Midlands Regional Health Network Charitable Trust

ANNUAL REPORT 2017

Contents

Introduction

New Zealand, along with the rest of the world, is facing changing demographics alongside increasing health demands and workforce issues. These factors all combine to challenge the sustainability of our current health system.

Midlands Regional Health Network Charitable Trust, Pinnacle and the Midland DHBs, via the Midlands Alliance, have been working collectively to address these challenges.

We are already leading the way with changes in establishing the Health Care Home, by enabling primary care to play a bigger role in the broader health sector and through embracing new technologies and methods of service delivery.

The Midlands Alliance is designed to support a different approach to healthcare. It's about moving away from silos of providers focused on their needs, to a patient centered approach. It's about looking at the whole-of-system and engaging with all the parties to agree and drive what's best for outcomes. It is based on the premise of:

"One Plan, one contract, enabling regional thinking supported by local implementation."

This approach was designed to improve on the already high standard of healthcare for the population of Midlands, with NO GAPS for high need, rural and Māori families.

Our Network Plan 2014-2017 described how the partners, working collectively as the Midlands Alliance, would improve the health of the Midlands population, taking into account its demographic health profile and the need to achieve equity of outcome for everyone.

It set out the strategic direction, health outcomes and the way the eco-system will be developed to support the strategic objectives during this time frame.

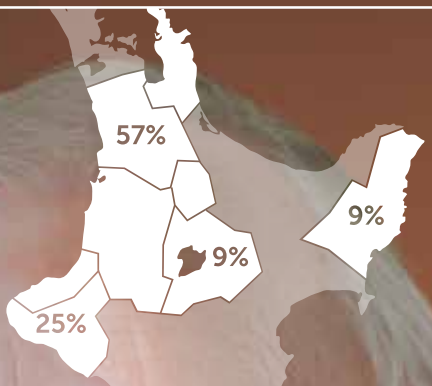
The overarching objective was to develop an effective Health Care Home to enable the maintenance and improvement of the health of the Network's population.

There are currently

433,431

enrolled patients across the Network

with Taranaki practices accounting for **25%** (110,111) of these enrolled patients, Waikato practices **57%** (246,650), Lakes practices **9%** (38,084) and practices in Tairawhiti account for **9%** (38,586)



Over

10,443

patients were managed successfully in primary care through Primary Options

35%

Of the 86 practices 35% are categorised as rural practices

Provided over

10,532

immunisations for eight month and two year old children

Provided

55,720

flu vaccinations for our over 65 year olds

The average practice size is

4,875

enrolled patients, although practice sizes vary across the Network. The smallest with **<500** and the biggest **>18,000** enrolled patients

Increased primary care capacity in

15

Health Care Home sites

20.4%

of the enrolled population are Māori

Undertook

160,273

cardiovascular risk assessments (CVRA)

Provided over

50,738

pieces of brief advice to smokers

Patient portal made available to over

355,833

patients

Midlands Alliance

Midlands Alliance

The Midlands Alliance is about supporting a different approach to healthcare, based on the premise of developing a new health eco-system for the region focused on supporting individuals, whānau and communities to manage and maintain their health and wellbeing.

"One plan, one contract, enabling regional thinking supported by local implementation"

If implemented effectively, it will guarantee that the population of Midlands will experience superior health status with NO GAPS for high need and Māori populations.

The Midlands Alliance brings together the government's District Health Boards and their hospital services, primary care and Non-Government Organisations in the community, and patients, to take a whole-of-system view on how the system should be operated and funded.

This plan aims to support changing the way the system works and to establish a greater balance of resource where the population needs it, closer to home and in the community.

Currently, less than 10 per cent of the health budget is spent in the primary care setting, despite over 95 per cent of the interactions occurring there. We need to move away from a healthcare system that is dominated by the hospital setting and, instead, move towards a person centred approach that coordinates the resources of the healthcare system around the needs of patients, seeking to maintain and improve their health rather than just treating illness. Focusing on the person results in better outcomes for both the person and the system.

Chairman's Report

Year ending 30 June 2017.

The Midlands Regional Health Network Charitable Trust was established to bring together a number of key health providers in the midland region. The region covers four midlands District Health Boards (DHBs) – Tairāwhiti (Gisborne), Lakes, Waikato and Taranaki. The geographic area has approximately 500,000 enrolled patients.

The key-founding partners are Pinnacle Incorporated, Tui Ora Limited and Te Hauora o Turanganui a Kiwa.

Our focus continues to be a regional approach to delivering outstanding primary health services and working closely with the four DHBs to develop a holistic system for better health outcomes across primary, community and secondary. Where possible we deliver this through a single contract/plan.

Our key strategic initiatives continue to be:

- leveraging the power of our regional collective (talent, knowledge, economies, capability, influence on the national system)
- high quality services and actions
- striving for superior health outcomes for our population in the midland region, particularly those most marginalised/vulnerable
- high performance from provider networks and individual providers
- sustainability of services for all
- "great value for money" from a funder perspective
- impacting national health targets positively
- continued success of our individual organisations/ members
- having a structure that is flexible and can make appropriate "quick shifts" before and/or with the sector
- supporting (and evidencing) the benefit of community based intervention.

The Trust's key achievements for the past financial year have been:

- greater primary care integration, with Tairāwhiti and Taranaki DHBs particularly
- greater integration with Tui Ora Limited and Te Hauora o Turanganui a Kiwa
- the ongoing development and roll-out of the Health Care Home
- our Trust wide focus on child health initiatives
- three practices in the network successfully accessing the new contestable Facility Development Fund. The purpose of the fund is to provide support in the form of grants for practices investing in new buildings or upgrading their practice facilities.

I would again personally like to thank our Trustees for their dedicated service, our founding partner organisations (and their teams for their commitment to this alliance), and lastly the Pinnacle MHN team for their ongoing sector leadership.

Craig McFarlane
Chairman

Strategic Programmes

The Network's Plan 2014-2017 prioritised seven strategic programmes.

1. Child and youth health coordination services

The Child and Youth Health Coordination Service (Cay-C) team is constantly working with health providers, including midwives, general practices and Well Child/ Tamariki Ora providers, to ensure children access the right services and receive all of their checks on time. A strong focus remains on getting 95 per cent of practices meeting the 95 per cent immunisation target and 80 per cent completion of Year 9 HEADDS assessments.

A key focus this year has been integrating the work flow of the team to eliminate silos and give our families the best possible chance of receiving their health service requirements. The team continues to develop relationships with the providers working with the National Child Health Information Platform (NCHIP) and with our inter-sectoral partners such as the Ministry of Social Development and the Ministry of Education.

A highlight for Cay-C last year has been working closely and creatively alongside two providers in particular, the National Screening Unit (NSU) and lead maternity carers (LMCs), to help improve health outcomes for children.

In New Zealand, the newborn metabolic screening programme screens for rare but potentially serious disorders such as phenylketonuria, cystic fibrosis, and congenital hypothyroidism. The NSU identified that a small number of newborn children were missing out on metabolic screening.

Cay-C's work with the NSU has involved comparing databases of children and exchanging National Child Health Information Platform (NCHIP) data with the unit to help ensure fewer children miss out on this important test.

The Cay-C team and the NSU have formed an ongoing relationship to reach families whose newborn children still need to undergo metabolic screening. Specifically, the team will contact the appropriate provider (most likely the LMC) to advise that metabolic screening hasn't taken place, and the provider can ensure the heel prick test is still performed in a timely manner.

Additionally, Cay-C has worked with the LMCs to launch a 'super user' group to help CaY-C understand and improve providers' experience of NCHIP prior to the platform undergoing enhancements.

NCHIP provides a single online view for all practitioners involved in the 29 child health milestones from birth to six years of age. The platform captures and monitors midwife checks, Well Child/Tamariki Ora assessments, immunisations, hearing and vision checks, oral health checks and B4 School Checks. The CaY-C service can assist in the tracing of children lost to providers so that no child misses out. The team will keep working towards the target of 80 per cent of children achieve all general practice milestones within NCHIP. In addition electronic enrolment will be trialled through NCHIP.

2. Engaged network

Our general practice network is integral to the delivery of timely, appropriate and targeted primary care. To do this, our practices need to feel connected with Pinnacle MHN, their region, their communities and their patients.

The aim of this programme is to inform and support Pinnacle MHN practices to be high performing and progressive so they can continue to deliver sustainable patient-centric care.

We have engaged and supported practices to achieve against the quality plan. A particular highlight was seeing all practices in the network as at 30 June achieving Foundation Standards or on the pathway to Cornerstone Accreditation.

Education via the Pinnacle Education Pods (GP PEP) and the needs of rural practices (in terms of education and technology) are key features of this programme going forward, along with facilitating practice access and analysis of their own data.

A workforce survey will be undertaken in 2017/18 to further understand the needs of the network.

3. Health Care Home

Health Care Home (HCH) is a primary care development programme to ensure effective and sustainable care for future generations that meets the needs of a stratified population. It enables transformational change in general practice to better manage unplanned demand, proactively care for complex health needs, support integrated care and create a sustainable work environment.

Health Care Home (HCH) is a primary care development programme to ensure effective and sustainable care for future generations that meets the needs of a stratified population.

It's a model that's been designed to support the everyday needs of general practice while keeping the focus on the patients. Patients have better access to clinical advice via alternatives to face to face such as email, have more choice on how they interact with health care providers and under the HCH model general practice can better focus on planning as much care as possible to ensure the patient receives the right care, at the right time, by the right person.

Following on from Pinnacle MHN leadership the model is now being introduced around New Zealand by partnerships between PHOs and DHBs.

Looking forwards the HCH programme continues to be a key feature of the Pinnacle MHN strategic plan, with a particular focus of expanding growth through adoption of the model in Taranaki.

Further work will be done to integrate community services with general practice, using indici™ as the technology enabler. Pilots will be undertaken on point of care testing and diagnostics to bring care and clinical decision making closer to the patient and the practice. Continued development of the HCH model is planned to include health coaching and shared medical consults, along with other extended general practice roles such as peer facilitator and community health workers.

Data will be collected for formal evaluation of the HCH model.

4. Long term conditions

The long term conditions (LTC) programme is a clinical best practice programme supporting the network practices to deliver care for patients with a long term condition. The aim for long term condition management is to ensure people are well as possible for as long as possible and primary care is vital to improving the management of care for these patients.

Long term conditions are managed by:

- **early and accurate diagnosis**
- **support and promotion of self-management**
- **prevention of complications**
- **symptom management**
- **timely management of end of life care.**

Diabetes and those eligible for a cardiovascular risk assessment (CVRA) remain the key focus for the coming year. Work will continue defining the chronic obstructive pulmonary disease (COPD) programme for the network and ensuring practices are engaged with the current LTC programme.

We as a network focus on continuing to support and upskill the primary care workforce to provide comprehensive care to their patients with long term conditions. We encourage targeted interventions to identify at risk populations.

Extending that education into the community healthcare environment ensures that care is truly provided in a wraparound fashion and as close as possible to the patient.

Our use of technology has resulted not only in the continued development of decision support tools and robust data collection but also ground-breaking work on pre-diabetes through innovative self-management tools.

Our focus on self-management continues with new models of service delivery such as our multidisciplinary teams and podiatry service ensuring that patients are not only central to healthcare delivery but are also part of the solution.

As more care is transitioned from secondary care into primary care, we need to ensure that both the funding and the skill mix align with strategic directives.

5. Primary Health Care Limited

Primary Health Care Limited (PHCL) is a membership service for our network practices committed to ensuring sustainable high quality healthcare throughout the midlands region.

It allows us to:

- **sustain the network's general practices that are at risk of collapse/closure by offering the GP owners a fair and cost effective succession pathway – ensuring communities are not left without sustainable primary care services**
- **create sustainable business models through the implementation of the Health Care Home**
- **supports key regional initiatives such as the Patient Access Centre**
- **within DHB districts, it ensures members of the Pinnacle Network are seen as the key primary care partners that can deliver primary care solutions to whole system challenges**

- **within localities, to ensure implementation of Pinnacle Midlands Health Network Health Care Home, locality planning, and primary/specialist integration**
- **develop new remuneration models to engage the next generation of practitioners as a credible alternative to corporatisation and owner-operator**
- **supporting rural communities and practitioners through integrated delivery systems**
- **focus on a sustainable model of care, not profits.**

6. Mental health

The primary mental health service provides access to a variety of interventions that support general practices to look after people experiencing mental health distress.

We have a variety of contracts in the regions such as brief intervention therapy via either an Pinnacle MHN employed brief intervention clinician or a third party counsellor/ psychologist for patients with mild to moderate mental health and addiction issues. Pinnacle MHN has delivered over 13,000 sessions of brief intervention in the Waikato region.

Pinnacle MHN has delivered over 13,000 sessions of brief intervention in the Waikato region.

The service also provides GP's with access to funded extended consults to better meet the acute mental health needs of their patients.

Over the coming year we will continue to support the new Te Kuwatawata service in Gisborne. This new service was the result of a successful RFP bid with the Ministry of Health for a joint venture arrangement between Hauora Tairāwhiti, Pinnacle MHN, Te Kupenga Net Trust and Te Kurahuna to work together to develop a single point of access and better ways to support whānau in distress.

Agreement has been reached with the Waikato DHB to recruit a psychiatrist to lead the development of new models of intervention.

7. Smoking

The strategic objective of this program is to meet the goal of 2025 Smokefree Aotearoa in our localities.

We will continue to lead the way in supporting smoking cessation. We will create technology that empowers individuals to take control of their care. Our Ministry of Health contract continues to support our network and is achieving good outcomes.

The strategic objective of this program is to meet the goal of 2025 Smokefree Aotearoa in our localities.

Pinnacle MHN will continue to:

- **support all Pinnacle MHN practices to achieve the smoking brief advice target across the network**
- **run stop smoking services in Waikato and Tairāwhiti to assist at least 5 per cent of current smokers to quit.**

The stop smoking service is going well, however converting referrals to enrolments is a constant challenge. In the Waikato area we are still not achieving the volumes we would like.

Promotions trialled through radio advertising and Facebook have had limited success. We plan to work more closely with the general practices and other health professionals across the sector to encourage referrals to the stop smoking service. Waikato staff have been particularly helpful in the last quarter brokering connections to birthing units across the region.

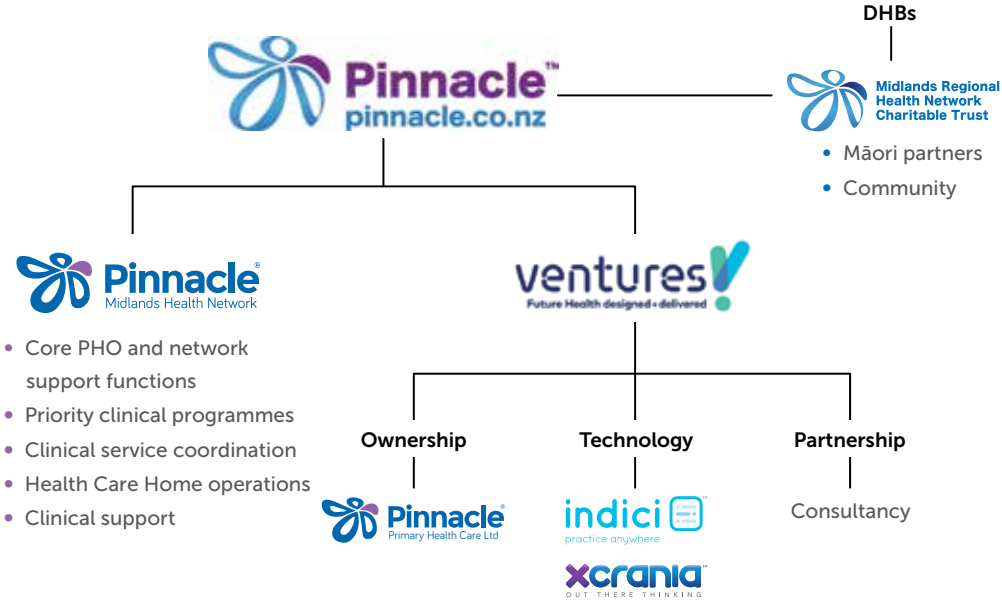
We have offered to provide workplace based support within a small number of Waikato employers and Turanga Health has been very proactive with Tairāwhiti workplaces.

Looking forward — new structure, new strategy

As at 1 July 2017, Pinnacle Incorporated announced a realignment of the group's structure, separating out innovation, technology and some development activities into a standalone not-for-profit organisation, Ventures and retaining the core primary health organisation activities within Pinnacle MHN.

Pinnacle MHN's sister organisation Ventures is focussed on delivering today's innovation and inventing the future of primary healthcare. Their innovative developments are essential to the overall sustainability and future development of the Group and the network through strengthening capacity and capability.

Supporting the network will always be Pinnacle Incorporated's top priority. This business reorganisation allows each entity to ramp up and focus its efforts to meet the ever-changing needs of Pinnacle's members.



Pinnacle MHN is developing a new network plan based on three principles.

- **Know – we are well informed about our practices, their patients and our communities.**
- **Focus – We support our practices, enabling them to identify and target care to patients, populations and communities of the highest need.**
- **Act – We are high performing and progressive and deliver care through sustainable models to achieve high quality, personalised patient outcomes.**

We've applied five lenses to our plan that drive our activities and desired outcomes:

- **patient connections and engagement**
- **general practice and community provider capability and capacity requirements**
- **reducing gaps and barriers for Māori**
- **system wide measures**
- **quality improvement across the Pinnacle MHN group.**

In this new plan Pinnacle MHN will deliver improved outcomes through five interrelated programmes of work.

1. Engaged network – supporting our network to deliver high quality care.
2. Starting well – for child, youth and family health services.
3. Physically well – for people with enduring physical illness.
4. Mentally well – for people living with the spectrum of mental health distress.
5. Staying well – for helping people to stay healthy and prevent illnesses.

Financial Statements

For the year ended 30 June 2017

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AS AT 30 JUNE 2017

REGISTERED OFFICE

Norris Ward McKinnon Centre
711 Victoria St
Hamilton

TRUSTEES

Craig McFarlane
Stephen French
Patrick Leary
Wayne Mulligan
Pehimana Brown
Lisa Hayes
Dianne Mulhern
Fraser Hodgson
Peter Battersby

AUDITORS

KPMG
P O Box 929
Hamilton

SOLICITORS

Tompkins Wake
Hamilton

BANKERS

ANZ
Hamilton

MIDLANDS REGIONAL HEALTH NETWORK CHARITABLE TRUST FINANCIAL STATEMENTS

Statement of Comprehensive Income and Expense

FOR THE YEAR ENDED 30 JUNE 2017

	Note	2017 $	2016 $
Revenue	3	36,167,802	32,997,590
Interest Received		71,157	108,291
TOTAL REVENUE		36,238,959	33,105,881
Operating Expenses		36,171,426	33,793,245
Administration Expenses		394,105	195,523
TOTAL EXPENSES	4	36,565,531	33,988,768
NET DEFICIT		(326,572)	(882,887)
Other Comprehensive Income and Expense for the Period		-	-
TOTAL COMPREHENSIVE INCOME AND EXPENSE		(326,572)	(882,887)

MIDLANDS REGIONAL HEALTH NETWORK CHARITABLE TRUST FINANCIAL STATEMENTS

Statement of Financial Position

AS AT 30 JUNE 2017

	Note	2017 $	2016 $
CURRENT ASSETS			
Cash and Cash Equivalents	5	4,654,691	3,122,465
Accounts Receivable	6	2,930,929	3,142,558
TOTAL CURRENT ASSETS		7,585,620	6,265,023
TOTAL ASSETS		7,585,620	6,265,023
CURRENT LIABILITIES			
Accounts Payable	7	7,465,852	5,818,683
TOTAL CURRENT LIABILITIES		7,465,852	5,818,683
TOTAL LIABILITIES		7,465,852	5,818,683
NET ASSETS		119,768	446,340
TOTAL EQUITY		119,768	446,340

For, and on behalf of, the Trustees who authorised the issue of these statements on the date shown below.

7 December 2017

7 December 2017

MIDLANDS REGIONAL HEALTH NETWORK CHARITABLE TRUST FINANCIAL STATEMENTS

Statement of Changes in Equity

FOR THE YEAR ENDED 30 JUNE 2017

	Retained Earnings $	Total Equity $
Balance at 1 July 2015	1,329,227	1,329,227
Total Comprehensive Income and Expense		
Deficit for the period	(882,887)	(882,887)
Total Comprehensive Income and Expense	(882,887)	(882,887)
Balance at 30 June 2016	446,340	446,340
Total Comprehensive Income and Expense		
Deficit for the period	(326,572)	(326,572)
Total Comprehensive Income and Expense	(326,572)	(326,572)
Balance at 30 June 2017	119,768	119,768

MIDLANDS REGIONAL HEALTH NETWORK CHARITABLE TRUST FINANCIAL STATEMENTS

Statement of Cash Flows

FOR THE YEAR ENDED 30 JUNE 2017

	Note	2017 $	2016 $
Cash flows from operating activities			
Cash was provided from:			
Receipts from customers		37,367,004	31,866,322
Interest received		71,158	111,742
		37,438,162	31,978,064
Cash was applied to:			
Payment to suppliers		(35,905,936)	(32,249,078)
Net cash flow - operating activities	10	1,532,226	(271,014)
Net cash flow - investing activities		-	-
Net cash flow - financing activities		-	-
Net cash flow for the year from all activities		1,532,226	(271,014)
Cash at beginning of year		3,122,465	3,393,479
Cash at end of year		4,654,691	3,122,465
Represented by:			
Cash on hand and at bank	5	4,654,691	3,122,465

MIDLANDS REGIONAL HEALTH NETWORK CHARITABLE TRUST FINANCIAL STATEMENTS

Notes to the Financial Statements

FOR THE YEAR ENDED 30 JUNE 2017

1. REPORTING ENTITY

Midlands Regional Health Network Charitable Trust (the "Trust") is a trust incorporated under the Charities Act 2005.

The Trust is considered a public benefit entity for the purposes of financial reporting in accordance with the Financial Reporting Act 2013.

The core activity of the Trust is to maintain and improve community health outcomes in the Midlands Regional Health Network.

2. BASIS OF PREPARATION

The financial statements have been prepared on a going concern basis, and the accounting policies have been consistently applied throughout the period.

Accounting policies are selected and applied in a manner which ensures that the resulting financial information satisfies the concepts of relevance and reliability, thereby ensuring that the substance of the underlying transactions or other events is reported.

(a) Statement of Compliance

The consolidated financial statements have been prepared in accordance with New Zealand Generally Accepted Accounting Principles ("NZ GAAP"). They comply with Public Benefit Entity International Public Sector Accounting Standards ("PBE IPSAS") and other applicable Financial Reporting Standards, as appropriate for Tier 1 not-for-profit public benefit entities.

These financial statements were authorised for issue by the Trustees on 7 December 2017.

(b) Measurement Basis

The financial statements have been prepared on the basis of historical cost.

(c) Functional Currency

The financial statements are presented in New Zealand dollars and all values are rounded to the nearest dollar ($0).

(d) Goods and Services Tax

All balances are presented net of goods and services tax (GST), except for receivables and payables which are presented inclusive of GST.

(e) Accounting policies

The accounting policies in the following notes have been consistently applied in preparing the financial statements for the year ended 30 June 2017 and the comparative information for the year ended 30 June 2016.

MIDLANDS REGIONAL HEALTH NETWORK CHARITABLE TRUST FINANCIAL STATEMENTS

Notes to the Financial Statements

FOR THE YEAR ENDED 30 JUNE 2017

3. REVENUE

	2017 $	2016 $
Provision of Healthcare services (exchange)	20,562,912	17,604,932
Provision of Healthcare services (non-exchange)	15,604,890	15,392,658
	36,167,802	32,997,590

Policies

Revenue from provision of healthcare services rendered is recognised in proportion to the stage of completion of the transaction at the reporting date and performance against other ongoing obligations under the contracts. The stage of completion is assessed by reference to work performed and milestones achieved in project and contract based funding.

Exchange revenue is revenue received in exchange for goods or services of approximate equal value.

Non-exchange revenue is revenue received without the exchange of goods or services of approximately equal value (e.g. grants or donations). The non-exchange revenue received by the Trust is funding from the DHBs' allocation of Flexible Funding.

Exchange revenue from Provision of Healthcare Services rendered is recognised in proportion to the stage of completion of the transaction at the reporting date and performance against other ongoing obligations under the contracts. The stage of completion is assessed by reference to work performed and milestones achieved in project and contract based funding.

Non-exchange revenue from Provision of Healthcare Services is recognised as received.

4. OPERATING & ADMINISTRATION EXPENSES

	2017 $	2016 $
Audit Fees	10,350	10,350
Trustee Fees	59,300	52,500
Other Expenses	36,495,881	33,925,918
	36,565,531	33,988,768

Notes to the Financial Statements

FOR THE YEAR ENDED 30 JUNE 2017

5. CASH AND CASH EQUIVALENTS

	2017 $	2016 $
Cash and Bank Balances	1,616,688	1,085,478
Term Deposits	3,038,003	2,036,987
	4,654,691	3,122,465

Policies

Cash and cash equivalents are cash balances that are short term in nature for the purposes of the Statement of Cashflows, and are classified as a Loans and Receivables financial asset.

6. ACCOUNTS RECEIVABLE

	Note	2017 $	2016 $
Accounts Receivable		1,639,330	1,427,253
Related Party Receivable	11	146,445	741,591
Income Accrued		854,994	759,768
Related Party Income Accrued	11	241,441	213,946
Prepayments		48,719	-
		2,930,929	3,142,558

Accounts receivable are shown net of allowances for bad and doubtful debts of $nil (2016: nil).

Policies

Accounts receivable are initially measured at fair value, then adjusted for any impairment. Accounts receivable are classified as a Loan and Receivables financial asset.

Accounts receivable are reduced through the use of an allowance account. When a receivable is uncollectable, it is written off against the allowance account. A receivable is deemed to be uncollectable upon reference to the current customer/patient/general practitioners circumstances and past default experience. Changes in the carrying amount of the allowance account are recognised in the Statement of Comprehensive Income and Expense.

Notes to the Financial Statements

FOR THE YEAR ENDED 30 JUNE 2017

7. ACCOUNTS PAYABLE

	Note	2017 $	2016 $
Accounts Payable		307,614	332,291
Related Party Payables and Accruals	11	4,295,461	3,670,052
GST Payable		49,353	71,519
Income in Advance		2,424,100	1,436,525
Accrued Expenses		389,324	308,296
		7,465,852	5,818,683

Policies

Accounts payable are recognised at cost when the Trust becomes obliged to make future payments resulting from the purchases of goods and services. Accounts payable are classed as an 'other amortised cost financial liability'.

8. CONTINGENT LIABILITIES

There were no contingent liabilities as at 30 June 2017 (2016: nil).

9. SUBSEQUENT EVENTS

No material events occurred subsequent to the Statement of Financial Position date.

Notes to the Financial Statements

FOR THE YEAR ENDED 30 JUNE 2017

10. RECONCILIATION OF PROFIT FOR THE PERIOD WITH THE NET CASH FLOWS FROM OPERATING ACTIVITIES

	2017 $	2016 $
Deficit for the year	(326,572)	(882,887)
	(326,572)	(882,887)
Movements in Working Capital:		
Accrued interest decrease/(increase)	-	3,451
Accounts receivable decrease/(increase)	211,630	(79,362)
Prepayments decrease/(increase)	-	783,725
Deferred Income (decrease)/increase	987,575	(1,051,906)
Accounts payable (decrease)/increase	659,593	955,965
	1,858,798	611,873
Net cash flows from/(applied to) Operating Activities	1,532,226	(271,014)

Notes to the Financial Statements

FOR THE YEAR ENDED 30 JUNE 2017

11. RELATED PARTY TRANSACTIONS

(i) Key Management Personnel Remuneration

The Group classifies its key management personnel into one class:
- Trustees

Trustees are paid an annual fee of $6,800, except for the Chairperson who receives $13,600. Those Trustees who are on the FAR Committee receive an additional $750.

	2017 $	2016 $
Trustees		
Remuneration	59,300	52,500
Total Key Management Personnel Remuneration	59,300	52,500
Number of Trustees	9	8

(ii) Transactions with other related parties

The Trust transacts with other related parties in the normal course of their business. Such entities include associates, other investees and those related by virtue of common or substantially common ownership and governance/ management.

The Trust made the following sales to related parties during the year. At year end, the following receivable balances remained due:

	Sales to 2017 $	Receivable 2017 $	Sales to 2016 $	Receivable 2016 $
Other Related Parties				
Midlands Health Network Limited	106,293	89,137	35,000	86,264
Pinnacle Incorporated	1,239,320	298,749	978,906	869,273
	1,345,613	387,886	1,013,906	955,537

Notes to the Financial Statements

FOR THE YEAR ENDED 30 JUNE 2017

The Trust made the following purchases from related parties during the year. At year end, the following payable balances remained owing:

	Purchases 2017 $	Payable 2017 $	Purchases 2016 $	Payable 2016 $
Other Related Parties				
Midlands Health Network Limited (exchange)	5,601,363	915,605	2,941,385	524,547
Midlands Health Network Limited (non-exchange)	5,795,956	161,012	7,728,912	355,058
Pinnacle Incorporated	20,290,984	3,068,793	20,687,962	2,790,447
Xcrania Limited	150,396	150,051	-	-
	31,838,699	4,295,461	31,358,259	3,670,052

There is a GST difference in the 2016 Related Party transactions reported between between the Pinnacle Group and Midlands Regional Health Network Charitable Trust (the Trust). The difference arises because Accounts Payable are recorded GST inclusive while Accrued Liabilities are recorded GST exclusive. The GST exclusive Related Party transaction amounts between the Pinnacle Group and the Trust are aligned.

12. CAPITAL AND FINANCIAL RISK MANAGEMENT

The Trust manages its capital to ensure that it will be able to continue as a going concern.

The capital structure of the Trust consists of cash and cash equivalents, and equity as disclosed in the Statement of Changes in Equity.

The Trust's overall strategy remains unchanged from 2016.

There are no externally imposed capital requirements on the Trust.

Exposure to credit, interest rate and liquidity risks arises in the normal course of the Trust's business.

(a) Credit Risk

The Trust's exposure to credit risk is mainly influenced by its customer base. As such it is concentrated to the default risk of its industry. In order to determine which customers are classified as having payment difficulties, the Trust bases the decision on the age of the outstanding balances. The Trust does not require collateral in respect of trade and other receivables.

Notes to the Financial Statements

FOR THE YEAR ENDED 30 JUNE 2017

The status of trade receivables at the reporting date is as follows:

	Gross Receivable 2017 $	Impairment 2017 $	Gross Receivable 2016 $	Impairment 2016 $
Current	1,777,862	-	2,073,706	-
Past due 30 days	7,913	-	83,859	-
Past due 31-60 days	-	-	-	-
Past due 60+ days	-	-	11,279	-
	1,785,775	-	2,168,844	-

(b) Liquidity Risk

Liquidity risk represents the Trust's ability to meet its contractual obligations. The Trust evaluates its liquidity requirements on an ongoing basis. The following table sets out the contractual cash flows for all financial liabilities that are settled on a gross cash flow basis.

	2017 Balance Sheet	Contractual Cash Flows	Less than 1 year	1-2 Years	3+ Years
Trade and Other Payables	7,465,852	7,465,852	7,465,852	-	-
Total Non-Derivative Liabilities	7,465,852	7,465,852	7,465,852	-	-

	2016 Balance Sheet	Contractual Cash Flows	Less than 1 year	1-2 Years	3+ Years
Trade and Other Payables	5,818,683	5,818,683	5,818,683	-	-
Total Non-Derivative Liabilities	5,818,683	5,818,683	5,818,683	-	-

Notes to the Financial Statements
FOR THE YEAR ENDED 30 JUNE 2017

(c) Interest Rate Risk

Interest rate risk is the risk that the value of the Trust's assets and liabilities will fluctuate due to changes in market interest rates. The Trust is exposed to interest rate risk primarily through its cash balances and loans.

Variable Rate Instruments that are subject to interest rate risk.

	2017 $	2016 $
Cash and Cash Equivalents	3,038,003	2,036,987
Total	3,038,003	2,036,987

KPMG

Independent Auditor's Report

To the trustees of Midlands Regional Health Network Charitable Trust

Report on the financial statements

Opinion

In our opinion, the accompanying financial statements of Midlands Regional Health Network Charitable Trust (the trust) on pages 16 to 28:

i. present fairly in all material respects the trust's financial position as at 30 June 2017 and its financial performance and cash flows for the year ended on that date; and

ii. comply with Public Benefit Entity Standards (Not For Profit)

We have audited the accompanying financial statements which comprise:

— the statement of financial position as at 30 June 2017;

— the statements of comprehensive income and expenses, changes in equity and cash flows for the year then ended; and

— notes to the financial statements

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (New Zealand) ('ISAs (NZ)'). We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

We are independent of the trust in accordance with Professional and Ethical Standard 1 (Revised) Code of Ethics for Assurance Practitioners issued by the New Zealand Auditing and Assurance Standards Board and the International Ethics Standards Board for Accountants' Code of Ethics for Professional Accountants (IESBA Code), and we have fulfilled our other ethical responsibilities in accordance with these requirements and the IESBA Code.

Our responsibilities under ISAs (NZ) are further described in the auditor's responsibilities for the audit of the financial statements section of our report.

Other than in our capacity as auditor we have no relationship with, or interests in, the trust.

Use of this independent auditor's report

This report is made solely to the trustees as a body. Our audit work has been undertaken so that we might state to the trustees those matters we are required to state to them in the independent auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the trustees as a body for our audit work, this report, or any of the opinions we have formed.

KPMG

Responsibilities of the Trustees for the financial statements

The Trustees, on behalf of the trust, are responsible for:

— for the preparation and fair presentation of the financial statements in accordance with generally accepted accounting practice in New Zealand (being New Zealand Equivalents to International Financial Reporting Standards for Public Benefit Entities);

— implementing necessary internal control to enable the preparation of a set of financial statements that is fairly presented and free from material misstatement, whether due to fraud or error; and

— assessing the ability to continue as a going concern. This includes disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless they either intend to liquidate or to cease operations, or have no realistic alternative but to do so.

Auditor's responsibilities for the audit of the financial statements

Our objective is:

— to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error; and

— to issue an independent auditor's report that includes our opinion.

Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs NZ will always detect a material misstatement when it exists.

Misstatements can arise from fraud or error. They are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of these financial statements is located at the External Reporting Board (XRB) website at:

https://www.xrb.govt.nz/Site/Auditing_Assurance_Standards/Current_Standards/Page8.aspx.

This description forms part of our independent auditor's report.

KPMG.

Hamilton

7 December 2017

THE NETWORK

86 Practices, including **15** Health Care Homes

383 General practitioners

445 Practice nurses

87 Practice/ business managers

363 Administrators/ receptions/ primary care assistants

433,431 Enrolled service users

Tairāwhiti - 38,586

- **5** Practices
- **37** General practitioners
- **42** Practice nurses
- **6** Practice/business managers
- **28** Administrators/ receptionists/MCAs

Waikato - 246,650

- **47** Practices
- **230** General practitioners
- **246** Practice nurses
- **48** Practice/business managers
- **228** Administrators/ receptionists/MCAs

Lakes - 38,084

- **5** Practices
- **26** General practitioners
- **42** Practice nurses
- **5** Practice/business managers
- **126** Administrators/ receptionists/MCAs

Taranaki - 110,111

- **29** Practices
- **83** General practitioners
- **120** Practice nurses
- **20** Practice/business managers
- **60** Administrators/ receptionists/MCAs

1,136,000 **Consults to the primary care team (GP and nurses)** occurred in the year 1 July 2016 to 30 June 2017 – with an expected growth in demand of 2.5 per cent expected due to an ageing population

35% of our practices are rural

4,875 ESUs is the average practice size, with a range of <500 to >18,000

Midlands Regional Health Network Charitable Trust

Norris Ward McKinnon House
711 Victoria Street, PO Box 983,
Hamilton 3240, New Zealand

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