LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

STANDING COMMITTEE ON PUBLIC ACCOUNTS

(Reference: Auditor-General's report No 7 of 2008: *The aged care assessment program and the home and community care program*)

Members:

DR D FOSKEY (The Chair)
MS K MacDONALD (The Deputy Chair)
MR B SMYTH

TRANSCRIPT OF EVIDENCE

CANBERRA

THURSDAY, 28 FEBRUARY 2008

Secretary to the committee:
Mr H Finlay (Ph: 6205 0136)

By authority of the Legislative Assembly for the Australian Capital Territory

WITNESSES

HEARNE, MR RUSSELL, Senior Audit Manager, Auditor-General's Office **1**

NICHOLAS, MR ROD, Director, Performance Audits and Corporate Services, Auditor-General's Office **1**

The committee met at 3.16 pm.

NICHOLAS, MR ROD, Director, Performance Audits and Corporate Services, Auditor-General's Office
HEARNE, MR RUSSELL, Senior Audit Manager, Auditor-General's Office

THE CHAIR: This is a public hearing. You need to be familiar with the privilege statement. I move:

> That the contents of the privilege statement be incorporated into the *Hansard* transcript.

That is accepted.

The statement read as follows—

> **Privilege statement**
>
> The committee has authorised the recording, broadcasting and rebroadcasting of these proceedings in accordance with the rules contained in the Resolution agreed by the Assembly on 7 March 2002 concerning the broadcasting of Assembly and committee proceedings. Before the committee commences taking evidence, let me place on record that all witnesses are protected by parliamentary privilege with respect to submissions made to the committee in evidence given before it.
>
> Parliamentary privilege means special rights and immunities attach to parliament, its members and others, necessary to the discharge of functions of the Assembly without obstruction and without fear of prosecution.
>
> While the committee prefers to hear all evidence in public, if the committee accedes to such a request, the committee will take evidence in camera and record that evidence. Should the committee take evidence in this manner, I remind the committee and those present that it is within the power of the committee at a later date to publish or present all or part of that evidence to the Assembly. I should add that any decision regarding publication of in camera evidence or confidential submissions will not be taken by the committee without prior reference to the person whose evidence the committee may consider publishing.
>
> I also have a few housekeeping matters which I need everyone in the room to observe:
> All mobile phones are to be switched off or put in silent mode;
> Witnesses need to speak directly into the microphones for Hansard to be able to hear and transcribe them accurately
> Only one person is to speak at a time
> When witnesses come to the table they each need to state their name and the capacity in which they appear.

If you have read it before, you only need to skim it, but if you have never read it before, please read it thoroughly. Do you understand the privilege implications of the statement?

Mr Nicholas: Yes.

Mr Hearne: Yes.

THE CHAIR: Do you have a general statement that you would like to make before you plunge into the presentation?

Mr Nicholas: We would like to take the usual approach. We have a presentation that we have prepared for the committee in which we will run briefly through the objectives, findings and opinions of the audit. We would be happy to take questions at any stage, either during or at the end of the presentation.

A PowerPoint presentation was then given—

Mr Nicholas: The audit that we have undertaken here started off in our initial thoughts as being a bit of a general review of the provision of services to the aged in the ACT. We started to focus a little more closely on a couple of the programs as we got into the planning process, and in the end we singled out only two of a fairly significant range of programs, the first being the aged care assessment program—ACAP—that has been undertaken through the aged care assessment team in the ACT, and the second being the home and community care program.

Home and community care is certainly a very significant component of the services that are provided to the ACT community—$22-odd million. ACAP is a sort of gateway or entrance into many of the other programs that are offered. We felt that if we looked at the way in which people get into the system and satisfied ourselves about the way in which that occurs, that gives us a good heads up for the rest of the program.

We looked at the assessment of the needs of aged people through the aged care assessment program and the way that ACT Health manages the delivery of services through the home and community care program. The thing to say here is that ACAP is basically undertaken by ACT Health. It has a small number of staff, about 15 or so, working in that program to provide assessments. The home and community care program services are largely provided by non-government organisations. In 2006-07, I think there were in the vicinity of 30 NGOs providing services and two ACT government services providing assistance. So the HACC program becomes more a case of monitoring delivery of services through contractual arrangements.

We did not go out and look at the actual operation of the NGOs, although we did attend a number of NGOs as part of our research and fieldwork. So we observed the way they were delivering their services but the report is not about the specific provision of services by those NGOs.

I suggest that we go through the ACAP area and then go into the HACC area, rather than jump backwards and forwards. We have led off with the aged care assessment. We are looking at about $1.3 million in all going into that team that is doing the assessment processes. That is basically covering about 15-odd staff. Their objective is to look at the needs of the people that are referred to them or that they come across, and to ensure that they have access to the services they need. While the program is predominantly aimed at frail older people, some young people with disabilities are included in the program; they are certainly not outside it.

The team that provides this assessment is, as we have described it here, a bit of a gateway into other community and residential care programs. As I said, that is why we have chosen to focus on that area. The teams look at conducting an assessment to determine the type of care that is needed by an individual, to provide a choice of the services that are available to them and to provide information and make further referrals to other providers. So ACAT itself does not do any servicing; it just provides that assessment process.

Overall, we were quite pleased with the way in which the services were being delivered. The assessment team, from our point of view, was delivering appropriate assessment services and its referrals were quite appropriate. They were managing that process in a rather efficient manner. We thought there were some steps they could take to improve the way in which they were doing their business, and that is a little bit around some of the infrastructure to it, I guess. They have policies and guidelines but not anything specific to the ACT. We felt there were some unique characteristics of the ACT that they could address.

MR SMYTH: Rather than take notes, could we get a copy of this?

Mr Nicholas: Yes, certainly. The secretary has a copy. There were some procedures that we felt could be streamlined and certainly that the accountability arrangements could be improved by having better documentation of the way in which those procedures were carried out. We felt there was some value in providing additional information to the stakeholders. By that we mean the potential clients of the service, plus medicos and residential services et cetera.

We also found there was a lack of reporting on the way in which this service was being provided. The annual report of ACT Health does not go into much detail at all on this area, so we felt that by improving the reporting, and particularly reporting against key performance indicators, we would get better information out into the community and improve the general accountability of that service.

We will now go through a series of the key findings. Largely, these are referred to in the report under the key findings aspect of each of the chapters. They link back into our overall opinion, as you will no doubt see. When we were looking at the way in which the services were being initially planned, what we identified straightaway was that, although ACT Health have some reference to the aged care assessment team in their overall program of services, and particularly the business plan of the Aged Care and Rehabilitation Service, the information in there was not very specific to ACAT. There was not much use in the business plan to allow the ACAT to identify the priorities they should be putting into their business for a particular year, the sorts of indicators they ought to be measuring themselves against, time frames and so on. With respect to all the things that we would consider to be generally good value in a business plan, for this particular aspect of their services, it was missing. There was a recommendation that sought to address that particular aspect.

We looked at the staff that were being used to provide this aged care assessment team. While we generally feel they are qualified people and are certainly keen on their work, there is scope for some overall assessment of the needs of that team to make sure we

have all bases covered. There is no specific learning and development program for the folk in that team, and we felt that some more targeted work could provide some benefits. As they lose staff and seek to re-recruit, we suggest they might move into particular areas and particular disciplines so they can get a more rounded team.

THE CHAIR: How many are on the team and where are they based?

Mr Hearne: 14.8 FTEs.

THE CHAIR: Where do they work from?

Mr Hearne: They were working from the old library building at Griffith in mid last year, but where they are now, I don't know.

MS PORTER: What skill sets do they currently have?

Mr Hearne: They are mostly RNs, with some allied health. They have services available to them of a geriatrician.

MS PORTER: What would you suggest would be the other areas that you think they would need to add to that team if they were going to recruit additional people or if other people left?

Mr Hearne: The commonwealth guidelines refer to a wide range of skills, and we took up that point. We refer to a diverse range of health professionals, so that would include not only the nurses but others—allied health and medical staff.

Mr Nicholas: The preponderance at the moment is obviously towards the nurses. We just feel there is a capability to get a wider spread of expertise in that area.

MS MacDONALD: So podiatrists, physiotherapists et cetera?

Mr Nicholas: Yes.

THE CHAIR: Is it a "tick the box" sort of assessment? You said that you had no problems with the assessments themselves. What did you view to come to that conclusion?

Mr Hearne: We reviewed a number of assessments. Some were files, but we did visit or we were present for about half a dozen actual assessments face-to-face. There are a number of tools that the team uses to make an assessment.

THE CHAIR: And they include?

Mr Hearne: They are listed in the report. The geriatric assessment tool is one. These are national or international tools. I cannot recall where they are listed, actually, but they are in there.

Mr Nicholas: On page 35 we have a specific assessment tool that has been prepared through Health, through the commonwealth, as a mental examination, if you like, that

is also undertaken, or an assessment.

THE CHAIR: So these are in conversations or questions and answers?

Mr Nicholas: Yes. It is a guided question and answer approach. It is initially undertaken through the CHI?

Mr Hearne: That is right. The initial contact with the client can be through the Community Health Intake or directly to the ACAT team, but most of them are through the CHI, which is a separate organisation, a separate part of Health.

THE CHAIR: So they are referred to it rather than self-referring?

Mr Hearne: That is right, yes. The referrals can come from a whole range of people. It could be self-referral. It could be the medical practitioner, it could be family or it could be the neighbour. So there is a whole range of people and a whole range of ways in which our folks can come to the attention of the ACAT team. They can come through the CHI area—the community health intake area. It can come through that and that is just a directed phone call, a scripted phone call. They seek to get them to answer certain questions and have a bit of a triage-type approach there and then refer it to the ACAT team or it can come into the team itself.

THE CHAIR: Thank you for that. I am quite happy that I understand the process.

Mr Nicholas: We will get a bit more into the tools in a moment. We looked at the way in which the assessments were being undertaken, particularly through our very limited sample of sitting in on the face-to-face assessments. But through our reviews we were quite satisfied that the particular needs of clients were being identified and were being identified well. The assessors were quite responsive to the individuals, which is exactly what you need, and also responsive to the carers because they are a very large part of this process as well.

We looked at that community health intake, which is often the point of referral. We were a bit concerned that there were no specific standards of service that were dictated between health and that particular body. While they had a very close working relationship, there is nothing documented as to how it should work or why it should work or what sort of targets or performance measures were going to be used to assess that overall performance. So we have made recommendations that there should be some development of those standards.

We looked at the way in which the ACT was actually conducting assessments and some of the throughput-type measures. We found that for the priority 1 and 2 clients we were doing pretty well comparatively. When compared with the other jurisdictions we were doing fairly well. But often the face-to-face contact was wanting. I indicate there that it took, on average, twice as long for a referral for face-to-face for all ACAT clients. The delays were predominantly in the priority 3 area, so it is maybe not that worrying.

We did see through our analyses that there appeared to be some priority given to assessing patients while they were in hospitals themselves. That is not a bad thing per

se. It tends to free up or could free up a hospital bed that is needed elsewhere. But in terms of equity, I guess, our view was that there should be equitable service across all client needs and we were a bit worried if priority to hospital patients was meaning that those folks out in the community were missing out or their assessments were being delayed in some way.

MR SMYTH: How does that work? Is there an ACAT officer stationed in the hospital or are they called in?

Mr Nicholas: I cannot be specific about that.

Mr Hearne: They are not called in, I do not think. I am not 100 per cent sure, Mr Smyth, but I understand they work as a team, so they are not actually on site.

MR SMYTH: So how does somebody in the hospital get seen before somebody outside? Surely if your name goes on a list you are the next cab off the rank because you have not had an assessment done.

Mr Nicholas: I think it is the triage-type aspect. They would probably be rated at a higher priority.

Mr Hearne: They are the priority 1s.

MR SMYTH: Just because they are in hospital?

Mr Nicholas: Quite possibly.

MR SMYTH: But that might not be an accurate assessment—

Mr Nicholas: Part of the whole process is to ensure there is equitable access to services, so a high priority to the hospital patients could potentially mean that those out in the community are not receiving the attention they need. We have made reference to that to the department and they have indicated to us that they are addressing that.

We took a sample of around about 60 or so cases that we audited in total or in some detail and in a small number of those—about nine per cent—we found that the referral was, I guess, declined in a sense, if you like. The CHI or the ACAT team found that the client was either ineligible for an assessment at that time, so they were outside that eligibility group, or they just did not need it at the time.

Now, it is only a small number and I guess one might take a little bit of comfort in that, but that suggests that there is some resource that is allocated to that group to undertake the assessment, or least consider them in the first place, that could be better used elsewhere. We just felt there that maybe there is a way that the department, ACT Health, in particular, can get information out into the community so that the community as a whole is more aware of the services and the way in which those services are provided.

For example, we have anecdotal information suggesting that people were seeking the

ACAT assistance just in case, to provide a bit of comfort factor for either themselves or for their family. What we are suggesting, I guess, is that ACT Health promote it so that it does not emphasise that aspect, so that it is not a just in case service but a service that is provided when you actually do need it; it is not really comfort factor.

As we indicated earlier on the ACAP, the program itself, was established under commonwealth direction and they provide a whole series of commonwealth guidelines—operational guidelines and procedural guidelines. They are all very generic. We feel that there is a need for the ACT to revise or refine those so that they reflect the specific environment that we are living in here. We are a different community. We do not have the rural base that many of the other communities have, for example. We have a fairly large proportion of aged people in the community, and clearly that is growing.

Just to quote a couple of numbers that we refer to in the report, in 2006, 14 per cent of our population was aged over 60. By 2031—and that is a while away—it is going to be 27 per cent. It is a fairly significant jump and obviously means a significant change in the way in which these services are going to be provided.

MR SMYTH: And we will be part of it?

Mr Nicholas: And we will be part of it, yes. That is true. At least some of us will be.

MR SMYTH: We will all be part of it and Hamish will be paying for it.

Mr Nicholas: This is the aspect about the tools and the forms that we were using. Yes, there are some clinical assessment tools that are prepared. Our review of the files indicated that they were only being used in about 60 per cent of the cases anyway. In about half of those cases where they were being used they were not being used in totality and they were not being used consistently.

MR SMYTH: How were the assessments being made if they were not using the tools or the forms required?

Mr Nicholas: That is an interesting question. I guess what it is largely is that the tools were being short-cut. Maybe some of the questions were being omitted. Where there was duplication—we did find duplication in the tools themselves, so the duplicates were not being prepared, even though the requirement is that there be a full set of documentation et cetera. We are not suggesting that the assessments were not giving appropriate outcomes. What we are suggesting is that the tools themselves need some revision.

THE CHAIR: So they were choosing not to use the tools because they probably found them inadequate.

Mr Nicholas: Yes.

THE CHAIR: Is that because they were using commonwealth guidelines or—

Mr Nicholas: It may be part of that, that there is a duplication of activity and

assessment here. The teams will naturally fall into a flow of processes that is, I guess, most efficient for them, and as long as it is producing reasonable outcomes they will continue with that in the light of anything else. Our suggestion here is essentially a review of tools so that they are streamlined and so that they are tailored for the ACT environment. In audit-speak, if you are not using the tools in 40 per cent of the cases and, where they are used, half the time they are not being done properly, it is a worry.

THE CHAIR: So that was agreed?

Mr Nicholas: Yes.

THE CHAIR: That sounds good.

Mr Nicholas: All of our recommendations have been agreed. There is only one that was agreed in principle and a number of them have already been addressed or were certainly under way at the time we tabled the report. So the response has been quite positive in that sense.

But when we couple the last dot point there with the observation that the tools were not being used well, what we found is that in many cases the delegate who was approving the recommendation for the team was just saying, "The recommendation is approved." He or she was not necessarily going back over the assessment itself and satisfying himself or herself that the proper assessment had been done. We are not trying to imply that there were inappropriate assessments, but in our view that increases the risk of inconsistency and increases the risk of lower quality assessments.

MR SMYTH: Did you actually look for inappropriate assessments specifically?

Mr Nicholas: Inappropriate assessments?

MR SMYTH: Yes. You just said it did not mean there were inappropriate assessments. Did someone look to see if there were?

Mr Nicholas: No, I do not think we specifically targeted the sample that way. We were more inclined just to take a general assessment and take a representative sample or what we considered to be a representative sample. If it was large enough—and 60-odd cases is a reasonable selection there—and if there were anomalies they should be turning up.

One could suggest that the nine per cent that were failed, if you like, indicates that there were one or two that were getting through that were inappropriate in the sense that they were ineligible or they were being stopped before they get through the full process. So that is a bit of a bonus. It is a plus and a minus if they went through any further. We did not identify anything specific.

THE CHAIR: I am just pointing to the time. We aim to finish by four. I am just letting you know. I am sorry to be slowing you down.

Mr Nicholas: We will move through, then. I was aware that we had a number of slides that we perhaps—

THE CHAIR: It is very interesting.

MR SMYTH: Yes, it is a fascinating area.

Mr Nicholas: It is a fascinating area and obviously one that we are all very interested in. The performance information discussion that we have got here basically is talking about the information that has been fed by the ACT into the commonwealth Department of Health and Ageing's dataset, the minimum dataset. What we found is that there is and has been a persistent data entry problem there. Some of the errors have been identified and are being addressed. But data entry problems render some of the reports that might come out of that DOHA system slightly less reliable than we would want it to be.

We also found that the ACAT team themselves did not measure the satisfaction with their services. They were assuming that no news is good news. There were very few complaints about the system and the way in which it was provided. On that basis they were not specifically seeking responses from the carers or their clients.

ACT Health does not have any consolidated listing or waiting list in relation to aged care assessments or aged care needs. That is a bit of a concern to us. There is information in a whole range of areas, including in the residential care units themselves, the facilities, and that is probably where the major component of the unmet need is being felt, but it is not being collected and collated by ACT Health and used for their planning purposes.

On the other issues there we found that while we were reasonably well allocated in terms of residential care places by the commonwealth we have been slow in converting that into real places. There has been a change to that with the introduction of some of the newer homes and newer facilities that have been opened up very recently, so this is based on some data of a while ago.

MR SMYTH: Was there a specific reason for the—

Mr Nicholas: There was a whole lot of stuff within the pipeline that I guess is what we could see at the time we were doing our audit. There were about 700 beds that were either in the approval stage or going through the construction phase, so there is a whole stack coming on line. Some of those delays are caused by the private sector themselves getting the funding, getting the arrangements running, but some of that lies with ACTPLA and so on.

Mr Hearne: In the report at paragraph 2.147 we go into some detail on this.

Mr Nicholas: I guess that is roughly the aged care and assessment program. In terms of the home and community care, we got $20 million-odd in 2005-06 going into this program, of which the ACT government funds just over 50 per cent. As I mentioned, these are services that are generally not delivered directly by ACT Health; they go through in this case 30-odd NGOs and a couple of ACT health providers. When you look at those NGOs, though, we find that more than half are going to the eight largest, so we have a series of relatively small organisations providing services as well.

THE CHAIR: Have you got those listed?

Mr Nicholas: No, I don't believe we do.

Mr Hearne: We have got the main ones; there would be 12, the 12 that account for most of the funding. I will find a reference for that.

Mr Nicholas: In terms of the home and community care services, we came to the view essentially that Health can improve the delivery of those services through, again, attending to the infrastructure and some of the framework associated with the way they do their business. They do not have the information that they need or we feel they might need on unmet need, on the demand. Some of their planning in our view is a bit short term. Partly that is not Health's fault, because the commonwealth initially set up triennial plans and an intention to do so but never actually sought them from the various jurisdictions, so they were not developed.

The acquittal process for the services was deficient in our view. There were certainly some risks associated with that and we have made some recommendations to address that. There is a fair sum of money that is collected by the service providers themselves, some of the fees—I think it was about $2 million in 2005-06—that is supposed to go back into the service. We were not satisfied that ACT Health could say that that was happening; they were not specifically reviewing the information coming back from the service providers to confirm that that was undertaken.

MR SMYTH: Is there an implication in that that the money was going somewhere else?

Mr Nicholas: No, I do not want to say that and I do not believe that is what we are specifically getting at. I do not think there was any—

Mr Hearne: There is a risk.

Mr Nicholas: There is clearly a risk, but there is no strong indication from our perspective that that money was going AWOL. It is just that it is part of the conditions of services that they get back in there. It would be our expectation that ACT Health would satisfy themselves that the fees were being returned to the service. They were not doing that to our satisfaction.

MR SMYTH: There was not any evidence or any suggestion that the money was being used inappropriately?

Mr Nicholas: No. We have no evidence to that effect.

MR SMYTH: Was that looked for or is it an assumption—

THE CHAIR: You didn't look at the NGOs and the—

Mr Nicholas: We did not go specifically into the NGOs; we were looking at their returns. We spoke with them, clearly, and we have had their—

MS MacDONALD: Could it be partly because of the nature of the organisations who are providing these services being small organisations?

Mr Nicholas: The problem was probably not with the smaller ones. Where we had difficulty identifying whether these funds were being returned was perhaps with the larger organisations that were not providing reports that were specific to the funding provided by the ACT government, and that is again a requirement under the agreement.

MS MacDONALD: So they are a national organisation whose focus was not on the ACT?

Mr Nicholas: Yes.

Mr Nicholas: The eight largest were—they are at 3.15 of our report—Red Cross, Communities@Work, Community Options, FaBRIC, HandyHelp, Home Help Service, Northside Community Services and Respite Care ACT. It is on page 59.

MS PORTER: For information, Home Help Service and HandyHelp have now amalgamated into the one organisation.

Mr Hearne: This is 2005-06 data.

Mr Nicholas: This was during 2006-07 when we were looking—

MS PORTER: They have now amalgamated, so that has become larger then.

Mr Hearne: Even larger still, yes.

Mr Nicholas: That was one of the problems with the acquittal process: it was that the providers were not always delivering the reports and the information that was expected or required under the agreements; it was not necessarily being pursued by the department.

MR SMYTH: Should the committee be concerned with that or are you happy that the department has put in place processes to address that?

Mr Nicholas: The department have indicated to us that they have developed procedures and they are continuing to develop those, including some revisions to the agreements themselves in the context of the agreements. We are reasonably happy at this stage, Mr Smyth.

THE CHAIR: It is an annual reports question.

Mr Nicholas: We have not yet seen the government response to this. I am not sure whether it has come through. That might help us a little bit in directing that as well.

I will just run very quickly through this. ACT Health does have an effective annual plan for the HACC services. We are quite happy with that but, as I mentioned, they

were not going much longer than a year or a couple of years out. We felt that there was some capacity for them to look at demand further down the track to ensure that attention was paid to the developments that are going to occur over the next five to 10 years. While they may not be able to allocate specific funding, it is certainly an area that they ought to be directing their attention to. Their view largely is that the funding is provided by the commonwealth on a triennial basis and that is the major focus of their planning.

We indicate that there are no robust processes to collect the data or analyse the data on unmet needs. There is no central point for HACC clients like there is for the ACAT assessment. There is no CHI type equivalent so the information is really not coming in. Health relies on the reports coming through from the service providers for its indicators as to where changes are occurring or expected.

We were talking about the processes for assessment for eligibility and some of the review processes. We found that there are duplicated processes here and there. Because there are duplications and because a single client will need to go to each and every service provider if they are getting different services from different providers—they will go through an assessment with each of those—that information is not shared. So we get this inconvenience factor for the clients; we get an inconvenience factor and a degree of uncertainty. We certainly get some additional administrative burden for the service providers.

We have suggested that some sort of coordinated process be examined. It is not necessarily an easy thing to say or an easy thing to do, so we understand if there is some reluctance to accept that wholeheartedly. This is I think the one recommendation they accepted in principle. But it gives a start and we feel that what we have here, a service that is going out to the community, ought to be as accessible to the members of the community and as unintrusive as it possibly can be.

There were some indications that folks from culturally or linguistically diverse backgrounds were not seeking the services in the same sort of representation that they are in the community. As we have indicated, this tends to support views of the group that there are some barriers to them getting access to those services. We do not have hard data on that other than just our analysis of the numbers. We do see that there is a multicultural liaison officer that has been established within the HACC program. That person's duties are not very well defined. Their accountability structures at the time of audit were not very well laid out. They are being attended to now so there is some hope for that now.

Service delivery areas: we were talking about the $2.2 million being collected in fees from the clients by the HACC providers. Because the ACT does not have a formal fees policy that it puts to the providers, there is some degree of uncertainty about the way that should be administered and the fees that would be charged, so we felt that there was some value in ACT Health defining their own policy and ensuring that that is adhered to by the providers.

We looked at the financial returns and the processes that Health had applied there when looking at the reports and returns and, as we have indicated, we felt that they were somewhat deficient. That does put the process at risk. We have not seen any

hard evidence to suggest those risks have eventuated but we would be concerned anyway.

The quality assurance stuff is largely about our view that the reports are not being well examined in total by Health. They do have regular feedback from the providers and they are in contact with them a lot, so it is not as if they are going entirely unnoticed, but the reports are the predominant process of accountability from the providers and we expect that they would be used and examined closely by ACT Health. That is not necessarily the case.

We made 19 recommendations in our report, as I indicated. They have all been agreed; one agreed in principle. Action has been taken on a number of them so we will follow those through in due course.

I guess the summary is in the second of the major dot points. We found that ACT Health were delivering appropriate assessment referral services through their Aged Care and Assessment Team. We felt that they were not effectively monitoring the HACC services—they can certainly improve that—although we had no evidence the clients were being overserviced or provided inappropriate services, so we are not necessarily saying that there is a whole lot of money being spent or services being provided in an incorrect way, but the risk is there. We clearly see that there are opportunities for improvement.

We are happy to take whatever questions you might have.

THE CHAIR: I think we pretty well asked them as we went along, so thank you very much. Our best wishes to Tu Pham and to your office.

Mr Nicholas: Thank you very much.

The committee adjourned at 3.58 pm.