AMSANT ANNUAL REPORT 2012 - 2013

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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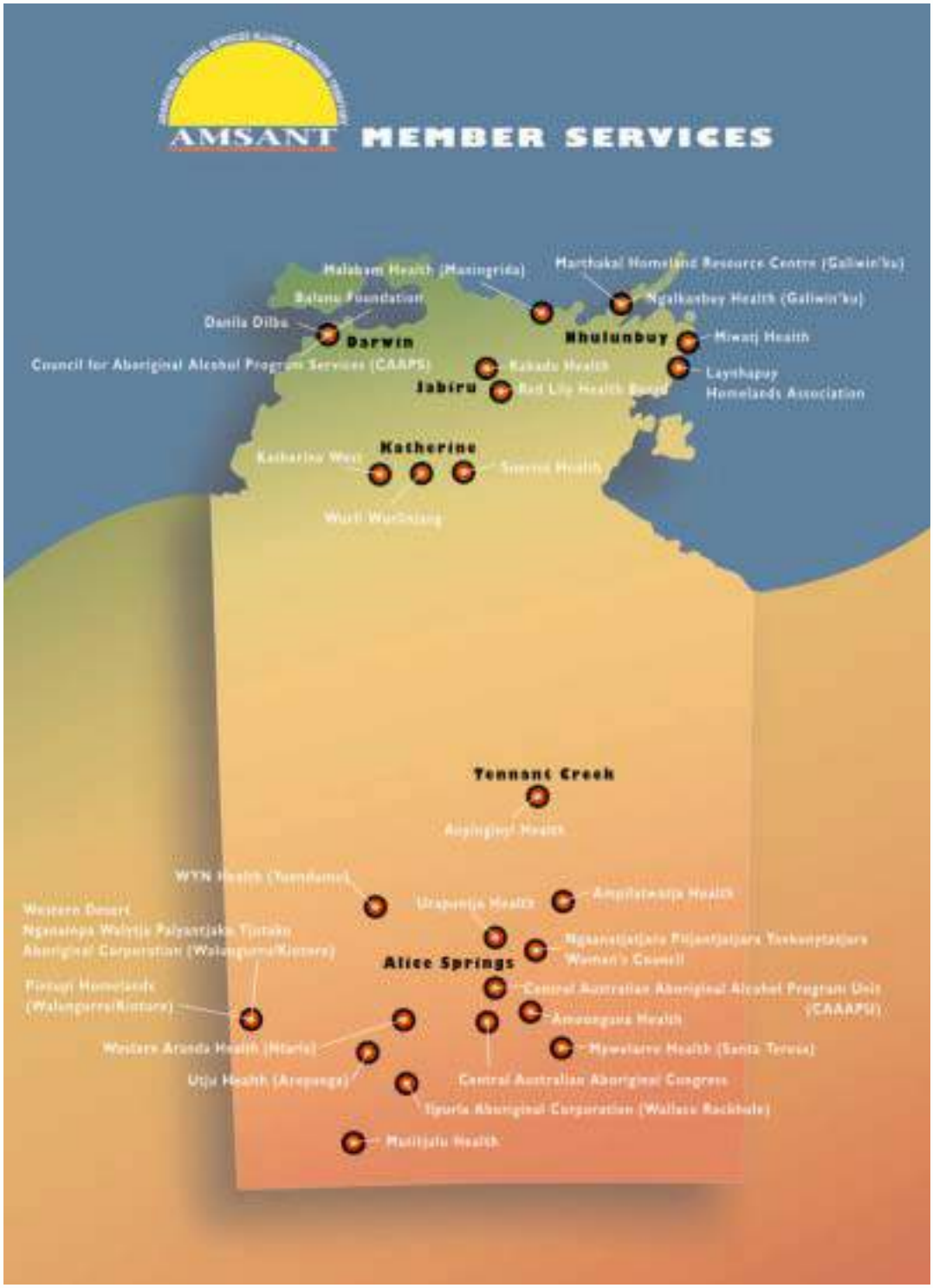
AMSANT is the peak body for Aboriginal Community Controlled health services in the Northern Territory and advocates for equality in health, focusing on supporting the provision of high quality comprehensive primary health care services for Aboriginal communities.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MEMBER SERVICES
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FROM THE CHAIR

Aboriginal comprehensive primary health care – a good work in progress…

Aboriginal comprehensive primary health care works, as was noted in last year's Annual Report, and this has been borne out by updates to those statistics this year. Aboriginal community controlled primary health care in the Territory is a confounding success story. We remain the only jurisdiction on target to close the life expectancy gap by 2031.

The performance of our sector underpins this headline success achieved in the NT. The 2013 Australian Institute of Health and Welfare report on national Healthy for Life (HfL) indicators singled out the achievement of the Northern Territory HfL health services, almost all of which are community controlled.

Participation in Healthy for Life is but one example of how our services have led the way in improving primary health care—through the adoption of evidence based practices and continuous quality improvement (CQI) processes combined with the development and uptake of cutting edge technologies such as electronic patient records and e-Health—within a framework of collaborative needs-based health planning.

However, the successes we have achieved are tempered by the significantly poorer health profile of our communities and the need to continue reforms of the health system begun but far from completed.

In particular, AMSANT would now like to see certainty around funding and a continued and renewed commitment to the creation of

Regional Aboriginal Health Bodies throughout the Territory. After all, our work is as much "core business" as the hospitals—to keep people out of hospital as long as possible! The evidence is clear that Aboriginal community control of health is the preferred path for the NT; with overall improvement to Closing the Gap and key health service indicators in our jurisdiction. And the best way to sustain improvements in outcomes is through the ongoing work to establish regional health services throughout the Territory under the *Pathways to Community Control* model.

Governance Renewal

A change within the leadership of some of our Members has been a challenge to AMSANT within this overall picture of successes and difficulties, with myself as the third Chairperson in the reporting period. Structural and constitutional changes commenced by the Board in 2011-2012 were overtaken by events, not least a series of external reviews of the organisation. These were time consuming, as they occurred during a period in which the organisation itself was building towards ISO accreditation (which pleasingly we have received).

At the heart of the matter has been the issue of governance—and it is an issue Aboriginal Community Controlled Health Services across the nation have been dealing with over the last couple of years. While we strongly support the NACCHO principles around good governance, none of our Members wish to lose sight of the core principles of community control over our governance. This commitment is not just out of mere sentiment: community ownership and control has been the bedrock of the improvements to Aboriginal primary health care we have seen—and will continue to achieve.

In recent months, the AMSANT Board has taken up this challenge, and will be reporting on progress to our Annual General Meeting, with changes expected within this coming financial year. The Membership will examine a raft of amendments to our structure, Constitution and governance arrangements at the coming end of year AGM. These measures to be considered will give us the opportunity to make AMSANT a more effective and dynamic organisation in the contemporary health service delivery space. At the same time we will be mindful of maintaining a commitment to the principle of community control and appropriate consultation of all of our Members.

I would like to thank my fellow Board Directors for their support to this process —and to myself as Chairperson since late 2012.

Sean Heffernan
Chairperson

FROM THE CEO

This year has seen the centenary of the opening of Kahlin Compound in Darwin: the beginning of a dark and cruel part of Aboriginal history. A bit later this year, we will see a public performance surrounding the history of The Bungalow in Alice Springs. These two events signify much for Aboriginal people in the Northern Territory. They tell us about our past and the tumultuous years since those days—but they are signposts for the future, as well.

This is not least the case for the Aboriginal health movement in the Northern Territory. In the last year, one of Member services—Congress—saw 40 years of service to the Aboriginal people of Central Australia. The year before that, Danila Dilba celebrated 20 years of service to its people. Other significant anniversaries are coming, notably the 30th anniversary of the Pintupi Homelands Health Service, our most remote Member service.

And, almost as an afterthought, next year will see the 20th birthday of AMSANT.

Those two decades have seen much change in the landscape of Aboriginal Community Controlled Health in the Territory—and it has not always been smooth travelling. Nevertheless, it was AMSANT that led the challenge to remove Aboriginal health from ATSIC which, in turn, laid the foundations of a dramatic increase in funding of Aboriginal comprehensive primary health care throughout Australia.

We can be proud of the work carried out by AMSANT 20 years ago, just as we can be proud of our ongoing work as an organisation that represents primary health care service delivery to more than half the Aboriginal people of the Northern Territory—and that number will grow.

From an organisational point of view, 2012-2013 has been one of the most challenging we have faced in a long time. As ever, as we are almost entirely resourced on short term project funding, long term planning for the organisation has presented great challenges. I'd like to highlight just two of our achievements: for the

rest you will have to read the full report!

The first, which you can read about in greater detail in this report, has been our continued strength in building Continuous Quality Improvement (CQI) as an integral part of the practice of Aboriginal Comprehensive Primary Health Care here in the Northern Territory. Significantly, this has flowed to the Government primary health care system out bush as well as the Community Controlled sector. In other words, our CQI team here at AMSANT has been successfully taking up the challenge of making CQI "Everybody's business". Usually when I hear the word "partnership", I take it with a grain of salt, but in this case it is a word with genuine meaning—and intent. The extension of CQI training into the Aboriginal health workforce this last year has been a welcome development.

The second is more of a "hidden story" of the organisation: our successful commitment to ISO accreditation. Almost all of our Members have clinical accreditation, many are also working towards organisational accreditation.

Accreditation is not about creating a perfect organisation, it is about working towards being the best organisation you can be—and getting better at what you do over time. For me, what has been great about the process is the way it has involved the "shop floor" of the organisation: it's not a process for the "bosses", but the whole organisation. And, it's also about CQI—getting better at what we do as an organisation that supports and represents its Members in many different ways.

As our Chairperson has noted, the last year has been a difficult one, not least because of our self-imposed approach to CQI through accreditation, but also through external reviews. It has been a huge impost on our staff, who are already busy enough doing their day jobs. I take this opportunity to thank them for their work and commitment to the organisation.

I mentioned our approaching anniversary as a salute to our past, but also as a reminder that we must at the same time look to renewal and change. In the last year two of our senior staff have left, with another to leave in the coming months. In management terms, this leads to potential problems in "succession planning" but, as usual, AMSANT has taken a more innovative approach based on our ethos of 'family'. All three have a commitment to ongoing support to the organisation with both corporate memories and continued intellectual input to us. As well as recruiting externally, AMSANT has a strong commitment to building the capacity of Aboriginal staff within the organisation to take on senior roles—a fundamental component of succession planning for an Aboriginal organisation. I can assure you that this is happening.

Finally, I would like to thank the Board and staff equally for their passion and commitment in what has been a hard year. When people start with us, there isn't a part of the contract that commits our employees to "above and beyond the call of duty"—but it is part of the culture of AMSANT nevertheless, and I thank them all for that.

John Paterson

CEO

STRATEGIC PLAN

Executive Assistant, Sonia Lew Fatt

The AMSANT Board and staff have spent considerable time and energy in developing the *Operational Plan 2010-2012* to better support member services and to promote more widely the benefits of Aboriginal Community Controlled Health Services.

This Plan is ending its life, and the current Board is moving towards developing a 3-5 year plan which builds on previous work of the organisation.

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 work force 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

THE AMSANT CONSTITUTION

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.)

WHAT IS COMMUNITY CONTROL?

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.

Since its inception, 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, 1989, xiv)

REGIONALISATION

The role of the AMSANT Regionalisation Development Unit (RDU) has been twofold, to facilitate the development of new regional Aboriginal Community Controlled Health Services, referred to as "regionalisation", and as a mechanism through which AMSANT engages in system wide NT Aboriginal primary health care reform. These complementary activities were funded by the Expanding Health Service Delivery Initiative (EHSDI) which concluded at the end of the 2011-2012 financial year. EHSDI was a joint program under the Northern Territory Aboriginal Health Forum (NTAHF), and benefited from the close working relationship between the three partners, AMSANT, NT DoH and OATSIH. This program is now part of the Stronger Futures.

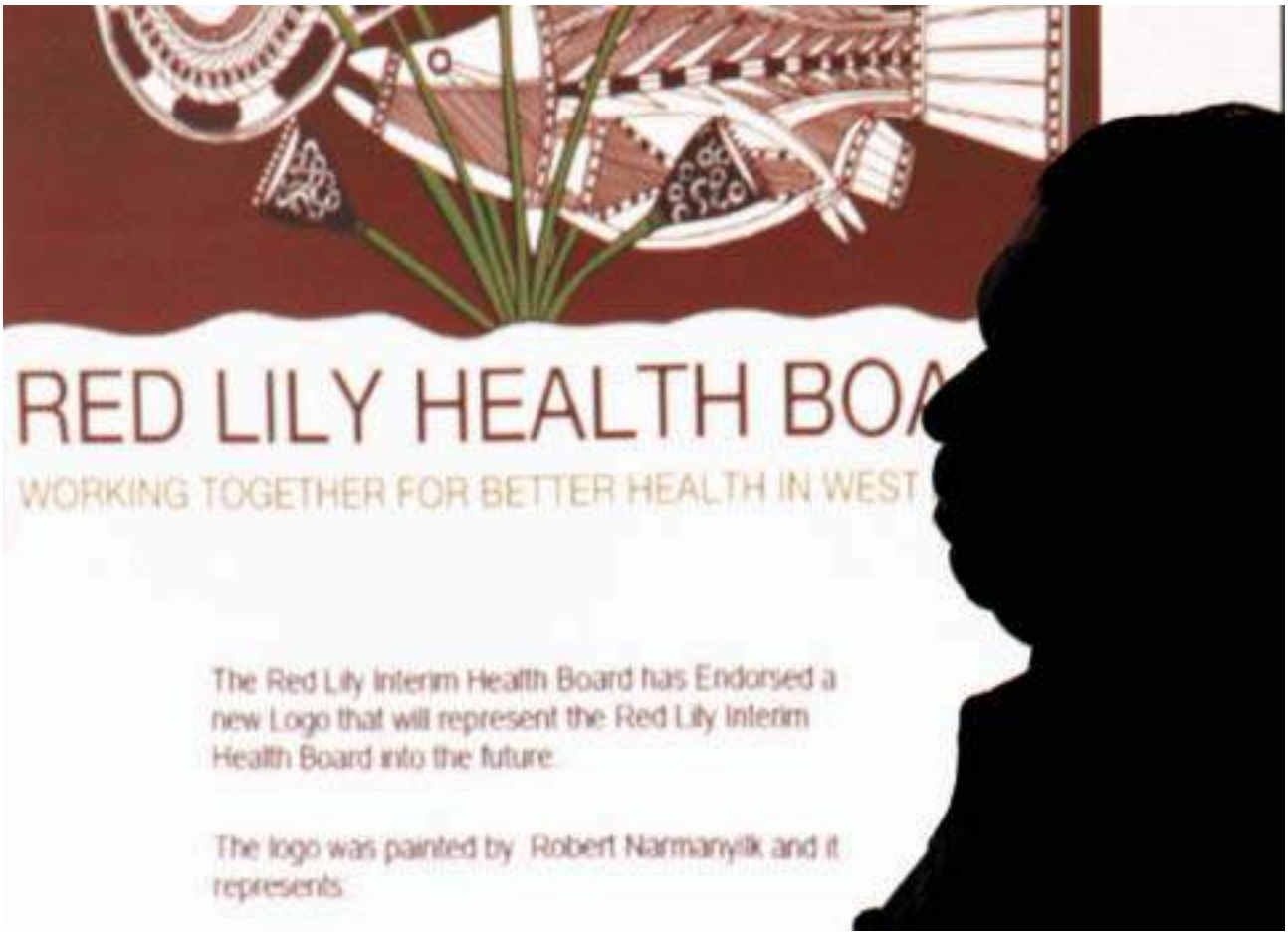
Regionalisation activities have continued to progress, although under difficult conditions, with limited and uncertain funding and no capacity in the Top End.

At its November 2012 Annual General Meeting, the AMSANT Membership re-affirmed that the development of community controlled regional health services through regionalisation remains core business and a highest priority for AMSANT.

However, progress towards regionalisation has slowed despite our best efforts. As noted in the Chairperson's Report, prolonged political and funding uncertainties in the last year has exacerbated the situation.

Although there have been near-weekly Partnership Team meetings between staff from AMSANT, DoH and OATSIH, the results have been minimal. OATSIH accepted the suggestion of a planning workshop (forum) to develop a plan to be binding on the three parties and to get the initiative back on track. This forum was held in June.

Progress in regionalisation through the year has occurred in a number of Health Service



Delivery Areas (HSDAs). In East Arnhem, the Final Regionalisation Plan is still being negotiated with Miwatj; DoH is currently assessing what additional information it requires from Miwatj. AMSANT is no longer directly involved in these negotiations. The East Arnhem Clinical and Public Health Advisory Groups (CPHAG) has been meeting regularly and the meetings are well attended and have useful outcomes especially around improving coordination of services and resolving local issues.

In West Arnhem, the Red Lily Board has met and governance consultants are in place. DoH is now the only provider in the region, and progress towards transition is slow, with very limited capacity for AMSANT to work directly with the Red Lilly Health Board. The West Arnhem CPHAG has not yet met; as DoH is the sole provider in the West Arnhem region it has responsibility for organising this group.

The Barkly negotiations are continuing between Anyinginyi Health Service and the two departments of health. The Barkly CPHAG has been meeting monthly with attendance including Anyinginyi and DoH representatives, and AMSANT.

In Central Australia progress on developing the steering groups into health boards has been delayed due to the OATSIH decision to cancel and restart the procurement process for governance consultants. We have been in continual contact with steering committee members to explain the reasons for the delay and reassure steering committee members that the Commonwealth is still committed to the process. Central Australian CPHAG meetings were called for February, but cancelled; an Alyawarra meeting is planned for July.

A milestone has been the establishment of three regional CPHAGs bringing together health professionals and community members from different providers within regions to facilitate more effective regional coordination and planning of health services.

AMSANT wishes to thank the staff of RDU past and present for their hard work on regionalisation, and looks forward to the continued development of effective regional Aboriginal Community Controlled Health Services.

PUBLIC HEALTH MEDICAL OFFICER ACTIVITIES

Darwin Regional Indigenous Suicide Prevention Network rally, September 2012.

Public Health Network

The Public Health Network (PHN) continued to be very active during the last 12 months. We have continued to provide regular information to clinicians—being mindful to try to fill the gaps with what is not provided through regular clinical bulletins from other organisations. We have maintained monthly teleconferences on the first Wednesday of the month and we have also recorded these (available on the PHMO part of AMSANT website). In 2013 the topics have included: Orientation, HPV vaccination in boys, STRIVE, NT Cardiac, Pharmacy, s100 and quality use of medicines, Communication with Deaf people in Community and Closing the Gap in the NT—we are doing really well! The team has also taken over the management of monthly public health forums in Alice Springs which provide an educational opportunity for clinicians in health and related areas.

We had a very successful combined PHN-CARPA conference in August 2012, on the theme of Aboriginal and non-Aboriginal clinicians working successfully together in Alice Springs. This complemented the largely Darwin-focused activities for the Year of the Aboriginal Health Worker. It was especially pleasing that many Aboriginal clinicians and managers attended the conference. One of the main speakers, Ken Lechleitner, spoke on "First Nations People Working Better with Australian People". It was a thought provoking wide ranging talk. Michael Tyrrell (a psychologist with a background in Remote Health) talked about what motivates and attracts people to work in remote settings and how the attributes which may attract people such as being adventurous and able to cope with risk and unpredictability need to be harnessed thoughtfully to ensure that teams function well. The conference concluded with a panel on Indigenous primary health care focusing on how to ensure that Aboriginal clinicians were integral and highly valued members of clinical teams. Special interest groups in Social and Emotional Well Being, Aboriginal workforce and sexual health met in the afternoon.

AMORPH (AMSANT Member Operational Reference for Public Health) was formed by AMSANT as a way to ensure we have good two-way communications with senior clinicians in every ACCHS. The AMORPH has been used for disseminating important clinical information—e.g. CDC updates, new services, funding opportunities, changes to systems and guidelines.

A successful face-to-face AMORPH meeting was held in April focusing on clinical governance. The group consisted of senior clinicians including health service managers, AHPs, GPs and nurses. We reviewed historical issues in the NT regarding clinical governance including some past analyses such as the Hennessy Report, roles within the health team, shared various approaches to risk management including several specific software packages. The group also looked at an approach to root cause analysis and subsequent systems improvement following an adverse event. There is planned ongoing advocacy through this group to improve clinical governance systems and agreement on these across the ACCHS sector. We plan to collaborate with the CARPA, Women's Business Manuals groups to support safe roll-out of the upcoming new manuals and guidelines.

We have also compiled a list of very useful orientation materials and included these materials in the AMSANT Administration Manual. We are engaging services in an ongoing dialogue about how to improve orientation and we are also talking with key locum agencies including RAHC.

Some key issues PHMOs are involved in are detailed below:

SONT/MSOAP ICD

The Tender for new outreach services has now been announced (previously called SONT or MSOAP or MSOAP-ICD). The providers will be DoH for medical specialist outreach—now called RHOF—and the NTML for outreach services focussed on supporting Indigenous people with chronic diseases—now called MOICD. There are plans to restructure the outreach systems to be more focused on addressing health need and with a strong focus on equity across the NT. Significant coordination will also be required—especially to ensure that the services provided through DoH and RHOF complement and work well with each other.

AMSANT had dialogue with NTML and DoH about this restructure, helped to write the successful proposal and will have an ongoing role to support coordinated planning across the NT.

Sexual and reproductive health

AMSANT is a partner in STRIVE which is a trial of a CQI approach to sexual health. STRIVE completed its second year successfully and early indications are that services engaged in a CQI approach are increasing testing rates. We also completed the second and final year of the NT component of GOANNA; a research project aiming to ascertain the attitudes and behaviours of Aboriginal young people in relation to sexual health and AOD use. The results of this survey are currently being analysed with results to be provided to the AMSANT Board and the sector at the end of 2013.

Renal advocacy

AMSANT has been pivotal to forming the Kidney Action Network (KAN)—an advocacy network pushing for improved services for patients on dialysis and their families as well as improved PHC management of renal disease. The Network includes a large number of mainstream and Aboriginal NGOs. The Network had a very

successful launch in March with a moving speech by the Chair of KAN, AMSANT CEO John Paterson. We are continuing to negotiate with government—federal, NT, South Australia and Western Australia—to try to encourage joint efforts on supporting Aboriginal people dealing with this very difficult disease, rather than the current situation of ad hoc responses to a deepening problem.

Orientation, education and clinical support

The PHMO team continues to work closely with the AMSANT NTGPE (Northern Territory General Practice Education) project officer to support ACCHSs to host GP registrars and to ensure that the GP registrars have a good understanding of community control and how ACCHSS differ from other training settings.

The AMSANT/NTGPE Project Officer is responsible for developing a model for future AMSANT/NTGPE engagement and in planning for and supporting the expansion of Indigenous Health Training for GP Registrars, whilst fostering closer relationships with AMSANT (and its member services) with NTGPE. The Project Officer is also responsible for promoting the conceptual framework of community control to registrars at orientation and throughout their education program through delivering modules, and promoting the unique attributes of AMSANT member services and ACCHOs as positive training environments for GP Registrars.

As the role has evolved, other responsibilities include assisting with the coordination of workshops, the initiation of a pilot cultural mentoring program, preparation of abstracts/presentations for conferences AMSANT/NTGPE are involved with, and the professional development of Indigenous staff. Currently AMSANT receives the funding for this role but from January 2014, the role will be funded by NTGPE but continue to work closely with both organisations. A good foundation has been laid for a very close working relationship between NTGPE and AMSANT.

Training opportunities within the PHMO unit

We have worked with Danila Dilba to employ a GP extended skills registrar who works half time at AMSANT on public health issues and half time at Danila Dilba. The first incumbent in this position enjoyed the position and contributed to the work of the PHMO team whist learning public health skills that are invaluable to clinicians in Aboriginal primary health care. We will welcome our second registrar in this role in July 2013.

This year we also employed a public health registrar position for the first time for a twelve month post. Dr Coffey is focusing on early childhood to strengthen policy and advocacy work in this crucial area which has been highlighted in the National Aboriginal and Torres Strait Islander Health Plan. Dr Coffey has reviewed the literature on the nurse family partnership program which is currently implemented at Congress and which is one of the few early childhood programs with robust trial evidence of long term benefit for both mothers and children.

Research

AMSANT has continued to work with research teams to support PHC services to engage and contribute to ongoing research partnerships including in the areas of CQI (National ABCD partnership), sexual health (STRIVE and GOANNA), diabetes (diabetes in pregnancy). We have reviewed and provided input into multiple research proposals this year and have been somewhat frustrated that the engagement with PHC occurs at a relatively late stage of research development. We have therefore been developing an "early engagement" template

with the aim of encouraging researchers to engage at an early stage of research development.

Public Health Advisory Group

The PHAG continues to provide public health and clinical policy advice to the CEO and board. Through PHAG, the PHMOs have provided major input to submissions including the submission on the National Aboriginal and Torres Strait Islander Health Plan.

Clinical indicators

The AMSANT PHMOs continue to be involved in the further development of the NT Aboriginal Health key performance indicators (NTAH KPIs) and advocacy/communication about the national Aboriginal health indicators. Dr Liz Moore has continued to chair the Clinical Reference Group for the NTAH KPIs. The indicator set has expanded this year to include a new indicator on RhD, and immunisation in young children. Other indicators have been aligned to the new national indicators.

The AMSANT board has given in principle support for a pooled ACCHS data set to be developed by the Health Service Data Unit at DoH with this data to be made available to each ACCHS and to AMSANT. This will be very useful for CQI, and ongoing policy and advocacy work.

We are still concerned at the lack of sector engagement in the roll out and further development of the national Aboriginal health key performance indicators (nKPIs) and are advocating for more structured engagement with OATSIH and the Australian Institute for Health and Welfare about the development of the indicators and issues with data quality. The eHealth team has successfully advocated for Communicare to be funded to develop reports for the new national key performance indicators.

Hospital/primary health care liaison

There has been major reform in the health system in the NT with a new CLP government and AMSANT continues to monitor the opportunities and challenges that this presents. John Paterson and Dr Liz Moore were on the governing councils of the Top End and Central Australian Hospital Networks which were appointed by the previous ALP government. Both of these councils were disbanded in July 2013 with new councils appointed by the CLP. These new councils will be financially accountable for the function of the two networks which will expand to include government-provided Aboriginal primary health care. There are some concerns with the two nominated councils (which will become boards once the relevant legislation has been enacted) in that neither Board currently includes people with expertise in the community controlled sector; all members are based in either Alice Springs or Darwin and the new Alice Springs Council does not include any Aboriginal people. We are therefore concerned that the new Boards will lack relevant expertise. There may be opportunities for further people to be appointed to the new Boards in the coming months.

PATS

The CLP government made election commitments on the Patient Assistance Travel Scheme (PATS) including that they would review the minimum travel distance required for PATS eligibility (currently 100 kilometers). AMSANT provided a short submission to the PATS review based on member feedback and we are interested in ongoing feedback about this vital service.

PUBLIC HEALTH MEDICAL OFFICER ACTIVITIES

Input into regionalisation through CPHAGs

The PHMOs represent AMSANT at the Barkly and East Arnhem Clinical and Public Health Advisory Groups (CPHAGs) and were involved in planning a CPHAG workshop in Alice Springs. The CPHAGs provide a mechanism to foster a coordinated approach to CQI, data and outreach across HSDAs with multiple providers. However, it is clear that CPHAGS in general will only flourish if regionalisation reform continues so that they can report to an emerging ACCHS board. Dr Alex Hope works with the regionalisation team. Dr Hope is a very experienced remote GP and provides invaluable clinical and public health expertise to the team.

AOD & SEWB Program Support & Clinical Supervision

Sarah Haythornthwaite continues in a role focusing on supporting workers throughout our sector who are working to enhance social and emotional wellbeing and reduce substance use within their communities. This support is available through the provision of clinical supervision to a number of workers but also through Sarah's availability for consultation in regard to SEWB, Mental Health (MH) and AOD issues and program areas. Sarah continues to work closely with the Remote AOD Workforce Support Program in supporting AOD workers throughout our health services.

Sarah has worked with others at AMSANT on policy, research and advocacy issues that have related to SEWB, MH and AOD issues throughout our communities. In 2012-2013, AMSANT provided submissions in relation to the development of the National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing and in relation to the development of the National Aboriginal and Torres Strait Islander Peoples' Drug Strategy. Over the last year, AMSANT, as a member of the Aboriginal Peak Organisations of the NT, was also involved in the organisation of two Grog Summits, one in Darwin and one in Alice Springs. The aims of these summits were to provide an opportunity for Aboriginal communities and leaders to discuss alcohol issues and approaches to reducing alcohol related harm within their communities.

Sarah's role has also involved participating in the NT AOD and Licensed Social Clubs research committees.

Aurora interns

During this reporting period, Sarah Haythornthwaite and Dr David Cooper have been involved in sharing the supervision of seven interns, who have each come to work with AMSANT for a period of approximately six weeks, through the Aurora Project. These interns have come with a variety of academic and professional backgrounds, in areas such as public health, Aboriginal health and wellbeing, and Law. A common thread to some of the interns' projects has been to examine historical and present day trauma as a significant underlying determinant to compromised wellbeing and substance misuse issues within Indigenous communities. One such project examined the relevance of models of trauma-informed care to the delivery of comprehensive primary health care within the NT. Another project recently completed by an Aurora intern examined the concept of Justice Reinvestment and the relevance of this concept to the work of Community Controlled Health Services in the NT. Supporting these internships has contributed significant capacity to AMSANTs ability to gather information and critically evaluate literature relevant to enhancing social and emotional wellbeing and reducing substance use issues for Indigenous communities.

At latest count, staff and Board members of AMSANT serve on 115 various committees, reference groups, working groups, advisory bodies and boards.

Many of these relate to issues surrounding electronic health; many more are concerned with clinical and health system matters. As one might imagine, it involves an apparently endless series of meetings!

MEETINGS MEETINGS

With respect to electronic health issues, these groups include:

Advanced Share Electronic Care Planning Steering Committee (ASeCP), AMSNET Steering Committee, MeHR - Clinical Reference Group, MeHR - Technical Working Group, RHd Australia data management committee, NT eHealth Working Group, Ochrestreams Working Group, One21seventy E-learning Package Working Group, SeMS - Technical Working Group.

Health groups include:

Public Health Advisory Group (PHAG), Renal Clinical Reference Group, SARC (Sexual Assault Referral Centre) MOS (Mobile Outreach Service) Expert Reference Group, RHD advisory committee (NT), Sexual Health Advisory Group, STRIVE Investigators Meeting, Tobacco Control - Project Reference Group, Visiting Optometrists Scheme Northern Territory Reference Group. AMORPH, Cancer Care Optimisation Group NT, Cardiac Reference Group NT, Cardiac Rehab and Secondary Prevention (CRSP) Steering Group, Care Coordination and Supplementary Services Program Advisory Group, CCPMS (Chronic Conditions Prevention and Management Strategy) Early Detection and Management Clinical Reference Group (CCPMS EDM CRG), Corrections Health (Prisons) Project - Clinical Working Group, Diabetes in pregnancy advisory committee, East Arnhem CPHAG (Clinical and Public Health Advisory Group), Healthy Living NT - Diabetes Education Advisory Committee, NACCHO Immunisation Committee, National KPI Technical Working Group, NT AHKPI Clinical Reference Group and Technical Working Group.

System and other working groups include:

Remote Primary Health Care Manuals Editorial Committee, NTGPE, AMSANT administration manual reference group, Central Australian Aboriginal and Torres Strait Islander Health Practitioner Professional Development Working Group, Centre of Research Excellence in Rural and Remote Primary Health Care National Advisory Committee, Correctional Services Stakeholders Reference Group, Greater Northern Australia Regional Training Network, Identifying effective CQI strategies project - ABCD Partnership, NT Clinical School Advisory Committee.

CONTINUOUS QUALITY IMPROVEMENT (CQI) PROGRAM

The aim of the CQI program is to build on existing CQI initiatives and experience, to develop a sustainable, long-term approach to service improvement across the Aboriginal Primary Health Care service system in the Northern Territory (NT).

Continuous Quality Improvement is "Everybody's Business". It is about responding to the question "How can we do this better?" Aboriginal Primary Health Care services in the Northern Territory are using CQI to support the delivery of quality health care to the people who access their services. There is a broad range of good clinical data available to health services to inform and empower clinical decision-making and tools to help make sense of the data and implement changes.

PHC Services are supported in their CQI work by dedicated CQI staff with most based in their health services or HSDAs where they support a number of smaller clinics. Kerry Copley and Louise Patel are the CQI Coordinators based in AMSANT who provide leadership and coordination to the CQI Strategy; developing and delivering training, mentoring and supporting the CQI Facilitator team, participating in the NT AHKPI Committees and reporting to the NT CQI Steering Committee.

Two of the highlights of the last 12 months have been the great interest and engagement in the CQI Collaborative workshops and in the development and delivery of Aboriginal and Torres Strait Islander Health Practitioner-specific CQI training.

CQI Training for Aboriginal Staff

It is a priority of the CQI Strategy to support Aboriginal PHC staff to actively engage and provide leadership in their health services around CQI. Aboriginal engagement is a key element of the NT CQI Approach and to support this aim a training workshop was delivered in Darwin in November 2012 for 25 Aboriginal Health Practitioners. The workshop aims were to build the knowledge, skills and confidence of those attending to enable them to actively participate in quality improvement in their health services. This pilot workshop will be the first of a series of up skilling opportunities specifically designed for Aboriginal staff to ensure that they have access

to appropriate, effective training in CQI.

Feedback from those attending was very positive. They had an enjoyable day and gained in confidence and understanding of what CQI is and how they can be more involved. During the day, participants were given hands on training in how to do a PDSA (Plan Do Study Act) cycle, a SWOT Analysis (Strengths, Weaknesses, Opportunities and Threats) and had practical training on auditing where everyone completed a clinical audit. Participants found the training interesting and practical; they enjoyed bouncing ideas off each other and gave us some great ideas for future workshops. The AHP CQI Workshop was held in conjunction with the November CQI Collaborative and many of the AHPs also attended the Collaborative Workshop. Planning is underway for further CQI training specifically for Aboriginal staff.

Hands on Learning - Aboriginal Health Practioners' CQI Day

CQI Collaborative workshops

The CQI Collaborative workshops continue to engage large numbers of clinical staff with up to 80 people attending each workshop. The Collaborative workshops provide opportunity for Aboriginal Community Controlled and NT Government health services to showcase the quality improvement work they are doing. Those attending hear success stories from other services, learn new skills and tools to support their own work and are given the opportunity to network and connect with staff in similar roles.

The message from clinicians and health service staff in the NT is that they value hearing how others are making improvements using the various data sets—NTAHKPIs, the nKPIs, One21Seventy and "traffic light" reports. Sharing generously, our speakers at the two CQI Collaborative workshops held in Darwin in November 2012 and in Alice Springs in May 2013, shared their stories of how they are using their data to highlight areas of strength and identify gaps that need to be addressed through CQI processes.

A range of shared learning options are provided from plenary speakers, to brief Table Top presentations and more interactive concurrent sessions. Many inspiring and useful ideas are shared and feedback from those attending confirms the value of coming together to learn from each other.

CQI Evaluation

A comprehensive evaluation of the NT CQI Strategy has been undertaken by Allen+Clarke in the last 12 months. The purpose of the evaluation was to determine the effectiveness, appropriateness and efficiency of the CQI Strategy. It is intended that the evaluation findings and recommendations will inform the ongoing implementation of the NT CQI Strategy, and national considerations relating to CQI in Aboriginal health.

The findings of the NT CQI Strategy Evaluation were largely positive and identified high levels of participation in CQI across health service staff in the NT as a result of the CQI Strategy. Health services' knowledge and capacity in CQI had also increased. The Evaluation recognised that there has been a great deal and wide range of CQI activities supported under the Strategy. Many of these activities are based around tools and practices specifically developed for CQI, such as the One21seventy tools, NT AHKPIs and PDSA cycles. The CQI Strategy has led to increased interpretation and and services are beginning to share, compare and benchmark data at a regional level. Allen+Clarke identified the need for health services to complete all parts of the CQI cycle to really see the improvements that CQI can offer. The evaluation noted there was good synergy between the NT CQI Approach and best practice guidelines. It did however identify that while there had been significant increase in CQI awareness and activity, health services were at very different stages of embedding CQI as part of core primary health care.

Kerry Copely, Jodie Gunderson and Louise Patel

Allen+Clarke made a number of recommendations for future development of the CQI Strategy that will be made public when the Evaluation Report is released.

Delegates from the Aboriginal and Torres Strait Islander Health Practitioner CQI Workshop, November 2012

At the time of writing, the Allen+Clarke Evaluation Report has not been released by OATSIH.

Over the last 24 months, the Lowitja Institute commissioned a National CQI Appraisal which also highlighted the achievements of the NT CQI Strategy. This report is available on the Lowitja website: http://www.lowitja.org.au

Over the last 12 months it has been exciting to support the great work that is being undertaken in many health services across the NT to improve their systems of delivering care. AMSANT, through the NT CQI Strategy is supporting services to implement their CQI goals, delivering training, facilitating Systems Assessments, supporting services with data analysis and providing opportunities for health services to share what they are doing, through the CQI Collaborative workshops and other training workshops.

Together, we are making CQI "Everybody's Business".

The AMSANT eHealth team

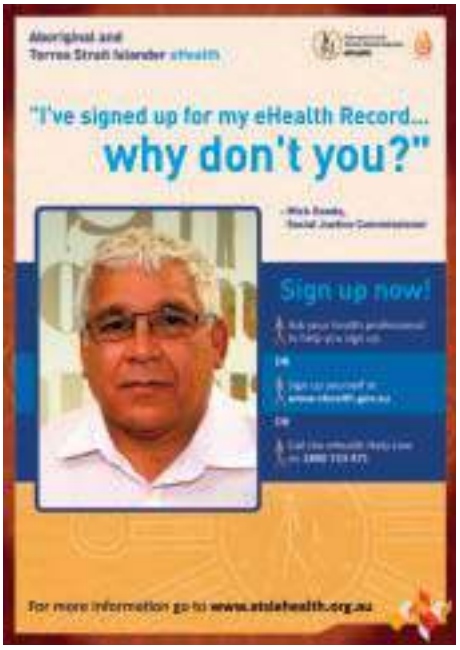
eHEALTH

AMSANT members remain at the forefront of eHealth developments. The AMSANT eHealth Unit has had a busy year supporting and advocating for our membership in what is becoming an increasingly more complex environment.

Our support team has continued to travel to member services to assist staff with issues related to use of their Communicare systems. They have supported health services in:

- reporting on both their national and Northern Territory Key Performance Indicators
- training of staff in Communicare use
- Medicare billing issues
- troubleshooting technical issues
- auditing of Communicare systems
- collaborating on Communicare enhancements

The six monthly Communicare and eHealth workshops have been well attended. These workshops have been presented within the CQI framework that AMSANT is supporting throughout the Territory.



This year saw the decommissioning of the AMSNet infrastructure. All services that had made use of the AMSNet managed health network as a means to deliver Communicare over a wide area network have moved to new contracts. AMSANT took great heart in the fact that the health services transitioned to a variety of different providers but essentially maintained the model of delivery set by the original AMSNet initiative. We were gratified that one of the options selected was provided by a local ICT firm but it was also exciting that some services chose to move to an on-line service direct from Communicare. AMSANT would like to thank all those health services, staff and providers that helped to make the AMSNet initiative a success.

Yet again the need for appropriate, reliable and cost effective connections to the internet has been a huge issue for AMSANT members and the eHealth Unit. This is not such an issue for those health services located on the optic fibre backbones of national communications networks which allows for access to ADSL connections. It is however a world of pain for those organisations providing services in remote locations. As ever in the Territory you do not need to be far from the main population centres before you can be considered in a remote location.

We have helped several members migrate from existing satellite connections to some of the new offerings from the NBN. Remote health services are now aware that access to commercial grade satellite technology is a requirement for complex technology to function well. As ever they are expected to do this on consumer grade budgets.

There have been some interesting developments on this front with the Remote Outback Satellite Infrastructure Enablement for eHealth (ROSIE-eH) initiative which brings together a consortium of technology and communications providers who have constructed a satellite service that combines donated and paid satellite bandwidth at commercial quality. The service combines effective communications technologies with research projects to measure effective Telehealth interventions. The service is available to all

remote health and allied health service providers. We are hoping that initiatives like this and the launching of the NBN dedicated satellites will give our members some improved choice on the communications front.

AMSANT had a busy year in terms of Telehealth support. We received some dedicated funding and were able to dovetail into the NACCHO Telehealth Project to develop some simple assistance guides and resources to services beginning the Telehealth journey. The NT Health Department Telehealth service is achieving demonstrated results with their corporate system. We continue to work with them on developing a gateway service that will allow our membership to access this network. If we can solve this it offers a solution to the issue of non-government health services linking with central government specialist services Australia wide. It is apparent to us that Telehealth will be an area of remote medicine that continues to grow. It is important that it supports clinical care and does not become a burden on remote clinicians by being overly technical.

The eHealth Unit has continued to work with our member services with information management solutions. We have supported health services in developing and maintaining tailored intranet installations that allow centralised approaches to corporate data collection and communication. This in turn assists health services in meeting workflow and information management audit requirements in an ever-increasing world of compliance.

AMSANT has continued its role on the consortium project with the NT Department of Health, the Northern Territory Medicare Local (NTML), the Aboriginal Health Council of SA (ACHSA) and the WA Country Health Service (WACHS) focusing on the transition of the My eHealth Record (MeHR) to the Personally Controlled Electronic Health Record (PCEHR) – or National eHealth Record. In the past year the following has been achieved:

- Successful application by all AMSANT members of administrative requirements for the national record
- Over 80% of clinicians in our member services successfully applied for the individual clinician identifier
- Engagement with clinicians to ensure that a migration to the PCEHR will not result in the loss of clinical function
- Installation of secure messaging delivery (SMD) solution to all members
- Contributing to the high level system design of the PCEHR in the Northern Territory
- Completed the implementation of the National eHealth Transition Authority (NEHTA) national eHealth standards into Communicare and the MeHR.

The AMSANT eHealth Unit has continued to be an active member of the NACCHO eHealth expert group (EHEG) and John Paterson has retained his position as the Chairperson of that group. In March AMSANT took on the role of auspicing the National Aboriginal Community Controlled Health Sector eHealth Project. The project focuses on the national eHealth record and given the work that AMSANT and its members have done on the National record to date, it was an easy fit. We have been able to successfully conclude work on phase 1 of this project and are looking forward to taking the project into phase 2 next year.

WORKFORCE SUPPORT

The Workforce support resources at AMSANT remain small in comparison to the scope of workforce planning and development needs in Aboriginal primary health care in the NT. The Aboriginal and Torres Strait Islander Health Practitioner (ATSIHP) workforce continues to decline and the sector overall still suffers from instability due to high rates of turnover of non-Aboriginal health professional staff. AMSANT and the broader ACCHS sector will need to build capacity and advocacy in coming years to stabilise and strengthen all aspects of the PHC workforce.

The current staffing focused on workforce issues are:

- Rob Curry as Programs Manager
- Erin Lew Fatt as the Workforce Information Project Officer (WIPO)
- Sharon Wallace as the Indigenous Health Project Officer (IHPO) focused on support of the new Indigenous Chronic Disease package workforce.
- Dawn Daly on a 12-month project coordinating Good Medicines Better

Health training for Aboriginal and Torres Strait Islander Health Practitioners in the field

- A part-time Indigenous Leadership position – currently unfilled.

Together this team is known as the AMSANT Workforce & Leadership Support Group or WALS Unit with Erin Lew Fatt as team leader.

Key Workforce Developments for 2012-13

1. Aboriginal Health Worker Review Implementation Committee (AHWRIC)

AMSANT has been a party to this bilateral committee with NT Health over the past 18 months. The purpose has been to progress the recommendations of the AHW professional Review from 2010. Progress has been slow due the scale of challenges confronting the AHW

profession with significant reductions in ATSIHP numbers in recent years. There has also been some paralysis in the NT Health Dept as a consequence of political change in the NT and bureaucratic restructuring and downsizing of the Department. The key areas of work have included the following:

- The AHWRIC has developed a Cultural statement for ATSIHPs. The purpose of this statement is to clarify the central importance of ATSIHPs in the Aboriginal PHC workforce, and to reinforce that without ATSIHPs cultural security in health care can be compromised and health care limited. The CEOs of both NT Health and AMSANT have supported the statement and it has been broadly disseminated for feedback. Ultimately it is expected that agreement on the statement will shore-up the development of the ATSIHP profession in the NT and improve health outcomes for Aboriginal community members.
- Training and education: All parties concede that the training and professional development of ATSIHPs requires reform. In response the AHWRIC has developed a model for improving support and supervision on the ground for ATSIHP trainees and has submitted a proposal to OATSIH and DoHA to develop Educator positions to be placed within ACCHSs in the NT as employers of ATSIHPs. There are some prospects for funding to be made available for this initiative. In addition multi-agency working groups have been set up in the Top End and Central Australia to work together on improving coordination of professional development for ATSIHPs in the field and building the range of PD programs available to this workforce.
- ATSIHP Roles and responsibilities: Some confusion persists in Aboriginal PHC as to the roles/responsibilities of ATSIHPs in the workplace as compared to other provider groupings such as nurses, doctors and allied health staff. A working group of AHWRIC has focused on clarifying these roles shared by the

professions, and also on career structure and development for ATSIHPs. This activity has been slow and a workshop has been planned for early in the 2013-14 year for progressing this important work.

2. NT Aboriginal Health Forum Workforce Subcommittee

This Subcommittee and its work has been compromised over the year by the lack of functionality of the Forum itself which only met once for the period. Without direction from the Forum, the Subcommittee has no validated direction or lines of reporting. However, recent developments suggest that the Forum is re-establishing as a PHC reform structure and a number of recently developed proposals have been developed by AMSANT Sub-committee representatives for consideration in the coming period, including:

- Workforce data: A Paper has been prepared highlighting the lack of quality or coherent data for the Aboriginal PHC workforce in the NT. This deficiency hinders effective workforce planning or monitoring of progress and the Paper recommends the relevant stakeholders come together to restructure data collection and reporting on a collaborative basis. The Sub-committee will focus on this task.
- Trainee positions: OATSIH has proposed the creation of a number of funded ATSIHP and management skills traineeships for Aboriginal staff in coming years. Again the Sub-committee will focus on bringing the partners together on this important initiative.
- Merging of AHWRIC with the Forum Workforce Subcommittee: A paper will go to the next Forum meeting in August proposing to merge the AHWRIC (a bilateral committee) under the Forum Workforce Sub-committee for greater efficiency and to re-engage DoHA (OATSIH) as key partner in workforce development and reform.

3. Workforce Information Project Officer (WIPO) Network

As well as working on local and territory wide initiatives as outlined above, the WIPO plays a key role in a number of workforce projects and forums nationally. Much of this is coordinated through a national network of WIPOs in each state and territory. Some of the key areas that have been a priority for this network and the AMSANT WIPO are:

- Liaising with the Aboriginal & Torres Strait Islander Health Practice Board of Australia (ATSIHPBA) and ACCHO members on the establishment and implementation of national ATSIHP Registration;
- As a member, working with the Aboriginal & Torres Strait Islander Health Registered Training Organisation National Network (ATSIHRTONN) on national training and professional development initiatives, such as the review of the national primary health care training packages, and national projects such as the ear hearing health and TAE training;
- Promoting and assisting NATSIHWA to increase membership and liaising with the association and our members with planning and participation in regional and national forums;
- Liaising with Health Workforce Australia (HWA) on a number of projects, particularly the Aboriginal & Torres Strait Islander Health Worker Project. The WIPO network was instrumental in assisting with the development of the project and in ensuring the ACCHO sector was involved throughout the process;
- Strengthening links between NACCHO, Affiliates and ACCHO member services to maintain strong communication with

regards to current and future workforce initiatives;

- Liaising with key stakeholders and peak bodies at a national level to have input into relevant projects and initiatives as well as working to develop future workforce initiatives to meet demands.

4. COAG Indigenous Chronic Disease Package Workforce Development

- AMSANT worked in partnership with NTML to hold a successful workshop in May 2013 for Indigenous Outreach Workers and Care Coordinators in the NT from both sectors, to support networking and working collaboratively to improve the patient journey.
- Healthy Lifestyle and Tobacco teams driven by the IHPO Sharon Wallace and directly engaged with and monitored by the Regional Tobacco Coordinators within members services, worked with the Department of Corrections to assist with an ethical and culturally sensitive roll out of the smoke free prisons in the NT which was launched on 1st July 2013. The collaboration began 12 months prior to the roll out, was done in stages and had a focus of finding ways to support the newly released ex-smoker when returning to the community so they can be linked up with Tobacco Action Workers.
- Ongoing support was provided to employers of ICDP workforce with recruitment and training eg, QUIT Training and attendance at National Workshops and other professional development activities.
- At the end of the financial year 2012/2013 the following services had been allocated funding for ICDP Workers. At each roll out health services are usually allocated 7 positions with another position (TAW) in the second roll out making a full cohort of 8. These positions are made up of:
  - 1 x Regional Tobacco Coordinator (RTC),
  - 2 x Tobacco Action Workers (TAW),
  - 2 x Healthy Lifestyle Workers (HLW) and
  - 2 x Indigenous Outreach Workers (IOW)
- Services which now have funding for an ICDP Workforce are: Alice Springs - Congress (urban); Alice Springs - Congress (remote) WAHAC – (Congress teams have merged); Tennant Creek – Anyinginyi; Katherine - Wurli Wurlinjang; Katherine – Sunrise; Katherine West Health Board (will be based in Kalkaringi); Darwin - Danila Dilba; Maningrida – Malabam;

Nhulunbuy/Galiwinku – Miwatj; a non-member service – Tiwi/Darwin - Heart Foundation.

- The AMSANT Indigenous Health Project Officer Sharon Wallace has been advocating and supporting recruitment and networking as much as possible as recruitment and work plans are ongoing.

5. Good Medicines Better Health (GMBH) Training for ATSIHPs

The Good Medicines Better Health (GMBH) commenced as a pilot project in 2006 before moving to a national rollout from 2010. The pilot was implemented via a collaborative arrangement between NACCHO and the Aboriginal Health Council of South Australia (AHCSA). The program consisted of five units of competence: an overall QUM unit, a customised unit from the Certificate IV in Training and Assessment, and three units focused on QUM for specific health conditions (diabetes, asthma and hypertension).

The pilot and national program were funded by the National Prescribing Service (NPS), which established a partnership agreement with NACCHO for both phases of GMBH. The funding was provided by the Australian Government Department of Health and Ageing. The current contractual arrangement with NPS finished in June 2013. The following were implemented by AMSANT within the 2012/2013 timeframe:

- Meetings were held with Central Australia & Top End Aboriginal Health Practitioners Professional Development Networks to promote the training and identify potential participant regional sites and conduct visits/deliver presentations to ACCHSs and other employers to introduce the GMBH training program;
- In close collaboration with AHCSA, level 1 (3-day study blocks) training was delivered at each of the 4 Territory regional sites of Alice Springs, Darwin, Nhulunbuy and Katherine;
- Level 1 Training QUM 3 day workshops delivered in four separate regions;
    - **Alice Springs March 12th – 14th 2013**

      (11 participants attended, 10 completed, 1 incomplete attendance)
    - **Darwin April 30th – May 2nd 2013**

      (8 participants attended, 6 completed, 2 incomplete due to cultural reasons)
    - **Nhulunbuy May 28th - 30th 2013**

      (5 participants attended, 4 completed, 1 incomplete due to cultural reasons)
    - **Katherine June 18th – 20th 2013**

      (6 participants attended, 6 completed).

The focus up until October 2013 will be in delivering the Level 2 training for specific health conditions (diabetes, asthma and hypertension). This training to date has been beneficial to the continuing professional development for the

Aboriginal Health Practitioners currently enrolled in the course and being employed in the health sector. There have been expressions of interest from other Aboriginal Health Practitioners who for various reasons have not been able to attend the current course. There is no commitment for ongoing funding to continue delivering the short course past 2013 and Aboriginal Health Practitioners will yet again be disadvantaged with continuing their professional development.

Focus for Coming Year (2013-14)

The workforce priorities for the coming year for the WALS Unit and for AMSANT include the following:

- Consolidate the Workforce Sub-committee of the Forum.
- Better link the work of the Sub-committee to the National ATSIH Workforce Plan.
- Strengthen the ATSIHP workforce via:
    i. reforming the training model for ATSIHPs to a regional footing;
    ii. improving on-the-ground supervisory support for trainees via the ATSIHP Educator proposal; and
    iii. negotiating agreement on the ATSIHP Cultural Statement in support of the central role of ATSIHPs in Aboriginal PHC.
- Build and consolidate supports for the COAG Indigenous Chronic Disease Package workforce of Regional Tobacco Coordinators and Action Workers, Outreach Workers, and Health Lifestyle Workers.
- Raising the profile of workforce issues as a key priority for improving health outcomes for Aboriginal Territorians via:
    i. ensuring regular consideration of workforce issues at the Forum; and
    ii. review and reform of data collection and reporting for the Aboriginal PHC workforce in the NT.
- Build the multi-disciplinary workforce team in the sector by:
    i. consolidating the ATSIHP role;
    ii. building Allied Health resources in the field to fill current gaps; and
    iii. clarifying healthcare roles and responsibilities of all the workforce professions in the field.

ACCREDITATION SUPPORT PROGRAM

Under the continuation of the Federally-funded Expanding Quality Health Services (EQHS-C) program AMSANT continues to support eligible Aboriginal organisations achieve accreditation under the relevant standards for both clinical and organisational accreditation. Organisations seeking clinical accreditation do so under standards developed by the RACGP and we are very pleased to report that almost 100% of eligible clinics have now achieved this national benchmark accreditation, with many ACCHSs moving on to re-accreditation efforts and success.

There are however some issues with the RACGP standards and AMSANT continues to actively campaign for appropriate changes to match the needs and issues of our sector. A key concern has been attempts to re-define the definition of "general practice" eligible to apply for RACGP standards. We appear to have won this debate so that remote clinics without a full-time doctor will still be able to seek the standards. Another concern has been the requirements around gaining patient feedback on health services—the current survey options have been highly inappropriate for gaining quality information from Aboriginal community residents. This is troubling most ACCHSs and we still have a way to go with our Affiliate partners and NACCHO to lobby for the necessary changes.

With the great advances in clinical accreditation for ACCHSs in the NT has come a shift in focus now towards a second level of quality achievement, accreditation in the broader organisational systems of our businesses. This is a special challenge for comprehensive primary health care services because it means working towards dual accreditation. To date about 20% of our membership has achieved organisational accreditation, but many more have signed up and are working towards certification, either under the ISO or QIC programs. Some other members are holding back having just put enormous efforts into the RACGP standards.

In August 2012 AMSANT achieved inclusion on the OATSIH approved accreditation facilitators list which enables our members to choose AMSANT as one of three options to tender for facilitation support for ACCHSs. To date AMSANT has been successful in winning two of these contracts and our facilitation consultant, Bec Gooley, has embarked on work with these two local ACCHSs. Over the coming 12 months we hope many more members will consider the AMSANT option and we look forward to delivering you a high quality of support in your endeavours towards accreditation.

In May 2013 AMSANT held its annual Quality and Accreditation workshop over three days in Alice Springs. There were over 25 participants, including some member CEOs, and over 12 AMSANT member organisations were represented. As always this was a great networking opportunity for ACCHS staff in the field and key sessions included:

- a full day workshop from AGPAL (Australian GP Accreditation Limited), the major survey of RACGP standards in the NT
- ISO and QIC standards
- OATSIH update on the EQHS-C measure
- Risk management
- Document systems

AMSANT's two Accreditation Support Officers – Britt Puschak in Alice Springs and Ken O'Brien in Darwin – remain actively engaged with a number of services assisting them in their accreditation efforts. They remain at the ready to take on your requests for assistance and both are continually up-grading their skills in the quality field to build their capacity to support. Both have undertaken lead auditor training under the ISO domain and both have gained further qualifications in the Work Health & Safety area.

LEADERSHIP PROGRAM

The AMSANT Leadership Program continues to be a priority for AMSANT in building Aboriginal and Torres Strait Islander leadership across the community controlled health sector. The program retains strong support from our funders, Fred Hollows Foundation and Oxfam Australia, as well as by our Member services.

AMSANT recently undertook a review of the program since its inception in 2006 in order to evaluate progress against the Leadership Strategic Plan, its strengths and weaknesses, and to explore further opportunities for the program.

During 2012 a consultant was engaged to work with the three partners—AMSANT, Oxfam and Hollows—to review both the program itself and the partnership between AMSANT and Oxfam. The review of the program included:

- a workshop with representatives from each partner and a number of past participants from our Member services,
- a series of partner meetings with the consultant, and
- one-on-one interviews with a number of past program participants.

Both reports have since been finalised with AMSANT working to progress the recommendations and determine what the Leadership program will look like in the future. The recommendations urge a continuation of the Leadership program to benefit our potential and future Aboriginal leaders in the community controlled health sector. The Review also pointed to improvements required, particularly in the areas of sustaining a network of young Aboriginal leaders over the full year cycle, and developing an effective data base of leadership course and workshop information for the use of past and present program participants. A working group has been established to develop a new Leadership Strategic Plan that will address these recommendations and provide a structured program including annual workshops with support for participants.

This year there was no Leadership Workshop conducted with the priority being to review the Program and establish a clear direction going forward. However planning has commenced for the next Leadership Workshop to be scheduled for late 2013. With the support of our funders we are confident for the future of the Program and the benefit it can bring to our new and emerging leadership.

ABORIGINAL PEAK ORGANISATIONS NT (APO NT)

APO NT was established in response to a longstanding need in the NT for effective collaboration amongst Aboriginal organisations on issues affecting our communities.

The abolition of ATSIC in 2004 silenced an important Aboriginal voice, both in the Northern Territory and nationally. When the Northern Territory Emergency Response—the Intervention—was imposed on our people and our lands, the need for a rejuvenated and united voice became acutely urgent.

Alongside this was a need to coordinate engagement between us in responding to the plethora of government actions—and inactions—that we experience.

APO NT was established by AMSANT, the Central and Northern land councils, the Central Australian Aboriginal Legal Aid Service and the North Australian Aboriginal Justice Agency. Between us, we act in the interests of our people a number of times over: in health, justice and land issues. APO NT works for our peoples from the very remote parts of the Territory through to urban areas.

APO NT's principal roles are:

- providing effective and proactive responses to policy issues affecting NT Aboriginal people;
- increasing Aboriginal involvement in policy design and implementation;
- expanding opportunities for Aboriginal control;
- strengthening networks between Aboriginal organisations in the NT and nationally; and
- providing and building strong leadership and governance.

With the support of The Fred Hollows Foundation, APO NT employs a full-time Policy Officer, providing critical capacity to the alliance. Member organisations also contribute financial and in-kind support, including staff and CEO time, to resource the alliance. AMSANT administers the Fred Hollows grant, and employs and supports the Policy Officer on behalf of APO NT.

Governance

APO NT is not incorporated, but operates as an alliance. Nevertheless, strong and effective governance is key to its success.

The Governing Committee comprises the CEOs of the member organisations, provides direction and makes decisions regarding the alliance's work, in consultation with their respective boards and executives. Below the Governing Committee is an Officers Group, comprised of senior staff of APO NT members and the APO NT Policy Officer. The Officers Group is responsible for providing strategic policy advice and ensuring that the work of the alliance is carried out.

AMSANT/APO NT Health Forum, Alice Springs, Aug 2012

The Officers Groups meets regularly and the Governing Committee on a needs basis.

An important element to the success of the alliance is that it does not, in and of itself, seek to be a player independent of the organisations that established it.

With Australian Government assistance APO NT has now employed a Forums Project Officer and an Aboriginal Policy and Research Officer. The Forums Project Officer has provided organisational support for the APO NT Governance and Leadership forums held in 2012-2013 financial year. The Aboriginal Policy and Research Officer has undertaken a variety of work for APO NT, including leading APO NT's research into the decline of Aboriginal organisations.

APO NT Governance and Leadership Forums

A significant aspect of APO NT's work during the year has been to conduct a series of forums for Aboriginal organisations and leaders to discuss and develop our own agendas on key issues affecting our peoples. These forums were supported by the Australian Government.

AMSANT/APO NT Health Forum

In August 2012 a combined AMSANT/APO NT Health Forum was held in Alice Springs. The forum brought together Aboriginal organisations from across the NT, including AMSANT member services and the newly formed Strong Aboriginal Families, Together (SAF,T), to discuss issues associated with health, child protection and housing.

Strong Aboriginal Governance Summit

APO NT held an historic Governance Summit in Tennant Creek on 18-19 April: "Strong Aboriginal Governance: Our Decisions, Our Action, Our Future". Over two hundred representatives were in attendance from a wide range of organisations and communities across the NT—the largest gathering of its kind for over a decade. The Summit focused on:

- understanding the challenges and common barriers to achieving greater governance control for Aboriginal people and to work towards solutions;
- learning from the working examples of good Aboriginal governance practices in the NT; and
- developing practical and grounded solutions that give Aboriginal people opportunities to govern now.

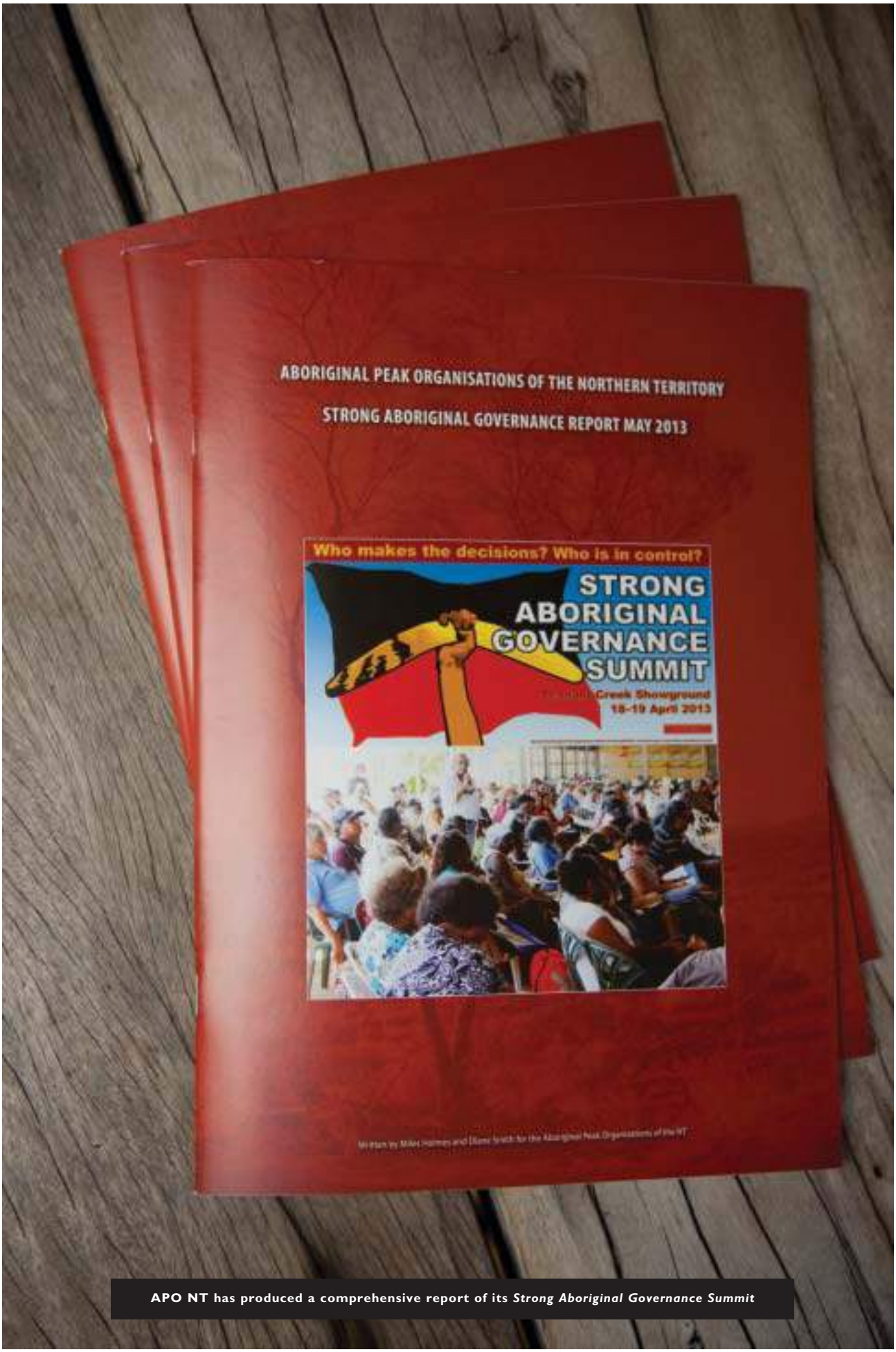
Participants discussed a range of issues including law and culture, organisational challenges, local government, youth and leadership and dealing with conflict. The Summit report has been produced and is available on the APO NT website, www.apont.org.au.

Grog in the Territory Summit

In November 2012 a summit was held in Darwin to provide a forum for Aboriginal communities to discuss alcohol policy, its impact on Aboriginal people and communities, and evidence about what works to reduce alcohol-related harm.

The forum heard from a number of speakers from Aboriginal communities and organisations across the Territory, as well as from expert speakers. The key messages from the day-long meeting were clear. Alcohol is harming Aboriginal peoples in the NT.

ABORIGINAL PEAK ORGANISATIONS NT (APO NT)



APO NT has produced a comprehensive report of its *Strong Aboriginal Governance Summit*

The causes for these harms are complicated. The Summit agreed that solutions should involve: prevention, restrictions, support programs and control for Aboriginal communities. At the summit, Aboriginal community members and organisations called on both levels of Government to consider and undertake a number of actions.

APO NT developed a successful funding proposal for a second Grog Summit in Alice Springs to be held in July 2013.

Principles on the role of non-Aboriginal NGOs

APO NT, National Congress, ACOSS, NTCOSS and SAF,T jointly hosted a Forum in Alice Springs in February 2012, to bring together senior representatives of non-Aboriginal NGOs operating in the NT with Aboriginal NGOs and peak organisations. APO NT prepared a paper to guide discussion at the forum.

The Forum was a strategic initiative to engage non-Aboriginal NGOs and government on Aboriginal development and service delivery in the NT, specifically on how:

- non-Aboriginal NGOs should operate in the Aboriginal service delivery and/or development space;
- Aboriginal organisations can play a lead role in testing and implementing the development model most effective for remote Aboriginal Australia; and
- governments and non-Aboriginal NGOs can best support this work and contribute to the development of Aboriginal-controlled service delivery and development organisations.

The Steering Committee comprising APO NT, SAF,T, National Congress, ACOSS and NTCOSS, developed a set of draft principles for NGOs and government to guide the delivery of services and development initiatives to Aboriginal communities in the NT. There was strong support for the principles and for the need to shift the focus of investment from narrow service delivery programs towards a comprehensive development approach. The Steering Committee briefed both Commonwealth and Northern Territory government departments on the outcomes of the forum.

The finalised Principles, which will act as a voluntary code, were circulated in late April to international, national and Territory based NGOs for formal endorsement. Many have already endorsed the Principles and further endorsements are expected. The Steering Committee is planning to publicly launch the Principles and is developing a plan for the next steps towards their implementation. A copy of the Principles is provided on page 42 of this report.

Aboriginal Governance and Management Program

APO NT has secured three years' funding from 2013-2016 for a program that aims to provide governance and management support to ensure the sustainability and success of Aboriginal organisations, and to encourage the growth of the sector. The Aboriginal Governance and Management Program will have a two-year program planning, design and pilot phase, followed by a second stage focused on operationalising this work. It is intended that after three years the program will be established as a sustainable independent organisation.

ABORIGINAL PEAK ORGANISATIONS NT (APO NT)

APO NT Strong Aboriginal Governance Summit, Tennant Creek.

Stronger Futures

APO NT continued an ongoing engagement with the Federal Minister's office, and senior bureaucrats in FaHCSIA in relation to the implementation of the Stronger Futures legislation. FaHCSIA and the NT Government have expressed a desire to improve engagement with Aboriginal peoples and APO NT in the delivery, monitoring and evaluation of Stronger Futures. This has lead to an increase in requests from FaHCSIA for assistance and advice on policy implementation of a number of programs: Communities for Children; the Remote Jobs and Communities Program; Engagement framework; Aboriginal Workforce Development Strategy; Information Management, Evaluation of Stronger Futures; Alcohol Management Plans; and Enhancing Communities.

Remote Jobs and Communities Program (RJCP)

APO NT in conjunction with the Australian Government organised a workshop for Aboriginal employment providers in Darwin on 3 August to discuss the RJCP and the expression of interest process. The workshop aimed to enhance the capacity of Aboriginal Employment service providers to respond to the opportunities of the RJCP (which replaces the CDEP and related remote employment programs), and to provide feedback to government on the needs of the sector. A workshop summary document was produced and provided to Government. APO NT has continued to raise Aboriginal employment providers' concerns with the RJCP in consultation meetings with the Commonwealth Government.

Housing

APO NT has identified housing as a priority area for action. The APO NT intern, Kanana Fujimori, has continued to refine research examining the relationship between overcrowding and the social determinants of health, and has looked at means of collecting data which links housing to health in the NT. APO NT is also participating in a housing research project with our partner, the Indigenous Law Centre. Housing will continue to be an area of priority for APO NT in 2013-2014.

Research

The decline of Aboriginal organisations in the NT

APO NT's Aboriginal Policy and Research Officer has led a research project into the decline of Aboriginal organisations in the

NT. This project will provide strategic research essential for effectively targeting government investment in building Aboriginal organisational and employment capacity and improving consultation and engagement efforts. It will also inform APO NT's work in serving our various constituencies well and achieving our collective objective to (re)build an effective Aboriginal controlled service and development sector in the NT.

Aurora Interns

The Aurora interns have again undertaken work which was not only useful for APO NT, but which they also found interesting and challenging. The work of the 'Aurorariastas' significantly enhanced APO NT's research capacity and will continue support APO NT's future research.

From January until the end of March 2013, APO NT benefited from the assistance of interns, Hilary Miller and Jessie Smith, who conducted work on trauma, and youth in the justice system, respectively.

In June 2013, intern Kanana Fujimori, started with APO NT. Kanana continued the work started by previous interns in the area of housing, in particular overcrowding and health.

Media

In 2013 APO NT issued a number of media releases:

- seeking public consultation on mandatory alcohol rehabilitation legislation (24 April 2013);
- seeking the scrapping of the Alcohol Mandatory Treatment Bill (13 June 2013);
- calling for a for a joint NT/ Commonwealth Board of Inquiry into Alcohol in the NT (26 June 2013);
- condemning the lack of programs and sentencing approach for alcohol and drug dependent offenders in the NT (3 July 2013).

Submissions

Alcohol Mandatory Treatment Bill: APO NT has conducted significant advocacy work in relation to the Alcohol Mandatory Treatment Bill (see under 'Media'). In May 2013 APO NT made a submission on the NT Government's Alcohol Mandatory Treatment Bill entitled "Not under the influence of evidence: A sober critique of the Alcohol Mandatory Treatment Bill".

Low Aromatic Fuel Bill: In July 2012 APO NT made a Submission to Senate Community Affairs Committee Inquiry into the Low Aromatic Fuel Bill 2012.

FaHCSIA AMP Draft Minimum Standards: APO NT provided comment on the FaHCSIA Alcohol Management Plan Draft Minimum Standards.

National Congress' draft Education Policy: In March 2013 APO NT made a submission on the National Congress of Australia's First Peoples Draft Education Policy.

NT Local Government review: In June 2013 APO NT made a submission on the NT Government's review of Regional Governance.

PRINCIPLES FOR A PARTNERSHIP-CENTRED APPROACH FOR NGOs WORKING WITH ABORIGINAL ORGANISATIONS AND COMMUNITIES IN THE NORTHERN TERRITORY

Purpose

These principles are designed to guide the development of a partnership-centred approach for non-Aboriginal NGOs engaging in the delivery of services or development initiatives in Aboriginal communities in the NT.

Objective

Development of these principles is underpinned by the strong aspiration of Aboriginal community controlled peak organisations in the NT to work with and secure the support of non-Aboriginal NGOs towards the essential goal of strengthening and rebuilding an Aboriginal controlled development and service sector in the NT. It is about putting Aboriginal people back in the driver's seat.

Context

These principles embody the spirit and substance of the UN Declaration on the Rights of Indigenous Peoples (UNDRIP). They have been developed through an understanding that a fundamental shift is required in policy approaches towards Aboriginal communities from a narrow service delivery focus to one based on a development approach. It is understood that to be effective, these principles require a corresponding commitment from government to provide an enabling environment to properly support and resource action under the principles.

Principles

In supporting these principles, non-Aboriginal NGOs agree to undertake to:

1. **Consider their own capacity:** Non-Aboriginal NGOs shall objectively assess whether they have the capacity (either in service delivery or development practice) to deliver effective and sustainable outcomes in the NT context.
2. **Recognise existing capacity:** Non-Aboriginal NGOs will recognise the existing capacity and particular strengths of Aboriginal NGOs and identify how they can contribute to further developing this capacity.
3. **Research existing options:** Non-Aboriginal NGOs shall thoroughly research existing Aboriginal service providers and development agencies before applying for service delivery contracts or prior to considering community development projects.
4. **Seek partnerships:** Where there is an Aboriginal NGO willing and able to provide a service or development activity, non-Aboriginal NGOs shall not directly compete with the Aboriginal service provider, but will seek, where appropriate, to develop a partnership in accord with these principles.
5. **Approach to partnership:** Non-Aboriginal NGOs will be guided by the priorities of the Aboriginal NGO in developing a partnership. Partnerships will be based on building and strengthening, rather than displacing, Aboriginal organisational capacity and control. Processes for developing

partnerships will need to recognise the inherent power imbalance between large NGOs and small Aboriginal organisations, and will need to allow sufficient time for partnership development.

6. **Recognise, support and promote existing development practice:** Non- Aboriginal NGOs acknowledge that many Aboriginal organisations already have robust and effective development practices embedded in a cultural framework, although some of this may be implicit and undocumented. Non- Aboriginal NGOs agree to recognise and support these practices, including through partnership arrangements.
7. **Work together with Aboriginal people to create strong and viable Aboriginal organisations:** Non-Aboriginal NGOs recognise Aboriginal organisations and communities as lead agents in creating sustainable governance and leadership in Aboriginal communities in the NT, and agree to work within structures and processes that provide Aboriginal decision-making control. This may require formal delegation of power and the dedication of self-generated resources to assist with this process.
8. **Ensure Aboriginal control, not just consultation:** Non-Aboriginal NGOs agree that Aboriginal organisations need to be in the 'driver's seat' and have control of development initiatives, services and programs delivered to their communities. This should include having input to decisions regarding resource allocations and staffing.
9. **Develop a clear exit strategy:** Where the desired outcome is for local Aboriginal organisations to deliver services or provide a development role, non-Aboriginal NGOs will develop a mutually agreed, transparent exit strategy in consultation with their partners. Contracts with government should incorporate a succession plan and long term planning for local Aboriginal organisations to deliver services, with appropriate resourcing included.
10. **Ensure robust evaluation and accountability:** Non-Aboriginal NGOs will develop a robust accountability framework and evaluation process together with partner Aboriginal organisations and communities.
11. **Cultural competency and appropriate development practice:** Aboriginal organisations and non-Aboriginal NGOs will seek to work together to share learnings and establish effective development practice and cultural competency standards for development projects and service delivery initiatives.

About these principles:

These principles were developed through a collaborative process led by Aboriginal Peak Organisations NT (APO NT), Strong Aboriginal Families, Together (SAF,T), National Congress of Australia's First Peoples, ACOSS and NTCOSS, with input from a forum in February 2013 that brought together twenty seven non-Aboriginal NGOs with Aboriginal peak organisations. For further information see http://www.apont.org.au

RESEARCH ADVOCACY POLICY

Sarah Stoller (APO NT), interns Kana Fujimori, Patty Veliz with David Cooper and Chips Mackinolty

The Research Advocacy Policy (RAP) unit of AMSANT was established in the context of the rapid expansion of the roles and functions of AMSANT consequent to the Intervention. By then, the issue of relations with government and non-government stakeholders was difficult to assess and coordinate.

The unit was also designed to play a key role in relation to working with the AMSANT Board and be part of the Senior Management Team.

The team includes Manager, Chips Mackinolty, Senior Policy Officer, Dr David Cooper, and an NT AHF Secretariat position (currently unfilled). The RAP unit also supervises APO NT staff based at AMSANT.

Research

Public Health Advisory Group (PHAG)

Established by the Board in March 2008, PHAG is designed to provide advice to the PHMOs and, where requested, the CEO and Board on:

- policy issues that require medical expertise;
- public health initiatives that AMSANT is consulted on by governments or other agencies;
- assistance with providing input to government working groups in major policy areas if the PHMOs don't have the necessary expertise or experience;
- clinical research proposals that AMSANT is asked to provide input on and which may affect member services;
- give advice to the CEO or Board about issues that need processes established within AMSANT, such as issues around research, giving advice on how clinical issues might be managed within AMSANT staff and members, advice on public health strategies, process or policy implications, etc.
- advice on policies or processes and guidelines.

A core document is the AMSANT Health Research Policy (avaialable at www.amsant.org.au), which has been designed to establish procedures and protocols for the

Aboriginal Community Controlled sector in dealing with research proposals. The policy incorporates a research template to assess such proposals in order to advise our Members. This document has received widespread acceptance within the Aboriginal health research community.

It is currently being reviewed to provide an additional simpler process by which external researchers can notify AMSANT and its membership at a much earlier stage of research proposal development. Importantly, on an irregular basis, researchers and clinicians attend PHAG meetings to outline their work.

Internal research projects

In calendar years 2012-2013, David Cooper and Sarah Haythornthwaite have been developing a major research project on the significance of trauma, its intergenerational effects on Aboriginal people, and how these issues can be dealt with inside the Aboriginal Community Controlled health sector. The work is an extension of a longstanding research project on the social determinants of health and was assisted in 2013 by Aurora interns, Hilary Miller and Elena Paul-Cooper.

Another Aurora intern, Patty Veilz, conducted research on justice reinvestment and its relevance to comprehensive primary health care service delivery in the NT.

Aboriginal Peak Organisations Northern Territory (APO NT)

In October 2010, AMSANT initiated the establishment 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 Aid Service and AMSANT (www.apont.org.au).

The alliance was created to provide a more effective response to key issues of joint interest and concern affecting Aboriginal people in the Northern Territory, including through advocating practical policy solutions to government. APO NT has adopted a social determinants of health framework in its approach to its research advocacy and policy work, *Guiding principles for our research, advocacy and policy work.*

APONT issues have been dealt with above in this report.

2 Advocacy

Advocacy with government stakeholders

AMSANT has specific protocols in its dealings with government, at the ministerial and departmental level. In short, primary responsibilities lie with the Chairperson (ministers) and CEO (departmental leaders).

The Manager Research Advocacy Policy is responsible for maintaining regular contact and relations with ministerial officers and, where relevant, ministerial DLOs and media officers, as well as departmental media offices. This is not limited to health ministers, but includes, at Commonwealth level, ministers and staffers for Families Housing Community Services and Indigenous Affairs, Indigenous Health, and Employment and Workplace Relations, and at NTG level, ministers and staffers for Housing, Child Protection, Indigenous Affairs, Justice and Local Government.

From time to time, this has involved the preparation of background material directly to ministers and their departments, including speaking notes and notes for media releases.

In addition, as a non-political organisation that deals in a world of politics, the Manager Research Advocacy Policy is

responsible for maintaining relationships with Opposition, cross bench parties and independents at both federal and NT levels. This is to ensure, wherever possible, bipartisan support for our sector.

Peculiar to the Northern Territory context has been AMSANT's specific relationship with and dealings over the NTER and Stronger Futures. AMSANT acting alone, as well as in conjunction with APO NT, has been involved in direct negotiations with the Australian Attorney General, and ministers for Families Housing Community Services and Indigenous Affairs, Indigenous Health, and Employment and Workplace Relations on matters relating to the roll out and development of Stronger Futures.

Advocacy with non-government stakeholders

The Manager Research Advocacy Policy is responsible for coordinating the maintenance of regular contact with non-government stakeholders including health and non-health NGOs. This includes dissemination of material in support of our sector, attendance at forums and meetings, responding to requests for assistance and information.

Media advocacy: general

Research Advocacy Policy is responsible for maintaining regular contact with local and national media outlets. As well as general news media, this incudes health professional media outlets, and includes the preparation of media releases, articles, visual material and background material.

3 Policy

National policy development: general

AMSANT has contributed through papers and submissions towards national health reform processes of the last few years. This included, in 2012-2103, submission to the development of the National Aboriginal Health Strategy, and to the Senate inquiry into Australia's response to the landmark report of the WHO Commission on the Social Determinants of Health.

Manager Research Advocacy Policy has also been involved in coordinating AMSANT responses to health and other social policy development within the Northern Territory as noted above in the work carried out in research by AMSANT alone and in conjunction with APO NT.

Internal AMSANT policy development

The Manager Research Advocacy Policy, through the Senior Management Team, worked on internal organisational policy development either as author or reviewer.

4 Board Secretariat role

The Manager Research Advocacy Policy acts in the role of providing Board Secretariat duties. This includes the following functions:

a) in consultation with Board Members, setting the annual calendar of meetings and other events

b) with the Chairperson and CEO, coordinating the setting of Board agenda and preparation of board briefing and background papers

c) taking and distributing minutes

d) maintaining Board Decisions/actions register

e) liaising with the Registrar of Associations with respect to legislative requirements of the Associations Act NT.

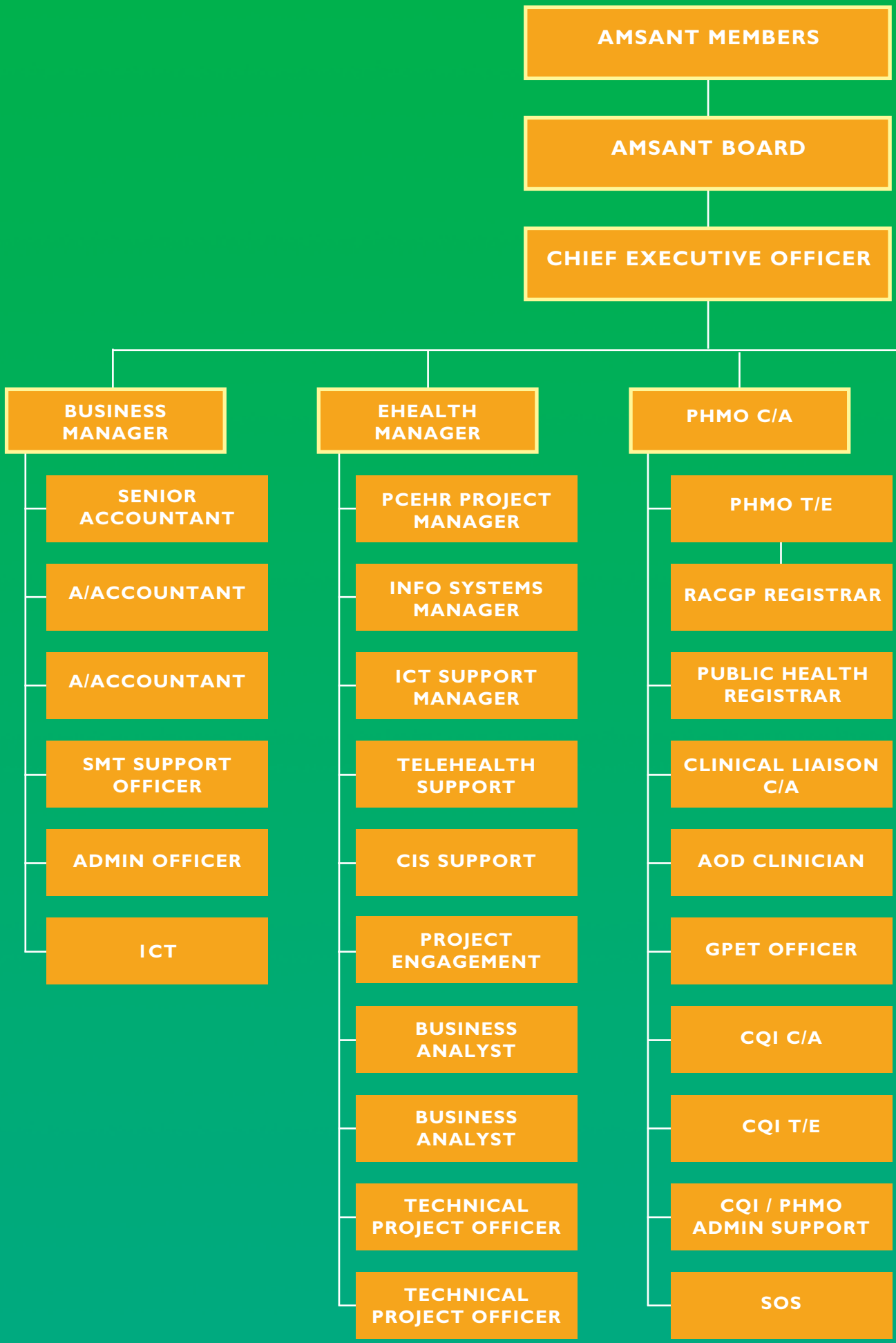
Intern Elena Paul-Cooper

Admin Support Officer, Muki Muir

Indigenous Health Project Officer, Sharon Wallace

WALS Unit Team Leader, Erin Lew Fatt

ORGANISATIONAL CHART



- PROGRAM MANAGER
  - WIPO
  - GMBH
  - IHPO T/E
  - IHPO C/A
  - LEADERSHIP
  - ACCREDITATION T/E
  - ACCREDITATION C/A
- RESEARCH ADVOCACY POLICY MANAGER
  - SENIOR POLICY OFFICER
  - NTAHF SECRETARIAT
  - APONT POLICY OFFICER
  - APONT PROJECT OFFICER
  - APONT PROJECT OFFICER
  - APONT ADMIN SUPPORT
- CENTRAL AUSTRALIA / BARKLY / REGIONALISATION MANAGER
  - PHMO REGIONALISATION C/A
  - ADMIN / RECEPTION

AMSANT Incorporated
ABN 26 263 401 676

General Purpose Financial Statements 30 June 2013

AMSANT Incorporated Executive Committee's report 30 June 2013

The Executive Committee present their report, together with the financial statements, on the Association for the year ended 30 June 2013.

Executive Committee members

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

Continuing Members

- Sean Heffernan (Chairperson)
- Leon Chapman (Treasurer)
- Zaw Maung (Public Officer)
- Donna Ah Chee
- Eddie Mullholland
- Graham Castine
- Trevor Sanders
- Linda Keating
- Marion Scrymgour
- Olga Havnen

Non-Continuing Members

- John Fletcher (Deceased)
- Paula Arnol
- Sarah Doherty
- Stephanie Bell

Principal activities

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

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

Significant changes

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

Operating results

The deficit of the Association for the year amounted to $782,044 (2012: $103,642 surplus).

On behalf of the Executive Committee

Sean Heffernan
Chairperson

Leon Chapman
Treasurer

18 October 2013
Darwin NT

Contents

General information

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

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

The financial report was authorised for issue on 18 October 2013. The Executive Committee does not have the power to amend and reissue the financial report.

AMSANT Incorporated Statement of profit or loss and other comprehensive income For the year ended 30 June 2013

	Note	2013 $	2012 $
Revenue	3	8,298,641	11,723,688
Expenses			
Auspice payments and consultants		(478,062)	(1,779,729)
Administration	4	(387,837)	(436,293)
Employee costs	4	(4,830,850)	(5,624,674)
Motor vehicle		(104,370)	(234,605)
Depreciation and amortisation		(113,177)	(192,363)
Operations	4	(1,495,239)	(2,421,351)
Travel		(479,216)	(931,031)
Return of unexpended funds		(1,191,934)	-
Surplus (deficit) for the year		(782,044)	103,642
Other comprehensive income (loss) for the year		-	-
		-	-
Total comprehensive income (loss) for the year		(782,044)	103,642

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

	Note	2013 $	2012 $
Assets			
Current assets			
Cash and cash equivalents	5	6,250,975	4,724,382
Trade and other receivables	6	337,893	504,462
Prepayments and other assets		75,225	-
Total current assets		6,664,093	5,228,844
Non-current assets			
Property, plant and equipment	7	149,061	271,300
		149,061	271,300
Total assets		6,813,154	5,500,144
Liabilities			
Current liabilities			
Trade and other payables	8	1,295,173	984,856
Provisions	9	525,840	558,377
Grant liabilities	10	4,241,533	2,419,905
Total current liabilities		6,062,546	3,963,138
Non-current liabilities			
Provisions	11	77,390	81,744
Total non-current liabilities		77,390	81,744
Total liabilities		6,139,936	4,044,882
Net assets		673,218	1,455,262
Equity			
Accumulated funds	12	673,218	1,455,262
Total equity		673,218	1,455,262

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

AMSANT Incorporated Statement of changes in equity
For the year ended 30 June 2013

	2013 $ Accumulated funds	2012 $ Total equity
Balance at 1 July 2011	1,351,620	1,351,620
Surplus for the year	103,642	103,642
Other comprehensive income for the year	-	-
Total comprehensive income for the year	103,642	103,642
Balance at 30 June 2012	1,455,262	1,455,262

	Accumulated funds	Total equity
Balance at 1 July 2012	1,455,262	1,455,262
Deficit for the year	(782,044)	(782,044)
Other comprehensive income for the year	-	-
Total comprehensive loss for the year	(782,044)	(782,044)
Balance at 30 June 2013	673,218	673,218

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

	Note	2013 $	2012 $
Cash flows from operating activities			
Receipts from customers (inclusive of GST)		279,214	269,707
Grants received		8,465,944	11,858,099
Payments to suppliers and employees (inclusive of GST)		(7,260,579)	(10,603,793)
		1,484,579	1,524,013
Interest received		90,821	83,766
Net cash provided by operating activities	20	1,575,400	1,607,779
Cash flows from investing activities			
Acquisition of property, plant and equipment	7	(48,807)	(88,103)
Net cash used in investing activities		(48,807)	(88,103)
Net increase in cash and cash equivalents		1,526,593	1,519,676
Cash and cash equivalents at the beginning of the financial year		4,724,382	3,204,706
Cash and cash equivalents at the end of the financial year	5	6,250,975	4,724,382

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

Note 1. Significant accounting policies

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

New, revised or amending Accounting Standards and Interpretations adopted

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

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

Any significant impact on the accounting policies of the Association from the adoption of these Accounting Standards and Interpretations are disclosed in the relevant accounting policy. The adoption of these Accounting Standards and Interpretations did not have any significant impact on the financial performance or position of the Association.

The following Accounting Standards and Interpretations are most relevant to the Association:

AASB 2011-9 Amendments to Australian Accounting Standards - Presentation of Items of Other Comprehensive Income

The Association has applied AASB 2011-9 amendments from 1 July 2012. The amendments require grouping together of items within other comprehensive income on the basis of whether they will eventually be 'recycled' to the profit or loss (reclassification adjustments). The change provides clarity about the nature of items presented as other comprehensive income and the related tax presentation. The amendments also introduced the term 'Statement of profit or loss and other comprehensive income' clarifying that there are two discrete sections, the profit or loss section (or separate statement of profit or loss) and other comprehensive income section.

Basis of preparation

These general purpose financial statements have been prepared in accordance with Australian Accounting Standards

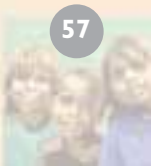
- Reduced Disclosure Requirements and Interpretations issued by the Australian Accounting Standards Board ('AASB'), the NT Associations Act and associated regulations, as appropriate for not-for-profit oriented entities. These financial statements do not comply with International Financial Reporting Standards as issued by the International Accounting Standards Board ('IASB').

Historical cost convention

The financial statements have been prepared under the historical cost convention, except for, where applicable, certain classes of property, plant and equipment.

Critical accounting estimates

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



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

Government grants
Government grants are measured at the value of contribution received or receivable. Income arising from contribution shall be recognised when the Association obtains control of or the right to receive the contribution and it is probable that the economic benefits will flow to the Association.

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

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

Income tax
As the Association is a not-for-profit organisation, the Association is not subject to taxation under the existing income tax legislation.

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

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

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

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

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

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

Plant and equipment	**3-7 years**

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

Leasehold improvements and property, plant and equipment under lease are depreciated over the unexpired period of the lease or the estimated useful life of the assets, whichever is shorter.

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

Impairment of non-financial assets

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

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

Trade and other payables

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

Provisions

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

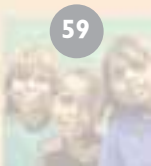
Employee benefits

Wages and salaries, annual leave and sick leave

Liabilities for wages and salaries, including non-monetary benefits and annual leave expected to be settled within 12 months of the reporting date are recognised in current liabilities in respect of employees' services up to the reporting date and are measured at the amounts expected to be paid when the liabilities are settled.

Long service leave

The liability for long service leave is recognised in current and non-current liabilities, depending on the unconditional right to defer settlement of the liability for at least 12 months after the reporting date. The liability is measured as the present value of expected future payments to be made in respect of services provided by employees up to the reporting date using the projected unit



credit method. Consideration is given to expected future wage and salary levels, experience of employee departures and periods of service. Expected future payments are discounted using market yields at the reporting date on national government bonds with terms to maturity and currency that match, as closely as possible, the estimated future cash outflows.

Goods and Services Tax ('GST')

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

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

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

New Accounting Standards and Interpretations not yet mandatory or early adopted

Australian Accounting Standards and Interpretations that have recently been issued or amended but are not yet mandatory, have not been early adopted by the Association for the annual reporting period ended 30 June 2013. The Association's assessment of the impact of these new or amended Accounting Standards and Interpretations, most relevant to the Association, are set out below.

AASB 9 Financial Instruments, 2009-11 Amendments to Australian Accounting Standards arising from AASB 9, 2010-7 Amendments to Australian Accounting Standards arising from AASB 9 and 2012-6 Amendments to Australian Accounting Standards arising from AASB 9

This standard and its consequential amendments are applicable to annual reporting periods beginning on or after 1 January 2015 and completes phase I of the IASB's project to replace IAS 39 (being the international equivalent to AASB 139 'Financial Instruments: Recognition and Measurement'). This standard introduces new classification and measurement models for financial assets, using a single approach to determine whether a financial asset is measured at amortised cost or fair value. The accounting for financial liabilities continues to be classified and measured in accordance with AASB 139, with one exception, being that the portion of a change of fair value relating to the entity's own credit risk is to be presented in other comprehensive income unless it would create an accounting mismatch. The Association will adopt this standard from 1 July 2015 but the impact of its adoption is yet to be assessed by the Association.

AASB 13 Fair Value Measurement and AASB 2011-8 Amendments to Australian Accounting Standards arising from AASB 13

This standard and its consequential amendments are applicable to annual reporting periods beginning on or after 1 January 2013. The standard provides a single robust measurement framework, with clear measurement objectives, for measuring fair

value using the 'exit price' and it provides guidance on measuring fair value when a market becomes less active. The 'highest and best use' approach would be used to measure assets whereas liabilities would be based on transfer value. As the standard does not introduce any new requirements for the use of fair value, its impact on adoption by the Association from 1 July 2013 should be minimal, although there will be increased disclosures where fair value is used.

AASB 119 Employee Benefits (September 2011) and AASB 2011-10 Amendments to Australian Accounting Standards arising from AASB 119 (September 2011)
This revised standard and its consequential amendments are applicable to annual reporting periods beginning on or after 1 January 2013. The amendments make changes to the accounting for defined benefit plans and the definition of short-term employee benefits, from 'due to' to 'expected to' be settled within 12 months. The later will require annual leave that is not expected to be wholly settled within 12 months to be discounted allowing for expected salary levels in the future period when the leave is expected to be taken. The adoption of the revised standard from 1 July 2013 is expected to reduce the reported annual leave liability of the Association.

AASB 2012-2 Amendments to Australian Accounting Standards - Disclosures - Offsetting Financial Assets and Financial Liabilities
The amendments are applicable to annual reporting periods beginning on or after 1 January 2013. The disclosure requirements of AASB 7 'Financial Instruments: Disclosures' (and consequential amendments to AASB 132 'Financial Instruments: Presentation') have been enhanced to provide users of financial statements with information about netting arrangements, including rights of set-off related to an entity's financial instruments and the effects of such rights on its statement of financial position. The adoption of the amendments from 1 July 2013 will increase the disclosures by the Association.

AASB 2012-3 Amendments to Australian Accounting Standards - Offsetting Financial Assets and Financial Liabilities
The amendments are applicable to annual reporting periods beginning on or after 1 January 2014. The amendments add application guidance to address inconsistencies in the application of the offsetting criteria in AASB 132 'Financial Instruments: Presentation', by clarifying the meaning of "currently has a legally enforceable right of set-off"; and clarifies that some gross settlement systems may be considered to be equivalent to net settlement. The adoption of the amendments from 1 July 2014 will not have a material impact on the Association.

AASB 2012-5 Amendments to Australian Accounting Standards arising from Annual Improvements 2009-2011 Cycle
The amendments are applicable to annual reporting periods beginning on or after 1 January 2013. The amendments affect five Australian Accounting Standards as follows: Confirmation that repeat application of AASB 1 (IFRS 1) 'First-time Adoption of Australian Accounting Standards' is permitted; Clarification of borrowing cost exemption in AASB 1; Clarification of the comparative information requirements when an entity provides an optional third column or is required to present a third statement of financial position in accordance with AASB

101 'Presentation of Financial Statements'; Clarification that servicing of equipment is covered by AASB 116 'Property, Plant and Equipment', if such equipment is used for more than one period; clarification that the tax effect of distributions to holders of equity instruments and equity transaction costs in AASB 132 'Financial Instruments: Presentation' should be accounted for in accordance with AASB 112 'Income Taxes'; and clarification of the financial reporting requirements in AASB 134 'Interim Financial Reporting' and the disclosure requirements of segment assets and liabilities. The adoption of the amendments from 1 July 2013 will not have a material impact on the Association.

Note 2.
Critical accounting judgements, estimates and assumptions

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

Provision for impairment of receivables
The provision for impairment of receivables assessment requires a degree of estimation and judgement. The level of provision is assessed by taking into account the recent sales experience, the ageing of receivables, historical collection rates and specific knowledge of the individual debtors financial position. No impairment of receivable was recognised as at 30 June 2013 and 2012.

Estimation of useful lives of assets
The Association determines the estimated useful lives and related depreciation and amortisation charges for its property, plant and equipment and finite life intangible assets. The useful lives could change significantly as a result of technical innovations or some other event. The depreciation and amortisation charge will increase where the useful lives are less than previously estimated lives, or technically obsolete or non-strategic assets that have been abandoned or sold will be written off or written down. Net book value of property, plant and equipment amounted to $149,061 and $271,300 as at 30 June 2013 and 2012, respectively.

Long service leave provision
As discussed in note 1, the liability for long service leave is recognised and measured at the present value of the estimated future cash flows to be made in respect of all employees at the reporting date. In determining the present value of the liability, estimates of attrition rates and pay increases through promotion and inflation have been taken into account. The provision for long service leave amounted to $164,245 and $170,163 as at 30 June 2013 and 2012, respectively.

Note 3. Revenue

	2013	2012
Other revenue	$	$
Interest	90,821	83,766
Grant Income	9,506,154	11,903,851
Unexpended grants	(1,669,904)	(758,951)
Other revenue	371,570	495,022
Revenue	8,298,641	11,723,688

Note 4. Expenses

	2013	2012
	$	$
Deficit (surplus) includes the following items:		
Administration expenses		
Administration expense	25,933	-
Audit fees	38,265	37,995
Board/Governance expenses	6,475	86,390
Meetings and workshops hosted	317,164	311,908
Total administration expense	387,837	436,293
Employee costs		
Fringe benefits tax	72,808	60,435
Recruitment	6,412	33,399
Salaries	4,243,774	5,082,420
Staff training	41,773	21,214
Superannuation	359,701	427,206
Workers compensation	106,382	-
Total employee costs	4,830,850	5,624,674

	2013	2012
	$	$
Operations expenses		
Rent	310,768	387,596
ICT	196,161	340,621
Business planning and reporting	89,915	186,418
Project expenses	298,494	839,380
Publications	32,666	85,255
Cleaning	47,392	48,668
Communications	62,233	118,200
Conference and seminars	33,743	86,535
Insurance	38,108	68,905
Minor capital purchases	11,877	41,621
PO approved expenses	147,918	19,717
Printing	36,145	36,634
Other	189,819	161,801
Total operation expenses	1,495,239	2,421,351

Note 5. Current assets - cash and cash equivalents

	2013	2012
	$	$
Cash at hand	407	2,776
Cash at bank - Operating accounts	2,912,119	586,917
Cash at bank - Investment accounts	3,338,449	4,134,689
	6,250,975	4,724,382

Restricted Cash

Purpose		
External Restrictions		
- Grant Liabilities	4,241,533	2,146,680
- Grant Commitments	-	273,225
Total External Restriction	4,241,533	2,419,905
Internal Restrictions		
- Employee Entitlements	603,230	640,121
- Other Restrictions	-	-
Total Internal Restriction	603,230	640,121
Total Unrestricted	1,406,212	1,664,356
Total Cash Available	6,250,975	4,724,382

Note 6. Current assets - trade and other receivables

	2013 $	2012 $
Trade receivables	337,893	503,992
Interest receivable	-	470
	337,893	504,462

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

	2013 $	2012 $
Plant and equipment - at cost	296,435	965,354
Less: Accumulated depreciation	(147,374)	(694,054)
	149,061	271,300

Reconciliations

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

	2013 $	2012 $
Cost		
Opening balance	965,354	891,210
Additions	48,807	74,144
Disposals	(717,726)	-
Ending balance	296,435	965,354
Accumulated depreciation		
Opening balance	694,054	515,650
Depreciation and amortisation expense	113,177	192,363
Disposals	(659,857)	-
Adjustments	-	(13,959)
Ending balance	147,374	694,054
Net book value	149,061	271,300

Note 8. Current liabilities - trade and other payables

	2013 $	2012 $
Trade payables	334,390	379,745
Credit card	10,593	10,209
BAS payable	590,755	198,686
Accrued expenses	174,136	33,594
Accrued wages	177,402	237,516
Other payables	7,897	125,106
	1,295,173	984,856

Note 9. Current liabilities – provisions

	2013 $	2012 $
Annual leave	395,925	469,958
Long service leave	86,855	88,419
Other provisions	43,060	-
	525,840	558,377

Note 10. Current liabilities – grant liabilities

	2013 $	2012 $
Grant liabilities	4,241,533	2,419,905

Refer to Note 21 for the details of the unexpended grants.

Note 11. Non-current liabilities - provisions

	2013 $	2012 $
Long service leave	77,390	81,744

Note 12. Equity – accumulated funds

	2013 $	2012 $
Accumulated funds at the beginning of the financial year	1,455,262	1,351,620
Surplus (deficit) for the year	(782,044)	103,642
Accumulated funds at the end of the financial year	673,218	1,455,262

Note 13. Financial instruments

Financial risk management objectives

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

Market risk

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

Price risk
The Association is not exposed to any significant price risk.

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

Credit risk
The Association is not exposed to any significant credit risk.

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

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

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

2013	Weighted average interest rate %	1 year or less $	Between 1 and 2 years $	Between 2 and 5 years $	Over 5 years $	Remaining contractual maturities $
Non-derivatives						
Non-interest bearing						
Trade payables	-	334,390	-	-	-	334,390
Credit card	19	10,593	-	-	-	10,593
BAS payable	-	590,755	-	-	-	590,755
Accrued expenses	-	174,136	-	-	-	174,136
Accrued wages	-	177,402	-	-	-	177,402
Other payables	-	7,897	-	-	-	7,897
Provisions	-	525,840	77,390	-	-	603,230
Grant liabilities	-	4,241,533	-	-	-	4,241,533
Total non-derivatives		6,062,546	77,390	-	-	6,139,936

2012	Weighted average interest rate %	1 year or less $	Between 1 and 2 years $	Between 2 and 5 years $	Over 5 years $	Remaining contractual maturities $
Non-derivatives						
Non-interest bearing						
Trade payables	-	379,745	-	-	-	379,745
Credit card	19	10,209	-	-	-	10,209
BAS payable	-	198,686	-	-	-	198,686
Accrued expenses	-	33,594	-	-	-	33,594
Accrued wages	-	237,516	-	-	-	237,516
Other payables	-	125,106	-	-	-	125,106
Provisions	-	558,377	81,744	-	-	640,121
Grant liabilities	-	2,419,905	-	-	-	2,419,905
Total non-derivatives		3,963,138	81,744	-	-	4,044,882

Fair value of financial instruments

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

Note 14. Key management personnel disclosures

Compensation

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

	2013 $	2012 $
Short-term employee benefits	946,327	919,818

Related party transactions

Related party transactions are set out in note 18.

Note 15. Remuneration of auditors

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

Audit services – BDO AUDIT NT	2013 $	2012 $
Audit of the financial statements	38,265	37,996

Note 16. Contingent liabilities

The Association had no contingent liabilities as at 30 June 2013 and 2012.

Note 17. Commitments

	2013 $	2012 $
Capital commitments		
Committed at the reporting date but not recognised as liabilities, payable:		
Lease commitments - operating		
Committed at the reporting date but not recognised as liabilities, payable:		
Within one year		
One to five years	50,200	40,533
More than five years	59,800	10,000
	110,000	50,533
Leasehold rental commitments		
Committed at the reporting date but not recognised as liabilities, payable:		
Within one year	336,000	331,344
One to five years	370,000	62,370
More than five years	-	-
	706,000	393,714
ICT rental commitments		
Committed at the reporting date but not recognised as liabilities, payable:		
Within one year	150,000	150,000
One to five years	-	150,000
More than five years	-	-
	150,000	300,000
Equipment rental commitments		
Committed at the reporting date but not recognised as liabilities, payable:		
Within one year	15,000	16,164
One to five years	57,000	19,848
More than five years	-	-
	72,000	36,012

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

Note 18. Related party transactions

Transactions with related parties
There were no transactions with related parties during the current and previous financial year.

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

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

Note 19. Events after the reporting period

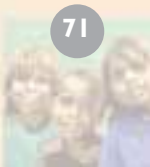
No matter or circumstance has arisen since 30 June 2013 that has significantly affected, or may significantly affect the Association's operations, the results of those operations, or the Association's state of affairs in future financial years.

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

	2013 $	2012 $
Surplus (deficit) for the year	(782,044)	103,642
Adjustments for:		
Depreciation and amortisation expense	113,177	192,363
Loss on sale of property, plant and equipment	57,869	-
Operating income (loss) before changes in operating assets and liabilities	(610,998)	296,005
Changes in operating assets and liabilities:		
Decrease (increase) in:		
Trade and other receivables	166,569	487,884
Prepayments	(75,225)	-
Increase (decrease) in:		
Trade and other payables	310,317	(75,003)
Provisions	(36,891)	185,694
Grant liabilities	1,821,628	713,199
Net cash flows provided by operating activities	1,575,400	1,607,779

Note 21. Unexpended grants

		2013	2012
		$	$
P001 T	Secretariat	403	-
P003 T	CP Child Protection	-	310,317
P004 O	Workforce Issue	4,912	-
P004a T	Year of AHW		33,394
P005 X	GPET Framework Agreement	48,089	63,281
P012 O	Secretariat Officer	48,164	-
P017 X	Leadership Program	54,564	11,361
P017a X	Leadership Evaluation	1,965	3,772
P021 N	NACCHO GMS	82,778	-
P023 N	Good Med, Better Health	66,203	-
P030 T	AOD Remote Clinic Support	-	20,716
P031a X	Health Policy Research	262	14,902
P033 X	CABIEHS Coordination 2012	-	5,229
P034 O	Program Manager	(38,851)	-
P035a F	FaHCSIA APO	409,694	529,455
P035b F	FaHCSIA 2012	63,945	-
P035c F	CA Grog Summit	53,920	-
P035 X	APONT	-	1,906
P036a Y	Chief Minister Fund	(477)	1,636
P036b Y	Darwin City	-	4,000
P036c F	FaHCSIA	50,000	40,874
P036d Y	Inpex	(779)	4,139
P036e Y	Australian Apprentice	-	1,000
P036f X	NAIDOC Sponsorship	13,500	-
P036t Y	CAAPS	14,542	10,887
P037 F	NT AGMP	1,000,000	-
P038 O	NT (ICT/IM/PIRS) Supp	4,293	-
P040 O	AWH Implementation	1,546	58,698
P043 O	Public Medical Office	(9,805)	-
P044a X	UNSW Sexual Health R	-	19,522
P044 O	Service Exp (PHMO)	10,119	-
P045 R	Specialist Training Posts	9,439	-
P046 A	Health Workforce Training	-	88,654
P050 O	Accreditation	37,669	-
P050a O	Accreditation Scoping	22,622	-
P051 O	RADU	132,249	63,544
P051c O	Regionalisation Workshops	86,865	-
P053a O	Finance Workshop	-	(15,000)
P053 O	Bus Dev Manager	7,340	-



Note 21. Unexpended grants (continued)

		2013	2012
		$	$
P054 O	Policy & Strategy Mgr	(7,023)	-
P057 O	CQI	8,120	64,288
P058 O	AMSANT ICT	(10,316)	11,880
P059 X	AOD	15,011	30,308
P060 O	Red Lily	-	97,770
P063 O	Fresh Food Summit	-	26,137
P066 O	IHPO ICD	10,738	41,885
P066a O	IHPO - Workshop	32,400	-
P100 T	PCEHR	1,519,464	339,592
P100d T	Dialog	21	60,519
P100ta T	DD2013/1968 Variation	38,050	-
P101 T	CDC Trachoma	38,236	38,236
P102 T	SMD SEMS	955	955
P103 A	Telehealth Support	1,613	46,653
P103a N	Telehealth "Orientation"	23,657	-
P105 A	National eHealth	93,217	-
P120c T	East Arnhem Software	-	40,812
	Primary Health Care	-	75,354
Others		302,219	273,229
		4,241,533	2,419,905

AMSANT Incorporated Notes to the financial statements 30 June 2013

In the Executive Committee's opinion:

- the attached financial statements and notes thereto comply with the Australian Accounting Standards - Reduced Disclosure Requirements and are in accordance with the NT Associations Act;

- the attached financial statements and notes thereto give a true and fair view of the Association's financial position as at 30 June 2013 and of its performance for the financial year ended on that date;

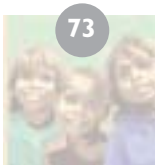
- there are reasonable grounds to believe that the Association will be able to pay its debts as and when they become due and payable.

On behalf of the Executive Committee

Sean Heffernan
Chairperson

Leon Chapman
Treasurer

18 October 2013
Darwin NT



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AUSTRALIA

INDEPENDENT AUDITOR'S REPORT

To the members of AMSANT Incorporated

Report on the Financial Report

We have audited the accompanying financial report of AMSANT Incorporated, which comprises the statement of financial position as at 30 June 2013, the statement of profit or loss and other comprehensive income, the statement of changes in equity and the statement of cash flows for the year then ended, notes comprising a summary of significant accounting policies and other explanatory information, and statement of management committee.

Management Committee's Responsibility for the Financial Report

The Management Committee is responsible for the preparation and fair presentation of the financial report in accordance with Australian Accounting Standards - Reduced Disclosure Requirements and *Northern Territory Associations Act*, and for such internal control as Management Committee determine is necessary to enable the preparation and fair presentation 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 the auditor's judgement, including the assessment of the risks of material misstatement of the financial report, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial report in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by Management 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

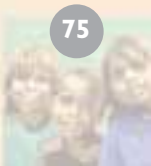
In our opinion, the financial report presents fairly, in all material respects, the financial position of AMSANT Incorporated as at 30 June 2013, and its financial performance and cash flows for the year then ended in accordance with Australian Accounting Standards - Reduced Disclosure Requirements and *Northern Territory Associations Act*.

BDO Audit (NT)

C J Sciacca

Audit Partner

Darwin: 24 October 2013



GLOSSARY

ACCHS	Aboriginal Community Controlled Health Services
AGPAL	Australian General Practice Accreditation Limited
AHCSA	Aboriginal Health Council of South Australia
AHP	Aboriginal Health Practitioner
AHW	Aboriginal Health Worker
AHWRIC	Aboriginal Health Worker Review Implementation Committee
AMSANT	Aboriginal Medical Services Alliance Northern Territory
AOD	Alcohol and other drugs
APO NT	Aboriginal Peak Organisations Northern Territory
ATSIHP	Aboriginal and Torres Strait Islander Health Practitioner
CPHAG	Clinical and Public Health Advisory Group
CAAC	Central Australian Aboriginal Congress
CAALAS	Central Australian Aboriginal Legal Aid Service
CARPA	Central Australian Remote Practitioners Association
CDC	Centres for Disease Control (Northern Territory)
CIS	Clinical Information System
CPHAG	Clinical Public Health Advisory Group
CQI	Continuous Quality Improvement
DoH	Department of Health (Northern Territory)
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
GPR	General Practice Registrar
HSDA	Health Service Delivery Area
ICDP	Indigenous Chronic Disease Package
KAN	Kidney Action Network
LHN	Local Hospital Network
MeHR	My Electronic Health Record

MOICD	Mobile Outreach Indigenous Chronic Disease
MoU	Memorandum of Understanding
NAAJA	North Australian Aboriginal Justice Agency
NACCHO	National Aboriginal Community Controlled Health Organisation
NATSIHWA	National Aboriginal & Torres Strait Islander Health Worker Association
NBN	National Broadband Network
NKPI	National Key Performance Inidcators
NTAHF	Northern Territory Aboriginal Health Forum
NTAHKPI	NT Aboriginal Health Key Performance Indicators
NTER	Northern Territory Emergency Response or 'the intervention'
NTG	Northern Territory Government
NTGPE	NT General Practice Education
NTML	Northern Territory Medical Local
OATSIH	Office of Aboriginal and Torres Strait Islander Health (Commonwealth)
PHAG	Public Health Advisory Group
PHC	Primary Health Care
PHCAP	Primary Health Care Access Program
PHMO	Primary Health Medical Officer
PIRS	Patient Information Recall Systems
RACGP	Royal Australian College of General Practitioners
RAHC	Remote Area Health Corps
RhD	Rheumatic Heart Disease
RHOF	Rural Health Outreach Fund
RDU	Regionalisation Development Unit
SAF,T	Strong Aboriginal Families, Together
SeMS	Secure Electronic Message Services
SEWB	Social and Emotional Well-being
STRIVE	STI in Remote communities: Improved & Enhanced primary health care
WALS	Workforce and Leadership Support unit
WIPO	Workforce Implementation Project Officer

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