CENTRAL AUSTRALIAN ABORIGINAL CONGRESS
ABORIGINAL CORPORATION

2012 / 2013 Annual Report

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CENTRAL AUSTRALIAN
ABORIGINAL CONGRESS INC.
HEAD OFFICE
CENTRAL AUSTRALIAN ABORIGINAL CONGRESS
SOCIAL & EMOTIONAL WELL BEING
COMMUNITY WELL BEING TEAM
SAFE AND SOBER SUPPORT SERVICES
TARGETED FAMILY SUPPORT SERVICE
PUBLIC HEALTH

"We are no longer a closed shop, we are committed, as the new Board, to being open and transparent."

WILLIAM TILMOUTH
PRESIDENT, BOARD OF DIRECTORS

President's Report

The 2012/13 financial year has been a year of significant change for Congress. The year began with the return of the former Deputy CEO, Donna Ah Chee, after 12 months as the CEO of the National Aboriginal Community Controlled Organisation (NACCHO). Following the resignation of the former CEO, Stephanie Bell, Donna Ah Chee became the Acting CEO.

Soon after Donna Ah Chee's appointment, the former Congress Board recognised that due to technical issues with the way the election of Board Members had been undertaken in recent AGMs, the Board at that time had not been properly elected in accordance with the constitution. This was in spite of the fact that the Board had been advised that the way it was conducting the business of the AGMs, including the appointment of Directors, was acceptable and in accordance with the constitution. However, it became clear that the advice given to the Board was incorrect. The Board found themselves in a very unfortunate situation that precipitated a constitutional problem for the organisation.

Given these circumstances, the former Board became very concerned that the governance of the organisation was legally uncertain which may have placed the delivery of essential primary health care services to our community at risk. Throughout this difficult period the Board always acted in good faith and put the interests of Congress first, which is why they came to the very difficult decision to invite the Northern Territory Department of Justice to appoint a Statutory Manager.

The former Board in partnership with the Statutory Manager, McGrathNichol, then oversaw the development of a revised constitution that clarified important issues such as the election of Board Members and the membership of the Corporation. The Board also decided that it was appropriate for the organisation to become incorporated under the Office of the Registrar of Indigenous Corporations' (ORIC) CATSI Act and therefore the Board worked in partnership with ORIC in developing the revised constitution.

At the Special General Meeting of the Corporation, held on December 14 last year, a revised constitution was adopted and a new Board was elected. It was at this meeting that I began my two-year term as the President of the Corporation, who have officially become known as the Central Australian Aboriginal Congress Aboriginal Corporation after successful registration with ORIC on December 19. On this same day the Statutory Manager handed back the affairs of the Corporation to the newly elected Board. There was only a brief transition period when the Statutory Manager was in charge of the Corporation and there was little or no disruption in the workplace with service delivery continuing as normal throughout this period of change. On behalf of the Members of the Corporation I want to thank McGrath Nichol for the professional manner in which they conducted themselves in the Statutory Manager role and for their support for the very rapid transition back to community control.

There have been important developments at a governance level some of which have been outlined in the Board Communiqué earlier this year. These Communiqués are themselves a sign of a new way of doing business – Congress is open, transparent and accountable to all of the Members of the Corporation. This has been an important part of the overall change process for Congress.

Another major change was the creation of three Non-Member Director positions on the Board to be filled by Aboriginal people with special expertise. There were advertisements in the newspapers earlier this year seeking expressions of interest for the three Non-Member Aboriginal Director positions in the areas of governance and administration, finance and primary health care. Following a formal national recruitment process the Board made these appointments at its June 6 meeting.

At the same time as these changes were occurring, Donna Ah Chee was appointed as the new CEO of the Corporation. Congress has been very fortunate that Donna decided to return to Alice Springs when she did and under both the leadership of the new Board, along with Donna,

The Central Australian Aboriginal Congress Aboriginal Corporation Board of Directors* with CEO Donna Ah Chee.
Left to right: Chansey Paech (Youth Representative), Donna McMasters, Dawn Ross (Treasurer), Chippy Miller, Joe Hayes, William Tilmouth (President), Donna Ah Chee (CEO)
*The Non-Member Directors are not present.

the organisation has rapidly restored its proud reputation and standing.

The new Board attended a two day orientation to Congress including a detailed assessment of the financial situation, its current services and programs and strategic directions. There was also an induction session on the legal responsibilities of Directors conducted by ORIC, including the role and function of the new Audit and Finance Subcommittee which the Board has established. This new committee is a key part of ensuring that the organisation's finances are well managed going forward, together with other changes such as the creation of a new position for a Chief Financial Officer, who is part of this committee which is chaired by our Treasurer, Dawn Ross.

One of the key tasks for the new Board is to lead the development of a new Strategic Plan for the Corporation as the current plan expires this year. The process for this will be consultative and Members will have a chance to have input.

The Board has established four subcommittees in areas of special strategic interest in addition to the Finance Subcommittee mentioned earlier. The first of these is the Congress Clinic which remains the lifeblood of the Corporation, and we want to make this a major focus area. The second is Research, which we believe is the key to innovation and strategic development into the future. The third is Youth, an area that is well managed going forward, and the final area is Aged Care as this, thankfully, is becoming more important as more of our people are living into old age, requiring additional care and support to be able to live well in their own homes.

OATISH agreed with the Board to commission an independent review of the organisation which was undertaken by Communio Pty Ltd in February and March of this year. The focus of the review was on the organisation's corporate support functions, especially finance, human resources and executive management. The report was workshopped at the June meeting with the Board and the recommendations of the review were endorsed. The most significant change is the creation of a new executive management structure for the corporation which is now separated into five new Divisions including Alice Springs Health Services, Finance, Human Resources, Public Health and the pre-existing Regional Health Services Division. The General Managers of each of these Divisions report directly to the CEO and the main result of this change is ensuring that expert financial and human resource advice is directly accessible to the CEO.

I am excited to be leading an organisation as important to our community as Congress and I am confident that the new Board and CEO will take the organisation forward in a manner which will further improve the health and well-being of our people here in Alice Springs and beyond. It is vital that Congress is strengthened by ensuring that the membership of the Corporation continues to grow. In this regard the Board has undertaken a number of initiatives to promote the value of membership and encourage as many Aboriginal people as possible to apply to become members. I hope that Aboriginal people from Central Australia reading this annual report, who are not already members, may be encouraged to apply and become part of the great work that Congress is doing.

Finally, I want to thank my fellow Directors who have all worked with me to ensure that Congress is being governed effectively and in a manner that will improve the overall quality of our services and programs.

William Tilmouth

President | Central Australian Aboriginal Congress Aboriginal Corporation

Chief Executive Officer's Report

The 2012/13 financial year has been challenging for both Congress and I, with changes to our governing Constitution and Organisational Structure in place by year's end. Having returned from a little over a year in Canberra, where I had been CEO of the National Aboriginal Community Controlled Health Organisation (NACCHO), I was confirmed as CEO of Congress in December 2012 which was an honour and a great privilege. In this position, I have had the opportunity to work with the Board and Senior Executive to undertake a broad transformation of Congress.

A number of governance and operational issues created the catalyst for fundamental change within Congress. This change resulted in the appointment of a new Board of Directors and Chairperson. In addition, a new constitution formed the basis for reform within Congress and the adoption of a more enlightened approached to community control. Importantly, this new approach saw Congress create for the first time, three Non-Member Director positions in the specialist areas of Primary Health Care, Governance & Administration and Finance. This initiative is rightly deserving of broad recognition by our stakeholders across the sector. The benchmark set by Congress places us as a leader in the area of best practice governance and constitutional reform.

This reform grew out of the challenge of adversity. Unfortunate and unwelcome governance and legal deficiencies resulted in the Board having to address fundamental issues that went to the core of its stewardship of the organisation. As a result of these matters, the Board was required to face the inevitable appointment of a Statutory Manager by the Northern Territory Department of Justice. The Statutory Manager took control of the organisation for a period while the technical and legal issues were resolved.

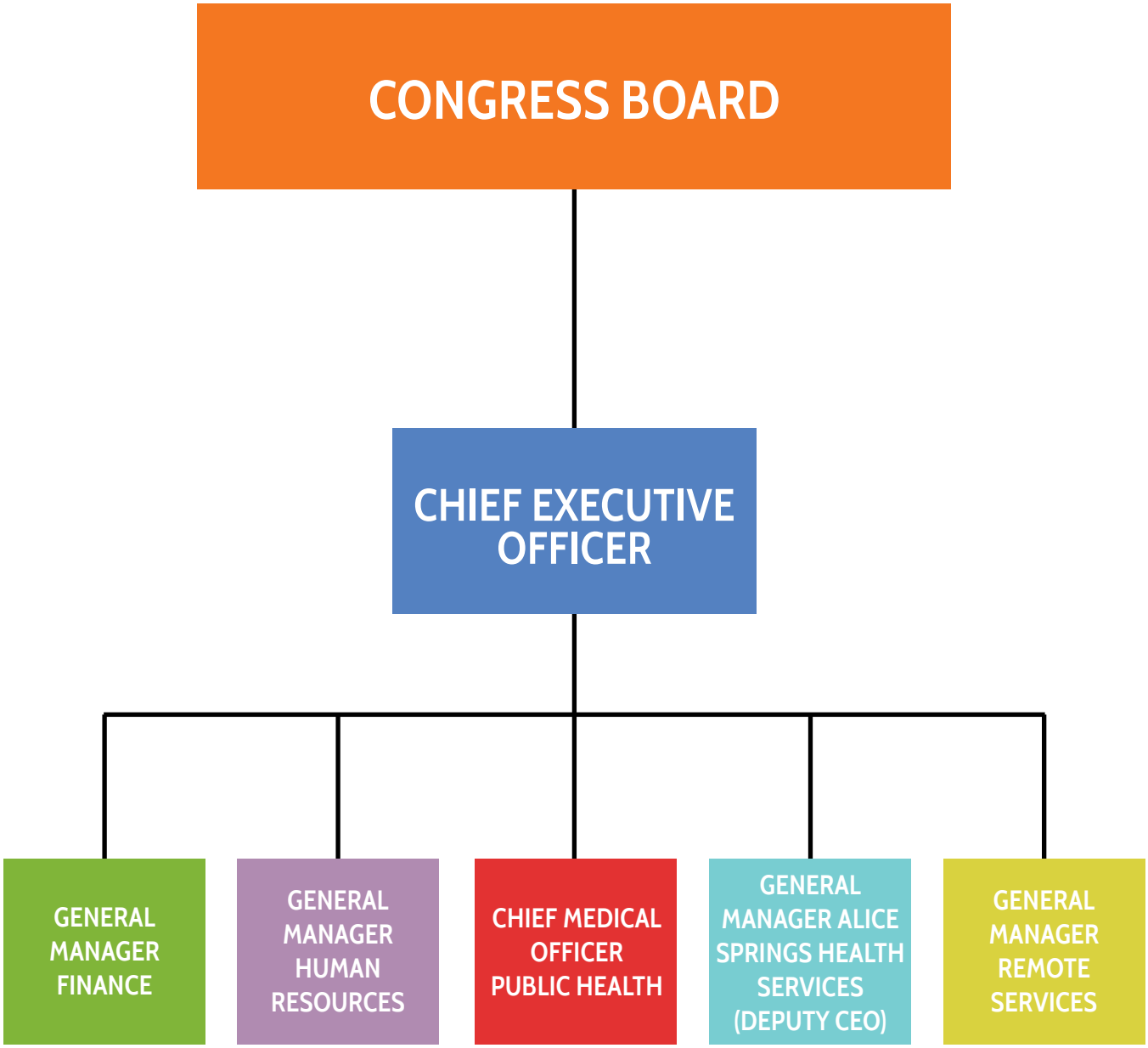
Whilst perceived to be a blow to the pride and reputation of Congress, the reality of this opportunity to take stock proved to be an invaluable respite. In partnership with McGrathNichol, the Statutory Manager, Congress was able to conduct a deep and intensive review of its systems and procedures. In addition, the Department of Health and Ageing, Office for Aboriginal and Torres Strait Islander Health (OATISH) supported Congress in the review of its business.

A number of transformative actions and proposals emerged from this period. The organisational review identified weaknesses in the legislation under which Congress was incorporated. Careful consideration revealed that Congress would be more appropriately incorporated under the Corporations (Aboriginal and Torres Strait Islander) Act. This legislation applied higher standards of accountability, transparency and reporting. All features which would stand Congress on a more solid governance and professional footing. This change occurred in December 2012.

During this period, the Department of Health and Ageing approved funding for the appointment of an independent consultant – Communio Pty Ltd, to undertake a review of the organisation's structure and administrative processes. Once again, the opportunity to actively participate in a critical structural and systems review created valuable insights and innovative solutions to Congress' business.

A key feature of the review was the recommendation to implement a new organisational structure. The restructure saw the creation of five Divisions – Alice Springs Health Services, Remote Health Services, Public Health, Finance and Human Resources. The new organisational structure can be seen on the opposite page.

Congress Organisational Structure 2012/2013



The restructure simultaneously abolished the positions of Manager Corporate Services and Manager Human Resources. In their place, the more strategically focused positions of General Manager Finance and General Manager Human Resources were created. Advertising to recruit to these key positions was well underway by the end of the reporting period. This structure will strengthen Congress' objectives of transparency, accountability and engagement, whilst importantly, facilitating more prompt and efficient responses to changes in business and its direction. It also meant that for the first time the CEO had a direct line of report to the key Financial and Human Resource Advisors strengthening the focus on these critical areas for the Corporation. As a result of this, it also created a situation where the Deputy CEO position was able to focus much more on the key operational management of the internal service delivery branches of the organisation including the Main Services, Children's Services, Ingkintja, Alukura, Social & Emotional Well Being, headspace and Education & Training

At the same time as the organisational review was underway, the Department of Health and Ageing (OATSIH) negotiated a series of highly significant funding variations. These included funding necessary to support a remediation plan, developed in concert by Congress and McGrathNichol. These sums were derived from previously unspent funding rolled over from the 2010/11, as well as unspent funding from the 2011/12 financial years. Finally, OATSIH provided Congress with one-off funding of $500,000 to further assist with remediation. This funding allowed Congress to implement the new computer systems for Finance, HR, Payroll and Risk Management along with the necessary training and support. These were vital acknowledgements as Congress operated very primitive systems. This funding also enabled the employment of the 3 new positions of CFO, Grants Officer and Quality & Risk Officer HR.

A further benefit of this period arose from the opportunity to undertake a review of Congress' Strategic Plan 2008-2013, which was entering its final year and due for renewal. This review highlighted the changes in our business and the priority need to revise Congress' strategic approaches. Congress plans to call for tenders from suitable consultants to work with the Board and Executive to develop Congress' new 5-year strategic plan by the end of 2013.

To consolidate the gains in its business reform, governance, performance and rigour, Congress elected to pursue ISO Accreditation in addition to the previous AGPAL accreditation. The RACGP standards, assessed by AGPAL relate to the clinical activities, with little focus on the administrative systems required to maintain those clinical standards. Congress has sought to capture the gains of an organisational accreditation process, ISO, that shifts the focus away from the provision of clinical services and concentrates on the broader administrative processes and systems throughout the organisation. As Congress has achieved AGPAL Accreditation at each of its sites, both in Alice Springs and remotely, this is an appropriate time to ensure quality outcomes for all internal and external clients, and to facilitate continuous quality improvement activities.

While all of this organisational change activity has been occurring Congress has maintained its leadership roles in the Aboriginal health sector. Congress has actively participated in workshops, public forums and professional debates regarding health system reform, early childhood, education, diabetes, maternal health, housing, mental health, alcohol, employment community violence, sexual health and other issues.

In this period a key paper was produced proposing "an integrated model for Child and Family Services" in order to further operationalise the Board's strategic focus on early childhood as endorsed in the Rebuilding Family Life paper. The proposals in this paper were endorsed by the Board and led to the creation of the new Children's Services Branch which took over the operations of the very successful Preschool Readiness Program as well as the 55 place long day care centre for children. This then allowed for a new focus in the centre for greater learning through the Abecedarian approach as well as a focus on therapeutic childcare for children with special needs.

The Menzies School of Health Research, led by Prof Sven Silburn, completed an evaluation of the **Preschool Readiness Program** which demonstrated how successful the program has been in increasing enrolment and participation for Aboriginal children in preschool as well as promoting healthier development prior to enrolment for young children utilising elements of the Abecedarian approach. The program won an award at the NT Chronic Disease Network Annual Conference in recognition of the impact it was having on the primary prevention of chronic disease. Given the importance of this area, and the key work that Congress is doing, there is a special section of this Annual Report focused on Early Childhood.

There were two new programs fully implemented at Congress in this annual reporting period. The first of these is **Renal Dialysis Primary Health Care Service** which is funded by the NTML and provides a service to people on dialysis in the dialysis unit itself. This primary health care service is largely around better chronic disease management, including immunisations as well as assisting people to get through the workup that is needed to get on to the transplant list. Another important part of this service is additional social and cultural support for dialysis patients. The service commenced with an MOU with Nephrocare in Gap Rd and then progressed into the main Flynn Drive Dialysis Centre. From the perspective of the dialysis patients one of the major benefits from this service is that they can get their health needs met on one of the

days that they attend dialysis rather than having to use one of their "dialysis free" days to seek further health care. This in itself improves the quality of life for people on dialysis.

A second new service is the **Intensive Family Support Service** which builds on the success of the Targeted Family Support Service but works with families of even higher needs and in cases where the family is an open Child Protection Case. This service therefore works in close collaboration with services provided by the Office of Children and Families and tries to build the capacity of parents to better respond to their children's needs and prevent children being removed in very complex and difficult family situations.

A further initiative undertaken during this period was to commission Prof Heather Hancock, to undertake a follow up review of Alukura with particular emphasis on antenatal care, postnatal care and the feasibility and potential benefits of re-establishing the Alukura Group Midwifery Practice which had been suspended in late 2011.

The National Drug Research Institute (NDRI) also completed their evaluation of the **Safe and Sober Support Service** in July 2012 and this revealed both the strengths of the program and the challenges that are still there in trying

to provide a community based, alcohol treatment program. The program has ongoing funding and continues to try to combine "three streams of care" (medical care including pharmacotherapies, structured therapy and social and cultural support) in assisting people with significant alcohol issues.

In October 2012, the NDRI also produced the final report of a FaHCSIA funded research project, done in collaboration with Congress, "**A Longitudinal Study of influences on alcohol consumption and related harm in Central Australia: with a particular emphasis on the role of price.**" This study examined alcohol consumption, alcohol price and alcohol related harms over a ten-year period and the key finding was a very strong correlation between price, consumption and harm. When price went up, consumption went down as did harm, mainly measured by a significant decline in the admission trend for Aboriginal women for assault. This study provides strong local evidence for the need for an alcohol floor price for beer in combination with the other national and international evidence on this issue.

Congress continued its involvement with the Southgate Institute at Flinders University in a research project that is evaluating the differential impact of different models of primary health care including Aboriginal community controlled comprehensive primary health care. In this project there is emphasis on the way different primary health care service models are able to impact on the care of patients with diabetes, and prevention including the impact they may have on addressing the underlying determinants of these illnesses. As part of this project a very successful symposium was held in Alice Springs on Comprehensive Primary Health Care which was attended by Prof Ron Labonte and Jack McCarthy from Canada, Prof David Sanders from South Africa and many other experts and practitioners.

Congress continued to work in partnership with CASSE (Creating a Safe and Supportive Environment), to try to better understand and address issues of violence and underlying trauma that currently exist within many Aboriginal communities. The project, titled "Kurruna Mwarre", meaning 'to make my spirit good inside me', will run for four more years and employs a psychoanalytic approach to develop and implement culturally appropriate demonstration projects that facilitate and empower Aboriginal people to heal from their traumatic experiences in their own way.

Finally I want to end by discussing what in many ways remains the corporations' biggest challenge – to provide services in five remote community clinics through our Remote Health Services Division (RHSD). When Congress originally agreed to take on the role of providing primary health care services in remote communities more than ten years ago it was thought that this would be a transition arrangement as communities moved towards their own Aboriginal community controlled health services. All levels of government and AMSANT signed off on a key document known as "Pathways to Community Control" and were implementing a process known as "regionalisation' that would see Aboriginal community controlled health service develop in designated Aboriginal Health Service Delivery Areas across the NT. For a while this process seemed promising, but unfortunately it has not delivered, and the remote community clinics that Congress supports continue as they have done now for many years.

The uncertainty about the strategic directions for regionalisation has created significant challenges for how Congress manage these remote clinics internally, especially the dilemma of how much to integrate the remote operations into the overall operations of Congress, which create many efficiencies, versus how much to leave the RHSD completely separate in the belief that it won't be very long until these communities will be managing their own services. The latter approach was where Congress was at for many years, but as the light at the end of the tunnel for regionalisation and the implementation of Aboriginal community control has grown dimmer, Congress has tended to integrate more of the RHSD functions creating a significant RHDS head office in this reporting period in the old CAT building on Priest Street. Making a commitment to such a move was fraught with complexities, as, if communities do achieve community control the funds to support such a regional office will not be there. These are

the risks and uncertainties that the RHSD operate in.

In spite of these tensions there have been some very significant achievements in the RHSD in this period. Most importantly there has been a major improvement in the recruitment of staff with most positions being filled most of the time which has led to an increase in services provided. There has been some internal changes in the new Alice Springs based regional office for RHSD which has led to better, more integrated management of regional programs and a corresponding improvement in staff morale. For the first time a clinical governance group was created made of the leading clinicians from the respective clinics, the CQI team and selected managers.

The RHSD Advisory group has been meeting through this period made up of the Chairs of each of the Health Boards and other appointed Board Members. This group also includes the President of the Congress Board and two other Directors as well as the RHSD General Manager and myself. This group has led to improve communication between the Congress Board of Directors and the respective remote community Health Boards and has been able to discuss strategic issues across all of the RHSD sites. Of course one of the major issues on the agenda is how to achieve regionalisation and Aboriginal community control as this is clearly what the Aboriginal health leaders from the Boards from these remote communities really want to see happen. This group is also able to discuss the regional programs that deliver services across all the remote clinics such as the very successful Allied Health Program and the Eye Health Program.

Finally, a lot of work has gone into the development of better systems within RHSD including policies and procedures.

I am pleased to be able to lead an organisation like Congress, which continues to make a very substantial contribution to improving the health of Aboriginal people in Central Australia and beyond. In the next section of the Annual Report we will look at the key data that demonstrates the work that is done here in Alice Springs by Congress which I am sure you will agree is impressive.

Yours sincerely,

Donna Ah Chee
Chief Executive Officer

Key Performance Indicators

Under the OATSIH single funding agreement Congress is required to report to the Board on both the new National Key Performance Indicators (nKPIs) and the Aboriginal Health NT KPIs which have now existed for five years.

This is the first full 12 month reporting period where the new national Key Performance Indicators (nKPIs) have been reported on. Presently, there are 19 nKPI indicators covering:

- Child and Maternal Health
- Health Assessments and Early Detection
- Immunisation
- The Prevention and Treatment of Chronic Disease
- Risk Factors that Contribute to the Burden of Disease

for Aboriginal Australians in the regular client population of an OATSIH-funded primary health care service. There will be a further five nKPIs added for next year.

For the nKPIs a regular client is defined as a client who has an active medical record; that is, a client who attended the OATSIH-funded primary health care service at least three times in 2 years based on Medicare data. This is a different definition to that used for the NT KPIs which is for a client who lives in the health service area or locality and has presented at least once in the last 2 years.

This definition makes a significant difference for Congress for the number of clients who are considered "current patients" for Congress with the nKPI definition including significant numbers of clients who do not live in the Congress Health Service Area (HSA) and who under the NT definition are therefore visitors. For example some of the differences in number of current patients in different categories are:

- There are about 160 babies who are born in the Congress HSA under the NT definition and 220 under the National definition
- There are around 1000 diabetics under the NT definition and about 1500 under the National definition

The NT KPIs have been reported on previously and include:

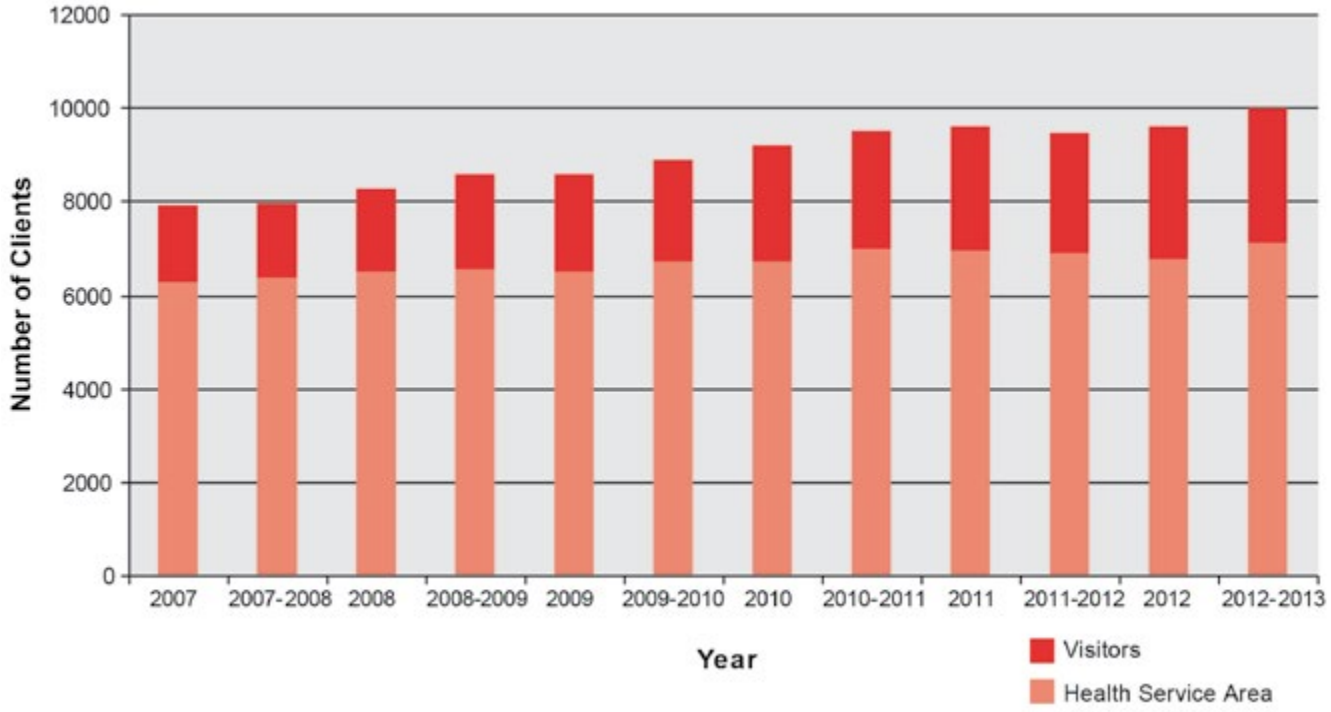
- Episodes of health care
- First antenatal visit
- Birth weight
- Fully immunised children
- Underweight children
- Anaemic children
- Chronic Disease Management Plan
- HbA1c tests
- ACE inhibitor and/or AB
- Adult Health Check
- Pap Smear tests

For the first time there is a new indicator on Rheumatic Heart Disease. There is some overlap between the nKPIs and the NT KPIs.

Service Activity

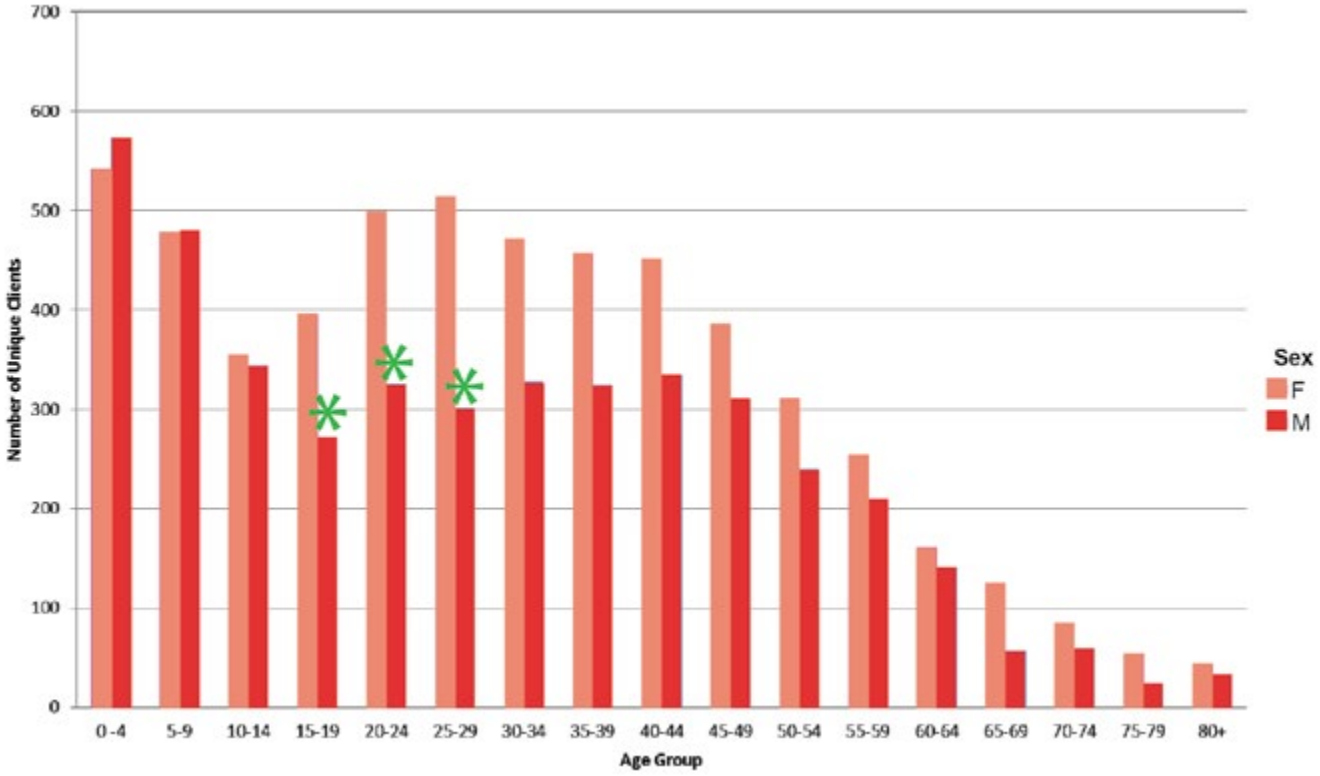
1. There has been a slow but steady increase over time in the individual clients that utilise Congress services each year, from a total of 8,000 in 2007 to 10,000 in this reporting period. On average more than 10 episodes of care are provided every year for each individual client (each client is only counted once). Congress is one of the few health services in Australia that can proudly say that nearly all Aboriginal people living in our health service area utilise our services every year. In fact, the 7,000 individual Aboriginal people who come to Congress each year and are recorded as living in Alice Springs on the Congress data base, far exceeds the Aboriginal population count in the 2011 census of 4,689 Aboriginal people. Congress is possibly the most accessed health service each year by its service population of any health service in Australia. Visitors add an additional 3,000 individual Aboriginal people to this number and this has been increasing as a proportion of overall individual clients.

INDIVIDUAL CONGRESS ALICE SPRINGS CLIENTS



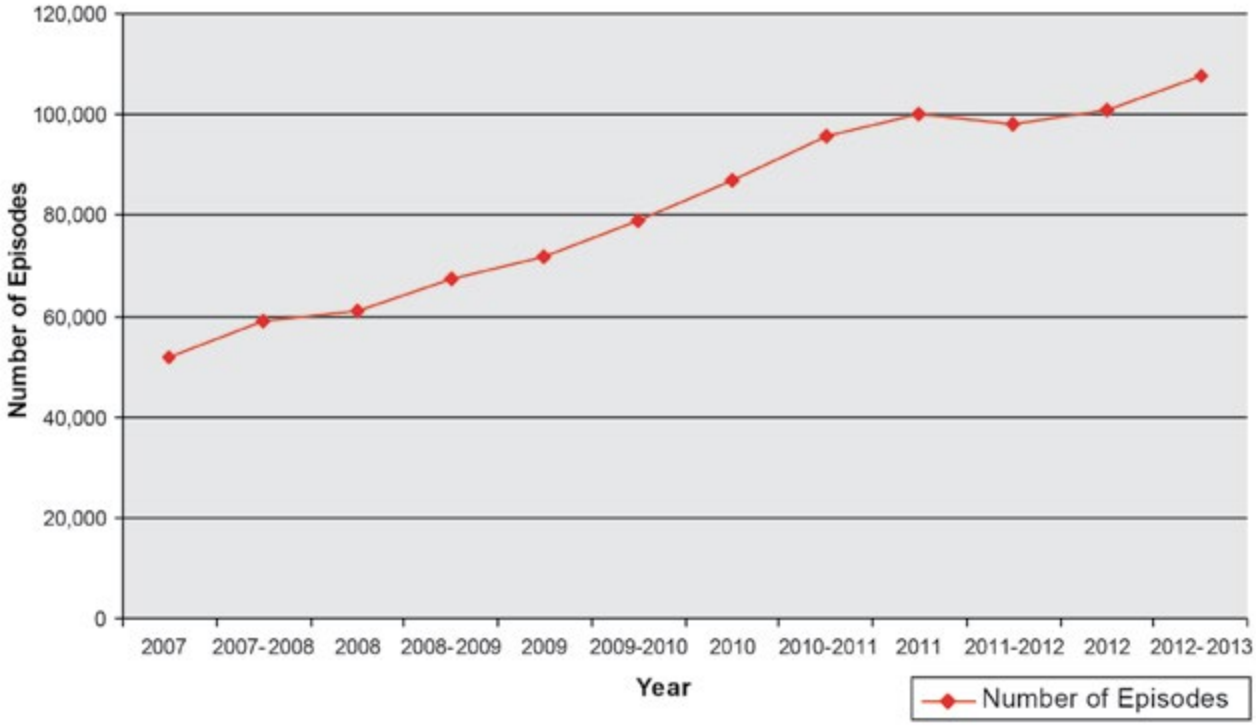
2. The major issue in the age and gender breakdown of clients is for young men from the age of 15 to 30 (see asterisk), where there is an access gap for a range of reasons. This includes the reality that young women all over Australia use health services more than young men for maternity purposes, contraceptive advice and other women's health checks at these ages as well as the fact that, unfortunately, a significant number of young men are in jail and cannot therefore use Congress services. However, Congress has much better access for men than many other health services.

BREAKDOWN OF INDIVIDUAL CLIENTS BY AGE AND GENDER 2012 - 2013



3. There had been a very significant increase in activity in all major service delivery areas of Congress as measured through episodes of care provided compared with the previous financial year. This appears to primarily be due to better leadership across the organisation leading to an improvement in staff activity and a greater focus on ensuring all positions are filled and there is a good retention of staff. In addition, this is part of a welcome long term trend where Aboriginal people are seeking health care more and more as part of better self-managing their own health needs. Our people have learned to become much more pro-active in this regard and are now much more aware of the effectiveness of the clinic in treating illnesses and preventing hospitalisations if conditions are managed early and well.

CONGRESS EPISODES OF HEALTH CARE (ALL)



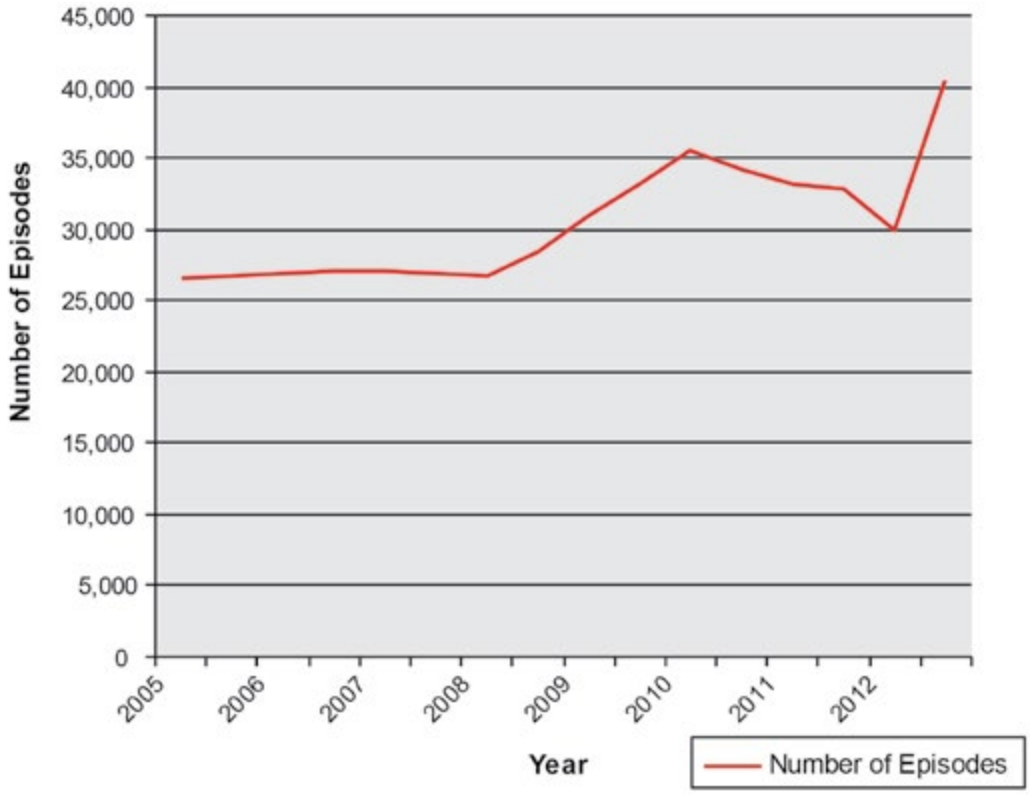
4. (Table appears on opposite page) This table includes all of the different centre based services including the general clinic, the Alukura clinic, the Ingkintja (male health) clinic, the dental clinic, the healthy kids clinic, GP nursing home services and pharmacy services (but not the headspace clinic). It also includes the outreach programs including the Family Partnership Program (FPP), the Children's Services Program, the Frail Aged and Disabled Program (FAAD), the Preschool Readiness Program, the School Program and all of the Social and Emotional Wellbeing Programs including the Safe and Sober Support Service (but not the Family Support Programs who record their data in a different way). The more intensive outreach programs see a smaller number of clients much more often, in their homes each year, than some of the centre based services which rely on clients to come to them. Once again, taken as a whole the level of access is very impressive. The largest increase has occurred in the general clinic where episodes of care have increased by a third, or more than 10,000 extra episodes per year to 40,000, but there have also been significant increases in Alukura, Ingkintja and Social and Emotional Wellbeing as well.

INDIVIDUAL CLIENTS AND EPISODES OF CARE BY PROGRAM/SERVICE

PROGRAM	UNIQUE CLIENTS (INCLUDING VISITORS)	EPISODES OF CARE	AVERAGE NUMBER OF VISITS FOR EACH UNIQUE CLIENT
Alukura	1666	5969	3.6
Childrens Services	589	2030	3.4
Dental Clinic	1056	2605	2.5
FAAD	75	1339	17.9
FPP	286	3820	13.4
General Clinic	8153	40369	5.0
Healthy Kids Clinic	779	1144	1.5
Hearing Program	610	2072	3.4
Male Health	1224	4349	3.6
Nursing Home	119	1016	8.5
Pharmacy	3540	24971	7.1
Preschool	298	1397	4.7
Safe & Sober Support Service	490	5803	11.8
School Program	531	1416	2.7
SEWB-Community Wellbeing	605	4446	7.3
SEWB-Youth Outreach	131	1323	10.1

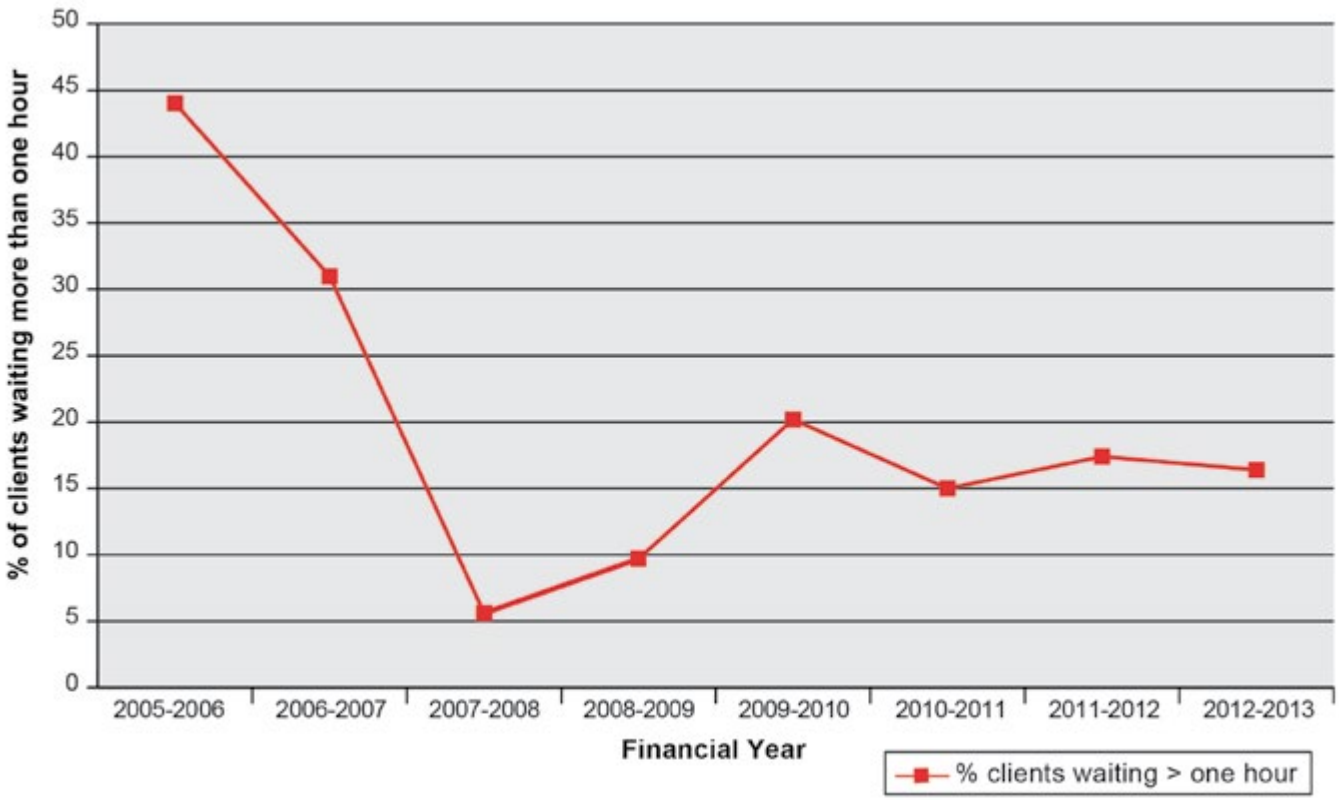
5. The increase in the services provided by general clinic is especially impressive and has come about through many improvements at a range of levels across the organisation.

EPISODES OF CARE: SERVICES BRANCH GENERAL CLINIC



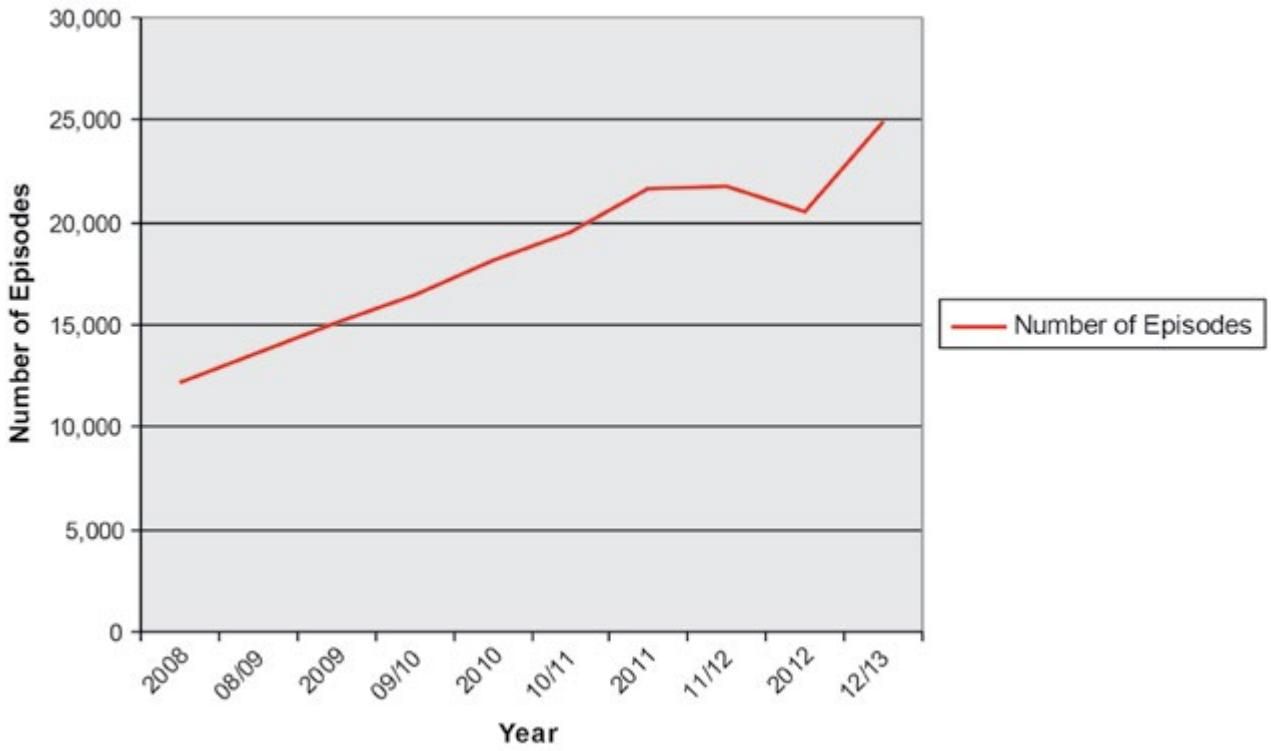
6. In spite of this significant increase in episodes of care provided in the General Clinic, waiting times in the General Clinic have declined, in fact they have declined from 20% of clients waiting for more than an hour in 2012 to 16% in 2012-13. The very large drop in waiting times that can be seen from 2006 to 2007 was due to the introduction of an appointment system in addition to the usual walk-in system which has continued to operate. This system has enabled the workload of the clinic to be better distributed across the day rather than having too many clients present between 9.30am and 11am. There is still room for further improvement in this area and this remains an area of focus for the clinic.

CONGRESS SERVICES BRANCH GENERAL CLINIC WAITING TIMES



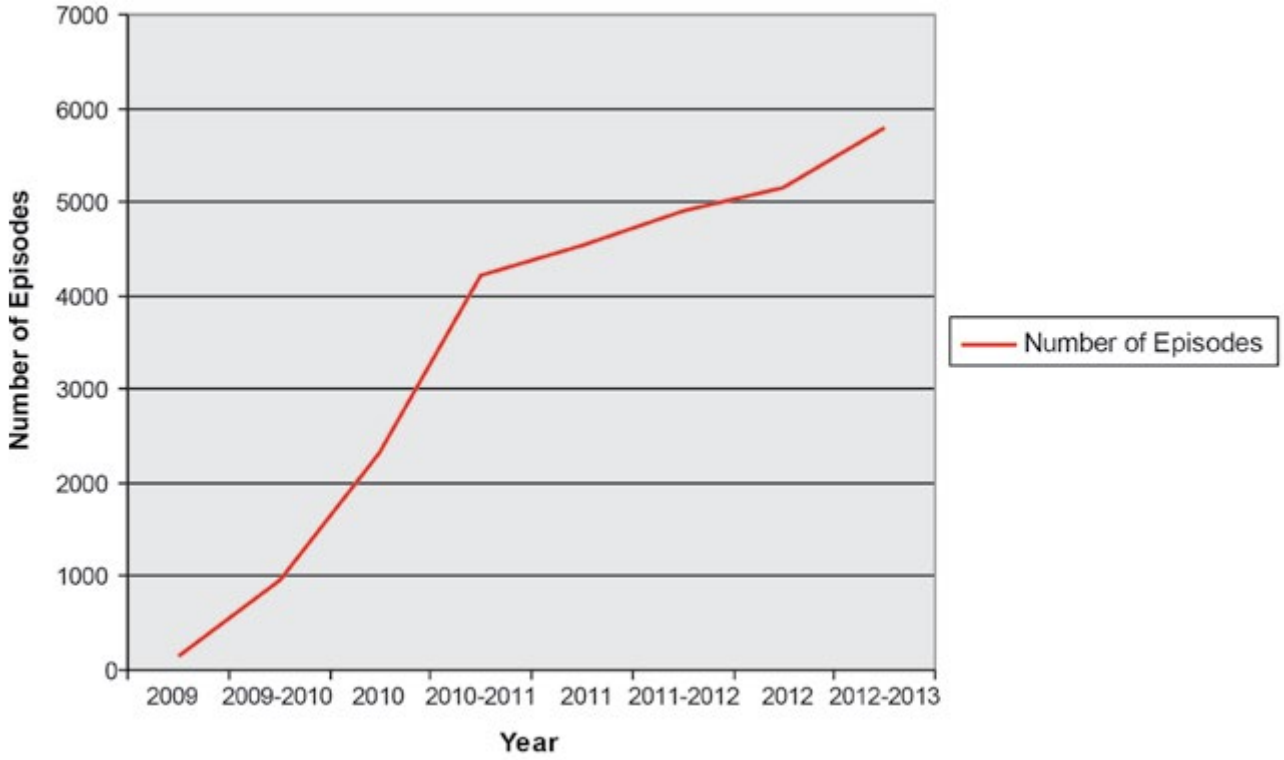
7. (Graph appears on opposite page) A corresponding increase has occurred in the use of the Pharmacy with additional staff and more efficient work practices. More and more Aboriginal people are presenting to the Pharmacy to obtain essential medicines and about 30% of these people are visitors. As a result of this trend there has been almost an eight fold increase in PBS expenditure on medicines over the last decade. This additional access to medicines is very likely to be contributing to the health improvement that is now evident in the Northern Territory. The Congress Pharmacy is now a major location for direct client services. It was not that long ago when medicines could only be accessed by going through the clinic itself – even for repeat prescriptions. This improved direct access for repeat medications has made it easier for patients to ensure they are able to maintain their supply of essential medicines and a really important development.

EPISODES OF CARE: PHARMACY TREND



8. From small beginnings in the Grog Mob Research Program, the expanded Congress alcohol treatment program, now known as the Safe and Sober Support Service has continued to provide increasing services to Aboriginal people with alcohol problems. The program works with Aboriginal people with alcohol problems by offering a service model which is based on "3 streams of care". These streams consist of social and cultural support, structured therapy and medical care including pharmacotherapies. Addiction is a very complex and difficult area to work in and there are many challenges in addressing the needs of these clients.

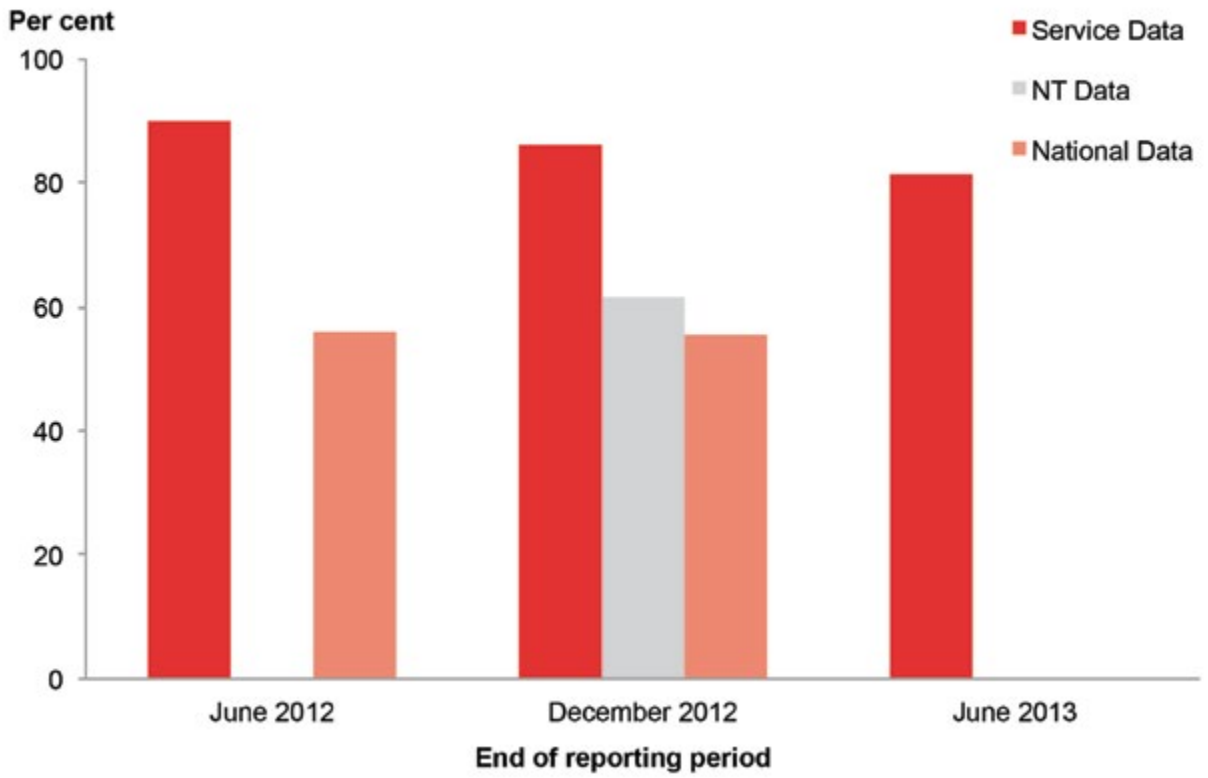
EPISODES OF CARE: SAFE & SOBER SUPPORT SERVICE



Maternal and Child Health

9. Low birth weight related to an adverse pregnancy environment can program the baby to become overweight and develop diabetes, heart disease, high cholesterol, and renal disease later in life. Given the link between birth weight and lifetime health, it is important that it is recorded on every clients' medical file. Congress is doing much better than average in this regard.

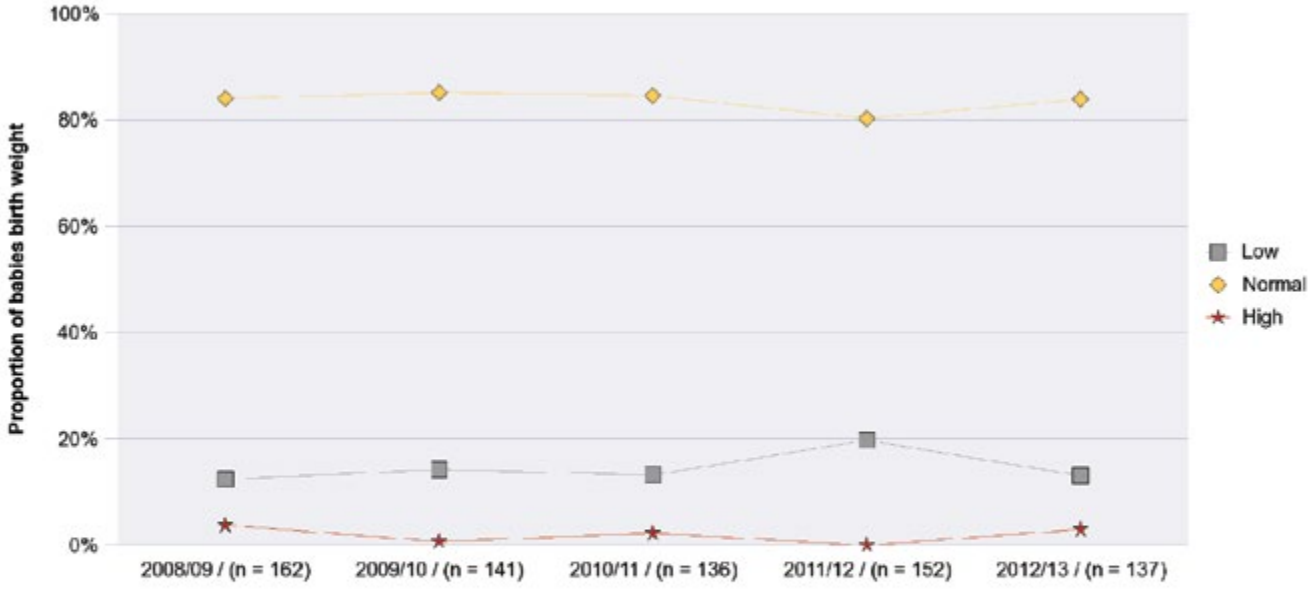
COMPARISON: Percentage of Indigenous babies born within the previous 12 months whose birthweight was recorded, reporting periods ending 30 June 2012, 31 December 2012 and 30 June 2013



10. (Graph appears on opposite page) The average low birth weight percentage has returned to the longer term average of 13% after the unexpected increase last financial year. This is an area where we hope to see significant improvement in coming years with programs such as the Nurse Family Partnership Program making further inroads and continued improvements in our model of maternity care.

AHKPI 1.3 - BIRTH WEIGHT

Figure 1.3c Trend of babies born to an Aboriginal mother by birth weight category and reporting year



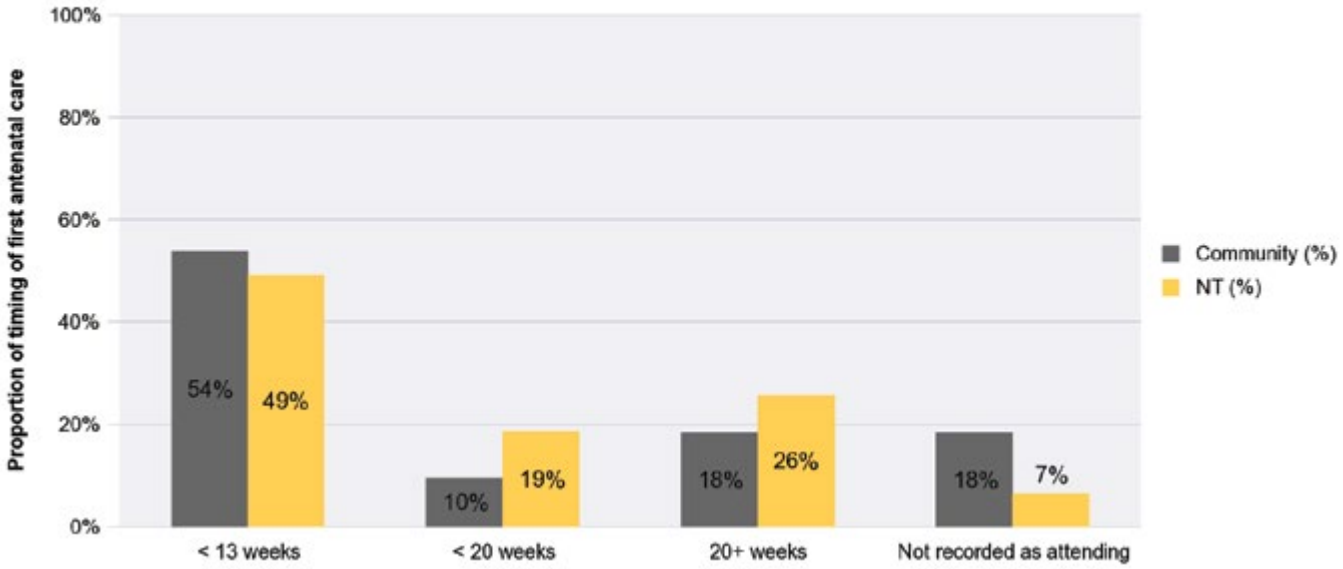
Reporting Year(s)	2008/09	2009/10	2010/11	2011/12	2012/13
Population (Denominator)	162	141	136	152	137
Low	12%	14%	13%	20%	13%
Normal	84%	85%	85%	80%	84%
High	4%	1%	2%	0%	3%

n = Population (denominator) is the number of resident babies born to an Aboriginal mother who were live born during the current reporting period.

11. The proportion of pregnant women presenting in the first trimester has increased from 44% to 54%. It has also become clear that some data had not been correctly entered, which has led to under reporting for women presenting in the first trimester. The benefit of presenting early in pregnancy is that it provides an opportunity for health professionals and women to establish a relationship that may encourage behaviour changes that can improve the health of women and babies. This includes lifestyle changes such as, stopping smoking and alcohol use, access to emotional support and improving nutritional intake. The earlier that these positive changes occur in pregnancy the better the chance of a healthy start to life for the baby.

AHKPI 1.2 - FIRST ANTENATAL VISIT

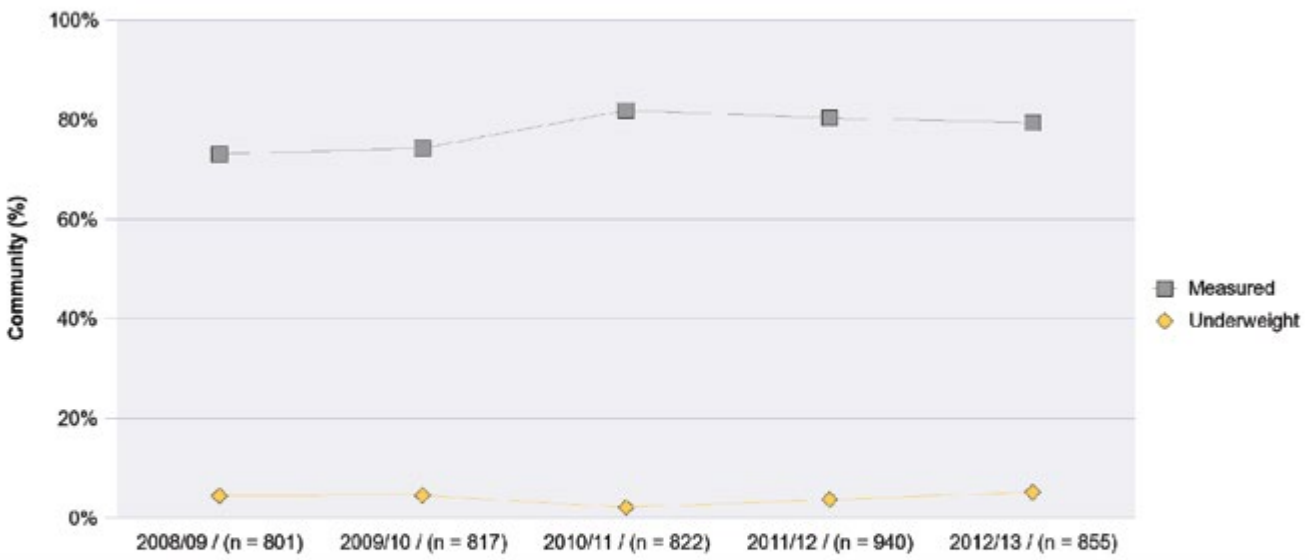
Figure 1.2a Proportion of resident Aboriginal women receiving antenatal care during the previous 12 months by gestation age group



12. On this measure of poor health most children are doing well. The number of underweight children is now much less of a problem than it used to be. There are less than 10 children failing to thrive at any one time now, compared to 5 years ago when there were more than 70. However, childhood obesity is becoming more of a concern and this will require a public health response that could include making high fat and high sugar foods more expensive while making healthier foods, like fresh fruit and vegetables cheaper and better quality.

TREND OF RESIDENT ABORIGINAL CHILDREN 0-59 MONTHS OF AGE MEASURED FOR WEIGHT & RECORDED AS UNDERWEIGHT BY REPORTING YEAR

Figure 1.5b Trend of resident Aboriginal children 0-59 months of age measured for weight & recorded as underweight by reporting year

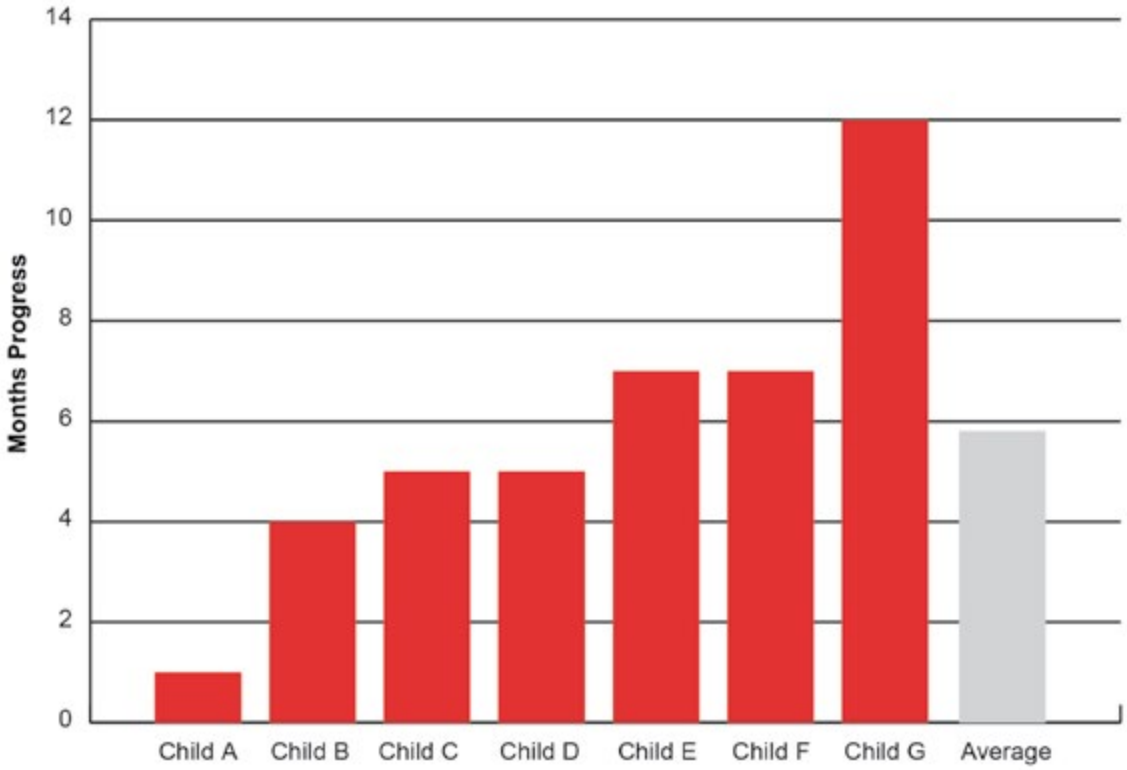


Reporting Year(s)	2008/09	2009/10	2010/11	2011/12	2012/13
Population (Denominator)	801	817	822	940	855
Coverage	585	607	673	755	678
Measured	73%	74%	82%	80%	79%
Underweight	4%	5%	2%	4%	5%

n = Population (denominator) is the number of resident Aboriginal children who are less then 5 years of age during the reporting period.
Coverage is the number of resident Aboriginal children who have been measured for weight at least once during the reporting period.

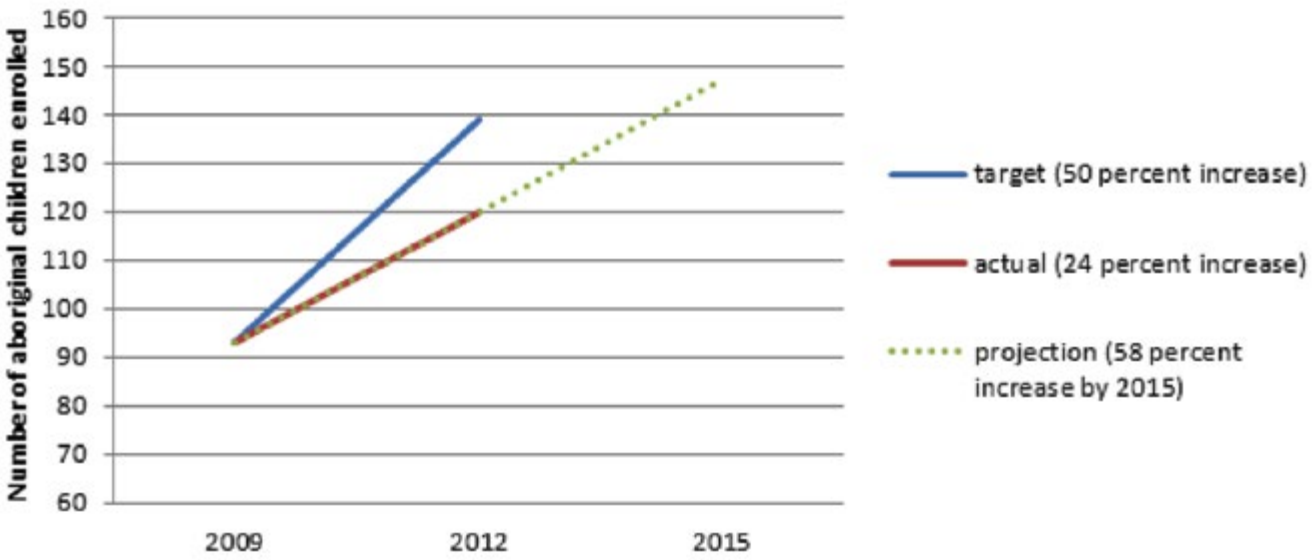
13. The Preschool Program has achieved some major improvements in the cognitive development of children by using elements of the Abecedarian program in a 7 week intervention. This graph shows the vocabulary improvement from baseline for 7 children who went through the program with more than a 90% attendance rate. Vocabulary is a good indicator of cognitive development.

VOCABULARY PROGRESS FROM BASELINE TO REVIEW



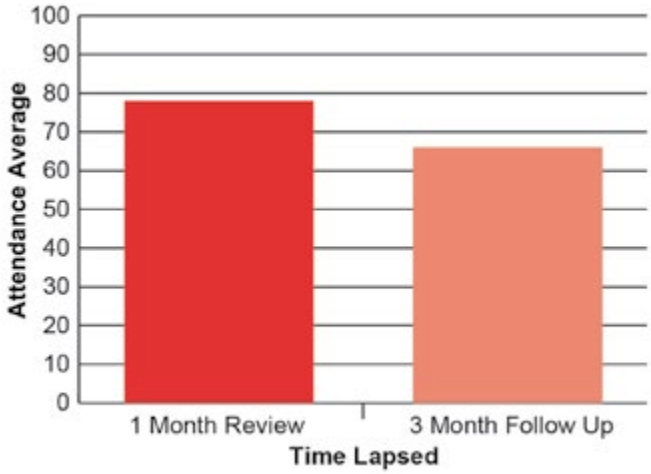
14. The program has achieved a 24% increase in preschool enrolments and on current trend will achieve its target of 50% by 2015.

ACTUAL VS TARGETED CHANGE AND FUTURE PROJECTIONS BASED ON CURRENT TREND



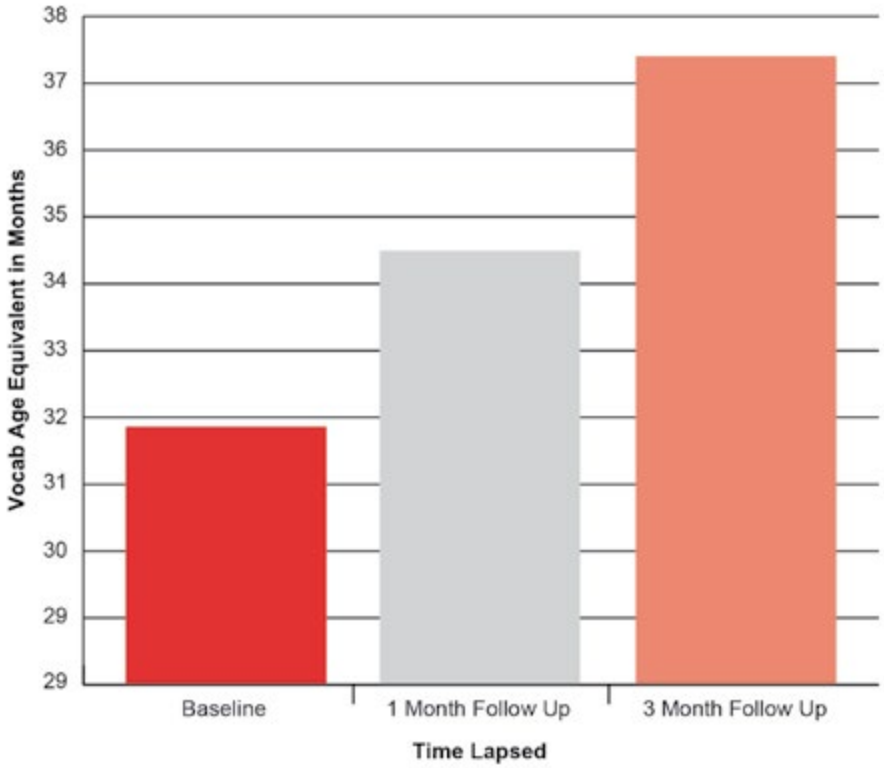
15. In addition to enrolling children the program continues to support their attendance post-enrolment. The Preschool Readiness Program continues to work with the child and family through the first few weeks of schooling. For some children and families this is a big adjustment but results indicate that if we provide intensive assistance at the start of school, when we revisit children several months later they are still engaged as visible in a sustained attendance.

ATTENDANCE AT REVIEW AND FOLLOW UP



16. What is most exciting is the rapid improvement in cognitive development as measured by age equivalent vocabulary following enrolment, as well as continued participation in preschool. Children who enter preschool having been supported through the Preschool Readiness Program demonstrate the potential to rapidly achieve. Many children have well developed language skills in multiple languages, but often limited exposure to English. This graph shows how quickly Aboriginal children develop their vocabulary at preschool. Without this, many children can have significant learning problems especially reading. These children show measurable and consistent growth in the beginning of their schooling and are well placed for future success with this strong early start.

VOCAB AGE EQUIVALENT IN MONTHS FOLLOWING ENROLMENT



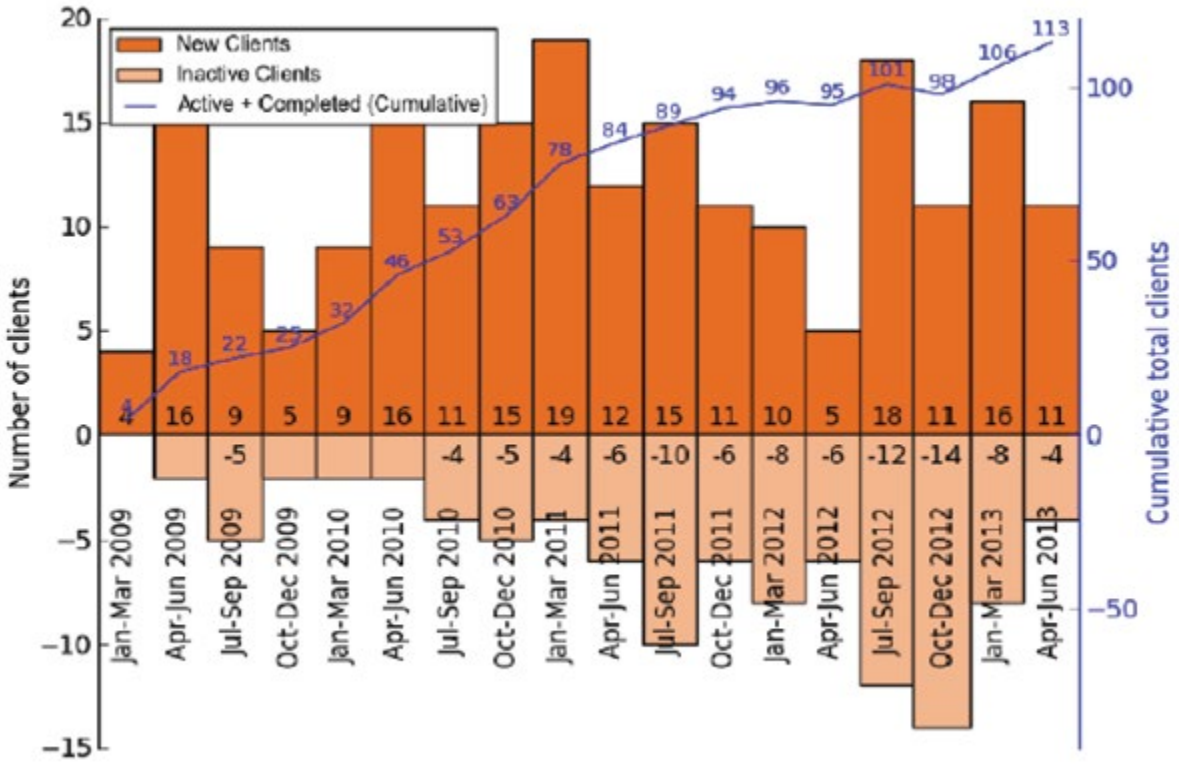
17. The Nurse Family Partnership Program has been well accepted in the community and there are many great stories of the way this program is helping to empower young parents in particular to better respond to the many needs of their babies. The most significant reason why mothers leave the program is that they move from Alice Springs to live in remote community where the program is not being offered and this is unfortunate as parents should be able to get the benefits of this program wherever they are living.

NURSE FAMILY PARTNERSHIP PROGRAM

	AS AT 31/03/2013	AS AT 30/06/2013	CHANGE
a) Client referrals to program	391	406	15
b) Clients accepted into program	202	213	11
c) Accepted Clients who became inactive	96	100	4
d) Clients who have completed the program	26	31	5
e) Accepted Clients who remain active	80	82	2
f) Completed visits	3754	4082	328
g) Telephone encounters with program content	119	125	6
h) Attempted visits	2019	2168	149

18. The Nurse Family Partnership Program has seen a significant improvement in the client attrition rate following the report six months ago where there had been a concerning increase in client attrition. This has steadily declined over the past six months following action to address this issue.

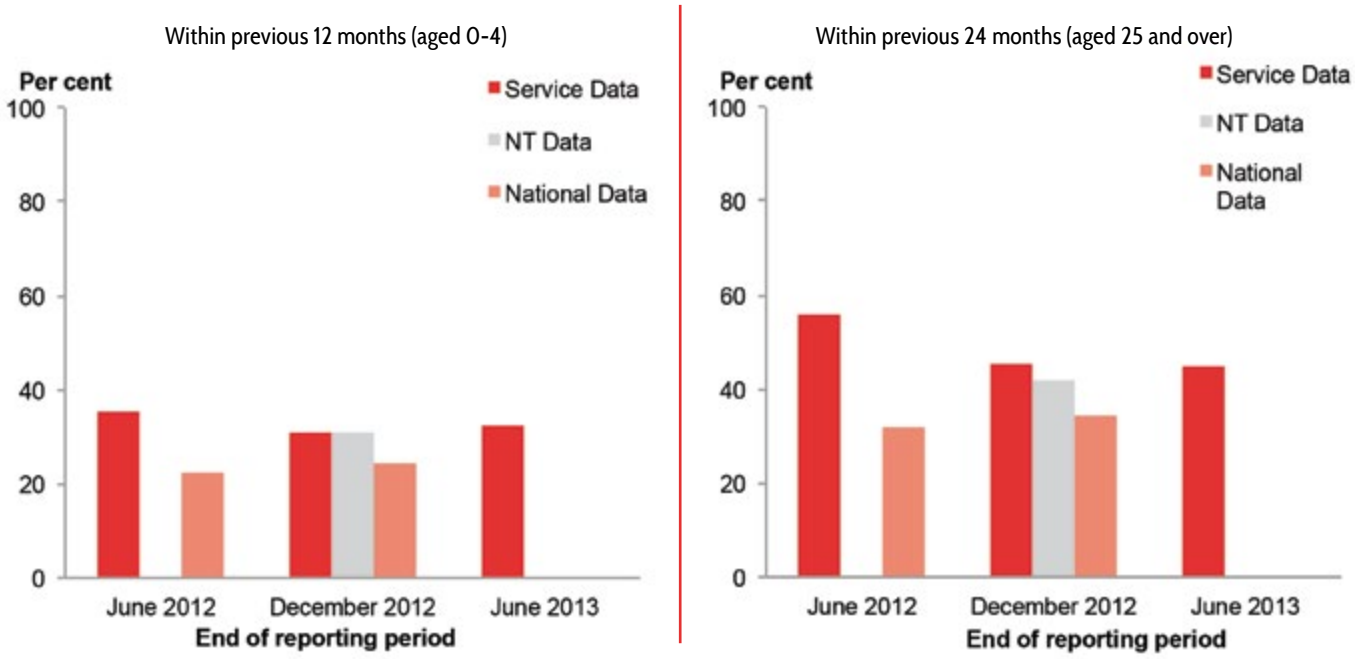
CLIENT ACCRUAL AND CLIENT ATTRITION BY MONTH



Health Assessment and Early Detection

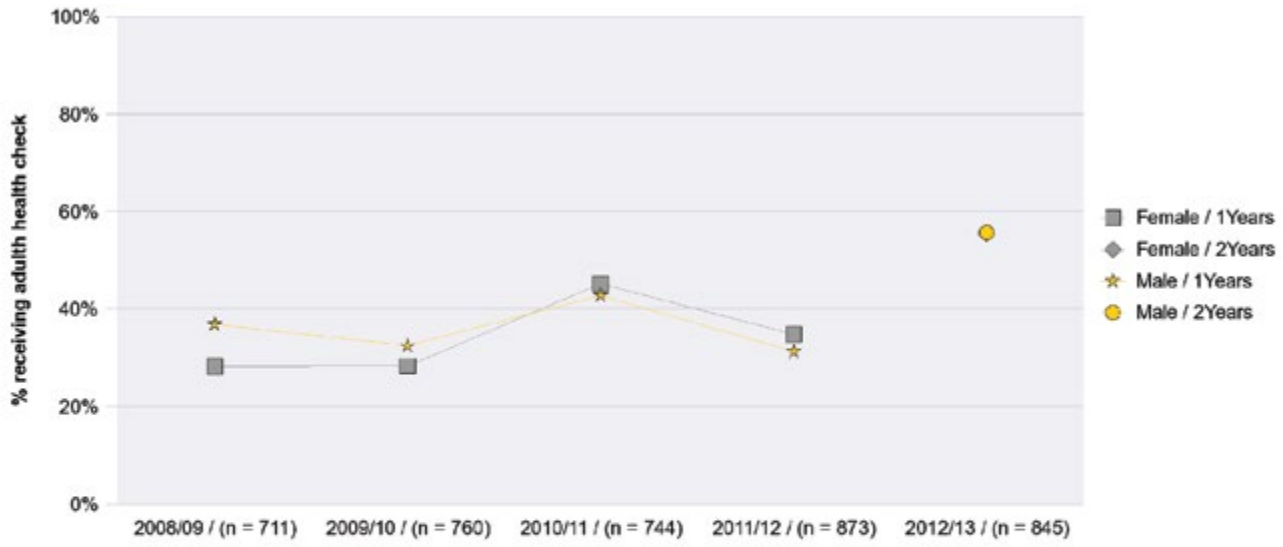
19. Congress is above average regarding the provision of both child and adult health checks. Child health checks are an important way to detect early any developmental or other health concerns such as dental, ear and skin conditions. Congress is becoming more systematic in terms of how these checks are being offered through our Healthy Kids Clinic and we now have programs such as the Preschool Program that can work with children who need additional stimulation to enhance their development. In the same way, Adult Health Checks are also a useful way to detect health problems early as well as to educate about unhealthy lifestyles that are likely to lead to the development of disease. Smoking, alcohol, lack of physical activity and poor diet all contribute to early onset of preventable diseases.

COMPARISON: Percentage of Indigenous regular clients who received an MBS health assessment (MBS item 715), reporting periods ending 30 June 2012, 31 December 2012 and 30 June 2013



20. (Graph appears on opposite page) The proportion of clients over 55 who had a completed Adult Health Checked has increased to its highest ever level at more than 55%. Health Checks on people over 55 assess a range of additional issues to general health and wellbeing, including competence in activities of daily living and the level of social support that a person has in their home.

TREND OF RESIDENT ABORIGINAL CLIENTS 55 YEARS AND OVER WHO HAVE HAD A COMPLETE ADULT HEALTH CHECK BY SEX AND REPORTING PERIOD

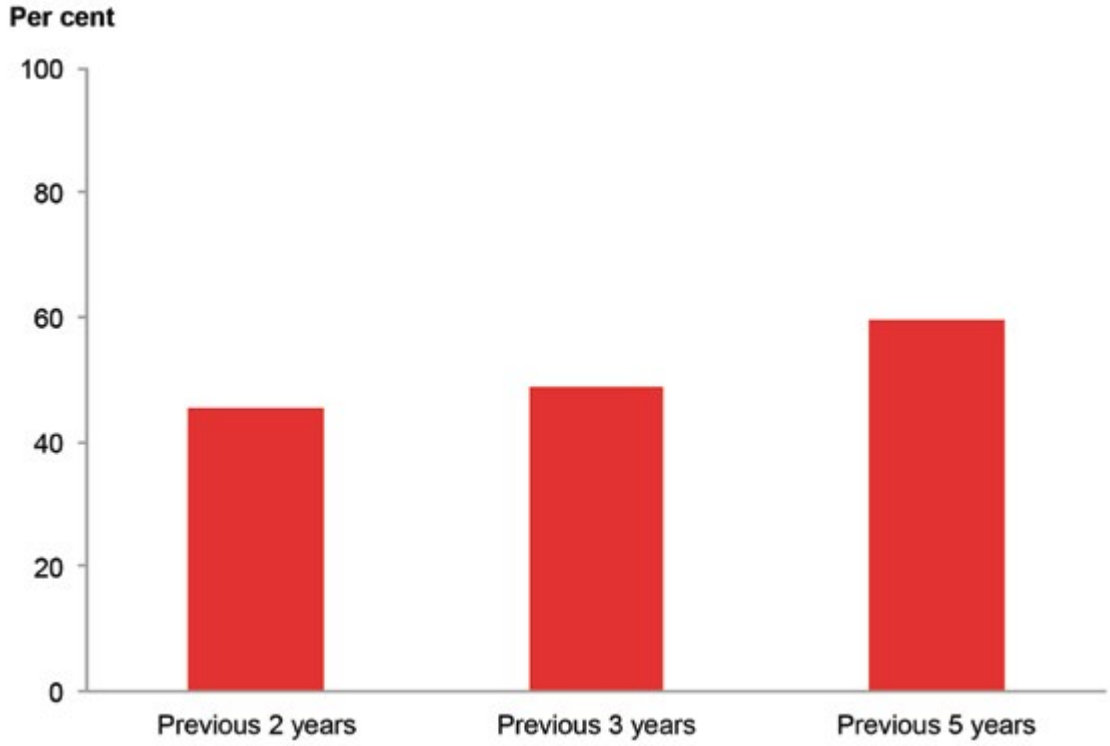


Reporting Year(s)	2008/09	2009/10	2010/11	2011/12	2012/13
Population (Denominator)	711	760	744	873	845
Female completed AHC in previous 1 Year	28%	28%	45%	35%	0%
Male completed AHC in previous 1 Year	37%	32%	43%	31%	0%
Female completed AHC in previous 2 Years	0%	0%	0%	0%	55%
Male completed AHC in previous 2 Years	0%	0%	0%	0%	56%

n = Population (denominator) is the number of resident Aboriginal clients who are 55 years old and over.

21. The death rate from cervical cancer has significantly declined in recent years due to improved early detection and better access to treatment. However, there is still a need to ensure more high risk young women in particular are being screened more often. Although the new HPV vaccine will make a difference there is still a need to continue to have the normal Pap Smear as the vaccine does not prevent all types of the virus that cause Cervical Cancer.

PERCENTAGE OF FEMALE INDIGENOUS REGULAR CLIENTS AGED 20 TO 69 WHO HAD A CERVICAL SCREENING WITHIN THE PREVIOUS 2 YEARS, 3 YEARS AND 5 YEARS

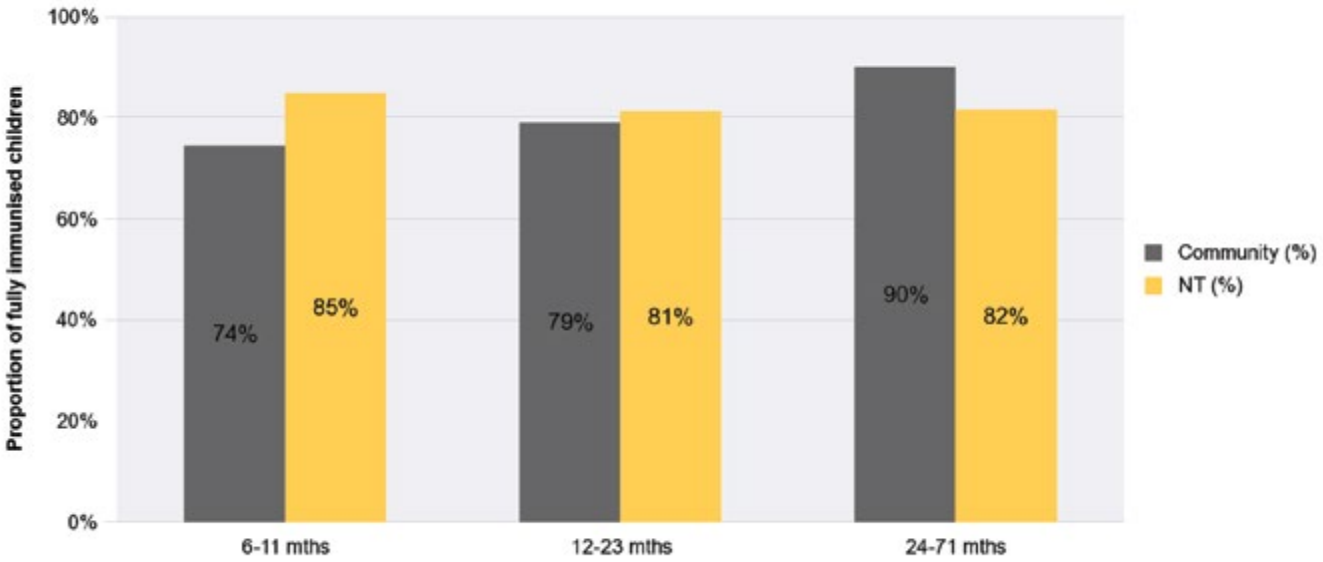


Immunisation

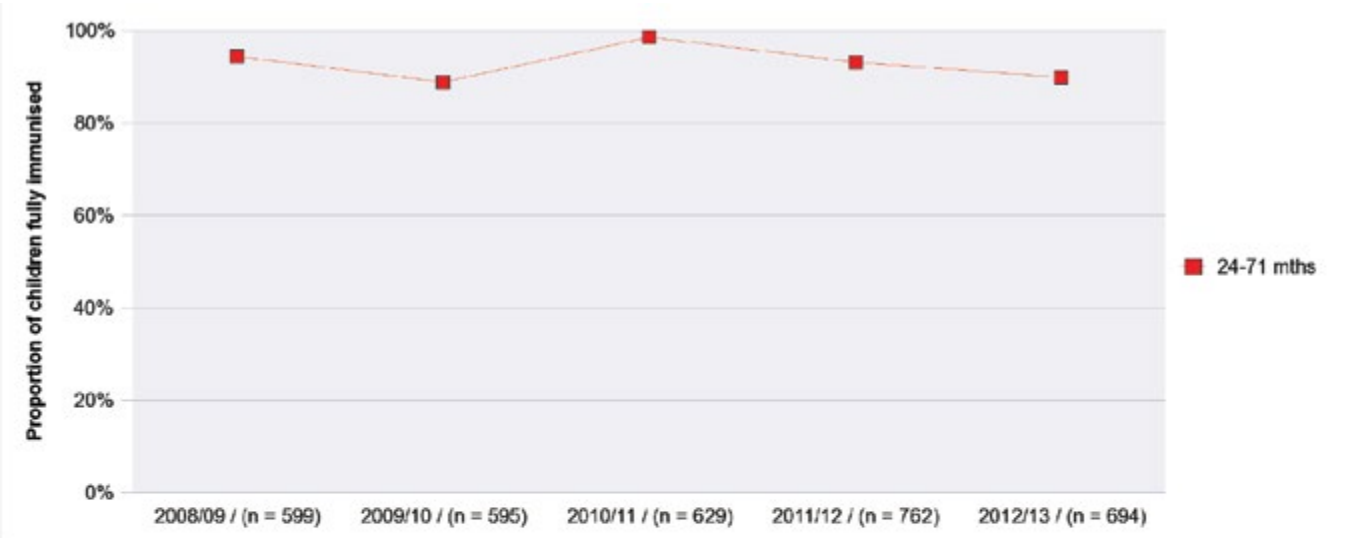
22. The overall coverage rate is still acceptable at 90% but this is a small but significant decline from previous levels. The timeliness of immunisations has declined especially in the key age range from 6 months to 1 year. The immunisation levels have returned to the levels that existed prior to the increase in staffing of the Healthy Kids Clinic to having 4 specialist child health nurse positions. For half of this reporting period 3 of these positions were allowed to remain unfilled and this is the reason for the decline in immunisation levels in children. This has now been addressed by the Acting Services Branch Manager and all positions are now filled and immunisation levels will improve again.

AHKPI 1.4 FULLY IMMUNISED CHILDREN

Figure 1.4a Proportion of resident Aboriginal children 6 to 71 months of age recorded as fully immunised during reporting period by age group



TREND OF RESIDENT ABORIGINAL CHILDREN 24-71 MONTHS OF AGE FULLY IMMUNISED BY REPORTING YEAR



Reporting Year(s)	2008/09	2009/10	2010/11	2011/12	2012/13
Population (Denominator)	599	595	629	762	**694**
Fully immunised children at age : 24-71 mths	94%	89%	99%	93%	**90%**

n = Population (denominator) is the number of resident Aboriginal children aged 24-71 months.

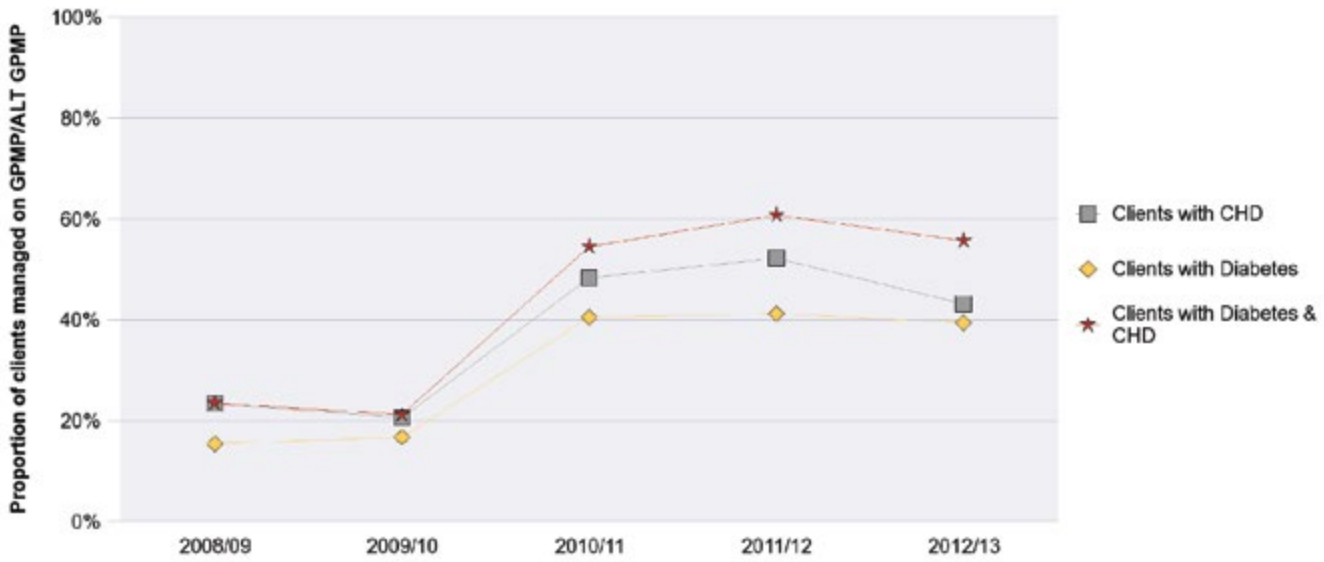
AHKPI 1.4 Number and proportion of Aboriginal children fully immunised at 1, 2 and 6 years of age

Aboriginal children	Age of Children			TOTAL
	6-11 mths	12-23 mths	24-71 mths	
Fully immunised children	64	139	624	**827**
% fully immunised children	74%	79%	90%	**87%**
Number of resident Aboriginal children	**86**	**176**	**694**	**956**

Chronic Disease

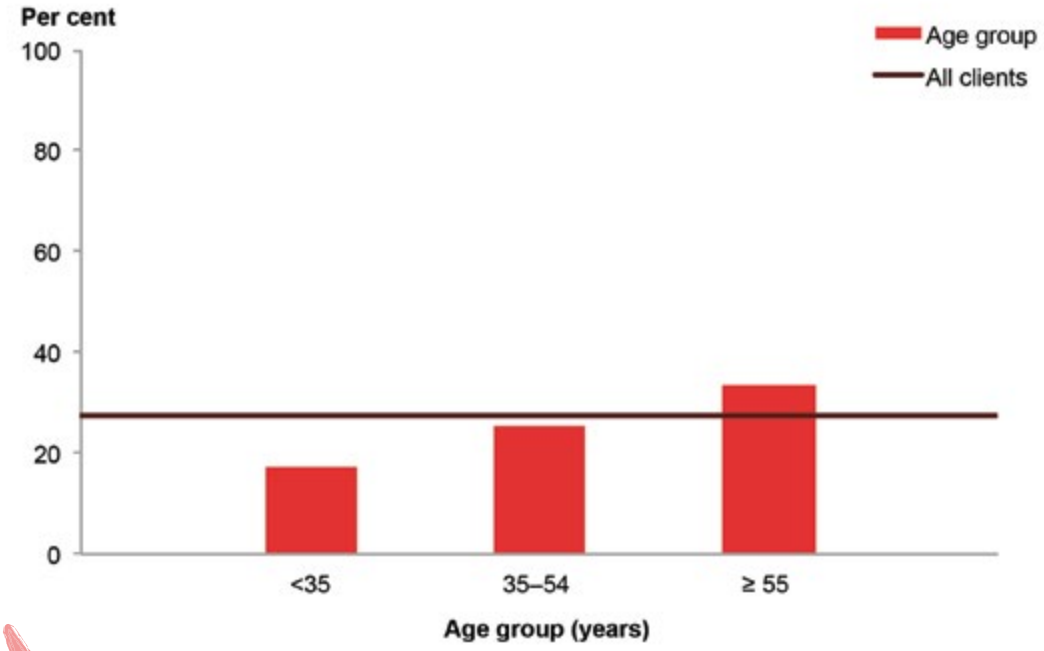
23. Care planning has slightly declined but outcome measures have improved especially for diabetic glucose control, blood pressure control and cholesterol control which has maintained the improvement shown in the previous period.

TREND OF RESIDENT ABORIGINAL CLIENTS MANAGED ON CHRONIC DISEASE MANAGEMENT PLAN BY DISEASE GROUP AND TWO YEAR REPORTING PERIOD



Reporting Years(s)	2008/09	2009/10	2010/11	2011/12	2012/13
Population (Coronary Heart Disease)	205	258	265	295	276
Population (Type II Diabetes)	960	988	920	1,008	972
Population (Type II Diabetes & Coronary Heart Disease)	128	156	167	176	158
Clients with CHD on GPMP/Alt GPMP	23%	21%	48%	52%	43%
Clients with Diabetes on GPMP/Alt GPMP	15%	17%	41%	41%	39%
Clients with Diabetes & CHD on GPMP/Alt GPMP	23%	21%	54%	61%	56%

TEAM CARE ARRANGEMENT: Percentage of Indigenous regular clients with Type 2 diabetes who received a TCA (MBS item 723) within the previous 24 months, by age group



24. The proportion of diabetic patients who had had their average glucose level measured; has also increased from 45% to 63% for females and 41% to 57% for males. There is still opportunity for improvement on this indicator. As it is essential to know the level of glucose control in all diabetic clients on regular basis. Congress is going to trial point of care testing in the clinic to assist in this area.

TREND OF RESIDENT ABORIGINAL CLIENTS WITH TYPE II DIABETES RECEIVING A HbA1c TEST IN THE PREVIOUS 6 MONTHS BY SEX AND REPORTING YEAR

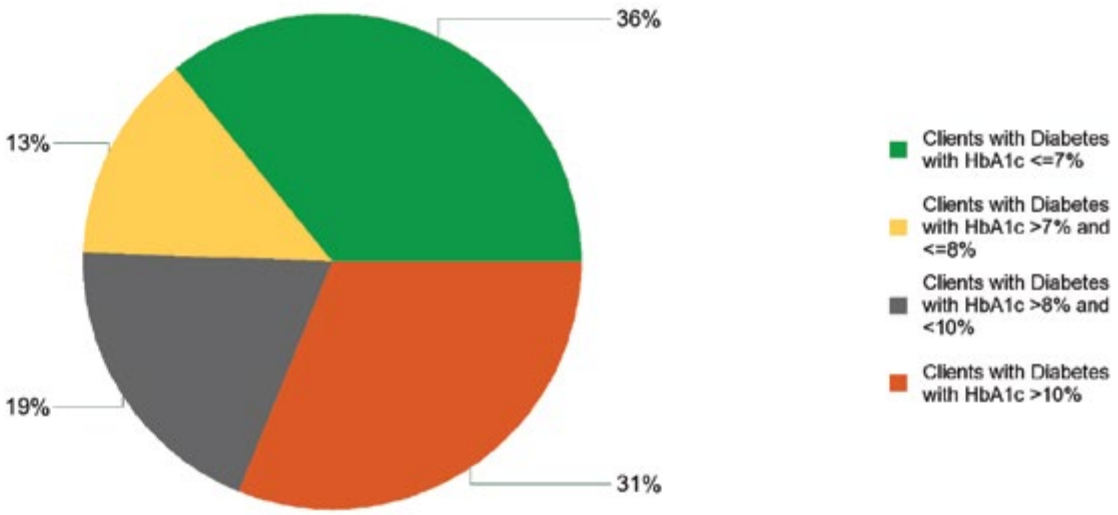
Reporting Year(s)	2008/09	2009/10	2010/11	2011/12	2012/13
Population (Denominator)	960	988	920	1,008	972
Female	45%	46%	60%	45%	63%
Male	44%	44%	52%	41%	57%

n = Population (denominator) is the number of Aboriginal clients who have been diagnosed with Type II diabetes.

25. The level of glucose control along with blood pressure control and cholesterol control are important outcome indicators for good quality diabetes management. Congress does better than average on all these three indicators. 36% of diabetics have excellent sugar control (<=7%) with a further 13% with good control (between >7% and <=8%).

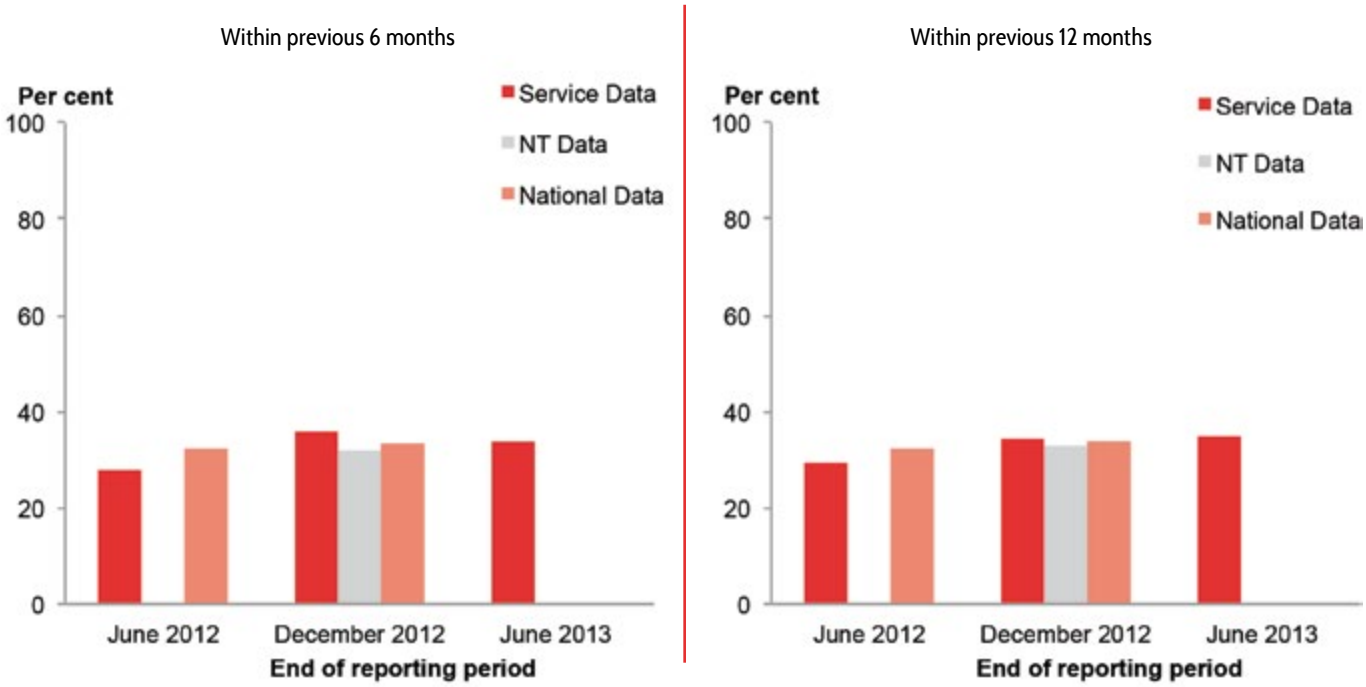
AHKPI 1.14 HbA1c MEASUREMENTS

Figure 1.14a Proportion of resident Aboriginal clients with type II diabetes and whose HbA1c measurements are within certain levels in the previous 12 months by Community (%)



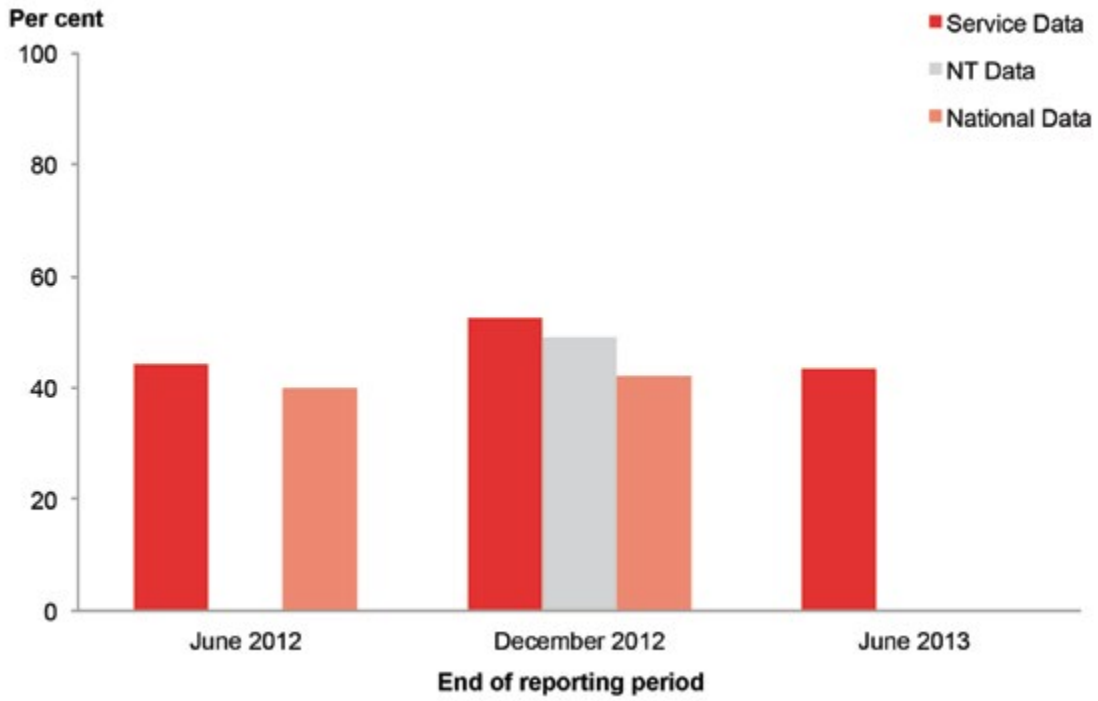
26. The proportion of Aboriginal diabetics with excellent control (<=7%) is better than the NT and national average.

COMPARISON: Percentage of Indigenous regular clients with Type 2 diabetes, with an HbA1c recorded result of less than or equal to 7%, reporting periods ending 30 June 2012, 31 December 2012 and 30 June 2013



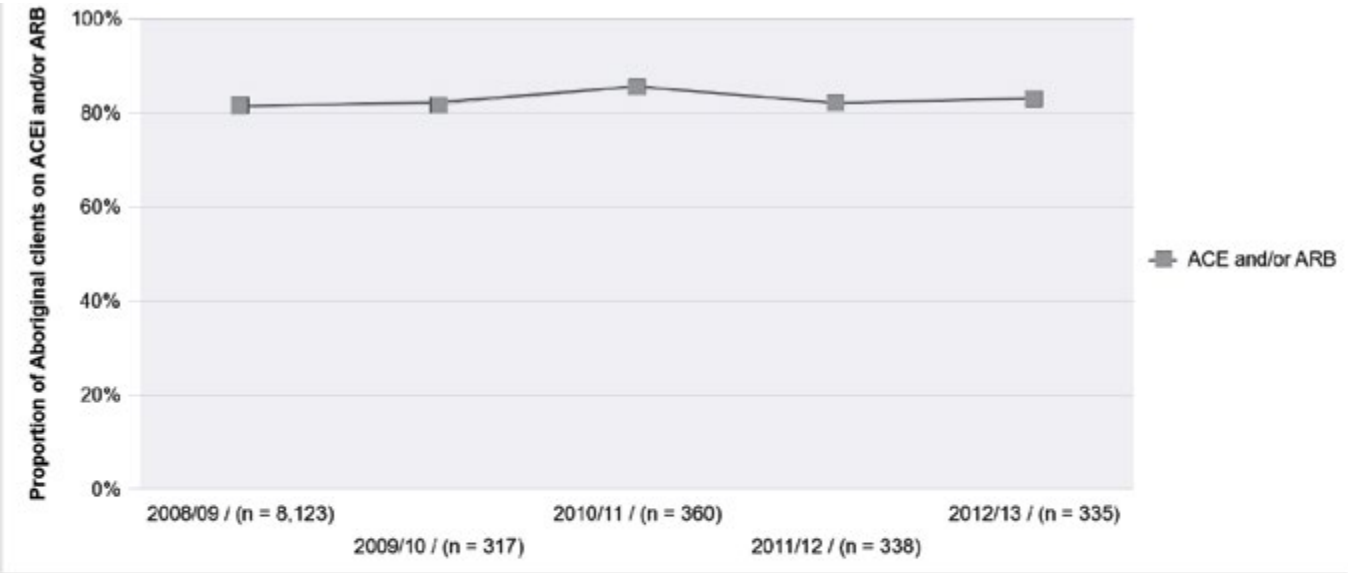
27. Congress is also doing better than average with excellent Blood Pressure control (<=130/80) with more than half of diabetics in this category.

COMPARISON: Percentage of Indigenous regular clients with Type 2 diabetes whose blood pressure measurement result recorded within the previous 6 months was less than or equal to 130/80mmHg, reporting periods ending 30 June 2012, 31 December 2012 and 30 June 2013



28. It is also vital to ensure that all diabetics with protein in the urine (Albuminuria) are on the right medication to prevent the progression of kidney disease. Angiotensin Converting Enzyme (ACE) Inhibitors or Angiotensin Receptor Blockers (ARB) are medicines that make a difference to kidney disease and more than 80% of appropriate diabetic clients are on one of these two medicines.

TREND OF TYPE II DIABETES RESIDENT ABORIGINAL CLIENTS WITH ALBUMINURIA ON ACE AND OR ARB MEDICATION DURING THE REPORTING PERIOD (12 MONTHS)



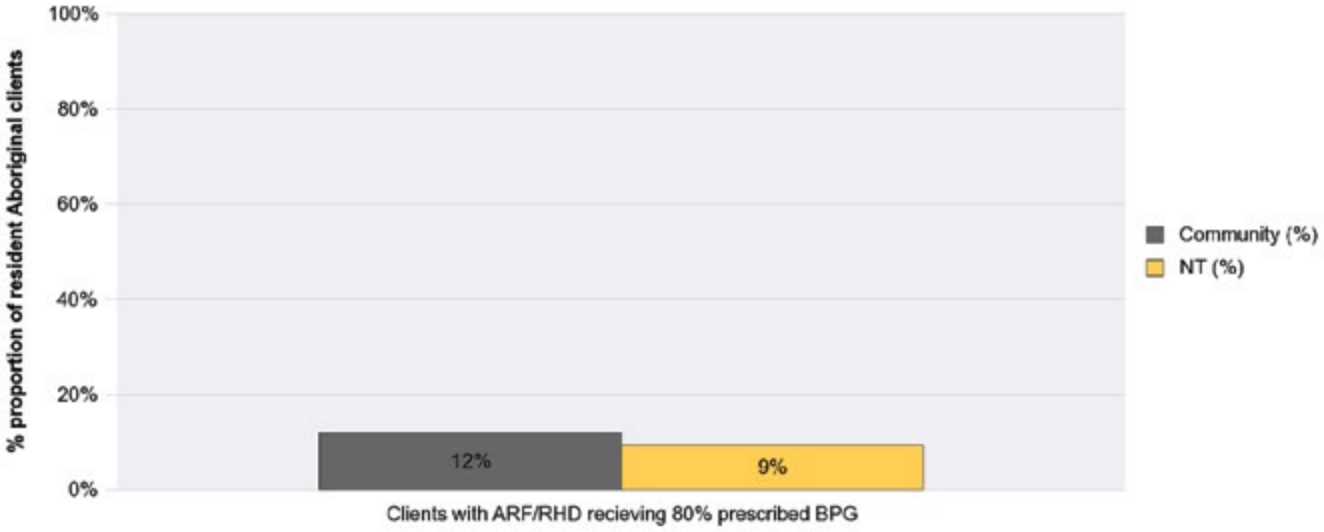
Reporting Year(s)	2008/09	2009/10	2010/11	2011/12	2012/13
Population (Denominator)	8,123	317	360	338	335
ACE and/or ARB	82%	82%	86%	82%	83%

n = Population (denominator) is the number of resident clients who are 15 years old and over, who have been diagnosed with type II diabetes with albuminuria during reporting period.

29. (Graph appears on opposite page) A new NTKPI measures the proportion of clients with Rheumatic Fever or Rheumatic Heart Disease who have received more than 80% of their required penicillin injections. There are 44 clients at Congress with RF/RHD and of these only 12% have had the required needles. This is better than the NT average but not acceptable. We had been monitoring the monthly coverage rate which has been more than 60% but over 12 months the coverage rate is much worse. There was a time when the coverage rate for this was much better but the system that was working was dismantled such that these patients have no longer had priority access to the clinic. This priority access system has now been restored, recalls set for 3 weeks rather than 4 and targeted education undertaken. Only 4 of these clients are under 18 compared with more than 20 ten years ago, this is good news for the future as it seems the incidence in childhood of Rheumatic Fever has declined.

AHKPI 1.15 – RHEUMATIC HEART DISEASE

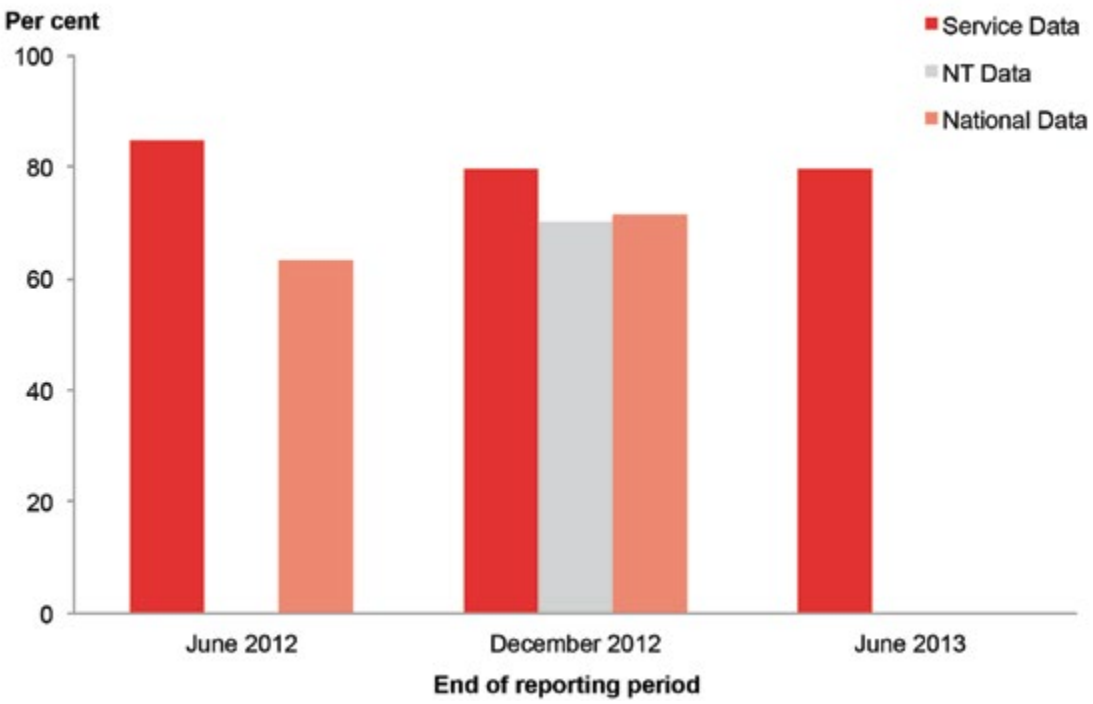
Figure 1.15a Proportion of resident Aboriginal ARF/RHD clients who are prescribed to be requiring 2-4 weekly BPG Penicillin Prophylaxis and have received 80% of their injections over a 12 month period by Community (%)



Risk factors

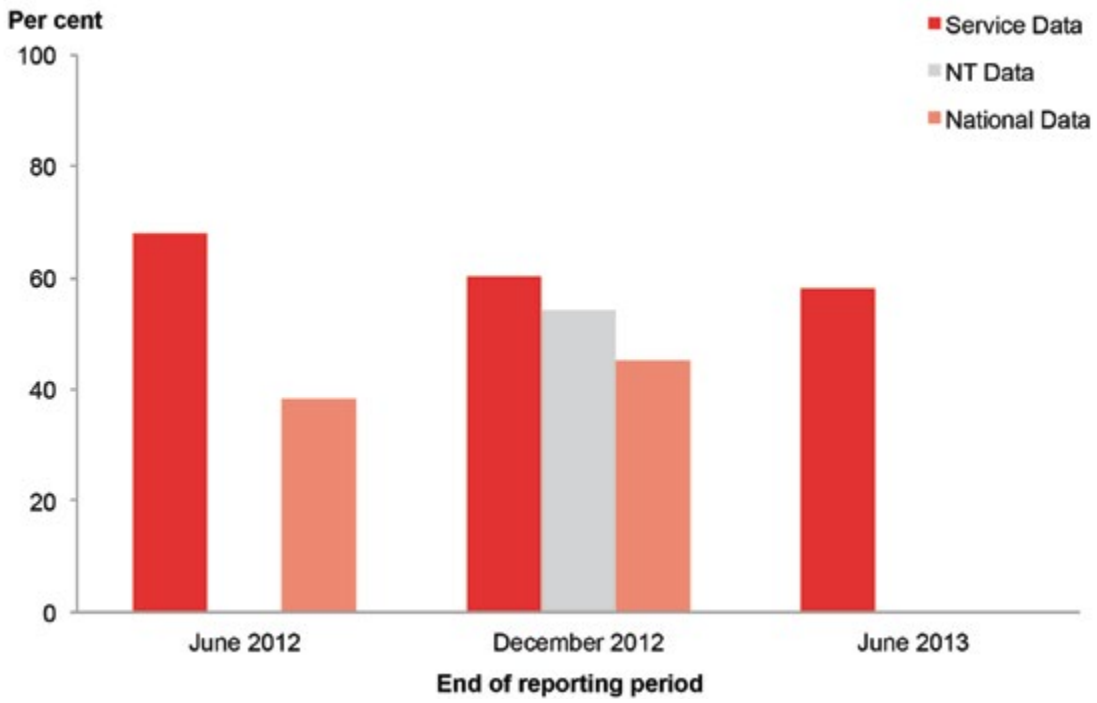
30. Congress is doing better than average on recording smoking status and over recent years community smoking prevalence has declined from 57% in 2009 to 48% now. Evidence shows if smoking status is recorded in the medical file the GP or other health professional is twice as likely to have offered a brief intervention than if it is not recorded. Given the serious adverse health consequences of smoking this is an important and relatively simple thing for practitioners to do.

COMPARISON: Percentage of Indigenous regular clients aged 15 and over who had their smoking status recorded, reporting periods ending 30 June 2012, 31 December 2012 and 30 June 2013



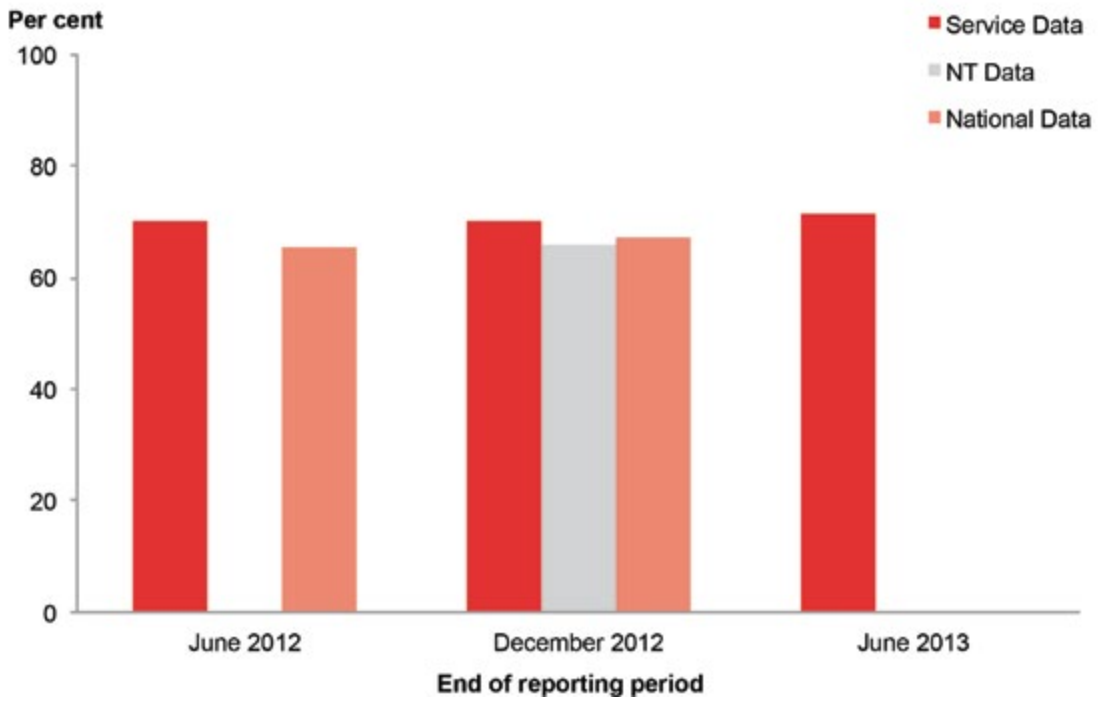
31. The way in which alcohol consumption is assessed at present in the clinical record is not as good as it could be and in the near future a new tool will be added into the electronic medical record system known as the AUDIT C tool which is a better, more standardised way to ask patients about their level of alcohol consumption.

COMPARISON: Percentage of Indigenous regular clients aged 15 and over who had their alcohol status recorded within the previous 24 months, reporting periods ending 30 June 2012, 31 December 2012 and 30 June 2013



32. Overweight and Obesity is a major health problem across Australia with the prevalence of these conditions only being slightly higher in Central Australia than elsewhere – this is a national health problem that requires a national public health response and not just an individual response.

COMPARISON: Percentage of Indigenous regular clients aged 25 and over who had their BMI classified as overweight or obese within the previous 24 months, reporting periods ending 30 June 2012, 31 December 2012 and 30 June 2013



Early Childhood Special Feature

Central Australian Aboriginal Congress (Congress) has a focus on improving health and developmental outcomes for Aboriginal children. Central to this goal is the position that the best way to close the gap is to make sure it is not created in the first place. This is of significant importance because children are at their greatest developmental vulnerability at a time when they have the least capacity to influence their trajectory in life.

Early childhood is also an area of great strategic investment. Once deficits are observed, more and more resources are needed to undo developmental concerns, while at the same time the scope for recovery is diminished.

There are many factors contributing to developmental concerns. One major influence is adverse childhood experiences leading to several developmental problems. These problems, often unnoticed in early childhood, have consequences in later life and are observed in low educational attainment, poor health outcomes, substance misuse, significant mental health problems and higher incarceration rates. Unfortunately these are all problems well known within the Alice Springs community.

A key to overcoming poor developmental outcomes and their subsequent long term effects is the coordinated implementation of preventative and early intervention programs. This period has marked a major step forward for Congress in its focus on improving health and developmental outcomes for vulnerable and at risk Aboriginal children in Central Australia, with the establishment of a Children Services Branch.

The capacity for Congress to support a Children Services Branch is the culmination of a long-term investment in child and family focussed programs that have contributed to Congress developing a reputation as a leading service provider in this area. Running parallel to the development and implementation of these programs has been discussion about the need for a coordinated approach and the importance of continued investment to support child health and development. This dialogue has taken place at Board, Executive and Operational levels.

The culmination of these discussions has resulted in the document **Integrated Model of Child and Family Services** which has been informing integration of both current and future programs and in particular the Children Services Branch, which, in the first instance, brings together two key areas, the Preschool Readiness Program, and also the Congress Child Care Centre.

This will also support the strategic vision mapped out in the Congress document, **Rebuilding Family Life in Alice Springs and Central Australia: the social and community dimensions of change for our people** (http://www.caac.org.au/files/pdfs/Rebuilding-Families-Congress-Paper.pdf). A major focus of this was the need to implement the types of evidence-based policy proposals that are going to further improve the social situation in Alice Springs in the short, medium and long term. Some key points made in the section on **Early Childhood Programs, Educational Attainment, Employment and Health** were:

1. **A key role of the primary health care system is to support children from disadvantaged backgrounds to be able to enrol in pre-school and school to support the optimal level of brain development.**
2. **Much greater focus needs to be given to the early childhood education that young children receive at home prior to age three.**
3. **Children who grow up in a disadvantaged early childhood environment do not develop the capacity to do well in education and, even though they attend primary school, will, on average, do badly and drop out as soon as they are old enough to vote with their feet.**
4. **The things that make the difference include daily one on one interactions and talking with young children, daily reading, going to bed at regular times, being physically active and having a good playgroup of children of similar age.**

Key recommendations included:

- That the Olds "Nurse-Family Partnership" Program of home-visitation for new mothers be rolled out across all communities in Central Australia as an early intervention strategy to improve the health and social functioning of low-income mothers and their babies.
- That high-quality childcare centres be established for all children aged one to three from disadvantaged households in Alice Springs and surrounding communities [and] . . that these centres implement the Carolina Abecedarian early-intervention approach to build school readiness and maximise potential for positive educational and social outcomes in young adulthood.
- That these children transition into two years of pre-school.

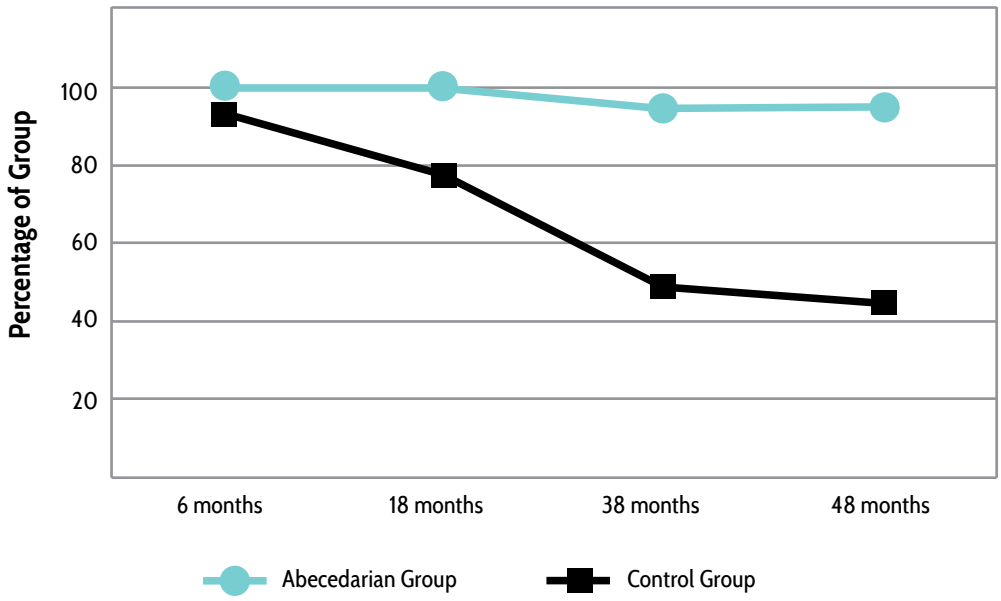
Nurse Family Partnership Program

Through a series of randomised controlled trials, NFP has demonstrated significant impact across a variety of maternal and infant health and social outcomes, including reducing child maltreatment, reductions in serious accidental injuries to children, delays in subsequent pregnancies, and increased maternal employment as well as reductions in child and maternal criminal and anti-social behaviours as long as 15 years after program completion (Olds et al 2007). Importantly, two independent groups have shown that the program has yielded significant cost benefit (Aos, Lieb, Mayfield, Miller, & Pennucci, 2004; L Karoly, Kilburn, & Cannon, 2005). This program has been successfully implemented in Congress and is in its fourth year of operation.

Abecedarian Educational Day Care

The Abecedarian model has been rigorously evaluated with longitudinal studies following up children in adulthood. Positive findings have been replicated in several jurisdictions. Participants were from impoverished families and were all healthy, full-term infants. The aim was to see if providing systematic, high quality education could prevent or reduce the negative developmental trajectory experienced by these high-risk children. It was a randomised, controlled trial and because the aim was to test the specific value of an early educational program, both treatment and controls were given adequate nutrition, social services, and medical care. The original Abecedarian approach has demonstrated gains that have been shown to persist well into adulthood and is a future area of development for Congress.

Figure 1. The initial Abecedarian project saw children in the treatment group follow a more 'normal' developmental trajectory in terms of IQ measurements compared to controls.



Preschool Readiness Program

The Congress Preschool Readiness Program was established in response to a high number of Aboriginal children in Central Australia who were not attending preschool, and also the high rate of children who were entering school with developmental concerns. This program has a multidisciplinary team with a focus on successful transition from home to school, and an intensive program to support children enter school with the confidence and ability to take on the challenges of starting preschool. The program has been independently evaluated and there is a clear positive trend in overall enrolment figures, with the intensive programs being run showing how quickly children can progress when provided intensive and enriched learning opportunities.

2012 - 2013 Financial Information

Deloitte.

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The Directors
Central Australian Aboriginal Congress Aboriginal Corporation
P O Box 1604
ALICE SPRINGS
0871

Dear Board Members

Central Australian Aboriginal Congress Aboriginal Corporation

In accordance with the Corporations (Aboriginal and Torres Strait Islander) Act, I am pleased to provide the following declaration of independence to the directors of Central Australian Aboriginal Congress Aboriginal Corporation.

As lead audit partner for the audit of the financial statements of Central Australian Aboriginal Congress Aboriginal Corporation for the financial year ended 30 June 2013, I declare that to the best of my knowledge and belief, there have been no contraventions of:

(i) the auditor independence requirements of the Corporations (Aboriginal and Torres Strait Islander) Act in relation to the audit; and
(ii) any applicable code of professional conduct in relation to the audit.

Yours sincerely

Deloitte Touche Tohmatsu

DELOITTE TOUCHE TOHMATSU

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E Dry
Partner
Chartered Accountants

Alice Springs, 26 /09 /2013.

Deloitte.

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INDEPENDENT AUDIT REPORT TO

THE BOARD OF DIRECTORS OF CENTRAL AUSTRALIAN ABORIGINAL CONGRESS ABORIGINAL CORPORATION

We have audited the accompanying financial report of Central Australian Aboriginal Congress Aboriginal Corporation which comprises the statement of financial position as at 30 June 2013, the statement of comprehensive income, the statement of cash flows and the statement of changes in equity for the year then ended, notes comprising a summary of significant accounting policies and other explanatory information and the directors' declaration, as set out on pages 7 to 20.

The Directors' Responsibility for the Financial Report

The directors are responsible for the preparation and fair presentation of the financial report in accordance with Australian Accounting Standards and the Corporations (Aboriginal and Torres Strait Islander) Act 2006 (the "Act") and for such internal control as the directors determine is necessary to enable the preparation of the financial report that is free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

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

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

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

Deloitte.

INDEPENDENT AUDIT REPORT TO

THE MEMBERS OF CENTRAL AUSTRALIAN ABORIGINAL CONGRESS ABORIGINAL CORPORATION (continued)

Opinion

In our opinion the financial report of Central Australian Aboriginal Congress Aboriginal Corporation presents fairly, in all material respects, the Corporation's financial position as at 30 June 2013 and it financial performance for the year then ended in accordance with Australian Accounting Standards, as described in Note 1, and the Corporations (Aboriginal and Torres Strait Islander) Act 2006.

Deloitte Touche Tohmatsu

DELOITTE TOUCHE TOHMATSU

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Partner
Chartered Accountants

Alice Springs, 30 / 09 / 2013.

Director's Declaration for 12 months ending June 30 2013

The directors declare that, in their opinion:

(a) there are reasonable grounds to believe that the corporation will be able to pay its debts when they become due and payable; and

(b) the financial statements and notes are in accordance with the regulations, including:

(i) compliance with the accounting standards; and

(ii) providing a true and fair view of the financial position and performance of the corporation.

Signed in accordance with a resolution of the directors made on the date of signature below.

Signed at Alice Springs this 26th day of September 2013.

President of Board

Statement of Comprehensive Income for 12 months ending June 30 2013

	Notes	2013 $	2012 $
OPERATING INCOME			
Grants and contributions provided		31,710,080	30,748,987
Interest		396,840	313,740
Other operating revenues		5,918,600	5,239,377
Net gain on disposal of assets		-	54,055
		38,025,520	36,356,159
OPERATING EXPENSES			
Employee costs		27,527,080	26,571,694
Interest charges		18,769	-
Depreciation & amortisation	5	581,644	667,539
Medical supplies		508,781	520,411
Motor vehicle expenses		1,813,120	1,747,789
Rent		1,398,366	967,592
Other operating expenses		5,782,987	6,528,010
Net loss on disposal of assets		48,219	-
		37,678,966	37,003,035
SURPLUS (DEFICIT) FOR THE YEAR		346,554	(646,876)
Other Comphrehensive Income		-	-
TOTAL COMPREHENSIVE INCOME		346,554	(646,876)

Statement of Financial Position as at June 30 2013

	Notes	2013 $	2012 $
CURRENT ASSETS			
Cash and cash equivalents	2	14,942,305	12,399,975
Trade and other receivables	3	1,229,315	2,593,859
Other assets		114,156	-
Investments	4	1,002	-
TOTAL CURRENT ASSETS		**16,286,778**	**14,993,834**
NON CURRENT ASSETS			
Property, plant and equipment	6	5,402,638	5,077,976
Investments	4	-	1,002
TOTAL NON CURRENT ASSETS		**5,402,638**	**5,078,978**
TOTAL ASSETS		**21,689,416**	**20,072,812**
CURRENT LIABILITIES			
Trade and other payables	8	1,620,815	2,323,994
Employee benefits	7	2,870,557	2,283,562
Unexpended grants	9	4,031,502	7,250,409
Unexpended grants (prior years)		2,151,088	-
TOTAL CURRENT LIABILITIES		**10,673,962**	**11,857,966**
NET ASSETS		**11,015,454**	**8,214,846**
EQUITY			
Accumulated funds		2,515,282	3,447,072
Reserve Funds	10	8,500,172	4,767,774
		11,015,454	**8,214,846**

Statement of Changes in Equity for 12 months ending June 30 2013

	Accumulated surpluses $	Asset reserves	Total $
Balances at the beginning of the previous year	4,277,105	4,584,617	8,861,722
Transfers to/from reserves from accumulated surplusses	(183,157)	183,157	-
Total comprehensive income for the year	(646,876)	-	(646,876)
Balances at the beginning of the previous year	3,447,072	4,767,774	8,214,846
Transfers to/from reserves from revenue (see note below)	-	2,454,054	2,454,054
Transfers to/from reserves from accumulated surplusses	(1,278,344)	1,278,344	-
Total comprehensive income for the year	346,554	-	346,554
Balances at the end of the current year	2,515,282	8,500,172	11,015,454

Note:
Transfers were approved by the funding body in order for funds to be used in subsequent years for specific capital projects.

Central Australian
ABORIGINAL CONGRESS
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