Consultation Report

Charleville regional consultation

14 APRIL 2021

Making Tracks towards health equity with Aboriginal and Torres Strait Islander peoples—working together to achieve life expectancy parity by 2031

Discussion Paper

QAIHC
Queensland Aboriginal and Islander Health Council

Queensland Government

Making Tracks towards health equity with Aboriginal and Torres Strait Islander peoples—working together to achieve life expectancy parity by 2031

Consultation report: Charleville regional consultation

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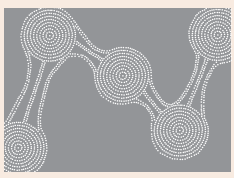
An electronic version of this document is available at **health.qld.gov.au** and **qaihc.com.au**

Acknowledgement of Country

Queensland Health and the Queensland Aboriginal and Islander Health Council (QAIHC), the peak body representing Aboriginal and Torres Strait Islander Community Controlled Health Organisations (ATSICCHOs) in Queensland, acknowledge the Traditional and Cultural Custodians of the lands, waters and seas across Queensland, pay our respects to Elders past and present, and recognise the role of current and emerging leaders in shaping a better health system. We recognise the First Nations peoples in Queensland are both Aboriginal peoples and Torres Strait Islander peoples, and support the cultural knowledge, determination and commitment of Aboriginal and Torres Strait Islander communities in caring for the health and wellbeing of our peoples for millennia.

Making Tracks artwork produced by Gilimbaa for Queensland Health.



Sharing Knowledge artwork produced by Casey Coolwell for QAIHC.

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Introduction

The Charleville consultation workshop was undertaken on 14 April 2021 at the Charleville Hospital Campus. The consultation had 15 participants and was conducted over a five-hour period.

Workshop Purpose

The regional workshops were held statewide to:

- **increase the understanding of the Health Equity agenda**
- **explore how the Health Equity Regulation will change the health landscape in Queensland**
- **discuss what this means for Hospital and Health Services (HHSs) and Aboriginal and Torres Strait Islander Community Controlled Health Organisations (ATSICCHOs) in delivering health services**
- **explore the implications and associated challenges for HHSs in meeting their requirement to prepare their Health Equity Strategy (HES) within 12 months of the regulation being passed**
- **identify any tools that would assist HHSs to develop their HES**
- **socialise other potential health reforms (outlined in section 3 of the Discussion Paper) to identify the ones that have the greatest support and to identify any other important reform items.**

Workshop Structure

The workshop was broken into three parts to correspond to the three sections of the Discussion Paper. Each section was discussed and explored through key questions and subsequent discussion with the groups. Scribes from Queensland Aboriginal and Islander Health Council (QAIHC) and the Department of Health took notes to capture the essence of the discussions and the thoughts and opinions of the participants.

Section 1

Discussed the journey that Aboriginal and Torres Strait Islander peoples have taken to improve health outcomes in Australia and Queensland since 1971.

This included the services undertaken by the Aboriginal and Torres Strait Islander community-controlled sector and Queensland Health. While there have been some health gains, the current pace of reform and activities is not enough to meet the Close the Gap (CTG) targets by 2031.

Section 2

Discussed the health equity journey since 2017, including the current tranche of reforms being introduced in Queensland through the new Health Equity Strategy Regulation. There are going to be additional accountability requirements on HHSs to demonstrate co-design and working in partnership with ATSICCHOs.

Explored the current issues with the local health system and what will need to be done to build a health system that better meets the needs of community and where all providers are working collaboratively towards improved health outcomes.

Section 3

Discussed the 20 proposed ideas to drive further system reforms to supplement the new HESs.

These 'ideas' are not limited to 20 as others could be identified, but it is important to have an idea of what could be relevant to this region and its priority. Details of the ideas are provided in Appendix 3.

Report structure

During the consultative process across the state, there was overall agreement that the health equity design principles (page 23 of the Discussion Paper) should include cultural capability and social determinants of health. Accordingly, the health equity design principles used for this report are:

- First Nations leadership
- local and regional decision making
- reorienting local health systems
- cultural capability (this could be changed to cultural safety)
- social determinants of health.

Further, five key themes have emerged from the workshops. These are:

- systems
- care
- funding
- workforce
- culture.

This report drills down further to map the principles to the key themes. There is often overlap in the learnings and how they have been attributed to the principles, so you may see some comments in multiple places as they are applicable to a variety of areas.

Executive summary

The workshop generated robust discussions about the need for local health system change and reform. A lot of specific (real-life) examples were discussed about the experiences of Aboriginal and Torres Strait Islander community members, which is often vastly different to the commitments made in numerous state and national policy documents. Participants welcomed the opportunity presented by the new HES to reset the local health system but were realistic about the challenges because previous attempts over the years had not resulted in sustained or substantive improvements.

The South West Hospital and Health Service (SWHHS) catchment includes many of the clients of Charleville and Western Areas Aboriginal and Torres Strait Islanders Community Health (CWAATSICH), Cherbourg Regional Aboriginal and Islander Community Controlled Health Service (CRAICCHS), Cunnamulla Aboriginal Corporation for Health (CACH) and Goondir Health Service. The current mechanisms for co-design in health care and a collaborative approach to shared clients varies greatly between SWHHS and the Aboriginal health services.

Key themes discussed included:

- Models of care and the issues that occur given the remote location need to be addressed. The current model of care and the issues of distance continue to be barriers to good health outcomes for First Nations peoples. The journey through the health system is complex for First Nations peoples and needs to be simplified and consideration given to 'at home' and 'e-health' options.
- There needs to be accountability for each client along the whole 'patient journey', with a better and more streamlined system that ensures culturally safe ongoing care at each stage; from home and back to home. Models of care need to be developed that will see clients being able to receive treatment locally rather than being sent away to major cities to access care. Technology and e-health can play a major role in place-based care, thus ensuring streamlined care and minimising the requirement for further interventions.
- The need to have a better coordinated approach to client care, along with more culturally appropriate secondary and tertiary care, is vital to improve health outcomes in this area.
- As with most rural and remote areas, the attraction and retention of a skilled workforce is difficult, and this is particularly true for this area and its ability to attract and retain skilled First Nations health professionals. This shortfall exacerbates the health issues faced by the local Aboriginal peoples. There is a need for a workforce pipeline with a longer-term ability to grow their own workforce and to have training available locally.
- Racism needs to be addressed; audits need to occur with the findings addressed. More training and support need to be available to hospital staff, and complaint mechanisms need to be streamlined to allow Aboriginal and Torres Strait Islander peoples to feel comfortable using the system. Current complaint mechanisms are too cumbersome, and many patients feel that there is no accountability when complaints are made. The education system was listed as a major concern in contributing to poor wellbeing and thereby contributing to a lack of growth of a local workforce. Truant children are suspended, escalating the cycle of poor education outcomes and trauma.
- Social determinants such as education and housing are not integrated into the health and wellbeing of Charleville's First Nations peoples. Family is paramount and the need to consider social determinants in this interconnectedness and in the long-term welfare of First Nations peoples is desperately needed.

Top five health reforms

considered a priority for this region by the participants.

20 Drive an anti-racism strategy across the health system

2 Increase Queensland Health's First Nations employment targets commen-surate to local population or hospital presentation and user rates (whichever is greater)

11 Embed cultural capability into the Clinical Services Capability Framework

6 Introduce First Nations special measures for priority consideration and preference selection in public health sector recruitment

13 Undertake annual independent institutional racism assessments across Queensland Health

Key discussion points

The discussion from the Charleville consultation will be incorporated into the overall state consultation report, which will be used to develop the guide and toolkit that HHS will use to develop their health equity strategies over the next 11 months.

The ideas discussed during the workshop have been mapped against the health equity design principles and can be used to have further conversations about what actions need to be undertaken to redesign the local health system to better meet the needs of people in the Charleville region.

Principle 1: First Nations leadership	
Systems	• Need to work together. • Need to hold system accountable for racist practices. • Need to hold people within the system accountable. • Make sure that people understand the health system and their journey to address their health issues, and where this does not happen, then the providers are able to explain for understanding. • Need to establish regular audits. • Ensure cultural safety at all levels within the patient journey. • Establish ongoing cultural onboarding of staff and regular checks of capacity to work in a culturally safe manner. • Need to put structures into place that give people a voice in the mainstream. • Ensure that the CEs and CEOs are working together effectively in the design and delivery of health services. • Identify issues between health providers which need to be addressed and have effective partnerships going forward. • Establish governance mechanism in region to ensure collaboration and co-design. • Need to review and reflect on what has worked, what has not worked and why to be able to map forward journey. • Establish governance mechanism in region to ensure col-laboration and co-design. • Identify local needs. • Need to get all levels of government working together. • Establish/build a data portal that can be shared between stakeholders (centralised database). Ensure the data is strictly governed by Aboriginal and Torres Strait Islander peoples. • Ensure all staff understand the relevance and use of the data they collect in the ongoing care and health of the community.
Care	• First Nations peoples need to be involved in decisions about their care. • Need models that meet the local need for our region, which are developed collaboratively. • Need culturally appropriate models of care.
Funding	• Need to consider where resources are best used and erase duplication of effort.

Principle 1: First Nations leadership	
Workforce	• More First Nations staff within the whole system—top down. • Need to grow workforce. • Need to ensure pipeline matches requirements of sector.

Principle 2: Local and regional decision making	
Systems	• Need to work collaboratively and in genuine partnership. • Need to work together. • Understand the need and gaps and look at where successes are happening. • Ensure that systems are working to support each other—not duplicate. • Need to review and reflect on what has worked, what has not worked and why to be able to map forward journey. • Need to have the right regional governance, with the right organisations/members making informed decisions. • Need to analyse what is needed and what position is best used to achieve that outcome. • There are issues between health providers which need to be addressed and effective partnerships need to be forged moving forward. • The health system must fit the needs of the region and ensure patients feel culturally safe. • Need to ensure the system is family-focused and place-focused, looking at all determinants and working to achieve wholistic outcomes. • Need to include social determinants in how to improve health. • Need to ensure the right data is being collected and shared to improve outcomes. • Establish a 'Coalition of Regional Stakeholders' to develop and implement collective response (deliver integrated, comprehensive and culturally responsive services for the community).
Care	• Need to appreciate other impacts on health of individual and family. • Need models that meet the local need for our region which are developed collaboratively.
Funding	• Need to understand what investment is needed to implement the model of care that will bring health gains.
Workforce	• This should be addressed as part of the model of care and the supporting workforce needed to deliver. • Acknowledge the skills outside the hospital sector and how they can complement and assist. • The ATSICCHO sector has good experience and can step up as a partner.
Culture	• Need community to understand the health system regardless of education or understanding level and to feel comfortable and confident to engage. • Make sure that people understand the health system and their journey to address their health issues, and where this does not happen, then the providers are able to explain for understanding.

Principle 3: Reorienting local health systems	
Systems	• Need to establish a good data-sharing mechanism that is privacy appropriate. • Establish/build a data portal that can be shared between stakeholders (centralised database). Ensure the data is strictly governed by Aboriginal and Torres Strait Islander peoples. • Ensure that the CEs and CEOs are working together effectively in the design and delivery of health services. • Establish governance mechanism in region to ensure collaboration and co-design. • Referral pathways between primary and secondary/tertiary needs to be culturally safe for community. • Establish a 'Coalition of Regional Stakeholders' to develop and implement collective response (deliver integrated, comprehensive and culturally responsive services for the community). • Establish a provision of brokerage of services such as NDIS in rural and remote communities. • Review of current rural and remote health system.
Care	• Need to appreciate other impacts on health of individual and family. • Need to explore the causal factors of poor health—social determinants. • Need community to understand the health system, regardless of education or understanding level, and to feel comfortable and confident to engage. • SEWB is more than mental health. • Wholistic tool needs to be developed. • Establish a culturally appropriate mental health response system. • Need models that meet the local need for our region which are developed collaboratively. • Need to review and reflect on what has worked, what has not worked and why to be able to map forward journey. • Look at innovative ways to deliver health. • Need to ensure patient is at the centre.
Funding	• Need to identify and agree where funding will go. • Need to ensure the right data is being collected and shared to improve outcomes. • The model of care should be needs based, identify workforce and other support structures and fully costed against current health investment into the region.
Culture	• Make sure that people understand the health system and their journey to address their health issues, and where this does not happen, then the providers are able to explain for understanding. • Ensure cultural safety at all levels within the patient journey. • Referral pathways between primary and secondary/tertiary needs to be culturally safe for community. • The health system must fit the needs of the region and ensure patients feel culturally safe.

Principle 4: Cultural capability	
Systems	• The health system must fit the needs of the region and ensure patients feel culturally safe. • Need to make the system more transparent and easier to navigate. • Need to ensure that the education system is supportive of family environment. • Undertake regular audits.
Care	• Need models that meet the local need for our region. • Need culturally appropriate models of care. • First Nations peoples need to be involved in decisions about their care. • Not only mainstream health has the answers.
Workforce	• More First Nations staff within the whole system—top down. • Lived experience relates to what the model of care should look like and how it's delivered. • Establish ongoing cultural onboarding of staff and regular checks of capacity to work in a culturally safe manner.
Culture	• Need to assist community to understand the health system regardless of education or understanding level and to feel comfortable and confident to engage. • Make sure that people understand the health system and their journey to address their health issues and where this does not happen, then the providers are able to explain for understanding. • Greater First Nations voice within the HHS. • Aspects of cultural capability. • Establish regular audits. • Ensure cultural safety at all levels within the patient journey.

Principle 5: Social determinants	
Systems	• Need a flexible approach and to evaluate and change as needed. • Need to get all levels of government working together. • Need to include social determinants in how to improve health. • Undertake regular audits. • Establish a provision of brokerage of services such as NDIS in rural and remote communities.
Care	• Need to appreciate other impacts on health of individual and family. • Need models that meet the local need for our region which are developed collaboratively. • Referral pathways between primary and secondary/tertiary needs to be culturally safe for community.
Culture	• Need to ensure the system is family-focused and place-focused, looking at all determinants and working to achieve wholistic outcomes. • Lived experience relates to what the model of care should look like and how it's delivered.

Appendix 1—Section 1: The journey so far...

**Have aligned comments to the health equity principles as a guide to move from concept/ideas/comments to action.*

Attendee's comments/views/input	Learnings	Health Equity Design Principles*
General discussion		
• It looks good on paper; the reality is that we can't get better outcomes unless we focus on addressing key issues of the community.	• Need to work together.	P1: First Nations leadership
• The issues agreed in the definition are important to shape the Health Equity Strategy.	• Achieving First Nations health equity requires eliminating the avoidable, unjust and unfair health differences experienced by Aboriginal and Torres Strait Islander peoples by addressing social and economic inequalities, historical injustices, racism and discrimination that lead to poorer health.	P1: First Nations leadership P2: Local and regional decision making
• Health should be looked at and understood in "Aboriginal way" (holistic health). • Cultural identity and social identity need to focus on incorporating youth issues.	• Need models that meet the local need for our region.	P2: Local and regional decision making P4: Cultural capability
• Racism still exists in society and in the system, addressing racism should be the primary focus. Huge barrier for Aboriginal and Torres Strait Islander people, not only in the health system, across all parts of the system. Educating whole system and society on racism is a biggest challenge.	• Need to hold system accountable for racist practices.	P1: First Nations leadership P3: Reorientating local health systems
• Preventing young people from entering into the Justice system is the huge challenge and HES should consider this issue as well.	• Need to appreciate other impacts on health of individual and family.	P3: Reorientating local health systems P2: Local and regional decision making NEW: Social determinants

Attendee's comments/views/input	Learnings	Health Equity Design Principles*
Co-design; and greater collaboration between HHS and ATSICCHO sector		
• People's voices are important on improving health outcomes. A strong collaboration is needed between Aboriginal and Torres Strait Islander communities, organisations (ATSICCHO) and the HHS and other service providers in the community to develop solutions that best meet their needs.	• Need to work collaboratively and in genuine partnership.	P2: Local and regional decision making
• Health system should work collaboratively to improve access for better health outcomes. An example was sought about 'Charleville Cardiovascular Partnership' (a partnership forum) where stakeholders are trying to develop a system (cycle) of care to improve cardiovascular outcomes.	• Understand the need and gaps and look at where successes are happening.	P2: Local and regional decision making
• Shift is required from funding-based model to needs-based model of care. Example was provided that St George HHS offered local ATSICCHO a Chronic Disease Nurse position, which is needed for the community. However, the process did not follow co-design as there are different factors that need to be addressed at the same time such as diabetes, exercise etc. to improve chronic disease outcomes.	• Need models that meet the local need for our region which are developed collaboratively.	P1: First Nations leadership P2: Local and regional decision making
• Joining collective skills and working together is a real co-design. Based on this principle HHS and other stakeholders should work together. Provided an example of Goondir Wellbeing Centre that different activities can be offered collaboratively for the community successfully such as exercise, cooking/skill development, health literacy etc.	• Need models that meet the local need for our region which are developed collaboratively. • Need to review and reflect on what has worked, what hasn't worked and why to be able to map forward journey.	P1: First Nations leadership P2: Local and regional decision making P3: Reorientating local health systems
Social Determinants		
• This whole exercise is about addressing disparity in health outcomes experienced by Aboriginal and Torres Strait Islander peoples. Unless we focus on addressing social determinants, we would not be able to improve health outcomes (close the gap).	• Need a flexible approach and to evaluate and change as needed.	NEW: Social determinants

Attendee's comments/views/input	Learnings	Health Equity Design Principles*
• ATSICCHO are the primary health care providers and HHS mainly focus on acute care; however, we need look on other determinants of health such as education, housing, employment, poverty, justice/social services etc. Government departments/agencies.	• Need models that meet the local need for our region.	NEW: Social determinants
• Other than health, must be socialised on various issues and focus must be creating an environment where all government agencies and the non-government agencies work in collaboration to address various socio-economic issues to improve overall life outcomes.	• Need models that meet the local need for our region.	P1: First Nations leadership NEW: Social determinants
• How do we address causal factors? • Trauma and the impacts.	• Need models that meet the local need for our region. • Explore the causal factors of poor health—social determinants.	P3: Reorienting local health systems
• Co-design projects should be supported at the top, should be a standing agenda item at the executive level.	• Need models that meet the local need for our region.	P1: First Nations leadership P2: Local and regional decision making

Appendix 2—Section 2: Embedding health equity into local health...

Placing First Nations peoples and voices at the centre of healthcare service delivery

**Have aligned comments to the health equity principles as a guide to move from concept/ideas/comments to action.*

Attendee's comments/views/input	Learnings	Health Equity Design Principles*
Challenges		
• Maintain true collaboration between stakeholders (ATSICCHO and HHS).	• Need to work together.	P1: First Nations leadership P2: Local and regional decision making
• Service integration—minimising duplication of efforts	• Ensure that systems are working to support each other—not duplicate.	P2: Local and regional decision making
• Take a look at the big gaps in our communities. Can't address issues if we aren't getting proper outcomes.	• Identify local needs.	P2: Local and regional decision making
• How do you get together to include social determinants within the community?	• Need to get all levels of government working together.	NEW: Social determinants P2: Local and regional decision making
• Institutional racism and discrimination. • 'Culturally appropriate programs which have a male and female doctor'.	• Need culturally appropriate models of care.	P1: First Nations leadership P4: Cultural capability
• Trauma how do we improve the voice.	• Lived experience relates to what the model of care should look like and how it's delivered.	
• Duty of care as government workers. • How do we make sure the job is being delivered.	• Holding people within the system accountable.	P1: First Nations leadership
• People don't feel comfortable with going to hospital, often feeling judged, only way seeing problems is in the back of an ambulance. • Stereotype/judgemental thoughts when an Aboriginal and Torres Strait Islander patient visits hospital for the treatment.	• Need community to understand the health system regardless of education or understanding level and to feel comfortable and confident to engage. • Making sure that people understand the health system and their journey to address their health issues and where this doesn't happen, then the providers are able to explain for understanding.	P1: First Nations leadership P2: Local and regional decision making P3: Reorientating local health systems P4: Cultural capability

Attendee's comments/views/input	Learnings	Health Equity Design Principles*
• Mentality of our people thinking that it's our fault.	• Need to make the system more transparent and easier to navigate.	P4: Cultural capability
• How do we focus on family? • How do we improve? • Do we bring in youth? • Do we bring in Elders? • Who do we have at the table?	• Need community to understand the health system, regardless of education or understanding level, and to feel comfortable and confident to engage. • Need to engage with everyone in the community or just selection of people.	P1: First Nations leadership P2: Local and regional decision making
• Pathways in and out of the tertiary facilities.	• Need to ensure pipeline matches requirements of sector.	P1: First Nations leadership
• Models of care—Institute for Urban Indigenous Health how do we share. • First conversation—how do we bring mechanisms together to talk about a governance structure?	• There are issues between health providers which need to be addressed and effective partnerships going forward.	P1: First Nations leadership P2: Local and regional decision making
• St George supportive approaches in the schools translating that for other areas.	• Need to ensure that the education system is supportive of family environment.	P1: First Nations leadership P4: Cultural capability
• Legal equipment use agreement.		
• Where is the continuity of care?—AMS information sharing. • Regional plan to effect change. • Completing the loop. • Creating a seamless journey between the systems, sharing of the data.	• Need to ensure patient is at the centre. • The model of care should be needs based, identify workforce and other support structures and fully costed against current health investment into the region. • Need to identify and agree where funding to go.	P3: Reorienting the local health systems
• Requires people to conduct the consultation as AMS, don't have the capacity to conduct consultations.	• Need to put structures into place that give people a voice in the mainstream.	P1: First Nations leadership
• Ryan's rule.	• Ryan's Rule is a three-step process to support patients of any age, their families and carers, to raise concerns if a patient's health condition is getting worse or not improving as well as expected.	

Attendee's comments/views/input	Learnings	Health Equity Design Principles*
• Embedded hierarchy of system—cultural safety is considered as 'one size fits for all'. It is important to consider diverse perspectives of Aboriginal and Torres Strait Islander peoples and their cultural needs.	• The health system must fit the needs of the region and ensure patients feel culturally safe.	P2: Local and regional decision making P3: Reorientating local health systems P4: Cultural capability
• Resources (workforce and financial resources) are very limited.	• Need to consider where resources are best used and erase duplication of effort. • Need to grow workforce.	P1: First Nations leadership
• Limited provision of education packages under 'Cultural Capability Framework'.	• Greater First Nations voice within HHS. • Aspects of cultural capability.	P4: Cultural capability
• Referral process/system—current QH/HHS referral system does not meet the needs of people living in rural and remote communities; very complex/harsh and focused on system rather than the meeting needs of people.	• Need to have the right regional governance, with the right organisations/members making informed decisions.	P2: Local and regional decision making
• Workforce is huge challenge—lack of skilled health workforce in rural and remote communities.	• Need to analyse what is needed and what position is best used to achieve that outcome. • This should be addressed as part of the model of care and the supporting workforce needed to deliver.	P2: Local and regional decision making
• Responding community needs—health problems are complex in rural and remote communities.	• Need to understand what investment is needed to implement the model of care that will bring health gains.	P2: Local and regional decision making
• Lack of service availability such as NDIS, specialist care etc Incarceration rate is high. Current government system is punitive, which makes Aboriginal and Torres Strait Islander people feel unsafe and stigmatised. Example was provided that kids in trauma as police tagging them as a 'naughty kid'; which is not working. Simply, to get respect from kids you should respect them.	• Need to ensure the system is family- and place-focused looking at all determinants and working to achieve wholistic outcomes. • Need to include social determinants in how to improve health.	P2: Local and regional decision making NEW: Social determinants
• Lack of data. • Lack of proper data-sharing mechanism has huge impact on continuity of care. Currently lack appropriate data-sharing and governance/control mechanism.	• Need to ensure the right data is being collected and shared to improve outcomes.	P3: Reorientating local health systems

Attendee's comments/views/input	Learnings	Health Equity Design Principles*
• Collaborate efforts of other sectors—housing, employment, social services are challenging.	• Need to ensure the system is family-focused and place-focused, looking at all determinants and working to achieve wholistic outcomes. • Need to include social determinants in how to improve health.	P2: Local and regional decision making NEW: Social determinants
• How do you get together to include social determinants within the community.	• As discussed above.	NEW: Social determinants
Enablers		
• ATSICCHOs have expertise to work with HHS to provide support. • Existing Aboriginal and Torres Strait Islander health workforce at HHS.	• Acknowledge the skills outside the hospital sector and how they can complement and assist.	P2: Local and regional decision making
• Well established system—mechanism to work in partnership.	• The ATSICCHO sector has good experience and can step up as a partner.	P2: Local and regional decision making
• Provision of telehealth services/ e-consultation—technology.	• Look at innovative ways to deliver health. • Models of care.	P3: Reorientating local health systems
• Existing data collection mechanism (HHS, ATSICCHO and other government and non-government organisations).	• Need to establish a good data-sharing mechanism that is privacy appropriate.	P3: Reorientating local health systems
• Develop a survey tool to measure/ understand racism (how people are feeling) within the health system.	• Establish regular audits.	P1: First Nations leadership P4: Cultural capability
• Create Aboriginal and Torres Strait Islander friendly environment at the HHS so that Aboriginal and Torres Strait Islander people feel welcomed when visiting hospitals.	• Ensure culturally safety at all levels within the patient journey. • More First Nations staff within the whole system—top down.	P1: First Nations leadership P4: Cultural capability
• Exclusively, use social and emotional wellbeing assessment tool to access patient health and wellbeing.	• SEWB is more than mental health. • Wholistic tool needs to be developed.	P3: Reorientating local health systems
• Put strong focus on co-design of health services and initiatives by Aboriginal and Torres Strait Islander peoples.	• First Nations peoples need to be involved in decisions about their care. • Not only mainstream health has the answers. • Lived experience relates to what the model of care should look like and how it's delivered.	P1: First Nations leadership P4: Cultural capability

Attendee's comments/views/input	Learnings	Health Equity Design Principles*
• Establish a coordination mechanism; dedicated person to collaborate efforts in each HHS region.	• Establish governance mechanism in region to ensure collaboration and co-design.	P1: First Nations leadership P3: Reorientating local health systems
• Review of current referral process to establish an accessible referral process that meets needs of people living in rural and remote communities.	• Referral pathways between primary and secondary/tertiary needs to be culturally safe for community.	P3: Reorientating local health systems
• Establish a 'Coalition of Regional Stakeholders' to develop and implement collective response (deliver integrated, comprehensive and culturally responsive services for the community).		P2: Local and regional decision making P3: Reorientating local health systems
• HHS and ATSICCHO to work collaboratively to improve care coordination, such as antenatal, nutrition, chronic disease, readiness to school, which can make huge difference in 10-years' time.	• Establish governance mechanism in region to ensure collaboration and co-design.	P2: Local and regional decision making
• Establish a provision of brokerage of services such as NDIS in rural and remote communities.		P3: Reorientating local health systems NEW: Social determinants
• Establish a culturally appropriate mental health response system.		P3: Reorientating local health systems P4: Cultural capability
• Establish/build a data portal that can be shared between stakeholders (centralised database). Ensure the data are strictly governed by Aboriginal and Torres Strait Islander peoples.		P1: First Nations leadership
• Review of current rural and remote health system.		P3: Reorientating local health systems
• Introduce recovery model that is based on strength rather than the incarceration.	• Referral pathways between primary and secondary/tertiary needs to be culturally safe for community.	NEW: Social determinants P3: Reorientating local health systems
• Introduce mandatory staff education/ coaching on patient data collection.	• Ensure all staff understand the relevance and use of the data they collect in the ongoing care and health of the community.	P1: First Nations leadership

Attendee's comments/views/input	Learnings	Health Equity Design Principles*
• Cultural safety. • Embedded racism—under-resourced. • SEWB Health Check —embedded to get outcome.		P3: Reorientating local health systems P4: Cultural capability
• Survey people—encountering racism—care interactions. • Example of racism: Heart operation seven years ago—bad reaction to medication—told family that this was an alcoholic. • Education packages—real-life experience.	• Undertake regular audits. • Lived experience relates to what the model of care should look like and how it's delivered.	P4: Cultural capability NEW: Social determinants
• Cultural capability framework—education about how race works. • Different communities—different issues.	• Ensure cultural safety at all levels within the patient journey. • More First Nations staff within the whole system—top down. • Establish ongoing cultural onboarding of staff and regular checks of capacity to work in a culturally safe manner.	P1: First Nations leadership P4: Cultural capability
• CEs and CEOs co-design.	• Ensure that the CEs and CEOs are working together effectively in the design and delivery of health services.	P1: First Nations leadership P3: Reorientating the local health system

Other comments—Ideas

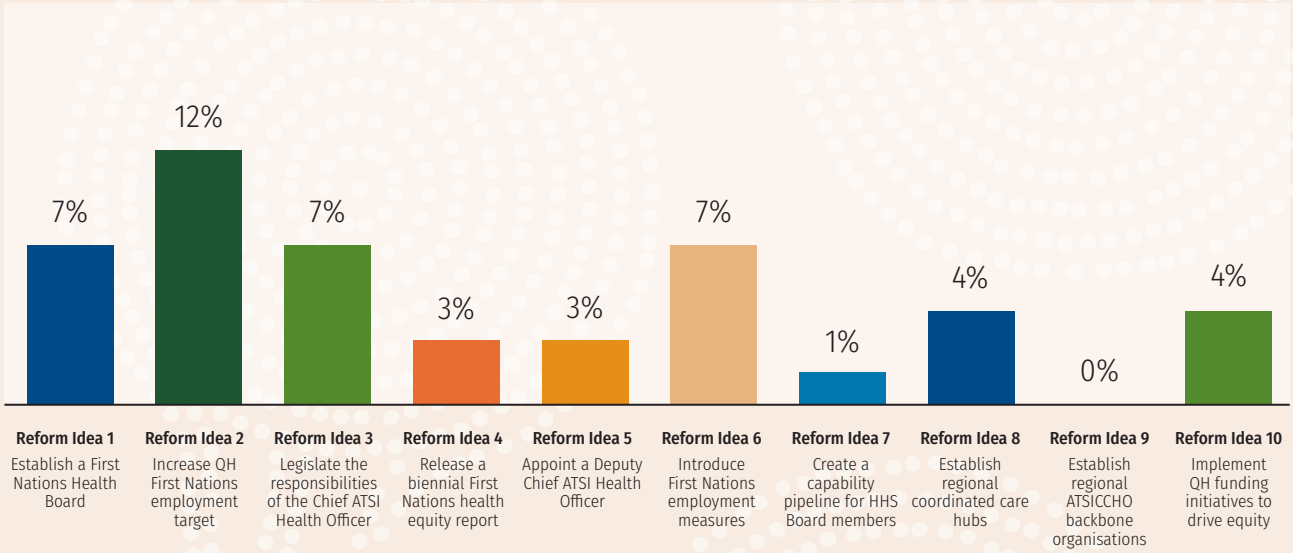
Attendee's Comments/Views/Input
Suggestion for inclusion in HES toolkit: • schedule (timeline for HES activities) • success stories, tools to measure 'racism' at mainstream health services/HHS • example of initiatives/ideas that were successful to address institutional racism so that other health service providers can implement those initiatives in their region (no need to reinvent a wheel) • develop a survey tool to measure/understand racism (how people are feeling) within the health system • a guide to review current referral process—open and softer referral system/process that is flexible to meet people's needs.

Appendix 3—Section 3: Driving health equity across the health system and addressing the social and cultural determinants of health...

Future ideas for discussion

Charleville Health Equity Consultation Workshop

Voting on the 20 health reform ideas in Section 3 of the Health Equity Discussion Paper



Reform Idea 1 Establish a First Nations Health Board

Reform Idea 2 Increase QH First Nations employment target

Reform Idea 3 Legislate the responsibilities of the Chief ATSI Health Officer

Reform Idea 4 Release a biennial First Nations health equity report

Reform Idea 5 Appoint a Deputy Chief ATSI Health Officer

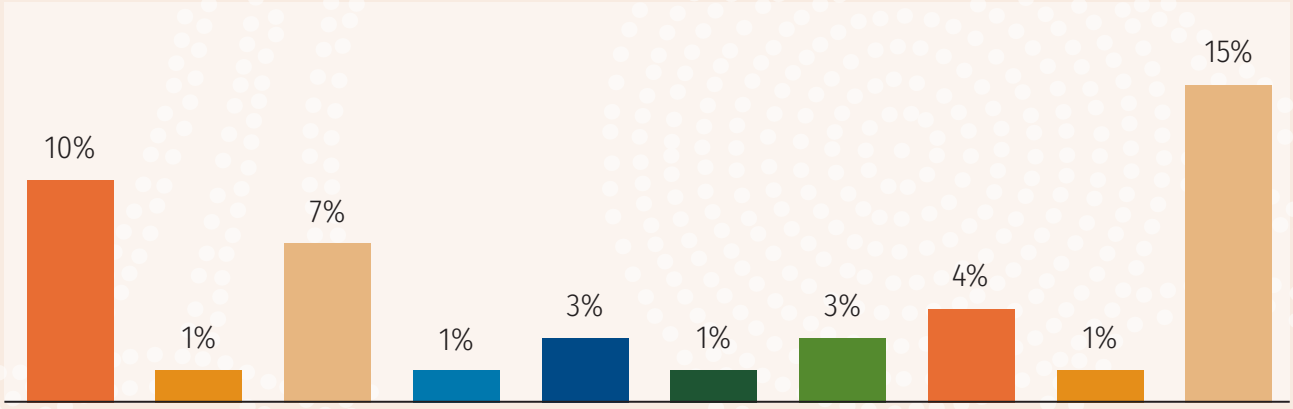
Reform Idea 6 Introduce First Nations employment measures

Reform Idea 7 Create a capability pipeline for HHS Board members

Reform Idea 8 Establish regional coordinated care hubs

Reform Idea 9 Establish regional ATSICCHO backbone organisations

Reform Idea 10 Implement QH funding initiatives to drive equity



Reform Idea 11 Embed capability into *Clinical Services Capability Framework*

Reform Idea 12 Refresh *QHATSI Cultural Capability Frameworks 2010–2033*

Reform Idea 13 Undertake annual independent institutional racism audits

Reform Idea 14 Amend birth notification to acknowledge birth parents cultural connection to Country

Reform Idea 15 Strengthen functions of other health statutory authorities to drive health equity

Reform Idea 16 Factor equity into existing QH funding models

Reform Idea 17 Utilise the Health Equity Strategies as future health investment plans

Reform Idea 18 Establish pilot Marmot city regions across Queensland

Reform Idea 19 Set statewide and regional QH procurement targets to purchase from ATSI-owned businesses

Reform Idea 20 Drive an anti-racism strategy across the health system

Appendix 4—Attendee list

Name	Organisation
Janet Gaulton	Charleville and Western Areas Aboriginal and Torres Strait Islander Community Health Limited (CWAATSICH)
Donna Enders	Cunnamulla Aboriginal Corp for Health
John Maris	CWAATSICH
Norman Burns	CWAATSICH
Patricia Fraser	CWAATSICH
Sheryl Lawton	CWAATSICH
Troy Williams	CWAATSICH
Floyd Leedie	Goondir Health Services
Gary White	Goondir Health Services
Cleveland Fagan	QAIHC
Govind Ohja	QAIHC
Karen Thompson	QAIHC Consultant
Tiana Lea	QAIHC
Yasmin Muller	Queensland Health
Jermain Isua	Queensland Health
Leonie Edwards	Services Australia—Centrelink
Helen Wassma	South West Hospital and Health Service (SWHHS)
Dalene Robinson	South West Hospital and Health Service Drug Arm/Bidjara
Louisa Duffy	SWHHS
Melinda Brassington	SWHHS
Rebecca Greenway	SWHHS
Rod Lander	SWHHS

Appendix 5—Agenda

Proposed times	Agenda item
10:00–10:30am	Welcome to Country, Housekeeping, Introductions
10:30–11:00am	The Health Equity Project— • Who is on the Project Team? • What will the project do? • How will it bring better health for me and my family in the future?
11:00am–12:00pm	Discuss Section 1: The journey so far... (page 6–23)
12:00–12:30pm	LUNCH
12:30–1:30pm	Discuss Section 2: Embedding health equity in local health systems... (page 24–31)
12:30–1:30pm	Discuss Section 3: Driving health equity across the health system and addressing the social and cultural detirminants of health... (page 32–43)
2:30–3:00pm	Wrap up and close the meeting

Appendix 6—Glossary

Abbreviation	Meaning
AIHW	Aboriginal and Island Health Worker
AMS	Aboriginal Medical Service
ATSICCHO	Aboriginal and Torres Strait Islander Community Controlled Health Organisation
CATSIHO	Chief Aboriginal & Torres Strait Islander Health Officer
CE	Chief Executive
CTG	Closing the Gap
CWAATSICH	Charleville and Western Areas Aboriginal and Torres Strait Islanders Community Health
DAMA	Discharge Against Medical Advice
DATSIP	Dept of Aboriginal and Torres Islander Partnerships
ED	Emergency Department
FN	First Nations
FNQ	Far North Queensland
HHS	Hospital and Health Service
HR	Human Resources
IUIH	Institute for Urban Indigenous Health
KPIs	Key performance Indicators
LANA	Local area needs analysis
MHAOD	Mental Health and Other Drugs
OH&S	Occupation Health and Safety
PHC	Primary health care
PHN	Primary Health Network
QAIHC	Queensland Aboriginal and Islander Health Council
QH	Queensland Health
RN	Registered Nurse
SDoH	Social determinants of health
SEWB	Social and Emotional Well Being (also ESWB)
SWHHS	South West Hospital and Health Service (SWHHS)
WHO	World Health Organization

QAIHC
Queensland Aboriginal and Islander Health Council

Queensland Government