FNQ Connect
Connecting people, connecting care

A proposal for reform of
disability, rehabilitation and lifestyle services
for children, young people, adults and older people of FNQ

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Executive Summary

It's time to leave the siloes behind and set a new course. **FNQ Connect: connecting people, connecting care** is a proposed model for disability, rehabilitation and lifestyle services for children, young people, adults and older people in Far North Queensland (FNQ). **FNQ Connect** will drive a reform agenda to integrate and strengthen existing services in the 21 Local Government Areas (LGAs) which make up FNQ. Integration of services will reduce preventable hospitalisations and increase social return on investment. **FNQ Connect** will provide quality care for FNQ people, in the right place and at the right time.

FNQ Connect was created in response to a groundswell of interest and concern from FNQ people with lived experience of disability, their families and communities, together with stakeholders responsible for supporting them. They expressed an urgent need for service reform: current supply of services is outweighed by needs and is well below national standards; inaccuracies in national data conceal these inequities. Existing government, non-government and private services are largely fragmented; opportunities created by NDIS have added another layer of fragmentation. At the same time, demand for services is relentlessly increasing. To ensure equitable investment in services and continuity of care for the people of FNQ, accurate data and integration of services, were required.

The FNQ collective came together through **a collective impact approach** to enable collaboration across silos and to embrace complex service systems and community structures. This approach is widely considered the most effective for place-based collaborative initiatives; it has the potential to produce significant social return on investment. The backbone team from James Cook University worked with three reference groups: a Consumer, Aboriginal and Torres Strait Islander, and Service Provider Reference Group. The team also consulted widely with government, non-government, Aboriginal and Torres Strait Islander community controlled and private stakeholder organisations and four pilot community sites: Thursday Island, Kowanyama, Tablelands and Cairns. **FNQ Connect** grew out of a shared vision for FNQ: that everyone feels included, connected, safe and supported; that everyone has the opportunity to live their own life, follow their hopes and dreams; and has access to culturally safe services close to home.

This proposal outlines the formation of **FNQ Connect: the case for change, the model for change, and a plan for implementation and evaluation over a 5-year period**. The proposal aligns well with local, state and national priorities, including Better Health NQ, Northern Aboriginal and Torres Strait Islander Health Alliance and National Disability Insurance Agency; to name but a few.

> *"If we can work together, …then it will make a world of difference."*

FNQ Connect will be an independent entity, guided by a Leadership Table, to ensure effective governance based on transparency, participation and accountability. The Leadership Table will be led by people with lived experience of disability and representatives of Aboriginal and Torres Strait Islander communities, senior executives from key FNQ government, non-government and private stakeholder organisations. The Leadership Table will begin by developing a joint funding mechanism to leverage existing capacity and assets of agencies within FNQ Connect. A backbone team for FNQ Connect will: develop a shared data measurement system; and a two-pronged approach for implementation and evaluation of the model, combining the work of place-based Community Action Groups (bottom-up) and Stakeholder Action Groups (top-down).

FNQ Connect will operate through a network of hubs. A proposed central hub in Cairns will connect with five satellite hubs, and several mobile hubs across the FNQ region. Each hub will act as a 'one-stop-shop' for community rehabilitation services, information, education and advocacy. Three priorities will drive each hub's activities: 1) Connecting care and support through shared health records, shared clinical governance and expansion of transition and navigation services; 2) Strengthening local community workforce and locally owned services through the development of certified workforce pathways and sustainable local services to match local needs; and 3) Building inclusive communities through inclusive policies, procedures, education and investment.

FNQ Connect will be trialled in two stages over a 5-year period. The first two years will be devoted to establishing the independent entity, building the foundations for the network of hubs, and 'road testing' the model in three pilot communities; Tablelands, Kowanyama and Cairns. The remaining three years will involve full-scale roll-out across FNQ according to community readiness.

FNQ Connect will be formally evaluated from the outset; developmental evaluation in the early stages (try it and see), formative evaluation in the middle (monitor changes in practices and systems), and summative evaluation in the final stages (measure outcomes). An additional economic evaluation will confirm service need and requirements, to generate a business case to acquire funding for full scale implementation, and assess value for money for the FNQ community.

FNQ Connect will bring about reforms that benefit individuals, families and communities. It will promote seamless services that cut across silos and champion a local workforce, locally-owned or managed services and inclusive communities. The time has come to address entrenched inequality and disadvantage in FNQ through urgent systems reform.

"We've always felt like if we had moved down south we might have access to much better services….we've always lived in Cairns … and it's just the whole lifestyle we want for our family."

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Glossary of Abbreviations

Abbreviation	Definition
ATSICCHOs	Aboriginal and Torres Strait Islander community controlled health organisations
CHHHS	Cairns and Hinterland Hospital and Health Service
CI	Collective impact
CQI	Continuous Quality Improvement
FNQ	Far North Queensland
IPCHS	Integrated People Centred Health Services
LGA	Local Government Area
NATSIHA	Northern Aboriginal Torres Strait Islander Health Alliance
NDIA	National Disability Insurance Agency
NDIS	National Disability Insurance Scheme which is delivered by the NDIA
NGO	Non-government organisation
PCHC	People Centred Health Care
PHN	Primary Health Network
PPH	Potentially preventable hospitalisations
TCHHS	Torres and Cape Hospital and Health Service

Glossary of Terms

Term	Definition
All abilities	All people, including people with disabilities, are respected for their abilities.
Lived experience of disability	Individuals and families who have lived through and responded to disability, either directly as an individual with a disability or as a significant other.
FNQ collective	Individuals and organisations who have contributed to the project and have an interest in contributing, in the long-term, to the outcomes of the project.
Reference groups	Three representative groups who advised on project process and outcomes.
Stakeholders	Any individual or organisation with an interest or responsibility to support disability, rehabilitation and lifestyle services and the project outcomes.
FNQ priorities	The three priorities for FNQ Connect derived from stakeholder strategies to meet the needs and aspirations of people with lived experience of disability.
FNQ vision	Vision for the new FNQ model, derived from views of reference groups.
Leadership Table	Peak leadership body for FNQ Connect
Joint Funding Mechanism	Mechanism to engage with public, private, NGOs and ATSICCHO providers to align funding and resources to support FNQ Connect and its priorities
Community Action Groups	Place-based groups of people with lived experience of disability, community members and key agencies, that work on community initiatives.
Stakeholder action groups	Senior representatives of stakeholder organisations that work on discrete and manageable projects to complement the work of community action groups

People of Far North Queensland (FNQ) carry a higher burden of disease and injury than their fellow Australians.[1] Paradoxically, supply of services to address the disabling consequences of disease and injury are disproportionately low compared to need, and well below national standards. Existing services are fragmented and inefficient and demand is relentlessly increasing. Reform of FNQ services in line with national standards is urgently required.

1.1 Background

Tropical FNQ is a vast region (380,748 km²) stretching north to Cape York Peninsula and the Torres Strait, and west to the Gulf of Carpentaria (see Figure 1). For the purposes of this proposal, FNQ is defined as 21 Local Government Areas (LGAs), six classified as outer regional, three as remote and 12 as very remote. The FNQ region is serviced by the Torres and Cape Hospital and Health Service (TCHHS) and Cairns and Hinterland Hospital and Health Service (CHHHS).

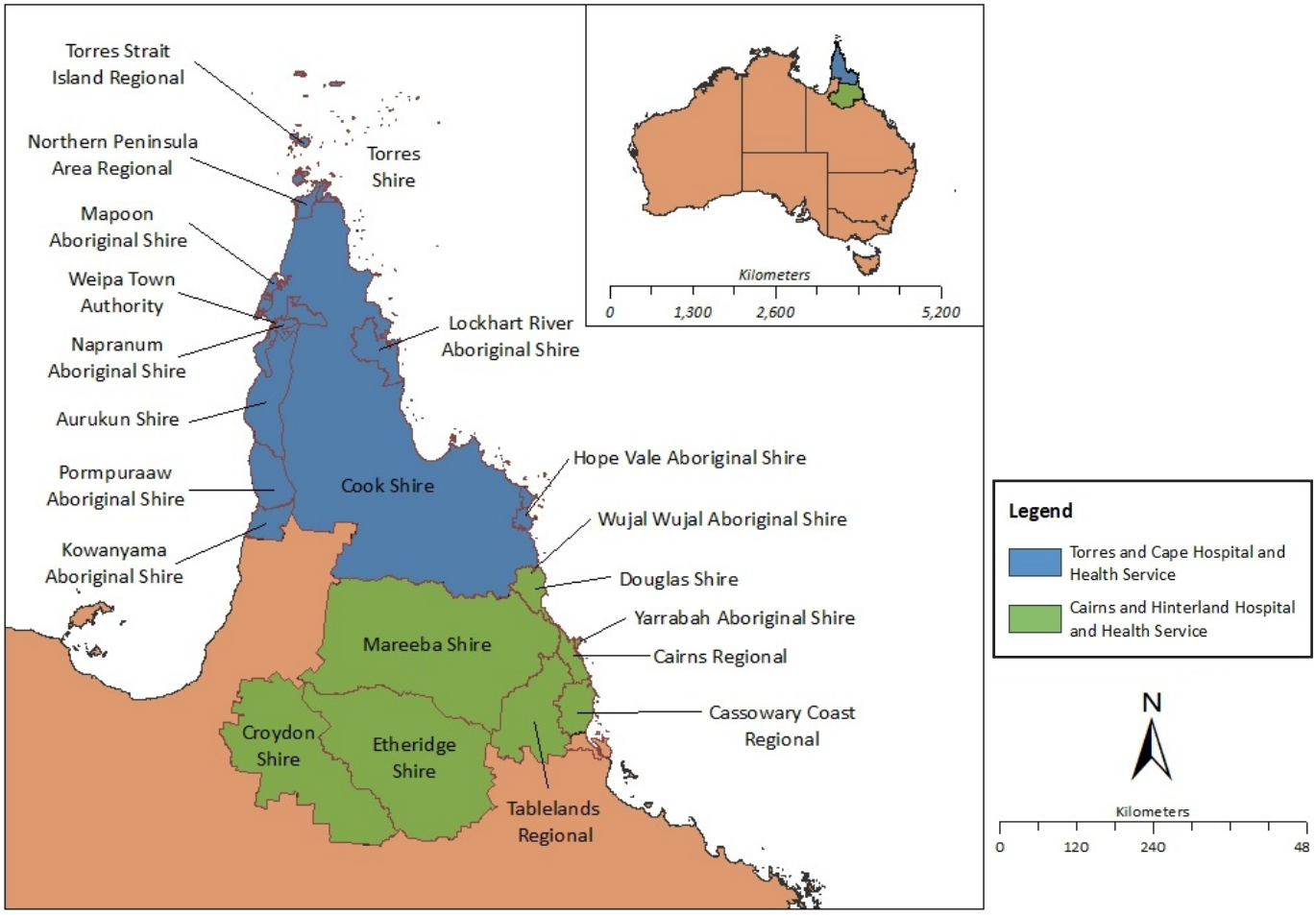

Figure 1: Far North Queensland Local Government Areas

FNQ has an estimated population of 289,234 including 154,000 who live in the LGA of Cairns.[2] Aboriginal or Torres Strait Islander people represent 15% of the population.[3] The people of FNQ experience a high level of socioeconomic disadvantage, with 35% of residents in the most disadvantaged quintile.[4] The two HHSs in FNQ both have a paucity of community services.[5] This places pressure on hospital services due to avoidable hospital admissions and prolonged length of stay, all too often leading to premature admission to residential care.

Provision of disability, rehabilitation and lifestyle services in the FNQ region presents unique challenges. Government, non-government and private agencies deliver a siloed assortment of services against a background of remoteness, a geographically dispersed population, plus cultural and socio-economic diversity.[6] Some services are based in the community, some visit by road or air. Other services are based in large urban centres, requiring people to leave their home community.[7] This involves complex and expensive travel arrangements and often crippling social isolation.[8]

1.2 Momentum for reform

The people of FNQ have raised the alarm - people with lived experience of disability, their families and communities and stakeholders who support them. Children and young people are falling behind, adults often don't return to the workforce after injury and illness, and older people are prematurely entering residential care. The time has come to address the entrenched inequity and disadvantage to ensure the people of FNQ receive services akin to their needs.

The purpose of this proposal is to provide a plan for reform of disability, rehabilitation and lifestyle services in FNQ. Assumptions underpinning this plan are that: i) the community is the best environment for services that will meet the needs of most people living with a disability; and ii) that everyone could temporarily or permanently experience disability at some point in life.[9] Thus, the key goal for reform is 'a good life for FNQ people of all abilities across the lifespan.'(Figure 2).

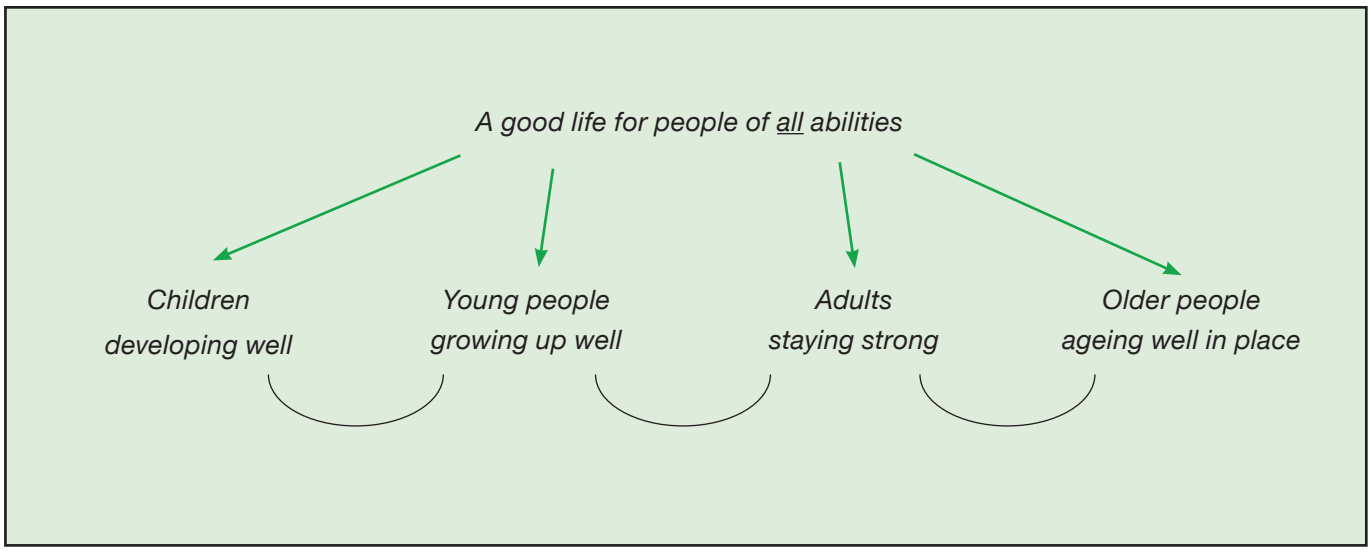

Figure 2: The goal for reform of FNQ services

‘A good life’ according to FNQ Connect

Jack and Mavis have moved from their island in the Torres Strait to the Star of the Sea Elders’ Village on Thursday Island. Now they are staying connected with their family via Zoom.

Members of the FNQ collective came together using a collective impact approach[10], to enable them to work collaboratively across the complex service systems and community structures within FNQ. A semi-structured process nurtured the five conditions for collective success: a shared agenda; shared measures of success; mutually reinforcing activities; continuous communication; and a backbone organisation. The World Health Organisation (WHO) Integrated People-Centred Health Services (IPCHS) Framework[11] provided a strength-based approach for strategic action at all levels of the health and disability systems: individuals, families and communities; workforce; organisations and systems. The social model of disability grounded the approach on changing the environment to accommodate impairment, not changing people with impairment.

The FNQ collective was led by a backbone team from James Cook University (JCU). The team worked with three reference groups - a Consumer, Aboriginal and Torres Strait Islander and Service Provider Group. Government, non-government and private stakeholder organisations, and four community sites - Thursday Island, Kowanyama, Tablelands, Cairns – were also included. The three objectives of the FNQ collective were to develop a case for change, a model for change and a plan for implementation and evaluation of the new model over a 5-year period. Processes used to achieve these objectives are in Table 1 and outcomes of these processes are in sections 3, 4 and 5.

Table 1: Processes used to achieve the objectives of the FNQ collective.

Objective 1:	**Prepare a case for change**
Need for reform	Gathered the views of the FNQ collective on their lived experience
Scale for reform	Scoped publicly available data and reviewed the literature
Objective 2:	**Create a model for change**
Vision	Consulted with reference groups; endorsed by the FNQ collective
Needs & aspirations	Interviewed people with lived experience of disability from study sites.
Strategies	Consulted with reference groups to identify good existing strategies, new ideas.
Priorities	Prioritised strategies through FNQ collective workshops.
Model for change	Prepared a dynamic systems model and logic model in line with FNQ vision.
Objective 3:	**Develop a plan for implementation and evaluation over a 5-year period**
Implementation	Consulted with the FNQ collective – reference groups, sites, stakeholders. Designed governance platform to drive reform agenda, integrate services. Prepared self-audit toolkit to initiate, monitor and evaluate initiatives.
Evaluation	Consulted with experts - other collective impact projects and health economist. Prepared a plan for evaluation in line with IPCHC policy framework.

3 A CASE FOR CHANGE

The time had come to design and scale a new service model for FNQ. The need was indisputable and immediate. The case for change for a new service model was based on the experience of FNQ people[12], scoping of publicly available national and state data[12] and review of the literature[13]. The case for change is summarised in Table 2, and outlined in detailed in section 3 following.

Table 2: A summary of the case for change in FNQ disability, rehabilitation and lifestyle services

Inequity in FNQ compared to Australia overall is **concealed** by inaccuracies in national and state data due to missing data, aggregated data, and data based on historical undersupply of services.

FNQ people repeatedly report that **need is high, yet supply of services is low and fragmented**.

The FNQ health profile reveals **high risk of disability across the lifespan**

- Unacceptably high burden of chronic disease and injury leading to disabling consequences.
- 35% of people are among the most socio-economically disadvantaged, magnifying disability.
- Aboriginal and Torres Strait Islander people, who make up 15% of the FNQ population, are three times more likely to have a disability than non-Indigenous people in Australia.

The FNQ services profile indicates **high unmet need and increasing demand**

- The lack of community rehabilitation services in FNQ is placing children, adults and older people at risk of avoidable disability and premature admission to residential care.
- PPHs are amongst the highest in Australia indicating high unmet need in the community.
- $120 Million underspend on NDIS plans in one year in FNQ indicating high unmet need in the community.

Fragmentation of FNQ services has led to notoriously **disjointed and inefficient care**

- services are siloed between government, non-government and private providers each with their own health records across many digital platforms with little connection between them.
- there is little connection between visiting and local services and turnover of staff is high.
- resources and expertise are limited to support people to navigate the complex web of services.

Barriers to people-centred care are evident in FNQ particularly relating to single sector clinical governance, inflexible individual funding models, and duplication of infrastructure.

Large-scale changes in FNQ are required to integrate services and secure equity of investment.

3.1 Inequity in FNQ compared to Queensland and Australia

Inequity in FNQ has been concealed. Estimates of need and supply of disability, rehabilitation and lifestyle services suggest that FNQ is comparable to Queensland and Australia as a whole (Table 3). These estimates are based on publicly available national and state government and non-government data.[3, 14-18]

Table 3: Estimates of need and supply of services based on publicly available data

	Estimates based on national and state data	FNQ	Qld	Australia
Need	Prevalence of disability[14]	4.6%	5.1%	5.1%
Supply	Allied health practitioners per 100,000[20]	46	58.3	NA
	NDIS providers per 100,000[18]	92.7	53.6	38.4
	Average cost of plans per participant[18]	$86K	$76K	$67K
	Utilisation of NDIS services[18]	66%	66%	69%

These estimates stand in stark contrast to the lived experience of people in FNQ who **repeatedly report that need is high, and that supply is low and fragmented**. This disparity is partially explained by shortcomings in data collection and analysis that have been revealed through data scoping. These shortcomings include: data not collected from the entire FNQ region; use of proxy measures based on historical undersupply; and data aggregation that masks details and masks variability between LGAs in FNQ. Examples of the variability in need and supply of services across the four study sites is provided in Table 4.

Table 4: Variability in LGAs in FNQ by study sites compared to all of Queensland

Indicators of need and supply of services	Local Government Area				
	Kowanyama	Torres	Tablelands	Cairns	Qld
Aboriginal &/or Torres Strait Islander people[19]	90%	68.8%	7.3%	9%	4%
Median Age in years[19]	28.3	30.6	47.9	38	37.8
SEIFA - % in most disadvantaged quintile[19]	100%	44%	39%	27%	20%
Utilisation of NDIS services 2021[18]	38%	56%	66%	73%	73%
PPHs – Age standardised rates per 100,000[1]	TCHHS - 7,121		CHHHS - 3,791		3,267

Without accurate data, there is a real risk that the actual need and supply of services and the variability within FNQ will be concealed, and that **underinvestment in services will continue**.

3.2 Disabling consequences of disease compounded by socioeconomic disadvantage

FNQ people experience unacceptably high prevalence of chronic disease, injury[1] and socioeconomic disadvantage[4]. Disabling consequences of disease and injury compound socioeconomic disadvantage; disadvantage compounds disability,[20] particularly in remote areas.[21] The greatest impact of this double disadvantage falls on the people in the Torres and Cape region[19] and particularly the Aboriginal and Torres Strait Islander people, who make up 15% of the FNQ population.[4] This pattern of disadvantage is reflected Australia wide. Aboriginal and Torres Strait Islander people are up to three times more likely to report having a disability or restrictive long-term condition than non-Indigenous Australians of the same age.[22] Undoubtedly, the level of disability in FNQ has been underestimated.

3.3 Increasing demand on the hospital and health system

FNQ has experienced the largest regional population growth (182%) in Queensland over the past 40 years that is predicted to continue; this places increasing pressure on the health system.[23] Over the last 10 years, Northern Queensland has also become a hot spot for potentially preventable hospitalisations, with rates more than 50% higher than Queensland's annual average.[24] As a result, Cairns Hospital will exceed capacity by 2022 even taking into account improvements in care models.[24] This pressure on the hospital sector has paradoxically depleted the community health sector; priority is now given to supporting hospital discharge and preventing hospital admission, and readmission. Escalating waiting lists mean that any services offered in the community are time limited and largely inflexible. This shortage of community services, places even more pressure on hospital services.

FNQ lacks community rehabilitation services for children, adults and older people. Only a lucky few receive rehabilitation; this is usually via inpatient hospital services located in Cairns. For those living in remote regions, travel to these services is complex and costly in both time and money, socially isolating and disruptive to family and community life. Most miss out, leaving them with disabling consequences that could otherwise have been avoided. Such consequences include younger people not joining the workforce, adults not regaining their fitness and returning to work after a heart attack, older people remaining dependent after a fall. Innovative efforts to create community rehabilitation services have been ongoing. Currently there is a small private service operating in Cairns[25] and a student-implemented older persons service operating in Napranum in Cape York.[26] Until there are comprehensive community rehabilitation services in FNQ, pressure on the hospital system and premature admission to residential care will only escalate.

> *"…if we invest that money …. they have every opportunity to stay well and to stay strong and healthy… without ending up in a hospital setting, because they had no choice, because they deteriorated, because they were just left… to their own devices."*

3.4 Increasing demand on the disability sector

Introduction of the NDIS has been lifechanging for many people in FNQ who now receive the disability supports they need.[27] With the proliferation of new NDIS providers however, workforce shortages in the FNQ disability sector have intensified.[28] This shortage is particularly evident in remote communities of the Torres and Cape Region. The NDIS underspend of $120 million in FNQ in 2020, is indicative of significant unmet need. Without disability services, families will be responsible for care, often without payment or support.[29, 30] Of concern is that pressure on disability services is likely to increase further with release of recommendations of the Disability Royal Commission and the potential for additional regulatory requirements. Without ample disability services, the pressure on both families and the health sector to deliver necessary care, will rise.

3.5 Fragmentation of services

Fragmentation currently dominates services in FNQ. Fragmentation, largely due to siloing of government, non-government and private providers, drives service inefficiencies that are compounded by remoteness - vast distances, unpredictable transport conditions, changeable weather and unreliable digital communication. Services based in remote communities generally take second place to visiting services, with minimal engagement with the local workforce. Demands of remote work make recruitment and retention of workforce difficult, with high turnover further fragmenting services and further eroding continuity of care.

The opportunities brought by the NDIS have added another layer of complexity to an already fragmented service system. For example, allied health professionals who are new NDIS providers are typically early career professionals from urban centres outside the FNQ region. They often have limited expertise in disability and limited knowledge of the local cultural context and disease burden. Many are solo professionals who offer costly fly-in, fly-out services and provide little or no inter-professional collaborative care. With many offering these small scale services, service viability, quality and continuity of care are constantly under threat.

3.6 Disjointed care

Sporadic and disjointed care for FNQ people is a direct consequence of fragmented services. Duplication and gaps in service delivery often go hand-in-hand. For instance, in a single year, a child could have hearing tests from three different agencies - education, health or disability - with little communication between agencies. Conversely, an older person could fall, wait 12 months for home modifications, and only receive falls prevention services once they have ended up in hospital.

Multiple health records for each individual with a disability (~50) exist within multiple agencies inside and outside the region, across many digital platforms with no connection between them. Options for care are often overwhelming and difficult to decipher, with a mishmash of services across different geographical regions, each with different eligibility criteria and payment options. Navigating health and disability services defies many health professionals let alone families, with the result that some families simply disengage. While care coordination and navigation services do exist, the quality of these services vary markedly just as co-ordinator knowledge, skills, networks and endurance vary.

Formal mechanisms for transition within and between services are rare: between professions, sites, government and private services, and health, disability and education sectors. Transitions between life-stages are particularly problematic for the developing child, for adolescents moving from school into the workforce, and older people transitioning to residential care.

New gaps in care and support have appeared with the NDIS roll-out. The first hurdle has been to demonstrate eligibility to register for the NDIS due to a shortage of medical specialists or allied health professionals to complete assessments. In Kowanyama for instance, 38 out of 56 applications to register were returned for information requiring these assessments.[31] The second hurdle has been to purchase any service, let alone have choice between services [32-34], as NDIS providers are thin-on-the-ground in most rural and remote communities[35]. The third hurdle has been to access private services that have a level of expertise required. For example, with the shift from public block funded services to individualised NDIS packages, a range of visiting services have been lost, most notably the Specialist Seating Services for people with physical disability and the Mobility and Orientation Service for vision impaired children in the school environment. Loss of these specialist services has led to a skills drain from the FNQ region and loss of avenues for capacity building in specialist areas for the region.

Funding models also contribute to professional and sector siloing of services. For instance, Medicare funding, albeit limited funding, is a key source of funding for allied health services for Aboriginal and Torres Strait Islander Community Controlled Organisations (ATSICCHOs). GP referral is made to a single allied health profession, leading to a single professional assessment and care plan. When multidisciplinary care is required (e.g., after a stroke), a host of assessments and care plans are provided for the one individual, rather than a single comprehensive assessment and care plan. Similarly, while individualised NDIS funding allows tailoring of services to individual need and choice, it does however, stifle the opportunity to create an innovative response to community need or to strengthen local workforce capacity accordingly. In this way, individualised funding alone, can work against Aboriginal concepts of holistic health and wellbeing for the whole community[36].

> *“…. now that NDIS has come in we do not have any access to the seating clinic which is a really big deal.”*

3.7 System level barriers to people-centred care and support

System-level barriers to people-centred care are all too common in FNQ, similar to our literature review findings on disability, rehabilitation and lifestyle services in non-metropolitan services in Australia.[13] Wrapping care around the individual and family is inhibited by the array of single sector regulatory and funding frameworks, single sector clinical governance, and duplications of infrastructure. Hence large-scale fundamental change at the system level is required to create an enabling environment, that supports, rather than inhibits collaboration and integration, that is key to people-centred services and that will support viable models of service delivery.

3.8 Urgent need for reform of FNQ services

In summary, there is a clear case for change and an urgent need for reform. FNQ people in need of services frequently miss out, others receive an array of services over which they have little control. Others endure complex and expensive travel arrangements to access services in major centres, while some even relocate to a larger community to receive the support they need. A despairing proportion just disengage; they find the quest for services too inflexible, and difficult to navigate. The people of FNQ deserve a better deal.

If 'business as usual' continues without robust community services, pressure on families and the hospital system will continue to rise. Without reform, we can expect a downward community service trajectory and upward cost trajectory for hospital services. Any model of service delivery must include government, ATSICCHOs, non-government and private services, working together without siloes. Any proposed model must complement and expand the benefits of the NDIS. A reliable and accessible dataset is a critical first step to inform the design, scale and investment in a new model for FNQ disability, rehabilitation and lifestyle services in line with national standards.

4 FNQ CONNECT: A NEW MODEL OF SERVICE DELIVERY FOR FNQ

FNQ Connect: Connecting people, connecting care is the proposed model for FNQ that has been created by the FNQ collective. FNQ Connect provides **a platform to drive a reform agenda**. The aim is to integrate and strengthen existing FNQ services and advocate for equity with national standards.

4.1 FNQ Connect vision and principles

FNQ Connect is built upon a shared vision for FNQ people of all abilities (illustrated In Figure 3) and set of key principles.

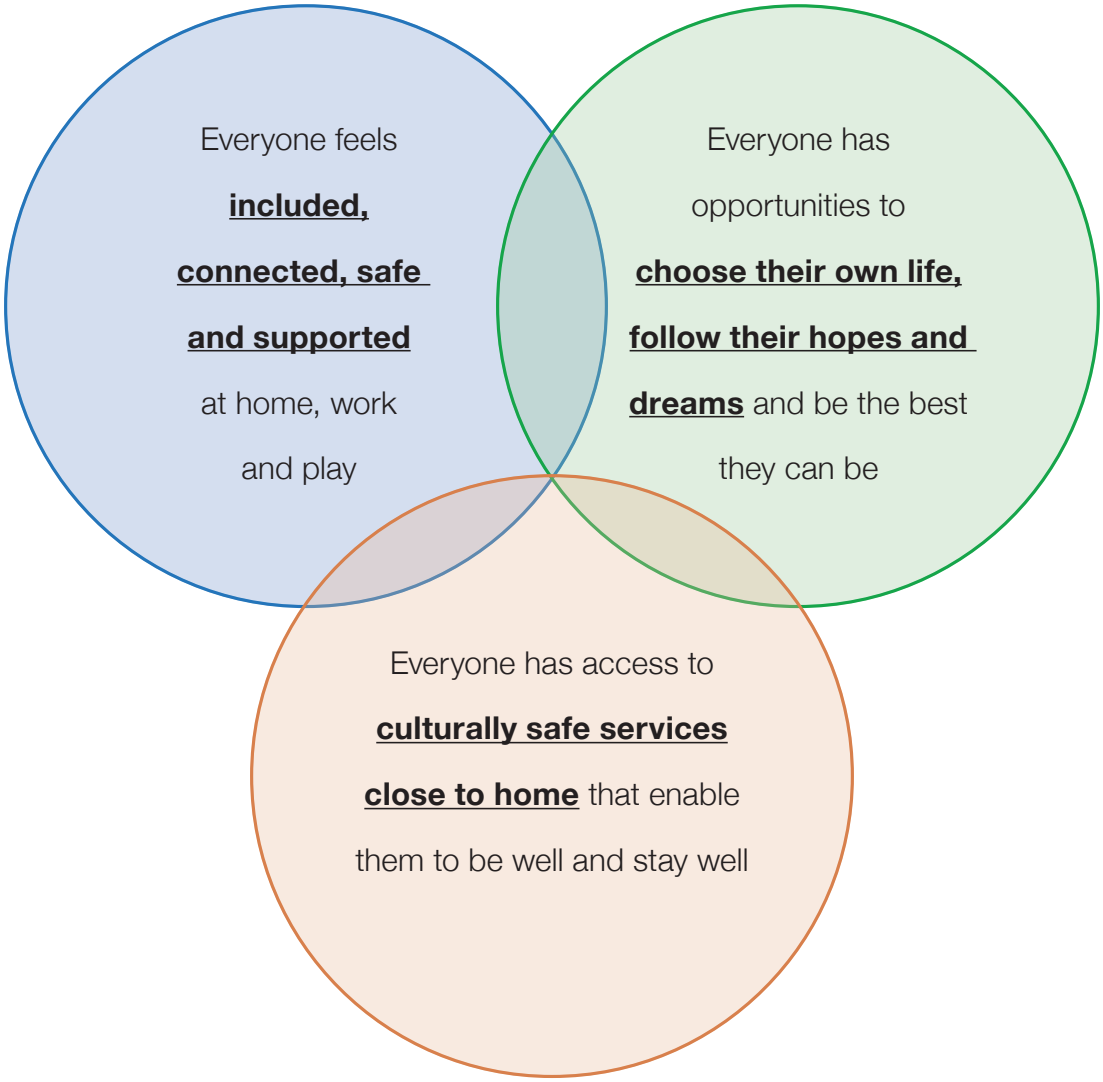

Figure 3: FNQ Connect vision

Key principles

- People with lived experience of disability will be **central to decision-making** and reform.
- Services will be **people-centred**, wrapping around the individual, their family and community.
- Services will be **inclusive** and flexible, meeting unique needs especially of the most vulnerable.
- Services will be **culturally safe**, particularly for Aboriginal and Torres Strait Islander people.
- Services will be **strength-based** focusing on enabling not disabling, wellness not illness.
- Services will **strengthen local workforce and community capacity**.

'A good life' according to FNQ Connect

Trevor is working at the Council helping young men to get a job and get enrolled in TAFE. Trevor's NDIS funding package means he gets help everyday for bathing and dressing. Because the service employs local people Trevor can get these services every day. That means Trevor can live his own life and participate in his own community on his own terms.

4.2 FNQ Connect needs and aspirations

FNQ Connect is designed for FNQ people of all abilities. It is based on the needs and aspirations expressed by FNQ people with lived experience of disability as summarised in Table 5.

Table 5: The needs and aspirations of FNQ people with lived experience of disability

	Children developing well → Young people growing up well → Adults staying strong → Older people ageing well in place
Feel included and connected, safe and supported	To have my own friends and social life of my own age or interests. To do things for myself, with support from others. To love and be loved. To have a valued role within my family and community. To enjoy experiences in the community together with family or friends. To be included in everyday community life and to live as good a life as possible. To have support to take the next step in life, to have certainty around my future. After injury or illness, have support for me and my family to get on with life.
Opportunities to choose our own life and be the best we can be	To have support to be mentally healthy to be my best self. To be respected for my rights, privacy and choice of where and how I want to live. To fully understand my rights, options and supports available to me. To have my hopes and dreams taken seriously and to excel at what matters to me. To live how I want to live – with family, or independently with supports if needed. To join interest groups including outdoor interests and recreational activities. To learn, undertake study, education and training of my choosing. To be able to work, whether volunteer or paid work, to pursue a worthwhile career. To be connected to my spiritual or cultural life and take my place within it.
Access to culturally safe services close to home	To have access to sustainable independent living options within my own community. To have access to quality rehabilitation services across the lifespan close to home. To have access to specialist services with support and little time away from home. To have access to transport options that are reliable, supported and affordable. To have appointments coordinated to reduce the burden on me and my family. To understand services available to me and to access them with minimal red tape. To have support to transition between services across life-stages. To have support to transition and navigate between services in the city and home.

4.3 FNQ Connect priority areas

FNQ Connect will focus on three priority areas as outlined in Table 6.

Table 6: Priorities for FNQ Connect

Priority 1	Priority 2	Priority 3
Connected care and support	**Local workforce and services**	**Inclusive communities**
Create a network of hubs New central hub in Cairns and five satellite hubs across FNQ. One-stop-shops for community rehabilitation services. Clinical pathways that include councils, ATSICCHOs, public, private, local, visiting services.	**Strengthen local workforce** Local people of all abilities trained and employed in local services. Visiting services linked with and provide routine training for the local workforce.	**Strengthen community capacity to be inclusive** Education on what constitutes an inclusive community. Barriers to inclusion removed for people with different impairments.
Continuity of care Shared clinical governance including shared clinical records and pathways. Support to navigate and transition across services and life-stages.	**Strengthen locally-owned or managed services** Strengthen existing or establish locally-owned or managed services to match local need and that reduces reliance on visiting services.	**Infrastructure and services to enable inclusion:** Social and built e.g., paths, interpreters, hearing loop. Supported transport. Social events for all and programs to foster social connectedness.

> *"We're not going to be able to have experts in everything everywhere all of the time. But... if we can have people feel more comfortable … some resources for community groups, or employees … if we've got the resources available to support them…then I think it's worth it."*

4.4 FNQ Connect as a network of hubs

FNQ Connect will be a **network of community hubs**, with a newly constructed central hub in Cairns and five satellite hubs across FNQ. Where possible, existing hubs will be strengthened (e.g., Kowanyama Aged and Disability Hub and Atherton Precinct) rather than building new hubs. All hubs will host remote satellite and mobile hubs enabling services to reach everyone (Figure 4).

Each hub will be a locally designed, multi-purpose physical and virtual space for integrated care and support; a place for social interaction and connectedness where everyone can feel at home. Hubs will focus on community participation for people of all abilities. They will provide services that draw on local skills and resources to match local need (e.g., fitness and healthy eating programs, outdoor mobility and wellbeing programs). Priority will be given to engaging with the most vulnerable people whose capacity to engage and participate is compromised.

Co-location of community and visiting services will be ideal for strengthening coordination, navigation and transition between services. Co-location of services will also provide benefits of scale, where government, non-government and private organisations can share space and pool resources. While primarily designed to provide people-centred care, hubs will also provide the local workforce with access to expertise, particularly support coordinators or navigators. A key element will be in-community workforce training and professional development.

Hubs will create partnerships and pathways between local councils, ATSICCHOs, government and non-government sectors, and local and visiting services. Leaders of hubs will need to engage with the whole community and various local and regional organisations. This will require good governance and clear lines of accountability. Critically, community hubs will provide care close to home, yet be connected to specialist services in larger centres using existing and new pathways.

> *“I think personally, because of what I want to achieve, if I had a little bit more accessibility, I probably wouldn’t have the arthritis … I probably would have got it fixed. I wouldn’t have to wait so long to get into a physio.”*

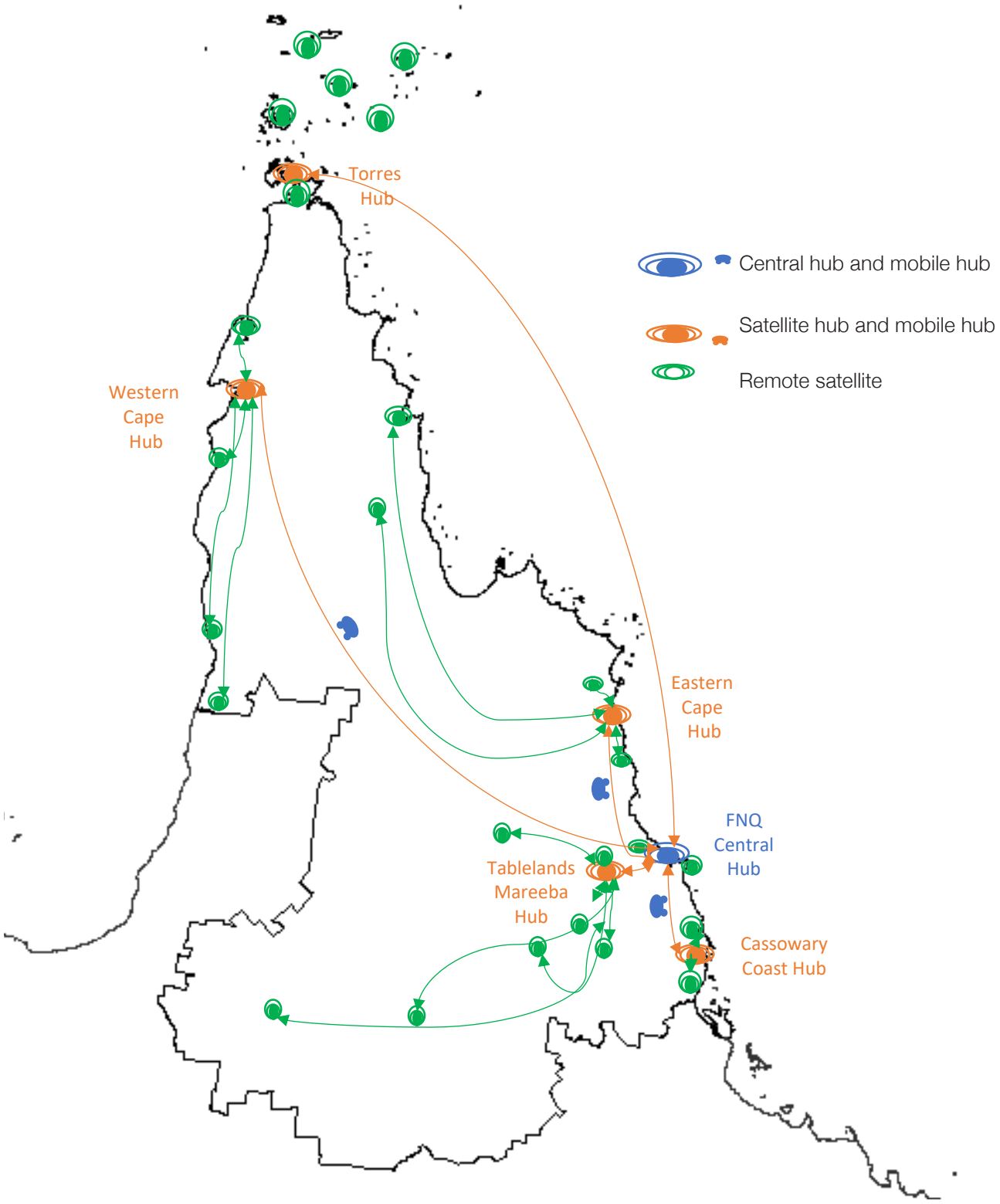

Figure 4: FNQ Connect: a network of hubs

4.5 FNQ Connect as a platform to drive the reform agenda

FNQ Connect will provide the platform to drive the reform agenda. The governance structure, based on a collective impact approach, is shown in Figure 5.

FNQ Connect will consist of:

- an independent entity, led by people with lived experience of disability and senior executives of private, public and ATSICCHO stakeholder organisations, with guidance from existing Reference Groups: Aboriginal and Torres Strait Islander; Consumer and Service Provider Reference Groups
- a Backbone Team that will use a two-pronged approach – working with place-based Community Action Groups (ground-up) and; with Stakeholder Action Groups (top-down).
- a shared measurement system to: comprehensively and accurately estimate service need and supply, to advocate for services in line with national standards; and to build evidence to demonstrate service effectiveness and value for money.
- a joint funding mechanism for rationalising and coordinating investment across the Collective.

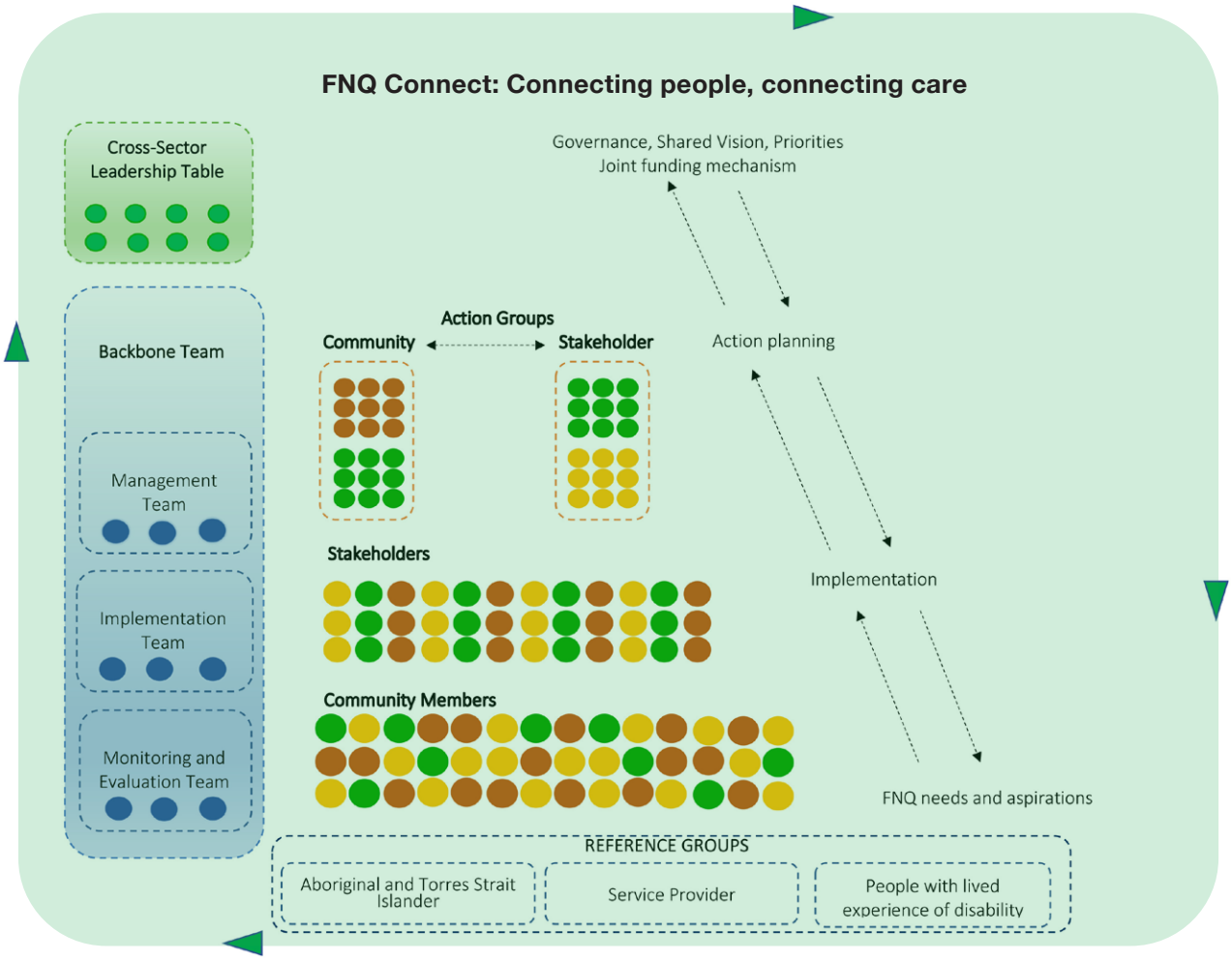

Figure 5: FNQ Connect as a platform to drive the reform agenda

4.6 Benefits of FNQ Connect

4.6.1 Strengthening the community sector, reducing pressure on the hospital sector

Connected and integrated care and support in the community will improve the experience for FNQ people[37] and improve service efficiency.[38] Through the network of hubs, individuals and families will be able to visit a familiar space where care and support can wrap around them in an integrated and seamless way. There will be timely access to services and smooth transitions between services.[39, 40] When care is required away from home, coordinated appointments will mean less time away from home and family[41] and lower costs for families and the health system.

Improving integration of care and support will improve quality of life and health outcomes[38] which will lead to a reduction in PPHs and reduced pressure on the hospital sector over the medium-to-long term. A new hub in Cairns for community rehabilitation and lifestyle services will also contribute to better health outcomes[42] and health systems efficiency by reducing unnecessary hospital admission and reducing length of stay for rehabilitation.[42] Resultant savings will more than likely exceed the initial short-term investment required to re-orient services towards the model of integrated care and support.[38, 42]

FNQ Connect will boost the size, capability and capacity of a local, culturally-appropriate, fit-for-purpose workforce. Such a workforce, embedded in the community, will improve engagement with services, uptake of health advice, and follow-up.[43, 44] Locally-owned or managed businesses will be best equipped to provide services such as personal care, help with household tasks and day-to-day participation needs. These needs include school attendance, work or community activities and family events. Reduced reliance on visiting services will make communities less vulnerable to the impact of external events such as COVID-19 travel restrictions. The wages of the local workforce will also inject money into the local economy. Locally-owned or managed services will also attract government funds, particularly NDIS and Aged Care funds. Higher levels of disposable income will stimulate local expenditure and creation of new services, which in turn will lead to further employment as businesses grow.[45]

Cultivating inclusive communities, will mean people of all ages, and the people who care for them, can choose to participate in family and community events such as cultural and religious festivals, fishing, sport, and rodeos. Inclusion will increase productivity in the workplace and employment outcomes.[46] An inclusive community means better physical and mental health and greater incentive to remain in the community with less need to travel for health services.[8] Inclusiveness leads to healthier and wealthier populations with substantial social return on investment.[47]

> *"She needs an accessible van but our support workers don't have those ... If I want her to go on a movie trip or something there's a lot of planning. And structure that goes into logistics."*

4.6.2 Increasing social return on investment

The collective impact approach to reform will reduce costs through efficiencies of scale and resource sharing. Evidence of social and economic benefits of collective impact is well established in the USA and Canada, and is beginning to emerge in Australia. One example of the success of collective impact in Australia is Maranguka in Bourke, remote New South Wales[48], where Aboriginal people make up 38% of the population of 1,824 people. In 2017, they achieved social benefits that included a 31% increase in Year 12 school retention, a 42% reduction in days in custody and a 23% reduction in violence as well as economic benefits. Their success also extended to savings of $3 million which was five times their operational costs. Further examples are presented in Appendix 4.

4.7 Alignment of FNQ Connect with local, regional, state and federal priorities

FNQ Connect aligns strongly with the plans and priorities of the relevant local, state, national government and non-government organisations. Examples of this alignment in FNQ are provided in Table 7. Examples of alignment at a local, state, national and global level are provided in Appendix 5.

Table 7: Alignment of FNQ with local FNQ priorities

Strategic Plan/Policy	FNQ Connect aligns with the strategic plan or policy by:
FNQ Regional Organisation of Councils	Connecting, collaborating, sharing resources and expertise between private and public sector and advocating for equity.
Northern Aboriginal and Torres Strait Islander Health Alliance	Integrating health care, advocating for health equity, recognising and addressing unique needs of Aboriginal and Torres Strait Islander people, strengthening social and economic environment.
North Queensland Primary Health Network	Bringing together FNQ stakeholders from all levels of government and non-government to improve health and wellbeing; recognising unique needs of Aboriginal and Torres Strait Islander people, as first inhabitants and most vulnerable and disadvantaged.
Cairns and Hinterland Hospital and Health Service	Advocating for equity; recognising unique needs of Aboriginal and Torres Strait Islander people, as first inhabitants and most vulnerable and disadvantaged; Striving for positive health outcomes and value for money; reducing future pressure on struggling hospital system.
Torres and Cape Hospital and Health Service	Recognising unique needs of Aboriginal and Torres Strait Islander people, as first inhabitants and most vulnerable and disadvantaged Connecting with communities and with stakeholder organisations to achieve positive health outcomes and value for money.
National Disability Insurance Scheme	Supporting a better life for FNQ people with a disability and their families and carers; striving to transform the lives of people with disability, by using a transformative way of working together.

‘A good life’ according to FNQ Connect

Hattie will go to high school next year along with her friends. As Hattie has a hearing impairment, she will receive equipment and training to support her to participate in school, for instance in class, assemblies, sport, eisteddfods, and school trips. The high school will also receive equipment and training to support Hattie to participate, for instance captions on audio online materials and interpreters. Like everyone at school, Hattie needs to feel included and connected within the new high school environment.

Implementation and evaluation of FNQ Connect will proceed over a 5-year period in a 2-staged process. The first two years will be focused on building the foundations for FNQ Connect and the remaining 3 years will be focused on full-scale roll-out across FNQ. The timeline is provided in brief in Table 8 and in detail in section 5.1 which follows. The Logic Model is provided in Appendix 8.

Table 8: Timeline for implementation and evaluation of FNQ Connect

	Years 1 and 2	Years 3, 4 and 5
Implementation	Create FNQ Connect as an independent entity Recruit the Backbone Team Design the joint funding mechanism Build the shared measurement platform Road test the 3 priorities and connecting the hubs in Kowanyama, Tablelands and Cairns Design a new central hub for Cairns Develop and refine processes in preparation for full-scale implementation	Implementation across FNQ
Evaluation	Needs assessment Business case for Years 3,4,5 Developmental evaluation Formative evaluation	Formative evaluation Summative evaluation Economic evaluation Develop Dynamic Systems Model

5.1 Implementation of FNQ Connect

The Collective Impact Approach[10] will guide the process of implementation of FNQ Connect, drawing on the success of other collective impact projects across Australia.[49-52] The WHO IPCHS Policy Framework[11] will guide the process of reform to ensure FNQ people and communities are placed at the centre of disability, rehabilitation and lifestyle services. The five strategies recommended by the WHO to adapt the framework to the local setting are illustrated in Figure 6.

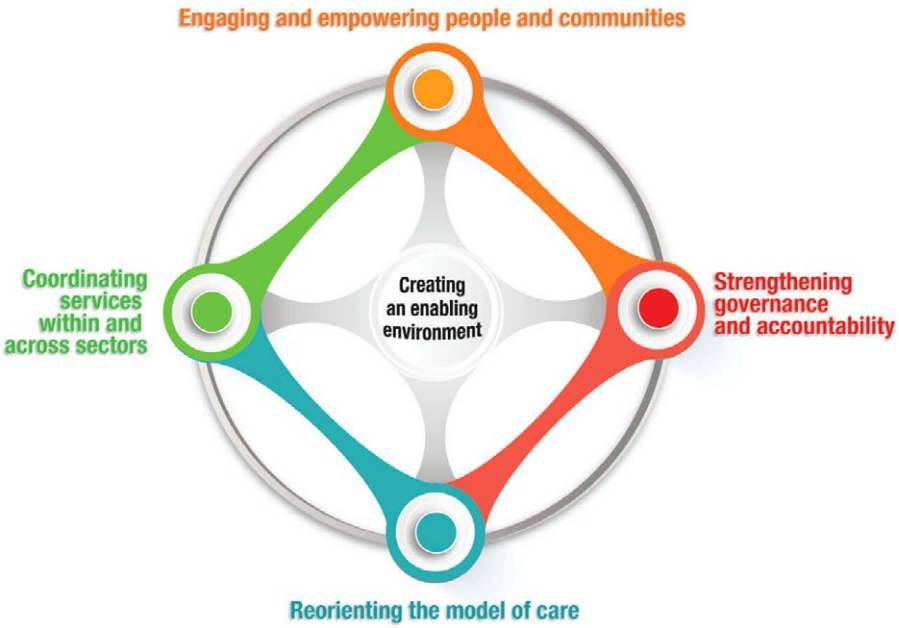

Figure 6: Strategies recommended by the WHO for integrated people-centered health services

5.1.1 Establishing FNQ Connect as an independent entity to drive the reform agenda

Legal expertise will be contracted to create FNQ Connect as an independent entity to drive the reform agenda. **The Cross-Sector Leadership Table** will be the peak decision-making and governing body for FNQ Connect. The Leadership Table will be chaired by two people of prominent standing: one person with lived experience of disability; and another representing the Aboriginal and Torres Strait Islander communities. Key stakeholders will be represented by **senior executives from government**, **ATSICCHOs, non-government, and private organisations** including NDIS, DSS, CHHHS, TCHHS, PHN, Northern Aboriginal and Torres Strait Islander Health Alliance (NATSIHA), local councils and disability organisations. In the early stages, the Leadership Table will focus on preparing a Roadmap for FNQ Connect and a joint funding mechanism to align resources.

The three **existing Reference Groups** (Consumer, Aboriginal and Torres Strait Islander and Service Provider) will provide guidance to the Leadership Table and Backbone Team and take their place on relevant Stakeholder Action Groups as FNQ Connect evolves. Members will be made up of people with high level day-to-day experience of disability and of associated services.

The **Backbone Team** will work under the direction of the Leadership Table and will be guided by Reference Groups. The Backbone Team will include:

- Director to provide leadership to ensure the vision, principles and priorities are realised.
- Office Manager / Communications / Grants to provide engine-room support for FNQ Connect.
- Implementation team to facilitate implementation of priorities and connecting of hubs.
- Monitoring and evaluation team to establish the shared measurement system and conduct the evaluation.

5.2 Implementation of FNQ Connect priorities

FNQ Connect will trial implementation of priorities (process outlined in Appendix 6), in the LGAs nominated as trial sites – Kowanyama in the Cape; Tablelands in Cairns hinterland; and Cairns.

Community Action Groups will conduct their self-assessments, develop their own plans and mutually reinforcing activities. Community Action Groups will be place-based and include local people with lived experience of disability together with senior employees of key service agencies.

Stakeholder Action Groups will work on system level changes required for the success of initiatives identified by community action groups. For example, if Kowanyama Community Action Group plans to engage an allied health assistant to work with visiting allied health professionals. The Stakeholder Action Group will work on shared clinical governance across visiting organisations.

5.3 Establishment of the FNQ network of hubs

The Backbone Team will initially work with Kowanyama and Tablelands Regional Councils, to support them with **strengthening and expanding their existing hubs**. Once Councils have clarified their hub objectives, stakeholders will use the objectives as reference points for decision making.

Designing a new central hub in Cairns will require a consultant to prepare a pre-construction proposal and budget estimate for locating a suitable property, designing, planning and funding the new hub (Appendix 7). The consultant will work with a design working group of representatives of the FNQ stakeholders to take the project forward to be 'spade ready'.

Connecting hubs via pathways that are easy to navigate and responsive to the needs of individuals, families and communities will mean building connections and breaking down existing siloes between levels of government, non-government, ATSICCHOs and private providers. The Backbone Team will prepare a plan of action, together with reference groups and the Leadership Table.

5.4 Development of the shared measurement system

A shared measurement system will provide a foundation for collaboration, for aligning efforts across FNQ, and improving efficiency. High quality data will be required to accurately estimate need and supply, support evidence-driven decision making and continuous quality improvement. A consultant in data platform development, will work with the Data Manager (Backbone Team) and Data Committee to design a system incrementally, ideally as part of an existing FNQ data system.

‘A good life’ according to FNQ Connect

Thomas is back on his feet and happy to be home in Cooktown. Thomas had a stroke and went to Cairns hospital and then onto community rehabilitation at the Cairns hub. Now that he is home again he wants to keep improving. He is attending the Cooktown hub and getting help from visiting therapists. Thomas is happy that he can stay living in his community and can keep doing what matters for him and his family.

5.5 Evaluation of FNQ Connect

FNQ Connect must self-evaluate. Evaluation will require a shared measurement dataset to provide data aggregation across FNQ, for comparison within FNQ and to national standards.

The Backbone Team will conduct the evaluation to monitor progress, measure the impact of the new model and determine value for money. As outlined in Figure 7, emphasis will be on developmental evaluation in the early stages, formative evaluation in the middle stages, and summative evaluation in later stages. In parallel, FNQ Connect will conduct an economic evaluation, to confirm level of need, services required, and social return on investment for the FNQ community.

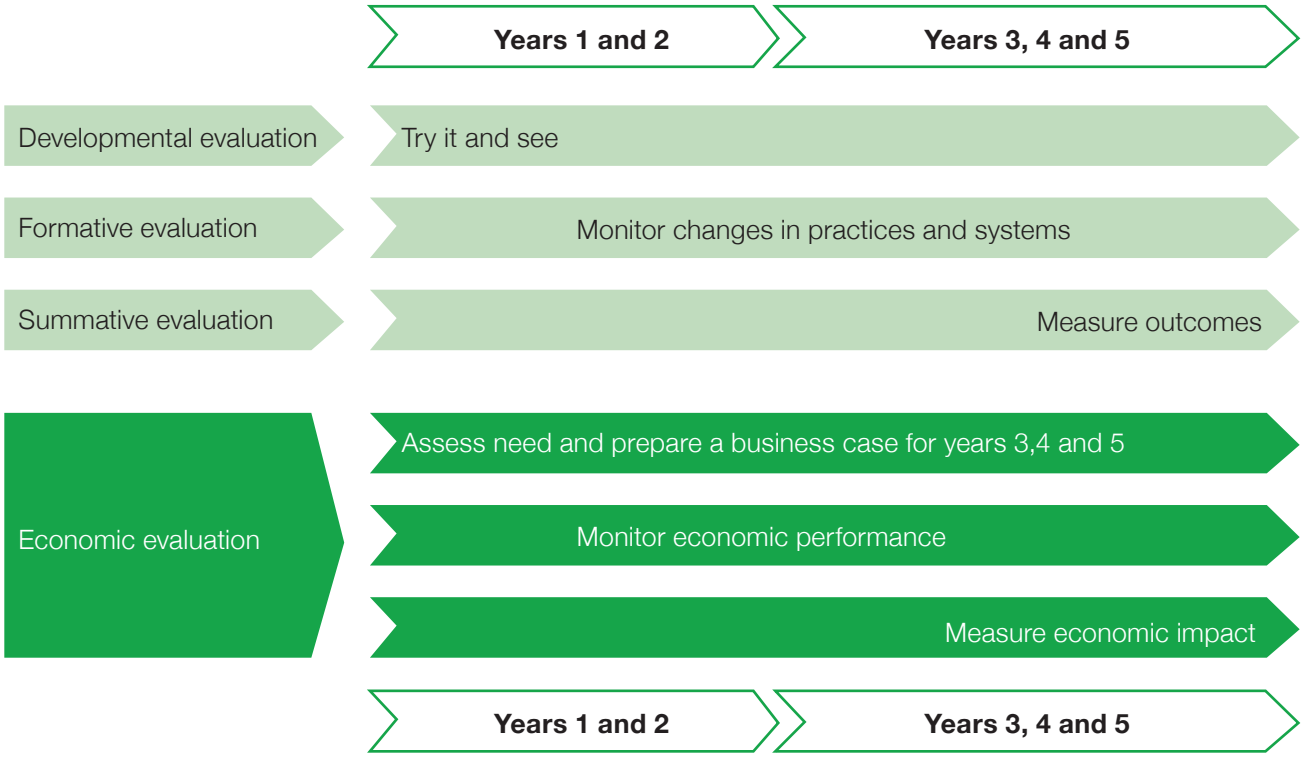

Figure 7: Evaluation of FNQ Connect

5.5.1 Developmental evaluation to road-test initiatives

Developmental evaluation will guide implementation of initiatives. Similar to a Plan Do Study Act (PDSA) cycle, it will provide a systematic process of **learning by doing**, trying something, seeing what works and doesn't work, and adapting it to make it work better. Developmental evaluation will serve to adapt the model as new communities, funding opportunities and government policies arise.

5.5.2 Formative evaluation to monitor changes in practices and systems

Formative evaluation will **monitor changes** in behaviour, such as inter-professional and cross-sector practice. It will assess changes in operating systems, such as links between organisations to enhance care transition. It will assess whether funding and policy are aligned towards success.

5.5.3 Summative evaluation to measure outcomes

Summative evaluation **will measure service transformation as proposed in the original vision and according to the three priorities**. Measures of success will focus on 'what matters most' to FNQ people, based on the understanding that 'what gets measured gets managed'.[53] The evaluation will also provide evidence of accountability to funding bodies, stakeholders and communities.

5.6 Economic evaluation of FNQ Connect

In Years 1 and 2, FNQ Connect will conduct a **comprehensive needs assessment to generate a Business Case** for investment in Years 3, 4 and 5. The Business Case will include **likely impacts** on service provision, health and quality of life. It will include **flow-on impacts** on acute health service use (e.g., reduced hospitalisations) and participation (e.g., readiness for employment). The needs assessment will also provide a baseline from which to track changes over time to assess impact.

In Years 3, 4 and 5, FNQ Connect **will monitor economic performance and provide feedback to the FNQ collective**. Improvements in needs, services, and outcomes over the 5-year period will be assessed in a sub-sample of people selected from the baseline needs assessment.

In the final stages, FNQ Connect will assess the overall economic impact of FNQ Connect, on people with a disability, their families and community, the local economy and the health system. Data from the end of 5-years will be compared with baseline data to determine change in service provision, service use and outcomes. The cost of FNQ Connect will be compared to expected cost reductions and health benefits (e.g., hospitalisations; economic productivity). This will provide an estimate of **societal impact from investing in FNQ Connect**; the social return on investment.

Annual **cost of delivery, consumer use and outcomes** will be tracked and used in two ways: (i) **Priority setting** – investment in some services and disinvestment of others (ii) **Continuous quality improvement** using feedback from evaluations to improve implementation and performance.

Finally, a computer simulation model will be developed that will use the shared measurement system to collate all data into a 'System Dynamic Policy Model',[54] the first for disability in Australia and internationally. An 'interactive dashboard' will provide participating organisations with information to conduct 'what-if' exercises and simulate the potential impacts of new policies and initiatives prior to implementation. The Model will be programmed to automatically generate business cases and conduct evaluations.

‘A good life’ according to FNQ Connect

Rowena has a new job in a new workplace which is at a higher level and higher pay. To prepare, Rowena is attending a ‘Ready to Work’ program at the Cairns central hub. As part of the program, she will receive orientation and mobility training to her new workplace. The new workplace will receive guidance on preparing the work environment to accommodate Rowena’s vision impairment. For instance, installing a braille keyboard. This allows Rowena to choose the job she wants and to do the job to the best of her ability.

6 FUNDING

FNQ Connect will require funding in two stages, in line with the two-staged implementation and evaluation plan. The budget for Years 1 and 2 is itemised in Table 9.

6.1.1 Years 1 and 2

Seed funding will be needed to employ the Backbone Team and engage expert consultants to establish the FNQ Connect independent entity. Funding will be needed to develop the shared measurement system and design a new central hub in Cairns; and road-test the priorities in three sites – Tablelands, Kowanyama and Cairns. Funds will also be required to prepare a business case for the remaining three years. Stakeholder organisations will be asked to contribute in-kind. Recommended funders include: NQPHN to ensure the FNQ vision is prioritised; DSS or NDIA funding to resolve the NDIS underspend, HHS to resolve the pressure on the hospital system and philanthropic funding to improve community wellbeing and foster equity for the people of FNQ.

6.1.2 Years 3, 4 and 5

FNQ Connect will devise **sustainable funding arrangements** for the remainder of the trial period and beyond. The arrangements will embrace:

- existing funding opportunities or incentives;
- existing resources that could be aligned or pooled;
- new funding opportunities for new innovations and for areas that have been historically under-funded;
- philanthropic funding opportunities;
- reallocations and savings from a better aligned service system.

The Cross-Sector Leadership Table will plan actions, aligned with each of the priorities, on an annual basis. Recommended funders include state and federal government departments of disability and health and philanthropic organisations with interest and commitment to collective impact initiatives.

Table 9: Budget for implementation and evaluation in Years 1 and 2

Budget Item	Est 4 months	Year 1	Year 2
Leadership and Management Team			
Director/CEO	$60,000.00	$ 170,000.00	$ 170,000.00
Community engagement officer	$40,000.00	$ 120,000.00	$ 120,000.00
Office Manager/Executive Assistant	$25,000.00	$ 85,000.00	$ 85,000.00
Implementation Team			
Lead priority 1 and Atherton		$ 120,000.00	$ 120,000.00
Lead priority 2 and Kowanyama		$ 120,000.00	$ 120,000.00
Lead priority 3 and Cairns		$ 120,000.00	$ 120,000.00
Monitoring and Evaluation Team			
Lead - monitoring and evaluation (.5FTE)	$30,000.00	$ 97,000.00	$ 97,000.00
Data analyst - shared measurement		$ 148,000.00	$ 148,000.00
PhD student - economic evaluation		$ 50,000.00	$ 50,000.00
Frontline research officer		$ 120,000.00	$ 120,000.00
Combined salaries	$155,000.00	$ 1,030,000.00	$ 1,030,000.00
Oncosts – incl office space and support - 40%	$62,000.00	$ 412,000.00	$ 412,000.00
Total salaries & oncosts	**$217,000.00**	**$ 1,442,000.00**	**$ 1,442,000.00**
Expert Consultants			
Legal - establish FNQ Connect as independent entity	$20,000.00	$ 30,000.00	
Health economist with experience of disability		$ 20,000.00	$ 50,000.00
Data - shared measurement platform		$ 100,000.00	$ 50,000.00
Architectural - central hub design and budget		$ 277,850.00	
Total Expert Consultants		**$ 427,850.00**	**$ 100,000.00**
Other expenses			
Leadership table and Reference Groups payments	$10,000.00	$ 40,000.00	$ 50,000.00
Events, venue hire, catering	$5,000.00	$ 25,000.00	$ 15,000.00
Communication, print, design, website	$15,000.00	$ 30,000.00	$ 30,000.00
Office equipment and IT Infrastructure	$15,000.00	$ 10,000.00	$ 10,000.00
Travel costs	$5,000.00	$ 25,000.00	$ 30,000.00
Total other expenses	**$50,000.00**	**$ 130,000.00**	**$ 135,000.00**
Sub-total	$267,000.00	$ 1,999,850.00	$ 1,677,000.00
JCU Organisational support (finance, HR @ 20%)	$53,400.00	$ 399,970.00	$ 335,400.00
TOTAL	**$320,400.00**	**$ 2,399,820.00**	**$ 1,812,000.00**

7 RISK MANAGEMENT

Potential risks for **FNQ Connect** and strategies to mitigate these risks are outlined in Table 10.

Table 10: Risk Management

	Risk	Description	Mitigation
1	Community engagement and decision making	Engagement with those most affected and disadvantaged. Collaborating across sectors with different cultures. Power balances – e.g., consumers versus service providers. Negotiating private and public sector to procure hub venue.	Communication strategy to regularly reach full range of stakeholders, common language, focus on strengths of each player and how they complement each other. Two-pronged - community and stakeholders action groups.
2	Leadership	A Director with: values and skill set to chase vision; capable of adaptive and systems leadership; willing to trial and evaluate initiatives, scale up those that work, and reject or change those that don't.	Identify potential leaders from past performance who share FNQ vison, have skill set, politically savvy, courage of convictions. Emphasise adaptable leadership for each stage of development. Emphasise systems leadership with a macro and micro view.
3	Governance	Governance structure with integrated decision making to keep organisations working well together; coherent operational structures to suit local conditions; joint funding mechanism for integrating resources, devolution of expenditure, accountability linked to outcomes.	Draw on successful CI projects to guide governance structure Gain agreement on shared values, vision and targets, who governs and who is accountable. Governance that rewards collaborative action towards goals.
4	Human resources	Well-resourced, skilled and capable backbone team. Long-term commitment by stakeholders to: in-kind support; organisational flexibility to respond to community need.	Prioritise funding for and CI training of backbone team. Prioritising CI training of entire FNQ collective. MOU on roles, responsibilities, accountability.

Table 10: Risk Management continued:

	Risk	Description	Mitigation
5	Funding	Long-term rather than short-term funding mechanisms. Resourcing of the backbone team for the period of 5 years. Flexible financial systems to blend cross-sector funds. Capital funding for central hub.	Economic evaluation to show value for money. System dynamic policy model to predict value, set priorities. A full-spectrum cross-sector funding calendar. Recruit for skills in securing funding across collective.
6	Shared data system	High quality shared information, delivered through well designed and safeguarded shared information systems. Regular data collection, reporting, cycles of action. Willingness by consumers, stakeholders to share information.	Engage expert consultants to develop platform, train team and provide ongoing mentorship in platform use. Seek funding to create, maintain and grow data system. Clear, transparent processes for ensuring privacy and data use.
7	Policy and systems change	Consistency between agency goals and goals of collective. Focus on transformative system change rather than services. Willingness to shift from siloed to integrated programs, from risk-averse cultures to a collective learning, safe-to-fail culture.	Map separate financial and regulatory drivers and plan solutions. Backbone to remain neutral and lead from the back. Find the 'coalition of the willing' and work with it. Embrace barriers and incrementally overcome them.
8	Hub infrastructure	Available land or buildings for each hub in a central location. Recruiting and accommodating suitably qualified, skilled staff.	Private public partnership to broaden options and open up opportunities to generate revenue in the future.

8 CRITICAL SUCCESS FACTORS

To establish **FNQ Connect** and achieve the three priorities, the critical success factors in Table 11 will be monitored across the 5-year period.

Table 11: Critical success factors for FNQ Connect

FNQ Collective Key leaders committed to community vision, open to innovation. Robust relationships and cooperation between players. Passionate champions within organisations. Clear and regular communication across the collective. Long-term commitment of in-kind support. Organisational flexibility to respond to community needs.
Leadership and governance Adaptive leadership; systems leadership. Good governance, effective policy and legal frameworks. Leadership that promotes equity, cohesion, shared decision making. The right people at the table particularly those who are most affected. Collaborating across sectors with different cultures, ways of engaging. Regular training in the collective impact approach to reinforce each organisations individual contribution for success.
Resources – workforce, infrastructure and funding Backbone team skilled, competent, work as team, well-funded. Long term funding mechanisms e.g., backbone team for 5 years. Commitment to blending and braiding funds across the collective. Flexible financial systems for aggregation of funding across sectors. Appropriate data platform and training to facilitate data sharing.
External factors Shift from siloed to integrated whole of government or public /private. Resolving conflicts between goals of each player and of FNQ Connect. Alignment with regulatory and legislative system – local, state, national. Government requirements that need to be accommodated. General economic conditions; Government subsidies or incentives.

‘A good life’ according to FNQ Connect

Essie can get support to travel to Thursday Island now. That means she is able to get her own money from the shop, go fishing with family, attend medical appointments and attend the Winds Of Zenadth festival.

FNQ Connect: Connecting people, connecting care offers a new model of service delivery for disability, rehabilitation and lifestyle services for children, young people, adults and older people of Far North Queensland (FNQ). **FNQ Connect** will address the urgent need for integration and co-ordination of services. It will accurately document, advocate for, and address unmet need across the FNQ region.

Social and economic benefits of FNQ Connect for individuals, families and communities in FNQ will be far reaching. People of all abilities will be active members of our community. They will: feel included and connected; be able to choose their own life and follow their hopes and dreams; and have access to culturally safe services close to home.

FNQ Connect requires funding now, to deliver greater value in the future for FNQ communities. By improving community service provision and efficiency, FNQ Connect promises to reduce individual, family, community and health system costs through reduced hospital admissions and length of stay. Economic benefits for FNQ will come from greater participation and productivity through local employment and stimulation of private sector growth.

In summary, **FNQ Connect** aspires to meaningful and sustained reform that is specific to the FNQ context. **FNQ Connect has been designed by, and strongly supported by, the people of FNQ**. It is time to address the entrenched inequality and disadvantage in FNQ compared to Australia as a whole. **FNQ people deserve equity in health, wellbeing and lifestyle along with their fellow Australians.**

Feeling included and connected

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Appendix 1: Members of the Consumer Reference Group

Member	Life-stage	Lived experience
Alicia Sabadi	Children Developing Well	Cerebral Palsy
Melinda Whipp	Children Developing Well	Vision Impairment
Sue Forbes	Young People Growing Well	Down Syndrome
Tanya Sinclair	Young People Growing Well	Multiple Sclerosis
Sue Frank	Adults Staying Strong	Hearing Impairment
Terry McDonald	Adults Staying Strong	Stroke
Jan McLucas	Adults Staying Strong	Rheumatoid Arthritis
Jason East	Adults Staying Strong	Spinal Cord Injury
Del Childs	Older People Ageing Well	Spinal Cord Injury

Appendix 2: Members of the Aboriginal and Torres Strait Islander Reference Group

Member	Organisation	Role
Jennifer Cullen	Synapse	Chief Executive Officer
Hylda Wapau	TCHHS	Nurse Navigator
Julie Boneham	CHHHS/NATSHIA	Board Member
Alan Wason	Mulungu	Clinical Development Officer
Rachael Ham	Wuchopperen Health Service	Deputy CEO
Asta Naden	RAATSICC	Resource Officer
Justin Brown	Anglicare	Manager
Tania Davis	CHHHS	Indigenous Health Worker
Nicole Ramsamy	TCHHS	Nurse Practitioner
Leeann Ramsamy	Ngoonbi Aboriginal Corp	NDIS Consultant
Venessa Curnow	TCHHS	Executive Director
Torres Webb	CSIRO	Indigenous Co-coordinator
Theresa Simpson	Mookai Rosie	Chief Executive Officer
Lavinia Coyle	Mookai Rosie	Nurse Navigator

Appendix 3: Members of the Service Provider Reference Group

Member	Organisation	Role
Vivienne Sandler	TCHHS	Executive Director Allied Health (Physio)
Linda Bailey	CHHHS	Executive Director Allied Health (OT)
Amanda Wilson	CHHHS	Senior Speech Pathologist
Lynda McNamara	CHHHS	Senior Physiotherapist
Melinda Smith	CHHHS	Senior Occupational Therapist
Jacki Mein	Wuchopperen	Director of Medical Services
Vic Rodney	Wuchopperen	Clinical Psychologist
Paula Fisher	Apunipima	NDIS Project Manager
Kerry Stingel	FNQ Allied Health Association	President (OT)
Sarah Brown	Mission Australia	Area Manager NDIS Roll-Out
Erica Odenthal	Education Queensland	Principal Education Officer
Louise Thompson	Education Queensland	Senior Physiotherapist
Simone Kenmore	NDIA-Australia	Deputy Director – Remote Markets
Rosie Bird	CHHHS	Physiotherapist
Jacki Black	Benevolent Society	Occupational Therapist
Wendy Tucker	NDIA	Assistant Director – Remote Planning
Anita Veivers	Centacare	Executive Director
Kim McComb	Anglicare – Quigley Street	Program Director
Leeann Ramsamy	Ngoonbi Aboriginal Corporation	Consultant
Vic Rodney	Wuchopperen	Clinical Psychologist
Tracey Jia	Extreme Health	Disability and Human Services
Flo Cornish	ITEC Health	Coordinator of Support Team Leader
Ben Keast	ARC Disability	Chief Executive Officer
Maggie Jackson	NDIA – NQ Regional Officer	Ass Director, Provider and Marker Relations
Padmini Saxena	NDIA – Queensland	Director, Provider and Market Relations
Kate Ham	DATSIP	Principal Project Officer, Torres and Cape
Scott Davis	Director	My Pathway

Appendix 4: Benefits of collective impact projects in Australia

Collective	Status	Focus	Impact	Funding
90 homes for 90 lives	Achieving transformation	Homelessness	>62 people housed Permanent reduction in rough sleeping	Local council with NGO
Maranguka Justice Reinvestment	Achieving transformation	Children and their families	23% reduction in DV 31% increase year 12 retention 38% reduction in top five juvenile offences 42% reduction days in custody $3 million savings	Philanthropic Federal government
Mid Murray family connections	Achieving transformation	Children and their families	Reduction in Developmentally Vulnerable Children in 2018/19	Local council State government NGO
500 Lives 500 homes	Achieving transformation	Homelessness	Housed > 580 individual and family households	State government Local council

Appendix 5: Alignment of FNQ Connect with regional, state and federal priorities

	Strategic Plan/Policy	FNQ Connect aligns with the strategic plan or policy by:
Far North Qld	FNQ Regional Organisation of Councils	Connecting, collaborating, sharing resources and expertise between private and public sector and advocating for equity.
	Northern Aboriginal and Torres Strait Islander Health Alliance	Integrating health care, advocating for health equity, recognising and addressing unique needs of Aboriginal and Torres Strait Islander people, strengthening social and economic environment.
	NQ Health Service Master Plan 2019–22	Integrating people-centred care and support; collaborating across all sectors and jurisdictions; advocating for equity.
	NQPHN	Bringing together FNQ stakeholders from all levels of government and non-government to improve health and wellbeing of FNQ region; recognising unique needs of Aboriginal and Torres Strait Islander people, as first inhabitants and most vulnerable and disadvantaged.
	CHHHS	Advocating for equity; recognising the unique needs of Aboriginal and Torres Strait Islander people, as first inhabitants and most vulnerable and disadvantaged; Striving for positive health outcomes and value for money; reducing future pressure on struggling hospital system.
	TCHHS	Recognising the unique needs of Aboriginal and Torres Strait Islander people, as first inhabitants and most vulnerable and disadvantaged in FNQ. Connecting with communities and with stakeholder organisations to achieve positive health outcomes and value for money.
	FNQ Region for Department of Education	Prioritising transition services to ensure children attend school with peers with supports in place, and to transition out of school to take up further study or employment.
	Tropical Australia Academic Health Centre	Evaluating the impact on FNQ to ensure return on investment and value for money; providing evidence-based decision-making through shared measurement systems; advocating for increased resources in FNQ to ensure equity in line with all Australians.

	Strategic Plan/Policy	FNQ Connect aligns with the strategic plan or policy by:
Qld	QAIHC	Striving for people-centred health care; collaborating between all levels of government and non-government organisations; recognising unique needs of Aboriginal and Torres Strait Islander people, as first inhabitants of FNQ and the most vulnerable and disadvantaged in FNQ. Prominence of Aboriginal and Torres Strait Islander in decision-making.
	Queenslanders with Disability Network	Nothing about us without us - people with disabilities leading and guiding FNQ Connect, playing a central role in decision-making during design and during 5-year implementation.
	Advancing Health 2026	Taking a strength-based approach: enabling rather than disabling; wellbeing rather than illness; drawing on and strengthening existing services and networks. People with disabilities leading FNQ Connect and playing a central role in decision making. Providing evidence-based decision-making and benchmarking to ensure equity for FNQ people.
	Department of Employment, Small Business and Training	Focusing on strengthening local workforce and locally-owned services to meet local need; ensure service viability and sustainability.
	System Outlook to 2026	Focusing on integration of services, building community services to reduce reliance on acute services, increasing efficiency, value for money for FNQ.
National	Australian Human Rights Commission	Advocating for equity, that everyone feels included and connected, safe and supported, can choose their own life.
	Closing the Gap	Taking a strength-based approach, recognising, addressing unique needs of Aboriginal and Torres Strait Islander people of FNQ who are the most disadvantaged and ensuring they have a prominent role in decision-making.
	NDIS	Supporting a better life for FNQ people with a disability and their families and carers; striving to transform the lives of people with disability, by using a transformative way of working together.
	NDIA – Rural and Remote Strategy	Strengthening the local workforce and locally-owned services to ensure supply can keep up with demand for NDIS funded services; enabling Aboriginal and Torres Strait Islander people to receive services from Aboriginal and Torres Strait Islander people; taking a community-by-community approach; collecting data on supply and demand for services.
	National Strategic Framework for Rural and Remote Health	Collaboratively planning services and programs according to local needs; improving access to appropriate care and sustainable service delivery; increasing skilled and well supported health workforce; advocating for FNQ people to be as healthy as other Australians.

	Strategic Plan/Policy	FNQ Connect aligns with the strategic plan or policy by:
	Disability Royal Commission	Promoting a more inclusive society that supports people with disability to be independent, to feel safe and supported.
	Aged Care Royal Commission	Working together to ensure 'older people are ageing well in place' through strengthening at the individual, workforce, organisation, system level.
	Department of Education Skills and Employment	Striving towards our vision that 'everyone can choose their own life and follow hopes and dreams and be the best they can be.
	Department of Social Services	Striving towards the vision that 'everyone can choose their own life and follow hopes and dreams and be the best they can be'.
	National Disability Strategy	Striving towards our vision that: 'everyone feels included and connected, safe and supported'; 'everyone can choose their own life, follow their hopes and dreams and be the best they can be'; and everyone has access to culturally safe services close to home to be well and stay well'.
	National Disability Employment Strategy	Striving to increase opportunities for employment and promotion; employer engagement, capability and demand; focusing on transition from school to work; strengthening community attitudes for inclusion.
	National Carer's Action Plan	Valuing the role of carers; focusing on information for carers so that they can make informed decisions; improving access to services and supports Carer's engaged as partners in care improve data to inform future policy, and service delivery; training to undertake caring role.
	Stronger Places, Stronger People	Working together with all levels of government, communities, local stakeholders, policy makers and funders using a place-based collective impact approach to deliver a locally designed model of service delivery.
Global	Integrated people-centred health care	Applying the IPCHS to design our priorities for FNQ: engaging and empowering people and communities; strengthening governance and accountability; reorienting the model of care; coordinating services within and across sectors; creating an enabling environment.
	WHO Policy on Disability	Emphasising inclusion of people with disability in all their diversity and systematically integrating people with disability in all areas of FNQ and more broadly in life, thereby contributing to the practical implementation of the globally agreed commitments.

Appendix 6: Implementation of priorities in the trial sites

Conditions	Description	Indicators of success
Shared agenda	Community working groups develop a shared vision for one or all priorities, and agree on actions for change.	Key stakeholders engaged in working groups and local champions identified. Shared agenda endorsed.
Mutually reinforcing activities	Stakeholders undertake different actions that contribute to a common agenda and are complementary.	Stakeholder self-assessments and plans completed and towards common goal. Action taken in line with common goal.
Shared measures of success	Progress towards the goal is measured using a set of shared indicators. Stakeholders come together to refine priority based on analysis of the data.	Region-wide indicators determined. Data collected, analysed and reported. Progress reviewed by stakeholders, strategies and actions refined.
Continuous communication	Regular meetings occur between stakeholders to stay informed and to ensure progress.	Regular communication: - training on collective impact approach; - stakeholder communication schedule; - reporting of progress to community.
Backbone support organisation	Backbone team guides implementation of initiatives within each priority, coordinates stakeholder engagement, monitors data collection and analysis; mobilises funding.	Backbone team resourced, established. Strategic planning facilitated. Stakeholders engaged and informed. Data collected, monitored, analysed reported. Funding identified and pursued.

Appendix 7: Background information for preparation of a pre-construction proposal

Proposed Cairns Central Hub

Purpose:

Provision of centre-based disability and rehabilitation services – public, private, NGO and ATSICCHO providers:

- For people of FNQ including children, young people, adults and older people
- A training ground for the current and future workforce in delivery of these services
- A central community hub, a one-stop shop for services, information, education and advocacy that connects to 5 satellite hubs in rural and remote FNQ

Principles:

The key principle is that services in the community provide the most appropriate setting for meeting the needs of most people recovering from a traumatic event or living with a chronic disabling condition.

- People with lived experience of disability are to be central to the process of decision-making
- Family members and carers are included according to the preference of the service recipient
- Services are to be people-centred, they will wrap around the individual and family
- The facility and the services provided need to be inclusive, culturally safe and strength-based:
  - o inclusive for all, irrespective of ability, religion, culture or economic situation
  - o flexible to address unique needs, especially for Aboriginal and Torres Strait Islander people
  - o enabling rather than disabling; wellness rather than illness
  - o community participation rather than clinical treatment
- Services are integrated and connected – linked to local services, community facilities, support services
- Service recipients are to be engaged in learning to self-manage using resources and networks from within and outside their community
- Services are to link with each service recipient's local health services and community facilities
- Workforce education programs will be tailored to the unique context of NQ

Location of the facility:

The location for FNQ Connect is yet to be determined. Options to be considered include:

- a new building on a new site, or refurbishment of an existing building and site.
- a private public partnership for acquisition of the land and facility

Ideally, FNQ Connect would be in a central location in Cairns within a beautiful tropical environment. The location of the facility would provide easy access to recreational (outdoor walks, pools), social activities and grocery shopping and easy access to public transport.

Ideally, the facility would be located in the general vicinity of the hospital and medical facilities to allow people from rural and remote FNQ easy and timely access to services while in Cairns and away from family.

Contents of the Facility

The facility is to be approximately 2000 m2 and is to be open to and surrounded by a tropical environment. It could be on one or more levels however the ground floor would need to be for delivery of services while an upper floor could have conference rooms for education sessions, self-management groups etc and executive offices. Parking space, supported transport spaces and public transport stops would be required.

In keeping with a public private model, the facility would have spaces for rent for private services and with the option that they use the various therapy spaces. Private services could be housed permanently within the facility or could be hired for a short period by visiting services (e.g., a seating service could be on location for one week every three months)

Other requirements include:

- Infrastructure and support services to ensure inclusion for everyone e.g. for people with physical disabilities as well as for people with hearing and visual impairments.
- Indoor and outdoor multipurpose spaces – perhaps some focused on children and some on adults
  - o ~2 large open indoor spaces for physical activity classes /sessions
  - o ~2 small and 2 large spaces for meetings / education / conference rooms
  - o ~2 large kitchen, bath, laundry and workshop to allow for training in activities of daily living
  - o ~ 6 interview rooms for private conversations (e.g. with a social worker) or for quiet spaces (speech retraining) away from distractions (allow concentration)
  - o ~ 4 consult rooms for simple clinical procedures (e.g. by medical specialist, nurse and dietitian)
- No 'them and us'
- Shared bathroom, shower facilities, kitchen facilities, lunchtime spaces
- Staff and student shared offices with easy access to the shared spaces
- Waiting areas /spaces with easy access to shared kitchen and bathroom facilities
- A number of storage spaces for equipment

<u>Governance and funding</u>

The facility would be run by FNQ Connect which would be an independent entity led by people with lived experience of disability, and key stakeholders – private and public service providers and council.

A private public partnership model with services and revenue drawn from the public and private sector:

- for procurement of the site and for the build or refurbishment.
- for use of the hub for both services and revenue

One-off capital funding would be required for the site and build

A joint funding mechanism would be required for on-going operations

Ultimate ownership of the building and site would most likely be Queensland Health

<u>Timeframe</u>

We are anticipating a 5- year project to establish FNQ Connect

- 2 years to build the foundations of the service and to design and build the facility
- 3 years for full scale implementation and evaluation

Aim: To implement and evaluate FNQ Connect - a network of hubs that is designed to *enable* FNQ communities to support people of all abilities to have a good life
a) 1-2 year build foundation for FNQ Connect and trial priorities and; b) 3 year full-scale implementation and evaluation

Vision statement	Inputs: Resources required	Outputs: activities	Outputs: deliverables	Outcomes		
				Short term (1-2 years)	Intermediate (2-4 years)	Long-term (5 years)
In FNQ, children are developing well, young people are growing up well, adults are staying strong, and older people are ageing well in place Everyone feels Included, connected safe and supported Has opportunities to choose their own life and has access to culturally safe services close to home Supply of services in FNQ, relative to need and cost of delivery, will be consistent with national standards FNQ people are getting the best bang for every buck i.e. gaining greater benefit for every dollar spent, than in the past decade.	Funding required: In-kind - service providers In-kind – community stakeholders Recurrent ??NQPHN for backbone ~ $750k - $1 M p.a. Capital -Central hub ~ $20M -Satellite hubs ~ $10M -shared measurement platform – $1M Operational - Central & mobile hub ~ $30M -Satellite hubs ~ $5M Project funding for priorities FNQ Connect (create Stage 1) Independent entity with Leadership Table and Chair Collective inclusive of: People with lived experience of disability Local, state, federal govt Reference Groups -Consumer -Aboriginal and Torres Strait Islander -Service Provider & community stakeholders Backbone Team (created in Stage 1) -Leadership -Implementation team -Monitoring and Evaluation team Shared measurement platform Created Stage 1 Appetite, opportunity, momentum for change Model and plan for change Stakeholders engaged	FNQ Connect Establish and incorporate an independent entity with collective governance dominated by people with lived experience of disability. Establish strategic leadership council Build collective impact model of operation Provide direction for 2-staged project. Backbone Team Engage and train team in CI Facilitate change on behalf of FNQ Connect For each initiative, assign team member, identify funding opportunities, support preparation of applications and lobby Collaborate to design platform, software and processes for shared measurement - collection analysis, reporting Prepare and submit ethics applications Collect data, monitor, evaluate process and outcomes for priorities and model overall Ongoing communication to FNQ collective Build network of Hubs Central hub–locate, design, construct 5 satellite hubs – identify venue, mods Assess readiness for integration in hubs Prepare policies, procedures, pathways Priority 1: Connected care and support Engage and assess –providers, councils Initiate action Organise for impact Begin implementation Review and renew Priority 2: Local workforce, services Engage and assess –councils, VET, Unis Initiate action Organise for impact Begin implementation Review and renew Priority 3: Inclusive communities Engage and assess – councils and consumers Initiate action Organise for impact Begin implementation Review and renew	FNQ Connect FNQ collective incorporated Strategic leadership council instated Collective impact model embedded Stage 1 and Stage 2 implementation & evaluation reports endorsed Backbone Team Shared measurement system, processes and resources in-place Funding applications Ethics approval Annual progress and financial reports Annual evaluation reports Final economic evaluation Network of Hubs Business and architectural plan for central hub (Y1) Hub readiness to integrate & plans Policy, procedures, pathways Annual reports Funding package Priority 1: Connected care and support Transition and navigation Report on pilot of student-led transition service (y1, y2) Funding package Integrated care FNQ agreement- shared clinical governance (Y3) Policy, procedures for integrated care Funding package Priority 2: Workforce & services Yrs 1,3,5 - Workforce reports – LGAs, Yrs 1,3,5 -Workforce reports – FNQ Yrs 1,3,5 -Service reports - LGAs Yrs 1,3,5 -Service reports – FNQ Funding package Priority 3: Inclusive communities Yrs 1,3,5 - Inclusion reports – LGAs Yrs 1,3,5 - Inclusion reports – FNQ Funding package	FNQ Connect Independent entity operational Strategic leadership table operational 5 pillars of collective impact evident Plan refined for implementing priorities Backbone Team Team engaged, trained to facilitate change Monitoring and evaluation plan developed Agile shared measurement system initiated Short term funding secured Longer term funding secured for full scale implementation and evaluation Network of Hubs Business and architectural plan for central hub (Y1) and funding secured Priority 1: Connected care and support Transition services trialed and refined Navigation services trialed and refined Integrated care - shared clinical governance model prepared. Funding package prepared / secured Priority implementation process refined Priority 2: Local workforce and services At trial sites – Needs assessed and plan devised -services required V available -services local V visiting Co-created local employment models and training to needs of community Committee, policy, champions, Funding package prepared / secured Initiative implementation process refined Priority 3: Inclusive communities At trial sites: Inclusion self-audit and plan devised Inclusion committee, policy, procedures with decision-making by most affected, educational resources, champions in-place Funding for infrastructure and services Initiative implementation process refined	FNQ Connect Strong collective impact model – selected process and outcome measures of CI Backbone Team Backbone team fully operational Agile shared measurement system refined in response to trial Shared measurement processes refined; measures and processes prepared for summative evaluation. Network of Hubs Central hub created Central hub, mobile hubs and satellite hubs operating Policy, procedures, pathways endorsed and operational Priority 1: Connected care and support # transition and navigation services received; satisfaction with services # visits to town, time away from home and # services while in town # community services v acute travel expenditure Integrated care - shared clinical governance model operational Priority 2: Local workforce and local services # trained # employed locally # employed in local businesses # businesses # referrals, #OOS # services # OTs, PT, SP services supporting local services # services received Priority 3: Inclusive communities Community inclusion audit and plans reaching community targets Community inclusion rating up	FNQ Connect Demand for FNQ high, fits with vision, public opinion and policy environment Leadership reflects those most affected Backbone Team Evidence of impact demonstrated Children developing well, young people growing up well, adults staying strong, older people ageing well in place Improved function & QOL across lifespan Decreased PPH and length of stay Increased community capacity to support all abilities to have a good life People feel *more* included, connected, have *more* opportunities to choose their own life and better access to culturally safe services. Local workforce Increased in size, qualifications and hours of services Viable and sustainable local businesses providing services for all abilities Services received = services required Service satisfaction increased Cultural acceptability of services Compared to baseline and visiting: More locals employed, more local services; more local businesses viable á revenue generated for community - Generating more NDIS funds locally Reliable access and satisfaction with FNQ community disability and rehab services and transitions between services across the lifespan FNQ Connect model embedded: Governance structures support model Policies that support model Financing that supports model Evaluation that supports IPCHS model FNQ funding commensurate with Australia - increased revenue generated for FNQ - better access to existing funds FNQ getting best bang for every buck

Assumptions: Social model of disability; WHO Integrated People-Centred Health Care Policy Framework[2;] including action across 4 domains; individual, family and community, workforce, organisation, system; Decision-making to be most strongly influenced by those most affected.

In-scope: FNQ people of all abilities across the lifespan, recognising the unique needs and circumstances of Aboriginal and Torres Strait islander people;
Out-of-scope: Mental health services; Acute hospital services

Appendix 9: Dynamic of ability and disability: Model for change in FNQ