AMSANT Annual Report 2014–2015


Marthakal Homeland Resource Centre (Galiwin'ku)
Ngalkanbuy Health (Galiwin'ku)
Balunu Foundation
Danila Dilba
Darwin
Malabam Health (Maningrida)
Nhulunbuy
Miwatj Health
Council for Aboriginal Alcohol Program Services (CAAPS)
Jabiru
Red Lily Health Board
Laynhapuy Homelands Association
Katherine
Katherine West
Sunrise Health
Wurli Wurlinjang
Tennant Creek
Anyinginyi Health
Ampilatwatja Health
Western Desert Nganampa Walytja Palyantjaku Tjutaku Aboriginal Corporation (Walungurru/Kintore)
Urapuntja Health
Ngaanatjatjara Pitjantjatjara Yankunyatjara Women's Council
Alice Springs
Central Australian Aboriginal Alcohol Program Unit (CAAAPU)
Pintupi Homelands (Walungurru/Kintore)
Western Aranda Health (Ntaria)
Amoonguna Health
Mpwelerre Health (Santa Teresa)
Utju Health (Areyonga)
Central Australian Aboriginal Congress
Mutitjulu Health

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AMSANT:
BUILDING
LEADERSHIP

Who is AMSANT?

The Aboriginal Medical Services Alliance Northern Territory (AMSANT) is the peak body for Aboriginal community controlled health services (ACCHSs) in the NT and advocates for equality in health, while supporting the provision of high-quality comprehensive primary health care services for Aboriginal people.

Since 1994, AMSANT has developed health policy and provided practical solutions to the development of community control, especially in the areas of eHealth, public health, workforce issues, research and communications. AMSANT has 26 member services throughout the Northern Territory.

AMSANT is committed to the principles of community controlled primary health care as set out by the National Aboriginal Health Strategy (1989) as essential to improving the health status of Aboriginal and Torres Strait Islander people. The principles encompass:

- a holistic view of health care which includes physical, social, spiritual and emotional health of people.
- capacity-building of community-controlled organisations and the community itself to support local and regional solutions or health outcomes.
- local community control and participation.
- partnering and collaborating across sectors.
- recognising the inter-relationship between good health and the social determinants of health.

From the Chair

The past year has seen major milestones achieved by AMSANT.

AMSANT's 20th anniversary and 40 years of Aboriginal community controlled health services in the Territory were celebrated in a landmark conference in Alice Springs in November—*Our Health, Our Way*.

The journey we have travelled over those years has been an extraordinary one, and our record of achievement, progress and innovation was well reflected in the many presentations from our member services. It was also an opportunity to hear from the leaders and architects of our sector.

It was an inspiring and positive event that didn't simply dwell on past achievement, but outlined for us the strategic and practical challenges ahead.

I am pleased to report the completion of our governance reform process aimed at strengthening AMSANT's ability as an organisation to achieve our objectives. AMSANT's new rule book was approved by members at a Special General Meeting in Katherine in June 2015 and an interim Board elected. The new constitution enables the Board to appoint non-Member Directors. This

From the Chair

completes our reincorporation under the Commonwealth Corporations (Aboriginal and Torres Strait Islander) Act 1996 (CATSI Act).

Complementing AMSANT's new constitution is our new Strategic Plan 2015–2018 that will provide AMSANT with a strong platform and direction for its work over the next three years.

AMSANT's engagement in collaborative planning with the Commonwealth and NT Governments through the NT Aboriginal Health Forum continues to be a priority as an important mechanism in achieving better primary health care services and improved health outcomes for our people.

This year Forum set up a Pathways to Community Control Working Group to progress opportunities to expand community control of health services, and to guide the transition of those services to community control.

AMSANT also prepared, on the invitation of Assistant Minister Nash, and on behalf of Forum, a business case for the three agreed community control regionalistion priority areas, East Arnhem, West Arnhem and Alyawarr, to enable the release of held-back Commonwealth funding. We look forward to this funding enabling these regions to make significant progress over the coming year.

AMSANT has continued to engage constructively with the ongoing reforms to health and Indigenous affairs at the Commonwealth level, and the AMSANT secretariat has worked closely with the Department of Health on reforms to our sector. We were heartened to see the scrapping of the proposal to introduce a $7 copayment for GP consultations and other services.

A further milestone has been the successful transition of the Northern Territory Medicare Local, in which AMSANT was uniquely a one third shareholder, to the new Territory PHN, Health Network Northern Territory, which retains the same membership structure.

Particular thanks must go to my fellow Board members for their contribution and support; to our CEO, John Paterson, and to all the AMSANT staff for their hard work and dedication over the year.

Marion Scrymgour

Chairperson

From the CEO

This year afforded me the great privilege as CEO to lead the celebration of AMSANT's 20th anniversary and 40 years of Aboriginal Community Controlled Health Services in the Northern Territory. AMSANT's *Our Health, Our Way* Conference in Alice Springs, showcased our achievements as a sector, the innovation and skill of our member services, and the dedication of our combined staff to our mission.

The conference punctuated what has been a characteristically busy and challenging year for AMSANT that has seen the completion of our incorporation under the CATSI Act and the development of AMSANT's new Strategic Plan 2015–2018.

We have continued work with NACCHO and the Commonwealth Rural and Indigenous Health Division on developing a new Standard Funding Agreement (SFA) and a set of key performance indicators to enable better measurement of the outcomes of the work of State and Territory Peak bodies. The Commonwealth has also announced a review of the roles and functions of NACCHO and the State and Territory Peaks in the coming year and has engaged us in developing the terms of reference for the review.

From the CEO

Other significant developments during the year included providing input into the development of the Aboriginal and Torres Strait Islander Health Plan Implementation Plan and responding to the Indigenous Advancement Strategy tender process.

During the year we have met with the Assistant Minister Nash and also Shadow Minister Catherine King, along with NT Health Ministers and Shadow Minister.

We have continued to develop our capacity to proactively engage with Aboriginal health research and to support our members in this sphere—a constant challenge given that we are not funded for this role. However, we view it as essential to our commitment to ensuring that Aboriginal communities become the directors of research rather than passive recipients and subjects.

We maintain strong partnerships with health research bodies, principally the Lowitja Institute along with Baker IDI, Menzies School of Health Research and others. Many of these are also partners in the Central Australian Academic Health Science Centre consortium, of which I am the Chairperson.

With the successful launching of the new NT Public Health Network from 1st July 2015 under transition conditions, AMSANT has worked with the other shareholders as part of a steering committee overseeing the development of the new constitution and structure for the new body.

Our dedicated staff have continued to achieve impressive outcomes in the diverse programs and activities that AMSANT delivers: providing support to our member services, from CQI to accreditation, eHealth and workforce support; key events such as hosting a workshop for the Mental Health Commission and organising an Early Childhood Forum; to working with intersectoral partners such as the Kidney Action Network and APO NT.

We can be proud of the work AMSANT has achieved and I thank my staff for their dedication and high quality work, and the AMSANT Board for their strong leadership and support.

John Paterson

CEO

What is 'community control'?

According to the AMSANT Constitution, a community controlled organisation must:

- Be incorporated as an independent legal entity.
- Have a constitution which guarantees control of the body by Aboriginal people and ensures that it will function under the principle of self-determination, and
- Have compulsory accountability processes, including the holding of annual general meetings which are open to all members of the relevant Aboriginal community, and the regular election of management committees.

AMSANT promotes the development of community control, which enables people who are going to use health services to determine the nature of those services, and then participate in the planning, implementation and evaluation of those services.

> Community control is the local community having control of issues that directly affect their community. Implicit in this definition is the clear statement that Aboriginal people must determine and control the pace, shape and manner of change and decision making at [all] levels.
>
> (National Aboriginal Health Strategy, 1989, xiv)


Closing the Gap through
people

The AMSANT constitution

The governance reform process led by the AMSANT Board culminated in the past year with the endorsement of a new Constitution and completion of the process of incorporation of AMSANT under the Commonwealth Corporations (Aboriginal and Torres Strait Islander) Act of 1996.

The new Constitution introduces a number of significant changes to the objectives, membership and governance of the Corporation, including the adoption of Individual Members and non-Member Directors.

Objectives

The primary objects for which the Corporation is established are:

- To promote the health and wellbeing of Aboriginal people of the Northern Territory. Through strong advocacy, support the delivery of culturally appropriate health services for Aboriginal people and their communities.
- To advocate and promote through our Member services, culturally safe research into causes and remedies of illness and ailments found within the Aboriginal population of the Northern Territory.
- To continue to advocate for, and support, Aboriginal self-determination and to establish and grow the Aboriginal Community Controlled Health Sector in the Northern Territory.
- To alleviate the sickness, destitution, suffering and disadvantage, and to promote the health and wellbeing of Aboriginal people of the Northern Territory.

To assist in achieving its primary objects, the Corporation will endeavour to:

- Promote cultural awareness and integrity of Aboriginal Community Controlled comprehensive primary health care.
- Serve as a peak body for Aboriginal Community Controlled Health Services in the Northern Territory.
- Drive the agenda and advocate for positive change to the status of the health of Aboriginal people of the Northern Territory.
- To operate and maintain a gift fund to be known as 'The AMSANT Indigenous Corporation Gift Fund' in accordance with the requirements of the Income Tax Assessment Act 1997.
- Respect the views and protect the rights and interests of Members.

The AMSANT constitution

Membership

AMSANT has three classes of membership: Full Members, Associate Members and Individual Members.

General Meetings

General meetings are open to all AMSANT Full Members, Associate Members and Individual Members. Each Full Member is entitled to appoint one Designated Representative to attend and vote at general meetings on its behalf. Associate Members and Individual Members are entitled to attend general meetings, but are not entitled to vote. A number of general meetings are held each year, with an Annual General Meeting held once a year. General meetings are generally held either in Darwin or Alice Springs because they are the easiest places for members to get to, although other places may host meetings from time to time.

General meetings are usually held to discuss current issues facing AMSANT and its members and to determine what action needs to be taken to advance community control and Aboriginal health. AMSANT ordinarily works on consensus decision making, attempting to get agreement from all representatives on a particular policy or course of action.

The AMSANT Board

The AMSANT Board is made up of up to eight member Directors elected by the Full Members, and may also appoint up to three non-Member Directors.

(The structures and functions of AMSANT are set out in the Constitution, copies of which are available from our Darwin office or at www.amsant.org.au.)

AMSANT Strategic Plan 2015–2018

During the year AMSANT's Operational Plan was replaced by a new three-year Strategic Plan 2015–2018, developed by the AMSANT Board and staff. The new Strategic Plan will provide a more effective foundation for supporting member services, promoting the benefits of the Aboriginal Community Controlled Health sector and, ultimately, achieving better health outcomes for our communities. The new plan focuses AMSANT's strategic priorities through six Goals.

Strategic Priorities

Goal 1

Greater access to community controlled comprehensive primary health care services

1. Promote the Aboriginal community controlled health sector's model of comprehensive primary health care
2. Play a leadership role in the ongoing reform of Aboriginal primary health care, working through the NT Aboriginal Health Forum and other forums
3. Support emerging auspiced community controlled government services and communities that want to transition to community control
4. Develop and contribute to system wide clinical and public health initiatives, business systems and continuous quality improvement.

Goal 2

Strong and supported AMSANT members

1. Plan, coordinate and deliver support services that meet the needs of members and prioritise those most in need
2. Provide leadership and support to members to strengthen financial management, business management, and governance systems
3. Support members to improve and maintain information systems
4. Support members to implement national initiatives
5. Improve reporting and documentation of member support activities
6. Share ideas, resources and data across the sector to promote best practice and innovation.

Goal 3

Skilled and sustainable workforce

1. Develop and contribute to planned workforce development strategies in collaboration with key stakeholders
2. Promote initiatives that increase the recruitment, retention and training of Aboriginal people and support career pathways
3. Strengthen leadership in Aboriginal health, including through identifying and supporting emerging leaders.

Goal 4

Effective relationships and cooperation

1. Proactively engage with government on policy and program priorities
2. Strengthen cooperative partnerships with key stakeholders, contributing expertise and advice on Aboriginal health care
3. Build AMSANT profile, reputation and brand, drawing on 40 years demonstrated success in Aboriginal community controlled health care
4. Implement marketing, communications and media relations strategies to support engagement with key stakeholders and advance AMSANT's objectives.

Strategic Priorities

Goal 5

Health care is informed by research and data and fosters innovation

1. Build an evidence base of what works in Aboriginal health, underpinned by quality research and data
2. Use research and data to demonstrate value and effectiveness of the sector and advocate for change
3. Form strong research partnerships and collaborations to maximise value
4. Support member organisations to make better use of data to improve service planning and delivery.

Goal 6

Strong, sustainable and accountable organisation

1. Enhance AMSANT corporate governance to better manage risk and deliver on the organisation's objectives
2. Increase sustainability through effective financial management and strategies to grow and diversify funding
3. Support and develop AMSANT's workforce through effective HR management practices
4. Align and improve business structures, processes and systems
5. Ensure effective strategic and operational planning and reporting mechanisms are in place to manage change, growth and development.


OUR
HEALTH
OUR
WAY

Our Health, Our Way
Celebrating 20 years of AMSANT

In November 2014 more than 300 people met in Alice Springs to reflect on 20 years of AMSANT's achievements in health and to discuss strategies for the promotion and expansion of Aboriginal community controlled health services in the Northern Territory, at a time of great political and financial uncertainty across the sector.

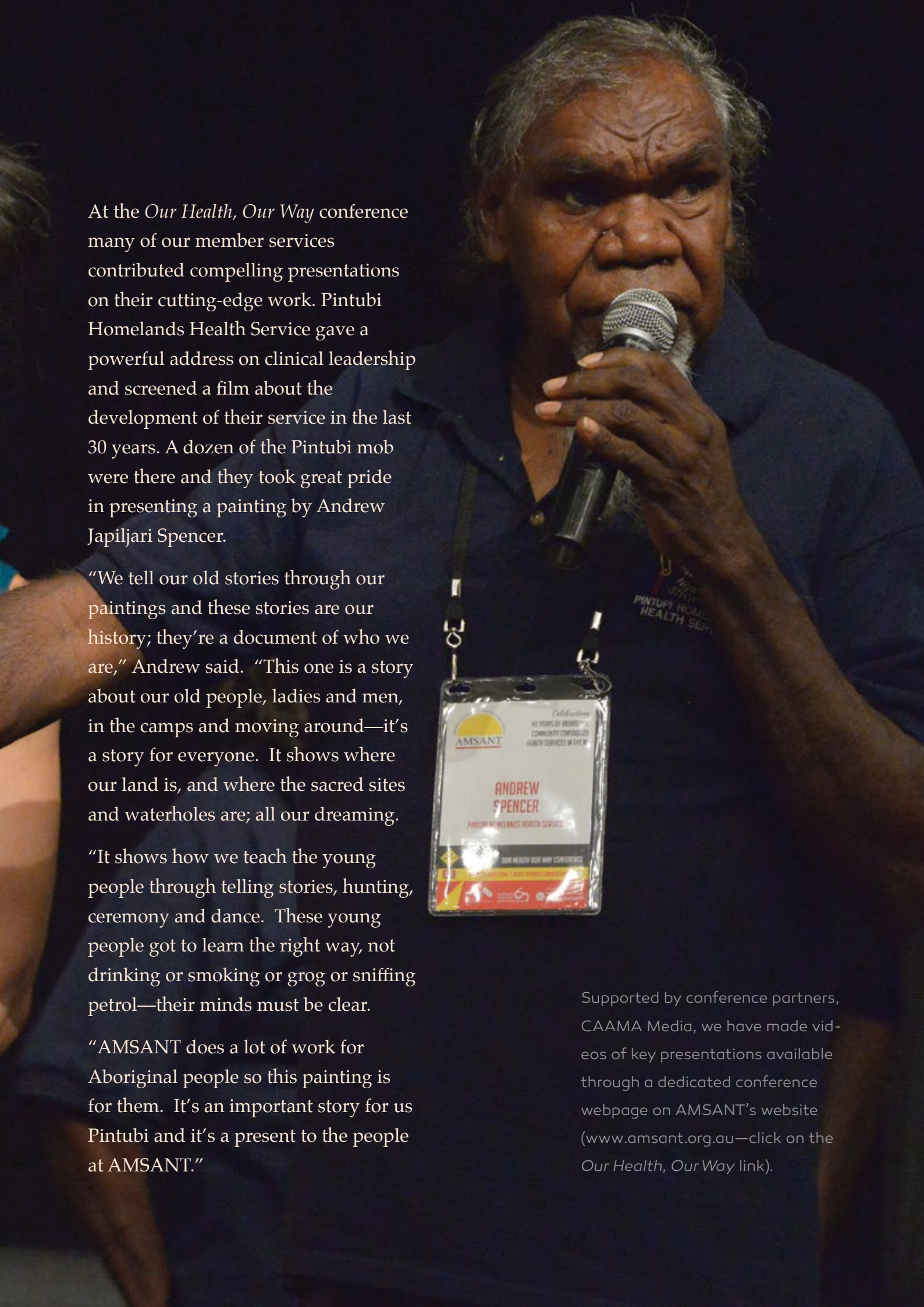
Aboriginal Health Practitioners (AHPs), administrators, nurses, doctors, patients, policy officers, CEOs, academics, bureaucrats and politicians joined a broad two-day *Our Health, Our Way* program that outlined the clinical, cultural and practical evolution of Aboriginal comprehensive primary health care, while mapping a way forward for the sector.

Great leaders and early architects of the sector like Pat Anderson, Marion Scrymgour, John Liddle and Donna Ah Chee addressed the meeting with deep pride and spoke of the need to remain resolute in these difficult times and to increase our advocacy for positive change. They acknowledged the role that new Aboriginal leaders will play in the sector and called for united action in advocacy, policy development and clinical progress.

Counselling against complacency, AMSANT's first executive officer, Pat Anderson, told the meeting "We need to increase our advocacy of community control through the media and to involve our many allies, right across all areas of society … Whatever happens, we've got to keep the passion strong and the fire in our bellies!"

Our Health, Our Way was both a critical assessment of community control and a call-to-arms to the sector—AMSANT begins its next 20 years with the strong backing of its member services and a growing reputation as a key player in national Aboriginal health reform.

Andrew Japiljari Spencer presents the Pintubi painting to Donna Ah Chee, AMSANT Board member and CEO of the Central Australian Aboriginal Congress.



At the *Our Health, Our Way* conference many of our member services contributed compelling presentations on their cutting-edge work. Pintubi Homelands Health Service gave a powerful address on clinical leadership and screened a film about the development of their service in the last 30 years. A dozen of the Pintubi mob were there and they took great pride in presenting a painting by Andrew Japiljari Spencer.

"We tell our old stories through our paintings and these stories are our history; they're a document of who we are," Andrew said. "This one is a story about our old people, ladies and men, in the camps and moving around—it's a story for everyone. It shows where our land is, and where the sacred sites and waterholes are; all our dreaming.

"It shows how we teach the young people through telling stories, hunting, ceremony and dance. These young people got to learn the right way, not drinking or smoking or grog or sniffing petrol—their minds must be clear.

"AMSANT does a lot of work for Aboriginal people so this painting is for them. It's an important story for us Pintubi and it's a present to the people at AMSANT."

Supported by conference partners, CAAMA Media, we have made videos of key presentations available through a dedicated conference webpage on AMSANT's website (www.amsant.org.au—click on the *Our Health, Our Way* link).

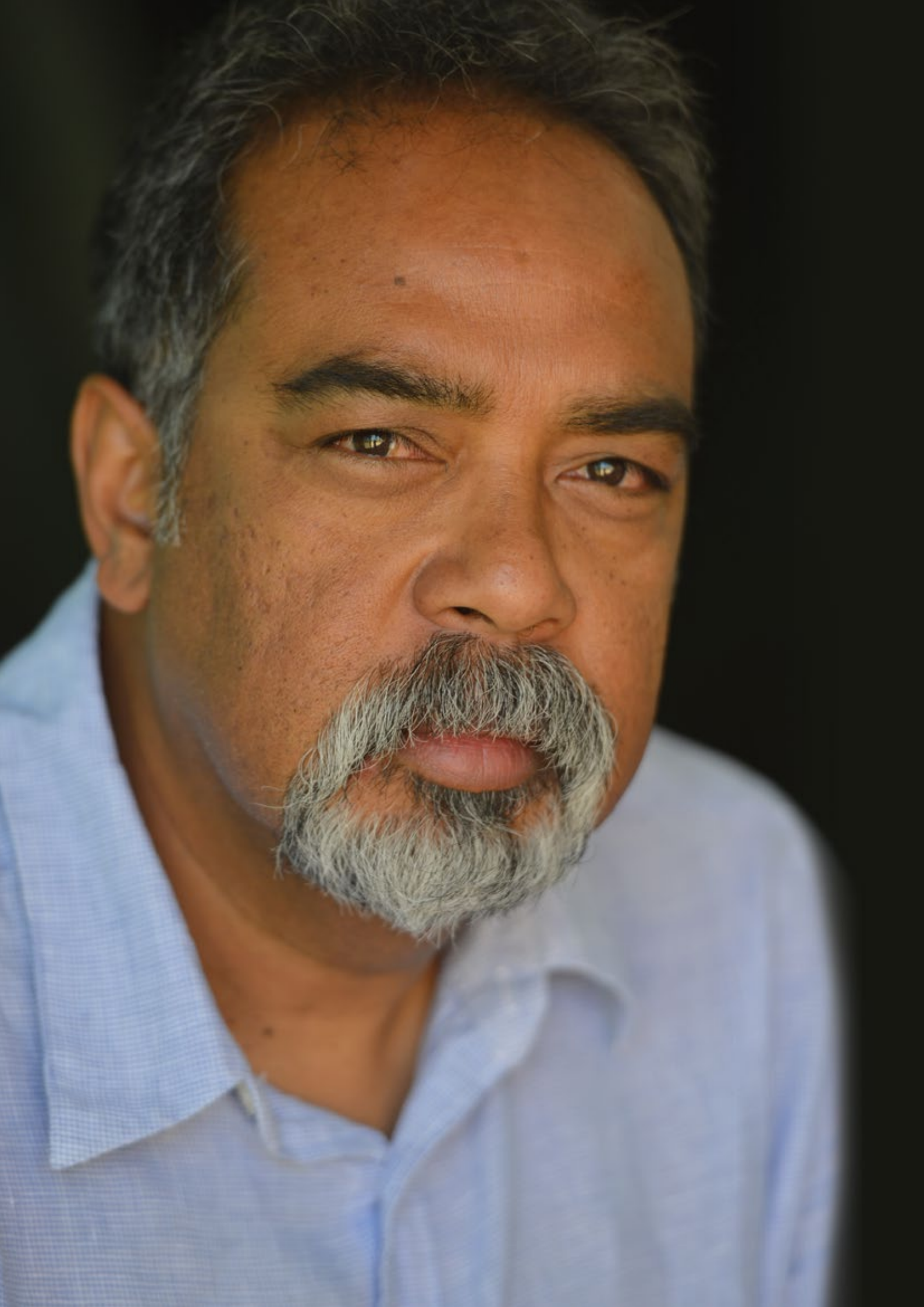
“Whatever happens, we’ve got to keep the passion strong and the fire in our bellies.”

Pat Anderson addresses the conference about AMSANT’s early years.


ABORIGINAL MEDICAL SERVICES ALLIANCE NORTHERN TERRITORY
AMSANT
Our health
Our way
OUR
HEALTH

“The best clinics and health services in the Territory are community controlled and staffed with Aboriginal people—it just sticks out like a sore thumb!—so we need to continue the transition to community control as a priority.”

Robyn Lambley MLA, NT Health Minister.



“Community controlled health promotes a deep sense of obligation that you just don’t find in the commercial world—it’s multi-dimensional in space and time. In this way, people have a deep ownership of their services and a certain empowerment and connection.”

Romlie Mokak, CEO, Lowitja Institute.

Regionalisation
Pathways to Community Control

Pathways to Community Control is a policy framework endorsed by the NT Aboriginal Health Forum (the Forum) in 2008 which guarantees a cross-sector commitment to improving the access and quality of comprehensive primary health care through AMSANT's member services.

Regionalisation is the mechanism by which the Pathways to Community Control policy is being implemented across Aboriginal communities in the Territory. Regionalisation establishes agreed health service delivery areas (HSDAs) each with a defined geography, linked by cultural practice and language. In a regionalised HSDA, community services, such as health clinics, are under an Aboriginal-controlled regional health board.

AMSANT remains strongly committed to regionalisation and continues to advocate at all levels of government for community control. Several of AMSANT's member services are making good headway with developing regional HSDAs, despite the sometimes inconsistent support given by NT and Commonwealth governments.

In late 2014 the Forum strengthened its efforts in this area by establishing a working group to further promote community control. The working group gives advice to Forum on the transfer of NT Government health services to community control, and other associated regionalisation matters.

The working group has set up a shared action plan to direct its activities in the coming financial year, under the direction of the Forum, in three priority HSDAs: East Arnhem, West Arnhem and Alyawarr. Further regions will be identified for development in the next twelve months.

AMSANT's members of the working group have been strong advocates for the recognition and support of Aboriginal leadership and participation in regionalisation processes. AMSANT's representatives are Graham Dowling, Paula Myott and Geeta Cheema who maintain liaison with Aboriginal boards and executives in the priority regions. Working group meetings have been scheduled in West Arnhem and Alyawarr regions as an opportunity to engage with communities.

In another related initiative AMSANT has facilitated the development of a three-year business case in the priority HSDAs at the request of Senator Fiona Nash, the federal Assistant Minister for Health. The business case has been endorsed by the AMSANT Board and the community controlled Boards in each of the priority HSDAs. At the time of publication, the Commonwealth Government had not yet committed funds to support the AMSANT-led business case.

AMSANT will continue to support the regionalisation aspirations of our member services and to provide strong advocacy for better health care and health outcomes for Aboriginal people.

Central Australia and Barkly office

In early 2015 the Central Australia & Barkly AMSANT office moved to a new location on the second floor of the Yeperenye Shopping Centre in Alice Springs. At this location we are better able to host the member services when they visit town and to facilitate community meetings of importance to Aboriginal people.

The Central Australia & Barkly team, led by Graham Dowling, provides a wide range of support services to our members including: public health, e-health, continuous quality improvement, accreditation, workforce, media and leadership. Our team runs on-going programs, provides training and networking opportunities, and is always accessible for advice by phone, email or face-to-face meetings.

The Central Australia & Barkly office plays a key role in engaging with member services to ensure that AMSANT remains well-connected to community needs and aspirations. Staff are involved with strategic initiatives within AMSANT and with a growing range of external partners.

Public Health

Communication with clinicians

In the past year AMSANT continued to operate a senior clinicians' network. We use this network to inform leading clinicians about important clinical system changes and to obtain feedback on key system issues such as patient assisted transport and specialist outreach. We also have regular teleconferences on important clinical issues to a broader network of clinicians in both the community and government sector. Our meetings are recorded to make them accessible to clinicians working in the field who are often too busy to get to teleconferences.

There has been focused support to some smaller ACCHSs that do not have as much capacity in the area of public health, clinical leadership and system development because of their size. This input has been strengthened by clinicians undertaking locum placements in member services.

AMSANT has also provided input into Clinical and Public Health Advisory Groups (CPHAGs), particularly in East Arnhem and the Barkly.

System issues

AMSANT's public health team provides input from the community controlled perspective to committees operating across various clinical issues including ear and eye, sexual health, renal, prison health and rheumatic heart disease. The team had significant input into reform in these areas including hepatitis B testing and management, cardiac care/rehabilitation and point-of-care.

System changes and reform in key clinical specialist areas were largely driven by the NT Department of Health however, critically, AMSANT contributes to the process by giving practical feedback from our health services. Point-of-care testing using the I-stat machine (a portable clinical analyser) provides immediate results for blood tests that normally require the specimen to be sent to pathology—which can take many

days in remote sites—and identifies potential heart attacks. The use of I-stats has, thus far, been limited in our sector because of a lack of funding for quality assurance and training. However, we believe expanded funding may soon be made available to support services in the provision of point-of-care.

Hepatitis B can cause cirrhosis and liver cancer and occurs at a higher rate in Aboriginal people in the NT than in mainstream Australia, and we have been vaccinating children in the NT since 1990. Many people infected with hepatitis B become chronic carriers, especially if they were infected at birth. Clinicians need special training to be able to provide treatment and only a minority of Aboriginal people who would benefit from this treatment are receiving it. Therefore, AMSANT is working with the NT Health Department to better detect and manage this chronic infection through the provision of education to doctors in our sector.

Policy, advocacy and research

The public health unit continues to contribute our ideas and strategies to major policy issues including reviews and inquiries into General Practice training and incentives; health policy and expenditure; and the Community Pharmacy agreement. We provided input to the draft National Framework for Health Services for Aboriginal and Torres Strait Islander Children & Families as well as to APONT's (Aboriginal Peak Organisations NT) submission to the government inquiry into the misuse of methamphetamine, or 'ice'.

We also strongly advocated on issues around poker machine numbers and securing continued funding from the NT and Commonwealth governments for the adolescent sexual education program. Advocacy on renal issues continued through AMSANT membership of the Kidney Action Network and through direct lobbying. Unfortunately, the dialysis system is still under significant strain, particularly in Central Australia and

Public Health

the Barkly. However, there has been welcome news recently with both Commonwealth and NTG funding for considerable expansion of nurse-assisted dialysis.

AMSANT participates in research partnerships in the areas of diabetes in pregnancy and sexual health. New research partnerships funded this year included the evaluation and cost effectiveness of models-of-care for dialysis patients, including nurse-assisted dialysis in remote communities. We believe the research will show that assisting people to return to remote communities with nurse-assisted dialysis is cost effective when viewed holistically.

We are also participating in a research partnership on child health and social outcomes to investigate children's physical, social and emotional development and factors that influence it.

Data

All our member services report on the NT Aboriginal Health KPIs (key performance indicators) which are held by the NT Department of Health. The review of pooled data maps the performance of the sector and identifies issues which may be affecting performance. For instance, recent data showed that pap-smear rates were considerably lower in our sector than the national rate (40% versus 57%). AMSANT has investigated this issue and found that there is a lack of access to training for the procedure and not enough Aboriginal female staff working in women's health. We have provided this feedback to Family Planning Welfare NT for action. Although two extra pap-smear courses will be held in Tennant Creek and Katherine this year, more work needs to be done to ensure women have access to screening.

The NT AHKPI data set continues to expand with additional indicators, including smoking, sexual health and screening for renal disease. The

national KPI set has also expanded but has limited applicability to the Aboriginal community controlled health services. AMSANT continues to advocate for the appropriate use of these indicators to measure outcomes in Aboriginal primary health care.

Social and Emotional Wellbeing (SEWB)

Community Controlled Health Services play a significant role in enhancing the social and emotional wellbeing (SEWB) of Aboriginal communities. AMSANT continues to advocate for the need for appropriate resourcing of community controlled mental health, SEWB and alcohol and other drug (AOD) programs as integral components of comprehensive primary health care. AMSANT contributed these perspectives to the National Mental Health Commission's Review of Mental Health Services and Programs. The final report of the review, released in 2015, echoed the view that community controlled health services play a significant role in providing culturally appropriate and effective mental health services within Aboriginal communities.

AMSANT continued to support the work of our health services in addressing mental health, social and emotional, alcohol and other drug issues. One such avenue of support was the ongoing employment of Clinical Psychologist, Sarah Haythornthwaite, who provided program and staff support, as well as clinical supervision for staff working in these program areas. Sarah provided clinical supervision and support to many members of the Remote AOD Workforce who work throughout our health services and participated in the Remote AOD Workforce Forums in Darwin September 2014 and in Alice Springs April 2015.

Public Health
Trauma Project

In an innovative project, AMSANT continues to explore the relevance and impact of trauma on Aboriginal people for our sector and how this might influence the delivery of primary health care—a policy paper on trauma will soon be published by AMSANT to give a greater understanding of the issue to the sector.

There is a growing body of evidence that shows how historical events and on-going adverse experiences often impact significantly on the health and wellbeing of Aboriginal people. These impacts can be understood in relation to the psychological and biological features of complex trauma and have been experienced by Indigenous people around the world.

Recognising, understanding and responding appropriately to trauma is critical for those working with Aboriginal peoples due to the greater level of complex trauma experienced in our communities. If trauma is overlooked—as is so often the case—issues related to unresolved trauma can reduce the effectiveness of the services provided to a community, and put both patients and health workers at risk of further harm.

In late 2014 AMSANT employed Tanja Hirvonen (a member of the Australian Indigenous Psychologists' Association) to work with Sarah Haythornthwaite on the trauma project.

At the request of our member services, Sarah and Tanja are visiting them and spending time with staff to discuss trauma, pathways to healing, trauma-informed care and its relevance to primary health care service delivery.

Comprehensive PHC must include mental health, social & emotional wellbeing, and alcohol and other drug (AOD) programs if it is to reduce the gap in health equality that exists with our disadvantaged people. And, it is shown, that becoming 'trauma informed' in our practice promotes sensitive, culturally-appropriate and client-centred health care.

The following are identified as central to trauma-informed service provision: preventing re-traumatisation; awareness, understanding and education; safety; control and choice; relationships, connections and collaboration; empowerment, strength and resilience; and, cultural competence and diversity.

The principles of trauma-informed care and the operations of our health services are aligned—they both increase the accessibility to services; promote self-reliance, participation, collaboration and control; and recognise the underlying social determinants of health. An integrated trauma-informed approach would represent a viable and relevant opportunity to help 'close the gap'.

AMSANT leads the sector in this research and has been invited to speak about trauma at a variety of forums and conferences this year, including the Remote AOD Workforce Forum in Alice Springs in April 2015 and the National Rural Health conference in Darwin in May 2015.

Throughout the year Sarah and Tanja have provided trauma-informed care information and training sessions to health services and clinic staff across the NT. This training and support for health services has involved the development of training materials and questionnaires to evaluate the project as it develops.

AMSANT's clinical psychologists Tanja Hirvonen and Sara Haythornthwaite discuss 'trauma' at the *Our Health, Our Way* conference.

Public Health
SOLO

This past year has been very busy for the **Specialist Outreach Liaison Officer** (SOLO) with work conducted across the Territory to support our health services and improve their access to specialist care and advice.

The SOLO represents AMSANT on the Cardiac Rehabilitation Outreach Committee which is developing a cardiac rehab model that can be rolled out in remote communities throughout the NT. AMSANT will advocate for a well-resourced cardiac rehabilitation program that extends to remote areas.

Another key SOLO task is to help health services access the programs they need to meet community demand. In the past year this has included advocacy work to retain the RFDS primary mental health service to Westside Central Australian communities, and using MOICD reserve days to increase service provision to primary health centres.

Much effort was made creating a directory for health care and social service professionals which describes what services are available to people living with chronic conditions in remote Top End communities. The scope of this project is very broad and a holistic definition of primary health care is used to guide it. This work is being done in partnership with the NT Medical Local, the AMSANT eHealth team, the NT government eHealth team and the National Health Services Directory (NHSD).

Continuous Quality Improvement—CQI

Danila Dilba's CEO and AMSANT Board member, Olga Havnen, addresses a CQI conference in Darwin.

Continuous Quality Improvement—CQI

Building skills and confidence—learning from each other

At the CQI jurisdictional workshop in Alice Springs in June one of our presenters said, "I caught CQI by accident!". What she meant was that she had realised that CQI was central to her role and unless she always focused on improvement and kept asking, "How can I do this better?", she wasn't doing her job effectively.

The CQI strategy assists primary health care (PHC) services to build their knowledge and skills and it provides training in a range of CQI tools to ensure services are able to achieve their quality improvement priorities. Kerry Copley and Louise Patel are the CQI Program Coordinators based in AMSANT and they lead and coordinate by developing and delivering training, mentoring and supporting the CQI facilitator team, participating in the AHKPI (Aboriginal health key performance indicators) committees and reporting to the NT CQI steering committee.

The aim of the CQI strategy is to make improvement everybody's business. We want to spread CQI like a virus—we want everyone to 'catch the bug'. AMSANT believes CQI thinking, tools and processes should be woven through all the work that we do.

In the last five years the NT CQI Strategy has focused on building the capacity of PHC teams to implement effective processes within their services. We are doing this in a number of ways:

- By providing CQI orientation, training and ongoing mentoring to the CQI facilitators employed by services across the Territory
- Delivering on-site training to PHC teams in CQI tools and processes
- Running the CQI collaborative workshops to promote shared learning and to strengthen skills
- Supporting regional collaboratives—taking a CQI approach to address local issues
- Delivering CQI training to the Aboriginal workforce in nine workshops in Darwin, Alice Springs and throughout the NT.

- Primary health care staff have valued the opportunity to collaborate to increase their confidence and expertise in the use of CQI tools and processes, and to interpret and analyse (or 'make sense' of) clinical data so it can be used to inform system improvement.

More than 120 people attended the 8th CQI collaborative in Darwin in November 2014. The collaboratives bring clinicians and PHC staff together to discuss areas of concern, highlighted by the NT AHKPIs or other clinical data, and to identify strategies for improvement. There has been a strong focus on 'childhood anaemia' this year with many services developing templates and care plans to support these systems in Communicare and PCIS, and to ensure that all staff are competent in the identification and treatment of childhood anaemia.

Other topics that have been highlighted at the Collaboratives have included:

- Men's health
- Health promotion
- Systematic use of clinical data
- Service redesign
- Women's health.

Continuous Quality Improvement—CQI

NT provides CQI leadership at a national level

It has been exciting to share the CQI knowledge and expertise we have in the NT at a national level and to be help develop the National CQI Framework for Aboriginal and Torres Strait Islander Primary Health Care. The framework has drawn on the findings of the NT CQI strategy evaluation, the experiences of the NT PHC sector and the work done in other states and territories towards continuous quality improvement.

The national CQI framework fosters strong commitment and a coordinated approach in primary health care for Aboriginal and Torres Strait Islander people, wherever and whenever they seek healthcare. In many ways the framework reflects our own Northern Territory CQI strategy, with a focus on these key elements: client and community focus; commitment at all levels of CQI leadership; organisational culture; functional teams; a systems approach; and, systematic use of data.

In the last year AMSANT has promoted a growing commitment to CQI throughout our member services and built a strong team of facilitators and champions who support the delivery of best-quality primary health care.

Kerry Copley and Louise Patel—AMSANT CQI Program Coordinators.

AMSANT collaborates with many NGOs and community groups, such as Impact—Foundation for Young Australians. Georgie Erlandson, Vicki Berges, Dawn Cardona, Stevie-Louise Oliver and Hayley Baliva from Impact have given several presentations about their work at recent AMSANT meetings.

eHealth

AMSANT has just finished its eighth year supporting our member services to implement and operate eHealth systems, an important component of providing high quality health services in isolated and remote locations. The eHealth team works behind-the-scenes to enhance these systems and advocates for their functionality and appropriateness for the wide variety of health services outside of the Government firewalls.

Our goal is to ensure that best-practice clinical care is delivered through the eHealth systems—this leads to better management of both individual and population-level health care, higher patient safety, and more accurate reporting to funding bodies.

Work has continued this year towards developing and improving the clinical information system, Communicare, to implement best practice clinical guidelines and pathways. AMSANT hosted an annual Communicare and eHealth forum to explain the deployment of Communicare according to best practice on anaemia, hepatitis B management, maternity care, medication management, recall and referrals. This forum was attended by 40 people representing eight of our member services.

Face-to-face forums, site visits, teleconferences, regular emails, telephone calls, remote assistance by phone and video-conference meetings are crucial aspects of AMSANT's support to services in the areas of analysis and development; advising and assisting with data cleansing/matching; problem solving to produce accurate reports; and for staff training.

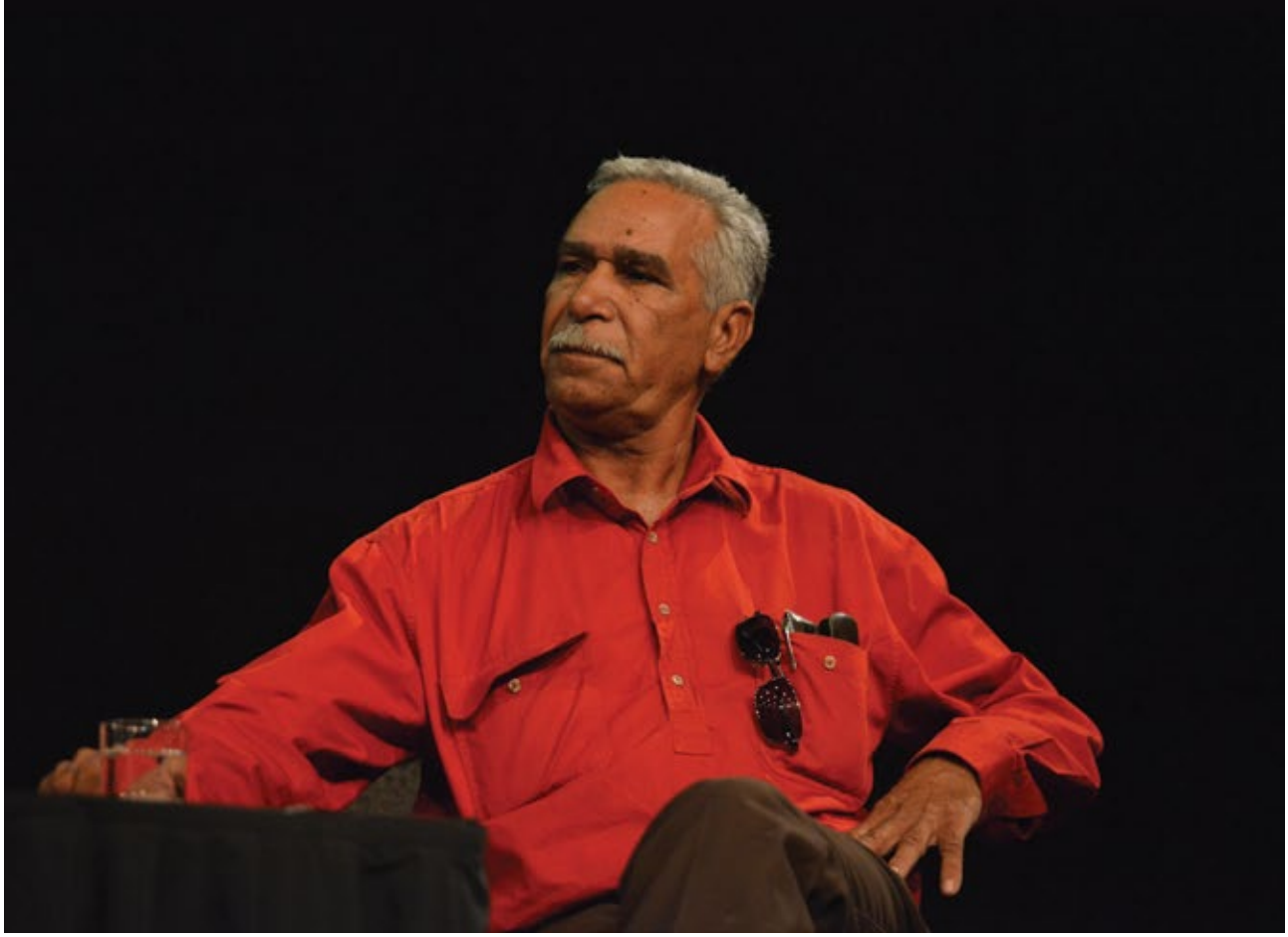
AMSANT has worked to help develop, implement and refine the NT and the national key performance indicators (KPIs) in the clinical information systems to ensure that accurate data can be extracted.

AMSANT also participates in the transition of the NT Government's 'My eHealth Record' to the national eHealth record system and assists services in reaching the requirements for the national system. AMSANT staff visited 39 health clinics to train and support the health service front-office staff on how to register their patients using Communicare. AMSANT staff also visited 70 towns and communities to engage with Aboriginal people and register them to the national eHealth Record System.

AMSANT assisted two health service trial sites, Santa Teresa and

"All our health services are stronger when we link up with AMSANT on eHealth, especially the smaller services like Ampilatwatja which lack capacity. It's a working partnership that allows us to plan for the future and to link up with professional services to 'close the gap' on inequity."

Richard Downes, Board member, Ampilatwatja Health Service.



eHealth

Anyinginyi, to participate in the NT TeleHealth Connection Trial through technical advice, co-ordination and training. AMSANT will now support more services to participate in this successful trial, sponsored by the NTG Department of Health and the Telstra Health Connection Service. The aim is to embed telehealth consultations as a component of NT clinical practice. Telehealth will never fully replace face-to-face consultations with specialist clinicians, but is an important component of health care for people in remote areas, far away from specialist care.

AMSANT also provided technical advice and assistance to NT health services with their selection of communications equipment, installation, utilisation and trouble-shooting.

AMSANT's close working relationships with its member services allows early connection between the new project's staff and key contacts within participating services to ensure a smooth and collaborative 'launch'.

Critically, AMSANT's input ensures that the eHealth systems support all Territorian patients, not just those who attend NT Government health centres and hospitals, by making sure that secure data is shared to promote the continuity of care for the patient, regardless of which health service they attend.

AMSANT also assisted and mentored member health services to develop corporate intranets and business system templates so that the services can retain the skills to manage their systems. These quality information management systems are essential components of efficient businesses and are necessary to attain national accreditation standards.

Workforce support

The Workforce and Aboriginal Leadership Support (WALS) team has continued to work on a range of workforce and leadership initiatives that impact on AMSANT member services. There have been significant changes to the workforce environment with the cutting of key national forums and committees including the Aboriginal & Torres Strait Islander Health Registered Training Organisation National Network (ATSIHRTONN), the National WIPO Network, the absorption of Health Workforce Australia into the Commonwealth Department of Health and uncertainty around the Indigenous Chronic Disease Package (ICDP).

The WALS Team has undertaken planning throughout the year to adapt to the changes and ongoing issues regarding workforce to best suit member and workforce needs. There will be more emphasis on local and regional projects and a focus on those factors that impact on workforce recruitment like housing, public health policy and research.

The AMSANT Workforce Policy Officer (WPO) has advised many of the reference, steering and advisory groups that relate to workforce capacity, education, training and professional development. There has been a renewed focus to promote awareness of health careers, particularly to high school students, and to find ways to build pathways for students to take on careers in health.

The groups the WPO has contributed to include the Heart Foundation, TATS (Talking about the smokes), the Aboriginal & Torres Strait Islander Health Professionals (ATSIHP) excellence awards, Flinders University medical program, Aboriginal health training networks and community responses to the growing abuse of 'ice' or methamphetamine.

Workforce leadership and mentoring, as well as regular team meetings, have strengthened the communications and planning of our staff in Darwin and Alice Springs, allowing us to widen our support to all levels of the workforce.

Workforce support

AMSANT attended key meetings in Nhulunbuy, Alice Springs, Katherine, Tennant Creek, Darwin and Melbourne to build new partnerships with the broader health sector and to promote the career paths of ATSIHPs. We also represented the NT on the National Scope of Practice Project for ATSIHPs to ensure that the scope or practice of an ATSIHP remains at the high level we've had here in the NT for many years.
In the spirit of developing fruitful partnerships, the WPO has given orientation sessions for NTGPE, NTML and the Brien Holden Vision Institute to educate them on the role of the ATSIHP in a health centre.

The coordination of our team has improved this year as we've developed an email list and data base of ATSIHPs, trainees, doctors, clinic managers and administrators to support and grow the profession. We keep the information very topical and this year our emails covered ATSIHP registration information, training and professional development options, job vacancies, scholarship opportunities, leadership groups, public health issues, university courses and professional development.

Chronic disease workforce support

The Indigenous Health Project Officers (IHPOs) visited member services in urban, regional and remote NT during the year, focusing on those members who employ chronic disease workers, to discuss the training and resources available for health promotion.
Key projects and initiatives for the IHPOs included collaborating with the National Heart Foundation NT, Medicare Local, NT Department of Health and many other partners.

In May 2015 AMSANT delivered training to 21 ACCHS participants in Health Promotion CQI, in particular 'Program Logic' and 'Plan-Do-Study-Act' cycles. The workshop was created directly out of feedback from our member services and is applicable to other program areas such as SEWB and AOD. We are also investigating appropriate and accredited medical reception training to the NT because our member services have considerable interest in this and would like to get their staff involved.

Our team has started work with AMSANT's Communicare experts and Medicare specialists to develop a tool to assist services in auditing and claiming Medicare, principally by making it as easy as possible for clinicians and services to claim for the work that they are already doing.

At AMSANT's *Our Health, Our Way* conference we coordinated and chaired a session on health promotion, and we were heartened to see first-time speakers from Utju and Miwatj health services presenting their work so confidently. At the Barunga Festival we shared a stall with the Northern Land Council (NLC) and APO NT, where we distributed health information and sold truckloads of AMSANT T-shirts.

We continue to provide content and design ideas to the AMSANT website and are developing innovative ways to communicate better with our member services and the broader community.

Erin Lew Fatt and Sharon Wallace talk up 'workforce' at the *Our Health, Our Way* conference.

Joseph Pearce from Danila Dilba is an enthusiastic member of AMSANT's Aboriginal leadership program.

Workforce support

Collaboration with the NT General Practice Education (NTGPE)

The AMSANT/NTGPE Project Liaison Officer is responsible for promoting the conceptual framework of community control to General Practitioner Registrars (GPRs) at orientation, and throughout their education program, which includes a pastoral care role for many GPRs while on placement. This position has grown and evolved in the last three years and now includes a full day of cultural education within the GPR orientation program.

A cultural mentoring program (CMP) has been established at Galiwin'ku and a similar program will be rolled out at Wadeye (Port Keats). The CMP is seen as an extension of the cultural education provided to GPRs at orientation, whereby registrars are provided with a local community mentor for the duration of their placement.

Other successful initiatives include the launching of the GPR online resource tool at the Our Health Our Way conference and the promotion of the resource at workshops; the development of the AMSANT Reconciliation Action Plan (RAP); and the ongoing mentoring and support of NTGPE's cultural educators. This position is funded by NTGPE, although the Project Liaison Officer works half-time with both organisations.

Research Advocacy Policy

The Research Advocacy Policy (RAP) Unit manages the complex and ever-changing relations with government and non-government stakeholders and liaises with the AMSANT Board on all relevant matters. The RAP Manager is a member of the senior management team and coordinates research, policy and advocacy on behalf of AMSANT.

The RAP Unit provides secretariat functions for the AMSANT Board, and the NT Aboriginal Health Forum, as well as coordinating AMSANT's participation in the Aboriginal Peak Organisations NT (APO NT) alliance and managing APO NT secretariat staff.

A highlight of the past year and a project of some magnitude was AMSANT's *Our Health, Our Way* conference in November 2014 (see pages 22–31).

Research

Public Health Advisory Group (PHAG)

The Pubic Health Advisory Group (PHAG) provides advice to the PHMOs, the CEO and the Board on policy issues that require medical, public health or clinical research expertise. PHAG coordinates the development of expert responses to government working groups, inquiries and policy consultation processes. PHAG also provides advice to the CEO and Board about issues that require processes established within AMSANT, as well as relevant policies and guidelines.

Aboriginal health research

AMSANT's Aboriginal Health Research Policy defines procedures and protocols for health research proposals involving Aboriginal communities and our member services. Health researchers complete AMSANT's Pro-forma for assessing health research proposals which is considered by PHAG, before it feeds back advice to the CEO, Board, member services and the researchers themselves.

There is also an Early Research Concept Pro-forma, allowing external researchers to seek feedback from AMSANT and its membership at a much earlier stage of research proposal development.

AMSANT's Trauma Project

The RAP Manager, along with AMSANT's PHMO and clinical psychologist, manage the Trauma Project, focusing on the inter-generational and on-going impacts of trauma on Aboriginal people, and the value of trauma-informed care within our health sector. During 2014 an Indigenous clinical psychologist, Tanja Hirvonen, joined the project.

Lowitja Institute CRC Participants Forum

AMSANT's membership of the Lowitja Institute CRC is an important relationship, representing a commitment to increase Aboriginal control within health research. The RAP Manager and CEO attended the Participants Forum which provided direction and input from members to the CRC.

Advocacy

The RAP unit fosters a productive relationship with government stakeholders including ministerial officers, liaison staff and media officers, and staff outside the health portfolio. As a non-political organisation, AMSANT maintains relationships with Opposition, cross-bench parties and independents at both Commonwealth and NT levels.

The reform processes within the Commonwealth health portfolio and the incorporation of Indigenous programs within the Department of the Prime Minister and Cabinet (DPM&C) have continued. In particular, the complex Indigenous Advancement Strategy (IAS) tender process affected our member services, with AOD and SEWB programs being opened to a competitive tendering process.

AMSANT has continued to build a positive relationship with the Assistant Minister for Health, Senator Fiona Nash, and her ministerial staff and senior department officers, with special emphasis on the reform of health funding.

Research Advocacy Policy

Regular contact is also maintained with non-government stakeholders, including health and non-health NGOs. This involves the dissemination of expert advice and materials that promote our sector, attendance at forums and meetings, and responding to requests for assistance and information. AMSANT also seeks to develop wider cross-sectoral relationships through our participation in the APO NT alliance.

Regular contact has been maintained with local and national media outlets. This includes providing general news and health journalists with media releases, articles, visuals and background material.

Policy

AMSANT contributes strongly to national and NT policy development and has guided and advised the national and NT health reform processes through policy papers and submissions. These included: General Practice rural incentives program; GP training and service delivery; the 6th Community Pharmacy Agreement; national frameworks for Aboriginal and Torres Strait Islander children and families health services and mental health & SEWB; Constitutional Recognition; Parliamentary review of Stronger Futures; Health Policy, Administration and Expenditure; the abuse of 'ice' or methamphetamine; and Commonwealth tendering processes.

AMSANT's CEO, PHMO and RAP Manager gave evidence to a hearing in Darwin of the Senate Select Committee Inquiry on Health Policy, Administration and Expenditure.

The RAP Manager is a member of the NACCHO National Policy Group and participates in regular meetings on sector-wide policy issues at a national and jurisdictional level.


AMSANT
Oxfam

Aboriginal Peak Organisations NT

The Aboriginal Peak Organisations Northern Territory (APO NT) was formed in 2010 as an alliance of AMSANT, the Central and Northern land councils, the North Australian Aboriginal Justice Agency and the Central Australian Aboriginal Legal Aid Service[1]. AMSANT views its participation in the APO NT alliance as a significant commitment to cross-sectoral action on the social determinants of health.

The alliance was created to provide effective responses to key issues of mutual interest affecting Aboriginal people, including advocating practical policy solutions to government. APO NT has created an important role in engaging with the government and NGO sectors and provides a mechanism for Aboriginal organisations to develop and promote their own priorities and solutions.

As APO NT is not an incorporated body, AMSANT auspices its grant funding and staff.

NGO Partnership Principles

A key initiative of APO NT has been to engage with mainstream NGOs working in Aboriginal communities to develop the NGO Partnership Principles[2] to guide how NGOs can effectively contribute to building Aboriginal organisational capacity and service delivery.

The Principles have been endorsed by 18 mainstream NGOs and a steering committee has been formed to further promote and act on the Principles.

Aboriginal Remote Housing Forum

APO NT hosted an Aboriginal remote housing forum in Darwin in March 2015, held in conjunction with NT Shelter and the Central Australian Affordable Housing Company and funded by the DPM&C.

1. http://www.amsant.org.au/index.php?option=com_content&view=article&id=154&Itemid=258

2 Available on the APO NT website: www.apont.org.au

Submissions and presentations

APO NT has prepared many submissions during the year responding to various Commonwealth and NT reviews and inquiries, including alcohol harm, workforce development, income inequality, welfare policy, domestic and family violence, and Constitutional recognition.

The CEOs of AMSANT and NAAJA represented APO NT by giving evidence to the Joint Select Committee on Constitutional Recognition of Aboriginal and Torres Strait Islander Peoples at the Constitutional Recognition public hearing in Darwin.

Aboriginal Governance and Management Program

APO NT's Aboriginal Governance and Management Program (AGMP) is managed by David Jagger and funded by the DPM&C. AGMP's two Project officers are based at AMSANT.

The program has continued to develop strongly and has established four demonstration sites in remote Aboriginal organisations. Evaluation of the forums and demonstration sites will be used to determine a suitable model and structure to move the program into a permanent Aboriginal governance and management centre.

Leadership

The AMSANT leadership program is in its ninth year and continues to nurture leadership qualities and promote professional development among health workers in the community controlled sector. The program hosts regular workshops across the NT to support Aboriginal leadership aspirations, identify career opportunities, broaden the knowledge of participants and expand their networks and contacts.

Leadership in health is a top priority at AMSANT and our program is coordinated by Patrick Johnson and strongly supported by our Board. The program attracts both young and more experienced people (many of them Aboriginal Health Practitioners) from our health centres and is a great opportunity for them to collaborate with their colleagues from other health settings.

Indigenous actor and personality, Luke Carroll, was a delightful MC at AMSANT's leadership workshop. He said he'd like to be the first blackfella to win an Academy Award—AMSANT reckons he's in with a good chance!

Leadership

Our last leadership workshop was held in November 2014 at Desert Park, just outside Alice Springs. The workshop was held just before the *Our Health, Our Way* conference to give our young leaders the maximum exposure to the people, the policies and the programs that guide our sector both in the NT, and nationally.

The workshop created many new networks and mentoring links for our mob while defining and exploring the notion of 'leadership' and encouraging new skills that could be taken back to communities and workplaces. Actor Luke Carroll was too deadly as the MC.

Sessions on 'lateral violence' (when you are put down or harassed by a colleague or peer) and cyber-bullying identified the great harm that these behaviours bring to many workplaces and communities, and the disunity that the 'tall poppy syndrome' has often caused Aboriginal people. Feedback was lively and mature to this growing societal problem.

Young voices and opinions flowed hot and strong when IMPACT (Young Indigenous Leadership program, run by the Foundation for Young Australians) joined the workshop and discussed their ideas of leadership and professional development. Their personal insights were especially powerful, coming from people on the cusp of adulthood.

Traditional healing was shown to benefit and strengthen people and prepare them mentally for negative or confronting situations. This session highlighted the power of the mind and the true control we can have over our actions, if we have clarity and calmness in our lives.

A governance tutorial was delivered by AMSANT's long-term leadership sponsor, The Fred Hollows Foundation, which showed the power of good (and bad!) governance practices on the community controlled health sector. Our other main sponsor, NT General Practice Education (NTGPE), also contributed to all levels of the workshop.

Once again the feedback from our 30 young leaders was very instructive and well-considered and will guide the development of our program. This year we had delegates from right across the Territory—Sunrise Health, Pintubi

Homelands, Danila Dilba, Central Australian Aboriginal Congress, Wurli Wurlinjang, Anyinginyi Health, Katherine West and Ltyentye (Santa Teresa).

We will host our next Aboriginal leadership workshop in Nhulunbuy, to consolidate AMSANT's swift development in Aboriginal leadership since the first workshop in Alice Springs in 2006. We're also developing training opportunities for our ACCHS workforce and identifying career advancement options through professional development and tertiary education.

AMSANT has set up a leadership group on Facebook and connects our aspiring leaders with social media platforms and new professional networks. We were also busy this year promoting our program at the National Rural Health Conference, the Barunga Festival, NAIDOC week, and other community events.

AMSANT continues to visit our member services to consult with workers about leadership, professional development, mentoring and career plans, with a focus on healthy lifestyles and the need for new youth and mental health services.

Our leadership CD will soon be sent to our member services to inspire new ideas about leadership and to explain the AMSANT program in more detail; and our business plan for future directions and sponsorship support is ready to go. We are in the final design phrase of the latest AMSANT leadership booklet from Desert Park and we will continue to document our program in this way.

AMSANT maintains its commitment to seek funding for the program from non-government and philanthropic organisations and has already found potential sponsors to continue this innovative program.

NT health workers join forces at Desert Park as part of AMSANT's ground-breaking leadership program.

NT Aboriginal Health Forum

AMSANT continues to provide secretariat support for the NT Aboriginal Health Forum, a high-level group for the joint planning and strategic policy guidance of Aboriginal health in the NT. The Forum is comprised of representatives from the Commonwealth, NT Government, AMSANT and the Northern Territory Medicare Local and meets four times a year, under guidance from its 2014–2017 work plan.

Forum's decisions are put into action through dedicated working groups and this year two new working groups were set up—Pathways to Community Control (to develop opportunities to expand community control of health services, and to guide the transition of those services to community control); and Hospital and Specialist (working to ensure Aboriginal Territorians have access to quality hospital, specialist and allied health care).

Existing working groups covering a range of specialty areas continued their work: Primary Health Care (with eye, ear and oral health working groups); eHealth; CQI; NTAHKPI and Workforce. AMSANT led the eHealth group and provided secretariat support to the Primary Health Care, eHealth and CQI groups.

Under the guidance of Forum's Primary Health Care working group, the Secretariat and AMSANT staff led the development of a successful early childhood workshop in June, attended by 50 people with expertise across a range of areas and sectors relevant to early childhood.

There were some clear common themes across the workshop including the need for evidence-based programs and policies, greater engagement of men, and better coordination between organisations. A report on the workshop is being developed and will be shared with AMSANT members and other stakeholders once it's completed. It is anticipated the report will guide future provision of core services, assist the NTAHF with its planning and improve advocacy to government.

Accreditation support

AMSANT's Quality & Accreditation Support Team has maintained the highest levels of support to our members and other eligible groups. Accreditation officers provide guidance, assistance and support to health services to attain organisational and clinical accreditation. So far our success rates have exceeded our targets and the engagement in clinical accreditation of services under the RACGP standards has now reached 100%. The rate of eligible services that have either gained accreditation or are pursuing accreditation is now 90%.

Health services are aware of the many challenges that face our sector (especially the uncertainty about funding) but they recognise the great benefits in achieving and maintaining clinical and organisational accreditation, and they engage us to assist with that process. AMSANT itself has ISO 9001 organisational accreditation and is committed to maintaining this as a quality improvement measure for the benefit of our members and their patients.

Accreditation activities were funded until 30 June this year for facilitation, gap assessments and support but—despite a diminished capacity this financial year—AMSANT will continue its support of members gaining, or maintaining, their accreditation. We're finding new ways of doing business in a sometimes hostile and challenging environment.

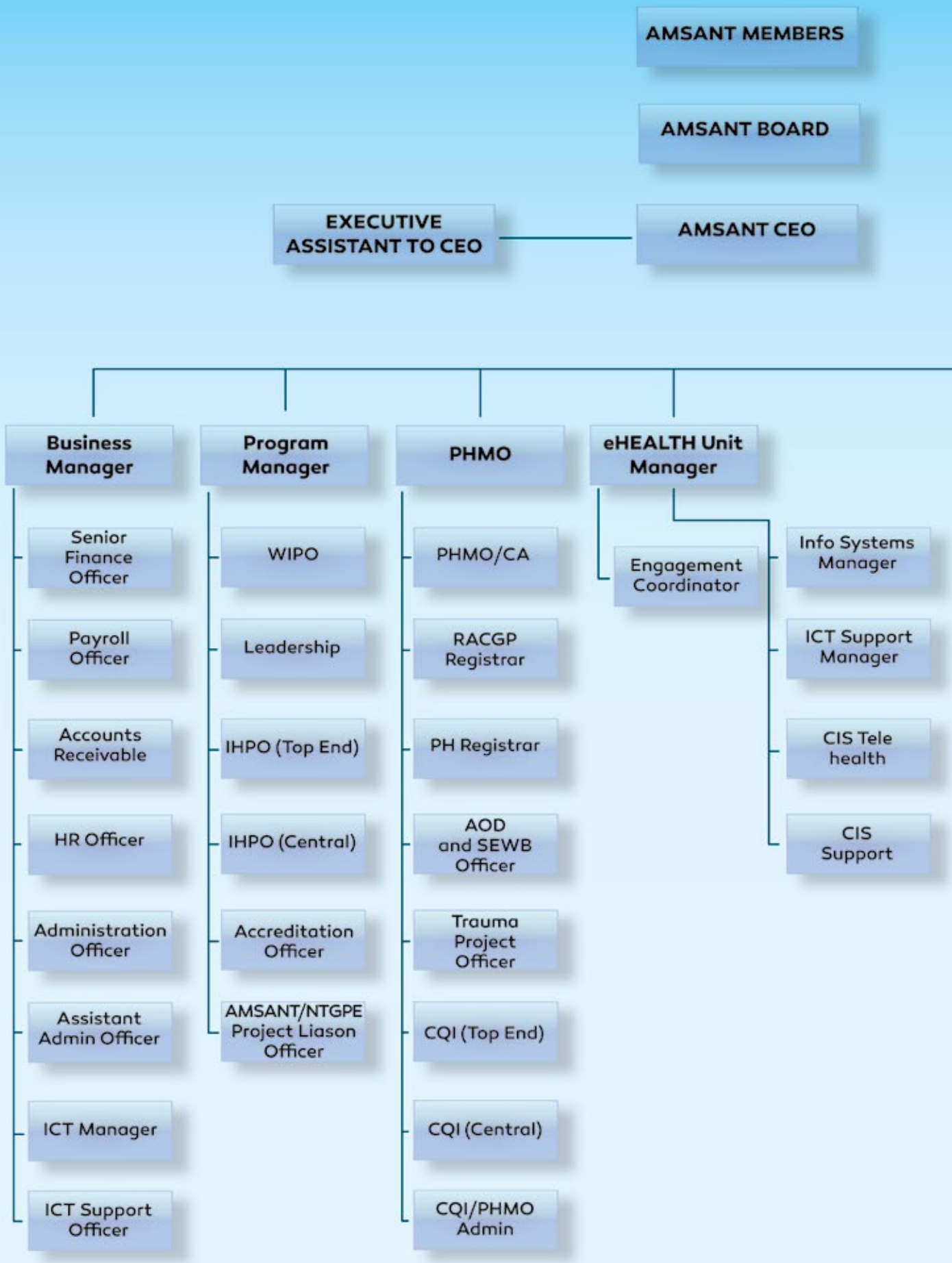
Earlier this year, in direct response to the needs of our member services, we hosted a Legal Compliance training workshop in Alice Springs, attended by 30 people.

The AMSANT Administration Manual has long been regarded as a great resource to assist with quality and accreditation; it will undergo a major review in the coming year and be relaunched on-line. The manual assists health workers at all levels in the areas of accreditation, admin, rostering, human resources, governance, and work health and safety.

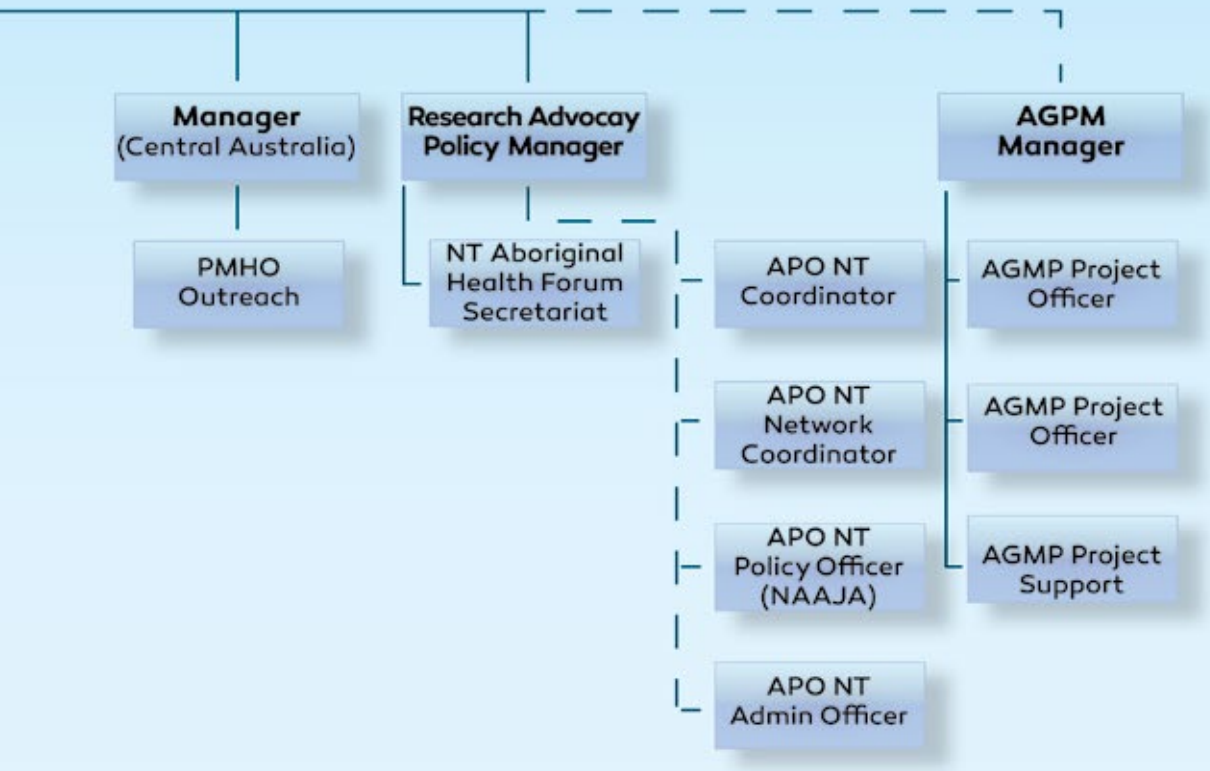
Glossary

ACCHS	Aboriginal Community Controlled Health Service
AGMP	Aboriginal Governance and Management Program
AGPAL	Australian General Practice Accreditation Limited
AHW	Aboriginal Health Worker
AHP	Aboriginal Health Practitioner
AMS	Aboriginal Medical Service
AMSANT	Aboriginal Medical Services Alliance Northern Territory
AOD	Alcohol and other drugs
APO NT	Aboriginal Peak Organisations Northern Territory
ATSIHP	Aboriginal and Torres Strait Islander Health Practitioner
CAAC	Central Australian Aboriginal Congress
CAALAS	Central Australian Aboriginal Legal Service
CARPA	Central Australia Remote Practitioners Association
CIS	Clinical Information System
CPHAG	Clinical and Public Health Advisory Group
CQI	Continuous Quality Improvement
DOH	Department of Health (NT and Commonwealth governments)
EHSDI	Expanded Health Service Delivery Initiative
FASD	Foetal Alcohol Spectrum Disorders
GPET	General Practice Education and Training
GPR	General Practice Registrar
HSDA	Health Service Delivery Area
ICDP	Indigenous Chronic Disease Package
IRCA	International Register of Certified Auditors

NAAJA	North Australian Aboriginal Justice Agency
NACCHO	National Aboriginal Community Controlled Health Organisation
NATSIHWA	National Aboriginal & Torres Strait Islander Health Worker Association
NTAHF	Northern Territory Aboriginal Health Forum
NTG	Northern Territory Government
NTKPI	Northern Territory Key Performance Indicators
NTAHKPI	Northern Territory Aboriginal Health Key Performance Indicators
PCIS	Primary Care Information System (NTG)
PHAG	Public Health Advisory Group
PHC	Primary Health Care
PHMO	Public Health Medical Officer
PHN	Primary Health Network
PIRS	Patient Information Recall System
RHOF	Rural Health Outreach Fund
SEMS	Secure Electronic Message Service
SEWB	Social & Emotional Wellbeing
SOLO	Specialist Outreach Liaison Officer
WALS	Workforce and Aboriginal Leadership Support


AMSANT MEMBERS
AMSANT BOARD
EXECUTIVE ASSISTANT TO CEO
AMSANT CEO
Business Manager
Senior Finance Officer
Payroll Officer
Accounts Receivable
HR Officer
Administration Officer
Assistant Admin Officer
ICT Manager
ICT Support Officer
Program Manager
WIPO
Leadership
IHPO (Top End)
IHPO (Central)
Accreditation Officer
AMSANT/NTGPE Project Liason Officer
PHMO
PHMO/CA
RACGP Registrar
PH Registrar
AOD and SEWB Officer
Trauma Project Officer
CQI (Top End)
CQI (Central)
CQI/PHMO Admin
eHEALTH Unit Manager
Engagement Coordinator
Info Systems Manager
ICT Support Manager
CIS Tele health
CIS Support

AMSANT Organisational chart



AMSANT direct funding

Auspiced acitvity

General Purpose Financial Statements—30 June 2015

AMSANT Incorporated Board Members' report 30 June 2015

The Board members present their report, together with the financial statements, on the Association for the year ended 30 June 2015.

Board members

The following persons were Board members of the Association during the whole of the financial year and up to the date of this report, unless otherwise stated:

Continuing members

Marion Scrymgour (Chairperson)
Leon Chapman (Treasurer)
Donna Ah Chee
Eddie Mullholland
Olga Havnen
Emma Barrett
Barb Shaw
Dale Campbell

Principal activities

During the financial year the principal continuing activities of the Association consisted of:

- Advocacy, policy and strategy development for all issues related to Aboriginal Health at sectoral level and in the Northern Territory and as the peak body for Aboriginal Community Controlled Health Services providing a range of members' support services to its members.

Significant changes

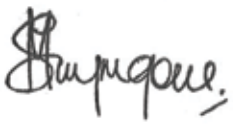
There were no significant changes in the nature of those activities that occurred during the financial year.

Operating results

The deficit of the Association for the year amounted to $136,588 (2014: $255,138 surplus).

On behalf of the Board Members

Marion Scrymgour
Chairperson



Leon Chapman
Treasurer

21 October 2015
Darwin NT

AMSANT Incorporated Financial Report 30 June 2015

Contents

Financial report

General information

The financial report covers AMSANT Incorporated as an individual entity. The financial report is presented in Australian dollars, which is AMSANT Incorporated's functional and presentation currency.

The financial report consists of the statement of profit or loss and other comprehensive income, statement of financial position, statement of changes in equity, statement of cash flows, notes to the financial statements and the Board members' declaration.

The financial report was authorised for issue on 21 October 2015. The Board do not have the power to amend and reissue the financial report.

AMSANT Incorporated
Statement of profit or loss and other comprehensive income for the year ended 30 June 2015

	Note	2015 $	2014 $
Revenue	3	8,528,026	9,319,150
Expenses			
Auspice payments and consultants		(797,366)	(520,635)
Administration	4	(149,135)	(201,122)
Employee costs	4	(5,461,399)	(5,704,513)
Motor vehicle		(204,681)	(165,469)
Depreciation and amortisation		(106,097)	(90,394)
Operations	4	(1,357,155)	(1,570,129)
Travel		(588,781)	(731,498)
Return of unexpended funds		-	(80,252)
Surplus (deficit) for the year		(136,588)	255,138
Other comprehensive income (loss) for the year		-	-
		-	-
Total comprehensive income (loss) for the year		(136,588)	255,138

The above statement of profit or loss and other comprehensive income should be read in conjunction with the accompanying notes.

AMSANT Incorporated
Statement of financial position
As at 30 June 2015

	Note	2015 $	2014 $
Assets			
Current assets			
Cash and cash equivalents	5	2,859,271	5,228,531
Trade and other receivables	6	193,331	405,775
Prepayments and other assets		139,882	67,580
Total current assets		3,192,484	5,701,886
Non-current assets			
Property, plant and equipment	7	285,819	301,960
Total non-current assets		285,819	301,960
Total assets		3,478,303	6,003,846
Liabilities			
Current liabilities			
Trade and other payables	8	561,668	784,073
Provisions	9	740,803	780,686
Grant liabilities	10, 21	1,286,804	3,442,122
Total current liabilities		2,589,275	5,006,881
Non-current liabilities			
Provisions	11	97,260	68,609
Total non-current liabilities		97,260	68,609
Total liabilities		2,686,535	5,075,490
Net assets		791,768	928,356
Equity			
Accumulated funds	12	791,768	928,356
Total equity		791,768	928,356

The above statement of financial position should be read in conjunction with the accompanying notes.

AMSANT Incorporated
Statement of changes in equity
For the year ended 30 June 2015

	Accumulated funds	Total equity
Balance at 1 July 2013	673,218	673,218
Surplus for the year	255,138	255,138
Other comprehensive income for the year	-	-
Total comprehensive income for the year	255,138	255,138
Balance at 30 June 2014	928,356	928,356

	Accumulated funds	Total equity
Balance at 1 July 2014	928,356	928,356
Deficit for the year	(136,588)	(136,588)
Other comprehensive income for the year	-	-
Total comprehensive income for the year	(136,588)	(136,588)
Balance at 30 June 2015	791,768	791,768

The above statement of changes in equity should be read in conjunction with the accompanying notes.

AMSANT Incorporated
Statement of cash flows
For the year ended 30 June 2015

	Note	2015 $	2014 $
Cash flows from operating activities			
Receipts from customers (inclusive of GST)		2,637,778	1,418,941
Grants received (inclusive of GST)		6,569,263	7,789,520
Payments to suppliers and employees (inclusive of GST)		(11,562,017)	(10,038,065)
		(2,354,976)	(829,604)
Interest received		71,520	37,851
Net cash used in operating activities	20	(2,283,456)	(791,753)
Cash flows from investing activities			
Acquisition of property, plant and equipment	7	(85,804)	(230,691)
Net cash used in investing activities		(85,804)	(230,691))
Net increase in cash and cash equivalents		(2,369,260)	(1,022,444)
Cash and cash equivalents at the beginning of the financial year		5,228,531	6,250,975
Cash and cash equivalents at the end of the financial year	5	2,859,271	5,228,531

The above statement of cash flows should be read in conjunction with the accompanying notes.

Note 1. Significant accounting policies

The principal accounting policies adopted in the preparation of the financial statements are set out below. These policies have been consistently applied to all the years presented, unless otherwise stated.

New, revised or amending Accounting Standards and Interpretations adopted

The Company has adopted all of the new, revised or amending Accounting Standards and Interpretations issued by the Australian Accounting Standards Board ('AASB') that are mandatory for the current reporting period.

Any new, revised or amending Accounting Standards or Interpretations that are not yet mandatory have not been early adopted.

Any significant impact on the accounting policies of the Company from the adoption of these Accounting Standards and Interpretations are disclosed below. The adoption of these Accounting Standards and Interpretations did not have any significant impact on the financial performance or position of the Company. The following Accounting Standards and Interpretations are most relevant to the Company:

AASB 2012-3 Amendments to Australian Accounting Standards —Offsetting Financial Assets and Financial Liabilities

The Company has applied AASB 2012-3 from 1 July 2014. The amendments add application guidance to address inconsistencies in the application of the offsetting criteria in AASB 132 'Financial Instruments: Presentation', by clarifying the meaning of 'currently has a legally enforceable right of set-off'; and clarifies that some gross settlement systems may be considered to be equivalent to net settlement.

AASB 2013-3 Amendments to AASB 136—Recoverable Amount Disclosures for Non-Financial Assets

The Company has applied AASB 2013-3 from 1 July 2014. The disclosure requirements of AASB 136 'Impairment of Assets' have been enhanced to require additional information about the fair value measurement when the recoverable amount of impaired assets is based on fair value less costs of disposals. Additionally, if measured using a present value technique, the discount rate is required to be disclosed.

AASB 2014—1 Amendments to Australian Accounting Standards (Parts A to C)

The Company has applied Parts A to C of AASB 2014-1 from 1 July 2014. These amendments affect the following standards: AASB 2 'Share-based Payment': clarifies the definition of 'vesting condition' by separately defining a 'performance condition' and a 'service condition' and amends the definition of 'market condition'; AASB 3 'Business Combinations': clarifies that contingent consideration in a business combination is subsequently measured at fair value with changes in fair value recognised in profit or loss irrespective of whether the contingent consideration is within the scope of AASB 9; AASB 8 'Operating Segments': amended to require disclosures of judgements made in applying the aggregation criteria and clarifies that a reconciliation of the total reportable segment assets to the entity's assets is required only if segment assets are reported regularly to the chief operating decision maker; AASB 13 'Fair Value Measurement': clarifies that the portfolio exemption applies to the valuation of contracts within the scope of AASB 9 and AASB 139; AASB 116 'Property, Plant and Equipment' and AASB 138 'Intangible Assets': clarifies that on revaluation, restatement of accumulated depreciation will not necessarily be in the same proportion to the change in the gross carrying value of the asset; AASB 124 'Related Party Disclosures': extends the definition of 'related party' to include a management entity that provides KMP services to the entity or its parent and requires disclosure of the fees paid to the management entity; AASB 140 'Investment Property': clarifies that the acquisition of an investment property may constitute a business combination.

Basis of preparation

The financial statements comprise AMSANT Incorporated financial statements as an individual entity. For the purposes of preparing financial statements, the association is a not-for-profit entity.

These general purpose financial statements have been prepared in accordance with Australian Accounting Standards—Reduced Disclosure Requirements and Interpretations issued by the *Australian Accounting Standards Board ('AASB'), Northern Territory Associations Act, Australian Charities and Not-for-Profits Commission ('ACNC') Act 2012* and associated regulations, as appropriate for not-for-profit oriented entities. The Association's financial statements and notes comply with Australian Accounting Standards—Reduced Disclosure Requirements, except for AASB 120 Accounting for Government Grants and Disclosure of Government Assistance. This is because the recognition criteria in AASB 1004 are different from those of AASB 120, which is a compliance requirement for not-for-profit entities. These financial statements do not comply with International Financial Reporting Standards as issued by the International Accounting Standards Board ('IASB').

The financial statements are presented in Australian dollars, which is the Association's functional and presentation currency. The financial statements were authorised for issue by the Board on 21 October 2015.

Historical cost convention

The financial statements have been prepared under the historical cost convention, except for, where applicable, certain classes of property, plant and equipment and financial instruments that are measured at revalued amounts or fair values at the end of each reporting period, as explained in the accounting policies below. Historical cost is generally based on the fair values of the consideration given in exchange for assets. All amounts are presented in Australian dollars, unless otherwise noted. Fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date, regardless of whether that price is directly observable or estimated using another valuation technique. In estimating the fair value of an asset or a liability, the Association takes into account the characteristics of the asset or liability if market participants would

take those characteristics into account when pricing the asset or liability at the measurement date. Fair value for measurement and/or disclosure purposes in these financial statements is determined on such a basis, except for, leasing transactions that are within the scope of AASB 117, and measurements that have some similarities to fair value but are not fair value, such as value in use in AASB 136.

In addition, for financial reporting purposes, fair value measurements are categorised into Level 1, 2 or 3 based on the degree to which the inputs to the fair value measurements are observable and the significance of the inputs to the fair value measurement in its entirety, which are described as follows:

- Level 1 inputs are quoted prices (unadjusted) in active markets for identical assets or liabilities that the entity can access at the measurement date;
- Level 2 inputs are inputs, other than quoted prices included within Level 1, that are observable for the asset or liability, either directly or indirectly; and
- Level 3 inputs are unobservable inputs for the asset or liability.

Critical accounting estimates

The preparation of the financial statements requires the use of certain critical accounting estimates. It also requires management to exercise its judgement in the process of applying the Association's accounting policies. The areas involving a higher degree of judgement or complexity, or areas where assumptions and estimates are significant to the financial statements, are disclosed in note 2.

Revenue recognition

Revenue is recognised when it is probable that the economic benefit will flow to the Association and the revenue can be reliably measured. Revenue is measured at the fair value of the consideration received or receivable.

Government grants

Government grants are measured at the fair value of contribution received or receivable. Income arising from contribution shall be recognised when there is reasonable assurance that the Association has control of or the right to receive the contribution and all attached conditions will be complied with.

Interest

Interest revenue is recognised as interest accrues using the effective

interest method. This is a method of calculating the amortised cost of a financial asset and allocating the interest income over the relevant period using the effective interest rate, which is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset to the net carrying amount of the financial asset.

Other revenue

Other revenue is recognised when it is received or when the right to receive payment is established.

Income tax

As the Association is a charitable institution in terms of subsection 50–5 of the Income Tax Assessment Act 1997, as amended, it is exempt from paying income tax.

Cash and cash equivalents

Cash and cash equivalents includes cash on hand, deposits held at call with financial institutions, other short-term, highly liquid investments with original maturities of three months or less that are readily convertible to known amounts of cash and which are subject to an insignificant risk of changes in value.

Trade and other receivables

Trade receivables are initially recognised at fair value and subsequently measured at amortised cost using the effective interest method, less any provision for impairment. Trade receivables are generally due for settlement within 30 days.

Collectability of trade receivables is reviewed on an ongoing basis. Debts which are known to be uncollectable are written off by reducing the carrying amount directly. A provision for impairment of trade receivables is raised when there is objective evidence that the Association will not be able to collect all amounts due according to the original terms of the receivables.

Other receivables are recognised at amortised cost, less any provision for impairment.

Property, plant and equipment

Property, plant and equipment are stated at historical cost less accumulated depreciation and impairment. Historical cost includes expenditure that is directly attributable to the acquisition of the items.

Depreciation is calculated on a straight-line basis to write off the net cost of each item of property, plant and equipment (excluding land) over their

expected useful lives as follows: Plant and equipment: 3–7 years.

The residual values, useful lives and depreciation methods are reviewed, and adjusted if appropriate, at each reporting date.

An item of property, plant and equipment is derecognised upon disposal or when there is no future economic benefit to the Association. Gains and losses between the carrying amount and the disposal proceeds are taken to profit or loss. Any revaluation surplus reserve relating to the item disposed of is transferred directly to retained profits.

Impairment of non-financial assets

Non-financial assets are reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount may not be recoverable. An impairment loss is recognised for the amount by which the asset's carrying amount exceeds its recoverable amount.

Recoverable amount is the higher of an asset's fair value less costs to sell and value-in-use. The value-in-use is the present value of the estimated future cash flows relating to the asset using a pre-tax discount rate specific to the asset or cash-generating unit to which the asset belongs. Assets that do not have independent cash flows are grouped together to form a cash-generating unit.

Trade and other payables

These amounts represent liabilities for goods and services provided to the Association prior to the end of the financial year and which are unpaid. Due to their short-term nature they are measured at amortised cost and are not discounted. The amounts are unsecured and are usually paid within 30 days of recognition.

Provisions

Provisions are recognised when the Association has a present (legal or constructive) obligation as a result of a past event, it is probable the Association will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the consideration required to settle the present obligation at the reporting date, taking into account the risks and uncertainties surrounding the obligation.

Employee benefits

Short-term employee benefit obligations

Liabilities for wages and salaries, including non-monetary benefits, annual leave and long service leave expected to be settled wholly within 12 months of end of reporting date are recognised in other liabilities in respect of employees' services rendered up to end of reporting date and measured at amounts expected to be paid when the liabilities are settled. Liabilities for wages and salaries are included as part of other payables and liabilities for annual leave are included as part of employee benefit provisions.

Other Long-term employee benefit obligations

Liabilities for long service leave and annual leave that are not expected to be settled wholly within 12 months after the end of the financial reporting period are recognised as part of the provision for employee benefits and measured at the present value of expected future payments to be made in respect of services provided by employees up to the reporting date using the projected unit credit method. Consideration is given to the expected future wage and salary levels, experience of employee departures and periods of service. Expected future payments are discounted using market yields at the reporting date on national government bonds with terms to maturity and currency that match, as closely as possible, the estimated future cash outflows.

Regardless of when settlement is expected to occur, liabilities for long service leave and annual leave are presented as current liabilities in the statement of financial position if the entity does not have an unconditional right to defer settlement for at least 12 months after the end of the reporting period.

Current and non-current classification

Assets and liabilities are presented in the statement of financial position based on current and non-current classification.

An asset is current when: it is expected to be realised or intended to be sold or consumed in normal operating cycle; it is held primarily for the purpose of trading; it is expected to be realised within twelve months after the reporting period; or the asset is cash or cash equivalent unless restricted from being exchanged or used to settle a

liability for at least twelve months after the reporting period. All other assets are classified as non-current.

A liability is current when: it is expected to be settled in normal operating cycle; it is held primarily for the purpose of trading; it is due to be settled within twelve months after the reporting period; or there is no unconditional right to defer the settlement of the liability for at least twelve months after the reporting period. All other liabilities are classified as non-current.

Goods and Services Tax ('GST')

Revenues, expenses and assets are recognised net of the amount of associated GST, unless the GST incurred is not recoverable from the tax authority. In this case it is recognised as part of the cost of the acquisition of the asset or as part of the expense.

Receivables and payables are stated inclusive of the amount of GST receivable or payable. The net amount of GST recoverable from, or payable to, the tax authority is included in other receivables or other payables in the statement of financial position.

Cash flows are presented on a gross basis. The GST components of cash flows arising from investing or financing activities which are recoverable from, or payable to the tax authority, are presented as operating cash flows.

Commitments and contingencies are disclosed net of the amount of GST recoverable from, or payable to, the tax authority.

New Accounting Standards and Interpretations not yet mandatory or early adopted

Australian Accounting Standards and Interpretations that have recently been issued or amended but are not yet mandatory, have not been early adopted by the Company for the annual reporting period ended 30 June 2015. The Company's assessment of the impact of these new or amended Accounting Standards and Interpretations, most relevant to the Company, are set out below.

AASB 9 Financial Instruments

This standard is applicable to annual reporting periods beginning on or after 1 January 2018. The standard replaces all previous versions of AASB 9 and completes the project to replace IAS 39 'Financial Instruments: Recognition and Measurement'. AASB 9 introduces new classification and measurement models for financial assets. A financial

asset shall be measured at amortised cost, if it is held within a business model whose objective is to hold assets in order to collect contractual cash flows, which arise on specified dates and solely principal and interest. All other financial instrument assets are to be classified and measured at fair value through profit or loss unless the entity makes an irrevocable election on initial recognition to present gains and losses on equity instruments (that are not held-for-trading) in other comprehensive income ('OCI'). For financial liabilities, the standard requires the portion of the change in fair value that relates to the entity's own credit risk to be presented in OCI (unless it would create an accounting mismatch). New simpler hedge accounting requirements are intended to more closely align the accounting treatment with the risk management activities of the entity. New impairment requirements will use an 'expected credit loss' ('ECL') model to recognise an allowance. Impairment will be measured under a 12-month ECL method unless the credit risk on a financial instrument has increased significantly since initial recognition in which case the lifetime ECL method is adopted. The standard introduces additional new disclosures. The Company will adopt this standard from 1 July 2018 but the impact of its adoption is yet to be assessed by the Company.

AASB 15 Revenue from Contracts with Customers

This standard is applicable to annual reporting periods beginning on or after 1 January 2017. The standard provides a single standard for revenue recognition. The core principle of the standard is that an entity will recognise revenue to depict the transfer of promised goods or services to customers in an amount that reflects the consideration to which the entity expects to be entitled in exchange for those goods or services. The standard will require: contracts (either written, verbal or implied) to be identified, together with the separate performance obligations within the contract; determine the transaction price, adjusted for the time value of money excluding credit risk; allocation of the transaction price to the separate performance obligations on a basis of relative stand-alone selling price of each distinct good or service, or estimation approach if no distinct observable prices exist; and recognition of revenue when each performance obligation is satisfied. Credit risk will be presented separately as an expense rather than adjusted to revenue. For goods, the performance obligation would be satisfied when the customer obtains control of the goods. For services, the performance obligation is satisfied when the service has been provided, typically for promises to transfer services to customers. For performance obligations satisfied over time, an entity

would select an appropriate measure of progress to determine how much revenue should be recognised as the performance obligation is satisfied. Contracts with customers will be presented in an entity's statement of financial position as a contract liability, a contract asset, or a receivable, depending on the relationship between the entity's performance and the customer's payment. Sufficient quantitative and qualitative disclosure is required to enable users to understand the contracts with customers; the significant judgments made in applying the guidance to those contracts; and any assets recognised from the costs to obtain or fulfil a contract with a customer. The Company will adopt this standard from 1 July 2017 but the impact of its adoption is yet to be assessed by the Company.

Note 2. Critical accounting judgements, estimates and assumptions

The preparation of the financial statements requires management to make judgements, estimates and assumptions that affect the reported amounts in the financial statements. Management continually evaluates its judgements and estimates in relation to assets, liabilities, contingent liabilities, revenue and expenses. Management bases its judgements, estimates and assumptions on historical experience and on other various factors, including expectations of future events, management believes to be reasonable under the circumstances. The resulting accounting judgements and estimates will seldom equal the related actual results. The judgements, estimates and assumptions that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year are discussed below.

Provision for impairment of receivables

The provision for impairment of receivables assessment requires a degree of estimation and judgement. The level of provision is assessed by taking into account the recent sales experience, the ageing of receivables, historical collection rates and specific knowledge of the individual debtors' financial position. No impairment of receivable was recognised as at 30 June 2015 and 2014.

Estimation of useful lives of assets

The Association determines the estimated useful lives and related depreciation and amortisation charges for its property, plant and equipment and finite life intangible assets. The useful lives could change significantly as a result of technical innovations or some other event. The depreciation and amortisation charge will increase where the useful lives are less than previously estimated lives, or technically obsolete or non-strategic assets that have been abandoned

or sold will be written off or written down. Net book value of property, plant and equipment amounted to $285,819 and $301,960 as at 30 June 2015 and 2014, respectively.

Long service leave provision

As discussed in note 1, the liability for long service leave is recognised and measured at the present value of the estimated future cash flows to be made in respect of all employees at the reporting date. In determining the present value of the liability, estimates of attrition rates and pay increases through promotion and inflation have been taken into account. The provision for long service leave amounted to $301,966 and $292,358 as at 30 June 2015 and 2014, respectively.

Note 3. Revenue

	2015 $	2014 $
Grant Income	7,837,105	5,896,461
Grants carried forward from prior year	1,162,073	3,921,188
Unexpended grants	(891,804)	(1,148,466)
	8,107,374	8,669,183
Interest	71,520	37,851
Recoupment	110,531	342,846
Insurance reimbursements	83,424	93,921
Profit on disposal of assets	4,152	12,602
Other income	151,025	162,747
	420,652	649,967
Total revenue	8,528,026	9,319,150

Note 4. Expenses

	2015 $	2014 $
Surplus (deficit) includes the following items:		
Administration expenses		
Administration expense	18,827	30,000
Audit fees	40,153	39,795
Board/Governance expenses	3,900	3,134
Meetings and workshops hosted	86,255	128,193
Total administration expenses	149,135	201,122
Employee costs		
Fringe benefits tax	38,204	34,961
Recruitment	10,128	18,549
Salaries	4,812,325	5,085,207
Staff training	35,296	5,311
Superannuation	420,100	422,018
Workers compensation	145,346	138,467
Total employee costs	5,461,399	5,704,513
Operations expenses		
Rent	468,186	453,019
ICT	243,951	157,780
Business planning and reporting	86,328	169,764
Project expenses	114,074	141,583
Publications	43,661	34,875
Cleaning	48,265	41,577
Communications	(243)	55,457
Conference and seminars	156,232	53,263
Insurance	19,264	25,116
Printing	37,386	31,435
Bad debts	250	30,181
Other	139,801	376,079
Total operation expenses	1,357,155	1,570,129

Note 5. Current assets—cash and cash equivalents

Cash at hand	867	780
Cash at bank—Operating accounts	1,172,089	4,304,337
Cash at bank—Investment accounts	1,686,315	923,414
Total cash and cash equivalents	2,859,271	5,228,531

Restricted Cash

Purpose		
External Restrictions		
- Grant Liabilities	1,286,804	3,442,122
Total External Restriction	1,286,804	3,442,122
Internal Restrictions		
- Employee Entitlements	809,874	849,295
Total Internal Restriction	809,874	849,295
Total Unrestricted	762,593	937,114
Total Cash Available	2,859,271	5,228,531

Note 6. Current assets—trade and other receivables

	2015 $	2014 $
Trade receivables	189,885	390,882
Other receivable	3,446	14,893
Total trade and other receivables	193,331	405,775

Note 7. Non-current assets—property, plant and equipment

	2015 $	2014 $
Plant and equipment—at cost	560,236	504,429
Less: Accumulated depreciation	(274,417)	(202,469)
Total property, plant and equipment	285,819	301,960

Reconciliations

Reconciliations of the written down values at the beginning and end of the current and previous financial year are set out below:

	2015 $	2014 $
Cost		
Opening balance	504,429	296,435
Additions	140,373	275,213
Disposals	(84,566)	(67,219)
Ending balance	560,236	504,429
Accumulated depreciation		
Opening balance	202,469	147,374
Depreciation and amortisation expense	106,097	90,394
Disposals	(29,628)	(39,820)
Adjustments	(4,521))	4,521
Ending balance	274,417	202,469
Net book value	285,819	301,960

The disposals during the year pertains to trade in of two old vehicles to purchase two new vehicles. The old vehicles had trade in values of $24,545 & $34,545 which was offset against the purchase cost of the new vehicles. The trades are considered as a non-cash transaction, thus, not reflected in the Statement of Cash Flows.

Note 8. Current liabilities— trade and other payables

	2015 $	2014 $
Trade payables	176,018	261,467
Credit card	-	-
BAS payable	279,364	431,296
Accrued expenses	55,881	58,497
Accrued wages	33,700	19,808
Other payables	16,705	13,005
Total trade and other payables	561,668	784,073

Note 9. Current liabilities—provisions

	2015 $	2014 $
Annual leave	507,908	513,428
Long service leave	204,706	223,749
Other provisions	28,189	43,509
Total provisions	740,803	780,686

Note 10. Current liabilities—grant liabilities

	2015 $	2014 $
Grant liabilities	1,286,804	3,442,122

Refer to Note 21 for the details of the unexpended grants

Note 11. Non-Current liabilities—provisions

	2015 $	2014 $
Long service leave	97,260	68,609
Total provisions	97,260	68,609

Note 12. Equity—accumulated funds

	2015 $	2014 $
Accumulated funds at the beginning of the financial year	928,356	673,218
Surplus (deficit) for the year	(136,588)	255,138
Accumulated funds at the end of the financial year	791,768	928,356

Note 13. Financial instruments

Financial risk management objectives

The Association's activities do not expose it to many financial risks, with only liquidity risk being needed to be actively managed.

Market risk

Foreign currency risk

The Association is not exposed to any significant foreign currency risk.

Price risk

The Association is not exposed to any significant price risk.

Interest rate risk

The Association is not exposed to any significant interest rate risk.

Credit risk

The Association is not exposed to any significant credit risk.

Liquidity risk

Vigilant liquidity risk management requires the Association to maintain sufficient liquid assets (mainly cash and cash equivalents) to be able to pay debts as and when they become due and payable.

The Association manages liquidity risk by maintaining adequate cash reserves by continuously monitoring actual and forecasted cash flows and matching the maturity profiles of the financial assets and liabilities.

Remaining contractual maturities

The following tables detail the Association's remaining contractual maturity for its financial instrument liabilities. The tables have been drawn up based on the undiscounted cash flows of the financial liabilities based on the earliest date on which the financial liabilities are required to be paid. The tables include both interest and principal cash flows disclosed as remaining contractual maturities and therefore these totals may differ from their carrying amount in the statement of the financial position.

2015	Weighted average interest rate	1 year or less	Between 1–2 years	Between 2–5 years	Over 5 years	Remainng contractual maturities
	%	$	$	$	$	$
Non-derivatives						
Non-interest bearing						
Trade payables	-	176,018	-	-	-	176,018
BAS payable	-	279,364	-	-	-	279,364
Accrued expenses	-	55,881	-	-	-	55,881
Accrued wages	-	33,700	-	-	-	33,700
Other payables	-	16,705	-	-	-	16,705
Grant liabilities	-	1,286,804	-	-	-	1,286,804
Total non-derivatives		**1,848,472**	**-**	**-**	**-**	**1,848,472**

2014						
	%	$	$	$	$	$
Non-derivatives						
Non-interest bearing						
Trade payables	-	261,467	-	-	-	261,467
BAS payable	-	431,296	-	-	-	431,296
Accrued expenses	-	58,497	-	-	-	58,497
Accrued wages	-	19,808	-	-	-	19,808
Other payables	-	13,005	-	-	-	13,005
Grant liabilities	-	3,442,122	-	-	-	3,442,122
Total non-derivatives		**4,226,195**	**-**	**-**	**-**	**4,226,195**

Fair value of financial instruments

Unless otherwise stated, the carrying amounts of financial instruments reflect their fair value. The carrying amounts of trade receivables and trade payables are assumed to approximate their fair values due to their short-term nature. The fair value of the financial liabilities is estimated by discounting the remaining contractual maturities at the current market interest rate that is available for similar financial instruments.

Note 14. Key manaagemant personnel disclosures

Compensation

The aggregate compensation made to officers and other members of key management personnel of the Association is set out below:

	2015 $	2014 $
Short-term employee benefits	1,207,274	1,009,700

Related party transactions

Related party transactions are set out in note 18.

Note 15. Remuneration of auditors

During the financial year the following fees were paid or payable for services provided by BDO Audit (NT), the auditor of the Association:

	2015 $	2014 $
Audit services—BDO Audit (NT)		
Audit of the financial statements and aquittal reports	38,400	39,795

Note 16. Contingent of liabilities

The Association had no contingent liabilities as at 30 June 2015 and 2014.

Note 17. Commitments

	2015 $	2014 $
Capital commitments		
Committed at the reporting date but not recognised as liabilities, payable:		
Leasehold rental commitments		
Committed at the reporting date but not recognised as liabilities, payable:		
Within one year	415,254	358,600
One to five years	185,508	-
More than five years	-	-
	600,726	358,600

Note 17. Commitments (continued)

ICT rental commitments

Committed at the reporting date but not recognised as liabilities, payable:		
Within one year	180,000	150,000
One to five years	183,600	-
More than five years	-	-
	363,600	150,000

Equipment rental commitments

Committed at the reporting date but not recognised as liabilities, payable:		
Within one year	2,256	15,000
One to five years	-	57,000
More than five years	-	-
	2,256	72,00

Commitments, as listed above, includes contracted amounts for various offices and plant and equipment under non-cancellable operating leases expiring within 2 to 5 years with, in some cases, options to extend. These commitments leases have various escalation clauses. On renewal, the terms of the leases are renegotiated.

Note 18. Related party transactions

Transactions with related parties

The Association received grant funding of $341,666 from NT Medicare Local. The Association is a member of the company. Apart from the above transactions, there were no other material transactions with related parties during the current and previous financial year.

Receivable from and payable to related parties

There were no trade receivables from or trade payables to related parties at the current and previous reporting date.

Loans to/from related parties

There were no loans to or from related parties at the current and previous reporting date.

Note 19. Events after the reporting period

No matter or circumstance has arisen since 30 June 2015 that has significantly affected, or may significantly affect the Association's operations, the results of those operations, or the Association's state of affairs in future financial years.

Note 20. Reconciliation of surplus (deficit) for the year to net cash used in operating activities

	2015 $	2014 $
Surplus (deficit) for the year	(136,588)	255,138
Adjustments for:		
Depreciation and amortisation expense	106,097	90,394
Loss (gain) on sale of property, plant and equipment	(4,152)	(12,602)
Operating income (loss) before changes in operating assets and liabilities	(34,643)	332,930
Changes in operating assets and liabilities:		
Decrease (increase) in:		
Trade and other receivables	212,444	(67,881)
Prepayments	(72,302)	7,645
Increase (decrease) in:		
Trade and other payables	(222,405)	(511,102)
Provisions	(11,232)	246,066
Grant liabilities	(2,155,318)	(799,411)
Net cash flows used in operating activities	2,283,456	(791,753)

Note 21. Grant Liabilities

		2015 $	2014 $
P001 T	Secretariat	787	13,579
P050b O	Accreditation W/Shop	-	36,879
P007 O	Dip of Management Training	-	37,514
P012 O	Secretariat Officer	-	90,800
P013 O	S&E Admin Man/Website	-	20,000
P035a F	FaHCSIA APO	403,769	395,000
P035b F	FaHCSIA 2012	-	733
P036c F	FaHCSIA	57,200	20,833
P036f X	NAIDOC Sponsorship	-	2000
P037 F	NT AGMP	-	434,212
P037 Fa	NT AGMP	645,471	500,000
P039 O	Amsant ICT	-	9,071
P043b X	GP Registrar Placement	-	663
P045 R	Specialist Training Posts	15,515	12,268
P047 O	NTML SOS	105	-
P050 O	Accreditation	-	3,120
P051c O	Regionalisation Workshops	-	86,646
P053 O	Bus Dev Manager	-	3,518
P054 O	Policy & Strategy Mgr	-	11,535
P065 X	IHPO Central Australia	19,518	130,275
P066 O	IHPO ICD	10,280	453
P066a O	IHPO—Workshop	-	5,514
P100s T	Unexpended BF from PCEHR	-	(7,184)
P100 T	PCEHR	(2,719)	747,230
P100t T	Transition	(620)	202,308
P100d T	Dialog	-	21
P100ta T	DD2013/1968 Variation	80,136	425,620
P101 T	CDC Trachoma	38,236	38,236
P102 T	SMD SEMS	-	955
P103 A	Telehealth Support	-	778
P103a N	Telehealth “Orientation”	-	2,645
P107 T	Technical System Architect	14,126	216,800
Others		5,000	-
		1,286,804	3,442,122

AMSANT Incorporated notes to the financial statements 30 June 2015

In the Board members' opinion:

- the attached financial statements and notes thereto comply with the Australian Accounting Standards— Reduced Disclosure Requirements and are in accordance with the NT Associations Act and Australian Charities and Not-for-Profits Commission 2012;
- the attached financial statements and notes thereto give a true and fair view of the Association's financial position as at 30 June 2015 and of its performance for the financial year ended on that date;
- there are reasonable grounds to believe that the Association will be able to pay its debts as and when they become due and payable.

On behalf of the Board Members

Marion Scrymgour

Chairperson

Leon Chapman

Treasurer

21 October 2015
Darwin NT

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INDEPENDENT AUDITOR'S REPORT

To the members of Aboriginal Medical Services Alliance Northern Territory ("AMSANT") Incorporated

Report on the Financial Report

We have audited the accompanying financial report of AMSANT Incorporated, which comprises the statement of financial position as at 30 June 2015, the statement of profit or loss and other comprehensive income, statement of changes in equity and statement of cash flows for the year then ended, notes comprising a summary of significant accounting policies and other explanatory information, and board members' declaration.

Board Members' Responsibility for the Financial Report

The Board Members of AMSANT Incorporated are responsible for the preparation of the financial report that gives a true and fair view in accordance with Australian Accounting Standards - Reduced Disclosure Requirements, *Australian Charities and Not-for-Profits Commission 2012 (ACNC Act)* and *Northern Territory Associations Act*, and for such internal control as Board Members determine is necessary to enable the preparation of the financial report that gives a true and fair view and is free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on the financial report based on our audit. We conducted our audit in accordance with Australian Auditing Standards. Those standards require that we comply with relevant ethical requirements relating to audit engagements and plan and perform the audit to obtain reasonable assurance about whether the financial report is free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial report. The procedures selected depend on the auditor's judgement, including the assessment of the risks of material misstatement of the financial report, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the responsible entities' preparation of the financial report that gives a true and fair view in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by the board members, as well as evaluating the overall presentation of the financial report.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Independence

In conducting our audit, we have complied with the independence requirements of the Australian professional accounting bodies.

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Opinion

In our opinion the financial report of AMSANT Incorporated has been prepared in accordance with Division 60 of the *Australian Charities and Not-for-profits Commission Act 2012* and *Northern Territory Associations Act*, including:

(a) giving a true and fair view of AMSANT Incorporated's financial position as at 30 June 2015 and of its financial performance and cash flows for the year ended on that date; and

(b) complying with Australian Accounting Standards - Reduced Disclosure Requirements and Division 60 of the *Australian Charities and Not-for-profits Commission Regulation 2013*.

BDO

BDO Audit (NT)

C J Sciacca
Audit Partner

Darwin: 23 October 2015

AMSANT respects Aboriginal and Torres Strait Islander cultures and makes every effort to avoid publishing the names and images of deceased people.

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