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Cape and Torres Health Commissioning Ltd (CaTHC) Project Final Evaluation Report

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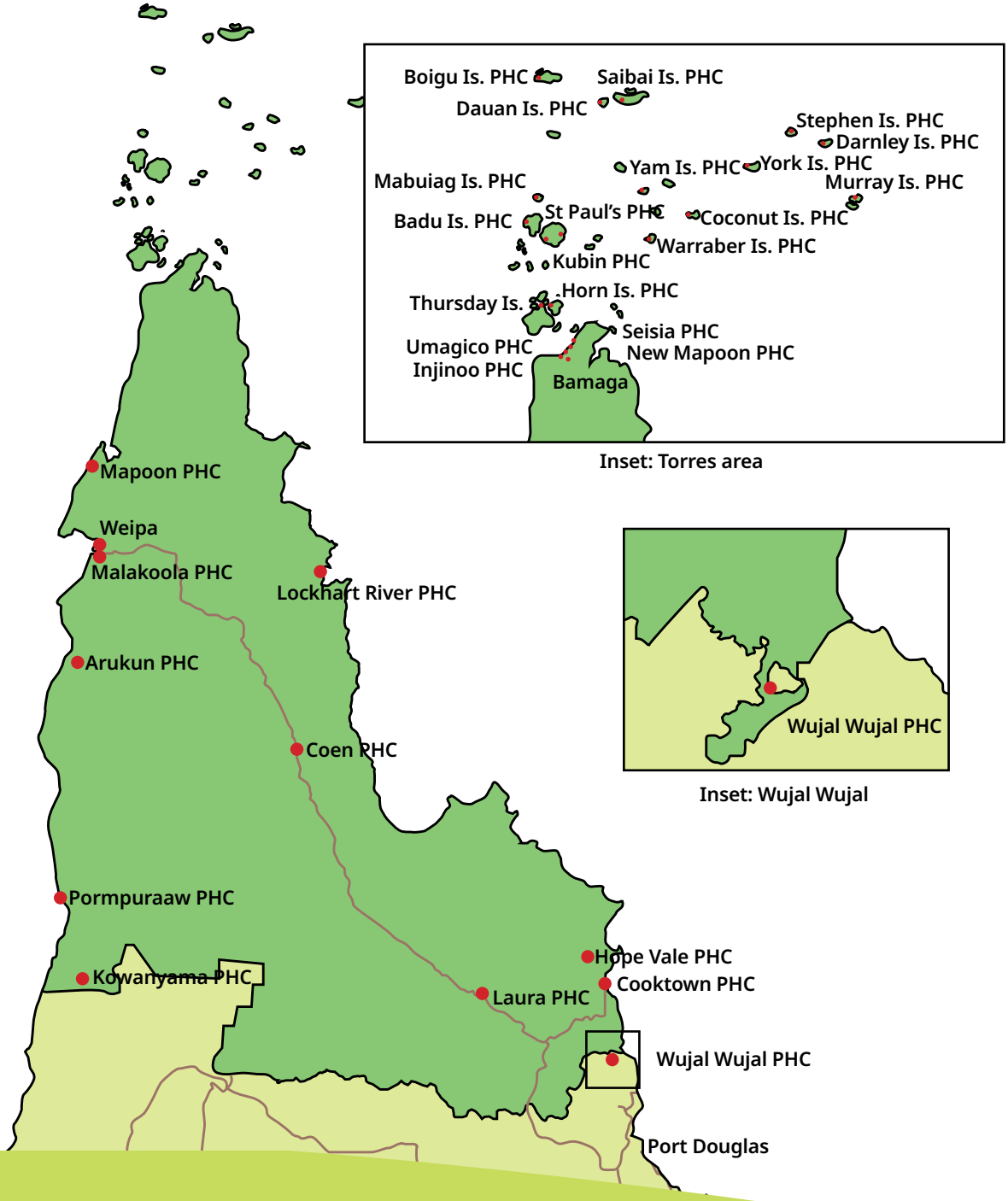

Acknowledgement of Country

We respectfully acknowledge the Traditional Custodians of the lands on which we work and learn. We pay respect to the First Nations Peoples and their Elders, past, present and emerging for they hold the memories, the traditions, the culture and hopes of Indigenous Australians. Aboriginal and Torres Strait Islander people and communities are also respectfully referred to within this Strategy as Indigenous Australians, First Australians and First Nations Peoples. Further, we acknowledge the unceded land, sea, and waterways of First Nations people; the sovereignty of First Nation peoples; the detrimental impacts invasion/colonisation have had and is having on First Nations peoples; and we acknowledge First Nations Self-Determination. This land is and will always be Aboriginal land.

Artwork

Chasing Dreams Artist: Samantha Campbell | Coolamon Creative

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ABBREVIATIONS

ATSICCHO Aboriginal and Torres Strait Islander Community-Controlled Health Organisation
CaTHC Cape and Torres Health Commissioning Ltd
CtG National Agreement on Closing the Gap
DoHAC Australian Department of Health and Aged Care
HIF Health Innovation Fund
MBS Medical Benefits Scheme
NACCHO National Aboriginal Community Controlled Health Organisation
NDIS National Disability Insurance Scheme
NHRA National Health Reform Agreement
NPA Northern Peninsula Area
PHN Primary Health Network
QAIHC Queensland Aboriginal and Islander Health Council
QH Queensland Department of Health
PSC Project Steering Committee
RFDS Royal Flying Doctor Service
SPG Strategic Partnership Group
TCHHS Torres and Cape Hospital and Health Service
TCICA Torres Cape Indigenous Council Alliance
TORCH Torres and Cape Health Care Commissioning

Executive summary

In May 2024, the Cape and Torres Health Commissioning (CaTHC) Ltd was established as a regional community-controlled commissioning entity. CaTHC is governed by a Board of Aboriginal and Torres Strait Islander Directors and is independent from government. It is planned that over a 10-year period CaTHC will develop the capabilities to receive public funding and commission health services that respond to community need. The aim is to shift the way care is planned, purchased, and delivered, to drive improved health system effectiveness, equity and whole of population health and wellbeing outcomes.

This report provides a detailed evaluation of the CaTHC project covering the period of entity establishment between August 2022 and December 2024. It focusses on project deliverables and resourcing; collaboration and governance; model design and implementation; and community and engagement. The project was formerly called the Torres and Cape Health Care Commissioning Fund (TORCH), with a name change to the CaTHC project in 2024.

BACKGROUND

In March 2021, the Australian and Queensland governments committed to the establishment of an independent commissioning entity, resourced through the Health Innovation Fund (HIF). CaTHC has been co-designed and co-developed through a project partnership between community leaders, the Australian Department of Health and Aged Care (DoHAC), Queensland Department of Health (QH), and the Queensland Aboriginal and Islander Health Council (QAIHC).

CQUniversity's Jawun Research Centre, in partnership with the University of Sydney's Leeder Centre for Health Policy, Economics and Data and the Poche Centre for Indigenous Health, conducted the evaluation. A combination of evaluation approaches was applied, including the Ngaa-bi-nya framework which focuses on Aboriginal and Torres Strait Islander health and wellbeing. A series of interviews and workshops were conducted with more than 60 leaders and representatives from community, heath service providers, Councils, representative organisations and government agencies. Multiple documents and reports related to the CaTHC project were also reviewed. A set of evaluation questions provided by QH guide the analysis to answer the following overarching question:

What enabling conditions (e.g. resourcing, workforce, legislation and other inputs) and strategies (e.g. stakeholder engagement, collaborative governance, co-design) were required to establish the CaTHC entity and commissioning model?

OVERALL SUCCESS AND OUTCOMES

The CaTHC establishment and implementation project has delivered significant outputs since commencing. Overall, the reform appears well positioned for the next phase. Regional leaders supported by QAIHC established a new commissioning entity, a focal point and major milestone for the project. CaTHC is a self-governed body, providing a foundation for self-determination over the future commissioning of health services. Commissioning has widespread support from regional representatives and service providers. The Australian and Queensland governments have mapped investment into the region, reviewed options for funding models and legislative reforms, and progressed governance, data sharing and accountability frameworks. Operational funding for CaTHC has been secured from QH for 2024-2028.

However, complex and unprecedented reforms remain for CaTHC to commission services across the regional health system. A planned 10-year development pathway will enable CaTHC to build capabilities, and conduct needs assessment and service planning, supported by data analytics and systems for performance monitoring and reporting against agreed health outcomes. The Australian and Queensland governments will co-design and implement the required funding mechanisms, legislative changes, and other enablers required for pooling health investment into the entity. All these components require coordinated delivery to realise the longer-term sustainability and success of CaTHC.

PROJECT AND DELIVERABLES

The CaTHC project involved multiple activities that were jointly delivered by project partners through seven workstreams and related work packages. From the information provided, these workstreams and related activities were successfully planned, managed and coordinated. Each stage involved detailed assessments, and the preparation of documents and materials to inform the process, deliberate and negotiate over options, and outline appropriate steps to implement each component. The complex range of tasks has required dedicated effort, innovation and perseverance from all

project partners to deliver combined outputs over the extended reform period.

Regional Aboriginal and Torres Strait Islander leaders and elected representatives have made an invaluable and enduring contribution to project activities and success over multiple years. A complementary mix of skills and expertise has contributed to outcome delivery, and employing dedicated project staff in QH, DoHAC and QAIHC has facilitated overall interagency and cross-partner coordination. The initial Health Innovation Fund (HIF) government contribution was Aus$4.56m. Financial and non-financial resources were adequate for overall project delivery. Several work packages, including co-design and engagement, would have benefited from increased resourcing. Project partners noted the significant in-kind contribution to deliver the reform, including from regional leaders.

Challenges were experienced with project implementation, leading to delays in work package delivery. Several milestones were completed within estimated timeframes prior to the planned entity launch, whereas others were reassigned to the commencement phase. Project disruptions can be attributed to a changeover in project teams within QH, DoHAC and QAIHC that affected momentum, uncertainty and disagreements between partners over reform components, key stakeholders withdrawing support, and external factors. Multiple interdependencies meant that delays with certain activities impeded workloads in other areas. Delivery timelines were also underestimated for the scope of activities. Drawing on resources and expertise earlier from other government branches could have improved output delivery.

COLLABORATION AND GOVERNANCE

Governance arrangements involved a project partnership, with strategic oversight provided by a Project Steering Committee (PSC). The PSC was comprised of executives from the Queensland and Australian Government, QAIHC, and elected leaders from Councils and regional governance bodies. Both the project partnership and the PSC operated effectively as collaborative planning and decision-making forums. Interviewees noted, however, that the PSC would have benefited from strengthened regional representation to enable community perspectives to be presented and then actioned.

Government agencies highlighted the strength of the partnership, and consistency from members. Extensive relationship management and flexibility underpinned project delivery and provided avenues to overcome setbacks. Project partners displayed capacity to learn, adapt and negotiate solutions in response to new information. The capabilities and commitment of government and community-controlled managers proved invaluable for managing complexity and navigating a pathway amongst diverse interests.

Self-determination and community-control are founding principles of the CaTHC reform, and the entity was established as a self-governing body. Regional Aboriginal and Torres Strait Islander representatives, QAIHC and community stakeholders continually reinforced that community should determine how and through what mechanisms commissioning operates. The creation of a Community Caucus and Interim CaTHC Board were important forums for regional leaders to advance entity establishment and integrate community priorities into the co-design process.

Project governance encountered some significant challenges. These primarily relate to enacting shared decision making through a partnership model and realising community-control, reflecting priorities under the National Agreement on Closing the Gap (CtG). Feedback emphasised that a partnership does not equate to governments exercising influence or control over all project components. QAIHC and regional leaders required independence to conduct activities and exercise decisions in the interests of the community but felt disempowered by government involvement. The partnership experienced tensions, with major disagreements over entity establishment contributing to a communication breakdown between December 2023 and April 2024.

A reconvened project partnership resulted in a strategic realignment. Governments assumed a more supportive role, aiming to deliver an enabling environment for CaTHC to operate independently. As agreed with the CaTHC Board, they will not be directly involved in entity operations or commissioning health services. The continued expansion of CaTHC will necessitate that governments cede increasing decision-making authority and control over health funding and planning. Governments have emphasised that CaTHC is a joint commitment, and that robust mechanisms are required to account for the large volume of public health investment. Longer-term management of the partnership, and setting mutually agreed policy and program direction, will be important for success.

MODEL DESIGN AND IMPLEMENTATION

Co-design of the CaTHC entity was the major output from the project. Detailed planning and analysis were undertaken into entity type, governance structure, and scenarios for funding transition. Each component involved assessment of options, with selection based on suitability/applicability for commissioning across the health system, ease of operation, and requirements for community governance and accountability. Agreement was reached on establishing a company limited by guarantee as it offered independence and community-control through its Board and objectives, whilst satisfying financial auditing requirements. From the information provided, the process was rigorous and transparent, and the selection was endorsed by the Community Caucus and the PSC.

Critical to the success of CaTHC will be the pooling of government health investment that can be flexibly allocated to meet community need. Deliverables were completed on the funding component, including a comprehensive mapping of regional health investment and decision support tools for funding transfers.

Operational funding for CaTHC has been secured for four years. Different sources, models and timeframes were analysed to pool funds from government sources, including the National Health Reform Agreement (NHRA). A four phased commissioning approach was adopted and appears logical, as it can accommodate increasing funding and legislative complexity that corresponds with CaTHC and health system readiness. Governments emphasised the complex and nuanced changes to enable transfer of public health funding to the entity. Funding thresholds will be co-designed with CaTHC and implemented throughout the funding transition period to ensure the entity demonstrates readiness to receive and control increasing amounts of public health investment over time.

Progress was made on a draft Queensland Government policy proposal, as well as required legislative changes, data access agreements and accountability frameworks. However, a Queensland Government cabinet submission and accompanying first round of legislative changes have been rescheduled from 2024 to 2026. Interview participants placed high importance on data sharing to support client needs and developing capabilities in data analytics for planning, monitoring and reporting health outcomes. Significant problems exist with the quality and sharing of health data between service providers and will need to be addressed.

Uncertainty remains over health outcomes from commissioning, and how responsibility will be shared/transferred between governments and CaTHC. Service providers requested further clarity over the scope of commissioned services and emphasised a seamless transition. Others noted that funding mechanisms, including any existing contracts, will require flexibility to enable CaTHC to innovate and trial new programs. Concerns were raised that CaTHC may be limited by current investment and unable to commission services to meet demand or address social determinants of health. Additional funding may be required to address the burden of disease, improve service integration, and support community-based models of care.

There is a broad consensus amongst stakeholders that it will take time and resources to build the capabilities to plan and contract services to address systemic problems in the health system. CaTHC will need to co-design a commissioning framework that accommodates cultural and social diversity across the region and offers supportive structures for community participation. It was widely expressed that commissioning should be driven by the community, as they can inform their own health priorities. A well-established governance structure, with good risk management, financial accountability and clinical guidance is a priority. Importantly, CaTHC will need to build confidence in commissioning through some early outcomes, or risk losing legitimacy from both community and government funders.

COMMUNITY AND ENGAGEMENT

Engagement and co-design with regional stakeholders evolved through several phases. Engagement with regional leaders was led by QAIHC and was delivered through local leadership structures as the conduit of community interests. Application of co-design enabled regional leaders to contribute to different workstreams, aiming to draw community experience into the program, and to build capacity. QH engaged with service providers including Torres and Cape Hospital and Health Service (TCHHS), and Royal Flying Doctor Service (RFDS), and was generally well received. A Regional Stakeholder Summit held in September 2023 was valuable in presenting the principles of CaTHC and identifying health priorities.

A key objective of the engagement process was to obtain a region-wide endorsement or mandate for CaTHC. Most Councils and peak bodies have confirmed strong support for establishing a community-controlled commissioning body. The broad level of support and legitimacy across the region is a major achievement for the reform and underpins its momentum to date. Service providers are broadly supportive, but strong reservations were made by some about the utility of CaTHC, including potential impacts on the health workforce. In mid-2023 elected representatives from Torres Strait withdrew from the process, citing other priorities. Operating a single regional commissioning body is unviable without their participation, and a suitable resolution is required.

Engagement and co-design were well below expectations for a cross-section of stakeholders. Many expressed criticism that a wider group of stakeholders had not been afforded adequate opportunities to participate at a meaningful level, particularly Aboriginal and Torres Strait Islander Community-Controlled Health Organisations (ATSICCHOs). Reported issues included inadequate time to review information and provide feedback, and limited clarity around objectives or the CaTHC 'concept'. Communication was also uneven across local government areas in the region, ranging from extensive to limited and infrequent. Governments noted that detailed engagement/co-design with community was initially planned but wasn't implemented at the scale envisaged. Project partners disagreed on the frequency and urgency of engagement throughout 2024.

Despite more than three years of activity for the CaTHC project, there exists limited knowledge amongst end users or the health workforce about the transition to commissioning, its implications and opportunities. This has contributed to widely expressed mistrust amongst stakeholders and a perceived lack of transparency with the process. Probity concerns were also raised, related to the participation of service providers in the project and appointments of Board Directors. Government partners aimed for consensus from all Councils and representative bodies, and considerable resources and time were directed at this objective. This included a multi-party Statement of Intent, which proved unsuccessful. Strategically, reaching broad agreement was highly unlikely, and regional leaders advised it was unnecessary.

INSIGHTS AND PRIORITIES

An overwhelming response from participants to this evaluation is that urgent and systemic change is required to improve health service delivery in the region. A common refrain was that 'we can't continue with the current model as it doesn't work, and we need to do something different.' CaTHC is uniquely placed to deliver structural changes and address issues with the quality and delivery of healthcare across Cape York and Torres Strait. Building relationships/collaboration across the health system will underpin the transition to community-controlled commissioning that drives innovations to address systemic issues with coordination and delivery of care.

Key insights and findings from this evaluation that can inform the commencement phase include:

- Government partners will need to clarify and formalise their longer-term commitments to CaTHC, such as through an agreement.
- Enablers, such as funding and legislation reforms, should be prioritised and completed during the early commencement period to provide certainty and encourage a streamlined process.
- Implementation will require dedicated resources and staff in partner agencies to jointly deliver the funding transitions and wider system changes.
- CaTHC will require adequate and flexible resourcing and timeframes to build commissioning capabilities, frameworks and data systems, and to ensure its sustainability and longevity.
- For CaTHC to assume increasing autonomy over the health system within the Torres Strait and Cape York, governments will need to remove administrative roadblocks and proactively transfer authority and responsibility.
- Engagement and co-design are a very high priority, particularly at the community and service provider level.
- Adequate resourcing is needed to facilitate community-driven engagement processes, including deeper listening with families and end-users.
- Communication materials should target specific groups and sectors through each phase of CaTHC development.
- The high levels of mistrust expressed by all stakeholders about the health system, and uncertainty about CaTHC, require significant attention.
- Early outcomes that demonstrate improved performance in service delivery would build confidence and trust in the benefits of CaTHC amongst end users.
- Governance frameworks and commissioning approaches will need to accommodate regional/local decision-making processes that are reflective of community and cultural needs.
- Managing probity and conflict of interest requires suitable and potentially novel mechanisms that provide a level of assurance and transparency to all parties.
- Accountability and reporting mechanisms will need to be flexible to enable CaTHC, service providers and communities to devise innovative care solutions that respond to need.
- Investment in relationship management and collaboration across the health system will underpin the development of CaTHC and a transition to effective commissioning.

Background

Establishing a regional community-controlled health commissioning body was proposed in 2014 by Aboriginal and Torres Strait Islander organisations as a pathway to improved population health and wellbeing in the region. In March 2021, the Australian and Queensland Health Ministers signed the HIF Bilateral Agreement, committing to the establishment of an independent community-controlled regional healthcare commissioner. A project partnership was formed to co-develop the new entity comprising community leaders across the Cape York and Torres Strait region, the Australian and Queensland governments, and QAIHC. Formerly called the Torres and Cape Health Care Commissioning (TORCH) project, the name was subsequently changed to the CaTHC project.

CaTHC was established on 1 May 2024 as a Public Company Limited by Guarantee registered with the Australian Securities and Investment Commission, and proposed registration with the Australian Charities and Not-for-Profit Commission. A Board comprising Aboriginal and Torres Strait Islander Directors was appointed to reflect the diversity of communities across East Cape York, West Cape York and Torres Strait. The CaTHC entity's inaugural Chief Executive Officer commenced on 11 November 2024. CaTHC is independent from governments, but will provide regular reporting on expenditure, performance and health outcomes.

Over the next 10 years, the aim is for relevant healthcare funding from the Australian and Queensland Governments to gradually transition to the CaTHC entity for the purpose of commissioning health services. A phased process will enable CaTHC to develop a suitable operating model and commissioning functions and conduct strategic planning and priority setting. Commissioning will be informed by data and evidence to understand population health needs, plan and co-design innovative responses, and contract services that deliver models of care informed by community. At full capability CaTHC should exercise increasing responsibility over health funding decisions in the region.

CaTHC aims to contribute to Aboriginal and Torres Strait Islander peoples' self-determination over their health and wellbeing and the quality of care they receive. Aboriginal and Torres Strait Islander peoples comprise approximately 70% of the regional population yet experience marked health disparities compared to the wider regional and state-wide population [1]. CaTHC has the potential to deliver systemic change and aligns with the CtG, and other government policies that place equity and genuine partnerships at the centre of healthcare design and delivery.

EVALUATION OF CaTHC

CQUniversity's Jawun Research Centre, in partnership with the University of Sydney's University of Sydney's Leeder Centre for Health Policy, Economics and Data and the Poche Centre for Indigenous Health were contracted by QH to evaluate and provide quality assurance for the CaTHC project in October 2023. The evaluation provides an:

- Assessment of the establishment and initial commencement phases of CaTHC to inform quality improvements.
- An Impact Evaluation Framework to inform the transition to full commissioning.
- Insights and learning that have potential application for other jurisdictions.

A series of reports have been completed and delivered to QH as per the contract agreement including:

1. Project Assurance and Evaluation Approach, Oct 2023.
2. Project Assurance and Evaluation Methodology and Plan, Nov 2023.
3. Initial Strategic Assessment and Quality Assurance Report, Dec 2023.
4. Mid-Term Assessment and Quality Assurance Report, Jun 2024.
5. Impact Evaluation Framework (including Logic Model), Jun 2024.
6. Final Assessment and Quality Assurance Report, Dec 2024.
7. Publication: Commissioning health services for First Nations, regional, and remote populations: a scoping review, Dec 2024.
8. Final Evaluation Report (including Logic Model), Jan 2025.
9. Evaluation Summary, Mar 2025.
10. Community-Informed Health Outcomes Framework, Mar 2025.
11. Manuscripts for publication (x3), Mar 2025.

AIM, QUESTIONS AND ETHICS

This evaluation report covers the CaTHC project over the period August 2022- December 2024, following its internal transfer within QH from Community Services Funding Branch - Healthcare Purchasing and System Performance Division, to the Reform Office - Strategy, Policy and Reform Division.

The aim of the evaluation is to assess the quality and delivery of the combined CaTHC project components, their contribution to the overall reform, and how well they meet the requirements of project partners, regional leaders and stakeholders. The evaluation offers detailed analysis of the following components:

- Project planning and delivery, resources, and workforce required for successful implementation.
- Governance and collaboration, covering the project partnership, interagency coordination, PSC oversight and realising self-determination through the reform process.
- Model design and implementation, including selection of entity type and governance options, funding mechanisms, policy and legislation, data access and accountability frameworks.
- Community and engagement, the application of co-design, communication activities, and the level of support and legitimacy amongst stakeholders.

This report is structured according to an Evaluation Framework provided by QH and endorsed by the former PSC, as found in Figure 1 below. The evaluation answers the series of questions listed in the Framework. (Please note several questions have been slightly updated to reflect project priorities). The evaluation is guided by the following overarching question:

What enabling conditions (e.g. resourcing, workforce, funding and other inputs) and strategies (e.g. stakeholder engagement, collaborative governance, co-design) are required to establish the CaTHC entity and commissioning model?

The evaluation applied for and received ethics approval from the Far North Queensland Human Research Ethics Committee (HREC/2023/QCH/97970 (Jun ver 2)–1723). Site-specific Authorisations covering the QH Reform Office, First Nations Health Office, and Healthcare Purchasing and System Performance Division was granted in early November 2023, and separately for the TCHHS in May 2024. A second approval was granted from the CQUniversity Human Research Ethics Committee (ID: 0000023943), for all non QH participants.

FIGURE 1: PROJECT STEERING COMMITTEE ENDORSED EVALUATION FRAMEWORK

Project & Deliverables	Collaboration & Governance	Model Design & Implementation	Community & Engagement
EVALUATION DOMAINS Cost, Feasibility, Fidelity	**EVALUATION DOMAINS** Acceptability, Feasibility, Scalability, Sustainability	**EVALUATION DOMAINS** Acceptability, Feasibility, Fidelity, Scalability, Sustainability	**EVALUATION DOMAINS** Acceptability, Awareness, Sustainability
EVALUATION QUESTIONS › Has the project been delivered in accordance with the allocated resources (including financial and non-financial inputs) and timeframes? › To what extent were the right workforce capacities and capabilities leveraged to ensure the project was delivered effectively and efficiently? › How appropriate were the resources allocated to the TORCH project to achieve its objectives (including financial and non-financial resources, such as funding, workforce, time and so on)?	**EVALUATION QUESTIONS** › To what extent have the agreed governance arrangements for collaboration operated effectively, efficiently and with legitimacy and appropriate authority? › How well has data and evidence been used for strategic learning and decision making - to understand and adapt to problems, opportunities and progress? › Have the established procedures and approaches for collaboration between governments and government agencies (vertical & horizontal) been effective and what lessons for bilateral relations, implementation and collaboration can be learnt?	**EVALUATION QUESTIONS** › How has the TORCH model evolved and to what extent does the agreed Steering Committee model align to established principles and objectives of TORCH? › To what extent has the TORCH approach established a sustainable, integrated model within the broader health system (including policy and governance, regulation, legislation and service system) and place of intervention? › To what extent have appropriate supports been established to support the intended functions and readiness of TORCH model (including governance supports, data frameworks and access and appropriate skills, capacity and capability)? › What lessons have been learn from a health system perspective on the conditions, approaches and strategies needed to create systemic change, including appropriate allocation of commissioning expertise aligned to capacity, capability and population health needs of the region?	**EVALUATION QUESTIONS** › Has the governance, decision-making and engagement through TORCH been transparent and sufficiently responsive, representative and accountable to those with a stake in the system? › To what extent were ethical practices and probity considerations embedded in TORCH, including appropriate measures and practices First Nations people and cultures?

SETTING

CaTHC aligns with the TCHHS region, covering Cape York Peninsula and the Torres Strait Islands. At 130,238km2 the regions are geographically large, and comprise a culturally and linguistically diverse Aboriginal and/or Torres Strait Islander and non-Indigenous population of approximately 28,000 [1]. The population resides in small rural towns, remote communities, and very remote communities based on the Modified Monash Model. The regions are divided into 14 Local Government Areas, with 10 comprising Aboriginal or Torres Strait Islander Councils that provide representation and leadership for community interests. Health services are delivered through a mix of public, community and a small number of private providers. The TCHHS is the largest public health provider, with four hospitals located in regional centres, and 31 primary health care facilities located in communities [1]. ATSICCHOs operate multiple community facilities, providing a combination of primary care, maternal and paediatric care, mental health and social and family wellbeing services. In addition is a Primary Health Network (PHN) that commissions select programs, and the RFDS that delivers aero-medical care across the region.

EVALUATION APPROACH

Theory driven program evaluation [2] was used to develop a plAusible logic model for the CaTHC project and can be found in Appendix 1 (see attached). Using program logic makes explicit the goals, objectives and interrelationships between each of the activities undertaken within the CaTHC project. It focusses the evaluation on elements of the reform that are of relevance to project partners, to assess if they have been implemented as intended [3, 4]. The program logic outlines the different inputs and activities, identifies relationships and pathways leading to outcomes, and the contextual factors that contribute to impacts [5]. Application of a program theory involved systematic use of knowledge about CaTHC to: (1) develop an explicit model about how each enabler and strategy in the project operates (2); test and revise assumptions to determine merit and value of each; and (3) generate new knowledge and insights to inform quality improvements for the next phase of CaTHC. Information generated through the program theory aims to facilitate organisational level learning about factors that contributed to success.

The Ngaa-bi-nya Indigenist evaluation framework [6] was adapted to the CaTHC project. Ngaa-bi-nya is designed to stimulate data collection and analysis of issues relevant to Aboriginal and Torres Strait Islander peoples' knowledge, values, ethics, and ways of caregiving that influence success of health programs [6, 7]. Application of Ngaa-bi-nya, will focus the evaluation on the priorities and values that regional leaders and stakeholders hold in relation to health commissioning, as well as the governance and objectives of the new entity. Ngaa-bi-nya also accounts for the wider social, cultural and political determinants of health in the Torres Strait and Cape York regions, which are directly influenced by health system effectiveness and performance. Ngaa-bi-nya is structured around four domains: contextual landscape, diverse resources, cultural relevant ways of working and the learnings realised. Each domain contains a series of prompts and statements to guide the evaluation. Prompts broadly cover the social, policy and program context; financial, human and material resources; cultural care and competency; sustainability, self-determination and community-control; and developing the evidence base [6].

Ngaa-bi-nya domains and prompts informed the analysis. They were refined to develop a set of criteria for assessing the performance of various CaTHC enablers and strategies. A straightforward Likert scale system (very good - poor) was applied to assess quality of implementation relevant to each criterion. The assessment contributed to overall judgments about reform components. A full table with assessment scoring can be found in Appendix 2.

METHODS

Data was collected from a series of semi-structured interviews and workshops. Over the data collection period 25 interviews and 5 workshops were held with a combined 48 participants. Sampling aimed to account for the diversity of interests with a stake in the CaTHC initiative. Guided by advice from project partners, a cross section of participants was invited to participate in interviews/workshops. These included executive and senior managers from Aboriginal and Torres Strait Islander organisations, Councils, Queensland and Australian government agencies, service providers including ATSICCHOs, public health providers and other commissioning bodies. Interviews and workshops were conducted either in-person and/or on-line, depending on availability, with interviews taking on average 1 – 1.5 hours. A semi-structured interview questionnaire and workshop briefs were prepared and reviewed by project partners. Participants were asked about the steps and processes for establishing a new entity, any barriers or risks, and wider health priorities and challenges in the region. Subject to participant consent, interviews and workshops were recorded and transcribed, and all data were deidentified.

A total of 135 documents related to the project were analysed together with the interviews and then triangulated to improve reliability. Documents were provided by QH and included draft internal policy and discussion papers, reports, briefings, updates, presentations, official meeting agenda papers, consultation materials, and materials prepared by external consultants. The documents covered all related aspects of the CaTHC project; however not all material was made accessible to the evaluation. Several reports were provided by DoHAC, however a broader set of pertinent documents from this agency and QAIHC were not accessed. Confidentiality agreements as required by QH were signed by evaluation team members.

Information from the interviews/workshops and documents was analysed using grounded theory methods. Grounded theory methods are suited to conducting applied evaluative studies of complex system-wide interventions designed to address structural issues with the health system [8]. Interview transcripts were imported into NVIVO 20 for analysis and then coded. Open coding grounded theory methods were applied to identify and build a set of concepts and insights that can be drawn from the data. The application of grounded theory aimed to understand interrelationships, properties and processes inherent in the CaTHC reform and across multiple levels of analysis [8]. The coded material was then organised to answer the evaluation questions and each component of the reform.

Section 1: Project and Deliverables

Assess if project planning, resourcing and other inputs are sufficient and appropriately utilised to deliver CaTHC project outcomes within agreed timeframes.

QUESTION 1

Has the CaTHC project been delivered in accordance with allocated resources (including financial and non-financial inputs), planning and timeframes?

QUESTION 2

To what extent were the right workforce capacities and capabilities leveraged to ensure the project was delivered effectively and efficiently?

QUESTION 3

How appropriate are the resources allocated to CaTHC project to achieve its objectives (including financial and non-financial resources, such as funding, workforce, time and so on)?

PROJECT DELIVERY AND TIMELINES

Table 1 below provides a status of the main outputs, completion and delivery ratings. Work package outputs have been rated on how well they were delivered with metrics based on timeliness, and application and contribution of the deliverable to project objectives. Each will be covered in more detail throughout the report.

Please note that this next section focusses on planning activities and processes engaged by QH, as referenced from project documents. It does not detail the internal planning undertaken by CaTHC, QAIHC or DoHAC as this was outside the scope of the evaluation.

From the information provided, CaTHC project workstreams and related activities were successfully planned, managed and coordinated amongst the project partners. Significant progress has been made across multiple outputs, and overall, the reform appears well positioned for the next phase. Each stage involved detailed assessment, the preparation of reports, documents and materials to inform the process, deliberate over options, and outline pathways and appropriate steps to implement each component. Government partners noted that the preparation of reports and discussion papers, although resource intensive, provided valuable information to guide decisions. The range of tasks has required dedicated effort and investment to deliver combined outputs over the reform period. However, complex and detailed reforms will need to be actioned if CaTHC is to commission services into the region.

Extensive planning was undertaken for delivery of the CaTHC project following transfer to the QH Reform Office in August 2022. Planning was structured around seven workstreams and work packages that outlined the main deliverables and activities to establish the entity. Each of the work packages will be covered in more detail throughout the evaluation. Work package 7 focused on forward planning to implementation. Deliverables included the Critical Path, Gannt chart and Project Workplan (6 monthly) documents that scheduled each

activity and identified responsibilities, with decision points mapped to milestones. The Critical Path document provides a valuable tool to sequence, track, and reassess outputs against timelines. Progress reporting was provided against each work package to the PSC. The QH Reform Office also provided regular project reporting and output tracking to executive management.

Milestones shifted throughout the process to accommodate changes in project priorities or in response to delays. Several work packages were completed within estimated timeframes prior to the planned entity start date of July 1, 2024. For example, the CaTHC entity was established ahead of time, operational funding was secured, investment streams were mapped and transfer mechanisms identified. Other work packages experienced slower than expected implementation, with some milestones only partially completed, and were reassigned to the CaTHC commencement phase. Early commissioning activities and legislative reforms, for example, were rescheduled to occur from 2026 onwards.

Alignment and efficient sequencing of workloads in a cross-jurisdictional reform can be intensive and challenging. Project partners offered different perspectives on milestone delivery and cAuses for slippage. Governments identified that the nuanced, complex and unprecedented nature of the reform meant that project components evolved in an organic way and required analysis and testing of different options. Several noted that output timelines were overly ambitious considering the range of tasks. Uncertainty over how project components should be delivered also affected progress. As stated by a government partner:

We haven't met the timeframes that we originally thought possible, and the original timeframes were completely ambitious. It hasn't gone fast enough in some regards, but it's understandable when you are going through something that's completely new that we've never done before.

Multiple interdependencies between work packages meant that delays with certain activities impeded progress and impacted workloads in other areas. Several respondents questioned the planning and prioritisation of deliverables, and those that were left until later in the process and remained incomplete. The changeover in QH project responsibility from the Community Services Funding Branch to the Reform Office in mid- 2022 affected momentum and reduced corporate knowledge, and there was limited transfer of project documentation. Further delays include the contracting of QAIHC to conduct regional engagement activities, commencing in early 2023. Project disruptions, though not uncommon, may have particularly impacted CaTHC as progress was critically dependent on relationships, trust and regular communication with stakeholders. A full discussion of these challenges is covered throughout the report.

WORKFORCE

The CaTHC project workforce included staff in each of QH, DoHAC and QAIHC, contributing directly to the reform. Additional workforce capabilities and resources within agencies have been drawn upon as appropriate to meet project requirements or for specific expertise, including senior executives. DoHAC employed additional officers in 2023, indicating renewed commitment to the CaTHC reform. Employing dedicated staff has contributed to stronger internal agency planning and delivery, and to overall inter-agency and cross-partner coordination. The workforce experience and contribution were adequate for the project, and there was a complementary mix of skills, experience and expertise amongst the partners. The level of consistency in staff engaged in the reform over 2023-2024 contributed to stronger corporate knowledge and overall outcomes during this period.

Personnel and corporate planning issues have at certain stages precipitated delays. The changeover in project teams within QH resulted in realignment and pAusing of activities, and staff turnover also occurred within DoHAC and QAIHC. This contributed to the 12-month timeline extension for the proposed establishment of the entity to July 2024, to complete the required work. Additional capacity and expertise drawn earlier from other sections and branches within governments could have improved implementation, particularly for work packages requiring wider input and with tight timelines.

Regional leaders and elected representatives made an invaluable and enduring contribution to the CaTHC reform across multiple years. Regional leaders nominated to be conduits to the community, garner feedback into co-design processes, and regularly attend meetings, briefings and workshops. Although remunerated for attending formal engagement sessions and PSC meetings, their expertise and contribution remain undercompensated. Multiple competing work and representative priorities, and wider community responsibilities place demands on their time and commitment. Much of their wider contribution to the CaTHC reform was voluntary, with an expectation that community members will contribute their time and resources.

Consideration of workforce requirements is viewed as a priority for the next phase, to deliver the components required from project partners, and to enact structural changes within the health system. Health reform programs have higher impact and improved health wellbeing outcomes when they Aboriginal and Torres Strait Islander led, and communities are engaged throughout. This necessitates adequate investment and resources for the employment of community members and facilitators, as well as skills and workforce development where required. As recommended by interview respondents, CaTHC will require an experienced workforce to facilitate each stage of the commissioning process. This may prove challenging in the region.

If you think about that whole commissioning cycle you need good skills sets around procurement, design, marketing, engagement and people with health practitioner backgrounds as well as corporate backgrounds. The challenges are great in finding a workforce that is skilled and confident in those positions and in Far North Queensland we have workforce challenges.

So, one of the considerations is where do you get the people with the skills to do the required work as commissioners and to deliver on the functions when CaTHC is stood up.

If you are trying to recruit Torres Strait Islander people with the skills to be able to run this facility, run this commissioning framework and body, that's something that is difficult to maintain. They will need experience in mental health, in workforce management, clinical, youth and all the different priorities for commissioning across multiple areas.

RESOURCES

The initial HIF contribution from the Australian to Queensland Government was Aus$4.56m. Expenditure over this period has focused on QH staff costs, legal advice and stakeholder engagement and communication activities. QAIHC was resourced to deliver several work packages, including community engagement and entity establishment, in support of the Interim Board and Chairperson. Costs incurred by QAIHC have been funded from the project.

The budget appears suitable for overall project delivery and was adequately managed. Additional resources have been drawn from Queensland and Australian governments for specific components, including contracting to third parties for specific pieces of work (see table 1 below). Governments emphasised that dedicated resources enabled the different project teams to work collaboratively to produce combined outputs. Others noted the contribution of significant non-financial resources and in-kind costs, including executive staff time. In terms of scalability these high establishment costs may prove unfeasible for other jurisdictions.

Incomplete or delayed work package activities indicate insufficient resources were allocated to some areas. A significant proportion of the budget was invested in regional engagement and co-design, however delivery challenges in this area suggest that resources (financial and non-financial) were underestimated. Delays were also experienced in negotiating and finalising contracts, affecting the roll-out of engagement activities. Issues were noted with the invoicing and payment of contracted work to project partners (and consultants) without prior agreement from sponsors.

TABLE 1: PROJECT OUTPUTS AND DELIVERY AUG 2022 – DEC 2024

Metric: Timeliness, delivery and/or contribution to project outcomes.
Good: Well delivered and important contribution.
Moderate: Delivery could be improved, but valuable contribution
Poor: Delivery has been delayed, and/or of limited contribution.

Workstream	Work packages	Outcomes	Outputs/ deliverables	Lead	Status	Delivery rating
Engagement Consultation, engagement and co-design, supporting appropriate engagement and input from relevant stakeholders and community	WP1.1 Community engagement WP1.2 Engagement with other key stakeholders	› Co-design informs work packages and selected outputs. › Ongoing co-design during transition phase that reflects stakeholder needs. › Appropriate education and communication materials developed and shared. Consultation supports smooth transition period.	Engagement plan	QH/QAIHC	Completed 23	Good
			Engagement activities	QH/QAIHC	Ongoing/delayed	Moderate/poor
			Co-design plan	QAIHC	Completed 23	Good
			Co-design activities	QAIHC	Ongoing	Moderate
			Forums (Summit, Caucus)	KPMG/QH	Completed 23	Good
			Communication pack	QH/QAIHC	Completed 23	Moderate/poor
			Website, newsletters, presentations	QH/QAIHC	Completed 24	Moderate
			Statement of Intent		Discontinued	Poor
Legislation and policy Legislative and policy review to assess impact of CaTHC and actioning required legislative and policy changes to operationalise commissioning.	WP2.1: Legislative and policy review WP2.2: Impact assessment WP2.3: Data sharing	› Detailed legislative review completed that informs entity design and operation. › Scope of impacts for CaTHC understood to inform planning and communication. › Required data sharing and sovereignty arrangements are in place. › Entity has appropriate data and systems to enact initial functions.	Draft policy paper update	QH	Ongoing	Moderate
			Legislative review	QH	Completed 24	Good
			Impact assessment	QH	Completed 24	Good
			Cabinet submission	QH	Ongoing/delayed	Moderate
			Legislative changes	QH	Ongoing/delayed	Moderate
			Data discussion paper	DoHAC	Discontinued	Moderate/poor
			Data sets identified	QH	Completed 24	Good
			Data deed of disclosure	QH/CaTHC	Ongoing	Good/ moderate
			Data sharing agreement	QH/CaTHC	Ongoing	Moderate
Funding Health service funding review and eligibility for transition to CaTHC and to support planning. Includes entity operational funding.	WP 3.1: Investment mapping phase 1 WP 2.2: Investment Mapping Phase 2 & 3. WP 3.3: Operational funding WP 3.4: Review of funding transition and prioritisation. WP 3.5: Funding model and outcomes framework	› Phase 1 investment mapping informs scope of funding and threshold decisions. › Phase 2 investment streams are tested. › CaTHC has sufficient operational funding to fulfil functions and develop. › Phase 3 funding identified for transition to CaTHC over time. › Application of prioritisation framework & analysis of funding options inform investment model & transfer schedule.	Initial investment scoped	DoHAC/ KPMG	Completed 23	Good
			Full investment report	DoHAC/ KPMG	Completed 23	Good
			Prioritisation framework	DoHAC/ KPMG	Completed 24	Good/ moderate
			Funding options analysis	QH	Completed 07/24	Good
			Funding mechanism	DH/DoHAC	Ongoing	Moderate
			Long term agreement	DH/DoHAC	Ongoing	Moderate
			Operational budget	DH/DoHAC	Completed 24	Good (QH only)

TABLE 1: PROJECT OUTPUTS AND DELIVERY AUG 2022 – DEC 2024

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Moderate: Delivery could be improved, but valuable contribution
Poor: Delivery has been delayed, and/or of limited contribution.

Workstream	Work packages	Outcomes	Outputs/ deliverables	Lead	Status	Delivery rating
Entity design Effective design of commissioning entity, including governance bodies with a view of phased functions	WP4.1: Entity design and governance	› Appropriate entity structure and governance model is co-designed and established.	Entity structure option	QAIHC/QH/ DoHAC	Completed 23	Good
			Commencing functions	QH	Completed 23	Moderate
			Entity governance options	QAIHC	DoHAC/QH	Moderate
			Accountability framework	QH/DoHAC	Ongoing/delayed	Moderate/poor
Implementation Implementation and transition planning for CaTHC, including operationalisation of the entity.	WP5.1: Implementation planning WP5.2: Entity establishment WP5.3: Health needs and services assessment	› Plan in place to support successful implementation and transition, with no disruption to services. › Entity is successfully established, with relevant registrations complete and appointments, tasks completed. › Entity develops clear understanding of region's health and service needs. › Entity effectively manages system change and builds capacity across stakeholders.	Interim Board process	QAIHC/QH	Completed 23	Moderate
			Transition plan outline	QH/DoHAC	Discontinued	Moderate
			Entity design	IB/QAIHC	Completed 24	Good
			Entity registration, constitution	IB/QAIHC	Completed 24	Good
			Directors	IB/QAIHC	Completed 24	Good
			Constitution	IB/QAIHC	Completed 24	Good
			CE appointment	CaTHC	Completed 24	Moderate
			Health needs assessment	CaTHC	Ongoing	N/A
			Engagement/ planning	CaTHC	Ongoing	N/A
Evaluation Evaluation of the CaTHC project that supports iterative maturation of the entity over time.	WP6.1: Project evaluation, quality assurance and impact framework	› Understanding of successes and lessons from CaTHC project. › Iterative process of learning and change is embedded into entity and system. › Impact evaluation framework developed to measure impact and outcomes of CaTHC.	Methodology and plan	CQU/USyd	Completed 23	N/A
			Quality Assurance Reports x 3	CQU/USyd	Completed 23-24	N/A
			Impact Evaluation Framework	CQU/USyd	Completed 24	N/A
			Evaluation Report	CQU/USyd	Completed 24	N/A
			Plain English Summary	CQU/USyd	Completed 25	N/A
			Outcomes Framework	CQU/USyd	Completed 25	N/A
			Publications	CQU/USyd// QH	Completed 25	N/A
Project governance Effective governance of CaTHC project, including transition of project governance once CaTHC is established.	WP7.1: Agreement for CaTHC governance WP7.2: Governance transition	› Formal agreement between QLD and Australian governments in place to operationalise entity. › Governance is effectively transitioned to new mechanism(s) to oversee entity operation.	Project Steering Committee	DH/DoHAC/ QAIHC	Completed 24	Moderate
			Project Partnership	DH/DoHAC/ QAIHC	Completed 24	Moderate
			Partnership Agreement (new)	DH/DoHAC/ CaTHC	Ongoing	Moderate
			Steering Committee ToR (new)	QH	Ongoing	Moderate
			Bilateral agreement	QH/DoHAC	Ongoing	Moderate/poor

Section 2: Collaboration and governance

Evaluate if governance of the CaTHC project is collaborative, effective and conducive to the establishment of the new entity and facilitates regional self-determination.

QUESTION 1

To what extent have the agreed governance arrangements for collaboration operated effectively, efficiently and with legitimacy and appropriate authority?

QUESTION 2

How well have data and evidence been used for strategic learning and decision making – to understand and adapt to problems, opportunities and progress?

(Please note - this question is answered in Section 3)

QUESTION 3

Have the established procedures and approaches for collaboration between project partners (vertical and horizontal) been effective and what lessons for bilateral relations, implementation and collaboration can be learnt?

QUESTION 4

To what extent have the governance arrangements and procedures been responsive to Aboriginal and Torres Strait Islander members and their priorities for self-determination within the health system?

Project governance

Governance arrangements for the CaTHC project were established early and evolved to accommodate shifting priorities. A flowchart of engagement and governance processes can be found in Appendix 3. A partnership operated between QH, DoHAC, QAIHC and community leaders to deliver reform elements and was overseen and supported by the PSC. Both the project partnership and the PSC operated effectively as collaborative planning and decision-making forums to deliver mutually agreed outcomes over an extended period. Strengthening and managing relationships and building rapport across government agencies, and with external organisations and regional leaders, has contributed to success thus far. Project partners displayed capacity to learn, adapt and adjust priorities as information became available, and to navigate challenges as they emerged. Challenges were experienced within the project partnership, including significant differences around shared decision-making between the Board/QAIHC and governments. The PSC would have benefited from strengthened direction by regional Aboriginal and Torres Strait Islander representatives, and improved information flow from community to inform high-level decisions.

PARTNERSHIP

The project partnership operated over the duration of the reform, with responsibility for implementation of the seven work packages. Each party assumed the lead for different components, although cross-organisational collaboration was essential in multiple areas. The partnership convened regularly, and flexibility and adaptiveness has been important for planning and negotiating agreed approaches and solutions to various steps. Government partners highlighted the strength of the partnership, and that consistency and commitment from members had proven pivotal to overall project momentum. Others shared the view the partnership experienced tensions and was inconsistent with CtG commitments to shared decision making (see discussion below). At times it required deft relationship management and negotiation to resolve differences, and not 'walk away' from the project.

Several persistent challenges were encountered that required resolution on a path forward. Interviewees emphasised that governments were reluctant to share decision-making responsibilities with community representatives and were unwilling to relinquish control over aspects of the project. A breakdown in the project partnership occurred between December 2023 and April 2024, precipitated by divergent views on pathways and timeframes for entity establishment and Interim Board arrangements. During this period, the Interim Board supported by QAIHC moved separately to establish the entity. There was limited communication or clarity on project milestones between QAIHC/Interim Board and governments, although each party continued leading activities. Importantly, the project partners, together with the Interim Board, reconvened in April 2024 and renewed their commitment and reset expectations and roles moving forward.

The relationship challenges precipitated a notable shift in the focus and direction of the partnership. Governments adopted a more supportive role, providing the enabling environment by delivering specific components, such as legislation and funding reform. As agreed with the Board, they will not be directly involved in operations of the entity, or commissioning functions, and will provide the operative space for CaTHC to set its strategic direction. Supporting the continued expansion of CaTHC will necessitate governments to deliver components as required, but also cede increasing responsibility to the entity, and by extension community interests. Experience from the transition to community-control of health services suggests that bureaucratic resistance, uncertainty about the process, and shifting priorities and expectations will all need to be effectively managed [8]. Government partners will need to understand and be willing to remove the institutional barriers, address any power imbalances and provide latitude for CaTHC to work in the interests of the community. As stated by one project partner on the future of CaTHC:

The view held by the Board is that they need to provide much greater autonomy to the individuals in a community than governments are prepared to do. Governance arrangements, reporting accountabilities need to give the entity freedom to explore those concepts, make investments, see whether the community do accept the level of responsibility that's being offered them by the CaTHC entity and just see what happens.

PROJECT STEERING COMMITTEE (PSC)

The PSC oversaw the high-level governance of CaTHC since its inception in May 2021, until its dissolution in June 2024. However, the PSC did not meet formally after December 2023. As a collaborative decision-making forum, the PSC appeared suited to its purpose and was well-supported with pre-prepared materials. It provided a regular forum for senior government and regional leaders to come together and deliberate, with decision making by consensus. The Terms of Reference were amended multiple times, to reflect its shifting role from providing strategic leadership to facilitator of outcomes. The purpose and functions of the PSC were updated in August 2023 to '...oversees the development and execution of the shared health reform agenda for the Torres and Cape region (the region) to develop a community-endorsed proposal for a Torres and Cape Health Care (TORCH) Commissioning Fund, in line with regional health needs, community objectives and voices, and government priorities.' The PSC also oversaw strategic risk management and project monitoring and evaluation.

Membership comprised executive level officers from QH (Co-Chair Deputy Director General, Healthcare Purchasing and System Performance and Chief Fist Nations Health Officer), DoHAC (Co-chair First Assistance Secretary, Primary Care Division, and First Assistant Secretary, First Nations Health Division), QAIHC (Chair and Board Member), Torres Strait Regional Authority (TSRA) (Chair), Torres Cape Indigenous Council Alliance (TCICA) (Chair). Additional members were invited in July 2023 to improve consistency in representation, namely Cape York Land Council (Chair) and Gur A Baradharaw Kod (GBK) (Chairs). Observers from the above organisations also participated. Major stakeholders not included were service providers including ATSICCHOs (Apunipima, Torres Health) and TCHHS, although the latter is part of QH. The PSC met six times, with one cancellation. Attendance at meetings was not always consistent, and regional Aboriginal and Torres Strait Islander representation was insufficient at two meetings. The PSC was officially dissolved in March 2024, aligned to its ToR. However, a multi-party governance structure was not operating throughout 2024 to provide strategic leadership and a shared decision-making forum. Further, the PSC was unable to mitigate risks leading to the breakdown in partnership outlined above, or retain participation by Torres Strait representatives, see below.

The PSCwas co-chaired by senior government executives and by intention or default remained a state-driven governance mechanism. This represents parties to the Bilateral Agreement under the HIF but does not realise the full extent of shared decision-making required under the CtG. A co-chair position could have been established/offered to representatives from an Aboriginal and Torres Strait Islander body (such as Chair of TCICA or QAIHC) given the centrality of partnerships to the reform. A co-chair could have contributed accountability for regional members, particularly in the absence of the proposed Aboriginal and Torres Strait Islander Community Controlled Steering Committee (discussed below). Experience with health commissioning in other jurisdictions has emphasised the need for mechanisms that facilitate the flow of information from community through to governance and accountability bodies.

Several PSC members noted the need for clearer delineation of decision-making functions, including management of contentious issues, and how community members can influence those decisions. Each member brings certain skillsets, but cultural knowledge and expertise is equally, if not more valued in this context. Mechanisms for how community perspectives have been presented and then actioned within the PSC could have been improved. Pre- and post-meeting communication processes needed to encourage and support participants to engage more fully and provide informed feedback, either in-person or remotely. Challenges with information volume in meeting materials, internet coverage, time commitments, competing priorities and the meeting environment also impacted on the quality of feedback. Suggestions include:

Help and support people in their preparations for very formal meetings so that they come feeling engaged and informed and that their voice is valued and acknowledged, and so decisions can be made.

Information channels need to be established and/or strengthened between community members, service providers and any high-level governance and decision-making body, to reflect and action priorities driven by community members and end-users in response to major decision points.

STRATEGIC PARTNERSHIP GROUP (COMMENCEMENT PHASE)

A Strategic Partnership Group has been proposed as the formal mechanism between CaTHC, QAIHC, and governments for implementation of the next phase. A Draft Partnership Agreement and Draft Accountability Framework are also under development which aim to clarify the roles and responsibilities for each party. The proposed Partnership Group has a broad scope and capacity to address any issues relevant to the reform. Further, it aims to collectively identify and address systemic barriers to delivery of community-controlled commissioning outcomes. In a notable shift, meetings will be chaired by the CaTHC Board Chair or CEO. Although sharing similarities with the former PSC, the draft ToR indicates a change in approach and a focus on delivering the four priority reform areas of the CtG.

Members will work in partnership to facilitate the implementation of CaTHC including phased transition of commissioning functions. Members will work together to provide an enabling environment that will deliver a collaborative and outcomes-focused approach that actively supports, and systemically enables, self-determination in healthcare planning and commissioning.

Self-determination

Leadership by Aboriginal and Torres Strait Islander representatives was critical to the governance and success of the reform initiative, and they have repeatedly stated the primacy of community-control. Regional leaders and QAIHC have stressed that community should determine aspects of how and through what mechanisms commissioning operates. The creation of the Community Caucus and Interim Board were worthwhile governance forums for enacting community-control. The Interim Board and QAIHC took steps to exercise their authority in setting up the entity, appoint directors and approve a constitution. Board Directors will act independently in overseeing operations of the new entity, without governments directly advising or intervening.

Self-determination and community-control are foundational to the CaTHC reform. The initial HIF Bilateral Agreement supported the establishment of an independent community-controlled regional healthcare commissioner. A draft QH Policy Paper developed in 2022 makes explicit reference to CaTHC as a population-wide initiative, but with self-determination to be realised through Aboriginal and Torres Strait Islander leadership. CaTHC was established as a self-governed body and when fully operational will support Aboriginal and Torres Strait Islander sovereignty over decisions and programs that impact their health. As stated in its constitution, CaTHC aims to have the capabilities to determine funding and program priorities that drive improvements in health service performance and health outcomes for the community.

The reform process has experienced some persistent issues in realising community-control, and reconciling differences on how to implement project components through a partnership approach. In feedback provided to the evaluation it was stressed that partnerships do not equate to governments having influence over, or input into, every component, reflective of their strategic priorities. QAIHC and regional leaders required space to conduct activities and exercise decisions in the interests of community but felt disempowered by government involvement. Government partners have emphasised that CaTHC is a joint commitment, but navigating their role in the evolving process has at certain stages been problematic.

There remain different interpretations amongst project partners on what constitutes community-control and how decision-making is to be actioned by various parties. Government respondents suggested an agreed definition for community-control was required, such as provided by National Aboriginal Community Controlled Health Organisation (NACCHO) (see below). However, any definition and its application to Cape York, Northern Peninsula Area (NPA) and Torres Strait regions should be adaptable to local governance and decision-making procedures.

...community-control in health services is a process which allows the local Aboriginal [and Torres Strait Islander] community to be involved in its affairs in accordance with whatever protocols or procedures are determined by community.

Governments have emphasised that suitable mechanisms and agreements need to be in place, considering the large volume of public health investment. Underlying this position is that the state retains responsibility over all components and all levels of the health system, as regulator, majority investor and provider of services. Transitioning to community-control of health funding is untested and poses major uncertainties and risks for governments in terms of service delivery and continuity of care. QH reiterated that there are complicated legislative, policy, and funding reforms to operationalise commissioning, and these reforms must be conducted by governments, and informed by community. However, issues around scope, governance and decision-making authority, and community-control vis a vis government require agreements that accommodate the changing requirements of CaTHC and the communities and beneficiaries they will serve.

COMMUNITY CAUCUS

QAIHC, together with regional leaders and elected representatives have been engaged over the duration of the reform. In 2023, QAIHC convened a Community Caucus to bring together multiple community stakeholders to formally deliberate on aspects of the reform, make decisions and advise governments. The Community Caucus provided a valuable forum for regional leaders and was a catalyst for entity establishment. Meetings were held in May and October 2023 - comprising representatives from Councils, Traditional Owner Groups and ATSICCHOs from Cape York, NPA and Torres Strait. TCICA also provided a forum for elected leaders to advise the process.

At the Community Caucus meeting held in May 2023 it was agreed to support a regional community-controlled commissioning model. Further, the Caucus proposed establishment of a Regional Aboriginal and Torres Strait Islander Community Controlled Steering Committee as a formal governance mechanism that would make recommendations to the PSC. The Committee would lead the creation of the entity, design its operational structure, engage community, and lead or inform other work components. The Committee was never established, with the Interim Board appointed in December 2023. Considering the importance of self-governance and regional leadership, the Community Controlled Steering Committee offered a sound proposal, and if created earlier could have served a valuable function through the reform period. It could have facilitated negotiation over key reform elements and enabled more direct and comprehensive community exchange, adding transparency and legitimacy to the process.

A focus on the political determinants of health has reinforced the benefits of Aboriginal and Torres Strait Islander sovereignty over policy and program priorities in the health system. Political determinants encompass the collective governance capabilities and foundational capacities that enable Indigenous Nation Building, which fosters healthy futures for Aboriginal and Torres Strait Islander citizens and community[9]. Experience has shown that Nation Building through self-governance enables community leaders to strengthen health and social infrastructure, and to integrate services and programs across sectors in ways that cumulatively improve health[9]. Self-determination also underpins models of commissioning founded upon First Nations approaches to collective governance, cultural identification and holistic concepts of health and wellbeing[10].

INTERIM BOARD

An Interim Board was established in response to recommendations from elected representatives and community leaders at the Community Caucus held on 10 October 2023. The Interim Board was a key body for realising the wider objectives of the CaTHC initiative, creating the authority to perform the administrative/legal functions towards rapid entity set-up. It also symbolised a central aspect of community-control, by creating a structure to make and implement collective decisions, with the practical capability to translate decisions into action.

An Interim Board Terms of Reference outlining functions, governance, and membership was approved by the PSC. Multiple options were formally canvassed for appointing the Interim Board, including through QAIHC, TCICA, or procurement through QH. QAIHC was considered the most suitable and efficient option and Auspiced its creation. Appointees to the Interim Board were to represent Cape York, NPA and Torres Strait, and have cultural and governance expertise, community leadership, commissioning and/or strategic planning experience. A formal process was established to recruit nominees, however the process resulted in few applicants, and none were appointed. Board Directors and Chair were appointed directly by QAIHC (drawn from Community Caucus members) and then endorsed by the PSC. An interim CEO was also proposed for the establishment and transition period, but a position was not filled.

Initially, the Interim Board would make recommendations to the PSC for feedback and endorsement. However, Board members assumed independence late in 2023, becAuse of the need to assert jurisdiction over components of the reform process that were central to their longer-term vision for the region. These tasks were subsequently completed by QAIHC and hired consultants. Interim Board functions included:

- Registering the entity and ensuring corporate governance requirements have been satisfied.
- Designing a governance model and constitution.
- Engaging in co-design with communities and providers on select pieces of work.

Regional representatives identified the distinct differences with a community-controlled process, and the need for separate governing structures to enact their rights to self-determine health outcomes. Project partners raised the perceived intent by governments to delimit the authority and membership of the Interim Board. Others reinforced that the community should determine all aspects of the commissioning process, including setting their own health preferences and priorities for funding, but underpinned by adequate technical and administrative support.

Part of the point of putting CaTHC together is that community knows what community wants, then community should be able to police and govern themselves.

Who determines on a community level what the priorities are and what are the preferred strategies? It needs to be driven by the community in terms of what they prefer, what the community thinks will work towards certain health issues within their local area.

This is what I explained to people and it's not about getting new money to the region, it's about using the existing funding that exists across the region and having more control over the allocation of those funding to meet community-based service levels and outcomes that your community is chasing.

Governments need to move away from controlling the process, indicating what is required and determining health needs for service providers and local populations. They do need to facilitate the process and provide support to communities to engage in health service delivery or commissioning, but only in a supporting role and when requested by the community.

CaTHC leadership can be supported with the right data and information, so they feel more than capable of developing the systems. Then the operating arm, the bureaucratic arm steps in and figures out how we're going to implement the direction set by the elected leaders.

The purpose of setting up an Interim or Transitional Board was so there was a voice for the Torres and Cape communities and the region to participate in the development of these key documents and approaches.

A lesson learned is the reinforcement of community-control. Government processes were offering up alternate avenues for leadership, dumbing down a community-controlled Board to an advisory committee. Government intervened with an alternate process that took away the empowerment of the original intent of having community-control over the process.

It was the government's definition of what community-control was in relation to their roles, both the state and the Commonwealth, in terms of monitoring their investment, communicating their investment.

We can be partners without all having an equal hand in every decision that is made, and the government agencies should be focusing on doing the legislative design, but the enabling steps to create the entity, that should be led by community.

The proof will be in delivery. Governments currently retain all control, including the purse strings. They can effectively regulate the entity's behaviour through the terms of the contract they set. We still would like them to live the spirit of community-control, community ownership, community leading without government dictating every aspect of what's going on.

Section 3: Model Design and Implementation

Evaluate the design of CaTHC and the feasibility, scalability and sustainability of the commissioning model to address health system priorities across the Torres Strait and Cape York region.

QUESTION 1

How has the CaTHC model evolved, and to what extent does the agreed model align to principles and objectives of CaTHC?

QUESTION 2

To what extent has the CaTHC approach established a sustainable and integrated model within the broader health system (including policy and governance, regulation, legislation and service system), and place of intervention?

QUESTION 3

To what extent have appropriate supports been established to support the intended functions and readiness of the CaTHC model (including governance supports, funding mechanisms, data access and frameworks, and strengthening of appropriate skills, capacity and capability)?

QUESTION 4

What lessons have been learnt from a health system perspective on the conditions, approaches and strategies needed to create systemic change including appropriate allocation of commissioning expertise aligned to capacity, capability and population health needs of the region?

Entity model and design

Significant effort was focussed on establishing the CaTHC entity, with a widely promoted launch date of 1 July 2024. The entity was formally established by the Interim Board in May 2024, two months ahead of schedule, representing the focal point of efforts over the preceding three years. Detailed planning and assessments were undertaken into entity type, governance structure and to support the transition process. Each component involved analysis of different options, which then evolved or changed based on suitability/applicability for commissioning, ease of operation, and endorsement from project partners, PSC and regional stakeholders. The model aligns with draft policy principles and project objectives in terms of creating a single independent entity guided by community to be supported by system wide data visibility to match investment decisions to beneficiary need. Establishing the entity earlier in the process may have provided more clarity and certainly for regional constituents, and expedited progress.

CaTHC currently sits alongside/outside the health system. There is a broad consensus from stakeholders that it will take time and resources to build the capabilities to plan, design, contract and evaluate services in innovative ways that address systemic issues in the delivery of care. CaTHC will need to create a commissioning framework that accommodates cultural and social diversity across the region and provides supportive structures for community and service providers to fully participate. A commissioning framework will be important for the viability and sustainability of CaTHC. Suitable governance arrangements require the capacity to evolve, accommodate change and be responsive to local priorities and decision-making structures. A well-established governance structure, with good risk management and financial accountability is a priority for stakeholders.

The proposed 10-year phased development approach is logical; however, tensions exist between building effective commissioning and the urgency to improve health outcomes for end users. CaTHC will need to build confidence in commissioning through some noticeable improvements and early outcomes, or risk losing legitimacy. Accountability frameworks and agreements also need to be developed/negotiated. CaTHC will be accountable to government funders, and to community interests, and monitor service provider performance and wider health outcomes. There remains significant uncertainty and risks with these components.

SINGLE REGIONAL MODEL

A single regional commissioning model was selected from the outset covering the Cape York, NPA and Torres Strait sub-regions. An appraisal of several alternatives was outlined in the Policy Proposal (QH 2022) including benefits and constraints, and justification made for the pooled funds approach. Two or three commissioning agencies were also canvassed, covering each sub-region, however a single model was the only option that governments would accommodate. Justification for a single entity included:

- Covered the same boundaries as the current TCHHS.
- More efficient, and able to allocate funding according to need and service availability. Maximises operational funding to cover small and dispersed populations, with few providers and high costs.
- Multiple commissioning agencies could potentially compete for services, and for a skilled workforce already in high demand. Commissioning small volumes could limit options for integrated care and result in further duplication.
- Several commissioning agencies would add significant administrative overheads that are unlikely to be absorbed within current budgets.

The single model raised concerns from interviewees about its ability to accommodate distinct cultural and political diversity in the region and various community models of healthcare. Some still consider a dual model as more politically acceptable, but the feasibility of this approach is untested. Others suggested that further clarity was required regarding how a single integrated model would operate, and what systems are required to support it. Representatives from one service provider strongly questioned the justification for creating a new regional commissioning body, when the outcomes sought could be delivered through existing providers and/or related programs. Further, they argued that CaTHC would add little value to the current health system and poses a risk of further fragmenting service delivery.

ENTITY TYPE

Project work package 4.1 was focused on entity co-design, aiming for an appropriate structure in place to receive funding and commence strategic planning and initial commissioning activities. An extensive process was undertaken to canvass options for the entity, including its geographic reach, and organisational and corporate structure. Multiple options were assessed on their strengths, merit and application to commissioning, governance by community, suitability across the health system, and accountability to funders. From the information provided, the process was rigorous and transparent, with project partners and Community Caucus members reaching consensus on the selected model.

[1] A 12-month extension for entity establishment from July 1, 2023, followed the internal transfer of the project to the QH Reform Office, citing the need for further community engagement and co-design.

Various options were considered including:

a. Public company limited by guarantee. Independence from governments, and can be registered as a charity. High accountability. Government relationship through funding agreement.
b. Statutory body. Established under Queensland legislation. Less independence with board appointed by governor in council. Accountable through parliamentary processes.
c. Incorporated association. Legal entity independent from government. Effective for smaller organisations. Less public accountability.
d. Aboriginal and Torres Strait Islander Organisation, registered with ORIC. Legal entity independent from government. Can accommodate local customs. May not suit population wide commissioning responsibilities.

Project partners sought independent advice, with a company limited by guarantee and registered as a charity, the option preferred by all partners and subsequently confirmed by the Community Caucus. The company limited by guarantee provided independence and community-control through its board and objectives, whilst satisfying rigorous financial auditing requirements. The structure is widely used by Aboriginal and Torres Strait Islander charities, as well as PHNs. The selection appears justified based on multiple requirements for creating a body to pursue strategic investment decisions. Several interviewees questioned this option becAuse of the high level of corporate accountability, and limited application to cultural contexts or community services. It is a Western based structure and may prove less flexible for commissioning in regional and remote community settings.

ENTITY ESTABLISHMENT AND TRANSITION

Community leaders with support from QAIHC led the development and registration of the new entity and it was a major milestone of the CaTHC project.[1] The process to set up the entity occurred through 2024, commencing with the appointment of the Interim Board (see above section). Interim Board, QAIHC and consultants Deloitte completed the following:

- Outlining roles and responsibilities to be discharged.
- Appointing directors, members and company secretary.
- Registering with ASIC, TFN and ABN.
- Drafting the constitution.

Four members of the Interim Board were appointed as Founding Board Directors, including a Chair and secretary. The process was conducted separate from government partners due to the breakdown in the project partnership explained above. Although this expedited delivery, and should be commended, concerns were raised with the evaluation regarding the transparency and level of due diligence exercised by government agencies during this stage.

CaTHC now has responsibility for all the transition elements. Transition planning and options for day one functioning of the entity were outlined in October 2023. However, these transition timelines were overly optimistic, as CaTHC required time to build capacity to undertake its new functions. A Chief Executive Officer (CEO) commenced in November 2024. The CEO and Board will lead CaTHC though the commencement and early commissioning phases from 2025-2028. Strategic planning, engagement, capability and systems development are proposed for this period, as are commissioning activities such as joint needs assessment, and service planning.

ENTITY GOVERNANCE

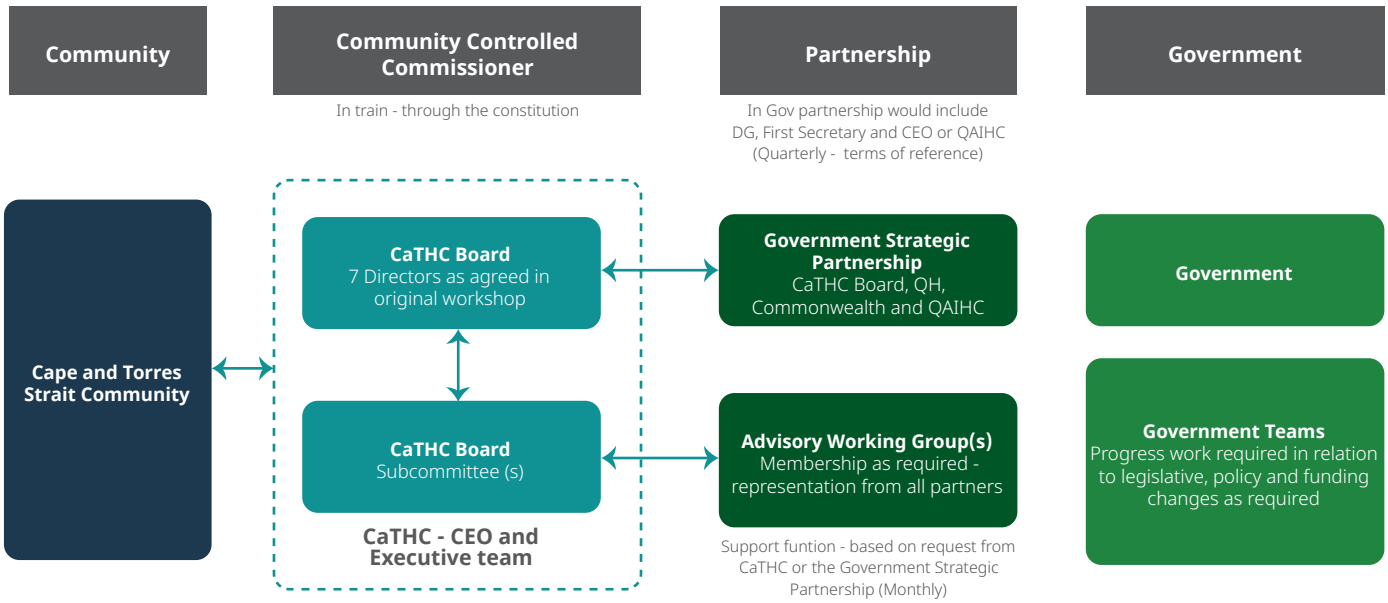
The TORCH Policy Proposal (2022) and Draft Updated Policy Paper (February 2024) outlined that governance mechanisms are to be established that incorporate the scope and responsibilities of CaTHC and retain oversight and accountability to both government and community. Advice from relevant expertise is also recommended. The proposed governance framework/structure has shifted and adapted, but the objectives and general principles have remained consistent over the duration of the reform. A draft of the governance structure from November 2024 can be found below:

Other suggested governance mechanisms that would support entity functions:

- Bilateral agreement to provide high-level, clearly defined and regionally shared health and population outcomes and indicators. Currently under development.
- Possible service agreement with the new entity to deliver the above accountabilities.
- Regional and technical advisory groups for engaging community and service providers and leveraging local or regional bodies.

Adequate cross-regional representation and technical/clinical expertise on the entity Board, its sub-committees and other governance organs, will support operational requirements. Any governance approach will have some benefits and challenges, but (re)building relationships and collaboration will be important. Experience from other jurisdictions indicates that effective co-commissioning requires relationship building and network maturing between commissioning agencies, service providers, clinicians, community, and government regulatory bodies[11-13]. Relationships and formal partnerships have contributed to shared goals and performance outcomes, and joint planning and ownership of funding decisions[14]. Partnerships also provided maturity to develop and test models of care, and to the integration of care across clinical treatment or program areas. Collaboration can be affected by unclear division of responsibilities between federal and state governments, commissioning agencies and service providers[12].

FIGURE 2: PROPOSED CaTHC GOVERNANCE MODEL 2024



*Note: CaTHC means Cape and Torres Health Commissioning

Interview participants advised that development and agreement on the governance arrangements for the new entity is critical, considering that everything flows from governance. A well-established governance structure, with good risk management and financial accountability, was viewed as a priority. At the same time governance arrangements will need to be responsive to community structures, applying culturally grounded and respectful approaches. Interview participants noted the importance of representative balance and experience, including Board membership and any additional advisory bodies that may be established. This included geographic representation, as well as corporate, governance, and clinical and technical expertise. Balancing the governance structure must ensure one component/party does not dominate. Operating any governing arrangements will be an evolving process and possibly unique to each sub-region and community.

I think having the right expertise in the entity itself, I think the current Board members are strong, and they probably could be strengthened with additional members.

I strongly believe that people who are sitting on those things, especially in a commissioning perspective where you're talking about service delivery and funding decisions, they really need to have that strong governance background.

How do we ensure there's robust clinical governance as part of whatever services are commissioned in the future, becAuse we all want there to be robust clinical governance across whichever entity is providing clinical services.

We must do things differently by making sure that we have the right processes in place to provide the cultural oversite to provide by the local solutions, but to maintain good strong governance. And again, how do we take this Western governance model and integrate cultural safety.

How community feedback is taken at that level needs to be driven by the local leaders of that region becAuse they understand their community best and how to get that meaningful community feedback from a governance perspective and to feedback into the CaTHC governance process.

CaTHC is going to have to set up some sort of community engagement mechanism, whether it's some sort of community representation through a committee structure. Perhaps they can even run two committee structures, just to make sure they get that governance right.

There are other ways to put safety nets in place for both governments around investments in CaTHC and to work with the community-controlled board. That's not sitting on the Board as directors, that's sitting potentially in subcommittees that inform the Board in making their decisions. Whether that's needs assessments, population funding, or public health, there's a level of expertise in guiding the Board's decision making.

A cross section of interviewees emphasised the importance of developing a commissioning framework or model that is responsive to unique community needs and accommodates the diversity of cultural and social processes. Several highlighted the cultural differences between the Torres Strait, NPA and Cape York regions, and innovation will be required to accommodate these into the governance framework and commissioning model. Each of the Local Government Areas and multiple communities have expressed priorities and circumstances that are different, and there are complexities and political differences within each community. Developing a framework is the responsibility of the CaTHC entity, but a community driven or sub-regional approach was recommended.

The planning, setting priorities and allocating funding should be bottom up through the community and according to their local processes. Each of the Torres Strait communities has their own way of making decisions, their own ways of deciding on who represents their interests, and appointing representatives. These are unique to each community. Any regional approach will need to be implemented with each of the individual communities. This is the only way that CaTHC will deliver for communities and contribute to improving their health and wellbeing outcomes.

There are big cultural diversities between Cape York and Torres Strait, including outer and inner Island cultures. Also, the mainland, the NPA versus the different cultures down closer to Hopevale and Kowanyama. This is going to be valuable learning for us, and we have already discovered some obstacles. The Torres Strait Leadership acts in a very different way, makes decisions in a very different way to the Aboriginal leaders on the mainland. There is no consistency in any of what I've just highlighted, so it is going to be a significant cultural piece of work that we're going to discover.

It's about being able to look at the unique factors we have here in the NPA and ensuring we can target and commission funding for those things, becAuse there's lots of differences between the challenges we face compared to our neighbours. They're all different communities that have different historical cultures, they have different relationships, and different health challenges.

The discussion would be with each community around what model of care would suit them. What's the ability of CaTHC to be able to tailor the model of care, and the governance assistance, and the processes supporting that become potentially unique to that location. At the same time, it creates a degree of consistency at the organisational level for CaTHC to meet its requirements.

PHASED OPERATIONS

Planning for the development and operation of CaTHC will occur through a phased approach to be realised over a 10-year timeline. The four-phases were adopted in the initial Policy Proposal from 2022, although activities and timelines have been redefined and adjusted based on possible funding reforms. The path to improved health outcomes through commissioning will take time, to ensure there are the appropriate structures and agreements in place, and that adequate systems and capabilities support commission at scale. The proposed draft four phases are:

- Commencement phase 2024-26: operational development, trial commissioning.
- Early commissioning 2026-28: operational development, small contracts.
- Mid commissioning 2028-30: broad commissioning functions, increased control.
- Full commissioning 2030-34: control of health system across the region.

The draft phased approach is logical, as it can accommodate increasing complexity in the funding and legislative environment that corresponds with CaTHC and system readiness. The aim is for fully operational commissioning functions to be in place by 2030-2034 leading to consolidation and autonomy over service funding in the regional health system. All required enabling conditions should be completed. Experience from commissioning in other jurisdictions indicates that extended lead periods were needed to co-design and implement commissioning models, engage service providers and beneficiaries in program planning and needs assessment, redesign and streamline contracts, and implement suitable monitoring/reporting frameworks[10, 11, 14-16]. The phased approach must also capture the requirement for network consolidation and collaboration across the health service landscape, and with end-users, to enable co-commissioning.

Multiple interviewees shared their thoughts on the phased approach. Many agreed that long lead times are required to build all the components, whilst others considered that existing models and frameworks are available that could be drawn upon to expedite the process. There is a clear tension between building capability and the systems to effectively administer funds and the urgency to improve service performance and health outcomes for end users in Cape York and Torres Strait. Others pointed out the pressure on CaTHC to build confidence it can commission in the short term or risk losing support amongst stakeholders. For example:

We must be very mindful to be patient and allow those things to develop. When you look at the Institute for Urban Indigenous Health, it's taken 10 years to get to where it is, and it's just been through trial and error.

It's going to be a long journey, but the thing is the community wanted this yesterday. It will take at least 10 years given all the complexities.

I'm not sure CaTHC is going to have the luxury of time given the expectations. There's just not going to be this large sum of money to go out and do everything at once. There is just so much involved in developing an organisation that has competencies, the capacity, the systems and processes, the governance, and then applying that across such a diverse footprint. It's a challenge.

10 years to establish commissioning is long, considering that the models and commissioning frameworks and reporting systems are already out there. 10 years seems like a very long timeframe when technically it could be set up quite a bit quicker.

If the money flows too slowly and the community doesn't see any change in behaviour, then they may lose faith in community-control and commissioning.

For this to be successful and to build confidence in both governments, you need to get some low hanging fruit. You need to get some wins on the board, not only for the community-controlled organisation or company, but also for the government from a political point of view, right, you need some good wins. You need community to see that this is different and it's working.

Clearly a market driven approach like is so often the case with Commonwealth funded arrangements, such as the National Disability Insurance Scheme (NDIS), or Medical Benefits Scheme (MBS) - where you've got a prevalence of thin markets, those approaches just don't work for people. That obviously is why we need to do something different. But I think the challenge is operationalising commissioning.

Uncertainty was expressed widely amongst service providers about how the new entity will commission, and if their responsibilities and priorities will be accommodated within a new structure. Several interviewees noted that during the next phase the parameters for commissioning need to be planned and clearly outlined, with agreements and principles about what services are to be commissioned. Others advised that the transition to commissioning will need to be as seamless as possible, with minimal impacts on community and the provision of care.

The entity has a bit to overcome just in terms of getting agreement and understanding or acceptance on what this is, what it's about, what it's going to do, what it's going to achieve, and what it can and can't achieve.

We need some guidance outlining how the entity is going to interact with Queensland Health and with the Australian Government, how the hospital fits within that space, and how it's going to work. These are the guidelines about who you can talk to or who you can negotiate with, and how it is set up.

The change to a commissioning entity should be a very seamless process that has minimal impacts on the consumer. At this establishment phase the focus is that back-end service provider engagement

and figuring out which contracts are going to transition, and communicating with the correct group of people. But ultimately, it's making sure that consumers aren't going to lose a service and then have a negative connotation with CaTHC.

But through this process, if there is going to be a transition plan, we do give the community as much notice as we can and obviously for that transition to happen seamlessly.

We need to make sure that the groundwork has been done for this transition and invest in the capabilities for what's required. Maintaining a level of service delivery whilst continuing to build the capability and capacity moving forward to get to where we want to get to. I'm just conscious that we really can't afford to go backwards in this space.

Funding mechanism

Extensive work has focused on the funding components, including an operational budget for CaTHC. This reform component has made demonstrable progress and is a fundamental enabler. Funding related outputs include a comprehensive assessment of health investment flowing into the region, analysis of funding mechanisms and options, and decision support tools for reinvestment and planning. Securing a four-year operational budget for CaTHC is a positive outcome, although funding from the Australian Government is unconfirmed. Major work remains on the complex models and pathways that will create a suitable funding mechanism(s), and to understand likely system impacts. CaTHC will not progress beyond a basic entity without a fundamental redesign of the current system.

Government partners noted that the funding component is complex and nuanced and will require core changes to allow CaTHC to receive funds, and equitable recalculation of future investment into the region. The transition is dependent upon unprecedented reforms to state and national health funding systems so that CaTHC can utilise those levers. Uncertainty remains over who is ultimately responsible for outcomes from the funding, whether this remains with the Health Minister(s), and/or is transferred to the CaTHC entity. Others noted that funding will require flexibility and not be limited by current contractual terms. In addition, funding agreements and accountability frameworks should accommodate capacity for experimentation and learning and not expose CaTHC to risk/threat of immediate closure.

The success of CaTHC relies on the pooling of government health investment that can be allocated to meet community need and agreed outcomes. The proposed strategy is for the scope of funding to increase over time as the entity's capabilities to commission become more sophisticated. Once fully developed, the entity should be able to administer the spectrum of regional healthcare funding. The health funding and commissioning of service provision in scope for transition to the CaTHC entity includes primary, secondary, and tertiary healthcare services and programs in the Torres Strait and Cape York region. Health related spend in aged care and the NDIS is not currently in scope, however, they may be considered later in the reform. Socio-economic determinants of health (housing, community services etc.) are of high importance to the CaTHC Board and Aboriginal and Torres Strait Islander leaders. However, these investment options are not currently in scope and will require collaboration across other government portfolios.

Investment Mapping stages 1-3 are complete and produced a report on current and committed operational investment between 2020-21 and 2021-22. Funds amenable to transfer in the short-medium term include the non-recurrent grants or contracts for health promotion programs, specialist services and Aboriginal and Torres Strait Islander health. Early transfers could target QH contracts that are straightforward and require minimal legislative change. More complex pools, including block and activity-based funding for the TCHHS, may be considered later. A Prioritisation Framework offers detailed assessment criteria and a weighting system to inform reinvestment decisions, based on complexity and ease of transition. Prioritisation may involve a structured and negotiated process amongst project partners, however testing the utility of the Framework is required. As explained, a priority is:

To raise the vision of CaTHC across the government and to seek a higher-level authorising environment that then enables us to go and talk to different areas about funding availability, recurrent contracts, all the kinds of details we need to know to use the Prioritisation Framework for that specific funding stream.

A draft Funding Options Analysis has been developed and is an informative and valuable document. It identifies different sources, options and timeframes to pool funds from government sources. Mechanisms under the NHRA may involve either a new bilateral agreement between governments and CaTHC, and/or creating entirely new funding models, and pooled accounts. A draft timeline for transition has been developed outlining operational and health investment from commencement through to full commissioning. Legislative changes are needed to support larger transfers, as is a schedule/plan for when certain funding types and volumes can be transitioned.

COMMENCEMENT FUNDING

A Queensland State Budget submission was made in March 2024 for CaTHC operational requirements for the first four years. Matching funding from the Australian Government was initially proposed, but unconfirmed. This will cover five areas including strategic planning,

corporate services, stakeholder engagement, population health service planning and needs assessment. Seed funding will also be offered to commence initial commissioning. Whether the estimated funding is sufficient requires advice from the CaTHC executive. Issues were raised that the fixed operational funding was potentially too restrictive to carry out planned activities or recruit the required administrative and technical workforce. Early commissioning will require additional investments in capacity, particularly with the high costs of coordinating health services in the region.

Interview participants noted the importance of a new funding model for several reasons, including the need to reassess and potentially increase the amount of investment into the region. Concerns were raised that CaTHC, and service providers may be limited by current funding requirements and unable to commission services to meet demand. Additional funding may be required to reach full commissioning capability, address the burden of disease, deliver an integrated care approach, and implement models of care based on different communities or sub-regions. Others recommended a change in investment to focus on better outcomes, and not necessarily limited to service efficiencies. Importance was placed on the flexibility of funding/contracts that are pooled into the entity, particularly as the Queensland and Australian governments have different approaches.

There is a need for a bigger investment and a change in the investment for better outcomes. One of the things that may be under thought about is in the initial setup phase, this is going to cost more in the very beginning becAuse you're going to need a larger investment than the $350m that's invested now.

We can make whatever is required for commissioning work from a funding and a purchasing side of things. But we really need to know what the structure and the legislative boundaries of how CaTHC is being established so that we can make the funding process work, including how the reporting roles will flow down and how CaTHC will go about negotiating for additional funding.

We would prefer that they took a more sophisticated approach to the legislative design to learn lessons from the UK and others where there are much better, well at least in our view, more robust governance frameworks that protect the entity from influence by government. For example, the right legislation to create a fund holding entity that receives the money and passes it on to the board, or standing between government and the board, as one model.

The scope of activities and services potentially covered by the new entity was raised by multiple interview participants. For example, clarity is required around whether acute services are included, and how the TCHHS fits within the scope of commissioning. Several service providers commented that providing holistic care in community-based practices for Aboriginal and Torres Strait Islander people is more than the clinical side of health. It requires wraparound services that address social determinants like workforce, housing, and socioeconomic disadvantage. This could legitimise conversations in other departments to address upstream requirements.

It should have permission to stretch to the social determinants without spreading its reliability too far. Otherwise, it will be driven back into a compliance framework to acquit for the current way of funding, and it'll just be a different version of the current model, and you will do an evaluation in two years or five years, and you'll be struggling to see what has changed in terms of outcomes.

If we go upstream using an equity funding approach to support Councils with market gardens and better refrigeration and fresh fruit and vegetable, better housing, sanitation, water, getting kids to school, it will improve health downstream through using a social determinant framework.

ACCOUNTABILITY

Accountability for commissioning under the new entity will be multi-dimensional and multidirectional. CaTHC will need to provide accountability to government funders, considering the large volume in public health investment, as well as the corporate requirements of a public company and registered charity. Project documents propose development of an Accountability Framework that outlines the roles and responsibilities of each party, the functions of the new entity, and the oversight role of the Strategic Partnership governance group. A draft Accountability Framework has been developed but was not sighted for the evaluation.

Accountability also relates to regional stakeholders, community and end-users in terms of CaTHC and service provider performance over time. The CtG Priority Reform 3 commits to increasing accountability and improving transparency of resource allocation by governments designed to meet the needs of Aboriginal and Torres Strait Islander people. How CaTHC will provide accountability in the contracting of services to meet community priorities is unclear but potentially could be through the commissioning model(s), regional and local decision-making bodies or other mechanisms. Government partners identified uncertainty and risks with transitioning to commissioning in terms of who is accountable for outcomes, which currently are borne by the Minister and HHS.

Interview participants rated accountability as a significant issue, including who CaTHC will be accountable to and through what mechanism(s). Others emphasised the accountability and transparency of service providers delivering against agreed contract outcomes and performance measures, and the need to improve transparency of resource allocation. Constituents have voiced concerns about an increase in community-control over funding of services, requiring assurance that access will be maintained.

It also comes back down to who is this organisation accountable to? Is it accountable to the Australian Government, or is it Queensland? Is it responding to state needs? The more resources you can allocate at the beginning, the better it will be in terms of outcomes, accountability and planning. We still don't know how that accountability for the CaTHC entity will operate.

We must balance that need for government, when we're talking about hundreds of millions of dollars of funding, to be defensible and transparent.

The complexity really comes from when you are given government funding that's tied to reporting requirements, how does a community body feel about that?

Accountability will be important in the allocation of funding to ensure that service providers are delivering quality care. Systems of accountability need to limit funding to those originations who do not meet service priorities or not providing care according to the agreed parameters.

The aims are to improve outcomes or efficiencies, but they need to be measured in dollars and health terms. If service providers are not achieving it, they should not receive funding. If you are forwarding public taxpayer service dollars to an organisation they must be as accountable as everybody else. There's responsibility for the CaTHC entity to hold everyone to the same level of accountability, not public services to one layer and other health providers on a different layer.

It's about creating better accountability and transparency of service delivery.

It will provide a more focused opportunity for improving health and well-being and it'll also help individuals and organisations to be accountable. When they're not delivering what they need to be doing in terms of delivery of care, to just stop putting funding into a provider.

That happens every day in the government where they're contracting, and services are not being provided, and they terminate contracts becAuse of a review or breach. But in the health sector, that's not an expected outcome and you're holding somebody accountable for not delivering the service.

Policy, legislation and data

Policy and legislative changes are required to pool public health investment and allow CaTHC to expand commissioning capabilities. Transition requires timely, sequential and increasingly complicated legislative changes. The rationale for this timeframe is the novel and untested funding model and arrangements, and for CaTHC to develop fiscal capability to manage any service agreement. When considering the reform timeline, it is unclear why legislative change was not proposed as an early milestone, and initial cabinet process completed through 2024 as planned. Project partners noted that:

...we are still at the point where things are changing rapidly. We can't take that policy and legislative change proposal to cabinet yet until there's widespread agreement on, you know, the steps that we're going to take collectively and therefore what funding is required.

Work packages 2.1-2.3 include analysis and implementation of legislative reforms, and an impact assessment on the wider health environment. Documents relating to any legislative changes and impacts have not been made available to the evaluation due to cited cabinet in confidence issues. At a minimum it is understood that amendments may be required to the Hospital and Health Boards Act (2011) and several others. Further options may include a new Act and renegotiation of agreements under the NHRA. A Queensland Government matter to note, cabinet submission, and authority to prepare is under development to accompany the first round of legislative changes. These are now scheduled for 2026 in preparation for the proposed mid-commissioning phase. Further legislative reform may require implementation by 2026 for CaTHC to progress. Partners noted that understanding the entity's perspective/position and overall stage of development will inform progress on any changes to cabinet and parliament. Reforms can have extensive lead times of up to 18 months. Any delays risks exposure to ministerial or machinery of government change or shifting corporate priorities. Further, newly elected government(s) may necessitate a renegotiation of options should it result in a major policy realignment, or loss of endorsement for commissioning.

POLICY PROPOSAL

A draft Policy Paper developed in 2022 outlined the CaTHC reform for ministerial consideration. Draft updated policy proposals were prepared in 2023 and 2024, to inform wider Queensland Government consultation. The overall approach was relatively consistent, with further detail provided as components evolved. The policy proposals provide a comprehensive and sound justification for CaTHC as a solution to the structural constraints and challenging health environment in the Cape York and Torres Strait. However, the policy remains an internal QH draft only and is not Queensland Government policy. A finalised policy will accompany the proposed first tranche of legislative change.

The revised draft policy outlines how CaTHC will contribute to improved integration in the delivery of culturally appropriate care. A list of broad and yet ambitious performance outcomes is provided, but there is limited detail on how these are to be achieved, and over what time horizons. The lack of defined outcomes or vision exposes the new entity and the

regional health system to performance risks, and high expectations amongst stakeholders. Experience from other jurisdictions could be drawn upon to identify what is required to successfully introduce commissioning, and to optimise application in this case.

CaTHC has been aligned to a range of Australian and Queensland system wide reform programs and strategies. CaTHC is positioned as a multilateral, place-based and innovative reform that gives effect to these policy commitments, whilst also seeking to leverage elements and synergies between these policies and to maximise support across government portfolios. A review was conducted in 2023 of Australian and Queensland government strategies and plans against which CaTHC delivers or is aligned. These include the CtG, and the Future Focused Primary Health Care: Australia's Primary Health Care 10 Year Plan 2022- 2032 which makes explicit reference to the staged implementation of community-led commissioning models.

DATA AND REPORTING

Access to health data across the system and from service providers will underpin all stages of commissioning. Data sharing agreements and governance are priorities but require collaboration between QH and CaTHC to progress. CaTHC will need to develop data analytical capabilities which will become more sophisticated as commissioning scope widens. Even though data will be accessed, having suitable skillsets will be important for effectively utilising that data. Additional data collection may be required to inform joint decision making and to report on performance that reflects community designed outcomes and metrics. Sources may include accurate community level data and robust culturally relevant health and wellbeing information.

Work package 2.3 focused on data sharing including a suitable approach and agreement. Areas for data sharing may include, but are not limited to, data from needs assessments, utilisation data and patient flow data. Data will be de-identified and pertain primarily to population-level information. A list of QH data sets and items have been created covering perinatal, hospital admissions, outpatient, oral health, emergency, future activity and system performance. Regulatory changes will establish CaTHC as a prescribed entity and a deed of disclosure will need to be executed between QH and CaTHC to gain legal access to QH data. Other national level data will need to be accessed from the Australian Institute for Health and Welfare.

Commissioning rests on information retrieval systems and analytical capability for planners to conduct needs assessment, service planning, and fulfil mandatory performance monitoring and reporting requirements for [11, 19]. Available health datasets, including patient reported outcomes are used to model projected service demand, volume and supply, and to inform reinvestment decisions. Access to appropriate data across the health system has been a consistent barrier. Challenges remain with the collection, quality, analysis, application and reporting of this data, particularly for Aboriginal and Torres Strait Islander populations and end users [20]. These issues are also likely to influence the development of data collection and analysis systems for CaTHC.

Senior managers from service providers noted that sharing patient data can be problematic across providers in the region, which hinders coordination and the continuity of care. However, others suggested that data is effectively shared between ATSICCHOs and the HHS. Several interview participants offered solutions for effective patient consent mechanisms and arrangements for sharing data between providers, as well as governance of data sovereignty. Addressing issues around data collection, access and sovereignty remains a wider concern for end-users.

The commissioning agency must have access to good health data to make informed decisions about need, and this is where the state and Commonwealth will need to help them. Some of our ATSICCHOs up there are already sharing data effectively with the health service. So, they maintain patient data and get all the authorities to share the data with the HHS.

Information gets collected, but it's not shared well and there's what is called soft data sovereignty. The ATSICCHOs receive funding to treat Aboriginal and Torres Strait Islander people, but they will not provide the data to the PHN becAuse of data sovereignty and privacy.

Funding is provided for a level of output, but the change in outcome is uncertain becAuse we don't know who was treated. If you look at maternal and child health, who was treated, what was the presenting condition, what was the outcome? We don't know. We haven't got the depth of knowledge of what happened in the first presentation to a PHC provider.

The NGO says no, I'm not sharing that information unless you get the patient consent. OK, so you obtain patient consent, and they say we're still not going to provide it becAuse that creates a problem for us.

Data sharing will be important to support commissioning, and particularly for the benefit of the clients' health outcomes. Current medical services and data confidentiality issues make it difficult to understand or provide consistency in a client's health needs in a service environment. This data needs to be visible to those responsible for providing care, to ensure client health outcomes are prioritised.

So, you have that ground rule deciding that the actual patient owns and controls that medical record they all must agree to sign up to my health record, so that you have one repository of your information. Then it doesn't matter then where that person goes, whether they go to this provider, or when that provider leaves and can't perform or doesn't get their contract renewed.

So, a solution is that you have one license agreement and then everybody signs onto that through their own protocols or agencies.

Then it doesn't matter which provider comes or goes, a specialist from Brisbane or Sydney or someone else turns up. We just indicate that is the record that you need to import into, so then you have some ownership and consistency of that record for that person in the community.

Data is important for continuity care of a client on the whole health journey. I feel like an explanation is given to people when they come and look for a service. If they gave their consent, if it's within the circles of their care and treatment, they could consent to sharing that information with another service provider.

There was a strong emphasis on developing capabilities in data systems and analytics for monitoring and reporting health outcomes.

I think there's an interesting question around diverting money from national programs into a new commissioning entity. What does that do to national program data sets and reporting?

Are we still expecting the entity to report in the same way as a different organisation receiving those funds?

There needs to be that framework and strict guidelines and outcomes and reporting as it's taxpayers' money... We need to know that it's making impact and actually closing the gap and doing what we're saying we're doing.

Not only do you need to invest in improved service delivery, but you need to back that up with health monitoring and reporting. Otherwise, there will be criticism about the amount of money that's being spent, as there is now. There's very little transparency with some of the some of the services that have been contracted from the Australian Government and who's monitoring and reviewing that?

Section 4: Community and Engagement

Determine if stakeholder involvement in CaTHC governance, co-design, and establishment is representative, inclusive and accountable.

QUESTION 1

Has the governance, decision making and engagement through CaTHC been transparent, and sufficiently responsive, representative and accountable to those with a stake in the system?

QUESTION 2

To what extent were ethical practices and probity considerations embedded in CaTHC, including appropriate measures and practices inclusive of Aboriginal and Torres Strait Islander peoples and cultures?

Engagement

Please note: the discussion on governance and decision making was discussed in detail in Section 2 above.

Community engagement and co-design are recognised success factors in health system reform. Engagement for the duration of the CaTHC program has evolved through several phases in response to stakeholder needs, and a diversity of communities and interests in the region. A flowchart of engagement and governance processes can be found in Appendix 3. Engagement processes were extensively planned, with some components well delivered. For regional leaders and QAIHC, engagement and co-design were determined and delivered through local leadership structures, as representatives of community. This was their preferred approach, and it has contributed to sustained participation from elected leaders throughout the reform period. QH engaged with service providers including TCHHS, RFDS, CheckUp and others, and was well generally received. Several regional forums were also successful in presenting the principles of commissioning and identifying health priorities.

Engagement and co-design activities were well below expectations for a cross-section of stakeholders. Several consider engagement was adequate for the establishment phase, whilst others view that greater effort was required to consult with a wider collection of interests. A difference exists between processes outlined in project documents and the extent and depth of engagement conducted. Project partners noted that detailed engagement/co-design with community was initially planned but wasn't implemented. Explanations for this under-delivery include an initial lack of clarity on the 'concept' of CaTHC, and insufficient and/or delayed resourcing for the scale of activities.

Disagreements between project partners on the frequency and urgency of engagement occurred through 2024. Other reported challenges include events outside the control of the project (cyclones, elections), and parallel reforms/inquiries. Despite over three years of the CaTHC project there exists limited knowledge or awareness amongst end users or the health workforce about the transition to commissioning, its implications and opportunities. This has contributed to widely expressed mistrust amongst stakeholders and a perceived lack of transparency. Considering the emphasis and high importance of engagement and co-design, a significant commitment of resources will be required during the commencement period, and particularly at the community level.

RAISING AWARENESS 2021-2022

The initial phase required extensive effort to engage with elected representatives (Councils), service providers and other leaders from the region. Engagement leveraged existing regional and local networks, as well as established community governance mechanisms. Leadership structures in each council area were mapped to identify key stakeholders, based on their strategic importance to the reform. QAIHC and QH adopted a 'placed-based' approach in communities across Cape York and Torres Strait. The aim was to solicit greater knowledge of each community, generate understanding and momentum for commissioning, and how it could meet local needs and priorities. This initial phase appears relatively well delivered in terms of generating solid region-wide support.

QH and QAIHC utilised various formats to inform and seek input. These included local community visitations and leadership briefings by senior government officers (Deputy-Director General level); attendance at regional events, like the TCICA Health Forum; and regular briefings with stakeholders/service providers. Attendance by government executives signalled a high level of commitment to CaTHC amongst regional leaders. Resolutions endorsing CaTHC were sought from each local council, as well as letters of support from Traditional Owner representative bodies and service providers. Internally, effort was directed at engaging with other government departments through Ministerial briefings.

WIDER ENGAGEMENT 2022-24

As CaTHC progressed emphasis shifted to complementary approaches to engage and communicate with a wider set of community representatives and service providers. The commitment to engage through Councils and statutory authorities continued as the preferred approach. There was a shift to 'meaningful' engagement through a self-determined, community-driven approach '.... to ensure that the voice of the community is represented in all aspects of the consultation process.' Effort continued to secure formal endorsement from all Councils and representative bodies. QH conducted regular briefings with TCHHS and RFDS and met with some Councils. The approach provided a sound basis, but unfortunately delivery was not always responsive to stakeholder needs. Additional activities outlined in project documents were either not formally approved, or did not progress to implementation including:

- Communications plan and engagement plan Workstream 1.1.
- Community engagement/co-design Working Group, and Community Champions.

Several events were organised to showcase CaTHC. These included a forum at Thursday Island held in January 2023 and hosted by GBK and the Regional Stakeholder Summit held in Cairns in August/September 2023. The events produced generally positive outcomes in terms of introductory information exchange. The forum provided a regional dialogue on the priorities and aspirations for healthcare in the Torres Strait and NPA. The Summit aimed to build a shared understanding of CaTHC, and to finalise a Statement of Intent and principles for a co-design process. The Summit hosted 64 attendees across government, including the Queensland Minister for Health, and a range of stakeholders. Consensus was reached that CaTHC is a priority, and that the community requires further engagement.

Multiple participants in this evaluation provided feedback and comment on the type, quality, extent and usefulness of engagement activities. It was noted that the initial stages delivered a suitable introduction and opportunity for regional leaders to participate and be informed. Engagement with elected representatives over the duration of the program has been extensive, consistent and valuable for soliciting input and support. Counsellors are the elected, democratic leadership in community and therefore have responsibility to listen to and represent their constituents.

The Council as the as the elected leadership, the democratic leadership for this community have got some responsibility to be hearing community voices, concerns and ideas for a way forward in relation to a health service health system and then obviously the state as its provider.

This again is coming back to the fundamentals of community-control. They are elected from the community. They're the leadership. The elected arm talks to the elected arm. That's how we engage.

I think one of the things that everyone forgot was elected Councils are members of community from community and they're usually elected to represent for the betterment of community.

Not excluding the NPA, just the Cape York region which we have our own opinions about these sorts of things. But community can talk, they can speak for themselves, they don't need us to talk for them, don't need QAIHC to talk for them.

We've had presentations, we've had individual conversations with QH, they've provided us with information, attended our board meetings and provided information to our Board and the regional coordinators and there have been a couple of workshops up in Cairns as well.

Other respondents reported, however, that a wider group of stakeholders had not been afforded adequate opportunities to participate at a meaningful level or be involved in the co-design process. Critically, knowledge and understanding of CaTHC in community and across the health workforce is relatively low and requires dedicated attention. In each community people have ideas and contributions and can offer solutions on the best way to work in that setting. Some considered that commissioning and CaTHC have not been explained in sufficient detail, nor that clarity or vision has been communicated about how it will operate as a single integrated system. Criticisms included the short duration of meetings/presentations, and inadequate time to review information and provide feedback. For example:

So how does community have a say in the design so that they feel that someone's listening to them? How do you ensure that you're listening to what community are saying? But the answer so far is that we talked to Council, that's not community. There are other people in the community that have opinions and ideas about what's the best way to do things in their community.

At the meeting, don't put up the governance structure and expect everyone to understand and provide feedback at the time. That's not a way to do meaningful community engagement or consultation. People need time to get the information or reflect on that information and then feedback as well.

I think that focus has been quite narrow in terms of who they need to be speaking to. I think they need to strengthen it in the sense that they need to talk to the ATSICCHO sector as well and not have this wall up. The wider they cast their conversations will improve feedback.

There simply wasn't enough to explain it to them. And there's been none of their people involved in the process.

There has been limited consultation with the organisation and its members have not been involved in discussions around the establishment of the CaTHC entity or the codesign of various components of the CaTHC project. This is particularly the case with Torres Strait Islander representatives, but also with health service providers in the region.

This lack of local representation raises concerns about the future involvement of communities and their representatives in commissioning, and whether existing systems of services delivery will remain with little change.

We are trying to limit the fallout from it as much as humanly possible in this space, and I appreciate it is what it is. I can't change those machinations, but I'm disappointed too in the level of communication.

Perhaps this is an opportunity to go back to reflect on the mistakes that they've made so far and the feedback that has been given to them by leaders, use that feedback to look at a path forward and to sit down and explain CaTHC to people.

Our experiences in engagement and interaction with Councils where there might be four or five clans in that community or more. We engage with the Council, but some of the other clans become upset becAuse you're dealing with the Council. Or one representative is more proactive and dominant, yet other groups or the remainder of community have a different view.

COMMUNICATION MATERIALS

A component of the engagement process was the development of ethical communication materials that are considered 'culturally safe' and appropriate for the diverse range of communities. Consultation materials were to include key messages and provide information for guided discussions. Principles underpinning the communication were:

- Respectful, timely, accurate, reliable, accountable and reflective of community needs/wants.
- Accessible and relevant, clarified and adapted to ensure shared understanding.
- Respectful of, and sensitive to, the wide range of cultural protocols.
- Underpinned by strengths-based language
- Working with stakeholders to develop materials that are accurate and relevant.

A range of communication materials were developed including an accessible health needs profile for each sub-region, consultation pack, website, newsletters and presentations. The consultation pack provides a general introduction to CaTHC and the stages of commissioning. The website created in 2023 offers a very brief outline of the CaTHC reform. QAIHC provided more detailed presentations on community-controlled commissioning to Caucus members. Although the consultation materials target a cross-section of audiences, they are introductory and provide few details. There is limited indication that the material has been presented widely to stakeholders, been adapted to reach target audiences, or align with community protocols and ethical standards. As presented, consultation materials offer only moderate value and may be counterproductive to creating understanding, transparency and trust.

There is a need for follow-up material that provides a more detailed explanation of commissioning, how it may be applied in Cape York and Torres Strait, and the tangible benefits it may deliver to health services and quality of care. Culturally appropriate explanations of commissioning could be drawn from Whanau Ora health commissioning in Aotearoa/New Zealand or PHNs in Australia to provide more detailed and informed materials.

Interview respondents suggested that communication lacked sufficient depth. Concerns were raised about the practicalities of messaging on CaTHC, its wider reception and risk of misinformation. For example, communication and promotion will need to reassure community members that they will receive a satisfactory service, and that service quality and access will not decline. Others suggested that a well-developed communication plan,

targeted to specific groups and sectors, will be essential at each stage. Communication approaches and language could integrate different conceptions of illness, health and wellbeing, holistic care, and respond to varying levels of literacy.

The messaging to the health workforce needs to be clear. How will it provide opportunities at an individual level for the commissioning agency to preserve my benefits or do better. Or for someone that's curious about the benefits of working in environments such as the Cape York and Torres Strait region, how this is an attractive job opportunity for me to go to.

I think transparency and improving communication. I mean obviously there's not going to be complete transparency to what's being decided, but they need to have some regular communication, and the website would be a good start.

That would be my feedback about improving their communication, having a regular newsletter, outline the Board and having a clear plan about the horizons.

There's still a lot of room for engagement for us to work a bit better to really identify how we can move forward. I'm just worried about the promotion of commissioning and the practicalities of how the message will get out there. Even though Auntie on the ground doesn't apply for funding there still needs to be reassurance and understanding that each community will get a satisfactory service.

Communication needs to be very specific on a political level, service provider level, community level and then also having a plain language level of understanding the different aspects of commissioning. They are communicating with people from different health areas, and levels of literacy and numeracy. I think there needs to be a lot of work and time put into that.

It creates a lot of stigma and resentment if it's not communicated properly. If a communication plan is not done properly at the start, no matter how good you think it's going to be, it will be derailed.

Co-design

Co-design was adopted as a way for community representatives to lead and contribute to the development of different workstreams. Co-design principles underpinned the collaborative, partnership based, and shared decision-making approach of the CaTHC project. There has been a genuine attempt to build co-design principles into the process, and members of the Community Caucus, and then the Interim Board have been instrumental. The purpose was to bring community experience and knowledge into the program, recognising their increasing role, and to build their capacity. Work packages earmarked for co-design included community engagement, design/creation of the new entity and its governance structure, and transition planning.

Formal processes listed in project documents included co-design working groups that would advise the PSC. Where permitted, remuneration was to be provided. However, the application of codesign has been inconsistent and not utilised to the extent envisaged. The planned co-design working groups were not formally established. Expectations for extensive co-design may have been difficult to implement. This is especially the case when regional community leaders and other stakeholders have multiple competing priorities. Other barriers include insufficient resources and short timeframes to conduct an in-depth process.

Project partners felt that the co-design had demonstrable strengths during entity design and working with Board members, and across government agencies. Several interviewees noted that limited incentives and opportunities were afforded to a wider group of stakeholders to contribute expertise at this initial stage. They felt that all related information should be captured to set up a functioning and well-designed entity, and service providers should be contributing to that process. They could also point out challenges with current approaches, reasons why they aren't working, or provide insights relevant to the region.

FUTURE ENGAGEMENT/CO-DESIGN

Community wide engagement is a priority for the new entity. Experience from commissioning in other jurisdictions indicates that engagement and participation with wider sets of stakeholders and/or clients has significant benefits. Engagement and co-design across multiple sectors and organisations contributed to increased capabilities and wider impacts, and assisted in change management to support new programs [21]. It also facilitated deeper listening with community to better serve the needs of beneficiaries. However, engagement and co-design involving the wider community need to be culturally anchored, equitable, empowering and suited to the context or community setting [22, 23]. Stakeholders, including end users and service providers need to be well resourced to provide informed decisions into the co-design process[22].

Several interview participants noted that future engagement will need to be guided by the phase of commissioning and will contribute to managing change. For example, contract transition and renegotiation will require working collaboratively with service providers over that period. Engagement processes should be more adaptable and responsive to stakeholder preferences. Service planning, for example, will rely on deeper engagement with community members, families and end-users to determine how services can respond to health demand, which changes over time. Capacity at the community and service provider level, such as through employment of community engagement officers was strongly recommended.

It requires direct engagement of all communities and their representatives in the development of commissioning, and the planning of health services that are community-controlled or delivered by other providers, but with community making the decisions about health needs and priorities. It needs to be up to communities to determine who delivers services, how those services and designed, including appropriate models of care, and where funding is allocated.

I was looking at it from a population health planning perspective. So how do you do population health planning for each of those communities that creates ownership by community to understand their health status but allows them to see why you're doing what you're doing.

How do we engage? How do we get services to meet the needs of the community? It's not just service planning for the sake of service planning, but service planning that engages community.

So how does community have a say in the design so that they feel that there is someone listening to them?

... identifying local leads in those places, who someone can be connected to provide orientation around each place and what's available. We develop Community profiles, but I think there's nothing better than developing a relationship with someone and having them to guide you in each place. And these are just practical common-sense things that I feel are required.

When they're designing a particular program, they need to be thinking about how we get, not just the data and information from the service providers to know what we're doing, but also what the feeling and the sense of community is about their own health and wellbeing.

Engagement with service providers and figuring out which contracts are going to transition when and communicating with that group of people. But ultimately, making sure that consumers aren't going to lose a service becAuse of it, and then have that negative connotation with CaTHC.

Support and trust

A primary objective of the engagement and co-design processes was to obtain a region-wide endorsement or mandate for the reform. From the outset it was decided that stakeholder support and consensus was required to progress project elements. Most community leaders and elected representatives have reiterated sustained commitment for establishing a community-controlled commissioning body. Multiple Councils have passed resolutions, and this support was reconfirmed at the Stakeholder Summit, and by the Community Caucus. The strong level of support and legitimacy across the region is significant, and a major achievement that underpins project success to date.

In mid-2023 elected representatives from the Torres Strait withdrew from the process, including the Torres Shire Council, Torres Strait Island Regional Council and Torres Strait Regional Authority. Although in support of commissioning, they raised concerns about the impact on parallel processes, including a Health Service Investigation into the TCHHS and local government elections held in March 2024. Representatives made deputations to the Queensland and Australian Ministers requesting a stay on CaTHC. Operating a single commissioning body is potentially unviable without wider participation from Torres Strait representatives. A suitable resolution and joint pathway are required for their priorities to be accommodated within CaTHC's strategic operations and governance structure.

Strategically, seeking consensus for CaTHC from all Councils and representative bodies does not appear justified, and at times proved counterproductive. In a region comprising multiple communities with high cultural, linguistic and political diversity it is unlikely that consensus would be reached or sustained. Further, bodies such as TCICA have region wide representation and advised that they were able to declare support on behalf of members. As noted by project partners, consensus is rarely required or achieved in any policy reform undertaken in a democratic system and should not be applied to the community-controlled health sector.

Service providers have offered in-principal support for regional commissioning, but some have expressed strong reservations about the process to establish CaTHC. Others raised potential impacts from commissioning on workforce and retention as a significant issue. Several interviewees considered that CaTHC is not the solution to regional health service performance and that existing processes for rebuilding partnerships and collaboration amongst providers would be more feasible and productive. Project partners noted that more effort was required to encourage knowledge uptake and generate support for CaTHC in the community.

A strong theme to emerge from the interviews was the level of mistrust between service providers, community and government that impacts perceptions of how well the health system is performing. Several regional representatives highlighted that residents have limited trust in service providers to deliver the care they need and are even fearful, including of emergency services. It was emphasised that CaTHC will need to build trust with community by delivering service improvements.

But you know there's a mistrust between service providers. The Commonwealth don't fund us to provide that service, it's provided by an NGO who is then inadvertently criticised for not providing the service. There may be legitimate reasons for it. Or the service might be provided, but it's not visible to those people stating that they're not receiving the service.

There is a lack of clear communication and appears to be mistrust in the system at this point in time. People don't trust government services, and people don't believe that the services are good. However, I don't believe that this perception is correct.

There's no transparency for people here in the NPA. People ask questions and they don't receive answers about health service delivery and people are scared about accessing health services becAuse they don't think they'll get the care that they need.

We are losing trust in the health system. The challenge for CaTHC and its success or failure, I think, hinges off your level of engagement and trust.

But ultimately it comes back to trust, and all these principles we talk about in terms of reconciliation and engaging with us and moving past some of this stuff. Trust is there and we've got good relationships with a lot of the stakeholders that help with a project like this, which is about change.

From a cultural perspective, when you're working with people, they always like to develop a trusting relationship with the service provider and that was some of the feedback we received around the partners in care program that we developed relationships with the local staff.

This is a great opportunity, and could be replicated successfully elsewhere, leading to greater community-control over health funding across northern Australia. But it needs to be done correctly and requires the direct engagement of all communities and their representatives in the development of commissioning, and the planning of health services that are community-controlled or delivered by other providers.

STATEMENT OF INTENT

Establishing a formal partnership between governments and regional leaders was identified as a priority to deliver genuine health system change. Initially a bilateral or tripartite agreement was proposed between the new entity and governments to outline shared health outcomes, and to formalise scope, functions and accountabilities. This was superseded by the Statement of Intent, which was proposed as a non-binding document between governments and stakeholders outlining commitments to CaTHC. It included a set of high-level principles and shared intentions to drive action to achieve a community-controlled entity.

A community led process was enacted for co-signing the Statement by Councils and any regional stakeholders, but the process was contentious and strategically misjudged. The Australian Government advised they wouldn't progress the Statement unless there had been formal endorsement from all Councils. Mayors advised that this wasn't necessary, and that QAIHC and regional bodies such as TCICA would suffice. The Torres Strait representative declined to sign, and it was advised that a consensus type document was not required for CaTHC to proceed. This was a failed outcome considering the significant investment in time and resources to progress the document. The requirement for formal endorsement from all Councils seems misplaced, given that it was unnecessary and highly unlikely.

PROBITY AND TRANSPARENCY

Conflicts of interest and probity issues have cAused some concern amongst project partners and regional stakeholders. Conflicts of interest were cited as reasons for excluding service providers from the PSC. As recipients of substantial public health investment, situations needed to be avoided where they could exercise undue influence in certain decisions. However, several service providers felt intentionally excluded from the reform, and that decisions were made at a higher level without disclosure to a wider group of organisations. Probity and transparency issues arose with representation on various panels and appointments to the CaTHC Board. Criticisms were raised concerning a lack of transparency in the appointment of Board Directors, noting that some constituents may not recognise the Board as representative of the Torres Strait and Cape York regions.

Interview respondents recommended that conflict of interest would need to be effectively managed, with suitable measures to ensure a level of transparency and probity, including externally to service providers, community and the wider public. Others cautioned that mitigating conflict of interest can be challenging in the Cape York and Torres Strait region. Representatives can occupy multiple positions within different organisations, and in community contexts different expectations and perceptions of probity can occur. In locations where a single service provider operates, independent representation may prove problematic. Transparency will be important in the context of service planning and contracting through a commissioning framework.

There also needs to be some transparency in the decisions and how decisions are made and who's on those panels. If you have a joint entity that's got a vested interest in providing the service, then that's going to be a conflict that can't easily be managed.

This Interim Board that was created happened outside the partnership of the three organisations. There is no excuse for doing terrible governance on these things. There is a potential conflict of interest for everybody on the Board who sits on a Council, sits on an ATSICCHO, sits on a governing body that will be commissioning to themselves.

The current Board representation is not accountable to Torres Strait communities, and they should not be in a position to make decisions that affect these communities.

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Appendix 1. Program logic

FIGURE 3: PROGRAM LOGIC: CATHC PROJECT EVALUATION

Situation: CaTHC will provide community control of health funding and planning, leading to improved health and wellbeing outcomes to meet community need

Inputs: Resources
Project and Deliverables Project funding: $4.56m under Health Innovation Fund
QLD State Budget Funding for CaTHC operational and seed funding expenses ($9.2M)

Enablers and Strategies		Outcomes & Challengers		Impacts
Activities 2022-2024	Delivered outputs 2022-2024	Outcomes 2022-2024	Challenges 2022-2024	
Project planning › Work plans, work packages and activities linked to outcomes › Gantt Chart and Critical Path document with key decision points and timelines (QLD) › Risk register (QLD)	› Progress monitoring to Steering Committee, managers › Risks and contingencies assessed, tracked and updated	› Work packages delivered against project timelines › Critical Path informs project dependencies and decision making	› Work packages behind schedule and extended timeframes › No measures/ indicators for performance/outcomes › Risks not adequately mitigated	› Work plans and packages aligned for successful co-delivery › Planning supports implementation, monitoring and reporting › Delivery of work packages leads to success against objectives
Project resources › Total/annual project expenditure › Workforce	› Annual/monthly project expenditure summaries	› Project components delivered within allocated financials	› Under resourcing of some project deliverables (i.e. engagement) › inconsistencies in invoicing	› Project resources matched to delivery of reform requirements and outputs › Annual expenditure consistent with estimates

Inputs: Resources
Collaboration and Governance | CaTHC Board | Community Leaders | Elected Representatives | Peak Bodies
Queensland Government | Australian Government | Queensland Aboriginal and Islander | Health Council (QAIHC) | Ministers

Enablers and Strategies		Outcomes & Challengers		Impacts
Activities 2022-2024	Delivered outputs 2022-2024	Outcomes 2022-2024	Challenges 2022-2024	
Project Steering Committee › Bilateral government and regional representation › Meetings, communiqués, reports	› High level consensus decision making, facilitates collaborative process › Monitoring of project workplans and progress	› Sets strategic direction, monitors outputs and risks	› Inquorate for several meetings	› Coordinates outcomes and success across the project
Project Partnership › Joint planning and co-delivery › Agreed responsibilities	› Project partners lead and collaborate on work package deliverables	› Provides support to project partnership team	› Format not conducive to extensive input from regional representatives or community	› Empowers regional representatives and governments to jointly drive CaTHC
Community-control › Community Caucus › Interim Board	› Community Caucus facilitates input and decision making by leaders › Interim Board drives entity set-up	› Partnership delivers mutually agreed and negotiated outputs	› Breakdown in partnership in 2024, required renegotiation of path forward	› Relationships, learning, flexibility and adaptation deliver innovative project outcomes
Ministerial commitment › Closing the Gap › Health Innovation Fund Bilateral › First Nations First Strategy	› Official statements of support › Meetings/responses to stakeholders	› Minsters maintain endorsement of CaTHC as priority health reform	› Board appointment process	› Community Caucus and Interim Board provide platform for leadership and community-control of CaTHC

FIGURE 3: PROGRAM LOGIC: CATHC PROJECT EVALUATION

Situation: CaTHC will provide community control of health funding and planning, leading to improved health and wellbeing outcomes to meet community need

Inputs: Resources
Model Design & Implementation Regional Health Investment: total $338m
Australian and Queensland Government Policy Frameworks and Legislation | Health Data

Enablers and Strategies		Outcomes & Challengers		Impacts
Activities 2022-2024	**Delivered outputs 2022-2024**	**Outcomes 2022-2024**	**Challenges 2022-2024**	
Entity Design › Design of suitable entity › Design of governance structure › Transition planning	› Entity options reviewed and selected › Governance models reviewed and updated › Transition plans for Day 1 functions › Accountability framework	› Entity model agreed by consensus › Proposed governance structure for entity, community and governments › Transition managed by CaTHC › Roles and responsibilities identified	› Renegotiation of roles to provide independence, entity responsible for all commissioning functions	› Entity model selected with capacity for large scale commissioning, auditing › Governance structure that specifies roles / responsibilities of all parties › Accountabilities of each party agree
Implementation › Entity establishment › Appointment of directors › Recruitment of Chief Executive	› Company Limited by Guarantee, registered with ASIC and charity › Board Directors appointed and regular meetings	› CaTHC established and initial operations commence May 2024 › Chief Executive appointed Nov 2024	› Disagreement on entity establishment process, appointment of Directors › Delayed capacity	› Entity is established with constitution to commence operations › Corporate structure that delivers community-control over health funding
Funding › Mapping and prioritisation › Funding reform options › CaTHC operational and seed funding	› Investment mapping report › Prioritisation framework › Funding options analysis › Budget submission (QLD) › Funding database update and funding paper	› Detailed analysis of health investment into region › Decision tool to support phased investment pooling › Funding mechanisms identified, including regulatory changes	› Funding complexity may require significant legislative and policy reforms	› Framework informs sequenced fund pooling, based on complexity and risk › Funding mechanism reforms linked to four phases of development › Funding secured for initial 4 years of operations
Policy and Legislation › Review of policy/ legislation › Impact assessment › Proposed changes and reforms	› Revised CaTHC Policy Paper › Assessment of impact on wider health system, to inform stakeholders	› Legislative review identifies required changes to facilitate commissioning › Policy paper provides rationale, strategic approach, governance and design options	› Cabinet submission and legislative change process rescheduled to 2026-28	› Understanding of the legislative and policy environment instructs necessary forward planning › Knowledge of wider impacts on service system informs change management
Data › Dataset assessment › Prescribed entity	› Review of available datasets › Planned legislative change to establish prescribed entity	› Entity has access to required datasets and information › Deed of Disclosure to provide access to health data	› Data access and quality › Sovereignty and governance › Data analytical capability	› Access to available health data enables early planning and needs assessment

FIGURE 3: PROGRAM LOGIC: CATHC PROJECT EVALUATION

Situation: CaTHC will provide community control of health funding and planning, leading to improved health and wellbeing outcomes to meet community need

Inputs: Resources
Engagement and Community Councils | Regional Authorities | Service Providers
Aboriginal Torres Strait Islander Community Controlled Health Organizations (ATSICCHOs) | Native Title Representative Bodies

Enablers and Strategies		Outcomes & Challengers		Impacts
Activities 2022-2024	Delivered outputs 2022-2024	Outcomes 2022-2024	Challenges 2022-2024	Impacts
Engagement and support › Strategy/approach › Workshops and briefings › Regional Summit › Statement of Intent	› Regular workshops with councils, service providers › Regional Summit 2023, 64 attendees › Statement of Intent developed for Council signing	› Educate and inform stakeholders, build understanding and support › Secured formal endorsement from multiple Councils for CaTHC	› Torres Strait ves with-drew from process › Limited awareness in community, end-users and health workforce › Inconsistent delivery › Statement of Intent not signed	› Broad and sustained support for CaTHC/ commissioning from Councils, service providers › Community demand for health system reform/ improvements
Co-design › Co-design plan › Co-design working groups (proposed)	› Co-design of entity establishment, transition, and communication plans	› Co-design enables regional and community priorities to inform/drive the project	› Proposed co-design processes did not eventuate as planned	› Entity design and governance informed by regional knowledge and addresses regional/community priorities
Communication › Materials › Delivery modes and plan/strategy	› Consultation pack, presentations website, newsletters › Summit materials	› Materials designed to provide clear, culturally appropriate communication of project	› Materials not widely viewed › Limited targeting of materials to different audiences	› Suite of targeted materials supports consultation and co-design and raises community understanding of reform

Appendix 2. Evaluation criteria

TABLE 2: NGAA-BI-NYA EVALUATION CRITERIA AND ASSESSMENT

Ngaa-bi-nya domains and prompts were refined to develop a set of criteria for assessing performance of various CaTHC enablers and strategies. A straightforward Likert scale system (very good – poor) was applied to assess how well the CaTHC project is addressing these prompts and criteria.

Domain: Landscape	Very good	Good	Moderate	Poor
History & Environment				
Factors influencing program: History of local area, experience of traditional owners			✓	
History of program establishment			✓	
Extent to which: Program acknowledges colonisation, disempowerment, trauma, racism, poor health across generations				✓
Factors influencing program: Demographic characteristics, comparisons & changes		✓		
Socio-economic determinants, (housing, education etc.)			✓	
Accessibility to health, social services & barriers	✓			
Programs & Services				
Factors influencing program: Integration with other programs, resources, services & access			✓	
Level of collaborations with other programs/services			✓	
Investment in infrastructure: technologies, workforce		✓		
Extent to which: Responsibilities & expectations across related organisations & sectors are defined /realised		✓		
Mechanisms for sharing information, data & resources with related programs & services			✓	
Policy & Legislative Reform				
Factors influencing program: Alignment with legislation & policies related to program	✓			
Quality & feasibility of policy supporting program		✓		
Scoping & delivery of required legislative changes to meet requirements		✓		
Understanding and preparation of wider health system changes to facilitate reform			✓	
Self Determination				
Factors influencing program: First Nations people's role/leadership in program co-design, delivery, governance	✓			
First Nations people's role/leadership in policy development & reviews impacting the program			✓	
Extent to which: First Nations people are defining needs & priorities in the reform		✓		
First Nations community-control of program governance		✓		
First Nations people's way of relating, decision making, doing business are embedded in the program.			✓	

Domain: Ways of Working	Very good	Good	Moderate	Poor
Engagement & Relationships				
Factors influencing program: How well program promotes & achieves participant engagement			✓	
How well staff develop trusting relationship with stakeholders, participants and clients		✓		
How relationships are experienced through trust, integrity, equality, reciprocity, & flexibility			✓	
Extent to which: First Nations people with relevant experience are involved		✓		
Collaboration with other services & agencies occur			✓	
Co-design of program occurs with stakeholders			✓	
Sustainability				
Extent to which: Timeframes, expectations of program align			✓	
Governance arrangements are in place and support objectives of the program			✓	
Change is managed at program & workforce level		✓		
Relationships strengthen, adapt, cease or transform as program evolves			✓	
First Nations people with relevant experience are involved	✓			
First Nations community-control of program governance		✓		
First Nations people's way of relating, decision making, doing business are embedded in the program.			✓	

Domain Resources	Very good	Good	Moderate	Poor
Financial Resources				
Extent to which financial resources: Meet demand for program requirements and support			✓	
Support First Nations workforce development			✓	
Meet needs of First Nations people in the program		✓		
Support transfer of knowledge and policy advocacy		✓		
Human Resources				
Factors influencing program: Mix of skills, experience & roles amongst program staff	✓			
Culturally relevant training for staff & leaders		✓		
In-kind, volunteer & informal supports		✓		
First Nations people's knowledge & resources in program			✓	
Networks that support the program				
Material Resources				
Factors influencing program: Use of data & evidence in program design	✓			
Planning for the program, investments & commitments			✓	
Extent to which: Information technology meets program needs & growth		✓		
Infrastructure meets program needs & growth			✓	

Domain: Learning and Outcomes	Very good	Good	Moderate	Poor
Outcomes				
Factors influencing program: Progress made towards project outcomes, despite challenges and setbacks		✓		
Non-indigenous peoples' critical reflexivity of standpoints & training in cultural awareness and anti-racism			✓	
How well aspects of self-determination were experienced and realised		✓		
Use of strengths-based program delivery		✓		
Evidence Base & Evaluation				
Evaluation considers: How program contributes to the evidence base with culturally relevant tools, methods, measures & indicators				✓
Strategies and processes to decolonise program, research & evaluation		✓		
Extent to which: Evaluation & monitoring are embedded program & funded	✓			
Evaluation & quality assurance process impact program		✓		
Culturally relevant data collection tools are used			✓	

Appendix 3. Engagement and governance flowchart

TABLE 3. ENGAGEMENT AND GOVERNANCE FLOWCHART

Phase 1: Seeking regional support and legitimacy						
2021	**Community Engagement**	**Regional engagement - elected leaders, service providers etc**	**Community, regional leaders' commitment to CaTHC**	**PSC and planning decisions**	**Governance activities and decisions**	**Challenges**
MAY-JUN	CaTHC model to be developed through locally driven process and community legitimacy			**PSC inaugural meeting.** Agreed ambition, principles and planning steps for project.	Members of PSC including QH, DoHAC, QAIHC and regional leaders and elected representatives.	
AUG	Engagement strategies and planning adopting a place-based approach.			**PSC meeting:** models of collective impact focusing on leadership and accountability	PSC Terms of Reference: roles and responsibilities and increased regional representation.	
SEP	Initial briefings on CaTHC ambition, objectives and project scope, including cross-over initiatives.	QH and QAIHC briefing on CaTHC provided to RFDS; and Chair TCICA.	Community Leadership Briefing to establish CaTHC legitimacy. Engage councils to develop community support.		Further cross-departmental consultation.	
OCT-DEC	Briefing pack developed. Community leaders provided with Health needs profile of their region.	QH and QAIHC series of CaTHC briefings (roadshow) to local councils, community leaders, regional service providers. Briefing to TCICA Health Forum (Nov)	Seeking resolution for CaTHC endorsement from TCICA, councils and others. Community leaders to engage community in CaTHC agenda.	**PSC Meeting:** Approved ToR, project plan and community engagement and co-design approach.	Major intergovernmental briefing with QLD minsters and elected representatives.	Resolution from councils to support CaTHC pending
Phase 2: Endorsement from regional leaders						
2022	**Community Engagement**	**Regional engagement - elected leaders, service providers etc**	**Community, regional leaders' commitment to CaTHC**	**PSC and planning decisions**	**Governance activities and decisions**	**Challenges**
FEB-MAR	Suite of documents provided during community briefings.	QH and QAIHC continue initial briefings with TCICA, TSRA, Torres Strait Islands Regional Council, GBK, local councils, and service providers.	Local councils across region agree to CaTHC model to obtain QLD and Aus Ministerial support	**PSC Meeting:** Agreed sequencing of consultation model and co-design for community commissioning, and clarity of messaging. Ministerial submission to be developed.	Proposed development of QLD/Aus gov bilateral agreement to support entity establishment by Sept 2022	Discussions around existing priorities, formal endorsement of CaTHC, scope and accessibility of commissioning funds.
JUL		QH, QAIHC attend TCICA meeting, discuss potential CaTHC structures				
AUG	**QH transition CATHC from Community Services Funding Branch to the Reform Office.**					
OCT-NOV	Negotiation of contract with QAIHC for community engagement	QH presented to TCICA meeting in Nov.	There remains strong community support for system reform.	**PSC meeting:** reaffirmed member commitment to CaTHC. Agreed entity establishment extended to 1 July 2024		Delays with community consultation due to team/staff changeover in QH, DoHAC. Entity establishment was delayed 12 months to enable co-design process.
DEC	Finalisation of funding for QAIHC	QH meetings with CheckUp and RFDS; TSRA and QAIHC			Proposed QLD/Aus bilateral agreement drafted.	Delays with community consultation due to resourcing issues.

TABLE 3. ENGAGEMENT AND GOVERNANCE FLOWCHART

Phase 3: Plan and Reach Agreement and on CaTHC.						
2023	**Community Engagement**	**Regional Engagement - Elected Leaders, Service Providers etc**	**Community, Regional Leaders' Commitment to CaTHC**	**PSC and Planning Decisions**	**Governance Activities and Decisions**	**Challenges**
JAN	› Finalisation of contract for QAIHC for community engagement.	› CaTHC Governance Forum - Torres Strait and Northern Peninsula Area – chaired by GBK and attended by regional reps, QH and QAIHC.	› In principle agreement from regional leaders supporting CaTHC model. Requests for deputations / presentations to each council.		› QLD/Aus bilateral agreement to be principles based, and consideration of Statement of Intent.	› Delay in signing bilateral agreement due regional meetings.
FEB-MAR	› **Work package 1:** Community consultation and co-design.	› QH meetings with TCHHS, NQPHN, GBK. › Attended TSRA Health Communities Forum where QAIHC presented on the CaTHC project.		› **PSC meeting:** new Terms of Reference with strategic leadership functions outlined. 6 project work packages endorsed	› Statement of Intent (SoI) proposed between QLD/Aus and elected regional representatives and community leaders in place of bilateral agreement.	› Slow progress on some CaTHC activities, awaiting approval from PSC. › Postponement of Torres Strait and NPA Councils, TSRA and GBK meetings due to senior project staff turnover.
APR	› Consultation materials drafted. Engagement approach 'wherever possible ' adopted.	› Proposed regional stakeholder engagement workshop/ summit.		› **PSC Meeting:** Completion of CaTHC project plan and governance between project partners.	› **PSC:** Options canvassed for formalised Statement of Intent (SoI) versus other agreements.	
Community-control to be the focus of CATHC entity design, governance and planning.						
MAY	› Information/ artwork materials on CaTHC and commissioning completed.	› **CaTHC Community Caucus:** QAIHC, Torres Strait and Northern Peninsula Area community leaders. › Draft SoI circulated to elected reps (councils), 2 online engagement sessions.	› Community Caucus attendees support commissioning and phased implementation. › Advise not all mayors or councils need to sign/pass resolution for a revised SoI.	› **PSC meeting:** DoHAC required SoI to be signed by all regional mayors prior to the planned Regional Stakeholder Summit.	› Community leaders to convene a CaTHC Aboriginal and Torres Strait Islander Community Controlled Steering Committee / Community Caucus to inform PSC and lead work to establish entity and engage community.	› **Regional Stakeholder Summit postponed:** Need for further community engagement and requirement for SoI signatories.
JUN		› QH met with TCHHS executive to present CaTHC. › QAIHC develops a plan for engaging all regional Councils in signing SoI.	› Commitment confirmed from TSRA and GBK to CaTHC.	› PSC meeting: DoHAC need for 100% commitment across region to SoI, will require Councils to pass resolutions in support.	› Revised draft SoI with increased focus on Community-controlled entity and scope.	› Requirement for Councils to sign SoI delaying process. Not all councils engaged or confirmed support, and regional consensus unlikely.

TABLE 3. ENGAGEMENT AND GOVERNANCE FLOWCHART

Phase 4: Co-Design of Community-Controlled ntity						
2023	**Community Engagement**	**Regional Engagement - Elected Leaders, Service Providers etc**	**Community, Regional Leaders' Commitment to CaTHC**	**PSC and Planning Decisions**	**Governance Activities and Decisions**	**Challenges**
JUL	› CaTHC website created. › Consultation pack developed. › Co design approach developed further with regional expertise on specific work areas.	› SoI presented to TCICA meeting. › Alternative options for mayors signing SoI canvassed, including TCICA as regional representative.	› Letter to Aus and QLD Health Ministers from QAIHC, TCICA, TSRA, and GBK supporting the CaTHC on behalf of the community they represent.	› PSC meeting: GBK and Cape York Land Council to join PSC. › Workshop between project partners on co-design, community engagement etc.	› PSC agreed establishment of Aboriginal and Torres Strait Islander Community Controlled Steering Committee / Community Caucus in CaTHC governance. › Proposed co-design working groups.	› Minor ongoing delays in community engagement and co-design and other work packages.
AUG	› CaTHC website launched. › Presentations at regional summit on community-controlled commissioning.	› Regional Stakeholder Summit held 31 Aug – 1 Sep. Attended by 60. › Australian Gov Health Minister did not attend.	› SoI not signed on advice from stakeholders that it was not required. › Torres Strait representatives were not supportive of SoI, and informed Ministers.	› **PSC meeting:** consultation pack approved.	› Entity design discussions commenced at the Summit, including a co-design approach.	› Torres Strait representatives disengaged, awaiting outcomes of Health Service Investigation and LGA elections in 2024.
SEP	› Updated community engagement approach.			› CaTHC Project Partnership Workshop.	› **Proposed transitional governance structure (Interim Board):** to be community-controlled.	› Several workstreams on hold until transitional governance (Interim Board) in place.
OCT	› Co-design of entity, community engagement to be shifted to Interim Board.	› CaTHC Community Caucus - multiple regional stakeholders, QAIHC and QH. › Proposed establishment of Interim Board, including functions and responsibilities.	› Broad endorsement at Community Caucus for Interim Board. › Chair nominated and other attendees noted interest in joining.	› **PSC meeting (out of session):** Entity Day 1 functions and proposed structure agreed. › CaTHC Transition Group. Agreed to Interim Board and process to establish and appoint members/CEO.	› Options canvassed for Interim Board, including host organisation, workplan, funding. EoI for Board members to accommodate regional interests.	› Several workstreams on hold (co-design, entity design, transition) until Interim Board operational. › Probity and conflict of interest concerns raised.
NOV-DEC	› CaTHC Newsletter launched. › Engaged TCHHS though workshop.	› Interim Board presentation made to TCICA for recommendation. › EOI for Interim Board membership closed – 8 nominations received (1 EOI, 7 from QAIHC) and 1 CEO nomination.	› Letter from QAIHC, TCICA, GBK to Health Ministers with recommendation to appoint Interim Board.	› CaTHC project team workshop to discuss workstreams. › CaTHC discussed at Joint Ministerial Roundtable.	› Progress on governance awaiting appointment of Interim Board.	› Torres Mayors meet with Aus Health Minister – prefer Interim Board delayed until after Health Service Investigation and Council elections. › Formal QH appointment of Interim Board delayed. › Consultation with councils cancelled - cyclone.

TABLE 3. ENGAGEMENT AND GOVERNANCE FLOWCHART

Phase 5: CaTHC Establishment						
2023	**Community Engagement**	**Regional Engagement - Elected Leaders, Service Providers etc**	**Community, Regional Leaders' Commitment to CaTHC**	**PSC and Planning Decisions**	**Governance Activities and Decisions**	**Challenges**
NOV-DEC	› CaTHC Newsletter launched. Engaged TCHHS though workshop.	› Interim Board presentation made to TCICA for recommendation. › EOI for Interim Board membership closed – 8 nominations received (1 EOI, 7 from QAIHC) and 1 CEO nomination.	› Letter from QAIHC, TCICA, GBK to Health Ministers with recommendation to appoint Interim Board.	› CaTHC project team workshop to discuss workstreams. › CaTHC discussed at Joint Ministerial Roundtable.	› Progress on governance awaiting appointment of Interim Board.	› Torres Mayors meet with Aus Health Minister – prefer Interim Board delayed until after Health Service Investigation and Council elections. › Formal QH appointment of Interim Board delayed. › Consultation with councils cancelled - cyclone.
2024						
JAN			› Continued support for CaTHC from regional stakeholders. › Adoption of independent community-controlled process for establishing Interim Board and CaTHC Entity.	› DoHAC and QH workshops conducted, Entity decision and funding prioritisation framework. › Internal QH engagement on legislation and funding requirements.	› CaTHC Interim Board was independently established, supported by QAIHC. › Interim Board membership includes Mayors of Mapoon, NPA, Kowanyama, Lockhart River, Hope Vale, and GBK	› Torres Shire Council Mayor does not support Interim Board establishment CaTHC Project workstreams and milestones delayed. › CaTHC Project Partnership on hold and limited communication.
FEB	› Service provider engagement plan revised. NARHDC and ORRH stakeholder meetings- provide overview of the CaTHC project.	› Health Minsters respond to QAIHC, TCICA, GBK requesting joint workshop around Interim Board and project partnership moving forward.		› Commenced legislative impact assessment. › 1st CaTHC Project Partners meeting 2024.	› CaTHC Interim Board independently established, driven by QAIHC - met 3 times during Feb. › QAIHC contracting externally for establishment of Entity.	› CaTHC Project workstreams and milestones were delayed. › CaTHC Project Partnership on hold. › PSC did not meet. Elected Torres Strait leaders not engaging in CaTHC Project.
MAR	› Workshop/all staff meeting with TCHHS.	› Chair Interim Board, QAIHC, Minster Fentiman and QH meet to discuss workshop -partnership principles and workplan.	› Communication between chair Interim Board and Health Ministers.			› Project workstreams delayed and status unknown. › Role of QH uncertain, with limited communication from Interim Board on Project status.
APR			› Interim Board and QAIHC commence steps to establish CaTHC, constitution, registrations etc.	› Workshop between Interim Board, QAIHC, QH and DoHAC to reset agreed roles and approaches moving forward. › QH agrees to fund CaTHC operation.		› QH unsure of work package status, responsibilities and timing for project.

TABLE 3. ENGAGEMENT AND GOVERNANCE FLOWCHART

Phase 5: CaTHC Establishment						
2024	**Community Engagement**	**Regional Engagement - Elected Leaders, Service Providers etc**	**Community, Regional Leaders' Commitment to CaTHC**	**PSC and Planning Decisions**	**Governance Activities and Decisions**	**Challenges**
MAY	Establishment of CATHC Entity and Board.					
		› QH meeting with CaTHC Board and TCHHS Board in Cairns. QH met CHHHS and RFDS for briefings and updates.	› Appointment of CaTHC Board Directors. Monthly meetings to establish new entity functions.	› Partnership group (re) established between CaTHC, QH, DoHAC and QAIHC.	› Terms of Reference for new governance arrangements under development by QAIHC.	› Torres Strait representatives remain disengaged.
JUN			› CaTHC Board monthly meeting.	› PSC formerly closed.	› Accountability Framework and Partnership Agreement under development by DoHAC.	› Awaiting the appointment of CaTHC CEO to progress reform items.
JUL			› CaTHC Board monthly meeting.		› Redrafted bilateral agreement between Aus and QLD governments.	› Torres Strait representatives remain disengaged.
AUG			› CaTHC Board monthly meeting.		› QH and DoHAC meet on reform priorities. Recruitment of CEO.	› Divergence on who should be members of the Strategic Partnership Group.
SEP			› CaTHC Board monthly meeting. › **CaTHC publicly launched.**	› Draft Terms of Reference for Strategic Partnership Group developed.		
OCT			› CaTHC Board monthly meeting. › CEO internally appointed.			
NOV			› CaTHC Board monthly meeting.		› CaTHC CEO commences in position.	
DEC				› Monthly meetings between QH, DoHAC and the CaTHC CEO commence.		

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