No. 146

LEGISLATIVE ASSEMBLY OF THE NORTHERN TERRITORY

WRITTEN QUESTION

Mrs Finocchiaro to the Minister for Health:

Annual Report – Department of Health

1. **Are the recently announced Meningococcal vaccine rollouts to all children outside the Top End paid for out of the existing vaccine budget? Or is this an unbudgeted expense?**

   It is an unbudgeted expense.

2. **How much did the Wi-Fi upgrades cost and was there a specific budget allocation for this expense?**

   The total cost of Wi-Fi upgrades was $1.8 million. Specific budget allocation for this work was provided through the Core Clinical Systems Renewal Program.

3. **Does the Department have the requisite specialist practitioners and staff to maintain the required level of service for cardiothoracic and neurosurgical services at Royal Darwin Hospital?**

   The commencement of neurosurgical services at Royal Darwin Hospital has been a great success. A Consultant Neurosurgeon has been recruited to lead the service and has enhanced services in Darwin and recently commenced consultative services at Alice Springs Hospital. Additional Neurosurgeon specialists will be commencing early in 2018.

   The Cardiothoracic surgical service is in a planning and development phase. The clinical service will not commence until there is a robust planned service that will deliver the same or better standard of care as that offered in other cardiac surgical services around Australia.

4. **How many specialists engaged at Territory Hospitals were engaged on an agency basis as distinct from being employed during the reporting year?**

   Nil specialists were engaged on an agency basis.

5. **How many people have received voluntary alcohol treatment at the Berrimah facility since it opened?**

   Since 1 September 2017 to 30 November 2017, 20 people have received voluntary alcohol treatment at the Berrimah facility.

6. **How can this year's high number of TEHS Weight Activity Units be explained? (page 60)**

   Activity (WAU) increases are a result of increased activity (e.g. elective surgery, emergency department presentations) and improved activity counting and coding.

7. **How can the lower-than-expected percentage of emergency patients leaving within 4 hours of presentation be explained at RDH? (page 60) TEHS**

   The Royal Darwin Hospital (RDH) Emergency Department faces ongoing challenges to continuously improve performance in an environment of increasing demand for urgent care. There was a growth of 1700 (2.5 per cent) presentations to the RDH Emergency Department for 2016-17 compared to 2015-16.

   Work continues to increase the proportion of emergency department presentations departing within four hours.

8. **Can the sustained increase in aged care occasions of service in TEHS be explained? (page 61)**

   The NT has the highest growth nationally in the aged population and this is reflected in the increasing Occasions of Service numbers over past years.

   In regard to 2017-18:
   - The commencement of the Short Term Restorative Care program just prior to 1 July 2017 would account for an increase in numbers.
   - Significant increases in the Memory Service have continued with referral numbers up to 60-70 per month.

9. **Can the steady rise in TEHS prison incidences of care be explained? Why is an annual increase considered "on target"? (page 63) TEHS**

   Increase in episodes of care is due to increased prisoner numbers and the expansion of on-site services offered within the prison. *Sentence to a Job* also commenced in 2014, with the PHC health team requested to undertake work clearances for all prisoners. This has also increased the incidence of care statistics. The episodes of care met and exceeded target.

10. **According to the report the CAHS Alcohol Mandatory Treatment is struggling to keep up with demand, and lacked resources, are the same resources required for voluntary treatment programs? (page 73)**

    - CAHS AMT Treatment service met the demand as required.
    - AMT service provision ceased on 31 August 2017, with repeal of the AMT Act on 1 September 2017.
    - Roles legislated by the AMT Act which were provided by CAHS are no longer required.
    - The staffing model for voluntary treatment has been streamlined to better meet the needs of service users in Central Australia.

11. **Can the steady rise in CAHS prison incidences of care be explained? Why is an annual increase considered "on target"? (page 76)**

The increase is due to enhanced PHC services to meet the existing needs of prisoners and also providing care to youth detention centre located adjacent.

12. **Are there any associated costs with the reconstituting of the NT Clinical Council as the Clinical Senate? (page 87)**

There are no costs associated with the reconstituting of the NT Clinical Council as the Clinical Senate.

13. **Can CAHS explain the increased incidence of "golden staph" infection this year? (page 91)what has been done to prevent a re-occurrence at such high rates?**

The variation in *Staphylococcus aureus* Bloodstream Infections (SAB) for the period of the Annual Report is attributed to increased surveillance and reporting requirements being fully implemented in Alice Springs Hospital.

<u>Measures implemented to address SABs</u>

- Implementation of updated Aseptic Not Touch Technique program (ANTT) in line with Standard 3 Prevention and Control of Healthcare Associated Infections.
- Regular and on-going Hand Hygiene training and auditing (hand hygiene compliance meets national benchmark)
- Improved collaboration and information sharing between Infection Prevention and Control and Infectious Diseases Team.
- A working group has been formed to review Surveillance of all Healthcare Associated Infection with Infectious Diseases Team leading.

14. **Is RDH's high energy consumption and large carbon footprint due to the age of the buildings and facilities? (page 96)**

RDH's high energy consumption and large carbon footprint is chiefly due to the fact that it operates 24 hours a day, 365 days a year. The age of the facility is not considered to be a significant contributor to its carbon footprint.

15. **How will Palmerston Regional Hospital's design enhance energy efficiency and keep its carbon footprint small?**

Palmerston Regional Hospital has been designed to meet best practice energy efficiency standards. The hospital's design includes:

- Roof and wall insulation and window design to meet the minimum energy efficiency requirements in the Building Code of Australia (not mandatory in the NT)
- A high efficiency water cooled air conditioning system
- Solar hot water heating with LP gas boosting
- LED lighting.

16. **What recruitment strategies are underway to ensure a sustainable workforce for the Palmerston Regional Hospital? Will any staff be recruited from agencies?**

- Northern Territory Government Whole of Government Recruitment Awareness Campaign launched 5 December 2017, attracting interstate and overseas applicants for health care positions (social media, job sites, websites). Priority given to Top End Health Service and Palmerston Regional Hospital https://ourlifeouthere.nt.gov.au/
- Recruitment and timing for the Palmerston Hospital has been structured in "waves" to allow progressive on-boarding of key staff required as part of the operational commissioning stage and then transition to service opening and ongoing operations
- Recruitment of medical staff is being managed by Senior Medical staff at Royal Darwin Hospital in concert with the relevant Medical Training Colleges
- Ongoing recruitment campaign on e-Recruit with a TEHS wide approach
- Advertisements on Seek, Linked In, Facebook, CranaPLUS journal

17. **When will the birthing suites be operational at the Palmerston Regional Hospital?**

The Palmerston Regional Hospital's maternity services will be part of an integrated maternity service across the Top End. The birthing suites at Palmerston Regional Hospital will be opened when the right workforce is in place to provide the service safely.

18. **Does it serve departmental objectives to have 60% of DoH FTEs as administrative employees? How does the Department justify this? (page 104)**

Data on page 104 of the Department of Health only refers to the Department of Health which as the System Manager for N T Health, is responsible for territory wide health planning and policy, which are administrative functions. The Health Services, as service providers, have mostly clinical staff.

19. **What proportion of Aboriginal employees recruited under the Special Measures Plan come from remote communities? (page 110)**

The Human Resource systems utilised in the recruitment process (eRecruit and PIPS) do not record the origin of job applicants.

20. **How can the Department explain that 38% of worker compensation payments were made to DoH employees, when 60% are administrative workers? (page 119)**

For the 2016-17 reporting period, the number of workers compensation claims has been found to be incorrect and should be reported as follows:

- Department of Health had 10 claims (9 per cent of total claims lodged)

Please note an erratum notice has been published to this effect.

21. **How can the $46.5 million increase in operating expenses be explained? (page 122)**

The table below details major factors that contributed to the net deficit of $46.5 million.

2015-16

Explanation	**$Million**
Depreciation and non-revenue funded items	1.6
Lower DCIS free of charge	(0.6)
Additional one-off Commonwealth funding	5.5
Grand Total	**6.5**

2016-17

Explanation	**$Million**
Depreciation and other non-revenue funded items	(7.7)
Refund for overpaid prior year GST mostly offset by lower than expected DCIS Free of Charge	0.4
Delays in the delivery of Commonwealth funded Alcohol and Other Drugs	5.2
Disability service demand and transition to the National Disability Insurance Scheme	(24.2)
Strategies in managing service demand not achieved for Environmental Health, Disease Control and Territory-Wide Services	(10.9)
Higher than expected corporate costs predominately due to legal and ICT cost pressures	(3.2)
Delays in office relocation, fit-out and database requirements for Office of the Public Guardian	0.5
Total net deficit	**(39.9)**
Total movement	**(46.5)**

22. **How many of the department's assets are liquid? Are there any unfunded liabilities once non-liquid assets are accounted for? (page 125)**

As at 30 June 2017, the Department's liquid assets included cash and receivables with a value of $8.9 million. Non-liquid assets do not impact on unfunded liabilities.

23. **Does TEHS project that it will be at least operating budget neutral at any point over the forward estimates? (page 167)**

Top End Health Service (TEHS) is committed to delivering balanced budgets across the forward estimates. Factors influencing and challenging this outcome include increased demand from an ageing and chronically unwell population, supportive social infrastructure and the extent to which a flexible health workforce can be recruited and sustained. TEHS is meeting this challenge with the delivery of increased capacity through the commissioning of Palmerston Regional Hospital and investing in innovative health service delivery to treat patients as close to home as possible, with the added result of better

efficiencies in service delivery being achieved as by product of improved service quality.

24. **What is the Department doing to address the high number of Recruitment agency personnel engaged?**

Workforce initiatives designed to improve the working conditions and tenure of nurses and midwives, reducing turnover and the reliance on agency personnel, have evolved and been implemented, in part, as a result of the Remote Area Nurse Safety Review. These have included:

- A new panel contract for third party employment agencies to supply nurses and midwives for fixed term placement up to 12 weeks is in place. This will allow for recruitment by NT Health to take place.
- A pilot to utilise the eRecruitment system for the bulk recruitment of nurses and midwives, and establishment of a pool of nursing and midwifery employees.

It is expected both initiatives will have an effect on the use of agency personnel in 2017-18 financial year across NT Health.

25. **What is the department doing to address the wait list for public dental patients?**

Public dental waitlists are utilised in respect of general dental and denture services for adults in the Darwin region. A waitlist audit reduced the number of people waiting for general dental services in the Darwin region from 3680 to 1085 people. An active waitlist management and patient prioritisation program will be launched in January 2018, which will manage waitlist demand based on patients' clinical needs.
There is no public dental waitlist in Central Australia.

26. **What is the difference in the number of Aboriginal Health Practitioners year on year?**

ATSI HP Numbers – FY Ave. Paid FTE

FY Av FTE	2013-14	2014-15	2015-16	2016-17	2017-18
Av Paid FTE	77	77	74	75	77
Variance	-	0	-3	1	2

27. **How many health clinics have transferred to Aboriginal Community controlled in the year under report and what are their specific locations and names of managing organisations?**

In 2016-17, one clinic transferred to Aboriginal Community Control. The Milingimbi Health Centre transferred to Miwatj Health Aboriginal Corporation on 1 July 2016. The clinic is now named Malmaldharra Health Centre.

Annual Report – Australian Health Practitioner Regulation Agency 2016

1. **The report shows that the number of registered health practitioners in the National Scheme grew by 3.2% this year, to 678,938. However, registered practitioners by principal place of practice has been slowly dropping in the NT. In 2013-14 it appears to be 1.09%; in 2014/15 – 1.05%; in 2015-16 – 1.05%; in 2016-17 – 1.04%.**

   Can you please advise the percentage of registered practitioners by profession, by principal place of practice for the years 2010-11, 2011-12, 2012-13?

   While the proportion of NT practitioners (as a percentage of the national total) is decreasing, the number of practitioners in NT is increasing in each of these years. Please note the following data below and attached:

YEAR	% of National	Actual NT Registrants	Actual National Registrants
2010-11	0.9%	4,788	530,115
2011-12	1.0%	5,581	548,528
2012-13	1.1%	6,354	592,470
2013-14	1.07% (not 1.09%)	6,650	619,509
2014-15	1.05%	6,696	637,218
2015-16	1.05%	6,913	657,621
2016-17	1.04%	7,038	678,938

2. **Can you please advise the reason for this disturbing statistic, given the overall national increase in practitioners and what the current Government is planning to do about it?**

   The number of registered practitioners is increasing. Refer to the answer for Q16 for workforce recruitment and retention strategies.

3. **Can you please explain the reason why at 2.2%, the Northern Territory, together with Queensland, has the highest percentage of all registered health practitioners with notifications made about them in 2016/17, by profession and state or territory?**

   AHPRA is an independent national body that accepts referrals from a number of sources about practitioner matters. AHPRA is continuing a national program of notifications analysis across a number of professions to identify risk areas that may be appropriate for intervention.

4. **Can you please provide details on the 53 NT cases that are being actively monitored by AHPRA, against all five categories: conduct, health, performance, prohibited practitioners/students and suitability/eligibility?**

   AHPRA is an independent body that accepts referrals from a number of sources about practitioner matters.

   The details of cases are not available publicly owing to Section 216 of the Health Practitioner Regulation National Law.

5. **It is noted that AHPRA provides reports by monitoring cases established, rather than by registrants being monitored. This is because a registrant may have a set of restrictions (conditions or undertakings) in more than one stream. Please advise the length of time it takes to actively monitor 'a case'.**

   The length of time that is required for a monitoring case depends on the nature of the restriction being monitored and could range from less than 12 months to several years.

6. **Is the registrant free to practice while the case is being monitored and is this considered a risk?**

   An overview of the monitoring and compliance function is available on AHPRA's website at: www.ahpra.gov.au/Registration/Monitoring_and_compliance.aspx including a link to the National Restrictions Library.