Dear Minister

In accordance with the provisions of Section 28 of the Public Sector Employment and Management Act, it gives me pleasure to submit the Annual Report to you on the activities and operations of Territory Health Services, for the year ending 30 June 1997.

I advise that, in respect of my duties as an Accountable Officer, and to the best of my knowledge and belief:

- proper records of all transactions affecting the Agency were kept and that employees under my control observed the provisions of the Financial Management Act, the Financial Management Regulations and Treasurer's Directions;

- procedures within Territory Health Services afforded proper internal control, and a current description of these procedures can be found in the Accounting and Property Manual which has been prepared in accordance with the Financial Management Act;

- no indication of malpractice, fraud, major breach of legislation or delegation, major error in or omission from the accounts and records existed;

- in accordance with the requirements of Section 15 of the Financial Management Act the internal audit capacity available to the Agency was adequate and the results of internal audits were reported to the Secretary;

- the financial statements included in the Report have been prepared from proper accounts and records and are in accordance with Part 2, Section 5 and Part 2, Section 6 of the Treasurer's Directions where appropriate; and

- all Employment Instructions issued by the Commissioner for Public Employment have been complied with.

Yours sincerely

PETER PLUMMER
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SECRETARY’S FOREWORD

The health sector is presented with many challenges. Some of these challenges, such as population ageing, the high cost of new medical technology, the emergence of new infectious diseases and increasing community demand, are experienced to a similar degree by all States and Territories. In addition to these, the Northern Territory must confront many challenges which do not exist in other jurisdictions, or which are present to a much lesser degree. Some of these are: high population growth; Aboriginal ill health; critical workforce shortages; high staff turnover; and major increases in hospital treatment and renal dialysis.

The NT is further challenged by the need to fund services in rural and remote communities that the Commonwealth Government directly funds in other States and Territories. This anomaly is caused by the low number of private medical practitioners servicing the Territory’s rural and remote areas. Territory Health Services provides these communities with medical services that would otherwise be provided by private medical practitioners directly billing the Commonwealth. This results in a substantial shortfall of funds (approximately $45M per year) and presents the NT with a major financial barrier to the provision of health services at a level equal to that of other States and Territories. Resolving this problem, and the overall problem of Aboriginal ill health, has proved to be a very big challenge. A number of strategies are being implemented which hold considerable potential for success over the medium to long term. The most notable of these strategies is the Coordinated Care Trials in the Katherine Region and the Tiwi Islands. These Trials are important because they involve Aboriginal people in determining their own health priorities and in gaining better access to national medical and pharmaceutical benefits.

Although community expectations continue to increase, public health sector providers are no longer able to meet all the present and emerging demands for service. Previously, the main basis for funding new or expanded services was a clear determination of community need. This rationale is clearly insufficient when service demand substantially exceeds the availability of resources. Where demand for limited resources is so intense, the relative value of all services has to be understood before priorities can be determined and appropriate decisions made. Currently, one of the most difficult challenges experienced by the health sector worldwide is the lack of adequate information and effective analytical methods to support the process of determining priorities and making appropriate resource allocation decisions.

This information barrier presents decision makers with a significant dilemma. Without adequate information, decisions cannot be made to prioritise funding for those services which are the most effective and offer the best value for the community. The 1980s strategy of regularly increasing the proportion of the public dollar dedicated to health cannot work in the 1990s. Such a strategy would see Territory Health Services budget double in less than ten years and consume additional funds equivalent to that of the Territory’s total expenditure for education. Thus Territory Health Services present commitment to improving information technology and developing effective analytical capabilities, whilst costly, is a crucial strategy to overcome this serious information deficit.
Over the past decade the role of public health sector providers has changed markedly. The rate of this change continues to accelerate and rigorously challenge the individuals and organisations dedicated to improving community health and well being. In some program areas, for example, the majority of new or expanded services are provided by non government providers. The Department’s role is changing from provider of services to funder of services. With increasing frequency, voluntary organisations and private providers are being asked to meet the demand for new or expanded services. In 1989/90, Territory Health Services funded 260 external services or projects with a total cost of $28.3M. By the 1996/97 reporting period, the number of external services funded by THS increased to 561, with a total cost of $48.9M. The continuation of these trends will require a major shift in emphasis for THS and its staff. Many of the strategies identified throughout this report are designed to better position Territory Health Services and non government service providers to meet the challenges of the next decade.

Funding for non government service providers has historically been rooted in a political process. These providers have enjoyed an approval process distinct from other forms of government contracting or tendering. However, major changes will be necessary as a result of the increasing requirements for demonstrated outcomes, quality, efficiency, accountability, and, in some jurisdictions, competition. It should be recognised that many of these changes are being driven by the recognition that community resources are shrinking relative to increasing community expectations and the existing level of unmet demand.

Territory Health Services, with the support of government, will encourage the continual shift of resources to community managed organisations for the delivery of services and improved outcomes. This will be accompanied by a planned reduction in Territory Health Services service delivery. Success in achieving better outcomes for the community through this shift in service delivery and resources cannot be accomplished without agreed mechanisms for assessing efficiency, quality, client outcomes and determining overall value for the community dollar.

Achieving better outcomes with limited resources will be one of the major challenges facing all of us over the next few years. I am aware that some organisations and individuals are already looking for solutions as to how the system evolves to a new level of service delivery. Partnerships, not competition, is the way forward, however, timing will be important.

To achieve our mission of improved health status and well being for all Territorians, Territory Health Services has adopted a strategy which is best summarised in the formula 5+5+5.

The first 5 refers to the 5 strategic directions against which progress will be identified throughout this annual report.

The second 5 refers to the 5 major issues confronting the improvement of health and well being for Territorians: adequate primary health services; appropriate preventative strategies in Aboriginal health; appropriate and sustainable mix of public hospital and community health services; community services appropriate to changing needs; and appropriate workforce strategies.
The final 5 represents the 5 priority areas where we intend to focus our efforts in order to tackle the 5 major issues. The 5 priority areas are: strategies to optimise the Territory’s share of national funding; preventive health strategy projects; enhanced community based services and community care; chronic diseases and renal disease strategies; and smarter recruitment and retention practices.

Some of our key achievements against these strategic directions are: Coordinated Care Trials; Health Infrastructure Priority Projects and National Aboriginal Health Strategy Environmental Health Program; Alice Springs Hospital redevelopment; Royal Darwin Hospital substantial upgrade in services; NT Clinical School for teaching undergraduate medical students; funding for the Community Care information system; the strategic five year plan for Children’s Services ($3.5M over next two years); and the Disability Services five year plan ($2.5M).

As I come to the end of my first year, I would like to record my appreciation to the many dedicated staff working in Territory Health Services. I have been impressed with the high level of professionalism and commitment to clients which they bring to their work, their enthusiasm for improving community health and well being, and their willingness to work cooperatively across the organisation. My brief experience with the health sector has quickly increased my awareness of the many difficult, seemingly intractable challenges facing the community as it attempts to improve overall health status and well being. Many significant changes continue to be required across the sector and with these changes will come some difficult adjustments in the way we all work. Our ability to face these challenges has been strongly reinforced by the level of support and optimism demonstrated to me by staff.

PETER PLUMMER
CORPORATE OVERVIEW

“Health is a social investment, the invisible partner to economic capacity building, productivity, family unity, social harmony, public cohesion.... As a key investment in the Territory and its future, we must put the emphasis on health creation and not just illness treatment” Ministerial Statement. Denis Burke MLA, Minister for Health Services, 24 April 1997.

Our Mission
To improve the health status and well being of all people in the Northern Territory.

This Mission is an important part of the NT Government’s overall objectives to:

• attain a critical mass in population growth by providing first rate health and community services;
• support Territory families;
• ensure the development of young Territorians;
• work in partnership with Aboriginal communities;
• care for the elderly and disadvantaged;
• protect the Territory lifestyle; and
• promote economic growth.

Strategic Directions
Territory Health Services Corporate Plan 1996/99 spells out our five strategic health priorities:

1. Strengthen public health services to deliver effective prevention and health promotion strategies with particular emphasis on populations with high levels of sickness and early death.
2. Work towards the provision of adequate early intervention and primary level health services in which local communities are able to exercise appropriate control and direction.
3. Further develop an appropriate range of acute care and specialist services of an equivalent quality to that available to other Australians.
4. Strengthen the focus and integration of community services to support individual and family well being.
5. Gear Territory Health Services to better support and equip staff to deliver results.

The 1996/97 Annual Report is the first year of the three year strategy and is structured to report against these priorities. Activity and Program Reports identify their strategies and achievements in meeting these priorities.

The strategic directions are not time limited to three years but become pathways to tackle the future. This future will include:

• being more explicit about the legitimate limits of government reach;
• finding ways to fund the demand for treatment which will outpace economic growth;
• involving the public more creatively in their health care by applying information technology and sharing that information;
• a continued resourcing of community managed organisations;
• promoting inter and intra government planning and effort realising that health can not in itself meet peoples needs; and.
• placing a premium on better stewardship of the health dollar which may see government not as a main service provider but a knowledge provider through standard setting and targeted funding.
ORGANISATIONAL STRUCTURE, SERVICE OUTLETS AND STAFFING

Territory Health Services Corporate Plan 1996/99 was in its initial year of operation for this Annual Report. The corporate structure of Territory Health Services was organised to achieve the strategic directions set out in the Corporate Plan by:

- preserving the organisational structures needed for the continuing tasks in health services such as acute care;
- aligning funding allocations to programs to achieve transparency and accountability; and
- using a project management approach across programs to ensure flexibility.

The organisational structure operating during the year is presented in the accompanying chart. The Chief Executive Officer, the two Deputy Secretaries, Divisional Heads General Managers of Royal Darwin and Alice Springs Hospitals and Assistant Secretary, Aboriginal Health Strategy comprise the Corporate Executive.

Programs and services are grouped into five Activities for which expenditure is separately reported in the Financial Statements.

Services to the public are provided or funded through two Regions: Operations North, including East Arnhem and Katherine, as well as Darwin Rural and Urban; and Operations Central, including Alice Springs Rural and Urban as well as Barkly.

Planning and coordinating of Territory wide programs are undertaken within Corporate Services, Program Development and Planning, Public Health Strategy, and Aboriginal Health Strategy. The focus was on cross program coordination and project management. Aboriginal, women’s, and children’s health service planning and delivery during the year typified this approach.

Territory Health Services structure gives single point accountability for the implementation of each strategic priority.

SERVICE OUTLETS

An aim of the NT Government is to provide health and community services of an equivalent or better quality to those available throughout Australia. To achieve this end, health services are delivered throughout the Territory by public and community service workers in over 75 service outlets. In addition, there is a network of hospitals located in the five major population centres within the Northern Territory.

As well as delivering direct services, Territory Health Services funds non government organisations through service agreements to provide community and health services.
OPERATIONS NORTH
Darwin rural & remote area:
Darwin ➤ THS Staffed Hospital
Phone: 89562727, Fax: 89562427

Alice Springs remote area:
Alice Springs ➤ THS Staffed Hospital
Phone: 89561711, Fax: 89561727
Piranginp (Garden Point) ➤ THS Staffed Hospital
Phone: 89569942, Fax: 89569971

Katherine area
Katherine ➤ THS Staffed Hospital
Phone: 89563857, Fax: 89563820

East Arnhem area
Nulunbuy ➤ THS Staffed Hospital
Phone: 89567433/845, Fax: 89567473
Nurruiyi (Ti Tree Station) ➤ THS Staffed Hospital
Phone: 89569820, Fax: 89569820

Bulla Camp ➤ THS Funded
Phone: 091-687303, Fax: 89567431

Operations Central Australia - Barkly
Tennant Creek ➤ THS Staffed Hospital
Phone: 89624399, Fax: 89624311
Al-Curling (Murray Downs) ➤ THS Staffed Hospital
Phone: 89641954, Fax: 89641971
Brunette Downs Station ➤ THS Staffed Hospital
Phone: 89644522
Barkly Mobile
Phone: 89624254/218, Fax: 89624207

Canteen Creek ➤ THS Staffed Hospital
Phone: 89641510
Elliot ➤ THS Staffed Hospital
Phone: 89692060, Fax: 89692070
Epenarr ➤ THS Staffed Hospital
Phone: 89641964
McLaren Creek ➤ THS Staffed Hospital
Phone: 89622385, Fax: 89641961
Murumurula ➤ THS Staffed Hospital
Phone: 89622385
Nadjaburra ➤ THS Staffed Hospital
Phone: 89622385
MAP
STAFFING

Territory Health Services recognises that it is the staff, in partnership with all stakeholders, who will determine better health outcomes. Human Resource Services in its report (page 88) details the activities undertaken this year in support of employees. The accompanying tables provide information about the gender and classification of staff 1994/95 to 1996/97.

Figure 1: Staffing Trends for Males

Figure 2: Staffing Trends for Females

There was minimal variation in the classification of staff employed over the three year period despite increases in the volume of services provided. This was due in part to efficiencies from new technologies, an increase in services purchased from external organisations and improved information resulting in more accurate costings and better planning and decision making. A decrease in nursing numbers resulted from the efficient use of external agencies for the provision of casual staff. Increases in administrative staff were primarily due to additional staff in: information technology, local and remote training, and administrative support.

Figure 3: Classification as Percent of Total Staff

Full time equivalents staff numbers (FTE) are provided in Financial Table 1 by Activity/Program (page 101).
PERFORMANCE MANAGEMENT
During 1996/97, initiatives were introduced to enhance existing performance management systems including:

- a three year Corporate Plan,
- an integrated approach to business planning,
- enhanced information management for program and financial reporting,
- a systematic approach to program evaluation, and
- a comprehensive planning cycle integrating business planning, budget development and program performance reporting.

Performance measurement for most programs concentrated on appropriateness because measurement of effectiveness and efficiency of programs is much more difficult requiring sophisticated information systems. Resources have been committed to improve information systems as a strategy to better measure effectiveness and efficiency of programs.

Nine program reviews and a number of internal and external audits were completed.

Three Year Corporate Plan
A new three year Corporate Plan covering 1996 to 1999 was completed setting strategic directions for THS. A wide cross section of staff and external stakeholders were consulted in the development of the Corporate Plan, which was launched by the Minister, Denis Burke MLA, in October 1996. Five strategic directions, five major issues and five priority areas were established in 1996/97 and referred to as the 5 plus 5 plus 5 plan.

Business Plans
Divisional, branch and individual work unit business plans for 1996/97 and 1997/98 were completed. A Business Planning Guideline was developed to facilitate consistent implementation of plans across the organisation and to translate the corporate strategic directions and vision for the future into action to be undertaken at work unit and individual levels. Divisional business plans for 1997/98 were completed prior to the end of 1996/97 and were presented to the Minister at a planning workshop.

Information Management for Program and Financial Reporting
Monthly and quarterly program information reporting processes were significantly enhanced with a new format incorporating additional management information on program activity. As the information systems upgrade continues to be implemented, program reporting capability will assist in better planning.

Program Evaluation
A number of programs were evaluated during 1996/97 in accordance with the requirements of the Financial Management Act of 1995. Agency Programs must be evaluated at least once every three years; 1996/97 was the conclusion of the first three year program evaluation requirement for all NT agencies.

Program evaluations completed by Territory Health Services during 1996/97 were:
- Corporate Services,
- Hospitals (efficiency evaluation),
- Mental Health,
- Disease Control,
- Family and Community Services,
- Alcohol and Other Drugs, including Living With Alcohol,
- Aged and Disability Services,
- Community Health, and
- Women’s Health.

Some key review findings are reported under the relevant program sections in this Annual Report. The Executive will consider the findings emanating from these evaluations early in 1997/98 and approve necessary action recommendations.

The Environmental Health Program evaluation was not concluded by 1996/97 but will be completed within 1997/98.

**Report on Government Service Provision**

A report on government service provision is part of the Review of Government Services Report which is published under the auspices of the Council of Australian Governments (COAG). This is an annual publication in which information is presented on the effectiveness and efficiency of government funded services. Territory Health Services provided data for this Review in conjunction with all other jurisdictions. The Report provides some comparative information across jurisdictions and is intended to assist governments in looking at better ways to provide services.

**Internal Audit**

Wide ranging activities were undertaken by internal audit to improve performance by providing assurance that systems and internal controls operating within the Agency were adequate and effective.

Extensive risk management analysis, and management training in risk management methodology, were undertaken in Operations Central.

Audits were undertaken in the following areas:

<table>
<thead>
<tr>
<th>Audit</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Travel</td>
<td>Review of the travel contract</td>
</tr>
<tr>
<td></td>
<td>Generally found procedures and controls to be adequate and the travel contract to have been financially advantageous.</td>
</tr>
<tr>
<td>Foster parents</td>
<td>Review of the Darwin cottage homes</td>
</tr>
<tr>
<td></td>
<td>Recommended that a clear statement of services be provided along with standards of care and provisions for monitoring the services.</td>
</tr>
<tr>
<td>Foster payments system</td>
<td>Recommendation of closer monitoring of the system to ensure staff compliance and additional staff training.</td>
</tr>
</tbody>
</table>
Audits were also taken in relation to:
- inventory control systems,
- risk management, and
- the accountability of grants to non government service providers.

These issues are still under active consideration.

**External Audit**

End of year Agency Compliance Audits for 1996/97 included:
- Living With Alcohol;
- Drug Control in Alice Springs Hospital and Remote Locations; and
- Overtime Control Alice Springs Hospital.

Performance Management Audits included:
- Royal Darwin Hospital;
- Primary Health Care, Rural; and
- Contracting Out Policies.

These matters have been concluded successfully. Comments on the above audits have been included in the Auditor General’s Reports.

**Planning**

Territory Health Services continued to enhance and develop an integrated approach to corporate planning, budget planning, business planning, individual performance agreements, program review and performance monitoring.

The diagram represents the overall THS approach to performance management, integrating corporate and business planning into performance targets for action, with a capability for monitoring and evaluation.
ACTIVITY AND PROGRAM REPORTS
ACUTE AND SPECIALIST CARE ACTIVITY

ACUTE AND SPECIALIST CARE SERVICES
There are five public hospitals in the NT, located in Nhulunbuy, Darwin, Katherine, Tennant Creek and Alice Springs. These hospitals are the major providers of acute care in the Territory.

GOAL
The goal of Acute and Specialist Services is to provide prompt access to a range of high quality, effective and culturally appropriate acute and specialist health services.

Where specialist inpatient or outpatient services are not available locally, services are accessed through the Patients Assistance Travel Scheme, Medical Evacuation or Interhospital Transfer programs.

OBJECTIVES
• To provide a more extensive acute and specialist outreach service for rural and remote communities.
• To develop and implement practices which increase the cultural effectiveness of acute and specialist services.
• To strengthen provision of acute and specialist health services by making the most effective use of appropriate proven technological advances.
• To monitor clinical performance on an ongoing basis and redesign practices to maintain optimum standards in the quality of care that patients receive.
• To improve cooperation between the public and private sectors maximising benefits from available resources for the population.
• To develop practices to achieve greater coordination and continuity of care between acute, specialist and primary health services.
• To achieve a reduction in elective surgery waiting times in line with national and NT recommended goals.
• To strengthen the understanding and practice of contemporary funding and revenue practices in all NT public hospitals to maximise health outcomes for dollars invested.

STRATEGIC DIRECTION ACHIEVEMENTS
Strategic Direction Three of the Corporate Plan seeks to Further develop an appropriate range of acute and specialist services of an equivalent quality to that available to other Australians. Achievements in Acute and Specialist Service programs relating to this Direction during 1996/7 were:

• Output based funding was developed through the Hospital Budgeting Model using a Casemix concept for classification of patient care episodes and introduced into the five NT public hospitals in July 1996.
• Separations, a count of admitted patients, increased by 4.9% over the 1996/97 year
• Although there has been an increase in the number of patients admitted to NT hospitals, the average length of stay of those patients decreased in line with national trends.
• Standardised definitions and procedures for reporting and analysis of five quality indicators were achieved across NT public hospitals relating to the:
* rate of post operative wound infection following clean surgery;
* rate of post operative wound infection following contaminated surgery;
* rate of hospital acquired bacteraemia;
* rate of emergency patients readmitted to hospital within twenty eight days of separation;
and
* rate of unplanned patients returning to operating theatre.

- There was a formal agreement with Flinders University of South Australia to become part of the Northern Territory Clinical School for teaching undergraduate medical students.
- Continuity of care was improved with the policy for Written Communications for Inpatient and Outpatient Separations from NT Hospitals produced by the Casemix Clinical and Technical Reference Group.
- Elective surgery waiting times were reduced in line with targets established under the Medicare Agreement.
- Culturally effective practices were implemented by:
  * the introduction of Aboriginal health workers into clinical units of NT public hospitals; and
  * the use of the Aboriginal Cultural Awareness Program in NT hospitals.
- The Interhospital Committee framework was extended and strategic issues across hospitals were identified.

**PROGRAM REPORTS**

Program reports incorporating overviews, together with strategies to achieve goals, objectives and performance information, are set out for the following:
- Royal Darwin Hospital,
- Alice Springs Hospital,
- Katherine Hospital,
- Tennant Creek Hospital,
- Gove Hospital,
- Patients Travel Assistance Scheme, Medical Evacuations and Interhospital Transfers, and
- Output Based Funding.

**NORTHERN TERRITORY HOSPITAL STATISTICS**

During 1996/97 there has been continued strong growth in hospital workload demand, with total patient separations increasing by 10.2% over the last two years. Higher demand is due to a substantial increase in admissions of Aboriginal clients with chronic diseases, new born babies and young children suffering from low birth weight, nutritional deficiencies and acute infections. Other major factors include a growing and ageing Territory population, increases in the range of specialist services provided in NT hospitals rising community expectations about availability, access to hospital services, and a 17% increase in renal dialysis treatments.
The attached Table indicates that Aboriginal people comprise more than half of the patients treated in NT hospitals, making up 55.7% of all separations.

### Table 1: Northern Territory Wide Outputs

<table>
<thead>
<tr>
<th></th>
<th>1994/95</th>
<th>1995/96</th>
<th>1996/97</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>All Separations</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Separations</td>
<td>43861</td>
<td>46025</td>
<td>48316</td>
</tr>
<tr>
<td>Non Aboriginal Separations</td>
<td>20317</td>
<td>20756</td>
<td>21381</td>
</tr>
<tr>
<td>Aboriginal Separations</td>
<td>23544</td>
<td>25269</td>
<td>26935</td>
</tr>
<tr>
<td>Aboriginal as % of All Separations</td>
<td>54%</td>
<td>55%</td>
<td>56%</td>
</tr>
<tr>
<td><strong>Overnight Separations</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Separations</td>
<td>26057</td>
<td>26112</td>
<td>25125</td>
</tr>
<tr>
<td>Non Aboriginal Separations</td>
<td>13127</td>
<td>12667</td>
<td>12459</td>
</tr>
<tr>
<td>Aboriginal Separations</td>
<td>12930</td>
<td>13445</td>
<td>12666</td>
</tr>
<tr>
<td>Aboriginal as % of Overnight Separations</td>
<td>50%</td>
<td>51%</td>
<td>50%</td>
</tr>
<tr>
<td>Overnight Separations as a % of All Separations</td>
<td>59%</td>
<td>57%</td>
<td>52%</td>
</tr>
<tr>
<td><strong>Day Only Separations</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Separations</td>
<td>17804</td>
<td>19913</td>
<td>23191</td>
</tr>
<tr>
<td>Non Aboriginal Separations</td>
<td>7190</td>
<td>8089</td>
<td>8922</td>
</tr>
<tr>
<td>Aboriginal Separations</td>
<td>10614</td>
<td>11824</td>
<td>14269</td>
</tr>
<tr>
<td>Aboriginal as % of Day Only Separations</td>
<td>60%</td>
<td>59%</td>
<td>62%</td>
</tr>
<tr>
<td>Day Only Separations as a % of All Separations</td>
<td>41%</td>
<td>43%</td>
<td>48%</td>
</tr>
<tr>
<td><strong>Day Surgery</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Separations</td>
<td>16631</td>
<td>18456</td>
<td>21596</td>
</tr>
<tr>
<td>Non Aboriginal Separations</td>
<td>6442</td>
<td>7210</td>
<td>8096</td>
</tr>
<tr>
<td>Aboriginal Separations</td>
<td>10189</td>
<td>11246</td>
<td>13500</td>
</tr>
<tr>
<td>Aboriginal as % of Total Separations</td>
<td>61%</td>
<td>61%</td>
<td>63%</td>
</tr>
<tr>
<td>Day Surgery as % of All Separations</td>
<td>38%</td>
<td>40%</td>
<td>45%</td>
</tr>
</tbody>
</table>

Excludes Borders.

1994/95 figures adjusted to include renal dialysis over full year.

### Table 2: Northern Territory Wide Performance

<table>
<thead>
<tr>
<th>Description</th>
<th>Ethnic Group</th>
<th>1994/95</th>
<th>1995/96</th>
<th>1996/97</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Bed Utilisation</strong></td>
<td></td>
<td>85%</td>
<td>89%</td>
<td>86%</td>
</tr>
<tr>
<td><strong>Available Beds</strong></td>
<td>585</td>
<td>569</td>
<td>577</td>
<td></td>
</tr>
<tr>
<td><strong>Average Length of Stay (days)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aboriginal</td>
<td>7.41</td>
<td>7.21</td>
<td>7.14</td>
<td></td>
</tr>
<tr>
<td>Non Aboriginal</td>
<td>5.58</td>
<td>5.48</td>
<td>5.47</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>6.48</td>
<td>6.37</td>
<td>6.31</td>
<td></td>
</tr>
<tr>
<td><strong>Average Length of Stay (days)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aboriginal</td>
<td>5.44</td>
<td>4.3</td>
<td>3.89</td>
<td></td>
</tr>
<tr>
<td>Non Aboriginal</td>
<td>4.09</td>
<td>3.73</td>
<td>3.61</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>4.75</td>
<td>4.05</td>
<td>3.76</td>
<td></td>
</tr>
</tbody>
</table>

Excludes Boarders

1 Average Length of Stay EXCLUDES same day stay patients
2 Average Length of Stay INCLUDES same day stay patients
(2 Also includes Renal Dialysis from January 1995)

With improved technologies and increased specialist staffing the average length of stay has reduced in all hospitals.
Figure 4: Average Length of Stay In NT Hospitals

![Figure 4: Average Length of Stay In NT Hospitals](image)

Figure 5: Utilisation of NT Public Hospital Beds

![Figure 5: Utilisation of NT Public Hospital Beds](image)

Over a four year period there were changes to utilisation of hospital beds which varied between hospitals. Overall there was an increase to meet the health needs of Aboriginal people from rural and remote areas. For some hospitals utilisation decreased as out patient services were substituted for inpatient care.
ROYAL DARWIN HOSPITAL

Overview
Royal Darwin Hospital (RDH) is the principal acute care and tertiary referral hospital in the Northern Territory with 297 authorised beds.

RDH offers general surgery, medicine, obstetrics and gynaecology, nephrology, rehabilitation medicine, ENT (ear, nose and throat) services, ophthalmology, dermatology, plastic and reconstructive surgery, paediatrics, psychiatry and orthopaedics. Other speciality services are delivered on a visiting basis by interstate consultants spanning cardiology (both adult and paediatric), neurology, neurosurgery, oncology, urology, podiatry and rheumatology. Clinics are conducted for pain management, sleep disorders, prosthetics and orthotics and for maxillo facial problems.

To support these services, the hospital offers comprehensive diagnostic radiology facilities including magnetic resonance imaging (MRI), CT scanning as well as broad based pathology services. Hyperbaric oxygen therapy treatment, reproductive medicine and nuclear medicine facilities are also available.

RDH continues to maintain close links with the Menzies School of Health Research and participates in a variety of research projects.

Strategies
• To provide a patient service focus (improve customer satisfaction and service delivery, improve continuity of care, and enhance community base service delivery).
• To have a commitment to learning (develop a safe and interesting work environment, and maximise of the potential of the organisation’s employees).
• To practice innovative management (achieve continuous improvement of all key processes and improve cost performance).
• To create an environment of academic excellence.
• To retain and educate staff.
• To optimise revenue
• To reduce reliance on interstate hospitals by ensuring Territorians have access to more services in RDH.

Performance
• Surgical waiting lists continued to follow a downward trend from 2,700 in 1993/94 to 1,400. There has been a major increase in the number of operations from 5,300 in 1993/94 to 9,225 in 1996/97. There has also been a significant increase in overall medical positions from 94 in 1993/94 to 138 today.
• An immunohistochemistry laboratory was established in February 1997 to aid in patient management.
• The Fine Needle Aspiration (FNA) Clinic was used by clinicians in the hospital as well as general practitioners and specialists in the greater Darwin area for the diagnosis of neoplastic and infectious diseases.
• Cytology reporting at RDH was standardised in line with the Australian Society of Cytology recommendations using a modified *Bethesda System* in line with world best practice.
• RDH was recognised as a national/international leader in clinical areas like infant nutrition, infectious diseases and renal medicine.
• Detailed cost centre budgeting was introduced and further developed.
• New computer systems for emergency services and outpatients booking were introduced to enhance patient service and throughput.
• Patients sent interstate for cancer chemotherapy as well as interstate visiting specialist visits were reduced.
• A clinical diabetes service integrating medical and surgical care for diabetic patients was established.
• The Division of Medicine formed a close working relationship with Territory Palliative Care providing a continuum of care services for patients.
• The Territory Health Services Policy and Procedures for *Waiting Lists for Elective surgery in Northern Territory Hospitals* was implemented.
• The hospital’s Emergency Department gained accreditation status from the Royal College of Emergency Physicians.
• A burns nurse specialist position was created resulting in hospital wide changes to the management of clients with burns.
• New Endoscopic Retrograde Cholecysto Pancreatogram (ERCP) procedures were introduced resulting in a reduction in the number of patients who needed to be transferred interstate.
• A *Graduate Diploma in Neonatal Nursing* was established in February and attracted 12 participants.
• Protocols were developed for improved management of diarrhoeal disease in Aboriginal admissions to isolated paediatrics (ISOP).
• Oncology/critical care rooms were established and equipped by the Variety Club of Australia.
• A spinal injuries education package was developed as well as a self medication program for inpatients.
• Recruitment to new academic positions in the Northern Territory Clinical School commenced.

Table 3: Royal Darwin Hospital Performance

<table>
<thead>
<tr>
<th>Description</th>
<th>Ethnic Group</th>
<th>1994/95</th>
<th>1995/96</th>
<th>1996/97</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bed Utilisation</td>
<td></td>
<td>91%</td>
<td>97%</td>
<td>93%</td>
</tr>
<tr>
<td>Available Beds</td>
<td></td>
<td>289</td>
<td>287</td>
<td>297</td>
</tr>
<tr>
<td>Average Length of Stay (days) 1</td>
<td>Aboriginal</td>
<td>9.35</td>
<td>8.86</td>
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<tr>
<td></td>
<td>Non Aboriginal</td>
<td>6.3</td>
<td>6.23</td>
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</tr>
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<td>Total</td>
<td>7.31</td>
<td>7.19</td>
<td>7.19</td>
</tr>
<tr>
<td>Average Length of Stay (days) 2</td>
<td>Aboriginal</td>
<td>5.88</td>
<td>4.48</td>
<td>4.07</td>
</tr>
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<td></td>
<td>Non Aboriginal</td>
<td>4.49</td>
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<td></td>
<td>Total</td>
<td>4.99</td>
<td>4.23</td>
<td>3.97</td>
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</table>

Excludes Boarders
1 Average Length of Stay EXCLUDES same day stay patients
2 Average Length of Stay INCLUDES same day stay patients
(2 Also includes Renal Dialysis from January 1995)
### Table 4: Royal Darwin Hospital Outputs

<table>
<thead>
<tr>
<th></th>
<th>1994/95</th>
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<th>1996/97</th>
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</thead>
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<td>9261</td>
<td>10253</td>
<td>11230</td>
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<td>Aboriginal as % of Total Separations</td>
<td>41%</td>
<td>43%</td>
<td>44%</td>
</tr>
<tr>
<td><strong>Overnight Separations</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Total Separations</td>
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<tr>
<td>Non Aboriginal Separations</td>
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<td>Aboriginal Separations</td>
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<td>Aboriginal as % of Total Separations</td>
<td>33%</td>
<td>36%</td>
<td>34%</td>
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<tr>
<td>Overnight as a % of All Separations</td>
<td>54%</td>
<td>52%</td>
<td>48%</td>
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<tr>
<td><strong>Day Only Separations</strong></td>
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<td></td>
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<tr>
<td>Total Separations</td>
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<td>Non Aboriginal Separations</td>
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<td>5718</td>
<td>7041</td>
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<tr>
<td>Aboriginal as % of Total Separations</td>
<td>51%</td>
<td>50%</td>
<td>53%</td>
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<tr>
<td>Day only as a % of All Separations</td>
<td>46%</td>
<td>48%</td>
<td>52%</td>
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<tr>
<td><strong>Day Surgery</strong></td>
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<tr>
<td>Total Separations</td>
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<tr>
<td>Non Aboriginal Separations</td>
<td>4555</td>
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<td>Aboriginal Separations</td>
<td>5115</td>
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<td>6915</td>
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<tr>
<td>Aboriginal as % of Total Separations</td>
<td>53%</td>
<td>52%</td>
<td>55%</td>
</tr>
<tr>
<td>Day surgery as a % of All Separations</td>
<td>43%</td>
<td>45%</td>
<td>50%</td>
</tr>
</tbody>
</table>

Excludes Boarders
1994/95 figures adjusted to include renal dialysis over full year

### ALICE SPRINGS HOSPITAL

#### Overview

Alice Springs Hospital provides within its allocated budget inpatient, outpatient, outreach hospital and specialist services appropriate to the diverse and unique needs of the people of Central Australia and to a standard that ensures the outcome for each patient is acceptable.

Alice Springs Hospital (ASH) has 170 beds and provides a general range of secondary and some tertiary inpatient and outpatient services. It also provides an emergency department providing the major trauma response centre for the region. The major specialist services are medicine, surgery including eye, ENT and orthopaedic consultants, paediatrics, obstetrics and gynaecology. The hospital also provides medium level intensive care facilities. An unusual characteristic of the hospital is its infectious paediatric ward treating childhood infectious diseases, mainly gastroenteritis, endemic in Central Australia. ASH also supports psychiatric inpatient facilities managed by Mental Health Services, and the Child Health Unit managed by Remote Health Services, which provides follow up care for underweight children plus antenatal support.

ASH is the major referral hospital for Central Australia. Its catchment area covers two thirds of the Northern Territory and extends into the bordering areas of South Australia and Western Australia. Approximately 45,000 people reside within the area. Many visiting interstate and overseas tourists use the hospital’s services.
Regular visiting specialist medical services and other specialised support on a needs basis are supplied by ASH to Tennant Creek Hospital.

ASH is affiliated with the Universities of Flinders of South Australia, New South Wales and Sydney for medical teaching purposes. The hospital provides formal training for midwives through the NT School of Midwifery and undergraduate elective placements for students of all health disciplines.

A major highlight of the year was the announcement of government’s commitment to undertake a major building program over the next four years to upgrade the hospital’s facilities. All areas will be improved to enable the hospital to meet its expanding role well into the next century. Initial works to relocate the main entry to the hospital and construct a rehabilitation unit commenced in June 1997.

Other highlights included:

- the completion of several major studies: the Master Property Development Control Plan (Woodhead, Firth Lee and Associates); Improving Aboriginal People’s Access to Alice Springs Hospital (Paul Memmot); and the Staff Residential Accommodation Review (Tanganyere Design);
- the formation of an Aboriginal health action group to advise the Executive and the Board on matters relevant to Aboriginal people and the hospital;
- introduction of additional inhouse educational programs to better equip registered nurses to work in specialised units of the hospital such as special care nursery, critical care and orthopaedics;
- a significant upgrade of laundry equipment (washer and roller ironer) to improve capacity and productivity; and
- presentation of information about ASH and the Central Australian catchment population to the Commonwealth Grants Commission for consideration in the next Commonwealth/States five year funding agreement.

**Strategies**

- To introduce output based funding.
- To improve quality of care.
- To establish the Northern Territory Clinical School.
- To improve coordination and continuity of care.
- To reduce elective surgery waiting times.
- To implement culturally effective practices.

**Performance**

- 1996/97 was the first year for the use of the THS output based funding for ASH.
- ASH staff contributed to THS processes for standardising definitions and procedures to enable reporting and analysis against national quality indicators for items such as hospital readmissions and hospital acquired infections.
- The policy and processes for managing consumer complaints were revised and standardised during the year to ensure a timely response to all complainants and to better evaluate services.
- ASH entered into a formal agreement with Flinders University of South Australia to become part of the Northern Territory Clinical School for teaching undergraduate medical students.
• ASH had minimal waiting lists for elective surgery as defined by the Commonwealth therefore was eligible to receive $120,000 bonus as per the Performance Agreement. This was expended on items of capital equipment.

• An eye laser commissioned June 1997 enabled specialist treatment of preventable blindness caused by diabetic retinopathy.

• Teleradiology equipment, commissioned June 1997 provided direct digital transmission of CT scans and ultrasounds to specialist radiologists based in Adelaide. This enabled interstate specialists to advise on the diagnosis and management of patients who might otherwise have needed to be transferred interstate.

• A project funded by a Commonwealth grant to introduce Aboriginal health workers into clinical units was successfully completed as was a THS funded project to extend the use of Aboriginal liaison officers and interpreters throughout the hospital.

Table 5: Alice Springs Hospital Performance

<table>
<thead>
<tr>
<th>Description</th>
<th>Ethnic Group</th>
<th>1994/95</th>
<th>1995/96</th>
<th>1996/97</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bed Utilisation</td>
<td></td>
<td>80%</td>
<td>88%</td>
<td>89%</td>
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<tr>
<td>Available Beds</td>
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<td>186</td>
<td>171</td>
<td>170</td>
</tr>
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<tr>
<td>Aboriginal</td>
<td></td>
<td>7.67</td>
<td>7.54</td>
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<td>Non Aboriginal</td>
<td></td>
<td>5.04</td>
<td>4.69</td>
<td>4.97</td>
</tr>
<tr>
<td>Total</td>
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<td>6.69</td>
<td>6.48</td>
<td>6.44</td>
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<tr>
<td>Average Length of Stay (days) 2</td>
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</tr>
<tr>
<td>Aboriginal</td>
<td></td>
<td>5.32</td>
<td>3.95</td>
<td>3.55</td>
</tr>
<tr>
<td>Non Aboriginal</td>
<td></td>
<td>3.58</td>
<td>3.28</td>
<td>3.21</td>
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<tr>
<td>Total</td>
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<td>4.67</td>
<td>3.75</td>
<td>3.45</td>
</tr>
</tbody>
</table>

Excludes Boarders

1 Average Length of Stay EXCLUDES same day stay patients
2 Average Length of Stay INCLUDES same day stay patients
(2 Also includes Renal Dialysis from January 1995)

Table 6: Alice Springs Hospital Outputs

<table>
<thead>
<tr>
<th>Description</th>
<th>1994/95</th>
<th>1995/96</th>
<th>1996/97</th>
</tr>
</thead>
<tbody>
<tr>
<td>Separations</td>
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<tr>
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<tr>
<td>Non Aboriginal Separations</td>
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<td>Aboriginal Separations</td>
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<td>Aboriginal as % of Total Separations</td>
<td>69%</td>
<td>70%</td>
<td>71%</td>
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<tr>
<td>Overnight Separations</td>
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<td>Aboriginal as % of Total Separations</td>
<td>63%</td>
<td>63%</td>
<td>64%</td>
</tr>
<tr>
<td>Overnight as a % of All Separations</td>
<td>53%</td>
<td>50%</td>
<td>45%</td>
</tr>
<tr>
<td>Day Only Separations</td>
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<td></td>
</tr>
<tr>
<td>Total Separations</td>
<td>6731</td>
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<td>Non Aboriginal Separations</td>
<td>1641</td>
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<td>Aboriginal Separations</td>
<td>5090</td>
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<td>6676</td>
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<td>Aboriginal as % of Total Separations</td>
<td>76%</td>
<td>77%</td>
<td>76%</td>
</tr>
<tr>
<td>Day only as a % of All Separations</td>
<td>47%</td>
<td>50%</td>
<td>55%</td>
</tr>
<tr>
<td>Day Surgery</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Total Separations</td>
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<td>Aboriginal Separations</td>
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<tr>
<td>Aboriginal as % of Total Separations</td>
<td>76%</td>
<td>78%</td>
<td>77%</td>
</tr>
<tr>
<td>Day surgery as a % of All Separations</td>
<td>46%</td>
<td>48%</td>
<td>52%</td>
</tr>
</tbody>
</table>
Excludes Boarders
1994/95 figures adjusted to include renal dialysis over full year
KATHERINE HOSPITAL

Overview
Katherine Hospital has 60 acute beds and serves an area of 340,000 square kilometres between the Western Australian and Queensland borders from Dunmarra in the south to Pine Creek in the north. While the catchment population from this area is approximately 19,000, the hospital services an annual tourist presence in excess of 500,000 visitor nights.

The hospital provides medical, diagnostic and treatment services to cater for the needs of the population which has a significant rural component. Specialist services, which include more complex general surgery, paediatrics, medicine, gynaecology, ophthalmology, ear nose and throat, orthopaedics, cardiology and paediatric cardiology, are available on a visiting basis. For some specialist treatments, patients are routinely referred to the Royal Darwin Hospital, or less frequently, interstate. A palliative care room within a hospital ward officially opened 24 April 1997.

Strategies
• To provide an integrated approach to quality care which is client focused and culturally appropriate.
• To establish an Aboriginal health policy working party within the hospital to provide ongoing advice to management.
• To develop consultative forums with community organisations.
• To provide useful budgetary information and feedback to cost centre managers.
• To successfully recruit and retain staff.

Performance
• Average length of stay (ALOS) was reduced from 5.61 to 4.92 for Aboriginal patients and from 3.17 to 2.98 for non Aboriginal people with the overall ALOS reduced from 4.56 to 4.04 days.
• The waiting list was significantly reduced.
• There were upgrades to staff accommodation blocks and buildings.
• An infection control officer was appointed to monitor and implement appropriate standards throughout the hospital.

Table 7: Katherine District Hospital Performance

<table>
<thead>
<tr>
<th>Description</th>
<th>Ethnic Group</th>
<th>1994/95</th>
<th>1995/96</th>
<th>1996/97</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bed Utilisation</td>
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<td>79%</td>
<td>75%</td>
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</tr>
<tr>
<td>Available Beds</td>
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<td>60</td>
<td>60</td>
<td>60</td>
</tr>
<tr>
<td>Average Length of Stay (days) 1</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Aboriginal</td>
<td></td>
<td>6.32</td>
<td>6.12</td>
<td>5.42</td>
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<td>Non Aboriginal</td>
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<td>3.74</td>
<td>3.81</td>
<td>3.6</td>
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<td>5.2</td>
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<td>Average Length of Stay (days) 2</td>
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<tr>
<td>Aboriginal</td>
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<td>5.61</td>
<td>4.92</td>
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<tr>
<td>Non Aboriginal</td>
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<td>3.29</td>
<td>3.17</td>
<td>2.98</td>
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<tr>
<td>Total</td>
<td></td>
<td>4.76</td>
<td>4.56</td>
<td>4.04</td>
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</tbody>
</table>

Excludes Boarders
1 Average Length of Stay EXCLUDES same day stay patients
2 Average Length of Stay INCLUDES same day stay patients
Table 8: Katherine District Hospital Outputs

<table>
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<th>1994/95</th>
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<td>3496</td>
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<tr>
<td>Non Aboriginal Separations</td>
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<td>1577</td>
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<td>Aboriginal Separations</td>
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<td>1919</td>
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<tr>
<td>Aboriginal as % of Total Separations</td>
<td>53%</td>
<td>57%</td>
<td>55%</td>
</tr>
<tr>
<td><strong>Overnight Separations</strong></td>
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<td></td>
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</tr>
<tr>
<td>Total Separations</td>
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<tr>
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<td>Aboriginal as % of Total Separations</td>
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<td>59%</td>
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<td>Overnight as a % of All Separations</td>
<td>90%</td>
<td>85%</td>
<td>83%</td>
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<tr>
<td><strong>Day Only Separations</strong></td>
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<td></td>
</tr>
<tr>
<td>Total Separations</td>
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<td>Aboriginal Separations</td>
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<td>219</td>
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<tr>
<td>Aboriginal as % of Total Separations</td>
<td>26%</td>
<td>36%</td>
<td>37%</td>
</tr>
<tr>
<td>Day only as a % of All Separations</td>
<td>10%</td>
<td>15%</td>
<td>17%</td>
</tr>
<tr>
<td><strong>Day Surgery</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Separations</td>
<td>197</td>
<td>275</td>
<td>355</td>
</tr>
<tr>
<td>Non Aboriginal Separations</td>
<td>170</td>
<td>198</td>
<td>238</td>
</tr>
<tr>
<td>Aboriginal Separations</td>
<td>27</td>
<td>77</td>
<td>117</td>
</tr>
<tr>
<td>Aboriginal as % of Total Separations</td>
<td>14%</td>
<td>28%</td>
<td>33%</td>
</tr>
<tr>
<td>Day surgery as a % of All Separations</td>
<td>5%</td>
<td>8%</td>
<td>10%</td>
</tr>
</tbody>
</table>

Excludes Boarders

BARKLY HEALTH SERVICES

Overview

Tennant Creek Hospital, with 20 authorised beds, is part of the integrated service offered by Barkly Health Services.

The hospital offers inpatient, domiciliary, outpatient and emergency services. Visiting specialist services are provided by Alice Springs Hospital and include general surgery, ophthalmology, obstetrics/gynaecology, paediatrics, orthopaedics, physician, rehabilitation and ear, nose and throat.

Serving a dual role as hospital and district medical officers, doctors provide hospital care and conduct routine medical visits to outlying Aboriginal communities and cattle stations.

Two Aboriginal health workers together with an Aboriginal liaison officer are employed to work within the hospital to assist in addressing the special needs of Aboriginal people in a culturally appropriate manner.

Aero medical evacuations are undertaken by medical officers and nursing staff. Patients requiring services that are unavailable in Tennant Creek are transported by interhospital transfers and Patient Assisted Travel Scheme (PATS) to Alice Springs Hospital.

Strategies
• To provide a range of culturally appropriate health and community services to all people within Tennant Creek and the Barkly Region,
• To address the special needs of Aboriginal people in rural and remote areas.

**Performance**

• An integrated model of care was introduced whereby doctors and nurses are able to undertake both rural and hospital responsibilities. This improved continuity of care and was an incentive for recruitment and retention of professional staff.
• Cross cultural educational workshops combined with hospital based Aboriginal health workers and an Aboriginal liaison officer to provide a service that was culturally appropriate.
• Regular visits by an ultrasonographer enhanced the quality of obstetric care available in Tennant Creek.
• Occasions of service through the emergency services increased leading to a change in focus of operational management of the hospital as more resources were required for ambulatory clients.
• The implementation of casemix funding assisted in the continuing process of efficient use of hospital resources.

**Table 9: Tennant Creek District Hospital Performance**

<table>
<thead>
<tr>
<th>Description</th>
<th>Ethnic Group</th>
<th>1994/95</th>
<th>1995/96</th>
<th>1996/97</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bed Utilisation</td>
<td></td>
<td>71%</td>
<td>65%</td>
<td>62%</td>
</tr>
<tr>
<td>Available Beds</td>
<td></td>
<td>20</td>
<td>20</td>
<td>20</td>
</tr>
<tr>
<td>Average Length of Stay (days) 1</td>
<td>Aboriginal</td>
<td>3.38</td>
<td>3.53</td>
<td>3.64</td>
</tr>
<tr>
<td></td>
<td>Non Aboriginal</td>
<td>3.38</td>
<td>3.13</td>
<td>3.38</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>3.38</td>
<td>3.41</td>
<td>3.56</td>
</tr>
<tr>
<td>Average Length of Stay (days) 2</td>
<td>Aboriginal</td>
<td>3.11</td>
<td>3.22</td>
<td>3.15</td>
</tr>
<tr>
<td></td>
<td>Non Aboriginal</td>
<td>2.92</td>
<td>2.6</td>
<td>2.78</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>3.05</td>
<td>3.02</td>
<td>3.04</td>
</tr>
</tbody>
</table>

Excludes Boarders
1 Average Length of Stay EXCLUDES same day stay patients
2 Average Length of Stay INCLUDES same day stay patients

**Table 10: Tennant Creek District Hospital Outputs**

<table>
<thead>
<tr>
<th>Separations</th>
<th>1994/95</th>
<th>1995/96</th>
<th>1996/97</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Separations</td>
<td>1701</td>
<td>1573</td>
<td>1481</td>
</tr>
<tr>
<td>Non Aboriginal Separations</td>
<td>563</td>
<td>486</td>
<td>449</td>
</tr>
<tr>
<td>Aboriginal Separations</td>
<td>1138</td>
<td>1087</td>
<td>1032</td>
</tr>
<tr>
<td>Aboriginal as % of Total Separations</td>
<td>67%</td>
<td>69%</td>
<td>70%</td>
</tr>
<tr>
<td>Overnight Separations</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Separations</td>
<td>1463</td>
<td>1319</td>
<td>1178</td>
</tr>
<tr>
<td>Non Aboriginal Separations</td>
<td>455</td>
<td>365</td>
<td>336</td>
</tr>
<tr>
<td>Aboriginal Separations</td>
<td>1008</td>
<td>954</td>
<td>842</td>
</tr>
<tr>
<td>Aboriginal as % of Total Separations</td>
<td>69%</td>
<td>72%</td>
<td>71%</td>
</tr>
<tr>
<td>Overnight as a % of All Separations</td>
<td>86%</td>
<td>84%</td>
<td>80%</td>
</tr>
<tr>
<td>Day Only Separations</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Separations</td>
<td>238</td>
<td>254</td>
<td>303</td>
</tr>
<tr>
<td>Non Aboriginal Separations</td>
<td>108</td>
<td>121</td>
<td>113</td>
</tr>
<tr>
<td>Aboriginal Separations</td>
<td>130</td>
<td>133</td>
<td>190</td>
</tr>
<tr>
<td>Aboriginal as % of Total Separations</td>
<td>55%</td>
<td>52%</td>
<td>63%</td>
</tr>
<tr>
<td>Day only as a % of All Separations</td>
<td>14%</td>
<td>16%</td>
<td>20%</td>
</tr>
<tr>
<td>Day Surgery</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Separations</td>
<td>38</td>
<td>56</td>
<td>68</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>--------------------------------</td>
<td>-------</td>
<td>-------</td>
<td>-------</td>
</tr>
<tr>
<td>Non Aboriginal Separations</td>
<td>25</td>
<td>37</td>
<td>40</td>
</tr>
<tr>
<td>Aboriginal Separations</td>
<td>13</td>
<td>19</td>
<td>28</td>
</tr>
<tr>
<td>Aboriginal as % of Total Separations</td>
<td>34%</td>
<td>34%</td>
<td>41%</td>
</tr>
<tr>
<td>Day surgery as a % of All Separations</td>
<td>2%</td>
<td>4%</td>
<td>5%</td>
</tr>
</tbody>
</table>

Excludes Boarders
GOVE DISTRICT HOSPITAL

Overview
Gove District Hospital (GDH) is a 30 bed hospital based at Nhulunbuy serving the East Arnhem District. In addition, health services are provided from rural health centres in 10 predominantly Aboriginal communities within the East Arnhem District.

Available services include general medical and surgery, obstetrics and gynaecology, accident and emergency, orthopaedics, psychiatry, substance abuse, respite care and anaesthetic services. Hospital staff liaise closely with other health services based in Nhulunbuy and in East Arnhem towns and communities.

Doctors provide inpatient hospital care, conduct routine medical visits by aircraft to outlying communities and undertake emergency aeromedical evacuations. These medical services are supplemented by visiting specialists in general surgery, gynaecology, orthopaedics, ear nose and throat, dermatology, paediatric and adult cardiology, psychiatry and ophthalmology.

Support services include pathology, physiotherapy, occupational therapy, radiography, ultrasound, communicable diseases control, pharmacy and dietitian.

With the experience of the first year of casemix funding and a new senior management team in place, the hospital has used the latter part of 1996/97 to examine its operations whilst at the same time continuing to function at a high level of activity.

Strategy
- To deliver excellence in health care in East Arnhem focusing on culturally appropriate primary health care.

Performance
- The district continued its strong orientation towards improving the cultural appropriateness of health services with 29 staff members participating in the three day Aboriginal Cultural Awareness Program based in East Arnhem.
- All discharge summaries were completed and coded within 10 days of discharge.
- A Gove District Hospital patient survey was completed using bilingual interviewers for Aboriginal patients surveyed which indicated a generally high level of satisfaction with services at the hospital.
- There was a review of medical services within the district, including a specific examination of medical public health, with a view to identifying opportunities for improving the organisation and quality of medical services.
- The building management system was implemented to improve equipment monitoring within GDH achieving optimal equipment functioning and reduced energy consumption.
- The district achieved the distinction of having the highest immunisation rates in the Territory.
Table 11: Gove District Hospital Performance

<table>
<thead>
<tr>
<th>Description</th>
<th>Ethnic Group</th>
<th>1994/95</th>
<th>1995/96</th>
<th>1996/97</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bed Utilisation</td>
<td></td>
<td>77%</td>
<td>75%</td>
<td>69%</td>
</tr>
<tr>
<td>Available Beds</td>
<td></td>
<td>30</td>
<td>30</td>
<td>30</td>
</tr>
<tr>
<td>Average Length of Stay (days) 1</td>
<td>Aboriginal</td>
<td>5.15</td>
<td>4.78</td>
<td>4.54</td>
</tr>
<tr>
<td></td>
<td>Non Aboriginal</td>
<td>3.47</td>
<td>2.86</td>
<td>2.88</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>4.79</td>
<td>4.37</td>
<td>4.19</td>
</tr>
<tr>
<td>Average Length of Stay (days) 2</td>
<td>Aboriginal</td>
<td>4.9</td>
<td>4.54</td>
<td>4.2</td>
</tr>
<tr>
<td></td>
<td>Non Aboriginal</td>
<td>2.65</td>
<td>2.24</td>
<td>2.16</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>4.28</td>
<td>3.9</td>
<td>3.63</td>
</tr>
</tbody>
</table>

Excludes Boarders
1 Average Length of Stay EXCLUDES same day stay patients
2 Average Length of Stay INCLUDES same day stay patients

Table 12: Gove District Hospital Outputs

<table>
<thead>
<tr>
<th>Separations</th>
<th>1994/95</th>
<th>1995/96</th>
<th>1996/97</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Separations</td>
<td>1973</td>
<td>2120</td>
<td>2076</td>
</tr>
<tr>
<td>Non Aboriginal Separations</td>
<td>549</td>
<td>586</td>
<td>583</td>
</tr>
<tr>
<td>Aboriginal Separations</td>
<td>1424</td>
<td>1534</td>
<td>1493</td>
</tr>
<tr>
<td>Aboriginal as % of Total Separations</td>
<td>72%</td>
<td>72%</td>
<td>72%</td>
</tr>
<tr>
<td>Overnight Separations</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Separations</td>
<td>1706</td>
<td>1825</td>
<td>1712</td>
</tr>
<tr>
<td>Non Aboriginal Separations</td>
<td>367</td>
<td>391</td>
<td>362</td>
</tr>
<tr>
<td>Aboriginal Separations</td>
<td>1339</td>
<td>1434</td>
<td>1350</td>
</tr>
<tr>
<td>Aboriginal as % of Total Separations</td>
<td>78%</td>
<td>79%</td>
<td>79%</td>
</tr>
<tr>
<td>Overnight as a % of All Separations</td>
<td>86%</td>
<td>86%</td>
<td>82%</td>
</tr>
<tr>
<td>Day Only Separations</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Separations</td>
<td>267</td>
<td>295</td>
<td>364</td>
</tr>
<tr>
<td>Non Aboriginal Separations</td>
<td>182</td>
<td>195</td>
<td>221</td>
</tr>
<tr>
<td>Aboriginal Separations</td>
<td>85</td>
<td>100</td>
<td>143</td>
</tr>
<tr>
<td>Aboriginal as % of Total Separations</td>
<td>32%</td>
<td>34%</td>
<td>39%</td>
</tr>
<tr>
<td>Day only as a % of All Separations</td>
<td>14%</td>
<td>14%</td>
<td>18%</td>
</tr>
<tr>
<td>Day Surgery</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Separations</td>
<td>189</td>
<td>199</td>
<td>273</td>
</tr>
<tr>
<td>Non Aboriginal Separations</td>
<td>150</td>
<td>147</td>
<td>187</td>
</tr>
<tr>
<td>Aboriginal Separations</td>
<td>39</td>
<td>52</td>
<td>86</td>
</tr>
<tr>
<td>Aboriginal as % of Total Separations</td>
<td>21%</td>
<td>26%</td>
<td>32%</td>
</tr>
<tr>
<td>Day surgery as a % of All Separations</td>
<td>10%</td>
<td>9%</td>
<td>13%</td>
</tr>
</tbody>
</table>

Excludes Boarders

PATIENTS TRAVELLING

Overview

Three schemes/services benefit patients requiring treatment for which they would need to travel.

* **Patient Assistance Travel Scheme** (PATS) assists with: travel and accommodation costs for patients referred to specialist treatment at a distant location including treatment interstate if unavailable in the NT; and travel by medical and surgical specialists to rural centres to complement existing services.

* **Medical Evacuation Scheme** (Medivac) is a radio/telephone consultation and emergency retrieval service to remote areas of the NT.

* **Interhospital Transfers** are arranged for patients transferring from one hospital to another either interstate or intrastate for treatment.
Cross Border Interstate Charging are payments claimed from other States and Territories for the treatment of interstate patients accessing services from NT hospitals.

**Strategies**
- To promote access to acute and specialist care services for all Territorians

**Figure 6: Patients Travelling**

<table>
<thead>
<tr>
<th>Year</th>
<th>PATS</th>
<th>Medivac</th>
<th>Inter Hospital Transfer</th>
</tr>
</thead>
<tbody>
<tr>
<td>1993/94</td>
<td>8977</td>
<td>5740</td>
<td>939</td>
</tr>
<tr>
<td>1994/95</td>
<td>9442</td>
<td>5233</td>
<td>1105</td>
</tr>
<tr>
<td>1995/96</td>
<td>10334</td>
<td>5939</td>
<td>1097</td>
</tr>
<tr>
<td>1996/97</td>
<td>8973</td>
<td>4968</td>
<td>973</td>
</tr>
</tbody>
</table>

**Performance**
- The increased specialist service to the smaller hospitals and remote clinics contributed to a reduction in PATS, Medivacs and Interhospital Transfers.
- Interstate referrals for NT residents during 1996/97 decreased by 10% due to an increase in a range of specialist services provided locally and new and expanded services further reduced the need for interstate transfers.
- The number of interstate residents accessing NT hospitals has increased by 32% due to: an increase in Aboriginal patients from South Australia, Western Australia and Queensland accessing NT Hospital services; increased use by interstate tourists; and improved identification of interstate residents through new hospital information systems.
- The reduction of residents requiring interstate transfers, combined with an increase of interstate residents accessing NT hospital services, contributed to an overall increase in the workloads of NT hospitals and revenue obtained by the NT.
- Costs for patient travel increased from the previous year despite fewer people using the services. This was due to:
  * increased use of accommodation by renal dialysis patients;
  * civil aviation costs and fare increases; and
  * a three month period when access to commercial aircraft which could carry stretchers were unavailable.

**OUTPUT BASED FUNDING**

**Overview**
A requirement under the Medicare Agreement is for state and territory governments to achieve optimum efficiency in hospital services through reforms such as output based funding.

During 1996/97 THS introduced output based funding in the five NT hospitals. This method of funding recognises and allows for areas where NT costs are higher than interstate but funds
hospital activity according to the services provided. Additionally there are weightings for smaller hospitals to take into account diseconomies of scale.

Each successive model is becoming more refined: the model for 1996/97 had a fixed component for various factors, which at the time, were unable to be identified by activity; the model for 1997/98 has now encompassed some of these fixed payments into the activity payment. It is anticipated that successive models will incorporate a greater percentage through activity payments.

The hospital budgeting model provides a transparency in relation to the various activities of the hospitals generating responsibility and accountability as well as greater freedom to manage. This will more clearly identify how and where the acute care budget is spent.

**Strategies**
- To build and make use of classifications of patient care episodes.
- To provide casemix information about service use and costs for clinicians who are the key decision makers in relation to admissions, ordering diagnostic tests, prescribing the treatment required, and discharge.
- To improve casemix information to enable Territory hospitals to measure their performance against comparable hospitals interstate.
- To ensure that output based funding incorporates any changes in clinical practice and national developments.

**Performance**
- Ongoing staff training and orientation were undertaken.
- The first year of output based funding in hospitals was introduced and evaluated.
- There was development and completion of a refined second generation model.
COMMUNITY SERVICES ACTIVITY

COMMUNITY SERVICES

GOAL
The goal of Community Services is to support individuals and families to enhance well being and to provide assistance in overcoming crisis and in maintaining independence within their homes and communities.

OBJECTIVES
• To assist communities to provide for the protection and care for children and young people and to promote the well being of communities, families and individuals.
• To meet the needs of frail aged, people with disabilities, their families and carers, to enable them to maintain maximum independence and quality of life in their own communities.
• To provide accessible and culturally appropriate care for people with mental disorders and severe mental health problems.
• To provide adequate support services to families to enable them to successfully fulfil a care function, and where they are unable to do so, ensure that quality substitute care is available.
• To ensure that services operate according to established service standards.

STRATEGIC DIRECTION ACHIEVEMENTS

Strategic Direction Two
Work towards the provision of adequate early intervention and primary level health services in which local communities are able to exercise appropriate control and direction.

Major Achievements
• Early intervention interagency forums were organised in Darwin to develop best practice for children with disabilities requiring early intervention.
• A draft Aboriginal mental health policy was written following extensive community consultations.
• The Aboriginal Mental Health Unit was awarded a gold medal for health promotion and a bronze medal for mental health work by the Mental Health Services Conference Incorporated of Australia and New Zealand (THEMHS).

Strategic Direction Four
Strengthen the focus and integration of community services to support individual and family well being.

Major Achievements
• The NT children’s services plan was developed and approved by Cabinet.
• Minimum standards for centre based child care services in the NT were developed for gazetral by the Minister.
• A specialist out of home care unit was established in Darwin to undertake case management responsibilities for children in the care of the Minister.
• A positive parenting program framework was developed for initial implementation in Darwin.
• The Taxi Subsidy Scheme was expanded and made available to Katherine and Tennant Creek residents.
• A new mental health forensic service was established in Alice Springs.
• Standards for working with sexual assault survivors were completed and training models for working with sexual assault survivors and domestic violence cases were developed and delivered to approximately 300 THS staff.
• A discussion paper on youth suicide prevention strategies was developed.
• A five year strategic plan was developed for disability services.
• A three year strategic plan was developed for HACC.
• Rooming in services were initiated in Katherine for people in need of mental health services.
• Innovative child care services were funded in Yuendumu, Daly River and Galiwinku.
• An alternative family care project established a culturally appropriate model of support for young Aboriginal children with disabilities and their families.
• A home care coordination project was piloted with aged and younger disabled people to increase their independence.

Strategic Directions Five
Gear Territory Health Services to better support and equip staff to deliver results.

Major Achievements
• Training models for community based rehabilitation workers were developed.

PROGRAM REPORTS
Community Services Activity consists of the following programs:
• Family, Youth and Children’s Services,
• Aged and Disability Services, and
• Mental Health Services.

Program and sub program reports are set out in the section following.

FAMILY, YOUTH AND CHILDREN’S SERVICES
Overview
Family, Youth and Children’s Services assists communities to provide for the protection and care of children and young people and to promote the well being of communities, families and individuals. To achieve this, program resources are used to assist communities, families and individuals to:

* strengthen their capacity to overcome threats to well being and to improve quality of life;
* minimise the impact of conditions that have threatened their well being; and
* reduce the level of risk to children from physical or emotional harm.

Services provided by the program include:

* child protection,
* substitute (out of home) care,
* local and intercountry adoptions,
* sexual assault and domestic violence services,
* family support services,
* children’s services, and
* crisis accommodation and support services.

Services may be provided by funded community based organisations or directly by THS staff. Early in 1996/97 responsibility for the development of a youth policy was transferred to the new Office of Youth Affairs within the Chief Minister’s Department.

The following strategies and performances cover all of the services within this program.

**Strategies**
- To develop a five year strategic plan for children’s services in the NT.
- To review the Community Care Centre model to recommend on ways for better service coordination and to develop a framework for further development of centres across the NT.
- To implement the recommendations of the Substitute Care Review.
- To implement the reform agenda under the 1994/99 Supported Accommodation Assistance Program (SAAP) agreement.
- To develop and provide training in relation to protocols and minimum standards for sexual assault and domestic violence services delivery by THS.
- To review child protection investigation and intervention practice standards in services provided by THS.
- To devolve intercountry adoption services.
- To develop mechanisms for the devolution of case management responsibility for Aboriginal children in the care of the Minister.
- To develop a THS family support services policy framework.

**Performance**
- A five year strategic plan for children’s services was approved by government and $1.7 million allocated in the budget for implementation of the plan in 1997/98.
- Minimum standards for centre based child care services in the NT were approved for gazettal by the Minister.
- Space requirement regulations for centre based child care were amended to bring them into line with the national minimum standards creating an additional 130 child care places.
- Innovative child care services were funded in Yuendumu, Daly River and Galiwinku for a total of 60 new child care places.
- A review of Community Care Centres was commissioned to identify future service frameworks and models.
- Recommendations of the Substitute Care Review acted upon were:
  * a new foster care payment system introduced in October 1996;
  * a case management practice framework completed for piloting during 1997; and
  * procedures for reporting, investigating and managing complaints of child maltreatment in out of home care finalised.
- In Darwin Urban District a specialist out of home care unit was established to undertake case management responsibilities for children in the care of the Minister.
- A project commenced in Alice Springs Rural District to develop a model for the provision of services for disabled children for whom care could not be provided within their communities.
- A positive parenting program framework was developed for initial implementation in Darwin Community Care Centres.
• Fees for intercountry adoptions were introduced as from 1 January 1997 and a timetable for the devolution of this service to the South Australian based organisation, Australians Aiding Children, was agreed upon.
• THS protocols for streamlining access by people from the Stolen Generation to personal information were approved and implemented.
• A grant of $70 000 per annum for two years was made to Danila Dilba to provide counselling services to people affected by past policies of removing Aboriginal children.
• A consultancy to assist SAAP service providers to improve case management practices was implemented.
• The National Data Collection system was introduced in 1996 in NT SAAP services to provide information that will inform service and program planning.
• $64,200 was provided to assist SAAP services to upgrade computer systems.
• Standards for working with sexual assault survivors were disseminated and training modules for working with sexual assault and domestic violence cases were developed and delivered to approximately 300 THS staff.
• A practice review of child protection investigations and interventions was undertaken with work on the refinement of child protection services to be undertaken in 1997/98.
• Evaluations of the National Women’s Health Program and Alternative Birthing Services were completed.
• Aboriginal community workers worked from Maningrida and the Tiwi Islands providing family and children’s services

**Child Protection**

Child protection services aim to promote the well being of communities, families and individuals by ensuring the protection and care of children and young people. Investigations relating to the maltreatment of children are conducted and support services offered to families where maltreatment issues are identified. Cooperative arrangements with the NT Police ensure that joint investigations of child maltreatment occur where necessary.

**Figure 7: Number of Child Protections Investigations and Outcomes 1996/1997**

There was a reduction in the number of investigations of child abuse conducted, however levels of substantiation increased slightly from 49% in 1995/96 to 52% in 1996/97.

**Figure 8: Outcome of Child Abuse Investigations**

**Figure 9: Most Serious Abuse Substantiated**
Of all the investigations conducted where abuse was found to have occurred, the most serious form of maltreatment identified was physical maltreatment in 57% of cases, neglect in 25% of cases, sexual abuse in 12% of cases and emotional abuse in 6% of cases.

Compared with 1995/96, there was an 11% increase in neglect and a 13% decrease in physical abuse as the most serious abuse substantiated. Rates for sexual and emotional abuse remain comparatively unchanged.

**Substitute Care**

Substitute care services are provided to children and young people who have been placed in the custody and/or guardianship of the Minister by virtue of the *Community Welfare Act*. Approximately 130 registered volunteers provide foster care services to children who require alternative family care. Family group homes also provide care to children in the major centres of Darwin and Alice Springs.

122 children were in the care of the Minister on the 30 June 1997. This represents a 6% decrease in the number of children in care from 1995/96.

**Table 13: Authority Type of Children In Care as at the end of Financial Years, 1995/96 and 1996/97**

<table>
<thead>
<tr>
<th>Authority Type</th>
<th>No. of Children in Care as at 30.6.96</th>
<th>No. of Children in Care as at 30.6.97</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consent to Adopt</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Court Order</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Immigration Act</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Transfer Pending</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Section 57 - Interstate Transfer</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Section 62 - Temporary Custody</td>
<td>17</td>
<td>10</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>130</strong></td>
<td><strong>122</strong></td>
</tr>
</tbody>
</table>

**Table 14: Guardianship Status of Children In Care as at end of Financial Years, 1995/96 and 1996/97**

<table>
<thead>
<tr>
<th>Guardianship Status</th>
<th>No. of Children in Care as at 30.6.96</th>
<th>No. of Children in Care as at 30.6.97</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent(s)</td>
<td>19</td>
<td>20</td>
</tr>
<tr>
<td>Minister</td>
<td>80</td>
<td>72</td>
</tr>
<tr>
<td>Joint Minister/Parent(s)</td>
<td>18</td>
<td>18</td>
</tr>
<tr>
<td>Director</td>
<td>10</td>
<td>8</td>
</tr>
<tr>
<td>Transfer from other State</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td><strong>Total NT</strong></td>
<td><strong>130</strong></td>
<td><strong>122</strong></td>
</tr>
</tbody>
</table>

The majority of these children (82%) were placed in some form of family based care, either with relatives, known adults or foster carers.
Family Care includes the following placement types: parent or relative, adoptive parent, specific foster relative, other adult care.

The number of children being admitted to joint guardianship orders, where the Minister and their parent(s) share guardianship of the children, increased over the last two years. This is indicative of a greater focus on working towards family reunification by ensuring parents participation in the decisions regarding the care of their children.

**Adoption Services**

Adoption services are provided to relinquishing parents, adopted persons and prospective adoptive parents. Services are primarily offered through a specialist service in Darwin, however information and assessment services are provided by local FYCS offices where necessary. The NT Adoption Information Service offers adopted persons and relinquishing parents opportunities to seek identifying information related to their adoption experience.

**Table 15: Intercountry Adoption Orders Made**

<table>
<thead>
<tr>
<th></th>
<th>1995/96</th>
<th>1996/97</th>
</tr>
</thead>
<tbody>
<tr>
<td>Korea</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Colombia</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>India</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>5</strong></td>
<td><strong>4</strong></td>
</tr>
</tbody>
</table>

**Table 16: Applications for Adoption Information**

<table>
<thead>
<tr>
<th>Year</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>1994/95</td>
<td>84</td>
</tr>
<tr>
<td>1995/96</td>
<td>49</td>
</tr>
<tr>
<td>1996/97</td>
<td>47</td>
</tr>
</tbody>
</table>

Figures for this service were higher when the 1994 legislative changes were first introduced. They have remained steady over the past two years.

**Sexual Assault And Domestic Violence**

Sexual Assault and Domestic Violence counselling and support services have been established in most major centres in the NT. These services aim to minimise the harm from sexual assaults and domestic violence and work towards reducing the incidence of these forms of violence in the community.
Family Support
A range of family support services are provided by both THS and the non government sector. These services are designed to strengthen and support families to adequately care for their children and are available in all parts of the NT.

Children’s Services
Children’s services encompasses: child care services for parents in the workforce or training; playgroup and kindergarten child development services; mobile playgroup programs; toy libraries; and program support activities such as Children’s Week and the NT Children’s Services Conference. Territory Health Services is involved in service planning, licensing and standard setting, and the provision of grants and subsidies.

Figure 11: Formal Child Care Places in the NT

Formal long day care places have expanded 25% in the last five years, with an increase of 16% between June 1996 and June 1997.

Figure 12: NT Child Day Care Subsidy Expenditure 1986/87 to 1996/97
Expenditure on the NT Child Day Care Subsidy has increased in proportion to increases in child care places.

**Crisis Support And Accommodation**

Crisis support and accommodation services are provided under the joint Commonwealth/NT Supported Accommodation Assistance Program (SAAP). These services provide transitional supported accommodation and related support to help people who are homeless or in crisis achieve the maximum possible degree of self reliance and independence. Services are provided by non government organisations in all major centres in the NT.

**AGED AND DISABILITY SERVICES**

**Overview**

Aged and Disability Services provides or funds a range of support services for the frail aged and younger people with multiple, moderate and or severe disabilities. While many aged people and those with a disability participate fully in the community only occasionally needing to access specialist services, others receive support services from this program throughout their life.

Aged and disability services include those which are provided directly or are grant funded by THS to non government organisations. Excluding the Pensioner Concession Scheme, total program expenditure is split 25:75 between THS and the non government sector respectively.

The Aged and Disability Services Program includes the following sub programs:

* Pensioner Concession Scheme,
* Adult Assessment and Coordination Teams (AACT),
* Home and Community Care (HACC),
* Taxi Subsidy Scheme,
* Commonwealth State Disability Agreement (CSDA),
* Challenging Behaviour Support Unit,
* Territory Independence and Mobility Equipment (TIME) Scheme,
* Seating and Equipment Assessment Team (SEAT), and
* Disability Resources Unit.

The program is complemented by other Territory Health Services programs such as Family and Children's Services, Mental Health and Community Health.

HACC and CSDA are both national programs having intergovernmental arrangements that prescribe eligible consumer groups, service types, national standards and reporting requirements.

Aged care services are primarily the responsibility of the Commonwealth Government. The Commonwealth provides funds for residential aged care (nursing homes, hostels) and community aged care places. There are national standards for nursing homes and hostels. The Commonwealth Standards Monitoring Teams annually inspect nursing homes and hostels against these standards.

In 1996/97 THS provided $500,000 top up funds to residential aged care (nursing homes and hostels) to meet funding shortfalls. THS annually inspects and licenses nursing homes and registers hostels. These inspections concentrate on occupational health and safety, as well as environmental and infection control. THS administers the Adult Assessment Coordination Teams and provides additional funds mainly in corporate support and overhead costs of teams.

The following strategies and performances incorporate the sub programs of Aged and Disability Services.

**Strategies**
- To improve services planning processes by seeking input from operational staff, non-government organisations and consumers.
- To develop specialist training for rehabilitation in remote areas.
- To better inform consumers on available generic and specialist services.
- To target special needs of people with communication disabilities.
- To integrate services where possible to achieve better coordination and efficient services.
- To develop service coordination models for people with complex care needs.
- To develop strategic plans with appropriate input from key outside stakeholders.
- To effectively plan, implement and evaluate services to consumers.
- To develop proactive program strategies.

**Performance**
- A five year strategic plan for disability services was developed and funds were earmarked for implementation in 1997/98 and beyond.
- NT wide workshops were conducted on community-based rehabilitation services focusing on their development in remote Aboriginal communities.
- Training models for community-based rehabilitation workers were developed and were available for gait training and communication disability.
- A six month project to develop appropriate services for people with communication disabilities in Darwin Remote was completed.
• A disability resource book for Darwin Urban was updated and distributed through the Community Care Centres.
• Occupational therapists provided a new advisory service on access for people with disabilities.
• A Disability Resources Unit (DRU) was established after combining several work units leading to more cohesive and integrated services for clients.
• Business cases for implementing a client driven care coordination model for Darwin Urban for people with complex care needs was developed.
• An improved planning process which identified gaps in service and priority areas requiring HACC resources was developed.
• A triennial strategic plan was developed that was consistent with the National HACC Training Strategic Plan.
• Funding for two HACC positions was devolved to Red Cross in Darwin following a review of the homemaker services.
• The Taxi Subsidy Scheme was expanded and made available to Katherine and Tennant Creek residents during 1996/97.
• An alternative family care project was established providing support for young Aboriginal children with disabilities and their families which recognised the importance of culturally appropriate liaison and support to families.
• Interagency forums were established in Darwin Urban to develop best practice guidelines for children requiring early intervention.
• The Independent Living Centre WA Mobile unit was brought to Darwin and Katherine as part of an equipment display and advice service for people with disabilities.

Pensioner Concession Scheme

The Scheme encourages older residents to remain in the Territory during their retirement and provides assistance with the cost of living to pensioners of all ages. Concessions and rebates are provided for pensioners, people of retirement age, war widows and widowers and a number of other categories of eligible people. Concessions cover NT Government and local government services including electricity, council, sewage and water rates, garbage charges, motor vehicle registration and driver’s licence fees, bus services, interstate travel and the cost of spectacles.

Figure 13: Breakdown of Current Clients of Pensioner Concession Scheme by Eligibility Category 1997

![Figure 13: Breakdown of Current Clients of Pensioner Concession Scheme by Eligibility Category 1997](image)

Figure 14: Breakdown of Expenditure on Pensioner Concessions by Concession Category 1997

![Figure 14: Breakdown of Expenditure on Pensioner Concessions by Concession Category 1997](image)
Figure 15: Pensioner Concession Expenditure Trend from 1992/93 to 1996/97

Adult Assessment and Coordination Team (AACT)
The teams are part of national Aged Care Assessment Teams (ACATs) and provide multidisciplinary assessment services for the frail aged and younger people with multiple disabilities. The teams operate to ensure that those in need of a substantial level of care and support gain access to the available residential and community care services. The teams provide assessment, short term intervention and coordination of support services to the target group.

Table 17: Number of Assessments per District by Financial Year.

<table>
<thead>
<tr>
<th>Financial Year</th>
<th>Darwin</th>
<th>East Arnhem</th>
<th>Katherine</th>
<th>Barkly</th>
<th>Alice Springs</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>94/95</td>
<td>438</td>
<td>11</td>
<td>258</td>
<td>68</td>
<td>168</td>
<td>943</td>
</tr>
<tr>
<td>95/96</td>
<td>531</td>
<td>38</td>
<td>289</td>
<td>49</td>
<td>101</td>
<td>1008</td>
</tr>
<tr>
<td>96/97</td>
<td>589</td>
<td>50</td>
<td>291</td>
<td>51</td>
<td>282</td>
<td>1283</td>
</tr>
</tbody>
</table>

Home and Community Care (HAAC)
This program is cost shared by the Commonwealth and Territory providing services for the frail aged, younger people with disabilities and their carers. It enables people to live at home for as
long as possible by providing support where otherwise they might have to consider moving to a hostel or a nursing home. Services available under HACC include home help, personal care, home maintenance, food services, respite care, transport, education, information, advocacy and service coordination.

**Taxi Subsidy Scheme**
The NT Taxi Subsidy Scheme operates within a 30 km radius of Darwin, Palmerston, Katherine, Tennant Creek and Alice Springs town centres. 350 people access the Scheme throughout the Territory.

Changes were introduced in February 1997 in an attempt to improve the efficiency and effectiveness of the Scheme in the NT.

This was achieved by allocating consumers to one of three categories of benefit according to their assessed need for transport. A set value voucher system of payment was introduced and a data base developed which allows the project to monitor expenditure and consumer activity within the Scheme.

At the time the changes were introduced, 80 eligible people were placed on a waiting list to access the Scheme. All from the waiting list have been absorbed into the Scheme with no additional resources, and the expenditure for the 1996/97 financial year maintained within the allocated budget.

Administration charges have been reduced to 10% of the metered fares.

Improved management strategies funded an increase in the base level of benefit from $250 to $400 per consumer each financial year.

**Commonwealth State Disability Agreement (CSDA)**
This is a joint Commonwealth/Territory program under the Commonwealth State Disability Agreement. It provides funds for specialist disability services which assist people with disabilities to live as valued and participating members of the community. Most CSDA services are provided by non government organisations which are funded via service agreements.

Services provided are:
- accommodation support (eg group homes, attendant care, outreach support);
- community support (eg advocacy, information/referral, case management, self help groups);
- community access ( eg independent living training, day activity, recreation);
- respite; and
- support services associated with both direct service delivery and program management.

*Figure 16: Primary Disability Type, Recorded from CSDA Survey 1996*
Notes: 1. ABI + Neurological includes the following disability types: acquired brain injury, neurological.
2. Intellectual includes the following disability types: intellectual/learning, autism, development delay, specific learning.
3. Sensory includes vision.
While Aboriginal people represent 27% of the total Northern Territory population, they constitute more than half of consumers receiving disability services. This suggests that Aboriginal people may have a higher prevalence of disability than the remainder of the Northern Territory population.

**Challenging Behaviour Support Unit (CBSU)**

The Unit is based in Darwin Urban District and provides behavioural assessment, intervention and training for individuals with developmental disabilities who exhibit challenging behaviour which restricts their lifestyle. It also provides support and training to their families and/or organisations supporting them.

**Adult Guardianship**

This provides a legal mechanism whereby a guardian can be appointed to make decisions on behalf of adults with intellectual disabilities who are unable to make competent decisions for themselves and are at risk of neglect, abuse or exploitation. Where there is no family member or other appropriate person available to act as guardian, the Minister may be appointed as the Public Guardian.

The *Adult Guardianship Act* commenced on 30 June 1989. Under the Act, the Minister exercises certain powers and functions which may be delegated as specified in the Act. These powers and functions fall into two categories:

- the Minister may, by notice in the Gazette appoint an employee within the meaning of the *Public Services Act* to be the Adult Guardianship Executive Officer; or
• the Minister is the Public Guardian.

The statutory functions of the Executive Officer and the Public Guardian are discrete. The Adult Guardianship Executive Officer has carriage of all guardianship court hearings and is required to ensure that the fundamental principles and the statutory requirements of the Act are adhered to and that Local Court procedures and processes are followed.

Table 18: Adult Guardianship Court Activities

<table>
<thead>
<tr>
<th>Year</th>
<th>1993/94</th>
<th>1994/95</th>
<th>1995/96</th>
<th>1996/97</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applications lodged</td>
<td>52</td>
<td>32</td>
<td>72</td>
<td>56</td>
</tr>
<tr>
<td>New orders</td>
<td>32</td>
<td>37</td>
<td>44</td>
<td>44</td>
</tr>
<tr>
<td>Review existing orders</td>
<td>25</td>
<td>43</td>
<td>56</td>
<td>55</td>
</tr>
</tbody>
</table>

**Territory Independence Mobility Scheme (TIME)**

This Scheme provides a range of equipment and appliances for people with disabilities to increase their independence and to enable them to function at optimal levels in their homes and communities.

Health professionals, departmental and external, with specialist skills and knowledge required in relation to specific functions of the equipment, are authorised to prescribe equipment for eligible consumers.

Categories of equipment provided under the Scheme are:

• mobility equipment including wheelchairs and seating systems;
• positioning equipment;
• communication equipment;
• equipment for daily living;
• orthotics;
• pressure care items;
• continence equipment;
• oxygen;
• continuous positive airway pressure;
• mammary prostheses;
• visual equipment/prostheses;
• tube feeding equipment;
• glucometer;
• nebuliser;
• tens units; and
• home and vehicle modification.

**Seating and Equipment Assessment Team (SEAT)**

SEAT provides comprehensive assessment and customised seating and equipment for people with physical disabilities affecting their mobility and independence. It aims to improve posture, functional skills and to reduce deformities and pressure ulcers.

Services provided include:

• assessment of individuals for customised mobility and seating equipment;
• modifications to existing wheelchairs and other mobility devices;
• fabrication of customised seating systems;
• fabrication of cushions and mattresses to prevent or manage pressure ulcers;
• provide inservice training and educational material; and
• research and development of non commercially available equipment.

MENTAL HEALTH SERVICES

Overview

Mental Health Services provides a culturally appropriate, innovative and accessible services to the NT population by focusing on consumer rights, community needs, quality of service and strategic resource allocation.

Services are provided through:

* inpatient facilities (Darwin and Alice Springs),
* specialist child adolescent and family services,
* community based general adult psychiatric and forensic services,
* extended hours teams,
* rehabilitation facilities,
* day centres,
* psychiatric liaison services to the Royal Darwin and Alice Springs Hospitals,
* rural and remote services,
* support of non government organisations, and
* support and consultation services to Aboriginal communities.

Services are delivered in a culturally sensitive way through a combination of sub programs in a variety of settings across the Northern Territory. Each site of service delivery has the potential to provide the entire range of mental health services. Services in rural and remote areas are often provided by visiting specialists or by consultation with other professionals in urban regions.

Funding for Mental Health Services is through a discrete budget allocation from the Northern Territory Government. In addition, based upon agreed indicators and targets defined in Schedule F1 of the Medicare Agreement, the Commonwealth Government provides reforms and incentive funding to advance the national reform agenda.

Currently Mental Health Services is influenced and shaped by the National Mental Health Strategy, the objective of which is to facilitate the rate of mental health reform in a nationally consistent and coherent manner.

Strategies

• To develop mental health legislation in consultation with interested community groups and agencies that reflects Northern Territory conditions and is consistent with national and international standards.
• To investigate factors involved in the provision of culturally appropriate services for all Territorians and to develop policies and programs in response to these.
• To increase the involvement of non government agencies and consumer groups in service planning and delivery.
• To evaluate the current services delivered and respond to the results to ensure a high standard of service delivery.
• To conduct projects aimed at identifying causes of mental disorders or minimising their effects on the individual and the community.
• To ensure that mechanisms are in place to monitor the standard of service delivery and that staff are equipped to implement quality services.

**Performance**
• The new Mental Health and Related Services Bill is an innovated piece of legislation designed to meet the particular needs of the Northern Territory. Significant new features of the legislation include:
  * a provision which allows for individuals, who, while not mentally ill, are behaving in such an irrational manner as to place either themselves or others in danger and therefore may warrant a brief period of hospitalisation; and
  * the creation of a Mental Health Review Tribunal which will review all involuntary admissions and protect the rights of individuals subject to the legislation.
• An Aboriginal Mental Health Policy was under development.
• The Aboriginal Mental Health Unit was awarded Gold for Health Promotion and Bronze for Mental Health Team Program, in the area of Aboriginal Mental Health. This was awarded by The Mental Health Services Conference Incorporated of Australia and New Zealand, (THEMHS) in recognition of innovations and achievements by mental health services, consumers, organisations and individuals.
• The Commonwealth funded a project being conducted by the Australian Rural Health Research Institute in conjunction with Mental Health Services focusing on youth suicide in the Tiwi Islands.
• Rooming in services were initiated in Katherine. These services avoid the unnecessary evacuation of people from their communities by providing rooms which can be utilised to care for people in need of mental health services in a culturally appropriate fashion.
• Two reference groups were formed to assist with the development of the Draft Aboriginal Mental Health Policy reference paper. It is envisaged that these groups will be maintained to provide THS with further input into the final implementation of the plan and as a future resource group.
• Working parties were established to advance the process of achieving accreditation and the development of appropriate practices and protocols.
• A nursing program consultant was employed to develop quality assurance programs, to conduct research, and to assist in staff development.
• There was recognition of Aboriginal rights to access traditional healers and compensation provided for travel, accommodation and other associated costs incurred by the healers.
• A review of forensic services was conducted. As a result of this review a new forensic service was established in Alice Springs.
• The current ratio of community based direct care full time Mental Health staff is 27 per 100,000. Although the aim was to establish our ratio at 28/100,000, when viewed against other major states the Northern Territory is well placed to maintain a ratio which is comparable to national trends.

<table>
<thead>
<tr>
<th>New South Wales</th>
<th>Victoria</th>
<th>Queensland</th>
</tr>
</thead>
<tbody>
<tr>
<td>23/100,000</td>
<td>29/100,000</td>
<td>16/100,000</td>
</tr>
</tbody>
</table>
• In combination with National Mental Health Strategy funding Northern Territory Mental Health Services has invested more than $100,000 and a 0.5 full time equivalent for the development of Mental Health Services functional specifications for a more appropriate information system.

• Grants to the non government sector rose from 0.8% in 1992 to 5.7% in 1996. The amount is a percentage of total Northern Territory Mental Health Services expenditure. The table below indicates the amount the non government sector received in funding during the same period.

<table>
<thead>
<tr>
<th>YEAR</th>
<th>NGO</th>
</tr>
</thead>
<tbody>
<tr>
<td>92/93</td>
<td>85</td>
</tr>
<tr>
<td>93/94</td>
<td>148</td>
</tr>
<tr>
<td>94/95</td>
<td>327</td>
</tr>
<tr>
<td>95/96</td>
<td>709</td>
</tr>
</tbody>
</table>

• Mental Health Services increased the role of consumers and carers in the formulation of future directions and development of service deliveries through support for the Mental Health Advisory Group which has direct contact with the Minister for Health Services.
ORGANISATIONAL SUPPORT ACTIVITY

ORGANISATIONAL SUPPORT

GOAL
Organisational Support equips staff to deliver results particularly through strategic, effective and efficient use of human, financial, technological and information resources.

OBJECTIVES
• To provide advice on the strategic direction of support services, establishment of policy for management of resources and monitoring of the use of financial, human, and technological resources.
• To deliver services to operations in the strategically sensitive areas of information technology and staff development.
• To assume overall responsibility for financial and human resource services.

ACHIEVEMENTS
The major component of Organisational Support work was to progress strategic direction five, to gear Territory Health Services to better support and equip staff to deliver results, and is reported under performance by each branch.

PROGRAM REPORTS
Corporate Services comprises seven branches;

• Finance and General Services,
• Human Resource Services,
• Staff Development Services,
• Information Technology Services,
• Internal Audit,
• Library Services,
• Legal Services, as well as
• Program Development and Planning, and
• Executive Support.

Branch reports follow and include a description of their functions, strategies and performance.

FINANCE AND GENERAL SERVICES

Overview
Finance and General Services are responsible for:
• budget development and monitoring;
• accounting policy and services;
• capital works, minor new works, and repairs and maintenance programming;
• contract services for the acquisition of medical and other supplies;
• office services;
• asset control; and
• records management.
Strategy
• To provide advice, assistance and administrative support to facilitate efficient and effective service delivery including information which assists management decision making and evaluation of services.

Performance
• The cost of providing financial and general services was $9.896 million in 1996/97. This represents 2.79% of total Territory Health Services expenditure, as compared to 2.95% in 1995/96.
• Capital works programs approved for 1996/97 approximated $5.35 million which included $5 million for the construction and upgrade of 15 rural health clinics throughout the NT.
• Accounting Services’ major achievements included a total rewrite to the ledger in readiness for 1997/98, and a complete revision of the financial delegations into a new streamlined format.
• Budget Services updated the internal budget systems, significantly adding to the timeliness and accuracy of information provided to management and Treasury.

HUMAN RESOURCE SERVICES

Overview
Human Resource Services (HRS) focuses on the support and management of approximately 4000 staff.
HRS encompasses;
  * Equal Employment Opportunity,
  * Occupational Health and Safety,
  * Employee Relations,
  * staffing operations,
  * employment policies and practices,
  * remuneration and conditions,
  * performance management,
  * human resource development, and
  * human resource planning.

The aim is to provide an effective and efficient service to staff and management on human resource issues which reflect best practice and assists in the creation of a productive workforce enabling the achievement of THS goals and strategic directions well into the next century.

Strategies
• To decentralise operational human resource services to provide an effective and efficient service to staff.
• To improve recruitment and retention of staff by identifying and addressing issues affecting the efficiency and effectiveness of recruitment.
• To train staff about good employee relation practices to prevent and/or limit industrial action.
• To monitor employment trends in the organisation and to assess the impact of the equity and merit plan.
• To develop and implement a strategic plan (1997 to 1999) to reduce the number and cost of accidents, illness and injury within the organisation.
• To introduce remote electronic input in all areas to increase the accuracy and efficiency of salary payments and data retrieval.
• To develop an interface between the hospital computerised nursing rosters (ANSOS) and the NTPS information system to reduce costs associated with the processing of payrolls.
• To review organisational restructuring to ensure the (re)evaluation of jobs and the redeployment of affected staff is carried out in an effective and efficient manner.

Performance
• Decentralisation of human resource services was finalised in June with the effectiveness of this action to be assessed.
• A recruitment and retention project commenced with recommendations to be included in the human resource strategic plan.
• Industrial action in Territory Health Services was limited although a total of 30 days involving 70 employees (average less than half a day each) were lost when junior medical officers stopped work in protest over the Federal Government’s decision to restrict access to medical provider numbers.
• Implementation of a back pain prevention program achieved a reduction in back injuries at Royal Darwin Hospital of 34% and a reduction in the cost of new claims of 90% ($269,000) since its introduction 12 months ago.

Figure 18: Workers Compensation Costs as % of Salary

The cost of compensable injuries was the equivalent of 1.84% of gross annual salary. (The health industry average is calculated as approximately 1.8%).

• The best ratios for payroll clerk to staff in the NT Public Service existed in:

<table>
<thead>
<tr>
<th>Department</th>
<th>Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northern Region</td>
<td>329 payees/clerk</td>
</tr>
<tr>
<td>Katherine</td>
<td>195 payees/clerk</td>
</tr>
<tr>
<td>Gove</td>
<td>240 payees/clerk</td>
</tr>
<tr>
<td>ANSOS Nursing etc</td>
<td>240 payees/clerk</td>
</tr>
<tr>
<td>RDH Other (Medical etc)</td>
<td>205 payees/clerk</td>
</tr>
</tbody>
</table>

• 200 positions were evaluated this financial year.
• The status of 32 redeployees was resolved this financial year with a further 28
redeployees still to be determined.

Staff Development

Overview
Staff Development provides training and organisational development services to better support
and equip staff to deliver results.

Strategies
• To improve orientation and induction for remote area staff.
• To assist managers to access a range of management development options according to need.
• To make cross cultural awareness programs available to staff throughout the NT.
• To ensure information technology training plans are built into planning for all major purpose
built and office systems.
• To enable technical and professional staff to access training and education services to meet
identified high priority needs.

Performance
• A Territory wide team was established to focus on training for remote area staff.
• A Pathways to Professional Primary Health Care Practice program was developed and trialed
for remote area nurses in Central Australia. Two week multi disciplinary remote area
orientations were carried out in the Top End.
• The two day Prevention is Better than Cure program was initiated to provide an overview of
critical human and physical resource management issues.
• Short accredited courses in project management, recruitment, selection and induction
processes, workplace trainer and cost centre management were developed and offered. These
will become part of THS’ Advanced Diploma in Management.
• Attendances at the Aboriginal Cultural Awareness program in Alice Springs for 1996/1997 were:

| Stage 1 | 496 |
| Stage 2 | 59  |
| Stage 3 | 43  |
| Stage 4 | 25  |

• In the Top End, stage 1 of the program was conducted eight times and attended by 139
participants.
• Training was provided for the following systems; CARESYS, various office systems
applications, ANSOS and OCIS. A total of 1109 separate sessions were delivered and
attended by 4164 participants.
• Extensive work was undertaken with the Public Health Services to develop training
approaches to support implementation of the Public Health Strategy.
• Training and development programs were offered for technical and professional staff including
Advanced Life Support, Enrolled Nurse Development, Pain Management, RDH Nursing
Orientation and Giving Vaccines.
INFORMATION TECHNOLOGY SERVICES

Overview
Information Technology develops, maintains and manages the agency's information systems strategy plan, information system initiatives and technology infrastructure.

Computer support includes help desk services, problem resolution, service management, change management, system administration and management of equipment installation and maintenance.

The Branch works with program areas to provide information technology services which enhance their ability to serve the community.

Strategies
• To plan and implement the Territory Health Services Strategy
• To assist rural access in developing a health information system.

Performance
• Implementation of the Health Net data communications network was completed which included:
  * the installation of 2027 double cable outlets and 150 kilometres of cable in 52 buildings at 15 departmental sites; and
  * the installation of nearly 600 new PCs, the hardware upgrade of 548 existing PCs and the installation of the new standard software image on 1,648 PCs.

• The implementation of the Hospital Information System Strategic Plan was completed, as well as the implementation of the new version of the software product, Caresys. The following new or enhanced modules were installed;
  * birthing details,
  * medical imaging services,
  * infection control,
  * discharge summaries,
  * Emergency Department,
  * appointment booking, and
  * patient accounting.

• The Caresys technology plan was completed and computer processing of the system was transferred to the Cardinal Network Utility Service.
• The Trendstar patient costing system was implemented to support output based funding of Territory hospitals.
• A post implementation review was undertaken of the following projects:
  * HIS Strategic Plan,
  * HealthNet data communications,
  * Clinical Costing System, and
  * Nurse Resource Management System.
LEGAL SERVICES

Overview
Legal Services comprises the Office of Adult Guardianship Executive Officer, the Professional Registration Boards as well as Legal Support.

Office of Adult Guardianship
The Office of Adult Guardianship administers the Adult Guardianship Act (1989) and is responsible for investigating guardianship applications and for reviewing existing guardianship orders. The Office responds to a wide range of enquires and is responsible for the dissemination of information about all aspects of adult guardianship.

Professional Registration Boards
The role of the Professional Registration Boards is to protect the public by ensuring that practitioners are safe to practise before granting them registration. There are 11 boards which are responsible to the Minister for Territory Health Services. Boards have legal powers and responsibilities and comply with legislative requirements. The boards provide advice and assistance to employers, practitioners and the general public on matters associated with registration and other relevant issues.

Legal Support
Legal Support coordinates the legal, litigation and legislative activities of THS to ensure services are underpinned by a sound legal foundation. To this end Legal Support responds to staff inquiries on legal issues, contracts, litigation, claims, disputes and coronial inquiries. Legal Support facilitates the obtaining of advice from the Solicitor for the Northern Territory and the preparation of new and amending legislation, contracts, instruments of appointment and delegation, and other documents of a legal nature. It also arranges legal representation in all proceedings in which Territory Health Services is a party or has an interest.

Performance
• A computerised registration system to enhance monitoring and reporting of the status of applications for persons to be placed under guardianship, and of persons already under guardianship, was designed and implemented.
• Amendments were made to a number of regulations under the Public Health Act to update the fees payable under these regulations and to achieve greater efficiencies.
• Inservice presentations on legal issues relevant to health service providers were delivered to Aboriginal health workers, medical practitioners and nurses in Alice Springs, Darwin and Katherine.

PROGRAM DEVELOPMENT AND PLANNING

Overview
The Program Development and Planning Division assists the Minister, Secretary and the Executive to develop and implement:

• the Strategic Framework
  * identification of health trends and issues,
  * establishment of government priorities,
development of policy options and strategies to meet government objectives, and
development of financing strategies.

the Program Framework (except for Public Health)
program level objectives, policy and performance indicators,
legislative development and review, and
models of service delivery appropriate for NT circumstances such as Community Care
Centres, Strong Women, Strong Babies, and Strong Culture.

the Performance Management Framework
development and review of the Corporate Plan,
development and review of strategic program plans,
planning support for business, and
development of information systems to support services and the coordination of
management information reporting

The Division operates in the following way:

Monitors the external and internal environment and synthesises available intelligence to assist
strategic and program level planning.
Works in consultation with key stakeholders, service providers, both internal and external,
consumer organisations, Commonwealth Agencies, and other interest groups;
Uses a project management approach where;
projects have a beginning and an end,
they have clearly defined objectives,
there is a specific allocation of staff and other resources, and
project plan and timetable exist.
Establishes a steering committee or reference group involving key stakeholders for major
projects; and
Buys in or contracts out to get necessary expertise when this is not available within the
Division.

Strategies
To develop new policy and program initiatives to meet changing community needs.
To monitor external environments and to synthesise available intelligence to assist strategic
planning.
To contribute to the review and evaluation of existing policies and programs including:
appropriate program standards, practice frameworks and performance indicators; and
cost benefit analysis.
To provide information for management and planning services through:
epidemiology;
coordinated reporting and analysis of services/management information; and
appropriate information systems to facilitate service delivery and to assist in the monitoring
and evaluation of programs.
• To negotiate agreements and new program directions with the Commonwealth to ensure NT needs are taken into account in the development of national programs and that the NT receives a fair share of resources.
• To provide strategic and program policy advice to the Minister, the Secretary and operational managers.
• To develop Agency wide resource acquisition and resource allocation strategies in the achievement of Departmental objectives.

Performance

• Performance is largely reported in the relevant program sections of this Annual Report and in the section on Performance Management System. The performance report below relates only to the Epidemiology, Business Information Management and Planning and Finance branches of the Division.

Table 20: List of Publications

<table>
<thead>
<tr>
<th>Title</th>
<th>Authors &amp; Sources</th>
</tr>
</thead>
</table>

Reports and Technical Papers
Family and Children’s Services Quarterly Bulletins

NT Contributions to National Reports


EXECUTIVE AND SUPPORT

Overview

The Executive Support group provides a range of services to facilitate communication between the Department, the Executive, the Minister and the public. The group reports to the Chief Executive Officer and comprises Management Review, Marketing and Communications, and Ministerial Liaison.

Government requires Territory Health Services to review its programs every three years. Management Review is responsible for developing the performance management systems needed to achieve this.

Marketing and Communications manages the Department’s public relations, media liaison, internal and external communications, promotions, display and print. It also provides a strategic marketing consultancy service to the Executive and all programs across the Department.

65
Ministerial Liaison provides a liaison service between the Department and the Minister’s office including the coordination of the Minister’s legislative program, Cabinet matters, Ministerial briefings and Legislative Assembly briefings. It also provides administrative support to the Chief Executive Officer and the Executive.

**Strategies**
- To develop administrative and information systems that provide management information for better planning and accountability.
- To provide self help procedures, protocols and frameworks that allow programs to focus more on customer service delivery and less on administrative process.
- To continually review and develop communication methods for efficient and effective information flow.
- To provide training to support strategic change.

**Performance**
- Development of a corporate business planning framework.
- Design and implementation of a program evaluation process for Mental Health, Community Health, Alcohol and Other Drugs, Aged and Disability Services, Women’s Health and Disease Control.
- Major marketing activities were undertaken, including: the launch of the Corporate Plan; TV campaigns for the Rights of the Terminally Ill Act, Pap Smear, Women’s Infonet, Mosquitoes, Nits Not; launches for Prevention and Education, Child Abuse and Neglect (PECAN), Food and Nutrition Community Store Guidelines, Elcho Island Aboriginal Dental Health video, and Freds Pass and the Territory Show Circuit.
- A complete review of the self help Ministerial Liaison Handbook.
- Nine program evaluations were completed, a further one will be finalised early in 1997/98

<table>
<thead>
<tr>
<th>Activity</th>
<th>1995/96</th>
<th>1996/97</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ministerials processed to and from Minister's Office</td>
<td>1800</td>
<td>2042</td>
</tr>
<tr>
<td>Departmental Cabinet Submissions processed</td>
<td>27</td>
<td>36</td>
</tr>
<tr>
<td>Comments to Cabinet Submissions from other NT</td>
<td>62</td>
<td>51</td>
</tr>
<tr>
<td>Government Agencies provided</td>
<td>198</td>
<td>254</td>
</tr>
<tr>
<td>Legislative Assembly Briefings provided</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
HUMAN RESOURCE ACCOUNTABILITY:

Territory Health Services is subject to a range of legislative directions about the rights, safety and equality of the people delivering its services with Corporate Services responsible for monitoring compliance with the appropriate legislation.

- Legislation relevant to THS human resource responsibilities includes:
  - NT Public Sector Employment and Management Act (PSE&MA),
  - The Work Health Act and Regulations,
  - The Workplace Relations Act 1996,
  - The Northern Territory Dangerous Goods Act and Regulations,
  - The Northern Territory Anti Discrimination Act,
  - various Commonwealth discrimination acts, and
  - various awards and agreements.

THS operates in compliance with the Public Sector Employment and Management Act and Regulations. It complies with all bylaws, instructions and determinations issued by the Commissioner for Public Employment and provides information required by the Commissioner for compliance with the Section 18 of this Act and is summarised as follows.

Employment Instruction Number 1: Advertising, Selection, and Appointment

THS is using the following documentation in relation to advertising, recruitment, selection and appointments;

- internal guidelines in the Human Resource Manual,
- guidelines for the Job Evaluation System process, and
- OCPE Selection Process handbook.

Employment Instruction Number 2: Probation

New employees are told of the probation process at orientation. It is also part of the work guidance process. Managers are expected to follow the employment instruction in the Public Sector Employment and Management Act and seek advice from Human Resource Services.

Employment Instruction Number 4: Performance Management

The THS work guidance process was designed to be the basis of a comprehensive process of performance management. This process is now under review and a modified performance management system will be developed and implemented by December 1997. The new system is to be streamlined and simplified and will include an auditing component. The system is expected to continue to:
• assist in the overall achievement of enhanced standards of work performance;
• assist managers and staff to work towards defined goals consistent with THS directions;
• ensure staff receive regular feedback on their performance;
• allow managers and staff to identify the knowledge, skills, attitudes and values needed to perform their jobs effectively; and
• encourage performance reviews which are open and reflect a fair evaluation of an employee’s performance.

Employment Instruction Number 6: Inability to Discharge Duties

Managers were provided with this instruction and the Human Resource Manual has a section that covers inability to perform duties and poor performance. These provide the procedures for inability to discharge duties.

Employment Instruction Number 7: Discipline

Managers have been provided with procedures on discipline in the Manual.

Employment Instruction Number 8: Review of Grievances

Managers have been provided with grievance procedures in the HR manual.

Employment Instruction Number 10: Employee Records

Employees details are recorded as required on files which are stored in a secure area. Employees, on making an appointment with Human Resource Services, are able to access these records for perusal.

Employment Instruction Number 11: Equal Opportunity Management Plans


Employment Instruction Number 12: Occupational Health and Safety Programs

THS has developed and implemented a new strategic plan for OH and S after consultation with staff and management. OH and S policies and programs consistent with the requirements of Employment Instruction 12 and the Work Health Act 1986 have also been implemented.

THS is committed to the consultative process and has instituted a structure of OH and S Committees which enabled employees and managers at all levels to have input in matters relating to the management of occupational health and safety, rehabilitation and workers compensation. The development of these committees has progressed to the extent that workplace committees are operating in all hospitals and other major operational areas.
Employment Instruction Number 13: Code of Conduct

New employees have been provided with a copy of the Code of Conduct through THS orientation courses.
COMPLAINTS HANDLING

Service delivery areas within THS received and responded to complaints through a process of investigation, conciliation and resolution. Table 23 summarises complaints handling across five administrative areas for all service outlets, including hospitals and community services. Complaints are listed by category of complaint for the past two years.

There is recognition that an effective complaints handling process can assist in continuous service improvement and in building public confidence. This recognition resulted in two major initiatives to improve complaints handling this year:
- a number of THS staff participated in the investigation officers course sponsored by the Office of the Commissioner for Public Employment; and
- a decision was reached and work commenced to establish an independent health complaints commission to be in place with its own legislation by January 1998.

Table 21: Complaints

<table>
<thead>
<tr>
<th>Category</th>
<th>Darwin 95/96</th>
<th>96/97</th>
<th>Katherine 95/96</th>
<th>96/97</th>
<th>East Arnhem 95/96</th>
<th>96/97</th>
<th>Barkly 95/96</th>
<th>96/97</th>
<th>Alice Springs 95/96</th>
<th>96/97</th>
<th>Total 95/96</th>
<th>96/97</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Delay/Provision</td>
<td>259</td>
<td>258</td>
<td>17</td>
<td>14</td>
<td>24</td>
<td>19</td>
<td>3</td>
<td>2</td>
<td>28</td>
<td>11</td>
<td>331</td>
<td>304</td>
</tr>
<tr>
<td>Inadequate Information</td>
<td>20</td>
<td>37</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>9</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>24</td>
<td>49</td>
</tr>
<tr>
<td>Breach of Ethics</td>
<td>5</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>1</td>
<td>8</td>
<td>1</td>
</tr>
<tr>
<td>Financial</td>
<td>14</td>
<td>28</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>15</td>
<td>29</td>
</tr>
<tr>
<td>Insensitive Handling</td>
<td>46</td>
<td>46</td>
<td>4</td>
<td>5</td>
<td>1</td>
<td>9</td>
<td>2</td>
<td>1</td>
<td>12</td>
<td>16</td>
<td>65</td>
<td>77</td>
</tr>
<tr>
<td>Other</td>
<td>69</td>
<td>30</td>
<td>13</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>7</td>
<td>3</td>
<td>92</td>
<td>35</td>
</tr>
<tr>
<td>Totals</td>
<td>413</td>
<td>399</td>
<td>37</td>
<td>21</td>
<td>28</td>
<td>37</td>
<td>7</td>
<td>6</td>
<td>50</td>
<td>32</td>
<td>535</td>
<td>495</td>
</tr>
</tbody>
</table>

Legal Claims where allegations of negligent medical treatment were made.

The following tables provide information on the outcomes of claims made in the financial years 1987/88 to 1996/97.

Table 22: Medical Negligence Claims

<table>
<thead>
<tr>
<th>Category</th>
<th>87/88</th>
<th>88/89</th>
<th>89/90</th>
<th>90/91</th>
<th>91/92</th>
<th>92/93</th>
<th>93/94</th>
<th>94/95</th>
<th>95/96</th>
<th>96/97</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Claims Lodged</td>
<td>11</td>
<td>5</td>
<td>1</td>
<td>7</td>
<td>9</td>
<td>6</td>
<td>5</td>
<td>10</td>
<td>10</td>
<td>11</td>
<td>75</td>
</tr>
<tr>
<td>Claims Where Damages Paid</td>
<td>4</td>
<td>3</td>
<td>1</td>
<td>5</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>7</td>
<td>7</td>
<td>1</td>
<td>40</td>
</tr>
<tr>
<td>Claims Discontinued</td>
<td>6</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>13</td>
</tr>
<tr>
<td>Claims Continuing</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>10</td>
<td>22</td>
</tr>
</tbody>
</table>

Total Amount Paid in Damages in respect of the 40 claims referred to in Table 24: $3,669,913

Table 26: Damages Paid Relating to Medical Negligence Claims
Amount Paid per Claim | No. of Claims
---------------------|---------------
$0 to 50,000          | 28            
$50,000 to 100,000    | 5             
$100,000 to 500,000   | 6             
over $500,000         | 1             

**Summary**

There is no evident pattern or trend to the number of new claims made each year. People generally do not enter into litigation lightly. For most people it is a long and costly process. It is significant to note that of the 53 claims finalised, in 13 (25%) of these, the claimants discontinued their actions. The damages paid in most (70%) of the claims which were successful, were under $50,000 including the claimant's legal costs.

**Notes**

New Claims Lodged includes only those cases where a formal claim has been made or legal proceedings instituted.

The date of lodging the claim is the date on which correspondence making a formal claim, or a Writ instituting legal proceedings, was received, whichever is the later.

Claims Where Damages Paid includes claims which were settled or where the judgement was in favour of the claimant. Only those claims where all monies due as part of the settlement or judgement have been paid are included. Those where part payment has been made have not been included.

Claims Discontinued refers to claims where the parties agreed to the claimant discontinuing the action with or without penalty.

Total Amount Paid in Damages and Amount Paid per Claim includes monies paid in respect of the claimant's legal costs.
LEGISLATION

The legislation which enables Territory Health Services to fulfil its responsibilities is contained within the following Acts:

Adoption of Children Act
Adult Guardianship Act
Cancer (Registration) Act
Community Welfare Act
Dental Act
Disability Services Act
Emergency Medical Operations Act
Food Act
Guardianship of Infants Act
Health Practitioners and Allied Professionals Registration Act
Hospital Management Boards Act
Human Tissue Transplant Act
Medical Act
Medical Services Act
Mental Health Act
Natural Death Act
Notifiable Diseases Act
Nursing Act
Optometrists Act
Pharmacy Act
Poisons and Dangerous Drugs Act
Private Hospitals and Nursing Homes Act
Public Health Act
Radiation (Safety Control) Act
Radiographers Act
Silicosis and Tuberculosis (Mine workers and Prospectors) Act
Therapeutic Goods and Cosmetics Act
Tobacco Act
Transfer of Powers(Health) Act

The Minister for Health Services is also responsible for the following Act:

Menzies School of Health Research Act

During the year the following Acts were commenced:

Community Welfare Amendment Act (No. 54/1995)
Regulations commenced during the year were:

Amendment of the Community Welfare (Child Care) Regulations (No. 55/1996)
Amendment of the Public Health (Barbers' Shops) Regulations (No. 43/1996)
Amendment of the Public Health (General Sanitation, Mosquito Prevention, Rat Exclusion and Prevention) Regulations (No. 44/1996)
Amendment of the Public Health (Night Soil, Garbage, Cesspits, Wells and Water) Regulations (No. 45/1996)
Amendment of the Public Health (Noxious Trades) Regulations (No. 46/1996)
Amendment of the Public Health (Nuisance Prevention) Regulations (No. 47/1996)
Amendment of the Public Health (Shops, Eating Houses, Boarding Houses, Hostels and Hotels) Regulations (No. 48/1996)
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* Occupant during/part of the reporting period
SUBJECT INDEX

-A-
Aboriginal and Torres Strait Islander Commission (ATSIC)
Aboriginal Community Worker
Aboriginal Cultural Awareness Program
Aboriginal Environmental Health Worker
Aboriginal Health
Aboriginal Health Policy
Aboriginal Health Promotion Incentive Funds
Aboriginal Health Promotion Officer
Aboriginal Health Strategy Unit
Aboriginal Health Worker
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