The Auditor-General

Audit Report No.1 1999–2000
Performance Audit

Implementing Purchaser/Provider Arrangements between the Department of Health and Aged Care and Centrelink

Australian National Audit Office

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Australian National
Audit Office

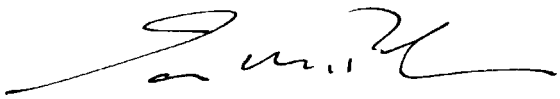
Canberra ACT
13 July 1999

Dear Madam President
Dear Mr Speaker

The Australian National Audit Office has undertaken a performance audit of the Department of Health and Aged Care and Centrelink in accordance with the authority contained in the *Auditor-General Act 1997.* I present this report of this audit, and the accompanying brochure, to the Parliament. The report is titled *Implementing Purchaser/Provider Arrangements between the Department of Health and Aged Care and Centrelink.*

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

Yours sincerely



Ian McPhee
Acting 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

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Abbreviations/Glossary

AAT	Administrative Appeals Tribunal
ACATs	Aged Care Assessment Teams of Health
A&CCD	Aged and Community Care Division of Health
Aging in place	the provision of varying levels of care within the one aged care facility, without the need for an aged care resident to relocate to a different facility as his or her needs change.
ANAO	Australian National Audit Office
AROs	authorised review officers of Centrelink
BPR	business process re-engineering
CEO	Chief Executive Officer
COAG	Council of Australian Governments
DEETYA	(former) Department of Employment, Education, Training and Youth Affairs
DoFA	Department of Finance and Administration
FaCS	Department of Family and Community Services
DHFS	(former) Department of Health and Family Services
DSS	(former) Department of Social Security
DVA	Department of Veterans' Affairs
FIS officers	Financial Information Services officers of Centrelink
FOI	freedom of information
FUNIWG	Funding and Other Implementation Issues Working Group
Health	Department of Health and Aged Care
Hotline	Health Telephone Hotline
ISD	Information Services Division of Health
IT	information technology
MAB/MIAC	Management Advisory Board / Management Improvement Advisory Committee
MCGC	Ministerial Committee on Government Communications
OGIA	Office of Government Information and Advertising

PIR	post implementation review
RA	rent assistance
RCA	Residential Care Allowance
RCS	Retirement Customer Segment of Centrelink
SLA	Service Level Arrangement
SNI	Systems Network Interconnection
SRSSC	Structural Reform Systems Steering Committee
SSAT	Social Security Appeals Tribunal

Summary and Recommendations

Audit Summary

Introduction

1. Centrelink was established as an independent statutory authority on 1 July 1997 in the former Department of Social Security (now the Department of Family and Community Services) portfolio. Centrelink's responsibilities include the integrated service delivery of a range of Commonwealth social welfare payments and services. These services are delivered under formal purchaser/provider arrangements with the Department of Family and Community Services (FaCS), Department of Education, Training and Youth Affairs, (DETYA) and Department of Employment, Workplace Relations and Small Business (DEWRSB).

2. Since its establishment, Centrelink has also begun service delivery under purchaser/provider arrangements with the Department of Health and Aged Care[1] (referred to as 'Health' throughout this report). The services delivered under this agreement encompass:

- services relating to the residential care fee income testing component of the Government's Aged Care Structural Reform Package. This Package was introduced by the Government as part of the 1996 Federal Budget. The reforms were designed to: meet the need for a more equitable funding system for residential aged care (which included the introduction of income tested residential care fees); enable 'ageing in place'[2]; and improve the quality of aged care infrastructure. The focus of Centrelink's service delivery has been in respect to the provision of information to Health on income details of individuals which the Department will use in assessing residential care fee subsidies;
- income testing and provider payment services for Childcare Assistance[3];
- assessment of, and referral to, employment assistance for people with disabilities[4]; and
- processing applications and assessing eligibility for assistance for hearing services.

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1 Formerly the Department of Health and Family Services (DHFS).

2 'Ageing in place' aims to facilitate the provision of varying levels of care within the one aged care facility, without the need for an aged care resident to relocate to a different facility as his or her needs change.

3 Now part of the SLA between DFAC and Centrelink.

4 *ditto*

3. The former DSS and DEETYA were heavily involved in establishing Centrelink. They worked in partnership transferring a total of 24 000 staff from their Departments to the new service delivery agency. While DHFS/Health was kept informed of the developments, it was not directly involved in Centrelink's establishment. In this respect, the implementation of purchaser/provider arrangements for DHFS services to be delivered by Centrelink, represented the first component of service delivery on behalf of what could be considered a fully arms-length third party arrangement.

4. A performance audit, that examines the implementation of purchaser/provider arrangements between Health and Centrelink for service delivery, was seen by the ANAO as being beneficial in identifying the issues and practice that will assist the efficiency and effectiveness of future third party service delivery implementations, as well as providing an audit opinion on the administrative effectiveness of this particular implementation.

5. The ANAO acknowledges that the implementation of aged care service delivery was a complex administrative process designed to minimise the impact on aged care residents. There was also a range of policy, legislative and resource factors that created the complexity and volatility of the environment in which the implementation of income testing for residential care fees was being undertaken. These factors are discussed in detail in Chapter 2 and have been taken into account in the analysis throughout the audit.

Audit objective and criteria

6. The objective of the audit was to determine the administrative effectiveness of the implementation of the service delivery arrangements between Centrelink and Health by examining project planning for, and management of, the implementation, and the establishment of ongoing purchaser/provider arrangements.

7. The audit criteria used in this audit were to determine if:

- project planning for, and management of, the implementation was consistent with good practice, in particular whether the implementation was:
  - consistent with Government policy and legislation; and
  - underpinned by an appropriately structured approach to project planning and management, that is:
    - * included a formal documented risk management approach;

    * was undertaken with appropriate senior management overview and coordination arrangements at the operational level;
    * was planned and monitored using formal project plans; and
    * was undertaken with full identification of, and monitoring against, the establishment costs and appropriate performance information; and

- the establishment of on-going purchaser/provider arrangements encompassed:
  - service level arrangements which take account of the full range of good corporate governance principles and practice, as are relevant within a purchaser/provider arrangement. These include adequate identification of: roles and responsibility, on-going coordination, resourcing, reviews, risk management and performance information collection, monitoring and reporting; and
  - planning to evaluate the implementation to inform similar implementations in the future.

8. The audit examined the work of the former DHFS in undertaking the aged care implementation from the time of the 1996 Federal Budget announcement of the Aged Care Reforms to mid-September 1998. The audit also examined Centrelink's management from 1 October 1997, the date at which it took responsibility for the implementation from the former DSS, to mid-September 1998. The project planning and implementation aspects of the audit concentrated on the period up to the 1 March 1998 implementation. Because of their significance, the ANAO took account of the coordination arrangements with the former DSS and with DVA, but did not include these agencies in this audit as it was focused on the purchaser/provider arrangements with Centrelink.

Overall conclusion

9. The ANAO concluded that Health and Centrelink achieved the implementation of aged care service delivery by the amended due date of 1 March 1998, as required by Government. Both Health and Centrelink complied with the Government's policy and legislative requirements. However, had the original implementation date of 1 July 1997 remained Government policy, implementation would not have been adequately progressed to meet the standard required by Government.

10. With respect to Health the ANAO concluded that implementation could have been more effective with better project planning and management. Project plans had not been sufficiently developed for either the overall project or for all key sub-projects for the implementation.

Therefore senior management did not have a suitable basis on which to monitor the progress of the implementation and to have adequate assurance regarding coverage of gaps. The lack of a sufficiently structured approach to project planning and management by Health exposed the implementation to risks that otherwise could have been identified, assessed and ranked which would have led to their effective management. The ANAO counsels that future implementations by Health will be subject to unwarranted risk if project planning is not improved.

11. Centrelink's project planning approach was considered to be adequate.

12. The ANAO also concluded that the purchaser/provider arrangements, including the performance reporting framework, are adequate. However, arrangements of this kind, developed as they are under pressure of time with limited precedent and associated experience, can inevitably be improved. Consequently, the ANAO has highlighted a number of improvements required to more closely align the arrangements with better management practices and to ensure a common understanding between the parties of the requirements under the agreements. It could be beneficial if these improvements were taken into account in reviewing the current arrangements and for future similar arrangements.

Agencies' responses

13. Both Centrelink and Health agreed with all of the recommendations that were relevant to their respective agencies.

14. Further, Health and Centrelink indicated progress on implementing the recommendations regarding project planning and management, as well as plans to address the recommendations in relation to the Service Level Arrangements. Health emphasised, in their response, the complexity of the environment within which the implementation was achieved.

Project planning and management

Processes to ensure consistency with Government policy and legislation

15. The agencies complied with the key elements of the Government's policy in so far as there was an operational income testing process in place by the approved implementation date of 1 March 1998 with characteristics consistent with Government announcements. However, the ANAO found that adequate progress would not have been made to meet the initial deadline of 1 July 1997 due to lack of a sufficiently structured approach to planning and management (discussed below). The decision to amend this implementation date was based on a delay in the passage of the necessary legislation. The ANAO concluded that, had the original implementation date still been in effect, income testing at the standard required by Government would not have been in place.

16. The ANAO found both agencies complied with legal requirements in the implementation as appropriate consultation with respect to the requirements of the *Privacy Act 1988* was undertaken and legal advice sought in relation to the Service Level Arrangement (SLA). However, legal responsibilities were not clearly identified in the Aged Care Schedule within the SLA, which details the requirements by Health of Centrelink in undertaking income testing on its behalf. This increases the risk that responsibilities will not be fully discharged due to uncertainty between the parties to the SLA.

Structured approach to project planning and management

17. The implementation of income testing was part of the Aged Care Structural Reform Package, a large and complex project requiring implementation within a tight time-frame and subject to subsequent policy changes. For such a project, a structured approach is particularly important. A structured approach is characterised by:

- a formal documented risk management process to identify, assess and treat the risks to the implementation and to provide the basis for managing and monitoring key risks;
- coordination arrangements that cover all relevant stakeholders, including both managers and operational staff with responsibility for sub-projects and tasks. This coordination should ensure coverage of all significant implementation issues, timely implementation of project

and contingency plans, monitoring of implementation tasks against identified milestones, identification of respective responsibilities and appropriate accountability arrangements. Furthermore, coordination arrangements at the operational level provide a key tool in effective staff management at a time when staff are working in potentially high pressure situations;

- formalised project plans to assist in fully identifying and monitoring progress against implementation tasks and their milestones; and
- the identification and monitoring of resources required for the project to inform decision-making and take remedial action where necessary.

18. Health, at the early planning stages, through the identification of responsible officers and development of broad timelines, laid the groundwork for sound practice planning but did not fully develop or maintain formal project plans with sufficient detail to facilitate project monitoring. For the overall project, Health did not adopt a structured approach to project planning and management.

19. As a result, the ANAO found that Health was not in a position to fully identify and manage the risks associated with this implementation. In particular:

- if 1 July 1997 had continued to be the implementation date, income testing would not have been in place to a standard required by Government;
- there were increased risks, some of which eventuated, that sub-projects could be overlooked, delayed, ineffective or under-resourced, with subsequent delays in meeting milestones;
- while the Department has advised that the difficulties in achieving the original timetable was foreseen, there was no documented analysis of the key risks and their potential impact to provide the basis on which to advise the Minister adequately at an early stage of the implementation; and
- while the Department advised that the Minister was provided with sufficiently comprehensive briefing on the risks to the implementation, the ANAO notes there was not an appropriate record of such briefings and decisions taken by the Minister in the light of Departmental advice for accountability purposes.

20. Lack of a structured approach impacts adversely on effective staff management as roles and priorities at any point in time are not well defined. There are indications that suggest such impacts on the management of project staff occurred within Health.

21. The ANAO acknowledges that Health had a structured approach to project planning and management in implementing the IT systems component of the project, but the indicative level of planning was not evident in the overall project.

22. While noting that Centrelink had responsibility for a relatively self-contained and less complex component of the implementation, the ANAO found that it adopted many elements of the structured approach outlined in paragraph 15 above. However, Centrelink had not adopted a formal risk management approach. While it had made efforts at costings, as did Health, it had not identified nor monitored the full cost of implementing the residential fee income test.

Establishing effective on-going purchaser/provider arrangements

Service Level Arrangement

23. The ANAO concluded that the Service Level Arrangement (SLA) was adequate for the purpose. However, the ANAO identified a number of aspects of the SLA which would benefit from refinement in any future revision of the Arrangement or for arrangements of this kind in the future. These are:

- inconsistencies across parts of the Arrangement, with no indication of an order of precedence to apply to each part;
- delays in signing the Arrangement well beyond the implementation date which in turn have restricted comprehensive reporting on performance;
- a lack of specification within the SLA of the following:
  - the full range of risks impacting on the Arrangement;
  - the costing basis for components that will be reimbursed by Health on a 'cost-recovery' basis;
  - environmental and administrative policy factors that impact substantially on Centrelink's workloads.
  - the process to change payment level if these policy factors change significantly is not specified; and
  - the objectives, scope and resourcing for the reviews of the Arrangement; and
- the timing of the second of the two scheduled reviews, which does not closely align with the renegotiation process. The ANAO considers that a subsequent agreement between the parties within the consultative arrangements for the SLA satisfactorily addressed this issue during the course of the audit.

24. In addition, while the performance reporting framework was considered to be adequate, the following issues need to be addressed to ensure that the framework is fully effective:

- the inclusion of an indicator of quality for 'data matching', and an outcome indicator for 'reviews of decisions and appeals' could improve the balance of indicators;
- the lack of data collection standards that address definitions, validity, reliability, accuracy and timeliness of performance information has left some related key areas open to misinterpretation by the parties; and
- under the SLA, if any of a number of prerequisite conditions are not met, the achievement of targets / performance standards is not required. The SLA does not specify how performance is to be measured in this situation.

25. The ANAO notes that the Consultative Committee (see paragraphs 4.17 and 4.18) and SLA review processes provide appropriate forums through which the general SLA issues can be clarified.

Evaluation of the implementation

26. The ANAO concluded that the planning for Centrelink's post-implementation review is adequate. However, the ANAO found that Health had not planned a similar review. The importance of such a review has been highlighted by the need to address, for future significant projects, the planning and management issues identified in this audit.

Recommendations

Set out below are the ANAO's recommendations with the Report paragraph reference and agencies' abbreviated responses. The ANAO considers that the agencies should give priority to Recommendation Nos. 5–8, as these relate to the current, rather than future implementations. More detailed responses and any other ANAO comments are shown in the body of the report.

Recommendation No.1 Para. 3.21

In line with sound corporate governance practices, the ANAO recommends that Centrelink and the purchasing agency fully identify in the service level agreement their respective responsibilities, based on appropriate legal advice.

Centrelink: Agreed

Health: Agreed

Recommendation No.2 Para. 3.97

The ANAO recommends that, for future major projects, the Department of Health and Aged Care and Centrelink adopt a more formal, systematic risk management approach to planning which includes risk identification, analysis of likely impacts, identification of appropriate treatments for major risks and monitoring the treatment of risks in accordance with better practice.

Centrelink: Agreed

Health: Agreed

Recommendation No.3 Para. 3.100

For significant new service provision arrangements, the ANAO recommends that the Department of Health and Aged Care develop a structured approach to planning its implementation, including:

- appropriate implementation arrangements to facilitate coordination across sub-projects; and
- formal project plans (supported by appropriate sub-project plans) that identify:
  - lines of accountability;
  - resources required for each sub-project; and
  - key milestones to be achieved.

Health: Agreed

Recommendation No.4 Para. 3.103

The ANAO recommends that the Department of Health and Aged Care systematically monitor the implementation of significant projects against formal project plans, including resource usage, and use this information to inform decisions made by the coordinating bodies responsible for implementing the project. In addition, in order to inform future decision-making effectively and to assist communication and improve accountability, the Department should document:

- decisions taken as a result of monitoring formal project plans, to assist in the early identification of project management issues which should be addressed;
- decisions taken by key coordinating bodies; and
- the key elements of briefings to, and decisions taken by, Ministers in the light of Departmental advice.

Health: Agreed

Recommendation No.5 Para. 4.54

The ANAO recommends that, in order to ensure a common understanding of the conditions for income testing service delivery, the Department of Health and Aged Care and Centrelink review the current SLA to ensure:

- consistency between, and order of precedence for, agreement components;
- specification of funding arrangements, particularly relating to costing bases and processes for changing funding if particular factors which impact on service delivery resourcing change significantly;
- identification and analysis of risks to the operation of the agreement; and
- specification of the objectives, scope and resourcing for the reviews of the agreement.

Centrelink: Agreed

Health: Agreed

Recommendation No.6 Para. 4.57

The ANAO recommends that the Department of Health and Aged Care and Centrelink jointly develop as part of the SLA:

- an indicator of quality for 'data matching', and an outcome indicator for 'reviews of decisions and appeals'; and
- data collection standards that address definitions, validity, reliability, accuracy and timeliness to underpin the performance information within the agreement.

Centrelink: Agreed

Health: Agreed

Recommendation No.7 Para. 4.60

The ANAO recommends that, as there is a real risk that the current indicators cannot be used to measure satisfactorily the service provider's performance, the Department of Health and Aged Care and Centrelink should develop alternative performance measures which ensure that assessment and monitoring of performance can continue under the SLA.

Centrelink: Agreed

Health: Agreed

Recommendation No.8 Para. 4.68

The ANAO recommends that the Department of Health and Aged Care undertake a post implementation review of the introduction of income testing to assist in the planning and management of similar projects in the future.

Health: Agreed

Audit Findings and Conclusions

1. Introduction

This chapter provides a background to the audit and sets out its objectives, scope, approach and criteria.

Background

1.1 Centrelink was established as an independent statutory authority on 1 July 1997 in the former Social Security (now Family and Community Services) portfolio.[5] Centrelink's responsibilities include the integrated service delivery of a range of Commonwealth social welfare payments and services. These services are delivered under formal purchaser/provider arrangements initially with what are now the Department of Family and Community Services (FaCS),[6] the Department of Education, Training and Youth Affairs, and the Department of Employment, Workplace Relations and Small Business.[7]

1.2 Since its establishment, Centrelink has also begun service delivery under purchaser/provider arrangements with the former Department of Health and Family Services (DHFS) now Department of Health and Aged Care (referred to as 'Health' throughout this report). The services delivered under this agreement encompass:

- services relating to the residential care fee income testing component of the Government's Aged Care Structural Reform Package. This Package was introduced by the Government as part of the 1996 Federal Budget. The reforms were designed to meet the need for a more equitable funding system for residential aged care (which included the introduction of income tested residential care fees), enable 'aging in place' and improve the quality of aged care infrastructure. The focus of Centrelink's service delivery has been in respect to the provision of information to Health on income details of individuals which the Department will use in assessing residential care fee subsidies;
- income testing and provider payment services for Childcare Assistance[8];
- assessment of, and referral to, employment assistance for people with disabilities[9]; and

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5 The implementation of Centrelink, including the establishment of purchaser/provider arrangements with the agencies noted was examined in the performance audit report. *Management of the Implementation of the Commonwealth Services Delivery Arrangements—Centrelink*. Audit Report No.18, Canberra.

6 Formerly the Department of Social Security (DSS).

7 Formerly the Department of Employment, Education, Training and Youth Affairs (DEETYA).

8 Now part of the SLA between DFAC and Centrelink.

9 ditto.

- processing applications and assessing eligibility for assistance for hearing services.

Reasons for the audit

1.3 In early 1997, a performance audit was undertaken to determine the extent to which the new Commonwealth service delivery arrangements were being implemented efficiently and effectively. Specifically, the audit of the *Management of the Implementation of the Commonwealth Service Delivery Arrangements* (Audit Report No.18, 1997–98) examined the planning and implementation of Centrelink to early July 1997, the time when Centrelink became a legal entity. At the time of the audit fieldwork the transfer of service delivery from the former DSS and DEETYA to Centrelink had largely been completed, whereas this transfer in relation to the former DHFS' services was approximately six months away. Consequently, the findings and conclusions of Report No.18 were based mainly on work undertaken by the former DSS and DEETYA.

1.4 The former DSS and DEETYA were heavily involved in establishing Centrelink. They worked in partnership transferring a total of 24 000 staff from their Departments to the new service delivery agency. While DHFS/Health was kept informed of the developments, it was not directly involved in Centrelink's establishment. In this respect, the implementation of purchaser/provider arrangements for DHFS services to be delivered by Centrelink, represented the first component of service delivery on behalf of what could be considered a fully arms-length third party.

1.5 A performance audit that examines the implementation of purchaser/provider arrangements between Health and Centrelink for service delivery, was seen by the ANAO as being beneficial in identifying the issues and practice that will assist the efficiency and effectiveness of future third party service delivery implementations, as well as providing an audit opinion on the administrative effectiveness of this particular implementation.

Audit objective and criteria

1.6 The objective of the audit was to determine the administrative effectiveness of the implementation of the service delivery arrangements between Centrelink and Health by examining project planning for, and management of, the implementation, and the establishment of ongoing purchaser/provider arrangements.

1.7 The audit criteria used in this audit were to determine if:

- project planning for, and management of, the implementation was consistent with good practice, in particular whether the implementation was:
  - consistent with Government policy and legislation;
  - underpinned by an appropriately structured approach to project planning and management, that is:
    * included a formal documented risk management approach;
    * was undertaken with appropriate senior management overview and coordination arrangements at the operational level;
    * was planned and monitored using formal project plans; and
    * was undertaken with full identification of, and monitoring against, the establishment costs and appropriate performance information; and
- the establishment of on-going purchaser/provider arrangements encompassed:
  - service level arrangements which take account of the full range of good corporate governance principles and practice, as are relevant within a purchaser/provider arrangement. These include adequate identification of: roles and responsibility, on-going coordination, resourcing, reviews, risk management and performance information collection, monitoring and reporting; and
  - planning to evaluate the implementation to inform similar implementations in the future.

1.8 The criteria used in the audit analysis are further described within each chapter. The better practice on project planning and management that guided the audit, *Management of the Implementation of the Commonwealth Services Delivery Arrangements—Centrelink* was also applied to this audit. In addition, the ANAO drew on the following guides in assessing purchaser/provider arrangements:

- ANAO and Department of Finance (1996) *Performance Information Principles: Better Practice Guide*;
- Department of Finance and Administration (1998) *Specifying Outcomes and Outputs—Implementing the Commonwealth's Accrual-based Outcomes and Outputs Framework;* and
- ANAO (1997) *Applying Principles and Practice of Corporate Governance in Budget Funded Agencies.*

Audit scope

1.9 The audit examined the work within the former DHFS in undertaking the aged care implementation from the time of the 1996 Federal Budget announcement of the Aged Care Reforms to mid-September 1998. The audit also examined Centrelink's management from 1 October 1997, when it took responsibility for the implementation from the former DSS, to mid-September 1998. The project planning and implementation aspects of the audit concentrated on the period up to the 1 March 1998 implementation.

1.10 To enhance applicability for the future, this audit report refers to the Department of Health and Aged Care (Health) rather than the former DHFS in referring to functions which did not transfer from the "Health" portfolio. Where clarity permits, the report refers to FaCS rather than the former DSS.

Audit approach

1.11 The audit was based on interviews with key staff in Health and Centrelink and an analysis of relevant Government and agency documents. Significant issues were cross-referenced with the former DSS and Department of Veterans' Affairs (DVA), where necessary. The fieldwork for the audit took place between June and September 1998.

1.12 Because of their significance, the ANAO took account of the coordination arrangements with the former DSS and DVA, but did not audit these per se as this audit was focused on the purchaser/provider arrangements with Centrelink.

1.13 The audit was conducted in conformance with ANAO standards and cost approximately $320 000.

2. Aged care service delivery and the environmental factors impacting on its implementation

This chapter describes the background to the aged care service delivery, the service delivery process itself, and the environmental factors that impacted on the implementation.

Background to aged care service delivery

2.1 The 1996–97 Budget announced a major package of structural reforms to long term care in response to key pressures of Australia's aging population, the need for a more equitable funding system (which included the introduction of income tested residential care fees), the need to enable 'aging in place' and to improve the quality of aged care infrastructure. The majority of the new arrangements came into effect on 1 October 1997. However, the implementation date for income tested fees for new aged care residents was rescheduled to 1 March 1998. All the aged care reforms involved major policy and administrative changes for the Commonwealth Government, aged care service providers and the Australian community. The implementation process was complicated by a number of policy, legislative and resource issues.

2.2 The components of the aged care reform package included the introduction of:

- income tested residential care fees;
- accommodation bonds for residents;
- Resident Classification Scale; and
- an Aged Care Standards Agency.

2.3 Although Centrelink has been involved in provision of information to customers across the Reform Package, its principal focus for service delivery has been in respect to the provision of information to Health on income details of individuals, retrieved from its data base on Social Security beneficiaries, or else collected from individuals. The Department will use this information to assess residential care fee subsidies.

Overview of aged care services delivery

2.4 Instead of undertaking income assessments for all current residents at implementation and new residents thereafter[10], the Government recognised that both Centrelink[11] and DVA have a significant amount of income data for those in receipt of pensions and benefits from these agencies. The Government therefore decided to use this data to determine the residential care fee (and the Government fee subsidy to the aged care facility), and only collect income data from those residents who could not be identified as in receipt of benefits. Such a decision minimised the administrative impact on aged care residents. It also significantly increased the complexity of the administrative processes, as demonstrated in Figure 1.

2.5 The planned process was to only income test those residents who were not in receipt of benefits from either DVA or Centrelink. For these residents and for part-rate pensioners, their component of the care fee payable to the aged care facility would be dependent on their level of income. Health would then calculate and pay the subsidy to the facility to cover the balance of the cost of the care. A simplified description of the administrative processes is as follows:

- the aged care facilities provide Health with identification data on residents, which is then entered into Health's IT system;
- this data is transferred to DVA where it is matched against the service pension database. DVA returns income details of its service pensioners to Health, and forwards the remaining unmatched records to Centrelink;
- Centrelink matches this data with the pension/beneficiary database, and returns income details to Health;
- Centrelink then invites the remaining residents to be income tested and returns the results (including identification of those who choose not to be income tested) to Health;
- Health determines the care fee payable by each new resident. Full-rate pensioners do not pay care fees, while self-funded retirees who do not undergo income testing are subject to maximum care fees; and
- based on the assessed care fee payable, and the level of care required by the new resident, Health forwards a subsidy to the aged care provider.

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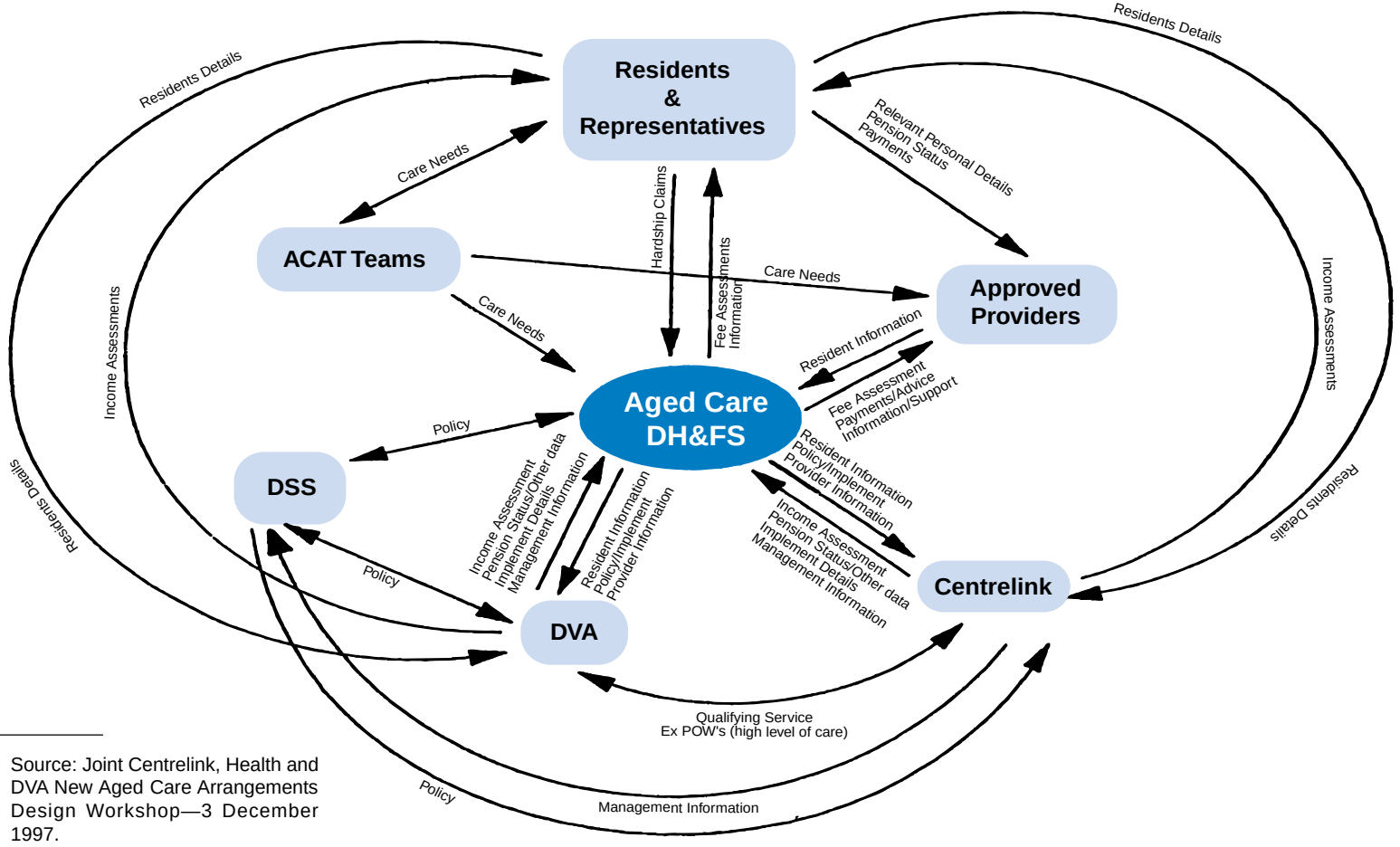
[10] Since the original Government decision, the Government decided that existing residents at implementation date were exempt from income tested residential care fees.

[11] The original Government decision was with respect to DSS, as Centrelink had not been created at the time.

Figure 1

Map of administrative processes and stakeholders for the residential care fee *income test.*[12]



[12] Source: Joint Centrelink, Health and DVA New Aged Care Arrangements Design Workshop—3 December 1997.

Environmental factors

2.6 There were a range of policy, legislation and resource factors that impacted on the complexity of the environment for the implementation. These factors, described below, were taken into account in the formulation of the audit findings, conclusions and recommendations detailed in this report.

Transfer of responsibility to Centrelink and subsequent involvement of four agencies

2.7 The implementation of the income tested residential care fee was originally envisaged by Government to involve three government departments:

- DHFS—responsible for overall management of the Aged Care Reform Package, including advising residents of their income tested care fees;
- DSS—responsible for the policy and operational aspects affecting its payments, and data matching and income assessment service delivery; and
- DVA—responsible for policy and operational aspects of data matching.

2.8 However, with the establishment of Centrelink, the delivery of income testing transferred from the former DSS to Centrelink as the service delivery agency on 1 October 1997. At this time, Centrelink was an organisation with structures, processes and procedures that had been newly established and were in a settling-in period. Furthermore, while staff and managers from the former DSS and DEETYA had transferred with the respective service delivery upon Centrelink's establishment, there was no commensurate transfer of staff with associated program knowledge from Health. However, IT staff working on the associated systems development were transferred from the former DSS to Centrelink at that time.

2.9 In addition, while the services transferred from the former DSS and DEETYA at the time of Centrelink's establishment were largely established processes, residential aged care income testing was a new initiative.

2.10 At the time that Centrelink took responsibility, there was a high level of public interest in the Aged Care Reforms. This generated significant numbers of public enquiries, not only to Health, but also through Centrelink's teleservice centres. Centrelink and Health therefore needed to develop and did implement a rapid response to these enquiries.

2.11 The transfer of responsibility for service delivery from the then DSS into Centrelink, meant that Health now had three, rather than two,

other agencies with which to coordinate implementation of an already complex process. The former DSS, and now FaCS, has continued involvement with the related income support policy issues.

Coordination with stakeholder groups

2.12 In introducing the Aged Care Structural Reform Package, the Government gave a public commitment to consult widely with stakeholders including service providers, consumers, unions and health professionals. The Funding and Other Implementation Issues Working Group (FUNIWG) was the body established by Health to undertake consultation on a range of issues including residential care fee income testing.

2.13 As FUNIWG provided input into related micro-policy development as well as scrutiny of all aspects of the implementation, Health needed to ensure that its implementation planning took account of the time and resources required for consideration of matters by FUNIWG.

2.14 In addition, Health needed to undertake consultation and negotiations with State and Territory Governments, as some nursing homes are owned by state governments, and State/Territory Governments have responsibility for some of the areas impacted by the Reform Package, for example, building codes for residential care facilities.

Changes to implementation arising from Government decision-making

2.15 Throughout the period, there was a series of Government decisions which directly impacted on the implementation. The key Government decisions affecting the administration of the implementation included to:

- delay implementation initially set for 1 July 1997 to 1 October 1997 due to delays in the passage of the *Aged Care Income Testing Bill 1997*. The Bill provided the legal basis for income assessment to be undertaken on existing residents in the lead up to the implementation date for reforms within the *Aged Care Bill 1997*. DSS estimated that this would require three months to complete with minimal risks (announced late May 1997);
- further revise the implementation date to 1 November 1997 to take account of the impact of changes on income assessment arising from the new DSS pension deeming rates (announced late September 1997);
- appoint a new Minister for Family Services in October 1997, with a subsequent need for briefings on the implementation;

- subsequently revise the implementation date to 1 March 1998 and change policy details relating to income testing by:
  - only requiring new residents to be income tested, and
  - only taking assets gifted after 20 August 1996 into account for income purposes (announced 27 October 1997);
- no longer require the collection of accommodation bonds, which only affected information provision through Centrelink (announced 5 November 1997);
- change the income basis to exempt income received from renting the family home (announced 1 December 1997); and
- introduce a 28 day period of grace with respect to the care fee for new residents, allowing an administrative period in which agencies can determine the fee payable (announced 10 February 1998).

2.16 The list of key original policy elements and events for the implementation of income testing for residential care fees is set out at Appendix 1.

Linking systems for data matching

2.17 The data matching process relied on linking separate data-bases from each agency's IT system, each of which had been designed with different functionality; in particular:

- the Health system's primary purpose is to pay residential age care facilities rather than collect residents' details;
- the DVA pension system does not maintain a record of customers' previous payments (although this can be constructed from a maintained record of payment changes)[13]. This lack of payment histories has specific implications for gifting arrangements affecting part-pensioners, and for the Health fee subsidies if the DVA pension changed as a result of reassessments or appeals; and
- the Centrelink system holds histories of customer payments. Centrelink has standard protocols for exchanging data with external agencies that specify the format of data files to ensure the integrity of data processing. This required changes to the data file format used by Health and DVA.

2.18 In addition, aged care facilities do not require proof of identity. Therefore, residents would provide 'commonly used' names which would not necessarily match with the 'official' names held by agencies in their

[13] The ANAO has established that DVA has plans for 1999 to revise its IT system which will address this complexity.

databases for pension payment purposes. Consequently, the agencies had to take this into account in the development of systems for electronic data matching.

2.19 Implementation of the data exchange process was further impacted by the means through which testing was undertaken. The respective agencies' data centres were remotely located, and were not linked electronically until immediately prior to the 1 March 1998 implementation date. The testing process for data matching was therefore undertaken through an exchange of computer tapes, and as this took time, the testing was slowed.

COAG decision on responsibility for aged care

2.20 In June 1996 the Council of Australian Governments (COAG) decided to develop new aged care arrangements under which the States would have responsibility for managing aged care programmes. Whilst this decision has not subsequently gone ahead, it led to a staffing shortage in the Aged and Community Care Division[14] (A&CCD) during the critical implementation period, as A&CCD put in place a recruitment freeze and staff took up other career options, both in anticipation of the functional transfer to the state governments.

2.21 This staffing environment in A&CCD limited the resources available in Health for allocation to the income testing implementation.

[14] The Aged and Community Care Division, Health, had responsibility for implementing the Aged Care Structural Reform Package, including the income tested residential care fee.

3. Project planning and management

This chapter examines project planning and management undertaken by Health and Centrelink for the implementation of the residential care fee income test. The project was implemented on 1 March 1998, in a complex and changeable implementation environment, particularly from Health's perspective. The ANAO found that both Health and Centrelink complied with the Government's policy and legislative requirements. The ANAO concluded that implementation could have been more effective with better project planning and management by Health. The lack of a structured approach to project planning and management by Health exposed the implementation to risks that otherwise could have been identified and more effectively managed. The ANAO considers that future implementations by Health will be subjected to unwarranted risk if project planning is not improved. Centrelink's project planning approach was considered to be adequate. The ANAO has identified scope for improvement in project planning and management in both agencies and has made three recommendations to address these issues.

Introduction

3.1 Project planning and project management are two essential phases of efficient and effective management of any major project and are particularly important for complex projects undertaken in rapidly changing environments, such as the implementation of the Aged Care Structural Reform Package of which income testing was a part. Good practice in project planning is characterised by a structured approach, namely:

- the management of risks to the implementation, including development of contingency strategies;
- appropriate coordination arrangements to provide senior management oversight and coordination at the operational level for the implementation;
- formalised project plans to assist in fully identifying and monitoring progress against implementation tasks and their milestones; and
- the identification and management of resources required for the project.

3.2 In implementing large projects, public sector managers should put in place processes which ensure consistency of project outputs and outcomes with Government policy and legislation.

3.3 The ANAO recognises that project planning and ongoing management of project implementation are two distinct phases of a project where the outcome and the process to achieve that outcome can be well defined up front. However, in a complex, changing environment, the planning stage needs to be revisited frequently, and therefore becomes an integral part of the whole management strategy process. Consequently, they are examined together in this chapter because the series of Government decisions impacting on the residential care fee income test required Health and Centrelink to review and revise the planning during the implementation phase to address these changes.

3.4 The complexity of the service delivery arrangements and environmental factors outlined in Chapter 2, impact on both the stability and certainty of the project implementation process and outputs. In such an environment, project planning that highlights the interactions of sub-project components with regard to key milestones and establishes processes for monitoring and updating of project plans to reflect changes in the environment arising from, for example, Government decisions, becomes increasingly important in order to efficiently and effectively achieve implementation outcomes.

Approach

3.5 The implementation of the residential care fee income test is one component of the Aged Care Structural Reform Package, and as such the planning and management of this component cannot always be considered separately from the overall implementation of the Government's aged care reforms. Therefore, throughout this chapter, the ANAO's findings are in the context of the income testing component being one part of a broader package. Figure 2 provides an overview of this relationship.

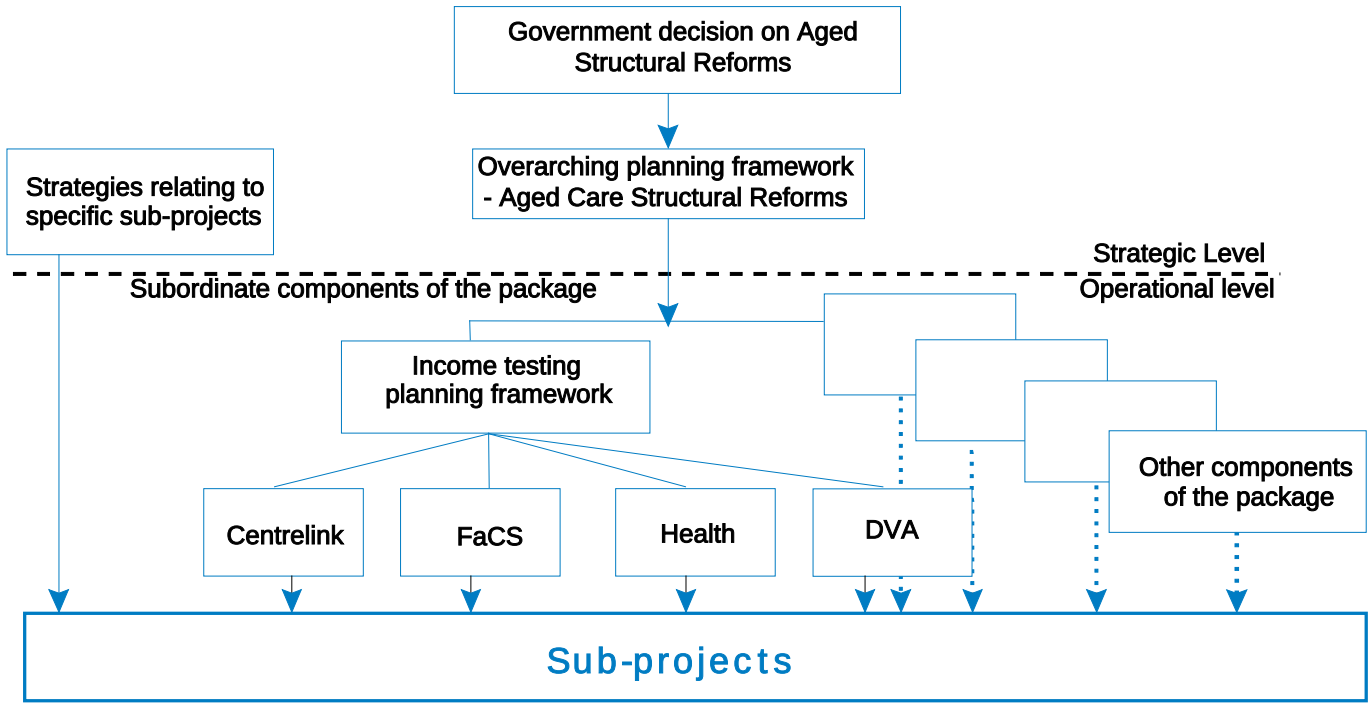
3.6 In this context, the audit examined project planning for, and management of, the implementation of the residential care fee income test in the following areas:

- processes to ensure consistency of project outputs and outcomes with Government policy, and legislation; and
- a structured approach to project planning and management as outlined at paragraph 3.1.

3.7 The ANAO's findings in relation to each of these areas are discussed separately below. The ANAO has drawn on the planning and implementation of sub-projects to illustrate good practice and other implications. The audit sought to examine in detail project planning and management for key implementation sub-projects that have the potential

Figure 2

Aged Care Structural Reforms—physical planning framework[15]



[15] Examples of sub–projects would include IT systems, communication strategies, legislation, project management and co–ordination, agreements, and training.

to significantly impact upon service delivery and require high levels of coordination between Health and Centrelink; namely:

- communication with customers and other stakeholders;
- training for agency staff and aged care providers;
- IT systems development;
- income assessment forms; and
- business process re-engineering to integrate service delivery into Centrelink's processes.

3.8 A description of the planning and management of these sub-projects is provided in Appendices 2 to 6 respectively, as well as an assessment of key aspects of the activity.

Processes to ensure consistency of project outputs and outcomes with Government policy and legislation

3.9 The following aspects of project planning and management were examined in the audit to determine whether processes were undertaken to ensure consistency of project outputs and outcomes with Government policy and legislation; in particular:

- compliance of outcomes with Government policy; and
- compliance with relevant legislation.

Compliance with Government policy

3.10 The key characteristics of Government policy in relation to the service delivery arrangements with Centrelink that were required to be implemented[16] as a component of the aged care reform package, were to:

- introduce an income based residential care fee for residents of aged care facilities and an associated income assessment process to be administered by Centrelink[17] and DVA;
- require Centrelink to income test those residents who were not in receipt of benefits from either DVA or Centrelink. The outcome of this income test would be used as the basis to determine their residential care fee; and
- use the significant amount of income data held by Centrelink and DVA for those residents in receipt of pensions and benefits from these agencies, to determine their residential care fee.

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[16] See Appendix 1 for more details.

[17] The original Government decision was with respect to DSS, as Centrelink had not been implemented at the time.

3.11 As discussed in the previous chapter the original implementation date was 1 July 1997; this was subsequently amended three times with the final implementation date being 1 March 1998. There were also several policy changes announced prior to the implementation date that impacted on income testing (see 2.15 for further details).

3.12 The ANAO found that an operational income testing process was put in place on 1 March 1998, as described in paragraph 2.5, and reflected in the Service Level Arrangement (SLA)[18]. These processes were consistent with the Government announced policy for Centrelink's service delivery component of the Reform Package. Therefore, the ANAO concludes that the agencies have achieved the implementation which was consistent with the policy framework decided by the Government.

3.13 However, had 1 July 1997 remained the Government's required implementation date, the ANAO has identified a number of key elements that would not have been completed. Concerns relating to the achievement of deadlines is discussed further under the section on the development and review of formal project plans (see paragraphs 3.70–3.72).

Compliance with legislation

3.14 To determine whether, as part of the project implementation, Health and Centrelink ensured that they complied with relevant legislation, the ANAO examined whether appropriate advice had been sought to ensure that:

- the requirements of the *Privacy Act 1988* were complied with in implementing the residential care fee income test; and
- the respective responsibilities of agencies under purchaser/provider arrangements were based on legal advice, specified to a sufficient level, and agreed between parties, to assist monitoring of compliance.

Compliance with legal requirements of the Privacy Act 1988

3.15 The ANAO found that:

- Health sought and acted upon advice from the Privacy Commissioner and the Attorney-General's Department on drafting the privacy provisions of the *Aged Care Reform Bill 1997;*
- the agencies had consulted with the Privacy Commissioner to ensure that the administrative arrangements for income testing complied with the requirements of the *Privacy Act 1988* and the associated Information Privacy Principles; and

[18] Chapter 4 describes and assesses the SLA.

- the necessary authority had been given, under the *Social Security Act 1991*, to release information to Health from Centrelink to enable calculation of residential care fees and subsidies.

3.16 The ANAO considers that Health and Centrelink consulted appropriately to ensure that legal requirements for the protection of privacy were complied with in implementing the income testing and data matching components of the aged care reforms.

Legal advice on responsibilities under purchaser/provider arrangements

3.17 The ANAO considers that an important component of sound corporate governance is for the parties to the SLA to fully understand their responsibilities, from a legal perspective, in purchasing or providing service delivery under outsourced arrangements. In the case of the service delivery of residential care fee income testing, this is particularly important, as a third party, namely FaCS has a role in advising on the policy implications of income testing on income security with respect to the *Social Security Act 1991*. In addition, FaCS also has other interests with respect to Centrelink's arrangements with Health, as follows:

- under the *Aged Care Act 1997*, it is to FaCS that Health may delegate residential care fee income testing responsibilities, and FaCS may, in turn, sub-delegate these to Centrelink;
- DoFA advised Centrelink that FaCS is responsible for paying compensation for Centrelink's defective administration with respect to all service delivery under the Compensation for Defective Administration Scheme[19]; and
- the then Minister for Social Security transferred funding from FaCS to Centrelink to assist in, amongst other service delivery, the implementation of residential care fee income testing.

3.18 The ANAO found that legal advice had been sought in developing those parts of the service level agreement which were common across Centrelink's delivery of Health's services. While legal advice in regard to some specific issues was sought in the drafting of the Aged Care Schedule, the document was not subject to comprehensive legal scrutiny. Legal advice was not sought to clarify the parties' respective legal responsibilities particular to the Aged Care Schedule and these are not addressed within the Schedule. During the audit, the ANAO identified a problem with delegations that has subsequently been fixed with little overall impact on service delivery. However, had legal responsibilities

[19] Since signing the Core Arrangement of the SLA, DoFA has made arrangements so that such payments can now be made by Centrelink.

(for example, those arising from the *Financial Management and Accountability Act 1997* and the *Aged Care Act 1997*) been specified within all elements of the SLA in sufficient detail, based on legal advice, and monitored, this would have reduced the risk of problems such as those with delegations occurring in the first place, as there should be less uncertainty between the parties on this issue.

Conclusion—processes to ensure consistency of project outputs and outcomes with Government policy and legislation

3.19 The agencies complied with the key elements of the Government's policy in so far as there was an operational income testing process in place by the approved implementation date of 1 March 1998 with characteristics consistent with Government announcements. However, the ANAO found that adequate progress would not have been made to meet the initial deadline of 1 July 1997 due to lack of a sufficiently structured approach to planning and management. The decision to amend this implementation date was based on a delay in the passage of the necessary legislation. The ANAO concluded that, had the original implementation date still been in effect, income testing at the level required by Government would not have been in place.

3.20 The ANAO found both agencies complied with legal requirements in the implementation as appropriate consultation with respect to the requirements of the *Privacy Act 1988* was undertaken and legal advice sought in relation to the SLA. However, legal responsibilities were not clearly identified in the Aged Care Schedule attached to the SLA, which sets out in detail Centrelink's responsibilities in respect to the services, in relation to aged care, that it is to deliver on behalf of Health. This increases the risk that responsibilities will not be fully discharged due to uncertainty between the parties to the SLA.

Recommendation No.1

3.21 In line with sound corporate governance practices, the ANAO recommends that Centrelink and the purchasing agency fully identify in the service level agreement their respective responsibilities, based on appropriate legal advice.

Centrelink response

3.22 Agreed

Health response

3.23 Agreed. Legal advice was sought on the principles and protocols of the SLA.

Structured approach—managing implementation risks

3.24 The identification and management of risk is an essential part of project planning. There were a number of potential areas of risk that needed to be effectively managed by Health (and Centrelink in some instances) in implementing the residential care fee income test. For example, there are risks arising from the following:

- the need for substantial IT systems development to be implemented within a short time frame and for coordination of IT systems across three agencies;
- delays in the passage of the *Aged Care Act 1997*—requiring the development of contingency strategies;
- community concerns on the government policies reflected in the Aged Care Reform Package;
- the need for consultation with industry and community stakeholders in the development of micro-policy; and
- the effect of legislative delays and policy changes on the costs and resources originally identified for the implementation.

3.25 The ANAO sought to establish whether Health (and Centrelink, as necessary) had:

- adopted a risk management approach to the implementation at all levels of the planning process that took into account better practice risk management principles. Such better practice indicates that risk management should underpin and be an integral part of project and sub-project planning;[20] and
- provided briefings to the relevant Ministers on key risks to the implementation.

Formal risk management approach

Within Health

3.26 The ANAO found the following approaches to risk management were taken by Health with respect to this implementation:

- risk management was said to be undertaken as part of the normal course of management by senior managers in A&CCD. In particular, Health advised that the difficulties in achieving the original timetable were foreseen at an early stage. However, as analysis of risks was

[20] MAB/MIAC 1996, *Guidelines for Managing Risk in the Australian Public Service*, Report No. 22 AGPS, Canberra.

not documented, the ANAO is not in a position to confirm the nature, extent or quality of any risk assessment undertaken through this means;

- at an operational level, the risk of time-frames not being met with respect to passage of the relevant legislation was identified as a key risk. Health advised that contingency strategies were discussed by systems, policy and legislation areas within Health to address this risk. However, these strategies were not documented; and
- risk identification was undertaken to some extent on a sub-project basis. Examples identified include: the risk of community concern over accommodation bonds; legislative delays impacting on communication regarding income testing; and risks associated with the IT systems sub-project.

3.27 For the IT systems sub-project, a formal risk assessment was undertaken to progressively assess the various risks associated with the development and implementation of the IT systems to support the reform package (including system changes required to implement income testing). This risk assessment identified and ranked risks directly impacting on system development and identified strategies to treat key risks. Risks were monitored through the Structural Reform Systems Steering Committee (SRSSC). The ANAO considers that the risk assessment process adopted for the IT systems sub-project is in line with the better practice principles of risk management.

3.28 The ANAO noted documentary evidence that some advice on risks had been provided by Health to the Minister. However, Health did not develop a formal risk management plan for other sub-projects required for the implementation of the residential care fee income test. Health therefore did not have an adequate basis for briefing the Minister comprehensively on the risks to the implementation.

3.29 The ANAO was advised that at the time of this implementation, formal risk management was not a requirement of project planning and management within Health. Since this implementation, however, Health has developed a guide to introduce risk management in the Department that includes a summary of the MAB/MIAC Guidelines. The ANAO considers that this is a step toward integrating risk management into all project planning and management in the Department. The ANAO also considers that risk management approaches to all planning for major projects (similar to that undertaken for the IT systems sub-project) should be introduced by Health as a matter of priority.

Within Centrelink

3.30 The ANAO found the following approaches to risk management were taken by Centrelink with respect to this implementation:

- as in Health, senior managers undertook general risk management in the normal course of their management duties. However, as discussions were not documented the ANAO could not determine the level, extent or quality of any informal risk assessment;
- a high level management update that identified key risks associated with the implementation, but did not include an assessment of these risks or identify the means by which they would be managed; and
- Centrelink advised that risks and associated contingency plans were discussed at Centrelink Internal Stakeholders Group meetings in terms of critical time-frames and processes that needed to be undertaken to achieve the milestones set out in the Centrelink implementation plan, for example, contingency plans to meet a critical time-frame, following the request for changes to the income testing form.

3.31 Nonetheless, Centrelink did not develop a formal risk management plan for the implementation of the residential care fee income test that systematically identified risks to the implementation, action to treat identified risks and mechanisms for monitoring risks.

Risk management through coordination mechanisms

3.32 The ANAO identified the following examples of risk management through cross-agency coordination mechanisms:

- coordination at a senior management level between agencies—although high level meetings were not documented, correspondence between the agencies indicates that discussion on action following the delay in the passage of the *Aged Care Act 1997* and problems with advice being provided by Centrelink Call Centres occurred; and
- meetings of the Tri-Departmental Steering Committee—while risk management was not an agenda item for these meetings, problems were identified and plans or actions to deal with them were discussed by Health, Centrelink and DVA.

Ministerial briefings

3.33 The ANAO sought to establish that Health and Centrelink had briefed their respective Ministers on progress with respect to the implementation of income testing and key risks.

Health

3.34 The ANAO identified a range of formal briefings by the Department to the Minister for Family Services that identified risks, including:

- early in the project implementation phase (25 September 1996), providing information on sub-projects to be undertaken to implement the Aged Care Reform Package and the processes to achieve these. For each of these sub-projects, responsible officers and issues were identified. While many of the issues related to micro-policy resolution, some risks were highlighted, including criticality of the legislative time-frame. A high level project plan that outlined timelines for each sub-project was also included in the briefing;
- on 9 April 1997, providing information on the risks associated with continuing with 1 July 1997 as the implementation date given the delays in the passage of legislation, particularly the *Aged Care Income Testing Bill 1997*[21]. The briefing also included options for revising the implementation date and associated costs and benefits;[22]
- on the issue of service difficulties with respect to Centrelink Call Centres in August 1997 and contingencies to improve service to clients; and
- on risks to the implementation of income testing on 1 March 1998, in particular those relating to IT systems, in late December 1997.

3.35 The ANAO was advised that in addition to formal briefings, Health regularly briefed their Minister verbally on a range of issues with respect to the implementation. Some written briefings referred to these discussions.

3.36 As the formal written briefings do not cover Departmental advice or decisions taken by the Minister in the light of that advice, at some critical milestone times within the implementation, the ANAO only has limited assurance that the Minister was kept fully briefed on the risks to the implementation. In addition, as identified in paragraph 3.40, Health did not undertake a formal risk management plan, and therefore did not have a basis for briefing the Minister comprehensively on the risks to the implementation.

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[21] Optimally, three months were required for income testing existing residents prior to the implementation date of the income tested residential care fee. This Bill provided the legislative authority to undertake this testing prior to the implementation date, and so for a 1 July 1997 implementation, optimally the Bill needed to be passed by 31 March 1997.

[22] The Department has advised that senior officers of Health were in regular contact with the Minister on the proposed approach to the implementation of the Aged Care Structural Reform Package including factors to be considered in a 1 July 1997 implementation date.

Centrelink

3.37 The ANAO was able to identify examples of formal briefings to the Minister for Social Security that highlighted risks to the implementation as follows:

- on implementation progress, at the time of the hand-over and risks arising from IT systems complexity;
- on the development of a draft Memorandum of Understanding[23], between Health and the former DSS jointly with the CSDA (Centrelink), as an interim purchaser/provider arrangement in late October 1997; and
- in discussions of the background and associated facts in response to adverse media comments on Centrelink's performance in mid-February 1998.

3.38 In addition to these briefings, the former DSS was providing briefings to its Minister on the impact of policy changes, including impacts on Centrelink's service delivery role.

Conclusion—Structured approach (risk management)

3.39 Given the risks associated with such a large and complex project, the ANAO considers that adopting a more formal systematic approach to risk management (including the development of contingency strategies also on a systematic basis to minimise the impact of potential risks), is essential in order to effectively and efficiently manage the implementation.

3.40 The ANAO found that Health and Centrelink had identified some risks. However, with the exception of the IT systems sub-project in Health, formal risk management practices, in line with accepted better practice, did not underpin the implementation. As a result, the ANAO did not find evidence of systematic assessment of the implications arising from key risks on the overall project, nor evidence of development of early contingency plans to address these risks.

3.41 A formal risk management process provides a sound basis for briefing relevant Ministers comprehensively on risks to the implementation of Government policies. From an accountability perspective, it is important that such briefings be documented to inform future decision making and to assist better communication and accountability. The ANAO found that the Minister had been provided with briefings on key risks by Health. However, the Department could only provide the ANAO with limited assurance that these briefings were

[23] This Memorandum of Understanding was never finalised, with negotiations on the Service Level Arrangement and Aged Care Schedule taking precedence.

sufficiently comprehensive as they were not based on a formal risk management approach. There was not an appropriate record of such briefings and decisions taken by the Minister in the light of Departmental advice for accountability purposes.

3.42 The ANAO considers that, given Centrelink had responsibility for a relatively self-contained and less complex component of the implementation, and did not have overall responsibility for program delivery, the briefings it provided were sufficient to keep the Minister for Social Security informed on identified risks to the implementation. However, for future, more complex implementations where Centrelink has a higher proportion of the workload, the agency should adopt a more formal risk management approach to ensure that briefings on risks to the Minister are sufficient.

Structured approach—coordination arrangements

3.43 In order to ensure that complementary and consistent outcomes are achieved across a project, coordination is required between all relevant stakeholders, including both managers and operational staff with responsibility for sub-projects and tasks. This coordination should ensure coverage of all significant implementation issues, timely implementation of project and contingency plans, monitoring of implementation tasks against identified milestones, identification of respective responsibilities and appropriate accountability arrangements.

3.44 In examining this issue, the ANAO sought to determine whether there were effective coordination arrangements to provide:

- coordination at the operational level; and
- senior management overview of the implementation.

3.45 The ANAO's findings with respect to each of these areas are discussed separately below.

Coordination at the operational level

3.46 The ANAO sought to establish that both Health and Centrelink had implemented coordination arrangements to support the implementation of the residential care fee income test, both internally and at an inter-agency level.

Within Health

3.47 While a specific area, the Aged and Community Care Division (A&CCD) within Health had responsibility for implementing the Aged Care Structural Reform Package, other areas within Health needed to be involved in the implementation, for example:

- Information Services Division (ISD), for the aspects of IT systems development;
- Legal Services Branch, for aspects relating to legislation; and
- Corporatisation Unit, on the development of the purchaser/provider arrangements.

Health has advised that there was ongoing liaison and consultation with ISD, Legal Services Branch and the Corporatisation Unit on these matters.

3.48 A formal mechanism was not put in place to properly coordinate all of the areas with implementation responsibility. However, it is acknowledged that, for one particular sub-project, the IT systems development aspect of the implementation of the Reform Package across all areas of the Department was coordinated through the SRSSC, which met regularly throughout the implementation. This Committee's work was supported by a joint Project Team, comprising staff of A&CCD and ISD[24].

3.49 The ANAO considers that while the SRSSC provided an important coordination mechanism across the Department for the IT system aspect of the overall implementation, it does not fully substitute for an overarching coordination mechanism that has as its focus the overall implementation of the Reform Package. The ANAO considers that such a coordination arrangement could have identified, and provided input to management on the risks to other sub-projects from, for example, the delays such as in the development of the communication strategy which would have meant that Health would not have had an effective communication strategy in place for the 1 July 1997 implementation dates. A further example of such a delay is that of commencing and progressing the development of a SLA between Health and Centrelink in time for the 1 March 1998 implementation. This meant that income testing was operating for approximately 4.5 months after the implementation date without a core agreement between the parties, and for 6.5 months without an Aged Care Schedule.

3.50 For the income testing aspects of the aged care reforms implementation at an operational level, Health initially appointed an action officer,[25] tasked to work closely with a number of senior officers responsible for aspects of establishing an income testing system. The action officer was responsible, under supervision, for a number of micro-

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[24] Many of these staff were out–posted to the A&CCD throughout the implementation.

[25] The Department has advised that in late November 1997, additional resources were made available to Health (four to five officers) to implement the residential care fee income test in recognition of the level of client inquiry being received and the sensitive nature of the implementation.

policy matters relating to the income testing process as well as facilitating coordination within Health and between Health, Centrelink and DVA on income testing implementation issues.[26] The Department advised that the action officer achieved these tasks in consultation with all relevant areas within Health and between Health, Centrelink and DVA.

3.51 The ANAO found that the scope of the action officer's work was considerable, and recognises that it would not be feasible for the action officer to undertake all of the operational work required for the implementation, and that expertise was required from other areas of the Department, for example IT systems and legal areas. As the ANAO did not find an operational level coordination mechanism across all relevant areas within Health to support the work of the action officer, the ANAO sought evidence of substitute arrangements and identified the following:[27]

- communication by the action officer, of the outcomes of Tri-Departmental Steering Committee meetings,[28] in terms of time-frames, tasks and decisions, to Health officers involved in the implementation;
- attendance by the action officer at meetings of a cross-agency Technical Working Party to discuss data matching and exchange issues;
- substantial ad-hoc communication between the action officer and other areas of Health, that had key roles in supporting the implementation of the residential care fee income test; and
- working groups and sub-working groups formed to work on specific implementation tasks on an 'as-needs' basis. Some of these groups, in particular systems and communication working groups, met with their counterparts at the former DSS (and later Centrelink) and DVA from time to time to coordinate agency activities. However, minutes or other documentation outlining, for example, the frequency of, and attendance at, meetings of these groups were generally not recorded.

3.52 As the result of a lack of adequate documentation of the responsibilities and outputs of these groups, the ANAO is unable to draw a firm conclusion regarding the effectiveness and efficiency of the implementation structures in assisting coordination of the income testing

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[26] In addition, the Department advised that this officer had a substantial workload in answering public queries on complex administration and policy issues referred from the Telephone Hotline. Once service delivery was transferred to Centrelink in October 1997, the responsibility for coordination with Centrelink, including the development of the Aged Care Schedule, was assigned to a dedicated officer, in recognition by Health of the importance of this relationship.

[27] Health has also advised that the role of Corporatisation Unit in the development of the SLA with Centrelink was as a coordination mechanism. The unit circulated drafts of the SLA to all Divisions and all States at various formative stages during the development of the agreement.

[28] The Tri–Departmental Steering Committee was a key coordinating structure between Health and Centrelink (see Appendix 7).

implementation within Health. Nonetheless, the ANAO considers that an arrangement that facilitated coordination of the implementation at officer level with documented reporting required against the development and monitoring of a formal project plan for the implementation of income testing, would have provided Health with the most effective and accountable means of coordinating the project. Examples of such a mechanism could include a coordinating committee at officer level that brought together all responsible areas of Health to facilitate the work of the project officer or else a multi-disciplinary project team tasked with this responsibility. Such a committee or team would also need to function in parallel to, provide input into and receive management direction from, the mechanisms providing senior management overview of the implementation.

3.53 The ANAO emphasises the importance of adopting a structured approach to coordination at the operational level for complex implementations in a volatile environment, since a lack of structure can impact negatively on effective staff management, leading to staff:

- not understanding the implementation process and their role in contributing to its success;
- conducting ineffective handovers with a consequent loss of knowledge;
- having confused lines of accountability;
- failing to create, record and retain adequate documentation of processes and important decisions pertinent to the implementation; and
- being uncertain about appropriate coordination mechanisms in place for the implementation, leading to poor communication.

3.54 During the course of the audit, the audit team noted anecdotal evidence in relation to several of the above outcomes that would suggest that there was an adverse impact on staff management in Health throughout much of the implementation. If a structured approach to coordination was adopted, effective staff management processes could be put in place that allow staff to understand their roles and priorities at any point in time, thus contributing more effectively to the achievement of objectives in high pressure situations.

Within Centrelink

3.55 Within Centrelink, the implementation of income testing was managed by the Assistant National Manager, and a Senior Project Officer from the Retirement Customer Segment. These officers reported directly to the National Manager and were responsible for:

- developing a project plan for the implementation, with the assistance of the Strategic Theme Team;
- designing service delivery and IT systems processes, in consultation with National Office and Area Office staff;
- facilitating coordination within Centrelink and between Centrelink, Health and DVA on all implementation issues, including attending meetings of a Tri-Departmental Steering Committee and negotiating the Aged Care Schedule of the SLA between Health and Centrelink;
- coordinating the implementation across the customer service outlets through a network of Area Aged Care Coordinators. These Coordinators were kept informed of the implementation developments through a series of telephone hook-ups, culminating in a two day conference in January 1998 to discuss details of local level implementation by the Centrelink network; and
- chairing meetings of an Internal Stakeholders Group, comprising relevant senior officers from areas responsible for sub-projects and tasks. This was a key coordinating mechanism for the implementation within Centrelink. These meetings were held fortnightly from early December 1997 until late January 1998 following the development of Centrelink's implementation project plan (this is discussed in more detail at paragraphs 3.77 to 3.78) and were used for decision-making and reporting progress against key sub-projects and tasks identified in the project plan.

3.56 Centrelink also appointed an account manager for Health from the Business Development Unit, whose role included negotiating the overarching SLA with Health. This account manager worked in close collaboration with the Retirement Customer Segment to coordinate interaction between Health and Centrelink on many aspects of the implementation.

3.57 The ANAO considers that the coordination arrangements within Centrelink provided a level of consistency in project management and a clear coordination point for areas of Centrelink responsible for implementation of sub-projects and tasks, and therefore assisted with effective project implementation.

Between agencies

3.58 The ANAO identified a range of coordination arrangements across the various levels of responsibility to ensure communication and coordination between Health and Centrelink; in particular, the Tri-Departmental Steering Committee, Tri-Departmental working groups, a joint project design workshop, and a range of informal contacts between

Health and Centrelink (and DVA) at officer level. A more detailed description of these is at Appendix 7.

3.59 The ANAO considers that the above coordination arrangements provided an adequate mechanism to facilitate coordination between Health and Centrelink on the implementation and ensure coverage of all significant implementation issues. However, the ANAO considers that coordination would have been more effective and efficient had Health:

- implemented overarching coordination mechanisms which would have assisted their input into the cross-agency processes; and
- developed formal project plans at a level of detail that could provide the potential for cross-agency bodies to reference an integrated and consistent set of project plans.

Senior management overview

3.60 The ANAO found several key examples that indicated that there was senior management overview and coordination of the implementation within Health, within Centrelink and between agencies. These examples are outlined in Appendix 7.

3.61 There were sufficient mechanisms put in place with the potential to provide adequate senior management overview of the implementation within and between agencies. However, the ANAO found that there was not adequate documentation of significant discussions and decisions. Such an accountability trail informs future decision-making and enhances communication with, and the accountability of, both agencies. In addition, for these mechanisms to be fully effective, sufficient information is necessary to allow informed decision-making; for example, progress reports against comprehensive project plans, appropriate risk analysis and resource allocation, usage and reports. This issue of effectiveness is discussed further at paragraphs 3.64 and 3.65.

Conclusion—Structured approach (coordinating arrangements)

3.62 There were adequate mechanisms in place to facilitate coordination between Health and Centrelink, and within Centrelink, to ensure coverage of all significant implementation issues. However, within Health, the ANAO was unable to identify coordination mechanisms for the project as a whole. Such mechanisms would have provided Health with the most effective and accountable means of managing the project. The lack of an overall project coordination mechanism within Health created risks for both agencies that key sub-programs or tasks impacting on the implementation of income testing would be overlooked, delayed, ineffective or under-resourced and subsequently cause delays to the implementation beyond the date set by government.

3.63 The ANAO found that there were suitable arrangements put in place with the potential to provide adequate senior management overview of the implementation within and between agencies. However, the failure to establish appropriate coordination mechanisms within Health would have led to a decrease in information quality in relation to program management issues, which in turn would have led to a decrease in senior management overview and, potentially, management effectiveness. It is likely that administrative effectiveness would also have been further decreased due to inadequate documentation of significant discussions and decisions at the senior management level. Other factors that impact on the effectiveness of overview and coordination mechanisms include formal project planning, risk management and resource management. These are discussed in the following sections.

Structured approach—formal project plans

3.64 Breaking large, complex projects into simpler manageable sub-projects allows the management of each sub-project to be tailored to the level of risk, criticality and complexity. In large projects, formal plans provide a tool to assist in monitoring progress of the project by:

- identifying fully, all tasks and their interaction and boundaries;
- specifying those sub-projects and tasks that are critical to the timely completion of the project;
- allocating responsibilities; and
- documenting the results required, including time-frames and deadlines.

3.65 In the highly complex and volatile circumstances of the Aged Care Structural Reform Package the need for a formal process of planning, and systematic management of the implementation against plans, becomes more important. Without such a process, it is more likely that:

- not all key tasks will be identified and implementation milestones met;
- critical paths will not be identified;
- significant risks will not be identified nor contingency plans developed;
- impacts from environmental changes on sub-projects and their linkages will not be fully identified;
- cooperative procedures will not be in place to achieve the necessary outcomes; and
- resources will not be allocated efficiently.

3.66 The ANAO sought to establish that as a key part of planning and managing the implementation, Health and Centrelink had developed project plans and systematically managed the implementation against these plans.

Health

3.67 The ANAO sought to determine whether Health had a formal strategic project plan for the implementation of the overall Aged Care Structural Reform Package that was underpinned by more detailed sub-projects for, for example, IT systems development, communications, purchaser/provider arrangements, legislation and training. The ANAO also sought to determine whether Health had a formal plan for the implementation of residential care fee income testing as a component of the overall plan.

3.68 On 1 August 1996, an Aged Care Restructuring implementation workplan meeting was held involving officers and managers primarily in the Aged and Community Care Division. This meeting was to discuss a draft workplan, to fully identify tasks, to allocate responsibilities for tasks, and to determine the process for establishing critical paths and dates across individual tasks—the meeting discussed the need for individual sub-project managers to have an understanding of the linkages between their work and that of other sub-project managers. As a result of this meeting, information on sub-projects which identified responsible officers and time-frames and a broad level project plan in the form of a GANTT chart, was developed.[29]

3.69 The audit team found the following gaps in the initial formalised plan:

- not all tasks were identified in the GANTT chart or associated detailed briefing. For example, the need to develop a communication strategy for clients of residential facilities was not identified, nor was the need for an SLA or another form of memorandum of understanding between the Department and Centrelink, which at the briefing stage had been announced as the Commonwealth Service Delivery Agency;
- with the exception of IT systems development and legislation sub-projects, there were no formalised sub-project plans underpinning the overall plan. However the ANAO noted a number of ad hoc time-lines for various project tasks at different stages of their implementation;
- while income testing was identified as a sub-project, it was described

[29] This information was used to brief the Minister on 25 September 1996.

as an IT systems process, rather than an implementation requiring a multi-disciplinary approach; and

- no overall critical paths and linkages were identified between sub-projects. The responsibility for this planning requirement was allocated to sub-project managers on an individual basis.

3.70 The Department advised that the sub-project information and broad level project plan was widely disseminated to senior managers throughout the Division and to the Departmental Executive. The Department further advised that it used this information as the basis for monitoring the Reform Package within the normal divisional coordination arrangements, updating the associated GANTT chart three to four times during the period up to September 1997. The ANAO was unable to confirm this monitoring activity as the Department advised of the difficulty it would have in locating such updates. However, the ANAO considers that the monitoring process was not fully effective as indicated by the following examples:

- the communication strategy and training for service providers would not have been ready for a 1 July 1997 implementation if this had continued to be a requirement of Government, and contingencies were not planned for; and
- work on a SLA with Centrelink, which incorporated aged care service delivery, did not commence until September 1997. In anticipation that the residential care fee income test would continue to be the responsibility of the then DSS, outsourced under purchaser/provider arrangements between DSS and Centrelink, Health has advised that it was in regular consultation with the former DSS regarding implementation timing within a DSS-Centrelink SLA. Nonetheless, the ANAO considers, as program administrators, Health should have put in place early plans to ensure that it would receive timely reporting on service delivery, either directly from Centrelink or alternatively through the former DSS.

3.71 In comparison, the ANAO found that IT implementation tasks were systematically managed against the IT systems redevelopment plan (which clearly identified timelines, responsibilities and resources), with regular reviews and updates undertaken and documented. This was used as the basis to advise senior management at an early stage that full system functionality would not be available at the time of the original implementation date of 1 July 1997.

3.72 The Department advised that it used the IT systems sub-project plan to coordinate the implementation of income testing within the Department. However, this plan was a lower level operational document

that presumed that other higher level linkages and dependencies were being managed elsewhere. As a result, there were the following risks:

- implementation tasks would not be fully identified and undertaken in a timely way. For example, the IT plan did not set targets for the development of relevant communication strategies and the negotiation of a SLA; and
- resources would not be allocated to functions to reflect the number and complexity of tasks. For the initial period, there was only one Health officer specifically allocated to developing many of the micro-policy aspects, and coordinating the implementation, of income testing. The complexity of this coordinating role was acknowledged by Health in November 1997 when additional resources were allocated to this function. For the scope of the work, one officer initially was, in the ANAO's opinion, inadequate. Had the full extent of tasks been transparent through an operational project plan, more resources may have been allocated earlier to the function.

Conclusion—Structured approach (formal project plans): Health

3.73 The ANAO concluded that project planning was inadequate as project plans had not been sufficiently developed for either the overall project or for all key sub-projects for the implementation. Therefore, senior management did not have a suitable basis on which to monitor the progress of the implementation and to have assurance regarding coverage of gaps. The project was therefore unnecessarily exposed to the risk of misallocation of resources at key stages in the project, and consequent delays in the implementation of key sub-projects. The ANAO notes that the Department had developed project plans for some sub-projects (for example, IT systems). These plans incorporated better practice planning principles. In addition, the Department, at the early planning stages, through the identification of responsible officers and development of broad timelines, laid the groundwork for better practice planning but did not fully develop or maintain formal project plans with sufficient detail to facilitate project monitoring overall.

3.74 As discussed in paragraph 3.19, the ANAO concluded that, had the original implementation date of 1 July 1997 still been in effect, income testing at the standard required by Government would not have been in place. Because Health was not monitoring progress against an appropriate project plan, the Department did not have sufficient information to allow identification of risks and implement necessary remedial action in a timely fashion. This would have contributed to delays to key sub-projects. Further, the Department did not have a sufficient basis on which to provide the Minister with early advice on risks to key sub-projects and the need for contingency action.

3.75 The ANAO considers that for future implementations of this magnitude Health should ensure that formal project plans are developed to provide an effective means of managing large and complex projects. Such plans should:

- identify the key sub-projects that will require more detailed operational plans and their lines of accountability;
- identify the resources for each sub-project;
- provide the framework for timelines and linkages between sub-projects as well as managing coordination and communication across areas with sub-project responsibility; and
- provide the basis for monitoring budgets and progress against milestones.

Centrelink

3.76 In examining the formal project plans developed by Centrelink for the implementation of income testing, the ANAO recognised that, as the development of such plans needed to be undertaken very early in the project (that is, soon after the August 1996 Budget announcement), this responsibility was FaCS' rather than Centrelink's as Centrelink was not operational at the time. While no formal project plans were provided in the hand-over from FaCS to Centrelink on 1 October 1997, FaCS did identify the tasks that it had been required to undertake, and its delivery against these tasks, at the time of the hand-over and the division of responsibilities between the two agencies with respect to income testing.

3.77 Following the Government decision in November 1997 to delay the implementation until 1 March 1998 and modify some aspects of the reform package, Health and Centrelink both recognised that there was a need to commence a new joint planning process to take account of the changes. Subsequently, in early December 1997, a joint design workshop was conducted that resulted in Centrelink developing a detailed project plan for the implementation that covered all of the project components (underpinned by sub-projects and tasks) for its part of the implementation. This implementation project plan identified timelines, critical paths, milestones and responsibilities for the tasks involved. The project plan was formally agreed by Health, Centrelink, FaCS and DVA as the focus for agency activity to ensure the smooth implementation of income testing on 1 March 1998.

3.78 Centrelink used this project plan as the basis of all of their implementation work, including coordination with Health and DVA. The ANAO found that Health referenced this plan both as a basis for coordinating its responsibilities with respect to the implementation from

January to March 1998, and also for identifying tasks and their completion dates for inclusion in the Aged Care Schedule of the Health-Centrelink purchaser / provider arrangement.

Conclusion—Structured approach (formal project plans): Centrelink

3.79 The ANAO concluded that Centrelink had a suitable formal project plan against which it could monitor its work on the implementation of income testing and ensure adequate coverage of all key project components, sub-projects and tasks.

3.80 The ANAO further considers that a project planning design workshop initiated by Centrelink (see paragraph 3.77), provided a useful forum for developing a common understanding of overall implementation requirements.

Structured approach—project resources

3.81 Identifying overall resource costs in project planning is considered good practice as it allows:

- informed decisions to be made by Government regarding whether to proceed with a project and what form the project will take;
- project costs to be monitored against approved estimates and remedial action to be undertaken where necessary; and
- resource usage to be analysed following the project's completion to assist in the assessment of the success of the project, and to inform decision-making by Government for future similar projects.

3.82 In Audit Report No.18, 1997–98, *Management of the Implementation of the Commonwealth Service Delivery Arrangements*, the ANAO recommended:

> *that Centrelink and relevant agencies identify the full cost of establishing any new service delivery arrangements in order to better inform decision-making, assist effective project management and improve accountability.*

Both Centrelink and Health agreed to this recommendation.

3.83 The ANAO examined whether Health and Centrelink had identified the establishment costs for the implementation of the residential care fee income test and monitored costs throughout the implementation.

Establishment costs for the implementation

3.84 Funding for administration costs for establishing and undertaking income tested aged care fees were initially allocated to Health, the then DSS and DVA as part of the August 1996 Budget. Additional resources

were also allocated for further requirements arising from subsequent Government decisions. These allocations were based on broad estimates of costs provided to Government by the Departments for implementing and running the Aged Care Reform Package.

3.85 The ANAO sought to identify whether these estimates provided to the Government were subsequently refined by the Departments to provide sufficient detail to allow project costs for the implementation to be monitored, as:

- the original estimates do not clearly differentiate between establishment and ongoing operational costs;
- the funds provided to Health were for the implementation of the Aged Care Structural Reform Package as a whole, rather than simply for the income testing component of the package; and
- both Health and Centrelink absorbed some establishment costs for income testing from other sources.

3.86 While the ANAO found evidence that Health estimated the overall costs of establishing income testing late in 1997, it did not produce detailed costing against which the overall project could be monitored at its establishment.

3.87 Health produced budgets and costings for several sub-projects, for example, the communication strategies (total budget in excess of $4 million) and the extensive training program delivered to providers of residential care throughout Australia (budget of approximately $3 million). However, these documents detail costs associated with implementation of the whole reform package and do not allow for discrete apportionment of these costs to the income testing component of the reform package. The value of such apportionment in assisting decision-making for future implementations was the basis for the ANAO making the recommendation in ANAO Report No.18, 1997–98 (see paragraph 3.82).

3.88 As discussed previously (paragraph 3.50), Health originally allocated one officer specifically to the implementation of income testing. While recognising that the Department had limits on its staffing arising from the COAG decision (see paragraph 2.20), the ANAO considers that, had the Department identified the full-range of tasks and resources required for the implementation up-front as part of the development of a formal project plan, this would have highlighted the need to allocate further resources to the implementation at an earlier stage. Without detailed project plans, estimates of resource requirements for an effective implementation are difficult to justify.

3.89 Centrelink attempted to estimate the cost of the implementation within its planning but this costing was not finalised, nor were costs

tracked throughout the implementation. However, Centrelink has developed the following initiatives which it considers will ensure project costing and monitoring in the future:

- the development of an activity-based costing methodology which will assist project cost planning and monitoring; and
- the establishment of an executive level Business Improvement Committee whose work includes monitoring project planning and management to ensure the efficient and effective use of resources allocated to Centrelink projects, with overarching business rules requiring that project expenditure be budgeted, recorded and reported against planned milestones.

Conclusion—Structured approach (project resources)

3.90 While there was evidence that both agencies had made efforts at project costing, neither Health nor Centrelink had identified, or monitored, the full cost of implementing the residential care fee income test.

3.91 Centrelink's initiatives to develop activity-based costing and to establish an executive level body who will take responsibility for the monitoring and management of project resources, have the potential to address this better practice in future implementations. In order to inform decision-making and minimise the risks of ineffective resources allocation, Health should implement practices to identify and monitor resources for future implementations.

Overall conclusion—Structured approach to project planning and management

3.92 Health, at the early planning stages, through the identification of responsible officers and development of broad timelines, laid the groundwork for sound planning but did not fully develop or maintain formal project plans with sufficient detail to facilitate project monitoring. For the overall project, Health did not adopt a structured approach to project planning and management.

3.93 As a result, the ANAO found that Health was not in a position to fully identify and manage the risks associated with this implementation. In particular:

- if 1 July 1997 had continued to be the implementation date, income testing would not have been in place to a standard required by Government;
- there were increased risks, some of which eventuated, that sub-projects could be overlooked, delayed, ineffective or under-resourced, with subsequent delays in meeting milestones;

- while the Department has advised that the impossibility of achieving the original timetable was foreseen, there was no documented analysis of the key risks and their potential impact to provide the basis on which to advise the Minister adequately at an early stage of the implementation; and
- while the Department advised that the Minister was provided with sufficiently comprehensive briefing on the risks to the implementation, the ANAO notes there was not an appropriate record of such briefings and decisions taken by the Minister in the light of Departmental advice for accountability purposes.

3.94 Lack of a structured approach impacts adversely on effective staff management as roles and priorities at any point in time are not well defined. There are indications that suggest such impacts on the management of project staff occurred within Health.

3.95 The ANAO acknowledges that Health had a structured approach to project planning and management in implementing the IT systems component of the project, but the indicative level of planning was not evident in the overall project.

3.96 While noting that Centrelink had responsibility for a relatively self-contained and less complex component of the implementation, the ANAO found that it adopted many elements of a structured approach. However, Centrelink had not adopted a formal risk management approach. While it had made efforts at costings, as did Health, it had not identified nor monitored the full cost of implementing the residential fee income test.

Recommendation No.2

3.97 The ANAO recommends that, for future major projects, the Department of Health and Aged Care and Centrelink adopt a more formal, systematic risk management approach to planning which includes risk identification, analysis of likely impacts, identification of appropriate treatments for major risks and monitoring the treatment of risks in accordance with better practice.

Centrelink response

3.98 Agreed. Since the implementation of aged care income assessments on behalf of the Department of Health and Aged Care in March 1998, Centrelink has adopted more formal risk assessment and management strategies and approaches in project planning.

Health response

3.99 Agreed. Since the time of the implementation of income testing by Centrelink, the Department has put in place a risk management framework that reflects the MAB/MIAC model. This framework is linked closely to the Department's corporate and business planning processes.

Recommendation No.3

3.100 For significant new service provision arrangements, the ANAO recommends that the Department of Health and Aged Care develop a structured approach to planning its implementation, including:

- appropriate implementation arrangements to facilitate coordination across sub-projects; and
- formal project plans (supported by appropriate sub-project plans) that identify:
  - lines of accountability;
  - resources required for each sub-project; and
  - key milestones to be achieved.

Centrelink response

3.101 Not applicable to Centrelink.

Health response

3.102 Agreed. The Department of Health and Aged Care has established protocols in line with APS Better Practice.

Recommendation No.4

3.103 The ANAO recommends that the Department of Health and Aged Care systematically monitor the implementation of significant projects against formal project plans, including resource usage, and use this information to inform decisions made by the coordinating bodies responsible for implementing the project. In addition, in order to inform future decision-making effectively and to assist communication and improve accountability, the Department should document:

- decisions taken as a result of monitoring formal project plans, to assist in the early identification of project management issues which should be addressed;
- decisions taken by key coordinating bodies; and
- the key elements of briefings to, and decisions taken by, Ministers in the light of Departmental advice.

Centrelink response

3.104 Not applicable to Centrelink.

Health response

3.105 Agreed. The Department of Health and Aged Care has established protocols in line with APS Better Practice.

4. Establishing on-going purchaser/ provider arrangements

This chapter examines the factors important for establishing and improving the on-going purchaser/provider arrangements between Health and Centrelink. The ANAO considers that the purchaser/provider arrangements, including the performance reporting framework, are adequate. However, arrangements of this kind, developed as they are under pressure and with limited precedent and associated experience, can inevitably be improved. Consequently the ANAO has identified a number of improvements required to more closely align the arrangements with better management practices and to ensure a common understanding between the parties of the requirements under the agreement.

Introduction

4.1 To assist an efficient and effective on-going purchaser / provider relationship, the expectations of that relationship should be documented and formally agreed by both parties, and key aspects of the relationship should be subject to formal review with a view to improvements in the future. Key indicators of such a relationship being established include:

- service level arrangements which are consistent with the principles and practices of good corporate governance as are relevant within a purchaser / provider arrangement, for example, clear definitions and descriptions of respective responsibilities, and a robust performance management system; and
- planning for an evaluation of the implementation to allow streamlining of future partnership arrangements.

The ANAO assessed each of these areas for the aged care implementation.

Service level arrangements

4.2 Good corporate governance requires clear definitions of responsibility and a clear understanding of relationships between the organisation's stakeholders and those entrusted to manage resources and deliver its outcomes. Risks can be reduced by ensuring participants in the governance process are aware of their roles, responsibilities and accountabilities. A well governed agency can provide assurance to its CEO, its Minister and all other stakeholders that, for example, reform agendas are being effectively implemented and performance targets met[30].

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[30] ANAO (1997), *Applying Principles and Practice of Corporate Governance in Budget Funded Agencies.*

4.3 When services are delivered through purchaser/provider arrangements, the principles and practices of good corporate governance should be reflected in the SLA agreed by both parties. The development and implementation of such arrangements then become key components of both agencies' (that is, purchaser and provider) corporate governance frameworks. Consequently, for the Health-Centrelink SLA, including the Quality Care for Older Australians (Aged Care) Schedule, the ANAO examined whether the documented agreement included clear specification of the items detailed in Table 4.1.

Table 4.1

Criteria Used to Assess the Health-Centrelink Service Level Arrangement

To assist the principles and practices of good corporate governance within the parties to the arrangement, the Service Level Arrangement should include:

- an agreement structure which
  - covers a comprehensive range of issues,
  - indicates an order of precedence over parts of the agreement, and
  - demonstrates internal consistency;
- roles and responsibilities;
- timing for the arrangement, including
  - identifying the term of the current arrangement, and
  - negotiating a replacement arrangement;
- consultative arrangements, including
  - on-going consultative mechanisms across the scope of the arrangements that specify responsibilities, membership, secretariat support, and arrangements for meetings,
  - mechanisms to vary the arrangements, and
  - mechanisms for dispute resolution;
- funding arrangements, including
  - levels of funding,
  - source of funding,
  - levels of service delivery required from funding; and
  - financial incentives and sanctions linked to Centrelink's performance;
- processes for managing risks;
- mechanisms to evaluate and review the arrangements, including
  - scope, objectives and resourcing for the reviews, and
  - timing to provide potential for the reviews to input into the on-going Arrangement and the renegotiation process; and
- performance information that is consistent with good practice[31]; in particular, performance measures that are
  - linked to strategies and objectives,
  - balanced across indicator type,
  - underpinned by agreed data collection standards that assist in determining the validity, reliability, accuracy and timeliness of the indicators,
  - assessed against performance standards and targets, and
  - regularly reported against, with reference to significant results and to external factors affecting the results, and monitored so that, for example, there is a feedback into operations.

[31] Guided by: ANAO and Department of Finance (1996), *Performance Information Principles: Better Practice Guide.*

4.4 The ANAO's findings in each of the areas highlighted in Table 4.1 are detailed under the respective headings below.

Agreement structure

4.5 The Core Arrangement specifies that it, together with the Protocols and program specific Schedules, form the whole agreement between the agencies. As demonstrated in Table 4.2, the SLA covers a comprehensive range of issues.

Table 4.2
Contents of Arrangements

Core Arrangement	***Protocols***
Statement of intent	*Provision of data and information*
Parties to the arrangement	*Ministerial and parliamentary requests*
Period of the arrangement	*Policy and services development and coordination*
Purposes of the arrangement	*Consultation Committee responsibilities*
Principles guiding the strategic partnership	*Administrative arrangements*
Organisational roles	*Records management*
Delegations under legislation	*Dealing with claims (for example, compensation claims for injury resulting from negligence, or for detriment caused by defective administration)*
Coordination and consultation	***Quality Care for Older Australians Schedule***
Dispute resolution	*Purpose*
Review and appeals (by customers)	*Program Objectives*
Customer complaints	*Service Delivery Objectives*
Variation of the arrangement	*Obligations of Centrelink*
Review of the arrangement	• *services provided by Centrelink by phases—design, implementation and on-going management*
Intellectual property and data management	• *property*
Privacy and FOI responsibilities	• *timeframe*
Records management	• *performance indicators by phase*
Financial matters	• *reporting*
Parliamentary, ministerial and media issues	• *specified personnel*
Protocols *(see column 2)*	• *additional support services*
Schedules	*Obligations of the Department*
• *Quality Care for Older Australians (see column 2)*	• *liaison officers*
• *Office of Hearing Services Application Processing*	• *funding—program funding details, fees, allowances, capital funding*
• *Employment Assistance for People with Disabilities*	• *responsibilities of the Department*
• *Children's Services (1)*	

(1) With the changes to the Administrative Arrangement Order of 21 October 1998, Employment Assistance for People with Disabilities and Children's Services were no longer Health's responsibilities.

4.6 The ANAO found that there are a range of areas relating to the structure of the agreement where further clarification, variation, or additions would assist the on-going management of the SLA. These are:

- no indication of an order of precedence to guide the parties where there are conflicting arrangements which may result in unforseen conflicts in certain situations;
- inconsistencies across the Core Arrangement in references to the protocols. Subsequent confusion may arise as to whether the reference is to the protocols in general or one specific protocol;
- reference in the Core Arrangement to customer complaints processes in the program specific Schedules, but no such guidance in the Aged Care Schedule; and
- the applicability of Health's responsibilities outlined in the Aged Care Schedule, across all program schedules. These responsibilities relate to providing Centrelink with policy advice and decisions, and customer and community feedback on service delivery matters, and therefore may be better placed as part of the Core Arrangement to apply across service delivery.

4.7 In addition, the following sub-sections indicate the need for additions to the SLA to promote common understanding on issues such as level of service delivery for the funding provided, management of risks, performance reporting, and processes underpinning evaluation and review. These are discussed separately below.

Roles and responsibilities

4.8 A wide range of roles and responsibilities for both purchaser and provider have been defined throughout the SLA, assisting the operational aspects of the purchaser/provider arrangements.

4.9 However, the ANAO has noted that the legal roles and responsibilities, as defined, for example, through the *Aged Care Act 1997*, have not been fully referenced in the SLA. In Chapter 3, (paragraphs 3.20 to 3.21), the ANAO concludes and recommends that agencies should ensure respective responsibilities within purchaser/provider arrangements are specified to a level that clarifies these responsibilities in order to assist in the corporate governance aspects of the relationship.

Timing of the arrangement

4.10 The term of the Core Arrangement is specified as from the date of signing (17 July 1998 for Health and 20 July 1998 for Centrelink) until 30 June 2001. The term of the Aged Care Schedule which confirms service delivery[32] from 1 January 1998, also specifies that it terminates on 30 June 2001.

4.11 However, the ANAO identified the following issues with regard to the term of the arrangement:

- a senior management purchaser/provider arrangement workshop in early December 1996 indicated the need for the Department to develop a SLA with Centrelink. Work on the development of a SLA which included aged care service delivery did not begin until September 1997, after the initial implementation date of 1 July 1997, and only a short period prior to the first revised implementation date of 1 October 1997;
- the SLA does not cover work undertaken by Centrelink from the date that that organisation assumed responsibility for arranging for the implementation of aged care service delivery (1 October 1997 until 31 December 1997). There are no other formal arrangements covering this period; and
- the Core Arrangement was not formally agreed until over four months after the start of on-going aged care service delivery on 1 March 1998, and the Aged Care Schedule was not signed until mid-September 1998.

4.12 The finalisation of the Aged Care Schedule was delayed pending the finalisation of the Core Arrangement, which itself was delayed pending resolution of responsibility of the parties to the arrangement for paying Compensation for Defective Administration (see paragraph 3.17)[33]. In early March 1998, Centrelink sought to finalise the SLA (Core Arrangement) by recognising in the agreement that this matter was subject to negotiation and resolution, and that following resolution, the agreement would be appropriately amended. This option was not agreed between the parties.

4.13 The ANAO found that there was a practical implication arising from the delay in signing the Aged Care Schedule; in particular, Centrelink could not fully report on all performance indicators until they were finally decided and agreed upon in the lead up to signing the Schedule.

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[32] Services in the context of the SLA include the design as well as delivery of services.

[33] At the time of the negotiations for the SLA, FaCS had been allocated the funding by Government for any compensation arising from successful claims based on defective administration by Centrelink.

4.14 The ANAO recognises that Centrelink had a number of clear indications that the Government expected it to undertake income testing aspects of the Aged Care Structural Reform Package, from both the funding allocated to the former DSS[34] for this function in the 1996 Budget, and the reference regarding sub-delegations for Centrelink officers in the *Aged Care Act 1997*. Furthermore, as outlined in paragraph 3.77, both Health and Centrelink reached formal agreement in December 1997 on project plans for part of the implementation for which Centrelink was responsible.

4.15 While the ANAO recognises that Centrelink had some assurance on tasks and funding regarding service delivery, this does not substitute for a fully negotiated arrangement between the parties. The ANAO therefore considers that Health should have developed, agreed and signed with Centrelink at least an interim agreement to cover aged care service delivery in the period until a SLA could be fully negotiated. Such an interim agreement could have addressed the process for negotiating on issues which had not, at that time, been agreed.

4.16 The SLA identifies that negotiations for the next agreement will commence at least three months before the termination date, and that the current Arrangement will continue until a new arrangement is agreed. The ANAO considers that the timing of negotiating the new agreement is adequately addressed in the SLA.

Consultative arrangements

4.17 The ANAO found that the SLA had addressed the following:

- an on-going consultative mechanism for the Core Arrangement, through a Consultative Committee. The SLA identifies the responsibilities, membership and secretariat support for the Committee. The Arrangement does not address how often the Committee should meet, however this could potentially be addressed through the operating guidelines open to the Committee to adopt. The SLA does not address any on-going consultative arrangements for the Aged Care Schedule, although there is the potential for the Consultative Committee to draw its membership from the areas responsible for aged care service delivery in Health and Centrelink, and concentrate particular meeting agendas on Aged Care service delivery;
- a process for varying the Agreement during its term; and

[34] This funding decision was prior to the establishment of Centrelink, to which the Government allocated all DSS's service delivery functions.

- an escalating process for resolving disputes between Health and Centrelink relating to the SLA.

4.18 The ANAO considers that the consultative arrangements relating to varying the SLA and to resolving disputes are sufficient to achieve on-going consultation on the arrangement. The ANAO considers that operational aspects, such as minimum frequency of meetings and specification of sub-committees or other mechanisms to address aged care service delivery issues, would assist in ensuring the effectiveness of these arrangements. The ANAO would encourage these issues to be addressed through operating guidelines.

Funding arrangements

4.19 The Government allocated funding for Centrelink Aged Care service delivery as part of the 1996 Budget, and for additional requirements arising from Government policy changes, as set out in Table 4.3.

Table 4.3

Funding for Centrelink Service Delivery ($000)

Year	*1997–98*	*1998–99*	*1999–00*	*2000–01*
from Budget '96	2 276	2 145	2 145	2 145
for additional requirements	255	160	160	160

4.20 The ANAO found that the SLA linked these funding levels to service delivery specified in the Aged Care Schedule. Funding for services required in addition to the main-stream service delivery were specified as follows:

- for additional support services for aged care, a list of services that Centrelink will provide for an pre-agreed price; and
- ad hoc reports provided on request to Health on a 'cost recovery' basis.

4.21 The ANAO identified the following issues with regard to the funding arrangements:

- although funding is implicitly linked to an estimated number of assessments, at a specified service standard, that Centrelink will need to undertake on behalf of Health, the SLA does not specify mechanisms to deal with possible significant changes to Centrelink's workload requirements caused by environmental or administrative policy changes, that vary, for example:
  - the turnover of aged care residents. A greater turnover would increase the number of assessments, and therefore the workload undertaken by Centrelink;

  - the proportion of new residents who receive pensions from Centrelink or DVA. A greater proportion of pensioners should result in more matches against existing data and fewer assessments based on new information requiring collection; and
  - the level of risk built into the data matching procedures which could impact on the number of residents invited to undertake assessments, and consequently on the resources required by Centrelink.[35]
- the provision of funding on a 'cost recovery' basis, provides no indication as to how the cost recovery will be determined; for example, on marginal or average costs. Centrelink has advised the ANAO that this will be estimated on an accrual accounting basis, in line with Government requirements which will provide the information to determine marginal and average costs; and
- while the SLA addresses the issue of default with respect to Centrelink's obligations by requiring Centrelink to 'promptly remedy' such a default, the SLA does not provide financial sanctions or incentives for under- or over-performance linked to performance indicators. In identifying this issue, the ANAO recognises that the SLA is not legally enforceable as the Commonwealth cannot contract with itself and that the original funding agreed by Government did not include incentives or rewards. Nonetheless, successful contracting-out projects have sanctions and incentives linked to performance standards as a key feature and as such it represents a better practice worth consideration when negotiating service level arrangements.[36]

4.22 The ANAO considers that the funding arrangements specified in the SLA for Aged Care service delivery are generally adequate in that they specify the amount for overall service delivery on an annual basis and the basis for payment for extra services. However, the ANAO considers that there is scope to improve the arrangements by:

- reaching agreement between the purchaser and provider on the factors that will significantly impact on service delivery workloads and identifying processes to seek approval for funding or workload variations if these factors eventuate; and
- specifying within the SLA that costs for services provided on a cost-recovery basis will be determined on a marginal or average cost basis.

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[35] The greater the tolerance built into the data matching procedure, the greater the chance of a match against an existing Centrelink client, and a decrease in the need for an assessment based on new information.

[36] See ANAO (1997) Audit Report No. 18, *Management of the Implementation of the Commonwealth Services Delivery Arrangements—Centrelink.*

4.23 In addition, the ANAO considers that there is scope for Health to seek opportunities in the future to provide sanctions and incentives within its purchaser/provider arrangements in order to better align with successful contracting out practices across industry.

Process for managing risks

4.24 The ANAO found that in the Aged Care Schedule, there was acknowledgment of risks associated with income testing service delivery, but no specification of what these might be. Elsewhere in the schedule, two risks to service delivery have been identified; namely:

- quality of the initial data collection from aged care facilities; and
- reliability of electronic transfers of data between the relevant agencies (that is, Health, DVA and Centrelink).

4.25 The ANAO was informed by Centrelink that the risk acknowledgment relates to the accuracy of income assessments: the government required that the form for income testing for self-funded retirees be shorter than that for pension payments. This meant that compliance testing questions were not included in the form (see Appendix 5) which could impact on the accuracy of the assessment. In addition, a further risk, (not raised in the SLA) relates to the level of tolerance in the data matching process (see footnote 33).

4.26 The ANAO found that an assessment of the likelihood and impact of these and other risks associated with Centrelink's service delivery of income testing for the residential care fee, had not been undertaken. Recently, however, at the October 1998 Consultative Committee meeting, Health agreed to undertake a risk assessment on the implication of the ongoing relationship with the Centrelink IT system.

4.27 Given the range of risks, the ANAO considers that a comprehensive assessment and management plan for significant risks would assist Health and Centrelink to have a common understanding of their impact on service quality and to have in place appropriate risk minimisation remedial measures. Such an exercise could draw upon Health's planned IT risk assessment. Risk assessment could be incorporated into the initial review process for the SLA (see below) and the management plan for significant risks could be agreed as part of the SLA.

Mechanisms to evaluate and review the SLA

4.28 The SLA specifies two reviews of the Arrangement. The objectives, scope, and resourcing of the reviews are not addressed in the SLA. However, the ANAO notes that the Consultative Committee has been given the responsibility to oversight reviews and evaluations, and as such there is a means of establishing agreement on these matters. The ANAO considers that once these processes are agreed, they should form part of the SLA.

4.29 The timing of the reviews is such that both will be conducted in the first seven months of the Arrangement which itself covers a period of three years. While the timing for one of these provides an opportunity to improve the on-going operation of the Arrangement following a settling-in period, the ANAO considers that the second review should be conducted closer to the end of the term of the Arrangement, to provide a more effective basis for assisting with the renegotiation process.

4.30 The ANAO has noted that in October 1998, the Consultative Committee for the Arrangement agreed to change the dates for the reviews, with the intent that these subsequently be reflected in the SLA.

Performance information

Links between strategies and objectives

4.31 The primary objective of the program related to the Aged Care Schedule, *to enhance the quality of life of older Australians*, was not easily measured nor did it relate directly to the delivery of relevant services by Centrelink. However, there was a secondary objective, *provision of a cohesive framework of high quality and cost effective services for frail older people and their carers.* Furthermore, in relation to the broader objective, a number of more specific, service delivery sub-objectives had been identified as follows:

- advice on pensioner status and associated by-products;
- income testing for fees; and
- liaison, advisory and communication services to the general public.

4.32 The ANAO found that there were a number of tasks or strategies relating to each of these sub-objectives for each particular phase of the implementation; namely, design, implementation and on-going management. The links between these are demonstrated in Table 4.4.

4.33 Notwithstanding the minor improvements to these linkages, outlined in the footnotes below the table, the ANAO considers that the strategies (or tasks) are capable of being linked to objectives, and in the context of a purchaser/provider relationship, the objectives and strategies are clearly stated.

Table 4.4
Links between sub-objectives and strategies

	Design phase[1]	*Implementation phase*	*On-going management phase*
sub-objective	**strategies** (tasks)	**strategies** (tasks)	**strategies** (tasks)
advice on pensioner status and associated by-products	systems development; for example: design of data flows for daily processing establishing the SNI link	systems implementation[2]	Data matching
income testing for fees	process design systems development forms design job aids development	training finalisation of forms delivery of Job Aids completion and implementation of systems provision of income assessment forms[3] provision of advice and assistance in completing forms[4]	non-pensioner income assessments variations to customer record timeliness, accuracy review of decisions and appeals
liaison, advisory and communication services to the general public	development of letters to customers development of all centre scripts development of Centrelink's role in external communication	participation in external training[5] participation in delivery of external communication[6]	customer satisfaction[7], timeliness

(1) As well as tasks relating to specific sub-objectives there are a number of tasks that can be linked to all of the sub-objectives. These relate to internal communication, training and management information.

(2) Some of the 'systems development' sub-tasks could also be classified as 'systems implementation' sub-tasks.

(3) As this task is on-going and is a sub-task of 'non-pensioner assessments' task it should also be included in the on-going management phase.

(4) Ditto.

(5) *Ditto.*

(6) Ditto.

(7) 'Customer satisfaction' is not a task. To assist common understanding, this might better be stated as an action for Centrelink.

Links between strategies and performance information

4.34 For each of the tasks in the design phase and for those which are not on-going in the implementation phase, there is a performance indicator; in particular, completion and sign-off (by both Health and Centrelink) of the task by a specified date, prior to income testing implementation on 1 March 1998. However, for those four tasks specified in the implementation phase as on-going (see Table 4.4), provision of income assessment forms, provision of advice and assistance in completing forms, participation in external training and participation in delivery of external communication, there are no related indicators.

4.35 For each of the tasks in the on-going phase, there are a number of performance indicators. Most of these are listed in Table 4.5. In addition to the performance information that is in the table, Health will receive supplementary information on:

- financial expenditures on non-program expenditures;
- unit costs associated with each service; and
- the number of program recipients (outputs).

4.36 The ANAO considers that performance information is being provided for most strategies and, therefore, links to the strategies. There is an opportunity, however, to enhance these linkages by developing performance indicators for the on-going tasks in the implementation phase; for example, for those tasks relating to Centrelink's participation in external training and communication. Performance information related to the frequency, content and level of participation, with associated performance standards would assist in ensuring a common understanding and accountability in relation to these tasks.

Balance across performance indicator type

4.37 For the discrete tasks in the design and implementation phases, performance indicators are completion dates and sign off by both parties. The ANAO considers such indicators provide sufficient balance for such tasks, as achievement of completion dates provide an indicator of timeliness and given that Health needs to sign off, this can be used as an indicator of quality.

4.38 The category of indicators for the on-going management phase are outlined in Table 4.5. The ANAO found that these indicators are not balanced across input, process, output, outcome and customer service measures to the extent that might be expected for a program managed within a department. From the purchaser's perspective, the indicators are generally focused on process. In this arrangement, that focus is appropriate as it enables the purchaser to directly monitor the level and quality of service delivery to the customer by the provider.

Table 4.5

Links between strategies and performance information by type category

Strategies (or tasks)	*Performance information*	*Performance information category*
data matching	85% cases matched in 3 days[1]	process/output (efficiency)[2]
	100% cases matched in 8 days	process/output (efficiency)
non-pensioner income assessments	85% cases matched in 5 days on receipt of details	process/output (efficiency)
	100% cases matched in 10 days	process/output (efficiency)
variations to customer record	85% updated in 5 days on receipt of details	process/output (efficiency)
	100% cases updated in 10 days	process/output (efficiency)
customer satisfaction, timeliness, accuracy	customer service standards	
	customer satisfaction	client satisfaction (output from providers perspective—see tablenote (2) below
	timeliness - call centres - waiting times - interpreters - Ministerial correspondence	process/output
	accuracy	process (quality, also relates to income assessments and variation tasks)[3]
review of decision and appeals	authorised review officers—28 days to finalise after request lodged (75%)	process/output (efficiency)
	SSAT—28 days to lodge after advice (100%)	process/output (efficiency)
	AAT—28 days to lodge after application (100%)	process/output (efficiency)

(1) Working days.

(2) The classification of indicators is not always fixed. From the point of view of the purchaser (or the public) this indicator (and others in the table classified likewise) are 'process' measures. However, a provider could legitimately classify these measures as outputs. For a similar reason, the provider may categorise client satisfaction as an outcome. Because the outputs are required within certain time constraints, they are also an efficiency measure.

(3) That is, non-pensioner assessments and variations to customer record.

4.39 As well, these processes, when delivered accurately, in a timely manner and to an agreed standard of quality constitute the outputs required to help meet the purchaser's outcomes. This demonstrates how the purchaser / provider environment, within which these agencies operate, affects the types of indicators required to measure performance. The ANAO therefore considers that the Aged Care Schedule contains a reasonable balance of indicators for this purchaser / provider arrangement.

4.40 Notwithstanding the above, the ANAO noted a couple of gaps in the balance of indicators, as follows:

- quality for the data matching task. Such a quality indicator could provide Health with some assurance on the level of tolerance built into the data matching process; and
- outcomes for the task of reviewing undertaken by the authorised review officers (AROs). Such an outcome indicator for ARO findings would provide Health with some information on the level of compliance with respect to the accuracy of forms processing.

4.41 With such enhancements, the ANAO considers that the performance information in the Aged Care Schedule provides an appropriate balance across indicator types (notwithstanding that performance information should be developed for some strategies, see paragraph 4.36).

Data collection standards

4.42 The ANAO found that the issue of data collection standards had not been addressed in the SLA. The ANAO noted that there were a number of areas where it was important that such standards be in place to allow a common understanding between the purchaser and provider and to provide assurance for the purchaser. For example:

- for the performance information on customer service, a definition of the 'customer' would assist common understanding. In the case of the performance indicator on 'Ministerial correspondence', this may be the general public, whereas for the other such performance indicators, it may relate to the aged care residents, or alternatively, their representatives or nominees;
- for the customer surveys designed to collect information on customer service, specification of the survey methodology would provide Health with an indication of, for example, data timeliness, sample bias, and data reliability; and
- for all indicators for the on-going management phase, specification of a mechanism to provide quality assurance, would give Health on-going information on the validity and accuracy of the reported performance information.

4.43 The ANAO considers that, in order to provide a common understanding on definitions and assurance on the validity, reliability, accuracy and timeliness of performance information, data collection standards should be incorporated in the SLA.

Performance targets and standards

4.44 The ANAO found that all the performance indicators identified in the agreement have targets and performance standards either integrated into the indicator (for example, 'assessment and provision of information for 85% of cases in 5 working days') or closely related to the indicator (for example, 'customers satisfied: staff are friendly and waiting times'—85%; and 'training to network'—completed by 27.2.98).

4.45 However, the ANAO notes that the targets for data matching, assessment of non-pensioner income and assessment updates are conditional on:

- daily data transfers;
- criticality in deadlines for Systems Network Interconnection (SNI) being met;
- completeness in residents' data; and
- exclusion of corrupt, cancelled and deceased records.

The Schedule does not address the impact on targets and how performance will be assessed if any of these conditions are not met.

4.46 As written in the SLA, many of the targets will be void, as all the conditions are unlikely to be met in any quarterly period. There is no guidance on how Centrelink's performance will be assessed in this situation. The ANAO considers that the performance targets should be clarified so that the Schedule explicitly states how Centrelink will be assessed in the event of any one of the prerequisite conditions not being met.

Performance monitoring and reporting

4.47 The ANAO found that a framework exits for the promotion of feedback on performance into operations and to stakeholders. In particular, the responsibilities of the joint Consultative Committee include performance monitoring and stakeholder communications. The SLA also explicitly requires Health to inform Centrelink on matters that impact on the delivery of residential care fee income testing services, so that appropriate action can be taken.

4.48 The SLA specifies the following performance reporting arrangements:

- for discrete tasks, reporting is achieved through the sign off process on their completion; and
- for the on-going management indicators, reporting is to be undertaken initially on a monthly basis for the first four months following implementation and quarterly thereafter.

4.49 The ANAO identified that there was no specification of the format for reporting against on-going performance indicators. The ANAO would encourage the partners to the SLA to address this issue as part of the review of the SLA, so that reports highlight environment factors, significant trends, good practice, and issues that require management attention.

4.50 In addition, the ANAO considers that the lack of full compliance with reporting requirements to date, has highlighted the need for an interim agreement to be in place while the details of the SLA were finalised, as discussed previously (paragraph 4.15).

Overall conclusion—Service Level Arrangement

4.51 The ANAO concluded that the SLA was adequate for the purpose. However, the ANAO identified a number of aspects of the SLA which would benefit from refinement in any future revision of the Arrangement or for arrangements of this kind in the future. These are:

- inconsistencies across parts of the Arrangement, with no indication of an order of precedence to apply to each part;
- delays in signing the Arrangement well beyond the implementation date which in turn have restricted comprehensive reporting on performance;
- a lack of specification within the SLA of the following:
  - the full range of risks impacting on the Arrangement;
  - the costing basis for components that will be reimbursed by Health on a 'cost-recovery' basis;
  - environmental and administrative policy factors that impact substantially on Centrelink's workloads;
  - the process to change payment level if these policy factors change significantly is not specified; and
  - the objectives, scope and resourcing for the reviews of the Arrangement; and
- the timing of the second of the two scheduled reviews, which does not closely align with the renegotiation process. The ANAO considers that a subsequent agreement between the parties within the consultative arrangements for the SLA satisfactorily addressed this issue during the course of the audit.

4.52 In addition, while the performance reporting framework was considered to be satisfactory, the following issues should be addressed to ensure that the framework is fully effective:

- the inclusion of an indicator of quality for 'data matching', and an outcome indicator for 'reviews of decisions and appeals' could improve the balance of indicators;
- the lack of data collection standards that address definitions, validity, reliability, accuracy and timeliness of performance information has the potential to leave some related key areas open to misinterpretation by the parties; and
- under the SLA, if any of a number of pre-requisite conditions are not met, the achievement of targets/performance standards is not required. The SLA does not specify how performance is to be measured in this situation.

4.53 The ANAO notes that the Consultative Committee (see paragraph 4.17) and SLA review processes provide appropriate forums through which the general SLA issues can be clarified.

Recommendation No.5

4.54 The ANAO recommends that, in order to ensure a common understanding of the conditions for income testing service delivery, the Department of Health and Aged Care and Centrelink review the current SLA, to ensure:

- consistency between, and order of precedence for, agreement components;
- specification of funding arrangements, particularly relating to costing bases and processes for changing funding if particular factors which impact on service delivery resourcing change significantly;
- identification and analysis of risks to the operation of the agreement; and
- specification of the objectives, scope and resourcing for the reviews of the agreement.

Centrelink response

4.55 Agreed.

Health response

4.56 Agreed. The SLA Consultative Committee will include the ANAO recommendations in the terms of reference for the mid-term review and adjust the SLA and Schedules as appropriate.

Recommendation No.6

4.57 The ANAO recommends that the Department of Health and Aged Care and Centrelink jointly develop as part of the SLA:

- an indicator of quality for 'data matching', and an outcome indicator for 'reviews of decisions and appeals'; and
- data collection standards that address definitions, validity, reliability, accuracy and timeliness to underpin the performance information within the agreement.

Centrelink response

4.58 Agreed.

Health response

4.59 Agreed. The SLA Consultative Committee will include the ANAO recommendations in the terms of reference for the mid-term review and adjust the SLA and Schedules as appropriate.

Recommendation No.7

4.60 The ANAO recommends that, as there is a real risk that the current indicators cannot be used to measure satisfactorily the service provider's performance, the Department of Health and Aged Care and Centrelink should develop alternative performance measures which ensure that assessment and monitoring of performance can continue under the SLA.

Centrelink response

4.61 Agreed. Centrelink expects that a substantial number of the issues raised in the audit recommendations relating to establishing on-going purchaser / provider arrangements will be addressed as part of a mid-term review of the SLA.

Health response

4.62 Agreed. The SLA Consultative Committee will include the ANAO recommendations in the terms of reference for the mid-term review and adjust the SLA and Schedules as appropriate.

Evaluation of the implementation

4.63 The ANAO examined whether evaluation mechanisms were being planned by Centrelink and Health to allow streamlining of the development of future partnership arrangements, both between these agencies, and others seeking to have Centrelink deliver their services. In particular, the ANAO sought to establish that this planning identified:

- scope and coverage of the evaluation;
- resourcing; and
- timeframes.

4.64 Centrelink, as part of its normal policy and procedures, had planned to undertake a post implementation review (PIR) with the objective of seeking lessons from the implementation. The audit found that the planning for the PIR covered the following:

- issues to be examined. This included project management, implementation at the different organisation levels, coordination with Health, and specific sub-project planning and management;
- stakeholders from whom input would be sought, including Health, and operational staff;
- the funding for this review, as identified as part of the 1996 Budget; and
- time-frame—commencing in September 1998 and reporting in October 1998.

4.65 The ANAO found that while Health plans to facilitate an Independent Review of Residential Aged Care Reforms, this is with respect to the operational aspects of the *Aged Care Act 1997*. There are no plans to undertake a review similar to that being undertaken by Centrelink.

4.66 The ANAO found that the planning for Centrelink's post-implementation review is adequate. However, the ANAO considers that there is an opportunity for Health to undertake a similar review, particularly in the light of some of the project planning and management issues identified in Chapter 3. While the ANAO recognises the Administrative Arrangements Order (October 21 1998) may decrease the opportunity for Health to have other partnership arrangements with Centrelink, many of the project issues identified are sufficiently generic to be applicable across all large projects in the Department. The ANAO therefore considers that Health should undertake its own PIR to assist in future project planning and program management, such as for further partnership arrangements with Centrelink.

Conclusion

4.67 The ANAO concluded that the planning for Centrelink's post-implementation review is adequate. However, the ANAO found that Health had not planned a similar review. The importance of such a review has been highlighted by the need to address, for future significant projects, the planning and management issues identified in this audit.

Recommendation No.8

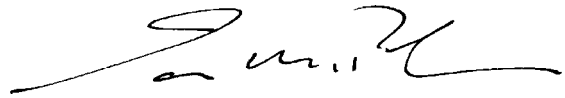
4.68 The ANAO recommends that the Department of Health and Aged Care undertake a post implementation review of the introduction of income testing to assist in the planning and management of similar projects in the future.

Centrelink response

4.69 Not applicable to Centrelink.

Health response

4.70 Agreed. A post-implementation review is very similar in content and scope to the proposed mid-term review. This issue can be addressed by combining post-implementation review within the context of the mid-term review.



Canberra ACT
13 July 1999

Ian McPhee
Acting Auditor-General

Appendices

Appendix 1

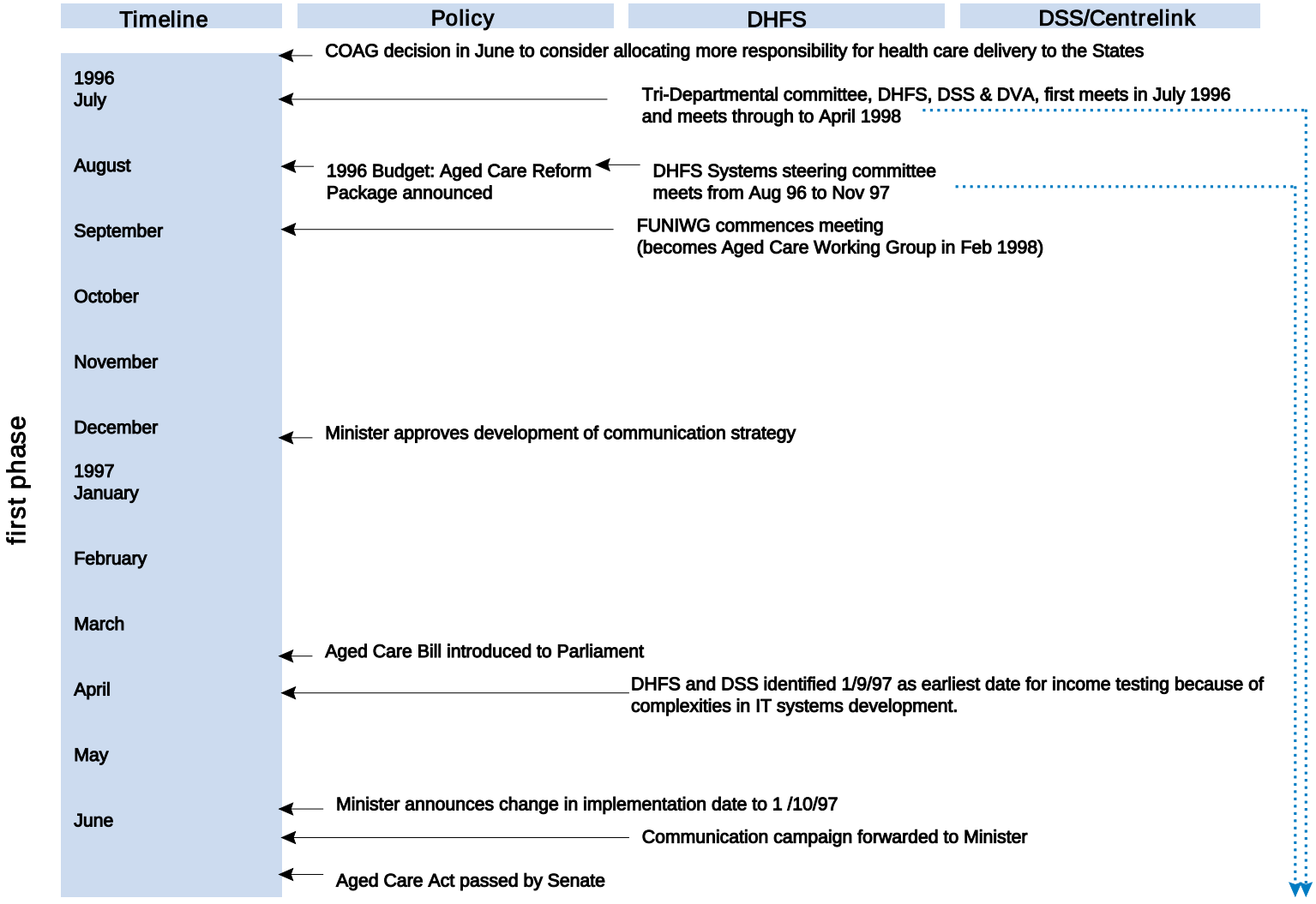
Key policy elements and timeline of events

The original government policy decision on the introduction of income tested residential care fees was made as part of the 1996–97 Budget. The key elements of policy impacting on the introduction of the fees are as follows:

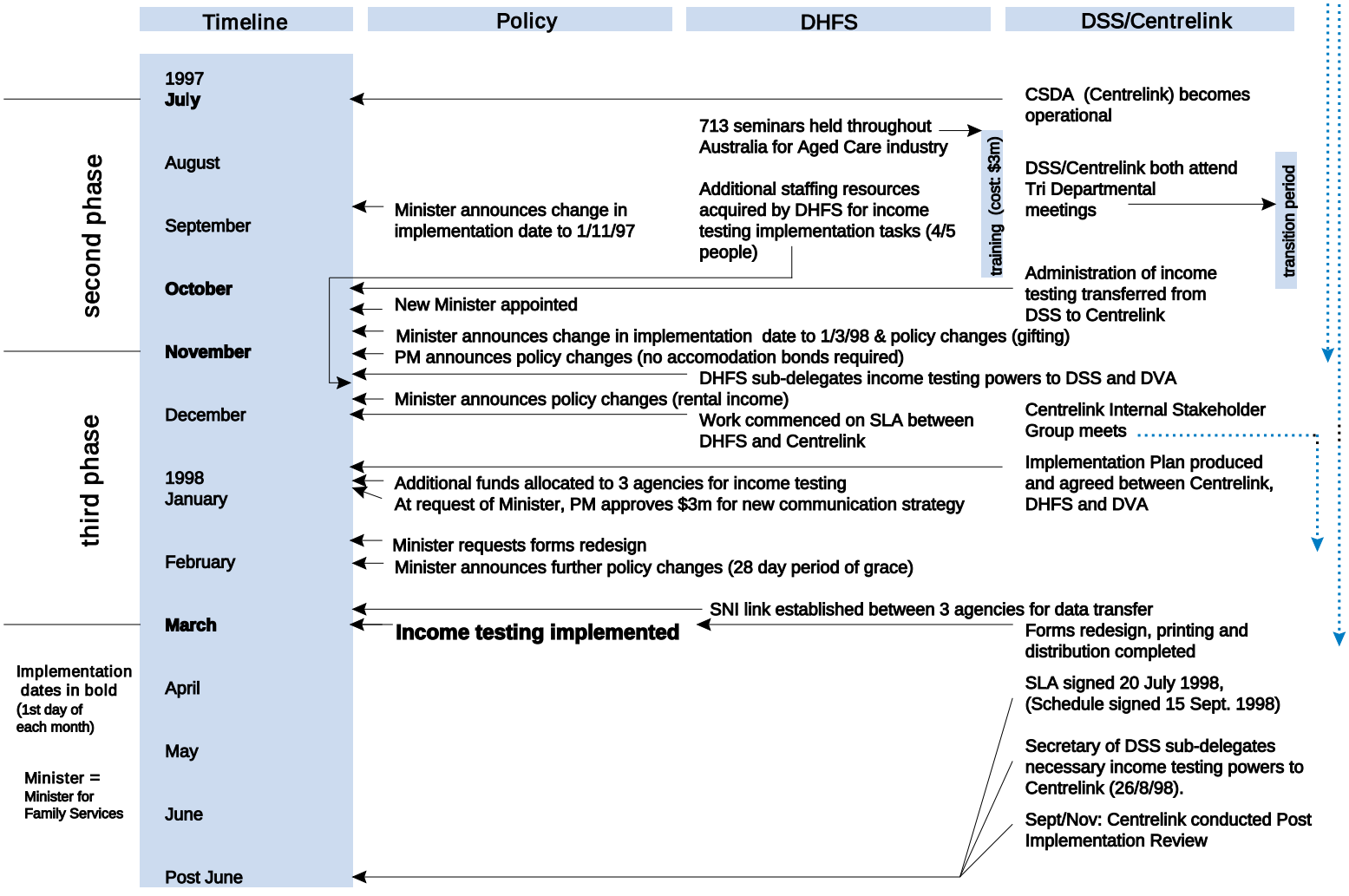
- part of a major package of structural reforms to long term aged care, including:
  - accomodation bonds for residents;
  - Resident Classification Scale; and
  - an Aged Care Standards Agency;
- implementation date for the introduction of the reforms on 1 July 1997;
- underpinned by a legislative package;
- the former DSS and DVA to undertake income testing with the former DSS assessing those who are not receiving any income tested pension from either Department;
- income for non-pensioners will be assessed on the same basis as those receiving pensions;
- information held by the former DSS and DVA on income of pensioners will be used to assess residential care fee;
- level of residential care fee paid related to income;
- exempt residents defined;

In addition to the above there was the creation of Centrelink as the Government's service delivery agency, and as such Centrelink undertook service delivery on behalf of the former DSS.

Key Events - Implementation of Residential Care Fee Income Test



Key Events - Implementation of Residential Care Fee Income Test



Appendix 2

Communication strategy

Development of a communication strategy

1. As the agency that had primary responsibility for the implementation of the Aged Care Structural Reform Package, Health was responsible for the framework within which communication was to occur. The other agencies also undertook communications in line with their role in the implementation of residential care fee income testing.

2. The Health communication strategies that were developed for the various implementation dates were aimed at providing information on the Aged Care Structural Reform Package as a whole, of which the residential care fee income test was an integral part.

Three phases of Health communication strategy

3. An examination of Health communication strategy development, reveals three distinct phases. These phases can be linked to the changes that occurred to the implementation timeframe. The first phase communication strategy relates to developments for the original implementation date of 1 July 1997, the second phase to the 1 October 1997 (and subsequently 1 November 1997) implementation date and the third phase to the eventual 1 March 1998 implementation date. This appendix outlines the planning for and management of the communication strategy within each of these phases, including discussion of Centrelink's role during the third phase.

Phase one

4. In late October 1996, Health met with the former DSS to plan communications on those parts of the Aged Care Reform Package in which DSS was involved, particularly focussing on income testing. The meeting identified the target audiences, communication channels and products, and possible content for an information kit. This meeting recognised that the details of a communication strategy were dependent on other Reform Package sub-projects, such as legislation and micro-policy, and identified the need for developing contingencies for delay in the passage of the legislation.

5. Subsequently, Health sought and gained agreement from the Minister for Family Services to undertake research to inform the development of a public communication strategy in December 1996. In this briefing, time-lines for the development and implementation of a strategy were identified, in line with the requirement for a 1 July

implementation, as well as for informing existing residents of the income testing requirements prior to that date.

6. The time-lines for undertaking the research to inform the strategy development were not met. The Department advised that the Minister was concerned with the content of key messages provided to the public and sought focus testing on these prior to further research work. The Department contracted a consultant to undertake this work. In addition, the Office of Government Information and Advertising (OGIA) advised the Department that the research brief and list of consultants would need approval from the Ministerial Committee on Government Communication (MCGC), the process for which had not been factored into the original time-lines. Both of these requirements delayed the completion of the research to underpin the development of a strategy by at least three months.

7. On 12 May 1997, a report on the research from the consultant was presented to departmental staff and staff of the Minister's office. This would have left a very short timeframe for the recommendations to be incorporated into a strategy and for a strategy to be approved and implemented (particularly given the requirements for MCGC consideration), had the 1 July 1997 implementation date been retained, given the necessary lead times. The ANAO acknowledges that Ministerial concerns are likely to have delayed the time-frame for developing a strategy. However, due to lack of documentation, it cannot provide assurance about the adequacy of the Department's briefing of the Minister on the risks to the original communication strategy development time-frames of requiring two separate research phases. The requirement for the two phased approach was outlined in a verbal briefing to the Minister that had not been documented. Furthermore, in the initial time-frame for the communication strategy within advice to the Minister, the Department did not identify any requirement for MCGC consultation.

8. During the period leading up to July 1997, however, Health undertook a number of communication activities to inform the public and providers about the reforms. These included: the introduction of a Telephone Hotline in February 1997, articles in *Age Pension News*, and production and dissemination of information fact sheets. The amount of activity was not significant as there was no specific funding allocated for communications at that stage, other than for the research consultancy and for employment of a journalist. These and any other costs had to be limited to that which could be absorbed within the Divisional administrative budget.

Phase two

9. In June 1997, following the announced delay in implementation, a communication strategy was prepared by the Department. This could be regarded as the commencement of the second phase of communication strategy development. The department sought and obtained Ministerial approval of the strategy.

10. In late June 1997, Health forwarded the strategy through the Office of Government Information and Advertising (OGIA) to the Ministerial Committee on Government Communications (MCGC) for information.

11. OGIA considered that the draft communication strategy was *"very informative and extensive."* This strategy was for the Aged Care Reform Package as a whole and covered the following key aspects:

- objectives;
- key messages;
- target audiences;
- strategies;
- tactics, which covered a wide range of media;
- monitoring and evaluation plan—Health approached four companies with a research evaluation brief for the strategy and requested that they provide proposals by 27 June 1997. Subsequently a consultant was appointed to do a benchmarking and evaluation study, which at the time of the fieldwork for the audit was ongoing;
- proposed costings (estimated at $1.2 million[37]); and
- time frames.

12. By mid-August, Health reported to the Tri-Departmental Implementation Steering Committee on progress on several parts of the communication strategy. Soon after this briefing, there was an intense period of media attention and public debate about the reforms. This in turn led to very high levels of concern and inquiry from the public about the reforms. A large number of these inquiries were directed to the Health Telephone Hotline.

13. As the resources originally allocated to the Health Hotline were inadequate for the number of calls being received, additional staff were

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[37] This does not include some initiatives which were to be funded either from the training budget ($30 000 plus one minor uncosted item) or the Public Affairs budget ($49 500). In addition the then DSS had been funded up to $200 000 to communicate the structural reform changes relevant to their clients, and DSS had indicated its willingness to use the funding jointly with Health.

employed.[38] As subsequently still more resources were required to meet inquiries, Health negotiated with Centrelink for a call centre (Centrelink's Cardiff Call Centre) to provide the extra resourcing. This arrangement was only required for a few days, as the Prime Minister's announcement of changes in policy on 5 November 1997 led to a dramatic drop in calls to a level where the Health Hotline could manage alone.

14. The second phase of communication strategy development could be considered to be complete following the policy announcements of the Prime Minister in early November.

Phase three

15. In mid-October, following discussions with the Minister, Health began exploring options for developing another communication strategy aimed at the 1 March 1998 implementation date. A public relations consultant brief was prepared by Health in November 1997, and Prime Ministerial agreement was sought on additional funding for communications ($2.62 million). In the advice to the Prime Minister, the Minister recognised that the previous communication activity (valued at $1.2 million) had not been successful in informing the target audience.

16. On 21 November 1997, the Prime Minister agreed to the increased expenditure on the reforms and suggested that the advice of the MCGC be sought. The MCGC approved the appointment of a public relations consultant to facilitate the communication strategy, based on presentations against Health's brief.

17. With the assistance of the contracted public relations consultant, Health produced the communication strategy and then implemented communications activities in line with the strategy. This strategy, based on research findings which identified the need for different levels of detail of information across target groups, outlined the three levels of product type. The strategy also included distribution and dissemination approaches for each of the product types. Qualitative and quantitative evaluation were also built into the strategy.

18. Centrelink used this strategy to manage their part in the communication strategy. Coordination of the development and dissemination of communication material was undertaken through meetings of a cross-agency communications sub-committee which ensured consistency and clearance of material produced by Health, DVA and Centrelink.

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[38] An indication of the level of activity for the Hotline, is that, by the end of November 1997, almost 37 000 calls had been received.

Research to identify the most effective means of communication

19. The communication strategy produced and implemented during phase two and three was based on the research and expert opinion of a consultant which sought to identify the most effective means of communicating with customers and other stakeholders. The phase three communication was also modified, in light of the perceived outcome of the strategy in phase two. An increased emphasis, for example, was placed on communication through printed material over other communications media, as research showed a preference for this.

20. The ANAO considers that there was sufficient research undertaken to inform the development of the communications strategies.

Health monitoring and evaluation of the communication strategies

21. Health have employed consultants who, based on a July 1997 benchmark tracked the impact of the various communications strategies in order to measure and monitor their effectiveness. This quantitative, longitudinal study was still in progress at the time of the audit fieldwork.

22. Qualitative evaluation of the communications strategy for the 1 November 1997 implementation influenced the development of the subsequent strategy.

23. As part of the communications strategy for the 1 March 1998 implementation, the Department contracted a consultant to undertake qualitative research into the earlier communications campaign, to determine the effectiveness of various communication activities, and to make recommendations to address any identified inadequacies.

24. This research resulted in a number of initiatives, including the development of a *Community Speakers Program*, and an information booklet for dissemination to general practitioners, *General Practitioners' Guide to Aged Care Services*.

25. In addition, the Department advised that the Telephone Hotline provided a means of monitoring communication strategies. From the time it was established, information was provided on a weekly basis to Health managers, that indicated the number of callers and the key topics of their inquiries.

26. The ANAO considers that there was adequate evaluation of the effectiveness of the strategy in communicating key messages and feedback to refine the implementation of the strategy.

Summary

Coordination across agencies

27. The ANAO identified coordination and consultation between Health and the then DSS on the progress to implement the phase two communication strategy. The phase three communication strategy, developed for the 1 March 1998 implementation of income tested residential care fees, also shows evidence of consultation and integration between Health and Centrelink, with Health taking an appropriate leading role in the development and implementation of that communication strategy.

Formal project planning

28. The ANAO recognises that the need for consultation with MCGC and Ministerial concerns is likely to have affected the timing of research and subsequently the development of a Phase 1 communication strategy for a 1 July 1997 implementation of the aged care reforms. However, the limited progress on those parts of a strategy possible in such an environment and the lack of a specific funding allocation indicates that had the *Aged Care Act 1997* been passed in time and a 1 July 1997 implementation remained a requirement of Government, there was a risk that the public would not have been adequately informed about the reforms in general, and income tested residential care fees in particular. Contingencies to address this risk could have been developed earlier.

29. The communication strategy developed by Health for the 1 October 1997, and subsequently 1 November 1997, implementation was comprehensive and able to be implemented in a systematic manner. The communication strategy developed during phase three also had such characteristics.

Appendix 3

Training

1. The implementation of income tested residential care fees involved the following broad types of training:

- training for care providers;
- operational training for staff within the agencies, particularly in dealing with public inquiries; and
- IT systems specific training within the agencies.

2. Training for care providers and for Health staff was across the whole of the Aged Care Structural Reform Package, of which income testing was a component.

Training for care providers

3. In a briefing to the Minister on 25 September 1996, Health advised that it was planning to undertake the following initiatives with regard to training service providers:

- publish information in *Aged Care News*, a quarterly publication for service providers. The ANAO found that this had taken place, including updates to reflect amendments to policy. The Department has advised the ANAO that other information supplied to service providers included:
  - a service provider newsletter in December 1996;
  - facts sheets on structural reforms in February 1997; and
  - provision to providers in April 1997 of a Centrelink broadcast/video on the broad policy framework for the reforms and a question and answer session;
- issue the Residential Care Manual in the period May to June 1997. Health has advised that a draft version of this manual was issued in hardcopy in late July 1997, with subsequent updates to reflect policy changes; and
- undertake training program for providers in the period May to August 1997.

4. The ANAO found that there was further consideration of time-lines, training methods, content, targets, and evaluation mechanisms in November 1996. In addition, the Department has advised that seminars were conducted in March 1997 aimed at staff and providers with the release of the exposure draft of the *Aged Care Bill 1997*.

5. Subsequently, for the original 1 July 1997 implementation date, placement of advertisements for a training program for industry took place on 15 March 1997. These advertisements sought expressions of interest to tender from training providers, with the request for tender indicating that the delivery of training was to begin in May 1997, focussing on crucial topics prior to 1 July 1997. However, the contract for the successful consultant, for the first stage of the training, was not approved until 6 June 1997. This was approximately two months after originally planned, with delivery of training to providers unlikely to have been completed in time had the Government continued to require a 1 July 1997 implementation. The ANAO found that the delays in approval of the contract resulted from delays in passing the legislation. Health's response to the delays was to split the original contract into two – the first stage, to develop training material, was able to be undertaken prior to passing of the legislation; and the second stage was the management of the training delivery.

6. Departmental and service provider staff were informed of the training program through a satellite broadcast using Centrelink's Business TV facilities on 9 May 1997. Videos of the broadcast were also made available to providers.

7. Contractor selection and contract management was oversighted by the Training Project Steering Committee which comprised representatives from Health and peak industry bodies. The Consultant was contracted to develop and manage the delivery of an extensive training and information program aimed at all providers of residential aged care, members of aged care assessment teams (ACATs), and Departmental staff. With the revised implementation date of 1 October 1997 announced in late May 1997, training was scheduled for delivery in line with the new requirements.

8. Stage 1 of training, the development of courses and materials, was completed by 11 July 1997. In the second stage of the training, the delivery of the courses, a total of 19 986 participants attended 713 seminars across Australia, between July and September 1997. The objective of the training was

> *to provide the aged care industry with comprehensive understanding of the reforms and to thus enable them to embrace the new policy initiatives with real commitment.*

The training was delivered by several teams of two trainers, each comprising of a Health officer from a State Office, and one of a number of trainers nominated by three industry peak bodies. All trainers undertook an intensive 'train-the-trainers' course prior to delivering training.

9. A detailed report on the budget, processes and outcomes of the training was prepared by the coordinating consultant. The value of the contract was approximately $3 million.

Operational training for staff—Health

10. The training requirements of Health staff in administrative and policy aspects of the Reform Package, was considered along with industry training requirements in the initial planning, which resulted in the Ministerial briefing of 25 September 1996. Subsequently, Health planned to deliver training to Departmental staff in conjunction with service providers. It was also intended that the Departmental trainers would be an ongoing resource within the State Offices to conduct further workshops, as required, for their fellow staff. Responsibility for delivering these workshops was with the Health State Offices, as was release of staff to undertake the training with industry staff.

11. In addition, following the passage of the *Aged Care Bill 1997* by Parliament on 27 June 1997, the Department undertook the development of a number of training modules relating to decision making under the *Aged Care Act 1997*. These were prioritised with the intention of delivering the high priority modules prior to 1 October 1997.

12. The need to coordinate IT systems and policy training was considered by the Structural Reform Systems Steering Committee.

13. The ANAO considers that given delays in finalising the necessary contract arrangements, (see paragraph 5 above), Health would not have had the ability to provide adequate administrative and policy training for Health staff sufficiently prior to a 1 July 1997 implementation, had this continued to be a requirement of Government.

IT systems training—Health

14. Apart from the administrative and policy training described in the previous sub-section, Health also developed training specifically for operators of IT systems relating to the Reform Package. At a national meeting of program managers and State System Coordinators on 27–28 February 1997 a session was held to identify:

- the users, and potential trainees, of the new systems, and how these would be grouped for planning the training and system access;
- implications for work practices;
- technical and procedural knowledge that would be prerequisite to the training;
- the role of the system coordinator in training; and
- the time line for the training plan.

15. Planning for IT systems training was a sub-project within the IT systems planning framework. In late May 1997, the first part of a 'train-the-trainers course' to develop basic skills in delivering this systems training was conducted for Health staff. The second part of this course was held in late August 1997. The IT plans indicate implementation of this training by the Health systems trainers within their respective States in time for the various implementation dates.

Centrelink IT and operational training

16. Centrelink's implementation project plans indicate that the design of training and training support requirements was to be completed by late January to early February 1998. This training was then to be delivered to the Centrelink network, providers and to ACATS during February 1998.

17. Centrelink developed two key means of training their staff: A 'National Instruction' which focussed on IT systems issues in detail, and a training module to complement the National Instruction. This module, developed in-house by the Service Delivery Training Team was targeted at customer service officers in call centres, customer service centres and retirement service centres. The responsibility for ensuring the training was conducted was allocated to the Area Aged Care Coordinators. Planning indicates that the material would be accessible to all Centrelink staff by placing it on the On-Line Training Library. One of the objectives of this training was to

> *State the role of the customer service officer in the administration of the income and asset test in relation to aged care income tested fees.*

Material to support training

18. Each of the seminars and training modules conducted by, or on behalf of, Health was supported by printed materials including manuals. In addition, from August 1997, staff had access to a range of material through an Aged and Community Care intranet site. Staff were advised by e-mail of updates to this material.

19. In addition, information material supporting the training of staff and residential care providers was redeveloped or updated a number of times in response to policy changes, in particular, the *Program Manual for Residential Aged Care Facilities* was updated. By December 1997 Health had also developed a total of 33 Fact Sheets on the Aged Care Reform Package. These were available to their own and Centrelink staff. Centrelink staff accessed these fact sheets through their Financial Information Services (FIS) officers and Area Coordinators. The fact sheets

were not only available to all staff for training purposes, but also to the public via the internet. Call Centre scripts were also made available to all Centrelink staff.

Summary

Coordination across agencies

20. While there were several streams of training aimed at different target groups including residential care providers and staff from the agencies, overall there were adequate coordination mechanisms in place. These included coordination with outside stakeholders, within Health and Centrelink, and between agencies through a standing agenda item of training and job aids at meetings of the Tri-Departmental Implementation Steering Committee.

Formal project planning

21. The planning for training indicates early consideration of a number of aspects consistent with good practice, and a structured approach to undertaking the training.

22. The ANAO recognises that the late passage of the legislative package is likely to have affected the finalisation of a training package for service providers for a 1 July 1997 implementation. However, the delay in signing the contract for training package development and management of training delivery, indicates that had the *Aged Care Act 1997* been passed in time and a 1 July 1997 implementation remained a requirement of Government, providers and staff would not have had sufficient knowledge to undertake the Reform Package requirements in the first instance. This highlights the importance of risk management and early contingency planning.

Appendix 4

IT systems

Introduction

1. A crucial task in implementing income-tested residential care fees was the development of IT systems capable of undertaking the required data matching and provision of advice to Health on the results of income assessment to enable Health to determine the care fee subsidy payable to the service provider. Data was to be provided from both the DVA and Centrelink databases or, alternatively, from information provided directly by residents if details couldn't be identified on these databases.

2. Data matching also allows the following functions:

- cancellation by Centrelink of rent assistance (RA) once a resident enters a residential care service; and
- notification by DVA to Health of the residents on whose behalf DVA pays the daily subsidy.

3. IT system development was a complex and difficult task involving coordination across three agencies and was initially undertaken within a short time-frame. Incompatibility of the systems used by the agencies added significantly to the complexity of the task. In short, the computer systems in Health, DVA and Centrelink were not compatible as the data collected by them, and the purposes for which it was used, varied significantly across systems. It was therefore necessary to establish the required systems specifications, including developing and agreeing a common format for data file transfers, to enable data matching and provision of advice. A key means used to assist the IT systems implementation in sufficient time was that of building on the programs and coordination arrangements across agencies, that had been developed for the Residential Care Allowance (RCA) data matching.[39]

4. The technical appropriateness of the systems developments themselves were not examined by the ANAO as this was beyond the scope of the audit. In addition, the ANAO notes that the income testing aspects of IT systems development were part of a broader IT systems development required to facilitate the implementation of the Aged Care Structural Reform Package.

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[39] RCA required data matching with DVA and Centrelink/DSS data bases, because it was payable to the service providers by Health, and substituted for the payment to pensioners/beneficiaries of Rent Assistance by DVA and Centrelink/DSS.

Coordination arrangements

5. The key coordination mechanisms for the development of the IT systems were as follows:

Within Health

- the Structural Reform Systems Steering Committee (SRSSC). This committee met on a monthly basis and was responsible for the development of, and monitoring against, a formal project plan. The plan included income testing as a sub-project. The chair of the SRSSC was the division head of A&CCD, and its membership was drawn from A&CCD and IT areas within Health. A common chair of both the SRSSC and FUNIWG ensured a close relationship between the body producing much of the micro-policy impacting on systems and the committee planning and overseeing the implementation of systems developments;
- for the year from March 1997 through to final implementation on 1 March 1998, there was considerable other communication between managers in the systems area within Health and the project coordinator within Health and other key managers in A&CCD;

Within Centrelink

- the Retirement Customer Segment undertook the systems development as well as the overall implementation of income testing within Centrelink. DSS systems staff working on this project transferred to Centrelink at the time of handover;

Between Agencies

- Tri-Departmental Steering Committee, which met monthly and dealt with all aspects of the implementation across agencies; and
- a Tri-Departmental technical working group reporting to the Steering Committee which met on an ad-hoc basis to discuss systems issues related to the aged care reform package.

Formal project planning

6. The Health SRSSC, produced a formalised project plan for IT systems development which identified milestones, resources and key responsibilities for each of the IT sub-projects. Underpinning the formalised project plan, were a series of project planning papers, that provided the basis for SRSSC decision-making. These were:

- a scoping paper developed by mid-October 1996 which provided options for systems development. This paper recommended an option

that took account of cost effectiveness and minimisation of risks associated with meeting required implementation dates;

- a *System Development Strategy* paper developed by mid December 1996. This paper delineated responsibilities for the many aspects of the strategy and included consideration of a number of specific sub-strategies such as data conversion, further risk identification and contingency planning as well as training issues;
- a *Proposed Implementation Strategy* developed in early April 1997, covering many of the same issues as the previous, but which noted the impact of delays in passing legislation and policy changes on systems development and testing; and
- a further series of detailed sub-strategy papers, including the *Data Conversion Strategy* and the *System Development Testing Strategy*.

7. Centrelink's project plan for the implementation of income-tested residential care fees has three separate sub-projects impacting on systems development; one was for data exchange, and the other two for development of specific systems.

Risk management

8. A risk assessment was undertaken by the Health IT systems project team in December 1996, to progressively assess the various risks associated with the development and implementation of the IT systems to support the aged care structural reform initiatives (including system changes required to implement the residential care fee income test).

9. This risk assessment identified and ranked risks directly impacting on system development, including:

- delays in the passage of legislation;
- changes in government policy;
- problems in interfaces with external agencies, in particular those required for data matching associated with the residential care fee income test; and
- loss of experienced IT staff.

10. The risk assessment also identified strategies to treat these, and other risks. The risk assessment was considered by the Structural Reform System Steering Committee and was updated by the Project Team as risks were monitored and reviewed. The risk assessment process adopted by the IT systems Project Team is in line with the better practice principles of risk management outlined in the MAB/MIAC guidelines.

11. There was a formal briefing in late December 1997 by Health staff to the Minister for Family Services on risks to the implementation of income testing on 1 March 1998, in particular those relating to IT systems. The Minister for Social Security was also provided with a formal briefing by Centrelink staff on implementation progress and risks arising from IT systems complexity at the time of the hand-over to Centrelink.

Other issues

12. Each of the policy changes had impacts on the IT systems being developed. In particular, in order to accommodate the changes in gifting arrangements and rental income streams, Centrelink needed to develop an IT system, in parallel to, but different from its pensions payment system.

13. In addition, micropolicy decisions that were being made throughout the implementation period, created a need for Health to vary their systems in order to implement these decisions

14. There were two phases of physically linking systems across agencies for data matching during the implementation:

- initially, and throughout most of the testing process, these links were undertaken by physical exchange of data tapes; and
- just before the 1 March 1998 implementation, a Systems Network Interconnection (SNI) link was established, allowing daily exchange of data files between the three agencies, through an encrypted electronic data line.

15. The eventual need for an SNI link was being discussed by the agencies as early as September 1996, however, it was not operational until immediately prior to the 1 March 1998 implementation date. Centrelink's strategic plan had a target date for implementing the SNI links of 13 February 1998. The main cause for the delay was attributed to a difficulty experienced by one of the agencies in acquiring a budget to install the link, although the cost of the link was relatively small in terms of the total funds required for systems development to implement the Aged Care Reform Package. While data matching could, as a contingency, still have proceeded by way of exchange of tapes, this is inefficient. The earlier development of an SNI link could have streamlined the testing process, and ensured smooth operation of the link from 1 March 1998. Problems with processes supporting the link were then not fully resolved until two months into the operations.

Summary

Coordination

16. There was appropriate coordination by the agencies, both strategic and micro, in a rapidly changing policy and complex technological environment.

Formal project planning

17. The implementation of the IT systems development for income testing was undertaken with regard to early strategic planning, and detailed operational planning for technical developments, particularly for the IT development in Health.

Risk management

18. The ANAO considers that an appropriate risk management approach underpinned the IT systems sub-project of the implementation of income testing.

Appendix 5

Forms development

Introduction

1. The function of the residential care fee income test form is to collect details of income from new residents who are self-funded retirees (or else cannot be identified on the DVA or Centrelink databases). Health can then be advised and can determine the care fee subsidy payable to the provider. The finalised form consisted of three parts:

- the main income testing form itself, which contains sections that provide for identification of the resident, their income, including any payments they receive from either Centrelink or DVA and a declaration;
- an explanatory booklet; and
- a separate form to allow the resident to appoint a nominee should they choose to do so.

2. In making reference to the form within this appendix the ANAO also includes the two supplementary documents described above.

Early form development

3. The former DSS, and subsequently Centrelink, had primary responsibility to develop appropriate forms to enable the implementation of income tested residential care fees. They did so with input from Health.

4. The earliest versions of the form for the 1 July1997 implementation were subject to testing in late March 1997 and subsequently in June 1997. The version of the form aimed at the 1 October 1997 implementation date was produced by FaCS on 9 July 1997.

Form development for 1 March 1998 implementation

5. In its development of a formal plan in early December 1997, aimed at the 1 March 1998 implementation date for income tested residential care fees, Centrelink included forms implementation as a sub-project. The tasks for this, with target dates (in brackets) were:

- determine forms requirements (12 December 1997);
- design forms (24 December 1997);
- market test design (16 January 1998); and
- deliver forms (27 February 1998).

6. In early December 1997, Centrelink started revisions to the form to reflect policy changes that had occurred. The older versions of the form were used as a starting point and were updated using material supplied by Health.

7. Centrelink, in accordance with agreed protocols between the agencies, sought Health's approval of the form through the Tri-Departmental Steering Committee meeting on 9 January 1998.

8. In line with internal procedures, Centrelink planned and undertook market testing of the revised form with a specialist consultancy firm. Testing was undertaken by the planned milestone date of 16 January 1998.

9. On 21 January 1998, Centrelink staff met with Health staff to discuss the outcome of the testing which was regarded by Centrelink as acceptable.

10. On 22 January 1998, the Minister's office advised both Health and Centrelink that the length of the form was unacceptable to Government, in line with concerns expressed earlier in December by the Government. Centrelink (with assistance from DSS and Health officers) redesigned the form and reduced it from 16 to four pages by excluding the proof of identity and compliance related sections of the form. This action was undertaken on the same day as the advice was received on the Government's decision.

11. Centrelink undertook market testing of this shorter version of the form through their consultant. Health employed a different consultant to review the form on their behalf as they considered that they required an independent perspective.

12. A formal briefing to the Minister for Family Services, seeking approval of the revised income testing form and associated documents, was provided in early February 1998.

13. The revision of the form impacted on the timeframe for printing and distribution of the forms. To ensure that the forms were available for the implementation date, Centrelink activated a contingency plan, couriering the forms to their network, rather than using the normal distribution channels.

14. The first three of the planned project milestones for forms development were met by Centrelink, and while the fourth milestone, the delivery of forms, was met later than planned, it was achieved prior to the implementation date.

Summary

Coordination across agencies

15. There was adequate inter-agency communication and coordination in developing the form.

Formal project planning

16. While the ANAO found that the planning process was adequate, the development of contingencies based on risk assessment (in particular, the risk of the Minister not approving the form, given the previous concerns expressed by Government) would have facilitated a more efficient implementation.

Appendix 6

Business process re-engineering

1. In examining this issue, the ANAO was primarily seeking to identify planning and implementation of work undertaken to integrate the new aspects of service delivery of the income tested residential care fee into Centrelink's operations, primarily through business process re-engineering (BPR).

2. BPR was not undertaken with respect to income testing during the implementation, however, broader re-engineering work is being undertaken within Centrelink. This may, in the future, incorporate the functions of the Retirement Customer Segment (RCS) of Centrelink, including delivery of the income tested residential care fee.

3. RCS is currently mapping the processes involved with income testing. This activity would assist any future re-engineering exercise. However, the form, and the basis for assessing income, differs between this income testing and that for aged pensions. This may provide a constraint in the future for fully integrated service delivery.

Appendix 7

Details of coordinating arrangements

Senior management overview and coordination

1. The ANAO found the following key examples that indicated that there was senior management overview and coordination of the implementation:

- within Health, responsibility for implementing the Aged Care Structural Reform Package was delegated to the Division Head of the Aged and Community Care Division (A&CCD), with the responsibility for residential care fee income testing delegated to a Branch Head within that Division. Coordination of implementation projects and tasks was undertaken through the normal operation and communication structures of the A&CCD;
- within Centrelink, the National Manager, Retirement Customer Segment coordinated the implementation of the residential care fee income test. In performing this role, the National Manager was responsible directly to the Deputy Chief Executive Officer (CEO), Centrelink; and
- between agencies
  - the Deputy CEO, Centrelink and the Deputy Secretary, Health met on a monthly and ad-hoc basis to discuss a range of issues, including the overall purchaser/provider arrangements between the two agencies.[40] The ANAO considers that these meetings were of sufficient frequency to ensure coverage of implementation issues at a high level;
  - underpinning these executive level meetings were a series of meetings at senior management level (that is, First Assistant Secretary/National Manager and Assistant Secretary) between Health and Centrelink held on an *ad hoc* basis during the implementation after responsibility had transferred to Centrelink. However, there are minutes for only one of these meetings. The outcomes of senior management implementation meetings were communicated to officers undertaking the operational work in Health and Centrelink. The ANAO considers that this process would have assisted in ensuring that a common understanding of implementation requirements and time-frames was achieved; and

[40] Ad–hoc meetings were usually in response to critical issues, for example policy changes and adverse media reports regarding policy and service delivery.

– high level correspondence was exchanged between Health and Centrelink on a range of implementation issues throughout the period following the hand-over from the former DSS to Centrelink.

Coordination between agencies

2. The ANAO identified a range of coordination arrangements across the various levels of responsibility to ensure communication and coordination between Health and Centrelink; in particular:

- the Tri-Departmental Steering Committee. This Committee was the key strategic planning mechanism for coordinating the implementation of the residential care fee income test across agencies. Meetings were held approximately monthly[41] over the period July 1996 to April 1998 and were attended by senior officers of Health, FaCS, Centrelink[42] and DVA responsible for managing the implementation, including representatives from key systems, and communication working groups**.** The meetings discussed a range of implementation issues / projects. Once the Centrelink project plan was in place in December 1997 (see paragraphs 3.77 and 3.78), a schedule of action items, with timelines referenced to the project plan, and responsibilities resulted from each meeting. Progress against action items was then discussed at the next meeting of the Committee;
- Tri-Departmental working groups, comprising representatives of the three agencies, supported the work of, and reported to, the Tri-Departmental Steering Committee. Examples of these groups include:
  - a technical working party on IT systems issues;
  - a communications sub-committee for the development and dissemination of communication material and to ensure that information produced was consistent and cleared between the agencies;
- a joint project design workshop, and subsequent development by Centrelink of an implementation project plan, which was referenced by Health as a basis for coordinating work internally within Health for the period January to March 1998 (see paragraph 3.78); and
- a range of informal contacts between Health and Centrelink (and DVA) at officer level to facilitate timely discussion and resolution of implementation tasks / issues.

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[41] Meetings were held approximately fortnightly from December 1997 in the lead up to the 1 March 1998 implementation.

[42] Project planning for the implementation was handed over from FaCS to Centrelink on 1 October 1997. Following this hand–over, FaCS no longer attended meetings of the Tri–Departmental Steering Committee. There was a transition period from August to October 1997 during which time both agencies attended these meetings.

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