Consultation Report

Regional stakeholders consultation

20 APRIL AND 26 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: Regional stakeholders consultation

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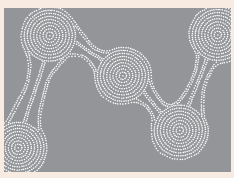
An electronic version of this document is available at **health.qld.gov.au** and **qaihc.com.au**

Disclaimer

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

To capture the views and opinions of as many stakeholders as possible, alongside the fourteen workshops held regionally across Queensland, three smaller workshops were held.

These smaller workshops included one for Workforce Agencies and one for Academics on 20 April 2021 at QAIHC, South Brisbane and one for the First Nations Leads at the Hospital and Health Services (HHS) on 26 May 2021, via Microsoft Teams.

Workshop purpose

The smaller, targeted stakeholder workshops were held 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 two 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.

Report structure

During the consultations for stakeholders, 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

Each of the workshops focused on their key areas of expertise, however strong themes ran through the workshops as outlined above. In particular, the issues of funding and workforce dominated the discussions. There is a need to ensure there is adequate long-term funding within the system and to ensure that funding is directed where it is needed most. Further, any underspends should not be redirected outside of Aboriginal and Torres Strait Islander health programs; but refocused to support other programs within the sector.

It was highlighted that there are far too many people in the HHSs in long-term acting and temporary positions. This is not conducive to stability and building a culturally capable workforce and a review should be conducted to ratify all these positions.

More focus needs to be given to working with the education and training systems to ensure that cultural safety is a core component of the syllabus for all courses. There needs to be a career pipeline established to ensure a long term culturally capable and targeted workforce for urban, rural, and remote areas and support provided for Aboriginal and Torres Strait Islander Health Workers to transition into nursing and allied health degrees.

There needs to be better integrated systems to ensure the patient's journey is as smooth as possible with all providers working collaboratively to transition the patient's care. Services need to be culturally appropriate, and data needs to be better shared.

Key discussion points

The discussions from the 17 state-wide consultations will be incorporated into the overall state consultation report that will be used to develop the guide and toolkit for each HHS to develop their Health Equity Strategy over the next 11 months.

The ideas and suggestions from the consultations will inform the development and redesign of a local health system that meets the needs of people across the region.

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

Attendee's comments/views/input	
General discussion	
• Some suggested that location should be included within the Health Equity definition, to acknowledge the difference within regions. • It was discussed that adaptability should be included in the definition to ensure health systems are accessible/responsive.	
Systems	• Lack of service/care integration between primary care services and the acute care is a huge problem (GP, NDIS, Nurse Navigator, ITC, Patient Care, Care Coordination etc). • Toolkit should incorporate actions that support improved service integration. • Priorities: assess the need, work out how it can be done so that it meets the need. • Need accountability for CEs and the Boards. • Principle 3 (Reorientating local health systems: Increasing investment in upstream health interventions and care outside of hospitals)—is there room to make other systems accountable? E.g. education, social services, child protection and disability etc. • Principle 3 (Reorientating local health systems: Increasing investment in upstream health interventions and care outside of hospitals)—with local and regional it's about sharing information across geographical regions between HHSs and ATSICCHOs.
Care	• People are experiencing a huge struggle to navigate the system. Improving access is an important factor. • Health system is failing to support Aboriginal and Torres Strait Islander patient journey appropriately; and should be responsive to people's needs. • It was agreed that the current health equity definition was adequate. • Some attendees were unsure of where SEWB fits into the definition, and that the definition was more of a physical health focus rather than holistic and suggested that there may be room to include mental health within the definition.
Funding	• Funding comes under Making Tracks which only allows for temporary positions. • Making Tracks was intended to grant funding, but consultation planning will include aligning Making Tracks to Workforce Strategy. • The funding model is a key component, temporary employees are supposed to be offered permanency after 2 years, but the group reiterated Making Tracks funding is all temporary. • Missing information about funding component. • How do we address this gap at HHS Levels? How many additional positions are needed and how many dollars from extra funding is needed to enable the workforce and build health initiatives to meet this gap? • Funding for Making Tracks has been going for a long time, performing, but no position surety or long-term security.

Attendee's comments/views/input	
Funding	• Strong point – Aboriginal and Torres Strait Islander funding gets siphoned into making up for the HHS overspend, does not actually get used for Aboriginal and Torres Strait Islander Health—*attendees roundly agreed—need to ensure funding gets spent where needed. Making Tracks funding goes to ATSICCHOs AND mainstream health. • Need to claw back funds and anchor Aboriginal and Torres Strait Islander health funding. Comment from an attendee that their Financial Controller makes it clear that if these funds are accessed it will be clawed back later (so this demonstrates it CAN be done). • Need to have consistency about management of funding for Indigenous health—but not just funding specifically for Aboriginal and Torres Strait Islander health, also entitled to a portion of mainstream funding and this can be tied down through funding contracts. • Accountability will be in the legislation.

Workforce	• Ensuring rural and remote health workforce is challenging task
	• Health workforce issue in rural and remote Aboriginal and Torres Strait Islander communities could be improved by:
	  • Prioritising academic teachings to meet community needs. Health and Academic sector should come together and work around prioritising workforce needs. Education should target meeting current needs of the market.
	  • Government and academic institutions should work collaboratively and focus on implementing transition programs such as Aboriginal Health Worker should be offered opportunities to undertake Nursing and Allied Health degree, which could be effective approach to improve workforce target in rural and remote communities.
	  – Pathways for the transition programs should be identified this is possible through intensive planning.
	• Queensland Health, the Office of the Chief Nursing and Midwifery Officer (OCNMO) have important roles in workforce development.
	• Currently, Aboriginal and Torres Strait Islander workforce targets are aggregated (majority included administrative workforce not clinical/health), however setting Aboriginal and Torres Strait Islander health workforce targets to specific professional categories is key to improve real health workforce to meet community needs.
	• Workforce is needed to deal with health issues which have been prioritised based on evidence and empirical data. There must be the ability to redirect funding to the address the need and meet the gaps.
	• Under Queensland Health directive, any temporary position over 2 years should be considered for permanency.
	• Many existing staff have been in temporary positions for four to five years—how can we make people permanent (so they have job security and employment in sector more appealing)?
	• Discussion around including HHS in upcoming workforce discussions with Queensland Health.
	• Issue raised that there are 2 categories of employees—either Government employees that are NOT public Servants or Government employees that ARE public servants.
	• There is a separation between government employees at HHS and public servants.
	• Need to identify whether 'temporary to permanent' opportunities only apply to front line staff or if also available to project officers, Aboriginal and Torres Strait Islander health workers, health practitioners and hospital liaison officers.

Attendee's comments/views/input	
Culture	• Comment was made around including 'cultural safety' not 'cultural capability' into the Health Equity framework. • Nursing and Midwifery Board has mandated to teach all nursing students about 'cultural safety' as part of professional accreditation. So, the curriculum is also designed around cultural safety. However, when students go to Queensland Health, HHSs they come across Cultural Capability Framework. • Cultural safety is about treating people respectfully, it allows health practitioners to look a person in a holistic view, which is critically important for Aboriginal and Torres Strait Islander peoples. • Racism and cultural safety are different issues. • Recommendation: Theme 4 should be framed around 'Cultural Safety' rather than 'Cultural Capability' (HE Tool Kit should focus on 'Cultural Safety').

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

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

Attendee's comments/views/input	
General discussion	
Systems	• Health Equity Toolkit design and implementation (buy-in). • Accountability for HHS, CE and Boards. • Needs to not just fall on individuals to implement Health Equity on top of their existing roles—need a dedicated team. Health Equity should be endorsed at HHS Senior Executive level as 'everybody's business'. • Suggest a project team or committee and a responsible officer. • Preferred model: Board > Management lead > Project team. • Need a directive from Chief Aboriginal and Torres Strait Islander Health Officer and Deputy Director-General that it needs to be a whole of HHS involvement and suggestions re. structure, oversight, and governance. • Model needs to identify who are responsible officers at HHS and who accountable officers are. While HHS responsible Officers or planning officers should drive it, planners don't exist in many HHS and may not have exposure in ATSICCHOs—missing skill sets. Non-Aboriginal and/or Torres Strait Islander staff must be prepared to step in and support at all levels. • Legislation includes Board accountability. • The Board and CE can delegate duties but not accountability. • Needs to be separate: Strategic role, operational role and accountability (Monitoring, adjusting, measuring). • Big challenge will be rounding up executives—really need Board to play champion role, needs buy-in from executive. Already getting buy in for Aboriginal and Torres Strait Islander wellness centre. • In terms of implementation, needs to be a focus on implementation and operationalising and of regulatory requirements of the framework. • What is the cross effect/impact? • Lean on the empirical evidence/evidence base re direction of priorities. • Collaboration, co-design: The development of the HES must be in conjunction with HHS, ATSICCHOs, PHNs and other stakeholders. • Example: Mental health sits separately to other departments within the HHS, what is the accountability to ensure that all departments within HHS will be included in the development of the HES? • Important: accountabilities in government.

Attendee's comments/views/input	
Systems	• Discussed disease grouping—understanding who is responsible? • Data sharing is important. • Data: The collection of baseline data at the HHS level is important it will help to better understand the need within each region. • Getting some anti-discrimination audits into place—an audit first than a quality audit tool or something else, ensuring there is a baseline. • National Standards, there would probably be reluctance including it as a standalone accreditation—but could it be included in the existing standards accreditation. • Information sharing, governance, and accountability. A whole range of things are occurring, but how do we engage with all stakeholders—information sharing, governance and accountability is crucial. State levels and specific work governance. Cross fertilisation between stakeholders. Can't do the silo stuff. • Example: Regional forums. Communique is important could show what is occurring in post communication at a state level particularly when HES are being developed. • There are two levels the people who attend the meetings (CEOs) but the doers (staff) in the operational miss the information shared up above them. An operational, and a high level needs to be included in the in the toolkit. Including working groups. • Can standardisation measures be used to hold HHS accountable? • Health partnership—there could be more than just QH, QAIHC—it hasn't worked but it will be a conversation that needs to happen.
Care	• Comment: Greatest influence from this framework needs to be where care takes place, i.e. eliminating medication errors, improving interaction at bedside. • How do we at primary health care prevent hospital admissions? • All levels of data are required e.g. HHS, ATSICCHO. How do we capture the right data? • Causal factors: understanding state-wide and the additional areas—add extra principle—which includes data and investments. • Across each HHS how do we collectively deal with disease? State plan for overarching HES and within that there would be parts for the ATSICCHOs to work, contribute to. • Integration: it is about understanding the points of entry into the health system. • Example: there are multiple points of entry, which highlights the importance of working collaboratively—there is $100 million from State Budget being put into schools for GP, psychology which is another example of point of entry into health care. • Diagnosis and treatment are one thing, but it is ensuring that people are supported to manage their own health. • Preventative health at the early intervention stage as it is more expensive once in the tertiary care. Preventative health can begin by being supportive of families, building life skills within schools. • Goal setting is important, implementing changes at school. • Target: as health measures are important, understanding the environment.

Attendee's comments/views/input	
Funding	• Find out how HHS gets resources needed to do the work—levels of chronic disease/staff rate/ and funding—and how we get access to resources. • Provide associated resources.
Workforce	• Understanding how to address workforce and what role people play in it. • Non-clinical roles (connector roles) are just as vital—the journey can start at home. • How can we understand how to support everyone? We don't want to mess it all up.
Culture	• How does the definition of institutional racism apply in accreditation? The Mental Health Commission has done some work around AOD and this could be flipped to find out if it is addressing at an institutional level.
Toolkit	• Toolkit needs to have delineation and engagement between workforce, management, and accountability. (Needs to be clear responsibilities between Board, CE, on the ground staff). • Need to double check consultation versus sign off on HEC—sign off or demonstrated involvement/invitation to become involved. What does consultation look like? • Document associated sources for Health Equity and related guidelines/frameworks (local/ statewide/federal). Where are they, what are they, let's make them available to ATSICCHOs and stakeholders. Current draft Health Equity Framework does not provide clear pathway. • Attendee asked for a depiction of 'how things will work'. • Triple A—KPI's in Areas, Action and Alignment (with health equity). • There was a call for simple definitions to be provided for the words: framework, strategy and implementation plan. • Toolkit—ensuring that the local stakeholders are engaged by the HHS. HHS need to prove that they are working with stakeholders when developing HES. • Qualitative—importance capturing stories e.g., rather than having the negative lens. Shared story of health problems. • Example: Evaluation—sharing stories of peoples experience of the health system (my significance changes). It is a different approach of evaluating. • Having a Framework is good but needs to allow for flexibility. Toolkits need to also prioritise flexibility and innovation. But the requirement for governance and accountability needs to be mirrored in the Department and Government. How is that going to happen? • The framework and toolkit need to work for First Nation Leads, having buy in and support and clearly set out and clarified actions will make it achievable. Needed from both HHS and ATSICCHOs. • What is possible is developing a guide which could measure complaints? Managed by operational staff.

Appendix 3—Attendee list

Name	Organisation
Cleveland Fagan	QAIHC
Deanne Minniecon	Health and Wellbeing Queensland
Karen Thompson	QAIHC Consultant
Odette Best	School of Nursing University of Southern Queensland
Rachel Doolan	University of Queensland
Ray Mahoney	CSIRO
Angela Young	Children's Health Queensland HHS
Christine Mann	North West HHS
David Eastgate	Metro South HHS
Jermaine Isua	Queensland Health
Jessica Oostenbroek	Queensland Health
Joy Savage	Cairns and Hinterland HHS
Kiel Weigel	Queensland Health
Lee Yeomans	QAIHC
Linda Medlin	Central Queensland HHS
Melissa Browning	Queensland Health
Noeleen Mulley	Torres and Cape HHS
Raelene Baker	Wide Bay HHS
Rica Lacey	Darling Downs HHS
Rodney Landers	South West HHS
Sharon Barry	Sunshine Coast HHS
Sherry Holzapfel	Metro North HHS
Tiana Lea	QAIHC
Trudi Sebasio	Mackay Hospital HHS
Lee Yoemans	QAIHC
Chris Mitchell	Health Workforce Queensland
Sarah Venn	Health Workforce Queensland

Appendix 4—Glossary

Abbreviation	Meaning
AIHW	Aboriginal and Island Health Worker
AMS	Aboriginal Medical Service
ATSICCHO	Aboriginal and Torres Strait Islander Community Controlled Health Organisation
CATSIHO	Chief Aboriginal & Torres Strait Islander Health Officer
CE	Chief Executive
CTG	Closing the Gap
DAMA	Discharge Against Medical Advice
DATSIP	Dept of Aboriginal and Torres Islander Partnerships
ED	Emergency Department
FN	First Nations
FNQ	Far North Queensland
HHS	Hospital and Health Service
HR	Human Resources
IUIH	Institute for Urban Indigenous Health
IWC	Indigenous Wellbeing Centre
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)
WHO	World Health Organization

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