Consultation Report

South East Queensland consultation

4 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: South East Queensland consultation

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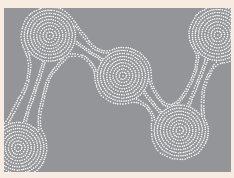
An electronic version of this document is available at **health.qld.gov.au** and **qaihc.com.au**

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.

Contents

Introduction

The South East Queensland consultation workshop was undertaken on 4 June 2021 at the Brisbane Convention and Entertainment Centre. The consultation had 56 participants and was conducted over a three-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

A bold approach is being undertaken in South East Queensland to 'network' the Health Equity Strategies across Metro South, Metro North, Gold Coast, West Moreton and Children's Hospital and Health Services, Mater Hospital Brisbane, and Kambu Aboriginal and Torres Strait Islander Corporation for Health, Yulu-Burri-Ba Aboriginal Corporation for Community Health, Brisbane Aboriginal and Torres Strait Islander Community Health Service, Kalwun Health Service, and the Institute of Urban Indigenous Health. This will require identifying who has strengths in certain areas and how this can be used across the collective region for the benefit of all clients.

The premise is that patients do not recognise boundaries between each area within the system, so the system should not place boundaries within the patient journey. Use of resources can be maximised and commonalities used to advantage. The Metro North Board responded that it "Recognises the opportunity for more connections across services, leveraging good initiatives and sharing its own work (for example partnerships between HHSs and community-controlled healthcare organisations; and workforce initiatives).

Key themes discussed

- Institutional racism: There needs to be a baseline audit conducted to identify institutional racism and then ongoing cultural training for all staff. Gold Coast report good outcomes with their Courageous Conversations program and it may be useful for other areas to consider its use.
- Data collection and sharing.
- Funding reform to allow for different models of care: Models of care that allow for better service integration and for innovative ways in delivering patient care are required, as is the need for patients to feel culturally safe accessing these services.
- Workforce recruitment and retention: This requires more First Nations staff within the system at all levels, with a targeted recruitment and placement program underpinning it.
- The ongoing issues created by the social determinants of health, such as lack of housing, education, and interaction with the justice system, which are factors in the health outcomes for First Nations peoples in this catchment.
- Recognition of cultural skills as skill set in professional practice: First Nations staff are called on to provide vital cultural assistance and provide linkages that are over and above their core professional skills.

Key discussion points

The discussion from the South East Queensland 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 South East Queensland region.

Principle 1: First Nations leadership	
Systems	• Look at root cause of patients discharging early; consider written reports into this. • Integrate data sharing across all areas of health. • Enhance flexibility in process and procedure. • Update systems to identify racism. • Undertake baseline and ongoing racism audits. • Address institutional racism and unconscious bias. • Ensure accountability mechanisms are in place. • Ensure data is driving health reform. • Work to harness all players. • Have cultural capacity in decision making. • Ensure that First Nations people are at the table and their voices are heard. • Need to have all players at the planning, delivery, and accountability table. • Have an accountability framework for co-design.
Care	• Look at models of care—outreach, inreach, specialist care in situ. • Ensure wrap-around services and patient-centred care. • Need concierge services.
Funding	• Consider funding reform to provide flexibility for care provision. • Invest in the system. • Ensure sufficient funds are available to make partnership and co-design a reality. • Provide realistic resourcing for workforce training.
Workforce	• Understand the importance of staff wearing First Nations brand as cultural ambassadors. • Ensure cultural safety for staff. • Review scope of practice for AIHW within mainstream settings. • Review workforce recruitment and retention strategies. • Implement long-term workforce strategies.

Principle 1: First Nations leadership	
Workforce	• Ensure maximum usage of skill sets and training. • Increase First Nations workforce at all levels. • Have targeted workforce pipelines. • Have targeted recruitment strategies. • Embed cultural safety into all education and training programs. • Ensure workforce data is accurate.
Culture	• Improve cultural input and feedback. • Ensure cultural safety is embedded into all education and training.

Principle 2: Local and regional decision making	
Systems	• Have a streamlined user-friendly complaints process. • Get patient feedback and act. • Influence social determinants of health. • Have an accountability framework for co-design. • Ensure channels are available for people to input.
Care	• Address interpersonal relationships in real time. Need to ensure that racism is called out and there is an empathetic environment . • Revise models of care to ensure best care is provided. • Provide concierge services and establish data-sharing protocols. • Look at root cause—consider reports written into why patients discharge early. • Have service integration. • Ensure consistency in service. • Improve cultural input and feedback. • Ensure patient-centred care. • Ensure wrap-around services and patient-centred care.
Funding	• Introduce funding reform to allow for flexible models of care.
Workforce	• Understand the importance of staff wearing First Nations brand as cultural ambassadors. • Ensure cultural safety for staff. • Increase First Nations workforce at all levels. • Create targeted workforce pipelines. • Expand targeted recruitment strategies. • Implement targeted identified workforce recruitment and retention.

Principle 3: Reorienting local health systems	
Systems	• Develop policy and procedures to assist specialist care. • Establish accountability mechanisms. • Establish data-sharing protocols. • Update systems to identify racism. • Ensure that all areas are effectively communicating with each other. • Include all players at the planning, delivery, and accountability table.
Care	• Design models of care to meet patient needs. • Need service integration. • Consider outreach. • Ensure consistency. • Ensure wrap-around services and patient-centred care. • Ensure outcomes focus. • Move beyond just health and focus on total wellbeing.
Funding	• Ensure adequate funding for strategies. • Need funding reform—need flexibility to meet needs.
Workforce	• Review scope of practice for AIHW within mainstream settings. • Ensure maximum usage of skill set and training. • Have targeted workforce pipelines.
Culture	• Provide concierge services. • Recognise lived experience.

Principle 4: Cultural capability	
Systems	• Undertake baseline and ongoing audits into racism. • Have a streamlined user-friendly complaints process. • Address institutional racism and unconscious bias. • Update systems to identify racism (e.g. RiskMan). • Have flexibility in process and procedure so patient needs can be addressed.
Care	• Consider outreach. • Provide concierge services. • Move beyond just health and focus on total wellbeing. • Address institutional racism and unconscious bias.

Principle 4: Cultural capability	
Workforce	• Work with teaching system to grow workforce pipeline and ensure cultural safety is embedded in training. • Recognise the value of cultural knowledge as a skill set utilised within sector. • Ensure cultural safety for staff. • Understand the importance of staff wearing First Nations brand as cultural ambassadors. • Continually educate and train on difference. • Embed cultural safety into all education and training programs. • Have workforce strategies to attract and retain First Nations staff at all levels. • Recognise the value of cultural knowledge as a skill set utilised within sector. • Have a First Nations voice at all levels of the workforce/system.
Culture	• Respect traditional ways of health practice. • Embed cultural safety. • Access traditional ways of healing. • Address institutional racism and unconscious bias. • Have processes to address racism. • Recognise the value of cultural knowledge as a skill set utilised within sector. • Have cultural authority to sit with Aboriginal and Torres Strait Islander peoples in roles—DATSIP should be the cultural authority and has the delegation of authority to approve and sign off. • Use culture as a protective factor—the ways of knowing, being, learning and doing.

Principle 5: Social determinants
• Consider social determinants. • Influence social determinants of health.

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		
Yarning circles ways of learning, healing knowing and doing linkages with the Healing Foundation.	• Respecting traditional ways of health practice.	P4: Cultural capability
Challenging wrongs and include empathy—patients and staff.	• Need to address interpersonal relationships in real time. Need to ensure that racism is called out and there is an empathetic environment.	P2: Local and regional decision making
Identify root cause of racism and address the root cause in solutions.	• Need to undertake audit into racism.	P1: First Nations leadership P4: Cultural capability
What does cultural capability look like? How do we ensure culture is prioritised?	• Need to embed cultural safety.	P4: Cultural capability
Design of a model that integrates specialist services in PHC.	• Revise models of care.	P2: Local and regional decision making
Model of success—BiOC, INALA – Dr Noel Hayman.	• Need to emulate success and share theses.	P1: First Nations leadership
Templates for P+P that enable inreach and outreach services—specialists care to community services.	• Develop policy and procedures to assist specialist care in outreach/inreach.	P3: Reorientating local health systems
How do we influence the curriculum to reflect the future proofing of the health workforce?	• Work with teaching system.	P1: First Nations leadership P4: Cultural capability
System, accountability and legislation 'check'.	• Establish accountability mechanisms.	P1: First Nations leadership P3: Reorientating local health systems
Knowing how to outreach and inreach.	• Design models of care to meet regional need.	P3: Reorientating local health systems
How to remunerate the Indigenous knowledge education—workforce strategy/pipeline.	• Recognise the value of cultural knowledge as a skill set utilised within sector.	P4: Cultural capability

Attendee's comments/views/input	Learnings	Health Equity Design Principles*
How to ensure AHW/AHP can work to maximum scope describing health career pathways.	• Review scope of practice for AIHW within mainstream settings to maximise their contribution.	P1: First Nations leadership P3: Reorientating local health systems
Measures in purchasing parts of the workforce.		
A strategy that is resourced.	• Ensure adequate funding for strategies.	P1: First Nations leadership P3: Reorientating local health systems
Model that details patient journey with points of care and accountability/lead assigned specifying agreed timely shar-ing of critical information between and across all the levels of care.	• Provide concierge services and establish data-sharing protocols.	P2: Local and regional decision making P3: Reorientating local health systems

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		
Patients discharged against medical advice—reports written: • funding is not allocated to address this issue • drill down and you will see the evidence demonstrates documented racism.	• Need to look at root cause—consider reports written into this.	P1: First Nations leadership P2: Local and regional decision making
Damage to reputation through 'branding' via uniforms—staff that have undertaken the training are increasingly approached	• Understand the importance of staff wearing First Nations brand as cultural ambassadors.	P1: First Nations leadership P2: Local and regional decision making P4: Cultural capability
Retention and racism	• Need to ensure cultural safety for staff.	P1: First Nations leadership P2: Local and regional decision making P4: Cultural capability
Complaints mechanisms and process flawed both for staff and patients	• Need a streamlined user-friendly complaints process.	P2: Local and regional decision making P4: Cultural capability
Improving access to specialist care	• Look at models of care.	P2: Local and regional decision making P3: Reorientating local health systems
Discharge times, e.g. late on Friday—where is the balance for support to the Aboriginal and Torres Strait Islander person to coordinate care?	• Provide concierge services.	P3: Reorientating local health systems
HHS working with PHC and ATSICCHO as a valued part of the system	• Need service integration.	P2: Local and regional decision making P3: Reorientating local health systems

Attendee's comments/views/input	Learnings	Health Equity Design Principles*
Addressing multiple pathways	• Look at models of care.	P1: First Nations leadership P2: Local and regional decision making P3: Reorientating local health systems
Clients that have issues with the law	• Consider social determinants.	NEW: Social determinants
Funding for training and being able to be employed across scope of practice	• Review scope of practice for AIHW within mainstream settings.	P1: First Nations leadership P2: Local and regional decision making P3: Reorientating local health systems P4: Cultural capability
Understanding the system—Where the money comes from to enact and access traineeships Department of Health, HHS and PHN, PHC and AICCHO	• Need to review workforce recruitment and retention strategies.	P1: First Nations leadership
Piecemeal funding	• Funding reform.	P1: First Nations leadership P3: Reorientating local health systems
Merging the funding cycles to influence extension of funding cycles with the legislation	• Funding reform.	P1: First Nations leadership P3: Reorientating local health systems
Access to data	• Need to ensure local community's involvement in all aspects of design and delivery.	P1: First Nations leadership
The experience of the individual navigating the health system	• Need to consider outreach. • Provide concierge services.	P3: Reorientating local health systems P4: Cultural capability
Data is missing from GPs—PHN for those accessing private GPs. Access to the data from Queensland Health, AICCHOs and the PHN data	• Need to integrate data sharing across all areas of health.	P1: First Nations leadership
Consistent strategies across multiple sites	• Need to ensure consistency.	P2: Local and regional decision making P3: Reorientating local health systems
Courageous conversations—looking at unconscious bias—big tick	• Need to address institutional racism and unconscious bias.	P1: First Nations leadership P4: Cultural capability

Attendee's comments/views/input	Learnings	Health Equity Design Principles*
Education piece—mandatory—Courageous Conversations	• Need to address institutional racism and unconscious bias.	P1: First Nations leadership P4: Cultural capability
Accountability about racism when it is reported—needs to be visible	• Need to address institutional racism and unconscious bias.	P1: First Nations leadership P4: Cultural capability
RiskMan does not address racism	• Need to update systems to identify racism.	P3: Reorientating local health systems P4: Cultural capability
Metro South—has racism reporting in RiskMan		
Rigidity with what policy is implemented—this then poses a barrier	• Flexibility in process and procedure.	P1: First Nations leadership P4: Cultural capability
Education within the universities—to ensure that people coming out are advocates for	• Need to embed cultural safety into all education and training programs.	P1: First Nations leadership P4: Cultural capability
Workforce is given opportunity to access ways of healing, knowing and doing.	• Need to access traditional ways of healing.	P4: Cultural capability
Anti-discrimination strategy	• Need to address institutional racism and unconscious bias.	P4: Cultural capability
We need to enable the system to recognise difference	• Need to continually educate and train on difference.	P4: Cultural capability
Quarantining positions	• Need to implement long-term workforce strategies.	P1: First Nations leadership
Needs-based funding—think about transient population	• Funding reform and models of care.	P2: Local and regional decision making P3: Reorientating local health systems
Enablers		
Addressing through patient experience—intent to address the system and the experience of the person	• Need to get patient feedback and act.	P2: Local and regional decision making
Policies that are trauma aware and trauma informed—nurses abide by P+P	• Need training to focus on acknowledging trauma.	P4: Cultural capability
Uniforms—approved uniforms or t-shirt that staff can wear: • rebranded uniforms—patients increasingly accessing staff that appear approachable.	• Need staff who are approachable.	P4: Cultural capability

Attendee's comments/views/input	Learnings	Health Equity Design Principles*
Whole-of-health-service redesign	• Need to consider funding reform and models of care.	P2: Local and regional decision making P3: Reorientating local health systems
Mandate education as foundational across all professions	• Need to embed cultural safety into all education and training programs.	P4: Cultural capability
Ensuring maximised scope of practice and those roles understood	• Need to ensure maximum usage of skill set and training.	P1: First Nations leadership P3: Reorientating local health systems
Staff being able to identify personal bias to change behaviour and attitude/approach: • staff are then held to account using learnings to improve the way they work • staff recognise systemic issues—actively recognise how service is designed.	• Need to address institutional racism and unconscious bias. • Need processes to address racism.	P4: Cultural capability
Ensuring cultural knowledge is valued	• Need to embed cultural safety into all education and training programs. • Recognise the value of cultural knowledge as a skill set utilised within sector.	P4: Cultural capability
Simple approaches that are respectful—the system needs to be able to cope with change and difference	• Need to embed cultural safety into all education and training programs.	P4: Cultural capability
Increase Aboriginal and Torres Strait Islander peoples, clinical leads voice—integrated and connected	• Need workforce strategies to attract and retain First Nations staff at all levels.	P4: Cultural capability
Clinical cultural roles—include in clinical governance	• Recognise the value of cultural knowledge as a skill set utilised within sector.	P4: Cultural capability
Consistency across sites—access at HHS		P3: Reorientating local health systems
Foundational Learning: Work with tertiary education systems to ensure all professions work towards eliminating racism—multiprong approach—education redesign	• Need to embed cultural safety into all education and training programs. • Recognise the value of cultural knowledge as a skill set utilised within sector.	P4: Cultural capability

Attendee's comments/views/input	Learnings	Health Equity Design Principles*
Opportunity to influence the key roles to ensure communication mechanisms go both up, down, and across	• Need to have a First Nations voice at all levels of the workforce/system.	P4: Cultural capability
Building clinical governance standards—NSQHS and tied to AHPRA to drive change	• Need to embed cultural safety into all education and training programs.	P1: First Nations leadership
Making it known and publishing experiences in addressing racism—look at RiskMan for accountability to include race, to respond to racism—meets auditing, accountability and visibility	• Need to update systems to identify racism. • Need to have racism audit.	P1: First Nations leadership
Workforce: Aboriginal and Torres Strait Islander staff across all roles and levels—clinical and administrative—sensitively navigate the system	• Need to increase FN workforce at all levels.	P1: First Nations leadership P2: Local and regional decision making
Consultation with Elders	• Need to improve cultural input and feedback.	P1: First Nations leadership
Education within health HIPPY		P1: First Nations leadership
Inreach and outreach services	• Need funding reform and revised models of care.	P3: Reorientating local health systems
Understanding the patient journey and the areas around continuity of care—more connected care	• Provide concierge services.	P3: Reorientating local health systems
Specialists employing rights of private practice including practicing back into community	• Need funding reform and revised models of care.	P3: Reorientating local health systems
Integrate specialist care into the PHC setting—opthomology, rheumatology, cardiology (STP training $$$): • navigating and integration to tertiary care • centres that do the teaching and research and teach other health specialties.	• Need funding reform and revised models of care.	P3: Reorientating local health systems
Cultural authority to sit with Aboriginal and Torres Strait Islander peoples in roles—DATSIP should be the cultural authority and has the delegation of authority to approve and sign off		P4: Cultural capability
Increase equity in access to diplomas and degrees for health workers to progress—workforce pipeline	• Targeted workforce pipelines.	P1: First Nations leadership
Access to legal advice	• Influence social determinants of health.	NEW: Social determinant of health

Attendee's comments/views/input	Learnings	Health Equity Design Principles*
Access to education and housing	• Influence social determinants of health.	P3: Reorientating local health systems
Short, medium, and long-term strategy with targets	• Targeted workforce pipelines.	P3: Reorientating local health systems
The leadership—the legislation enables peoples to rightfully take the place at the table		P1: First Nations leadership
Training dollars	• Targeted workforce pipelines.	P1: First Nations leadership
Using broader planning to tap into alternate streams		P1: First Nations leadership
Workforce pipeline: • school-based traineeships • ensure guaranteed employment—cadetships worked • Queensland Department of Education incentive • health industry skills advisor—CheckUp • Aboriginal and Torres Strait Islander peoples accessing nursing start with AIN—but where is it reflected in jobs EEO.	• Targeted workforce pipelines.	P1: First Nations leadership
Coordinated approach working towards the same goal	• Need to ensure patient-centred care.	P2: Local and regional decision making
Partners with tertiary education	• Targeted workforce pipelines.	P2: Local and regional decision making
Working towards work with the university and schools to ensure appropriate pipeline for the health workforce	• Targeted workforce pipelines.	P2: Local and regional decision making
Research—building the evidence base. Translation of research into practice being a focal point—include workforce as key.	• Targeted workforce pipelines.	P1: First Nations leadership
Ensure guaranteed employment—cadetships worked; scholarships	• Targeted workforce pipelines.	P1: First Nations leadership P2: Local and regional decision making
Ensure pathways across Department of Health, HHS, PHN, PHC and ATSICCHO	• Look at reciprocal work rights across agencies.	
Aboriginal and Torres Strait Islander health workforce strategy		P1: First Nations leadership
Aboriginal and Torres Strait Islander health workforce plan		P1: First Nations leadership

Attendee's comments/views/input	Learnings	Health Equity Design Principles*
Resource the workforce pipeline	• Targeted workforce pipelines.	P1: First Nations leadership
Cultural program for medical students	• Ensure cultural safety is embedded into all education and training.	P1: First Nations leadership
Using culture as a protective factor—the ways of knowing, being, learning and doing		P4: Cultural capability
QNMU—remuneration for cultural knowledge—Respect for Indigenous knowledge	• Recognise the value of cultural knowledge as a skill set utilised within sector.	P4: Cultural capability
Holding mainstream colleagues to account	• Ensure accountability mechanisms are in place.	P1: First Nations leadership
Needs-based funding opportunities to target those buckets of funds to enable funds	• Need to consider funding reform and models of care.	P1: First Nations leadership
Under Haylene—Queensland Aboriginal and Torres Strait Islander Workforce Strategy	• Targeted workforce pipelines.	P1: First Nations leadership
Mobility—working across HHS boundaries—support the patient journey and supported in the navigation through the system, i.e. coordinated care hubs	• Need to ensure wrap-around services and patient-centred care. • Concierge services.	P1: First Nations leadership P3: Reorientating local health systems
How good would it be for the HHS to provide the local data so we can redesign the system to redesign our services?	• Need to ensue data is driving health reform.	P1: First Nations leadership
Mapping the patient journey and the resources attached and where and which is best placed to actualise the best for the patient	• Need to ensure wrap-around services and patient-centred care. • Concierge services.	P2: Local and regional decision making P3: Reorientating local health systems
Embedding a well-resourced, evidence-based sustainable system	• Need to invest in the system.	P1: First Nations leadership
Using research and data to map the workforce	• Need to ensue data is driving health reform.	P1: First Nations leadership
Ensuring scope of practice is maximised (the HHS target)	• Review scope of practice for AIHW within mainstream settings.	P1: First Nations leadership
Capture EEO and input to correctly reflect in data—reflect true cultural capability	• Need to ensure workforce data is accurate.	
Identifying the collaborators	• Need to work to harness all players.	

Attendee's comments/views/input	Learnings	Health Equity Design Principles*
Mapping the patient journey and points of care	• Need to ensure wrap-around services and patient-centred care.	P2: Local and regional decision making P3: Reorientating local health systems
Led by Aboriginal and Torres Strait Islander Peoples—hearing what measures identified by peoples and communities, not just the funders—incorporating ways of knowing being and doing	• Need to ensure that First Nations people are at the table and their voices are heard. • Need cultural capacity in decision making.	P1: First Nations leadership
Look for opportunities to share, access, review and analyse data across all health system	• Need to ensure that data is share and utilised by the system as a whole.	P1: First Nations leadership
Focus on outcomes as a driver for change	• Ensure outcomes focus.	P3: Reorientating local health systems
Address and include experience measures to inform change	• Recognise lived experience.	P3: Reorientating local health systems
Better coordination of services will use funds efficiently and effectively	• Need to ensure that all areas are effectively communicating with each other. • All players at the planning, delivery and accountability table.	P3: Reorientating local health systems
Ensuring equity in resourcing, in funding and available spend	• Funding reform.	P3: Reorientating local health systems
Co-design must be resourced	• Ensure sufficient funds ae available to make partnership and co-design a reality.	P1: First Nations leadership
The whole health system is required to be around the table to have honest discussions around it	• All players at the planning, delivery and accountability table.	P1: First Nations leadership
Having data sets to inform the decisions	• Need to ensue data is driving health reform.	P1: First Nations leadership
Use of the locally produced data set through Queensland Health. Use of data for health service planning can be shared. Data will drive the outreach services	• Need to ensue data is driving health reform.	P1: First Nations leadership

Attendee's comments/views/input	Learnings	Health Equity Design Principles*
Ensuring a genuine co-design process	• Need to have an accountability framework for co-design.	P1: First Nations leadership P2: Local and regional decision making
Listening to people—focus groups	• Need to ensure channels are available for people to input.	P2: Local and regional decision making
Specialists out of the system and into community—strengths bases	• Need funding reform and revised models of care.	P3: Reorientating local health systems
First 1000 days—co-design, identified positions, integrated care		P3: Reorientating local health systems
Clinicians' positions need to be identified—quarantined	• Targeted identified workforce recruitment and retention.	P2: Local and regional decision making
Indigenous respiratory outreach	• Need funding reform and revised models of care.	P3: Reorientating local health systems
Systems and policies to support outreach	• Need funding reform and revised models of care.	P1: First Nations leadership
Students to have increased access to courses—placements/parking costs etc.	• Need realistic resourcing for workforce training.	P1: First Nations leadership
Measure health outcomes—but need to measure wellbeing outcomes	• Need to move beyond just health and focus on total wellbeing.	P3: Reorientating local health systems P4: Cultural capability

Attendee's comments/views/input

Other comments—Ideas

- How to align boundaries to patient flow that is across HHS boundaries.
- New models for health based on population growth—8K to 47+K growth.
- Leaders have agreed to focusing on health system reform not service reform.
- CEs/CEOs agreed to systems approach with one and each HHS having their HES as a schedule.
- Talk about implementation not development.
- Cataract surgery—identify need in IUIH and outsource resources to address the issues and reduce, using public $ and resources—one system using the same bucket of $ to get outcome for people.
- ENT from Children's to get family involved to get the care for sector clients in public system.
- NETWORKED APPROACH TO DEVELOP STRATEGY:
  - Layer of commonality
  - Clients don't recognise boundaries
  - Test this using existing structure—planning forums, existing networks.
- Who is going to be doing the work from within the department?
- How to fund or do this fall across boundaries?
- How to do consultation across boundaries HHS or do collectively across the wider area?
- MN started to talk with their planners to wait for what the framework looks like to then progress.
- SHARED VISION BY THE LEADERS—SHARED RESPONSIBILITY.
- NEED TO HAVE A FRAMEWORK TO GUIDE WHAT HHS STAFF DO TO PROGRESS THE WORK.
- Data from CC with HHS data.
- What is the basis of the strategy?
- Be brave to go through over around them.
- Don't get competitive between each other.
- Role of the PHN in this work.
- Identify who have strengths in certain areas and how this can be used across the collective region for the benefit of all clients.
- LETTING GO OF THINGS AND DOING WITH CC FROM HHS PERSPECTIVE.
- WHO CARES WHO DOES WHAT AS LONG AS THE NEEDS OF PEOPLE ARE BEING MET.
- What need to make system change while still making service changes.
- Put the indigenous overlays into mainstream initiatives.
- COLLECTIVE SYSTEMS TOGETHER AND NOT SEPARATELY.
- Review some of the work earlier (six months) and not wait for the 12 months.

Metro North Board responded:

- Appreciates the opportunity to be involved in this important work.
- Metro North values the importance of its own HHS plan to ensure clear and measurable outcomes for Metro North and having a broader SEQ plan to identify regional priorities and actions.
- Recognises the opportunity for more connections across services, leveraging good initiatives and sharing its own work (for example partnerships between HHS's and community-controlled healthcare organisations; and workforce initiatives).

Appendix 3—Attendee list

Name	Organisation
Aaron Hoffman	Aboriginal and Torres Strait Islander Health Division, Queensland Health
Adrian Clutterbuck	Children's Health Queensland
Angela Young	Children's Health Queensland
Dom Tait	Children's Health Queensland
Glynis Schultz	Community and Oral Health
Jennifer Rossiter	Department of Health (Qld)
Amanda Carver	Gold Coast Hospital and Health Service
Courtney Garrett	Gold Coast Hospital and Health Service
Cassandra Nest	GCHHS/Wajungbah Jarjums
Hannah Bloch	Gold Coast Hospital and Health Service
Rita Hudson	Gold Coast Hospital and Health Service
Kyriaki Artis	Gold Coast Hospital and Health Service
Marianna Serghi	Institute for Urban Indigenous Health
Wayne Ah Boo	Institute for Urban Indigenous Health
Adrian Carson	Institute for Urban Indigenous Health
Kieran Chilcott	Kalwun Health Service
Lindsay Johnson	Kambu Health
Ali Broadbent	Mater Health
Paul Drahm	Metro North Health—Community and Oral Health
Robyn Symons	Metro North Hospital and Health Service
Alex Chaudhuri	Metro North Hospital and Health Service
Bonny Barry	Metro North Hospital and Health Service
Kirsty Leo	Metro North Hospital and Health Service
William Bern	Metro North Hospital and Health Service
Rayna Cowburn	Metro North Hospital and Health Service
Richard Abednego	Metro North Hospital and Health Service
Angie Dobbrick	Metro North Hospital and Health Service
Colleen Jen	Metro North Hospital and Health Service
Natasha White	Metro North Hospital and Health Service

Name	Organisation
Zarina Khan	Metro North Hospital and Health Service
Cherie Franks	Metro North Hospital and Health Service
Sherry Holzapfel	Metro North Hospital and Health Service
Chris Thorburn	Metro South Hospital and Health Service
Leonie Martin	Metro South Hospital and Health Service
Debbie Cowan	Metro South Hospital and Health Service
Cleveland Fagan	QAIHC
Karen Thompson	QAIHC Consultant
Lauren Trask	QAIHC
Tiana Lea	QAIHC
Kim Walker	Queensland Health
Wanda James	Queensland Health
Haylene Grogan	Queensland Health
Kiel Williams-Weigel	Queensland Health
Noel Hayman	Queensland Health
Roslyn Wharton-boland	Queensland Health
Toni Kely-brown	Queensland Health
Trudi Sebasio	Queensland Health
Jermaine Isua	Queensland Health
Yasmin Muller	Queensland Health
Tracy Grant	Stars Hospital
Darsha Beetson	The Prince Charles Hospital
Kimina Andersen	West Moreton Hospital and Health Service
Lauren Gillespie	Yulu-Burri-Ba Aboriginal Corporation for Community Health
David Collins	Yulu-Burri-Ba Aboriginal Corporation for Community Health
Loretta Bingham	Yulu-Burri-Ba Aboriginal Corporation for Community Health
Tia Kaden	Yulu-Burri-Ba Aboriginal Corporation for Community Health

Appendix 4—Agenda

Agenda item
Welcome
What does health equity mean?
What is needed to meet the legislative requirements?
What are some things that could be included in a Health Equity Strategy?
Wrap up and close the meeting

Appendix 5—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 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, Alcohol 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)
WHO	World Health Organization

QAIHC
Queensland Aboriginal and Islander Health Council

Queensland Government