Learning Report

Advance to Zero in the Country to Coast QLD region

Year 2 (2025-26)

July 2026

the good shift

Contents

This report documents the second phase of work to roll-out the Advance to Zero approach in Central Queensland, Wide Bay and the Sunshine Coast. That roll-out was contracted by Country to Coast Queensland and delivered in partnership between Roseberry Qld (Central Qld) and IFYS (Sunshine Coast and Wide Bay).

The Good Shift has worked as learning partner to support implementation, learning and iteration. We thank the stakeholders from across Central Queensland, the Sunshine Coast, Wide Bay and Brisbane who participated in workshops, interviews, journey mapping sessions and conversations that have informed and helped to refine this report.

This report learns from work to implement, learn about, and iterate Brisbane Zero and Logan Zero initiatives.

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Executive Summary

Progress, learning and implications

Advance to Zero (AtoZ) is a methodology being implemented in communities around the world to:

make homelessness rare, brief and once-off.

CCQ began stewarding implementation of the AtoZ approach in Queensland in partnership with Roseberry Queensland and IFYS in 2024 via initiatives in Sunshine Coast, Wide Bay and Central Queensland. Implementation of AtoZ in these communities continued to evolve during 2025–26, strengthening its contributions to both ending homelessness and improving the health of people experiencing homelessness across Central Queensland, Wide Bay and the Sunshine Coast. While housing outcomes remain constrained by broader shortages in affordable and social housing, the initiative has evolved beyond establishing core Advance to Zero infrastructure towards long-term systems change: more communities are undertaking service coordination; collaboration between health, housing and homelessness providers has deepened; participation by primary healthcare providers is increasing; ZERO data is beginning to influence commissioning and investment decisions; and practical examples of integrated outreach and co-responder models were tested and refined.

A defining feature of 2025–26 was the recognition that coordination alone is insufficient to achieve systems change. Learning across all three regions highlights the importance of combining high-quality data, collaborative relationships, and structured experimentation to respond to recurring service barriers with practical improvements. Prototyping emerged as a critical new capability, enabling partners to test locally relevant solutions, challenge assumptions, strengthen cross-sector collaboration and clarify the role of primary healthcare within ZERO initiatives. At the same time, the year reinforced that ending homelessness requires more than improved service coordination. Long-term progress will depend on strengthening collaborative infrastructure, embedding learning and continuous improvement, embedding and expanding integrated outreach models, using intelligence from the ZERO initaitives to influence commissioning and investment decisions, and continuing to position health and housing as inseparable components of an effective response to homelessness.

ZERO Aims

=

Improving Health

+

Ending Homelessness

Headline results (2025-26)

- 276 people housed
- 162 people experiencing homelessness received health support
- Rich data gathered about the health + housing needs of 993 people experiencing homeless using AHVTT
- Active service coordination mechanisms increased from 2 to 6
- Mobile health services delivered supported 81 people experiencing homelessness in Rockhampton and Bundaberg averting 57 hospitalisations and 59 ambulance trips. A third, longer service also commenced in Gympie which supported 29 people and avoided/reduced the need for hospital presentation or ambulance involvement in 50 of 57 interactions.
- 4 prototypes developed to tackle local service barriers that are currently being tested in Rockhampton + Tin Can Bay
- People experiencing homelessness contributed to Sunshine Coast ZERO through a co-design workshop and Kawana Health Hub Day
- 19 people received in-reach primary health support via the Kawana Health Hub Day
- Inaugural Central Queensland Health and Homelessness Forum engages health, housing, homelessness, education and other actors
- Primary health providers contributed to ZERO implementation via in-reach, out-reach, participation in forums and in problem framing and prototyping activities
- CCQ commissionsed Mental Health + AOD contracts were adjusted to require providers to deliver assertive outreach to people experiencing homelessness
- ZERO data was used to inform housing investment and policy and planning processes

1.0 (Re)introduction to Advance to Zero in the CCQ Region

Country to Coast Queensland (CCQ) is committed to driving locally-led change to improve health, including through its work as the PHN for Central Queensland, Wide Bay and Sunshine Coast. CCQ commissioned Roseberry Qld (Central Queensland) and IFYS (Wide Bay and Sunshine Coast) via Micah Projects in 2024 and directly in 2025 to apply the Advance to Zero (AtoZ) methodology to improve the health of people experiencing homelessness in the region. The AtoZ approach, stewarded by the Australian Alliance to End Homelessness (AAEH), aims to make homelessness rare, brief and once-off. More information on AtoZ can be found on the AAEH website. Information on the localised applications of the methodology in CCQ can be found on websites for CQ ZERO, and Sunshine Coast – Wide Bay ZEROs.

Implementation of the AtoZ method in CCQ has an explicit focus on both ending homelessness and improving the health of people experiencing homelessness. Core elements of the AtoZ approach which are being implemented in the CCQ region include:

- Use of the **Australian Homelessness Vulnerability Triage Tool** (AHVTT) as a common data collection and triage tool
- A real-time, **By Name List** of people experiencing homelessness within a geographic community and their health and housing needs
- **Multi-agency service coordination** to identify opportunities to connect people from the By Name List, who have a completed AHVTT with housing, homelessness, health and other support services
- **Improvement cycles** characterised in the CCQ region, by multi-agency commitment to prototype and test innovative actions to address recurring barriers to people on the By Name List accessing housing and health services.

A Theory Change (Figure 1) was developed with CCQ project leads to describe how the commissioning agency anticipated that the three locally-led ZERO initiatives would contribute to change in their regions, and across the broader CCQ Region.

To support implementation and iteration of ZERO initiatives in response to lessons learned through action, CCQ also commissioned The Good Shift Pty Ltd as a learning partner in 2024 (via Micah Projects) and again in 2025. The Good Shift has helped to facilitate engagement, reflection and prototyping, along with data gathering and sensemaking. This report is the second learning report produced for ZERO initiatives in Central Queensland, Wide Bay and the Sunshine Coast, the first can be found here.

2.0 Learning report purpose

The purpose of this learning report is to document and connect learnings evolving across the ZERO intiatives in the CCQ region and make recommendations to inform ongoing improvement and evolution of the initiative.

The report is framed around learning questions developed by CCQ and the three ZERO initiatives.

To support understanding about the context in which these learnings evolved, the report also provides a high-level timeline of key events which have occurred over the last 12 months (July 2025 – June 2026) and shares examples of activities and achievements that have arisen (see Figure 2).

3.0 Methodology

To make best use of existing data resources, and to minimise un-necessary duplication of reporting, this report draws from:

- published data sets (e.g. AHVTTs, in-flow/out-flow reports, data dashboards)
- de-identified meeting minutes (e.g. service coordination, ZERO Steering Committee)
- learnings, insights, reports developed by The Good Shift to summarise engagement activities, facilitated by The Good Shift over the last 12 months to support ZERO initiatives (e.g. Lived Experience Co-Design Workshop, Hub Day, Rockhampton + Cooloola Coast prototyping workshops)
- reports, and other documents published by ZERO initiative stakeholders.

A limited number of focused learning conversations were also held with a small number key ZERO stakeholders. Focused conversations were also held to inform journey mapping (see Figure 6).

Consistent with the partnership-based and learning-led approach adopted by CCQ and the ZERO initiatives, this report was shared in draft with relevant stakeholders for feedback prior to finalisation.

4.0 What's happened in 2025-26?

The ZERO backbone teams prepare, publish and distribute regular and detailed newsletters, social media posts and other communiques that describe the range of activities being undertaken within each community (see for example Latest News & Events at Sunshine Coast ZERO - Sunshine Coast - Wide Bay ZERO and CQ ZERO: Posts | LinkedIn. Rather than duplicate those sources, the section below provides a snapshot of key implementation activities that have shaped learnings amongst ZERO partners over the last 12 months (see Figure 2).

CQ ZERO Theory of Change

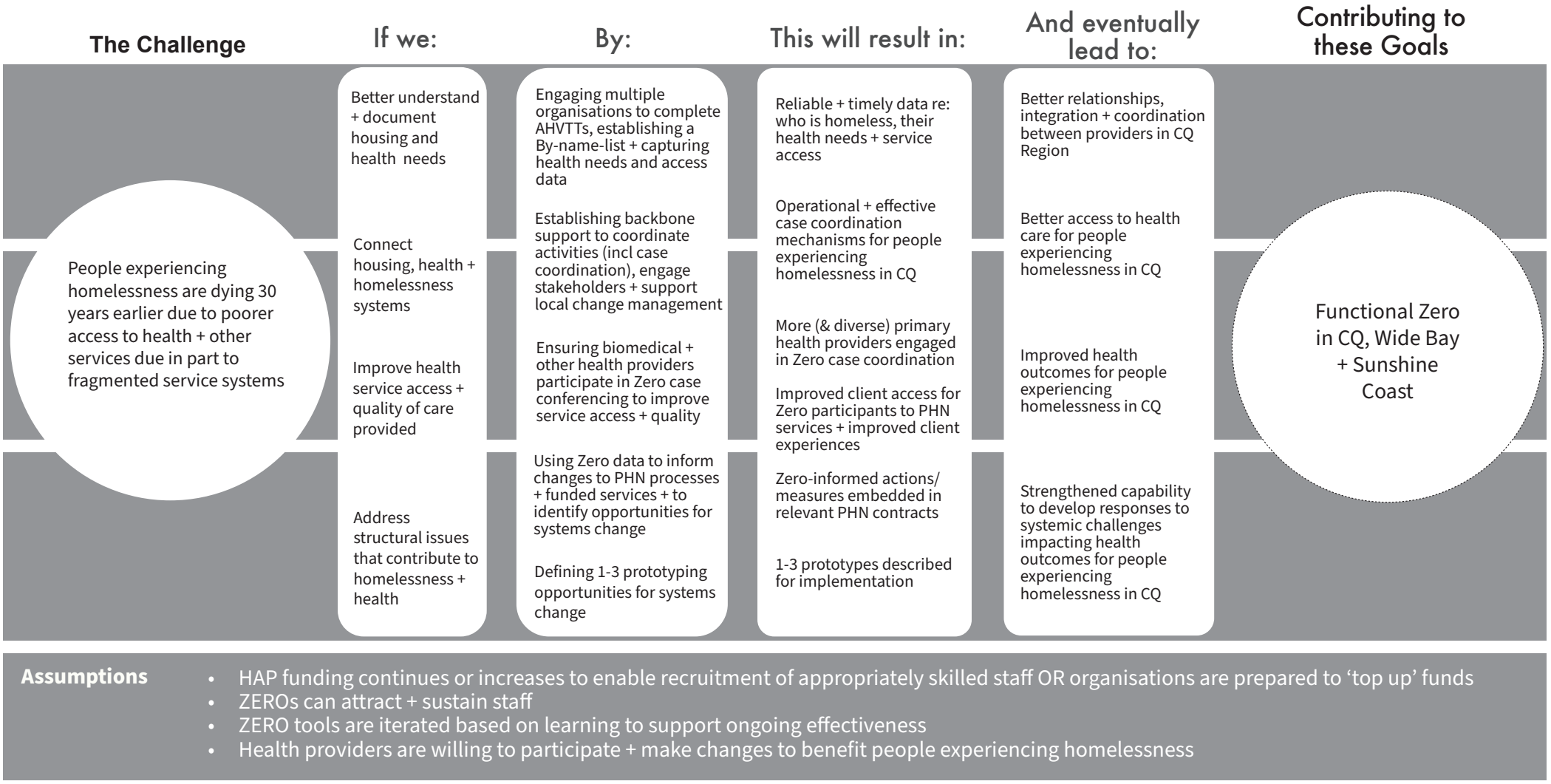

Figure 1: CCQ's Theory of Change for commissioning ZERO initaitives in the region

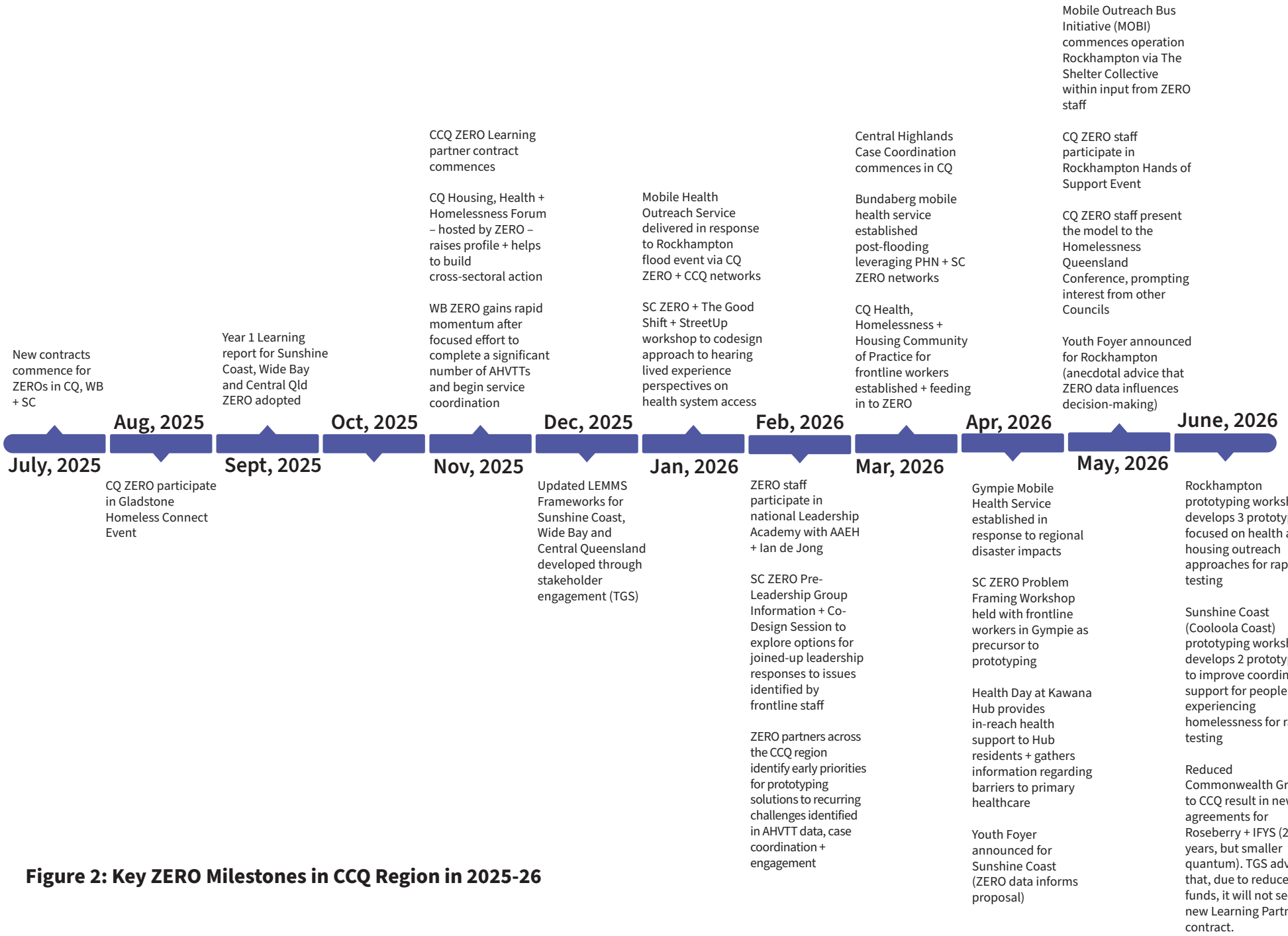

Figure 2: Key ZERO Milestones in CCQ Region in 2025-26

5.0 What was being learnt in 2025-26?

The Learning, evaluation, measurement, monitoring and storytelling (LEMMS) Framework developed with CCQ and representatives from the 3 ZEROs, recognises the unique contributions that learning, evaluation, measurement, monitoring, and storytelling play in understanding project implementation and impact, and in informing project refinement. Stakeholders developed core learning, measurement and monitoring questions that have shaped this report. This next section presents responses to learning questions and more quantitative responses to the monitoring questions. Storytelling is used to illustrate key points throughout the report.

Regional Learning Questions

5.1 What does existing ZERO initiative data tell us about:

- ***Where ZERO participants are currently accessing health supports?***

While AHVTTs provide detail of health conditions experienced by individuals experiencing homelessness along with their use of ambulances and hospital admissions, they do not provide information about where people access primary health supports. At times, case coordination discussions explore health issues and access to primary care however, this does not occur in a systematic way. The following services have been discussed as having potential to support people experiencing homelessness:

- Hospitals (ED, In-patient services, Social Workers, Mental Health, Alcohol and Other Drugs services, including Acute Care Teams and Drug and Alcohol Brief Intervention Team)

- CCQ funded Community Mental Health + Alcohol and Other Drug Services (e.g. QuIHN, Open Minds, Lives Lived Well, Gumbi Gumbi, CQID, Better Connect, Moonya Rehabilitation services, Gympie Women's Health Service, Bridges)

- Nurse Navigators

- General Practitioners + specialist outpatient services

- Mobile Health Outreach Services (Rockhampton, Bundaberg, and Gympie)

- Aboriginal Community-Controlled services including Helem Yumba, Gumbi Gumbi, CQID, Manngoor Dja, Galangoor

- Community-based peer support, bereavement and outreach health services

- Tuberculosis Clinic + public health follow-up

- Specialist disability, neurological and psychiatric care providers

- Medicare Mental Health Clinics + 1300 Mental Health

- NDIS support coordinators (e.g. ADAPT, Forever Connect) + IFYS Disability Support team, Hello Sunshine NDIS support

- Aged Care providers (e.g. Footprints).

A number of case coordination conversations note that people experiencing homelessness were unable to be located or contacted and that others had declined medical care including ambulance care due to negative prior experiences. Concerns about leaving pets, vehicles and belongings unattended while seeking medical intervention are also understood to be barriers to care.

Stakeholder engagement undertaken by The Good Shift across the year revealed that anecdotal information is often shared between providers and people experiencing homelessness about which GP practices, pharmacies and other primary care providers might be more likely to provide support to rough sleepers and other people experiencing homelessness. The prototype being tested on Cooloola Coast (see Section 5.4) aims to improve visibility of information about visiting primary health services to improve access.

- ***How ZERO contributes to increased or enhanced investment in housing?***

While there is no concrete evidence that ZERO directly contributed to increased or enhanced investment in housing in the region, CQ ZERO was advised that ZERO data, analysis, advocacy and collaboration informed decision-making regarding investments into a new Youth Foyer in Rockhampton which will provide 40 units and onsite support for young people at risk of, or experiencing homelessness. Sunshine Coast ZERO data and actions are also informing updates to the Gympie Region Local Housing Action Plan. In Wide Bay, ZERO data and processes have contributed to the work of the Maryborough Anti-social Behaviour Governance Group (the taskforce) run by DPC. The growing quantity and quality of data gathered and synthesised by the ZERO's is enabling more opportunities to support evidence-informed investment decisions.

- ***The health and housing needs of people experiencing homelessness?***

Table 2 summarises available data regarding the health needs of people experiencing homelessness as at 30 June 2026. Note that these figures represent cumulative results achieved and recorded by each ZERO as at 30 June 2026. Figure 3 provides information about health and housing outcomes within each ZERO along with data regarding health needs based on AHVTT reporting.

Table 2: Percentage of people experiencing homelessness in CCQ Region reporting key physical and mental health conditions at 30 June 2026

Health Condition	CQ	Wide Bay	Sunshine Coast	
		Fraser Coast	Sunshine Coast	Gympie
Physical health				
Asthma/respiratory disorders	34%	10%	17%	24%
Brain injury	24%	26%	26%	32%
Heart + vascular conditions	19%	10%	12%	17%
Cancer	3%	10%	5.5%	4%
Foot/skin infections	10%	10%	5%	4%
Dental problems	20%	28%	14%	18%
Mental health concerns				
Anxiety disorders	55%	43%	54%	51%
Depression	40%	39%	40%	43%
Post-traumatic stress disorder	35%	25%	36%	38%
Obsessive compulsive disorder	4%	2%	8%	8%
Bi-polar disorder	15%	16%	18%	18%

CQ ZERO
Working Together to End Homelessness

By Name List:

- **182** at 30 June 2026
- **80** people on BNL had slept rough at some point during 2025-26

2025-26 ZERO outcomes

- **146 new AHVTTs**
- **137 receive multi-agency service coordination**
- **54 housed**
- **78 received health suppot**
- 94 temporarily accommodated
- 22 moved to inactive

When reporting on their last 12 months, people completing AHVTTs revealed:

- 42% were high health system users
- 23% had 5 or more ambulance trips
- 33% had 5 or more ED visits
- 25% had been admitted to hospital for 5 or more nights
- 33% did not seek help when unwell
- 22% faced discrimination
- 36% did not have access to a shower when they needed it

SUNSHINE COAST ZERO
ENDING HOMELESSNESS IN OUR REGION

By Name List:

- **876** at 30 June 2026
- **469** people on BNL had slept rough at some point during 2025-26

2025-26 ZERO outcomes

- **782 new AHVTTs**
- **218 receive multi-agency service coordination**
- **214 housed**
- **58 received health support**
- 320 temporarily accommodated
- 111 moved to inactive

When reporting on their last 12 months, people completing AHVTTs revealed:

- 37% were high health system users
- 14% had 5 or more ambulance trips
- 25% had 5 or more ED visits
- 26% had been admitted to hospital for 5 or more nights
- 34% did not seek help when unwell
- 42% faced discrimination
- 52% did not have access to a shower when they needed it

WIDE BAY ZERO
ENDING HOMELESSNESS IN OUR REGION

By Name List:

- **108** at 30 June 2026
- **87** people on BNL had slept rough at some point during 2025-26

2025-26 ZERO outcomes

- **65 new AHVTTs**
- **71 receive multi-agency service coordination**
- **8 housed**
- **26 received health support**
- 19 temporarily accommodated
- 3 moved to inactive

When reporting on their last 12 months, people completing AHVTTs revealed:

- 49% were high health system users
- 26% had 5 or more ambulance trips
- 35% had 5 or more ED visits
- 32% had been admitted to hospital for 5 or more nights
- 46% did not seek help when unwell
- 52% faced discrimination
- 36% did not have access to a shower when they needed it

Figure 3: Health and housing needs of people experiencing homelessness in ZERO intiatives in the CCQ Region

To better understand the health experiences of people experiencing homelessness on the Sunshine Coast, The Good Shift facilitated 2 lived experience activities (at Nambour and Kawana). Core themes that emerged from these engagements included:

- Homelessness compromises health (e.g. "I've lost the ability to care – lost my sense of self") and creates practical barriers to health (e.g. Not having a postal address means I can't get hospital letters and can't access local services [when I move around]")
- High demand for in-person, bulk-billed, GP, mental health and dental services along with specialist care and medications to manage chronic conditions
- Health system access could be improved via support with transport and meeting costs associated with appointments and treatment regimes, personal support before and during appointments and access to safe and trauma-informed care. Outreach and in-reach models were also recommended.
- Experiences of discrimination are common when accessing health services such as denial of assessments, services or medication, assumptions of criminality, feeling judged and witnessing privacy breaches
- Transitioning from Sunshine Coast University Hospital to community-based care was often a positive and supported experience
- People experiencing homelessness would like more empathic care from health providers that recognises the unique personal histories that have contributed to individuals becoming homeless.

The evidence considered in this learning report highlights the strong connections between homelessness and health with five broad patterns emerging from learning conversations, AHVTTs, case coordination notes and reports:

1.**Health needs are complex, cumulative and intensified by homelessness** - the vast majority of people on the By Name Lists also report a combination of physical and mental health concerns. Participants in lived experience workshops facilitated this year described health as inseparable from housing, safety, trauma, and everyday survival *"homelessness affects all aspects of wellbeing".*

2.**Housing is about accommodation, and is also key to improving health** – many examples emerged via case coordination and lived experience engagement of existing treatment regimes being compromised by homelessness (e.g. challenges with wound care, medication management and sleep deprivation) and new health issues emerging due to rough sleeping (e.g. injuries, anxiety, and dehydration) *"our [CQ ZERO] data was demonstrating what we all know, that taking someone out of sleeping on the street…the health needs of people in temporary accommodation halved comparted to rough sleepers"*

3.**What may appear as 'non-engagement' is often rational decision making** - trauma, exhaustion, repeated system failures and practical access barriers shape engagement by people experiencing homelessness with health and housing systems (see Figure 6). Housing stock is limited and service offerings constrained. Eligibility, triage, access, booking, treatment, and referral processes are complicated. People without Medicare cards or other identification, reliable phones, or calendars struggle to make and keep appointments. *"It's not a refusal of service, the service just doesn't meet her needs".*

4.**People need integrated, relationship-based support not disconnected or partial services** – multidisciplinary and assertive outreach, coordinated case management, integrated health and housing responses, streamlined consent and intake processes and flexible long-term support emerge repeatedly as priorities for improving both health and housing outcomes.

5.**Homelessness results from a complex set of interactions between personal circumstances, community contexts and system barriers** – Individuals and families with complex needs struggle to navigate fragmented eligibility criteria between health, housing, homelessness and community service providers. Shortages of all forms of accommodation stock (e.g. units and housing in the public, private and social housing portfolios); and provider procedures such as TICA listing, "3 strikes you're out" and "cherry picking" the easier to support clients all combine to contribute to homelessness.

5.2 What changes have been observed regarding participation in ZERO by people experiencing homelessness?

Year 1 saw ZERO partners using the AHVTTs as a key mechanism for engaging people experiencing homelessness. As momentum and relationships have built through year 2, a small number of opportunities have been created to engage some people as process designers (e.g. the Street Up members co-designing the Kawana Health Hub Day) and as knowledgeable informants (e.g. via surveys and workshop-style data gathering via the Kawana Health Hub Day). This shift has enabled ZERO partners to develop richer, and more personalised understandings of barriers to primary health care for people experiencing homelessness which is in-turn, shaping the development of prototypes intended to address barriers identified. These deeper engagement opportunities reveal that participation is most likely when there is a clear, immediate and practical benefit associated with participation (e.g. access to a health check, food, payment) and processes are respectful, flexible, conversational and provide choice.

Changes in participation by organisations are discussed in Section 5.3 while changes in participation by Primary Health Care providers are described in Section 5.5.

5.3 How is the integration, coordination and collaboration going between partners? What differences have been observed in the quality of partnerships?

The number of communities with signed up ZERO members and active case coordination processes in place has increased reflecting both, the appeal of the model to service providers, and, the increased number of communities in which people experiencing homelessness are now being supported by local providers with coordination via ZERO (see Figure 4).

CQ ZERO
Working Together to End Homelessness

Service Coordination 2024-25
- Rockhampton/Gladstone combined

Service Coordination 2025-26
- Rockhampton
- Gladstone
- Central Highlands

SUNSHINE COAST ZERO
ENDING HOMELESSNESS IN OUR REGION

Service Coordination 2024-25
- Sunshine Coast

Service Coordination 2025-26
- Sunshine Coast
- Gympie
- Noosa under development

WIDE BAY ZERO
ENDING HOMELESSNESS IN OUR REGION

Service Coordination 2024-25
- Bundaberg under development

Service Coordination 2025-26
- Fraser Coast

Figure 4: Change in ZERO service coordination mechanisms by community

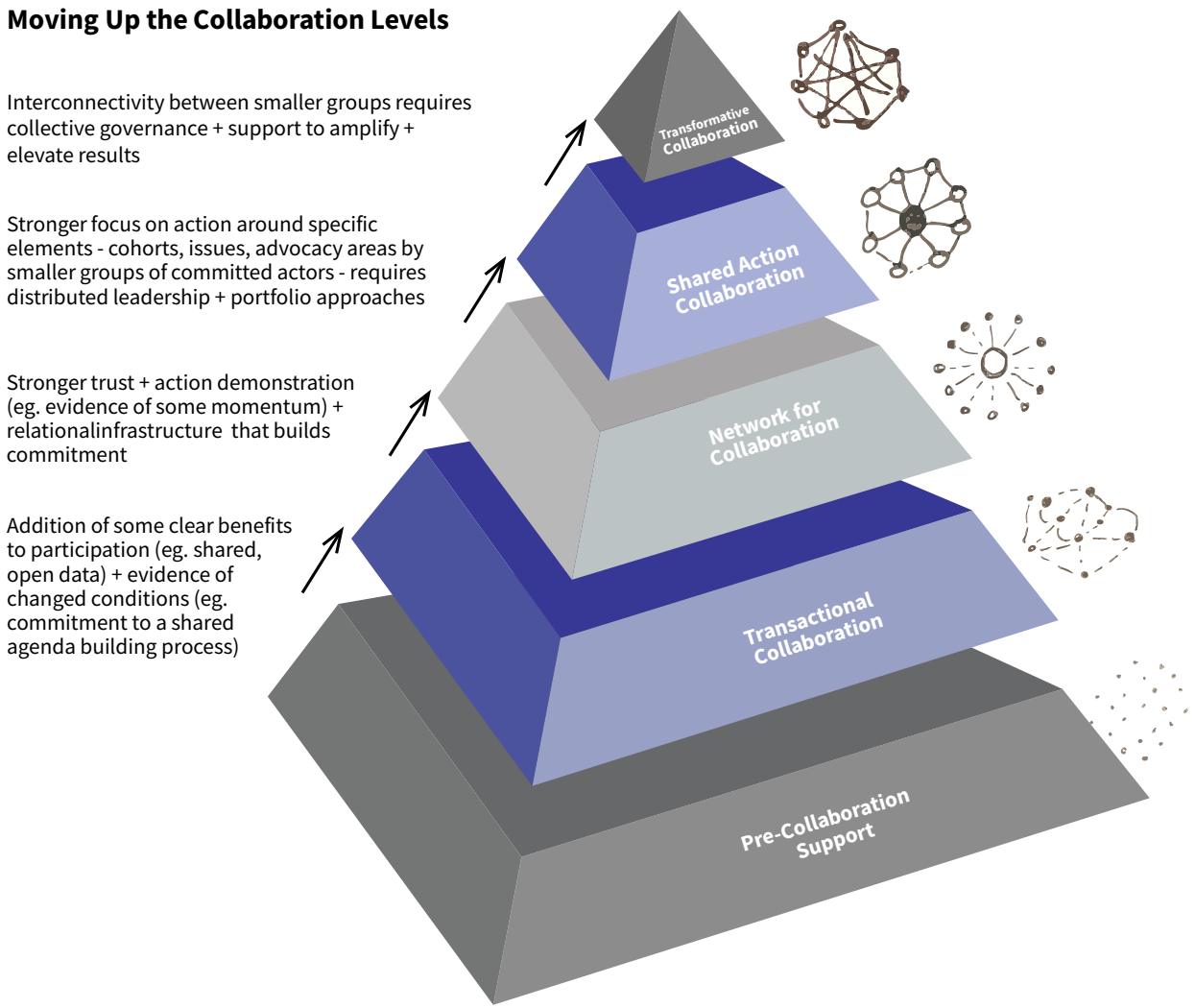

Figure 5: Levels of collaboration amongst ZERO participants

Figure 5 describes the different levels of collaboration which have been consistently observed in Advance to ZERO initiatives implemented in Queensland. Learning conversations undertaken to inform this report suggest that in all 3 ZEROs, collaboration has improved in 2025-26 when compared with the previous year.

In Year 1 collaboration in **CQ ZERO** was considered to be moving from transactional toward more networked approaches to collaboration. In Year 2, stakeholders suggested that networked collaboration was well established, and examples of shared action for collaboration were emerging in both Rockhampton and Gladstone which were now operating stand-alone service coordination meetings engaging different local providers. The commitment to shared action was clear in the **Rockhampton** prototyping work described below. In **Gladstone**, it was reflected in ongoing collaboration amongst health and community service providers to establish pop-up medical clinics (vaccines, wound care, mental health, Alcohol + Other Drugs) in the Gladstone Dignity House. Even though service coordination on the **Central Highlands** had been recently established, collaboration was considered to be networked as service providers in Emerald were enthusiastic in pursuing the benefits of ZERO where the service footprint was much smaller. Establishment of the **Central Queensland Health, Homelessness and Housing Community of Practice,** to improve referral pathways and jointly solve operational problems is another clear indication of improved collaboration.

On the **Sunshine Coast**, in Year 1, collaboration was considered to be moving from pre-collaboration to transactional collaboration. In Year 2 collaboration in the various communities was considered to be at different levels. In **Gympie** where ZERO had 15 active members and provided regular updates to the

broader Gympie Homelessness and Housing Forum collaboration was considered to be at the 'shared action' level, evidenced by practical examples such as:

- Through collaboration between Gympie Women's Health Centre, IFYS Outreach, SC ZERO, Better Connect and CCQ, a six-month pilot was established to test how **clinical mental health support could be embedded within assertive outreach for people experiencing homelessness and rough sleeping**. The worker funded through this model also contributed as a member of the multidisciplinary team delivering the Gympie Mobile Health Service, strengthening the integration of mental health, primary care and social support responses for people experiencing homelessness.
- Cross-sectoral participation in a workshop to deeply understand health challenges for people experiencing homelessness as a precursor to prototyping
- Working together to establish supportive housing that is pet inclusive and to undertake outreach.

On the **Sunshine Coast** collaboration was broadly considered to be consistently reflecting a network for collaboration, but also demonstrating some examples of shared action such as:

- initiation of un-funded co-responder outreach models
- pooling of resources between Specialist Homelessness Service providers to maximise the support able to be provided to clients (e.g. provider 1 provides accommodation, provider 2 releases brokerage funds to access fuel and identification, while provider 3 provides staff support)
- increasing agreements between providers to prioritise available accommodation options to people assessed as most vulnerable using the AHVTT scores.

More emergent work at the northern end of Sunshine Coast (Noosa) was considered to still be at the pre-collaboration level.

In **Wide Bay** in Year 1, collaboration was considered to be still at the pre-collaboration level. Despite starting from a lower base, in Year 2 collaboration on the Fraser Coast was considered to reflect a networked collaboration approach amongst 15 member organisations with many examples of organisations combining effort and resources to support clients in a small community with limited housing and few services. Lack of dedicated staff was seen to be hindering the ability to catalyse greater shared action. In **Bundaberg**, collaboration was also considered to be at a pre-collaboration level.

Despite these positive gains, a number of challenges identified in year 1 continued to be observed by all 3 ZERO initiatives including:

- Variable participation and engagement across local service systems: Some key organisations within local service ecosystems have not yet engaged with ZERO processes, limiting opportunities for comprehensive AHVTT data collection, coordinated referral pathways, and collective tracking of outcomes for individuals.
- Differences in understanding and alignment with the ZERO methodology: Variations in stakeholder understanding, readiness and confidence in applying ZERO approaches have influenced the consistency of participation and action planning.
- Challenges in translating participation into active collaboration: While many organisations participate in ZERO meetings, levels of engagement and contribution vary, highlighting the ongoing need to strengthen shared ownership, accountability and collective action across the system.

Critically, the improved integration, coordination and collaboration is enabling organisations that are members of ZERO to work together through case or service coordination processes to develop housing pathways for complex cohorts in highly constrained housing contexts as demonstrated in the Learning Journey captured in Figure 6. The map reflects how, a large family was identified by CQ ZERO in November 2025 and how, over a period of monthly discussions via ZERO case coordination and other meetings, possible housing pathways were identified, tested with, rejected, refined, and ultimately accepted by the large family facing complex challenges.

This journey map reveals several service system **barriers** that make it difficult to address the health and housing needs of complex individuals and families experiencing homelessness including:

- Lack of housing stock and government requirements regarding the number of bedrooms that must be provided to large families, which in this case, contributed to a family remaining homeless as 3 bedroom homes were not deemed suitable
- Service providers are funded to offer particular services. When they can't offer what a family needs, families may decline a service, and be considered as difficult for refusing unhelpful services
- Given high levels of need, many health, homelessness, and community services are at capacity and have therefore established a practice of trying to contact a client three (3) times and, if they are not able to make contact in those three instances, cancelling the referrals. While this is understandable, this case reveals that it can result in the most vulnerable clients, with the greatest needs for services, and the most significant access challenges, not receiving services.

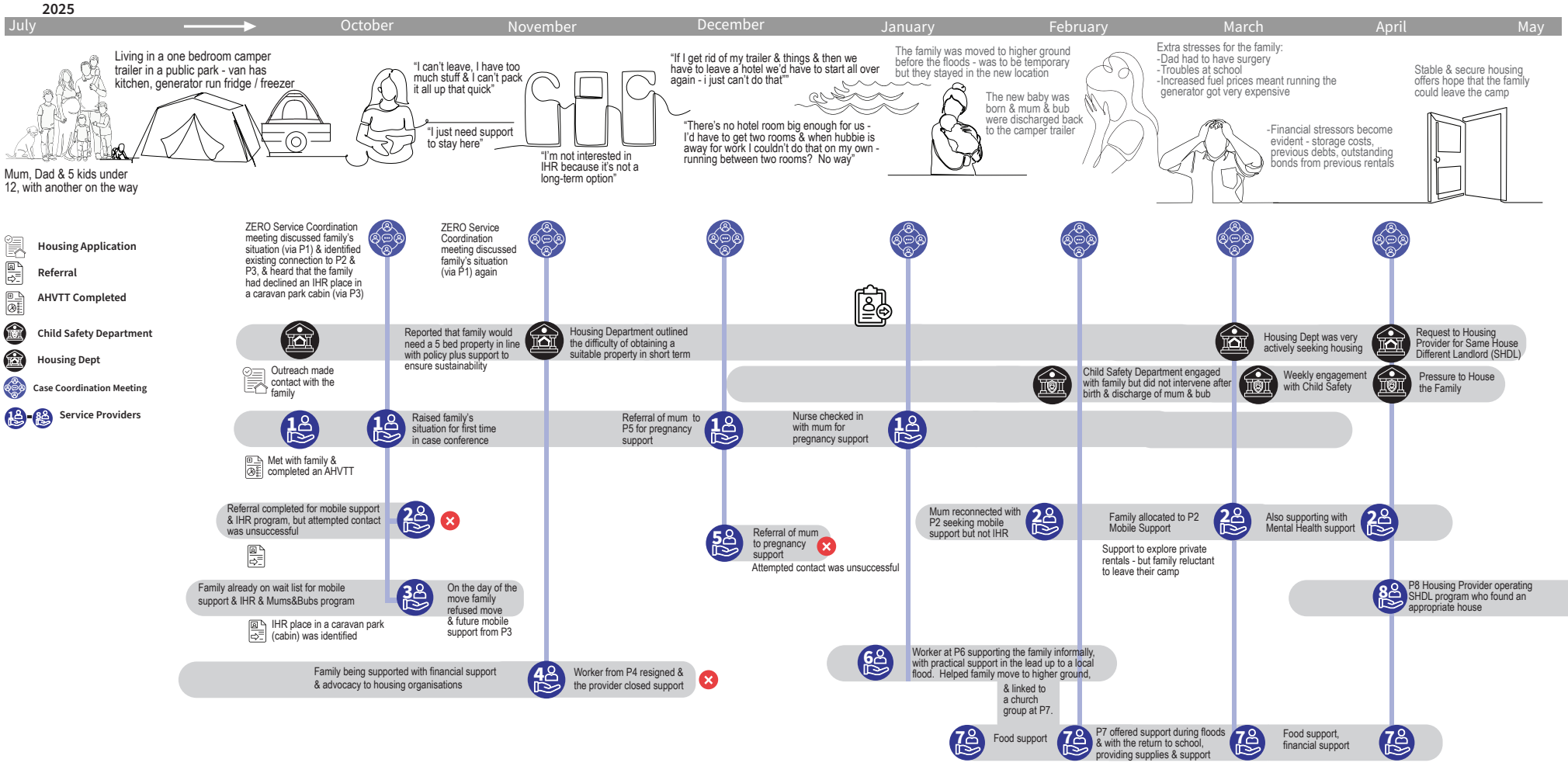

Figure 6: A journey map demonstrating collaboration between ZERO members + others to house a family with complex needs

- Workforce challenges including difficulty recruiting people to roles, and sustaining funding for roles, can disrupt service continuity for clients with complex needs.

It also reveals service system **strengths** that enabled a housing outcome to be achieved including:

- Having ZERO as a forum to continue to advocate for the family, ensuring that they remained a focus for attention, despite early challenges, created a situation where providers started to think 'outside the box' to find solutions
- Having 5 Government agencies connected with the family, and 9 NGO providers that stepped in at key points to help the family with food, school supplies, health and relocation supports, also enabled more to become known about the challenges the family faced, and confirmed that private rental couldn't be a pathway for the family, requiring a different response to be found
- The Department of Housing was able to offer housing, despite the family being TICA listed
- The "Same house different landlord" arrangement creates pathways for families to move from high support, to lower levels of support over time, without needing to move house.

5.4 Beyond AHVTTs, Case Coordination + shared data, what system-level actions and mechanisms does ZERO need to put in place to deepen integration across health, housing and homelessness sectors?

A core element of the AtoZ methodology is the implementation of improvement cycles. These cycles create opportunities to draw from AHVTT and service coordination data to identify key barriers which are preventing ZERO partners from advancing health and/or housing outcomes for people experiencing homelessness and to develop and test 'fixes' to overcome these barriers.

In CCQ, a prototyping approach was initiated to develop shared understandings of local problems, and engage stakeholders in design and testing potential solutions. The Good Shift as learning partner supported this process which began by facilitating ZERO partners to identify a range of strategic challenges and criteria for useful prototypes via structured and participatory mini-workshops held within broader ZERO meeting processes. Two issues met the agreed criteria and were prioritised for refinement and prototyping:

- Lack of outreach services (health and homelessness) in CQ
- Variable participation of primary health providers in ZERO on Sunshine Coast.

A prototyping workshop in **Rockhampton** facilitated by The Good Shift developed 3 prototypes which were being tested at the time of writing:

- **Five in Five** - aims to identify the five most vulnerable rough sleepers and deliver coordinated support
- **Coordinated outreach model** - builds on the Mobile Health service model used during a flooding response, emphasising collaborative health outreach
- **Rising to resilience for mothers and children** - focused on supporting pregnant women and new mothers in crisis accommodation.

Additional work was undertaken to narrow the scope of the challenge identified for the **Sunshine Coast**. This involved:

- partnering with SC ZERO to engage people experiencing homelessness on the Sunshine Coast via a co-design workshop in Nambour, and a modified World Cafe at Kawana to better understand the challenges they faced when trying to address health issues
- Facilitating a Problem Framing Workshop with service providers in Gympie that narrowed the primary strategic challenge to be tackled to 'GP access'
- Facilitating a prototyping workshop on the Cooloola Coast, involving primary health providers recruited by CCQ, that developed two very similar prototypes with plans in place test a hybrid prototype from July 2026. The ***TCB we are here for you*** prototype aims to improve access to specialist health services for people experiencing homelessness in Tin Can Bay by developing and sharing a calendar of visiting services and then encouraging other providers to deliver outreach to the community.
- Supporting the SC ZERO lead to prepare for prototype testing.

Learning conversations informing this report suggest that prototyping was a significant development in ZERO during 2025-26. Participants consistently describe it as a missing capability that helped

ZERO partners evolve from regularly and routinely identifying problems to actively developing opportunities to test systems change strategies. Some of the benefits described by partners included that prototyping:

- created an environment that supported cross-sectoral experimentation and learning and thinking beyond programs
- challenged assumptions about funded outreach models (Rockhampton) and lack of access to GPs (Tin Can Bay)
- encouraged a focus on patterns and systems with potential to benefit multiple people experiencing homelessness
- helped clarify different roles for various health providers across the prototypes
- increased energy and optimism amongst providers grappling with long-term and difficult challenges
- created opportunities for the core collaborative ethos of ZERO to be demonstrated by diverse actors motivated to help tackle one challenge (even though they might struggle to commit to ZERO as a whole).

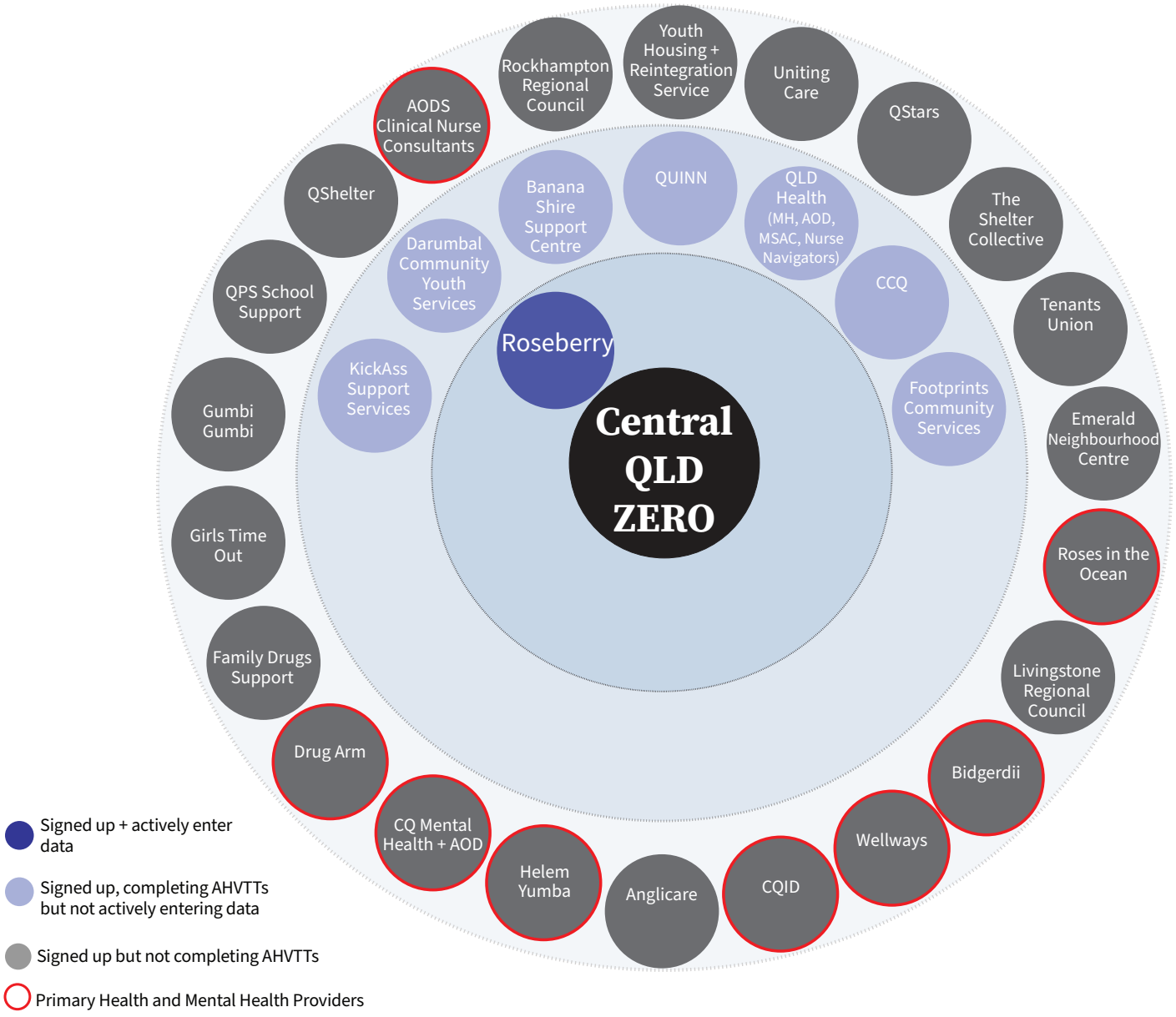

Figure 7: Participating members of Central Qld ZERO

5.5 Which local primary healthcare and other providers are involved as signed up members of ZERO, or collaborators and how has the participation of Primary Health Care providers changed?

Primary healthcare and other providers are contributing to ZERO in all three communities. Figures 7, 8, and 9 map current contributors to ZERO in each region. Primary health providers are ringed in red.

In the last 12 months, the number of PHC providers actively participating as core and contributing members to all 3 ZEROs has increased. Important changes in the nature of participation were also noted, with primary health providers participating in case coordination processes, along with other ZERO-initiated activities including:

- Delivering outreach GP and nurse services via mobile health outreach services in Rockhampton, Bundaberg and Gympie
- Contributing to problem framing and prototyping strategies to improve health and housing outreach services, and access to GPs and specialist services in Rockhampton, Gympie and Tin Can Bay
- Providing health check-ups during the Kawana Hub Health Day
- Participating in the Rockhampton Homelessness and Health Forum.

CCQ made valuable contributions to enduring, structural change by adding a clause into the contracts of organisations engaged to deliver mental health and alcohol and other drug services requiring

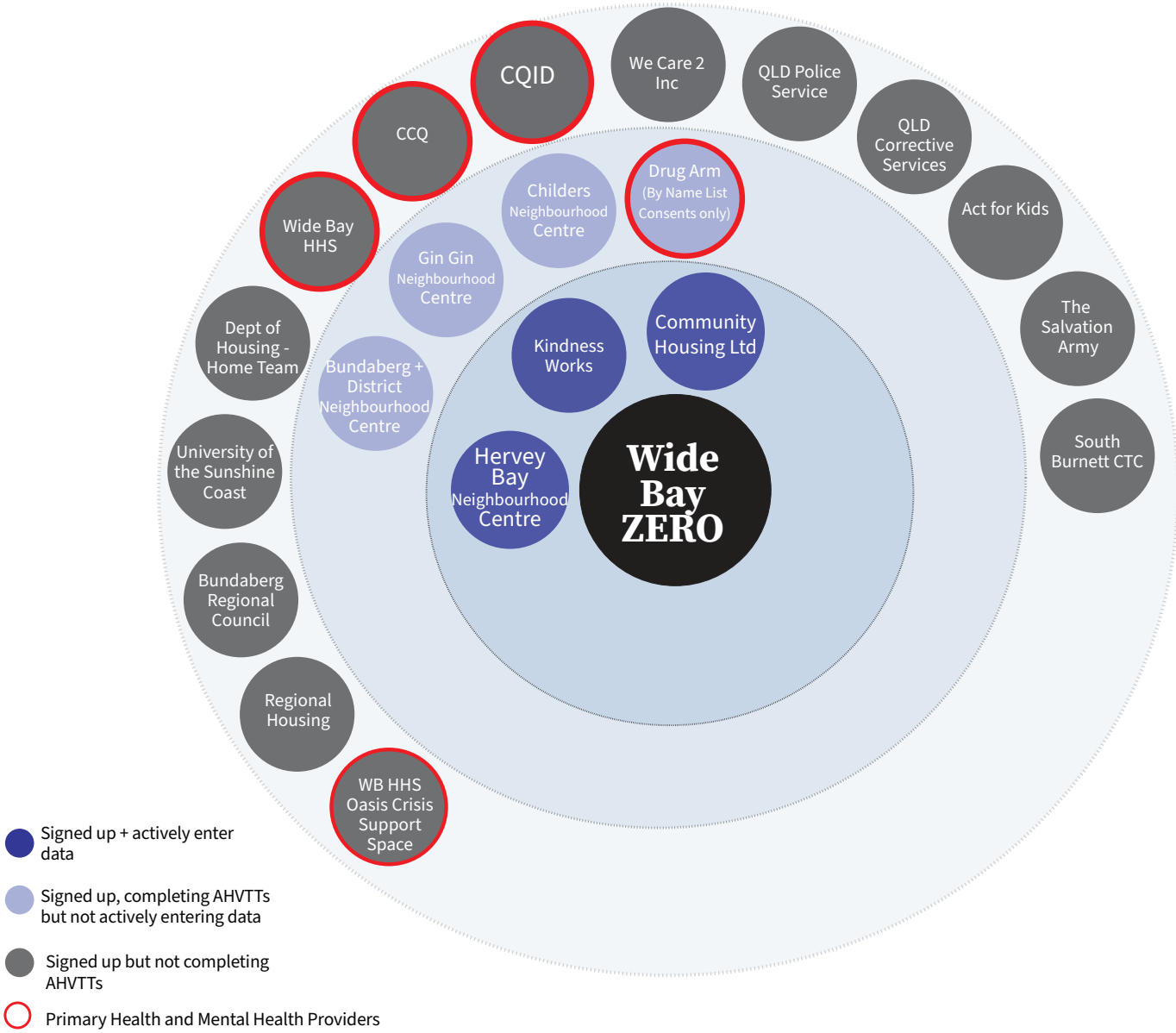

Figure 8: Participating members of Wide Bay ZERO

that they: deliver assertive outreach; coordinate with homelessness services; and support people into ongoing care.

Despite these valuable contributions, a range of challenges to PHC provider support were also identified including:

- Costs associated with delivering outreach services (e.g. insurance and transport) and the profit requirement of health businesses
- Difficulties attracting and retaining suitable skilled staff, including those with the ability to treat people with highly complex needs and difficultly attracting locums to deliver in-practice services when GPs and nurses are delivering outreached services
- Siloed health services and funding models which do not incentivise, reward or enable outreach service delivery and preference short, single issue appointments which make it difficult to triage and treat the multiple health needs often experienced by people experiencing homelessness
- Challenges for health providers in knowing how to access community-based models like ZERO and inconsistent executive support.

5.6 What awareness raising activities have been undertaken?

Activities undertaken in each region are described below:

Central Queensland

- Newsletters
- CQ Health, Housing and Homeless Forum
- Briefings
- Social media posts / accounts
- Conference presentations
- Participation in local events

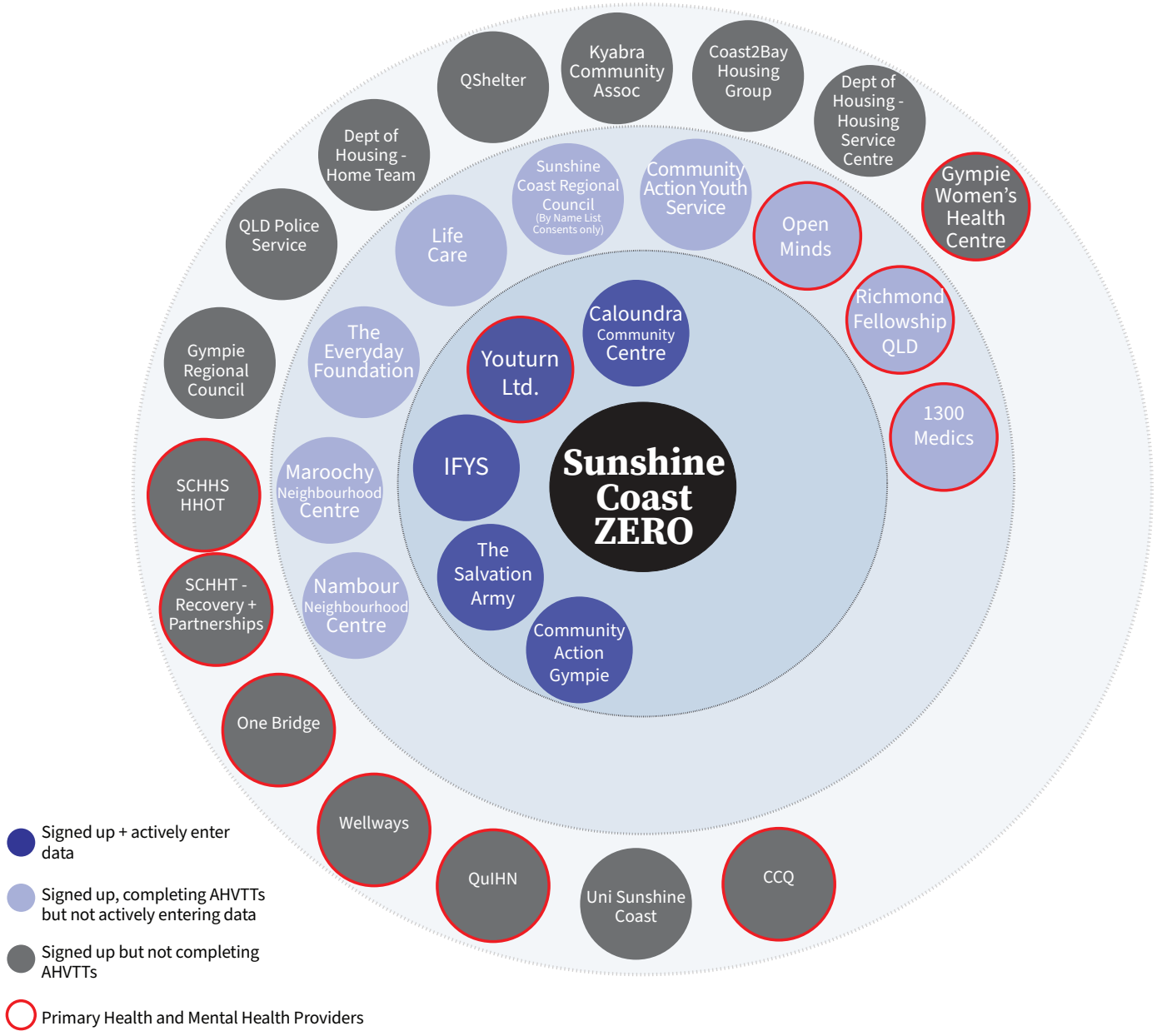

Figure 9: Participating members of Sunshine Coast ZERO

Wide Bay

- Newsletters
- Focused training activities
- Launch + intense activation period
- Discussions/presentations on ZERO at other regional and cross-sectoral forums

Sunshine Coast

- Newsletters
- Focused training activities
- Social media
- conference presentations
- participation in local advocacy groups
- Launch + activation period
- Discussions/presentations on ZERO at other regional and cross-sectoral forums
- Multi-sector/ multi-agency leadership forum.

Regional Evaluation Questions

5.7 What signals suggest that ZERO case coordination contributes to improved access to health services, including primary care services for people experiencing homelessness that might not have been achieved without the program?

A number of signals are emerging that suggest that ZERO is making some progress in creating new pathways into primary healthcare, strengthening collaboration between health and homelessness sectors, and influencing how health services are designed and delivered. For example, Service Coordination meetings:

- are fostering connected responses by primary health and other services to improve health and housing support for shared clients
- create opportunities to consider the same clients over a period of months, testing different approaches until satisfactory health services can be identified and put in place
- foster the relationships needed for providers to come together quickly to activate initiatives like the Mobile Health Services.

Beyond case coordination, ZERO initiatives also support improved health outcomes via other mechanisms for example:

- Some health providers are now engaging with people who have been excluded from mainstream primary health services (e.g. via mobile health services, hub visits, IFYS outreach workers accompanying health outreach teams)

- ZERO data has highlighted equity and access barriers experienced by people experiencing homelessness (PEH) within the current service landscape. These insights have informed adjustments to existing MHAOD service arrangements, supporting CCQ commissioned providers to better respond to the needs of PEH and strengthen access pathways
- ZERO problem framing and prototyping activities moved beyond 'improving referrals' to considering opportunities to redesign the way primary care is provided to people experiencing homelessness (e.g. dedicated weekly GP appointments held open for this cohort, shared calendars of visiting services to strengthen wrap-around care)
- The *Improving the Mental Health & AOD Service System for People Sleeping Rough in Maryborough Project* was developed in partnership between CCQ and Wide Bay Hospital and Health Service under the Joint Regional Plan (JRP) for Mental Health, Alcohol and Other Drugs and Suicide Prevention. The JRP provides a shared governance framework that enables partners to identify priority system issues and work collaboratively to design and implement improvements. In this case, partners leveraged the data and collaborations developed through ZERO to prioritise improvements to the MHAOD service system for people sleeping rough in Maryborough.

The Rockhampton Mobile Health Service featured in the case study on page 20 provides a rich example of how ZERO is contributing to improved health outcomes for people experiencing homelessness.

5.8 What does it take for a PHN to successfully contract place-based collaborative impact?

Lessons learnt across this second year of ZERO implementation in Central Queensland, Wide Bay and the Sunshine Coast suggest that some useful progress has been made in supporting place-based collaborative impact (see Section 5.3 for a description of that collaborative impact). This change has been supported by a broader range of actions and approaches demonstrated by CCQ as PHN including:

- **Articulating a shared goal** (make homelessness rare, brief and once-off + improve the health of people experiencing homelessness) that multiple organisations, contracted or otherwise, are motivated to contribute to
- **Investing in the convening, coordinating, relationship building and data maintenance functions and infrastructures** that enable diverse service providers to: collect, aggregate and make sense of data; build collaborative relationships and join up service offerings; and track change over time.

Case study: CQ ZERO + Disaster responses for people experiencing homelessness

In January 2026, the Central Queensland region identified an opportunity to design and test a model of primary health care provision in response to ex-TC Koji. That weather system resulted in significant flooding of the Fitzroy River in Rockhampton. Many rough sleepers camp along the banks of the river and the CQ ZERO team and CCQ staff were concerned about potential health threats and implications for health and emergency services. With financial support from the Commonwealth Government – staff from CQ ZERO worked with staff from CCQ, 1300 Medics (Registered Nurses), ForHealth (General Practitioners) and homelessness and housing outreach staff from CQID and the Department of Housing HOME Team to design and stand up the Rockhampton Mobile Health Service for a period of 2 weeks. The service provided free, multidisciplinary care to rough sleepers via a mobile health van, and on-foot clinical engagement provided in parks, crisis accommodation locations, and at sites often accessed by people experiencing homelessness to engage with community services such as food relief and laundry services. A total of 12 staff were rostered to deliver the service, supported by 16 organisations, over the 13 days.

During this period, 36 people experiencing homelessness received access to a range of primary health care including wound care, GP consultations, referrals to specialists and warm hand-overs to triage staff in hospital EDs via a mix of street outreach and in-reach to crisis accommodation and community services. Clinical staff reported that the service avoided hospitalisation in 17 cases and ambulance use in 19 cases and helped to register 11 people as new patients with local GPs. AHVTTS were also completed where appropriate, and engagements with people already on the By Name List were recorded. Many learnings emerged from this case includingregarding the health needs of people experiencing homelessness along with opportunities for systems change as described below:

Learnings about health needs:

- Many people experiencing homelessness in Rockhampton have health needs that are not disaster-related, and are not being met by current arrangements
- Trust building, care/hygiene packs and access to free medications were important pre-requisites for people being prepared to access primary care
- Lack of identification restricts access to bulk-billing health services that require Medicare numbers. Fewer restrictions exist in private practice, though costs are generally prohibitive.
- Lack of transport prevents people from attending follow-up appointments (e.g. to specialists). While existing outreach providers may have access to vehicles, policies often prevent using the vehicles to transport clients.
- Lack of access to a mobile phone limits access to services such as Uber Health (a mechanism health providers can use to book and pay for transport to and from appointments)
- Primary health staff involved reported that direct engagement with people experiencing homelessness improved their ability to provide health care to the cohort.

Systems change learnings:

- Relationships built via 12 months of implementing ZERO in CCQ provided critical foundations from which to rapidly design and activate the model, highlighting the value of building and sustaining enduring social infrastructure
- Primary health providers involved in the service valued the opportunities participation provided to engage with this cohort and evolved their professional practice as a result
- Providing outreach care requires a specific scope of practice underpinned by: strong clinical judgement in low-resource settings: the ability to problem-solve, collaborate and communicate; trauma-informed, person-centred and culturally safe practices highlighting opportunities for professional development.
- Staff uniforms and van branding needed to clearly differentiate health responders from police responders to encourage access
- Cross-agency, learning through doing in response to the disaster provided opportunities to learn very quickly what would be required in a successful outreach health service for this cohort (quicker, more comprehensive and nuanced than would have been possible via desk top only)
- Relatively low-cost models are likely to be most effective (e.g. use a car not an ambulance; provide part-time, not full-time outreach; prioritise nurse care, supplemented by less regular care from a Doctor)
- A mix of in-reach (e.g. at a local breakfast program) and outreach (e.g. driving to find people) was necessary to enable continuity of health care during the activation.
- Anticipating and preparing for the specific needs of people experiencing homelessness in local disaster management planning processes is likely to reduce disaster-related health risks, reduce pressure on emergency services and provide pathways to ongoing health and other care.

The success of the service in Rockhampton led to its replication to support flood-impacted people experiencing homelessness in Bundaberg and Gympie.

- **Contracting for learning and adaption** that builds collective capability to identify and understand shared problems, test assumptions, prototype potential solutions, learn and adapt services. This is particularly important in complex contexts when experimentation is necessary because the solutions are not yet known.
- **Building commissioning around equity** and in ways that combine clear expectations with local flexibility. Ensuring that the full spectrum of services funded by the full corpus of PHN resources (with very few exceptions) can be accessed by people experiencing homelessness is a valuable step in helping address the health issues that contribute to homelessness. Ensuring that provider expectations are clear (e.g. deliver assertive outreach in partnership with homelessness providers) and combined with local flexibility (e.g. where and when outreach happens) is likely to support this equitable access.
- **Acting as both a contract manager, and a ZERO participant**. ZERO demonstrated that the PHN could contribute in many valuable ways including:
    - helping to address challenges via changes to commissioning and contracting
    - advocating for, engaging with, and resourcing primary health providers
    - convening community members, primary health providers and others and brokering relationships to tackle local health challenges
    - advocating for State and National policy reform.

  In ZERO, many of these functions have emerged over time, and were therefore under-resourced which has put strain on the team.
- **Resourcing collaboration as 'real work'.** The success of ZERO (and arguably other place-based collaborative impact ambitions) relies on staff from multiple organisations engaging people experiencing homelessness, sharing AHVTT data, attending service coordination, responding collaboratively, and participating in prototyping as core, not optional work
- **Acting quickly and relationally** in response to local challenges and in ways that connect activities within the place (e.g. Rockhampton mobile health service developed to support people experiencing homelessness in response to localised flooding).

6.0 Local learning questions

The learning questions below were developed by Regional ZERO representatives to help guide the ongoing operation of ZERO in their communities.

6.1 Sunshine Coast + Wide Bay + Central Qld:

- ***How can we effectively + accurately evidence and demonstrate success of ZERO?***

While improved housing and health outcomes are critical demonstrations of success, other opportunities to describe the contribution that ZERO is making towards changing systems that influence housing and health services and outcomes are also important. Some opportunities identified over Year 2 include:

- Describing change achieved at multiple levels e.g. individual lives, organisation behaviour, cross-sector action, investment, policy
- Supplementing quantitative data outlining the number of people housed, with stories, cases, journey maps to describe contributions towards practice and systems change
- Capturing evidence of changed relationships between organisations and sectors, and increases in collaboration and/or innovation which become possible because of this (e.g. Mobile health outreach enabled through ZERO partnerships; prototypes built and tested with support from ZERO)
- Highlighting examples of organisations such as IFYS changing their operating processes, practices, and services to better meet the needs of people experiencing homelessness, in line with ZERO data, service coordination or prototyping processes
- Documenting examples of ZERO data and learnings being used to inform investment decisions, contracting clauses, policy, and systems reform
- Establishing developmental learning questions to continue to grow knowledge and practice toward systems change.

Appendix 1 provides a suggested framework for capturing and describing changes that ZERO may contribute to for individuals, organisations, collaborative practice and systems in Year 3 and beyond.

Learnings from Year 2 did highlight that while data and stories are powerful in highlighting issues, in a highly constrained housing market and operating contexts characterised by tight budgets, they are not sufficient to drive change. The problem framing and prototyping approaches tested this year to engage local providers in exploring low-cost, innovative options for making small-scale changes with potential to improve health and wellbeing of PEH have generated energy, attracted new partners and potential solutions. These approaches will be important in continuing to build success in Year 3 and beyond.

- *How can we identify and articulate priorities for systems change that could improve ZERO results?*

ZERO generates a large amount of rich intelligence about why people remain homeless, but there is less consistency in how that intelligence is translated into a small number of strategic systems change priorities. In Year 2, progress was made in both CQ and the Sunshine Coast in identifying a small number of systemic challenges, and then prototyping potential solutions (see Section 5.4). Work to test those solutions in underway.

ZERO could strengthen its systems change work by continue to develop a disciplined approach to identifying , prioritising and acting on a small number of leverage points each year using tools and approaches developed in Year 2. Appendix 2 outlines proposed steps for future prototyping.

6.2 Sunshine Coast: What helps to develop AHVTT 'superusers'?

While SC ZERO hasn't pursued an explicit strategy of supporting 'super users' evidence from Year 2 suggests that the people and organisations most likely to complete and upload AHVTTs are the ones that can see clear alignment of purpose and existing practice (e.g. existing outreach roles). Recognising the value of the AHVTT beyond it's function as a data collection tool also helps. IFYS has embedded the AHVTT into intake policy and procedures, which is thought to have encouraged other organisations to use the AHVTT as an intake, or case management tool that helps to advocate for clients to receive coordinated services to improve their health and housing status. Interestingly, many of these organisations are not specialist homelessness providers, rather, they are the organisations providing direct and regular support to rough sleepers and see AHVTTs and service coordination as structured mechanisms to connect their clients with services. Delivering training and organisational support and making results achieved via the collation and use of AHVTT data also encourage further practice.

6.3 Wide Bay: What does the intersection of health + homelessness look like in Wide Bay?

The inter-relationship between health and homelessness in Wide Bay is clear, as it is in each of the other ZERO communities. People on the By Name List typically report experiencing multiple physical and mental health conditions. Trauma-related mental health conditions such as PTSD, anxiety and depression are widely reported. When asked what will help people feel "Safe and Well", accommodation is typically the priority. Where health is mentioned, it is often reported as an outcome of improved housing (e.g. "I need a unit to get of the streets…[so] I can better manage my mental health, my medication and seek access to NDIS"). Health conditions are reported as creating barriers to accessing housing (e.g. need for wheelchair access, needing housing close to services). Additionally, homelessness is contributing to poor health e.g.:

- sleeping in a car while managing COPD and broken ribs
- suffering from stress related seizures
- difficulties maintaining hygiene and nutrition
- vulnerability to abuse.

As with the CQ and Sunshine Coast ZEROs, Wide Bay ZERO includes a number of regional towns and smaller communities, each of which have different service footprints and challenges tackling health and homelessness. On the Fraser Coast and Maryborough, the 'thin nature' of the service systems seems to be driving greater cooperation in supporting priority clients. Proactive effort to complete a large number of AHVTTs in a short period of time in Maryborough further galvanised the rapid operationalisation of service coordination.

The declaration of an 'exclusion zone' in Maryborough is creating additional service barriers, particularly however for service providers located within this zone. State-Government led coordination mechanisms operating within this community add an additional layer of complexity not encountered in the other ZERO communities.

6.4 Central Qld: What helps/ hinders use of the AHVTT and the creation of a single by-name list in CQ?

In Central Queensland, as with the other ZERO communities, the experience amongst people using the AHVTT is often that it is much easier to use than expected. While the length of the tool can be off-putting, once people have used it a few times people typically find that it is quite straightforward and that many benefits can flow from its' use. Use of the AHVTT has been a focus of the recently established Central Queensland Health, Homelessness and Housing Community of Practice. This, plus ongoing ZERO messaging highlighting connections between health and homelessness, and describing results achieved via use of AHVTT data and case coordination are considered to be helpful motivators for evolving a single by-name list in the region.

Uploading completed AHVTTs to CSNet is a critical step in supporting the development of a single by-name list. In CQ, responsibility for entering AHVTTs and maintaining the by-name-list rests with the CQ ZERO data officer. This approach differs from the Sunshine Coast and Wide Bay which do not have data officers and that therefore rely on partner organisations entering completed AHVTTs.

It is noted that in CQ (as in the other regions), some organisations have signed up as members of ZERO without actively participating in completing and sharing AHVTTs for uploading. The explanations for this failure to follow through are often attributed to staffing shortages, though underlying organisational constraints might also play a role. Where these barriers are not openly discussed, opportunities to grow participation remain unclear.

7.0 What didn't happen in 2025-26 that we were hoping for, and what have we learnt from that?

A number of changes that partners had hoped to see in 2025 did not emerge as anticipated. Firstly, while valuable examples of change emerged, mainstream primary health services did not become as accessible as hoped. A related challenge is that significant uncertainty remains about how primary health providers could most effectively participate in ZERO. A real tension exists between not wanting to' waste' valuable health provider time by asking them to participate in case coordination when health is not a focus, versus, engaging health providers in case coordination to design comprehensive and integrated responses for people with complex needs. Three of the four prototypes currently being tested will help to clarify this for next year.

Across regions there was also an expectation that once ZERO was established, organisations would quickly begin participating, sharing data, undertaking AHVTTs and attending service coordination. In many cases and in many communities progress was slower and more disjointed than anticipated, highlighting the importance of relationships, local history and the foundational work that makes later acceleration possible.

Many partners had also hoped that systems change would occur as a result of service coordination. What became clear this year is that some form of prototyping or service improvement process is required to act on patterns that emerge from service coordination. Prototyping was undertaken in 2 of the 3 regions towards the end of the year, highlighting the importance of ongoing learning about all of the elements that are required for ZERO to make progress on its goals.

Partners had also hoped to secure stable, if not permanent and increased funding in 2025-26 to support ongoing implementatin of ZERO in Central Queensland, Wide Bay and the Sunshine Coast. While welcome longer term funding was secured under the Commonwealth Funded Homelessness Access Program, it was at a reduced level meaning elements of the model needed to be refined for 2026-27 and beyond.

Additionally, some priorities set in Year 1 learning report were not actioned e.g. access to dental care. This highlighted the impact that a changing auspice body (i.e. from Micah to CCQ) had on operational priorities. While poor dental health remains a priority within the AHVTT data, it did not receive direct attention in Year 2.

Finally, while there were encouraging announcements about new supported housing options within the ZERO communities, these will take time to come on line, as will any broader increases in housing affordability and accessibility that may flow from budget announcements this year. As a result, hopes of achieving functional ZERO in the CCQ remain a somewhat distant goal. While efforts to improve the health of people experiencing homelessness are essential, they risk being perceived as 'making homelessness more comfortable' rather than as a valuable contribution to supporting people to improve their ability to gain and maintain housing in the absence of complementary attention to increasing diverse housing options in the region.

8.0 Recommendations for CCQ + Central Qld, Wide Bay and Sunshine Coast ZEROs

8.1 **Routinely analyse the maturing data sets** developed via the ZERO initaitives in the CCQ region to identify recurring system barriers, inform commissioning and policy decision-making and grow systems change capability

8.2 **Continue to resource coordination functions** that bring relevant services together to build the relationships, trust and shared responsibility and infrastructure needed to foster collaborative and innovative action to address complex health and housing needs

8.3 **Embed ongoing tracking and reflection on progress to support cross-regional action, learning and reporting** that continues to: build capability and knowledge; demonstrate results and areas for improvement; and support awareness raising and future resourcing. Appendix 1 recommends core data gathering to support learning and monitoring.

8.4 **Use learnings from the temporary mobile outreach response models to develop strategies that embed integrated assertive outreach models** in ZERO communities to strengthen opportunities for health, homelessness, housing and community service providers to better address the complex needs of people experiencing homelessness in ways that reduce costs for single organisations, improve safety, and support more comprehensive services

8.5 **Continue to test and refine methods for driving system improvement,** and understandings of which methods are most useful in different contexts, to enable partners to identify priority system barriers, co-design practical responses, test innovations, evaluate results and scale successful approaches. Appendix 2 learns from protopying activities undertaken in 2025-26 to describe how this one method could be applied in future.

8.6 **Continue to develop focused opportunities for health providers to engage in ZERO** that address current barriers to participation including by clarifying roles within prototypes, addressing participation costs, advocating for executive support, adjusting commissioning expectations, demonstrating how participation in ZERO supports broader health and organisational priorities and recognising / rewarding participation.

8.7 **Continue to advocate for adjustments to disaster planning processes** to actively plan for and respond to the unique health and safety needs of people experiencing homelessness.

8.8 **Commission services in ways that reward learning, experimentation, and adaption** to maximise innovative responses to entrenched and complex challenges like the poor health of people experiencing homelessness

8.9 **Continue to grow and resource CCQ's capability as a place-based systems-change catalyst** to maximise the service delivery and sytems-change benefits derived from the PHN's multiple functions including contract manager, commissioner, advocate, capability builder, convenor, connector and enabler and policy advisor.

9.0 Supporting publications

Throughout 2025-26, The Good Shift co-designed and co-facilitated a number of learning activities designed to improve understanding of the health challenges facing people experiencing homelessness and opportunities to tackle some of these via practical prototypes. Separate reports were developed summarising these activities which are available via the relevant ZERO. CCQ also developed detailed reports describing the three Mobile Outreath Health Services. The following documents have informed this report:

1. **Gympie Co-Design Report** (Cathy Boorman, The Good Shift)
2. **Health & Homelessness Findngs Report** [including summary of Kawana Hub Day Report[(Emma Christie & Marianne Bell SC ZERO+ Cathy Boorman, The Good Shift)
3. **Rockhampton Prototyping Report** (Cathy Boorman, The Good Shift)
4. **Cooloola Coast Prototyping Report** (Cathy Boorman, The Good Shift)
5. **Mobile Outreach Health Service for People Experiencing Homelessness in Rockhampton: Results and insights Report** (Country to Coast Queensland)
6. **Mobile Outreach Health Service for People Experiencing Homelessness in Bundaberg: Results and insights Report** (Country to Coast Queensland)
7. **Mobile Outreach Health Service for People Experiencing Homelessness in Gympie: Result and Insights Report** (Country to Coast Queensland)

10.1 Appendix 1: Potential Reporting Framework in Year 3 and Beyond

Each ZERO is currently collecting and reporting data in slightly different ways. To support a whole-of-CCQ understanding of the changes being supported by the 3 ZEROs, the following reporting framework is recommended to capture core evidence of change. It can be supplemented with additional learning information as required.

Level of change	Minimum evidence to track progress	Data capture method	Rationale
Changes for indivudals experiencing homelessness	# of people on By Name List	Submitted by each ZERO	Helps understand the number of people ZERO is connecting with + has potential to help
	# of people housed	Submitted by each ZERO	Ending homelessness is a core aim of ZERO
	# of people on By Name List supported to access health services by type	Build routine data capture into Service Coordination processes - then submittted by each ZERO	Health + homelessness are integrally linked. CCQ need to understand and report the health benefits of ZERO
	Illustrative stories of change / journey maps (including housing + health sustainment)	To be prepared + submitted by each ZERO	Supports richer + more nuanced understandings than data alone
Changes within health, homelessness + other supporting organisations	# + type of organisations with ZERO agreements in place + participating in Service coordination	Submitted by each ZERO	Helps understand extent to which ZERO is connecting diverse providers across service systems
	# + type of primary health organisations involved	Submitted by each ZERO	Participation is core to improving health outcomes
	# of organisations completing AHVTTs + # of organisations entering AHVTTs into CSNet	Submitted by each ZERO	Helps understand passive Vs active participation
	Illustrative stories of collective action in response to shared barriers	Submitted by each ZERO	Helps undersatnd what barriers/opportunities are galvanising change locally
Changes in practice	Illustrative stories of changed practice (e.g. joint outreach, shared consent tools)	Submitted by each ZERO	Provides opportunities to understand what is emerging in response to local need and resourcing
	Evidence of learning, innovation + adaption	Submitted by ZERO + CCQ	System change requires ongoing learning + adaption
System changes	# of times ZERO data + prototypes are used to inform housing or health investment	Submitted by ZERO + CCQ	Data is a core ZERO asset that can be used to support evidence-informed change
	Changes made to commissioned services to improve outcomes for people experiencing homelessness	Submitted by ZERO + CCQ	The health of people experiencing homelessness could be improved by making it easier for them to access a wider range of health, housing and community services

10.2 Appendix 2: Appendix 2: Recommended prototyping steps and criteria for ZERO initiatives

Prototyping is one method that can be used to support collaborative action and innovation to tackle recurring challenges. Use of prototyping is consistent with the 'continuous improvement cycles' suggested by the Advance to Zero methodology. The following steps are suggested for future prototyping by ZERO initaitives in CCQ region.

Step 1: Identify patterns in AHVTT data + case coordination notes that are consistently hindering improved health and housing outcomes for people experiencing homelessness. The criteria developed with ZERO partners in Year 2 were:

i. Prototype would addresses a known structural barrier impacting the health of people experiencing homelessness in CCQ
ii. Multiple stakeholders agree the structural barrier is a problem that is worth trying to solve
iii. The barrier can be feasibly addressed at a local scale in ways that benefits local people
iv. Prototype design process is likely to attract necessary/key stakeholders
v. Potential prototyping participants can access the information needed to inform prototype design
vi. There is likely to be an appetite to test and refine a prototype in 2026/27

Step 2: Engage relevant stakeholders to develop robust and shared understanding of the problem using diverse data sets, including lived experience input. The Problem Framing Canvas tool can help.

Step 3: Circulate agreed problem definition and framings for input/revision

Step 4: Once problem definition is agreed, invite relevant stakeholders to a workshop to:

- Confirm/refine problem
- Design prototypes
- Design approach (including timeline) to testing prototype
- Agree timelines for check-ins and achievement of key milestones (e.g. 30, 60, 90 days)
- Agree how learnings will be shared to inform decision making about whether to discontinue or refine the prototype, adapt practice and/or scale prototyped change (e.g. a follow-up learning forum, email updates, mini reports).

Using a prototyping canvas can help. If participants have previously been involved in problem framing + the problem is quite tightly defined, 2.5hrs may be sufficient (see Cooloola Coast prototyping canvas + slides). If the problem is larger, and more stakeholders are likely to participate – 4hrs is suggested (see Rockhampton prototyping canvas + slides).

Step 5: Support stakeholders to test prototypes + gather data to learn about the changes that follow. Check-in as agreed.

Step 6: Implement agreed process for sharing learnings from prototypes, exploring change potential + agreeing prototype discontinuation or refinement /practice adaption/ scaling change in response to data and learnings (e.g. follow-up workshops, learning forrums, email updates, reports)

Step 7: Make any agreed adjustments to the prototype and/or revised processes established via the prototype + monitor over time, document + share process + results to inform ongoing process and systems change.

10.3 Appendix 3: Summary of responses to recommendations from Year 1 Learning Report

Consistent with the learning approach adopted by CCQ and ZERO partners, adjustments have been made to implementation activities in response to recommendations made in a learning report completed at the end of year 1 as summarised in Table 1 below (read the Year 1 learning report here).

Year 1 recommendation	Status
For the Central Qld, Wide Bay + Sunshine Coast ZEROs	
Consider opportunities to narrow the focus of early implementation efforts (e.g. on specific geographic communities, age cohorts, or other focal characteristics such as health) to support more focused engagement, Service Coordination, solutions development, and outcomes.	• One prototype from Rockhampton prototyping workshop is focused on finding housing for the 5 most vulnerable people on the By-Name-List • Sunshine Coast and Central Queensland ZERO have developed focused coordination mechanisms for different communities within these large geographic areas that face different challenges and have different service provider profiles (e.g. Gympie on SC and Central Highlands in CQ) • Prototyping on the Sunshine Coast focused on the highly specific health access issues facing people experiencing homelessness on the Cooloola Coast.
Revisit and refine learning questions in line with insights gained over the initial months of implementation and to reflect the interests of new partners.	• New learning questions were developed at the end of 2025 to reflect learnings from the 1st year of operations and priorities for 2026. Those revised learning questions have shaped the structure of this learning report.
Explore opportunities to consolidate and strengthen local collaborative governance in ways that engage local ecosystem actors in embedding ZERO processes within existing processes and help to adjust implementation over time.	• CQ ZERO governance continued to be run collaboratively with the QShelter-led Service Integration Initiative • SC ZERO convened a leadership meeting and participated in the Qld Data Governance Group. • Prototyping in both Rockhampton and Cooloola Coast developed collaboratively-led initiatives that could be implemented and tested within existing resources • IFYS has embedded AHVTT use within operational policies and procedures.
For CCQ	
Continue to support Cental Queensland, Sunshine Coast and Wide Bay ZEROs to identify and respond to the health needs of people experiencing homelessness in those communities	• CCQ Primary Health Coordinators and Regional Managers act as system connectors and brokers, facilitating relationships between ZERO initiatives and primary health care providers (e.g General Practice) • Strengthened connections between ZERO initiatives, First Nations organisations and Hospital and Health Services • CCQ's Mental Health and AOD Directorate have been engaged to strengthen understanding of MHAOD referral pathways for people experiencing homelessness and support the engagement of CCQ-commissioned MHAOD service providers in ZERO initiatives •The CCQ and Wide Bay Hospital and Health Service Joint Regional Plan provides a platform for joint action to address barriers and improve access to MHAOD services for people experiencing homelessness in Maryborough.

Table 1: Responses made to Year 1 recommendations

Year 1 recommendation	Status
For CCQ cont.	
Continue to learn, and share information about the impact of different operating contexts on the implementation AtoZ across the CCQ region and the different outcomes observed	• Awareness of the impacts of local operating contexts and implementation is growing and has influenced recommissioning decisions (e.g. WB ZERO started more slowly but momentum grew quickly once underway which resulted in a decision to continue to re-fund that region). • The format for engagement between CCQ and the ZEROs was adjusted in 2025 to enable a closer focus on each of the ZERO communities.
Prioritise investment in health services that are accessible to people experiencing homelessness – outreach services (wound care, dental, mental health), nurse-led clinics etc	• CCQ has included a clause in the contracts of funded Mental Health and Alcohol and Other Drug providers requiring them to proactively deliver services to people experiencing homelessness through assertive outreach in coordination with homelessness organisations. • Mobile Health Services have delivered health outreach services following natural disasters in: o Rockhampton (13 days, 36 people assisted over 51 occasions of care, avoiding 17 hospitalisations and 19 ambulance trips) o Bundaberg (13 days, 45 people assisted over 89 health occasions of service delivered which avoided hospitalisation in 40 of 65 interactions and ambulance in 40 of 65 interactions) o Gympie (16 service days over 6 weeks, 29 people assisted via 139 health and wellbeing interventions, avoiding or reducing the need for hospital presentation or ambulance involvement in 50 of 57 interactions)
Consider opportunities to support primary care providers who are already providing healthcare to people experiencing homelessness (e.g. Doctors and nurses who are volunteering their time) in ways that strengthen existing infrastructure (e.g. Neighbourhood Centres), minimise the financial impacts borne by volunteers and maintain and/or extend existing, trusted services.	• Limited tactical progress however, there has been a growing recognition of the dual roles CCQ plays as both commissioner of ZERO services and as supporter of primary health care providers and how both roles might be leveraged to improve health outcomes for people experiencing homelessness. • The Kawana Health Hub Day created an opportunity for existing primary health providers to deliver in-reach services to residents at the 68 bed facility.
Work with a small number of strategic partners (including potentially people with lived experience) to prototype mechanisms to tackle prioritised systemic issues which emerge within ZERO communities and/or across the region. Lessons from the Brisbane and Logan ZEROs could provide initial framing for this work.	• Prototyping workshops were held in Rockhampton and on the Cooloola Coast and developed 4 prototypes (see Section 5.4) which are being tested at the time of writing. • The Cooloola Coast workshop was informed by purposeful engagement with people with lived and living experience of homelessness.

Table 1: Responses made to Year 1 recommendations cont.

the good shift