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MURRAY

An Australian Government Initiative

Report to the Community

December 2016

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Front Cover:
From left: Ageing well in the Murray PHN community; getting headspace in Swan Hill; playtime in Numurkah

Murray PHN acknowledges the traditional owners of the lands we work on and would like to pay our respects to their elders past and present and extend that respect to all Aboriginal people.

"We invest in primary care to improve the health outcomes in Murray PHN communities"

—

Contents

The Tooleybuc Bridge over the Murray River at Swan Hill

Our region

593,000+ total population

18.8% aged over 65 years

14,800+ Aboriginal and Torres Strait Islander population

5.29% projected population growth by 2021

12.9% are 5-14 years old

51% female

49% male

7,100+ babies born in 2015

Median age 43

710+ General Practitioners

47 hospitals

150+ Aged Care facilities

200+ General Practices

400+ Pharmacists

230+ Dentists

Patients aged 65+ account for 27-31% of GPs workload

9,200+ Nurses

400+ Specialists

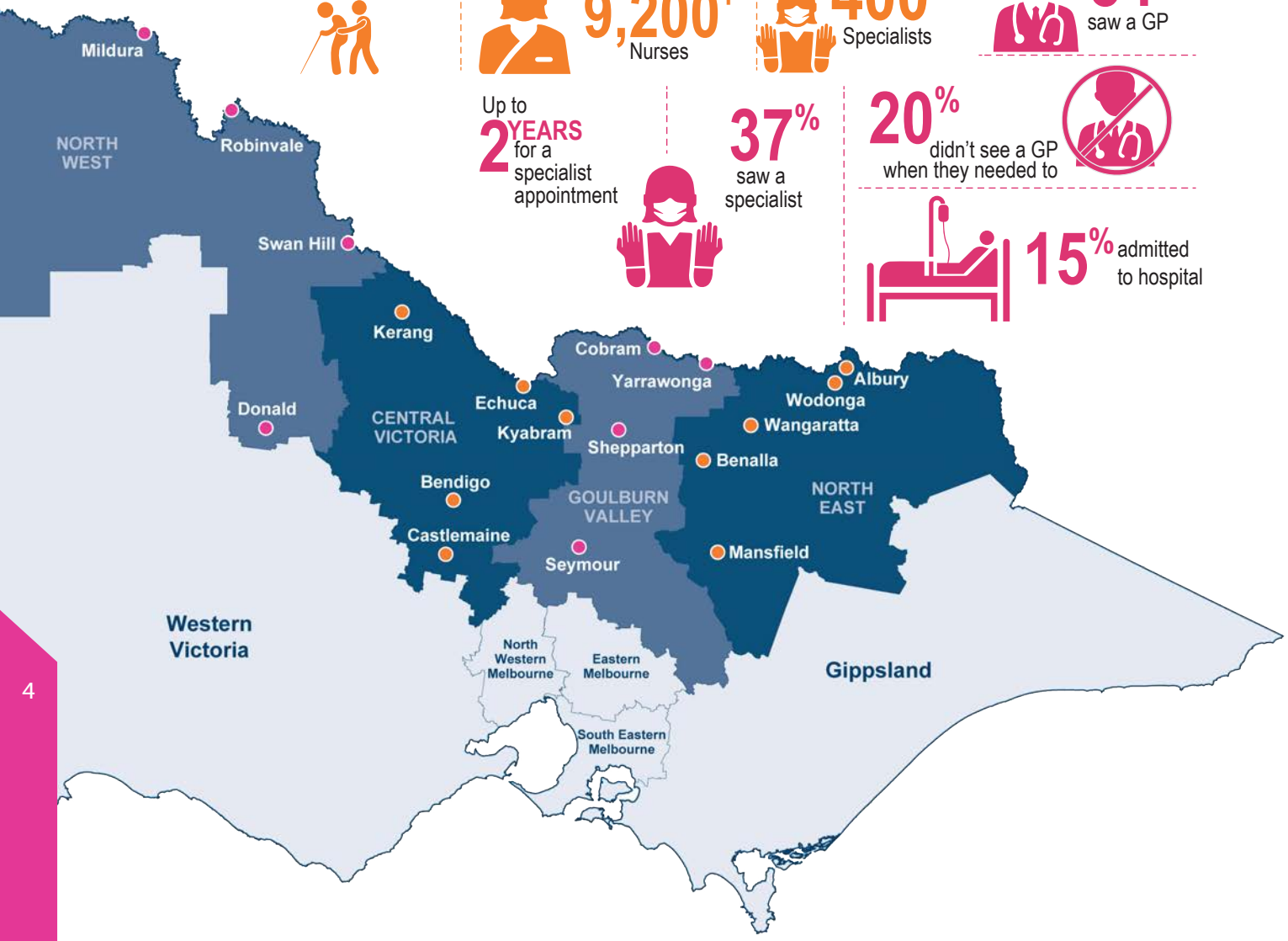
84% saw a GP

Up to 2 YEARS for a specialist appointment

37% saw a specialist

20% didn't see a GP when they needed to

15% admitted to hospital



About Murray PHN

Murray PHN (Primary Health Network) has been in operation since 1 July 2015. It operates from Mildura in the North West, to Woodend in the south, across to Seymour and up to Albury - an area of almost 100,000 square kilometres that is home to more than 560,000 people.

As one of six PHNs in Victoria and 31 established across Australia by the Federal Government, Murray PHN's role is to:

- increase the efficiency and effectiveness of medical services for patients; particularly those at risk of poor health outcomes, and;
- improve coordination of care to ensure patients receive the right care, in the right place, at the right time.

To service our catchment and its diverse population, Murray PHN has regional offices in Bendigo, Shepparton, Mildura and Albury, where we use local knowledge and local professionals to help optimise our primary care systems. In each of our regions, we have established both Clinical Advisory Councils and Community Advisory Councils to contribute to our strategic and operational planning.

Working in partnership with general practitioners, major hospitals, community leaders, health services and other health providers, Murray PHN will continue to focus on both national and local health priorities, with the welfare of the patient always front of mind.

National data and locally gathered evidence on the health of our population, continue to be the bedrock on which our work is based.

Murray PHN is not a health service provider. Our organisation has two major roles - improving the coordination of primary care services and the commissioning of effective, efficient and equitable health services. Both of these functions are based on health information systems that provide a clear understanding of the burden of disease that our communities face.

We have specific funding to be allocated for mental health services and for alcohol and other drug treatments. We also have the capacity to commission a range of locally indicated services through our Flexible Fund. Population health evidence and local intelligence enable us to understand where we can use the funding available to make the maximum impact on health outcomes.

Since July 2015, Murray PHN has developed a range of major initiatives, including the rollout of Murray HealthPathways for GPs, the establishment of our population health information hub, Murray Exchange, the workplace mental health initiative Stop Stigma, and a new commissioning framework for 2017 - all of which are detailed later in this Report. We have also maintained many activities previously managed by the Medicare Locals that preceded the establishment of Primary Health Networks.

This Report to the Community provides a snapshot of our work to date and an indication of our work in the year to come. We thank you for your ongoing interest in Murray PHN and invite you to stay abreast of our work in future at murrayphn.org.au

Murray PHN's Strategic Plan 2016-2018 and Needs Assessment can be found at: murrayphn.org.au/about/corporate-documents

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Statement from the Chair
Fabian Reid

With a lifelong understanding of regional Victoria, Fabian Reid began his professional career in education before moving into politics as an advisor in the 1980s. Mr Reid holds tertiary qualifications in agricultural science and education and has consulted to organisations including Haven, VicRoads and the City of Greater Bendigo.

Mr Reid is a director of Bendigo Access Employment and Chair of Bendigo Youth Coordination Group. He has served as chair of the Bendigo Regional Advisory Board for La Trobe University, Chair of the Goldfields Local Learning and Employment Network, a Director of the Golden Dragon Museum, and convenor of the Bendigo - A Thinking Community Reference Group.

The Federal Government established PHNs to ensure the effective coordination of care within our regions and to ensure the provision of the right care, at the right time and the right place. As a society we are requiring increasing levels of health care and our growing health needs continue to stretch the costs and demands on our health system.

In our rural and regional areas, we know that the health outcomes of our communities are disproportionately lower than areas of higher population density and that access to effective health services and skills are major issues.

We also know that our health system is inherently fragmented because it relies on individual health services and practitioners, funded by a mix of a collection of private or Commonwealth and State Government funding. Traditionally there has been limited capacity for organised and structured regional planning to address population health needs.

The challenge before us all at Murray PHN has been to establish and build an organisation with the capacity to improve primary care coordination in a health system servicing a population of more than 550,000 people, across 100,000 sq kms, and communities with great diversity of need and capacity. We have enjoyed a very successful beginning and initial period of operation and it is with great pleasure and pride that I welcome you to this first Murray PHN Report to the Community. This historic Report provides an overview of the dynamic period of time associated with our establishment and the initial work of our organisation.

As Chair of Murray PHN, I would like to thank my fellow Board Directors for their dedication and the high calibre strategic and governance support they have provided to our organisation over this dynamic and exciting period.

Our strong commitment to building relationships and engagement throughout our region has been intensified by the stakeholder and community events we have held prior to our Board meetings in Mildura, Robinvale, Shepparton, Wangaratta, Albury/Wodonga and Bendigo.

I would like to thank the communities and health providers in our region for their strong support, enthusiasm and willingness to be part of the Murray PHN journey. We look forward to building upon this strong platform of support to strengthen the responsiveness, accessibility, coordination and integration of our health system.

I would also like to thank our Chief Executive Officer Matt Jones for his hard work and leadership to build the organisational team, and the structures and systems to enable Murray PHN to develop such strong capability and presence in our region over this short time.

On behalf of our Board, I would also like to thank our dedicated staff for their tireless efforts and commitment to our organisation. It is evident in the way they undertake their work that they see and understand the value of the contribution this organisation can make to our communities and the health system.

I invite you to use this Report to our Community as an opportunity to understand and appreciate how we may work together to improve health outcomes in our region.

Statement from the CEO *Matt Jones*

The Board and staff of Murray PHN have enjoyed the rare opportunity of building the culture and capacity of an organisation with a very significant role in improving health outcomes in the communities in which we live and work. We shared the unique situation of having to establish and build an organisation with significant capability to build relationships and create capacity to coordinate primary care services across our large and diverse geographical catchment.

As part of this process, Murray PHN had to ensure the seamless transfer of valued heath service provision to our communities. We have continued arrangements administered by the previous Medicare Local program, while introducing and building a commissioning capability that will reshape and improve health care delivery in our region. For those that have been part of this journey it is an understatement to say this time has been a busy and dynamic period for our organisation.

Murray PHN does not deliver health services. We work with health providers and communities to identify opportunities to improve the coordination and integration of care in ways that are responsive to need and tailored to community and regional circumstance.

Our contribution is predicated on an ability to use engagement and data to provide evidence and knowledge to generate health service improvements - from service innovations, through to system reform across our region.

We have an important opportunity to strengthen the provision of health care to improve health outcomes. Our successful pursuit of this is dependent upon a coherent, co-ordinated approach, applied flexibly and with the appropriate adaptation to suit the diverse regional contexts across our catchment.

We have developed an organisational team and structure that has taken great strides in building the relationships and capacity to engage these various moving parts in a coordinated organised systemised approach to fulfilling our role. I would like to thank our Executive Directors, Penny Wilkinson, Jag Dhaliwal, Anne Somerville and Bruce Baehnisch for their outstanding efforts over this very exciting and challenging time. Our successful establishment is due to their leadership and management skills, and the dedication and efforts of their respective teams.

An early and major priority has been the establishment of four regional offices to enable the essential relationship building, engagement and delivery of our services and support to health providers and our communities. Murray PHN has offices and teams in Albury, Bendigo, Mildura, Shepparton and to enable engagement and planning in our Central Victoria, Goulburn Valley, North East Victoria and North West Victoria regions.

Matt Jones has a long and experienced rural health management career in primary health care, acute public health and Aboriginal health settings in Victoria, Queensland, Northern Territory and Western Australia. These experiences have shown Matt that the opportunities to improve health outcomes in regional areas lies in collaboration and effective community and provider engagement.

Matt Jones is the CEO of Murray PHN. Matt was previously the CEO of Loddon Mallee Murray Medicare Local and also CEO of two Divisions of General Practice.

As part of our executive structure, we recruited Regional Managers to oversee and manage the support and delivery of our contribution to their regions. I would like to thank David Kirby, Jan Radrekusa, Faye Hosie and Richard McClelland for very capable management and direction. I would also like to thank their respective teams, for the fantastic manner in which they represent our organisation with stakeholders and communities and embraced building our organisation's efforts in our regions. For many of them, this is their first experience of primary care coordination.

As part of our successful establishment and initial operational phase, Murray PHN has introduced our commissioning role and processes; established an advisory council structure to capture and incorporate regional and catchment-wide clinical and community input; implemented enablers such as Murray PHN HealthPathways; and produced the Murray Exchange to capture and share data. I would like to thank our Board for their support and direction over this period and particularly to Dr Talitha Barrett and Mr Fabian Reid for their personal support and guidance in their respective times as Murray PHN Chair. On behalf of our team and staff we look forward to extending our commitment and capability and achieving our shared objectives of improving health outcomes in our region.

Our Board

The constitution of Murray PHN – a company limited by guarantee – sets out the responsibilities of the Board and its Directors and provides authority to govern the organisation in order to achieve our vision and deliver on the Strategic Plan.

Dr Chris Atkins

GP and qualified lawyer Dr Chris Atkins is involved in all areas of health care including acute and emergency care, paediatrics, aged care and chronic disease management. He is a Director of the Brooke Street Medical Centre and a former chair of Kyneton Health.

Dr Talitha Barrett

Dr Tali Barrett is a private general practitioner and GP associate with the Eaglehawk Medical Group. With a strong commitment to community health and GP training, Dr Barrett does sessional GP work in indigenous health and at a local women's prison. She was Chair of Loddon Mallee Murray Medical Local.

Ms Leonie Burrows

Leonie Burrows is a management consultant and company director, with extensive experience in local government, regional development, agriculture, education and strategic planning. Former CEO of Mildura Rural City Council, Ms Burrows is also chair of Sunraysia Community Health Services and Sunraysia TAFE.

Mr Kevin Boote

Businessman and executive Kevin Boote is operations manager for a supermarket and hotel group in regional Victoria. Mr Boote has been a Director of Goulburn Valley Medicare Local and of Ambulance Victoria. He is Chair of Primary Care Connect in Shepparton.

Mr Victor Hamit

Lawyer and director of Wentworth Lawyers in Echuca and Melbourne, Victor Hamit practices in commercial and taxation matters.
Mr Hamit previously sat on the boards of SBS Community Board, Rural Ambulance Victoria and the Riverine Herald group.

Ms Sue Clarke

Starting her career as a nurse, consultant and company director Sue Clarke has held senior positions in health, government and community services for more than 35 years.
Ms Clarke is a Director of Bendigo Health Care Group and Chair of Haven; Home, Safe and Ambulance Victoria.

Professor Hal Swerissen

An expert on health policy and program development, Hal Swerissen has researched extensively in the design and development of primary health and community services.
Professor Swerissen is a research fellow at the Grattan Institute and emeritus professor of public health at La Trobe University.

Mr Ted Rayment

Ted Rayment had held CEO roles in major hospitals across Australia before being appointed as chief executive officer of Swan Hill District Health.
A former director of the Health Roundtable, Mr Rayment is on the board of Primary Care Partnership and is deputy chair of the Loddon Mallee Rural Health Alliance.

Ms Di Thomas

With 30 years' experience as a newspaper journalist, most recently as editor and deputy editor of The Border Mail, Albury-Wodonga, Di Thomas is the chairwoman of the Albury-Wodonga Regional Cancer Centre Trust Fund, and chairwoman of the headspace Albury Wodonga consortium.

Our Executive

Murray PHN executive team consists of a Chief Executive Officer, Matt Jones, four Executive Directors and four Regional Managers, who all have a strong commitment to the health sector and improving health outcomes for our communities.

Mr Bruce Baehnisch
Executive Director Corporate Services

Bruce Baehnisch has held senior positions in the tertiary education sector and brings vast experience in organisational development, change management, finance, human resources, communications, capital works, and quality and risk management.

Mr Jag Dhaliwal
Executive Director Primary Health Services

Jag Dhaliwal has worked in the health industry since 1997, starting as a podiatrist in the United Kingdom. He has international experience in program and service development, health service management, community engagement and business management.

Ms Anne Somerville
Executive Director Systems and Innovation Development

Anne Somerville has experience in the health sector with overseas aid organisations, youth services, women's and community health and family welfare services. She has worked with both State and Federal Government and her governance work includes board memberships across the health and VET sectors.

Ms Penny Wilkinson
Executive Director Health Integration and Engagement

Penny Wilkinson has worked in both the private and public sectors shaping the development of civic spaces and has consulted for local and state governments. Penny is Chair of the Community Foundation for Central Victoria.

Ms Faye Hosie
Goulburn Valley Regional Manager

Faye Hosie has 25 years' experience in Goulburn Valley providing leadership within a variety of public and private health care organisations and holds a Masters of Rural Health (Research).

Mr David Kirby
North West Regional Manager

David Kirby is a Registered Nurse with postgraduate qualifications in management and mental health and over 20 years' experience working in healthcare in rural and metropolitan Australia.

Mr Richard McClelland
North East Regional Manager

Richard McClelland has over 20 years' operational and strategic experience at senior management and executive level, including at Murrumbidgee Local Health District.

Ms Janice Radrekusa
Central Victoria Regional Manager

Janice Radrekusa has 30 years' experience in the health sector, spending the last 16 years in management at Bendigo Health in a variety of roles across inpatient, outpatient and community care.

Key Priorities

One of the first major activities undertaken by Murray PHN was a detailed localised health needs assessment for our region, focussing on people most at risk of poor health outcomes and applying a local lens to our six national health priority areas – mental health, Aboriginal and Torres Strait Islander health, aged care, population health, health workforce and eHealth.

Our needs assessment showed us we needed accurate and up-to-date health and demographic data, that we needed to map capability and support primary care services across our region. It also confirmed our appreciation that successful engagement would be achieved with localised capability based in regional offices supported but not delivered by a central office.

Our knowledge management and engagement system and processes are now in place. Our primary care workforce and quality improvement programs are being rolled out through our network of clinical advisors, regional managers, primary care coordinators, workforce development officers, clinical editors and other health executives. Our staff are committed to helping deliver a more accessible, affordable, patient-centred health care system.

By working closely and collaboratively with clinicians, health providers, hospitals, health services and consumers, we can identify and implement better ways to coordinate care, particularly for people at risk of poor health outcomes.

The PHN Needs Analysis, helps us set priorities, allocate appropriate resources coordinate and commission primary care activities and monitor performance to deliver improved health outcomes in our area.

We also look to help community members in our region achieve better health outcomes through appropriate primary care prevention activities. Cancer screening rates, child immunisation rates, mental health treatment rates and potentially preventable hospital admissions are all areas that we use to measure our performance to influence effective improvements.

The Murray PHN region performs comparatively well and on target with cancer screening and with child immunisation. But there is still great deal of work to be done to reduce avoidable hospital admissions and improve mental health treatment and outcomes.

Potentially Preventable Hospitalisations

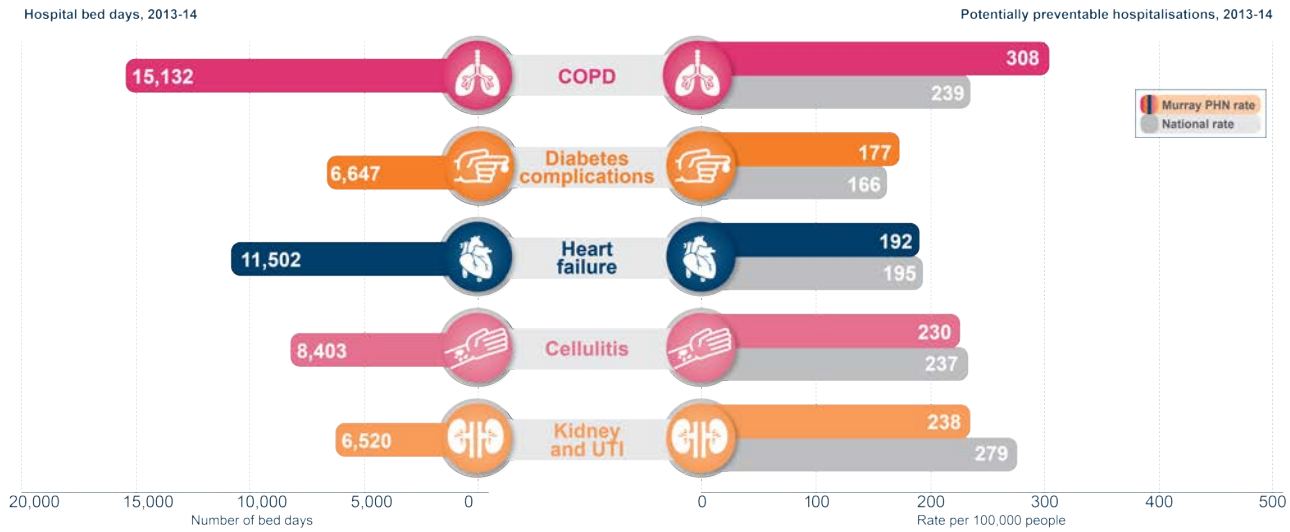
The Australian Institute of Health and Welfare (AIHW) estimates there are almost 71,500 potentially preventable hospital bed days each year in the Murray PHN area alone.

Every day, around 244 people are admitted to hospitals in the Murray PHN region – almost 89,000 per year, which is above the national average. Of those, an estimated 16,787 people are hospitalised for acute or chronic issues that may have responded to earlier treatment, or have been prevented completely, before they were severe enough to require hospitalisation.

Each year, more than 5,100 people in our community are hospitalised overnight or longer for mental health issues, including 550 hospitalisations caused by alcohol and drug use. Disturbingly, AIHW estimates there are as many as 692 potentially avoidable deaths in our region each year.

Even when they are necessary, hospital stays can be distressing and disruptive for patients and their families. With targeted and locally tailored primary care services, many people may be able to receive timely and effective early care that could help them avoid an unnecessary hospitalisation.

Since July 2015, Murray PHN has expanded on the work of Medicare Locals by fostering local clinical networks, developing strategic partnerships across the region, engaging consumers and clinicians and using technology and knowledge management systems to work towards innovation and a better primary care system.

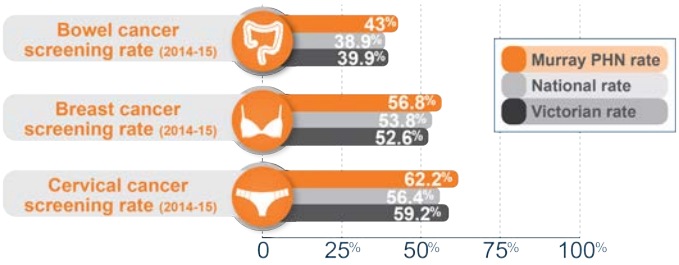


Cancer survival

Cancer screening is an important way to identify the early onset of many cancers and we are pleased that screening rates in the Murray PHN region are close to, or above the Australian average. But we know that Victorians living in regional and remote locations have a lower cancer survival rate than those in urban areas, so early detection and pathways to effective treatment and survivorship are vital.

Cancer screening data released earlier this year by the Australian Institute of Health and Welfare (AIHW), has the Murray PHN region ranked in the top 10 for bowel, breast and cervical cancer screening rates out of the 31 PHN areas across Australia.

Murray PHN's role is to work closely with clinicians and communities to improve the access to, and coordination of health services, like cancer screening, to support better outcomes. Local GPs are key to understanding a patient's risk of cancer and discussing the screening options available to them.



Protecting children

Childhood immunisation rates for five year olds across our region are 93%, but we need targeted interventions to tackle specific populations below the 90% needed to ensure community safety. Our focus is on high risk groups - over 65s, Aboriginal and Torres Strait Islander people, pregnant women; chronic disease sufferers; hospital and child care staff and geographically centred pockets of community resistance to immunisation.

Aboriginal and Torres Strait Islander health

Aboriginal and Torres Strait Islander people still experience much lower life expectancy rates, acute levels of sickness and poorer access to appropriate medical care than most non-indigenous Australians.

Murray PHN works to support increased access to primary health services for Aboriginal and Torres Strait Islander people with chronic disease, in partnership with Aboriginal Community Controlled Health Organisations (ACCHOs).

We have made the pledge to Close the Gap in indigenous disadvantage by fostering genuine long-term partnerships between our community, local agencies and services, governments and Aboriginal and Torres Strait Islander people.

Ageing population

While over 65s make up an average 14.8% of the Victorian population, regional areas experience proportionately higher numbers of aged residents, as young people gravitate towards metropolitan and regional cities. In our region, we also possess areas with distinctly lower socio-economic indices and as a mark of relative disadvantage, more than 76% of our over 65 residents receive the aged care pension.

Mental health

By July 2017, Murray PHN will be ready to commission new or redesigned models of care, allowing improved access to a range of mental health care services and to adapt service delivery systems to better respond to identified needs and appropriate care pathways.

As part of the commissioning strategy, Murray PHN will lead a range of system improvement and development activities to strengthen system readiness to embed positive change in models of care. Murray PHN has committed to adding real value to the funds we distribute in the healthcare system by placing the patient experience at the heart of integrated and coordinated care.

Medical Advisors

Our Medical Advisors ensure that the needs of general practice across the region are identified and addressed. We have a Medical Advisor overseeing the requirements of the entire Murray PHN area, and one located in each regional office.

Dr Ewa Piejko
Murray PHN and Central Victoria
Regional Medical Advisor

Dr Susan Furphy
Goulburn Valley
Regional Medical Advisor

Dr Wendy Connor
North East
Regional Medical Advisor

Dr Philip Webster
North West
Regional Medical Advisor

The case for change

When primary care is needed, especially when a patient may have multiple and enduring health and social care needs, the knowledge and confidence needed to coordinate the care on offer can be as complex as the needs of the person.

Despite many years of policy directions and program efforts, patient and consumer experience of our primary care service system is that it continues to be fragmented, confusing and at times, inaccessible.

In 2013–14, health spending in Australia was estimated at $155 billion, with more than two thirds being provided by Federal, State and territory Governments. The governance, coordination and regulation of Australia's health services are the joint responsibilities of all levels of government. The planning and delivery of services is shared between the government (public) and non-government (private) sectors. This complexity of funding and service provision has created a fragmented system, as shown in the AIHW funding diagram (right).

We know that the systemic barriers and shortfalls often have an even greater negative impact for the most vulnerable in our communities.

The primary care system needs to fundamentally adjust its capability to provide for the needs of individuals, groups or communities who experience even poorer health outcomes, often as a result of system inadequacies.

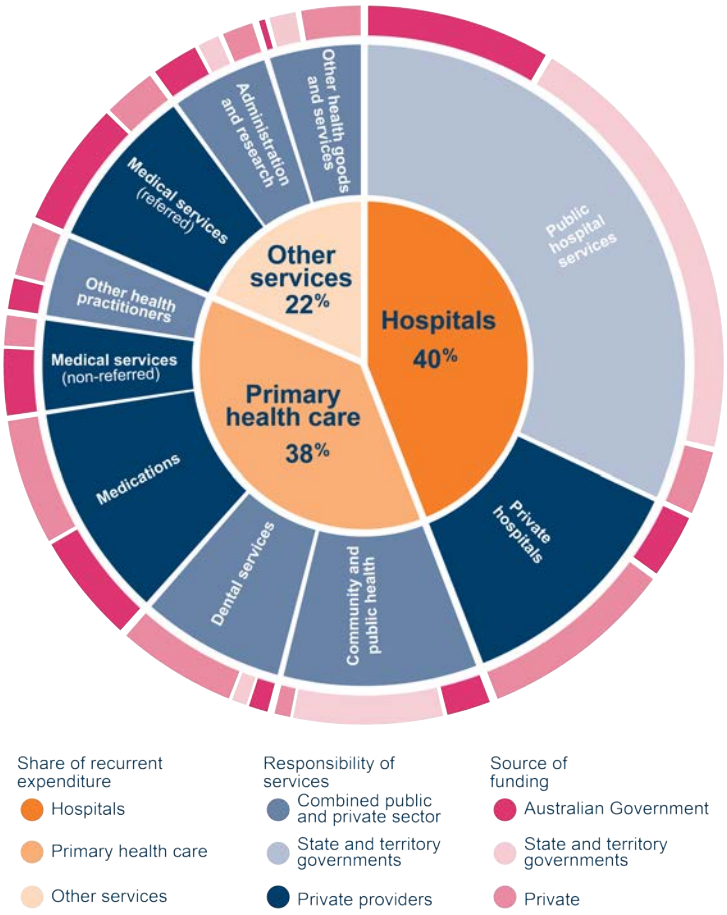
Murray PHN's strategic plan outlines three key goals to focus its intentions:

- ensure that the coordination of care is targeted and tailored to our communities and that innovation and engagement are core to our efforts;
- address national priority areas as well as explore emerging health and healthcare issues with our communities, and work with service providers pursuing opportunities based on evidence and expertise; and
- strengthen our organisational capability so that we are responsive, accountable and productive with what we know, in what we provide, and in how it contributes to improved health outcomes

To meet the challenge to reform at this level, Murray PHN is working to tackle health inequities in the areas of greatest need; to optimise system reforms; and to monitor improvement in health outcomes for whole populations.

Service system reform will need strong, collaborative and well informed partnerships, so Murray PHN cannot do this alone.

Through innovative partnerships, we can enter into new provider arrangements that are effective, efficient and equitable. We can construct new and collaborative models of care that involve consumers and patients from the beginning, rather than focusing on them at the end point in care. Our monitoring and evaluation activities will help us to understand how and when improvements in health outcomes are occurring across our region. The importance placed on this level of partnership cannot be overstated. Murray PHN has established both Clinical and Community Advisory Councils in each of its four regions - Central Victoria, Goulburn Valley, North East Victoria and North West Victoria.



There are a total of 62 newly appointed advisory council members who bring with them an enormous array of skills, diverse areas of knowledge and expertise and most importantly, the experience of living in our communities.

Our eight advisory councils are an effective example of our commitment to co-designing and localising solutions wherever possible. We will use a population health-based dialogue to prepare for changing the service system to better respond to the national health priorities and to the needs of our communities.

We will measure our success when we have feedback from people about purposeful engagement and activity that includes both clinical and community perspectives and speaks to the benefits from improved service responses, better access that suits local community needs, and a positive sense about real change.

The personal impact

Mother of three, Michelle lives 75km from the nearest town with specialist primary care services. Her three school-aged children have a range of health issues - her 13 year old daughter recently broke her leg playing netball; her nine year old son struggles with a significant developmental delay and her six year old daughter suffers with asthma. Michelle's elderly father lives nearby, but is in poor health with emphysema after a lifetime of smoking. He needs to visit his doctor regularly and takes part in a respiratory clinic each week.

A single parent, Michelle works part-time for a local agricultural supplier who would have her full time if her family responsibilities permitted. But in any given week, Michelle must get her family to four or more GP, hospital or allied health appointments, while maintaining her own work schedule and ensuring the children don't miss any more school. She has already been asked to see the school about the number of times her two youngest have been out of class.

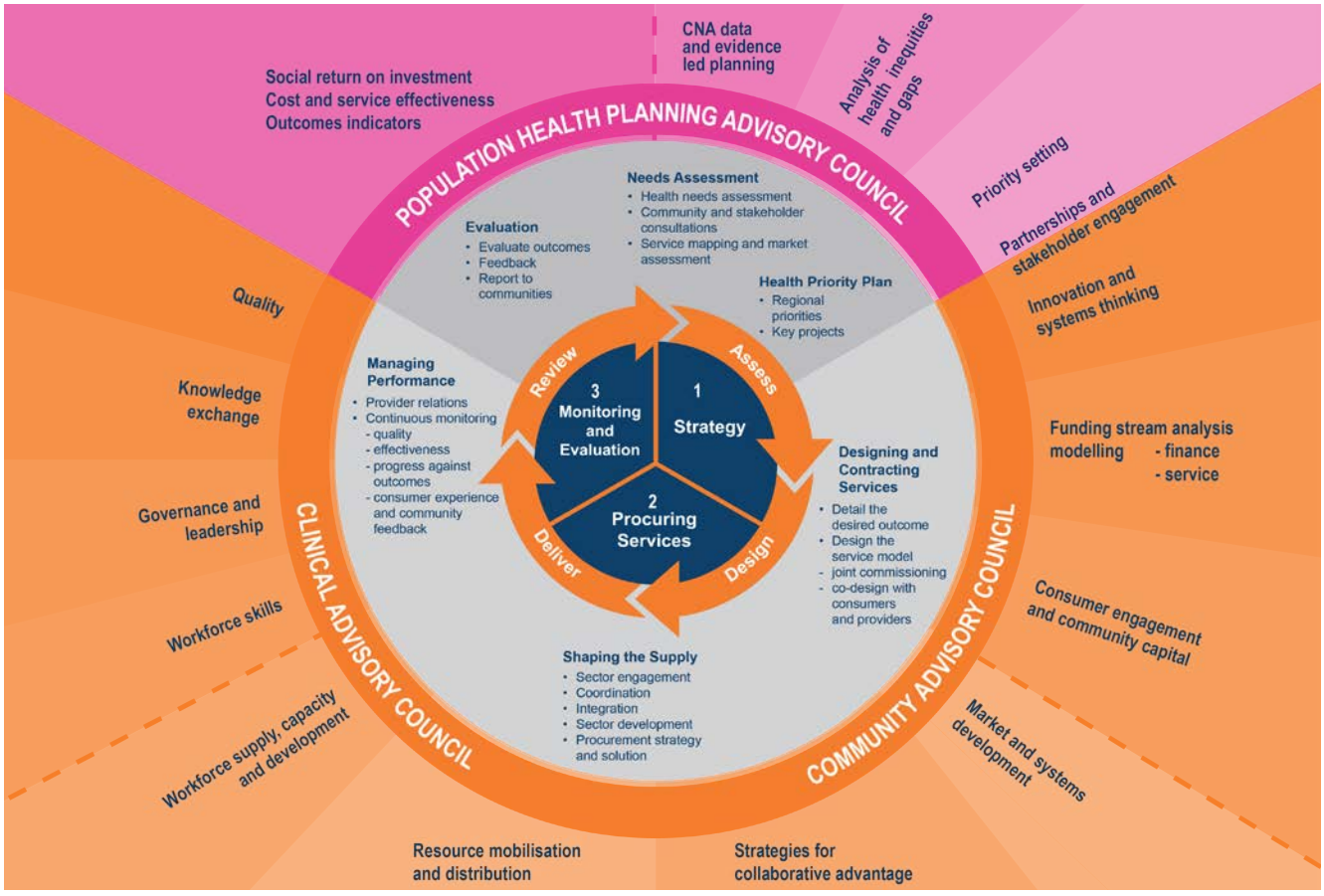
Even worse, without a full-time job, Michelle can't afford to run a car, so the family has to get to appointments by bus - much more challenging with one daughter in a plaster cast and a grandfather who struggles to walk any distance. She is also overdue for a regular mammogram and pap smear test, but she hasn't been able to find the time for herself. Neither can she find the referral the GP gave her for the visiting educational psychologist who will be able to help her son. This is all making Michelle stressed and anxious.

In a truly patient-centred primary care system, Michelle could have the capacity to coordinate appointments more effectively across her children and her father's health needs. There would be a greater focus on services that would be available out of school or business hours, and services that could visit the family home.

As a medical "frequent flier", her GP practice might arrange a care coordinator or practice nurse to help Michelle juggle her family's health issues, and her own preventative screening tests. The children's schools can also help, by giving her eldest child access to the school GP or school nurse, or allowing an asthma nurse to treat her younger daughter, all during school hours.

Technology will play a major role. Many hospital clinicians and medical specialists could offer telehealth consultations to rural and regional families, in their home, or from the family doctor's office. The effective use by Michelle and her GP of the My Health Record system would mean Michelle would not have to explain the problems time and again. eReferral systems would mean a quicker, more accurate and more effective system for everyone involved.

If Michelle can get her family's health needs under control, she will be able to work the hours that she needs to support her family, and to avoid her stress and anxiety turning into a more serious mental health issue.



Commissioning is a major policy shift in thinking about how to build collaborative service systems in primary care. Our commissioning thinking is based on the best available population health evidence, backed by data, market understanding and community inputs. We know that significant change will happen when we focus simultaneously on the patient experience, service system capabilities and vulnerable populations in communities of greatest need.

Population health

2016 Bendigo Bank Fun Run
AJ Taylor Images

Population health is an approach that aims to improve the health of communities and to reduce health inequities.

There are significant differences in health and life expectancy between populations within countries and between communities, often based on socio-economic status. In population health, outcomes are measured at the level of populations by life expectancy, maternal and infant mortality rates, death rates from various conditions and diseases and the burden of different conditions and diseases.

Population health takes into account the social determinants of health – the social, economic and political conditions that impact on good health, ill health, or disease. People who do not have access to healthy food, to social supports or education are more likely to experience ill health than those who do. A person's early life, their gender, their employment or their culture can also impact on their health outcomes.

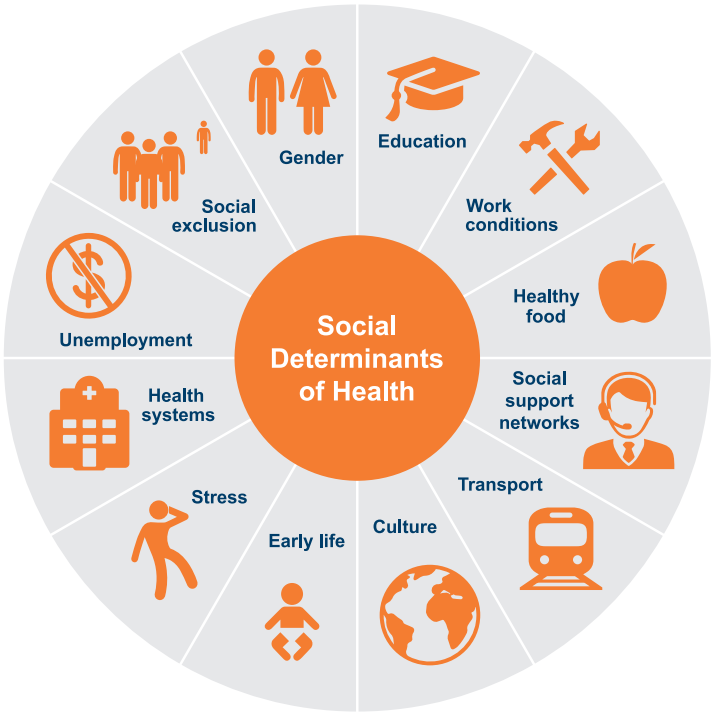
Primary care is an episode of care for diagnosis, treatment of illness, disease management or individualised prevention such as immunisation. When prevention is scaled up to whole populations (e.g. all children) or sub-populations (e.g. screening all adults over 55 years) it is a population health approach.

A core aspect of population health is comprehensive needs assessment and analysis, with a focus on identification of health inequities, taking account of social conditions and circumstances, such as disability, that cause poor health.

Population health interventions aim to reduce those health inequities using population level indicators (rather than at the level of individuals) to measure change and demonstrate effectiveness.

Population health can be seen as the bridge between primary care and improved outcomes for particular population sub-groups, communities and whole populations.

Murray PHN is committed to using population health data as the bedrock of its work in coordinating quality improvements to general practice and in commissioning new health services to meet the evidenced needs of local communities.



Murray Exchange

To build knowledge, we have developed Murray Exchange, an enterprise-wide initiative that drives effectiveness and efficiencies through service mapping; research, evaluation and analytics; and market analysis. Murray Exchange is the platform on which population health information is gathered. It will include our interactive online population health knowledge system and our soon-to-launch population health planning network. Over time, it will refer to our ongoing community conversations, as key stakeholders and partners across our catchment add to the information on the Exchange.

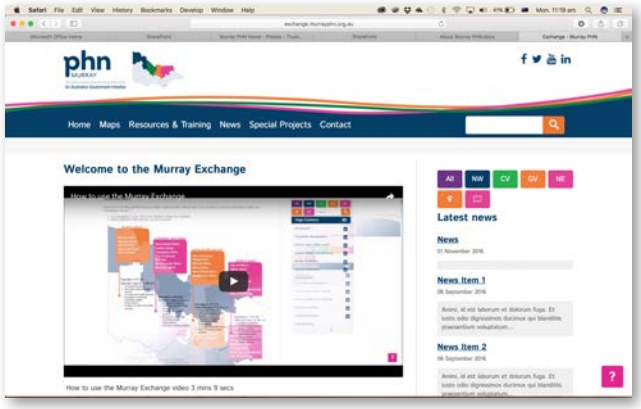
Exchange provides a central repository for health evidence and knowledge for our catchment, with three main types of information:

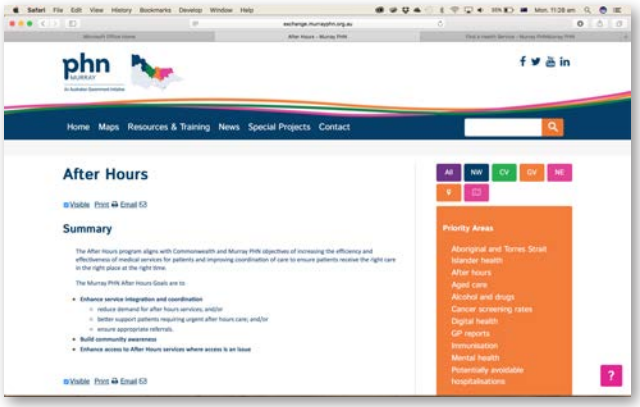
1. The Market – detailed mapping of public, private and not for profit service providers - including non-health sector services that support the social model of health.
2. The Community – people living in the community who use the services.
3. The Data – information gathered by government and peak bodies relating to demographics, service use and disease incidence.

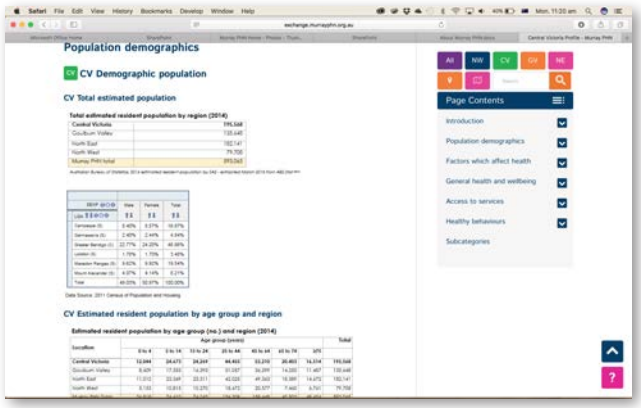
It is important to note that the Murray Exchange is not a data warehouse. The system regularly uploads data, from validated sources and publishes it in a way that is useful for our planning and strategic thinking.

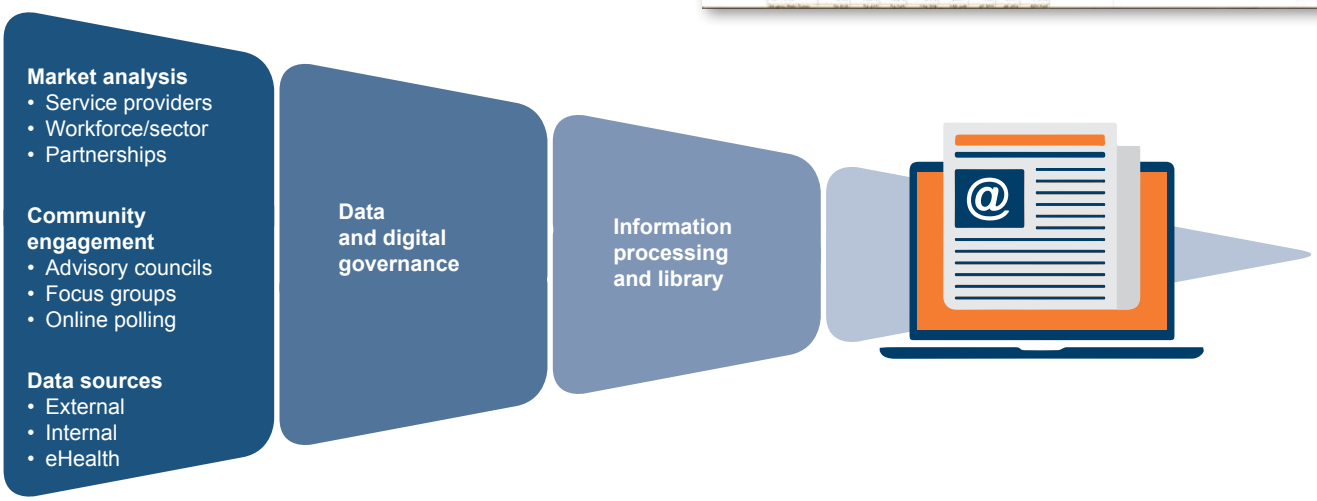
As the general health of our population grows, the community expectations and financial impact of delivering good health grow with it. Finite budgets and an ageing population mean that health funding needs to be strategic, measured and accountable.

Murray Exchange is an accessible tool to help us determine the best allocation of funding through evidence-based needs analysis.









Community engagement

More than 60 members of the Central and Northern Victorian community have been appointed to eight regional Advisory Councils that will help shape the health system needs of the Murray PHN region.

Based in Albury, Bendigo, Mildura and Shepparton, four Community Advisory Councils and four Clinical Advisory Councils will provide local knowledge on health priorities and gaps in service, guided by clinical, consumer, carer and community views.

Central Victoria Community Advisory Council Members

Clare Fountain
Chair, Bendigo

Kate Coleman
Kyneton

Wayne McKay
Heathcote

Paula Murray
Bendigo

Catherine Pearson
Echuca

Vicki Poxon
Boort

Ric Raftis
Wedderburn

Clinical Advisory Council Members

Jan Sheringham
Chair, Strathdale
General Practitioner

Richard Bills
Woodend
General Practitioner

Cameron Cail
Kennington
Nurse

Kathryn Cunning
Bendigo North
Nurse

Marcus Gardner
Bendigo
Podiatrist

Glenn Howlett
Echuca
Director of Medical Services

Toni Riley
Strathfieldsaye
Pharmacist

Mark Savage
Bendigo
Director of Medicine and Clinical Dean

Robin Tchernomoroff
Strathdale
Nurse

Goulburn Valley Community Advisory Council Members

Natalie Wischer
Chair, Yea

Bronwyn Allen
Seymour

Jessica Crawley
Kialla

Joanne Kinder
Shepparton

Kerry Murray
Strathmerton

Menon Parameswaran
Shepparton

Kate Wright
Cobram

Clinical Advisory Council Members

Robert Campbell
Chair, Shepparton
General Practitioner

Annette Cudmore
Grahamvale
Nurse

Vasudha Iyengar
Shepparton
Chief Medical Officer

Stephanie Kennedy
Yarrawonga
Physiotherapist

Raju Lakshmana
Shepparton
Psychiatrist

Rebecca Murphy
Seymour
Assistant Executive Officer and Population Health Planner

Lynnette Patullock
Tatura
Clinical Service Specialist

Lawrence Tay
Kyabram
GP/Anaesthetist

North East Victoria Community Advisory Council Members

Emma Ghys
Chair, Wodonga

Fred Ford
Wodonga

Carmel Hicks
Lavington, NSW

Michael Leonhard
Corryong

David Noonan
Baranduda

Jacqueline Smith
Wangaratta

Clinical Advisory Council Members

Greg Gladman
Chair, Wodonga
GP/Obstetrician

Matt Byrne
Wangaratta
General Practitioner

Jade Cartwright
Myrtleford
Nurse

Gary Croton
Beechworth
Nurse

John Elcock
Wangaratta
Director of Medical Services

Angela Lawrence
Rutherglen
Pharmacist

Ruth Mulligan
Wangaratta
Allied Health

Rebecca Piazza
Albury
Physiotherapist

Anu Tillekeratne
Wodonga
General Practitioner

North West Victoria Community Advisory Council Members

Allison McTaggart
Chair, Mildura

Cheryl Barnes
Mildura

Courtney Biggs
Mildura

Andrew John (Jack) Forbes
Irymple

Michelle Malycha
Mildura

Norsiya Mokak
Merbein

Sharon Smith
Irymple

Clinical Advisory Council Members

John Buckley
Chair, Merbein
General Practitioner

Anthony Albert
Mildura
Pharmacist

Tom Callaly
Mildura
Clinical Director

Linda Henderson
Mildura
Allied Health

Renee Kelly
Mildura
Occupational Therapist

Brett McKinnon
Mildura
Manager

Lisa Taggert
Robinvale
Manager Primary Care

Alison Walker
Mildura
Director of Medical Services

Fiona Wright
Mildura
General Practitioner

Coordination

VPHNA member CEOs: Acting Professor Christopher Carter (North Western Melbourne PHN), Jason Trethowan (Western Victoria PHN), Dr Elizabeth Deveny (South Eastern Melbourne PHN) Robin Whyte (Eastern Melbourne PHN), Matt Jones (Murray PHN) and Marianne Shearer (Gippsland PHN)

Collaborating across Victoria

Murray PHN is one of six members of the Victorian Primary Health Network Alliance (VPHNA). Through this collaborative Alliance, Murray PHN is involved in two statewide projects funded by the Victorian Government:

1. Optimal Care Pathways (OCPs) in primary care for lung and colorectal cancer

Taking a patient centered approach, the six PHNs are partnering with the Integrated Cancer Services to improve cancer screening, early detection and diagnosis, referral pathways and care coordination between primary and acute care providers. Murray PHN is working with the Hume Region Integrated Cancer Service (Hume RICS) and Loddon Mallee Integrated Cancer Service (LMICS) to target local priorities.

2. Supporting accelerated uptake of new hepatitis C drug treatments in primary care

More than 230,000 Australians and 74,200 Victorians currently live with hepatitis C. In March 2016, new medicines were listed on the Pharmaceutical Benefits Scheme (PBS) to treat hepatitis C. General practitioners can now, in consultation with a specialist, prescribe these medicines. The six PHNs in Victoria are working together to increase the uptake of these new medicines within primary care by developing localised clinical pathways, professional interest groups and delivering education and training.

My Health Record

My Health Record

A guiding principle of Murray PHN is that primary health care should always be patient centred. The patient-controlled My Health Record system, launched by the Australian Government early in 2016, is a key plank in our quality improvement platform.

My Health Record securely records a person's important health information such as allergies, current conditions and diagnostics, in one place. This means that in an emergency situation (or when you need health care out-of-town or interstate) a clinician can easily see these details online. It also means that patient information lives with the patient, not just with his or her doctor.

Murray PHN supports GPs in our region to use My Health Record by providing training for general practice teams on the My Health Record system, quality improvement activities in general practice, and information and guidance for informed decision-making on digital health technologies such as telehealth and My Health Record.

In addition, our workforce development officers have held more than 120 Continuing Professional Development (CPD) seminars, webinars or workshops for GPs and practice nurses and managers across all four Murray PHN regions.

Quality Improvement in General Practice

A significant part of the work of Murray PHN is to help coordinate quality patient care and improved health outcomes at a local and regional level.

We do this by supporting primary health practices, specifically through:

- technology and data quality support (CAT Plus, CAT 4, TopBar)
- diagnostic and referral support (HealthPathways) professional development (seminars, webinars and workshops)
- clinical audit activities and/or peer reviews

Our Quality Data Program encourages GPs to maintain up-to-date and accurate patient data in their clinical information systems. The understanding of patient demographics, risk factors and care activities marks a significant technological change in GP practice.

This means that general practices have patient information available to them in a way that makes it easier to identify factors that can risk patient health – to keep people well and out of hospital.

With the right tools, GP practices can use data to determine, for example, how many patients they have with respiratory or heart disease, whether the average age of their practice is changing and to check the level of chronic conditions like diabetes and arthritis.

Data analysis can help them make the decision to offer specialist care within the practice, like physiotherapy, psychology or dietetics, on a regular or permanent basis. CAT Plus, a planning and reporting platform for primary health care, allows doctors to generate specific reports, detailed statistics and health indicators.

Murray PHN has partnered with Pen CS to provide CAT Plus free of charge to general practices in our region and we are delighted that almost half of all practices in our region have taken this up.

CAT Plus

The technology suite includes CAT 4, a new generation clinical audit tool that works with other GP clinical information systems; Topbar, a real-time decision support tool for GPs, and PAT CAT, a population health tool.

Importantly, more than 80% of our CAT Plus users are sharing de-identified practice data with Murray PHN through PAT CAT, allowing us to better understand health needs and priorities at a population health level. This helps us determine how we can best fund and support health services so that we match local needs.

"The Tristar Medical Group have worked closely with Pen CS and Murray PHN to enhance capabilities in data collection. We look forward to being an innovative and driving force in technological advancements that enable access to de-identified health data that promotes ongoing improvements in health care service delivery."

Tristar Medical Group

Tristar, one of the largest corporate GP practices in Australia, and Murray PHN have signed a CAT Plus end user licence agreement to share de-identified data from all Tristar practices in our region. Pictured are: Murray PHN's Brendan McGarry with Kim Harlock and Dewald Botha from Tristar.

Murray HealthPathways

A pathway to better health outcomes

One of our major activities for 2016 has been the launch of Murray HealthPathways, a free, web-based information portal supporting primary care clinicians at the point of patient care. Aimed predominantly at GPs, HealthPathways is also available to nurses, allied health professionals and hospital specialists who treat or refer patients within the Murray PHN area.

HealthPathways stores extensive, updated health information and referral pathways that help to coordinate better access to primary health, closer to people's homes in Central and Northern Victoria.

By improving the standards of care and minimising variations in treatment, HealthPathways will also help reduce unnecessary hospital visits – estimated at more than 71,000 bed days each year across the Murray PHN region.

It provides best practice models of patient care for the diagnosis and treatment of a range of both common and complex conditions. Among the first Murray HealthPathways to be localised are cardiovascular disease, chronic kidney disease, infectious diseases, older persons' health, care provision for Aboriginal and Torres Strait Islander people and child health, which intersect with our national priority areas.

At launch, more than 50 local pathways had been developed in partnership with regional hospitals, GPs, community health services, allied health professionals and specialists and all based on population health and local needs. Major hospital partners include Albury Wodonga Health, Bendigo Health Care Group, Goulburn Valley Health, Mildura Base Hospital, and Northeast Health Wangaratta.

The Murray HealthPathways team has consulted widely, touching base with 1,300 people in GP practices and health services and at professional development events across our catchment.

Murray PHN CEO Matt Jones at the launch of Murray HealthPathways in November 2016.

More than 70 health professionals have now taken part in nine clinical working groups, with in excess of 80 new pathways already in the pipeline at the time of this Report. Our Clinical Editors, based in each of our four regions, will continue to collaborate to localise an estimated 900 clinical and resource pathways, with local clinicians being encouraged to suggest new pathways or feedback for our regular reviews.

HealthPathways, which is operating successfully in other parts of Australia and New Zealand, is part of our General Practice Quality Improvement Program.

HealthPathways is:

- *a resource for quality clinical information*
- *an avenue for local referral pathways*
- *a process that wraps the system around the patient*
- *a platform for collaboration*

Murray HealthPathways Clinical Editors

Dr Ann-Marie McKinnon
Central Victoria

Dr Elspeth Harrison
Central Victoria

Dr Margi Gould
Goulburn Valley

Dr Christie Rodda
North East Victoria

Dr Jane Neyland
North West Victoria

Dr Fiona Wright
North West Victoria

Murray HealthPathways staff Jan Lang, Sue Elias and Chris Fishley

Murray PHN Medical Advisor Ewa Piejko

Dr Rob Grenfell, Health Director of CSIRO's Health and Biosecurity Business Unit

Commissioning

Since establishment in July 2015, primary health networks around Australia have transitioned to work under a commissioning model.

The introduction of commissioning marks a significant shift to the way resources are allocated and an approach that seeks to drive improvements in efficiency and effectiveness of primary health care services.

Through commissioning, priorities and decisions in funding are informed by regional planning and regional input. In a system with finite funds, commissioning drives a greater focus on investing for population health outcomes, improved service coordination, system integration and ultimately, value for money.

Population health based commissioning shifts the focus from purchasing services and funding them on the basis of usage, to the design of models of patient care that aim to deliver improved health outcomes and may involve a mix of interventions from a range of appropriate providers.

The Australian Department of Health describes commissioning as "a continual and interative cycle involving the development and implementation of services based on planning, procurement, monitoring and evaluation".

Three broad elements of the commissioning process are:

1. Strategic planning

- analysing population health needs
- setting priorities and
- determining desired outcomes

2. Procuring services

- designing and contracting services
- identifying opportunities for collaboration and partnerships to strengthen the service system response
- encouraging greater coordination and integration within the health system

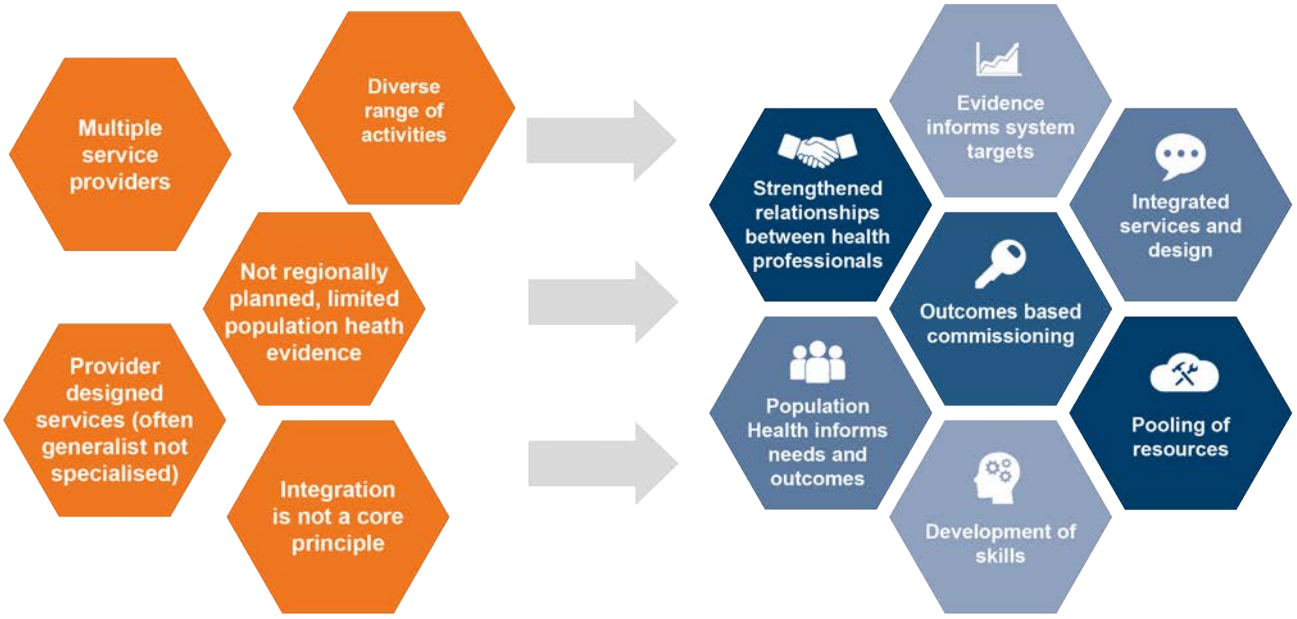
3. Monitoring and evaluation

- monitoring providers' performance
- evaluating the impact of commissioned services

An important enabler for successful commissioning is input from users of services, service providers and other stakeholders. Murray PHN has invested in eight regionally based community and clinical advisory councils, which will provide a formal mechanism to support insights to health needs, and help match local health services to the primary health care needs of our communities.

The shift to needs-based, evidence-led commissioning will result in changes to services that have previously been funded to enable targeting of resources against priority health needs. We will ensure that our work with service providers will be governed by high standards of probity and transparency in decision making and our approach to working with service providers will demonstrate shared accountability.

Murray PHN has specific responsibilities for commissioning in the areas of Mental Health, Suicide Prevention and Alcohol and Other Drugs. Commissioning of new services in these areas will be based on evidence of regional need and context to develop a stepped care approach. We will commission with the aim of ensuring that the needs of individuals are matched to the most appropriate type of care, across a continuum of primary mental health services.



Moving towards a more coordinated, integrated, health care system.

Guiding Principles

1. We will develop models of care that are informed by evidence, responsive to need and community context and demonstrate progress towards improved health outcomes
2. We will ensure that consumers, carers and their families, communities and service providers are enabled to participate in service design and delivery of models of care
3. We recognise that primary care exists within the broader health service system
4. We will build enduring partnerships that will invest and share accountability with us for innovation, quality and systems improvement
5. We will strengthen the primary care service system to gain greater service coordination and system integration
6. We will strengthen capacity and capability of service providers to meet new and emerging market demands
7. We will embed effective evaluation to improve models of care and build our commissioning knowledge and skills
8. We will ensure decisions about resource mobilisation and distribution will be based on population health evidence, market analysis, efficiency, effectiveness and value for money
9. We will demonstrate commitment to high standards and principles of good governance
10. We will operate with high standards of probity and transparency in our procurement strategy

Murray PHN's strategic plan has been the foundation for our work for the first 18 months of our operation and will continue to guide our efforts in 2017-2018.

As mentioned earlier in this Report, we have committed to three strategic goals:

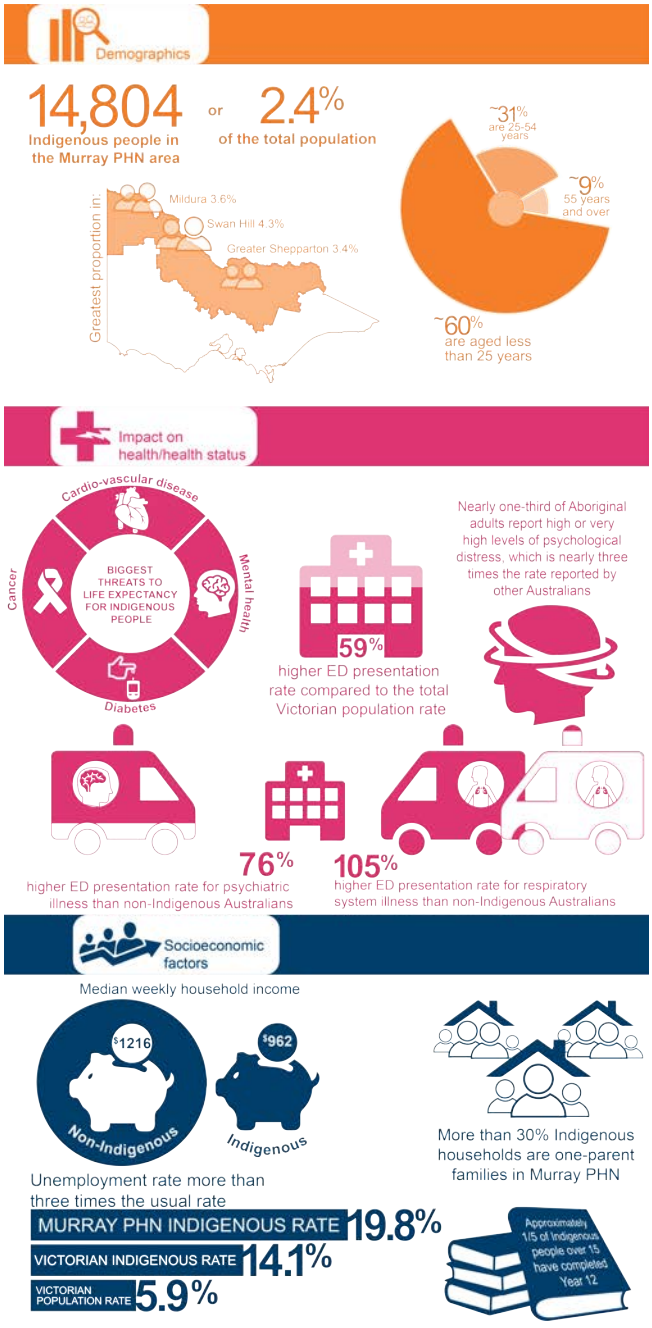
- First, we will ensure that the coordination of care is targeted and tailored to our communities and that innovation and engagement are core to our efforts in improving our healthcare systems and service delivery.
- Secondly, we will address national priority areas as well as explore emerging health and healthcare issues with our communities, and work with service providers pursuing opportunities based on evidence and expertise, and being clear about how we will measure shared success.
- Finally, we will strengthen our organisational capability so that we are responsive, accountable and productive with what we know, in what we provide, and in how it contributes to improved health outcomes.

Aboriginal and Torres Strait Islander health

Aboriginal and Torres Strait Islander people have significantly worse health outcomes than the general Australian population.

Across the Murray PHN catchment area, there are approximately 14,800 people who identify as Aboriginal and Torres Strait Islander with significant populations in Swan Hill 4.3%, Mildura 3.6%, and Greater Shepparton 3.4%.

Aboriginal and Torres Strait Islander health is one of our key national priority areas and in our first year, we have established an evidence framework to assist in our strategic planning and to ensure the effective use of resources, across the region.



Our collaboration with the Aboriginal Community Controlled Health Organisations (ACCHOs) in our catchment is key to how we work.

Earlier this year we hosted a combined meeting with all eight ACCHOs across the region where we identified chronic disease, early years and mental health as shared priorities.

Murray PHN has held a range of successful partnership activities including NAIDOC week events, breast cancer screening for Aboriginal women and a clinical engagement project to reduce hospital re-admission of Aboriginal children.

Our focus has also been on cultural safety and effective communications with two major projects - "Hello, my name is ..." (to encourage hospital staff to introduce themselves to the patient at the beginning of a conversation) and Ask the Question (to encourage health professionals to check a patient's indigenous status).

The identification of Aboriginal and Torres Strait Islander people in mainstream health services and national health data sets is important because this information is used by governments to plan services that meet the needs of different groups of Australians. We know that Aboriginal and Torres Strait Islander people are at greater risk of some health problems and we want to make sure that all patients have the option to access specific services that can help to reduce these risks.

Aboriginal and Torres Strait Islander people experience higher rates of emergency department presentations and hospitalisation for respiratory illness and psychiatric illness. It is estimated 70% of the health gap is due to chronic diseases such as cardiovascular disease, diabetes, cancer, chronic respiratory disease and chronic kidney disease.

The Closing the Gap program hopes to close the life expectancy gap within a generation and halve the gap in mortality rates for indigenous children under five within a decade.

The Commonwealth requires PHNs to commission a new approach to support better access to health care for Aboriginal and Torres Strait Islander people with chronic disease.

Integrated Team Care (ITC) is provided by a team/s of Indigenous Health Project Workers, Care Coordinators and Outreach Workers to support access to health services. ITC teams will be commissioned across the Murray PHN catchment area and will work across health services (mainstream and ACCHOs) to support better access and coordination of health care for Aboriginal and Torres Strait Islander people.

I Pink I Can - Aboriginal women's breast screening lunch, Robinvale

NAIDOC Week Youth Basketball Clinic, Swan Hill

Mental health

Mental ill health is a major issue for many people in Murray PHN communities. Residents experience higher rates of depression and anxiety over a lifetime than the rest of Victoria, and there are significantly more registered mental health clients in our area than the state's average.

We also know that people who experience severe mental health issues are more likely to develop significant physical health problems, with three times the rate of cardiovascular disease and respiratory disease and twice the rate of diabetes and osteoporosis. They are 70% more likely to smoke and 50% more likely to be overweight or obese.

Murray PHN funds access to primary mental health services in 42 locations across the Murray PHN region. Last year Murray PHN provided funding for the delivery of psychological therapies to 4,825 people who received a total of 19,013 sessions of therapy.

Services include psychological therapy services for people in rural and remote areas where access to Medicare Benefits Schedule (MBS) funded services is limited, people from low incomes, children, Aboriginal and Torres Strait Islander people, people from Culturally and Linguistically Diverse (CALD) backgrounds, women experiencing perinatal depression and people who are at risk of suicide.

We have also pioneered the Stop Stigma campaign, which aims to stop mental illness stigma in the general community and in the workplace.

Murray PHN also funds clinical care coordination for people who experience severe mental illness in many communities across the region. This coordination of care puts the patient first and is undertaken in partnership with the individual, their GP or psychiatrist and a mental health nurse.

Increasingly, our role is in the planning and commissioning of primary mental health services that are targeted, accessible and better integrated to meet the needs of local populations.

Murray PHN has six main priority areas in mental health:

- improving access to self-directed and managed interventions at an earlier stage
- services for children and young people, particularly those at risk of severe mental illness
- increasing access to psychological therapies for underserviced groups
- services for people who experience severe mental illness
- integrated mental health services for Aboriginal and Torres Strait Islander people
- community based suicide prevention.

Alcohol and other drugs

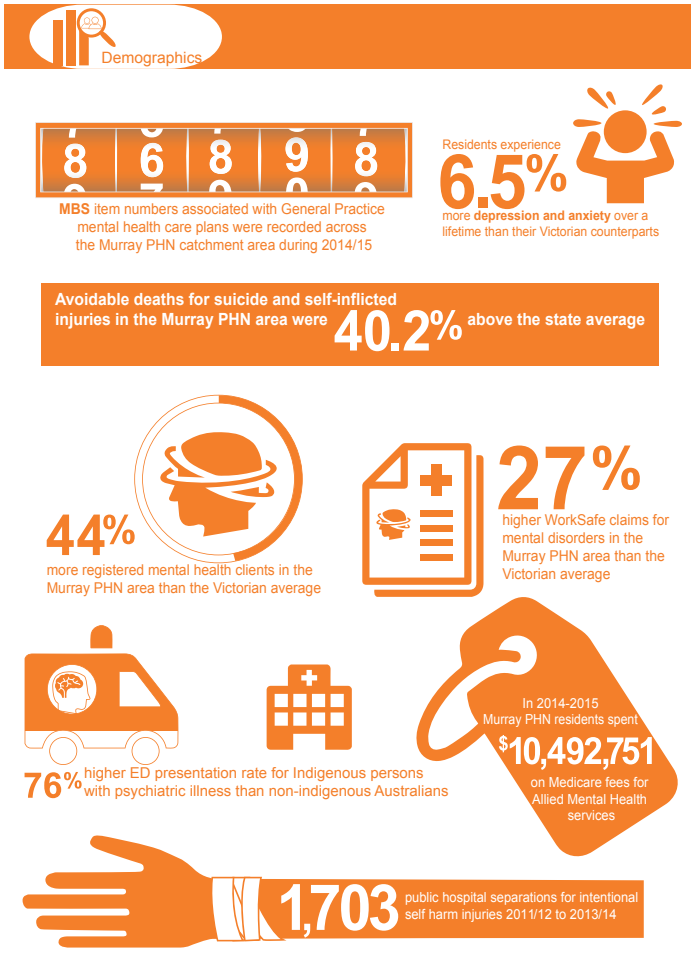
Alcohol and other drugs remain a significant problem for health outcomes across Australia, with the Murray PHN catchment recording above average rates for smoking and risky alcohol use. We also have higher rates of alcohol related assaults, car accidents, drug dealing and trafficking, and alcohol related deaths.

PIR and NDIS

Murray PHN is the lead agency for two Partners in Recovery (PIR) programs, in the Hume and Loddon Mallee Murray regions. These programs provide coordinated support and flexible funding for people with severe and persistent mental illness and complex service needs. PIR is now focused on supporting participants into the National Disability Insurance Scheme (NDIS) or to alternative support where they are not eligible for the NDIS.

"Murray PHN has been very responsive to our needs in setting up dynamic, sensitive patient centred mental health services."

Deborah Stidwell
COO Brooke Street Medical Centre, Woodend



Jodie Rasmussen, PIR Project Coordinator presenting the at the 2016 International Mental Health Conference, Gold Coast

Kyabram Aboriginal Mental Health First Aid CPD event

Murray PHN CEO, Board and Hume and Loddon Mallee Murray Partners in Recovery staff launching the Stop Mental Illness Stigma Charter.

Partnerships

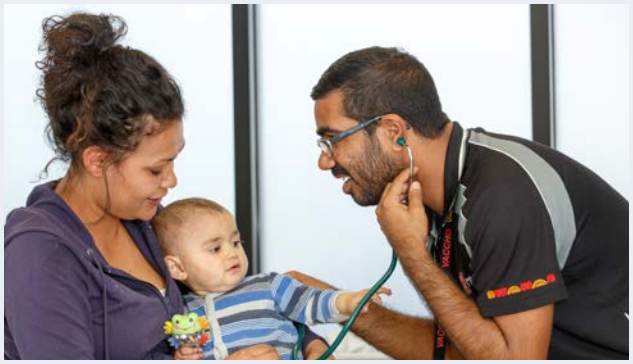
Bendigo Health, Murray PHN, Loddon Mallee Rural Health Alliance and Bendigo Loddon Primary Care Partnership are piloting a new, secure electronic medical referral system that will make it easier and safer for hospitals, GP clinics and community centres in the Loddon Mallee region to share relevant referral information.

The **Loddon Mallee eReferral** project will pilot an electronic referral system to enable sending and receiving between pilot regional health services, GP practices and health centres in 25 locations throughout Bendigo, Castlemaine, Echuca, Kerang and Rochester.

Tooth decay is one of Australia's most prevalent health problems. Poor oral health has been linked with mental health issues, cardiac disease, cancer and diabetes.

Rural ECOH, is a three-year partnership (funded by NH&MRC), with La Trobe University, James Cook University, Dental Health Victoria and the Royal Flying Doctor Service.

It is looking at how community participation can identify and establish local solutions to improve oral health in the communities of Kyabram, Swan Hill and the Shire of Gannawarra.



Acute respiratory infections are responsible for one in five deaths in children under the age of five years. Mildura Base Hospital had a high number of presentations of 0-12 month old Aboriginal children with respiratory illness, and as Aboriginal health is one of our priority areas, the **Deadly Mallee Bubs** project was developed.

The project identified the need to improve communication with external community services, develop an interagency referral form, and improve the ARGUS discharge summary process. The number of successful discharge summaries increased from 8% to 85%, resulting in significant system improvement and better outcomes for Aboriginal children.

The rate of potentially preventable hospitalisations for diabetes complications in the Murray PHN catchment during 2013-14 was at a rate of 177, per 100,000 people. As avoidable hospital presentations are one of our priority areas, Murray PHN partnered with Cobram District Health to undertake the **Diabetes Model of Care** project. Within the Cobram practice, 445 patients are active diabetics.

During the four month project, the number of diabetic patients who completed an annual cycle of care increased from 11% to 37%. The number of referrals to allied health practitioners, completing foot, eye and blood pressure checks and weight/waist measurements, were also increased.

Health problems don't just happen between 9am and 5pm. The After Hours GP telephone helpline provides free primary health care advice for people at night, at weekends and on public holidays, when their regular GP clinic isn't available.

The helpline 1800 022 222 is funded by the Australian Government and operated by HealthDirect, which works with PHNs across Australia to develop localised campaigns.

Murray PHN ran an **After Hours** campaign from April to June 2016, which received positive feedback from GPs and other stakeholders. The campaign itself has been used by PHNs in other parts of Australia.

Although the service is used only in specific circumstances, there was a small but steady increase in calls to the line from our region following advertisements on traditional and social media. The helpline is particularly effective for peace of mind in rural and remote communities and helps reduce the burden on hospital emergency departments for non-urgent medical advice.

The campaign suggested patients first check their own GP practice for after hours arrangements, or call the after hours helpline, but stressed that in a genuine emergency they should call Triple 000.

The **Managing Chronic Disease** partnership is an ongoing project to better understand and improve the quality of life for people living with chronic disease in North East Victoria. It is supported by Northeast Health Wangaratta, Department of Health and Human Services, Central Hume Primary Care Partnership, University of Melbourne, health services in Wangaratta and Benalla, and a reference group of 19 individuals.

Almost 200 questionnaires have been sent to patients, health organisation staff and GPs, with over 100 responses. The project will be tested and reviewed in 12 months, along with the impact on unplanned hospital admissions.

Nine health services established a partnership to look at ways to address the issues with the most impact on their services. The five priorities included drug and alcohol, mental health, obesity, cancer and diabetes; many of which are key priority areas for Murray PHN.

The structure to support this approach was developed by the Department of Health and Human Services and called the Service Planning Logic Model. The **Campaspe Health Needs Analysis** project partners sought to develop a combined service and implementation plan that considered system needs and capabilities, innovation, investment, area needs and capabilities, and technical guidelines.

Finance

At Murray PHN, we pride ourselves on our financial accountability to the communities we serve and to our funders, ensuring we deliver on our agreed activity work plans. We are funded predominantely by the Federal Department of Health.

In the 2016 financial year, Murray PHN recorded a profit of $514,205. The previous year's loss of $1.669 million was due to reclassification of revenue in the financial statements. In other words, the company would have generated a net profit of $173,022 in 2015 if revenue had been recognised in line with actual services provided.

In the company's transformation to Murray PHN, it has experienced significant financial growth, from $10.2 million when it operated as Loddon Mallee Murray Medical Local, to $25 million in the first year of Murray PHN. This enabled a further $8.45m to be directly commissioned to our communities, bringing the 2016 total to $15.04 million, compared with $6.58 million in 2015.

Revenues have grown again in FY 2016/2017 to $39 million – an increase of 55%. The majority of this increase relates to funding from the Department of Health for Primary Mental Health Care activity from June 2016, to build and enhance our capacity to lead mental health and suicide prevention planning, along with commissioning and integration of services at a regional level.

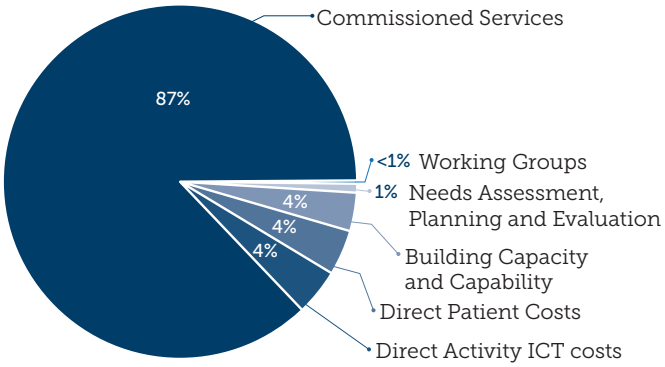
Our Board has approved a cash reserves and liquidity policy that governs the investment of cash to maximise returns to the planned activities while ensuring sufficient cash to meet business needs. During 2016 our investments returned $319,000 and in 2017 returns are projected at $450,000.

Murray PHN operates a comprehensive activity based costing financial environment that ensures all unspent activity direct money is recorded as a liability until the funds have been expended against the Department agreed activity work plans.

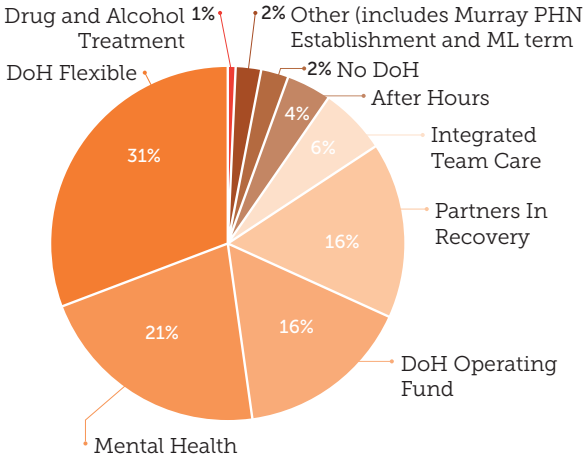
Murray PHN's current ratio at year end was 1.14 and is forecast to stay the same during 2017. Net equity is $1,482,050 and is predicted to be around $1.9 million by the end of 2018. As Murray PHN has few fixed assets the majority of the net equity is represented by cash deposits and term deposits with the bank or accounts receivable.

For the full 2015-2016 Finance report go to: murrayphn.org.au/about/corporate-documents

Direct Activity Costs
by Expense Category 2015-16



Revenue Figures
Financial Year 2015-16



Limited Statement of Profit or Loss and other Comprehensive Income

	2016 ($)	2015($)
Income		
Revenue	25,117,284	10,209,227
Total income	**25,117,284**	**10,209,227**
Expenditure		
Employee benefits expense	7,109,545	4,191,634
Depreciation, amortisation and impairment expenses	170,662	36,635
Rental and occupancy expenses	478,084	256,195
Program expenses	15,036,908	6,585,426
Motor vehicle expenses	162,493	104,768
Administration	1,224,416	472,722
Loss on disposal of fixed assets	10,573	14,388
Other expenses	410,398	216,744
Total expenditure	**24,603,079**	**11,878,512**
Profit/(loss) before income tax	**514,205**	**(1,669,285)**
Income tax expense	-	-
Profit/(loss) for the year	**514,205**	**(1,669,285)**
Other Comprehensive Income for the year	**-**	**-**
Total Comprehensive Income for the year	**514,205**	**(1,669,285)**

Statement of Cash Flows

	2016 ($)	2015($)
Cash flows from Operating Activities		
Grants revenue and other receipts	28,449,278	13,793,575
Interest received	319,621	174,680
Payments to employees, directors and suppliers	(21,783,124)	(13,908,266)
Net cash provided by Operating Activities	**6,985,775**	**59,989**
Cash flows from Investing Activities		
Payments for plant and equipment	(257,803)	-
Payments for intangible assets	(38,650)	-
Payments for held-to-maturity investments	-	(658,527)
Proceeds from held-to-maturity investments	658,527	-
Net cash provided by/(used in) Investing Activities	**362,074**	**(658,527)**
Cash flows from Financing Activities		
Increase/(decrease) in borrowings	2,549	(51)
Net cash provided by/(used in) Financing Activities	**2,549**	**(51)**
Net increase/(decrease) in cash held	7,350,398	(598,589)
Cash and cash equivalents at the beginning of the financial year	4,108,071	4,706,660
Cash and cash equivalents at the end of the financial year	**11,458,469**	**4,108,071**

Statement of Financial Position

	2016 ($)	2015($)
Current assets		
Cash and cash equivalents	11,458,469	4,108,071
Trade and other receivables	160,035	16,170
Other financial assets	-	658,527
Other assets	167,766	184,806
Intangible assets	38,650	-
Total current assets	**11,824,920**	**4,967,574**
Non-current assets		
Property, plant and equipment	127,079	50,511
Total non-current assets	**127,079**	**50,511**
Total assets	**11,951,999**	**5,018,085**
Current liabilities		
Provisions	492,733	466,149
Trade and other payables	3,516,412	954,450
Interest bearing liabilities	2,549	-
Grants refundable	1,043,206	824,110
Unearned grants	5,310,155	1,750,811
Total current liabilities	**10,365,055**	**3,995,520**
Non-current liabilities		
Employee benefits	104,894	54,720
Total non-current liabilities	**104,894**	**54,720**
Total liabilities	**10,469,949**	**4,050,240**
Net assets	**1,482,050**	**967,845**
Members' equity		
Retained surplus	1,482,050	967,845
Total members' equity	**1,482,050**	**967,845**

Statement ofChanges in Equity

	Retained earnings ($)	Program reserves ($)	Totaly equity ($)
Balance at 1 July 2014	**794,823**	**1,842,307**	**2,637,130**
Loss for the year	(1,669,285)	-	(1,669,285)
Total other comprehensive income for the year	**-**	**-**	**-**
Transferred from reserves	1,842,307	(1,842,307)	-
Balance at 30 June 2015	**967,845**	**-**	**967,845**
Balance at 1 July 2015	**967,845**	**-**	**967,845**
Profit for the year	514,205	-	514,205
Total other comprehensive income for the year	-	-	-
Transferred to reserves	-	-	-
Balance at 30 June 2016	**1,482,050**	**-**	**1,482,050**