

**REPORT**  
**OF THE**  
**REVIEW OF THE NORTHERN**  
**TERRITORY DEPARTMENT OF HEALTH**  
**AND COMMUNITY SERVICES**

**Banscott Health Consulting Pty Ltd**



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## Letter of Transmittal

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The Honourable Jane Aagaard MLA  
Minister for Health and Community Services  
Parliament House  
Darwin NT 0800

Dear Minister

It is with pleasure that I forward to you the Report of the Review of the Northern Territory Department of Health and Community Services.

The Review was conducted pursuant to Terms of Reference issued by you on 18 June 2002.

On behalf of the Review Team, I thank you and the Government of the Northern Territory for giving us this opportunity to be of service to you and to all Territorians.

Yours sincerely



Alan Bansemer

**Review Team Leader**

27 January 2003



## Preface

001. The Review has been an exercise in listening and hearing. The Review Team has taken pains to offer to all stakeholders, both internal and external, an opportunity to bring forward views on the Department of Health and Community Services (DHCS) and its services, its style of operation, its responsiveness, its priorities, its structure, its relationships, and its role. The Review has heard praise and criticism, suggestions, critiques, and pleas for change. These have come from all parts of the Department, from all parts of the Northern Territory (NT) and interstate, from individuals and from groups, from a wide cross-section of Territorians.

002. During its consultative phase, the Review received 132 written submissions, and met for discussion with 484 people who presented oral submissions. Wherever appropriate, the Review has, in this Report, reflected the views expressed to it, often incorporating the body of some of the more noted submissions into the Report. It places on record its gratitude to the many hundreds of Territorians who made the time and effort to contribute to this significant study of an important NT Government enterprise. The positive way in which they made their contributions gave us great heart to think that the changes that are necessary will be approached with the same positive attitude.

003. The Review Team consisted of Alan Bansemer (Project Leader), Michael Clarke and Bernie McKay, with significant contributions on aspects of the Review from Gordon Best, the Hon Michael Field, Professor John Horvath, Ron Parker, Associate Professor Michael Reid, and Professor Bryant Stokes.

004. The Review expresses special appreciation to the departmental staff made available to assist the Review, Jan Evans and Rosy Warden, who were of great assistance to the Review Team throughout the process. Without their dedicated professionalism, the task of the Review would have been much more difficult.

005. Other people also assisted the Review in a very material way. The Review wishes to thank Minister Aagaard and her staff for their valuable advice and assistance, the Acting Chief Executive Officer Graham Symons and the departmental Executive Committee for their cooperation and input, and the many staff of the Department who were at all times willing to help.

006. Many other Reviews of DHCS have fallen down at the implementation stage. The Review Team hopes that this time there will be the willingness to see the task through to its completion.

007. It is the nature of reports such as this to reflect the need for change, for alteration, for reform. The fact that the Report may, to the reader, seem to concentrate on the negatives should not be allowed to detract from an important fact: DHCS does have very many talented, dedicated

and committed staff, and has delivered many programs and services of which the people of the NT can be justifiably proud. We acknowledge this at the outset, and hope that our work in this Review will help to ensure the continuation of the many elements of excellence in the Department, and correct those deficiencies which limit or detract from the delivery of high quality health and community services to Territorians.

008. As daunting as the Report may appear, the Review Team is firmly of the view that it can all be done, but that it requires good will, sound processes to focus the efforts of committed staff, discipline, and leadership.

Note: Throughout the Report, we have specifically identified the **principal and supporting** recommendations that flow from our consideration. There are, however, many other conclusions and recommendations made in the text of the Report itself. These should be taken into account during any process of implementation.

## Executive Summary

001. While the Review relied to a great extent on the written submissions received and on the many consultations undertaken with stakeholders (and can, to that extent, be said to be stakeholder driven), it was also a deliberate scan across the breadth of the entire Department and of the many programs and services managed by the organisation.

002. It was from both this broad survey of the Department and its programs, and from the stakeholder consultation, that the Review Team formed its conclusions and formulated its recommendations.

003. Reaching conclusions was facilitated by the application to each area of the Department and its operations of a series of principles (discussed more fully elsewhere in the Report), especially Care Closer to Home, Avoidance of Duplication, Priorities Determine Investment/Disinvestment, and Rigour in Administration.

004. Budget imperatives remain critical issues to be addressed by the Department.

005. It became clear during the course of the Review that there is a significant structural problem with the health and community services budget. This underlying problem will need to be corrected if the Government's health agenda and its priorities are to be addressed. One significant aspect of the budget issue affecting health and community services in the Territory relates to the public hospital system. Hospitals drive health system costs. Throughout Australia, these costs are growing at around 6% per annum, a rate of increase greater than the CPI and exceeding the rate of increase applying to other social programs.

006. In the Territory there are a number of factors that have exacerbated this trend. These include the costs associated with a larger Aboriginal population in very poor health, the fact that the Aboriginal population is increasing as a proportion of the NT population, and the distribution of a significant proportion of the NT population across remote areas.

007. In the community services area, changed community expectations mean that people with severe disabilities who would once have received limited care in an institution or in prison now receive care in a community setting at a cost of hundreds of thousands of dollars per year.

008. Funding pressure has also been driven significantly by a breakdown in management systems and control. The Department failed to implement strategies to achieve medium to long-term efficiencies and has demonstrated inadequate management in key areas, lack of transparency in resource allocation, poor budget control, and service "creep".

009. This situation will require both significantly improved management within the Department and Government to review and possibly reconsider a number of commitments it has

either made or inherited from the previous Government to ensure very basic priority areas are addressed within the health and community services system.

010. The principal recommendations of the Review (discussed in more detail throughout the Report) are as follows.

### **Chronic Disease Management**

011. Services should be further developed to address current shortfalls in managing adult chronic diseases and to cope with increasing demand for services.

### **Renal Services**

012. Renal services should be planned and implemented in such a way as to minimise social dislocation, including:

- prevention and chronic renal impairment programs adequately resourced to prevent dialysis (where possible) and to prevent the progression of disease beyond a requirement for dialysis (where inevitable);
- adequate resourcing and partnerships between all service sectors to share the burden of patient care;
- integration of the management of diabetes and its complications into management plans;
- provision of quality tertiary patient care to enable patients to return home safely and to be able to be supported in their home environment; and
- delivery of quality dialysis care as close to home as possible, **always following rigorous assessments of safety and sustainability**, with the necessary investment in hardware, people and their education, and partnerships with communities and all health facilities.

013. The Department should establish an integrated, effective, transparent clinical stream, headed by a Director, that encompasses the spectrum from primary health care to tertiary treatment for Renal Services across the Territory, including:

- an appropriate organisational structure for the delivery of renal services across the Territory;
- a framework which provides for decision-making, prioritisation, resource allocation and appropriate sustainable delivery of quality services;
- an integrated Territory-wide service which is accountable and responsible for the delivery of services;

- an approach to issues relating to recruitment, retention and human resource management and development; and
- strategies to address facets of care that relate to awareness of patient rights, treatment options, communication and education and that underpin all health service delivery.

### **Aeromedical Retrieval**

014. The Review believes that the Department should set up a single point of aeromedical evacuation service coordination.

015. The Department should appoint a single, Territory-wide coordinator for aeromedical activities to manage access, control and effectiveness of all aeromedical retrieval in the NT. The coordinator should be responsible for determining the most appropriate transportation option in the Barkly region, taking into account all the facilities that are available. The coordinator should have access to all current aeromedical resources, including those from Katherine, Alice Springs, and Mt Isa, as well as from Tennant Creek.

016. Patients transported out of the Barkly Tableland should preferentially go to TCH, unless the Coordinator or referring medical practitioner deems otherwise.

### **Outreach Services**

017. The Department should develop clinical plans to increase the availability in regional centres of some specialist services, and should review the program of outreach visits by clinicians to remote and isolated communities with a view to

- increasing the frequency and destinations of such visits;
- maximising the effectiveness of the visits by developing better remote and isolated community infrastructure and by better planning in the communities for the visits;
- providing adequate backup in the acute care hospitals and elsewhere so as to avoid any increase in waiting lists as a result of outreach visits;
- better integrating the outreach program into clinical responsibilities; and
- phasing out reliance on discrete Commonwealth funding.

### **TeleHealth**

018. The Department should develop a business case for the implementation of TeleHealth in the NT.

019. The business case should examine the possibility of linking TeleHealth in the NT with the TeleHealth networks already established in other States (for example Western Australia and Queensland); the usefulness of TeleHealth for Territory-wide communication and staff training; existing infrastructure and its applicability for TeleHealth; and the possible clinical, social and financial benefits of TeleHealth for the NT.

### **Call Centre**

020. The Department should develop a business case for a Health and Community Services Call Centre.

021. The business case should examine the possibility of the NT Call Centre being implemented through expansion of an existing service (for example in Western Australia or in Queensland); the Call Centre having broad usage including for health and community services information, referral to clinicians and service providers, nurse-based triage for after hours medical referral, etc; access issues, including the availability of telecommunications infrastructure across the NT.

### **Hospital in the Home**

022. The Department should expand and increase the effectiveness of its HITH Program by earlier involvement in and better use of discharge planning, and by identification of ways whereby HITH services can be made more widely available to Territorians living outside urban areas.

023. The Department should also develop a more strategic approach to pre- and post-hospital admission management, encompassing the establishment of Aboriginal-specific step-down facilities, increased provision of overnight beds associated with day surgery, maximum use of home and community dialysis, and improved palliative care.

024. More effective use should be made of community nurses, especially in the HITH program, by utilising, where appropriate, other staff to undertake the non-nursing duties currently performed by community nurses.

### **Tenure of Chief Executive Officer**

025. The incoming CEO should be given a clear expectation of job security for the term of his/her contract of appointment and be given a clear mandate to manage the Department within a framework of the Government's policy and budget.

### **Executive**

026. The Department's Executive should be smaller, should have clearly-defined areas of responsibility and accountability, and should assist the CEO in the management of the



Department's service delivery, financial operations, budget processes, and overall management and performance.

027. The departmental Executive should consist of seven persons: the CEO; the Assistant Secretaries responsible for acute care, health services, community services, and corporate services; the Principal Medical Adviser; and the Executive Director of the Office of Aboriginal Health and Service Support.

028. One of the Assistant Secretaries should be appointed Deputy Secretary of the Department.

### **Strategic Management Group**

029. The Department should establish a Strategic Management Group to assist the CEO in driving and directing the policy development and business planning processes of the Department.

030. The Principal Psychiatrist should be responsible for the maintenance of and adherence to quality mental health standards throughout the NT.

031. The Principal Nursing Adviser should be responsible for the maintenance of and adherence to high quality nursing standards throughout the NT, and should have a particular responsibility to collaborate with the Principal Aboriginal Health Worker Adviser in ensuring that nurses and AHWs move towards a more robust and effective partnership in the provision of health care to Territorians.

032. The Principal Aboriginal Health Worker Adviser position should not be held in conjunction with any other position in the Department but should be responsible for the maintenance of and adherence to high quality AHW standards throughout the NT, and should come to play a significant role in maximising the effectiveness and contribution of AHWs across the Territory.

### **Principal Medical Adviser**

033. A senior, high-level position of Principal Medical Adviser should be created and should be a member of the departmental Executive.

034. The Principal Medical Adviser should be vested with the statutory powers and responsibilities of the CHO under NT legislation and subordinate legislation (except those relating to public health).

035. The Principal Medical Adviser should be responsible for the maintenance of and adherence to high quality clinical standards throughout the NT.

036. The Principal Medical Adviser position should incorporate the responsibilities of the current Principal Medical Consultant.

### **Reference Groups**

037. Two Reference Groups should be established to provide an opportunity for health and community services practitioners to have input to and participate in the Department's policy and planning processes: a Clinical Reference Group, for the health sector; and a Professional Reference Group, for the community services sector.

038. There should be a systematic development of clinical plans that reflect the actual health needs of Territorians, that accommodate the different roles of the Territory's clinical centres, that delineate roles within those centres, and that identify the appropriate relevant workforce required.

### **Executive Services**

039. The Department's Executive and its Strategic Management Group should be supported by a dedicated secretariat.

040. The Executive Services Branch should be responsible for monitoring compliance with Executive decisions and compliance with the Department's business planning, resource allocation, and budget processes.

041. The Executive Services Branch should provide the secretariat for the three Consumer Councils and the two Reference Groups.

042. The Executive Services Branch should be responsible for the Department's media relations and public affairs activities, and for its activities in relation to freedom of information, privacy and legal support.

### **Consolidation of Legal and Quasi-legal Functions**

043. The Freedom-of-Information Section should be co-located and integrated with the following parts of the Department: the Internal Complaints Resolutions Section; the Department's Legislation Officer; the CHO's Legislation Policy Adviser; and the Legal Support Section.

### **Ministerial, Cabinet and Parliamentary Liaison**

044. The Ministerial, Cabinet and Parliamentary Liaison Branch should be responsible for the provision to the Minister and to her Office of timely and accurate briefings on all matters relating to the Minister's exercise of her ministerial responsibilities, including submissions, proposals and recommendations from the Department; Question Time, Estimates Committee, and other Legislative Assembly briefings; and current and controversial issues briefings.

## **Internal Communications**

045. An internal communication process should be put in place to enable the CEO to ensure that all staff in the Department are kept directly, regularly and fully informed about decisions of the Department's Executive, the development of policy, and significant events.

## **Departmental Committees**

046. The rigorous examination of departmental committees and working groups previously recommended should be undertaken.

## **Previous Reviews**

047. The Department should re-examine its response to the recommendations arising from both the CRESAP and the Parker Reviews in the context of the organisational and service delivery recommendations of the current Review, and ensure that each of the recommendations made by the previous Reviews have been properly considered and, if still appropriate, implemented.

048. The Departmental Executive should approve any future review proposed to be conducted by consultants or personnel external to the Department prior to their being undertaken.

## **Advisory Councils**

049. There should be increased community involvement in the Department.

050. Three Councils should be established to provide an opportunity for input into the Department's policy development and service delivery processes: a Health Advisory Council; a Family and Children's Services Advisory Council; and a Disability Services Advisory Council.

051. Other advisory or consultative bodies should be created to bring together relevant departmental officers and members of the community with relevant expertise.

## **Peak Bodies**

052. The Review proposes that Government consider whether NTCOSS should be funded through the Chief Minister's Department as the umbrella Peak, with responsibility to provide co-located and accessible office accommodation and services, together with administration and financial management, for the sectoral peaks in the NGO sector. These smaller sectoral peaks would operate as partner peaks with NTCOSS. They would receive funding (other than for administration and management) from their respective Government agencies.

### **Ease of Access**

053. The Department should be structured so that people can easily identify access points for service providers, consumers, and members of the public.

### **Non-Government Organisations**

054. Relative need for and levels of funding provided to, non-Government organisations should be reviewed over the next three years to ensure that those levels of funding across the sector accord with Government priorities and contemporary need.

### **Carers and Foster Carers**

055. The Department should consult more closely with carers in determining the most appropriate services for children with disabilities.

056. The Department should consider outsourcing placement support in Darwin to one or more appropriate NGOs.

057. The Department should re-examine the whole question of foster care for children with disabilities.

### **Complaint Resolution**

058. The Department should better publicise and resource a centrally located and properly resourced mechanism to enable it, in the first instance, to deal internally with the resolution of complaints from members of the public.

### **External Communication**

059. The Department should, each year, produce a single consolidated Annual Report.

### **Transparent Processes**

060. The Department should develop and publish a set of Business Rules setting out how it intends to conduct its internal and external processes..

### **Menzies School of Health Research**

061. Collaboration between the Department and MSHR should receive early attention and consideration by the Department and by the Government of the NT.

### **Co-operative Research Centre in Aboriginal and Tropical Health**

062. Collaboration between the Department and the CRCs should receive early attention and consideration by the Department and by the Government of the NT.

### **Focus on Program Outcomes**

063. The Department should be integrated in a more effective way and should be organised with a focus on program outcomes so that its functions and responsibilities are clearly transparent to external observers.

064. The Department's policies should regularly be updated, should be published on the Internet, and should be available in hard copy.

### **Evidence-Based Policy**

065. The Department should sharpen its policy focus in both the health and community services areas, ensuring that the policy process is evidence-based and consultative.

### **Support to Service Providers – Funder/Purchaser/Provider Arrangements**

066. The Funder/Purchaser/Provider model should be abandoned and the funder and purchaser streams should be amalgamated, with increased emphasis being given within the amalgamated stream to the vital role of policy formulation and development.

067. Staffing levels in the funder / purchasing areas should be reduced, with an equivalent increase in staffing for the provider areas.

068. Funders/purchasers and providers should all be party to the consultations leading up to the determination of the annual budget. Once program budgets have been settled, they should be available to funders and purchasers and providers.

### **Service Agreements and Service Plans**

069. The current approach to the development of Service Agreements and Service Plans between the Department and internal and external service providers should be retained, with the process being further developed to ensure that each of the Agreements: clearly specifies the services to be purchased and the agreed cost of those services; contains no more than three or four performance indicators by which service delivery outcomes can be measured; has wherever possible a term of three years; results from bona fide negotiations between the parties; is, once signed, a publicly available document; and mandates capacity building, business planning and outcome reporting for each service provider.

### **Approval Process for New Services**

070. A process should be developed by the Department to facilitate the assessment of proposals for new services, both clinical and other. The process should assess and prioritise service development proposals by way of a written submission to Government detailing their service delivery proposal.

## **New Clinical Services – A Cautionary Note**

071. An external specialist should be commissioned to provide advice and options for the provision of radiation oncology services in the NT over the next ten years. In the meantime, there are sufficient concerns about the sustainability and clinical safety of a new radiation oncology service for the NT to warrant its deferral.

## **Adult and Public Guardianship**

072. The funding, functions, statutory officers, and staff relating to guardianship matters should be transferred from DHCS to the Department of Justice.

## **Departmental Structure**

073. The Department should adopt the organisational structure set out in Appendix 1.

## **Health Services**

074. A Health Services Group should be established, to consist of three Divisions, each headed by an Executive Director: a Public and Community Health Division; a Mental Health and Drugs of Dependence Division; and a Health Policy and Service Development Division.

## **Public and Community Health**

075. A Public and Community Health Division should be established.

076. The management and direction of the Public and Community Health Division should be undertaken by an Executive Director, who should be vested with the relating to public health-related statutory powers and responsibilities of the CHO under NT legislation and subordinate legislation.

## **Centre for Disease Control**

077. The Centre for Disease Control should become a Territory-wide integrated service.

078. That urgent consideration be given to expanding prevention responses to the heterosexual transmission of HIV/AIDS.

## **Environmental Health**

079. There should be a review of the role of local Government with respect to environmental health with a view to the negotiated transfer over time of responsibility for environmental health to local authorities.

## **Oral Health Services**

080. The Department should ensure that a report relating to the recommendations of the Loan Review of Oral Health Services in the NT reaches the Minister prior to the commencement of preparation of the 2003/2004 Budget. Improving Oral Health Services at least to a parity level with other Australian jurisdictions is a priority, especially given the oral health needs in the NT population.

## **Mental Health and Alcohol and Drug Services**

081. A Mental Health and Alcohol and Drug Services Division should be established and should be charged with responsibility for ensuring the provision of a full range of mental health services across the NT.

082. Bringing mental health services in the NT to a parity level with other Australian jurisdictions, with guidance from the current Report of the specialist examination into NT mental health services, is also a priority given the poor level of service coverage.

083. There should be a Principal Psychiatrist for the NT, a position that could be jointly funded by the Department and an appropriate academic institution. The Principal Psychiatrist should be responsible for the maintenance of and adherence to quality mental health standards throughout the NT.

084. The Alcohol and Other Drugs Program should be located and managed within the new Mental Health and Alcohol and Drug Services Division in a way that clearly and explicitly ensures the clear restoration and continuation of a specific focus on alcohol and other drugs, on related NT Government priorities, and on the range of alcohol and drugs services including substantial public health policy and other health promotion and prevention work.

## **Health Policy and Service Development**

085. Within the Health Services Group, there should be a Health Policy and Service Development Division that should bring together the current funder and purchaser functions of the Department as they apply to the health sector.

086. The Division should contain three Branches, each headed by a General Manager: a Health Policy Development Branch; a Health Service Purchasing and Modelling Branch; and a Health Gains Branch.

087. The Division should work closely with and provide the full range of its services to, the Acute Care Group.

088. One of the core functions of Health Policy and Service Development Division should be to support and facilitate the development of a robust health sector through capacity building activities.

089. Another of the core functions of the Health Policy and Service Development Division should be to determine and act on the program and service priorities for investment and disinvestment.

### **Health/Community Services Gains**

090. The Department should establish a Health Gains Branch and a Community Services Gains Branch.

091. The core functions of these Gains Branches should be to manage the process that determines the key priority investment areas for the Department.

### **Acute Care Operations Group**

092. The Department should establish an Acute Care Operations Group.

### **Community Services**

093. A Community Services Group, headed by an Assistant Secretary, should be established.

094. The Community Services Group should consist of two Divisions, each headed by an Executive Director: a Community Services Division; and a Community Services Policy and Services Development Division.

095. The Community Services Division should consist of the Disability Services Branch; the Family and Aged Care Branch; and the Youth and Children's Services Branch, together with the Child Protection Branch.

### **Child Protection**

096. Any departmental restructure should recognise the importance of the child protection role of the Department and the Department's clear statutory obligation to protect children at risk. Enhancement of the current level of child protection function is a priority, given current levels of risk in the area.

097. A senior departmental officer should be nominated to examine the Department's current performance in this area, to report on current strategies, and to identify improved approaches.



## **Disability Services**

098. The Territory's legislation and approach to disability service provision should be reviewed by the Disability Services Advisory Council.

099. The Department should negotiate at least to match Commonwealth growth offered in the current Commonwealth State/Territory Disability Agreement negotiations and when possible re-open negotiations with the Commonwealth to achieve a joint approach to further growth, in light of unmet need for disability services in the NT.

## **Community Services Policy and Services Development**

0100. The Community Services Policy and Services Development Division should consist of the Community Services Policy Development Branch; the Community Services Development and Modelling Branch; and the Community Services Gains Branch.

0101. One of the core functions of Community Services Policy and Service Development Division should be to support and facilitate the development of a robust health sector through capacity building activities.

## **Corporate Development and Accountability**

0102. There should be a Corporate Development and Accountability Group, headed by an Assistant Secretary.

0103. The Group should consist of two principal Divisions, each headed by an Executive Director: a Corporate Services Division, and an Information and Communication Services Division, together with two, small, regionally-based coordination offices.

## **Corporate Services**

0104. The Corporate Services Division should consist of four Branches: a Performance Evaluation and Audit Branch; a Budget, Finance and General Services Branch; a Human Resource Management and Development Branch; and a Health and Aged Care Facilities Licensing Unit.

## **Performance Evaluation and Audit**

0105. The Performance Evaluation and Audit Branch should be responsible for

- the provision of a Secretariat to the departmental Audit Committee;
- the identification and management of risk within the Department;
- regular periodic evaluation and review of the programs run by the Department;

- the establishment and support of a performance management regime applicable to departmental staff;
- the coordination of the internal and external audit requirements of the Department and the monitoring of the implementation of audit recommendations; and
- the establishment and maintenance of an evaluation and audit program covering the entire Department.

### **Quality**

0106. The Department should identify health leaders in quality and, as soon as possible, establish an NT Health Quality Council with a mandate to produce quality and safety change in the health system.

0107. The Chair of the Health Quality Council should be independent, and the Council should report to the Minister for Health and Community Services.

### **Budget Finance and General Services**

0108. There should be an effective Budget Finance and General Services Branch. This requires both immediate attention to the identified deficits in the Department's accounting systems and support of a fundamental cultural shift toward corporate and collective management responsibility for financial outcomes.

### **Human Resource Management and Development**

0109. A Human Resource Management and Development Branch should be established to rebuild the Department's capacity in human resource management, and to concentrate appropriately upon the development of staff, and upon human resource policy development, monitoring and reporting.

### **Health and Aged Care Facilities Licensing**

0110. The maintenance of appropriate standards of buildings and care in health and aged care facilities (including public and private hospitals, nursing homes and aged care hostels, child care centres, psychiatric hostels, community health centres, and other like facilities) should be supervised and maintained by the adoption in the NT of the conclusions and recommendations of the recent review of health and aged care licensing arrangements in Western Australia.

### **Information and Communication Services**

0111. An Information and Communication Services Division of the Corporate Development and Accountability Group should be established, consisting of two principal Branches: an IT

Infrastructure and Assistance Branch; and an Information Management and Library Services Branch.

0112. The Department should reassess and review its management of outsourced Information Technology in order to reduce costs and improve service.

0113. The Department should enter into discussion with other states (like New South Wales or Western Australia) with a view to introducing in the NT the delivery of internet-based health information resources by joining the multi-state contract with Health Communication Network.

0114. The Information Management Branch should ensure that the Department's information management systems are able to deliver timely, reliable and valid information to support effective decision-making.

### **Regional and District Administration**

0115. Regional and District administration and management structures should be abolished, and should be replaced by Regional coordination, by devolved management processes and professional supervision, by increased local service delivery and coordination, and by District-level mechanisms to promote communication and collaboration.

### **Health Professionals Licensing Authority**

0116. The Health Professionals Licensing Authority and Registration Boards should remain within the Health Portfolio, but should directly employ their own staff.

0117. Registration fees should be increased to bring them into line with the average registration fees charged in the other States/Territory, and should then be supplemented by the Government through a budget appropriation sufficient to cover agreed administrative costs.

### **Office of Aboriginal Health and Service Support**

0118. The Department should establish an Office of Aboriginal Health and Service Support.

### **Commonwealth Programs**

0119. The Department should pursue Commonwealth program and project funding only when such programs/projects have policy objectives that coincide with Territory priorities.

### **Business Planning, Resource Allocation, Performance Management and Budget**

0120. The Department should develop and adhere to an integrated business planning cycle coordinated by the Executive Services Branch.

0121. Departmental priorities should be agreed between the departmental Executive and the Minister, and should be grouped as objectives under four to six key result areas encompassing the full scope of the Department's operations. For each objective there should be identified a number of specific activities required to attain that objective, with two or three quantifiable, measurable and outcome-oriented performance indicators attaching to each objective.

0122. The preparation of the Department's Business Plan should involve a broad range of intradepartmental consultation, together with relevant external stakeholder consultation.

0123. The completed Business Plan should be submitted to the Minister for endorsement.

0124. Resources should, during budget negotiations, be allocated across departmental programs in accordance with the priorities set out in the Business Plan. Once the Department's budget is settled, the Business Plan should be revised if necessary to incorporate the final outcome of Cabinet's budget decisions.

0125. The Department's Executive should, as the year progresses, closely and regularly monitor, on a monthly basis, expenditure against budget for each cost centre, as well as progress in implementing the Business Plan. The Executive should take appropriate remedial action whenever it identifies a divergence from the budget or from the directions set in the Business Plan.

0126. At the end of each financial year, there should be an evaluation of outcomes, measured both against the budget and against the performance indicators set out in the Business Plan. The evaluation of outcomes should be reported on to the Minister and to the Government.

0127. The outcomes report should be a major input into the development of the revised Business Plan for the succeeding year, and should be the basis for the Department's Annual Report.

### **Finance Committee**

0128. The Department should establish a Finance Committee, chaired by the CEO and including among its members the Assistant Secretary responsible for Corporate Development and Accountability, and the General Manager responsible for budgets and finance.

### **Budget Finance and General Services**

0129. The Budget Finance and General Services Branch should be headed, as General Manager, by a newly created position of CFO, who should be a qualified accountant.

0130. The CFO should be accountable directly to, and given specific authority by, the CEO for the development and promulgation of, and adherence to, departmental accounting standards and for all departmental accounting processes relating thereto.

0131. The CFO should, as soon as possible after his/her appointment, commission work to put in place a properly designed accounting system for the Department.

### **Co-Location of the Department**

0132. The Department should in the short term give consideration to the possibility of co-locating as much of the Department as possible into single premises.

### **Delegations**

0133. Personnel and financial delegations should be revised to reflect the new structure, to accord with the new cost centre arrangements to maximise the personal responsibility and accountability of cost centre managers to manage their resources in accordance with the Department's Business Plan, and to reflect, to the greatest extent possible, the principle of subsidiarity.

### **Departmental Audit Committee**

0134. The role of the Departmental Audit Committee, chaired by the CEO, should be strengthened to ensure that a realistic, structured risk assessment process is instituted for the Department and that an internal audit program is developed, consistent with the risk assessment, and that regular program evaluations are conducted so that each departmental program is evaluated every three to five years.

### **Conflicts of Interest**

0135. All relevant employees, and especially senior staff in the Department, should strictly adhere to the requirement to lodge and annually to update a register of pecuniary interests.

0136. The register of pecuniary interests should be based upon the model used in the Commonwealth Public Service and adhere to the requirements of Section 12 of the Principles and Code of Conduct issued under the Public Sector Employment and Management Act.

### **Procurement Processes**

0137. The Department's procurement processes should be revised.

0138. Prior to any procurement action, the Department should explicitly define, by way of a request for information if appropriate, the precise service or article to be procured, and should assess realistically the likely cost implications.

0139. For all procurement activities with a cost likely to exceed \$50,000, a procurement panel should be appointed by the CEO to manage the process, and to make a recommendation to the accountable officer or his/her delegate, prior to its being referred to the Procurement Review

Board for endorsement or otherwise. The accountable officer or delegate should be the only person authorised to make, and accountable for, the final decision.

0140. Where procurement cost is likely to exceed \$250,000 or where the procurement activity is likely to be complex, a Treasury representative should always be invited to join the Procurement Panel immediately upon its establishment.

0141. The Department should explore the possibility of the NT participating in and taking advantage of the bulk procurement arrangements operated by New South Wales or another appropriate jurisdiction.

### **Workforce Planning**

0142. Effective and service outcome focussed workforce planning should be incorporated into departmental service planning.

0143. The current relationships with OCEP and employee associations concentrate on short-term human resource management/ industrial relations issues and need to be refocussed to take a more strategic approach.

### **Workforce Status**

0144. Rigorous workforce planning and resourcing is required at a work unit level as well as at an organisational level, with accountability of both human resourcing and relevant, cost based fiscal resourcing.

0145. The Department should initiate processes to articulate and differentiate the roles of nurses and AHWs, general practitioners and DMOs, and social workers, family support workers and community welfare workers.

0146. The Department should sponsor legislation to give formal recognition to the role of nurse practitioners in the NT.

### **Staff Turnover, Recruitment and Retention**

0147. The Department should ensure that a specific budget allocation is made each year to enable the implementation of the recommendations made by previous reports on recruitment and retention, leadership training, and graduate recruitment and replacement.

0148. Staff joining the Department (including clinical staff) should be provided with a thorough induction program so that they can be given an appropriately detailed understanding of the Department's organisational culture and routines, their role in the Department, and the Department's roles and responsibilities as part of the NT Government.

0149. The Department should embrace and facilitate the widest-possible use of permanent part time employment and job sharing.

### **Managing People**

0150. The NT Public Sector Employment and Management Act and the Department's human resource management policies and procedures should be given more effective implementation throughout the Department.

### **Performance Management**

0151. Professional responsibility and accountability of departmental staff should be reinforced by the adoption across the Department of performance management closely aligned to the business planning process.

### **Staff Development**

0152. Professional development should be an integral component of the department's workforce development strategies and not be susceptible to erosion by poor budgetary practices in cost centre or elsewhere in department.

### **Structural Arrangements**

0153. The Department should rebuild its capacity in human resource management and concentrate appropriately upon the development of its most important asset, namely its staff, and upon human resource policy development, monitoring and reporting.

### **Joint Working Group**

0154. The Department should initiate the formation of a joint working group between the Departments of Health and Community Services, of Employment Education and Training, and of Community Development, Sport and Cultural Affairs to forge a common approach to pre-workforce and workforce training and ongoing education; and better linkages between departmental workforce needs and the courses offered, in the first instance, by NTU, BIITE, and FUSA.

### **Medical Workforce**

0155. The Department should plan its medical workforce needs in accordance with its budget and identified service demands.

### **Nursing Workforce**

0156. Nurses should be offered appointment to a Territory-wide nursing service.

0157. The Department should examine mechanisms whereby its hospitals can take advantage of the capacity of public benevolent institutions to make salary sacrifice arrangements with their staff (especially for nurses).

0158. The Department should assess the potential for overseas-trained nurses and other overseas-trained health professionals to fill gaps in the departmental workforce, utilising such mechanisms as conditional registration.

### **Agency Nurses**

0159. The Department should use a tender process to enter into a single, NT-wide contract for the provision of agency nurses under a common set of terms and conditions.

0160. The Department should explore with its counterparts in Queensland and Western Australia the possibility of the three jurisdictions joining in a program to encourage and facilitate working visits to northern Australia by appropriately qualified overseas nurses.

### **Acute Care Group**

0161. In the Acute Care Group, a General Manager, reporting to the Assistant Secretary, should head each of the hospitals.

### **Hospitals Network**

0162. A Hospitals Network should be established to link the five Territory acute care hospitals thereby facilitating the interchange and transfer of resources and specialist skills to meet changing demands.

### **Acute Care Hospitals Budget**

0163. The networked acute care hospitals should be funded under a separate, one-line budget appropriation to ensure that resources over and above that appropriation can be made available only with specific Cabinet endorsement.

### **Private Practice Trust Funds**

0164. The Government should review the present arrangements for private practice trust funds to ensure that both the specialists and the Government gain advantage, that a single agreement covers rights to private practice across the proposed hospitals network, and that the medical indemnity issue is properly taken into account.

### **Hospital Clinical Employment Contracts**

0165. Employment contracts for clinicians across the Northern Territory Health system should be standardised.



### **Royal Darwin Hospital - Patient Election**

0166. Patients should, upon admission to hospital, be interviewed and asked to complete election forms to declare whether they are public or private patients, workers compensation claimants, or Motor Accident Compensation Act patients.

### **Alice Springs Hospital**

0167. The private wing beds at ASH should be used for clinical consulting rooms and clinical offices and/or to provide up to ten self care / transit lounge spaces in the vacated ward 4 area.

0168. The use of flexing and overflow beds should be tightly controlled in all NT hospitals and should be undertaken in association with formal demand management processes, increased day care episodes, and increased day surgery in order not only to reduce the demand on beds but also to maximise convenience for patients.

### **Alice Springs Hospital – Theatre Suite**

0169. ASH should implement a single management structure for the main theatres and the day surgical unit.

0170. As many procedures as possible should be shifted to day surgery where this is appropriate, safe, and in accordance with evidence-based practice.

0171. A space audit of all areas within ASH should be undertaken, with the development of a plan to ensure that all future decisions on the utilisation of space optimise functional relationships and interdependencies.

### **Alice Springs Hospital – Nursing Structure**

0172. The composition of the nursing workforce at ASH should be reviewed to establish whether changes can be made to strengthen the direct patient care nursing capacity.

### **Palliative Care Service**

0173. The proposed Palliative Care Service, incorporating the NT Hospice, should be managed within the Acute Care Group, and be incorporated into and managed by RDH.

### **Pathology**

0174. The NT should develop a single pathology service by integrating existing services across DHCS.

## **Biomedical Engineering**

0175. Biomedical engineering should be a Territory-wide service, with the employment of a biomedical engineer to head the service.

## **Patient Assisted Travel Scheme**

0176. The Patient Assisted Travel Scheme (PATS) should be centralised and managed within the Acute Care Group.

## **Darwin Private Hospital**

0177. The Department, through the Acute Care Group, should assume full responsibility for managing any contractual arrangements between RDH and the Darwin Private Hospital. In this way, each partner in all such arrangements would be treated equitably, and potential conflicts of interest would be avoided.

## **Ambulance Services**

0178. As part of the acute care continuum, the Acute Care Group should be responsible for managing the provision of ambulance services in the NT, and, in this context, should manage the contract with St. John Ambulance.

## **Multi-Purpose Service Proposal and the Hospital Improvement Project**

0179. The Department should give real priority to the continuing implementation of two priority projects, the Multi-Purpose Service proposal and the Hospital Improvement Project.

## **Establishment of an Office of Aboriginal Health**

0180. The Office of Aboriginal Health should have the following specific responsibilities:

- to encourage performance management and professional development of Aboriginal staff;
- to assist managers properly to manage their Aboriginal staff;
- to increase the number of Aboriginal staff employed in the Department;
- to drive Aboriginal employment opportunities throughout the health and community services sectors in the NT;
- to tailor departmental policy and services to meet the needs of Aboriginal people throughout the Territory;
- to monitor, evaluate and report on the effectiveness of policies and services on the health and well-being of Aboriginal people; and

- to facilitate departmental interaction with established Aboriginal groups.

### **Aboriginal Staff**

0181. The Department should take action to correct deficiencies identified in:

- the assessment and accreditation of Aboriginal staff;
- slowness in assessing Aboriginal employees against a national standard training package;
- failure to ensure equivalence in classification between Aboriginal and non-Aboriginal staff;
- failure to acknowledge AHWs as legitimate members of the team;
- a perception that visiting doctors and nurses often lack proper cultural orientation.

### **Aboriginal Health Workers**

0182. A review of AHW training and employment outcomes should be undertaken. The review should examine specifically the number of AHWs completing training at the various training institutions, the number attaining registration, the number then entering employment, and the number undertaking continuing education, and resultant promotions.

0183. The Department should further develop and adhere to a close and mutually beneficial with AMSANT and with BIITE, particularly in relation to assessment, training, accreditation and registration.

### **Aboriginal Health**

0184. The Department should include Aboriginal participation in policy development as well as in decision making, and should utilise and access its own Aboriginal expertise as appropriate.

### **Cultural Issues**

0185. The Department should take measures to create a workplace situation where people are not, for cultural reasons, constrained or inhibited from full and proper participation. Among the measure which could be implemented are promulgating and adhering to existing standards and protocols; further developing performance indicators and benchmarks to monitor and measure outcomes; and developing policy accordingly.

0186. The Department should recognise cultural awareness competency and proficiency (in both Aboriginal and non-Aboriginal staff) of Aboriginal language skills, as well as providing, through its staff development programs, funding to enable appropriate language courses to be taken.

### **Primary Health Care Access Program**

0187. The Department should identify the Public and Community Health Division as the area of the Department responsible for the implementation of PHCAP. A specially-created unit within that Division should be provided with sufficient human and other resources to undertake the work needed to oversee the process of change management within the Department, as well as the detailed planning and other tasks.

0188. The Department should not devolve health service management to primary health services that are not able to demonstrate sustainability in the short, medium and longer term.

0189. The Department should undertake a process to convince the non-Aboriginal populations in the Zones that they will receive better access to improved service under the new arrangements, and should resolve the question of non-Aboriginal representation on Health Boards.

0190. The Department should determine whether it will directly or indirectly influence the Health Boards to ensure that health care is uniformly delivered throughout the NT.

0191. The Department should, through formal partnerships related to the PHCAP process, engage the wider Aboriginal and Torres Strait Islander communities, particularly those in remote areas.

### **Aboriginal Health Action Plan**

0192. The Department should develop an Aboriginal Health Action Plan for implementation.

### **Men's Health**

0193. The Department should, as a pilot, undertake a men's health project in Alice Springs to cater for the health needs of men in the Alice Springs Town Camps.

## Chapter 1: Introduction

101. Western health systems share common and increasing pressures, including the need to satisfy consumers and providers; contain costs; maintain safety and quality; achieve equity both socioeconomically and geographically; increase efficiency; and achieve a reasonable balance between meeting the “needs” of today and investing in the future. In the NT, a small, dispersed population adds to these pressures. The Government’s ability to fund health services within a reasonable and politically realistic framework is necessarily limited. At the same time there are real add-ons to the cost of providing services both within and away from the major population centres.

102. In describing western health systems, Alistair Mant says: “The evidence is that all of these interlocking problems are being dealt with mostly in a piecemeal way because few Governments have had much success in generating a total systems framework for public health/illness. As the public slowly learns to understand the realities of the system, there must be a substantial payoff for any Government which succeeds in adopting and implementing a total systems regime.”

103. Demographics, particularly population distribution, has always been a key determinant of the nature and provision of health and community services in the NT.

104. Improvement in health and community services will require a system in which community health needs, Government objectives, both Commonwealth and Territory health priorities, community values, and provider realities are transparently linked in a growing relationship.

105. The recommendations of this Report are made against this background. If adopted they will take services in the right direction but they are not sufficient in themselves. Leadership from the Government, from the Minister for Health and Community Services, and from the incoming Chief Executive Officer (CEO) of DHCS is essential, as is the commitment of all involved.

106. The Department needs to accept that one of its key roles is to support service providers, both those within the Department and those outside the Department. Providers need to revitalise their approach so that the services offered to local populations are customer-focussed, accountable, and equitably responsive to need.

107. This will require the Department to establish inclusive policy and funding frameworks that link Government objectives, health needs, values and service capacity as part of a total system designed to organise and animate a dynamic and inclusive relationship.

108. Territorians will need to appreciate that they are part of a integrated system respecting the varying roles they have as providers, carers and consumers of services, financial contributors, workers within the system, and as citizens engaged in decisions allocating finite resources.

109. The overall thrust of the Review's activities has been to identify what should be done to give the Department better and more appropriate focus and a higher degree of transparency. The aim was to create a situation where, two years from now, the Government will be able to show clearly that a number of serious deficiencies in the Department have been corrected. Among these, and most importantly, is the establishment of budgetary control.

110. The Government needs to be able to point to better-organised and supported service delivery, thereby enabling Territorians to feel confident that services are being provided effectively. To this end, our work provides a framework within which the Government and Territorians can better understand the mechanisms whereby the Government's health and community service policy is to be implemented, and can better identify the particular parts of the Department to which they should turn to seek advice or help.

111. It has become clear during the course of the Review that there is a significant structural problem with the health and community services budget. This underlying problem will need to be corrected if the Government's health agenda and its priorities are to be addressed.

112. One significant aspect of the budget issue affecting health and community services in the Territory relates to the public hospital system. Hospitals drive health system costs. Throughout Australia, these costs are growing at around 6% per annum, a rate of increase greater than the CPI and exceeding the rate of increase applying to other social programs. For the most part, technology drives these costs. New diagnostic tests and equipment, new medical techniques, and new drugs all assist in keeping people alive longer, but often at significant additional cost. For example, the use of MRI or CAT scans is standard today in many situations where an X-ray would have been used 15 years ago. Both MRI and CAT scans cost almost four times the cost of an X-ray.

113. On a cyclical basis, each Australian jurisdiction has been required to inject funds into its health system to enable 'catch up' with system cost pressures. For example, the great majority of Victorian public hospitals finished 2001/02 in deficit.

114. In the Territory there are a number of factors that have exacerbated this trend. These include the costs associated with a larger Aboriginal population in very poor health, the fact that the Aboriginal population is increasing as a proportion of the NT population, and the distribution of a significant proportion of the NT population across remote areas. For example the costs of treating renal disease have grown at an average of 24% per annum for the last ten years. Improvements in primary health care will increase pressures for adequate specialist care for remote Aboriginal and non-Aboriginal populations.

115. In the community services area, changed community expectations mean that people with severe disabilities who would once have received limited care in an institution or in prison now receive care in a community setting at a cost of hundreds of thousands of dollars per year.

116. Funding pressure has also been driven significantly by a breakdown in management systems and control. The Department received an additional \$17M one-off and \$17M recurrent in the November 2001 Mini Budget, including funding for Government initiatives. However, the Department experienced difficulties managing within budget in 2001/02, the extent of which did not become fully apparent until 2002/03. In the 2002/03 budget, the Department received an additional \$6M one-off, partly to help deal with the flow-on of problems from 2001/02, and \$14M recurrent for cost increases, service demand pressures, and Government initiatives. Of the approximate \$31M additional recurrent funding provided to the Department in the two budgets, almost 50% was earmarked for the nurses Enterprise Bargaining Agreement and career structure, for staff training, and for specialist staff remuneration.

117. Following the November 2001 Mini Budget, the Department failed to implement strategies to achieve medium to long-term efficiencies. This failure placed additional pressure on the remaining additional recurrent funding that had been provided to cover cost pressures, shortfalls in aero-medical retrieval, hospital services, cross-border payments, and foster-care payments, as well as Government initiatives.

118. In 2001/02, there were budget over-runs in the areas of high demand pressure: hospitals, renal dialysis, aero-medical retrieval, patient travel, disability services, mental health, and family and children's services.

119. Deferred grants payments from 2001/02 of over \$7M and the full year effect of 2001/02 staff increases (150 in the last 6 months of 2001/02) has created a "flow-on" effect in 2002/03 of \$17-18M in addition to 2001/02 expenditure levels. Even with continued tight budget management, it is projected that the Department will overspend its current 2002/03 budget by \$20M in the absence of significant cuts to service delivery.

120. This has resulted in part from the inherent pressure in hospital costs and the impact of poor Aboriginal health (for example, as both the need for and access to renal dialysis improves), and in part from inadequate management in key areas, lack of transparency in resource allocation, poor budget control, and service "creep". There have been increases in the scope and quality of services, especially at Royal Darwin Hospital, without Government approval of the full flow-on costs or, in some cases, without any Government approval at all.

This situation will require both significantly improved management within the Department and Government to review and possibly reconsider a number of commitments it has either made or inherited from the previous Government to ensure very basic priority areas are addressed within the health and community services system.

121. In the Report that follows, we have to the greatest extent possible adhered to a number of underlying concepts and principles. These are:

## **Care Closer to Home**

122. Effort needs to be made to ensure that, where clinically appropriate and economically viable, services are provided as close to where people live as possible.

## **Avoidance of Duplication**

123. Giving people choice is desirable but not where it results in duplication. Every endeavour needs to be taken to avoid duplication while the demographics remain much as they are now. When the population grows, choice can be increased without duplication.

## **People Focussed Approach**

124. The core focus is people and improving people's health and well-being. Structure and funding should reflect that focus, rather than focusing on programs. The people-focus should not be lost in the desire to set and meet program goals. Only if people remain the focus will greater opportunities arise to develop partnerships with communities and providers.

## **Support to All Providers**

125. The Department should support all service providers to deliver outcomes for Territorians. This may involve capacity building to ensure that providers are able to deliver. Investment in the Department is not just to make individual departmental services work well, but to ensure that the Department's services can also work in partnership with each other and with other funded services - a truly robust service system.

## **Strategic Priority Setting**

126. The Department should take a longer-term view of where it is going, looking ahead five years and beyond. The Department's strategic directions should guide priority setting and resource allocation to ensure it can meet the objectives set in the strategy. It is essential to demonstrate a clear path from the strategic directions to the objectives by way of the actions, while specifying the measures of success.

## **Priorities Determine Investment/Disinvestment**

127. Investment should be focussed on meeting the Department's strategic directions. It is easier to disinvest if resource allocation is linked to priorities that are themselves linked to strategic directions.

## **Evidence Based Decisions**

128. Resource allocation should be linked to services and approaches that have been shown to work and to areas where there is a clear need. Disinvestments and reforms to service models and systems are easier to effect if priorities are evidence based.



## **Planning for Communities**

129. Communities do not think in terms of programs, they think in terms of place, of population groups, of needs. Communities do not care if one or several programs fund a needed service, as long as someone does. Planning approaches need to be developed and strengthened so that decisions are made which take account of the population data and trends. The Department should work with the community to analyse existing service systems, and to determine what needs to be enhanced, added or altered to meet the changing needs.

## **Risk Dispersal**

130. Incorporating community and consumer input into planning leads to a dispersal of risk for the Department. There is greater diversity of views considered and more opportunity for shared ownership of the decisions and shared engagement in implementing those decisions.

## **Community Input to Planning**

131. Involving consumers in decision making and seeking regular feedback ensures that processes are constantly matched to consumer need and that services are well targeted to consumer needs.

## **Rigour in Administration**

132. The NT's small, dispersed population means that to be affordable, services need to be rigorously administered. Energy expended should be tailored to reflect the potential gains or outputs sought. At the same time, management processes should be streamlined to reflect the associated investment and therefore risk.



## Chapter 2: Demographics of the Northern Territory

### Population

201. The NT, with a population density of 0.1 per square kilometre, is the most sparsely populated jurisdiction in Australia. The estimated resident population of the NT at the end of December 2000 was 196,300, an increase of 19% over the previous 10 years. The NT population represents about 1% of Australia's total of 19.3 million.

202. Of the total population, 29% were Aboriginal people. This compares with the national figure whereby Aboriginal people constituted 2% of the population. The proportion of Aboriginal people in the NT population has increased from 26% in 1990, and is expected to reach 31% by 2006. The NT has a higher proportion of Aboriginal people than other jurisdictions, although a smaller total number.

203. The fastest population growth in Australia in the five years to June 2001 was recorded in the NT (1.9% per year on average). In the decade to June 2001, Darwin and Brisbane were the fastest-growing capital cities. Between 1996 and 2001, Darwin experienced the fastest growth with an average annual rate of 2.5%, while Brisbane grew at an average rate of 1.7% per year. In contrast, Brisbane's growth of 2.3% per year between 1991 and 1996 was faster than Darwin's growth (2.1% per year) over the same period. The growth in the Territory's population during 2000 was due to gains of 2,800 from natural increase, 880 from net overseas migration and a loss of 1,640 from net interstate migration.

204. In 2002, 71% of Aboriginal people live in rural/remote areas of the NT while 83% of non-Aboriginal people live in the urban areas of Alice Springs or Darwin. Aboriginal people constituted 10% of the Darwin population in 2001, although there was a turnover of approximately 52% amongst this population during the period 1991–1996.

205. A large proportion of the NT's non-Aboriginal population has moved to the Territory from other states for employment reasons. The large increase in the military population in the past ten years is a good example of a highly mobile group who are resident in the NT for a period of years as 'migrant workers'. A migrant worker population is characterised by a population of younger adults with young children.

206. The Territory also has a high transient/visitor population. In 2000/01, it was estimated that the number of visitors to the NT exceeded 1.5 million. The average length of stay was 5.2 days. In 2000/01, 25% of all visitors in the Territory were intra-Territory visitors (i.e. Territorians travelling within the Territory). Interstate visitors made up the greatest proportions of all visitors in the Top End, Katherine and Tennant Creek regions. For the Centre region, however, international visitors were the most prevalent.

207. The NT has a small and relatively young population compared to the rest of Australia. It is predicted to continue to grow rapidly over the next ten years, although it will remain a comparatively young jurisdiction. The NT has the youngest median age of any jurisdiction in Australia. In June 1996 the median age of the Australian population was 34.0 years compared with 27.8 years in the NT. By June 2001 the national median age had risen to 35.7 compared to 29.6 years in the NT. The NT's population will continue to age but at a slower rate than Australia's population as a whole.

208. The Aboriginal population in the NT is particularly young with 38% of people aged less than 15 years compared to 22% of the NT non-Aboriginal population and 21% of the Australian population.

209. The younger age structure of the Aboriginal population has a bearing on some social determinants of health and well-being where age is an associated factor. For example, birth rates may be higher among the Aboriginal population compared to the total population partly due to the greater proportion of women of child-bearing age within the Aboriginal population. Indeed, Aboriginal women in the NT have the highest fertility rate of any State or Territory, at 2.8 babies per woman on current rates (for all women in the NT the rate was 2.2 babies per woman).

210. Aboriginal mothers also tend to be younger than other mothers in the NT. In 1999, the average age of Aboriginal mothers was 25.0 years, compared to 29.0 years for non-Aboriginal women. Despite the age structure factor, however, there are significant differences in many of the indicators that inform the health and socio-economic status of Aboriginal and Torres Strait Islander people, including fertility and mortality rates.

#### Determinants of Health

211. Overcrowding is a particular problem in NT, which had an average of nine people in each household in remote Aboriginal communities in 1996. This high occupancy rate places a heavy load on household infrastructure, accelerating the breakdown of health hardware such as showers, toilets and washing machines and exacerbating the potential for the spread of infectious disease.

212. Aboriginal Territorians are more likely to live in remote areas than non-Aboriginal Territorians. This limits their ability to access not only health and community services, but also good quality food, education and employment opportunities, compounding the impact of distance on health outcomes. Furthermore, the distance between remote communities and urban centres may reduce the desirability of these communities as a place to work, or even visit, for the health and community services workforce, making it more difficult to adequately staff their health centres.

213. Many strategies and initiatives have been implemented by both the Government and non-Government sectors to improve these determinants of health and well-being. For example, the

NT Food and Nutrition Policy and the Store Book initiative aimed to enhance the range and quality of food available in remote communities, as well as to build community capacity around food supply. Similarly, recommendations for appropriate housing and “health hardware” (eg. toilets) in remote communities have been made, people trained and buildings and equipment modifications undertaken. However, in many instances these improvements have not been sustainable. Service continuity is a particular problem and unfortunately, recent surveys indicate that there are instances where food supply and housing/health hardware simply do not meet NT or national standards.

214. A significant challenge to the health and community services sector is that many causal factors lie out of its direct control. Intersectoral collaboration is critical if Territorians are to achieve the goal of improved health and well-being. Indeed, this is recognised as part of DHCS core business, described as “*A catalyst for total health solutions, achieved intersectorally*”. Unfortunately intersectoral collaboration is not always successful despite good intentions and Memoranda of Understanding. Learning to collaborate more effectively, and doing so, is a critical factor in reducing the current excessive morbidity and mortality rates of Aboriginal Territorians in particular.

215. Strengthening community capacity has been long recognised as a health promoting activity, particularly in Aboriginal communities. It is also now included as a departmental stretch goal: *Strengthen Community Capacity*, with the following explanatory statement: *DHCS will support Territorians and Northern Territory communities to take control of their own health and well-being*. Nevertheless, it has also been recognised that this is not a short term and simple activity, but one that requires considerable time and commitment with challenges for all involved. Recent comments by NT Minister the Hon John Ah Kit MLA have clearly identified and supported the need for capacity building in Aboriginal communities (urban and remote) and encourage active participation in decision-making and community life. This may be an important development in reducing adverse health determinants. Indeed, capacity building and community participation have been recognised as two of the key elements in both the NT Coordinated Care Trials, and the new Primary Health Care Access Program (PHCAP) health zones. PHCAP is supported by the NT Aboriginal Health Planning Forum, a collaboration between DHCS, Aboriginal Medical Services Alliance of the Northern Territory (AMSANT), Aboriginal and Torres Strait Islander Commission (ATSIC) and the Commonwealth Department of Health and Ageing (DHA).

216. Lower socio-economic status is internationally recognised as an important determinant of poor health status. This is borne out in the NT, with those with the poorest health status, Aboriginal Territorians, having low education levels, employment rates and income.

#### Health Status

217. Aboriginal Territorians are younger and have a shorter life expectancy than the non-Aboriginal population, due both to higher birth and mortality rates. Aboriginal Territorians are

among the least healthy Australians, having the highest prevalence of some chronic diseases such as cancer, diabetes, heart and respiratory disease in Australia. Injury rates for both Aboriginal and non-Aboriginal people are also high compared with other jurisdictions. Indicators of social and emotional well-being, such as the increasing incidence of youth suicide, also strongly suggest that the NT is not “healthy” in this regard. These figures parallel the national trend for Aboriginal health and well-being, being significantly worse in most instances than that of non-Aboriginal people, and skew the overall NT health status.

218. Numerous studies have documented the poor status of Aboriginal health and well-being in the NT, and identified possible or actual causes including remoteness, dispossession, food and nutrition, reduced physical activity, housing and sanitation, education and employment.

219. The non-Aboriginal population of the NT has a similar health status to that of other Australians, and significantly better than that of Aboriginal Territorians. Indeed, non-Aboriginal women enjoy better health than the national average. A contributing factor to the difference between Aboriginal and non-Aboriginal Territorians’ health status may be that a significant component of the non-Aboriginal population is from interstate (and is highly mobile). Because it is healthy, this group is able to choose and sustain jobs in the NT away from family and other supports.

220. Some behaviours contributing to ill-health are more common in non-Aboriginal Territorians than in other Australians. These include smoking and excessive alcohol consumption. Furthermore, non-Aboriginal Territorians are also more likely to die from injury than other Australians.

#### *Implications for Health and Community Services Provision*

221. The profile of the NT population has significant implications for current and future health and community service provision, including the service mix required to improve the current health profile. Determination of appropriate service mix and allocation of resources to support these services is a complex issue, and one that has provided, and will continue to provide, significant challenges.

222. The NT is no different to other jurisdictions, nationally and internationally, which have grappled with the development of a model of funding and providing services which best fits the health and community services requirements of their jurisdictions, the needs of their clients, and the resources available. Indeed the profile of the NT population is significantly different from the national profile, independent of the high proportion of Aboriginal people. This fact may necessitate specific negotiations with the Commonwealth Department of Health and Ageing to ensure that Commonwealth emphasis (and funding) on initiatives for older Australians does not adversely impact on the NT’s ability to access health and community services funding.

223. Similarly, the high burden of “disease” in the NT provides a significant challenge to current and future health and community services providers to reduce the prevalence of high levels of morbidity and mortality to levels more “equitable” with the rest of Australia. There is a clear national and international trend to shift from an emphasis on treating illness to promoting health and well-being, and towards enhancing primary health and community-based health care services. In the NT, this may well require significantly more effort and resources on a per capita basis than for a jurisdiction with a more favourable health and well-being profile. The comparatively high proportion of the Aboriginal population who live in remote and rural areas and require health services further exacerbates this.

224. The poor health profile and life expectancy of Aboriginal Territorians is not improving to the same extent as that of other indigenous populations throughout the world. This suggests that the performance of the NT health system has not kept pace with other national and international systems. This may be due to the services that have or have not been delivered, the means by which they have been delivered, and their availability to the population that needs them. It may also be a reflection on the national Aboriginal health strategy and services in that the Commonwealth funds AMSANT to provide some of the primary health care services across the NT and these are not integrated with Territory funded primary health care services.<sup>i</sup>

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## Chapter 3: Services Closer to the Home

### Care Closer to Home

301. Care closer to home is a philosophical approach to health delivery. The approach aims to ensure that health services are delivered in the best possible setting, and to give people the opportunity to have their health needs met in their own homes or as locally as possible.

Although having services closer to home may require a trade-off against the need for critical mass and maintenance of quality, the fact that the provision of such services may be more difficult and more inconvenient for service providers should not of itself be a sufficient reason to prevent such services.

302. Critical assessments of the role of long stay hospitals and other residential institutions for people with chronic illness and disability have been a feature of health policy for over a quarter of a century. The concept of community care today is strongly rooted in the principle of care in the least restrictive environment with the least social disruption.

303. In the NT there is a hidden cost burden in taking people to services rather than services to people. There are very stark and obvious examples of this type of cost burden when people in need of care are taken to urban locations for treatment. In many cases they are followed by extended family, stays become indeterminate and associated with the added social costs of homelessness, alcohol and drug abuse, and at the same time there is a negative impact on the community from which they come. This means providing the right level of intervention and support to enable people who are affected by problems of ageing, mental illness or physical or sensory disability to live as independently as possible in their own homes or in homely settings in the community.

304. The successful implementation of community care policy depends on the availability of, and ease of access to, adequate and appropriate services in the community. The development of a wide range of services provided in a variety of settings is essential. These range from:

- domiciliary support strengthened by the availability of respite care and day care for those with more intensive needs, to
- sheltered housing, group homes and hostels where increasing levels of care are available, to
- residential care, nursing homes and long stay hospital care for those for whom other forms of care are no longer adequate.

305. In the past, people with severe, disabling and long-term illness were often confined to institutions for long periods of time. Today, many of these people now live most of their lives in the community. They therefore have to find most of their services for themselves through a complex array of community health and welfare agencies. But the change in the focus of care

from institutions to community settings has to date not been reflected in a corresponding distribution of resources. This situation is not confined to the NT but is exacerbated by the geographic spread of Territorians and the burden of disease.

306. Community care generally means care in the community rather than care by the community. It needs to be acknowledged that most of this care is provided by family, friends and neighbours. It has to be recognised that carers need help and support to enable them to carry out their role effectively.

307. The key components of community care should be:

- a mix of public, voluntary and private services which respond flexibly and sensitively to the needs of individuals and their carers;
- services which focus on the health and social needs of individuals and allow a range of options for consumers;
- services which are coordinated in a manner which allows people to move easily between the various elements of care;
- services which intervene no more than necessary to foster independence; and
- services which concentrate on those with the greatest needs.

#### Chronic Disease Management

308. Chronic disease management works well only when delivered as close to the community as possible, and only within a coordinated team framework. Although the NT has a highly regarded preventable chronic disease strategy and some work has been done in primary care, little has been done to develop teams providing secondary and tertiary care. Given the disease burden and the complexity of care required in the absence of such teams, primary care resources will be insufficient to deliver the standard of care required.

309. The changes currently being made to primary care funding should ensure that adequate resources for primary care are available in the NT, although access in areas with low bulk billing rates (like Alice Springs) will result in some access difficulties.

310. The funding for secondary and hospital care is much more problematic, as it is currently inadequate despite marked service shortfalls. Non-Government funding sources, in particular private health insurance, will need to be more significant before a private sector is feasible.

311. Adult chronic diseases (such as cardiovascular disease, renal disease, diabetes, respiratory disease, cancer, and liver disease) are all likely to increase dramatically over the foreseeable future. Services should be further developed to address current shortfalls and to cope with increasing demand for services.

**Principal and Supporting Recommendations:**

**Services should be further developed to address current shortfalls in managing adult chronic diseases and to cope with increasing demand for services.**

*Renal Services*

312. Professor John Horvath undertook work, on behalf of the Review, to review the current status of renal services in the NT. The work included site visits, formal and informal discussions, and a clinical consultation session. Professor Horvath's report to the Review is reflected in the following observations and recommendations. A key consideration was the provision of renal care closer to home.

313. Professor Horvath made site visits to RDH, Nightcliff Dialysis Centre, Tiwi Islands Dialysis Centre, Alice Springs Hospital (ASH), Flynn Drive Dialysis Centre, and the Kintore Community. Key stakeholders were interviewed as part of these site visits. A clinical consultation was also held with a wider group of stakeholders.

314. Renal disease is a major contributor to morbidity and mortality in the NT. The incidence and prevalence is significantly worse than the Australian average. In 1998 there were 299 new cases per million people in the NT (compared to 85 nationally), and a prevalence of 726 cases per million people (555 nationally). This is due to the high burden of renal disease borne by the NT's Aboriginal people.<sup>1</sup> Indeed, Aboriginal people, despite their comprising less than 30% of the population, suffer 72 percent of all end stage renal failure in the NT.<sup>2</sup> Nationally, the incidence of renal disease is increasing. However, in the NT, this is occurring at a faster rate than the national average and is reflected in the requirement for renal replacement treatments such as dialysis (increasing at approximately 15-20% per annum as opposed to the national rate of approximately 8% per annum).<sup>3</sup>

315. Renal services in the NT have had a phenomenal development over the last six years. They have gone from four visits per annum by an out of state nephrologist to the appointment of three nationally respected nephrologists running one of the largest services in Australia (both numerically and geographically). There has also been a concomitant increase in both the numbers and quality of renal nursing services. An internationally recognised successful research program has also supported the development of innovative and appropriate service approaches for the NT.

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<sup>1</sup> You, J. Hoy, W. Zhao, Y. Beaver, C. & Eagar, K. End-stage renal disease in the Northern Territory: current and future treatment costs. *Med J Aust* 2002; 176:461-465.

<sup>2</sup> *ibid*

<sup>3</sup> Russ, G. Editor. ANZDATA Registry Report 2001. Australia and New Zealand Dialysis and Transplant Registry. Adelaide, South Australia, 2001.

316. The safety of the renal services provided at all sites visited was acceptable. There are indicators of good care eg. native fistulas and dialysis attendance and outcomes for both peritoneal dialysis (PD) and haemodialysis (HD) are within nationally accepted standards. However, the availability of these renal replacement treatments, the identification and early treatment of chronic renal insufficiency (CRI) and the incidence of transplantation require attention to ensure a viable and effective service for the future, ensuring an appropriate level of care is provided as equitably as possible across the NT.

317. There is concern about the current inability of the primary health care sector adequately to provide resources for the implementation of preventive measures, screening and intervention for early renal disease. Recent local evidence strongly suggests the importance of effectively managing CRI to delay or prevent the need for dialysis and to ensure better patient outcomes.<sup>4</sup>

318. There appears to be general agreement that a good model of service would be to establish a Territory-wide service including Darwin, Alice Springs and regional locations. Strong relationships with larger interstate renal units would strengthen this service capacity, with the potential for mutually beneficial arrangements eg. rotations and secondments of both medical and nursing staff. However, there is also a critical need for there to be strong relationships within such a service, as well as strong leadership for, and management of, the service and responsibility for its outcomes. This is not currently apparent. There is evidence that there is a lack of cohesion between the physicians (which may be symptomatic of the ‘growing pains’ of the service), and that, in general, there is a lack of connectivity between the Top End and Central Australia.

319. Many of the current satellite patients being treated in Alice Springs and Darwin may be able to be managed closer to their communities. A decision-making process is required to identify these patients. There is a real desire by many staff, patients and their communities for this to occur. A matching of service requirements against local needs will need to be undertaken as part of this process. This may include the following three domains:

- the capacity of the community, eg. being logistically able to support a complex treatment program;
- the capacity of service provision, eg. being able to provide an outreach service to patients not based in regional centres; and
- the capacity of individual, eg. being medically suitable to be treated in a remote location.

320. In the Top End there appears to be significant support for this proposal; there appears to be less by DHCS personnel in the Centre. Kintore community believe that the social dislocation

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<sup>4</sup> Cass, A. Cunningham, J. Arnold, P.C. Snelling, P. Wang, Z. & Hoy, W. Delayed referral to a nephrologist: outcome among patients who survive at least one year on dialysis. *Med J Aust* 2002; 177:135-138.

caused by the need for its people to be dialysed in Alice Springs has resulted in social isolation, boredom and alcohol abuse; there is a very strong desire to bring the family home.

321. Information management of data required for making decisions regarding clinical care and resource allocation appears to be haphazard. Best practice renal patient care is based on monitoring and using relevant clinical data in conjunction with agreed service provision standards. Without either component, there is a risk of poor patient outcomes. From observation, it is the former that is currently of greater concern in the NT.

322. While there is a commitment to collecting, analysing and disseminating information, there are a range of systems and reporting requirements which do not dovetail, and are not particularly user friendly, thus negating the benefits of an effective information management system. A more simple, streamlined approach to information that yields reliable and useful information should be implemented.

323. As mentioned above, there has been a dramatic increase in the quality and quantity of personnel involved in the delivery of renal services over the past six years. A strong commitment to up-skilling staff is apparent. However, there are still concerns regarding the recruitment and retention of staff across the NT, and, in particular, specialised renal nursing staff.

324. In Central Australia, the employment of one, but preferably two renal physicians is an imperative. There appears to be few Aboriginal people employed within the renal services, and the potential for Aboriginal Health Workers (AHW) to play an active role in the delivery of renal services appears to be limited at present. This should be reversed. Concerns regarding the impact of the rigidity of current work practices, industrial relations and professional silos on the potential for innovative work practices were voiced on a number of occasions. This is an area where change could yield significant benefits.

325. The facilities at Nightcliff, Tiwi Islands, Flynn Drive and the two renal beds at ASH appear most satisfactory, with the first two being quite outstanding. RDH renal unit is satisfactory, although the current location of the unit is poor. There are insufficient beds at ASH, and there is a need for a larger dedicated inpatient facility, reducing the current situation where seriously ill patients are required to leave the hospital for dialysis if the two machines are being used. Although a new health centre is currently under construction at Kintore with a purpose built room for patients with renal disease, there are significant environmental health concerns apparent in the community.

326. RDH has appropriate service delivery, management of patient load, and staff/patient ratios. There is, however a lack of connectivity between the Renal Unit and the Intensive Care Unit with respect to acute renal failure. There appears to be minimal collaboration and communication between these two units, potentially impacting on optimal patient care. This situation should be addressed by the hospital.

327. The Nightcliff Dialysis Centre is a high quality satellite service giving clear indication of a desire to change. The Centre has a Territory-wide view of service delivery, with good indicators of care eg. native fistulas, dialysis attendance. However, the Centre has an 80% non-Darwin patient load with resultant issues of dislocation. The Centre should extend the input of AHWs and other appropriate community support.

328. The Tiwi Islands Dialysis Centre is an excellent satellite, offering the highest standard of service and facility. It is cost effective, safe, and produces good results. It offers a valid model if that model could be supported centrally. However, it may set an unrealistic benchmark for less resourced communities. The Centre is currently staffed by Nightcliff Dialysis Centre nurses, and there is potential for the Tiwi Islands Dialysis Centre to build and expand innovative staffing mechanisms.

329. ASH is grossly under-resourced for what needs to be done in Central Australia. It offers an outreach service in name only. There is clear tension between Alice Springs and the communities with respect to the adequacy and appropriateness of, and ASH's willingness to provide, outreach services. There is a need for a dedicated inpatient area of more than two beds. ASH has dedicated, keen nurses with vision and a desire to improve services. However, there are potential risks for service safety and quality as the nurses are unsupported by specialist medical personnel. The hospital is inadequately resourced for diabetes care, surgical support and transplant work-up and care. There is a need for a diabetologist and a renal transplant-focussed physician on site, and for appropriate surgical support.

330. Despite comparatively high level of medical input, the Kintore Community offers discontinuous primary health care programs. Major public health concerns must be addressed in Kintore, including currently high rates of scabies, diabetes, and poor environmental health status. The latter may be exacerbated by increased amounts of medical waste if HD or PD is undertaken in the community. There are uncertainties as to the level of understanding by community members of the requirements and complexities of renal dialysis.

331. While there is the nucleus of a good renal service in the NT, significant service development is required to enable an effective and appropriate program of care to be offered. This will need adequate resourcing and capacity building, both for the clinicians involved in delivering the service, and the community and individuals who will be receiving the service. Many of the management and resourcing issues for renal services are whole of Government issues, relating to housing, employment and transport, as well as health. These factors should be taken into consideration to ensure successful dialysis, transplant and outreach service outcomes.

332. Renal services should be planned and implemented in such a way as to minimise social dislocation, including:

- prevention and chronic renal impairment programs adequately resourced to prevent dialysis (where possible) and to prevent the progression of disease beyond a requirement for dialysis (where inevitable);
- adequate resourcing and partnerships between all service sectors to share the burden of patient care;
- integration of the management of diabetes and its complications into the management plans;
- provision of quality tertiary patient care to enable patients to return home safely and to be able to be supported in their home environment; and
- delivery of quality dialysis care as close to home as possible, with the necessary investment in hardware, people and their education, and partnerships with communities and all health facilities.

333. As part of effective decentralisation of services, there should be developed (within underlying parameters of safety, efficacy and cost effectiveness) a clear statement of the requirements of a micro-satellite unit in respect to all levels of care, including responsibilities of health care workers, community contribution and infrastructure, and the needs of the patient.

334. Where a micro-satellite is not viable, there should be provision of care in regional centres, rather than in Darwin and Alice Springs. The NT should adopt a whole of Government approach in the implementation of the renal strategy with savings achieved across the whole of Government (eg. travel, education, employment, and housing) offsetting the possible additional costs to the health sector in terms of outreach services.

335. The Department should establish an integrated, effective, transparent clinical stream, headed by a Director, that encompasses the spectrum from primary health care to tertiary treatment for Renal Services across the Territory, including:

- an appropriate organisational structure for the delivery of renal services across the Territory;
- a framework which provides for decision-making, prioritisation, resource allocation and appropriate sustainable delivery of quality services;
- an integrated Territory-wide service which is accountable and responsible for the delivery of services;
- an approach to issues relating to recruitment, retention and human resource management and development; and
- strategies to address facets of care that relate to awareness of patient rights, treatment options, communication and education, and that underpin all health service delivery.

336. Recognising that treatments such as peritoneal dialysis and transplantation are the quickest ways to return patients to their communities, the Department should examine why such

optimal modalities of treatment for End Stage Renal Failure in the NT environment have not been taken up, why their current uptake is suboptimal, and ways to increase this to an optimal level.

**Principal and Supporting Recommendations:**

**Renal services should be planned and implemented in such a way as to minimise social dislocation, including:**

- **prevention and chronic renal impairment programs adequately resourced to prevent dialysis (where possible) and to prevent the progression of disease beyond a requirement for dialysis (where inevitable);**
- **adequate resourcing and partnerships between all service sectors to share the burden of patient care;**
- **integration of the management of diabetes and its complications into management plans;**
- **provision of quality tertiary patient care to enable patients to return home safely and to be able to be supported in their home environment; and**
- **delivery of quality dialysis care as close to home as possible, always following rigorous assessments of safety and sustainability, with the necessary investment in hardware, people and their education, and partnerships with communities and all health facilities.**

The Department should establish an integrated, effective, transparent clinical stream, headed by a Director, that encompasses the spectrum from primary health care to tertiary treatment for Renal Services across the Territory, including:

- an appropriate organisational structure for the delivery of renal services across the Territory;
- a framework which provides for decision-making, prioritisation, resource allocation and appropriate sustainable delivery of quality services;
- an integrated Territory-wide service which is accountable and responsible for the delivery of services;
- an approach to issues relating to recruitment, retention and human resource management and development; and
- strategies to address facets of care that relate to awareness of patient rights, treatment options, communication and education and that underpin all health service delivery.



### Aeromedical Retrieval Services

337. Professor Bryant Stokes undertook work, on behalf of the Review, to review aeromedical retrieval services in the NT, and particularly in the Barkly District. The purpose of this part of the Review was to determine the best form and type of aeromedical transportation service that could be provided to the residents of the Barkly Tableland, including Elliott and its surrounds. During the work, it became obvious that this could not be determined without looking at the total clinical services provided to the Barkly. The work included site visits, formal and informal discussions, and a public consultation session held in Tennant Creek. Professor Stokes' report to the Review is reflected in the following observations and recommendations.

338. The population of the NT is almost 200,000, of whom 100,000 reside in the Darwin region, 35,000 in the Alice Springs region, and 2,000 in Tennant Creek. The accurate population of the Barkly region has been difficult to obtain, but lies in the vicinity of 3,800 (including those living in Tennant Creek).

339. Tennant Creek has a small hospital of 20 beds, and has an average occupancy of 67-72%. Trauma surgery cannot be conducted at Tennant Creek, and there are no resident specialty services. Cataract surgery and renal haemodialysis have recently been established successfully at TCH. This has been perceived as a very positive service development.

340. In the NT there are four aeromedical evacuation services:

- a Darwin-based service with secondary services in Katherine and Gove, contracted to Pearl Aviation which operates as NT Aero-Medical Service (NTAMS);
- an Alice Springs-based service, contracted to the Royal Flying Doctor Service (RFDS);
- at Tennant Creek, a non-contracted service which currently uses a non-pressurised aircraft; and
- out of Mt Isa in Queensland, an RFDS Service that covers the Eastern Barkly.

341. Since 1987, aeromedical evacuation in the NT has used pressurised aircraft, except for evacuation out of Tennant Creek. The use of unpressurised aircraft from Tennant Creek for aeromedical evacuation is undesirable, and provides an outmoded service to the Barkly - especially to patients with hypoxia, blood loss, and cardiac and respiratory conditions. However, many of the evacuations carried out from Tennant Creek are for conditions (such as obstetrics) where pressurisation is not significant in respect of care.

342. The Pearl Aviation (NTAMS) service has recently had its contract renewed for 10 years with a 5-year extension. NTAMS operates King Air aeroplanes. Nursing staff for this service is managed regionally by the Community Nurse (Rural) Service run by the Department. The medical staff come from RDH, District Medical Officers (DMOs) at Katherine, and hospital-based doctors at Gove.

343. The RFDS Service out of Alice Springs operates Pilatus (PC12) aeroplanes and has a service agreement with the Department. This service has dedicated medical evacuation pilots, trained medical evacuation nurses, and flight doctors. DMOs and, when necessary, specialists from ASH can accompany these flights.

344. The service out of Tennant Creek is not provided under contract. It is logged and paid for on the basis of hours flown. It operates a Navajo Chieftain aircraft that is unpressurised and is not fitted out as a medical evacuation aeroplane. A patient stretcher hoist is not fitted to this aircraft. These circumstances raise safety concerns for both patients and staff.

345. In 2001/2002, the Tennant Creek aeroplane transported 276 patients. Some 66% of these were inter-hospital transfers between TCH and Alice Springs or Darwin, while around 80 patients were classified in an emergency category. Only 2.5% were Priority 1 patients<sup>5</sup>; 5% of the total came from cattle stations.

346. The current aeroplane at Tennant Creek does not have a properly equipped cabin; there is no radio contact between the in-flight clinical personnel and ground support; and there is no internal lighting when the engines are switched off. It would appear that the nursing and medical personnel who staff the Tennant Creek flights have had no formal aeromedical evacuation training, nor is the pilot trained in that work.

347. The Pilatus aircraft of the RFDS at both Alice Springs and Mt Isa have a block speed that is significantly higher than that of the Navajo Chieftain. The response time from Alice Springs to the central and southern regions of the Barkly Tableland by these aeroplanes would equal or better the response time of the Navajo from Tennant Creek. The eastern Barkly Tableland could be very speedily serviced from Mt Isa using the RFDS Pilatus aircraft from there.

348. King Air aeroplanes operated by NTAMS are stationed at Katherine. These aeroplanes can very adequately service the northern Barkly region. In that region there is a significant population in the Elliott area; and the response time from Katherine to Elliott is 84 minutes, and from Tennant Creek to Elliott is 55 mins.

349. The clinical facilities at Mt Isa are good, with specialised medical staff and Pilatus PC12 aircraft.

350. Visiting clinical services to the Barkly are provided regularly by DMOs from TCH. On these visits, a rural nurse and an AHW accompany the doctor. These visits are, however, made using a 4-wheel drive vehicle. Much valuable clinical time is taken up purely in driving. The Review was made aware that it sometimes took several days for prescriptions written at a remote community to reach TCH pharmacy, and even longer for the dispensed drugs to reach the

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<sup>5</sup> Priority 1 means that there is a response time of 30 minutes between the time of receiving the call and the time at which aircraft doors are closed and engines are started.

patient concerned. Delivery of outreach clinical services by road is an inefficient means of managing clinical time. The affordable use of an aircraft would strengthen this service immensely. Similarly, an aircraft doing this work could be used to transport patients to Tennant Creek for non-urgent clinical treatments and also to respond in an emergency if required.

351. The residents of the Barkly are very concerned about their health and safety in this remote area. TCH offers major security to the people of the district, and they are very concerned about the future of the hospital should its role be downgraded. At the same time, they see the presence of a medical aircraft in Tennant Creek as a major lifeline for them. Concern has, however, been expressed about the adequacy of the clinical outreach service currently provided. The community feeling in these matters is exceptionally high and vociferous. To retain people in rural Australia requires that every attempt be made to produce equality of access to good clinical services.

352. The Review also received advice from pilots and aircraft operators. Flying conditions in Central Australia can for many months of the year be difficult due to heat turbulence and thunderstorms. This means that ideally all-weather high altitude aircraft are best suited to these conditions. Most of the airstrips in the Barkly are all-weather operational, and many are night operational. Some have pilot operated lighting. Those without pilot operated lighting use flares that are manually placed and lit.

353. On the basis of the information gathered from Government, non-Government and community sources, the Review believes that the Department should set up a single point of aeromedical evacuation service coordination to manage the safe and efficient movements of patients by air, and to plan and monitor the most efficient use of resources in the Territory for these purposes.

354. The Department should appoint a single, Territory-wide coordinator for aeromedical activities to manage access, control and effectiveness of all aeromedical retrieval in the NT. The coordinator should be responsible for determining the most appropriate transportation option in the Barkly region, taking into account all the facilities that are available. The coordinator should have access to all current aeromedical resources, including those from Katherine, Alice Springs, and Mt Isa, as well as from Tennant Creek. The coordinator could work in conjunction with a coordinator of ground ambulance services with a view to integrated management of both aeromedical and ambulance assets in the interests of better public safety for Territorians.

355. In the first instance, patients transported out of the Barkly Tableland should preferentially go to TCH, unless the coordinator or referring medical practitioner deems otherwise. To this end, the current medical and nursing staff of TCH should be trained in aeromedical evacuation. With the expansion of the Services Closer to Home Program (discussed elsewhere in this Report), the range of services available at Tennant Creek is likely to expand, so reducing the need for aeromedical evacuation. For example, if affordable anaesthetist services were available at the

hospital, caesarean sections could be performed there, so obviating the need for many of the obstetrics-related evacuations.

356. The role and function of TCH in providing services to the Barkly Tableland should be reviewed to determine, for example, what obstetrics services (if any) should be performed at that hospital.

357. The aircraft currently based at Tennant Creek (or a suitable replacement) should be retained and be used to provide transportation for clinical and DMO outreach services to the Tableland, and should continue to be available for acute emergencies. The Tennant Creek aircraft should be fitted out as a medical evacuation aeroplane to provide more appropriate in-flight services to the ill. This situation should again be reviewed in two years. Wherever possible, pressurised aircraft should be used to transport compromised patients, which will require the use of aircraft based in Alice Springs, Mt Isa and Katherine.

**Principal and Supporting Recommendations:**

**The Review believes that the Department should set up a single point of aeromedical evacuation service coordination.**

The Department should appoint a single, Territory-wide coordinator for aeromedical activities to manage access, control and effectiveness of all aeromedical retrieval in the NT. The coordinator should be responsible for determining the most appropriate transportation option in the Barkly region, taking into account all the facilities that are available. The coordinator should have access to all current aeromedical resources, including those from Katherine, Alice Springs, and Mt Isa, as well as from Tennant Creek.

Patients transported out of the Barkly Tableland should preferentially go to TCH, unless the Coordinator or referring medical practitioner deems otherwise.

*Outreach Services*

358. Outreach services by visiting specialists and clinicians to remote communities are an essential component of the provision of services closer to home. These services have proved effective in ensuring that clinical services reach areas of significant need.

359. Respondents to the Review have drawn attention to a number of issues that require resolution, including:

- the need for better planning and coordination of specialist visits in order to maximise their effectiveness and patient reach,
- the problem of lack of backup in the acute care sector during outreach visits occasioning waiting list build-up,

- the infrastructure in place in some remote communities, and
- the divorce of outreach specialties from normal clinical responsibilities.

360. More effective integration of Territory, Commonwealth and community-based programs and interventions is clearly warranted. One case raised the need for better coordination between the Commonwealth, the Department and community organisations in relation to the provision of specialist outreach services, and concerns the provision of the specialist outreach program for ophthalmology. One clinician working within this program occupies a position administered through RDH with travel organised through the Specialist Outreach Service office at the hospital. The clinician spends around half his time at RDH and the other half in remote and rural areas in the Top End. He spends one week of every month in either Katherine or Gove, and makes two visits per year to virtually all of the remote communities in the Top End.

361. Under the National Indigenous Eye Health Program, the Aboriginal Medical Services (AMS) in Darwin Region (Danila Dilba), Katherine Region (Wurli Wurlinjang) and East Arnhem Region (Miwatj) received significant funding for Aboriginal Eye Health. This funding is administered through the Office of Aboriginal and Torres Strait Islander Health (OATSIH) in order to achieve the objectives of the Top End Eye Health Plan.

362. The principal focus of the Top End Eye Health Plan was that AHWs could screen for diabetic retinopathy, using digital fundus cameras. The goal was to ensure that every diabetic patient in the Top End would have a fundus photograph taken once per year. The photos were to be sent to the clinician concerned to be reported on so that follow up and laser treatment could be organised when necessary.

363. According to one respondent, each of the three AMS has received a \$150 000 digital fundus camera. For the past twelve months, they have each received funding to cover a full-time Eye Health Worker position and a travel budget to enable each Eye Health Worker to visit each community in each region twice per year.

364. The problem is that two of the four Aboriginal Medical Services that the Commonwealth Health Department funded to provide this service were not able to recruit staff able to use this equipment, while one service employed a staff member who was then required to spend the majority of their time on other priorities. In the fourth case a staff member was recruited and travelled widely throughout the Territory taking large numbers of fundus photographs.

365. The problem was confounded following the formation of the Top End Eye Health Working Group approximately six months ago in response to concerns about the Top End Eye Health Plan. The Group has representation from OATSIH, AMSANT, Danila Dilba, ATSIC, the Specialist Outreach Service and St. John Ambulance. In order to try to solve some of the problems, St. John Ambulance made an offer to donate three years funding for a full time Eye Health Coordinator to oversee the three Eye Health Workers and to resolve problems. A

suitable candidate for this position was selected four months ago however, the appointment, which was to have occurred through one of the Aboriginal Medical Services, has been delayed.

366. The respondent argues that when, in 2001, an Aboriginal Eye Health Worker position was administered through the Department, one AHW took approximately 1,000 photographs in a year. According to the respondent, the change in arrangements has resulted in virtually no photographs being taken in a year. The criticism able to be drawn from this lies partly with the Aboriginal Medical Services which did not respond to the new program funding but also with the Commonwealth for not coordinating its intervention with existing service infrastructure and with the NT Department for not protecting baseline service provision. Beyond this there is a clear appearance of at least one of the Aboriginal Medical Services deliberately choosing not to cooperate with the program, despite having agreed to do so. The Department and the Aboriginal Medical Services need to deal with these issues more effectively.

367. The Department should develop clinical plans to increase the availability in regional centres of some specialist services, and should review the program of outreach visits by clinicians to remote and isolated communities with a view to:

- increasing the frequency and destinations of such visits;
- maximising the effectiveness of the visits by developing better remote and isolated community infrastructure and by better planning in the communities for the visits;
- providing adequate backup in the acute care hospitals and elsewhere so as to avoid any increase in waiting lists as a result of outreach visits;
- better integrating the outreach program into clinical responsibilities; and
- phasing out reliance on discrete Commonwealth funding.

**Principal and Supporting Recommendations:**

**The Department should develop clinical plans to increase the availability in regional centres of some specialist services, and should review the program of outreach visits by clinicians to remote and isolated communities with a view to:**

- **increasing the frequency and destinations of such visits;**
- **maximising the effectiveness of the visits by developing better remote and isolated community infrastructure and by better planning in the communities for the visits;**
- **providing adequate backup in the acute care hospitals and elsewhere so as to avoid any increase in waiting lists as a result of outreach visits;**
- **better integrating the outreach program into clinical responsibilities; and**
- **phasing out reliance on discrete Commonwealth funding.**

## TeleHealth

368. There is a growing worldwide trend towards health care in or closer to home. TeleHealth is now widely recognised as the future of health care outside of the hospital system. For health care closer to home to succeed, patients should be able to be monitored almost as efficiently as if they were in a hospital or a doctor's surgery.

369. Under the TeleHealth models trialed and implemented in other Australian jurisdictions, neither patients nor their carers need possess computer skills, with monitoring being done using the standard telephone system. Those jurisdictions have found solutions that enable a very high level of quality care to be available to patients in the comfort of their own home. The approach is designed to enable a nurse or doctor to establish over standard telephone lines an audio-visual link to a patient in a remote location and to perform monitoring functions.

370. The clinician can:

- see and talk to the patient to evaluate them visually and aurally;
- listen to heart, lung and other bodily sounds using a telephonic stethoscope;
- take blood pressure, pulse, temperature and weight readings; and
- use a high resolution camera to examine wounds and dressings, for example, and to allow close monitoring of the healing process or of fluid retention etc.

371. Within Australia, TeleHealth is being used cost-effectively, not only for patient monitoring, but for a broad range of diagnostic and treatment applications including telepsychiatry, teleophthalmology, telecardiology, teleradiology, speech pathology, and others. It is also being used for intra-jurisdictional communication, for professional development of remote staff, and to provide access from remote locations to hospital-based events such as grand rounds.

372. The Review is aware that the NT made some attempt to examine TeleHealth some years ago, but that little or nothing resulted from that examination. The time is now ripe for a further look at this service modality. The possible benefits of a successful entry into the TeleHealth field include not only the provision of services closer to home in many cases but also the avoidance in so many cases of the dislocation and expense involved in travelling long distances for diagnosis, screening, monitoring and treatment.

373. It is doubtful that recruitment and retention problems can be addressed without the NT doing something special. Perhaps the adoption of the appropriate use of TeleHealth as well as recent advances in information technology could be harnessed in the interests of better health outcomes for Territorians by addressing remoteness in a way that would make the NT something special.

374. The Department should develop a business case for the implementation of TeleHealth in the NT. The business case should examine:

- the possibility of linking TeleHealth in the NT with the TeleHealth networks already established in other States (for example Western Australia and Queensland);
- the usefulness of TeleHealth for Territory-wide communication and staff training;
- existing infrastructure and its applicability for TeleHealth; and
- the possible clinical, social and financial benefits of TeleHealth for the NT.

**Principal and Supporting Recommendations:**

**The Department should develop a business case for the implementation of TeleHealth in the NT.**

The business case should examine the possibility of linking TeleHealth in the NT with the TeleHealth networks already established in other States (for example Western Australia and Queensland); the usefulness of TeleHealth for Territory-wide communication and staff training; existing infrastructure and its applicability for TeleHealth; and the possible clinical, social and financial benefits of TeleHealth for the NT.

### Call Centre

375. Another example of the application of telecommunications technology to the health and community services sector is the development in other parts of Australia of dedicated call centres.

376. Health call centres have been used to provide patients with a variety of health care services including information and advice about established health care problems, advice on managing an illness, support of chronic illness management, and for telephone triage to determine the level and timing of care needed. Internationally, significant growth has occurred involving this method of providing health care by health professionals that does not require face-to-face contact. Call centres have been part of health service provision for over a decade in the United States, since 1997 in the United Kingdom, and more recently in 1999 in Australia. It appears that call centres as a form of TeleHealth have been accepted as a legitimate part of the health care delivery network.

377. Use of call centres in the health and community services fields would facilitate immediate contact for people, especially those living in remote parts of the NT, with clinical and other professionals. It would enable advice and information to be sought over the telephone, would allow the introduction of nurse-based triage services, and could facilitate referral to available local general practitioners. In addition, call centres can facilitate the availability of translator services



for non-English speaking people including people whose principal or only language is an Aboriginal language, as well as providing first point of access to health information in languages other than English.

378. Among possible benefits are a reduction in levels of anxiety arising when advice is not readily available in particular health-related or personal/family circumstances, the availability of basic-level medical advice and the referral to the most appropriate clinical intervention if necessary, whether that be a local medical practitioner, a hospital, or an emergency service.

379. Telepsychiatry has been used for many years in Australia as a response to the remoteness of some communities and the difficulties associated with delivering mental health services face-to-face. Studies have reported high levels of consumer satisfaction, effectiveness of treatment, and reliability in assessment with telephone-based mental health services. Today, telephone-based mental health services are available to consumers and access is not contingent upon remoteness of residence.

380. Structuring telephone-based health care through a single point of entry is a growing trend and also has a number of advantages for the consumer. Algorithm-driven models of assessment and triage provide more consistent decision-making on consumer disposition, responsiveness and referral where appropriate. Call centres providing mental health advice, assessment and triage are staffed by clinicians experienced in the field of mental health.

381. A centralised triage line is a telephone assessment that may result in information and advice, support, direction, follow-up, problem identification and service solution provided by skilled health professionals with comprehensive information resource databases at their immediate disposal. It provides a single point of contact 24 hours, 7 days a week.

382. The services delivered by health call centres such as telephone triage and chronic disease management were initially promoted as forms of “demand management”. While this may be a key outcome of this type of service, call centres also fit comfortably into a technological society that has seen consumers embrace telephone transactions and the Internet.

383. The two primary aims of demand management are:

- patient education to achieve more appropriate use of the health system; and
- provider education with the goal of improving patient compliance.

384. The use of call centres for the management of chronic disease has gained momentum, particularly for diseases such as diabetes, asthma, and cardiac conditions. There are perceived benefits in chronic disease management as the patient learns how to manage his/her own illness, and is subsequently able to reduce the cost of health care via a combination of reduced admission rate, reduced length of stay and decreased presentations to emergency departments.

385. There is the potential to address some of the demand and disease management issues in the NT through the application of call-centre technology. These may include:

- limited access to after hours medical care;
- pressure on public hospital emergency departments;
- case management and continuity of care for people with chronic conditions;
- quick easy access to health information for the general public enabling improved self-management of health conditions; and
- access to general health care in rural and, particularly, remote areas of the NT.

386. A number of measures are used in evaluating the use and effectiveness of telephone triage and health advice lines, including:

- clinical outcomes;
- patient satisfaction;
- compliance with advice given; and
- changes in the caller's original intent.

387. Studies examining the clinical outcomes of telephone consultation have indicated no increase in the number of adverse events resulting from this form of intervention. In a recent evaluation of the United Kingdom system, NHS Direct, patient satisfaction levels were reported at 90 to 97 per cent.

388. Mental health triage and call centres are operated in Australia and in New Zealand. In Australia, the Greater Murray Accessline has been operating since 1998 and provides a 24 hour, 7 days per week mental health triage, information and referral service. An Australian study of telephone-based mental health services found levels of patient satisfaction in excess of 95 percent, although the sample was small. The consumers that responded rated staff professionalism, and the relevance of information provided as very high. A recent evaluation of the performance of Accessline has reportedly led to an extension of the contract for a further three years.

389. Emerging data from Mental Healthline, the centralised triage service operated in New Zealand, suggests that the application of an algorithm-driven triage model for mental health does assist in demand management and referral of consumers to appropriate levels of care in a timely fashion.

390. It is difficult to assess accurately the financial implications of demand management strategies on the cost of health care service delivery within the Australian health care system. In the current context, one means of ascertaining the true cost of telephone triage care is to determine the proportion of the total calls received that are triaged and redirected away from more costly face to face services to self-care, and conversely the proportion that utilise ambulance and emergency department services. Of course, the financial implications of call centres on the health system are dependent upon the cost of the care/intervention being recommended by the protocols.

391. Any expectation of short-term financial gain in the cost of health service delivery may be misguided. The true financial effects of any health promotion, prevention or self-management of chronic disease programs are not likely to occur until improved health outcomes in the community are recognised.

392. The NT should consider its capacity to utilise call centre technology to enhance its ability to deliver health advice and information services to remote regions of its catchment. There is scope to “piggy-back” onto the established service known as “Health Direct”. This call centre already has experience of the health needs of rural and remote areas of Western Australia.

393. The Department should develop a business case for a Health and Community Services Call Centre. The business case should:

- examine the possibility of the NT Call Centre being implemented through expansion of an existing service (for example in Western Australia or in Queensland);
- the Call Centre having broad usage including for health and community services information, referral to clinicians and service providers, nurse-based triage for after hours medical referral, etc; and
- access issues, including the availability of telecommunications infrastructure across the NT.

**Principal and Supporting Recommendations:**

**The Department should develop a business case for a Health and Community Services Call Centre.**

The business case should examine the possibility of the NT Call Centre being implemented through expansion of an existing service (for example in Western Australia or in Queensland); the Call Centre having broad usage including for health and community services information, referral to clinicians and service providers, nurse-based triage for after hours medical referral, etc; access issues, including the availability of telecommunications infrastructure across the NT.

### Hospital in the Home

394. Critical assessments of the role of long stay hospitals have been a feature of health. However, reassessment of the boundaries between home and acute hospital care has been less evident. The central position of hospital-based health care has been reinforced by several factors. These include:

- biomedical advances, including effective drug treatment and improved anaesthetic techniques;
- the advent of high technology medicine; and
- the need to rationalise the employment of specialised staff and expensive equipment.

395. Acute hospitals continue to dominate the health care picture both in terms of human and financial resources. With large numbers of specialist staff and complex technical facilities concentrated on site, hospitals obviously play a vitally important role within the health system.

396. However, increasing attention is now being paid to the idea of caring for seriously ill people at home by offering them intense domiciliary support for limited periods in order to avoid admission to hospital, or to keep their stay in hospital as short as possible. Interest in the concept of delivering the necessary care within the patient's home is being driven by a variety of factors, including:

- concern about the high overall cost of inpatient hospital care and long waiting times endured by many people needing non-emergency operations;
- the development of new technologies which make sophisticated home care more viable;
- improvements in housing standards;
- expressed patient preferences for home services, ranging from support for those with terminal illness through to maternity and child care;
- an expectation that for some people care outcomes will be enhanced by home nursing and allied provisions; and
- ageing of the population that will generate increased demands for acute levels of care.

397. The concept of hospital in the home involves the provision of intensive levels of care for acutely ill people in their own homes. This means bringing a hospital level of care to the home, supplying medical, nursing and rehabilitation services as well as social support and equipment. The concept began with the provision of services for people suffering from terminal cancer, but has subsequently been broadened to include:

- alternatives to hospital admission (eg in children and the elderly);

- achieving early discharge after hospital treatment (eg post-surgery);
- rehabilitation after acute illness (eg post-stroke);
- occasional intensive therapy within chronic illness (eg respiratory conditions); and
- domiciliary care for people with a terminal illness.

398. There is considerable scope for the further development of home based care, particularly in the areas of early discharge, rehabilitation, maternity care, mental health and terminal care. The challenge is to make sure that this new service potential is realised without, in the process, harming or reducing the elements of existing hospital provision that remain relevant to, and necessary for, meeting health care needs of Territorians.

399. Current arrangements in health care in the NT lead to an emphasis on service provision in Alice Springs and in Darwin, rather than on the provision of services in the communities. The Review believes that there is considerable opportunity to provide/increase services in regional centres and in the communities and thereby to avoid the social dislocation resulting from large numbers of people coming to Darwin or Alice Springs for health care. (See elsewhere in the Report for additional discussion under *New Clinical Services – A Cautionary Note*)

3100. One current Hospital in the Home Service (HITH), that at Royal Darwin Hospital (RDH), was developed in mid-1999. A patient admitted to HITH is admitted as a public inpatient, and medical care, radiology and pathology, pharmaceuticals, and consumable products are provided by the hospital. Two nurse coordinators located in the HITH Clinic at RDH coordinate the care. An infectious disease specialist is attached to the service. Patients are referred to HITH by RDH consultants, the Emergency Department or by their general practitioner. The HITH nurses coordinate care and patients return to RDH for follow up appointments with the infectious diseases team, and/or with a surgical or medical team providing care. Outside of hospital, care is provided by nurses from Casuarina Community Care Centre, Palmerston Community Care Centre and the After Hours Community Care Service. Care may be delivered in the patient's home, at the Self Care Unit, in hostels, hotels and caravan parks.

3101. Since the introduction in 1999 of the HITH Service, the numbers accepted on to the program have reduced from 321 patients in 1999 to 255 patients in 2001. There is under-utilised capacity within the service. A contributing factor is the present system for the provision of nursing care. The need to refine and expand the service is clear. As an example, catheter changes could be carried out by the HITH Service. Patients currently attend the Emergency Department to have a catheter changed. They are often picked up and transported to the hospital, then wait for treatment, and are eventually transported home. This is inefficient and inconvenient for patients. A 15-minute procedure takes hours of a patient's time when the catheter change could have been made in the patient's home.

3102. The Department should review, and then expand and increase the effectiveness of its HITH Program by earlier involvement in and better use of discharge planning, and by identification of ways whereby HITH services can be made more widely available to Territorians living outside urban areas.

3103. The Department should also, in the context of hospital in the home and in the interest of more cost-effective service provision, develop a more strategic approach to pre- and post-hospital admission management, encompassing the establishment of Aboriginal-specific step-down facilities, increased provision of overnight beds associated with day surgery, maximum use of home and community dialysis, and improved palliative care.

3104. More effective use should be made of community nurses, especially in the HITH program, by utilising, where appropriate, other staff to undertake the non-nursing duties currently performed by community nurses.

**Principal and Supporting Recommendations:**

**The Department should expand and increase the effectiveness of its HITH Program by earlier involvement in and better use of discharge planning, and by identification of ways whereby HITH services can be made more widely available to Territorians living outside urban areas.**

The Department should also develop a more strategic approach to pre- and post-hospital admission management, encompassing the establishment of Aboriginal-specific step-down facilities, increased provision of overnight beds associated with day surgery, maximum use of home and community dialysis, and improved palliative care.

More effective use should be made of community nurses, especially in the HITH program, by utilising, where appropriate, other staff to undertake the non-nursing duties currently performed by community nurses.

## Chapter 4: Effective Management and Governance

401. Adding to the impact of fragmentation is the fact that departmental management has, for the past five years or so, been adversely affected by a series of factors.

402. Among these adverse circumstances we include:

- a constant succession of relatively short term incumbents of the office of CEO (with more than five CEOs or acting CEOs in the past five years);
- lack of budget discipline;
- organisation of “silos” that requires a convoluted and generally ineffective interlocking network of senior level executive and standing committees;
- poor linkages between strategic directions, purchasing plans, and budgets;
- too few people trying to do too much, with too many people doing little of relevance to the priorities and objectives of the Department; and
- everyone responsible for everything, but nobody accountable for anything.

### *Tenure of Chief Executive Officer*

403. The serial engagement of five successive CEOs in the past six years has clearly hampered the management of an already unwieldy administration. The Review has formed the very firm conclusion that the incoming CEO should be given a clear expectation of job security for the term of his/her contract of appointment. He/she should also be given a clear mandate to manage the Department within a framework of the Government’s policy and budget. A departmental officer should be appointed as Executive Officer to the CEO.

### **Principal and Supporting Recommendations:**

**The incoming CEO should be given a clear expectation of job security for the term of his/her contract of appointment and be given a clear mandate to manage the Department within a framework of the Government’s policy and budget.**

### *Executive*

404. Respondents frequently submitted to the Review that the current Executive has too many members, and that its role is mirrored by mini-executives in the Regions/Districts and in service networks. It is argued that its decision-making capacity is hobbled by a plethora of quasi-decision-making standing committees, membership of each frequently overlapping with that of

the Executive and with each other. There is a perception of a lack of acceptance of personal responsibility by members of the Executive.

405. The effects of confused and dissipated top-level administration have resulted in budget blowouts and planning blunders. The Department has, as one respondent put it, suffered organisational change without progress.

406. This is not to say that the Executive has not, in the past five years, guided the development of some good policy initiatives. Worthy of note in this context is the chronic disease strategy, coordinated care trials, responsible alcohol/smoking initiatives, some of the nursing recruitment strategies, the policy on Aboriginal employment etc. Development of policy is one thing; successful implementation is another. Progress in implementation has been very poor, staff do not have a sense of a united team and the leadership of the Executive has not been strong.

407. The Review is convinced that significant progress towards quality improvement in the development and delivery of services will require a streamlined management and the elimination of the current arrangement of standing committees, together with other reforms canvassed elsewhere in this Report.

408. Obviously, the incoming CEO will need to create his/her own Executive team. There will, therefore need to be some flexibility in the arrangements adopted. The Review has taken the opportunity to present its views in order to assist the CEO.

409. The Department's Executive should be smaller, should have clearly-defined areas of responsibility and accountability, and should assist the CEO in the management of the Department's service delivery, financial operations, budget processes, and overall management and performance.

410. The Executive should meet weekly for a maximum of two/three hours, be chaired by the CEO, and operate in accordance with agreed and published Business Rules.

411. The Executive should be streamlined to consist of seven persons:

- the CEO;
- the Assistant Secretaries responsible for acute care, health services, community services, and corporate services (discussed elsewhere in this Report);
- the Principal Medical Adviser; and
- the Executive Director of the Office of Aboriginal Health and Service Support (discussed elsewhere in this Report).



412. One of the Assistant Secretaries should be appointed Deputy Secretary of the Department.

**Principal** and Supporting Recommendations:

**The Department's Executive should be smaller, should have clearly-defined areas of responsibility and accountability, and should assist the CEO in the management of the Department's service delivery, financial operations, budget processes, and overall management and performance.**

The departmental Executive should consist of seven persons: the CEO; the Assistant Secretaries responsible for acute care, health services, community services, and corporate services; the Principal Medical Adviser; and the Executive Director of the Office of Aboriginal Health and Service Support.

One of the Assistant Secretaries should be appointed Deputy Secretary of the Department.

*Strategic Management Group*

413. This Report has, elsewhere, canvassed the need to involve both consumers and service providers in the processes of policy development and service delivery, and has recommended mechanisms to achieve this aim. It has also dealt separately with the need to establish a small, highly focused Executive to assist the CEO in the management of the Department.

414. There remain two further requirements.

415. First, there should be included in the policy mechanisms other important departmental officers who are not to be members of the Executive but who have an essential role to play in both the management of aspects of the Department's activities and in the policy development and service delivery processes. These are the Principal Nursing Adviser, the Principal Aboriginal Health Worker Adviser, the Principal Psychiatrist, and the General Manager of RDH.

416. Our view is that these senior professional positions should not form part of the departmental Executive. Nonetheless, the desirability of facilitating input to the departmental Executive from these four officers supports our argument for the establishment of an on-going mechanism separate from, but feeding into, the Executive.

417. Second, some means should be found to draw together the various consultative and managerial elements that the Review has recommended.

418. The Department should establish a Strategic Management Group to assist the CEO in driving and directing the policy development and business planning processes of the Department.

419. The Strategic Management Group should meet monthly, be chaired by the CEO, and operate in accordance with agreed and published Business Rules.

420. It should be comprised of:

- the members of the Department's Executive, together with
- the Chairs of the Health, the Family and Children's Services, and the Disability Services Advisory Councils;
- the Chairs of the Clinical and the Professional Reference Groups;
- the Principal Nursing Adviser;
- the Principal Aboriginal Health Worker Adviser;
- the Principal Psychiatrist; and
- the General Manager of RDH.

421. Given the size of the budget allocation to RDH relative to the total departmental budget, the Review has concluded that the General Manager of RDH should be a member of the Strategic Management Group.

422. The Review supports the retention/creation of senior, high-level positions of Principal Psychiatrist, Principal Nursing Adviser, and Principal Aboriginal Health Worker Adviser.

423. In the provision of specialist advice to the CEO and to the Executive, the roles of the Principal Psychiatrist, the Principal Nursing Adviser and the Principal Aboriginal Health Worker Adviser are significant. We see these three senior officers working in concert with the departmental Executive to develop innovative ways of better using the staffing resources available to the Department in the furtherance of the Government's policy objectives.

424. The Principal Psychiatrist should be responsible for the maintenance of and adherence to quality mental health standards throughout the NT (see elsewhere in this Report for further detail).

425. The Principal Nursing Adviser should be responsible for the maintenance of and adherence to high quality nursing standards throughout the NT. This officer should also have a particular responsibility to collaborate with the Principal Aboriginal Health Worker Adviser in ensuring that nurses and AHWs move towards a more robust and effective partnership in the provision of health care to Territorians.

426. The Principal Aboriginal Health Worker Adviser position should not be held in conjunction with any other position in the Department. The position should be responsible for

the maintenance of and adherence to high quality AHW standards throughout the NT, and should play a significant role in maximising the effectiveness and contribution of AHWs across the Territory.

427. We also consider that the incoming CEO should retain scope to determine, in consultation with the Minister, the final form of the Strategic Management Group.

**Principal and Supporting Recommendations:**

**The Department should establish a Strategic Management Group to assist the CEO in driving and directing the policy development and business planning processes of the Department.**

The Principal Psychiatrist should be responsible for the maintenance of and adherence to quality mental health standards throughout the NT.

The Principal Nursing Adviser should be responsible for the maintenance of and adherence to high quality nursing standards throughout the NT, and should have a particular responsibility to collaborate with the Principal Aboriginal Health Worker Adviser in ensuring that nurses and AHWs move towards a more robust and effective partnership in the provision of health care to Territorians.

The Principal Aboriginal Health Worker Adviser position should not be held in conjunction with any other position in the Department but should be responsible for the maintenance of and adherence to high quality AHW standards throughout the NT, and should come to play a significant role in maximising the effectiveness and contribution of AHWs across the Territory.

*Principal Medical Adviser*

428. The Review supports the creation of a senior, high-level position of Principal Medical Adviser as a member of the departmental Executive.

429. The Principal Medical Adviser should be vested with the statutory powers and responsibilities of the CHO under NT legislation and subordinate legislation (except those relating to public health). This officer should be responsible for the maintenance of and adherence to high quality clinical standards throughout the NT. This position should incorporate the responsibilities of the current Principal Medical Consultant.

**Principal and Supporting Recommendations:**

**A senior, high-level position of Principal Medical Adviser should be created and should be a member of the departmental Executive.**

The Principal Medical Adviser should be vested with the statutory powers and responsibilities of the CHO under NT legislation and subordinate legislation (except those relating to public health).

The Principal Medical Adviser should be responsible for the maintenance of and adherence to high quality clinical standards throughout the NT.

The Principal Medical Adviser position should incorporate the responsibilities of the current Principal Medical Consultant.

### Reference Groups

430. Significant systemic reform can be achieved only if ways can be found to change clinical/professional behaviour. If doctors and other clinicians/professionals in the health and community services sectors are unwilling to change what they do (eg. where they work; how they work; who they work with) there is little prospect of effecting significant change.

431. Effective change requires identification of responsibility for the corporate agenda, even agreement on the definition of 'corporate'. In the Department, no group or collection of individuals can take responsibility for the corporate agenda without major clinical/professional input.

432. This statement, of course, begs the question: do enough clinicians/professionals understand what it means to 'look after the corporate agenda', including concepts of taking the broader view in order to manage trade-offs in an informed way, balancing continuous improvement and transformational change, scanning the horizon, harnessing emergence, etc?

433. If clinicians/professionals engaged in delivering primary and community care cannot be persuaded to contribute to the critical mass necessary to exercise system-wide stewardship, the focus will remain on hospital-based services. There is no one other than clinicians/professionals to educate officialdom. If, then, a critical mass of clinicians/professionals are willing to take some responsibility for system stewardship, they will 'make deals' with officials in the Department. A means, therefore, has to be found to enable the two groups to come face to face.

434. It is, therefore, in the best interests of the Department to identify and establish mechanisms whereby clinicians and community services professionals can be engaged in the change process. One such means is through senior-level consultative or reference committees.

435. Two Reference Groups should be established to provide an opportunity for health and community services practitioners to have input to and participate in the Department's policy and planning processes: a Clinical Reference Group, for the health sector; and a Professional Reference Group, for the community services sector.

436. They will apply a common function to their specific areas of interest and expertise. That function is to provide a strategic, impartial perspective to the CEO on the Department's strategic planning, priority setting and investment areas.

437. Each Reference Group should report to the CEO and consist of members appointed by the CEO. Each should be chaired by a clinician/community services professional as appropriate, and include in its membership clinicians/community service professionals drawn from within the Department and from the non-Government sector. Each should operate in accordance with agreed and published Business Rules.

438. The consultative or reference committee model is based on the concept of clinical governance which is emerging as the most robust overarching framework for reducing risk in many centres throughout Australia and in many Western Countries. The model is based on four premises. First, clinicians/professionals are the best people to oversee and deliver changes in clinical or professional practice. Second, senior management and clinicians / professionals working in partnership are likely to be far more effective than either group acting on their own. Third, it makes sense to bring the talent and intelligence of the clinical and community services professions to bear on the Department's strategic change agenda. Fourth, if clinicians and professionals understand the rationale for change and are centrally involved in shaping it, they are likely to be effective advocates for that change.

439. An effective consultative or reference committee should consist initially almost solely of clinicians/professionals. It should be large enough broadly to represent all interests and significant strands of opinion and consist of individuals who are respected and trusted by their peers and therefore can exercise effective leadership. While being seen to be very influential, it should be located outside the formal management structure.

440. It is almost certain that they will, to some extent at least, fail in addressing the real issues unless they receive some astute help over, say, the first six months. They will need ideas, possible models, facilitation, cajoling, encouragement, pressuring, and the like.

441. The most effective consultative or reference committees are established on the explicit understanding that they represent an opportunity for senior management and the clinical or professional corps to strike a bargain that will empower both parties, and that they exist to promote the corporate (i.e. whole organisation) interest. The consultative or reference committees are not therefore a representational or advisory body, but exist to take decisions and to follow them through. They should consist of individual clinicians/professionals that are respected, trusted, capable of representing and promoting the corporate interest, and capable of exhibiting leadership. They can be effective only if the relationship between management and the clinical/professional corps is based on honesty and mutual respect.

442. As well as members of the clinical specialties, public health physicians should be involved in the change process that will emerge from the introduction of a clinical governance model into the NT. These physicians are a dispersed group, working in a number of locations, units and programs. Some work as managers, with responsibility for both budget and program outcomes. In order to ensure that the needs and interests of all Territorians are put forward and appropriately addressed, it would be of benefit to utilise the expertise and diversity of the public health physicians currently working in the NT. They are, by definition and training, involved in and advocates for the health of populations, yet most of them are currently only marginally and sporadically involved in governance, which consists after all of the processes which determine the Department's engagement with the Territory's population. It is important to emphasise, particularly in this context, that public health physicians are clinicians, and thus distinguished from other public health professionals by their medical and clinical knowledge and practice. Clinical considerations influence their interpretation and implementation of policy, at whatever level of the organisation they work. Public health physicians should therefore engage with this process, and bring their experience and expertise to bear on the policy and decision making process.

443. There should, as well, be systematic development of clinical plans that reflect the actual health needs of Territorians. These clinical plans should accommodate the different roles of the Territory's clinical centres, delineate roles within those centres, and identify the appropriate relevant workforce required.

**Principal and Supporting Recommendations:**

**Two Reference Groups should be established to provide an opportunity for health and community services practitioners to have input to and participate in the Department's policy and planning processes: a Clinical Reference Group, for the health sector; and a Professional Reference Group, for the community services sector.**

There should be a systematic development of clinical plans that reflect the actual health needs of Territorians, that accommodate the different roles of the Territory's clinical centres, that delineate roles within those centres, and that identify the appropriate relevant workforce required.

Executive Services

444. The Department's Executive and its Strategic Management Group (discussed elsewhere in this Report) should be supported by a dedicated secretariat. For that reason, an Executive Services Branch should be created, headed by a General Manager. The General Manager of the newly created Executive Services Branch should attend Executive meetings with responsibility to provide a secretariat to the Executive.

445. In addition to its Executive secretariat functions, the Executive Services Branch should be responsible for monitoring compliance with Executive decisions and compliance with the Department's business planning, resource allocation, and budget processes.

446. The Branch should provide the secretariat for the three Consumer Councils and the two Reference Groups (discussed elsewhere in this Report). It should also manage the Executive suite, and accept responsibility for recruitment, management and development of Executive administrative staff, and management of the Executive's budget, travel, IT and other administrative services.

447. It would be appropriate for the Branch to be responsible for the Department's media relations and public affairs activities. All media and public relations personnel currently based in hospitals and elsewhere outside the Department's head office should administratively be transferred to and become the responsibility of the Executive Services Division, and be integrated into the consolidated media unit that will form part of this Branch. The Branch should be responsible for internal communication with departmental staff throughout the Territory.

448. The Review attempted, unsuccessfully, to obtain accurate information on consultancies undertaken in and for the Department. It would appear that no central register of consultancies is maintained. To enable the CEO as accountable officer to fulfil his/her obligations pursuant to the *Financial Management Act*, the *Procurement Act*, and the relevant procurement processes, the Executive Branch should establish and maintain an accurate, up-to-date register of all consultancies undertaken in and for the Department.

**Principal and Supporting Recommendations:**

**The Department's Executive and its Strategic Management Group should be supported by a dedicated secretariat.**

The Executive Services Branch should be responsible for monitoring compliance with Executive decisions and compliance with the Department's business planning, resource allocation, and budget processes.

The Executive Services Branch should provide the secretariat for the three Consumer Councils and the two Reference Groups.

The Executive Services Branch should be responsible for the Department's media relations and public affairs activities, and for its activities in relation to freedom of information, privacy and legal support.

Consolidation of Legal and Quasi-legal Functions

449. The projected introduction of Freedom of Information (FOI) legislation and the relatively recent enactment of amendments to the Commonwealth Privacy Act bring with them new demands on the Department. Each of these developments is likely to generate considerable public interest, and demands transparency and responsiveness in terms of access to the Department.

450. The establishment of a small FOI Unit within the Department would be more cost-effective if it was to be co-located with other legal and quasi-legal elements of the Department. These include the Privacy Section, Internal Complaints Resolutions Section, the Department's Legislation Officer, the Chief Health Officer's (CHO) Legal Policy Adviser, and the Legal Support Section.

451. Such an arrangement would also contribute to the management of the legal and legislative responsibilities of the Department. Of course, all professional legal advice should continue to be outsourced, either to the Department of Justice or to private legal firms within the NT.

452. This FOI, Privacy and Legal Support Section should form part of the Executive Services Branch.

453. An issue brought to the attention of the Review concerned the number of matters being settled without legal advice. All settlements should be made on legal advice, with delegations and departmental rules being reviewed to bring about that result. In all litigated claims, settlements are recommended by the Department's external legal advisers and are approved by both the Department of Justice and the Department. Not all unlitigated claims are referred to the Department of Justice. This should be reviewed, as some major claims can be unlitigated. Some major unlitigated claims are pursued through the Health and Community Services Complaints Commission. If advice is not sought, settlement costs can be excessive.

**Principal** and Supporting Recommendations:

The Freedom-of-Information Section should be co-located and integrated with the following parts of the Department: the Internal Complaints Resolutions Section; the Department's Legislation Officer; the CHO's Legislation Policy Adviser; and the Legal Support Section.

Ministerial, Cabinet and Parliamentary Liaison

454. From its own observations and discussions with staff in the Department and in the Minister's Office, the Review has formed the view that the General Manager of the Ministerial, Cabinet and Parliamentary Liaison Branch should continue to report directly to the CEO.



455. The Ministerial, Cabinet and Parliamentary Liaison Branch should be responsible for the provision to the Minister and to her Office of:

- timely and accurate briefings on all matters relating to the Minister's exercise of her ministerial responsibilities, including submissions, proposals and recommendations from the Department;
- Question Time, Estimates Committee, and other Legislative Assembly briefings; and
- current and controversial issues briefings.

456. The Branch would also be responsible for:

- maintaining high standards of presentation and accuracy in materials forwarded by the Department to the Minister;
- coordinating the preparation of draft replies to ministerial correspondence;
- organising and providing briefings to the Minister in preparation for meetings and events to be attended by her;
- coordinating the attendance of relevant departmental officers at meetings attended by the Minister which relate to departmental functions and responsibilities;
- ensuring that the Department's media staff collaborate closely in an effective working relationship with the Minister's Media Adviser;
- preparing speeches for the Minister; and
- coordinating the provision of material to assist the Minister in her dealings with the media.

457. In addition, the Branch should continue to accept responsibility for coordinating all matters relating to Ministerial Councils of which the Minister is a member.

458. One of the key responsibilities of the Department is to provide services to the Minister and the Government of the day. In discharging this responsibility, the Department should undertake a number of key functions. These include the provision of specialist, technical and portfolio-related advice to the Minister, and ensuring that commitments made and decisions taken by the Minister are discharged promptly and accurately.

459. In order to facilitate this aspect of the Department's responsibilities, it is essential that an appropriate departmental officer be present at all meetings between the Minister and external stakeholders (except, of course, where those meetings relate to the Minister's political role as a member of the Government party or to her parliamentary role as Member for Nightcliff). The role of the departmental officer at such meetings should be to provide relevant advice to the

Minister prior to the meeting (by way of written brief), to advise the Minister as and when requested during the meeting, to note any decision or commitment made by the Minister during the meeting, and to ensure that all decisions taken or commitments made at the meeting are followed up and implemented promptly and accurately.

460. The judgement as to when officers are to attend meetings between the Minister and external stakeholders should be taken by the Head of the Minister's Office; the decision as to which departmental officers should attend any such meetings is one which should be taken by the CEO in consultation with the Head of the Minister's Office.

**Principal and Supporting Recommendations:**

**The Ministerial, Cabinet and Parliamentary Liaison Branch should be responsible for the provision to the Minister and to her Office of timely and accurate briefings on all matters relating to the Minister's exercise of her ministerial responsibilities, including submissions, proposals and recommendations from the Department; Question Time, Estimates Committee, and other Legislative Assembly briefings; and current and controversial issues briefings.**

*Internal Communications*

461. The Review has identified a very serious weakness in current arrangements with respect to internal communication in the Department. Communication of decisions and policies to departmental staff appears to us to be somewhat haphazard and uncoordinated.

462. Respondents have put to the Review that there are few links of formal communication and a lack of effective frameworks for policies to be communicated to operational staff. Both vertical and horizontal lines of communication need improvement. Respondents have said that the Department does not have particularly good communication systems, either vertically or laterally. Whilst information may pass from the Executive to Senior Managers, it seems that it does not necessarily pass further than that.

463. Standard operating procedures need to be developed to ensure that all staff are made aware of decisions of management and departmental procedures. Departmental communication requires active management. Staff, especially at the operational level, need to be kept informed of and consulted about relevant projects, departmental changes, policy or strategy development. Electronic communication alone is not sufficient.

464. Development of and adherence to a fast and effective system of communication with staff would serve to improve departmental cohesion, consistency and morale, and would lead to a more uniform approach to decision making and service delivery.

465. For that reason, an internal communication process should be put in place to enable the CEO to ensure that all staff in the Department are kept directly, regularly and fully informed about decisions of the Department's Executive, the development of policy, and significant events.

**Principal and Supporting Recommendations:**

**An internal communication process should be put in place to enable the CEO to ensure that all staff in the Department are kept directly, regularly and fully informed about decisions of the Department's Executive, the development of policy, and significant events.**

*Departmental Committees*

466. The Department has established a number of committees and working groups to assist it in its operational and strategic activities. Officers also participate in extra-departmental committees and working groups. A previous review<sup>1</sup> recommended that the rationale for continuation and the focus of departmental committees should be examined and, where appropriate, they should be wound up.

467. No examination of participation in departmental and external committees has been undertaken by the Department since that recommendation was made, nor has action been taken to wind up unnecessary committees. Work undertaken by the Review suggests that multiple committees still exist, and that current committee membership is not always strategic, nor at an appropriate level. The rigorous examination of departmental committees and working groups previously recommended should be undertaken.

**Principal and Supporting Recommendations:**

**The rigorous examination of departmental committees and working groups previously recommended should be undertaken.**

*Previous Reviews*

468. There have been two major Reviews of DHCS in the past decade: the CRESAP Review (1992) and the Parker Review (1999). Despite the fact that the Government spent upwards of \$1M on those two Reviews, their implementation was extremely patchy. Some recommendations were implemented in full; some were implemented in part; many were ignored. Of those that were implemented in full or in part, some have been undone.

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<sup>1</sup> Review of Services and Structure of Territory Health Services: Ron Parker, June 1999

469. The recommendations of the CRESAP and Parker Reviews are at Appendices 2 and 3 respectively.

470. The Department should re-examine its response to the recommendations arising from both the CRESAP and the Parker Reviews in the context of the organisational and service delivery recommendations of the current Review, and ensure that each of the recommendations made by the previous Reviews have been properly considered and, if still appropriate, implemented.

471. There is a history within the Department of individual divisions, programs or services commissioning reviews without adequate justification and without any attempt to align the results of the review with the strategic directions of the Department. In most cases, the results of reviews are not implemented. This is costly and often disruptive to the operations and effectiveness of the Department. The departmental Executive should approve any future review proposed to be conducted by consultants or personnel external to the Department prior to their being undertaken.

**Principal and Supporting Recommendations:**

The Department should re-examine its response to the recommendations arising from both the CRESAP and the Parker Reviews in the context of the organisational and service delivery recommendations of the current Review, and ensure that each of the recommendations made by the previous Reviews have been properly considered and, if still appropriate, implemented.

**The departmental Executive should approve any future review proposed to be conducted by consultants or personnel external to the Department prior to their being undertaken.**

## Chapter 5: Creating Transparent and Responsive Partnerships

501. In our consultations, some respondents said of the Department that it was “secretive”, “insular”, “risk adverse”, “not to be trusted”, “possessed of a bunker mentality”. Others complained that they “do not know who to speak to”.

502. These views of the Department were put to us in good faith, and reflect an organisation where the community, service providers, and the agencies of Government have lost faith in its capacity to perform.

503. Our own observation reveals an organisation that is no longer prepared to take risks. It tries to tie up all the loose ends before it gets into discussion with outsiders, leading to the criticism that it is insular and not receptive to outside ideas. Alternatively, it enters into discussions but is not prepared to take a position or contribute, leading to criticism that it is secretive and not informed.

504. To change the current perception will require strong leadership and a commitment to the values of openness and responsiveness at all levels of the Department. Without that commitment the measures recommended will fail.

### Advisory Councils

505. Community input into the Department’s operations was one of the issues most commonly raised during the Review’s consultation phase. Many of the people who responded to the Government’s invitation to make oral and/or written submissions to the Review drew attention to the lack of effective machinery to enable consumers and service providers to have input into the Department’s policy development and service delivery processes. They identified many areas within the health and community services sectors where the Department and the Minister could take advantage of the skills and expertise of Territorians external to the Department. These opportunities have not been taken up sufficiently.

506. Overall, there appears to be too little community participation in departmental processes. Where there is input, it is, in most instances, limited to relatively small projects. Even where it occurs, community involvement is often no more than a response to requirements set down by the project funder, usually the Commonwealth. The community health sector appears to have the highest community involvement from both an operational and a program perspective. There appears to be minimal community involvement in the acute care sector, despite national and international trends for greater involvement in this area. The community services and the non-acute health services sectors also have limited community involvement.

507. There is a confused understanding of just what defines a “consumer”, as well as a perception that the existing, limited consumer representation may not appropriately reflect the

actual consumer mix for given services and, in particular, may not enable Aboriginal consumers' voices to be heard.

508. There is currently a greater involvement in departmental committees by representatives from other Government agencies, from non-Government service-provider organisations, and from Commonwealth departments than from actual consumers. The use of such representatives, or of departmental staff from areas other than that directly convening the committee, is not a substitute for consumer input.

509. Nonetheless, in many instances the appropriate use of such representatives does enable the Department to tap into relevant knowledge and skills, and to be proactive in its approach to issues of concern. For example, representation from the Department of Corporate and Information Services (DCIS) and the trade union movement is appropriate for inclusion on human resource related committees.

510. Advice to the Minister can be enhanced by direct contact with consumers and service providers selected to reflect a cross section of interests and experience. Traditionally, the relationship between health/community service providers and consumers has been one of expert to patient/client. However, the need for them to engage together and to work with Government on planning and priorities is essential if sound health strategies are to be developed and implemented.

511. The Government has already undertaken to "establish a Health Council consisting of urban and regional practitioners and specialists, with representatives from nurses, industry bodies and unions". It has also undertaken to establish a Family Services Advisory Council "consisting of representatives of a range of non-Government agencies, including Aboriginal family support agencies, representatives of the broader community, local Government". The Review fully supports this general approach.

512. An informed and representative advisory council could be an important mechanism for consumers and service providers to advise the Minister in the planning and evaluation of NT health and community services. An advisory council is a collection of individuals who bring unique knowledge and skills that complement the knowledge and skills of those who govern the organisation. Such a council would have no formal authority to govern or to issue directives to the organisation. However it would make recommendations and/or provide key information to the Minister.

513. The role of an advisory council would be to provide advice to the Minister on health system matters and to address health and community services needs, to understand the issues, focus on priorities, balance alternative approaches and recommend solutions and actions.

514. There should be increased community involvement in the Department. Given the scope of the Department's activities, the Review has concluded that the original proposals to establish a

‘Territory Health Council’ and a ‘Family Services Advisory Council’ should be reviewed, and modified as discussed below.

515. Increased community involvement should facilitate input into the principal areas of the Department’s responsibilities: health, family and children’s services, and disability services. Three Councils should be established to provide an opportunity for input into the Department’s policy development and service delivery processes:

- a Health Advisory Council;
- a Family and Children’s Services Advisory Council; and
- a Disability Services Advisory Council.

516. Each of the three Advisory Councils should report to the Minister through the CEO. Members should include persons representing the interests of consumer and service provider organisations and individual consumers and service providers, and an independent Chair, all of whom should be appointed by the Minister following a process of advertising for expressions of interest. Each Council should include ex officio members drawn from relevant areas of the Department.

517. The Chair of each Council should represent the Council on the most senior departmental policy and strategic planning forums. Councils should operate in accordance with agreed and published Business Rules. A small common Secretariat should be established to support all three Councils.

518. The three Councils will apply a common function to their specific areas of interest and expertise. That function is to provide a strategic, impartial perspective to the Minister on the Department’s strategic planning, priority setting, and investment/disinvestment decisions.

519. Where appropriate, other advisory or consultative bodies should be created to bring together relevant departmental officers and members of the community with relevant expertise, with the bodies reporting to the appropriate Advisory Council. In this way, the Department would engage in ongoing community consultation, while at the same time ensuring that the community itself gains knowledge and a sense of ownership of the policy and service delivery directions taken by the Department. Areas suggested for this approach include mental health, HIV/AIDS and hepatitis, aged care, childcare, and youth services.

**Principal** and Supporting Recommendations:

**There should be increased community involvement in the Department.**

Three Councils should be established to provide an opportunity for input into the Department's policy development and service delivery processes: a Health Advisory Council; a Family and Children's Services Advisory Council; and a Disability Services Advisory Council.

Other advisory or consultative bodies should be created to bring together relevant departmental officers and members of the community with relevant expertise.

*Peak Bodies*

520. There are currently few peak bodies in the NT, and they are generally not well resourced. Peaks could play a key role in developing, supporting, and resourcing consumer groups.

521. It was suggested to the Review that, for example, the funding of the NT Youth Affairs Network would aid the establishment and resourcing of a youth advocacy group or forum. The Network is currently funded through a grant provided by the Department to the Darwin City Council. The Network is advocating to be funded as the peak body for youth affairs, now a responsibility of the Chief Minister, having been moved from the Department some years ago but with the historical funding arrangements remaining. The question to be resolved is whether the Network should be a separate peak or should be linked with another peak like the Northern Territory Council of Social Services (NTCOSS). The Review sees the resolution of this particular issue as being outside its terms of reference.

522. Similarly, it has been argued in submissions to the Review that a contribution to the funding of the Multicultural Council of the NT could enable that organisation to play a key role in consumer advocacy in the health area. Multicultural affairs, too, is a responsibility of the Chief Minister's Department, and so this particular question also falls outside the Review's terms of reference.

523. There are, of course, consumer advocacy groups in existence, including in the mental health, aged care, and disability areas. The Review has noted current work to establish consumer health bodies in both Alice Springs and Palmerston, and to establish a foster carers group. These are not, however, peak bodies in the sense that the Review has in mind.

524. DHCS funds the Council on the Ageing as a peak. Yet the Council deals with many issues outside the scope of the Department and which are whole of Government issues and even cross Government issues (for example, Commonwealth aged care, income security, and taxation issues etc). Moreover, the Office of Senior Territorians is a responsibility of the Chief Minister.



525. NTCOSS considers that it has a role to play in supporting consumer organisations. The Council has taken an active part in the past in establishing services and peak groups where there are identified gaps/needs. NTCOSS has indicated its willingness to undertake further development work in this area. The Review supports such an expanded role for NTCOSS.

526. The Government's new Social Development Strategy is to be coordinated and developed through the Chief Minister's Department - the Review suggests this framework as the most appropriate to resolve the issue of an overarching peak body. Economies of scale mean that the NT cannot afford to establish a whole range of separate peaks, yet there is still a need for sectors to meet as sectors and to discuss their unique issues. There are, nevertheless, many issues that cross sectoral boundaries (for example, indexation, insurance, viability, governance, and management support for small non-Government organisations etc.) which would profit from a common approach.

527. In this context, the Review proposes that Government consider whether NTCOSS should be funded through the Chief Minister's Department as the umbrella Peak, with responsibility to provide co-located and accessible office accommodation and services, together with administration and financial management, for the sectoral peaks in the NGO sector. These smaller sectoral peaks would operate as partner peaks with NTCOSS. They would receive funding (other than for administration and management) from their respective Government agencies. In this way, Shelter would be funded through the Department of Housing, the Youth Affairs Network through the Office of Youth Affairs, the Council on the Ageing through the Office of Senior Territorians, the Australian Council for Rehabilitation of Disabled (now the National Industry Association for Disability Services) through DHCS, the Multicultural Council of the Northern Territory through the Office of Ethnic Affairs, etc.

528. In the meantime, the Department should explore with NTCOSS the most appropriate means whereby NTCOSS' role as a peak body in the health and community services area could be enhanced.

**Principal and Supporting Recommendations:**

**The Review proposes that Government consider whether NTCOSS should be funded through the Chief Minister's Department as the umbrella Peak, with responsibility to provide co-located and accessible office accommodation and services, together with administration and financial management, for the sectoral peaks in the NGO sector. These smaller sectoral peaks would operate as partner peaks with NTCOSS. They would receive funding (other than for administration and management) from their respective Government agencies.**

Ease of Access

529. Territorians who have matters to raise with departmental officers should be able to approach the most appropriate part of the Department without undue difficulty. For that reason, the Department should be structured in such a way as to ensure transparency and easy identification of access points for service providers, consumers, and members of the public.

530. While consumers are of vital importance, they are not the only group with which the Department needs to establish solid and responsive partnerships. Service providers and members of the public have a very real need to access the Department. Many respondents expressed their confusion and difficulty in understanding the most appropriate access points for their particular query or problem.

**Principal and Supporting Recommendations:**

**The Department should be structured so that people can easily identify access points for service providers, consumers, and members of the public.**

Non-Government Organisations

531. The importance of the partnership with non-Government organisations (NGOs) in the delivery of health and community services cannot be overestimated.

532. NGOs are a cost-effective means of delivering departmental services. They maximise the involvement of interested and/or affected members of the community in service provision and bring to the Department levels of expertise that the Department cannot, and should not, do without. They encourage volunteers.

533. The Review believes that relationships with NGOs can be improved.

534. As part of the rebuilding of these relationships, there should, in the first instance, be an analysis of just what services and activities the Department wishes to fund in order to meet Government and departmental priorities and contemporary need. Following that analysis, there should, over time, be a review of the historical levels of funding provided to NGOs in the health and community services sector, with investment/disinvestment decisions again being based upon Government and departmental priorities and contemporary need. It appears to the Review that some organisations are funded at very comfortable levels, while others, often representing more disadvantaged sectors of the community, struggle hard for minimal funding.

535. This review of comparative funding levels should be conducted slowly and carefully over time, with plenty of notice given of any adverse change to funding levels. Benchmarking of costs to ensure service outcomes will be a critical element of this review. Once the initial review has

been completed, an on-going cycle of reviews should be initiated to maintain fine-tuning of the NGO sector.

536. In dealing with the NGO sector, the Department should be cognisant of the population it serves and the resource base available. As a general principle, therefore, the Department should encourage the amalgamation of small NGOs to create more sustainable and more cost effective organisations. In addition, NGOs should be encouraged to co-locate wherever possible, and thereby to achieve administrative efficiencies and sharing of resources. As a funding and capacity building agency, the Department's role should be to facilitate, nurture and support the development of partnerships between NGOs. These partnerships should be such that the participants do not lose their autonomy, their identity, their particular community focus, but where they gain strength and material resources from their collaboration with allied groups.

537. By way of example, the recent collapse of the community-based organisation in Alice Springs responding to the HIV/AIDS epidemic, together with the very significant increase in the rate of infection of HCV/hepatitis, offers an opportunity for reform along the lines envisaged by the Review.

538. There is a need to re-establish community-based services to combat HIV/AIDS, HCV/hepatitis and blood-borne viruses in Central Australia. That objective, and the development of a broader and more cost-effective response in the Top End, should be achieved by broadening the responsibility of, and increasing funding to, the Northern Territory AIDS Council (NTAC) to encompass service delivery in Alice Springs. NTAC should, by constitutional change, explicitly encompass hepatitis in its name and objectives and the whole NT in its scope. We understand that NTAC is considering increasing the membership of its board, with some positions being reserved for members residing in Central Australia. We support this move.

**Principal and Supporting Recommendations:**

**Relative need for, and levels of funding provided to, non-Government organisations should be reviewed over the next three years to ensure that those levels of funding across the sector accord with Government priorities and contemporary need.**

#### Carers and Foster Carers

539. Carers and foster carers play a vital role in the NT community. They are important partners of the Department in the provision of support and services:

- in the case of carers, to people who are aged, disabled, and/or mentally or physically ill, or
- in the case of foster carers, to children.

540. Carers are people (usually relatives) who care for adults or children. Caring tends to be a life-long relationship based on familial obligation. In foster care, on the other hand, the caring is by its very nature time-limited. Most children or young people return home after a relatively short time in foster care. A few do move into long-term foster care, but even then there is a time limit because eventually the relevant court order or foster care arrangement expires.

541. Both carers and foster carers identified to the Review a range of issues that impacted adversely on the relationship between them and the Department.

542. Many carers have expressed the view to the Review that far from being seen by the Department as partners in service delivery, they are regarded as supplicants or as problems to be assuaged. There is a fear in the carer community that, should they complain about the service they or their care recipients receive, there will be negative consequences. This feeling was expressed not only by community-based services that receive funding through the Department but also by service delivery staff of the Department.

543. Aside from the lack of any genuine partnership between the Department and carers, there are a number of other matters affecting carers that should be reviewed by the Department, such as the availability of equipment and transport through the Territory Independent Mobility Equipment Scheme, and the Taxi Voucher Scheme. Both are regarded as overly bureaucratic, invasive, and time consuming. Similarly, the transport of patients to southern centres for treatment is seen as being conducted in a way that takes little or no account of the realities of family situations. Carers of children with disabilities believe that they have inadequate access to therapeutic services for their children. The Department should consult more closely with carers in determining the most appropriate services for children with disabilities. The long-term underfunding of community organisations providing services and support to carers remains a major concern and limits the services available to both carers and care recipients.

544. Inadequate access to on-going respite is a major problem for many carers, as are the waiting lists for home care services. Major dissatisfaction is expressed by many of the carers of people suffering from mental illness, including:

- the lack of responsiveness from the crisis team to pleas for help;
- inappropriate discharge from hospital with no reference to those who are expected to provide care, and
- the perception of an apparently negative attitude to family carers.

545. Foster care is the principal way in which care is provided to children and young people who cannot live with their families or community. The basic aim of the foster carer is to reunite children and young people with their families wherever possible, and most foster care is of short duration. Where longer-term care is necessary, the aim is to locate other extended family or community members who can help look after children or young people. In cases where no

extended family or community members are available on a long-term basis, a family can usually be found to shelter and support children or young people as they grow up.

546. Respondents made a number of suggestions to improve the relationship between the Department and foster carers. As part of the partnership between the Department and foster carers, foster carers should always participate in case planning conferences and receive copies of documented case plans and updates as they occur. Similarly, departmental policy in respect of essential information records should be adhered to in all cases.

547. The Review believes that, in order to equip them better for the task they are undertaking, foster carers should be given access to appropriate and relevant training opportunities. Relevant training might include parenting skills, first aid, conflict resolution, and the like. The Department should meet the costs of such training. The Department should ensure that adequate processes for handling allegations of breaches of duty of care are implemented, and introductory training of foster carers should incorporate information in respect of allegations of breaches of duty of care.

548. In Darwin, it might be possible for the Department to consider outsourcing placement support to one or more appropriate NGOs thus utilising more of the resources of the community in this aspect of service provision.

549. Some children in foster care also have a disability. Often these are children of Aboriginal descent who have been placed in care as the only way to provide adequate services for them in the absence of suitable care within their own communities or kin groups. In most cases, there are no protective issues arising from overt actions by parents, merely an incapacity on the part of some parents in remote communities to care for their disabled children.

550. Many of these children should not be in the care of the Minister, as the process results in the parents losing responsibility for their children and, often, all contact with their children. Rather, wherever possible families should retain responsibility for their children, with relevant assistance being provided to the family by Disability Services and/or by Family and Children's Services, as appropriate under the particular circumstances. In addition, the funding burden should not inappropriately be shifted between Disability Services and Family and Children's Services. The Department should re-examine the whole question of foster care for children with disabilities.

**Principal and Supporting Recommendations:**

**The Department should consult more closely with carers in determining the most appropriate services for children with disabilities.**

The Department should consider outsourcing placement support in Darwin to one or more appropriate NGOs.

The Department should re-examine the whole question of foster care for children with disabilities.

### Complaint Resolution

551. Some respondents advised the Review that the effectiveness and availability of the Department's complaint procedures were a cause of frustration.

552. It was suggested to the Review that many disgruntled individuals approach their local Member of Parliament (MP) as the first point of complaint because they do not know of the internal complaint resolution processes established by the Department or because experience has shown that this is the way to get what they want. MPs appear keen to keep their constituents happy by applying pressure to overturn departmental decisions with little regard for consistent policy, budget implications or the appropriateness of the request.

553. Word quickly spreads through communities in the NT that this is the best way to resolve problems. Overuse of this informal process only serves to undermine staff morale and confidence in staff's professional capacity to assess a client's needs and make appropriate recommendations.

554. Of course, recourse to one's local MP is fundamental to our system of Government, and the Review would not in any way want to question that right, or to discourage Territorians from approaching their MP as they see fit. Nonetheless, having in place well-publicised and effective mechanisms would enable complaints from consumers, service providers and members of the public to be dealt with speedily and fairly through an internal complaints process. If this internal process was to be seen as the first, effective avenue of grievance before recourse was had to external processes (including MPs, the Health Complaints Commissioner, the Ombudsman or the courts), both the Department and the general public would be better served. In order to give the complaints mechanism real strength and status, reports on the outcome of grievances dealt with should be forwarded to the departmental Executive on a regular basis, and a detailed report on internal complaints handling should continue to form part of the Department's Annual Report.

555. The Department should publicise and resource a centrally located mechanism to enable it, in the first instance, to deal internally with the resolution of complaints from members of the public. This internal complaint process should be available across the full range of departmental services and programs.

#### **Principal and Supporting Recommendations:**

**The Department should better publicise and resource a centrally located and properly resourced mechanism to enable it, in the first instance, to deal internally with the resolution of complaints from members of the public.**

External Communication

556. The Department expends much (perhaps too much) effort in the production of its Annual Report. Each of the five Territory Hospital Boards produces a separate Annual Report. The proliferation of such reports dilutes the significance of the annual reporting process. An Annual Report is a means whereby an organisation, in this case, DHCS reports to the Parliament and to the people of the NT on its outcomes for the year.

557. This objective would be more effectively served if, rather than the current piecemeal approach, the entire Department and all its component parts produced a single Annual Report, with appropriate differentiation within that single Report to satisfy legislative requirements.

558. The Department should, each year, produce a single consolidated Annual Report. This Report should incorporate the Annual Reports of the Department and of the five Hospital Boards. The CHO should, as part of the Department's Annual Report, produce each year a statement on the health of the NT. The Annual Report should also contain reports or statements by other statutory office-holders within the portfolio.

**Principal and Supporting Recommendations:**

**The Department should, each year, produce a single consolidated Annual Report.**

Transparent Processes

559. Transparency requires that people interacting with the Department from outside, and those operating within the Department, have available to them a set of 'rules of engagement' or Business Rules under which the Department's policy formulation, service delivery and other functions are conducted. These Rules should, among other things, provide clear advice, especially to external stakeholders, coverings matters such as how to contact the Department to obtain advice and assistance, the procedure and timing required for funding submissions, contact officers for each program, the Department's decision-making processes, the conditions and purposes of grant programs administered by the Department, etc. Publication of such a set of rules would help to keep all parties informed as to what is required, and to promote fair and equitable treatment.

560. The Department should develop and publish a set of Business Rules setting out how it intends to conduct its internal and external processes.

**Principal and Supporting Recommendations:**

**The Department should develop and publish a set of Business Rules setting out how it intends to conduct its internal and external processes.**

561. In considering the functional areas of public and community health (including the Centre for Disease Control), the Review saw great merit in close collaboration between the Department and the Menzies School of Health Research (MSHR).

562. The mission of MSHR is to improve the health of people of northern and central Australia and regions to the near north through high quality, multidisciplinary research and education. It has an important public health training role. This includes building strong partnerships with community groups, service providers, policy-makers, and other academic institutions.

563. MSHR is clearly the principal health research organisation in the NT. It has a long history of addressing local issues and finding innovative solutions to the unique problems of Aboriginal remote health. It has a track record that research does yield results and can offer many opportunities to inform policy and practice. Senior MSHR researchers are strongly connected into national and international research networks. Senior researchers are influencing the national agendas in health and health research. Its research profile is very congruent with the priorities of the Department: chronic diseases, skin health, child health, tropical diseases, nutrition, housing, and education.

564. MSHR is developing a strong base in social and environmental determinants of health, particularly focused on Aboriginal populations. Its focus on Aboriginal, remote, tropical and international health has been commended at the national level.

565. There is a great deal of new knowledge that is not yet reflected in policy or practice. By better utilising the expertise at MSHR, the Department could be well placed to become a national leader in facilitating research transfer in a number of key areas. This could extend well beyond the research conducted in the NT by taking advantage of internationally and nationally recognised researchers who are connected into national and international research networks and knowledge.

566. Both MSHR and the NT Government would benefit from stronger relationships. The Review sees that there is a strong case for joint or partnered operations, and perhaps even some sharing of management.

567. A closer relationship would expand opportunities for exchange between researchers and decision-makers by establishing forums that enable effective dialogue between researchers and those in policy and practice. This needs to go beyond just providing information about new evidence, but should become a two-way exchange about using evidence and the practical realities of Government policy. The aim should be to build alliances so that over time research is likely to become more applied and useful to the practice arena.



568. An excellent means of achieving this is to create more senior joint appointments. MSHR has already entered into successful partnerships, for example that currently involving Professor Bart Currie, who has a three-way appointment between MSHR, NT Clinical School, and RDH. Professor Currie facilitates research driven by clinical and population health priorities. Such joint appointments should be extended broadly, both within health and across sectors.

569. A policy unit within the Department with a clear function to facilitate research uptake would more effectively utilise research findings in the policy decision-making and development phases, rather than being discovered after a policy is developed and the direction set. Conversely, an applied research cell within MSHR where emerging issues can be discussed early in the research process would increase the timeliness and usefulness of research. Fast-track options for evaluations of new policy initiatives should also be considered.

570. The Department should use MSHR as a lever for intersectoral work. MSHR could bring together agencies from different sectors to focus on the factors outside the health sector that have such a strong influence on the health of populations. Complex causal pathways require sophisticated analytical skills, and much expertise is already available from MSHR researchers. MSHR has a track record of working very productively with other sectors, such as housing and education.

571. The Department should consider establishing a research fund for health promotion, modelled on examples such as Healthway and VicHealth that have proven so successful in other jurisdictions.

572. This type of collaboration will require investment. However, the potential gains are massive. The most valuable investments are in people. Both MSHR and the Department want to attract the highest calibre professionals and researchers. The best health professionals (both clinical and non-clinical) want also to be involved in research. Joint appointments will be very attractive to such people.

573. MSHR has a critical role in the future of the health system in the NT. It could:

- provide infrastructure for managing health knowledge and information flow;
- develop intellectual capital in health;
- set the agenda for health research in northern and central Australia;
- attract high calibre health professionals to northern and central Australia;
- develop collaborative strategic alliances; and
- support the maintenance of a critical mass for clinical and public health operations in northern and central Australia.

574. The implications for service delivery of the NT's small population (discussed elsewhere in this Report) also apply to research and planning. There is general recognition of the need for collaboration between the Department and MSHR. No one put a view to us that was in anyway opposed to collaboration.

575. Despite this, opportunities to work together are currently missed, and avoidable duplication of effort exists. The Department recognises that it needs to base its investment decisions on evidence. Particularly in respect to the health of Aboriginal people, part of that evidence comes from MSHR. MSHR's research profile parallels the evidence needs of the Department. If the two were to work together, the likelihood of their finding innovative solutions to problems in Aboriginal health increases.

576. This issue should receive early attention and consideration by the Department and by the Government of the NT.

**Principal and Supporting Recommendations:**

**Collaboration between the Department and MSHR should receive early attention and consideration by the Department and by the Government of the NT.**

*Co-operative Research Centre in Aboriginal and Tropical Health*

577. The Co-operative Research Centre in Aboriginal and Tropical Health (CRCATH) has an important role to play in promoting and transferring knowledge from Aboriginal Australian research projects. CRCATH provides a link with key Aboriginal organisations at both a state and national level.

578. The Department is a current core partner of CRCATH, and has nominated to be a core partner in the proposed Co-operative Research Centre in Aboriginal Health. These CRCs provide further opportunities for intersectoral collaboration across health and community services and with other health service providers and academic institutions.

579. Many of the potential benefits identified above for a closer working relationship with MSHR hold true for working with the CRCs, including their use as a lever for intersectoral work, and their cooperation (with MSHR) in bringing together agencies from different sectors to focus on the factors outside the health sector that have such a strong influence on the health of populations.

580. The discussion above with respect to investment in the MSHR is equally applicable to the question of investment in the CRCs.

**Principal and Supporting Recommendations:**

**Collaboration between the Department and the CRCs should receive early attention and consideration by the Department and by the Government of the NT.**

## Chapter 6: Delivering Outcomes

### Focus on Program Outcomes

601. In order to ensure better accountability and a better responsiveness by the Department to the policy imperatives and initiatives of the Government, the Department should be organised with an explicit focus on program outcomes.

602. It was put to the Review that the Department should be split, but we are of the view that it should remain as a single Department. Nonetheless, there is a need to identify its various components so that its functions and responsibilities are clearly transparent to external observers.

603. One of the real difficulties experienced by the Department is that it is fragmented so that relevant views do not come together at senior levels in the organisation. One result of this fragmentation is that when the Department establishes committees, those committees are large; when the Department has to be represented on external committees, it either sends a large team or sends staff at levels that are unable to make decisions on behalf of the Department.

604. The Department should be integrated in a more effective way and should be organised with a focus on program outcomes so that its functions and responsibilities are clearly transparent to external observers. If the organisation was to be knitted together in a more effective way, as the Review is proposing in its recommended structure, people at senior levels in the Department who are sufficiently across a breadth of issues will be able to represent the Department. Of course, in a Department as diverse as DHCS there will be some issues where this approach will not be possible.

605. Among criticisms made to the Review was the lack of ready access (by members of the community as well as by departmental staff) to departmental policies on the programs and services managed by the Department. This deficiency should be corrected. The Department's policies should regularly be updated, should be published on the Internet, and should be available in hard copy. Managers should ensure that copies of all relevant policies are available in the work area.

#### **Principal and Supporting Recommendations:**

**The Department should be integrated in a more effective way and should be organised with a focus on program outcomes so that its functions and responsibilities are clearly transparent to external observers.**

The Department's policies should regularly be updated, should be published on the Internet, and should be available in hard copy.

*Evidence-Based Policy*

606. There is now an increasing consensus that policy development, implementation and evaluation should be informed by relevant and appropriate research outcomes and methodology.

607. Evidence-based policies have applicability across the spectrum of activities within the health sector, including practice-based policies (practitioner based resource utilisation), service policies (service resourcing and utilisation) and governance policies (pertaining to an organisation, its structures and processes). Evidence-based practitioner policy such as that pertaining to medical care is well accepted in the main. However, in the NT, as in other jurisdictions, its implementation requires support and encouragement. The National Institute of Clinical Studies (NICS) is currently providing practical and peer support to organisations. DHCS is participating in at least one of its trials.

608. However, in both service policies and governance policies, there has been less progress in the adoption of an evidence-base as a foundation for policy development and its implementation. Admittedly, there is a more complex field of variables to contend with, including Government directions and a range of views as to the outcomes/performance measures of any given policy. These variables make the task more challenging.

609. This is not to say that evidence-based policy should not be used, rather that it should engender a robust debate as to the contestability and validity of all relevant information.

610. It is no exaggeration to say that part of the financial and budgetary problem facing the Department at present is the result of the continuation of some programs and activities for which there is no current evidence base.

611. Novel information gathering and testing mechanisms, including both qualitative and quantitative data should be used. Indeed, it is a short-sighted view of the scope of the underpinning information required which restricts comprehensive service and governance policy development, implementation and evaluation. Unfortunately this has occurred in the NT health and community services sectors. Using the skills and knowledge of those with the intellectual skills to test and contest the information, as well as of those who are able to provide relevant data (such as consumers, service providers, and health and community services gains units), is vital to ensure quality policy development.

**Principal** and Supporting Recommendations:

**The Department should sharpen its policy focus in both the health and community services areas, ensuring that the policy process is evidence-based and consultative.**

Support to Service Providers – Funder/Purchaser/Provider Arrangements

612. DHCS is currently structured on a funder / purchaser / provider model. Of all the issues canvassed during the Review, this arrangement was one of the most hotly contested.

613. The objectives of the funder/purchaser/provider approach, which functionally and administratively separates the funder and purchaser from the providers, include:

- greater role clarity between the funder, purchaser and provider units;
- improved efficiencies amongst providers by promoting greater competition; and
- clear accountability through contractual agreements between the purchaser and providers for service delivery.

614. Under the model originally introduced, the separation of roles would enable Government and non-Government service providers to focus on delivering health and community services. Providers would be guided by the purchaser who would:

- assess the health status of the population,
- research what health gains are achievable,
- consider the appropriateness of care and interventions,
- ensure quality and continuity of supply of services,
- monitor delivery and its quality, and
- pay on the basis of delivery, the outcomes of which would be reflected in the contractual arrangements with providers.

615. However, very few people consulted supported the retention of the purchaser/provider model as it is applied currently. Critics of the NT arrangements argued that the Department should give better support to service providers, both internal and external, through a significant reallocation of resources to service support. It was put to the Review that current staffing levels in the funder/purchaser areas of the Department should be reduced, with an equivalent increase in staffing in the provider areas. It was also argued that there should be, within the funder/purchaser areas, a significantly increased concentration on policy development.

616. There is a common view in the non-Government sector that the Department has not embraced the available opportunities to engage in real partnership alliances with NGOs, and that there has been only limited involvement of the NGO sector in planning. Respondents argued that the Department has been too inward looking. On the other hand, it was also put to the Review that some service providers are very resistant to change and demonstrate a patch mentality.

617. The lack of adequate provider support was identified as an area of frustration and difficulty, as were the confused roles of District Managers and Regional Directors. It was argued that funders, operating in a new context, found it difficult to identify program priorities and to convey those priorities to the Service Development Division to inform purchasing decisions. In other cases, funders could not distance themselves appropriately from either purchasers and/or providers.

618. There was a perceived lack of policy framework, an inequity in resource distribution, excessive micro management, and a lack of understanding or acceptance of structural roles and responsibilities. The Review heard that the system requires excessive administrative time in the preparation of service agreements, and that the highly competitive nature of the system is in conflict with the concept of community and with the stated aim of cooperation between many non-Government agencies. It was claimed that a barrier has been artificially created between the providers of the services and the policy development staff as funders.

619. The current arrangements had strong defenders too. It was argued that the arrangements had brought much-needed transparency, rigour and accountability to the Department's internal systems and to its relationships with NGOs and other providers.

620. Many external commentators have argued that the purchaser/provider model is intrinsically flawed (as distinct from its application in the NT)<sup>1</sup>. The best policies and plans arise when doctors, nurses, allied health workers and health managers are involved during the development of policy and planning. The exclusion of health professionals from this role has been detrimental to the formation of good health policy and plans. The sole function of health personnel in the pure purchaser/provider model is to provide services according to the contract – for reasons of competitive advantage, individual health personnel are not to be engaged in assisting the 'purchaser' plan the provision of services.

621. As in other jurisdictions, the Department appears to have devoted disproportionate attention to contract negotiations at the expense of plans to guide the contract content. The theory of purchaser/provider intended a very strong role for the purchaser through the competitive bidding by providers and the contractual arrangements for the purchaser to define and monitor service requirements. Clearly this has not occurred in the NT.

622. The intent of the purchaser/provider model was to ensure best use of the health dollar through promoting competition amongst providers. Yet the capacity of promoting competition amongst the small number of providers in a jurisdiction the size of the NT is virtually non-existent, particularly for public hospital services. Using the purchasing plans to drive greater

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<sup>1</sup> ACT Health Review, Michael Reid and Associates, May 2002

efficiencies is a very blunt instrument. Overseas, even where the model was applied to much larger populations, evidence showed greater inefficiencies than efficiencies.

623. Equally questionable is the desire to promote competition. A health service the size of the NT should be characterised by collaboration, collegiality, shared accountabilities, clinical involvement in planning, complementarity and integration, as the tools for quality and efficiency, rather than rivalry and duplication.

624. Other issues arise when one examines the content of, and negotiations around, the service contracts themselves. Many of the contracts are not timely, with negotiations often concluded well into the financial year. A significant bureaucracy has developed, both on the provider and purchaser side, engaged in the contract negotiation processes. The focus of the contracts is narrow – mainly related to outputs – and does not reflect other aspects that consumers and Governments look for in health services. Non-compliance with contracts has rarely if ever resulted in penalties to the providers.

625. The Review believes that much that is beneficial has flowed from those arrangements, particularly in the areas of transparency and accountability. Nonetheless, the Review does see that some refinement is now required, and has concluded that, given the size of the Department, the strict separation of funder and purchaser responsibilities currently in place is both unnecessary and ineffective for a population of 200,000 people. The funder and purchaser streams should be amalgamated, and increased emphasis should be given within the amalgamated stream to the vital role of policy formulation and development. The funder/purchaser units with the Department should analyse and address the concerns and problems identified to the Review and summarised above.

626. The Review is also of the view that the current allocation of staffing between the funder / purchasing areas and the provider area is inappropriate and unaffordable. Staffing levels in the funder / purchasing areas should be reduced, with an equivalent increase in staffing for the provider areas.

627. Funders/purchasers and providers should all be party to the consultations leading up to the determination of the annual budget. Once program budgets have been settled, they should be available to funders and purchasers and providers on the basis that, without budget information, cost centre accountability is impossible.

**Principal and Supporting Recommendations:**

**The Funder/Purchaser/Provider model should be abandoned and the funder and purchaser streams should be amalgamated, with increased emphasis being given within the amalgamated stream to the vital role of policy formulation and development.**

**Staffing levels in the funder / purchasing areas should be reduced, with an equivalent increase in staffing for the provider areas.**

Funders/purchasers and providers should all be party to the consultations leading up to the determination of the annual budget. Once program budgets have been settled, they should be available to funders and purchasers and providers.

*Service Agreements and Service Plans*

628. The current arrangements with respect to service agreements and service plans have brought clarity and transparency to service funding, and have provided the basis for better accountability. There are aspects of these arrangements that have added considerable benefit, and these should be retained. There are other aspects that need revision in the interests of better partnership development and more effective management. The current approach to the development of service agreements and service plans between the Department and internal and external service providers should be retained, with the process being further developed.

629. It is essential that the Department determine, in advance, precisely what services it wants to purchase from the non-Government sector, and at what price. Having identified the services to be purchased from the non-Government sector, relevant areas of the Department should engage in collaborative and sincere negotiations with community-based organisations and NGOs in order to develop robust and soundly based service agreements and service plans.

630. Service agreements and associated service plans should continue to specify the services to be provided by NGOs, the cost of those services to the Government, and an element of capacity building to strengthen the NGO sector. They should also continue to specify the outcomes required from NGOs, the nature and timing of reports, and other requirements of the Department.

631. The Department should maintain the current usual practice of service agreements having terms of three years, and should move to eliminate all shorter-term agreements. Three years should, as a general rule and in the absence of conditions that make a shorter-term contract appropriate, become the standard term. Wherever possible, service plans, too, should be for periods of three years. Periods of less than three years for service plans should be limited to situations where the Department and the NGO are negotiating improvements in the service, or where the service is by way of a trial or pilot which might or might not be continued.

632. In this way, NGOs could better plan their activities with an assured level of funding over a time span sufficient to enable them to employ staff, to plan their activities, and to deliver the services appropriately. Of course, agreements are two-sided affairs. The NGO sector should understand clearly that, where the organisation has not submitted performance reports, not provided audited financial statements, or not provided the services specified in the service plan,



the option of disinvestment and defunding is open to the Department at any time. In serious cases, this option should be used.

633. Business planning and outcome reporting should be mandated for each NGO receiving Government funding and providing services on behalf of, or in cooperation with, the Department. Each service agreement or plan should contain an explicit statement of no more than three or four performance indicators to be achieved. The performance indicators should be based on outcomes, with the agreement containing an explicit commitment that, if outcome measurements are being attained, the Department will refrain from micro-managing the NGO and will allow NGOs to manage their services in their own way throughout their service agreement period. Such a commitment does not derogate from the obligation of the Department to involve itself in the service delivery operations of funded NGOs where service outcome indicators are not being met. Nor does it prevent active capacity building interventions.

634. Each service agreement and service plan, once signed, should in the interests of transparency, be a publicly available document. The current form of agreement will need to be changed to allow the introduction of this element of transparency. Nonetheless, where public funds are being spent to purchase services on behalf of the Government from the non-Government sector, the community (as well as consumers and other providers) have a right to know what services are contracted and at what price.

**Principal and Supporting Recommendations:**

**The current approach to the development of Service Agreements and Service Plans between the Department and internal and external service providers should be retained, with the process being further developed to ensure that each of the Agreements: clearly specifies the services to be purchased and the agreed cost of those services; contains no more than three or four performance indicators by which service delivery outcomes can be measured; has wherever possible a term of three years; results from bona fide negotiations between the parties; is, once signed, a publicly available document; and mandates capacity building, business planning and outcome reporting for each service provider.**

*Approval Process for New Services*

635. A process should be developed by the Department to facilitate the assessment of proposals for new services, both clinical and other. A number of key features should be taken into consideration when assessing and prioritising service development proposals. A more equitable approach is required whereby organisations provide a written submission to Government detailing their service delivery proposal. This submission would not necessarily have to be linked to a tender process. However in some instances this may be the case.

636. Submissions will be assessed against specific criteria to include:

- Needs-based evidence to support proposals;
- Avoidance of service duplication;
- Possibilities for enhancement of the role of existing services and/or collaboration where possible between providers to meet the needs of the community;
- Quality standard and measures against which performance can be monitored;
- Provider experience in the proposed area of service delivery; and
- Capacity to appropriately resource the proposed agency.

**Principal and Supporting Recommendations:**

**A process should be developed by the Department to facilitate the assessment of proposals for new services, both clinical and other. The process should assess and prioritise service development proposals by way of a written submission to Government detailing their service delivery proposal.**

*New Clinical Services – A Cautionary Note*

637. In considering proposals for new clinical services, it should be borne in mind that there are some conditions that require special consideration. In the first place, there are complex conditions that require multi-professional teams, expensive and complex equipment, and specialised staff to both run and maintain the equipment. Good examples here include cardio-thoracic surgery, neurosurgery (except trauma and some simple spinal surgery), and transplant surgery. Second, there are conditions in which the incidence is so low that there are inadequate patient numbers to maintain staff skills. An example here is complex obstetrics in certain places. Third, there are conditions that are treated by nationally funded centres. Among these we would number pancreatic transplantation, paediatric cardiac transplantation and interventional radiology.

638. Any proposal to introduce or expand such clinical services in the NT should be treated with extreme caution, given the population and resource base of the Territory.

639. The specialty of oncology is a special case, with serious implication to be taken into account before any service development decision is taken. To be practised optimally, oncology requires a multi-disciplinary team on site or at least available by teleconference, including an oncologist, a radiotherapist, a surgeon and a pathologist, as well as patient support staff.

640. Effective use of a linear accelerator requires a population of at least 240,000 to be economically viable. However, given the current population of the NT, a linear accelerator service for the NT could be developed in a relationship with an established centre (for example, Adelaide, Brisbane or – perhaps – Cairns) at which patient planning could be done, with

treatment carried out using the NT linear accelerator. This approach would still require the patient to travel for the planning process, the appointment of a number of radiation therapists (three per machine if the machine was being used to capacity), regular visits from a radiation oncologist and a medical physicist, the latter to maintain machine accuracy and safety.

641. Before any firm decisions are taken with respect to the future direction of radiation oncology in the NT, an external specialist should be commissioned to provide advice and options for the provision of such services in the NT over the next ten years.

**Principal and Supporting Recommendations:**

**An external specialist should be commissioned to provide advice and options for the provision of radiation oncology services in the NT over the next ten years. In the meantime, there are sufficient concerns about the sustainability and clinical safety of a new radiation oncology service for the NT to warrant its deferral.**

#### *Adult and Public Guardianship*

642. In undertaking its work, the Review has had raised with it a serious conflict of interest arising out of the current administrative arrangements. We refer to the location within the Department of the role of public guardian (a statutory office held by the Minister for Health and Community Services) and of the statutory role of the Executive Officer, Adult Guardianship (held by a member of the Department).

643. In our view, the location of the guardianship function, statutory office holders, and staff within the Department is both inappropriate and fraught with the danger of clear and potentially serious conflict of interest. The funding, functions, statutory officers, and staff relating to guardianship matters should be transferred from DHCS to the Department of Justice as is the case in many other jurisdictions.

**Principal and Supporting Recommendations:**

**The funding, functions, statutory officers, and staff relating to guardianship matters should be transferred from DHCS to the Department of Justice.**

#### *Departmental Structure*

644. The Department should adopt the organisational structure set out in Appendix 1. Relevant features are highlighted at various places elsewhere in this Report.

**Principal and Supporting Recommendations:**

**The Department should adopt the organisational structure set out in Appendix 1.**

### Health Services

645. A Health Services Group should be established, to consist of three Divisions, each headed by an Executive Director:

- a Public and Community Health Division;
- a Mental Health and Drugs of Dependence Division; and
- a Health Policy and Service Development Division.

**Principal and Supporting Recommendations:**

**A Health Services Group should be established, to consist of three Divisions, each headed by an Executive Director: a Public and Community Health Division; a Mental Health and Drugs of Dependence Division; and a Health Policy and Service Development Division.**

### Public and Community Health

646. The community health service is the most frequent point of contact with the public in intervention, management, and education to prevent the onset of illness or slow the progress of chronic illness/disability. It provides for the maintenance of people in the community. It ensures the provision of a primary health care service that includes clinical maintenance and preventative care, and promotes positive community attitudes to health.

647. Community health provides primary health care, child and maternal health care, allied health interventions, disease control (including screening and immunisations), and aged and disability services (including pensioner concessions). These services are delivered from service outlets, in the home environment, in the work place, and at child care centres or schools.

648. Public health, on the other hand, is a combination of health promotion and public health services that provide both specialist public health service delivery and workforce support and professional development. In the NT, public health is well done, overall.

649. The services offered within the public health context in the NT currently include:

- clinical services relating to alcohol and other drugs;
- well women's cancer screening;
- environmental health;
- nutrition;
- health promotion;

- provision of community drug educators and alcohol and other drugs frontline trainers; and
- health promoting activities undertaken by school nurses.

650. The Review received many responses relating to community health and/or public health.

651. Some respondents perceived a lack of direction and guidance in relation to the priorities of the Government and the Department regarding service delivery. Analysis of community need versus community demand is not well articulated in the Department, and there is therefore no feedback system for service providers to use to review their effectiveness in meeting needs.

652. Furthermore, many respondents commented adversely on the Community Care Information System (CCIS). CCIS was introduced less than three years ago to provide community health data storage and analysis. It has been subject to frequent upgrading with the implementation of new features. A thorough evaluation of CCIS from a functional and user point of view should be undertaken.

653. There is currently no restriction on who can access community health services. If services are to meet continuing growth without increased funding, a clearly articulated priority client group should be identified (eg. health care cardholders only).

654. Staff at the operational level argue that they are not kept informed of or consulted about relevant projects, including departmental change, and policy or strategy development. Some respondents identified a lack of clear policy direction and of reasonable performance indicators that capture the provision of public health and in particular, health promotion services.

655. In order to re-emphasise the importance of public and community health, a Public and Community Health Division should be established, thereby restoring much needed significance to the role of public and community health in the NT. The management and direction of the Public and Community Health Division should be undertaken by an Executive Director, who should be vested with the public health-related statutory powers and responsibilities of the CHO under NT legislation and subordinate legislation.

656. Establishment of this Division, through its Branch structure, will see a sharpened focus on both urban and remote community health, supporting both the principles and practice of Primary Health Care. The Division should also carry prime responsibility for the implementation of PHCAP.

**Principal and Supporting Recommendations:**

**A Public and Community Health Division should be established.**

The management and direction of the Public and Community Health Division should be undertaken by an Executive Director, who should be vested with the relating to public health-related statutory powers and responsibilities of the CHO under NT legislation and subordinate legislation.

*Centre for Disease Control*

657. The Department's Disease Control Program works as an expert group of disease control physicians, medical officers, nurses, educators, Aboriginal health workers and administrative officers principally to service other health care professionals throughout the Territory. The group provides sound evidence-based policy and protocols to guide best practise and, in particular, provides risk management strategies in times of outbreaks, disease upsurges, and threat of outbreak of new disease. The program provides expert clinical services in specific areas, for example, TB, Leprosy and HIV medicine. Within the NT, the Disease Control Program includes the community physician, the community paediatrician, TB/Leprosy control, HIV/AIDS, STD and blood-borne virus control, immunisation, and surveillance.

658. The Disease Control Program is currently carried out through local Centre for Disease Control (CDC) units. Its main clients are health service providers in the regions. Additionally, the program provides expert clinical services to patients where specialist services are required, for example, in the case of certain STIs, HIV, TB, leprosy, and lyssa virus (following bat bite/scratch) prevention.

659. The Review accepts the view of Program staff that they work best as a Territory-wide team, and that the Program requires a structure to support such a team. Presently, the structure is not consistent throughout the Territory.

660. A unified, Territory wide Centre for Disease Control (incorporating epidemiology and medical entomology) should be created. The Centre should be set up as a specialist, professional, and well resourced but streamlined organisation within the Public and Community Health Division.

661. Specifically in relation to HIV/AIDS increased levels of activity are needed in the face of an increasing threat of the heterosexual spread of HIV/AIDS, related in part to visitors from high prevalence countries in the region and in part to the high prevalence of STDs within the Aboriginal community. The risk identified is to specific high risk communities, not to the general heterosexual population of the NT. Additional specific interventions to these high risk communities need to be made. There is good evidence that aggressive programs to screen, test and treat for STDs will reduce those high rates as they relate to lack of access to such services.

**Principal** and Supporting Recommendations:

**The Centre for Disease Control should become a Territory-wide integrated service.**

**That urgent consideration be given to expanding prevention responses to the heterosexual transmission of HIV/AIDS.**

Environmental Health

662. The Review considers that it is time for a renewed emphasis on environmental health. The recommended Environmental Health Branch should, besides managing the environmental health responsibilities of the Department, be responsible for negotiating, where possible and as appropriate, the transfer of environmental health officers and environmental health responsibilities to local Government throughout the Territory. There is certainly a need for Aboriginal environmental health officers to work for Aboriginal community councils.

**Principal and Supporting Recommendations:**

**There should be a review of the role of local Government with respect to environmental health with a view to the negotiated transfer over time of responsibility for environmental health to local authorities.**

Oral Health Services

663. In 1999, a review of Oral Health Services in the NT was undertaken “to identify the most appropriate service model and system of management consistent with a funder/purchaser/provider framework and promotion of optimal oral health for the client and the community; and to make recommendations about how best to achieve them.” The Review reported (the Loan Report), describing significant problems in oral health services to Territorians and making a series of recommendations, none of which have been acted upon since that time. The recommendations are reproduced at Appendix 4.

664. A Children’s Dental Service Oral Task Force was instigated in 2002 as a result of a decision by the Minister to release the Loan report. The Minister approved the formation of a group of significant stakeholders to meet and consider the recommendations within the report that related to the Children’s Dental Service. The Task Force was to provide advice to the Minister and the departmental Executive. It has not as yet reported.

665. The Department should ensure that a report relating to the recommendations of the Loan Review of Oral Health Services in the NT reaches the Minister prior to the commencement of preparation of the 2003/2004 Budget.

**Principal and Supporting Recommendations:**

**The Department should ensure that a report relating to the recommendations of the Loan Review of Oral Health Services in the NT reaches the Minister prior to the commencement of preparation of the 2003/2004 Budget. Improving Oral Health Services at least to a parity level with other Australian jurisdictions is a priority, especially given the oral health needs in the NT population.**

666. The Review has found that this sector of the health system is, despite the production (and subsequent non-implementation) of a series of reports and studies over the past decade, under-resourced, fragmented, and poorly supported.

667. The NT has adopted, and is in the process of implementing, the National Mental Health Strategy. The Strategy and its associated policies and plans have been unfolding over the past decade. In broad terms they emphasise an array of services that covers the full spectrum of mental health needs, from prevention and health promotion to the long term care of those with chronic mental illnesses. There is considerable emphasis on partnerships between mental health workers in different parts of the sector; with general practitioners; and with carers and their families.

668. Continuity of care is an acknowledged objective, and the services thus emphasise integration and networking. There has been pressure on each state and territory to develop plans consistent with the National Mental Health Plans and Strategies. If community teams are well resourced it is feasible for inpatient teams to function more efficiently. The issue everywhere in Australia is that there are not enough resources to progress all these things at once.

669. In parallel, there has been an increase in demand from the community for services. This increase is partly driven by health promotion activities, partly by consumer organisations, and partly by the recognition that help is available for those who come into the category of unmet need. There is increased recognition in the community that services can be helpful, and there is reduced stigma.

670. The NT is not exceptional in attempting to respond to these issues. Meeting these changes has been a difficult task, and many have been perplexed, confused, and drained by the rapid changes. No state has the resources to do this task adequately. All states have had problems addressing the comprehensive changes arising from the National Mental Health policies, plans and strategies. The Review understands that the NT has been very active in addressing the National Plan, and may in fact have gone ahead too quickly on too broad a front in that the expansion of services has outpaced resources, particularly the availability of skilled staff.

671. A net effect in the Territory of attempting to meet the National Mental Health Strategy is that workers have become very stretched, and other very important components of their core responsibilities (such as training, education, and supervision) have suffered. It is often the case that, with under-resourced units, the full expression of optimal mental health care is not achieved. For example inpatient teams often find themselves not able to address the social needs of their patients sufficiently but rather find themselves having to concentrate almost exclusively on the symptomatic status of patients. All of these issues are explicit in the NT.



672. Demand has risen; each team has a full quota of responsibilities; no team feels that they adequately meet their defined responsibilities; there is little time for reflection or planning. The inpatient service becomes a victim of these changes because it is seen as the only place that cannot turn away a client.

673. A picture emerges of stressed mental health staff with a high turnover and a high level of sick leave. While there is a major preoccupation with recruitment, this is not matched by a preoccupation with retention. This issue is discussed elsewhere in this Report. Long term planning is extremely difficult when demand is so high.

674. Further, it is not clear that each component of the service understands the other components well enough. Staff are left with a feeling of not being in control of their situation and perhaps not being a part of planning at a senior level.

675. In the Top End Mental Health Service, there are a number of specific problems that need attention in relation to the Cowdy Ward at RDH.

676. Dealing with rural and remote patients is more complex than dealing with metropolitan patients in that transfer is difficult and it is harder to obtain relevant information from Aboriginal communities. The first language of the patients is sometimes not English, particularly with Aboriginal patients. The unit is small, and the array of patients with widely varying psychiatric conditions is quite difficult to care for under such circumstances. Difficulties in meeting excessive demand are often addressed by employing agency nurses or by staff being required to work double shifts. The use of agency nurses reduces continuity of care, while over-use of double shifts increases stress and sickness levels.

677. The confusion about the actual number of acute mental health beds available in Cowdy Ward should be resolved. Numbers of fifteen, eighteen, twenty and twenty-four have all been provided as the maximum occupancy level. Internal departmental reports note that it is a fifteen-bed unit and is staffed for fifteen beds. Yet there have been occasions when it has had twenty-five occupants. The maximum number of beds needs to be firmly established and adhered to.

678. At the same time, bed usage should have a clear relationship to staff numbers. In addition, bed usage should be able to be reduced according to patient characteristics. For example, if there are too many floridly psychotic patients or too many borderline personality disorder patients, a reduction in bed usage should be contemplated.

679. The impact of “boarders” needs evaluation. The unit currently takes all comers, and there is usually a mixture of rural and remote patients (often Aboriginal). Many of these patients bring a person with them who is called a boarder. It is common for there to be 4-6 boarders. The boarders are not counted as part of the demand on the unit although it is obvious that they impact on the work of the unit.

680. In Central Australia, a range of issues was brought to the attention of the Review. They include availability of resources, the lack of psychiatric epidemiology in the NT in respect of remote Aboriginal Australians, the provision of basic mental health services for the most disadvantaged and at risk groups (particularly for prisoners, Aboriginal people, remote people), and the need for a single data entry system.

681. In addition, because the Central Australia Mental Health Service is not recognised as a public benevolent institution by the Australian Taxation Office, the Medical Officers are unable to benefit from salary sacrifice options as do their colleagues who are employed as hospital Medical Officers and their Mental Health Service counterparts in the Top End.

682. A number of medical issues were raised with the Review, including the number of unfilled Medical Officer positions, the issue of clinical governance and the unclear roles and responsibilities of the psychiatrist positions, the lack of a Director of Psychiatry with the authority to take end-line clinical responsibility, and the lack of funding to enable the rotation through ASH of an intern.

683. The Review was advised that inpatient services in Central Australia are inadequate. ASH High Dependency Unit does not function adequately in providing psychiatric in-patient services. In forensic psychiatry there is inadequate capacity to supervise staff and provide ongoing professional development and relevant training in what is a demanding area. Respondents say that it is almost impossible to transfer prisoners with mental illness to a hospital. This, of course, has an echo Territory-wide, as there is no dedicated forensic inpatient facility in the NT.

684. The newly amended Criminal Code with respect to *Mental Impairment and Fitness to be Tried* has significant resource implications. It will require increased time for reports and non-custodial supervision orders. It will accentuate the need for a forensic facility (in reality likely to be co-located within Darwin Prison and to be managed by Correctional Services within the NT Department of Justice with a mix of people who are mentally ill, others with organic brain damage, and those with intellectual disability). This is particularly important in view of the conclusions and recommendations of the Royal Commission into Aboriginal Deaths in Custody. This will mean that people who live in Alice Springs will have to be transferred away from family support. In the absence of any psychiatric survey, it is impossible to quantify the mental health needs of prisoners in the NT.

685. The Review is aware that a separate examination of mental health services in the NT is currently being undertaken, and is due to report in December 2002. It would not, therefore, be useful for the Review to attempt to pre-empt or predict the outcomes of that more specialised examination. The Review is of the opinion that detailed consideration of mental health service provision in the NT should await the publication of the Report of the specialist examination. Our discussions with the examination group lead us to the understanding that the outcomes of

that specific exercise will be compatible with our own, more general recommendations that follow.

686. A Mental Health and Alcohol and Drug Services Division should be established and should be charged with responsibility for ensuring the provision of a full range of mental health services across the NT.

687. The establishment, clear identification and role delineation of this Division will enhance the quality of both acute care and community support services in the NT for clients affected by mental illness. The Division would be responsible for the provision of mental health care services throughout the NT.

688. The new Mental Health and Alcohol and Drug Services Division should develop strategies to address a number of issues for clients who have problems related to both mental illness and an alcohol or drug problem, including crisis intervention; acute care; custodial care; community care and support for the chronically ill and for those people affected by mental illness; prevention of mental illness; forensic psychiatry; and training of primary mental health care workers.

689. A Principal Psychiatrist should be appointed. The Principal Psychiatrist is a position that could be jointly funded by the Department and an appropriate academic institution. The Principal Psychiatrist should be responsible for the maintenance of and adherence to quality mental health standards throughout the NT.

690. Because of the significant and well-documented co-morbidity between the misuse of alcohol and other licit/illicit drugs and various forms of mental illness, the Alcohol and Other Drugs Program should be located and managed within the new Mental Health and Alcohol and Drug Services Division in a way that clearly and explicitly ensures the clear restoration and continuation of a specific focus on alcohol and other drugs, on related NT Government priorities, and on the range of alcohol and drugs services including substantial public health policy and other health promotion and prevention work.

**Principal and Supporting Recommendations:**

**A Mental Health and Alcohol and Drug Services Division should be established and should be charged with responsibility for ensuring the provision of a full range of mental health services across the NT.**

Bringing mental health services in the NT to a parity level with other Australian jurisdictions, with guidance from the current Report of the specialist examination into NT mental health services, is also a priority given the poor level of service coverage.

There should be a Principal Psychiatrist for the NT, a position that could be jointly funded by the Department and an appropriate academic institution. The Principal Psychiatrist should be responsible for the maintenance of and adherence to quality mental health standards throughout the NT.

The Alcohol and Other Drugs Program should be located and managed within the new Mental Health and Alcohol and Drug Services Division in a way that clearly and explicitly ensures the clear restoration and continuation of a specific focus on alcohol and other drugs, on related NT Government priorities, and on the range of alcohol and drugs services including substantial public health policy and other health promotion and prevention work.

#### *Health Policy and Service Development*

691. Within the Health Services Group, there should be a Health Policy and Service Development Division that will bring together the current funder and purchaser functions of the Department as they apply to the health sector. In this way, an appropriate health policy focus will be retained, as will the advantages that have accrued from the introduction of purchaser/provider arrangements. This Division should also play a key role in modelling new service types, and in measuring and reporting on health outcomes.

692. The Division should contain three Branches, each headed by a General Manager:

- a Health Policy Development Branch;
- a Health Service Purchasing and Modelling Branch; and
- a Health Gains Branch.

693. The Division should work closely with, and provide the full range of its services to, the Acute Care Group (discussed elsewhere in this Report).

694. One of the core functions of this Division should be to support and facilitate the development of a robust health sector through capacity building activities. In this way, the Division could coordinate and provide advice to DHCS-funded service providers, and coordinate and facilitate service and/or organisational support in, for example, re-engineering service approaches, developing strategic plans and business plans, and trouble shooting on governance issues. The work of this Division will enable service providers to aspire to and achieve continuous quality improvement in line with Australian standards.

695. Another core function of the Division should be to determine and act on the program and service priorities for investment and disinvestment. In so doing, the Division would develop new models of service to meet defined program and investment priorities, and undertake, on a community or urban centre basis, regional service planning and resource allocation conducted in

consultation with community and service providers. The Division would undertake service purchasing, including negotiating, monitoring and reviewing agreements.

696. Other responsibilities of the Division should be to:

- Develop policy to support service modelling, legislative requirements and practice standards;
- Establish and maintain (where applicable) Commonwealth links and negotiations;
- Develop and report on Treasury Outputs and national reporting requirements;
- Develop financial systems and monitor expenditure;
- Determine program information needs and influence information system development;
- Make payments to service providers (both NGOs and internal); and
- Project-manage specific program and service development initiatives.

**Principal** and Supporting Recommendations:

**Within the Health Services Group, there should be a Health Policy and Service Development Division that should bring together the current funder and purchaser functions of the Department as they apply to the health sector.**

The Division should contain three Branches, each headed by a General Manager: a Health Policy Development Branch; a Health Service Purchasing and Modelling Branch; and a Health Gains Branch.

The Division should work closely with and provide the full range of its services to, the Acute Care Group.

One of the core functions of Health Policy and Service Development Division should be to support and facilitate the development of a robust health sector through capacity building activities.

Another of the core functions of the Health Policy and Service Development Division should be to determine and act on the program and service priorities for investment and disinvestment.

#### Health/Community Services Gains

697. Health gains units have been established in a number of health departments around Australia. The rationale for their development has been to provide the evidence base for setting priorities and strategic directions, for assessing service activity, and for determining resource allocation. In essence, they analyse demographic, epidemiological and service outcome data to

forecast “best buys” in terms of health and well-being gains. An equivalent case exists for the establishment of community services gains units.

698. A Health Gains Planning Unit has existed in the Department since 2000, and although its remit was consistent with that described above, it seems to have had little impact on departmental/NT health and community services sector strategic directions, service activity, or resource allocation. There are a number of potential explanations for this failure. There seems to have been minimal Executive commitment to utilising the information generated by the Unit to inform departmental decision making processes, a lack of clarity in terms of outcomes required from the Unit, and little capacity within the Unit to deliver the required outcomes.

699. Notwithstanding the limited success of that earlier attempt, the Department should establish a Health Gains Branch and a Community Services Gains Branch. The core functions of these branches should be to manage the process that determines the key priority investment areas for the Department.

6100. There should be a deliberate commitment on the part of the departmental Executive to ensure that each of the proposed Branches delivers their agreed outcomes. In the planning of health and community services, there should be an increased emphasis on the measurement and quantification of outcomes, and on the application of those measurements to policy formulation and service delivery. The effective functioning of these two key units will enable a more evidence-based and targeted use of resources, not just within DHCS, but also sector wide. This increase of effort in areas of identified need will make possible a significant improvement in the overall health and well-being of Territorians, and particularly of those currently with the worst health and well-being - Aboriginal Territorians.

6101. In essence, the proposed Branches are to be committed to strategic priority setting and investment. Their core function is to determine the long-term key priority investment areas for the Department. We see them achieving this goal by health/community services gains activity - eg cost benefit analysis, population health and well-being measurement using 5 year program planning or 5 year planning for each strategic priority area. They will need to develop a research agenda and implement that agenda. One of their principal tasks will be to provide informed advice about the relevance of Commonwealth investment to NT priorities (a matter we discuss further elsewhere in this Report). They will seek, establish and nurture research partners locally, nationally and internationally, including MSHR, the Co-operative Research Centres, or by outsourcing.

**Principal** and Supporting Recommendations:

**The Department should establish a Health Gains Branch and a Community Services Gains Branch.**

The core functions of these Gains Branches should be to manage the process that determines the key priority investment areas for the Department.

*Acute Care Operations Group*

6102. Acute care is a critical area for the Department. An Acute Care Operations Group, headed by an Assistant Secretary, should be established. The key issues pertaining to acute care are discussed elsewhere in the Report.

**Principal and Supporting Recommendations:**

**The Department should establish an Acute Care Operations Group.**

*Community Services*

6103. The Review observes that the current integration of health and community services has tended to blur the focus between these areas and to disadvantage the important area of community services. Our proposals redress this situation. The Department should re-create a specifically identified focus on community services, incorporating programs encompassing disability services, family and aged care services, and youth and children's services.

6104. The Review's proposal for the establishment of a Community Services Group, headed by an Assistant Secretary, flows from the need to ensure appropriate focus, accountability, and clear identification of responsibility for the pursuit of the Government's policy objectives and the Department's service delivery obligations for this sector.

6105. The new Group should consist of two Divisions, each headed by an Executive Director:

- a Community Services Division; and
- a Community Services Policy and Services Development Division.

6106. The Community Services Division, with three service provision Branches, should consist of:

- the Disability Services Branch, responsible for the provision of a full range of services to people with disabilities;
- the Family and Aged Care Branch, accountable for the provision of services to families and to the elderly; and
- the Youth and Children's Services Branch, providing services required to assist young Territorians.

6107. A fourth Branch within the Division, the Child Protection Branch, should highlight the Department's clear statutory obligation to protect children at risk. Our consultations with the community have demonstrated that, hitherto, this element of the Department's responsibilities has tended to be somewhat overshadowed.

**Principal and Supporting Recommendations:**

**A Community Services Group, headed by an Assistant Secretary, should be established.**

The Community Services Group should consist of two Divisions, each headed by an Executive Director: a Community Services Division; and a Community Services Policy and Services Development Division.

The Community Services Division should consist of the Disability Services Branch; the Family and Aged Care Branch; and the Youth and Children's Services Branch, together with the Child Protection Branch.

*Child Protection*

6108. One of the primary concerns of a compassionate and effective health and community services system should be the health and well-being of children and young people. Children and young people have the right to grow in a society and community that promotes their physical, intellectual, social and cultural well-being and development. Essential to this is the need to secure their dignity, promote their able engagement in a caring family and social environment, and ensure their protection. Individuals, families and communities hold joint responsibility to strive towards these goals.

6109. Acts of child abuse (including but not limited to sexual abuse) are criminal acts that create a significant detrimental effect on a child's physical, psychological or emotional well-being and development and offend these core principles and rights. Child sexual abuse is the misuse of power by someone over a child for the purposes of exploiting a child for sexual gratification and includes incest, molestation, sexual assault and the exploitation of children for pornography or prostitution.

6110. The Department and its staff are integral players in the effort to prevent and ameliorate the consequence of child abuse. The Department and staff fulfil this function and responsibility as individuals and as part of a larger service provider network. The Department holds that underpinning this function are a number of key principles including:

- The best interests of the child should remain paramount. All actions should benefit the child in the best possible way.
- Children should be given the opportunity appropriate to their age to participate in decisions about their lives. Children have perspective to share and can enrich the decision making process.
- Child protection decisions should take account of the culture, religion, developmental age and sexuality of the child or young person, family or carers.



- Children should have every opportunity to realise their full and harmonious development without discrimination.

6111. Child protection and related issues, especially in Aboriginal communities, are currently attracting an increasingly high public profile. A senior departmental officer should be nominated to examine the Department's current performance in this area, to report on current strategies, and to identify improved approaches.

**Principal and Supporting Recommendations:**

**Any departmental restructure should recognise the importance of the child protection role of the Department and the Department's clear statutory obligation to protect children at risk. Enhancement of the current level of child protection function is a priority, given current levels of risk in the area.**

A senior departmental officer should be nominated to examine the Department's current performance in this area, to report on current strategies, and to identify improved approaches.

*Disability Services*

6112. The provision of adequate and appropriate services to people with disabilities is a national problem. Among the principal issues to be confronted are those surrounding the funding of services to tackle unmet need, the need to apply principles of equity to the provision of disability services, and the problems raised by the need to ensure sustainability of service provision.

6113. While the Review received a small number of submissions addressing aspects of disability services provision, these concentrated on issues such as hospital care for people with disabilities, carers and foster-carers of people with disabilities, the role of community health in disability services, and the need for a peak body to bring together disability-related NGOs. Each of these issues has been considered elsewhere in this Report.

6114. Nonetheless, the Territory is not immune from the wider issues affecting the provision of disability service in other Australian jurisdictions. In many ways, its problems are more serious than other parts of Australia because of the incidence of disability among the Territory's Aboriginal population.

6115. Commonwealth, State and Territory legislation covering the provision of disability services will be subject to review in the near future. This review should provide an opportunity for the Territory's legislation and approach to disability service provision to be examined thoroughly. This wide-ranging review should be undertaken by the Disability Services Advisory Council.

**Principal** and Supporting Recommendations:

**The Territory’s legislation and approach to disability service provision should be reviewed by the Disability Services Advisory Council.**

The Department should negotiate at least to match Commonwealth growth offered in the current Commonwealth State/Territory Disability Agreement negotiations and when possible re-open negotiations with the Commonwealth to achieve a joint approach to further growth, in light of unmet need for disability services in the NT.

*Community Services Policy and Services Development*

6116. The Community Services Policy and Services Development Division, through its three Branches:

- the Community Services Policy Development Branch;
- the Community Services Development and Modelling Branch; and
- the Community Services Gains Branch,

should bring together the current funder and purchaser functions of the Department as they apply to the community services sector. This Division should sharpen the Department’s focus on policy and service development by integrating the former funder and purchaser roles, while retaining the essential underpinning of the former funder/purchaser/provider model.

6117. If the approach outlined above is adopted, the community services policy focus of the Department will be strengthened, while the advantages of purchaser/provider arrangements will be retained. The Division should also play a key role in modelling new service types, and in measuring and reporting on community services outcomes.

6118. One of the core functions of this Division should be to support and facilitate the development of a robust community services sector through capacity building activities. This role combined with the function of determining program and service priorities for investment and disinvestment, will mean that the functions of the Division should mirror, in the community services sector, the core functions and activities of the Health Policy and Service Development Division discussed elsewhere in this Report.

**Principal** and Supporting Recommendations:

**The Community Services Policy and Services Development Division should consist of the Community Services Policy Development Branch; the Community Services Development and Modelling Branch; and the Community Services Gains Branch.**

One of the core functions of Community Services Policy and Service Development Division should be to support and facilitate the development of a robust health sector through capacity building activities.

*Corporate Development and Accountability*

6119. A Corporate Development and Accountability Group, headed by an Assistant Secretary, is pivotal to the smooth internal operations of the Department and to appropriate coordination of service delivery in the NT's two regions, the Top End and Central Australia.

6120. The Group should consist of two principal Divisions, each headed by an Executive Director: a Corporate Services Division, and an Information and Communication Services Division, together with two, small, regionally-based coordination offices.

**Principal and Supporting Recommendations:**

**There should be a Corporate Development and Accountability Group, headed by an Assistant Secretary.**

The Group should consist of two principal Divisions, each headed by an Executive Director: a Corporate Services Division, and an Information and Communication Services Division, together with two, small, regionally-based coordination offices.

*Corporate Services*

6121. The Corporate Services Division should consist of four Branches:

- a Performance Evaluation and Audit Branch;
- a Budget, Finance and General Services Branch;
- a Human Resource Management and Development Branch; and
- a Health and Aged Care Facilities Licensing Unit.

**Principal and Supporting Recommendations:**

**The Corporate Services Division should consist of four Branches: a Performance Evaluation and Audit Branch; a Budget, Finance and General Services Branch; a Human Resource Management and Development Branch; and a Health and Aged Care Facilities Licensing Unit.**

*Performance Evaluation and Audit*

6122. The Performance Evaluation and Audit Branch should be responsible for managing a number of key functions of the Department, and should be headed by a Director of Audit Services. The incumbent of the position of Director should possess highly regarded accounting qualifications and the capacity to undertake internal audits from time to time as requested by the CEO and/or the departmental Audit Committee.

6123. The Branch should be located within the Corporate Services Division for management and administrative purposes, but should have a direct reporting responsibility to the CEO for those elements of its functions that pertain to its audit responsibilities. It should be responsible for coordinating all responses on behalf of the CEO to the Auditor-General and for the Department's Audit Report in the Annual Report.

6124. This Branch should be the principal interface with the internal and external audit operations coordinated by the Chief Minister's Department, the Auditor-General, and contractors conducting audits. Its functions should include:

- the provision of a Secretariat to the departmental Audit Committee;
- the identification and management of risk within the Department;
- provision of specialist advice to the Department on corporate governance and audit;
- regular periodic evaluation and review of the programs run by the Department;
- the establishment and support of a performance management regime applicable to departmental staff;
- the coordination of the internal and external audit requirements of the Department and the monitoring of the implementation of audit recommendations; and
- the establishment and maintenance of an evaluation and audit program covering the entire Department.

6125. The Department (through the Performance Evaluation and Audit Branch) should accentuate the responsibility and accountability of its staff by adopting performance management across the Department. This should be closely aligned to the business planning process. To date there has been at best only token attention to this critical issue. Performance management is discussed in more detail elsewhere in this Report.

**Principal and Supporting Recommendations:**

**The Performance Evaluation and Audit Branch should be responsible for**

- **the provision of a Secretariat to the departmental Audit Committee;**
- **the identification and management of risk within the Department;**
- **regular periodic evaluation and review of the programs run by the Department;**
- **the establishment and support of a performance management regime applicable to departmental staff;**
- **the coordination of the internal and external audit requirements of the Department and the monitoring of the implementation of audit recommendations; and**
- **the establishment and maintenance of an evaluation and audit program covering the entire Department.**

*Quality*

6126. Quality improvement should be included among the responsibilities of the Performance Evaluation and Audit Branch.

6127. A culture of quality and safety, and of continuous improvement in quality and safety is essential for any health service in order to protect its customers and staff and to provide the best possible service within its sphere of activity. A quality health service should be safe, appropriate, acceptable, accessible, effective and efficient.

6128. In Australia it is estimated that between 12% and 16% of hospital admissions are associated with an adverse event related to the delivery of health care. Very few of these events are related to true negligence by staff, but are invariably due to system process failures. There is no reason to believe that the same does not apply to NT health services.

6129. The Federal Government has formed the Australian Council on Quality and Safety in Health Care (ACQSHC). This organisation has identified a number of strategic areas that need to be addressed as matters of urgency. These include incident reporting mechanisms, reduction in medication errors, reduction in falls, and appropriate accreditation and credentialing. Work by the Council on informed consent is progressing.

6130. In the Department, while there is a commitment to the principles of quality, there is little systematic and effective quality audit process.

6131. The Department should identify health leaders in quality and, as soon as possible, establish an NT Health Quality Council with a mandate to produce quality and safety change in

the health system. These changes will come about only with strong leadership and Government support. The Chair of the Health Quality Council should be independent, and the Council should report to the Minister for Health and Community Services.

6132. The Council should develop a work plan approved by the Minister. Adherence to the work plan and the outcome of the plan will determine the efficacy of the Council. The engagement of clinicians is vital in the process of change, and the development of a good Clinical Governance model will assist in this process.

6133. The Department should institute an annual Quality Award Program.

**Principal** and Supporting Recommendations:

**The Department should identify health leaders in quality and, as soon as possible, establish an NT Health Quality Council with a mandate to produce quality and safety change in the health system.**

The Chair of the Health Quality Council should be independent, and the Council should report to the Minister for Health and Community Services.

*Budget Finance and General Services*

6134. Budget, finance and general services have all been identified as departmental issues requiring significant improvement. The establishment of an effective Budget Finance and General Services Branch will remedy these issues. The Budget Finance and General Services Branch will be discussed more fully elsewhere in this Report.

**Principal** and Supporting Recommendations:

**There should be an effective Budget Finance and General Services Branch. This requires both immediate attention to the identified deficits in the Department's accounting systems and support of a fundamental cultural shift toward corporate and collective management responsibility for financial outcomes.**

*Human Resource Management and Development*

6135. The establishment of a Human Resource Management and Development Branch within the Division will redress one of the clear shortfalls in the current administrative arrangements. The establishment of this Branch will provide an opportunity for the Department to rebuild its capacity in human resource management and to concentrate appropriately upon the development of its most important asset, namely its staff, and upon human resource policy development, monitoring and reporting. This issue is discussed in more detail elsewhere in the Report.

**Principal and Supporting Recommendations:**

**A Human Resource Management and Development Branch should be established to rebuild the Department's capacity in human resource management, and to concentrate appropriately upon the development of staff, and upon human resource policy development, monitoring and reporting.**

*Health and Aged Care Facilities Licensing*

6136. The establishment within the Division of a small Health and Aged Care Facilities Licensing Unit will provide a vehicle whereby the Department will be able to ensure that standards of buildings and care in health and aged care facilities (including public and private hospitals, nursing homes and aged care hostels, child care centres, psychiatric hostels, community health centres, and other like facilities) are reviewed, supervised and maintained, without significant additional impost upon either the Department or the facilities themselves.

6137. The Review recommends adoption in the NT of the conclusions and recommendations of the recent review of health and aged care licensing arrangements in Western Australia<sup>2</sup>, the findings and recommendations of which<sup>34</sup> were adopted by the Western Australian Government and are in the process of implementation.

6138. The principles underlying the recommended approach are that:

- to the maximum extent possible, jurisdictional duplication and overlap should be eliminated in the licensing of aged care facilities;
- complete exemption from Territory licensing provisions be granted to nursing homes and aged care hostels (i.e. for aged care facilities that provide high care, low care, or both high and low care) where the facility has already achieved or does in the future achieve and maintain Commonwealth certification or accreditation under the provisions of the Commonwealth Aged Care Act 1997;
- separate Territory-based licensing standards covering proprietors, facilities and care be developed for hospitals, for psychiatric hostels, for day surgeries, and for nursing posts,

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<sup>2</sup> Oceana Consulting PL, Report, *A Review of the Licensing of Private Sector Health and Other Facilities in Western Australia*, Health Department of Western Australia, 7 November 1998

<sup>3</sup> Oceana Consulting PL, Final Report, *A Review of the Licensing of Private Sector Aged Care Facilities in Western Australia*, Health Department Of Western Australia, 31 March 1999

<sup>4</sup> Oceana Consulting PL, Final Report, *A Review of the Licensing of Private Sector Health Care Facilities in Western Australia*, Health Department Of Western Australia, 30 April 1999

and that these sets of standards reflect the roles and responsibilities of each of these services;

- depending upon the quality of each facility and the care provided, and upon the level to which it complies with the relevant published standards, the duration of each licence granted vary so that one-year, two-year or three-year licences are granted;
- subject to their compliance with other requirements of the licensing framework, a three-year period of licence normally be granted to hospitals accredited with ISO/ACHS;
- a better balance be struck between public sector licensing and private sector service provision with a more appropriate allocation and acceptance of risk and cost, and that this balance be achieved by adopting a framework for licensing (except in the aged care area) which requires third party certification of facility standards as a prerequisite for licensing;
- the Territory adopt as a principle the formulation of a three-tiered approach to the setting of standards for licensed health care facilities involving:
  - formal adoption of Building Code of Australia and/or Australian Standards Association standards (where available, and as amended from time to time);
  - incorporation of Territory local Government and statutory requirements (including fire and public health regulations, local authority building codes etc.); and
  - augmentation of the above standards by the preparation and promulgation by the Department of additional requirements only as strictly required to meet specific and otherwise unmet Territory and Departmental needs.

**Principal and Supporting Recommendations:**

The maintenance of appropriate standards of buildings and care in health and aged care facilities (including public and private hospitals, nursing homes and aged care hostels, child care centres, psychiatric hostels, community health centres, and other like facilities) should be supervised and maintained by the adoption in the NT of the conclusions and recommendations of the recent review of health and aged care licensing arrangements in Western Australia.

*Information and Communication Services*

6139. An Information and Communication Services Division of the Corporate Development and Accountability Group should be established, consisting of two principal Branches:

- an Information Technology Infrastructure and Assistance Branch; and
- an Information Management and Library Services Branch.



6140. In placing responsibility for IT infrastructure and systems within the IT Infrastructure and Assistance Branch, the Review is convinced that access to robust, stable, cost effective and contemporary IT and systems is essential for the smooth operation of the Department and for the collection and management of information required to inform the development of programs and the delivery of services.

6141. In this context, the Review is concerned at the extraordinarily high cost borne, and less than satisfactory service received, by the Department from the current outsourcing arrangements applicable to information technology. As IT outsourcing is a whole-of-Government matter, and is not limited to the Health and Community Services portfolio, we observe that management of the relationship between the Department and the outsourced service providers will be a matter for this Division to manage. This issue has the potential to impact adversely on the Department's discretionary budget.

6142. The role of the Information Management and Library Services Branch is of significance to the operations of the entire Department. Appropriate collection, management and dissemination of information across the whole system provides an essential tool to monitor system performance, to monitor performance against budget, to measure the outcomes of service provision, and to design and reform programs to make them most effective.

6143. In addition, this Branch should be responsible for such matters as the preparation of the Department's Annual Report. The Review believes that too much time and money is spent currently on the presentation and publication of the Department's Annual Report. While the Annual Report is an important statutory requirement, and is an integral part of the management cycle of the Department (as we have discussed elsewhere in this Report), it does not warrant the current allocation of resources. This effort and resource would be better expended on brief, regular communication with internal and external stakeholders.

6144. In terms of communication with staff, clinicians and stakeholders, and of improving the accessibility of electronic health/community services resource materials, the Department should enter into discussion with other states (like New South Wales or Western Australia) with a view to introducing in the NT the delivery of internet-based health information resources by joining the multi-state contract with Health Communication Network, an Australian based e-health company.

6145. The Review has been advised of a range of matters relating to the availability, quality and relevance of information collected as part of the Department's activities. The concerns raised with the Review can be summarised as:

- there is not enough active and informed consideration given to the type of data needed to support decision making on the budget, workforce issues, health gains, programs or services;

- the Department's information systems (people, processes and infrastructure) do not, in the main, have the capacity to deliver appropriate quality information at the present time.

6146. While the Department as a whole has responsibility for resolving this issue, the Information Management Branch should ensure that the Department's information management systems are able to deliver timely, reliable and valid information to support effective decision-making.

**Principal and Supporting Recommendations:**

**An Information and Communication Services Division of the Corporate Development and Accountability Group should be established, consisting of two principal Branches: an IT Infrastructure and Assistance Branch; and an Information Management and Library Services Branch.**

The Department should reassess and review its management of outsourced Information Technology in order to reduce costs and improve service.

The Department should enter into discussion with other states (like New South Wales or Western Australia) with a view to introducing in the NT the delivery of internet-based health information resources by joining the multi-state contract with Health Communication Network.

The Information Management Branch should ensure that the Department's information management systems are able to deliver timely, reliable and valid information to support effective decision-making.

#### Regional and District Administration

6147. The Review has observed that there exists widespread confusion between the concepts of decentralised structures and devolved processes. The former is expensive and probably unnecessary; the latter is essential.

6148. In our view, resolution of this confusion would see no fewer people 'on the ground' providing services, but would see those service deliverers managed by people with appropriate expertise. There is, therefore, a good argument to remove Regional or District administration (or both) and replace those structures with devolved management processes and professional supervision, at the same time giving opportunities to increase local service delivery and coordination. This would require a strong commitment to rigorous recruitment practices that ensure best fit of skills to job requirements, and to devolution, accountability and delegation. A high degree of integrity in dealing with those delegations is essential.

6149. Coordination of service delivery across the Top End of the NT and across Central Australia is vital if the Department is effectively to deliver its service delivery responsibilities.

Nonetheless, the Review does not believe that the existing arrangements, that is the Top End Service Network (TESN) and the Central Australian Service Network (CASN), have been successful in achieving this objective.

6150. To the contrary, the line management responsibilities of the Regional Directors of TESN and CASN have served in many cases to obscure and even to dilute the capacity of central office program managers to give effect to appropriate levels of service delivery in those two regions. Moreover, there has developed an ethos whereby a service delivery approach deemed appropriate for TESN is, in the view of many CASN staff, almost automatically deemed suitable for CASN. This has become a source of frustration and concern for departmental personnel in Central Australia involved in service delivery.

6151. The anomalous situation of TESN and CASN is brought into stark relief when one takes into account the superimposition of TESN and CASN management over the various districts that make up the TESN and CASN regions. The end result of the interplay between program, regional and district management has led, in many cases, to discontent, confusion, frustration and excessive resource consumption.

6152. It appears on the evidence that the administrative burden of the Department (namely the Head Office, Regional and District administrative structures) is far too great. Our view is that the Department should give better support to service providers, both internal and external. To enable this, we envisage a significant reallocation of resources to service support and to other vital areas such as human resource management and development.

6153. For that reason, the Review recommends that Regional line management in TESN and CASN, as well as District management, should be abolished. Two Executive Directors, Central Australian Service Coordination and Top End Service Coordination, each assisted by a very small and focussed staff and located within the Corporate Development and Accountability Group, should replace the Networks. These two senior officers should operate in a matrix which gives them the opportunity and responsibility to ensure overall coordination of service delivery across their respective regions while not interposing themselves in the line management chain of accountability which should, throughout the NT, flow through to the relevant Territorial program manager.

6154. In this way, these two coordinating Executive Directors will play a significant role in enabling the Assistant Secretary, Corporate Development and Accountability to ensure that the Department remains sharply focussed in the delivery of its services in the most geographically appropriate way to all areas of the NT.

6155. At the same time, while the TESN and CASN Executive Committees are no longer necessary or appropriate (except by way of a relatively informal mechanism for ensuring adequate communication across the respective regions), the District Committees could continue as

vehicles for intra-district communication, collaboration and coordination. They should not, however, be allowed to become de facto management committees. Regional and District administration and management structures should be abolished, and should be replaced by Regional coordination, by devolved management processes and professional supervision, by increased local service delivery and coordination, and by District-level mechanisms to promote communication and collaboration.

**Principal** and Supporting Recommendations:

**Regional and District administration and management structures should be abolished, and should be replaced by Regional coordination, by devolved management processes and professional supervision, by increased local service delivery and coordination, and by District-level mechanisms to promote communication and collaboration.**

*Health Professionals Licensing Authority*

6156. The Review has addressed the issue of the Health Professionals Licensing Authority and Registration Boards. It is our view that a greater degree of separation should be established between the Authority/Boards and the Department that employs many of the professional staff registered by them.

6157. The Health Professionals Licensing Authority and Registration Boards should remain within the Health Portfolio, but should directly employ their own staff. They should utilise registration fees for this purpose (with the fees being increased to bring them into line with the average registration fees charged in the other States/Territory, and then being supplemented by the Government through a budget appropriation sufficient to cover agreed administrative costs). As an alternative, the Boards could obtain staff through contracts with relevant firms in the NT, again using professional registration fees to cover the costs of the small staffing complement required by the Boards.

**Principal** and Supporting Recommendations:

**The Health Professionals Licensing Authority and Registration Boards should remain within the Health Portfolio, but should directly employ their own staff.**

Registration fees should be increased to bring them into line with the average registration fees charged in the other States/Territory, and should then be supplemented by the Government through a budget appropriation sufficient to cover agreed administrative costs.

*Office of Aboriginal Health and Service Support*

6158. Aboriginal health is a key area for the Department, and as such an Office of Aboriginal Health and Service Support, headed by an Executive Director, should be established. The key issues pertaining to Aboriginal health are discussed elsewhere in the Report.

**Principal** and Supporting Recommendations:

**The Department should establish an Office of Aboriginal Health and Service Support.**



## Chapter 7: Financial Accountability

701. As discussed below in this Report, there are significant shortcomings in the Department's accounting processes that do not allow expenditure forecasts with high levels of confidence.

702. The basic processes lack integrity in the application of accounting principles, in particular in the allocation of expenditure across different cost centres. This makes the extrapolation of first quarter expenditure to a full year prediction difficult. This also makes budget control (that necessarily happens at a lower level) much more difficult.

703. On the assumption that accruals in the first quarter of the year have been appropriately treated, a straight-line projection would suggest that the Department could be over budget by as much as \$30 million at 30 June 2003. Given the present state of the accounting processes little confidence can be had in such an estimate. Over the last months budget control strategies have been put in place which will have reduced this amount, however eliminating it is not possible at this time in the financial year.

704. It is essential that the Department takes action now to re-establish confidence in its accounting processes, financial reports and budget control (see discussion and recommendation below).

705. The work on accounting processes recommended to be undertaken by the Department with support from expert consultants is the Department's first priority. Once this work is complete a reassessment of the budget position is essential.

### *A Marginal Analysis of Expenditure Against Budget*

706. In an attempt to illustrate the current and projected pressures on the budget, we have undertaken a marginal analysis that assumes all other factors remain unchanged. This of course is not the case and means that this analysis gives a "best guess" but is not sufficient for budget planning.

707. This analysis excludes Government initiatives for which additional funds were specifically provided in the Territory Budget and some other additional expenditure for which specific provision was made.

708. Flow on effects from 2001/2002 financial year into the 2002/2003 budget are in the order of \$17.3M, and broadly made up of:

<b>Flow-on Impact From 2001/2002</b>	<b>\$M</b>	<b>\$M</b>
Deferred payments	12.1	
Full year impact of additional 150 staff employed in the last half of the year	10.1	
Less One off payments	(4.9)	
		<hr/>
		17.3

709. The over-expenditure in 2001/2002 was met in part by a one-off allocation from the Treasurer's Advance Account and in part by the deferment of payments into 2002/2003. This has an impact on the 2002/2003 budget of \$12.1M.

710. The Department had an unplanned increase of 150 staff in 2001/2002, many of which were appointed late in the financial year. The additional impact in 2002/2003 of these appointments is \$10.1M. This reflects a serious breakdown in management processes and a disregard for the budget. There are many signs of breakdown of budgetary discipline within the Department but the appointment of staff without ongoing budget provision is the most graphic. It is a high priority for the Department to re-establish budgetary discipline.

711. There are service demand pressures that will be largely unavoidable in 2002/2003. They should be recognised, funded and managed, not just used as an explanation for over-expenditure at the end of the year. The larger and more obvious of these have been identified and, together with some unavoidable costs, are estimated to cost approximately \$14M in 2002/2003.

712. Some areas such as renal dialysis is very predictable and in future needs to be planned and provision made. In disability services the drivers of growth are less clear and need further analysis.

713. Total impact of these factors is in the order of \$31M. However the budget includes provision of \$3.2M for net cost increases, and \$0.5M for RDH Accident and Emergency which are legitimately offset against this sum. This leaves a potential budget overrun of \$27.6M.

714. The budget includes \$7.1M that was finally to be allocated after Cabinet's consideration of this Report. Cabinet's consideration of the final allocation will need to include this potential overrun of \$27M, actions recommended in this Report that require funding, and the Department's current capacity to implement them.

715. At the present time the Department's capacity to make significant offset savings is limited by its management capacity. However, over time there are significant reductions in outlays that might be achieved without adversely affecting services.

### The Outyears

716. Analysis is needed to establish meaningful forward estimates for the financial years 2003/2004, 2004/2005 and 2005/2006. This cannot be conducted effectively until the work recommended elsewhere in this Report is completed.

717. It is recognised that inadequate provision has been made for the operating expenditure of the new facilities of the Accident and Emergency and Intensive Care Units at RDH. The impact is estimated to be an additional \$4M and \$2M in 2003/2004 and 2004/2005 respectively.



718. There are a number of pressures causing expenditure growth that are now largely unavoidable. Much of this Report goes to the issue of what services are funded rather than whether services growth is funded or not. For example, many people are brought to Darwin for hospitalisation while, with additional effort, the needed services could be provided in one of the secondary hospitals closer to home. There is a choice of where the services are provided; this choice should be made explicitly.

<b>Forward Estimates</b>	<b>Current Year</b>	<b>2003/2004</b>	<b>2004/2005</b>	<b>2005/2006</b>
	<b>\$M</b>	<b>\$M</b>	<b>\$M</b>	<b>\$M</b>
Hospital Inpatient Costs including hospitalisation provided in other States	4.4	20.0	19.8	22
Renal Dialysis	2.25	3.43	4.25	5.28
Disability Services	2.6	0.9	1.9	2.8
Child Day Care	0.3	0.3	0.3	0.25

719. The above figures are for illustration only and are not the result of sophisticated analysis. They do not include pressures in areas such as mental health where demand pressures are being looked at in a separate review. They do not include capital funding. As indicated elsewhere in this Report, growth in primary care provision will also lead to an increase in demand for secondary care services.

#### Commonwealth Programs

720. Commonwealth Government tied grants to the NT Government in 2001/2002 funded 22% of the health and community services expenditure of \$490M for that year.

721. Commonwealth Government grants and specific purpose payments (SPPs) need to be more closely managed. The accounting treatment of Commonwealth funds appears inconsistent, with a tendency to expend receipts in the period they are received as one might do with true grants. Commonwealth so-called “grants” are provided mostly to support service provision and expenditure by the Territory, and should be matched to the period within which that expenditure takes place.

722. The Commonwealth Government is an important source of funds for the Department, and Commonwealth grants clearly should be maximised where the purpose for which they are sought are congruent with the Department’s objectives. PHCAP is one such and allows the Department to pursue the Territory’s objectives more quickly. However, some of the smaller SPPs are not consistent with NT priority objectives and draw scarce resources away from the implementation of the Territory’s priorities. Not only should a project have value, but it should also contribute to the Department’s priorities.

723. The Department should pursue Commonwealth program and project funding only when such programs/projects have policy objectives that coincide with Territory priorities.

**Principal and Supporting Recommendations:**

**The Department should pursue Commonwealth program and project funding only when such programs/projects have policy objectives that coincide with Territory priorities.**

*Business Planning, Resource Allocation, Performance Management and Budget*

724. Proper compliance with business planning, resource allocation, performance management and budget processes are, in the Review's opinion, key to the ongoing success of the Department. These processes and approaches are not currently adhered to, nor is the relationship between those processes strong enough. They lack focus, and suffer from too many "priorities". The processes should be integrated better and applied more rigorously. The Department should embark upon an ongoing and rigorously applied business planning process, coordinated by the Executive Services Branch.

725. This process should see the development of a business plan covering the entire organisation, concentrating on a limited number (no more than four to six) of key result areas (KRA). Each KRA should encompass a series of clear and achievable objectives, for each of which there should be set out a number of specific activities required to attain that objective. A number of quantifiable and measurable performance indicators should attach to each objective.

726. Once the business plan has been completed (involving as broad a range of intra-departmental collaboration and consultation as possible, together with relevant external consultation) it should be submitted to the Minister for endorsement.

727. Resources should, during budget negotiations, be allocated across departmental programs in accordance with the priorities set out in the Business Plan. When the Department's budget is settled, the Business Plan should be revised if necessary to incorporate the final outcome of Cabinet's budget decisions. Once endorsed, the Department's Executive should, as the year progresses, closely and regularly monitor, on a monthly basis, expenditure against budget for each cost centre, as well as progress in implementing the Business Plan. The Executive should take appropriate remedial action whenever it identifies a divergence from the budget or from the directions set in the Business Plan.

728. At the end of each financial year, there should be an evaluation of outcomes, measured both against the budget and against the performance indicators set out in the Business Plan. This frank and realistic evaluation of outcomes should be reported on to the Minister and to the Government. The outcome report should be a major input into the development of the revised business plan for the succeeding year, as well as providing the basis for the Department's Annual Report.

729. The Review has seen the Report<sup>1</sup> prepared by Ernst and Young, and has met with the authors. Our observations and discussions lead us to conclusions not at variance with those in that Report. Our view is that the recommendations of our Report and those of Ernst and Young are complementary, and that our more strategic recommendations will provide a basis upon which, and a structure within which, the recommendations of the Ernst and Young Report will be easily accommodated and implemented.

**Principal and Supporting Recommendations:**

**The Department should develop and adhere to an integrated business planning cycle coordinated by the Executive Services Branch.**

Departmental priorities should be agreed between the departmental Executive and the Minister, and should be grouped as objectives under four to six key result areas encompassing the full scope of the Department's operations. For each objective there should be identified a number of specific activities required to attain that objective, with two or three quantifiable, measurable and outcome-oriented performance indicators attaching to each objective.

The preparation of the Department's Business Plan should involve a broad range of intradepartmental consultation, together with relevant external stakeholder consultation.

The completed Business Plan should be submitted to the Minister for endorsement.

Resources should, during budget negotiations, be allocated across departmental programs in accordance with the priorities set out in the Business Plan. Once the Department's budget is settled, the Business Plan should be revised if necessary to incorporate the final outcome of Cabinet's budget decisions.

The Department's Executive should, as the year progresses, closely and regularly monitor, on a monthly basis, expenditure against budget for each cost centre, as well as progress in implementing the Business Plan. The Executive should take appropriate remedial action whenever it identifies a divergence from the budget or from the directions set in the Business Plan.

At the end of each financial year, there should be an evaluation of outcomes, measured both against the budget and against the performance indicators set out in the Business Plan. The evaluation of outcomes should be reported on to the Minister and to the Government.

The outcomes report should be a major input into the development of the revised Business Plan for the succeeding year, and should be the basis for the Department's Annual Report.

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<sup>1</sup> Report: *Working for Outcomes Review*, Ernst and Young, November 2002

### Finance Committee

730. To assist the CEO in managing the Department's budget, the Department should establish a Finance Committee, chaired by the CEO. This should replace the current Finance Standing Committee. This Committee should include among its members the Assistant Secretary responsible for Corporate Development and Accountability, and the General Manager responsible for budgets and finance. The role of the Finance Committee should be to ensure that monthly financial reports to the Executive are clear and accurate, to resolve factual disputes before reports are submitted to the Executive, and to ensure that the monthly reports to the Executive rigorously analyse performance against budget, and contain recommendations addressing significant divergence from the budget.

#### **Principal and Supporting Recommendations:**

**The Department should establish a Finance Committee, chaired by the CEO and including among its members the Assistant Secretary responsible for Corporate Development and Accountability, and the General Manager responsible for budgets and finance.**

### Budget Finance and General Services

731. The Department should create, within the Corporate Services Division, a Budget Finance and General Services Branch which will bring together a number of departmental functions essential for its smooth operation. This Branch should be headed, as General Manager, by a newly created position of Chief Finance Officer (CFO), who should be a qualified accountant.

732. The CFO should be accountable directly to, and given specific authority by, the CEO for the development and promulgation of, and adherence to, departmental accounting standards and for all departmental accounting processes relating thereto. The Department should move as soon as possible to fill the position of CFO.

733. The CFO should, as soon as possible after his/her appointment, commission work to put in place a properly designed accounting system for the Department.

734. The task should be to:

- create a working group with the skills, resources and tools to establish a platform that can be built upon to deliver accurate financial reporting;
- implement the work undertaken in stage 1 and develop internal skills required to deliver financial reporting with the required accuracy and integrity; and
- implement a framework and culture of continual improvement, risk management and financial integrity.

735. It should be observed that the creation some years ago of the Department of Corporate and Information Services (DCIS) and the resultant transfer of many corporate services functions and staff to that new agency from all Government Departments (except the Chief Minister's Department) was a significant change in administrative arrangements.

736. It appears to us from our discussions and studies within the Department that areas such as financial accountability and transparency, the maintenance of financial and other workplace records, and protection against misappropriation/fraud in the area of purchasing and procurement require very real attention. This requires attention to the relationship with DCIS. A service agreement does not currently exist between the Department and DCIS pertaining to financial and budget management. The Department needs to follow this up and ensure it enters such an agreement.

737. The Review received submissions expressing concern at current levels of outstanding debt to the Department, and at the apparent lack of action being taken by both the Department and by DCIS to address the situation. Much of this "debt" is in fact related to either Commonwealth GST related to grants from the Commonwealth, a transaction which was introduced at the same time as the transfer of the function to DCIS, and to potentially compensable clients who may not end up being accepted.

738. About nine months ago, Stantons undertook a review under the authority of Risk Management Services. The Stantons review identified the lack of an interface between the Government Accounting System-Accounts Receivable and CareSys as a major problem. This interface has only recently become operational, but still involves a delay of ten days. A further exercise to rectify problems is scheduled for completion by end-November 2002. In the meantime, a number of changes have been made which will impact positively on future levels of accounts receivable.

739. Management of the relationship between the Department and DCIS should be principally a matter for the Corporate Services Division to manage.

740. The Budget, Finance and General Services Branch will serve as a primary interface with DCIS on financial and appropriate corporate services matters. It will also be charged with responsibility for coordinating the preparation and monitoring of the Department's budget, and with the management of departmental facilities.

741. The Review received various submissions in relation to apparently inadequate or inappropriate recording, auditing and disposal of departmental assets not recorded on the Assets Register maintained by DCIS (i.e. assets under \$5,000 in value), including assets kept in departmental stores. All minor assets purchased by the Department should be recorded and accounted for. An annual audit should be carried out, and records of disposal to the departmental store or otherwise should be kept.

742. Accountable forms (such as Vehicle Fuel Maintenance Orders and CabCharge/Taxi Vouchers) are often inadequately registered, controlled, and monitored and discrepancies are not being notified to the CEO or delegate as prescribed in the Department's Accounting and Property Manual.

743. It similarly appears that there are no adequate policies in place governing the purchase by staff and cost centre managers of such items as mobile phones, leather bound diaries, stationary, software and other equipment. Submissions have been received by the Review suggesting that cost centre managers may be purchasing and/or approving the purchase of stationary, equipment and software, the functionality and cost of which far outweigh any legitimate requirement.

744. Submissions received by the Review provided examples of the use of Government vehicles for non-official business during and outside work hours. The use of pool/Government vehicles should be scrutinised and managed better, with the written approval of the relevant business manager being obtained prior to the use/issue of vehicles.

745. A number of respondents have advised that a significant number of sections of the Department refurbish, relocate or rearrange their own work areas, sometimes for no substantial reason. These moves entail expenditure on removalists, telephone reinstalment, and information technology reconnection, and incur significant down time and dislocation of staff. The relevant Division Head should approve all refurbishment and reorganisation of office accommodation, and only in circumstances where it is essential to the effective operation of the work area.

746. Once the Department has been restructured, the chart of accounts and the allocation of cost centres should be revised to accord with the new structure.

747. The move to accrual accounting within the Department has not been a smooth one. It appears to us that there has been insufficient staff training, too little attention paid to systems and processes to support the change, and incomplete communication with and education of staff about the implications and detail of the change. This will need to change, and change soon, if the Department is to avoid a failure to make the transition in concert with other NT public service departments. In the transition from cash to accrual accounting, the Department should ensure that all relevant departmental staff are properly trained in the new financial system, that required recording and processing systems and procedures are in place, and that the capacity for historical trend analysis is not lost.

**Principal and Supporting Recommendations:**

**The Budget Finance and General Services Branch should be headed, as General Manager, by a newly created position of CFO, who should be a qualified accountant.**

The CFO should be accountable directly to, and given specific authority by, the CEO for the development and promulgation of, and adherence to, departmental accounting standards and for all departmental accounting processes relating thereto.

The CFO should, as soon as possible after his/her appointment commission work to put in place a properly designed accounting system for the Department.

#### *Co-Location of the Department*

748. Budget Finance and General Services Branch should carry responsibility for departmental properties, including minor new works and property maintenance. The Review believes that it would be appropriate in the short term to give real consideration to the possibility of co-locating as much of the Department as possible into single premises.

749. The Review makes this observation in light of the dispersal of many of the departmental functions and staff across numerous buildings in the Darwin metropolitan area, and in light of the impending conclusion during 2003 of the current leasehold over Casuarina Plaza, a building occupied by staff engaged in Services Development and in the provision of services under many of the programs of the Department.

#### **Principal and Supporting Recommendations:**

**The Department should in the short term give consideration to the possibility of co-locating as much of the Department as possible into single premises.**

#### *Delegations*

750. The use of delegations within the Department requires radical revision. One significant deficiency identified in the Department's current mode of operation is the fact that the CEO and members of the Executive appeared swamped by relatively trivial administrative decision making tasks.

751. If the departmental budget was to be broken down to appropriate cost centres, and if the relevant program cost centre manager was to be held accountable for proper management of that cost centre budget, effective and efficient management would dictate that the necessary delegations (and provisos) should also flow to cost centre managers so that budgetary and other decisions can be taken at a more appropriate level in the organisation.

752. In this way, members of the Executive of the Department would be free to concentrate on the more strategic tasks involved in managing a complex agency, while program and cost centre managers could be held properly accountable for both the management of their budgets and for the delivery of services within their sphere of responsibility.

753. Once the Department has been restructured, personnel and financial delegations should be revised:

- to reflect the new structure,
- to accord with the new cost centre arrangements,
- to maximise the personal responsibility and accountability of cost centre managers to manage their resources in accordance with the Department's Business Plan, and
- to reflect, to the greatest extent possible, the principle of subsidiarity.

**Principal and Supporting Recommendations:**

**Personnel and financial delegations should be revised to reflect the new structure, to accord with the new cost centre arrangements to maximise the personal responsibility and accountability of cost centre managers to manage their resources in accordance with the Department's Business Plan, and to reflect, to the greatest extent possible, the principle of subsidiarity.**

*Departmental Audit Committee*

754. The role of the Departmental Audit Committee, chaired by the CEO, should be strengthened to ensure that a realistic, structured risk assessment process is instituted for the Department and that an internal audit program is developed, consistent with the risk assessment. The Committee should also ensure that regular program evaluations are conducted so that each departmental program is evaluated every three to five years.

755. The Departmental Audit Committee should report to the CEO, and should have the following functions and responsibilities:

- to monitor corporate risk management and the adequacy of the internal controls established to manage identified risk;
- to monitor the adequacy of the Department's internal control environment and to review the adequacy of policies, practices and procedures in relation to their contribution to, and impact on, the Department's internal control environment;
- to oversee the internal audit function including development of audit programs and monitoring of audit outcomes and the implementation of recommendations;
- to review financial statements and other public accountability documents (such as annual reports) prior to their approval by the CEO;



- within the context of the Committee’s primary objective, to undertake any other functions determined from time to time by the CEO.

756. The Audit Committee should self-assess the state of Corporate Governance in the Department using the check list contained in the Australian National Audit Office publication “*Applying Principles and Practice of Corporate Government in Budget Funded Agencies*”.

757. The Audit Committee should meet at least five times in each year and as required on an ad hoc basis. The membership and terms of reference of the Committee should be reviewed every second year.

758. In addition to the amount allocated for each Agency by Risk Management Services within the Department of the Chief Minister, the relevant program area in which an audit is being conducted should meet the cost of the audit.

759. The Director of Audit Services should provide the secretariat support to the Departmental Audit Committee, including preparation of agenda, meeting papers and minutes.

760. The Departmental Audit Committee should comprise:

- The CEO as Chair;
- The Deputy Secretary;
- Five other relevant/key departmental staff;
- A representative of Risk Management Services in the Department of the Chief Minister;
- An external qualified accountant with extensive audit experience; and
- A representative of the Office of the Auditor-General.

**Principal and Supporting Recommendations:**

**The role of the Departmental Audit Committee, chaired by the CEO, should be strengthened to ensure that a realistic, structured risk assessment process is instituted for the Department and that an internal audit program is developed, consistent with the risk assessment, and that regular program evaluations are conducted so that each departmental program is evaluated every three to five years.**

*Conflicts of Interest*

761. The Review has had brought to its attention a number of serious instances of unresolved conflict of interest. These cases were identified in the Department’s central administration, in the hospital system, and in departmental service provision. Some of them were serious; most of

them had the potential to jeopardise the reputation of the Department and its management, and to embarrass the Minister and the Government of the day; all of them betoken less than appropriate adherence to standards of public sector probity and ethical conduct.

762. In order to identify and eliminate potential conflicts of interest in the future, all relevant employees, and especially senior staff in the Department, should strictly adhere to the requirement to lodge and annually to update a register of pecuniary interests. By senior staff, the Review includes the CEO, members of the Executive, and officers at or above Branch head level. The model to be used should be based upon the model used in the Commonwealth Public Service and adhere to the requirements of Section 12 of the *Principles and Code of Conduct* issued under the *Public Sector Employment and Management Act*.

763. Members of management and advisory boards in the health and community services sector should similarly be required to lodge statements of pecuniary interest.

764. The register of pecuniary interests should be maintained by the CEO, with the keeping of the register not to be delegated. The register should be consulted in any circumstances where potential conflict of interest is thought likely to arise.

**Principal and Supporting Recommendations:**

**All relevant employees, and especially senior staff in the Department, should strictly adhere to the requirement to lodge and annually to update a register of pecuniary interests.**

The register of pecuniary interests should be based upon the model used in the Commonwealth Public Service and adhere to the requirements of Section 12 of the *Principles and Code of Conduct* issued under the *Public Sector Employment and Management Act*.

Procurement Processes

765. The Review has examined a range of procurement exercises conducted by the Department over the past five or so years. While some of these procurements were conducted appropriately, and had beneficial outcomes for the Department, many were not. Unsuccessful procurement activities sometimes resulted in the Department paying far more than it needed for the goods or services purchased; sometimes the entire process led to a complete failure to effect any purchase at all.

766. The Department's engagement in procurement activities appears to be marked by a number of repeated deficiencies. Too often, there is insufficient planning to enable there to be a clear understanding of just what goods or services are to be procured. There is little successful attempt properly to assess the likely cost of the goods or services to be procured. Realistic cost/benefit analysis is often lacking. Procurement specialists from elsewhere in the NT public

sector are too seldom brought into departmental procurements exercises, and when they are, they are often consulted too late or, worse, excluded from the process if their advice appears not to suit departmental management or elements within it.

767. The Department's procurement processes should be revised.

768. Detailed and rigorous planning is the absolute and unavoidable key to all successful procurements. Prior to any procurement action, the Department should explicitly define, by way of a request for information if appropriate, the precise service or article to be procured, and should assess realistically the likely cost implications. A number of procurement exercises will, following receipt of this information and the application of appropriate analysis and consideration, be terminated at this juncture.

769. For all procurement activities with a cost likely to exceed \$50,000, a procurement panel should be appointed by the CEO to manage the process, and to make a recommendation to the accountable officer or his/her delegate, prior to its being referred to the Procurement Review Board for endorsement or otherwise. The accountable officer or delegate should be the only person authorised to make, and should be accountable for, the final decision.

770. Territory Procurement Guidelines, as well as provisions relating to real or potential conflict of interest, should be strictly adhered to at all times. Where procurement cost is likely to exceed \$250,000 or where the procurement activity is likely to be complex, a Treasury representative should always be invited to join the Department's Procurement Panel immediately upon its establishment.

771. The NT is a small jurisdiction, in terms of population and procurement leverage. It cannot therefore exercise the purchasing power in terms of the trade-off between quantity and price that often advantage large jurisdictions. To address this problem, and to assist in reducing costs, the Department should explore the possibility of the NT participating in and taking advantage of the bulk procurement arrangements operated by New South Wales or another appropriate jurisdiction.

772. The Procurement Review Board within the Treasury Department is accountable to the Minister for Business, Industry and Resource Development for ensuring compliance with the Government's procurement policies and guidelines. Either directly or indirectly, the Under-Treasurer is accountable to that Minister for maintaining best practice in those policies and guidelines.

773. To ensure that higher standards of adherence to best practice in procurement are achieved and maintained within DHCS, the Department should, in collaboration with the Department of the Chief Minister and the Department of Treasury, establish a strategic procurement review group. This group, comprising a representative from each of the participating Departments, should be empowered to review annually any procurement activity

undertaken by the Department within the preceding twelve months with a view to determining whether or not the procurement was warranted and in the best interests of the Territory. It should be required to present a report on its findings to the Chief Minister, the Treasurer, and the Minister for Health and Community Services identifying any shortfall in meeting procurement best practice.

**Principal** and Supporting Recommendations:

**The Department's procurement processes should be revised.**

**Prior to any procurement action, the Department should explicitly define, by way of a request for information if appropriate, the precise service or article to be procured, and should assess realistically the likely cost implications.**

For all procurement activities with a cost likely to exceed \$50,000, a procurement panel should be appointed by the CEO to manage the process, and to make a recommendation to the accountable officer or his/her delegate, prior to its being referred to the Procurement Review Board for endorsement or otherwise. The accountable officer or delegate should be the only person authorised to make, and accountable for, the final decision.

Where procurement cost is likely to exceed \$250,000 or where the procurement activity is likely to be complex, a Treasury representative should always be invited to join the Procurement Panel immediately upon its establishment.

The Department should explore the possibility of the NT participating in and taking advantage of the bulk procurement arrangements operated by New South Wales or another appropriate jurisdiction.

## Chapter 8: Workforce

801. Human resource management and development within the Department was the issue attracting most critical comment during the process of consultation. In every part of the Department, and in every part of the NT visited, this area was volunteered as that most in need of reform and change. Concerns encompassed both operational human resource management and development, and strategic workforce planning and activities. The suggestions and criticisms left the Review in no doubt that there has been, for some years now, a marked failure of management, vision, and leadership in this area of responsibility. Human resource management across the Department is of particularly poor quality. Training and development of staff is haphazard. It is indicative of the problem that no accurate organisation chart of the Department could be produced for the Review. While this section will focus on generic comments and recommendations around departmental workforce issues, where appropriate mention will be made of profession specific (eg. nursing) issues. The Department's attention to its Aboriginal workforce is discussed elsewhere in this Report.

802. As one respondent said, the key to quality service, robust policy development, and budget management is a skilled workforce. However, a lengthy catalogue of issues was raised during the consultation process. The Review heard examples of poor human resource management within the Department including: unacceptably high staff turnover, redeployment around the system of non-performing senior staff, the absence in the Department's Corporate Plan of a coherent staffing strategy, the apparent undervaluing of employees, and a perception of poor selection of staff at middle and senior management levels.

803. The human resource management ramifications of the inception of the Department of Corporate and Information Services (DCIS) in 1998 are still impacting on the Department today. Although a Service Agreement for human resource services was signed between the two Departments, this has not been monitored and has now expired. Some resources that went to DCIS have now been returned, although this has occurred in an ad hoc fashion, and has not been reflected in changes to the service agreement. However, this should not negate the responsibility the Department has for the overall planning and management of its human resources.

804. The degree of frustration, anger and cynicism expressed by so many staff during the consultation process highlights the need to redress what appears to be a systemic failure in the Department to manage and develop its staff. This task cannot be delayed if the Department is to be equipped to develop the programs and deliver the services that the people of the NT deserve and demand and that the Government is pledged to deliver.

805. Among the many respondents to the Review on the issue of human resource management, there were a number of recurring issues, revealing a serious problem in the Department's management of its staff. Among these issues were lack of appropriate training,

stressful workloads, limited career pathways, poor staff management, inadequate professional supervision, and less than adequate approaches to recruitment and retention of staff.

806. As well as identifying problems, many staff proposed positive suggestions to address issues of concern. Many of these should be taken up as the Department begins the process of rebuilding its capacity in this area. Among the ideas proposed was the development of a consistent management culture and positive leadership from top management. Staff expressed the view that the Department needed to develop and maintain a vision and a long term strategy, consistent service approaches, flexibility in coordinated service delivery, promotion of community-based models of service delivery, effective recruitment supported by appropriate packages for staff in remote areas, well thought out strategies for retention, and better use of existing technology.

807. These issues and expressions were offered by many staff, but articulated most clearly by allied health staff. This group saw major difficulty arising from fragmentation of services and rigidity in the management of the workforce that fails to address gaps in service. They argued that professional management of allied health staff is deficient, that lack of flexibility in placements and rotations was a source of frustration, and that opportunities for peer support from other professionals were restricted.

808. These are among the issues that the new Human Resource Management and Development Branch should address in the short to medium term.

### Workforce Planning

809. Minimal work appears to have been undertaken to develop a coherent or a strategic process for workforce planning in the Department. Where workforce planning has been undertaken, it has been predominantly done from a professional or service “silo” perspective, with little input from other related areas. Comprehensive environmental scanning (including emerging trends in health and community services and human resource practices) and accessing all available data sources are essential tools for developing an appropriate workforce. In particular, the linkages between departmental strategic directions, required outcomes and outputs, and even work unit business plans, should be utilised.

810. Effective and service outcome focussed workforce planning should be incorporated into departmental service planning. The associated processes should be rigorous and robust, and the data used for the workforce planning should be reliable and valid.

811. Strategic partnerships, for example with the Office of the Commissioner for Public Employment (OCPE) and employee associations (both professional and industrial), will facilitate any associated workforce reform that is required as an outcome of this planning. The current relationships with OCPE and employee associations concentrate on short-term human resource

management and/or industrial relations issues and need to be refocused to take a more strategic approach. This includes Enterprise Bargain Agreement negotiations.

**Principal and Supporting Recommendations:**

**Effective and service outcome focussed workforce planning should be incorporated into departmental service planning.**

The current relationships with OCPE and employee associations concentrate on short-term human resource management/ industrial relations issues and need to be refocused to take a more strategic approach.

*Workforce Status*

812. Currently, a large percentage of the Department's workforce (46%) is not nominally attached to a position number. Of these, 45% are contracted staff (executive, temporary or casual) who are in supernumerary positions, and 38% are permanent NT Public Service (NTPS) employees. This equates to 39% of the total departmental workforce.

813. Nursing is the classification with the highest proportion of unattached staff, with RDH, CASN and TESN being the divisions with the highest use of supernumeraries. Although the figures above may be rubbery (due to departmental data collection and analysis systems), this high use of supernumerary positions suggests both a lack of workforce planning in terms of required personnel to achieve outcomes, and a lack of rigour around due human resource management processes at a local, branch, divisional and departmental levels.

814. A similar situation exists with regard to existing unfunded positions, where funding has been used for alternate purposes – for example AHW positions filled by nurses in remote areas. Rigorous workforce planning and resourcing is required at a work unit level as well as at an organisational level, with accountability for both human resourcing and relevant, realistic fiscal resourcing. This should not be susceptible to erosion by poor budgetary practices in either the relevant cost centre or elsewhere in the Department.

815. A significant and related issue brought to our attention during the consultation phase was that of role differentiation and mutual respect for legitimate roles. This issue emerges on a number of fronts: for example, in the primary health care context between nurses and AHWs, between general practitioners and DMOs, and in the community welfare context, between social workers, family support workers and community welfare workers. The Department should initiate processes to articulate and differentiate the roles of nurses and AHWs, general practitioners and DMOs, and social workers, family support workers and community welfare workers. The Principal Nursing Adviser and the Principal Aboriginal Health Worker Adviser should play an active part in the deliberations about their professions. Efforts made and energy

expended on recruitment and retention strategies will lack effectiveness unless this issue is tackled and resolved.

816. Furthermore, the Department should sponsor legislation to give formal recognition to the role of nurse practitioners in the NT. This has already occurred in other jurisdictions.

**Principal and Supporting Recommendations:**

**Rigorous workforce planning and resourcing is required at a work unit level as well as at an organisational level, with accountability of both human resourcing and relevant, cost based fiscal resourcing.**

The Department should initiate processes to articulate and differentiate the roles of nurses and AHWs, general practitioners and DMOs, and social workers, family support workers and community welfare workers.

The Department should sponsor legislation to give formal recognition to the role of nurse practitioners in the NT.

*Staff Turnover, Recruitment and Retention*

817. There have been numerous studies into and reports on staff recruitment and retention in the NT. Attempts have been made to implement some of them, notably those pertaining to recruitment. However, it is remarkable how many subsequent recruitment and retention reports recommend the implementation of the 1997 Capper report into recruitment and retention, suggesting that little in fact has changed. Implementation usually founders when no specific budget allocation is made to enable the decisions arising from these studies to be implemented, or when there is no real management support for the major structural change required.

818. Furthermore, the contribution of recruitment practices versus factors that influence retention should be clearly differentiated. The Department should ensure that a specific budget allocation is made each year to enable the implementation of the recommendations made by previous reports on recruitment and retention, leadership training, and graduate recruitment and replacement.

819. Staff turnover is a huge cost to any organisation and is a challenge faced by public sector agencies internationally. Irrespective of the reasons for staff departures, there is a measurable cost to the organisation. If reasons for staff departure can be identified, action can often be taken to reduce the rate and incidence of departure. For example, staff may have expectations about the position or the agency to which they are recruited that are not borne out subsequently. Departures resulting from this situation can often be prevented if both the position and the agency are depicted accurately from the outset.



820. Effective induction processes can bridge this potential gap between expectations and reality. Staff joining the Department (including clinical staff) should be required to participate in a comprehensive induction program such that they develop an appropriate detailed understanding of the Department's organisational culture and routines, their role in the Department, and the Department's roles and responsibilities as part of the NT Government.

821. Preparation of the necessary induction packages and identification of the most suitable mechanisms for providing staff induction and on-going support should be a priority activity for the appropriate Division.

822. The Department needs to examine its recruiting practices and to consider ways of retaining valuable staff, especially in remote locations. Among the issues which should be examined in this context are:

- the lack of clear career paths (especially for Aboriginal staff),
- staff being required to carry for too long the workload of vacant positions;
- the practice of staff acting in other positions when colleagues are away or on leave in the absence of back-filling or locums;
- staff feeling unsupported in the work place;
- low morale; and
- staff feeling unrecognised or undervalued within the Department.

823. A further issue raised with the review is the fact that a staff member resigning has to give only two weeks notice, whereas to obtain approval to fill a position, recruit, advertise, interview and employ may take many weeks. This problem is exacerbated in remote locations.

824. Furthermore, there appears to be a lack of flexibility in employment arrangements to encourage greater participation in the workforce. In examining means of improving the retention of its staff (and in particular nurses), the Department should embrace and facilitate the widest-possible use of permanent part-time employment and job sharing.

**Principal and Supporting Recommendations:**

**The Department should ensure that a specific budget allocation is made each year to enable the implementation of the recommendations made by previous reports on recruitment and retention, leadership training, and graduate recruitment and replacement.**

**Staff joining the Department (including clinical staff) should be provided with a thorough induction program so that they can be given an appropriately detailed understanding of the Department’s organisational culture and routines, their role in the Department, and the Department’s roles and responsibilities as part of the NT Government.**

The Department should embrace and facilitate the widest-possible use of permanent part time employment and job sharing.

*Recruitment Processes*

825. The recruitment process was criticised frequently by respondents who commented that recruitment practices often lack integrity and objectivity. It was said to the Review that staff employed in human resource areas lack interpersonal skills and the capacity to assist employees and supervisors. Expert advice is required (particularly by new supervisors and managers) to ensure that recruitment processes are appropriate. Clarity as to the best source of advice (namely, the Department, DCIS, or OCPE) is critical to ensure a consistent and smooth approach.

826. It is also widely claimed that position descriptions often do not match either the tasks or the level of the position. Position descriptions are allegedly not reviewed appropriately prior to recruitment processes, nor are they approved or circulated for comment by relevant supervisors within the program areas. People in permanent positions are often not asked to be involved in the process of updating their position descriptions.

827. The validity of the process to classify positions has been questioned repeatedly by respondents. It is claimed that similar positions are not rated at the same level, that the Job Evaluation System (JES) process lacks integrity, that it is often circumvented or avoided, and that there is a widespread lack of skills in preparing the necessary documentation. In some instances, of course, this results from “knowing the game” rather than due process.

828. There is a perception that position levels are often chosen without the required JES process simply to meet work unit budget constraints or, conversely, that decisions as to position levels are made by JES panels without requisite knowledge of the work requirements. Appropriate documentation is not stored in appropriate places to enable benchmarking other relevant positions.

829. It has been said that internal recruitment, staff movements and transfers are managed poorly. This poor management impacts adversely on the person being moved or transferred, on their capacity to do their work, and on the capacity of the work unit which is left to meet its commitments. Often very short notice is given of transfer, with the result that IT security can be compromised, and salary payments and higher duties allowances are not followed through in a timely manner. Deficiency of process and, frequently, insensitivity in human resource management are cited as a principal cause of staff frustration and cynicism.

### Managing People

830. A critical factor in enhancing the Department's human resource management is ensuring that supervisors and managers at all levels have the requisite knowledge and skills for managing in a complex and changing organisation. In 2001, the Department's Executive agreed to the Department's Leadership Development strategy and framework. This framework details management and leadership capabilities for all levels of the Department (including human resource management and leadership) and provides practical suggestions for skills enhancement for managers. The Review understands that the only evidence of its implementation is in informing the content of the initial departmental Leadership Development Program.

831. An unequivocal understanding of the Department's human resource role and responsibilities to its staff would better equip its managers to manage effectively. The NT *Public Sector Employment and Management Act* and the Department's human resource management policies and procedures should be given more effective implementation throughout the Department. This would be facilitated by appropriate delegation and accountability, and by timely, reliable and useful monitoring and reporting.

832. Specific concerns were raised with the Review about occupational health and safety. There is a perception that permanent staff, including senior staff, do not take responsibility for resolving workplace safety and maintenance issues in a timely manner. Fire and evacuation procedures, as well as safety information, are not updated on a regular basis.

833. Equal Employment Opportunity principles and practices do not, so the Review is advised, meet best practice standards, particularly those affecting the employment of Aboriginal and Culturally and Linguistically Diverse (CALD) people. This is discussed further elsewhere in the Report.

#### **Principal and Supporting Recommendations:**

**The NT *Public Sector Employment and Management Act* and the Department's human resource management policies and procedures should be given more effective implementation throughout the Department.**

### Performance Management

834. Respondents say that consistent performance management is rare, and that managers, even senior executives, more often than not avoid the task. Requests for training are managed in an ad hoc manner; there appears to be little effort to identify professional or personal skills deficits, or to tailor a strategically designed program of human resource development to meet those deficits. It is claimed that privacy and confidentiality are often compromised during the process of managing work place issues due in part to extremely poor record management and inappropriate management behaviour.

835. The Department appears unduly reliant on other agencies, such as DCIS and OCPE, to provide a comprehensive audit process on poor performance. There is little evidence that information on issues such as grievances and workers compensation is used in a strategic manner to identify “hot spots” or as an informant to training requirements of managers and other staff.

836. The Department, through the Performance Evaluation and Audit Branch, should accentuate the responsibility and accountability of its staff to adopt performance management across the Department, and report on the departmental status in this regard. Performance management should be closely aligned to the business planning process. To date there has been at best only token attention to this critical issue.

837. Under performance management, each Group, Divisional, Branch and section leader would enter into a performance agreement with their immediate supervisor, the agreement being based on their specific role in meeting the objectives of the departmental business plan, their contribution to departmental management and cohesion, and their identified need for ongoing professional development.

838. Employee performance against the agreements should be monitored through regular one on one discussion, and, at the end of each year, there should be a formal review of performance against the performance agreement.

839. If this approach is adopted, the Department and its whole management team can be kept focussed on agreed objectives while individual performance can be monitored and assessed.

**Principal and Supporting Recommendations:**

**Professional responsibility and accountability of departmental staff should be reinforced by the adoption across the Department of performance management closely aligned to the business planning process.**

#### Staff Development

840. Ongoing professional development, as identified in an individual’s performance agreement, is an integral component of developing the capacity of the Department to meet its current challenges, and to reshape the organisation to address the future health and community service needs of the Territory. This should take the form of knowledge and/or skills development relevant to current job requirements, to emerging needs of an individual’s current job, or to career advancement. The last-mentioned two appear to be less often recognised as important workforce development tools. Indeed, the issue of succession planning appears to be absent.

841. Innovative approaches to staff development, such as mentoring, job rotation, and the development of peer support networks appear to be under-utilised. Furthermore a more

rigorous approach by the Department to the selection and use of training providers, including internal trainers and educators, is required to ensure the quality of relevant educational outcomes.

842. Where possible, education and training undertaken by staff should be able to be accredited through either the Vocational Education and Training or University sectors and /or by a profession's Continuing Professional Education scheme. Partnerships with training providers (for example the Northern Territory University (NTU) and Batchelor Institute of Indigenous Tertiary Education (BIITE)) should be further developed to capitalise on mutually beneficial arrangements - for example, joint clinical/academic appointments and curricula informed by current and emerging workplace issues. These arrangements would also reap benefits for pre-service education and training.

843. There are anomalies and inequities in terms of professional development support available to different classifications, professions and different workplaces.

844. There is currently no requirement for a cost centre manager to budget for professional development of staff, despite this being a tenet of good human resource management, resulting in a wide variation in expenditure on this activity between cost centres. Furthermore, the Review has been told that, over the past few years, when financial stringency is required due to budget overruns, professional development and travel to access professional development are among the first activities to be cancelled.

845. Professional development should be an integral component of the Department's workforce development strategies and not be susceptible to erosion by poor budgetary practices in cost centres or elsewhere in Department.

**Principal and Supporting Recommendations:**

**Professional development should be an integral component of the department's workforce development strategies and not be susceptible to erosion by poor budgetary practices in cost centre or elsewhere in department.**

*Structural Arrangements*

846. The establishment of a Human Resource Management and Development Branch within the Corporate Services Division will redress one of the clear shortfalls in the current administrative arrangements. As we have said above, the Review has formed the view that human resource management across the Department is of particularly poor quality, and that training and development of staff is haphazard.

847. The establishment of this Branch will provide an opportunity for the Department to rebuild an integrated capacity of workforce planning and human resource management and to

concentrate appropriately upon the development of its most important asset, namely its staff, and upon human resource policy development, monitoring and reporting.

**Principal and Supporting Recommendations:**

**The Department should rebuild its capacity in human resource management and concentrate appropriately upon the development of its most important asset, namely its staff, and upon human resource policy development, monitoring and reporting.**

*Joint Working Group*

848. We have remarked elsewhere in this Report that DHCS cannot be seen in isolation. Much of what it does requires collaboration with the Departments of Employment Education and Training, and of Community Development, Sport and Cultural Affairs. This is particularly so in the case of its work with Aboriginal people in the NT. The same principle holds when it comes to the recruitment, retention and development of staff.

849. The Department should initiate the formation of a joint working group between the departments responsible for health and community services, education, and community development to forge a common approach to pre-workforce and workforce training and ongoing education; and better linkages between departmental workforce needs and, in the first instance, the courses offered by NTU, BIITE, and Flinders University of South Australia (FUSA).

**Principal and Supporting Recommendations:**

**The Department should initiate the formation of a joint working group between the Departments of Health and Community Services, of Employment Education and Training, and of Community Development, Sport and Cultural Affairs to forge a common approach to pre-workforce and workforce training and ongoing education; and better linkages between departmental workforce needs and the courses offered, in the first instance, by NTU, BIITE, and FUSA.**

*Medical Workforce*

850. The Australian Medical Workforce Advisory Committee (AMWAC) profiled Australian medical workforce characteristics in 1998. Among the findings of that profile was evidence of workforce maldistribution, with only 15.6% of medical practitioners working in rural and remote Australia.

851. The profile also showed that there was an increasing numbers of specialist medical practitioners, that 9.4% of the medical workforce was aged 65 and over, and that 28.1% of employed medical practitioners are female.

852. The factors influencing the future role of doctors in the Australian health care system are seen to include the ageing population, more educated consumers, and technological advances in service delivery. These factors, in conjunction with the general trends in health service delivery, impact on the location and specialty choices made by junior doctors.

853. The following tables provide data on the national distribution of medical practitioners, comparing the profile of the NT with the rest of Australia. The impact of the comparisons is that, to some extent at least, claims of medical practitioner shortage in the NT have been somewhat overstated.

**Table 1. Employed medical practitioners per 100,000 population by State and Territory, 1998<sup>1 2</sup>**

<b>Practitioners per 100,000 Population</b>	<b>ACT</b>	<b>NSW</b>	<b>NT</b>	<b>QLD</b>	<b>SA</b>	<b>TAS</b>	<b>VIC</b>	<b>WA</b>	<b>Total</b>
Clinicians	279.4	255.1	239.1	225.6	273.4	233.5	243.4	220.3	<b>259.6</b>
Medical Specialists	96.0	90.2	59.9	72.6	99.7	72.0	96.9	78.0	<b>87.5</b>
Primary Care Practitioners	124.5	111.0	115.1	104.5	120.7	125.9	113.5	98.7	<b>110.6</b>

**Table 2. Employed medical practitioners per 100,000 population: region of main job, States and Territories, 1998.**

<b>Region of Main Job</b>	<b>ACT</b>	<b>NSW</b>	<b>NT</b>	<b>QLD</b>	<b>SA</b>	<b>TAS</b>	<b>VIC</b>	<b>WA</b>	<b>Total</b>
Capital City	310.1	329.1	363.0	306.4	359.2	361.3	295.1	280.2	<b>314.0</b>
Other metropolitan centre	0.0	228.8	0.0	249.4	0.0	0.0	281.4	0.0	<b>241.2</b>
Large rural centres	0.0	268.6	0.0	282.3	0.0	290.6	242.3	0.0	<b>266.9</b>
Small rural centres	0.0	145.1	0.0	152.6	140.8	157.6	180.3	143.3	<b>154.3</b>
Other rural centres	0.0	98.0	61.7	70.8	118.5	87.8	93.8	82.8	<b>91.1</b>
Remote	0.0	65.8	199.4	71.9	32.0	198.9	66.5	124.4	<b>105.2</b>
<b>Total</b>	<b>310.1</b>	<b>271.5</b>	<b>262.2</b>	<b>235.8</b>	<b>293.3</b>	<b>246.5</b>	<b>257.8</b>	<b>235.9</b>	<b>259.6</b>
Metropolitan centres	310.0	312.3	363.0	293.4	359.2	361.3	294.5	280.2	<b>306.3</b>
Rural and remote	0.0	145.4	177.8	153.1	113.6	165.6	143.8	114.4	<b>143.6</b>

<sup>1</sup> Source: AMWAC (2000)

<sup>2</sup> It was noted that 'South Australia provides significant, but unquantified, specialist services to the Northern Territory' (AMWAC, 2000)

854. Geographic maldistribution of medical practitioners in Australia has been an important issue for a number of years, leading both Commonwealth and State Governments to develop a range of initiatives aimed at encouraging practitioners to take up practice in rural/remote areas. These initiatives have generally taken the form of:

- the establishment of medical schools in major rural centres based on the notion that there is a link between place of study and staying in the rural area;
- the inclusion of rural areas as part of medical training rotation; and
- financial incentives.

855. In 1994, the Rural Undergraduate Steering Committee Program provided funding to medical schools so that the number of rural origin medical students could be increased. Additional workforce initiatives have been developed by the Commonwealth Government to improve the representation of Aboriginal Australians in the medical workforce. However, we are advised that, at present, the Department employs only two Aboriginal doctors.

856. The establishment of the NT Clinical School has provided an impetus for both encouraging medical students to invest in a career in the NT (rural and hospital-based medicine) and for attracting academic medical staff. There has been good retention of NT Clinical School graduates into DHCS workforce.

857. James Cook University has voiced its interest in building on the NT Clinical School concept so that it could also send senior medical students to the NT. It has indicated that it is prepared to invest appropriate resources to support its students in the NT in partnership with the Department, in much the same way it has collaborated with Queensland Health to expand academic and clinical service capacity in North Queensland.

858. The following table shows that the specialists employed in the NT cover a limited range of specialist areas. Significant to this discussion are the Specialist/Population ratios necessary for the establishment of a viable service. Both the Colleges and AMWAC have developed a set of Specialist/Population ratios that can be applied to catchment areas to determine capacity to support specialist medical practice. The table demonstrates that a medical workforce shortage in the NT does exist among specialist practitioners.



Table 3. Specialists: main specialty of practice, Northern Territory, 1998.

Main Specialty of Practice	Northern Territory	Australia	NT as % Total Australia
<b>Internal Medicine</b>	<b>40</b>	<b>4,377</b>	<b>0.91</b>
General Medicine	12	572	
Geriatrics	2	206	
Infectious Diseases	5	102	
Paediatric Medicine	13	793	
Renal Medicine	5	170	
Thoracic Medicine	3	267	
<b>Pathology</b>	<b>7</b>	<b>722</b>	<b>0.96</b>
Anatomical Pathology	3	353	
Forensic Pathology	2	23	
Microbiology	2	78	
<b>Surgery</b>	<b>21</b>	<b>2,937</b>	<b>0.71</b>
General Surgery	14	1,028	
Orthopaedic Surgery	3	714	
Paediatric Surgery	3	77	
<b>Other Specialties</b>	<b>47</b>	<b>8,454</b>	<b>0.55</b>
Anaesthesia	11	1,972	
Emergency medicine	2	296	
Intensive Care	3	232	
Obstetrics and Gynaecology	10	1055	
Ophthalmology	4	713	
Psychiatry	10	1985	
Public Health Medicine	7	54	

859. The real problem with the medical workforce in the NT is not so much a problem with the numbers of medical practitioners (except in medical specialties), but in the number of private sector practitioners who, on anecdotal evidence, decline to utilise bulk-billing arrangements. The Table below gives national comparisons for all medical practitioners, including salaried doctors and medical officers working for Aboriginal Medical Services.

**Table 4. Medical Practitioners Using Direct Billing, 2000/01.**

State	%	State	%
NSW	74.9	WA	69.9
VIC	69.8	TAS	58.6
QLD	70.9	ACT	60.6
SA	68.4	NT	73.1
Total		71.4	

**Principal and Supporting Recommendations:**

**The Department should plan its medical workforce needs in accordance with its budget and identified service demands.**

*Nursing Workforce*

860. Currently, Australia is experiencing a nation-wide shortage of both generalist and specialist nursing staff. The NT has not been immune from this shortage, especially in the remote parts of the Territory. The wider variety of job choice for women has been cited as a significant contributor to the declining nursing enrolments. Attrition from the profession is associated with shift work, remuneration and family commitments.

861. Some state Governments have implemented workforce-planning strategies, campaigning to attract nurses back to the workforce. These programs have been reported to be reasonably successful in addition to the introduction of nurse/patient ratios in the public hospital system.

862. The issue of attracting nurses to and retaining them in the NT public hospital system is of particular importance. A number of nursing recruitment and retention initiatives have been introduced in the NT over the past few years. These have included initiatives for remote, urban and hospital-based nurses, and have, for example, included professional development support. These initiatives have not been reviewed comprehensively, and the data management pertaining to recruitment, retention and workforce management is poor. The resourcing of nursing information management appears inappropriate, and the data collected seems to be voluminous, and neither effectively analysed nor useable.

863. The Territory currently recruits nursing staff to individual hospitals and to its community nursing workforce to provide services in rural and remote areas. The national and international pressures on nursing labour pools will remain strong for the foreseeable future, and the NT will be unable, in a financial sense, to offer competitive enough rates to overcome these pressures. There are, however, some avenues that could be pursued that might make nursing in the Territory a little more attractive.

864. Nurses should be offered appointment to a Territory-wide nursing service, with opportunities (perhaps by rotation, perhaps at request) to work in a major teaching hospital, a medium-sized regional hospital, small rural hospitals, and in remote communities. In this way, nursing in the Territory might become a more attractive proposition with opportunities for variety and multiple skills development.

865. In the interests of making NT remuneration as attractive as possible, the Department should, for example, make full use of the capacity of public benevolent institutions (namely, the public hospitals in the NT) to make salary sacrifice arrangements with their staff (especially for nurses). To date these appear to have only been implemented for medical practitioners.

866. At the same time, it seems anomalous that overseas-trained clinicians can be recruited to NT hospitals under conditional registration procedures, while in the area of the most critical labour shortage, namely nursing, similar provisions are not available. The Review has been advised that, was conditional registration to be available, many English-speaking nurses trained in India, Pakistan and Malaysia would be eager to work for some time in the NT.

867. The Department should assess the potential for overseas-trained nurses and other overseas-trained health professionals to fill gaps in the departmental workforce, utilising such mechanisms as conditional registration. The Review is mindful of the requirement for competent and appropriately skilled health professionals. However, there appears to be a lack of will by the Department to explore the potential for overseas-trained nurses and other overseas-trained health professionals to fill gaps in the departmental workforce. There appears to be pressure to maintain the status quo in terms of country of origin of health professionals, irrespective of current and potential capacity.

**Principal and Supporting Recommendations:**

**Nurses should be offered appointment to a Territory-wide nursing service.**

The Department should examine mechanisms whereby its hospitals can take advantage of the capacity of public benevolent institutions to make salary sacrifice arrangements with their staff (especially for nurses).

The Department should assess the potential for overseas-trained nurses and other overseas-trained health professionals to fill gaps in the departmental workforce, utilising such mechanisms as conditional registration.

Agency Nurses

868. The Department, to manage its nursing staffing, frequently uses agency nurses. The high use of agency nurses in the NT and the variations in terms of costs and agency demands in terms of conditions for agency staff have been raised with the Review. Clearly, use of agency nurses is

a necessary response to the nursing shortage being experienced not only in the NT, but elsewhere in Australia and overseas.

869. However, there are problems inherent in the use of agency staff. The very large differential in salaries paid to agency as distinct from non-agency staff may well be an attraction, but it also leads to salary inequities and ill-feeling with staff working side-by-side and doing identical tasks receiving widely disparate rates of remuneration. Nurses are attracted out of the hospital system to work for an agency, and are then contracted back to similar positions at a vastly increased salary.

870. Moreover, anecdotal evidence provided to the Review indicates that Territory hospital nurses are sometimes simultaneously engaged by agencies and are contracted back to the hospital system to work multiple shifts, so impacting on their ability to work usual rosters and in some instances, transgressing the *Public Sector Employment and Management Act* provisions regarding outside employment. This practice carries with it an inherent safety problem and should be prohibited.

871. To address this problem, the Department should use a tender process to enter into a single, NT-wide contract for the provision of agency nurses under a common set of terms and conditions. At the same time, the Department should explore with its counterparts in Queensland and Western Australia the possibility of the three jurisdictions joining in a program to encourage and facilitate working visits to northern Australia by appropriately qualified overseas nurses. Under this type of program, the three jurisdictions would pay return airfares to and from Australia, and would guarantee periods of clinical employment in each of their health systems. Nurses would thus be encouraged to undertake working holidays in the Northern Territory and in the two participating states.

**Principal and Supporting Recommendations:**

**The Department should use a tender process to enter into a single, NT-wide contract for the provision of agency nurses under a common set of terms and conditions.**

**The Department should explore with its counterparts in Queensland and Western Australia the possibility of the three jurisdictions joining in a program to encourage and facilitate working visits to northern Australia by appropriately qualified overseas nurses.**

## Chapter 9: Acute Care

901. The acute care sector in the NT includes five hospitals: RDH, ASH, the Katherine Hospital (KH), TCH, and the Gove Hospital. In terms of budget outlays this group of hospitals accounted for 45.82% of total outlays in 2001/02. The hospital sector is, therefore, the single most significant item in terms of budget. It is also the most publicly visible facet of the Department, attracts most of the publicity accruing to health in the NT (both positive and adverse). It employs 61% of the Department's staff.

### Acute Care Group

902. To manage the hospitals and their budget, the Department should create an Acute Care Group headed by an Assistant Secretary. In the proposed Acute Care Group, a General Manager, reporting to the Assistant Secretary, would head each of the hospitals.

903. Establishment of this Group would fulfil a number of functions vital to the success of the outcomes of the Review.

**Principal** and Supporting Recommendations:

**In the Acute Care Group, a General Manager, reporting to the Assistant Secretary, should head each of the hospitals.**

### Hospitals Network

904. The Group would encompass a new arrangement for the NT hospitals. A Hospitals Network should be established to link the five Territory acute care hospitals thereby facilitating the interchange and transfer of resources and specialist skills to meet changing demands. The Network might well see one of the hospitals other than RDH taking a lead role in some areas of clinical service delivery.

905. The Network should encompass Territory-wide clinical streaming (as appropriate), the linkage of disciplines/specialties across hospitals, and inter-hospital transferability of the clinical workforce made possible by Territory-wide appointments.

**Principal** and Supporting Recommendations:

**A Hospitals Network should be established to link the five Territory acute care hospitals thereby facilitating the interchange and transfer of resources and specialist skills to meet changing demands.**

Acute Care Hospitals Budget

906. RDH and ASH overspend each year. In an attempt to stay within overall budget, the Department contains expenditure below budget in other areas. There is a lack of rigour in resource allocation processes – this is untenable. The Review has concluded that the current resource allocation and budgetary arrangements and practices have facilitated an unintended but continuing transfer of resources to the acute care sector, in particular, to RDH and ASH from equally important areas of the Department, for example, disability services, child protection, and family and children’s services. As an end result, these arrangements have restricted the growth and improvement of community services within the NT, reduced transparency and accountability across the Department’s programs and inhibited devolved management.

907. To address this ongoing problem, the networked acute care hospitals should be funded under a separate, one-line budget appropriation.

908. This will serve to identify the budgetary demands of the acute care sector, and will better enable appropriate levels of accountability for performance against budget to be measured and maintained. It will, unless Cabinet determines otherwise on a case-by-case basis, prevent the acute care sector from continuing to behave as a “cash magnet”, drawing resources from all other parts of the health system in order to make up for budget overruns in the hospital area.

909. In other words, having the hospital network budget in the one line will actually quarantine the hospital budget to ensure that it can be expanded above the one line allocation only with Cabinet endorsement, and at the same time protect the rest of the departmental budget from being drawn upon to make up shortfalls in the hospital budget.

**Principal and Supporting Recommendations:**

**The networked acute care hospitals should be funded under a separate, one-line budget appropriation to ensure that resources over and above that appropriation can be made available only with specific Cabinet endorsement.**

Private Practice Trust Funds

910. It has been drawn to the attention of the Review that private practice trust funds exist at both RDH and ASH. Staff specialists with rights to private practice contribute an agreed amount to these funds from their private practice earnings. A proportion of the fees paid into the funds are payable to the participating specialists. The proportion set aside as administration fees is available to be used to support relevant research, facilities improvement, education and training, and like purposes. There are currently different agreements for the funds at RDH and at ASH.

911. At the same time, the Government apparently bears the costs of medical indemnity insurance for staff specialists, including (according to information made available to the Review) for their private practice activities.

912. The agreements relating to the trust funds are subject to periodic renegotiation.

913. On this issue, information provided to the Review was both confused and, at time, contradictory.

914. The Government should review the current operation of the trust funds. The arrangements should be such that both the specialists and the Government gain advantage – the present arrangements seem to benefit principally the specialists. A single agreement should be negotiated to cover rights to private practice across the proposed hospitals network. The agreement should properly take into account the medical indemnity issue.

**Principal and Supporting Recommendations:**

**The Government should review the present arrangements for private practice trust funds to ensure that both the specialists and the Government gain advantage, that a single agreement covers rights to private practice across the proposed hospitals network, and that the medical indemnity issue is properly taken into account.**

*Hospital Clinical Employment Contracts*

915. Employment contracts for clinicians across the Northern Territory Health system currently exhibit wide variability. They lack any sound, consistent basis. The Department, working with hospital management, should standardise all such contracts, with several bands for remuneration and with some degree of flexibility within the bands.

**Principal and Supporting Recommendations:**

**Employment contracts for clinicians across the Northern Territory Health system should be standardised.**

*Royal Darwin Hospital - Patient Election*

916. Respondents have advised that significant loss of revenue is being occasioned due to the fact that patients are apparently seldom interviewed and asked to complete election forms to declare whether they are public or private patients, workers compensation claimants, or Motor Accident Compensation Act patients. One recent example provided to the Review was that, in one ward, an audit was conducted and revealed that, out of 39 patients, only one had completed an election form. As a matter of course, patients should, upon admission to hospital, be interviewed and asked to complete election forms to declare whether they are public or private patients, workers compensation claimants, or Motor Accidents (Compensation) Act patients.

**Principal** and Supporting Recommendations:

Patients should, upon admission to hospital, be interviewed and asked to complete election forms to declare whether they are public or private patients, workers compensation claimants, or Motor Accident Compensation Act patients.

*Alice Springs Hospital*

917. Mr Ron Parker undertook work, on behalf of the Review, to examine some issues brought to the attention of the Review relating to ASH. The work included site visits, and formal and informal discussions. Mr Parker's report to the Review is reflected in the following observations and recommendations.

918. It was put to the Review that the management and control of authorised and available bed numbers at ASH has been an issue of concern for some years. Given that beds authorised and beds in use should be safely staffed on a sustainable basis, there are difficulties in consistently staffing the current number of beds, resulting in a top priority now being accorded to demand management. There has been a practice of opening additional beds without a comprehensive staffing plan linking nursing numbers, skills mix, and nursing hours per patient day.

919. Records show the following variations in bed numbers over the last few years: 1996 – 170 authorised beds; 1998 - 160 authorised beds; 1999 164 authorised beds; 2002 - 141 available beds (during and immediately after the hospital redevelopment); 2002 - 164 available beds. The figure of 164 authorised beds was being used in hospital promotional material until early 2002. At that time a bed review established that the number of beds available during the redevelopment was only 141, including six mental health beds managed by the mental health service. Fifteen beds had been transferred to the private wing, but had remained closed.

920. Prior to the hospital redevelopment (completed in April 2002), there had been a policy of "flexing" bed numbers between 164 beds and 195 beds, depending on demand and staffing capacity. This level of "flexing" is extremely high and creates real staffing and budget management problems. With the current difficulties in recruiting and retaining staff, particularly appropriately skilled nursing staff, the emphasis should be on developing comprehensive staffing plans for the available 164 beds. Only when there is the capacity to safely and consistently staff 164 beds should the planning be extended to consider further beds.

921. With recent intense pressure on beds the hospital has moved back to 164 authorised / available beds, excluding the 15 beds in the private wing. The hospital management believes that 164 beds is a realistic number, particularly with the nursing resources available, and does not see the need to open the 15 bed private wing for either public or private use.

922. It has been suggested that this area be used for clinical consulting rooms and clinical offices while up to ten self-care/transit lounge spaces could be provided in the vacated ward 4



area. The consolidation of clinicians in one area would improve communication and coordination. The Review supports this approach.

923. The use of flexing and overflow beds should be tightly controlled in all NT hospitals and should be undertaken in association with formal demand management processes, increased day care episodes, and increased day surgery in order not only to reduce the demand on beds but also to maximise convenience for patients.

**Principal and Supporting Recommendations:**

**The private wing beds at ASH should be used for clinical consulting rooms and clinical offices and/or to provide up to ten self care / transit lounge spaces in the vacated ward 4 area.**

**The use of flexing and overflow beds should be tightly controlled in all NT hospitals and should be undertaken in association with formal demand management processes, increased day care episodes, and increased day surgery in order not only to reduce the demand on beds but also to maximise convenience for patients.**

*Alice Springs Hospital – Theatre Suite*

924. As part of the redevelopment of ASH, a new theatre suite has been opened and a new day surgical unit has been commissioned. There are three operating theatres available in the main theatre suite and a dedicated theatre and a day procedure room in the Day Surgical Unit. The operating theatres and the day surgical unit are managed independently. It has not been possible to have the three main operating theatres in full operation due to a shortage of skilled nursing staff and a shortage in surgical bed stock to support three inpatient theatres. There is little prospect of this being overcome in the short to medium term. In any case, the provision of four operating theatres as well as a day procedures room in a hospital the size of ASH is generous to say the least, particularly in a hospital with 30 surgical beds and 12 day surgical places.

925. With the appointment of new surgeons, there has been no concomitant process to allocate either realistic theatre time or the resources and equipment to adequately support them. This has caused frustration and less than optimal use of the surgical skills and capacity available.

926. ASH should implement a single management structure for the main theatres and the day surgical unit. This would provide flexibility in staffing, improve the utilisation of all theatres, and assist in the equitable allocation of theatre sessions.

927. At the same time, the hospital should ensure that the Theatre Management Committee provides regular and timely advice on optimising the use and efficiency of all available theatres and on the allocation of theatre sessions. The development of a suite of key performance indicators to measure theatre utilisation and efficiency should be finalised by the Theatre

Management Committee as a top priority and be benchmarked against similar theatre suites. In undertaking its task, the Committee should make every effort to have two of the main theatres and the day surgical unit operating as effectively as possible and then review the best use of the third theatre. In order to increase the amount of surgery that can be carried out and to make best use of the 30 surgical beds available, as many procedures as possible should be shifted to day surgery where this is appropriate, safe, and in accordance with evidence-based practice.

928. In any case, a space audit of all areas within the hospital should be undertaken, with the development of a plan to ensure that all future decisions on the utilisation of space optimise functional relationships and interdependencies.

**Principal and Supporting Recommendations:**

**ASH should implement a single management structure for the main theatres and the day surgical unit.**

As many procedures as possible should be shifted to day surgery where this is appropriate, safe, and in accordance with evidence-based practice.

A space audit of all areas within ASH should be undertaken, with the development of a plan to ensure that all future decisions on the utilisation of space optimise functional relationships and interdependencies.

*Alice Springs Hospital – Divisional Structure*

929. The divisional structure at ASH is not working effectively. While it involves clinicians in planning, management, and ownership of decision making, it has resulted in a silo effect where decisions are made in isolation from whole of hospital issues and logical continuum of care flows are compromised. There are significant accountability issues with the present structure at ASH, with duplications in functions and gaps in accountability. The concept of single point accountability is not part of the existing structure. One option worth considering is to develop an appropriate clustering of clinical streams with designated heads reporting directly to the Director of Medical and Clinical Services.

*Alice Springs Hospital – Nursing Structure*

930. The nursing structure at ASH appears to be top heavy. Each of the three divisions has its own Director of Nursing (DON) ultimately reporting to the Executive Director of Nursing (EDON). The worldwide shortage of nurses means that it is important to ensure that an appropriate number of administrative nursing positions support direct care nursing positions. With a fixed nursing budget and a shortage of nurses, attention should be focused on maximising the number of direct care nursing positions. At present at ASH, around 15% of the nursing workforce is at EDON, DON and Clinical Nurse Consultant level, with 85% being at Level 2

and below. It could be of benefit to review the composition of the nursing workforce at ASH to establish whether changes can be made to strengthen the direct patient care nursing capacity.

**Principal and Supporting Recommendations:**

**The composition of the nursing workforce at ASH should be reviewed to establish whether changes can be made to strengthen the direct patient care nursing capacity.**

*Palliative Care Service*

931. The NT Government through DHCS proposes to construct an inpatient/outpatient community palliative care unit on the grounds of the RDH campus. It is proposed that the unit be single story with 12 inpatient beds, and be designed with extensive roof overhangs and verandah areas to suit the tropical environment. The unit will also house the community palliative care team and rural and remote and urban nursing staff, and have a day care facility.

932. The proposed unit will be a stand-alone unit but connected to RDH's essential services (electricity and water supplies). These services will be metered separately for accounting purposes. RDH will supply central sterilising, laundry, catering, and waste services, as well as engineering/maintenance services, security, and switchboard services. It will also provide clinical services such as pathology, radiology and pharmacy.

933. There has been debate as to whether the unit should be managed by RDH, or by the current TESN.

934. Proponents of RDH management argue that the hospital has all the resources to run a 24-hour service and that many resources will be duplicated if the unit does not come under hospital management. With the unit as part of the Division of Medicine, resources such as medical officers, nursing staff and allied health professionals would be shared providing economies of scale. Services could be provided in a seamless fashion. There would be flexibility in staffing, with personnel being able to move from one facility to another. Less cost would be involved in establishing a management structure. Admissions, whether direct from the community or through the Emergency Department, would be facilitated because RDH Emergency Department already has policies in place for palliative care admissions. Pharmacy services and PBS drugs would be provided by the hospital.

935. On the other hand, opponents argue that RDH management could pressure the unit to admit non-palliative care patients in times of bed shortages, and that change in management structure and/or work practises could be difficult for existing staff. While the palliative care medical officers currently report to the Director of RDH Division of Medicine, it appears that they seek autonomy and want clearly defined admission policies (restricting the unit to palliative care patients) and guarantees about service delivery and staffing arrangement. Since no other discipline has this degree of autonomy it may cause internal conflict. The request that an

Advisory Board be established as a sub-committee of RDH management to give the community more ownership of and involvement in the facility may also create some internal conflict.

936. Proponents of TESN management argue that all staff (except the palliative care doctor) currently report to the TESN and are aware of their roles and the ethos of the service to a far greater extent than is the management of RDH.

937. Opponents argue that the integration of community care nurses into the palliative care team would create difficulties in the TESN. Palliative care nurses have different work practises, but would be employed in the same policy setting. Palliative care medical staff are currently employed by RDH, and a single management structure would therefore be more appropriate. Accreditation may be more difficult because of reliance on RDH for so many services.

938. Having considered the arguments (and particularly those related to flexibility of staffing and sharing of services), the Review has concluded that the Palliative Care Service, incorporating the proposed NT Hospice, should be managed within the Acute Care Group, and be incorporated into and managed by RDH.

**Principal and Supporting Recommendations:**

**The proposed Palliative Care Service, incorporating the NT Hospice, should be managed within the Acute Care Group, and be incorporated into and managed by RDH.**

### Pathology

939. The Review believes that, with appropriate business management and support staff, it would be advantageous to develop a single NT pathology service with an integration of pathology services across the Department.

940. Such a unified pathology service would lead to a reduction in duplication of human resources and operational management, and would lead to economies of scale with respect to instrument and consumable purchases. The current system drains each NT hospital of funds, whereas a Territory-wide pathology service would have the potential to generate fees for service from referrers of pathology services, whether public or private.

941. Demands on pathology are growing, and control of pathology costs is difficult. The referrers would become more accountable under a fee for service arrangement. The current funding mechanism has led to constant pressure to defer major equipment expenditure and capital works improvements, and has provided no reserve for development and service improvement.

942. Five separate managers for five separate pathology laboratories in a jurisdiction the size of the NT appears unjustifiably generous. There may remain a need for regional laboratories, but

a unified service will reduce the cost burden, will rationalise management and will improve accountability.

**Principal** and Supporting Recommendations:

**The NT should develop a single pathology service by integrating existing services across DHCS.**

*Biomedical Engineering*

943. Biomedical engineering encompasses the safety testing, maintenance, installation, acquisition and disposal of medical equipment. It also includes research and development, and the implementation of new technologies, asset management, and in service training for operators of life support and other equipment.

944. Biomedical engineering should be a Territory-wide service, with the employment of a biomedical engineer to head the service. Such a single service would bring with it the advantages of rationalised management, the provision of high quality biomedical engineering services throughout the NT, better utilisation of resources and expenditure, and the achievement of best practice. It would facilitate the preparation of appropriate and consistent protocols and standards, would reinforce and monitor the meeting of the requirement for regular safety checks, and would enhance risk management.

**Principal** and Supporting Recommendations:

**Biomedical engineering should be a Territory-wide service, with the employment of a biomedical engineer to head the service.**

*Patient Assisted Travel Scheme*

945. The Patient Assisted Travel Scheme (PATS) should be centralised and managed within the Acute Care Group.

**Principal** and Supporting Recommendations:

The Patient Assisted Travel Scheme (PATS) should be centralised and managed within the Acute Care Group.

*Darwin Private Hospital*

946. RDH and the Darwin Private Hospital are co-located on the one campus. In an effort to improve efficiency and to provide choice for privately insured patients, a Memorandum of Understanding was developed between the two hospitals two years ago. It provided mechanisms for clarifying service developments and the relative roles and responsibilities of each of the two

hospitals where there was to be any contracted sharing of services. A decision was made that the management and implementation of elements of the Memorandum would be the responsibility of RDH. This did not progress as envisaged, and it is timely to review the arrangement so that it is not directly controlled by either hospital.

947. The Department, through the Acute Care Group, should assume full responsibility for managing any contractual arrangements between RDH and the Darwin Private Hospital. In this way, each partner in all such arrangements would be treated equitably, and potential conflicts of interest would be avoided.

**Principal** and Supporting Recommendations:

**The Department, through the Acute Care Group, should assume full responsibility for managing any contractual arrangements between RDH and the Darwin Private Hospital. In this way, each partner in all such arrangements would be treated equitably, and potential conflicts of interest would be avoided.**

*Ambulance Services*

948. As part of the acute care continuum, the Acute Care Group should be responsible for managing the provision of ambulance services in the NT, and, in this context, should manage the contract with St. John Ambulance.

**Principal** and Supporting Recommendations:

As part of the acute care continuum, the Acute Care Group should be responsible for managing the provision of ambulance services in the NT, and, in this context, should manage the contract with St. John Ambulance.

*Multi-Purpose Service Proposal and the Hospital Improvement Project*

949. The Department should give real priority to the continuing implementation of two priority projects, the Multi-Purpose Service proposal and the Hospital Improvement Project.

**Principal** and Supporting Recommendations:

The Department should give real priority to the continuing implementation of two priority projects, the Multi-Purpose Service proposal and the Hospital Improvement Project.

## Chapter 10: Aboriginal Health

1001. Improvements in Aboriginal health across the NT are clearly of the highest priority to the Department and the Government. This priority extends across all areas of the Department's operations.

1002. A viable Aboriginal workforce has been recognised locally, nationally, and internationally as an effective strategy to enhance Aboriginal health. The Review notes the problems faced by the Department in recruiting, retaining and developing its Aboriginal workforce. The Department has a relatively low proportion of Aboriginal employees (the figure is indeterminate due to poor reporting and analysis processes), very small numbers of senior Aboriginal managers and professionally qualified staff, and a propensity to overload and under-support those recognised as having potential to progress their careers. Some appointments appear to be based on tokenism, and not on an appropriate marriage of skill requirement and capability of the individual. This supports a cycle of under-performance and disenchantment, particularly for Aboriginal employees.

1003. There has been no real commitment or resourcing to develop a motivated, skilled and empowered Aboriginal workforce in the department. However, Aboriginal people with the skills, knowledge and management capacity needed by the Department are present in other Departments and in the community sector, raising the issue of why this Department finds such difficulty.

### *Establishment of an Office of Aboriginal Health*

1004. An Office of Aboriginal Health should be established as a focus within the Department on issues relating both to Aboriginal health and to Aboriginal employment. The Office should, among other things, encourage performance management and professional development of Aboriginal staff, assist managers to manage their Aboriginal staff properly, and increase the number of Aboriginal staff employed in the Department.

1005. The principal role of the Office will be to drive Aboriginal employment opportunities throughout the health and community services sector in the NT and to tailor departmental policy to meet the needs of Aboriginal people throughout the Territory. It should be charged with monitoring and evaluating the effectiveness of departmental policies and services on the health and well-being of Aboriginal people, and with facilitating departmental interaction with established Aboriginal groups.

1006. An Executive Director who would have a place on the departmental Executive should head this Division. This Division should have a focus on ensuring that the Department is better positioned to improve, and more effective in improving, Aboriginal health. It should not have a direct service delivery role.

1007. All divisions of the Department should have development of Aboriginal-specific policy and people and services as part of their core mandate. It appears to us that the Department currently finds that responsibility difficult to meet. Therefore we believe that there needs to be some very real focus brought to this issue. The Office of Aboriginal Health is intended to be the vehicle for that focus.

1008. The proposed new Division is also intended to have a capacity to bring to the attention of the departmental Executive as a whole the views and aspirations of Aboriginal officers/employees and of Aboriginal communities. We see this as being done in a formal way. At the moment it would appear that those views are not taken into account other than in a somewhat haphazard way through individuals who are sensitive to those interests.

1009. The new Division should consist of two Branches:

- an Aboriginal Workforce Development and Service Support Branch; and
- an Aboriginal Policy Development and Evaluation Branch,

each of which should be headed by a General Manager. Each of the two Branches should concentrate on areas of greatest deficiency within the Department.

1010. The Workforce Development and Service Support Branch should tackle issues related to Aboriginal recruitment, retention, and career development (discussed in more detail elsewhere in this Report).

1011. The Policy Development and Evaluation Branch should work in three main areas:

- to develop health and community services policies specifically tailored to meet the needs of Aboriginal people throughout the NT;
- to evaluate and report on the outcomes of the Department's service delivery endeavours in relation to the health and well-being of Aboriginal people; and
- to identify and maximise opportunities for intersectoral collaboration in the delivery of health and community services to Aboriginal people in the NT.

1012. The NT has good data compared to the eastern states. It is, with South Australia and Western Australia, one of three jurisdictions with publishable quality data used by the Australian Bureau of Statistics. The Policy Development and Evaluation Branch should build on that data collection capacity, supported if possible by CRCATH, by NTU, and by MSHR. If the Department, through the Office of Aboriginal Health, could develop an innovative and progressive relationship between data, research and operational agencies, the NT could become a leader in this field.



**Principal** and Supporting Recommendations:

The Office should have the following specific responsibilities:

- to encourage performance management and professional development of Aboriginal staff;
- to assist managers properly to manage their Aboriginal staff;
- to increase the number of Aboriginal staff employed in the Department;
- to drive Aboriginal employment opportunities throughout the health and community services sectors in the NT;
- to tailor departmental policy and services to meet the needs of Aboriginal people throughout the Territory;
- to monitor, evaluate and report on the effectiveness of policies and services on the health and well-being of Aboriginal people; and
- to facilitate departmental interaction with established Aboriginal groups.

*Aboriginal Staff*

1013. The Department's inability to recruit and retain an adequately skilled Aboriginal workforce is a major problem, especially in the lead-up to the implementation of PHCAP. The capacity to drive change relies as much on the development of a sound Aboriginal workforce within the Department as it does on the development of a sound Aboriginal workforce within the non-Government sector. It also requires an overall system that can develop the confidence to promote agency interchange for development purposes.

1014. There are a number of national initiatives affecting Aboriginal workforce development. Departmental representation should be at an appropriate level that ensures the Department is able to participate with authority.

1015. The Department should actively support the NT Aboriginal Health Forum as a framework within which to address Aboriginal workforce and other issues and to develop a joint action plan for the Territory.

1016. Aboriginal staff respondents have said to the Review that they feel undervalued, confused, frustrated and demoralised in the Department. They argue that the Department has not demonstrated a capacity or will to move from rhetoric to reality either in its strategic policy directions or in operational issues affecting their work.

1017. There is evidence that the Department's Aboriginal Employment and Career Development Strategy is given lip service, that there is a perceived lack of support for Aboriginal

staff in general, and a feeling that there is no real commitment to or support for the Strategy at any level of the organisation.

1018. There is a concern that, despite employing Aboriginal people for over 30 years and despite past success, the Department has failed to continue to groom and promote Aboriginal staff to permanent senior management positions, and thereby to provide to Aboriginal staff an opportunity to be involved in departmental decision making and management, including financial delegation, and responsibility for budget and resources.

1019. The Department has no overall strategy for supporting Aboriginal staff (including AHWs) who come into the Department but find it hard to progress because there is no career structure for them. This issue needs to be addressed because it impacts both on current staff and on potential recruitment. The lack of career paths for Aboriginal staff should be addressed urgently.

1020. Among the matters brought to the attention of the Review are:

- problems with following the processes leading to the assessment and accreditation of Aboriginal staff;
- slowness in assessing Aboriginal employees against a national standard training package;
- failure to ensure equivalence in classification between Aboriginal and non-Aboriginal staff;
- failure to acknowledge AHWs as legitimate members of the team;
- a perception that non-Aboriginal staff, including visiting doctors and nurses, often lack proper cultural orientation; and
- a failure to address in-house training or career development activities for Aboriginal staff, including appropriate inter-agency placements.

1021. These are all deficiencies that the Department should take action to correct. This is a critical issue. It is vital that Aboriginal people become progressively involved in policy development and program implementation. The Review believes this to be a central issue if the NT Government is to achieve success in Aboriginal health outcomes in the longer term.

**Principal and Supporting Recommendations:**

**The Department should take action to correct deficiencies identified in:**

- **the assessment and accreditation of Aboriginal staff;**
- **slowness in assessing Aboriginal employees against a national standard training package;**

- **failure to ensure equivalence in classification between Aboriginal and non-Aboriginal staff;**
- **failure to acknowledge AHWs as legitimate members of the team;**
- **a perception that visiting doctors and nurses often lack proper cultural orientation.**

*Aboriginal Health Workers*

1022. It is also imperative that problems with respect to AHW training and employment outcomes be resolved. The resolution should include identifying specifically the number of AHWs completing training at the various training institutions, the number attaining registration, the number then entering employment, and the number undertaking continuing education, and resultant promotions. The relevance of AHW education and training to program and service outcomes should be to the forefront in this resolution. Barriers to the effective use of skilled AHWs should be eliminated.

1023. Although the importance of AHWs, particularly in primary health care, is a widely-held tenet in the Department, there is little evidence that it is given real effect. The Review was advised, for example, that there are currently only about 47 AHW positions filled in Central Australia, with over 70 vacancies, and that nurses are frequently employed using funds allocated for, and in positions reserved for, AHWs.

1024. In addition, the Department should evaluate the benefits or otherwise of the new paraprofessional groups that have been created (such as Aboriginal Nutrition Workers, Aboriginal Environmental Health Workers, Aboriginal Mental Health Workers, Aboriginal Health Promotion Officers). It has been put to the Review (and we agree) that there is a need to ensure that AHWs are a viable profession, and that there is appropriate differentiation and an identification of core/common skills between AHWs and the other paraprofessional groups. In other jurisdictions, these other paraprofessional groups are all AHW. The AHMAC Aboriginal Health Workforce Strategy has identified this as an issue for resolution.

1025. As part of any examination, the Department should further develop and adhere to a close and mutually beneficial relationship with AMSANT and with BIITE, particularly in assessment, training, accreditation and registration. The current relationship is poor in operational areas of the Department.

**Principal** and Supporting Recommendations:

**A review of AHW training and employment outcomes should be undertaken. The review should examine specifically the number of AHWs completing training at the various training institutions, the number attaining registration, the number then entering employment, and the number undertaking continuing education, and resultant promotions.**

The Department should further develop and adhere to a close and mutually beneficial with AMSANT and with BIITE, particularly in relation to assessment, training, accreditation and registration.

Aboriginal Health

1026. Aboriginal and other respondents have expressed concern that the Department seems to struggle to provide a coordinated strategic framework for addressing health policy directions that impact on NT Aboriginal communities. This is despite recent Commonwealth and State/Territory Government effort to improve the health outcomes for Aboriginal people. There appears to be a lack of coordinated departmental strategic planning on how to respond to nationally driven policy development initiatives like the *National Strategic Framework for Aboriginal and Torres Strait Islander Health 2002 – Framework for Action by Governments*, as well as a deficiency in the resources allocated to this task.

1027. Aboriginal health is seen genuinely by the Department as ‘core business’ of the Department, fully justified by the demographics of the NT.

1028. There are deficiencies within the current structure of the Department. The NT is the only jurisdiction within Australia that does not have a dedicated Aboriginal health branch or unit. There is, in fact, only one officer in the Department specifically dedicated to Aboriginal health policy. There appear to be few if any senior Aboriginal departmental representatives attending high-level intersectoral meetings with other NT Government agencies. It is important that Aboriginal staff have real input into discussions and decision making on matters that affect the health of their families and communities.

1029. The Department should include Aboriginal participation in policy development as well as in decision making. In this context, while ATSIC and AMSANT certainly play a vital role in Aboriginal health in the NT, the Department should not go exclusively to them for advice, but should also utilise and access its own Aboriginal expertise as appropriate.

**Principal** and Supporting Recommendations:

**The Department should include Aboriginal participation in policy development as well as in decision making, and should utilise and access its own Aboriginal expertise as appropriate.**

### Cultural Issues

1030. There continues to be incidents of cultural conflict and internal contradictions in the way the Department treats its Aboriginal staff. For example, there are occurrences of Aboriginal and non-Aboriginal staff undertaking the same work but being differently classified and receiving different rates of pay; the Department creates a career development strategy for its Aboriginal staff, but the strategy is of limited effect because it is under-resourced; AHWs are employed in hospitals, but lack of role clarity in terms of their function within the clinical team leads to frustration by both Aboriginal and non-Aboriginal staff. The impression is given that the organisation as a whole demonstrates a lack of comprehensive cultural competence.

1031. Principles of cultural respect need to be established, promulgated and measured to ensure that cross-cultural conflicts in the workplace are reduced considerably. Competency standards for working effectively with Aboriginal colleagues, clients and organisations have been developed by the Department, are included in the Department's leadership development capabilities, and are nationally accredited. There is little or no evidence of their widespread use for either job descriptions or as the basis for workplace and/or off-the-job cultural awareness training. Their use would impact positively on maintenance of best practice standards, on accreditation, on benchmarking, and on the measurement of performance indicators, as well as on Aboriginal staff recruitment and retention strategies. This need for a fresh approach applies not only to staff in operational areas, but to all other staff as well.

1032. The Review has been advised of complaints from Aboriginal staff about the lack of a supportive working environment. There is an apparent lack of Aboriginal advocacy to ensure that fair and proper processes are adhered to before cultural conflicts in the workplace become industrial issues. Many of the cultural tensions that occur regularly within DHCS stem from a lack of skill in managing a work unit with mixed cultures. This may be due to a generic inability to manage. Managers often exhibit a reluctance to performance manage their Aboriginal staff as they would manage other staff. It may derive in part from poor skills in communicating with Aboriginal staff, from a degree of isolation of Aboriginal staff, and from improper behaviour in managing Aboriginal staff. It may also be a case of bending over backwards to avoid the slightest possibility of giving cultural offence, thereby giving Aboriginal staff an unreal view of management's performance expectations. Aboriginal staff, too, play a role in contributing to this problem, in that they sometimes isolate themselves from interaction with non-Aboriginal staff, and, on occasion, play on cultural issues to gain personal advantage. In essence, aboriginality should not be used, by either Aboriginal or non-Aboriginal staff, as an excuse for poor performance or poor management of that performance. Either way, Aboriginal staff will not be allowed to progress to positions of real decision making influence until there is far more honesty about the issues involved.

1033. In remedying this situation, the Department should take measures to create a workplace situation where people are not, for cultural reasons, constrained or inhibited from full and proper participation. Among the measure which could be implemented are:

- promulgating and adhering to existing standards and protocols;
- further developing performance indicators and benchmarks to monitor and measure outcomes; and
- developing policy accordingly.

1034. In addition, the Department should recognise cultural awareness competency and proficiency (in both Aboriginal and non-Aboriginal staff) of Aboriginal language skills, as well as providing, through its staff development programs, funding to enable appropriate language courses to be taken. The Review believes that, in addition to taking special measures to increase Aboriginal representation in the workforce, the Department should consider all positions and determine in each case whether being culturally competent is essential or highly desirable to do the job effectively. Most employment strategies do not look at this aspect systematically if at all. Such an audit of the workforce would help to ensure that where cultural competence is essential or desirable, it is listed as such on the relevant job description.

1035. Consideration should be given to the possible involvement of the Faculty of Aboriginal and Torres Strait Islander Studies and other providers in the delivery of a revamped Aboriginal Cultural Awareness Program. One critical issue is that many clinicians do not undertake a program addressing the legitimate cultural views, values and expectations of Aboriginal consumers. All providers should ensure that a sufficient element of cultural understanding is built into their programs so graduates receive more than a few hours of tuition on this issue. The Department should ensure that staff are released to undertake this training.

1036. As a related matter, more attention should be paid to the needs of non-Aboriginal culturally and linguistically diverse (CALD) groups within the Department. The employment needs of people from non-English speaking backgrounds appear not to be well resourced across the Department.

**Principal and Supporting Recommendations:**

**The Department should take measures to create a workplace situation where people are not, for cultural reasons, constrained or inhibited from full and proper participation. Among the measure which could be implemented are promulgating and adhering to existing standards and protocols; further developing performance indicators and benchmarks to monitor and measure outcomes; and developing policy accordingly.**

The Department should recognise cultural awareness competency and proficiency (in both Aboriginal and non-Aboriginal staff) of Aboriginal language skills, as well as providing, through its staff development programs, funding to enable appropriate language courses to be taken.

*Primary Health Care Access Program*

1037. The Review commends PHCAP as an initiative that, if implemented carefully and successfully, will do much to address the health needs of Aboriginal people. This initiative is probably the most significant development that has occurred in the NT health system, and requires a radical change in the Department's modus operandi if it is going to be implemented successfully.

1038. As part of that change, the Department will need to redefine its core primary health care business from that of a primary health care service provider to that of an institution that supports non-Government primary health care service providers. Hospitals, too, will have to integrate themselves into the provision of community health. Such a change will require strong leadership from the Department's CEO and from the entire senior management team.

1039. The enormity of the challenge does not as yet seem to have been matched by a resource commitment within the Department that will enable it to undertake such a massive change management exercise. The Department should identify the Public and Community Health Division as the area of the Department responsible for the implementation of PHCAP. PHCAP is not something that can simply be project managed, and so a specially-created unit within that Division should be provided with sufficient skilled human and other resources to undertake the work needed to oversee the process of change management within the Department, as well as the detailed planning and other tasks.

1040. It appears to the Review that there is a considerable divergence of views within the Department in relation to PHCAP. There are people in the Department who see PHCAP as visionary and who do not want to focus on the detail. There are others who see it as such a horrendous challenge that they fear its implementation. The truth falls in between.

1041. Many middle managers are finding it difficult to make the major change in thinking and practice that is required. The positive PHCAP message has not yet filtered down thoroughly through the ranks of departmental staff. There is therefore a degree of confusion and considerable resistance to the goals of PHCAP – greater Aboriginal control over primary health care services, including the establishment of new Aboriginal Community Controlled Health Services (ACCHS).

1042. The Review stresses the need to ensure that very careful detailed planning together with solid community capacity building precede any zonal rollout. Real effort needs to go into examining in detail the implications of PHCAP. The Review observes an element of unrealistic

expectation in relation to both the timing of the zonal rollout and the readiness of some zones to participate in this program.

1043. The Department should take more responsibility for supporting the joint strategic planning processes that are an integral precondition of the success of PHCAP, and for obtaining appropriate Ministerial and Cabinet endorsement. The outcome of these processes thus far seems to have been poor, in part because the Department has not prioritised the process, and has required staff to try to fit these new roles into their existing workloads. Support means more than merely participating in meetings. It requires the provision to the strategic planning process of a research and policy development capacity. This in turn requires that staffing resources be made available (or, if necessary recruited into the Department), that existing staff be directed to make this an integral part of their job, and that, where necessary, staff working on PHCAP be relieved of other duties and functions.

1044. The Review is fully supportive of the principles underlying PHCAP, but believes that not enough evidence is being gathered, decisions taken or resources allocated to fill in the detail. Real effort now needs to be made by all of the partners (the Commonwealth, AMSANT, ATSIC and the Territory) to fill in that detail. This should include the development of a set of mutually agreed Business Rules to facilitate effective collaboration in the future.

1045. Effort should be made by all of the Forum partners (the Commonwealth, AMSANT, ATSIC and the Territory) to identify the communities to be included, the criteria governing inclusion, the nature of the delegations to be granted, the processes of on-going consultation with unions and professional associations, and the constraints to be placed on the Boards' capacity to set salaries and remuneration in order to prevent salary auctions and bidding wars between Zones in efforts to attract/retain clinical and other staff.

1046. Decisions are still required on the use of existing departmental resources. This is a fundamental part of the implementation of PHCAP, which is not just about new Commonwealth funding but also about the better use of existing departmental funding. An important consideration here is the impact of any expansion in primary health care upon demand for secondary care, an impact generally acknowledged as in excess of 8%.

1047. Among these resourcing decisions yet to be made is the question of whether or not to pool the funding for DMOs and just what disposition of existing DMO services will be made under the new arrangements. This issue will loom even more prominently in the future as it is becoming increasingly difficult to recruit doctors to DMO positions, even more so than to other general practitioner positions. Medical training has undergone major changes in the last decade and the DMO-type doctor (competent in general practice, emergency medicine, and public health) is no longer commonly available. Each of these areas now requires specialist training and such medical practitioners are no longer as easy to find or recruit.



1048. There are a number of communities in the NT that are incorporated townships rather than Aboriginal communities, and which encompass non-Aboriginal as well as Aboriginal residents. As well, there are pastoralists and other remote enterprises involving mining, tourism and fishing that employ both non-Aboriginal and Aboriginal staff. The non-Aboriginal populations in the Zones need to know that they will receive better access to improved service under the new arrangements. This, too, requires detailed planning work. The Commonwealth's position is unequivocal, namely that the composition of the Health Boards as between Aboriginal and non-Aboriginal members is one for local determination and agreement. The question of non-Aboriginal representation on Health Boards is, therefore, a relevant consideration in these cases.

1049. Duplication cannot be afforded in the provision of services to small communities. It will eventually result in high costs and poor quality of care. There needs to be sound linkages between primary and secondary care. In setting up the Zones, planning should commence now to accommodate the certain increase in demand for secondary care, especially in those communities where, at present, little secondary care exists. This is a weakness in the current approach.

1050. Another serious matter yet to be resolved in the planning of PHCAP is whether or not DHCS will directly or indirectly influence the Health Boards to ensure that health care is uniformly delivered throughout the NT. An issue arises around authority of the Health Boards. It is clear that the Boards are responsible for the provision of primary health services including, for example, recruitment and retention of staff. It is presumed by many that the Boards' authority in these matters will be unfettered. Government organisations are limited by Government policy in such matters, including levels of remuneration. Government limits on remuneration have been a restriction in recruiting staff in some instances. On the other hand, there is a high risk of a 'price war' if there is not some similarity in what different Health Boards offer as remuneration. There is a further risk that the Health Boards' remuneration levels will impact directly on other employers, including the Department. To avoid misunderstandings at a later time, issues of this kind need to be considered and endorsed by Cabinet in reasonable detail.

1051. The need for effective support services should also be addressed. It is clear that, under PHCAP, a range of support services will need to be provided at the regional and, perhaps, Territory-wide level. Such services include management support, IT support, program development, human resource management and development, research and development capacity, and clinical audits. The Department should establish the essential support services that will be necessary. This is made more critical by the fact that the identification and delivery of such services are not within the experience or expertise of many Aboriginal communities to determine. The Department cannot afford to maintain a view that the development of regional primary health care support services should wait until the new zones have agreed to fund them from within PHCAP allocations.

1052. AMSANT will need the provision, by the Department and/or by the Commonwealth, of resources to enable it to participate fully in the development of the new arrangements.

1053. The Department needs to work with the other Forum partners to ensure that there are no further delays in implementing the core clinical and support services needed in PHCAP zones. Other core services, such as special programs to address the underlying social determinants of health, and related policy development and advocacy, cannot be implemented in the same way. These services require community agreement and will have to wait until health boards have been established. Once health boards have been established, all services can be transferred to their control when they are ready. Thus, it may well be that the Department or existing ACCHS will need to remain primary health care service providers for some time until all zones are able to take on their own service delivery responsibilities. On the other hand, it might well be possible for at least some of the primary health resources to be applied now, and to be segregated from any future cash-out.

1054. There appears also to be a need for an allocation of some responsibility for environmental and public health, including in areas such as inspection of food outlets. The Territory Government will, of course, wish to retain sufficient capacity in this area to be able to ensure that these health requirements are being met satisfactorily. Nonetheless, environmental health and public health are, in other jurisdictions, functions principally carried out by local Government. In this context, it has to be remembered that the Health Boards are not going to be quasi-local Government authorities even though they will assume some of the role of such authorities as they pursue primary health care delivery. The question of the proposed transfer of environmental health responsibility to local Government is discussed elsewhere in this Report.

1055. The future collapse of a health board established under PHCAP would be a major disaster from the point of view of health delivery. There should consequently be recognition of the need for ongoing risk management and ongoing monitoring. The Department should begin the process of moving from broad vision to fine detail and implementation.

1056. The Review has received expressions of concern that many of the consultants engaged at the operational and service-provider levels as part of PHCAP have not seen fit to involve Aboriginal staff. Most of the Department's Aboriginal staff in potential zone sites are community members of the identified health zones and yet they are apparently not being included in consultations about zonal matters affecting their own communities. Further, Aboriginal staff of DHCS could play an integral role in cultural brokerage within the Department in the context of the zone process, but appear not to have been involved to date. The end result is that zone development is perceived as being managed secretly, controlled by a few, and with little information being communicated.

1057. While AMSANT fulfils a valuable advocacy and representative role of behalf of its members, not all communities captured by the roll out of PHCAP are members of AMSANT.

The Department needs to ensure that those communities directly affected by the roll out of PHCAP are included in decisions about its development and implementation. It should therefore, through formal partnerships, engage the wider Aboriginal and Torres Strait Islander communities, particularly those in remote areas. Similarly, the Department's Aboriginal employees should actively be employed in the development of the zone process, particularly at community level.

1058. If PHCAP is to be implemented successfully, it will require a whole of Government commitment. PHCAP involves interdepartmental collaboration, especially with capacity building and with issues around development and maintenance of adequate infrastructure and services in remote communities.

1059. The Review observes that there appears, to date, to be insufficient recognition of the importance of and commitment to collaboration and cooperation between various elements of the Government and the community in addressing Aboriginal health needs. This is most noticeable in the lack of engagement with Aboriginal people. In this context, the Review draws attention to the need to draw on and incorporate the findings and recommendations of the Collins Report "*Learning Lessons*". The Review is concerned that the Department sees 'health' as the only agenda for Aboriginal communities, and that the Department does not sufficiently understand or practice a holistic approach to health which also includes leadership, education, economic development, and housing.

1060. In the PHCAP context, the Review has formed the view that very strong links should be forged between DHCS and the intrinsically related Departments responsible for education and for community development. In this respect, as in many others, close collaboration with the Indigenous Affairs Unit within the Chief Minister's Department would be invaluable.

1061. During the Review, a number of people have put to us that zonal boundaries are important and that there should be common boundaries between PHCAP zones and those of the service districts used by the Department responsible for community development. However there are other considerations. We do not see the boundaries per se as the issue. We recognise that boundaries should reflect the community realities, they should be flexible, they will evolve and develop over time. What is important, in our view, is that the boundaries used by PHCAP and by the Department responsible for community development should reflect the same realities, the same evolution, the same development.

**Principal and Supporting Recommendations:**

**The Department should identify the Public and Community Health Division as the area of the Department responsible for the implementation of PHCAP. A specially-created unit within that Division should be provided with sufficient human and other resources to undertake the work needed to oversee the process of change management within the Department, as well as the detailed planning and other tasks.**

The Department should not devolve health service management to primary health services that are not able to demonstrate sustainability in the short, medium and longer term.

The Department should undertake a process to convince the non-Aboriginal populations in the Zones that they will receive better access to improved service under the new arrangements, and should resolve the question of non-Aboriginal representation on Health Boards.

The Department should determine whether it will directly or indirectly influence the Health Boards to ensure that health care is uniformly delivered throughout the NT.

The Department should, through formal partnerships related to the PHCAP process, engage the wider Aboriginal and Torres Strait Islander communities, particularly those in remote areas.

### Aboriginal Health Action Plan

1062. In the context of the Minister's Statement of 21 May 2002 and in accordance with her directive, the Department should develop an Aboriginal Health Action Plan for implementation.

1063. The Action Plan should:

- identify a set of five-year targets and the actions required to meet those targets;
- encompass core elements of existing departmental and Government plans and incorporate existing implementation activities on such key initiatives as PHCAP and the Government's other policy commitments;
- take into account the recommendations of this Review;
- ensure that the acute care sector assumes a greater community health orientation;
- address current policy and service gaps;
- explore the means of negotiating effective funding and program partnerships with the philanthropic and corporate sectors, as well as with the Commonwealth; and
- contain defined, time-specific outcomes with regular reporting to Government on progress made.

1064. Beyond those initial five-year targets, however, the Action Plan should set for itself a goals horizon greater than 5 years. In a 5-year time frame, much tactical work can be completed and realised, but gains in health may take longer than that to consolidate.

### **Principal and Supporting Recommendations:**

**The Department should develop an Aboriginal Health Action Plan for implementation.**

Men's Health

1065. While many women's health projects have been successfully initiated in the NT, particularly among the Aboriginal population, and are proving effective in achieving real improvements in health, the Aboriginal cultural context requires similar interventions whereby health services can be offered specifically to men by men.

1066. Such an initiative is worthy of a higher level of policy and budgetary priority, with subsequent service initiatives. The potential for intersectoral collaboration and service delivery by NGOs should be explored. In this context, a pilot men's health project should be established in Alice Springs to cater for the health needs of men in the Alice Springs Town Camps.

1067. Implementation of this pilot project, which should be given an initial life of at least three years, should be negotiated between the Department and the Central Australia Aboriginal Congress (Congress). Congress should be encouraged to invite the Tangentyere Council to participate in the delivery of the service.

**Principal** and Supporting Recommendations:

The Department should, as a pilot, undertake a men's health project in Alice Springs to cater for the health needs of men in the Alice Springs Town Camps.



## **Appendix 1: Recommended Departmental Structure**

Chart 1

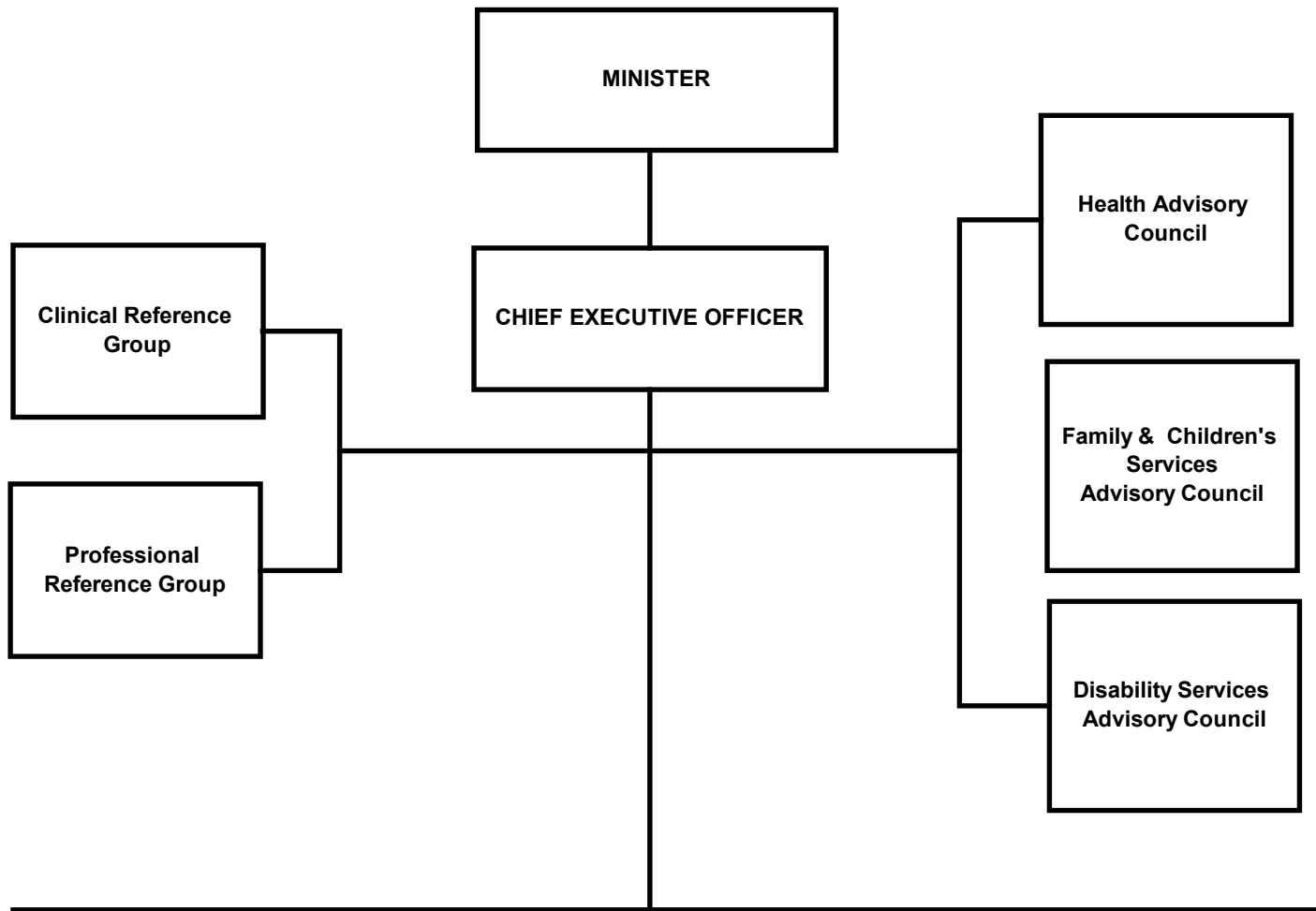




Chart 2

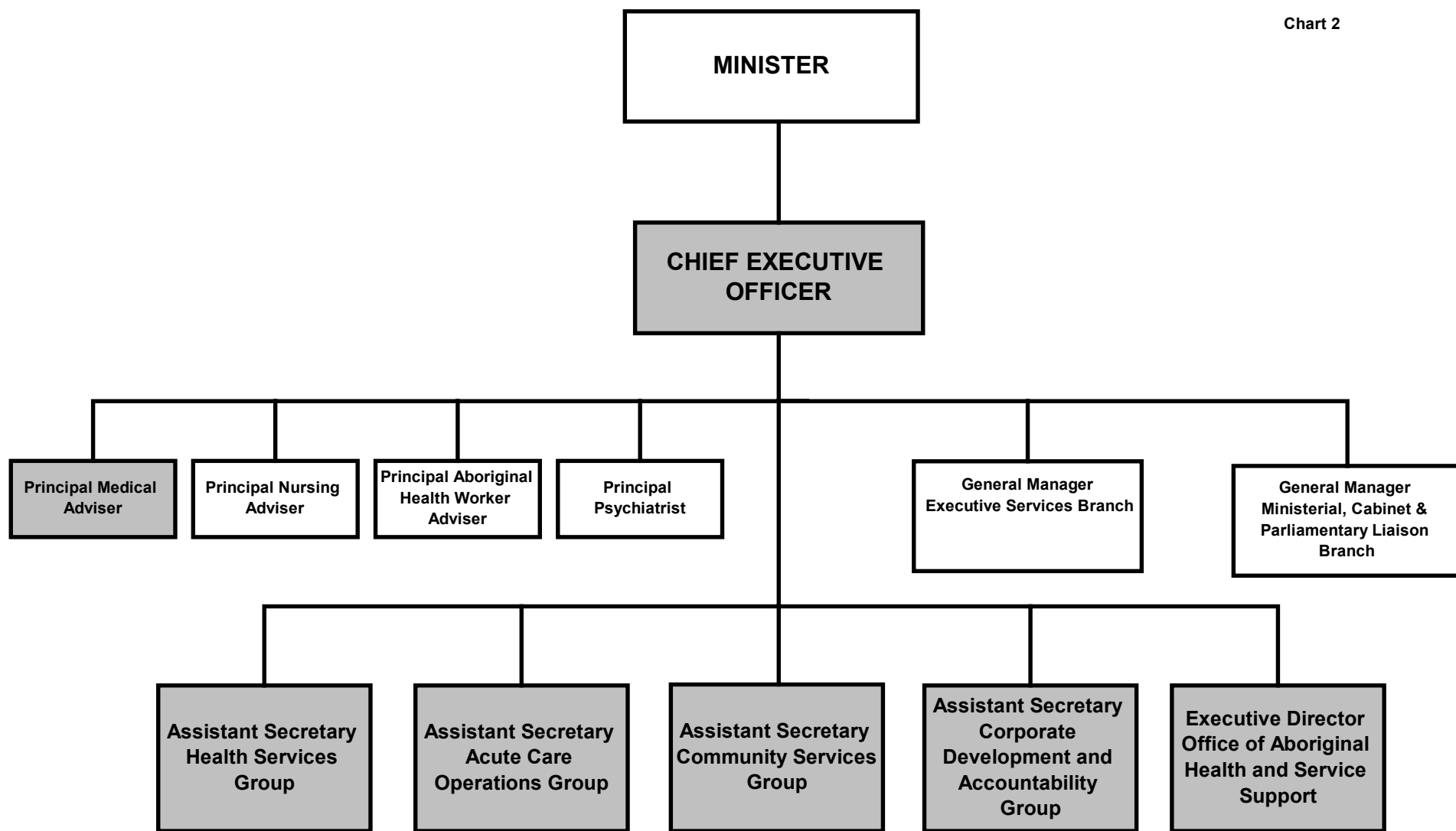
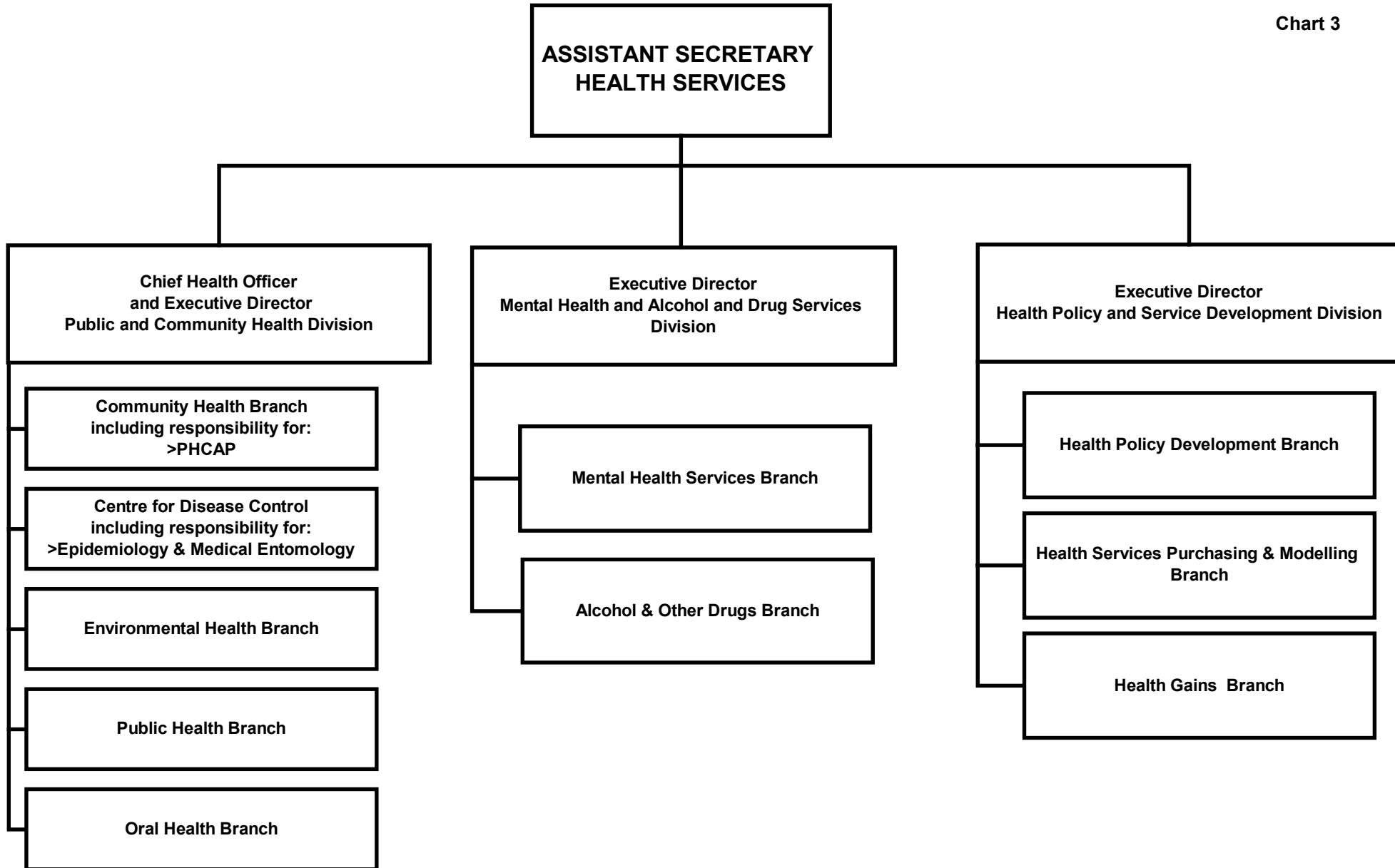


Chart 3



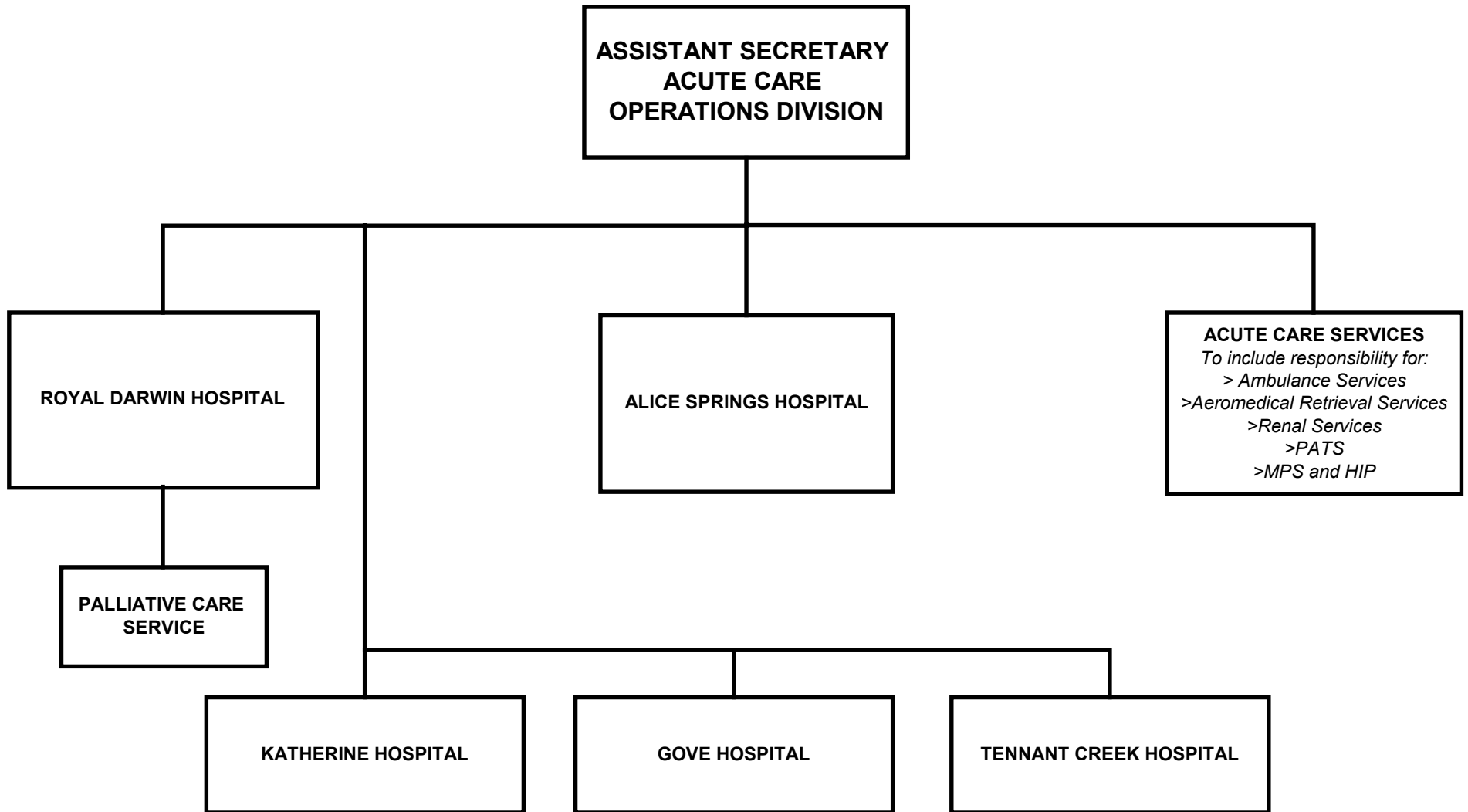


Chart 5

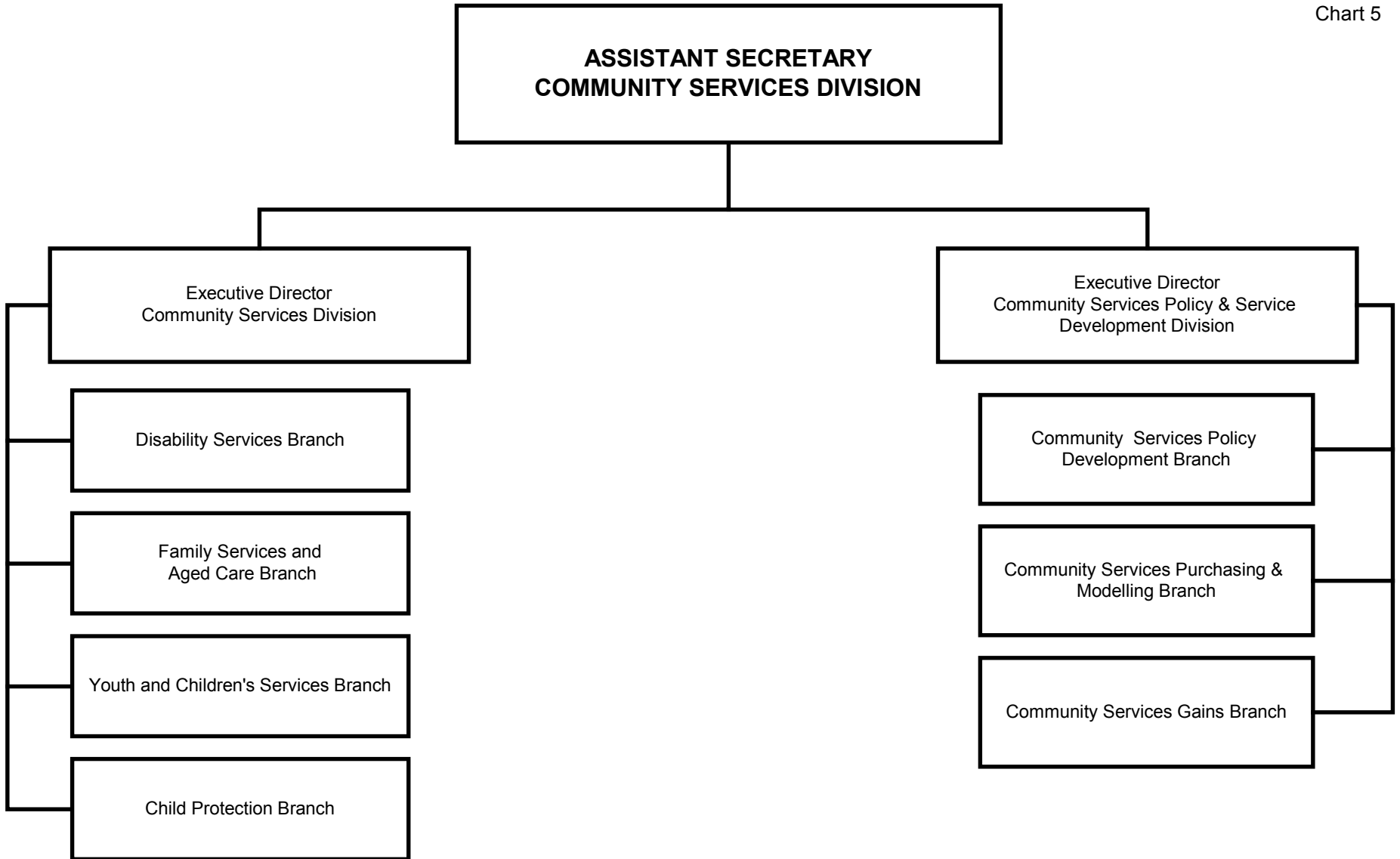


Chart 6

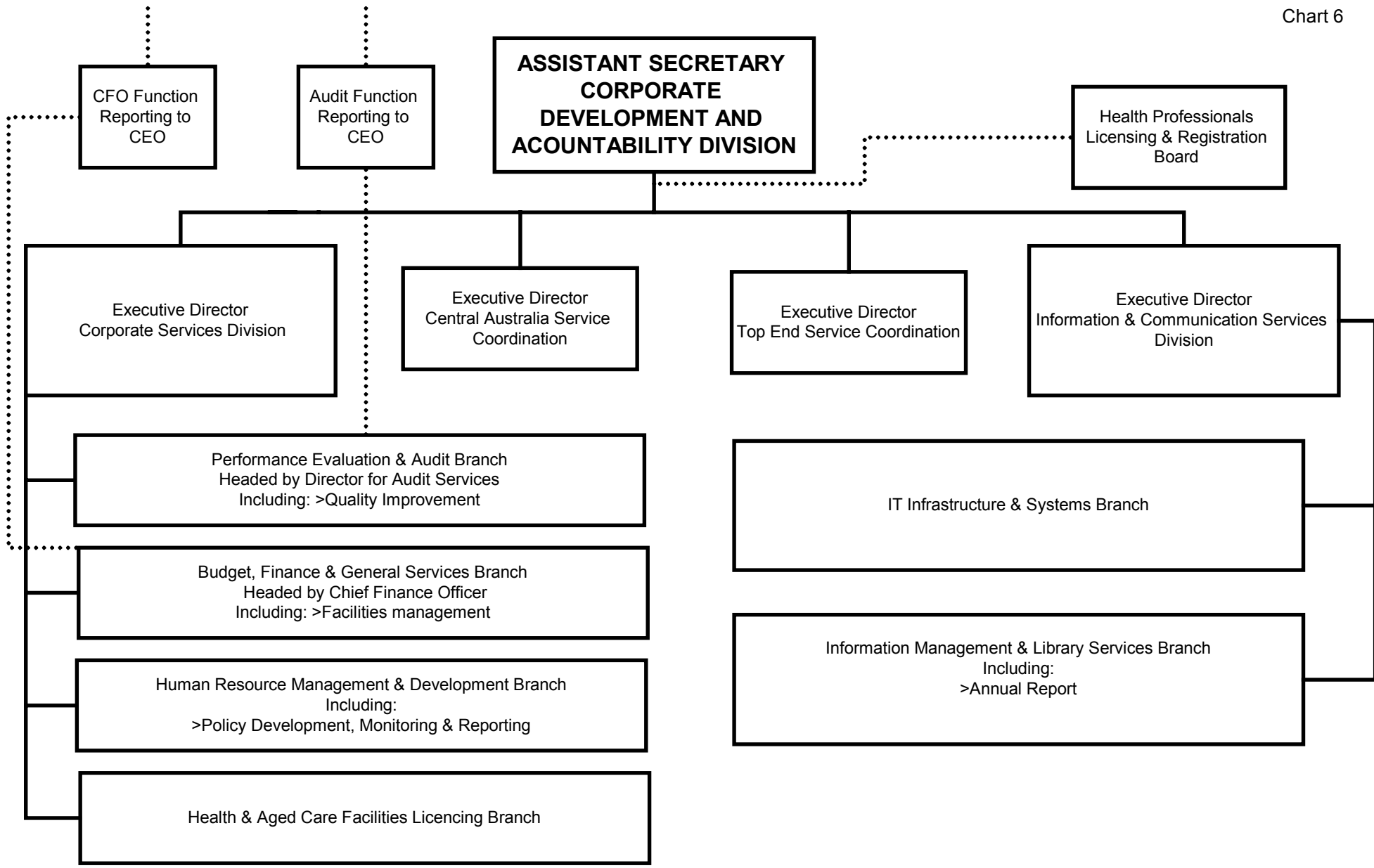
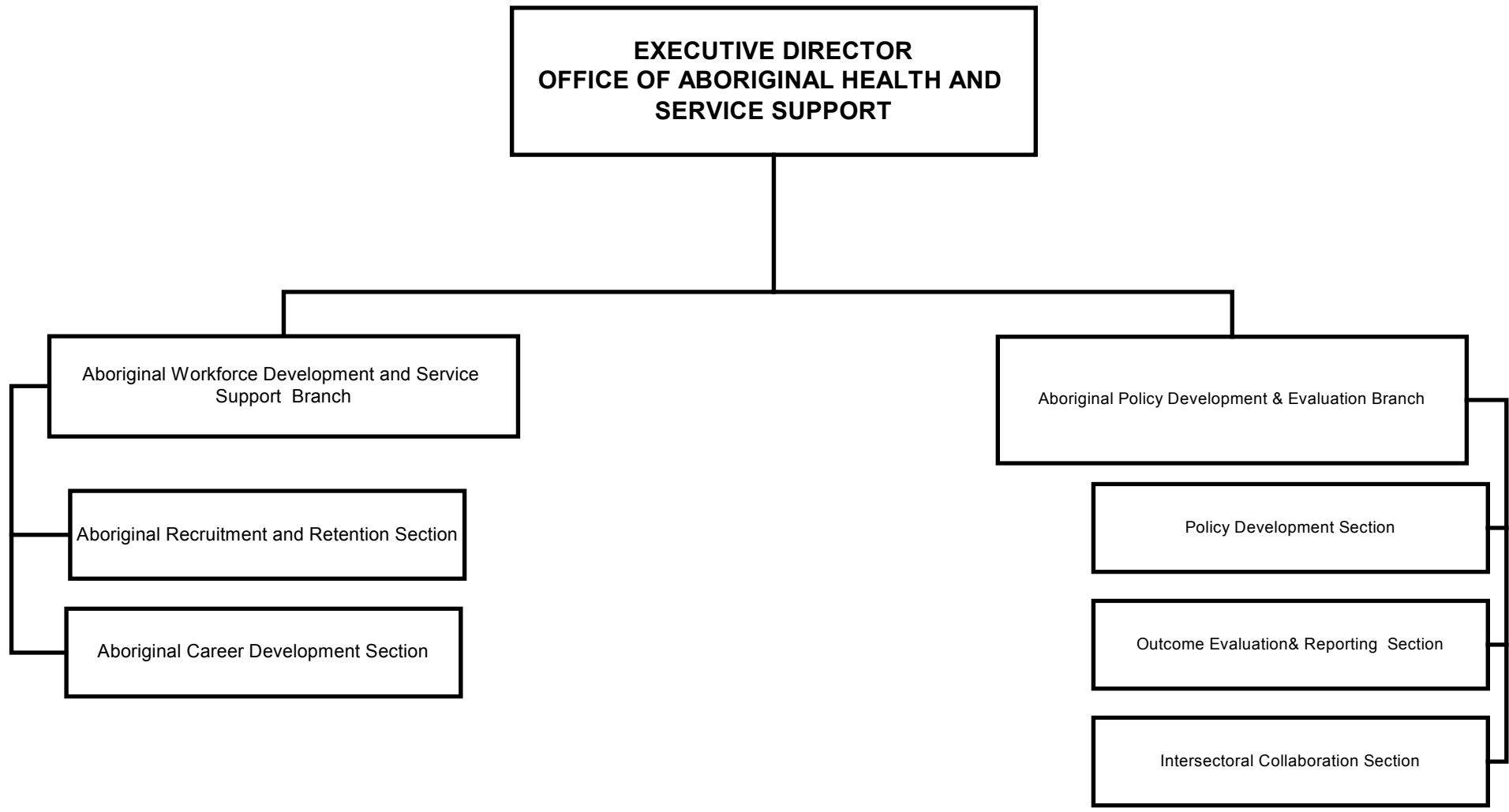


Chart 7



## Appendix 2: Recommendations of the CRESAP Review

No	Recommendation
	<b>5.1 Hospital Services</b>
	<b>Royal Darwin Hospital</b>
1	Nurse Staffing at RDH should be managed to achieve the formula level recommended by the Hospital
2	Improvements in Nursing Deployment and Leave Management should be implemented to achieve efficiencies
3	The 26-hour shift coverage of the nursing day should be reduced to 24-hours in line with best practice elsewhere
4	The number of acute care beds at RDH should be reduced by twenty-five. One ward should be closed and beds reconfigured to maximise efficient utilisation of resources
5	Overtime costs for salaried medical officers should be reviewed and procedures implemented to contain these costs
6	The allocation of specialists' sessions should be monitored and the numbers of sessions regularly reviewed
7	Opportunities for multi-skilling of laboratory technicians should be taken up, administrative efficiencies implemented and quality control procedures employed to reduce costs in the pathology section
8	Work practices of the Hospital Assistants and Wardsmen at RDH should be modified to bring them in line with best practice elsewhere
9	The Reproductive Medicine Unit should be phased out and the services continue to be provided by the private sector. The Department should provide some financial assistance for the establishment of an IVF Satellite Service in the Territory
10	The Hyperbaric Chamber at RDH should be closed and divers requiring decompression treatment flown to Broome
11	Work practices for Cleaning Staff should be modified to achieve efficiencies
12	Multi-skilling opportunities should be taken up with Catering Staff
13	Increased throughput, improved automation, and the adoption of best practices in other laundries should be employed to increase the efficiency of RDH laundry
14	Routine maintenance services at RDH should be privatised
15	Medical Engineering Services at RDH should be more competitive with private sector services. Efficiencies can be realised through multi-skilling and changed work practices
16	The efficiency of garbage services at RDH should be substantially improved by revising rosters and changing work practices
17	Priorities should be established for maintenance of the grounds at RDH and the overall level of service reduced in line with these priorities
18	RDH should seek to reduce the cost of power for the operation of the hospital
19	The powers of the Board of RDH should be expanded to include Financial Management on a trial basis
	<b>Alice Springs Hospital</b>
20	Nursing staff at ASH should be increased by seven and the staffing mix changed as recommended in the recent nursing resource review
21	The 26-hour shift coverage of the nursing day should be reduced to 24-hours in line with best practice elsewhere
22	Work practices and duties of the Hospital Assistants and Wardsmen should be modified to increase efficiency
23	Multi-skilling should be adopted with Cleaning Staff to achieve efficiencies

24	Multi-skilling should be adopted with Catering Staff to achieve efficiencies
25	ASH laundry equipment should be upgraded to provide a more efficient service
26	Maintenance services at ASH should remain in-house
27	The contract for Radiology Services at the hospital should be reviewed and arrangements adopted to bring costs in line with best practice elsewhere
28	ASH should seek a feasibility study to assess the potential for co-generation to reduce the power costs of the hospital
	<b>Katherine Hospital</b>
29	Work practices of Hospital Assistants and Wardsmen should be modified to bring them in line with best practice elsewhere
30	More efficient cleaning practices should be adopted at KH to bring them in line with best practice elsewhere
31	KH laundry should be closed and the service provided by RDH
	<b>Tennant Creek Hospital</b>
32	TCH should remain open and continue to provide the current level of service
33	Management responsibility for TCH should be devolved to ASH
34	The Maternity Ward at TCH should be restructured so as to achieve efficiencies in Nursing staff numbers
35	The Accident and Emergency Service After Hours should be shifted to the treatment room of the general ward to realise a further reduction in nursing staff numbers
36	Nurse numbers at TCH can be reduced by a further one position thereby bringing the hospital in line with staff numbers in other NT hospitals
37	Rental costs borne by the Department for the local GP and Private Dentist should be reduced by providing facilities on the hospital campus
38	The Private Medical Practitioners in Tennant Creek should be invited to provide services to the hospital on contract, thereby allowing medical staff to be reduced by one
39	The number of Hospital Assistants and Wardsmen should be reduced by one to bring TCH staffing in line with that of other hospitals
40	The laundry at TCH should be closed and the service provided by ASH
41	The Catering Staff at TCH should be reduced by one to bring it in line with more efficient practices elsewhere
	<b>Gove District Hospital</b>
42	Multi-skilling should be adopted with Catering and Cleaning Staff to achieve efficiencies
	<b>5.2 Community Care</b>
	<b>Urban Community Health Centres</b>
43	Community Health Centres in the Darwin region should be restructured
44	Domiciliary Nursing Services in Darwin should continue to be provided from the Community Health Centres
45	The Darwin Central Health Clinic should remain open
46	The Nightcliff Health Centre should be refocussed as a Renal Dialysis Unit
47	Casuarina Health Centre should provide an integrated health service covering health, welfare and hearing services
48	Services at Berrimah Health Centre should be redirected to the Palmerston and Casuarina Health Centres
49	An integrated health service should be established at the Palmerston Health Centre



50	The after hours medical service in Palmerston should be privatised and the Department's on-call service cease
51	The Mataranka Health Centre should be retained
52	The ERC decision to close Victoria River Downs Health Centre should be upheld
53	Efficiencies in the St John Ambulance Service should be realised
	<b>Primary Health Care - Rural</b>
54	The Primary Health Care Model should be strengthened by implementing appropriate structures which focus on the community to ensure equity of resources and access to services
55	District Health Councils should be established with local community representation to ensure accountability of Departmental Health Services to the community served as well as community input on decisions relating to local health needs and priorities
56	A high priority should be given to increasing the number of registered AHW positions by forty and increasing participation rates
57	The management of AHWs should be strengthened by additional staff to assist the present managers
58	An additional four staff should be dedicated to AHW training
59	An additional twenty AHWs should be dedicated to Health Promotion and Environmental Health roles and their distinctive training needs addressed
60	Accommodation standards for Health Centre staff in remote localities should be upgraded as a matter of priority
61	Induction, Orientation and Inservice training for remote area nurses should be expanded as a matter of priority and greater training emphasis given to cross-cultural issues
62	The Department should consult with the school of nursing at the NTU to ensure that specialist education in remote area nursing is established as a priority
63	DMOs should continue to be responsible for routine clinics for remote communities, medical advice to Nurses and Health Workers in these communities, and evacuations
64	The Department should accept the role of independent health services as legitimate and develop policies of greater co-operation with non-Government providers of health services
	<b>Patient Transport</b>
65	The community health program manager should be responsible for monitoring expenditure on Aerial Medical Services
66	Clear and uniform policies should be adopted across the Territory for the classification of priorities for evacuations and inter-hospital transfers. The policies should also cover procedures for responding to these situations, and for determining the type of aircraft to be used
67	The Department policy on patient escorts should be adhered to, and escort approval practices monitored
68	Aerial medical services for the Top End and the Centre should be coordinated by the managers of Darwin and Alice Springs Rural Districts respectively
69	Procedures for interhospital transfers should be reviewed to ensure efficient utilisation of resources
70	Consideration should be given to greater utilisation of RFDS services in the Barkly District
71	The expiry of the current contract for Aerial Medical Services in Darwin and East Arnhem provides an opportunity for the Department to obtain a more efficient and comprehensive service
72	Practices and procedures should be revised to increase the efficiency of operation of Aerial Medical Service
73	The Department should charge commercial rates for private usage of the Aerial Medical Service
	<b>Aged And Disability Services</b>
74	Eligibility for benefits under the Pensioner Concession Scheme should be restricted to Social Security and Veteran's Affairs pensioners

75	The Department should negotiate a contract for the supply of spectacles to pensioner concession cardholders and limit the provision of spectacles to one pair every two years unless more frequent change is prescribed by a qualified practitioner
76	The concession for pensioners' drivers' licences should be removed
77	The level of passenger contributions for urban bus travel under the pensioner concession scheme should be increased to fifty per cent of the fare
78	Air travel (or car travel in lieu) concessions paid to aged persons should be removed
	<b>Family, Youth and Children's Services</b>
79	A means test should be applied to the Child Care Subsidy Scheme
80	An Integrated Community Service Advice Bureau should be established to provide information on services for women, the disabled, and pensioner concessions
81	The Department should withdraw from the Commonwealth/NT remote areas funding program, but continue to fund remote area support services
	<b>Hearing Services</b>
82	The position of specialist audiologist in Alice Springs should be reinstated. Audiology Hearing Services should be integrated into the Community Care Division
83	The NT Hearing Program should be amalgamated with the Territory Hearing Services and the position of coordinator retained. The Ear Washing Program should be absorbed into the Community Health Centres
	<b>Mental Health Services</b>
84	The Mental Health Services Program should be located within the Community Care Division. A Secure Care Unit with sixteen beds should be established
	<b>Dental Health Services</b>
85	The ERC proposals for reducing Dental Services are supported but the Department should monitor the impact of those recommendations. Dental Health Services should be located within the Community Care Division
	<b>Alcohol And Other Drugs</b>
86	A High Level Policy Development and Coordination Capacity for Alcohol and Drugs should be located within the Department of the chief minister. An operational focus should be developed for alcohol and other drugs within DHCS
87	The ERC decision to close the Detoxification Unit at RDH should be reversed
	<b>Rehabilitation</b>
88	A comprehensive review of Rehabilitation Services should be undertaken throughout the Territory
	<b>Consumer Affairs</b>
89	The Office of Consumer Affairs (including Trade Measurement) should be transferred to the Department of Law
	<b>Mammography</b>
90	The Department should defer participation in the National Program for Early Detection of Breast Cancer
	<b>Correctional Services</b>
91	Current financial resources for the provision of Health Services to the Department of Correctional Services should be transferred to that Department to ensure accountability for costs
	<b>Environmental Health</b>
92	Environmental Health should be restructured in the Community Care Division to provide a strengthened Territory-Wide Service
	<b>Health Promotion</b>

93	A Health Promotion Unit should be established in the Community Care Division
	<b>Disease Control</b>
94	The Communicable Diseases Branch should be re-organised on a Territory-Wide basis as part of the Community Care Division
	<b>5.3 Scientific Services</b>
95	A Scientific Services Unit encompassing Pharmaceuticals and Poisons, Entomology, and Radiation and Toxic Waste should be established
	<b>5.4 Cost Recoveries and Transfers</b>
96	Greater cost recovery should be introduced into the provision of staff meals at all NT hospitals
97	Greater cost recovery should be achieved in claiming Medicare rebates for Pathology tests for the rural communities
98	The Department should explore realistic options for the privatisation of Pharmaceutical Services for rural communities
99	DMOs should obtain the full potential of Medicare recovery for their consultations
	<b>Medicare Agreement</b>
100	The extent of financial disadvantage experienced by the Territory under the current Medicare agreement, its effect on Commonwealth Special Purpose Grants, and mechanisms to redress the situation should be identified for the purpose of renegotiating a new agreement
	<b>6.1 Inefficiencies in Administrative Systems</b>
101	The Department should review its delegations to provide line management with an appropriate level of authority
102	When reviewing <i>The Public Service Act</i> , the Public Service Commissioner should take account of the need to provide Department heads with powers which can be delegated
103	Average staffing levels (budget allocation) should be the basis of counting staff
104	Clear Departmental procedures should be developed for moving resources between programs
	<b>6.2 Policy and Planning</b>
105	The CHO should head the Policy and Planning Division
	<b>Epidemiology and Statistics</b>
106	The Policy and Planning Division should have an Epidemiologist as an integral part of the planning team
	<b>Professional Boards</b>
107	The DHCS should accept the professional accreditation of other states
	<b>Ministerials</b>
108	The Ministerial Liaison Branch should be upgraded and the head of the Branch should participate in Departmental executive meetings. Ministerial responses should continue to be managed by Ministerial Liaison with the Divisions and Branches being responsible for providing relevant, accurate and timely responses to the Ministerial Liaison Branch
	<b>6.3 Human Resource Management</b>
109	The Human Resource Management Division should have a central office Human Resource Project Team which undertakes projects for the Executive on HRM issues
110	An Organisational Strategy and Development Branch should be established
111	Operation of the Job Evaluation System needs to be significantly improved
112	Responsibility for employee relations should be moved from the Industrial Relations Branch to the Human Resource Services Branch

113	The Department should address the issue of Occupational Health and Safety, Workers Compensation and Rehabilitation centrally through the HRS Branch of the Human Resource Management Division
114	Resources should be allocated to Employee Health at Work to reduce the Department's compensation liability and increase productivity
115	Payroll should be processed in both Darwin and Alice Springs
116	Analysis of potential staff savings from the Integrated Payroll and Personnel System should occur after that system has been implemented
117	Further analysis of the Compuclock System is required to assess its suitability for wider use in the Department
118	Recruitment officers should not normally participate on selection panels
	<b>Staff Development</b>
119	The Staff Development Program should be coordinated on a Territory-wide basis
120	Training centres should be created in Darwin and Alice Springs, with Nurse, Rural and Welfare Training remaining within their functional area but reporting on a day-to-day basis to the Manager Training Centre in Darwin or Alice Springs
121	A second Welfare Training Officer should be appointed
	<b>6.4 Corporate Services</b>
	<b>Financial Policy</b>
122	A Financial Policy Branch should be created with responsibility for overseeing finance-related issues on a Department-wide basis
	<b>Risk Management</b>
123	Risk Management Policies and Procedures should be developed by the Department to minimise potential losses to Human and Financial Resources
	<b>Asset Management</b>
124	A strategic approach to asset management should be adopted and an asset register compiled as a matter of priority
	<b>Accounts Payable/Accounts Receivable</b>
125	Accounts Payable and Accounts Receivable should be centralised in Darwin as recommended by ERC
126	A position should be retained in each of the areas to handle Credit Card Transactions and to arrange direct Credit Payments
	<b>Nhulunbuy Electricity Accounts</b>
127	Responsibility for electricity accounts in Nhulunbuy should be transferred to PAWA as soon as possible
128	Nhulunbuy consumers should be subsidised to the level of the average Territory-wide domestic electricity account and then be required to pay the full unit cost on the excess
	<b>Works Programming</b>
129	The guidelines for submitting requests for Works and Programming Funds should be more strictly adhered to
130	Submissions should be more stringently screened at the area level
131	Eligibility criteria for projects should be further defined
	<b>Information Systems</b>
132	The Information Systems Branch should play a more active role in the strategic management of systems for the Department
133	The role of the Central Office's Information Systems Branch should focus on Department-wide Information Technology Strategy, Policy Formulation and Monitoring

	<b>Hospital Information System</b>
134	Implementation of the Hospital Information System (HIS) should proceed, but an attempt should be made to reconcile technical, financial and management concerns
135	A major thrust of IT Policy should be to assist in providing facilities to access data resident in the various systems
	<b>6.5 General Services</b>
	<b>Co-location of Central Office</b>
136	The HACS Central Office should be co-located with the present Darwin Regional Office in Casuarina
	<b>Travel Arrangements</b>
137	Travel arrangements for the Department should be contracted to the private sector
	<b>Transport</b>
138	The size of the motor vehicle fleet should be decreased by 33 vehicles and controls on usage tightened
139	The Department of Correctional Services should manage its own transport function
140	Future Government lease arrangements should provide for smaller vehicles or alternatively, the Department should be given the flexibility to purchase smaller vehicles as deemed appropriate
	<b>Stores, Purchasing, Contracts and Asset Management</b>
141	In the Darwin Region, Stores, Purchasing, Contracts and Asset Management should be co-located on RDH campus
142	A full- time clerical position should be created in RDH Pharmacy to enter and verify data on the Qantel System
143	The Pharmacy Purchasing Officer should be transferred to stores
144	Off-campus delivery of goods at RDH should be consolidated
145	The services provided by RDH store should be limited to Departmental units
	<b>Publications</b>
146	The Publications Branch should stop providing graphic and printing services to other Departments
147	The Publications Branch should be relocated into the field
148	Job costings should be computerised
	<b>Library</b>
149	Inter-library loans should be managed from Darwin or Alice Springs with journal orders being centralised in RDH Central Medical Library
150	The Central Office Library should be physically integrated with RDH Library
151	The library in ASH should be staffed by a Librarian and a Librarian Technician, in line with Australian Library Standards
152	Cataloguing for the ASH Library should be undertaken by the Central Medical Library and journal orders should be centralised in the Central Medical Library
	<b>6.6 Administration of Grants and Allowances</b>
	<b>Patient Assistance Travel Scheme (PATS)</b>
153	A means-tested patient and escort contribution for PATS fare should be introduced and the accommodation subsidy for the first three nights of every visit for patients and escorts who do not meet the means test should be removed
	<b>Grant Administration</b>
154	Grant Administration should be restructured, retaining a central office role and devolving to the districts responsibility for liaising with grant organisations and the evaluation of their performance

155	The process of grant approval should be simplified
	<b>6.7 Conditions of Service</b>
	<b>General Conditions of Service</b>
156	Subsidies on accommodation leased by the Department should be eliminated, subject to approval by the Public Service Commissioner
157	The level of subsidy for HECS fees should be reduced to 85 per cent for courses of study that result in a direct benefit to the Department and eliminated for all others, subject to the approval of the Public Service Commissioner
158	It is recommended that the by-laws on study leave be reviewed
159	The provision of temperate clothing allowance should be discontinued, subject to the approval of the Public Service Commissioner
	<b>Remote Areas</b>
160	The freight of perishables allowance should be withdrawn from Nhulunbuy and the entitlement to fares out of isolated localities provision should not apply to Nhulunbuy or Jabiru, subject to the approval of the Public Service Commissioner
161	Rental rates in non-urban localities should be set at a rate that reflects the remoteness of the locality and the standard of accommodation provided, and rental rebate rates for Nhulunbuy should be removed, subject to approvals of the Public Service Commissioner and the Department of the Lands and Housing
162	Provision of domestic furniture to staff residences in Nhulunbuy should be terminated
163	Free electricity to staff in remote areas should cease and be replaced by a subsidy negotiated by the Public Service Commissioner

### Appendix 3: Recommendations of the Parker Review

NO	RECOMMENDATION
1.	That a Strategy 21 <sup>st</sup> Century Steering Committee be established to replace the current HTS Executive. This would be the top level strategic directions Committee aligning strategic intent with THS objectives.
2.	That three Standing Committees be established to support the Strategy 21 <sup>st</sup> Century Steering Committee: A Finance and Administration Standing Committee A Quality Improvement/Best Practice Standing Committee A Program Development/Stretch Goals Standing Committee These Committees would meet monthly and report to the Strategy 21 <sup>st</sup> Century Steering Committee.
3.	That a Policy Coordination capacity be developed at the present Assistant Secretary, Planning & Systems Support level in order to coordinate the present policy development issues by establishing a THS wide policy framework. Policy development to be aligned with the Strategy 21 <sup>st</sup> Century Strategic Intent.
4.	That a Health Gain Planning Unit be established within the present Planning & Systems Support corporate area. The major task to develop an <u>annual</u> “health gain” plan to inform resource allocation and program/service development. It would set out the health and well-being status of the Territory and its population and identify key problems and priorities. The plan would be a summary of the <b><i>“State Of Health Of Territorians”</i></b> .
5.	That the current model for the organisation of THS and the delivery of services be replaced by Option 3. (See page 24.) Of the four options considered, the Organisation Review Project Steering Committee endorsed Option 3 as the preferred option.
6.	That a hierarchy of comprehensive and clear service agreements be developed to underpin the internal purchaser/provider roles in Option 3. These will facilitate specificity and accountability in the service provision areas and bring about THS wide consistency at all levels.
7.	That a Strategy 21 <sup>st</sup> Century Support Unit be established for a time limited period to project manage all of the changes endorsed as part of the review project. See page 33A.
8.	That a Purchasing Advisory and Resource Unit be established under the present structure, Assistant Secretary, Health Planning & Systems Support, for an initial period of one year.  The key functions to include developing a clear understanding of the funder/purchaser/provider concept throughout THS. It would also develop an action plan, in association with senior management for extending purchaser/provider arrangements for the next 12 months and then through to 2003. It would also facilitate a series of workshops and training courses for all staff involved in the process of implementing purchaser/provider arrangements.
9.	That a standard contract model be developed for all purchaser/provider contracts and service agreements with NGO’s. The complexity and scope of contracts to be indicated by the schedules and attachments to the standard contract documentation.
10.	That annual “Health Service” plans be developed with and by local communities to establish the real priorities for providing services to the individual remote area communities. This would assist in clarifying the role and responsibilities of staff working in THS clinics in particular.
11.	That a close working relationship be developed between DMO’s, General Practitioners in remote areas and hospital clinical staff where this is not currently the case.
12.	That an emphasis be placed on better coordinating visits to community controlled health services by staff employed by THS at various levels.
13.	That area specific cultural awareness and basic language training be provided to THS health clinic staff on an ongoing basis.
14.	That a priority be placed on establishing regular discussion, either formally or informally, between health clinic staff and school teaching staff where this is not already occurring.
15.	That training and support for health clinic staff be provided by epidemiologists in analysing the health trend

	data collected in the clinics. (There is little analysis of the data currently collected.)
16.	That the results of the various internal and external reviews of health clinics carried out over the last few years be reviewed to establish “post review” changes.
17.	That subject to the endorsement of Recommendations 1 and 2, the following be delegated to a designated number of key managers:  Decisions on the centrally managed “essentiality” staff replacement system;  Decisions on interstate travel up to a designated cost;  Clear delegated parameters and targets to be set for each key manager. These would be monitored monthly through the Finance and Administration Standing Committee.
18.	That consideration be given to reviewing the current nursing structures within THS as there is a perception amongst some nursing staff that the present structures in some areas are “out of balance”.
19.	That in association with DCIS a review be carried out of all discretionary salary and wages costs to establish the current processes for authorisation. These would include overtime/penal payments and HDA's.
20.	That decisions made as a result of external and internal reviews/consultations be communicated to staff throughout THS to give feedback.
21.	That a priority be placed on developing and promoting practice guidelines and service protocols in key service delivery areas to guide staff and achieve consistency in service provision.
22.	That consideration be given to “contracting in” a tailored middle and senior management development program to best equip selected staff for managing within the Strategy 21 <sup>st</sup> Century strategic framework.
23.	That a performance management system be introduced between the CEO and his direct reports and the staff reporting to them. The system to be evaluated at the end of 12 months with the objective of extending it further.
24.	That the strongly held and widespread concerns on the issues of staff recruitment and retention be addressed as a top priority by the Finance and Administration Standing Committee (subject to endorsement of Recommendation 2). Progress on implementing the recommendations of the October 1997 Recruitment and Retention Taskforce project could be reviewed as the first step.
25.	That a review be carried out of all committees and working groups currently in place within THS to establish the need for them continuing. (A methodology for the review was provided earlier and the review has taken place.) The objective of the review being to significantly reduce the large number of committees currently in place and to refocus those that are to continue and are seen as “adding value” to the organisation and its activities.
26.	That a top priority be placed on finalising the detailed service agreement between Territory Health Services and the Department of Corporate and Information Services. There are significant risks for both parties without a clear service agreement being in place in the critical areas forming this new relationship.
27.	That the Hospital Executive Group be continued and be chaired by the Deputy Secretary, Service Provision.
28.	That the Territory wide role of Medical Director (Hospitals) be formally recognised. The Medical Director (Hospitals) to also be Medical Director for the major teaching hospital, RDH.



## Appendix 4: Recommendations of the Loan Review

- A401. We propose that the DDC should be closed now and integrated with other community services at Palmerston and Casuarina.
- A402. We propose that the CDS should be expanded to treat secondary students and current staffing resources should be realigned to meet this need.
- A403. We propose the rationalisation of CDS school clinics and consolidation into combined child and adult clinics. The CDS has a strongly dependent mode of service delivery that does not encourage parental responsibility for the oral health care of their children. In addition, the current model of a dental clinic in every primary school is unsustainable, in terms of both future capital costs and staffing opportunities. The CDS clinics should be rationalised with some clinics integrated into community health centres, located in areas with good access and growing demand.
- A404. We propose a strong promotion of the benefits of consolidation. The rationalisation of CDS clinics and the integration of adult and children's services in urban areas will require strong promotion of the benefits to the community if it is to be successful (otherwise, there is high risk of a large drop out in primary school children).
- A405. We propose that the goals of the workforce planning model become objectives for the Service.
- A406. We propose that additional funds are not required through client co payments or other forms of revenue raising.
- A407. We propose the development of a sustainable and consistent approach to rural and remote service provision, based on proven success factors. These factors appear to include:
- Integrating dental services into community health centres and community organisations;
  - Building community capacity through social action;
  - Using AHWs as community advocates;
  - Building a long term relationship with the community; and
  - Demonstrating a commitment to improving the health and well-being of the community.
- A408. We propose that the Oral Health Program should change its approach to oral health promotion from an emphasis on education of the individual by the dental professional to complementary approaches such as strengthening community action, and involving multi-sectoral collaboration. Other complementary approaches include building public

health policy, creating supportive environments, reorienting health services and developing personal skills.

- A409. We propose the development of a Facilities Strategic Plan for both the Top End and Central Australia. The Plan should focus on the staged closure of fixed primary school clinics and the development of combined child and adult clinics, matched to areas of demand and integrated into community health centres or RDH. We consider that the expansion of the Palmerston clinic could proceed straight away. The Plan should incorporate contemporary and future infection control and occupational health and safety (OH&S) requirements.
- A410. We propose that pre-school children be assessed for dental disease by child health nurses.
- A411. We propose that the resourcing of prosthetic (denture) services is determined as a matter of priority. This will enable a balanced waiting list for denture and conservative care to be determined as well as the amount of laboratory technician support required.
- A412. We propose the development of a more comprehensive data collection and reporting system that provides a clearer focus on oral health, and effectiveness and efficiency “outcomes” rather than service “inputs”.
- A413. We propose the development of funder/purchaser/provider framework; which supports the integration of Oral Health Services with other community health services and encourages them to act in partnership in the promotion of oral health. We consider the proposed district-based management structure has the potential to achieve these goals.
- A414. We propose the expansion of the therapist role to enable better matching of the dental workforce to the needs of the community.
- A415. We propose that the objectives of the Personalised Dental Therapy (PDT) program are reaffirmed as part of the strategy. to promote the new model for oral health care, which is built on self responsibility and management of risk..
- A416. We propose the promotion of an AHW with a specialisation in dentistry to be part of the rural dental workforce.
- A417. We propose the development of dental education and professional training programs using Darwin as a campus to ensure a supply of dentists and therapists, including the expanded role therapist/dental auxiliary.
- A418. We propose a balanced performance measurement system is introduced, which complements the traditional financial indicators with measures of performance for customers (both clients and purchasers), internal processes, and innovation and improvement activities.

## **Appendix 5: Terms of Reference**

- A501. How to improve the quality of the delivery of health and community services in the NT through effective policy development and planning, integration of services, and efficient management of costs and resources.
- A502. The financial and resource capacity of the Department to deliver on the Government's priorities.
- A503. Future demand pressures in the NT.
- A504. Financial management and accountability.
- A505. Service delivery sustainability.