Consultation Report

Townsville consultation

31 MAY 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: Townsville consultation

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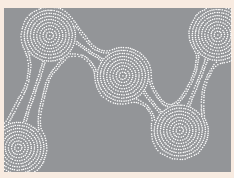
Acknowledgement of Country

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.

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Introduction

The Townsville consultation workshop was undertaken on 31 May 2021 at The Grand Chancellor, Townsville. The consultation had 31 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 Queensland Health took notes to capture the essence of the discussions and the thoughts and opinions of the participants.

Section 1

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

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

Section 2

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

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

Section 3

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

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

Report structure

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

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

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

- systems
- care
- funding
- workforce
- culture.

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

Executive summary

The workshop generated robust discussions about the need to 'systematise' existing working relationships between service providers. Strong foundations exist in the region with many people having long-standing working relationships, but little time is spent on implementing systemic improvements across the health system. The barriers and challenges are well known but integrated planning and service system redesign are not prioritised because the focus is on the immediate priorities for each provider rather than the health system as a whole.

Because more Aboriginal and Torres Strait Islander peoples access primary healthcare from private GPs in the region, the need to systematise coordinated and integrated care across the patient journey (inclusive of private GPs) was identified as critical for improving Aboriginal and Torres Strait Islander health outcomes. Only by providing genuine patient-centred care will health equity be achieved for Aboriginal and Torres Strait Islander peoples and all other equity groups requiring tailored care to reach their full health potential.

Key themes discussed included:

- The lived experience of racism and discrimination, and the heavy burden it places on the Aboriginal and Torres Strait Islander health workforce and patients accessing care—many people don't speak about their experiences because it's too difficult and non-Indigenous people continue to struggle to 'see' institutional racism and other forms of covert racism.
- Culturally safe and capable care needs to be more than symbolic and become embedded in accreditation standards and business as usual/ standardised practices.
- Case management and care coordination need to become the new norm to effectively support the patient journey across primary and acute care (hospital) settings and tie in other social support organisations to address the social determinants of health when needed.
- Data sharing is required between healthcare providers to improve the patient journey for individuals and to better understand local health needs for different geo-locations and demographic groups.
- Targeted investment and local strategies are needed to grow the local Aboriginal and Torres Strait Islander health workforce and create a career pathway for young people into the health sector.

Top five health reforms

considered a priority for this region by the participants

8	Establish regional coordinated care hubs
11	Embed cultural capability into Clinical Services Capability Framework
16	Factor equity into existing Queensland Health funding models
17	Utilise the Health Equity Strategies as future health investment plans
6	Introduce First Nations employment measures

Key discussion points

The discussion from the Townsville 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 Townsville region.

Principle 1: First Nations leadership

- Aboriginal and Torres Strait Islander models of care need to operationalise the principles we often talk about—there's still a lot of symbolism that doesn't translate into processes, practices or actions that respect Aboriginal and Torres Strait Islander ways of knowing, being and doing.
- Need to build the supply pipeline for the future Aboriginal and Torres Strait Islander health workforce.
- Many Aboriginal and Torres Strait Islander health workers in the HHS are denied the opportunity to work to their full scope of practice.

Principle 2: Local and regional decision making

- Healthcare providers in the Townsville region have established many strong relationships with each other and stakeholders—a strong foundation exists to drive local health system improvements.
- Palm Island Action Plan is a great plan but there's no accountability for other providers and stakeholders to deliver against the agreed commitments.
- Currently, personal relationships and not systems and structures define the level and extent of health service coordination and integration between healthcare providers – meetings are infrequent and focused on immediate priorities rather than undertaking joint planning and service system design. Health system integration needs to 'go beyond who you know' and become systematised.
- The new HES creates an opportunity to bring together all key stakeholders to understand and reach agreement about who is doing what, current service gaps and how to address existing unmet needs.
- Every healthcare professional and clinician needs to have a working knowledge of local health priorities and the burden of disease in the region or location.
- Good relationships exist between Townsville Aboriginal and Islander Health Service (TAIHS), the HHS and PHN—need to strengthen relationships with private GP providers in the region.
- Need to get the Commonwealth on board in terms of funding and planning to maximise the effectiveness of the new HES.
- KPIs tied to the HES need to be measures that matter for the local service providers and community.
- Timely data sharing between service providers needs to occur at critical points of the patient journey.

Principle 3: Reorienting local health systems

- All Australians should have the opportunity to achieve their full health potential—this is currently not the reality for many Aboriginal and Torres Strait Islander peoples.
- HHSs need increased flexibility to realign and repurpose funding away from hospital throughput/service activity.
- Healthcare needs to become genuinely patient- and community-centred for all patients.
- No advocacy or wrap-around support is provided to Aboriginal and Torres Strait Islander people who access private GPs.
- Sometimes there's a breakdown in the patient journey between primary (TAIHS) and acute care (Townsville HHS). Care coordination and case management needs to become the new norm.
- Need to share localised/geographical data between healthcare providers.
- Better integrated and coordinated care is needed for people accessing care across the health system.
- Need to design and invest in innovative ways to improve access to healthcare and look at existing good practice models and apply the lessons. New models need to prioritise going to the client rather than expecting the client to access care.
- Integrated workforce models that involve sharing positions across primary and acute care settings (or locations) need to be actively supported and encouraged.
- Need to map the patient journey to understand the key coordination points across the patient journey from home to hospital and back home again.

Principle 4: Cultural capability

- Aboriginal and Torres Strait Islander peoples, including the health workforce and patients, still experience racism and discrimination. Experiencing it, reporting it and then explaining the impact is a heavy burden for Aboriginal and Torres Strait Islander staff members and patients.
- Culturally safe care can't be tokenistic.
- Need to build upon, expand and strengthen existing cultural competency/anti-racism training for new recruits and existing staff within HHS.
- Racism will not be fixed overnight—a relationship of trust is needed to address racism.
- Institutional racism is not understood or obvious for a lot of non-Aboriginal and Torres Strait Islander peoples.
- Recruitment practices and service models within the HHS need to value 'non-technical' cultural skills that are required with working with Aboriginal and Torres Strait Islander peoples and communities.
- Broad support exists to eliminate racial discrimination but this needs to translate into action.
- Use accreditation standards as a means to embed culturally safe patient care into business as usual/ standardised practice.

Principle 5: Social Determinants

- There's a lack of integration between healthcare and addressing broader social and economic factors affecting Aboriginal and Torres Strait Islander peoples and communities.
- The new HES needs to bring together key partners and stakeholders from housing, education and training, and economic development—everyone needs to be in the room to yarn about the impact they have on the health of families and communities.
- Further conversations are needed with other non-health stakeholders to explain the impact of the social determinants of health (SDoH)—the health system alone does not create the conditions for good health.

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

Attendee's comments/views/input
General discussion
• **Aboriginal and Torres Strait Islander people, including the health workforce and patients, still experience racism and discrimination**. This needs to be acknowledged. Australian society is still racist and the THHS is not an anti-racist setting. Many Aboriginal and Torres Strait Islander people don't talk about their experiences because it's too difficult. There needs to be genuine recognition and understanding about what Aboriginal and Torres Strait Islander people have experienced and continue to experience. Staff and patient identification rates will improve when they feel safe to identify as being Aboriginal and/or Torres Strait Islander. • **All Australians should have the opportunity to achieve their full health potential—**This is currently not the reality for many Aboriginal and Torres Strait Islander peoples. • **The Townsville region has established many positive relationships between service providers and stakeholders—**a strong foundation exists to drive local health system changes by building on the relationships that already exist. • **Aboriginal and Torres Strait Islander models of care need to operationalise the principles we often talk about—**There's still a lot of symbolism that doesn't translate into practical processes, practices or actions that respect Aboriginal and Torres Strait Islander ways of knowing, being and doing. Culturally safe care can't be tokenistic. • 'We need to *change tracks* to improve health for our mob—m*aking tracks* is not getting us where we need to go'.

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		
HHSs need increased flexibility to realign and repurpose funding away from hospital throughput/service activity. Current funding arrangements create a perverse incentive to get more people through the hospital rather than focusing on primary care, early prevention/education and providing additional case-management/wrap-around support. Our shared priority needs to be preventing Aboriginal and Torres Strait Islander people from needing to receive hospital-based care due to improved health. There need to be fundamental changes to the allocation of resources within the HHS and across other healthcare providers—recreate an innovation fund pooled between providers to test new service models.	• Improved funding arrangements.	P3: Reorientating local health systems.
Healthcare needs to become genuinely patient and community-centred for all patients. This will result in achieving health equity for Aboriginal and Torres Strait Islander peoples and all other equity groups ('black, brown or brindle') who experience poorer health outcomes. Education is needed across the health system for healthcare professionals/clinicians to work with and understand the whole person—not only the presenting condition.	• Enhance/expand existing models of care.	P3: Reorientating local health systems.
Need to build upon, expand and strengthen existing cultural competency/anti-racism training for new recruits and existing staff within HHS. The training needs to be practical and tailored to the everyday experiences encountered by staff in the hospital.	• Cultural capability.	P4: Cultural capability.
Further cultural sensitivity/safety training needs to be provided to administration staff in regards to follow-up practices used with patients (regarding the types of communication channels used, how letters are written, removing patients from outpatient and specialist waitlists if they have not responded). Existing practices and processes do not take into account the lived experience and challenges of many Aboriginal and Torres Strait Islander peoples.	• Cultural capability.	P4: Cultural capability.
A lot of non-Aboriginal and Torres Strait Islander HHS staff do not understand the practical impact of the social and economic challenges experienced by some Aboriginal and Torres Strait Islander patients with complex needs (i.e. no fixed address or high transience, low literacy levels).	• Cultural capability.	P4: Cultural capability.

Attendee's comments/views/input	Learnings	Health Equity Design Principles*
Racism will not be fixed overnight—a relationship of trust is needed to address racism. General racism exists in the Australian community because there is a lack of understanding about what it means (re unconscious bias) and it is sensationalised by the local media. **Racist beliefs and the way some people act in the health system need to be challenged and called out.**	• Racism.	P4: Cultural capability.
Numbers attending cultural competency training are not high—training is mandatory but because many 'mandatory' training requirements exist in QH, it is sometimes given a lower priority by staff and management.	• Cultural capability.	P4: Cultural capability.
Institutional racism is not understood or obvious for a lot of non-Aboriginal and Torres Strait Islander people. Interpersonal experiences of racist abuse are easier to understand and identify but institutional racism and other forms of covert racism are not easily understood. Sometimes non-Indigenous people do not and will not listen—they are not interested in understanding the experiences of Aboriginal or Torres Strait Islander people.	• Cultural capability.	P4: Cultural capability.
Not many complaints are made by Aboriginal and Torres Strait Islander people (patients or staff members)—patients can be afraid it could compromise their patient safety/quality of care and staff members are concerned about the impact in the workplace. When feedback is given, it must be actioned by introducing changes to the practice, process or health service. Previously when complaints have been made it hasn't resulted in any action.	• Local health system improvements.	P3: Reorientating local health systems.
Approximately 12 per cent of the population are transient from north or west Queensland—don't go to TAIHS or local GPs for primary healthcare and end up receiving care through ED or paramedics when very ill.	• Enhance/ expand existing models of care.	P3: Reorientating local health systems.
No advocacy/support/wrap-around support provided to Aboriginal and Torres Strait Islander people who access private GPs. Most people access private GP providers and limited to no relationship exists with these providers between the HHS and TAIHS.	• Enhance/ expand existing models of care.	P3: Reorientating local health systems.
HHS currently provides advocacy support to Aboriginal and Torres Strait Islander patients who see private GP providers and are not referred to other social support services.	• Enhance/ expand existing models of care.	P3: Reorientating local health systems.
Need to get access to private GP data and geographical data (e.g. Palm Island).	• Local health system improvements.	P2: Local and regional decision making.
High levels of intergenerational trauma and lack of cultural identity for young people, including those in out-of-home care.	• Enhance/ expand existing models of care.	P3: Reorientating local health systems.
Social and Emotional Wellbeing (SEWB) needs to be prioritised—a relationship exists between providing culturally safe care and SEWB that is not understood or valued.		

Attendee's comments/views/input	Learnings	Health Equity Design Principles*
Lack of integration between healthcare and addressing broader social and economic factors affecting Aboriginal and Torres Strait Islander peoples and communities; because of other social and economic pressures, health can be a lower priority.	• Local health system improvements.	NEW: Social determinants.
Palm Island Action Plan is a great plan but there's no accountability for other providers/stakeholders to deliver against the agreed commitments, especially providers outside of the health system. Plans and strategies need to have levers that tie in and commit other stakeholders/providers (HHS Board Chair).	• Local health system improvements.	P2: Local and regional decision making.
Breakdown in the patient journey—sometimes patient referrals get lost between TAIHS/primary healthcare providers and THHS. Existing processes and systems need to be strengthened to improve the continuity of care—patient records need to be shared and other handover practices introduced beyond discharge summaries. **Care coordination and case management needs to become the new norm**—starting with patients with complex needs/co-morbidities and then extending out to other priority groups. Often patients with co-morbidities have changes to their medication (or new medication) that does not take into account their other conditions.	• Enhance/ expand existing models of care.	P3: Reorientating local health systems.
Need to build the supply pipeline for future Aboriginal and Torres Strait Islander health workforce and prioritise this work as BAU (for example, HHS currently does not attend career expos).	• Build and strengthen local Aboriginal and Torres Strait Islander workforce.	P3: Reorientating local health systems.
Currently personal relationships and not systems and structures define the level and extent of health service coordination and integration between healthcare providers—local healthcare providers do not meet regularly to undertake joint planning and service design. Meetings are infrequent and focused on immediate priorities. Structures and processes are not embedded in the health system or BAU. Health system integration needs to '... go beyond who you know and become systematised'. Frank discussions are needed between service providers and the best provider to deliver particular services/care.	• Local health system improvements.	P2: Local and regional decision making.
Need to share localised/geographical data between healthcare providers—for example, on Palm Island the life expectancy age is 53 for men, which is significantly less than the state average.	• Local health system improvements.	P2: Local and regional decision making.
History matters because some communities and families remain distrustful of the health system because of previous experiences. The health system (i.e. service providers) needs to genuinely walk together with community/mob and be transparent.	• Enhance/ expand existing models of care.	P3: Reorientating local health systems.

Attendee's comments/views/input	Learnings	Health Equity Design Principles*
Aboriginal and Torres Strait Islander healthcare workers need to be employed across the health system and located in service centres beyond Townsville. More Aboriginal and Torres Strait Islander peoples need to be working in rural and remote locations.	• Build and strengthen local Aboriginal and Torres Strait Islander workforce.	P3: Reorientating local health systems.
Many Aboriginal and Torres Strait Islander health workers in the HHS are denied the opportunity to work to their full scope of practice—they are required to work to/with nurses. Aboriginal health workers are the pivotal cog between hospitals and community.	• Build and strengthen local Aboriginal and Torres Strait Islander workforce.	P1: First Nations leadership.
Our future cannot be one that means being born as an Aboriginal or Torres Strait Islander puts us at risk—health equity will be achieved when there are no differences between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians in health outcomes, healthcare access and experiences with the health system.	• Local health system improvements.	P4: Cultural capability. NEW: Social determinants.
Racism and discrimination—experiencing it, reporting it and then explaining the impact—is a heavy burden for Aboriginal and Torres Strait Islander staff members and patients. The burden needs to be shifted to non-Indigenous people to change their behaviours and attitude—courageous conversations are needed to understand how un-conscious bias negatively impacts First Nations peoples. Some non-Indigenous healthcare professionals still do not fully understand the impact of social and economic factors (the social determinants of health) and blame patients. Intergenerational trauma and the impact of historical and ongoing racism experienced by Aboriginal or Torres Strait Islander peoples is not understood by many health professionals. Non-Aboriginal and Torres Strait Islander people need to listen to what's being said and asked for and talk about the social factors (SDoH) that affect a person's health.	• Racism.	P4: Cultural capability.
The new HES creates the opportunity to bring together all the key stakeholders to understand and reach agreement about who is doing what, current service gaps and how to address existing unmet need. Increased accountability between service providers and back to community needs to result from the HES.	• Local health system improvements.	P2: Local and regional decision making.
The new HES needs to bring together key partners and stakeholders from housing, education/training and economic development—everyone needs to be in the room to yarn about the impact they have on the health of families and communities. Need to partner and work with other departments (portfolios) and social support services and not just work within 'the health silo'.	• Local health system improvements	NEW: Social determinants

Attendee's comments/views/input	Learnings	Health Equity Design Principles*
Better integrated and coordinated care is needed for people within the health system—for example, between dental, allied health, primary healthcare and hospital-based care—and with related sectors, such as transport and housing/accommodation. Fragmented care across the health sector and with other social support providers is the norm rather than the exception. The high rates of co-morbidities require having an overarching senior physician or specialist to oversee care.	• Local health system improvements.	P3: Reorientating local health systems. NEW: Social determinants.
Every healthcare professional/clinician needs to have a working knowledge of local health priorities and burden of disease in the region/location—this requires regular data sharing between healthcare providers and an understanding of referral pathways/processes for specialists. For example, accessing specialist care for Palm Island residents requires an increased level of knowledge and information to access timely care.	• Enhance/ expand existing models of care.	P3: Reorientating local health systems.
Recruitment practices and service models within the HHS need to value 'non-technical' cultural skills that are required when working with Aboriginal and Torres Strait Islander peoples and communities—these relationship and engagement skills are often not prioritised and viewed as optional 'add-ons' rather than being essential to the position and Model of Care. Without cultural safety, the likelihood of a program or service resulting in improved health outcomes is limited.	• Enhance/ expand existing models of care.	P4: Cultural capability.
Enablers		
Increased attention and improvements have been made by the HHS over the last few years—triggers for change include the release of a Reconciliation Action Plan, the appointment of the Aboriginal and Torres Strait Islander Health Executive Director and increased Board oversight and leadership to drive change, including the appointment of an Aboriginal and Torres Strait Islander board member.	• Strengthened leadership and accountability.	P1: First Nations leadership.
Good relationship between HHS, TAIHS and PHN—need to strengthen relationship with private GP providers in the region.	• Local health system improvements.	P2: Local and regional decision making.
Inclusion of KPIs in HHS service agreement focus attention/effort of HHSs—need to consider how the HES KPIs are tied to/referenced in the service agreement.	• Strengthened leadership and accountability.	P3: Reorientating local health systems.
The Chief Aboriginal and Torres Strait Islander Health Officer could lead state-wide communication strategies to promote and explain the HESs—this would be supplemented by local targeted campaigns. The purpose of the state-wide campaigns would be to inform and get buy-in from stakeholders to partner in the development and implementation of the HESs.	• Statewide health system management.	P1: First Nations leadership.

Attendee's comments/views/input	Learnings	Health Equity Design Principles*
Broad support exists to eliminate racial discrimination, but this needs to translate into action. Townsville HHS has released a five-year strategy to improve the cultural competency and safety of the HHS—at the beginning of the journey (first year). The cultural competency training currently includes online training, two-hour mandatory face-to-face training, and tailored workshops (conversations) for different areas/sections of the hospital based on identified needs. Board members also need to participate in cultural capability training. Hospitals are hierarchical and there is limited understanding about the cultural value Aboriginal and Torres Strait Islander healthcare professionals bring to their roles.	• Local health system improvements.	P4: Cultural capability.
HHS Indigenous Liaison Officers and Patient Liaison Services currently undertake surveys with patients about their experiences in HHS (six or seven questions)—existing survey could be reviewed/redesigned to ask specific questions about cultural safety and experiences of racism.	• Enhance/expand existing models of care.	P4: Cultural capability.
Need to strengthen and expand the delivery of tailored cultural safety training for different areas of the HHS from administration support and management, through to clinicians. HHS staff members need to understand why training is required. Some areas of the hospital need more attention/effort to improve cultural safety and challenges (ie renal). All staff members need to understand they have a role in providing culturally safe (anti-racist) care and they are accountable to their team, organisation and patient.	• Local health system improvements.	P4: Cultural capability.
Existing HHS consumer groups (Consumer Advisory Network—CAN) and the First Nations advisory group could be used as avenue for patients to provide feedback about care (positive and negative experiences), including experiences of racism. These groups could also consider strategies/actions to identify structural or process improvements based on the feedback provided.	• Local health system improvements.	P1: First Nations leadership.
Post-operative follow-up could be another point in time for patients to provide feedback about the care they received (positive/negative experiences)—this could be an internal KPI for the HHS and conducted by an external provider/organisation (including an ATSICCHO) for independence.	• Enhance/expand existing models of care.	P4: Cultural capability.
Need to embed cultural capability measures into standardised practices and structures, for example including cultural capability training participation rates in HHS CE and Executive performance contracts. Further conversations are needed about proactive/positive discrimination and the reason tailored approaches are needed for Aboriginal and Torres Strait Islander people—limited understanding exists.	• Local health system improvements.	P4: Cultural capability.

Attendee's comments/views/input	Learnings	Health Equity Design Principles*
Need to design and invest in innovative ways to improve access to healthcare and look at existing good practice models (for example, vaccination rates) and the apply the lessons. New models need to prioritise going to the client rather than expecting the client to access care—examples include: • Increase the number of school-based nurses in high schools and provide health checks/POC testing and screening. TAIHS currently provides health services in schools (six-month program)—can build on this. Need to engage with young people about their health needs and priorities. • Provide health checks to local workforces/employers with large numbers of Aboriginal and Torres Strait Islander workers. • Provide health technology for patients to monitor their own health at home with data automatically provided to care providers (primary/acute). This is starting in the HHS (currently in planning stages).	• Enhance/ expand existing models of care.	P3: Reorientating local health systems.
Increase health literacy across the community and all demographic groups (young people, families, Elders) and provide health literacy training for teachers.	• Enhance/ expand existing models of care.	P3: Reorientating local health systems.
CheckUP partners with higher education providers, TAFEs, and schools **—need to build upon and strengthen activity between industry advisor (CheckUP) and healthcare providers.**	• Build and strengthen local Aboriginal and Torres Strait Islander workforce.	P1: First Nations leadership.
Commonwealth invests in schools to support high achievers—need to tap into existing programs and link them to a career pathway/pipeline into the health sector.	• Build and strengthen local Aboriginal and Torres Strait Islander workforce.	P1: First Nations leadership.
Use accreditation standards as a means to embed culturally safe and patient-centred care into BAU/standardised practice—HHS recently failed its mock accreditation assessment (*some of the six standards related to First Nations health) and is looking at introducing changes to meet accreditation standards.	• Local health system improvements.	P4: Cultural capability.
Expand the governance of the Palm Island Action Plan to include other parties/stakeholders and develop similar plans for other geographical regions in Townsville catchment (but strengthen accountability mechanisms).	• Local health system improvements.	P2: Local and regional decision making.

Attendee's comments/views/input	Learnings	Health Equity Design Principles*
Build stronger partnerships with education providers, universities, and schools—**need to establish education pathways for young people to secure employment/start a career in the health sector.**	• Build and strengthen local Aboriginal and Torres Strait Islander workforce.	P3: Reorientating local health systems.
Local data needs to be both shared and understood across healthcare providers. The HES needs to include local community-based indicators to measure progress and improvements and what success looks like for mob.	• Local health system improvements.	P3: Reorientating local health systems.
Community-controlled primary health services work. TAIHS having a presence (five - six years) and is co-located with the HHS in Charters Towers. Our mob know TAIHS is there and committed to providing a comprehensive primary healthcare.	• Local health system improvements.	P1: First Nations leadership.
Integrated workforce models that involve sharing positions across primary and acute care settings (or locations) need to be actively support and encouraged. This will strengthen relationships and processes/practices across both sectors (HHS and TAIHS currently considering this).	• Local health system improvements.	P3: Reorientating local health systems.
Opportunities exist to strengthen and revise existing practices and processes as part of the HES, including: • review existing risk-based approaches and actively follow-up and provide additional support for people who have missed specialist appointments (for example, category three has higher rates of missed appointments) • revise language—rather than 'Failed to Attend' describe as 'Missed Appointment' • enhance and expand access to telehealth • review various points across the hospital system including waiting lists, weighting criteria and triage practices—all parts of the hospital that show existing inequities between Aboriginal and Torres Strait Islander peoples and non-Indigenous people • reset existing performance measures to value equity and not volume as demonstrating effective healthcare.	• Enhance/ expand existing models of care.	P3: Reorientating local health systems.

Attendee's comments/views/input

Other comments - deas

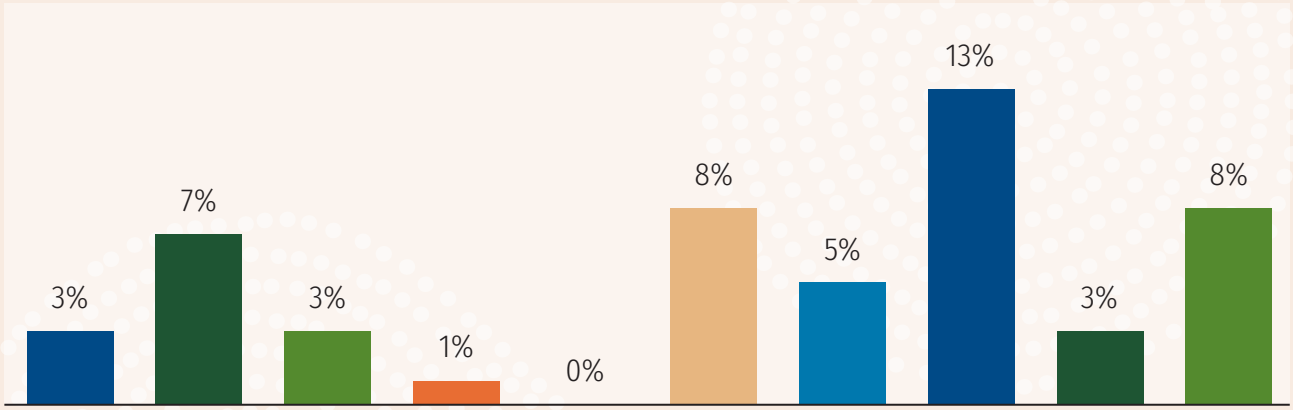
- **Need to get the Commonwealth on board in terms of funding and planning to maximise the effectiveness of the new Health Equity Strategies**—refresh existing Commonwealth-State governance body and consider the role of the Tier 2 group in oversighting the Health Equity Strategies.
- The Aboriginal and Torres Strait Islander Health Division/Department of Health needs to provide practical support to HHSs at a state-wide level—communication campaigns.
- **The Health Equity Strategies need to look and feel different to other strategies produced in the past—it can't be more of the same.**
- **The health system needs to respect Aboriginal and Torres Strait Islander ways of being, knowing and doing**—it needs to be more than symbolism.
- **Existing recruitment, retention and training processes and practices need to be strengthened** to get more Aboriginal and Torres Strait Islander people working and developing careers in the health sector.
- **KPIs tied to the HES need to be measures that matter** for the local service providers and community members.
- **Data sharing between service providers needs to occur** and be timely at critical points of the patient journey.
- **Our shared goal is ensuring our people have good experiences across the health system.**
- **Accountability framework for HESs to include economic analysis**, including return on investment from increased primary health care and cost savings for HHS and RFDS.
- **Improvements are needed to existing models of care**—for example, FASD and hearing measures need to be included into standard health checks (715s).
- **Need to map the patient journey to understand the key care coordination points across the patient journey from home to hospital and back home again** including:
  - who is involved with the care and their role
  - authorisation to work with specialists or nurse navigators
  - documentation required at each step (including medication sign-offs)
  - referral mechanisms for transportation and accommodation.
- **Further conversations are needed with other non-health stakeholders to explain the impact of the social determinants of health**—the health system alone does not create the conditions for good health. For example, housing conditions such as overcrowding have a large impact on health status.
- **Health system partners need to be repeating the same messages about the opportunity the HES** provides for reforming the health local system. Consistent and agreed messaging needs to be used by all partners.

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

Future ideas for discussion

Townsville 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

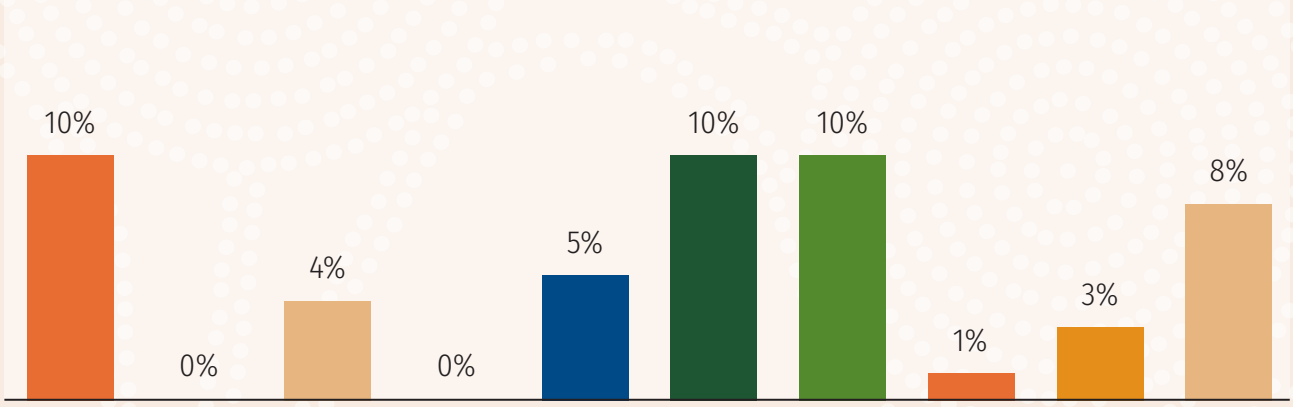
Reform Idea 6 Introduce First Nations employment measures

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
Fran Keeble-Buckle	CheckUP
Tanya Morris	CheckUP
Edward Hollingsworth	Dept of Seniors, Disability Services and Aboriginal and Torres Strait Islander Partnerships
Sandra Crosato-Matters	Dept of Seniors, Disability Services and Aboriginal and Torres Strait Islander Partnerships
Patricia Schluter	Lung Foundation Australia
Nick Loukas	NQ Primary Health Network Townsville
Melanie Walsh	NQ Primary Health Network Townsville
Rachel Atkinson	Palm Islander Community Company
Kath Anderson	Palm Islander Community Company
Cleveland Fagan	QAIHC
Karen Thompson	QAIHC Consultant
Lauren Trask	QAIHC
Tiana Lea	QAIHC
Trevor Prior	Queensland Health
Lynette Anderson	Townsville Aboriginal and Islander Health Service
Erik Lai	Townsville Aboriginal and Islander Health Service
Kieran Keyes	Townsville Hospital and Health Service
Teresa Stratton	Townsville Hospital and Health Service
Salli-Ann Buttigieg	Townsville Hospital and Health Service
Barbara Banu	Townsville Hospital and Health Service
Judy Morton	Townsville Hospital and Health Service
Liza Tomlinson	Townsville Hospital and Health Service
Marina Daly	Townsville Hospital and Health Service
Matthew Rooney	Townsville Hospital and Health Service
Niall Small	Townsville Hospital and Health Service
Sally Schaumburg	Townsville Hospital and Health Service
Sharon Kelly	Townsville Hospital and Health Service
Donald Whaleboat	Townsville Hospital and Health Service
Stephen Eaton	Townsville Hospital and Health Service
Dallas Leon	Townsville Hospital and Health Service
Danielle Hornsby	Townsville Hospital and Health Service
Giovanna Castellani	Queensland Health
Craig Williams	Queensland Health
Danette Hocking	Townsville Hospital and Health Board
Nicole Hayes	Townsville Hospital and Health Board
Tony Mooney	Townsville Hospital and Health Board

Appendix 5—Agenda

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

Appendix 6—Glossary

Abbreviation	Meaning
AIHW	Aboriginal and Island Health Worker
AMS	Aboriginal Medical Service
ATSICCHO	Aboriginal and Torres Strait Islander Community Controlled Health Organisation
CATSIHO	Chief Aboriginal 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
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)
TAIHS	Townsville Aboriginal and Islander Health Services
THHS	Townsville Hospital and Health Service
WHO	World Health Organization

QAIHC
Queensland Aboriginal and Islander Health Council

Queensland Government