Campbell: My understanding is the NHS, but I will ask Mr Prince to confirm that.

Mr Prince: There are two different agencies. In England the relevant agency is now the health— sorry, the name keeps changing. It is the Care Quality Commission, which is independent of the NHS but is part of the Department of Health or is governed by the Department of Health. They make independent inspections, both planned and unplanned and unannounced inspections. In Scotland the regime is different. There is a body called the Health Environmental Inspectorate, which again is an independent inspectorate.

The CHAIRMAN: If we can come to obviously what won Serco the contract and that is how you deliver cost savings and efficiencies. Looking at your UK experience, can you give us some insight into what are the factors that you are claiming allow Serco to deliver these services cheaper than your competitors or to the governmental trust.

Mr Campbell: If I may open that up and ask Mr Catterall to go through some of the detail of the project. Serco is an international service company. We are not a security company as sometimes portrayed. We are a service company and we provide services across a remarkable diverse range of services, including, for example, the management of Greenwich Mean Time through our National Physical Laboratory in Teddington. These are mission-critical services that we provide, so we understand the criticality of many of these quite essential services. Because of our experience we have a very deep understanding of how governments seek to tender and to improve services and through that deep understanding we are able to deliver appropriate service delivery plans to tender for a very wide and diverse range of services. What brings us all together, I would add, is that we are a very values-based organisation. The glue that allows us to deliver high-quality public services across a range of services is the ethic-based approach to our business. In this particular case, by taking a fully integrated service we are able to generate a whole range of innovative and new methodologies, which will allow us to generate a far more efficient service. This is a once-in-a-generation opportunity whereby taking a greenfields approach we can develop a very new solution, moving away from traditional methodologies. I might ask Mr Catterall to sift through some of the key elements of our proposal.

The CHAIRMAN: My question did not go at this stage to Fiona Stanley. It goes to your hospitals in the UK where you have a track record. What I am asking is: How do you actually get the cost down? Do you employ less people? Do you do it more efficiently using new technologies? What are some of the methodologies and management uses to actually deliver a cheaper service?

Mr Campbell: The bottom line is this comes back to a value-based proposition and value for money, not necessarily the cheapest price. We are quite often awarded a tender against that proposition of value for money, not the cheapest price. We do apply technology and modern methodologies. In many cases we are able to apply a greenfields approach. So, we create completely new solutions not bound by legacy issues in many cases. As a matter of course we do not reduce terms and conditions for our people. This is the case in Western Australia. Our people will be employed and are employed on the same or better conditions than the public sector. It is not about reducing overall costs. Because we have a new model and can develop a new service delivery model, in some cases there will be a requirement for less people to develop or to deliver a much more efficient service.

The CHAIRMAN: One factor you are saying there is through new techniques, greater efficiency, you can potentially get the same job done or done even better employing less people; that is one area in which you can get cost savings?

Mr Campbell: That is one area. If I can point to, for example, the use of AGVs, the automatic guided vehicles, by releasing people into more productive employment, reducing occupational health and safety risks by employing robots, we can get greater efficiencies in the system.

The CHAIRMAN: I am trying to get examples from you from the UK because the example you gave here would have happened if the health department had run the hospital. It would have looked around Australia. This is going to be Australia's best hospital; that was the ambition. So, clearly all these things would have been done if it was done in house. What I am looking for is what is the discriminator? What are the efficiencies or new techniques that you are using in the UK which means you can deliver a good outcome or a better outcome at lower cost?

Mr Campbell: I will ask Mr Prince to address specific issues from the UK.

[10.00 am]

Mr Prince: It is a difficult question to answer because Fiona Stanley is a different hospital from those we have in the UK and I think the approaches that are relevant to Fiona Stanley Hospital are probably looking across services and integrating services rather than individual services as traditionally provided. So, for example, one of the innovations that we have made in the UK is the introduction of a ward housekeeper role in Forth Valley. That role is part of the reconfiguration of thinking around service delivery, which is being implemented in Fiona Stanley Hospital. I would like to ask my colleague, Tim, if he can expand on that and explain how that innovation is being employed here to benefit the hospital here.

Mr Catterall: Certainly. I think one of the characteristics of our service model is about the effective way that we manage people in the delivery of services. In the UK we have deployed patient-centric service models that have been branded under various names. At the time that we did our tender submission we transferred from the UK a patient-plus methodology which ensured that every service line was delivered from a patient view outwards.

This service methodology is now referred to as Better Together, which focuses on ensuring that all of our staff have a whole-of-experience view of the patient so that catering staff are not just focused on catering, and cleaning staff are not just focused on cleaning. It is that management methodology that sits across the top of it. In some instances and in the specific instance of Fiona Stanley, we have created a ward housekeeper role to bridge many of the services that touch the patient to ensure that we are focusing on the patient in their experience of the services that are being delivered to them. We find that in terms of patient outcomes our operating efficiency is higher because we are reducing the amount of re-work or single point work that tends to get done in environments where you have channels of business activity. There is a focus at various points in our integration for Fiona Stanley where we have brought together those capabilities out of the UK. In many instances at the hospitals that have been referred to by Mr Prince, we have transferred NHS staff from pre-existing hospitals into new facilities and working with those staff and the unions that support them, we have actually been able to improve the efficiency and productivity at the site without actual changes in staff numbers. As demand grows through efficiency, we have been able to achieve better outcomes for the NHS.

Mr Campbell: I am able to give you specific examples of innovations that we are applying at Fiona Stanley that we are bringing from UK.

The CHAIRMAN: Before we come to that, I really would like to get—given your history of involvement with five major hospitals in the UK, and Mr Catterall just went part of the way to explaining it, how do you deliver a better outcome at lower cost? Or perhaps you do not; perhaps you cost more but you get the job because you deliver a better service.

Mr Catterall: In many instances it is the portfolio of service delivery and price that is what we are assessed on. In each instance our services have been competitively tendered against other propositions. Forth Valley Royal Hospital, for example, which was a PFI project, we participated in a tender for that project and our services are benchmarked there. The innovations that were put into Forth Valley to improve efficiency included AGVs, because in particular in the UK many of their hospitals are actually built in the horizontal scale. They are typically not tower hospitals like we have here. They have very similar footprints in terms of gross floor area, but they are typically over larger areas. The use of AGVs has shown to improve both the timed service for solutions such as meal service. Meal services can be delivered in more efficient fashion as well as clinical outcomes such as improved or lower risk of infection through transitional services at different points of time in the back-of-house infrastructure. That AGV is an example of that. We have improved patient response times through portering by more effective management of the initiation of the call for a porter, that the patient is ready when the porter arrives and that their end point is also ready as well. It is that service chain. We do not have staff who are necessarily waiting for a patient to become available in order to move them to a site where they then have to wait again. It is having that view across the hospital site that assists in that. The ability to schedule staff activities through a common control point, being the help desk, assists in that workflow management. It is the application of those types of technologies to workflow management which means that staff ultimately are more productive, are more involved in the management of their own service activities as well that improves the efficiencies. In many instances we are able to substitute capital investment against operating costs as well. It is the effective capital investment—again AGVs is an example or in an IT platform—against the direct operating cost to improve an outcome on the basis of appropriate business cases. We work through those business cases with our clients in the UK.

Mr J.M. FRANCIS: Mr Campbell, I am fairly concerned about the welfare and the pay and the conditions of people who work in the health system. I refer to the comment you made that the fact that people who work for Serco get paid better, with better conditions than people who work in the public system. Has that been your experience?

Mr Campbell: I think my comment was that we have a history of paying the same or better. Our history in Western Australia actually testifies to that. We were originally awarded the contract for the court services contract where we actaully employ more people than the previous supplier and the rates of pay are better than the previous supplier. We have a demonstrated history of that. We have strong and professional relationships with the majority of unions throughout Australia, and we work objectively with them to ensure that terms and conditions are within expectations.

Mr J.M. FRANCIS: If I was a hospital cleaner, I would be just as well off, if not better off, working for Serco than working for the government directly.

Mr Campbell: In the strict terms and condition, I can say you would be no worse off.

Mr C.J. TALLENTIRE: But that is speculation because you do not do hospitals in Australia.

Mr Campbell: No; that is our commitment in our bid proposal.

Mr C.J. TALLENTIRE: It is a commitment but it is not a proven fact.

Mr Campbell: I can only witness our 9 000 employees in Australia who are on terms and conditions that are equal to or better than their peers.

Mr Quarrie: I can also respond to that. In a market such as Western Australia it is also commercial reality for us. Apart from our commitment to paying appropriate salaries and appropriate conditions, it is a commercial reality that we have to pay the market rate.

Mr C.J. TALLENTIRE: So you are going to be able to compete with the mining sector and people like that?

Mr Quarrie: Correct.

Mr Campbell: I think that is a significant issue of which we are very aware. We have 1 400 employees in Western Australia now, and we compete in that market and we compete successfully because we provide a more complete environment.

Mr J.M. FRANCIS: Surely if your workers were worse off, they would leave.

Mr Campbell: That is pretty much the case, I would guess.

The CHAIRMAN: I will just have another go to try to get a better understanding of the efficiencies you have brought in. Mr Catterall has tried to explain that, but I am not getting anything that gives a really firm understanding of how you can do better. Is this partly because it really is a management style? If so, it is the management style which creates the efficiencies—is that intellectual property of Serco?

Mr Campbell: I will attempt to answer that. I do not think it is an intellectual property issue. It is our management style. Serco is a very values-based business. We come from an ethics-based approach to delivering commercially-based solutions to the high delivery of public services. That is our business, and we are very good at it, and we are very experienced at that. The culture that brings that together is, I guess, in a sense, the mystery. A lot of people can provide a technical solution. A lot of people can provide a commercial solution. We provide an integrated solution which includes a particular management style. I do not see that that is IP. It is a particular management style based around a certain culture, which is focused on, in this case, a patient-centric solution.

[10.10 am]

The CHAIRMAN: It may be an appropriate time to ask a question with actually goes off on a bit of a tangent. If, for instance, the contract was removed from Serco at some time in the future, after everything was set up and running on whatever basis, would a new contractor coming in, whoever that might be, be able to continue in the same style, or would Serco potentially be claiming that some of the management techniques and the arrangement of workflow was intellectual property owned by Serco?

Mr Campbell: Again, that is a difficult question to answer. We would not speculate that we would be terminated although the contract does allow for termination for non-performance. Should the contract run its term, and the first term is 10 years, and the state decide to bring a new supplier in to deliver services, they would of course inherit the hardware and the equipment and assets to manage that, and it would be their management style, presumably, that they bring to that, not necessarily adopting or adapting the Serco management style.

Mr Quarrie: Mr Chairman, if I can add to Mr Campbell's comments. IP is always a complex area. My understanding is all of the operational procedures that will be developed through the pre-operational phase which we are going through at the moment, should Serco not have a contract renewed or be terminated for whatever reason, those manuals, those procedures, those systems, remain part of the Fiona Stanley Hospital. Another incoming contractor, or in fact the state, could pick things up and run with them.

Mr J.M. FRANCIS: Mr Campbell, you say you cannot envisage that. I will just refer you to a statement made by Mr Ripper and Mr Roger Cook. Mr Ripper said —

> If the Barnett Government signs the contract with Serco a future Labor government would do whatever it could to reverse the decision, including include negotiating with Serco to bring an early end to the contract.

My alarm bells ring. Let us say the next state election will be in March 2013 and three, six months later or even at the time of opening of this hospital, this contract is ripped up by a then Labor government, we know that the Department of Health have estimated the cost to taxpayers to be somewhere around $60 million or perhaps greater. What would be the cost to Serco? How many employees would you be looking at sacking?

Mr Campbell: Thank you, Mr Francis. Again, that is a difficult question because it requires a certain level of speculation. In the first instance we have a signed contract and we intend to deliver to that contract. Indeed, our particular methodology said we will constantly strive to exceed the expectations of that contract. If there was, for some reason, at the end of the contract or a termination during the contract, I would contemplate that the staff would transfer to a new supplier in the main. How many we would make redundant would be speculation.

Mr J.M. FRANCIS: I am aware that I am asking this question without notice, but perhaps you could take on board a supplementary question and provide later an estimate from Serco on the amount of staff you would have employed at various stages—say, mid-2013 and mid-2014—so that we can get some idea of the impact to your business if the Labor Party won the next election and ripped up that contract at either of those times, and what the cost would be.

Mr Campbell: I can give you an indication of the staffing levels, current and anticipated. We currently employ 75 people in our offices at Murdoch University.

Mr J.M. FRANCIS: Already?

Mr Campbell: Already. They are on the ground working. By early next year we will have over 100. By the middle of 2013 we will have 500 and by the time we go live in March–April 2014 we will have somewhere around 1 100 people in our employment. Of course, we will have a role in employing and managing the 3 000 public servants who will be on site providing the clinical services.

Mr J.M. FRANCIS: All of whom would be equal or better off working for you than they would be directly for the Department of Health?

Mr Campbell: The direct Serco employees would be on the same or better terms and conditions than their peers. Mr Quarrie has indicated we are in a competitive employment market; we know that. I want to add also we are a service industry and our asset is our people. We treat them with great caution and care and we treat them well.

The CHAIRMAN: Those numbers you just gave, are they direct or Serco employments plus your self-contractors?

Mr Campbell: Those are Serco direct employees.

The CHAIRMAN: Can I just come back to that intellectual property issue? Has the intellectual property rights between Serco and the health department been sorted or is there still some ongoing discussions there?

Mr Campbell: My understanding is they have largely been sorted. Mr Catterall led the negotiations directly so I will ask him to respond.

Mr Catterall: Intellectual property rights are jointly owned between Serco and the state in relation to the development of services for Fiona Stanley Hospital and, as Mr Quarrie has pointed out, they non-exclusively transfer to the state on termination. So, both parties have the right to exploit intellectual property that is being developed. In fact, it is contemplated that works that are being undertaken in the design of Fiona Stanley Hospital solution are actually lead activities for implementation of other service solutions within the broader area-wide health service.

The CHAIRMAN: If I can turn now to questions on the actual contract management and your subcontracts, can we get some understanding of the nature of the contracts that Serco will have with both BT and Siemens?

Mr Campbell: Yes. I think the person best qualified, again, is Mr Catterall. He has been involved directly with those negotiations.

Mr Catterall: Serco has the contracts for the provision of ICT design services with BT and for the provision of part of the MES service specification with Siemens. The BT services contract is a 10-

year contract, so it is coterminous with the first term of the Serco contract. The Siemens contract is a 15-year contract related to the life cycle of assets that are referred to in the Siemens contract. Both of those contracts are subcontracts to Serco's contract. The state has one contract; that contract is with Serco. It has one point of risk transfer; that point of risk transfer is with Serco. Serco manages the integration of Siemens and BT's deliveries to the overall service solution and does not expose the state to any risk or shortfall or gap that may exist in the delivery of those services. The scope of BT's ICT services is to design an ICT framework that will enable the non-clinical services to be delivered at the hospital. It is quite appropriate that that contract embedded inside the services delivery contract because it is the enabler of the services delivery. That design work is being undertaken by BT but informed by Serco in collaboration with the state as we develop patient pathways, work practices and the like.

The CHAIRMAN: Just if you could perhaps follow through on the ICT area, what are some of the boundary issues between the software or systems that BT will have to have and the systems that the health department already has or will provide, such as the patient administration scheme?

Mr Catterall: The answer to that could actually be quite technical, and I am not that technically adept, but to describe it, the state's portfolio of clinical applications sits in a clinical environment and Serco's non-clinical applications sit in another environment. There are links between those environments that enable information to transfer across the environments. For example, the patient entertainment system, which is one of the non-clinical applications, sits within the scope of the Serco–BT solution, but needs to communicate back to the patient administration system, as well as the imaging libraries and the medical record, to enable that information to be displayed at the patient bedside. We have the obligation to deliver a full suite of integrated applications that will enable connectivity to the state in a way that is described by the state in terms of their push of information and by us to the state in terms of the type of information that we need from the state. For example, to run the catering service we need to know that a patient is in a particular bed on a particular ward. So, there is a rules-based information transfer that allows that information to transfer across.

The CHAIRMAN: You are describing the system and I thank you for that, but the point of my question is: have those issues of who is doing what and how it will relate all been sorted or is it still in ongoing negotiation?

Mr Catterall: Yes, they are sorted. The scope of BT's work and the delivery for Serco is defined already within the contract.

The CHAIRMAN: In terms of the actual management of the BT contract or subcontract by Serco, does that involve Serco in many staff and what sort of cost implications does that have?

[10.20 am]

Mr Catterall: We have a project control group sitting over the top of the BT design solution. BT's design solution is, as I understand, up to about 75 staff. We have, I believe, in the order of 20 staff who are project managing BT's service delivery. They are our project control group that sit over the top of that and who are interfacing with the rest of our service delivery team.

The CHAIRMAN: Can we turn to Siemens? What is the relationship there?

Mr Catterall: In terms of management?

The CHAIRMAN: In terms of the responsibility Serco has for Siemens providing it and whether or not Serco has to provide some of the capital towards that or whether it is just a lease agreement for Siemens?

Mr Catterall: Siemens is providing a managed equipment service, which is a management service. That service includes the working with the states clinical products review committee on the identification and specification of the types of digital imaging assets and high-end technology assets

that need to be installed into the hospital in collaboration with the requirements of the specialist technicians. They then are responsible for competitively tendering those equipment items in the market and nominating assets back to the clinical products review committee. The assets will be purchased through a lease arrangement, which is structured underneath the Serco contract portfolio. The assets sit separately from the Siemens contract. However, Siemens have the obligation to maintain and ensure that those assets are available for any of the clinical activity that is required. They are also reviewing the legacy assets within the state to see what assets can be moved from other hospitals to Fiona Stanley Hospital as well as the technology horizon for the timing of procurement of assets.

The CHAIRMAN: In terms of procurement, the point I am trying to get to is: does Siemens cover the capital cost and basically have a lease fee, or does Serco have to inject some capital in terms of the starter for that equipment?

Mr Catterall: No, all the assets are covered under a lease that is separate to the Siemens arrangement. A lease arrangement exists between Serco, the state and the bank. That facilitates the purchase of all of the operating assets for the hospital.

The CHAIRMAN: Is the bank already a partner in this deal or is that yet to be established?

Mr Catterall: There is a banking partner in this deal; that is the Commonwealth Bank of Australia.

The CHAIRMAN: The question I am getting to is: what is the amount of capital that is likely to be involved and whether the state could access that capital more cheaply at the rates it can borrow rather than having to go through a bank?

Mr Catterall: The state have an option; they do not have the obligation to procure assets through the lease. They have an option to take up the available capital that has been defined in the lease structures and it can choose the direction that it wishes to take at any point in time. So, in the way that the contract is currently structured, the state's view is that the lease proposition is appropriate. If the state was to change its view, the state has the ability to buy those assets directly.

Mr C.J. TALLENTIRE: So you are not having to access capital to buy these amazing machines that we see in hospitals?

Mr Catterall: As I understand it, there is about $109 million worth of high-end clinical equipment that is going to the hospital and that money will be available through a lease. The leasing structure that has been put forward was designed to provide the state with the lowest cost of capital, so if either of the operating entities in Serco, BT or Siemens were providing capital into the project, the cost to the state would be substantially higher than it is through a state-backed lease arrangement.

The CHAIRMAN: It was only the reported this week when it comes to contract management that Serco actually had your service payments reduced by nearly $15 million with respect to your contract to the immigration detention process. I am wondering, Mr Campbell, if you can explain what actually happened there in terms of failure to meet the requirements of the contract?

Mr Campbell: Certainly, Mr Chairman. That refers to the immigration contract and $14.5 million is a figure that has been bandied around. That contract is remarkably different to the Fiona Stanley contract. We signed that contract to deliver services to a maximum of 800 people on five sites. Within 18 months we were providing services at 23 sites to 6 500 people to a client base of which the demographics had changed dramatically and with the number of people who, as late as yesterday when the Hawke–Williams report was announced, indicated that there was a substantial and overwhelming impact on the infrastructure and capacity of the immigration services to actually handle the numbers that they were currently handling. On top of that, of course, there were numbers who were not passing through the system. They had been given what was called a negative pathway and had been told that they were not going to be given refugee status. Against that backdrop we had to ramp up from 200 staff to 2 100 staff; we had to ramp our systems up. So, there were times when the system was simply overstressed; however, what it points to is the significant levels of

accountability that still held in place despite that backdrop of extreme growth. Some of the abatements were difficult; some of the abatements are still under discussion, but we stand by our claim that we deliver our promises, and in every case we have done so. I think the Hawke–Williams report that was announced yesterday indicates that the system was simply overwhelmed and that Serco was probably one of the few organisations that could respond and deliver the services in those extraordinary circumstances.

Mr C.J. TALLENTIRE: Can I just follow up on that? I understand though that the penalties that you incurred—there is a cap in the contract, so in fact the scale of the failings in the system could have been much, much larger than the $14.8 million that you were charged.

Mr Campbell: There is a cap, but that $14 million did not reach the cap.

Mr C.J. TALLENTIRE: It did not reach the cap?

Mr Campbell: It did not reach the cap, and that is over nearly a two-year period. I should say also that the there is a curiosity with the scale of abatements and it depends on the size and scale of the particular site. So, for an issue that happens on a small site, say at Leonora, Western Australia, abatement might attract, say, $3 000. That same instance on Christmas Island would attract an abatement of $30 000, so it is related to the scale and size of the operation. In some cases we have successfully continued to challenge the abatements that have been applied.

Mr C.J. TALLENTIRE: I guess it all comes to the community's confidence in the ability of Serco to deliver on contracts. I have seen footage on Channel Seven about people who were in an admin role who were transferred into an actual security role and asked to put on blue shirts to indicate that they were part of the security team during the riots in March. What is the story there?

Mr Campbell: I think that that is very much an overstated circumstance. It was one instance in which some administration staff were asked to form a perimeter as observers to ensure that anybody who was leaving the site, we had an idea where they were going. At no time were any of our staff required to perform as a custodial officer or custodial manager.

Mr C.J. TALLENTIRE: But they were asked to appear as —

Mr Campbell: They were asked to observe activities on that site in, I have to add, quite extreme circumstances.

Mr C.J. TALLENTIRE: How do we know you are not going to do the same sort of thing in hospitals?

Mr Campbell: This is such a different environment that it is almost not comparable. There is a stated number of beds, a stated number of rooms and a stated number of treatments. We have pre-determined staff ratios and we will have, and are in the process of negotiating, contracts with unions. There is almost no comparison between what was happening during a riot on Christmas Island and what will happen in Fiona Stanley Hospital.

The CHAIRMAN: Look, we are running over time, so I am wondering if we could move to some questions on the timing and the procurement process for the Fiona Stanley Hospital. Can I ask: when did Serco first become aware that there might be an opportunity for private sector involvement with the delivery of non-clinical services at Fiona Stanley Hospital?

Mr Campbell: Thank you, Mr Chair. I will ask Mr Quarrie to address that, he is our strategy and business development director and has been engaged on this opportunity from the very beginning.

[10.30 am]

Mr Quarrie: Certainly; thank you, Mr Campbell and Mr Chairman. It was mid-2009 when we were first made aware of the opportunity and in fact took part in the market sounding process that the state undertook around about that period.

The CHAIRMAN: So, Mr Quarrie, what you are saying is that the first contact Serco had on this issue was when the Department of Health approached you to do its market soundings?

Mr Quarrie: The market sounding of mid-2009, correct.

The CHAIRMAN: So, it was not an issue that you had already raised with government in terms of what Serco could offer?

Mr Quarrie: Ninety per cent of Serco's contracts are with government. We are regularly in touch with government expressing the services that we may provide to them in the future, but the first formal contact with regard to Fiona Stanley Hospital was the market sounding.

The CHAIRMAN: So, the first formal contact was when the Department of Health came to you as part of their market sounding —

Mr Quarrie: That is correct.

The CHAIRMAN: — but there may have been contacts earlier than that with government, not necessarily the health department, relating to what Serco could offer?

Mr Campbell: Perhaps, Mr Chair, if I could answer that. By way of the fact that we have been in Western Australia for 16 years providing services to government—our original contract was the public transport information systems contract that we have been doing for 16 years. Through that period of time there have been periods where we have obviously engaged with members of Parliament and with government officials at various levels.

Mr J.M. FRANCIS: I think, Mr Chairman, that that is a great line of questioning. Mr Campbell, you may be aware of the brochure that was circulated through a number of electorates, including mine, and I will just refer you to it, I will read a bit from it. It is authorised by Mr D. Hume in Hilton, Western Australia, who by way of background was the Labor candidate for Cottesloe in the 2008 election, he is a Labor councillor on Fremantle council now and a failed pre-selection candidate for Labor for the seat of Fremantle and the seat of Willagee.

The CHAIRMAN: Joe, we are running out of time, if you could come to the point.

Mr J.M. FRANCIS: Fine, Mr Chairman. I refer you to a particular quote on the back of this. It states —

> SERCO WINED & DINED JOE FRANCIS IN MARCH 2009,
>
> BEFORE WINNING THE MULTI-BILLION DOLLAR CONTRACT.

I find that imputation to be highly offensive and defamatory; in fact it is just another example of the dishonest and fraudulent dirty campaign that is waged against Liberal MPs by the likes of Dave Kelly, the United Voice union and members of the Labor Party. I would be curious to know what Serco's reaction to that particular statement would be.

Mr Campbell: Surprise and, I guess, a sense of dismay. As I said, we are an organisation that is ethics based and values driven. That has been reinforced in July 2011 where we are now bound by the UK anti-bribery legislation that vastly tightens up our ability to—so, we keep very proper and appropriate relationships. It is impossible to do business on the scale of a project like Fiona Stanley without engaging with a public official; it is just simply impractical and impossible to do so, and it would be actually rather dangerous if we were attempting to outguess or guess what the government's expectations were. We have engaged in conversations with various officials over the last 16 years, but at no stage would we engage in a process described in that thing as "wining and dining"; that is not our style —

Mr J.M. FRANCIS: In order to win a billion-dollar contract. I mean that implies that Serco and obviously myself acted corruptly. That is highly offensive.

Mr Campbell: That is not merely offensive, that is extremely inaccurate.

Mr C.J. TALLENTIRE: So, have you held a dinner which Mr Francis attended?

Mr Campbell: I recall Mr Francis joining us for a meal about two years ago.

Mr C.J. TALLENTIRE: So he did.

Mr Campbell: A single meal, yes. At which stage I have no recollection of Fiona Stanley —

Mr J.M. FRANCIS: I do not actually remember who paid!

Mr Campbell: I recall there was no conversation related to Fiona Stanley during that meal.

The CHAIRMAN: If I can come back, Mr Catterall, in terms of those early contacts with the Department of Health when they were doing their market soundings, obviously we cannot do it in just one of two minutes, but can you give some understanding of what advice Serco was able to give the government at that very early stage?

Mr Quarrie: I can probably comment because it was before Mr Catterall's time with Serco. A gentleman by the name of Steve Cary, who was a consultant for WA Health, undertook quite a wide-ranging series of meetings with potential providers, of which Serco was one. Mr Cary came across to Serco's office in North Sydney and presented the plans for Fiona Stanley Hospital, and we were asked to comment during the meeting on our view of what was planned for Fiona Stanley Hospital and the range of services that may or may not be contracted out.

The CHAIRMAN: Would you advise that there were potential efficiency gains by bundling some or all of those services into a smaller contract?

Mr Quarrie: Absolutely. Integration of service is the key to improving outcomes like that at Fiona Stanley Hospital.

The CHAIRMAN: So it would have been sound advice that the more services you can bundle together and integrate, the better the overall result?

Mr Quarrie: My recollection of that time is that the state had already formed a reasonably firm view that by bundling services there would be efficiencies. We were asked to comment, at which we pointed quite positively.

Mr A. KRSTICEVIC: On that point, with the five hospitals you have in the UK and obviously this new greenfield site of Fiona Stanley, in terms of service delivery, how does this compare with the other hospitals? Is it something that is world best practice, and what results do you expect in terms of efficiencies and delivery, more importantly?

Mr Campbell: Perhaps if I can start the answer. Certainly, it is our intention, which is why we have responded to this opportunity, to bring international best practice and to provide the people of Western Australia with world first class public health services. There are models we have explored already that go somewhere to describing the efficiencies and the effectiveness of things. Mr Catterall mentioned the whole concept that sits behind this is that this is a patient-centric approach and everything that we have talked about, delivered and described is about actually making the patient experience that much more pleasurable or pleasant. One would appreciate that a hospital experience can be somewhat traumatic. This is about removing the trauma and making this a much more engaged experience. So the whole patient experience drives everything that surrounds the Fiona Stanley model. Do you have anything to add?

Mr Catterall: The difference between, say, Forth Valley hospital and Fiona Stanley Hospital is that there are 16 services being delivered by Serco at Forth Valley hospital and there are 28 being delivered by Serco at Fiona Stanley. In terms of those 16 services at Forth Valley hospital, we have modelled our solution in and around those, so we are looking to achieve similar efficiency outcomes as have been exhibited at Forth Valley hospital. The other service lines, we are going through a very interesting design process to achieve those efficiencies. They are first to market opportunities that are not being done elsewhere in this marketplace.

Mr A. KRSTICEVIC: Can I ask you a question as well, David, in terms of the patient experience and the integrated approach? My mother used to work in a public hospital a long time ago now, and she used to tell me lots of stories, but one story was when she became a cleaner in one of the hospitals. It is about government departments being stylised and about people not crossing boundaries. She used to hear stories and be there when patients could not get out of bed to go to the toilet and needed to be handed their bowl or whatever they needed. The cleaner would say, "Ring the bell and the nurse will come and do that." They'd say, "I've rung the bell and the nurse has not come and I need to go, can you help me?" The response, "Sorry, not my job. I'm not going there." And they continue with their cleaning and do not get involved. The patient then wets the bed and the nurse comes in and gets upset and screams at the patient for wetting the bed. In terms of you providing non-clinical services and clinical services, and patient experience, when you have situations like that, how do you see your staff in that situation? Or, if a cleaner needs to go get a nurse because there is a bit of an emergency, are they going to say "Sorry, that's not my job. Ring the bell", or whatever other process is in place; or are they going to have that more integrated approach, like you said, where they are more flexible about what they do and do not do?

Mr Campbell: I think possibly there are two ways to answer this. I might ask Mr Prince to describe maybe what actually happens in the UK and the methodologies we are putting in place for Fiona Stanley.

Mr Prince: The ethos that we inculcate in our staff at all levels in the UK is it is your responsibility; "patient first" means patient first. If that means putting down your cleaning mop and helping the patient—not crossing into the care area, obviously, but in terms of looking after the patient, then that is what our staff would be expected to do; that is what they would expect to do. Mr Catterall mentioned earlier the program "Better Together", which is the label under which we promote that kind of ethos, and that is not just "together" in terms of the non-clinical staff, that is actually working together with clinical staff, particularly nurses on the ward, which is where the most touch points with the patient are, to make sure there is a coherent and seamless interface. The first point is: how can I help the patient, because that is what I am here for?

[10.40 am]

Mr Catterall: We certainly have designed a solution that does not have handover points, except where there are the clinical boundaries that need to exist, and in those environments, effective communication. We are focussing on a one-team view between the Department of Health's clinical staff and our staff and working with the department to shape that to ensure that there are not any of those type of boundaries. We have actually got performance indicators that relate to the ability of staff to recognise that something needs to be actioned, and ensuring that it is actioned, to call through to the help desk or pass it on, or done. Not only in the contract are there mechanisms to ensure that that type of patient focus is first, but the culture of our workforce and the culture of what we have across the Fiona Stanley site will drive that.

Mr A. KRSTICEVIC: No silos, basically.

Mr Catterall: No silos.

The CHAIRMAN: Finally, in terms of that whole procurement planning, it is obviously a very detailed process with those 28 or 30 non-clinical services. What would have been the overall cost to Serco of actually preparing its submission?

Mr Campbell: I have to say, Mr Chairman, I do not have that figure in front of me. All I can say is that we have been working on and off on this project since 2009, and certainly through 2010 we had a substantial team engaged on that. I am happy to take that on notice. I would ask that that information be provided in camera in that it is commercially sensitive information and goes to the core of our methodologies.

The CHAIRMAN: It does not have to be dollars and cents, but if you can give us the nearest million dollars, then we would take that as closed information.

Mr Campbell: If I can supply it on notice, Mr Chairman, I will be happy to.

The CHAIRMAN: That leads onto that issue of commercial confidentiality and I appreciate your opening statement, Mr Campbell, that the KPIs are in large part going to be made public. We appreciate that. Are there any issues with respect to the contract which Serco has for Fiona Stanley Hospital which you would have issues of commercial confidentiality, or from Serco's side of the agreement are you happy if that is made public?

Mr Campbell: The contract as it stands now has I understand been made public by the minister's office, although that may be a partially redacted version, and we have a philosophy of accountability and transparency; however, we will be guided by the minister and the government as to the degree that they wish to reveal that. We would ask to be consulted in terms of commercial sensitivity. There are clever people out there who can use that information in a way that gives them a lead as to our particular methodologies, which we like to think we have the right to protect.

The CHAIRMAN: My question is simply: what is Serco's position? The government will give us their position on it. The Acacia Prison, which you have spoken about as a successful contract; that contract was made fully public.

Mr Campbell: That is correct.

The CHAIRMAN: I am saying, what is Serco's position with respect of the contract for Fiona Stanley Hospital non-clinical services? Does Serco have any problems if that was to be made public?

Mr Campbell: If the minister chose to make that public, after consultations with us, we would support the minister's decision.

The CHAIRMAN: Perth is a small town, and so I would ask if Serco or any of your companies have actually engaged the services of any of these companies or their related companies—Paxon?

Mr Campbell: We have no relationship with Paxon.

The CHAIRMAN: Engaged their services. Stamfords?

Mr Campbell: To my knowledge, no relationship, but I will check with Mr Quarrie.

Mr Quarrie: No.

The CHAIRMAN: Or the Stantons or the Stantons Group?

Mr Campbell: No; no engagement.

Mr A. KRSTICEVIC: You said you have over 400 KPIs in your contract. How does that relate in terms of KPIs generally with, say, hospitals in the UK, the immigration detention centres that you have got in Australia or your other contracts? Is that a comparison for that size of the contract? Is that more or less?

Mr Campbell: Four hundred and fifty KPIs is a large number of performance indicators to manage to. I will ask Andrew on the UK.

Mr Prince: The most complex KPI regime that we have in UK is Forth Valley, not surprisingly since it is the most recent and one of the biggest hospitals. It is not as comprehensive as the Fiona Stanley regime, but then we are not—Mr Catterall mentioned so many services involved, so it is probably comparable for the range of services.

Mr Quarrie: In the Australian market, given the complexity of Fiona Stanley, it is appropriate.

The CHAIRMAN: In closing, I do not know whether I also need to thank Serco or the Serco Institute for assisting Infrastructure Partnerships Australia in the submission they made, because I understand you would be a member of the Infrastructure Partnership strategy.

Mr Campbell: Serco Australia is a member of Infrastructure Partnership Australia, but we had no role in preparing their submission.

The CHAIRMAN: Very well, I do not need to thank you for that. But I do need to thank you for your written evidence and for your evidence here today. A transcript of this hearing will be forwarded to you for correction of minor errors. Any such corrections must be made and the transcript returned within 10 days from the date of the letter attached to the transcript. If the transcript is not returned within this period, it will be deemed to be correct. New material cannot be added via these corrections and the sense of your evidence cannot be altered. Should you wish to provide additional information or elaborate on particular points, please include a supplementary submission for the committee's consideration when you return your corrected transcripts. And if you would also provide a number in terms of the cost to Serco, we will treat that as closed evidence of the committee. Again, I thank you very much for appearing before us today and helping us with our inquiry.

Hearing concluded at 10.46 am