No. 104

LEGISLATIVE ASSEMBLY OF THE NORTHERN TERRITORY

WRITTEN QUESTION

Mrs Finocchiaro to the Minister for Health:

Appropriation Bill – Health

1. Please provide copies of:

   - All questions, which have been received from the public in relation to the Estimates process and consideration of the Appropriation Bill for the 2017/18 financial year; and

     A whole-of-government response to this question will be provided by the Chief Minister.

   - The answers to those questions that were presented to the Estimates Committee.

     A whole-of-government response to this question will be provided by the Chief Minister.

Please provide the information requested below for the Department of Attorney-General and Justice and the Department of Health, as at 31 March 2017.

DEPARTMENT OF HEALTH

Please accept apologies if questions are not under the correct Output. Where this is the case, it would be appreciated if you could indicate the appropriate Output in your response. Thank You.

OUTPUT GROUP: TERRITORY-WIDE SERVICES

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1. Compared to the funding allocated in the 2016-17 Budget, there has been a reduction of $22 145 000 in funding committed in the 2017/18 Budget. Why has there been such a reduction in funding committed?

   Reduction in funding mainly relates to the transfer of the Commonwealth funded Indigenous Australians' Health Programme to the health services and the cessation of the Healthy Ears – Better Hearing, Better Listening Programme. Advice from the Commonwealth indicates that the program may be continuing from 2017-2021.

2. There has been an increase of 2% in grant funding. Where has this come from since the 2016/17 Budget and what it has been spent on?

   A response has not been provided as the source of the financial value that has been queried is unable to be aligned to Budget Paper No 3.

3. Funding on Territory-Wide Services will drop from $12 650 000 to $10 723 000. Why is this happening and where will the savings go?

   The decrease in 2017-18 mainly reflects the reduction in the Commonwealth funded Healthy Ears - Better Hearing, Better Listening program. Advice from the Commonwealth indicates that the program may be continuing from 2017-2021.

4. Is the Northern Territory Government currently investigating taking Ambulance Services in house rather than outsourcing the contract, as currently happens with St John Ambulance Services?

   No. St John Ambulance Australia NT (SJAANT) holds the contract to provide road ambulance and medical transport services in the major urban areas of the Northern Territory and has done so since 1995.

5. Is St John Ambulance Service currently meeting the performance standards outlined in their contract?

   SJAANT are delivering all outputs required under the contract, with performance monitored and reviewed to ensure compliance with the contract terms and align with the performance indicator framework outlined in the annual Report on Government Services (ROGS).

6. Following the passage of the *Termination of Pregnancy Law Reform Bill 2017*, it was indicated that the draft clinical guidelines would be made available for draft consultation during May 2017 with the Bill being gazetted on 1 July 2017, however as yet no draft clinical guidelines have been released for public consultation.
   a. When will the draft clinical guidelines be released for public consultation?
   b. Will the Gazettal of the Bill now be delayed to allow for public consultation to take place?
   c. When is it expected that all the provisions of the *Termination of Pregnancy Law Reform Bill 2017* will come into force?

6a. Targeted clinical consultation on the clinical guidelines occurred over a two week period ending 17 May 2017.
6b. Gazettal of the commencement of the Act occurred on 28 June 2017.
6c. All provisions of the Act came into force from 1 July 2017.

OUTPUT GROUP: DISEASE PREVENTION AND HEALTH PROMOTION

OUTPUT: ENVIRONMENTAL HEALTH

1. There has been a reduction of $1 356 000 in funding this year for environmental health when compared with the 2016/17 Budget. Why has the funding been reduced?

   The reported budget reduction for environmental health is a combined result of the 2.5 per cent wage inflator applied to employee costs and a CPI factor of zero per cent applied to operational costs in 2017-18 as well as a whole of agency review which realigned output budgets to program requirements. There has been no reduction to service delivery.

   It should be noted that output budgets at the beginning of each financial year are indicative until they are reviewed as part of the Department's annual budget development processes.

OUTPUT: DISEASE CONTROL

1. What are the reasons for the 40% increase in notification of HIV between 2016/17 and this year's Budget and what will the costs to the Budget be due to this increase?

   The increase may be attributed to recent campaigns promoting testing for STIs and BBVs; and an increase in new arrivals from overseas and interstate with HIV who have not been counted in the NT before.

   The clinical support needed for HIV patients will be met within existing budgets for 2017/18.

2. Why has there been a 315 occasion increase in services at Clinic 34 in Darwin and Alice Springs and what are the costs of these increased occasions?

   The increase in occasions of service at Clinic 34 in Darwin and Alice Springs represents a three per cent increase in clinic activity as more patients attend for testing, treatment and/or as a consequence of health education and promotion. This increase may contribute to some increased cost in relation to staffing, medication and testing.

3. What initiatives will the Government put in place to increase the rates of immunised children by 2% in both the 12 months of age and 2 years of age categories?

   The Northern Territory Government is committed to attaining the highest coverage possible to ensure that Northern Territory children are protected from vaccine preventable diseases. Achieving further improvements on the current high rates of immunization when population numbers are small is particularly challenging and can be

influenced by reporting and data quality issues rather than just recording children receiving vaccinations.

There will be a focus on improving data quality within the Northern Territory Immunisation Register, as well as collaboration with Commonwealth Australian Immunisation Register (AIR) and Medicare to assist data quality improvement within AIR to ensure their coverage reports reflect the cohort of children living in the NT.

4. Noting the explanation in the Budget Papers for the increase of 50 000 units of sterile injecting equipment distributed through the needle and syringe program as being due to 'the increase is mainly due to the inclusion of injecting drug users into the program as part of public health efforts to curb the rates of HIV, Hepatitis C and Hepatitis B in the Territory', what are the costs of this increase and why has it occurred?

   The rise in units of sterile injecting equipment distributed through the NT Needle and Syringe Program is an estimated projection.

   The Minister authorised the installation of vending machines in Darwin, Palmerston and Alice Springs. This is hoped to generate an increase in the number of units dispensed to injecting drug users, as part of the public health efforts to curb the rates of HIV, Hepatitis C, and Hepatitis B in the NT. It is estimated that this may cost up to an additional $12 000.

5. Funding for Disease Prevention and Health protection will reduce by $3 341 000, why has this occurred and where will the money now be spent?

   Funding for disease prevention and health protection reduced predominantly due to Commonwealth funding for Rheumatic Fever Strategy and Improving Trachoma Control Services for Indigenous Australians Programs ceasing in 2016-17. This funding is now expected to be extended. A smaller component of the reduction is due to the 2.5 per cent wage inflator applied to employee costs and a CPI factor of zero per cent applied to operational costs in 2017-18.

OUTPUT GROUP: COMMUNITY TREATMENT AND EXTENDED CARE

OUTPUT: ALCOHOL AND OTHER DRUGS

1. Why has the funding committed for alcohol and other drugs in the 2017/18 Budget reduced by $3 816 000 when compared to last year's Budget?

   The decrease mainly relates to a reduction in Commonwealth funding with agreements still under negotiation, the 2.5 per cent wage inflator applied to employee costs and a CPI factor of zero per cent applied to operational costs in 2017-18 as well as a whole of agency review which realigned output budgets to program requirements. There has been no reduction to service delivery output.

   It should be noted that output budgets at the beginning of each financial year are indicative until they are reviewed as part of the Department's annual budget development processes.

2. Given the average daily bed usage at sobering up shelters is not included in the Department's KPI's in this year's Budget, what are the usage rates, compared to the 50% listed in the 2016/17 Budget?

   There were 8066 admissions to all Sobering up Shelter in 2016-17. This represents an utilisation rate of 35%

3. Sobering up Shelter utilisation has declined markedly in recent years, from 63% in 2013-14 to 35% this year. Given that the number of 'closed episodes in non-government treatment services' were not included in the budget, what are the actual figures for 2016-17 compared to the 3546 listed in the 2016-17 Budget and what it's predicted to be for 2017-18?

   The number of closed episodes in Non-Government Organisations treatment services in 2016-17 was 3688. Note that this excludes AMT-related episodes. The likely result for 2017-18 is expected to be in the range 3900 – 4100.

4. Given that the number of 'completed closed episodes in non-government treatment services' were not included in this year's budget, what are the actual figures for 2016-17 compared to the 1910 listed in the 2016-17 Budget and what is predicted for 2017-18?

   The number of completed closed episodes in Non-Government Organisations treatment services in 2016-17 was 2087. Note that this excludes Alcohol Mandatory Treatment -related episodes. The likely result for 2017-18 is expected to be in the range of 2000 – 2100.

5. Why were these two measures removed from the Department of Health's KPI's and replaced with three new measures?

The terminology previously used in the two measures was confusing for services and the public. The change in measures better reflects the actual client journey and the process/work undertaken by the Alcohol Other Drug services.

6. Why is the budget for Alcohol and Other Drugs decreasing from $38 340 000 to $37 318 000?

   The decrease in 2017-18 mainly relates to the reduction in Commonwealth funding, which is currently under negotiation.

OUTPUT: DISABILITY SERVICES

1. Noting that the substantial variations in clients of Disability Services in the Northern Territory, according to the budget papers, are 'due to the transition to the National Disability Insurance Scheme (NDIS)', are there any other reasons why 108 less clients will be accessing full-time accommodation, 200 less clients will be accessing community support services, 2 171 less clients accessing professional support services and why there will be 8 926 less clients accessing professional support services?

   The decrease in the number of clients reflects the Darwin supported accommodation and East Arnhem NDIS transition. The clients are now participants of the NDIS and have funded packages of support.

2. Funding for disability services in financial year 2017/18 will decrease by $3 480 000 when compared with the Mid-Year Economic Financial Outlook. Why has this occurred and where is this money now going?

   The funding reduction is a combined result of the 2.5 per cent wage inflator applied to employee costs and a CPI factor of zero per cent applied to operational costs in 2017-18 as well as a whole of agency review which realigned output budgets to program requirements. There has been no reduction to service delivery.

   It should be noted that output budgets at the beginning of each financial year are indicative until they are reviewed as part of the Department's annual budget development processes.

OUTPUT: MENTAL HEALTH

1. Given the Government is developing its next Suicide Prevention Strategy, is it envisaged that the number of individuals attending suicide prevention training in the Territory will increase? What will this cost?

   Community consultations to inform the renewed Northern Territory (NT) Suicide Prevention Strategy have commenced, and will be completed by the end of July 2017. Feedback received from consultation forums, our online survey and written submissions will be considered by our

Suicide Prevention Coordination Committee in the development of the next NT Suicide Prevention Strategy.

Northern Territory Government Suicide Prevention funding ($1.4 million) is currently allocated to the provision of suicide prevention training (including Suicide Story, ASIST, and safe TALK) across the NT. DoH funding is utilized for evidenced based training in this sector.

OUTPUT GROUP: NATIONAL CRITICAL CARE AND TRAUMA RESPONSE

NATIONAL CRITICAL CARE AND TRAUMA RESPONSE

1. Why is the number of responses to local, national and international deployment requests dropping by 10 between the 2016/17 Estimate and the 2017/18 Budget?

   There has been no decrease in the number of responses to local, national and international deployment requests for the 2017-18 Budget. They continue to be maintained at 100 per cent.

OUTPUT GROUP: OFFICE OF THE PUBLIC GUARDIAN

OUTPUT: OFFICE OF THE PUBLIC GUARDIAN

1. How many FTE's are currently in the Office of the Public Guardian?

   As at 17 July 2017, the Office of the Public Guardian has 24 FTE's.

2. What is the annual budget of the Office of the Public Guardian?

   As at 2017-18 budget, the annual funding allocation for Office of the Public Guardian is $4.364 million. It should be noted that output budgets at the beginning of each financial year are indicative until they are reviewed as part of the Department's annual budget development processes.

3. Have there been any cost overruns during the establishment period of the Office of the Public Guardian?

   There have been no cost overruns during the establishment period.

4. Given the increase in numbers of individuals under the Office of the Public Guardian, is it anticipated that the numbers will continue to grow over the coming years?

   As a result of the expansion of the eligibility criteria for guardianship to include people with impaired decision-making capacity, in addition to the Office of the Public Guardian undertaking community information activities, it is anticipated there will continue to be an increased

demand for the services offered and provided by the Office of the Public Guardian.

5. Given the numbers of individuals under the Public Guardian has increased, why has the budget reduced from $4 608 000 to $4 364 000?

   The funding reduction is a combined result of the 2.5 per cent wage inflator applied to employee costs and a CPI factor of zero per cent applied to operational costs in 2017-18 as well as a whole of agency review which realigned output budgets to program requirements. There has been no reduction to service delivery.

   It should be noted that output budgets at the beginning of each financial year are indicative until they are reviewed as part of the Department's annual budget development processes.

6. Given the increased demand for the services of the Public Guardian, why is the funding reducing?

   Refer to question 5

OUTPUT GROUP: HEALTH SERVICES

OUTPUT: TOP END AND CENTRAL AUSTRALIA HEALTH SERVICES

Top End and Central Australia Health Services

1. What is the reason for the Top End and Central Australia Health Boards being abolished from 30 June 2017?

   The Top End and Central Australia Health Services and Boards were established on 1 July 2014 as part of the national health reforms. Alongside their respective Chief Operating Officers, the Boards worked to develop the Health Services and establish the necessary systems and processes for quality, integrated care.

   Three years later, the Health Services have now matured as service providers, and it was considered appropriate to move to a more streamlined and cost-effective governance arrangement.

2. What were the issues with the current governance structures?

   There were no significant issues. Refer answer to question 1 above.

3. Is this an attempt to 'recentralise' the governance of Territorians healthcare?

   No. The Northern Territory Government is committed to ensuring that key decisions relating to the management and delivery of public health services continue to be made at the local level. The establishment of a

Health Advisory Committee for each Health Service will further enhance local input into health planning and service delivery.

4. Why couldn't the existing health boards remain in place whilst alternative arrangements were consulted on and instituted?

   This Government chose to develop and follow a transition plan.

5. Please advise when the two transitional Service Administrators will be appointed. Who will they be?

   The Service Administrators commenced on 1 July 2017. The Service Administrator for Central Australia Health Service is Dr Patricia Miller OA. The Service Administrator for Top End Health Service is Mr Paul Tyrrell OA.

6. What powers will they have?

   The Service Administrators each have the functions and powers of the Health Service Board for the term of their appointment.

7. Who will they be required to consult with before making any decisions?

   The Service Administrators will consult with key stakeholders for the Health Service including the Service's community, each other Service, other providers, the Chief Operating Officer, the Chief Executive Officer and the Minister.

8. What recruitment process, if any, will be undertaken to attract quality applicants to these positions, how will they be chosen and what skill sets will they be required to possess?

   Under the NT *Health Services Act*, there is no 'recruitment' process for Service Administrators. The Service Administrators were selected based on their extensive leadership and executive experience which included management of large and complex organisations and significant contribution to social, health and/or economic policy and development.

9. What consultation did the Department undertake with stakeholders prior to making the decision to abolish the health boards?

   The decision by the Minister for Health to dissolve the Health Service Boards was made in accordance with the *Health Services Act*. The Act does not prescribe consultation prior to dissolving a Board.

10. Were the boards advised of the decision to terminate them prior to the announcement?

    Yes.

11. How was this information communicated?

    Both via telephone and letter.

12. What legislative changes will be required to bring in the new governance system?

    The NT *Health Services Act* provides for the appointment of a Service Administrator if the Board for a Service is dissolved. The appointment of Service Administrators is an interim arrangement until such time as a final governance model is agreed and implemented. The Department has commenced work to determine potential legislative changes.

13. What will be the difference between the Health Service Boards and the new Health Advisory Committees?

    The new Health Advisory Committees will be consultative bodies. The Committees will support the decision making processes of their respective Health Service through provision of information to, consultation with, and advocacy on behalf of the community served by the Health Service. The Health Service Boards principally functioned to ensure the efficient and effective management of the Health Service for which the Board was established, a role which will now be fulfilled by the Service Administrators.

14. Will they have the same powers?

    No.

15. Who will be appointed?

    Membership of the Health Advisory Committees will reflect a mix of backgrounds, skills and expertise which includes individuals with one or more of the following experiences or attributes: health care consumers, carers, individuals who identify as Aboriginal or Torres Strait Islander, clinicians or administrators in an Aboriginal Community Controlled Health Organisation (ACCHO), current or formerly practicing clinicians, remote based residents and other relevant stakeholders to the health system.

16. What recruitment process, if any, will be undertaken to attract these members, how will they be chosen and what skill sets will they be required to possess?

    The Call for Expressions of Interest for the Health Advisory Committees was announced on Wednesday 21 June 2017 and has been widely advertised, including in print media and across the Northern Territory show circuit. The closing date for Expressions of Interest is Monday 31 July 2017. Skill set is as above.

17. What will be the role of the Clinical Advisory Council? What powers will it have?

    The NT Clinical Senate will provide high-level expert advice, information and recommendations to support clinical decision-making for the NT health system. The Senate will focus on clinical governance strategy, and clinical quality and safety.

18. Who will be appointed to this Council?

    The Senate will be a multidisciplinary body including clinicians and consumers with appropriate skills and experience in clinical quality and patient safety systems and processes across the NT health system.

19. How will they be chosen? What recruitment process, if any, will be undertaken to attract these new members?

    An Expression of Interest process is proposed to be used.

20. What skill sets will they be required to possess?

    Clinical appointees will currently practicing clinicians.

21. What will be the cost of establishing this new governance system to replace the existing system?

    A final total of costs is not yet available.

22. Where will the $1 million in savings from the abolition of the Health Boards, come from? Where will this money go?

    The $1 million is included in the budgets of the two Health Services. The balance of the funding will be redirected to front-line service delivery.

OUTPUT GROUP: CORPORATE AND GOVERNANCE

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1. Given Corporate Governance KPI's are not listed in this year's budget, what is the percentage of corporate risks ranked as 'extreme' or has a risk mitigation plan been in place within 30 days of initial risk assessment?

   The Department of Health has 0% corporate risks ranked as 'extreme residual risk' due to existing mitigating controls in place.

2. How many staff have been given health literacy and cultural security training?

   NT Health has undertaken a series of pilot workshops on *Effective Communication: improving health literacy and cultural safety in health*

care in Darwin, Alice Springs, Katherine and Nhulunbuy from February 2016 to July 2017.

3. The cost of Corporate and Governance will rise by $873 000, what is this increased funding being spent on?

   Funding increase is a result of a whole of agency review which realigned output budgets to program requirements. There has been no increase to service delivery.

   It should be noted that output budgets at the beginning of each financial year are indicative until they are reviewed as part of the Department's annual budget development processes.

4. How many Full Time Equivalents are currently employed within this Agency, broken down by Output and Business Unit?
   Data presented below are as at Pay 19 (2017)

Output	**Business Unit**	**FTE**
Territory Wide Services	Territory Wide Services, Office of Aboriginal Health Policy and Engagement	49.13
Disease Prevention and Health Protection	Environmental Health and Centre for Disease Control	148.79
Community Treatment and Extended Care	AODD, OOD, MHD	264.16
NCCTRC	NCCTRC	40.7
Office of the Public Guardian	Office of the Public Guardian	27.23
Health Services	TEHS	4058.22
	CAHS	1768.58
Corporate and Governance	Office of the Chief Executive/Executive Services and branches, Office of the Deputy CE	47.10
Shared Services	Corporate Service Bureau	312.17

5. How many Full Time Equivalents have resigned, retired, taken a redundancy package or have been made redundant, or terminated? Please break down these numbers by Output and Business Unit.

   Data presented below are as at Pay 19 (2017). Please note there have been no redundancies during the last financial year 2016/2017.

Output	**Business Unit**	**Resign**	**Retire-Other**	**Dismissal**	**Total Paid FTE**
Territory Wide Services	Territory Wide Services, Office of Aboriginal Health	2.26	0	0	2.26

	Policy and Engagement				
Disease Prevention and Health Protection	Environmental Health and Centre for Disease Control	13.40	0	0	13.40
Community Treatment and Extended Care	AODD, OOD, MHD	28.29	0	0	28.29
NCCTRC	NCCTRC	1.23	0	0	1.23
Office of the Public Guardian	Office of the Public Guardian	2.43	0	0	2.43
Health Services	TEHS	369.53	7.72	7.14	384.39
	CAHS	191.91	2.65	2.14	196.70
Corporate and Governance	Office of the Chief Executive/Executive Services and branches, Office of the Deputy CE	18.71	0	0	18.71
Shared Services	Corporate Service Bureau	18.32	0.90	0.28	19.50
				Total FTE	666.91

6. What has happened to these positions? Has the work been reallocated to existing staff?

   Of the 938 (headcount) separated employees, 333 were occupying temporary roles to cover specific projects (supernumerary) and 605 were occupying actual established positions on their last day. Of the 605 positions, 423 (or 70%) are occupied as at 17/07/2017.

   Where the remaining vacancies are in the process of recruitment the functions have been reallocated within current FTE. Those currently not being recruited to are being considered as part of ongoing workforce planning activities, aligned to strategic and operational priorities, and more efficient processes.

7. Are there any plans to fill these positions in the near future?

   The remaining vacancies are either in the process of recruitment or are being considered as part of ongoing workforce planning activities, aligned to corporate strategic planning (currently underway), and more efficient processes.

OUTPUT: SHARED SERVICES PROVIDED

What was the level of satisfaction of the Health Services with the corporate support services provided by the Department?

75 percent satisfaction.

OUTPUT GROUP: TOP END HOSPITALS

OUTPUT: TOP END HOSPITALS

1. An additional $32.5 million was allocated to this Output at Mid-Year Review. Please explain what this was for and what outcomes can be expected.

   Variations are attributed to Commonwealth funding agreements for existing services being renewed; transfer of funding between agencies and additional funding as per budget announcements.
2. Why is the average length of stay in the 2017/18 Budget reduced from 5.4 days in PEFO to 5.1 days?

   The 2017-18 Budget for the Key Performance Indicators are all improvement targets. Top End Health Service (TEHS) has numerous initiatives in place to improve patient flow and reduce the time patients spend in hospital, which in turn will continue to improve access for other patients.

3. Why has the percentage of patients who present at emergency departments that depart within 4 hours increased from 66% to 78%?

   The 2017-18 Budget for the Key Performance Indicators are all improvement targets, either set locally by TEHS or by the Department of Health. Last financial year, 66% was the estimated performance for Emergency Department access across TEHS. TEHS is striving to improve performance against this target and have agreed with the Department, the target of 78%.

4. What is the number of interstate Doctors and Specialists (locums) contracted by the Top End Health Services?

   We cannot differentiate between local and interstate doctors/specialists. In July 2017, we had approximately 78 locums and 43 VMOs.

5. What is the cost of the wages for these contracted Doctors and Specialists to the Top End Health Services?

   Not all contracted locums and VMOs are from interstate and we cannot differentiate between local and interstate doctors/specialists. In July 2017, we had approximately 78 locums and 43 VMO.

Facility	000's July 1 to March 31 Locum	VMO
East Arnhem Hospital	618	12
Katherine Hospital	1 658	
Royal Darwin Hospital	1 549	3 797
NT Pathology Network		6
	3 825	**3 814**

6. What is the cost of accommodation for these contracted Doctors and Specialists to the Top End Health Services?

   Not able to be accurately separated from the figures provided in Question 5.

7. What Medical Specialties are under-resourced in terms of qualified practitioners in the Top End Health Services?

   Recruitment remains an ongoing process to ensure that qualified specialists are available to service the needs of Territorians.

8. What is the cost of recruitment for Doctors and Specialist Physicians to the Top End Health Services?

   It is difficult to determine the total cost of recruitment due to there being a mix of outsourced recruitment activities with internal recruitment activities. The cost of internal recruitment activities is unable to be differentiated from normal duties.

9. How many Nurses and Personal Care Assistants are contracted from outside service providers to make up for the shortfall in staffing in the Top End Health Services?

   Staff are majority Northern Territory Government employees. Agency staff are used to fill short-falls as required

10. What is the daily rate of Nurses and Personal Care Assistants who are contracted to this service?

    Rates differ depending on the skill mix of the role required.

11. What is the cost of these Nurses and Personal Care Assistants to the Top End Health Services?

    This cost fluctuates from year to year.

12. What is the average length of stay for these Nurses and Personal Care Assistants with the Top End Health Services?

    It is difficult to provide a useful answer as the variance is very broad.

13. How does the Top End Health Services ensure continuity and quality of care if outside contracted medical and nursing staff are used on a regular basis at a medical facility?

    Agency nurses work as part of a team, defined by the models of care. When allocating agency nurses, TEHS considers skills and experience of each nurse and matches this to the appropriate clinical area. This ensures that patients receive the right care at the right time by the right person.

Palmerston Regional Hospital

1. What funding has been allocated for the commissioning of the Palmerston Regional Hospital?

   $3 million in 2016-17.

2. How many FTE's have been allocated to the coordination of activities associated with the commissioning of the Palmerston Regional Hospital?

   The exact number is unable to be determined as many of the staff working on the project have shared responsibilities with other program areas and the FTE component is not separated.

3. What is the anticipated date of the commissioning of the Palmerston Regional Hospital?

   Building handover from the Builder to the Department of Health is expected to be mid-March 2018. Operational Commissioning of the Hospital will commence from March 2018 and it will take approximately three months to get the Hospital ready for patients. Hospital opening is expected to be mid-year 2018

4. What funding has been allocated for the fit-out of furniture, equipment and miscellaneous items for the Palmerston Regional Hospital?

   Approximately $30 million in total.

5. What funding has been allocated for the annual operating costs of the Palmerston Regional Hospital?

   The funding allocation will vary as services come on line.

6. What services will be located at the Palmerston Regional Hospital?

   Services to be located at the Palmerston Regional Hospital include clinical and non-clinical services as follows:
   - Emergency Department including mental health and paediatric emergency care
   - Day surgery for planned cases

- Ambulatory care including allied health and some outpatient clinics
- Rehabilitation/inpatient and outpatient service
- Geriatric Evaluation and Management services for Older people
- Extended Emergency Management Unit (admissions greater than 4 hours, but less than 24 hours) managed as part of the Emergency Department service
- Maternity services
- General Medical ward services
- Transit Centre for patients

Support services will include:

- Pharmacy
- Pathology
- Medical Imaging
- Medical Records
- Learning and Development along with Clinical Administration Wing
- Commercial kitchen facility
- Central Sterile Service Department
- Morgue
- Engineering/Maintenance Workshop
- Generator backup
- Back of house facilities

7. Will any services be relocated from the Royal Darwin Hospital to the Palmerston Regional Hospital?

   Yes.

8. When will the rehabilitation pool be constructed at the Palmerston Regional Hospital?

   Construction is aimed to commence from July 2018.

9. What funding has been allocated to the construction of the rehabilitation pool at the Palmerston Regional Hospital?

   $2.5m capital has been allocated in 2018-19.

OUTPUT GROUP: COMMUNITY TREATMENT AND EXTENDED CARE

OUTPUT: MENTAL HEALTH

1. Why has the number of individuals indicated to receive community-based public mental health services been reduced by 200, from last year?

   In February 2016, Top End Health Service (TEHS) Mental Health re-launched the Crisis Assessment and Triage Team (NT CATT) and the Mental Health Access Team (NT MHAT). New functions included a

short term intervention function, essentially filling the gap between crisis care and long term case management. The team has successfully prevented a proportion of crisis referral entering the long term case management function. This has contributed to preventing numerous re-presentation episodes.

2. Why has the number of individuals under the age of 18 who receive community-based public mental health services been reduced by 300, from last year's figures?

   Secondary public mental health child and adolescent services continue to liaise with Headspace Top End around role and function. Joint working models are likely to have reduced episodes of representation. The estimated increase in 2017-18 is based on prior year's general annual growth of the service.

3. Why is the target for post-discharge community health care for mental health consumers been reduced to 70% for 2017/18 when the figures from 2016/17 show the demand to be 87%?

   TEHS Mental Health has invested considerable effort into improving rates of post hospital discharge follow up within seven days by community based mental health services.

   In 2016 TEHS Mental Health established a dedicated position to follow-up patients within seven days post discharge. An experienced mental health practitioner works closely with the mental health inpatient unit discharge coordinator to ensure as many patients as possible are followed-up, after hospital.

4. Are these KPI's realistic given the actual demand occurring on mental health services?

   Yes.

OUTPUT: AGED CARE

1. Please explain how the additional $2 205 000 will be spent on aged care.

   Variations are attributed to Commonwealth funding agreements for existing services being renewed.

2. Has the Government any further plans for additional aged care facilities across the Northern Territory?

   Aged Care facilities the responsibility of the Commonwealth Government. The allocation of residential places across Australia is decided federally.

OUTPUT: ALCOHOL AND OTHER DRUGS

1. Please explain the reduction of $3 621 000 at Mid-Year Review.

   Variations are attributed to Commonwealth funding agreements for existing services being renewed; transfer of funding between agencies and additional funding as per budget announcements.

OUTPUT GROUP: PRIMARY HEALTH CARE

OUTPUT: REMOTE PRIMARY HEALTH CARE

1. An additional $6 million was allocated to this Output at Mid-Year Review. Please explain what this was for and what outcomes can be expected.

   Variations are attributed to Commonwealth funding agreements for existing services being renewed or re-aligned.

2. How many visiting specialists has the Government engaged to deliver services in rural and remote communities?

   TEHS does not engage separate specialists to deliver services in rural and remote communities. Specialists providing outreach services in rural and urban communities are engaged through the hospitals. Outreach services are managed and coordinated through the Specialist Outreach NT service.

3. What is the cost of these specialists and are there any specialties which the Government is experiencing difficulty in recruiting?

   Costs for specialists are not separated for urban, rural and remote services. Please see question 7 under Top End Hospital output for difficulty in recruiting specialties.

4. How many primary health care clinics across the Territory have been transferred to the control of Aboriginal Health organisations since 1 September 2016? Which ones have been transferred?

   No primary health care clinics have been transferred since September 2016.

   The NT Government has committed to transitioning four clinics to Community Control over four years. Top End Health Service is actively engaging with Red Lily health Board (West Arnhem region) and Malabam Health Board (Maningrida) about transfer of services.

OUTPUT: URBAN PRIMARY HEALTH CARE

1. How many Aboriginal Health Practitioners are employed by the Top End and Central Australia Health Services? Please provide a list.

A total of 51 Aboriginal Health Practitioners are employed with Top End Health Services. A total of 33 Aboriginal Health Practitioners are employed with Central Australia Health Services.

2. What specific training is provided at clinic level and outside Batchelor College?

   Aboriginal Health Coordinators provide individual support and on the job training at the Health Centre level to all Aboriginal Health Practitioners. Nurse Educators also provide support and training in the remote setting.

   Trainee Aboriginal Health Practitioners are supported through their clinical skill development and also attend Bachelor College.

OUTPUT: TOP-END WIDE COMMUNITY SERVICES

1. An additional $4 million was allocated to this Output at Mid-Year Review. Please explain what this was for and what outcomes can be expected.

   Variations are attributed to Commonwealth funding agreements for existing services being renewed; and transfer of funding between agencies.

2. How many remote health clinics are without a full complement of medical and nursing staff?

   Remote health clinics are currently at full complement of medical and nursing staff. This is achieved through the use of locums and agency nurses.

3. Which clinics are they and what is being done to address these shortfalls?

   As above.

OUTPUT GROUP: TOP-END WIDE SUPPORT SERVICES

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1. The allocation to this Output was reduced by $3 million at Mid-Year Review. Please explain why this happened and how it will impact on support services in the Top End.

   Variations are attributed transfer of funding between agencies.

2. Since the opening of the Super Clinic at Palmerston, how much has it cost to fly in doctors to provide after-hour's services to patients?

   There have been no fly-in doctors providing after hours services.

OUTPUT GROUP: CENTRAL AUSTRALIA HOSPITALS

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1. The allocation to this Output was reduced by $3 870 000 at Mid-Year Review. Please explain why this happened and how it will impact on this output.

   Variations are attributed to transfer of funding between agencies and additional funding as per budget announcements.

2. Why is the average length of stay in the 2017-18 Budget reduced from 5.4 days in PEFO to 5.1 days?

   The decrease in the average length of stay is due to improved efficiencies in inpatient service delivery including the commencement of an additional medical team to meet increased demand and through improved bed management processes to improve patient flow.

3. Why has the percentage of patients who present at emergency departments that depart within 4 hours increased from 66% to 78%?

   CAHS budget for this KPI remains at 78% as per the National benchmark targets from 2016-17 to 2017-18.

4. What is the number of interstate Doctors and Specialists (locums) contracted by the Central Australia Health Services?

   For the 2016-17 financial year CAHS had utilised the equivalent of 15 locum FTE.

5. What is the cost of the wages for these contracted Doctors and Specialists to the Central Australia Health Services?

   CAHS had spent $8.88 million on locum wages for the 2016-17 year.

6. What is the cost of accommodation for these contracted Doctors and Specialists to the Central Australia Health Services?

   Wherever possible CAHS utilises existing accommodation such as on site accommodation or existing housing stocks. Therefore the cost of additional accommodation for contracted doctors is only $46,804 for the 2016-17 financial year.

7. What Medical Specialties are under-resourced in terms of qualified practitioners in the Central Australia Health Services?

   Recruitment remains an ongoing process to ensure that qualified specialists are available to service the needs of Territorians.
   .
8. What is the cost of recruitment for Doctors and Specialist Physicians to the Central Australia Health Services?

It is difficult to determine the total cost of recruitment due to there being a mix of outsourced recruitment activities with internal recruitment activities. The cost of internal recruitment activities is unable to be differentiated from normal duties.

9. How many Nurses and Personal Care Assistants are contracted from outside service providers to make up for the shortfall in staffing in the Central Australia Health Services?

   Staff are majority Northern Territory Government employees. Agency staff are used to fill short-falls as required

10. What is the daily rate of Nurses and Personal Care Assistants who are contracted to this service?

    Rates differ depending on the skill mix of the role required.

11. What is the cost of these Nurses and Personal Care Assistants to the Central Australia Health Services?

    This cost fluctuates from year to year.

12. What is the average length of stay for these Nurses and Personal Care Assistants with the Central Australia Health Services?

    It is difficult to provide a useful answer as the variation is very broad.

13. How does the Central Australia Health Services ensure continuity and quality of care if outside contracted medical and nursing staff are used on a regular basis at a medical facility?

    Agency nurses work as part of a team, defined by the models of care. When allocating agency nurses, TEHS considers skills and experience of each nurse and matches this to the appropriate clinical area. This ensures that patients receive the right care at the right time by the right person.

OUTPUT GROUP: COMMUNITY TREATMENT AND EXTENDED CARE

OUTPUT: AGED CARE

1. There has been an increase of $714 000 in funding between the 2016/17 and 2017/18 Budgets. What will this money be spent on and where?

   The increase is a result of Australian Government Agreements for existing services expiring 30 June 2017. These agreements have since been renewed and services have continued unchanged.

OUTPUT: ALCOHOL AND OTHER DRUGS

1. Why has there been a reduction of $2 980 000 in funding when comparing the 2016/17 and 2017/18 Budgets in this vital area? Where will this money now be spent?

   The variation is due to the ceasing of Alcohol Mandatory Treatment and the transition to the Labor Government's Alcohol reforms.

2. The allocation to this Output was reduced by $3 million at Mid-Year Review. Please explain why this happened and how it will impact on this Output.

   The variation is due to the ceasing of Alcohol Mandatory Treatment and the transition to the Labor Government's Alcohol reforms.

OUTPUT GROUP: PRIMARY HEALTH CARE

OUTPUT: REMOTE PRIMARY HEALTH CARE

1. There has been an increase of $12 230 000 in funding between the 2016/17 and 2017/18 Budgets. What are the reasons for this increase and what will this increased funding be spent on

   Variations are attributed to Commonwealth funding agreements for existing services being renewed; and additional repairs and maintenance funding allocated through the Northern Territory Government's economic stimulus program.

OUTPUT - CHILDREN – OTHER

1. When will the Child and Adolescent Health Plan be developed?
   a. Who will be involved in developing the plan?
   b. Will expert panellists be recruited?
   c. How will outcomes of the plan be measured?

   The Child and Adolescent Health Plan will be developed across the balance of 2017.

   Developing the Child and Adolescent Health Plan is a cross government and non-government integration project aimed at all services that support the health and wellbeing of children and adolescents. Included among the agencies and non-Government organisations to be involved in this work are representatives from the Department of the Chief Minister, Department of Education, Department of Housing, Territory Families, Department of the Attorney General and Justice, NT Council of Social Services, Aboriginal Medical Services Association NT, Aboriginal Peak Organisations NT, Top End Health Service, Central Australia Health Service, Department of Transport and the Department of Sport and Recreation.

Public consultations will be held to ensure that the voices of young Territorians, and particularly vulnerable young Territorians, are heard in the plan's development.

OUTPUT: LICENSING NT

1. How much money has been budgeted for the Government's Alcohol Policies and Legislation Review?

   A specific sum has not been budgeted for the Alcohol Policies and Legislation Review. All expenditure decisions relating to the Review are subject to appropriate governance oversight.