



Northern  
Territory  
Government

DEPARTMENT OF HEALTH

# Central Australia Health Service

Service Delivery Agreement 2014-15

FOR REFERENCE ONLY  
NOT CURRENT VERSION

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# Interpretations and Definitions

## Interpretations

*Board* means a Health Service Board.

*CEO* means the Chief Executive Officer, within the meaning of the *Public Sector Employment and Management Act*, of the Department.

**Chairperson**, see section 31(1) of the *Health Services Act 2014* (hereafter the Act).

**Charter**, means the Service Delivery Agreement Charter.

**COO**, of a Service, means the Chief Operating Officer appointed for that Service under section 34 of the Act.

**Department** means the Agency principally responsible for health policy in the Territory.

**Health Service** means an entity established under section 17(1) of the Act.

**Health Service Board**, see section 21 of the Act.

**Health Service Directive** means a written directive by the System Manager to a Service or the COO of a Service, directing the Service or COO to do, or not do, certain things or take certain actions.

**hospital services** means services provided by or on behalf of a public hospital.

**performance**, of a function, includes the purported performance of the function.

**PSEMA** means the *Public Sector Employment and Management Act*.

**public health service** means a health service provided by:

- (a) a Service; or
- (b) the Department; or
- (c) an affiliated health organisation.

**Service Delivery Agreement**, see section 45 of the Act.

**System Manager**, see section 11(2) of the Act.

## Acronym Definitions

ABF	Activity Based Funding
ACAP	Aged Care Assessment Program
ACAT	Aged Care Assessment Team
ACHS	Australian Council on Healthcare Standards
AMSANT	Aboriginal Medical Services Alliance Northern Territory
ASH	Alice Springs Hospital
ATSI	Aboriginal and Torres Strait Islander
CAHS	Central Australia Health Service
CATT	Crisis Assessment and Triage Team
CEO	Chief Executive Officer
COO	Chief Operating Officer
COPE	Commonwealth Own Purpose Expenditure
CSB	Corporate Support Bureau
ED	Emergency Department
FMHS	Forensic Mental Health Services
GDH	Gove District Hospital
GP	General Practitioner
HACC	Home and Community Care
HSD	Health Service Directive
IPHS	Improving Public Hospital Services
KH	Katherine Hospital
KPIs	Key Performance Indicators
NEAT	National Emergency Access Target
NEST	National Elective Surgery Target
NHA	National Healthcare Agreement
NHRA	National Health Reform Agreement
NMDS	National Minimum Data Sets
NPA	National Partnership Agreement
NPAF	National Performance and Accountability Framework
NPAs	National Partnership Agreements
NTEP	Northern Territory Efficient Price
NWAUs	National Weighted Activity Units
PG	Psychogeriatric
PHC	Primary Health Care
RCA	Root Cause Analysis
RDH	Royal Darwin Hospital
SAB	<i>Staphylococcus aureus</i> bacteraemia
SDA	Service Delivery Agreement
SLAs	Service Level Agreements
TCH	Tennant Creek Hospital
TCP	Transition Care Program
TEHS	Top End Health Service
TEMHS	Top End Mental Health Services
TIME	Territory Independence and Mobility Equipment
WAU	Weighted Activity Units

## Details

In accordance with the *Health Services Act 2014* (the Act), before 30 June in a year, a Service Delivery Agreement between the System Manager and a Health Service will be signed for the following financial year unless the existing SDA is for a longer period (up to three years).

Parties	System Manager for the Department of Health and the Central Australia Health Service (CAHS)	
System Manager	Position	Chief Executive Officer
	Address	Health House L4, 87 Mitchell Street, Darwin NT 0800
	Telephone	08 8999 2766
Central Australia Health Service as Service Provider	Position	Chairperson, Board
	Address	Alice Springs Hospital PO Box 2234 Alice Springs NT 0871
	Telephone	08 8951 7777
Recitals	A	The System Manager wishes to contract CAHS to provide specified services for the Department of Health.
	B	CAHS accepts the contract to provide the services for the Department of Health on the terms in this Agreement.
Date of agreement	See signing page	

## Introduction

This Service Delivery Agreement (SDA) outlines the responsibilities and accountabilities of the Minister for Health, the Department of Health (the Department) as System Manager and CAHS in the delivery of the services to be purchased under this agreement.

Key elements of this agreement are the:

- specification of services to be delivered by CAHS
- funding to be provided for the delivery of these services
- measures against which the performance of the terms of the agreement will be assessed
- processes for the management of the agreement.

The success of this agreement depends on a strong commitment by: CAHS and its Board; and the System Manager of the Northern Territory Public Health System to work together to achieve the best health outcomes from available resources.

## Objectives

The objectives of this Agreement are to:

- specify the healthcare services to be provided by CAHS with respect to outcomes and outputs
- specify the funding to be provided to CAHS for the provision of these services
- clearly set out the service delivery and performance expectations for the funding provided to CAHS
- ensure Northern Territory and Australian Government health priorities and strategies are implemented and the intended outcomes achieved
- promote accountability to the Northern Territory Government and the community
- articulate a performance management and accountability system for monitoring and assuring the achievement of effective and efficient service provision
- address the requirements of the National Health Reform Agreement (NHRA) and *the Act* in relation to the establishment of SDAs between the System Manager and CAHS.

## Scope of the Service Delivery Agreement

This SDA comprises an overarching statement of its objective, scope and processes for management, followed by a number of Schedules which provide the details of the services and the service activity to be delivered under the SDA and budget allocated to provide them. The SDA also outlines the Key Performance Indicators (KPIs). The Schedules are:

Schedule 1 – Tier 1 KPIs

Schedule 2 – Tier 2 KPIs

Schedule 3 – Service Descriptions

Schedule 4 – Reports from Health Services – Safety, Quality and Risk

Schedule 5 – Territory and Department Strategic Directions

Schedule 6 – Support Services to Health Services

Schedule 7 – Reporting Arrangements and Schedule

## Strategic Context

This SDA is the vehicle through which services delivered by CAHS are purchased by the Department in its role as System Manager of the Northern Territory Public Health System. This purchase-of-service arrangement is designed to enable health service planning and delivery which more closely addresses the needs and expectations of those living in the Central Australia regions of the Northern Territory. It is also intended to provide greater transparency and accountability in relation to use of allocated resources, services provided and the health benefit that they deliver.

The scope and detail of the SDA has also been structured to meet the requirements of the NHRA noting that the NHRA requires:

- establishment of processes through which the System Manager identifies and manages variations of hospital performance that pose risks to health outcomes
- development of arrangements by which the National Performance and Accountability Framework will be implemented.

## Principles

This agreement reflects and enables the principles on which the structure of the Department of Health and the Territory's Health Services are based, being:

- an integrated Territory-wide health system with regional and local services designed to meet overarching objectives and outcomes
- community responsiveness
- coordination and integration of services across the care continuum
- local decision-making
- fair and reasonable accountability requirements
- clarity of roles, responsibilities and accountabilities.

## Legislative Context

Schedule D of the NHRA required all states and territories to create Local Hospital Networks including other health services at the discretion of the jurisdiction. In the Northern Territory Local Hospital Networks became Health Services when they absorbed other operational health services during 2013 and 2014. This agreement is thus created in accordance with the NHRA and s40 of the Act created to provide a New Service Framework for Health Services in the Northern Territory and for related purposes.

As stated in the Act (s12(2)) each Service is governed by a Health Service Board which is accountable to the System Manager for the Service's performance. A Health Service is accountable for its performance in accordance with the SDA for the Service, any Health Service Directive (HSD) issued to the Service and any other requirements under the Act (s13(1)).

The System Manager is responsible for setting up and monitoring performance standards for the provision of health services by the Health Services (under s14(1)(a), (b) of the Act). SDAs (s40 of the Act) describe the services to be provided and performance standards to be met by the Health Services.



SDAs will be guided by the objectives and implementation principles of the National Health Reform Agreement (s4 pA2 and s12 p8).

## Policy and Planning Context

CAHS is required to ensure that all planning and service delivery activities are aligned with Northern Territory and national health policies, priorities and service frameworks.

The 2014-15 CAHS budget includes revenue provided under a range of National Partnership Agreements (NPAs), Commonwealth Own Purpose Expenditure payments and other agreements. CAHS is expected to comply with all of the program, financial and performance reporting required by these agreements, irrespective of being detailed here.

## Roles and Responsibilities of the Parties to the SDA

### Service Provider (CAHS)

Without limiting any other obligation of CAHS, it must meet the following accountabilities and responsibilities:

- the terms of this SDA and its schedules
- all Territory and Australian Government legislation applicable to it
- service planning and delivery that aligns with national and Territory policy, plans, frameworks, and quality and safety standards
- professional registration and clinical credentialing standards and practice
- achievement and maintenance of service and/or facility accreditation
- implementation of any new initiatives as required from time to time.

### System Manager

Without limiting any other obligations, the System Manager must meet the following accountabilities and responsibilities:

- the terms of this SDA and its schedules
- all Territory and Australian Government legislation and agreements applicable to it
- dealing, negotiating and entering into agreements with the Australian Government
- contributing to negotiating Northern Territory-wide industrial agreements for the terms and conditions of employees, as required by the Office of the Commissioner for Public Employment
- Northern Territory-wide health service, workforce and capital planning
- Northern Territory-wide health policy development, including leadership of clinical quality and safety
- Territory-wide system management including health system planning, coordination and setting of standards
- managing major capital works (estimated value exceeds \$500 000)

- delivery of Territory-wide services in ways which enable coordination and integration of service delivery in the Central Australia region
- negotiating and managing contracts with non-government organisations (or affiliated health organisations).

It is noted that where costs of meeting infrastructure, equipment and legal responsibilities (such as safety) cannot be managed within the Health Service budget due to their significant or unusual nature the System Manager will assist Health Services in funding these. Examples could include provision of emergency services or major infrastructure failure. Should it be needed, a HSD will be issued to manage the situation.

## Management of the Service Delivery Agreement

On 1 July 2014 the *Health Services Act 2014* comes into force and the first formal SDA under that Act will be in place. As the first SDA under the Act, marking also the first time the Health Service Boards have signed agreements on behalf of their services, this initial agreement is to some extent exploratory and an exercise in working together to develop the relationship, funding and balance of responsibilities between the parties.

This SDA will be managed under the terms and conditions outlined in the Service Delivery Agreement Performance Charter (the Charter) 2014-15.

The Charter will outline how the terms and conditions of the SDA, as detailed in the relevant Schedules, will be monitored to assess actual against projected performance in the achievement of the KPIs and other performance measures. It will also establish the points at which further action will be taken, if and when required. The Charter will define the point at which any ongoing performance variation will trigger escalation for formal review under an agreed Escalation Process. The performance review process will be collaborative with both parties to the SDA working together to maximise health outcomes in the Northern Territory.

Formal review of the SDA will occur in November of each year, as part of the Northern Territory Government Mid-Year Review process. See the Charter for details of other performance review meetings.

## Performance Measurement

Assessment of CAHS performance against the terms and conditions of the SDA will be measured by:

- KPIs
- progress reports on implementation of new initiatives and strategic directions.

KPIs are largely those specified in commitments given in the Northern Territory Budget Paper 3 and in NPAs (see Schedules 1 and 2), which comprise:

- whole of service indicators for workforce and safety, quality indicators from the NPAF (pursuant to the NHRA with the Australian Government)
- activity based funding indicators for each service category
- any other measures that are or may be included in the SDA to ensure specific objectives and related outcomes are achieved.

KPIs in the SDA are compliance measures. Each will be assigned performance levels that, if not achieved as specified, may trigger escalation as outlined in the Charter.

The performance measures in the agreement may be varied from time to time in response to developments in standards and indicators. This will be managed by making variations to the SDA using HSDs and Minister's Directions as outlined in the Act and Charter or through agreement between the parties.

## Data Provision and Management

There is a requirement for CAHS to capture all data necessary for: clinical care; service delivery and management; and strategic data delivery, analysis and reporting. Reporting should occur at least quarterly, but preferably monthly or more frequently if possible. The scope of data is established in front-line clinical settings and in agreements related to the provision of National Minimum Data Sets and other data to support Territory and national reporting and analysis.

CAHS is responsible for the quality, completeness and timely provision of all data required to be collected and entered into Department's corporate information systems. CAHS must provide all information required to the Department under relevant legislation e.g. the *Freedom of Information Act* and the *Public Sector Employment and Management Act*.

CAHS is also responsible for the quality and timeliness of coding of admitted patient care, with coding to be completed within five weeks of a patient's discharge.

## Research and Training

The parties to this agreement will continue current arrangements for research and training. Researchers given approval by the Human Research Ethics Committee will be allowed access to available relevant data and to staff and patients as is practicable. The System Manager will also provide data and access to staff as possible within service constraints. Student and intern training arrangements involving hospitals within the Health Service will continue under current contracts between training institutions and the Department. Any (re)negotiation of related contracts occurring during the year will involve both parties.

## Public Health Responsibilities

The System Manager and CAHS will work collaboratively to manage public health issues such as the detention of infected patients (not necessarily requiring health care) under the *Notifiable Diseases Act*, as well as preparation for and response to disasters and epidemics including clinical and laboratory services.

## Variation to this Agreement

Consistent with the *Health Services Act 2014* variations may be made by HSD and/or Minister's Direction. The System Manager and CAHS may also agree between the parties to vary this agreement. This variation may be proposed by either party, in writing, followed by a process of negotiation on the terms under which the service scope will be changed.

This negotiation process will take into account the costs and benefits of such a change on service users, providers and the general community and include consideration of key deliverables, budget, staffing and performance measurement and monitoring. Agreement to change the scope of services would be documented as a new schedule to this Agreement, thereby implying agreement to all of the overarching commitments, responsibilities and accountabilities encompassed in the SDA.

Discussions over any variations to this agreement will occur at the Quarterly Performance Review meetings to be held within six weeks from the end of the quarter (i.e. mid November 2014; mid February 2014; and mid May 2015).

## Dispute Resolution

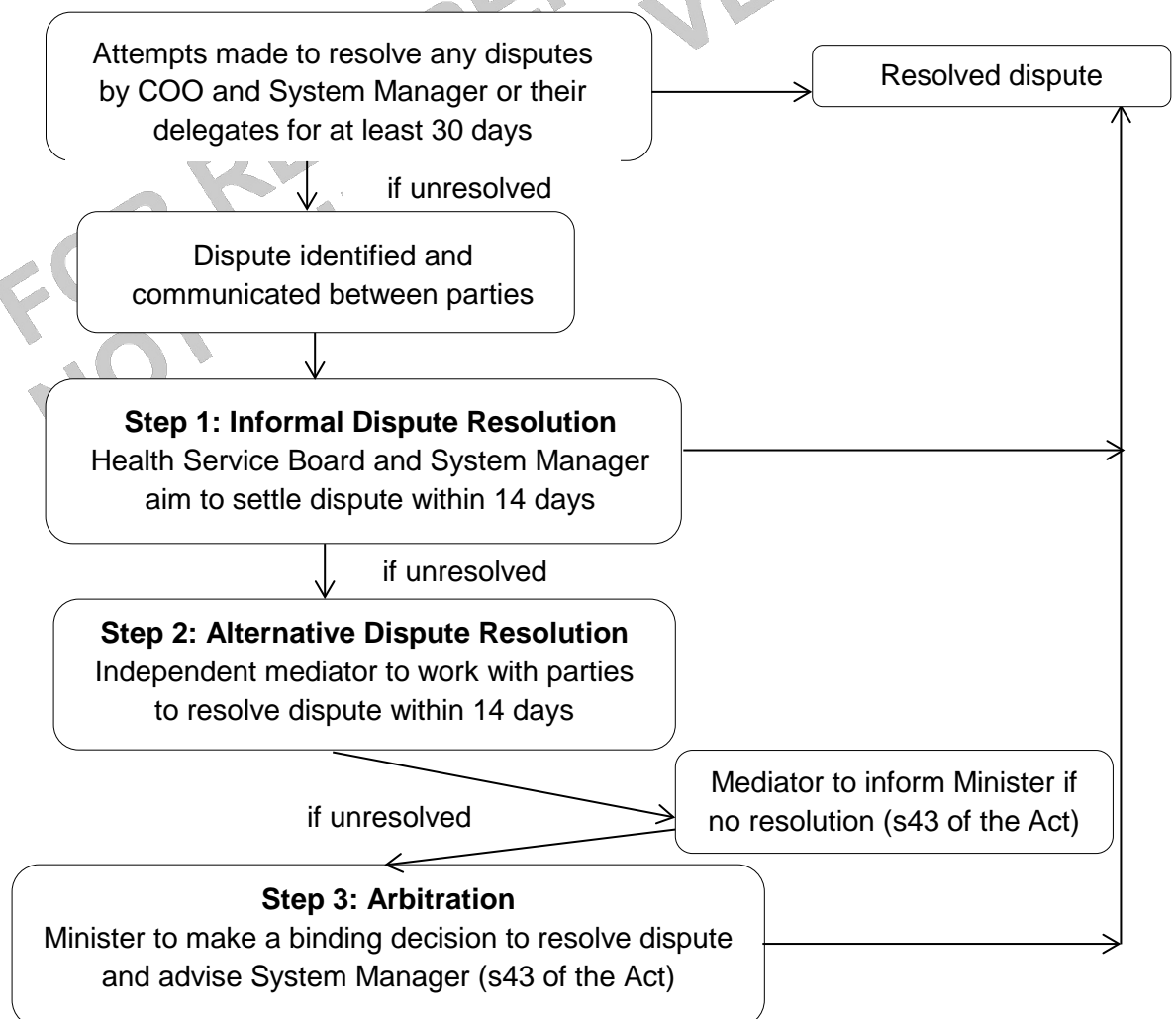
In the event of a dispute arising under this Agreement, the parties must make reasonable endeavours to attempt to resolve the dispute in good faith and in the public interest.

This begins with an informal process to be conducted at two levels: between the COO and System Manager (or their delegates – officer to officer) and (if the matter is not resolved within 30 days), then between the Board Chair and System Manager.

If the parties are still unable to resolve the dispute within 14 days, then the parties must refer the matter to alternative dispute resolution as conducted by an external party identified by the Australasian College of Health Service Management.

If the issue is still not resolved, then the mediator will inform the Minister who will consider the issues and make a decision under s43 of the Act.

### Dispute Resolution Process Flow Chart



## Signatures

Signed by the Executive Officer, Department of Health for and on behalf of the Department of Health:

Signature: Signed by Dr Len Notaras,

Date: 13 August 2014

Signed by the Chair, Board CAHS, for and on behalf of CAHS:

Signature: Signed by Mr Damien Ryan,

Date: 13 August 2014

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## Schedule 1: Tier 1 KPIs\*

### 1.1 National Weighted Activity Units NWAUs and Expenditure

#### CAHS Activity and Funding Schedule (NT Price per NWAU: \$4,662)

FUNDING TYPE	ACTIVITY (NWAUs)	BUDGET \$
<b>Activity Funded Services</b>		
Admitted Acute	29,721	138,559,302
Admitted Sub Acute	4	18,648
Admitted Mental Health	768	3,580,416
Emergency Department and/or Emergency Services	4,704	21,930,048
Non-admitted	2,960	13,799,520
	<b>38,157</b>	<b>177,887,934</b>
<b>Block Funded Services</b>		
ABF In scope Hospital Services (Tennant Creek Hospital)	3,842	21,779,763
NT Only Block Funded Hospital Services	1,180	8,529,140
Revenue Funded Services		21,068,920
Central Australia Aged Care Services		362,044
Central Australia Community and Residential Mental Health		13,098,025
Central Australia Primary Health Care Services		45,740,000
Depreciation Expense		8,026,278
	<b>5,022</b>	<b>118,604,170</b>
<b>Cross Border</b>		
Cross Border Services	3,809	17,752,896
<b>CAHS Total</b>	<b>46,988</b>	<b>\$314,245,000</b>

\*CAHS NWAU Total is BP3 Total NWAUs plus Cross border NWAUs.  
See Appendix 1 for further information on KPIs and Traffic Light tolerances.

1.2 Other Tier 1 KPIs\*

Subject Grouping	Performance Framework		Other Tier 1 KPIs	Target	Disaggregated by *	Accountability
	Domain	Sub-domain				
Aged Care	Equity and Effectiveness	Access	Aged Care Assessment Program Clients Receiving Timely Intervention	91%	(1) Priority Category	NT
Elective Surgery	Equity and Effectiveness	Access	Elective Surgery Waiting List Patients Treated Within Time By Urgency Category	Cat. 1: 86.5% Cat. 2: 77% Cat.3: 90.5	(1) Urgency Category	NPA-IPHS [NEST], NPAF (6.2.3.4)
Emergency Department	Equity and Effectiveness	Access	ED Presentations Departing Within 4 Hours	67%	(1) Departure Status (2) Triage Category	NPA-IPHS [NEAT], NPAF (6.2.3.3)
	Equity and Effectiveness	Access	ED Presentations Seen In Time	Cat. 1: 100%; Cat. 2: 70.5%; Cat. 3: 66%; Cat. 4: 65.5%; Cat. 5: 92%	(1) Triage Category	NPAF (6.2.3.2)
Other	Efficiency	Efficiency	Coded Separations Within Time	80% within 5 weeks		NT
Safety and Quality	Effectiveness	Quality - Safety	National Safety and Quality Health Service Standards Compliance	100%		ACSQHC
	Effectiveness	Quality - Safety	Healthcare Associated <i>Staphylococcus Aureus Bacteraemia</i> (SAB) Infections	0.92		ACSQHC (CHBOI 5)
	Effectiveness	Quality - Safety	Hand Hygiene Compliance	70%		ACSQHC
Primary Health Care	Effectiveness	Quality - Safety	Potentially Preventable Hospitalisations	9.6%	(1) Category	NPAF (6.3.1.1)
			Adult Health Checks	65%		NAHKPI
Workforce	Equity	Access	Aboriginal Health Practitioners	4		NT

\*See Appendix 1 for further information on KPIs and Traffic Light tolerances.

### ***1.3 Other NHRA Performance and Accountability Framework Indicators***

The Department's System Performance Review Committee will negotiate to progressively include these indicators within the SDA KPI set as targets and definitions are confirmed nationally and data collection and processing arrangements locally are in place. Some of these KPIs may also be identified for reporting within the Reporting Service Level Agreement.

### ***1.4 Definitions and Reporting***

Brief KPI definitions are given in Appendix 2. Detailed definitions are provided in a separate companion document to the Charter available from the System Performance Branch. The Charter gives the SDA performance review: context; process; traffic light monitoring; escalation/de-escalation; and governance arrangements.

The System Manager will provide monthly reports against the agreed KPIs for CAHS within the timelines given in Schedule 7 of this SDA. These reports will form the basis for monitoring and review of CAHS performance.

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## Schedule 2: Tier 2 KPIs

CAHS will still be accountable for delivering performance against the targets identified below, but a different escalation process will apply as described in the SDA Performance Charter.

Subject Grouping	Performance Framework		Tier 2 PIs		Disaggregated by *	Accountability
	Domain	Sub-domain	KPI Name	Target		
Aged Care	Equity and Effectiveness	Access	Aged Care Occasions Of Service	2545		NT
Mental Health	Effectiveness	Quality - Continuity	Mental Health Community Follow Up Within First 7 Days Of Mental Health Inpatient Discharge	70%		NPAF (6.2.1.7)
	Effectiveness	Quality - Safety	Mental Health 28 Day Readmissions	10%		ACSQHC

\*See Appendix 1 for further information on KPIs and Traffic Light tolerances.

### 2.1 Definitions and Reporting

Brief KPI definitions are given in Appendix 2. Detailed definitions are provided in a separate companion document to the Charter available from the System Performance Branch.

The System Manager will provide monthly reports against the agreed KPIs for CAHS within the timelines given in Schedule 7 of this SDA. These reports will form the basis for review of CAHS performance.

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## Schedule 3: Service Descriptions

### 3.1 Hospital Services

Under this SDA, CAHS has responsibility for delivery and ongoing development of a wide range of hospital services in inpatient, outpatient, community health, residential aged care and in-home settings. These are delivered by two hospitals as detailed below.

#### Alice Springs Hospital

Total active overnight beds: 183.

Alice Springs Hospital will continue its role in providing acute care services to resident population and visitors to the Central Australian region. The hospital will continue to provide a range of clinical, diagnostic and support services including:

- General Medicine, Paediatrics, Obstetrics and Gynaecology, General Surgery, Renal Medicine, Ophthalmology, Ear Nose and Throat, Orthopaedics, Emergency Medicine, Intensive Care, Anesthetics, Midwifery Group Practice, Palliative Care, Ambulatory Care, Outpatient Department, Addiction medicine, Gastroenterology, Infectious Disease, Oncology and Allied Health services including Welfare, Diagnostic and Treatment (including Hospital in the Home).
- Visiting Medical Officers provide services including Neurology, Neurosurgery, Immunology, Oncology, Rheumatology, Urology, Cardiology, Respiratory Medicine, Pain Services, Gastroenterology, Plastic Surgery, Sleep Studies, Dermatology, Rehabilitation Medicine, Endocrinology and Gerontology.
- Medical Specialist Outreach provides services to remote communities for Obstetrics, Adult, Eye clinics and Ear Nose and Throat clinics.

The completion of major works may lead to the provision of expanded services in some areas, particularly relating to:

- a new Emergency Department that has been recently opened
- a new 24 hour Medical Imaging Service and MRI
- redevelopment of ICU/HDU and maternity services.

Alice Springs Hospital will maintain its accreditation with an approved accrediting agency and take appropriate action on any recommendations made as part of its accreditation process.

#### Tennant Creek Hospital

Total active overnight beds: 20.

Tennant Creek Hospital will continue its role of providing hospital services to the Tennant Creek and Barkly regions.

The hospital will maintain its current range of clinical, diagnostic and support services including:

- 24-hour Accident and Emergency Care, Outpatients with visiting General Medical, Cardiology, Renal, Surgical and Paediatrics Specialists, General Practice clinic, Review Clinic, which covers recall patients, Chronic Diseases patients and Paediatric patients, Minor operations, Medical, Paediatric, Minor Surgical Inpatient services and Allied Health Outreach

- Antenatal, Postnatal and Emergency Midwifery services
- Renal Dialysis, Social Worker, Clinical Support services (Radiography, Pathology and Ultrasound)
- Aero Medical Retrieval and Medivac services
- Aboriginal Liaison.

Patients requiring services not available in Tennant Creek will be referred to Alice Springs Hospital through inter hospital transfers or the Patient Assistance Travel Scheme.

Tennant Creek Hospital will maintain its accreditation with the Australian Council on Healthcare Standards and take appropriate action on any recommendations made as part of this process.

### **3.2 Mental Health**

Mental Health will deliver agreed services to the Central Australia Health Service (CAHS) catchment population.

Mental Health is a specialist clinical service and will provide a multi-disciplinary approach to treatment and therapeutic intervention for people experiencing a mental illness or mental health problem in Central Australia. This will include assessment, treatment and clinical interventions to consumers of all ages presenting with moderate to severe disability associated with mental illness or mental health problems in urban and remote communities.

Priority access to services will be determined in accordance with clinical need, following a comprehensive assessment that includes assessment of risk. Inpatient and outpatient services will have a recovery focus with an emphasis on rehabilitation and relapse prevention. Mental Health will actively promote shared care planning and interagency collaboration in provision of its services.

A team of Consultant Psychiatrists and Registrars will undertake clinical assessment, provide diagnosis and offer psychiatric and medical advice through the Outpatient Clinic for patients referred from Primary care and General Practitioners.

The multi-disciplinary team based in Tennant Creek will support clients in the Barkly area.

Principles from the Department's Cultural Security agenda are in operation in Mental Health. Aboriginal and Torres Strait Islander (ATSI) people and individuals from other cultures will present with symptoms that are the result of, or behaviours which are mediated by, cultural factors. Consequently:

- in cases involving ATSI people, Aboriginal Mental Health Workers will contribute to the assessment process to determine a suitable service and culturally appropriate response
- in the case of culturally and linguistically diverse (CALD) people, Mental Health staff will ensure the involvement of appropriate cultural brokers to enhance assessment
- where language issues may influence interactions and assessments, accredited interpreters will be used.

## Community Mental Health Services

Comprehensive age-appropriate assessment, treatment, consultation liaison and case management services in the community will be provided to catchment population within CAHS. Outreach services to remote communities will be provided across Central Australia and include making services more accessible through telephone and video conferencing.

The Community Mental Health Team will also provide a 24 hour crises intervention, assessment and triage service available via a free-call phone number.

### Remote Mental Health Service

The Mark Sheldon Remote Mental Health Team, a multi-disciplinary team, will travel through Central Australia and work with local Remote Health Centres and other regional services to provide support to people with a mental illness, or who need assistance in maintaining their mental well-being.

### Child and Youth Mental Health

The Child and Youth Mental Health Team will provide assessment and time limited therapeutic support for children and young people up to the age of 18 years and their families, experiencing moderate to severe conditions affecting their mental health and well-being.

### Mental Health Sub-Acute Unit

The sub-acute facility will provide recovery focused care for clients in a residential setting. Six beds are available for clients for shorter term support and two beds are available for longer term supported accommodation clients.

## Forensic Mental Health Services (FMHS)

FMHS will be provided by TEHS and will cover Top End and Central Australian Health Services. This service' primary focus will be with people who have a mental disorder and become involved in the criminal justice system as a result of being charged with an offence. The team will work in the community and in the prison. A component of the team's work will involve the preparation of reports for the courts and the Parole Board. In addition to providing direct clinical services to adult prisoners with a mental health condition, Forensic Mental Health Team members will provide:

- education to Prison Officers on mental illness
- conduct group work, mental health education and skills development training for prisoners
- liaise with other key stakeholders to manage clinical support for clients on parole in the community.

## Acute Mental Health Inpatient Services

The Mental Health Unit has twelve beds for inpatient use, comprising eight beds for general use and up to four high dependency beds. The Mental Health Unit will provide inpatient services for people with mental illness needing structured intervention in an acute care hospital setting. Provision of services is for both voluntary and involuntary clients, as per the *Mental Health and Related Services Act*.

### 3.3 Aged Care Services

#### Aged Care Assessment Program (ACAP)

Through this program, CAHS will maintain/improve the independence and ability of older people to remain at home and, should this be required, exercise its Commonwealth delegation to approve people for admission to residential aged care facilities.

ACAP will continue to provide multi-disciplinary, comprehensive holistic assessments which include psychosocial, medical and functional aspects. Following assessments, ACAP will then recommend and coordinate appropriate services that meet clients, carers and family needs. This may include referral for home care supports, support to carers, approvals for Residential Respite and Community Aged Care Packages (CACP), Extended Aged Care at Home (EACH) and Transition Care.

ACAP will also provide education and training to clients, family, carers, external and internal service providers, build community capacity, gather electronic data, and identify gaps in services.

#### Home and Community Care (HACC) – Dementia Nurse

The Dementia Nurse located within the Alice Springs Aged Care Unit will assist in and coordinate the Dementia screening process of individuals where dementia is suspected, in conjunction with the client's General Practitioner (GP) and the Aged Care Assessment Team (ACAT) visiting specialist Geriatrician when available. The Dementia Nurse will also assist ACAT in the assessment of people with Dementia to be provided community services that will help them remain at home or to access residential aged care respite, community aged care packages or residential aged care placement.

The Dementia Nurse also provides education and support to people with dementia, their carers, family and other service providers, gathers electronic data, identifies gaps in service and maintains a reference library.

#### Home and Community Care Program Equipment Program for Older People in the Northern Territory

The Department has agreed to provide the following services on behalf of the Commonwealth until 30 June 2015:

- provision of equipment through the Disability Equipment Program (formerly Territory Independence and Mobility Equipment (TIME) Scheme)
- Allied Health Assessments through the adult disability teams in each region for older people in the Territory.

Under this agreement and a more detailed memorandum of agreement between the parties, CAHS and the Aged and Disability Program will jointly administer the equipment program, and conduct assessments for eligible HACC clients in both remote and urban regions; administer, install and repair the equipment; and report on the this activity.

#### Psychogeriatric Service

The provision by CAHS of the Psychogeriatric Service (PG Service) will improve the health, modify the experienced symptoms and enhance the function, behaviour and/or quality of life for a patient with mental health disorders and age-related organic brain impairment.

Complex PG Service case management will include comprehensive and ongoing assessment, counselling and goal focused therapies and developing clinical / collaborative pathways. There will also be a focus on client and carer advocacy and changing expectations of all stakeholders. This includes working to increase the capacity of providers of client care to maintain this client group successfully in their community

### 3.4 Primary Health Care

Primary Health Care (PHC) comprises five core functions<sup>1</sup>:

- 1) **Clinical services** delivered to individual clients and/or families in clinic, home or community settings including treatment, prevention and early intervention, rehabilitation and recovery, and clinical support.
- 2) **Health promotion**, being non-clinical measures to improve the health of the community, as a whole, such as healthy public policy, health information and education and community development.
- 3) **Corporate services and infrastructure** that support the provision of health services including workforce and financial management, administration, management and leadership, and systems for quality improvement.
- 4) **Advocacy, knowledge and research, policy and planning** such as health advocacy on behalf of clients, research and its application, and participation in policy and planning across the health system.
- 5) **Community engagement, control and cultural safety** to ensure cultural safety throughout the organisation, engagement of clients with their own healthcare, community participation in priority setting, program design and delivery, and community control and governance.

#### Primary Health Care Service Scope

The PHC services provided by the Central Australia Health Service encompass the following range of services from Domains 1 and 2 of the NTPHC Framework, noting that not all services will be provided at every PHC centre and some services will be provided outside the clinical setting. The services are largely captured in the clinical services core function, with the expectation that there will be appropriate investment in corporate services and infrastructure (core function 3) and relevant elements of community engagement, control and cultural safety (core function 5). (See Appendix 3 for a description of the service scope at each health centre/clinic.)

#### 3.4.1 Treatment

- First contact treatment of illness and injury using evidence-based standard treatment practices and protocols.
- Continuing management of chronic illness, including development and implementation of chronic disease management plans, support for self-care approaches, dispensing of medicines and monitoring for adverse effects.
- 24-hour after hours on-call service, including response to emergency incidents and access to the advice of a doctor either on site or via telecommunications.
- Provision of essential drugs including provision of medicine kits to designated holders.

<sup>1</sup> NT Aboriginal Health Forum, *Core functions of primary health care: a framework for the Northern Territory*, prepared by Edward Tilton Consulting and the Lowitja Institute, August 2011.

- Facilitate access to specialist and allied health treatment services in the community or through referral, including palliative care.
- Renal dialysis services.

### 3.4.2 Prevention and Early Intervention

- Maternal health services, including:
  - Remote Health and Remote Outreach Midwives, visiting ASH Midwives and Strong Women Workers
  - antenatal care including engagement of woman and family in routine reviews, coordination of access to external service providers and antenatal health education
  - facilitating access to birthing services
  - postnatal care for mother and baby.
- Child health services, including immunisation, nutrition, hearing health, developmental screening / follow up, action on all issues affecting child health.
- Screening and early detection of disease through appropriate health checks for infants, children, adults and older persons.
- Chronic disease management and prevention of complications.
- Immunisation programs.
- Communicable disease control actions including notifications.
- Delivery of brief interventions and support for and coordination with other health promotion approaches.

### 3.4.3 Rehabilitation and Recovery

- Care for clients following treatment or discharge from hospital or other institution (with support from external specialised services) including implementation of rehabilitation plans, follow up and care following alcohol and other drug treatment, and mental health recovery and relapse prevention.
- Use of case-management / case coordination approaches to ensure access to a full range of services to support patients in their rehabilitation and recovery, including regular assessment and review processes.

However some rehabilitation is not dealt with in PHC, i.e. pulmonary and stroke rehabilitation is dealt with in Alice Springs Hospital and cardio rehabilitation is contracted out.

## CAHS Primary Health Care Settings

The size and mix of services provided by CAHS PHC centres vary according to the size and health need of the population and the level of access to alternative PHC services such as GP practices and hospital emergency departments. This has resulted in three distinct PHC service settings in CAHS: urban, remote and prison PHC centres. Details of the numbers of each type of centre, population size, service mix and general scope of service provided are given in Appendix 3.

Should CAHS wish to significantly alter the scope or nature of any of these services, approval must be first sought from the System Manager. Approval by the System Manager will be dependent on provision of details regarding the basis for any proposed change and its broad impact on the community. This information should be provided to the System Manager no less than three months prior to the proposed date of the change.

## Schedule 4: Reports from Health Services – Safety, Quality and Risk

### 4.1 Cultural Security

The Department's Cultural Security Policy requires that the health services offered to Aboriginal Territorians by CAHS will respectfully recognise and respond to their cultural rights and values in service planning, delivery and evaluation.

CAHS commits to working collaboratively with the System Manager to ensure that systems and processes are in place to facilitate culturally secure health services by providing evidence that:

- Aboriginal communities and representatives are actively engaged in health service planning, delivery and evaluation
- health services offer and provide Aboriginal Territorians with language assistance services in their preferred language at all points of contact wherever possible
- staff are aware of the cultural security policies/initiatives and their implications for practice models/service delivery
- staff at all levels have access to and participate in cultural security /awareness training and education
- Aboriginal workforce initiatives are actioned to:
  - increase the number of Aboriginal people employed across all levels and professional streams
  - develop capacity of the existing Aboriginal workforce through training and career development opportunities.

### 4.2 Consumers

#### Consumer Feedback

CAHS will ensure there are mechanisms in place to monitor and evaluate consumer feedback and report back to the System Manager through their governance arrangements and ensure where there is any feedback of concern (that may attract significant media attention or substantial liability) is escalated to the CEO.

#### Reporting:

CAHS will provide the Department, as System Manager, with a quarterly report which presents the number of:

- complaints and compliments
- complaints finalised /outstanding by average time to closure/outstanding/waiting to be finalised
- complaints by severity rating.



### ***4.3 Reporting of Significant Risks and Action on their Mitigation***

To provide assurance of effective risk identification and mitigation, CAHS will adhere to the Department's Risk Management Policy.

#### **Reporting:**

CAHS will advise the System Manager of the identification of an extreme or very extreme risk that emerges and the proposed action to mitigate that risk, within two working days of when it has been identified. It will also advise the System Manager when the risk has been addressed to the point where its rating has reduced to an acceptable level and/or the risk has been fully resolved.

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## Schedule 5: Territory and Department Strategic Directions

### *5.1 Strategic Directions within which Services are to be Delivered*

[Health Promotion Strategic Framework](#)

[Smoke-free Policy](#)

[Chronic Disease Prevention and Management Strategy:](#)

[Northern Territory Public Hospital Charter: Patient's Rights and Responsibilities:](#)

[Cultural Security Policy](#)

[Stakeholder Engagement Framework 2012](#)

[Hospital Services Capability Framework](#)

[Renal Services Framework 2012-2017](#)

**NT Cardiac Framework**

[NT Cancer Plan 2013-2016](#)

Also the following strategies, to be released in 2014-15:

- NT Grant Management Framework including all policies and operating guidelines
- NT Contract Management Framework
- CAHS Clinical Services Plan
- NT Clinical Service Framework
- NT Health Strategic Plan
- Financial Management Framework
- Strategic Information Plan
- Capital Investment Plan.

### *5.2 Corporate Policies and Standards*

All Northern Territory Government and Department corporate policies and standards in relation to finance, [human resource management](#), procurement and related matters are to be adopted and implemented by CAHS, as required under the Act.

## Schedule 6: Support Services to Health Services

The CEO of the Department of Health will be responsible for providing specific areas of corporate support to the Health Services. This will principally be through the Corporate Support Bureau (CSB).

CSB has been established to better align the corporate support functions of the Department with the Health Services. The services to be provided by CSB will include:

- financial accounting services
- infrastructure services
- learning and development services
- workforce services
- reporting services (including management reports to support KPI monitoring)
- major contracting services
- media and communications services.

Other services to be provided by the CEO, outside of the CSB include:

- legal services
- research services.

A Customer Council has been established to monitor service provision and provide feedback on the quality and effectiveness of services provided by the CSB. CAHS will be represented on the Customer Council.

Service Level Agreements (SLAs) between branches of the CSB and CAHS have been put in place to clearly establish the scope and quality of services to be provided by the CSB to its customers. Other services will be developed as required.

## Schedule 7: Reporting Arrangements and Schedule

### 7.1 Accountability Reports Provided to CAHS

The System Manager will provide monthly and quarterly reports on KPIs to CAHS from its corporate systems, as detailed in the SDA schedules, according to the following schedule.

#### 7.1.1 Monthly reports

**6<sup>th</sup> to 8<sup>th</sup> day of month subsequent to actual activity recorded** (depending on weekends and public holidays) as shown below. Reports will include all KPIs in Schedules 1 and 2.

As at end of Month:	Scheduled Delivery Date
July	Wednesday 6 August (Monday 4 Picnic Day)
August	Monday 8 Sept
September	Tuesday 7 Oct
October	Thursday 7 Nov (also Quarterly Report on 13th)
November	Monday 8 Dec
December	Tuesday 7 Jan
January	Monday 9 Feb (also Quarterly Report on 12th)
February	Friday 7 March
March	Wednesday 8 April (Good Friday 3 and Easter Monday 6)
April	Wednesday 8 May (Monday 4 May Day) (also Quarterly Report on Tuesday 14)
May	Tuesday 9 June (Monday 8 Queens Birthday)
June	Tuesday 7 July

#### 7.1.2 Quarterly reports

The System Manager and CAHS will provide quarterly supplements to the monthly reports relating to analysis of KPI performance over the quarter. Quarterly Performance Reports will be provided within six weeks from the end of the quarter (i.e. mid November 2014; mid February 2014; and mid May 2015) to coincide with review meetings.

### 7.2 Information Reports for CAHS and System Manager

Monthly reports as per the relevant SLAs will be provided by the System Manager to inform the accountability and monitoring of KPIs for both parties.

### 7.3 CAHS Reports to System Manager

CAHS will provide reports to the System Manager on the elements outlined in Schedule 4: Quality, Safety and Risk and Schedule 5: Strategic Directions as follows:

### 7.3.1 Consumer Feedback Report

Quarterly: 14 November 2014, 14 February 2015, and 7 May 2015.

### 7.3.2 Risk Management

Notification to the System Manager, within two days of identification, of any very extreme or extreme risk that has been identified and the proposed action to mitigate that risk.

Notification of when the risk has been addressed to the point where it is an acceptable risk or fully resolved.

### 7.3.3 New Initiatives and Strategic Directions/ Strategic Plan

At minimum six monthly reports are to be supplied to the System Manager on **12 November 2014 and 13 May 2015**.

More frequent reports should be supplied if milestone reporting against the relevant project plan requires this.

## 7.4 *Other National Performance and Accountability Framework Indicators*

The following indicators may be included in future from the national framework as they are implemented nationally/resources become available. They will only be included if data is reportable in a timely fashion (within at least six weeks of the event) and the trend reported can be meaningful within a financial year.

- C Difficile infection rates
- Waiting times for cancer care
- Hospital standardized Mortality Ratio
- Death in low-mortality DRGs
- In hospital mortality rates for... (selected conditions)
- Relative stay index for multi-day stay patients
- Day of surgery admission rates for non emergency multi-day stay patients
- Percentage of asthma patients with a written asthma plan
- Age standardized mortality of potentially avoidable deaths
- Primary care type ED attendances

# Appendix 1 – Traffic Light KPI Tolerances

## Schedule 1.1 – Tier 1 KPIs

KPI	Target	Green	Amber	Red
Expenditure budget (\$'000s)	314,245,000	≤315,847,650	317,387,450 to 315,847,651	>317,387,450
Total NWAUs (including cross border)	46,988	≤47,228	47,458 – 47,229	>47,458

## Schedule 1.2 – Tier 1 KPIs

KPI	Target	Green	Amber	Red
Aged Care assessment program clients receiving timely intervention	91%	≥89.2%	<89.2 to 87.4%	<87.4%
Elective surgery waiting times – category 1: admission within 30 days	86.5%	≥84.8%	<84.8 to 83%	<83%
Elective surgery waiting times – category 2: admission within 90 days	77%	≥75.5%	<75.5 to 73.9%	<73.9%
Elective surgery waiting times – category 3: admission within 130 days	90.5%	≥88.7%	<88.7 to 86.9%	<86.9%
ED presentations departing within 4 hours	67%	≥65.7%	65.7 to 64.3%	<64.3%
Emergency department presentations seen in time:				
• category 1: resuscitation – attended to immediately	100%	100%		<100%
• category 2: emergency – attended to within 10 minutes	70.5%	≥69.1%	<69.1 to 67.7%	<67.7%
• category 3: urgent – attended to within 30 minutes	66%	≥64.7%	<64.7 to 63.4%	<63.4%
• category 4: semi-urgent – attended to within 60 minutes	65.5%	≥64.2%	<64.2 to 62.9%	<62.9%
• category 5: non-urgent – attended to within 120 minutes	92%	92%	<92-90%	<90%
Coded Separations Within Time	80% within 5 weeks	≥78.4%	<78.4 to 76.8%	<76.8%
National Safety and Quality Health Standards Compliance	100%	100%		<100%
SAB infections	0.92	≤0.92	>0.92-0.94	>0.94
Hand hygiene compliance	70%	≥68.6%	<68.6 to 67.2%	<67.2%
Additional Aboriginal Health Practitioner Full Time Equivalents (net of any losses during year)	4 FTE	4 FTE		< 4 FTE
Potentially Preventable Hospitalisations	9.6%	≤9.8	>9.8 to 10.0%	>10.0%
Adult Health Checks – proportion of resident remote Aboriginal population	65%	≥63.7%	<63.7 to 62.4%	<62.4%

## Schedule 2 – Tier 2 KPIs

KPI	Target	Green	Amber	Red
Aged Care Occasions Of Service	2545	≥2494	<2494 to 2443	<2443
Mental Health Community Follow Up Within First 7 Days Of Mental Health Inpatient Discharge	70%	≥68.6%	<68.6 to 67.2%	<67.2%
Mental Health 28 Day Readmissions	10%	≤10.2	>10.2-10.4%	>10.4%

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## Appendix 2 – KPIs – Brief Definitions

### National Weighted Activity Units (NWAUs)

An NWAU is a measure of activity that enables comparison and valuing of services, irrespective of the setting (e.g. admitted versus ED) in which they are delivered.

NWAUs weight activity for clinical complexity, taking into account patients whose conditions are more complicated to treat than others. If the average hospital service is worth one (1) NWAU, then more intensive and expensive services would be worth multiple NWAUs; with the simplest and least expensive being worth only a portion of an NWAU.

A number of adjustments form part of the calculated NWAU for each episode, such as remoteness and the Indigenous status of the patient. In addition, a zero (0) NWAU is calculated for episodes where the majority source of funding is from a non-health service revenue stream (e.g. Department of Veterans Affairs and insurance compensable).

An **acute admitted** NWAU is broadly determined by the price weight for the DRG assigned to the episode, and adjusted for one or more of the following factors:

- paediatric age
- Indigenous status of the patient
- remoteness of the patient's usual place of residence
- remoteness of the hospital
- specialist paediatric hospital
- Level 3 Intensive Care Unit (ICU)/Paediatric ICU care
- private patient (private health insurance or self-funded)
- specialist psychiatric age
- mental health patient.

The NWAU for **admitted sub-acute** separations is currently on a per diem basis and adjusted for one or more of the following factors:

- paediatric age
- Indigenous status of the patient
- remoteness of the patient's usual place of residence
- remoteness of the hospital
- private patient (private health insurance or self-funded).

An **emergency NWAU** is determined by the price weight for the Urgency Related Group assigned to the presentation adjusted for the Indigenous status of the patient.

A **non-admitted NWAU** is determined by the price weight for the Tier 2 clinic assigned to the service adjusted for the Indigenous status of the patient. There is a range of Tier 2 clinics which are assigned a NWAU of zero (0).



**Aged Care Assessment Program Clients Receiving Timely Intervention**

The percentage of clients assessed by an Aged Care Assessment Team (ACAT) who have a contact of a clinical nature (i.e. non-administrative) by an ACAT (or their representative) within the recommended time for the client's assessed priority category.

**Elective Surgery Waiting Times by Urgency Category**

The percentage of patients removed from the elective surgery waiting lists who received surgery within the clinically recommended time, by urgency category.

**Emergency Department Presentations Departing within 4 Hours**

The percentage of all presentations to ED where the length of the emergency department stay, is  $\leq 4$  hours (i.e.  $\leq 240$  minutes).

**Emergency Department Presentations Seen in Time**

Percentage of patients who are treated within national benchmarks for waiting times for each triage category in emergency departments.

**Coded Separations within Time**

The proportion of all separations which have been clinically coded within the required time.

**National Safety and Quality Health Standards Compliance**

The current level of compliance resulting from a formal accreditation assessment of the NSQHS standards by an approved accrediting agency, for the reference period.

**Hand Hygiene Compliance**

The rate of correctly performed hand hygiene actions observed for a hospital or health service during a hand hygiene audit.

**Aboriginal and Torres Strait Islander Health Practitioner Employment Growth**

Additional Aboriginal and Torres Strait Islander Health Practitioner Full Time Equivalent employment within the time period (net of any resignations or dismissals).

**Aged Care Occasions of Service**

The number of occasions of service provided by the Aged Care Service area.

**Mental Health Community Follow Up within First 7 Days of Mental Health Inpatient Discharge**

The proportion of patients separating from public acute mental health inpatient units for which a mental health community service contact was recorded in the seven days following the separation.

**Mental Health 28 Day Readmissions**

The proportion of separations from public acute mental health inpatient units that are followed by readmission to the same or to another public acute mental health inpatient unit within 28 days of discharge.

**Potentially Preventable Hospitalisations**

Admissions to hospital that could have potentially been prevented and managed through the provision of appropriate non-hospital health services. Includes vaccine preventable, chronic and acute conditions.

(Further details are available in the full Technical Definition Compendium available through the System Performance Branch of the Department of Health.)

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## Appendix 3 – Central Australia Health Service Primary Health Care

### Services Provided at Remote Health Centres

Health Centre Location	No in catchment	A&E response /medevac 24/7	Primary health care	Ante natal care	Healthy School aged kids program	Healthy Under 5 Kids program	Childhood & adult Immunisation	Well Women's & Men's health screens	Preventable chronic conditions program	Infectious disease prevention and control	Opening times for health services		
											Monday to Friday (no weekends or PH)	Closed for admin	24hr On-call
Wallace Rockhole	117	✓	Visiting Services from Hermannsburg										✓
Ali Curing	830	✓	✓	✓	✓	✓	✓	✓	✓	✓	0900-1900	Fri pm	✓
Docker River	370	✓	✓	✓	✓	✓	✓	✓	✓	✓	0800-1200/ 1300-1700		✓
Haast's Bluff	180	✓	✓	✓	✓	✓	✓	✓	✓	✓	0800-1200/ 1300-1700		✓
Hart's Range	236	✓	✓	✓	✓	✓	✓	✓	✓	✓	0800-1300/ 1400-1700		✓
Bonya	63	✓	Visiting services from Harts Range										✓
Hermannsburg	66	✓	✓	✓	✓	✓	✓	✓	✓	✓	0900-1700	Thu pm	✓
King's Canyon	140	✓	✓	✓	✓	✓	✓	✓	✓	✓	0830-1200/ 1300-1630	Thu pm	✓

Health Centre Location	No in catchment	A&E response /medevac 24/7	Primary health care	Ante natal care	Healthy School aged kids program	Healthy Under 5 Kids program	Childhood & adult Immunisation	Well Women's & Men's health screens	Preventable chronic conditions program	Infectious disease prevention and control	Opening times for health services		
											Monday to Friday (no weekends or PH)	Closed for admin	24hr On-call
Lake Nash	570	✓	✓	✓	✓	✓	✓	✓	✓	✓	0800-1300 /1400-1600		✓
Aputula	220	✓	✓	✓	✓	✓	✓	✓	✓	✓	0800-1200/1300-1700		✓
Imanpa	120	✓	✓	✓	✓	✓	✓	✓	✓	✓	0800-1200/1300-1700		✓
Nyirripi	192	✓	✓	✓	✓	✓	✓	✓	✓	✓	0830-1630		✓
Papunya	361	✓	✓	✓	✓	✓	✓	✓	✓	✓	0800-1700	-	✓
Willowra	246	✓	✓	✓	✓	✓	✓	✓	✓	✓	0900-1200/1400-1700	Thu pm	✓
Yuelemu	227	✓	✓	✓	✓	✓	✓	✓	✓	✓	0800-1700	Thu pm	✓
Yuendemu	772	✓	✓	✓	✓	✓	✓	✓	✓	✓	0800-1700	Thu pm	✓
Yulara	3500	✓	✓	✓	✓	✓	✓	✓	✓	✓	0830-1630	Thu pm	✓
Mt Liebig	185	✓	✓	✓	✓	✓	✓	✓	✓	✓	0800-1700	Thu pm	✓
Titjikala	250	✓	✓	✓	✓	✓	✓	✓	✓	✓	0800-1630		✓

Health Centre Location	No in catchment	A&E response /medevac 24/7	Primary health care	Ante natal care	Healthy School aged kids program	Healthy Under 5 Kids program	Childhood & adult Immunisation	Well Women's & Men's health screens	Preventable chronic conditions program	Infectious disease prevention and control	Opening times for health services		
											Monday to Friday (no weekends or PH)	Closed for admin	24hr On-call
Tara	66	✓	✓	✓	✓	✓	✓	✓	✓	✓	0800-1700		✓
Wilora		✓	Visiting services from Tara										✓
Ti-Tree	227	✓	✓	✓	✓	✓	✓	✓	✓	✓	0800-1700		✓
Ti-Tree 6 mile		✓	Visiting services from Ti Tree										✓
Elliott	300	✓	✓	✓	✓	✓	✓	✓	✓	✓	0830-1630	Thu pm	✓
Alcoota	240	✓	✓	✓	✓	✓	✓	✓	✓	✓	0800-1700	Thu pm	✓
Epenarra	159	✓	✓	✓	✓	✓	✓	✓	✓	✓	0800-1700		✓
Canteen Creek		Visiting services from Epenarra										✓	
Laramba	226	✓	✓	✓	✓	✓	✓	✓	✓	✓	0800-1700		✓

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**Community Health Services Provided in Urban and Regional Centres**

Community Care Centre / Service location	Primary Health Care	Healthy Under 5 Kids Partnering -Families Program	Childhood & Adult Immunisation	Well Women's & Men's Health Screens	Specialist Nursing Service	Service Hours	
						Monday to Friday Only	After-hours on-call
Flynn Drive Alice Springs	✓	✓	✓	✓	✓	0800-1630	✓
Tennant Creek	✓	✓	✓	✓		0800-1200/1300-1630	

Service coverage	Outreach Child, Youth and Family Services / School based services				
	Healthy Under 5 Kids - Partnering Families Program	School Health Service	School Immunisation Program	School Screening Service	Service Hours Mon-Fri
Alice Springs and suburbs	✓	✓	✓	✓	0800-1630
Tennant Creek	✓	✓	✓	✓	0800-1630

**Prison Primary Health Care Services**

Services and Delivery Location	Alice Springs Correctional Centre Health Centre – men and women	G Block (maximum security)	Cottages Clinic (low security)	Juvenile Detention Centre	Aranda House (overflow)	Police Watch House	Approximate split of Full Time services (%)
Early Intervention and Reception	✓	✓	✓	✓	✓	✓	20
Treatment and Emergency Care	✓	✓	✓	✓	✓	✓	50
Health Promotion and Health Protection	✓	✓	✓	✓	✓	✓	5
Rehabilitation / Chronic Disease Prevention	✓	✓	✓	✓	✓	✓	12
Specialist Referral	✓	✓	✓	✓	✓	✓	5
Dept/NTDCS staff Education	✓	✓	✓	✓	✓	✓	3
Prison Health Administration	✓	✓	✓	✓	✓	✓	5
After Hours on-call and Emergency	✓	✓	✓	✓	✓	✓	N/A

Visiting Services							Frequency
Physiotherapy	✓	✓	✓	✓	✓	✓	As required
Podiatry	✓	✓	✓	✓	✓	✓	As required
Optometry	✓	✓	✓	✓	✓		5hrs/month main prison, remainder as required

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