The Auditor-General
Audit Report No.42 2012–13
Performance Audit

Co-location of the Department of Human Services' Shopfronts

Department of Human Services

Australian National Audit Office

© Commonwealth of Australia 2013

ISSN 1036–7632
ISBN 0 642 81351 5 (Print)
ISBN 0 642 81352 3 (On-line)

Except for the content in this document supplied by third parties, the Australian National Audit Office logo, the Commonwealth Coat of Arms, and any material protected by a trade mark, this document is licensed by the Australian National Audit Office for use under the terms of a Creative Commons Attribution-NonCommercial-NoDerivatives 3.0 Australia licence. To view a copy of this licence, visit
http://creativecommons.org/licenses/by-nc-nd/3.0/au/

You are free to copy and communicate the document in its current form for non-commercial purposes, as long as you attribute the document to the Australian National Audit Office and abide by the other licence terms. You may not alter or adapt the work in any way.

Permission to use material for which the copyright is owned by a third party must be sought from the relevant copyright owner. As far as practicable, such material will be clearly labelled.

For terms of use of the Commonwealth Coat of Arms, visit It's an Honour at http://www.itsanhonour.gov.au/coat-arms/index.cfm.

Requests and inquiries concerning reproduction and rights should be addressed to:

Executive Director
Corporate Management Branch
Australian National Audit Office
19 National Circuit
BARTON ACT 2600

Or via email:
webmaster@anao.gov.au

Canberra ACT
6 June 2013

Dear Mr President
Dear Madam Speaker

The Australian National Audit Office has undertaken an independent performance audit in the Department of Human Services with the authority contained in the *Auditor-General Act 1997*. I present the report of this audit to the Parliament. The report is titled *Co-location of the Department of Human Services' Shopfronts.*

Following its presentation and receipt, the report will be placed on the Australian National Audit Office's Homepage—http://www.anao.gov.au.

Yours sincerely

Ian McPhee
Auditor-General

The Honourable the President of the Senate
The Honourable the Speaker of the House of Representatives
Parliament House
Canberra ACT

AUDITING FOR AUSTRALIA

The Auditor-General is head of the Australian National Audit Office (ANAO). The ANAO assists the Auditor-General to carry out his duties under the *Auditor-General Act 1997* to undertake performance audits, financial statement audits and assurance reviews of Commonwealth public sector bodies and to provide independent reports and advice for the Parliament, the Australian Government and the community. The aim is to improve Commonwealth public sector administration and accountability.

For further information contact:
The Publications Manager
Australian National Audit Office
GPO Box 707
Canberra ACT 2601

Telephone: **(02) 6203 7505**
Fax: **(02) 6203 7519**
Email: **webmaster@anao.gov.au**

ANAO audit reports and information about the ANAO are available at our internet address:

http://www.anao.gov.au

Audit Team

Linda Kendell
Philip Hamilton
Anne White
Bill Bonney

Contents

Abbreviations ... 7
Glossary ... 8

Summary and Recommendations ... 9

Summary ... 10
- Introduction ... 10
- Audit objectives, criteria and scope ... 13
- Overall conclusion ... 14
- Key findings by chapter ... 17
- Summary of agency response ... 20

Recommendations ... 21

Audit Findings ... 23

1. Introduction ... 24
   - Background ... 24
   - The Service Delivery Reform agenda ... 24
   - The broader channel strategy ... 27
   - Types of co-locations ... 29
   - Objectives of the Co-location Program ... 32
   - The evolution of the Co-location Program ... 32
   - Progress with co-location ... 37
   - Co-location of other DHS services ... 39
   - Audit approach ... 40
   - Structure of the report ... 41
2. Co-location Decision-making Processes ... 42
   - Introduction ... 42
   - Appropriateness of the criteria ... 42
   - Application of the criteria ... 49
   - Conclusion ... 52
3. Performance Monitoring and Reporting Framework ... 53
   - Introduction ... 53
   - Performance measures ... 53
   - Performance monitoring and reporting ... 56
   - Effect of Efficiency Dividend consolidations on performance framework ... 58
   - Public reporting on the Co-location Program ... 59
   - Assessment of the performance measurement and reporting framework ... 59
   - Conclusion ... 61

4. Performance Outcomes ... 62
Introduction ... 62
Convenient and accessible services ... 62
Coordinated services ... 68
Complaints ... 72
Information for customers on co-located services ... 73
Savings ... 74
Conclusion ... 77
Appendices ... 81
Appendix 1: Agency's response to the proposed report ... 82
Index ... 83
Series Titles ... 85
Current Better Practice Guides ... 90

Tables

Table 1.1 Timeframe for SDR phases ... 25
Table 1.2 Progress (actual and forecast) by type of co-location ... 38
Table 2.1 Three periods of the Co-location Program ... 43
Table 2.2 Consolidation criteria ... 45
Table 2.3 Assessment of the consolidation criteria ... 47
Table 3.1 Performance measures for the Co-location Program ... 55
Table 4.1 SDR Performance measures relating to convenient and accessible services ... 66
Table 4.2 Wait times for Medicare transactions before and after co-location ... 68
Table 4.3 Complaints in relation to the Medicare program ... 72
Table 4.4 2011–12 Budget funding for the Co-location Program ... 75
Table 4.5 Comparison of savings targets, actual, and forecasts ... 76

Figures

Figure 1.1 Changes in Medicare patient claiming service channels[a] ... 28
Figure 1.2 Anticipated proportions of co-location types ... 33
Figure 3.1 Framework for monitoring and reporting on SDR measures, including Co-location Program ... 57

Abbreviations

ANAO	Australian National Audit Office
ATO	Australian Taxation Office
DHS	Department of Human Services
EFT	Electronic Funds Transfer
MYEFO	Mid-Year Economic and Fiscal Outlook
SDR	Service Delivery Reform

Glossary

Consolidations	Co-location through consolidation involves the merging of two shopfronts into one, resulting in one less public point of entry.
Efficiency Dividend	The Efficiency Dividend is an annual reduction in Australian Public Service agencies' departmental funding. It was introduced in the 1987–88 Budget and has generally been set between 1 per cent and 1.5 per cent annually. In two years (2008–09 and 2012–13) an additional 2.5 per cent reduction has been imposed.
Service Delivery Reform	Service Delivery Reform refers to a decade long agenda of major structural and service delivery reforms within the Human Services Portfolio. It was announced by the Minister for Human Services in December 2009. One component of Service Delivery Reform was the co-location of Medicare and Centrelink shopfronts.
Service extensions	Service extension co-locations involve the addition of services into an existing shopfront, either the addition of face-to-face services, generally by the redeployment of staff or by the training of existing staff in cross-portfolio service delivery or the addition of self-service.
Service Zone	Service Zones refer to geographical areas of Australia. Prior to integration into DHS, Centrelink's and Medicare's service networks were divided into various geographical areas. Following their integration in July 2011, geographical boundaries were modified and are now referred to as Service Zones.

Summary and Recommendations

Summary

Introduction

1. The co-location of the Department of Human Services' (DHS) shopfronts is one of the most visible components of the Australian Government's Service Delivery Reform (SDR) agenda. The co-location of DHS shopfronts was also one of the first SDR measures, commencing in early 2010.

2. The SDR agenda foreshadowed major structural and service delivery reforms within the Human Services portfolio, to be implemented over a 10 year period. SDR has three objectives[1]:

- to make people's dealings with government easier through better service delivery and coordination of services;
- to achieve more effective service delivery outcomes for government by contributing to the achievement of government policy objectives; and
- to improve the efficiency of service delivery by integrating and automating service delivery and creating a flexible and agile system.

3. When the Co-location Program commenced in early 2010, there were 313 Centrelink and 240 Medicare shopfronts.[2] At March 2013, DHS advised that 344 shopfronts were offering co-located services. DHS has committed to co-locating all shopfronts by mid-2014.

4. The Co-location Program is being implemented in a dynamic organisational and service delivery environment. The program was affected by the integration of Medicare and Centrelink into DHS and technology is opening up more options for delivering services to DHS customers. New technology also offers an opportunity for achieving greater administrative efficiencies and influences the way customers prefer to access services. In this regard, the proportion of patient claims for Medicare transactions made

---

1 Department of Human Services, *Service Delivery Reform, Transforming government service delivery* [Internet]. DHS, Canberra, 2011, p.5, available from <www.humanservices.gov.au/spw/corporate/about-us/resources/service-delivery-reform-overview.pdf> [accessed 4 July 2012].

2 Hansard, Senate Finance and Public Administration Legislation Committee, Additional Estimates, *Human Services Portfolio – Answer to Question on Notice* (HS8), from 9 February 2010. Some co-locations of shopfronts were undertaken prior to SDR—as at December 2009, Centrelink and Medicare were already co-located at 15 sites.

over-the-counter in DHS shopfronts has declined from 50 per cent in 2009–10 to less than 10 per cent in 2012–13.[3]

Types of co-locations

5. DHS is implementing two types of shopfront co-locations:

- consolidations—merging two shopfronts into one; and
- service extensions—putting additional services into an existing shopfront.

Co-location through consolidation

6. Co-location through consolidation involves merging two existing shopfronts that are in close proximity (one providing Medicare services and the other providing Centrelink services) to provide co-located services. This results in one less public point of entry and potential savings from reduced property costs. The trigger for this type of co-location is usually a property event such as the expiry of a lease or the possibility of leasing more space at an existing site. At March 2013, DHS advised that 100 co-locations had been completed through consolidation.

7. The logistical complexities of consolidating locations are significant, particularly in the period prior to the integration of Centrelink and Medicare into DHS. A large number of arrangements have to be managed and coordinated while also ensuring minimal interruption to customer services. Most consolidations have involved the closure of a Medicare shopfront and the re-location of Medicare services and staff into a nearby Centrelink shopfront. Approval for each proposed consolidation is sought from the Minister for Human Services (the Minister), prior to its public announcement.

Service extension co-location

8. Service extension co-locations involve providing additional services in an existing shopfront, for instance, placing Medicare services into an existing Centrelink shopfront or vice-versa. Service extension co-locations do not result in shopfront closures. At March 2013, DHS advised that 244 service extension co-locations had been completed.

---

3 ANAO analysis of patient claiming data provided by DHS. The data only includes patient claiming and therefore excludes bulk billing or simplified billing claims which comprise the majority of Medicare claims (over 80 per cent). A rapid decline in over-the-counter patient claims followed the decision in April 2012 to phase-out cash refunds for Medicare transactions. The data for 2012–13 is based on the months of July 2012 to March 2013 only.

9. There are two types of service extension co-locations:

- Face-to-face service extensions—the addition of face-to-face services in a shopfront, generally by the redeployment of staff from another office. For instance, the redeployment of an employee from a Medicare shopfront into a shopfront offering Centrelink services.
- Self-service extensions—the addition of self-service facilities in existing shopfronts. For instance, self-service Centrelink services into a shopfront offering face-to-face Medicare services.

10. The logistics of service extension co-locations are generally less complex than consolidations, and the introduction of self-service facilities is less complex again.

Objectives of the Co-location Program

11. DHS has stated that the objective of the co-location of services is to improve 'the way people deal with the Australian Government by providing convenient, easy to access, coordinated services from a single point of contact'.[4] Another objective of co-location by consolidation is to achieve savings from the reduction in lease costs associated with the closure of shopfronts. The 2011–12 Budget forecast savings of $14 million over four years from around 61 consolidations. In addition, the savings from a further 61[5] consolidations scheduled from 2012 onwards are forecast to be $2.7 million in 2012–13.[6] A longer term ambition of the Co-location Program is for co-located shopfronts to become a platform for the co-location of a broader range of other services offered by federal and state governments and community organisations.[7]

---

4 Department of Human Services, *Service Delivery Reform*, op. cit., p. 8.

5 The number of additional consolidations to assist in achieving savings to fund the additional Efficiency Dividend is 67. However, six of these are consolidations of the same face-to-face service (for instance, consolidating two Medicare shopfronts) so do not involve the co-location of services.

6 The additional 61 consolidations are part of DHS' response to the increased Efficiency Dividend in 2012–13. The Efficiency Dividend is an annual reduction in Australian Public Service agencies' departmental funding. It was introduced in the 1987–88 Budget and has generally been set between 1 per cent and 1.5 per cent annually. In two years (2008–09 and 2012–13) an additional 2.5 per cent reduction has been imposed.

7 A number of non-DHS services have already co-located in DHS shopfront sites. For instance, ATO services are offered in seven Centrelink shopfronts, and in 12 Centrelink shopfronts state housing authorities have some presence as part of the response to the Australian Government's White Paper on Homelessness. The 2010 report *Ahead of the Game: Blueprint for the Reform of Government Administration* recommended that state offices of Australian Government agencies in regional areas co-locate (page 36).

The evolution of the Co-location Program

12. The Co-location Program has evolved significantly over the three years of its operation, reflecting the changing environment in which it has been implemented. The anticipated proportion of co-locations by consolidation has varied over time, showing both increases and decreases. Early in the life of the program it was anticipated that 18 per cent of all co-locations would be consolidations. This fell to 12.5 per cent during 2011 because of practical difficulties encountered with consolidations, such as the security requirements associated with cash refunds for Medicare transactions and the different ICT and management systems in place prior to the integration of Medicare and Centrelink into DHS. By April 2012, however, the proportion of total co-locations expected to be by consolidation had increased to 28.5 per cent as the previous difficulties had been removed or ameliorated and additional consolidations were scheduled as part of DHS' plans to find savings to fund the higher Efficiency Dividend in 2012–13.

13. Early in the life of the Co-location Program it was anticipated that all service extension co-locations would involve the co-location of face-to-face services. However, there has been a significant change in thinking about the nature of service extension co-locations. After mid-2011 there was a shift away from face-to-face extension co-locations to self-service co-locations, reflecting difficulties in redeploying staff and the broader strategy of reducing costs by transitioning customers to self-service. By April 2012, it was anticipated that of the 71.5 per cent of co-locations that were expected to be service extensions, 13 per cent would be face-to-face service extensions and 87 per cent would be self-service extensions.

Audit objectives, criteria and scope

14. The objective of the audit was to assess the effectiveness of DHS' administration of the shopfront co-location of DHS services.

15. To address the objective, the audit examined the Co-location Program against the following criteria:

- sound guidelines/criteria have been developed and applied to co-location decisions; and
- DHS effectively monitors, achieves and reports the benefits to customers and the cost savings from the shopfront co-location of DHS services and uses this information to improve the co-location processes.

16. The audit scope did not include consideration of:

- co-locations that occurred prior to the announcement of the SDR agenda in December 2009;
- the privacy issues surrounding customer data associated with co-location and SDR;
- current co-location initiatives involving non-DHS services such as Local Connections to Work and co-location with the Australian Taxation Office; and
- the achievement of savings from the decision to implement additional consolidations to contribute to meeting the increased Efficiency Dividend that applies in 2012–13.

Overall conclusion

17. The Co-location Program is one of the most visible components of the Government's decade-long Service Delivery Reform agenda, which among other things, aims to make people's dealings with government easier through better service delivery and coordination. DHS has committed to providing co-located services (that is, both Medicare and Centrelink services) in all of its shopfronts by mid-2014.

18. DHS is implementing different types of shopfront co-locations. By mid-2014 DHS anticipates that 28.5 per cent of all co-locations will be co-locations by consolidation (involving the merging of two shopfronts into one, resulting in one less public point of entry) with the remaining 71.5 per cent of co-locations being service extension co-locations (involving the addition of services into an existing shopfront but not the loss of a public point of entry). Of the service extension co-locations, 13 per cent are anticipated to involve the addition of face-to-face services, with the remaining 87 per cent involving the addition of self-service.

19. Over the three years of the Co-location Program's operation, DHS has generally administered the program effectively, and has made good progress with co-locating shopfronts in the context of a rapidly changing service delivery environment driven by new technology, the goal of achieving administrative efficiencies, and changing customer preferences. The department has changed aspects of the program to address implementation issues as they arose, including the practical challenges presented by the different ICT and management systems and the separate workforces in

Medicare and Centrelink prior to their integration with DHS. Over the life of the program, DHS' timeframe for implementing co-locations has changed from around 40 shopfronts to be consolidated by 2012 (with no publicly announced timeframe for the co-location of the remaining shopfronts) to a timeframe which envisages the co-location of all shopfronts by mid-2014. To meet evolving timeframes, and address implementation challenges, DHS has varied the balance between consolidations and service extension co-locations. Further, within service extensions, the department has moved from the addition of face-to-face services to the addition of self-services. This approach has also reinforced a broader strategy of transitioning customers with less complex transactions and needs to self-service, contributing to efficiencies in service delivery.

20. DHS has also put in place an effective performance monitoring and reporting framework for the Co-location Program, which has evolved to reflect changes to the program. The department actively monitors both the outcomes of the additional consolidations implemented as part of its plans to find savings[8], and the level of customer satisfaction with the changes. While co-location decisions can affect members of the local community, customer satisfaction data indicates that convenience and accessibility have improved in co-located shopfronts. In particular, the majority of customers recently surveyed by DHS agreed that co-location has made it more convenient to access Centrelink and Medicare services, with a minority of customers, particularly older customers accessing Medicare services in newly consolidated shopfronts, expressing dissatisfaction. There is scope for DHS to further improve the convenience and accessibility of services by monitoring the uptake by relevant staff of training to assist customers using self-service facilities to access the range of online DHS services. This is particularly important in self-service extension co-located shopfronts. It would also assist customers to access the most convenient shopfront, if the DHS website was to provide more information on co-located shopfronts including the face-to-face services and the assisted self-service facilities available in each shopfront.

21. Improved coordination of services, both in terms of processes (for instance having both Centrelink and Medicare transactions dealt with by the same staff member) and around the customer's individual circumstances (such

---

8 As part of its response to the additional Efficiency Dividend announced in November 2011, DHS undertook to increase the number of consolidations, thereby achieving further savings of $2.7 million in 2012-13.

as only having to tell your story once), is an objective of the Co-location Program. In a minority of co-located shopfronts customers still have to queue separately if they need to access both Centrelink and Medicare services, while in other shopfronts varying degrees of coordination are apparent. While this variation is not unexpected given the barriers to greater coordination (including different ICT and management systems prior to the integration of DHS[9] and the security requirements associated with Medicare cash refunds[10]), most of the potential gains relating to improved coordination for customers are yet to be realised. Continued effort in this respect has the potential to deliver benefits for both customers and the department.

22. Co-location through consolidation is intended to deliver $14 million in savings over four years to the government from reduced lease costs[11], and DHS has advised that the savings target is on track to be achieved. Given the Government's decision to harvest these savings upfront from the DHS budget, the department's management will need to continue to carefully plan and monitor implementation to ensure that actual savings are realised as the consolidations occur. An inability to achieve actual savings will create the risk of resource pressures affecting other aspects of DHS services and operations.

23. The progress achieved to date with the co-location of shopfronts has laid solid foundations for future service delivery reforms and the co-located shopfronts have the potential to be leveraged further by DHS to the mutual benefit of customers and the department. For instance, the results of recent trials of integrated service delivery processes and the cross-portfolio training of staff have the potential to improve the department's capacity to deliver coordinated services across its network through more flexible work design and multi-skilled staff. Further, the lessons learned in implementing the Co-location Program, a major structural component of SDR, can usefully inform the wider service delivery reform process within DHS.[12]

---

9 For instance, the different ICT and management systems prior to the integration of Medicare and Centrelink into DHS in July 2011 were key reasons why early attempts to train staff in cross-portfolio processes in shopfronts co-located by consolidation were unsuccessful.

10 Medicare cash refunds were a significant barrier to greater coordination of processes prior to the Minister's announcement in April 2012 to phase out cash refunds over the second half of 2012.

11 In the 2011-12 Budget, the Government announced net savings from co-locations of $14 million over four years and the department harvests the annual savings target upfront during its internal budget allocation process. The $14 million does not include the savings from the additional consolidations implemented in response to the higher Efficiency Dividend in 2012–13. The Efficiency Dividend savings are out of scope for the audit.

12 For instance, the Co-location Program is creating a potential platform for further co-location of other government and non-government services as envisaged under Phase 3 of SDR. Some of the lessons learned in consolidating shopfronts when Medicare and Centrelink were separate agencies could usefully inform this process.

24. The audit has made two recommendations aimed at improving the effectiveness of co-location and the services offered to customers, including by monitoring whether staff in self-service extension co-locations are better able to assist customers to access DHS services online and for the DHS website to provide more information on the services provided in co-located shopfronts.

Key findings by chapter

Co-location Decision-making Processes (Chapter 2)

25. When implementing a program such as the co-location of Centrelink and Medicare shopfronts it is expected that there will be clear and well documented processes for the selection, prioritisation and resultant scheduling of the shopfronts to be co-located. Having well defined criteria for the selection of shopfronts assists in prioritising effort and improving the prospects of the successful implementation of the co-location.

26. Overall, the criteria that were used by DHS for selecting shopfronts for consolidation or extension co-locations were soundly based. However, there was little documentation available on the selection and prioritisation of shopfronts for service extensions. While the selection of shopfronts for consolidation was better documented, only around 45 per cent of all consolidation decisions had sufficient documentation to assess how the criteria had been applied. There was some inconsistency apparent in the application of the criteria.

27. Future decisions on shopfront locations would be improved by better record keeping practices and the more consistent application of established criteria. In this context, DHS has advised that the Co-location team has developed a high level process map to promote decision-making based on the application of criteria and is reviewing DHS' record keeping practices.

Performance Monitoring and Reporting Framework (Chapter 3)

28. It is important that agencies have performance monitoring and reporting frameworks that measure a program's progress towards meeting relevant objectives. Such frameworks should include performance measures that cover both the outputs being delivered and the outcomes being achieved, as they relate to the overall objective(s).

29. DHS' monitoring and reporting framework for the Co-location Program has evolved to reflect the changing circumstances of the program.

The range of performance measures for the program have been kept up to date in the changing environment and overall, the set of performance measures established by DHS are relevant, objective, clear and measurable. The performance framework for the SDR package of measures funded in the 2011–12 Budget, of which the Co-location Program is a component, was assessed favourably in a 2012 Gateway Program Review of SDR.[13]

Performance Outcomes (Chapter 4)

30. A key objective of the co-location of services is to improve service delivery for DHS' customers. Another objective of the Co-location Program is to achieve savings from co-locating by consolidation.

31. Evidence indicates that there have been positive outcomes for customers from the Co-location Program. Specifically, a recent survey of customers visiting co-located shopfronts indicates that over three-quarters of customers agreed that the one stop shop made it more convenient to access Centrelink and Medicare services. Also, the number of complaints relating to co-location has been relatively small.

32. However, consolidations, where one shopfront (generally a Medicare shopfront) closes can require adjustment by members of the local community. A minority of customers, particularly aged customers using Medicare services, have experienced some dissatisfaction related to, amongst other things, finding the new shopfront location less convenient and new queuing systems confusing. Staff and stakeholders reported that the dissatisfaction of some of these customers has abated over time as they became accustomed to the new location and queuing systems, or took advantage of alternative service channels.

33. There is scope for DHS to improve the convenience and accessibility of services by monitoring the uptake by relevant staff of training to assist customers using online facilities to access the full range of DHS services. This is particularly important in self-service extension co-located shopfronts. It would also assist customers to access the most convenient shopfront, if the DHS website were to provide more information on co-located shopfronts including

[13] Gateway Reviews involve short, intensive reviews at critical points in a project/program's lifecycle by an independent team of reviewers. Reviewers are selected by the Department of Finance and Deregulation from the public or private sectors for their expertise in relation to a particular review.

the face-to-face services and the assisted self-service facilities available in each shopfront.

34. The extent to which services have been coordinated varies considerably across co-located shopfronts, both in terms of coordinated processes (for instance only having to queue once to access both Centrelink and Medicare services) and in terms of coordination around the circumstance of the customer (such as only having to tell your story once). While this is not unexpected given the barriers to greater coordination over the three years of the Co-location Program (for instance, the different ICT and management systems and the difficulties in training staff in cross-portfolio processes while Centrelink and Medicare were separate agencies and the security requirements associated with Medicare cash refunds) it means that most of the potential gain is yet to be realised. In some shopfronts customers still have to see more than one staff member if they have both Centrelink and Medicare transactions and in a minority of shopfronts they have to queue separately to do so. Further, while the services to customers are generally well coordinated in consolidated shopfronts where there has been a death of a family member, there is scope to adopt a similar approach to coordination in a broader range of circumstances faced by individual customers. However, the progress with the co-location of shopfronts has laid a solid foundation and the results of DHS' 2012 trial of integrated service delivery processes have the potential to accelerate the benefits to customers.[14]

35. DHS has advised that the $14 million target for the savings from the SDR consolidations is on track to be achieved over the four years to 2014–15. While a higher number of consolidations than initially planned occurred in 2011–12, there was a shortfall in savings for that year of $0.4 million. However, DHS has advised that it expects this to be fully recovered in 2012–13.

---

[14] DHS implemented a trial in the second half of 2012 to test a set of integrated business processes for use in co-located shopfronts.

Summary of agency's response

36. The proposed report was given to DHS for formal comment. DHS provided the following summary response, with its full response at Appendix 1.

> DHS welcomes this report and considers that implementation of its recommendations will further increase the benefits of the shopfront co-location of DHS services. Making DHS services more convenient to access and allowing people to understand the service options available and how to use these, enables them to choose the option best suited to their needs.
>
> Extending self-service facilities and empowering staff with the skills and confidence to show customers how to use these, enables customers to learn to use these facilities and access a greater number of DHS program services in locations where they previously had no access. Additionally, once customers have the skills to use this service channel, they have the option of doing so in locations outside of DHS service centres, for example from their own homes.
>
> Enhancing the DHS website to provide more information about co-located shopfronts, including advice on the face-to-face services and the assisted self-services available in each shopfront will make it easier for customers to identify the most convenient location to do their DHS business. This includes being able to identify the business that can be completed using self-service options without the need to attend a service centre.
>
> DHS agrees with the recommendations outlined in the report.

Recommendations

Recommendation No. 1

Para 4.15

To improve services for customers in self-service extension co-located shopfronts, the ANAO recommends that DHS monitors the uptake by relevant staff of training intended to assist customers to access the full range of DHS online services and transactions.

DHS' response: Agreed

Recommendation No. 2

Para 4.42

To improve the effectiveness of co-location and the services offered to customers, the ANAO recommends that the DHS website provides more information about co-located shopfronts, including advice on the face-to-face services and the assisted self services available in each shopfront.

DHS' response: Agreed

Audit Findings

1. Introduction

This chapter provides background information on DHS' Co-location Program including the program's evolution over the three years of its operation. The chapter also outlines the audit approach including the rationale for the audit and its objective, scope and methodology.

Background

1.1 The co-location of the Department of Human Services' (DHS) shopfronts is a central component of the Australian Government's Service Delivery Reform (SDR) agenda for the Human Services portfolio. At the launch of SDR in December 2009, the then Minister for Human Services stated that 'the most visible aspect of the Government's service delivery reform plan will be a move to co-locate Human Services agency offices to make it more convenient for Australians to deal with government'.[15] DHS has committed to co-locating all shopfronts by mid-2014.[16]

1.2 The Co-location Program was one of the first SDR measures, commencing in early 2010, nearly 18 months before the integration of Medicare and Centrelink into DHS in July 2011.[17] In early 2010 there were 313 Centrelink and 240 Medicare shopfronts.[18] At March 2013, DHS advised that 344 shopfronts were offering co-located services.

The Service Delivery Reform agenda

1.3 The SDR agenda foreshadowed major structural and service delivery reforms within the Human Services portfolio, to be implemented in three phases over a 10 year period.

---

[15] The Hon Chris Bowen MP, Minister for Human Services, Address to the National Press Club, *Service Delivery Reform: Designing a system that works for you*, Canberra, 16 December 2009, p. 10, [Internet]. Available from <http://www.chrisbowen.net/media-centre/speeches.do?newsId=2809> [accessed 4 July 2012].

[16] Department of Human Services, *Service Delivery Reform: Transforming government service delivery* [Internet]. DHS, Canberra, 2011, p.8, available from <www.humanservices.gov.au/spw/corporate/about-us/resources/service-delivery-reform-overview.pdf> [accessed 4 July 2012].

[17] On 1 July 2011 the *Human Services Legislation Amendment Act 2011* integrated the services of Centrelink and Medicare Australia in DHS. The integration was a key structural component of the SDR agenda. The Child Support Agency and CRS Australia had been integrated into DHS earlier. Australian Hearing remains a separate agency within the DHS portfolio.

[18] Hansard, Senate Finance and Public Administration Legislation Committee, Additional Estimates, *Human Services Portfolio – Answer to Question on Notice* (HS8), from 9 February 2010. Some co-locations of shopfronts were undertaken prior to SDR—at December 2009, Centrelink and Medicare were already co-located at 15 sites.

1.4 SDR has three objectives[19]:

- to make people's dealings with government easier through better service delivery and coordination of services;
- to achieve more effective service delivery outcomes for government by contributing to the achievement of government policy objectives; and
- to improve the efficiency of service delivery by integrating and automating service delivery and creating a flexible and agile system.

1.5 Table 1.1 outlines the three phases of SDR. The co-location of DHS shopfronts is a component of Phase 2. The focus of Phase 3 is to expand service delivery reform across government, including at the state and local government level. The Australian Government has indicated that further opportunities to partner with third party providers and the community sector will also be explored. Co-located shopfronts are planned to be a platform for the future joint delivery of face-to-face services by a growing number of government and non-government organisations.[20]

Table 1.1

Timeframe for SDR phases

Phase 1 2010–11	Phase 2 2011–12 to 2014–15	Phase 3 2015–16 to 2019–20
Planning and design	Integrating, simplifying and automating frontline services	Coordinating service delivery across government

Source: Department of Human Services, *Service Delivery Reform.*

1.6 A number of non-DHS services have to date co-located in DHS shopfront sites. ATO services are offered in seven Centrelink shopfronts[21], and in 12 Centrelink shopfronts state housing authorities have some presence as part of the response to the Australian Government's White Paper on Homelessness.[22] There are also 14 Local Connections to Work sites in co-located Medicare and Centrelink shopfronts.[23]

---

[19] Department of Human Services, *Service Delivery Reform,* op. cit, p.5

[20] Department of Human Services, *Service Delivery Reform,* op. cit, p.6.

[21] www.ato.gov.au/corporate/PrintFriendly.aspx?ms=corporate&doc=/content/30006.htm [accessed 8 August 2012]. The co-locations with the ATO have been at the instigation of the ATO as part of the ATO's strategy to reduce its stand-alone shopfronts.

[22] Department of Human Services, *Department of Human Services Annual Report,* 2011–12, Canberra, 2012, p. 79.

[23] Under Local Connections to Work, tailored support is provided to highly disadvantaged job seekers by connecting them to a range of employment, education and welfare services that are available on a visiting basis at the DHS shopfront.

1.7 The co-location of services, or 'one stop' shops as they are also known, has a relatively long history both in Australia and overseas. A one stop shop experiment was conducted by the Coombs Royal Commission into Australian Government Administration in 1976 (see Case Study 1).[24] More recently, the desirability of co-located Australian government agencies was recognised in the 2010 report *Ahead of the Game: Blueprint for the Reform of Australian Government Administration.*[25] Co-located government services are also consistent with the direction of service delivery reforms undertaken by a number of other countries, notably Canada and New Zealand (see Case Study 2).

Case Study 1

The Northwest One stop Welfare (NOW) Centre

In 1975 the Royal Commission on Australian Government Administration initiated an experiment with a one stop shop, the Northwest One stop Welfare (NOW) Centre in Coburg, Melbourne. Employees of the then Australian Department of Social Security, the then Victorian Department of Social Welfare and Local Councils, voluntary agencies and community groups were co-located in a large open plan space in a local shopping centre.

At the time of the report of the Royal Commission in 1976 it was too early to fully evaluate the NOW Centre but initial indications in relation to increased customer satisfaction were positive. The Royal Commission recommended that the shopfront be continued for at least two years. It further recommended that the Australian Government indicate its willingness to help establish other one stop shops where local and regional organisations wished to sponsor them and where the relevant state government was willing to participate. The initiative, however, lost impetus in the following years.

Source: Royal Commission on Australian Government Administration Report, AGPS, Canberra, 1976.

---

[24] Royal Commission on Australian Government Administration, *Royal Commission on Australian Government Administration—Report,* AGPS, Canberra, 1976, p. 161 and Appendix 2.F, p.371.

[25] Advisory Group on Reform of Australian Government Administration (2010) *Ahead of the Game—Blueprint for the Reform of Australian Government Administration,* p.36.

Case Study 2
Service Canada

In 1998, the *Citizens First* survey reported that Canadians wanted improved access to government services, and improved service delivery performance. In response, in 2000 the Canadian government committed to establishing an agency to provide one-stop access to federal government services in person, by telephone and online.

Following a pilot program, Service Canada was formally established in 2005 and is now accessible in over 600 locations (330 full-service centres, 215 scheduled outreach locations, and 63 community offices). The channel strategy also supports Canadians who prefer to conduct their transactions online, by phone and by mail.

Service Canada offers a first point of contact for up to 80 services, depending on the location, including those relating to immigration, health, housing, education, training, employment, business, and income support. In many instances, the service offer is based around 'life events' such as Having a Baby, Finding a Job, Starting a Business, and Travelling Abroad.

Source: Canadian government publications.

The broader channel strategy

1.8 The Co-location Program is being implemented in a dynamic service delivery environment driven by new technology, changing customer preferences and the pursuit of efficiencies in service delivery. DHS customers can access services through a variety of channels. While shopfronts are the main channel for face-to-face service delivery, DHS also has two mobile offices, 177 Rural Agents, 179 Community Agents and 17 remote service centres that also provide face-to-face services.[26] In 2011–12 DHS began developing a National Broadband Network service offer to pilot the delivery of virtual face-to-face services through video conferencing, and targeting customers who may find it difficult to visit a shopfront.[27]

1.9 Other service channels[28] include a range of online options such as the growing number of transactional services available through Centrelink, Child Support and Medicare online services which can be accessed from any computer with internet access. Most shopfronts have a number of self-service computers. New smartphone applications for students receiving Youth Allowance and Austudy have also been developed recently.

---

[26] Department of Human Services (2012), *Annual Report 2011–12*, Chapter 4, pp. 65-72. Rural Agents provide a range of services including assistance with self-service, accepting Centrelink claim forms, responding to customer enquiries, and access to automated phone systems, while Community Agents provide similar services in remote Indigenous communities.

[27] ibid., p. 132.

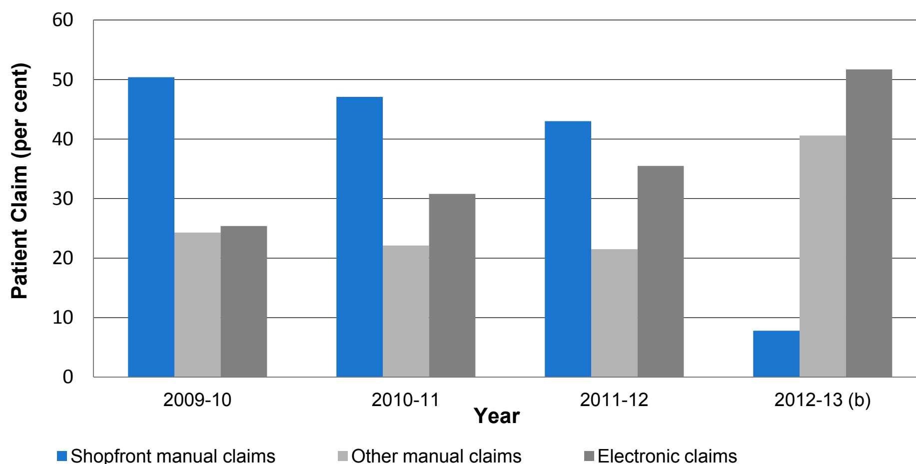
[28] ibid., pp. 65-72.

1.10 Call centres and phone self-service using integrated voice recognition are other key access channels. There are also 229 Access Points which provide free self-service facilities in indigenous and rural communities, such as brochures, phone claiming access and faxing/photocopying facilities. Some Access Points have self-service computers.

1.11 Customers' use of the various service channels has been changing significantly over recent years, often in response to new service delivery initiatives. Figure 1.1 shows the changing service channel profile relating to Medicare patient claims. Since 2009–10 there has been a progressive decrease in the proportion of over-the-counter Medicare patient claims. During the same period there has been a corresponding increase in electronic claims, such as online claims. Further, in the first four months of 2012–13 there was a significant decrease in the proportion of over-the-counter patient claims, reflecting the decision to cease offering cash refunds.[29] This decrease has been largely offset by an increase in 'other manual claims' as customers have moved to using 'drop boxes' located in shopfronts.

Figure 1.1

Changes in Medicare patient claiming service channels[(a)]



Source: ANAO analysis of patient claiming data provided by DHS.

Note (a): The data only includes patient claiming and therefore excludes bulk billing or simplified billing claims which comprise the majority of Medicare claims (over 80 per cent).

Note (b): The 2012–13 year includes patient claiming data for the months July 2012 to March 2013 only.

---

[29] In April 2012, the Minister announced that cash refunds for Medicare transactions would be phased out by the end of 2012.

1.12 Within this dynamic service channel environment DHS' Strategic Plan 2012–16 outlines the overall channel strategy. The strategic priorities are twofold:

- when appropriate, move transactions from a personal service basis (face-to-face or phone) to self-managed mechanisms; and
- customer service staff are to focus on more complex services and helping those most in need rather than dealing with simple transactions.[30]

1.13 Underpinning the overall channel strategy are more detailed portfolio channel strategy documents, including an overarching *Access Strategy 2010–2014* supported by draft implementation plans for on-site, online and on-call channel strategies. The Co-location Program is a central component of the draft on-site implementation plan, which in combination with other SDR on-site initiatives such as Local Connections to Work, Case Management, and ICT integration, is aimed at facilitating a shift in the focus of face-to-face services to more complex, coordinated services.[31] The Co-location Program also reinforces the online strategy as staff in co-located shopfronts can be used as change agents to assist and encourage customers to complete transactions online for a range of DHS services.

Types of co-locations

1.14 DHS is implementing two types of shopfront co-locations:

- consolidations—merging two shopfronts into one; and
- service extensions—putting additional services into an existing shopfront.

---

[30] Department of Human Services (2012), *Strategic Plan 2012–16 — Excellence in the provision of government services to every Australian*, p.8. A forthcoming ANAO audit *DEEWR-DHS Cross Agency Coordination of Employment Programs* includes some analysis of DHS' service delivery strategic priorities in the context of the DEEWR-DHS Bilateral Management Arrangement.

[31] Under Local Connections to Work, tailored support is provided to highly disadvantaged job seekers by connecting them to employment, education and welfare services that are available on a visiting basis at the DHS shopfront. Case coordination staff work with vulnerable customers to establish a plan of action and to link them with a range of other services such as emergency relief, housing, health services and financial services. The range of projects under ICT integration is large and includes: a common queuing system for Front of House, common DHS website and phone numbers, improving the stability of the ICT environment so that staff have confidence in the self-service options available for customers, the development of new portfolio business processes to support integrated channels, and a common desk top.

Co-location through consolidation

1.15 Co-location through consolidation involves merging two existing shopfronts that are in close proximity (one providing Medicare services and the other providing Centrelink services) to provide co-located services. That is, the services currently offered at two sites become available from a single location resulting in one less public point of entry and savings from reduced property costs. The trigger for this type of co-location is usually a property event such as the expiry of a lease or the possibility of leasing more space at an existing site. Other factors are also considered, such as whether the forecast level of customer demand is sufficient for the combined service but not excessive for the merged site. At March 2013, DHS advised that 100 co-locations had been completed through consolidation.

1.16 Most consolidations have involved the closure of a Medicare shopfront and the re-location of Medicare services and staff into a nearby Centrelink shopfront. Only two consolidations have seen the closure of a Centrelink shopfront and the re-location of Centrelink staff and services into a Medicare shopfront. A minority of consolidations have involved closing and moving both shopfronts into a new location. Approval for each proposed consolidation is sought from the Minister for Human Services (the Minister), prior to its public announcement.

1.17 The logistical complexities of consolidating locations are significant, particularly in the period prior to the integration of Centrelink and Medicare into DHS. A large number of arrangements have to be managed and coordinated while also ensuring minimal interruption to customer services. These arrangements include: leases; ICT systems and hardware; communications with staff, managers and stakeholders; shopfront design, fit-out and signage; security issues associated with Medicare cash refunds[32]; reconciling different opening hours; different workplace relations arrangements[33]; different workplace cultures including management practices; and the delivery of staff training.[34] In some cases an unexpected lease termination means that consolidations need to be implemented quickly, potentially adding to the logistical complexities.

---

[32] Cash ceased to be a security issue for co-locations by late 2012 when cashless Medicare refunds had been implemented across DHS shopfronts.

[33] The significance of workplace relations as an obstacle to co-location diminished after the negotiation of a common DHS certified agreement in December 2011.

[34] Such as training to deal with customer aggression for Medicare staff moving into a Centrelink shopfront.

Service extension co-location

1.18 Service extension co-locations involve providing additional services in an existing shopfront, for instance, placing Medicare services into an existing Centrelink shopfront or vice-versa. Service extension co-locations do not result in shopfront closures. In contrast to consolidations, Ministerial approval is not sought for individual service extension decisions. At March 2013, DHS advised that 244 service extension co-locations had been completed.

1.19 There are two types of service extension co-locations:

- Face-to-face service extensions—early service extension co-locations involved the addition of face-to-face services in a shopfront, generally through the redeployment of staff from another office. For instance, the redeployment of an employee from a Medicare shopfront into a shopfront offering Centrelink services. It was recognised early in 2010 that cross-portfolio training of staff was an alternative to redeploying staff to provide additional face-to-face services. Cross-portfolio trained staff would be able to provide information and advice on both Centrelink and Medicare Australia programs and services and facilitate the lodging of claims. However, early trials of cross-portfolio training and delivery were not successful and as a result the redeployment of staff remained the main option for adding face-to-face services.[35]
- Self-service extensions—service extension co-locations implemented after mid-2011 have involved the addition of self-service facilities in existing shopfronts. For instance, self-service Centrelink services into a shopfront offering face-to-face Medicare services.

1.20 The logistics of service extension co-locations are generally less complex than consolidations, and the introduction of self-service facilities is less complex again.

---

[35] Trial sites at Tuggeranong (Centrelink shopfront ACT) and Burwood (Medicare shopfront NSW) in early 2010 were established. The lack of success of the trials was due to a range of reasons including incompatible information technology, the difficulties of implementing the trials when Centrelink and Medicare Australia were separate agencies, and workplace relations issues relating to the classification of tasks (most Centrelink front-line service delivery staff were employed at the APS 4 level while Medicare Australia front-line staff were employed at the lower APS 3 level). The integration of Centrelink and Medicare Australia into DHS in July 2011, and the negotiation of a common certified agreement in December 2011, reduced the barriers to cross-training staff and another trial involving cross-portfolio training of staff in eight co-located shopfronts was implemented and evaluated in the second half of 2012.

Objectives of the Co-location Program

1.21 DHS has stated that the objective of the co-location of services is to improve 'the way people deal with the Australian Government by providing convenient, easy to access, coordinated services from a single point of contact'.[36] Another objective of co-location by consolidation is to achieve savings from the reduction in lease costs associated with the closure of shopfronts. The 2011–12 Budget forecast savings of $14 million from around 61 consolidations. The savings from an additional 61[37] consolidations scheduled from 2012 onwards, part of DHS' response to the increased Efficiency Dividend, are forecast to be $2.7 million in 2012–13.

The evolution of the Co-location Program

1.22 Over the three years of the Co-location Program the department has changed aspects of the program in response to a range of internal and external pressures and in light of experience. DHS' timeframe for implementing co-locations has changed from around 40 shopfronts to be consolidated by 2012 (with no publicly announced timeframe for the co-location of the remaining shopfronts)[38] to a timeframe which envisages the co-location of all shopfronts by mid-2014. DHS has varied the balance between the different types of co-locations to assist in meeting timeframes, and to address implementation challenges.

Initial focus on face-to-face services

1.23 When the then Minister announced the SDR agenda in December 2009, including the co-location of shopfronts, it was envisaged that co-locations would involve either the consolidation of shopfronts or face-to-face service extensions. Internal DHS documentation confirms that until the end of 2010 the concept of co-location, either by consolidation or service extension, was focused on the co-location of face-to-face services. At June 2010 it was envisaged that 18 per cent of all co-locations would be consolidations while the remainder would be face-to-face service extensions. However, as shown in

---

[36] Department of Human Services, *Service Delivery Reform*, op. cit., p. 8.

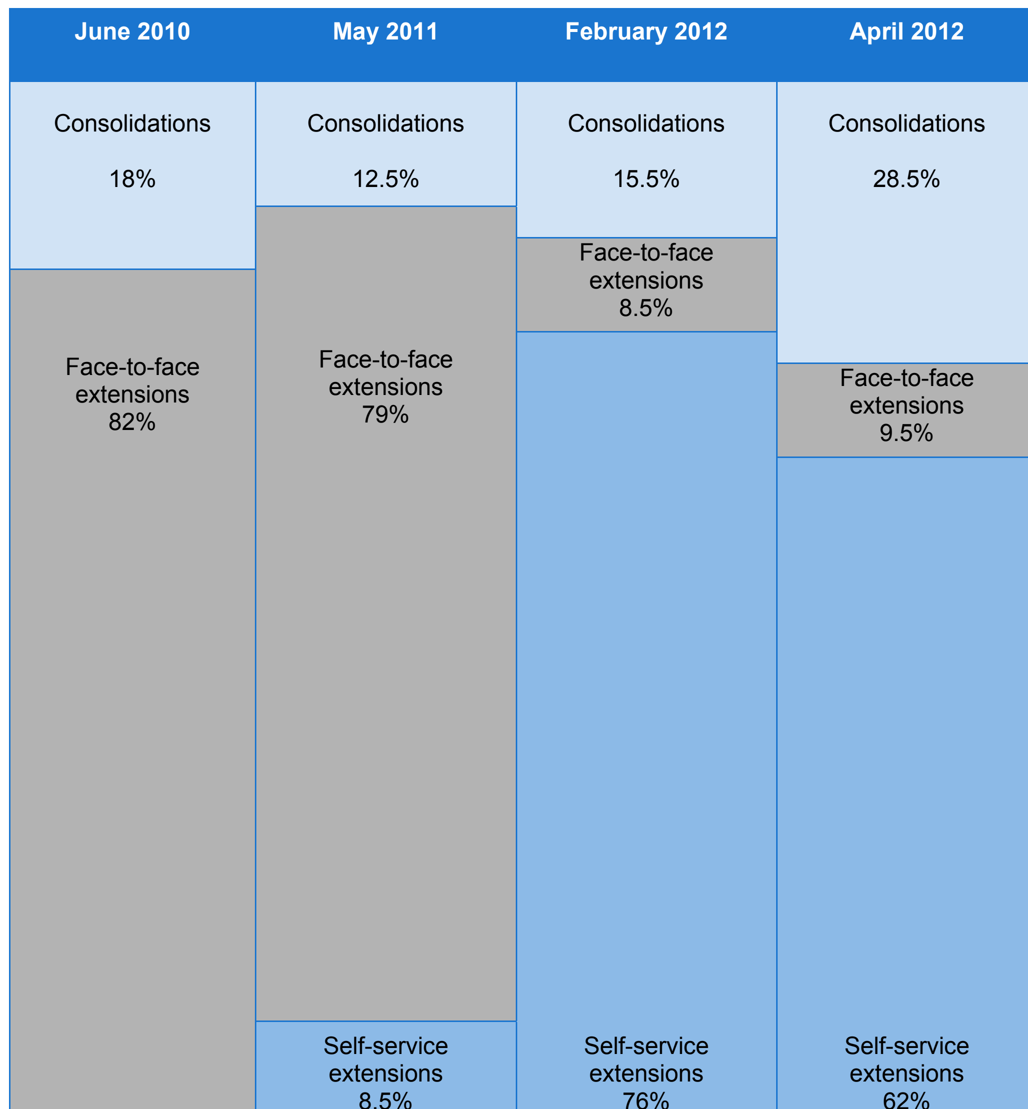
[37] The number of additional consolidations to assist in achieving savings to fund the additional Efficiency Dividend is 67. However, six of these are consolidations of the same face-to-face service (for instance, consolidating two Medicare shopfronts) so do not involve the co-location of services.

[38] As announced by the then Minister for Human Services, The Hon.Chris Bowen in 2009, in an address to the National Press Club, *Service Delivery Reform: Designing a system that works for you*.

Figure 1.2, the anticipated proportions of co-location types has changed significantly over time.

Figure 1.2

Anticipated proportions of co-location types



Source: ANAO analysis of Department of Human Services documentation.

Note: This figure illustrates how the anticipated proportion of different types of co-locations changed over time. For instance, at June 2010 DHS anticipated that, of all the co-locations that would be implemented by 2014, 18 per cent would be consolidations and 82 per cent would be face-to-face extensions. By April 2012, expectations had changed, with 28.5 per cent of all co-locations to be implemented by 2014 anticipated to be consolidations, 9.5 per cent to be face-to-face extensions and 62 per cent to be self-service extensions.

Shift to fewer co-locations by consolidation

1.24 In early 2011, in the lead up to the 2011–12 Budget, there was a shift away from consolidations to service extensions. This occurred for a range of reasons including the difficulties that the cash rebates paid by Medicare posed for consolidated sites (see Case Study 3 below). Handling cash involves a range of security requirements including the building of a strong room, and the purchase of cash dispensing machines (which enable the secure distribution of cash in the open-plan design of new consolidated sites). By contrast, extension co-locations have been implemented on a cashless basis. Where Medicare face-to-face services have been added to a Centrelink shopfront, customers can only receive Medicare rebates by electronic funds transfer (EFT).

Case Study 3
Frankston - cash as a barrier to consolidation

In September 2010, the Frankston Medicare shopfront needed to move from its shopfront in a shopping centre because of an unexpected leasing event. DHS considered a number of options, including consolidation with the nearby Centrelink shopfront or leasing another shopfront in the same shopping centre. Both the Medicare and Centrelink shopfronts were large.

The need for Medicare to move to an open plan office environment if it consolidated with Centrelink, coupled with the use of cash, presented significant security issues. Representatives from DHS, including the Portfolio Agency Security Advisor, visited the Centrelink and Medicare shopfronts and concluded that the existing Centrelink site would present a greater security risk than the alternative shopfront in the shopping centre, especially during Thursday night late trading.

The Centrelink shopfront, to serve as the basis for a consolidated shopfront, would have required the implementation of cash minimisation strategies as well as other measures such as after-hours cash delivery, duress alarms, CCTV installation, the building of a strong room and the employment of a security guard.

It was decided that the alternative shopfront in the shopping centre would be the most appropriate site and no consolidation took place.

Source: ANAO analysis of DHS documents.

1.25 There had also been a small number of cases of negative community feedback in relation to consolidations involving the closure of Medicare shopfronts located in a shopping mall or in the middle of a shopping precinct. Service extension co-locations, by contrast, have not resulted in any community opposition as services are added to an existing shopfront and no closure of shopfronts is involved. As a result of these factors, the 2011–12 Budget, which provided $27.7 million of additional funding to support

the Co-location Program, stated that there would be only around 61 consolidations over the period to the end of 2014[39], representing 12.5 per cent of all co-locations.

Shift from face-to-face to self-service extension co-locations

1.26 Internal DHS documentation indicates that there was a gradual shift in thinking around what should constitute a service extension co-location in the first half of 2011. While there was initially no widespread move away from face-to-face service extensions, DHS documentation indicates that in some circumstances the addition of self-service was considered a more suitable way to achieve co-located services and in a number of cases was considered the only practical way to do so.[40]

1.27 The factors behind the thinking to move away from face-to-face service extensions to self-service extensions included the problems encountered with redeploying staff to co-located sites and the desire to reduce costs by moving customers to self-service arrangements. The problems with redeploying staff included: the 'home' shopfront losing the productivity of the redeployed staff member; and in some cases, redeployed staff not being fully utilised in the co-located site. The move to self-service extension co-locations was also consistent with the broader channel strategy to transition customers to self-service. It was recognised that self-service extensions would deliver co-located services at minimal cost. By mid-2011 DHS anticipated that nearly all future extension co-locations would involve the addition of self-service rather than face-to-face services.

Move back to co-location by consolidation

1.28 Towards the end of 2011 there was some demand from within the Service Zones[41] for more consolidations. This followed the integration of Centrelink and Medicare into DHS, and the integration of leadership structures

---

39 *Portfolio Budget Statements 2011–12* [Internet]. Canberra, 2011. Available from <www.budget.gov.au/2011-12/content/bp2/html/bp2_expense-13.htm> [accessed 4 July 2012].

40 It is noted, however, that as late as May 2011 a ministerial press release announced that 'co-locations will more than double the number of shopfronts where customers can have face-to-face access to Medicare from around 240 today to more than 500 by the end of 2014', indicating that co-location was still anticipated to involve face-to-face services. Media Release, The Hon Tanya Plibersek MP, Minister for Human Services, *Giving Australians better access to services,* 10 May 2011.

41 Before their integration into DHS, Centrelink's and Medicare's service networks were divided into various geographical areas. Following their integration in July 2011, geographical boundaries were modified and are now referred to as 'Service Zones'.

in the Service Zones, resulting in greater visibility of the opportunities available for consolidations. In particular, there were a number of small Medicare shopfronts which were becoming less viable for a range of reasons (see Case Study 4 below). These included declining customer traffic as the alternatives to seeking cash rebates from shopfronts became increasingly utilised (such as claiming the rebate at the doctor's practice or by using online or telephone services).

Case Study 4
Kalgoorlie Consolidation

In the first half of 2011 the future viability of the Kalgoorlie Medicare shopfront was a concern as cash claims were falling and bulk billing rates were close to 50 per cent.

There were four Medicare staff, two full-time and two part-time. Due to staff departures, DHS was flying in staff from Perth to keep the shopfront open.

Service Zone managers saw the benefits of consolidating the Medicare shopfront into the Centrelink shopfront, and this occurred in October 2011.

Source: ANAO analysis of DHS documents.

1.29 The expected proportion of consolidations increased significantly at the beginning of 2012, when expanding the number of consolidations became one of the measures adopted by DHS, with the approval of the then Minister, to achieve the savings necessary to fund the additional Efficiency Dividend announced in the 2011–12 Mid-Year Economic and Fiscal Outlook. DHS planned to achieve savings by way of reduced lease costs following the closure of shopfronts which were consolidated with others. In April 2012, DHS anticipated that co-locations through consolidation would represent 28.5 per cent of all co-locations by the end of 2014.

1.30 In summary, the Co-location Program has evolved significantly over the three years of its operation. The proportion of co-locations by consolidation has varied over time, showing both increases and decreases. There has been a significant shift away from face-to-face extension co-locations to self-service co-locations, reflecting the broader strategy of reducing costs by transitioning customers to self-service.

Progress with co-location

1.31 DHS has committed to extending services in all shopfronts by mid-2014.[42] Table 1.2 shows the actual and forecast progress by type of co-location at the end of each financial year from the commencement of the program in December 2009 to its expected completion in mid-2014.[43] The table indicates that prior to the integration of Centrelink and Medicare into DHS, and the shift to self-service extensions, progress with co-locations was relatively slow—at the end of June 2011 there were 66 co-located shopfronts (19 consolidations and 47 face-to-face extensions). By the end of June 2012 this had accelerated to 294 co-located shopfronts (66 consolidations, 45 face-to-face extensions[44] and 183 self-service extensions). DHS has advised that it is on track to have all shopfronts co-located by mid-2014.

---

[42] Department of Human Services, *Service Delivery Reform,* op. cit, p.8.

[43] Table 1.2 was compiled based on known factors in November 2012.

[44] A small number of face-to-face extensions had subsequently become consolidations.

Table 1.2

Progress (actual and forecast) by type of co-location

Shopfronts	Actual							Forecast [a]			
	Dec 2009	June 2010		June 2011		June 2012		June 2013		June 2014	
		Change	Total	Change	Total	Change	Total	Change	Total	Change	Total
Total shopfronts	552		552		534		487		440 [b]		426
Consolidations	1	-	1	+18	19	+47	66	+42	108	+14	122
Service extensions [c]	14	+6	20	+27	47	+181	228	+82	310	-6	304
Face-to-Face [c]	14	+6	20	+27	47	-2	45	-4	41	-1	40
Self-Service [c]	-	-	-	-	-	+183	183	+86	269	-5	264
Shopfronts remaining to co-locate	537		531		468		193		22 [b]		0

Source: Department of Human Services and ANAO analysis.

Note (a): The table was compiled based on known factors in November 2012. During a financial year, a range of factors will influence DHS' planning of the anticipated timing, number and types of co-locations. Such factors may include unexpected changes in leasing and staffing arrangements, either of which could result in a co-location occurring sooner or later than planned, or a change of co-location type. Thus the forecast data are indicative only.

Note (b): In addition to closures due to consolidations this figure takes into account that, during 2012–13, six shopfronts closed and one new shopfront opened for reasons other than the co-location of Medicare and Centrelink services.

Note (c): Decreases in this row are due to service extensions that later became consolidations.

Co-location of other DHS services

1.32 While the main focus of the Co-location Program has been on co-locating Centrelink and Medicare shopfronts, there was also an intention, as part of SDR, to co-locate Child Support services.[45] The status of other services in the Human Services portfolio—CRS Australia and Australian Hearing—has been less clear.

Child Support Services

1.33 The co-location of child support services started in 2006, prior to the SDR agenda. When the implementation of the Co-location Program began in early 2010, 31 of the 44 child support sites providing face-to-face services were already co-located in Centrelink shopfronts. Until April 2012 progress with co-locating the remaining child support services sites was slow, however, an accelerated implementation was announced as one of the measures adopted by DHS to achieve the savings necessary to fund the additional 2.5 per cent Efficiency Dividend for 2012–13. The measure involved the co-location of the seven remaining child support sites into nearby DHS shopfronts. However, acts of customer aggression in some of these sites resulted in a decision in December 2012 to cease face-to-face services at the sites. While most separated parents manage their child support matters over the phone or online, DHS advised that it is important to continue to provide a face-to-face service option for customers using child support services. The department further advised that to provide face-to-face services in more locations, it is developing a child support face-to-face offer, which will have broader application across DHS' shopfront network, for implementation later in 2013.

CRS Australia

1.34 DHS advised that due to competitive neutrality considerations[46] CRS Australia has not generally been included in the Co-location Program. However, where there were small CRS shopfronts operating with less than four staff, a number of consolidation co-locations with other DHS shopfronts have taken place to help meet occupational health and safety and security requirements.

---

45 Department of Human Services, *Service Delivery Reform*, op. cit, p.8.

46 CRS Australia operates in a competitive market for the provision of rehabilitation services.

Australian Hearing

1.35 Australian Hearing was not included in the Co-location Program until the first quarter of 2012 even though it provides outreach services in a range of locations, including some DHS shopfronts. DHS is currently assessing which of its shopfronts may be able to accommodate Australian Hearing services, including the requirement for sound-testing rooms.

Audit approach

Audit objective, criteria and scope

1.36 The objective of the audit was to assess the effectiveness of DHS' administration of the shopfront co-location of DHS services.

1.37 To address the objective, the audit examined the Co-location Program against the following criteria:

- sound guidelines/criteria have been developed and applied to co-location decisions; and
- DHS effectively monitors, achieves and reports the benefits to customers and cost savings from the shopfront co-location of DHS services and uses this information to improve the co-location processes.

1.38 The audit scope did not include:

- co-locations that occurred prior to the announcement of the SDR agenda in December 2009;
- the privacy issues surrounding customer data associated with co-location and SDR;
- current co-location initiatives involving non-DHS services such as Local Connections to Work and co-location with the Australian Taxation Office; and
- the achievement of savings from the decision to implement additional consolidations to contribute to meeting the increased Efficiency Dividend that applies in 2012–13.

Audit methodology

1.39 The audit was conducted by:

- an examination of files and documentation relating to the assessment and approval of co-location decisions;

- interviews with DHS managers and staff involved in the co-location process both in DHS Canberra and in the service network;
- interviews with DHS managers involved in the co-ordination and governance arrangements for SDR;
- interviews with external stakeholders including peak bodies such as the Council of the Ageing and National Disability Services Limited, local and state government representatives and non-government service providers in locations where services have been co-located;
- visits to a number of co-located sites covering both consolidation and service extension co-locations in a range of urban and regional locations; and
- an examination of data and documentation around complaints, measures of accessibility and savings from changed leasing arrangements and other performance related indicators.

1.40 The audit was conducted in accordance with the ANAO's auditing standards at a cost to the ANAO of approximately $393,000.

Structure of the report

1.41 The remaining chapters in the report are:

- Chapter 2 (Co-location Decision-making Processes)—which examines the criteria used by DHS to assist in making decisions about the selection of shopfronts for consolidation and extension co-locations, and analyses how consistently these criteria were applied to co-location decisions.
- Chapter 3 (Performance Monitoring and Reporting Framework)—which outlines and assesses the performance measurement and reporting framework for the Co-location Program.
- Chapter 4 (Performance Outcomes)—which examines the outcomes of the Co-location Program in terms of customer benefits and financial savings.

2. Co-location Decision-making Processes

This chapter examines the criteria used by DHS to assist in making decisions about the selection of shopfronts for consolidation and extension co-locations. It analyses how consistently these criteria were applied to co-location decisions.

Introduction

2.1 When implementing a program such as the co-location of Centrelink and Medicare shopfronts it is expected that there will be clear and well documented processes for the selection, prioritisation and resultant scheduling of shopfronts to be co-located. Having well defined criteria for the selection of shopfronts assists in prioritising effort and improving prospects for the successful implementation of co-locations.

2.2 DHS internal documentation demonstrates that DHS is aware of the need for co-location assessment criteria to provide a transparent and consistent methodology to guide and coordinate decision making between key areas across DHS. Specifically, internal documentation states that the criteria used by DHS aims to provide a mechanism for assessing individual shopfronts for suitability and feasibility against the two co-location types: consolidation and service extension.

2.3 This chapter examines available DHS documentation to assess the criteria used by DHS in the selection of shopfronts to co-locate and the application of these criteria to individual shopfront decisions.

Appropriateness of the criteria

2.4 Since beginning in 2010, the Co-location Program has continued to evolve. This evolution has resulted in changes to the processes supporting co-location decisions, including the criteria for the selection of shopfronts. Table 2.1 outlines the three key periods of the Co-location Program.

Table 2.1

Three periods of the Co-location Program

Period	Dates	Characteristics
One	March 2010–January 2011	Centrelink, Medicare and DHS are separate agencies. Consolidations expected to be 18 per cent of all co-locations. Minister approves criteria for consolidation and service extension co-locations. All service extension co-locations are additions of face-to-face services via staff redeployment.
Two	January 2011–February 2012	Lessons learned from earlier co-locations lead to the drafting of additional consolidation criteria with a greater emphasis on accessibility. Planned consolidations initially fall to around 13 per cent of all co-locations (because of barriers posed by cash in Medicare and public reactions to some earlier consolidations). Consolidations increase to around 16 per cent of all co-locations after Medicare and Centrelink are integrated into DHS in July 2011 because opportunities for consolidation become more visible and easier to manage. Change from face-to-face service extensions to self-service extensions from mid–2011 onwards increases the rate of progress of co-locations.
Three	February 2012–current	Increase in planned consolidations to 28 per cent of all co-locations as part of DHS' planning to achieve savings necessary to fund the increased Efficiency Dividend (via reduced lease costs). Barriers to consolidations posed by cash are removed as Minister announces phasing out of Medicare cash rebates. Common DHS certified agreement and progress with ICT integration makes consolidations easier. Minister approves strategy to increase community engagement activities prior to announcement of shopfronts for consolidation.

Source: ANAO analysis.

Consolidation criteria

2.5 An analysis of DHS' key decision-making and assessment documentation shows that shopfront assessments for potential consolidation have been based on two types of criteria:

- high-level criteria that outlined the broad principles to be considered in the assessments, with the over-riding principle being that 'the community receives an improved service offer'. These high-level criteria were approved by the Minister in March 2010 and have remained unchanged, although there has been some change in emphasis because of changes in operational criteria (see below); and
- criteria that operationalised the higher-level criteria and provided more specific guidance. These criteria, while never formally labelled or consolidated as 'operational' criteria by DHS, were derived from a wide range of DHS documentation relating to assessments for individual shopfronts and internal briefs. The operational criteria have been progressively expanded and refined by DHS to reflect the evolution of the Co-location Program and the lessons learned from previous co-locations.

2.6 Table 2.2 outlines how the criteria for selecting shopfronts for co-locating by consolidation have changed over time.

Table 2.2

Consolidation criteria

Period	High-level criteria	Operational criteria
One	A property event—a shopfront has an upcoming lease expiry, lease improvement (refurbishment), forced relocation, or new property acquisition. This criterion was the trigger for assessments	Type and date of property event for Medicare and/or Centrelink offices
	Level of demand—the demand for services is sufficient but not excessive for the consolidated shopfront	Services delivered by the Medicare office: • Number of services delivered • Proportion of bulk-billed and patient-claimed services, including proportion of services processed at the counter or electronically • Average number and amount of daily cash claims • Predicted new presence demand Services delivered by the Centrelink office: • Number of services delivered • Predicted new presence demand
	Proximity of shopfronts—there is a short distance between them	Distance between shopfronts (no explicit values were specified)
	Flexibility of accommodation—the consolidated shopfront is able to meet customer traffic levels	Medicare and Centrelink staffing profile: • Number of staff • Role of Medicare staff (face-to-face, back-office and public telephony roles) Compatibility of Centrelink and Medicare offices: • Office size • Opening hours • Number and types of Medicare counters • Whether the Medicare office operates with a full queue system
	Customer experience—the consolidation takes into account customer satisfaction and comfort	• Centrelink office's customer satisfaction rate • Number of Centrelink customer aggression incidents

Period	High-level criteria	Operational criteria
Two	Same as period 1 with an increased focus on accessibility. Specifically, 'accessibility must not deteriorate as a result of the co-location'	Same as period 1 plus: • Additional operational criteria relating to the level of demand, shopfront accessibility and customers' levels of satisfaction: - Population - If a shopfront is located in a shopping mall it is less likely to be a candidate for consolidation - Availability and suitability of parking arrangements and other transport alternatives • Thresholds set for the following criteria - Distance between offices—not more than one kilometre apart - Centrelink and Medicare offices' customer traffic - Medicare office: o Front of house desk and staff numbers o Cash volumes o Electronic claiming rates o Bulk billing rates - Centrelink office: o Staff numbers o Customer satisfaction o Number of customer aggression related incidents
Three	Same as periods 1 and 2 with an increased focus on community consultation	Same as periods 1 and 2 plus assessments considered the results of community engagement activities before the consolidation was confirmed and publicly announced by the Minister

Source: ANAO analysis of DHS documentation.

Assessment of consolidation criteria

2.7 Well designed consolidation criteria can contribute to good decision-making and the delivery of program outcomes where they align with program objectives. There are two objectives of the Co-location Program:

- to improve 'the way people deal with the Australian Government by providing convenient, easy to access, coordinated services from a single point of contact'[47]; and

[47] Department of Human Services, *Service Delivery Reform: Transforming government service delivery* [Internet]. DHS, Canberra, 2011, p.8, available from <www.humanservices.gov.au/spw/corporate/about-us/resources/service-delivery-reform-overview.pdf> [accessed 4 July 2012].

- to achieve lease savings when two shopfronts are consolidated into one.

2.8 The consolidation criteria were assessed against good practice characteristics for site or project selection (specifically whether they are outcomes focused and aligned with the program objectives, comprehensive, clear, objectively assessable and internally consistent).[48] Table 2.3 indicates that the criteria for consolidations mostly met these characteristics, including that they were generally consistent with the objectives of the collocation initiative.

Table 2.3

Assessment of the consolidation criteria

Characteristic	Result	Comment
Outcomes focused and aligned with the policy objective	✓	The high-level and operational criteria were generally linked to the co-location initiative's objectives. The high level criteria did not fully reflect the importance of accessibility and convenience, and did not include stakeholder views. However, over time the operational criteria were expanded and refined to incorporate these key issues and the lessons learned from previous co-locations. The objective of lease savings through consolidation was reflected in the high-level criteria.
Comprehensive	✓	The high-level criteria did not explicitly include customer convenience, accessibility and community engagement; however, as the Co-location Program progressed, these were included in operational criteria.
Clear	✓✓	The high-level criteria were broad and flexible enough that they allowed more detailed operational criteria to be defined. It was useful to have criteria that were flexible and able to accommodate the evolution of the program.
Objectively assessable	✓✓	Due to their broad nature, the high-level criteria were not amenable to assessment in an objective manner. The operational criteria, however, were specific and measurable, and so could be objectively assessed.
Internally consistent	✓✓	The criteria were internally consistent.

Source: ANAO analysis.

✓✓ Criterion met characteristic.

✓ Criterion partly met characteristic.

[48] The criteria were adapted by the ANAO from the grants administration framework outlined in the ANAO Better Practice Guide *Implementing Better Practice Grants Administration, 2010*. While the Co-location Program is not a grants administration program, it involves similar processes for selection and prioritisation.

Service extension co-location criteria

2.9 Similar to the approach taken for co-locations by consolidation, DHS developed a set of high-level criteria for service extension co-locations that were approved by the Minister in March 2010. These included the same over-riding criteria that the co-location 'must result in an improvement in service offer' and other criteria relating to the capacity of a shopfront to accommodate additional services, whether staff could be redeployed to the shopfront if required, the demand for additional services and the distance between shopfront sites.

2.10 DHS advised that it did not systematically apply the high-level criteria approved in March 2010 to extension co-locations because much of the focus initially was on co-locating by consolidation. Also, due to the fact that service extension co-locations are not as clearly dependent on lease events, the scheduling of these co-locations was more discretionary compared to consolidations. The assessments undertaken by DHS to select the shopfronts for service extension co-locations were largely undocumented. The department advised that the extension service offer was generic and the high level intent was that all sites would co-locate. If a site did not meet the criteria for a consolidation, a service extension would be implemented.

2.11 In January 2011, DHS engaged an external consultant to design an implementation strategy for the roll-out of service extensions. To provide a robust platform and rationale for prioritising co-locations, the consultant developed a schedule based on the following criteria (in priority order):

- Necessity—impending lease event such as a scheduled refurbishment or forced relocation. For instance, it would be a waste of resources to co-locate a shopfront if there was the potential for an impending move, whereas it would be cost effective to schedule extension co-locations to coincide with refurbishment schedules;
- Priority—pilot of new programs and other portfolio requirements. For instance, shopfronts trialling Case-coordination and Local Connections to Work initiatives were given priority;
- Equity—increasing accessibility of services in remote and regional areas. The roll-out of service extensions was weighted to provide services in locations where they were not available or where access was limited; and

- Opportunity—flexibility to accommodate property related opportunities. For instance, if a larger alternate property suitable to allow a Medicare office to accommodate Centrelink facilities became available it may be advantageous to relocate ahead of schedule.

2.12 DHS advised that the consultant's report was formally accepted by the Portfolio Co-location Steering Committee.[49] The consultant's methodology appeared to be based on the assumption that service extension would mainly involve adding face-to-face services to an existing office (either by redeploying or cross-training staff). However, from July 2011, DHS shifted the focus of service extension to the provision of self-service facilities rather than face-to-face services, due to the difficulties associated with redeploying and cross training staff. DHS advised that it had been able to generally use the approach that was developed by the consultant in these new circumstances as the criteria were still broadly applicable.

2.13 The criteria that were used in practice from March 2011 onwards (those defined by the consultant) are sound, as they align with the program objectives, are comprehensive, clear, objectively assessable and internally consistent. They were also sufficiently adaptable to be able to cope with the shift from face-to-face to self-service service extensions.

Application of the criteria

2.14 To assess the application of the criteria for the selection of shopfronts, DHS documentation on the decision-making processes for individual shopfronts were examined. Only consolidated shopfronts were included in the assessment, as there was insufficient documentation for an analysis of decisions about service extension co-locations. While consolidations were supported by some documentation, this was inconsistently maintained and only around 45 per cent of all consolidation decisions had sufficient documentation.[50] A sample of 25 shopfronts (23 per cent of all shopfronts consolidated from January 2010 to December 2012) was chosen from those

[49] The Portfolio Co-location Steering Committee, comprising senior managers from DHS, Centrelink and Medicare, provided advice on strategic decision-making on co-location issues, and input to other relevant committees in the portfolio, from late 2010 until the merger of the three agencies in July 2011.

[50] 'Sufficient documentation' was defined as: documentation in any of a number of forms, which taken together, provided enough evidence that the shopfront had been assessed against the criteria.

cases where there was sufficient documentation around decisions to analyse the application of the consolidation criteria.[51]

2.15 In period one, the majority of the operational criteria identified in Table 2.2 were assessed by DHS in the shopfronts sampled. Criteria such as staffing levels and customer traffic were considered in every case but shopfront size was noted in just over 75 per cent of the sampled shopfronts. In none of the shopfronts sampled were the criteria of population, parking and public transport availability considered. There was also no evidence of consideration of community views and engagement. Case Study 5 below, however, illustrates the influence that community feedback can have on a potential co-location.

Case Study 5
Dubbo Co-location

In June 2009, Dubbo Centrelink began a tender process to procure new premises. Its existing building was in need of refurbishment and the floor plan did not fit open plan guidelines. Early in 2010, it was proposed that Dubbo Medicare should consolidate into the new Centrelink building and a pre-commitment lease on a new development was signed off by the Minister in May 2010.

The local community expressed concerns about the new location after its announcement as it was close to a church and a primary school. A key concern related to access to parking. Parking around the new shopfront was limited and could become a problem with DHS customers, church-goers and parents of the school children competing for car parks. Due to this community feedback, at the start of 2011, it was decided to maintain the existing Medicare shopfront in the main shopping district of Dubbo so that Medicare customers did not add to the parking pressures.

DHS also mitigated the community's concerns about Centrelink moving to the new shopfront by expanding the proposed car park. Community engagement and agreement was achieved through discussions with the developer, the local Council, the primary school Principal, the Parents and Citizens group and the church pastor.

Centrelink moved to the new shopfront in September 2011 and the community has become more comfortable with the location. The new shopfront was designed to be spacious enough for a consolidation. Following the phasing out of Medicare cash rebates, customer traffic halved, and the Dubbo Medicare and Centrelink shopfronts were consolidated in December 2012.

Source: ANAO analysis of DHS internal documents.

[51] The sample of shopfronts was chosen to fit within certain parameters: it included a spread of shopfronts co-located between and within the three periods of the evolution of the Co-location Program; it included shopfronts visited in the field work phase of the audit if possible; it included some shopfronts where the type of co-location was reconsidered (for instance, the planned type of co-location changed from consolidation to service extension or vice versa); and the shopfronts had to be assessed against the consolidation co-location criteria at some point in time, even if they did not eventually become consolidations. Five of the 25 sampled shopfronts became service extensions instead of consolidations.

2.16 In period two, while most of the operational criteria were applied to most of the shopfronts in the sample, there was still some inconsistency in their application. For instance, the population of the area serviced by the proposed consolidated shopfront and the forecast need for face-to-face services were not considered for around 20 per cent of sampled shopfronts. Evidence of consideration of community needs and engagement was not available in one third of the shopfronts sampled and public transport availability was noted in just over three quarters of shopfronts.

2.17 In period three, some inconsistency was again evident. For instance, population and parking availability were only considered in around 75 per cent of the shopfronts sampled. The availability of public transport was included in shopfront analysis in less than half of cases, as was evidence of consideration of community needs and engagement.

2.18 Inconsistency in applying decision-making criteria can create a risk that decisions are based on an incomplete assessment of relevant considerations and are therefore not fully informed.

Balancing the criteria

2.19 The over-riding principle for co-locations is for the customer to receive an improved service offer. DHS advised that this criterion was not formally defined, but that the aim was to balance the other shopfront assessment criteria in order to create an improved service offer overall. For instance, a negative assessment against one criterion could be outweighed by favourable assessments for other criteria. Additionally, there was consideration of service improvements which may result in inconvenience in the short term, but which would yield longer term benefits.

2.20 Lease events were the major trigger for considering a shopfront's suitability for co-location by consolidation and this was generally the first criterion to be considered. However, little evidence was found as to how other criteria were prioritised to make a judgement on whether the proposed co-location would result in an improved service offer.

Conclusion

2.21 Overall, the criteria that were used for both consolidation and extension co-locations were soundly based. While the consolidation criteria approved by the Minister in 2010 were at a high-level, their design enabled operational criteria to be put in place, and these operational criteria evolved as the circumstances surrounding the Co-location Program changed.

2.22 The documentation available on the department's assessment of individual shopfronts against the criteria indicates a degree of inconsistency in the criteria's application. Future decisions on shopfront locations would be improved by better record keeping practices and the more consistent application of the established criteria. DHS has advised that the Co-location team has developed a high level process map to promote decision-making based on the systematic application of criteria, and is reviewing record keeping practices to ensure that records are kept and maintained on how decisions are made.

3. Performance Monitoring and Reporting Framework

This chapter outlines and assesses the performance measurement and reporting framework for the Co-location Program.

Introduction

3.1 The Parliament's and the public's consideration of a program's performance, especially in relation to its outcomes and cost effectiveness, rely heavily on reliable and appropriate performance information. The OECD has observed that:

> How government activities are measured matters. … Citizens are entitled to understand how government works and how public revenues are used.[52]

3.2 Program performance measurement and reporting, however, is not just important from an accountability perspective. It is also important for an agency's effective management—it allows managers to provide sound advice on the appropriateness, success, shortcomings and future directions of programs. This information also allows for informed decisions to be made on the allocation and use of program resources.

3.3 In this regard, it is important that agencies have in place performance frameworks that measure progress towards meeting relevant objectives. Performance measures should cover both the outputs being delivered and the outcomes being achieved, as they relate to the overall objective(s).

Performance measures

3.4 At the launch of SDR in December 2009, the then Minister established a performance measure and targets for the Co-location Program:

> By the end of 2010, there will be at least another 20 co-located offices around Australia and, by 2012, around 40 offices will house Medicare, Centrelink and CSA under one roof.[53]

---

[52] Organisation for Economic Cooperation and Development, *Measuring Government Activity*, 2009.

[53] The Hon Chris Bowen MP, Minister for Human Services, Address to the National Press Club, *Service Delivery Reform: Designing a system that works for you*, Canberra, 16 December 2009, p. 12, [Internet]. Available from <http://www.chrisbowen.net/media-centre/speeches.do?newsId=2809> [accessed 4 July 2012].

3.5 The total number of co-locations remained the single performance measure until mid-2011. This measure was not disaggregated by consolidation or extensions co-locations. In mid-2011 co-location became one of a number of programs funded through a SDR-related package of measures announced in the 2011–12 Budget.[54] As part of the performance framework put in place for the package, a number of performance measures and targets were established for the Co-location Program. The main performance measures established by DHS are listed in Table 3.1.

---

[54] The SDR measures in the 2011–12 Budget were grouped into four categories:

- 'improving access' included extending services through Medicare and Centrelink one-stop-shops, claiming Medicare benefits online, transition to a single web and telephone service, and extension of rural mobile services and outreach support for the homeless;
- 'improving services' included involving users and the community in designing improved service delivery, and increased support for people needing assistance;
- 'improving portfolio business' included improving online services, simplifying and automating online services, and integrating business operation and workflow management systems; and
- 'integrating the portfolio' included corporate integration and information and communications technology integration.

Table 3.1

Performance measures for the Co-location Program

Performance measures	Targets			
	2011–12	2012–13	2013–14	2014–15
Number of service extension shopfronts	123	120	107	
Number of service extension shopfronts delivered within confirmed timeframe	123	120	NYA	
Number of consolidated shopfronts	15	12	14	
Number of consolidated shopfronts signed off by Minister	15	12	NYA	
Percentage of customers satisfied with the accessibility of on-site services	66	68	NYA	
Average number of customer transactions completed per on-site visit	NYA	NYA	NYA	
Number of staff trained in cross-portfolio services and procedures	NYA	NYA	NYA	
Number of staff working out of co-located shopfronts	NYA	NYA	NYA	
Percentage increase in staff satisfaction in co-located shopfronts	NYA	NYA	NYA	
Savings	$2.3m	$3.2m	$4.4m	$4.1m

Source: DHS documentation and ANAO analysis.

Note: NYA – not yet available.

3.7 The new suite of performance measures was an improvement over the single measure applying until mid-2011, and has a number of positive features. The new measures are clearly linked to the objectives of the Co-location Program[55] and are thus relevant. They are also specific and expressed in clear and concise terms. Where DHS has developed targets (Table 3.1 also shows targets), the performance measures are measurable within a particular timeframe. Where targets are not yet available, DHS has judged that the

[55] DHS has stated that the objective of the co-location of services is to improve 'the way people deal with the Australian Government by providing convenient, easy to access, coordinated services from a single point of contact'. Another objective of co-location by consolidation is to achieve savings from the reduction in lease costs associated with the closure of shopfronts.

outcome will only be apparent after there has been sufficient time for the activity to have occurred or to have had an effect. DHS has advised that work is currently being undertaken to develop targets for these performance measures, including the means of gathering relevant data.

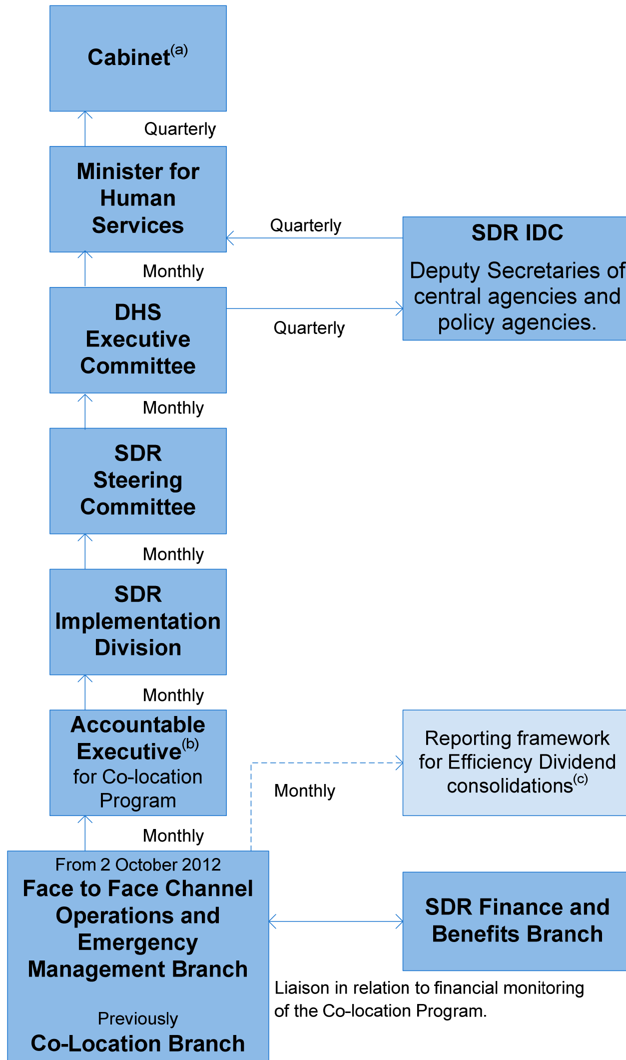
Performance monitoring and reporting

3.8 A committee (comprising executives from the then separate portfolio agencies) had been formed after the announcement of the SDR agenda in 2009 to monitor the progress of the Co-location Program along with other SDR-related initiatives. This committee developed the SDR package of measures which was considered for funding in the 2011–12 Budget. Following the SDR budget announcement in May 2011 and the creation of the merged DHS in July 2011, a revised framework for SDR was developed to monitor and report on the implementation of the SDR 2011-12 Budget measures, including the Co-location program.

3.9 The monitoring and reporting arrangements from July 2011 are outlined in Figure 3.1. The main changes to the earlier framework were the addition of the SDR interdepartmental committee (IDC), and processes for reporting to Cabinet. These additional layers of reporting focus on SDR projects in aggregate, rather than the Co-location Program specifically.

Figure 3.1

Framework for monitoring and reporting on SDR measures, including Co-location Program



Source: DHS.

Notes:

(a) The reporting to Cabinet is additional to the routine reporting to the Cabinet Implementation Unit of the Department of the Prime Minister and Cabinet.

(b) Within DHS, each of the SDR projects has been assigned to an Accountable Executive. The Accountable Executive for the Co-Location Program is the SES Band 3 Deputy Secretary for Service Delivery Operations, who is responsible for high-level oversight of the Program.

(c) The reporting framework for Efficiency Dividend consolidations is discussed at paragraphs 3.11 to 3.13.

3.10 As outlined in Figure 3.1, the monitoring and reporting framework for SDR programs is centralised, and is coordinated by the SDR Implementation Division. The focus of monitoring and reporting is on the performance indicators established for each SDR project. The framework in Figure 3.1 relates to the non-public reporting and monitoring on co-location: within DHS; to stakeholder agencies in the public service; and to the Minister and the Government. The main purpose of this reporting is to support the management function and to be accountable to the Government for the funding received in the 2011–12 Budget.

Effect of Efficiency Dividend consolidations on performance framework

3.11 Part of DHS' response to the additional 2.5 per cent Efficiency Dividend which took effect in 2012–13 was to implement additional consolidations.[56] A separate framework was established to monitor performance measures and targets for Efficiency Dividend consolidations; that is, the number of consolidations[57] and the associated savings.[58]

3.12 In this separate monitoring framework, the Face to Face Channel Operations and Emergency Management Branch (formerly the Co-location Branch) perform the same functions as outlined in Figure 3.1. However, reporting is not to the SDR Steering Committee, but to a MYEFO Service Delivery Reference Group that oversees the measurement, monitoring and reporting of the numbers of, and savings from, the Efficiency Dividend consolidations. This reporting is not public, and is focused on supporting the management function.

3.13 For the other performance measures outlined in Table 3.1 (that is those measures not relating to the number of consolidations or savings) the performance framework described in Figure 3.1 is also the relevant reporting and monitoring framework for the additional Efficiency Dividend consolidations. The performance measures, such as 'the average number of

[56] The additional Efficiency Dividend was announced in the Mid-Year Economic and Fiscal Outlook (MYEFO) statement in November 2011. The Efficiency Dividend is an annual reduction in Australian Public Service agencies' departmental funding. It was introduced in the 1987–88 Budget and has generally been set between 1 per cent and 1.5 per cent annually. In two years (2008–09 and 2012–13) an additional 2.5 per cent reduction has been imposed.

[57] The number of Efficiency Dividend consolidations is 67. However, six are consolidations of the same face-to-face service (for instance, consolidating two Medicare shopfronts) and so are not co-locations; the remaining 61 consolidations are co-locations of Medicare and Centrelink services.

[58] The savings target for Efficiency Dividend consolidations is $2.743 million in 2012-13.

customer transactions completed per on-site visit' and 'the per cent of customers who are satisfied with the accessibility of on-site services' will be measured for all co-locations, including the additional consolidations implemented to fund some of savings required for the increased Efficiency Dividend.

Public reporting on the Co-location Program

3.14 The main public reporting on the outcomes of the Co-location Program is done through annual reports. Specifically, the 2011–12 Annual Report shows the following:

- the total number of co-located shopfronts—'294 service centres offer co-located Medicare and Centrelink services'[59];
- the number of additional co-located shopfronts during the year—'during 2011–12 the department created 228 additional one-stop shops where Medicare and Centrelink are available under one roof'[60]; and
- the number of service centres where Medicare or Centrelink services were available compared to the number at the start of SDR—'at 30 June 2012 Medicare services were available in 381 service centres, compared with 240 service centres at the beginning of 2010. As well, Centrelink services were available in 427 service centres, compared with 313 service centres at the beginning of 2010'.[61]

3.15 None of the indicators used in annual reports disaggregate the information by consolidation or extension co-locations.

Assessment of the performance measurement and reporting framework

3.16 DHS' monitoring and reporting framework for the co-location program has evolved to reflect the changing circumstances of the program. The two separate frameworks for non-public reporting that have operated since the additional Efficiency Dividend consolidations, while administratively cumbersome for the Branch implementing the program, have meant that the performance measures for the co-location program have kept up to date with

59 Department of Human Services (2012), *Annual Report 2011–12*, p. 66.

60 ibid. p. 120.

61 ibid.

changing circumstances. Overall, the performance measures are relevant, objective, clear and measurable.

3.17 The performance measurement and reporting framework established for the SDR package of measures funded in the 2011–12 Budget has been assessed favourably in recent review processes. In June 2012, as part of a Gateway Program Review of SDR required by the Department of Finance and Deregulation[62], DHS attained the second-highest score on a five point scale. The Review Team observed that:

> The project management documentation is exemplary and of a standard rarely seen in the experience of the Review Team; it shows all the signs of being well utilised and 'alive'.[63]
>
> The planned outcomes are achievable with continued senior management involvement and attention. There are good governance arrangements to deal with scope changes.[64]

3.18 DHS also achieved good results in a P3M3 assessment[65] conducted in September 2012 on behalf of the Department of Finance and Deregulation.[66] The P3M3 assessment was not a review limited to the SDR or the co-location program, but covered all ICT-enabled change being undertaken by DHS. However, a number of SDR projects are ICT-related or ICT-dependent, including the Co-Location Program. It is therefore relevant that the P3M3 assessment found that 'the benefits management and realisation process is well established across all DHS change initiatives'.[67]

---

[62] The Gateway Review Process (Gateway) was introduced to strengthen the oversight and governance of major projects/programs and assist agencies to deliver initiatives in accordance with stated objectives. Gateway involves short, intensive reviews at critical points in a project/program's lifecycle by a team of reviewers not associated with the activity. Sourced from the public or private sectors, reviewers are selected for their expertise in relation to a particular review, and not to represent their agency. The SDR review team comprised Mr David Goble (team Leader), Mr John Growder, Mr Peter Hamburger, and Ms Rebecca Skinner.

[63] Department of Finance and Deregulation, *Gateway Program Review Report for Department of Human Services Service Delivery Reform Program*, June 2012, p. 4.

[64] Ibid, p. 8.

[65] Owned by the UK Cabinet Office, the Portfolio, Programme and Project Management Maturity Model (P3M3®), is a globally recognised methodology for assessing organisational capability maturity.

[66] The Australian Government Information Management Office, a part of the Department of Finance and Deregulation, advises the Australian Government and agencies on ICT investment management, project delivery, and the implementation of ICT policies. The Australian Government introduced the Agency Capability Initiative to improve agencies' organisational capability to commission, manage and realise benefits from ICT-enabled investments. Agencies are using P3M3 as the common methodology for assessing their organisational capability.

[67] Tanner James Management Consultants, *P3M3 Assessment Report Department of Human Services,* September 2012, p. 5.

Conclusion

3.19 The performance measurement and reporting framework for the Co-location Program has established appropriate performance measures which are relevant, specific and measureable. The framework has evolved to reflect the changing circumstances that have affected the program.

4. Performance Outcomes

This chapter examines the outcomes of the Co-location Program in terms of customer benefits and financial savings.

Introduction

4.1 A key objective of the co-location of services is to improve service delivery for DHS' customers. DHS has stated consistently over the life of the Co-location Program, including in its most recent annual report, that the objective of the co-location of shopfronts is to improve 'the way people deal with the Australian Government by providing convenient, easy to access, coordinated services from a single point of contact'.[68] This indicates that the key benefits to customers of co-location are:

- convenient services;
- easy to access services; and
- coordinated services.

4.2 Another objective of the Co-location Program is to achieve savings from co-locating by consolidation. Outcomes for the Co-location Program are analysed below against three objectives: convenient and accessible services[69]; coordinated services; and savings.

Convenient and accessible services

4.3 The main contribution made by co-located shopfronts to customer convenience and service accessibility is by delivering multiple services in the one location, that is, through a one stop shop arrangement. Co-location is particularly valuable to customers if the complementarity between the services provided in the same location is high.[70]

---

[68] Centrelink (2011) *Annual Report 2010–11*, p. 32, Department of Human Services, *Service Delivery Reform*, op. cit., p. 8, and Department of Human Services (2012), *Annual Report 2011–12*, p. 120.

[69] The Macquarie Dictionary indicates that accessibility is an aspect of convenience. The 4th Edition defines convenient as 'at hand, easily accessible; well suited, with respect to facility or ease of use'.

[70] High complementarity occurs if customers are likely to use multiple services in the one visit, for instance a shop selling both food and drinks. Low complementarity occurs if customers are unlikely to use multiple services in the one visit, for instance a shop selling food and plumbing equipment.

Consolidations

4.4 The majority of consolidations involve the closure of a Medicare shopfront and the movement of staff and services into a nearby shopfront offering Centrelink services. For customers using the Centrelink services this is a clear benefit. They are already familiar with the location of the co-located shopfront and, if they have Medicare transactions, can complete them in the same location that they access Centrelink services. For instance, if they change their address, bank account details, suffer a death in the family, become separated or divorced or have a new baby they are likely to have transactions involving both Centrelink and Medicare. In such circumstances the degree of complementarity is high.

4.5 Several community stakeholders and shopfront staff and managers also emphasised that for vulnerable Centrelink customers (such as homeless customers and those with a mental illness) having face-to-face Centrelink and Medicare services under the one roof is particularly valuable. A common circumstance where these arrangements add value is when a customer needs proof-of-identity documents for a Centrelink benefit application and they have lost their Medicare card (which is accepted for proof-of-identity purposes). If Medicare face-to-face services are available they can get a temporary replacement card while they wait and then complete their Centrelink transactions. In the past many of these customers have had to make multiple visits to finalise their application, or they have not returned to the shopfront and have not received benefits for which they may have been eligible.

4.6 For customers using Medicare services the convenience and accessibility benefits of consolidated co-located sites are more mixed, at least in the short-term and can require some adjustment by local communities. In some cases, the consolidated shopfront's location is perceived by Medicare customers to be similarly or equally convenient and accessible compared to the previous Medicare shopfront (that is, the consolidated shopfront is close to other shops, doctor's surgeries, pharmacies, has ample parking and is accessible by public transport). A stakeholder representing people with a disability interviewed by the ANAO was positive about consolidations as the accessibility of Centrelink shopfronts for people with disabilities is generally better than Medicare shopfronts, particularly those located in shopping malls. In addition, Medicare customers with specific needs and vulnerabilities have better access in co-located shopfronts to support services, such as the interpreters and social workers that were previously only available in Centrelink shopfronts.

4.7 In other cases some customers using Medicare services, particularly aged customers, have found the move challenging. Issues that were raised include: lack of parking; greater distance from public transport and other retail shops (particularly if moving out of a shopping mall); longer wait times; feeling intimidated by some of the customers using Centrelink services; having trouble hearing if their name or ticket is called because of the open plan design; and confusing queuing systems. This is particularly the case if the Medicare customer has not used Centrelink services in the past, because for these customers the degree of complementarity of Medicare and Centrelink services is low.

4.8 Staff and stakeholders reported that the dissatisfaction of some of these customers has abated over time, as customers became familiar with the new arrangements. In addition, there are alternative means for Medicare customers to complete their Medicare business without the need to travel to a shopfront. These include 12 Medicare transactions that can be completed online, one of which is a Medicare rebate claim. A rebate can be claimed online for 25 different item numbers. There is also a growing number of transactions processed at medical practices, bulk-billing and phone services. As Figure 1.1 in Chapter 1 indicates, the number of over-the-counter patient Medicare transactions has been on a downward trend in recent years due to these alternatives. This trend accelerated significantly with the cessation of Medicare cash refunds in 2012.

Extension co-locations

4.9 As extension co-locations do not involve moving or closing shopfronts, the increase in convenience and accessibility from the addition of face-to-face or self-service arrangements to existing shopfronts is more straightforward—customers can access more services in more locations.

Face-to-face extensions

4.10 In the 27 extensions involving the addition of Medicare face-to-face services to Centrelink shopfronts, the benefits to customers are similar to those related to consolidations. For the 13 extensions involving the addition of Centrelink face-to-face services to Medicare shopfronts, often providing Centrelink services for carers and seniors only, the benefits are also comparable to consolidations.

Self-service extensions

4.11 The majority of co-locations are self-service extensions (anticipated to be 62 per cent of all co-locations by 2014). Staff who are able to encourage and assist customers to use online DHS services contribute significantly to the increased accessibility and convenience offered by the addition of self-service facilities in DHS shopfronts. They also reinforce DHS' channel strategy to shift customers to online services if appropriate.

4.12 In order to be counted by DHS as an extension co-location for the purpose of performance reporting, staff are required to have received training on the self-service transactions available for all DHS services and on how to assist customers to use the self-service facilities. The department provides online training modules to support staff assisting customers with online services. These packages were available online in all shopfronts from the end of August 2011. Prior to this, training and support for extension co-locations was via the relevant Service Zone and included 'side by side' on the job training, class room training and self-paced learning.

4.13 DHS advised that staff participation in the required training is monitored by the Co-location Team in the Face to Face Channel Operations and Emergency Management Branch. The team checks with the shopfront manager that staff have completed the training before the shopfront is counted as being co-located. However, in some self-service extensions examined during this audit the staff had not undertaken the training to assist customers to use self-service transactions for the range of DHS services.

4.14 The reasons for the uneven participation in training include staff turnover and a lack of time to complete training due to customer service pressures. Training gaps highlight the benefit of more effectively monitoring the delivery of training intended to improve organisational performance. In at least one self-service extension co-location, the lack of participation in training contributed to the shopfront manager and staff not being aware that the shopfront was expected to be operating as a co-located shopfront, putting at risk the effectiveness of the initiative.

Recommendation No.1

4.15 To improve services for customers in self-service extension co-located shopfronts, the ANAO recommends that DHS monitors the uptake by relevant staff of training intended to assist customers to access the full range of DHS online services and transactions.

DHS' response:

4.16 *Agreed*

Performance measurement of convenient and accessible services

4.17 Assessing the effect of co-locations on convenience and accessibility occurs at both the program level as well as the individual shopfront level in the case of a co-location by consolidation.

Program level performance framework

4.18 The SDR performance measures for the Co-location Program are set out in Chapter 3. Table 4.1 sets out the results for the measures relating to convenience and accessibility of services to customers in 2011–12.

Table 4.1

SDR Performance measures relating to convenient and accessible services

Customer Benefit	Performance Measures	2011–12	
		Target	Actual
Convenient and accessible services	Number of service extension shopfronts	123	181
	Number of consolidated shopfronts	15	22
	Percentage of customers who are satisfied with the accessibility of on-site services	66	78

Source: DHS documentation and ANAO analysis.

4.19 Table 4.1 indicates that DHS has exceeded the targets set for the performance measures that relate to convenient and accessible services in 2011–12. In particular, the positive result for the percentage of customers who were satisfied with the accessibility of on-site services indicates that the majority of customers find the co-location of services convenient and easy to

access. This result was obtained from a random survey undertaken in 2012, which asked customers who had used a DHS one stop shop in the past 12 months[71]: 'thinking more about the one stop shop service, to what extent do you agree that the one stop shop service made it more convenient to access Centrelink, Medicare and Child Support Services?' Seventy eight per cent of customers agreed while four per cent disagreed and the remainder neither agreed nor disagreed.[72]

Service centre level framework

4.20 At the service centre level there is a range of performance information used by DHS Canberra and shopfront managers to assess the effect of a consolidation. After each consolidation a post-implementation review is conducted by the Face to Face Channel Operations and Emergency Management Branch (previously the Co-location Branch). These reviews are based on interviews with the Medicare and Centrelink shopfront managers. The reviews assess customer and staff reactions to the co-location and identify any issues that arose, for instance, problems with communications or ICT. Lessons learned from each consolidation inform subsequent consolidations and guidance material.

4.21 In June 2011, the findings from 17 post-implementation reviews were summarised in a Project Post-Implementation Review, which made a number of recommendations for improving consolidation processes. The recommendations were reflected in a range of guidance material released to staff, including the *Manager's Guide to Co-location—twelve week implementation*. Regional managers interviewed during fieldwork for the audit commented that later consolidations were generally significantly smoother than earlier ones, indicating that the lessons learned and good practice from earlier consolidations were useful and had been adopted.

4.22 Service centre and regional managers used a range of performance information to assess the effect on customers of consolidations. Many managers spent time in waiting areas listening to customers' reactions in the weeks immediately after consolidation. They also monitored

---

71 The random sample of 243 was drawn from any person who had visited any type of co-located shopfront (consolidation, face-to-face extension or self-service extension) regardless of whether they had accessed multiple services at that site.

72 The margin of error at the 95 per cent confidence interval for the estimate of 78 per cent is +/-5.1 per cent. This means that there is 95 per cent confidence that the actual population level of agreement that the one stop shop service made it more convenient to access Centrelink, Medicare and Child Support services does not deviate from 78 per cent by more than plus or minus 5.1 per cent.

complaints/comments made directly to staff. Wait times were also monitored, particularly for customers using Medicare services (as these were the customers usually most affected by consolidations).

4.23 Managers reported that they had sufficient information to accurately assess the effect of the consolidation and take ameliorating action if required. Instances of such action included adjusting the internal signage or lay-out of the shopfront to better direct customer traffic, and rostering on an additional Customer Liaison Officer to meet and guide customers as they entered the shopfront.

4.24 Waiting time data for Medicare transactions is only available for the 24 shopfronts which had ticketing machines both before and after consolidation (these were generally larger shopfronts). Table 4.2 presents average wait times for Medicare transactions in these shopfronts. It shows that the average wait times increased by just over a minute one month after consolidation and remained at that higher level six months later. However, despite this increase, the average wait times reported by DHS remained significantly below the performance target for serving customers using Medicare services, that is, less than 10 minutes.[73]

Table 4.2

Wait times for Medicare transactions before and after co-location

	6 months before	1 month after	2 months after	6 months after [(a)]
Average wait times in minutes and seconds	4:47	5:56	5:52	5:56

Source: ANAO analysis of data supplied by DHS.

Note (a): Based on less than six months of data (minimum four months of data) for those shopfronts co-locating after May 2012.

Coordinated services

4.25 The majority of DHS staff interviewed during fieldwork, both in shopfronts and DHS Canberra, recognised that one of the longer term goals of the Co-location Program was to create an integrated workforce that could offer customers the full range of DHS services. Workforce integration would give customers the benefit of seamless service delivery across the range of DHS

[73] Medicare Australia, *Annual Report 2010–11*, p. 106

transactions without separate queues for Medicare or Centrelink services or a distinction made between staff delivering Medicare or Centrelink services. Staff recognised that such integration would also provide more opportunities for their own career progression, particularly former Medicare staff following the reduction in customer visits resulting from cashless processing and alternative access arrangements such as the internet. Managers recognised the benefits of having more flexibility in organising working arrangements and in staff deployment.

Progress with coordinating services

4.26 Early attempts to develop coordinated services in 2010 were unsuccessful for a range of reasons. These included the difficulties of implementing cross-portfolio training for staff when Medicare and Centrelink were separate organisations, workplace relations issues and incompatible ICT systems. Over time, however, as some of these barriers were reduced or removed some consolidated shopfronts began to develop new approaches to coordinated service delivery.

4.27 A DHS review of coordination within the service network was undertaken in July 2012. This review was part of the development of a 2012 trial to test a set of integrated business processes for use in all consolidated shopfronts. The review assessed the state of integration in existing consolidated co-located shopfronts prior to the start of the trial. A sample of 20 consolidated shopfronts was chosen and staff were surveyed on the current degree of coordination, and whether they agreed with the need for a standard integrated service offer. The review found that:

- former Centrelink staff were offering some Medicare services to customers and vice versa in 58 per cent of the sampled shopfronts;
- customers sometimes had to queue twice for Medicare and Centrelink services in 26 per cent of sampled shopfronts; and
- 95 per cent of staff in the sampled shopfronts identified the need for a standard integrated service offer.

Approaches to service coordination

4.28 The review findings were consistent with arrangements encountered in shopfronts visited during field work. Two concepts of coordinated (or integrated) services were observed. The more common was the coordination of processes—for instance, staff in some shopfronts had been trained to process

transactions common to both Centrelink and Medicare customers, such as change of address, bank account details and some family assistance payments. Some staff had also been trained in less complex processes that were particular to Medicare or Centrelink such as Medicare refunds.

4.29 The second concept of the coordination of services observed was around the individual circumstances of customers. A circumstance that was commonly cited by shopfront staff was the death of a family member. Staff would coordinate with each other to ensure that the customer only had to tell their story once, and that all possible transactions relating to the death were dealt with in the one visit. This could include: changing aged pension to single rate, advising any change in earned or investment income, removing the deceased person's name from the Medicare card and dealing with any related Medicare refunds.

4.30 In the majority of shopfronts visited during fieldwork a degree of process coordination had been implemented, often around family assistance payments and bank account details. 'Warm-handovers'[74] were generally done if possible between staff delivering Medicare or Centrelink services to avoid customers queuing twice, or processes were in place so that customers could go the front of the 'second' queue to avoid a lengthy wait. The coordination of services around the circumstances of an individual was less apparent in these shopfronts, other than in the case of death of a family member.[75]

4.31 A few shopfronts had gone further and fostered cultures where the distinctions between former Centrelink and Medicare staff were diminishing. In these shopfronts staff were motivated to learn cross-portfolio skills to benefit customers, but also to assist their colleagues during peak customer demand (demand for Centrelink services and Medicare services tends to peak at different times). Staff had gained an understanding of the services offered by both Medicare and Centrelink, and were able to assist in actively coordinating services around the individual circumstances of the customers in a greater range of circumstances. In these shopfronts, the biggest barriers to greater coordination were generally ICT-related.

---

[74] Warm handovers involve a staff member introducing a customer to another staff member for further assistance and, if appropriate, passing on relevant information so that the customer does not have to tell their story twice.

[75] Barriers to further integration commonly cited were: different ICT systems; different cultures of former Medicare and Centrelink staff; customer service pressures; and lack of access to cross portfolio training.

4.32 Only in a small minority of the shopfronts visited during this audit had the former Centrelink and Medicare staff retained separate cultures and processes. In these shopfronts customers generally had to queue separately for Medicare and Centrelink services. In summary, the level of coordination of services varies considerably across the service network. While this is not unexpected given the barriers to greater coordination, particularly prior to the integration of Medicare and Centrelink into DHS, most of the potential gains are yet to be realised.

Measuring progress of coordinated services

4.33 The two performance measures for the Co-location Program (shown in Table 3.1) that relate to providing coordinated services to customers are:

- average number of customer transactions completed per on-site visit (based on the reasoning that customers will be able to complete more transactions in a co-located shopfront offering coordinated services); and
- number of staff who are trained in cross-portfolio services and procedures.

4.34 However, no data is available for these performance measures for 2011–12. DHS has advised that targets and data collection processes are currently being developed.

The 2012 trial of integrated services

4.35 The 2012 trial of integrated services, mentioned in paragraph 4.27, has been a vehicle for disseminating good practice while establishing a standard and consistent set of integrated business processes across consolidated shopfronts.[76] An evaluation report on the trial was completed in January 2013 and recommended that 11 integrated business processes be adopted in all co-located shopfronts supported by cross-portfolio training for staff.[77]

---

[76] Eight consolidated shopfronts with varying degrees of integration were chosen to take part in the trial, each from a different service zone across the Eastern seaboard. The trial was run during the third quarter of 2012. During the trial, former Centrelink and Medicare staff were trained to complete eight commonly used processes such as death and bereavement procedures, change of address details, and the child care benefit and rebate. Feedback from shopfronts that had begun integrating processes at their own initiative was used in the development and choice of trial processes.

[77] The evaluation found that five of the eight processes included in the trial were suitable for roll out to all co-located shopfronts. The report recommended that a further six common processes, which had been identified by customer service officers during the trial, also be adopted in co-located shopfronts.

4.36 The 2012 trial opens up a range of possibilities, including the ability to deliver some face-to-face cross-portfolio services via the cross-training of staff in what are currently self-service extension co-locations. It is not clear, however, how the recommendations from the evaluation of the trial will be implemented across the service network, as they are currently being considered by DHS in the broader context of future service delivery design. Reflecting this, the team in the former Co-location Branch that worked on the trial was restructured into the Operations Projects Branch in the Service Delivery Transformation Division in September 2012.

Complaints

4.37 The number of complaints from customers about the co-location of shopfronts is an important indicator of the effect of co-location on service quality and customer satisfaction. DHS acknowledges the importance of customer complaints as a source of feedback to identify systemic issues and whether further staff training is required.[78] The analysis of complaints from individual customers—sent to the then Co-location Branch by the Service Zones and the National Feedback and Analysis Team[79]—indicates that most complaints relating to co-location (over 98 per cent) have been received from Medicare customers. Table 4.3 outlines the complaints in relation to the Medicare program.

Table 4.3

Complaints in relation to the Medicare program

	2010–11	2011–12
Total number of complaints	4 471	5 394
Total number of complaints relating to co-locations [(a)]	54	137
Co-location complaints as a percentage of total complaints	1.2	2.5
Number of consolidations	18	47
Co-location complaints per consolidation	3.0	2.9

Source: DHS documentation.

Note (a): 'Co-location' only became a defined category of complaint in April 2012. For complaints prior to April 2012, the Medicare Feedback Register was searched by DHS using free-text keyword searches of the following terms: one stop shop, co-location, co location, colocation, co located, co-located, collocated and Centrelink.

78 Department of Human Services (2012), *Annual Report 2011–12*, p. 59.

79 Now known as the Service Recovery Team.

4.38 The data in Table 4.3 indicates that the total number of complaints received about co-locations is relatively small, comprising only 1.2 per cent of all complaints received in 2010–11. While the proportion increased to 2.5 per cent of total complaints in 2011–12, this reflects the relatively large increase in the number of consolidations implemented in that year. As shown in the table, the average number of co-location complaints received per consolidation was steady across both 2010–11 and 2011–12. This is despite some of the co-location complaints in 2011–12 likely being related to the withdrawal of cash rebates. Some customers conflate co-location with the decision to introduce cashless processing because in a number of shopfronts the two events occurred on or around the same date.

Information for customers on co-located services

4.39 For customers to take full advantage of co-located shopfronts they need to be aware of where such shopfronts can be found. The 'find us' function on the DHS website, designed to be utilised by customers looking for shopfront locations, has not kept pace with the progress of co-location. For instance, consolidated shopfronts are reported separately as a Medicare shopfront and as a Customer Service Centre (for Centrelink services). Only if the customers notice that the shopfronts have the same address would they be able to deduce that it is a co-located shopfront offering both full Medicare and Centrelink services.

4.40 For self-service extension co-locations there is no indication on the website that the shopfronts offer this additional service. For face-to-face service extensions there is also generally no indication, particularly when face-to-face Medicare services have been added to a Centrelink shopfront. However, when Centrelink services for carers and seniors have been added to a Medicare shopfront, the face-to-face service extension co-location is presented on the website in the same way as a consolidation, that is, the shopfront locations are reported separately.

4.41 The lack of up-to-date information on the website means that customers, particularly those who may be happy to use self-service with the assistance of staff or those who would take advantage of staffed service extensions, cannot determine from the website which shopfront would be most useful and convenient to access. This is inconsistent with the objective of the Co-location Program to provide convenient and easy to access services. It means that some of the benefits to customers of co-location are not being adequately communicated, and therefore, may not be being fully realised. DHS

could enhance the effectiveness of the Co-location Program by more accurately communicating to customers where co-located self-services and face-to-face services are available.

Recommendation No.2

4.42 To improve the effectiveness of co-location and the services offered to customers, the ANAO recommends that the DHS website provides more information about co-located shopfronts, including advice on the face-to-face services and the assisted self-services available in each shopfront.

DHS' response:

4.43 *Agreed*

Savings

4.44 A key objective, and one of the performance indicators, of the Co-location Program is the achievement of savings in lease costs by consolidating locations.

4.45 The 2011–12 Budget specified that the closure of 'around 61' shopfronts involved in consolidations would result in $14 million in savings to be achieved through reduced property costs over the four years to 2014–15.[80] The $14 million has been adopted as the target for the savings performance measure.

4.46 The $14 million in savings is harvested annually over four years and returned to government each year rather than as consolidations occur. To give effect to this the department harvests the annual savings target upfront during its internal budget allocation process. Administratively, this is managed through the department's Property Operating Corporate Account, which is used to pay for leased customer service properties, including all Centrelink and Medicare shopfronts.

4.47 In the package of SDR measures announced in the 2011–12 Budget, the Government budgeted $107.5 million over four years to continue the progressive co-location of 520 Centrelink and Medicare Australia shop fronts.[81]

---

[80] Australian Government, *Budget Measures: Budget Paper No. 2: 2011–12*, Commonwealth of Australia, Canberra, 2011, p. 249.

[81] Ibid.

After adjusting for internally funded capital and operating expenses, and the harvested savings, the net appropriation to DHS for the Co-location Program was $27.7 million over four years. Table 4.4 summarises the budget funding arrangements announced for the Co-location Program.

Table 4.4

2011–12 Budget funding for the Co-location Program

$m	Purpose
107.5	**Budget commitment to the Co-location Program** The 2011–12 Budget commitment of $107.5 million over four years to 2014–15 comprised capital expenses (Capex) of $65.8 million and operating expenses (Opex) of $41.7 million.
65.8	**Capex for the Co-location Program** Capex covers physical improvements that support the co-location of services in shopfronts, such as furniture and fittings. The Budget specified that the $65.8 million for Capex would be met from within the existing resources of DHS.
41.7	**Opex for the Co-location Program** Opex includes employee expenses, branding, communication, training, travel, and project and property administration.
14.0	**Savings returned to Government** The Budget specified that the closure of 'around 61' shopfronts involved in consolidations would result in $14 million in savings to be achieved through reduced property costs over the four years to 2014–15.
27.7	**Budget appropriation to DHS for the Co-location Program** The savings of $14 million were offset against Opex of $41.7 million, resulting in a net appropriation to DHS of $27.7 million.

Source: Portfolio Budget Statements 2011–12 and DHS documentation.

4.48 As a result of the Government's decision to harvest $14 million in savings upfront from the DHS budget, the department's management will need to carefully plan and monitor implementation to ensure that actual savings are realised as the consolidations occur. A failure to achieve actual savings will create the risk of resource pressures impacting on other aspects of DHS services and operations.

Progress with achieving savings

4.49 Table 4.5 compares targets with actual and forecast results in relation to the target of $14 million in savings over the four years to 2014–15. While a higher number of consolidations occurred in 2011–12 than initially planned,

there was a shortfall in savings of $0.4 million in that year. However, DHS has advised that it expects this to be fully recovered in 2012–13.

Table 4.5

Comparison of savings targets, actual, and forecasts

2011–12 $m	2012–13 $m	2013–14 $m	2014–15 $m	Total $m
Target	**Target**	**Target**	**Target**	**Target**
2.3	3.2	4.4	4.1	14.0
Actual	**Forecast**	**Forecast**	**Forecast**	**Forecast**
1.9[(a)]	3.6[(b)]	NYA	NYA	14.0

Source: DHS.

NYA – not yet available. DHS advised that it had not yet prepared forecasts for the following two years.

Note (a): The result for each year comprises the full financial year benefit from co-locations in previous years, plus part-year savings from new co-locations. Under this principle, the result for 2011–12 includes savings from co-locations in 2009–10 and 2010–11, plus part-year savings from new co-locations in 2011–12.

Note (b): Forecast at December 2012.

4.50 DHS attributes the shortfall in the first year largely to the need to develop initial costings for the Co-location Program before a list of specific consolidations had been determined. Costings were therefore based on an anticipated average saving per consolidation and did not fully take into account that most consolidations would not yield a full year's savings in their first year.

Other developments

4.51 Two further developments since the 2011–12 Budget have changed the environment within which the $14 million savings are to be achieved. Both arose out of the Mid-Year Economic and Fiscal Outlook (MYEFO) statement in November 2011: a one-off additional 2.5 per cent Efficiency Dividend for 2012–13; and a reduction in agencies' capital budgets in 2012–13.

4.52 As part of its response to the Efficiency Dividend announced in November 2011, DHS undertook from April 2012 to increase the number of consolidations, thereby achieving savings of $2.7 million in 2012–13 due to the merging of shopfronts and the consequent reduction in property expenses.

No additional funds were provided to DHS for operating and capital expenses associated with the Efficiency Dividend consolidations. The additional 61[82] Centrelink-Medicare consolidations are being undertaken as an internal budgeting measure. The achievement of savings from the additional Efficiency Dividend consolidations is not in scope for this audit.

4.53 Another development that has the potential to affect the achievement of the savings from SDR co-locations funded in the 2011–12 Budget is the November 2011 MYEFO decision to reduce agencies' capital budgets.[83] DHS' capital budgets in 2012–13 and 2013–14 will each be about one third the size of its capital budget in 2011–12. As a flow-on effect, the component of DHS' capital budget allocated to property management (known as the Leasehold Improvement Program) reduced from $90 million in 2011–12 to $51.7 million in 2012–13, creating additional pressure for the Co-location Program as it competes for limited internal resources.

4.54 DHS advised that the rate of SDR consolidations, and associated savings, will not slow as a result of additional Efficiency Dividend consolidations or the reduction in the capital budget. Specifically, DHS advised that it will ensure that the SDR consolidations and savings will be achieved by giving them priority over the Efficiency Dividend consolidations and that this approach will allow the shortfall in savings in 2011–12 to be recovered and the 2012–13 savings target to be achieved. The department further advised that it is committed to ensuring all scheduled consolidations are achieved in 2012–13.

Conclusion

4.55 DHS data indicates that there have been positive outcomes for customers from the Co-location Program. A recent survey of customers visiting co-located shopfronts indicates that over three quarters of customers agreed that the one stop shop made it more convenient to access Centrelink and Medicare services. The number of complaints relating to co-location has been relatively small.

[82] The number of Efficiency Dividend consolidations is 67. However, six are consolidations of the same face-to-face service (for instance, consolidating two Medicare shopfronts) and so are not co-locations; the remaining 61 consolidations are co-locations of Medicare and Centrelink services.

[83] The measure relates specifically to those agencies subject to departmental capital budgeting arrangements. Funding provided under departmental capital budget arrangements is intended to meet the costs associated with the replacement of minor assets (assets valued at $10 million or less).

4.56 However, a minority of customers affected by consolidations, particularly aged customers using Medicare services, have experienced some dissatisfaction with the new consolidated shopfronts. Over time, this dissatisfaction has abated for some customers as they have become accustomed to the new location and queuing systems, or have taken advantage of alternative service channels available to access Medicare services.

4.57 There is further scope for DHS to improve the convenience and accessibility of services by monitoring the uptake by relevant staff of training to assist customers to use self-service facilities to access the range of online DHS services. This is particularly important in self-service extension co-located shopfronts. It would also assist customers to access the most convenient shopfront, if the DHS website were to provide more information on co-located shopfronts, including the face-to-face services and the assisted self-service facilities available in each shopfront.

4.58 The level of coordination of services varies considerably across the service network; some shopfronts have relatively high levels of integration (within the limitations of the current ICT systems) whereas in other co-located shopfronts, Medicare and Centrelink services are still provided separately. Further, while the services to customers are generally well coordinated in consolidated shopfronts where there has been a death of a family member, there is scope to adopt a similar approach to coordination in a broader range of circumstances faced by individual customers. A degree of variability in shopfronts' abilities to provide coordinated services is not unexpected given the barriers to greater coordination (including different systems and processes prior to the integration of DHS[84] and the security requirements associated with Medicare cash refunds[85]). However, most of the potential gains are yet to be realised. The results of recent trials of integrated service delivery processes and the cross-portfolio training of staff have the potential to improve the department's capacity to deliver coordinated services across its network, through more flexible work design and multi-skilled staff.

---

[84] For instance, the different ICT and management systems prior to the integration of Medicare and Centrelink into DHS in July 2011 were key reasons why early attempts to train staff in cross-portfolio processes in shopfronts co-located by consolidation were unsuccessful.

[85] Medicare cash refunds were a significant barrier to greater coordination of processes prior to the Minister's announcement in April 2012 to phase out cash refunds over the second half of 2012.

4.59 DHS has advised that the $14 million target for savings from the SDR consolidations is on track to be achieved. While a higher number of consolidations than initially planned occurred in 2011–12 there was a shortfall in savings of $0.4 million. However, DHS has advised that it expects this to be fully recovered in 2012–13.

Ian McPhee

Auditor-General

Canberra ACT

6 June 2013

Appendices

Appendix 1: Agency's response to the proposed report

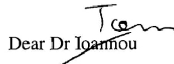
Australian Government

Department of Human Services

Kathryn Campbell CSC
Secretary

Ref: EC13/178

Dr Tom Ioannou
Group Executive Director
Performance Audit Services Group
Australian National Audit Office
GPO Box 707
CANBERRA ACT 2601



Dear Dr Ioannou

I am writing to you in response to the proposed report on *Co-location of the Department of Human Services' Shopfronts* Audit. Thank you for the opportunity to comment on the Section 19 report.

The Department of Human Services (the department) agrees with the two recommendations outlined in the report.

Attachment A to this letter details the department's response to the proposed audit report, the recommendations and critical conclusion and includes the summary of the department's formal response for inclusion in the ANAO report summary.

Attachment B provides the department's response to the requests for additional information comprising updated data and information. This information was also provided directly to Linda Kendall, ANAO Audit Manager, via email on 8 May 2013.

If you would like any further clarification on these comments please contact Mr Graham Maloney on (02) 6155 0274.

Yours sincerely

Kathryn Campbell

21 May 2013

PO Box 3959, Manuka ACT 2603 • Telephone (02) 6223 4411 • Facsimile (02) 6223 4489
Internet www.humanservices.gov.au

Index

A

Accessible services, 12, 15, 18, 27, 32, 42, 44, 47–49, 56, 60, 63– 67, 74, 79

Aged customers, 15, 18, 65, 71, 79

Australian Government Information Management Office, 61

Australian Hearing, 24, 40–41

Australian Tax Office, 12, 14, 25, 41

C

Channel strategy, 15, 17–18, 20, 27–29, 30, 36–37, 40, 55, 65–68, 79

Child support services, 24, 27, 40, 68

Co-location Branch, 59, 66, 68, 73

Complaints, 18, 42, 69, 73–74, 78

Consolidation criteria, 44–48

Consolidation-definition, 8, 11, 30

Convenient services, 12, 15, 18, 20, 24, 32, 47–48, 56, 63–68, 74, 78–79

Coordinated services, 10, 12, 14–16, 19, 25, 30–32, 43, 47, 49, 56, 63, 70–71, 72, 79

CRS Australia, 24, 40

Customer satisfaction, 15, 18, 26, 46–47, 56, 60, 65, 67, 73, 79

D

Decision making criteria, 17, 43

Department of Finance and Deregulation, 18, 61

Disability, 42, 64

E

Efficiency Dividend, 8, 12–16, 32, 37, 40–41, 44, 58– 60, 77–78

Evolution of co-location program, 13, 15, 17, 33, 43, 45, 48, 60, 62

I

ICT, 13, 14, 16, 19, 30, 31, 44, 61, 68, 70–71, 79

L

Local Connections to Work, 14, 25, 30, 41, 49

O

Objectives of co-location program, 12, 16, 18, 32, 47–48, 50, 56, 63, 74, 75

P

Performance framework, 18, 54–55, 59, 67

Performance measures, 17, 18, 54–56, 59–62, 67, 72, 75

Performance reporting, 15, 17, 57

Post Implementation Reviews, 68

S

Savings, 11–16, 18–19, 30, 32, 36–37, 40–42, 44, 48, 56, 59, 63, 75–78, 80

Service Delivery Reform, 8, 10, 14, 16, 18–19, 24–25, 33, 38, 40–42, 54, 55, 57–61, 67, 75, 78, 80

Service Extension criteria, 49

Service Extension-definition, 11, 30, 31

Service Zone, 8, 36–37, 66, 73

T

Training, 15, 16, 18, 19, 21, 31–32, 50, 56, 66–67, 70–73, 76, 79

W

Waiting times, 65, 69, 71

Web site, 15, 17–18, 20–21, 30, 55, 74–75, 79

Series Titles

ANAO Audit Report No.1 2012–13
Administration of the Renewable Energy Demonstration Program
Department of Resources, Energy and Tourism

ANAO Audit Report No.2 2012–13
Administration of the Regional Backbone Blackspots Program
Department of Broadband, Communications and the Digital Economy

ANAO Audit Report No.3 2012–13
The Design and Conduct of the First Application Round for the Regional Development Australia Fund
Department of Regional Australia, Local Government, Arts and Sport

ANAO Audit Report No.4 2012–13
Confidentiality in Government Contracts: Senate Order for Departmental and Agency Contracts (Calendar Year 2011 Compliance)
Across Agencies

ANAO Audit Report No.5 2012–13
Management of Australia's Air Combat Capability—F/A-18 Hornet and Super Hornet Fleet Upgrades and Sustainment
Department of Defence
Defence Materiel Organisation

ANAO Audit Report No.6 2012–13
Management of Australia's Air Combat Capability—F-35A Joint Strike Fighter Acquisition
Department of Defence
Defence Materiel Organisation

ANAO Audit Report No.7 2012–13
Improving Access to Child Care—the Community Support Program
Department of Education, Employment and Workplace Relations

ANAO Audit Report No.8 2012–13
Australian Government Coordination Arrangements for Indigenous Programs
Department of Families, Housing, Community Services and Indigenous Affairs

ANAO Audit Report No.9 2012–13
Delivery of Bereavement and Family Support Services through the Defence Community Organisation
Department of Defence
Department of Veterans' Affairs

ANAO Audit Report No.10 2012–13
Managing Aged Care Complaints
Department of Health and Ageing

ANAO Audit Report No.11 2012–13
Establishment, Implementation and Administration of the Quarantined Heritage Component of the Local Jobs Stream of the Jobs Fund
Department of Sustainability, Environment, Water, Population and Communities

ANAO Audit Report No.12 2012–13
Administration of Commonwealth Responsibilities under the National Partnership Agreement on Preventive Health
Australian National Preventive Health Agency
Department of Health and Ageing

ANAO Audit Report No.13 2012–13
The Provision of Policing Services to the Australian Capital Territory
Australian Federal Police

ANAO Audit Report No.14 2012–13
Delivery of Workplace Relations Services by the Office of the Fair Work Ombudsman
Department of Education, Employment and Workplace Relations
Office of the Fair Work Ombudsman

ANAO Audit Report No.15 2012–13
2011–12 Major Projects Report
Defence Materiel Organisation

ANAO Audit Report No.16 2012–13
Audits of the Financial Statements of Australian Government Entities for the Period Ended 30 June 2011
Across Agencies

ANAO Audit Report No.17 2012–13
Design and Implementation of the Energy Efficiency Information Grants Program
Department of Climate Change and Energy Efficiency

ANAO Audit Report No.18 2012–13
Family Support Program: Communities for Children
Department of Families, Housing, Community Services and Indigenous Affairs

ANAO Audit Report No.19 2012–13
Administration of New Income Management in the Northern Territory
Department of Human Services

ANAO Audit Report No.20 2012–13
Administration of the Domestic Fishing Compliance Program
Australian Fisheries Management Authority

ANAO Audit Report No.21 2012–13
Individual Management Services Provided to People in Immigration Detention
Department of Immigration and Citizenship

ANAO Audit Report No.22 2012–13
Administration of the Tasmanian Forests Intergovernmental Contractors Voluntary Exit Grants Program
Department of Agriculture, Fisheries and Forestry

ANAO Audit Report No.23 2012–13
The Australian Government Reconstruction Inspectorate's Conduct of Value for Money Reviews of Flood Reconstruction Projects in Victoria
Department of Regional Australia, Local Government, Arts and Sport

ANAO Audit Report No.24 2012–13
The Preparation and Delivery of the Natural Disaster Recovery Work Plans for Queensland and Victoria
Department of Regional Australia, Local Government, Arts and Sport

ANAO Audit Report No.25 2012–13
Defence's Implementation of Audit Recommendations
Department of Defence

ANAO Audit Report No.26 2012–13
Remediation of the Lightweight Torpedo Replacement Project
Department of Defence; Defence Material Organisation

ANAO Audit Report No.27 2012–13
Administration of the Research Block Grants Program
Department of Industry, Innovation, Climate Change, Science, Research and Tertiary Education

ANAO Report No.28 2012–13
The Australian Government Performance Measurement and Reporting Framework: Pilot Project to Audit Key Performance Indicators

ANAO Audit Report No.29 2012–13
Administration of the Veterans' Children Education Schemes
Department of Veterans' Affairs

ANAO Audit Report No.30 2012–13
Management of Detained Goods
Australian Customs and Border Protection Service

ANAO Audit Report No.31 2012–13
Implementation of the National Partnership Agreement on Homelessness
Department of Families, Housing, Community Services and Indigenous Affairs

ANAO Audit Report No.32 2012–13
Grants for the Construction of the Adelaide Desalination Plant
Department of Sustainability, Environment, Water, Population and Communities
Department of Finance and Deregulation
Department of the Prime Minister and Cabinet

ANAO Audit Report No.33 2012–13
The Regulation of Tax Practitioners by the Tax Practitioners Board
Tax Practitioners Board
Australian Taxation Office

ANAO Audit Report No.34 2012–13
Preparation of the Tax Expenditures Statement
Department of the Treasury
Australian Taxation Office

ANAO Audit Report No.35 2012–13
Control of Credit Card Use
Australian Trade Commission
Department of the Prime Minister and Cabinet
Geoscience Australia

ANAO Audit Report No.36 2012–13
Commonwealth Environmental Water Activities
Department of Sustainability, Environment, Water, Population and Communities

ANAO Audit Report No.37 2012–13
Administration of Grants from the Education Investment Fund
Department of Industry, Innovation, Climate Change, Science, Research and Tertiary Education

ANAO Audit Report No.38 2012–13
Indigenous Early Childhood Development: Children and Family Centres
Department of Education, Employment and Workplace Relations

ANAO Audit Report No.39 2012–13
AusAID's Management of Infrastructure Aid to Indonesia
Australian Agency for International Development (AusAID)

ANAO Audit Report No. 40 2012–13
Recovery of Centrelink Payment Debts by External Collection Agencies
Department of Human Services

ANAO Audit Report No.41 2012–13
The Award of Grants Under the Supported Accommodation Innovation Fund
Department of Families, Housing, Community Services and Indigenous Affairs

Current Better Practice Guides

The following Better Practice Guides are available on the ANAO website.

Public Sector Internal Audit	Sep 2012
Public Sector Environmental Management	Apr 2012
Developing and Managing Contracts – Getting the right outcome, achieving value for money	Feb 2012
Public Sector Audit Committees	Aug 2011
Human Resource Information Systems – Risks and Controls	Mar 2011
Fraud Control in Australian Government Entities	Mar 2011
Strategic and Operational Management of Assets by Public Sector Entities – Delivering agreed outcomes through an efficient and optimal asset base	Sept 2010
Implementing Better Practice Grants Administration	Jun 2010
Planning and Approving Projects – an Executive Perspective	Jun 2010
Innovation in the Public Sector – Enabling Better Performance, Driving New Directions	Dec 2009
Preparation of Financial Statements by Public Sector Entities	Jun 2009
SAP ECC 6.0 – Security and Control	Jun 2009
Business Continuity Management – Building resilience in public sector entities	Jun 2009
Developing and Managing Internal Budgets	Jun 2008
Agency Management of Parliamentary Workflow	May 2008
Fairness and Transparency in Purchasing Decisions – Probity in Australian Government Procurement	Aug 2007
Administering Regulation	Mar 2007
Implementation of Program and Policy Initiatives – Making implementation matter	Oct 2006