NACCHO

www.naccho.org.au

# National Aboriginal Community Controlled Health Organisation

# Annual Report

## 2017–2018

**ARTIST RECOGNITION:** Artist Tahnee Edwards (Yorta Yorta) and Toby Dodd. Ngarrindjeri/Narungga/Kaurna Dreamtime Public Relations, 2013 http://dreamtimepr.com/artwork/

**STORY:** The waves in the pattern mimic those in the ochre pits. The colours represent Aboriginal and Torres Strait Islander peoples. The meeting places represent our affiliates and the larger meeting place is the National Aboriginal Community Controlled Health Organisation (NACCHO).

**DESIGN AND LAYOUT:** Dreamtime Creative.

Dreamtime CREATIVE

Images courtesy of NACCHO or supplied, unless otherwise noted.



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**NACCHO acknowledges the financial support of the Australian Department of Health.**

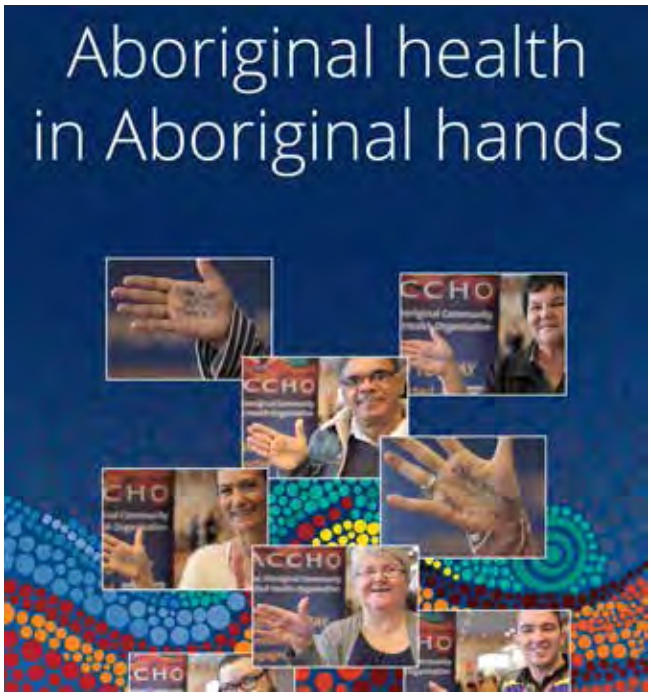
*"NACCHO acknowledges Aboriginal and Torres Strait Islander peoples as the Traditional Owners of country throughout Australia and their continuing connection to both their lands and seas. In the spirit of respect, NACCHO recognises the Aboriginal and Torres Strait Islander peoples' past, present and future cultural, spiritual, physical and emotional connection with their lands and seas. NACCHO honours and pay respects to all elders, both past and present, and all generations of Aboriginal and Torres Strait Islander peoples, now and into the future."*

# CONTENTS

# OUR VISION OUR VALUES

## NACCHO'S CORE VALUES ARE EMBEDDED IN THE FOLLOWING:

- Aboriginal Community Control
- A holistic, comprehensive Primary Health Care approach
- A ground-up approach to planning, policy development and implementation
- Aboriginal cultural integrity
- Co-ordinated and integrated activity
- Strategic partnerships and alliances
- Proactive and responsible action
- Respect and loyalty
- Equity
- Quality.




**Opposite page:**

**Welcome to Country and Smoking Ceremony by Aunty Matilda for the NACCHO National Members' Conference and Annual General Meeting in Canberra**

**Bottom photo AHCSA NACCHO Karaoke Cup Champions 2017 at the NACCHO Canberra Conference 2017**


HYATT HOTEL CANBERRA
BANQUET ENTRANCE

*"Government must take the impacts of institutional racism in our health system seriously"*

MR JOHN SINGER

# CHAIRPERSON'S REPORT

It has been an honour to be the National Aboriginal Community Controlled Health Organisation (NACCHO) Chair.

NACCHO continues to be an effective voice in Canberra for our sector. For example, through my role as Chair I became a member of the Funding Model Advisory Committee which is the key mechanism for us to advise Government on the development of the new funding model for our member services. This is a critical issue for our members and our views need to be heard.

I have also met with Ministers and senior bureaucrats on different occasions throughout the year. I met with the Hon Greg Hunt MP (Minister for Health), raising a number of issues and alerting him to the effectiveness and impact of our community controlled model. With Hon Ken Wyatt MP (Minister for Indigenous Health) I conveyed concerns with the proposed funding arrangements and discussed options for men's health and other initiatives. With Senator Nigel Scullion (Minister for Indigenous Affairs) I passed on concerns from the Board in relation to the 'refresh' of the Closing the Gap targets and emphasised the need to have Aboriginal health in Aboriginal hands.

We have also secured the support in many areas from key stakeholders and allies such as the Australian Medical Association and the Medical Colleges.

This year NACCHO has reported against the 2017-2018 Network Funding Agreement. NACCHO has and will continue to be committed to increasing our workforce capability, requirements and service capacity. Again, this year, we have provided expert policy advice and formalised mechanisms to enhance cooperation between all levels of governments, ACCHOs, Primary Health Networks, private sector and other service providers to improve patient journeys.

The NACCHO Board Strategy workshop, which was held in February 2018, provided further clarity for the Board to focus on a national perspective of issues confronting our sector and provided practical advice for planning future activities that are aligned with our policy objectives. The Board also continued throughout the year to consult members on the development of the new constitution.

In December 2017 NACCHO moved to our new Canberra office, located at Level 5, East Tower, 2 Constitution Avenue in Civic. New staff have been recruited, our website renewed, internal policies and procedures are being updated and we are progressing the accreditation processes.

Aboriginal people must have educational opportunities, careers, and health services to meet their needs and overcome inequality, poverty and increase life expectancy. Enabling Aboriginal people to live good quality lives while enjoying all their rights and fulfilling their responsibilities to themselves, their families and communities is critical. NACCHO will continue to collaborate with relevant stakeholders to improve care pathways and coordination in our sector.

NACCHO has highlighted evidence of systemic racism and discrimination so that government can better understand, address and prevent it happening in future. Aboriginal people should feel free from racism and empowered as individuals.

The Board acknowledges that it is vital that Aboriginal and Torres Strait

**Tullawon Health Service with NACCHO Chair John Singer launch at the opening of the "Yalata Blue House " for men's health, social, and cultural activities.**

Islander adults continue to have access to regular health assessment checks and that improvements be made with culturally appropriate aged care models, including ageing on country. NACCHO maintains a focus on palliative care and end-of-life decision making for individuals, their families and carers, that are developed and implemented.

It is important for the Chairman of NACCHO to visit members and listen to what they have to say. In March and April 2018, I visited Affiliates and members in Western Australia, Victoria and the Northern Territory. I received an invitation in June from Pormpur Paanthu Aboriginal Corporation at Pormpuraaw Community in Cape York to listen to concerns the community had around the community council and the local hospital in terms of supporting the local action teams which have been set up by Apunipima Health Council on the ground to help drive reform. I took the opportunity while up in North Queensland to visit Wuchopperen Health Service Cairns, Gurriny Yealamucka Health Service, Gindaja Treatment and Healing Centre, Mutkin Residential and Community Aged Care Yarrabah. While in Cairns I also attended the NATSIHA regional forum which was held at Wuchopperen.

NACCHO was called upon to provide our insights and views many times over the last 12 months. The strength, depth and reach of our 145 member services is truly inspiring. Our staff continue to implement Board directives that assist our members, despite numerous challenges, to remain the strong voice in Canberra advocating for Aboriginal Community Controlled health across Australia.

NACCHO has influenced and helped shape public policy, challenged and called out institutionalised racism, confronted ill-judged media commentary and consistently provided advice and analysis regarding primary health care objectives of our members.

Globally this year, we celebrated the 10th Anniversary of the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) and here at home, we continue to prioritise the Uluru Statement from the Heart, the right of Aboriginal and Torres Strait Islander peoples to exercise self-determination and to be genuinely involved in government decision-making that impacts on our people.

NACCHO continues to provide policy submissions, advice to working groups, representing the national Network on external committees, participation in CEOs' Forums and Subcommittees.

I thank Patricia Turner on her continuing role as Chief Executive Officer and our committed and passionate staff during the last year who devote countless hours to improving conditions in our many communities.

Looking ahead I see another great year and bright future for NACCHO and thank the members and my colleagues on the Board for their dedication and supportive leadership.

John Singer
**NACCHO Chairperson**


*"Aboriginal people remain the poorest, sickest and most marginalised people in this country. We continue to grapple with more than two centuries of dispossession, discrimination and alienation"*

***- Patricia Turner***

NACCHO CEO Pat Turner

# CHIEF EXECUTIVE OFFICER'S REPORT

Over the last twelve months, the National Aboriginal Community Controlled Health Organisation (NACCHO) has undertaken a number of reforms to strengthen its support to its State Affiliates and its member Aboriginal Community Controlled Health Organisations (ACCHOs), increase its advocacy, build internal expertise and foster closer relationships with key partners including the Australian Medical Association (AMA) and the Royal Australian College of General Practitioners (RACGP).

We are changing the way we work with State Affiliates, making sure we are more accountable and responsive to each other and that our policies and advocacy is better informed by our members. Our relationship is underpinned by a new National Funding Agreement.

NACCHO has made significant policy contributions and forged new partnership to help address key health issues affecting Aboriginal and Torres Islander peoples.

- We have secured the agreement by Government that no ACCHO will lose its funding with the introduction of the funding model for the next five years and we received a 12-month delay to the introduction of the funding model. We also secured agreement not to introduce the new Funding Model with nKPIs as a measure. This was achieved with the support of the AMA and RACGP in influencing the Government's decision.
- NACCHO welcomed the creation of a multi-jurisdictional Enhanced Syphilis Working Group in 2017 tasked with writing an action plan to address the health problem. Based on our advocacy and in recognition of their vital role, ACCHOs have been embedded in the Commonwealth Government's response to the syphilis outbreak, and communicable diseases more broadly. Additional funding has been provided to ACCHOs to increase testing, provide treatment plans and develop culturally appropriate health education campaigns.
- We have stepped up our work with the END RHD Coalition to ensure that Indigenous-owned, community-led strategies are at the forefront of efforts to tackle the disease. We are also a key partner in Rheumatic Heart Disease initiatives in the Northern Territory and the Kimberley region in Western Australia, where thousands of Aboriginal and Torres Strait Islander people are confronted with the disease. I believe that securing this important program will save lives.
- We have signed an MOU with the Pharmacy Guild and agreed on a number of changes to Indigenous Pharmacy programs which will significantly improve Aboriginal and Torres Strait Islander peoples' access to medicines. NACCHO negotiated and is a partner in a trial with the Pharmaceutical Society (PSA) and the James Cook University to embed pharmacists within ACCHOs. NACCHO, Affiliates and ACCHOs are funded

NACCHO Chair John Singer, NACCHO CEO Pat Turner, Senator Louise Pratt and Senator Dodson

Australian Political Exchange Council and the 12th Delegation from the Philippines meet with NACCHO CEO Pat Turner to be briefed about Aboriginal Community Controlled Health Organisations in Australia

for their for involvement. NACCHO also negotiated and is a partner in a trial with the Guild and Griffith University to develop a framework for the quality use of medicines in ACCHOs. NACCHO, Affiliates and ACCHOs are funded for their involvement.

- We are working with our Affiliates and ACCHOs from around the country to develop and provide advice to government a service delivery model for the National Disability Insurance Scheme (NDIS) and provide advice on Indigenous workforce strategies. We know that too many Aboriginal and Torres Strait Islander peoples face barriers to access the support they deserve under the NDIS and ACCHOs could be well placed to increase its service offerings with the right supports and policy settings. This work is underpinned by a small grant from the Department of Social Services and follows many months of advocacy work, including the development of network position papers and a workshop convened in Canberra with senior government officials, Affiliate CEOs, Board members and our colleagues at First Peoples Disability Network.
- Mental health continues to be a priority and I attended meetings of the Kimberley Suicide Prevention Trial (KSPT) roundtable, which is chaired by Minister Wyatt. KPST is one of ten trials being undertaken throughout Australia. The Government has committed funding of up to $1 million per year over three years to KSPT to support suicide prevention activities. Improved initiatives will arise from the trial and we will seek appropriate funding to ensure community-led solutions to arrest suicide as best we can.
- NACCHO negotiated financial support for the sector to assist a closer engagement with the Federal Government's My Health Record Expansion Program's strategic implementation so that all Aboriginal and Torres Strait Islander peoples Medicare, PBS records, GP files and hospital admissions are all safely stored in one digital place and can be accessed by individuals to provide enhanced care.

NACCHO is also working with the Australian Medical Colleges to assist with improved access to specialist Indigenous health medical care, clinical training, education and continuing professional development programs. The Accreditation Standards now include specific standards concerning Indigenous health curriculum content, College partnerships with organisations working in the Indigenous health sector and support for Indigenous doctors in training.

With support from the Commonwealth Government, we are developing a Continuous Quality Improvement Framework, to ensure all Primary Health Care providers deliver culturally competent care to Aboriginal and Torres Strait Islander peoples and learn from ACCHOs as examples of best practice. This work is being done in collaboration with Affiliates and members.

PwC Partner James van Smeerdijk and NACCHO CEO Pat Turner at the NACCHO National Conference

NACCHO continues to provide policy advice to governments on issues affecting the sector and Aboriginal and Torres Strait Islander health. I attended several parliamentary hearings. Together with our Affiliates, we have also provided submissions to government and parliamentary policy and legislative deliberations. NACCHO also provided policy advice to the Federal Treasury regarding Indigenous health priorities of the 2018 Budget. On behalf of our Members, we are working to hold the Commonwealth Government accountable on the implementation of the National Aboriginal and Torres Strait Islander Health Plan.

We have supported the Commonwealth's Closing the Gap Refresh considerations by providing a written submission and attending Government convened forums. NACCHO delivered a Redfern Alliance Closing the Gap Refresh workshop on priorities for Indigenous health, including developing an outcomes document from the workshop as a key advocacy tool to support discussions with government. NACCHO is also a representative on the non-government organisation Close the Gap Steering Committee and contributed to its annual report to Parliament which this year included an analysis of the Closing the Gap framework to date and recommendations for its future. Importantly, we have been collaborating with other Aboriginal peaks across Australia to propose a model of genuine partnership between Aboriginal and Torres Strait Islander peoples and governments on the negotiation, implementation (including funding) and monitoring of any refreshed approach.

Across the NACCHO network, we are represented on over 80 government, external committees and reference groups. For example, I sit on and collaborate with the Aboriginal Health Justice Partnership and the Australian Council of Social Services. I participated in regular Redfern Statement Alliance leadership meetings. I have also presented at conferences and symposiums, raising the profile of ACCHOs and the important work done by our 145 members across the country.

I have sought to strengthen our partnership with the AMA in addition to my role on the Australian Medical Association Taskforce on Indigenous Health.

NACCHO is continuing to work with Affiliates and Members' to strengthen NACCHO's organisation's Constitution. A revised Constitution was put to Members at the November 2017 Annual General Meeting in Canberra where it was agreed that further consultations were required. The Deputy Chair, Ms Donnella Mills, has led the consultation process on behalf of the Board.


**NACCHO CEO Pat Turner and Dr Chris Lawrence from Tonic Health Media**

In October 2017, NACCHO successfully delivered our largest ever national Conference with 60 speakers and over 410 delegates attending. The two-day event brought together NACCHO members, academics, research bodies, public servants and twenty-one sponsors. Speakers included Department of Health, Secretary Glenys Beauchamp PSM and the Chief Medical Officer Professor Brendan Murphy.
The Annual Ochre Day Aboriginal Male Health Conference in Darwin was another success with over 160 Aboriginal men in attendance.
The Indigenous Health Minister, the Hon. Ken Wyatt AM MP was a keynote speaker.

It has been a busy and ambitious year, our positive reputation is growing, and I am proud of the influence, growth and direction of our organisation. I acknowledge the hard work of our committed staff to improving the lives of our people and particularly thank the NACCHO Board Chair, Mr John Singer, and Deputy Chair, Ms Donella Mills and the NACCHO Board members for their continued support, as well as my Deputy CEO Dawn Casey and all our NACCHO staff. As we look to a new year our priorities remain: to strengthen and expand the Aboriginal Community Controlled Health Services for the benefit of improving Aboriginal and Torres Strait Islander peoples' health outcomes across the country.

Pat Turner
**Chief Executive Officer**

NACCHO Board Meeting

# STRATEGIC DIRECTION

OUR MEMBERS CONTINUE TO DEMONSTRATE THAT THEY ARE THE LEADING PROVIDER OF CULTURALLY APPROPRIATE, COMPREHENSIVE, PRIMARY HEALTH CARE TO ABORIGINAL PEOPLE ACROSS THE NATION, EXCEEDING GOVERNMENT OR PRIVATE PROVIDERS. ABORIGINAL HEALTH MEANS NOT JUST THE PHYSICAL WELLBEING OF AN INDIVIDUAL, BUT REFERS TO THE SOCIAL, EMOTIONAL AND CULTURAL WELLBEING OF THE WHOLE COMMUNITY IN WHICH EACH INDIVIDUAL IS ABLE TO ACHIEVE THEIR FULL POTENTIAL AS A HUMAN BEING, THEREBY BRINGING ABOUT THE TOTAL WELLBEING OF THEIR COMMUNITY. IT IS A WHOLE OF LIFE VIEW AND INCLUDES THE CYCLICAL CONCEPT OF LIFE-DEATH-LIFE.

## NACCHO'S VISION IS:

Aboriginal people enjoy quality of life through whole-of-community self-determination and individual spiritual, cultural, physical, social and emotional wellbeing. Aboriginal health in Aboriginal hands.

## STRATEGY

Government's introduction of a Funding Model.
NACCHO played the key leadership role in the following:

- Secured the agreement by Government not to introduce the new Funding Model with nKPIs as a measure.
- Secured the Government's agreement that no ACCHO (NACCHO member) will lose their funding with the introduction of the funding model for the next 5 years.
- Secured the delay of introduction of the funding model until 1 July 2019.
- Secured the support of the AMA and RACGP in influencing the Government's decision.

## NEW NATIONAL NETWORK SECTOR SUPPORT FUNDING AGREEMENT

- Successfully negotiated the Agreement resulting in NACCHO, the Affiliates and the Department of Health signing the agreements by the commencement date of 1 July 2017.
- Successfully negotiated the additional ongoing funding for NACCHO to administer the new agreement.

## STRATEGY 1

NACCHO will maintain and strengthen its position as the National Peak body for Aboriginal health and wellbeing in Australia.

### KEY PERFORMANCE INDICATORS

✓ Achievement of a National Framework Agreement with the Commonwealth government

✓ NACCHO represented on key national advisory groups and committees

✓ NACCHO recognised as the leader on Aboriginal health and wellbeing in government policy frameworks and key documents.

## STRATEGY 2

NACCHO will develop a research and continuous quality improvement framework.

✓ increased capacity of State and Territory Peaks to support members

✓ Engagement of NACCHO in national initiatives like My Health Record.

## STRATEGY 3

NACCHO will enhance and demonstrate the value it offers to members by exhibiting strong leadership

✓ Establishment of functional Medical Advisory Group and a Policy Officer's Forum

✓ Undertake an annual Board performance review.

## STRATEGY 4

NACCHO will continue to strengthen its governance structure and skills base processes assist similar improvements in State and Territory Peaks and ACCHSs

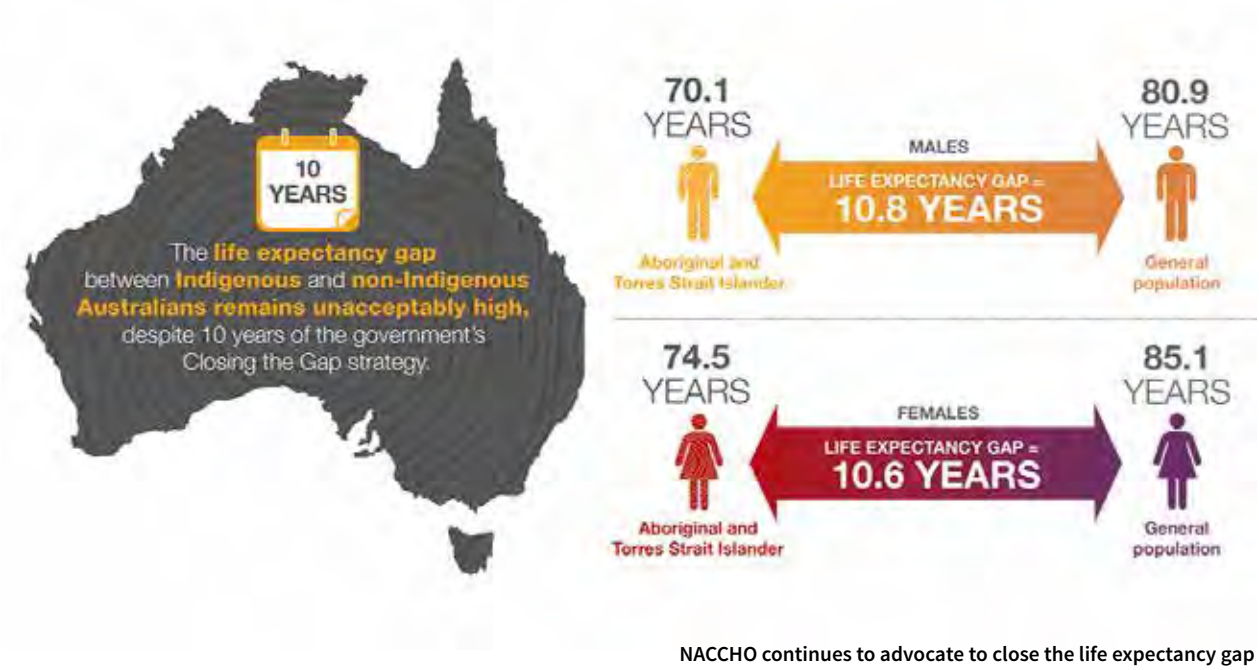
✓ Establishment of a NACCHO Board State and Territory Peaks CEOs Committee.

## STRATEGY 5

NACCHO will lead, shape and advocate national reform in health policy

✓ Evidence of continued growth in the Community Controlled sector

✓ Endeavours to achieve bipartisan support on the NACCHO Strategy have been made.




**NACCHO continues to advocate to close the life expectancy gap**

# ABOUT NATIONAL ABORIGINAL COMMUNITY CONTROLLED HEALTH ORGANISATION

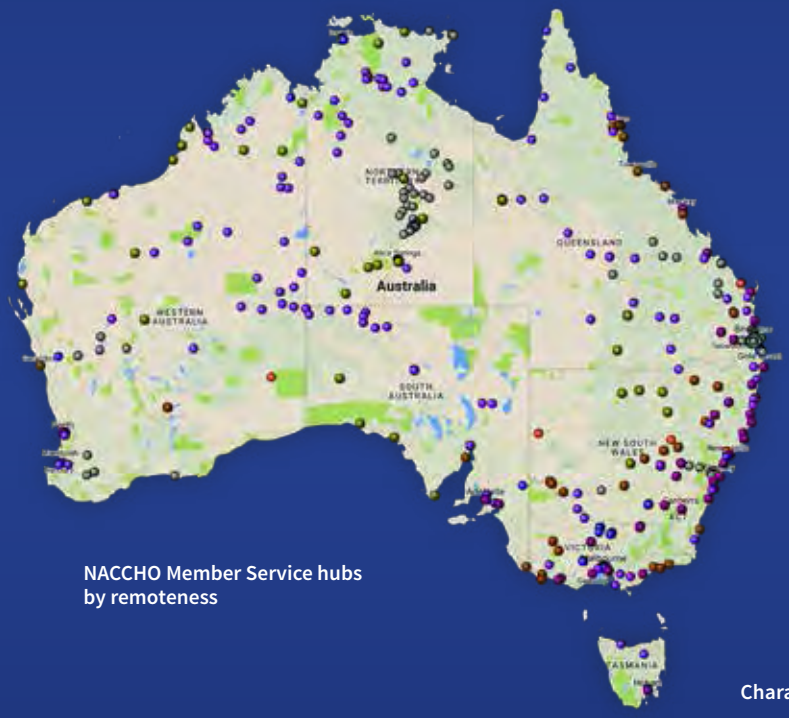
THE NATIONAL ABORIGINAL COMMUNITY CONTROLLED HEALTH ORGANISATION (NACCHO) IS THE NATIONAL PEAK BODY REPRESENTING ABORIGINAL HEALTH.[1] NACCHO REPRESENTS ITS MEMBERSHIP OF OVER 140 ABORIGINAL COMMUNITY CONTROLLED HEALTH SERVICES (ACCHS') AT THE COMMONWEALTH GOVERNMENT LEVEL AND SPEAK WITH ONE CLEAR, UNITED AND DISTINCT VOICE. THE ACCHS', WHICH ARE PRINCIPALLY FUNDED BY THE DEPARTMENT OF HEALTH (DOH), ARE THE LEADING AND PREFERRED PROVIDER OF CULTURALLY SAFE AND COMPREHENSIVE MULTIDISCIPLINARY PRIMARY HEALTH CARE TO ABORIGINAL AND TORRES STRAIT ISLANDER CLIENTS, FAMILIES AND COMMUNITIES. THIS INCLUDES TARGETED ACTIONS TO CLOSE THE GAP. ACCHS' REMAIN THE FOREMOST HOLDER OF EXPERT KNOWLEDGE AND 'KNOW HOW' FOR THESE HEALTH PURPOSES.

It is important to highlight and acknowledge the different understandings of health between a western context and an Aboriginal cultural context. The western understanding of health is an absence of disease; someone is healthy if they do not have a disease, or illness.

*The Aboriginal understanding of health is holistic and includes land, the physical body, the mind, clan, relationships, and lore. Health, in an Aboriginal cultural context, is the social, emotional and cultural wellbeing of the whole community, not just the individual.*

Our health care services have been established and operated by local Aboriginal communities, through locally elected Boards of Management, to deliver holistic, comprehensive and culturally appropriate health care. ACCHS' form a network, but each is autonomous and independent of one another and of government.

The culturally safe and multidisciplinary models of comprehensive primary care provided by the Sector have evolved over the last 40 years and represent its enduring and continuously innovating strengths. These include distinctive mixes of local community and cultural authority, the promotion of healthy life choices, chronic disease prevention and management to enabling personally empowered and smooth client/patient journeys. The unique synthesises of these community controlled care models cannot be replicated in public or private-for-profit mainstream systems of primary health care.




NACCHO Member Service hubs by remoteness


Characteristics Indigenous primary health care service delivery model[2]

NACCHO is guided by a Board of Directors, with the Chair and Deputy elected from its Members to embody community control and they have been pivotal in improving circumstances for Aboriginal and Torres Strait Islander people. It has achieved this by working with its Members and its State and Territory peak Aboriginal Community Controlled Health bodies to agree upon and address a national agenda for Aboriginal and Torres Strait Islander health and associated social justice matters.

NACCHO advocates to government for evidence-supported, community-developed responses and solutions to the deep-seated social, economic and political conditions that prevail in many Aboriginal communities. These conditions affect the holistic health of people within those communities. NACCHO strives to maintain the highest levels of professionalism and to remain apolitical in its advocacy.

## ABOUT THE ACCHS' SECTOR

*The ACCHs' were established in the early 1970s in response to Aboriginal and Torres Strait Islander people finding that mainstream services could not provide adequate health care.*

ACCHs' operate in urban, regional, remote and very remote Australia. They range from large multi-functional services employing a number of medical professionals and health workers who provide a wide range of comprehensive primary care services, often with a preventative, health-education focus, to smaller, rural and remote health care facilities.

1 Aboriginal and Torres Strait Islander: is the term NACCHO uses in all documentation when referring to the original habitant of all the lands now known as Australia. Aboriginal is used if referring to the original habitants of mainland Australia.

2 Modified form 'Characteristics of Indigenous primary health care service delivery models: a systematic scoping review.' CREATE,

Adelaide Harfield, S., C. Davy, E. Kite, A. McArthur, Z. Munn, A. Brown, and N. Brown. 2016

NACCHO Network Meeting 2018

# GOVERNANCE

## THE NACCHO BOARD OF DIRECTORS

NACCHO'S 16 MEMBER BOARD IS ELECTED BY OVER 140 ACCHS (ABORIGINAL COMMUNITY CONTROLLED HEALTH SERVICES) THAT ARE NACCHO MEMBERS. IT IS MADE UP OF ONE DELEGATE EACH FROM THE ACT AND TASMANIA, TWO DELEGATES EACH FROM THE REMAINING SIX JURISDICTIONS, AND A CHAIRPERSON AND DEPUTY CHAIRPERSON.

ELECTIONS FOR DELEGATES TO THE NACCHO BOARD ARE HELD ANNUALLY TO COINCIDE WITH EACH AFFILIATE'S ANNUAL GENERAL MEETINGS. HOWEVER, THE FULL NACCHO MEMBERSHIP ELECTS NACCHO'S CHAIRPERSON AND DEPUTY CHAIRPERSON FOR THREE-YEAR TERMS AT TRIENNIAL ANNUAL GENERAL MEETINGS OF NACCHO MEMBERS.

## THE NACCHO – STATE AND TERRITORY AFFILIATES RELATIONSHIP

NACCHO Board Members are aware of NACCHO Member expectations and priorities through their direct contact and direction at meetings of their jurisdictional Affiliate. NACCHO and its Affiliates have a strong working relationship work to coordinate feedback on policy development, advocacy and promote priorities at a national level.

NACCHO has coordinated many national projects involving its Affiliates, so there is a long-standing history of collaboration to achieve shared goals that result in benefits at a jurisdictional and national level. ZThe NACCHO Board has also endorsed a process to out-source national projects, within the parameters of expertise within our Affiliates, to ensure an effective and stronger working relationship between all our peak organisations.

Our NACCHO Board spent the year discussing issues like the new constitution, new funding agreement and models to begin in mid 2019, Community Grants Hub within the DSS, vulnerable services, development of a Board Charter and Code of Conduct.

**Smoking Ceremony by Aunty Matilda for the opening of the new NACCHO National office in Canberra.**

## THE BOARD MEETS REGULARLY THROUGHOUT THE YEAR:

Over the last 12 months NACCHO continued its consultations with Affiliates and members regarding a revised draft of a new NACCHO constitution with legal pro bono advice provided by law firm Gilbert & Tobin TB.

- Made decisions regarding the strategic policy directions of the organisation
- Developed, monitored and reviewed NACCHO's Strategic Directions, support of the network, various committees and approved the annual business plan
- agreed to the key performance indicators
- Maintained and strengthened connections between the Affiliates, Members and The Board
- Organised the Members' Conference and Annual General Meeting that last convened at the Hyatt Hotel in Canberra ACT from 30 October-1 November 2017.

The Chairperson, CEO and staff at NACCHO extend our thanks to outgoing Board members for their dedication, time, insights, passion and hard work.

3 For the names of all the NACCHO Board Directors during the financial year please refer to the Financial Report on page 74.

Sylvia Rosas, Indigenous Health Division, Department of Health

Health Data Portal

# OUR PARTNERS AND PROGRAMS

NACCHO PARTNERS WITH ORGANISATIONS THAT HAVE AN INTEREST IN AND COMMITMENT TO DEVELOPING AND MAINTAINING HEALTH CARE SERVICES FOR ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLE.

During the last year NACCHO has continued to deliver on its numerous successful partnership activities and innovative programs and collaborated with health providers to publish papers and submissions. NACCHO conferences, roundtables, workshops and forums have been enthusiastically received by the network and advice from them was provided to federal, state and territory governments.

## THE DEPARTMENT OF HEALTH (DOH)

The Department of Health (DoH) is the major funding contributor to NACCHO. In 1997 the Commonwealth Government funded NACCHO to establish a Secretariat in Canberra which greatly increased the capacity for Aboriginal and Torres Strait Islander Peoples involved in ACCHSs to participate in national health policy development. NACCHO and the DoH signed a new single funding agreement for three years which has secured our role in the Sector and provided certainty for our member services.

NACCHO championed the provision of our community controlled health services across communities but also continued to state a case for increased resources from governments to build enhanced capacity and effective health outcomes for Aboriginal and Torres Strait Islander people. NACCHO acknowledges the important work that each partnership provides.

## ENHANCED SYPHILIS RESPONSE

NACCHO welcomed the creation of a multi-jurisdictional Working Group in late 2017 tasked with writing an action plan to address high rates of syphilis in communities. NACCHO and the Department of Health have coordinated an $8.8 million response to address the syphilis outbreak in Northern Australia. This will address the disproportionately high rates of syphilis and other Blood-Borne Viruses (BBV) and Sexually Transmissible Infections (STI) in regional and remote Indigenous communities.

NACCHO has appointed an Enhanced Response Coordinator to build community awareness and work with the following Aboriginal Community Controlled Health Organisations (ACCHS) Wuchopperen Health Service, Danila Dilba Health Service and Townsville Aboriginal and Islanders Health Services (TAIHS).

NACCHO and Flinders University have commenced work on the program, rolling out a series of workshops and training Point of Care (PoC) testing that is being supported by an $8.8 million grant from the Federal Department of Health. NACCHO is also delivering education, testing kits and organising pharmaceutical supplies across Northern Australia.

## NACCHO HEALTH INFORMATION AND DATA

Data is critical at NACCHO in providing detail about the role and contribution to the delivery of our Member Services to the national health system. ACCHSs have had electronic health systems for their patients and their families, for nearly 20 years, providing integrated well-being and care records when services are provided within the Sector.

NACCHO have also provided information and data sets for national institutional based researchers that are vital for government resource allocation and facilitation of effective Aboriginal health service delivery across Australia.

Obtaining information from public and private providers can be problematic.

The ACCHSs are endorsing the national My Health Record as a vehicle for cross-sector data aggregation of health data at the level of the individual provided patient information and privacy is protected. The patient must be in control of what information is placed in their electronic record and who else has access to it.

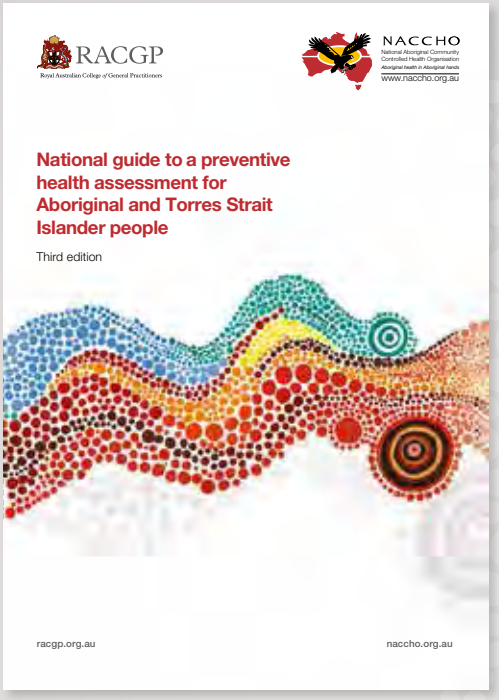
With My Health Records clinicians now have easy access to life saving information. This is especially vital if they are in acute care, for allergies, medications, scan results, up to date records of all visits by a patient to their own community controlled clinic, regional hospital or interstate emergency departments. My Health Record has received widespread support not only from NACCHO but also from national health and consumer peak bodies that are aligned with NACCHO including the Australian Medical Association (AMA), Consumer Health Forum (CHF) and Royal Australian College of General Practitioners (RACGP), the Pharmacy Guild of Australia and the Pharmaceutical Society of Australia (PSA).

Many of our members have also been involved in the co-design of the Department of Health's new Indigenous health data reporting capability in the Health Data Portal (Portal) throughout 2017 and 2018. Co-design has contributed to a Portal build that, based on the feedback from the recent trial, is easy to use and provides features and user experience which are superior to the current external portal, OCHREStreams.

Other data meetings, consultations and input has been made during the year about data governance, extraction, updates and program rollouts into the Medicare Benefits Schedule, the IAHP Funding model, Closing the Gap and CQI Framework.

## REDFERN STATEMENT ALLIANCE

NACCHO was the key player in the convening of a workshop on priorities for Indigenous health, including developing an outcomes document from the workshop as a key advocacy tool to support discussions with government. The CEO participated in regular Redfern Statement Alliance leadership meetings, steering the group to more effective advocacy and development of priorities underpinned by the Aboriginal Community Controlled Health Services philosophy of Aboriginal led development. Under the CEO, NACCHO has provided input into the Redfern Alliance's contribution to the Closing the Gap Refresh and federal budget priorities.




**Cover of the National guide to a preventive health assessment for Aboriginal and Torres Strait Islander people, 3RD Edition.**

# RACGP AND NACCHO IMPROVING THE GP GUIDE FOR ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH

THE ROYAL AUSTRALIAN COLLEGE OF GENERAL PRACTITIONERS (RACGP) AND THE NATIONAL ABORIGINAL COMMUNITY CONTROLLED HEALTH ORGANISATION (NACCHO) HAVE JOINED FORCES TO PRODUCE A GUIDE THAT AIMS TO IMPROVE THE LEVEL OF HEALTHCARE CURRENTLY BEING DELIVERED TO ABORIGINAL AND TORRES STRAIT ISLANDER PATIENTS AND CLOSE THE GAP.

Chair of RACGP Aboriginal and Torres Strait Islander Health Associate Professor Peter O'Mara said the third edition of the National guide to a preventive health assessment for Aboriginal and Torres Strait Islander people (the National Guide) is an important resource for all health professionals to deliver best practice healthcare to Aboriginal and Torres Strait Islander patients. "The National Guide will support all healthcare providers, not just GPs, across Australia to improve prevention and early detection of disease and illness," A/Prof O'Mara said.

"The prevention and early detection of disease and illness can improve people's lives and increase their lifespans. "The National Guide will support healthcare providers to feel more confident that they are looking for health issues in the right way."

RACGP President Dr Bastian Seidel said the RACGP is committed to tackling the health disparities between Indigenous and non-Indigenous Australians.

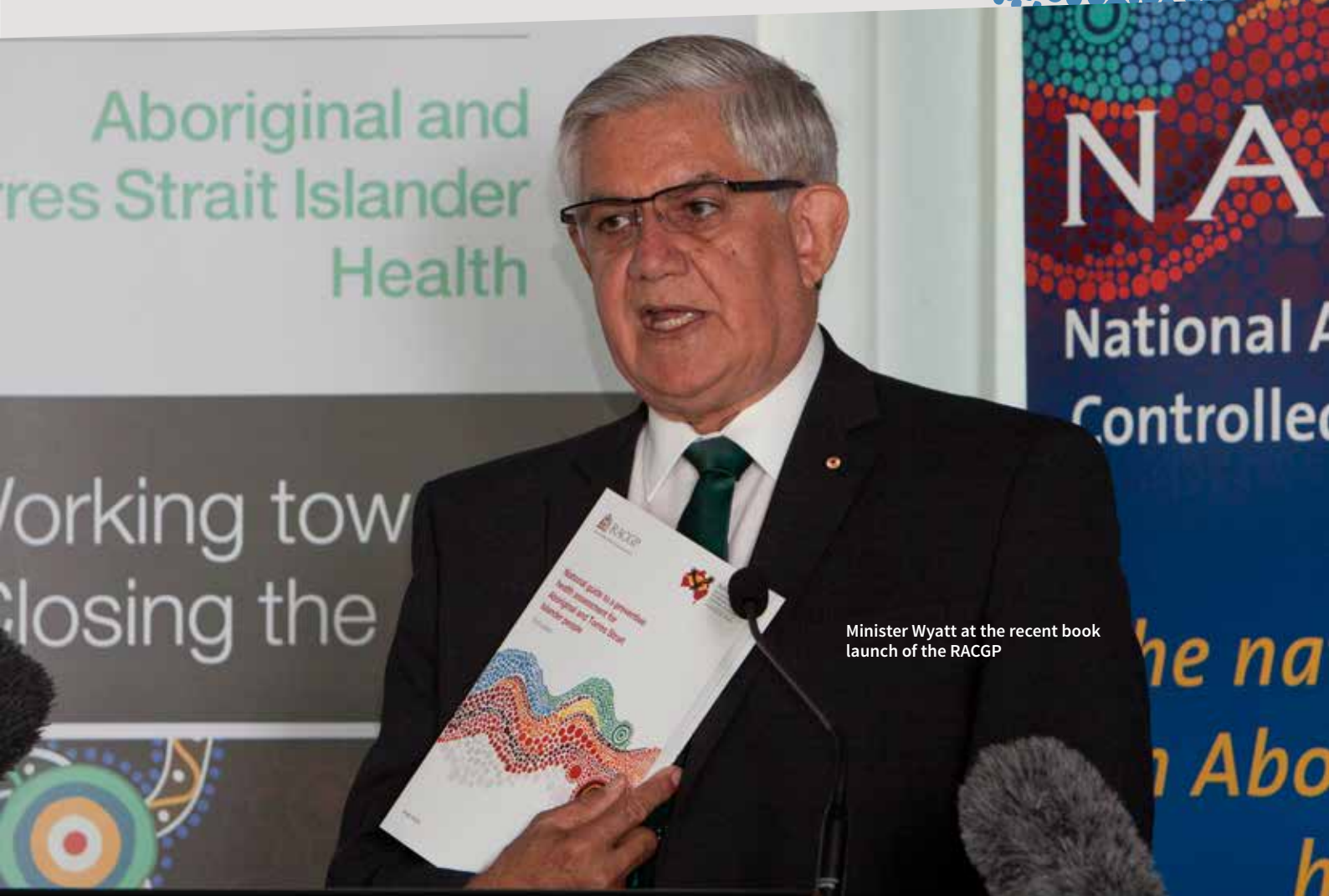
"The National Guide plays a vital role in closing the gap in Aboriginal and Torres Strait Islander health disparity," Dr Seidel said.

"Aboriginal and Torres Strait Islander people should have equal access to quality healthcare across Australia and the National guide is an essential part of ensuring these services are provided.

"GPs and other healthcare providers who implement the recommendations within the National Guide will play an integral role in reducing health disparity between Indigenous and non-Indigenous Australians and ensuring culturally responsive and appropriate healthcare is always available."

NACCHO Chair John Singer said the updated National Guide would help governments improve health policy and lead initiatives that support Aboriginal and Torres Strait Islander people. "All of our 6,000 staff in 145 member services in 305 health settings across Australia will have access to this new and update edition of the National Guide. It's a comprehensive edition for our clinicians and support staff that updates them all with current medical practice," Mr Singer said. NACCHO is committed to quality healthcare for Aboriginal and Torres Strait Islander patients and will work with all levels of government to ensure accessibility for all.


Royal Australian College of General Practitioners staff, NACCHO CEO and Chair at the launch of the National guide to a preventive health assessment for Aboriginal and Torres Strait Islander people 3RD Edition.




Minister Wyatt at the recent book launch of the RACGP


## QUALITY USE OF MEDICINES MAXIMISED (QUMAX) FOR ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLE

The QUMAX Program is a collaboration between NACCHO and the Pharmacy Guild of Australia and funded by the Commonwealth Department of Health. QUMAX is delivered by ACCHSs and community pharmacies and contributes to better health outcomes through improved Quality Use of Medicines (QUM). To support QUM activities and services at the local level, funding is available to eligible ACCHSs in inner and outer regional areas, urban areas and major cities.

## WHAT IS QUMAX?

The QUMAX Program aims to improve health outcomes by improving the QUM through seven support categories:

- Dose Administration Aids Agreements and Flexible Funding
- QUM Pharmacy Support
- Home Medicine Reviews (HMR) models of support
- QUM Devices
- QUM Education
- Cultural Education and
- Transport

In 2017-2018, around 60 per cent of NACCHO members participated in the QUMAX program – virtually all who were eligible. This equated to 79 ACCHSs across each State and Territory participating in the program reaching 242,628 Aboriginal and Torres Strait Islander clients.

The registration for the 2017-2018 QUMAX cycle was completed in June 2018, with one new ACCHS registering, taking numbers to 79 for that period.

The annual QUMAX cycles continue to run on schedule and has proven to be acceptable to NACCHO members and community pharmacies due to the ongoing management and support from NACCHO and the Guild.
The QUMAX Program Coordinator supports ACCHSs through all stages of work planning and reporting.
A simplified spreadsheet for planning and reporting has been used to streamline the workflow for ACCHSs and has been implemented effectively across all participating sites. All QUMAX contract reporting deliverables have been met for this period.

NACCHO held two national QUMAX workshops for members in 2018.
The workshops were promoted via the QUMAX network contact list, and based on the response from outreach, it was decided two larger workshops would run:

- Melbourne Tuesday 6th February 2018
- Sydney Thursday 8th February 2018.

The purpose of the workshops was to provide opportunities for ACCHO staff an opportunity to:

- learn more about QUMAX funding and budget allocation
- understand the QUMAX Program Specific Guidelines, including deliverables, eligibility and the seven support areas
- understand potential and practical benefits of QUMAX to tailor the program to local client need
- network with other ACCHOs about the program
- share ideas, good news stories and any issues with the group and Program Coordinators (NACCHO and The Guild).

A total of 36 participants from 25 different ACCHOs across Australia travelled to attend the workshops. Twelve attended in Melbourne and 24 in Sydney. A brief process evaluation with eight questions was provided to participants at the end of each workshop. Nearly all participants completed the evaluation, with 35 of the 36 collected at the end of the workshops. The results were overwhelmingly positive and showed that both workshops were well-organised, informative and appropriate to members' needs.

Pharmacists Special Interest Group meeting in Canberra at the NACCHO National Conference. Committee members consist of pharmacist representatives from every State and Territory who provided peer support, advocacy and input into key medicines-related policy items for NACCHO and PSA. The Committee plays a valuable role in supporting pharmacists working in ACCHOs, particularly those in rural and remote areas. Committee members are working to encourage the growth of this career path with a sharedcommitment to embedding pharmacists in ACCHOs nationally.

NACCHO pharmacist Alice Nugent at her desk at the Wellington Aboriginal Health Service

# NACCHO MEDICINES

## SUMMARY

NACCHO's role in managing national pharmacy projects, programs and providing input into medicines policy has been sustained by ongoing leadership and expanded staffing over the last 12 months.
The medicines team have accessed new funding through the Commonwealth Department of Health, within the Pharmacy Trial Program. NACCHO is currently co-leading two large pharmacy projects (IPAC and IMeRSe) spanning four states and territories, in addition to modest growth of funds in the established QUMAX program.
As of early 2018 NACCHO has employed three new Coordinators, and has secured funding to provide overall project governance and management.

## MEDICINES AND PHARMACY POLICY

NACCHO remains proactive in policy and member support relating to medicines and pharmacy.
The NACCHO medicines team have serviced key medicines policy documents to several key decision makers, panels and stakeholders.
The ongoing medicines policy developments that may impact NACCHO's members include:

- The Commonwealth's Review of Indigenous Pharmacy Programs (The 'IPP Review', including CTG, s100 and QUMAX)
- The MBS Review – including ACCHS pharmacist MBS items
- The Workforce Incentive Program (WIP) that subsidises ACCHSs employing a pharmacists directly
- The 7th Community Pharmacy Agreement – e.g. this may fund QUMAX
- The PSA Guide to Providing Pharmacy Service for Aboriginal and Torres Strait Islander People – the key pharmacist policy document may be reviewed soon.

NACCHO continues to liaise with individual Member Services, Affiliates, expert informants and several stakeholders to continue to build on current policy for enhanced medicines access, use and program development for the ACCHS sector.
NACCHO continues to liaise with key stakeholders including:

- Commonwealth Department of Health (monthly meetings)
- The Pharmacy Guild (including a joint policy media release and MoU signed in 2017)
- The Pharmaceutical Society of Australia
- NPS MedicinesWise
- RACGP
- Society of Hospital Pharmacists Australia.

NACCHO has advocated for enhanced support for ACCHOs to be able to embed pharmacists within their models of care. This has been supported in the IPP Review, the King review, through securing grant funding for the IPAC project in the 24 sites across Australia and in the 2018 budget announcement that ACCHOs will be able to use the Workforce Incentive Payment (WIP) to employ pharmacists directly in their service. NACCHO has also advocated for ACCHOs to be able to be able to access enhanced MBS-subsidised pharmacist services through the current MBS Review.

NACCHO's ACCHS Pharmacist Leadership Group has been active in addressing policy issues as they arise and has had regular email correspondence, 3 teleconferences and one face-to-face meeting since its inauguration in 2017 at NACCHO's national conference. NACCHO medicines team will host the presentations on the IPAC and IMeRSe projects at its 2018 conference as well as member consultation on the IPP Review.

## IPAC PROJECT UPDATE

The Integrating Pharmacists within ACCHSs to improve chronic disease management project (IPAC) is a joint research partnership between James Cook University (JCU), The Pharmaceutical Society of Australia (PSA) and NACCHO. The project in funded by the Commonwealth Department of Health, through the Pharmacy Trial Program. The project aims to explore if quality of care outcomes for Aboriginal and/or Torres Strait Islander adult patients with chronic disease can be improved by integrating a practice pharmacist within the primary health care team of ACCHS, when compared with prior care. This service is being implemented to start from June to October 2018 and ACCHS will have access to a pharmacist for 15 months in total.

Affiliates are supported to provide oversight and assistance in recruiting and managing ACCHSs' participation. There are 20 contracted ACCHS involved in NT, Queensland and Victoria. This includes coverage of a total of 24 clinic sites for evaluation. These sites are spread evenly across urban regional and remote areas. NACCHO has established an Aboriginal Project Reference Group with representatives from all ACCHS and Affiliates chaired by Wendy Brookman from NACCHO.

## IMERSE STUDY

The IMeRSe Feasibility Study (Indigenous Medicines Review Service) is a collaborative partnership between NACCHO, Griffith University and the Pharmacy Guild of Australia. The aim is to evaluate the feasibility of a culturally responsive, individualised medication review service delivered collaboratively by community pharmacists and Aboriginal health services.

Five NACCHO Member sites are participating in the IMeRSe Study. NACCHO has several duties for the Study, including: providing Study oversight; members services and coordination; and developing a collection of medicines resources for use during the Study.

Photo of the ACCHO Pharmacist Leadership Group which includes PSA and NACCHO staff at the Members' Canberra Conference. The group has met regularly and provides useful insights and expertise for a variety of policy areas (such as the MBS and IPP Review).

# National Guide lifecycle chart | Adult

RACGP Royal Australian College of General Practitioners

NACCHO National Aboriginal Community Controlled Health Organisation Aboriginal health in Aboriginal hands www.naccho.org.au

| Screening/assessment | How often? | Who? | Page* | Age (years) 10–14 | 15–17 | 18–19 | 20–24 | 25–29 | 30–34 | 35–39 | 40–44 | 45–49 | 50–54 | ≥55 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Lifestyle** | | | | | | | | | | | | | | |
| **Smoking** | | | | | | | | | | | | | | |
| Smoking status | Annually and opportunistically | People aged ≥10 years | 10 | | | | | | | | | | | |
| Assess willingness to quit and level of nicotine dependence to guide intervention choice | Opportunistically | People who currently smoke | 10 | | | | | | | | | | | |
| **Overweight and obesity** | | | | | | | | | | | | | | |
| Body mass index (BMI) using age-specific and sex-specific centile charts | Annually and opportunistically | People aged <18 years (refer to Chapter 3: Child health) | 12 | | | | | | | | | | | |
| BMI and waist circumference | Annually and opportunistically | People aged ≥18 years | 12 | | | | | | | | | | | |
| **Physical activity** | | | | | | | | | | | | | | |
| Assess level of physical activity and sedentary behaviour as per Australian age-appropriate recommendations | Annually and opportunistically | All people | 16 | | | | | | | | | | | |
| **Alcohol** | | | | | | | | | | | | | | |
| Quantity and frequency | Annually | People aged ≥15 years | 20 | | | | | | | | | | | |
| Comprehensive alcohol assessment | Opportunistically | High-risk groups (refer to Chapter 1: Lifestyle, 'Alcohol') | 20 | | | | | | | | | | | |
| **Gambling** | | | | | | | | | | | | | | |
| Screen by asking a single-item question | Annually and opportunistically | People aged ≥12 years (refer to Chapter 1: Lifestyle, 'Gambling') | 23 | | | | | | | | | | | |
| **Antenatal care** (For pregnant girls aged <15 years, follow recommendations for people aged ≥15 years) | | | | | | | | | | | | | | |
| **General antenatal care and screening** | **Refer to Chapter 2: Antenatal care** | **Refer to Chapter 2: Antenatal care** | **30** | | | | | | | | | | | |
| Ask about psychosocial factors and screen for depression and anxiety using a validated perinatal mental health assessment tool | Early in pregnancy and at subsequent visits | All pregnant women | 32 | | | | | | | | | | | |
| Ask about exposure to family abuse and violence (FAV) and respond immediately if a woman discloses FAV | Early in pregnancy and at subsequent visits | All pregnant women | 32 | | | | | | | | | | | |
| **Smoking cessation** | | | | | | | | | | | | | | |
| Regularly assess smoking status and remind patients to limit/avoid exposure to cigarette smoke | First visit and subsequent antenatal visits | All pregnant women | 25 | | | | | | | | | | | |
| **Genitourinary and blood-borne virus (BBV) infections** | | | | | | | | | | | | | | |
| Offer either screening for Group B streptococcus (GBS) colonisation or an assessment of risk factors for GBS transmission during labour | At 35–37 weeks' gestation | All pregnant women | 26 | | | | | | | | | | | |
| Chlamydia testing | First antenatal visit and consider screening later in pregnancy in areas of high prevalence | Pregnant women aged <25 years and all pregnant women from communities with high prevalence of sexually transmitted infections (STIs) | 26 | | | | | | | | | | | |
| Gonorrhoea testing | First antenatal visit and consider repeat screening later in pregnancy in areas of high prevalence | Pregnant women who have known risk factors or who live in or come from communities with a high prevalence of gonorrhoea, including those in outer regional and remote areas | 26 | | | | | | | | | | | |
| Offer syphilis, human immunodeficiency virus (HIV) and hepatitis B virus (HBV) testing | First antenatal visit | All pregnant women | 27 | | | | | | | | | | | |
| Offer serological testing for hepatitis C virus (HCV) antibodies | First antenatal visit | Pregnant women with risk for HCV, including intravenous drug use, tattooing and body piercing, and incarceration | 27 | | | | | | | | | | | |
| Asymptomatic bacteriuria test | First antenatal visit | All pregnant women | 26 | | | | | | | | | | | |
| Bacterial vaginosis test | On presentation | Pregnant women with symptoms of bacterial vaginosis | 26 | | | | | | | | | | | |
| Trichomoniasis test | On presentation | Pregnant women with symptoms of trachomoniasis | 26 | | | | | | | | | | | |
| **Nutrition and nutritional supplementation** | | | | | | | | | | | | | | |
| Measure height and weight and calculate BMI | At first visit; at subsequent visits only if clinically indicated | All pregnant women | 28 | | | | | | | | | | | |
| Full blood examination to assess for anaemia | First antenatal visit and at 28 and 36 weeks | All pregnant women | 28 | | | | | | | | | | | |
| Consider serology testing for vitamin D levels | First antenatal visit | Pregnant women with risk factors for vitamin D deficiency | 28 | | | | | | | | | | | |
| **Diabetes** | | | | | | | | | | | | | | |
| Fasting plasma glucose | First antenatal visit | Pregnant women who do not have diagnosed diabetes | 29 | | | | | | | | | | | |
| 75 g two-hour oral glucose tolerance test (OGTT) | Between 24 and 28 weeks | Pregnant women who do not have diagnosed diabetes | 29 | | | | | | | | | | | |
| 75 g fasting OGTT | At six weeks postpartum | Women diagnosed with gestational diabetes who are now postpartum | 29 | | | | | | | | | | | |
| **Health of older people** | | | | | | | | | | | | | | |
| **Osteoporosis** | | | | | | | | | | | | | | |
| Assess risk factors for osteoporosis | Annually | All postmenopausal women and men aged >50 years | 60 | | | | | | | | | | | |
| Dual-energy X-ray absorptiometry on at least two skeletal sites to measure bone density | Baseline, then two-yearly if needed | People at moderate and high risk (refer to Chapter 5: The health of older people) | 60 | | | | | | | | | | | |
| **Falls** | | | | | | | | | | | | | | |
| Assess for risk factors for falls | Annually<br>On admission, then six-monthly | People aged ≥50 years at all risk levels<br>Aged care residents | 63 | | | | | | | | | | | |
| Detailed assessment including cardiac, neurological, medication, vision/gait/balance, home environment | Opportunistically | People with a history of falls or at high risk | 63 | | | | | | | | | | | |
| Referral for pacemaker | As needed | Falls due to carotid sinus hypersensitivity | 63 | | | | | | | | | | | |
| Referral for cataract surgery (first eye) | As needed | Vision-threatening cataract disease | 63 | | | | | | | | | | | |
| **Dementia** | | | | | | | | | | | | | | |
| Obtain history, perform comprehensive physical examination and consider cognitive screening test (refer to Chapter 5: The health of older people) | Opportunistically | People with: memory loss, behaviour change, concerned family, history of repeated head trauma, Down syndrome, elevated cardiovascular disease (CVD) risk, depression or history of depression | 65 | | | | | | | | | | | |
| **Eye health** | | | | | | | | | | | | | | |
| **Visual acuity** | | | | | | | | | | | | | | |
| Ask about vision | Every 1–2 years | All age groups | 66 | | | | | | | | | | | |
| Near and far visual acuity assessment | Annually and opportunistically | People aged >40 years and people with poor vision | 66 | | | | | | | | | | | |
| Referral to ophthalmologist | Opportunistically | Where problems identified | 66 | | | | | | | | | | | |
| Visual acuity and retinal assessment | Annually | People with diabetes | 66 | | | | | | | | | | | |
| Conduct eye examination by dilated fundus examination or retinal digital imaging and counsel clients about risk of diabetic retinopathy | First trimester (refer to Chapter 6: Eye health) | Pregnant women with pre-existing diabetes | 66 | | | | | | | | | | | |
| **Trachoma** | | | | | | | | | | | | | | |
| Community screening program | National guideline recommendations | People living where trachoma is endemic (refer to Chapter 6: Eye health) | 67 | | | | | | | | | | | |
| **Trichiasis** | | | | | | | | | | | | | | |
| Eye examination | Two-yearly (age 40–54 years); annually (age ≥55 years) | Adults aged >40 years raised in trachoma endemic area | 67 | | | | | | | | | | | |
| Refer to ophthalmologist | | People with trichiasis | 67 | | | | | | | | | | | |
| **Hearing loss** | | | | | | | | | | | | | | |
| Vaccination (rubella, measles, *Haemophilus influenzae* type b, meningococcus) | National Immunisation Program Schedule (NIPS) and state/territory schedules | Children aged <15 years | 68 | | | | | | | | | | | |
| Test for rubella immunity and syphilis serology and recommend enhanced hygiene practices for cytomegalovirus prevention | Refer to Chapter 2: Antenatal care | All pregnant women | 68 | | | | | | | | | | | |
| Ear examination | Annually and opportunistically | Children aged <15 years | 68 | | | | | | | | | | | |
| Monitor for hearing loss and maintain high suspicion of hearing loss | Annually | Children aged <5 years and older children at high risk of hearing impairment; people aged ≥15 years | 69 | | | | | | | | | | | |
| Monitor for hearing impairment, provide advice re free hearing assessment and refer where needed | Opportunistically | All people aged ≤50 years | 69 | | | | | | | | | | | |
| **Oral and dental health** | | | | | | | | | | | | | | |
| Oral health review, including assessment of teeth, gums and oral mucosa | Annually<br>First antenatal visit<br>Every two years | People aged 6–18 years; adults with poor oral health and/or risk factors for dental disease (refer to Chapter 8: Oral and dental health)<br>All pregnant women<br>Adults with good oral health | 74 | | | | | | | | | | | |
| Oral health review and oral hygiene advice to minimise oral bacteria levels | Six-monthly | People with history of rheumatic heart disease and cardiovascular abnormalities | 74 | | | | | | | | | | | |
| **Respiratory health** | | | | | | | | | | | | | | |
| **Pneumococcal disease** | | | | | | | | | | | | | | |
| Immunisation: refer to Chapter 9: Respiratory health, 'Pneumococcal disease prevention' | | | 76 | | | | | | | | | | | |
| **Influenza** | | | | | | | | | | | | | | |
| Influenza vaccine | Annually pre-influenza season<br>Part of routine antenatal care (refer to Chapter 2: Antenatal care) | Children aged six months to five years; people aged ≥15 years; people aged >6 months with chronic illness; healthcare providers<br>Women who are pregnant or planning a pregnancy | 79 | | | | | | | | | | | |
| **Asthma** | | | | | | | | | | | | | | |
| Consider early detection strategies | | All people | 81 | | | | | | | | | | | |
| **Chronic obstructive pulmonary disease** | | | | | | | | | | | | | | |
| Influenza vaccine | Annually pre-influenza season | People with an established diagnosis of COPD | 83 | | | | | | | | | | | |
| 23-valent pneumococcal polysaccharide vaccine (23vPPV) | Refer to Chapter 9: Respiratory health, 'Pneumococcal disease prevention' | People with an established diagnosis of COPD | 83 | | | | | | | | | | | |
| Check for symptoms of chronic obstructive pulmonary disease (COPD) as part of targeted approach | Opportunistic | People aged >35 years who currently smoke or are ex-smokers | 83 | | | | | | | | | | | |
| Spirometry to assess for presence of airflow obstruction | Opportunistic | All people presenting with symptoms, especially shortness of breath, chronic bronchitis and recurrent acute bronchitis | 83 | | | | | | | | | | | |
| **Bronchiectasis and chronic suppurative lung disease** | | | | | | | | | | | | | | |
| Ensure timely immunisation provided | NIPS and state/territory schedules | All children and adults, including pregnant women | 84 | | | | | | | | | | | |
| Review after acute respiratory infection (ARI) episode | 3–4 weeks post-episode, then two-weekly until symptoms resolve or the patient is referred | People with pneumonia and lower ARIs (refer to Chapter 9: Respiratory health, 'Bronchiectasis and chronic suppurative lung disease') | 84 | | | | | | | | | | | |
| Consider bronchiectasis diagnosis and repeat chest X-ray; specialist referral (refer to Chapter 9: Respiratory health) | Opportunistically | People with recurrent lower ARIs | 84 | | | | | | | | | | | |
| Clinically assess for chronic lung disease symptoms and undertake spirometry | Opportunistically | People with history of tuberculosis | 84 | | | | | | | | | | | |
| Undertake spirometry; assess for bronchiectasis and consider referral to specialist where needed (refer to Chapter 9: Respiratory health, 'Bronchiectasis and chronic suppurative lung disease') | Opportunistically | Adults with COPD | 84 | | | | | | | | | | | |
| **Acute rheumatic fever and rheumatic heart disease** | | | | | | | | | | | | | | |
| Vaccination (routine childhood and adult vaccinations, annual influenza as per NIPS, and provide pneumococcal vaccination) | As per national guidelines | People with a history of acute rheumatic fever (ARF) or known rheumatic heart disease (RHD) | 87 | | | | | | | | | | | |
| Take a comprehensive medical history and family history for CVD | Annually and opportunistically | Individuals coming from high-risk groups or living in high-risk settings for ARF/RHD; all pregnant women | 87 | | | | | | | | | | | |
| Maintain a high index of clinical suspicion of streptococcal pharyngitis in people presenting with a sore throat | As presented | All people in high-risk communities where Group A streptococcus (GAS) infections are common and ARF is prevalent | 87 | | | | | | | | | | | |
| Assess for overcrowding and refer to social support services for housing assistance if indicated | Opportunistically | People living in communities where GAS infections are common and ARF is prevalent | 88 | | | | | | | | | | | |
| Refer for echocardiography and subsequent follow-up | As per management guidelines (refer to Chapter 10: Acute rheumatic fever and rheumatic heart disease) | People with past ARF or murmurs suggestive of valve disease | 87 | | | | | | | | | | | |

Age-specific  Condition-specific

*Page number refers to print version of *National guide to a preventive health assessment for Aboriginal and Torres Strait Islander people*

Rebecca Crisp
Kimberley pharmacy
services

Royal Australian Air Force officers speaking about the MoU at the at the Canberra NACCHO National Members Conference. The RAAF fly medical specialists into Aboriginal and Torres Strait Islander communities, and cover all costs, to enhance primary health care outcomes in these communities.

# MEMORANDUMS OF **UNDERSTANDING**

NACCHO HAS SEVERAL MEMORANDUMS OF UNDERSTANDING (MOUs).

## AUSTRALIAN HEALTHCARE AND HOSPITALS ASSOCIATION

NACCHO's partnership with the Australian Healthcare and Hospitals Association (AHHA) harnesses the strength of both organisations to reverse the differences in the health of Aboriginal and Torres Strait Islander Australians. Our partnership explores new opportunities for collaboration on policies, research and public health campaigns to Close the Gap and address health issues in Aboriginal and Torres Strait Islander communities. In December 2015 NACCHO and the AHHA Chairpersons signed a Memorandum of Understanding to facilitate policy development, advocacy, communication, joint planning and collaboration between the two organisations regarding all aspects of Aboriginal and Torres Strait Islander Health. Together we now share resources, skills and explore opportunities to build the capacity and reach of both organisations.

## COUNCIL OF PRESIDENTS OF MEDICAL COLLEGES AND NACCHO

The Council of Presidents of Medical Colleges is committed to working with NACCHO and the Australian Government to reduce the current gap in health outcomes and life expectancy between Indigenous and non-Indigenous Australians. NACCHO, the three federal health ministers and the 15 Medical Colleges signed a collaborative agreement last year with the NACCHO Chair.

## END RHD COALITION

The coalition aims to eliminate rheumatic heart disease in Australia. A national endgame strategy and a national endgame report are to be presented by 2020. AMSANT, AHCWA, AMA, Heart Foundation, Menzies School of Health Research, Telethon Kids Institute, and NACCHO are the founding members.

NACCHO CEO Pat Turner and Pharmacy Guild of Australia CEO David Quilty sign the MoU at the Canberra NACCHO National Members Conference.

## PHARMACY GUILD OF AUSTRALIA AND NACCHO

Recognition of community pharmacists as the peak providers of pharmacy work across the sector. Recognition of NACCHO as peak health policy advisory body for ACCHO's. Pledge to work along the guidelines of the National Aboriginal and Torres Strait Islander Health Plan and its Implementation Plan, as well as the National Medicines Policy. Agreement to share information of mutual interest, jointly develop public/media statements, seek agreement from each other before contacting their membership.

## NACCHO AND THE RACGP

NACCHO and the RACGP work collaboratively to advocate that the Australian healthcare system is appropriately structured and resourced to enable all health professionals to provide continuity of care that is clinically and culturally appropriate for Aboriginal and Torres Strait Islander communities. Together we will develop the standards, guidelines, funding models and resources to equip general practitioners, all health professionals and Aboriginal Community Controlled Health Services to maximise health outcomes for Aboriginal and Torres Strait Islander People. NACCHO and RACGP build a reputation of partnerships and joint advocacy in Aboriginal and Torres Strait Islander health. Together we will develop initiatives that attract and retain a skilled workforce for the Aboriginal Community Controlled Sector.

## ROYAL AUSTRALIAN AIR FORCE (RAAF)

The purpose of the MoU with the Royal Australian Air Force (RAAF) was to add to the number of partnerships to deliver ongoing affordable and accessible health care to Aboriginal and Torres Strait Islander people. This partnership with NACCHO will facilitate RAAF Dental personnel to work alongside Aboriginal Health Workers in Aboriginal Community Controlled Health Organisations. This will help reduce waiting time for Aboriginal health services and allow more Aboriginal people to access the care they need. It will also provide benefits for RAAF dentists who will be able to use their skills in different health settings and patients with complex needs.

## JAMES COOK UNIVERSITY, PHARMACEUTICAL SOCIETY OF AUSTRALIA AND NACCHO

Aims to embed pharmacists into ACCHSs and collect bio-statistical data through Community Based Participatory Research that will improve Aboriginal and Torres Strait Islander people's access to medicines. This equitable involvement from community members, organisational representatives and researchers will develop a framework to be implement over the next few years.


**Fetal Alcohol Spectrum Disorder - Aboriginal awareness campaign poster 2018**

# NACCHO OCHRE DAY

Men's health, our way. Let's own it!

## National conference

National Aboriginal Community Controlled Health Organisation

NACCHO

www.naccho.org.au


Ochre Day John Paterson with Minister for Indigenous Health Ken Wyatt AM MP and Dr Michael Adams

# OCHRE DAY

THE NACCHO OCHRE DAY CONFERENCE WAS HELD ON THE TRADITIONAL LANDS OF THE LARRAKIA NATION IN DARWIN ON 4-5 OCTOBER 2017 AND WAS ATTENDED BY 160 ABORIGINAL MEN WHO LISTENED TO OVER 40 SPEECHES AND PRESENTATIONS.

The event was opened by the Minister for Indigenous Health and Aged Care Ken Wyatt AM MP and was also attended by Territory MP Luke Gosling on the second day. The conference's theme was "Men's health, our way. Let's own it!" which signals the intentions of the conference to empower ACCHO programs to address Aboriginal men's health issues. The attendance of two MPs also highlights NACCHO's recognition for engaging and delivering high quality expertise and strategic advice at a national level regarding primary health care for male health in Australia.

Topics included speeches about the Royal Commission into the Protection and Detention of Children in the NT, Deadly Choices, Men's Clinic, Strong Bala Program, Aboriginal Men's Sexual Health, Trans Inter-Generational Trauma, Family Violence, Anger Management, Health and Formation of Adolescent Males, Male Suicide, Ice Addiction and Nicotine consumption.

The Jaydon Adams Memorial Oration was delivered by Professor Tom Calma about Indigenous smoking. The entertainment at the dinner was by David Leha whose performance was delivered in soul and spoken word. This related to his life experiences from hopelessness to healing; highlighting the need to never lose the ability to love and have compassion. Some of the audience also shared painful personal life experiences that left people deeply moved.

The Jaydon Adams Memorial Oration Award was presented by Jaydon's parents Lizzie and Mark Adams to Nathan Jones-Cubillo in recognition of his development as an outstanding Aboriginal Health Practitioner and young workplace leader. Nathan is employed by the Danila Dilba Health Service.

The Welcome to Country was performed by Larrakia Elders Tony Lee and Richie Fejo who were adeptly assisted by the One Mob, Different Country Dance Group.

The event was hosted by the Danila Dilba Health Service and the contribution by members of the Steering Committee is also gratefully acknowledged.

The Ochre Day Conference is an annual event which is held in a different jurisdiction each year. In 2018 the men will gather in Hobart, Tasmania.


New NACCHO board meeting delegates at Canberra conference

# STAKEHOLDER ENGAGEMENT

NACCHO IS OFTEN CALLED UPON TO REVIEW ACADEMIC PAPERS, MAKE PUBLIC STATEMENTS, SIGN OPEN LETTERS AND AGREEMENTS, ENDORSE PROPOSITIONS OR PUBLIC POLICY POSITIONS, PARTICIPATE IN FORUMS, EVENTS, CONFERENCES AND ATTEND PARLIAMENTARY HEARINGS OR INQUIRIES.

NACCHO secured funding to complete the National CQI Framework which will guide a systematic and coordinated approach to CQI in Primary Health Care delivered by ACCHSs. Our staff also received funding for NACCHO to support ACCHSs to transition to the NDIS operational environment and deliver services in urban, rural and remote settings.

NACCHO has a proud tradition and has developed over the last 20 years a strong coalition of support with other NGO's already across a diverse range of areas. NACCHO offers an alternative point of view or makes recommendations which have been enhanced by 40 years of dedicated experience. Aboriginal perspectives from our governing bodies and staff about culturally appropriate healthcare needs are admired and respected by government, NGOs and other stakeholders. Through strengthening existing relationships and embracing new opportunities we will use our experience to benefit the sector.

NACCHO continued to advocate for its Members by researching and submitting numerous policy submissions, consulting with working groups, representing the national Network on external committees and participated in CEOs' Forums.

## POLICY SUBMISSIONS

- The NACCHO Network Submission on Mental Health Services in Rural & Remote Australia for the Senate Community Affairs Reference Committee on the Accessibility & Quality of Mental Health Services in Rural & Remote Australia

- The Network Position on the NDIS from the Aboriginal Community Controlled Health Sector to the Productivity Commission on 22 February 2018. When appropriately resourced, Aboriginal Community Controlled Health Services (ACCHSs) are uniquely placed to support Aboriginal people through the NDIS to improve health and wellbeing outcomes. However, there are barriers for ACCHSs becoming providers of the NDIS including cost, thin markets as recognised by the Productivity Commission and limited Aboriginal workforce.
- The sector submission to the Optimal Care Pathway (OCP) for Aboriginal and Torres Strait Islander People with Cancer drew on our Network's PHMO capability to highlight and influence models of primary health care and to highlight the unique and significant role of the ACCHS plays in the service delivery of healthcare to Aboriginal people with cancer.
- A sector submission for the secondary use of My Health Data that highlighted that safeguards are required to prevent unintended consequences of misguided research, inaccurate interpretation or reporting, or the possible misuse of Indigenous health data derived from the My Health Record.
- A sector submission on the Department of Prime Minister and Cabinet's exposure draft of the Evaluation Framework for the Indigenous Advancement Strategy.
- A sector submission on a statement of requirement put out by the Department of Health to engage a consultant for Stage 1 of the Data Quality Assessment and Support Project to verify data for use in the new funding model.
- Budget 2018 submission that included a sector review and considered impacts for our member services.
- NACCHO Submission to the Review of Pharmacy Regulation and Remuneration Interim Report.

## NACCHO POLICY COMMITTEE MEMBERSHIP REPRESENTATION

The CEO and Chair devote time to attend numerous committees as do other staff, such as NACCHO Deputy CEO Dawn Casey, who sits on Australian Association of Gerontology, Australian Digital Health Agency, My Health Record Expansion Program, Australian Health Protection Principal Committee (AHPPC) - Emergency Response Taskforce for BBV/STI in Indigenous populations, Australian Trachoma Alliance National Trachoma Surveillance & Control Working Group, Australian Research Alliance for Children & Youth (ARACY). Other committees include: CEOs' Forum Policy Subcommittee, CQI Working Group and the CQI: National Framework. A list of our prominent committees can be reviewed on page 101.

Age of Criminal Responsibility Roundtable at Parliament House Canberra with Senators and senior key staff

# POLITICAL LEADERSHIP

## PARLIAMENT HOUSE STANDS ON LAND TRADITIONALLY OWNED BY THE NGUNNAWAL AND NGAMBRI PEOPLE.

Political leadership in Canberra is now vital to NACCHO to assist us plan health policy for the future as our increasingly large and growing population will pass one million in the next few years. Aboriginal and Torres Strait Islander peoples now represent 3.3 per cent of the Australian population or 787,000 people. The median age of an Aboriginal is 23 years and only one in ten reported speaking one of the 150 Australian Indigenous languages at home.

NACCHO worked with the Prime Minister, Cabinet Ministers, Leader of the Opposition, shadow Ministers, governments backbenchers, MPs and Senators. Throughout our engagements with them we fostered positive relationships with the parliamentary representatives, their staffs and senior departmental bureaucrats and agency staff while in Parliament House.

We often advocate and speak to the Federal Parliamentary Indigenous Friends Group or at special gatherings of prominent Indigenous Australians, Parliamentary Breakfasts, Closing the Gap campaigns press conferences, budget night briefings and to the journalists in the parliamentary press gallery. NACCHO attends, often at short notice, Ministerial, departmental and committee meetings which are often held at Parliament House as well.

NACCHO, its Affiliates and our hardworking Member services have had recent success with various national health programs. We help establish and work with the multi-jurisdictional Enhanced Syphilis taskforce response, End Rheumatic Heart Disease coalition and the Ministerial Suicide Prevention Working Group's Steering Committee. NACCHO also continued its work highlighting significant health issues in parliament about Fetal Alcohol Spectrum Disorder (FASD) and high Indigenous smoking rates in our communities.

**Closing the Gap Report to Parliament press conference**

**Dawn Casey speaking with Ministers at Parliament House Canberra**

NACCHO made a Budget night submission and on the whole welcomed the Federal Budget for Aboriginal and Torres Strait Islander programs and services with an ongoing average increase of 3.75 per cent per year. It was disappointing to note that no mention was made about the Closing the Gap Refresh in the Treasurers speech. NACCHO welcomed the measures to tackle ear and eye health and crusted scabies in the top end but NACCHO now understand that these measures are funded from existing allocations. The addition of a new Medicare Benefits Schedule renal medicine item to fund dialysis services in very rural and remote regions was also welcomed.

We should celebrate and acknowledge our mob on the Hill with Ken Wyatt, Patrick Dodson, Linda Burney and Malarndirri McCarthy for being elected in the first place, winning ministerial honours and placing Indigenous Affairs at the forefront of Australian political debate. These politicians are a pragmatic lot with a lifetime of experience in Indigenous Affairs and know how engage with non-Indigenous Australians. NACCHO will continue to have a contribution to make to the Parliament and ensure our voice is heard and respected.

NACCHO has also reached out to various medical associations, foundations and colleges to discuss opportunities regarding mentoring services, clinical projects or placements in ACCHOs. NACCHO continues to be a strong and influential voice for Aboriginal community controlled health with governments and other key stakeholders. We know that Aboriginal and Torres Strait Islander people and people in rural and remote areas do not have equitable access to appropriate, culturally safe health services. NACCHO aims to increase the recruitment and retention of doctors to rural and remote locations and provide support for clinical placements and research projects.

It is through NACCHO and our own Aboriginal and Torres Strait Islander community controlled leadership that we hope to enjoy improved quality of life, immersing ourselves in our own languages, and practicing our cultural roles and responsibilities to the full.

# MEDIA AND COMMUNICATION ACTIVITIES

**NACCHO Aboriginal Health Communique Subscribers**

**4,753**

**2017-18**

| 2013-14 | 2014-15 | 2015-16 | 2016-17 |
|---|---|---|---|
| 1203 | 3,740 | 3,973 | 4,314 |

**NACCHO Aboriginal Health Communique Views**

**789,223**

**2017-18**

| 2013-14 | 2014-15 | 2015-16 | 2016-17 |
|---|---|---|---|
| 245,599 | 375,804 | 506,603 | 628,887 |

## OVERVIEW

IN 2017/18 NACCHO'S STRATEGIC MEDIA AND COMMUNICATIONS CONTINUED TO BE EMPLOYED TO GOOD EFFECT SUPPORTING NACCHO'S GOALS AND ENSURING ABORIGINAL HEALTH ISSUES WERE ELEVATED IN THE NATIONAL ARENA. THESE GOALS WERE ACHIEVED BY:

- Disseminating press releases, speeches, member alerts and organising national media interviews
- Publishing a daily online Aboriginal Health News Alert
- Organising conferences, launches, events, press conferences, workshops, roundtables and backgrounding journalists
- Media monitoring and writing newspaper editorials, speeches and background briefs
- Extensive social media engagement on our various platforms including Facebook, Twitter, Instagram and NACCHO TV via YouTube.

NACCHO's communication objectives involved educating ACCHs' staff regarding NACCHO programs, branding, marketing, event management, sharing success stories between members, and educating our sector, the media and the broader community about NACCHOs' successes.

## SOCIAL MEDIA ENGAGEMENT

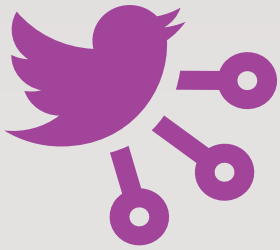
NACCHO continued to regularly communicate with members, media, stakeholders and community 24/7 via a wide range of integrated social media platforms delivering a steady stream of up to date information on Aboriginal national, regional and remote health issues. Our communications emphasis is on sharing positive stories and information from all our network services.

**NACCHO Australia Twitter followers**

**27,900**

**2017-18**

| 2013-14 | 2015-16 |
|---|---|
| 9,907 | 20,600 |
| **2014-15** | **2016-17** |
| 15,604 | 24,200 |



**NACCHO Australia Tweets to date**

**77,400**

**2017-18**

| 2013-14 | 2015-16 |
|---|---|
| 23,100 | 51,400 |
| **2014-15** | **2016-17** |
| 23,100 | 64,500 |

**NACCHO Facebook Followers**

**11,484**

**2017-18**

| 2013-14 | 2015-16 |
|---|---|
| 3,131 | 8,736 |
| **2014-15** | **2016-17** |
| 5,154 | 9,561 |

1. Daily Aboriginal Health News Alert ( www.nacchocommunique.com ) continues to be major online publisher of Aboriginal Health News in Australia having posted over 2,301 informative news alerts over the past 6 years to our 4,753 subscribers. Besides our subscribers our posts have been read over 784,233 times (Daily record 2373) with Pat Anderson's Aboriginal Health and Racism in 2014 having the most readers (20,290) with this one post. This year we have focused and consolidated our posts by servicing our members with weekly Save a dates, job alerts and Deadly good news stories.
2. Twitter: NACCHO was awarded in 2017 a prestigious Blue Tick from Twitter for our bona fides health sector contributions and engagement. Our followers grew to 27,900 and with 77,400 posts to date we are now leaders in the dissemination of Aboriginal health and social determinant news.
3. Facebook: Facebook continues to be a popular channel for our member communications with over 10,000 followers.
4. Instagram: In 2017 we opened an integrated NACCHONEWS account and this account now reaches over 400 followers.
5. NACCHOTV: We continue to utilise our NACCHO YouTube account with ACCHO member interviews embed in our communiques.


NACCHO TV Secretary of the Department of Health Glenys Beauchamp PSM and Wendy Brookman


Pat Turner interviewed by Stan Grant

## MEDIA

NACCHO was interviewed on NITV, Sky News, ABC TV and radio, SBS, Channel Seven, The Wire, FM and AM radio newspapers, magazines and community radio as well as online media like *The Guardian*, Croakey and *New Matilda*.

NACCHO continues to disseminate information relating to Commonwealth policy, grants and programs to support a well-informed health sector and encourage strengthened links with government agencies. The NACCHO Annual Report was published and disseminated to all Affiliates, Member services and government agencies. A number of press releases, member alerts, submissions speeches and papers were published and disseminated.

The NACCHO National Members' Conference and AGM was organised by the communications team and held in Canberra from 31st October - 2nd November 2017. The theme was *Our Health Counts: Yesterday*, Today and Tomorrow. Over 410 delegates attended and heard from over 60 speakers, research bodies and academics. This included keynote address by Ms Glenys Beauchamp, Secretary of the Department of Health and Professor Brendan Murphy, the Chief Medical Officer of Australia.

On the final Day of the Conference the AGM was held and though a majority voted for Constitutional Reform the threshold of 75 per cent was not met. Further consultation ensured on the floor and further consultation was requested and agreed to by delegates. Mainstream health system participants and peak organisations were invited to attend and help strengthen the ACCH sector so that it can maintain and further develop and enhance Aboriginal community controlled health services in an accessible, responsive, and culturally inclusive manner.

NACCHO Chair John Singer responds to NITV on Budget Night after NACCHO staff attended several health Budget Lockups 2018


NACCHO Chairperson John Singer and CEO of the Lowitja Institute Romlie Mokak

## LAUNCHES

National guide to a preventive health assessment for Aboriginal and Torres Strait Islander people

The peak Aboriginal Health body in Australia (NACCHO) and the RACGP have worked together to develop this resource for health professionals. The National Guide is now in its 3rd edition and is one of the most widely used clinical guidelines in Australia. The National Guide can be used by primary healthcare providers. It supports them to provide the best preventive healthcare for Aboriginal and Torres Strait Islander people, anywhere in Australia. The National Guide advises on activities that can help prevent disease, detect early and unrecognised disease, and promote health in Aboriginal and Torres Strait Islander communities, while allowing for local and regional variations.

The National Guide covers many of the major chronic conditions experienced by Aboriginal and Torres Strait Islander peoples. It is supported by evidence-based recommendations, 'good practice points' and child, youth and adult lifecycle wall charts with age-specific recommendations. The team developing the National Guide has included grassroots general practitioners, and researchers who have experience working with Aboriginal and Torres Strait Islander peoples and within Aboriginal community controlled health services.

# STAFF PROFILES

## PAT TURNER AM

Pat is the daughter of an Arrente man and a Gurdanji woman, and was born and raised in Alice Springs. After her father's death in an accident at work, Ms Turner's family experienced extreme financial hardship. Her mother's courage and leadership in the face of such difficult circumstances was a constant inspiration.

Ms Turner joined the Australian Public Service in the early 1970s and joined the senior executive ranks by the mid-1980s. She worked in a range of prominent roles, including as Deputy Secretary in the Department of the Prime Minister and Cabinet during 1991-92, where she had oversight of the establishment of the Council for Aboriginal Reconciliation. In 1994-98, Ms Turner was the CEO of the Aboriginal and Torres Strait Islander Commission, making her the most senior Indigenous government official in the country.

Over the years, Ms Turner became more committed to the politics of self-determination. At a professional level, this meant being a firm supporter of community-based service delivery of health and welfare programs for Aboriginal people.

Today, Ms Turner is the CEO of the National Aboriginal Community Controlled Health Organisation (NACCHO). NACCHO is the peak body representing 145 Aboriginal community controlled health services across the country on Aboriginal health and wellbeing issues.

## DR DAWN CASEY PSM FAHA: DEPUTY CEO NACCHO

Dawn joined NACCHO in November 2016. Dawn is a descendant of the Tagalaka clan in North Queensland. Dawn held part-time positions as the Chair of ILC and IBA and full-time positions of Director of the Western Australian and Powerhouse Museum and National Museum of Australia. Dawn was responsible for managing the design and construction of the National Museum of Australia and the Australian Institute of Aboriginal and Torres Strait Islander Studies through a world first project delivery alliance contract.
Dawn's career also includes a number of key executive positions in the Public Sector in areas including; Department of Prime Minister and Cabinet, Indigenous Affairs, Cultural Heritage and Overseas Aid and Development. Dawn has been awarded three Honorary Doctorates (Charles Sturt, QLD and Macquarie Universities), Commonwealth Government's Public Service Medal (PSM), Australian Government's Centenary Medal, Three Australia Day Public Service Medals, The Australian Institute of Architects' Glem Cummings Award and a Fellow of the Australian Academy of the Humanities.

## OLIVER TYE

I started work at NACCHO in August 2017 as part of the media and communications team. I have since moved into the policy team, where I orchestrate the formulation network pieces such as submissions, position statements and briefs. I still act in a media context as well, doing much of the member communications and other forms of engagement between NACCHO and the broader health sector.

I'm also a descendant of the Wardandi-Noongar mob in the coastal region south of Perth. My mother came to Canberra where I was raised before moving to the South Coast of NSW. I'm in my 4th year of a Science degree at the ANU, graduating this year with majors in Biology and Biological Anthropology. I hope to see NACCHO grow in national influence and reach its potential as a leader in the ACCHO sector.

## WENDY BROOKMAN

Wendy Brookman is a Butchulla woman, the Traditional Owners of K'Gari (Fraser Island). Wendy joined NACCHO in August 2017 and is working in the media and communications team.  Wendy also works as our Membership Services Officer.

Wendy has worked in the fitness industry for over 18 years, owning and operating a Fernwood Women's Health Club in Canberra. Wendy completed her Diploma in Fitness in 2010, as has had extensive experience as a Personal Trainer throughout her career. Wendy is extremely passionate about health and keeping her local Indigenous community active. In 2014 Wendy ran free bootcamps with Indigenous Women in her community in Canberra, and in 2015 teamed up with Medicare Local to expand these bootcamps to include men and into the Queanbeyan NSW area.

Wendy's passion is also engage and discuss with our Indigenous youth about business, health and giving back to your community. Wendy is a mother of five children, which drives her to continue her work in keeping her community as healthy and active as possible for future generations.

## KAYLA ROSS

Kayla Ross was a NACCHO employ who worked as our receptionist and administrative assistant. She recently was successful with the Indigenous Australian Government Development Program in the Department of Foreign Affairs and Trade. The skills and knowledge gained at NACCHO will assist her in her future career and NACCHO wishes her well.

NACCHO Conference


MC Garry Goldsmith welcomes delegates to the National NACCHO Conference

# MEMBERS CONFERENCE AND AGM 2018

## THE THEME OF THE MEMBERS' AND AFFILIATES CONFERENCE WAS, OUR HEALTH COUNTS: YESTERDAY, TODAY AND TOMORROW.

The national Conference and AGM was well attended with 410 registrations and 21 trade tables. The social function proved popular with 1,127 people attending the networking events Karaoke, Songlines Exhibition and Welcome Reception.

NACCHO published the 2016-2017 Annual Report and delegates heard from over 60 speakers at the Conference. At the Conference NACCHO and the Pharmacy Guild of Australia have signed a Memorandum of Understanding focusing on the implementation of Aboriginal and Torres Strait Islander pharmacy programs and trials.

During the AGM, John Singer was elected as the new NACCHO Chairperson and Donnella Mills as Deputy Chairperson. Mr Singer's family is from Ngaangtjara, Pitjantjatjara and Yankunyatjara Lands, which is the cross-border area of Northern Territory, South Australia and Western Australia. Donnella is a Torres Strait Islander woman with ancestral and family links to Masig and Nagir in the Torres Strait.

The proposed new NACCHO Constitution was not passed despite winning a majority of the vote and our Management executive will consult further to facilitate and explain the new constitutional alterations in 2018.

Our request for conference feedback from delegates in various yarning circles was appreciated, informative and helpful to the NACCHO work plan for 2018. It is anticipated that the Brisbane 2018 NACCHO Members' conference and AGM will prove just as popular as last year.

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**Opposite page:**

1. **NACCHO Canberra Conference and AGM**
2. **STI Content Professor Brendan Murphy briefs members about the STI outbreak in Australia**
3. **Jackie Huggins, Pat Turner and Dawn Casey relaxing at the NACCHO Conference**
4. **Tonic Executive Director Dr Norman Swan being interviewed by Young NACCHO Oliver Tye**

1


2

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4

Lakes Entrance Board members

# MEMBERSHIP SERVICES

## OUR WORK WITH NACCHO MEMBER SERVICES WAS ENHANCED WITH THE CREATION OF A NEW FULL-TIME POSITION OF AN INDIGENOUS IDENTIFIED MEMBERSHIP SERVICES OFFICER.

Mrs Wendy Brookman started work in August 2017 as NACCHO continued to build on our relationships with members to enhance their work as primary health care providers in community controlled health settings. The Membership services officer was engaged to facilitate internal communications with 144 Members and provide additional new external communications on the NACCHO website and in social media feeds.

Our NACCHO Member services provide continuity of care so that chronic conditions are managed and preventative health care can be effectively targeted in over 300 health settings. Aboriginal culture has many strengths that can provide a positive influence, such as supportive extended family networks, connection to country and language.

It is imperative that a person's health be considered in the context of their social, emotional, spiritual and cultural wellbeing, and that of their community. We know that being able to better manage and control your own affairs is directly linked to improved wellbeing and mental health. Studies have shown that Aboriginal controlled health services are 23 per cent better at attracting and retaining Aboriginal clients than mainstream providers.

NACCHO is committed to being responsive to our members needs and celebrating their stories and highlighting their successful case studies to federal, state and territory governments. The Member services officer conducted site visits in various Aboriginal community controlled health settings to obtain a better understanding of how NACCHO can assist on the ground. Services visited included Awabakal, Burri Burri, Kambu, Katungul, Kalwun, Ipswich, IUIH, Lakes Entrance, Redfern, VAS, Winnunga.

Young NACCHO staff Oliver Tye receives his flu shot from Clinical staff from Winnunga Nimmityjah Aboriginal Health and Community Services


Wendy Brookman at the Institute for Urban Indigenous Health in Brisbane

In 2018 the national office is focused on increasing our health policy capacity and advocating for our Members' interests in Canberra. Our network of Member services also provides a critical and practical pathway into employment for many Indigenous people. Currently, 56 per cent of our 6,000 staff are Indigenous. Our NACCHO Board is supported by a small but motivated staff secretariat based in Canberra and they are the first point of contact regarding policy, advocacy, media and education. Our new office is now located on Level 5 East, 2 Constitution Avenue, Canberra City and all our phone numbers and emails remain the same.

The Board recently decided that NACCHO Member Anniversaries at AGMs will be as celebrated as follows:

- 25- and 30-year anniversaries – framed certificate
- 40-year anniversaries – framed certificate and Wathaurong Platter and
- 50-year anniversaries - framed certificate and a plaque.

Membership of NACCHO is open to member organisations of our State or Territory peak Aboriginal Community Controlled Health Organisations (ACCHS's) affiliated with NACCHO that have been deemed by the respective peak body to have met the following criteria for membership:

- an incorporated Aboriginal organisation
- initiated by a local Aboriginal community
- based in a local Aboriginal community
- governed by an Aboriginal body that is elected by the local Aboriginal community, and
- delivering a holistic and culturally appropriate health service to the Community that controls it.

We welcomed an additional member in the Northern Peninsula Area Family and Community services advising them of the successful application in 2018.


**A fantastic and fun basketball book series by Australian Olympian and San Antonio Spurs NBA star Patty Mills who entertained young readers at Marist College Primary school in Canberra. His books inspire children of all ages to achieve their goals through sport and showcase Patty's pride in his Indigenous heritage.**

**Indigenous Marist students Jack Janke and Will Janke with Daniel Fitzgerald enjoyed reading their new books.**

# TRIBUTE TO **SOL BELLEAR** ABORIGINAL ACTIVIST

NACCHO CHAIR JOHN SINGER SPEAKING ON BEHALF OF ALL THE 145 ABORIGINAL COMMUNITY CONTROLLED HEALTH SERVICES THROUGHOUT AUSTRALIA SAID HE WAS SADDENED TO HEAR OF THE UNTIMELY PASSING OF ONE OF THE NATION'S LEADING SPOKESPEOPLE ON ABORIGINAL HEALTH ISSUES, MR SOL BELLEAR AM. SOL WAS A RESPECTED ELDER, FRIEND, LIFETIME ABORIGINAL ACTIVIST, A CO-FOUNDER AND CHAIR OF ABORIGINAL MEDICAL SERVICE REDFERN AND A RECENTLY APPOINTED NACCHO BOARD MEMBER.

*"We would like to record our sincere gratitude and admiration for Sol's service to our nation and communities, and tender our profound sympathy to his family and community in their bereavement, Mr Singer said.*

Sol Bellear, a Bundjalung man from Mullumbimby, was also the first chair of the Aboriginal Legal Service when it was founded in the early 1970s.

In 1990 Sol became a member of the Aboriginal and Torres Strait Islander Commission (ATSIC), where he served as deputy chair before stepping down in 1994. Throughout his career he advocated a philosophy of community control, self-reliance and independence, attributes that would be vital for the survival of ACCHO's over the decades.

Mr. Singer said Sol Bellear was an inspiration to everyone involved with or interested in Aboriginal issues and specifically Indigenous health. He was admired and respected leader who served his community for nearly 50 years.

*" Sol was a tireless worker for his people," Mr Singer said.*

"He travelled all over Australia and the world championing the cause of Indigenous Australians as we have had historically some of worst health outcomes in the western world." He was a fearless advocate not afraid to take on politicians and bureaucracies.

"And he certainly was a man of great compassion and commitment to improving the health of his Redfern Community and all Indigenous Australians."

*"Sol Bellear leaves an important legacy that must be carried on by the board of NACCHO and all our members if indigenous Australians are to ever enjoy health services and standards that other Australians take for granted," Mr Singer concluded.*

# STATE AND TERRITORY

## ABORIGINAL HEALTH AND MEDICAL RESEARCH COUNCIL OF NSW

**Address:** Level 3, 66 Wentworth Avenue, Surry Hills, NSW 2010

PO Box 1565 Strawberry Hills, NSW 2012

**T** (02) 9212 4777
**F** (02) 9212 7211
**E** ahmrc@ahmrc.org.au
**W** www.ahmrc.org.au

## ABORIGINAL HEALTH COUNCIL OF SOUTH AUSTRALIA LIMITED

**Address:** 220 Franklin Street, Adelaide SA 5000

PO Box 719 Adelaide SA 5001

**T** (08) 8273 7200
**F** (08) 8273 7299
**E** ahsca@ahsca.org.au
**W** www.ahsca.org.au

## ABORIGINAL HEALTH COUNCIL OF WESTERN AUSTRALIA

**Address:** 450 Beaufort Street, Highgate WA 6003

PO Box 8493 Business Centre WA 6849, Sterling Street Perth WA 6000

**T** (08) 9227 1631
**F** (08) 9228 1099
**E** reception@ahcwa.org
**W** www.ahcwa.org.au

## ABORIGINAL MEDICAL SERVICES ALLIANCE NORTHERN TERRITORY

**Address:** MOONTA HOUSE 43 Mitchell Street, Darwin NT 0800

GPO Box 1624, Darwin NT 0801

**T** (08) 8944 6666
**F** (08) 8981 4825
**E** reception@amsant.org.au

## QUEENSLAND ABORIGINAL AND ISLANDER HEALTH COUNCIL

**Address:** Level 2, 55 Russell Street, South Brisbane QLD 4101

PO Box 3205 South Brisbane QLD 4101

**T** (07) 3328 8500
**F** (07) 3844 1544
**W** www.qaihc.com.au

## TASMANIAN ABORIGINAL CENTRE

**Address:** 198 Elizabeth Street, Hobart TAS 7001

GPO Box 569 Hobart TAS 7001

**T** (03) 6234 0700
**F** (03) 6234 0799
**E** hobart@tacinc.com.au
**W** www.tacinc.com.au

## VICTORIAN ABORIGINAL HEALTH COMMUNITY CONTROLLED HEALTH ORGANISATION

**Address:** 17-23 Sackville Street, Collingwood VIC 3066

PO Box 1328 Collingwood VIC 3066

**T** (03) 9411 9411
**F** (03) 9411 9599
**E** enquiries@vaccho.org.au
**W** www.vaccho.org.au

## WINNUNGA NIMMITYJAH ABORIGINAL HEALTH AND COMMUNITY SERVICES LTD

**Address:** 63 Boolimba Crescent, Narrabundah ACT 2604

**T** (02) 6284 6222 or free call 1800 120 859 or 1800 110 290
**F** (02) 6284 6200
**W** www.winnunga.org.au


Aboriginal Health and Medical Research Council of NSW Building

## ABORIGINAL HEALTH AND MEDICAL RESEARCH COUNCIL OF NSW

IN 2017, ABORIGINAL HEALTH AND MEDICAL RESEARCH COUNCIL OF NSW (AH&MRC) WENT THROUGH A YEAR OF CHANGE. THIS BEGAN WITH THE CREATION OF THE AH&MRC'S ACTION 2020 PLAN WITH THE THEMES OF RENEWAL, UNITY AND STRENGTH. USING THIS AS OUR DRIVING FORCE, AH&MRC HAS BEEN COMMITTED TO MAKING 2017-2018 THE YEAR OF IMPLEMENTATION AND INNOVATION.

AHMRC continues to provide support and assistance to the Member Services to build capacity and capability of ACCHSs by incorporating and enhancing continuous quality improvement (CQI) initiatives both clinical and non-clinical activities within their primary health care service to ultimately improve patient health outcomes.

*In the past year, the team has visited 13 Aboriginal Medical Services across the state of NSW.*

These were Viney Morgan AMS, Orange AMS, Tamworth AMS, Waminda, Yerin, Bourke, Brewarrina, Bullinah, RivMed, Ungooroo, Awabakal, Griffith AMS and Pius X.

The team provided PIMS data quality training, guidelines for chronic disease management workflows, guidance for Medicare maximisation, ongoing support for organisational accreditation and best practice.

We have focused on a range of issues, including primary health care, sexual health, mental health, social emotional and wellbeing. AH&MRC has provided National and State policy advice on the following submissions: Closing The Gap Refresh submission, NDIS Aboriginal Service Sector, Aboriginal Child Protection Policy paper, changes to registration for Aboriginal and Torres Strait Islander Health Practitioner's, 8th edition healthcare in Focus 2017: *How does NSW compare* report for the Bureau of Health Information peer review, Review of the Cervical Screening training conduct by Benchmarque group, participation in the evaluation for the Centre for Aboriginal Health, IAHP New Funding Model, Aboriginal Sexual Health Program – NSW, Chief Health Officer's Annual Report (Aboriginal Kids – A healthy start to life), consultation paper on Out Of Home Care, NSW Aboriginal Patients' Experiences Briefing Paper and Their Futures Matter Briefing Paper.

Additionally, in the last year we have successfully worked on the following state and national projects: Take Blaktion, NSW Syphillis Working Group, AH&MRC NSW Member Service Chief Executive Forum, Needs Analysis for Member Services, provided training such as the Trauma Informed Practice and Motivational Interviewing, the AH&MRC NSW Cancer Forum, Aboriginal Early Childhood Conference, Tackling Tobacco Champions for NRT and the AH&MRC Strategic Planning Day.

*We continue to build strong relationships and partnerships within the last year seeing a range of stakeholder relationship come to fruition. The 33 strategical aligned partnerships which have been formed by the AH&MRC since the restructure ensure that they benefit our Member Services through advocacy, funding opportunities, and that our Members are provided with policy and advice on issues affecting our sector.*

Our Aboriginal Health College (AHC) has provided full qualifications for 29 students on a Diploma level, 29 students on a Certificate IV level and 10 students on a Certificate III level. Additionally, AHC has awarded statement of attainment to eight students on a Diploma level and eight students on a Certificate IV level.
In 2017, AHC has delivered the Diploma of Nursing course successfully and began the Diploma of Counselling course that has been suspended until further notice. The AHC has catered over 12 external venue hires in the past year and continues to receive more bookings.

The Research Ethics and Governances Team (REGT) have relocated to the Aboriginal Health College at Little Bay. The Ethics Committee has been working hard over the last twelve months and since 1st July 2017, there have been 133 applications submitted to the AH&MRC Ethics Committee for full Human Research Ethics Committee review.

*AH&MRC has always been committed to the 49 Aboriginal Medical Services across NSW and will continue to provide support to Member Services through training opportunities, development of policy at a National and a State level, regional workshops, strategic partnerships, ethical research and education.*

AHCSA accepting the Karaoke Trophy for 2017.

# ABORIGINAL HEALTH COUNCIL OF SOUTH AUSTRALIA LIMITED

BEING THE PEAK BODY FOR ABORIGINAL HEALTH IN SOUTH AUSTRALIA, THE ABORIGINAL HEALTH COUNCIL OF SOUTH AUSTRALIA (AHCSA) AS AN ORGANISATION HAS PARTICIPATED IN A WIDE RANGE OF MEETINGS, FORUMS AND CONFERENCES TO PROVIDE INPUT AND ADVOCATE ON BEHALF OF OUR MEMBER SERVICES AND ABORIGINAL COMMUNITIES. AHCSA CONTINUES TO HAVE STRONG WORKING RELATIONSHIPS WITH OUR FUNDERS AND PARTNERS AS WE WORK TOGETHER TO IMPROVE THE HEALTH OUTCOMES OF ABORIGINAL PEOPLE IN SOUTH AUSTRALIA.

AHCSA has continued to maintain solid relationships and ongoing support from key stakeholders including Wardliparingga Aboriginal Research Unit from the South Australian Health and Medical Research Institute (SAHMRI), Cancer Council SA, Heart Foundation, the South Australian Council of Social Services (SACOSS), Health Consumers Alliance, Mental Health Coalition, Rural Doctors Workforce Agency (RDWA), GPEx, Lowitja Institute, and the Adelaide and Country South Australia Primary Health Networks. AHCSA also enjoys strong links with the University sector both within South Australia and interstate.

### Public Health Medical Officer

The PHMO role continues to provide public health advice and support to AHCSA and its member services, with involvement in a wide range of activities and initiatives. Activities that received particular attention in 2017-18 included: working closely with the AHCSA ear health program and the Rural Doctors Workforce Agency to further support the capacity of ACCHS to identify and manage middle ear disease particularly in young children; the coordination and delivery of a community-wide Meningococcal W vaccination program in partnership with Umoona Tjutagku Health Service; continued to advocate with SA Health immunization to change the current Vaccine Administration Code to enable AHPs to independently vaccinate with additional training and appropriate supervision; and on behalf of two Members, drafted a submission to a senate parliamentary inquiry into the implementation of the Cashless Debit Card Trial (CDCT).

### The Quality Systems Team

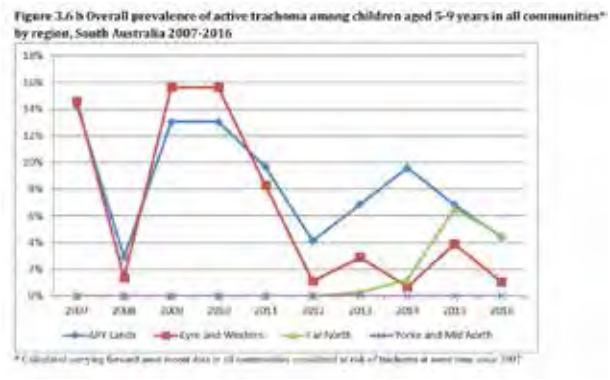
The Quality Systems Team provides comprehensive clinical and organisational support to Members by applying a continuous quality improvement (CQI) focus to patient information management systems, data collection and analysis, and clinical governance. Some of the projects have been: Medicare Access Improvement Program; SA Quality Improvement Data (SQID) Cycles - a state-based, three-monthly, interactive clinical quality improvement cycle; Communicare Projects; Clinical Governance Project; General Practice Registrar Program; GP Registrar Workforce in SA; and the AHCSA Member Portal.

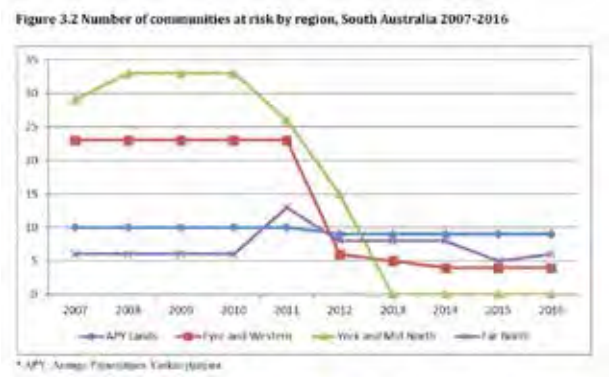
### Blood Borne Virus

The AHCSA Blood Borne Virus Program works with Aboriginal health services and the broader health sector across South Australia supporting the prevention and management of viral hepatitis. Program activity over the 2017/18 reporting period has focused on promoting the new treatments for hepatitis C, strengthening patient information management system, undertaking clinical audits, improving workforce knowledge through education workshops, health promotion activities, and working with a range of services to expand the number of needle and syringe programs operating across South Australia.

### Trachoma Elimination Program

The number of at-risk communities in SA has reduced from 11 to 7 in 2018. In 2016 the observed prevalence of trachoma in SA was 2.8%. AHCSA's Trachoma Elimination Project Officer attended WHO Trachoma Grader training in the Solomon Islands. As one of three people in Australia with this training it will help ensure the quality of South Australia's trachoma grading data. On a national level it will help provide confidence in the quality of the dossier to be submitted to the World Health Organisation by 2020 to show that Australia has been successful in eliminating blinding trachoma. There is a greater focus on environmental health across local, state and national levels which will help in eliminating blinding trachoma and prevent it recurring post 2020.




### The AHCSA Eye Health Program

The AHCSA Eye Health Program has two main functions: to support and provide leadership for member health services, including capacity building and onsite staff training in Primary Eye Health Care and Vision Testing; and on the ground service delivery – coordinate/facilitate/attend periodic optometrist/ophthalmologist visits to ACCHSs within SA. Core program visits run twice yearly to 12 communities - Ceduna, Yalata, Oak Valley, Tjuntjuntjara (WA), Coober Pedy, and 7 communities within the APY Lands. The Program also supports the visiting optometry service to Whyalla, Murray Bridge and Raukkan. AHCSA, largely through the Eye Health Program, is proudly the sole Aboriginal organisation within the Consortium who won the tender to deliver the National Eye Health Equipment Project. This Project is rolling out new retinal cameras and associated training to Aboriginal health services across the country, and the AHCSA Eye Health Project Officer is the lead trainer for SA.

### Maternal Health Tackling Smoking

Since commencement of the Maternal Health Tackling Smoking (MHTS) program at AHCSA in 2010, we have seen a steady decline (11.6%) in smoking rates of pregnant Aboriginal women in SA. Current statistics indicate that there has been a further decrease in smoking rates in Aboriginal pregnant women in SA to 41.6% at the first antenatal visit, further declines in smoking rates at the second trimester is the common trend.

Tackling Indigenous Smoking

The Program had a reach of 121 engagements/ activities over the 17-18 period with an increase of 74 people from late December. Approximate calculations of the number of Indigenous people accessing and attending the program, activities and receiving information, have found that over 3,800 people have been involved with the program. This has a potential reach beyond the numbers of people, extending to family members of children and youth receiving the smoke free messages, organisations and workforce receiving tobacco education and available services to support quitting. AHCSA has received a new agreement and the programme will continue until June 2020.

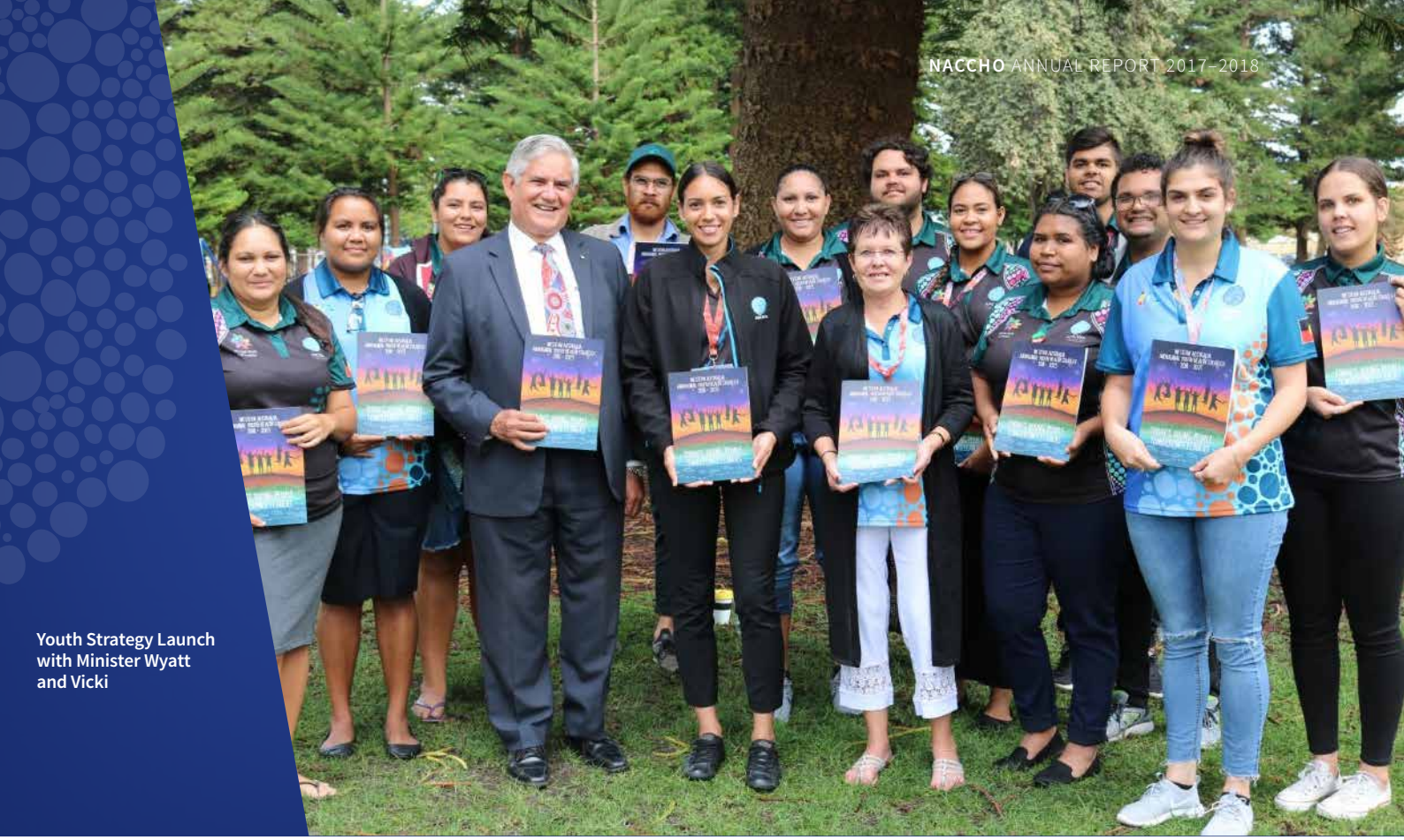
Research

There are currently three projects at AHCSA working with our Members at the moment and our partners – SAHRMI, University of South Australia, Northern Adelaide Local Health Network, and the Robinsons Institute: the Shedding the Smokes project funded through the Department of Health: the Gender Equity (due to finish in October 2018) and the Strong Dads Strong Futures both funded through the Lowitja Institute.

AHCSA Registered Training Organisation (RTO)

For the 2017-18 period AHCSA has seen the commencement of five new class intakes, including one Certificate III class and four Certificate IV Practice classes. In addition to these new class groups, the RTO also had two Certificate IV level classes continue on from 2017, bringing the total number of active students to 65.

From 2015 to 2017 inclusive, AHCSA has seen 135 program enrolments (full qualifications). To date 73 full qualification completions have been recorded, with a further 21 continuing with anticipated completion before the end of 2018. This would bring AHCSAs completion rate from January 2015 to June 2018 to 69.62% for full qualifications.



Youth Strategy Launch with Minister Wyatt and Vicki

# ABORIGINAL HEALTH COUNCIL OF WESTERN AUSTRALIA

**Chairperson's Report – Vicki O'Donnell**

About Us: The Aboriginal Health Council of Western Australia (AHCWA) exists to support and act on behalf of our 22 Member ACCHSs throughout WA. AHCWA aims to promote and strengthen the ACCHS Model of Care, which is built around the delivery of comprehensive, holistic and culturally secure primary health care services.

We come together as one to: respect, welcome and understand the social and cultural needs; network; provide support; advocate; influence policy; monitor performance; build work capacity; improve and strengthen the social and emotional wellbeing of Aboriginal people and their communities.

We advocate for the rights and entitlements of all Aboriginal people and ACCHS throughout Western Australia at local, regional, state and national levels. AHCWA is the leading authority for Aboriginal primary health care in Western Australia.

ACCHS Model of Care: At AHCWA's annual conference held in April 2018, the WA ACCHS's Model of Care was showcased through a theatrical play performed by a cast of young local Aboriginal actors. The Model of Care underpinned by eight fundamental dimensions pivotal to the health and wellbeing of Aboriginal people and their communities.


WA Aboriginal Youth Health Strategy - 'Today's Young People, Tomorrow's Leaders': During the conference, The Hon. Ken Wyatt AM, MP - Minister for Aged Care; Minister for Indigenous Health, launched the Strategy, which accentuates the rights of all young Aboriginal people to look to the future with cultural pride and strength, and to embrace life's experiences, including the challenges, with optimism and resilience.

The W.A. Aboriginal Health Ethics Committee (WAAHEC): Our WA Committee continues to be inundated with applications to carry out research on our people. A new initiative during the 2017/18 year was to invite two young Aboriginal people to sit on WAAHEC to ensure that the voices, opinions and concerns of young Aboriginal West Australians are heard. The AHCWA Directors also invite a representative of the AHCWA Youth Committee to attend all Board meetings, which has been a great success, particularly in relation to numerous concerns raised in the new My Health Record.

Certificate II in Family Well-being: AHCWA recently began delivering training in the Certificate II in Family Wellbeing. The aim of the training is to increase awareness of all the contributing factors that impact on family wellbeing and to identify strategies to help build better foundations to overcome these factors. The FWB program aims to bring together Aboriginal Health professionals and others who work

with Aboriginal people, to gain the necessary skills to be able to support individuals, families and communities to overcome their social and emotional challenges and to help create stronger communities and family environments.

'WA Aboriginal Smoking Cessation Brief Intervention Training Package: An exciting new initiative, developed in a partnership between the AHCWA TIS Program and the Broome Regional Aboriginal Medical Service (BRAMS) TIS Team has seen the creation of the WA Aboriginal Smoking Cessation Brief Intervention Training Package. With support from the WA Aboriginal Tobacco Control Strategic Leadership Group, the new training package provides participants with a variety of skills, up to date information and the confidence to have a yarn with clients about their smoking. More than 300 participants from other TIS Teams, ACCHS and others working with Aboriginal people, have completed the training and put their work into practice. The project's motto is: 'Quit Today for a Healthier Tomorrow – Promoting Smoke-free Western Australian Aboriginal Communities, protecting our next generation'.

A significant number of WA Member Services celebrated milestone anniversaries during the 2017/18 year including the Carnarvon Medical Service Aboriginal Corporation (CMSAC), Wirraka Maya Aboriginal Health Service (WMAHS), Derby Aboriginal Health Service (DAHS), Broome Aboriginal Medical Service (BRAMS) and the South West Aboriginal Medical Service (SWAMS).

**CEO – Des Martin**

The Nation's Health System is in a continuous state of reform and change. As the architecture of the Health System undergoes change, we are very mindful that the voice of the Aboriginal Community Controlled Health Sector cannot afford to be silent.

Funding Formula: Work has continued with the Commonwealth to finalise the funding formula for Member Services under the Indigenous Australians' Health Program (IAHP) to provide primary health care services and it is hoped that this is completed in a timely manner. AHCWA has been involved in a great deal of lobbying to ensure that the final formula acknowledges the specific needs of Aboriginal Western Australians, especially those living in remote and very remote locations.

My Health Record: This continues to be a priority, with much work needing to be done by the Commonwealth Government and the Australian Digital Health Authority (ADHA) to ensure AHCWA and therefore, Members Services are fully informed, concerns addressed and that the scheme operates in the very best interest of Aboriginal people and clients.

Policy: AHCWA has been involved in significant policy work over the past 12 months, particularly in relation to the National Disability Insurance Scheme (NDIS), which will inevitably create new challenges for our Member services. Progress to date includes negotiations and discussion with the State-wide Manager for the National Disability Insurance Agency for ACCHS engagement; the Western Australian community connector of the First Peoples National Disability Network and lobbying the Minister for Disability Services to secure representation on the Western Australian NDIS Transition Governance Advisory Group.

AHCWA also contributed to National Policy responses on the National Alcohol Strategy and the HTLV-1 Briefing for the Minister for Health. On a state level, we coordinated the WA Aboriginal Health Partnership Forum response to the WA Health Sustainable Health Review and provided feedback to the Department of Finance DCSP policy.

Mappa
Mapping Health Services Closer to Home

Mappa: WA is a massive state with large numbers of Aboriginal people living in remote and very remote communities. Accessing health and allied health services, hospitals and specialist care can be problematic for people living in these locations. It can also be difficult for the specialists and hospitals who have little or no understanding of how far our people have to travel to receive treatment and care. AHCWA initiated the development of a free-to-use online mapping tool, which we call Mappa. Funding for this project was provided by the W.A. Department of Health.

The aim of Mappa is to improve the patient experience and journey by providing reliable and up to date information about ACCHSs and other health service providers to ensure that patients living rural and remote, particularly Aboriginal people and their communities, are well serviced and informed. The Mappa Phase 2 (Controlled Live Trial) is underway with Royal Perth Hospital (RPH) and selected sites in the Kimberley and Pilbara taking part. Mappa may one day be expanded for use in other states and territories.

AHCWA continues to support our Member Services and when requested, we step in to provide assistance to services at risk. Support provided includes operational management, clinical governance, HR management, organisational culture and change management, audit/compliance and IT support/upgrades. Whilst this support has seen many AHCWA personnel make huge commitments by spending time away from home, we aim to ensure that our Member Services remain in Aboriginal hands and continue operations with limited or no disruption to service delivery.


Dr Michael Adams, Joe Williams, Patrick Johnston and John Paterson

# ABORIGINAL MEDICAL SERVICES ALLIANCE NORTHERN TERRITORY

AMSANT'S YEAR WAS PUNCTUATED BY THE 'BEFORE' AND 'AFTER' OF THE HANDING DOWN, IN NOVEMBER 2017, OF THE REPORT AND RECOMMENDATIONS OF THE ROYAL COMMISSION INTO THE PROTECTION AND DETENTION OF CHILDREN IN THE NORTHERN TERRITORY

This was always going to be a watershed issue for Aboriginal people in the NT, with no less than the future welfare of our children at stake. For AMSANT and our members, a priority was ensuring that the way forward was framed by a public health approach and therapeutic responses and integrated with comprehensive primary health care. Along with our fellow Aboriginal Peak Organisations NT (APO NT) members, we provided strong leadership to ensure that the reforms will be Aboriginal-led and evidence-based.

The combined Aboriginal response included producing a comprehensive set of briefing papers and conducting advocacy on key reforms including the development of a single act covering child protection and juvenile justice. AMSANT was also involved with APO NT in the development of the model and terms of reference for a Children and Families Tripartite Forum, which will complement the existing NT Aboriginal Health Forum. AMSANT is represented on the Tripartite Forum.

An important focus for us over the past year has been assisting member services in transition to community control processes. Highlights have included the continuing progress with the transition process for Red Lily Health Board towards beginning taking over service delivery roles, and successfully gaining approval for the Malabam Health Board to become a priority transition site. Miwatj Health Service has continued progress towards taking over a further two NT Government clinics. This is in addition to support that we provide to members across a range of areas including HR, finance, workforce development, patient information records systems (Communicare), eHealth and IT, CQI and public health. AMSANT's support is particularly important for smaller member services, such as Pintubi, Ampilatwatja and Peppimenarti Health Association, that from time to time face significant challenges associated with their limited size and remote locations.

Much of AMSANT's staff time is taken up in engaging with funders and assisting member services with a range of Commonwealth, Northern Territory Government and NT PHN programs. The Health Care Homes trial involves six ACCHS members, however, implementation of the trial of this promising model in the NT has been hampered by technical issues outside of the control of ACCHSs, which have resulted in frustrating delays. Problems with the risk stratification tool in particular, have delayed recruitment to the trial and AMSANT is concerned that this

will affect the ability of the trial to demonstrate improved outcomes under the current evaluation timeline.

The automated reporting regimes demanded by funding bodies, and requirements for individual level data, for example, through the Mental Health Minimum Data Set (MDS), have re-ignited the debate on 'secondary use of data' and data sovereignty. AMSANT has advocated in support of our members to ensure data requests are appropriate and strong protection and governance standards are in place. AMSANT and its members are supporters of electronic sharing of health records and AMSANT has advocated in relation to the My Health Record (MHR) expansion and opt out process and the framework for the secondary use of MHR data.

The new Commonwealth Indigenous Health Division funding model for ACCHSs, to be implemented from 1 July 2019, is still in development and AMSANT has advocated on a range of concerns with the model. The pay for performance element has been scrapped but concerns remain with the proposal for benchmarks for Medicare revenue, and the use of the 2018 nKPI data extraction round for calculating initial funding levels. AMSANT also expressed concern that the 2.5% population growth money for Aboriginal people for 2017-18 was allocated to the Primary Health Care Networks rather than directly enhancing service delivery through ACCHSs. The future use of this growth money remains uncertain.

At the NT jurisdictional level, AMSANT has engaged with a number of initiatives stemming from reforms around child and family services. The NT Early Childhood Development Strategy was completed and includes a commitment to implement seven key core services identified through the NT Aboriginal Health Forum. AMSANT also contributed to the development of an NT Child and Adolescent Health and Wellbeing Plan, and the consultation process for reforming processes on entry into the child protection system.

A further area of early childhood has been processes for the expansion of nurse home visiting programs in the Territory, with both the Commonwealth and NT governments rolling out additional Nurse Family Partnership Program sites and the NT also adopting plans to offer the MESCH program in the NT.

Following a workshop convened in 2016, AMSANT has continued to advocate in relation to the worsening syphilis outbreak in Northern Australia. The Commonwealth Government has committed funds to an enhanced response to the syphilis outbreak, including in Darwin, and has agreed to additional funding for ACCHSs in the Katherine, East Arnhem and Maningrida regions.

A significant achievement during the year was the Launch of the NT Aboriginal Health Academy, a joint initiative between AMSANT and the Indigenous Allied Health Australia (IAHA). The academy is a community-led model that is about re-shaping and redesigning how training is delivered to Aboriginal and Torres Strait Islander high school students.

The development of capacity of our members in delivering social and emotional wellbeing services has also continued as a priority for AMSANT, with further consolidation of our Social Emotional Wellbeing & Trauma Informed Care Support team.

For a number of years now, AMSANT's membership of the Aboriginal Peak Organisations NT (APO NT) alliance, has resulted in significant successes in engaging and achieving progress across a range of social determinant areas in the NT. AMSANT has been actively engaged in the implementation of the Local Decision Making (LDC) policy of the NT Government that will see greater delivery of services by Aboriginal controlled organisations. This includes development of the Aboriginal Housing NT (AHNT) committee, supported by APO NT, to become the peak Aboriginal housing body for the NT. AMSANT has supported APO NT in conducting a project to develop an Aboriginal controlled out of home care sector in the NT and on other initiatives related to the Royal Commission reforms in children and family services.

APO NT has also developed a widely supported alternative model for remote employment seeking to replace the current failed CDP program that our members have reported as causing significant impacts in remote communities as a result of high levels of financial penalties and disengagement from the scheme.

AMSANT is committed to ensuring that health research involving our communities is culturally safe and directed by the community through better engagement with health researchers. AMSANT is a partner in a number of research projects, including the Mayi Kuwayu National Study of Aboriginal and Torres Strait Islander Wellbeing, and, in partnership with Human Capital Alliance (HCA), is undertaking a national workforce research project on career pathways for Aboriginal & Torres Strait Islander health professionals funded through the Lowitja Institute. AMSANT's Research Subcommittee considers requests from researchers for support from AMSANT, and the CEO also chairs the Central Australian Academic Health Science Centre (CAAHSC).

During the year, the AMSANT Board embarked on a process to develop a new strategic plan and to also develop a cultural safety framework. This was the first year of the change in the process of funding AMSANT by the IHD to the new Network Funding Agreement sitting under NACCHO. AMSANT also participates in the new NACCHO Policy Network.


NACCHO Membership services officer Wendy Brookman at Kalwun Health Service

# QUEENSLAND ABORIGINAL AND ISLANDER HEALTH COUNCIL

QAIHC CONTINUES TO DELIVER HIGH QUALITY SUPPORT TO THE ABORIGINAL AND TORRES STRAIT ISLANDER COMMUNITY CONTROLLED HEALTH SERVICES (ATSICCHS) SECTOR IN QUEENSLAND. QAIHC HAS STRENGTHENED ITS' ORGANISATIONAL CAPACITY BY REALIGNING SYSTEMS AND TEAM STRUCTURES TO BETTER RESPOND TO THE NEEDS OF OUR MEMBER SERVICES.

Our service to Members has delivered pleasing results, including securing approximately $3 million in program funding to directly support increased needs within our sector. New funding programmes focus on Sexual Health, Rheumatic Heart Disease and Alcohol and Other Drugs; these projects will contribute to the priority health needs of Queensland's Aboriginal and Torres Strait Islander communities.

QAIHC is pleased to have achieved recertification and transition to the ISO9001:2015 standards. Similarly, QAIHC has supported 23/24 (eligible) Member Services to achieve Organisational Accreditation and all eligible Member Services to achieve Clinical Accreditation.

**Celebrating Our Members**

In November 2017 QAIHC hosted the inaugural QAIHC Awards for Excellence. The Awards were held with the support of partners established to recognise the exceptional performance of individuals and teams who work in Queensland Aboriginal and Islander Community Controlled Health Services who have demonstrated outstanding achievement in activities that are aligned to QAIHC's vision.

The winners were;

- QAIHC Member of the Year Award – Gurriny Yealamucka Health Service Aboriginal Corporation, Yarrabah
- QAIHC Leader of the Year – Aunty Gail Wason, Mulungu Aboriginal Corporation, Mareeba
- QAIHC Partnership Excellence– Cunnamulla Aboriginal Corporation for Health, Cunnamulla
- QAIHC Innovation Excellence – Carbal Medical Services, Toowoomba
- QAIHC Patient Satisfaction & Service Excellence Award – The Dental Team, Wuchopperen Health Service, Cairns

The evening also celebrated past Hall of Fame recipients and paid tribute to 4 departing Chief Executive Officers of Member Services. The QAIHC Awards for Excellence were sponsored by CheckUp, General Practice Training QLD, Generalist Medical Training and Health Workforce Queensland.

**Developing Our Sector**

QAIHC provided exciting training opportunities this year, including Chronic Disease workshops, Medical Reception, immunisation, Otitis Media (in conjunction with Benchmarque and CheckUp) and regional Data and Reporting Workshops. Additionally, QAIHC hosted several Member forums designed to provide advice, up-to-date information, systems and facilitate the sharing of best practice. Forums included Finance and HR, Clinical leadership and Continuous Quality Improvement (CQI).

QAIHC's Regional Managers have offered an expanded suite of services to Members including: governance, clinical governance, Model of Care, workforce strategy planning and support, advocacy, research and data analysis, service mapping ad stakeholder engagement, data management support and analysis and general research. The Regional Managers have commenced the development of Service Delivery Statements demonstrating a commitment to focusing service delivery towards the specific needs of each service.

QAIHC's IT Department has produced a large scope of works this year for Members delivering over 500 hours of work including technical advice, hardware install and upgrade and procurement advice and support.

In supporting the Social and Emotional Wellbeing workforce in QLD, the QAIHC SEWB team hosted Regional Forums and the Annual State Gathering was held in May 2018 in the Gold Coast. This year the SEWB team also hosted the inaugural Program Manager's Meeting starting a network of SEWB program managers in the state. In consultation with the sector a new Training Needs Analysis was developed and will be used to survey the SEWB workers in Queensland to ensure minimum skills and qualification standards are met and to identify the training and professional development needs of the sector.

**Advocating for Our Members through Policy and Research**

QAIHC's policy presence has increased in 2017/18 with the release of written submissions informed by Member Services, such as; Salary Support Program, the Integrated Team Care review, the Queensland Productivity Commission – Service Delivery in Remote Communities, A response to the revised registration standards for Aboriginal and Torres Strait Islander Health Practitioners and the Closing the Gap Refresh: The Next Phase. In 2018, policy positions are being developed in relation to Medicare-generated income, section 19(2) Health Insurance Act, Transition to Community Control and a submission to the review of the Commonwealth's review of the Corporations (Aboriginal and Torres Strait Islander) Act 2006.

In supporting the NACCHO policy sub-committee QAIHC has taken the lead on working with other Sector Support Organisations to develop a documented Model of Care for the ATSICCHS Sector. Consultation on the Model of Care resource will take place late 2018.

The growth in the research capability at QAIHC has produced pleasing results. The Health Information Team is using sophisticated Business Intelligence software to produce a volume of modern data reports for services designed to encourage clinical improvements and support evidence-based practice. Additional staff in 2018 will see the research portfolio at QAIHC continue to grow and provide Member Services with greater assistance in terms of building general research capability. The Policy and Research team have been engaged as experts in several high-profile research opportunities involving data collaboration, genomics, evaluation and CQI.

**Stakeholder Partnerships**

QAIHC continues to strengthen relationships with the broader health system, supporting increased cultural safety and advocating for the ATSICCHS sector. The Queensland Aboriginal and Torres Strait Islander Health Partnership with Department of Health and Queensland Health has achieved pleasing results this year with agreement reached in relation to a set of 7 key strategic priorities and a renewed Terms of Reference.

QAIHC continues its long-standing partnership with CheckUp to support the delivery of outreach services to urban, rural and remote locations and high-need populations throughout Queensland.

On National Close the Gap day this year, a new Memorandum of Understanding between QAIHC and the Heart Foundation was executed demonstrating a shared commitment to reducing the health disparities between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians, particularly in terms of the rates of cardiovascular disease.

QAIHC and the Stroke Foundation are working together to review the Stroke Foundation's "My Stroke Journey" information and resources, to ensure it meet the needs of Aboriginal and Torres Strait Islander people who have suffered a stroke and are in hospital or are returning to their community.

As part of the Queensland Government's Action on Ice Strategy, the Queensland Department of Child Safety, Youth and Women provided funding to QAIHC to employ a Project Officer and to participate as a partner in the development and delivery of the Breakthrough for Families Queensland program, which will occur in 2018-19 and 2019-20. The BFFQ program is designed to support families (particularly those with children) and significant others who are affected by methamphetamines and other substances by providing information, developing support strategies and connecting them to treatment and other services.

Diabetes Queensland has engaged QAIHC to work with the My Health for Life (MH4L) team to develop culturally appropriate support materials and to promote and support the provision of the program to Aboriginal and Torres Strait islander people throughout Queensland. QAIHC has employed a Diabetes Coordinator to work in partnership with the MH4L team across the ATSICCHS Sector.

QAIHC is proud of its commitment to supporting the cultural awareness of some of its broader health system partners. In June 2018, a two-day 'Aboriginal and Torres Strait Islander Health' Masterclass (in partnership with Generalist Medical Training) was delivered to James Cook University's general practitioner Registrars presenting a great opportunity to embed Aboriginal and Torres Strait Islander health into the training of emerging clinicians in Queensland. Additionally, QAIHC co-facilitated three introductory cultural education workshops to over 70 general practice registrars with General Practice Training Queensland.

**QAIHC's Commercial Capacity**

QAIHC's Business Quality Centre has provided high quality finance, Human Resources and Information Technology Support and has expanded its clientele. Approximately 10 new fee-for-service agreements have been entered into in relation to high quality Human Resources, Data and Information Technology support.

**Looking Forward**

In 2018/19 QAIHC is looking forward to providing high quality to services to members contributing to the strength of the sector in Queensland. Supporting members' workforce concerns, implementing service delivery statements, increasing the policy and research platform and growing QAIHC's commercial capabilities are key focus areas.

Tina Goodwin presenting at NACCHO Conference in Hobart

# TASMANIAN ABORIGINAL CORPORATIONL

THE TASMANIAN ABORIGINAL CENTRE (TAC) AFFILIATE CONTINUED THEIR WORK OVER THE PAST YEAR BY SUPPORTING THE ABORIGINAL COMMUNITY CONTROLLED HEALTH ORGANISATION, NON-GOVERNMENT ORGANISATIONS, COMMONWEALTH, AND STATE GOVERNMENTS, TO KEEP ABORIGINAL HEALTH ISSUES EMBEDDED IN POLICY AND PLANNING AT ALL LEVELS.

### Tasmanian Aboriginal Health Partnership Framework

The Tasmanian Aboriginal Health Forum identified three projects for collaborative partnerships that have continued during this 2017/18, with representation from the Affiliate, Commonwealth Department of Health, Department of Health and Human Services, Tasmanian Health Service, Department of Prime Minister and Cabinet and Primary Health Tasmania.

The Mental Health Subcommittee, is investigating the patient journey for clients accessing support for mental health issues. The Subcommittee will identifying areas for improvement, to increase client access and care pathways, in the State health system.

The second project brings together key stakeholders within Early Childhood Services, with a focus on mapping the breadth of programs and relationship to improved health outcomes. Finally, the third subcommittee with a focus on Health Information, has been established to scope relevant data sources within agencies, to gain a better understand of discrepancies in data collection, analysis, and reporting.

### Workforce Development in the Alcohol and other Drug Sector

The Affiliate and the Drug Education Network (DEN) developed a partnership to address the workforce capacity of those working with Aboriginal clients in the alcohol and other drug (AoD) sector. This resulted in a funded program by Tasmanian Primary Health Network (PHT) for the TAC's Registered Training Organisation to deliver Certificate 4 in Alcohol and other Drugs.

37 participants have commenced the training across Tasmania from various organisations. The training will equip participations to be appropriately skilled and culturally safe, when working with Aboriginal and Torres Strait Islands people.

In addition, the funded project will support 60 participants to attend Cultural Awareness Training and 30 participants to attend Cultural Safety Training. This training is targeted to the AoD sector to support culturally appropriate service provision.

### Accreditation

The Affiliate provides leadership in the development of more accessible, responsive, safer and appropriate health services for the Tasmanian Aboriginal population through modelling best practice delivery in the Tasmanian Aboriginal Health Service (AHS). These initiatives include providing quality improvement system design for mainstream health service delivery, in a culturally safe environment.

The Affiliate supported three Aboriginal Health Services (AHS) with AGPAL accreditation in the past 12 months, with the TAC also being reaccredited with Quality Innovation Performance (QIP) accreditation.

The TAC have a long history as a provider of services under the National Aboriginal and Torres Strait Islander Flexible Aged Care Program (NATSIFACP). In late 2017, they were advised the funding criteria no longer met the service delivery requirements in Tasmania. To continue to provide services to the client cohort, TAC were required to become a provider of services under the National My Aged Care Program. The Affiliate,

have worked with the TAC to meet the requirements under the Legislation to be an Approved Provider of Aged Care Services. The depth of work has been substantial, with the organisation achieving Approved Provider status in late June. Work is now underway to support the organisation to meet the required Standards and implement systems and processes to deliver services under the My Aged Care Program.

**General Practice Training Tasmania Partnership**

The Affiliate and General Practice Training Tasmania (GPTT) have work collectively to develop cultural competency training for GP registrars.

The training is a mix of options, from self-learning, computer based learning modules, classroom-based training, and a cultural immersion camp.

The cultural immersion camp has been accredited as a category 1 cultural safety activity.

Cultural educators and mentors have participated in national meetings to build on the knowledge and share their experience with others working in the field.

GPTT have worked on a Reconciliation Action Plan during this reporting period with the Affiliate and expect to have this launched at the cultural immersion camp in November 2018.

**Continuous Quality Improvement**

The Affiliate and the Aboriginal Health Service, identified increasing screening for cardiovascular risk factors and disease as an area for improvement.

Using June 2018 data for nKPI 3, in the last 2 years 58% of regular TAC patients aged 25+ (compared to 34% in 2014, 44% in 2015, 54% in 2016 and 56% in 2017) and 73% aged 55+ were recorded as having an MBS Item 715.

These health checks include assessments of cardiovascular risk factors such as smoking, alcohol, BMI, BP, and the presence of cardiovascular and renal disease or diabetes.

For regular patients aged 35-74 years without a history of existing CVD disease, 54% had their absolute cardiovascular risk assessment recorded (nKPI 21) and 50 people were identified at high risk of a CVD event in the next 5 years.

Designing and implementing a CQI activity to improve clinical management of high CVD risk. The PDSA involved a file audit (using a medical student on placement) to review clinical notes of the people identified at high CVD risk against best practice guidelines, the TAC Medical Director followed up the audit findings with the treating GPs, and educational activities were provided for all clinical team members. Appropriate follow-up for high risk patients is available through clinics, medication reviews, quit smoking support, exercise and cardiopulmonary pre-habilitation programs.

The cardiovascular CQI activity is ongoing with the goals of increasing screening rates, ongoing auditing of management of people identified at high risk and planned extension to patients identified at moderate risk.

CQI is embedded in daily practice including through the provision of quarterly nKPI data and CQI updates to clinical team members and managers. Regional performance (North, North West and South) is benchmarked against statewide (TAC) and national (ACCHS) performance.

**Policy development and partnerships**

The Department of Health and Human Services (State), in partnership with the Affiliate, have collaboratively worked on, and implemented a Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2016-2026. A Tasmanian Implementation Plan has been developed, along with a consultation and stakeholder engagement strategy. The Cultural Respect Framework consultations are completed and published. The State Government have endorsed the findings and commenced implementation of the recommendations.


Victorian Aboriginal Community Controlled Health Organisation Building

# VICTORIAN ABORIGINAL COMMUNITY CONTROLLED HEALTH ORGANISATION

VACCHO IS THE PEAK BODY FOR ABORIGINAL HEALTH AND WELLBEING IN VICTORIA, WITH 30-MEMBER ACCO'S PROVIDING SUPPORT TO APPROXIMATELY 25,000 ABORIGINAL PEOPLE ACROSS THE STATE.

VACCHO champions community control and health equality for Aboriginal communities. Our members have a proud history as sustainable, grassroots organisations that assist in building community capacity for self-determination. VACCHO believes that each Aboriginal community needs its own community-based, locally-owned, culturally appropriate, and adequately resourced primary health care facilities.

During 2017/18 VACCHO introduced its new Strategic Plan 2018-2022, which underpins VACCHO's absolute commitment to maintaining strong cultural identity and connection.

With a strong balance sheet, VACCHO is set to meet its Strategic Priorities and continue to support our Members the delivery of culturally safe health and wellbeing services of Aboriginal Peoples living in Victoria.

As a consequence, during the 2017/18 Financial year VACCHO has compelled funders towards embracing the principles of self-determination for Aboriginal people, recognising it is the only policy that has produced real and sustainable outcomes for Aboriginal Communities. It is vital that these partnerships between Aboriginal Victoria and Government continues.

During 2017/18 VACCHO has ensured its program delivery focuses more on a sustainable solution and has commenced defining the types of investment that must be made in furthering the health and wellbeing of Aboriginal people in Victoria. There are significant funding and workforce gaps across a number of communities within VACCHO's Membership.

VACCHO has continued to invest in developing the capacity of its staff and Members.

Arguably the most significant impact within VACCHO was the departure of our CEO of 16 years, Jill Gallagher AO, who is now the Victorian Treaty Advancement Commissioner.

The Board and VACCHO will be looking towards the 2018/19 year with a strong focus on the coming State Election and the securing support for a number of key initiatives outlined in 'Walk with us towards a brighter future for Aboriginal Victorians'.


John Singer and Pat Turner at VACCHO Conference

The key initiatives in part are:

- Continued partnership with Aboriginal Victorians, honour and fund existing strategies and plans;
- Support for Aboriginal involvement in strategic decision making;
- Develop a Ten Year Industry Plan for ACCOs;
- Improve the capacity of mainstream services to deliver culturally safe care;
- Investment in justice prevention instead of detention;
- Identifying other funding streams to reduce the dependency on government funding.

VACCHO and Cancer Council Victoria, in collaboration with the Rethink Sugary Drink Alliance, partnered to develop a series of three videos sharing stories from Rumbalara Aboriginal Cooperative (Mooroopna) showcasing their leadership in being a water only health service and two Aboriginal community members, Michelle Crilly and Uncle Daryl Smith, in Melbourne about how they reduced their sugary drink consumption.

This latest collaboration has been produced, launched and aired on regional WIN Television. The website www.rethinksugarydrink.org.au/koori that had been made to house all Aboriginal community specific sugary drinks resources, now includes the 'Our Stories' videos with a makeover to the sites look and feel to include the well-recognised #DrinkWaterUMob artwork.

Three 30 second ads were launched, featuring: Michelle Crilly, Uncle Daryl Smith and Rumbalara Aboriginal Co-operative.

The ads feature local Aboriginal health champions yarning about their personal journeys of cutting back on sugary drinks and creating healthier environment for our Communities. The ads aired on regional WIN TV for two months (March and April 2018).


Winnunga Nimmityjah Aboriginal Health and Community Services truck

# WINNUNGA NIMMITYJAH ABORIGINAL HEALTH AND COMMUNITY SERVICES LTD

WINNUNGA AHCS MAINTAINED CLINICAL AND ORGANISATIONAL ACCREDITATION AGAINST THE AGPAL AND QIC STANDARDS AND WE ARE PREPARING FOR THE UPCOMING ACCREDITATION ASSESSMENT CYCLE TO BE CARRIED OUT EARLY IN THE 2018-2019 FINANCIAL YEAR.

Winnunga AHCS internal Continuous Quality Improvement (CQI) and reporting processes have been supported through development of data collection templates in Communicare. These templates assist clinical and program staff to record the work they conduct, and also record data in an extractable form for both reporting and CQI processes.

MBS claiming, client numbers and encounter numbers have been monitored monthly and progress fed back to Winnunga AHCS managers. This assists with clinical governance, staffing and financial management.

Winnunga AHCS clinical staff have been supported to improve influenza vaccination rates in 2018, in response to high influenza rates in the ACT in 2017. By June 2018 Winnunga AHCS influenza vaccinations had increased by 30% over the same time period as in 2017. In addition, we negotiated with ACT Health to ensure Winnunga AHCS had a consistent supply of vaccines during the period of influenza vaccine shortages.

An audit and CQI process has been used to improve cardiovascular disease risk assessment at Winnunga AHCS. This started with an ANU medical student clinical audit and research project which compared two CVD risk calculators, based on nKPI data extractions. Clients in the high CVD risk category were followed up, and Winnunga AHCS staff were encouraged to undertake more CVD risk assessments. In addition, a short-term Integrated Team Care Project funded by the ACT's Capital Health Network enabled more clients to be recalled for CVD risk assessments and chronic disease management plans. CVD risk assessments in the June 2018 nKPI report increased by 37% over June 2017.

Winnunga AHCS is implementing a standalone health and wellbeing service in the Alexander Maconochie Centre (AMC, adult prison) with our own model of care, funded by the ACT Government. This service will not only provide culturally safe services to detainees, it will interface with Winnunga AHCS to provide continuity of care and support to families of detainees. Implementation of this service has required working closely with Justice Health and ACT Corrective Services.

Specialist in-reach services have continued to increase, with a mix of public (ACT Government) and private service providers visiting Winnunga AHCS. In 2017-18 visiting specialist client contacts increased by 7% and allied health contacts by 19% over the previous financial year. The greatest increase was psychology client contacts, which more than doubled. There is high demand for psychology services, and psychology clinical services were increased this year. Optometry and podiatry clinics were also introduced, and these contributed to significantly increased allied health client contacts.

Student and Registrar placements at Winnunga AHCS provide more than just clinical experience. They provide exposure to culturally safe, community controlled comprehensive primary health care for Aboriginal and Torres Strait Islander peoples. This gives students knowledge and understanding they can take with them and use when they return to mainstream services. Over this reporting period, Winnunga AHCS provided clinical placements for ANU medical students, a GP registrar and psychiatry registrars.

Research at Winnunga AHCS strengthens the relationships we have with academic institutions and the ANU Medical School. This year Winnunga AHCS participated in the WATCH and INFLATE otitis media trials with the University of Western Sydney. ANU medical student research projects

Lecturer Kristofer Chang Alexander and the students from Purdue University are briefed about Aboriginal Community Controlled Health Organisations by NACCHO Board Member and Winnunga Nimmityjah CEO Julie Tongs

provide mutual benefits. Students learn how to conduct respectful research with Aboriginal and Torres Strait Islander people, and Winnunga AHCS benefits from in-depth clinical audit and research studies.

ANU medical students undertook research on the association between cardiovascular disease risk and mental health conditions at Winnunga AHCS, and conducted a study comparing Winnunga AHCS referrals to the Emergency Department with mainstream GP and conducted a study comparing

Winnunga AHCS referrals to the Emergency Department with mainstream GP referrals. In addition we provided advice and feedback to the ANU Medical School and the ACT Health Human Research Ethics Committee on gaps in their processes for assessing research proposals involving Aboriginal people.

The Winnunga AHCS PHMO is an Affiliate representative member of the Health Services Data Advisory Group (HSDAG). The PHMO has provided extensive input on HASDAG agenda items, and also participated in the OSR and nKPI Data Framework Working Group.

The Winnunga AHCS PHMO and Data Officer provided ongoing assessment and advice to the Australian Government Department of Health on NKPIs, OSR changes, data extraction changes and the new Health Data Portal content and governance. They have also monitored data extraction changes in Communicare and provide feedback to Telstra Health when issues have arisen.

The Winnunga AHCS PHMO presented information to the Australian Government (through the HSDAG) and ANU researchers on work conducted at Winnunga AHCS comparing CVD risk assessment algorithms, including how this affects interpretation of the CVD risk assessment nKPIs. The PHMO also participated in an ANU led (Australian Government funded) CVD Risk Assessment Alignment Roundtable in February 2018.

Winnunga AHCS provided feedback to the Australian Government on the proposed IAHP Funding Model, including highlighting problems with using nKPIs as performance measures, and issues with the use of Episodes of Care as a basis for funding distribution.

Policy advice was provided on: the ANAO IAHP audit, the Primary Mental Health Care Minimum Dataset, My Health Record Secondary Use of Data consultation, Nous Review of the PIP Indigenous Health Incentive and Voluntary Indigenous Identifier, KPMG Data Quality Assessment and Support Project and the National Aboriginal and Torres Strait Islander Primary Health Care CQI Framework.

Winnunga AHCS CEO conducted a vast range of policy advice on many issues including but not limited to, removal of children, incarceration, deaths in custody, Boomanulla Oval, ACT Treaty, housing and homelessness, alcohol and other drug treatment options, and My Health Record.

Responses to draft policies included:

- Response to ACT Draft Drug Strategy Plan
- Review on Methadone Program at AMC
- Closing the Gap Refresh
- Call for Indigenous Housing Strategy
- Call for Government Indigenous Policy.

# OUTCOME 1:

## A STRENGTHENED ACCH SECTOR TO MAINTAIN AND FURTHER DEVELOP A STRONG NETWORK OF ACCHSs

### WNAH&CS

- implemented procedural and practice management tool changes to operationalise the new national cervical screening program (NATSIHP – Domain: Healthy Adults)
- contributed to the delivery of the introduction in the ACT of the meningococcal ACWY vaccination for teenagers (NATSIHP – Domain: Adolescent and Youth Health)
- undertook a project to look at the best ways to embed and sustain CQI cycles at WNAH&CS.

### AH&MRC

- surveyed NSW ACCHSs regarding their needs, support and further assistance requirements
- conducted site visits to assist over 75% of ACCHSs with data validation to enable ACCHSs to maintain clean and accurate data
- analysed data to understand service 'gaps' where CQI processes can assist
- 100% of NSW ACCHSs participated in a Meeting Ground Forum to look at how to reshape AH&MRC.

### AMSANT

- provided influential policy advice to the Royal Commission into the Protection and Detention of Children in the NT (NATSIHP – Domain: Social and Cultural Determinants of Health)
- provided advice to senior clinicians regarding the Meningitis W outbreak
- supported 24 ACCHSs to achieve clinical accreditation and 28 to achieve organisational accreditation (NATSIHP – Domain: Health Systems Effectiveness)
- redesigned and upgraded a Members portal to more actively engage Members
- supported Members to use eHealth and make better use of data to drive increased service performance
- provided rollout support to the six NT ACCHSs selected to undertake a Health Care Homes pilot (NATSIHP – Domain: Health Systems Effectiveness).

### QAIHC

- in conjunction with AHCWA took the lead on the development of a national Client Relationship Management system
- actively supported all ACCHSs to achieve clinical and organisational accreditation
- developed Service Delivery Statements tailored for each ACCHS with agreed support and assistance to be provided by QAIHC
- developed a workforce career pathways model to upskill selected Certificate IV Aboriginal and Torres Strait Islander Primary Health Care Practice Workers into the Enrolled Nursing qualification
- successfully advocated for Aboriginal and Torres Strait Islander health to be embedded in the core curriculum of UQ's Health Education Programs (NATSIHP – Domain: Social and Cultural Determinants of Health)
- undertook financial modelling for the new IAHP funding model and lobbied extensively for the delay and redrafting of the proposed IAHP funding model (NATSIHP – Domain: Health Systems Effectiveness).

### TAC

- supported all three Aboriginal Health Services to maintain their accreditation
- supported AHS CQI by collating, analysing, reporting and workshopping clinical data
- responded effectively to a severe influenza outbreak
- facilitated access to new treatment pathways for viral hepatitis
- provided input to a review of best practice in the delivery of health services to Aboriginal children and families (NATSIHP – Domain: Childhood Health and Development; Domain: Adolescent and Youth Health)
- participated in policy development through the Tasmanian Tobacco Coalition and in national tobacco control research through the Talking about Tobacco Smoking project.

## VACCHO

- proactively identified and addressed instances where cultural safety was lacking e.g. the RACGP 5th Edition Standards for General Practices did not contain culturally appropriate feedback forms for ACCHSs (NATSIHP – Domain: Health Systems Effectiveness)
- provided intensive crisis intervention support to an ACCHS to embed ongoing processes and ensure the future sustainability of its governance, management and service delivery
- delivered governance training to Members and non-Member organisations leading to a dramatic increase in governance knowledge.

## AHCWA

- increased the delivery of new certifications targeting upskilling of local people
- entered a new contract (with WA Mental Health Commission) to bring a culturally appropriate family wellbeing course on scope
- provided support to all Members to maintain accreditation
- promoted a HR Network leading to Members increasingly utilising the Network as a source of information and advice, and for resource sharing to minimise unnecessary duplication (NATSIHP – Domain: Health Systems Effectiveness)
- supported all Members with clinical and corporate governance; quality improvement; shared services; funding advice; My Health Record; pharmacy rules; medication changes; Medicare use and billing; reporting for audit analysis; and review of CQI plans and processes
- facilitated networking between ACCHSs leading to a notable increase in the support ACCHSs are willing to provide each other e.g. there is now consideration of state-wide funding applications where services collaborate to implement local solutions in their catchment areas (NATSIHP – Domain: Health Systems Effectiveness)
- assisted Members to identify priority areas: mental health and social emotional wellbeing; child protection; incarceration; the patient journey; funding models; and youth health
- support to Members on the best use of Medicare has improved understanding of claiming and eligibility
- explored strategies to improve the ability of Members, especially in remote areas, to attract and retain suitably qualified staff
- provided intensive unfunded support to three ‘services of concern’.

# OUTCOME 2:

## A STRENGTHENED BROADER HEALTH SYSTEM TO PROVIDE ACCESSIBLE, RESPONSIVE AND CULTURALLY SAFE CARE TO ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLE.

### WNAH&CS

- increased visiting specialist and allied health services, including the commencement of regular optometry and podiatry services
- developed a new ground-breaking partnership with the ACT Government to deliver stand-alone health and wellbeing services, using its own model of care, in the Alexander Maconochie Centre adult prison for detainees – this partnership is an Australian first and is being watched by other jurisdictions (NATSIHP – Domain: Social and Cultural Determinants of Health).

### AMSANT

- successfully advocated for the inclusion of two new elective units (loss, grief & trauma and cancer support) in the Diploma of Aboriginal and Torres Strait Islander Primary Health Care Practice
- established a NT Aboriginal Health Academy pilot VET project to support 25 Indigenous senior school students to complete Certificate III in Allied Health Assistance - a unique initiative as students learn together at CDU from Aboriginal health professionals, with leadership, mentoring and career development incorporated in the program (NATSIHP – Domain: Health Systems Effectiveness).

### QAIHC

- positioned itself as a leader in Aboriginal and Torres Strait Islander cultural education to develop the cultural capability of QLD GPs
- successfully advocated for Aboriginal and Torres Strait Islander health to be embedded in the core curriculum of UQ's Health Education Programs.

### AHCSA

- conducted preliminary work to engage Members in a review of the State-wide Sector Strategic Plan to identify need, gaps and key priority issues for each region and community
- identified areas of focus: NDIS Mental Health; STI and BBV; sexual health; RHD; disease prevention, health promotion; syphilis outbreak response
- engaged in activities that reach beyond SA and support health issues relevant across the nation
- hosted a successful two-day National CQI face-to-face meeting
- developed a national surveillance system for STI and BBVs for Aboriginal people.

### TAC

- provided a quality improvement system design for mainstream health service delivery (NATSIHP – Domain: Health Systems Effectiveness)
- implemented a Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2016-2026
- engaged stakeholders re the Tasmanian Implementation Plan for the Framework, to begin Feb 2018
- delivered cultural awareness or cultural safety training to over 30 organisations (NGOs, Commonwealth and State Government Departments and Local Councils) (NATSIHP – Domain: Health Systems Effectiveness)
- contributed to policy and planning in specific agencies and the development of more responsive and appropriate clinical practice through referrals and joint case management
- a partnership with the Drug Education Network to build capacity of those working with Aboriginal clients in the alcohol and other drug (A&OD) sector has led to funding for the TAC RTO to deliver Certificate IV in A&OD
- developed stakeholder groups to look at how to improve the patient journey of clients accessing support for mental health issues and better health outcomes for children.

## AHCWA

- provided cultural safety training, RAP development support and cultural mentoring
- one of the only WA organisations invited by the National Digital Health Agency to give a presentation to mainstream GPs and hospital staff promoting the benefits of the My Health Record for the Aboriginal community
- supported an ACCHS to trial a new, culturally friendly, Aboriginal focused bowel screening kit
- involvement in the National Aboriginal and Torres Strait Islander Immunisation Network (NATSIIN) resulted in an evaluation of the influenza program for Aboriginal clients and led to a re-release of the schedule in an easier to read format and a notable increase in the level of engagement of ACCHSs in promoting and issuing the flu vaccine
- supported Communicable Disease Control Directors to have the immunisation course for Aboriginal Health Workers nationally accredited and recognised as national training allowing transferability of certification for Aboriginal Health Workers and Aboriginal Health Practitioners nationally
- assisted with the pulling staff from routine roles to respond to meningitis outbreak and commence an intensive vaccination program in remote regions showed the flexibility of ACCHSs and their ability to rally together to tackle health outbreaks
- proactively worked with Western Australian General Practice Education & Training Ltd (WAGPET) and Rural Health West on a regional and remote medical workforce plan to overcome issues with the removal of funding to support registrars in remote regions
- prepared a submission regarding the funding of GP registrars to undertake training placements in rural and remote locations.

# OUTCOME 3:

## NATIONAL POSITIONS FROM THE ACCH SECTOR THAT DELIVER HIGH QUALITY EXPERTISE AND ADVICE TO GOVERNMENT

### AMSANT

- led a CQI strategy for Aboriginal PHC in NT (including government and community control) mentored and supported CQI facilitators in PHC and provided education to NT PHC professionals and regional CQI collaboratives
- contributed to the Royal Commission into the Protection and Detention of Children in the NT, including being an active member of the Aboriginal Peak Organisations NT (APONT) Working Group that is responding to the Royal Commission.

### QAIHC

- persistent lobbying to allow Aboriginal and Torres Strait Islander Health Workers in ACCHSs to supply and administer scheduled medicines - QLD State Government has tabled a proposal with Cabinet to allow this to occur initially in isolated practice areas (NATSIHP – Domain: Health Systems Effectiveness).

### TAC

- introduced a full-time Patient Information Management Coordinator
- provided policy input on: national alcohol strategy; NDIS; emergency management of Hyperglycaemia clinical position statement; expansion of RFS Strategy preventative activities; ANAO's IAHP audit re CQI; PHN Mental Health Data reporting requirements; Optimal Care Pathway-Cancer; IAS Evaluation; national response to CATSI Act review developed a Clinical Governance Toolkit to share.

### AHCWA

- 100% of responses/submissions (including community and public feedback) State/Commonwealth lodged on time
- worked with ACCHSs to ensure same information recorded so data comparisons are possible
- engaged Members to contribute to national policy debates to advance the agenda of ACCHSs and Aboriginal people.

# MEMBER CASE STUDIES

## PHARMACISTS CLOSING THE GAP

The Federal Government has committed to implementing reforms and investigating new funding models for pharmacists to help close the gap between the health outcomes of Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians. Australian Pharmacist spoke with several pharmacists working in Aboriginal Health Services (AHS) to find out how pharmacists are playing a key role in closing the gap and helping Indigenous patients navigate Australia's complex health system.

According to PSA CEO Dr Lance Emerson, 'Aboriginal Australians are four times more likely to be hospitalised for chronic conditions compared with non-Indigenous Australians – and the life expectancy of Aboriginal people in this country is 10 years lower than non-Aboriginal people.

The Government has implemented several programs to provide timely and affordable access to PBS medicines and Quality Use of Medicines (QUM). The Review of Pharmacy Remuneration and Regulation Interim Report noted last year, however, that 'although they are related, these programs operate independently with differing eligibility criteria applied for each. This raises difficulties for both consumers in terms of access and for pharmacists and other health professionals with respect to administration.

'In considering how pharmacy options may contribute to improved health outcomes for Aboriginal and Torres Strait Islander people, the Panel has questioned whether currently arrangements are sufficient and how might they be improved.'[1]

## INTEGRATING PHARMACISTS

In his opening speech at PSA17 in Sydney, Federal Health Minister Greg Hunt announced a trial, funded through the Pharmacy Trial Program, to support Aboriginal health organisations to integrate pharmacists into their services. The trial has strong stakeholder support amid growing evidence that pharmacists employed by Aboriginal Community Controlled Health Organisations (ACCHOs) can help increase patients' life expectancy and health outcomes.

'We will work immediately to have Indigenous-specific medication reviews available and we will fund and support that as part of Tranche 1 to make sure they are culturally specific. 'We want in these Aboriginal Health Services to ensure there's a pharmacy presence. The first line there is to see if we can have a direct link and an offer to community pharmacists to participate, but where that's not possible, the breakthrough agreement … is that the Aboriginal Health Services will be able to directly employ a pharmacist.

This announcement follows the Review's Interim Report recommendation to trial the ability for AHSs to employ pharmacists and operate a pharmacy because 'the current inability of an AHS to operate a community pharmacy poses a significant risk to patient health in some rural and remote areas.

The Panel presented the option that 'All levels of government should ensure that any existing rules that prevent an Aboriginal Health Service (AHS) from owning and operating a community pharmacy located at the AHS are removed. As a transition step, these changes should first be trialled in the Northern Territory, and governments should work together with any AHS that wishes to establish a community pharmacy.'

PSA National President Dr Shane Jackson said having a culturally responsive pharmacist integrated within an AHS builds better relationships between patients and staff, leading to improved results in chronic disease management and Quality Use of Medicines.

Mike Stephens, Director of Medicines Policy and Programs for the National Aboriginal Community Controlled Health Organisation (NACCHO), welcomed the announcement of the trial. 'We know from recent studies, including systematic reviews, that pharmacists delivering services within a practice setting can have a significant impact on health outcomes,' Mr Stephens said. 'While there is surely some level of role translatability between ACCHO and non-ACCHO sectors, we really don't know where the "sweet spots" are in terms of health outcomes, community demand and value for money when embedding pharmacists in ACCHOs.

'There are a lot of different activities happening from ACCHO to ACCHO. The approach needs to be flexible and responsive to communities' needs, as well as integrated into the holistic care models ACCHOs use, but the detail on what has the biggest health impact is unknown.

'Several practice pharmacists are currently employed by AHSs across Australia. Some ACCHOs are also hiring intern pharmacists and pharmacy technicians, allowing the pharmacists to focus more on the clinical, education and practice-based activities that work well in a general practice setting.

'These pioneers are also promoting the newer roles of pharmacists. I see a lot of pharmacists focusing on systems-based activities like clinical governance, DUEs and audits, as well as working across teams in and outside of the organisation, such as improving transitional care with local hospitals.'

Mr Stephens said there had been 'a lot of interest' in the trial from NACCHO's Members Services. 'Research has shown that access and acceptability of pharmacy services could be improved. Current feedback from ACCHOs indicates the benefits of embedding pharmacists can be diverse, but may include improved clinical governance and prescribing practices, improved internal and external workflow, increased MMR uptake and better relationships with community pharmacies.'

## SHARING IDEAS

In recognition of the growing number of pharmacists working in ACCHOs, PSA and NACCHO launched the ACCHO Special Interest Group (SIG) at PSA17.Dr Jackson said pharmacists working in ACCHOs have specific needs and skills and developing a SIG to support them will help drive the growth of this career path. 'In many cases pharmacists working in these positions are providing innovative and diverse services that have the potential to be informative and relevant to the evolution of pharmacy services and inter-professional care,' Dr Jackson said.

The ACCHO SIG will allow PSA and NACCHO to foster collaboration, inform relevant policy and consult with ACCHO pharmacists about their needs. The ACCHO SIG will also support pharmacists participating in the Aboriginal health organisations trial. Mr Stephens, who convened the ACCHO SIG, started connecting this network of peers when he was working at Danila Dilba Aboriginal Health Service in Darwin.

'The key aim was to share resources and ideas and give each other support in a relatively niche area. I have learnt a lot from each of the participants and their input has definitely shaped my clinical practice and policy output.

'I have had support from both PSA and NACCHO in building this group and now I hope it can evolve organically as needs and issues that affect this area develop.'

'We currently have an email network for pharmacists in that environment and are open to suggestions about how it can work. We plan to have a group committee. The idea is to hear from our members and pharmacists working in these services to understand what they need.

'Optimising medicines use for Aboriginal and Torres Strait Islander people has been an ongoing challenge for this country,' Mr Stephens said.

'Despite some great programs, policy and resources available, Aboriginal PBS utilisation is still only about two-thirds of non-Indigenous Australians' use. Most pharmacists would have heard of Closing the Gap prescriptions but how is that delivering outcomes? How could it be improved? We have responded to this question and more in a recent submission to the Review of Indigenous Pharmacy Programs. There is a real sense of goodwill from many industry players in this area at the moment.'

Mr Stephens said another network of pharmacists and health professionals with an interest or expertise in Aboriginal and Torres Strait Islander medicines issues had also grown organically over recent years to share information and peer support. 'Around once a month NACCHO sends out a medicines bulletin with updates on NACCHO's medicines and pharmacy activities, and some practical resources or links for clinicians.'

Mr Stephens described his previous workplace, Danila Dilba Aboriginal Health Service, as a dynamic multidisciplinary environment. 'It opened my eyes to the details of how a large holistic health service works, and how general practice and other primary care services fit into that. I did everything from HMRs to pharmacy accounts, board briefings to drug utilisation evaluations and clinical governance, GP education and much more.

'The team vibe was great and I had a lot of fun with colleagues from different disciplines and backgrounds. I performed in a musical duo with the senior medical officer as a farewell which was really cheesy, but so much fun.

'The challenge was the complexity and nuances of community relationships and systems, and learning where your skills will work best. Engagement is critical and I saw some programs struggle because clients and employees were not driving the change.' Mr Stephens is a strong believer in lifelong learning and found PSA's Guide to providing pharmacy services to Aboriginal and Torres Strait Islander people invaluable. 'It has a lot of detail but is applicable for pretty much all pharmacists across Australia, and it has some great case studies.

'There's never been a better time to upskill and get involved, with PSA's support modules for Aboriginal Health Service pharmacists, the ACCHO SIG and network. NACCHO can also provide specific networks and support for pharmacists looking to get involved.'

## A DAY IN THE LIFE OF AN ACCREDITED PHARMACIST

Alice Nugent MPS is an accredited pharmacist working in several AHSs around Dubbo, regional NSW.

**7.30** Get coffee for the 45-minute drive from my large regional town to the small rural town I visit once a week.

**8.30** Hold team meeting with GPs, nurses and health workers. Discuss clients who have been in hospital – I will organise a HMR referral including up-to-date pathology, specialist letters and clinical notes.

**9.00** Talk with GP about a mental health patient I did a home visit for last week. I discovered he had not been taking all his medication and was feeling unwell.

**9.05** Attempt to check emails including the weekly Australian Indigenous Health Bulletin, a summary of peer-reviewed articles published on Indigenous health each week. Have a conversation with the clinic nurse regarding an injectable drug she is booked to give for the first time – an Epoetin product for a dialysis patient with anaemia. Unfortunately, we have very high rates of kidney disease in our client population so I am frequently advising on dose adjustments in renal impairment. Recent changes to PBS scripts for over-the-counter items such as iron appear to be affecting our patients when cost can be an issue.

**9.30** Prepare some information for the GP for a patient on multiple mental health drugs including Sodium Valproate, who wants her Implanon contraceptive implant removed.

**10.00** See a new patient in the clinic who has brought in their bag of medications. Discard half of them, enter the list in the computer system and make some notes for suggested changes for the GP.

**10.30** Help one of the reception staff who has just started doing her health worker training with an assignment question 'What is Quality Use of Medicines?' It gets me thinking.

**10.45** Phone the local hospital who supply our imprest stock to update our formulary to include some extra medication for emergency treatment of migraine.

**12.00** Join fortnightly integrated care meeting with hospital care coordinator, Indigenous liaison officers, diabetes unit staff and practice nurse to discuss patients who have been in hospital or at high risk. I will organise HMRs for some recent discharges and some patients identified from the 8 plus medication report I run.

**Lunch** Join a drug rep and GPs for a sandwich. Listen to a demonstration of the latest COPD device. Get some more sample devices to add to the collection I maintain for the clinic.

**1.30** See a patient in the clinic for a non-claimable HMR.

**2.30** Home visit for HMR with Aboriginal Health Worker. She checks BP, INR and BSLs while I check medications. This is a very common scenario of multiple medications for diabetes, heart disease, renal impairment and mental health issues. Visits tend to take a while as it is important to listen, discuss family issues and build relationships.

**4.00** Discussion regarding a family health care worker whose member recently had a stroke. They are feeling overwhelmed with lots of specialist visits and changes to medication.

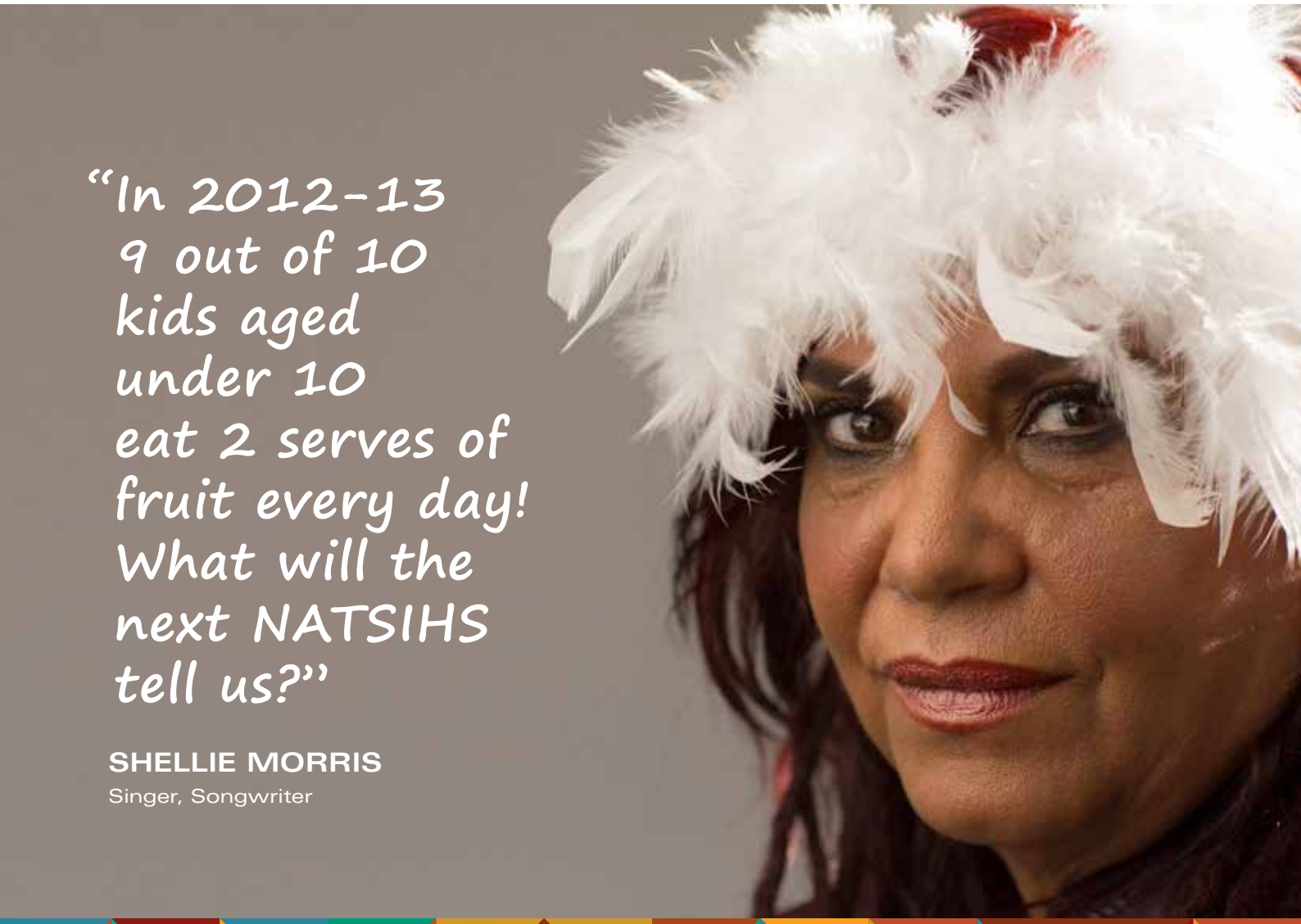
**4.15** Talk with local pharmacist and dispense technician about HMR patients. They tell me about three patients who haven't collected blister packs. I apologise they have not been notified that one of the patients is in hospital. I will follow up and check the patient is enrolled in the integrated care scheme.

**4.30** Work through my 8 plus medication report, reviewing the patient notes in the computer system, leaving suggestions for GPs, and highlighting those who would benefit from an appointment with me in the clinic or a HMR.

**5.00** Spend the drive home thinking about how much more I could do if I was funded for more than one day a week. I would love to spend more time yarning with our patients to help them understand it is important to take your medicine the right way, so it helps you feel better and live longer! This is my definition of Quality Use of Medicines.

Australian Bureau of Statistics

# NATIONAL
## Aboriginal and Torres Strait Islander
# HEALTH SURVEY



"In 2012-13 9 out of 10 kids aged under 10 eat 2 serves of fruit every day! What will the next NATSIHS tell us?"

**SHELLIE MORRIS**
Singer, Songwriter

*Good health, our future*

Conference delegates heard from the ABS's Mr Dean Bowley who explained that once again his agency will be conducting the next National Aboriginal and Torres Strait Islander Health Survey (NATSIHS). The data collected will help governments and healthcare providers decide where to spend money on health services, health programs and education about healthy lifestyle choices to ensure people enjoy long and healthy lives. Information provided by communities helps to ensure money is being spent where it's needed most.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# FINANCIAL STATEMENTS

## NATIONAL ABORIGINAL COMMUNITY CONTROLLED HEALTH ORGANISATION

**ABN 89 078 949 710**

## GENERAL PURPOSE FINANCIAL REPORT FOR THE YEAR ENDED 30 JUNE 2018

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# DIRECTORS' REPORT

Your directors present their report on the company for the financial year ended 30 June 2018.

## Directors

The names of the directors in office at any time during or since the end of the financial year are:

John Singer (Chair)
Donnella Mills (Deputy Chair)
Donna Ah Chee
Adrian Carson
Kieran Chilcott
Raylene Foster
Olga Havnen
Vicki Holmes
Rod Jackson
John Mitchell
Scott Monaghan
Lesley Nelson
Chris Bin Kali
Mark Lovett
LaVerne Bellear
Julie Tongs
Sandy Davies (resigned 2 November 2017)
Matthew Cooke (resigned 2 November 2017)
Michelle Nelson-Cox(resigned 2 November 2017)
Shane Mohor (resigned 2 November 2017)
John Patterson (resigned 2 November 2017)
Christine Corby (resigned 2 November 2017)

Directors have been in office since the start of the financial year to the date of this report unless otherwise stated.

## Operating Results

The loss of the company for the financial year after providing for income tax amounts to $73,173 (2017 profit: $150,965).

## Review of Operations

A review of the operations of the company during the financial year, and the results of those operations, found that during the year, the company continued to engage in its principal activity, the results of which are disclosed in the attached financial statements.

## Significant Changes in State of Affairs

The most significant changes in the state of affairs of the company is the implementation of the 3-year network funding agreement which commenced 1 July 2017. From said date, reporting to the Department of Health has moved away from Activities Reporting to Outcome Based Reporting.

## Principal Activity

The principal activity of the company during the financial year was to act as the national umbrella organisation representing Aboriginal Community Controlled Health Services relating to the self-determined holistic approach to Aboriginal Health and Wellbeing. This comprises the running of the National Secretariat and the provision of secretarial services to the National Executive Committee and the full membership. No significant change in the nature of these activities occurred during the year.

## Objectives

The establishment or conduct of all or any of the following objectives are within the context of the Aboriginal understanding of health within the Aboriginal community: to alleviate poverty within the Aboriginal community; the advancement of Aboriginal religion; to provide constructive educational programmes for members of the Aboriginal community; and to deliver holistic and culturally appropriate health and related services to the Aboriginal community.

## DIRECTORS' REPORT (CONTINUED)

**Strategy for Achieving the Objectives**

NACCHO provides leadership and direction in policy development and aims to shape the national reform of Aboriginal health. This is so that our people can access the highest quality; culturally safe community-controlled health care in a way that builds our responsibility for our own health.

NACCHO builds the capacity of Aboriginal Community Controlled Health Services and promotes and supports high performance and best practice models of culturally appropriate and comprehensive primary health care.

NACCHO develops more efficient and effective services for its members and promotes research that will build evidence-informed best practice in Aboriginal health policy and service delivery.

**Meetings of Directors**

| DIRECTORS | DIRECTORS' MEETINGS | |
|---|---|---|
| | Number eligible to attend | Number attended |
| John Singer (Chair - Appointed 2/11/17) | 3 | 3 |
| Donella Mills, (Deputy Chair – Appointed 2/11/17) | 3 | 3 |
| Julie Tongs | 6 | 5 |
| Adrian Carson | 3 | 3 |
| Vicki Holmes | 6 | 5 |
| John Mitchell | 6 | 4 |
| Raelene Foster | 6 | 4 |
| Donna Ah Chee | 6 | 5 |
| Scott Monaghan | 6 | 6 |
| Lesley Nelson | 6 | 6 |
| Kieran Chilcot | 6 | 6 |
| Rod Jackson (Appointed 5/9/17) | 5 | 5 |
| Chris Bin Kali | 3 | 2 |
| Olga Havnen | 3 | 2 |
| Mark Lovett | 3 | 1 |
| LaVerne Bellear (Appointed 23/5/18) | 1 | 1 |
| Shane Mohor (Resigned 2/11/17) | 2 | 2 |
| John Paterson (Resigned 2/11/17) | 3 | 3 |
| Michelle Nelson-Cox (Resigned 2/11/17) | 3 | 3 |
| Christine Corby (Resigned 2/11/17) | 3 | 0 |
| Sol Bellear (Appointed 2/11/17) | - | - |
| Sandy Davies (Resigned 2/11/17) | 3 | 3 |
| Matthew Cooke (Resigned 2/11/17) | 3 | 2 |

**Contributions on wind up**

If the company is wound up, the constitution states that each member is required to make a maximum contribution of $10 towards meeting any outstanding obligations. At 30 June 2018, the total maximum amount that members of the company are liable to contribute if the company is wound up is $10 per member.

**Auditor's Independence Declaration**

The lead auditor's independence declaration for the year ended 30 June 2018 has been received.

Signed in accordance with a resolution of the Board of Directors:

Director _____ Director _____

Vicki Holmes John Singer

Dated: 19/9/2018

## STATEMENT OF PROFIT OR LOSS AND OTHER COMPREHENSIVE INCOME
## FOR THE YEAR ENDED 30 JUNE 2018

| | Note | 2018 $ | 2017 $ |
|---|---|---|---|
| Revenue from ordinary activities | 3 | 5,398,202 | 4,844,097 |
| Employee benefits expense | | (3,152,051) | (2,203,829) |
| Depreciation & amortisation expenses | 4 | (597,411) | (100,638) |
| Other expenses from ordinary activities | 4 | (1,721,915) | (2,388,665) |
| **Profit from ordinary activities** | | **(73,175)** | **150,965** |
| **Other comprehensive income** | | - | - |
| **Total comprehensive income** | | **(73,175)** | **150,965** |

## STATEMENT OF FINANCIAL POSITION
## AS AT 30 JUNE 2018

| | Note | 2018 $ | 2017 $ |
|---|---|---|---|
| **CURRENT ASSETS** | | | |
| Cash and cash equivalents | 5 | 2,433,619 | 2,707,770 |
| Cash held in trust | 6 | 1,270,458 | - |
| Investments | 7 | 263,000 | 99,871 |
| Receivables/Other receivables | 8 | 100,934 | 305,327 |
| **TOTAL CURRENT ASSETS** | | **4,068,011** | **3,112,968** |
| **NON-CURRENT ASSETS** | | | |
| Property, plant and equipment | 9 | 1,740,360 | 82,635 |
| **TOTAL NON-CURRENT ASSETS** | | **1,740,360** | **82,635** |
| **TOTAL ASSETS** | | **5,808,371** | **3,195,603** |
| **CURRENT LIABILITIES** | | | |
| Payables | 10 | 460,324 | 334,749 |
| Employee Provisions and other liabilities | 11 | 569,096 | 121,845 |
| Other | 12 | 2,659,732 | 1,242,423 |
| **TOTAL CURRENT LIABILITIES** | | **3,689,152** | **1,699,017** |
| **NON-CURRENT LIABILITIES** | | | |
| Employee Provisions | 11 | 12,760 | 11,036 |
| Non-Current Lease Liability | 11 | 538,247 | - |
| Provision for Make Good | 11 | 155,837 | - |
| **TOTAL NON-CURRENT LIABILITIES** | | **706,844** | **11,036** |
| **TOTAL LIABILITIES** | | **4,395,996** | **1,710,053** |
| **NET ASSETS** | | **1,412,375** | **1,485,550** |
| **EQUITY** | | | |
| Retained profits | | 1,412,375 | 1,485,550 |
| **TOTAL EQUITY** | | **1,412,375** | **1,485,550** |

## STATEMENT OF CHANGES IN EQUITY
## FOR THE YEAR ENDED 30 JUNE 2018

| | Retained profits | Total |
|---|---|---|
| | $ | $ |
| **Balance at 1 July 2016** | 1,334,585 | 1,334,585 |
| Net Profit for the year | 150,965 | 150,965 |
| **Balance at 30 June 2017** | **1,485,550** | **1,485,550** |
| | | |
| **Balance at 1 July 2017** | 1,485,550 | 1,485,550 |
| Net Profit for the year | (73,175) | (73,175) |
| **Balance at 30 June 2018** | **1,412,375** | **1,412,375** |

## STATEMENT OF CASH FLOWS
## FOR THE YEAR ENDED 30 JUNE 2018

| | 2018<br>$ | 2017<br>$ |
|---|---|---|
| **CASH FLOW FROM OPERATING ACTIVITIES** | | |
| Receipts from customers | 2,039,776 | 1,340,529 |
| Operating grant receipts | 4,711,998 | 4,272,794 |
| Payments to suppliers and employees | (4,601,612) | (4,784,480) |
| Interest received | 46,259 | 35,378 |
| Interest paid on lease liability | (52,307) | - |
| **Net cash provided by/(used in) operating activities** | **2,144,114** | **864,221** |
| **CASH FLOW FROM INVESTING ACTIVITIES** | | |
| Payment for property, plant and equipment | (2,268,219) | (19,187) |
| Proceeds from sale/write-off of property, plant and equipment | 13,083 | - |
| Investment in Term Deposits | (163,129) | (2,329) |
| **Net cash used in investing activities** | **(2,418,265)** | **(21,516)** |
| Net increase/(decrease) in cash held | (274,151) | 842,705 |
| Cash at beginning of financial year | 2,707,770 | 1,865,065 |
| **Cash at end of financial year** | **2,433,619** | **2,707,770** |

## NOTES TO THE FINANCIAL STATEMENTS FOR THEYEAR ENDED 30 JUNE 2018

### NOTE 1. STATEMENT OF 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.

**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') and the Australian Charities and Not-for-profits Commission Act, as appropriate for not-for-profit oriented entities.

**Historical cost convention**

The financial statements have been prepared under the historical cost convention.

**New or amended Accounting Standards and Interpretations adopted**

The company has adopted all the new or amended Accounting Standards and Interpretations issued by the Australian Accounting Standards Board ('AASB') that are mandatory for the current reporting period. The company has early adopted AASB 15 *Revenue from Contracts with Customers*, AASB 16 *Leases*, and AASB 1058 *Income of not-for-profit Entities*. The Modified retrospective method was used. There is no impact to the net assets as at 1 July 2017 due to the early adoption of said standards.

Any other new or amended Accounting Standards or Interpretations that are not yet mandatory have not been early adopted.

*AASB 15 Revenue from Contracts with Customers*
The standard provides a single standard for revenue recognition. The core principle of the standard is that an entity will recognise revenue to depict the transfer of promised goods or services to customers in an amount that reflects the consideration to which the entity expects to be entitled in exchange for those goods or services. The standard will require: contracts (either written, verbal or implied) to be identified, together with the separate performance obligations within the contract; determine the transaction price, adjusted for the time value of money excluding credit risk; allocation of the transaction price to the separate performance obligations on a basis of relative stand-alone selling price of each distinct good or service, or estimation approach if no distinct observable prices exist; and recognition of revenue when each performance obligation is satisfied. Credit risk will be presented separately as an expense rather than adjusted to revenue. For goods, the performance obligation would be satisfied when the customer obtains control of the goods. For services, the performance obligation is satisfied when the service has been provided, typically for promises to transfer services to customers. For performance obligations satisfied over time, an entity would select an appropriate measure of progress to determine how much revenue should be recognised as the performance obligation is satisfied. Contracts with customers will be presented in an entity's statement of financial position as a contract liability, a contract asset, or a receivable, depending on the relationship between the entity's performance and the customer's payment. Sufficient quantitative and qualitative disclosure is required to enable users to understand the contracts with customers; the significant judgments made in applying the guidance to those contracts; and any assets recognised from the costs to obtain or fulfil a contract with a customer. The company will adopt this standard from 1 July 2019 but the impact of its adoption is yet to be assessed by the company.

## NOTES TO THE FINANCIAL STATEMENTS FOR THEYEAR ENDED 30 JUNE 2018

### NOTE 1. STATEMENT OF SIGNIFICANT ACCOUNTING POLICIES (continued)

*AASB 1058 Income for not-for-Profit Entities*
This Standard clarifies and simplifies the income recognition requirements that apply to not-for-profit (NFP) entities, in conjunction with AASB 15 Revenue from Contracts with Customers. The timing of income recognition depends on whether such a transaction gives rise to a liability or other performance obligation (a promise to transfer a good or service), or a contribution by owners, related to an asset (such as cash or another asset) received by an entity. The standard requires that any asset, including cash, given to the entity principally to enable the entity to further its objectives, should be recognised as income when control is gained by the entity.

There was no impact to the financial statements on initial adoption of this standard.

*AASB 16 Leases*
The standard replaces AASB 117 'Leases' and for lessees will eliminate the classifications of operating leases and finance leases. Subject to exceptions, a 'right-of-use' asset will be capitalised in the statement of financial position, measured at the present value of the unavoidable future lease payments to be made over the lease term. The exceptions relate to short-term leases of 12 months or less and leases of low-value assets (such as personal computers and small office furniture) where an accounting policy choice exists whereby either a 'right-of-use' asset is recognised or lease payments are expensed to profit or loss as incurred. A liability corresponding to the capitalised lease will also be recognised, adjusted for lease prepayments, lease incentives received, initial direct costs incurred and an estimate of any future restoration, removal or dismantling costs. Straight-line operating lease expense recognition will be replaced with a depreciation charge for the leased asset (included in operating costs) and an interest expense on the recognised lease liability (included in finance costs). In the earlier periods of the lease, the expenses associated with the lease under AASB 16 will be higher when compared to lease expenses under AASB 117. For classification within the statement of cash flows, the lease payments will be separated into both a principal (financing activities) and interest (either operating or financing activities) component. For lessor accounting, the standard does not substantially change how a lessor accounts for leases.

**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 company'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 from contracts with customers**

Revenue is recognised at an amount that reflects the consideration to which the consolidated entity is expected to be entitled in exchange for transferring goods or services to a customer. Revenue is recognised when it the performance obligation to the customer is met, being either when the customer obtains control of the goods, which is generally at the time of delivery, or when any services to be provided under the contract are rendered.

**Sales revenue**

Events, fundraising and raffles are recognised when received or receivable.

**Donations**

Donations are recognised at the time the funds are received, or a commitment becomes contractually enforceable.

## NOTES TO THE FINANCIAL STATEMENTS FOR THEYEAR ENDED 30 JUNE 2018

### NOTE 1. STATEMENT OF SIGNIFICANT ACCOUNTING POLICIES (continued)

**Grants**

Grants are recognised at their fair value where there is a reasonable assurance that the grant will be received, and all attached conditions will be complied with.

**Interest**

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

**Other revenue**

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

**Income tax**

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

**Current and non-current classification**

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

**An asset is classified as current when**: it is either expected to be realised or intended to be sold or consumed in the company's normal operating cycle; it is held primarily for the purpose of trading; it is expected to be realised within 12 months after the reporting period; or the asset is cash or cash equivalent unless restricted from being exchanged or used to settle a liability for at least 12 months after the reporting period. All other assets are classified as non-current.

**A liability is classified as current when**: it is either expected to be settled in the company's normal operating cycle; it is held primarily for the purpose of trading; it is due to be settled within 12 months after the reporting period; or there is no unconditional right to defer the settlement of the liability for at least 12 months after the reporting period. All other liabilities are classified as non-current.

Deferred tax assets and liabilities are always classified as non-current.

**Cash and cash equivalents**

Cash and cash equivalents include 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**

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

**Property, plant and equipment**

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.

## NOTES TO THE FINANCIAL STATEMENTS FOR THEYEAR ENDED 30 JUNE 2018

### NOTE 1. STATEMENT OF SIGNIFICANT ACCOUNTING POLICIES (continued)

**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:**

| | |
|---|---|
| Buildings | 3 years |
| Freehold improvements | 3 years |
| Plant and equipment | 3-7 years |
| Motor vehicles | 5-7 years |
| Office equipment | 3-5 years |

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

An item of property, plant and equipment is derecognised upon disposal or when there is no future economic benefit to the company. Gains and losses between the carrying amount and the disposal proceeds are taken to profit or loss.

**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 of disposal 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 company 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.

**Employee benefits**

**Short-term employee benefits**

Liabilities for wages and salaries, including non-monetary benefits, annual leave and long service leave expected to be settled wholly within 12 months of the reporting date are measured at the amounts expected to be paid when the liabilities are settled.

**Other long-term employee benefits**

The liability for annual leave and long service leave not expected to be settled within 12 months of the reporting date are measured at the present value of expected future payments to be made in respect of services provided by employees up to the reporting date using the projected unit credit method. Consideration is given to 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.

**Defined contribution superannuation expense**

Contributions to defined contribution superannuation plans are expensed in the period in which they are incurred.

## NOTES TO THE FINANCIAL STATEMENTS FOR THEYEAR ENDED 30 JUNE 2018

### NOTE 1. STATEMENT OF SIGNIFICANT ACCOUNTING POLICIES (continued)

#### Fair value measurement

When an asset or liability, financial or non-financial, is measured at fair value for recognition or disclosure purposes, the fair value is based on the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date; and assumes that the transaction will take place either: in the principal market; or in the absence of a principal market, in the most advantageous market.

Fair value is measured using the assumptions that market participants would use when pricing the asset or liability, assuming they act in their economic best interests. For non-financial assets, the fair value measurement is based on its highest and best use. Valuation techniques that are appropriate in the circumstances and for which sufficient data are available to measure fair value, are used, maximising the use of relevant observable inputs and minimising the use of unobservable inputs.

#### Goods and Services Tax ('GST') and other similar taxes

Revenues, expenses and assets are recognised net of the amount of associated GST, unless the GST incurred is not recoverable from the tax authority. In this case it is recognised as part of the cost of the acquisition of the asset or as part of the expense. Receivables and payables are stated inclusive of the amount of GST receivable or payable. The net amount of GST recoverable from, or payable to, the tax authority is included in other receivables or other payables in the statement of financial position.

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

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

#### Leases

At the inception of a contract, the company assess whether a contract is, or contains, a lease.

Where a lease is present, the company recognises a right-of-use asset and a corresponding lease liability at the date of the commencement of the lease. The right-of-use asset is initially measured at cost, which comprises the initial amount of the lease liability, together with any payments made prior to the lease commencement date, any initial direct costs, and an estimate of any costs associated with the requirement to restore the leased asset to its original condition. Any lease incentives received are deducted from the cost of the asset.

The right-of-use asset is subsequently depreciated on a straight-line basis over the term of the lease or, if shorter, the useful economic life of the asset. The estimated useful economic life of the asset is determined on the same basis as similar assets within property, plant and equipment.

The lease liability is initially measured at the present value of the lease payments, discounted using the interest rate implicit in the lease, or, if that rate cannot be readily determined, the company's incremental borrowing rate. Lease payments include any fixed payments, any variable lease payments that depend on an index or a rate, any amounts expected to be payable under a residual value guarantee, and any payments relating to optional renewal periods which the company is reasonably certain to exercise.

The lease liability is measured at amortised cost using the effective interest method. The lease liability, and the corresponding right-of-use asset, is remeasured when there is a change in future lease payments arising from a change of index or rate, or if there is a change in the company's assessment of whether it is reasonably certain to exercise any renewal or termination option. If the carrying amount of the right-of-use asset has been reduced to zero, any change to the lease liability is recorded in profit or loss.

## NOTES TO THE FINANCIAL STATEMENTS FOR THEYEAR ENDED 30 JUNE 2018

### NOTE 1. STATEMENT OF SIGNIFICANT ACCOUNTING POLICIES (continued)

Right-of-use assets that do not meet the definition of investment property are presented within property, plant and equipment, and lease liabilities are presented within other borrowings within the statement of financial position. Lease liabilities are classified as either current or non-current depending on the contractual terms of the lease.

The company has elected not to recognise right-of-use assets and lease liabilities for short-term leases with a term of less than 12 months, or for low value assets with a value of less than $5,000. Lease payments associated with these leases are recognised as an expense on a straight-line basis over the term of the lease.

### NOTE 2. CRITICAL ACCOUNTING JUDGEMENTS, ESTIMTES 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 estimate and assumptions that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities (refer to the respective notes) within the next financial year are discussed below.

Estimation of useful lives of assets
The company determines the estimated useful lives and related depreciation and amortisation charges for its property, plant and equipment and finite life intangible assets, including right-of-use 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.

Impairment of non-financial assets other than goodwill and other indefinite life intangible assets
The company assesses impairment of non-financial assets other than goodwill and other indefinite life intangible assets at each reporting date by evaluating conditions specific to the company and to the particular asset that may lead to impairment. If an impairment trigger exists, the recoverable amount of the asset is determined. This involves fair value less costs of disposal or value-in-use calculations, which incorporate a number of key estimates and assumptions.

Employee benefits provision
As discussed in note 1, the liability for employee benefits expected to be settled more than 12 months from the reporting date are 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.

### NOTE 3. REVENUE

| | 2018 | 2017 |
|---|---|---|
| | $ | $ |
| Grant funding | 4,711,998 | 4,272,796 |
| Other income | 639,945 | 535,923 |
| Interest income | 46,259 | 35,378 |
| | **5,398,202** | **4,844,097** |

## NOTES TO THE FINANCIAL STATEMENTS FOR THEYEAR ENDED 30 JUNE 2018

### NOTE 4. EXPENDITURE

| | 2018 $ | 2017 $ |
|---|---|---|
| **Depreciation of non-current assets** | | |
| Plant and equipment | 243,776 | 100,638 |
| Right-of-use assets - leased property (refer to note 9 explanation) | 353,635 | - |
| | **597,411** | **100,638** |
| **Other expenses from ordinary activity** | | |
| Advertising and promotion | 58,312 | 34,301 |
| Computer expenses | 77,347 | 76,452 |
| Consultancy fees | 218,122 | 466,627 |
| Interest | 59,392 | - |
| Management fees | 46,675 | 103,673 |
| Meetings, workshops and seminar costs | 268,756 | 427,349 |
| Provision for Bad Debts | 3,506 | - |
| Postage, printing and stationary | 34,325 | 72,293 |
| Publications | 19,839 | 16,763 |
| Occupancy costs | 75,066 | 356,499 |
| Repairs and maintenance | 36 | - |
| Staff costs | 6,170 | 5,993 |
| Telephone | 51,579 | 39,008 |
| Training and development | 8,295 | 5,102 |
| Travel expenses | 546,086 | 409,008 |
| Other expenses | 218,409 | 351,597 |
| | **1,691,915** | **2,364,665** |
| Auditor's remuneration: | | |
| - Audit Services | 30,000 | 24,000 |
| | **30,000** | **24,000** |
| | **1,721,915** | **2,388,665** |

### NOTE 5. CASH AND CASH EQUIVALENTS

| | 2018 $ | 2017 $ |
|---|---|---|
| Cash on hand | 564 | 566 |
| Cash at bank | 2,433,055 | 2,707,204 |
| | **2,433,619** | **2,707,770** |

## NOTES TO THE FINANCIAL STATEMENTS FOR THEYEAR ENDED 30 JUNE 2018

### NOTE 6. DEPOSITS HELD IN TRUST

| | 2018 $ | 2017 $ |
|---|---|---|
| Deposits held in trust | 1,270,458 | - |
| | **1,270,458** | **-** |

Deposits held in trust comprise of cash balances held in trust for NACCHO state and territory affiliates. A corresponding liability was recognised as grants in advance (see Note 12).

### NOTE 7. INVESTMENTS

| | 2018 $ | 2017 $ |
|---|---|---|
| Term deposits | 263,000 | 99,871 |
| | **263,000** | **99,871** |

### NOTE 8. TRADE AND OTHER RECEIVABLES

| | 2018 $ | 2017 $ |
|---|---|---|
| Trade and other debtors | 63,690 | 106,110 |
| Provision for doubtful debts | (12,176) | (8,670) |
| Other current assets - prepayments | 49,420 | 207,887 |
| | **100,934** | **305,327** |

## NOTES TO THE FINANCIAL STATEMENTS FOR THEYEAR ENDED 30 JUNE 2018

### NOTE 9. PROPERTY, PLANT AND EQUIPMENT

Property, plant and equipment comprises both owned and leased assets which do not meet the definition of investment properties.

| | 2018<br>$ | 2017<br>$ |
|---|---|---|
| Plant and equipment | | |
| At cost | 115,709 | 108,453 |
| Less accumulated depreciation | (93,792) | (87,285) |
| | **21,917** | **21,168** |
| Motor vehicles | | |
| At cost | - | 31,395 |
| Less accumulated depreciation | - | (16,744) |
| | - | **14,651** |
| Office equipment | | |
| At cost | 202,113 | 173,395 |
| Less accumulated depreciation | (158,075) | (129,577) |
| | **44,038** | **43,818** |
| Computer equipment | | |
| At cost | 13,409 | 13,409 |
| Less accumulated depreciation | (13,208) | (10,411) |
| | **201** | **2,998** |
| Freehold Improvements | | |
| At cost | 817,704 | - |
| Less accumulated depreciation | (204,406) | - |
| | **613,298** | - |
| Right-of-use Asset - Land and Buildings (leases) | | |
| At cost | 1,414,541 | - |
| Less accumulated depreciation | (353,635) | - |
| | **1,060,906** | - |
| Total property, plant and equipment | **1,740,360** | **82,635** |

## NOTES TO THE FINANCIAL STATEMENTS FOR THEYEAR ENDED 30 JUNE 2018

### NOTE 9. PROPERTY, PLANT AND EQUIPMENT (continued)

**Movements in carrying amounts**
Movement in the carrying amounts for each class of property, plant and equipment between the beginning and the end of the current financial year is as follows:

| | Right-of-use Asset - Land and Buildings | | Freehold Improvements | Plant & equipment | Motor vehicles | Office equipment | Computer equipment | Total |
|---|---|---|---|---|---|---|---|---|
| | $ | | $ | $ | $ | $ | $ | $ |
| **Balance at the beginning of the year** | - | | - | **21,168** | **14,651** | **43,818** | **2,998** | **82,635** |
| Additions | 1,414,541 | * | 817,704 | 7,256 | - | 28,718 | - | 2,268,219 |
| Disposals | - | | - | - | (13,083) | - | - | (13,083) |
| Depreciation expense | (353,635) | | (204,406) | (6,506) | (1,568) | (28,499) | (2,797) | (597,411) |
| **Carrying amount at end of year** | **1,060,906** | | **613,298** | **21,918** | - | **44,037** | **201** | **1,740,360** |

As disclosed in Note 1 and Note 13, the Company early adopted AASB16 at 30 June 2018.

Adopting AASB 16 resulted in the Company creating a right-of-use asset and a corresponding lease liability (refer Note 13).

* This right-of-use-asset will be depreciated over the term of the lease or in this case the term of the grant funding agreement.

### NOTE 10. CURRENT LIABILITIES - TRADE AND OTHER PAYABLES

| | 2018 | 2017 |
|---|---|---|
| | $ | $ |
| Trade creditors and accruals | 323,185 | 291,740 |
| Sundry creditors (ATO) | 137,139 | 43,009 |
| | **460,324** | **334,749** |

## NOTES TO THE FINANCIAL STATEMENTS FOR THEYEAR ENDED 30 JUNE 2018

### NOTE 11. CURRENT AND NON-CURRENT LIABILITIES - EMPLOYEE BENEFITS AND OTHER

| | 2018 $ | 2017 $ |
|---|---|---|
| CURRENT | | |
| Employee benefits - annual leave | 106,980 | 100,705 |
| Employee benefits - long service leave | - | - |
| Employee benefits - time in lieu | 19,766 | 21,140 |
| Lease liability (see Note 13) | 442,350 | - |
| TOTAL CURRENT | **569,096** | **121,845** |
| NON-CURRENT | | |
| Employee benefits - long service leave | 12,760 | 11,036 |
| Lease liability (see Note 13) | 538,247 | - |
| Provision for Make Good | 155,837 | - |
| TOTAL NON-CURRENT | **706,844** | **11,036** |

### NOTE 12. CURRENT LIABLITIES - OTHER

| | 2018 $ | 2017 $ |
|---|---|---|
| Unspent grants | 1,173,694 | 441,260 |
| Grants Received in Advance | 1,270,458 | 801,163 |
| Revenue Received in Advance | 29,887 | - |
| Leasehold Incentive Liability | 185,693 | - |
| | **2,659,732** | **1,242,423** |

### NOTE 13. LEASE LIABILITIES

The company leases its premises at 2 Constitution Avenue, Canberra, ACT. The lease runs for three years with an option to renew the lease for an additional period of two years. Under the lease terms, the rent payable under the lease increases each year by 3.75%. The company has entered into a lease with an option in order to enhance operational flexibility. The company has not included the option to renew the lease within its estimate of the lease liability, since the option is not considered reasonably certain to be exercised.

There were no expenses recognised in the income statement in respect of short-term leases, or leases of low value assets.

## NOTES TO THE FINANCIAL STATEMENTS FOR THEYEAR ENDED 30 JUNE 2018

### NOTE 13. LEASE LIABILITIES (continued)

Lease liabilities included in the statement of financial position as at 30 June 2018

| | 2018 |
|---|---|
| | $ |
| Current | 442,350 |
| Non-current | 538,247 |
| | 980,597 |

The total cash outflow from leases during the year was $337,500.

The maturity analysis of the company's lease, based on the contractual undiscounted cash flows, is set out below.

| | 2018 |
|---|---|
| | $ |
| Less than one year | 462,656 |
| One to five years | 601,102 |
| Less future finance charges | (83,161) |
| | 980,597 |

### NOTE 14. RELATED PARTY TRANSACTIONS

No material related party transactions took place during the year.

**Key Management Personnel**

Any person(s) having authority and responsibility for planning, directing and controlling the activities of the company, directly or indirectly, including any director (whether executive or otherwise) is considered key management personnel.

| | 2018 | 2017 |
|---|---|---|
| | $ | $ |
| Short term benefits | 378,699 | 356,413 |
| Post-employment benefits | 64,316 | 32,497 |
| | 443,015 | 388,910 |

The annual stipend paid by National Aboriginal Community Controlled Health Organisation in respect of director services provided by the Chairpersons, and their costs associated with providing those services, during the financial year was $98,415. Other directors do not receive any forms of remuneration.

### NOTE 15. COMPANY DETAILS

The registered office of the company is:
National Aboriginal Community Controlled Health Organisation
Level 5, East Tower, 2 Constitution Avenue
CANBERRA ACT 2601

## NOTES TO THE FINANCIAL STATEMENTS FOR THEYEAR ENDED 30 JUNE 2018

### NOTE 16. CONTINGENT LIABILITIES

The company had no known contingent liabilities as at 30 June 2018.

### NOTE 17. EVENTS AFTER THE REPORTING PERIOD

No matter or circumstance has arisen since 30 June 2018 that has significantly affected, or may significantly affect the company's operations, the results of those operations, or the company's state of affairs in future financial years.

**NATIONAL ABORIGINAL COMMUNITY CONTROLLED HEALTH ORGANISATION**
**ABN 89 078 949 710**

## DIRECTORS' DECLARATION

The Directors of the Company declare that:

1. The financial statements and notes, are in accordance with the Australian Charities and Not-for-profits Commission Act 2012 and:

(a) Comply with Accounting Standards; and

(b) Give a true and fair view of the financial position as at 30 June 2018 and of the performance for the year ended on that date of the Company.

2. In the Directors' opinion there are reasonable grounds to believe that the Company will be able to pay its debts as and when they become due and payable.

This declaration is made in accordance with a resolution of the Board of Directors.

Director _____ Director _____

Vicki Holmes John Singer

Dated: 19/9/2018

RSM Australia Partners

Equinox Building 4, Level 2, 70 Kent Street Deakin ACT 2600
GPO Box 200 Canberra ACT 2601

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F +61 (0) 2 6217 0401

www.rsm.com.au

## AUDITOR'S INDEPENDENCE DECLARATION

As lead auditor for the audit of the financial report of National Aboriginal Community Controlled Health Organisation for the year ended 30 June 2018, I declare that, to the best of my knowledge and belief, there have been no contraventions of:

(i) the auditor independence requirements of the *Australian Charities and Not-for-profit Act 2012* in relation to the audit; and

(ii) any applicable code of professional conduct in relation to the audit.

RSM

**RSM AUSTRALIA PARTNERS**

G Stenhouse

Canberra, Australian Capital Territory
Dated: 20 September 2018

**GED STENHOUSE**
Partner

RSM Australia Partners

Equinox Building 4, Level 2, 70 Kent Street Deakin ACT 2600
GPO Box 200 Canberra ACT 2601

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www.rsm.com.au

## INDEPENDENT AUDITOR'S REPORT

## TO THE MEMBERS OF

## NATIONAL ABORIGINAL COMMUNITY CONTROLLED HEALTH ORGANISATION

### Opinion

We have audited the financial report of National Aboriginal Community Controlled Health Organisation ("the entity"), which comprises the statement of financial position as at 30 June 2018, the statement of comprehensive income, the statement of changes in equity and the statement of cash flows for the year then ended, and notes to the financial statements, including a summary of significant accounting policies, and the directors' declaration.

In our opinion, the financial report of National Aboriginal Community Controlled Health Organisation has been prepared in accordance with Division 60 of the *Australian Charities and Not-for-profits Commission Act 2012*, including:

(a) giving a true and fair view of the registered entity's financial position as at 30 June 2018 and of its financial performance and cash flows for the year ended on that date; and

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

### Basis for Opinion

We conducted our audit in accordance with Australian Auditing Standards. Our responsibilities under those standards are further described in the *Auditor's Responsibilities for the Audit of the Financial Report* section of our report. We are independent of the National Aboriginal Community Controlled Health Organisation in accordance with the ethical requirements of the Accounting Professional and Ethical Standards Board's APES 110 *Code of Ethics for Professional Accountants* (the Code) that are relevant to our audit of the financial report in Australia. We have also fulfilled our other ethical responsibilities in accordance with the Code.

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

### Other Information

Those charged with governance are responsible for the other information. The other information comprises the information included in National Aboriginal Community Controlled Health Organisation's annual report for the year ended 30 June 2018, but does not include the financial report and the auditor's report thereon.

Our opinion on the financial report does not cover the other information and accordingly we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial report, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial report or our knowledge obtained in the audit or otherwise appears to be materially misstated.

If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact. We have nothing to report in this regard.

**Responsibilities of Management and Those Charged with Governance for the Financial Report**

The Management of the registered entity are responsible for the preparation of the financial report that gives a true and fair view in accordance with Australian Accounting Standards and the *Australian Charities and Not-for-profits Commission Act 2012* (ACNC Act) and for such internal control as the Management determine is necessary to enable the preparation of the financial report that gives a true and fair view and is free from material misstatement, whether due to fraud or error.

In preparing the financial report, Management are responsible for assessing National Aboriginal Community Controlled Health Organisation's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless management either intends to liquidate National Aboriginal Community Controlled Health Organisation or to cease operations, or has no realistic alternative but to do so.

**Auditor's Responsibilities for the Audit of the Financial Report**

Our objectives are to obtain reasonable assurance about whether the financial report as a whole is free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with the Australian Auditing Standards will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of this financial report.

A further description of our responsibilities for the audit of the financial report is located at the Auditing and Assurance Standards Board website at: http://www.auasb.gov.au/auditors_responsibilities/ar4.pdf. This description forms part of our auditor's report.

**RSM AUSTRALIA PARTNERS**

Canberra, Australian Capital Territory
Dated: 20 September 2018

**GED STENHOUSE**
Partner

# APPENDIX A

## MEMBERS

| Organisation Name | State |
|---|---|
| Winnunga Nimititjya Health and Community Centre | ACT |
| Aboriginal Medical Service Cooperative Redfern | NSW |
| Albury Wodonga Aboriginal Health Service | NSW |
| Armajun Aboriginal Health Service | NSW |
| Awabakal Newcastle Aboriginal Cooperative Limited | NSW |
| Bega Clinic | NSW |
| Biripi Aboriginal Corporation Medical Centre | NSW |
| Bourke Aboriginal Health Service Limited | NSW |
| Brewarrina Aboriginal Health Service Limited | NSW |
| Brungle Aboriginal Health Service | NSW |
| Bulgarr Ngaru Medical Aboriginal Corporation | NSW |
| Bullinah Aboriginal Health Service Aboriginal Corporation | NSW |
| Condobolin Aboriginal Service Inc | NSW |
| Coomealla Health Aboriginal Corporation | NSW |
| Coonamble Aboriginal Health Service Incorporated | NSW |
| Cummeragunja Housing and Development Corporation (Viney Morgan Aboriginal Medical Service) | NSW |
| Durri Aboriginal Corporation Medical Service | NSW |
| Galambila Aboriginal Health Service Incorporated | NSW |
| Griffith Aboriginal Medical Service Incorporated | NSW |
| Illawarra Aboriginal Medical Service Aboriginal Corporation | NSW |
| Katungul Aboriginal Corporation Community & Medical Service | NSW |
| Murrin Bridge Aboriginal Health Service Incorporated | NSW |
| Ngaimpe Aboriginal Corporation | NSW |
| Orange Aboriginal Medical Service Incorporated | NSW |
| Peak Hill Aboriginal Medical Service | NSW |
| Pius X Aboriginal Corporation | NSW |

| Organisation Name | State |
|---|---|
| Riverina Medical & Dental Aboriginal Corporation | NSW |
| South Coast Medical Service Aboriginal Corporation | NSW |
| Tharawal Aboriginal Corporation | NSW |
| The Oolong Aboriginal Corporation | NSW |
| Tobwabba Aboriginal Medical Service Incorporated | NSW |
| Ungooroo Aboriginal Corporation | NSW |
| Walgett Aboriginal Medical Service Cooperative Limited | NSW |
| Walhallow Aboriginal Corporation | NSW |
| Waminda - South Coast Women's Health and Welfare Aboriginal Corporation | NSW |
| Weigelli Centre Aboriginal Corporation | NSW |
| Wellington Aboriginal Corporation Health Service | NSW |
| Werin Aboriginal Corporation Medical Centre | NSW |
| Yerin Aboriginal Health Services Incorporated | NSW |
| Yoorana Gunya Family Healing Centre Aboriginal Corporation | NSW |
| Amoonguna Health Service Aboriginal Corporation | NT |
| Ampilatwatja Health Centre Aboriginal Corporation | NT |
| Anyinginyi Health Aboriginal Corporation | NT |
| Central Australian Aboriginal Congress Aboriginal Corporation | NT |
| Danila Dilba Biluru Butji Binnilutlum Health Service Aboriginal Corporation | NT |
| Katherine West Health Board Aboriginal Corporation | NT |
| Malabam Health Board Aboriginal Corporation | NT |
| Miwatj Health Aboriginal Corporation | NT |
| Mpwelarre Health Aboriginal Corporation (Santa Teresa Health Centre) | NT |
| Mutitjulu Health Service | NT |
| Ngaanyatjarra Health Service Aboriginal Corporation | NT |

| Organisation Name | State |
|---|---|
| Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women's Council Aboriginal Corporation | NT |
| Nganampa Health Council Incorporated | NT |
| Pintubi Homelands Health Service Aboriginal Corporation | NT |
| Red Lily Health Board | NT |
| Sunrise Health Service Aboriginal Corporation | NT |
| Urapuntja Health Service Aboriginal Corporation | NT |
| Utju Health Service Aboriginal Corporation | NT |
| Western Aranda Health Aboriginal Corporation | NT |
| Western Desert Nganampa Walytja Palyantjaku Tjutaku Aboriginal Corporation | NT |
| Wurli Wurlinjang Health Service Aboriginal Corporation | NT |
| Aboriginal and Torres Strait Islander Community Health Service Brisbane Limited | QLD |
| Aboriginal and Torres Strait Islander Community Health Service Mackay Ltd | QLD |
| Apunipima Cape York Health Council | QLD |
| Bidgerdii Aboriginal & Torres Strait Islander Corporation Health Service Central Queensland Region | QLD |
| Carbal Medical Services (Darling Downs) | QLD |
| Charleville & Western Areas Aboriginal Torres Strait Islander Community Health Limited | QLD |
| Cherbourg Regional Aboriginal and Islander Community Controlled Health Service (formerly Barambah Regional Medical Service Aboriginal Corporation) (CRAICCHS) | QLD |
| Cunnamulla Aboriginal Corporation for Health | QLD |
| Galangoor Duwalami Primary Health Care Service | QLD |
| Girudala Community Cooperative Society Ltd | QLD |
| Goolburri Aboriginal Health Advancement Company Limited | QLD |
| Goondir Health Services | QLD |
| Gurriny Yealamucka Health Service Aboriginal Corportion | QLD |

| Organisation Name | State |
|---|---|
| Injilinji Aboriginal and Torres Strait Islander Corporation for Children and Youth Services | QLD |
| Institute for Urban Indigenous Health (Administration) | QLD |
| Kalwun Health Service | QLD |
| Kambu Aboriginal and Torres Strait Islander Corporation for Health | QLD |
| Mamu Health Service Limited | QLD |
| Mount Isa Aboriginal Community Controlled Health Service (Gidgee Healing) | QLD |
| Mudth Niyleta Aboriginal and Torres Strait Islander Corporation | QLD |
| Mulungu Aboriginal Corporation Medical Centre | QLD |
| Nhulundu Wooribah Indigineous Health Organisation Inc. | QLD |
| North Coast Aboriginal Corporation for Community Health | QLD |
| Northern Peninsula Area Family and Community | QLD |
| Townsville Aboriginal and Torres Strait Islander Corporation for Health Service | QLD |
| Wuchopperen Health Service Limited | QLD |
| Yulu-Burri-Ba Aboriginal Corporation for Community Health | QLD |
| Aboriginal Sobriety Group Incorporated | SA |
| Ceduna Kooniba Aboriginal Health Service Aboriginal Corporation | SA |
| Kalparrin Community Incorporated | SA |
| Nunkuwarrin Yunti of South Australia Inc | SA |
| Nunyara Aboriginal Health Service Incorporated -Nunyara Wellbeing Centre | SA |
| Oak Valley (Maralinga) Incorporated | SA |
| Pangula Marnamurna Incorporated | SA |
| Pika Wiya Health Service Aboriginal Corporation | SA |
| Port Lincoln Aboriginal Health Service Incorporated | SA |
| Tullawon Health Service Incorporated | SA |

# APPENDIX A

| Organisation Name | State |
|---|---|
| Umoona Tjutagku Health Service Aboriginal Corporation | SA |
| Tasmanian Aboriginal Health Centre Incorporated | TAS |
| Aboriginal Community Elders Services Incorporated | VIC |
| Ballarat & District Aboriginal Co-operative Ltd | VIC |
| Bendigo & District Aboriginal Cooperative | VIC |
| Budja Budja Aboriginal Co-operative | VIC |
| Dandenong & District Aboriginal Cooperative Ltd | VIC |
| Dhauwurd-Wurrung Elderly and Community Health Service Inc | VIC |
| Gippsland & East Gippsland Aboriginal Cooperative-GEGAC | VIC |
| Goolum Goolum Aboriginal Cooperative | VIC |
| Gunditjmara Aboriginal Co-operative Ltd | VIC |
| Kirrae Health Services Inc. | VIC |
| Lake Tyers Health and Children's Service | VIC |
| Lakes Entrance Aboriginal Health Association | VIC |
| Mallee District Aboriginal Services | VIC |
| Moogji Aboriginal Council East Gippsland Inc. | VIC |
| Mungabareena Aboriginal Corporation | VIC |
| Murray Valley Aboriginal Cooperative | VIC |
| Ngwala Willumbong Cooperative Limited (Telkaya Drug and Alcohol Network) | VIC |
| Njernda Aboriginal Corporation - Njernda Aboriginal Women's & Children's Health Centre | VIC |
| Ramahyuck and District Aboriginal Corporation | VIC |
| Rumbalara Aboriginal Cooperative Ltd | VIC |
| Victorian Aboriginal Health Service Cooperative Limited | VIC |
| Wathaurong Aboriginal Co-operative Health Service | VIC |
| Winda-Mara Aboriginal Corporation | VIC |
| Beagle Bay Community Incorporated | WA |
| Bega Garnbirringu Health Service Incorporated | WA |
| Bidyadanga Aboriginal Health Service | WA |
| Broome Regional Aboriginal Medical Service | WA |
| Carnarvon Medical Service Aboriginal Corporation | WA |
| Derbarl Yerrigan Health Service Incorporated | WA |
| Derby Aboriginal Health Service Council Aboriginal Corporation | WA |
| Geraldton Regional Aboriginal Medical Service | WA |
| Jurrugk Aboriginal Health Service | WA |
| Kimberly Aboriginal Medical Services Limited | WA |
| Mawarnkarra Health Service Aboriginal Corporation | WA |
| Ngangganawili Aboriginal Health Service | WA |
| Nindillingarri Cultural Health Service Incorporated | WA |
| Ord Valley Aboriginal Health Service Corporation | WA |
| Puntukurnu Aboriginal Medical Service | WA |
| South West Aboriginal Medical Service | WA |
| Spinifex Health Service | WA |
| Wirraka Maya Health Service Aboriginal Corporation | WA |
| Yura Yungi Medical Service Aboriginal Corporation | WA |

# APPENDIX B

## REPRESENTATION ON COMMITTEES

**NACCHO represents our sector on a wide range of bodies:**

Aboriginal and Torres Strait Islander Suicide Evaluation Project National

Aboriginal and Torres Strait Islander Health Workforce Working Group

Aged Care Leadership Group

AMA Taskforce on Indigenous Health

Australian Trachoma Alliance Principals

BeyondBlue Advisory Group

Cancer Australia

Change the Record

Close the Gap Steering Committee

CREATE - Research Project

CQI Project Team

Deeble Institute Research

Funding Model Advisory Committee

Health Care Home Advisory Group

Indigenous Health Faculty

IPAG Forum

Leadership Group on Indigenous Cancer Control

Lighthouse Research Project

MBS Review Taskforce

National Health Leadership Forum

National Immunisation Committee

National Trachoma Surveillance and Reference Group

National Advisory Group for Aboriginal Torres Strait Islander Health, Information and Data - NAGATSIHID

NATSILMH

OCHREStreams Advisory Group

OSR Advisory Group

Practice Incentive Programme Advisory Group

Pharmacy Trials Programme Trials Advisory Group

QUMAX Program and also the QUMAX Reference Group

Racism in Health Forum

Redfern Statement Alliance meetings and workshops

Remote Vocational Training Scheme Advisory Group

Royal Australian College of General Practitioners Reference Group and Faculty Board

Stop. Think. Respect Campaign

Talking about the smokes – Menzies School of Health Research Project

Tackling Indigenous Smoking Best Practice Management Unit

Taskforce on Indigenous Health

University of Melbourne-Indigenous Eye Health, eHealth and Technology Roundtable

Vision 2020 Australia Aboriginal & Torres Strait Islander Committee

# APPENDIX C

## ABBREVIATIONS AND ACRONYMS

| | |
|---|---|
| ABS | Australian Bureau of Statistics |
| AC | Aboriginal Corporation or Congress |
| ACCHRTOs | Aboriginal Community Controlled Health Registered Training Organisations |
| ACCH | Aboriginal Community Controlled Health |
| ACCHs' | Aboriginal Community Controlled Health Services |
| ACNC | Australian Charities and Not-for-profits Commission |
| ACRRM | Australian College of Rural and Remote Medicine |
| ADNs | Aboriginal Disability Networks |
| AF | Asthma Foundation |
| AGM | Annual General Meeting |
| AHAC | Aboriginal Health Advisory Committee |
| AHCSA | Aboriginal Health Council of South Australia |
| AHCWA | Aboriginal Health Council of Western Australia |
| AHMRC | Aboriginal Health and Medical Research Council of NSW |
| AHMAC | Australian Health Ministers Advisory Council |
| AHS | Aboriginal Health Service |
| AHW | Aboriginal and Torres Strait Islander Health Worker |
| AHHA | Australian Healthcare and Hospitals Association |
| AIHW | Australian Institute of Health and Welfare |
| AIDA | Australian Indigenous Doctors Association |
| AIDS | Acquired Immune Deficiency Syndrome |
| AMA | Australian Medical Association |
| AMSs | Aboriginal Medical Services |
| AMSANT | Aboriginal Medical Services Alliance Northern Territory |
| APHC | Aboriginal Primary Health Care |
| APHCRI | Australian Primary Health Care Research Institute |
| BBV | Blood-Borne Viruses |
| ATA | Australian Trachoma Alliance |
| CCHS | Community Controlled Health Services |
| CEO | Chief Executive Officer |
| COAG | Council of Australian Governments |
| CS&HISC | Community Services and Health Industry Skills Council |
| CSTDA | Commonwealth, State and Territory Disability Funding Agreement |
| DAAs | Dosage administration aids |
| DoH | Department of Health |
| DSS | Department of Social Services |
| EPC | Enhanced Primary Care |
| FASD | Fetal Alcohol Spectrum Disorders |
| GP | General Practitioner |
| IMRS | Indigenous Medicines Review Service |
| IPP | Indigenous Pharmacy Programs |
| IPP Review | Indigenous Pharmacy Programs Review |
| KPI | Key Performance Indicators |
| MA | Medicare Australia |
| MAAPs | Medication Access and Assistance Packages |
| MBS | Medical Benefits Schedule |
| MOU | Memorandum of Understanding |
| NACCHO | National Aboriginal Community Controlled Health Organisation |

| | |
|---|---|
| **NATSIHC** | National Aboriginal and Torres Strait Islander Health Council |
| **NATSINSAP** | National Aboriginal and Torres Strait Islander Nutrition Strategy and Action Plan |
| **NCHECR** | National Centre for HIV Epidemiology and Clinical Research |
| **NCIRS** | National Centre for Immunisation Research and Surveillance |
| **NDIA** | National Disability Insurance Agency |
| **NDIS** | National Disability Insurance Service |
| **NHMRC** | National Health and Medical Research Council |
| **NIDAC** | National Indigenous Drug and Alcohol Committee |
| **NIHEC** | National Indigenous Health Equality Council |
| **NKPIs** | National Key Performance Indicators |
| **NPS** | National Prescribing Service |
| **NRHA** | National Rural Health Alliance |
| **NSFATSIH** | National Strategic Framework for Aboriginal and Torres Strait Islander Health |
| **OATSIH** | Office of Aboriginal and Torres Strait Islander Health |
| **PBAC** | Pharmaceutical Benefits Advisory Committee |
| **PBS** | Pharmaceutical Benefits Scheme |
| **PSA** | Pharmaceutical Society of Australia |
| **PCEHR** | Personally Controlled Electronic Health Record |
| **PGA** | Pharmacy Guild of Australia |
| **PHCAP** | Primary Health Care Access Program |
| **PIP** | Practice Incentive Payment |
| **PIRS** | Patient Information Recall System |
| **PM&C** | Prime Minister and Cabinet |
| **PSA** | Pharmaceutical Society of Australia |
| **QAIHC** | Queensland Aboriginal and Islander Health Council |
| **QUM** | Quality Use of Medicine |
| **QUMAX** | Quality Use of Medicines Maximised for Aboriginal peoples and Torres Strait Islanders |
| **RAAF** | Royal Australian Air Force |
| **RACGP** | Royal Australian College of General Practitioners |
| **RACP** | Royal Australian College of Physicians |
| **RDAA** | Rural Doctors Association of Australia |
| **SFA** | Standard Funding Agreement |
| **SEWB** | Social and Emotional Well Being |
| **SFA** | Single Funding Agreement |
| **STI** | Sexually Transmitted Infection |
| **TAC** | Tasmanian Aboriginal Centre |
| **VACCHO** | Victorian Aboriginal Community Controlled Health Organisation |
| **WACRRM** | Western Australian Centre for Remote and Rural Medicine |
| **WSF** | Aboriginal and Torres Strait Islander Health Workforce Strategic Framework |

# APPENDIX D

## NACCHO

Corporate Directory
Australian Business Number
ABN 89078949710

### DIRECTORS 2017-2018

John Singer (Chair), Donnella Mills (Deputy Chair),

Donna Ah Chee, Adrian Carson, Kieran Chilcott, Raelene Foster, Olga Havnen, Vicki Holmes, Rod Jackson, John Mitchell, Scott Monaghan, Lesley Nelson, Julie Tongs, Chris Bin Kali, LaVerne Bellear and Mark Lovett.

### COMPANY SECRETARY

Chris Chenoweth

### PRINCIPLE PLACE OF BUSINESS

Level 5, 2 Constitution Avenue,
Canberra City ACT 2601
P.O. Box 130, Civic Square ACT 2608

### CONTACT DETAILS

T (02) 6246 9300
E reception@naccho.org.au
W www.naccho.org.au

### BANKERS

Westpac

### AUDITORS

RSM Australian Partners

# CELEBRATING 30 YEARS OF EXCELLENCE

WINNUNGA NIMMITYJAH

ABORIGINAL HEALTH & COMMUNITY SERVICES

All welcome to come and celebrate this milestone with Winnunga there will be plenty to eat see and do come and celebrate Winnunga Style and enjoy many different activities from magic show petting zoo rock climbing wall the list goes on plenty of different food stalls on offer from around the world to know this is a free event

***HEADLINE Act***

***BUNNA LAWRIE & COLOURED STONE***

**SATURDAY 12th MAY 2018**

**10am-2pm**

**Winnunga Nimmityjah AHCS**

**63 Boolimba Cres Narrabundah**

**1988-2018**

NACCHO

www.naccho.org.au

*Aboriginal health in Aboriginal hands*


**Contact:**

National Aboriginal Community Controlled Health Organisation

Level 5, 2 Constitution Avenue,
Canberra City ACT 2601

**All correspondence to:**

P.O. Box 130
Civic Square ACT 2608

**T** (02) 6246 9300
**E** reception@naccho.org.au
**W** www.naccho.org.au


**Connect:**

naccho.org.au/connect

NacchoAboriginalHealth

NACCHOAustralia

NACCHOTV