phn MURRAY

An Australian Government Initiative

2026

REPORT TO THE COMMUNITY



Leadership. Respect. Accountability.

Acknowledgement of Country

Murray PHN acknowledges its catchment crosses over many unceded First Nations Countries following the Dhelkunya Yaluk (Healing River).

We pay our respects and give thanks to the Ancestors, Elders and Young People for their nurturing, protection and caregiving of these sacred lands and waterways, acknowledging their continuation of cultural, spiritual and educational practices.

We are grateful for the sharing of Country and the renewal that Country gives us. We acknowledge and express our sorrow that this sharing has come at a personal, spiritual and cultural cost to the wellbeing of First Nations Peoples.

We commit to addressing the injustices of colonisation across our catchment, and to listening to the wisdom of First Nations communities who hold the knowledge to enable healing.

We extend that respect to all Aboriginal and Torres Strait Islander Peoples.

Our commitment to being an anti-racist company

Murray PHN aspires to be an anti-racist organisation, embedding cultural humility as a daily practice to improve health outcomes and health equity in our communities. We recognise cultural humility as a lifelong commitment to self reflection, personal growth and redressing power imbalances in our society.

Recognition of lived experience

We recognise the individual and collective contributions of people with a lived and/or living experience of health issues, and their families, loved ones and supporters.

It is through listening to and acting on the voices of people with lived experience, those who provide services, those who fund services, and most importantly, those who use services, that we will find the expertise we need to move towards the health system that Australia needs.

Every person's story we hear, and every experience shared, helps to develop our understanding of the system that is required to best meet the needs of people who live with or care for someone with health concerns.



L-R: Bob Cameron, Board Chair and Matt Jones, CEO

Message from the Chair and CEO

This year has been one of significant change and strategic redirection for Primary Health Networks (PHNs), following the first national review of the PHN Business Model. Commissioned by the Department of Health, Disability and Ageing, the review examined how the operating environment has evolved since PHNs were established in 2015 and how the PHN Program can best support government priorities into the future.

A key outcome of the review was the continued recognition of the role of PHNs, with a growing emphasis as the local implementers of national policies and initiatives. Other recommendations called for more consistent practices and meaningful performance assessment across PHNs. Reforms based on these recommendations present an opportunity to strengthen confidence in the PHN Program and enhance our collective contribution to a more connected, responsive and sustainable health system in Australia.

Throughout the year, Murray PHN has proactively aligned its activities with this evolving role, while continuing to strengthen primary healthcare through commissioning, system coordination and partnerships that respond to local needs.

At the same time, like the broader community, we are experiencing a challenging financial environment, with increasing demand and pressure on health funding and public expenditure. After a decade of annual growth, we are now facing the realities of uncertain funding amounts in the future and what those scenarios might mean, as well as dealing with a period of increasing costs.

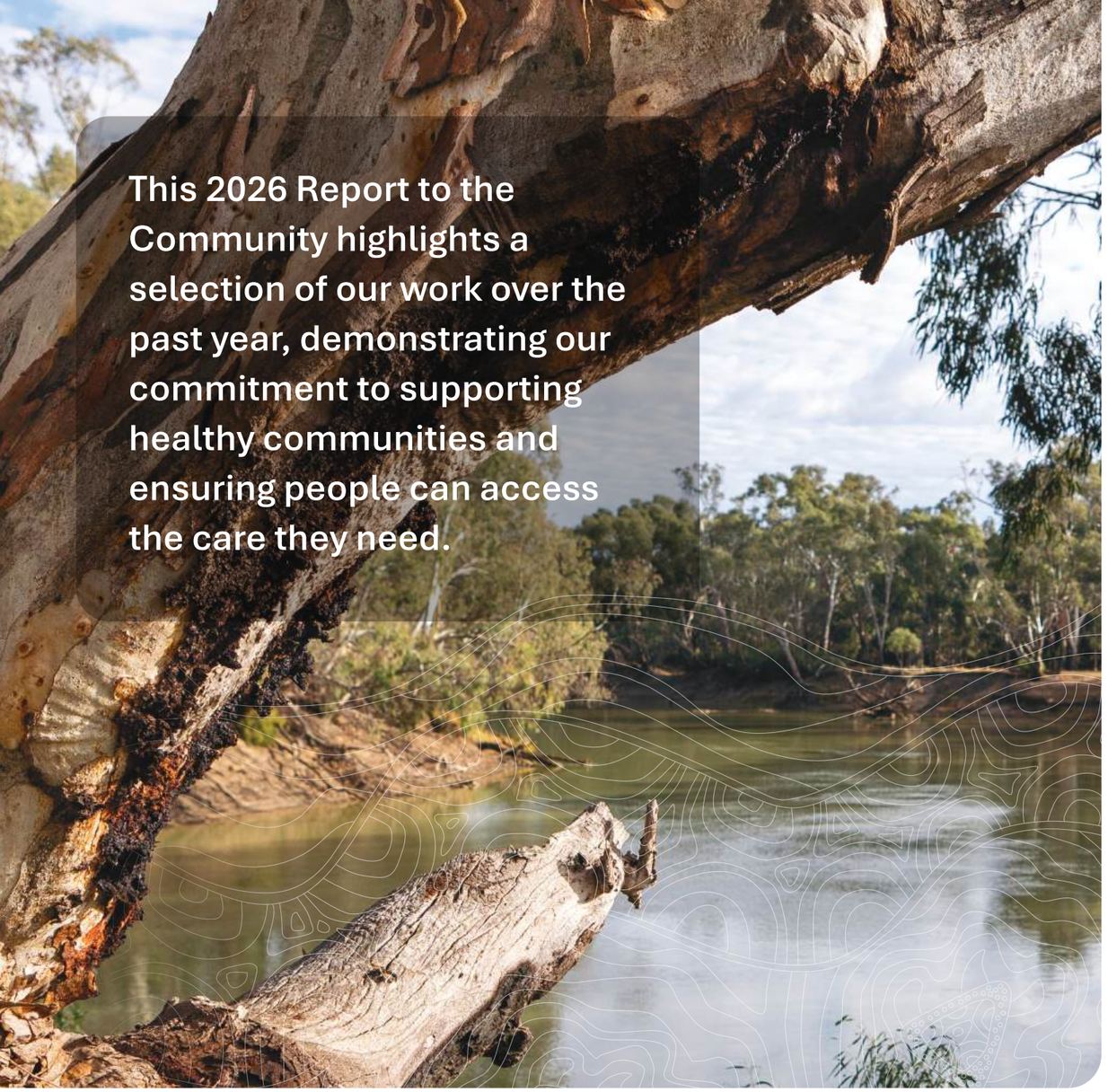
Simultaneously, an elevated focus on delivery and governance requires disciplined decision-making and a heightened focus on organisational sustainability.

To ensure Murray PHN remains well positioned for the future, we undertook a whole-of-organisation restructure aligned with our new strategic priorities and in response to the changed financial environment. These changes will help sustain our ability to continue to support primary care, commission essential services and address the health needs of our communities. Throughout this process, our commitment to quality, accountability and performance provided strong guiding principles to inform our planning.

The Board has continued to strengthen governance and oversight processes, with an ever-present focus on fulfilling our responsibilities of accountability, transparency and outcome delivery. Together, the Board and Executive team have balanced immediate operational demands with long-term planning and ensuring the health and wellbeing of our communities remain at the centre of our decision-making.

We sincerely thank our Directors, Executive team, People Leads and employees for their ongoing dedication and resilience during a demanding year. Their expertise and commitment have enabled Murray PHN to navigate change, maintain strong partnerships and continue strengthening access and coordination of services across our region.

As we look ahead, we remain confident in Murray PHN's ability to adapt, innovate and fulfill its purpose of improving health outcomes and strengthening primary healthcare for the communities we serve.



This 2026 Report to the Community highlights a selection of our work over the past year, demonstrating our commitment to supporting healthy communities and ensuring people can access the care they need.

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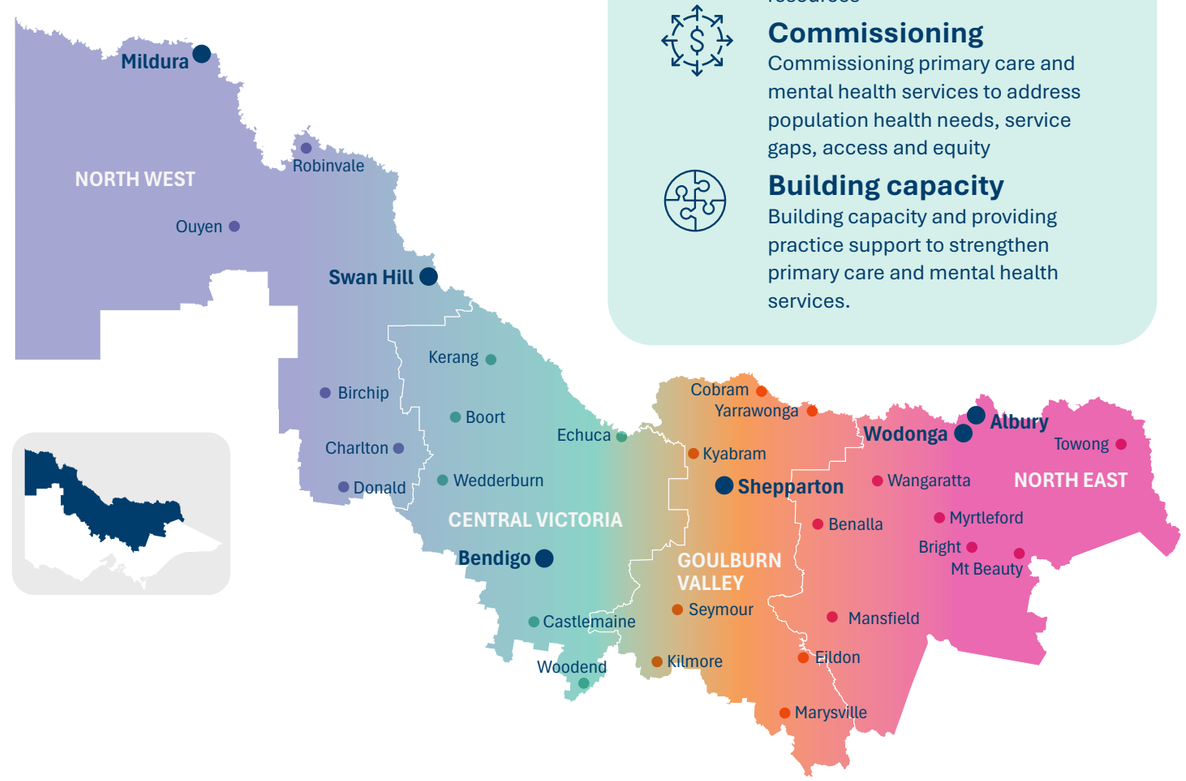
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About our work

Murray PHN is a not-for-profit organisation funded primarily by the Australian Government Department of Health, Disability and Ageing to commission primary healthcare services and better coordinate care, ensuring people in our region receive the right care, in the right place, at the right time.

Our region covers 22 local government areas across northern Victoria and extends over the border to include Albury, NSW, encompassing a diverse and beautiful area of almost 100,000 square kilometres with mountains, semideserts and vibrant regional cities.



PHNs are responsible for driving innovation to meet local health needs, while supporting the consistent delivery of national and co-commissioned programs. We deliver three core functions:

Coordinating
Coordinating local care in partnership with Local Hospital Networks to improve quality, experience and efficient use of resources

Commissioning
Commissioning primary care and mental health services to address population health needs, service gaps, access and equity

Building capacity
Building capacity and providing practice support to strengthen primary care and mental health services.






General practice

We work closely with general practice, providing tailored support, practical resources and ongoing education to strengthen the delivery of high-quality primary care. Our general practice team partners with practices to support the implementation of new Commonwealth initiatives, embed quality improvement processes, and ensure practices have access to the tools, data and guidance needed to deliver best-practice care.

This includes hands-on assistance with practice systems, clinical governance, accreditation requirements, digital health adoption and workforce capability. We also facilitate opportunities for peer learning, targeted training and connection with broader networks, helping practices remain aligned with emerging policy directions while responding to the needs of their local communities.



Providing emergency department alternatives

Medicare Urgent Care Clinics (MUCCs), which are Commonwealth funded, and Urgent Care Clinics (UCCs), which are state funded, provide free, timely care for people with urgent but non-life-threatening conditions, helping reduce pressure on hospital emergency departments while improving access to care closer to home. Services include treatment for minor infections and burns, suspected fractures and other urgent health concerns. Clinics also provide, or facilitate access to, pathology and diagnostic imaging services.

In the 2026 financial year, the region's five clinics cared for more than **48,000 people**

95% of people who completed the satisfaction survey rated the quality of care as "very good" or "good"

Supporting multidisciplinary care in general practice

For the past three years, Murray PHN has provided $1 million annually through our General Practice Investment Strategy (GPIS) to help up to 10 primary care clinics deliver better services for their communities.

This year, local general practices, including Aboriginal Community Controlled Health Organisations, were invited to apply for funding to improve or enhance models of care.

Clinics could apply for up to $100,000 to support care that was more coordinated and multidisciplinary team-based, and would result in improving practice efficiencies while promoting better health outcomes to communities they support.

The funding focused on supporting people with complex health needs related to chronic conditions, including cardiovascular disease, chronic obstructive pulmonary disease and diabetes. It aimed to enable earlier intervention, improve patients' ability to self-manage their conditions and reduce potentially preventable hospitalisations.

Helping farmers to breathe easier

Farmers in the Alpine Shire are at increased risk of occupational lung problems due to a past history of tobacco farming in the region and exposure to agricultural allergens such as chemicals, dust and mould.

Alba Health received funding through the GPIS to expand its Healthy Hearts program into the Healthy Hearts and Lungs Program.

The Alba Health team developed an eight-week health promotion model of care to support earlier diagnosis and better management of respiratory disease. The program provided initial health checks and ongoing support for community members who had not previously engaged in care.

The program focused on people who were aged 40 years and older, current or former smokers, those experiencing respiratory symptoms and with a sedentary lifestyle, and people identifying as Aboriginal and/or Torres Strait Islander.

Participants received an initial health check and could complete a spirometry test on site. Those with mild, moderate, severe or significant disease were referred to a GP for respiratory support, which could include prescriptions for inhalers, referrals to group exercise and lifestyle programs, and telehealth appointments with a respiratory specialist.

The project achieved strong participation, with 163 patients engaging in more than 414 occasions of service. During the project, the number of health assessments completed in the previous 12 months increased from 19 to 61, and GP Chronic Disease Management appointments rose significantly.

The program's success was supported by an embedded workflow, from screening through to increasing levels of care. Having services available locally helped reduce barriers to screening, lifestyle support and specialist appointments, increasing the likelihood that patients would stay engaged in the long term.

Following the success of the program, Alba Health hopes to continue delivering a sustainable model that offers local screening appointments, and access to cardiology and

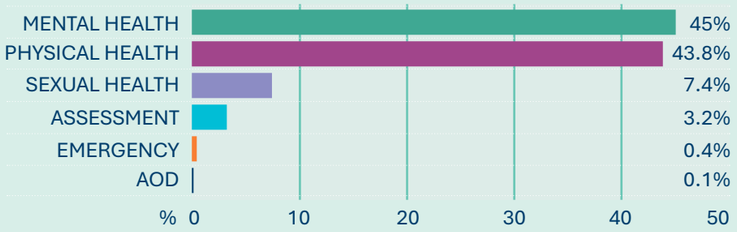
Fostering student health through school-based care

Adolescents in 100 Victorian schools can access free, confidential, accessible and developmentally appropriate primary healthcare at their school through the Doctors in Secondary Schools (DiSS) program. Funded by the Victorian Government, there are 21 DiSS clinics in the Murray PHN region. The program involves a partnership between the Victorian Department of Education, participating government secondary school councils and medical centres. It facilitates strong links between health, education, families and community services.

In the 2025-26 financial year, more than 2300 GP consultations were undertaken as part of the program, with 72 per cent returning patients and 27 per cent new patients.

This year, in response to findings from the Victorian Parliamentary inquiry, *Betrayal of Trust: Inquiry into the handling of child abuse by religious and other non-government organisations*, the Department of Education identified that some DiSS providers' existing professional indemnity policies did not include adequate cover for child abuse and molestation required under the Victorian funding guidelines for services to children. To ensure continued service delivery and compliance, the department purchased Betrayal of Trust insurance to cover all employees working in state-funded DiSS clinics until the end of 2027, with all 21 clinics in our region now having this coverage, providing an additional safety net for students and clinicians.

GP consultations by main reason



Common issues that students are supported with include:

- Mental health: anxiety, depression and school avoidance
- Chronic conditions: asthma, allergies, diabetes, epilepsy, inflammatory and gastrointestinal conditions
- Complex developmental needs and neurodiversity such as ADHD, autism and learning disabilities
- Excessive screen time, inadequate sleep and fatigue
- Injuries: sporting and recreational injuries, interpersonal violence
- Child safety: poverty, family, domestic and sexual violence
- Sexual and reproductive health
- Alcohol and other drugs (AOD): vaping and smoking, substance use
- Eating disorders and body image.

L-R: Sunraysia Community Health Services (SCHS) Nurse Melissa Vandenberg, SCHS Practice Manager Carolyn Whitehouse and Murray PHN Quality Improvement Consultant Sonali Gupta at Irymple DiSS clinic.

2300 GP consultations

72% return patients



Pictured: General Practice Engagement Manager, Vitor Rocha and Quality Improvement Consultant, Caitlan Bird present at the National Rural Health Conference.

Using technology for lung cancer screening

The Murray PHN region has a high incidence of lung cancer, poorer survival outcomes and limited access to services. General practices are central to the success of the National Lung Cancer Screening Program; however, in rural and regional areas, many have limited capacity due to workforce constraints, inadequate systems and incomplete smoking history data needed to proactively identify eligible screening patients.

To address these challenges, we partnered with Healthily to establish a pilot program using the GoShare digital platform. A short eligibility survey was sent to patients recorded as current or former smokers in each participating practice's clinical software. Patients were contacted through staged text messages, with an optional AI-assisted phone call. The survey collected smoking history and symptom information, identified potential screening eligibility, and provided practices with clear results for clinical review and follow-up.

Seventeen general practices participated in the pilot, with 1384 surveys completed and an overall response rate of 22.9 per cent. Among respondents, 174 people were identified as potentially eligible for screening, while 405 people, almost 30 per cent of all respondents, reported new or unexplained symptoms requiring clinical review. Subsequent assessment led to diagnoses of previously unidentified respiratory illnesses, including chronic obstructive pulmonary disease, as well as advanced lung cancer in three patients.

The pilot demonstrated a practical and scalable model that can be implemented across diverse general practice settings without creating an unsustainable administrative burden. A broader rollout would enable further refinement and expansion of the approach, supporting earlier detection, more equitable access to screening, particularly for rural general practices, and improved lung cancer outcomes for rural and regional communities.

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Bulk billing rates high across the region

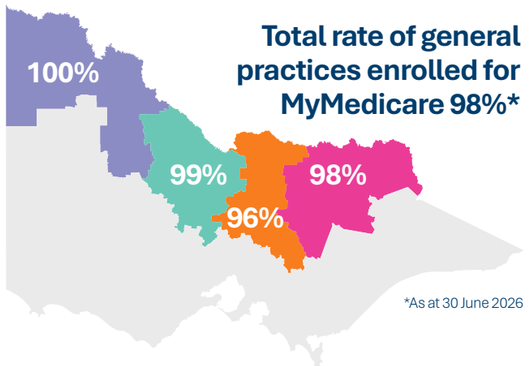
MyMedicare is a voluntary registration program that helps people build a stronger, ongoing relationship with their chosen general practice, GP and primary care team. General practices registered for MyMedicare can also take part in the Bulk Billing Practice Incentive Program (BBPIP), which provides additional payments for eligible Medicare Benefits Schedule (MBS) services. Importantly, it means that patients don't pay anything when they see a GP, because Medicare covers the full cost of the service.

Improved general practice level data is giving Murray PHN a clearer picture of how local general practices are responding to national reforms. This is also helping us to identify where and what support may be most useful for practices and the communities they serve.

This year, we continued supporting practices with information and resources to encourage participation in the program and assist newly registered practices to update their Healthdirect listings, helping people more easily locate clinics that offer bulk billing.

As at June 2026, 98 per cent of general practices across the Murray PHN region were registered for MyMedicare, which is consistent with the national registration rate of 96 per cent.

Bulk billing participation has also grown substantially, with the number of practices identifying as bulk billing increased from 20 per cent in October 2025 to 49 per cent in February 2026. By September 2026, 62 per cent of local practices were participating in BBPIP. As a result, 21 of the region's 22 local government areas now have at least one bulk billing clinic, saving people money in out-of-pocket costs. This also puts the Murray PHN region above both the Victorian average (54.9 per cent) and the national average (51 per cent).



Health minister visits Bendigo

In July, the Hon Mark Butler MP, Minister for Health and Ageing and Minister for Disability and the National Disability Insurance Scheme visited the Bendigo Medicare Urgent Care Clinic with Lisa Chesters MP to highlight locally implemented Strengthening Medicare measures.

Minister Butler shared that Greater Bendigo had the biggest increase in bulk billing out of 150 electorates in Australia, aside from one in Darwin. At the time of the visit, bulk billing rates for people without a concession card were up to more than 80 per cent - an increase from 50 per cent a few years ago.



Pictured: L-R: Becc Cheers - Clinical Manager/RN, Lisa Chesters MP, Mark Butler MP and Matt Jones, Murray PHN CEO.

Supporting bushfire affected communities

Since the January 2026 bushfires, access to regular GP appointments in some rural locations has been limited. In partnership with Strathbogie Shire Council, Central General Practice Mansfield and Alexandra Events, Murray PHN provided funding to help Ruffy residents access general practice services close to home.

In July, 12 people attended the Murrindindi Mobile Health Van with a range of health concerns, including injuries and skin conditions. All had been directly impacted by the fires, with most having lost their homes and continuing to live in temporary or makeshift accommodation. Many were continuing to endure significant emotional impacts related to the event.

The van parked at the local hall, which continued to serve as an important hub, bringing together locals and a range of supports in a single location. Alongside the general practice services, representatives from Agriculture Victoria, Blaze Aid, Mental Health and Wellbeing Local, Primary Care Connect, financial counselling services, council recovery workers and the Victorian Farmers Federation were on hand to offer information, assistance and advice.

Community members shared firsthand stories of the challenges they continued to face, including difficulties in accessing services and lengthy insurance processes that were delaying the rebuilding of their homes and lives.

The willingness of community members to come together and share reflected the resilience, determination and community spirit that continues to drive recovery efforts. We were proud to work alongside local partners to help make it easier for people to prioritise their health and wellbeing needs for a day.

The visit to Ruffy serves as an important reminder that recovery is a long-term journey, and while natural disasters come and go, ongoing impacts remain.

Pictured L-R below: Kate McKernan, Strathbogie Council Fire Recovery Manager; Karli Brkljacic, Central General Practice Mansfield General Manager and Nurse Practitioner; Leigh Ritchie, Strathbogie Council Community Recovery Officer and Kate O'Kell, Murray PHN Emergency Management Program Lead.





Team-based care for chronic disease

Almost 1000 people living with chronic health conditions received coordinated care closer to home through Murray PHN's multidisciplinary team program in 2025–26.

Across rural and regional communities, people experience high rates of diabetes, cardiovascular disease and chronic respiratory conditions. At the same time, workforce shortages and limited access to allied health professionals can make it difficult to get the right support locally.

Responding to needs identified in our Health Needs Assessment, we commissioned multidisciplinary team models in three areas with high levels of need, unmet demand and service gaps.

The program brought general practices together with lead agencies to design services around local community needs in Strathbogie–Mitchell, Loddon–Gannawarra–Buloke and Mildura–Swan Hill areas. Models were led by either general practices or allied health providers, depending on what worked best in each area.

By integrating nursing and allied health professionals into general practice settings, the program gave people more connected, person-centred support to manage chronic conditions. This included team-based case discussions, outreach services and shared care planning.

The approach has been particularly valuable for small and rural practices that may not have the workforce or resources to establish a multidisciplinary team on their own. It also strengthened collaboration across primary care, supporting new ways of working and testing more sustainable funding approaches.

During the 2026 financial year, the program supported 993 patients and delivered 1898 occasions of service through 14 general practice and outreach locations. Of the participants who reported on their health outcomes, 94 per cent maintained or improved their health status following care. Patient feedback was also encouraging, with 91 per cent of respondents reporting a positive experience.

These results demonstrate the value of bringing allied health professionals into and alongside general practice, helping people receive coordinated care nearer to where they live and supporting better health outcomes across rural and regional communities. The Strathbogie-Mitchell and Mildura-Swan Hill programs will continue through to June 2027.



L-R: Nurse Janine, patients and Dr Salamisaadatloo.

Kyabram after hours clinic celebrates one-year milestone

Murray PHN's 2023 Needs Assessment identified the Shire of Campaspe - including Kyabram, Echuca, Rochester, Rushworth and Stanhope - as an area experiencing significant disadvantage in access to urgent after hours primary healthcare.

To strengthen the local health system, support timely access to urgent but non-life-threatening care, reduce the risk of clinical deterioration and ease pressure on emergency departments, Kyabram District Health Service (KDHS) established an after hours program in partnership with Murray PHN.

KDHS formed a project control group to oversee service planning and developed a comprehensive model of care. A three-month proof-of-concept trial began on 1 April 2025. Following the successful trial, Murray PHN committed funding to continue the service through the 2027 financial year.

As a GP-led model with no out-of-pocket costs for patients, appointments can be scheduled online and by phone, while walk-ins are also available to enhance timely management of urgent conditions in the after hours period.

The service provides GP appointments to local communities every Saturday and Sunday from 9am to 5pm. In its first year, the service delivered 1703 consultations to patients from 38 postcodes, demonstrating its reach across the shire. If activity continues at current levels, the service is projected to deliver up to 2500 consultations annually.

Client experience survey results indicate high levels of satisfaction. Overall, 88.37 per cent of respondents reported a positive experience, and 92.25 per cent said they were 'very likely' to recommend the service to others.

The success of the after hours GP-led service reflects a shared vision, effective collaboration and a genuine commitment to improving healthcare access for local communities.

"I had a good experience and was very grateful to be able to receive care on a weekend, after hours."

"What a fantastic service to have in Ky! Has saved us many times!"

"Such a privilege to have this great service in Kyabram."

Helping primary care prepare for emergencies

Developed in collaboration with key stakeholders, Murray PHN's Emergency Exercise Toolkit guides primary care organisations through the process of planning, delivering and evaluating emergency exercises tailored to their local context.

The toolkit aims to build confidence by clarifying roles and responsibilities, strengthening communication pathways, exploring decision-making under uncertainty, and identifying actions for improvement to support the continuity of essential services during times of emergency.

The structured scenarios, facilitation guidance and reflective activities help teams to identify risks, test response processes and enhance coordination during emergencies. Whether used for tabletop exercises or team-based discussions, the toolkit supports continuous learning and improvement in primary care emergency management.



The toolkit, developed with Strategic Disaster Solutions, has been finalised following initial implementation, with valuable feedback used to further refine the resource. It has also been shared with other PHNs nationally.

The toolkit was submitted for the 2026 Victorian Resilient Australia Awards, which recognise initiatives that build resilience and inspire others to take action, helping communities become safer, more connected and better prepared for natural hazards and emergencies.

We are proud to share that Murray PHN was announced the winner of the Business category and has been shortlisted as a finalist for a National Resilient Australia Award.



"In the case of fire, we knew what to do, but in the case of cybersecurity, we didn't know what to do. We had never thought about what we do if we couldn't reach our IT people, so it was scary but a good and eye-opening scenario. We brainstormed during our practice meeting and followed up with our IT people and insurance company. We now feel ready if it happens because we know what to do." – Practice manager

First Nations

Aboriginal and Torres Strait Islander people have higher rates of chronic illness compared with non-Indigenous Australians. Access to comprehensive, affordable and culturally appropriate primary healthcare is critical for closing this gap. Murray PHN works in partnership with the seven Aboriginal Community Controlled Health Organisations (ACCHOs) in our region to deliver primary health services that are responsive to the needs of our First Nations communities.



Meaningful partnerships on Country

In April, Aboriginal Community Controlled Health Organisation (ACCHO) leaders came together on Wiradjuri Country to strengthen relationships, share what matters most to communities and reflect on how we can work better together in partnership.

Grounded in culture, truth-telling and respectful conversations, the gathering created space for ACCHOs to share their priorities, challenges, successes and opportunities. Discussions focused on community-led approaches, advocacy, models of care, strategic priorities and the importance of Aboriginal voices leading decisions that impact First Nations communities.

The gathering reinforced the value of listening, trust and genuine partnership, recognising that ACCHOs are best placed to understand and respond to the needs and aspirations of their communities.

Since the gathering, the Murray PHN Strategic Plan has been finalised and launched, informed by many of the themes raised through conversations with ACCHOs and community.



Celebrating NAIDOC Week and 50 years of deadly

Murray PHN recognises and celebrates a range of significant First Nations dates and events throughout the year, including National NAIDOC Week. As in previous years, support was offered to ACCHOs across our region to contribute to local NAIDOC Week celebrations and activities.

Consistent with our approach, each ACCHO was invited to determine how this support could best contribute to their local activities, acknowledging that communities are best placed to identify what is meaningful and important locally.

All seven ACCHOs across our catchment used the funding to support community-led NAIDOC activities, including community and family days that brought people together to celebrate culture, connection and community. One ACCHO also directed funding to support Elders to participate in a local Elders event and luncheon.

The support reflected a shared commitment to strengthening community connection and recognising the important role that NAIDOC Week plays in celebrating culture, honouring achievement and creating opportunities for communities to come together in ways that are meaningful to them.

Supporting improved health outcomes for First Nations people

The Integrated Team Care (ITC) program supports improved health outcomes for Aboriginal and Torres Strait Islander people living with chronic conditions by providing coordinated care, multidisciplinary support and assistance with self-management.

The program focuses on improving access to culturally appropriate mainstream primary care and helps individuals to better manage their condition, strengthen their independence and stay connected to the care they need.

In the 2025/26 financial year, via the region's Aboriginal Community Controlled Health Organisations, the ITC program was delivered to 5577 clients, comprising:

- 12,521 care coordination services
- 2030 supplementary services
- 11,116 clinical services.

The top three chronic conditions supported through the program were sleep disorders, chronic pain and mental health, and the top three allied health services accessed were physiotherapy, dietetics and podiatry. The top three specialist services accessed were ophthalmology, sleep management and neurology.

A person-centred approach to healthy ageing

The Healthy Ageing program supports older First Nations people to live at home for longer, through early intervention initiatives that promote healthy ageing and management of chronic conditions. It supports people at their own pace and allows them time to build a rapport with their worker before identifying goals and needs.

Case study

Eddie* is in his 60s and lives with type 2 diabetes, anxiety and depression. Before accessing the program, he was not regularly attending medical appointments or taking his medication, which contributed to increasing isolation and a decline in his mental health.

Through the program, Eddie received transport support to attend medical appointments and reconnect with his community. Staff also provided advocacy during his GP visits, helping to ease his anxiety and ensure he understood the information and medical terminology discussed.

Eddie is now consistently attending his GP appointments and taking his medication as prescribed. He has been gradually supported to re-engage with community activities, including joining a fortnightly men's group where he shares cultural knowledge and stories with younger people. This has strengthened his cultural connection, restored his sense of purpose and supported his confidence in social settings.

Eddie says he now feels part of his community again and respected as an Elder.

**name changed*

Case study

The combined supports of the Healthy Ageing program are helping Julie* stay engaged, independent and confident in managing her health. She is being supported to age well through a holistic, culturally informed approach that strengthens her physical health, social and emotional wellbeing, and connection to identity and culture.

To improve her physical wellbeing, Julie has been supported to attend regular GP and allied health appointments and to participate in healthy lifestyle activities. She has also received practical health education to help her better understand and manage her health conditions.

Julie's social and emotional wellbeing has been strengthened through regular check-ins with her worker, home visits and yarning sessions. She was referred to specialist mental health and counselling services, with warm handovers to ensure she felt comfortable and supported throughout the process.

Connection to culture and identity has been central to Julie's journey. She has been encouraged and supported to participate in community activities such as a women's group and art therapy - experiences that foster pride, belonging and self-determination.

Julie has also benefited from having someone who can help her navigate services, explore health information and provide encouragement. This support has strengthened her ability to manage her own health and feel more in control of her daily routine.

**name changed*



Chronic disease

Murray PHN works with allied health, general practice and Aboriginal health organisations to deliver chronic disease services, including diabetes education, dietetics, podiatry, nursing and cardiopulmonary rehabilitation. Our work focuses on supporting service system integration and care coordination to improve patient experience and health outcomes.



Training tomorrow's rural health professionals

Murray PHN supports the Rural Physiotherapy Teaching Clinic, which operates across Primary Care Connect's Shepparton and Euroa sites and hosts students from La Trobe Rural Health School and The University of Melbourne. The clinic demonstrates how innovative teaching and service models can improve healthcare access, while building a sustainable workforce pipeline for rural and regional communities.

Connecting diverse communities to healthcare

Over the last year, bi-cultural Health System Navigator services in Bendigo, Shepparton and Robinvale supported 289 migrants and former refugees from 24 countries who speak 23 languages. Navigators provided support on 1577 occasions, helping people to access and navigate health services. They also delivered 101 community and sector engagement activities, including four communities of practice, and co-designed dozens of translated and easy English resources, including flyers and videos.





Interpreter services supporting equitable care

Using a qualified interpreter helps ensure safe, high-quality and person-centred care for patients who speak limited English. This year, we extended the Interpreting for Allied Health and Primary Care Program until 2028 for eligible allied health and other primary care providers who are unable to access other funded interpreting programs. Since the program began, 41 health professionals have registered, with more than 100 interpreter-supported health consultations provided up to 31 October 2026.



Working to improve multicultural health

In February, Murray PHN convened a multicultural health roundtable in Shepparton to bring together local health services, community organisations and partner agencies. This included Goulburn Valley Health, Primary Care Connect, Uniting VicTas, Wise Well Women, Ethnic Council of Shepparton and District, Greater Shepparton City Council, Shepparton Medical Centre, Salvation Army, headspace Shepparton, Goulburn Valley Area Mental Health Services, Wellways and Shepparton English Language Centre.

The roundtable provided the opportunity to identify barriers to providing accessible primary healthcare and effective coordination between services for migrant and refugee communities. Discussions explored practical actions to improve access and outcomes for these communities.

Murray PHN is using these insights to inform local service planning and commissioning priorities, exploring ways to strengthen care coordination and navigation, engaging local health and community partners to progress priority actions, recognising shared ownership of outcomes.

Issues and barriers

- Limited visibility of available services and their eligibility criteria
- Informal communication and gaps in information-sharing between services
- Confusion around healthcare entitlements for different visa types
- Reliance on word-of-mouth and limited access to interpreters.

Priorities and opportunities

- More regular forums to improve inter-agency communication and collaboration
- Cultural responsiveness training
- Maintaining up-to-date shared service lists, case conferencing and referral pathways
- Investing in interpreters, navigators and bicultural workers and using lived experience to inform service design.

Connecting the allied health workforce

Allied health professionals play a critical role in helping people to lead healthier lives. Murray PHN works to support the allied health sector through dedicated resources, tools and programs, and education, training and networking events.

Informing place-based allied health workforce solutions

In December 2025, Murray PHN and Rural Workforce Agency Victoria (RWAV) came together with local providers, educators and regional partners for an allied health roundtable in Shepparton to discuss the barriers, opportunities and future models of early career allied health workforce support in the Goulburn Valley region.

Attendees heard from a range of speakers including Services for Australian Rural and Remote Allied Health (SARRAH) CEO Cath Maloney; GV Physiotherapy Clinical Educator, Brenton Kiel; and La Trobe University Discipline Lead of Physiotherapy, Ryan McGrath.

Following presentations, attendees participated in discussions to further explore workforce needs, barriers and opportunities for recruitment and retention to inform the co-design of a place-based allied health workforce development project.











Working together to improve dementia care

To support uptake and enhance the use of dementia-related pathways, a series of Murray HealthPathways and Dementia Care for Allied Health events were delivered in May and June.

Across four locations (Mildura, Albury, Bendigo and Shepparton), 85 participants registered, with 69 attendees and 41 evaluation responses, representing an overall response rate of 59 per cent. Attendance rates were strong across all sites, and evaluation response rates ranged from 42 to 65 per cent, indicating a moderate level of participant engagement in feedback processes.

During the events, participants shared insights on persistent barriers to timely and coordinated dementia care, including fragmented service pathways, long waits for assessments, limited awareness of available supports, delays in diagnosis, workforce shortages, low health literacy, geographic variations, and complex referral and eligibility processes.

Key enablers included committed local clinicians, dementia care coordinators, nurse navigator and care coordination roles, emerging end-of-life pathways, and opportunities to strengthen education and local referral knowledge.

The findings highlight the need for stronger integration between services, greater awareness of referral pathways, increased allied health involvement, and clearer pathways for palliative and end-of-life care. Murray PHN will continue to support a coordinated, system-wide approach focused on improving care navigation, workforce capability, multidisciplinary collaboration and access to timely information. This will include targeted clinical engagement, education and promotion of evidence-based resources to build clinician confidence and support more consistent practice, and strengthening links with Care Finder, Dementia Australia and community services to connect people with the right supports.

Following the workshops, Murray HealthPathways usage data showed increased engagement and registration, and pathways will be updated to support early identification, proactive care planning and management, including practical advice, alternative care options and escalation points.

New program to support chronic disease

It's important that people who experience barriers or difficulty in accessing and navigating a complex healthcare service system - such as distance, cost, language and digital access - receive the support they need.

With ongoing challenges in access and equity across the region, higher than national rates of multimorbidity, combined with static levels of funding and rising service delivery costs, Murray PHN evaluated its long-running Chronic Disease Management (CDM) Program last year.

Using regional data, together with policy review and engagement with providers, consumers and advisory groups, the evaluation helped identify opportunities to improve integration, and guide the development of new service models that better reflect regional needs and national best practice.

This year, the new Health Connection and Chronic Condition Management Program (HCCCM) was introduced to improve access to care, introduce system navigation and make the best use of available funding.

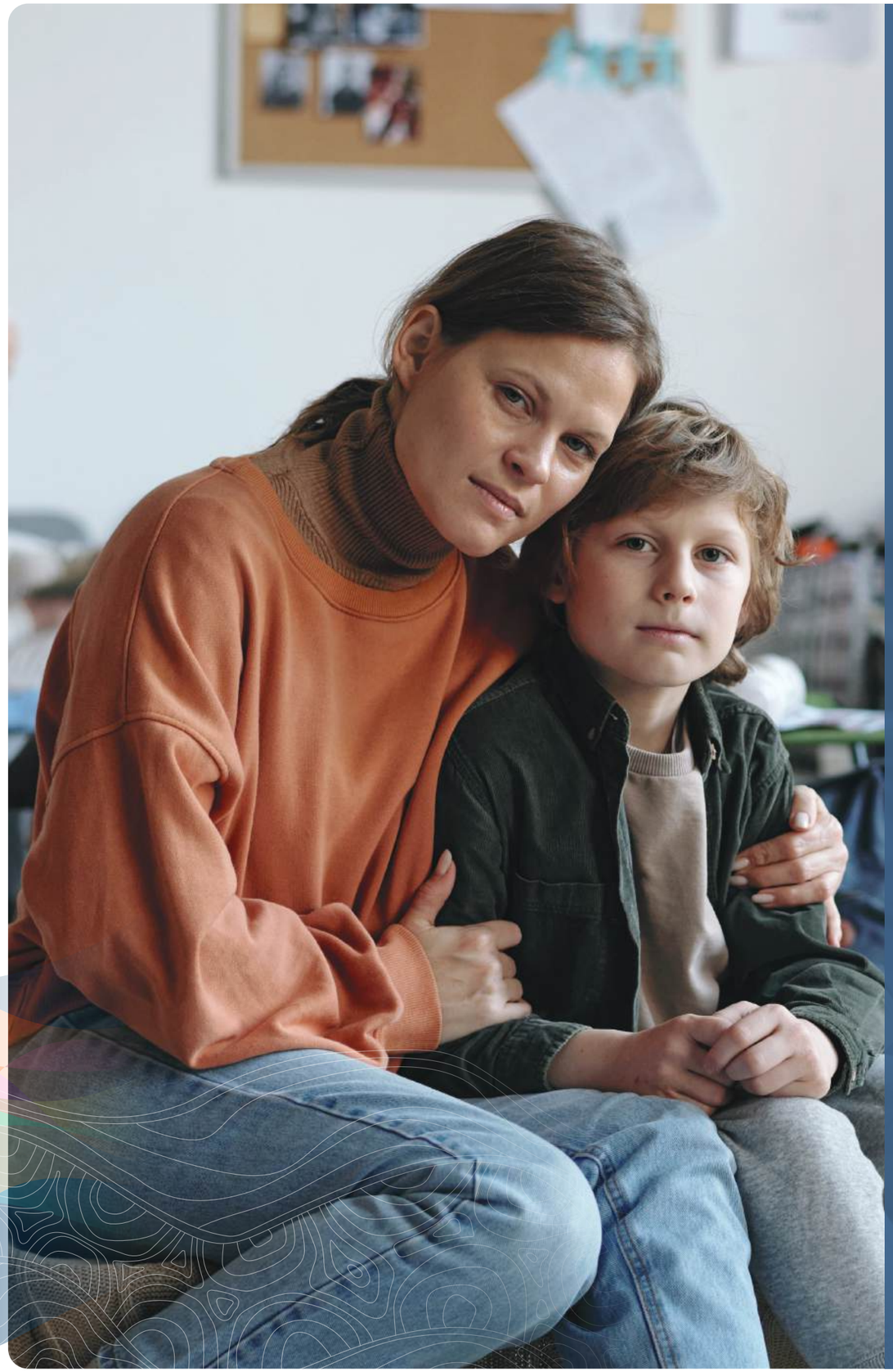
HCCCM focuses on geographical locations and vulnerable population groups that experience the most pressing health needs and disparities in access. This includes those with low English proficiency and socioeconomic disadvantage.

The program continues supporting people with chronic obstructive pulmonary disease, diabetes and cardiovascular disease, with ongoing clinical support in local government areas where prevalence and hospitalisation rates for priority chronic conditions remains high.

Twelve providers deliver the place-based and outreach primary care services via individual or group sessions either in person or via telehealth, working closely with the multicultural Health System Navigation program that assists refugee communities.

Key to the redesign is development of the Regional Health Navigator service, which is delivered across the four Murray PHN subregions – North West, North East, Central Victoria and Goulburn Valley - to help people who face significant barriers and engagement with relevant health services.

By targeting services where they are needed most, Murray PHN aims to support more connected, sustainable and equitable care for people living with chronic conditions.



Creating more pathways to safety

Domestic and family violence (DFV) is a community-wide problem that impacts the mental and physical health of people of all ages. With up to five survivors estimated to attend a GP every week*, Murray PHN funded Safer Families to deliver the Pathways to Safety Program to help build the capacity of primary healthcare providers to identify and support people experiencing DFV.

The training provides education, tools and support for practices to effectively identify, respond to and refer individuals and families to appropriate supports. Both clinical and non-clinical staff participate to build a whole-of-practice approach to improving identification, referral and coordinated care.

Twenty practices and 125 staff (39 GPs, 34 nurses, 34 administrative/reception staff, 15 practice managers, two GP registrars and one allied health professional) took part from Mildura, Albury-Wodonga, Benalla, Bendigo, Shepparton, Moira, Campaspe and Strathbogie local government areas.

Before the program, more than half of respondents had completed less than one hour of DFV training in their career. After the training, results showed consistent gains in self-reported confidence, comfort, and readiness to recognise and respond to DFV. Comfort in asking patients about DFV improved markedly, with the proportion of clinicians feeling 'comfortable' or 'very comfortable' rising from 47 per cent pre-training to 85 per cent post-training.

The lived experience co-facilitation and roleplay was identified as highly valued. Referral resources were also rated as highly useful by 96 per cent of participants.

"It really helps to solidify what you think is right and also to give you confidence in what you have provided is appropriate." - GP

"As a newly entered IMG GP, adapting to the Australian setting was one of the challenges that I have faced. Attending this program helped me to overcome that problem, especially with this type of sensitive issue." - GP

"I feel more equipped to ask the right questions in a supportive, trauma-informed manner." - GP

** 2021–22 ABS Personal Safety Survey*

Aged care

Murray PHN supports healthy ageing and aged care through a range of programs and activities, including initiatives that have arisen from the Royal Commission into Aged Care Quality and Safety. From sharing information and resources through dedicated newsletters and an online forum, to providing training and education to strengthen the skills and knowledge of the local workforce and ultimately, support older people maintain good health and wellbeing as they age.



Local support through Care Finder

Murray PHN funds seven local organisations to deliver Care Finder services across our region. Through the program, older people aged 65 years and older who don't have family or trusted carers can access free, localised, face-to-face support to help them navigate the aged care system, engage with services and stay connected.

Wellbeing support for aged care residents

Residents who have, or are at risk of developing, mild to moderate symptoms of mental illness can access free wellbeing support through the Psychological Therapy Services (PTS) in residential aged care program. Nine local organisations can help address a range of concerns in person, via telehealth and group sessions.





Advancing palliative care practice

Last year, Murray PHN provided funding so that aged care workers could attend the Hume region Palliative Care Summit at no cost. Delivered in person in Wangaratta and online, more than 100 people came together to hear from a range of speakers. Workshops included changed behaviours in dementia and creative practices for self care.



Helping residents and their families

Murray PHN assists residential aged care residents - often working with their families and aged care homes - to find a GP and general practice when they need one to enter, or continue living in, a residential aged care facility. Launched in 2024, the GP Aged Care Connect service helps new and existing residents access regular GP visits, care planning and health assessments available through MyMedicare.

Case study

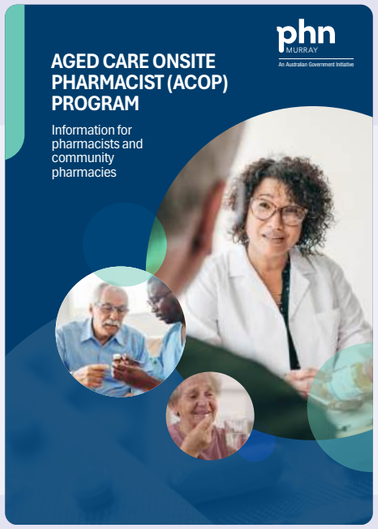
When Cohuna District Hospital's small rural residential aged care service went almost six months without a regular pharmacist staff needed a practical solution to ensure continued quality use of medicines for residents.

With limited local availability and long travel distances making recruitment difficult, they reached out to Murray PHN to enquire about the Aged Care Onsite Pharmacist program.

Murray PHN connected the service with an experienced, credentialed pharmacist who understood the onsite pharmacist role, and made it easy to embed and adapt it to a small rural aged care setting.

Since starting in late March, the pharmacist has become part of routine clinical care, reviewing medication changes, psychotropic medicines, medication incidents and falls where medicines may be a contributing factor. This visibility has helped build trust, ensuring pharmacist advice is connected to the day-to-day care of residents.

The role has also strengthened communication between nurses, visiting GPs, residents and families, while providing timely advice and education on medicines, including for diabetes and Parkinson's disease.



For Michele, Acting Aged Care Nurse Unit Manager at the time, the impact has been clear: "Good care has been enhanced; I really believe the change has provided better care for 16 people."

Michele said the outcome had been "a great thing for Cohuna" and it showed the value of working together with the PHN to find a local solution "that is really beneficial to our small community".

Case study

Due to an unexpected one-month absence of their regular GP, a nursing home engaged the GP Aged Care Connect Service to support the ongoing care needs of up to 30 residents.

With no other GPs available in the Swan Hill region, the service was able to identify a GP outside the local area with capacity to provide interim support, ensuring continuity of care for residents.

The primary objective was to source an interim GP capable of maintaining safe, high-quality clinical care and decision-making, so that residents and staff could access appropriate care while their usual GP was away.

A GP telehealth service was identified and engaged to provide interim coverage throughout the leave period. However, for telehealth to be provided, the GP first had to provide face-to-face assessments and the aged care home's systems needed to be set up to provide the telehealth model of care, which took time.

"The outcome exceeded expectations. When they [the GP] first took over the care, they spent an entire week onsite, seeing every resident, completing extensive investigations and ensuring all follow ups were addressed appropriately.

"This has now evolved into an ongoing relationship. The service has access to its own geriatricians, enabling referrals which provides an additional layer of support.

"There has been a noticeable reduction in hospital admissions, as well as fewer calls to the Victorian Virtual Emergency Department. Additionally, the GP has identified previously unrecognised conditions, enabling earlier intervention and improved management outcomes.

"A reduction in polypharmacy has also been observed, contributing to safer and more streamlined medication management for residents. Feedback from families and residents has been highly positive, with two residents formally requesting their ongoing care to be transferred permanently.

"The GP has consistently been described as attentive, thorough in assessments, proactive in conducting investigations, and diligent in coordinating referrals and follow-up care.

"Without the recent face-to-face visit from Murray PHN, we would not have been aware of the program or how to [initiate] contact. The overall experience was excellent. The transition progressed quickly and smoothly. Because it has been extremely positive, I have told the regional manager about it."

"The outcome exceeded expectations. This has now evolved into an ongoing relationship. The service has access to its own geriatricians, enabling referrals which provides an additional layer of support."



Digital health

Murray PHN supports health and aged care providers to improve digital health connectedness and effective use of technology that enables safe, efficient and coordinated healthcare. This includes Murray HealthPathways, My Health Record, Provider Connect Australia™, eScripts and Active Script List.

Providing guidance at the point of care

As local communities continue to experience the challenges of an ageing population, increasing chronic disease and varying access to services, Murray HealthPathways plays an important role in helping clinicians navigate evidence-based care and local referral options.

Since the introduction of individualised accounts in April 2025, 1979 primary care professionals have registered for access to Murray HealthPathways, with GPs the highest user group.

To ensure the information remains current, evidence-based and aligned with local clinical practice, new pathways are regularly developed and existing ones reviewed. This year, working groups came together to discuss medication management and driver assessments of older people. Several key population pathway suites were also updated, including for refugee health and children's conditions.

"Thank you for providing such a helpful response. I truly appreciate it. I was indeed searching for the obesity topic, and the pathway you shared was exactly what I was looking for. I have recently moved to Australia and have just started working here, and HealthPathways has already become an invaluable resource for me in understanding local guidelines and ensuring I am providing the best possible care. I am genuinely grateful for the work you and your team do." – GP



Supporting the use of electronic referrals

Murray PHN supports practices and works with hospitals to use eReferrals to send patient information securely between services.

Unlike paper-based referrals that can get lost or sent to the wrong recipient when faxed, electronic referrals are encrypted so only the intended receiving service can access them.

Improving communication and colonoscopy care

Providing complete and accurate information in a referral helps patients to move through the system faster and get the care they need. It also reduces administrative burden associated with following up information.

Albury Wodonga Health was working on a project to improve the quality of colonoscopy and endoscopy monitoring when it was identified that some GP referral letters were leading to delays in triaging and booking of appointments for patients.

To improve the coordination of information between the hospital and local practices, Murray PHN worked with Albury Wodonga Health to establish an eReferral network focused on improving the quality of colonoscopy referrals, in line with National Bowel Cancer Screening Program.

Murray PHN supported the onboarding of practices, including the installation of SeNT, a digital health solution and software application, providing education and training in its use for practice managers and GPs.

Because SeNT eReferrals support secure and standardised referral information, including referral date, patient symptoms and details, urgency and risk factors, it helps to measure referral-to-triage time, referral-to-colonoscopy time and time to treatment following positive screening results.

By improving communication between services and helping general practices provide necessary referral information from the start, the project has supported system-wide improvement across sectors. Importantly, faster triaging means that patients will now receive better access to timely bowel investigations.

Addressing mental health needs in Mitchell and Murrindindi shires

Building strong partnerships requires identifying shared objectives and co-designing solutions that effectively meet community needs through coordinated approaches and the delivery of key programs.

In 2024, Murray PHN completed a health needs assessment that identified gaps in access to mental health services across Mitchell and Murrindindi local government areas. Some of the issues identified included local availability, long wait times, poor communication between services and confusion navigating referral pathways. These were compounded by the rural location and lower mental health service supply compared with other parts of the region.

In response, Murray PHN supported a Lower Hume Primary Mental Health Service consortium approach through co-design with local stakeholders. This led to the development of an evidence-informed sub-regional model focused on improving access to primary mental healthcare, and strengthening communication between referrers and service providers.

A key activity was integrating the SeNT eReferral system into the new service model, however, as there was no existing SeNT footprint in the Lower Hume region, a significant effort was required to build new relationships and support practices to adopt a different referral process.

SeNT introduced standardised referral templates, mandatory referral information, secure referral transmission, receipt notifications and suicide-risk flagging. Receiver sites now access consistent referral information and use the same system to support intake, assessment, triage and transfer to clinicians.

Implementation of SeNT has helped reduce incomplete referrals, improve communication between general practices and mental health providers, and support more timely access to care for patients.

With several Hume-region practices onboarded, the eReferral footprint has expanded and there has been increased GP use of digital referrals, with recent engagement and training leading to a 106 per cent growth in referrals.

Implementation of SeNT has helped reduce incomplete referrals, improve communication between general practices and mental health providers, and support more timely access to care for patients.

Measuring digital health maturity

Healthcare services are using digital technology in more ways than ever before to share information more quickly, safely and securely to improve access to care.

This year, our second Digital Health Maturity Assessment showed steady improvement across general practice, residential aged care, community pharmacy and allied health services..

The voluntary assessment measures how effectively organisations use digital tools, information and technology to support patient care. It covers areas including telehealth, My Health Record, secure messaging, cyber security, digital skills and readiness for change.

The results show that digital health capability has improved since the first assessments were completed in 2023. Residential aged care made the strongest progress in use of digital tools, improving by 11.3 per cent, and achieved the highest overall maturity score. General practice continues to lead the way in digital health infrastructure, with widespread use of secure messaging, telehealth and My Health Record systems.

Allied health services and community pharmacies also showed substantial improvement in their preparedness to adopt and use digital tools, with 14 per cent growth in Murray HealthPathways use by pharmacy.

The findings are helping Murray PHN identify where additional support and investment are needed to continue building digital capability and create a more connected healthcare system that helps people to access the right care closer to home.

Overall Digital Health Maturity Assessment results across sectors

Sector	2023/2024 average maturity score*	2026 average maturity score^	Change
General practice	70.8	73.7	+2.9
Community pharmacy	64.4	70.7	+6.3
Aged care	67.2	75.3	+8.1
Allied health	62.1	64.1	+2.0
Total overall	**66.1**	**71.0**	**+4.9**

** Out of 100*
^ Out of 100 indexed









Mental health

Murray PHN commissions alcohol and other drug services and a range of primary mental health and psychosocial recovery services for people with, or at risk of, mental illness. From children to youth, and adults and older people who live in residential aged care homes, people are supported to maintain their wellbeing.

Caring for those who care for others

Health and aged care professionals play a critical role in supporting communities during times of crisis. Following the Victorian January 2026 fires, Murray PHN extended its employee assistance program to health and aged care professionals, providing access to counselling support seven days a week and during extended hours.





Psychological support for everyday living

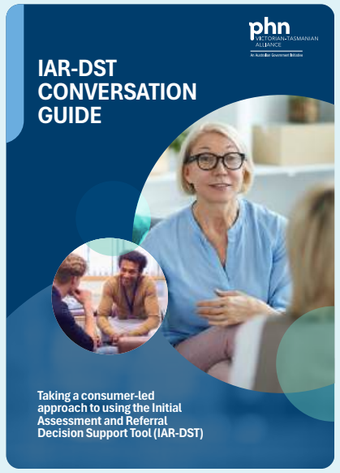
People with severe mental illness and associated psychosocial disability can receive strengths-based, recovery-focused, trauma-informed psychosocial supports through the Psychological Recovery Services (PRS) program. This includes one-on-one and group sessions for a range of non-clinical community-based supports, such as developing social skills and friendships, and managing money.

A resource to support 'level of care' assessments

The Initial Assessment and Referral Decision Support Tool (IAR-DST) is a nationally consistent approach to mental health assessment and referral. It helps inform the level of care a person may need.

While initially designed as a clinical resource, the IAR-DST is increasingly being used by a wider range of workers, including those in Victoria's Mental Health and Wellbeing Locals, such as peer workers and non-credentialled practitioners.

Recognising that clinical language and terminology could create barriers, Murray PHN led the development of a conversation guide on behalf of Victorian PHNs. Co-designed through working groups, the guide provides practical prompts for people administering the IAR-DST as to the kind of questions they can ask to explore and rate assessment domains. The guide supports consumer-centred conversations by suggesting open-ended, non-clinical questions that encourage people to share more of their story, rather than simply responding "yes" or "no".





Surveys to understand experiences of care

The national Your Experience of Service (YES) survey provides consumers with a meaningful opportunity to share feedback that supports continuous improvement across our commissioned primary mental health services. Results provide consumer insights to help us understand how well services are operating and improve the quality of services.

Findings from the most recent survey demonstrate delivery of strong relational care underpinned by empathy, professionalism and genuine commitment from service provider staff.

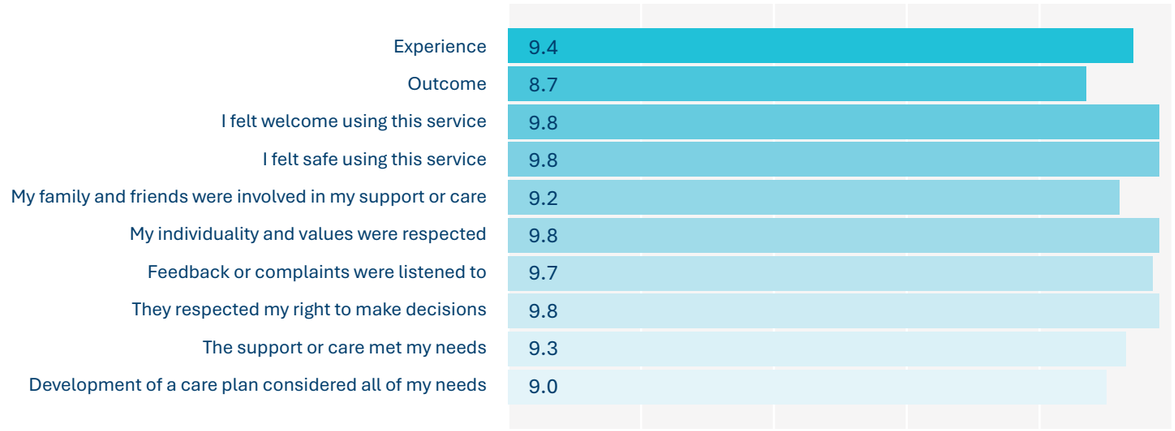
Of the 307 people who completed the survey, the average experience score was 9.4 out of 10 and the average outcome score was 8.7 out of 10. The table below presents selected experience measures.

What consumers value most

In addition to rating their experience and outcomes, people can provide written feedback about their care. Consistent themes from this feedback tell us that consumers value services that:

- show empathy and care
- make a person feel listened to and understood
- provide a welcoming and supportive environment
- make it easy to book appointments
- offer privacy and compassion
- suggest practical solutions
- follow up and check-in.

Average experience score from YES survey



Creative therapies delivering positive outcomes

In the last year, three new creative therapy services for people with moderate to severe mental health conditions have been established in Robinvale, Castlemaine and Albury-Wodonga.

As part of the Australian Government's Creative Therapies Pilot Program 2025-2027, the project has enabled innovative models of care and wide-ranging settings for delivery of creative therapy services, including outreach into rural schools and aged care facilities (Robinvale).

In addition to more conventional individual and group therapy sessions, the programs offering alternative pathways for community members to access creative therapies. These include drop-in groups in community spaces – a suggestion by community members during a consultation period in 2025.

One hundred and forty-three people have participated in creative therapy sessions so far, and in Castlemaine, a group for children impacted by the Harcourt/Ravenswood bushfires was attended by 34 individuals over nine sessions.

Early outcomes data indicates that 87.5 per cent of participants who have been discharged from the service have experienced significant improvements in their mental health.

"Running the creative art therapy program has already had a significant impact on the wellbeing of our students. It has given them a reason to get up and come to school, where previously we'd had reports of school refusal from parents."
– Primary school principal

"Art therapy helps me not get anxiety."
- Primary school student



Below: Community of Practice gathering (L-R): Amy Gross, Meredith Davies and Annie Fox from Dhelkaya Health; Esther Duursma, Gateway Health; Catherine Threlfall, Murray PHN Creative Therapies Pilot Program Project Lead; Cat Moser, Mallee Family Care; and Annie Cornell, Gateway Health.





Cultivating safe and supportive clubs

Following dedicated workshops for men last year, hundreds of women from netball, soccer, basketball, baseball and other clubs were supported to attend wellbeing workshops this year.

Between March and June, 14 Tomorrow Woman workshops were held in Albury, Bendigo, Boort, Corryong, Irymple, Mansfield, Mitta Mitta, Myrtleford, Newham, Rutherglen, Shepparton and Wangaratta.

Participants took the opportunity to come together and unpack what it means to be a woman in today's world, exploring social expectations and gender norms. Through creating safe spaces for connection, reflection and growth, they also explored what tomorrow might look like.

As well as enhanced self-awareness, confidence and resilience, the workshops provided tools and strategies to increase inclusivity and compassion to foster greater team morale and club culture, both on and off the court and field.

"A huge thank you to Murray PHN for funding this opportunity and helping bring such an impactful program to our community."
- Rutherglen Football Netball Club

"Really enjoyed it and certainly was a great bonding activity for our group."

"How powerful it can be to spare a few hours to really listen to each other in a vulnerable space."

"It validated how a lot of women feel and it made me feel not so alone. I also think it highlighted an area which we need to work on supporting more, which is our younger girls in the club."

"Thank you so much. I really needed to hear all of this."

"It has made me realise I am not alone."

"I am now inspired to make a change."

"I've walked away feeling strong and empowered."

"I have never been to one of these workshops, and I am so glad I came because there were so many things I have taken away and it was good to feel supported by everyone."

Young people at the centre

headspace provides young people aged 12 to 25 years old with early intervention support for mental health, physical and sexual health, alcohol and other drug services, as well as work and study assistance.

All headspace centres in our region – Albury-Wodonga, Bendigo, Echuca, Mildura, Shepparton, Swan Hill and Wangaratta as a satellite centre - are funded by the Australian Government and commissioned by Murray PHN.

We work closely with the centres and lead agencies to improve the supports available to young people and their families, with thousands receiving support every year.

headspace Bendigo to become a headspace Plus

headspace Bendigo is set to be among one of the first centres in Australia to introduce the headspace Plus model from 1 July 2027, following an announcement by the Hon Emma McBride, Assistant Minister for Mental Health and Suicide Prevention and Assistant Minister for Rural and Regional Health, and Lisa Chesters MP in August.

During the last financial year, headspace Bendigo delivered more than 5700 free sessions to more than 1100 young people, demonstrating the need for accessible, youth-friendly early intervention mental health support close to home.

headspace Plus will enable the Bendigo centre to strengthen its specialist workforce to increase capacity and regional footprint, and support more young people experiencing complex or serious mental health concerns. The multidisciplinary model will bring together mental health clinicians, GPs, peer workers and counsellors to provide more timely, integrated and high-quality care.

L-R: Lisa Chesters MP, Hon Emma McBride MP, Haylee Kennedy (headspace Bendigo), Mandy Hutchinson (Bendigo Community Health Services), Cilla Boucher (Bendigo Community Health Services), Lindsay Rose (headspace Bendigo), Jacque Phillips (Murray PHN), and Brandon James (Murray PHN).



National consistency, local flexibility

Murray PHN and headspace centre staff attended the headspace National Forum in Brisbane in June to hear from a range of speakers on the theme of Growing Together, reflecting how the network continues to evolve and adapt while remaining grounded in the shared purpose of supporting young people.

The forum reinforced the importance of connection, collaboration and contemporary approaches to care, with sessions covering early intervention, co-occurring conditions, workforce sustainability, integrated service delivery, data-informed decision-making and improving accessibility for hard-to-reach communities.

A key message was the need to balance national consistency with local flexibility, ensuring services align with frameworks, while responding to the unique needs of local communities. This approach underpins the work of Murray PHN and the six headspace centres in our catchment.





Top right L-R: Meaghan Sully, headspace Echuca Centre Manager and Brandon James, Murray PHN Mental Health and AOD Coordinator.
Bottom right L-R: Brandon James and Teresa Cavallo, headspace Mildura Centre Manager.
Below: headspace national conference Brisbane.

New outreach services for Kerang, Seymour and Robinvale

In rural areas, young people can face barriers to care, including cost, long wait times and limited local access. With many mental health conditions emerging during adolescence, early identification and timely support are critical.

In July 2025, funding for a national network of 20 headspace outreach services was announced by the Department of Health, Disability and Ageing, with Murray PHN submitting an application for five outreach locations following consultation with local headspace centres and mental health services, combined with review of population data and health service feedback.

Three of our submissions were selected, with headspace outreach services to be established in Robinvale (headspace Mildura), Kerang (headspace Swan Hill) and Seymour (headspace Shepparton) by the end of the 2026/27 financial year.

Outreach services will be trauma- and evidence-informed, and culturally safe and responsive. They will include the provision of therapeutic supports, and a selection of service offerings tailored to and in partnership with the local community.

Enhancing suicide prevention efforts

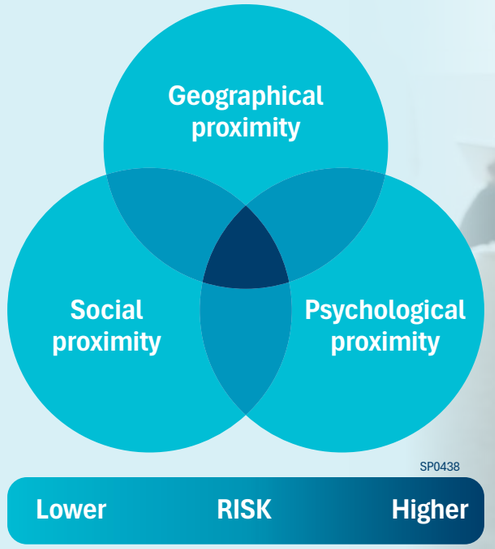
This year, Murray PHN developed a suite of resources, delivered workshops and provided funding to support community postvention planning and preparedness following a suicide. The initiative supported lead organisations in Alpine, Bendigo, Buloke and Upper Murray to build awareness, preparedness and confidence, to establish cross-sector partnerships, and form local response groups to develop plans that guide communities following a suicide.

Postvention planning is not an emergency response. Instead, it provides a framework to support communities and organisations in the weeks, months or even years after a suicide, helping to reduce the risk of further tragedy, while supporting recovery and healing.

The resources were designed to help local organisations, leaders and service providers create coordinated, compassionate and evidence-informed responses tailored to the needs of individuals and communities affected by suicide. The goal is to ensure people can access appropriate support during some of their most challenging times.



Developed as part of the Targeted Regional Initiatives in Suicide Prevention program, the materials combine best practice approaches, practical tools and step-by-step guidance. Together, they help communities prepare for and respond to suicide in ways that support recovery, reduce the risk of further harm and strengthen long-term resilience.





Improving mental healthcare in the Mallee

In August, Murray PHN supported improved regional collaboration by hosting the Northern Mallee Mental Health Services Forum in Mildura on behalf of the Northern Mallee Mental Health Leadership Network. The event brought together more than 70 professionals from mental health, health, local government and community services across Mildura, Robinvale, Ouyen and neighbouring NSW communities.

With a focus on service integration, the forum created the opportunity for participants to share knowledge, strengthen their professional connections and build a clearer understanding of local supports, roles and referral pathways. The conversations have helped to improve coordination across the service system and support more seamless care for people in the Northern Mallee region.

Keynote speaker Vrinda Edan, CEO of VMIAC, reinforced the value of centring lived and living experience in mental health service design and delivery. Vrinda’s address encouraged organisations to approach innovation with curiosity, strengthen cross-sector relationships and remain open to learning from different perspectives.

The forum demonstrated the value of bringing services together around a shared purpose. The relationships and insights will contribute to more connected, person-centred care system and improved outcomes for people accessing mental health supports.



Upskilling local community leaders

Following tragic events in the Boort and Quambatook areas last year, Murray PHN was approached to support local initiatives that could strengthen community resilience and wellbeing.

In partnership with of Northern District Community Health and Boort District Health, a group of community leaders was identified to participate in a two-day Seasons for Growth workshop funded by Murray PHN.

The workshop was held in February, the workshop equipped participants with the knowledge, skills and attitudes needed to better understand and respond to experiences of change, loss and grief, enabling them to support both their own wellbeing and that of their communities



Projects and activities

Murray PHN delivers targeted projects and activities that respond to the unique needs of our communities. Working in partnership with healthcare providers, community organisations and consumers, these initiatives aim to improve access, quality and outcomes across the health system.

Building death literacy and compassionate communities

Responding to priorities identified in Murray PHN's Palliative Care Population Health Series Report, the Good2Go Collective was engaged through the Greater Choice for At Home Palliative Care program to deliver a series of community workshops and events for North East Victoria and NSW border communities.

The goals of the workshops were to normalise conversations about death and dying, support people to consider documenting their preferences and wishes in advance care plans and foster greater connections through peer support groups.

From January to August 2026, the program reached more than 260 people through workshops, film screenings, Death Cafés and events designed for people facing life-changing illness, carers, families and community members wanting to better understand and navigate the health system.

Fourteen Death Cafés in Beechworth, Wangaratta and Yackandandah attracted approximately 100 attendees, creating welcoming spaces for people to talk about death, dying, grief and living well.

Seven Hope for the Best, Plan for the Rest workshops were delivered online and in Albury, Wangaratta, Beechworth, Corowa and Mt Beauty, with 63 community members attending. The workshops provided practical, step-by-step guidance to help people with serious illness, carers and families prepare, ask questions and make informed decisions.

Two *Edge of Life* film screenings were held with 54 attendees. The Australian documentary, which explores psilocybin-assisted therapy with palliative care patients, provided an entry point for community conversations about dying, end-of-life care options and experiences.

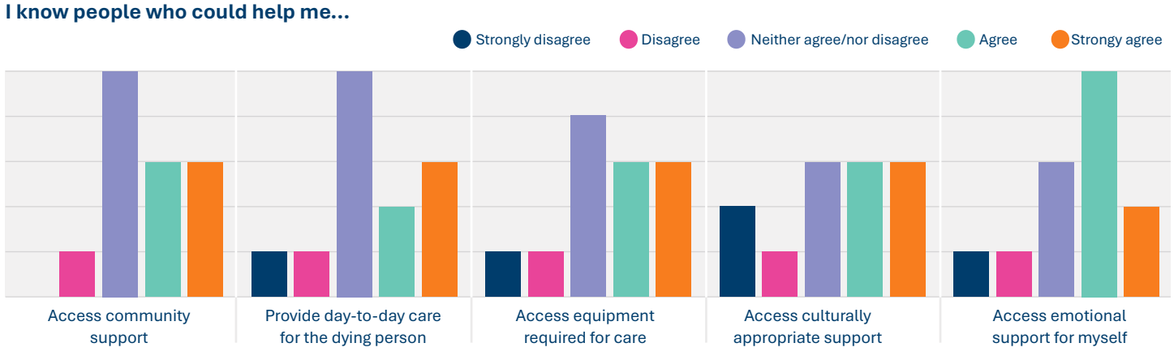
Three Whole Box & Dice workshops were delivered to 27 attendees, covering practical and personal aspects of end-of-life preparation, including death checklists, death cleaning, funerals and celebrations.

A Death in the Afternoon gathering was also held in Beechworth on Dying to Know Day, bringing 25 people together for conversation, connection and reflection.

Feedback shows the value of relaxed, practical and supportive learning environments, with workshop participants saying it helped them understand "how to be in control of your own life – be proactive, not passive" and learn about "options people have that can make the biggest difference in facing the end-of-life".

Death Literacy Index surveys were administered at workshops with 47 responses received. The findings help us to measure changes in community knowledge, skills and confidence around end-of-life care, including awareness of available supports, care options and practical planning.

If I were to provide end-of-life care for someone, I know people who could help me...





Pictured L to R: Helen Callanan, Esther Guinea, Tania Collins, Yvonne Kiel, Anna Beilharz, Jenny Blake and Carolyn Bathurst.

Rochester event sells out

A sold-out Dying to Know event brought together around 80 people from Rochester and surrounding communities to explore how to prepare for the future with care, confidence and purpose.

Participants met local organisations, asked questions and heard presentations on topics including advance care planning, palliative care, mindfulness, grief and home support, and voluntary assisted dying.

The event was coordinated by local End of Life Doula Esther Guinea, with support from Helen Callanan, founder, co-owner and lead educator of Preparing the Way, who has trained more than 2600 doulas.

In addition to supporting delivery of the day itself, Murray PHN provided important infrastructure that helped enable the event, including registration management, communications and promotion, agenda development, coordination support, and integration with local health and community services. This type of support helps build local capacity, strengthen relationships across the health and community sectors, and fosters a more connected and multifaceted approach to end-of-life care.

The event also generated momentum for future community-led activities by increasing awareness of available supports, identifying areas of interest and helping map existing strengths and opportunities for ongoing death literacy and compassionate communities work.

The evaluation findings were encouraging, with 100 per cent of respondents indicating that the event met their expectations. Furthermore, those who attended recorded an overall DLI-9 scaled mean score of 7.19/10, compared with the Australian benchmark of 4.83/10.

The Death Literacy Index (DLI) is a survey tool that measures people's knowledge and skills about death, dying and end-of-life care, and enables individuals and communities to better support dying people and those who are grieving.

Supporting workforce capability

To strengthen confidence and capability in person-centred palliative and end-of-life care, Murray PHN supported four regional health, aged care and disability workers to attend the Palliative Care Victoria 2026 Summit in Melbourne.

The scholarships covered travel, accommodation and attendance, enabling rural and regional workers who support diverse communities to take part in dedicated professional development.

Held in May, the summit theme was 'Every Voice Counts: Collaborative approaches to palliative care', and featured diverse population perspectives including LGBTQIA, multicultural, First Nations, dementia and disability.

The opportunity supported learning, reflection and connection, while aligning with Murray PHN's focus on improving access to high-quality, inclusive care closer to home.

Capacity building through education, training and development

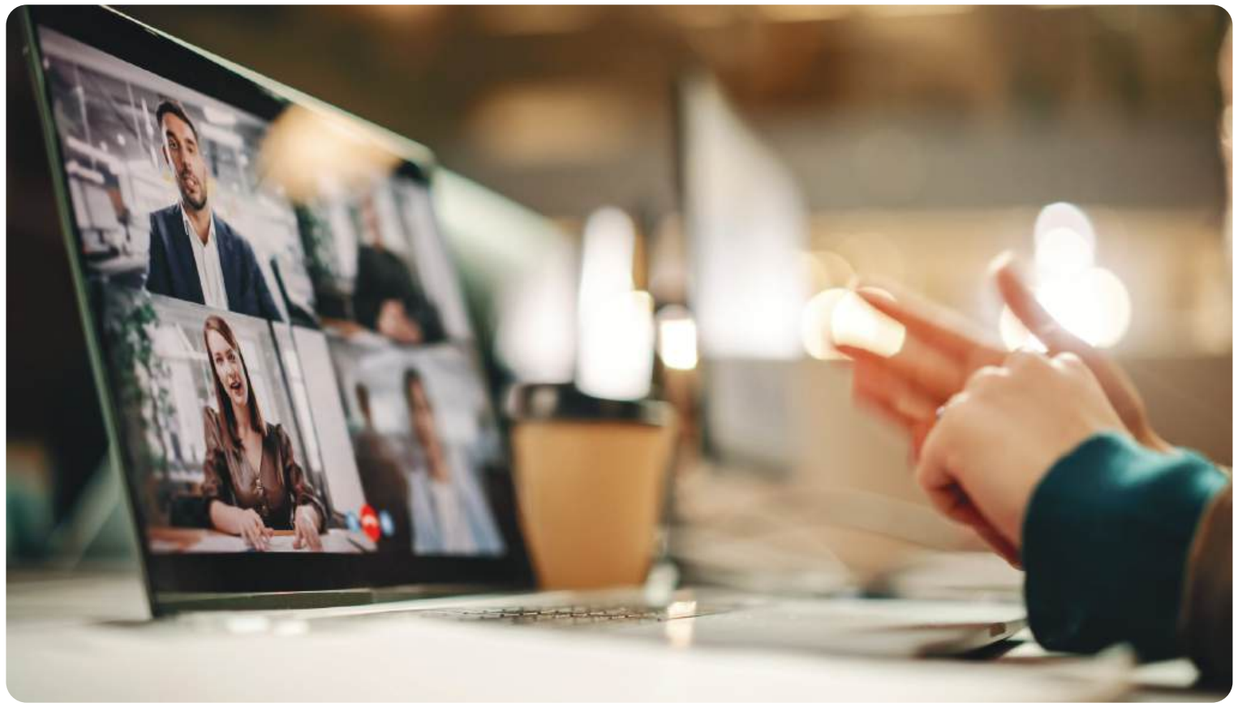
To strengthen our local primary healthcare workforce and help deliver improved patient care, Murray PHN supports capacity building through a range of activities that foster networks, and develop skills and knowledge through a variety of mostly free events delivered in-person, online and in hybrid formats.

In the 2025-26 financial year, our program included:

- 115 continuous professional development (CPD) events
- 1777 attendees
- Communities of Practice for allied health professionals, care finders, health system navigators, GPs and GP registrars, primary mental health service staff, psychosocial recovery services and youth enhanced services, and health professionals working in residential aged care
- A range of topics including Aboriginal cultural safety, ADHD, advance care planning, alcohol and other drugs, cancer screening, cardiovascular disease, chronic kidney disease, dementia, diabetes, gastroenterology, gestational diabetes, LGBTQIA+ healthcare, immunisation, infection prevention and control, mental healthcare, National Lung Cancer Screening Program, palliative care, sexual and reproductive health, spirometry, suicide prevention, urgent care identification, urogynaecology, women's health and wound management
- Partnering with a variety of organisations to deliver CPD events that included peak bodies, local health services, state and federal government departments, primary care providers, universities and other PHNs
- 18 recorded webinars with more than 350 views
- 49 Events Update newsletters distributed to more than 500 subscribers.

In addition to CPD events, an additional 43 other engagement events involving more than 600 attendees were held and provided community, primary and other healthcare professionals with opportunities to network and participate in focus groups, workshops, meetings, forums and information sessions focused on strengthening primary care.

To access upcoming and recorded CPD events and to subscribe to the Events update, visit: murrayphn.org.au/education



Education spotlight:

Improving dementia care

Across May and June, Murray PHN hosted four dementia care education sessions in Albury, Shepparton, Bendigo and Mildura for 96 GPs, GP registrars, nurses and other health professionals. Collaborating with a local geriatrician in each region, the topics presented included dementia care, management and support, medication and deprescribing, diagnosis and treatment, and non-pharmacological and pharmacological management options.

Murray PHN dementia and aged care resources were shared, including clinical and referral Murray HealthPathways, the Aged Care Onsite Pharmacist Program and GP Aged Care Connect.

91% of respondents shared an overall positive satisfaction rating with the activity





Pictured left, L-R: Dr Susan Furphy, Murray PHN Medical Advisor and presenter Dr Hong Yu, Specialist Physician and Geriatrician in Albury.

Right: Dr Femi Afolayan, Consultant Physician and Geriatrician in Shepparton.

Above: Shepparton participants.



Training spotlight: Spirometry

In collaboration with the National Asthma Council Australia and delivered by their asthma and respiratory educators, Murray PHN hosted Spirometry training for GPs, GP registrars, nurses and other health professionals in Albury, Shepparton, Bendigo and Mildura. Over five workshops, 75 participants received comprehensive training in the application and interpretation of expiratory spirometry in general practice.

100% of respondents shared an overall positive satisfaction rating with the activity



Participant feedback:
"Thanks for a great education session."
"Presenters were great and engaging."
"Excellent."



Training spotlight:

Introduction to Aboriginal Cultural Safety

Delivered by the Victorian Aboriginal Community Controlled Health Organisation (VACCHO), Murray PHN funded Introduction to Aboriginal Cultural Safety training for primary healthcare professionals with 110 participants across eight online workshops.

"It was valuable and helped deepen my understanding of how culture influences communication, expectations and patient care. The training provided practical tools, real examples and strategies that I can use every day in the workplace." - Workshop participant



Strategy

Murray PHN uses strategic, outcomes-based and evidence-informed decision-making to ensure our funding is directed where it can make the greatest difference to the health and wellbeing of people across our communities. By using data, evidence and local knowledge, we identify priorities and invest in initiatives that strengthen the capacity, sustainability and effectiveness of the rural health system.

Our Planning and Performance team supports this work by bringing together data, intelligence and community insights to inform planning and commissioning. This enables us to build a clear understanding of local health needs, service gaps and opportunities, and ensure our approach remains responsive to changing priorities.

Exploring palliative care needs of our population

Most people hope to spend their final stages of life comfortably and surrounded by the things that are important to them. Being able to access good palliative and end-of-life care early helps make those wishes a reality.

Released earlier this year, Murray PHN's Palliative Care Population Health Series Report brings together local and data, community voices and service experience to better understand what people need, what is working and where more support is required in palliative care.

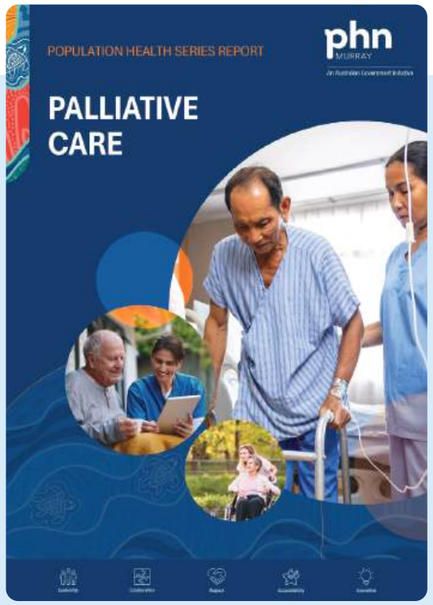
The report shows that demand for care is growing as the region's population ages, with people aged 65+ projected to make up 27 per cent of the catchment by 2030. It also highlights the challenges many local people face, including long distances to travel for care, workforce shortages, limited after hours support and inequitable access to specialist and primary care.

Through the Greater Choice for At Home Palliative Care program, Murray PHN is already working with communities, healthcare providers and partner organisations to strengthen connections across the palliative care system, support workforce capability, raise awareness of available services and resources, and encourage conversations that help normalise death and dying.

The report is available to healthcare providers, organisations, policymakers, partners and communities to inform planning and decision-making that supports high-quality palliative care. Access the report at: https://murrayphn.org.au/about-us/key-documents

The report's recommendations focus on practical actions such as:

- Supporting GPs, aged care and allied health workers to build palliative care skills
- Strengthening collaboration to improve care at home and after hours support
- Partnering with Aboriginal Community Controlled Health Organisations and First Nations communities to support culturally safe approaches to care
- Increasing awareness of available supports and information for multicultural and refugee communities
- Encouraging greater use of digital tools that enhance communication and coordination across services
- Supporting earlier conversations about people's wishes, values and preferences for care.



Understanding and responding to LGBTQ+ health needs

Lesbian, gay, bisexual, transgender, queer and/or questioning and other communities (LGBTQ+) in regional and rural Australia continue to experience poorer health and wellbeing outcomes than both non-LGBTQ+ rural residents and LGBTQ+ people living in metropolitan areas.

Following advice from our advisory councils who identified LGBTQ+ health as both a priority population issue and evidence gap, Murray PHN undertook a needs assessment to improve understanding of local health needs, service access barriers and opportunities for more inclusive primary healthcare.

Released in July, the Population Health Series Report brings together local consultation, secondary data analysis and a review of available evidence. The work was developed with the Australian Research Centre in Sex, Health and Society (ARCSHS) at La Trobe University, with support from Rainbow Health Australia and Thorne Harbour Country.

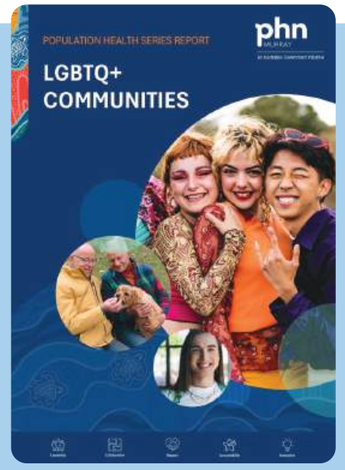
Community members, advocates and service providers helped shape the report, ensuring that local experiences and priorities were reflected throughout its findings and recommendations. Their contributions highlight where service systems are working well, where gaps remain and how planning, commissioning and partnerships can respond in practical ways.

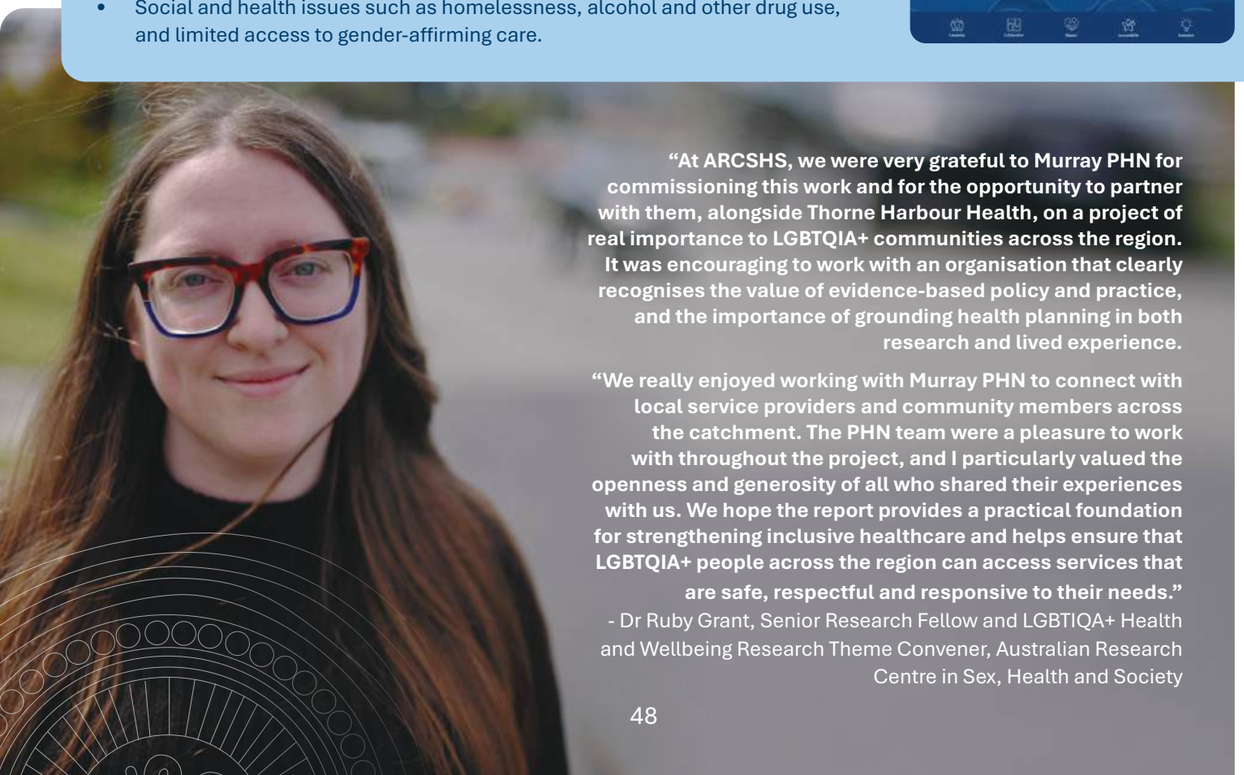
The recommendations focus on strengthening community engagement in planning and service design, improving inclusive data collection, building workforce capability, increasing visibility of safe services, and creating clearer referral pathways and accountability mechanisms.

The report provides an evidence base for Murray PHN, commissioned services and partner organisations to plan and deliver activities that improve health and wellbeing outcomes for LGBTQ+ communities across our catchment.

The report identifies a range of challenges including:

- High levels of psychological distress, loneliness and suicidality, with discrimination and unsafe service experiences contributing to poorer mental health
- Difficulty finding safe, inclusive and locally available care, with access often dependent on word-of-mouth referrals or a small number of trusted practitioners
- Compounding barriers for people with intersecting identities, including Aboriginal and Torres Strait Islander people, people from migrant and culturally diverse backgrounds, people with disability, and trans and gender diverse people
- Social and health issues such as homelessness, alcohol and other drug use, and limited access to gender-affirming care.





"At ARCSHS, we were very grateful to Murray PHN for commissioning this work and for the opportunity to partner with them, alongside Thorne Harbour Health, on a project of real importance to LGBTQIA+ communities across the region. It was encouraging to work with an organisation that clearly recognises the value of evidence-based policy and practice, and the importance of grounding health planning in both research and lived experience.

"We really enjoyed working with Murray PHN to connect with local service providers and community members across the catchment. The PHN team were a pleasure to work with throughout the project, and I particularly valued the openness and generosity of all who shared their experiences with us. We hope the report provides a practical foundation for strengthening inclusive healthcare and helps ensure that LGBTQIA+ people across the region can access services that are safe, respectful and responsive to their needs."

- Dr Ruby Grant, Senior Research Fellow and LGBTIQA+ Health and Wellbeing Research Theme Convener, Australian Research Centre in Sex, Health and Society

Connecting people, strengthening healthcare

As part of the Loddon Mallee Thin Markets Project - which supports sustainable access to primary healthcare services in Swan Hill, Rochester and Stanhope - the funded Attract Connect Stay (ACS) program continues to play a key role in strengthening the healthcare workforce across these priority catchments.

Through workforce attraction, recruitment support, settlement assistance and community connection activities, ACS helps healthcare professionals and their families build strong local networks and a sense of belonging, supporting long-term workforce retention and improved access to primary healthcare.

In 2026, ACS organised several engagement activities designed to bring healthcare workers, their families and local communities together.

In Stanhope, Kyabram District Health Service celebrated the ongoing growth of the Stanhope clinic with a Christmas in July event recognising the contributions of healthcare staff, support teams and community members. The clinic has expanded from an initial GP and nursing telecare service to now include allied health, physiotherapy, mental health and social work services, with further expansion opportunities being explored.

In Swan Hill, a staff and family connection event at the Pioneer Settlement brought together 192 healthcare workers from Swan Hill District Hospital and Swan Hill Primary Health Medical Centre, and their families. Attendees enjoyed activities including the Heartbeat of the Murray laser light show, creating valuable opportunities to connect outside the workplace and strengthen professional and social networks.

Feedback from attendees was overwhelmingly positive, with the event selling out and generating strong interest across health services. Together, these activities highlight how the Loddon Mallee Thin Markets Project and ACS program are supporting the recruitment, settlement and retention of healthcare professionals, helping to build a sustainable primary healthcare workforce and maintain access to vital local health services.







Pictured top and middle: Thin Markets community event in Swan Hlll; Right: Thin Markets Attract Connect Stay Christmas in July dinner.

Upskilling the medical workforce

In October, Murray PHN supported Swan Hill District Health to deliver a two-day workshop for 20 participants through the Thin Markets Project, together with Connecting the Docs and the Australian College of Rural and Remote Medicine. The event combined hands-on learning with opportunities for collaboration, helping the medical workforce strengthen skills and improve access to care in regional Victoria.









Showcasing services in St Arnaud

Representatives from the Department of Health, Disability and Ageing visited St Arnaud in October to learn about the East Wimmera Thin Markets project and the planned delivery of integrated primary healthcare services in the region.

During the visit, attendees toured the proposed St Arnaud Hub facility site, which will serve as the central location for a multidisciplinary team-based model of care bringing together GPs, nurse practitioners, nurses and allied health professionals to provide a single point of access for community members.

The visit provided the opportunity to showcase the future hub location and discuss how the project will support a sustainable, multidisciplinary primary care workforce while improving healthcare access and coordination for local communities.



Pictured L to R: Murray PHN Strategic Projects Coordinator, Susan O'Neill, and Health Systems Senior Manager Nerida Hyett; East Wimmera Health Service CEO, Trevor Adem; DHDA Thin Markets Program Assistant Director, Wendy Geoghegan and Project Officer, Cia Kay.

Corporate

At Murray PHN, our strength lies in the people who make up our organisation. Our team includes professionals from a broad range of fields, bringing valuable knowledge and experience to their work. Combined with a strong connection to rural communities and an understanding of local challenges and opportunities, this diversity helps us better support the health and wellbeing of our region.

Informing the future of the PHN model

People's experiences of primary healthcare are shaped by where they live, the services available to them and how well those services work together. The first national review of the Primary Health Network (PHN) Business Model provided an opportunity to consider how PHNs can continue to support communities, providers and government to improve access to timely, appropriate and coordinated care in a changing health policy environment.

Commissioned by the Department of Health, Disability and Ageing and undertaken by Boston Consulting Group, the review, together with the evaluation of the Mental Health Flexible Funding Stream, confirmed the important role PHNs play in supporting national reform and commissioning services that are responsive to population health needs.

Murray PHN contributed to the review by conducting stakeholder and advisory council interviews and providing written submissions, both independently and through the PHN Cooperative and the Victorian and Tasmanian PHN Alliance. Our input reflected what we heard: that any future PHN model must embed an understanding of regional contexts and actively engage with the voices of local providers and patients.

The review also highlighted opportunities to strengthen governance, engagement, funding arrangements and performance reporting, so PHNs maintain sustainable operations into the future.

Murray PHN welcomed the findings, recognising the potential to reduce fragmentation, strengthen collaboration and ensure investment is directed to where it can make the greatest difference in achieving better outcomes for communities.

Informed by the review, Murray PHN has focused its efforts this year on adapting strategies, structures, systems and processes. This reinforces our commitment to using local needs assessments, data and community insights to guide commissioning decisions, while maintaining accountability as a trusted partner of the Commonwealth and a steward of public investment in primary care.

By progressing the recommendations, Murray PHN and all PHNs are better positioned to support responsive, integrated and equitable care, particularly for people and communities experiencing barriers and inequities in primary healthcare access across Australia.

Regional planning for mental healthcare

In October, PHN policy and program directors from the Department of Health, Disability and Ageing (DHDA) met with key Murray PHN staff to discuss Primary Mental Health Care Flexible Funding and regional planning. During the trip, a site visit was made to Bendigo Community Health Services (BCHS).



Pictured L to R: Alistair Bonsey (Murray PHN), Chloe Tobin (Murray PHN), Owen Pettit (DHDA), Mandy Hutchinson (BCHS), Ian Johansen (Murray PHN), Shona Falconer (DHDA), Cilla Boucher (BCHS), and Matt Jones (Murray PHN).

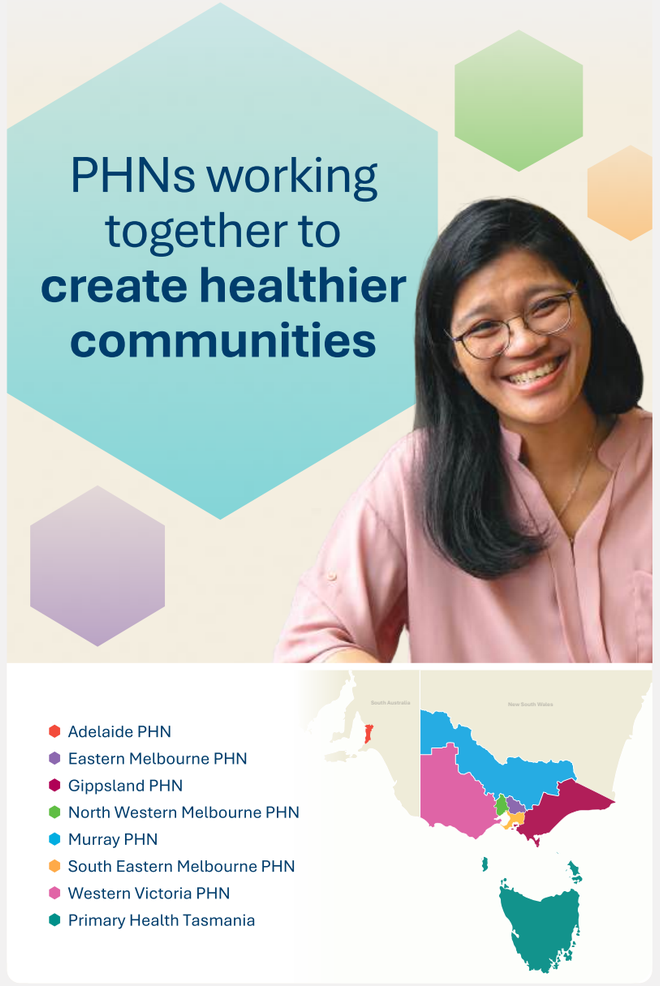
PHN Southern Alliance

Collaborating to create healthier communities

This year, Murray PHN's Communications team supported the rebranding of the Victorian and Tasmanian Primary Health Network Alliance as the PHN Southern Alliance, following Adelaide Primary Health Network's admission to the group.

The Alliance now brings together eight Primary Health Networks across three states: Adelaide, Eastern Melbourne, Gippsland, Western Victoria, Murray, North Western Melbourne, South Eastern Melbourne and Primary Health Tasmania.

Since 2016, member PHNs have worked together to share knowledge, develop consistent approaches and make better use of their collective expertise. This collaboration helps strengthen primary care and improve health outcomes across the communities they serve.



Driving improvement through feedback

We welcome feedback from stakeholders and community members, with all submissions recorded and responded to. Compliments, complaints and suggestions can be provided through a range of channels, including via our website.

Feedback helps us understand where we are delivering the most value and where we can strengthen our support for clinicians and the health of our communities.

Over the past year, we received a broad mix of feedback across our programs, services and employees, including:

"What you are doing is truly amazing. It's [suicide] been a silent epidemic for years waiting for someone to give it a platform. I hope the [His Story] campaign grows into something loud."

"Your presentation was greatly appreciated and very well received by the team. The insights and perspectives you shared made for an engaging and valuable session, and the feedback afterwards was overwhelmingly positive."

"I am writing to express my sincere gratitude for your help with this matter. Your assistance with this case was invaluable, and I truly appreciate your willingness to go above and beyond to ensure its success."

A new strategic direction for Murray PHN

In August, we launched our 2026-2029 Strategic Plan which details how we'll work over the next three years to strengthen primary healthcare across our region and support better health outcomes.

Developed through extensive engagement with staff, community members, health practitioners, advisory councils, regional health services and other partners,
the plan provides a clear roadmap for our role in translating national health reform into practical, locally relevant action.

The plan is built around three strategic pillars: service system capability, community and organisational performance.
These are supported by a focus on partnerships, workforce, population health planning, regional equity, commissioning, culturally responsive approaches, accountability, organisation orientation, and organisational systems and capability.

It also reinforces our unique role working between communities, providers and government to improve access, equity and quality of care so that people can stay healthier in their communities.

To read the 2026-2029 Strategic Plan , visit:
https://tinyurl.com/3wtzmdmb

Contributing to our Strategic Plan

Four regional stakeholder events were held during April and May to test our new strategic direction. Thirty-five stakeholders attended, representing 24 unique organisations. Each event was also attended by the relevant Community Advisory Council Chair (or a member representative) and a member of our Clinical Advisory Council.

The seven Aboriginal Controlled Community Health Organisations (ACCHOs) in our catchment were also engaged in this process, strengthening the relationship between Murray PHN and ACCHOs.

Stakeholder events saw attendees highly engaged, with rich conversations reflecting the focus Murray PHN has on developing and sustaining meaningful partnerships.

	Service system capability	Community	Organisational performance
Strategic pillars			
Strategic focus	Partnerships Workforce Population health planning	Regional equity Commissioning Culturally responsive	Accountable Organisation orientation Organisational systems and capability
Outcomes we seek	• Priority health needs are addressed • Improved primary healthcare provider capability and capacity	• Improved access to primary care services • Improved health and wellbeing outcomes	• Sustainable organisation • Engaged and capable workforce • Smarter systems

Measuring what matters

To better understand the difference our work is making for communities, Murray PHN has strengthened how performance information is collected, managed and reported.

Following the Australian Government's review of the PHN business model, the Performance Measurement and Reporting Framework was revised to include 27 indicators across coordination, capacity building, commissioning, compliance and impact. Annual case studies are also now themed around health prevention and early intervention, equity, digital health and technology, and integrated systems.

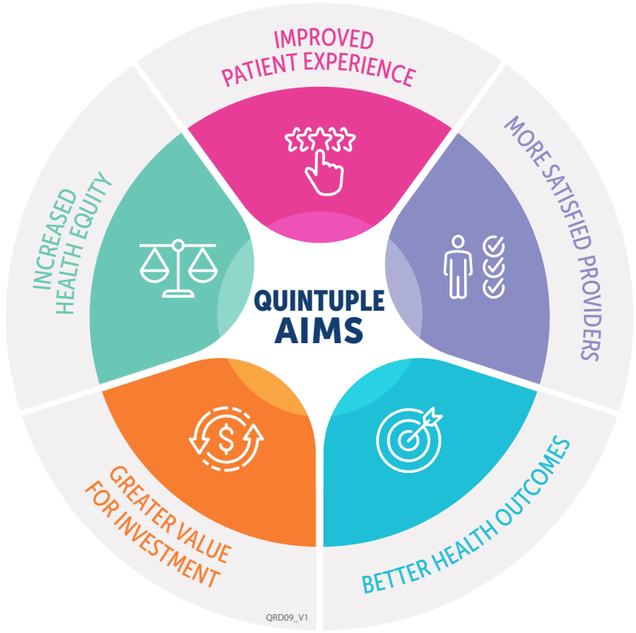
The framework is designed to show how PHN activities contribute to outcomes at both an individual PHN and program level, with a forward focus on the Quintuple Aim.

These enhancements have strengthened Murray PHN's ability to demonstrate impact, support continuous improvement and share meaningful insights with the Australian Government about how work is being delivered for communities across our region.

It also helps identify strengths, opportunities for improvement and ways to share learning across the PHN network.

Technical specifications and performance criteria for each indicator support consistent implementation across PHNs and clearer reporting on issues, objectives, activities, outcomes, evidence, lessons learned and future opportunities.

For Murray PHN, these changes created an opportunity to plan and consolidate reporting requirements, establish a new working group and strengthen data management processes and procedures. This supports the collection, extraction, collation, validation, storage and reporting of information needed to demonstrate



Refreshed values to guide our work

Murray PHN's values define how we work together and how we engage with our partners, providers and communities. They translate our purpose into consistent, everyday behaviours that guide our decisions, strengthen trust and help us navigate complexity.

This year, our values were updated as an outcome of developing the organisation's new strategic plan.

By demonstrating leadership, respect and accountability in every role, we create an inclusive and effective workplace, build strong relationships and deliver on our commitments.

Living our values enables us to make a meaningful contribution to better health outcomes communities across the Murray PHN region.



Leadership
We recognise our role as stewards and connectors in primary healthcare and the broader health system.

Respect
We treat all people fairly, valuing diverse perspectives, recognising the knowledge our communities hold about their health needs.

Accountability
We are transparent and informed in the delivery of our commitments to our funders, partners and communities.

Online community makes top priorities known

In January, Murray PHN's online community of Health Voices was asked to complete a survey to help inform the organisation's strategic planning process. The survey asked people to choose a primary care priority area and describe what is working well and what could be improved in their community.

Sixty people responded, ranking aged care, mental health and chronic conditions as their top priorities, with some regional variation.

What's working well?

- "I see a really good diabetes educator and dietitian who have helped me so much. I think I would've ended up in hospital without them. I love that they are local and I don't have to try and arrange for someone to drive me to the nearest regional town."
- "My GP is very proactive, particularly for chronic conditions. For the most part, referrals to specialist services are quickly managed if they are here in Bendigo."
- "A united group of agencies committed to improving population health outcomes, particularly through a preventative lens, who have trusted relationship with their communities."

What could be improved?

- "I work in community services, and I consistently see the struggle of people with ongoing mental health issues not being able to access appropriate services due to capacity and funding issues."
- "I don't think aged care ever works well because it is totally understaffed. According to the management, they always say they meet the criteria, but on the ground [it is] a very different matter."
- "Follow-up mental healthcare following a crisis continues to be very difficult to navigate and source. Many people with chronic conditions are evident in the general community and is contributing to increasing homelessness (along with housing shortages)."

GOULBURN VALLEY

7	2	1	1
Health workforce	Digital health	First Nations	Mental health

CENTRAL VICTORIA

8	5	4	4	3
Aged care	Mental health	Population health	Chronic conditions	Health workforce

NORTH WEST

4	2	2	1	1
Aged care	Mental health	Population health	Alcohol and other drugs	Chronic conditions

NORTH EAST

10	8	6	3	2	1
Chronic conditions	Mental health	Aged care	Health workforce	Alcohol and other drugs	Population health

WHAT WE HAVE HEARD



Achieving ISO/IEC 27001 certification

Technology, data sharing and cyber threats evolve every day. The health sector remains a prime target for attacks due to the highly sensitive information that's collected, stored and exchanged.

As custodians and stewards of data, we take our obligation to effectively mitigate and manage risks and to safeguard information very seriously.

In March, Murray PHN achieved ISO/IEC 27001:2022 certification - the international standard for information security - ahead of a mid-year mandate set by the Australian Government to ensure PHNs have effective systems in place to safely and securely manage data.

The achievement was made possible through months of rigorous work to audit, assess and uplift structures, systems, policies and procedures, and to increase awareness, training and practices across the organisation to strengthen information security management systems.

Receiving certification is not an end point, but reflects a solid foundation and strengthened culture of continuous improvement where every person recognises information security as part of their role.

Most importantly, achieving the standard demonstrates the organisation's high level of commitment to its partners, communities and funders in managing information securely to protect its confidentiality, integrity and availability.

bsi ISO/IEC 27001 Information Security Management CERTIFIED

IS 810771

Strengthening emergency management

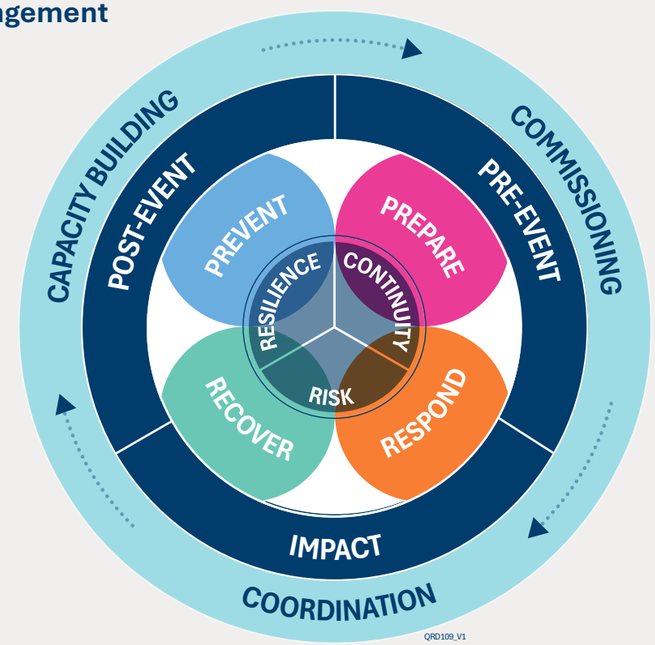
Many communities face challenges in accessing timely, appropriate and culturally safe healthcare, which is only amplified during emergencies.

Bushfires, floods and the COVID-19 pandemic of recent years have exposed vulnerabilities and gaps in the health system, underscoring the need for coordinated, collaborative and scalable responses tailored to local contexts.

Preparedness is a vital step in helping to reduce vulnerability, minimise risk and increase business and workforce resilience.

Building on our core organisational functions of coordination, commissioning and capacity building, Murray PHN has been working to strengthen how we prepare for, respond to and recover from emergencies. This has included working more closely with regional emergency management planning committees, public health units and local councils to support stronger integration of primary care considerations into planning and response arrangements.

This year, we launched our Emergency Management Framework which aligns with national and state emergency management arrangements and is based on the Prevention, Preparedness, Response and Recovery model.



The framework outlines our role during health-related emergencies, both as a Commonwealth-funded entity and as a key partner of the Victorian Department of Health. It also reflects our commitment to shared responsibility, local leadership and continuous improvement in managing disruptions to primary healthcare services.

"True emergency management goes beyond immediate response – it is about strengthening local capacity, building partnerships, and sharing responsibility before, during and after emergencies. It is about continuous learning, adaptation and improvement."
- Matt Jones, CEO

Testing our emergency response

In June, Murray PHN carried out Exercise Ember, a discussion-based exercise to test and strengthen the organisation's preparedness for managing an escalating emergency event affecting primary healthcare services across our region.

Working through a realistic but complex bushfire scenario, our leadership team applied the organisation's Emergency Management Plan to consider how best to support local providers. This included exploring decision-making and emergency activation processes, communication pathways, and the coordination that would be required with healthcare providers, government agencies and emergency management partners.

As the scenario evolved, staff considered how and when Murray PHN would activate its emergency response arrangements, the roles and responsibilities of those involved, and how information would be gathered and shared to support effective decision-making and community outcomes.

Following, a structured debrief captured lessons learned and opportunities for improvement, including enhancing processes and protocols and developing additional readiness tools and resources. Feedback and observations highlighted several strengths, including strong leadership, active engagement and importantly, a clear commitment to supporting primary care services and communities before, during and after emergencies.

Our Board


Bob Cameron - Chair


Joanne Kinder - Deputy Chair


Andrew Baker


Dr Philip Webster


Ella Cannon


Greg Hughes


Steve Tinker


Matt Sharp


Dr Tali Barrett

Detailed information about our Board members can be found in our Financial Report: https://tinyurl.com/yzu27wzd

Our Executive


Matt Jones,
Chief Executive Officer


Jacque Phillips OAM,
Chief Primary Health Care and Commissioning


Nick Shaw,
Chief Organisation Capacity and Performance

Financial summary

This year, Murray PHN recognised revenue of $77 million and employed 106 full-time equivalent employees. Of the funding recognised as revenue in FY26, 74 per cent - approximately $57 million - was delivered directly to providers through commissioned services for the benefit of communities across our catchment.

During the year, we funded 110 providers through 224 contracts, covering 77 unique activities. This funding supported commissioned services to strengthen primary care.

In FY26, 11 funding schedules supported work across a range of areas, including mental health, general practice, urgent care and aged care. This work translated Australian Government priorities into services informed by population health needs.

In mental health, Murray PHN was one of three PHNs selected nationally for the Australian Government's Creative Therapies Pilot Program 2025–2027, which provides music and art therapy services for people living with moderate to severe mental health conditions.

Our general practice team supported the new National Lung Cancer Screening Program, MyMedicare and Bulk Billing Practice Incentive Program. They also worked to embed multidisciplinary teams in rural general practice clinics in areas of high need, unmet demand and service gaps.

We continued to support the five Medicare urgent care clinics in our region, helping to ease pressure on nearby hospitals. The clinics provided an alternative to emergency departments for almost 50,000 people with urgent but non-life-threatening conditions.

In aged care, the Care Finder program continued to provide free support for older people who do not have family or trusted carers to assist them. The program was developed in response to a recommendation of the Royal Commission into Aged Care Quality and Safety.

Our new three-year strategic plan identifies organisational performance as a key focus area, with an emphasis on strengthening capability, sustainability and financial accountability so we can keep delivering for the communities we serve.

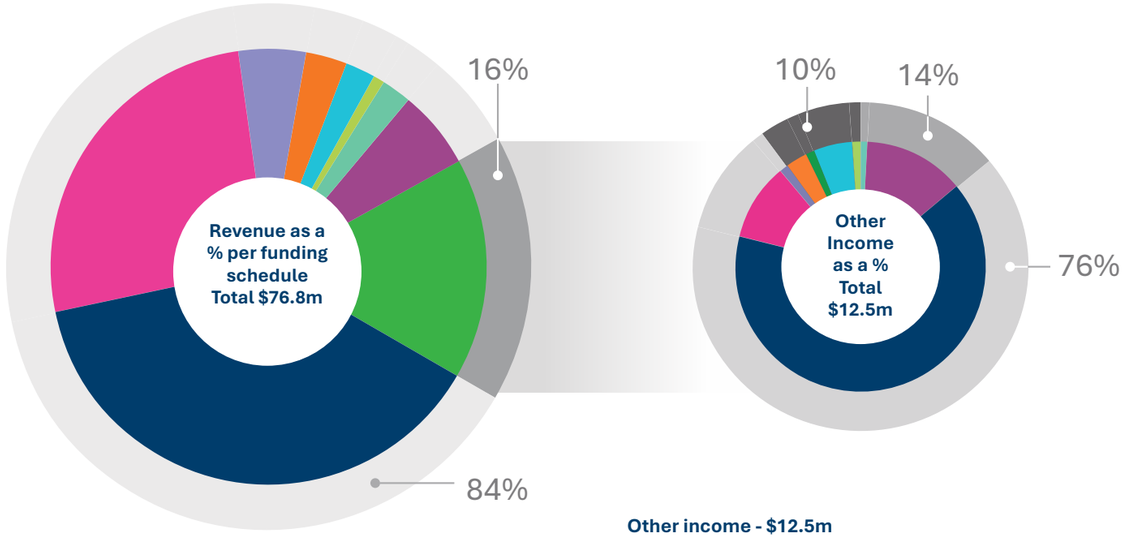
Total Revenue	$76,817,790
Total Expenditure	$76,811,693
Operating Surplus	$6,097
Equity	$6,560,969

Total Revenue:	$M
Core	$20.1
Primary Mental Health and Alcohol and Other Drugs	$29.4
Commonwealth Psychosocial Support	$4.2
Aged Care	$4.4
Integrated Team Care	$2.1
After Hours	$1.8
Medicare Urgent Care Clinics	$1.8
PHN Pilots and Targeted Programs	$0.5
Total Department of Health, Aged Care and Disability	$64.3
Other Income	$12.5
Total	$76.8

The work we commission	$56.8M
Our People	$17.2M
Administration	$2.7M
Our Operating Surplus	$0.01M

For our detailed Financial Report, visit https://tinyurl.com/yzu27wzd





DHDA - $64.3m

38	Primary mental health and alcohol and other drugs
26	Core
6	Commonwealth psychosocial support
3	Integrated Team Care
2	After hours
1	PHN pilots and targeted programs
2	Medicare Urgent Care Clinics
6	Aged care

Other income - $12.5m

16	Other Income

Other income - $12.5m

State Funding

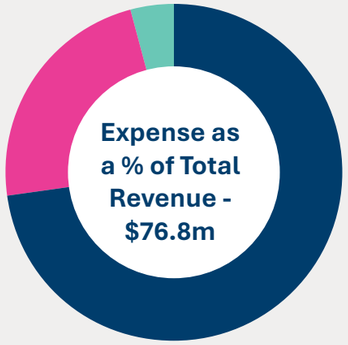
65	Priority Primary Care Centres
10	Department of Education
1	Other Programs

Other Funders

3	Other PHN Funders
1	Community
5	Interest
1	PHN Exchange

Federal Funding

1	Australian Digital Health Agency
13	Workforce Prioritisation and Planning



74	Direct Activity
22	Employee Expenses
4	Administration
0	Operating Surplus



95	Commissioned Services
1	Direct Integrated Team Care Activity Costs
2	Building Capacity and Capability
1	Needs Assessment, planning and evaluation
1	Direct patient costs

phn MURRAY

An Australian Government Initiative

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