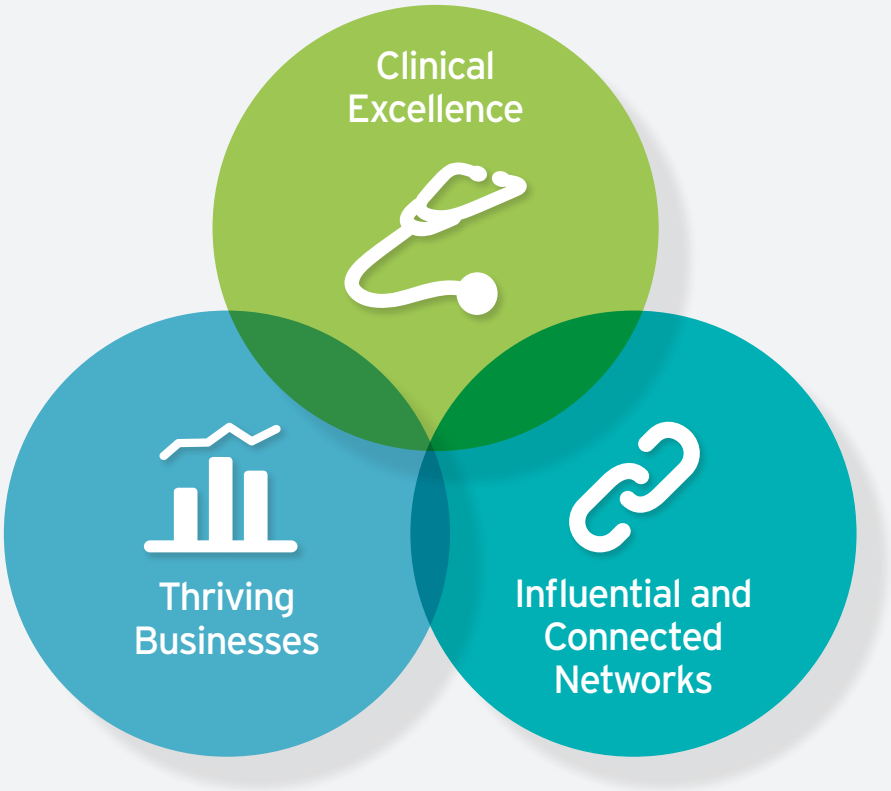
ANNUAL REPORT 2015

Valuing your time

ProCARE

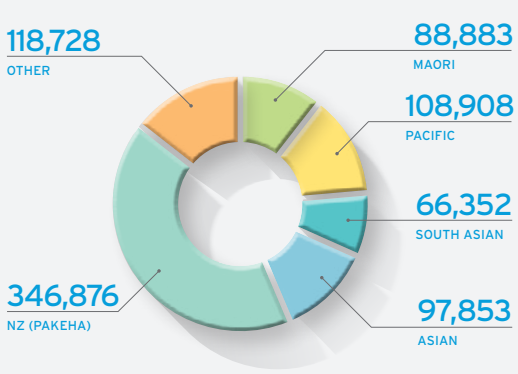
CONTENTS



As a cooperative of healthcare professionals, we are committed to achieving excellence in patient care.

We provide value by supporting practices in three essential and interconnected areas. Our programmes and services deliver **clinical excellence** through clinical innovation, professional satisfaction and quality education. Our **business services** achieve efficiencies and ensure a profitable and sustainable future for practices. And with our network's knowledge, we provide **an influential voice** to protect and promote our members' interests.

At a glance

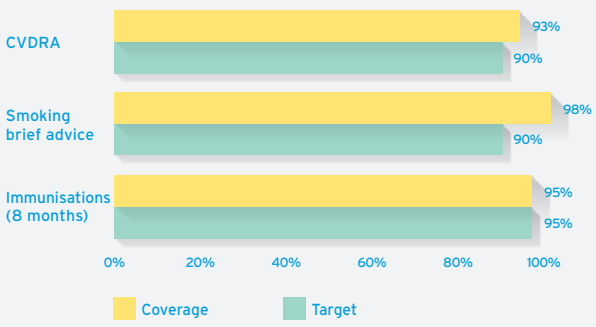


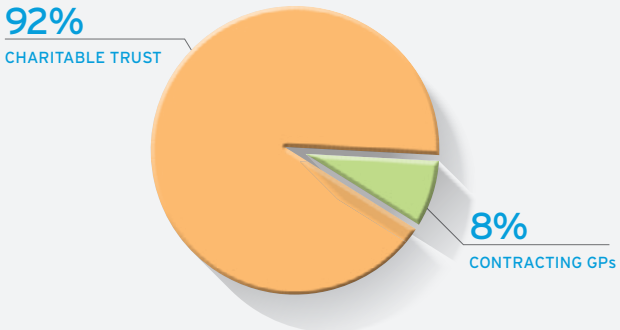
Our patient population

We care for more than 827,600 patients.

Our membership

We represent Auckland's largest network of General Practitioners and general practice teams.





National Health Targets

Our June 2015 results show the network's continued commitment to achieving the National Health Targets.

Charitable trust

The Charitable Trust is now established and seeking applications for grants.

ALLIANCES

- ProCare is part of a number of alliances, including:
- Community Care Auckland (CCA) – all Auckland PHOs
- Network 4 – ProCare, Pegasus, Midlands and Compass
- Auckland Regional Afterhours Network
- CMH Health District Alliance
- Auckland/Waitemata Regional Alliance
- Auckland DHB Youth Health Alliance

PPS

- 20 psychologists
- 15,000 subsidised psychological consultations a year
- 90% of clients' distress resolved by interventions
- 4 self-management courses completed with 55 participants across New Lynn, Henderson, Massey and Helensville. Expanding next year to include courses in ADHB and increase areas in WDHB.
- 15 days a week of psychological support in practices across the region
- 3 psychologists working 4 days in 7 low decile or isolated schools in ADHB

EDUCATION

ProCare's network signalled that workforce is one of its biggest challenges. In response we are:

- Facilitating summer cadetships with Homecare Medical
- Providing general practice placements for house officers and mentoring for practise ownership
- Providing new graduate nurses placements on the Nursing Entry to Practise Programme
- Held 2 nursing days, 23 practice managers meetings, 60 practice nurse meetings, 210 GP meetings, 6 large CME/CNE meetings
- 98% of all practices attended cell groups between February and April 2015

HOMECARE MEDICAL

Formed in early 2014 by ProCare (Auckland) and Pegasus Health (Canterbury):

- New Zealand-owned healthcare organisation providing telehealth services 24/7
- Anchored in primary healthcare and integrated into secondary care, emergency and community services
- Supports more than 600 general practices, caring for some 2.2 million New Zealanders
- Responding to more than 1 million calls for help a year
- June 2015 – identified as preferred provider of the National Telehealth Service

HEALTH PROMOTION

Creating activities that support clinicians in having 'that difficult conversation' with a diverse patient population, eg:

- The 2015 cervical screening awareness competition, was promoted through the network, Pacific churches, marae, migrant and refugee health events
- Outcome: 73 practices entered into the competition, 63 practices submitted their patient entries and 2333 unscreened or overdue women were screened in two months

NURSING

Senior primary care nurses work across our governance structure:

- Clinical Directorate and Clinical Quality Education Committee
- Dedicated nurse advisors for practices
- Nurse-led cell groups
- A nurse-led unit responsible for general practice education
- Access to a Nursing Council approved PDRP
- Representation in regional and national nursing forums

STRENGTHENING OUR CLINICAL EXPERTISE

The ProCare Board has strengthened ProCare's clinical expertise through additional resource to its Clinical Directorate:

- Dr Allan Moffitt – Clinical Director
- Dr Janine Bycroft – Associate Clinical Director, Self-Management
- Dr Karl Cole – Associate Clinical Director, Information
- Dr John Cameron - Associate Clinical Director, Medical
- Lorraine Hetaraka-Stevens – Nursing Director

ICT

- Investing in IT solutions that support our practices, eg our new Clinical Intelligence System which provides a single source for storing clinical information, giving ProCare the ability to produce reports to help practices manage their business.
- Our claims processing systems processed 167,528 claims in 2014

Healthcare Home – happier staff, happier patients

Earlier this year Mt Wellington Family Health Centre GP and ProCare associate clinical director Dr Janine Bycroft travelled to the States with a group of primary care leaders on an investigative tour of the healthcare home model of care. She returned convinced of the benefits of changing the way health teams deliver primary care.

JANINE BYCROFT – ASSOCIATE CLINICAL DIRECTOR AND GP

WHY ARE YOU SUCH AN ADVOCATE?

We seem to be stuck in an acute reactive model and with the changing healthcare needs of our population we must start exploring new ways of working that are more effective – working smarter not harder, are satisfying for us as health professionals and help our patients make lifestyle and behaviour changes to improve their health and wellbeing.

I've been reading about new models of care for many years and the work of Group Health[1] and the healthcare home movement in the States is one of the shining lights of primary care. I really wanted to see what elements we could bring home and use here. There's increasing evidence to show that this approach improves the health outcomes of the populations being served[2].

WHAT STOOD OUT FOR YOU?

Definitely the health coach model. The philosophy is to help people gain the knowledge, skills and tools to make changes in their lives and reach their health goals. Essentially, it's the difference between coaching a patient and rescuing a patient. You know the old adage... give a man a fish and he eats for a day. Teach a man to fish and he eats for a lifetime.

We know many patients with chronic conditions go away not understanding or remembering clearly what we've discussed and this contributes to poor adherence rates for medication[3].

Health coaches are there to help patients understand, agree and participate in the management of their health issues. I'd love to see health coaches working in practice teams here. They have excellent communications skills and understand the language and culture of the population you're working with.

IS THIS POSSIBLE HERE?

Making this work in a NZ context is the challenge. The way it's worked overseas is that instead of practices taking on another GP or nurse, they've employed a health coach who works to free up time for clinical teams to see more patients. Often the health coaches were the first and key contact person for patients.

On the trip we visited several practices with health coaches and the doctors seemed to love working with them because they could see the difference they made with patients who felt more listened to, more connected to the practice and more understood.

There were lots of stories from patients telling of the huge difference this model of care and health coaches made to them[4].

IS THERE ANY SUPPORT FOR THE HEALTHCARE HOME MODEL OF CARE HERE?

At a national level, ProCare, Pegasus, Midlands and Compass are advocating for government support to explore more effective models of care for general practice and how funding can be used to support the changes this would require. The PHOs are also looking at what training and resources are needed to progress to such a model. It's very early days still but ProCare is investigating ways of supporting practices in the network keen to lead the charge.

WHY SHOULD I MAKE SUCH A RADICAL CHANGE TO THE WAY I PRACTICE?

Improved outcomes, improved satisfaction, working smarter not harder, happier, healthier patients, freeing up capacity through improved productivity. Clearly, if it's not financially neutral or beneficial practices won't be interested so we're at that early stage of working up business models for practices. What is evident is that where this model of care is employed internationally, great strides in patient wellbeing and health are made.

The impact on our practices will be to improve quality of care for our patients, allow us to better support patients in making lifestyle changes, improve the finances and productivity of our practices and let us enjoy our work more.

SO WHAT WOULD A NZ PRACTICE USING THIS MODEL OF CARE LOOK LIKE?

It's all about sharing the workload. In the States they talk about working at the top of license so, for example, low acuity work for nurses is delegated to healthcare assistants so nurses can spend more time doing clinical work and seeing patients; this in turn frees up GPs to take on expanded roles. Teams work much more effectively and patients have more options for getting care in a way that works best for them, such as a telephone consult, email, video or face-to-face.

IS ANYONE DOING THIS IN NZ?

It's been great to visit and learn from the Midlands Health Network who began adapting the healthcare home model for NZ about five years ago. What's working well for them is enhanced teamwork with medical assistants, clinical pharmacists, nurses and GPs, essentially making sure the right person does the right job at the right time. This allows everyone to work at the top of their scope and frees up nurse and GP time for more complex care.

They also have a customer call centre that takes all calls for their healthcare home practices. They take a proactive approach so that when someone rings in, people can be offered telephone, email or face-to-face consults depending on acuity. The end effect is that practices are quieter, with much less phone interruption, and receptionists are able to focus on the person in front of them. Part of the triaging process is to sort out if patients need screenings or blood tests before they see their doctor, maximising everyone's time. There's been really good uptake of patient portals in Midlands because the practices prioritised them. The benefit of this is that patients are making online appointments, ordering their repeat prescriptions and are accessing their own lab results, significantly cutting down phone traffic and freeing up nurse and receptionist time.

> "The knowledge, skills and tools to make changes in their lives and reach their health goals. Essentially, it's the difference between coaching a patient and rescuing a patient."

What I really like about the healthcare home model is the willingness and goodwill of thousands of health professionals to share their learnings and experience. As practice teams we have our unique differences but there are so many things we do in common. This approach standardises workflow, streamlines processes and uses data in real time to allow continual quality improvements so we as clinicians can move from being reactive to proactive and partner more effectively with our patients.

1. www.ghc.org
2. www.pcpcc.org/resource/map-tools-pcmh-slide-presentations
3. www.who.int/chp/knowledge/publications/adherence_report/en/
4. www.aafp.org/fpm/2010/0900/p24.html

The beauty of patient portals

Queen Street Doctors, with 4000 enrolled patients and twice as many casual patients, started using the Health365 patient portal in April. In the first month they signed up 8% of their population to the portal. This increased to 15% in May, 21% in June, 27% in July and 31% in August. A patient portal becomes profitable when 20-25% of patients are enrolled; Queen Street Doctors achieved this in three months. GP Kathy McKay and accounts/administration manager Kathy Gardner tell how they accomplished this outstanding result.

KATHY MCKAY – GP; KATHY GARDNER – ACCOUNTS/ADMINISTRATION MANAGER

KATHY G: We started using a patient portal because it's beneficial to our practice and our patients and, in the medium to long-term, will save everyone money. Portals let patients access their lab results and see when they've made improvements, order repeat prescriptions, check records, such as when they last had vaccinations or when they're due, and make appointments. They can do it online on the bus on the way to work, at home, whenever it suits them. Portals give patients control.

KATHY M: From a practice point of view, there haven't been many challenges. We talk to every patient about portals when they come in; we also invite patients to give us feedback on how the portal is working for them and pass that on to our vendor. The patients who use it, use it well and really like it.

The challenge now is getting them to remember to use it; we are upgrading our website and that will have the link to the portal.

KATHY G: A portal is a cost to the practice. Because it's all so new, we're not charging patients to join the portal or for online consultations. We'll look at that as more people come onboard. We do charge for prescriptions but we do that anyway. We're all still learning.

KATHY M: I've got to say to anyone looking at setting up a portal that education really important. I went to some really good portal training sessions and we've made sure all our staff are comfortable with it. We've put all our staff on the portal; they're able to use it from a patient's point of view. This has helped them become confident with using the portal and also able to solve any issues patients throw at them. Some may feel anxious about their jobs but you need to reassure them that one of the benefits of a portal is freeing up people's time to do other work.

I think one of the keys to our success here is staff commitment. Our GPs do the enrolling but our receptionists are able to assist patients with any issues they have. It's a great way to engage with our patients. I was worried about exposing the notes database to external access but there are security systems in place. If you're apprehensive about patients reading their notes then don't give them access. You can choose. Our standard portal is everything but the notes but I am giving more and more people access now that I'm getting comfortable with the portal. Online banking, online health... it's just the way things are happening.

Rising from the flames

SARAH STEWART – GP; SUZANNE LONGMIRE – PRACTICE NURSE

On May 28, fire destroyed the Four Kauri Family Medical Centre in Mt Albert. While no-one was injured, the front of the building was destroyed and consultation rooms smoke-damaged and covered in soot. The fire was a terrible blow for staff and the practice has set up temporary rooms in a nearby motel. GP Sarah Stewart offers up some hard-learned lessons.

HAVE AN EMERGENCY PLAN – What we realised was that the work we'd done for Cornerstone made parts of getting back on our feet easy. If we'd had more of those things in place, like an emergency plan with all the numbers of the services we use, our stress would have been significantly reduced.

CONTACT YOUR PATIENTS – Get in touch as soon as you can. We sent personalised letters to each of our patients. We needed ProCare's help but it's so important. We also realised the value of having a website – or the impact of not having one. Luckily Healthpoint stepped up and covered for us.

DIVERT YOUR PHONES – It was critical that patients could ring our normal number and get through to us on our mobiles. Homecare Medical did a great job triaging calls for the first few days. Again, this relieved a lot of stress, knowing that our patients were being cared for.

MAKING USE OF YOUR FRIENDS – People in the community, the church, the rec centre, local pharmacies. ProCare offered us a clear head in the middle of the chaos. It makes a huge difference knowing you have someone backing you up. It was very practical support but also that feeling that you're not on your own.

HAVE A COMPREHENSIVE INVENTORY – Life would have been much easier if we'd had more of a stock list of what we needed in our consulting and treatment rooms, even down to having lists of the patient info pamphlets that you might want to replace and where you get them from.

GET UP AND RUNNING AGAIN IN A TIMELY FASHION – There were a lot of people prepared to help; our local chemists all came round to visit and arranged to handle repeat prescriptions on emergency basis. White Cross let us camp out in their premises for a few days which we greatly appreciated.

When you look at temporary rooms, make sure they function well. We had many kind offers but they weren't able to provide the basic essentials for patients to feel that they could have a normal consultation. Many places we were offered would not have had the necessary privacy. You need to minimise inconvenience to patients.

HAVE COMPREHENSIVE INSURANCE COVER – Make a point of regularly reviewing your insurance cover and make sure your policies meet your current needs.

BE OPEN WITH YOUR STAFF – It's a time of great uncertainty and very upsetting for staff. You need to provide a lot of reassurance and extra support. We found that during the first few weeks we needed more staff on reception as they were overwhelmed by the number and intensity of calls and patient contacts. Patients needed reassurance that their notes were

Giving people ownership of their health

MAY IKIHELE – NURSE;
MELE TAUFOOU – HEALTHCARE ASSISTANT;
LILY FRASER – CLINICAL DIRECTOR AND GP

GP referrals to our expanded self-management programmes are growing. On offer are community-based Stanford, LIFE, My Health, Our Life, pain and diabetes self-management courses.

Turuki Health Care clinical director and GP Lily Fraser is a frequent referrer and the practice has put nurse May Ikihele and healthcare assistant Mele Taufoou through Stanford training so the practice can run its own courses for patients.

LILY: We offer a good range of services to our patients here - Whanau Ora navigators, lactation consultations, teen parenting advice, rheumatic fever prevention programme, diabetes clinics, a cardiac and COPD nurse specialists. GPs have limited time in consultations and we're not able to get into depth about every condition patients have. These courses are a way of giving people ownership of their health, giving them the tools to ask their health professional about their own health. Health literacy is pretty low in south Auckland; it empowers people, helps them to get the care they need and want. Self-determination is important for our population.

Normalising mental health

not damaged and that we would be able to continue to care for them.

It's also vital that you keep to your normal holidays even though it's hard to get away. You really need to look after yourself and your staff.

Don't open until you're really ready – It's so hard not to just rush it and open up but you don't want patients coming in and having sub-standard care.

RESTOCKING THE PRACTICE – Be prepared to have to pay out for core expensive items but also accept that you have to spend a bit of money just to make your temporary rooms a bit nicer and easier to work in. We spent hours cleaning and making sure there were fresh flowers to make the place feel more welcoming.

MAKE SURE YOUR IT IS UP TO SCRATCH – It would have been so much quicker to get up and running if we'd been cloud-based. Smoke damages computers even though they might appear to be alright. It's only a matter of time before they fail.

TAKE A DEEP BREATH – We didn't just want to survive this devastating event. It's so easy to panic and go for the first thing on offer but if you don't feel you're going to end up with an improved model, it's really hard to keep motivated to do the work required to get up and running. That's where ProCare was very helpful. We really needed someone from the outside helping us to see things differently, otherwise you just have the same tunnel vision you always had.

OH, AND KEEP YOU SENSE OF HUMOUR.

PPS psychologist Rose Riley and Orewa Medical Centre business manager/ nurse leader Stephanie Watson explain the benefits of placing psychologists in practices. Rose started in February, working one day a week.

ROSE RILEY – PPS PSYCHOLOGIST; STEPHANIE WATSON – BUSINESS MANAGER AND NURSE LEADER

STEPHANIE: We're very focused on being the medical home for our patients, the majority of whom are 65 plus. We're a purpose-built practice with a deep-seated philosophy of providing compassionate, wrap-around care for our community. Having a psychologist based here fits perfectly; it means patients can be cared for in an environment they're familiar with and in real time. People come to our reception and say I'm here to see Rose, not I'm here to see the mental health team. If there's something emerging with one of Rose's clients, she's able to check in with the team here for help. And vice versa; if we need to gain some insight or support from Rose she's easy to get to for advice.

The beauty of being a satellite hub is that psychological help becomes part of general practice. It's just another one of the services we provide; we don't need to ship people off somewhere else and they don't have to worry about how to get here or being judged.

ROSE: It's all about taking away people's fears. Being part of the practice team is great. I had one client the other day who was diabetic and didn't understand what her blood test numbers meant. As I was on the spot, I was able to talk to the medical team and get her the information she needed and let her know about a support group she might like to join. If I can catch someone in the corridor it makes it easy; having direct access to clients' GPs and nurses, people who know them is a real advantage.

STEPHANIE: We've found that having a psychologist here melts the barriers in a really strong, proactive way and that cuts down on the DNAs tremendously.

ROSE: What better way to take away the stigma of mental health than to see people in their general practice? It normalising. Physical and mental health are one and the same thing; it's the old saying.. 'if you want to move your mind, you have to move your body; works in reverse too. Everything works together'.

STEPHANIE: I love hearing our nurses talking to patients with mental health concerns, hearing them question patients about whether or not they'd think twice about ringing us up if they had a physical ailment. Mental health issues are no different to having diabetes.

MELE: May and I have attended several courses; the first was run by ProCare and then we did a Train the Trainers course and facilitated a course. Turuki intended from the start to have staff as trainers as we know our patients. The self-management programmes are really good and people can use the tools and knowledge to help their whole family.

May: What I particularly like is that everything people do counts. The action plans allow for other ways of achieving goals, of managing lifestyles. For example, if a person's action plan says to go for 20 minute walk but for whatever reason they can't, then they can do the vacuuming or go dancing instead. It counts; it's not a fail.

Pacific people need Pacific people to help them, give them the information they need in a way they can understand; just being there with them. You have to be in there to make a difference. If you're passionate and know enough about it, something positive will come out of it. It's the same for our Maori patients. Our practice is about half Maori, half Pacific.

LILY: A lot of our patients are really passive; you can say to them, for example, you've got diabetes and then go on to say what it is but they won't ask you. These courses teach people to question. It's especially important for our patients because they're not googling their health condition. We encourage all our ARI patients to attend one of these courses, either here or at one of the sessions offered by ProCare if they live outside of Mangere.

LILY: When people become disabled or have a health condition they often withdraw and the only time they get out is to go shopping or go to the doctor. Having a forum where people can share similar concerns is very valuable. It's a free service; why wouldn't you refer your patients.

The year of change

In 2013 Counties Manukau Health discontinued the Chronic Care Management (CCM) programme which gave patients up to four free GP visits and a certain number of nursing hours, replacing it with the At Risk Individuals (ARI) programme which allows practice teams to fund and tailor interventions to meet their patient's needs.

Patients are enrolled on ARI for up to a year with the option to be re-enrolled if necessary. Unlike CCM, ARI is not a programme for life.

An enhanced version of ARI is being trialled in Pukekohe Family Health Care. Dubbed the year of change, the practice has heavily committed to implementing this new model of care. Pukekohe Family's year of change clinical champions Dr Selina Green and nursing director Erin Meads discuss some of the highs and lows of the last 12 months.

SELINA GREEN – PRACTICE OWNER AND GP; ERIN MEADS – NURSING DIRECTOR

THE PROJECT

SELINA: We took this on because we didn't have any choice; we had to do it. Our practice took up chronic care management because it provided us with funding to give patients four free consults a year prior to ARI. We were one of the practices that used it the most. While many of our patients are not high needs, we do have a lot who are struggling. We were already on this road, developing a team approach to managing long-term conditions and using all staff to their utmost ability; ARI allows us to work with nurses wanting to upskill, to work with patients at a higher level, dealing with conditions such as diabetes, COPD, congestive heart failure, cardiovascular disease.

Being the guinea pigs has let us move forward in a way that suited our practice. We've ended up completely changing our business model. It's been uncomfortable and challenging but the benefits to our patients are obvious. We've been very lucky to have a funded change manager sitting with us to help us structure this massive shift in how we do business. There were risks; that's one of the big challenges. Sometimes you just have to go with the feeling. This was where we wanted to go. It's been quite an expensive exercise for the practice but we're already seeing the clinical and social benefits of this way of working. We're developing a new type of relationship with patients; it does take more time at beginning but it means less intervention time later on.

ERIN: There's a huge increase in engagement between patients, GPs and nurses. With CCM we only ever got to the tip of the iceberg with patients. Now nurses have an hour and a half with patients and can complete a really holistic assessment to get to some of the root issues with the people in front of you. There's also the capacity for nurses to do home visits. We have a community health worker working alongside us, as well as a PPS psychologist.

COMBINING CHANGE WITH BAU

SELINA: The main thing we changed was turning the consultation around from what we wanted patients to achieve, to focusing on their health goals and working with them to get there. It's a planned proactive approach to care and ARI has finally given us enough time with patients to help them achieve their personal, as well as medical, goals.

General practices are based on a business model that doesn't necessarily fit well with the ARI philosophy and project implementation. For example, the fee-for-service model has made it hard for GPs to buy into the importance of team huddles to discuss patient cases. It's been a very collaborative process. Erin and I presented the vision of ARI to the whole practice, we had a pizza evening to talk our colleagues through the changes needed, including new processes and systems.

One of the biggest things we had to deal with, apart from the fact that people take up change at different speeds, was that about three months ago, we realised we'd done a great job of bringing our nurses on board with ARI but, man, were really behind with bringing our GPs alongside. For many, ARI was just a disruption that meant the nurses were always busy and often in their rooms.

ERIN: We also had to develop a whole new system to capture what the nurses were doing, from appointments to assessment forms to new ways of claiming; we've created resources for services for mental health and social issues, internal flow charts and process mapping.

SELINA: This process has been a massive change in how we practice. For the management team to be able to stand up to their shareholders and directors to say this is the direction to go in, it has to make fiscal as well as social sense. ProCare is currently analysing the business consequences for us so we can move forward and plan.

SOME OF OUR SUCCESSES

DECREASE IN HBA1C LEVELS	BUILDING EFFECTIVE RELATIONSHIPS WITH PATIENTS/ IMPROVING PATIENT EXPERIENCE
MEDICATION ADHERENCE	CONTINUITY OF CARE
POSITIVE PATIENT FEEDBACK	PATIENTS MORE EMPOWERED AND ENGAGED

ERIN: Smaller practices need really good engagement and support from their PHO; ProCare has to make sure systems and processes are all sorted. Individual practice dynamics impact on the size of change required and the time it takes to implement this change. We have 20,000 enrolled patients and a large staff and there are certain economies of scale. We've needed a very defined structure and very clear communication and training processes for change to be embedded successfully. We've been able to take someone off the floor to develop new things which for smaller practices might not be feasible. But change management is huge in practices, no matter what the size. Clear lines of communication between PHO and practices are essential, especially as processes are not always totally worked out and change as you go along. It can be very unsettling and can make your management team look incompetent. The way forward is to be honest and upfront with staff and ensure patient interactions are maintained. What you hear day-to-day may be different in a week; that's just primary care.

What we have learned is that it's essential to have a single point of contact in the PHO. We now have an issues register that gets sent once a week to one person and we expect action.

REAPING THE BENEFITS

SELINA: Despite all the IT headaches and pain of change, knowing what we know now, we'd do it all again. This model of care is positive for patients and staff. The nurses have a new buzz when they talk about the changes they've seen and the relationships they've developed with patients; our GPs are seeing confidence growing in our nurses and the development of community resources which is helping all our patients, not just those on ARI. There's a real joining up in care, clearer lines of communication, closer ties with community groups and social services.

ERIN: There are so many standouts. One of our patients has been type 1 diabetic for 30 year, ever since she was four. We've never been able to get her to take her insulin tests, she smoked like a trouper and worked 24 hours a day. Through ARI, we managed to get her two free sessions with a health psychologist who managed to get through to her. By the second appointment she started testing, changed her job and is now looking after herself. Between the two of them something opened her eyes in a way that allowed her to see what she needed to be doing. She's been with the practice since she was about six. We could barely get her to have blood test. Our care coordinators are bringing three or four success stories like this a week to our team meetings, often patients making small changes – someone's stopped smoking, lost a few kilos, those small things that for someone with a long-term condition make a difference over time.

SELINA: There's a real buzz when everyone's together at an ARI meeting. Because we're such a busy practice, there's often a bit of stress on the floor, especially in winter when you feel like you're dealing with sick people all the time. It's easy to forget we're working in a team. The mood really lifts when we start talking about some of the changes we're making in people's lives through ARI. We've still got some staff who need to come on board but we feel the programme and results speak for themselves and we will go on.

in training. More emphasis could have been placed on targeted training for each role

SELINA: We're looking really closely at the Midlands model as we're already on the healthcare home path and we're keen to take it further. We're looking at the LEAN principles; moving away from always needingto have the patient in front of you to work with them. What we've discovered is that you can't make changes like this piecemeal. You have to commit and have a very clear idea of where you want to end up.

What have we learned?

- An executive sponsor overseeing the change is crucial
  - The number one success factor for implementing change is active and visible executive sponsorship
  - This has to be at the right level – this person needs to be in a position to make decisions and mobilise resources as required
  - The sponsor role doesn't decline over time
- Change like this only works if the whole practice is on board
  - A whole practice approach impacts on all roles within general practice. Be prepared to invest
- You need to have exceptionally good, clear and frequent communication between teams – medical, administration, community health coordinators, external services
  - ARI keeps us focused on our patients' goals; it's now embedded in what we do here. It's obvious, in hindsight, but people pick up change at different speeds and we're now finding people we thought were up-to-speed with the changes who weren't and we're now training and retraining them
  - Sometimes you need to be a little creative to keep the team engaged (hence the pizza evening)
- Operational differences affect implementation
  - There is no one size fits all option
  - What's missing now is the team culture. We need to shift our focus now to creating a team approach; lifting the onus/stress from the nurses and supporting them to cope/manage with the holistic view of patient care

"We need to constantly look at improving, operationally and clinically."

Writing an annual report helps me focus on significant events in the life of ProCare and its members over the past year.

We made great strides across all of our Integrated Performance Incentive targets, no mean feat as a cooperative of individual businesses. And rates for Maori and Pacific populations match the wider population, showing that we are committed to high quality care for all our patients.

The ProCare Charitable Foundation opened up its first round of applications for grants from registered charities working to improve the health and wellbeing of communities in the Greater Auckland Region. This was made possible through your generosity in gifting your non-voting shares to the Foundation in 2013. I'm looking forward to finding out more about the first grants made by the Foundation in the coming months. Tom was the foundation Chair of ProCare Health Limited

In June we learned that Homecare Medical, jointly owned by Pegasus and ourselves, was successful in the National Telehealth Service tender. We look forward to the opportunities this venture will bring. I'd like to acknowledge the huge effort invested by James Sclater, Steve Boomert and the ProCare team.

During the year I was privileged to participate in a study tour to the USA, along with other primary care leaders, to examine their equivalent of the Healthcare Home. This is an exciting model of care in which practice teams provide not just treatment for particular diseases but focus on patients' long-term needs and goals. The Healthcare Home is comprehensive, multidisciplinary and patient-focused. The trip provided us with many new ideas for improvements in our own practices, and things to avoid. This is not a one-size-fits-all model of care but it does offer for some a means of addressing the capacity and capability pressures on primary care teams.

Along with Pegasus, Compass and Pinnacle, we provided the Minister of Health, at his request, a business case to implement the Healthcare Home model for general practice. We look forward to rolling out this model, or components of it, in willing practices, alongside our District Health Boards.

Our goal is to be "a cooperative of healthcare professionals committed to delivering world leading health services". To continue achieving this, we need to constantly look at improving, operationally and clinically. In the last year we invested a great deal of energy in creating and discussing with our members ProCare's first Outcomes and Quality Framework. Measuring what we can, with minimal extra work at the practice level, will help us improve the quality of healthcare we deliver.

So, to our staff, I say thank you. To our providers, I say thank you and stick with us on the path to excellence. To our funders and other stakeholders, thank you for being part of our journey, and let's continue on the road to improving health outcomes for Aucklanders. We look forward to growing the network in the next financial year and beyond.

Dr Harley Aish

CHAIR
PROCARE HEALTH LIMITED

"It has been our clinical performance that has caught the attention of several Ministers who have visited ProCare in recent times. "

Clinical excellence has continued to be a strong theme for the ProCare network this year, as recognised by the ADHB Excellence in Community Health and Wellbeing Award (2014) that we won for our Mission Smokefree project. While it's a positive thing for our network to receive recognition in this way, the true reward is knowing that our practices supported an estimated 1170 people to quit smoking in the Auckland region.

It has been our clinical performance that has caught the attention of several Ministers who have visited ProCare in recent times. ProCare along with our DHB and PHO colleagues hosted Health Minister Dr Jonathan Coleman as part of his nationwide tour of key players in the New Zealand health system. We have also shared with the Deputy Prime Minister, the Hon Bill English, ProCare's data capability when it comes to knowing our patients and communities, including identifying those families and whanau most at risk. We also highlighted the unique and enduring relationship that a general practice has with a patient.

The inextricable link between social factors and health outcomes has been a significant focus for us this year and this was a key part of our discussion with the Maori Development and Whanau Ora Minister, Te Ururoa Flavell. We were able to share with the Minister the work that GPs and practice teams are already doing to help a patient navigate the health system and access social services and support, as well as the relationships we are building at a range of levels across the government and NGO sectors.

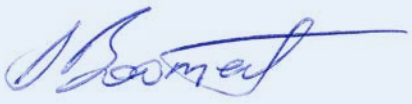
Of course integration and 'joining up of services' is the over-riding purpose of the national telehealth service, which ProCare and Pegasus' partnership Homecare Medical successfully secured the contract for this year. I would like to personally thank all of ProCare's partners and stakeholders who have supported us through this process – whether it's been letters of endorsement, advice, ideas or understanding, it has been greatly appreciated. While ProCare is a supporting parent in Homecare Medical's development of the national telehealth service, there are clear advantages for our own network in having this service delivered by an organisation that stems from general practice roots.

The importance and cause of general practice is what we have championed and advocated for throughout the year. Ensuring that the government has a clear view of the impact of subsidised visits for under 13s has been a paramount priority, as has the need to ensure funding is set at levels which support the sustainability of practices and their financial viability. This is also the reason we have successfully supported and represented practices before fee review committees, so that practices have the ability and autonomy to set their fees at appropriate cost recoverable levels.

Advocacy activities like these, along with services and tools that will help clinicians 'release time ', have been a major focus for me and the management team this year. Firstly we asked practices to invest some time in telling us what they thought of our services and what their key needs were as clinicians and businesses. These research findings have led us to realise that there is much more we can do to both improve our overall offering as well as ways in which we can make practices' lives easier. One of the first signs of our new engagement model has been the 'side-by-side' approach in which we have been working with practices on their annual business planning cycle. We have been taking more of a planned proactive engagement approach with practices, looking at joint solutions together – much like they would do with their patients.

In coming months the ProCare network will have access to a wider range of Enhanced Practice Services, designed to help with everything from financial benchmarking to back office services, like HR and ER support.

As I head into my third financial year as CEO of ProCare, I'm grateful to the team for their continued hard work and dedication. There are a number of changes and challenges on the horizon for us in 2015/16, but I'm confident that we have the strength and capability to support our practices to deliver another successful year for the ProCare network.



Steve Boomert

CHIEF EXECUTIVE
PROCARE HEALTH LIMITED

1 Dr HE Aish

BHB, MB, CHB, DIPOBST, FRNZCGP

Harley Aish started his career as a General Practitioner in Otara in 1997. Past roles include director of Southmed IPA and ProCare Health Ltd, and director and later chair of ProCare Networks Ltd. He served on the executive of IPAC, was part of the team for the PSAAP PHO contract negotiations and a member of the PHO Performance Programme Governance Group. He was actively involved in the Greater Auckland Integrated Health Network (GAIHN) as clinical champion for the High Risk Individual Workstream. Currently he is a director of Medical Assurance Society, a member of General Practice NZ Executive committee and Chair of ProCare Health Ltd. In between, he still loves to serve patients in Otara.

2 Dr JEM Fox

MB, BS, MRCS, LRCP, MRCGP,
FRNZCGP (DIST), FRACGP (HON) CMINSTD

Jonathan Fox has been in general practice in Meadowbank with his wife for 24 years, since arriving in New Zealand from the United Kingdom. Past national positions include NZMA Board member, President of the Royal New Zealand College of General Practitioners (RNZCGP) and Chair of the Council of Medical Colleges in New Zealand. He was reappointed to the Medical Council of New Zealand (1 July 2015) for a third and final term three year term. He is chair of the Medical Council's Audit Committee and deputy chair of their Education Committee.

3 Dr NJ Hefford

BHB, MB, CHB, FRNZCGP

Neil Hefford graduated from Auckland Medical School in 1985 and has been a GP in his own practice in Grey Lynn for 24 years. He is a director of ProCare Networks Ltd and chair of ProCare's Clinical Governance Committee. His passion is achieving better integrated care and quality outcomes for our patient population through improved models of care, vas well as improving GP work satisfaction and financial security.

4 TD Janes

BCA, FCA, CFINSTD, FCFIP

Trevor Janes' career has been in investment banking and financial analysis. He is a Chartered Fellow of the Institute of Directors, a Fellow of the Institute of Financial Professionals in New Zealand and of the College of Chartered Accountants. He is currently chairman of Abano Healthcare Ltd, deputy chairman of the Accident Compensation Corporation, chairman of Certus Solutions Ltd and deputy chairman of Pulse Energy Ltd. He is also a member of the New Zealand Markets Disciplinary Panel and the International Development Advisory and Selection Panel of the Ministry of Foreign Affairs and Trade, and of the Postal Network Access Committee. Trevor is also a member of ProCare's Audit and Risk Assurance, and Remuneration and Governance committees.

5 JN McCabe

MBA

June McCabe has had a diverse career in both the public and private sectors at senior levels, including 20 years of investment and banking experience. Her past and current corporate governance experience spans public, private and not-for-profit boards in the education, finance, health, housing, television and venture capital sectors. She is currently a director on the Northland District Health Board, ProCare Networks Limited, a member of ProCare's Audit and Risk Assurance Committee and chair of the Remuneration and Governance Committee. June is also chair of the ProCare Charitable Foundation.

6 JM Sclater

BCOM, CA

James Sclater is a professional company director and trustee acting for a number of companies and investment trusts, including Hellaby Holdings and Damar Industries. James is a chartered accountant and a member of Chartered Accountants Australia and New Zealand and the New Zealand Institute of Directors. Prior to 2009, James was chairman of Grant Thornton Auckland, where he was a business advisory services director for 18 years, specialising in small-to-medium enterprise accounting, taxation and management advice. James is chairman of ProCare's Audit and Risk Assurance Committee and a member of the Remuneration and Governance Committee.

7 Dr LEJ King

MB, CHB, DIPOBST, FRNZCGP, FNZMA

Lewis King is a Mairangi Bay GP. He is an accredited teacher for the registrar training programme of the RNZCG. He is also a former secretary of the RNZCGP and chairman of the NZMA.

8 Dr SM Clark

BMB, CHB, DIPOBST, FRNZCGP

Sue Clark has been a GP in Hobsonville for 15 years. She was a member of the Health West PHO Board and is currently chair of Clinical Assessments Ltd.

9 Dr JFV White

MB, CHB, FRNZCGP

Jan has been in general practice in Mt Eden for 30 years, having graduated from University Of Otago in 1973. She is currently a member of ProCare's Pacific Heath Advisory Committee (ProPa) and the Konnect Clinical Governance Group. She is deputy chair of the New Zealand Medical Association's General Practitioner Council.

ProCare Networks Limited

Ki he lelei taha – aim for the best.

This was my high school motto and it still pushes me to aim high. This pursuit of excellence drives this board as well, to put in place the best systems and programmes so that our network delivers the best healthcare to our communities, at the right time and in the right way.

My first full year as chair of PNL has been full of opportunities, challenges and achievements. When I canvased other members of the board about highlights from the year, managing the migration from PPP to IPIF topped the list for most. Front of mind, always, is that although we are dealing with numbers, meeting these targets is about making an impact on people's lives and health.

It's been inspiring to see how the network grappled with and overcame new ways of operating. Having a challenge, buying into the challenge, looking for innovation to meet it, working with practices and secondary care to solve the problem, watching it work. Magic. Our very successful CVDRA programme is just one example of the difference practice teams can make when given the right tools and information. More New Zealanders die from possibly preventable disease when compared to a similar cohort living in

"Front of mind, always, is that although we are dealing with numbers, meeting these targets is about making an impact on people's lives and health."

Australia (2014 Commonwealth Fund). If a significant number of these deaths are due to premature cardiovascular events then this opens a significant opportunity to address this discrepancy. Initial data shows that 80% of cardiovascular (CV) events occur in 20% of the population with the highest measure CV risk. If we know who this 20% are then we are in a position to more directly address modifiable risk factors within this group. But first you need to know the risk in your population.

Our first success developed from the concept of data mining; a pilot in one practice showed that up to 60% of non-screened individuals were able to be screened in a non-face to face way, with data already recorded in the patient management system. This concept of non face-to-face screening was discussed at length supported by the Ministry of Health and Heart Foundation, and was adopted as a clinically sound strategy.

Diabetes, smoking, cardiovascular disease can have a huge impact on people's quality of life and so discovering and modifying risk is critical. If we do our job right this means that hundreds of people throughout Auckland will not have devastating strokes, heart attacks or other vascular events because they were screened.

It was also heartening to see that we're focusing on the wellness of our high needs communities. Collectively we achieved the IPIF targets for our Maori and Pacific population. This shows that as a network we are reaching our total population even though we're not required to collect this information.

I've relished being able to draw on the expertise and knowledge of the board members and thank you for your motivation and commitment to improving the wellness of our population. I'd also like to acknowledge the collaborative work of our operational team, led by CEO Steve Boomert. The Board is very proud of the network's achievements.

Tevita Funaki

CHAIR
PROCARE NETWORKS LIMITED

ProCare Psychological Services Limited

PPS has continued to develop and grow over the past 12 months, providing primary mental health services to more than 7000 clients. We're currently working with 17 practices, offering increased access to counsellors and psychologists providing depression, anxiety, health psychology and sensitive claims support.

PPS has developed a new delivery model which integrates services to ensure clients receive wrap-around care that responds to the increasing social pressures impacting on their health and wellbeing.

We're taking this approach further through increasing the number of days and locations available to psychologists to work in general practice. The benefit of this is that practice teams gain confidence in supporting clients/whanau with mental health concerns in their medical home, reinforcing the role they play in providing continuous care.

We have increased our range of primary mental health services to include supported e-therapy, self-management, group therapy (eg mindfulness) and whanau support. Another exciting initiative is our Enhanced School-based Health Service (part of a PHO alliance), which has placed psychologists in seven low decile schools in ADHB. The aim is to reach young people at their most vulnerable, increase their resilience and encourage them to access resources and support mechanisms in the community, including their GP or secondary services. Common group therapy themes are anxiety, stress, grief and distress tolerance.

Finally, I'd like to welcome our new Patient Services Manager Shelley Willett. Shelley has managed high needs population groups for many years and has been instrumental in redesigning PPS' service delivery, including our new centralised booking system (ProCAN). This will provide practices with a smooth, seamless referral process. We see this as an opportunity to align medical homes with supporting ProCare services, to work together for the benefit of our clients and their whanau.

"We see this as an opportunity to align medical homes with supporting ProCare services, to work together for the benefit of our clients and their whanau."

Steve Boomert

CHAIR
PROCARE PSYCHOLOGICAL SERVICES LIMITED

Homecare Medical (NZ) Limited Partnership

I would like to start by acknowledge the time and effort that has gone into the procurement process for the National Telehealth Service. It's been an exciting journey which has allowed Homecare Medical and others to jointly shape the future of telehealth. The successful outcome was possible only because of the strong and enduring partnerships we developed across the sector; this constructive coming together of service providers means we're on the right track to providing a truly integrated service.

I'd also like to recognise the contribution of our support partners, including Accenture which has helped us develop the change management approach now being used in this transition phase. I must acknowledge our staff here, too. This has been a time of substantial transformation and I thank our nurses and receptionists for their readiness to adapt and take on new ways of working.

During the year we have continued to deliver a high quality, much valued service to our DHB and general practice customers around New Zealand. Our involvement in rural and isolated communities remains a focus as we aim to use our service to support a connected, accessible healthcare system for all, regardless of location. We believe the virtual healthcare opportunity before us is to increase coordination and integration, moving us away from a fragmented approach to health.

Quality remains at the centre of everything we do and we are continually investing in our capability and systems, such as Odyssey's clinical decision making tool for triaging and more recently the implementation of Spectrum, a new customer relationship management (CRM) system developed by Valentia. We've also strengthened our clinical governance approach and training so that our teams are constantly improving.

The St John Clinical Hub has been a great example of the team's commitment and enthusiasm to succeed and improve care for patients. Integrating with St John on this pilot has been an informative and positive experience which has seen the clinical hub handle more than 24,505 calls in 12 months and successfully support and redirect 6127 incidents that would have required ambulance transportation to ED. Congratulations to all involved for your enthusiasm and vision.

> "Quality remains at the centre of everything we do and we are continually investing in our capability and systems"

Thank you, too, to our parent organisations for their continued financial support and guidance, and to Homecare Medical's management and team members who have maintained a terrific service to practices and patients throughout this busy year. The depth of your care was especially evident during the aftermath of Four Kauri Family Medical Centre's fire when you provided critical information and triage services to their patients.

For the year ahead, we will be expanding the skill-base of our Board, management and clinical governance teams to make the most of the opportunities in front of us.

Dr Martin Seers

CHAIR
HOMECARE MEDICAL (NZ) LIMITED PARTNERSHIP

Clinical Assessments Limited

Clinical Assessments Limited, two-thirds owned by ProCare and one-third by East Health Clinical Assessments Limited (CAL), administers Primary Options for Acute Care on behalf of the three Auckland metro District Health Boards.

In the last year, more than 21,000 patients received funded community-based care as an alternative to hospital admission. Eighty-seven per cent of patients were successfully managed in the community, benefiting patients and relieving demand on hospital beds. The referral base includes GPs, hospital wards, ED, St John ambulance and rest homes. This service runs within budget and continues to look for opportunities to improve and extend patient care through collaboration with the DHBS.

I would like to thank the POAC staff based at East Health for their significant contribution to another successful year.

"Eighty-seven per cent of patients were successfully managed in the community, benefiting patients and relieving demand on hospital beds. "

Dr Sue Clark

CHAIR
CLINICAL ASSESSMENTS LIMITED

Proper governance is the hallmark of a responsible company.

ProCare's Boards and Committees provide business expertise, leadership and clinical governance for our organisation, ensuring the ongoing success of ProCare's business and clinical direction.

The Audit & Risk Assurance Committee

The Audit & Risk Assurance Committee acts as the point of contact with the group company boards for the external auditors and oversees how management discharges the delegated responsibility for financial reporting, internal control and the safekeeping of assets. The committee recommends the annual financial statements for approval and issue by each of the boards in the group and undertakes reviews of other specialist non-clinical matters referred by the boards. The committee reviews and reports to the boards on management's processes for the identification, prioritisation and management of risk.

The Remuneration & Governance Committee

The Remuneration & Governance Committee recommends remuneration policies for directors and senior staff for approval by the boards, approves senior management remuneration and monitors performance.

The Clinical Governance Committee (CGC)

The Clinical Governance Committee (CGC) supports the provision of safe and optimum health services in the populations for which we are responsible. The CGC has an advisory role to ProCare. It receives information and directive from the ProCare Health Board, ProCare administration and the greater ProCare membership.

The Community Engagement Committee

The Community Engagement Committee gathers information on the health needs and community aspirations within our enrolled populations, provides advice on public health issues, such as drinking age and tobacco legislation, works with other health organisations to promote greater cohesion within the health sector and offers community advice on the development and implementation of health services programmes within the ProCare network.

Clinical Directorate

The Clinical Directorate delivers clinical expertise to ProCare members and staff, as well as providing a forum for external key stakeholders to access clinical leadership within ProCare.

Dr Allan Moffitt: Clinical Director, Lorraine Hetaraka-Stevens: Nursing Director, Dr John Cameron: Associate Clinical Director, Dr Janine Bycroft: Associate Clinical Director, Dr Karl Cole: Associate Clinical Director/Clinical Director for HM (NZ) LP, Dr Sophie Ball: GP Lead Manukau Locality, Julian Reeves: Clinical Director for PPS, Rosemary Gordon: Quality Manager, Nicola Brentnall: Quality Coordinator

Clinical Governance Committee

The Clinical Governance Committee acts as a clinical quality check and provides oversight for the PNL Board of Directors.

Dr Neil Hefford (Chair), Dr Stephen Child, Professor Rod Jackson, Dr Lynne Lane, Metua Bates, Dr Jim Kriechbaum, Dr Allan Moffitt, Dr Dean Mackay, Dr John Cameron, Patience Te Ao, Lorraine Hetaraka-Stevens, Jessie Crawford

Clinical Quality and Education Committee (CECQ)

CECQ monitors the quality of the professional development and education services offered to ProCare members.

Dr Jim Kriechbaum (Chair), Dr Kim Bannister, Dr Allan Moffitt, Dr John Cameron, Dr Janine Bycroft, Dr Jason Hasan, Dr Maelen Tagg, Dr Randall Sturm, Cerys Lang, Rachel Pretorius

ProCare Maori Advisory Committee (ProMa)

ProCare's M ori health service follows the principles of Te Tiriti O Waitangi and is provided by a broad range of Maori staff throughout the ProCare network. The service is provided under ProCare's vision to increase health access for all high-needs groups within our region. ProMa provides advice and guidance to optimise the quality and cultural safety of health services and clinical programmes provided.

Patience Te Ao (Chair), John Marsden, Lyvia Marsden, Megan Tunks, Te Puea Winiata, Lorraine Hetaraka-Stevens

ProCare Pacific Advisory Committee (ProPa)

ProCare serves the largest Pacific population enrolled within general practice in New Zealand and has a dedicated team of professionals working daily to ensure our services match the community's needs. ProPa oversees the strategic direction of these services, providing input from the cultural perspective of the Pacific community.

Dr Sam Fuimaono (Chair), Dr Graeme Whittaker, Dr Jan White, Dr Maika Veikune, Ben Taufua, Tevita Funaki, Metua Bates

OTHER BOARDS

ProCare Network Ltd Board of Directors

Tevita Funaki (Chair), Dr Neil Hefford, Dr Kim Bannister, Dr Sam Fuimaono (Pacific Representative), Patience Te Ao (Tainui Representative). Renee Newman (Nurse Representative), Lesley Going, June McCabe

PPS Board of Directors

Steve Boomert (Chair), Dennis Baty, Liam Sheridan

HML Board of Directors

Martin Seers (Chair), Dennis Baty, Liam Sheridan, Vince Barry, James Sclater

FINANCIAL STATEMENTS

Statement of financial position

At 30 June 2014

	Notes	Group 2014 $	Group 2013 Restated[1] $	Parent 2014 $	Parent 2013 Restated[1] $
ASSETS					
Current assets					
Cash and cash equivalents	6	**16,882,274**	18,730,691	**5,718,046**	7,360,367
Investments – short term deposits	6	**3,800,000**	-	**2,000,000**	-
Trade and other receivables	7	**5,233,800**	4,590,763	**3,009,797**	2,309,272
Income tax receivable		**74,940**	-	**-**	-
Intercompany receivable	11	**299,575**	-	**2,614,297**	2,471,127
		26,290,589	23,321,454	**13,342,140**	12,140,766
Non-current assets					
Property, plant and equipment	13	**522,617**	964,530	**522,617**	964,530
Computer software	14	**458,675**	528,315	**458,675**	528,315
Deferred tax assets	17.2	**472,186**	446,072	**447,692**	401,657
Deferred settlement	8	**314,151**	-	**-**	-
Investment in subsidiaries	15,16	**-**	-	**648,403**	648,403
Investment in equity accounted investees	15,16	**608,941**	15,628	**5,118**	5,142
		2,376,570	1,954,545	**2,082,505**	2,548,047
TOTAL ASSETS		**28,667,159**	25,275,999	**15,424,645**	14,688,813
LIABILITIES					
Current liabilities					
Trade and other payables	9	**6,190,254**	5,450,357	**4,250,740**	3,614,017
Provisions	10	**293,669**	280,000	**293,669**	280,000
Deferred revenue	12	**14,658,605**	13,476,342	**4,464,599**	5,032,957
Income tax payable		**225,063**	69,822	**225,063**	31,313
Intercompany payables	11	**-**	-	**157,979**	186,655
Redeemable Preference Shares	18	**230,460**	91,172	**230,460**	91,172
		21,598,051	19,367,693	**9,622,510**	9,236,114
Long-term liabilities					
Redeemable Preference Shares	18	**2,166,000**	2,274,000	**2,166,000**	2,274,000
TOTAL LIABILITIES		**23,764,051**	21,641,693	**11,788,510**	11,510,114
NET ASSETS		**4,903,108**	3,634,306	**3,636,135**	3,178,699
REPRESENTED BY:					
EQUITY					
Share capital	19	**275,231**	275,731	**275,231**	275,731
Retained earnings		**4,588,005**	3,322,413	**3,360,904**	2,902,968
Equity attributable to parent		**4,863,236**	3,598,144	**3,636,135**	3,178,699
Non-Controlling Interests		**39,872**	36,162	**-**	-
TOTAL EQUITY		**4,903,108**	3,634,306	**3,636,135**	3,178,699

For and on behalf of the board

Director
7 October 2014

Director
7 October 2014

1 Refer to note 27 for detail of the prior period restatement

These financial statements are to be read in conjunction with the notes to the financial statements.

Statement of Comprehensive Income

For the year ended 30 June 2014

	Notes	Group 2014 $	Group 2013 $	Parent 2014 $	Parent 2013 $
Revenue	3.1	**177,232,758**	171,431,101	**34,523,859**	31,249,236
Other income	3.2	**-**	-	**228,392**	390,513
Total income		**177,232,758**	171,431,101	**34,752,251**	31,639,749
Expenses					
Clinical costs		**156,428,164**	151,540,159	**16,422,661**	14,700,337
Administrative costs	4.2	**21,025,802**	19,734,099	**17,749,775**	16,626,462
Total expenses	4.1	**177,453,966**	171,274,258	**34,172,436**	31,326,799
Operating profit		**(221,208)**	156,843	**579,815**	312,950
Finance income	3.3	**799,527**	733,369	**322,453**	212,155
Less: Finance costs		**122,466**	91,774	**122,460**	91,172
Net finance income		**677,061**	641,595	**199,993**	120,983
Share of profit/(loss) of associate (net of income tax)	16	**(22,035)**	336	**-**	-
Profit before tax		**433,818**	798,774	**779,808**	433,933
Income tax expense	17.1	**417,441**	213,126	**321,872**	131,943
Profit from continuing operations		**16,377**	585,648	**457,936**	301,990
Profit on discontinued operations, net of tax	21	**1,252,925**	74,406	**-**	-
Profit for the year		**1,269,302**	660,054	**457,936**	301,990
Other comprehensive income		**-**	-	**-**	-
Total comprehensive income for the year		**1,269,302**	660,054	**457,936**	301,990
Profit attributable to:					
Owners of the company		**1,265,592**	648,440	**457,936**	301,990
Non-controlling interests		**3,710**	11,614	**-**	-
Profit for the year		**1,269,302**	660,054	**457,936**	301,990
Total comprehensive income attributable to:					
Owners of the company		**1,265,592**	648,440	**457,936**	301,990
Non-controlling interests		**3,710**	11,614	**-**	-
Total comprehensive income for the year		**1,269,302**	660,054	**457,936**	301,990

These financial statements are to be read in conjunction with the notes to the financial statements.

ProCARE

ProCare Health Limited

ProCare Networks Limited
ProCare Psychological Services Limited
Homecare Medical Limited
Clinical Assessments Limited

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