NMC

MURRINDINDI HEALTH NETWORK

Murrindindi Shire Council

VICTORIA State Government

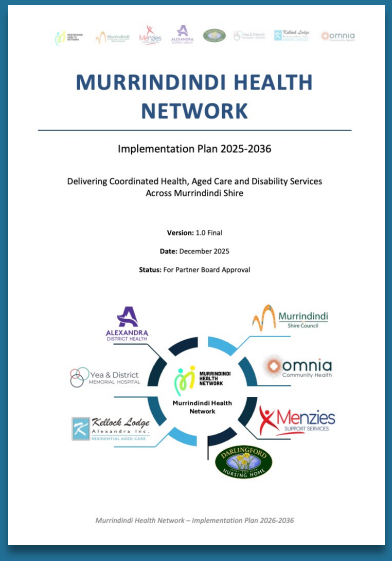
NETWORK PLAN

Murrindindi Health Network 2026-2036

ACKNOWLEDGEMENT TO COUNTRY

We acknowledge the Taungurung and Wurundjeri Woi-wurrung people as the Traditional Owners and Custodians of Country across Murrindindi Shire, and pay our respects to their Elders past, present and emerging.

The Current State and Future State confirm both the urgency for action and the opportunity to keep more care local in Murrindindi. This page explains what this Network Plan is for, what decisions it supports, and how it should be used alongside the companion Implementation Plan to deliver measurable change over 2026–2036.



TWO DOCUMENTS, TWO PURPOSES, ONE COORDINATED PROGRAM OF WORK.

This Network Plan sets the 10-year direction, priorities and governance. The companion Implementation Plan converts that direction into quarter-by-quarter delivery, role clarity, resourcing, and performance tracking.

This MHN Detailed Network Plan provides the strategic framework, evidence base, and design rationale for the Murrindindi Health Network 2025-2030.

COMPANION DOCUMENT:

The MHN Implementation Plan 2026-2036 provides:

- Detailed Year 1 quarterly implementation (Q1-Q4)
- First 90-day action plan
- Business cases for flagship projects
- RACI matrices and readiness assessments
- Grant pipeline management

USE THIS DOCUMENT FOR:

✓ Strategic understanding and evidence base

✓ Board approvals and governance decisions

✓ Funding applications (strategic case)

✓ Community communication and stakeholder briefings

USE IMPLEMENTATION PLAN FOR:

✓ Operational execution and quarterly milestones

✓ Role assignments and accountability

✓ Detailed project planning and tracking

✓ Day-to-day coordination

FOR FULL APPROVAL: Both documents required together

OVERVIEW

The Current State and Future State analysis confirms both the urgency and the opportunity for action in Murrindindi. This page summarises the cost of inaction, and what coordinated action can unlock for residents, services, and the local economy.

The Cost of Inaction vs the Opportunity Before Us

Our health system is under severe pressure. Without coordinated action, we face:

- ~**1,050 potentially preventable hospital admissions each year**, costing about **A$6.3 million** in avoidable acute care.
- A deepening health workforce crisis, with our regions facing **–11 GPs, –27 allied health workers, –25 aged-care workers, –60 nurses and –20 disability workers** by 2036 (FTE).
- Murrindindi's **mental health hospitalisations** are **23.6% higher** than the state average, resulting in roughly **260 additional admissions** and **3,200 extra bed-days** annually.
- **Suicide rates of about 14.2 deaths per 100,000 residents** (vs 7.6 for Victoria), with disproportionate impacts on farmers and young people.

Economic impact: Higher rates of chronic disease, mental health hospitalisations, and premature mortality cost the community an estimated **A$87–90 million each year**, equal to **4.5 healthy life-years lost for every 10 residents over 10 years**. Without action, these pressures erode economic vitality, community resilience, and quality of life.

What we lose if we wait

- Growing fragmentation as services contract and workforce pressures accelerate.
- Higher preventable harm: delayed care, delayed cancer diagnosis, and worsening mental health crises.
- Rising avoidable costs over the next five years, alongside broader social and economic decline.
- Families relocating, young people leaving, and local identity and resilience weakening.

What we gain by acting now

- Coordinated care, clearer pathways, and simpler access to the right support at the right time.
- Earlier intervention and prevention that reduce avoidable admissions and system pressure.
- A stronger local workforce pipeline through coordinated training, placements, and shared solutions.
- Stronger families, students, and services across all towns.
- Retaining local community connections.

450-600

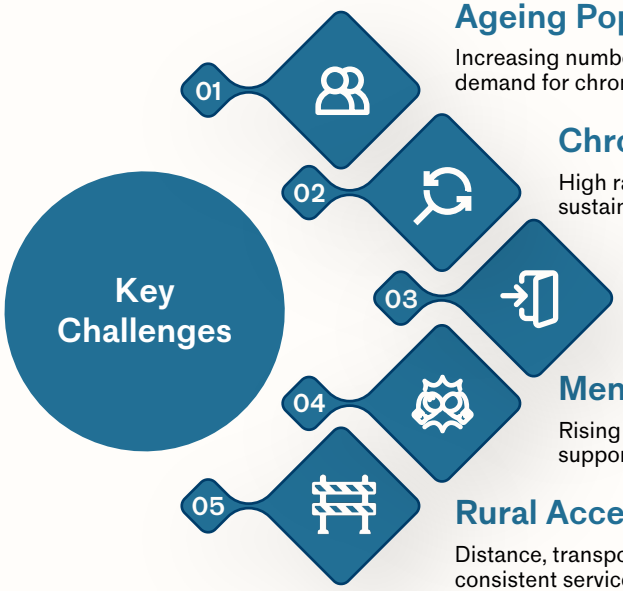
Years of life lost annually due to preventable hospitalisations and deaths, mental health crises, and suicide , equivalent to losing **around 8–12 residents each year**.

Turn the page to see how we act - together.

Murrindindi faces rising demand, workforce pressures and access barriers; without a more connected local system, the region risks worsening health outcomes, service loss, and escalating community impacts.

WHY THIS PLAN IS NEEDED

Murrindindi has an ageing, widely dispersed population, high rates of chronic disease and mental health issues, a thin local workforce, and major transport & housing constraints. Services work hard but often work separately. People – especially older residents, carers, young people, and farmers – report that the system is confusing, hard to navigate, and too often requires long travel.



Ageing Population

Increasing numbers of older residents are driving higher demand for chronic and complex care.

Chronic Disease Burden

High rates of preventable conditions are placing sustained pressure on local services.

Workforce Shortages

Limited clinical workforce supply restricts timely access to essential care.

Mental Health Strain

Rising psychological distress and limited local support impact community wellbeing.

Rural Access Barriers

Distance, transport gaps, and digital variability hinder consistent service access.

Our Vision

People in Murrindindi can live well, locally, with simple, connected care and learning opportunities that are easy to find, easy to access, and delivered as close to home as possible.

This Plan Responds To Strong Local Leadership

Drivers

- ✓ Community appetite to "join the dots"
- ✓ Previous analysis and consultations (2+ years of groundwork)
- ✓ Co-design and engagement (4 workshops, 100+ stakeholder conversations, 130+ survey responses, 200+ people engaged)
- ✓ Clear roadmap for the next 5 years: who is involved, what will change, how we will fund and deliver it

Insights

Key insight from GP: *"If navigators can take care coordination off my plate, I can see 2–3 more patients per day. That's the workforce solution right there."*

Key insight from aged care manager: *"Hospital sends people home with no follow-up. Navigation could fix that gap."*

Key insight from student: *"I'd stay if there was a clear pathway to employment here after graduation."*

Murrindindi Shire faces interconnected health and care challenges, creating an immediate need for strategic intervention to ensure sustainable, locally accessible health and aged care services.

Context and Setting

The *Murrindindi Health Network Plan* project represents a strategic initiative aimed at optimising healthcare services and improving local workforce capacity to meet current and future demands across Murrindindi Shire. Led by Murrindindi Shire Council (MSC) in partnership with the Murrindindi Health Network, this project is funded through the Department of Energy, Environment, and Climate Action's (DEECA) Victorian Forestry Transition Program, which supports communities to navigate long-term planning, job creation, foster innovation, and diversify the local economy through industry transitions.

Murrindindi Shire serves a geographically dispersed population across key townships, including Yea, Alexandra, Kinglake, and Marysville. The region is experiencing significant demographic and economic change. The healthcare landscape is characterised by a mix of public and private providers, including the Murrindindi Health Network – a consortium of six local health and community organisations working collaboratively to strengthen healthcare access and workforce capacity.

Current Challenges

The region faces multiple interconnected healthcare challenges that have created an urgent need for strategic intervention:

Workforce and Service Delivery Pressures

- Critical workforce shortages across the health and aged care sectors.
- Difficulty attracting and retaining qualified healthcare professionals in rural settings.
- Limited availability of specialist services and access to training within the region.
- Fragmented service delivery across multiple small providers.

Demographic and Geographic Challenges

- An ageing population requiring increased healthcare and aged care services.
- Geographically dispersed communities with limited transport access
- Sustainable population growth is anticipated in Alexandra, Kinglake, Eildon, and Yea, which will further strain existing services.
- Rural isolation, combined with forested and expansive landscapes, creates physical and distance-based barriers to accessing services and retaining the workforce.

Economic and Structural Changes

- The transition of the forestry industry is impacting local employment and the economic base.
- Service leakage requires residents to travel outside the Shire for healthcare.
- Significant hidden costs, including government-subsidised patient transport services, ambulance transfers, and carer burden.
- Limited infrastructure capacity to meet growing demand.
- Support is often accessed later than is ideal.

Health reforms, economic transition, and service integration needs drive the immediate requirement for strategic workforce planning to ensure sustainable, locally accessible healthcare for Murrindindi's rural communities.

Key Drivers For This Project

Murrindindi's workforce shortages and service delivery challenges are creating significant barriers to healthcare access for local communities. These pressures are being intensified by major health and aged care reforms and by the current economic transition across Victoria's forestry-dependent regions. Together, these changes present both immediate implementation challenges and strategic opportunities for innovative service redesign.

Policy and Reform Context

- Major health and aged care reforms are reshaping service delivery across Australia. As of November 2025, the Support at Home program has begun replacing existing home care packages with a new market-based model, raising concerns about continuity of care and affordability in smaller communities.
- Victoria's mental health reforms emphasise stronger integration between primary care, mental health, and aged care services, requiring new models of collaboration that respond to local needs.
- The establishment of Victorian Health Service Networks (HSNs) aims to strengthen regional planning and integration, while also introducing complexity for rural areas reliant on cross-boundary access and consistent referral pathways.

Economic Drivers

- The Victorian Forestry Transition Program provides funding for economic diversification following industry transition. A critical driver is **"service leakage"**, the substantial costs incurred when residents travel outside the region for healthcare, including patient transport schemes and ambulance transfers. Localising services presents significant economic opportunities alongside improved health outcomes.

Community Integration Needs

- Murrindindi's dispersed community, the geography, and small population make isolated service provision unsustainable. Innovative collaborative models involving public, private, and community providers are essential to build local workforce capacity and effectively deliver evolving health and aged care needs.

Project Objectives

Primary Objective

To review current health and care service provision across Murrindindi, develop evidence-based improvement options, and deliver actionable recommendations with business cases that enhance health and aged care outcomes for dispersed rural communities.

Specific Objectives

1. **Assess existing healthcare infrastructure, workforce capacity, and service delivery**, identifying gaps, barriers, and duplications. Quantify total economic costs, including service leakage and transport expenses.
2. **Research and co-design innovative rural service delivery models** through stakeholder engagement, incorporating partnerships, shared services, telehealth, and outreach while ensuring equity and accessibility.
3. **Create comprehensive workforce planning** addressing current shortages and future needs to 2035, focusing on local workforce attraction, retention, and development based on demographic and health trends.
4. **Develop actionable implementation plans** with performance indicators, governance structures, and sustainable funding pathways aligned with state and national health reforms.

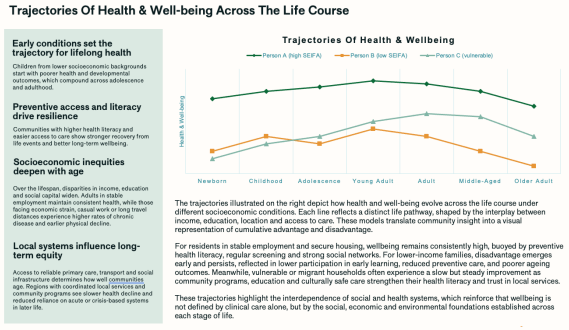
The plan was developed across three phases to provide a comprehensive strategic health network and workforce plan, including current state analysis, options development and validation, and integrated service model design.

Over the past year, we engaged deeply across Murrindindi's health, aged care, disability and community sectors. More than 100 interviews, four co-design workshops and 130+ survey responses brought in the views of over 200 people. This engagement, combined with population, demand and workforce modelling to 2036, led to the integrated Network Plan and 12 Priority Elements that guide the next decade of coordinated action.

1. Review & Analyse

- Consultation and engagement
- Data analysis and service mapping
- Stakeholder workshops
- Gap and needs assessment

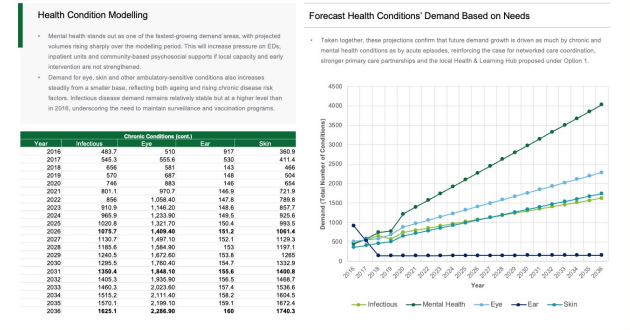
This phase explored Murrindindi's existing health service environment, identifying challenges, strengths and barriers through comprehensive data analysis, community surveys, stakeholder consultations, and service mapping. It established a clear baseline for planning.



2. Identify & Co-Design

- Future state design
- Financial and economic analysis
- Evidence-based model review
- Options development

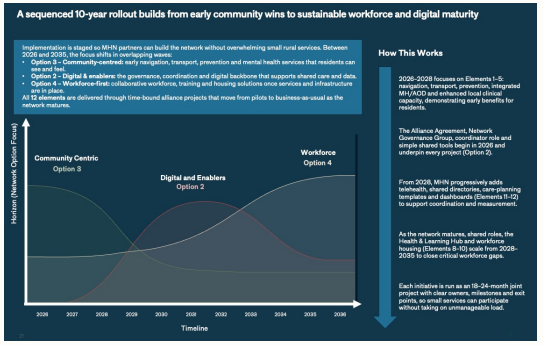
At this stage, we developed four distinct strategic options addressing the 12 priority elements. Partners can select or combine elements to create a tailored network solution.



3. Develop Model & Implementation Plan

- Design of integrated service and workforce model
- Workforce strategy development
- Phased implementation plan
- Governance and partnership framework development

Through feedback and alignment to previous findings, we developed the integrated model based on partner-selected options or a hybrid approach. This includes the workforce strategy, implementation roadmap, and governance framework ready for execution.



Murrindindi faces rising demand, workforce pressures and access barriers; without a more connected local system, the region risks worsening health outcomes, service loss, and escalating community impacts.

Current State Assessment:

Murrindindi's ageing, dispersed population, combined with transport barriers, housing shortages and elevated health risks, creates systemic access and workforce pressures. Strategic investment must focus on local service availability, integrated workforce solutions and transport-aware models of care.

Demographics & Population

- Population: **15,600 (2024)**, projected **17,450 by 2036** (0.93% annual growth, below regional average).
- Ageing population: **75+ cohort expected to increase by 113% by 2036**.
- Uneven township growth: **Yea and Marysville expanding**, **Eildon declining**.

Geography & Infrastructure

- Highly dispersed communities, over an hour's drive from Melbourne, with access periodically disrupted by natural disasters.
- Limited public transport (one bus/coach daily); heavy reliance on private vehicles.
- Housing shortages, rising rents and limited childcare hinder workforce attraction.
- Patchy internet and mobile coverage compound access issues.

Socioeconomic Context

- Several towns fall within the **most disadvantaged 40% nationally (SEIFA)**.
- Cost of living pressures: **25% of income spent on housing**; limited affordable rentals.
- Seasonal and casual employment is common; workforce participation is uneven.

Health Outcomes

- Higher than state averages for obesity, arthritis, asthma, mental health conditions and cancer incidence, reflecting long-standing trends and capacity constraints relative to state service benchmarks.
- Lower cancer screening rates (breast, cervical) and high dental avoidance due to cost.
- Hospital admissions are significantly above state averages across nearly all major conditions.

Community Insights & Lived Experience

- Barriers: transport, affordability, service gaps (children's health, dialysis, chemotherapy).
- Workforce challenges: shortages, professional isolation, reliance on casual/agency staff.
- Personas highlight the struggles of older residents, families under stress, and aspiring/overseas-trained workers.

Current State Key Findings:

Service access

- Highly dispersed geography and poor public transport make residents reliant on private vehicles.
- Long travel times to metropolitan Melbourne.

Workforce

- Workforce shortages across health and aged care, with reliance on casual and agency staff.
- Professional isolation and limited supervision capacity weaken retention and continuity of care.

Local Training

- No locally based health RTOs or higher education pathways.
- Students must leave the region to train, reducing retention and slowing the local workforce pipeline.

Health Outcomes

- Hospital admission rates significantly exceed Victorian averages across most major conditions.
- Lower screening rates, high dental avoidance and low uptake of home-based care contribute to preventable demand.

Health Literacy & Navigation

- 61% of surveyed residents are not confident in navigating the health system.
- Service information is fragmented, with limited digital literacy and outreach for disadvantaged groups.

As health needs grow and become more complex, Murrindindi will require stronger local pathways and a future-ready workforce.

Modelling Highlights Escalating Future Demand:

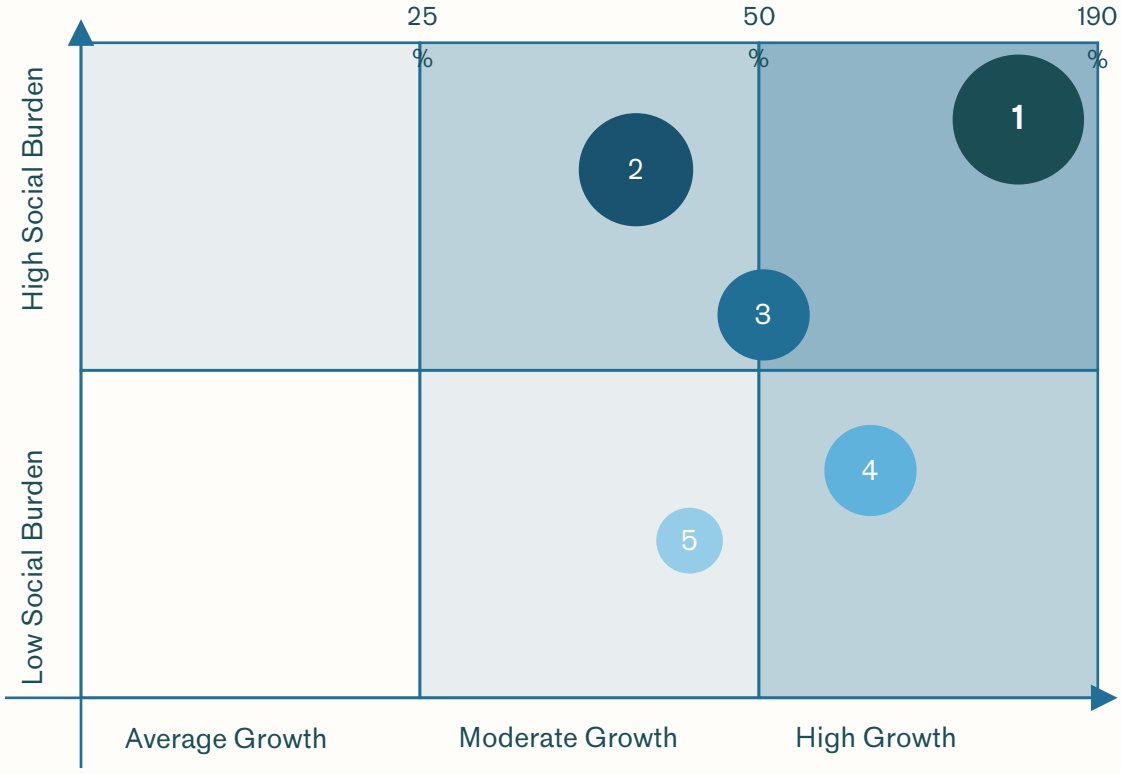
Future demand modelling shows that **Mental Health**, **Alcohol and Other Drugs (AOD)**, and **Chronic Conditions** will drive the most significant pressure across Murrindindi's health system by **2036**.

- **Mental health demand** is projected to grow by **almost 190%**, placing it firmly in the *extreme growth / high social burden* quadrant.
- **AOD presentations and chronic condition admissions** also show strong growth, compounding pressure on already limited GP, allied health, crisis response, and hospital capacity.
- **Aged-care demand** will rise steadily as the 65+ population expands, while **allied health demand** increases across all disciplines, widening current supply gaps.

Together, these trends point to a future where demand outpaces local service capacity without coordinated prevention, stronger community-based care, and a sustainably expanded workforce.

Forecast Increase (by 2036)

1	Mental health demand	190%
2	Alcohol and Other Drugs (AOD) demand	42%
3	Chronic condition admissions	50%
4	Aged-care bed requirements	60%
5	Allied health demand	40–70%



Forecast Increase vs Social Burden Matrix

Key Takeaway:

Mental health, Alcohol and Other Drugs (AOD), and chronic disease growth will drive the most significant pressure across the system. Strengthened primary care, community-based responses, and a coordinated workforce plan are essential to prevent escalating acute demand.

Using consistent historical datasets and local service activity, workforce requirements have been forecast to 2036 to identify the gaps most critical to maintaining safe, locally accessible care for Murrindindi residents.

Modelling Highlights Escalating Future Workforce:

Future workforce modelling indicates substantial growth is required across clinical and support roles by **2036**, driven by rising demand for chronic disease management, aged care, mental health, and Alcohol and Other Drugs (AOD).

- **Registered nurses** show the largest increase in absolute terms, reflecting expanding activity, population ageing and increasing clinical complexity.
- **Medical practitioners** also rise sharply, particularly in general practice and visiting specialist coverage, reinforcing the region's vulnerability to long waits, fragmented care and out-of-region transfers.
- **Enrolled nurses** will need to rise to maintain safe inpatient and aged-care coverage as home-care and residential aged-care demand accelerates.
- **Allied health FTE** requirements increase by **28–29 FTE**, reflecting strong projected demand across physiotherapy, occupational therapy, speech pathology, dietetics and podiatry.
- The most significant increase is in **disability support roles**, with an estimated **26 additional FTE** required to meet rising NDIS participation, psychosocial disability needs, and growing complexity in the ageing cohort.

Together, these increases signal a future where local workforce capacity will fall short without strengthened training pathways, regional collaboration and shared workforce models.

Required increase of headcount by 2036

1	Registered Nurses	**160** (+66.7)
2	Medical Practitioners	**60** (+43.5)
3	Enrolled Nurses	**44**
4	General Practitioners	**18.4** (+12.8)

Required increase of total FTE by 2036

1	Allied Health	**44** (+28.78)
2	Support Worker	**120** (+26)

Key Takeaway:

By 2036, workforce requirements across nursing, medical practice and caring roles will exceed current local capacity, reinforcing the need for regional training pathways, stronger generalist models and shared workforce solutions to sustain safe care.

Access to comprehensive, locally delivered health services produces measurable benefits for individuals, families, and regional economies.

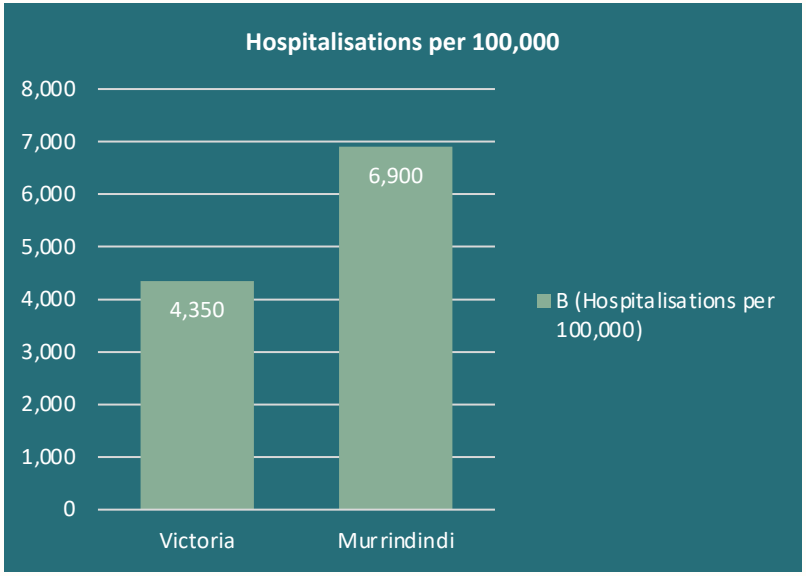
Social Implications of Health Access in Murrindindi:

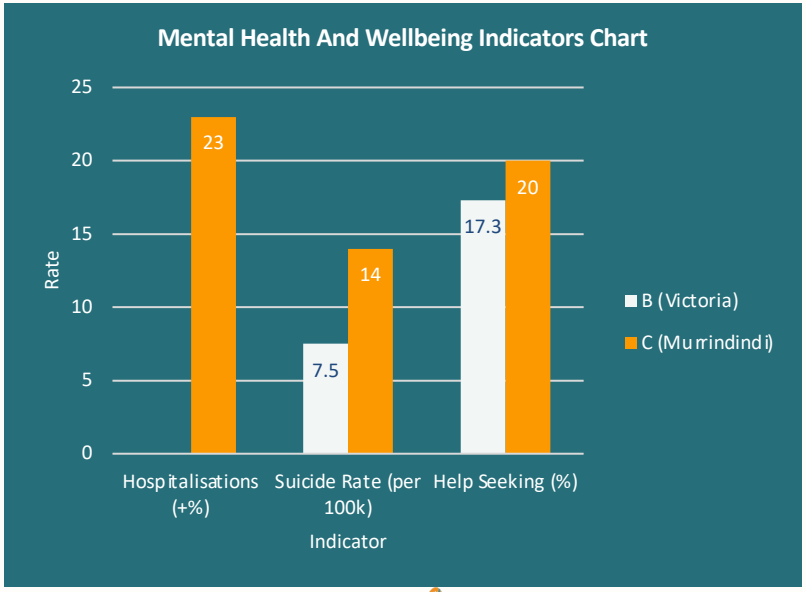
Access to integrated, equitable and locally delivered healthcare is a critical determinant of wellbeing in rural communities. In regions like Murrindindi, the intersection of geographic isolation, ageing demographics and workforce shortages has produced widening health inequities and significant social cost. Evidence across Victoria and Australia shows that fragmented health systems not only drive poorer health outcomes but also limit participation, resilience and social cohesion.

1. **Life Expectancy and Premature Mortality**
   - Murrindindi's **Potential Years of Life Lost (PYLL)** is **51.5 per 1,000 people**, compared with **35.7 per 1,000 in Victoria** (PHDU 2023) , an excess of **15.8 years lost per 1,000 people**.
   - Scaled to the Shire's population (15,179), this equates to ~**240 years of life lost annually** due to preventable conditions.
   - Applying the nationally recognised **Value of a Statistical Life-Year (A$222,000; Treasury 2023)** yields an annual social loss of ~**A$53 million** in forgone healthy life and productivity potential.
2. **Chronic Disease and Quality of Life**
   - With obesity (+88%), arthritis (+71%) and heart disease (+48%) above Victorian levels, an estimated **1,800 residents** live with avoidable disability or restricted activity.
   - Using AIHW burden-of-disease coefficients (0.12 DALY per case at A$150,000 per DALY), this equates to ~**A$32 million annually in wellbeing loss**, or **A$2,100 per person affected**.
3. **Mental Health and Social Participation**
   - Murrindindi's **mental health hospitalisations** are **23.6% higher** than the state average, resulting in roughly **260 additional admissions** and **3,200 extra bed-days** annually.
   - At an average of **A$330 per lost workday** (Productivity Commission 2022), this equals ~**A$1.05 million in lost productivity**.
   - **Suicide rates** (14.2 vs 7.6 per 100,000) suggest ~**6 preventable deaths per year**, representing a further ~**A$13.8 million** in lifetime earnings loss.
   - Socially, older residents' falls and transport isolation reduce volunteering and participation by ~**18%**, equivalent to **1,500 volunteer hours monthly**, valued at ~**A$740,000 annually** (ABS 2022).

Total Annual Impact

In total, poor health access in Murrindindi results in an estimated **A$87–90 million annual social and wellbeing loss** , equal to ~**4.5 healthy life-years lost for every 10 residents each decade**. Investment in integrated, locally delivered care under the **Murrindindi Health Network Future State** could recover up to **30% (+A$26 million)** of this value within five years.





Investing in local and integrated health systems generates strong returns across multiple economic dimensions.

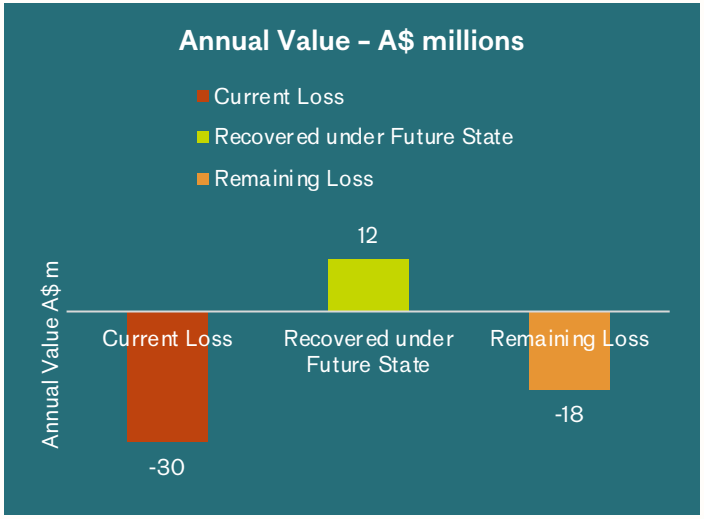
Economic Implications of Health Access in Murrindindi:

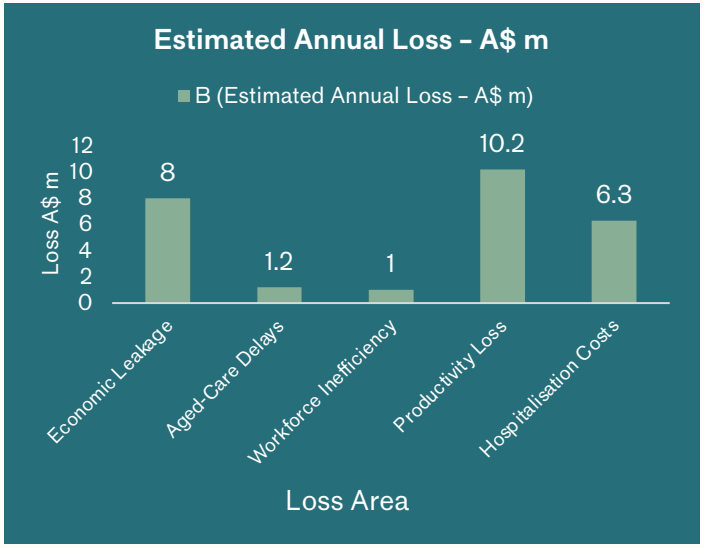
The financial cost of Murrindindi's fragmented health system extends across hospital expenditure, workforce inefficiency, aged-care delays and lost local economic output. These are quantifiable at the local scale using national health economics data.

1. **Preventable Hospitalisation and Treatment Costs**
   - Murrindindi's **preventable hospitalisation rate (6,900 per 100,000)** is **57% higher** than Victoria's (4,400).
   - This equates to ~**1,050 avoidable admissions annually** (6.9% of population vs state average).
   - At **A$6,030 per admission** (Vic DHHS 2023), the excess system cost equals ~**A$6.3 million annually**.
   - Every **10% reduction** in preventable admissions would save ~**A$630,000 per year**, validating the case for local chronic-disease and outreach programs.
2. **Workforce Shortages and Reliance Costs**
   - With **five GPs across four practices (32 per 100,000)**, one-third the state density, the Shire spends heavily on locums and agency staff.
   - If one-third of GP hours are covered by temporary contracts at a **40% premium**, this adds ~**A$1.2 million annually** in inefficiency costs.
   - Training and retaining just **two additional local clinicians** would yield ~**A$900,000 annual savings** in agency expenditure and patient-transport costs (Hooker et al., 2023).
3. **Productivity and Economic Participation**
   - Higher chronic disease prevalence (obesity, arthritis, heart disease) leads to ~**31,000 lost workdays annually** (9.8 days × 3,200 working-age cases).
   - At **A$330 per day**, this represents ~**A$10.2 million in lost local productivity**, or **2.8% of the Shire's estimated GRP (A$360 million)**.
4. **Aged-Care Access and Hospital Bed-Days**
   - Delayed access to residential and home care adds ~**450 bed-days annually** (scaled from 438,000 national total).
   - At **A$600 per bed-day**, this equals ~**A$1.17 million per year**, or **5% of total hospital operating cost** (DoH 2023).

Overall, Murrindindi's fragmented system generates an estimated **A$25–30 million annual economic loss**. Implementing the *Murrindindi Health Network Future State* model would:

- Reduce avoidable costs by **A$6–8 million per year**,
- Improve workforce efficiency by **A$1 million**, and
- Retain ~**A$4 million** in local economic value , a total net benefit of ~**A$12–13 million annually**, or **A$60 million over five years**.





The Murrindindi Health Network brings together local providers as full members and aligns with key external partners, particularly Eastern Health, Murray PHN, and education providers.

The Murrindindi Health Network (MHN) is an alliance of local organisations committed to acting as one coordinated local system while retaining their own governance and identity.

These organisations form the core membership of MHN and lead governance, planning and implementation:

Enabling Partnerships

Beyond its core members, MHN will work closely with:

- **Murray Primary Health Network (Murray PHN)**
- **Universities, TAFEs and training organisations**
- **Regional mental health, Alcohol and Other Drugs (AOD), and family violence services**
- **Housing, transport and community agencies**

These partners are critical to workforce, digital and program delivery, though they do not sit as full network members.

Strategic Partners:

Eastern Health & Northern Health

Murray PHN

Universities & TAFEs

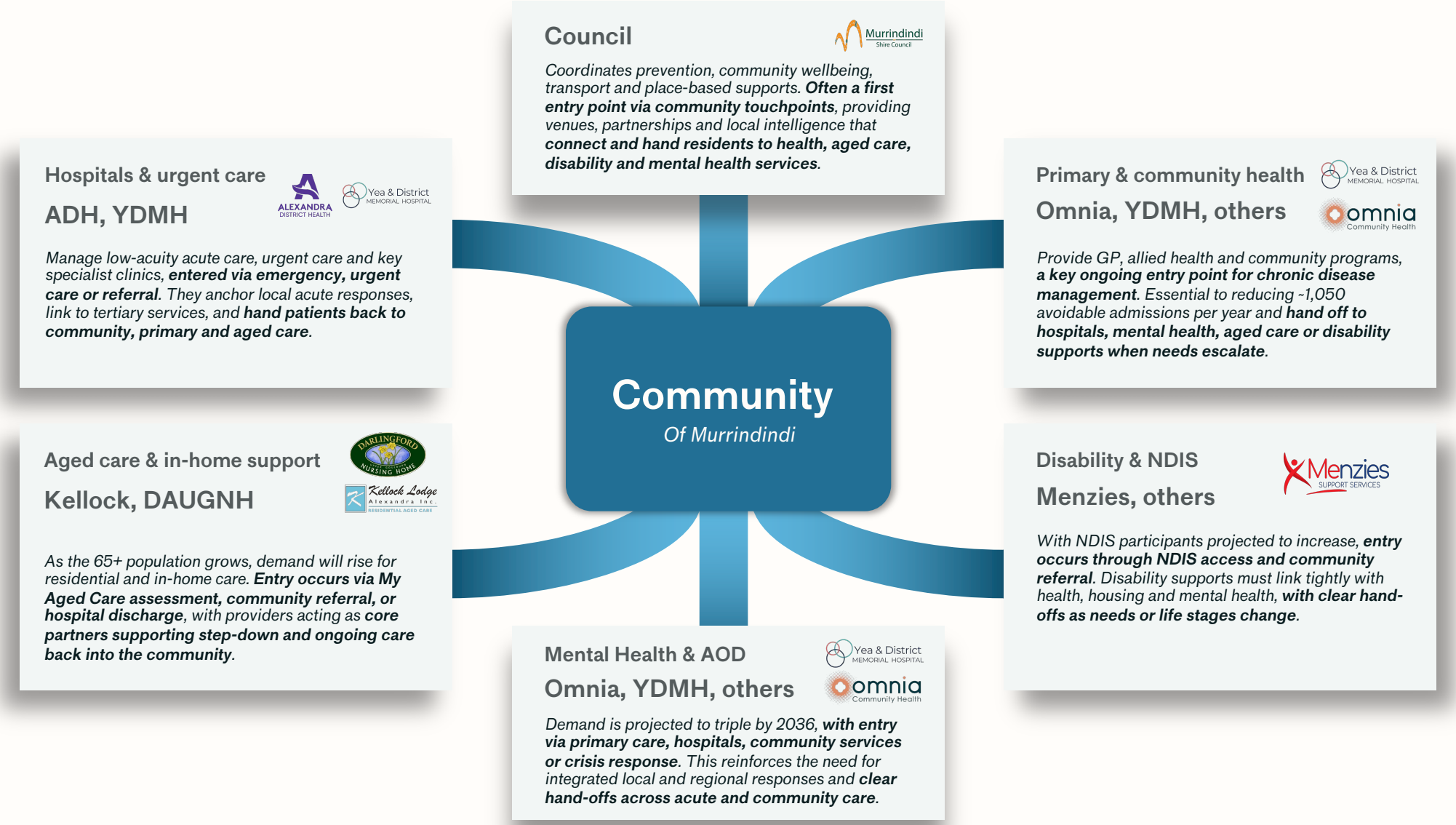
Department of Health

ADH has announced a potential voluntary merger with Eastern Health. Under this arrangement, if it proceeds:

✓ ADH continues as the local provider and local face of the hospital and clinical Services, while accessing Eastern Health capabilities for support within the network

✓ Provides clinical pathways, specialist workforce and clinical services, training placements, and digital capabilities

A single integrated service model connects hospitals, primary care, aged care, disability, mental health, and community services to tackle rising demand and preventable harm.



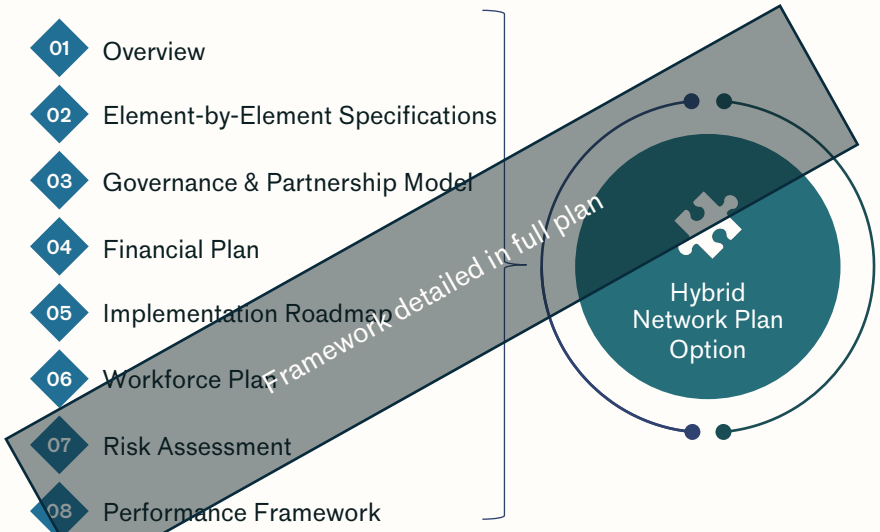
This Network Plan synthesises all project insights and brings together the Current State, Future State, and Options Analysis to define a single strategic direction and a practical pathway for MHN partners to align and deliver together.

Network Plan Approach

The Network Plan for the Murrindindi Health Network (MHN) is the culmination of extensive consultation, data review, benchmarking and forecasting. Informed by the Current State, Future State and Options Analysis reports, the Network Plan outlines the strategic direction and alignment MHN will carry into the future.

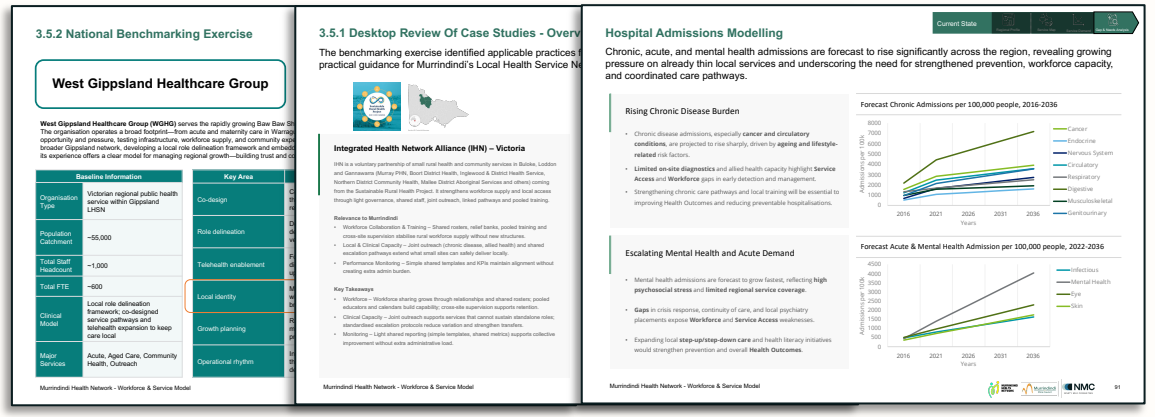
A comprehensive planning framework was used to assess key components and define practical implementation pathways. Strong emphasis was placed on identifying activities that address the priority elements, grounded in the findings from both current and future state analysis.

Network Plan Framework



Methodology

Current State	A comprehensive summary of demographics, service environment, access barriers and the current workforce baseline.
Future State	Forecasts of demand, public health impacts and workforce requirements to 2036, including priority gaps and investment implications.
Options Analysis	Presentation of four distinct scenarios, including detailed funding breakdowns, timelines and priority elements to inform network planning and alignment.
Network Plan	An integrated service and workforce model, 12 Priority Elements, governance arrangements, implementation roadmap, and measures for monitoring and evaluation.



Visual representation of final option development inputs

The Murrindindi Health Network Plan activates four complementary implementation pathways across a 10-year timeline, with intensive focus on foundational delivery in Years 1–5 (2025–2030).

Options Analysis – Summary of Provided Options

OPTION 1

Form New Network Entity

Build strong governance foundations systematically before scaling services.

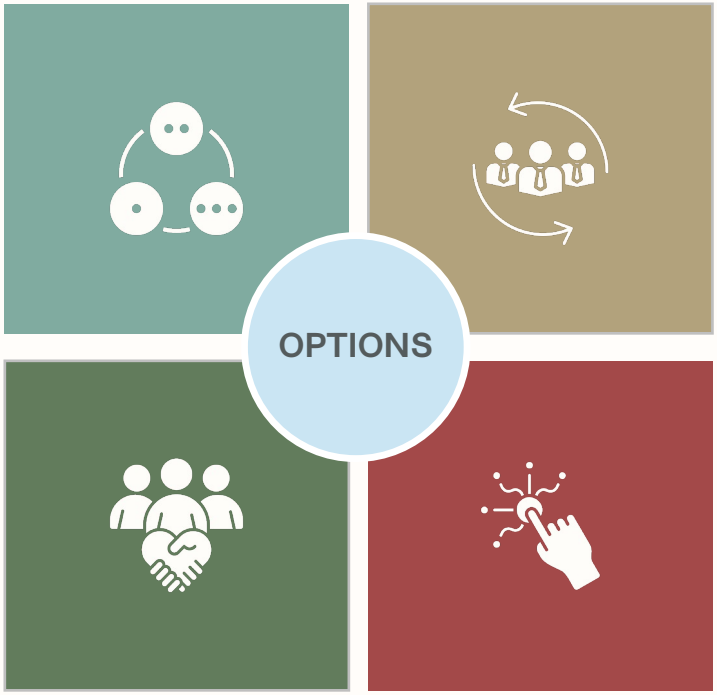
Governance pathway – available if the Alliance model proves successful. Provides future formalisation pathway for a mature network, enabling centralised employment, shared resourcing, and asset management.

OPTION 2

Workforce-First Collaboration

Solve workforce shortages first – everything else follows.

Core foundation – activated in Years 1–5. Addresses dominant workforce barriers through shared roles, a regional training hub, student placements, and coordinated retention strategies.



OPTION 3

Community-Centred Pragmatic

Deliver visible community benefits quickly with minimal organisational disruption.

Core foundation – activated in Years 1–5. Drives immediate community impact through time-bound alliance projects, navigation initiatives, transport solutions, and prevention programs.

OPTION 4

Digital-Enabled Lean Integration

Use digital infrastructure to enable comprehensive integration at a fraction of traditional cost.

Supporting enabler – phased 2025–2030. Right-sized digital tools (telehealth, shared calendars, dashboards) are tailored to rural bandwidth and capacity to support navigation, workforce coordination, and system integration.

The Murrindindi Health Network Plan integrates all four strategic pathways and activates complementary elements from each pathway based on implementation readiness, community priorities, and funding opportunities.

The Integration Framework

Community-Centred Pragmatic

Focused on what residents experience first and where the earliest impact is seen.

- Alliance governance
- Community navigation
- Transport coordination
- 6–8 alliance projects per cycle
- Alliance Facilitator hosting and coordination

Workforce-First Collaboration

Builds collaborative workforce capability so partners can share skills and staff.

- Training hub development
- Shared student placements
- Workforce collaboration and rotation models
- Retention strategies
- Shared or blended roles across partners

Supported By

Form New Network Entity

A future governance pathway that can be adopted only if partners see clear value.
Includes:

- Potential future shared entity
- Governance pathway beyond the Alliance
- Post-2030 implementation option
- Conditional on Alliance success and partner interest

Digital-Enabled Lean Integration

Pragmatic digital tools that are rural-appropriate, low-burden and scalable.
Includes:

- Staged telehealth uplift
- Shared calendars and shared directory
- Basic dashboards and reporting
- Rural-appropriate digital enablement

Why This Layered Approach Works

Core Foundations (Options 2 & 3)

- **Immediate community impact:** Residents see and feel improvements in navigation, transport, and access within Year 1.
- **Workforce stabilisation:** Training hub and collaboration mechanisms begin closing critical GP, allied health, and nursing gaps.
- **Low governance burden:** Alliance model preserves partner autonomy while enabling coordination.
- **Proven rural model:** Aligns with successful examples from comparable networks (Our Healthy Clarence, IHN Alliance).

Supporting Enablers (Option 4)

- **Right-sized digital:** Simple tools that work on existing infrastructure, not complex platform transformation.
- **Phased introduction:** Digital capabilities introduced as services scale, avoiding overwhelming small services.
- **Supports core work:** Telehealth extends outreach reach; dashboards measure alliance project impact.

Future Pathway (Option 1)

- **Preserves optionality:** Partners can formalise governance if Alliance proves successful.
- **No premature commitment:** Avoids governance burden that sank previous network attempts.
- **Clear transition criteria:** Defined triggers for when entity formation makes sense (e.g., proven impact, stable funding, partner readiness).

The plan sets a coordinated, decade-long approach that strengthens access, workforce and digital support, delivering simpler pathways for residents and clearer, shared priorities for partners working across the region.

Plan Overview

The Murrindindi Health Network Plan 2025–2030 sets out how local health, aged care, disability, primary care, community and education providers will work as one coordinated system while keeping their own governance, boards, services, and identities.

The model is a hybrid of three options:

Community-centred model (Option 3): Visible improvements in access, navigation, prevention, and integration across 12 priority elements.

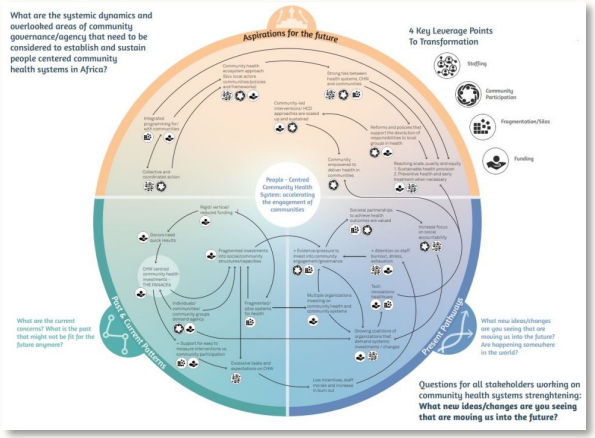
Workforce-first approach (Option 2): Shared planning, a Health & Learning Hub and housing/infrastructure to close large GP, allied health, aged care, and disability gaps.

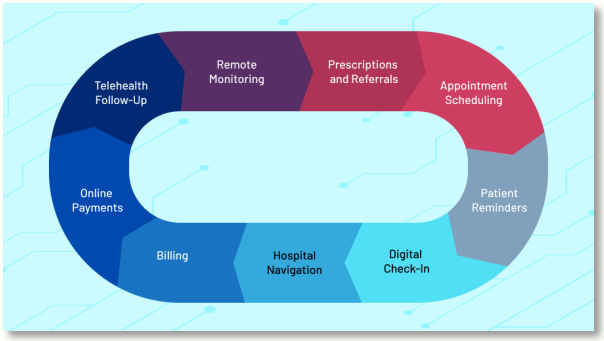
Rural-realistic digital enablement (Option 4): Simple tools (telehealth, shared calendars, directory, dashboards) that work for small services before any major platform change.

Over a 10-year horizon, the plan uses two-year project cycles to deliver 6–8 joint initiatives at a time, building from early wins (navigation, transport, MH outreach) into deeper integration of aged care, disability, workforce, and digital.

What The Plan Entails

- A clear 12-element service, workforce and digital blueprint covering navigation, transport, prevention, MH/AOD, aged care, disability, workforce, training, housing, and digital.
- A five-phase roadmap (**Foundation → Build → Scale → Mature → Sustain**) that sequences work so small services are not overwhelmed.
- A third-party facilitator and small backbone team to keep projects moving, support data, and grants.
- Governance that can be delivered initially via a strengthened network structure, with options for establishing a lean shared-services entity to host joint staff and pooled funds.





What It Looks Like For Residents

- One place to ask for help and find services more easily.
- Less travel for key care through coordinated transport, outreach clinics, and telehealth.
- More joined-up support for older people, people with disability, young people and farmers.
- Over time, fewer avoidable hospital stays and mental health crises, and more care is delivered close to home.

How Partners Work Together

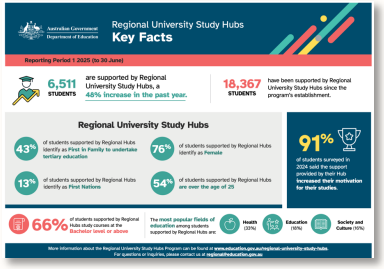
- Local providers select **6–8 joint projects** every two years from the 12 priority elements, based on community data, funding opportunities and partner readiness , preventing overload while ensuring steady progress.
- The **Alliance Facilitator** coordinates planning, implementation, measurement and funding bids across members, maintaining shared momentum and accountability.
- **Eastern Health, Murray PHN, and education partners** plug in around clear, defined roles, particularly for specialist care pathways, digital alignment, workforce supervision, and training pipelines.
- Four pathways activate strategically: community services and workforce collaboration lead (Options 2 & 3), supported by phased digital tools (Option 4) and preserving an option for governance formalisation if successful (Option 1).

A shared Health & Learning Hub strengthens the local workforce pipeline, supported by blended funding and staged implementation, while managing risks around fragmentation, grant dependency, and variable partner participation.

Workforce & Local Training / "Learning Hub"

The plan treats Murrindindi as one health and care employment ecosystem, with a collaborative workforce strategy coordinated through the Workforce Collaboration Group and a Health & Learning Hub that organises training and placements across all network partners.

- **Each organisation commits to minimum placement and supervision targets** aligned to their service scope:
  - **ADH:** 4–6 placements/year (nursing, allied health, medical)
  - **YDMH:** 4–6 placements/year (nursing, allied health)
  - **Aged care providers:** 6–8 combined placements/year (nursing, personal care, allied health)
  - **Omnia/Nexus:** 3–4 placements/year (community services, disability support)
  - **GP practices:** 2–4 placements/year (medical students, nursing)
- Builds to **25–35+ total placements annually**, with **2–4 converting to local hires** from established pathways.
- The Hub coordinates across local education partners (La Trobe, Goulburn Ovens TAFE, GOTAFE, schools and universities), potentially leveraging existing Regional University Study Hub (RUSH) infrastructure and other sector-supported initiatives, and links step-up pathways (work experience → VET → tertiary placements → early-career roles), with rotations to support exposure to metropolitan services while maintaining rural connection.
- Regular shared supervision, joint professional development, virtual learning to reduce isolation, support for clinical governance, and initiatives that build **retention through collegial culture and wellbeing.**



Funding & Viability

The plan requires **$4.5–5.0M total investment over five years**, with the workforce stream (Option 2 pathway) comprising roughly **$1.8M (35–40%).**

Funding is blended across multiple sources to reduce dependency risk:

- **Murray PHN:** Care coordination, MH/AOD workforce, digital connectivity
- **Federal and state workforce programs:** RWA/PHN grants, Commonwealth aged care workforce support
- **State prevention and reform funding:** VicHealth prevention grants, MH reform implementation funding
- **Regional development:** Commonwealth regional workforce programs, Council infrastructure contributions
- **Partner in-kind:** Supervision time, placement coordination, existing infrastructure use

As the plan matures and demonstrates impact, partners may choose to **establish a small shared-services entity** (Option 1 pathway) to host backbone coordination staff and manage pooled grants, creating efficiencies and clearer accountability.

This decision would occur post-2030, based on Alliance performance, not as an upfront requirement.

Risks

- X **Fragmented effort:** Mitigated through two-year project cycles with clear selection criteria, 6–8 joint projects per cycle, and formal evaluation.
- X **Short-term grant dependency:** Projects are designed to transition into business-as-usual funding if successful, with evidence and partner commitments built from the start.
- X **Structural workforce gaps:** Addressed through the collaborative workforce model, Health & Learning Hub, rotations, supervision infrastructure, and not recruitment alone.
- X **Variable partner participation:** Managed via minimum participation expectations in the Network Agreement, shared dashboards, and transparent reporting on contributions and benefits.

The priority elements outline practical actions partners can implement to strengthen coordination, workforce, prevention, digital connectivity and access while keeping solutions simple, scalable, and suited to rural realities.

Digital Enablement

(Option 4 Core)
Use low-cost, rural-appropriate tools to coordinate care: shared calendars, WhatsApp/Signal groups, a basic service directory and simple dashboards using existing PHN/POLAR data. Improves connectivity, telehealth access, and shared information across partners.

Enhanced Local and Clinical Capacity

(Option 3 Core + Option 4 Telehealth)
Predictable monthly outreach circuits (dental, podiatry, allied health, specialist). DHSH mobile dental van, RWAV-funded providers, Healthdirect telehealth. Coordinated booking system ensures high utilisation and minimal cancellations.

Preventive Health and Early Intervention Models

(Option 3 Core)
Alliance coordinates existing prevention programs, adds LiFE! expansion, Farming Families health checks, Men's Health initiatives. VicHealth and RWAV-funded. Eliminates duplication and targets underserved populations strategically.

Integrated Mental Health and AOD Services

(Option 3 Core + Option 2 Workforce)
Create clear local pathways across community MH, AOD, psychosocial supports, and state reforms. Use a single contact point, warm handovers, shared protocols, safety-planning training and regular case huddles to reduce ED presentations and improve continuity.

Transport and Access Enhancement

(Option 3 Core)
Coordinate existing transport, Council transport, volunteer drivers, VPTAS and community vehicles, through one booking point. Align clinic times with transport availability, bundle appointments, and use simple checklists so staff routinely screen for travel barriers and provide solutions.

Performance Monitoring and Network Processes

(All Options)
Quarterly light-touch dashboard using POLAR data, PHN reports and partner metrics. Power BI visualisation with 8–10 key indicators. Evidence-based decision making for Network Governance Group; demonstrates impact.

Community Navigator and Care Coordination System

(Option 3 Core)
Train-the-trainer model: 2 paid or volunteer lead navigators + 8–12 trained navigators across the shire supporting health, aged care, disability journeys. Murray PHN-funded (80–120k/year). Reduces preventable hospitalisations through coordinated access and care transitions.

Ease and Accessibility for Community and Advocates

(Option 3 Core + Option 4 Digital)
Create clear, plain-language service maps and online guides hosted across partner websites. Include fact sheets, phone-friendly pages, quarterly updates, and multilingual materials to help residents and carers find services quickly without navigating complex systems.

Workforce Collaboration

(Option 2 Core)
Bi-monthly Workforce Collaboration Group coordinates recruitment, enables shared roles (split / blended employment), provides peer support huddles and Project ECHO tele-mentoring. Reduces isolation and improves retention. RWAV grant-supported.

Infrastructure and Workforce Retention

(Option 2 Core)
Short-term accommodation pool, upgraded AHD staff housing, council investment, and community options to support 4–6 worker units. Digital infrastructure advocacy. Vet workforce programs. RWAV housing grants + Council partnership ($350–400k investment).

Aged Care and Disability Support and Pathways

(Option 3 Core)
Coordinated aged care navigation, facility outreach by allied health/mental health, My Aged Care application support. Prepares for Support-at-Home program (2025 Commonwealth reform). Simplified NDIS navigation, coordinated services across providers, shared NDIS coordinator role for regional disability navigation.

Local Training and Workforce Development

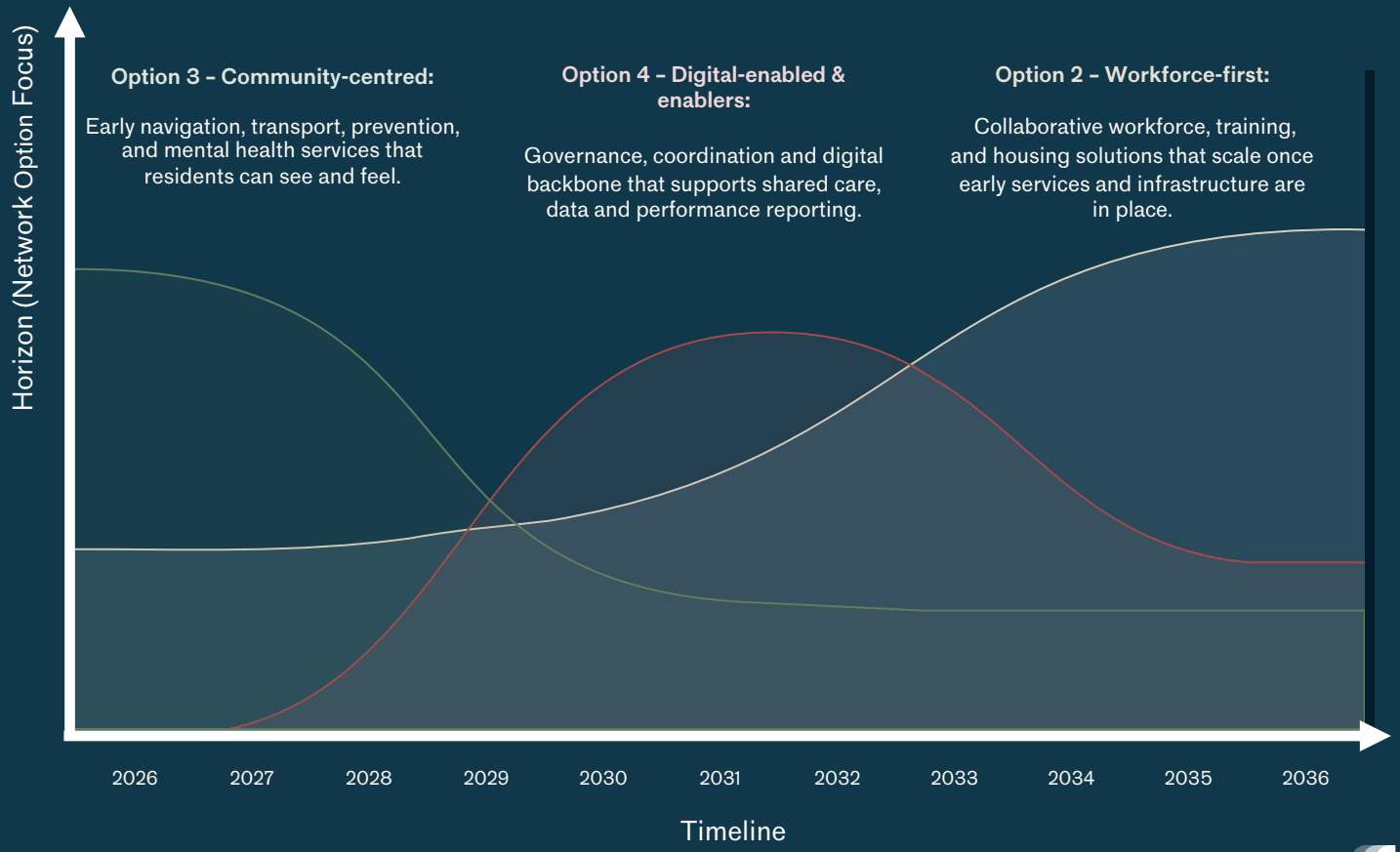
(Option 2 Core)
Coordinate regional placement schedule across hospitals, aged care, disability and community services. Partner with TAFEs and universities. Offer supported accommodation and mentoring and build clear "stay local" pathways to strengthen long-term workforce supply.

A sequenced 10-year rollout builds from early community wins to sustainable workforce and digital maturity.

Implementation is staged so MHN partners can build the network without overwhelming small rural services. Between 2026 and 2035, the focus shifts in overlapping waves:

- **Option 2 – Workforce-first:** collaborative workforce, training and housing solutions once services and infrastructure are in place.
- **Option 3 – Community-centred:** early navigation, transport, prevention and mental health services that residents can see and feel.
- **Option 4 – Digital & enablers:** governance, coordination and digital backbone that supports shared care and data.

All **12 elements** are delivered through time-bound alliance projects that move from pilots to business-as-usual as the network matures.



How This Works

2026–2028 focuses on Elements: navigation, transport, prevention, integrated MH/AOD, and enhanced local clinical capacity, demonstrating early benefits for residents.

The **Alliance Agreement, Network Governance Group, coordinator role and simple shared tools** begin in 2026 and underpin every project (Option 2).

From **2028**, MHN progressively adds telehealth uplift, shared directories, care-planning templates, and dashboards (Elements: digital enablement and access) to support coordination and measurement.

As the **network matures, shared roles, the Health & Learning Hub, and workforce housing** (Elements 8–10) scale from **2028–2035** to close critical workforce gaps.

Each initiative is run as an **18–24-month joint project** with clear owners, milestones and exit points, so small services can participate without taking on an unmanageable load.

Year 1 establishes the essential foundations for change - governance, partnerships, and priority initiatives, and address immediate community needs while positioning the network for sustained growth.

Year 1: Foundation (2026)

Q1 20256 (Jul-Sep)
- Finalise and sign Alliance Agreement with all partner CEOs and Board Chairs
- Recruit and onboard Alliance Facilitator (0.8 FTE, hosted by a network partner and agreed by the Alliance)
- Establish Network Governance Group and conduct inaugural meeting
- Confirm standing working group membership and terms of reference
- Launch community navigator recruitment (2 FTE target)

Q2 2026 (Oct-Dec)
- Complete first NGG annual planning session, select 6-8 flagship projects for 2025-2027 cycle
- Finalise data-sharing agreements and Network Minimum Data Set specification
- Launch transport coordination role recruitment (0.8 FTE)
- Commence Health & Learning Hub placement coordination (target 25-35 placements Year 1)
- Submit first joint funding applications (VicHealth, RWAV, PHN programs)

Q3 2026 (Jan-Mar)
- Community navigators operational, first clients enrolled in shared care planning
- Transport coordination service launches, volunteer driver recruitment underway
- Approve project charters for Year 1 flagship initiatives
- First quarterly performance dashboard presented to NGG
- Mental health access line scoping and design commences

Q4 2026 (Apr-Jun)
- First prevention programs launched (LiFE!, Farming Families pilots)
- Allied health outreach to aged care commencing (dental/podiatry schedules confirmed)
- Mid-year NGG governance review and partnership health check
- Year 2 funding applications submitted
- Annual community forum held to share progress

Year 1 establishes the essential foundations for change - governance, partnerships, and priority initiatives. Early wins in staff wellbeing, regional collaboration, and service planning build confidence, set clear direction, and address immediate risks to workforce stability and service continuity.

Years 2-3: Build Phase

- Scale successful Year 1 initiatives (navigation to 50-80 complex clients, transport trips increasing, placements to 40+ annually)
- Launch phase 2 projects based on Year 1 learnings (MH access line operational, expanded prevention programs, workforce housing initiatives)
- Deepen partnerships with Eastern Health, Murray PHN, and education providers
- Expand digital tools (telehealth protocols, shared calendars, dashboard enhancements)
- Develop business cases for transition to recurrent funding for proven initiatives

Build phase ensures that change is not only sustained but accelerated. By scaling what works, MHN drives further improvement, embeds collaboration, and starts to see measurable benefits in service quality, workforce stability, and community outcomes. This phase bridges initial change to lasting transformation.

Years 4-5: Optimise Phase

- Embed changes as business-as-usual operations within partner organisations
- Evaluate and refine all priority elements based on performance data
- Implement new service models emerging from Year 2-3 learnings
- Plan for 2030+ strategic direction, including assessment of Option 1 (entity formation) pathway
- Celebrate transformation achievements and sustainability milestones

By embedding new ways of working, MHN ensures that strategic changes are sustainable, resilience is strengthened, and the network remains ready to meet future challenges while maintaining community trust and partner commitment.

Immediate Actions (Days 1-30) → Short-Term Actions (Days 31-60) → Foundation Complete (Days 61-90).

The 90-day implementation plan provides a structured roadmap to begin delivering on the strategic priorities of MDH. It is designed to build early momentum through clear, time-bound actions that support effective execution and accountability. The plan is structured in three stages: Immediate Actions (first 30 days), focused on quick wins and urgent tasks; Short-Term Actions (next 30 days), aimed at progressing priority initiatives; and Foundation Complete (final 30 days), where strategic objectives are embedded to support sustained implementation over the longer term. This phased approach ensures that change is both purposeful and achievable.

FIRST 90 DAY IMPLEMENTATION PLAN

Immediate Actions (Days 1-30)

- Alliance Agreement finalised and circulated for partner CEO/Board Chair signatures
- Alliance Facilitator recruitment launched or candidate identified
- Network Governance Group inaugural meeting held, membership confirmed
- Standing working groups established with terms of reference
- Community navigator recruitment commenced (2 FTE positions advertised)
- First communication to partner staff and community announcing network launch
- Network Minimum Data Set specification drafted

Short Term Actions (Days 31-60)

- Alliance Facilitator commences role, onboarding with all partner organisations
- First annual planning session held with NGG to select 6-8 flagship projects for 2025-2027 cycle
- Transport coordinator recruitment launched (0.8 FTE position)
- Data-sharing agreements finalised and executed between partners
- First funding applications submitted (PHN care coordination, VicHealth prevention, RWAV workforce)
- Health & Learning Hub placement coordination framework agreed
- Baseline data collection commenced for performance dashboard

Foundation Complete (Days 61-90)

- All governance structures operational (NGG + 3 working groups meeting regularly)
- Alliance Facilitator coordinating first flagship project charter development
- Community navigators recruited or in final interview stages
- First quarterly performance dashboard specification finalised
- Partnership health check baseline survey completed
- Year 1 detailed implementation plan approved by NGG with milestones and accountabilities
- Community engagement mechanisms established (annual forum planned, consumer representatives active)

A robust first 90 days ensures MHN addresses immediate governance needs - including establishing the Alliance Facilitator role and NGG - while setting the stage for workforce and service initiatives. Early action on navigator and transport coordinator recruitment, supported by clear project selection and active partner engagement, delivers visible progress on core objectives. This rapid mobilisation builds organisational momentum, strengthens partner confidence, and lays the groundwork for sustained delivery and measurable impact throughout the network plan implementation.

An alliance governance model delivers shared decision-making and accountability while preserving each organisation's board, identity and statutory responsibilities.

MHN adopts a phased governance approach that builds collaboration capability before pursuing deeper integration. The Alliance model serves as the foundation phase (Years 1-5), establishing trust, demonstrating value, and developing the governance maturity needed for more integrated structures.

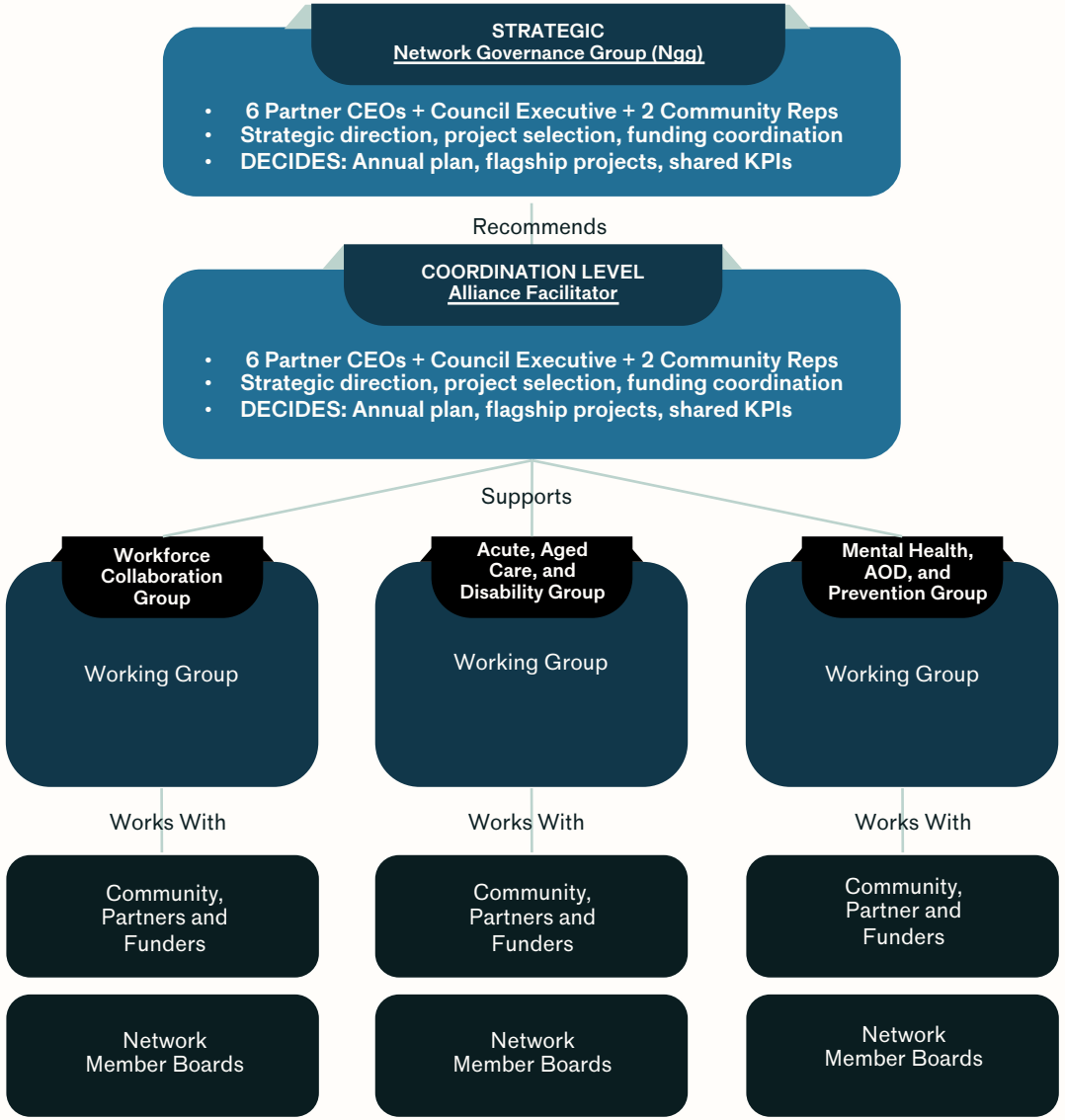
This approach learns from rural health networks where **staged governance** — earning integration rather than imposing it — delivers better long-term sustainability than immediate structural change.

The chosen solution is a **formal Alliance governance model** that balances coordination with autonomy while maintaining a clear pathway to Option 1 when the network is ready:

Core Principles:

- **Keeps local control** — Each organisation retains its own board, budget, industrial instruments, service profile, and statutory responsibilities
- **Adds a shared layer** — MHN creates a joint forum for planning, priority-setting, workforce, and digital decisions that affect the whole system
- **Supports ADH/Eastern Health complexity** — ADH sits at the table as full member and local provider, while Eastern Health is recognised as primary tertiary partner accessed mainly through ADH
- **Proportionate to scale** — Light but real structure for a shire of ~15,600 residents, not a metropolitan-style network
- **Future pathway available** — Can evolve toward Option 1 (formal entity) post-2030 if Alliance proves successful and partners desire deeper integration

Feature	Benefit
Keeps Local Control	Own boards, budgets, identity preserved
Adds Shared Layer	Joint planning across workforce, existing services, mental health, AOD, prevention decisions
Supports Complexity	Partnerships and service links
Proportionate Scale	Light structure for 15,600 residents



A staged, multi-source investment of around $4.5–5.0 million over five years underpins the Network plan without overwhelming local organisations.

TOTAL INVESTMENT REQUIRED: $4.5M - $5.0M (2025-2030)

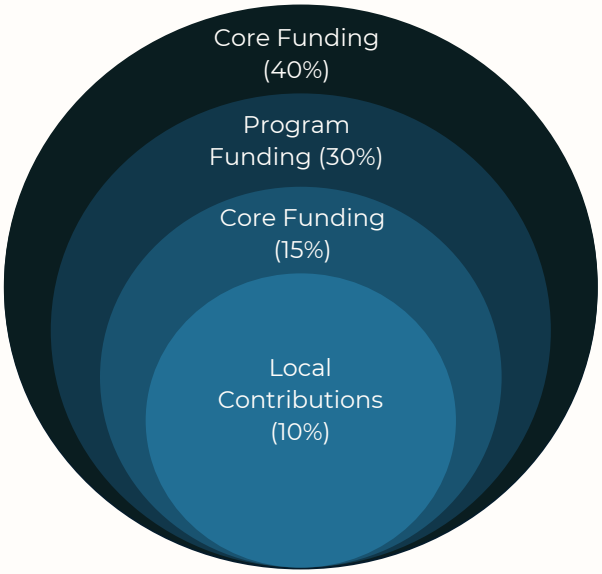
The Murrindindi Health Network requires a staged investment of approximately $4.5-5.0 million over five years to deliver coordinated health, aged care, and disability services across the shire. This investment is deliberately scaled for a small rural system serving 15,000 residents, balancing ambition with financial realism.

Investment Principles:

- **Phased and low-regret** — Start small with Year 1-2 quick wins, build on early successes, avoid large irreversible commitments
- **Leverage multiple sources** — Blend 85-90% external grants with 10-15% partner in-kind contributions
- **Maximise existing assets** — Use current spaces, systems, and staff capacity where possible
- **Build sustainability** — Design initiatives to transition into business-as-usual budgets by Year 5 if they demonstrate value

Value Proposition:

Murrindindi currently experiences ~1,050 preventable hospital admissions annually at $4,000 each = **$4.2M/year system cost**. A conservative 10-15% reduction through better navigation, transport coordination, prevention, and mental health integration would yield **$420K-$630K annually in avoided costs** — offsetting significant portions of the network investment within the 5-year period.



Pillar	Elements	5-Year Investment	% of Total
Access & Navigation	Community Navigation, Transport & Access, Ease & Accessibility	$0.9M - $1.1M	20-22%
Integrated Services & Prevention	Preventive Health, Mental Health & AOD, Clinical Capacity, Aged Care, NDIS/Disability	$1.5M - $1.8M	33-36%
Workforce & Enablers	Workforce Collaboration, Housing & Retention, Performance Monitoring, Training & Development	$2.1M - $2.5M	44-50%

Each flagship project (navigation, MH outreach, dental/podiatry, training hub, housing) is matched with 2–3 suitable grant programs and a lead organisation.

MHN will maintain a **living grant pipeline** spreadsheet, updated at least quarterly, showing opportunity, value, fit to elements, and Lead agency, deadline and status

The Alliance Facilitator coordinates joint bids and ensures proposals consistently reference the 12 elements, local data and rural context.

A simple outcomes framework links the 12 elements to shared goals in health, access, workforce, integration, experience, and sustainability.

The MHN plan is ultimately about better outcomes for residents, staff and services , not just new projects. To make this clear, we use a shared outcomes framework organised into six domains.

Health & Wellbeing

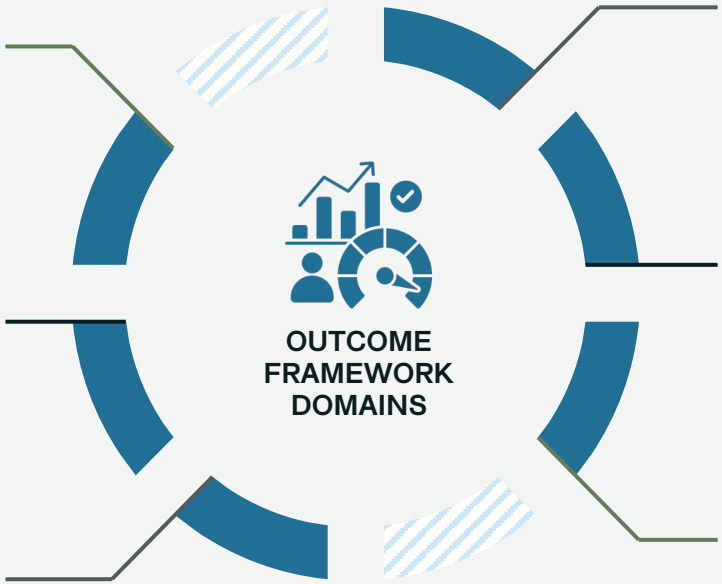
- Reduced potentially preventable hospitalisations (currently ~1,050 avoidable admissions per year).
- Reduced excess mental health admissions (~260 extra per year; ~3,200 bed-days).
- Improved self-reported physical and mental health.

Workforce & Capability

- Reduced vacancy duration and reliance on agency staff.
- Growth toward projected workforce needs (GPs, allied health, aged care, disability).
- Increased placements and more local people employed in health and care.

Experience & Trust

- Improved “ease of navigating the system” scores.
- Positive feedback from consumers, carers, and staff.



Access & Equity

- Fewer missed appointments due to transport barriers.
- More services delivered in or near local towns (outreach, telehealth).
- Better access for priority groups: older people, youth, farmers, people with disability.

Integration & Continuity

- More clients with shared care plans and a named coordinator.
- Smoother transitions between hospital, aged care, disability, and community services.

Sustainability & Value

- Demonstrable value from reduced avoidable hospital use and better mental health outcomes.
- Initiatives progressively funded from BAU budgets by Year 5.

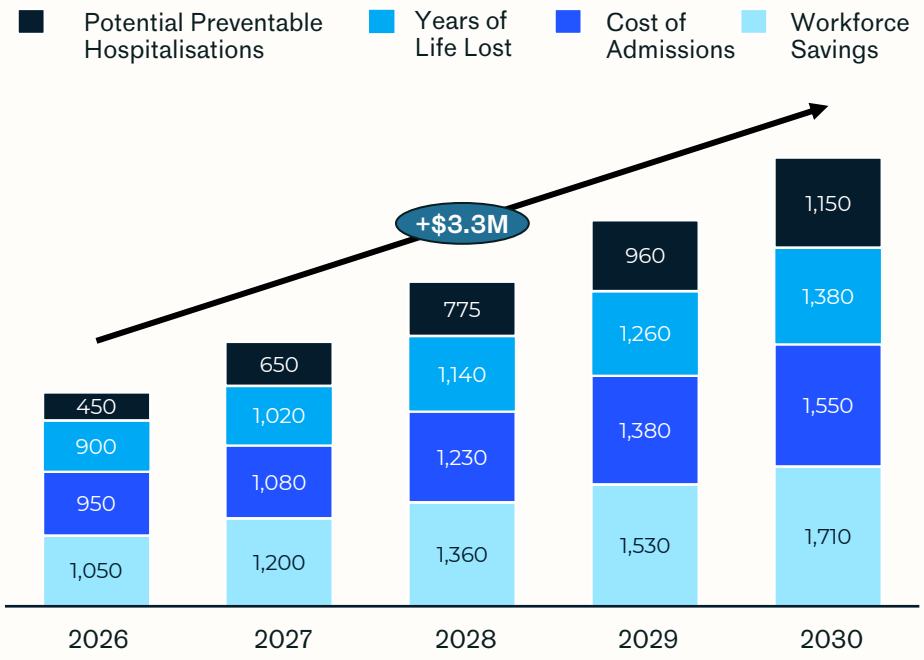
Domain	Example Indicators	Elements
Health & Wellbeing	PPH rate, MH admissions	1–5
Access & Equity	Transport trips, telehealth %	2, 5, 11
Workforce & Capability	Vacancy rate, placements	8–10
Integration & Continuity	Shared care plans	1, 6, 7
Experience & Trust	Navigation scores	1, 8
Sustainability & Value	BAU transition %	All

Each of the 12 elements contributes to several domains. This framework underpins KPIs, reporting, and evaluation.

The MHN Plan converts staged five-year investment into measurable reductions in hospital demand, mental health bed-days, and system pressure.

Using baseline data from the Future State analysis, we model conservative scenarios for how the three plan areas can shift demand over five years. Assumptions are transparent and can be refined with local costing.

Projected annual demand-related savings (A$'000)



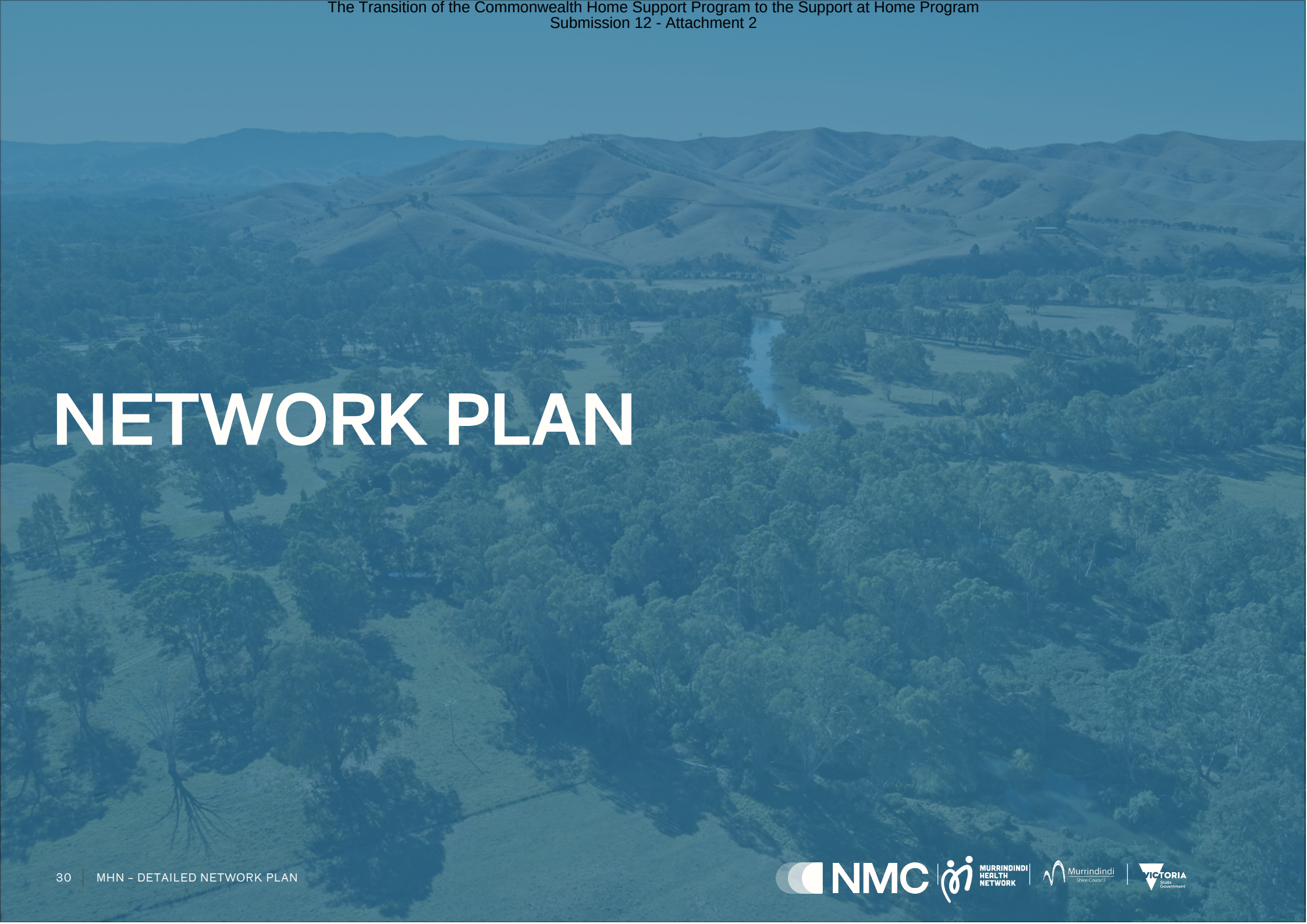
- Baseline: ~1,050 PPH/year at ~A$6,030 per admission; ~260 excess mental health admissions; ~3,200 MH bed-days.
- PPH reduction model: 10% in Years 2–5, increasing to 15% in Years 4–5 through navigation, transport, prevention and chronic disease programs.
- MH bed-day reduction model: 5–10% in Years 2–5, rising to 15% in Year 5 through integrated MH/AOD and prevention pathways.
- Bed-day value uses the indicative cost of A$800 per bed-day (refined with local costing).
- Values shown are conservative and avoid double-counting.

Context & Model Assumptions

- Baseline analysis shows around **1,050 potentially preventable hospitalisations (PPH)** per year. For planning-level modelling, we apply an indicative **average cost of ~A$6,030 per admission** (≈A$6.3M per year).
- **Mental health demand is also high**, with around **260 excess MH admissions and 3,200 bed-days** per year for Murrindindi residents.
- For PPH, we apply a **gradual reduction from 10% in Year 2 to 15% in Years 4–5**, delivered through navigation, transport, prevention, and chronic disease elements.
- For MH bed-days, we model a **reduction from 5% in Year 2 to 15% in Year 5**, reflecting stronger integration across MH/AOD and prevention pathways.
- **Savings shown are limited to acute-demand–related impacts**. They exclude workforce stability, improved productivity and other shared-care benefits, which are discussed qualitatively and can be quantified as better data and local costing become available.

Growth Drivers

1. Single front door, shared care plans, and coordinated transport reduce delays, duplication and avoidable ED presentations for high-risk cohorts.
2. Community-based programs, chronic disease groups, and youth wellbeing initiatives reduce deterioration and prevent conditions escalating to hospital care.
3. Shared pathways, MH access line, and outreach clinics reduce repeat MH admissions and shorten lengths of stay for enrolled clients.
4. Collaborative workforce planning, local training, and stabilised staffing make it possible to run navigation, outreach, and integrated services consistently across all towns.



NETWORK PLAN

This Network Plan synthesises all project insights and brings together the Current State, Future State, and Options Analysis to define a single strategic direction and a practical pathway for MHN partners to align and deliver together.

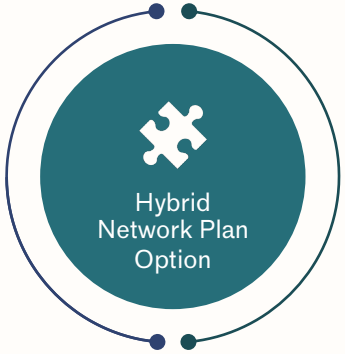
Network Plan Approach

The Network Plan for the Murrindindi Health Network (MHN) is the culmination of extensive consultation, data review, benchmarking and forecasting. Informed by the Current State, Future State and Options Analysis reports, the Network Plan outlines the strategic direction and alignment MHN will carry into the future.

A comprehensive planning framework was used to assess key components and define practical implementation pathways. Strong emphasis was placed on identifying activities that address the priority elements, grounded in the findings from both current and future state analysis.

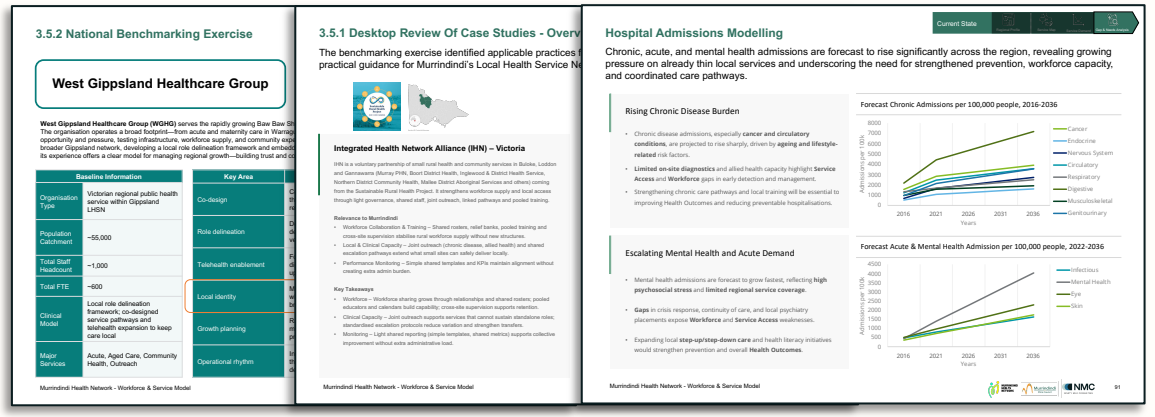
Network Plan Framework

01 Overview
02 Element-by-Element Specifications
03 Governance & Partnership Model
04 Financial Plan
05 Implementation Roadmap
06 Workforce Plan
07 Risk Assessment
08 Performance Framework



Methodology

Current State	A comprehensive summary of demographics, service environment, access barriers and the current workforce baseline.
Future State	Forecasts of demand, public health impacts and workforce requirements to 2036, including priority gaps and investment implications.
Options Analysis	Presentation of four distinct scenarios, including detailed funding breakdowns, timelines and priority elements to inform network planning and alignment.
Network Plan	An integrated service and workforce model, 12 Priority Elements, governance arrangements, implementation roadmap, and measures for monitoring and evaluation.



Visual representation of final option development inputs

The Murrindindi Health Network Plan activates four complementary implementation pathways across a 10-year timeline, with intensive focus on foundational delivery in Years 1–5 (2025–2030).

Options Analysis – Summary of Provided Options

OPTION 1

Form New Network Entity

Build strong governance foundations systematically before scaling services.

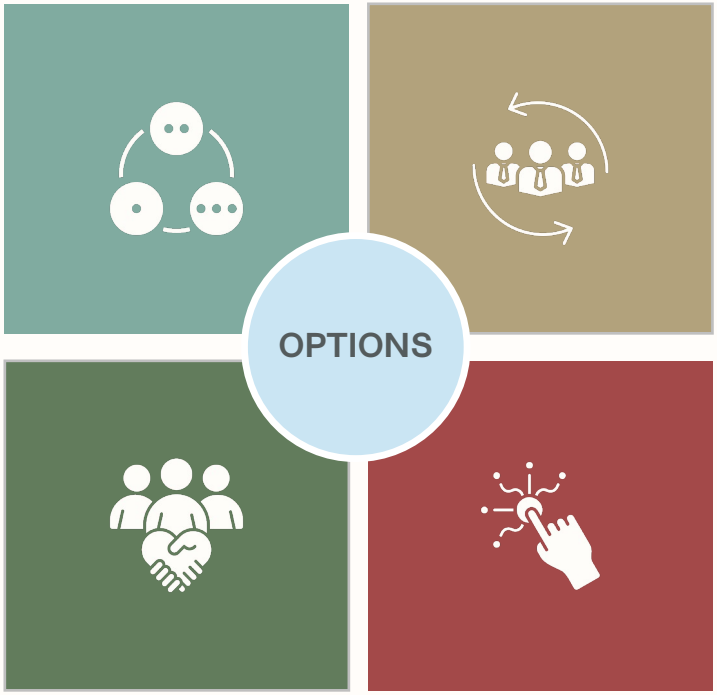
Governance pathway – available if the Alliance model proves successful. Provides future formalisation pathway for a mature network, enabling centralised employment, shared resourcing, and asset management.

OPTION 2

Workforce-First Collaboration

Solve workforce shortages first – everything else follows.

Core foundation – activated in Years 1–5. Addresses dominant workforce barriers through shared roles, a regional training hub, student placements, and coordinated retention strategies.



OPTION 3

Community-Centred Pragmatic

Deliver visible community benefits quickly with minimal organisational disruption.

Core foundation – activated in Years 1–5. Drives immediate community impact through time-bound alliance projects, navigation initiatives, transport solutions, and prevention programs.

OPTION 4

Digital-Enabled Lean Integration

Use digital infrastructure to enable comprehensive integration at a fraction of traditional cost.

Supporting enabler – phased 2026–2030. Right-sized digital tools (telehealth, shared calendars, dashboards) are tailored to rural bandwidth and capacity to support navigation, workforce coordination, and system integration.

The Murrindindi Health Network Plan integrates all four strategic pathways and activates complementary elements from each pathway based on implementation readiness, community priorities, and funding opportunities.

The Integration Framework

Community-Centred Pragmatic

Focused on what residents experience first and where the earliest impact is seen.

- Alliance governance
- Community navigation
- Transport coordination
- 6–8 alliance projects per cycle
- Alliance Facilitator hosting and coordination

Workforce-First Collaboration

Builds collaborative workforce capability so partners can share skills and staff.

- Training hub development
- Shared student placements
- Workforce collaboration and rotation models
- Retention strategies
- Shared or blended roles across partners

Supported By

Form New Network Entity

A future governance pathway that can be adopted only if partners see clear value.
Includes:

- Potential future shared entity
- Governance pathway beyond the Alliance
- Post-2030 implementation option
- Conditional on Alliance success and partner interest

Digital-Enabled Lean Integration

Pragmatic digital tools that are rural-appropriate, low-burden and scalable.
Includes:

- Staged telehealth uplift
- Shared calendars and shared directory
- Basic dashboards and reporting
- Rural-appropriate digital enablement

Why This Layered Approach Works

Core Foundations (Options 2 & 3)

- **Immediate community impact:** Residents see and feel improvements in navigation, transport, and access within Year 1.
- **Workforce stabilisation:** Training hub and collaboration mechanisms begin closing critical GP, allied health, and nursing gaps.
- **Low governance burden:** Alliance model preserves partner autonomy while enabling coordination.
- **Proven rural model:** Aligns with successful examples from comparable networks (Our Healthy Clarence, IHN Alliance).

Supporting Enablers (Option 4)

- **Right-sized digital:** Simple tools that work on existing infrastructure, not complex platform transformation.
- **Phased introduction:** Digital capabilities introduced as services scale, avoiding overwhelming small services.
- **Supports core work:** Telehealth extends outreach reach; dashboards measure alliance project impact.

Future Pathway (Option 1)

- **Preserves optionality:** Partners can formalise governance if Alliance proves successful.
- **No premature commitment:** Avoids governance burden that sank previous network attempts.
- **Clear transition criteria:** Defined triggers for when entity formation makes sense (e.g., proven impact, stable funding, partner readiness).

The Network plan aligns with major statewide reforms in mental health, aged care, primary care and digital health, while ensuring these changes are shaped for rural communities and local providers.

Victorian mental health and wellbeing reforms

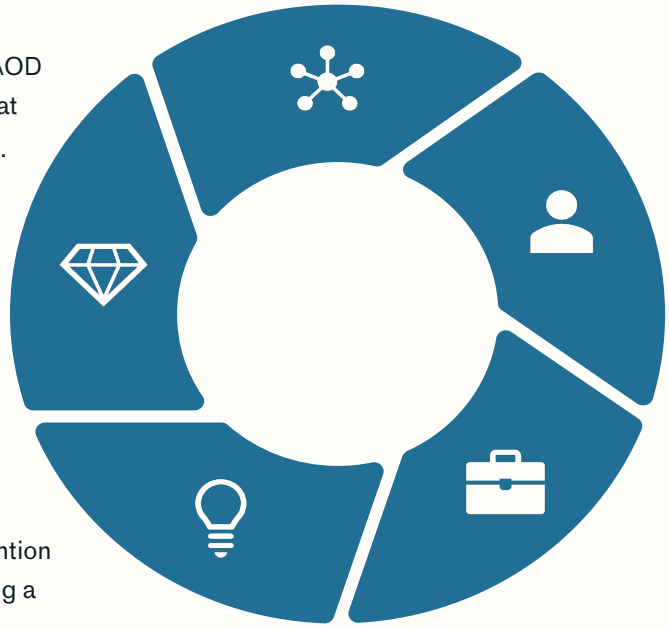
Supports the statewide shift to early, community-based MH/AOD care through navigation, outreach and integrated pathways that reduce avoidable admissions and respond to local suicide risk.

Aged care and Support at Home reform

Enables a coordinated Support at Home transition and integrated older-person pathways, with future RAC and home-care demand built directly into service and workforce planning.

Primary care and PHN commissioning

Aligns with PHN priorities by strengthening navigation, prevention and chronic-disease supports, with shared care plans providing a clearer structure for PHN-funded coordination.



Disability and NDIS

Advances NDIA/ILC and psychosocial reform priorities by integrating disability pathways and addressing the significant projected workforce gap in local disability support.

Digital health and data

Aligns with state digital strategies and Eastern Health's roadmap by prioritising telehealth, interoperability and shared dashboards over premature platform changes.

Together, these reforms are changing how care is delivered across Victoria. By aligning with them early, MHN positions the Shire to benefit from new funding streams, stronger workforce programs and clearer statewide pathways. This approach ensures that rural needs are understood and prioritised, and that the Network's model grows in step with broader system changes rather than sitting on the sidelines.

The Priority Elements Framework defines how each of the 12 network priorities will be delivered, outlining scope, approach, timing, stakeholders, resources, outcomes, dependencies and risks to guide implementation.

PRIORITY ELEMENTS FRAMEWORK

The network plan is derived from the **12 Priority Areas** collaboratively designed from current and future state workshops with network members. These provide a framework for assessing actions and health outcomes against identified needs in the community.

For each element, the following attributes (below and across) will be assessed:
Scope: The relative size and impact of the element and why.

Approach: A detailed explanation of the relevant systems, support, outcomes and technical aspects to deliver on the element.

Timing: The stage within the implementation plan the element will be focused on.

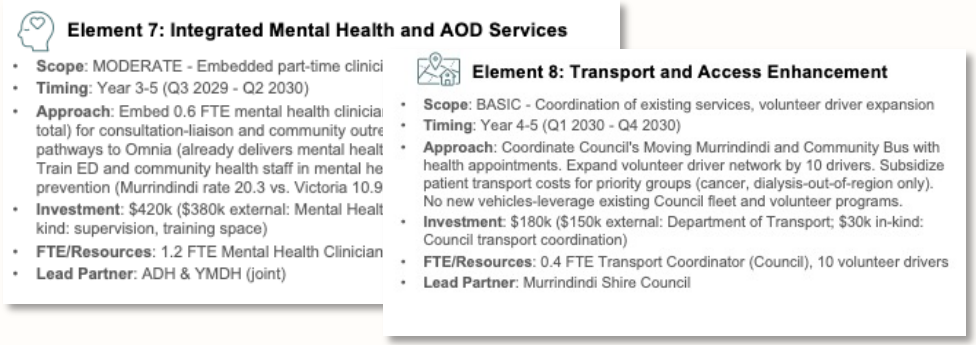
Stakeholders: A list of relevant stakeholders and their roles, including network members, community groups, supporting organisations and government bodies.

Resources Required: A breakdown of associated resources, including member staffing, funding requirements, in-kind support and infrastructure needed to deliver the element.

Outcomes: The expected changes in health outcomes, service availability and workforce size this element will bring to the network.

Dependencies: Highlighting which other elements relate, including dependencies, blockers, enablers and aligning elements.

Risks: A detailed matrix of identified risks, including mitigation strategies.

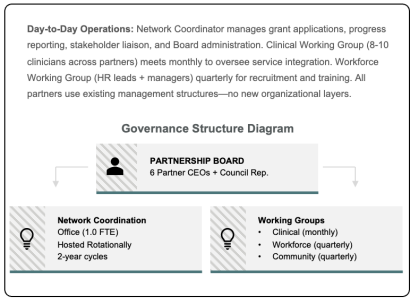


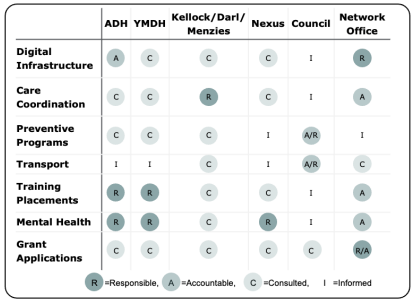
Governance and financial testing clarified how each option would operate in practice, highlighting differences in structure, authority, cost, risk and long-term sustainability that shaped the final network design.

GOVERNANCE AND PARTNERSHIP MODEL

Each option proposes a different governance structure defining how partners work together, make decisions, and share accountability. We evaluate four key dimensions across all options:

1. Legal Structure: Does the option create a formal legal entity (company, trust) or operate through partnership agreements? Entities enable employment and asset ownership but increase complexity and cost.
2. Decision-Making Authority: Who decides what, and how? Options range from consensus-based CEO meetings (collaborative but slower) to formal boards with voting rights (clear but requires surrendering autonomy).
3. Employment Model: Are network staff employed by a central entity, individual partners, or shared across organisations? This fundamentally affects HR complexity, liability, and workforce flexibility.
4. Partner Roles and Accountability: What does each partner contribute and control? Clear role delineation prevents duplication and conflict.





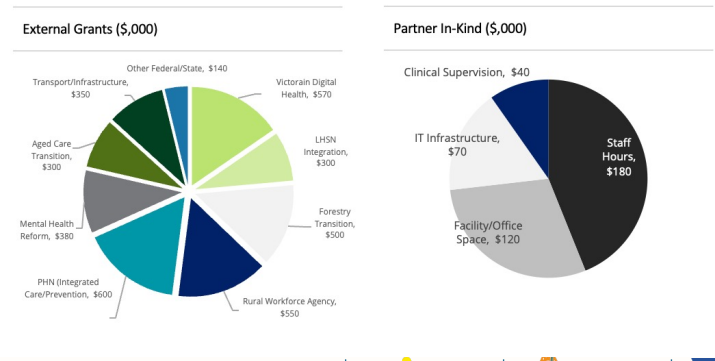
	ADH	YMDH	Kellock/Darl/ Menzies	Nexus	Council	Network Office
Digital Infrastructure	A	C	C	C	I	R
Care Coordination	C	C	R	C	I	A
Preventive Programs	C	C	C	I	A/R	I
Transport	I	I	C	I	A/R	C
Training Placements	R	R	C	C	I	A
Mental Health	R	R	C	R	I	A
Grant Applications	C	C	C	C	C	R/A

R =Responsible, A =Accountable, C =Consulted, I =Informed

FINANCIAL PLAN

Financial viability determines whether options are achievable and sustainable. We assess four critical financial dimensions:

1. Total Investment Required: Capital and operating costs over the implementation period. Options range from $2M (Community-Centered Pragmatic) to $4.5M (Digital-Enabled Lean).
2. Funding Sources: Ratio of external grants vs. partner contributions. All options prioritise external funding (85-95%) recognising partner financial constraints. We identify specific grant programs targeted for each option.
3. Funding Risk Profile: Dependency on few large grants (higher risk) vs. multiple small grants (more resilient). Options relying on single major grants (e.g., Victorian Digital Health Innovation Fund $1.4M) create critical funding dependencies.
4. Sustainability Model: How ongoing operations are funded post-implementation. Options transition through: recurrent grants, partner base budget absorption, usage fees, or self-sustaining revenue models.



Workforce capacity, risk exposure and performance measurement are assessed to understand service feasibility, highlight implementation challenges and define the KPIs needed to ensure accountability and long-term success.

WORKFORCE PLAN

Workforce availability determines service delivery capacity. We assess workforce requirements, recruitment strategies, and sustainability:

- Total FTE requirements (network-employed + partner-employed)
- Role categories (care coordinators, clinical, administrative, digital specialists)
- Recruitment strategies (local-first, graduate pipelines, experienced recruitment, international)
- Employment models (who employs, how deployed, professional development)

Role/Category	Year 1	Year 2	Year 3	Year 4	Year 5	Employment Model
Network Coordinator	10,000	10,000	10,000	10,000	10,000	10,000
Care Coordinators	-	2,000	4,000	6,000	8,000	10,000
Mental Health Clinicians	10,000	12,000	14,000	16,000	18,000	20,000
Health Promotion Officers	-	4,000	8,000	12,000	16,000	20,000
Care Coordinators	-	2,000	4,000	6,000	8,000	10,000
Mental Health Clinicians	10,000	12,000	14,000	16,000	18,000	20,000
Health Promotion Officers	-	4,000	8,000	12,000	16,000	20,000
Health Promotion Officers	-	4,000	8,000	12,000	16,000	20,000
Profit / Loss	**(10,000)**	**(8,000)**	**(6,000)**	**(4,000)**	**(2,000)**	**-**	**2,000**

RISK ASSESSMENT

Risk Categories Across All Options:

- Financial risk (grant funding failure, cost overruns, sustainability)
- Technology risk (platform failures, integration issues, cybersecurity)
- Workforce risk (recruitment failure, turnover, skill gaps)
- Governance risk (partner withdrawal, decision-making conflicts)
- Change management risk (organisational overwhelm, resistance)
- Community acceptance risk (service model rejection, equity concerns)
- Risk Rating: Likelihood (Low/Medium/High) × Impact (Low/Medium/High/Critical) → Residual Risk after mitigation.

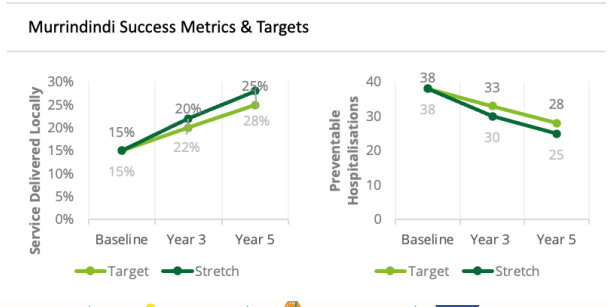
	Identified Risks	Likelihood	Impact	Mitigation	Residual Risk
1	**External Funding Shortfall** Grant applications unsuccessful or delayed, threatening implementation timeline.			Phased implementation—pause if grants fail; diversify across 8-10 funding sources; Forestry Transition anchor ($500k) secured; partners pre-commit to in-kind even if cash grants lower; business cases emphasize ROI	
2	**Partner Commitment Fatigue** Five-year timeframe tests organizational endurance, particularly through CEO changes, competing priorities, or financial pressures.			Rotating coordination distributes burden; early wins (telehealth, placements) build momentum; quarterly Board meetings keep visibility; CEO succession planning includes network orientation; demonstrate partner benefits (e.g., shared recruitment reduces costs)	
3	**Workforce Recruitment Failure** Rural health workforce shortage is systemic; Murrindindi competes with hundreds of rural LGAs for same small talent pool.			Local-first recruitment for coordinators; university partnerships guarantee placement pipeline; shared roles improve job appeal; housing support addresses key barrier; competitive salaries benchmarked to metro; flexibility (part-time, job share)	
4	**Technology Implementation Delays** Digital enablement assumes existing systems can be connected; may discover incompatibility requiring expensive workarounds.			Pilot telehealth at 2 sites before full rollout; leverage Victorian digital health expertise; realistic timelines (18 months not 6); contingency—manual processes continue if digital delayed; vendor support contracts included	
5	**Community Resistance To Change** Service changes may trigger community anxiety about "losing" local services, particularly if visiting specialists replace some local visits.			Co-design from Year 1: community reps on Board; transparent communication about what's changing/what's protected; pilot services gather feedback before expansion; celebrate local staff in new roles; emphasize "addition not subtraction"	

Difficulty: Low Medium High

PERFORMANCE FRAMEWORK

What gets measured gets managed." Performance frameworks define success metrics and accountability:

- Health outcomes (hospitalisations, ED presentations, chronic disease management)
- Access & equity (services delivered locally, wait times, community reach)
- Workforce stability (vacancy rates, turnover, agency usage)
- Partnership health (partner satisfaction, financial sustainability, community awareness)
- Monitoring Approach: Frequency (monthly/quarterly/annual), data sources (automated vs. manual), accountability mechanisms, public reporting.

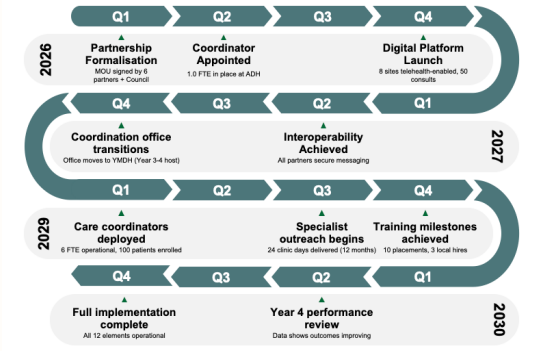


Implementation testing highlighted the sequencing, dependencies and capacity needed for delivery, while impact modelling showed how stronger health outcomes and long-term returns justify investment in a network approach.

IMPLEMENTATION ROADMAP

Implementation feasibility is critical-good plans fail through poor execution. We map detailed implementation timelines examining:

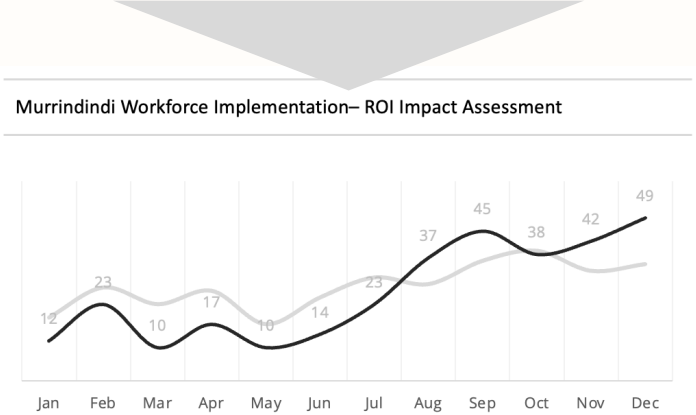
- Sequencing Logic: Why elements are ordered this way. Does the option require foundations before services (Option 1: digital first, then services) or deliver services immediately (Option 3: quick wins)?
- Critical Path Dependencies: What must happen before other activities can proceed? Digital platforms must work before care coordinators can use them; housing must be available before recruiting relocating staff.
- Milestone Gates: Decision points where partners assess progress and decide to proceed, adjust, or pause. Early milestones demonstrate viability before major investment.
- Timeframe Realism: Can implementation be achieved in proposed timeline given partner capacity? Three-year intensive programs (Option 4) pressure organisations differently than five-year phased approaches.



IMPACT AND RETURN ON INVESTMENT

Investment must deliver value-to community health outcomes AND financial sustainability. We assess impact across three dimensions:

- Health Outcomes: Measurable improvements in preventable hospitalisations, chronic disease management, mental health, access to care. Targets based on evidence from comparable networks and population health modeling.
- Economic Returns: Financial savings from avoided hospitalisations, reduced emergency presentations, workforce efficiencies, travel cost savings. Conservative estimates using established health economics.
- Social Return on Investment: Non-financial community benefits-reduced isolation, improved equity, workforce development, community confidence. Qualitative but crucial for community value.
- 10-Year ROI Calculation: We project returns over 10 years (not just implementation period) because health infrastructure investments compound benefits over time. Options with higher upfront costs (digital infrastructure, workforce creation) show improving returns as initial investment amortises.



PRIORITY ELEMENTS

Each element draws from one primary pathway (Options 1-4) with supporting pathways creating integration, ensuring the right delivery model for each type of work.

Understanding the Integration Model

The 12 Priority Elements are the **"what"** (what the network will do), while the Four Options are the **"how"** (how we organise and sequence delivery).

Option Overview:

- **Option 1** (Network Entity): Future governance pathway, not activated Years 1-5
- **Option 2** (Workforce-First): Core foundation for workforce, training, housing (Elements 9-10, 12)
- **Option 3** (Community-Centered): Core foundation for service delivery, access, coordination (Elements 1-8)
- **Option 4** (Digital-Enabled): Supporting enabler for dashboards, telehealth, websites (Element 11 + components)

Element Detail – Each element will be detailed with a set of recommendations,, following this, elements are assessed based on the following assessment criteria:

1. Evidence of Need & Demand
2. Health Impact Potential
3. Funding Certainty & Viability
4. Implementation Readiness
5. Strategic & Policy Alignment
6. Risk Profile & Mitigation

Utilising a scoring index of:

- ○ **No Fit:** Does not align with criteria, lacks evidence, no viable funding, or unacceptable risks.
- ◔ **Poor:** Minimal alignment, limited evidence, uncertain funding, significant barriers.
- ◑ **Satisfactory:** Reasonable alignment, some evidence, potential funding, manageable challenges.
- ◕ **Good:** Strong alignment, clear evidence, identified funding, good readiness.
- ● **Excellent:** Exceptional alignment across all criteria, compelling evidence, secure funding, high readiness.

Element	Option Core Alignment		Why?
1. Digital Enablement		Option 4	Future digital model
2. Enhanced Local and Clinical Capacity		Option 3	Outreach circuit model
3. Preventive Health and Early Intervention Models		Option 3	Alliance project coordination
4. Integrated Mental Health and AOD Services		Option 3	Service delivery focus
5. Transport and Access Enhancement		Option 3	Coordinating existing resources
6. Performance Monitoring and Network Processes		Option 1	Governance and network structure
7. Community Navigator and Care Coordination System		Option 3	Community-embedded service
8. Ease and Accessibility for Community and Advocates		Option 3	Community information
9. Workforce Collaboration		Option 2	Workforce development core
10. Housing Infrastructure and Workforce Retention		Option 2	Workforce infrastructure
11. Aged Care and Disability Support and Pathways		Option 3	Navigation & transitions
12. Local Training and Workforce Development		Option 2	Training pipeline core

The Digital Enablement element establishes shared, practical tools that improve communication, coordination and access to care across the network.

Element 1
Digital Enablement

Supports Option 4
Digital-Enabled

Years 1-2 — **Set the Foundation**

Years 3-5 — **Rural Scaling**

Summary
This element builds MHN's digital infrastructure using proven, existing systems rather than creating new platforms. It connects partners through Murray PHN's POLAR data system, Eastern Health's EMR and telehealth capabilities, simple shared calendars and secure messaging, and a basic Power BI dashboard. The focus is rural-appropriate tools that work on existing bandwidth, require minimal IT support, and deliver immediate coordination benefits without overwhelming small services with complex technology.

Area	Description
Service Model & Scope	Implement three-tier digital system: Tier 1 (2026, $15-25K) - shared Google Calendar for outreach/placements, secure messaging groups for clinical coordination, WordPress service directory, navigation tracking spreadsheet. Tier 2 (2027, $50-80K) - Murray PHN POLAR data access, Power BI dashboard (8-10 KPIs), Eastern Health telehealth platform for specialist consults (cardiology, geriatrics, mental health), Coordinate My Care rollout for 50-80 complex clients, telehealth room upgrades at 2-3 sites. Tier 3 (2028-30, $60-100K) - Eastern Health EMR access via ADH merger, remote monitoring pilot for high-risk patients, expanded allied health telehealth. Staged approach proves basic coordination before scaling.
Infrastructure & Access	Q1 2026 - Audit current infrastructure: internet reliability, telehealth equipment, staff device access, public WiFi. Year 1 ($40-60K via RWAV grants) - Upgrade 2-3 telehealth-deficient sites (Yea, Marysville, aged care facility) with VC equipment and backup internet; provide 8-10 tablets for mobile navigators/allied health; ensure public WiFi at 4-5 libraries/neighborhood houses; install 4G backup at drop-out prone sites. Years 2-3 - Establish "telehealth capable" minimum standard for all clinical sites by end 2027. Critical constraint: only invest in technology maintainable with existing staff + PHN/Eastern Health in-kind support.
Partnerships & Integration	Formalize three partnerships by mid-2026: (1) Murray PHN - provides POLAR data access, Power BI dashboard build, analyst support (0.2 FTE in-kind), grant pathways; MHN provides partner data feeds, pilot participation. (2) Eastern Health - provides telehealth platform, EMR integration pathway, IT troubleshooting, clinical training; MHN coordinates scheduling, facilities, patient flow. (3) Victorian Dept of Health - access Coordinate My Care (free state platform), participate in rural digital pilots, align with state digital strategy. Use standard data-sharing templates. Integration principle: leverage existing systems, align with state/PHN platforms, ensure interoperability, avoid proprietary lock-in.
Importance	Digital disconnection fragments rural care - GPs can't see discharge summaries, navigators miss specialist appointments, data sits in silos. Small services lack IT capacity for sophisticated infrastructure; building local solutions creates expensive, unsustainable systems that fail when staff leave. MHN's approach leverages existing PHN/Eastern Health/state systems, invests minimally in proven coordination tools, and builds just-enough digital literacy. This delivers immediate coordination benefits, enables telehealth expansion reducing travel burden, and creates evidence-based decision-making via quarterly dashboards. Success requires getting basics right first: if staff can't use a shared calendar reliably, sophisticated platforms won't help.

The Enhanced Local and Clinical Capacity brings essential services closer to home through outreach, strengthened staffing and integrated telehealth, improving continuity, reducing travel and ensuring equitable access across all townships.

Element 2
Enhanced Local and Clinical Capacity

Supports Option 3
Community-Centred

Years 1-2 — **Gap Mapping & Priority Services**

Years 3-5 — **Scale Services**

Summary
Establish a shared “acute capability uplift” across ADH and YDMH, standardised escalation pathways, scheduled specialist outreach/telehealth support (e.g., ED advice, wound care, cardiology/diabetes input), and joint workforce arrangements to improve safety, continuity and keep more care local where clinically appropriate. This aligns day-to-day acute operations with the wider network (navigation, transport, prevention, and workforce planning).

Area	Description
Service Model & Scope	Year 1 - Pathway Standardization ($20-40K): Develop 5-6 standardized acute pathways used consistently across ADH/YDMH: chest pain, COPD/asthma exacerbation, heart failure, sepsis screening, falls, complex wounds. Create single escalation protocol to Eastern Health covering when to transfer, when to consult virtually, when to manage locally. Year 2 - Specialist Outreach ($80-120K via RWAV): Establish predictable monthly circuits: cardiology clinic (ADH, 1 day/month), geriatrics (rotating ADH/YDMH, 1 day/month), diabetes/endocrinology (ADH, 1 day/month), respiratory (telehealth + quarterly in-person). Coordinate via Alliance Facilitator using shared calendar. Years 2-3 - Dialysis Feasibility: Work with Eastern Health to assess viability of satellite dialysis at ADH (currently patients travel to Melbourne 3×/week). If viable: establish 6-chair unit serving 15-20 regular patients, staffed by Eastern Health nurses rotating through ADH, reducing 18,000+ km annual travel burden for dialysis patients.
Infrastructure & Access	Outreach clinics operate from existing rooms in hospitals, community health centres, neighbourhood houses and aged care facilities, supported by minimum equipment standards to ensure safety and consistency. Transport solutions help residents reach appointments when required. This approach maximises current infrastructure, avoids capital burden and ensures that even smaller or remote communities have dependable access points for essential clinical services throughout the year.
Partnerships & Integration	Formalise an “Acute Partnership Protocol” between ADH, YDMH and Eastern Health (plus other regional partners as relevant) covering: specialist advice access, outreach scheduling, credentialing/clinical governance, shared pathway documentation, and transfer/referral expectations. Integrate with Navigation and Transport so every acute presentation has a planned follow-up pathway (meds, appointments, transport, community supports) that reduces re-presentation risk.
Why is it important	Currently, residents travel 80-120km to Melbourne for specialist care that could be delivered locally with Eastern Health support. This creates massive travel burden (dialysis patients: 40-60km each way, 3×/week), missed appointments, delayed care, and preventable ED presentations when conditions deteriorate. Expanding local clinical capacity through Eastern Health partnership keeps more care close to home, reduces the ~1,050 preventable admissions annually, and positions ADH (via potential merger) and YDMH as genuine clinical hubs rather than just urgent care facilities. The specialist outreach model is proven in rural Victoria - predictable circuits with coordinated transport achieve 85-90% utilization vs ad-hoc visits at 40-50%.

ELEMENT 3: PREVENTIVE HEALTH AND EARLY INTERVENTION MODELS

The Preventive Health and Early Intervention strengthens wellbeing by aligning existing programs, targeting high-risk groups and delivering simple, community-based supports that reduce long-term demand and improve early detection.

Element 3
Preventive Health and Early Intervention Models

Supports Option 3
Community-Centred

Years 1-2 — **Establish Programs**

Years 3-5 — **Scale Services**

Summary
This element coordinates and expands existing prevention programs run by YDMH, Omnia, and Council, targeting high-risk groups: older adults (falls, chronic disease), farmers (mental health, physical health checks), men (health screening, lifestyle), and youth (wellbeing, substance use). Eliminates duplication, fills gaps in smaller townships, and creates clear referral pathways from prevention into clinical care.

Area	Description
Service Model & Scope	Year 1 - Coordination & Expansion ($60-90K via VicHealth/PHN): Map all existing programs (YDMH's health checks at cattle sales, Omnia's LiFE! falls prevention, Council's Men's Sheds health talks, school wellbeing programs). Eliminate duplication, identify gaps. Launch 3 flagship programs: (1) Farming Families Health Checks - partner with agricultural events (cattle sales, field days) to offer brief health screening (BP, glucose, mental health check-in), delivered by YDMH/Omnia nurses, 4-6 events/year reaching 100+ farmers; (2) LiFE! Program Expansion - evidence-based falls prevention for 65+, expand from current Alexandra-only to Yea, Eildon, Kinglake via trained community leaders, target 60 participants/year; (3) Men's Health Initiative - partner with Men's Sheds, sporting clubs for health talks + screening, focus on CVD/diabetes/prostate, 40-50 participants/year. Year 2-3 - Deeper Integration: Add youth mental health outreach via schools (coordinate with Element 4), chronic disease self-management groups in neighborhood houses, digital health literacy sessions for older adults at libraries.
Infrastructure & Access	Use existing community venues - no new buildings: neighborhood houses (Kinglake, Toolangi, Marysville), libraries (Alexandra, Yea), Men's Sheds, sporting clubs, agricultural showgrounds, school halls. Run programs outside business hours (evenings, weekends) to reach working-age people. Provide materials in accessible formats (large print, multilingual where relevant). Coordinate with Element 5 transport for participants from outlying areas. Keep programs free/low-cost (gold coin donation maximum) to remove financial barriers - funded through VicHealth grants ($10-30K/program), PHN prevention commissioning, Council health promotion budget.
Partnerships & Integration	Core Partners: YDMH (rural health checks, agricultural outreach), Omnia (LiFE! program, chronic disease groups, MH prevention), Council (venues, Men's Sheds, community engagement), schools (youth wellbeing), neighborhood houses (program delivery venues). Funding Partners: VicHealth (prevention grants), Murray PHN (chronic disease prevention, MH early intervention), RWAV (rural health promotion). Integration with Other Elements: Navigation (Element 7) provides referral pathway when screening identifies risk; MH/AOD services (Element 4) receive warm handovers from farmer mental health checks; Digital Enablement (Element 1) shares program calendar so residents know what's available when/where.
Why is it important	Murrindindi's preventable hospitalizations are 57% above state average, dental admissions 68% higher, indicating massive missed prevention opportunities. Prevention works - evidence shows LiFE! reduces falls by 30%, farmer health checks increase help-seeking by 40%, chronic disease self-management reduces ED visits by 20-25%. But currently programs are fragmented, duplicated in some areas, absent in smaller towns. Coordinating existing efforts + strategically filling gaps (especially farmer and men's health) reaches high-risk populations before crisis, reduces long-term acute demand, and builds community health literacy. This is classic "upstream" investment that pays dividends in reduced preventable admissions within 2-3 years.

The Integrated Mental Health and AOD Services element creates a coordinated, stepped-care pathway that ensures earlier identification, smoother transitions and timely support for people experiencing distress across Murrindindi.

Element 4
Integrated Mental Health and AOD Services

Supports Option 3
Community-Centred

Years 1-2 — **Pathway Alignment & Pilots**

Years 3-5 — **Scalling**

Summary
This element creates coordinated mental health and AOD pathways reducing the 260 excess MH hospital admissions annually and addressing suicide rates double the state average. Establishes single access point, warm handover protocols, youth/farmer outreach, and regular case huddles across primary care, community MH, AOD services, and acute care.

Area	Description
Service Model & Scope	Year 1 - Access & Pathways ($50-90K PHN MH funding): Integrate mental health and AOD into local health navigation HUB through Murray PHN Care Finder and Care Navigation services. Create standardized referral pathways from 5 entry points: Navigation, GP, ED, schools, community settings. Develop warm handover protocols (never just "call this number" - active introduction between services). Youth & Farmer Outreach: Deploy 1.0 FTE youth MH clinician (Omnia/YDMH) doing school-based outreach, group programs, early intervention - target 80-100 young people/year. Embed MH check-ins in agricultural events via Element 3 prevention programs. Case Coordination: Monthly case huddles for complex clients involving GP, MH clinician, AOD worker, hospital, housing, family violence services - ensures coordinated response, reduces ED presentations.
Infrastructure & Access	Use existing clinical spaces - Omnia clinics, GP practices, YDMH counseling rooms, school wellbeing centers. For youth: create "drop-in" friendly spaces at Yea Community Centre, Alexandra library (not clinical-looking). For farmers: deliver support in community settings (Men's Sheds, agricultural venues, telehealth from home). Ensure crisis support 24/7 via established pathways: after-hours GP, ED, regional crisis services, Lifeline. Telehealth critical for ongoing counseling/medication reviews reducing travel burden - many MH clients struggle with transport, making virtual care essential.
Partnerships & Integration	Core Partners: Area Mental Health & Wellbeing Service (complex cases, crisis, state reform alignment), Omnia (primary MH, brief AOD intervention), headspace (youth), AOD specialist providers, The Orange Door (family violence intersection), police/justice (crisis response, forensic clients). Integration Points: Navigation (Element 7) provides single entry with MH screening; Prevention (Element 3) identifies early risk; Aged Care (Element 11) coordinates MH support for older adults; Hospitals coordinate discharge planning with community MH. Funding: PHN MH commissioning ($50-90K/year for access line, brief intervention), state MH reform funding (regional AMHWS integration), suicide prevention grants (ASIST training, farmer programs).
Why is it important	MH hospitalisations 23.6% above state rate, suicide 14.2 per 100K (vs 7.6 statewide) with farmers and youth disproportionately affected - this is a crisis demanding coordinated response. Currently fragmented: people bounce between GP, ED, regional services with no warm handovers, long waits, and frequent falling through gaps. Integrated pathways with single access point, warm transfers, and regular case coordination reduce preventable crises, improve early help-seeking, and ensure continuity. Evidence from similar rural networks shows 30-50% reduction in MH ED presentations when pathways work smoothly. Critical success factor: make it easy to access (one number, multiple entry points) and ensure no "wrong door" - wherever someone presents, they get connected to appropriate care.

ELEMENT 5: TRANSPORT AND ACCESS ENHANCEMENT

The Transport and Access Enhancement element removes travel barriers by coordinating transport options so all residents can reliably reach essential health and social care services.

Element 5
Transport and Access Enhancement

Supports Option 3
Community-Centred

Years 1-2 — **Mapping & Pilot Shuttles**

Years 3-5 — **Scalling**

Summary
This element removes transport as a barrier to accessing health and social care. It coordinates council transport, community vehicles, volunteer drivers, VPTAS, appointment bundling and telehealth-first alternatives through a single booking point. By aligning transport availability with clinic schedules and proactively screening for travel barriers, the model reduces missed care, unnecessary travel and carer burden. It ensures residents across the Shire can reliably reach essential services, improving equity for people who would otherwise delay or forgo care due to transport limitations.

Area	Description
Service Model & Scope	Year 1 – Establish a local health navigation HUB through Murray PHN Care Finder and Care Navigation services Pathways ($50-90K PHN MH funding) and transport connection program ($40-70K via Transport Connection grants + Council): Establish 0.4 FTE Transport Coordinator (Council-hosted) managing single booking line for all health transport needs. Coordinate existing assets: Council's community bus, volunteer driver pool (recruit 8-10 additional volunteers), community vehicles (neighborhood houses, aged care facilities), VPTAS eligibility support. Create simple eligibility tiers: (Tier 1) High-need, no alternatives - home pickup; (Tier 2) Moderate need - fixed pickup points at libraries/neighborhood houses; (Tier 3) Can use public transport with support - VPTAS navigation assistance. Year 2 - Appointment Bundling & Shuttles: Coordinate with specialist outreach (Element 2) to bundle appointments - patient sees cardiology + podiatry + pathology in one trip. Trial health shuttle on high-volume days (monthly specialist circuit days) running Alexandria → Yea → Eildon → Marysville route, return service same day.
Infrastructure & Access	Maximize Existing Assets: Council's community bus (currently underutilized), aged care provider vehicles (use off-peak times for health transport), neighborhood house cars (coordinate across organizations). Fixed Pickup Points: Establish 8-10 predictable locations (libraries, neighborhood houses, community centers, key intersections) with signage, seating, weather protection - residents know "health shuttle stops here Tuesdays 9am." Home Pickup: Reserve for frail older adults, people with disability, urgent appointments - higher cost but prevents missed critical care. Telehealth Alternative: For appropriate appointments (medication reviews, counseling, some specialist follow-ups), offer virtual option eliminating travel - coordinate with Element 1 digital enablement.
Partnerships & Integration	Council provides coordinator role, community bus, depot, insurance coverage, volunteer recruitment channels. Volunteer Organizations (Rotary, Men's Sheds, U3A, Lions) supply driver pool. Health Services coordinate appointment scheduling with transport availability - specialist clinics on transport-friendly days, bundled appointments to minimize trips. VPTAS (Victorian Patient Transport Assistance Scheme) - coordinator helps eligible patients claim reimbursement ($40+ for specialist trips). Integration with Navigation (Element 7) critical - transport screening happens at first contact, booking occurs simultaneously with appointment. Link to Outreach (Element 2) - transport and specialist clinics scheduled together.
Why is it important	Transport is consistently cited as top-3 access barrier in rural health - residents report missing 20-30% of specialist appointments due to travel difficulties (distance, cost, time, carer availability). Dialysis patients travel 18,000+ km/year to Melbourne (3×/week); specialist appointments require 4-6 hour round trips. This creates delayed care, preventable deterioration, ED presentations that could have been avoided with timely specialist/GP follow-up. Coordinated transport addressing this reduces missed appointments by 20-30% (proven in similar rural networks), supports chronic disease management, enables aging-in-place for older adults who would otherwise need residential care due purely to transport barriers. Investment: $40-70K/year delivers 400-600 trips/year, each trip preventing potential $2,000-5,000 ED presentation.

The Performance Monitoring and Network Processes element creates a clear, shared view of system performance so partners can make confident, evidence-based decisions and drive continuous improvement across the network.

Element 6
Performance Monitoring and Network Processes

Supports All Options

Years 1-2 — **Establish System**

Years 3-5 — **Optimise & Embed**

Summary
This element establishes light-touch performance monitoring using existing PPHIDU and PHN data, partner metrics, and simple Power BI dashboard (8-10 KPIs) enabling evidence-based decision-making for Network Governance Group. Avoids creating reporting burden on small services while providing clear visibility of system performance, gaps, and impact.

Area	Description
Service Model & Scope	Year 1 - Minimum Data Set ($15-25K): Define 8-10 core indicators tracked quarterly: (Access) Specialist wait times by township, transport-related missed appointments, navigator referral volume; (Workforce) Vacancy rate for critical roles (GP, RN, allied health, aged care workers), time-to-fill positions; (Health Outcomes) Preventable hospitalizations, MH-related ED presentations, chronic disease management; (Service Activity) Outreach clinic utilization, shared care plans active, student placements completed. Use existing data sources: Murray PHN POLAR extracts (free), partner spreadsheets, Element 1 shared calendar/tracking. Year 2 - Dashboard Build: Commission simple Power BI dashboard refreshed quarterly, visualizing trends, comparing townships, flagging emerging issues (e.g., sudden spike in MH presentations, declining outreach utilization). Dashboard accessible to NGG members, working group chairs, Alliance Facilitator - not public-facing.
Infrastructure & Access	Digital Platform: Use Power BI (free via PHN license) or Excel dashboards if BI not viable - keep technology simple and accessible. Data Governance: Establish basic data-sharing agreement by Q2 2026 using PHN template covering privacy, consent, access controls (who sees what data), retention periods. Each partner retains ownership of their data; MHN dashboard shows aggregated/de-identified trends. Reporting Cycle: Quarterly dashboard refresh aligns with NGG meeting schedule. Annual comprehensive report for member boards and funders showing year-on-year progress, ROI on MHN investments.
Partnerships & Integration	Murray PHN provides POLAR data access, analyst support for dashboard build/maintenance, data governance templates, benchmarking against other rural networks. Partners (ADH, YDMH, Omnia, Council, aged care, disability providers) contribute activity metrics via simple spreadsheets - Alliance Facilitator coordinates collection. Workforce Collaboration Group (Element 9) uses workforce metrics to target recruitment; MH/AOD Group uses crisis data to refine pathways; Transport Group uses missed appointment data to adjust routes. Dashboard informs all working groups, making data actionable rather than just reporting exercise.
Why is it important	Without shared performance visibility, partners work blind - unable to identify emerging crises (e.g., MH presentations spiking), prove impact to funders, or target resources effectively. Currently each organization has partial data showing their piece but no system-wide view. Quarterly dashboard costs minimal ($15-25K/year) but delivers huge value: enables NGG to make evidence-based decisions (e.g., "transport bookings doubled in Eildon - we need more volunteer drivers there"), demonstrates impact to secure ongoing funding (e.g., "preventable admissions down 15% since navigation launched"), identifies equity gaps (e.g., "Kinglake residents have 40% longer specialist wait times"). Most importantly, keeps monitoring lightweight - 8-10 KPIs using existing data, not creating 50-page reports overwhelming small rural services.

ELEMENT 7: COMMUNITY NAVIGATOR AND CARE COORDINATION SYSTEM

The Community Navigator and Care Coordination System creates a clear, trusted starting point for residents and ensures they are confidently guided, supported and connected to the right care, no matter where they first seek help.

Element 7
Community Navigator and Care Coordination

Supports Option 3
Community-Centred

Years 1-2 — **Design & Pilot**

Years 3-5 — **Scaling**

Summary
This element establishes a simple, reliable way for residents to “start anywhere and get help to the right place,” regardless of where they first seek support. A small navigation workforce is strengthened by trained community connectors embedded in familiar local settings, offering clear information, warm referrals, help with key forms and light-touch coordination for people with more complex needs. Together, they create a smoother, more confident experience of care, reduce preventable crises and strengthen equitable access across all townships.

Area	Description
Service Model & Scope	Year 1 - Navigator Deployment ($80-120K PHN Care Coordination funding): Recruit 2.0 FTE navigators - one based ADH/Alexandra, one YDMH/Yea (rotates to Eildon/Marysville). Train-the-trainer model: navigators train 8-12 community connectors (existing staff at neighborhood houses, aged care facilities, Council offices) in basic navigation - extending reach without full FTE. Core Functions: (1) First Contact - answer calls/emails, screen needs, provide information; (2) Coordination - book appointments, arrange transport, coordinate multiple providers for complex clients; (3) Warm Handovers - never just "call this number" - active introduction between services; (4) Care Planning - maintain simple shared care plans for clients with 3+ chronic conditions or frequent ED use, ensuring all providers know what others are doing. Scope Boundaries: Navigation does clinical case management (that's GP/nurse role) - they coordinate access and logistics.
Infrastructure & Access	Physical Presence: Navigators based at ADH/YDMH but spend 2-3 days/week in community (neighborhood houses, aged care facilities, GP clinics, Council offices) - bring navigation to residents rather than expecting them to come to hospital. Multiple Access Channels: Phone (1300 number), email, drop-in at community sites, referrals from GPs/ED/schools/aged care. Digital Tools: Use shared calendar (Element 1) to see service availability, Coordinate My Care for shared care plans, simple spreadsheet tracking referrals/outcomes for reporting. Hours: Core business hours with after-hours voicemail redirecting to appropriate crisis services (GP after-hours, MH crisis line, ED).
Partnerships & Integration	Navigation is THE integration point for all other elements: receives referrals from Prevention (Element 3) screening programs, coordinates with Transport (Element 5) for all appointments, triggers MH/AOD pathways (Element 4) when distress identified, ensures smooth aged care/disability transitions (Element 11), links to specialist outreach (Element 2). Formal Partnerships: Murray PHN (funds navigation, provides care coordination training), hospitals (ED discharge planning, complex case identification), GPs (shared care plans, clinical oversight), aged care/disability providers (transition support), Council (transport coordination). Navigation success depends on trusted relationships with ALL partners - navigators spend first 3 months building these connections.
Why is it important	"I don't know where to start" was #1 frustration in community consultation - residents face bewildering maze of services with no clear entry point. Navigation proven in rural health to reduce preventable hospitalizations 20-30% by ensuring people get right care, right time, right place. Critical success factors: navigators must have deep local knowledge (not call center in Melbourne), authority to problem-solve (not just info desk), and trusted relationships with all providers. Investment: $80-120K/year for 2 FTE delivers estimated 80-120 prevented ED presentations/year ($200-300K savings) plus immeasurable improvement in resident experience and confidence in accessing care.

The Ease and Accessibility for Community and Advocates element ensures clear, consistent information so residents and partners can confidently find and use services across the region.

Element 8
Ease and Accessibility for Community and Advocates

Supports Option 3
Community-Centred

Years 1-2 — **Foundation**

Years 3-5 — **Optimisation**

Summary
This element focuses on making information easy to find, understand and use for residents, carers, community advocates and service partners. It harmonises content across partner websites, produces plain-language guides, and establishes common formats for service maps, pathways and contact details. Consistent, accessible information reduces confusion, lowers the burden on frontline teams and builds confidence for people navigating the system. Clarity, accessibility and consistency are the core design principles that ensure all communities can engage with services more easily.

Area	Description
Service Model & Scope	Year 1 - Service Directory ($5-10K): Build simple WordPress website (or section of Council site) listing ALL MHN services: organization, services offered, contact, hours, locations, eligibility, how to access. Update quarterly via Alliance Facilitator. Mobile-friendly, searchable, accessible (screen reader compatible, large print option). Pathway Guides: Develop 5 plain-language guides (2-4 pages each): "Getting Older in Murrindindi" (aged care pathways), "Mental Health Support" (how to access MH/AOD services), "Living with Disability" (NDIS navigation), "Managing Chronic Disease" (diabetes, heart failure, COPD pathways), "Help for Families" (youth services, family violence, parenting support). Use simple language, flow charts, real examples, contact details. Communication Standards: All partners use consistent messaging about MHN, Navigator contact, and service availability - no more conflicting information.
Infrastructure & Access	Digital Platform: WordPress site costs $5-10K setup, $500-1K/year maintenance (Council IT team or volunteer web support). Print Materials: Produce 500-1000 print directories/year for distribution at libraries, neighborhood houses, GP clinics, pharmacies, aged care facilities - critical for older adults without internet access. Multilingual: If CALD communities identified (check census data), translate key documents into priority languages. Promotion: Launch with community information sessions in all townships, ongoing promotion through Council newsletter, local media, partner communications.
Partnerships & Integration	All Partners contribute service information, display directory/pathway guides in facilities, use consistent Navigator contact in referrals. Council hosts website, promotes through community channels, distributes print materials. Consumer Representatives ensure materials are clear, accessible, culturally appropriate. Integration: Directory links to Navigator (Element 7) as first contact, shows Transport (Element 5) options, displays Specialist Outreach (Element 2) clinic schedules, lists Prevention (Element 3) programs. All elements visible in one place for first time.
Why is it important	Fragmented information is massive access barrier - residents call 5 different services before finding right one, give up, delay care, end up in crisis. Clear directory and pathway guides reduce this frustration, build confidence in using services, enable informed decision-making. Particularly critical for older adults, people with disability, CALD residents who find current system most confusing. Investment tiny ($5-10K setup, minimal ongoing costs) but impact significant: reduced navigator time answering basic "who do I call" questions, fewer missed referrals, faster access to appropriate care. Success metric: resident can find correct service contact within 2 minutes of arriving at directory/guide.

ELEMENT 9: WORKFORCE COLLABORATION

The Workforce Collaboration element creates a unified regional approach that strengthens stability, reduces competition and builds sustainable career pathways across the Murrindindi health and care system.

Element 9
Workforce Collaboration

Supports Option 2
Workforce-First

Years 1-2
Establish Shared Workforce System

Years 3-5
Consolidate & Sustain

Summary
This element creates unified regional workforce strategy reducing competition, improving retention, expanding training. Shared recruitment campaigns, cross-organization roles, coordinated rotations, joint relief banks treat Murrindindi as one employment ecosystem addressing projected gaps: 9-12 FTE GPs, ~27 allied health, ~125 aged care, ~160 disability workers by 2036.

Area	Description
Service Model & Scope	Year 1 - Collaboration Infrastructure ($30-50K via RWAV/PHN): Establish shared critical roles list (updated quarterly): GPs, RNs, ENs, allied health (OT, physio, speech pathology), PCA/PCWs, disability support workers, MH clinicians. Launch "Work in Murrindindi Health & Care" recruitment brand with single website, careers expo presence, coordinated social media. Create shared relief bank: pool of casual/bank staff willing to work across partners reducing agency reliance. Year 2 - Shared Roles Pilot: Trial 2-3 cross-organization positions: (1) 1.0 FTE allied health role rotating ADH (0.4), YDMH (0.3), aged care (0.3) - creates attractive full-time role from fragmented part-time needs; (2) 0.6 FTE clinical educator shared across hospitals/aged care supporting student placements (Element 12); (3) 1.0 FTE MH clinician split primary care (0.5), schools (0.3), aged care (0.2). Shared employment agreement templates, coordinated supervision, clear role delineation.
Infrastructure & Access	Minimal Infrastructure: Shared recruitment brand needs basic website ($5-10K), printed materials, social media presence (Alliance Facilitator manages). Shared roles need employment agreement templates (HR legal review $5-10K), clear supervision protocols, coordinated rostering (simple Excel shared between partners). Support Infrastructure: For rotating roles, provide hot-desk space at each site, shared vehicles for multi-site travel (2-3 vehicles via Element 10 or existing fleet), IT access across organizations (VPN or guest access). Professional Development: Pool training budgets to bring speakers/workshops to Murrindindi rather than sending individuals to Melbourne - reaches more staff, builds network connections.
Partnerships & Integration	All Partners commit to Workforce Collaboration principles: share vacancy lists, coordinate recruitment timing, consider shared roles before recruiting independently, participate in joint retention initiatives. External Partners: Eastern Health (rotation pathways, supervision support), universities/TAFEs (placement coordination via Element 12), Murray PHN (workforce funding, data on regional workforce trends), RWAV (workforce grants, recruitment support). Integration: Shared roles serve multiple elements (navigator, transport coordinator, prevention programs, training hub), creating efficiency and reducing fragmentation. Workforce data feeds Element 6 dashboard showing vacancy trends and targeting interventions.
Why is it important	Workforce crisis is existential threat to rural health - without coordinated response, partners compete for shrinking pool, small organizations can't offer attractive roles (0.4 FTE positions don't attract candidates), and agencies capture talent at premium cost. Collaboration turns weakness into strength: pooling creates full-time attractive roles, shared brand raises Murrindindi's profile, coordinated retention reduces turnover (rural challenge is keeping staff, not just recruiting). Evidence from similar rural networks shows collaborative model reduces vacancy duration 20-30%, improves retention 15-20%, and creates career pathways keeping mid-career professionals rural rather than losing to metro. Critical success factor: requires trust between partners and acceptance that "rising tide lifts all boats" - helping competitor hire actually strengthens whole system.

ELEMENT 10: INFRASTRUCTURE AND WORKFORCE RETENTION

The Infrastructure and Workforce Retention element removes housing and practical barriers so staff, students and trainees can live, work and stay in Murrindindi with confidence and stability.

Element 10
Infrastructure & Workforce Retention

Supports Option 2
Workforce-First

Years 1-2 — **Mapping & Quick Wins**

Years 3-5 — **Consolidate & Expand**

Summary
This element addresses a core rural challenge: housing and infrastructure barriers that limit the ability to recruit and retain staff, students and trainees. It establishes a coordinated system for short- and medium-term key-worker accommodation, relocation support, rental access and future small-scale housing options. By reducing the practical obstacles that make living and working in Murrindindi difficult, the model strengthens retention, supports student placements and underpins the long-term viability of Navigation, Outreach, Aged Care, Disability and MH/AOD services.

Area	Description
Service Model & Scope	Year 1 - Asset Mapping & Quick Wins ($20-40K): Audit existing accommodation assets: ADH/YDMH staff units (how many, occupancy rate), Council properties, aged care provider housing, potential head-lease opportunities (private rentals willing to lease to MHN for 12-24 months). Establish 0.2 FTE Housing Coordinator role (Council-hosted) as single contact for new staff/students needing accommodation. Create tiered accommodation model: (Tier 1) Short-term (1-6 months) - locums, students, new staff while house-hunting: use existing units, motel partnerships, shared houses; (Tier 2) Medium-term (6-24 months) - early-career staff establishing themselves: head-lease 2-3 furnished properties for share-house arrangements; (Tier 3) Long-term - permanent staff: relocation support, rental assistance, priority access to affordable housing waitlists. Year 2-3 - Development Exploration: Partner with community housing providers, Council, regional development to assess feasibility of 6-10 unit key-worker housing development (modular/tiny homes on suitable site). Business case requires state/Commonwealth housing grants, not partner capital.
Workforce & Capability	Existing Assets Maximize: ADH has underutilized staff accommodation, YDMH similar - coordinate usage across network. Aged care providers have staff units for recruitment - share excess capacity. Council has some properties potentially suitable for health worker housing. Head-Lease Model: MHN (via Council as entity) head-leases 2-3 properties from private landlords (12-24 month leases), furnishes basically, sub-leases to students/early-career staff at affordable rate ($150-200/week per room in shared house). Reduces landlord risk, provides guaranteed income, creates stable student/worker accommodation. Longer-term Development: If feasible, explore 6-10 unit development on Council/health service land - modular construction ($200-300K/unit), rented to key workers at below-market rates, managed by community housing provider. Requires capital grants, not MHN/partner funding.
Infrastructure & Access	Council leads housing strategy, provides coordinator role, liaises with community housing providers, advocates for housing grants, identifies suitable development sites. Health/Aged Care Partners provide staff accommodation assets, identify housing needs in recruitment, contribute to head-lease arrangement costs proportional to staff housed. Community Housing Providers (Homes Victoria, regional housing associations) partners for potential development, property management expertise. Real Estate Networks identify head-lease opportunities, provide market intelligence. Integration: Housing enables Element 12 student placements (students need somewhere to stay), supports Element 9 shared roles (staff willing to work multiple sites if housing sorted), strengthens Element 2 specialist recruitment (easier to attract if housing provided).
Why is it important	Housing barriers regularly deter prospective staff and students from relocating or remaining in rural areas, undermining service stability. Addressing these barriers directly improves recruitment, strengthens early-career retention and ensures placements can be hosted consistently. It also reduces reliance on costly agency and locum arrangements. Over time, this approach supports a more secure, sustainable workforce capable of delivering essential services across all townships.

The Aged Care and Disability Support and Pathways element strengthens transitions, coordination and preventative pathways so older people and NDIS participants receive consistent, connected support across the whole system.

Element 11
Aged Care and Disability Support and Pathways

Supports Option 3
Community-Centred

Years 1-2
Interface Mapping & Quick Wins

Years 3-5
Consolidate & Advocate

Summary
This element strengthens pathways and coordination for older people (65+ population growing from ~3,800 to >6,300 by 2036, needing ~450 RAC places, ~1,450 home care places) and NDIS participants (projected ~360 by 2036) through standardised discharge planning, proactive outreach, and integrated referral processes that strengthen early intervention, increase timely uptake of home care and community supports, and prevent avoidable admissions and unsafe transitions.

Area	Description
Service Model & Scope	Year 1 - Pathway Standardization ($30-50K): Develop standardized hospital-to-home discharge template used by ADH/YDMH covering: functional assessment, medication review, home safety check, care needs, follow-up appointments, who's responsible for what. Template shared with aged care/disability providers, GPs, home care coordinators ensuring everyone has same information. Create clear aged care referral pathway: Navigator assists with My Aged Care registration, assessment booking, service selection - reducing 3-6 month delays currently experienced. Establish NDIS coordination: Menzies leads NDIS pathways (their specialty), coordinates with LAC partners, streamlines access for newly eligible residents. Year 2 - Proactive Outreach: Implement "in-reach" to aged care facilities: weekly GP/nurse practitioner visits to RACFs (Kellock, Darlingford) reducing avoidable transfers, medication reviews, early intervention. Allied health outreach (physio, OT, speech) into RACFs and home care settings addressing functional decline before crisis.
Workforce & Capability	Use existing facilities - no new buildings required. In-reach to RACFs uses existing GP/nurse/allied health rooms at facilities. Home care outreach delivered from provider vehicles (element 5 transport coordination). Telehealth (Element 1) enables specialist geriatric consults into RACFs avoiding transfers for routine reviews. Coordinate clinic times with RACF/home care schedules ensuring residents can access without disrupting care routines. Focus on making services come to older/disabled residents rather than expecting them to travel.
Partnerships & Integration	Core Partners: Kellock, Darlingford (RAC providers), Menzies, other CHSP/HCP providers (home care), NDIS providers, LAC partners (disability), ADH/YDMH (hospitals), GPs (primary care), My Aged Care, NDIS access teams. Integration Points: Navigation (Element 7) provides warm handovers to aged care/NDIS systems; Transport (Element 5) ensures older adults/people with disability can reach appointments; MH/AOD (Element 4) addresses older adult mental health and substance use; Discharge planning coordinates with Prevention (Element 3) linking to falls prevention, chronic disease programs. Monthly multi-disciplinary meetings for complex clients ensuring coordinated response across acute, primary, aged care, disability systems.
Why is it important	Older people and NDIS participants often face complex transitions that become unsafe when services do not align. Strengthening pathways reduces preventable hospital admissions, delays and gaps in follow-up. A more integrated model supports ageing-in-place and ensures people with disability are not left to coordinate their own care. Over time, this creates a more confident, connected system that responds earlier and more consistently to changing needs.

The Local Training and Workforce Development element builds a coordinated regional training system that grows a skilled, local workforce and strengthens long-term employment pathways across Murrindindi.

Element 12
Local Training and Workforce Development

Supports Option 2
Workforce-First

Years 1-2 — **Design & Pilot**

Years 3-5 — **Consolidation & Impact Evaluation**

Summary
This element creates a coordinated regional training and learning system that builds a future workforce for Murrindindi. It brings together TAFEs, universities, health and care providers, community organisations and the MHN Alliance to deliver supported study, structured placements, rural generalist pathways and early-career supports. By enabling people to train locally, it reduces recruitment costs, improves retention and opens meaningful opportunities for residents who prefer not to leave the region. Over time, this model strengthens workforce pipelines and supports more stable service delivery. As demand and partnerships mature, the Study Hub model could evolve into a Regional University Study Hub (RUSH), attracting broader tertiary programs and external funding.

Area	Description
Service Model & Scope	Launch a Study HUB model in Year 1 using existing facilities, operating 2-3 days per week initially. Prioritize short courses (Cert III Aged Care, Cert III Individual Support, Mental Health First Aid) through existing partnerships. Secure RWAV Clinical Training Support grants ($30-60K annually) and PHN workforce development funding to subsidize student costs. Implement a "train-and-place" agreement: students commit to 12-24 months local employment post-qualification in exchange for fee support and guaranteed placement. Structure placements across all partners (minimum: ADH 6, YDMH 4, aged care 6, Omnia 3, Menzies 2 annually = 21+ total) with coordinated scheduling through the Alliance Facilitator to avoid partner overload. Create pathways from VCE students → traineeships → qualified roles using local schools as feeder pipeline. This builds a "grow your own" workforce reducing reliance on external recruitment.
Workforce & Capability	Recruit a 0.6 FTE Hub Manager/Pathways Lead (hosted by ADH or Council, PHN/RWAV funded) responsible for: coordinating placement logistics, managing TAFE/university partnerships, supporting casual tutors, and tracking learner progression. Establish a clinical supervision pool: train 8-10 existing staff across partners as accredited preceptors/supervisors (using RWAV preceptor training grants). Pay supervisors a $2,000 annual stipend per placement student. Recruit 2-3 casual tutors/mentors (retired nurses, allied health) for skills workshops and learner check-ins. This distributed model shares supervision load, prevents burnout, and embeds learning support across the network without requiring one organization to carry all capacity.
Infrastructure & Access	Study HUB with 2 tutorial/group rooms, quiet study zone, VC setup for remote lectures, kitchenette, and accessible parking. Negotiate free/low-cost facility access through Council in-kind contribution. Coordinate transport: align study days with existing Council bus routes or provide learner travel subsidies ($20/session) for students from Kinglake, Marysville. Offer flexible delivery: evening sessions for working learners, weekend intensives for block courses, and hybrid online/in-person for TAFE programs. Establish a "learner support fund" ($10-15K annually, Council/PHN funded) for emergency costs (textbooks, uniforms, fuel) that prevent course completion.
Why is it important	A local, coordinated training system builds a pipeline of home-grown talent and reduces reliance on external recruitment. It also strengthens early-career retention by providing supported placements and clear employment pathways. Over time, this approach improves workforce stability and ensures essential services can be delivered consistently across all townships.

Train-the-trainer model deploying 2-6 FTE community navigators across the shire to support health, aged care, and disability journeys. Murray PHN-funded ($80K-$120K/year). Reduces preventable hospitalisations through coordinated access and care transitions.

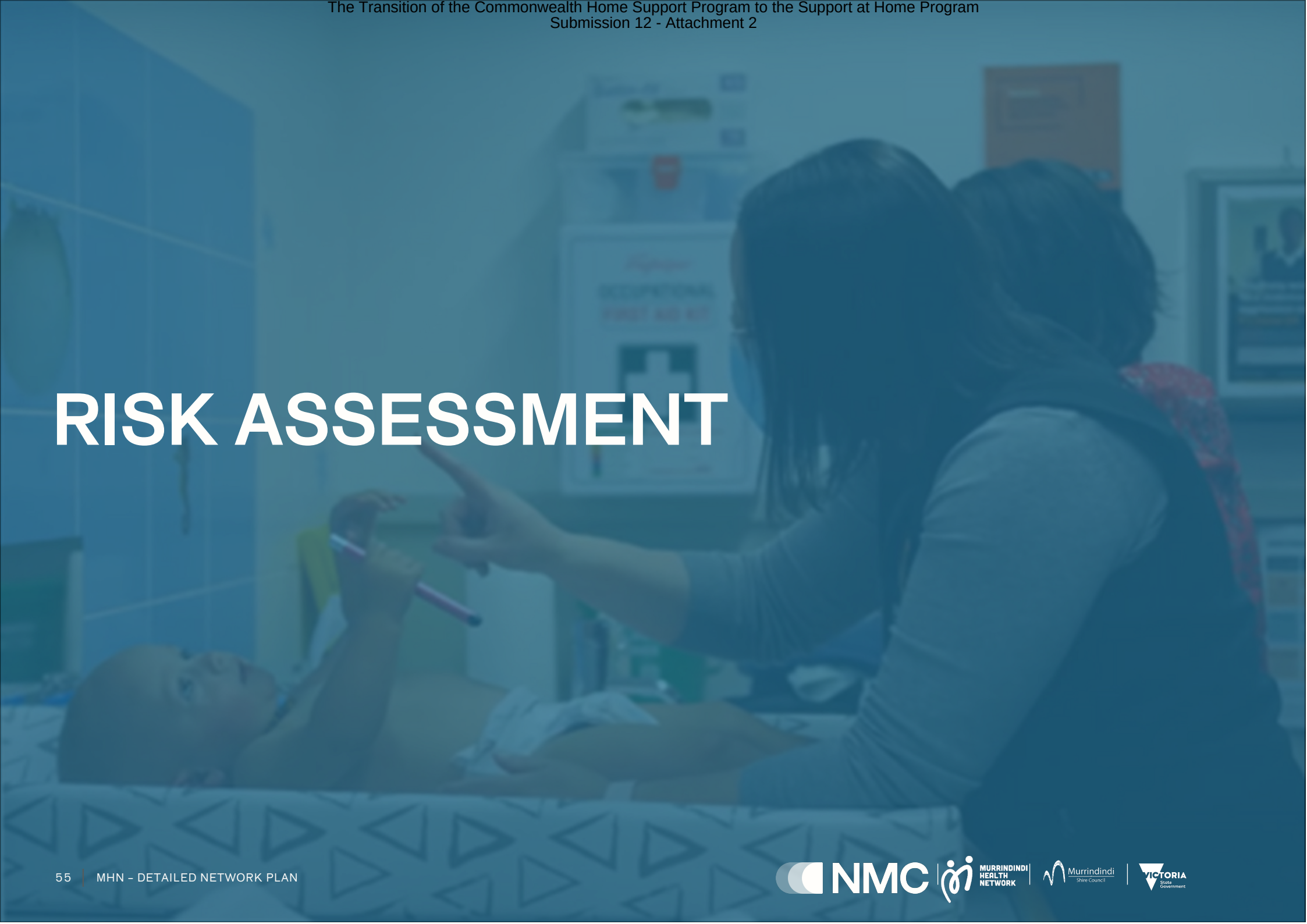
EVALUATION LENS	Element 1&8: Digital Enabled, Ease, and Accessibility	Element 2: Clinical Capacity	Element 3: Prevention	Element 4: Mental Health & AOD	Element 5: Transport	Element 6: Performance Monitoring
1. Evidence of Need & Demand	"Don't know where to call" #1 frustration, fragmented info	85% leave shire, self-sufficiency 15% vs 85% target, allied health gaps	Chronic disease 57% above state, rising admissions forecast	260 excess MH admissions, 3,200 bed-days, critical community need	Critical transport barrier, 40-60km distances, missed appointments	No shared monitoring, strategic need for accountability
2. Health Impact Potential	Indirect - enables self-service, reduces "wrong door" contacts	Incremental access improvement, 15%→22% self-sufficiency	20% PPH reduction for chronic disease, evidence-based programs	30-50% crisis reduction proven, $100K-$200K savings + quality of life	20-30% missed appointments prevented, enables other elements	Indirect - enables data-driven decisions and continuous improvement
3. Funding Certainty & Viability	Very low cost $25K-$75K, minimal funding risk	RWAV Outreach $40K-$80K/year, DHSV van available	VicHealth + RWAV multiple small grants, fragmented	PHN MH Access $50K-$90K/year, MH reform funding	Transport Connection grants $40K-$70K/year, volunteer costs	PHN data support, low cost $400K-$600K (Facilitator time)
4. Implementation Readiness	Very high - WordPress template, 2-3 months, immediate start	DHSV van 3-6 month booking, Year 2 after transport/booking	Programs exist but not coordinated, Year 2 realistic	MH workforce shortage critical, complex integration, Year 1-2	Moderate complexity, volunteer recruitment 6-12 months	Moderate - PHN data sharing 3-6 months, simple dashboard Year 2
5. Strategic & Policy Alignment	Consumer empowerment, health literacy - moderate	LHSN self-sufficiency, RWAV access - strong	VicHealth strategy, PHN chronic disease - strong	Victorian MH Royal Commission reform - exceptional	Rural access, equity, transport programs - strong	Outcome-based funding trends, accountability - strong
6. Risk Profile & Mitigation	Very low - outdated info main risk, quarterly updates mitigate	DHSV van availability, low utilisation - medium risk	Low engagement, funding fragmentation - medium risk	MH workforce failure (severe shortage) - medium-high risk	Volunteer retention, coordination complexity - medium risk	Low-medium - data sharing hesitancy, technical burden
OVERALL RATING						

Legend: ○ No Fit ◔ Poor ◑ Satisfactory ◕ Good ● Excellent

Train-the-trainer model deploying 2-6 FTE community navigators across the shire to support health, aged care, and disability journeys. Murray PHN-funded ($80K-$120K/year). Reduces preventable hospitalisations through coordinated access and care transitions.

EVALUATION LENS	Element 7: Navigation	Element 9: Workforce Collaboration	Element 10: Housing	Element 11: Aged Care & NDIS	Element 12: Training Hub
1. Evidence of Need & Demand	1,050 PPH/year, #1 community gap, unanimous partner support	Workforce crisis: 32 GP/100K vs 97 state, 22% agency reliance	Housing cited as top-3 recruitment barrier, limited capacity	450 delayed discharge bed-days, fragmented aged care, Support-at-Home urgency	13 ad-hoc placements now, need 19-25, "grow your own" essential
2. Health Impact Potential	15-25% PPH reduction proven, $420K-$630K annual savings	Foundational - reduces 22%→12% agency use, $180K-$300K savings	Indirect - enables 4-6 FTE recruitment, $160K-$240K value	25-30% delayed discharge reduction, $290K-$350K value	Long-term - 30-50% placement conversion, 3-5 hires/year by Year 5
3. Funding Certainty & Viability	PHN Care Coordination $80K-$120K/year established stream	RWAV Workforce grants $100K-$200K, partner salary commitments	Capital intensive $350K-$400K, RWAV grants competitive	Support-at-Home transition funding uncertain, PHN possible	RWAV Training $30K-$60K/year, university partnerships
4. Implementation Readiness	Proven CHIP/HARP model, 3-6 month recruitment, Year 1 ready	Moderate complexity - legal/HR for shared roles, Year 1-3 staged	High complexity - capital infrastructure 12-24 months, Year 3-4	High complexity, Support-at-Home reform uncertainty, Year 2-3	Moderate - university MOUs 6-12 months, Year 1-2 start
5. Strategic & Policy Alignment	PHN, hospital avoidance, Support at Home, NDIS - exceptional	National Workforce Strategy, RWAV priorities - exceptional	RWAV retention, regional development - strong	Support-at-Home reform, NDIS sustainability - excellent	Rural training mandates, RWAV strategy - exceptional
6. Risk Profile & Mitigation	Recruitment delays, Omnia duplication - low-medium risk	Medium - partner control concerns, legal complexity	Medium-high - capital funding gap, utilisation uncertainty	Reform uncertainty, provider fragmentation - medium-high risk	Medium - conversion uncertainty, supervision burden
OVERALL RATING	●	●	◑	◕	●

Legend: ○ No Fit ◔ Poor ◑ Satisfactory ◕ Good ● Excellent



RISK ASSESSMENT

A shared risk view highlights the biggest threats to delivering the plan and protects small services from unintended consequences.

Implementing the MHN plan involves system-level risk as well as opportunities. Key risks have been grouped and prioritised based on likelihood and impact.

1. Workforce Risk
- Inability to recruit or retain key roles (GPs, nurses, allied health, disability workers, navigators)
- Limited supervision capacity affecting training and quality

2. Financial Risk
- Failure to secure anticipated grants or program funding
- Short-term projects that cannot transition to sustainable funding streams

3. Governance & Partnership Risk
- Misaligned expectations between members; disagreements over priorities or resource sharing
- Changes in the ADH–Eastern Health relationship or other structural reforms that shift roles

4. Service Continuity & Safety Risk
- New models (e.g. outreach, telehealth, shared roles) not fully embedded, leading to gaps or quality issues

5. Digital & Data Risk
- Cyber incidents, privacy breaches or data quality problems
- Overly complex digital solutions stretching capacity

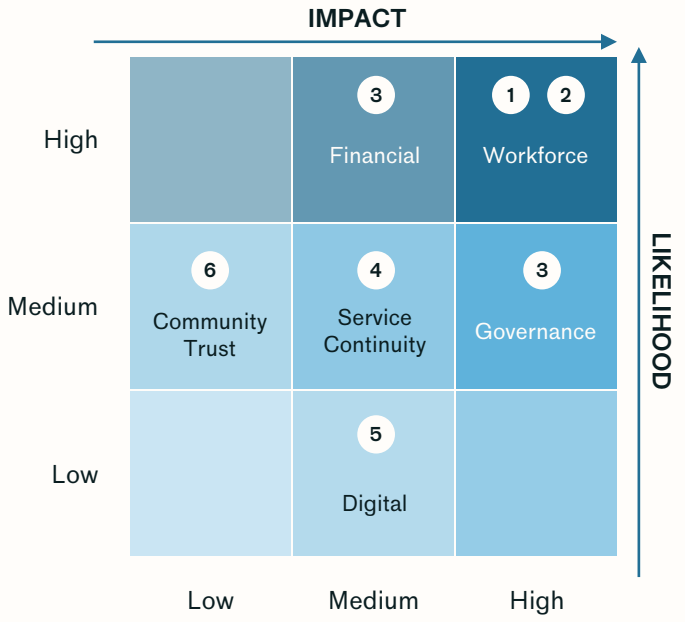
6. Community Trust & Reputation Risk
- Perception of service "loss" or centralisation
- Change fatigue among staff and community if communication is poor

Each risk intersects with the 12 elements differently; for example, workforce risk is particularly high for Elements 8–10, while digital risk is concentrated in Elements 11–12.

A shared risk view helps MHN:
- Focus mitigation efforts where they matter most
- Provide assurance to boards that risks are being actively managed, not ignored
- Design projects in ways that minimise unintended consequences for small services

#	Risk Category	Key Drivers	Elements Most Affected
1	Workforce	Recruitment, retention, supervision	8–10
2	Financial	Grant dependency, sustainability	All
3	Governance	Partner alignment, reform changes	All
4	Service Continuity	New model embedding	1–7
5	Digital & Data	Cyber, privacy, complexity	11–12
6	Community Trust	Perception, communication	All

Impact Matrix



Utilising a simple, shared risk framework across the three plan areas and 12 elements to keep the plan applicable.

Implementing the MHN Plan involves system-level risk as well as project-level risk. The aim is not to remove risk, but to make it visible, shared and proportionate to the size and capacity of Murrindindi services.

The Network will use a common risk approach across all projects and partners:

Step 1 – Apply six risk lenses: Each element and project is assessed against:

- Workforce
- Financial
- Governance & partnerships
- Service continuity & safety
- Digital & data
- Community trust.

Step 2 – Rate risk using a simple three-point scale: For each lens we assign one of three ratings:

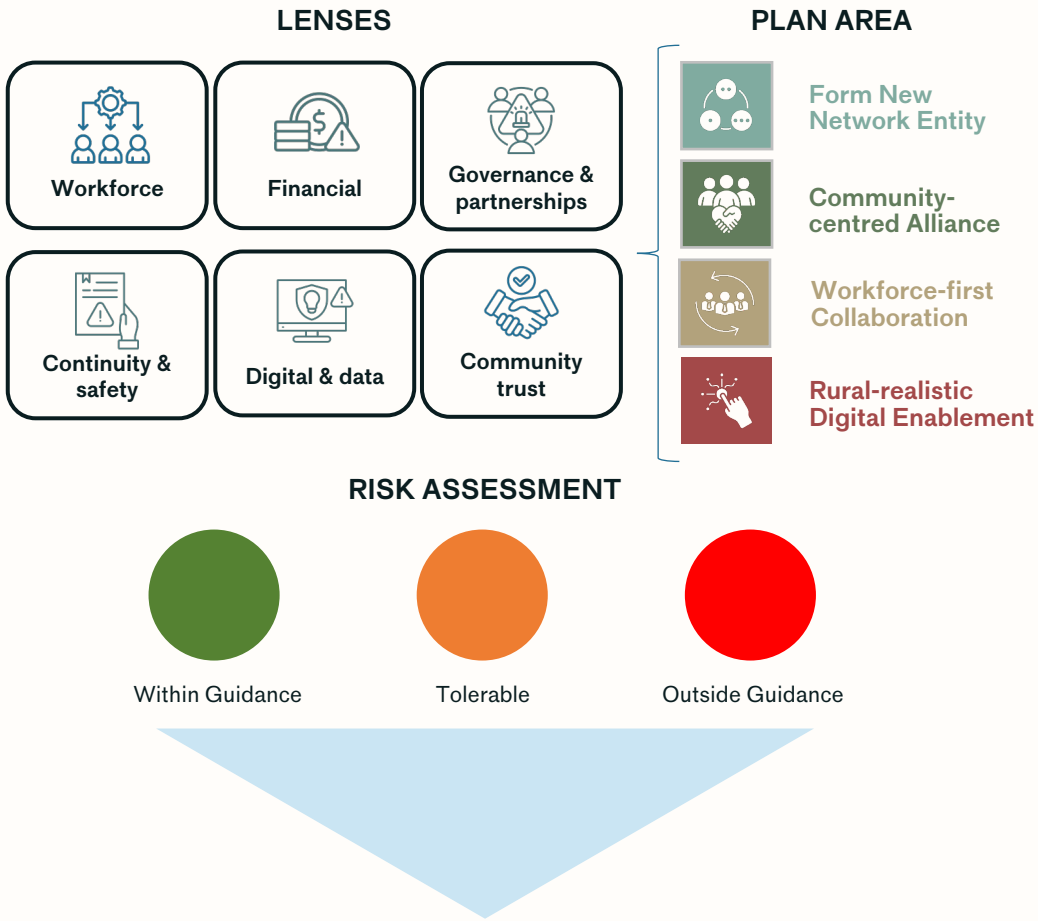
- **Within guidance (green)** – risks are understood and can be managed within normal operations.
- **Tolerable (amber)** – risks are material but can be reduced with targeted mitigations.
- **Outside guidance (red)** – risks are unacceptable without redesign, phasing or additional resources.

Step 3 – Aggregate by plan area: Ratings are then summarised across the three plan areas:

- **Form New Network Entity (Potential Governance Model)**
- **Community-centred Alliance (Network Foundation)**
- **Workforce-first Collaboration (Critical Enabler)**
- **Rural-realistic Digital Enablement (Future Scaling)**

This provides a clear picture of where risks concentrate (for example, workforce and housing, or digital change) and where early mitigation effort should be focused.

Risk Assessment Methodology



Risk criteria are tailored to Murrindindi's rural context so risks across the three plan areas and 12 elements are assessed consistently.

Risk Criteria

Risk criteria describe what "within guidance", "tolerable" and "outside guidance" look like for each lens. This provides a shared language for assessing risk and deciding where mitigation effort and staging are required. These criteria are applied to each plan area and element to determine an overall risk rating (within guidance, tolerable or outside guidance) and to target mitigation actions.

Risk Criteria	Description of component	Within guidance	Tolerable	Outside guidance
Workforce	Risks relating to attracting, retaining and supporting the workforce needed to deliver the 12 elements across small services and towns (including projected gaps of 9–12 FTE GPs, ~27 FTE allied health, ~125 FTE aged care and ~160–170 disability workers by 2036).	Roles can be filled from realistic local/regional pathways (via the Health & Learning Hub, RWAV and Eastern Health rotations); supervision is available in each town; rosters remain safe; initiatives can be delivered with shared roles across members without destabilising BAU services.	Some hard-to-fill roles or thin coverage in one or two towns; reliance on visiting clinicians, locums or shared positions is higher than ideal but manageable if rotations, supervision and housing supports proceed as planned. Short delays or staged roll-out may be required.	Assumes new services or significant activity in roles that are already critically short (e.g. several extra GPs, MH clinicians or disability workers) with no credible pipeline; would materially increase burnout or vacancy risk, or require ongoing high-cost agency/locums across multiple providers.
Financial	Risks relating to start-up and ongoing costs, funding sources and long-term sustainability of MHN initiatives in a small, low-rate-base rural shire. Includes reliance on PHN, state/federal prevention, aged care, disability and digital funding, as well as local contributions.	Start-up and recurrent costs are modest relative to member budgets; funding sources are identified (e.g. PHN coordinators, Support at Home, NDIA ILC, VicHealth, RWAV, RHIF) with clear alignment; initiatives can transition to BAU within 3–5 years without major exposure for any single provider.	Model depends partly on short-term grants or pilots with a plausible pathway to recurrent funding (e.g. proving impact on ~1,050 PPHs or MH bed-days); co-funding between members or partners is needed but achievable; some risk of gaps if future rounds are delayed.	Requires large, ongoing unfunded contributions from small services; hinges on uncertain policy decisions or major capital without identified programs; high risk that initiatives cease abruptly, leave stranded costs (e.g. buildings, IT platforms) or divert funds from essential local services.
Governance & partnerships	Risks around clarity of roles, decision rights and accountability across MHN members, the NGG, Alliance Facilitator, working groups, ADH–Eastern Health, PHN, education partners and other agencies.	Roles and decision rights are clearly described in MHN agreements; NGG and working groups have defined scope; Eastern Health, PHN and others have agreed "plug-in" roles; each initiative has a nominated lead organisation and simple project governance that fits existing structures.	Some ambiguity or overlap in responsibilities (e.g. between MHN and bilateral partnerships), but these can be resolved through MOUs, project charters and regular NGG oversight. Occasional escalation is required, but decisions are still timely and relationships remain constructive.	Governance is unclear or contested; initiatives require new legal entities or pooled funds without board buy-in; accountability for quality, finances or workforce is blurred; there is sustained disagreement between key partners (e.g. member vs tertiary provider vs PHN) that could stall or derail projects.

Risk criteria are tailored to Murrindindi's rural context so risks across the three plan areas and 12 elements are assessed consistently.

Risk Criteria

Risk criteria describe what "within guidance", "tolerable" and "outside guidance" look like for each lens. This provides a shared language for assessing risk and deciding where mitigation effort and staging are required. These criteria are applied to each plan area and element to determine an overall risk rating (within guidance, tolerable or outside guidance) and to target mitigation actions.

Risk Criteria	Description of component	Within guidance	Tolerable	Outside guidance
Service continuity & safety	Risks that implementing the MHN plan disrupts access, continuity or safety of care for residents across hospitals, primary care, aged care, disability, MH/AOD and community services.	Changes are incremental and well-sequenced; existing clinical governance, escalation pathways and on-call arrangements remain intact; small teams are not left without cover; any consolidation of clinics or roles is offset by improved outreach, telehealth or transport so residents do not lose access.	Some short-term disruption (e.g. service moves location, new referral processes) or temporary reduction in local hours while new roles or models bed in; risks can be mitigated with careful rostering, communication and contingency plans; safety and quality standards remain achievable.	Likely to create gaps in essential services (e.g. loss of urgent care or aged care capacity in a town) without guaranteed alternatives; substantially increases workloads beyond safe limits; materially weakens existing clinical governance or emergency response, especially given Murrindindi's distance to higher-level services.
Digital & data	Risks related to connectivity, digital tools and data use across members, given variable infrastructure, skills and existing systems. Covers telehealth, shared calendars/directories, dashboards and any future shared platforms.	Uses simple, proven tools that can run on existing infrastructure and bandwidth (telehealth rooms, shared calendars, basic directory, low-complexity dashboards); aligns with state and PHN initiatives; privacy, consent and cybersecurity controls are proportionate and documented.	Requires some uplift in systems, devices or skills (e.g. new telehealth hardware in several sites, basic shared care-planning tool) but can be phased in by town/service; support is available from Eastern Health, PHN or vendors; temporary workarounds may be needed but risks are manageable.	Depends on major EMR replacement or bespoke platform across all members; assumes reliable high-speed connectivity everywhere; significantly increases cyber exposure without resources for security; duplicates or conflicts with statewide systems, creating high risk of cost blow-outs or project failure.
Community trust	Risks that communities, consumers and carers will not understand, accept or use new models, or will perceive them as service loss, given strong local identity, past trauma (fires, closures) and high concern about losing local care.	Initiatives are co-designed with local residents and consumer reps; visible local benefits (e.g. more outreach clinics, easier navigation, improved transport) are evident in each town; communication is transparent and in plain language; no net loss of local access without clearly superior alternatives.	Some perceived trade-offs (e.g. fewer ad-hoc appointments but clearer navigation; more telehealth alongside fewer in-person specialist visits) that may cause concern; issues can be managed with early engagement, clear messages about benefits and honest discussion of constraints.	High likelihood of backlash or ongoing mistrust (e.g. perceived downgrading of a facility, centralising services without compensating outreach, or major change announced without consultation); communities feel decisions are imposed "from outside"; risk of reputational damage and resistance to future MHN initiatives.

Option 1 provides a future governance pathway with centralised employment, shared resourcing, and asset management when the Alliance demonstrates readiness for deeper integration.

Risk lens	Key risks for Option 1	Mitigation strategies (MHN approach)	Rating
Workforce	Centralised employment requires critical mass of roles (15-20 FTE minimum) to justify entity overhead; fragmented employment if insufficient scale	Stage formation post-2030 after Alliance proves coordination capability; ensure minimum FTE threshold before proceeding; maintain partner employment flexibility during transition	
Financial	Significant upfront costs ($200K-$300K) for legal, registration, compliance; ongoing board and audit requirements; stranded investment risk if entity dissolves	Only pursue when Alliance demonstrates sustained financial performance; secure multi-year government funding commitments before proceeding; develop clear wind-up provisions	
Governance & Partnerships	Community trust risk if perceived as "takeover"; partner board reluctance to cede authority; complexity managing Alliance-to-entity transition	Position as evolution of successful Alliance, not replacement; maintain strong local governance representation; 2-3 year phased transition with decision gates; transparent community consultation	
Service Continuity & Safety	Clinical governance complexity across service types; risk during employment transfer; potential service disruption during transition	Maintain existing clinical governance during transition; staged employment transfers by service line; no frontline changes until backend systems proven; robust contingency planning	
Digital & Data	Entity may drive digital integration beyond partner capacity; pressure for shared platforms creating implementation risk	Digital integration remains voluntary enhancement; partners retain system autonomy; shared platforms only where clear benefit and readiness demonstrated	
Community Trust	Past integration failures create skepticism; perception of "centralising" services; concern about losing local identity and decision-making	Only proceed if Alliance builds 5+ years community trust; frame as strengthening, not replacing, local services; maintain town-based delivery and engagement	
OVERALL RISK RATING: Within Guidance - when pursued as mature pathway post-2030 with proven Alliance performance			

Legend: Within guidance | Tolerable | Outside guidance

Option 2 delivers visible community benefits through 2-year project cycles while maintaining full partner autonomy and light governance structures.

Risk lens	Key risks for Option 2	Mitigation strategies (MHN approach)	Rating
Workforce	Limited capacity to release staff for navigation, outreach, prevention; new coordinator roles hard to recruit; risk of overloading existing staff	Design navigation/coordinators as shared MHN positions hosted by one partner; use Health & Learning Hub for entry pathways; MH/AOD integration through scheduled outreach not new specialists; embed workload monitoring	
Financial	Project-based funding creates sustainability risk; fragmented small grants difficult to manage; transport costs escalate if not controlled	Prioritise alignment to existing streams (PHN, VicHealth, Support at Home); package into 1-2 integrated business cases; define transport principles to cap exposure; build evaluation linking reduced demand to continuation	
Governance & Partnerships	Overlap with existing roles; complexity coordinating multiple partners; risk no single organisation accountable for whole pathway	Define working group structure under NGG with named lead; map existing functions to avoid duplication; simple MOUs specifying roles/data-sharing; include consumer representatives	
Service Continuity & Safety	New referral pathways may confuse consumers; outreach creates lone worker risks; MH/AOD integration requires careful risk management	Co-design and test before broad rollout; run parallel during transition; develop lone worker protocols; align MH/AOD with regional clinical governance; phased implementation with feedback	
Digital & Data	Risk over-engineering solutions; variable connectivity limits telehealth; data extraction inconsistent across providers	Start with low-complexity tools (directory, templates, calendars); align to existing state/PHN platforms; light training with offline options; small common indicator set with simple reporting	
Community Trust	Perception navigation replaces local relationships; skepticism of "centralised" approaches; MH/AOD privacy/stigma concerns in small communities	Co-design with residents ensuring town benefits clear; communicate navigation makes existing services easier not replacing; multiple confidential MH/AOD access channels; use local trusted connectors	
OVERALL RISK RATING: Within Guidance - low-risk foundation approach suitable for Years 1-5			

Legend:  Within guidance  Tolerable  Outside guidance

Option 3 addresses workforce shortages through shared roles, training hub, placements, and coordinated recruitment while strengthening clinical capacity.

Risk lens	Key risks for Option 3	Mitigation strategies (MHN approach)	Rating
Workforce	Existing GP, nursing, allied health shortages limit expansion; advanced scope roles difficult to recruit; aged care/disability struggling to attract staff; integration adds expectations without resources	Link clinical capacity to realistic pipelines (Hub, RWAV, placements, Eastern Health rotations); prioritise redesign over net-new FTE; cluster advanced roles at sites with supervision; joint solutions with aged care/disability	
Financial	Unfunded service expansion risk for small services under budget pressure; aged care/disability coordination not clearly funded; double-handling duplicating existing programs	Anchor to existing funding (ABF/NWAU, MBS, My Aged Care, Support at Home, NDIS, PHN); small number of clearly costed initiatives not many projects; reconfigure current activity; joint funding from aged care/disability where integration reduces duplication	
Governance & Partnerships	Confusion about who "owns" cross-cutting initiatives; clinical accountability across boundaries; partnership fatigue if separate governance per initiative	Single working group under NGG covering clinical capacity, aged care, disability interfaces; nominate lead with documented accountability; align with existing structures not parallel systems; standing "interface" NGG agenda	
Service Continuity & Safety	Reconfiguring pathways creates gaps if not aligned; reliance on community/home models without oversight; advanced scope needs robust delegation/supervision	Co-design and document integrated pathways using evidence-based guidelines; maintain clear escalation to hospital/specialists including after-hours; network protocols for scope of practice; staged implementation with feedback	
Digital & Data	Non-interoperable systems limit effectiveness; over-complex solutions; challenges extracting impact indicators	Low-complexity changes (templates, discharge summaries, directory, secure messaging); align advanced solutions to existing platforms; NDIA integration long-term not precondition; small pragmatic indicators; simple extraction with alternatives	
Community Trust	Fear integration means service loss, fewer beds, reduced face-to-face; provider changes unsettling; past centralisation experiences	Frame as strengthening local services not centralising; highlight benefits (fewer hospital trips, better follow-up); involve consumers/carers in pathway design; clear information about changes; share success stories	
OVERALL RISK RATING: Tolerable - requires careful workforce planning and partnership coordination but addresses critical gaps			

Legend:  Within guidance  Tolerable  Outside guidance

Option 4 uses right-sized digital tools (telehealth, shared calendars, dashboards) and Health & Learning Hub to enable coordination and workforce development.

Risk lens	Key risks for Option 4	Mitigation strategies (MHN approach)	Rating
Workforce	Projected gaps (9-12 FTE GPs, ~27 allied health, ~125 aged care, ~160-170 disability by 2036) create high baseline risk; Hub slow to deliver benefits; rotations pull staff from thin rosters; difficulty attracting supervisors	Single MHN workforce plan staging roles to realistic pipelines; prioritise "grow your own" (school-VET-tertiary, assistants, peer workers); bundle small FTE into regional roles; formal education partnerships; rotation design protecting BAU with backfill	
Financial	Significant investment for Hub, coordination, supervision, housing, digital; small services absorb unfunded costs; exposure if major grants don't materialise	Map to specific external funding (workforce grants, RHIF, housing, PHN digital); separate staged business cases (baseline/moderate/enhanced); explicitly cost supervision/backfill not hiding; multi-partner funding for shared assets; sequence high-cost after wins	
Governance & Partnerships	Confusion about Hub leadership and decision-making; duplication with regional training hubs; complexity for shared workforce/housing; resistance re autonomy	Clear Hub governance under MHN with defined lead, terms of reference, multi-sector representation; simple MOUs on roles/contributions/rights; position as local "front door" coordinating not competing; shared arrangements only with mutual benefit/trust	
Service Continuity & Safety	Rosters/rotations/shared roles create gaps if poorly sequenced; learners without supervision compromise quality; digital disrupts workflows	"No net loss of access/safe staffing" principle with minimum thresholds; robust supervision plans and competency frameworks; pilot workforce models before scaling; digital in small increments avoiding peaks; regular incident reviews	
Digital & Data	Ambition for shared tools/data risks over-reach; variable maturity/connectivity/cyber capability; integration complexity creates poor quality/manual workarounds	"Minimum viable" roadmap: low-complexity enablers (workforce dataset, placement coordination, directory, basic dashboards); align with state/PHN platforms avoiding bespoke; MHN digital group for privacy/security/standards; pragmatic collection with automation; future platform optional	
Community Trust	Housing/hub prioritising staff over residents; trainees/rotating staff/telehealth as "second-best"; workforce/data privacy concerns	Frame housing/infrastructure as "unlocking local care" enabling stable presence; include community benefits; communicate trainees/rotation support stable teams not replace; consumer reps in Hub/housing/data design; regular public reporting on improvements	
OVERALL RISK RATING: Tolerable - carefully staged digital and workforce initiatives with strong partnership governance make risks manageable			

Legend: Within guidance | Tolerable | Outside guidance

Clear risk owners, mitigations and review cycles keep the plan adaptive and proportionate to Murrindindi's size and capacity.

		OPTION 1	OPTION 2	OPTION 3	OPTION 4
		Form New Network Entity	Community-Centered Alliance	Workforce-First Collaboration	Rural Digital Enablement
RISK LENSES	WORKFORCE	●	●	●	●
	FINANCIAL	●	●	●	●
	GOVERNANCE & PARTNERSHIPS	●	●	●	●
	SERVICE CONTINUITY & SAFETY	●	●	●	●
	DIGITAL & DATA	●	●	●	●
	COMMUNITY TRUST	●	●	●	●
	OVERALL RISK SCORE	●	●	●	●

● Within guidance ● Tolerable ● Outside guidance

IMPLEMENTATION PLAN

Overview of the implementation framework guide for Adaptation & Customisation, Flexibility & Responsiveness, and Continuous Improvement.

This Implementation Framework serves as a comprehensive guide for delivering Murrindindi Health Network Plan 2025-2030. It provides structured recommendations for governance, resource allocation, timelines, and accountability mechanisms based on best practice network implementation approaches and the specific challenges and opportunities identified in the strategic planning process.

DETAILED IMPLEMENTATION

This section sets out the **strategic implementation phasing (Years 1–5 overview)** for the Network Plan.

For **detailed quarterly delivery**, operational milestones, and **Year 1 mobilisation actions**, refer to the companion document:

The Implementation Plan includes:

- Quarter-by-quarter **Year 1 milestones** (Q1–Q4 2025–2026)
- **First 90 days** mobilisation plan, actions and checklists
- **Business cases** for all flagship projects
- **RACI matrices** clarifying roles, responsibilities and accountabilities
- **Grant pipeline** and funding strategy
- **Implementation readiness** assessments
- **Network Minimum Data Set** specifications and reporting requirements
- **Years 2–5** priorities and delivery sequencing

MURRINDINDI HEALTH NETWORK

Implementation Plan 2025-2036

Delivering Coordinated Health, Aged Care and Disability Services Across Murrindindi Shire

Version: 1.0 Final

Date: December 2025

Status: For Partner Board Approval

Formative Actions Checklist Summary

Critical Path Items (MUST be completed before flagship projects launch)

Legal & Governance:

- ☐ Alliance Agreement executed by all partners
- ☐ NGG Terms of Reference approved
- ☐ Working group Terms of Reference approved
- ☐ Data-sharing agreements executed
- ☐ Privacy Impact Assessment completed

People:

- ☐ Alliance Facilitator recruited and onboarded
- ☐ Community representatives selected
- ☐ Working group membership confirmed
- ☐ NGG meeting schedule locked in for 24 months

Systems & Tools:

- ☐ Grant pipeline spreadsheet established
- ☐ Performance dashboard developed
- ☐ Meeting paper and minutes templates created
- ☐ Project charter template available
- ☐ Risk register template available
- ☐ Communication templates developed

Communication:

- ☐ Network logo and brand guidelines finalized
- ☐ Website launched
- ☐ Email address operational
- ☐ Launch announcement prepared
- ☐ Partner staff communications distributed

Funding:

- ☐ First 3-5 grant applications submitted
- ☐ Funder relationships established (PHN, VicHealth, RWAV)
- ☐ Partner in-kind contributions quantified

Partner Readiness:

- ☐ All partner boards briefed and supportive
- ☐ NGG representatives designated
- ☐ Working group representatives nominated
- ☐ Data collection contacts identified

Murrindindi Health Network – Implementation Plan 2026-2036

FLEXIBILITY & RESPONSIVENESS

Rural health networks face challenges in workforce, funding, and service delivery. This framework should be viewed as a living document that enables MHN to remain responsive to:

- Changing community health needs and demographic shifts in Murrindindi Shire
- Workforce availability and recruitment outcomes (navigators, coordinators, clinical staff)
- Partnership development and regional collaboration opportunities (Eastern Health integration, PHN commissioning priorities)
- Funding environment changes and grant application timing (VicHealth cycles, RWAV programs, new opportunities)
- Regulatory requirements and health reform implementation (Support at Home, mental health reforms)
- Unforeseen operational challenges or strategic opportunities (bushfire recovery, pandemic response, service gaps)

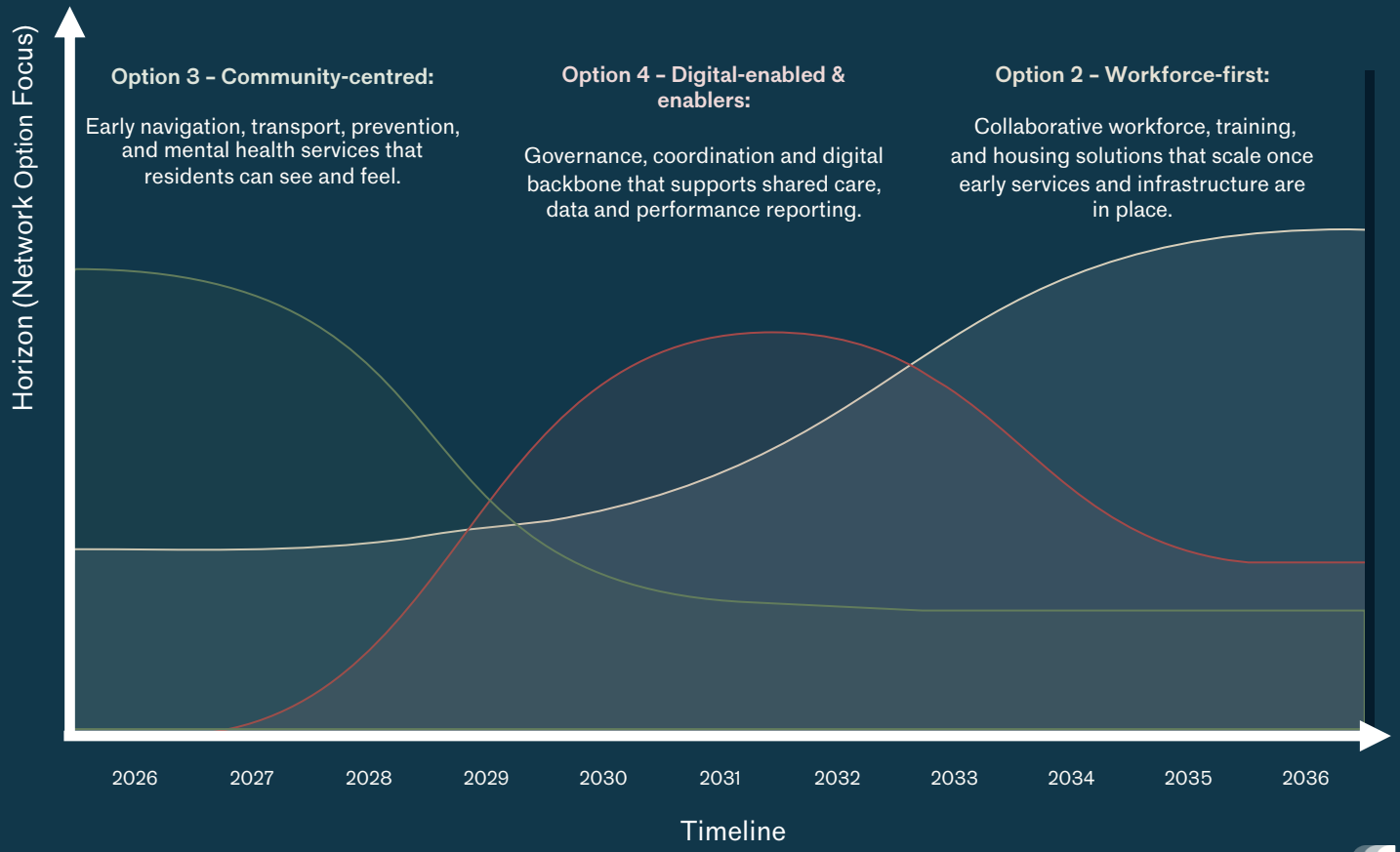
An adaptive, flexible, and continuously improving implementation framework ensures that MHN can respond rapidly to challenges and opportunities - whether they arise from workforce changes, funding shifts, reform requirements, or evolving community needs. This approach builds sustainability, supports resilience, and enables the network to maintain high standards of service coordination and deliver on its strategic ambitions, no matter how the operating environment evolves over the five-year plan period.

A sequenced 10-year rollout builds from early community wins to sustainable workforce and digital maturity.

Implementation is staged so MHN partners can build the network without overwhelming small rural services. Between 2026 and 2035, the focus shifts in overlapping waves:

- **Option 2 – Workforce-first:** collaborative workforce, training and housing solutions once services and infrastructure are in place.
- **Option 3 – Community-centred:** early navigation, transport, prevention and mental health services that residents can see and feel.
- **Option 4 – Digital & enablers:** governance, coordination and digital backbone that supports shared care and data.

All **12 elements** are delivered through time-bound alliance projects that move from pilots to business-as-usual as the network matures.



How This Works

2026–2028 focuses on Elements: navigation, transport, prevention, integrated MH/AOD, and enhanced local clinical capacity, demonstrating early benefits for residents.

The **Alliance Agreement, Network Governance Group, coordinator role and simple shared tools** begin in 2026 and underpin every project (Option 2).

From **2028**, MHN progressively adds telehealth uplift, shared directories, care-planning templates, and dashboards (Elements: digital enablement and access) to support coordination and measurement.

As the **network matures, shared roles, the Health & Learning Hub, and workforce housing** (Elements 8–10) scale from **2028–2035** to close critical workforce gaps.

Each initiative is run as an **18–24-month joint project** with clear owners, milestones and exit points, so small services can participate without taking on an unmanageable load.

Year 1 establishes the essential foundations for change - governance, partnerships, and priority initiatives, and address immediate community needs while positioning the network for sustained growth.

Year 1: Foundation (2026)

Q1 20256 (Jan-Mar)
- Finalise and sign Alliance Agreement with all partner CEOs and Board Chairs
- Recruit and onboard Alliance Facilitator (0.8 FTE, Council-hosted)
- Establish Network Governance Group and conduct inaugural meeting
- Confirm standing working group membership and terms of reference
- Launch community navigator recruitment (2 FTE target)

Q2 2026 (Apr-Jun)
- Complete first NGG annual planning session, select 6-8 flagship projects for 2025-2027 cycle
- Finalise data-sharing agreements and Network Minimum Data Set specification
- Launch transport coordination role recruitment (0.8 FTE)
- Commence Health & Learning Hub placement coordination (target 25-35 placements Year 1)
- Submit first joint funding applications (VicHealth, RWAV, PHN programs)

Q3 2026 (Jul-Sep)
- Community navigators operational, first clients enrolled in shared care planning
- Transport coordination service launches, volunteer driver recruitment underway
- Approve project charters for Year 1 flagship initiatives
- First quarterly performance dashboard presented to NGG
- Mental health access line scoping and design commences

Q4 2026 (Oct-Dec)
- First prevention programs launched (LiFE!, Farming Families pilots)
- Allied health outreach to aged care commencing (dental/podiatry schedules confirmed)
- Mid-year NGG governance review and partnership health check
- Year 2 funding applications submitted
- Annual community forum held to share progress

Year 1 establishes the essential foundations for change - governance, partnerships, and priority initiatives. Early wins in staff wellbeing, regional collaboration, and service planning build confidence, set clear direction, and address immediate risks to workforce stability and service continuity.

Years 2-3: Build Phase

- Scale successful Year 1 initiatives (navigation to 50-80 complex clients, transport trips increasing, placements to 40+ annually)
- Launch phase 2 projects based on Year 1 learnings (MH access line operational, expanded prevention programs, workforce housing initiatives)
- Deepen partnerships with Eastern Health, Murray PHN, and education providers
- Expand digital tools (telehealth protocols, shared calendars, dashboard enhancements)
- Develop business cases for transition to recurrent funding for proven initiatives

Build phase ensures that change is not only sustained but accelerated. By scaling what works, MHN drives further improvement, embeds collaboration, and starts to see measurable benefits in service quality, workforce stability, and community outcomes. This phase bridges initial change to lasting transformation.

Years 4-5: Optimise Phase

- Embed changes as business-as-usual operations within partner organisations
- Evaluate and refine all priority elements based on performance data
- Implement new service models emerging from Year 2-3 learnings
- Plan for 2030+ strategic direction, including assessment of Option 1 (entity formation) pathway
- Celebrate transformation achievements and sustainability milestones

By embedding new ways of working, MHN ensures that strategic changes are sustainable, resilience is strengthened, and the network remains ready to meet future challenges while maintaining community trust and partner commitment.

Overview of the network oversight structures including purpose, composition, meeting schedule and key responsibilities.

IMPLEMENTATION FRAMEWORK

The successful delivery of Murrindindi Health Network Plan 2025-2030 requires a robust implementation framework that ensures accountability, enables progress monitoring, and supports adaptive management. This framework establishes clear governance structures, defines roles and responsibilities, allocates resources strategically, and creates mechanisms for ongoing review and adjustment.

STRATEGIC PLAN OVERSIGHT COMMITTEE

Purpose: To provide executive oversight, monitor progress, remove barriers, and ensure strategic alignment across all network initiatives.

Composition:

- **Chair:** Rotating annually among partner CEOs
- **Deputy Chair:** Nominated by NGG members
- **Members:**
  - CEO, Alexandra District Health
  - CEO, Yea & District Memorial Hospital
  - CEO, Nexus Primary Health
  - CEO, Omnia
  - CEO, Kellock Lodge
  - CEO, Darlingford Upper Goulburn
  - CEO, Menzies Support Services
  - Executive, Murrindindi Shire Council
  - 2 Community Representatives
- **Ex-officio:** Eastern Health representative, Murray PHN representative
- **Meeting Schedule:** Bi-monthly (6 times per year)
- **Reporting:** Quarterly reports to member boards, annual report to community

Key responsibilities:

- *Monitor progress against network strategic objectives and KPIs*
- *Review and approve flagship project selection for 2-year cycles*
- *Approve major funding applications and resource allocation adjustments*
- *Oversee network risk register and escalate critical issues to member boards*
- *Ensure community and stakeholder engagement mechanisms are effective*
- *Champion network initiatives across partner organisations and advocate for system-level changes*

A dedicated oversight committee provides the strong leadership and active governance needed to turn strategy into results. By maintaining executive focus, supporting alignment across teams, and ensuring transparent reporting to the Board and community, the committee builds trust, supports accountability, and enables MDH to deliver on its vision and objectives. This approach ensures challenges are identified early, resources are directed to where they are most needed, and the organisation remains agile and responsive as it implements the strategic plan.

Overview of Year 1 investment requirements and guiding principles for allocating resources to network initiatives.

Year 1 Investment Requirements

Source	Estimated Amount ($'000)	Percentage
Partner In-Kind Contributions	$150	29%
External Grants (PHN, VicHealth, RWAV)	$280	54%
Council Contribution	$60	12%
Other Funding	$30	5%
Total	**$520**	**100%**

Estimates provided for Year 1 planning and alignment. Actual funding and budget allocations to be confirmed following internal partner approval and external funding application outcomes.

Resource Allocation Principles

1. ***Strategic Alignment:*** *All investments must directly support the 12 priority elements and deliver measurable community outcomes*
2. ***Evidence-Based:*** *Flagship projects require clear problem statements, evidence of need from current state analysis, and alignment to community consultation findings*
3. ***Measurable Impact:*** *Clear KPIs and success metrics for all funded initiatives, with quarterly performance tracking through network dashboard*
4. ***Phased and Low-Regret:*** *Preference for initiatives that start small, prove value, and can scale based on demonstrated impact rather than large upfront commitments*
5. *P**artnership Contribution:** Fair distribution of in-kind contributions across partners based on organisational capacity, with transparency on who contributes what*

Clear resource allocation ensures the network plan is both actionable and achievable. By establishing transparent funding principles and aligning investments with MHN's priorities, the network can deliver meaningful improvements in service coordination, workforce capacity, and community health. Using conservative estimates for internal planning allows for early readiness while providing flexibility to adapt as actual funding and partner commitments are finalised. This balanced approach supports strategic delivery while maintaining financial sustainability across all partner organisations.

Overview of key management strategies and performance monitoring to support effective delivery and continuous improvement of the network plan.

Key Management Strategies

1. Leadership Visibility

- *Alliance Facilitator provides monthly updates to all partner CEOs*
- *NGG representatives conduct quarterly updates at partner board meetings*

2. Communication Plan

- *Shared service directory updates (quarterly refresh cycle)*
- *Plain-language project progress updates via social media and local media*
- *Annual MHN community report*
- *Success story sharing across partners*

3. Partner Engagement

- *Working group champions from each partner organisation*
- *Regular partnership health check surveys (annually)*
- *Rotating leadership opportunities (NGG chair, working group leads)*
- *Recognition of partner contributions in communications*
- *Collaborative grant application processes*

4. Training and Support

- Alliance Facilitator orientation and governance training
- Project management training for flagship project leads
- Data collection and reporting training for working group members
- Shared professional development opportunities across partners

5. Adaptive Management

- Quarterly go/no-go decisions for underperforming projects
- Annual project cycle selection based on updated community needs and performance data
- Flexible resource reallocation based on funding outcomes
- Responsive to reform changes (Support at Home, MH reforms, PHN commissioning)
- Community feedback mechanisms to inform adjustments

Performance Monitoring

1. Monthly Monitoring

- *Working group meetings track project milestones*
- *Alliance Facilitator updates risk register*
- *Flagship project leads report progress*
- *Quick wins tracking*
- *Funding pipeline status updates*

2. Quarterly Reviews

- *Network Governance Group reviews performance dashboard*
- *Working groups report to NGG*
- *KPI progress against targets assessed*
- *Member board updates distributed*
- *Partner briefings conducted*

3. Annual Evaluation

- Network performance assessment
- Strategic priorities refined based on outcomes
- Resource allocation reviewed and adjusted
- Partnership health check and governance review
- Community consultation on Year 2+ priorities
- Planning for next 2-year project cycle

A robust management and monitoring approach ensures that the network plan stays on track, adapts to emerging challenges, and continuously improves. Visible leadership, clear communication, and active partner engagement build trust and momentum, while structured performance monitoring allows issues to be identified and addressed early. This enables MHN to deliver on its strategic objectives, drive positive change, and maintain accountability to partners, community, and funders.

Immediate Actions (Days 1-30) → Short-Term Actions (Days 31-60) → Foundation Complete (Days 61-90).

The 90-day implementation plan provides a structured roadmap to begin delivering on the strategic priorities of MDH. It is designed to build early momentum through clear, time-bound actions that support effective execution and accountability. The plan is structured in three stages: Immediate Actions (first 30 days), focused on quick wins and urgent tasks; Short-Term Actions (next 30 days), aimed at progressing priority initiatives; and Foundation Complete (final 30 days), where strategic objectives are embedded to support sustained implementation over the longer term. This phased approach ensures that change is both purposeful and achievable.

FIRST 90 DAY IMPLEMENTATION PLAN

Immediate Actions (Days 1-30)

- Alliance Agreement finalised and circulated for partner CEO/Board Chair signatures
- Alliance Facilitator recruitment launched or candidate identified
- Network Governance Group inaugural meeting held, membership confirmed
- Standing working groups established with terms of reference
- Community navigator recruitment commenced (2 FTE positions advertised)
- First communication to partner staff and community announcing network launch
- Network Minimum Data Set specification drafted

Short Term Actions (Days 31-60)

- Alliance Facilitator commences role, onboarding with all partner organisations
- First annual planning session held with NGG to select 6-8 flagship projects for 2025-2027 cycle
- Transport coordinator recruitment launched (0.8 FTE position)
- Data-sharing agreements finalised and executed between partners
- First funding applications submitted (PHN care coordination, VicHealth prevention, RWAV workforce)
- Health & Learning Hub placement coordination framework agreed
- Baseline data collection commenced for performance dashboard

Foundation Complete (Days 61-90)

- All governance structures operational (NGG + 3 working groups meeting regularly)
- Alliance Facilitator coordinating first flagship project charter development
- Community navigators recruited or in final interview stages
- First quarterly performance dashboard specification finalised
- Partnership health check baseline survey completed
- Year 1 detailed implementation plan approved by NGG with milestones and accountabilities
- Community engagement mechanisms established (annual forum planned, consumer representatives active)

A robust first 90 days ensures MHN addresses immediate governance needs - including establishing the Alliance Facilitator role and NGG - while setting the stage for workforce and service initiatives. Early action on navigator and transport coordinator recruitment, supported by clear project selection and active partner engagement, delivers visible progress on core objectives. This rapid mobilisation builds organisational momentum, strengthens partner confidence, and lays the groundwork for sustained delivery and measurable impact throughout the network plan implementation.

Year 1 puts in place the structures, pilots, and shared tools that allow coordinated care to begin, setting the conditions for scale and deeper redesign in Years 2–3.

A completed Year 1 will give MHN the practical infrastructure it needs: agreed roles and decision-making, navigators supporting clients, transport pathways that reduce missed care, shared data that highlights impact, and joint workforce mechanisms beginning to stabilise capacity. With these essentials in place, the Network is positioned for deeper service redesign, expansion and measurable outcomes in the following years.

Governance & coordination

- Finalise the Alliance Agreement, confirm governance groups and standing forums, and put the Alliance Facilitator in place.

Planning & design

- Agree Year 1–2 flagship projects, set detailed scopes and KPIs, and lock in the Minimum Data Set.

Early service changes

- Launch the navigation pilot, consolidate transport coordination, and activate early prevention programs.

Workforce & training

- Form the Workforce Collaboration Group, confirm critical roles and placements, and progress the Health & Learning Hub model.

Digital & communication

- Map digital systems, build the shared service directory and calendar, and roll out the initial communication plan.

KPI	Baseline (Year 0)	Year 1 Target	Year 3 Target	Data Owner	Direction
Alliance Governance in Place	Agreement in draft	Agreement signed; groups established	Governance cycle embedded across partners	Alliance Facilitator	↑
Flagship Projects Defined	No agreed list	6–8 projects approved with scopes and KPIs	Most projects showing measurable progress	NGG / Project Leads	↑
Navigation and Transport Implementation	No pilots	Navigation and transport pilots launched	Pilots scaled across the Shire with clear impact	Navigation Lead	↑
Prevention Programs Activation	Ad-hoc	Two early programs launched	Broader prevention stream active across towns	Omnia / Nexus	↑
Workforce Collaboration Structure	Informal coordination	Collaboration Group active	Shared roles, rotations and pooled recruitment operating	Workforce Group	↑
Health and Learning Hub Placements	~10 placements per year	25–35 placements established	40+ placements routinely supported	Hub Coordinator	↑
Digital Directory and Calendar	No shared directory	Directory and calendar online	Digital tools used daily	Digital Steering	↑
Network Communication Consistency	No consistent messaging	Shared communication plan in place	Standardised messaging across members	Alliance Facilitator	↑

Regular review and adjustment ensure the Network plan stays live, relevant and realistic as demand, funding and workforce conditions change.

The set of plans, including the implementation plan, is a **living document**, not a one-off report. Rural realities, workforce changes, reforms, bushfires, floods, new funding, mean MHN must review and adapt regularly.

Every year, MHN will update KPIs and dashboards, including:

- Potentially preventable hospitalisations (target 10–15% reduction by Year 5).
- Excess MH admissions (~260 extra/year; 3,200 bed-days).
- Workforce metrics (vacancy duration, placements, shared roles).
- Review progress on the 6–8 alliance projects in the current cycle.
- Refresh the risk register and mitigation strategies.
- Check alignment with new reforms, funding opportunities and local priorities.

Around Year 3, the NGG will lead a deeper review:

- Which elements and projects are delivering clear impact and should be scaled or embedded into BAU?
- Which need redesign or replacement?
- Are the 12 elements still the right focus areas for the next 5–10 years?
- What do communities and staff say is working or missing?

By the end of Year 5:

- MHN will produce a 2030 outcomes and lessons report.
- Members and partners will co-design the next 5–10 year strategy, using updated demand and workforce modelling.

The strategic governance framework described in this section is operationalized through detailed protocols, templates, and tools provided in the companion Implementation Plan:

See MHN Implementation Plan 2025-2030: Section 3 (pages 11-19): Detailed governance structures, NGG operating protocols, Working Group terms of reference | Appendix G (pages 55-56): Alliance Agreement template with all required provisions | Appendix E (pages 57-58):RACI matrices showing governance, responsibilities for Year 1 flagship projects | Section 4 (pages 36-41): Governance establishment milestones (Q1-Q4 Year 1) | Appendix H (pages 59-66): Implementation readiness assessment, including governance domain checklist

These operational tools ensure the Alliance governance model translates from strategic intent to day-to-day practice.

NETWORK GOVERNANCE

An alliance governance model delivers shared decision-making and accountability while preserving each organisation's board, identity and statutory responsibilities.

MHN adopts a phased governance approach that builds collaboration capability before pursuing deeper integration. The Alliance model serves as the foundation phase (Years 1-5), establishing trust, demonstrating value, and developing the governance maturity needed for more integrated structures.

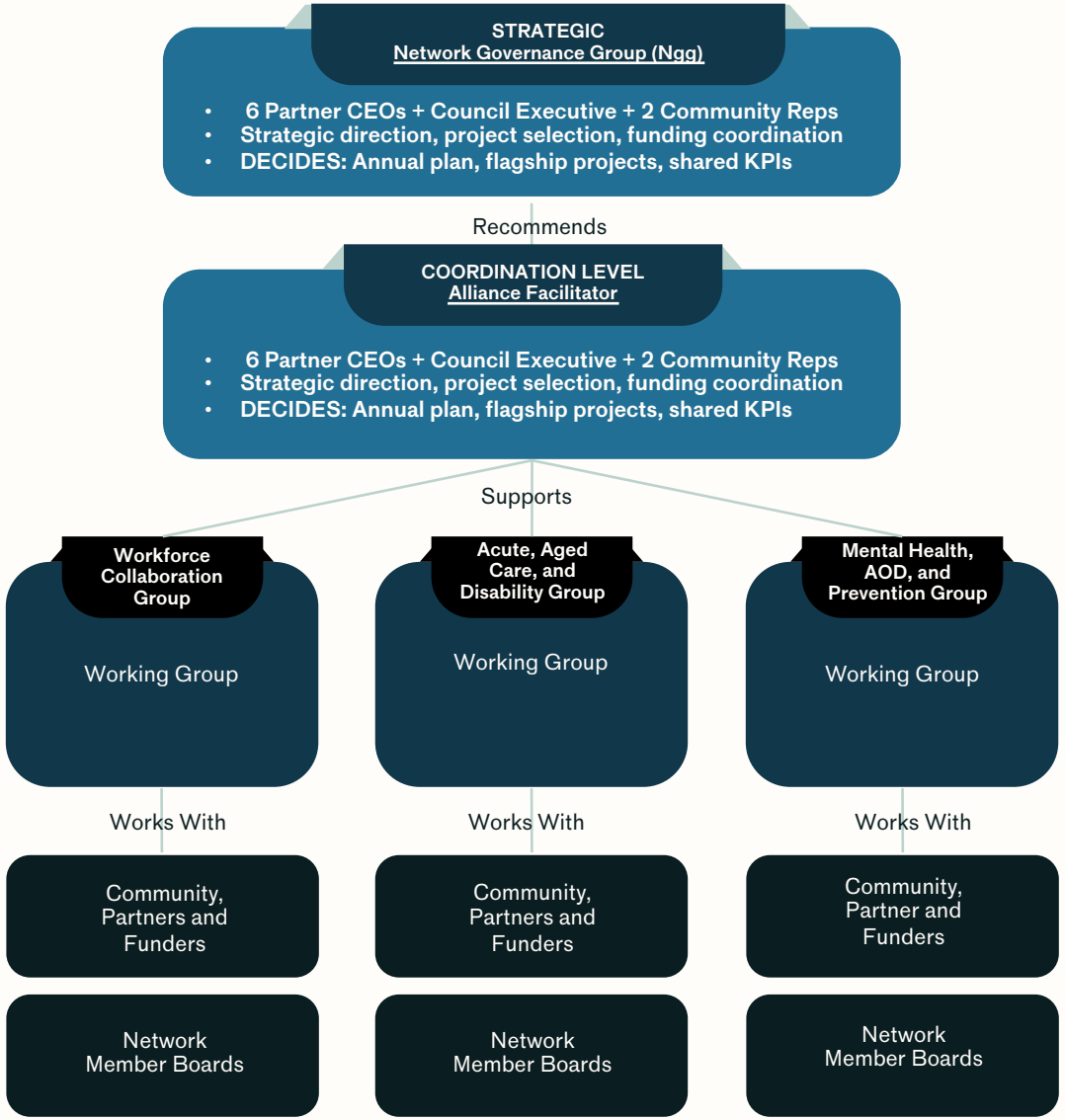
This approach learns from rural health networks where **staged governance** — earning integration rather than imposing it — delivers better long-term sustainability than immediate structural change.

The chosen solution is a **formal Alliance governance model** that balances coordination with autonomy while maintaining a clear pathway to Option 1 when the network is ready:

Core Principles:

- **Keeps local control** — Each organisation retains its own board, budget, industrial instruments, service profile, and statutory responsibilities
- **Adds a shared layer** — MHN creates a joint forum for planning, priority-setting, workforce, and digital decisions that affect the whole system
- **Supports ADH/Eastern Health complexity** — ADH sits at the table as full member and local provider, while Eastern Health is recognised as primary tertiary partner accessed mainly through ADH
- **Proportionate to scale** — Light but real structure for a shire of ~15,600 residents, not a metropolitan-style network
- **Future pathway available** — Can evolve toward Option 1 (formal entity) post-2030 if Alliance proves successful and partners desire deeper integration

Feature	Benefit
Keeps Local Control	Own boards, budgets, identity preserved
Adds Shared Layer	Joint planning across workforce, existing services, mental health, AOD, prevention decisions
Supports Complexity	Partnerships and service links
Proportionate Scale	Light structure for 15,600 residents



Clarifying roles and contributions across the Network creates the structure needed for better access, stronger workforce and smoother care pathways.

Alexandra District Hospital

- **Role:** Primary acute and clinical hub, linking directly with Eastern Health, with governance co-leadership.
- **Key contributions:** Urgent care, chronic-disease clinics, host community navigators, training placements and clinical governance leadership.
- **Working Group leadership:** Co-lead Clinical & Acute Care Group with YDMH; participate in Workforce Collaboration Group.
- **Benefits:** Clearer system role, stronger specialist ties, more stable workforce, reduced preventable presentations.

Yea & District Memorial Hospital (YDMH)

- **Role:** Local hospital and clinical hub for Yea and surrounds, co-leading acute care pathways and community health integration.
- **Contributions:** Urgent care, subacute care, local clinics, training placements, community health and prevention coordination.
- **Working Group leadership:** Co-lead Clinical & Acute Care Group with ADH; co-lead Mental Health, AOD & Prevention Group with Omnia.
- **Benefits:** Shared workforce pathways, stronger prevention focus, better integration with acute and community services.

Omnia

- **Role:** Primary community health anchor across MH/AOD, chronic disease, prevention and care coordination.
- **Contributions:** MH access line, outreach programs, group programs, care coordination, prevention leadership (LiFE!, health checks).
- **Working Group leadership:** Co-lead Mental Health, AOD & Prevention Group with YDMH; support Navigation & Access Group.
- **Benefits:** Stronger referral pathways, shared navigation, joint workforce planning and digital support.

Murrindindi Shire Council

- **Role:** Public health, community planning, transport coordination, housing advocacy and community engagement.
- **Contributions:** Community transport coordination, workforce housing initiatives, community engagement, in-kind support (venues, communications).
- **Working Group leadership:** Lead Navigation & Access Group; participate in Workforce Collaboration Group.
- **Benefits:** Clearer health role, stronger funding case, better alignment with community priorities.

Aged care and in-home providers (Kellock, Darlingford, Menzies, others)

- **Role:** Core providers of older-person care, disability support and coordinated discharge pathways.
- **Contributions:** Aged care alliance coordination, shared workforce and training, hospital-to-home transitions, NDIS pathway integration (Menzies lead).
- **Working Group leadership:** Kellock & Darlingford co-lead Aged Care Pathways; Menzies leads NDIS & Disability integration within the group.
- **Benefits:** Better integration with hospitals and primary care, stronger workforce pipeline, clearer referral pathways.

Health Network Alliance Facilitator

Role: Operational backbone of the MHN Alliance—coordinates governance, supports project delivery, connects partners , managed workforce plan, and tracks network performance.

Key contributions: Facilitate Network Governance Group and working group meetings, coordinate flagship projects, maintain shared calendars and service directory, support funding applications, provide light project management assistance, manage communications and stakeholder engagement.

The Network Governance Group brings senior leaders together to set priorities, oversee delivery and advise member boards on shared system decisions.

The **Network Governance Group (NGG)** is the central decision-making forum for MHN.

Role

- The NGG is responsible for:
- Approving the annual MHN implementation plan and 6–8 alliance projects per cycle
- Endorsing major funding applications submitted under the MHN banner
- Overseeing system-level risks, workforce priorities and digital direction
- Approving the network minimum data set and dashboard indicators
- Monitoring progress against key KPIs and recommending adjustments

Decision Rights

- The NGG makes **system-level recommendations** which are then tabled with each member board
- Individual organisations retain final authority for changes that materially affect their services, assets, workforce or finances
- For joint projects, the NGG approves:
  - Project scope and lead agency
  - Shared resourcing approach
  - Evaluation and reporting expectations

Operating Rhythm

- **Six meetings per year** (every two months), with one extended annual planning meeting
- Standard dashboard pack including: activity highlights, KPIs, risks, workforce and funding opportunities
- Short written communiqués after each meeting to support transparent communication with boards and staff

Member	Representative	Role
Alexandra District Health	CEO	Full member
Yea & District Memorial Hospital	CEO	Full member
Nexus Primary Health	CEO	Full member
Omnia	CEO	Full member
Kellock Lodge	CEO	Full member
Darlingford	CEO	Full member
Menzies	CEO	Full member
Murrindindi Shire Council	Executive	Full member
Consumer Representatives	2 community members	Full member
Eastern Health	Representative	Ex-officio
PHN	Representative	Ex-officio

Function	NGG	Member Boards	Alliance Facilitator	Working Groups
Strategy & Annual Plan	**A**	C	R	C
Funding Bids	**A**	I	R	C
Risk & Performance	**A**	I	R	C
Workforce Priorities	**A**	C	R	R
Digital Direction	**A**	I	R	R
Project Approval	**A**	I	R	C

Working groups bring together operational expertise to implement alliance projects, coordinate service delivery, and maintain strong connections with funders and member Board decisions, while protecting local trust and transparency.

Working groups are where network coordination happens in practice. Each group brings together staff with lived experience of delivering services, solving operational challenges, and navigating the complexities of health, aged care, and disability systems.

Working Group Structure

- **Workforce Collaboration Group** — HR and clinical leaders coordinate recruitment, placements, shared roles, and housing initiatives across Elements 9, 10, 12. Meets bi-monthly with university/TAFE partners and PHN workforce contacts to manage the Health & Learning Hub and workforce retention strategies.
- **Acute, Aged Care, and Disability Group** — RACF managers, discharge planners, and community service providers manage pathways, Support at Home reform transition, and NDIS coordination across Elements 6, 7. Meets quarterly with My Aged Care and LAC partners to reduce delayed discharges and improve integration.
- **Mental Health, AOD, and Prevention Group** — MH/AOD leads, GP mental health nurses, and school wellbeing coordinators operate the mental health access line and prevention programs across Elements 3, 4. Meets bi-monthly with headspace, VicHealth, and youth services to coordinate crisis pathways and community prevention initiatives.

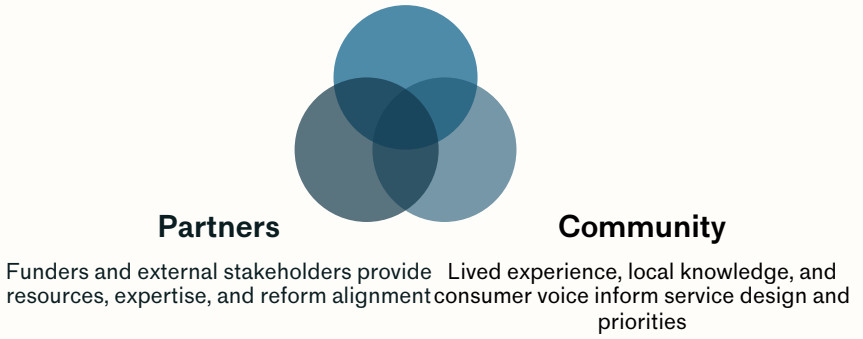
Partner and Funder Collaboration

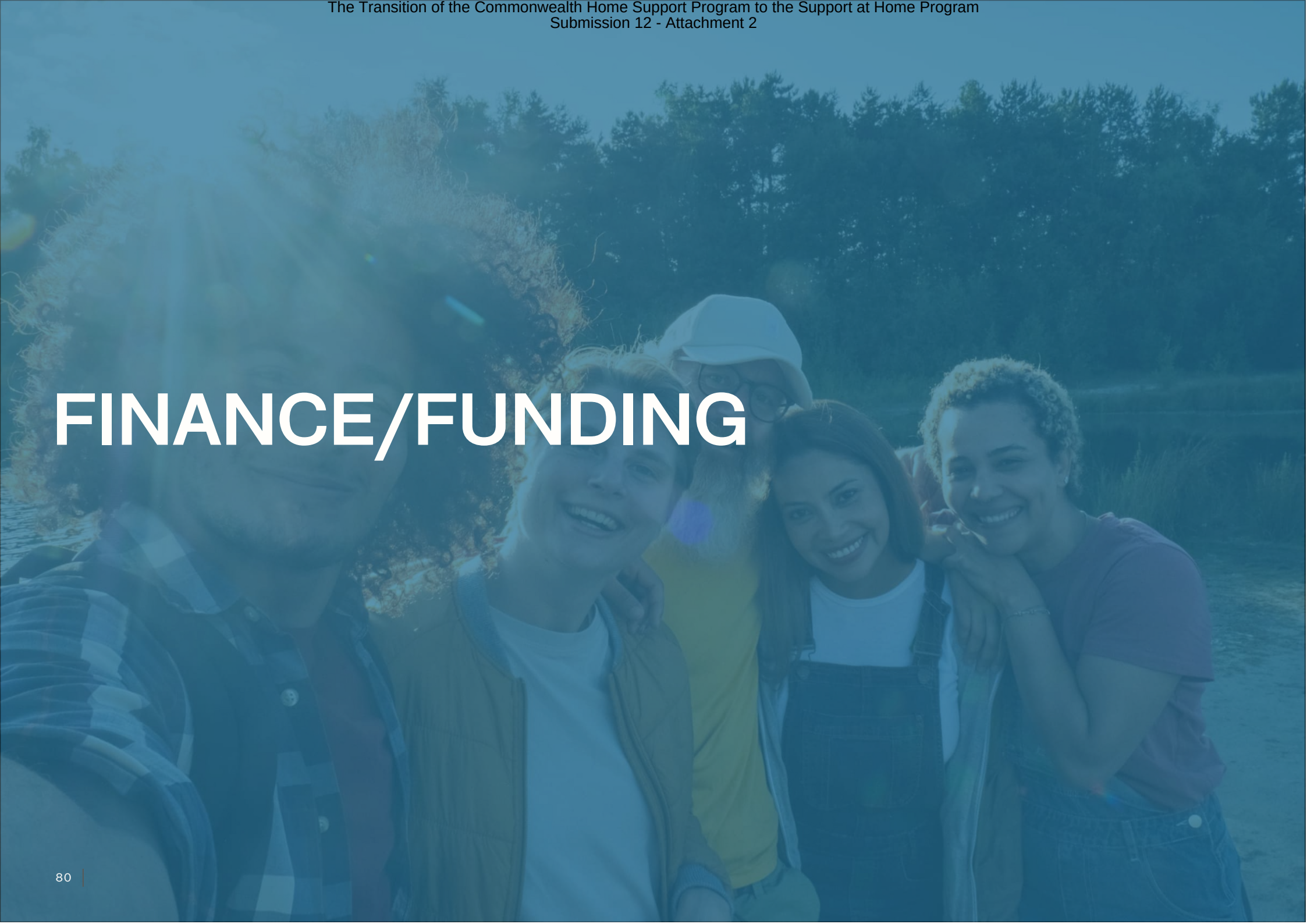
- **Eastern Health** — Regular participation in working groups to coordinate clinical pathways, virtual care expansion, workforce rotations, and tertiary access
- **Murray PHN** — Co-design of care coordination, mental health, and digital initiatives with alignment to regional commissioning priorities
- **Education and training partners** — Universities, TAFEs, and LLEN engaged through the Health & Learning Hub to coordinate placements, supervision, and workforce pipeline development
- **Government and community partners** — VicHealth, RWAV, Department of Health, and local organisations involved in grant development, reform alignment, and service delivery coordination

Member Board Oversight

- Working groups provide **quarterly written reports** to member boards through NGG updates, covering progress, risks, workforce challenges, and funding opportunities in their domain
- **Project approval pathway** flows from working groups through NGG recommendations to member boards for endorsement of significant resource commitments

Stakeholder	Engagement Mechanism	Frequency
Partners & Funders	Working group membership (PHN, Eastern Health, VicHealth, RWAV)	Monthly or bi-monthly
Partners & Funders	Co-design sessions for grants and programs	Quarterly
Partners & Funders	Reform alignment meetings	Quarterly
Network Member Boards	Written progress reports via NGG	Quarterly
Network Member Boards	Project approval recommendations	As needed
Network Member Boards	System barrier escalation	As needed
Alliance Facilitator	Working group coordination and support	All meetings





FINANCE/FUNDING

A staged, multi-source investment of around $4.5–5.0 million over five years underpins the Network plan without overwhelming local organisations.

TOTAL INVESTMENT REQUIRED: $4.5M - $5.0M (2025-2030)

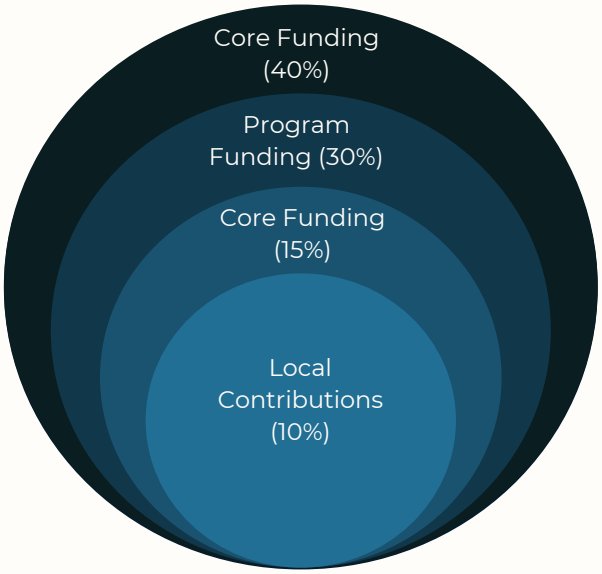
The Murrindindi Health Network requires a staged investment of approximately $4.5-5.0 million over five years to deliver coordinated health, aged care, and disability services across the shire. This investment is deliberately scaled for a small rural system serving 15,000 residents, balancing ambition with financial realism.

Investment Principles:

- **Phased and low-regret** — Start small with Year 1-2 quick wins, build on early successes, avoid large irreversible commitments
- **Leverage multiple sources** — Blend 85-90% external grants with 10-15% partner in-kind contributions
- **Maximise existing assets** — Use current spaces, systems, and staff capacity where possible
- **Build sustainability** — Design initiatives to transition into business-as-usual budgets by Year 5 if they demonstrate value

Value Proposition:

Murrindindi currently experiences ~1,050 preventable hospital admissions annually at $4,000 each = **$4.2M/year system cost**. A conservative 10-15% reduction through better navigation, transport coordination, prevention, and mental health integration would yield **$420K-$630K annually in avoided costs** — offsetting significant portions of the network investment within the 5-year period.



Pillar	Elements	5-Year Investment	% of Total
Access & Navigation	Community Navigation, Transport & Access, Ease & Accessibility	$0.9M - $1.1M	20-22%
Integrated Services & Prevention	Preventive Health, Mental Health & AOD, Clinical Capacity, Aged Care, NDIS/Disability	$1.5M - $1.8M	33-36%
Workforce & Enablers	Workforce Collaboration, Housing & Retention, Performance Monitoring, Training & Development	$2.1M - $2.5M	44-50%

Each flagship project (navigation, MH outreach, dental/podiatry, training hub, housing) is matched with 2–3 suitable grant programs and a lead organisation.

MHN will maintain a **living grant pipeline** spreadsheet, updated at least quarterly, showing opportunity, value, fit to elements, and Lead agency, deadline and status

The Alliance Facilitator coordinates joint bids and ensures proposals consistently reference the 12 elements, local data and rural context.

Investment is balanced across access, integrated services and enablers, with indicative allocations by stream and by key priority elements.

YEAR 1-2 FOUNDATION INVESTMENTS ($1.6M - $1.9M)

Priority is establishing governance, navigation, and quick-win projects that demonstrate value:

Element	Year 1	Year 2	Key Cost Drivers
1. Community Navigation	$160K	$200K	2-3 FTE navigators, training, care plan tools
2. Transport & Access	$85K	$120K	Transport Coordinator (0.8 FTE), volunteer management system, vehicle costs
8. Ease & Accessibility	$25K	$15K	Service directory development, website, printed materials
9. Workforce Collaboration	$120K	$140K	Alliance Facilitator (0.8 FTE), cross-service coordination meetings
11. Performance Monitoring	$40K	$50K	Dashboard development, POLAR data extraction, reporting
12. Training & Development	$90K	$110K	Placement Coordinator (0.6 FTE), student support, supervision
Year 1-2 Subtotal	**$520K**	**$635K**	**$1.16M**

YEAR 3-4 BUILD PHASE ($1.8M - $2.2M)

Scaling proven initiatives and launching prevention, clinical capacity, and housing projects:

Element	Year 3	Year 4	Key Cost Drivers
3. Preventive Health	$140K	$160K	Group programs, health checks, prevention workforce
4. Mental Health & AOD	$180K	$200K	MH access line, outreach clinicians, crisis response
5. Clinical Capacity	$160K	$180K	Dental/podiatry outreach, telehealth, visiting specialists
6. Aged Care Pathways	$110K	$130K	Aged care navigation, discharge coordination
7. NDIS & Disability	$90K	$100K	NDIS coordinator role, pathways development
10. Housing & Retention	$200K	$250K	Worker housing development, accommodation grants
Year 3-4 Subtotal	**$880K**	**$1.02M**	**$1.90M**

YEAR 5 OPTIMISATION ($900K - $1.0M)

Refining successful elements, scaling high-impact initiatives, discontinuing underperformers: Continued investment in proven navigation, transport, MH access, and training programs | Reduced investment in lower-performing initiatives | Transition planning for sustainable business-as-usual funding

A staged, multi-source investment of around $4.5–5.0 million over five years underpins the Network plan without overwhelming local organisations.

Multi-Source Funding Model (Risk Mitigation)

MHN's sustainability depends on blending multiple funding streams rather than relying on single large grants:

Core Funding & Internal Reorientation (10-15% = $450K-$750K)

- Existing hospital, PHN, aged care, Council budgets reallocated to host Alliance Facilitator, Placement Coordinator
- In-kind contributions: staff time, facilities, IT infrastructure, meeting spaces

Program Funding - Recurrent/Multi-Year (35-40% = $1.6M-$2.0M)

- **Murray PHN** care coordination and mental health programs
  - Care Coordination & Supplementary Services: $80K-$120K/year (navigation)
  - Mental Health Access Improvement: $50K-$90K/year (MH access line)
  - Total PHN over 5 years: **$650K-$1.05M**
- **State chronic disease and prevention** programs
- **Aged care Support at Home** transition and quality improvement funds

Local & Philanthropic Contributions (5-10% = $225K-$500K)

- Partner cash contributions for specific projects
- Community fundraising (vehicles, equipment)
- Rotary, Lions, local foundations

Grant Pipeline Management:

- MHN will maintain a **living grant pipeline spreadsheet** updated quarterly showing:
- Opportunity name and funder
- Value and fit to priority elements
- Lead agency and application deadline
- Status (planning / submitted / awarded / unsuccessful)
- Alliance Facilitator coordinates joint bids ensuring proposals consistently reference the 12 priority elements, local data (1,050 preventable admissions, workforce gaps), and rural context.

Grant Program	Lead Agency	Target Amount	Purpose
RWAV Outreach Support	ADH / Y&DMH	$40K-$80K/year = $200K-$400K total	Dental, podiatry, allied health outreach
RWAV Clinical Training Support	ADH	$30K-$60K/year = $150K-$300K total	Student placements, supervision, training hub
RWAV Accommodation Grants	Council / ADH	$100K-$200K (one-off)	Workforce housing development
VicHealth Community Grants	Omnia / Council	$30K-$60K/year = $150K-$300K total	Prevention programs, healthy eating, farmer wellbeing
Transport Connection Program	Council	$40K-$70K/year = $200K-$350K total	Transport coordination, volunteer drivers
Victorian Digital Health Innovation	Network	$50K-$150K (Years 2-3)	Telehealth, shared platforms, dashboards

Over time, avoided hospitalisations, better MH outcomes and workforce stability can offset investment and support transition to business-as-usual funding.

CRITICAL PHASING PRINCIPLES:

- **Start small, prove value**: Year 1 focuses on navigation, transport coordination, and alliance governance — deliverables that can be achieved with existing resources and early grant funding
- **Milestone-gated expansion**: Year 2-3 initiatives (prevention, MH outreach, housing) only proceed if Year 1 demonstrates impact (measured via performance monitoring element)
- **Funding precedes expenditure**: No element launches until minimum 50% funding is secured; partners are protected from unfunded recurrent commitments
- **Cash reserve target**: Maintain 2-3 months operating expenses (~$100K-$150K) as buffer for grant payment delays

Funding Risk Mitigation:

- **Diversified portfolio**: No single grant exceeds 20% of annual budget
- **Quarterly grant applications**: Continuous pipeline ensures consistent revenue
- **Partner hosting**: Core roles hosted by partner organisations reduce central cash flow pressure
- **Scalable design**: All elements can be paused or reduced if funding falls short

Quarter	Revenue	Expenditure	Net Cash Flow	Cumulative
Q1 (Jul-Sep 2025)	$85K (PHN initial, Council)	$110K (Alliance setup, navigation recruitment)	-$25K	-$25K
Q2 (Oct-Dec 2025)	$145K (RWAV, VicHealth)	$135K (Navigators start, transport planning)	+$10K	-$15K
Q3 (Jan-Mar 2026)	$125K (PHN quarterly, grants)	$140K (Full operations)	-$15K	-$30K
Q4 (Apr-Jun 2026)	$165K (Transport grants, aged care)	$135K (Operations, Year 2 planning)	+$30K	**$0K**
Year 1 Total	**$520K**	**$520K**	**Break-even**	—

Financial Success Metrics:

- 90%+ funding secured against annual targets by Q2 each year
- Cash reserve maintained at 2-3 months operating expenses
- Partner satisfaction >80% (annual survey) with financial transparency and value
- ROI demonstrated through reduced preventable admissions, improved workforce retention
- Sustainability pathway established for minimum 60% of initiatives by Year 4

Over time, avoided hospitalisations, better MH outcomes and workforce stability can offset investment and support transition to business-as-usual funding.

The Network plan is not just a cost; it is a value and risk mitigation strategy for the whole system.

Indicative Value Levers

1. Fewer Avoidable Hospitalisations

- Baseline: ~1,050 potentially preventable admissions per year at roughly $4,000 each (≈$4.2M/year)
- If Elements 1–3 and 5 (navigation, transport, prevention, chronic disease clinics) achieve a 10–15% reduction:
  - **105–160 fewer admissions/year**
  - **$420K–$630K/year** in avoided cost
  - **≈$2.1–$3.1M** over five years

2. Mental Health and AOD Outcomes

- Baseline: ~260 excess MH admissions and 3,200 bed-days/year
- If Element 4 (integrated MH/AOD) reduces repeat MH admissions by 10–15% among enrolled clients, potential savings are tens to hundreds of thousands of dollars per year, plus substantial quality-of-life benefits

3. Workforce Stability

- Better recruitment, training and housing (Elements 8–10) reduce vacancy periods and agency use
- A 25% reduction in vacancy duration in critical roles could save each member service tens of thousands of dollars per year in recruitment, agency, overtime and onboarding costs

SUSTAINABILITY APPROACH

- In **Years 1–3**, new funding sources (programs and grants) cover the bulk of additional costs
- In **Years 4–5**, MHN identifies which initiatives clearly demonstrate value, navigation, transport coordination, MH outreach, training hub, and works with funders to embed them into base budgets
- Initiatives that are not delivering sufficient impact can be scaled back or redesigned

Scenarios

- MHN will develop simple financial scenarios (0%, 10%, 20% reduction in preventable admissions) to support advocacy with funders, showing how small improvements in key metrics can offset a significant portion of the plan's cost over time.

The financial framework described in this section is operationalized through detailed budget allocations and funding strategies in the companion Implementation Plan:

See MHN Implementation Plan 2026–2036:
Section 5 (pp. 42–44):

- Year 1 investment framework (A$520k breakdown)
- Year 1 funding sources (grants, in-kind and partner contributions)
- Year 1 expenditure allocation by category
- Funding strategy and grant pipeline management approach
- Years 2–5 resourcing and scaling assumptions
- Conservative return-on-investment calculations

Appendices A–C (pp. 50–55): Business cases for flagship projects, including:

- Community Navigation and Care Coordination (Appendix A)
- Transport and Access Enhancement (Appendix B)
- Additional flagship project business cases (Appendix C)

Each business case includes project costings, ROI analysis and recommended funding pathways.

The Implementation Plan (Section 5, pp. 43–44) includes a consolidated grant pipeline tracker identifying 10–15 funding opportunities for Year 1, including application timelines, proposed lead agencies, and coordination requirements across partners.

PERFORMANCE FRAMEWORK & IMPACT ASSESSMENT

A simple outcomes framework links the 12 elements to shared goals in health, access, workforce, integration, experience and sustainability.

The MHN plan is ultimately about **better outcomes for residents, staff and services**, not just new projects. To keep this clear, we use a shared outcomes framework organised into 6 domains.

Health & Wellbeing

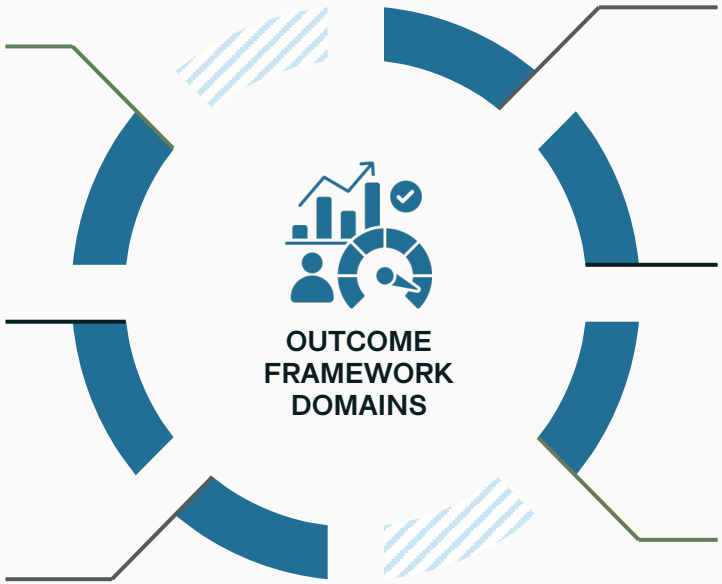
- Reduced potentially preventable hospitalisations (currently ~1,050 avoidable admissions per year).
- Reduced excess mental health admissions (~260 extra per year; 3,200 bed-days).
- Improved self-reported physical and mental health.

Workforce & Capability

- Reduced vacancy duration and reliance on agency staff
- Growth towards projected workforce needs (GPs, allied health, aged care, disability)
- Increased placements and local people employed in health and care

Experience & Trust

- Improved "ease of navigating the system" scores
- Positive feedback from consumers, carers and staff



Access & Equity

- Fewer missed appointments due to transport
- More services delivered in or near local towns (outreach, telehealth)
- Better access for priority groups: older people, youth, farmers, people with disability

Integration & Continuity

- More clients with shared care plans and a named coordinator
- Smoother transitions between hospital, aged care, disability and community services

Sustainability & Value

- Demonstrable value from reduced avoidable hospital use and better MH outcomes
- Initiatives progressively funded from BAU budgets by Year 5

Domain	Example Indicators	Elements
Health & Wellbeing	PPH rate, MH admissions	1–5
Access & Equity	Transport trips, telehealth %	2, 5, 11
Workforce & Capability	Vacancy rate, placements	8–10
Integration & Continuity	Shared care plans	1, 6, 7
Experience & Trust	Navigation scores	1, 8
Sustainability & Value	BAU transition %	All

Each of the 12 elements contributes to several domains. This framework underpins KPIs, reporting and evaluation.

The journeys illustrate a consistent transition from disjointed, reactive care to integrated, proactive support, which the Network aims to provide earlier intervention, coordinated pathways and fewer crisis points across all cohorts

Older person with multiple conditions

Before: Care is fragmented across separate providers and towns, with no coordinated entry point. Families face significant travel burdens, and deteriorating issues frequently result in repeated, avoidable ED episodes.

After: Clients are connected to a navigator who coordinates a shared care plan. Transport support and reviews reduce travel, and prevention programs make care predictable with fewer ED presentations.

Young person with emerging mental health issues

Before: Faces long waits for specialist services and limited local youth options. Family is unsure where to seek early help, increasing the risk of disengagement from school, worsening symptoms and crisis escalation.

After: Accesses a youth wellbeing program locally, with clear guidance on the MH access line. Quickly linked to a youth clinician, GP and counselling, with early support reducing disengagement, crisis risk and hospitalisation.

Farmer under stress

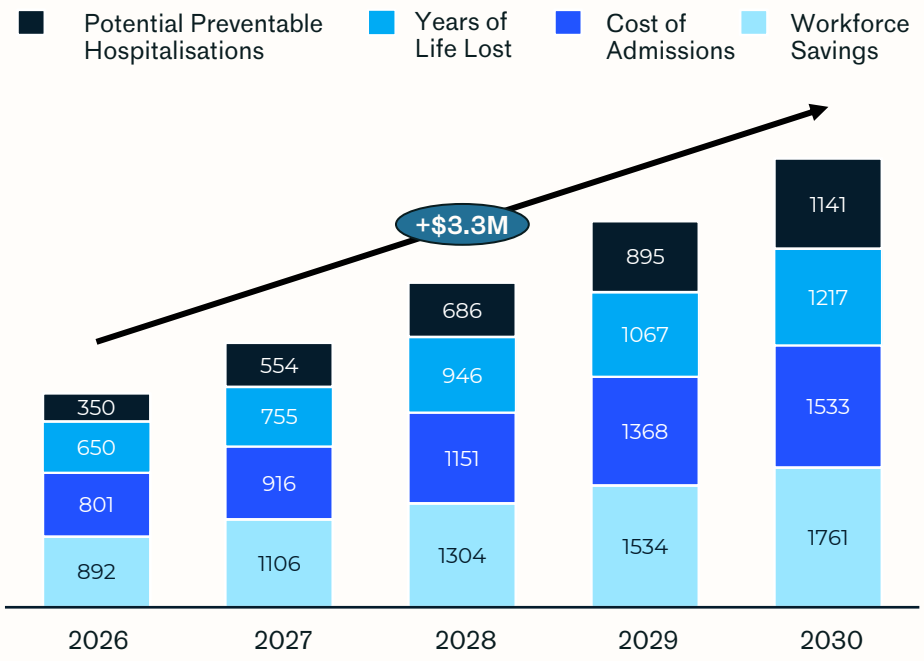
Before: Has irregular contact with services and stigma around help-seeking. Stress builds unnoticed until later crisis points, often resulting in emergency presentations or after-hours escalation without earlier support available.

After: Meets an outreach worker at local events and receives brief support. Gains a single contact through the MH access line and navigator, and connects to peer support and telehealth counselling to reduce travel and crisis escalation.

The MHN Plan converts staged five-year investment into measurable reductions in hospital demand, mental health bed-days and system pressure.

Using baseline data from the Future State analysis, we model conservative scenarios for how the three plan areas can shift demand over five years. Assumptions are transparent and can be refined with local costing.

Projected annual demand-related savings (A$,000)



Based on Future State baselines of 1,050 PPH/year, ≈A$4,000 per PPH, 260 excess MH admissions and 3,200 MH bed-days/year. PPH reductions move from 10% to 15% between Years 2–5. MH bed-day reductions move from 5% to 15% between Years 2–5. MH bed-day value uses an indicative net cost of A$800 per bed-day; this should be replaced with local costing when available. Savings are conservative and do not double-count across metrics or include workforce and productivity gains.

Context & model assumptions

- Baseline analysis shows around 1,050 potentially preventable admissions (PPH) per year, at an average cost of ≈A$4,000 per admission (≈A$4.2M per year).
- Mental health demand is also high, with around 260 excess MH admissions and 3,200 bed-days per year for Murrindindi residents.
- For PPH, we model a gradual reduction from 10% in Year 2 to 15% in Years 4–5, delivered through navigation, transport, prevention and chronic disease elements.
- For MH bed-days, we model a reduction from 5% in Year 2 to 15% in Year 5 among cohorts engaged through integrated MH/AOD and prevention elements.
- Savings shown here are limited to acute demand-related impacts. They exclude additional value from workforce stability, improved productivity and broader social benefits, which are discussed qualitatively and can be quantified as better local data become available.

Growth Drivers

1. Single front door, shared care plans and coordinated transport reduce delays, duplication and avoidable ED presentations for high-risk cohorts.
2. Community-based programs, chronic disease groups and youth wellbeing initiatives reduce deterioration and prevent conditions escalating to hospital care.
3. Shared pathways, MH access line and outreach clinics reduce repeat MH admissions and shorten lengths of stay for enrolled clients.
4. Collaborative workforce planning, local training and stabilised staffing make it possible to run navigation, outreach and integrated services consistently across all towns.