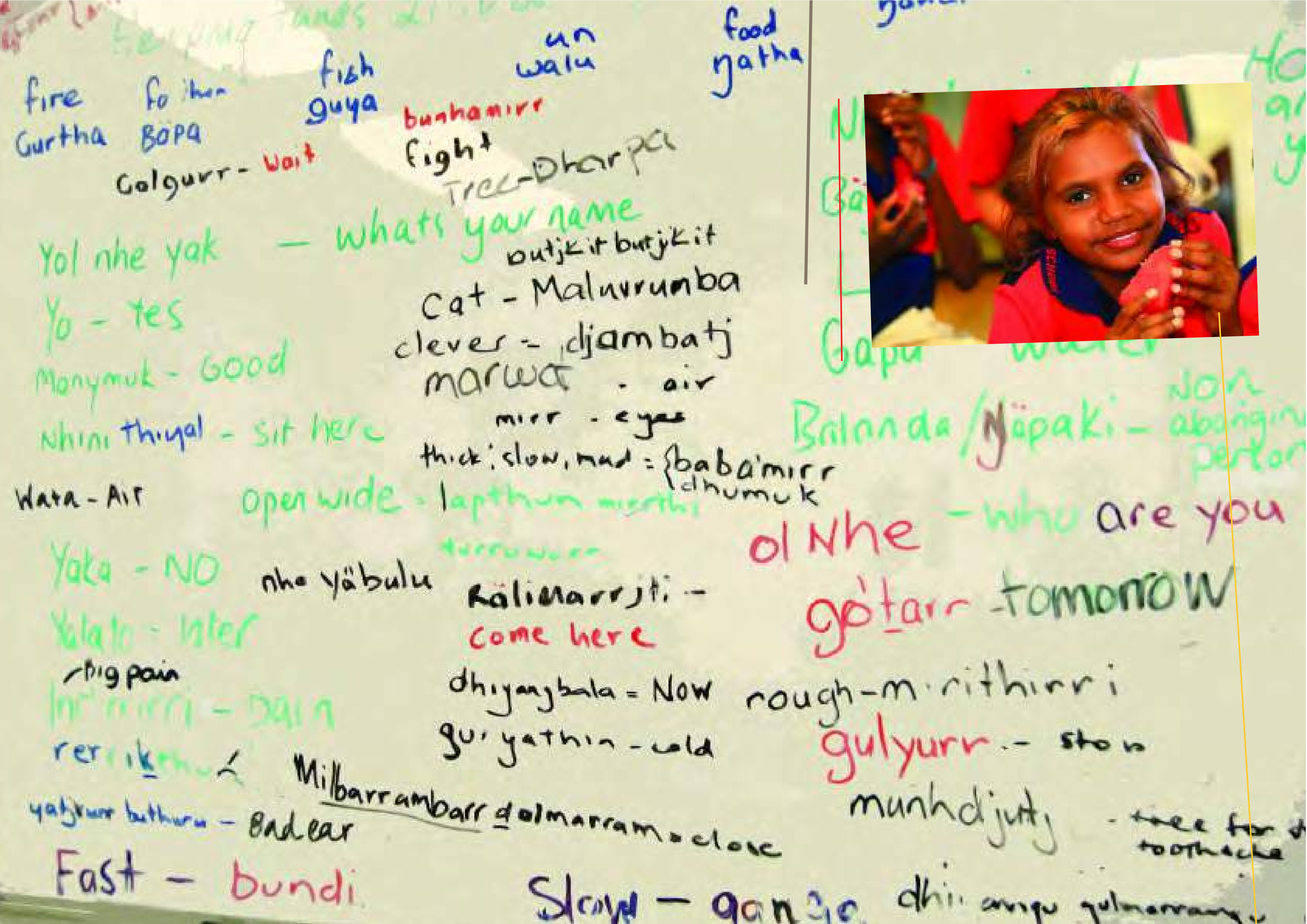
AMSANT

ANNUAL REPORT

2009-2010

ABORIGINAL MEDICAL SERVICES ALLIANCE NORTHERN TERRITORY

AMSANT



food
yatha
un
walu
fish
guya
fire
Gurtha
bunhamirr
fight
Golgurr - wait
Tree - Dharpa
Yol nhe yak — whats your name
butjkit butjkit
Yo - Yes
Cat - Malurrumba
clever - djambatj
Manymak - Good
marwat - air
mirr - eyes
Nhini thiyal - sit here
thick, slow, mud = babamirr dhumuk
Wata - Air
open wide
Yaka - NO
nhe yäbulu
Rälimarrjti -
come here
Yalala - later
big pain
dhiyangbala = Now
guyathin - cold
Milbarrambarr
Badear
dolmarram = close
Fast - bundi
Slow
Gapu water
Bälanda / Ŋäpaki - non aboriginal person
ol Nhe - who are you
gòtarr - tomorrow
rough - mirithirri
gulyurr - stop
munhdjutj
tree for toothache

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

Mission Statement

AMSANT is the peak body for Aboriginal community controlled health services in the Northern Territory and advocates for equality in health, focusing on supporting the provision of high quality comprehensive primary health care services for Aboriginal communities.

From the Chair

I think this year was summed up in no better way than the holding of an AMSANT Board meeting at Walungurru (Kintore) in June. It was emblematic of our commitment to our membership, no matter how remote, as well as to the passion of our membership in their dedication to comprehensive primary health care through Aboriginal community control.

Certainly Walungurru was the most remote place in Australia that the major national issue facing the health sector this year, Health and Hospital Reform, was discussed in such detail. While the politicians in Canberra and elsewhere were engrossed with the issues of how the proposed reforms would affect big city hospitals, our mob was in the Western Desert looking at the reform impacts on Aboriginal health care.

Appropriately, the National Health and Hospitals Reform process undertaken by the Rudd/Gillard governments, as well as the National Preventative Health Taskforce, drew strongly on 30 years of work by Aboriginal community controlled health services. These two processes have endorsed our work and the systems we have developed over many years in building a comprehensive PHC practice.

Those discussions at Walungurru have led to our aim of establishing an Aboriginal Primary Health Care Organisation, at least at a jurisdictional level, as the sole funds holder for Aboriginal primary health care in the Northern Territory.

Such a body would have the independent role of pooling all comprehensive primary health care funds

for Aboriginal people in the Territory. While it would still be informed by the work of the tri-partite Northern Territory Aboriginal Health Forum (NTAHF), it would have the task of delivering resources to Aboriginal people across the Territory in achieving equitable funding. It is a discussion that will be on-going in the coming financial year.

Parallel to the discussions among our membership, AMSANT this year has significantly expanded its engagement with political processes at a Federal and Territory level. This involved a major AMSANT delegation travelling to Canberra in February where we met with key figures in both government and opposition, as well as the Greens. We have also consolidated our contacts with the Territory Government through a number of important meetings with the Chief Minister and Health Minister during the year.

This expanded engagement has reflected AMSANT's new strategic plan which has refined and expanded the approach we will be taking in the years to come.

The Intervention has, of course, been our primary concern since June 2007. After an appalling start, with threats of compulsory forensic child health care checks designed to detect abuse, sounder minds came to the fore and comprehensive primary health care came to be seen as a more rational, evidence-based way to go.

But the majority of measures imposed by the Intervention had nothing to do with its stated objectives. More to the point, the vast majority of the measures have not been evidence-based.

Although we maintain a critical stance to the Intervention as a whole, AMSANT continues to work with the Intervention in trying to achieve real change for our people's health. In other words, we decided to work with those parts of the Intervention that had a real chance of working ... and were backed by evidence.

There was one area of the Intervention which was evidence-based and that was seen in substantial increases in the resources being made available to Aboriginal controlled primary health care.

The expanded resources made available as a consequence of the Intervention have done much to provide greater equity across the Northern Territory, with resources available to some remote areas where few, if any, were available before.

As part of developing good governance, a review was held of our Constitution this year, and changes endorsed at the last AGM. These included extending the period in office of the Chair and Board members (to take effect at the next AGM); updating our financial systems to reflect electronic banking; and introducing a new form of membership to AMSANT through affiliation.

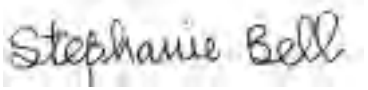
While we have a long way to go, we have got good stories to tell. Building on more than three decades of struggle and hard work, we do have a way forward for the health of our peoples. We have achieved advances, for example, in the life expectancy of Aboriginal women in the Northern Territory. Infant mortality rates are declining and some other key indicators are improving. Many of our services are now achieving outcomes that are certainly better than government run services. Some indeed are doing better than suburban-based GP services.

Good stories were there for the telling, as well, at the successful Fresh Food Summit held in Tennant Creek in May, a day after Anyinginyi opened its wonderful new clinic. It was the first Summit we had been able to hold since before the Intervention and was a great success. At the summit we heard about some great work being carried out in community gardens, as well as the big plans being proposed by CentreFarm. Food security will be an important issue for our people in coming years, so we anticipate positive developments as a response to the Summit.

As you will see elsewhere in this Annual report, AMSANT has been active across the Territory and across many different projects, as well as with the essential roll-out of regional community control of our health services.

There is a long way to go, but I am hopeful that we will continue to achieve great results for our members and for the tens of thousands of Aboriginal and Torres Strait Islander people in the Territory.

Stephanie Bell



Chairperson

From the CEO

As I look back on four years work with AMSANT I realise how far we have come in such a short time. But I also recognise the years of hard work, sacrifice and planning by those who came before me. They laid the foundations of the strong organisation we have today.

In October 2009 we celebrated AMSANT's 15th anniversary. Along with the carving of a giant birthday cake, we also marked the formal launch of *Pathways to Community Control*, the joint partnership between AMSANT and the Commonwealth and Northern Territory governments that provides the guiding principles of Aboriginal community control of primary health care in the Territory.

These "guiding principles" are critical to directions we take in the years to come, particularly through the process of regionalising Aboriginal community control of primary health care in the Territory. But they also tell us about new approaches to program delivery and support to our membership.

An important part of this is through our operational involvement with both the Northern Territory and Australian governments. AMSANT serves on more than 50 committees, boards and advisory groups with both governments across a diverse range of clinical and non-clinical issues. In addition, we have also worked on many submissions to government inquiries and consultations. All of these activities have been guided by the strong partnership we have built with government through the Northern Territory Aboriginal Health Forum, which we chair.

In addition, we have also worked to build across other networks in the Territory, and this has led to joint research and advocacy work with the Northern and Central Land Councils, the North Australian Aboriginal Justice Agency and the Central Australian Aboriginal Legal Aid Service. As well, we have developed strong partnerships with the Fred Hollows Foundation and Oxfam Australia.

What we do as an organisation is also being guided by our new Strategic Plan. The parameters of the Plan were set by the AMSANT Board, and then developed over a period of nine months by all of our staff. The Plan sets out our objectives over the next three years and provides a "map" of how we hope to achieve those goals. It is a living document that we'll adapt and amend at six-monthly reviews to cover new opportunities and challenges that arise.

When I first started at AMSANT we were an organisation that employed a mere handful of people. The rapid growth since then (much of it through projects supplying services to our members) has been one of our key challenges. A recent review led us to recruit Business and Policy managers who have been important in consolidating our operations and enhancing our effectiveness.

However, as an organisation we must continue to improve the way we do business for and on behalf of our membership, especially as we take on greater responsibilities and represent a much expanded Aboriginal community controlled PHC sector. Much of our new Plan is geared towards this operational objective; for example, in the next financial year we're looking at gaining ISO accreditation for AMSANT.

The new ways in which we do our work is perhaps best shown in our Continuous Quality Improvement [CQI] program. This is not just a service to our members but is also being delivered by our wonderful team into NT government clinics as well. This demonstrates our commitment to improving the health of our people across the whole of the Northern Territory in partnership with government, while we build towards community control across the Territory.

In looking back over the last year, may I thank the AMSANT Board for its strong guidance and support to AMSANT staff. The Board is made up of CEOs who are, in their own right, extremely busy people so their continuous commitment is gratifying. In turn, I would also like to thank the staff of AMSANT for the efforts they have all put in over the past 12 months.

Our Chair, Stephanie Bell, has described AMSANT's push towards Closing the Gap through comprehensive primary health care for our people as "a great ambition". The hard work and passion demonstrated by our staff shows that this great ambition can be achieved, for the benefit of all Aboriginal and Torres Strait Islander peoples. And for the benefit of all Australians.

John Paterson 

Chief Executive Officer

Strategic and operational planning

The AMSANT Board and staff have spent considerable time and energy this year in developing a new operational plan 2010-2012 to better support member services and to promote more widely the benefits of Aboriginal community controlled health services.

An initial meeting on Groote Eylandt was followed by workshops and meetings throughout the year and throughout the Territory to reach consensus on the most effective and appropriate ways for AMSANT to move forward. The final operational plan was endorsed by the Board in May 2010 and AMSANT will now report to OATSIH on our development and progress, as measured by the plan.

The plan has eight strategic objectives, with a variety of tactics and actions to ensure the success of AMSANT's operations:

THE AMSANT BOARD AND PINTUPI HOMELANDS STAFF AT WALUNGURRU (KINTORE) IN JUNE 2010.

Strategic Objective 1: Strengthen health leadership among member organisations

1.1 Identify and support emerging Aboriginal leaders in member organisations

1.2 Develop programs in support of Aboriginal leadership, external of AMSANT

1.3 Develop leadership programs for AMSANT staff

Strategic Objective 2: Enhance support to member organisations

2.1 Build capacity for effective governance training and support for member organisations

2.2 Provide support for members in the field of information technology and PIRS

2.3 Assist member organisations to implement quality improvement systems

2.4 Assist member organisations to improve their funding levels

2.5 Build the capacity of member organisations to achieve a comprehensive PHC delivery model

Strategic Objective 3: Build effective relationships that improve Aboriginal health

3.1 Increase profile of AMSANT in the broader community

3.2 Enhance relationships with all tiers of government in Australia (Australian, Territory and local)

3.3 Enhance relationships with NGOs including philanthropic, medical and social services

3.4 Build capacity to address the broader social determinants of Aboriginal health

3.5 Promote the new AMSANT strategic and business plans to governments and all relevant stakeholders, including members

Strategic Objective 4: Advocate for equality

4.1 Develop workforce modeling for the Aboriginal PHC sector

4.2 Continue to lead advocacy for Aboriginal community controlled health services

4.3 Develop policy platform for advocacy

4.4 Develop an effective communication strategy for AMSANT policy and positions

Strategic Objective 5: Enhance member relationships

5.1 Develop a shared vision for AMSANT's role in support of the membership

5.2 Develop member services in line with shared vision

5.3 Develop effective communications strategies with members

5.4 Enhance AMSANT engagement with communities that do not have an ACCHS

5.5 Assist services to source support where AMSANT lacks the capacity to provide support

Strategic Objective 6: Increase AMSANT Funding

6.1 Increase government funding opportunities

6.2 Diversify funding sources

Strategic Objective 7: Enhance internal capacity to deliver on strategic objectives

7.1 Build sustainable human resource capacity to deliver on AMSANT objectives

7.2 Enhance internal processes and systems

7.3 Enhance internal communications

Strategic Objective 8: Grow community controlled sector

8.1 Support and implement the regionalisation agenda through *Pathways to Community Control*

8.2 Provide advocacy to strengthen Aboriginal PHC in the NT

8.3 Promote further reform to the excessive administrative burden on ACCHSs.

AMSANT member services

What is a community controlled health service?

Over the years, AMSANT has advanced a clear definition of 'community control' and what constitutes a community controlled health service. Essentially, community control is the ability for the 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.

This interpretation of 'community-control' is supported by the National Aboriginal Health Strategy's definition which states that ~

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 (NAHS 1989a~ xiv).

According to the AMSANT Constitution, to be considered genuinely community-controlled, an organisation must ~

- be incorporated as an independent legal entity;
- have a constitution which guarantees control of the body by Aboriginal people and which guarantees that the body 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.

Aims and Objectives

The AMSANT Constitution outlines its aims and objectives as follows ~

To alleviate the sickness, suffering and disadvantage, and to promote the health and well-being of Aboriginal people of the NT through the delivery of health services and the promotion of research into causes and remedies for illness and ailment found within the Aboriginal population of the NT.

To promote 'Primary Health Care' which means essential health care based on practical, scientifically sound and socially acceptable methods and technologies which address the main health problems in the community through preventive, curative and rehabilitative services. It involves the treatment and prevention of disease and injury and the creation of the circumstances for personal and social well-being. Such services shall be universally accessible to individuals and families in the community who, through properly-elected representatives, control decision-making and service delivery in the spirit of self-reliance and self-determination. In the absence of control, the community should exercise maximum participation in decision-making and service delivery.

To serve as a peak body and a forum for the Aboriginal Medical Services in the Northern Territory.

To lobby for positive changes to the status of the health of Aboriginal people of the Northern Territory and Australia generally.

To advocate for Aboriginal self-determination and community control.

To represent its Members and Associate Members at any committees, forums, conferences, meetings, inquiries, commissions, seminars, or negotiations directly or indirectly relating to Aboriginal health, and to report back to its Members and Associate Members in respect of such representation.

To assist Aboriginal groups, including Associate Members, wishing to establish Aboriginal Medical Services to incorporate and to obtain direct funding as Aboriginal Medical Services in their own right, either in areas of the Northern Territory currently without health services, or those with health services which are not Aboriginal Medical Services.

To assist Aboriginal communities which do not control their health services to expand their participation in determining the policies and priorities of the health services that they do receive.

To provide a voice on any issue which affects the health and well-being of Aboriginal people represented through the Alliance, including health services, land issues, self-determination, economic development and environmental health.

Structures and Functions

Designated Representatives

Each Member, Associate and Affiliate Member specifies one person (usually the Director or Administrator) to officially represent them at AMSANT meetings. Each Member or Associate Member can specify up to three proxies, any one of whom may represent the organisation if the designated representative is unable to attend. Note that while the designated representative (or their proxy) officially represents the Member, Associate or Affiliate Member, each organisation may usually send as many representatives as they need to AMSANT meetings.

General Meetings

General meetings are meetings of all AMSANT Members, Associate and Affiliate Members. They must take place at least once every four months, with an Annual General Meeting held once a year. General Meetings are generally held either in Darwin or in Alice Springs because they are the easiest places for members to get to, though other places may host meetings from time to time. General Meetings are usually held to discuss the current issues facing AMSANT and its members and to determine what action AMSANT needs to take to advance community control and Aboriginal health.

At least five members must be present at a General Meeting. Members' designated representatives may attend, speak and vote at AMSANT General Meetings; Associate and Affiliate Members' designated representatives may attend and speak, but not vote.

Note that AMSANT ordinarily works on consensus decision making, attempting to get agreement from all representatives on a particular policy or course of action. It is very rare for issues to come down to the vote. Members, (or Associate and Affiliate Members) are free to contact the AMSANT Secretariat if they would like any item placed on the agenda for an AMSANT General Meeting.

Public Statements

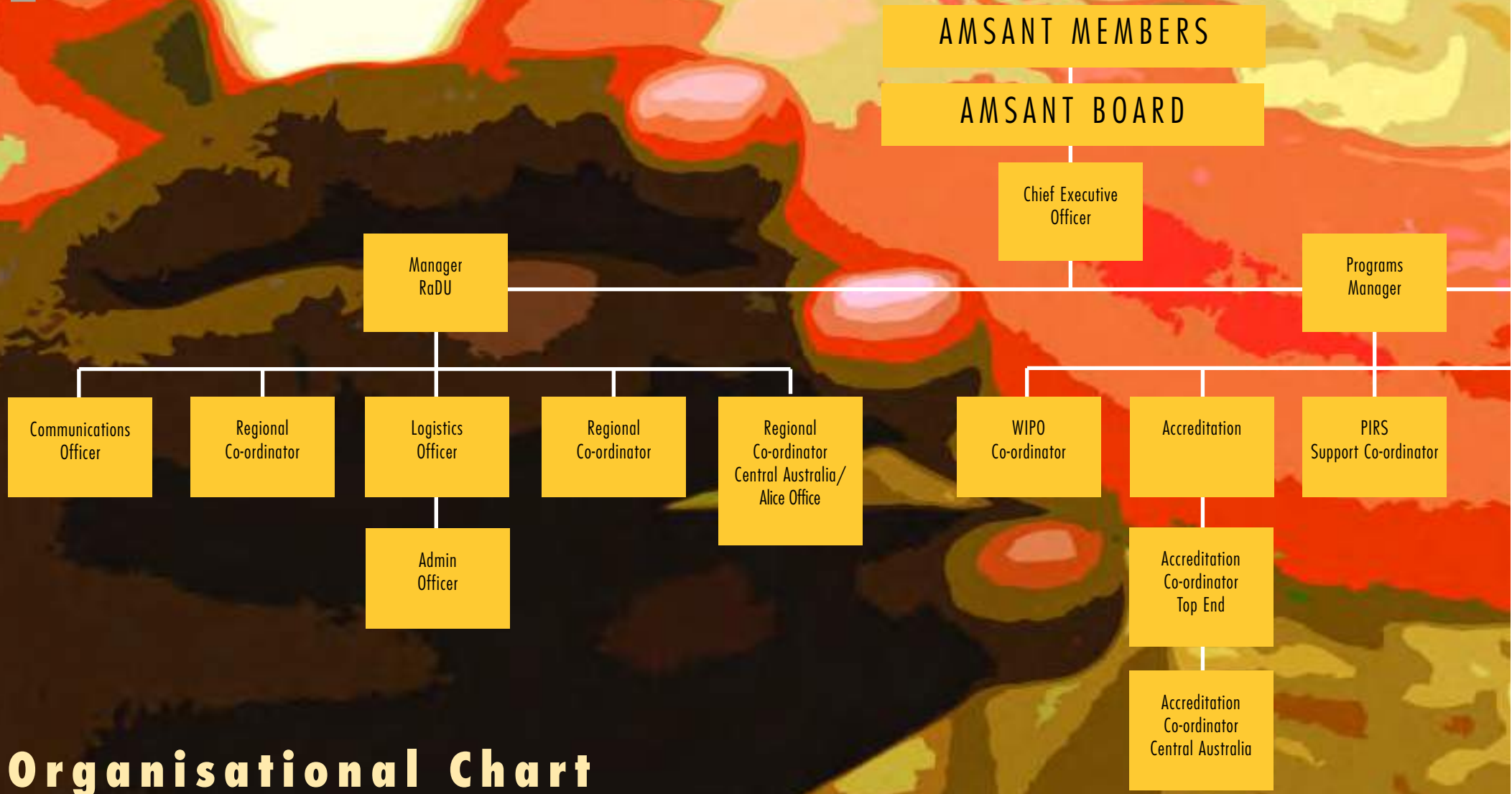
No Member or Associate Member may make a public statement on behalf of AMSANT without the permission of the AMSANT Board or the direction of an AMSANT General Meeting.

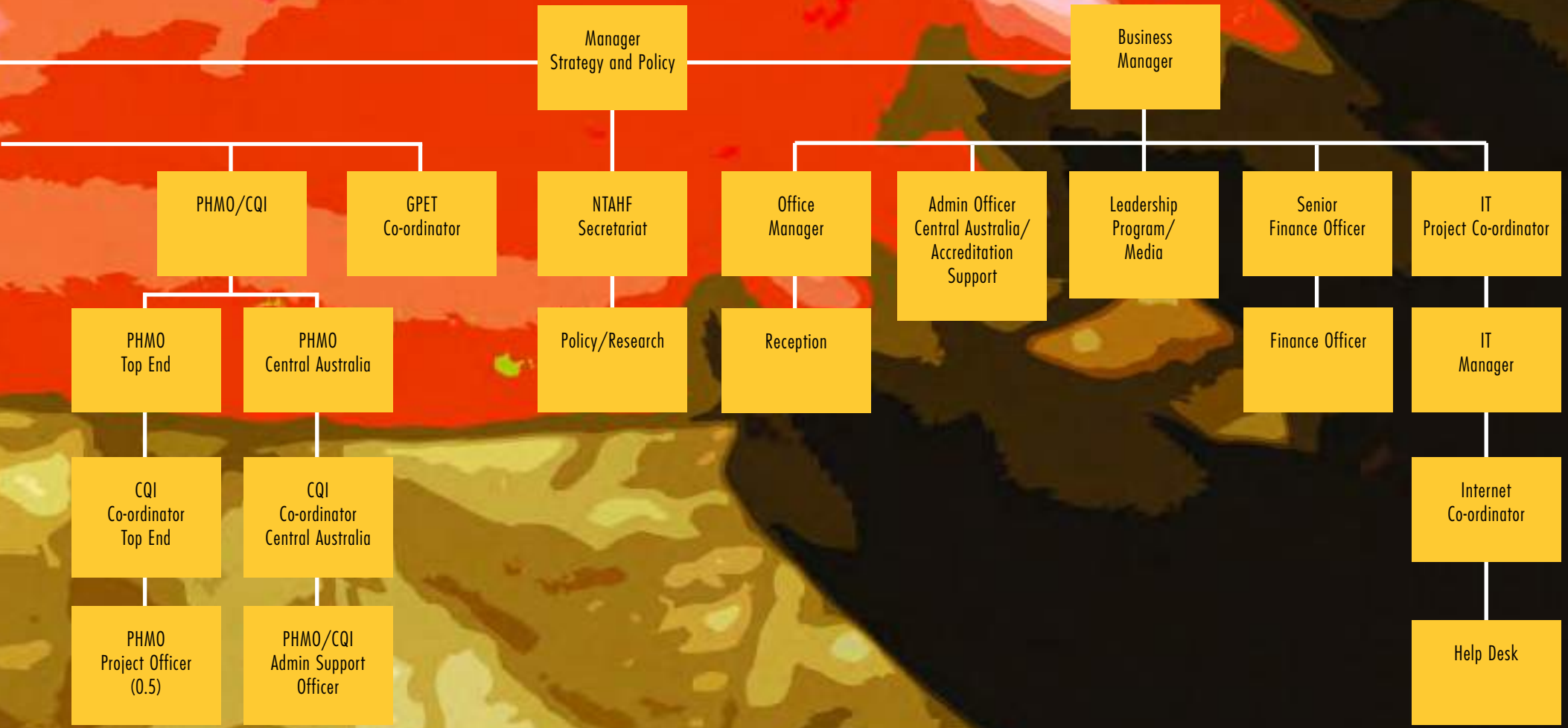
AMSANT Board

The AMSANT Board is made up of full AMSANT members who make decisions for AMSANT between the General Meetings.

(The general structures and functions of AMSANT are set out in the Constitution, copies of which are available from our Darwin office.)

Organisational Chart




Manager Strategy and Policy
Business Manager
PHMO/CQI
GPET Co-ordinator
NTAHF Secretariat
Office Manager
Admin Officer Central Australia/ Accreditation Support
Leadership Program/ Media
Senior Finance Officer
IT Project Co-ordinator
PHMO Top End
PHMO Central Australia
Policy/Research
Reception
Finance Officer
IT Manager
CQI Co-ordinator Top End
CQI Co-ordinator Central Australia
Internet Co-ordinator
PHMO Project Officer (0.5)
PHMO/CQI Admin Support Officer
Help Desk

Research and policy

AMSANT's commitment to an evidence base for its clinical and social practice has been at the heart of our philosophy for the 15 years of our existence. To this end, quality research continues to guide policy development within AMSANT and supplies AMSANT with a tool for advocacy for comprehensive Primary Health Care to the Territory's community controlled health sector.

The research and policy unit of AMSANT gives advice and support to the Board, the membership and the CEO. The unit works through elements within AMSANT, especially the Public Health Advisory Group (PHAG). We also share knowledge with other NGOs within the Territory including, in 2009-2010, the Northern Territory Council of Social Services (NTCOSS), Fred Hollows Foundation, the Northern and Central Land Councils, the North Australian Aboriginal Justice Agency, Central Australian Aboriginal Legal Aid Service, Peoples Alcohol Action Coalition and the Really Caring for Kids Coalition.

A key achievement for AMSANT this year was the adoption by the Board of a Research Policy for the community controlled primary health care sector in the Northern Territory. Many of our services (as well as Northern Territory Government clinics) are actively involved in research projects with a diverse range of researchers and research institutions. This puts considerable pressure on our members who, while supporting the need for an evidence base to guide their work, often find research projects a distraction to their day-to-day commitments, and are often uncertain as to the potential benefits that they might be able to translate into improved practice.

Many of our Members have also expressed interest in initiating research projects directly from services, rather than being passive "recipients" of research.

The research policy is designed to assist AMSANT in areas in which we are asked to participate in research projects, as well as assisting our Members in assessing and analysing the potential benefits of proposed projects that they are being invited to be involved in. We have developed a check-list which is also available to our Members, as well as the research community which seeks to engage with our sector.

At our Board's request we are also working towards creating a position within AMSANT that would be dedicated to assisting our Members, along with the research community, in getting the very best out of research projects that will assist the PHC sector. This person would operate as an analyst of proposals, as well as being a broker for community initiated research.

The research and policy unit of AMSANT has also been involved in broader development work, especially in helping to provide our response to the National Health and Hospital Reform process, the on-going issues related to the Intervention and working on advocacy positions on other issues to be taken to governments.

In 2009-2010, AMSANT developed submissions on:

Alcohol, including proposed take-away restrictions in Darwin-Palmerston; the Northern Territory Child Protection Inquiry; the health/economic benefits of outstations; the *Public Health Act* review; Aboriginal Primary Health Care workforce issues, including Aboriginal Health Workers; and the exposure draft of regulations on New Income Management measures. The research and policy unit has also worked on a range of policy positions taken to governments and their agencies.


AMSANT
FRESH
FOOD
SUMMIT
TENNANT CREEK
5-6 MAY 2010
Together for our Health
AMSANT

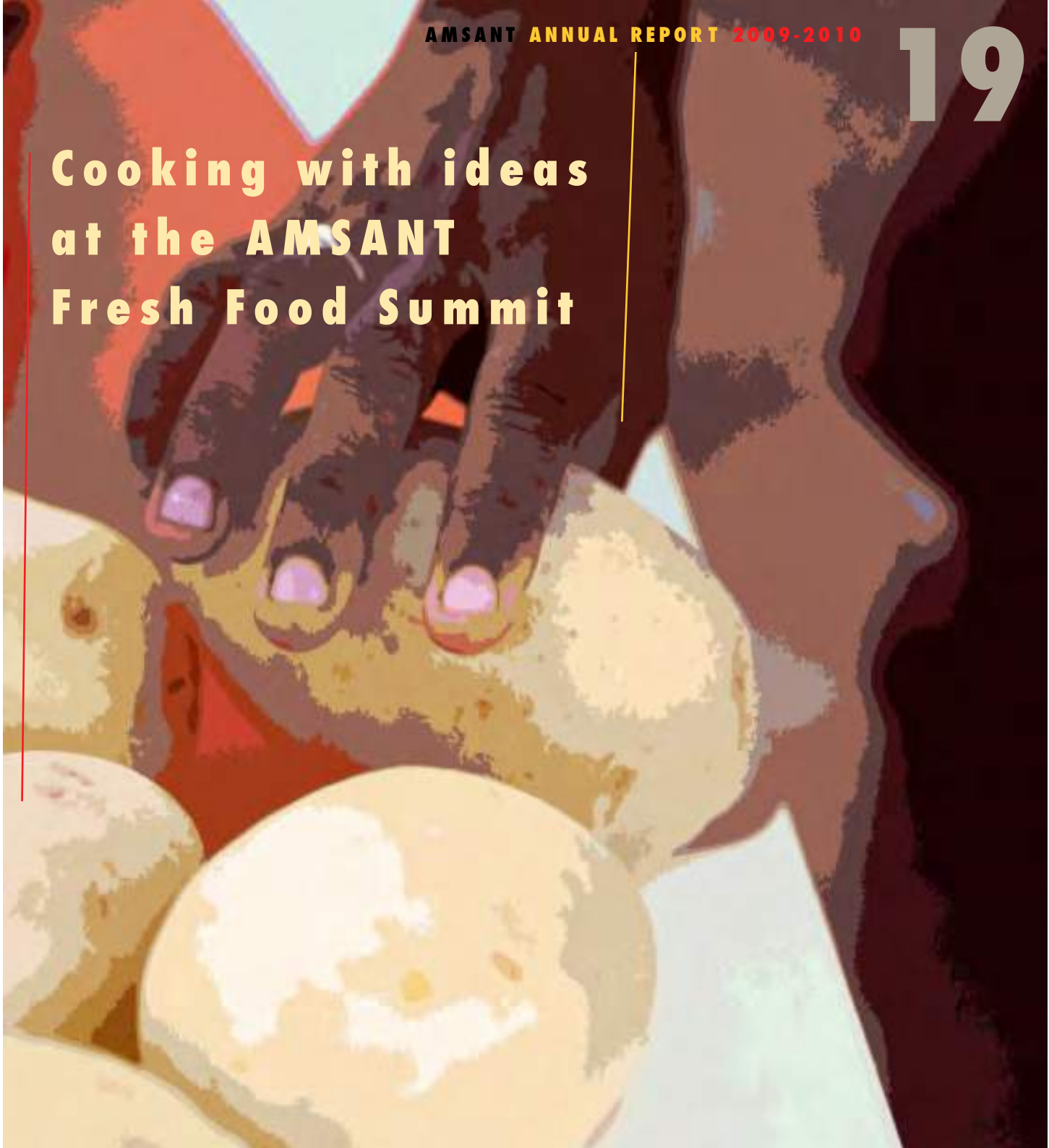
Cooking with ideas at the AMSANT Fresh Food Summit

Early May saw an invasion of more than 300 people from across the Territory and interstate attending the AMSANT Fresh Food Summit, the first summit held since the Northern Territory Intervention.

For many years the Aboriginal community controlled PHC sector has recognised that the supply of fresh, nutritious and affordable food is a critical part of health issues. The summit was about getting Aboriginal people together to work through the range of complex issues surrounding food security. It was designed to get all the players together: community members, health professionals, community stores and groups such as Outback Stores and ALPA, government and NGOs to chart new directions in the crucial task of boosting supplies of fresh food to our people.

The issue of fresh food supplies to regional and remote communities was a focus of the NT Intervention, and has led to a number of initiatives such as stores licensing and school food programs. There has also been a parliamentary inquiry into community stores in remote areas of Australia. At a national level, the issue of nutrition has been a focus of work carried out by the National Preventative Health Taskforce.

The summit was strongly supported by the Office of Aboriginal and Torres Strait Islander Health (OATSIH), along with assistance from the Department of Families, Housing, Community Services and Indigenous Affairs, the NT Department of Health and Families and the Fred Hollows Foundation. Key support was also delivered by Barkly Regional Arts and Winanjjikari Music.




The Fred Hollows Foundation
1800 352 352
NORTHERN TERRITORY
SEAFOOD

The summit, which followed a Members' general meeting and the opening of Anyinginyi's new clinic, covered a wide range of topics, including:

- Case studies of small-scale community horticulture projects,
- Large-scale initiatives such as those proposed by Centrefarm,
- Initiatives from the Northern Territory fishing industry,
- Projects from the Fred Hollows Foundation,
- The role of community stores and store groups such as Outback Stores and ALPA,
- The relationship between stores and the comprehensive PHC sector,
- Approaches to food and/or freight subsidies,
- The need for an independent monitoring of stores, and
- Getting cooking right for our health.

Major highlights of the summit were a variety of cooking demonstrations from nutritionists working at Anyinginyi and Congress. There was a also a strong cultural element to the summit, including dancers from Ale Kera nge; exhibitions of paintings featuring traditional foods; bush medicine demonstrations from senior women from Tennant Creek; and a concert each night featuring local musicians.

Public health

AMSANT's Public Health Medical Officers (PHMOs) have a very wide role in advising, supporting and consulting with member services regarding serious issues of public health, often in collaboration with other AMSANT staff. This has been especially true this year in the area of Continuous Quality Improvement where the PHMOs worked closely with the CQI Coordinators in the establishment of their program.

Dr Liz Moore is the PHMO in Alice Springs; Dr Tanya Davies is the PHMO in Darwin.

Public Health Network (PHN)

When the Public Health Network was set up in 2006 the main "action items" identified by the group concerned the general effectiveness of "health systems"; AMSANT has since set up methods of addressing these issues. The issues include support for CQI and accreditation, the reform of the Medical Specialist Outreach Assistance Program (MSOAP), reform of hub services and support for services to collect and use health data, including the 19 Key Performance Indicators. There is still much work to be done in the coming year, including addressing clinical governance, which is a major priority for the PHMOs.

The PHN is in the process of setting up special interest groups, including the NT Aboriginal Health KPIs Collaborative, a Maternal Health Special Interest Group, a Sexual Health Special Interest Group, and others.

PHN Communication

Over the past year, the PHMOs have contributed significantly to the communication that AMSANT has with its members, as per its Communication Plan.

1. A PHN bulletin that goes out to all PHN members every two weeks. This replaced the irregular emails that the PHMOs were sending out, so that clinicians working in Aboriginal primary health care get more coordinated information. In addition, the PHMOs contribute to the bi-monthly *Communique in Quality,* put together by a wider group of AMSANT staff.

2. The PHMOs have been working hard on getting a PHN website established, which should be available by the end of 2010.

3. One of the issues brought up by our Board was for AMSANT to improve our internal systems in order to deliver on strategic objectives. The PHMOs have worked closely with the ICT staff over improvements to the Intranet to assist in the general communications to members.

Representation

The PHMOs continue to sit on a wide range of clinical and public health committees. They are also supporting staff from ACCHSs to represent AMSANT on some of these committees and help them provide feed-back on key issues to the management and membership. The PHMOs are also using the PHN and special interest groups to get feed-back about grass-roots issues that can be analysed and actioned by these clinical and public health groups.

One of the key groups is the Renal Clinical Reference Group. AMSANT has advocated for better renal services, particularly in Central Australia where there was a crisis last year in capacity for renal dialysis. There was also considerable advocacy at the political level about renal dialysis with both the NT and Federal governments.

The crisis in capacity has now been temporarily resolved with the opening of new dialysis facilities in Alice Springs, and access for interstate patients has improved. However, there is an on-going issue of lack of social support and accommodation not only in Alice Springs but in all regional centres, including Darwin. Member services are keen to work on these issues with other stakeholders in their region.

There is also a review of renal services in Central Australia being carried out by the George Institute in Sydney. Member services in Central Australia and AMSANT will provide broad input into this review and AMSANT will continue to assist with ongoing networking and advocacy for improved services to patients on dialysis.

It is vital that ACCHSs are resourced to be able to provide high quality care to patients with renal disease as this will delay the need for dialysis and reduce the burden of other morbidities such as cardiovascular disease in this high-risk patient group. To this end, AMSANT has been advocating with OATSIH for the continuation of funding for renal coordinator positions in four regional Aboriginal health services.

System issues

The PHMOs continue to provide major input into system issues which affect the delivery of PHC in the NT and to provide feed-back from member services about how broader system issues are affecting PHC service delivery and patient care.

One of the major system issues affecting the NT is the review of the Medical Specialist Outreach Assistance Program (MSOAP). AMSANT continued to negotiate for reforms in specialist outreach services during the past year and this resulted in the new program, Special Outreach Northern Territory (SONT), which combines the SOS (Specialist Outreach Service), the MSOAP and funding from the Council of Australian Governments under the *Closing the Gap* Indigenous Chronic Disease program, as well as additional funding provided by DHF in the past year. SONT now has a coordination unit with an overall business plan for the whole program, as well as a yearly project plan. The new system includes:

1. Integration of all specialist visits under one program called SONT.
2. Central coordination of all outreach under one coordination centre at SONT.
3. Accountability to the SONT Steering and Advisory Committees and the Aboriginal Health Forum.
4. Transparency of funding from all sources, including DHF funding.
5. Improved data collection to facilitate the use of data to assist the planning process.
6. Improved process of determining 'needs-based planning' by DHF and having direct discussions and MOUs with PHC services.
7. Development of a new model of service delivery by primary health care providers and specialists.
8. Clarification of definition of "multi-disciplinary teams" ie that they are based with the primary health care team, not the specialist team.
9. Stronger relationships with PHC Services and the development of MOUs between DHF and each individual health service.
10. Development of mechanisms for dispute resolution.
11. Additional funding for a limited range of complementary support staff and allied health professionals. (eg midwife with obstetrician; audiologist with ENT surgeon; optometrist with ophthalmologist etc).

Public Health Advisory Group (PHAG)

The PHMO team continue to support and provide major input into the PHAG group which provides public health advice to the AMSANT CEO and the board. A wide range of advocacy, research and policy issues are discussed and acted on by this group. Recent activity includes providing a submission to the NTG on the review of the *Public Health Act* which strongly supported more accountability in the delivery of core PHC services, such as rubbish disposal. The PHAG group (particularly the senior medical advisor, Dr Andrew Bell, and Policy Manager, Chips MacKinolty) has supported the board by providing policy advice on the national primary health care reforms and how they affect the community controlled sector.

The PHAG has also provided major input into how services for children and families "at risk" can be integrated into comprehensive primary health care, including through a submission to the NT Inquiry into Child Protection and also by providing advice into programs directed towards families at risk. Alcohol control and integrating alcohol and other drugs services into primary health care has also been a major focus, with a successful workshop being held on this topic in February 2010.

Research

AMSANT now has a research policy which guides how staff deal with requests for advice by researchers, including requests for AMSANT to be a partner in a research project or support a project at the ethics or funding stages. All research proposals are assessed according to a template developed by AMSANT and discussed at PHAG. AMSANT is involved in four projects as a research partner, including STRIVE (a randomised controlled trial of a quality improvement approach to sexual health care in PHC) and a national partnership grant based on further work on the ABCD (Audit and Best Practice in Chronic Disease) CQI approach.

AMSANT would like to assist ACCHSs with taking a more pro-active approach to research involvement and is looking to employ a research officer to work with AMSANT and ACCHSs to ensure research is relevant, timely and of benefit to Aboriginal PHC.

One of the roles of the PHMOs concerns the analysis and use of data from the NT Aboriginal health sector. Three of the ways this is achieved are:

1 Evaluation of the Expanding Health Service Delivery Initiative (EHSDI) and Child Health Checks

The two PHMOs are members of the committee that is overseeing the evaluation of EHSDI and the Child Health Check Initiative (CHCI). The Federal government has now released three reports on the evaluation of the CHCI. A team of consultants (Allan and Clarke) is currently compiling a final report which will include an evaluation of EHSDI and a final review of the CHCI. The evaluators have conducted interviews in remote communities with Aboriginal leaders and community members, clinicians and managers at health services and others. The PHMOs (along with other staff at AMSANT) have provided major input into this work and AMSANT will provide written input into the final report which will be presented to the NTAHF meeting in October 2010. So far, there have been some valuable interim results which have been discussed with key stakeholders, including PHRG and NTAHF.

2 National issues

The PHMOs are part of a national network of PHMOs employed by all the NACCHO affiliates across Australia. One of the major issues discussed here are national indicators which OATSIH wants to introduce to all Aboriginal PHC services across Australia. The PHMOs have been active in advocating for the indicators to be part of a quality framework, in support of CQI, in all Aboriginal PHC services.

3 19 Key performance indicators and CQI

The PHMOs work with others at AMSANT to support services in collecting quality health service data (particularly the 19 KPIs) which they can then use as a basis for CQI. The PHMOs are also involved in the KPI steering committee and clinical reference group. In addition, the PHMOs provide clinical advice and support to the CQI program and coordinators.

GP issues

The PHMOs continue to provide input into GP recruitment by attending regular monthly meetings with GPNNT. The PHMOs also provided individual orientation to GPs to the role of AMSANT and the broader community controlled sector in the NT, as well as information about support available through AMSANT, including membership of the PHN.

Swine influenza

Swine influenza continued to be a major issue in the NT during the second half of 2009 and there was ongoing work in 2009-2010 to promote swine influenza "case finding", public health measures to reduce the spread of the 'flu and swine influenza vaccination. The disease is now in the post-pandemic period with only sporadic cases occurring. Seasonal influenza vaccination is now free for all Aboriginal people age 15 years or over as recognition of the disproportionate burden of disease caused by influenza viruses in Aboriginal people.

eHealth

As in previous years, the PHMOs have continued to work closely with the PIRS and ICT staff on issues raised by our members, or in advocating for our members about new policy and practical initiatives that impact on them but are being implemented by other organisations. In addition to the coordinated work they do on the NTAHKPIs, the PHMOs have also contributed to advocacy about multiple components of the *Digital Regions Initiative* being rolled out by DHF, and pharmacy issues raised by our members.

COAG Indigenous Chronic Disease Package

The introduction of the chronic disease package as part of Canberra's Close the Gap package is being guided by a committee that reports to NTAHF. This committee is oversighting the roll out of new workforce, including tobacco coordinators, healthy lifestyle workers and outreach workers. One of the PHMOs is a member of this NTAHF committee. AMSANT has also provided major input into the evaluation plan for the COAG chronic disease package.

Aboriginal Leadership

AMSANT's Aboriginal leadership program grew and developed impressively in the last financial year, culminating in a busy and productive five-day camp at Ross River in April.

Forty AHWs, child care workers, administrators and junior managers from many member services joined in AMSANT's fourth camp (following on from leadership events at Alice Springs, Kakadu and Banatjarl) to discuss the challenges facing young Aboriginal health workers who wish to make a difference in the sector. Public speaking, diplomacy, workforce support and professional development were key themes at the camp, which was attended by NT MLA, Karl Hampton.

"We are now developing the skills we've learned at other leadership camps and becoming more confident in facing the challenges that we come up against in the community controlled health sector," says Erin Lew Fatt, AMSANT's workforce officer and a veteran of all AMSANT's leadership activities.

"We are especially looking at new professional development opportunities as many of our young people are now acting in management positions and hoping to move further ahead in their profession."

Erin says many delegates at Ross River were transformed during the camp and became more confident, thoughtful and talkative during the week's activities: "Some people were really very shy when we started up but by the end of the camp they were talking up strong and making good connections with their colleagues."

AMSANT remains committed to developing Aboriginal leaders among our health services and the Board has made it a high priority to identify and nurture leaders to sustain and strengthen our community controlled health sector.

These efforts have been generously supported since 2006 by our valued partners at Oxfam Australia, the Fred Hollows Foundation and FaHCSIA, and have enabled AMSANT to employ a Leadership Support Officer to promote the development of new leaders.

ERIN LEW FATT (WIPO OFFICER), AND MUKI MUIR (LEADERSHIP SUPPORT OFFICER).

NORMA BENGER (GPET OFFICER).

General practice education and training

GPET framework

A framework was developed with the aim of providing effective planning support to the establishment and maintenance of best practice in Aboriginal and Torres Strait Islander health training, with the key principals listed below recommended by the RACGP Aboriginal Health Training Reference Group.

Key Principles

Aboriginal and Torres Strait islander Health is a national priority requiring responses addressing the relevant issues in all regions of Australia including remote, rural and metropolitan regions.

The provision of high quality training and optimal support for General Practitioners (GPs) and the services/practices in which they work and train is a critical means of enhancing recruitment and retention of GPs in Aboriginal and Torres Strait Islander communities.

Aboriginal and Torres Strait Islander community controlled health services provide a model for effective primary health care. Training in this field of medicine facilitates the acquisition of knowledge, skills and attitudes with applicability to many areas of General Practice. These include training in cross-cultural communication skills, holistic health care of communities and families and individuals, working as a member of a team, and a range of relevant clinical and public health skills.

GPET Officer NACCHO State/Territory Affiliates position

The GPET officers are placed in the NACCHO affiliates to carry out the recommendations of the RACGP Aboriginal Health Training Reference Group. The GPET officer's role is to support the Indigenous health training posts (member services) with the GP training. There are six IHTPs that the officer is required to visit and support is given on a needs basis; the officer is also available to offer cultural support and advice, together with the cultural educators from the regional training providers.

The AMSANT officer has formed a close working relationship with the Regional Training Provider (NTGPE) and takes part in cultural education, the promotion of Aboriginal community control, health training and the RACGP framework.

Media and Advocacy

A key role AMSANT plays on behalf of its membership is that of advocating for improvements in the delivery of comprehensive primary health care to Aboriginal Territorians. It is a complex process: explaining the interplay between evidence-based primary health care service delivery in remote areas with the broader issues of the social determinants of health is difficult, let alone doing it in ways that will effect real change.

While we very often have good stories to tell, it is often hard to get those stories out.

AMSANT has a three-pronged approach to the issue of advocacy.

First, is enhancing the knowledge of our Members so they can be better advocates for comprehensive primary health care within their own organisations, and the communities they serve. This involves regular electronic communication with Members on developing issues: political, social and clinical. Further, newsletters and report-back documents, such as our successful *CommuniQué In quality* newsletter are distributed widely. Work towards the end of the year will also see a re-vamped Public Health Network which will allow widespread distribution of information to our membership. All these outlets have a wide audience within the broader primary health care sector and beyond our membership.

Second, is communicating effectively with decision makers: political, professional and bureaucratic. On the one hand, this might involve formal lobbying and representation; on the other, through participating in forums and other presentations, or submitting material to professional journals.

Third, is "spreading the word" to the general public, as well as the politicians and others mentioned above, through the media.

AMSANT has long had a solid reputation for working with local and national media in getting our message across directly, or in responding to media inquiries about Aboriginal health in the Northern Territory, as well as nationally.

In the last year, this has included initiating contact with and responding to the media on a wide range of issues, including:

- the release of the National Health and Hospital Reform and Preventative Health Task Force reports and recommendations;
- our related campaign for an Aboriginal Primary Health Care Organisation as a sole funds-holder for Aboriginal primary health care funding and resourcing in the Northern Territory;
- eHealth and its importance to our sector in delivering flexible, effective health care;
- cost benefits of the Outstation Movement;
- the continuing scourge of end-stage renal disease in the Northern Territory, and in particular, the crisis in resources in central Australia;
- the launch of the National Health Worker Association;
- support to the Federal Government's increase in tobacco taxation to combat, in particular, the take-up of smoking by younger Aboriginal people;
- reform of the Northern Territory Emergency Response; and
- promotion of the AMSANT Fresh Food Summit.

In the coming year we anticipate reviving some of our neglected newsletters, as well as expanding our links with other NGOs in the Northern Territory in the area of advocacy, particularly with regard to alcohol policy.

Building leadership and capacity (BLAC)

AMSANT is the auspice and support organisation for an innovative program which targets town camp communities and works to address the symptoms of social disadvantage by strengthening the existing capacity in communities, coordinating service provision and developing positive and proactive leadership.

The Building Leadership and Capacity (BLAC) program is currently funded by the ABA (Aboriginal Benefit Account) which receives and distributes royalty equivalent monies generated from mining on Aboriginal land in the Northern Territory.

The BLAC program operates by employing community-nominated people to provide training, mentoring and support while developing a detailed community plan to focus on the future work of the program leader.

The BLAC program model has initially been implemented in four sites in the NT, near Darwin:

- Gurdorrka (formally known as 15 Mile or Palmerston Indigenous Village)
- Milgarri (formerly known as 11 Mile or Knuckey's Lagoon)
- Bagot community
- Amangal (Adelaide River).

The program has been developing productively in the past three years so it was decided that a program review would be helpful in identifying the aspects of BLAC that achieve the most impact and focus on areas where the program could be further developed. Key stakeholders and the BLAC program leaders were surveyed. In general the findings of the review were:

- There is a good understanding of BLAC and broad support for the program design
- BLAC is widely seen to be effective and achieving outcomes
- There is support for the expansion of the program to other communities and attracting secure longer-term funding
- There are some areas of operation which could focus on achieving greater outcomes for communities and a more proactive and predictable collaboration with service providers could be implemented.

BLAC is asset-based; it works with the strengths and resources of communities, the people who live there and their commitment to that community. The positive outcomes of this program in the four sites to date are significant and include the following:

- Greatly enhanced leadership capacity
- Community participation and skill enhancement
- Improvements in infrastructure
- Greatly improved school attendance
- Much improved access to services
- Employment of Aboriginal people in and outside their communities
- Access to responsive and accessible health services.

AMSANT hopes that the BLAC program will continue to develop and expand into new locations in the near future. AMSANT is committed to supporting the program in practical ways and championing such innovative strategies to address Aboriginal disadvantage.

SHEILA WHITE, MARITA MUMMERY, RONNIE AGNEW, EDWARD McGREGOR AND BRUCE DELAHUNTY.

Regionalisation: Reform and Development Unit (RaDU)

Aboriginal community controlled health is moving to meet the challenges of the 21st Century as operations in the future will be larger, regionally-based services able to provide a full range of quality comprehensive PHC. Some things will be the same; services will remain under Aboriginal community control and the emphasis on ensuring quality health services to Aboriginal people will remain a key objective.

ANDREW JAPALJARRI SPENCER (PINTUPI HEALTH) PRESENTS HIS "REGIONALISATION STORY" PAINTING TO AMSANT CEO, JOHN PATERSON.

The continuing crisis in Aboriginal health in the post-intervention period has bought recognition that we need an improved system of health service delivery. The new way moves us toward the delivery of core health services to improve the health outcomes of all Aboriginal Territorians.

Asking Aboriginal community controlled health services to shoulder responsibility for health service delivery for a whole region may sound like a "big ask". However, the Katherine West Health Board (KWHB) and the Sunrise Health Board have shown that Aboriginal health services are up to the task and that the approach works. Putting health decision-making into Aboriginal hands helps to achieve better health outcomes for everyone.

KWHB opened its doors in July 1997. Thirteen years later, the hard work of the Board and its dedicated staff has improved the health of local Aboriginal people to be as good as, and in many cases better than, the results achieved by doctors working in big cities down south.

But here's the difference: KWHB also delivers health services to 32 pastoral properties. Those cattle stations produce the beef for which the NT is famous. The message is clear. If a regional Aboriginal community controlled health service can achieve good results in Aboriginal health, those benefits can flow on to all residents.

Too often, Aboriginal people get sick and end up in hospital with preventable sickness. Too many die before their time. That's why Aboriginal people across the NT want to find a way to get better results in health. Just like the larger, regionally-based health boards, the "regionalisation" approach offers that opportunity.

A collaboration between AMSANT and the Federal and NT governments is promoting the establishment of regionally-based Aboriginal community controlled health services in many other regions of the NT.

Using *Pathways to Community Control*, a "blueprint" for regional Aboriginal community published in late 2009, the NT is evolving "health service delivery areas" (HSDAs): groups of related remote communities with at least 2,500 Aboriginal residents, and asking them to think seriously about health issues in their communities, both now and into the future. Many residents are saying that they want the chance to go regional when it comes to PHC service delivery in their back-yard.

Together with its partners, AMSANT's initial work is in two key areas:

- Working with local communities to develop health leadership and decision structures to steer future planning and development; and
- Working with existing health service providers and local communities to improve health planning, better cooperation and improved agency collaboration.

Canberra's Expanded Health Service Delivery Initiative (EHSDI) has injected much needed funding to enable a wider range of better services to be delivered, at the same time as the community-level consultations are occurring.

The intervention into NT Aboriginal communities showed that many aspects of Aboriginal public policy needed to change to cope with the modern reality of Aboriginal life. No issue is more important than Aboriginal health. The intervention showed change at the community level alone would not deliver the gains needed to "Close The Gap". If Aboriginal health is ever to achieve equity with the health of other Australians, then systemic change in NT primary health care was also required. Regionalisation is part of that reform agenda.

The following reports describe what the AMSANT Reform and Development Unit is doing to help reform Aboriginal PHC in the NT. It's a good story:

Highlights and issues

Interstate visitors have been coming to the NT to see the reform process for themselves. Those visitors have included: the Deputy Premier of Queensland and Minister for Health, Paul Lucas, who recently visited South Alligator to meet with members of the Red Lily Interim Health Board and members of the KWHB and their staff; and the Queensland Aboriginal and Islander Health Council (QAIHC) and the Aboriginal Health Council of Western Australia (AHCWA) have visited Darwin on several occasions, hosted by AMSANT.

THE RaDU TEAM: (LEFT TO RIGHT) DR ANDREW BELL, THERESA ROE, ROGER BRAILSFORD, AIMON RIYANA, GAVIN GREENOFF, KYLIE THORNE AND GRAHAM DOWLING.

ROSS MANDI SPEAKS UP STRONG AT AN EAST ARNHEM STEERING COMMITTEE MEETING.

Regionalisation Activities

East Arnhem

The East Arnhem Steering Committee has been working hard for the past two years to develop governance and service delivery models for a proposed single Health Board to manage PHC services across the region. East Arnhem is among the largest HSDAs in the NT with 10,000 Aboriginal residents living across 33,000 sq kms. A regionally-based planning unit, due in 2010-2011, will use the hard-won consensus to build the detailed proposal needed to establish a single regional Aboriginal community controlled health board. Meetings of local leaders have occurred over the past year in Darwin, Nhulunbuy, Galiwin'ku, Yirrkala and Angurugu.

Despite the challenges and difficulties, one commitment stands clear: the people of East Arnhem want to tackle Aboriginal ill-health and premature death. The path to the future involves local people working closely with clinical providers to improve health and health outcomes for all East Arnhem people.

West Arnhem

The Red Lily Interim Health Board (RLIHB) has been formed to represent Aboriginal communities to the west of Maningrida and to the east of Darwin. Centered on Jabiru within the Kakadu National Park, health service provision in this region services diverse groups. The RLIHB is well advanced in its regional planning and has established its own Regionalisation Planning Unit, assisted by OATSIH funding. Local identity Ronald Lami Lami leads the team and works closely with board representatives, traditional owners and local health service providers.

In the last year, Mr "FM" Spry, a former AMSANT staffer, was seconded to the RLIHB to provide extra support and guidance to the local planning unit. Until the board is incorporated, AMSANT is the fund-holder for the Regionalisation Planning Unit currently co-located within the Kakadu Health Service under an agreement with the Djabulukgu Association.

Barkly Region

Established in 1984, the Anyinginyi Health Aboriginal Corporation (AHAC) is one of the oldest Aboriginal services in the NT. Faced with worsening Aboriginal health statistics and a health service provision that was increasingly based in Alice Springs, 500 km to the south, Anyinginyi established itself as a viable regional Aboriginal service in 2005, well ahead of the Federal intervention into Aboriginal affairs in the NT.

The Barkly region has an area of 284,000 sq km (21% of NT landmass) and equivalent to the area of mainland Victoria and Tasmania combined. The Barkly Region population is around 6000 people or about 3% of the total NT population. About 60% of the population is Aboriginal.

The NT Aboriginal Health Forum nominated the Barkly as a priority HSDA in which to develop regionalisation. The Barkly Regionalisation Unit (formed in early 2009) continues to provide a local team able to identify the local issues that will affect the establishment of a regionalised health service.

In the last year, the Barkly Regionalisation Unit has facilitated a summit of community representatives, developed a Barkly health plan and continued consultations with local communities. The amendment of the Anyinginyi Constitution to ensure representation on the Board from all Aboriginal communities in the Barkly region is an important step in ensuring that all remote Aboriginal communities in the Barkly can nominate their delegate to sit on the Anyinginyi Board.

PINTUPI HOMELANDS HEALTH SERVICE
KUNGKA KUTJARRATJUKURRPA
WALANGURRUNGA NGINYTAKA TJUKRRPA
TJINTIRR TJINTIRRPA TJUKURRPA

Omar Henderson, formerly the Administration Officer with the Barkly Regionalisation Unit, has landed a prestigious Cadetship with the Australian Government, showing that although they're remote, the people of the Barkly can hold their own.

Central Australia

A second regionalisation summit was held in November 2009 at which representatives from remote communities agreed that the very large Central Australian region should be separated into Remote HSDAs on both the Westside and the Eastside (excluding the area of the Alice Springs Municipal Boundary). At this meeting, senior representatives from the Alyawarre, Anmatjerre and Arrente language groups agreed to form the 'Triple-A' (or Eastside) Remote HSDA and a Westside Remote HSDA that takes in the areas serviced by: WYN, WAHAC, PHHS, Mutitjulu as well as the communities of Kaltukatjara, Imanpa, Papunya, Ikuntji and Mt Liebig. Several meetings were held in 2010 to discuss governance arrangements, boundaries, representation and the need to establish a Central Australia Regionalisation Planning Unit to cover both regions.

Andrew Tjapaltjarri Spencer from the Pintupi Homelands Health Service (Kintore) has chaired all Westside Steering Committee and assisted as chair in the early meetings of Eastside. Mr Spencer has played an influential role in working to ensure that the regionalisation development stage is clearly articulated and understood by all. Andrew and Marlene Spencer have produced the "regionalisation story", a painting using traditional symbols that chart the journey facing Aboriginal people as they move toward better health. The Spencers kindly donated this painting to AMSANT and it now hangs in the Alice Springs office for all to see and understand.

Maningrida/Malabam

A health board has operated at Maningrida for the past 12 years and is a tangible reminder that local people aspire to a greater level of participation in health decision-making. At present, PHC services are provided to Maningrida and homeland communities in the area through the DHF. The Malabam Health Board has expressed a strong interest in using the regionalisation framework to take greater control of local health services.

Other regions

Both the Katherine East and Katherine West regions are already served by regionally-based Aboriginal community controlled health services. The KWHB services Katherine West, whereas the Sunrise Health Service provides PHC services in the Katherine East region. Both services are autonomous and fully-resolved services, not requiring access to development services of the type offered by RaDU.

South-East Top End (Borroloola Region)

PHC services are provided to communities in the area around Borroloola and Robinson River through DHF. The Aboriginal population of this region is about 1400 people. Under current agreements with Federal and NT health authorities, a regional Aboriginal population of at least 2,500 people is required before regionalisation options can be considered. One solution to this situation is for this region to consider amalgamation with another region. South-East Top End is bordered by Katherine East and the Barkly, and an area to the west of Dumaji in Queensland.

Tiwi

Between 1997 and 2003 the Tiwi people operated a successful Health Board that made some important gains for the health of Tiwi people. Although the insolvency and subsequent collapse of the Board has made the Tiwi people more cautious on matters of governance, the experience has not dampened their enthusiasm to assume a greater level of control in local health services.

Darwin

The principal Aboriginal health service operating in the Darwin urban/rural area is the Danila Dilba Health Service (DDHS). Negotiations have started to explore whether the community operated health clinic in the Bagot community in central Darwin could be transferred to (or operated by) the DDHS. A review of health services accessed by Aboriginal people in the Darwin region is being planned.

THE ANNUAL ABORIGINAL HEALTH WORKERS AWARDS HELD AT PARLIAMENT HOUSE, DARWIN.

Workforce Support

The Workforce Information Program Officer (WIPO) continues progressing the Workforce Support program area at AMSANT. A major focus for the program during 2009-10 has been to broaden the focus of activity beyond Aboriginal health workers into other areas of Aboriginal primary health care. To this end a number of projects have been initiated, including:-

- Engagement in the Indigenous Medical Reference Group for the NT Medical Program where there has been planning for recruiting many more Aboriginal people from the Territory into medical training based in the NT.

- Working with the National WIPO Network around the creation and establishment of the new COAG Indigenous Chronic Disease program workforce: Aboriginal and Torres Strait Islander Outreach Worker (ATSIOW), Healthy Lifestyle Worker (HLW) and Tobacco Action Worker (TAW) positions. These positions are currently being rolled out as a COAG initiative right around the country, including to ACCHSs in the NT.

- Membership of a reference group formed to develop an Aboriginal Workforce Development Strategy for the NT Health Sector. This project came about as a consequence of AMSANT lobbying in Canberra about a more coordinated approach to bring Aboriginal people into the health workforce and to treat Aboriginal people in PHC as a serious industry sector worthy of high level planning and support. The project is being coordinated by DEEWR and we anticipate some productive outcomes in the coming year.

- The start of a project to develop a broad framework for the Primary Health Care Workforce operating in Aboriginal health in the NT. This project is one of the EHSDI reform initiatives under the NT Aboriginal Health Forum and AMSANT has put its hand up to be lead agency for managing the project. Consultant Lee Ridoutt from Human Capital Alliance has been contracted to work with a partner steering group to consult and develop the framework. The ambition is to come up with a broad set of principles, strategies and recommendations that all relevant stakeholders in the NT can endorse as a way to develop a strong, viable and effective PHC workforce capable of addressing the key Aboriginal health priorities. Consultations will start later in 2010.

The health workforce is a key concern. Recruiting and retaining doctors and nurses is hard, especially for health services in the smaller remote towns and communities. But one area where health staffing is really difficult is among qualified and registered Aboriginal Health Workers (AHWs).

While some new opportunities have opened up in some health clinics, the number of registered AHWs in the NT is in serious decline. Some estimates suggest that the number of newly qualified AHWs has plummeted more than 80% in the last 10 years. This suggests that new graduates joining the NT health workforce each year is remarkably low at a time when the demand trend suggests an annual sector-wide vacancy rate of 60-80. If only the qualified people were available!

The reasons for the decline are complex and relate to poor literacy and numeracy among Aboriginal students leaving the school system, a drop in the number of Registered Training Organisations in the NT offering AHW courses, and policy and funding changes that have seen a growing disconnection between employer groups and training providers. AMSANT continues to advocate for a health workforce able to offer high quality Aboriginal PHC in the NT, as part of multi-disciplinary health teams. AHWs play a vital role as health care providers, as cultural brokers and as interpreters in a complex and technical field. Urgent action and positive change is needed to ensure incentives exist to attract more Aboriginal people into a home-grown health workforce.

The Workforce Support Program continues its efforts in support of the AHW profession. This has been addressed over the year by the following activities:

- Working with the National WIPO Network to support and assist the establishment of the National Aboriginal and Torres Strait Islander Health Worker Association. This has been a long time coming but we're still not quite there in terms of organising an NT branch of the national Association. But at last there is a Board of Directors and a CEO and we can now get busy on the task of forming a powerful voice for the AHWs, both here in the NT and nationally. A healthy AHW Association fighting for the profession will help put AHWs back on the map.

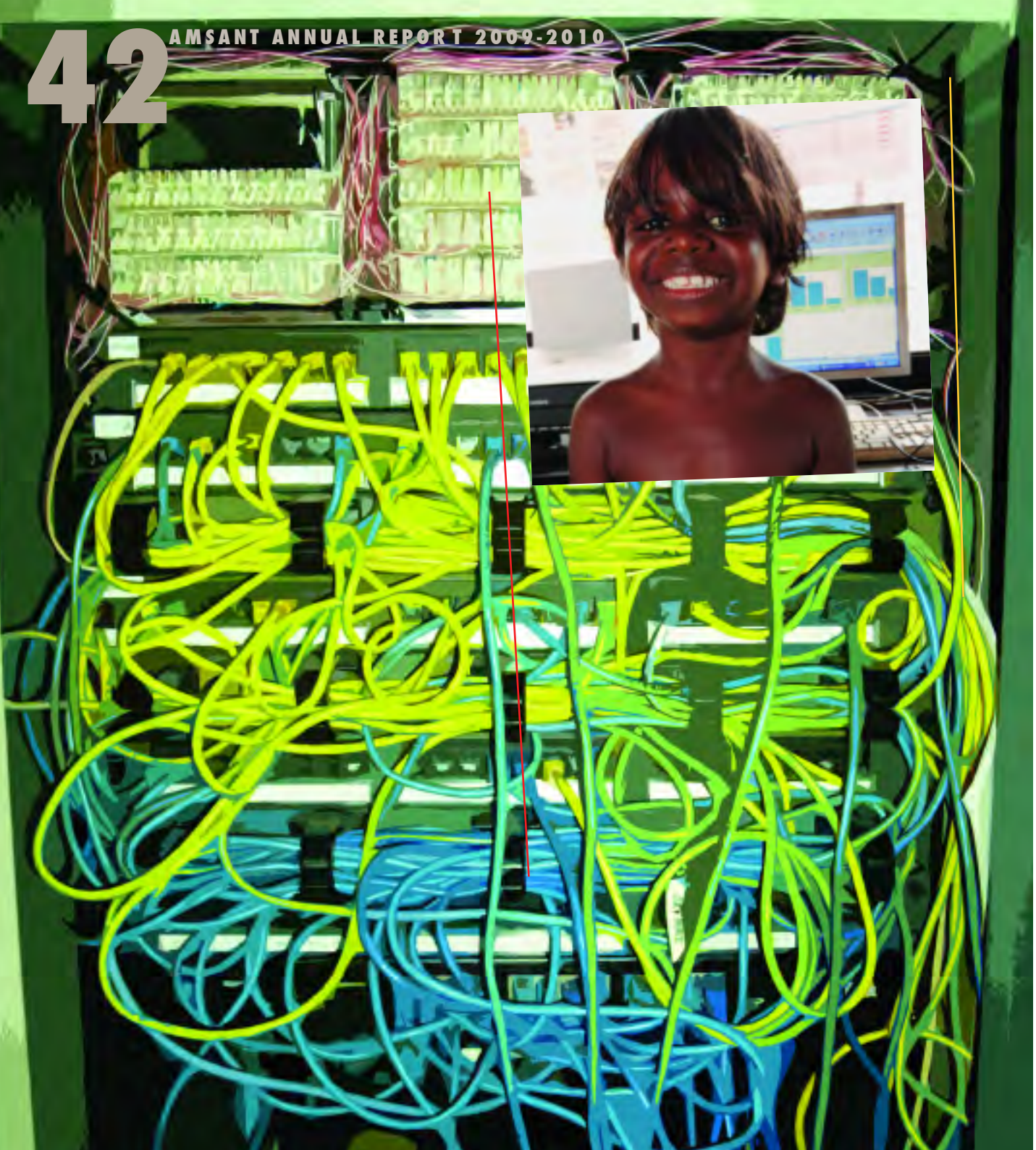
- During 2009 DHF commissioned a Review of the AHW profession in acknowledgement of the difficulties the profession faces here in the NT. The Aboriginal community controlled sector agreed that our sector should be included in the review and a project steering committee was formed, inclusive of AMSANT membership. Our members engaged in good faith in the review out of concern that the problems for AHWs be identified and addressed. Unsurprisingly, the review revealed major concerns about the current training model for AHWs, the marketing of the profession to young Aboriginal people, problems with role clarification for the multi-disciplinary team in Aboriginal health including the roles of AHWs, and a general lack of professional support and career development opportunities for AHWs in the workplace. In the coming year AMSANT will work hard to have the recommendations of the review implemented so that AHWs again become the central plank of our community PHC teams.

- During the year the AHW Training and Assessment program was completed with a number of AHWs from the Top End and Central Australia completing their assessor training and several also having their current qualifications upgraded to Certificate IV.

- In June 2010 AMSANT organised its first Senior AHW Forum of experienced AHW representatives from the ACCHS sector to discuss key matters affecting the profession and to plan for a stronger future. It is hoped that funds will be found to establish the AHW Forum as an on-going activity capable of raising the profile of AHWs in the sector and beyond.

- AMSANT continues to work with the National WIPO network on issues associated with national AHW Registration proposed for 2012.

Given all the tasks and activities described above we have made plans to form a Workforce Support Unit at AMSANT for the purposes of creating a stronger workforce focus and better supported team activity to address key workforce challenges. The work is much too much for the WIPO alone and we need to better harness our resources and seek additional program funds, to increase prioritisation on workforce on behalf of our members.



Information and Communication Technology (ICT)

AMSANT has maintained its commitment to identifying and solving information and communications technology (ICT) issues on behalf of its member services. The 2009-2010 year has been a transition year for the ICT team as the original funding received from DoHA's *Broadband for Health* Managed Networks Program to implement the AMSNet shared ICT network had been spent. Realising that the strategic vision for that project covered a five-year project, much of the past year has been spent seeking funds to secure that vision.

The AMSANT team views the use of technology in the Aboriginal primary health care (PHC) sector as a great enabler to improvements in PHC delivery. The NT clearly leads the way in the use of patient information recall systems (PIRS) for delivery of quality health care, primarily because of the desire our member services have shown for securing quality data collection.

AMSANT has maintained its support for the AMSNet managed network program that allows for the storage of health data in a secure data centre in Sydney. End-users access their data through a secure Internet connection. The benefit of this is that services do not have to be responsible for the security of their data

as this is guaranteed by a service-level agreement. It also allows the infrastructure in the remote setting to be far less complex, thus reducing the demands for service support. In addition, clinicians can now access data in any location they can connect to the Internet. This allows for much greater flexibility in staffing and scheduling.

AMSANT has worked to develop better services in remote settings as we recognise the central importance of good connection to the Internet to deliver ICT systems. This past year the AMSNet team has concluded the roll-out of remote end communications systems. By November 2009 we had established 39 satellite connections. This was done using 1.8 metre satellite dishes, enabling a better connection when weather conditions are poor. The larger dishes help to maintain reliable connection during heavy dust and rain.

As part of the roll-out of the satellite connections, AMSANT worked with the private sector to develop a web-based network monitoring service. We have continued to refine this service as it allows for remote monitoring of communications connections through an internet browser. It also allows a service to prioritise the use of internet connectivity, giving functions like "data transfer" priority over internet browsing and e-mail.

The work on delivery of intranet services through the SharePoint software has continued in the past 12 months. Intranets represent a real opportunity to organisations to centralise information and communication on their corporate functions. They can become an organisation's mini internal "world wide web". AMSANT has worked with a number of our members to develop intranets that suit their business model and this is likely to be a growing facet of service to our members.

Our plan for the coming year is to focus on support to our members on all aspects of ICT. To this end we have begun supporting several services with improvements to their technology systems. We are looking forward to offering ICT review tools and services to all member services.

We have also developed a good relationship with the DHF eHealth team. We are aiming to ensure that eHealth innovation across the NT benefits the operation of our member services at a grass-roots level. There are some exciting developments in the wings in terms of eHealth and it is critical that our sector is given an equal voice at the table.

AMSANT has continued to support the National ICT Reference Group made up of PIRS support and ICT professionals from the affiliate bodies across Australia. We meet regularly both by phone and face-to-face to discuss and share developments in technology and in eHealth. This has enabled AMSANT to both share our learnings and to benefit from the work that others have done. It will prove to be an important forum to shape our sector's approach to eHealth developments nationally.

We have also had time to play at the exciting end of ICT with the release on the market of the Ipad. Our team has worked hard to see how this new technology can benefit our members and improve functionality at a clinic level. All the early trials have been very promising. This again shows that Aboriginal community controlled health services are well and truly leading the way in terms of technological innovation in health care.

On-line Admin Manual

In 2000 AMSANT secured funding through the (then) NT Remote Health Workforce Agency for the development of an administration manual for Aboriginal PHC services. The first version was produced in hard copy as a book and was accessible on AMSANT's web-site in PDF format. In 2004 AMSANT contracted PlanHealth (the original authors of the report) to update the manual's content and to transform it into an electronic resource, based on the web.

AMSANT maintains a relationship with PlanHealth to keep the manual up-to-date and relevant, because changes to legislation and CQI initiatives are continually re-shaping "best practice" in the clinical settings of our member services. Check out AMSANT's Administration Manual at www.amsantmanual.com

eHealth

In the past year, primary health care services began reporting the new NT Aboriginal Health Key Performance Indicators (NTAHKPIs) and further developments were made by AMSANT towards planning and implementing electronic health projects that will have a significant effect on NT health services in the coming years.

In August 2009 all NT Aboriginal community controlled health services (ACCHSs) and DHF remote primary health care clinics reported on the NTAHKPIs to the DHF Data Centre for the first time. This was followed by a second report submitted in February 2010. These reports are providing essential data to ACCHSs and to the sector about health service activity and population health status trends that will enable them to better plan, monitor and evaluate their health service activities, based on population health needs and outcomes.

PHC services in the Territory lead the nation in their ability to produce accurate population health data such as the NTAHKPIs, due to the foresight and hard work of NT ACCHSs during the last ten years in implementing electronic Patient Information Recall Systems (PIRS) and ensuring that their staff use the systems with confidence by providing functioning IT networks and support.

Many health services have been using their health data from their PIRS for Continuous Quality Improvement (CQI) for some time, but importantly the NTAHKPI data assists AMSANT and regional CQI officers to work with ACCHSs in a more targeted fashion, to methodically improve health service activity and outcomes in a sustainable manner.

AMSANT and its members have been actively involved in developing and implementing the NTAHKPIs so that they are embedded into PIRS. Guided by the feedback from member services, AMSANT staff have been analysing the NTAHKPIs queries within Communicare and have developed specifications for the Steering Committee to engage Communicare to modify the queries or "clinical item pathways" so that the data will be more accurate. These changes will be implemented by the February 2011 NTAHKPI report.

The governance of the NTAHKPIs is the responsibility of the NTAHKPI Steering Committee which has representation from the NT Aboriginal Health Forum partners of OATSIH, DHF and AMSANT. Reporting to the Steering Committee is the Clinical Reference Group which oversees the clinical issues in relation to the KPIs and assesses the use of data for CQI purposes. The Technical Working Group analyses and modifies the queries that are implemented into the PIRS so that the data extracted from them is accurate.

Late in 2009, DHF partnered with the Federal Government to invest $16 million into the *Digital Regions Initiative*. This project is seeking to improve health service activity by providing improved means to access and utilise eHealth. It involves improving IT bandwidth to 17 of the 20 "growth towns" in the NT. This initiative is also implementing:

- An electronic care planning module with "decision support capabilities" which will enable sharing of specific care plans among health services to ensure continuity of care
- Tele-medicine capabilities for remote health centres through the implementation of teleconference facilities.

Other DHF eHealth projects which will have a future impact on NT ACCHSs are:

- The implementation of a Hearing Health Information Management System through funding from EHSDI that will enable a common web-based client Hearing Health Care Plan to be shared with health services that will pool the information on individual clients from the various health agencies involved (eg PHC clinics, audiologists, ENT specialists, school therapists etc)
- Development and implementation of a new Web-based Secure Messaging System (WSMA) built to NEHTA standards which will allow secure messaging between health services, replacing the current system which does not comply with NEHTA standards and has been found to be inadequate
- The implementation of the PACS software system into ACCHSs which will enable health services to view x-ray pictures and reports
- Access by ACCHSs to public hospital pathology results through a portal within the Shared Electronic Health Repository.

In all of these areas, AMSANT has been lobbying DHF to ensure that the eHealth developments will be beneficial to ACCHSs, while also being affordable to ACCHSs in future years.

AMSANT has also been closely involved in discussions with OATSIH, which is developing a web-based reporting tool, due to be implemented by June 2011. The tool is to be both a portal to OATSIH to securely send reports electronically, but importantly will allow for services to securely collate data from their PIRS reports which can be used for CQI by the health service.

With Canberra's announcement that there will be the development of an "individual electronic health record" and Tele-health that will enable for remote specialist consultations, AMSANT will be lobbying to ensure that these eHealth developments are beneficial to NT ACCHSs and, ultimately, to the health outcomes of Aboriginal people.

AMSANT has been successful in attracting funding for a sustainable Information Communication Technology/Information Management Unit which will have the capacity to assist services with analysing and improving their ICT network and will continue to lobby on behalf of the sector in eHealth developments.

This increased capacity through the ICT Unit funding allows AMSANT to give grassroots PIRS and MBS support to our members and provides leadership in centrally modifying PIRS in alignment with best clinical practice. These important functions have not been fully addressed as required over the last year due to the multiple eHealth agendas that AMSANT has been involved in on behalf of its members.

Accreditation

The AMSANT Accreditation team has been providing support to Aboriginal community controlled health services (ACCHSs) across the NT in the past year, through various stages of the accreditation journey. The 2009-10 year has seen a surge of our member services signing up for the accreditation process, with almost all ACCHSs having submitted an Accreditation Support Grant. Staff consultation visits have increased in line with increased accreditation activity, with most AMSANT members visited, consulted and supported during the last year.

During the visits, AMSANT staff identify and respond to the priorities of health services and provide necessary assistance, referrals and follow-up. This includes general discussions with the health service team about the processes involved in accreditation, continuous quality improvement and risk management.

From the AMSANT offices in Alice Springs and Darwin, accreditation team members provide practical advice to health services about implementing actions identified in Accreditation Work-plans and negotiating the accreditation landscape. Staff disseminate regular updates by e-mails and newsletters to members regarding accreditation issues and developments. An example of this is the Training Development Scheme which offers free study to those staff working in Aboriginal health services that are undergoing accreditation.

BRITT PUSCHAK, ACCREDITATION MEMBER SUPPORT OFFICER IN ALICE SPRINGS

AMSANT has held two workshops in the last year for member services in Alice Springs (November 2009) and in Darwin (May 2010). Sessions were held on understanding the accreditation process, tackling accreditation challenges and finding solutions, and discussions about the RACGP standards. Organisational frameworks of ISO 9001:2008 and CQI were also discussed. Interpretive guides to the RACGP Standards, QIC Standards and the OATSIH accreditation handbook were also launched at the Darwin workshop.

Participation in accreditation is a proactive approach to ensuring quality and safety are part of everyday practice. This will lead to improved health outcomes for everyone.

CANTEEN CREEK HEALTH WORKERS: TONY DUGGIE, GRAHAM CLEGG, LORISSA WALDEN, LORELLE COLE AND JOSEPHINE APPOO WITH BARKLY CQI COORDINATOR, KRISTINA VINE.

Continuous Quality Improvement

The aim of the Continuous Quality Improvement program is to build on existing CQI initiatives and experience and to develop a *sustainable*, long-term approach to service improvement across the Aboriginal primary health care service system in the NT.

The NT Aboriginal Health Forum and the Primary Health Reform Group (which is leading the EHSDI reforms) have agreed that embedding continuous quality improvement into primary health care is one of the key priorities for Aboriginal primary health care in the NT. The CQI Program provides a framework to support both the Aboriginal community controlled services and the NT government health services in CQI with a focus on clinical improvement. The CQI Program supports the implementation of the various quality initiatives being undertaken across all health services, bringing these initiatives together and providing a consistent yet flexible approach to promote clinical quality improvement across the Territory.

The CQI Program supports health services in their quality improvement strategies, and provides opportunities to improve systems and processes to ensure consistent best practice, and improved health outcomes for Aboriginal people.

In the year since the CQI Program started a significant amount of work has been undertaken by the two CQI Coordinators employed by AMSANT and the CQI Planning Committee that provides direction to the program.

CQI Coordinators

Melissa Roberts, CQI Coordinator

Melissa Roberts is the CQI Coordinator in Central Australia and the Barkly, and Kerry Copley is the CQI Coordinator in the Top End. The CQI Coordinators' role is to promote and coordinate improved service and health outcomes by working collaboratively with Aboriginal community and NT government health providers and other stakeholders to develop, implement and evaluate a sustainable long-term approach to clinical CQI across the Aboriginal primary health care sector in the NT.

The CQI Coordinators have visited more than 30 communities across the NT, meeting with health teams to talk about CQI and get input from clinicians and staff into the kind of support that will really make a difference to them.

One of the key roles of the CQI Coordinators is to train and mentor the CQI Facilitators who will be working on the ground in the health service delivery areas across the NT.

CQI Planning Committee

The CQI Planning Committee is made up of representatives from AMSANT, DHF, and clinicians (doctors, Aboriginal Health Workers and nurses) from the Aboriginal PHC sector. The role of the committee is to lead the development of an NT CQI Approach, provide guidance to the program and CQI Coordinators, and report back to the Primary Health Reform Group (PHRG) and the NT AHF.

Needs analysis

One of the first tasks was to undertake a Needs Analysis (NA) to enable us to gather information from health services to inform the development of the CQI Approach. The NA was conducted to assess the effectiveness and coverage of CQI across the NT, establish a baseline for evaluation, and to provide information about established CQI knowledge and processes to assist in the development of the CQI Framework and Approach. All Aboriginal health services (both Aboriginal community controlled and NT government health centres) were invited to participate.

More than 50 separate needs analyses were completed with about half received from Top End services and half from the centre. Half were from ACCHOs and half from NT Government services. Most of the responses reflected the view that if CQI was well supported, it would lead to improvement in health outcomes for Aboriginal people, with 48% of respondents saying it would lead to "significant improvement". The NA identified that many services were already undertaking work in CQI but that they needed more support and training to continue. It also revealed gaps in knowledge and skills that the CQI Approach should address. Health workers were asked what they needed to best take advantage of CQI initiatives. The following themes emerged from their responses:

MINYERRI HEALTH SERVICE TEAM: LOUISE PATEL, LANCE GREAM, DARYL O'KEEFE, MAVIS LIMEN, ROB ARNOLD, KATRINA MITCHELL, TOM HUME, KAY GRAINGER, PETER SAVAGE, DR SAM GOUNDAR AND VICKY STONE.

- Management support
- On-the-ground support
- A long-term, consistent yet flexible approach across the NT
- Opportunities for shared learning.

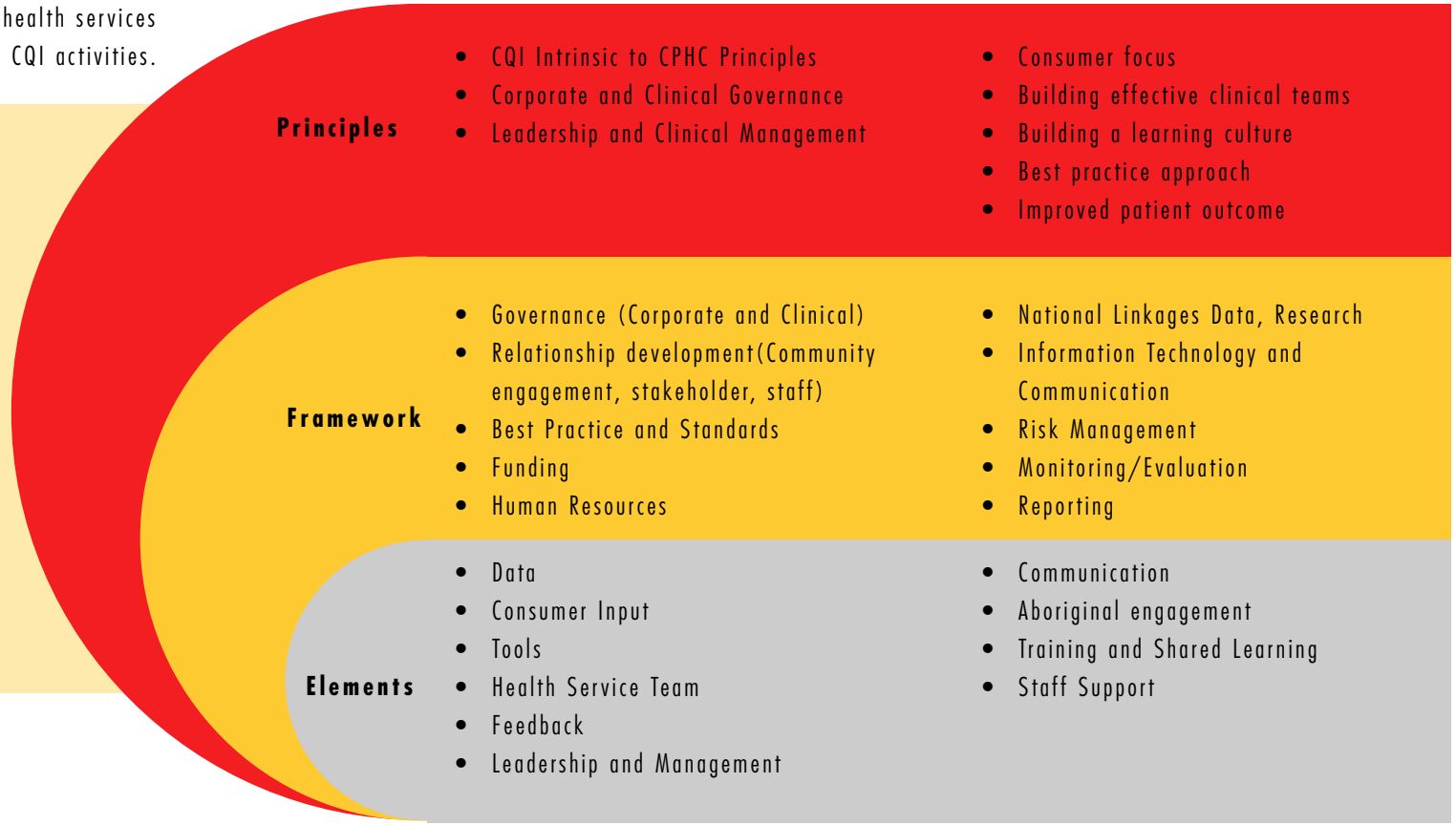
CQI Approach

The information gathered through the NA was reported back to the CQI Planning Committee and informed the development of the NT CQI Approach. The CQI Approach [see diagram below] is made up of three layers. The "principles" give an overarching guidance to the Approach ie the belief that CQI is intrinsic to CPHC and that it must have a consumer focus. The "framework" is the skeleton of the Approach including things like funding, staffing, IT systems etc. The "elements" are the specific areas that health services should consider when undertaking their CQI activities.

Ten Key Elements were identified:

1. Leadership and management
2. Aboriginal engagement
3. Consumer input
4. Health service team
5. Staff support
6. Training and shared learning
7. Tools
8. Data
9. Feedback
10. Communication

The CQI Approach was endorsed by the NTAHF in November 2009 and has been distributed widely since then. The CQI Coordinators have taken every opportunity to present the NT CQI Approach to many health services' management and clinical teams, to ACCHO Boards and at a wide range of forums including: the Quality and Accreditation Workshop, OATSIH Workshops, the AHW Workshop, orientation workshops for new NT government remote health staff and at national forums, including the Primary Health Care Research Conference and to Program Managers at the Australian Primary Care Collaborative Workshop in Brisbane.



Where to from here?

- Recruitment of a team of CQI Facilitators, who will work within a HSDA to provide hands-on assistance to health service teams in their CQI activities
- Delivery of orientation workshops for CQI Facilitators and training in One21Seventy (ABCD) tools for facilitators and key HS staff
- Developing forums to promote shared learning and resources across health services
- On-going development and promotion of the CQI Approach and supporting the Aboriginal PHC sector in their CQI activities.

The EHSDI funded program to support CQI is gaining very positive engagement from both the ACCHO and NT Government sectors. It has been exciting to see the enthusiasm from people working on the ground in health services who are committed to getting better results for the communities they work in.

Glossary

A&TSI	Aboriginal and Torres Strait Islander
ACCHSs	Aboriginal Community Controlled Health Services
AGPET	Australian General Practice Education and Training
AHW	Aboriginal Health Worker
AIHW	Australian Institute of Health and Welfare
AMSANT	Aboriginal Medical Services Alliance Northern Territory
AOD	Alcohol and other drugs
CAAC	Central Australian Aboriginal Congress
COAG	Council of Australian Governments
CQI	Continuous Quality Improvement
DoHA	Department of Health and Ageing (Commonwealth)
DHF	Department of Health and Families (NT)
EHSDI	Expanded Health Service Delivery Initiative
FaHCSIA	Dept of Families, Housing, Community Services and Indigenous Affairs (Commonwealth)
GPR	General Practice Registrar
HSDA	Health Service Delivery Agreement
IHTI	Indigenous Health Training Posts
KPI	Key performance indicators
MoU	Memorandum of Understanding
NACCHO	National Aboriginal Community Controlled Health Organisation
NHHRC	National Hospital and Health Reform Commission
NHMRC	National Health and Medical Research Council
NTAHF	Northern Territory Aboriginal Health Forum
NTAHKPI	Northern Territory Aboriginal Health Key Performance Indicators
NTER	Northern Territory Emergency Response or 'intervention'
NTG	Northern Territory Government
OATSIH	Office of Aboriginal and Torres Strait Islander Health (Commonwealth)
PATS	Patient Assistance Travel Service
PHC	Primary health care
PHMO	Public Health Medical Officer
PIRS	Patient Information Recall Systems
RACGP	Royal Australian College of General Practitioners
RaDU	Reform and Development Unit (within AMSANT)
SEMS	Secure Electronic Message Service
WHO	World Health Organisation
WIPO	Workforce Implementation Project Officer

AMSANT Incorporated Special Purpose Financial Report For the year ended 30 June 2010

ABN 26 263 401 676

ZAW MAUNG, CPA,
BUSINESS MANAGER, AMSANT

AMSANT INCORPORATED
STATEMENT BY THE EXECUTIVE COMMITTEE

The Executive Committee has determined that AMSANT Incorporated (the "Association") is not a reporting entity and that this special purpose financial report should be prepared in accordance with the accounting policies outlined in Note 1 to the financial statements.

Principal Activities

The principal activities of the Association during the financial year were the support of Aboriginal health services and promotion of research into causes and remedies of illness and ailment found within the Aboriginal population of the Northern Territory.

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

Executive Committee Members

The names of the members of the Executive Committee as at the date of this report are:

Chairperson:	Stephanie Bell
Treasurer:	Leon Chapman
Public Officer:	Zaw Maung
Members:	Paula Arnol
	Eddie Mullholland
	Sarah Doherty
	Trevor Sanders
	Sean Heffernan
	John Fletcher
	Graham Castine

Operating Result

The Association recorded a net surplus of $392,586 for the year ended 30 June 2010 (2009: net deficit of $36,456).

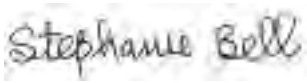
In the opinion of the Executive Committee:

1 The accompanying financial report as set out on pages 4 to 13, being a special purpose financial statement, presents fairly the financial position of the Association as at 30 June 2010 and its results for the year ended on that date;

2 The accounts of the Association have been properly prepared and are in accordance with the books of account of the Association; and

3 There are reasonable grounds to believe that the Association will be able to pay its debts as and when they fall due.

This statement is made in accordance with a resolution of the Executive Committee and is signed for and on behalf of the Committee by:



Stephanie Bell
Chairperson

Leon Chapman
Treasurer

Dated this 18th day of October 2010

merit partners

Independent Auditor's Report to the Members of AMSANT Incorporated

We have audited the accompanying special purpose financial report of AMSANT Incorporated (the 'Association'), which comprises the balance sheet as at 30 June 2010, and the income statement, and cash flow statement for the year ended on that date, a summary of significant accounting policies, other explanatory notes and the Statement by the Executive Committee.

The Committee's Responsibility for the Financial Report

The Association's Committee is responsible for the preparation and fair presentation of the financial report and have determined that the accounting policies described in Note 1 to the financial statements, which form part of the financial report, are appropriate to meet the financial reporting requirements of the Associations Act of the Northern Territory and the Association's constitution and are appropriate to meet the needs of the members. This responsibility includes establishing and maintaining internal controls relevant to the preparation and fair presentation of the financial report that is free from material misstatement, whether due to fraud or error; selecting and applying appropriate accounting policies; and making accounting estimates that are reasonable in the circumstances. These policies do not require the application of all Accounting Standards and other mandatory financial reporting requirements in Australia.

Auditor's Responsibility

Our responsibility is to express an opinion on the financial report based on our audit. No opinion is expressed as to whether the accounting policies used are appropriate to the needs of the members.

We conducted our audit in accordance with Australian Auditing Standards. These Auditing Standards require that we comply with relevant ethical requirements relating to audit engagements and plan and perform the audit to obtain reasonable assurance 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 our judgment, including the assessment of the risks of material misstatement of the financial report, whether due to fraud or error. In making those risk assessments, we consider internal controls relevant to the entity's preparation and fair presentation of the financial report 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 controls. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by the Committee, as well as evaluating the overall presentation of the financial report.

This financial report has been prepared for distribution to the members for the purpose of fulfilling the Committee's financial reporting requirements under the Associations Act of the Northern Territory and the Association's constitution. We disclaim any assumption of responsibility for any reliance on this report or on the financial report to which it relates to any person other than the members, or for any purpose other than that for which it was prepared.

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.

Auditor's opinion

In our opinion, the financial report presents fairly, in all material respects, the financial position of AMSANT Incorporated as of 30 June 2010 and of its financial performance and its cash flows for the year then ended in accordance with the accounting policies described in Note 1 to the financial statements.

Merit Partners

Merit Partners

Matthew Kennon
Director

DARWIN
Date 23/10/2010

merit partners

INCOME STATEMENT
FOR THE YEAR ENDED 30 JUNE 2010

	Note	2010 $	2009 $
REVENUE			
Grant income	9	7,583,951	4,072,761
Unexpended grants at beginning of year		893,436	3,320,366
Administration fee		777,913	532,414
Interest received		53,978	140,818
Unexpended grants at year end		1,468,327	893,436
Other income		77,535	44,748
TOTAL REVENUE		7,918,485	7,217,672
EXPENSES			
Employee costs	10	3,234,773	2,306,940
Depreciation		122,874	128,676
Consultants and auspice payments		1,421,074	845,771
Other expenses from ordinary activities	11	2,747,178	3,972,742
TOTAL EXPENSES		7,525,899	7,254,128
SURPLUS / (DEFICIT)		**392,586**	**(36,456)**

BALANCE SHEET
AS AT 30 JUNE 2010

	Note	2010 $	2009 $
CURRENT ASSETS			
Cash and cash equivalents	2	3,008,340	1,633,930
Trade and other receivables	3	59,821	396,443
TOTAL CURRENT ASSETS		**3,068,161**	**2,030,373**
NON-CURRENT ASSETS			
Property, plant and equipment	4	320,204	320,268
TOTAL NON-CURRENT ASSETS		**320,204**	**320,268**
TOTAL ASSETS		**3,388,365**	**2,350,641**
CURRENT LIABILITIES			
Trade and other payables	5	604,914	634,395
Employee provisions	6	263,054	160,630
Unexpended grants	7	1,468,327	893,436
TOTAL CURRENT LIABILITIES		**2,336,295**	**1,688,461**
NON CURRENT LIABILITIES			
Employee provisions	6	34,173	36,869
TOTAL LIABILITIES		**2,370,468**	**1,725,330**
NET ASSETS		**1,017,897**	**625,311**
ACCUMULATED FUNDS			
Accumulated surplus	8	1,017,897	625,311
TOTAL ACCUMULATED FUNDS		**1,017,897**	**625,311**

CASH FLOW STATEMENT
FOR THE YEAR ENDED 30 JUNE 2010

	Note	2010 $	2009 $
CASH FLOWS FROM OPERATING ACTIVITIES			
Receipts from customers		1,164,371	2,082,346
Payments to employees and suppliers		(7,305,080)	(6,999,791)
Interest received		53,978	140,818
Grants received		7,583,951	4,072,761
Net cash flows provided by / (used in) operating activities	12	**1,497,220**	**(703,866)**
CASH FLOWS FROM INVESTING ACTIVITIES			
Acquisition of property, plant and equipment		(122,810)	(22,809)
Net cash flows provided by / (used in) investing activities		**(122,810)**	**(22,809)**
CASH FLOWS FROM FINANCING ACTIVITIES			
Borrowings/(repayment of borrowings)		-	-
Net cash flows provided by / (used in) financing activities		-	-
Net increase / (decrease) in cash held		**1,374,410**	**(726,675)**
Add: Opening cash balanc		1,633,930	2,360,605
Ending cash balance	2	**3,008,340**	**1,633,930**

AMSANT INCORPORATED
NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2010

NOTE 1 - STATEMENT OF SIGNIFICANT ACCOUNTING POLICIES

(a) Financial Reporting Framework

This financial report is a special purpose financial report prepared in order to satisfy the financial reporting requirements of the Associations Act of the Northern Territory. The executive committee has determined that AMSANT Incorporated (the "Association") is not a reporting entity.

The Association is not a reporting entity because in the executive committee's opinion there are unlikely to exist users who are unable to command the preparation of reports tailored so as to satisfy all of their information needs, and these accounts are therefore "special purpose accounts" that have been prepared solely to meet the requirements of the Constitution and the Associations Act.

The financial report has been prepared on an accrual basis and is based on historical costs and does not take into account changing money values or, except where specifically stated, current valuations of non-current assets.

The financial statement is in Australian dollars and all values are rounded to the nearest dollar.

The following significant accounting policies, which are consistent with the previous period unless otherwise stated, have been adopted in the preparation of this financial report.

(b) Property, Plant and Equipment

Each class of property, plant and equipment is carried at cost less any accumulated depreciation and impairment loss.

Depreciation of Property, Plant and Equipment

Depreciation is provided on all property, plant and equipment on a straight line basis using rates which are reviewed each reporting period. Depreciation rates are calculated to allocate cost, to the entity, against revenue over the estimated useful life of the asset.

	2010 %	2009 %
Plant and equipment	20 - 40	20 - 40
Office equipment	20 - 40	20 - 40

NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS FOR THE YEAR ENDED 30 JUNE 2010

NOTE 1 - STATEMENT OF SIGNIFICANT ACCOUNTING POLICIES (Cont'd)

(c) Leases

Leases of fixed assets where substantially all the risks and benefits incidental to ownership of the asset, but not the legal ownership, are transferred to the association are classified as finance leases.

Finance leases (if any) are capitalised by recording an asset and a liability at the lower of the amount equal to the fair value of the leased property or the present value of the minimum lease payments, including any guaranteed residual values. Lease payments are allocated between the reduction of the lease liability and the lease interest expense for the period.

Leased assets are depreciated on a straight-line basis over their useful lives where it is likely that the association will obtain ownership of the asset or ownership over the term of the lease.

Lease payments for operating leases, where substantially all the risks and benefits remain with the lessor, are charged as expenses in the periods in which they are incurred.

(d) Goods and Services Tax (GST)

Revenues, expenses and assets are recognised net of the amount of GST. Receivables and payables are recognised inclusive of GST. The net amount of GST recoverable from, or payable to, the taxation authority is included as part of receivables or payables.

(e) Employee Benefits

The amount expected to be paid to employees for their pro-rata entitlements to long service and annual leave is accrued annually at current wage rates. Leave provisions include applicable oncost.

Sick leave is accrued in the payroll system but not provided for in the accounts, sick leave is non-vesting.

A provision for long service leave is recognised on a pro-rata basis and is measured at current rates and classified as a non-current liability.

Annual leave and long service leave in respect of employees with a present entitlement are shown as current Liabilities. All other long service leave is shown as a non-current Liability.

AMSANT INCORPORATED
NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS FOR THE YEAR ENDED 30 JUNE 2010

NOTE 1 - STATEMENT OF SIGNIFICANT ACCOUNTING POLICIES (Cont'd)

(f) Cash and Cash Equivalents

Cash and cash equivalents includes cash on hand, deposits held at call with banks, and other short-term highly liquid investments with original maturities of three months or less.

(g) Trade and Other Receivables

Trade and other receivables, which comprises amounts due from the provision of services are recognised and carried at original invoice amount less an allowance for any uncollectible amounts. Normal terms of settlement are within thirty days. The notional amount of the receivables is deemed to reflect fair value.
An allowance for doubtful debts is made when there is objective evidence that the debt will not be able to be collected. Bad debts are written off when identified.

(h) Income Other the Grants Income

Interest revenue is recognised at the interest rates applicable to the financial assets.
Income is stated net of the amount of goods and services tax applicable.

(i) Government Grants

Government grants are recognised when the Association has a right to receive them. A liability is recognised for unexpended grants when the funding agreement requires repayment of the unexpended grants less any committed funds.

(j) Income Tax

The Association is a public benevolent institution for the purpose of Australian taxation legislation and is exempt from income tax.

(k) Comparative Figures

If and when required by Accounting Standards comparative figures are adjusted, as far as practicable, to conform to changes in presentation for the current financial year.

NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS FOR THE YEAR ENDED 30 JUNE 2010

	2010 $	2009 $
NOTE 2 - CASH AND CASH EQUIVALENTS		
Cash at bank - Operating account	(12,332)	64,849
Cash at bank - Investment account	3,019,572	1,567,981
Cash and imprest accounts	1,100	1,100
	3,008,340	1,633,930
NOTE 3 - TRADE AND OTHER RECEIVABLES		
Trade debtors	57,819	395,799
Other receivables	2,001	644
	59,821	396,443
NOTE 4 - PROPERTY, PLANT AND EQUIPMENT		
Property, plant and equipment - at cost	674,157	551,346
Less: Accumulated depreciation	(353,953)	(231,078)
	320,204	320,268
NOTE 5 - TRADE AND OTHER PAYABLES		
Trade creditors	186,786	432,110
ANZ credit card	2,481	-
Accrued expenses	54,537	29,232
Grant income in advance	6,038	6,038
Net GST payable	185,855	7,582
Workcover payable	-	50,272
Payroll liabilities	169,217	109,162
	604,914	634,395

NOTE 6 - EMPLOYEE PROVISIONS

Current		
Workerscomp insurance	54,106	-
Annual leave	208,948	160,630
	263,054	160,630
Non Current		
Long service leave	34,173	36,869
	34,173	36,869

NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS FOR THE YEAR ENDED 30 JUNE 2010

NOTE 7 - UNEXPENDED GRANTS

	2010 $	2009 $
P10 - Data Entry Supp ACCHS in NT	-	18,153
P32 - Application Service	-	13,328
P33 - Networks Development	-	2,509
P46 - Health Workforce Training	88,654	168,872
P56 - Healthy Kids Check	-	22,273
P62 - eHealth NT SEHRP	41,746	-
P38D - PIRS MBS Support CA	90,617	-
P66 - IHPO Chronic Disease	84,335	-
P04 - Workforce	35,559	10,676
P12 - Secretariat Officer	686	21,737
P13 - S&E Admin Manual/Website	-	1,693
P16 - FBT Funding	-	2,807
P38 - OATSIH - PIRS Support	12,176	14,373
P39 - AMSANT ICTIM/PIRS	-	348
P42 - P&Q (ICT/PIRS) NT Supp	11,778	12,027
P43 - Public Medical Officer	99,166	58,608
P44 - Service Expansion (PHMO)	38,415	11,329
P48 - Amsant Policy & Procedure	-	4,025
P50 - Accreditation	110,043	174,604
P50A - Acceditation Scoping	-	38,269
P51 - RADU	-	12,996
P51A - EHSDI Communications	20,108	27,173
P51B - RDU Fitout	-	1,881
P52 - Sexual Health Workshop	-	24,440
P53 - Business Development Manager	18,793	19,710
P54 - Policy & Strategy Manager	3,357	24,720
P57 - CQI	150,477	-
P58 - AMSANT ICT	189,695	-
P59 - AOD	23,402	-
P60 - Red Lily	14,513	-
P61 - Support Malabam & AHCAC	8,120	-
P63 - Fresh Food Summit	72,199	-
P67 - Workforce Consultancy	65,818	-
P69 - Account Package Upgrade	20,000	-
P17 - Oxfam Leadership Workshop	33,145.29	58,362
P05 - GPET Framework Agreement	34,236	56,009
P28A - DHF / DET - BLAC	-	75,710
P28C - Building Lship & Cap	20,445	-
P47 - AMSANT External Review	-	15,846
P64 - Maningrida Youth Centre	95,455	-
P68 - PaCE	85,388	-
Other	-	957
	1,468,327	893,436

NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2010

	2010 $	2009 $
NOTE 8 - ACCUMULATED FUNDS		
Balance at 1 July	625,311	661,767
Surplus/ (Deficit) during the year	392,586	(36,456)
Balance at 30 June	1,017,897	625,311
NOTE 9 - GRANTS INCOME		
DHCS grants	372,971	305,463
DoHA grant	90,617	318,918
OATSIH grants	6,165,485	2,884,817
OXFAM funding	70,000	80,000
Other grants	884,878	483,563
	7,583,951	4,072,761
NOTE 10 - EMPLOYEE COSTS		
Fringe benefit tax	48,671	21,588
Recruitment	-	9,180
Salaries	2,895,472	1,967,889
Staff on-costs	34,743	74,607
Staff training	3,774	9,386
Superannuation	242,766	171,644
Workers compensation	9,347	52,646
	3,234,773	2,306,940
NOTE 11 - OTHER EXPENSES		
Administration	1,274,388	898,779
Motor vehicles	134,202	98,755
Operations	887,964	2,171,616
P32	-	301,677
P33	-	181,505
Travel	450,624	320,410
	2,747,178	3,972,742

NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2010

	2010 $	2009 $
NOTE 12 - CASH FLOW RECONCILIATION		
Reconciliation of the net surplus (deficit) to the net cash flows from operations:		
Net surplus (deficit)	392,586	(36,456)
Add: Depreciation	122,874	128,676
Add/ (deduct) changes in assets and liabilities:		
Trade and other receivables	336,622	1,505,184
Trade and other creditors	(29,481)	68,588
Unexpended grants	574,891	(2,426,930)
Employee provisions	99,728	57,072
Net cash flows provided by (used in) operating activities	1,497,220	(703,866)

NOTE 13 - ASSOCIATION DETAILS

The registered office and principal place of business of the Association is:

AMSANT Incorporated
Level 1 Tourism House
43 Mitchell Street
Darwin NT 0800

AMSANT thanks all our Member Services, staff and community people for their time, energy, advice and knowledge in compiling this Annual Report.

AMSANT gratefully acknowledges the photographic support of Nicole Foreshew in completing this document.

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