Guidelines for participatory place-based health planning: Northern Queensland experiences

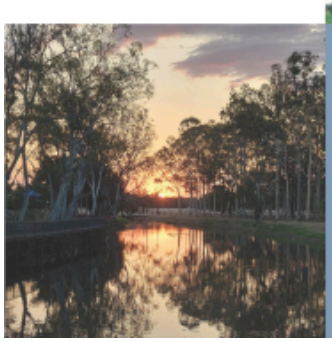


An output of the Integrating Health Care Planning for Health and Prosperity in North Queensland project

Deborah Smith, Karen Johnston, Mim Crase, Catherine Wilkes, Stephanie M Topp, Maxine Whittaker, Christopher Rouen, Alexandra Edelman and Sarah Larkins







Guidelines for participatory place-based health planning: Northern Queensland experiences

GUIDELINES FOR PARTICIPATORY PLACE-BASED HEALTH PLANNING: NORTHERN QUEENSLAND EXPERIENCES

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ACKNOWLEDGEMENT OF COUNTRY

At James Cook University we acknowledge with respect the Aboriginal and Torres Strait Islander peoples as the first peoples, educators and innovators of this country. We acknowledge that Country was never ceded, and value the accumulation of knowledge and traditions that reflect the wisdom of ancestral lines going back some 60,000 years, and recognise the significance of this in the ways that Aboriginal and Torres Strait Islander peoples are custodians of Country. As a University, we will continue to learn ways to care for and be responsible for Country, and we will collectively seek to build a future that is based on truth-telling, mutual understanding, hope, empowerment, and self-determination.



Kassandra Savage (JCU Alumni), 'Coming Together and Respecting Difference', acrylic on canvas, 2014, 90cm x 90cm. © Kassandra Savage, reproduced with permission of the artist.

ACKNOWLEDGEMENTS

Acknowledgement of Country

The authors respectfully acknowledge the Traditional Custodians of the lands on which our project team works, and the communities involved in this project. We honour their enduring connection to Country – to land, waters, and culture. We pay our deepest respects to Elders past and present and extend that respect to all First Nations peoples.

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PROJECT PARTNERS

Project partners in the *Integrating Health Care Planning for Health and Prosperity in North Queensland* Project provided oversight of the project through their involvement on the Technical Reference Group. Partners were:

- Cooperative Research Centre for Developing Northern Australia
- Tropical Australian Academic Health Centre Partners:
    - Cairns and Hinterland Hospital and Health Service
    - Mackay Hospital and Health Service
    - North Queensland Primary Health Network
    - North West Hospital and Health Service
    - Torres and Cape Hospital and Health Service
    - Townsville Hospital and Health Service
    - James Cook University / Australian Institute of Tropical Health and Medicine
    - Queensland Aboriginal and Islander Health Council
- Western Queensland Primary Health Network
- Queensland Health Office of Rural and Remote Health
- National Rural Health Commissioner
- Northern Territory Department of Health
- The Rural Clinical School of Western Australia

ABOUT THE AUTHORS

Dr Deborah Smith is an experienced Senior Project Manager and Researcher at James Cook University's (JCU) College of Medicine and Dentistry. Since 2018, she has led and supported a range of strategic research and implementation projects aimed at strengthening health systems, improving access to healthcare, and enhancing health outcomes in rural and remote communities. Deb's current work focuses on optimising telehealth processes to inform the development of contextually relevant service delivery guidelines.

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Mrs Catherine Wilkes worked as the Local Connector for the project, supporting the delivery of activities in the Clermont community. A former long-term resident, Catherine operated a local accommodation business and was actively involved in various volunteer roles across the community. She was employed by Clermont Connect, a local not-for-profit agency, which partnered with **JCU** to help implement the project.

Professor Stephanie M Topp is a health policy and systems researcher with a background in global public health, political, and social sciences. Stephanie co-convenes the James Cook University Masters of Public Health – Masters of Global Development, and is the Director of the **JCU** Centre for Rural Remote and Tropical Health Systems. Her research focuses on the political and power dynamics influencing equitable access to health systems and improved health outcomes. Stephanie has published in texts such as the World Health Oorganisation (WHO) Health Policy and Systems Research Reader on Human Resources for Health,

Maxcy-Rosenau-Last Public Health and Preventive Medicine, and The Routledge Handbook of Global Development and previously served on the Board of Directors for Health Systems Global.

Professor Maxine Whittaker is a public health physician and health systems researcher who is an international expert on improving the health systems and services to increase accessibility and acceptability of quality services to populations and a public health leader in One Health and the Director of the **WHO** Collaborating Centre for Vector Borne Diseases and Neglected Tropical Diseases. Maxine's research interests are in fields of operational and health services research and medical anthropology, with a primary focus on One Health, sexual and reproductive health, health seeking behaviour and quality of care. She has a special interest in the issue of scaling-up pilot programmes into policy and practice.

Christopher Rouen is a health economist, lecturer, and researcher within the discipline of Public Health and Tropical Medicine at **JCU**. He has a strong research interest in economic evaluation methodologies and the economics of mental health. In his spare time, Christopher is also a director of the Dr. Edward Koch Foundation, a suicide prevention organisation based in Cairns. Within the Clinical Psychedelic Research Lab, Christopher is interested in generating evidenced-based economic information for use in the economic evaluation of psychedelics.

Associate Professor Alexandra Edelman is Adjunct Research Fellow within the College of Medicine and Dentistry at **JCU**. She also leads both the Remote Health Systems and Climate Change Centre (RHC3) and Wellbeing and Preventable Chronic Diseases Division within Menzies School of Health Research. Alex leads multiple teams and programs of research relating to health systems, policy, knowledge translation, and remote health with partners based across remote and northern Australia, nationally, and internationally.

Professor Sarah Larkins is an experienced research leader, academic general practitioner, Dean, College of Medicine and Dentistry and Professor of Health Systems Strengthening at **JCU**. Sarah has particular skills and experience in health services and workforce research and in Aboriginal and Torres Strait Islander health research and is an internationally recognised expert in social accountability in health professional education. Sarah is also a current member of the NHMRC Research Committee (2022-24) and was Co-Director of the Anton Breinl Research Centre for Health Systems Strengthening, a centre of the Australian Institute of Tropical Health and Medicine for many years.

WHO SHOULD USE THESE GUIDELINES?

These guidelines will be useful for individuals or organisations (such as those listed below) who are contemplating or planning local health service change, innovation or redesign and students in preparation for work within the health sector. The guidelines may be useful for:

Sector	Stakeholders
Community:	• Community members and advocates • Community organisations • Local health services/providers • Local governments/councils • Aboriginal and Torres Strait Islander Community Controlled Health Services
Regional or State/ Territory:	• Hospital and Health Services (HHS) • Primary Health Networks (PHNs) • Service consortia/collaborations • Aboriginal and Torres Strait Islander Community Controlled Health Organisation Peak Bodies
Undergraduate / Postgraduate Students:	• Health professional students • Public health • Aboriginal and Torres Strait Islander Health



TIP!

If place-based health planning work is being driven by an individual or party external to the community or place, it is vital to ensure there is local community support for the work prior to commencement. Guidance is provided in the next chapter.

HOW TO NAVIGATE THESE GUIDELINES

These guidelines were developed as part of the *Integrating Health Care Planning for Health and Prosperity in North Queensland Project*, also known as the place-based health planning project. The guidelines describe overarching principles of place-based health planning and key steps including detailed procedures. The key elements of this approach include:

- gaining a deep understanding of the context in which services are accessed and delivered, including community dynamics, diversity, historical influences, and geographic considerations
- identifying and engaging critical partners at all levels who are essential to the success of the initiative
- collaboratively identifying community health priorities and service needs
- co-designing or redesigning service models with genuine, purposeful community engagement
- implementing, monitoring, and evaluating new or adapted models of care.

The guidelines are presented in the following chapters:

- **Chapter 1** provides a brief overview of the project and outcomes from phase one which informed the work in communities.
- **Chapter 2** discusses how to define a place for the purposes of place-based health planning.
- **Chapter 3** outlines the core principles underpinning participatory, place-based health service planning. These principles are fundamental to the planning process, highlighting key factors for consideration and providing a foundation for the process across various applications.
- **Chapter 4** adopts a procedural focus, detailing the essential steps involved in implementing participatory, place-based health service planning. This chapter is supported by practical examples and suggested activities to guide application.
- **Chapter 5** discusses the resources required to undertake this type of project.
- **Chapter 6** outlines the next steps to progress planning work.

After discussion of the guidelines, practical examples are provided to illustrate their application. These include examples of resources, templates, and case examples drawn from our work across the three project communities. All materials and templates developed during the project are available for use and adaptation with appropriate acknowledgement. Individuals or those within organisations interested in place-based health planning can use this guide either as a step-by-step roadmap or to consult specific sections for targeted information and support.



TIP!

Review the guidelines, explore the practice examples, and use the templates as appropriate to support your work.

CHAPTER 1: INTRODUCTION

The *Integrating Health Care Planning for Health and Prosperity in North Queensland project* aimed to improve the responsiveness of health services to the health needs of local communities in the Northern Queensland (NQ) region, by undertaking a place-based approach to health planning. Participatory place-based health service planning engages communities in achieving shared understandings and decision-making to co-produce solutions to local issues. It facilitates a locally grounded approach to generate locally relevant and sustainable solutions to health and health service issues with the aim of optimising health service effectiveness and efficiencies.[1] It is distinct from the more widely used population-based and place-focused planning which takes a top-down approach to service adaptation led by individuals or organisations external to the place or community of interest and with minimal community involvement.[2]

The four-year project commenced in April 2021 and was conducted in two phases. In phase 1, the Northern Queensland Health Atlas was developed and piloted to inform planning in the region. This is an online, freely available interactive tool that contains publicly accessible data about demographics, health services and health workforce that can be overlayed to facilitate comparisons and understandings of place. It provides proof of concept that data, that are otherwise difficult to find across a multitude of platforms, can be presented in a single, easily accessible place. Data accessibility challenges have been described elsewhere.[3] A gap analysis provided an initial overview of unmet need in the project region, that is, a general understanding of imbalances between population need and services available.

The Atlas and accompanying gap analysis (discussed in Chapter 2) informed consultations with key project partners and stakeholders to assist in prioritising communities for inclusion in phase two of the project and to trial place-based planning. Additional selection criteria included the desire to engage a diverse mix of communities and geographic regions to maximise learning opportunities. Crucially, the level of interest and willingness of stakeholders within each community to participate in the project confirmed the involvement of the community in the project. Following local engagement and confirmation of interest, three communities progressed into Phase 2: Clermont, Hughenden, and Kowanyama (Figure 1.1). These are all remote or very remote communities (MM6/7) as classified by the Modified Monash Model.[4] More details about each community are presented in community profiles noted in the Resources section below.

RESOURCES

A profile for each community was compiled including information that was available on health of the local population and services. These documents are available on the project website:

https://www.taahc.org.au/research/integrating-health-care-planning-for-health-and-prosperity-in-north-queensland/project-communities/

The development of these guidelines has been shaped by the knowledge and experiences gathered throughout the project. They provide practical information and guidance on participatory place-based health service planning, using a co-design approach, and incorporate key learnings from the project and from approaches that have been developed and tested in other rural and remote areas globally.



Figure 1.1. Project community locations

Notes

1. Yeboah, D. A. (2005). A framework for place-based health planning. *Australian Health Review, 29*(1), 30-36. https://doi.org/10.1071/AH050030
2. Panzera, A. J., Murray, R., Stewart, R., Mills, J., Beaton, N., & Larkins, S. (2016). Regional health workforce planning through action research: Lessons for commissioning health services from a case study in Far North Queensland. *Australian Journal of Primary Health, 22*(1), 63–68. https://doi.org/10.1071/PY15149
3. Topp, S. M., Thompson, F., Johnston, K., & others. (2023). Democratising data to address health system inequities in Australia. *BMJ Global Health, 8*, e012094. https://doi.org/10.1136/bmjgh-2023-012094
4. Australian Government, Department of Health, Disability and Ageing. 2025. Modified Monash Model. https://www.health.gov.au/topics/rural-health-workforce/classifications/mmm

CHAPTER 2: DEFINING AND ENGAGING WITH COMMUNITIES OF PLACE

The approach to place-based health planning described in these guidelines focuses on community engagement in planning within a 'community of place'. A community of place refers to a specific geographic area where a local society, defined by its structures, organisations, and processes, functions to facilitate collective action.[1] A town could be a community of place and defined by geographic town locality, or by administrative boundaries such as local government area (LGA), for example. A community of place could also be a series of localities in close proximity to each other that fall into the same Health Service catchment, or tend to work together due to geography, and shared resources or services such as visiting health professionals.

Identification of a need to undertake health planning may have various origins. For example, there may be a need for planning identified within a local community by individuals, groups or organisations. Larger organisations with responsibilities for health across a geographic region, such as a **PHN** or **HHS**, may identify a need to take a deep dive into the health and service needs of particular communities. Regardless, defining the 'community of place' is essential to inform the extent of context mapping, engagement activities and anticipated project outcomes.

Once the community, or place, has been defined, if the work is being driven by a party external to the place, such as a university, or urban-based unit within a **HHS**, or **PHN**, early engagement and consultation with local key stakeholders is required to determine interest in undertaking such work and establish buy in. Local interest in the work, at the current time, is essential, or encouraging participation will be very challenging.

IN PRACTICE

Defining and prioritising a community of place for place-based health planning for the project

Through the project, a broad approach was undertaken, defining a community of place at the level of local government. **LGAs** across the five northern **HHS** districts were ranked in order of unmet need using planning tools that were developed – the Northern Queensland Health Atlas and a gap analysis assessing unmet need. Initially, the Northern Queensland Health Atlas was compiled bringing together data about communities across the region, to help make data more accessible and to inform planning and decision making.

The Atlas is an interactive online platform that presents data on population, health status and behaviours, hospital use, workforce, health service provision, and service locations through detailed maps. It enables users to overlay various data types to compare and explore differences across North Queensland communities, helping to build a deeper understanding of each place. This planning tool supports the identification of service gaps, underserved areas, and potential inefficiencies caused by service duplication. The Atlas features more than 200 data layers and is complemented by a Data Sources and Information Booklet that outlines the origins and details of the included data. Challenges experienced by the team in accessing data have been published elsewhere (Figure 2.1).



Practice

Democratising data to address health system inequities in Australia

Figure 2.1. Read about challenges faced in accessing data.

A gap analysis took a pragmatic approach, drawing on key principles of health care

equity to develop a composite Index of Unmet Need. The Index integrated an Index of Population Health Need (which was developed using indicators related to health determinants, current and projected health needs, and service demand), and the Index of Service Availability (which was based on workforce data and geographic access. [2] This approach highlights variations in relative health needs and service availability across different locations by utilising known contributors to health inequity. The analysis was carried out at the **LGA** level and results at June 2022 are depicted in Figure 2.2.

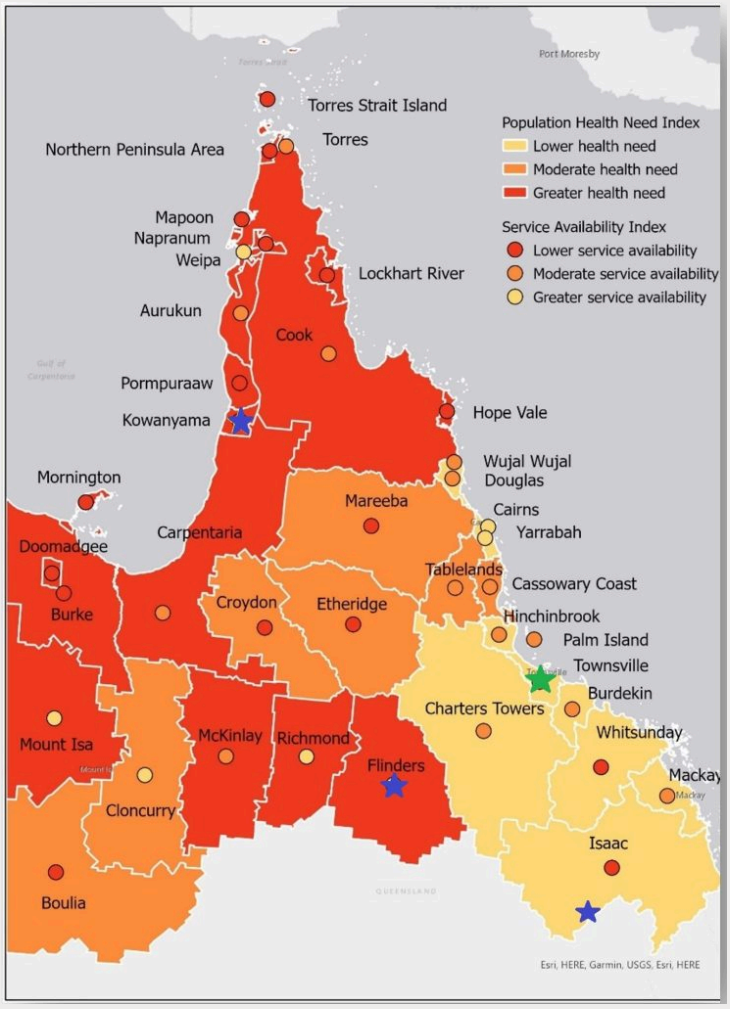


Figure 2.2. Atlas map showing population health needs, service availability and location of project sites.

The Atlas and gap analysis report informed discussions and guided consultation with

key project stakeholders to prioritise **LGAs** (and/or primary communities) across the region, where more effective models of care or the redistribution or integration of services to best meet need could be particularly beneficial. Consultation was undertaken broadly with key stakeholders in the project including:

- Project Technical Reference Group
- **TAAHC** Board (including **HHS** Executives)
- **TAAHC** Clinical Leadership Group
- Better Health **NQ** Health Needs Assessment / Local Areas Needs Assessment working group
- Other individual stakeholders (e.g. key **HHS** staff).

Other criteria were also considered in prioritisation, including assessing whether there was actually interest among the local community stakeholders in participating in place-based planning at the current time; and for the particular purposes of the project, we wanted coverage of a range of different community types and regions to maximise learnings. Once the communities were prioritised, further consultation was undertaken with key stakeholders in each community to determine if there was interest in participating in the project at the current time.

RESOURCES

Northern Queensland Health Atlas. Available at: https://arcg.is/5a4Xq

A Gap Analysis of Health Needs and Services in the Northern Queensland Region June 2022. Available under project resources at: https://www.taahc.org.au/research/integrating-health-care-planning-for-health-and-prosperity-in-north-queensland/

Topp, S. M., Thompson, F., Johnston, K., Smith, D., Edelman, A., Whittaker, M., Rouen, C., Moodley, N., McDonald, M., Barker, R., & Larkins, S. (2023). Democratising data to address health system inequities in Australia. *BMJ Global Health*, 8, Article e012094. https://doi.org/10.1136/bmjgh-2023-012094

.

TIP!

How to start early engagement with a community to confirm interest

A key requirement for effective place-based health planning is ensuring that the local community has both the interest and capacity to participate in planning activities. It's also important to consider the timing of engagement in relation to other ongoing initiatives and events.

In northern Queensland, a Council is the governing body of a local area, tasked with managing local affairs, including planning for community needs and providing public services for the local community. The Mayor and Councillors are elected to represent the community and make decisions on their behalf. As a leader and representative of the local community, the Mayor in each community was contacted to discuss the project and what it involved, and to ascertain whether there may be interest, capacity, and it being the 'right time' on behalf of the broader community (Figure 2.3).

Local and regional health service managers should ideally play a key role in prioritising locations. In some cases, early engagement with local health service managers, including Aboriginal and Torres Strait Islander Community Controlled Health Organisations/Services, may be necessary in the lead up to the work, to establish relationships and secure their support. Taking proactive steps in this regard can help ensure a well-coordinated approach.

Processes and approval requirements may vary in different communities, especially Aboriginal and Torres Strait Islander communities. In the remote Aboriginal community of Kowanyama, the local Council outlines processes for external stakeholders to make contact on its website.



Figure 2.3. Early discussions between the project team and Jane McNamara (Hughenden Mayor 2016-2024).

Notes

1. Taylor J., Braunack-Mayer A., Cargo M., Larkins S., & Preston R. (2013). A role for communities in primary prevention of chronic illness? Case studies in regional Australia. *Qualitative Health Research, 23*(8), 1103-13. https://doi.org/10.1177/1049732313494482
2. Impact Co. (2018) North Western Melbourne Primary Health Network - After hours primary health care: Gap analysis and recommendations. https://nwmphn.org.au/wp-content/uploads/2019/03/181219-NWMPHN-After-Hours-Gap-Analysis-Final-Report-FINAL.pdf

CHAPTER 3: PRINCIPLES OF PARTICIPATORY PLACE-BASED HEALTH PLANNING

Six core principles underpin participatory place-based health planning (Figure 3.1). In summary, at the heart of participatory, place-based health planning is the recognition that local people are best positioned to understand the needs of their communities, as well as the practical realities of what may or may not be effective within their specific environment and context. This locally grounded knowledge is essential for building on community strengths, ensuring the efficient use of resources and funding, and ultimately improving health outcomes.



Figure 3.1 Principles of participatory place-based heath planning.

It is important to acknowledge that each community is unique, and within communities, there is considerable diversity. Individuals and groups may have differing needs, perspectives, and experiences. By facilitating broad and inclusive participation in health planning processes, it becomes possible to recognise these differences, work toward identifying shared goals, and ensure that all partners have a common

understanding of the issues. This inclusive approach supports collective decision-making and more sustainable outcomes.

This work is inherently complex. It requires a commitment to understanding relationships and recognising that change can be challenging-often requiring stakeholders to step outside their comfort zones. Planning should not be seen as a one-time activity, but as an ongoing and adaptive process. Continuous monitoring, evaluation, and responsiveness are essential. Reporting back to the community will facilitate accountability and allow for real-time adjustments and iterative improvement over time. Each principle is explored in more detail in this chapter.



IN PRACTICE

It is important to define the scope of the work in the early stages.

The nature of the project described here was broad reaching in that it encompassed many different types of health services and invited participants from all sections of community to identify and discuss various factors affecting health in the local community. However, these guidelines can also be applied in a more targeted manner to explore specific health issues in greater depth. The work may focus on planning the delivery of particular health services—such as those provided by a specific organisation, a service stream like community health promotion, community-led planning initiatives, or strategies to facilitate social innovation.

PRINCIPLE 1. CENTRING LOCAL KNOWLEDGE

Centring local knowledge acknowledges local people are best placed to understand needs and practicalities of what will work in their context.

- Local residents (including local service providers) have valuable first-hand historical and contemporary knowledge about what health services are available in their community, how easy they are to access, how well they meet people's needs, and how smoothly they work together.
- Local residents are best placed to communicate their own priority health needs.
- Local residents may have expertise in understanding strategies that will be effective in their context.
- Communities often have key individuals who are 'boundary spanners' who have special knowledge of the relationship between community and health services.
- Local residents may not always want/be able to prioritise participatory health service planning due to other commitments or events in their community. Sensitivity regarding the timing of processes according to local events and readiness is therefore vital.



Figure 3.1.1. Connecting with local groups: the Clermont Men's Shed.

IN PRACTICE

Although we have access to data from a variety of sources, statistics alone rarely reveal the reasons behind observations and trends. The community holds valuable contextual knowledge and understands the realities of their local environment. For example, data may show a high rate of missed appointments (did not attend – DNAs), but it won't explain that in summer in the outback community of Hughenden, temperatures often reach 36^{0} Celsius and higher. People without transport may choose to not attend their appointment because the clinics are generally held at the **MPHS**, which is located on the outskirts of town on the Flinders Highway. It is an uphill walk with many passing road trains (Figure 3.1.2). Suggestions such as relocating the clinic to be run from a more central location in town such as at the **GP** clinic, could help improve attendance. Alternatively, another strategy is to tackle the limited availability of local public transport. During the project, no public transport services were operating in town.



Figure 3.1.2. The Flinders Highway out to the MPHS on the edge of town.

PRINCIPLE 2. RECOGNISING COMMUNITY DIVERSITY

Communities are not homogenous; they are comprised of individuals and services with varied experience, skills and needs; each community is unique.

- Communities comprise a diverse range of residents with differences that cut along linguistic, wealth, gender, age, ethnic, cultural, geographic and other lines.
- Various organisations and groups may be present and represent some sections of the community (Figure 3.2.1). However, keep in mind they may not represent the views of all their members.
- These differences inform competing, contested and changing values, needs, and agendas, and contribute to community-specific dynamics that reflect both current, and historical relationships and balance of power.
- Diversity and differences within the community of interest must be anticipated, recognised and acknowledged. Appropriateness of responses should be considered to incorporate diversity and variations.
- Effective community engagement and co-design work requires iterative, time-sensitive, deep listening approaches to understand these varied perspectives and relational dynamics and understand how they work in context.
- Selection and design of participatory approaches (see Principles 3 and 4) must be relevant to and effective in accounting for these intersecting contextual and community features.



Figure 3.2.1. Example of the diverse organisations and groups in the Hughenden community.

IN PRACTICE

In Hughenden, many participants in the project workshops expressed that they were not aware of the diverse range of individuals and groups living locally in and around the community. Whilst most were aware of different groups within the community, such as mums and bubs, older residents and the local Aboriginal and Torres Strait Islander population, many were unaware of the extent of others' needs and issues. Many were also unaware of emerging groups that were coming to town, particularly with economic initiatives and projects. For example, a Pacific Islander cohort had relocated and were working on the local grape farm and a cohort of Romanian people had been recruited and were working just outside of town through renewable energy projects (Figure 3.2.2). This brought new families to town from different cultures and a new range of work-related injuries as there previously had not been any solar or wind farms in the area.



Figure 3.2.2 Renewable energy projects have brought in workers and their families from different cultural backgrounds.

PRINCIPLE 3. ALIGNING VALUES AND GOALS

Place-based health planning involves implementing processes and stewardship to align values and goals, build mutual trust and respect among partners, and provide a foundation for collaborative work.

- Different individuals and organisations bring different values, goals, and 'power' to co-design activities.
- Deliberate use of participatory tools and techniques to engage different partners, identify mutual goals and align priorities is the basis of mutual trust and respect, and provides a foundation for both current and future collaboration.[1]
- Exploring assumptions about what is truly in or out of the control and remit of each partner can be empowering and lead to more creative thinking about solutions to identified issues.



IN PRACTICE

It is important for all stakeholders and partners to understand the needs and issues for all individuals and groups within the community. With this knowledge and understanding, participants can discuss values and identify common priorities. This enables participants to align and establish common goals and negotiate important actions for improvement to focus on in the short, medium and long term. During the co-design process, participants collaborated and agreed on an essential basket of services and principles for health service delivery. These values guided discussions about unmet health needs and possible solutions. Such discussions were held through the co-design process (see step 3). The needs and issues of all individuals and groups within a community were acknowledged by participants as essential to document in writing in a place-based plan for the community. Through the co-design discussions, participants discussed and negotiated a prioritised plan which set accepted goals to work toward in the short term.

Notes

1. The University of Kansas 1994-2025, Community Tool Box. Available online: https://ctb.ku.edu/en

PRINCIPLE 4. SHARED DECISION MAKING

Thoughtful design and application of mechanisms to distribute (rather than consolidate) decision-making power improve robustness, ownership and sustainability of actions taken.

- Shared decision making improves the robustness of decisions, ensures ownership across a network for actors, and strengthens sustainability of actions taken beyond project timeframes.
- Collaborative decision-making processes are not 'power-free' zones. Thoughtful design and application of participatory techniques are essential to distribute (rather than consolidate) decision-making power across all partners; centring local knowledge in those processes is critical (Principle 1).
- Existing forums or platforms for local decision-making may prove useful, but sensitivity to their strengths and weaknesses as spaces for shared decision-making is essential.



IN PRACTICE

Many lay community participants (non-health professionals) in the planning process felt that Hospitals and Health Services held much of the power in decision-making when it came to health care and health services. However, it was also confirmed that Community Advisory Networks and Health Advisory Network Teams were in place to facilitate consumer feedback on services and current and future health needs. Such consumer-focused channels only acknowledge the value of the consumer as an individual, neglecting their value as a community member with power through community collective action. The project was described as 'making waves' and the plans that were developed through shared decision-making and aligning values and goals provided evidence to present through consumer advisory channels to influence and encourage further shared decision-making with health services.

There were also some strategies or actions identified that could be directly addressed by individuals and external agencies. Shared goals were addressed through development of collaborative partnerships.

For example, a Council bus was used to pick up community members to transport them to the clinic for their flu shots, thus overcoming a long-standing issue of access to preventive health activities.

Place-based health planning takes a holistic approach and in all project sites there were factors

impacting on health, that were common goals that could be addressed by external agencies. Participants reported feeling empowered to advocate for improvements and changes.

PRINCIPLE 5. EMBRACING COMPLEXITY

Embracing complexity and using systems thinking helps to understand the rich tapestry of stakeholders; consider network effects; and adopt flexible and responsive planning cycles versus rigid, linear timelines.

- Organisations can be very complex, and many aspects of the health service environment will influence the willingness and enthusiasm of managers or providers in the health, disability, social, educational and community-based sectors to be engaged and involved. Factors include:
  - Leadership structure and lines of reporting (risk perception; sense of agency)
  - Workforce profile (availability; sense of relevance relative to other priorities)
  - Inter-professional, intra-service, and inter-service relationships
  - Impacts and pressures from previous unsuccessful advocacy or implementation of local innovations, and past or current policy-driven (top-down) change processes.
- Proposed actions to improve identified issues will vary in complexity. Implementing a mixture of quick wins (less complex but low impact) and more complex, time-consuming actions that have higher impact is important in maintaining momentum over the project timeline.
- Using systems thinking can help view communities as networks of tightly connected actors or stakeholders and recognise how changing the actions/decisions of one member will have ripple effects through the rest of the network.
- Complexity also reminds us that social networks are stable and often resistant to change; a commitment to relationship building at different levels and in different spaces, with different stakeholders is essential to supporting creative thinking and helping stakeholders step outside their comfort zone(s) to engage with possibilities, despite perceptions of barriers or past failures.
- Successful processes must be flexible to account for factors that influence engagement or participation at different times of the process.



IN PRACTICE

Complexity in place-based health planning was experienced in various ways. Engagement was required with managers at multiple levels in the preparatory stages and was ongoing. Frontline managers were not always able to, or were uncomfortable with, contributing without more

senior-level permission. As the work was part of a research project, evidence of community support was required, as well as ethics approval and governance authorisation. We found that understanding various programs and services supporting the health of the community, their funding models, scope and eligibility criteria was confusing. Arrangements for funding and serviceability also changed regularly, adding to the confusion.

Previous experiences with researchers and community politics impacted upon willingness to be involved in the project. In Kowanyama, previous research had branded researchers with a reputation for collecting data with no feedback provided, changes made or any perceived benefit for the community. Impacts and pressures from previous unsuccessful advocacy or implementation of local innovations, and past or current policy-driven (top-down) change processes were disincentives to participate in Clermont.

Relationships between organisations and social networks—whether among individuals or groups—can have both positive and negative effects. Active engagement, consistent presence in the community, and strong relationship-building contributed to enhancing the external teams' reputation in planning efforts. By aligning values, identifying common goals, and ensuring everyone had a voice in decision-making, the process fostered unity and strengthened the quality of the discussions.

PRINCIPLE 6. ENABLING ACCOUNTABILITY

Accountability requires meaningful and responsive community involvement, monitoring, evaluation and iteration in real time, reflecting on (and updating) shared goals.

- Coordinators should ensure processes are in place to appropriately govern and monitor the work, and ensure inclusive communication and regular feedback is provided.
- The planning work needs to be valued and seen as beneficial to all stakeholders and partners.
- Local governance of place-based health service planning initiatives through community reference groups and local connectors supports meaningful, responsive community involvement and accountability to the community and enhances sustainability.
- Cyclical and iterative (not rigid and time-bound) implementation strategies recognise that communities, services and networks comprise multiple stakeholders, with multiple levels of leadership that require flexible and responsive planning approaches. Continuous improvement is cyclical and evaluation of actions and outcomes can contribute to incremental and more significant improvement.
- Evaluation strategies may be adapted to different actions and shared goals and focus on process as well as outcomes. Early consideration of who will carry out evaluations is required, and how, will help to inform what data is collected, when and how it will be analysed. Evaluation and feedback loops can/should inform local groups and stakeholders as part of the planning cycle, as well as funding bodies.
- Planning and continuous improvement should be a cyclical process and this process repeated at regular and appropriate intervals.



IN PRACTICE

Within each community, a local reference group was appointed to oversee and provide guidance on the project. A key facilitator of collaboration with the local reference group was the Local Connector (employed by the university) who helped with engagement and networking with local service providers and the community. The project team were accountable to this group and provided regular updates on progress and sought clarification for direction if needed.

Actions could be tweaked or redirected if necessary. This also facilitated accountability of the various partners in implementation. Engaging with the local group encouraged local ownership of the work and may have contributed to sustainability beyond the project.

In addition, the project team met regularly with the full research team in relation to research design and data collection, analysis and reporting (Figure 1.6). Changes in approach were sometimes required based on progress and feasibility of activities within each community. Formal reporting was also conducted every quarter with funding bodies.



Figure 1.6. Local Connectors Mim Crase and Catherine Wilkes analysing data.

CHAPTER 4: KEY STEPS IN PARTICIPATORY PLACE-BASED HEALTH PLANNING

This chapter provides an overview of how place-based health planning using a co-design approach was implemented in the project. Five key steps will be outlined as depicted in Figure 4.1. Our team facilitated activities within each community to work through each of these steps, keeping locals centred at each step of the process.

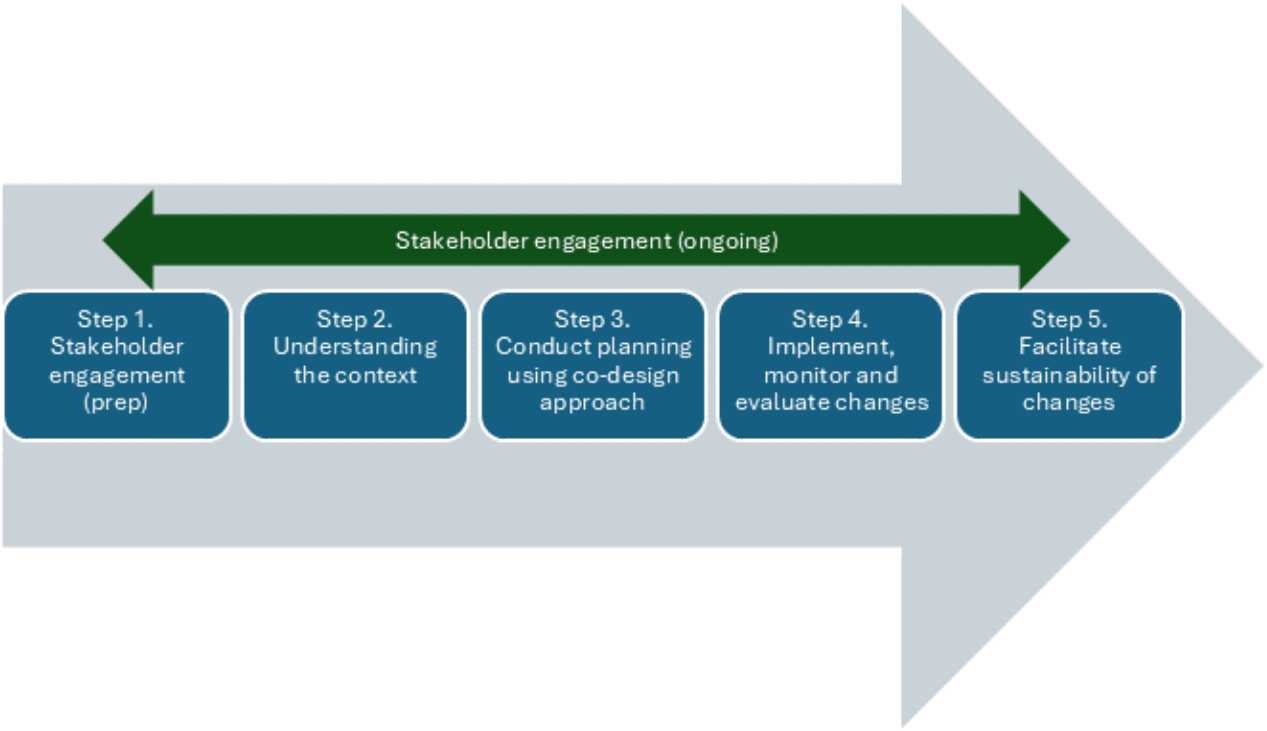


Figure 4.1. Key steps to conducting participatory place-based health planning.

Within each step, there are examples of how activities were implemented in the project and in some sections, templates or questions that can be used and/or adapted to guide the reader through the process.

STEP 1. STAKEHOLDER ENGAGEMENT (PREPARATORY AND ONGOING)

Stakeholder engagement

Stakeholder engagement is vitally important in the early stages leading up to, and ongoing throughout implementation of the work. Components of this step include:

- identify key stakeholders
- engage with community leadership early
- ensure community engagement is inclusive and ongoing
- consider cultural factors with engagement
- develop partnerships and community ownership
- engage with a local connector.

Identify key stakeholders

Who are they?

Identifying key stakeholders with a vested interest in health and health care services and engaging them early in the lead up to implementing the co-design planning process is paramount. Each community is unique and key stakeholders in health care planning and delivery will vary.

Key stakeholders are likely to include community leaders, health and community service providers, and community organisations at local and regional levels. Stakeholders may be identified as engagement continues and it's important to follow new leads as they emerge.

Particularly in small rural and remote communities, a mix of local and visiting health services is common. Try and identify all health professionals (private and public) who may visit the community. In addition, government departments at the state and federal level often have regional representatives who hold responsibility for delivery of government-funded services and programs in these communities (e.g., NDIS, My Aged Care). It may help to visually portray organisations and groups in the community in a stakeholder map (include other services and groups which might also be useful as communication channels). An example of a map for the Clermont community is presented in Figure 4.1.1. Stakeholder mapping may help to understand the relationships and networks within the community and it is important to note that

some stakeholders may have a perceived or real level of influence that may inform and/or impact on how the work progresses.

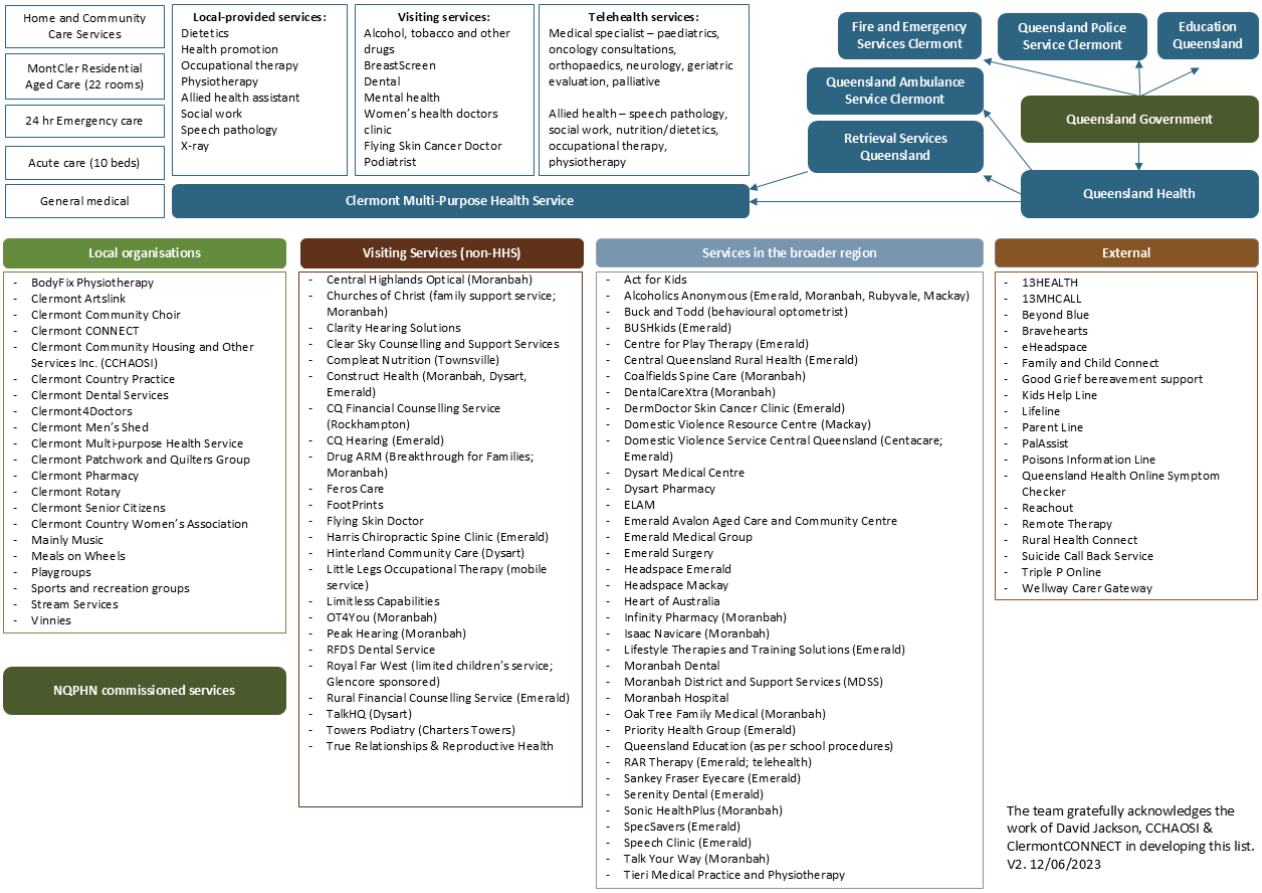


Figure 4.1.1 Clermont stakeholder mapping.

TIP!

Questions to ask!

Who are the local community? What groups are there? Consider social, cultural, industrial, sporting, etc.

Are there local champions who represent sections of the community? Be mindful that such champions may not represent the interests of all in their group.

What local organisations are present? Examples include individuals, families and local groups, local and regional hospital and health service staff, primary health network, public and private general practitioners, primary health care services, social and community services.

How to seek out stakeholders?

In addition to targeting the more obvious key stakeholders, conduct broad advertising and promotion of the project, its aims and planned co-design activities to increase awareness throughout the community and invite individuals and groups to be involved. Whilst email communication is useful in providing details, conversations with stakeholders both virtually and in person offer the opportunity to discuss aspects of the process and local contextual factors in more detail. Posters and flyers may help raise awareness of the work and facilitate those interested in being involved coming forward. Attendance at local community events can also help in promotion of the work (Figure 4.1.2).



Figure 4.1.2. Promotional stall at the Clermont Beef Expo.

Welcome all stakeholders who are interested and determine how they want to be involved. For example, some members may wish to be active participants, and others simply kept informed of progress and outcomes. Keep a record of all individuals, groups and agencies and their contact details and how they will be involved.

The development of a stakeholder engagement plan may assist in taking a strategic approach to identifying and seeking out stakeholders.

RESOURCES

Appendix 1 – Stakeholder Engagement Plan: provides an example of a plan for the Clermont community.

IN PRACTICE

Listen to our Local Connectors talk about promoting the project and encouraging participation:

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Engage with community leadership early

Community leaders include informal community champions, or formal leaders such as leaders of community organisations, local councillors, or health service professionals.

Communities often have a range of services that support different groups, so it's important to engage all relevant services early in the project. Clearly communicate how they can get involved. Focus on promoting social inclusion—for example, by considering gender, disability, age, and cultural diversity.

Discuss the proposal with key community leaders to understand timing and willingness to engage with the work, and gain support.

Ensure community engagement is inclusive

Information about the project, involvement and expected outcomes should be clearly communicated in forms that are accessible to all in the community. This could include existing local and regional networks, local newsletters or papers, community groups, social media, events and posters and flyers in common gathering places (Figure 4.1.3). Word of mouth through the 'community grapevine' has been identified as a key communication strategy to facilitate the promotion of planning work. Meet in places where stakeholders feel comfortable.



Figure 4.1.3. Providing information and engaging with stakeholders in places they feel comfortable. Used with permission.

Ensure that information about the work and issue is available before planned engagement activities. Clearly identify the options for participant involvement and benefit.

During engagement activities and throughout the work, ensure mutual respect for the language, values, standards, and voice of all. Developing guidelines together early in the work about the "ways we work together" is one effective strategy. Development of such guidelines would include discussion about anticipated differences and resistance, agreement on roles and responsibilities (including those of the facilitators initiating the engagement), and agreed visions of how to recognise conflicting priorities, engage respectfully and share decisions.

Guidance from the local reference group and local connector is essential in informing ways of working together and developing engagement strategies.

IN PRACTICE

Listen to our Hughenden Local Connector talk about community engagement:

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Consider cultural factors with engagement

Recognise that there may be separate procedures and approaches for respectfully engaging with Aboriginal and Torres Strait Islander communities and other culturally and linguistically diverse populations.

Cultural protocols differ across communities. They may involve liaison and discussion with local Aboriginal Shire Councils, Aboriginal and Torres Strait Islander Community Controlled Health Organisations/Services, local Elders or other protocols. It is a core responsibility of the group wishing to engage with a community to ensure they understand and follow protocols.

Develop partnerships and community ownership

Ensure modes of governance that promote local ownership of the work. The formation of a local project reference group consisting of key local and regional health and community stakeholders, including general community members (with inclusivity in mind), to advise and guide the work is important for community ownership. Inclusion of leaders who can effect change on this group will support the implementation of agreed solutions. Figure 4.1.4 depicts the initial meeting of group members for the project in the Clermont community.

An established local group may also be an option, depending on the scope of the group and representativeness of members. Utilising an existing group may help promote sustainability in the longer term. In Hughenden, the Community Advisory Network, a long-running group formed to advise the Hughenden Multi-Purpose Health Service, agreed to take on this role. In Kowanyama, the local interagency group agreed to take on the reference group role for the project.



Figure 4.1.4. Initial Clermont reference group meeting.

Develop terms of reference to ensure all participants are clear on the purpose of the group, its responsibilities, how it will operate and the approximate timeframe for the work to be completed.

Meet regularly throughout the project to monitor, for advice and guidance and alter actions where required. Whilst virtual modes enable easier participation, an initial in-person meeting is preferred to develop relationships between members. In-person meetings may also be beneficial at key times throughout the process.

RESOURCES

Appendix 2 – Terms of Reference: provides a template for rules and group composition of the governance group.

Engage with a Local Connector

If a local individual or agency is not driving the work, it is recommended that external agencies employ a local person, either directly or through a partnership with a local organisation, to inform and support the work and act as a ***Local Connector***. The role aims to introduce and connect the project team within local networks, communicate with the broader community and encourage participation and support the implementation of planning activities. The Local Connectors also provided local and historical knowledge about the community and promoted understanding of community-based interactions and discussions to the broader team. Through the project, Local Connectors were employed by the university to fulfil these roles (Figure 4.1.5).

Working together with a Local Connector or working in partnership with a community organisation throughout the project builds community ownership. It also ensures that external stakeholders initiating the project understand local interpretations and demonstrates that their commitment to a community is tangible through monetary investment.

Active inclusion of local people to advise, facilitate, implement, and evaluate the work offers two-way learning whereby all parties may, for example: increase knowledge of the community and region; build skills in project management, research and stakeholder engagement; or establish or renew local and regional relationships.

RESOURCES

Appendix 3 – Local Connector position description: lists potential accountabilities and selection criteria for a Local Connector role (project support officer).

IN PRACTICE

Listen to our Local Connectors talk about their roles:

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Factors influencing engagement and participation

There are many factors that influence involvement in place-based health planning and co-design activities. Factors include:

- timing of the work for the community
- leadership
- experiences of past engagement activities
- existing consultative and participatory mechanisms
- competing priorities.

Timing of the work for the community

Timing of the work should account for 'planned' and 'unplanned' events.

Planned events can be highly relevant to participatory place-based approaches but may also be a competing priority for engagement activities (e.g., school terms, council planning cycles, and community events such as the annual Show or expos).

Timing work to coincide with or build from other initiatives (locally led projects) or planning cycles (e.g. council and health service budget cycles, organisation health needs assessments cycles) can be an enabler of collaborative planning.

Unplanned events such as tragedies, sorry business and natural disasters will negatively impact community members' ability and desire to engage with planning work.

Timing is particularly important in small rural and remote communities where many local people may be involved/affected by such unplanned events.

Leadership

Early and continued engagement with local and regional organisations is essential to facilitate change or improvements.

Organisations often have hierarchical reporting lines, and building relationships with managers at multiple levels may be required to obtain support and the appropriate approvals for participation and subsequent implementation of change.

Navigating different processes in different organisations can be time and resource-intensive. But community leaders or champions can assist in driving enthusiasm for place-based planning work and facilitate involvement of harder-to-reach groups.

Experiences of past engagement activities

Rural and remote communities experience numerous, recurring requests for input/consultation by governments, academic and other organisations. Willingness to engage in planning activities will be influenced by past experiences of those interactions.

Awareness of positive and negative experiences of past work should inform approaches and timing of planning activities, with a firm goal of establishing positive, collaborative relationships that can lead to productive, sustainable partnerships.

Building trust will likely be necessary unless pre-existing relationships exist.

Building on existing work acknowledges previous community involvement and may offer early momentum for engagement activities.

Ensuring that outcomes and early impacts of work that involved community members are reported in accessible formats for the general community supports future positive collaboration with the community.

Existing consultative and participatory mechanisms

Understanding existing mechanisms for engagement among community members and/or with external stakeholders, and their strengths and weaknesses for broadening community engagement, is essential.

Existing mechanisms often bring together more powerful and motivated voices in the community. But decisions regarding the appropriateness of those mechanisms for longer-term health service place-based planning should be a shared process amongst the broader community.

Competing priorities

Community stakeholders in rural and remote settings who are most inclined to volunteer to engage and collaborate on projects are often already involved in many community and advocacy activities.

Community members (including local service providers) in these settings often have high social or familial responsibility to others in their community in addition to usual daily activities and workloads.



TIP!

Participation may vary over time; however, it is important to remain open and receptive to contributions at any stage.

STEP 2. UNDERSTANDING THE CONTEXT

Gathering information and accessing existing data

This step of the place-based health planning process aims to gain an understanding of the place by gathering information, exploring available data and mapping existing services available to the community. Key areas to explore include culture, the community, service organisations, relationships, infrastructure and environment, and the policy context (Figure 4.2.1).

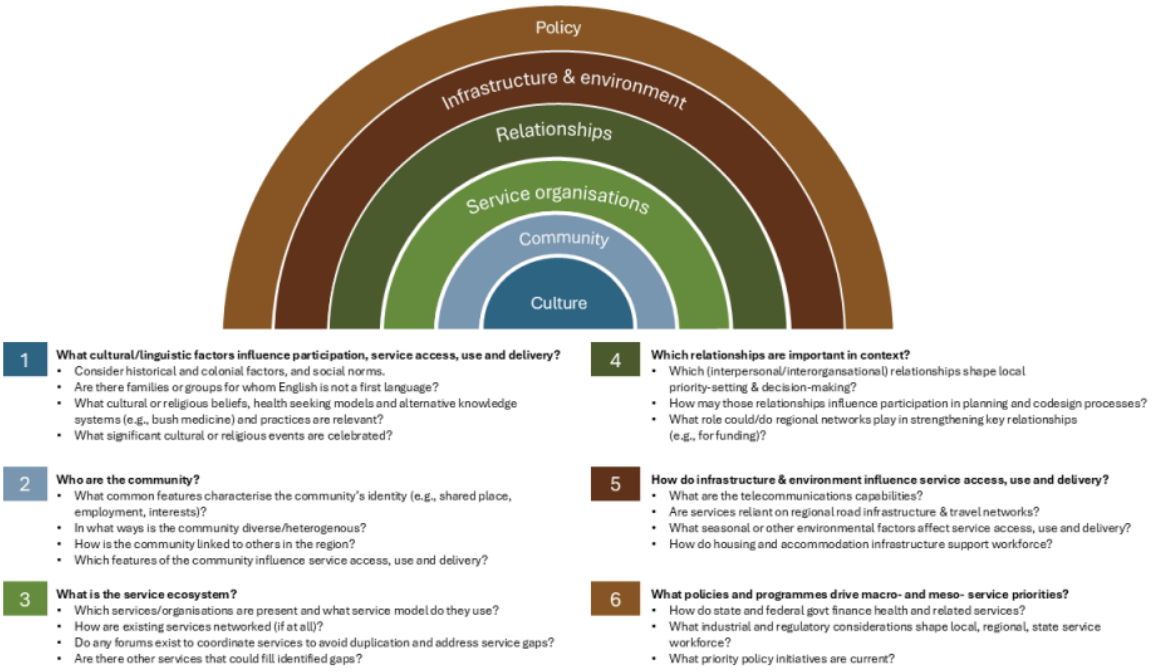


Figure 4.2.1 Questions to facilitate understanding context of a place or community.

Engaging with key stakeholders will confirm and explain community dynamics, historical incidents and other events that may impact on the planning work. This requires effective community engagement in the preparatory stages and throughout the implementation stages too. Effective community engagement facilitates iterative, time-sensitive, deep listening approaches to understand these varied perspectives and relational dynamics and understand how they work in context.

Local data about population, economy, health status, service utilisation and health workforce can be accessed from a variety of sources. Data may be accessed through the public domain or through data request procedures.

RESOURCES

Appendix 4 – Data Sources: lists possible data sources with a focus on regional and community areas.

Conduct service mapping

Compile a directory or table of services, including local and visiting services that provide health or health-related services. Depending on the local environment, other services can also be listed. For example, in remote Aboriginal and Torres Strait Island communities, including Kowanyama, Community Enterprise Queensland is a not-for-profit organisation that is engaged to provide essential goods to communities, such as through a supermarket. This group also provides health promotion activities.

Desktop searches of regional, state and national organisations, as well as national directories (such as My Community Directory), are a good place to start.

Local organisations, such as the local council, often have a service directory that may be used as a starting point.

Service mapping can be informed by community engagement activities as the work progresses.

Areas of interest include the purpose of the service, the mode and frequency of service delivery, type and quantity of workforce, funding sources and accessibility for community members.

Depending on the purpose of the work, service mapping may include health, social, education and welfare sector services as well as community-based support groups and digital services.

Service mapping activities generate useful outputs that demonstrate reciprocity (value for giving back to the community). Outputs include up-to-date service directories which can include information about referral pathways and costs, community calendars containing visits by outreach services and funding maps that help communities assess how and if funds are being spent as intended to benefit their community.

RESOURCES

Appendix 5 – Services Overview: provides an example overview of health and health related services in the Hughenden community at the time of the project.

Conduct environmental scans

Desktop searches and community engagement activities will provide information on structural factors that may influence service access (geographic accessibility, affordability, timeliness, acceptability, availability, appropriateness), use and delivery.

Information needs include policy direction (scan relevant health strategies, plans and policies), infrastructural factors such as accommodation for the workforce and geographic factors such as seasonal weather.

Other relevant data or information may be found in policies and program rules that impact the local community.

Explore local infrastructure and environmental factors. Remoteness, access, transport options and availability of local accommodation can impact service delivery, especially if there are fly-in/fly-out or drive-in/drive-out health professionals visiting community to provide services (Figure 4.2.2).



Figure 4.2.2. Remoteness significantly impacts access to services. Used with permission.

Environmental factors such as climate, fluoridation of water supplies, availability of fresh food, and accessible free spaces and options for physical activity can impact the health of the local community.

Explore community dynamics and other impacting factors

Consult with the local connector, reference group and key stakeholders to understand relationship dynamics and events that may influence participation and engagement (see step 1).

Engage with stakeholders to understand contextual aspects affecting health and services.

Consult with key stakeholders and local experts to understand the history and changes in local health status and service delivery (see step 1 and step 3).

RESOURCES

Through the project, data and information were collated to produce a 'health and services report' for each community. These were 'living' documents and updated throughout the project timeframe. The reports for each community are available on the project website at:

https://www.taahc.org.au/research/integrating-health-care-planning-for-health-and-prosperity-in-north-queensland/project-communities/

IN PRACTICE

Listen to our Hughenden Local Connector talk about sharing knowledge and learning:

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TIP!

A key component of effective planning involves considering all related factors that influence health and health service delivery in the community.

STEP 3. CONDUCTING HEALTH PLANNING USING A CO-DESIGN PROCESS

Conducting the co-design process

This step outlines how the co-design process was implemented through the project. It is presented in three sections:

- content for each step in the co-design process
- facilitating participation
- tips for implementation.

Content for each step in the co-design process

The co-design process utilised in our project involved four steps. Each step was carried out via workshops, small group or individual meetings. Co-design workshops and interviews were held in person in each community and online. The four steps in the co-design process are summarised in Figure 4.3.1.



Figure 4.3.1. Content for each step in the co-design process.

Workshops ran for approximately two hours each, with refreshments provided. Although the team began

each session with defined objectives, flexibility was necessary to adapt the workshop plans and follow the flow of discussions as they unfolded naturally. The objectives for each step were as follows:

Step 1: Community and Service Mapping

- to confirm essential basket of services and principles that underpin health care delivery (see Box 1 for an example from the Kowanyama community)
- explore the local population and their characteristics

Box 1. Example essential basket of services and principles underpinning health care delivery (Kowanyama community)

- People in the Kowanyama community matter as much as those living in urban centres.
- The Kowanyama community is unique. Aboriginal health workers from other communities, and health workforce in general, need to learn about local culture and community.
- Access to medical and primary care services locally including weekends and after hours e.g. local doctor.
- Access to secondary and tertiary care when required.
- Respect for health care providers and respect for community (two way).
- Care is culturally appropriate. Trusted local connectors can help facilitate care and bridge gaps.
- Recognising the place and value of bush medicine.
- Health promotion to keep people healthy and prevent or minimise health issues in the future.
- Ageing and palliative population needs - being able to stay in community for as long as possible, being able to "pass" in community with loved ones for support.
- Services are flexible to patient circumstances and can be delivered at home when needed.
- Consistency and trust in service providers. An understanding of what services are available and what they offer.

- identify environmental, social or cultural issues affecting health
- to confirm current services available (current model of service delivery)
- to identify strengths, gaps and barriers.

Step 2: Exploring key priorities and models of care

- to discuss gaps and barriers
- to explore new or modified models of health care delivery
- to prioritise areas for early action.

Step 3: Identifying resourcing needs and strategies

- to discuss the prioritised actions to determine workforce and skillsets required

- to determine resources/training/funding required to implement actions
- to identify feasible strategies for inclusion in project.

Step 4: Confirming an action plan and evaluation framework

- to confirm the action plan for the project, including the responsible party and timeframes
- to define measures of success.

At the end of each step, all discussions were compiled and summarised in detailed reports. These summaries serve as a vital record of conversations and decisions, and they help keep those who couldn't attend updated on progress. It is important that these summaries be shared with all participants for review to validate their accuracy.

Progress updates should also be communicated to the wider community to ensure everyone stays informed and engaged. Use a variety of communication channels to reach different audiences effectively. After each step, articles were published in local newsletters and newspapers. Social media proved effective in some communities, though less so in others. For individuals without internet or social media access, consider distributing printed copies directly. In areas where literacy or language may be a barrier, providing translated or simplified materials is recommended.



RESOURCES

Appendix 6 – Questions for workshops: outlines question sets that were developed to guide the implementation of each workshop to explore the objectives and help guide discussions. These may be used or adapted to support planning work. While the approach undertaken in this project was broad, questions may be adapted to focus on a particular topic or population group within the community.

Appendix 7 – Workshop session plans: presents session plans for each workshop, including timeframes and resources required. The plans were developed to take a broad approach and may be used or adapted to suit.

All summaries from the project are available on the project website: https://www.taahc.org.au/research/integrating-health-care-planning-for-health-and-prosperity-in-north-queensland/project-communities/

IN PRACTICE

Listen to our Local Connectors talk about how the co-design process worked in their communities:

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A note on prioritisation

Prioritisation may take place at various points throughout the process. In steps one and two of the place-based planning project, in all three communities, there were many areas for improvement identified, and within each area, many actions were proposed. Early prioritisation can be undertaken at the end of step two to narrow down areas on which to focus.

One simple approach to facilitate early prioritisation is asking all participants to list their top three areas for improvement (anonymously), and collating results to identify the top three areas. These results are then presented back to all participants for validation.

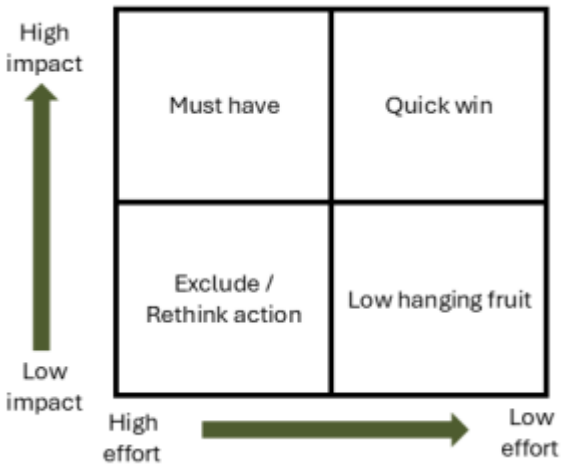


Figure 4.3.2. Prioritisation matrix.

Drilling down into these priority areas, each action can then be further assessed according to a prioritisation matrix (see Figure 4.3.2), to identify those that are most or least important (will have a high or low impact)

and the level of resourcing that will be required (will need high or low effort). A way of facilitating this assessment of feasibility is by presenting the list of actions on a chart, and inviting participants to put a dot against each action, to indicate in which of the four squares they believe the action sits (Figure 4.3.3). Depending on the timeframe in which to complete the planning work and conduct implementation, this method could be applied to all actions.



Figure 4.3.3. Prioritising actions.

Collaboratively examine the prioritised actions to assess their feasibility for implementation, taking into account their importance and the resources required, such as funding, materials, human capacity, training, and timeframes. It is also important to identify complex intersectoral priorities, understand where decision-making power lies, and explore the necessary steps to achieve the desired outcomes.

Some actions may be identified as "quick-wins" or "low-hanging fruit" innovations that are simple to execute and have low and high impacts. Other actions may be complex and high-impact innovations that might take longer to execute or may be resource-intensive. Some actions may demand significant effort but result in minimal impact, and therefore may be set aside or excluded.

Facilitating participation

The local reference group and local connector are best placed to advise on how to continue to engage with community stakeholders and encourage participation throughout the co-design process and implementation phase.

Provide a variety of options for engagement. Offer a few time slots for face-to-face participation. Evening workshops may be more suitable for the working community, and morning workshops for families and older adults. Consider lunchtime workshops for health and community service providers. If understanding language is a concern, consider the use of interpreters.

Consider social and structural factors, for example, cultural safety, community dynamics and accessibility, that may affect the ability of stakeholders to attend engagement activities. Consider how stakeholders

can be supported in participating. For example, can project funding be used to support accessibility with transport?

Consider the stakeholders that may attend and how the dynamics of engagement activities may be affected. Build in appropriate engagement opportunities to support inclusion and accept that other priorities may crop up for stakeholders, necessitating other mechanisms for engagement.

The option to participate via online workshops is a useful supplement to in-person engagement and supports an inclusive approach. Build in alternatives to gatherings of individuals as the primary strategy for engagement. Provide the option for separate meetings, written input or oral inputs with translation. Take the workshop or activities to the participants and deliver in a space where they are comfortable, or link in with existing meetings or gatherings of local groups.

Maintain open communication channels by ensuring that contact details are available, particularly those of the local connector and/or partner organisation workers.

Recognise expertise and participation by community members through appropriate catering, travel support and/or financial reimbursement.



IN PRACTICE

Conducting the co-design process

Within the place-based planning project, the full co-design process was fully implemented in both Hughenden and Clermont. In both communities the four rounds of co-design workshops were conducted over six months, with each round held approximately every two to six weeks apart depending on availability of participants and working around planned and unexpected events.

In the project there were no funds available for implementation. This made the assessment of feasibility and prioritisation of actions very important. Assessing impact and effort, including any requirements for human resources, materials or funding, was critical to identify cost-neutral actions that could be implemented during the project timeframe.

The place-based health plans provided evidence of community need. The plans could be used as evidence to advocate for further funding or resources beyond the project in pursuit of longer term or resource intensive actions.

Example of an update for community and advertising the next round of workshops

It's important to share progress updates with the broader community to keep everyone informed and involved. Local newsletters and social media were key communication methods used within the communities. An example is provided in Figure 4.3.4.

Hughenden Health Planning Project

In late November community members, local stakeholders service providers and the James Cook University (JCU) project team came together to talk about health priorities in Hughenden through a series of workshops. Interviews were conducted with those unable to attend. This was the first part of a co-design process to plan for better health and identify areas for improvement. Participants discussed what was important for good health, health needs of the community, service availability and use, and strengths and challenges that affect health. A summary of this first part of the co-design work is available on the project website at: https://www.taahc.org.au/research/integrating-health-care-planning-for-health-and-prosperity-in-north-queensland/ or contact Mim for a printed copy.

Part two of the co-design process will be conducted in Hughenden on the 1st and 2nd of March. Workshops will be held to further explore barriers and gaps, and possible solutions. All community members and local and visiting service providers are welcome to attend a workshop, or link in to a zoom the following day. If you are unable to attend, we can arrange to meet with you at another time.

Co-design Part Two Options
Join us to explore solutions!

Wednesday **1st March 2023** 5.30pm – 7.30pm RSL Hall, 17 Flinders St	*OR*	**Thursday** **2nd March 2023** 9.00am – 11.00am RSL Hall, 17 Flinders St	*OR*	**Friday** **3rd March 2023** 10.00am – 12.00pm **Online**, via Zoom

RSVP to Mim Crase by Tuesday 28 February, 2023 for catering purposes or to receive the zoom link!
mim.crase@jcu.edu.au / 04xx xxx xxx

The JCU place-based planning project is a unique opportunity to unite health industry partners and engage with local communities to improve efficiencies and effectiveness in service planning and delivery. The project is funded by the Cooperative Research Centre for Developing Northern Australia (CRCNA), with financial contribution from Tropical Australian Academic Health Centre (TAAHC), and in-kind support from project partners.

Figure 4.3.4. Example of a newsletter update and promotion of next round of workshops to the broader community.

Tips for the implementation of co-design activities

Consider workshop availability and accessibility in terms of location and timing:

- our team used easily accessible and common gathering places, including community halls and local cafes (see Figure 4.3.5)
- workshops for each step were run in-person twice, once after hours and once during working hours
- refreshments were always provided. Transport was able to be provided on some occasions
- a workshop was also offered virtually for those unable to attend.



Figure 4.3.5. Co-design discussions.

Consider a series of separate meetings for those unwilling or unable to attend workshops:

- when key stakeholders did not attend, separate meetings were arranged to ensure that pertinent views and diverse opinions were incorporated
- produce accessible summaries for each step of the process and disseminate them to all active participants and interested passive participants
- brief updates in newsletters were a great option to reach the broader community.

In co-design activities, encourage participants to think creatively and aspirationally, but aim for cost neutrality:

- creative thinking, aspiring to optimal health and health care delivery is welcomed, and should initially not be constrained by funding, policy or service delivery silos
- in terms of prioritising actions, starting with the principle of cost neutrality – i.e. redeploying existing funds and resources – is often most successful.

Obtain feedback immediately following participation in co-design activities to inform improvements for subsequent engagement and collaboration.

- anonymous surveys are a quick and effective tool.

RESOURCES

Appendix 8 – Evaluation survey: provides an example of a simple workshop evaluation survey.

IN PRACTICE

Listen to our Clermont Local Connector talk about benefits for participants:

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://jcu.pressbooks.pub/guidelines-place-based-health/?p=72

TIP!

Encourage broad participation in co-design activities to discuss strengths and challenges, identify community needs, explore potential solutions, and prioritise feasible actions. Localised approaches will help uncover solutions that are relevant and responsive to the specific context.

STEP 4. IMPLEMENT ACTIONS, MONITOR, AND EVALUATE CHANGES

Implementing prioritised actions

Following the conclusion of the co-design process, prioritised action plans can be implemented by partners responsible for progressing or supporting the implementation of each action. The Local Connector can help drive and support partners to implement actions. Sub-committees or groups may be formed to work on particular actions.

IN PRACTICE

Within the Clermont community, the Clermont Community Business Group who produced the monthly local newsletter, the Clermont Telegraph, took responsibility for promoting services, events and date claimers, including dates of visiting health professionals.

Figure 4.4.1 provides an example of a communication tool (flyer) used to update the Hughenden community on project progress and promote the actions prioritised for implementation. It was felt that the community preferred tools that used visuals and kept the words to a minimum. Adding a local touch to the design helped people connect with it and made it clear the work came from within the community. The Hughenden flyer featured a stylised image of Porcupine Gorge, a well-known local landmark and tourist spot, along with windmills, which are a common sight around town.

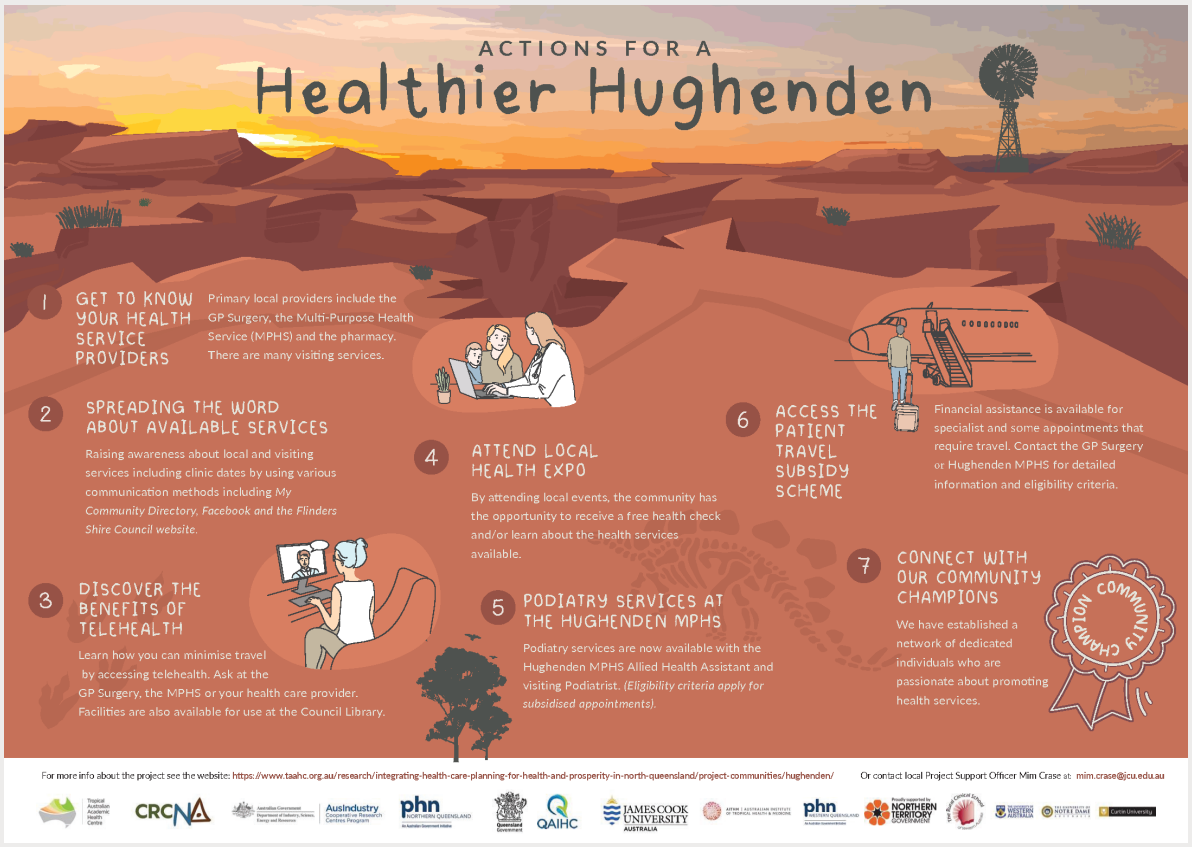


Figure 4.4.1. Flyer communicating actions to the broader Hughenden community.

In Hughenden, refurbishments or the construction of a purpose-built health facility were important. Although not prioritised for action within the timeframe of the project, as it was assessed as a longer term, resource intensive action, the local Chamber of Commerce acknowledged this was an issue for which they could advocate. The availability of appropriate health facilities was an important factor in attracting workers and their families as part of local economic initiatives (Figure 4.4.2).

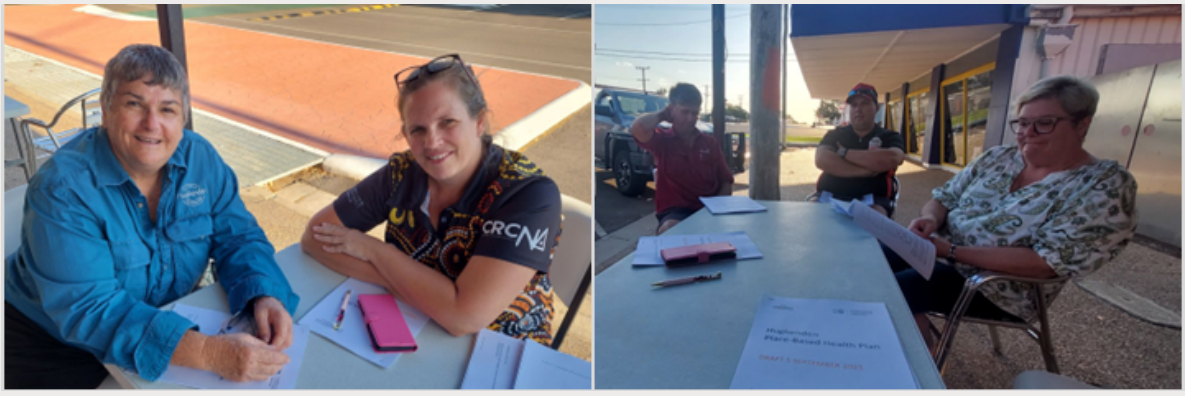


Figure 4.4.2. Project staff meeting with representatives from the Flinders Shire Chamber of Commerce.

Communicating about actions and progress

Clear and regular communication with all stakeholders and the general community about actions prioritised for implementation, progress and outcomes will bring everyone along on the journey. Stakeholders appreciate seeing progress and tangible outcomes, even if they are incremental, as it reinforces the value of their contributions and engagement.

In all participating communities, regular project updates were provided to the local reference groups. In Hughenden and Clermont, where actions were implemented, updates were also published in the local newsletters and on social media.

Applying a research approach

As the place-based health planning project involved research, the action plans were converted into logic models. Logic models aim to clearly map out how a program is planned to work, defining the need or demand, activities to address these needs and anticipated outputs, short-term outcomes and long-term goals.

RESOURCES

Appendix 9 – Logic model: provides an example of a logic model that was developed for work in the Clermont community.

Monitoring and evaluation

Progress on actions and associated activities should be reported back at local reference group meetings for monitoring purposes. The local reference group should review monitoring reports and provide oversight and guidance on any necessary adjustments to action implementation plans, including revising priorities and refining strategic directions.

It is important to evaluate both the process of co-design and health system redesign (including evaluation of each individual workshop) and the outcomes and impact of prioritised, identified actions or innovations.

Evaluation may comprise a combination of quantitative and qualitative methods. Quantitative methods may include recording numbers of enquiries and clients, numbers of uses of telehealth facilities, and

use of surveys to assess satisfaction and understanding. Qualitative methods may involve interviews with community members and their health care team to elicit the context of experiences or changes and impacts upon their health or wellbeing. Case study methodology may be used where appropriate. Other interviews may be undertaken to further understand clients/community experiences in project activities.

The local reference group should review evaluation reports and support review of plans, including revising priorities and refining strategic directions.



IN PRACTICE

At the conclusion of the project a report was compiled for Clermont Local Reference Group detailing all of the actions prioritised for implementation and progress against each action. See Figure 4.4.3 for an example of results and feedback on the implementation of one action to "Initiate a Clermont Service Provider Forum". An existing agency volunteered to take on the coordination of these meetings, and following strong positive feedback and service provider interest, continued with responsibility for the action.

Action: Initiate a Clermont Service Provider Forum

Led by: Greater Whitsunday Communities
In collaboration with Clermont CONNECT & JCU

What is it?
Greater Whitsunday Communities organised and facilitated a Clermont service provider forum on 8th May 2024 at the Clermont Civic Centre. The forum served to provide services, providers and agencies an opportunity to network and share information with one another to better build networks of care and support for the Clermont area.

What happened?
The service provider forum was to follow the Clermont Community Health & Information Expo however the expo was postponed due to the Caval Ridge incident. Despite the major disruption to travel, 14 organisations represented by 17 service providers attended the forum. Nine services were Clermont-based, five provided outreach services to Clermont and one was solely a regional service.

What was the impact?
Feedback from attendees was overwhelmingly positive with all attendees who completed a survey (n=13) agreeing that they would attend future forums. Over 60% of attendees reported that they were much more aware of other organisations and services provided for the Clermont community. Challenges to keep in mind for future forums were travel requirements, cost of attending and time of day for the forum.



BENEFITS OF ATTENDING	
75%	More aware or much more aware of other organisations & their services
67%	Build support networks
73%	Build professional networks
73%	Supports service coordination
100%	Learning about other organisations & services
91%	Meeting other providers

What's next?
GWC plan to facilitate and coordinate a further two virtual service provider forums in 2024 to support a regional stakeholder network, in addition to an annual face-to-face forum in Clermont.

Figure 4.4.3. Extract from the evaluation report presented to the Clermont Reference Group outlining progress on one action.

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Listen to our Local Connectors talk about project outcomes in their communities:

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TIP!

Stakeholders value hearing about progress and results – even small ones – as these affirm the importance of their involvement and contributions.

STEP 5. FACILITATE SUSTAINABILITY OF CHANGES

Embed sustainability into the action plan

Considering how successful interventions can be continued and resourced ongoing will be important. Sustainability considerations should be built into an action plan during the co-design planning process.

As much as possible, ensure that actions are associated with a partner (individual or organisation) who will be responsible for progressing the action. This is challenging and often requires further engagement. Clear, timely and ongoing communication with key stakeholders who have been identified as having influence in progressing actions will aid in this endeavour.

Action plans might also identify a range of actions that have longer timeframes and action owners who might sit outside the community, such as jurisdictional/federal level government departments. Strategies should be built into the action plan to identify "hand over" strategies to relevant bodies to facilitate their inclusion in other action registers and existing bodies of work.

Consideration can be given to the role of existing consortia/organisations such as academic health centres, university departments of rural health, or government committees in taking forward key learnings and longer term priorities identified by the community.

Mechanisms for inclusion of the action plan in existing health planning cycles or other relevant planning cycles for the community should be identified and accessed.

Action plans should be revised regularly to determine current and new priorities (which may change over time).

Encourage and support advocacy for change and in pursuit of resources and funds in the future.

Ensure that the action plan, reports generated through the co-design process and background reports are entrusted to key community groups and health services for future use. Strong stakeholder buy-in to the need for the action plan is essential for the plan and identified actions to be progressed past the planning project timeline.

IN PRACTICE

In one project community, an aim was to 'strengthen connections between all health and health-related service providers and organisations that serve the Clermont community', with an action being to facilitate service provider forums (figure 4.5.1). An existing agency took on the coordination of these meetings, and by embedding the responsibility for the action, meetings of providers continue every two months beyond the project.



Figure 4.5.1. Interagency meetings continue to be held beyond the project.

TIP!

Collaborating with existing local groups and integrating actions into partners' scopes where possible will help ensure long-term sustainability.

CHAPTER 5: IMPLEMENTING PLACE-BASED PLANNING: STAFFING, LOGISTICS AND COSTS

Resources required to implement place-based health planning will depend on various factors. In the illustrative project described in this book, an external party (the university) initiated the planning work. Some of the costs associated with conducting the work included:

- employment of project staff
- employment of a Local Connector (and provision of support and networking opportunities)
- travel costs for the university team to the community – flights, car hire, accommodation, meals and subsistence – this will vary considerably depending on the location of the community
- venues to hold workshops and meetings – community halls and clubs are generally more cost-effective, than restaurants/cafes with function rooms
- set up the meeting space with tables and chairs where possible, to allow participants to sit comfortably and face each other to encourage interaction and discussion (Figure 4.5.1)
- catering and refreshments for workshops – consider dietary requirements
- remuneration and reimbursement for participants that reflects Health Consumers Queensland Guidelines
- printing of posters, flyers for communications and promotion
- newsletter publishing costs.



Figure 4.5.1 Workshop set up.

There may be opportunities to partner with local organisations who may contribute to costs or support activities in-kind.

If the planning work is being driven by a local organisation or key stakeholder, costs may be able to be covered partially or entirely by that organisation.

Implementing actions

The aim of the planning work was to identify actions that were cost-neutral, that is, could be implemented at no additional cost. While this was achievable for some initiatives, certain expenses, such as the time commitment of the local connector, were unavoidable. Additionally, minor costs, primarily related to printing resources, were covered by the university.

However, the actions may have also led to cost savings. Raising awareness and encouraging the use of telehealth may have reduced expenses for both individuals and health services, as some people no longer needed to travel to the main referral centre for care. Additionally, filling a vacant part-time maternity and child health position — already on the nursing establishment — enabled local access to these services, further minimising the need for travel. These outcomes will be reported in a separate publication.

IN PRACTICE

Listen to our Local Connectors talk about benefits of their roles:

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CHAPTER 6: NEXT STEPS

This project highlighted the effectiveness of participatory, place-based planning in identifying and addressing health and service needs in rural and remote communities. By using a co-design approach, it empowered a broad range of community members and stakeholders to collaboratively define health priorities and implement practical solutions. Crucially, some of the solutions identified involved community-led actions in improving health and access to health services, further demonstrating the value of community participation as fundamental in health planning. The findings underscore the value of investing in local leadership, building trust through embedded roles such as local connectors, and fostering inclusive, ongoing engagement to support meaningful change.

This eBook has outlined the approach taken by the team through the *Integrating Health Care Planning for Health and Prosperity in Northern Queensland Project* and provided examples and templates that can be used by parties interested in replicating a similar process. Those interested in conducting place-based health planning are able to work through this guide step-by-step or tap into the sections for information and guidance as required.



IN PRACTICE

Listen to what our Local Connectors would like to see happen in their communities in the future:



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One or more interactive elements has been excluded from this version of the text. You can view them online here: https://jcu.pressbooks.pub/guidelines-place-based-health/?p=1011

The authors and other team members at the JCU Centre for Rural Remote and Tropical Health Systems are actively involved in participatory approaches and co-design work. You can contact our team by email: northausthealth@jcu.edu.au

APPENDIX 1. STAKEHOLDER ENGAGEMENT PLAN

Click here to download a word version of Appendix 1

Stakeholder Engagement Plan - Clermont

Objectives	Strategies	Target audience	Timeframe	Communication/media	Evaluation measures
1. Establish awareness of the place-based planning project	• Identification of health-related stakeholders (local, regional, visiting, referral) • Identification of other key local stakeholder groups • Provide general project information using multiple modes • Discuss with key stakeholders	• Key local and regional health service members • Community leaders and groups • General community	June 2022 Ongoing	• Email stakeholders with introductory project information • Follow-up phone calls with stakeholders • Targeted face-to-face visits with key individuals and community leaders • Discuss with existing group (if relevant) or establish new reference group • Meetings with relevant regional health service execs and managers	• Number of planning meetings held, and number and diversity of attendees • Community communications delivered
2. Increase awareness of the place-based planning project 3. Engage stakeholders to successfully conduct participatory co-design process	• Recruit well-connected Project Support Officer (PSO) • Recruit and engage appropriate range of local and regional stakeholders for reference group • Identify and engage all stakeholders • Follow place-based planning process	• Key local and regional health service members • Community leaders and groups • General community	July -Oct 2022	• Advertise PSO position in local newsletter, facebook groups and noticeboards • Regular meetings between JCU research team and local PSO (zoom and F2F) • Participation in local reference group meetings by PSO and JCU (F2F/email/zoom) • Advertise workshops through reference group network, flyers in newsletters and social media posts • Explore appropriate local options for workshops and interviews (structures and locations etc)	• Number and methods of communications delivered • Number of planning meetings, workshops and interviews held, and diversity of attendees • Development of action plan
4. Implementation and monitoring of priority actions from place-based plan	• Group prioritisation of actions in plan • Pilot implementation led by PSO and reference group • Provide ongoing feedback to key stakeholders and broader community	• Key local and regional health service members • Community leaders and groups • General community	Oct 2022-March 2024	• Regular meetings between JCU research team and local PSO (zoom and F2F) • Participation in local reference group meetings by PSO and JCU (F2F/email/zoom) • Updates to key stakeholders and the community via flyers, newsletters and on social media	• Attendance at reference group meetings • Delivery of priority actions • Number and methods of

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Objectives	Strategies	Target audience	Timeframe	Communication/media	Evaluation measures
					communications delivered
5. Evaluation of process, impacts and outcomes 6. Share learnings with the local community and broader project stakeholders	• Conduct evaluation of co-design process • Evaluate impacts and outcomes of actions • Provide feedback to key stakeholders and local community • Share learnings with broader project stakeholders	• Key local and regional health service members • Community leaders and groups • General community	Oct 2022-March 2024	• Participation in local reference group meetings by PSO and JCU (F2F/email/zoom) • Updates to key stakeholders and the community via flyers, newsletters and on social media • Newsletters and meetings with Project Technical Reference Group, TAAHC Board and Clinical Leadership Group	• Number and diversity of participants in evaluation activities • Number of newsletters, posts feedback sessions • Interviews with participants
7. Support sustainability of actions and further development	• Develop strategic plan for future development (supported with data and evidence) • Standing item on reference group agenda	• Key local and regional health service members • Community leaders and groups • General community	March 2024 and beyond	• Regular discussions between stakeholders at reference group meetings beyond the project • Updates to key stakeholders and the community via flyers, newsletters and on social media	• Development of strategic plan (or continuation of the action plan) • Agenda item

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Site specific stakeholders: Clermont

Organisation	Name	Position/Role	Onsite/Visit frequency	Email	Phone	Address when in town	Notes
Health Services							
Clermont MPHS		DON	Onsite			26 Francis Street	
Clermont MPHS		NUM	Onsite			26 Francis Street	
Clermont Country Practice		Doctor/Practice owner	Onsite			38 Jellicoe Street	
Clermont Country Practice		Practice manager	Onsite			38 Jellicoe Street	
Clermont Pharmacy		Pharmacist	Onsite			48 Daintree Street	
Clermont Dental Services		Dentists	Visit 3 days per week			Turners Arcade, Capella Street	
QAS			Onsite				
Stream Services (aka Clermont Country Care)		Founder and Director	Onsite			2 Daintree Street	
Stream Services (aka Clermont Country Care)		Project Worker	Onsite				
Bodyfix Physiotherapy (Funded)		Physiotherapist	Onsite or Visiting?				
Central Highlands Optical		Optometrist	Fortnightly			41 Capella Street	
Central Queensland Rural Health (Funded by NQPHN)		Midwife – antenatal, postnatal, lactation services.	Fortnightly				
Clarity Hearing Solutions			Regularly			41 Capella Street	
Compleat Nutrition (Synergy Health Centre; Funded)			Monthly				
Construct Health		Physiotherapy	Fortnightly				
Feros Care		Local Area Coordinator					
Flying Skin Cancer Doctor			3 monthly				
Harris Chiropractic Spine Clinic			Monthly				
Hinterland Community Care		Aged Care Service Coordinator					
Hinterland Community Care		General Manager					
Isaac Navicare		Mental Health Care Navigator					
Lifestyle Therapies and Training Solutions							

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Organisation	Name	Position/Role	Onsite/Visit frequency	Email	Phone	Address when in town	Notes
Northern Australia Primary Health Ltd		Diabetes educator Exercise physiology and dietician	Bi-monthly ?Telehealth				
RFDS Dental Service		Dentist Dental assistant	Visited 10-19 May 2022				
RFDS							
The Marshman Family Trust (Pioneer Podiatry; Funded)		Podiatrist	Fortnightly				
Towers Podiatry (Funded)		Podiatrist					
True Relationships and Reproductive Health (Funded)		General Practitioner Registered Nurse	Appears to be 3 monthly Telehealth			Clermont MPHS	
Clermont Community Housing and Other Services Inc.		Vice President	Onsite: Mon/Tues/Thurs/Fri 12.30-3pm Weds 12.30-2pm			2 Lime Street	
Belyando Enterprise Network Inc (BENI)							
CHANT		Local Reference Group	Onsite				
Clermont4Doctors			Onsite				
Clermont and District Senior Citizens Association							
Clermont Meals on Wheels							
CRU – Community Resource Unit Ltd							
Isolated Children's Parents' Association		President Secretary Treasurer Branch Mentor	Onsite				
Men's Shed			Onsite			25 Power House Lane	
Clermont CWA						CWA Hall, 28 Sirius Street	
Rotary Clermont		President Secretary Treasurer	Onsite				

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Organisation	Name	Position/Role	Onsite/Visit frequency	Email	Phone	Address when in town	Notes
Greater Whitsunday Communities		Senior Coordinator					
Isaac Shire		Mayor					
Isaac Regional Council		Chief Executive					
Isaac Regional Council		Head of Advocacy and External Affairs – Office of the Mayor/CEO					
Isaac Regional Council		Coordinator Executive Support Office of the Mayor and CEO					
JCU		Isaac Shire Project Team					
MHHS		CEO					
MHHS		Executive Director Research and Innovation					
MHHS		Executive Director – Public Health & Rural Services					
MHHS		Director, Strategy and Planning					
MHHS		Senior Director, Strategy, Governance and Engagement					
NQPHN		Integration and Partnerships Specialist - Mackay					

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APPENDIX 2. EXAMPLE TERMS OF REFERENCE INCLUDING GROUP COMPOSITION

Click here to download a word version of Appendix 2

Background

Place-based health planning aims to improve the responsiveness of health services to the needs of communities. It is an effective approach to health planning to improve programs and service provision by taking a holistic but localised perspective. This project will empower local community stakeholders to participate in health care planning to facilitate their needs being met. Overall, the project is expected to deliver benefits and positive impacts to individuals and communities, in terms of improved health care and wellbeing. Additionally, health services may also benefit as a direct result of the project activities through more efficient, re-designed health care delivery.

This work is being undertaken in [community]. Funding for the work has been received from [insert funding body] with in-kind contributions from Project partners. The [organisation] team are coordinating the project.

Purpose

The Local Reference Group, consisting of key health service and community stakeholders, will guide the place-based health planning work in [Community]. Members will guide planning and implementation of a series of co-design workshops, advise on (and guide as appropriate) implementation of any actions emerging from the workshops, and advise on evaluation of any implemented actions.

A Local Connector (or Project Support Worker) has been employed part-time to support the Local Reference Group and the project team to implement project activities. Local Reference Group members may also choose to participate in the co-design workshops, and/or the evaluation of the co-design process and outcomes from any implemented actions.

Duration

The project will end by [timeframe, eg. the place-based health planning project time for preparatory engagement, co-design, implementation and evaluation was approximately two years]. If the Local Reference Group sees value in the project work, options may be explored for ongoing sustainability after

the project finishes. Alternately if able to be integrated within an existing local group, monitoring and further work could be undertaken through a regular agenda item.

Role of members

- discuss, negotiate and make decisions regarding the local conduct of the project in collaboration with the Local Connector, and Project Team as required
- provide constructive, active contribution to meetings and engage in email, discussion or other forums as appropriate
- contribute to and read distributed material pertaining to the project development and implementation
- Establish a process to ensure all stakeholders are kept well informed and engaged.

Underpinning principles

The following partnership principles will underpin the work of this group:

- goodwill
- respect
- transparency and accountability
- shared values
- shared commitment
- honesty
- effective and positive communication
- flexibility
- creativity
- innovation
- focus on a positive, shared outcome
- focus on delivery according to the scope of the proposed project.

Membership

- local multi-purpose health service rep
- hospital and health service rep
- local General Practitioner/s (or Practice Manager)
- local Councillor
- community members (multiple)
- community organisations (multiple)
- primary health network
- project team (including Local Connector).

Group chair

- project lead (or another elected member).

Frequency and conduct of meetings

- Meeting frequency will be determined by the group and will vary according to project stages but will occur at least monthly.
- Meetings will be convened to ensure maximum participant involvement. This will include options for face-to-face meetings and technology-based participation, including video/teleconferencing.
- Emails may be used to advise/consult members between meetings when specific work/issues arise.
- Subcommittees may be formed for specific purposes.
- Additional members may be co-opted as needed.

Process and outcome of meetings

The Local Connector will support Local Reference Group meetings by:

- liaising with the group chair to finalise meeting times and the agenda, and distribute to Local Reference Group members (including setting up access to the meeting using technology)
- recording minutes of meetings and distributing to members within one week of the meeting
- ensuring all stakeholders are fully informed and engaged through report to the local groups and a circulation of a regular newsletter (as per communication strategy).

Review

The Terms of Reference will be discussed and ratified at the first meeting of the Local Reference Group.

Reporting

This is a local advisory group. The group may report to a local Health Advisory Committee or Health Service, and/or funding bodies. It may be accountable to the broader community.

APPENDIX 3. LOCAL CONNECTOR POSITION DESCRIPTION

Click here to download a word version of Appendix 3

Project overview

The *Integrating Health Care Planning for Health and Prosperity in North Queensland* Project aimed to improve the responsiveness of health services to the health needs of communities in the North Queensland region. Place-based health planning through a series of co-design workshops is an effective approach to improve programs and service provision by taking a holistic but localised perspective.

Position overview

The Local Connector (or Project Support Officer) supports the establishment of a local reference group and enables the group to lead, guide and participate in the place-based health planning process. The Local Connector will also engage with local community and promote participation in project activities. They may also lead or support the implementation of actions and evaluation activities.

Principal accountabilities

1. Establish and maintain professional working relationships through the development of networks with key stakeholders and community members.
2. Proactively conduct and support project activities in collaboration with the Project Team, assisting in the delivery of local workshops and activities, including the development and maintenance of communication strategies.
3. Assist with the recruitment of key stakeholders for participation in data collection for the evaluation strategy by facilitating local communication; support and contribute to evaluation activities.
4. Assist in the preparation and production of reports that will allow the research team to monitor research progress.
5. Perform general administrative tasks and functions specific to the research activities in a proactive, timely and helpful manner that will assist the Project Team.

Selection criteria

Essential

1. Demonstrated knowledge of and participation in the local community.
2. Effective communication and interpersonal skills, with the ability to communicate effectively and

confidently with people from a variety of backgrounds.

3. Excellent organisational and time management skills; ability to work unsupervised and respond to competing priorities.
4. Knowledge of the Microsoft Office Suite (specifically Word and PowerPoint) and Windows operating systems, and experience in using internet browsers and e-mail systems.
5. Understanding of, or ability to learn about, ethical issues in relation to research within communities, and principles of confidentiality and privacy.

Desirable

1. Knowledge of the Australian health system, including public and private services.
2. Demonstrated empathy and respect for Aboriginal and Torres Strait Islander people and culture.

APPENDIX 4. DATA SOURCES FOR PLACE-BASED HEALTH PLANNING

The data sources in this catalogue may be useful for place-based planning for health at regional or community levels. Most data sources/data collections are publicly available while others are publicly available with registration or are restricted. Data may be available through request processes which may also require ethics approval, and/or subscription or a one-off payment.

Workforce

Australian Bureau of Statistics – Labour Force Survey – Occupation and Employment: https://www.abs.gov.au/statistics/labour/employment-and-unemployment/labour-force-australia-detailed/latest-release#

Australian Bureau of Statistics – Census of Population and Housing – Employment, Income and Education: https://www.abs.gov.au/statistics/microdata-tablebuilder/tablebuilder

Department of Health and Aged Care – National Health Workforce Dataset: https://hwd.health.gov.au/datatool/

Department of Health and Aged Care – Medical Education and Training Dataset: https://hwd.health.gov.au/datatool/

Department of Health and Aged Care – Health Demand and Supply Utilisation Patterns Planning (HeaDS UPP): https://hwd.health.gov.au/headsupp/

Department of Health and Aged Care – General Practice Workforce: https://hwd.health.gov.au/resources/data/gp-primarycare.html

Health Workforce Queensland – Health Workforce Needs Assessment: https://www.healthworkforce.com.au/hwna

Health Workforce Queensland – Minimum Dataset: https://www.healthworkforce.com.au/workforce-planning-and-project/minimum-data-set

Queensland Health – Queensland Health System Performance Reporting (SPR) platform: https://www.health.qld.gov.au/system-governance/strategic-direction/health-workforce-information-gateway/data-and-analytics

Service delivery/performance

Australian Government Services Australia – Medicare Item Reports: http://medicarestatistics.humanservices.gov.au/statistics/mbs_item.jsp

Australian Institute of Health and Welfare – MyHospitals: https://www.aihw.gov.au/reports-data/myhospitals

Australian Institute of Health and Welfare – GEN (Aged Care Data): https://www.gen-agedcaredata.gov.au

Australian Institute of Health and Welfare – Australia's Health Performance Framework: https://www.aihw.gov.au/reports-data/australias-health-performance

Australian Institute of Health and Welfare – Aboriginal and Torres Strait Islander Health Performance Framework: https://www.indigenoushpf.gov.au/

CheckUp – Outreach Service Schedule: https://www.checkup.org.au/page/Initiatives/Outreach_Services/

Department of Health and Aged Care – Services Australia Medicare and PBS Item/Group Reports, Medicare Statistics: https://www.health.gov.au/topics/medicare/data-statistics-reportinging.nsf/Content/Medicare+Statistics-1

Department of Social Services – NDIS Demand Map: https://caresectordemandmap.dss.gov.au/map/ndis/postcode

Government of Australia – National Disability Insurance Scheme (NDIS): https://data.ndis.gov.au/data-downloads

Health Direct Australia – National Health Services Directory: https://about.healthdirect.gov.au/nhsd

Health Direct Australia – HealthMap: https://healthmap.com.au/

Productivity Commission – Report on Government Services: https://www.pc.gov.au/research/ongoing/report-on-government-services

Queensland Government Open Data Portal – Public dental waiting lists: https://www.data.qld.gov.au/dataset/public-dental-waiting-list

Queensland Government Open Data Portal – Queensland Ambulance Service Incidents by LASN: https://www.data.qld.gov.au/dataset/queensland-ambulance-service-incidents-by-lasn-2020-2021

Queensland Government Open Data Portal – Emergency departments: https://www.data.qld.gov.au/dataset/emergency-departments-quarterly-data

Queensland Government Open Data Portal – Retrieval Services Queensland (RSQ) activity: https://www.data.qld.gov.au/dataset/retrieval-services-queensland-rsq-activity

Queensland Government Open Data Portal – Elective surgery: https://www.data.qld.gov.au/dataset/elective-surgery

Queensland Health – Our Performance: http://www.performance.health.qld.gov.au/

Queensland Health – Inform My Care: https://www.informmycare.health.qld.gov.au/home

Queensland Health – Queensland Statistical Services Branch: https://www.health.qld.gov.au/hsu

Queensland Health – InfoBank: https://www.health.qld.gov.au/system-governance/strategic-direction/health-workforce-information-gateway/data-and-analytics

Health behaviours

Australian Bureau of Statistics – Health topics: https://www.abs.gov.au/statistics#health

Australian Institute of Health and Welfare – Cancer screening and monitoring data: https://www.aihw.gov.au/reports-data/health-welfare-services/cancer-screening/overview

Australian Institute of Health and Welfare – National perinatal data collection: https://www.aihw.gov.au/reports-data/population-groups/mothers-babies/data

Department of Health and Ageing – Childhood Immunisation Coverage: https://www.health.gov.au/resources/collections/childhood-immunisation-coverage-data-phn-and-sa3

Department of Health and Ageing – Vaccination numbers and statistics: https://www.health.gov.au/initiatives-and-programs/covid-19-vaccines/numbers-statistics

Queensland Government Open Data Portal – Queensland COVID-19 Case Line List – location and source of infection: https://www.data.qld.gov.au/dataset/queensland-covid-19-case-line-list-location-source-of-infection

Queensland Government Open Data Portal – Queensland COVID-19 Case Line List – age groups: https://www.data.qld.gov.au/dataset/queensland-covid-19-case-line-list-age-groups

Queensland Health – Preventive Health Survey: https://www.health.qld.gov.au/research-reports/population-health/preventive-health-surveys/about

Queensland Health – Planning Portal: https://www.health.qld.gov.au/system-governance/strategic-direction/plans/health-service

Health status

Australian Bureau of Statistics: Census 2021 – Health conditions: https://www.abs.gov.au/statistics/health/health-conditions-and-risks/health-census/2021

Australian Commission on Safety and Quality in Healthcare – Australian Atlas Healthcare Variation: https://www.safetyandquality.gov.au/publications-and-resources/australian-atlas-healthcare-variation-series

Australian Institute of Health and Welfare – Mortality Over Regions and Time (MORT) books: https://www.aihw.gov.au/reports/life-expectancy-death/mort-books/contents/about

Australian Institute of Health and Welfare – AIHW data by geography: https://www.aihw.gov.au/about-our-data/aihw-data-by-geography

Australian Institute of Health and Welfare – General Record of Incidence of Mortality (GRIM) books: https://www.aihw.gov.au/reports/life-expectancy-deaths/grim-books/contents/about

Australian Institute of Health and Welfare – Suicide and Self-Harm monitoring: https://www.aihw.gov.au/suicide-self-harm-monitoring

Cancer Council Queensland – Queensland Cancer Statistics Online (QCSOL): https://cancerqld.org.au/research/queensland-cancer-statistics/queensland-cancer-statistics-online-qcsol/

Cancer Council Queensland – Australian Childhood Cancer Statistics Online: https://atlas.cancer.org.au/

Cancer Council Queensland, Queensland University of Technology, FrontierSI – Australian Cancer Atlas: https://atlas.cancer.org.au/

Department of Health and Ageing – National Notifiable Disease Surveillance System: https://www.health.gov.au/resources/collections/nndss-public-datasets

Heart Foundation – Australian Health Maps: https://www.heartfoundation.org.au/health-professional-tools-(2)/interactive-heart-map-australia

National Diabetes Services Scheme – Australian Diabetes Map: https://www.ndss.com.au/about-the-ndss/diabetes-facts-and-figures/australian-diabetes-map/

Queensland Health – Notifiable Conditions Report: https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/diseases-infection/surveillance/reports

Queensland Health – Chief Health Officer Report: https://www.health.qld.gov.au/research-reports/population-health

RHD Australia – Queensland RHD Register and Control Program: https://www.rhdaustralia.org.au/queensland

Other topics

Australian Bureau of Statistics – Statistics: https://www.abs.gov.au/statistics

Australian Institute of Health and Welfare – Reports and data by topic/theme: https://www.aihw.gov.au/reports-data/a-z-topics

Australian Institute of Health and Welfare – Regional Insights for Indigenous Communities: https://www.rific.gov.au/regional-overview

Public Health Information Development Unit (PHIDU) – Health Atlases of Australia: https://phidu.torrens.edu.au/

Queensland Government – Queensland Government Statistician's Office: https://www.qgso.qld.gov.au/statistics

APPENDIX 5. EXAMPLE SERVICES SUMMARY

Hughenden - Overview of Current Services

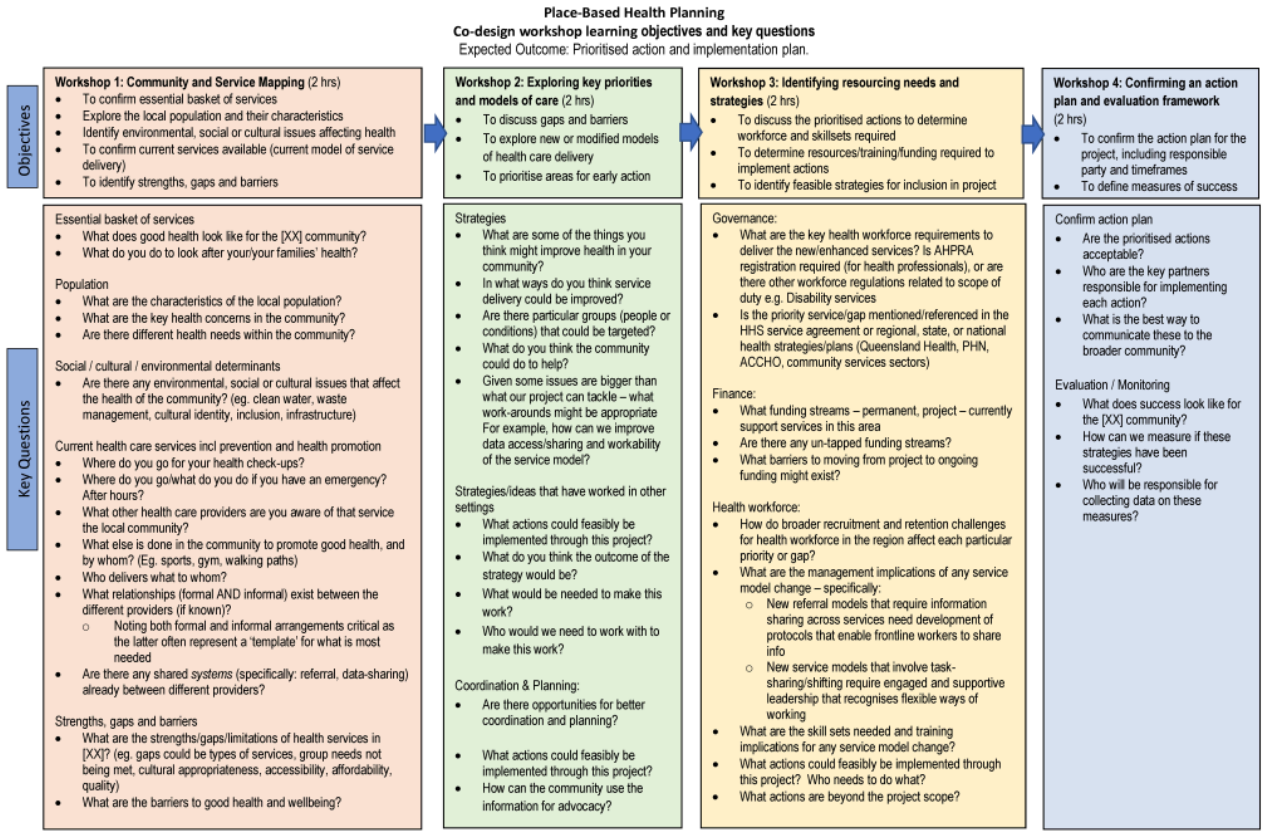
Service Name	Emergency / Acute Health	Health - Primary	Health - Secondary care	Health – Tertiary/specialist	Allied - Chiropractic	Allied - Dental	Allied – Diabetes Educator	Allied - Dietetics	Allied – Exercise Physiologist	Allied – Hearing/Ears	Allied - Mental Health / Counselling	Allied – Occupational Therapy	Allied – Optometry/Eyes	Allied – Pharmacist / Medications	Allied - Physiotherapy	Allied - Podiatry	Allied Speech Pathology	Aged Care - Accommodation	Aged Care - Respite	Community Srs – Aged	Community Srs - Children	Community Srs - Youth	Community Srs – Women's	Community Srs – Men's	AOD Support	Cardiac Services	Disability Support or Care plans	Health promotion / preventive	Palliative Care	Sexual Health	Skin Health		Charity clothing	Domestic Violence	Emergency Relief	Employment	Family Support	Financial assistance/Counselling	Housing Homelessness Support	Indigenous Services	Legal Services	Transport
GOVERNMENT / PRIMARY HEALTH																																								
Centrelink (Services Aust)																										H						H		H	H	H	H			
Disability (NDIS)																										V														
Qld Ambulance Service (QAS)	H																																							
Qld Fire & EmergencyServices (QFES)	H																																							
Qld Police Service (QPS)	H																																							
Retrieval Services Qld (RFDS / RACQ Life Flight)	O																																							
Flinders Shire Council																		H	H	H		H						H												H
Townsville University Hospital -TUH / QH TRAIC			O	VT[1]							V																													
Hughenden MPS	H	H	H	VT[1]		V					V	V		H[2]	V		V	H		V	V	V	V		V			T	V								H			
Hughenden Pharmacy		H												H																										
Hughenden Surgery (GP)		H																																						
SERVICES / PROGRAMS																																								
Alliance Rehabilitation (MPS)									V			V			V		V																							
BodyFix (MPS and Catholic Hall)									V						V																									
Clarity Hearing Solutions (MPS)										V																														
Country Women's Association																																						H		
DAWN Services (Community Care Nurse) FSC																				V						V														
Flying Skin Doctor (RSL)																														V										
Heart of Australia (Van on Brodie St)																									V															
Hodgson Optical (MPS)													V																											
Independent Advocacy NQ (?)																										V														
Lives Lived Well (Home or other)																								V																
Mercy Community (Tele)																										T														
North West Indigenous Community Centre (own building)																																								
North West Remote Health (MPS)							V	V	V		V	V			V																									
O'Brien Chiropractic (own building)					V																																			
Outback Futures (FSC and schools)											V																													
Project Outback Dental (own van)						V																																		
Prospect Community Services (RSL)																						V				V						?	V		V		?			
QIFVLS (courthouse)																																							V	
Rainbow Gateway (own building)																																		H			H			
RFDS Mental health (Tele)											T																													
Rural Financial Counselling Service (small business only)																																				V				
selectability (Home or other)											V																													
St Vincent de Paul (own building)																															H		H							
Talk HQ (library and schools)																	V																							
Towers Podiatry (CWA Hall)															V																									
True Relationships & Reproductive Health (MPS)																							V	V					V											
Uniting Care - NQ Rural Family Support (own on Richmond Rd)																																				V				
Yumba Community Co-op Society (Rainbow Gateway)																																					H	H		

H=Hughenden-based; V=Visiting; T=Telehealth; O=Other location;
1 Specialist visiting clinic – paediatrics. Specialist telehealth clinics include geriatrician and oncology. Other appointments by telehealth on an ad hoc basis.
2 Limited service

v01/03/2023

APPENDIX 6. CO-DESIGN WORKSHOP LEARNING OBJECTIVES AND KEY QUESTIONS

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APPENDIX 7. WORKSHOP SESSION PLANS FOR EACH CO-DESIGN STEP

Click here to download a word version of Appendix 7

PLACE-BASED HEALTH PLANNING
WORKSHOP SESSION PLANS

General planning notes:

- Flexibility to have meetings/interviews with individuals or groups who are unable to attend
- Approx. budget per workshop for venue hire, catering, advertising (accessibility; dietary requirements)
- (If involves research) ensure information sheets have been distributed and discussed. Consent to participate obtained.
- Record attendance – to support evaluation of community diversity represented in the process. Obtain demographic info for everyone that attends including gender, population groups e.g. Aboriginal/Torres Strait Islanders or other cultures, community members vs service providers, location where based - local vs visiting
- Need to pitch each workshop appropriate to the participants (community vs health professionals) - consider language, use of jargon.

Guidelines for participation

- We want to hear your stories, all views are welcome, and we are very keen to learn from you. We are not the experts on your community.
- Reminder of confidentiality of participation and respect for all participants.
- To assist in notetaking, we are recording the meeting (if permission received). No-one will be identified in the notes and only the project team will have access to the recording. It will be deleted after the notes are finalised.
- You may choose to participate in only some aspects of the project and decline others. If you wish to withdraw any information provided, we will only be able to remove any unprocessed data.
- Feedback can be provided between workshops to the Local Connector / Project Support Officer or Project Team.

- Format will depend on numbers: Interaction with whole group vs breakout in small groups vs individual interviews.
- Breaks will be taken at a convenient time within the discussions.
- Plans may need to be revised based on progress in each workshop at each site (we are flexible).
- For the purposes of this project, we seek small feasible actions able to be implemented cost neutral.
- The plan will provide evidence for further advocacy and potential grant applications.

Workshop resources checklist

Resource	Required?	Packed?
Refreshments		
Information sheets and consent forms		
Attendance sheet		
Name tags or labels		
Session evaluation surveys		
Laptop and portable data projector (wifi?)		
Electric leads and extension plug		
Digital recorders		
Flip chart		
Butchers paper and whiteboard markers		
Post it notes and pens		
Community Profiles / Services Summary / Other resources		

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Place-Based Health Planning
Co-design Workshop 1
Community health aspirations
Time 120 mins

Objectives:

- Confirm essential basket of services
- Explore the local population and their characteristics
- Identify environmental, social or cultural issues affecting health
- Confirm current services available (current model of service delivery)
- Identify strengths, gaps, limitations and barriers

Element	Time	Information to include	Resources
Welcome and Housekeeping	5 mins	• Welcome to workshop • Acknowledgement of Country • Introduce team • Check everyone has signed in • Plan for the session	Sign in sheet Name tags
Overview of project as a whole Overview of workshop 1	10 mins	• Project is a partnership project (name partners) • Focus is place-based planning, definition, importance • Duration of the research • Ethics and consent • Communities involved in the research • Go over the 4-step workshop plan • The plan developed at the end of the 4 workshops, implementation and monitoring • Project timeframe • Note limitations to manage expectations - what can be supported by this project - also how else the community could use the report and analysis for advocacy etc • Reporting back after each workshop, throughout implementation and at end of project • Any questions?	Powerpoint slides Digital recorders
Group exercise Essential basket of services (and principles for service delivery)	20 mins	• What does good health look like for the local community? • What do you do to look after your/your families' health? • What is important for the community to access?	Butchers paper and markers
Group exercise Population profile Social determinants	20 mins	Population • What are the characteristics of the local population? • What are the key health concerns in the community? • Are there different health needs within the community? Social / cultural / environmental determinants • Are there any environmental, social or cultural issues that affect the health of the community? (eg. clean water, waste management, cultural identity, inclusion, infrastructure)	Butchers paper and markers

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Element	Time	Information to include	Resources
		Presentation of community profile data for discussion	
Group exercise Current health care services including prevention and health promotion	20 mins	• Where do you go for your health check-ups? • Where do you go/what do you do if you have an emergency? After hours? • What other health care providers are you aware of that service the local community? • What else is done in the community to promote good health, and by whom? (Eg. sports, gym, walking paths) • Who delivers what to whom? • What relationships (formal AND informal) exist between the different providers (if known)? ○ Noting both formal and informal arrangements critical as the latter often represent a 'template' for what is most needed • Are there any shared *systems* (specifically: referral, data-sharing) already between different providers? Presentation of service profile data for discussion	Butchers paper and markers
Group exercise Strengths, gaps, limitations and barriers	30 mins	Looking at the essential basket of services, population characteristics and services available: • What are the strengths/gaps/limitations of health services in the local community? (eg. gaps could be types of services, group needs not being met, cultural appropriateness, accessibility, affordability, quality) • What are the barriers to good health and wellbeing?	Butchers paper and markers
Wrap up and forward plan for next meeting	10 mins	Summarise main points of discussion Feedback / reflections from participants Any questions Set date for next meeting and next steps	
Close and ask participants to complete evaluation survey	5 mins	Session evaluation survey and ask to complete Thank you and close	Survey forms
		Food / refreshments at convenient time or end	

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Place-Based Health Planning
Co-design Workshop 2
Strategies to improve health
Time 120 mins

Objectives:

- To discuss gaps and barriers
- To explore new or modified models of health care delivery
- To prioritise areas for early action

Element	Time	Information to include	Resources
General Introduction Sign in sheet	10 mins	• Welcome to workshop • Introduce team • Check everyone has signed in • Go over ethics and consent (for new attendees) • Quick overview of the project and that we are at workshop 2 • Note limitations to manage expectations - what can be supported by this project - also how else the community could use the report and analysis for advocacy etc • Plan for the session - What will work to improve health in the local community? (community owned plan)	Sign in sheet Name tags Consent forms Digital recorders
Outcomes from Workshop 1 (also available on project website)	20 mins	Main points from workshop 1 discussion: **What do we know about the local people / community?** Presentation of key demographic information about population e.g. Indigenous, young families, over 65years Posters of wordles ppt and printed? QUESTIONS: IS THIS AN ACCURATE SNAP SHOT? WHO/WHAT ELSE IS MISSING? **What health care services are available in town?** -Use service map ppt and printed QUESTIONS: DO YOU AGREE? HAVE WE MISSED ANYTHING? **What the gaps and barriers are to a healthy community?** QUESTIONS: DO YOU AGREE? HAVE WE MISSED ANYTHING?	Powerpoint slides Wordles / Word clouds Services map (ppt slide) Wordle for gaps and barriers?
Strategies to fill gaps and improve services	55 mins	Strategies • What are some of the things you think might improve health in your community? • In what ways do you think service delivery could be improved? • Are there particular groups (people or conditions) that could be targeted? • What do you think the community could do to help?	Powerpoint slide

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Element	Time	Information to include	Resources
		• Given some issues are bigger than what our project can tackle – what work-arounds might be appropriate eg. services don't share patient records (data silos exist) – how can we improve data access/sharing and workability of the service model?	
Strategies/ideas that have worked in other settings	20 mins	***Other strategies/ideas that have worked elsewhere*** Thinking about your ideas, and based on some things that we know work and also thinking about something that is sustainable and empowers the community ***the JCU research team members have come up with a few strategies/ideas that have worked in other similar settings (based on rapid review of literature)*** Presentation of slides with ideas? Of all potential strategies identified, consider: • What actions could feasibly be implemented through this project (within the timeframe and resources available; no additional funding)? • What do you think the outcome of the strategy would be? • What would be needed to make this work? • Who would we need to work with to make this work? Coordination & Planning: • Are there opportunities for better coordination and planning? • What actions could feasibly be implemented through this project? • How can the community use the information and plan for advocacy?	Slide of strategies
Wrap up and forward plan for next meeting	10 mins	• Summarise main points of discussion • Feedback / reflections from participants • Any questions • Set date for next meeting and next steps	
Close and ask participants to complete evaluation survey	5 mins	• Session evaluation survey and ask to complete • Thank you and close	Survey forms
		Food / refreshments at convenient time or end	

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Place-Based Health Planning
Co-design Workshop 3
Workforce and skillsets required
Time 120 mins

Objectives:

- To discuss the prioritised actions to determine workforce and skillsets required
- To determine resources/training/funding required to implement actions
- To identify feasible strategies for inclusion in the project

Element	Time	Information to include	Resources
General Introduction Sign in sheet Outstanding OHL Tool	10 mins	Welcome to workshop Introduce team Check everyone has signed in Go over ethics and consent (for new attendees) Quick overview of the project and that we are at workshop 3 Note limitations to manage expectations - what can be supported by this project - also how else the community could use the report and analysis for advocacy etc Plan for the session - What workforce and skillsets required? What do we need to make this work?	Sign in sheet Name tags Consent forms Digital recorders
Outcomes from workshop 2 (also available on project website)	25 mins	Strategies to fill gaps and improve services Actions required Actions prioritised. DO YOU AGREE OR HAVE WE MISSED ANYTHING?	Powerpoint presentation
Workforce, skillsets and training requirements	60 mins	Governance: • What are the key health workforce requirements to deliver the new/enhanced services? Is Ahpra registration required (for health professionals), or are there other workforce regulations related to scope of duty eg. Disability services • Is the priority service/gap mentioned/referenced in the HHS service agreement (could help in terms of advocacy for HHS-buy in) or regional, state, or national health strategies/plans (Queensland Health, PHN, ACCHO, community services sectors) Finance: • What funding streams – permanent, project – currently support services in this area • Are there any un-tapped funding streams? • Are there any funds that could be redirected? Eg. For vacant positions, could trainee roles be considered? • What barriers to moving from project- to ongoing funding might exist? Health workforce: • How do broader recruitment and retention challenges for health workforce in the region affect each particular priority or gap? • What are the management implications of any service model change – specifically:	Powerpoint presentation

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Element	Time	Information to include	Resources
		○ New referral models that require information sharing across services need development of protocols that enable frontline workers to share info ○ New service models that involve task-sharing/shifting require engaged and supportive leadership that recognises flexible ways of working • What are the skill sets needed and training implications for any service model change? Revise actions – are they able to be feasibly implemented through this project? What actions are beyond the scope of this project?	
Wrap up and forward plan for next meeting	20 mins	Summarise main points of discussion Feedback / reflections from participants Any questions Set date for next meeting and next steps	Ppt: possibly have main points typed up or on a flipchart
Close and ask participants to complete evaluation survey	5 mins	Session evaluation survey and ask to complete Thank you and close	Survey forms
		Food / refreshments at convenient time or end	

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Place-Based Health Planning
Co-design Workshop 4
Confirm action plan and measures
Time 120 mins (maybe shorter)

Objectives:

- To confirm the action plan for the project, including responsible party and timeframes
- To define measures of success

Element	Time	Information to include	Resources
General Introduction Sign in sheet	10 mins	• Welcome to workshop • Introduce team • Check everyone has signed in • Go over ethics and consent (for new attendees) • Quick overview of the project and that we are at workshop 4 • Project timeframe • Note limitations to manage expectations - what can be supported by this project - also how else the community could use the report for advocacy etc • Plan for the session – Present the prioritised action plan. Discuss measures of success.	Sign in sheet Name tags Consent forms Digital recorders
Outcomes from workshop 3 (also available on project website)	30 mins	• Present workforce, skillsets and training requirements for the action plan. • Discuss alignment with other initiatives, funding options. • Responsible partners or sub-committees DO YOU AGREE OR HAVE WE MISSED ANYTHING?	Powerpoint presentation
Measures of success	50 mins	Evaluation / Monitoring – work through each action and discuss: • What does success look like for the local community? • How can we measure if these strategies have been successful?	Powerpoint presentation
Wrap up and forward plan	10 mins	• Summarise main points of discussion • Outcomes and action plan on website • Feedback / reflections from participants • Any questions • Local Connector may lead or support implementation • Monitored by the ref group through its monthly meetings • Feedback to community periodically and project end	
Close and ask participants to complete evaluation survey	5 mins	Session evaluation survey and ask to complete Advise will be contacted for interview relating to the co-design process Thank you and close	Survey forms
		Food / refreshments at convenient time or end	

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APPENDIX 8. WORKSHOP EVALUATION SURVEY

Click here to download a word version of Appendix 8

Place-Based Health Planning
Co-design workshop evaluation survey

Thank you for attending the workshop/community meeting. Please take a moment to fill in this form. Your feedback will help us to improve the next sessions so that they are of most benefit for everyone involved.

1. **I am a…**

   Select more than one option as needed

   - ○ Community member (resident)
   - ○ Community member (visitor)
   - ○ Service provider (health)
   - ○ Service provider (social sector)
   - ○ Service provider (other)
   - ○ Other_____

2. **On a scale from 1 to 5, how useful did you find today's workshop?**
   (1 being the least useful, 5 being the most) Please circle one.

   1 2 3 4 5

3. **What did you find most useful about today's workshop?**

   _____

4. **What did you find least useful about today's workshop?**

   _____

5. **On a scale from 1 to 5, how easy did you find it to contribute in today's workshop?**
   (1 being very difficult and 5 being very easy) Please circle one.

   1 2 3 4 5

6. **How can the workshop be improved for next time?**

   _____

   _____

7. **Any other feedback?**

   _____

   _____

Thank you for taking the time to complete this questionnaire.

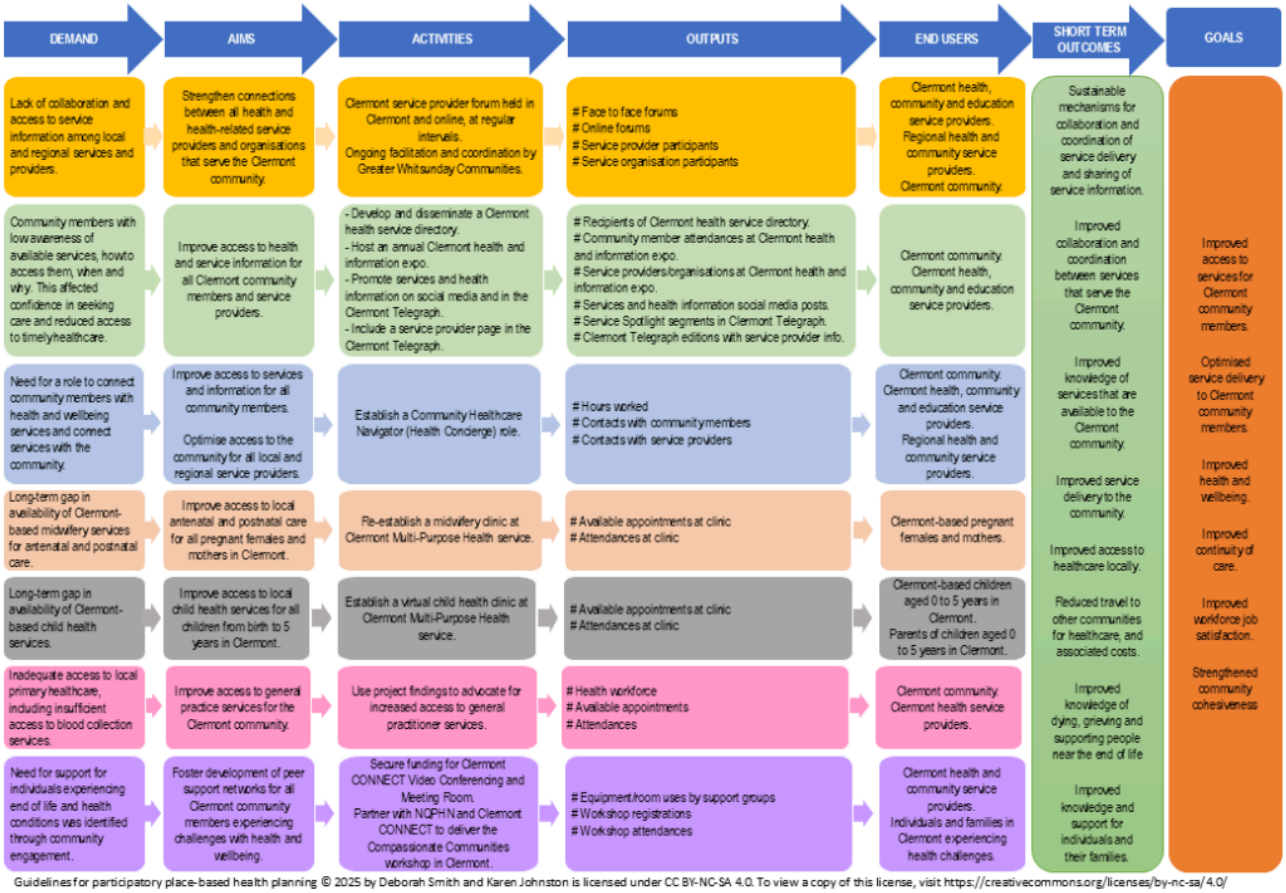
If you would like to expand on any comments or feedback that you have given in this questionnaire, please contact *[insert the name and contact details of the researcher conducting each workshop]*

Results from the feedback will be made available at the next session.

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APPENDIX 9. CLERMONT LOGIC MODEL

[Download the powerpoint version of Appendix 9]



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GLOSSARY

CRCNA

Cooperative Research Centre for Developing Northern Australia

GP

General Practice/Practitioner

HHS

Hospital and Health Service

JCU

James Cook University

LGAs

Local Government Area

MHHS

Mackay Hospital and Health Service

MPHS

Multi-Purpose Health Service

NQ

North Queensland

PHN

Primary Health Network

TAAHC

Tropical Australian Academic Health Centre

WHO

World Health Organisation

REVIEW STATEMENT

Guidelines for participatory place-based health planning: Northern Queensland experiences was peer reviewed by two subject experts. The review was structured around the needs of the intended audience of the book, and covered:

- subject matter
- accuracy
- presentation of diverse perspectives
- longevity of the text
- clarity of the writing
- structure
- consistency
- user experience.

The authors wish to thank Associate Professor Judy Taylor (Adjunct Principal Research Fellow at James Cook University) and Ms Lee Martinez (Rural and Mental Health Academic at the University of South Australia) for taking the time to thoroughly review the book.

Associate Professor Taylor, in her review of the book, notes:

> The content of this ebook is excellent. Congratulations to the team on getting a very complex topic to a point where it is easily understandable and useable for the intended audience. A strength of this ebook is the sound arrangement of the content into three components; provision of clear, evidence-based guidelines, illustrations from practice and then resources that have been tested in practice.

Ms Martinez notes in her review of the book that:

> The ebook covers the subject in detail. Excellent real-life examples are provided, which will assist to inform the intended audience and encourage further inquiry and thought. Having all the appendices will be a handy tool for the workshops. The information is relevant to rural, remote, and I believe could be used in metropolitan service redesign.

VERSION HISTORY

This page provides a record of edits and changes made to this book since its initial publication in the JCU Open eBooks Collection. Whenever edits or updates are made in the text, we provide a record and description of those changes here. If the change is minor, the version number increases by 0.1. If the edits involve substantial updates, the version number increases to the next full number.

The downloadable files available for this book always reflect the most recent version.

Version	Date	Change
1.0	24 September 2025	Publication available via JCU Open eBooks