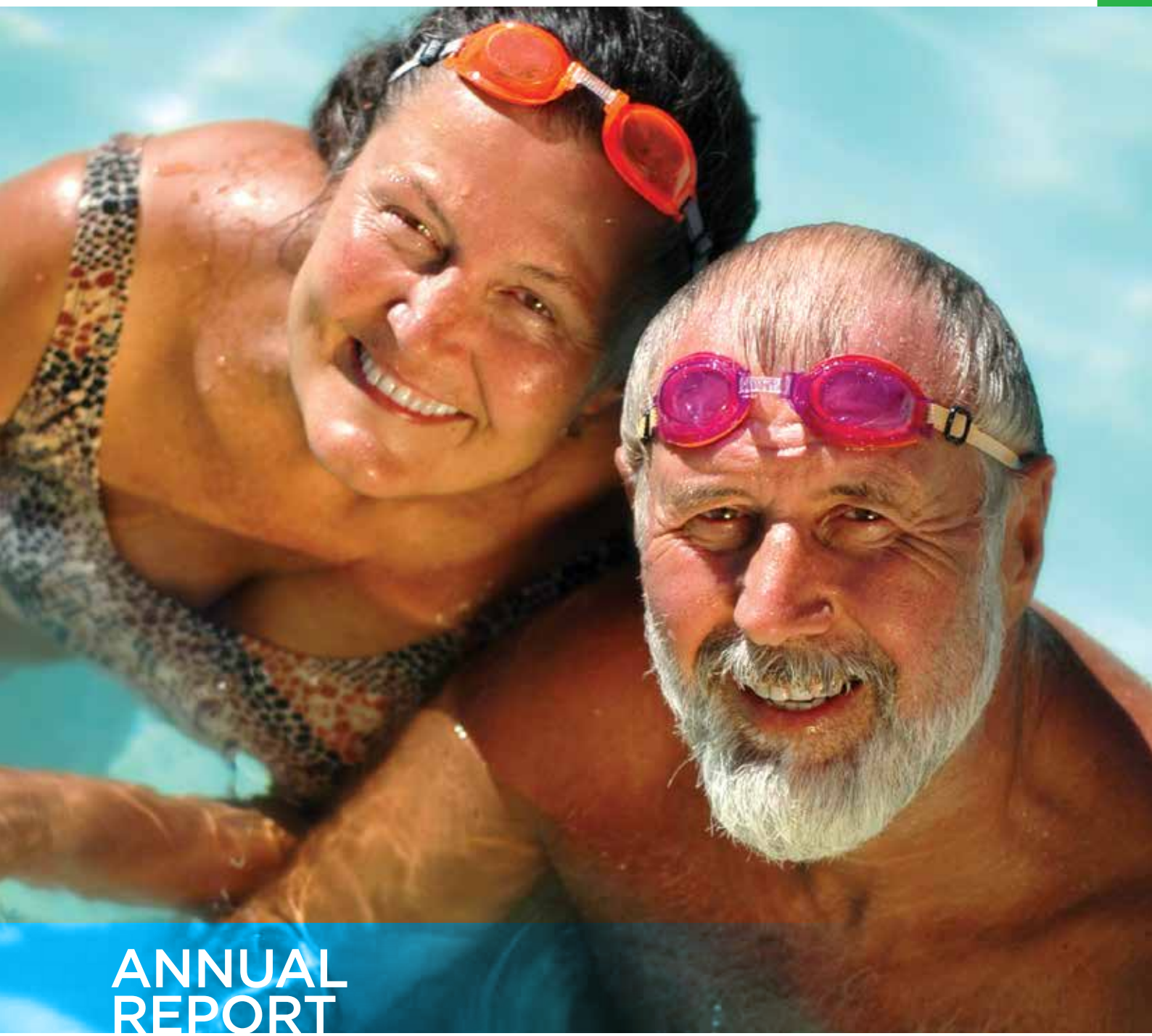
Hunter
PRIMARYCARE



ANNUAL REPORT 2015

KEEPING PEOPLE WELL AND OUT OF HOSPITAL

“OUR VISION IS AN EFFECTIVE PRIMARY HEALTH CARE SYSTEM THAT MEETS THE HEALTH NEEDS OF THE COMMUNITY.”

ABOUT THIS REPORT

This report is for the period 1 July 2014 to 30 June 2015.

Financial data has been audited by PKF Lawler Partners, Newcastle NSW 2300.

This report is available to download from our website www.hunterprimarycare.com.au.

To obtain printed copies or to seek further information, please contact the Communication team at Hunter Primary Care on 02 4925 2259 or email communication@hunterprimarycare.com.au.

Acknowledgement
Hunter Primary Care Ltd (trading as Hunter Medicare Local) gratefully acknowledges the financial and other support from the Australian Government Department of Health.

TABLE OF CONTENTS

CHAIR'S REPORT 2014-2015

Dr Trent Watson

On behalf of the Board of Hunter Primary Care, it gives me great pleasure to present my second and final Annual Report for the 2014-15 financial year.

In presenting this report, my fellow Directors and I would like to acknowledge the substantial contribution of outgoing board members Dr Belinda Guest, Kelly Jones and Bob Horne. We would also like to congratulate and thank our team of dedicated staff. With the end of Medicare Local funding at June 30 this year a significant number of long serving staff have left the organisation; many of these have moved on to gain positions with the new Primary Health Network. Fortunately, the vast majority of our staff have remained with Hunter Primary Care. Without the support and commitment of all of these staff, our organisation would not be in the strong position it is in today.

The pace of change in primary health care accelerated this year with the creation of Primary Health Networks across the country. The collaborative bid submitted by the Medicare Locals from the Hunter, Central Coast and New England areas was successful in winning the tender for the Primary Health Network (PHN) for this region and resulted in the creation of the Hunter New England Central Coast Primary Health Network (HNECC PHN). The new PHN will be responsible for the health planning, commissioning and integrating role, and for providing support to individual practices. However, they will not deliver services directly to the community.

Hunter Primary Care (previously trading as Hunter Medicare Local) will continue as a service delivery entity with a clear focus on delivering high value, quality, patient centred services that meet the needs of the community.

These services include:

- GP Access After Hours (GPAAH)
- Aged Care Emergency Program (ACE)
- Rural Primary Health Services (RPHS)
- Connecting Care for Hunter New England LHD
- Care Coordination for nib
- Care Coordination and Supplementary Services (CCSS)
- Closing the Gap programs
- Psychology Services (MHSRRA, ATAPS)
- headspace Newcastle
- Hunter Partners in Recovery (PIR)

In all of the programs that we deliver we aspire to the 'triple aim of health care': improving population health outcomes, improving the patient experience, and providing value for money.

Whilst some of our previous functions have moved to the PHN, our fundamental purpose remains the same and that is to:

Keep people well and out of hospital by:

- Delivering consumer focused, quality, primary health care services that improve health outcomes;
- Leading and supporting primary health care professionals to enable them to provide effective health care; and
- Working with stakeholders to improve the health system and patient experience.

Despite all of the changes and uncertainty, the outlook for the next year remains strong. We expect a total revenue exceeding $23m, with $12.5m of this being from non-PHN sources. This provides a solid foundation from which to deliver high quality services. We have over 200 committed and talented staff working across our existing services and a cooperative of over 250 GPs working in our GP Access After Hours service.

Whilst change can be reflected upon as a burden, change that brings positive outcomes might be called "innovation". Innovation will underpin our future as an organisation – it will galvanise our existing relationships, develop new functions and relationship with other stakeholders (including our members) and create new opportunities to deliver services. A number of new opportunities already emerging, include:

- Having developed a very successful care-coordination program for Hunter New England Health patients with high medical needs, we were able to utilise this expertise to develop a similar program for a private health insurer nib in October 2014. We have just recently signed a contract to deliver a similar care coordination program to patients covered by another private health insurer, Teachers Health
- We have a high level of expertise in the development and delivery of mental health programs including Psychology Services, headspace Newcastle, and being the lead agency for Hunter Partners in Recovery. We are currently bringing together a consortium of key mental health organisations in the Hunter to develop an innovative pilot program in the area of suicide prevention

The creation of the PHN and the transfer of certain member-based functions (e.g practice support) will change our relationship with our members. However, our ability to deliver services will rely on our relationship with our membership. Changes in government approaches to funding health services will open new possibilities to innovate and deliver effective and efficient services in collaboration with our membership.

Finally, I would like to thank my fellow Board members for their hard work, counsel and support during what has been both a challenging and exciting time for the organisation. I also acknowledge the hard work of our dedicated and committed staff who have embraced the change that has occurred over the past year and have laid solid foundations for a successful future for the organisation.

Trent Watson
Chair

CEO'S REPORT 2014-2015

Dr Kevin Sweeney

The 2014-15 financial year has been a very challenging one for Hunter Primary Care (trading as Hunter Medicare Local). However, I am pleased to be able to report that it is a year that has ended with a good outcome overall.

The cessation of funding for Medicare Locals and the creation of the new Primary Health Network (PHN) was centre stage for most of the year. The boundaries that were announced for the new PHN included all of New England, Hunter and the Central Coast. The three existing Medicare Locals in that region (New England ML, Hunter ML and Central Coast ML) set to work laying the foundations to create a new PHN entity and prepare a tender application. They were strongly supported in this by both Hunter New England Local Health District and Central Coast Local Health District. The Request for Tender documentation was released by the Commonwealth in late November and a combined tender was submitted in late January. This tender was successful and the new PHN entity was formed (Hunter New England Central Coast Ltd). This was the preferred outcome for the region – a PHN that was developed by the existing primary care organisations in the region and supported by the Local Health Districts and other key stakeholders. The size of the PHN may have been larger than many would have liked, but the final outcome was the best of those on the political table. Confirmation and finalisation of funding by the Commonwealth came very late in the day and left only a short timeframe for the PHN to establish itself and recruit staff in time for it to commence operating on July 1st.

The future for Hunter Primary Care gradually became clear as Commonwealth intentions regarding the PHNs were announced. PHNs were charged with the key responsibilities of health planning, consultation with consumers and clinicians, providing practice support, and progressing the integration and coordination of primary care with secondary/tertiary care. However, PHNs were not to deliver services directly to the community; rather they were to hold the funds for these services and contract these out by means of a commissioning process. Hunter Primary Care has historically delivered a large number of health services directly to the community and so its continuing role as a health service delivery entity became clear.

Given the need to ensure continuity of service delivery to the community, and the late formation and funding of the PHNs, the Hunter New England Central Coast PHN was able to directly contract Hunter Primary Care to continue to deliver existing services for the 2015-16 period. For the 2016-17 year, however, the PHN will need to undertake a full commissioning process and put all services out to the market for tender.

Retaining staff and expertise has been a challenge over the year. Uncertainty over future funding, and therefore future employment, resulted in a significant number of staff leaving during the year to take up alternative employment opportunities. With the cessation of funding to Hunter Primary Care for various programs destined for the PHN (health planning and promotion, health pathways, practice and workforce support) we needed to terminate a significant number of staff prior to June 30. Fortunately most of these staff have been subsequently re-employed by the PHN in similar roles. This also means that their knowledge and expertise has not been lost to primary care in the region.

From April to June there was considerable uncertainty over the continuation of funding for services due to delays in the Commonwealth confirmation of ongoing funding. This caused considerable anxiety amongst staff and rising concern in the community, but ultimately ongoing funding was confirmed for all of our key services including:

- GP Access After Hours (GPAAH)
- Care Coordination
  - Connecting Care for Hunter New England Health
  - Care coordination for nib
  - Care Coordination and Supplementary Services
- Mental Health
  - Psychology Services
  - headspace Newcastle
  - Partners in Recovery
- Closing the Gap
- Aged Care Emergency (ACE) Program
- Rural Primary Health Services

We also have been working on developing a couple of new programs and funding for these is in the pipeline.

We continued our participation in the Hunter Alliance (Hunter New England Local Health District, Calvary and Hunter Primary Care) and

supported innovative work in the three workstreams: care of people with diabetes; care of people with COPD; and care in the last year of life.

We commissioned Hunter Research Foundation and Hunter Medical Research Institute to undertake an independent economic evaluation of the GP Access After Hours service. The result of this cost study shows that the GPAAH service produces a net saving to the health system of some $10.5 million dollars per year. This is a remarkable result that validates the original design of the GPAAH service – which was to accurately triage patients and then provide the patient with the level of care that is appropriate to their medical need.

Looking forward, the loss of direct Commonwealth funding – and therefore of any 'core' funding – does significantly change the landscape for the organisation. In future we will need to compete in the market for funding opportunities and will need to be more financially focussed. We will need to ensure that all of our activities return a surplus if we are to remain viable. This will bring some challenges, however, it also brings opportunities – and we are currently working on developing some of these new opportunities.

Since June 30 we have reviewed and reset our strategic direction and set about creating community and stakeholder awareness of our 'new' Hunter Primary Care name and logo. We are working on making our health services more efficient and effective, preparing for the new funding environment and exploring the opportunities that this may bring for working more closely with our members. We are focusing on long term business development so that we can remain in the business of delivering quality primary health care services that meet the needs of the community and improve health outcomes.

A big thank you to John Baillie who was CEO for the whole of the 2014-15 financial year and who had to juggle the tasks of keeping the organisation and services running, developing the tender for the PHN, and establishing the PHN. John has now moved on to an executive position with the PHN. My thanks to the Board for their vigilance in setting direction through uncharted waters, and a particular thank you to all of the Hunter Primary Care staff who showed their dedication and determination in doing their work and delivering our services, while also contributing to tender and PHN development, through a period of great uncertainty for both the organisation and their individual futures – my sincere thanks.

Kevin Sweeney
CEO

OVERVIEW

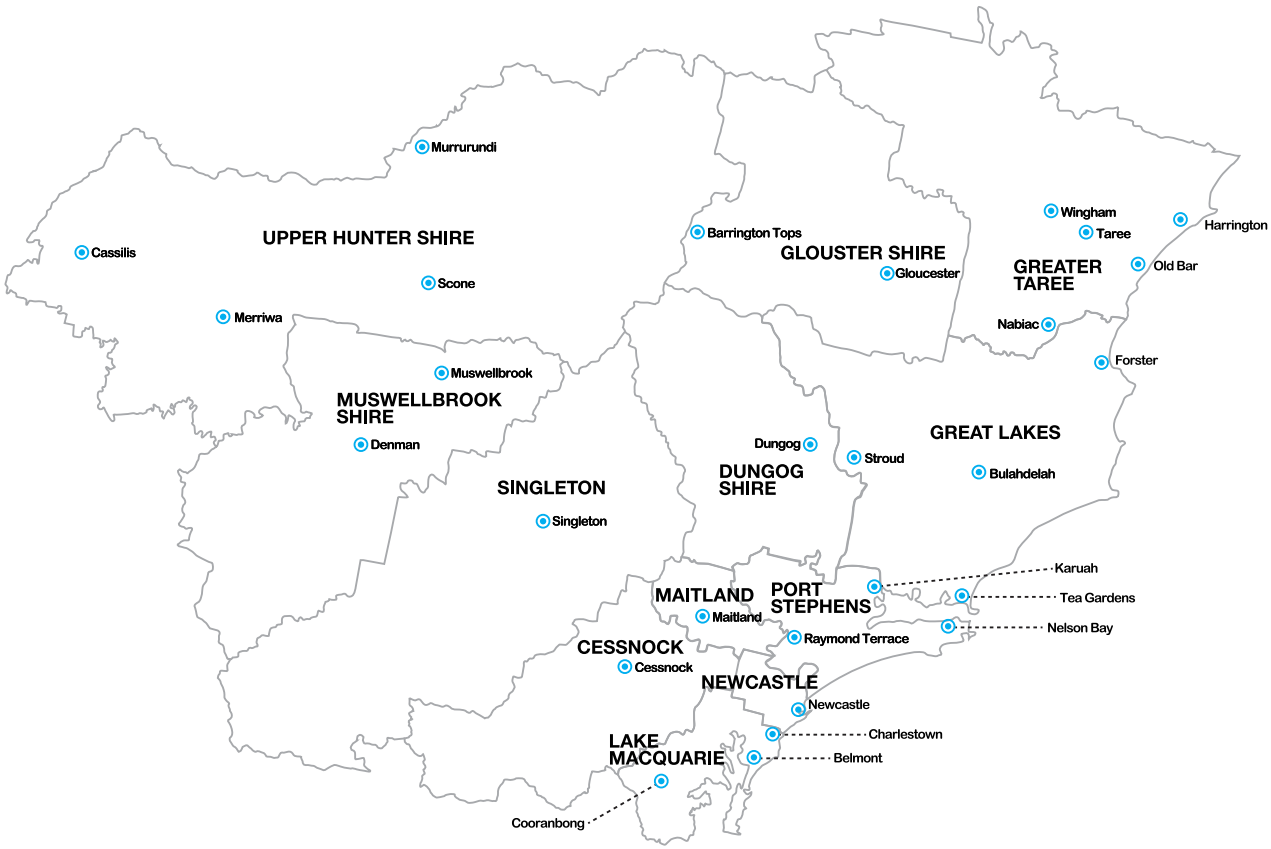
The Hunter Primary Care (HPC) region is situated on the NSW east coast and comprises 12 local government areas (LGAs): Cessnock, Dungog, Gloucester, Great Lakes, Greater Taree, Lake Macquarie, Maitland, Muswellbrook, Newcastle, Port Stephens, Singleton and the Upper Hunter Shire. The region covers a land area of 32,747 sq km.

There are over 700,000 people in the HPC region and it is predicted that by 2036 the population will increase by over 25% to 880,000.

The major Aboriginal nations within the HPC region are Awabakal, Worimi, Biripi, Darkinjung, Gaewegal, Kamilaroi and Wanaruah. This region is home to Aboriginal people from many different nations across Australia.

HPC is a not for profit, member based organisation whose purpose is keeping people well and out of hospital.

During the period 2011 to 2015, HPC has received funding from the Commonwealth Department of Health as a Medicare Local and has traded as 'Hunter Medicare Local'. This Medicare Local funding finished on 30 June 2015.



ACKNOWLEDGEMENT

Hunter Primary Care acknowledges Aboriginal and Torres Strait Islander peoples as the First Peoples of our region and we pay our respects to their Elders past and present with whom we share this great country.

Hunter PRIMARYCARE

OUR VISION

An effective primary health care system that meets the health needs of the community.

OUR PURPOSE

Keeping people well and out of hospital.

OUR VALUES

RESPECT
Trust • Open Communication • Inclusiveness

EXCELLENCE
Creativity • Continuous Improvement • Sharing

INTEGRITY
Transparency • Accountability • Honesty

RECOGNITION
Acknowledgement • Personal Development • Encouragement

headspace Newcastle | Hunter Partners in Recovery | Hunter PRIMARY CareCoordination | Hunter PRIMARY Psychology Services | GP access AFTER HOURS

RECONCILIATION ACTION PLAN

HPC continues to be committed and responsible for ensuring primary health care is accessible to Aboriginal and Torres Strait Islander people in our region.

In 2013 HPC formed a Reconciliation Action Plan Working Group consisting of seven staff, two of these being Aboriginal and/or Torres Strait Islander people.

The RAP Working Group developed a Reflect Reconciliation Action Plan (RAP) based on a framework provided by Reconciliation Australia. Our RAP is a practical plan of action built on relationships, respect and opportunities and highlights our commitment to reconciliation.

HPC is committed to improving health for all of our community by turning its intentions into actions. In May of this year we organised a Reconciliation Week event for staff where we held a smoking ceremony and gathered together to listen to cultural stories from one of our Aboriginal Outreach Workers. This type of event is an example of how we value the contribution, skills and knowledge of staff and promote values embraced by, and significant to, Aboriginal and Torres Strait Islander people.

Smoking Ceremony

Our people don't call our paintings pictures, they're LORE.

There are four animals - emu in the night sky, goanna, kangaroo and the echidna that is represented by Mt Yengo. On the bottom in the echidna with white lines to show the landscape and the contours, the goanna and kangaroo design shows families and that they all work together, the emu is the sky to show hunting. The figures near the goanna are from Western NSW, the figures near the kangaroo are from Wollombi NSW, and all are of LORE.

Hunter Primary Care wishes to acknowledge and sincerely thank Aboriginal Artist, Peter Williams for producing artwork that we can incorporate into our brochures, merchandise and other accessories.

Painting by Peter Williams

GOVERNANCE AND MANAGEMENT

The Constitution of Hunter Primary Care Limited (ACN 061 783 015), trading as Hunter Medicare Local and GP Access After Hours, sets out the responsibilities of the Board and the Directors and gives them the power to govern the organisation in order to achieve its strategic objectives. The Board at 30/06/2015 has nine members – five member elected Directors and four Board nominated Directors.

The Board is fundamentally responsible for:

- Corporate governance;
- Setting the strategic direction of the company and the goals for management;
- Monitoring the performance of the company against the strategic plan and goals;
- Ensuring compliance with statutory responsibilities; and
- Overseeing risk management.

HPC manages internal governance through its Board, policies and a number of committees that support and report to the Board. These include:

Finance, Audit and Risk Management Committee

Assisting the Board to effectively discharge its responsibilities for financial reporting, internal and external audit functions, risk management, internal control and compliance framework and its external accountability responsibilities.

Clinical Governance Committee

- Developing Board policies pertaining to Clinical Governance for approval by the Board;
- Reporting and reviewing serious complaints and issues of clinical competence; and
- Providing advice to management and/or the Board regarding operational or strategic issues related to clinical governance.

Nomination and Remuneration Committee

- Assisting the Board in fulfilling its responsibilities to members of HPC on matters relating to the Constitution of the Company, the composition, structure and operation of the Board, and CEO and senior executive selection, performance and remuneration; and
- Assisting the Board by recommending board policy and recommending nominations which require Board approval.

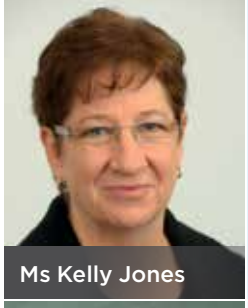
HPC also utilises the advice and feedback from the After Hours Advisory Board, the headspace Advisory Committee and the Hunter Partners in Recovery Consortium to oversee and provide guidance and direction on service delivery, governance and allocation of funding/incentives. A number of collaborative projects are also undertaken with Hunter New England Local Health District (HNELHD).

The CEO is responsible for overseeing the operations of the company to ensure activities align with and meet the strategic objectives and direction of the organisation as determined by the Board.

Supporting the organisational structure and delivery of services is an integrated strategic planning and reporting framework that was developed to assist in the articulation of strategic, tactical, operational and transactional functions within the organisation.

BOARD OF DIRECTORS

 Dr Trent Watson	BHSc(N&D), PhD, APD, MAICD	Appointed in February 2012. Currently Board Chair and Chair Nomination and Remuneration Committee and ex-officio attendee at all other Board Committees. CEO of Ethos Health, a multidisciplinary allied health business based in Newcastle and the Hunter region. Conjoint senior lecturer University of Newcastle and media spokesperson Dietitians Association of Australia. Over 17 years' experience in finding new ways to integrate the knowledge, skills and resources of allied health professionals and smart technology into medical practice to improve access, efficiencies and equity in health care, and improve quality safety, performance and accountability of health care services.
 Dr Peter Hopkins	MBBS(Hons), MMedSc(EPI), FRACGP	Elected November 2014. Currently Deputy Chair and member Nomination and Remuneration Committee. One of three directors of King Street General Practice. Founding Chair of the Hunter Division of General Practice, then for the Hunter Urban Division of General Practice and continued on that Board throughout its existence and was on the Board when it became Hunter Medicare Local until 2012 and was re-elected in 2014. On the Board of GPNSW (then the Alliance of NSW Divisions of General Practice) from 2001 to 2007 and Chair from 2003 to 2005.
 Mr Steven Adams	AdvDip Bus Man, FAICD	Appointed in February 2012. Currently member Nomination and Remuneration Committee. Over 35 years' experience as a chair, executive and non-executive director serving of a range of community, industry and private organisations. A senior professional in engineering, construction, health and community enterprises with a diversified skill set and industry/government network at regional, state and federal levels. Current board appointments include: Empowered Communities Central Coast; Lloyd McDermott Rugby Development Team Inc (LMRDT); EWB Indigenous Advisory Board; and Indigenous Communities Alliance.
 Dr Mark Foster	MBBS M Med Sci FRACGP DA, FFARCS DipRACOG GAICD	Elected in November 2014. Currently member Finance, Audit and Risk Committee. Formerly CEO of Hunter Medicare Local, remains passionate about strengthening primary health care and has strong understanding and experience of health system reform. Also brings hands on experience of our region's health system from working over the last 20 years as a GP. Currently a Director of the nib Foundation and member of the NSW Health Agency for Clinical Innovation GP Advisory Council.
 Dr Belinda Guest	BMed, BMedSc (Hons) DCH, FRACGP, GAICD	Elected in November 2012. Resigned 30 June 2015. General Practitioner (GP) in Newcastle region and supervising Registrars, PGPPP doctors and medical students. Previously Chairperson for General Practice Registrars Australia and understands the powerful role primary health care can play in improving the health of communities. Currently Director General Practice Training Valley to Coast and HNECC PHN. Member of RACGP National Standing Committee for GP Advocacy and Support.

 Mr Bob Horne	Dip Ed, BSc	Appointed in March 2009. Currently member Clinical Governance Committee. Previously Board member Mid North Coast Area Health Service, Deputy Chair Hunter Economic Development Corporation, Federal Member for Paterson and Shire President Port Stephens Shire Council.
 Ms Kelly Jones	BSc, MBA, FAICD	Appointed in February 2012. Currently Chair Finance, Audit and Risk Management Committee. Executive career in technology, banking and finance for more than 25 years with major international corporations including ANZ, IBM, Deutsche Bank, NAB and Westpac. Previously Director on the Red Cross Blood Service and the National ICT Australia Boards, Chair for Citrus Australia and a Mentor for Women on Boards.
 Dr Milton Sales	MBBS, Dip RACOG, FRACGP	Elected in November 2012. Currently Chair Clinical Governance Committee. Practice Principal and GP in Newcastle region. Currently Medical Educator and supervisor of Registrars for GP Training Valley to Coast and supervisor for medical students for University of Newcastle. Current Programme Committee Chair and previous Chair of the Hunter Postgraduate Medical Institute (HPMI). Over 30 years following a passion for improving health care through continuing professional health education program delivery via HPMI.
 Mr Ben Wilkins	BPharm MPS AACPA ACP, GAICD	Elected in November 2012. Currently member Finance, Audit and Risk Management Committee. Registered pharmacist in Newcastle with experience in business management and ownership, and clinical pharmacy services. Previously served on Pharmaceutical Society of Australia (NSW Branch) and HIC e-PBS. Received National Medal of Excellence for Primary Practice in 2003 and is passionate about preventative health measures around lifestyle, improving the community's health literacy with evidence-based practice and progressing innovation for improved health outcomes.

INTEGRATED AND COORDINATED SERVICES

"THERE ARE OVER 700,000 PEOPLE IN THE HPC REGION AND IT IS PREDICTED THAT BY 2036 THE POPULATION WILL INCREASE BY OVER 25% TO 880,000."

INTEGRATED AND COORDINATED SERVICES

GP Access After Hours (GPAAH) is an innovative model for the delivery of comprehensive, high quality after hours primary care to the community of the Lower Hunter region. The service runs as a cooperative of more than 250 experienced GPs, which covers more than 70% of local general practices, and also employs more than 100 nursing and administration staff on a casual basis.

GPAAH is an integrated medical service incorporating four elements:

1. A telephone patient streaming service (PSS).
2. GP clinics. There are five clinics situated across the Hunter Urban Region with four co-located in public hospital Emergency Departments (Belmont Hospital, Maitland Hospital, John Hunter Hospital, and the Calvary Mater Newcastle). The fifth is a clinic co-located with the Hunter New England Health Polyclinic at Toronto.
3. Transport service, provided to patients who could not otherwise attend a GPAAH clinic.
4. Home and residential aged care visits, for patients needing care or assessment at home.

Highlights & Achievements

After more than fifteen years since the program first began GPAAH continues to demonstrate the vital role it plays in keeping our community well. In the last year the service saw 49,466 patients in our five clinics and answered 84,495 calls in the patient streaming service.

Over the life of the program we have estimated that the service has saved tens of thousands of visits to hospital emergency departments and thus saved the health system millions of dollars. However, over this period we never had a formal economic evaluation of the service, so in April 2015 we engaged the Hunter Research Foundation (HRF) and Hunter Medical Research Institute (HMRI) to conduct a formal cost study of the program.

The economic evaluation covered all four elements of the GPAAH service, and assessed the costs of providing the GPAAH service relative to the costs of providing alternative models of care. The study focused on the cost to the health system in the GPAAH region, which included the financial cost to the Australian taxpayer and the financial cost (in the form of out-of-pocket costs) to the users of the health care services.

The study compared the cost of the GPAAH service to the cost of the alternative care that would be required if the GPAAH service did not exist. The alternative care was based on responses to a survey of GPAAH users asking them what they would have done if GPAAH did not exist. Using the results of this survey, along with actual patient volumes and costs across both GPAAH and the GPAAH alternatives in the 2013-2014 financial year, the study estimated the health system costs in two scenarios, one with GPAAH (the actual scenario), and one without GPAAH (the counterfactual scenario). The difference in health system costs between these two scenarios was the 'net cost' of GPAAH.

The total cost of operating the GPAAH service in the 2013/14 financial year was $7,551,932. If GPAAH did not exist, the cost of providing the extra alternative services that those patients would have accessed would be $18,094,330. Therefore the presence of the GPAAH service resulted in a net saving to the health system of $10,542,398.

This is a very impressive result and vindicates the original design of the GPAAH service which was to accurately triage patients and then to provide the patient with the level of care that is appropriate to their medical need – whether this be Emergency Department, an after-hours GP clinic, a home or residential aged care visit, review by their own GP the next day or phone advice.

GPAAH has long been recognised as providing patients with excellent access to quality care in the after-hours period. We now have strong evidence that the service is very cost effective and brings significant savings to the health system as a whole.

"Excellent service, prompt, professional and extremely valuable to me as my illness was acute and needed appropriate care"
– GPAAH client.

"Amazing service with great results, puts parents minds at ease when our children are sick, also knowing we won't wait long"
– GPAAH client.

INTEGRATED AND COORDINATED SERVICES

HUNTER & NEW ENGLAND HealthPathways

Hunter New England and Central Coast HealthPathways (HealthPathways) developed out of a partnership between Hunter New England Local Health District and HPC. It was the first HealthPathways community in Australia – there are now nineteen.

The partnership supports a new way of working to deliver appropriate care in the right place at the right time. HealthPathways is aimed at improving the assessment, management and referral of patients by GPs and clinical specialists and is an important element of service redesign.

HealthPathways is a password protected, web-based information portal that assists primary health clinicians to plan patient care through primary, secondary and community health care systems. The system is designed to be used at the point of care, primarily for GPs but is also available to hospital specialists, nurses, allied health and other health professionals in the region. A partner portal 'PatientInfo' provides open access to local patient information which is derived from HealthPathways.

Highlights and Achievements

In 2014-15 work continued on developing multi-disciplinary pathways to support clinicians in the evidenced-based management and referral of their patients. Evaluations have shown that HealthPathways is strengthening relationships, empowering GPs and improving communication, trust and respect across the system.

HealthPathways has also improved the quality of referrals and access to specialist care. Website usage is increasing with a 74% increase in self-reported use by medium and large general practices. The total number of pathways now developed is 186 with 26 new pathways developed in the last financial year and a 20% increase in page views on the website.

The work of the HealthPathways Team was recognised at the 2015 HNE Health Excellence Awards. The annual Excellence Awards acknowledges the people and projects that have improved patient care across the Hunter New England Local Health District and celebrates the organisation's achievements in clinical excellence, quality, and innovation over the past 12 months.

From L-R: Dr Margaret Lynch, Leanne Halliday, Martha Parsons & Ian O'Dea

Hunter PRIMARY Psychology Services

Hunter Primary Care Psychology Services has continued to offer effective and responsive mental health services to people and GPs in the Hunter region, targeting our services to high needs groups and people who are experiencing financial hardship. The services are delivered by highly qualified and experienced Psychologists and Clinical Psychologists.

The range of services offered includes:

- Psychology services for children and their families, adolescents and adults
- Services for women with perinatal mental health problems and their partners
- Quick response service for people who are suicidal or self-harming
- Consultation service with Psychiatrists for children/ adolescents and adults; and
- Psychology services provided within Aged Care Facilities.

Highlights and Achievements

Psychology/Psychiatry Services

- In 2014-15 over 4,100 patients were referred to our psychologists for a total of 18,414 sessions, this represents an increase of about 7% on the previous year.
- Over 85% of GPs in the region have referred at least one patient to the service.
- Over 350 patients have been referred to the two consulting Psychiatrists in our service with 221 assessment sessions being provided.

Urban Needs Assessment

- The completion of a Mental Health Needs Assessment for the four urban Local Government Areas in our region (Newcastle, Lake Macquarie, Maitland, and Port Stephens). This information has complemented the previous rural Mental Health Needs Assessment and has been integral in the planning of funded mental health programs across the Hunter region.

Rural Services

- Hunter Primary Care Psychology Services has continued to focus on the provision of equitable services in the rural regions of the Hunter with approximately one-third of all of our services being delivered by contracted providers and employed clinicians to these rural regions of the Hunter.

Suicide Program

- The Hunter Primary Care Psychology Services' Suicide and Self Harm program is delivered by specialist trained Clinical Psychologists who can provide support to GPs to assist them in caring for their at risk patients. The Suicide Fast Response is a responsive service available to patients assessed by a GP to be at moderate to high risk of suicide or who have attempted suicide or deliberate self-harm, and last year our team delivered over 1,560 sessions. This represents an increase of 14% on the previous year.

Aboriginal & Torres Strait Islander Program

- Hunter Primary Care Psychology Services has undertaken significant community engagement with the Aboriginal communities in the region. This has been assisted by closer links with the Closing The Gap team at HPC, as well as the community development work conducted by one of the Psychologists on the team who is an Aboriginal man. Compared to the previous year, there has been an increase of 32% in services delivered to Aboriginal and Torres Strait Islander peoples. HPC Psychology Services has established a working partnership with Nikinpa Child & Family Centre in West Lake Macquarie and have been delivering services at Nikinpa since the beginning of 2015.

Future Direction

Low level internet supported interventions

- Further work will be conducted in reviewing ways to deliver mental health services to people with mild to moderate mental health problems utilising evidence based internet supported programs as well as telephone supported interventions. This type of service delivery is well suited to address the barriers for people residing in rural and remote regions, as well as a way to increase options for people in the community where they may prefer to engage in a low level intervention and then 'step-up' to face-to-face care if required.

INTEGRATED AND COORDINATED SERVICES

"HUNTER PIR HAS HAD A SIGNIFICANT IMPACT ON THE SERVICE SYSTEM BY HIGHLIGHTING THE DIVERSE AND PARTICULAR SYSTEM GAPS AND BARRIERS AFFECTING PEOPLE WITH SEVERE AND PERSISTENT MENTAL ILLNESS IN THE HUNTER."

Hunter Partners in Recovery

Hunter Partners in Recovery (Hunter PIR) is part of a national mental health initiative aiming to facilitate the recovery of people with severe and persistent mental health illness and complex needs by connecting them more effectively to the services and support they need. Hunter PIR also recognises the needs for carers and families, and their role in the recovery journey.

Since its commencement in late 2013 Hunter PIR has provided Support Facilitation services to 520 people across the Hunter, 20% of who are Aboriginal and/or Torres Strait Islander people. Evidence of unmet needs on entry into the program indicates high levels of social disconnection, psychological distress, poor physical health and housing instability.

Hunter PIR has had a significant impact on the service system by highlighting the diverse and particular system gaps and barriers affecting people with severe and persistent mental illness in the Hunter. Hunter PIR identified key system issues and developed specific strategies for each, in partnership with a wide range of services.

The main issues and our 'working together' response are the following:

- GP Project – enhancing engagement with general practice
- Rapid Planned Coordination – improving coordination of services when a person is acutely unwell
- NDIS – contributing to the design of the NDIS for people with psychosocial disability
- Hoarding and squalor – improving awareness and provision of treatment to address hoarding and squalor behaviour
- Aboriginal and Torres Strait Islander people – improving culturally appropriate practice through partnerships with local communities and engagement of local mentors
- Pre-release planning for Aboriginal men exiting Cessnock prison
- Recovery and awareness of severe and persistent mental illness – forums, video stories, influencing recovery oriented service provision, participation in networks
- Partnerships with Hunter New England Mental Health, specialist homeless services, Family and Community Services, Aboriginal managed organisations and a wide range of other services.

Highlights and Achievements

A significant achievement during the year was an increasing awareness of the program among the Homeless community. Homeless people are very vulnerable to "falling through the gaps" or disengaging with the healthcare system. During the year Hunter PIR improved its connections with this community through its participation in activities such as the Homeless Connect Day at PCYC Broadmeadow. Following this event eleven people who attended the day self-referred to the Partners in Recovery program.

Following their self-referral Support Facilitators were able to assist the individuals on a one-to-one basis to access services such as health, housing, income support, education and employment in a timely and appropriate manner.

The Hunter Homeless Connect Day was a powerful demonstration of the importance of getting likeminded people and organisations together in the same place at the same time and making connections. Events of this type open doors for people facing problems and helps to build bridges between the organisations that can support people.

Hunter Partners in Recovery is making a positive difference in the lives of our consumers, their carers and families.

A Better Mum – Mellissa's Story

Mellissa had been experiencing significant challenges since her troubled childhood. She had lost the most important things in her life before finding Hunter PIR.

"I put myself in hospital... I was having a very hard time in life... I had nothing... I wasn't a good mum, I wasn't good for my children and I had to get better to become a good mum. If I didn't have Partners in Recovery in my life I would surely be back in hospital. Since getting better I've learned to interact with people again... my kids see a big change. I had to do a lot of work to get back up there. Hunter Partners in Recovery help people get back up, they care".

INTEGRATED AND COORDINATED SERVICES

Byron Williams, headspace Newcastle

> YOUNG PEOPLE ATTENDING HEADSPACE NEWCASTLE REPORTED SATISFACTION LEVELS ABOVE THE NATIONAL AVERAGE.

headspace Newcastle

headspace helps young people aged between 12-25 get help they need for problems affecting their wellbeing. This covers four core areas: mental health, physical health, work and study support and alcohol and other drug services. The service is funded under Australia's National Youth Mental Health Foundation.

headspace Youth Reference Group April 2015

Highlights and Achievements

headspace Newcastle had a busy year exceeding service targets in all areas. In clinical service delivery **headspace** had a total of 1,385 new referrals. The total number of occasions of service provided was 4,307 with young people attending on average 4.3 sessions in an episode of care.

Young people attending **headspace** Newcastle reported satisfaction levels above the national average.

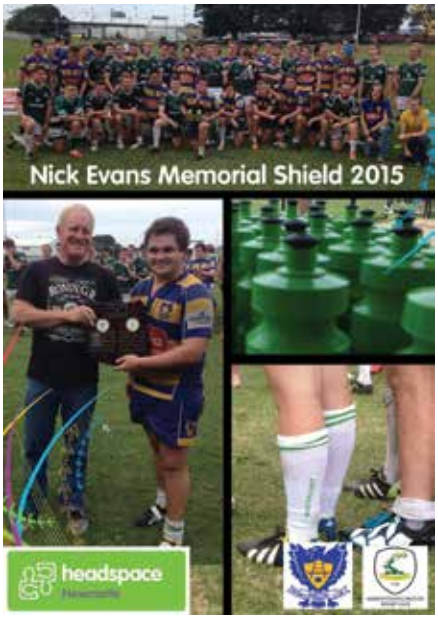
Community awareness of youth mental health issues is an important area of **headspace** Newcastle's work and we facilitated or attended 155 events, providing mental health awareness and support to schools, local service providers, community and sporting groups and the general community.

headspace Newcastle is passionate about involving young people in every decision the service makes. Young people making choices for young people is a core value of the service. The Youth Reference Group (YRG) meets regularly to provide feedback to staff regarding youth friendly service delivery. They are very active in volunteering their time to attend a large number of community events and are the "face and voice" of **headspace** Newcastle.

A significant achievement during the year was an invitation to Youth Reference Group members Bronte Taylor and Nicola Dean to represent the Hunter at the inaugural **headspace** Forum on 4 and 5 March 2015 at Etihad Stadium in Melbourne.

Both young women are key members of the **headspace** Newcastle team and have represented **headspace** at many community events over the year and have been an invaluable help in spreading the word and starting conversations about youth mental health.

headspace Newcastle was privileged and proud to be a part of the 3rd Annual Nick Evans Memorial Shield on Saturday 18 April 2015. The annual Nick Evans Memorial Shield has been created to celebrate the life of Nick Evans and his love of rugby as well as raise awareness and funds for **headspace** Newcastle. Money raised helps **headspace** Newcastle facilitate suicide awareness activities throughout Newcastle. These activities help to inform the community and encourage those who are experiencing difficulty to talk to someone about it.



INTEGRATED AND COORDINATED SERVICES

Hunter PRIMARY CareCoordination

The Care Coordination team provides three chronic disease programs:

1. Closing the Gap initiative for Care Coordination and Supplementary Services Program supports patients who identify as Aboriginal and/or Torres Strait Islander. Chronic diseases targeted include diabetes mellitus, chronic cardiovascular disease, chronic respiratory disease, chronic renal disease and cancer.
2. nib Care Coordination program supports integration across primary and secondary/tertiary public and private sector for best practice management. The program is for nib customers with chronic conditions and complex care needs.
3. The Connecting Care program (collaboration between HPC and HNELHD) is a chronic disease care coordination program staffed with registered nurses and occupational therapists that work as care coordinators and liaise with GPs, practice staff and their chronic disease patients to assist in the management of their complex needs. The program aims to provide patients and their families/carers with education and support in regards to their chronic disease and assistance in accessing health care services. It also provides support to GPs and practice staff in the management of their complex care patients. This will result in minimising emergency hospital admissions/presentations for patients with chronic disease. As well as improving health outcomes for consumers, the program also aims to promote communication between all service providers – both public and private sectors.

To be eligible for the program, the patient must have a chronic disease and have presented to their local emergency department once in the previous 12 months; and/or is at risk specifically in relation to their chronic disease; or at risk of deterioration from their disease.

The aim is to support patients through primary care integration, service navigation and self-management based on the Medical Home model to support existing general practice and health team for best practice patient outcomes.

Highlights and Achievements

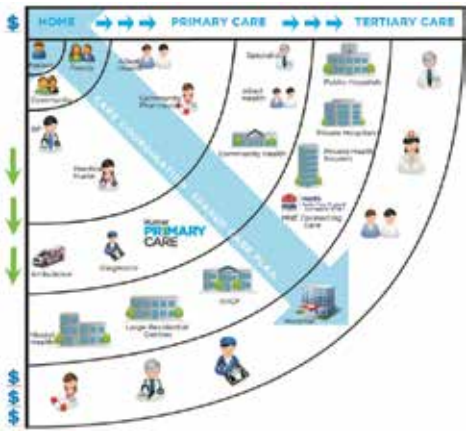
A major initiative during the year was an expansion of the care coordination program to include nib Health Fund (hospital cover) patients – 69 patients were provided with care in the period October 14-June 15. The joint program is a practical example of how partnering with the private health funds can reduce fragmented care by bringing health providers together to assist patients to negotiate our complex health system and to increase their access to services.

The alarming increase in preventable chronic diseases such as diabetes and obesity is placing a huge burden on the financial sustainability of the health system. By increasing the uptake of care coordination programs we are supporting patients to keep themselves well and out of the most expensive part of our health care system – hospitals.

During 2014-15 the Connecting Care program averaged 64 referrals per month. Advance Care Planning continued to be a focus throughout the year with 85 (20%) of plans developed being accepted.

A key benefit of care coordination programs are that they are patient-centred. Research has demonstrated that engaging patients more fully in their own healthcare not only improves the experience for patients and those who care for them but it also improves the quality of care and lessens the cost to all.

Using the new Complex Chronic Care Evaluation Tool for quality improvement, patients were surveyed on initial assessment and at four months or discharge from the coordination program and reported improved system navigation knowledge. Targeted domains of self-management of chronic disease, health service navigation, skills and technique acquisitions, self-monitoring and insight, social integration and support resulted in average improvement of 20%.



The above model has been adapted from The Medical Home model found at http://medicalhome.org.au

Aged Care Emergency (ACE) Service

ACE is a service that aims to reduce potentially avoidable presentations to hospital emergency departments (EDs) by elderly patients in Residential Aged Care Facilities (RACFs). These ED presentations are often related to chronic disease management or 'end of life' care, which can usually be well managed by staff of the RACF and by GPs.

Avoidable presentations to ED pose risks for older people with complex health problems such as delirium, falls, pressure sores and medication errors. To outweigh these risks we need to be sure that each transfer from an RACF to an ED is necessary.

The ACE service is a collaborative partnership between multiple stakeholders (Hunter Primary Care, HNELHD, Ambulance NSW, RACFs and GPs). It was first piloted in 2012 at John Hunter Hospital and now operates across 7 EDs (JHH, Belmont, Calvary Mater, Maitland and Manning Rural, Tamworth and Tomaree) with over 80% of RACFs in the Hunter region having implemented the system.

Highlights and Achievements

In the last financial year an evaluation of the ACE service was conducted by the Hunter Medical Research Institute (HMRI) to measure the costs and savings of the service.

The evaluation showed that after costs were subtracted, the implementation of ACE saved the health system almost $1M with the majority of these savings coming from reduced Ambulance and ED costs.

Significantly, the report found that 74% of calls to the ACE telephone line during business hours prevented a transfer to ED and after hours this rose to 86% of calls preventing an ED transfer.

All stakeholders interviewed for the report believe ACE is effective in reducing potentially avoidable presentations to the ED. The service is greatly improving residents of RACFs ability to receive the care they need, where and when they need it.

Additional benefits in reducing avoidable ED presentations are that acute care staff in the ED can focus resources on more acute presentations from the general community. Ambulance services are also spending less time transporting residents to and from the EDs and are able to respond more readily to urgent calls in the general community.

The work of ACE was recognised at the 2015 HNE Health Excellence Awards.

FEEDBACK FROM STAFF

"If ACE was stopped we would likely get a whole lot more, mostly inappropriate, presentations [to ED] for things that could be readily managed in the aged care home... it would impact on our ability to manage the rest of our activity and meet our targets."

INTEGRATED AND COORDINATED SERVICES

The Closing the Gap (CTG) initiative focuses on delivering culturally appropriate healthcare services to the Aboriginal community and improving access to mainstream health services. In our region about 3.2% of the total population identify as being of Aboriginal background.

A key component of our commitment to improving the health of the Aboriginal community is the employment of Indigenous Health Project Officers and Aboriginal Outreach Workers. These staff play a vital role in enhancing our community's understanding of health issues facing the Aboriginal community and improving the ability of primary care clinicians to support and manage Aboriginal clients with chronic disease.

Highlights and Achievements

In the last financial year General Practices in our region completed a record high 7,476 Aboriginal and Torres Strait Islander Health Assessments (Item 715).

A major focus for our CTG staff has been to highlight, both for clinicians and the community, the importance of having a regular health assessment that is specific to Aboriginal people. A review of the MBS data for the Hunter has shown Aboriginal and Torres Strait Islander 715 health assessments in our region have increased dramatically; an increase of 70% in 2013/14 and a further increase of 40% in 2014/15. Similarly, we observed an increase in the number of GPs participating in delivering these, with an increase in 2013/14 of 36% on the previous year and in 2014/15 a further increase of 27%. These are pleasing results that reflect an increasing level of positive engagement between our region's Aboriginal people and our General Practitioners and their staff.

During the year the following numbers of services were also provided:

- Allied Health – 1,458
- GP/Specialist services – 1,329
- Transports provided – 2,115
- Medical aids provided – 1,902
- New referrals to the CCSS program – 321

L-R: Nerida Walker, John Manton, Pania Tahu

Our Alliance
HUNTER NEW ENGLAND

The Hunter Alliance is a clinician led project funded by the Hunter's three major health organisations, Hunter Primary Care, Hunter New England Local Health District and Calvary Health Care.

The project aims to develop innovative solutions to improve health care and overcome the increasing burden chronic diseases are placing on health resources. After studying local data and using a prioritisation framework the first focus areas were identified and agreed to be:

- Care in the last year of life
- Care for people with diabetes
- Care for people living with chronic obstructive pulmonary disease

Highlights and Achievements

In the past year the Diabetes Workstream has posed the question... *Why are some people with diabetes getting worse even when they have access to diabetes care?*

Reasons identified have included:

- no clear stratification method to identify high risk patients early
- no way to monitor patient's progress that is visible to both patients and clinicians across the health system
- no accountability around providing best practice standards of care by all clinicians
- little patient engagement or alignment with their needs in the current models of care

To help tackle some of these obstacles to improved care the workstream has been investigating mechanisms which will allow:

- partnering with patients to achieve best diabetes care based on clinical and social need
- development of a stratification system for clinicians by level of diabetes complication risk
- establishing minimum standard of care expectations across all clinicians including an escalation process
- identifying registry solutions
- developing and testing new model of care options in consultation with patients
- developing an educational plan based on identified patient and clinician need

In the last year the COPD Workstream team developed and began piloting processes across primary care, hospital and RACF settings to optimise diagnosis, care planning and management of people with COPD.

This has included the development of resources and supportive protocols and tools, including a "Care Passport" and guide for utilising existing available funding sources.

To improve the experience of people in the last year of life, their families and carers, the Care in the Last Year of Life Workstream has been working to align care as closely as possible to the person's expressed needs and goals of care.

A key aim of the workstream is to reduce the need for hospitalisation and prevent unnecessary emergency department presentations for people in the last year of life.

CONTRACTS AND FUNDING

Figures quoted exclude GST

headspace June 2012 – June 2015	headspace National Youth Mental Health Foundation Ltd **2014/2015 Funding $924k**
Medical Specialist Outreach Assistance Program June 2014 – June 2015	NSW Rural Doctors Network **2014/2015 Funding $96k**
Connecting Care July 2012 – June 2015	Hunter New England Local Health District **2014/2015 Funding $703k**
GP Access After Hours July 2014 – June 2015	Hunter New England Local Health District – Regional After Hours **2014/2015 Funding $560k**
Medicare Local Core Funding Agreement July 2014 – June 2015	Commonwealth Department of Health – Medicare Local Schedule 21.1 **2014/2015 Funding $14.919m**

Figures quoted exclude GST

Access to Allied Psychology Services July 2014 – June 2015	Commonwealth Department of Health – Better outcomes in Mental Health Initiative Program – Medicare Local Schedule 10 **2014/2015 Funding $2.672m**
Closing the Gap – Care Coordination and Supplementary Services Program July 2014 – June 2015	Commonwealth Department of Health – Medicare Local Schedule 18 **2014/2015 Funding $1.757m**
Mental Health Services in Rural & Remote Areas July 2014 – June 2015	Commonwealth Department of Health – Medicare Local Schedule 19 **2014/2015 Funding $361k**
Closing the Gap – Improving Indigenous Access to Mainstream Primary Care Program July 2014 – June 2015	Commonwealth Department of Health – Medicare Local Schedule 22 **2014/2015 Funding $515k**
Partners in Recovery June 2013 – June 2016	Commonwealth Department of Health – Medicare Local Schedule 38 **2014/2015 Funding $4.754m**

FINANCIAL STATEMENTS

Hunter Primary Care Limited

Financial Statements for the
Financial Year Ended 30 June 2015

DIRECTORS' REPORT

30 June 2015

The directors present their report on Hunter Primary Care Limited for the financial year ended 30 June 2015.

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

Names	Appointed / resigned
Dr Mark Foster	Appointed - 21/11/2014
Dr Peter Hopkins	Appointed - 21/11/2014
Dr Trent Watson	
Mr Robert Horne	
Ms Kelly Jones	
Mr Steven Adams	
Mr Chris Barnett	Ceased - 21/11/2014
Dr Belinda Guest	Resigned - 30/06/2015
Dr Milton Sales	
Mr Benjamin Wilkins	
Dr Annette Carruthers	Ceased - 21/11/2014
Ms Karen Howard	Resigned - 02/09/2014

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

The following person held the position of Company Secretary at the end of the financial year:

Mr Matthew Plumridge

Mr Matthew Plumridge is the Corporate Services Executive of Hunter Primary Care Limited. Mr Plumridge replaced Ms Jane Mendelson who ceased as Company Secretary on 15 September 2014.

Principal activities

The principal activities of Hunter Primary Care Limited (t/a Hunter Medicare Local) ("Company") during the financial year were as follows:

1. A non-profit health promotion charity and community health services organisation, servicing the needs of primary health care clinicians in the delivery of care to their patients and communities.
2. This includes operating GP Access After Hours which provides an integrated system of after hours primary medical care for four Local Government Areas.
3. Psychology Services supports primary health care clinicians in providing mental health care services and facilitates access to mental health care for patients.
4. IT Services provides systems and desktop support to general practice and other health providers both within and beyond the Medicare local boundaries.

No significant changes in the nature of the Company's activities occurred during the financial year.

Information on directors

The names of each person who has been a director during the year and to the date of this report are:

DIRECTOR	Dr Mark Foster
Qualifications	MBBS; M Med Sci; FRACGP; DA; FFARCS; Dip RACOG; GAICD
Special responsibilities	Finance, Audit & Risk Management Committee

DIRECTOR	Dr Peter Hopkins
Qualifications	MBBS (Hons); M Med Sc (EPI); FRACGP
Special responsibilities	Deputy Chair of Board, Nomination and Remuneration Committee

DIRECTOR	Ms Kelly Jones
Qualifications	BSc; MBA; FAICD
Special responsibilities:	Chair of Finance Audit & Risk Management Committee

DIRECTOR	Mr Steven Adams
Qualifications	FAICD
Special responsibilities	Nomination and Remuneration Committee

DIRECTOR	Dr Milton Sales
Qualifications	MBBS; Dip RACOG; FRACGP
Special responsibilities	Chair of Clinical Governance Committee

DIRECTOR	Mr Benjamin Wilkins
Qualifications	BPharm; MPS; AACPA; ACP; GAICD
Special responsibilities	Finance Audit & Risk Management Committee

DIRECTOR	Dr Trent Watson
Qualifications	BHSc (N&D); PhD(N&D); APD; MAICD
Special responsibilities	Chair of Board, Chair of Nomination and Remuneration Committee

DIRECTOR	Mr Robert Horne
Qualifications	BSc; Dip Ed
Special responsibilities	Clinical Governance Committee

DIRECTOR	Mr Chris Barnett
Qualifications	Master of Physiotherapy; GAICD
	Ceased 21 November 2014

DIRECTOR	Dr Annette Carruthers
Qualifications	MBBS (Honours), FRACGP, FAICD, GradDip App Fin
	Ceased 21 November 2014

DIRECTOR	Dr Belinda Guest
Qualifications	B Medicine; B Med Sc (Hons); DCH; FRACGP; GAICD
	Ceased 30 June 2015

DIRECTORS' REPORT
30 June 2015

DIRECTOR Ms Karen Howard	
Qualifications	FAICD
Interest in shares and options	Resigned 2/09/2014

CLINICAL GOVERNANCE COMMITTEE MEMBER	
EXTERNAL MEMBER	Professor Anne Duggan
Qualifications	BA, Dip Ed, B Med, M Health Planning, PhD, FRACP

Operating results and review of operations for the year

The surplus of the Company for the financial year ended 30 June 2015 amounted to $478,266 (2014: loss of $(35,435)).

Significant changes in state of affairs

The following significant changes in the stale of affairs of the Company occurred during the financial year:

In May 2014, the Federal Government budget introduced changes to the way primary care services will be managed, replacing Medicare Locals with Primary Health Networks (PHNs) on 1 July 2015. Accordingly, the Department of Health has discontinued its existing core funding arrangements with Hunter Primary Care effective 30 June 2015.

Hunter Primary Care has secured funding until 30 June 2016 from:

- HNECC Limited ("HNECC"), the Hunter New England and Central Coast Primary Health Network;
- the Department of Health with respect to the Partners in Recovery program; and
- Headspace National Youth Mental Health Foundation Limited with respect to the Headspace program.

Events after the reporting date

No matters or circumstances have arisen since the end of the financial year which significantly affected or could significantly affect the operations of the Company, the results of those operations or the state of affairs of the Company in future financial years.

Environmental matters

The Company's operations are not regulated by any significant environmental regulations under a law of the Commonwealth or of a state or territory.

Meetings of directors

During the financial year, 12 directors' meetings were held. Attendances by each director at those meetings and the sub-committees meetings were as follows:

	Directors' Meetings		Finance Audit & Risk Management Committee		Clinical Governance Committee		Nomination and Remuneration Committee	
	Number eligible to attend	Number attended	Number eligible to attend	Number attended	Number eligible to attend	Number attended	Number eligible to attend	Number attended
Ms Karen Howard	1	1	-	-	-	-	2	2
Mr Robert Horne	12	10	-	-	2	1	2	2
Dr Trent Watson	12	12	-	-	2	2	2	2
Ms Kelly Jones	12	9	3	3	-	-	-	-
Mr Steven Adams	12	10	2	2	-	-	2	1
Mr Chris Barnett	3	2	-	-	2	1	-	-
Dr Annette Carruthers	3	3	-	-	2	2	2	1
Dr Mark Foster	9	8	1	1	-	-	-	-
Dr Belinda Guest	12	12	2	2	2	2	4	4
Dr Peter Hopkins	9	7	-	-	-	-	2	2
Dr Milton Sales	12	11	-	-	4	4	-	-
Mr Benjamin Wilkins	12	11	3	3	-	-	-	-
Prof Anne Duggan	-	-	-	-	4	3	-	-

DIRECTORS' REPORT
30 June 2015

Indemnification and insurance of officers and auditors

During the financial year, the Company paid a premium in respect of a contract insuring the directors of Hunter Primary Care Limited, the company secretary and all executive officers of the Company against liability incurred as such a director, secretary or executive officer to the extent permitted by the ACNC Act 2012. The contract of insurance prohibits disclosure of the nature of the liability and the amount of insurance.

The Company has not otherwise, during or since the end of the financial year except to the extent permitted by law, indemnified or agreed to indemnify an officer or auditor of the Company or any related body corporate against a liability incurred as such an officer or auditor.

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

Director
Dr Trent Watson

Director
Dr Peter Hopkins

Newcastle, NSW
Dated: 8 October 2015

AUDITOR'S INDEPENDENCE DECLARATION

PKF

Hunter Primary Care Limited

Auditor's Independence Declaration under Section 307C of the Corporations Act 2001

I declare that, to the best of my knowledge and belief, during the year ended 30 June 2015, there have been:

(i) no contraventions of the auditor independence requirements as set out in the *Corporations Act 2001* in relation to the audit; and

(ii) no contraventions of any applicable code of professional conduct in relation to the audit.

PKF

PKF NEWCASTLE
Chartered Accountants

MARTIN MATTHEWS
Partner

Newcastle, NSW
Dated: 8 October 2015

PKF(NS) Audit & Assurance Limited Partnership
ABN 91 850 861 839
Liability limited by a scheme approved under Professional Standards Legislation

Sydney
Level 8, 1 O'Connell Street
Sydney NSW 2000 Australia
GPO Box 5446 Sydney NSW 2001
p +61 2 8346 6000
f +61 2 8346 6099

Newcastle
755 Hunter Street
Newcastle West NSW 2302 Australia
PO Box 2368 Dangar NSW 2309
p +61 2 4962 2688
f +61 2 4962 3245

INDEPENDENT AUDIT REPORT

PKF

Hunter Primary Care Limited

Independent Audit Report to the Members of Hunter Primary Care Limited

Report on the Financial Report

We have audited the accompanying financial report of Hunter Primary Care Limited, which comprises the statement of financial position as at 30 June 2015, the statement of profit or loss and other comprehensive income, statement of changes in equity, and statement of cash flows for the year then ended, notes comprising a summary of significant accounting policies and other explanatory information, and the directors' declaration.

Directors' Responsibility for the Financial Report

The Directors of the Company are responsible for the preparation of the financial report that gives a true and fair view in accordance with Australian Accounting Standards and the ACNC Act 2012 and for such internal control as the Directors determine is necessary to enable the preparation of the financial report that gives a true and fair view and is free from material misstatement, whether due to fraud or error.

In Note 1, the Directors also state, in accordance with Accounting Standard AASB 101 *Presentation of Financial Statements*, that the financial statements comply with *International Financial Reporting Standards*.

Auditor's Responsibility

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

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial report. The procedures selected depend on the auditor's judgement, including the assessment of the risks of material misstatement of the financial report, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the Company's preparation of the financial report that gives a true and fair view 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 Company'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.

PKF(NS) Audit & Assurance Limited Partnership
ABN 91 850 861 839
Liability limited by a scheme approved under Professional Standards Legislation

Sydney
Level 8, 1 O'Connell Street
Sydney NSW 2000 Australia
GPO Box 5446 Sydney NSW 2001
p +61 2 8346 6000
f +61 2 8346 6099

Newcastle
755 Hunter Street
Newcastle West NSW 2302 Australia
PO Box 2368 Dangar NSW 2309
p +61 2 4962 2688
f +61 2 4962 3245

PKF

Hunter Primary Care Limited

Independent Audit Report to the Members of Hunter Primary Care Limited

Independence
In conducting our audit, we have complied with the independence requirements of the ACNC Act 2012.

Audit Opinion
In our opinion:

(a) the financial report of Hunter Primary Care Limited is in accordance with the ACNC Act 2012, including:

(i) giving a true and fair view of the Company's financial position as at 30 June 2015 and of its performance for the year ended on that date; and

(ii) complying with Australian Accounting Standards and the *Corporations Regulations 2001*; and

(b) the financial report also complies with *International Financial Reporting Standards* as disclosed in Note 1.

Significant Uncertainty Regarding Going Concern
Without modifying our opinion, we draw attention to Note 1 (g) in the financial statements which indicates the existence of a material uncertainty that may cast significant doubt about the company's ability to continue as a going concern and therefore the entity may be unable to realise its assets and discharge it liabilities in the ordinary course of business.

PKF

PKF LAWLER PARTNERS
Chartered Accountants

MARTIN MATTHEWS
Partner

Newcastle
Dated: 8 October 2015

PKF(NS) Audit & Assurance Limited Partnership
ABN 91 850 861 839
Liability limited by a scheme approved under Professional Standards Legislation

Sydney
Level 8, 1 O'Connell Street
Sydney NSW 2000 Australia
GPO Box 5446 Sydney NSW 2001
p +61 2 8346 6000
f +61 2 8346 6099

Newcastle
755 Hunter Street
Newcastle West NSW 2302 Australia
PO Box 2368 Dangar NSW 2309
p +61 2 4962 2688
f +61 2 4962 3245

DIRECTORS' DECLARATION

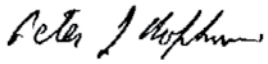
The directors of the Company declare that:

1. The financial statements and notes, as set out on pages 41 to 56, are in accordance with the ACNC Act 2012 and:
   (a) comply with Australian Accounting Standards; and
   (b) give a true and fair view of the financial position as at 30 June 2015 and of the performance for the year ended on that date of the entity.

2. In the directors' opinion, there are reasonable grounds to believe that the Company will be able to pay its debts as and when they become due and payable with due reference to Note 1 (g) to the financial statements.

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

Director
Dr Trent Watson



Director
Dr Peter Hopkins

Newcastle, NSW
Dated: 8 October 2015

STATEMENT OF PROFIT OR LOSS

and Other Comprehensive Income for the Financial Year Ended 30 June 2015

	Note	2015 $	2014 $
Revenue	3	30,525,516	31,591,823
Other Income	3	617,706	140,686
Employee benefits expense	3	(18,199,256)	(20,111,709)
Depreciation and amortisation expense	3	(343,199)	(460,912)
Administration expenses		(4,029,675)	(4,588,843)
Sub-contractors expense		(6,648,601)	(4,807,792)
Occupancy expense		(1,098,046)	(1,505,789)
Other operating expenses		(346,179)	(292,899)
Surplus/(Deficit) before income tax		**478,266**	**(35,435)**
Income tax expense	1(h)	-	-
Surplus/(Deficit) for the year		**478,266**	**(35,435)**
Other comprehensive income		-	-
Total comprehensive income/ (loss) for the year		**478,266**	**(35,435)**

The accompanying notes form part of these financial statements

STATEMENT OF FINANCIAL POSITION

as at 30 June 2015

	Note	2015 $	2014 $
ASSETS			
CURRENT ASSETS			
Cash and cash equivalents	16(a)	9,169,044	9,968,560
Trade and other receivables	5	2,320,679	475,838
Other current assets	6	187,794	158,249
Inventories	7	538	10,506
TOTAL CURRENT ASSETS		**11,678,055**	**10,613,153**
NON-CURRENT ASSETS			
Property, plant and equipment	8	448,035	821,699
TOTAL NON-CURRENT ASSETS		**448,035**	**821,699**
TOTAL ASSETS		**12,126,090**	**11,434,852**
LIABILITIES			
CURRENT LIABILITIES			
Trade and other payables	9	4,292,423	1,900,008
Provisions	10	1,313,983	1,625,639
Other financial liabilities	11	3,112,080	4,861,095
TOTAL CURRENT LIABILITIES		**8,718,486**	**8,386,742**
NON-CURRENT LIABILITIES			
Employee provisions	10	347,650	466,422
TOTAL NON-CURRENT LIABILITIES		**347,650**	**466,422**
TOTAL LIABILITIES		**9,066,136**	**8,853,164**
NET ASSETS		**3,059,954**	**2,581,688**
EQUITY			
Reserves	12	2,414,419	1,774,858
Accumulated surplus	13	645,535	806,830
TOTAL EQUITY		**3,059,954**	**2,581,688**

The accompanying notes form part of these financial statements

STATEMENT OF CHANGES IN EQUITY

for the Financial Year Ended 30 June 2015

2015	Accumulated Surplus $	Reserves $	Total $
Balance at 1 July 2014	806,830	1,774,858	2,581,688
Surplus for the year	478,266	-	478,266
Transfer to General Reserve	(639,561)	-	(639,561)
Transfers from Accumulated Surplus	-	639,561	639,561
Balance at 30 June 2015	**645,535**	**2,414,419**	**3,059,954**

2014	Accumulated Surplus $	Reserves $	Total $
Balance at 1 July 2013	977,912	1,639,211	2,617,123
Deficit for the year	(35,435)	-	(35,435)
Transfer to General Reserve	(135,647)	-	(135,647)
Transfers from Accumulated surplus	-	135,647	135,647
Balance at 30 June 2014	**806,830**	**1,774,858**	**2,581,688**

The accompanying notes form part of these financial statements

STATEMENT OF CASH FLOWS

for the Financial Year Ended 30 June 2015

	Note	2015 $	2014 $
Cash flows from operating activities:			
Receipts from clients and funding bodies		29,841,360	35,223,420
Payments to suppliers and employees		(30,976,033)	(35,340,999)
Interest received		335,157	402,944
Net cash (used in) / provided by operating activities	16(b)	(799,516)	285,365
Cash flows from investing activities:			
Payment for plant and equipment		-	(192,683)
Net cash used by investing activities		-	(192,683)
Cash flows from financing activities:			
Net cash used by financing activities		-	-
Net (decrease) / increase in cash and cash equivalents held		(799,516)	92,682
Cash and cash equivalents at beginning of year		9,968,560	9,875,878
Cash and cash equivalents at end of financial year	**16(a)**	**9,169,044**	**9,968,560**

NOTES TO THE FINANCIAL STATEMENTS

for the Financial Year Ended 30 June 2015

The financial statements are for Hunter Primary Care Limited as an individual entity, incorporated and domiciled in Australia. Hunter Primary Care Limited is a not-for-profit Company limited by guarantee.

The functional and presentation currency of Hunter Primary Care Limited is Australian dollars.

1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

(a) Basis of Preparation

The financial statements are general purpose financial statements that have been prepared in accordance with the Australian Accounting Standards, Australian Accounting Interpretations, other authoritative pronouncements of the Australian Accounting Standards Board and the ACNC Act 2012.

Material accounting policies adopted in the preparation of these financial statements are presented below and are consistent with prior reporting periods unless otherwise stated.

The financial statements have been prepared on an accruals basis and are based on historical costs modified, where applicable, by the measurement at fair value of selected non-current assets, financial assets and financial liabilities.

(b) Cash and cash equivalents

Cash and cash equivalents comprises cash on hand, demand deposits and short-term investments which are readily convertible to known amounts of cash and which are subject to an insignificant risk of change in value.

(c) Employee benefits

Provision is made for the Company's liability for employee benefits arising from services rendered by employees to the end of the reporting period. Employee benefits that are expected to be wholly settled within one year have been measured at the amounts expected to be paid when the liability is settled.

Employee benefits payable later than one year have been measured at the present value of the estimated future cash outflows to be made for those benefits. In determining the liability, consideration is given to employee wage increases and the probability that the employee may not satisfy vesting requirements. Those cashflows are discounted using market yields on national government bonds with terms to maturity that match the expected timing of cashflows.

Contributions are made by the Company to an employee superannuation fund and are charged as expense when incurred.

Obligations for contributions to defined contribution superannuation plans are recognised as an employee benefit expense in profit or loss in the periods in which services are provided by employees.

(d) Goods and Services Tax (GST)

Revenue, expenses and assets are recognised net of the amount of goods and services tax (GST), except where the amount of GST incurred is not recoverable from the Australian Taxation Office (ATO).

Receivables and payable are stated inclusive of GST. The net amount of GST recoverable from, or payable to, the ATO is included as part of receivables or payables in the statement of financial position.

Cash flows are included in the statement of cash flows are included on a gross basis and the GST component of cash flows arising from investing and financing activities which is recoverable from, or payable to, the taxation authority is classified as operating cash flows.

(e) Leases

Leases of fixed assets where substantially all the risks and benefits incidental to the ownership of the asset, but not the legal ownership that are transferred to the Company are classified as finance leases.

Lease payments for operating leases, where substantially all of the risks and benefits remain with the lessor, are charged as expenses on a straight-line basis over the life of the lease term.

(f) Impairment of assets

At each reporting date, the Company reviews the carrying amounts of its tangible assets to determine whether there is any indication that those assets have suffered an impairment loss. If any such indication exists, the recoverable amount of the asset is estimated in order to determine the extent of the impairment loss (if any).

If the recoverable amount of an asset is estimated to be less than its carrying amount, the carrying amount of the asset is reduced to its recoverable amount.

NOTES TO THE FINANCIAL STATEMENTS

for the Financial Year Ended 30 June 2015

(g) Going concern

In May 2014, the Federal Government budget introduced changes to the way primary care services will be managed, replacing Medicare Locals with Primary Health Networks (PHNs) from 1 July 2015. Accordingly, the Department of Health has discontinued its existing core funding arrangements with Hunter Primary Care effective 30 June 2015.

Hunter Primary Care has secured funding until 30 June 2016 from:

- HNECC Limited ("HNECC"), the Hunter New England and Central Coast Primary Health Network;
- the Department of Health with respect to the Partners in Recovery program; and
- Headspace National Youth Mental Health Foundation Limited with respect to the Headspace program.

As at the date of this report, it is unknown as to whether Hunter Primary Care Limited will be successful in securing funding post 30 June 2016. It is also unknown as to the level of funding that Hunter Primary Care Limited will receive to satisfy any obligations that may arise from future funding processes.

Notwithstanding this uncertainty, the Board has determined it appropriate that the financial report be prepared on a going concern basis in the belief that the Company will realise its assets and settle its liabilities and commitments in the normal course of business and for at least the amounts stated for a period not less than one year from the date of signing the financial report. If the Company is unsuccessful in the obtaining future funding and/or unable to obtain sufficient funding for any new obligations, the Company may not be able to continue as a going concern and therefore may be unable to realise its assets and extinguish its liabilities in the normal course of business and at the amounts stated in the financial statements.

(h) Income Tax

No provision for income tax has been raised as the Company is exempt from income tax under Division 50 of the *Income Tax Assessment Act 1997*.

(i) Reserves

Fees for services and other net revenues that are generated from the resources of the Company, as opposed to grant funding, are transferred at the end of the financial year from accumulated surplus/accumulated deficits to the General reserve. The details are set out in the Statement of Changes in Equity and Note 12.

(j) Payables

Trade payables and other accounts payable are recognised when the Company becomes obliged to make future payments resulting from the purchase of goods and services.

(k) Government Grants

Government grants present assistance from the Government in the form of transfers of resources to the Company in return for past or future compliance with certain conditions relating to the operating activities of the entity. Government grants include government assistance where there are no conditions specifically relating to the operating activities of the Company other than the requirement to operate in certain regions or industry sectors.

Government grants are not recognised until there is reasonable assurance that the Company will comply with the conditions attaching to them and the grants will be received.

Government grants whose primary condition is that the Company should purchase, construct or otherwise acquire non-current assets are recognised as deferred income in the statement of financial position and recognised as income on a systematic and rational basis over the useful lives of the related assets.

Other Government grants are recognised as income over the periods necessary to match them with related costs which they are intended to compensate, on a systematic basis. Government grants that are receivable as compensation for expenses or losses already incurred or for the purpose of giving immediate financial support to the Company with no future related costs are recognised as income of the period in which it becomes receivable.

(l) Property, Plant and Equipment

Classes of property, plant are measured using the cost method.

Where the cost model is used, the asset is carried at its cost less any accumulated depreciation and any impairment losses. Costs include purchase price, other directly attributable costs and the initial estimate of the costs of dismantling and restoring the asset, where applicable.

Plant and equipment that have been contributed at no cost, or for nominal cost are valued and recognised at the fair value of the asset at the date it is acquired.

The depreciable amount of all property, plant and equipment, except for freehold land is depreciated on a straight-line method from the date that management determine that the asset is available for use.

Assets held under a finance lease and leasehold improvements are depreciated over the shorter of the term of the lease and the assets useful life.

The depreciation rates used for each class of depreciable asset are shown below:

Plant and Equipment	15% – 40%
Leasehold improvements	25% – 40%

At the end of each annual reporting period, the depreciation method, useful life and residual value of each asset is reviewed. Any revisions are accounted for prospectively as a change in estimate.

When an asset is disposed, the gain or loss is calculated by comparing proceeds received with its carrying amount and is taken to profit or loss.

(m) Provisions

Provisions are recognised when the Company has a legal or constructive obligation, as a result of past events, for which it is probable that an outflow of economic benefits will result and that outflow can be reliably measured.

The amount recognised as a provision is the best estimate of the consideration required to settle the present obligation at reporting date, taking into account the risks and uncertainties surrounding the obligation. Where a provision is measured using the cashflows estimated to settle the present obligation, its carrying amount is the present value of those cash flows.

When some or all of the economic benefit required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is probable that recovery will be received and the amount of the receivable can be measured reliably.

(n) Revenue recognition

Revenue is recognised when the amount of the revenue can be measured reliably, it is probable that economic benefits associated with the transaction will flow to the Company and specific criteria relating to the type of revenue as noted below, has been satisfied.

Revenue is measured at the fair value of the consideration received or receivable and is presented net of returns, discounts and rebates.

Revenue from rendering of services is recognised upon delivery of the service to its clients.

Interest is recognised using the effective interest method.

Revenue from the disposal of assets is recognised when the Company has passed control of the goods or other assets to the buyer.

All revenue is stated net of the amount of goods and services tax (GST).

(o) Receivables

Trade accounts receivable generally settled within 30 days are carried at amounts due. A provision is raised for any doubtful debts based on a review of all outstanding amounts at balance date. Bad debts are written off in the period in which they are identified.

(p) New Accounting Standards and Interpretations

The AASB has issued new and amended Accounting Standards and Interpretations that have mandatory application dates for future reporting periods. The Company has decided not to early adopt these Standards. The following summarises those future requirements, and their impact on the Company:

- AASB 9: Financial Instruments (December 2014) and associated Amending Standards (applicable for annual reporting periods commencing on or after 1 January 2017).
- AASB 2014-4: Amendments to Australian Accounting Standards – Clarification of Acceptable Methods of Depreciation and Amortisation.

2 CRITICAL ACCOUNTING JUDGEMENTS, ESTIMATES AND ASSUMPTIONS

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

Long service leave provision

As discussed in Note 1, the liability for long service leave is recognised and measured at the present value of estimated future cash flows to be made in respect of all employees al the reporting date. In determining the present value of the liability, estimates of attrition rates and pay increases through promotion and inflation have been taken into account.

NOTES TO THE FINANCIAL STATEMENTS

for the Financial Year Ended 30 June 2015

	2015 $	2014 $
3 PROFIT / (LOSS) FROM OPERATIONS		
(a) Revenue		
Operating activities		
Services revenue	4,177,505	4,017,780
Interest received	335,157	402,944
Operating grants	26,012,854	27,171,099
Total operating revenue	30,525,516	31,591,823
Contribution from Hunter Rural Division of General Practice	350,000	-
Other miscellaneous income	267,706	140,686
Other income	617,706	140,686
Total Revenue	**31,143,222**	**31,732,509**
(b) Expenses		
Rental expense on operating lease	619,327	942,990
Depreciation	343,199	460,912
Loss on disposal of plant and equipment	30,465	-
Employee benefits expense	18,199,256	20,111,709
4 REMUNERATION OF AUDITORS		
Audit of the financial report	46,000	44,700
Other assurance services	7,500	9,000
	53,500	**53,700**
5 CURRENT TRADE AND OTHER RECEIVABLES		
Trade receivables	2,189,152	324,597
Provision for impairment	(3,359)	-
Other receivables	134,886	143,468
GST receivable	-	7,773
	2,320,679	**475,838**

Credit risk

Other than the Department of Health, the Company has no significant concentration of credit risk with respect to any single counterparty or group of counterparties. The class of assets described as 'trade and other receivables' is considered to be the main source of credit risk related to the Company. The major trade receivable as at 30 June 2015 was from the Department of Health which was received in July 2015 which has mitigated any credit risk as at 30 June 2015. The following table details the Company's trade and other receivables exposure to credit risk (prior to collateral and other credit enhancements) with ageing analysis and impairment provided for thereon. Amounts are considered as 'past due' when the debt has not been settled, within the terms and conditions agreed between the Company and the customer or counter party to the transaction. Receivables that are past due are assessed for impairment by ascertaining solvency of the debtors and are provided for where there is objective evidence indicating that the debt may not be fully repaid to the Company.

5 CURRENT TRADE AND OTHER RECEIVABLES (CONT'D)

The balances of receivables that remain within initial trade terms (as detailed in the table) are considered to be of high credit quality.

	Gross amount $	Past due and impaired $	Past due but not impaired (days overdue)			
			< 30 $	31 - 60 $	61 - 90 $	> 90 $
2015						
Trade and other receivables	2,189,152	3,359	2,162,638	6,035	2,861	17,618
Total	**2,189,152**	**3,359**	**2,162,638**	**6,035**	**2,861**	**17,618**
2014						
Trade and other receivables	324,597	-	42,389	273,850	2,656	5,702
Total	**324,597**	**-**	**42,389**	**273,850**	**2,656**	**5,702**

The Company does not hold any financial assets with terms that have been renegotiated, but which would otherwise be past due or impaired.

	2015 $	2014 $
6 OTHER ASSETS		
Prepayments	187,794	158,249
	187,794	**158,249**
7 INVENTORIES		
Information technology stock	538	10,506
	538	**10,506**

Write downs of inventories to net realisable value during the year were $ NIL (2014: $ NIL).

NOTES TO THE FINANCIAL STATEMENTS

for the Financial Year Ended 30 June 2015

8 PROPERTY, PLANT AND EQUIPMENT

Movements in carrying amounts of property, plant and equipment

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

	Plant and Equipment $	Leasehold Improvements $	Total $
YEAR ENDED 30 JUNE 2015			
Balance at the beginning of the year	577,405	244,294	821,699
Disposals	(52,230)	-	-
Depreciation expense	(158,984)	(162,450)	(343,199)
Balance at the end of the year	**366,191**	**81,844**	**448,035**
YEAR ENDED 30 JUNE 2014			
Balance at the beginning of the year	535,349	554,579	1,089,928
Additions	186,501	6,182	192,683
Disposals	(29,016)	-	(29,016)
Depreciation expense	(115,429)	(316,467)	(431,896)
Balance at the end of the year	**577,405**	**244,294**	**821,699**

	2015 $	2014 $
9 TRADE AND OTHER PAYABLES		
Trade payables	377,337	512,093
Sundry payables and accrued expenses	3,848,183	1,387,915
GST Payable	66,903	-
	4,292,423	**1,900,008**

10 PROVISIONS		
Current		
Provision for onerous contracts	22,005	108,627
Provision for employee benefits	1,291,978	1,517,012
	1,313,983	**1,625,639**
Non-Current		
Provision for employee benefits	**347,650**	**466,422**

	2015 $	2014 $
11 OTHER FINANCIAL LIABILITIES		
Unexpended government grants	3,112,080	4,861,095
	3,112,080	**4,861,095**

12 RESERVES		
General reserve		
Balance at the beginning of the financial year	1,774,858	1,639,211
Total transfer from accumulated surplus	639,561	135,647
Balance at the end of the financial year	**2,414,419**	**1,774,858**

13 ACCUMULATED SURPLUS		
Balance at beginning of financial year	806,830	977,912
Profit/(loss) for the year	478,266	(35,435)
Transfer to reserves	(639,561)	(135,647)
Accumulated surplus at end of the financial year	**645,535**	**806,830**

14 LEASES		
Disclosure for lessees		
Non - cancellable operating lease payments		
Not later than one year	159,853	192,395
Longer than 1 year and not longer than 5 years	73,606	40,329
Longer than five years	-	-
	233,459	**232,724**

Hunter Primary Care Limited has one non-cancellable property lease for which the rental payments beyond 30 June 2015 have been provided for an onerous contract in Note 10. The Company also has two leases on Ricoh photocopiers.

15 MEMBERS' GUARANTEE

The Company is incorporated under the *Corporations Act 2001* and is a Company limited by guarantee. If the Company is wound up, the Constitution states that each member is required to contribute a maximum of $20 each towards meeting any outstandings and obligations of the Company. At 30 June 2015 the number of members was 1,374 (2014: 1,404).

NOTES TO THE FINANCIAL STATEMENTS

for the Financial Year Ended 30 June 2015

16 NOTES TO THE STATEMENT OF CASH FLOWS

(a) Reconciliation of cash and cash equivalents

For the purpose of the cash flow statement, cash and cash equivalents includes cash on hand and in banks and investments in money market instruments, net of outstanding bank overdrafts. Cash at the end of the financial year as shown in the statement of cash flows is reconciled to items in the statement of financial position as follows:

	2015 $	2014 $
Cash and cash equivalents	9,169,044	9,968,560
	9,169,044	**9,968,560**

(b) Reconciliation of result for the year to cashflows from operating activities

Reconciliation of net income to net cash provided by operating activities:

Profit/(loss) for the year	478,266	(35,435)
Depreciation expense	343,199	460,912
Loss of disposal of plant and equipment	30,465	-
Changes in net assets and liabilities		
- (increase)/decrease in trade and other receivables	(1,844,841)	9,758,919
- (increase)/decrease in other assets	(29,545)	74,025
- (increase)/decrease in inventories	9,968	12,850
- increase/(decrease) in trade and other payables	2,392,415	(1,225,306)
- increase/(decrease) in provisions	(430,428)	367,828
- increase/(decrease) in other current liabilities	(1,749,015)	(9,128,428)
Cashflow from operations	**(799,516)**	**285,365**

17 FINANCIAL RISK MANAGEMENT

The main risks Hunter Primary Care Limited is exposed to through its financial instruments are credit risk, liquidity risk and interest rate risk.

The Company's financial instruments consist mainly of deposits with banks, short-term investments, accounts receivable and payable and leases.

The Company does not have any derivative financial instruments at 30 June 2015.

Financial Assets	2015 $	2014 $
Cash and cash equivalents	9,169,044	9,968,560
Trade and other receivables	2,320,679	475,838
	11,489,723	**10,444,398**
Financial Liabilities		
Trade and other payables	4,292,423	1,900,008
	4,292,423	**1,900,008**

i. Credit risk

Credit risk refers to the risk that a counterparty will default on its contractual obligations resulting in a financial loss to the Company.

The Company manages credit risk by management's review of trade receivables to assess collectability and determine write-offs.

The maximum exposure to credit risk at balance date to recognised financial assets is the carrying amount of those assets, net of any provisions for doubtful debts, as disclosed in the statement of financial position and notes to the financial statements.

The Company does not have any material credit exposure to any single debtor or group of debtors under financial instruments entered into by the Company.

The credit quality of financial assets that are neither past due nor impaired can be assessed by reference to external credit ratings (where available).

NOTES TO THE FINANCIAL STATEMENTS

for the Financial Year Ended 30 June 2015

Liquidity risk

The Company's liquidity risk arises from the risk that it will encounter difficulty in meeting its obligations associated with financial liabilities. The Company manages liquidity risk by continuously monitoring forecast and actual cash flows and matching profiles of financial assets and liabilities.

The Company's liabilities have contractual maturities which are summarised below:

	Less than 1 year		1 to 5 years		5 + years	
	2015 $	2014 $	2015 $	2014 $	2015 $	2014 $
Trade and other payables	**4,292,423**	**1,900,008**	**-**	**-**	**-**	**-**

ii. Interest rate risk

Interest rate risk is the risk that the fair value or future cash flows of a financial instrument will fluctuate because of changes in market interest rates. The Company's exposure to interest rate risk arises from the holding cash and cash equivalents. The Company actively monitors interest rates for cash at bank and on deposits to maximise interest income.

As at the reporting date, the Company had the following variable rate cash exposure:

	2015 $	2014 $
Cash and cash equivalents		
Cash at bank	**9,169,044**	**9,968,560**

The sensitivity analysis below have been determined based on the exposure to interest rates for both non-derivative instruments at reporting date and the stipulated change taking place at the beginning of the financial year and held constant throughout the reporting period.

At reporting date, if interest rates had been 1 % higher or lower and all other variables were held constant, the Company's net profit would increase or decrease by $91,690 (2014: $99,686). This is attributable to the Company's exposure to interest rates on its variable cash deposits.

The short-term bank deposits were subject to interest at the market variable rate being 1.94% (2014: 3.46%) as at 30 June 2015.

The other financial assets and financial liabilities are not subject to interest rate risk as they are non-interest bearing.

18 KEY MANAGEMENT PERSONNEL COMPENSATION

The directors and other members of key management personnel of the Company during the year were:

Dr Mark Foster	Director (Appointed 21/11/2014)
Dr Peter Hopkins	Director (Appointed 21/11/2014)
Mr Robert Horne	Director
Dr Trent Watson	Director
Ms Kelly Jones	Director
Mr Steven Adams	Director
Dr Milton Sales	Director
Mr Benjamin Wilkinson	Director
Dr Belinda Guest	Director (Ceased 30/06/15)
Ms Karen Howard	Director (Ceased - 2/9/14)
Mr Chris Barnett	Director (Ceased - 21/11/14)
Dr Annette Carruthers	Director (Ceased - 21/11/14)
Mr Kevin Sweeney	Executive
Mr Matthew Plumridge	Company Secretary / Executive
Mr Anthony Maher	Executive
Mr John Baillie	CEO (Resigned 10/07/15)
Ms Kaye Duffy	After Hours Independent Chair
Mr Bill Warren	PIR Independent Chair
Ms Carol Bennett	CEO (Resigned 14/07/14)
Mr Keith Drinkwater	Executive
Ms Jane Mendelson	Executive
Ms Katrina Delamothe	Executive

The totals of remuneration paid to the key management personnel of Hunter Primary Care Limited during the year are as follows:

	2015 $	2014 $
Short-term employee benefits	1,328,886	1,269,227
Post-employment benefits	44,139	23,679
	1,373,025	**1,292,906**

NOTES TO THE FINANCIAL STATEMENTS

for the Financial Year Ended 30 June 2015

19 RELATED PARTIES

The Company's main related parties are as follows:

(a) Key management personnel

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

For details of remuneration disclosures relating to key management personnel, refer to Note 18: Key Management Personnel (KMP) Compensation.

(b) Transactions with related parties

Transactions between related parties are on normal commercial terms and conditions no more favourable than those available to other parties unless otherwise stated.

Dr Milton Sales is the Principal of Brunker Rd General Practice. Practice incentive payments of $25,889 were paid to Brunker Rd General Practice throughout the financial year.

Dr Peter Hopkins is a Director of King Street General Practice (KSGP). Practice incentive payments of $13,231 were paid to KSGP throughout the financial year.

20 SUBSEQUENT EVENTS

No matters or circumstances have arisen since the end of the financial year which significantly affected or may significantly affect the operations of the Company, the results of those operations, or the state of affairs of the Company in future financial years.

21 ECONOMIC DEPENDENCY

During the year ended 30 June 2015, the Company received the majority of its funding from the Department of Health ('DOH'). From 1 July 2015, it will receive the majority of its funding from HNECC Limited ("HNECC") and accordingly is economically dependent on the continued financial and other support it receives from HNECC.

22 CONTINGENT ASSETS

The Department of Health has given its consent to HNECC Limited to compensate HPC to meet costs of a redundancy payment to an employee where certain conditions have been met. Due to the uncertainty of which programs will be operating past 30 June 2016, HPC are unable to quantify this figure at this point in time.

23 COMPANY DETAILS

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

Hunter Primary Care Limited
Ground Floor, 123 King Street
Newcastle NSW 2300

Hunter PRIMARY CARE

Hunter Primary Care Limited
(trading as Hunter Medicare Local)

PO Box 572
Newcastle NSW 2300

T 02 4925 2259
F 02 4925 2268

ACN 061783015

www.hunterprimarycare.com.au

headspace Newcastle | Hunter Partners in Recovery | Hunter PRIMARY CareCoordination | Hunter PRIMARY Psychology Services | GP access AFTER HOURS