Consultation Report

Rockhampton consultation

1 JUNE 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: Rockhampton consultation

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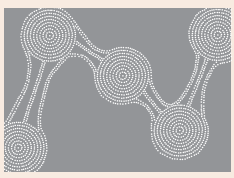
Acknowledgement of Country

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.

Contents

Introduction

The Rockhampton regional consultation workshop was undertaken on the 1 June 2021 at the Empire Hotel, Rockhampton. The consultation had 26 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

Workshop participants had vigorous discussions about the challenges and opportunities the new HES provides to genuinely redesign the local health system in Central Queensland. While the existing barriers were discussed frankly ("the health system does not work for patients"), there was strong commitment from Central Queensland's health leaders to partner with each other to integrate healthcare planning, investment, and delivery across the health system. The new legislative requirements were embraced as the mechanism to reset partnerships by having Queensland Health and First Nations (FN) peoples genuinely working together to co-design and drive local reforms across the health system.

Key themes discussed:

- integrating the patient journey and continuum of care across the primary and acute (hospital) care sectors
- strengthening connections between the health system and other social support services to support the needs of the whole person (social determinants of health)
- reforming existing funding arrangements to prioritise health equity and outcomes rather than hospital volume/throughput
- recognising the heavy burden of racism and discrimination on Aboriginal and Torres Strait Islander staff members and community members ('mob won't access care if they don't feel safe')
- placing patients at the centre of care by valuing cultural safety as a critical aspect of patient safety ('cultural capability needs to be more than symbols')
- improving communication with community and up, down and across the health system
- building, supporting and strengthening the local Aboriginal and Torres Strait Islander health workforce by streamlining recruitment practices, creating a workforce pipeline for the future and employing more Aboriginal and Torres Strait Islander peoples (commensurate with local population—six per cent).

Top five health reforms

considered a priority for this region by the participants

18	Establish regional coordinated care hubs
8	Factor equity into existing Queensland Health funding models
3	Drive an anti-racism strategy across the health system
7	Establish regional ATSICCHO backbone organisations
17	Establish a First Nations Health Board

Key discussion points

The discussion from the Rockhampton 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 Rockhampton region.

Principle 1: First Nations leadership	
Systems	• In the past, Aboriginal and Torres Strait Islander people have responded to reforms—now First Nations peoples can drive reforms and improvements in partnership with Queensland Health. • The new Health Equity Strategy Regulation is the mechanism for Aboriginal and Torres Strait Islander peoples to rightfully take their place at leadership tables to co-design health services. • Genuine consultation and engagement with Aboriginal and Torres Strait Islander peoples hasn't been done in the last 10 years—little engagement occurs with Torres Strait Islander peoples. • Need to ensure all Aboriginal and Torres Strait Islander equity groups are engaged, including young people, people with disabilities, LGBTIQ+ and people in prisons. • Proposal to amend the Act to create another prescribed governance committee to focus on achieving health equity for Aboriginal and Torres Strait Islander peoples and drive/oversight the Health Equity Strategy—this could be another prescribed committee to the existing three committees detailed in the Act.
Workforce	• Need to invest in a locally trained and skilled workforce to build a future workforce pipeline and encourage younger people to pursue health careers.

Principle 2: Local and regional decision making	
Systems	• The Central Queensland leadership need to come together to maximise the opportunities for reform. • Meaningful partnerships, shared decision-making and data sharing and treating each other as partners needs to become the new norm—together we are the health system. • Collective data needs to be shared to inform service/system planning between HHSs, ATSICCHOs and private GPs through PHN. • Central Queensland health leadership needs to come together to drive change and achieve reforms.
Care	• QAIHC can provide greater support to local ATSICCHOs to develop local models of care.

Principle 2: Local and regional decision making	
Workforce	• A tailored Aboriginal and Torres Strait Islander health workforce plan needs to be created from the Central Queensland region. • Flexible employment pathways need to be created between the HHS, ATSICCHO sector and PHN. • Need to strengthen local partnerships with universities and schools to create a pipeline for the future workforce and improve the cultural capability of other professional streams (re. medical students).

Principle 3: Reorienting local health systems	
Systems	• Need to ensure the new HES achieves equity of outcomes and experiences—not just equity of access. Don't want Aboriginal and Torres Strait Islander peoples accessing care at the same rate and still having poorer outcomes. • Healthcare planning, investment and delivery needs to be integrated across the health system—the current system is characterised by disconnection between the primary care and hospital/tertiary care. • Many successful primary healthcare models in New Zealand could inform renewed localised primary healthcare approaches for Central Queensland. • Communication needs to be improved across the health system and with community.
Funding	• Funding system needs to be redesigned and improved—both Commonwealth and State level. • Equity through funding has not materialised yet—First Nations health needs to get a bigger slice of the $18 billion annual Queensland Health budget. • Current hospital funding model is based on volume of activity/care provided—little flexibility and discretionary funds exist. This needs to change.
Care	• Placing patients at the centre of care requires changing and reshaping the health system to respond to the needs of patients. • Need to map the patient journey and points of care across the continuum to determine which provider is best placed to provide care to the patient.
Workforce	• Need to support HHSs to spend time on training and development—HHSs have lost the motivation to 'teach and train' and left training to the universities. • Greater transparency and clarity are needed about how to access funding for training and skilling, including traineeships, cadetships and scholarships. • Current recruitment practices are too complex—need to simplify and create pathways for all Aboriginal and Torres Strait Islander people who want to pursue a career in health. • Flexible employment pathways need to be created between the HHS, ATSICCHO sector and PHN. • Review, streamline and redesign all HR processes to maximise the number of Aboriginal and Torres Strait Islander people working in the health system.

Principle 4: Cultural capability	
Systems	• In the past the focus was on improving access to existing models of care—embracing equity requires a significant change to unpick and redesign services for them to be effective for First Nations peoples. • Revised systems, processes and practices are needed to identify and respond to institutional racism (for example, including it as a reportable incident on RiskMan). • Current HHS complaints process is described as tedious and unsafe because the person making the complaint is further targeted.
Care	• Current communication style with patients, consumers and community members creates barriers to access. • Best practice care is culturally safe—without culturally safety and trust, effective care can't be delivered. Mob won't come back if they don't feel safe.
Culture	• Cultural capability needs to extend beyond training—processes and systems need to become embedded within the health system. • Being truthful about white privilege is difficult for many non-Indigenous people—more non-Indigenous people need to deepen their understanding about the impact of racism and discrimination on First Nations peoples and the barriers it creates to accessing care. • Need a new language and new way of talking about racism and discrimination—we are all still learning. • Management don't often know how to respond to racism experienced by staff or patients—training and guidance is needed. • Many Aboriginal and Torres Strait Islander people choose not to identify in hospital because they don't feel safe. • Existing Aboriginal health workers, practitioners and liaison officers are stretched to the limit assisting patients to feel safe and navigate the health system. • The value of non-clinical interventions (such as Red Dust Healing) in supporting health and wellbeing outcomes is not understood or recognised. • Culture needs to be prioritised across the patient journey and an agreed understanding of what a culturally capable health system looks like in practice.

Principle 5: Social determinants	
Systems	• Greater understanding is needed about the complexity of Aboriginal and Torres Strait Islander peoples' lives—recognising intergenerational trauma and strengthening cultural identity are critical for the healing process. • Coordinated processes and pathways between the health system and other social support is needed to better support First Nations people with complex health and social support needs. • Discharge Against Medical Advice (DAMA) only tells half the story—it does not take into account what a person needs in their life. Flexible care and support is needed to reduce DAMA.

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

Attendee's comments/views/input
General discussion
• **Need to ensure the new HESs achieve equity of outcomes and experiences—not just equity of access.** We don't want Aboriginal and Torres Strait Islander peoples accessing care at the same rates and still having poorer outcomes. • **In the past, Aboriginal and Torres Strait Islander peoples have responded to reforms—now there's an opportunity for First Nations peoples to drive reforms and improvements in partnership with QH through a co-design model.** Co-design needs to be genuine—not consultation at the end of a process but a co-design partnership between Queensland Health and First Nations peoples and organisations from the beginning. • The new legislation (Health Equity Regulation) provides the mechanism for Aboriginal and Torres Strait Islander people to rightfully take their place at the table and co-design health services in partnership with providers.

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		
• **Meaningful partnerships, shared decision-making and data sharing and treating each other as partners needs to become the new norm**—not an 'us' and 'them' mentality but acknowledging that together 'we' are the health system. All parties need to understand each other's roles, responsibilities, systems and processes, and learn from each other. **Collective data needs to be shared to inform service/system planning—HHS, community-controlled sector and private GPs through PHN.** Currently there's little access to data about the health needs of patients access primary healthcare through private GPs.	• Local health system improvements.	P2: Local and regional decision making P3: Reorientating local health systems
• **Healthcare planning, investment and delivery needs to be integrated across the health system**—and integrated with other social services that influence health (re housing, education). The current health system 'is designed not to work' effectively or efficiently for the patient—it is currently characterised by disconnection between primary health care and hospital/tertiary care. The health system does not work for patients—this conclusion is based on numerous experiences of individuals attempting and failing to navigate the health system. • Collaborations need to happen at a State Level to establish transparent and sound foundations to assist with the 'Local Health System Improvements'. Unfortunately, both Housing and Education may acknowledge health's agenda, however, they currently do not have to agree nor respond to such.	• Local health system improvements.	P2: Local and regional decision making P3: Reorientating local health systems
• **Aboriginal and Torres Strait Islander leadership needs to be at the table working with HHSs** and other private providers of primary healthcare. Central Queensland leadership needs to come together to drive change and achieve reforms.	• Local health system improvements.	P1: First Nations leadership P2: Local and regional decision making
• **In the past, the focus has been on improving access to existing models of care—embracing equity requires a significant change to 'unpick and redesign services' so they are effective for First Nations peoples.** It means delivering care differently based on what First Nations peoples need and want. • Develop and deliver services that are affordable, improve access and acknowledge both the current local/regional statistics.	• Local health system improvements.	P3: Reorientating local health systems P4: Cultural capability

Attendee's comments/views/input	Learnings	Health Equity Design Principles*
• Submission-based funding does not allow community-controlled health services to respond to local needs—priorities are often decided (at national or state levels) and limited capacity exists to deliver and on time (re two or three months before the end of the financial year). **Funding system needs to be redesigned and improved—both Commonwealth and state level (*Making Tracks* and HHS base funding).**	• Improved funding arrangements.	P3: Reorientating local health systems P4: Cultural capability
• **Cultural capability needs to extend beyond training—processes and systems need to become embedded within the health system.** More non-Indigenous people need to deepen their understanding of the impact of racism and discrimination on First Nations peoples and the barriers it creates to accessing care. Owning and being truthful about white privilege is difficult for many non-Indigenous people; further education, training and leadership is needed to create safe places to have these conversations.	• Cultural capability.	P4: Cultural capability
• **Best practice care is culturally safe—**any other care, while clinically safe, will not be best practice if it's not culturally safe. Without trust and cultural safety, effective care can't be delivered. Will lose the patient if trust does not exist. Mob won't come back if they don't feel safe.	• Cultural capability.	P4: Cultural capability
• Need to respect and accept patient's choice and not withdraw care if a clinician/healthcare worker does not agree with a patient's choice (re a patient choosing to DAMA; a patient with alcohol addiction choosing to continue drinking). Flexible care can still be provided to patients who make decisions that the clinician/healthcare worker does not believe is in their best interest.	• Enhance/ expand existing models of care.	P3: Reorientating local health systems P4: Cultural capability
• **Some (non-Aboriginal and Torres Strait Islander people) still need to understand what racism is and the impact it has on Aboriginal and Torres Strait Islander peoples.** First Nations peoples are 'always on high alert—in the red zone. The only time they truly relax is in their home environment—the green zone'.	• Racism.	P4: Cultural capability
• **Need a new language and new way of talking about racism and discrimination**—need to journey and work/walk together; we are all still learning.	• Racism.	P4: Cultural capability
• **Management don't often know how to respond to racism experienced by staff or by patients—training and guidance is needed to model what has to be done (and how to do it).** Staff and patients still experience racism—it still exists and is a real experience for many people.	• Racism.	P4: Cultural capability
• Young people experience barriers to access healthcare, including at community-controlled health services.	• Enhance/ expand existing models of care.	P3: Reorientating local health systems

Attendee's comments/views/input	Learnings	Health Equity Design Principles*
• **Relationships between community-controlled health services and PHNs/private GPs need to be strengthened.** All providers need to understand each other's roles and responsibilities to reduce duplication and maximise efficiency/effectiveness.	• Local health system improvements.	P3: Reorientating local health systems
• **A lot of activities/services/programs are delivered across the health system—need to assess and review to determine which provider is best placed to deliver specific types of care. S**ome existing functions/care could be better provided by another healthcare provider.	• Local health system improvements.	P2: Local and regional decision making 3: Reorientating local health systems
• **Current communication style with patients, consumers and community members creates barriers to access**—need to redesign/improve communication engagement tools and methods. The health system is complex for everyone but better ways to communicate effectively with First Nations peoples are needed to reduce current barriers and complexities.	• Local health system improvements.	P3: Reorientating local health systems P4: Cultural capability
• **Greater understanding about the complexity of Aboriginal and Torres Strait Islander peoples' lives is needed**—recognising and responding to intergenerational trauma and strengthening cultural identity is critical for the healing process.	• Cultural capability.	P3: Reorientating local health systems
• **Social and cultural determinants of health are still not well understood by the health system**—the lives people live 'determine' their health. Health cannot be separated or divorced from a person's life. Models of care/service models need to provide greater care for patients by supporting them to link to other social support assistance where needed.	• Cultural capability.	P3: Reorientating local health systems P5: Social determinants
• **Coordinated processes and pathways between the health system and other social support/assistance is required to support the patient—many Aboriginal and Torres Strait Islander people have complex health and social support needs.** These processes and pathways also need to adhere to confidentiality requirements/principles to safeguard the privacy of patients.	• Local health system improvements.	P3: Reorientating local health systems P4: Cultural capability P5: Social determinants
• **DAMA only tells half the story—it does not take into account what a person needs in their life.** Patients need flexible care and support provided to address/respond to the reason they are discharging against medical advice. The current process involves following up with patients within 24 hours after they discharge against medical advice and referring them to the AHW for further ongoing support.	• Local health system improvements.	P2: Local and regional decision making

Attendee's comments/views/input	Learnings	Health Equity Design Principles*
• Placing patients at the centre of care requires changing and reshaping the health system to respond to the needs of patients. Need to build capacity and capability across the health system—both primary and acute/hospital-based care. **Many Aboriginal or Torres Strait Islander people choose not identify when they're in the hospital because they don't feel safe.**	• Local health system improvements.	P3: Reorientating local health systems
• QAIHC needs to support local AMSs differently—community-controlled health services have struggled to work with HHSs and QAIHC in the past. Community-controlled health services are stretched to the limit. QAIHC can provide greater support to local ATSICCHOs to develop local models of care.	• Local health system improvements.	P3: Reorientating local health systems
• **HHS and community-controlled health services are working well in their sector silos**—but not integrated while both of them are seeking the same goals/outcomes.	• Local health system improvements.	P2: Local and regional decision making P3: Reorientating local health systems
• **Equity through funding has not materialised yet—First Nations health needs to get a bigger slice of the $18 billion annual Queensland Health budget.** Currently community-controlled health services fight for $140M of Commonwealth funding across Australia—mainstream funding needs to shoulder more of the funding burden.	• Improved funding arrangements.	P3: Reorientating local health systems
• **Current funding model is based on volume of activity/care provided in hospitals—little flexibility and discretionary funds exist.** Funding arrangements need to prioritise health outcomes and not hospital inpatient activity/throughput.	• Improved funding arrangements.	P3: Reorientating local health systems
• Primary health care (community-controlled health services) and HHSs have different reporting requirements—need to look at ways to coordinate, integrate and streamline reporting requirements that prioritise outcomes based on local health needs/priorities (top five conditions that contribute to burden of disease/excess deaths in CQ).	• Local health system improvements.	P2: Local and regional decision making P3: Reorientating local health systems
• **Need to invest in a locally trained and skilled workforce**—need to implement local 'grow your own' workforce initiatives to build a future pipeline and encourage younger Aboriginal and Torres Strait Islander people to pursue careers in the health sector. Opportunities for ATSICCHO staff to access Aboriginal Health Practitioner training tied to the inaugural Aboriginal and Torres Strait Islander Health Certified Agreement (EB1) need to be explored and encouraged.	• Build and strengthen the local Aboriginal and Torres Strait Islander workforce.	P2: Local and regional decision making P3: Reorientating local health systems

Attendee's comments/views/input	Learnings	Health Equity Design Principles*
• **Pockets of coordinated care exist between the community-controlled (AMS/primary care) and hospital acute**, however, sometimes a patient's treatment plan is not considered and changes in medication for one condition lead to unintended consequences for other chronic health conditions; specialist (tertiary) care sometimes focuses on one condition and not the entire health of the patient. **Care is not 'patient-centred'—clinicians need to see beyond their own 'pockets of care'** and focus on the overall care provided to the patient.	• Enhance/ expand existing models of care.	P2: Local and regional decision making P3: Reorientating local health systems
• **Need to grow the Aboriginal and Torres Strait Islander health workforce and support HHSs to spend time on training and development.** HHSs have lost the desire/motivation to 'teach and train'— training has been left to the universities. Some pockets in the Central Queensland HHS still invest time and resources in training trainees (for example, Mount Morgan) but this is not replicated across the entire HHS. **Greater transparency and clarity are needed about how to access funding for training and skilling, including traineeships and cadetships**, for HHSs, PHNs and ATSICCHOs.	• Build and strengthen the local Aboriginal and Torres Strait Islander workforce.	P3: Reorientating local health systems
• **Current recruitment practices are too complex**—need to simplify and create pathways for all Aboriginal and Torres Strait Islander people who want to pursue a career in health.	• Build and strengthen the local Aboriginal and Torres Strait Islander workforce.	P3: Reorientating local health systems
• Genuine consultation and engagement with Aboriginal peoples and Torres Strait Islander peoples hasn't been done in the past 10 years—the term 'Aboriginal and Torres Strait Islander peoples' is used easily and readily but engagement with Torres Strait Islanders does not often occur.	• Local health system improvements.	P1: First Nations leadership P2: Local and regional decision making P4: Cultural capability
• **Previous consultation and engagement processes have not worked**—need to improve and change existing approaches. Some engagement structures have been developed that could be built upon/strengthened. The new HES provides HHSs with an opportunity to strengthen and improve engagement processes and mechanisms for the future.	• Local health system improvements.	P1: First Nations leadership P2: Local and regional decision making P4: Cultural capability

Attendee's comments/views/input	Learnings	Health Equity Design Principles*
• **Need to undertake engagement and ensure all Aboriginal and Torres Strait Islander equity groups—for example, young people, people with disabilities, LGBTQIA+ and people in prisons**—receive the level and type of care needed to achieve health equity.	• Local health system improvements.	P1: First Nations leadership P2: Local and regional decision making P4: Cultural capability
• Revised systems, processes and practices are needed to identify and respond to institutional racism (for example, including it as a reportable incident on RiskMan). The current complaints system within the HHS is viewed as tedious and many people describe it as unsafe because the person making the complaint is further targeted. **A lack of understanding still exists about the various aspects of racism, including institutional racism.**	• Racism.	P3: Reorientating local health systems P4: Cultural capability
• **Existing Aboriginal health workers and liaison officers are stretched to the limit assisting patients to feel safe and navigate the health system**—a limited understanding exists about the intensive level of support provided by workers across the HHS. Often discharge times occur late in the evenings and no Aboriginal and Torres Strait Islander health workers or liaison officers are on shift to coordinate care. The value of non-clinical cultural interventions (for example, Red Dust Healing) in supporting health and wellbeing outcomes, is not recognised or understood. **Further investment is needed to upskill and train Aboriginal Health Workers and Aboriginal and Torres Strait Islander Health Practitioners.**	• Build and strengthen the local Aboriginal and Torres Strait Islander workforce.	P3: Reorientating local health systems P4: Cultural capability
• **More Aboriginal and Torres Strait Islander peoples need to be appointed to leadership and executive roles** to be involved in high-level decision-making. The voices of Aboriginal and Torres Strait Islander staff members are often ignored or dismissed. A majority of the local Aboriginal and Torres Strait Islander health workforce in the HHS are in operational and administration positions.	• Build and strengthen the local Aboriginal and Torres Strait Islander workforce.	P1: First Nations leadership P3: Reorientating local health systems
• Lateral violence is a very sensitive topic and more discussions are needed within Aboriginal and Torres Strait Islander communities about the experiences of lateral violence.		P1: First Nations leadership
• QAIHC needs to support local AMSs differently—community-controlled health services have struggled to work with HHSs and QAIHC in the past. Community-controlled health services are stretched to the limit. QAIHC can provide greater support to local ATSICCHOs to develop local models of care.		P5: Social determinants
• Many Aboriginal and Torres Strait Islander workers in the HHS choose not to identify through EEO data collection.	• Build and strengthen the local Aboriginal and Torres Strait Islander workforce.	P4: Cultural capability

Attendee's comments/views/input	Learnings	Health Equity Design Principles*
Enablers		
• **Reinstitute regional governance/leadership body to undertake joint planning and local service system design based on shared data between healthcare providers.** This body could be a sub-committee of the HHS Board. This group needs to be decision-making body to co-design and redesign the health system for Central Queensland—not limited to information sharing.	• Local health system improvements.	P1: First Nations leadership P2: Local and regional decision making P3: Reorientating local health systems
• **Community-controlled health services to strengthen relationships with tertiary hospitals outside of Rockhampton to improve the patient journey when patients are transferred for specialist/ tertiary care**—currently no relationship with hospitals outside of Rockhampton.	• Local health system improvements.	P2: Local and regional decision making P3: Reorientating local health systems
• **Strengthen accountability and transparency by sharing regular data** (from HHS, community-controlled sector and private GPs—through PHN) back to the community.	• Local health system improvements.	P2: Local and regional decision making P3: Reorientating local health systems
• **Need to get real-time feedback from patients and staff about experiences of racism and discrimination**—and action must be taken. There need to be consequences for people who perpetuate racism.	• Racism.	P3: Reorientating local health systems P4: Cultural capability
• **Aboriginal and Torres Strait Islander people need to be given the space, trust and respect to discuss experiences of racism and discrimination.** They are not easy experiences to have or to discuss.	• Racism.	P3: Reorientating local health systems P4: Cultural capability
• **Need to turn intent about having an anti-racist health system into processes, systems and actions**—it must be more than just words. It needs to be backed up.	• Racism .	P3: Reorientating local health systems P4: Cultural capability
• **Need to grow/expand the Aboriginal Health Worker and Practitioner workforce** to have a workforce at all sites/locations and 24-hour patient access.	• Build and strengthen the local Aboriginal and Torres Strait Islander workforce.	P1: First Nations leadership P3: Reorientating local health systems

Attendee's comments/views/input	Learnings	Health Equity Design Principles*
• **Prioritise and invest in consumer/patient health literacy and education**—in language (eg: Creole) and cultural communication channels that have the biggest impact and buy-in.	• Local health system improvements.	P3: Reorientating local health systems P4: Cultural capability
• **New data/metrics are needed** to measure and track culturally safe care in HHSs—existing data (DAMA, ED wait times) are not providing the full story. Patient/client experience and satisfaction metrics (both qualitative and quantitative) need to be developed to inform change, and existing local data shared for planning purposes between the HHS, ATSICCHOs and PHNs.	• Local health system improvements.	P3: Reorientating local health systems
• Need to provide more on-the-job training, increase clinical placements and provide additional wrap-around support to trainees throughout their training journey.	• Build and strengthen the local Aboriginal and Torres Strait Islander workforce.	P3: Reorientating local health systems
• **Increase support/resources provided to management and clinicians to 'teach and train' the next generation of clinicians/health workforce**—it needs to be factored into their workload and not an additional extra.	• Build and strengthen the local Aboriginal and Torres Strait Islander workforce.	P3: Reorientating local health systems
• Increase Aboriginal and Torres Strait Islander health workforce target in the HHS to match the local population—six per cent (current target is three per cent).	• Build and strengthen the local Aboriginal and Torres Strait Islander workforce.	P3: Reorientating local health systems
• Prioritise young people and schools to build the future health workforce.	• Build and strengthen the local Aboriginal and Torres Strait Islander workforce.	P3: Reorientating local health systems
• **Some non-Aboriginal and Torres Strait Islander HHS staff members are uncomfortable asking someone if they are of Aboriginal and Torres Strait Islander descent even though it is a mandated requirement**—cultural capability needs to be embedded into clinical governance standards (National Safety and Quality Health Service Standards (NSQHS) and Australia Health Practitioner Regulation Agency (APHRA)).	• Cultural capability.	P4: Cultural capability

Attendee's comments/views/input	Learnings	Health Equity Design Principles*
• **Communication needs to be improved across the health system and with community**—mechanisms need to be created to ensure communication flows up, down and across the health system and with community.	• Enhance/ expand existing models of care.	P3: Reorientating local health systems
• **Building clinical governance standards—NSQHS and tied to AHPRA to drive change.**		
• **Many successful primary healthcare models in NZ could inform renewed localised primary healthcare approaches in CQ**, including repurposing/redefining the roles of Aboriginal Health Workers in the A&TSICCHO sector. Aboriginal health workers and liaison officers are pivotal to embedding cultural capability within processes and practices.	• Local health system improvements.	P3: Reorientating local health systems
• **The new HES needs to include short-, medium- and long-term actions and targets**, including early things that can be done to address some of the failures of the past.	• Build and strengthen the local Aboriginal and Torres Strait Islander workforce.	P2: Local and regional decision making P3: Reorientating local health systems
• **Many successful primary healthcare models in NZ could inform renewed localised primary healthcare approaches in CQ**, including repurposing/redefining the roles of Aboriginal Health Workers in the ATSICCHO sector. Aboriginal health workers and liaison officers are pivotal to embedding cultural capability within processes and practices.	• Local health system improvements.	P3: Reorientating local health systems
• **The new HES needs to include short-, medium- and long-term actions and targets**, including early things that can be done to address some of the failures of the past.	• Local health system improvements.	P2: Local and regional decision making P3: Reorientating local health systems
• **Need to strengthen local partnerships with universities and schools to create a pipeline for the future workforce** and improve the cultural capability of other professional streams (ie medical students).	• Build and strengthen the local Aboriginal and Torres Strait Islander workforce.	P3: Reorientating local health systems
• **Flexible employment pathways need to be created** between the HHS, PHN and ATSICCHO sector.	• Build and strengthen the local Aboriginal and Torres Strait Islander workforce.	P3: Reorientating local health systems

Attendee's comments/views/input	Learnings	Health Equity Design Principles*
• **A tailored Aboriginal and Torres Strait Islander health workforce plan needs to be created for the Central Queensland region** that allocates resources towards the workforce pipeline. Cadetships, traineeships and scholarships need to be re-introduced and linked to guaranteed employment.	• Build and strengthen the local Aboriginal and Torres Strait Islander workforce.	P3: Reorientating local health systems
• **Effective referral pathways need to be created for outreach and in-reach**—from aged care through to family wellbeing, housing, and disability services support (NDIS).	• Social determinants.	P3: Reorientating local health systems
• **Need to map the patient journey and points of care across the continuum** (to and from home through primary, secondary and tertiary care), identify and cost the resources allocated, and determine which provider is best placed to provide care to the patient.	• Local health system improvements.	P3: Reorientating local health systems P5: Social determinants
• All healthcare providers need to focus on outcomes as a driver for change to transform service and have honest discussions—**the Central Queensland leadership need to come together to maximise the opportunities** for reform from co-designing the new the HES. Better coordinated and integrated services will result in funds being used efficiently and effectively.	• Local health system improvements.	P1: First Nations leadership P2: Local and regional decision making P3: Reorientating local health systems

Attendee's comments/views/input

Other comments—Ideas

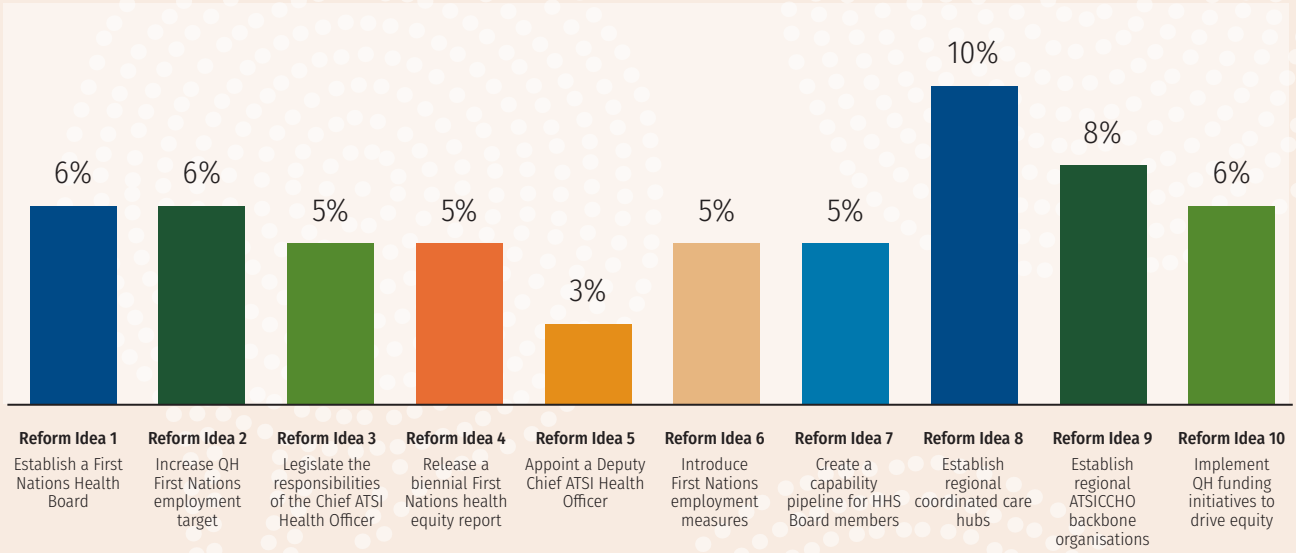
- Explore opportunities for Commonwealth (PHNs and ATSICCHOs) and QH to co-commission health services and programs.
- Amend proposal 4 (from Section 3 in the discussion paper) to be an annual report rather than a biennial report.
- Amend the Act to create another prescribed governance committee to focus on achieving health equity for Aboriginal and Torres Strait Islander peoples and driving/oversighting the HES—this will be another prescribed committee to the existing three committees detailed in the Act.
- Outline good practice/innovative models of care—learn from each other across the health system in Queensland. Many examples of effective and efficient models that can be contextualised to other settings and geo-locations across the State. Can improve both effectiveness and efficiency and create cost-savings that can be reinvested into other parts of the health system.
- Provide guidance for engagement and consultation with all equity groups within the Aboriginal and Torres Strait Islander population—young people, people with disabilities, LGBTQIA+.
- Review, streamline and redesign all HR processes from recruitment, retention and onboarding to maximise the number of Aboriginal and Torres Strait Islander people working in the health system.
- Need to identify, capture and share new health data to inform planning and strengthen accountability across the health system.
- Change won't occur overnight or in the short term—need to adopt a culture of continuous quality and service improvement and work towards long-term change.
- Cultural Safety needs to be prioritised across the patient journey.
- System redesign needs to revise the current methodology for the patient load for Aboriginal health workers and liaison officers—the intensive nature of the case management needs to be recognised.
- Innovative models that involve the HHS or PHNs contracting care coordination for patients with high/complex health needs need to be trialled.
- AHW/AHP need to work to their maximum scope of practice described in the health career pathways.
- Care coordination models to provide seamless support (including transport, accommodation, meals) and have effective communication channels to and from home, primary care and hospital/specialist care.
- Organise a series of workshops with HHSs, ATSICCHOs and other interested parties to explain each part of the Regulation for the new HESs.
- Making Tracks Investment Strategy submission / approval procedures, transparency and communication networks need to be improved significantly.

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

Future ideas for discussion

Rockhampton 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

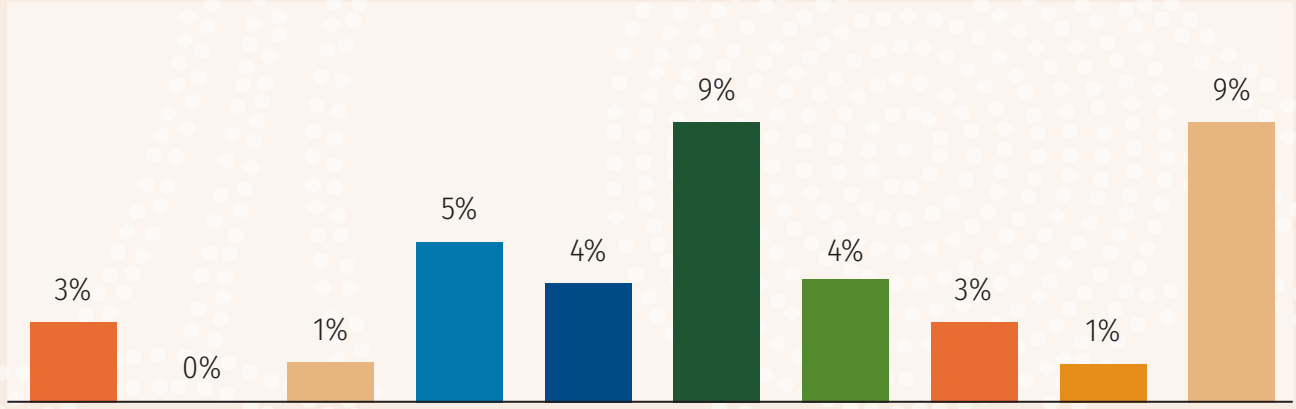
Reform Idea 6 Introduce First Nations employment measures

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
Linda Medlin	Aboriginal And Torres Strait Islander Health and Wellbeing
Mitzi Jarvis	Bidgerdii Community Health Service
Amy Lester	Bidgerdii Community Health Service
Thalep Ahmat	Bidgerdii Community Health Service
Ross Atu	Central Queensland Hospital and Health Service
Steve Williamson	Central Queensland Hospital and Health Service
Colin	Central Queensland Hospital and Health Service
Lucinda Nedwich	Central Queensland Hospital and Health Service
Shareen McMillan	Central Queensland Hospital and Health Service
Susan Foyle	Central Queensland Hospital and Health Service
Thomas John	Central Queensland Hospital and Health Service
Melena McKeown	Health Centre
Philip Hopkins	New Endings Men's Program Qld Health
Jenny Kerr	Gladstone Region Aboriginal and Islander Community Controlled Health Service Limited T/A Nhulundu Health Service
Jo Payale	Gladstone Region Aboriginal and Islander Community Controlled Health Service Limited T/A Nhulundu Health Service
Matthew Cooke	Gladstone Region Aboriginal and Islander Community Controlled Health Service Limited T/A Nhulundu Health Service
Nigel Daisy	Gladstone Region Aboriginal and Islander Community Controlled Health Service Limited T/A Nhulundu Health Service
Bevan Ah Kee	QAIHC
Graham Kissell	QAIHC
Karen Thompson	QAIHC Consultant
Lauren Trask	QAIHC
Tiana Lea	QAIHC
Gordon Luck	Queensland Health
Jermaine Isua	Queensland Health
Barbara Hatfield	Queensland Health
Julie-Ann Cox	Queensland Health or Community Member

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 Islander Health Worker
ATSIHW	Aboriginal and Torres Strait Islander Health Workers
AMS	Aboriginal Medical Service
ATSICCHO	Aboriginal and Torres Strait Islander Community Controlled Health Organisation
CATSIHO	Chief Aboriginal and Torres Strait Islander Health Officer
CE	Chief Executive
CTG	Closing the Gap
DAMA	Discharge Against Medical Advice
DATSIP	Department of Aboriginal and Torres Islander Partnerships
ED	Emergency Department
FN	First Nations
FNQ	Far North Queensland
HES	Health Equity Strategy
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
OOHC	Out-of-home care
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 Wellbeing (also ESWB)
WHO	World Health Organization

QAIHC
Queensland Aboriginal and Islander Health Council

Queensland Government