AMSANT ANNUAL REPORT 2010-2011

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.

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

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One of the problems of working in the Aboriginal Community Controlled Primary Health Care sector is that you can rarely mark a particular moment in time when you draw a line in the sand and say "that's finished" or complete … each step forward actually multiplies future possibilities and expands the work that needs to be done.

So it has been in the last year. The work of AMSANT, through the Board that I have had the privilege to chair, along with its Secretariat, has expanded across the year as it has met the growing challenge of advocating for Aboriginal health and representing the interests of our members.

One of our biggest challenges has been in the area of National Health Reform. Through the year our initial hopes for the Commonwealth taking responsibility for all primary health care funding—with the possibility of a national or jurisdictional Aboriginal Health Authority—were not realised.

While this was profoundly disappointing, AMSANT has taken the opportunity to engage in the process of establishing a Medicare Local for the Northern Territory. A collaboration between AMSANT, the General Practice Network of the Northern Territory and the Department of Health led to the establishment of North of 26°, and the submission of a detailed proposal to the Australian Government for such a Medicare Local.

Uniquely, North of 26° will have Aboriginal interests as co-owners of a Medicare Local. It is anticipated the Department of Health and Ageing will respond to the proposal early in 2011-2012.

A substantial amount of AMSANT's work involves lobbying politicians from all sides of politics, at the national and Territory level, as well as with senior public servants across a number of portfolios. This work continued throughout the year and remains a significant burden to Board members who contribute their time—and that of their organisations—to these endeavours. It is, nevertheless, a critical role of AMSANT in its work in representation, advocacy and research.

Of particular importance has been our role in discussing with the Commonwealth the possible arrangements for primary health care funding in the Northern Territory in the period post-Northern Territory Emergency Response after 1 July 2012.

In this context, of particular note during the year was the establishment in October 2010 of the Aboriginal Peak Organisations Northern Territory [APO NT], an alliance of the Central and Northern land councils, the North Australian Aboriginal Justice Agency, the Central Australian Aboriginal Legal Service and AMSANT. It has been a really crucial alliance, sharing ideas and resources, and joining with each other on research and advocacy projects, including submissions to government on a wide range of issues. A key part of the alliance has been framed in terms of negotiating with the Commonwealth over post-NTER arrangements.

Finally, what AMSANT is about—and the thing that drives me in my firm commitment to the organisation—is its support to those communities of the Northern Territory that are moving towards the goal of Aboriginal community control over health services.

That's why it was a great thrill to be present at South Alligator to celebrate the incorporation of the Red Lily Health Board. It was an affirmation of the absolute commitment of Aboriginal people towards taking control of our futures, and was a great source of pride to me in welcoming the people of western Arnhem Land into the AMSANT family.

Stephanie Bell

Stephanie Bell

Chairperson

The most heartening aspect of working in the community controlled Aboriginal Comprehensive Primary Health sector is its strong commitment to excellence.

Nowhere is this more apparent than in the commitment of our member services to gain accreditation. All our members have, or are in the process of acquiring, Royal College of General Practice accreditation. This requires our services to achieve standards equal to that of practices in the leafy suburbs of big cities … an extraordinary achievement considering so many of our health services operate in some of the most remote places in the world.

For our members, this is not a mere process of acquiring framed certificates to stick on waiting room walls; it is evidence of an absolute commitment to attaining the very best service possible for our people.

Similarly, members have a strong commitment to Continuous Quality Improvement (CQI) and this is a manifestation of the same desire for excellence … and then going the extra mile to get it better. Most importantly, the work carried out by our CQI officers extends well beyond the community controlled sector, and is delivering to Department of Health services as well, as part of our partnership with the Northern Territory Government under *Pathways to community control*.

Both these processes—accreditation and CQI—represent just two dimensions of AMSANT's work over the past year in supporting our members, and the sector as a whole.

One of the ironies of the much-criticised Northern Territory Emergency Response is that we have achieved considerably expanded resources to our sector and these increases have been at the core of challenges to our sector since AMSANT was first established in 1994.

A result of this has been the need for increased resources to 'service support' so the year 2010-2011 has seen a steady consolidation and expansion of AMSANT support to Aboriginal Comprehensive Primary Health Care.

Areas of additional work by AMSANT are outlined in this Annual Report and include growing support to eHealth, lobbying on behalf of the sector's workforce, the work of our Public Health Medical Officers, our commitment to developing leaders and leadership values within our member services, our on-going efforts in regionalisation, and our continuing role in advocacy and policy development.

This heightened activity right across AMSANT has been strongly supported by our Board. It should not be forgotten that the work of the Board is directly supported by the Members themselves. The Board is the lifeblood of AMSANT and gives direction to our operations, so this support is not just appreciated by the AMSANT secretariat. Indeed, it's directly responsible for our successes.

I would like to thank our Chairperson, Stephanie Bell, and the Board she leads, for their on-going commitment to the work of AMSANT.

One of the results of the AMSANT submission to the Bath Inquiry into the Northern Territory Child Protection system, released in October 2010, was a request by the Northern Territory Government for AMSANT to auspice the establishment of an Aboriginal community controlled peak agency for children, youth and families. As 80 per cent of children subject to child protection in the Territory are Aboriginal, this was a huge and important challenge for the organisation but one which was firmly supported by member services at the general meeting in Tennant Creek in May 2010.

In cooperation with the newly-formed Department of Children and Families, we started work on this in late January this year, and by June we had carried out extensive consultations across the Territory and appointed a CEO for the Interim Board which will be meeting for the first time in early 2011-2012.

The last part of the year saw the beginnings of preparation for the Year of the Aboriginal Health Worker. This promises to be a critical campaign, not just in reaffirming our support to this vital part of the health workforce, but in turning the tide of neglect for this profession over many, many years.

Finally, I would like to take the opportunity to thank our staff for their hard work over the past year. They're a great mob. While this year we successfully concluded a new EBA with staff—which guarantees management support—I can't promise you an easy year ahead! Our work will expand and the pressure will increase, as always, but I'm confident that our collective commitment to improve Aboriginal Comprehensive Primary Health Care will get us through.

John Paterson

CEO

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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.

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.

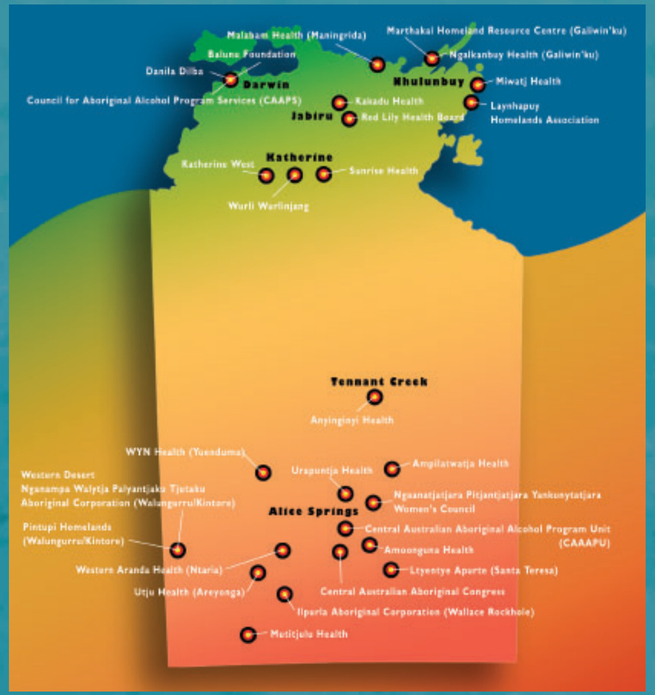
Over the years, AMSANT has advanced a clear definition of 'community control' and what constitutes a community controlled health service. Essentially, community control is the ability for the people who are going to use health services to determine the nature of those services, and then participate in 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.



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.

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 or at www.amsant.org.au.)

AMSANT ORGANISATIONAL CHART

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The highlight of this program was the annual Leadership Workshop held in Kakadu in late June. This was another very successful event that further bolstered the skills, aspirations and energies of the young participants. Yet behind the scenes there was significant change to the program as the program co-ordinator, Michelle Simmons, left in the middle of 2010 to re-settle in Adelaide. A period of four months ensued with the co-ordinator position being vacant before Muki Muir came on board in October 2010. To provide better support to Muki the leadership program was then integrated into the Workforce and Leadership Support (WALS) group at AMSANT with Erin Lew Fatt as team leader.

DELEGATES AT THE AMSANT ABORIGINAL LEADERSHIP WORKSHOP AT SOUTH ALLIGATOR RIVER, JUNE 2011.

Muki Muir has worked at AMSANT in various capacities for several years now and, as a senior Aboriginal woman on staff, has always played an active role in supporting our leadership programs over the years. Now as the new Program Co-ordinator she has started rebuilding the program with the assistance of the WALS team and other Aboriginal members of the leadership working group.

Now there is also a much more active engagement with the program supporters, Oxfam Australia and the Fred Hollows Foundation, to plan activities and secure relevant levels of funding.

The 6th AMSANT Leadership Workshop was held at the South Alligator Resort, Kakadu, 20 to 26 June 2011. Participants from around the NT gathered in Darwin and drove a bus out to the South Alligator. Some others drove in directly from Katherine. There was a pleasant stop on the way to visit the Windows to the Wetlands centre, and also a visit to the Pudakul Aboriginal Cultural Experience where all were welcomed to country and learnt about the culture and history of the Kakadu region.

Traditional owner, Samson Henry, welcomed 30 participants to his country to open the workshop. He and Gavin Greenoff gave an inspiring presentation about the on-going regionalisation of primary health care and the formation of the new Red Lily Health Board to represent the West Arnhem region.

Other sessions at the workshop included advocacy, lobbying, media, human rights and plans for the promotion of the Year of the Aboriginal Health Worker. AMSANT leaders and workers such as CEO John Paterson, Erin Lew Fatt, Sharon Wallace, Don Christophersen and Chips Mackinolty presented and facilitated various discussions. There were also strong contributions from Peter Nathan (Oxfam Australia), Mia Christophersen (Fred Hollows Foundation) and Jane Blunden from Wurli Wurlinjang.

A key focus of the workshop was to improve the public speaking skills of participants and ample opportunity was given throughout the session to build people's confidence to stand in front of their peers and present their thoughts and ideas with clarity and confidence. In these terms it was another great workshop and the feedback from both participants and presenters has been outstanding. It was also great to see the high numbers of young men in attendance.

We can't wait for the next year's workshop and we will be in touch with our Member Services regularly to let you know of our workshop plans and to provide information on other useful leadership courses and programs that you and your staff could tap into.

JANE BLUNDEN (AHW IMPLEMENTATION OFFICER).

GAVIN GREENHOFF (COMMUNICATIONS OFFICER) AND MUKI MUIR (LEADERSHIP PROGRAM OFFICER).

TONY MCMASTERS OF THE MEN'S CLINIC AT CONGRESS, ALICE SPRINGS.

The PHN has continued to develop and flourish over the last year and two special interest groups have been established in the areas of maternal health and sexual health.

The sexual health group complements a similar group established in Central Australia by the Centre for Sexual Health and is therefore primarily for Top End clinicians and others involved in sexual health. The group has met three times and has assessed a mapping exercise that reviews education and clinical resources that are available throughout the NT.

The maternal health group has discussed issues such as MBS items for midwives, direct-entry midwives and interactive care planning. Both groups have provided an opportunity for professional networking and the exchange of information between members.

The online *PHN Bulletin* has been produced about every two weeks with the aim of giving clinicians useful information on service and policy developments relevant to clinical care, as well as educational initiatives that are particularly relevant to Aboriginal primary health care.

A very successful workshop was held in November that focused on updating key areas such as the COAG Indigenous Workforce in Chronic Disease, developments in eHealth and Clinical Information Systems, among others. There was an interesting discussion about workforce issues including the stagnation in the number of Aboriginal Health Workers in clinics and the need for non-Indigenous staff to understand and support the role of Aboriginal Health Workers.

The afternoon was spent discussing tobacco with the Centre for Excellence in Indigenous Tobacco Control, who presented their 'talking up good air' package. There was a lot of enthusiasm for supporting Aboriginal-led tobacco abatement initiatives. The workshop was attended by 40 participants with a good spread of clinicians and managers from different regions and from both the government and community controlled sector.

Staffing changes

Dr Tanya Davies took a year's leave-without-pay in May 2011 and Dr Natasha Pavlin took her place as the Public Health Medical Officer (PHMO) in the Top End for a twelve month period. Vicki Gordon began work with AMSANT in a clinical liaison and support role in July 2010. Jodie Gundersen replaced Megan Dee as the PHMO-CQI administration officer in April 2011.

Representational work

The PHMO team has continued to represent AMSANT and member services on a range of clinical and public health committees that are usually convened by the NT Department of Health. Key committees include Specialist Outreach Northern Territory (SONT) steering committee, renal reference group and the NT AHKPI steering committee.

Specialist Outreach Northern Territory

Dr Tanya Davies has represented AMSANT on the SONT steering committee and the reformed Top End Advisory Committee while Dr Liz Moore represented AMSANT on the Central Australian SONT committee. AMSANT has pushed for a reform of SONT to ensure it is more primary health care focused with ACCHSs having more influence about what services are delivered and how they are provided. A major part of the reform has been the introduction of a Memorandum of Understanding between DoH (SONT) and each ACCHS which covers what services are provided and how they are delivered. This reform has occurred at the same time as MSOAP – ICD has delivered additional funding for Indigenous chronic disease. Unfortunately, progress has been patchy and there has been little change on the ground but we believe that the reforms will lead to improvements in the long term.

VICKI GORDON (CLINICIAN LIAISON OFFICER), DR NATASHA PAVLIN (PUBLIC HEALTH MEDICAL OFFICER, TOP END), DR LIZ MOORE (PUBLIC HEALTH MEDICAL OFFICER, CENTRAL AUSTRALIA) AND JODIE GUNDERSEN (CQI AND PHMO ADMINISTRATION ASSISTANT).

Public Health Advisory Group

The public health advisory group (PHAG) has continued to meet weekly to provide policy and advocacy advice to the AMSANT CEO and Board and to review research proposals according to the AMSANT research policy.

A wide range of issues has been discussed including advocacy about improving dialysis services and renal care coordination in ACCHSs, hospital and primary health care communication, alcohol and other drug services in ACCHSs and evacuation services in the Top End, among others.

The PHMOS have contributed to various submissions that AMSANT has prepared including submissions to the evaluators of EHSDI (Allan and Clarke) and the review of public health legislation in the NT and remote dental services.

Support of clinicians

The PHMOs continue to support clinicians through the *PHN Bulletin* and by formally orientating and supporting new general practitioners. The PHMOs also are a point of contact for clinicians or ACCHS managers wanting to raise any clinical/public health issues or to seek out information.

Research

Through PHAG, AMSANT reviews research projects at the request of researchers, ethics committees and individual ACCHSs. Research projects with major implications for policy or practice are referred to the Board for consideration.

AMSANT is a partner in six research projects and the PHMOs are involved in steering/reference groups for several of these projects.

Strive: This is a sexual health research trial that takes a CQI approach to improving sexual health service delivery within PHC. The trial is already providing enhanced support to health services; all ACCHSs will eventually receive support over the three-year trial period.

ABCD national project: This is a national project that will continue to work on the initial ABCD research project to review ABCD clinical audit and 'systems assessment' data from participating ACCHSs, so that the factors that influence quality of care can be assessed. The project also has a local NT-based research committee and employs a research officer. The local committee is encouraging participating ACCHSs to generate their own research questions by using ABCD data.

Sexual health and relationships in young Aboriginal people: AMSANT is conducting a sexual health survey of young Aboriginal people aged 16-29 as part of a national survey aiming to ascertain the attitudes and behaviours of young Aboriginal people regarding sexual health and blood-borne virus risks. This information will be used locally to better tailor services to young people and to advocate for improved services. So far, two surveys have been conducted at the Alice Springs and Darwin shows.

Diabetes in pregnancy trial: This trial is in the early planning phase and aims to improve the care of pregnant women by supporting PHC clinicians with training and improved PHC/specialist collaboration. As part of the research a register of women with diabetes in pregnancy will be developed. The register will collate information about women with DIP (with their consent) in a central register to enhance communication between PHC professionals and specialists. Epidemiological research will be conducted on women with DIP and their children to better understand the implications of DIP for both women and their children.

Hospital/primary health care liaison

Clinicians from AMSANT's member services in Central Australia met with the director of eHealth late in 2010 to discuss progress in eHealth developments and on-going issues with the Secure Electronic Messaging System (SEMS). General communication issues not directly related to health were also raised and included: discharge summaries going to the wrong clinic in a high proportion of cases; and a lack of communication about patients seen in emergency departments (up to 40%) because the patient had not consented to this information being provided.

AMSANT communicated our concerns to the Department of Health and the PHMO and eHealth team have subsequently been working with the hospital to resolve them. There has been some progress on the eHealth issues that has been aided by the expansion of the eHealth team at AMSANT.

The DoH has committed to having regional meetings to improve communication in general and to provide an opportunity for PHC clinicians to give feedback and input into hospital service delivery.

Alcohol and other drug reforms

The AMSANT board has endorsed the Northern Territory "Enough is enough!" alcohol reforms, although we remain disappointed that there has not been more action on alcohol control reforms, such as an introduction of a base price per unit of alcohol, or floor price. AMSANT was engaged in discussions with DoH about improved resourcing for primary health care as part of these reforms.

Unfortunately, limited funding was made available but AMSANT did secure support to employ a clinical psychologist (0.7). The focus of the new position will be supporting ACCHSs and clinicians to improve their response to patients with alcohol and other drug problems, including by educating and informing services about the alcohol reforms.

National Key Performance Indicators (NTKPIs)

A national set of key performance indicators is to be introduced in 2011-2012 with current Healthy for Life sites being obliged to report from July 2011 and all ACCHSs being required to report from July 2012. Aboriginal primary health care sites in the government sector will report in 2013.

There are 11 indicators in the first reporting round with three of these indicators being either existing Healthy for Life or NT indicators. The set of indicators will probably expand up to 24 indicators over the next two years.

AMSANT has been engaged (along with NACCHO and other affiliates) in discussions about the indicators and has been a part of a Technical Working Group which was convened to discuss the indicators.

There have also been robust discussions about the development of a data governance framework for the indicators. Health services will be provided access to the 'Pen Cat tool' in order to extract these indicators. This tool extracts clinical data from Clinical Information Systems such as Medical Director and is relatively easy to use with some training. The CQI coordinators and facilitators will support services to use this tool once it has been integrated with Communicare. Services can then use it to extract clinical data for their own purposes, such as for CQI.

Evaluation of the Child Health Check Initiative (CHCI) and Expanded Health Service Delivery Initiative (EHSDI)

The PHMOs sat on a review group oversighting the evaluation of the CHCI and EHSDI. The final report has now been released (Allan and Clarke, 2010). The report found that the CHCI was a flawed process that was centrally driven without adequate consultation. The report was generally positive about the principles and foundations of EHSDI, although it stated that it was too early to ascertain the clear benefits.

INDIGENOUS CHRONIC DISEASE PACKAGE

SHARON WALLACE (INDIGENOUS HEALTH PROJECT OFFICER).

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The Council of Australian Governments (COAG) has pledged to develop and implement strategies to address Indigenous disadvantage and has identified six high-level targets for 'closing the gap' between Indigenous and non-Indigenous Australians.

In November 2008, COAG agreed to an historic $1.6 billion National Partnership Agreement (NPA) on 'Closing the Gap in Indigenous Health Outcomes' to address the first of the COAG targets: to close the life expectancy gap within a generation.

The Commonwealth's contribution to the Indigenous Health NPA is the $800 million Indigenous Chronic Disease Package (ICDP) funded over four years from 2009-2013. The states and territories are contributing the other $800 million.

The aims of the ICDP are to:

- tackle chronic disease factors, in particular smoking
- improve chronic disease management and follow-up care
- expand and support the Aboriginal health workforce.

A new targeted workforce has been created and has started the roll-out to Aboriginal community controlled health services and Divisions of General Practice around the country. This workforce includes: Regional Tobacco Coordinators (RTCs), Tobacco Action Workers (TAWs), Healthy Lifestyle Workers (HLWs) and Indigenous Outreach Workers (IOWs).

In the NT the first ACCHSs to be allocated funds to recruit these workers were the Central Australian Aboriginal Congress, Katherine West Health Board and Danila Dilba Health Service. Three more ACCHSs will receive funding allocations in 2011-12.

To help support this new ICD workforce, AMSANT was funded to employ a project officer. Sharon Wallace was recruited in October 2010 and has brought skills as a registered AHW and AHW Lecturer/Course Coordinator in the NT, with many years of clinical, education and training knowledge.

Sharon's role is to provide support and mentoring to the new workforce employed in the ACCHSs. Key tasks will also include coordinating the development of generic orientation and a coherent training framework for these ICD workers.

The intention of the ICDP is to boost workforce capacity to deliver effective health promotion, prevention and brief interventions in a concerted effort to reduce tobacco use, increase physical activity and good nutrition, and to improve access to mainstream health services.

To achieve success with this project the new ICD workers will need focused support to prepare and train them for challenging new roles and to support their effective integration into primary health care activity. AMSANT's role in support will be critical over the next two years.

RESEARCH, ADVOCACY AND POLICY

While *Closing the gap* is the mantra of many different individuals and agencies, both government and non-government, for AMSANT it is much more than a rhetorical slogan. It means translating both the lived experience of Aboriginal people in the Northern Territory who have the worst health outcomes in the nation, and applying the evidence of 'what works' into concrete action.
And that action has to be sustained and not just seen as a short-term fix which simply will not work in face of the generational change required to turn the tide of ill health, and the social determinants that dictate the lousy conditions experienced by our people.

JENNIFER HAMPTON (DEPARTMENT OF HEALTH), TALKING IT UP STRONG FOR ABORIGINAL HEALTH ON CAAMA RADIO IN ALICE SPRINGS.

A crucial aspect of AMSANT's effort is promoting an evidence base for the work of our member services, both among clinicians and the decision-makers within government and research institutions.

Much of this evidence base comes from the research sector. In recent years many of our members have come under increased pressure from researchers, to the extent that at any point in time there are 100 or more research 'events' across the Territory, with many of our members being the subject of, or participating in, multiple projects. This has led to at least two of our members declaring a moratorium on participation in further research programs—it's simply too much to deal with.

Many of our members have considerable doubts about the utility of many research projects, which are often heavily bio-medical in emphasis and rarely offer much more than incremental advances in knowledge.

For our health services that have to deal with the day-to-day pressures of health delivery with limited resources, greater results will be achieved through the real 'evidence base'—prioritising an expanded workforce and providing housing to cope with it, better clinical facilities and vastly improved living conditions for our people.

Nevertheless, while being aware of these on-going shortfalls, AMSANT does support research and this year was the only Aboriginal community controlled peak health body to publicly lobby against threats to medical research funding nation-wide.

At the direction of the Board, AMSANT has developed a research policy to assess incoming proposals, including the utility of the research and its ethical base. In tandem with this, we continue to lobby to establish and resource an Aboriginal Health Research Assessment and Brokerage service. As well as assessing incoming proposals, such a group would also assist members in coping with research demands and, most importantly, broker research projects from proposals generated from the concerns of our members.

AMSANT has been extremely active in the past year with developing policy to inform membership, decision-makers and the general public. In particular we have concentrated efforts around alcohol policy and the related areas of mental health.

As well as a series of submissions to jurisdictional and national policy processes, we have also developed a productive policy relationship with other peak Aboriginal organisations in the Territory through APO NT—the Aboriginal Peak Organisations Northern Territory. Given our commitment to tackling the social determinants of health, this has expanded the capacity of Aboriginal people to develop more holistic policy beyond the relatively narrow confines of health.

Throughout the year, AMSANT continued to advocate on behalf of the sector through direct lobbying with politicians from all sides of politics, as well as with Territory and Commonwealth departments on a wide range of issues.
In addition, we have played a continuing role in promoting our sector's viewpoints to the public through the media. At times this has been in direct response to requests from our members, such as the continuing problems faced by remote areas needing aerial medical evacuation during the wet season. At other times we have advocated strong positions in the mainstream media on Aboriginal health issues such as child protection, alcohol control, tobacco and eHealth.

CHIPS MACKINOLTY (MANAGER OF RESEARCH, ADVOCACY AND POLICY).

STRONG ABORIGINAL FAMILIES, TOGETHER (SAFT)

The 2010 Board of Inquiry into the Child Protection System in the Northern Territory highlighted some of the massive challenges facing our children, families and services. The board recommended that:
the NT government funds the establishment and ongoing work of an Aboriginal peak body on child and family safety and well-being and child protection, and that this peak body would support the process of the development of Aboriginal child and family well-being, safety and child protection agencies.

In January 2011 the Northern Territory Department of Children and Families funded AMSANT to establish the peak body, *Strong Aboriginal Families, Together* and to develop an operating framework for Aboriginal child care agencies.

Between January and June 2011 AMSANT conducted a series of meetings, workshops and forums across the NT to raise awareness about the intent to establish new Aboriginal community controlled agencies in the NT. At the heart of any future success, most importantly, will be Aboriginal people making decisions and taking action to protect and support our children and young people.

AMSANT is proud to be standing beside Aboriginal and Torres Strait Islander peoples, government, the Department of Children and Families, mainstream non-government sector and the many other committed individuals and agencies tackling child safety and well-being reform in the Northern Territory.

We are delivering on our commitment to help create and 'grow up' the Aboriginal child, youth and family peak agency (NT) through our auspicing role and in supporting the on-going work of SAFT.

In 2011 Josie Crawshaw was appointed CEO of the SAFT. This is an exciting time for Aboriginal families and service providers, who have long awaited the political will and commitment from government to allow a long-term vision through sustainable funding and support, to turn the tide of generational disadvantage.

Most clients in the NT child protection system are Aboriginal so SAFT plans to be at the front and centre of decision making in the sector, for our children's sake and for our future.

SAFT
Strong Aboriginal Families, Together
Through little one's eyes

THE STRONG ABORIGINAL FAMILIES, TOGETHER (SAFT) GROUP: FLORIVELLE LAY (ADMINISTRATION), VICTORIA POLLIFRONE (ACTING POLICY OFFICER), JOSIE CRAWSHAW (CEO) AND SEU FOREMAN (PA AND ADMINISTRATION SUPPORT).

Interim Board

An Interim Board is important in providing a representative group that will be able to direct the important task of incorporating the new agency. Fourteen Board members were selected from across the Territory by AMSANT in an open and transparent process, after advertisements were placed calling for expressions of interest. The Board Members are:

Central Australia
Margaret Furber
Stephanie Bell
Andrew Spencer
Traceylee Forester

Darwin and Greater Darwin
Sue Stanton
Sharon Wallace
Mark Motlop
Stephanie Berrida

East Arnhem
Djuwalpi Marika
Sophia Garrala Gurruwiwi

West Arnhem
Helen Williams

Barkly
Linda Turner

Katherine
Norman "Crow" George
Lisa Mumbin

JACK LITTLE (KATHERINE WEST HEALTH BOARD).

This year has seen many notable highlights for the Reform and Development Unit (RDU):

- The Red Lily Health Board Aboriginal Corporation came into existence on 26 May 2011. The Board was established so that it can become an Aboriginal regionally-based provider of comprehensive primary health care services within the West Arnhem Health Service Delivery Area. The incorporation of the Board completes one essential step on that journey.
- Anyinginyi Health Aboriginal Corporation completed the development stage of the Regionalisation Guidelines and has received 'in-principle' approval from the NT Aboriginal Health Forum to become the Aboriginal community-controlled health service provider for the Barkly region.
- A separate 'regionalisation development unit' has been established in the East Arnhem Health Service Delivery Area (HSDA) to formulate a final regionalisation plan for the region.

The RDU was created in AMSANT in 2008 to provide a focus on the development of Aboriginal community-controlled regional PHC services across the Northern Territory. Although originally established to promote the formation of community-based regionalisation committees, the role of the RDU has expanded to address a number of other issues necessary to support the reform of Aboriginal PHC services. They include:

- Support for the Core Services Framework which seeks to ensure that PHC services include those services considered essential to ensure improved health outcomes for Aboriginal people
- Support to the Continuous Quality Improvement (CQI) initiative that aims to ensure that the quality of services provided by PHC providers is the best possible
- The establishment of regionally-based Clinical and Public Health Advisory Groups (CPHAGs) to support regional development. CPHAGs bring together key clinical staff from the region with members of the Regionalisation Steering Committee to address issues of regional health planning and regional health program evaluation.

During the year the RDU has facilitated a range of regionalisation activities, including 40 meetings of Regionalisation Steering Committees or Interim Health Boards, and 26 Executive or Working Group events. Another 26 community consultation events occurred over the period and further meetings to facilitate the establishment of regionally-based Clinical and Public Health Advisory Groups.

Probably the most significant event was the public release of the Evaluation of the Child Health Check Initiative (CHCI)

THE CHAIR OF THE RED LILY HEALTH BOARD, REUBEN COOPER, RECEIVES THE BOARD'S CERTIFICATE OF REGISTRATION FROM WARREN SNOWDON, THE FEDERAL MINISTER FOR INDIGENOUS HEALTH.

and the Expanding Health Service Delivery Initiative (EHSDI) by the New Zealand-based consultancy firm of Allen and Clarke. Allen and Clarke are specialists in policy and regulatory matters and were engaged by the Department of Health and Ageing and to undertake an independent evaluation of the NTER, CHCI and EHSDI. The evaluation report makes 17 recommendations in four groups: PHC governance, policy, financing and reform; the design

A MEETING OF THE EAST-SIDE REGIONALISATION GROUP AT HART'S RANGE RACECOURSE.

and delivery of child wellness checks and related referral services; workforce; and CQI, data collection and evaluation. The Evaluators said that: "Regionalisation, with its focus on Aboriginal community control and participation, has a sound rationale and is an appropriate way to plan and deliver health services in these parts of Australia," but added the warning: "The regionalisation component of the EHSDI has been under-scoped and under-resourced and the partners are not currently united about the reform and its aspirations. The process of regionalisation, and the partners' expectations of the process, need to be re-scoped so that the principles of regional Aboriginal community control of health services, equity of access and quality of services are sustained".

Around the regions

East Arnhem

The East Arnhem Regionalisation Steering Committee met on 19 separate occasions. The committee conducted ten meetings and there were six Working Group meetings. The nascent Clinical Public Health Advisory Group (CPHAG) met on three occasions.

As a result, this large region with more than 10,000 Aboriginal people has developed a common vision of the future in which Aboriginal people living on the mainland, and those on the outlying islands, have a common vision of health service provision in Aboriginal hands.

The CPHAG provides a mechanism through which professional expertise from health service providers within the region can be provided to the Steering Committee (and on further to other health service providers) to improve service delivery and to promote the regionalisation of PHC services.

The East Arnhem Regionalisation Planning Unit was set up and a Regional Coordinator and a Project Officer were appointed. The unit will contribute to improved health outcomes for Yolngu people throughout East Arnhem Land and support the Steering Committee to provide a final proposal on the agreed regionalisation model for the East Arnhem Land HSDA.

A significant achievement for the year was the agreement for the roll-out of a single Clinical Information System (CIS) to all East Arnhem community clinics. By June 2012, the CIS database will provide all clinics with access and a centralised regional Communicare database that provides access to detailed patient records from all clinic sites. This is a major step forward for this region and will bring patients' health records onto a regional computer-based system for the first time.

Red Lily Health Board (West Arnhem)

The adoption of the red lily as the symbol of hope and growth in Aboriginal health in the West Arnhem region has its origins in a story about the regeneration of the land after the removal of feral buffalo from the floodplains and wooded country of West Arnhem Land. Although once a common sight, the Red Lily was thought to be lost as a result of the introduced buffalo. Its re-growth and return to West Arnhem billabongs and swamps inspired the Board to name themselves in honour of this regenerated native species.

THE RED LILY HEALTH BOARD: DAISY YARMIRR, SAMSON HENRY, ROSEMARY NAMBALWAD (WITH HER SON, TYSON), JANE NADJAMERREK, RHODA NGALMAKU, MARY DJURUNDADU, RONALD LAMILAMI, REUBEN COOPER, CHRISTOPHER GALAMINDA, MICHAEL BANGALONG AND ROSS GUYMALA.

The Red Lily Health Board has taken three years to incorporate and has now set itself the task of establishing a new regional Aboriginal community controlled health board serving local people. Aboriginal members of Red Lily have been training in governance, financial issues and management, prior to the incorporation of the Board. The endeavours of Red Lily are strongly supported by AMSANT and both the Commonwealth and NT governments.

The Red Lily Health Board Aboriginal Corporation was recognised by the Registrar of Aboriginal Corporations on 26 May 2011. The Certificate of Incorporation was handed to Board Chairperson, Reuben Cooper, by Federal Minister Warren Snowdon at a public ceremony at South Alligator on 11 July 2011.

The Red Lily Board met on 15 occasions with eight full Board meetings and seven meetings of the Board Executive. Several community consultations were also completed across the region to spread the message to the people about the Red Lily Health Board.

AMSANT would like to thank the Djabulukgu Association for its support of the Red Lily Health Board in the period to December 2010.

THE REFORM AND DEVELOPMENT UNIT (RDU): THERESA ROE (REGIONALISATION COORDINATOR, TOP END), CHRYSTAL BRAY (ADMINISTRATION OFFICER), KYLIE THORN (REGIONALISATION LOGISTICS OFFICER), ROGER BRAILSFORD (MANAGER), GAVIN GREENHOFF (COMMUNICATIONS OFFICER) AND DR ANDREW BELL (SPECIALIST, PUBLIC HEALTH MEDICINE). [ABSENT: GRAHAM DOWLING (CENTRAL EAST-SIDE COORDINATOR) AND CHIPPY MILLER (CENTRAL WEST-SIDE COORDINATOR).]

Barkly Tableland

The Barkly Regionalisation Unit and the Barkly Health Steering Committee completed a final regionalisation plan in time to be considered by the NT Aboriginal Health Forum (NTAHF) meeting of December 2010. While recognising that Anyinginyi Health Aboriginal Corporation had some way to go before it would be able to assume the responsibilities of a PHC provider to all communities in the region, the plan received in-principle approval which allowed Anyinginyi to start the consolidation phase of the regionalisation process.

The in-principle decision to accept Anyinginyi as the regional PHC provider for the Barkly also meant the Barkly Regionalisation Unit was absorbed by Anyinginyi, so the unit continues to lead the health reform process from within the organisation.

Since then, Anyinginyi has been working with an external consultant to assess its operations against the requirements of the Competence and Capability Framework. The results from this activity will identify those key areas in which development of systems and policy frameworks will need to occur in the run-up to Anyinginyi becoming a funds-holder and purchaser of PHC services for the region. To support the Board in this process, the partners have formed a Monitoring and Support Group to assist the Anyinginyi Board and senior management team achieve that goal.

Central Australia

The Regionalisation Health Summits of November 2008 and November 2009 culminated in strong support to continue an urban-based HSDA based on Alice Springs and to then establish two separate remote HSDAs to serve the communities that lie to the west and to the east of Stuart Highway.

The East Side brings together communities that speak the related Alyawarr, Anmatjerr and Arrente languages. Despite a number of attempts to unify the groups, the Alyawarr-speaking communities withdrew from the alliance to seek recognition of an "Alyawarr-only" HSDA. In the meantime, the Anmatjerr and Arrente speaking communities have sought to further develop regionalisation within the East Side HSDA with much vigour and enthusiasm, led by Jasper Haines and Robbie Conway.

On the West Side of the highway a succession of 'bad weather' and 'bad luck' events continued to frustrate efforts to schedule meetings of the regionalisation steering committee.

AMSANT would like to acknowledge the efforts of Kumantjayai Njalka Williams, a tireless worker whose passing on 13 September 2010 was a sad loss to his family, the Western Arrernte and to Aboriginal health and regionalisation. AMSANT would also like to acknowledge the hard work of Andrew Tjapaltjarri Spencer and Mrs Spencer whose work is essential to the struggle to establish improved PHC services in the West Side HSDA.

Darwin

A Darwin Region Health Planning consultancy review is under way and meetings with the transition committee for Bagot Community Council, Danila Dilba Health Service and representatives from OATSIH, AMSANT and FaHCSIA continued.

The transition committee submitted a funding proposal to OATSIH for the employment of an Indigenous Project Officer for six months to assist in the transition of Bagot Health Services over to Danila Dilba.

Malabam/Maningrida

A Health Board has operated at Maningrida for 14 years and is a tribute to the strong interest of Maningrida people in health reform and improving health outcomes for residents of the main community and the many homelands centres that rely on services based in Maningrida.

The Malabam Health Board has sought to resolve a number of local issues before engaging fully with regionalisation. AMSANT is well aware that there is a strong desire among the people of the Liverpool River region to establish a community-controlled PHC service for the Maningrida HSDA.

Tiwi Islands

People of the Tiwi Islands remain enthusiastic about regionalisation and look forward to the prospect of re-establishing an Aboriginal community controlled health service for the Tiwi people and other island residents. AMSANT is aware that the Tiwi are awaiting outcomes of regionalisation activities elsewhere in the Northern Territory.

Top End West

At present, there are no Aboriginal community controlled health services serving the residents of Nauiyu Nambiyu, Peppimenarti, Palumpa, Wadeye, Woodycupaldya and the associated homelands that lie in the country around the

CHIPPY MILLER (CENTRAL WEST-SIDE COORDINATOR, WITH MICROPHONE) AND SAMSON HENRY (RED LILY HEALTH BOARD).

Daly and Moyle rivers. Communities in this HSDA are keen to explore a model of PHC service delivery that comes through a local community controlled organisation.

South-East Top End

The community of Borroloola has a long-term interest in the idea of establishing a local Aboriginal community controlled health service. Unfortunately, it was not possible in the past year to advance any opportunities for this to occur within this region.

It has been another busy and challenging year for the Workforce section at AMSANT with a number of local and national projects entering vital stages. There has been a strong focus on the Aboriginal Health Worker (AHW) profession particularly due to work around national AHW registration and the on-going development of the National AHW Association.

This year has also seen the establishment of the Workforce and Aboriginal Leadership Support (WALS) unit within AMSANT coordinated by the WIPO. The unit has been created from the existing positions of WIPO, the COAG Indigenous Health Project Officer, Leadership Program Officer and the GPET Officer. Restructuring to the WALS has significantly improved communications and built support for us to work more effectively as a team.

The WIPO has been involved in a number of key reference groups linking to numerous projects locally and nationally. These include-

An **AHW Review Implementation Steering Committee** has been established between AMSANT and the Department of Health to implement the agreed recommendations from 2009 of the NT AHW profession. The aim of the Review, and now of the Implementation Committee, is to improve training, support and professional development of AHWs and to clarify and consolidate the AHW role within the health care system in the NT.

Health Workforce Australia has undertaken a national review of the Aboriginal and Torres Strait Islander Health Worker profession which has included many national working group meetings and two national rounds of consultations. A very useful interim report of the project was produced and we eagerly await the final report later in 2011. It should assist all stakeholders in their thinking and decision-making regarding the AHW profession in the lead-up to national registration.

PAT ANDERSON (FORMER CEO OF AMSANT) AND ERIN LEW FATT (WORKFORCE INFORMATION AND POLICY OFFICER).

The **National WIPO Network** has worked on a number of key projects, including the NACCHO Cultural Safety Training Standards project to create a set of national standards which would enable NACCHO to endorse various cultural safety training programs around the country.

The **NT Senior AHW Network** continues to meet twice a year to provide input into projects and work around the AHW profession. This network enables AMSANT to work more effectively with member services to lift the focus on the AHW profession within Aboriginal primary health care in the Territory.

AMSANT has nominated 2011-2012 as the **AMSANT year of the AHW** and plans are well underway to launch the year at the AMSANT General Meeting in Katherine in September. AMSANT has initiated the Year of the AHW to promote the profession and to rebuild its position as central workforce component for Aboriginal primary health care.

The WIPO also continues to provide ongoing support and input into the following projects:
The NT Indigenous Medical Program
The Health Services Training Advisory Council (HSTAC)
The DEEWR Project to establish an NT plan to build the Aboriginal workforce in health.

The past year 2010-2011 has been a challenge but it has had its rewards with significant progress towards reform of AHW training and support, and with planning for our Year of the AHW. Workforce continues to be a priority for AMSANT and its members and we need to redouble our efforts to make sure more Aboriginal people are brought into healthcare as confident and competent members of the health team.

In recent years AMSANT and member organisations have grown increasingly concerned with the state of the Aboriginal Health Worker (AHW) profession in the NT, especially regarding the low number of graduates coming through AHW training programs and entering the workforce.

There is an ageing AHW workforce with many experienced practitioners reaching retirement age and very few young ones coming up to replace them. It seems the profession may fast lose its place as the cornerstone of Aboriginal primary health care in the NT.

In response to these concerns, and as a consequence of the findings of the *Review of the NT AHW Profession* undertaken in 2009, AMSANT developed an eight-point plan for the reform of AHW training and support. These points are:

- Transition to regional delivery of AHW training by RTOs rather than distant block training
- Develop a coordinated apprenticeship program as a key pathway for AHW Cert IV training
- Fund ACCHSs to employ AHW educators for on-site training and support of AHW trainees
- Re-introduce responsibilities of all PHC staff to support professional development of AHWs
- Develop effective literacy/numeracy programs for AHW trainees integrated into Cert IV training
- Support flexible timeframes for completion of AHW training for students requiring literacy and/or numeracy support
- Develop a coordinated marketing of the AHW profession as a recruitment effort
- Further develop VET in school programs to prepare Aboriginal students for AHW training and careers.

During the 2010-11 year some significant progress was made against several of these elements. These developments are summarised as follows:

COAG National Partnership Agreement in Health: One of the key planks of the COAG National Partnership Agreement to 'close the gap' in health announced in 2008 was to increase the number of Aboriginal and Torres Strait Islander people in the health workforce. Since the Aboriginal Health Worker profession is one of the key entry points for Aboriginal people into the health workforce, AMSANT will need to hold COAG to account on this point to ensure that the reform of AHW training and support is taken seriously and that it's adequately funded to increase Aboriginal health workforce participation over coming years.

The National AHW Association (NATSIHWA): This new entity kicked off in 2010 but has struggled to establish itself in its first year. AMSANT trusts that its teething problems can be fixed and that the Association can establish itself in each jurisdiction, including the NT, so that the membership has a strong professional voice addressing all the issues raised in AMSANT's eight-point reform plan.

AHW National Registration: A new National AHW Registration Board has been appointed with senior Territory AHW, Peter Pangquee, announced as the Chairperson. The task is to work towards national registration of AHWs by July 2012. National registration will build the profile and status of the AHW profession and will also firm up nationally accredited training and professional practice standards for AHWs.

National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework (2010 - 2015): The new National Workforce Framework aims to increase recruitment and retention of Aboriginal people in the health sector, improve delivery of education and training of Aboriginal people to prepare them for work in the health sector, and to support on-going professional development in the workplace. These are all important elements of the AMSANT AHW reform plan and every effort will be made to give effect to these aims through the work of the Workforce Working Group of the Aboriginal Health Forum, chaired by AMSANT.

REFORM OF AHW TRAINING AND SUPPORT

AHW Review Implementation Committee: After a long period of inaction following on from the final report of the *Review of the AHW Professional* in the NT in 2009, a joint Implementation Committee between the NT Department of Health and AMSANT has been formed to respond to the recommendations of the report. The Committee has prioritised action in three main areas to begin with: reform of the education and training model, clarifying roles of AHWs in primary health care and cultural security for AHWs in the workplace.

NT Aboriginal PHC Workforce Framework: This project aims to build some shared vision and collaboration in the NT around developing and sustaining the Aboriginal PHC workforce and it undertook extensive consultations in late 2010, resulting in a final report in May 2011. Its key recommendations speak of developing a stronger 'grow your own' policy and focusing on building the numbers of Aboriginal people entering the health workforce, particularly AHWs. The NT Aboriginal Health Forum is considering its response to the proposed Framework and its priority directions.

DEEWR/DBE project: The Commonwealth departments of Education, Employment & Workforce Relations and Business & Employment have recently brought a range of stakeholders together to develop a plan for increasing the numbers of Aboriginal people in the health workforce. This is in acknowledgement that although around 30% of Territorians are of Aboriginal descent, only 9% of the health workforce is Indigenous. Regular project workshops are conducted and the key areas of focus at the moment are to develop quality Territory-wide health workforce data and to tackle the difficult issue of literacy/numeracy deficits that prevent many remote area people undertaking the Cert IV level training that is required to enter the health field.

All of these initiatives will need to be backed up with funding from both levels of government to bring about the necessary changes to restore the AHW profession to the foreground of Aboriginal PHC in the NT.

AMSANT ANNUAL REPORT 2010-2011

In 2010 AMSANT made the decision to re-name the Information and Communications Technology (ICT) and Patient Information Recall System (PIRS) support functions under the banner of the AMSANT eHealth Unit. This was done to reflect the critical and growing role that data and technology are playing in primary health care delivery. AMSANT believes that eHealth is now a generic term that covers all aspects of technology use and data management in the primary health care setting.

It was also decided to refer to the clinical software we all use to gather and store patient information as a clinical information system (CIS) rather than PIRS. It was felt that 'CIS' better reflected the role that the software plays in the integration of data, technology and communications.

The eHealth unit has maintained its support for the AMSNet managed health network and this year a further ten sites began using the infrastructure. The AMSNet managed network allows for the storage of health data in a secure data centre in Sydney with end-users accessing their data through a secure Internet connection.

The benefit of this is that health 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 health setting to be far less complex, thereby reducing the demands for service support in the remote setting. Further to that, clinicians can access data in any location where they are able to connect to the Internet. This allows for greater flexibility in staffing and rostering in remote settings.

The AMSNet initiative has highlighted to AMSANT the critical role that communications networks play in eHealth. AMSANT member organisations generally rely on consumer-grade data connections but this is becoming untenable as technology use in primary health care advances so rapidly.

Our work in eHealth has brought us in contact with representatives from the National Broadband Network (NBN) as our membership is keenly awaiting the improvements in communications that this initiative will bring. Unfortunately, our initial discussions lead us to believe that the NBN will be a big player nationally but it will not serve the needs of our remote members, many of whom will be in the 3% of the population who will not have access to the NBN. Communications technology will be a growing issue for our team in the future.

The technical team has been working closely with Communicare this year to trial some enhancements to their software. This has been done in partnership with key staff from member organisations. There has been great success in health services operating Communicare on server infrastructure that better integrates with other ICT functions required in health organisations. The next step is to bed down a fully-supported virtualised version of the software.

This year has seen the last member service move to the Communicare software, meaning that Aboriginal primary health care services in the NT are now served by two products: Communicare and PCIS.

AMSANT has maintained a busy schedule of health service visits to support members on Communicare functioning. This has included support on 'Medicare claiming' and clinical pathways within the software. Several workshops have been held to provide clinicians with the opportunity to shape common functions within the Communicare product. We have also instigated regular Communicare training in Central Australia, as well as being key members on some clinical and technical reference groups such as the NT Aboriginal Health Key Performance Indicators (NTAHKPI), the Hearing Health Information Management System (HHIMS) and the Advanced Shared Electronic Care Planning (ASeCP).

'Information anxiety' is a reality in many ACCHSs and effective management of information is crucial to the success of their day-to-day business activities. The AMSANT eHealth Unit has developed frameworks, templates and 'best practice' approaches to the development and implementation of intranet and extranet sites.


DAVID MURTAGH (ICT MANAGER).


DAN KYR (IT HELP-DESK COORDINATOR).


MARGIE COTTER (CIS SUPPORT ADVISER).


VENJIE DIOLA (INFORMATION SYSTEMS MANAGER).


GREG HENSCHKE (eHEALTH SYSTEM SPECIALIST).


SIMON STAFFORD (EHEALTH UNIT MANAGER).


SHIRLEY SPICER (PROJECT ENGAGEMENT OFFICER).


SELENA WALKER (PROJECT OFFICER, LOGISTICS).

Intranets represent a real opportunity for organisations to centralise information and communications on corporate functions. They can become an organisation's mini-internal-Web. AMSANT has worked with a number of our members to develop intranets that suit their business models. In the coming year we will integrate systems that meet ISO accreditation standards into our intranet.

The eHealth unit has focussed on building partnerships with the NT Department of Health (DoH) on eHealth issues. Regular meetings have been held to ensure that issues and developments in the eHealth arena will provide benefit to Aboriginal primary health care. In June, the first meeting of the Northern Territory Aboriginal Health Forum (NTAHF) strategic eHealth group was held, providing a platform for eHealth to be on the agenda at the Health Forum for the first time.

This partnership with the NT DoH has brought about work on several joint projects. Firstly, we jointly hosted a forum in Katherine to showcase the NT Shared Electronic Health Record (SEHR). As a result of that meeting in December 2010, AMSANT joined in a consortium to submit an application for funding from the Federal Department of Health and Aging (DoHA), through the agency of the National eHealth Transition Authority (NEHTA) to participate in the Personally Controlled Electronic Health Record (PCEHR).

Also in the consortium are the NT Department of Health, the General Practice Network of the NT (GPNNT), the Aboriginal Health Council of SA (ACHSA) and the WA Country Health Service.

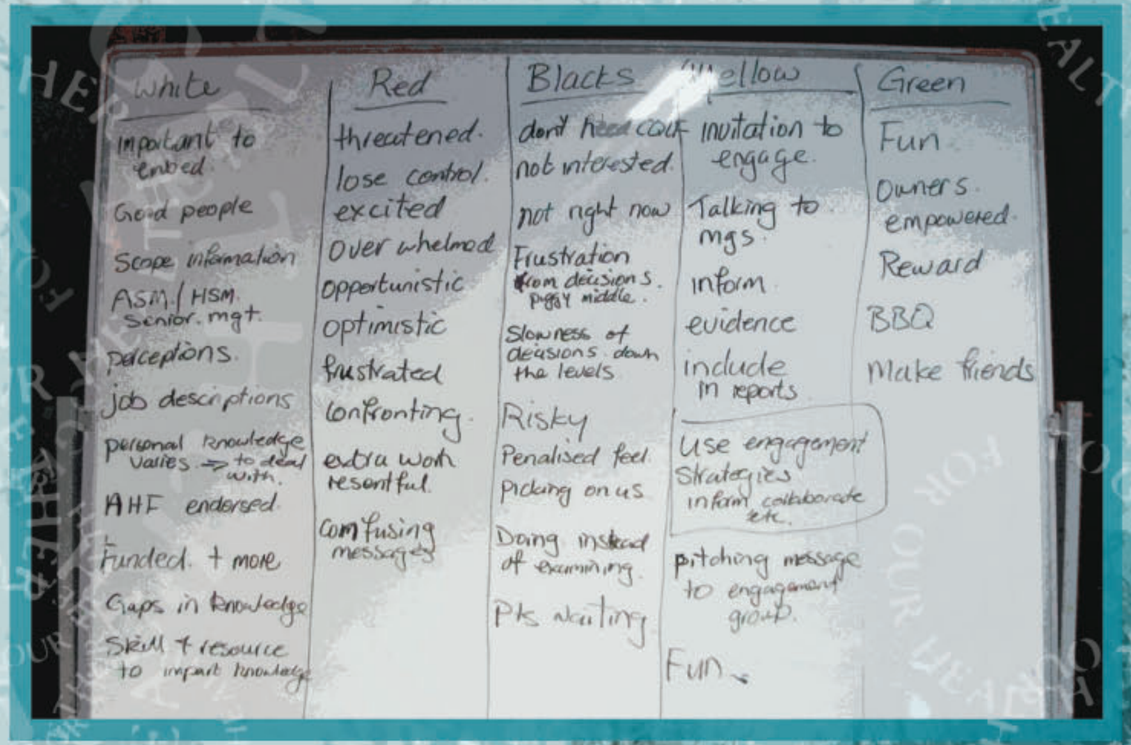
Staff from the partners went through an intensive process of developing a successfully funded implementation plan that aims to do the following over the coming year:

- continue the registration of NT Aboriginal people to the NT SEHR, especially in the Central Australia and East Arnhem regions where registration numbers are low
- provide assistance to implement the NEHTA national eHealth standards in the Clinical Information System, Communicare and the NT SEHR, which will allow NT health services and patients to participate in the national PCEHR
- provide assistance to our services to implement the national identifiers (IHIs, HPI-Os and HPI-Is) required for the electronic identification of client information for secure transfer of health information
- improve the quality and depth of client health information within the NT SEHR so that there can be improved management of complex conditions for mobile clients.

The project will also increase the footprint of the NT SEHR through:

- GPNNT registering health providers and patients who attend NT urban GP Practices
- AHCSA registering health providers and patients who attend SA ACCHSs
- WACHS registering health providers and patients who attend Kimberley public hospitals.

AMSANT is currently engaged in implementing Communicare into the four DoH health centres in East Arnhem at Yirrkala, Gapuwiyak, Raminginning and Millingimbi. We will put a Communicare server in the NT Government data centre and the health centres will all access the one database. This will be the first step towards implementing a single database for the region, providing an essential stepping stone on the pathway to community control.



The aim of the CQI program is to build on existing CQI initiatives and experience and to develop a sustainable, long-term approach to service improvement across Aboriginal primary health care (PHC) services in the Northern Territory.

MELISSA ROBERTS (CQI, CENTRAL AUSTRALIA) AND KERRY COPLEY (CQI, TOP END).

During the last year, the AMSANT CQI Coordinators Kerry Copley (Top End) and Melissa Roberts (Central Australia) have focused on implementing the 'CQI approach' to all aspects of Aboriginal PHC. The CQI approach outlines ten key elements for health services to consider when planning and undertaking CQI activities. These key elements include things such as: engaging and utilising the whole health service team around quality activities; pro-active support and leadership from management; empowering Aboriginal staff to be involved in the process; ensuring all staff have the knowledge and skills to participate in quality initiatives; and using clinical data to evaluate and plan priorities.

The CQI Coordinators are based at AMSANT and work closely with a team of CQI facilitators who work in local Health Service Delivery Areas (HSDAs), providing hands-on support and expertise around improvements to health systems and processes to support consistent best practice and improved health outcomes for Aboriginal people.

It is the CQI Coordinator's role to orientate, train and mentor the CQI Facilitators. An orientation workshop was held in October 2010, following an initial recruitment round that resulted in ten of the CQI Facilitator positions being filled. Several face-to-face workshops for the CQI Facilitators have subsequently been held to improve skills and to develop the capacity of the facilitators with regard to clinical audits, group facilitation, community engagement and a range of CQI tools.

The NT AHKPI Collaborative

It was exciting to see the engagement and enthusiasm that was generated when a group of clinicians and health service staff came together for the NT AHKPI (Aboriginal Health Key Performance Indicators) collaborative workshops.

Two workshops were held in the past year, with 70 people attending each one. The workshops promoted an environment of shared learning and provided an opportunity for health service staff to come together to consider ways of using their NT AHKPI data to improve their clinical systems and health outcomes through the use of CQI processes.

These workshops have provided an essential forum for health service staff to collaborate, to plan and to learn from each other. The program at each workshop included presentations from different health services (both Aboriginal community controlled health services and NT Government services) about the CQI strategies and activities that they were implementing in their services. There was opportunity for discussion and shared learning in areas of interest such as maternal and child health, chronic disease and population health.

The NT AHKPI Collaborative is building the capacity of health services to interpret and analyse their data, identify areas of strength and to create opportunities for improvement.

One21Seventy training

Five training workshops were delivered by AMSANT during the year in Darwin, Alice Springs and Tennant Creek for clinicians and other health service staff to train them on how to use the 'One21Seventy' CQI tools. Altogether, 110 clinicians and health service staff have been trained to use the One21Seventy audit, system assessment and action planning tools. This has enabled them to analyse and interpret data across a range of areas including: maternal and child health, diabetes services, renal disease, hypertension and coronary heart disease, preventative services, mental health, acute rheumatic fever and rheumatic heart disease.

CQI website

A CQI webpage accessed through the AMSANT website has been developed with information about the CQI program, the NT-wide CQI support team, upcoming workshops and training opportunities. It also has links to other relevant CQI websites and information.

An 'extranet' will be launched soon with information, tools and resources for the CQI facilitators and the CQI Planning Committee to access. The extranet will also host a discussion forum for the CQI facilitators and, in the near future, will attract others with a strong interest in CQI to enable more effective sharing of resources and knowledge.

AMSANT supports the website and the CQI extranet as a means of disseminating information and ideas about CQI. "Why reinvent the wheel when we can learn from each other and share generously?"

CQI planning committee

The CQI Planning Committee has met four times during the past year, including an all-day, face-to-face meeting in May, to consider options for an evaluation framework for the CQI program. These planning sessions informed the development of a proposal for a 'process evaluation' which was prepared by the CQI coordinators on behalf of the planning committee. The CQI facilitators from each HSDA attended the all-day meeting to enable them to update the planning committee on the status of CQI implementation across the Territory.

The CQI approach

The CQI approach outlines 10 key elements for health services to consider when planning and undertaking CQI activities:

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

Active participation in CQI is growing across both the Aboriginal community controlled sector and in NT Government health centres. In a nutshell, continuous quality improvement is really about asking ourselves: "Is there a better way of doing this?"

Our focus for the coming year will be to ensure that CQI is embedded into Aboriginal PHC throughout the NT. After all, quality improvement is everybody's business!

Principles

- CQI Intrinsic to CPHC Principles
- Corporate and Clinical Governance
- Leadership and Clinical Management
- Consumer focus
- Building effective clinical teams
- Building a learning culture
- Best practice approach
- Improved patient outcome

Framework

- Governance (Corporate and Clinical)
- RelationshipDevelopment (Community Engagement, Stakeholder, Staff)
- Best Practice and Standards
- Funding
- Human Resources
- National Linkages Data, Research
- Information Technology and Communication
- Risk Management
- Monitoring/Evaluation
- Reporting

Elements

- Data
- Consumer Input
- Tools
- Health Service Team
- Feedback
- Leadership and Management
- Communication
- Aboriginal engagement
- Training and Shared Learning
- Staff Support

KEN O'BRIAN (ACCREDITATION SUPPORT OFFICER, TOP END).

The Office of Aboriginal and Torres Strait Islander Health (OATSIH) funds a program called Enhancing Quality Health Services (EQHS) to support ACCHSs to attain accreditation. The program provides for affiliate support of ACCHSs, the contracting of expert accreditation facilitators to develop action plans and direct funding to ACCHSs for various costs associated with the attainment of accreditation.

EQHS funds AMSANT's Quality and Accreditation Support program which assists health services with the attainment and maintenance of both clinical and organisational accreditation programs.

Clinical accreditation is achieved under Royal Australian College of General Practice (RACGP) standards, and our members have used Australian General Practice Accreditation Limited (AGPAL) to survey the standards that are required. Organisational accreditation for our members uses either the International Standards Organisation (ISO) or Quality Improvement Council (QIC) frameworks.

AMSANT has two Accreditation Support Officers to assist our 26 member organisations. Britt Puschak has been in the Alice Springs office for more than two years and has developed close working relationships with member organisations in Central Australia, with regard to quality and accreditation programs. Ken O'Brien has been busy in the Darwin office for a year and is rapidly building his networks and providing support to members across the Top End.

Britt and Ken work closely together on the program and offer members the following kinds of support:

- provision, or sourcing, of expert technical advice to ACCHSs on all matters related to clinical and organisational accreditation
- practical support for the maintenance of accreditation status and re-accreditation
- on-going networking opportunities and collaboration with NACCHO and other affiliates
- an annual Quality workshop to bring representatives from the sector together to address accreditation challenges.

Regarding clinical accreditation under the RACGP standards, ACCHSs must meet a set of standards designed to protect the patient and the community and to promote best practice health care through quality improvement.

Fifteen ACCHSs in the NT are now accredited under the RACGP standards, with several health centres achieving accreditation for the first time in 2010-11. Several others have had more than one clinic site accredited within their organisation.

The Aboriginal community controlled health services accredited under RACGP are:

- Amoonguna Health
- Ampilatwatja Health
- Anyinginyi Health
- Central Australian Congress
- Danila Dilba Health
- Kakadu Health
- Katherine West Health
- Miwatj Health
- Mutitjulu Health
- Ngalkanbuy Health
- Pintupi Homelands
- Santa Teresa
- Sunrise Health
- Urapuntja Health
- Wurli Wurlinjang

Two health services, Wurli Wurlinjang and Katherine West, have achieved organisational accreditation under the ISO standards and several more are now preparing for accreditation under this program. Another service is seeking accreditation under QIC standards and AMSANT itself hopes to be accredited under ISO frameworks in late 2011.

Funding has now been secured from OATSIH for the continuation of the Accreditation Support Program until June 2014. The key aims of AMSANT support over the coming period are:

- the development of regional Quality and Accreditation networks
- the development of a Quality and Accreditation tool-kit for NT ACCHSs
- the creation of an AMSANT Quality and Accreditation 'extranet' site to provide resources, support, links and networking contacts
- to update the 'Interpretive Guide' for ACCHSs for the RACGP Standards (4th edition) and to develop an 'Interpretive Guide' for ISO frameworks
- to conduct a 'learning needs' survey on Quality and Accreditation for our members and provide, or source, relevant training activities.

The focus in the coming year will be supporting NT ACCHSs to attain organisational accreditation under the ISO or QIC standards programs, thereby maintaining and improving clinical standards in general.

DON CHRISTOPHERSEN (GPET OFFICER).

The Medical Registrar training program in the NT remains an important program for providing additional medical care for Aboriginal Territorians and also as a means of skilling up young medicos as effective practitioners in Aboriginal primary health care. The hope is that many of these training registrars will come back to ACCHSs as full-time GP employees once they are fully qualified.

The role of the AMSANT GPET Officer is to support those ACCHSs who function as Registrar Training Posts by running these training programs. The officer also works alongside the training provider, NTGPE, to run cultural orientation programs for newly placed registrars and assist with other training-related activities and cultural mentoring as required.

Norma Benger has filled the GPET position at AMSANT in the past couple of years where her focus has included developing ways to promote ACCHSs in the NT as good places for registrars to seek training placements. She has also worked on the development of a model for the provision of cultural mentoring for registrars living and working in remote Aboriginal communities. The proposed AMSANT model is still yet to be implemented on the ground but efforts are being made with NTGPE to find a funding source for the mentoring program.

Norma has since taken 12 months leave from AMSANT to commence studies to become a doctor. She commenced medical training in February and is progressing well.

In her place we have welcomed Don Christophersen, a well-known Iwaidja man from north-west Arnhem Land, with a strong background in cross-cultural training and the recording and telling of NT history, particularly from the Top End. He started in April 2011 and has spent his first couple of months getting acquainted with the ACCHSs and all the issues associated with registrar training. He is currently developing a special session on 'Aboriginal community control' to deliver at orientation sessions and in other relevant forums.

The key issues for registrar training in ACCHSs include: the challenges of medical supervision for registrars in very remote sites; the costs of travel for registrars; attracting registrar placements to certain regions; and the thorny old issue of accommodation for registrars, or for any new staff for that matter. Don will continue to do his best to support ACCHSs to overcome these challenges.

AMSANT Incorporated

Special Purpose Financial Report
ABN 26 263 401 676

For the year ended 30 June 2011

AMSANT ANNUAL REPORT 2010-2011

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JOE MAUNG (BUSINESS MANAGER).

AMSANT ANNUAL REPORT 2010-2011

SONIA LEW FATT (RECEPTION AND ADMINISTRATION),
HELEN DAY (ACCOUNTANT), IYESHA ADAMS (RECEPTION), KEVIN JOHNS (ICT SUPPORT), ANNA BERTO
(CORPORATE SERVICES), BRONWYN NETLUCH (OFFICE MANAGER) AND HONEY LIN (FINANCE OFFICER).

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 delivery of health services support 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 $333,723 for the year ended 30 June 2011 (2010: net surplus of $392,586).

In the opinion of the Executive Committee:

1. The accompanying financial report as set out on pages 57 to 67, being a special purpose financial statement, presents fairly the financial position of the Association as at 30 June 2011 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 — Leon Chapman

Stephanie Bell
Chairperson

Leon Chapman
Treasurer

meritpartners
CHARTERED ACCOUNTANTS

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Independent auditor's report to the members of AMSANT Incorporated

We have audited the accompanying special purpose financial report of AMSANT Incorporated, which comprises the balance sheet as at 30 June 2011, 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 of the Association.

The Committee's Responsibility for the Financial Report

The Association's Committee of the Association are responsible for the preparation 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 of Australia and are appropriate to meet the needs of the members. The committee are also responsible for such controls as they determine are necessary to enable the preparation of the financial report that is free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

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

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial report. The procedures selected depend on 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 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.

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.

Opinion

In our opinion, the financial report presents fairly, in all material respects, the financial position of AMSANT Incorporated as of 30 June 2011 and of its financial performance and its cash flows for the year the ended in accordance with the accounting policies described in Note 1 to the financial statements.

Basis of Accounting and Restriction on Distribution

Without modifying our opinion, we draw attention to Note 1 to the financial report which describes the basis of accounting. The financial report is prepared to assist AMSANT Incorporated to meet the requirements of the Associations Act of the Northern Territory of Australia. As a result the financial may not be suitable for another purpose. Our report is intended solely for AMSANT Incorporated and should not be distributed to parties other than AMSANT Incorporated.

Matthew Kennon
Director

Darwin
Date: 23/11/2011

meritpartners
CHARTERED ACCOUNTANTS

AMSANT INCORPORATED
INCOME STATEMENT
FOR THE YEAR ENDED 30 JUNE 2011

	Note	2011 $	2010 $
REVENUE			
Grant income	9	8,158,183	7,583,951
Unexpended grants at beginning of year		1,468,327	893,436
Administration fee		1,150,327	777,913
Interest received		98,360	53,978
Other income		104,993	77,535
Unexpended grants at year end		(1,706,706)	(1,468,327)
TOTAL REVENUE		9,273,484	7,918,485
EXPENSES			
Employee costs	10	4,258,702	3,234,773
Depreciation		161,698	122,874
Consultants and auspice payments		722,088	1,421,074
Other expenses from ordinary activities	11	3,797,273	2,747,178
TOTAL EXPENSES		8,939,761	7,525,899
SURPLUS / (DEFICIT)		333,723	392,586

AMSANT INCORPORATED
BALANCE SHEET
AS AT 30 JUNE 2011

	Note	2011 $	2010 $
CURRENT ASSETS			
Cash and cash equivalents	2	3,204,705	3,008,340
Trade and other receivables	3	992,345	59,821
TOTAL CURRENT ASSETS		4,197,050	3,068,161
NON-CURRENT ASSETS			
Property, plant and equipment	4	375,560	320,204
TOTAL NON-CURRENT ASSETS		375,560	320,204
TOTAL ASSETS		4,572,610	3,388,365
CURRENT LIABILITIES			
Trade and other payables	5	1,059,857	604,914
Employee provisions	6	366,281	263,054
Unexpended grants	7	1,706,706	1,468,327
TOTAL CURRENT LIABILITIES		3,132,844	2,336,295
NON-CURRENT LIABILITIES			
Employee provisions	6	88,146	34,173
TOTAL LIABILITIES		3,220,990	2,370,468
NET ASSETS		1,351,620	1,017,897
ACCUMULATED FUNDS			
Accumulated surplus	8	1,351,620	1,017,897
TOTAL ACCUMULATED FUNDS		1,351,620	1,017,897

AMSANT INCORPORATED
CASH FLOW STATEMENT
FOR THE YEAR ENDED 30 JUNE 2011

	Note	2011 $	2010 $
CASH FLOWS FROM OPERATING ACTIVITIES			
Receipts from customers		1,165,557	1,164,371
Payments to employees and suppliers		(8,174,185)	(7,305,080)
Interest received		98,360	53,978
Grants received		7,323,687	7,583,951
Net cash flows provided by / (used in) operating activities	12	413,419	1,497,220
CASH FLOWS FROM INVESTING ACTIVITIES			
Acquisition of property, plant and equipment		(217,054)	(122,810)
Net cash flows provided by / (used in) investing activities		**(217,054)**	**(122,810)**
CASH FLOWS FROM FINANCING ACTIVITIES			
Borrowings/(repayment of borrowings)		-	-
Net cash flows provided by / (used in) financing activities		-	-
Net increase / (decrease) in cash held		**196,365**	**1,374,410**
Add: Opening cash balance		3,008,340	1,633,930
Ending cash balance	2	3,204,705	3,008,340

AMSANT INCORPORATED
NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2011

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.

	2011 %	2010 %
Plant and equipment	20 - 40	20 - 40
Office equipment	20 - 40	20 - 40

AMSANT INCORPORATED
NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2011

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 oncosts.

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 2011

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.

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 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.

AMSANT INCORPORATED
NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2011

	2011	2010
	$	$
NOTE 2 - CASH AND CASH EQUIVALENTS		
Cash at bank - Operating accounts	764,302	(12,332)
Cash at bank - Investment account	2,440,926	3,019,572
Cash and interest accounts	(523)	1,100
	3,204,705	3,008,340
NOTE 3 - TRADE AND OTHER RECEIVABLES		
Trade debtors	923,108	57,819
Prepayments	63,835	-
Other receivables	5,402	2,001
	992,345	59,821
NOTE 4 - PROPERTY, PLANT AND EQUIPMENT		
Property, plant and equipment - at cost	891,210	674,157
Less: Accumulated depreciation	(515,650)	(353,953)
	375,560	320,204

	2011	2010
	$	$
NOTE 5 - TRADE AND OTHER PAYABLES		
Trade creditors	613,261	186,786
Credit card	2,309	2,481
Accrued expenses	84,150	54,537
Grant income in advance	6,038	6,038
Net GST payable	181,696	185,855
Integrated account	2,174	-
Payroll liabilities	170,230	169,217
	1,059,857	604,914
NOTE 6 - EMPLOYEE PROVISIONS		
Current		
Workers compensation insurance	-	54,106
Annual leave	332,108	208,948
Long service leave	34,173	-
	366,281	263,054
Non current		
Long service leave	88,146	34,173
	88,146	34,173

AMSANT INCORPORATED
NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2011

	2011	2010
	$	$
NOTE 7 - UNEXPENDED GRANTS		
Primary Health Care Schedule - (OATSIH)	75,354	-
P46 - Health Workforce Training	88,654	88,654
P62 - eHealth NT SEHRP	474	41,746
P38D - PIRS MBS Support CA	-	90,617
P66 - IHPO Chronic Disease	41,885	84,335
P04 - Workforce	60,000	35,559
P12 - Secretariat Officer	-	686
P30 - AOD Remote Clinic Support	130,000	-
P31A - Health Policy Research	26,380	-
P35 - APONT	10,938	-
P38 - OATSIH - PIRS Support	-	12,176
P42 - P&Q (ICT/PIRS) NT Supp	-	11,778
P43 - Public Medical Officer	-	99,166
P44 - Service Expansion (PHMO)	14,674	38,415
P50 - Accreditation	-	110,043
P50A - Accreditation Scoping	21,190	-
P51 - RADU	63,544	-
P51A - EHSDI Communications	57,088	20,108
P53 - Business Development Manager	-	18,793
P54 - Policy & Strategy Manager	-	3,357
P57 - CQI	64,288	150,477
P58 - AMSANT ICT	11,880	189,695
P58A - eHEALTH IPS	7,846	-
P59 - AOD	15	23,402
P60 - Red Lily	97,770	14,513
P61 - Support Malabam & AHCAC	8,120	8,120
P63 - Fresh Food Summit	26,137	72,199
P67 - Workforce Consultancy	7,457	65,818
P69 - Account Package Upgrade	-	20,000
P17 - Oxfam Leadership Workshop	53,227	33,145
P05 - GPET Framework Agreement	51,312	34,236
P28C - Building Lship & Cap	23,00	120,445
P64 - Maningrida Youth Centre	243,520	95,455
P68 - PaCE	-	85,388
P70 - ICD Orientation & Training	43,861	-
P120C - East Arnhem Software	299,650	-
P120I - East Arnhem Implement	67,531	-
Other	110,909	-
	1,706,706	1,468,327

AMSANT INCORPORATED
NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2011

	2011	2010
	$	$
NOTE 8 - ACCUMULATED FUNDS		
Balance at 1 July	1,017,897	625,311
Surplus/(Deficit) during the year	333,723	392,586
Balance at 30 June	1,351,620	1,017,897
NOTE 9 - GRANTS INCOME		
DOH - NT grants	320,787	372,971
DoHA grant	1,054,094	90,617
OATSIH grants	5,352,290	6,165,485
OXFAM funding	58,825	70,000
Other grants	1,372,188	884,878
	8,158,183	7,583,951
NOTE 10 - EMPLOYEE COSTS		
Fringe benefit tax	48,671	48,671
Recruitment	42,738	-
Salaries	3,824,899	2,895,472
Staff on-costs	-	34,743
Staff training	53,776	3,774
Superannuation	266,922	242,766
Workers compensation	21,695	9,347
	4,258,702	3,234,773

	2011	2010
	$	$
NOTE 11 - OTHER EXPENSES		
Administration	1,764,560	1,274,388
Motor vehicles	202,350	134,202
Operations	1,240,571	887,964
Travel	589,792	450,624
	3,797,273	2,747,178

AMSANT INCORPORATED
NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2011

	2011	2010
	$	$
NOTE 12 - CASH FLOW RECONCILIATION		
Reconciliation of the net surplus (deficit) to the net cash flows from operations:		
Net surplus (deficit)	333,723	392,586
Add: Depreciation	161,698	122,874
Add/(deduct) changes in assets and liabilities:		
Trade and other receivables	(932,524)	336,622
Trade and other creditors	454,943	(29,481)
Unexpended grants	238,379	574,891
Employee provisions	157,200	99,728
Net cash flows provided by (used in) operating activities	413,419	1,497,220

NOTE 13 - ASSOCIATION DETAILS

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

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

ACCHS	Aboriginal Community Controlled Health Service
AGPAL	Australian General Practice Accreditation Limited
AHKPI	Aboriginal Health Key Performance Indicators
AHW	Aboriginal Health Worker
AMSANT	Aboriginal Medical Services Alliance Northern Territory
CA	Central Australia
CAAC	Central Australian Aboriginal Congress
CHCI	Child Health Check Initiative
CIS	Clinical Information System
CPHAG	Clinical Public Health Advisory Group
CQI	Continuous Quality Improvement
DoHA	Department of Health and Ageing (Commonwealth)
EHSDI	Expanded Health Service Delivery Initiative
FaHCSIA	Department of Families, Housing, Community Services and Indigenous Affairs (Commonwealth)
GPET	General Practice Education and Training
GPNNT	General Practice Network Northern Territory
GPR	General Practice Registrar
HSDA	Health Service Delivery Area
MoU	Memorandum of Understanding
NACCHO	National Aboriginal Community Controlled Health Organisation
NTAHF	Northern Territory Aboriginal Health Forum
NTER	Northern Territory Emergency Response (or 'the intervention')
NTG	Northern Territory Government
OATSIH	Office of Aboriginal and Torres Strait Islander Health (Commonwealth)
PHC	Primary Health Care
PHMO	Primary Health Medical Officer
PIRS	Patient Information Recall Systems
RACGP	Royal Australian College of General Practitioners
RDU	Reform and Development Unit
SEMS	Secure Electronic Message Services
WIPO	Workforce Implementation Project Officer

ACKNOWLEDGEMENTS

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