First Nations Health Equity In Action Conference 2022-23

OUTCOME REPORT

12-13 October 2023
Brisbane Convention and Exhibition Centre

22 Cox Road, Windsor, Queensland 4030

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https://www.iuih.org.au/

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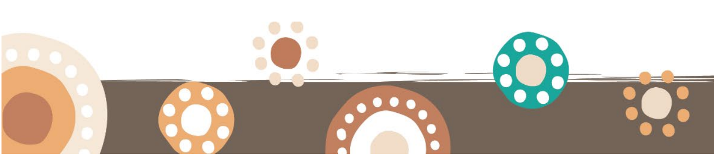
Please note: Throughout this document, the term *mainstream* is used to describe an organisation/practitioner that provides services to the general population (e.g. a private general practitioner, a hospital, a community mental health service) or a service or program that any eligible member of the Australian community may access. The terms *Indigenous-specific* or *targeted service* are used to describe services that are funded and delivered specifically to Aboriginal and/or Torres Strait Islander people and their families. A *Community Controlled Health Service* delivers a model of Indigenous-led and Indigenous-specific healthcare operated by Aboriginal and/or Torres Strait Islander non-government organisations. The terms *First Nations, Aboriginal and Torres Strait Islander* and *Indigenous* are used interchangeably with respect.



We honour the many Goori Tribal Nations whose territories we work across within South East Queensland.

We honour the legacy and the vision of those who paved the way and those who continue to guide us.

We honour our future generations by maintaining the vision with focused determination.

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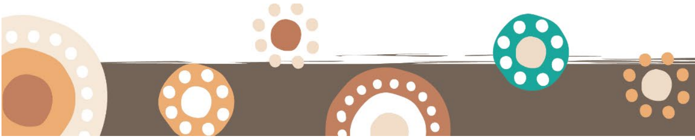

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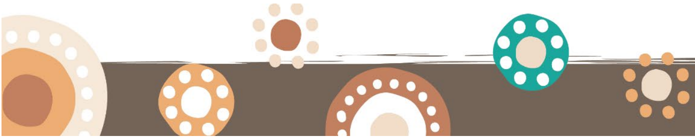


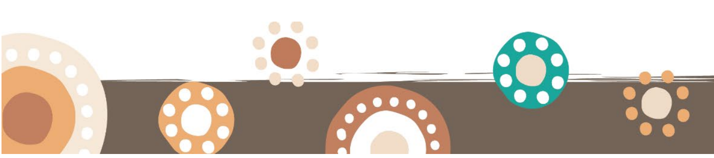
Abbreviations

AMS	Aboriginal Medical Service
ATSICHS	Aboriginal and Torres Strait Islander Community Health Service Brisbane Limited
BIOC	Birthing in Our Community Program
CCHS	Community Controlled Health Service
CHQ	Children's Health Queensland
DAMA	Discharge Against Medical Advice
HHS	Hospital and Health Service
IHLOs	Indigenous Hospital Liaison Officers
IROC	Indigenous Respiratory Outreach Care Program
ISEQ-NMHSPF	Indigenous SEQ National Mental Health Service Planning Framework Project
IUIH	Institute for Urban Indigenous Health
KPA	Key Priority Area
MATSICHS	Moreton Aboriginal and Torres Strait Islander Community Health Service
NMHSPF	National Mental Health Service Planning Framework
PHN	Primary Health Network
POWA	Pathways Our Way Academy, Institute for Urban Indigenous Health
QCMHR	Queensland Centre for Mental Health Research, The University of Queensland
QUIMHS	Queensland Urban Indigenous Mental Health Survey
SEQ	South East Queensland
UQ	The University of Queensland
WHO	World Health Organization

Appreciations

The SEQ First Nations Health Equity Governance Committee expresses our appreciation to:

- Members of the Conference Organising Working Group – Alison Nelson, Marianna Serghi, Renee Brown, and Kerry Skillington (IUIH), Warwick Pawsey (Brisbane North PHN) and Mary Jane Capp (Mater HHS) for planning and development.
- Members of the IUIH Organisational Development and Policy Teams for support on the day.
- All chairs, speakers, workshop convenors, and workshop scribes.
- The Murri School and Murri School dancers.
- Deadly Start Program Graduates and Powa Trainee Graduates
- Elders, community members, and all conference participants for taking time out of busy days to engage so fully in this conference.



Executive Summary

The second **SEQ First Nations Health Equity in Action Conference** was held from 12 to 13 October 2023, at the Brisbane Convention and Exhibition Centre in Brisbane, Australia. This annual event, hosted by the South East Queensland (SEQ) First Nations Health Equity Governance Committee, serves as a platform to reflect on the achievements of the SEQ First Nations Health Equity partnership by highlighting innovative and collaborative programs, services and initiatives, and fostering the exchange of knowledge and insights from across the region.

The primary objectives of the conference are to facilitate the sharing of best practices, promote collaborative learning, and encourage the replication and expansion of key priorities outlined in the *SEQ First Nations Health Equity Strategy*[1].

Attended by 274 participants, the conference drew participation from the board members, executives, operational staff, from the SEQ First Nations Health Equity Partner Organisations:

- The Hospital and Health Services (HHSs) in SEQ: Metro North HHS, Metro South HHS, West Moreton HHS, Gold Coast HHS, and Children's Health Queensland (CHQ).
- The Mater Health Service
- The four Primary Health Networks (PHNs) in SEQ: Brisbane North PHN, Brisbane South PHN, Darling Downs and West Moreton PHN, and Gold Coast PHN.
- The Institute for Urban Indigenous Health (IUIH) and all the Aboriginal and Torres Strait Islander Community Controlled Health Organisations (CCHOs) that form the IUIH Network: the Aboriginal and Torres Strait Islander Community Health Service (ATSICHS) Brisbane, Kalwun Community Development Corporation, Kambu Aboriginal and Torres Strait Islander Corporation for Health, Yulu-Burri-Ba Aboriginal Corporation for Community Health, and the Moreton ATSICHS.

It was also a privilege as part of the SEQ First Nations Health Equity commitment to transparency and accountability to community to host an increasing number of community participants this year.

The Conference gave participants an opportunity to learn more about:

- The regional partnership approach to Closing the Gap and achieving health equity through implementation of the *SEQ First Nations Health Equity Strategy 2021-31*.
- Practical ways of operationalising the aspirations of the *SEQ First Nations Health Equity Strategy,* through a showcase of effective service models and partnerships, and the identification of opportunities, for innovative scale up and/or replication, with updates on projects highlighted at the 2022 conference.

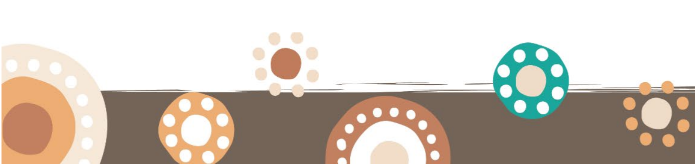
[1] Available here: https://www.iuih.org.au/strategic-documents/corporate-documents/south-east-queensland-first-nations-health-equity-strategy/?layout=default

- The need to take a whole of health system approach if we are to effect change together to Close the Gap and achieve health equity in SEQ., and the opportunities that could present through funding reform to achieve better outcomes.
- What the latest data says about the health and wellbeing of Aboriginal and Torres Strait Islander people in SEQ, and how the data is trending.

Key themes

Key themes that emerged in Conference workshops and participant feedback were:

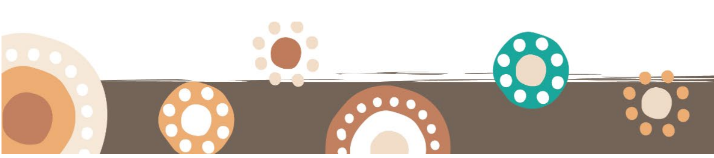
Theme	Description
Workforce Development:	•the importance of continuing to build pathways for the First Nations workforce through strategies for early engagement, diverse pathways, and creating a supportive and culturally safe environment for workforce development, including mentorship and ongoing training.
Cultural Competence and Safety:	•the essential need for programs, services and health care organisations to be culturally appropriate for staff and the community, and for cultural safety to be a priority for all levels and all parts of healthcare organisations.
Partnerships and Collaboration:	•the value of committing to respectful and enduring partnerships, that enable sharing of skills, expertise and resources to deliver the best health outcomes for clients.
Preventative Approaches and Holistic Care:	•the advantage of preventative approaches and a holistic, outreach-based model of care, particularly the need to address underlying issues causing health challenges and provide early intervention.
Data and Communication:	•the value of streamlining data systems, improving communication between services, and reframing language for better understanding. Longitudinal studies, data transparency, and effective communication are crucial for success.
Health System Navigation and Integration:	•the need for a system focused approach that integrates care and ensures a smooth transition of people across the healthcare continuum, making care accessible to community. Programs should aim to reduce barriers, streamline referral processes, and enhance coordination.
Continuous Learning and Improvement:	•continuous learning, innovation, and a commitment to challenge existing ways of working is essential. Programs should embrace learning from successes and failures, value lived experience, and incorporate feedback for co-designed service responses.
Leadership and Advocacy:	•leadership is crucial for securing resources, advocating for community needs, and driving system reform.
Community-Centred Approach:	•successful of programs are community-centred, value community engagement and social interactions, bring healthcare to the community, and are flexible, supportive, and tailored to individual client and family goals and preferences.
Expansion:	•scaling up and/or replicating good practice and service models that have proved successful is essential.



Take Away Actions

Throughout the conference, participants were encouraged and challenged to apply the knowledge, learnings and connections acquired over the two days of the conference in their workplace, including to implement priorities committed to under the SEQ First Nations Health Equity Strategy.

- Talk to a colleague about something you learnt at the conference
- Connect with SEQ FNHE Partners (local Hospital and Health Services, ATSICCHO, PHNs, and the Mater) about opportunities to improve care pathways for First Nations people
- Test the systems and processes in your organisations for staff or patients to raise concerns about racism
- Support secondments for staff and rotations for students between partner organisations.
- Systematise offering a referral to Mob Link on discharge from hospital or the emergency department
- Implement the Better Together Medications program



Background

Queensland's Aboriginal and Torres Strait Islander Health Equity Framework

The *Making Tracks Together - Queensland's Aboriginal and Torres Strait Islander Health Equity Framework*[2] is the cornerstone document placing Aboriginal and Torres Strait Islander peoples and voices at the centre of healthcare service design and delivery across Queensland. This complements the legislative requirement passed by the Queensland Parliament in 2020 and 2021 for Hospital and Health Services (HHSs) to co-develop and co-implement First Nations Health Equity Strategies with Aboriginal and Torres Strait Islander people and organisations.

For the first time, a commitment to working in partnership with prescribed Aboriginal and Torres Strait Islander stakeholders is embedded in the legal framework guiding the public health system in Queensland. In South East Queensland (SEQ), the partners have established a governance structure, and developed and endorsed a ten-year regional health strategy.

Overview of the SEQ First Nations Health Equity Strategy (2021-31)

The ***SEQ First Nations Health Equity Strategy (2021-31)*** (Regional Strategy)[3] was approved by all partners in April 2022. It aims to accelerate the pace of health system reform in SEQ to close the health gap between First Nations people and other Queenslanders by 2031.

The Regional Strategy further aims to strengthen targeted services, supports and programs for First Nations peoples, to enhance the role of the Community Controlled Health Service (CCHS) sector within the health system, and to improve the cultural safety of services delivered by the HHSs, including through action to eliminate institutional racism and discrimination.

It brings together the regional network of CCHSs that comprise the IUIH Network, SEQ HHSs, CHQ, Mater Health and the SEQ PHNs to collaborate on a systems-focused and networked approach to achieving health equity and justice in the SEQ region.

SEQ First Nations Health Equity Governance

The Regional Strategy is underpinned by the *SEQ Closing the Gap Health Performance Monitoring and Reporting Framework*, which sets out agreed measures, targets and reporting mechanisms that the Governance Committee will use to monitor individual and collective efforts to achieve health equity by 2031. The Regional Strategy's Vision and Key Priority areas are highlighted below:

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[2] Available here: https://www.health.qld.gov.au/__data/assets/pdf_file/0019/1121383/health-equity-framework.pdf
[3] Ibid, pg 6.

Vision

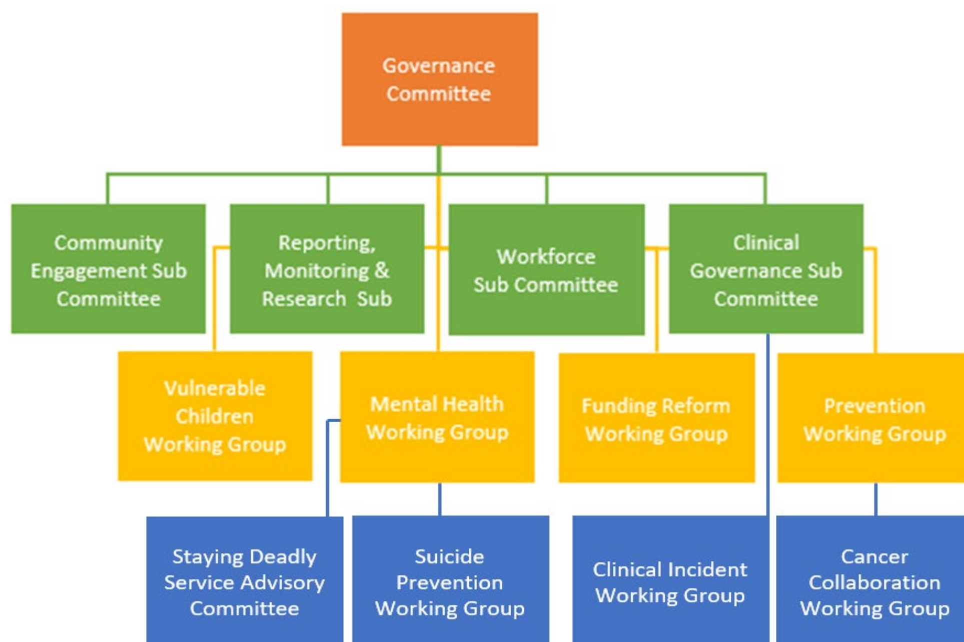
- Improved access to and experience of health services.
- First Nations people experience the same health outcomes as other Australians within our region.
- A culturally safe health system free of institutional and interpersonal racism.

Key Priority Areas

- KPA 1: Actively eliminating racial discrimination and institutional racism within services.
- KPA 2: Increasing access to healthcare services.
- KPA 3: Influencing the social, cultural, and economic determinants of health.
- KPA 4: Delivering sustainable, culturally safe, and responsive healthcare services.
- KPA 5: Working with First Nations people, communities, and organisations to design, deliver, monitor and review health services.
- KPA 6: Strengthening the First Nations health workforce.

The Regional Strategy is underpinned by a Monitoring and Reporting Framework and a Community Engagement Strategy. The SEQ First Nations Health Equity Governance Committee was established by the Partner Organisations to oversee implementation of the *Regional Strategy* and to monitor progress towards closing the gap in the SEQ region. The Governance Committee agreed to hold an annual conference to share information and learnings about partnership based service models that are working to improve access and outcomes.

SEQ FNHE Governance Structure, October 2023



Conference Overview

The **SEQ First Nations Health Equity in Action Conference** is an annual event that commenced in 2022. The 2023 Conference was hosted by the SEQ First Nations Health Equity Governance Committee, over the 12th and 13th of October 2023, at the Brisbane Convention and Exhibition Centre in Brisbane, Australia. The conference brought together stakeholders, leaders, and community members to engage in meaningful dialogue and reflect on the progress and accountability towards the objectives of the *SEQ First Nations Health Equity Strategy*. The conference showcased the collaborative activities of the SEQ First Nations partner organisations over the last 12 months and more, with the aim to share knowledge and learnings across the region, and to promote replication and scale up of priorities identified in the *SEQ First Nations Health Equity Strategy*.

The **Graduation Celebration for Deadly Start and POWA Trainees**, was delivered on the afternoon of the first day of the conference. The graduates were congratulated by delegates of the conference at an awards ceremony, with a speech by Order of Australia recipient and POWA Patron, Dr Aunty Mary Martin. The *Deadly Start Education2Employment Program* and *Pathways Our Way Academy (POWA)* coordinate school-based traineeships across HHSs and the Community-Controlled sector for Aboriginal and Torres Strait Islander students. The two programs are trialling joint intake processes as part of their commitment to the SEQ FNHE workforce strategy.

The conference event **brought together 274 participants** representing a wide range of stakeholders involved in Aboriginal and Torres Strait Islander health across SEQ.

Participants at the Conference included invited SEQ Elders and community members, and Board members, Executives, and operational staff from the SEQ First Nations Health Equity Partner Organisations, and invited professionals, policy and technical experts, government representatives, and academics.

Conference delegates were invited to ask questions, contribute to presentations, and participate in 12 group-based workshops over the two conference days. Workshop participants explored a diverse range of important issues – from growing a culturally responsive workforce to improving integrated care across primary and tertiary health care services and systems, to empowered community engagement for accountable and transparent health equity achievement. The workshops facilitated robust discussion and shared learnings to drive forward action and momentum to achieve the priority reform areas in the *SEQ First Nations Health Equity Strategy*.

Participants had valuable perspectives to offer as part of the conference panel presentations, breakout session workshops, Q&A segments, and side meetings. As with the first conference, feedback on this second conference has been very positive on the content, and on the opportunity it provided for networking, shared learning and strengthening intersectoral relationships and working partnerships.

This Report provides summaries of the conference sessions and shares the key action-oriented messages that conference participants agreed are important to advance Aboriginal and Torres Strait Islander health equity for the impactful achievement of intergenerational health justice of, for and with First Nations peoples in the SEQ region. Lessons and learnings presented in this Report will be of interest to all stakeholders who seek to advance First Nations Health Equity and Human Rights in Queensland and beyond.

Conference Program

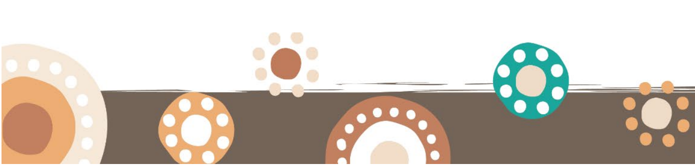
Please see Appendix 3.

Workshop Structure

Delegates attended workshops following plenary sessions, panel discussions and presentations. The workshops were focus groups fostering collective brainstorming, in-depth discussion and reflection. Each workshop heard from speakers working on collaborative projects with SEQ FNHE partners and subsequently broke into small groups to workshop a series of questions. Depending on the number of attendees and the nature of the presentations, some sessions took a less structured, whole-of-group, reflective and Q&A approach to the workshop.

Workshop Questions

The questions assigned to each workshop can be found in Appendix 2.



Conference Day 1 – Thursday 12 October 2023

Welcome to Country

The Welcome to Country was performed by the Nunukul Yuggera group[4].

We honour the many Goori Tribal Nations whose territories we work across within South-East Queensland. We honour the legacy and the vision of those who paved the way and those who continue to guide us. We honour our future generations by maintaining the vision with focused determination.

Introduction to the SEQ First Nations Health Equity Strategy

Chairs: **Kieran Chilcott** (Kalwun) and **Jim McGowan** (Metro North HHS)

Representing the SEQ FNHE Governance Committee, Kieran and Jim welcomed participants to the 2-day SEQ FNHE in Action Conference 2023 and emphasised the commitment to working in partnership in SEQ, and to accelerated action and system reform to achieve health equity by 2031. They outlined the Regional Strategy to which the Conference Program aligns and encouraged respectful communication and active participation in discussions.

Jim began by noting that "it's easy to sign a statement" to advance Aboriginal and Torres Strait Islander health equity in SEQ, but "it's important to understand we made a commitment" and "to listen and to work together to deliver outcomes". Jim emphasised that stakeholder strategies to implementing health equity across the region "must be complementary and not competitive". Jim reminded that each of the conference participants has a part to play:

"We need to move beyond care in the acute sector to the community and working collaboratively to do things differently".

Kieran began by acknowledging the investment of the Health and Hospital Services (HHSs), local Primary Health Networks (PHNs), the Mater Health Service, Children's Health Queensland and the community-controlled sector for their attendance at the conference. Kieran reminded participants that the goal to achieve First Nations Health Equity in Action in SEQ,

"This isn't work, this is our communities' lives". He emphasised, "For us, it's not about the system, it's about our people, our community, and about providing the best possible outcomes".

[4] For more information, see: https://www.nunukul-yuggera.com/.

Kieran looked forward to building on the success of last year's conference over the coming days. He acknowledged that although the community-controlled sector "has been nimble and adaptable, we haven't had the partners". Consequently, "to have everyone at the table now is heartwarming".

Kieran invited participants in coming together for the 2-day conference to lean into "our collectivism and the power of each other to go forward". Jim agreed and highlighted that until we have Aboriginal and Torres Strait Islander people at the forefront, we won't have the [health equity] impact".

Jim welcomed participants by noting "we need to be courageous in some of the decisions we need to take", reminding: "We will be judged on what it is we said we would do, and how well we do it, and the outcomes for Indigenous people down the track".

Keynote Address: Monitoring Progress – SEQ FNHE Partnership since 2020

Speakers: **Adrian Carson** (IUIH), **Adrian Clutterbuck** (CHQ)

Note: A series of data including SEQ First Nations demographic, health indicators and social determinant indicators were presented in this session. This data will form the first performance report of the SEQ First Nations Health Equity Strategy and be available in early 2024. The data will not be outlined here.

IUIH's CEO Adrian Carson welcomed all participants to the conference and began by highlighting that "what's different" about our approach to achieving First Nations health equity in SEQ is that "it's a networked approach".

"This is about the system coming together to actually achieve outcomes through action. Not just endless reports, but action. Evidence of action is evidence of impact on outcome".

He emphasised that outcomes will be achieved through action, and that the focus must remain on the performance of the health system, "not on individual services". Adrian identified four basic elements of success:

1. Strong collective commitment to collaboration
2. Governance
3. Actions
4. Measures – honest, open measures at a population level to see if we are actually making a difference and whether we are on track.

Adrian noted that looking at 'our' metrics "is a success in itself" because "we haven't done this as a collective before –

"This is our first attempt at putting together a baseline and look at [health] trends where possible. Not all data is available yet, but this is a start. This is our 'training camp' to look at this data together – as a population rather than at our individual organisational levels… We need to get used to meeting and openly sharing our data measures and findings, and holding ourselves accountable within that". – **Adrian Carson, IUIH**

Adrian noted that the social determinants are often considered outside our scope in health, "but health sits smack bang in the middle" of them. Through understanding and leveraging the data, we all can to look at the opportunities to explore the health status, impacts and/or outcomes of First Nations people in SEQ and "to use the weight of the health system" to influence other social indicators.

Adrian then set out that the first step is pulling the data together, with IUIH having a view to present regional data in an inaugural report published towards the end of the year. From there, the IUIH network will present a full scope of the region's Aboriginal and Torres Strait Islander health data though public reporting every two (2) years, noting every second year is appropriate due to data availability. The view is to look at the data for SEQ against other major urban areas in Australia.

"*Data presents the failures and success at a system-level… The big spend on Indigenous health is on people going in and out of hospital rather than keeping people well… We are going to increase the scale and pace of reform*" – **Adrian Carson, IUIH**

Adrian emphasised the need for data that provides a regional picture. Regardless of what that data says, he noted that the gap in Indigenous health won't be closed by 2031 ('the promise') and commitment in SEQ is to accelerate. He pressed that "if something works" to improve Aboriginal and Torres Strait Islander health and wellbeing regardless of whether in an Aboriginal Medical Service (AMS), HHS or PHN – "we have an obligation to support it". Adrian stressed that we also had to collectively work to overcome the myth that Mob in SEQ are part of an "urban elite" when there is widespread disadvantage in our SEQ region.

Adrian emphasised that the Aboriginal and Torres Strait Islander population in the SEQ region is growing at a high rate. Therefore, "we need to be able to grow primary care and wrap around supports" to address any patient wait lists. Available and reliable health data can help monitor that growth, and emerging health challenges among growing community, noting that "The whole system needs to move as one and close gaps across the system".

Adrian Clutterbuck acknowledged the importance yet challenge of delivering person-centred care and thanked Uncle Les for reminding the participants in the Keynote discussion that the SEQ FNHE partnership is an opportunity for leverage and spread to achieve the delivery of person-centred care. Here, Adrian Clutterbuck noted the opportunity for leverage and spread across the SEQ FNHE partners required organisational humility: "This isn't competitive. Everyone is winning through this alliance".

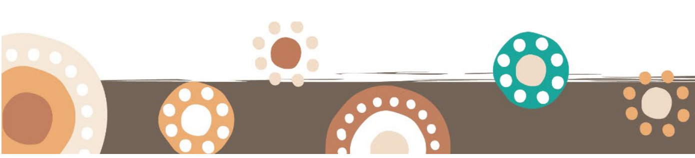
"*We need measures – honest open measures at a population level to see that we are making a difference and are on track. I want you to think about these numbers with a sense of courage and hope; courage and hope that sits in sharing data and changing them [data/statistics] over time… If we make a difference here in SEQ, that makes a difference at the national level*" - **Adrian Clutterbuck (CHQ)**

Plenary Session: Growing up Strong and Deadly Black Kids

Chair: **Simone Jackson** (Kambu Health)
Speaker: **Kristie Watego** (IUIH)

To anchor plenary discussions, Kristie began by challenging conference participants to think about services to and for Aboriginal and Torres Strait Islander children, and how we can transform the system to support families to access the support and care they need, when they need, to be Strong and Deadly: "*By families having the best possible start in life, we have the best chance of achieving health equity in the SEQ region*". As an example of how we grow up strong and deadly black kids, Kristie presented on the progress of IUIH's Birthing in Our Community (BiOC) program.

"*Our families are enough*" **– Kristie Watego**



Kristie pressed that participants need to focus on family wellbeing and strengthening families; connecting families to culture. Keeping families together must be priority. She spoke to the crucial role of the dedicated Family Support Worker in the BiOC program, who walks with families experiencing barriers to healthcare. Through BiOC, we are strengthening Mob to raise a Strong and Deadly Black Family by connecting BiOC families to culture and cultural pride; having our Indigenous staff as role models; providing BiOC Community Days that offer connections, art, activities and yarning opportunities; keeping families together by changing the representation of our Mob to Child Safety; and offering parental crafting skills and support that are culturally appropriate.

Kristie highlighted the BiOC program's strong governance structure underpinned its success, and the view to expand BiOC across the SEQ region because "demand outstrips supply".

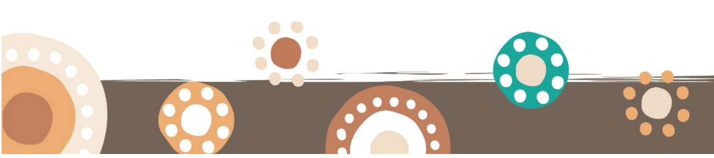
Kristie pointed to several other key factors that can be attributed to 10 years of successful BiOC operations. She began by noting that BiOC success is built on program partnerships among the actively involved health services, universities, research groups and community. Among project partners, there is collective and real willingness to consistently embed the importance of community-control and ownership into BiOC practice.

Indigenous leadership and governance is also key. Leadership is from the highest levels, with the CEOs from each partner organisation meeting quarterly as part of the joint steering committee.

"The BiOC partnership is authentic and [partner organisation] core values are aligned… There is trust and healthy conflict and rigorous and respectful debate, which reorients how we think and operate. However, delivering on obligations to Mob is at the centre of everything we do. We cannot do this without the other. Together we will always find a way" – **Kristie Watego**

Kristie considered that by partner organisations meeting here at the conference today, there is a recommitment to achieving health system reform to stop any and every First Nations baby and family from "falling between the cracks". Together, "we're changing our thinking" by coming from an Aboriginal Terms of Reference (primacy of place and family; positive group dynamics; positive conflict management; non-competitiveness and maintenance of harmonious families); creating an environment that enables families to be great families rather than providing a service delivery model; and focusing our attention on getting it right from the start not fixing what is wrong. For Kristie, this is a "heavy obligation that belongs to us all".

"We have the power to make change". – **Kristie Watego**



Day 1, Morning, Concurrent Workshop 1. Starting Strong: The impact of Birthing in Our Communities on the health of families

Chair: **Renee Blackman** (ATSICHS)
Presenters: **Kristie Watego** (IUIH), **Liz Wilkes** (My Midwives), **Invited Families**

Purpose of Workshop
Research demonstrates that improving outcomes in birthing sets a child up for a healthy life. This requires a cross-sector approach which is determined to overcome barriers for families. This session featured the Birthing in Our Community Program (BiOC) and the ways in which partnerships between community-controlled health services, hospitals and community midwifery have produced outstanding outcomes for Aboriginal and Torres Strait Islander babies and their families, including preterm birth rates of 6% compared to 14% (national rate), and almost closing the gap between First Nations preterm births and those of other Australians.
Relevant SEQ First Nations Health Equity Strategy KPAs
KPA 2: Increasing access to healthcare services. KPA 4: Delivering sustainable, culturally safe, and responsive healthcare services. KPA 5: Working with First Nations people, communities, and organisations to design, deliver, monitor and review health services. Key Priority Reform Area 5.1.1: Build on and replicate effective service delivery partnership models already established in SEQ, including (but not limited to): • Surgical Pathways • Birthing in our Community services • Gynaecological care pathways • Hospital in the Home arrangements • Oral health services • Prison transition services

Kristie Watego (IUIH) led the session with an overview of the BiOC program and explained that BiOC is about "raising a strong, black, deadly family". BiOC is continuing to expand across SEQ with partnerships on the northside between My Midwives and Brisbane ATSICHS, in Logan between Brisbane ATSICHS, Logan Hospital, and Mater Health Services, and in the Redland Bay area between Yulu-Burri-Ba and Metro South.

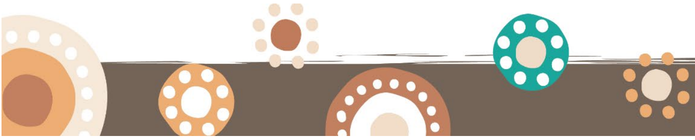
Kristie emphasises that while the program is rapidly expanding, it is critical to ensure the program remains family-centred and guided by the notion that "birth is a significant life event".

She then explained how the program is applicable to other regions without a hub with reference to the model at Redland Bay which has been operating for years. She highlighted that the model allows for families to remain connected to their Aboriginal Community-Controlled Organisation and provide wrap-around supports.

Collaborative work on BiOC means that the partner organisations are moving to one healthcare database to manage care plans. This has enabled the partners to work closely to develop a strategy on how to navigate care plan sharing which entails regular yarning, case conferencing, and reviewing between midwives and health professionals.

Kristie then focused on the role of Dad's in BiOC. The Deadly Dad's program is founded upon the view to maintain a family-centred approach. The program involves a male social worker who works with the family and are currently trialling a program for Dad's to come in and have a yarn with the social worker on a Friday afternoon.

"We have never promoted BiOC, it is the power of the Murri grapevine." **– Kristie Watego**



Kristie continued, "Logan is 12 months old, it is booked out, has a waitlist.". As demand continues to outweigh capacity, BiOC is looking for opportunities to expand.

Next, a panel yarn was held with **Renee Blackman** (Brisbane ATSICHS), **Jo Costello** (IUIH), and **Liz Wilkes** (My Midwives). After introductions, the panel was asked how the partnership has worked from their perspective. The panel reflected that aligned organisational values and goals enable a positive working relationship. Liz added that listening and learning from their partner organisation encouraged positive outcomes for both families and the partnership. Renee concluded, "From an Aboriginal and Torres Strait Islander perspective, coming to this partnership, you come with scepticism. I was pleasantly surprised, there was genuine commitment.".

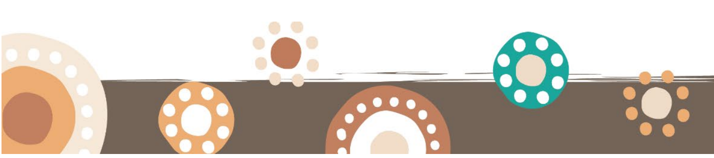
"When you hit the bumpy bits, and there were plenty, we committed to coming together every time, we committed to solutions." **– Renee Blackman**

The panel then discussed the wrap-around and integrated support of the BiOC model. Liz remarked that BiOC recognises the midwifery model of care is just one constituent of the bigger system of care and systems change requires a whole-of-system consideration to make the most impact in families lives. Jo added that the BiOC model is all about "creating a safe space for women and families" and that this notion is "rippling into mainstream services too".

"It's got generational impact and it's profound." **– Renee Blackman**

Feedback from workshop participants
Staying Strong: The impact of Birthing in Our Communities on the health of families

- Workforce – Build more pathways to grow and maintain the First Nations workforce.
- Family-centred support program – family-centred values produces wrap around-support and lifelong effects on wellbeing.
- The BiOC model is easily integrated – the BiOC model can be seamlessly integrated across the lifespan and across many health fields.
- How can the strengths of partners be harnessed? – How can we learn from BiOC?
- Funding – how can we reconsider/redistribute funding models to grow the program? Where are the new funding opportunities?
- Leadership – more leadership is needed to secure resources and opportunities for partnership and expansion.
- Data - more longitudinal studies conducted and data access transparency across partners is critical to support the program.
- Health promotion – what are some ways that the successes of this program can be shared to stimulate systems change?
- Understanding cultural challenges – what are the cultural barriers?
- Expansion – Identify organisations with similar models and values and areas of opportunity.
- More Dad's programs – must consider the expansion of Dad's programs for the family-centred support.
- Partnerships – more networking across the sector to address challenges, avoid duplication, and expand. Barriers such as competitors and limited funding can be tackled as a collective with consistent messaging about the value of the program.



Day 1, Morning, Concurrent Workshop 2. Growing Strong: culturally responsive multi-disciplinary paediatric services closer to home

Chair: **Renee Brown** (IUIH)
Presenters: **Chrisdell McLaren** (IUIH), **Sharon Sweeney** (BNPHN), **Milly Phillips** (IUIH)

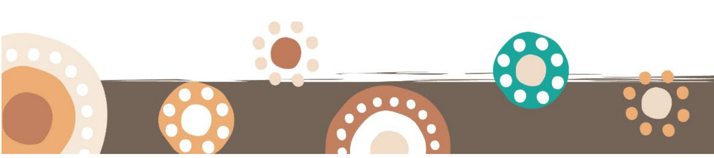
Purpose of Workshop
The First Nations Health Equity agenda requires re-orientation of systems and thinking outside of traditional siloes. When it comes to growing strong children, this means thinking about child development and what supports this from both a preventative and treatment perspective. This session featured a range of initiatives which aim to integrate the early childhood development/health sectors and build on propa cultural ways with support from PHNs and Queensland Health. These include the Deadly Kindies intensive playgroups, intergenerational programs, multi-disciplinary team assessments and supporting the growth of Paediatric Registrars.
Relevant SEQ First Nations Health Equity Strategy KPAs
KPA 2: Increasing access to healthcare services. KPA 3: Influencing the social, cultural, and economic determinants of health Key Priority Reform Area 3.2.4: Accelerate efforts to close the gap in early childhood health and education outcomes by supporting community controlled models of service delivery that integrate early childhood clinical therapies and learning KPA 4: Delivering sustainable, culturally safe, and responsive healthcare services. KPA 5: Working with First Nations people, communities, and organisations to design, deliver, monitor and review health services.

This workshop commenced with **Chrisdell McLaren and Milly Phillips (IUIH)** describing IUIH's approach to working with children and families in a culturally centred way within a family-centred practice framework. All interventions focused on children are considered in relation to the impact on the whole family – what the family needs, when it is needed, where it is needed and how the family needs that care delivered. Chrisdell and Milly discussed IUIH services that embrace such a model, including:

- BiOC's Early Learning Program, which provides playgroups and home visits to support early childhood education for Indigenous children and their families.
- Deadly Kindies program, which commenced in 2016 as a response to the disparity between Indigenous and non-Indigenous children's access to kindy across SEQ. Deadly Kindies leverages incentives (families need to have had 715 health checks) and helps to reduce out-of-pocket expenses for families and supports them to access kindy enrolment.
- A school readiness program, funded by Brisbane North PHN, which helped facilitate access to specialist, place-based paediatric services in kindies on the Northside of Brisbane. The program aims to link kids and families with services to support them to be school-ready, such as oral health, audiology and optometry. The program takes a long-term, sustainable approach to ensuring Aboriginal and Torres Strait Islander kids get the best start in education.

Chrisdell and Milly also highlighted the importance of developing a culturally informed workforce to deliver culturally responsive services to children and families. Within IUIH, this is achieved through a number of initiatives, such as:

- offering student placements within IUIH child and family services
- placement for a paediatric registrar, to expand IUIH's capacity to deliver paediatric services and ensure the future medical workforce accesses culturally appropriate training

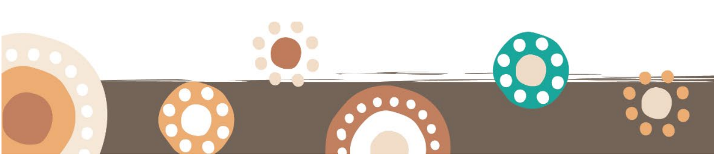


- Brisbane North PHN Intergenerational Program, which links Elders and high school-based trainees, providing health-based, social, educational and cultural connections and yarning
- partnering with CHQ to co-locate staff in IUIH services and offer placements to nursing graduates.

Working collaboratively with SEQ First Nations Health Equity partners in these endeavours is crucial but it is also important to consider how these partnerships work for Aboriginal and Torres Strait Islander people and how relationship building and benefits for Mob are built into contractual agreements. In terms of IUIH's partnership with Brisbane North PHN, this has involved open and honest discussion, the PHN visiting local kindies and genuinely engaging with them to truly understand their needs, and ensuring performance reporting is meaningful so that the PHN can see the positive outcomes of their funding. Building trust happens over time and with a great track record of working together, it is possible to set broad parameters for a program and have the basis of respect to allow each partner to 'get on with it' without micromanagement.

Feedback from workshop participants
Growing Strong: Culturally responsive multidisciplinary paediatric services closer to home

- Supporting the workforce to become culturally safe.
- Collaboration between education and health – thinking outside the box and connecting with different sectors.
- Flexibility in reporting mechanisms.
- Models of care involving the whole family.
- It's not a one-size-fits-all model – ensure community engagement in the local area to adapt to local needs.
- Replicating partnership models in other areas – PHNs working closer together to identify where programs can be replicated.
- Continue to develop culturally appropriate assessment and screening tools.
- Collaboration across agencies – learning from each other and not re-inventing the wheel.
- Working to upskill the existing and future workforce.
- More promotion of IUIH programs as some people weren't aware they were available.
- Integration is key.
- The advantage of preventative approaches rather than crisis/acute care.
- Taking a lifespan, holistic approach.
- Workforce development opportunities within existing programs, such as GP and paediatric registrar training – learnings can be taken to other environments and increase cultural understanding and team-based models of care.



Day 1, Morning, Concurrent Workshop 3. Staying Strong: Creating access and support pathways for children and families across the health sector

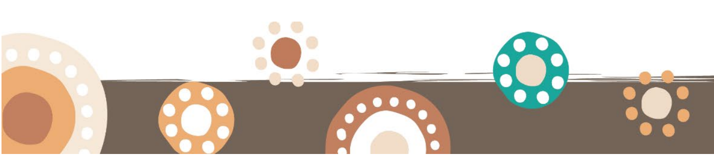
Chairs: **Kaava Watson** (IUIH) and **Dom Tait** (CHQ)
Presenters: **Jarryd Stanley** (Kalwun), **Chantelle Howse** (GCPHN), **Alf Davis** (IUIH), **Maria Uhr** (IUIH/CHQ)

Purpose of Workshop
The rates of First Nations children in out of home care continue to be alarming. These children often experience the added disadvantage of fragmented health care which increases their vulnerability. This session featured a discussion by some of the members of the FNHE Vulnerable Children Working Group about the progress made towards improving access and continuity of health care for children in out of home care.
Relevant SEQ First Nations Health Equity Strategy KPAs
KPA 2: Increasing access to healthcare services. KPA 3: Influencing the social, cultural, and economic determinants of health Key Priority Reform Area 3.3.5: Work with CCHSs and child protection agencies to support families to stay together and reduce rates of children in out of home care KPA 4: Delivering sustainable, culturally safe, and responsive healthcare services. KPA 5: Working with First Nations people, communities, and organisations to design, deliver, monitor and review health services.

Jarryd Stanley (Kalwun) and **Chantelle Howse** (GC PHN) opened the session with an overview of the *Strengthening Health Assessment Pathways* (SHAP) program. Initiated in 2008 and founded on an evidence base from the Victorian Royal Commission, SHAP responded to the national clinical assessment framework for children and young people in out of home care (OOHC), aiming to address the concerning fact that 96% of children in OOHC suffer from chronic illnesses. The program's objective shifted in 2020 towards implementing SHAP in health services in partnership with Kalwun. Its main objective was to collaborate with child safety services to connect children, especially those entering the system under two-year child protection orders, to Kalwun health services. The referral process, relying heavily on child safety health liaison officers, underscored the importance of consistent communication and partnership. By 2022, the program had strengthened its information sharing, coordination between child safety and Kalwun health services, and leadership in community practice. The program's evaluation demonstrated its success, particularly in the creation of Health Management Plans (HMPs) and the adoption of a family-inclusive approach to healthcare.

Maria Uhr (IUIH/CHQ) then led an overview of the CHQ-IUIH Pathway, emphasising the collaborative efforts between CHQ and the IUIH. Maria emphasised the importance of providing inclusive and comprehensive care for children with diverse needs, including youth experiencing homelessness and those in OOHC. She highlighted the critical role of community liaison officers as key facilitators, serving as a protective and connecting bridge between families and healthcare services. A case study featured in this session underscored the significance of the partnership in the collaborative care model, particularly in scenarios demanding specialised health care. It detailed the journey of a child with diabetes who had faced challenges in accessing consistent medical care. This situation, which was being misinterpreted by child safety, was instead recognised as a complex barrier to healthcare. The partnership's proactive approach to identifying and addressing these obstacles showcased a nuanced understanding of the child's needs and the dynamic factors affecting his care.

The workshop concluded with reflections from **Kaava Watson** (IUIH) and **Dom Tait (CHQ)**, reiterating the importance of the workforce in coordinating care and breaking down systemic barriers. Kaava emphasised that system reform is not only about structural changes but also hinges



on relationship building and the dedication of passionate individuals. Dom highlighted the strength that comes from enduring partnerships and collective commitments.

Feedback from workshop participants
Staying Strong: Creating access and support pathways for children and families across the health sector

- **Workforce** – dedicated personnel are needed to break barriers.
- **Partnerships** – system reform can be achieved with the power of unity.
- **Commitment** – change can be achieved with reaffirmed commitment to the mission.
- **Lessons learned** – working collectively is learning from each other's successes and failures and understanding each other's strengths and weaknesses.

What is BiOC? How do we know it works?

The Birthing in Our Community Program (BiOC) has key partnerships between My Midwives and Brisbane ATSICHS, Brisbane ATSICHS, Logan Hospital, and Mater Health Services, and Yulu-Burri-Ba and Metro South HHSs, collectively producing outstanding outcomes for Aboriginal and Torres Strait Islander babies and their families.

The program was established in 2013 by IUIH and ATSICHS Brisbane in partnership with the Mater Mothers' Hospital. Today, BiOC operates in Salisbury, Strathpine, Logan Central, and in Redland Bay. All services emphasise and facilitate continuity of care. Supports within the service include a dedicated midwife, a First Nations family support worker and health team, and transport services throughout pregnancy, birthing, and postnatal care.

Research published in the Lancet Global Health journal in 2021 found that women taking part in the community-led birthing program are 50% less likely to have a premature baby, and more likely to be able to breastfeed and access antenatal care than those using standard maternity care. The study found that women accessing the program are:

- Less likely to need a caesarean delivery.
- Less likely to have their baby admitted to the neonatal care nursery.
- More likely to attend 5 or more antenatal appointments.
- More likely to exclusively breastfeed on discharge.

These results are both dramatic and unprecedented - not only closing the preterm birth gap but delivering rates (6.6%) that are now better than mainstream (8.2%). BiOC has exceeded the 2031 Close the Gap Agreement healthy birthweight target (91%) and is delivering optimal birthweights at a better rate than mainstream services (92.7% compared to 92.5%).

Afternoon Session: Strong and Deadly Futures

Chairs: **David Collins** (Yulu-Burri-Ba), **Mike Bosel** (Brisbane South PHN)
Entertainment: Murri School Dancers

David and Mike outlined the importance of health services connecting with young people in strengths-based, community settings to promote positive health and wellbeing. David highlighted the Junior Murri Carnival as an exemplar of this approach. A short video clip of the 2023 carnival was played, with highlights of the dreams and aspirations of the children and young people who attended.

The Junior Murri Carnival is part of the broader Queensland Murri Carnival. Established in 2011, the Queensland Murri Carnival draws on the popularity of rugby league in Aboriginal and Torres Strait Islander communities to promote the value of health and education to young Indigenous people. The Murri Carnival aims to increase the profile of Indigenous Rugby League and enable further outreach to promote health and education.

Described as a modern-day corroboree, Mob flock from far and wide to attend and connect with community and culture. To participate in the Carnival, players are required to complete an up-to-date MBS 715 health check, and have 90% school attendance (for under 16s).

The 2023 Queensland Murri Carnival was the largest held in the history of the event, with a record 98 teams (comprising more than 2,600 players) registered to participate in the Queensland Murri Carnival, and 750 children aged 6-12 years registered to play in the Junior Murri Carnival. The event was held across eight days from 22nd to 29th of September at Redcliffe Dolphins Rugby League Complex, Redcliffe. Over 50,000 people gathered to watch, with teams participating from Far North Queensland, Townsville and Mackay, Central Queensland, Sunshine Coast, Greater South-West, Cherbourg, Toowoomba and all parts of the SEQ Region. The event games were live streamed via Facebook, with over 113,000 views.

The 2023 Murri Carnival was utilised by SEQ First Nations Health Equity partners in a practical and community-facing way to advance several of the agreed key priorities identified in the SEQ First Nations Health Equity Strategy 2021-31. Prime locations were secured for the staging of a series of joint HHS/CCHO activations that targeted agreed priorities. This included cancer screening and health promotion, Deadly Jobs employment expo, community engagement, as well as dedicated spaces for kids and elders.

Plenary Address: Accelerating the training and employment pipeline

Speakers: **Kipley Nink** (Jobs Queensland), **Tracy Hill** (IUIH)

Purpose of Plenary Session
The purpose of the plenary session was to provide an overview of the First Nations Health Workforce, and highlighting the IUIH POWA program and employment pipeline.
Relevant SEQ First Nations Health Equity Strategy KPAs
KPA 2: Increasing access to healthcare services. KPA 3: Influencing the social, cultural, and economic determinants of health Key Priority Reform Area 3.1.1: Identify and establish cross-agency partnerships to develop regional responses to the determinants of health, particularly with the education, housing, and justice sectors. KPA 4: Delivering sustainable, culturally safe, and responsive healthcare services. KPA 6: Strengthening the First Nations health workforce. Key Priority Reform Area 6.3.2: Increase the number of First Nations people in clinical roles

Kipley, A/Director, Research, Projects and Policy at Jobs Queensland, introduced Jobs Queensland as a "statutory entity providing strategic advice to the State Government on three primary areas: Future Skill Needs, Workforce Planning & Development, and the Apprenticeship & Traineeship system". She went on to detail the latest at Jobs Queensland – Round 1 of the Queensland Care Consortium project is underway and an important initiative under the *Queensland Workforce Strategy 2022-2032*. The Queensland Care Consortium[5] is a collaborative project between key peak bodies and partners, designed to address workforce retention and workforce attraction challenges in the workplace. Kipley highlighted that Round 2 funding will be opening in 2024.

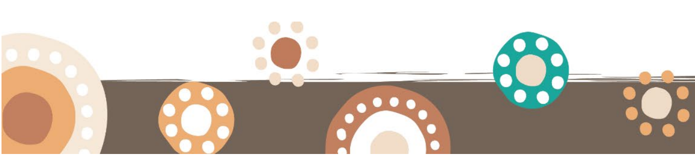
The audience was then grounded with an impressive snapshot of Queensland's current healthcare and social assistance workforce - there is a total of 400,000 healthcare and social assistance workers across the state and of those,

"one-third are employed in hospitals, one-fifth work in social assistance services, and one-seventh work in allied health." **– Kipley Nink**

Most alarmingly, Kipley emphasized that job vacancy growth has accelerated since the emergence of COVID-19 in 2020 and the nursing profession has suffered the most vacancies of all professions. In the same period demand for general practitioner primary health care has doubled.

The presenter then prompted the audience, "So, where are we going now?", leading smoothly to the *Jobs Queensland* 'Anticipating Future Skills Dashboard', a resource displaying employment projections at the regional and occupational level. By 2025-26, there will be approximately 2.9 million Queensland workers. Categorising these workers by industry revealed that currently the Healthcare and Social Assistance industry is the biggest employer in many Queensland regions and it is estimated to become the fastest growing industry at a rate higher than the state average. In SEQ, projections estimate that social assistance services will have the most expansion and registered nurses and disability carers will be the highest sought out profession by 2026. "Presently, SEQ First Nations employment in the healthcare and social assistance sector revealed that 4,995 First Nations people were employed, contributing to 2.1% of the total sector workforce".

[5] For more information, see: https://jobsqueensland.qld.gov.au/current-partnerships/queensland-care-consortium/.



First Nations workforce in the sector are most likely to be employed within hospitals or other social assistance services. High-demand roles in the First Nations workforce included child-care workers and aged and disabled carers. While, gaps in other healthcare service roles in the First Nations workforce included ambulance and blood bank workers.

Kipley articulated that parallel to the rapid progression of this sector, enrolments in health-related disciplines are rising annually and the completion rate has increased to approximately 98%. She noted that while public health is the biggest discipline of growth, it is "positive to see the diversification away from public health [across other disciplines]".

Tracy Hill, IUIH's Pathways Our Way Academy (POWA) Manager, built on Kipley's snapshot of SEQ First Nations employment bringing the audience back to the fundamental questions: why and how? She began by contextualising employment (or household income) as the primary predetermining factor of the social determinants of health and therefore, is the most significant predictor to target for improved health outcomes. Delving into progress, she highlighted the recent SEQ FNHE Workforce Symposium held in March 2023 which initiated the recently endorsed and equity-focused SEQ FNHE Workforce Strategy. The Strategy constitutes 23 actions over a five-year period to improve workforce outcomes for First Nations people in SEQ.

"We need to think about training and employment from an equity lens." – **Tracy Hill**

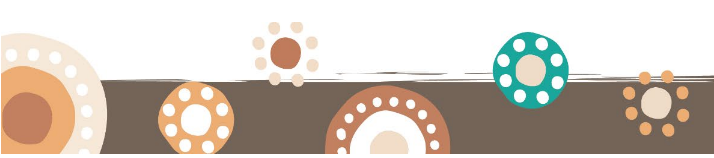
Tracy then reflected on the last 12 months and in particular, progress made towards approaching First Nations traineeships as a whole of health sector. This has included trialling a joint traineeship recruitment strategy so First Nations trainees can be matched to hospitals and/or community-controlled opportunities according to their interests and level of support needs.

What is POWA?

POWA is a culturally anchored and collaborative wrap-around support program led by the Institute for Urban Indigenous Health and supported by partner universities, Registered Training Organisations (RTO), and the Department of Employment, Small Businesses and Training (DEBST). POWA prioritises person-centred care and personalises training and traineeship opportunities to meet the goals and needs of individual students.

Tracy concluded the session by highlighting that we can increase participation in First Nations programs by breaking barriers from the beginning. First Nations people can be connected into the pipeline through engagement with schools, trainees, and community activities and mechanisms such as cadetships and traineeships.

"We need to invest now, to have a workforce in 10 years." – **Tracy Hill**



Day 1, Afternoon, Concurrent Workshop 1. Strong and Deadly Futures: Entry into the training and employment pipeline

Chair: **Jackie Hansen** (MNHHS) and **Fiona Hinchliffe** (Mater HHS)
Presenters: **Vivienne Hassed** (MNHSS), **Tracy Hill** (IUIH), **Billie-Lee Boudar** (IUIH) and **Lili-Jade Malone** (MNHHS)

Purpose of Workshop
In this session, delegates heard about the progress made in the last 12 months to connect up parts of the training and employment pipeline across the health sector so that each part of the system is working to its strengths and we are providing the best possible pathway for each trainee. Learn from those who have walked the walk to explore ways in which we can develop a pipeline into health that is both culturally safe and offers real growth opportunities across the whole health sector.
Relevant SEQ First Nations Health Equity Strategy KPAs
KPA 2: Increasing access to healthcare services. KPA 3: Influencing the social, cultural, and economic determinants of health Key Priority Reform Area 3.1.1: Identify and establish cross-agency partnerships to develop regional responses to the determinants of health, particularly with the education, housing, and justice sectors. KPA 4: Delivering sustainable, culturally safe, and responsive healthcare services. KPA 6: Strengthening the First Nations health workforce. Key Priority Reform Area 6.2: Increase the number of First Nations people in clinical roles

Vivienne Hassed (MNHHS) and **Tracy Hill** (IUIH) contextualised the session by informing the group on the successful collaborative work done by the Metro North Hospital and Health Service Deadly Start Education Program and the IUIH POWA Program. The Deadly Start Education Program is a First Nations trainee initiative supporting high-school students on their healthcare career journey; enabling students to work one day per week in a range of participating hospitals. Conjointly, teams of each program alternate visiting days at schools and participated in a joint stall at the Junior Murri Carnival. The Junior Murri Carnival generated high engagement with approximately 300 expressions of interest over the three days.

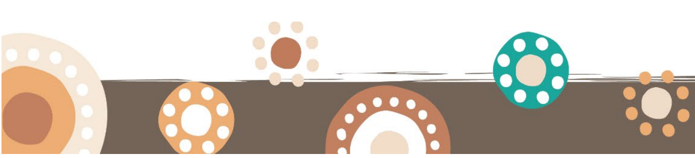
Tracy and Vivienne highlighted that their successes are attributable to united and collaborative work; emphasising that more work can be done to build more partnerships across the region.

To compliment this, **Fiona Hinchliffe** (Mater HHS) continued the session with an overview of the success of the Mater-IUIH partnership. The Mater Hospital's 'Improving Pathways to Physiotherapy for First Nations Students' program enables students to experience an 'Allied Health Simulation Day' which includes hands-on and action-packed clinical simulation activities based at the Mater Hospital. POWA and Deadly Start Education programs work in conjunction with the Mater to refer students for the Simulation day with a keen interest in health. Fiona emphasised that "100% of students said the program met their expectations for hands-on activities".

Fiona then introduced graduates of the POWA and Deadly Start Education programs, **Billie-Lee Boudar** (IUIH) and **Lili-Jade Malone** (MNHHS), who reflected on their journey and how their respective programs supported them to get where they wanted to go.

"POWA academy supported my dream to be in health." – **Billie-Lee Boudar**

Jackie Hansen (MNHHS) summarised the presentation with a call to action: "education and employment is the key. We have to grow the pipeline faster than what we are doing.". She stressed "we need to have the communities' trust.".



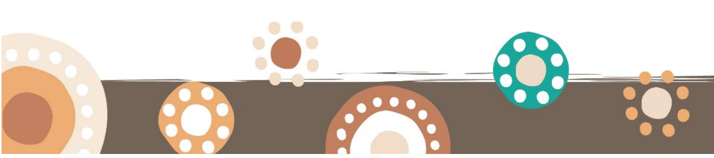
Feedback from workshop participants
Strong and Deadly Futures: Entry into the training and employment pipeline

- **More First Nations mentors** for students are needed.
- **How can more career pathways and training opportunities be integrated in the broader primary care landscape**. Are there opportunities to link in with current programs?
- **Programs need to seek to understand the individual goals, interests and needs** of a trainee and **offer pathways/roles that are flexible** to change and preferences.
- **Programs pathways must be diverse** and **supports available** to link trainees into **any opportunity.**
- **Programs should offer more hands-on and practical activities** for better engagement and exposure to different fields.
- Consider how can programs **support kids to remain on Country** to do training.
- Identified programs such as POWA already identify students. **How can programs leverage off POWA, rather than duplicate**?
- There needs to be **more opportunities to offer positions at the end of a traineeship**.
- Create a **safe space for students with the right supports.**
- Take action to **ensure the Reconciliation Action Plan** and **First Nations Health Equity plans** are **culturally appropriate** and have discussions about what this looks like.
- **Reinforce efforts and commitment** to supporting these programs.
- **Strategies for monitoring the growth** of a First Nations workforce include: development of a **data hub**, encouraging **staff to update their identification** and **asking staff for interest in traineeships**.
- **Build more connections**.
- **Work together to 'grow the pool'** rather than competing for the same staff.

Day 1, Afternoon, Concurrent Workshop 2. Strong and Deadly Futures: Moving through the pipeline

Chair: **Alison Nelson** (IUIH)
Presenters: **Michelle Stute** (MNHHS), **Angela Young** (CHQ), **Taliyah Hawkins**, **Loni McIlvena** (IUIH) and **Rhea Waia** (MNHHS).

Purpose of Workshop
In this session, delegates heard about ways that we are making it easier for Aboriginal and Torres Strait Islander people and their employers to identify and create employment opportunities beyond traineeships. In particular, delegates learned from those who have travelled through the workforce pipeline and into further employment and/or study. Hear about ways in which we are supporting opportunities and opening pathways with innovative employment initiatives and supports, including Indigenous cadetship and their CHQ-led Talent Pool.
Relevant SEQ First Nations Health Equity Strategy KPAs
KPA 2: Increasing access to healthcare services. KPA 3: Influencing the social, cultural, and economic determinants of health Key Priority Reform Area 3.1.1: Identify and establish cross-agency partnerships to develop regional responses to the determinants of health, particularly with the education, housing, and justice sectors. KPA 4: Delivering sustainable, culturally safe, and responsive healthcare services. KPA 6: Strengthening the First Nations health workforce. Key Priority Reform Area 6.3.2: Increase the number of First Nations people in clinical roles



Alison Nelson (IUIH) began the session by phrasing the question "beyond school-based traineeships, how do we make sure we have a strong and sustainable workforce?". The focus of this session was to explore what strategies can be used to employ First Nations people, how additional pathways can be opened, how employees can be supported, and how to prepare the workplace for the Indigenous workforce.

Michelle Stute (MNHHS) followed by introducing the Metro North Cadetship program. This program supports First Nations University students to participate in flexible and paid employment in their chosen pathway while they study and receive a regular study allowance. Cadets are found via promotion campaigns at universities and represent a range of health disciplines. A recent evaluation of the program, funded by the National Indigenous Australians Agency (NIAA), found that cadets are more likely than non-cadets to have better academic outcomes, finish their qualifications and find employment. Graduate cadet reviews are positive, with Michelle highlighting that all graduates over the last four years have jobs.

Michelle emphasised that more cadetship opportunities and collaboration is critical to meeting workforce targets and growing pathways for cadets. Michelle called on SEQ First Nations Health Equity partners to avoid competitive programs and reach for a unified approach that provides a single entry point for students to navigate their health careers and make contacts. She pressed that this action would relieve the workload but most importantly, better the experience for cadets.

Angela Young (CHQ) briefed the audience on the CHQ Talent Pool. The CHQ Talent Pool aims to operate as a one stop shop for First Nations attraction. It collates First Nations applications to eleven standard job descriptions advertised on Smart Jobs. The applicant is then contacted by the organisation to clarify the applicant's interests and details. The Talent Pool is distributed across CHQ services for recruitment and has been implemented into CHQ recruitment policy and procedure. To date, the Talent Pool has led to three placements and many interviews. The CHQ Talent Pool is built to share across all HHS and is undergoing technical work to make it available for CCHSs.

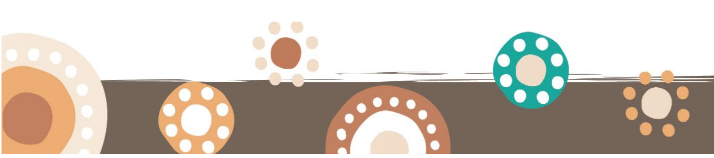
The room then prepared for a panel yarn with the MNHHS cadets with **Rhea Waia** (MNHHS)**, Taliyah Hawkins,** and **Loni McIlvena** (IUIH). The yarn started with the cadets' journeys, with the cadets emphasising the extensive financial supports and flexibility that the program provided. Taliyah and Rhea spoke to the positive encouragement and culturally safe supports that meant a great deal to their journey, while Loni praised that they were able to work in what they studied. The panel advised programs that students want consistency of payments and for programs to "take time to understand what the individual cadet wants to be as a practitioner.", and finally,

"That you check in with Mob, because sometimes we are too shame to speak." – **Taliyah Hawkins**

Angela spoke to the number one success factor for their 15 cadets: cultural mentoring. Angela continued, "We try immediately to hook up the cadets with a cultural mentor – someone who is there, who know who they are and asks how they are feeling".

Feedback from workshop participants
Strong and Deadly Futures: Moving through the pipeline

- **The importance of cultural safety** – what does this look like and how can it be embedded into the system?
- **Listening** – young people know what they want, we just need to listen.
- **Expansion** – need to explore ways to expand the program.
- **Centralization of cadetships –** a process done through a singular body with central funded positions that all organisations can access.
- **Consistent funding** - need consistent financial support for students across the board
- **Early student engagement** – need to engage the community earlier in life.
- **Corporate students in cadetship programs** – potential for more scope in cadetships.
- **Placement rotations in HHS' and NGOs'** – rotation between organisations and across different teams during the life of a student's degree



Day 1, Afternoon, Concurrent Workshop 3. The SEQ First Nations Health Equity Workforce Strategy: The next 12 months

Chair: **Mike Bosel** (BSPHN) and David Collins (YBB)
Presenters: **Dawn Schofield** (IUIH)

Purpose of Workshop
The SEQ FNHE Workforce subcommittee was tasked with developing a SEQ First Nations Workforce Strategy. This strategy was co-designed across the health sector and endorsed by the SEQ FNHE Governance Committee. In this session, delegates were given the opportunity to dive into the strategy and the plans for the next 12 months and determine how you can play a part.
Relevant SEQ First Nations Health Equity Strategy KPAs
KPA 2: Increasing access to healthcare services. KPA 3: Influencing the social, cultural, and economic determinants of health Key Priority Reform Area 3.1.1: Identify and establish cross-agency partnerships to develop regional responses to the determinants of health, particularly with the education, housing, and justice sectors. KPA 4: Delivering sustainable, culturally safe, and responsive healthcare services. KPA 6: Strengthening the First Nations health workforce. Key Priority Reform Area 6.1.1: Jointly develop a SEQ regional health workforce strategy Key Priority Reform Area 6.3.2: Increase the number of First Nations people in clinical roles

Mike Bosel (BSPHN) led the session with a remark on the "incredible" progress that the FNHE Workforce partners have made; moving from a summit to a strategy within just 6 months. He reinforced that "while strategies and policies are there to inspire and guide, we need to do the work". He continued to highlight the significance of collection and sharing of data in the next steps to accelerating the First Nations workforce.

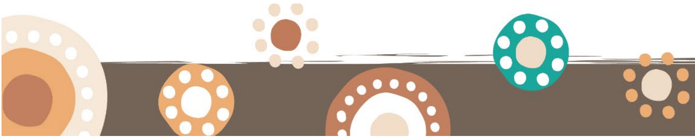
Dawn Schofield (IUIH) began with the importance of health workforce as a driver of healthcare. Despite this, the employment gap shift has closed marginally in 10 years. Training, work, and study data all speak the same story. However, Dawn emphasised, that this translates to opportunity and must be acted upon to increase the First Nations Workforce. First Nations people are still underrepresented in the health workforce. Despite the development of national and state targets, Indigenous Primary Care organisations constitute less than 51% of workforce that identifies as First Nations.

Dawn stressed that "we need to be complementary – not competitive" and that a system's approach must be built. There is effort in cadetships and traineeship programs, yet it is a fragmented pipeline. The challenges that organisations face, including access to data, pay disparities and competition, are shared across the sector. Organisations must look to purpose of the First Nations Health Equity Workforce Strategy: connect, collaborate, and integrate.

Most crucially, there must be development of a cultural and clinically responsive workforce for First Nations people.

Feedback from workshop participants
The SEQ First Nations Health Equity Workforce Strategy: The next 12 months

- **Culturally Safe** – programs must be culturally appropriate. This should be complimented by cultural trainings for staff.
- **Pathway Expansion** – growth in career pathway options. Utilise shadowing, rotations for students/staff to explore other roles. Nursing and health promotion pathways to community-controlled organisations.
- **Setting targets** – encourage an aspirational workforce.



- **More permanent positions** – temporary recruitment is difficult to source.
- **Engaging students** – need to make initiatives more interesting, meaningful, and engaging.
- **Wait lists for Health Worker training** – training needs to be opened at more facilities.
- **Breaking Barriers for Recruitment** – recruitment should be viewed as a "step in the door." E.g. on-the-job-training, relaxed qualification screening (working towards option or for people on a waitlist), recognition of transferrable skills.
- **Facilitate career growth** – support staff to grow on their career pathway at your workforce.
- **Shared resources and recruitment** – need to move toward a collective approach rather than individual organisations to improve mechanisms for shared data and recruitment pools.
- **Expand the CHQ Talent Pool** – utilise this tool as a collective mechanism for First Nations recruitment.
- **Pre-employment programs** – a program to help people be ready to apply for a job.
- **Support Workforce Strategy actions** – ongoing commitment to the FNHE sub-committee and other communication channels.
- **First Nations Leadership** – More First Nations staff being invited contribute to leadership projects and strategy development.
- **Pay parity** – this challenge must be discussed collectively to address.

Graduation Celebration for Deadly Start and POWA Trainees

The **Graduation Celebration for Deadly Start and POWA Trainees**, saw graduates congratulated by delegates of the conference at an awards ceremony. Order of Australia recipient and POWA Patron, Dr Aunty Mary Martin, delivered an inspiring speech congratulating the students on their achievement, acknowledging the support of their families, and encouraging the students to continue a journey of growth and development. Aunty Mary celebrated the young graduates, the opportunities ahead of them, and the valuable contribution they will make in their community into the future.

Conference Day 2 – Friday 13 October 2023

Day 2 Welcome

Chair: **Renee Blackman** (ATSICHS Brisbane); **Noelle Cridland** (Metro South HHS)

In reflecting on the first day of the conference, **Renee** highlighted that we should all be very proud – the SEQ corner is leading the way in how health system stakeholders across the region are coming together to implement the FNHE agenda for and with Mob. Whatever the outcome of The Voice referendum held the following day, Renee reminded participants that we are talking about Voices behind heard, and at this 2-day conference we are doing that in practice too. So, regardless of the referendum outcome, we will turn up on Monday and do the same thing. Everything that was yarned about yesterday is and remains of importance next Monday: the resounding facts and figures in terms of Indigenous health outcomes in comparison to non-Indigenous people; seeing the Murri kids here yesterday dancing and being Deadly, Black and Strong; getting our Aboriginal and Torres Strait Islander health graduates into the health workforce in our region and seeing and talking about that next wave of the workforce. The community-controlled sector has grown on the shoulders of our people over the past decades; on the shoulders of those Aboriginal and Torres Strait Islander health and community leaders who were committed to building those services. We will honour those leaders and continue their efforts.

Noelle acknowledged that, shifting into the second conference day, it's about acting together for outcomes as we press ahead. Fortunately, in the SEQ region we have a really strong and vibrant community-controlled sector that is leading the way.

Like Renee, she acknowledged that the local community-controlled sector has grown on the shoulders of some extraordinary people who have gone before us, "*because they wanted culturally safe services for their people, [despite] services running on the smell of an oily rag and with uncertain funding futures*".

"In honour of the work that has gone before us, we need to think about what we can do to ensure that the dreams of people who have gone before us have been realised, [the dreams of people] who managed through thick and thin to keep services going".

In this spirit, Noelle encouraged today's conference participants to think about where the opportunities may lay for system reform. For Noelle, the big takeaway from Day 1 of the conference is to ensure this is the intent: acting together for outcomes. Noelle emphasised that outcomes are "*the main game, and the data demonstrates important improvements and hope, [but] there is still a long way to go*".

Opening Panel Discussion. Funding Reform: Funding First Nations health differently for better outcomes

Facilitator: **Selwyn Button** (IUIH Board)
Panellists: **Adrian Carson** (IUIH); **Luke Baxby** (Deloitte); **Kristy Hayes** (Gold Coast HHS); **Shane Solomon** (Consultant)

Purpose of Opening Panel Discussion
To discuss funding reform in First Nations health, to enable new funding channels and models.
Relevant SEQ First Nations Health Equity Strategy KPAs
KPA 5: Working with First Nations people, communities, and organisations to design, deliver, monitor, and review health services

Key Priority Reform Area 5.3.5: Advocate for dedicated First Nations funding streams to facilitate purchasing or subcontracting of targeted First Nations services and for implementation of this Strategy, with flexible funding opportunities at both a regional and local level
Key Priority Reform Area 5.3.6. Increase the amount and percentage of baseline funding for First Nations programs and services within HHSs
Key Priority Reform Area 5.3.7. Increase the value of services purchased from CCHSs over time

Adrian Carson (IUIH) began by outlining that we can't just scale-up what we do; we need to fundamentally change what we do. This starts with how the funding flows. How do we redeploy funding that goes into acute spend into community spend where it makes better sense for services to be delivered in the community? We need to make sure funding flows have delivered expenditure return and health outcome return. Today's panel discussion speaks to that reform agenda.

Kristy Hayes (GC HHS) discussed the opportunities to think outside of formal process-driven ways of doing things and to consider Mob ways which are more relational. She discussed the importance of working together in documented ways such as through memorandums of understanding rather than contracts, so as to work within a cultural safe way – but to also recognise cultural Intellectual Property and to story tell the process for others who may come later.

Kristy noted how it takes time and sitting with the procurement areas to ensure sole source agreements may be put in place where there are limited suppliers, i.e., First Nations Health suppliers such as such as the Institute for Urban Indigenous Health and it's Network organisations. She discussed the importance of sharing and sitting with all stakeholders including procurement teams through to the Chief Financial Officer and the Chief Executive of the HHS to empower and educate them in the First Nations ways of doing things, but also ensuring procurement requirements are met.

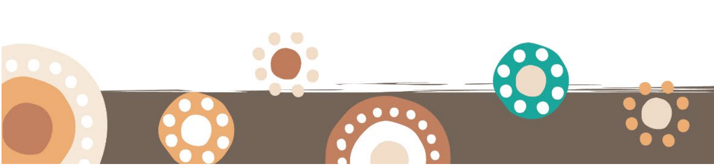
Finally, Kristy spoke about the difference between Community Controlled funding and the Department of Health funding priorities at different points in time. The simplest solution is working together for Mob and not being divisive over which pot the money is coming from but making sure it gets to the patient at the right time for equitable health outcomes.

Luke Baxby (Deloitte) noted that when asking people in the health sector what is the one thing they would like changed to enable the system to better respond to Indigenous peoples' needs, the answer he receives is about the need for new funding models. Luke considers there is a need to move away from (numerical/quantitative) 'activity' driving demand in the system, to a funding model that focuses on outcomes. There is need to ensure that new funding models are applied in ways to support health services, which move to promote health equity outcomes.

When thinking about new funding channels and models, we need to think about those models in terms of the context in which the services are being delivered and the priority needs services are looking to meet and how service leaders can apply these rules to service delivery. In other words, don't start with a funding model and then look to identify a model of care to 'fit' the funding model. Instead, Luke suggests starting with identifying what are the priority health needs among local community, followed by identifying what are the appropriate service responses to effectively meet those needs, and then identifying what are the funding models available to support that.

Governments are constrained at the moment, so they're looking at budget efficiency. For example, all the commentary around the Federal budget is on health and social care spend. But the starting position needs to be conversation about making better use of funding models that already exist. For instance, there is a preconceived idea that the National Health Reform Agreement (NHRA) only relates to hospitals and services in the acute care environment. But it doesn't.

Certainly, the NHRA relates to services in the acute care environment, but most healthcare occurs outside of that environment. There is a review of that Agreement occurring at the Federal level now, and a key question is how the NHRA can be changed to be more aggressive to meet the needs of



the health system, especially non-hospital-based service, i.e., targeting where acute-type care is required, but where such care doesn't necessarily need to be delivered in a hospital. We need to enable conversations now between the Hospital and Health Services and community-controlled sector, thinking about joint planning and commission, to create the right joint service model to receive NHRA funds – we need to begin by looking at the service need, what is culturally appropriate, and then identifying the right service model. We also need to look closely at what are the assessment requirements for services considered eligible for NHRA funding; what are the acute style services that are being delivered outside of hospital; services that are underpinned by formal discharge protocols between the hospital and community-controlled sector and overseen by strong governance and clinical principles and protocols; services that promote prevention and avoidance of hospital admission or delivery of what is ordinarily hospital-based care that has not been culturally appropriate, so Mob have been unwilling to access. When thinking about service models, we need to unbundle them to understand all the various service events and then consider what are the funding models we can leverage to deliver those individual service events and then bundle them back up, especially to identify what community-based models can be supported.

While there is a complexity here, it opens access to a funding stream that hasn't previously been available.

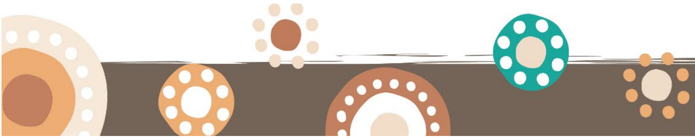
Shane Solomon (Consultant) continued that the Independent Hospital Pricing Authority (IHPA)'s task was to set the price and define what a hospital service is. A hospital service is not a service delivered in the hospital, but it is not primary care. Key eligibility criteria for a hospital service is that it is a:

1. Service related to a hospital admission or ED attendance.
2. Substitute for an above-named service, e.g., Hospital in the Home
3. Service that is intended to improve outcomes of people that are frequent attenders at the ED or have frequent hospital admissions.

Day 2, Morning, Concurrent Workshop 1. Meaningful Multidisciplinary Rehabilitation for Heart and Lung Conditions: A collaboration between organisations and sectors towards self-management

Chair: **Wayne AhBoo** (Moreton ATSICHS)
Presenters: **Katrina Ghidella** (IUIH) and **Dr Peter Hopkins** (MNHHS)

Purpose of Workshop
The new Cardiac and Pulmonary Services for First Nations people have been operating for 12 months. This includes both outreach of specialist services from the HHSs and establishment of multidisciplinary rehabilitation programs within the IUIH Network. This has brought care closer to home and enabled a culturally responsive service delivery model. Delegates were able to learn about this model and how it is already being replicated to other specialist areas.
Relevant SEQ First Nations Health Equity Strategy KPAs
KPA 2: Increasing access to healthcare services. Key Priority Reform Area 2.1.1: Establish models of care that deliver care closer to home in partnership with, and/or by subcontracting to, CCHSs; e.g., Hospital in the Home, shared specialist clinics. Key Priority Reform Area 2.2.5: Harness opportunities to expand First Nations primary healthcare services across the region. KPA 4: Delivering sustainable, culturally safe, and responsive healthcare services. KPA 5: Working with First Nations people, communities, and organisations to design, deliver, monitor and review health services. Key Priority Area 5.2.3: Transition appropriate community-based HHS services to the CCHS sector where possible and as guided by local co-design and service capacity



Wayne Ah Boo (Moreton ATSICHS) opened this session by introducing the presenters, Katrina Ghidella from IUIH, and Dr Peter Hopkins from Metro North HHS to present on the Urban Respiratory Outreach Clinic (UROC), and Cardiac Pulmonary Rehab program, and the pathway between the two programs.

Katrina Ghidella (IUIH) commenced the presentation by acknowledging that last year at the conference UROC was in its early stages and had just been rolled out, whereas this year, we have 12 months of program development and learnings to share, including the integration between UROC, and IUIH's Cardiac and Pulmonary Rehab program.

Dr Peter Hopkins (MNHHS) presented on the process of setting up the UROC clinics with IUIH, noting the that these clinics were initially set-up to address the high burden of respiratory illness in First Nations people living in SEQ, with respiratory needs being the third leading cause of death for First Nations people, and with First Nations people being overrepresented in hospital admissions and re-admissions. The first UROC clinic was held in 31 October 2022, at Margate. Since this commencement, Peter shared the clinic has received approximately 130 referrals, with the clinic about to see their `100th new patient. UROC is delivered across 2 IUIH clinics (Morayfield and Margate), providing the same level of care that patients would see in a hospital, but in a more culturally safe setting. Through the UROC model, the specialist sees the patient, provide a diagnosis, and then refers to the IUIH GP for continuation of care. UROC is able to see almost any patient with a respiratory illness, noting that (although rarely) some patients are best seen within a tertiary facility.

Peter shared that the key challenges of the UROC program has been developing a structure for referrals, ensuring the UROC specialists have access to MMEX (the patient management system used by IUIH), and improving attendance. The program has great support from Metro North HHS, and the UROC model is being expanded to cardiology, which has a huge demand.

Katrina Ghidella presented on the Pulmonary Rehab program called Work It Out Lung program. Over the past year, Pulmonary Rehab has been rolled out in 5 different locations across SEQ,. The program is delivered over 8 weeks, with two sessions per week. These 2-hour long sessions consist of yarning and group-based exercise. Katrina noted the importance of the yarning component in providing a powerful opportunity for social connection.

Over 250 referrals have been received over the heart and lung rehab programs, but Katrina noted that most of these referrals are from within the IUIH Network, not from the HHSs.

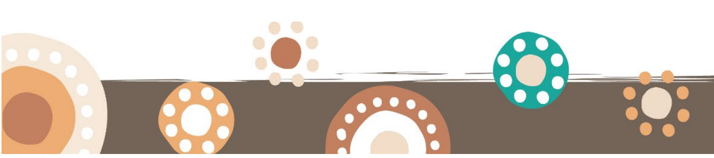
Following participation in the Pulmonary Rehab program, Katrina noted that most clients have moved into the general WIO chronic disease self-management program.

Katrina shared some of the challenges of delivering the Pulmonary Rehab program, including the geographical locations of the 5 locations – as many of the clients are exhausted by having to travel. An additional challenge identified is trying to improve the pathways for HHS referrals.

Katrina also acknowledged that the staffing needs differed from those initially planned, including the requirements for nurses and Indigenous allied health assistants - who support the nurses, managing referrals, and admin, as well as listening to the clients about what they need to make the program most effective for them.

Katrina also acknowledged the importance of the relationship with Queensland Health in the success of the Pulmonary Rehab program. She noted that the program has been successful because there is a mutual interest in making the program successful. Both Queensland Health and IUIH have been focused on marrying the clinical needs of the patients with the patient's stated needs, ensuring that the patients can move between HHS and IUIH services and ensure their needs are met.

To round out the presentation, Peter presented a case study of an Aunty who was participating in the UROC program.



Questions from the audience included asking 'where to from here', with Katrina and Peter noting they are planning to increase to more locations and bigger staffing, and improve the referral process with the HHS'.

Feedback from workshop participants
Meaningful Multidisciplinary Rehabilitation for Heart and Lung Conditions: A collaboration between organisations and sectors towards self-management

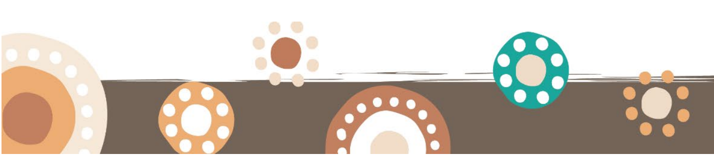
- One of the strengths of the program is the **social interaction** – the program is an opportunity for people to come and catch up. It's both a social and health program. Feedback noted that especially for this age group, much of the time they catch up is at sorry business, whereas this program provides an alternative social aspect.
- Inspiring to see **taking health care to the community** in a cultural safe way.
- Bringing the program to the people… **linking the systems** to make sure people get to the right place i.e. whatever your needs are you can access the programs you need in a timely way
- The program thinks about **who the patients are** and **what meets their needs.**
- Liked how patient can "graduate" from the program to WIO i.e. **continuation** of culturally safe care.
- **Partnerships** are key
- A **collaborative approach,** with strong communication points. Feedback noted the planning and development of model has been a really collaborate approach to strengthening delivery.
- **Innovation** – collaborative, multidisciplinary approach that can be learnt from for other models.
- Feedback noted that individually we need to have a commitment to **challenge our own ways of working**.

Day 2, Morning, Concurrent Workshop 2. Staying Deadly Hubs: Establishing community controlled specialised multidisciplinary mental health and AOD hubs in partnership

Chairs: **Angela Young** (CHQ) and **Dr Harvey Whiteford** (UQ/WMHHS)

Presenters: **Dr Carmel Nelson** (IUIH), **Rayno Potgieter** (IUIH) and **Emma Foreman (WMHHS)**

Purpose of Workshop
Last year's conference presented research from two co-designed mental health projects. The first of their kind in Australia, the projects provided valuable insight to mental health prevalence and service access in SEQ to inform the planning, funding and delivery of mental health services for urban Indigenous people. This year, delegates heard about a partnership approach to establishing Community Controlled mental health hubs to address identified needs and service gaps and support people living with mental health issues to stay deadly.
Relevant SEQ First Nations Health Equity Strategy KPAs
KPA 2: Increasing access to healthcare services. KPA 4: Delivering sustainable, culturally safe, and responsive healthcare services. Key Priority Reform Area 4.1.2: Using data from the ISEQ-NMHSPF project and QUIMHS to inform the planning and delivery of co-designed, targeted mental health services in SEQ. Key Priority Reform Area 4.2.7: Design and establish a regional community controlled specialist mental health service for people with mild to moderate mental health needs, that have strong referral pathways into, and partnerships with, acute mental health services KPA 5: Working with First Nations people, communities, and organisations to design, deliver, monitor and review health services.



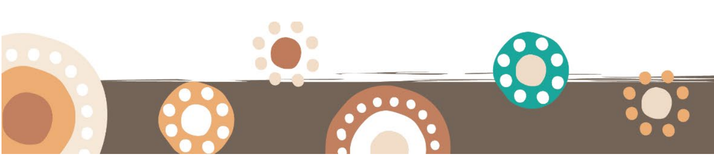
The workshop began with a joint presentation delivered by IUIH and WMHHS, outlining the journey to establishing the Staying Deadly Hubs and highlighting the benefits of partnership working between the Community Controlled and mainstream mental health sectors.

Dr Carmel Nelson (IUIH) began by reflecting on the great work of Community Controlled health services in SEQ over the past 50 years. Aboriginal and Torres Strait Islander people in SEQ have known all this time of the social and emotional wellbeing needs in the community, the services they need, where the gaps are and how these gaps might be filled. The two recent co-designed research projects exploring access to mental health services in SEQ – the *Staying Deadly Survey* and the *National Mental Health Service Mapping against the National Mental Health Service Planning Framework for Indigenous Populations in SEQ* – confirmed what the community has been telling us for years. There is a significant gap in services for the 'missing middle' – Indigenous people who are at risk of entering the acute care system if their symptoms are unmanaged or are stepping down from inpatient care and require culturally safe support in the community to reduce the risk of relapse. We now have a response to this need in the form of funding from Queensland Health's Mental Health and Alcohol and Other Drugs Branch to establish two Staying Deadly Hubs, on in the Ipswich region and one in Inner Brisbane.

Emma Foreman (WMHHS) openly reflected on her 'light bulb' moment at the 2022 FNHE Conference, where she heard about BiOC's model of First Nations people providing services to First Nations people and acknowledged that 'we can get arrogant in HHS land' and think we can provide all services and options to people. What is needed is a new way of thinking – more of the same won't work. Emma described the collaborative process involving HHSs and the Community Controlled sector in advocating together to achieve funding for the Staying Deadly Hubs and subsequent joint work to establish an Advisory Committee and Working Groups, where partnerships and relationships are fostered and grown. Emma also reflected on the 'game changing' nature of having robust data to provide objective evidence to support the needs and service gaps that clinicians and the community had been aware of for a long time.

Rayno Potgieter (IUIH) highlighted that establishing the Staying Deadly Hubs accords with and respects the strong preference of Aboriginal and Torres Strait Islander people in SEQ to access social, emotional and mental health services in the Community Controlled sector, which was a significant finding of the *Staying Deadly Survey*. Rayno also noted the importance of working in partnership with HHS colleagues to enhance the cultural safety of the entire mental health system in SEQ. The Staying Deadly Hubs will accept referrals from any source and walk alongside Aboriginal and Torres Strait Islander people and their support networks to link them to the right services, at the right time to meet their needs. When someone is referred to the service, they will be rapidly triaged and linked with the appropriate healthcare worker to provide place-based support where the person needs it. The philosophy of the Staying Deadly Hubs reflects IUIH's overall 'no-wrong-door' approach.

Randall Frazer (IUIH) emphasised that the approach of the Staying Deadly Hubs will be grounded in an Aboriginal and Torres Strait Islander Frame of Reference – mental health, our way. The Hubs will walk alongside people with an outreach focused model, going with them to access the services they need. Randall shared some stories of people he and his team have supported, highlighting the



benefits of Mob supporting Mob, not just in relation to accessing physical and mental health services but also wrap-around supports including access to clothing, housing, nutritious food, legal support, and Centrelink and NDIS services. Ultimately, the Staying Deadly Hubs will expand IUIH's capacity to keep Mob out of hospital, in the community and working on goals to strengthen who they are, their life and opportunities.

"It's our custodial ethic that we do what we do, our obligation and responsibility to support our people. When we come at our work from that point of view, wholly focused on what our Mob's goals and hopes and dreams are and what they want to achieve in their lives… it's a deadly service through that lens."
- Randall Frazer

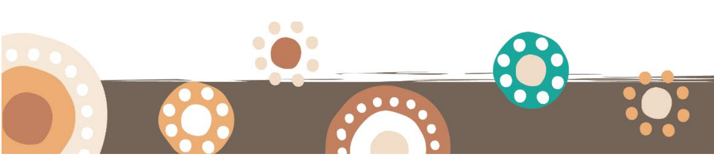
Following the joint presentation, participants heard from Kristie Harris, a proud Wiradjuri woman, IUIH staff member and one of the survey interviewers for the *Staying Deadly Survey*. Kristie described the personal significance of being part of the interview process and people sharing very personal and sensitive information, often things they had not told anyone before. When Kristie yarns with survey participants now, she can highlight that the Staying Deadly Hubs are the result of people sharing their journeys and having the data to show the need in community for culturally safe social, emotional and mental health services.

The workshop ended with a Q&A panel session involving **Carmel, Emma, Rayno, Randall** (IUIH)**, Renee Blackman** (ATSICHS Brisbane)**, Professor Harvey Whiteford** (Queensland Centre for Mental Health Research) and **Angela Young** (CHQ). Participants explored issues including:

- the ambition to eventually roll out Staying Deadly Hubs to all sub-regions of SEQ
- the importance of building in evaluation from the outset of a new service, noting that funding for the Staying Deadly Hubs includes evaluation, which will be undertaken in partnership with the Queensland Centre for Mental Health Research
- the need to move away from acute inpatient services and explore innovative options for providing safe and adequate care for people in the community.

Feedback from workshop participants
Staying Deadly Hubs: Establishing community controlled specialised multidisciplinary mental health and AOD hubs in partnership

- **Advocating for the voice of the community**
- **Holistic, outreach-based models** - refreshing to see models aren't necessarily clinician-focused.
- **Aboriginal Terms of Reference** – Aboriginal Terms of Reference at the core of the model enables adequate and safe care.
- **No-wrong-door approach -** allows for early intervention.
- **Move away from a psychiatry-based model -** ensuring a preventative approach and the missing middle are reached.
- **Keep strengthening partnerships and continued collaboration**.
- Engage with **compassion**.
- **Stigma** - we still live in a world where mental health is stigmatised. We need to overcome that.
- **Community solutions** - more work needs to be around addressing the issues that cause mental health challenges – these might not be health solutions but community solutions.



Day 2, Morning, Concurrent Workshop 3. Connecting to Support Mob in their surgery journey

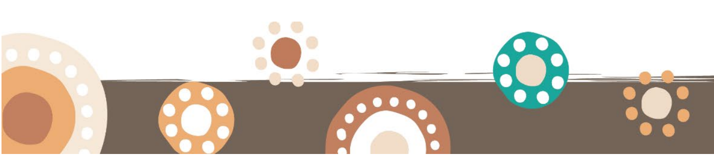
Chair: **Frank Tracey** (CHQ)
Presenters: **Nami Hirano** (IUIH), **Celia McCarthy** (IUIH), **Caroline Harvey** (IUIH) and **Edwina Powe** (MNHHS)

Purpose of Workshop
Accessing surgery for Aboriginal and Torres Strait Islander clients is often a story of long wait lists and repetition of appointments. Clients can then struggle to access follow-up appointments and rehabilitation. In this presentation, delegates heard about innovative models which have impacted on access to surgery and post-operative rehabilitation. Learn about models that stitch up care pathways across the primary/hospital interface and use the respective strengths of partner organisations to support patients through the patient journey.
Relevant SEQ First Nations Health Equity Strategy KPAs
KPA 2: Increasing access to healthcare services. Key Priority Area 2.1.1: Establish models of care that deliver care closer to home in partnership with, and/or by subcontracting to, CCHSs; e.g., Hospital in the Home, shared specialist clinics KPA 4: Delivering sustainable, culturally safe, and responsive healthcare services. KPA 5: Working with First Nations people, communities, and organisations to design, deliver, monitor and review health services. Key Priority Area 5.1.1: Build on and replicate effective service delivery partnership models already established in SEQ, including (but not limited to): • Surgical Pathways • Birthing in our Community services • Gynaecological care pathways • Hospital in the Home arrangements • Oral health services • Prison transition services Key Priority Area 5.2.2: Improve integrated care by (i) embedding referrals to MobLink (IUIH Connect Plus) into all HHS discharge planning policies and (ii) strengthening handover processes between nurse navigators/Indigenous Hospital Liaison Officers (IHLOs) and IUIH Connect Plus staff/IUIH Network clinics

A highly collaborative approach was demonstrated in this presentation, featuring models that stitch up care pathways across a variety of primary and hospital healthcare interfaces and contexts from cataract surgery pathways to post-operative rehabilitation to women's business. All presenters highlighted the value of the respective strengths of partner organizations to support patients through the patient journey and the need to reduce long wait times, and to walk in our patient's shoes and that a one-size approach does not work for all.

Celia McCarthy (IUIH) presented on community-based primary health care, eye-health and the Cataract surgery pathways, established since 2016. Celia highlighted that system connection is key and working on a seamless interface to bridge the gap between the Hospital and Primary Health Care pathway.

Caroline Harvey (IUIH) and **Edwina Powe (MNHHS)** presented on the Gynaecological Surgery Pathway which starts and ends in Primary Care. The Women's business pathway is the "bones" of the MNHHS and IUIH partnership. And the team works hard to improve access and address cultural barriers that present regularly within the clunky system interfaces. Enabling factors are shared passion, shared governance arrangements and workforce across agencies. Eg Gynaecologist and Service Coordinator employed by Metro North HHS. Constraining factors include system change, data/ medical records systems disconnect, staff turnover and fragility of workforce, QH referral system and deficit-based language. For example, suggest reframing DNQ (did not attend) to failure



to provide service. Caroline and Edwina also highlighted how the current system is a **labyrinth** to navigate – we need to do that as service providers – not burden the community to navigate it all.

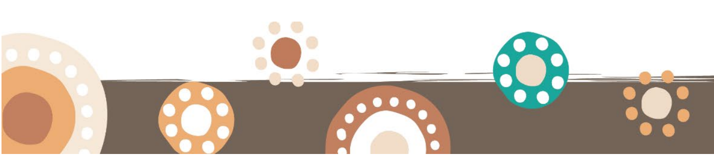
Nami Hirano (IUIH) presented on the post–operative rehabilitation pathway and the importance of integrating client feedback and strength-based language and approaches into clinical processes (case conferencing, plain language correspondence, access to clinical notes, health literacy and awareness) to bridge the gap between hospital and PHC.

Co-presenters encouraged participants to explore ways to better support Mob in their surgery journeys and to listen to clients who have lived experiences of what could be better and create ways to integrate continuous feedback mechanisms to improve practices.

We listen. We act. This is what we did – is that good enough?

Feedback from workshop participants
Connecting to Support Mob in their surgery journey

- **Connector roles are vital to the surgical pathways –** how can we use these roles better to help with navigating the system?
- **Integrate empowered patient choices to follow up** eg. where would you like your appt?
- Current system is very time-intensive and confusing eg Review theatre list processes so more streamlined and not duplicating appointment reminders etc.
- **Good experience in front end** eg friendly face. Improve integration at operational level between IUIH and QH and initiate systems improvements and share eg. Changed correspondence/ letters to be strengths-based rather than deficit language. (Failure to provide service rather than failure to attend).
- **Explore central intake** (2 weeks delay) can we co-design some of those processes and re-think and nuance the pathway if First Nations people identify?
- **Transient workforce fatigued**. How to maintain kind, compassionate and consistent services.
- **60,**000 **outpatient list -** feels too hard and the overwhelming system makes it hard to start. Slowly join up the system between primary health care and hospitals. We need to hold a culturally strong space and accessible community health spaces.
- **First Nations surgical pathways** – identify principles. Accessible care in the community. Reprioritize what we have – look at the vacancies.
- **Kill a committee – gain a clinic!** Similar ways of doing make it easier to navigate. Pre-admission plan.
- **Streamline Data systems** – creates more work for workforce by doubling up
- **Share more –** there is still limited awareness of some of the great services around
- **Importance of cultural/spiritual support** when using the health service and these models offer this
- **Walk the path with Mob -** from referral to getting the service, knowing scope of services for accurate referrals.
- **Improve communication and health literacy** – explain things in a way mob understands and go on journey together (reduce clinical terms- decode/less clinical)
- **First Nations Workforce** - ITC funding yarns across PHNs to employ First Nations Health Workers to support pathways.
- **Improving pipelines between IUIH, HHSs & PHNs** – and streamlining information to get to the right people.
- **Expanding service provision to areas not currently covered** e.g. Beaudesert, what can we do to provide access?
- **What does MobLink cover?** Who are we going to see and what services are we going to provide? More info about programs, linking IUIH in with Cultural Capability Officers new clinicians become aware of services. HLO's & Health Workers linked with what's happening at IUIH.
- **Discharge summaries** – how can we ensure this is sent with the referral. Streamlining the referral process.



• **Reframe language -** not 'DNA,' 'Failure to provide service' maybe 'service not provided' with a reason given. Confronting for a purpose, clinicians reflect on service they are providing.

Day 2, Panel Yarn. Engaging with our communities to achieve more together, Learnings from the Qld Murri Carnival – First Nations Health Equity Activations

Chair: **Kaava Watson** (IUIH)
Panellists: **Dallas Leon** (IUIH); **Mereki Copeland** (CHQ); **Philip Whap** (IUIH); **Belinda Charles** (ATSICHS Brisbane)

Purpose of Panel Yarn
To provide an overview of the Qld Murri Carnival First Nations Health Equity activations.
Relevant SEQ First Nations Health Equity Strategy KPAs
KPA 2: Increasing access to healthcare services. Key Priority Area 2.2.6: Implement culturally appropriate health promotion and prevention initiatives across SEQ including implementation of the Deadly Choices Schools Program, and associated community events and communications KPA 3: Influencing the social, cultural, and economic determinants of health Key Priority Reform Area 3.1.1: Identify and establish cross-agency partnerships to develop regional responses to the determinants of health, particularly with the education, housing, and justice sectors KPA 4: Delivering sustainable, culturally safe, and responsive healthcare services. Key Priority Reform Area 4.1.4: Work together to implement the SEQ Aboriginal and Torres Strait Islander Community Engagement Strategy (see Appendix Three) to ensure community perspectives are continuously informing health service planning, design and delivery KPA 6: Strengthening the First Nations health workforce. Key Priority Area 6.3.2: Increase the number of First Nations people in clinical roles

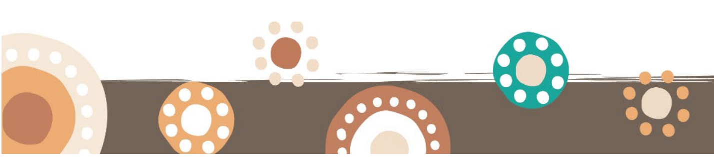
Dallas Leon (IUIH) commenced the session with the *Deadly Choices* (*DC*) community engagement strategy, explaining that the program uses sporting events as a method to engage directly with the community. *DC* sporting events are family-friendly socials rooted with health promotion messages that communities can follow along with during the year. So far, events are seeing high and positive engagement from families. The program has opportunities for collaborations consistent with the *DC's* mission and are exploring expanding sports development pathways for participants.

Deadly Choices is health access, away from the clinic **– Dallas Leon**

Kaava Watson (IUIH) briefed the audience on the success of the Queensland Murri Carnival 2023 an event affiliated with *DC*. The Jobs expo held at the Queensland Murri Carnival 2023 had over 300 expressions of interest. The carnival was statewide; however, attendee representation was strongest from SEQ participants.

Kaava pressed that while there are good things happening, more work needs to be done in the cultural safety space. This can be done by means of truth-telling and cultural safety training, more First Nations staff, asking the community, and sharing. At the present point, he continued, there is a lot of interest in health jobs with over 300 expressions of interest and over 200 responses to surveys.

The session then concluded with a panel session between **Dallas Leon** (IUIH), **Kaava Watson** (IUIH), **Belinda Charles** (ATSICHS Brisbane), **Mereki Copeland** (CHQ), and **Philip Whap** (IUIH). Mereki expressed that when it comes to engagement about jobs, "it is important to know that we will come to them instead of them having to come to us". Recognising the First Nations community that aren't aware of what employment opportunities there are, the panel discussed the importance of collaboration and working in an integrated way to grow awareness of these programs from the



beginning. Belinda rationalised that early conversations with community will break this barrier and goes hand-in-hand with growing the workforce. Dallas complemented this by highlighting the need for more First Nations representation and leadership to challenge barriers and start conversations. The session concluded with a call to action to the audience: "community engagement is an obligation that we have, for all of us, to ensure that we are connecting with our mob, so we are giving the opportunity to be heard, we are giving them the information to access employment pathways" they continued,

"we should be having this activation at all of those events, to ensure that mob is part of the movement we are undertaking as a system" **– Kaava Watson**

Day 2, Plenary Session. Addressing Issues of racism and discrimination in our health systems: Are we ready?

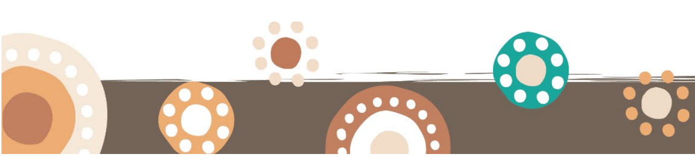
Chair: **Kaava Watson** (IUIH)
Panellists: **Keryn Ruska** (IUIH); **Scott McDougall** (Queensland Human Rights Commissioner)

Purpose of Plenary Session
To discuss the impact of racism and discrimination on our health system, and discuss opportunities to address racism within the health system.
Relevant SEQ First Nations Health Equity Strategy KPAs
KPA 1: Actively eliminating racial discrimination and institutional racism within services Key Priority Reform Area 1.1.1: Promote safe, inclusive, and respectful workplaces where staff are valued and supported Key Priority Reform Area 1.3.4: Develop systems and processes for the reporting of First Nations client and staff experiences of racism and discrimination Key Priority Reform Area 1.3.5. Analyse client/staff experience reports to inform improved practice and address racial discrimination where it occurs Key Priority Reform Area 1.3.6. Develop and implement a regional anti-racism campaign Key Priority Reform Area 1.4.9: Develop resources for clients to understand their rights and what they can do if they experience racial discrimination

The Chair, **Kaava Watson**, began the session by acknowledging the Elders present in the room, and especially Elders who are no longer with us, as they did the hard yards of addressing racism to assert our rights.

The Queensland Human Rights Commissioner, **Scott McDougall**, commenced by highlighting that 20 years ago in 2003, there was little academic work done on the nuance and dynamics of how systemic discrimination - racism - works and plays out. Cases were settled, and there was no precedent set in law. However, it was the work led by Adrian and Henrietta Marrie in preparing a matrix to identify and unpack institutional racism in health services, which took a detailed look at Queensland Health policies and procedures and identified and assessed the discrimination inherent in those procedures, which led to the development of the First Nations Health Equity Strategy in Queensland. Adrian and Henrietta Marrie's matrix report had to be signed off, and Queensland Health took its content seriously, and so when then Minister of Health Yvette D'ath introduced amendments to Queensland's Hospital and Health Services legislation directing every HHS to co-design and implement a First Nations Health Equity Strategy, it was a very powerful moment. This amendment also required that each HHS must have one Aboriginal and/or Torres Strait Islander person on the board. While it was very clear that these legislated requirements wouldn't address and 'fix' racism overnight, it was a start.

Queensland also has the *Anti-Discrimination Act 1991* as another tool to help individuals fight racism. While an individual can make a complaint to the Human Rights Commission under that Act, the Commission will try to resolve it first, although the matter can go to QCAT. According to Scott,



it's very hard to prove racial discrimination in court. The fact this is not straightforward is reflected in the low levels of complaints that his office receives under that Act from First Nations peoples in the community. In recognition of the challenges with the *Anti-Discrimination Act 1991 (Qld)*, last year the Queensland Human Rights Commission released its Building Belonging report, which was a review of the *Anti-Discrimination Act 1991*. Recommendations that were made in that report included:

- Shift to a preventative model
- Create a positive duty to eliminate discrimination, which can reduce the burden on people who are making complaints
- Address power imbalances in a Healing process
- Allow complaints by organisation and representative actions.

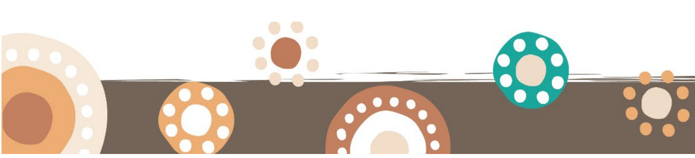
In Scott's view, the Queensland Human Rights Commission can be outward looking by working with communities to prevent/reduce risk without waiting for a complaint by the individual. The Commissioner is hopeful that the recommendations in the report will be picked up and new legislation will be introduced to the Queensland Parliament.

The Human Rights Commissioner also spoke about the coroner's findings into the inquest into the deaths of three First Nations women as a result of rheumatic heart disease at Doomadgee, which were released in the middle of the year. He pointed to the coroner's recommendations that racism within health services and systems needs to be identified, measured and monitored – that there is need for objective assessment because self-reporting and subjective assessment by services are clearly not sufficient. In advancing cultural safety, Scott highlighted the importance of agencies reframing their relationship with First Nations communities and First Nations healthcare staff, and working with Mob to change workplace health and safety standards around psychological hazards/safety in the workplace. In Scott's view, there is a real opportunity within workplace health and safety to bring this area into sharp focus and address systemic issues.

For **Keryn Ruska**, when Aboriginal and Torres Strait Islander people lodge complaints internally within and through HHS complaints mechanisms, they usually get a generic response that points to policies and procedures. By lodging a complaint to the Queensland Human Rights Commission, they then enter the legal system, and benefits include the opportunity for the individual complainant to sit at the table and feel heard. The next step from there – to QCAT – is a harder step often for First Nations complainants to commit to. Through QCAT they can ask for an apology, change of policy, staff training, and compensation. While QCAT provides an important space for individual complainants, the decision-making timeframes are lengthy. Also, once the complainant enters the legal system it can become an adversarial process if the First Nations person is making a complaint about a state government (i.e., Queensland Health) employee. The state will get Crown Law involved, and the employee will have their own lawyers. Crown Law are not so willing to resolve matters, so it gets litigious and adversarial quickly, and there is limited access to legal assistance for the First Nations person making the complaint. Also, among community there is distrust of legal and government systems. Mob have strong knowledge of where the power sits, and experience that when you bring a complaint, the goal posts change: there's cynicism in the community about outcomes that have actual change.

The panel discussed multi-level anti-discrimination interventions/responses –

- Individual – change behaviour of individuals, e.g., through cultural safety training
- Interpersonal – programs impacting relationship between healthcare worker and patient
- Community – where we have the First Nations Health Equity Strategy

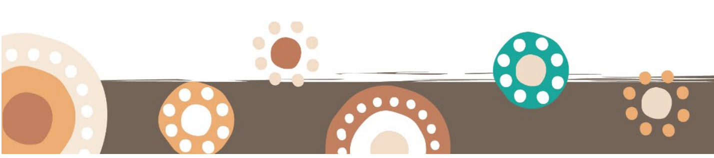


- Organisational – talking more about programs to recruit and retain staff to help make workplaces culturally safe
- Systemic - e.g., issues we come across with HHSs and Child Safety, unborn child risk notifications; accessing timely and culturally safe mental health services and supports is really hard and a systemic issue for Aboriginal and Torres Strait Island people. We know that services and programs exist that Mob aren't able to access due to systemic barriers.
- Anti-racism campaigns – concern that some anti-racism campaigns fail as they only focus on the individual level and don't address racist systems issues and organisational practices.

Panel discussion then shifted to identifying the foundational principles that are needed to embed anti-racism in healthcare services, systems and practices -

- Define the problem and set clear goals
- Incorporate explicit and shared anti-racist language. Don't water it down, talk about racism and need to change systems.
- Leadership buy-in and commitment.
- Dedicated funding and resources.
- Allowing time to have mandatory training, resources and time to do it well, otherwise only buy in from people who want to be there
- Right support and expertise – right people to have hard conversations to unpack where you need to be e.g., overseas example delivering training to doctors in health setting who were taking equality framework and say 'we are fine, we offer this to everyone'
- Ongoing meaningful community and patient partnerships
- Multi-level approaches – systemic/organisational approaches first because individual behaviour is shaped by organisational culture and practice
- Embed equity policies with explicit anti-racist leads to culturally safe workplaces
- Link mandatory anti-racism work with broader systems of power, hierarchy and dominance.
- Build in cyclical stop and reflect mechanisms so that appropriate monitoring and evaluation occurs.

Uncle Les asked the panellists how we can deal with constructs of racism in government and the legal system, when the very existence of these systems relies on racism. Keryn agreed, highlighting that this is in fact the challenge and why some of our people won't engage, because people see it as a racist system and don't have much faith in the outcomes so not many complaints are made, and they're less likely to be successfully when to do go through. Panellists discussed that when you have QCAT Tribunal Members (i.e., decision makers) who aren't Indigenous, they simply don't have the insight into what it's like to live in the skin of a First Nations person. What they see as ordinary interactions is not what is felt or experienced by community, so there's a lot of unconscious bias. There is some research into whether judges can deliberately set their minds to prevent themselves lurching into bias, and there is some evidence from other states/territories that they can to a degree, but this is nonetheless challenging and structural racism in the legal system is difficult to deal with. Kaava pointed out that it's not always the system that sees us as less than or 'other', but the system can be blind to our circumstances because it churns through activity with little regard for the context/circumstances of Mob who don't sit within the system and who are marginalised. Consequently, it's the failure of the human element of 'the system' that results in racism and racist outcomes.



Uncle Les Collins highlighted that at IUIH we talk about Our Ways. In Uncle Les' view, if we're going to address racism effectively, there needs to be something like a treaty or agreement that embeds Indigenous law/lore and enshrines rights of all Australians and that has a socialisation plan in place to rewire how we think and act. Otherwise, there will be law here, strategy there, and it will go on and on. Scott pointed to the importance of having more First Nations lawyers and judges, as currently only 0.8% of lawyers are Indigenous.

The discussion that followed highlighted how important it is for First Nations staff who are experiencing racism/discrimination in the health sector to feel safe to raise issues and confident they will be treated fairly. Can there be psychosocial additions to workplace regulations? In response, Keryn agreed that we have to be innovative about how to deal with complaints, because it's really hard to prove racism, and often people get knocked back, but they know that is why they're being treated the way they are. Keryn noted there is now a protection of psychosocial safety in the workplace, and the obligation is on employers.

Day 2, Afternoon, Concurrent Workshop 1. Addressing racism and discrimination in our health services: Where are we up to?

Chair: **Kaava Watson** (IUIH)
Yarnin Circle Facilitators: **Renee Brown** (IUIH), **Angela Young** (CHQ), **Aunty Mary Graham**

Purpose of Workshop
General consensus is that actions speak louder than words. So how do we move beyond campaigns to true action and transformation of our systems to be more culturally safe? This workshop featured snapshots of campaigns and initiatives currently underway to implement a regional anti-racism campaign. But even more importantly, it discussed what systems and processes are required to be in place before an anti-racism campaign can be rolled out.
Relevant SEQ First Nations Health Equity Strategy KPAs
KPA 1: Actively eliminating racial discrimination and institutional racism within services Key Priority Reform Area 1.1.1: Promote safe, inclusive, and respectful workplaces where staff are valued and supported Key Priority Reform Area 1.3.4: Develop systems and processes for the reporting of First Nations client and staff experiences of racism and discrimination Key Priority Reform Area 1.3.5. Analyse client/staff experience reports to inform improved practice and address racial discrimination where it occurs Key Priority Reform Area 1.3.6. Develop and implement a regional anti-racism campaign Key Priority Reform Area 1.4.9: Develop resources for clients to understand their rights and what they can do if they experience racial discrimination

"This is a colonial country. If it wasn't we'd be running our own affairs" **– Aunty Mary Graham**

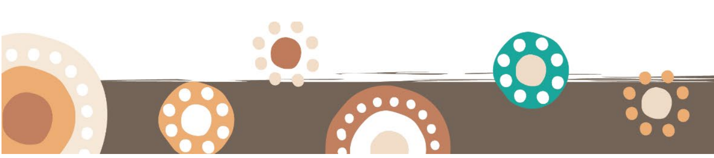
The afternoon workshop on addressing racism and discrimination in health services was very well attended, and powerful. Racism is insidious part of our society, and it comes back to the inculturation of our society through colonisation.

"We need to do more than just being nice, or teaching all the things we know. We need to strengthen and focus on regeneration of our system – asserting our sovereignty". **– Aunty Mary Graham**

There was in-depth discussion about how we get organisations to understand they are racist, when those organisations have a white lens, and see the world through lenses of privilege:

"If we don't talk about that in these forums, how will we do systemic change".

"How do we address a racist issue (within a health service or system) with a racist construct? For example, how do we take an institutional racism audit to a white executive?"



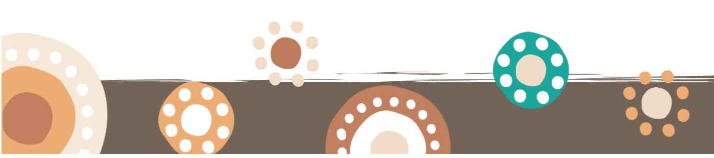
"We step with hope, always" **– Renee Brown**

Change happens in a generation. Aunty Mary emphasised that "We are owners and runners of the country, and we need to act like that". This doesn't mean protesting; it means walking and talking like we are the owners and runners of the country. The best way to make people argue is to give an either/or choice. Uncle Les highlights that when a person does something that's the right thing to do, they need to really think about what made that person do that at that point in time – do some critical thinking.

Concern was raised that if we tell our Mob to yarn with us about their experiences, but if we don't have a system that reports this, and creates a sense of accountability back to community, then how are we enabling the system, and governance of the system?

Feedback from workshop participants
Addressing racism and discrimination in our health services: Where are we up to?

- **HHSs should conduct a detailed annual audit of institutional racism.** This is the practice of CHQ, and 2023 is their second year of audit.
- **Need to depersonalize efforts to address systemic racism and discrimination.** We cannot rely on the goodwill of non-Indigenous people 'in the system' to stop being racist.
- **Racist institutions can exist with no racist people or with lots of racist people.** For example, health administrative criteria based on biomedical factors do not achieve equity. Very rarely is Indigeneity considered a merit; having lived the experience as an Aboriginal and Torres Strait Islander person should be the top criteria (merit).
- **You can't be culturally capable if you don't understand racial theory,** learning how not to be racist.
- **It needs to be simpler to make complaints.** As a staff member making a complaint about racism, the system doesn't even recognize Aboriginal and Torres Strait Islander Health work and workers as a distinct and important profession.
- **Racism is normal – so how do we do Healing? Healing comes when you feel listened to, feel heard, and there is action.**
- We need to **move together to address racism**, it's a collective thing. It is a network of creating change.
- **Language is so important and speaking with respect – kindly and gently.**
- When you think about the economic cost of racism on Aboriginal and Torres Strait Islander mental health, if we can't appeal to their compassion and humanity, maybe we appeal to their wallets.
- **Ensuring that mob are employed at all levels of the system will support structurally addressing racism.**



Day 2, Afternoon, Concurrent Workshop 2. Community engagement in partnership: Let's Yarn Health Equity 'Gold Coast Ways'.

Chairs: **Wayne AhBoo** (Moreton ATSICHS) and **Hannah Bloch** (WMHHS)
Presenters: **Laurie West** (Kalwun) and **Kristy Hayes** (GCHHS)

Purpose of Workshop
Engaging with our communities in a coordinated and connected way is critical to the success of the First Nation's Health Equity Strategy. We need to move beyond tokenistic and individualistic approaches to well-coordinated approaches across governance, organisational and individual levels. This presentation highlighted community engagement that has taken place as part of the Murri Carnival as well as the approach being taken on the Gold Coast to ensure community engagement happens in a coordinated and integrated way.
Relevant SEQ First Nations Health Equity Strategy KPAs
KPA 4: Delivering sustainable, culturally safe, and responsive healthcare services. Key Priority Area 4.1.4: Work together to implement the SEQ Aboriginal and Torres Strait Islander Community Engagement Strategy (see Appendix Three) to ensure community perspectives are continuously informing health service planning, design and delivery KPA 5: Working with First Nations people, communities, and organisations to design, deliver, monitor and review health services.

Kristy Hayes (GCHHS) opened the session and named the commitment to the First Nations Health Equity strategy as a key enabler for the strategic approach to community engagement on the Gold Coast to ensure it happens in a coordinated and integrated way.

Kristy talked about the value of local, First Nations community voices informing all community engagement work and how the partnership with Kalwun started with many community engagement forums, to enable the voices of First Nations people of the Gold Coast to inform joined-up service delivery improvements and new service design.

Laurie West (Kalwun) emphasised the importance of proactive, collaborative and strengths-based approaches modelled by FNHE leaders and key clinical staff (Practice Managers and Senior Medical Officers) in both agencies. This trust relationship and key governance mechanisms such as quarterly meetings and turning up at community events is key to the partnership and implementing joined-up health services in response to barriers in accessing healthcare for First Nations people. They shared stories of new service launches at Kalwun with Community Elders involved and co-designed responses from the last few years.

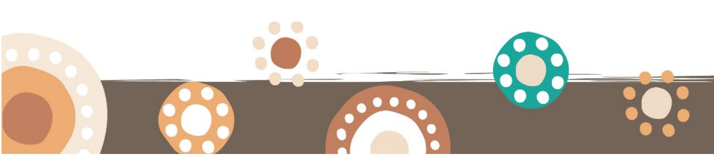
For example:

- Yugambeh youth choir have developed a lullaby for babies birthed at GC hospital,
- Coordinated COVID response –re: vaccination and follow-up between Kalwun and GCHHS
- Sister-shawls collaboration – Kalwun organized a breast screen initiative together with GC HHS hosting a sister shawls initiative.
- Improved data system access for clinicians with streamlined approach
- Improved discharge summary process for patients means connected to Kalwun earlier, so minimized risk of re-presenting at GCHHS

Kristy and Laurie wrapped up the session by highlighting the sustaining elements of good practice community engagement and partnership approaches. They also challenged participants to think about the bigger picture and how to go beyond relationships to **systematize joined-up community engagement** in practice.

Feedback from workshop participants
Community Engagement in Partnership

- We tend to set up advisory committees, we always need to ask: **Who else needs to be here?**
- **Build on connector roles like nurse navigators** – coordinating role how to connect mob to the services they need
- **Value lived experience** – create space for frontline workers to give feedback and contribute to co-designed service responses. Such insights can enable simple solutions/ work arounds to cold face challenges.
- **Communicate more between services and what each agency can offer the partnership** eg IUIH can transport Mob to hospital - could not believe it was possible!
- **Encourage shift to bigger picture thinking**– Zoom out to see stakeholders with a new lens. otherwise, we are blocking. It is cost-saving to invest in prevention – reduce the cost of service by increasing the capacity of each service – we want mob to be able to access culturally safe and holistic services.
- **We need to shift beyond silos –** identify key interface points in the clinical process
- **Keep working on cultural capability training** and using strengths-based language to empower Mob.
- **I took away that you should keep going**. Keep trying. It is so worth it. I love the idea of systematizing it, so it is beyond the people, and it's the process
- **Being a bit creative** – eg. At West Moreton HHS we have black morning teas, so you are going to community. The community facilitates this, and we attend – it's the Murri grapevine. It's an opportunity for the key people in the HHS and CCHS to get together and understand what each can provide.
- **We want all the staff members embedded in the partnership approach -** all our SMOs go back to their GPs and filter back any critical information. We have a system that flows, we have a set process, so new staff members will have to learn.
- **Turn up and be visible**. It was nice to see the collaborative attendance at each other's events by both GCHHS and Kalwun showing up and being there on the ground. This shows they are putting in the effort to connect with community-control.



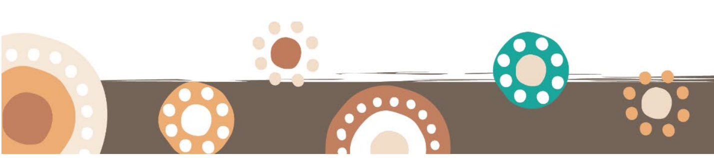
Day 2, Afternoon, Concurrent Workshop 3. Progress and outcomes in improving the pathway between hospital and home

Chairs: **Michael Cleary** (MSHHS) and **Dom Tait** (CHQ)
Presenters: **Camille Anlezark** (IUIH), **Darsha Beetson** (CHQ)

Purpose of Workshop
The transition from primary to tertiary care and back has many challenges including issues around DAMA and revolving doors. In this session, delegates learned about the evolution of Mob Link and its expansion in the past 12 months. As a Queensland Health supported program, learn about the ways in which clients are supported by Mob Link in their journey through the health system to ensure access to ongoing health and social care to meet their needs, including practical supports that prevent re-admissions. Data showing referrals to Mob Link over the past 12 months and stories that illustrate the impact of these referrals will be shared.
Relevant SEQ First Nations Health Equity Strategy KPAs
KPA 2: Increasing access to healthcare services. Key Priority Reform Area 2.1.1: Establish models of care that deliver care closer to home in partnership with, and/or by subcontracting to, CCHSs; e.g., Hospital in the Home, shared specialist clinics KPA 4: Delivering sustainable, culturally safe, and responsive healthcare services. KPA 5: Working with First Nations people, communities, and organisations to design, deliver, monitor and review health services. Key Priority Reform Area 5.2.2: Improve integrated care by (i) embedding referrals to MobLink (IUIH Connect Plus) into all HHS discharge planning policies and (ii) strengthening handover processes between nurse navigators/Indigenous Hospital Liaison Officers (IHLOs) and IUIH Connect Plus staff/IUIH Network clinics

Camille Anlezark (IUIH) opened the session by providing an overview of the history of Mob Link. In 2022–23, the IUIH Connect Care Coordination service was expanded to include both virtual clinical care and outreach service. The now known, 'Mob Link' service, has expanded its footprint to now provides services across the entire SEQ, with extended operating hours from 7am to 7pm, 7 days per week. The expanded service offerings and the development of strong referral pathways across the health system, has resulted in increased referrals and access across SEQ.

Darsha Beetson (CHQ) discussed the role of Mob ED at Queensland Children's Hospital, noting that 95% of Mob Link referrals from CHQ come from ED. Darsha noted that a significant number of patients, about 50-60%, initially consult with Aboriginal and Torres Strait Islander Health Workers, followed by assessments for potential Mob Link referrals. Darsha highlighted the importance of repeatedly inquiring about patients' First Nations identity, drawing a parallel to routine questions about allergies. The MOB ED team, comprising six staff members and cadets, was praised for creating a culturally safe environment, maintaining low rates of discharging against medical advice (DAMA) and ensuring that patient feedback is actively collected. Darsha emphasised the delivery of care in a culturally safe environment, using evidence-based nursing frameworks to reduce stigma and address racism to enhance the quality of care.



A panel discussion featuring **Oliver Walker** (MNHHS), **Camille Anlezark** (IUIH), **Dom Tait** (CHQ), **Darsha Beetson**, and **Michael Cleary** (MSHHS) followed. The panel highlighted the success in ED but acknowledged the need for expansion to other areas. There was agreement on the need for collective commitment and strong governance to make timely decisions, even amidst competing priorities. **Oliver Walker** shared insights on the Virtual Ward initiative, which emerged during COVID-19. This program provides hospital-level care at home, was illustrated by a case study of a woman who received comprehensive care, including virtual monitoring and community support via Mob Link. Michael concluded the session by, emphasising the importance of inviting Mob Link to collaborate with healthcare teams, particularly in the ED, to build strong intra-organisational relationships.

For more information on Mob Link, see: https://www.iuih.org.au/our-services/mob-link-connecting-with-mob-during-covid/

Feedback from workshop participants
Progress and outcomes in improving the pathway between hospital and home

- **Partnerships** – collective commitment.
- **Leadership** - create a structure to bring MobLink to key sector leaders.
- **Data transparency** – need a shared access to data and information across the board.
- **Racism in the workplace** – discussions and cultural safety training about culturally appropriate care is in the workplace.

Conference Wrap Up

Closing: Taking the Health Equity Journey Forward

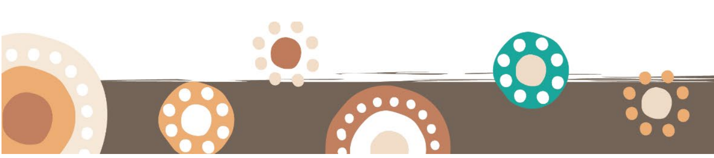
Chairs: **Jim McGowan** (Metro North HHS) and **Adrian Carson (IUIH)**
Speaker: **Haylene Grogan** (Queensland Health)

Representing the SEQ FNHE Governance Committee, Adrian and Jim invited **Haylene Grogan, Queensland's first First Nations Chief Health Officer** to provide the closing remarks for the conference.

Haylene acknowledged her Elders and her family and those who have supported her and all Aboriginal and Torres Strait Islander people on their journeys.

Queensland's Chief First Nations Health Officer and architect of the *Making Tracks Together - Queensland's Aboriginal and Torres Strait Islander Health Equity Framework,* congratulated the SEQ First Nations Health Equity Partnership on another successful conference.

Haylene acknowledged and congratulated the region for leading the way in fully embracing the intent of the First Nations Health Equity and Closing the Gap agendas, particularly:



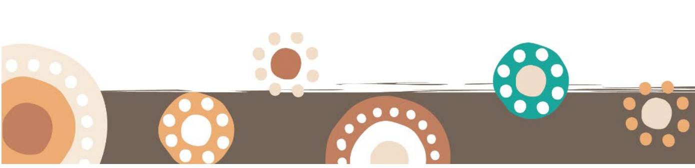
- Working across organisational boundaries as a health system and as a region
- Embracing Aboriginal and Torres Strait Islander leadership and in genuinely co-designing and implementing models of care in partnership
- Recognising that everyone has a part to play, and that rather than competing against each other, **health system partners can work to their respective strengths** – to let HHSs focus on building their cultural capability so that they can deliver hospital services that well serve our Communities; and to let the community controlled health sector deliver culturally safe healthcare as close to home as possible, supporting people to stay well, in community.

The Chief First Nations Officer reflected on highlights from the two days:

- The SEQ workforce strategy, and how **all have a part to play** in training and employment and that, here too, rather than competing against each other, sectors can identify and work to their respective strengths to open coordinated pathways that provide the right opportunities and supports for future and current employees.
- The work to establish community based and community controlled multidisciplinary mental health hubs that link primary mental health care and hospital care.
- Examples of HHSs delivering services into community controlled clinics and examples of community controlled services reaching into hospitals.
- Pathways where community is supported to cross organisational siloes, with mechanisms like warm handovers, collaborative discharge planning and good communication between partners.
- How to think differently about funding, relying less on traditional grant mechanisms and more about sustainable funding sources.
- Open and frank conversations about addressing racism and discrimination in the health system.
- The focus on community engagement and creating an environment for First Nations children and families in SEQ to fully participate in their health and to grow up strong and deadly, accessing culturally anchored support for birthing, early childhood development and pathways into employment and making sure those most vulnerable don't miss out.

Haylene observed that while each HHS is working locally toward health equity with their local stakeholders and partners, this regional approach is unique and necessary in this urban environment.

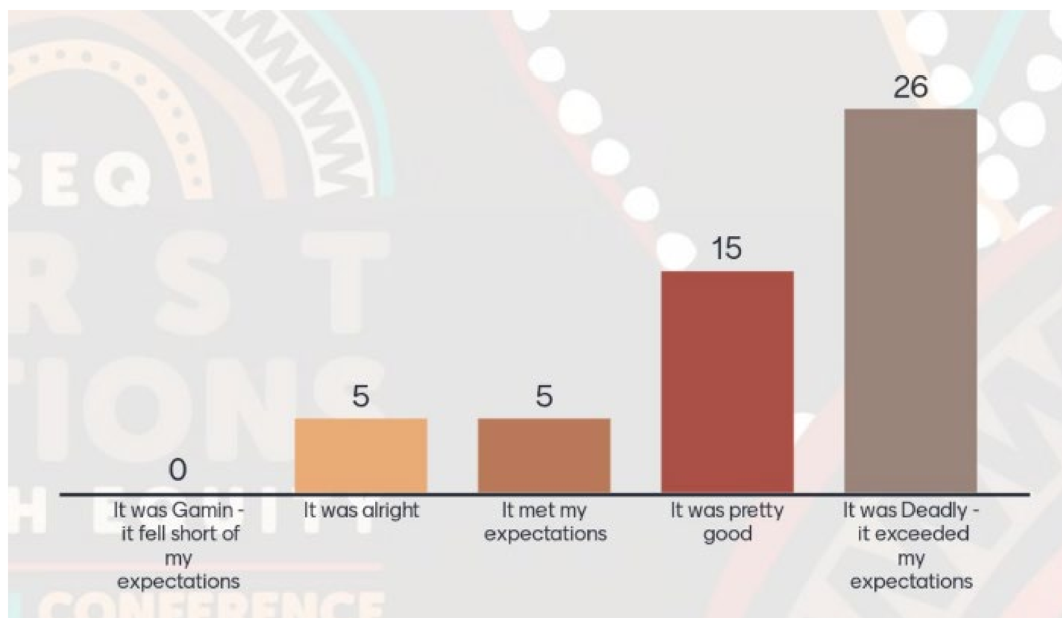
In closing, the Chief First Nations Health Officer encouraged participants to utilise the relationships built and the information gathered during the conference to take individual responsibility for improving the health system experience for Aboriginal and Torres Strait Islander people. Haylene encouraged participants to continue to tackle the systems and barriers that get in the way and looked forward to attending the 2024 conference to hear about progress.



Participant Feedback

After the afternoon workshops, conference delegates gathered together to reflect on conference content and yarn on action to take on the journey ahead to implement the *SEQ First Nations Health Equity Strategy* (2021-31). Participant feedback, obtained with the assistance of the Mentimetre in real-time, is presented below.

How did the First Nations Health Equity in Action Conference meet your expectations?



What are the main take-aways from the First Nations Heath Equity in Action Conference?

What do you plan to do differently as a result of the Conference?

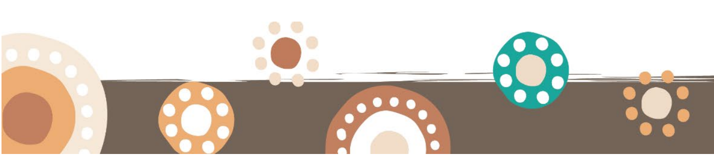
better engagement
cultural safety - workfce
promote fn services
support what is working
promote services
be more brave
engage more with fn
communication
student placements
ask questions
the personal stories
listen and learn
conversations
connection points
sleep
be uncomfortable
communicate
genuine collaboration
work together
advocate more
remodel care
trial and learn
consider
advocate
action
use my voice
listen
refer
collaboration
be brave
recruitment
collaborate
be confident
be creative
connect more
network
share
act
more action
yarn more
engage
partner
community
in-service
think
innovate
co design
engage
reflect
be open
genuine engagement
network more
consultation
reconnect
learn moblink process
trust
collaborate more
networking
ask for help outside
engage with other service
connect
not give up hope
connecting with others
stay the course
collaborate network
innovative models of care
build relationships
reach out
keep moving forward
be vulnerable
try different things
develop relationships
more time connecting

List one thing you enjoyed during the Conference

- Seeing the commitment from partners
- Hearing the stories for community
- Yarning
- The people!
- Meeting new people and connecting
- Networking
- Presentations
- Engagement from partner organisations
- Performances
- Meeting new people
- Networking and graduation
- Being able to meet people from other networks
- The presentations
- Networking
- Networking
- Realising what's possible
- Student graduation!
- Murri school kids
- Yarning
- Workshop time
- The food
- Networking
- Shared presenters from different organisations
- Networking
- Learning about the important work being done in our community. Fantastic!
- The breakout session and yarns from different networks
- Hearing the passion of our speakers

List one thing you enjoyed during the Conference, continued…

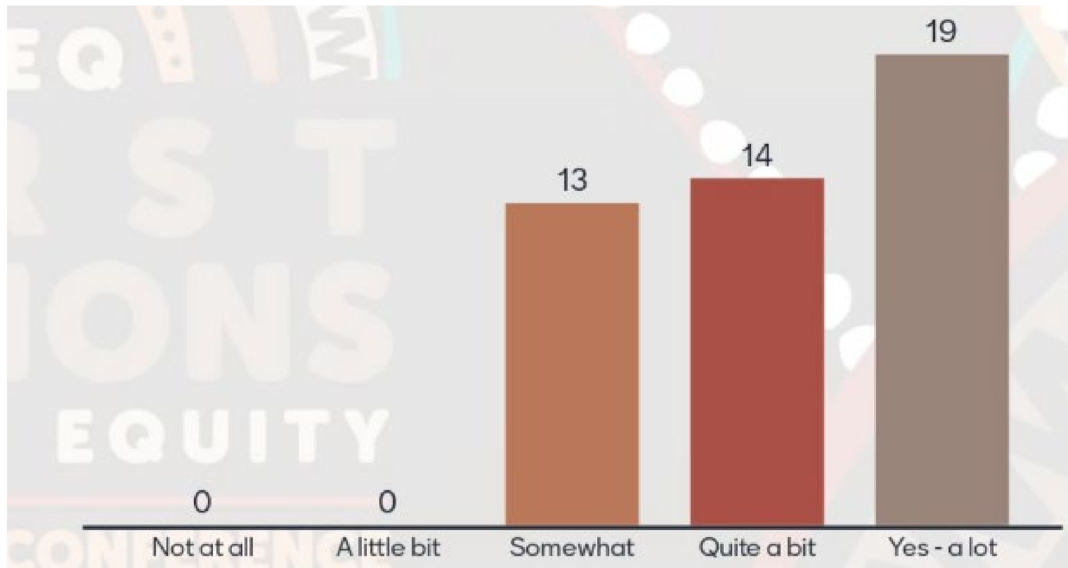
- Listening & yarns
- The ability to connect with people around health equity and changing the system
- Time to reflect on the issues and opportunities raised
- Listening to Aboriginal led solutions
- Learning
- Being surrounded by so many intelligent, passionate people and great ideas
- People being open and vulnerable
- Executive involvement
- The focussed time to take stock and think about what's next
- Chatting to Colleagues
- Networking
- Mewting mob and allies!
- Networking and yarning
- The honest and refreshing yarns
- Workshops to bring people together
- Deadly Murri School kids dancing!
- The Murri School performance & networking
- The breakout sessions were fantastic
- Murri school
- Feed
- The graduation celebration- beautiful
- Networking, gaining a deeper understanding, dancers
- Genuine partnership
- Seeing Mob from all walks working together for Mob
- Batman
- Hearing the great collaboration that already happens and how to build on it
- Networking
- The Murri school dancers
- Connecting with previous work colleagues
- The chance to connect with others and learn some simple things that we could implement now
- Learning and the variety of topics covered
- Meeting external colleagues and panel yarns
- Inspired by others
- Learning about innovation in action
- Everything!



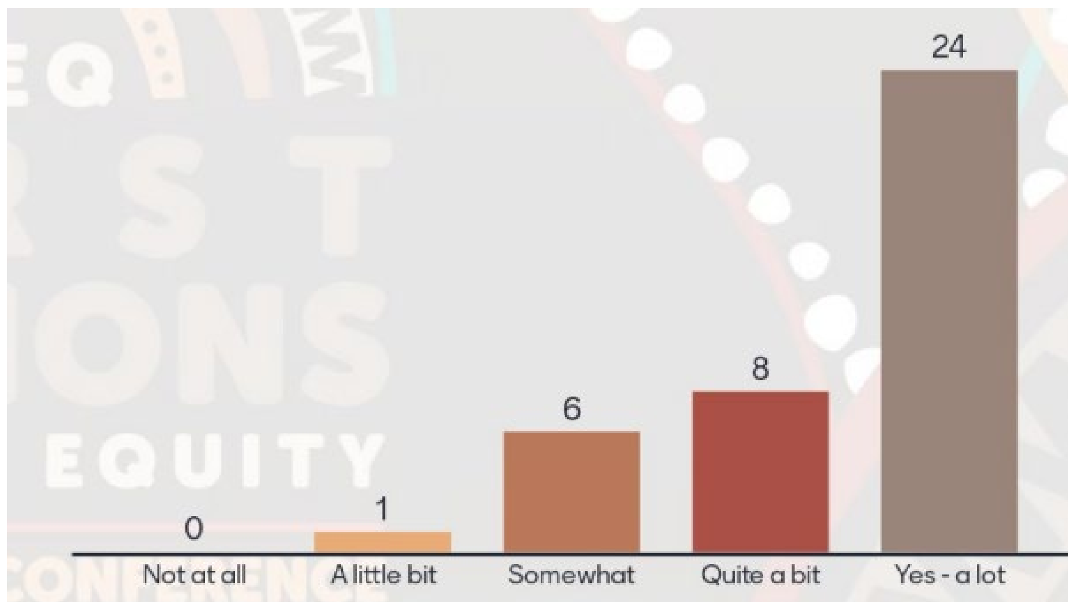
List one opportunity for improvement

- Outcomes from the ideas this year
- Changes to facilities after implementing health equality
- One day conference with networking dinner
- A list of attendees
- Outcomes
- Changes
- Consumer presentation
- Greater involvement from MSHHS
- Enhanced opportunity for workshopping
- More time for workshop yarns
- More info before hand
- Growth and outcomes from this year
- Tables in break out session
- List attendees
- Networking dinner
- Patient stories
- Include examples of mainstream services providing better services for First Nations people as well
- Include preventative health discussions.
- Diversity in attendees - more clinical in the ground people sharing stories
- New topics. Some felt repetitive from last year
- More dancers
- Different room layout - have tables
- Better setup for workshopping
- Break out room setup
- More information sharing on how to...
- Spoilt for choice - I wanted to be in every room!
- Timeliness of sessions
- Concrete commitments
- A think tank where people can bring their problem to collectively solve
- An invitation to attend
- More background information on some of the initiatives for people who are new/unfamiliar. Longer time in workshops
- Workshop rooms oriented differently in tables/ groups
- Workshop room layouts
- More data
- Spread out presentations so we can go to more
- Concrete commitments
- Hear from consumers
- Big picture IUIH, let AMS and HHS do there thing

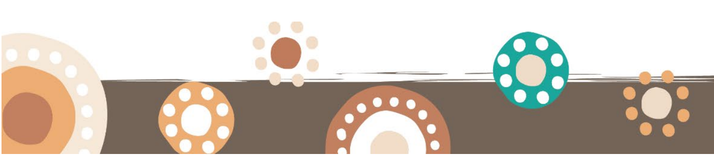
The Conference helped me connect with people I can collaborate with to do First Nations Health Equity work



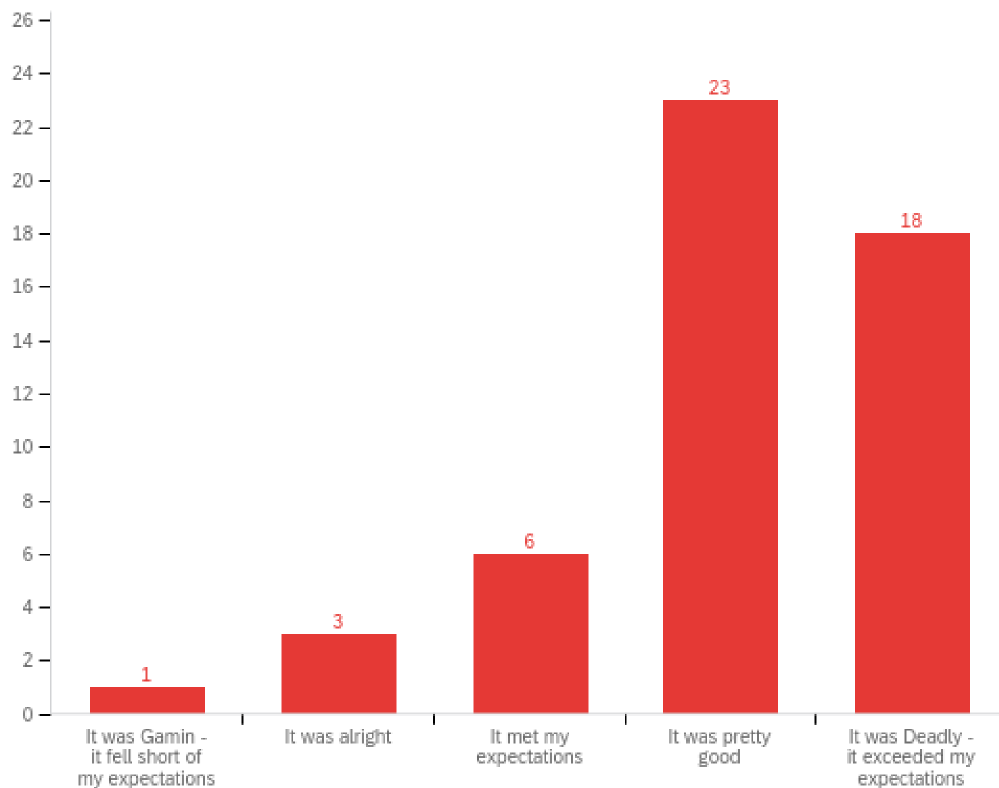
The Conference gave me a greater understanding of the work of the SEQ First Nations Health Equity Strategy



Post-Conference Evaluation Feedback Data



How did the First Nations Health Equity in Action Conference meet your expectations



What were your main take-aways from the Conference?

Key themes were summarised from the collated feedback responses of delegates:

The Conference:

- Positive feedback was given regarding the improved organisation of the event compared to the previous year.
- Attendees appreciated the new facility layout and the meaningful order of sessions.

Collaboration is Key:

- Many attendees emphasized the importance of collaboration and working together for better outcomes.
- Attendees were encouraged by the collaboratives and the deadly work being done by mainstream services, government, and other organisations.

Purpose:

- Attendees appreciated the progress the FNHE partners have achieved in uniting pathways toward a shared goal and a focus on First Nations health equity.
- Delegates were pleased with the progress of current initiatives, and to discover new programs and initiatives for First Nations people.

Data and Integration:

- The significance of data was noted, particularly, in the context of using data proactively to inform our progress.
- Integrative and accessible data sharing was stressed, recognising the value of shared learnings across services.

Community Engagement and Control:

- The importance of community engagement, community-controlled models, and culturally-safe pathways were discussed.
- Indigenous sovereignty and leadership was emphasised, acknowledging the role of leadership in systemic reform.

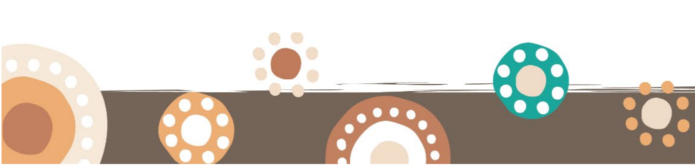
Call to Action:

- Attendees remarked that there is a lot left to be done for Mob, particularly in the Youth Justice and Workforce space.
- Attendees called for more funding availability for community-controlled organisations, and to expand deadly programs.

What do you plan to do differently as a result of this Conference?

Key themes were summarised from the collated feedback responses of delegates:

1. **Focus on First Nations Health:**
    - There is a consistent emphasis on ensuring that First Nations health is a priority and at the forefront of planning efforts.
2. **Data and Education:**
    - The importance of campaigns for staff self-identification, education on current statistics, and having a think tank to determine annual goals.
    - The significance of data collection as a tool for measuring progress and the needs of Community.
3. **Networking and Collaboration:**
    - Numerous statements highlight the importance of networking with different areas, building relationships, and collaborating more with various services.
    - Emphasis on identifying opportunities for collaboration between health services and working collectively.
    - Encouragement to engage more frequently with teams, HHS's, and attendance at conferences to foster collaboration.
    - Seek out service integration opportunities and establish connections with services such as MobLink.
4. **Partnerships and Relationship Building:**
    - A common theme is the desire to establish more partnerships, extend existing partnerships, and build stronger communication and rapport between services.



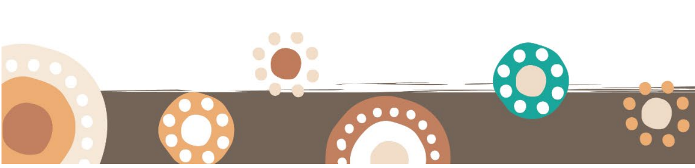
- Efforts to engage with different stakeholders and Working Groups and maintain relationships with organisations like IUIH.

5. **Community Engagement and Feedback:**
    - Commitment to engaging with Community, encouraging client feedback, and using data to show needs.
    - A commitment to deep listening, connecting with Community, and ensuring all work is equitable and co-designed.
    - Commitment to co-design approaches.
6. **Learning and Quality Improvement:**
    - Statements reflecting a commitment to learning, such as looking into Models of Care, implementing health equity themes, introducing effective care models, and educating staff on relevant topics.
    - The intention to review processes, quality improvement, and applying learnings systematically.
    - The importance of interacting with all services and encouraging client feedback to understand what is not working.
    - Specific actions, such as campaigns for staff self-identification and having a think tank for annual goals, are mentioned.
7. **Strategic Focus and Capacity Building:**
    - Focus on strategic partnerships, breaking down barriers, and finding positive change opportunities.
    - Acknowledgment of limited capacity but a desire to do more and engage more frequently with teams and HHS's.
    - Assess how regional learnings can be indicating transferred across the state.
8. **Keep up the good work:**
    - Common phrases like "continue to," "keep doing what we are doing," and "nothing, as I already do engagement really well" indicate a commitment to ongoing efforts.

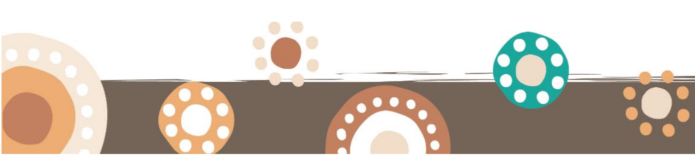
Please list one thing that your really enjoyed during the Conference.

Key themes were summarised from the collated feedback responses of delegates:

1. **Networking and Interactions:**
    - Emphasis on the opportunity to discuss, plan, collaborate, and build partnerships with other professionals and organisations.
2. **Presentations and Sessions:**
    - Positive feedback on various sessions, including plenary sessions, breakout sessions, workshops, and panel discussions.
    - Appreciation for the quality of presentations, interactive learning, and the variety of formats, such as large and small group sessions.
    - Attendees really enjoyed sessions supported by data and case studies.



3. **Highlighting Achievements and Success Stories:**
    - Recognition and celebration of achievements in the region and sharing success stories.
    - Positive feedback on the variety of stories and impactful presentations shared using shared data and in-person discussions from Mob using the program.
4. **Cultural Performances:**
    - Positive comments about cultural performances, such as the Murri School dancers.
    - Mention of the memorable and powerful experience of watching performances.
5. **Opportunities for Dialogue and Yarning:**
    - Appreciation for the yarns, Elders yarns, and the open yarning sessions.
    - The value of having discussions, dialogues, and opportunities to speak with Elders.
6. **Inclusive and Interactive Learning:**
    - Positive comments on the inclusive interaction, inclusive way people interacted, and interactive learning breakouts.
    - Mention of specific interactive tools like Mentimetre being valuable for future planning.
    - Recognition of the chance to understand what is happening in the sector and the importance of having a voice.
7. **Diverse Formats and Topics:**
    - Positive feedback on the variety of formats, such as large group sessions, smaller group discussions, and brainstorming sessions.
    - Appreciation for the diversity of topics covered, ranging from addressing racism and discrimination to cardiac services.
    - Attendees remarked that they would have appreciated the chance to attend more of the breakout sessions.
8. **The Experience:**
    - Positive comments on the food, session facilitators, and the opportunity for many people and organisations to have a voice.
    - Attendees appreciated the opportunity to see the graduation of the POWA students.
9. **Learning and Professional Development:**
    - Recognition of the learning opportunities, exposure to key speakers, professionals, and the chance to hear from and speak to elders.
    - Positive comments on the student presentations.

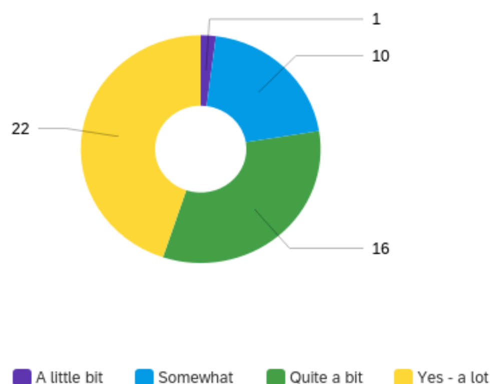


Please list one opportunity for improvement.

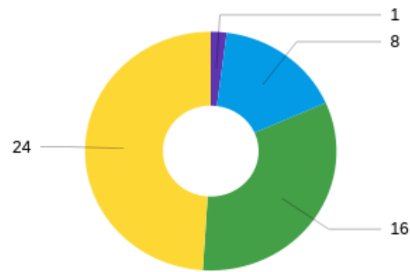
Key themes were summarised from the collated feedback responses of delegates:

1. **Promoting our mission:**
    - Suggestion of media coverage.
2. **Sustainability and Food:**
    - Suggestions to have a greater focus on sustainability, particularly in the context of minimising the environmental impact of the event.
3. **Conference Logistics:**
    - Challenges with the conference room layout, breakout group logistics, and a preference for a more interactive setup.
    - Feedback on the timing of data presentations and encouragement for more information on services/programs during sessions.
    - Additional seating.
4. **Inclusion and Collaboration:**
    - Calls for more inclusion from other member services, such as Moreton ATSICHS.
    - Suggestions for more Community voices in discussions.
5. **Positive Focus and Data Sharing:**
    - Requests for more success stories, showcasing data on improved outcomes.
    - A desire for more examples of effective changes from outside SEQ.
6. **Evaluation and Follow-up:**
    - Questions about the sharing of data and a desire for deeper engagement and understanding.
    - Examples of initiatives from outside South-East Queensland.

The Conference helped me connect with people I can collaborate with to do First Nations Health Equity work?



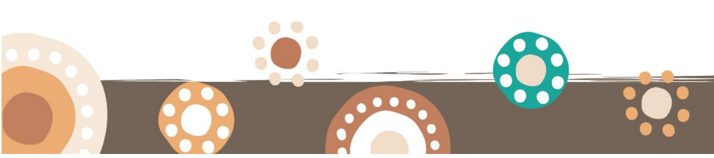
The Conference gave me a greater understanding of the work of the SEQ First Nations Health Equity Strategy?



Appendix 1. SEQ First Nations Health Equity Strategy (2021-31) Key Priority Areas

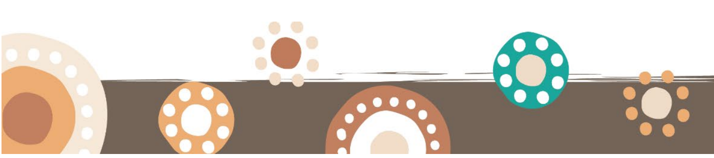
Key Result Area One – Cultural Safety

First Nations Health Equity *Priority Area 1: Actively eliminating racial discrimination and institutional racism within services*		
National Agreement on Closing the Gap	*Priority Reform 1: Partnership & shared decision-making*	1. Promote safe, inclusive, and respectful workplaces where staff are valued and supported 2. Ensure First Nations voices in corporate and clinical governance and decision-making and embed cultural and clinical governance within clinical service design and delivery 3. Reflect this *South East Queensland First Nations Health Equity Strategy 2021-2031* in HHS and CCHS strategic and operational plans by 30 June 2022
	Priority Reform 2: Building Community Controlled Health Services	
	Priority Reform 3: Transforming Government Organisations	4. Develop systems and processes for the reporting of First Nations client and staff experiences of racism and discrimination 5. Analyse client/staff experience reports to inform improved practice and address racial discrimination where it occurs 6. Develop and implement a regional anti-racism campaign 7. In the short term, implement available (generic) training aimed at educating and addressing racism, and simultaneously work with Universities to develop formal education in the context of Australia's First Nations people that can be recognised in continuing medical education and professional development 8. Include First Nations perspectives in the design of new facilities including the availability of culturally safe gathering places, including options for co-location of CCHS and HHS services
	Priority Area 4: Sharing access to data and information at a regional level	9. Develop resources for clients to understand their rights and what they can do if they experience racial discrimination 10. Develop a regional cultural protocol guideline for SEQ 11. Develop a First Nations staff satisfaction survey to be used across the region



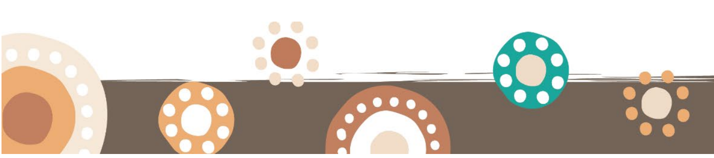
Key Result Area Two - Access

First Nations Health Equity *Priority Area 2: Increasing access to healthcare services*		
National Agreement on Closing the Gap	*Priority Reform 1: Partnership & shared decision-making*	1. Establish models of care that deliver care closer to home in partnership with, and/or by subcontracting to, CCHSs; e.g., Hospital in the Home, shared specialist clinics 2. Collaborate to improve access to culturally safe healthcare for First Nations people in prisons 3. Improve integration of care by investing in models of care coordination and strengthening the interface between primary, community and secondary care 4. Develop partnership models for palliative care
	Priority Reform 2: Building Community Controlled Health Services	5. Harness opportunities to expand First Nations primary healthcare services across the region 6. Implement culturally appropriate health promotion and prevention initiatives across SEQ including implementation of the Deadly Choices Schools Program, and associated community events and communications
	Priority Reform 3: Transforming Government Organisations	7. Implement Cancer Australia's Optimal Care Pathway for Aboriginal and Torres Strait Islander People with Cancer available at https://www.canceraustralia.gov.au/publications-and-resources/cancer-australia-publications/optimal-care-pathway-aboriginal-and-torres-strait-islander-people-cancer 8. Provide free discharge medications to First Nations people leaving hospital 9. Expand the availability of Aboriginal and Torres Strait Islander nurse navigators
	Priority Area 4: Sharing access to data and information at a regional level	



Key Result Area Three – Determinants

First Nations Health Equity *Priority Area 3: Influencing the social, cultural, and economic determinants of health*		
National Agreement on Closing the Gap	*Priority Reform 1:* Partnership & shared decision-making	1. Identify and establish cross-agency partnerships to develop regional responses to the determinants of health, particularly with the education, housing, and justice sectors 2. Co-design and co-implement targeted youth services and work with appropriate agencies to address the over-representation of First Nations people in youth detention 3. Contribute to Health and Wellbeing Queensland's multi-agency efforts to prevent and address obesity.
	Priority Reform 2: Building Community Controlled Health Services	4. Accelerate efforts to close the gap in early childhood health and education outcomes by supporting community controlled models of service delivery that integrate early childhood clinical therapies and learning
	Priority Reform 3: Transforming Government Organisations	5. Work with CCHSs and child protection agencies to support families to stay together and reduce rates of children in out of home care 6. Consistent with the Queensland Indigenous Procurement Policy, stimulate Aboriginal and Torres Strait Islander employment by procuring goods and services from First Nations businesses.
	Priority Area 4: Sharing access to data and information at a regional level	



Key Result Area Four – Delivering Quality Healthcare

<table>
<tr><th colspan="3">First Nations Health Equity
Priority Area 4: Delivering sustainable, culturally safe, and responsive healthcare services</th></tr>
<tr><td rowspan="4">National Agreement on Closing the Gap</td><td>Priority Reform 1:
Partnership & shared decision-making</td><td>1. Take a regional and systems approach to health service planning and service development for First Nations people in partnership with CCHSs
2. Use data from the ISEQ – NMHSPF project and QUIMHS to inform the planning and delivery of co-designed, targeted mental health services in SEQ
3. Jointly develop a SEQ Aboriginal and Torres Strait Islander Suicide Prevention and Aftercare Action Plan
4. Work together to implement the SEQ Aboriginal and Torres Strait Islander Community Engagement Strategy (see Appendix Three) to ensure community perspectives are continuously informing health service planning, design and delivery
5. Work collaboratively to strengthen urban First Nations health research and to develop researchers with expertise in urban First Nations health</td></tr>
<tr><td>Priority Reform 2:
Building Community Controlled Health Services</td><td>6. Design and establish community controlled suicide prevention and aftercare services that are culturally and clinically informed
7. Design and establish a regional community controlled specialist mental health service for people with mild to moderate mental health needs, that have strong referral pathways into, and partnerships with, acute mental health services</td></tr>
<tr><td>Priority Reform 3:
Transforming Government Organisations</td><td>8. Co-design and co-implement, with police, ambulance services, mental health services and CCHSs First Nations specific approaches to mental health crisis intervention
9. Disaggregate data used for planning and performance monitoring/ reporting by Indigenous status wherever possible, including in Local Area Needs Assessments, and in data reports at the Executive and Board level
10. Increase support and training for First Nations people/families undertaking carer roles</td></tr>
<tr><td>Priority Area 4:
Sharing access to data and information at a regional level</td><td>11. Create a data portal to share healthcare data between HHSs, CCHSs and PHNs at the regional level underpinned by a regional data sharing agreement
12. Work together to further develop the performance measures required to effectively measure progress in SEQ to close the health gap by 2031
13. Establish a regional First Nations Research Reference Group to inform research activity
14. Develop measures and mechanisms to capture data on First Nations patient-reported experiences with healthcare services</td></tr>
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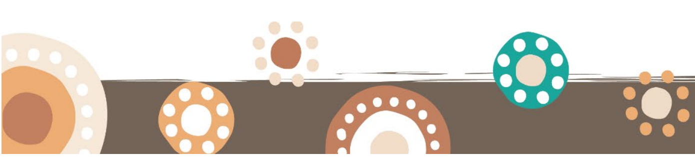
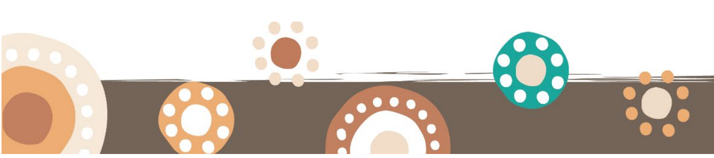


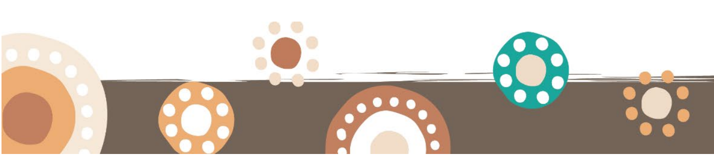
Key Result Area Five – Service Delivery Partnerships

First Nations Health Equity *Priority Area 5: Working with First Nations people, communities, and organisations to design, deliver, monitor, and review health services*		
National Agreement on Closing the Gap	*Priority Reform 1: Partnership & shared decision-making*	1. Build on and replicate effective service delivery partnership models already established in SEQ, including (but not limited to): • Surgical Pathways • Birthing in our Community services • Gynaecological care pathways • Hospital in the Home arrangements • Oral health services • Prison transition services
	Priority Reform 2: Building Community Controlled Health Services	2. Improve integrated care by (i) embedding referrals to MobLink (IUIH Connect Plus) into all HHS discharge planning policies and (ii) strengthening handover processes between nurse navigators/Indigenous Hospital Liaison Officers (IHLOs) and IUIH Connect Plus staff/IUIH Network clinics 3. Transition appropriate community-based HHS services to the CCHS sector where possible and as guided by local co-design and service capacity 4. Work with Queensland Health's Healthcare Purchasing and System Performance Division to identify opportunities for commissioning/ purchasing First Nations services and programs from the CCHSs sector
	Priority Reform 3: Transforming Government Organisations	5. Advocate for dedicated First Nations funding streams to facilitate purchasing or subcontracting of targeted First Nations services and for implementation of this Strategy, with flexible funding opportunities at both a regional and local level 6. Increase the amount and percentage of baseline funding for First Nations programs and services within HHSs 7. Increase the value of services purchased from CCHSs over time
	Priority Area 4: Sharing access to data and information at a regional level	



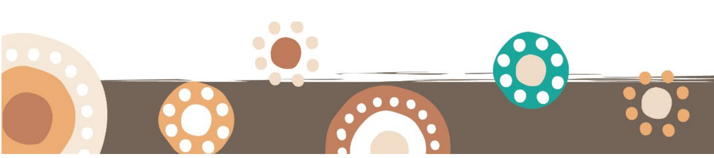
Key Result Area Six – A Strong Capable Workforce

First Nations Health Equity *Priority Area 6: Strengthening the First Nations Health Workforce*		
National Agreement on Closing the Gap	*Priority Reform 1:* *Partnership & shared decision-making*	1. Jointly develop a SEQ regional health workforce strategy that incorporates: • culturally appropriate governance • leadership development training and support for mentoring roles for First Nations staff • strategies to recruit, retain, and provide career progression for, First Nations people at all HHS workforce levels • a culturally appropriate regional workforce training and employment pipeline for First Nations people, to 'grow our own' workforce of First Nations people with health and social service qualifications and skills, to strengthen health system responsiveness and improve employment outcomes for First Nations people • shared workforce retention and leadership development strategies • partnerships with CCHSs for the formal placement of registrars and other clinical staff within CCHS clinics and job sharing arrangements • culturally responsive ways of working • First Nations workforce representation across all disciplines at levels commensurate with the local population
	Priority Reform 2: *Building Community Controlled Health Services*	
	Priority Reform 3: *Transforming Government Organisations*	2. Increase the number of First Nations people in clinical roles 3. Work with Universities and TAFE to establish cadetships for First Nations students that include opportunities for transition into formal employment within healthcare services
	Priority Area 4: *Sharing access to data and information at a regional level*	

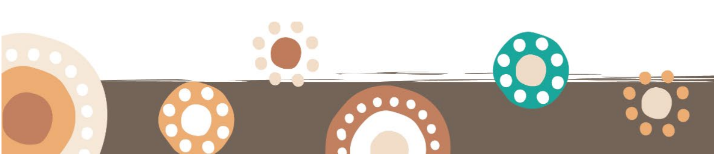


Appendix 2. Workshop Questions

Day 1, Morning, Concurrent Workshop 1. Starting Strong: The impact of Birthing in Our Communities on the health of families
1. What did you take away from the yarn? 2. What are the strengths of this approach? 3. How can we build on this model and/or replicate these initiatives in other parts of the region? 4. What other action can the health system take to support outcomes for babies and their families? 5. What actions we can commit to over the next 12 months to progress this work?
Day 1, Morning, Concurrent Workshop 2. Growing Strong: culturally responsive multi-disciplinary paediatric services closer to home
1. What did you take away from the yarn? 2. What are the strengths of this approach? 3. How can we build on this model and/or replicate these initiatives in other parts of the region? 4. What other action can the health system take to support child development? 5. What actions we can commit to over the next 12 months to progress this work?
Day 1, Morning, Concurrent Workshop 3. Staying Strong: Creating access and support pathways for children and families across the health sector
This workshop was conducted in a Q&A format.
Day 1, PM Concurrent Workshop 1. Strong and Deadly Futures: Entry into the training and employment pipeline
1. What did you take away from the yarn? 2. What other action can the health system take to re-orient systems so that they support the training and employment of our young people? 3. How do we ensure we match trainee need and aspiration to the right experience and the right support? 4. What strategies do you have for monitoring the growth of your First Nations workforce? 5. What actions can we commit to over the next 12 months to progress this work?
Day 1, PM Concurrent Workshop 2. Strong and Deadly Futures: Moving through the pipeline
1. What did you take away from the yarn? 2. How can we build on these initiatives across other parts of the health sector? a. Where and how can we employ cadets in other areas? b. How could we join cadets up across different organisations? 3. What additional action do we need to re-orient the systems which support employment and training opportunities for our young people? a. How do we make cadetships sustainable so cadets have certainty of funding AND ongoing employment? 4. What resourcing would we need to make this a reality? 5. What can we commit to over the next 12 months to progress this work?



Day 1, PM Concurrent Workshop 3. The SEQ First Nations Health Equity Workforce Strategy: The next 12 months
1. What did you take away from the yarn? 2. How can you contribute to the implementation of the SEQ First Nations Workforce Strategy in your workplace? 3. What strategies do you have for monitoring the growth of your First Nations workforce? 4. What actions can we commit to over the next 12 months to progress this work?
Day 2, Morning, Concurrent Workshop 1. Meaningful Multidisciplinary Rehabilitation for Heart and Lung Conditions: A collaboration between organisations and sectors towards self-management
1. What did you take away from the yarn? 2. What are the strengths of this approach? 3. How can we build on this model and/or replicate these initiatives with other specialties? 4. What other action can the health system take to re-orient systems so that they support access to culturally responsive services closer to home? 5. What barriers do we need to overcome and how can we do this? 6. What can we commit to over the next 12 months to progress this work?
Day 2, Morning, Concurrent Workshop 2. Staying Deadly Hubs: Establishing community controlled specialised multidisciplinary mental health and AOD hubs in partnership
1. What did you take away from the yarn? 2. What are the strengths of this approach? 3. How can we build on this model and/or replicate the model in other parts of the region? 4. What can we do to harness the respective strengths of FNHE partners to support improved care pathways for First Nations people with mental health issues? 5. What can we commit to over the next 12 months to progress this work?
Day 2, Morning, Concurrent Workshop 3. Connecting to Support Mob in their surgery journey
1. What did you take away from the yarn? 2. What are the strengths of this approach? 3. How can we build on this model and/or replicate the model in other parts of the region? 4. What can you do to improve communication and strengthen care pathways across the care continuum? 5. What can we commit to over the next 12 months to progress this work?
Day 2, Afternoon, Concurrent Workshop 1. Addressing racism and discrimination in our health services: Where are we up to?
This workshop was conducted in a Q&A format.
Day 2, Afternoon, Concurrent Workshop 2. Community engagement in partnership
1. What did you take away from the yarn? 2. What are the strengths of this approach? 3. How can we systematize joined up community engagement in practice? 4. What can we commit to over the next 12 months to progress this work? 5. What additional action do we need to re-orient systems for improved community engagement?



Day 2, Afternoon, Concurrent Workshop 3. Progress and outcomes in improving the pathway between hospital and home
This workshop was conducted in a Q&A format.

Appendix 3. Conference Program

DAY 1: THURSDAY 12 OCTOBER

Time	Session
8:30am	**Welcome to Country – Nunukul Yuggera** Welcome Ceremony Room: Boulevard Auditorium
8:50am	**Welcome to Conference** – Introduction to the SEQ First Nations Health Equity Strategy **Chairs:** Kieran Chilcott (IUIH Board Chair) and Jim McGowan (MNHHS Board Chair) Room: Boulevard Auditorium
9:15am	**Keynote Address: Monitoring Progress – SEQ FNHE Partnership since 2020** **Speakers:** Adrian Carson (IUIH) and Adrian Clutterbuck (CHQ) Room: Boulevard Auditorium
10:15am	**MORNING TEA**
10:45am	**Plenary Session: Growing up Strong and Deadly Black Kids.** **Chair:** Simone Jackson (Kambu) **Speaker:** Kristie Watego (IUIH) Room: Boulevard Auditorium

Time	Room B1	Room B2	Room B3
11:15am	**Listening and Learning to Inform Action: Introduction to Workshop Format**		
11:20am	**Starting strong: The impact of Birthing in our Communities on the health of families** **Chairs:** Renee Blackman (ATSICHS) **Presenters:** Kristie Watego (IUIH), Liz Wilkes (My Midwives), Invited Families Room B1	**Growing Strong: culturally responsive multi-disciplinary paediatric services closer to home** **Chairs:** Renee Brown (IUIH) **Presenters:** Chrisdell McLaren (IUIH), BNPHN, Milly Phillips (IUIH) Room B2	**Staying Strong: Creating access and support pathways for children and families across the health sector** **Chairs:** Kaava Watson (IUIH) and Dom Tait (CHQ) **Presenters:** Jarryd Stanley (Kalwun), Chantelle Howse (GCPHN), Alf Davis (IUIH), Maria Uhr (IUIH/CHQ) Room B3
	Research demonstrates that improving outcomes in birthing sets a child up for a healthy life. This requires a cross-sector approach which is determined to overcome barriers for families. In this session you will hear about the Birthing in Our Community Program (BIOC) and the ways in which partnerships between community-controlled health services, hospitals and community midwifery have produced outstanding outcomes for Aboriginal and Torres Strait Islander babies and their families, including preterm birth rates of 6% compared to 14% (national rate), and almost closing the gap between First Nations preterm births and those of other Australians.	The First Nations Health Equity agenda requires re-orientation of systems and thinking outside of traditional siloes. When it comes to growing strong children, this means thinking about child development and what supports this from both a preventative and treatment perspective. In this session you will hear about a range of initiatives which aim to integrate the early childhood development/health sectors and build on propa cultural ways with support from PHNs and Queensland Health. These include the Deadly Kindies intensive playgroups, inter-generational programs, Multi-disciplinary team assessments and supporting the growth of Paediatric Registrars.	The rates of First Nations children in out of home care continue to be alarming. These children often experience the added disadvantage of fragmented health care which increases their vulnerability. In this session you will hear from some of the members of the FNHE Vulnerable Children Working Group about the progress made towards improving access and continuity of health care for children in out of home care.
11:50am	**Workshop:** Starting strong: How do we enable an environment to enable strong, deadly families and babies?	**Workshop:** Growing Strong: How do we cultivate strong, deadly environments for little ones to thrive?	**Workshop:** Staying Strong: Creating access and support pathways for children and families across the health sector.
12:30pm	**LUNCH**		
1:15pm	**Strong and Deadly Futures** **Chair:** David Collins (Yulu-Burri-Ba) and Mike Bosel (BSPHN) **Murri School Dancers** Room: Boulevard Auditorium		

Time	Session		
1:30pm	**Video: celebrating growing up strong, black and deadly**		
1:45pm	**Accelerating the training and employment pipeline** **Speakers:** Kipley Nink (Jobs Queensland) and Tracy Hill (IUIH) Room: Boulevard Auditorium		
2:15pm	**Strong and Deadly Futures: Entry into the training and employment pipeline** **Chairs:** Jackie Hansen (MNHHS) and Fiona Hinchliffe (CHQ) **Presenters:** Tracy Hill (IUIH), Vivienne Hassed (MNHHS), Billie-Lee Boudar (IUIH), Lili-Jade Malone (MNHHS), Michelle Grant (Mater) Room B1	**Strong and Deadly Futures: Moving through the pipeline** **Chairs:** Alison Nelson (IUIH) **Presenters:** Michelle Stute (MNHHS), Wyomie Robertson (CHQ), Taliyah Hawkins, Loni McIlvena (IUIH) and Rhea Waia (MNHHS) Room B2	**The SEQ First Nations Health Equity Workforce Strategy: The next 12 months** **Chairs:** Mike Bosel (BSPHN) and David Collins (YBB) **Presenters:** Dawn Schofield (IUIH) Room B3
	In this session we will hear about the progress made in the last 12 months to connect up parts of the training and employment pipeline across the health sector so that each part of the system is working to its strengths and we are providing the best possible pathway for each trainee. Learn from those who have walked the walk to explore ways in which we can develop a pipeline into health that is both culturally safe and offers real growth opportunities across the whole health sector.	In this session we will hear about ways that we are making it easier for Aboriginal and Torres Strait Islander people and their employers to identify and create employment opportunities beyond traineeships. In particular, learn from those who have travelled through the workforce pipeline and into further employment and/or study. Hear about ways in which we are supporting opportunities and opening pathways with innovative employment initiatives and supports, including Indigenous cadetships and the CHQ-led Talent Pool.	The SEQ FNHE Workforce subcommittee was tasked with developing a SEQ First Nations Workforce Strategy. This strategy was co-designed across the health sector and endorsed by the SEQ FNHE Governance Committee. In this session, you will have the opportunity to dive into the strategy and the plans for the next 12 months and determine how you can play a part.
3:00pm	**AFTERNOON TEA**		
3:30pm	**Workshop:** Strong and Deadly Futures: Creating opportunities for young people to see what the future can be.	**Workshop:** Strong and Deadly Futures: Creating opportunities for employment and cadetships	**Workshop:** The SEQ First Nations Health Equity Workforce Strategy: What does it mean for me in the next 12 months
4:00pm	**Graduation Celebration for Deadly Start and POWA Trainees**		
4:30pm	**Welcome Reception and Entertainment until 6pm -** Boulevard Foyer		

DAY 2: FRIDAY 13 OCTOBER

8:30am

Theme of Day 2: Systems Reform: Accelerating Progress Together

Welcome and Housekeeping
Chair: Renee Blackman (ATSICHS Brisbane) and Noelle Cridland (MSHHS)

Room: Boulevard Auditorium

8:45am

Panel Discussion: Funding reform: funding First Nations health differently for better outcomes

Facilitator: Selwyn Button (IUIH Board)
Facilitator Panel: Adrian Carson (IUIH), Luke Baxby (Deloitte), Kristy Hayes (GCHHS) and Shane Solomon (Consultant)

Room: Boulevard Auditorium

9:45am

Listening and Learning to Inform Action: Introduction to Workshop Format

9:50am

Room B1	Room B2	Room B3
Meaningful Multidisciplinary Rehabilitation for Heart and Lung Conditions: A collaboration between organisations and sectors towards self-management **Chairs:** Wayne AhBoo (Moreton ATSICHS) **Presenters:** Katrina Ghidella (IUIH) and Dr Peter Hopkins (MNHHS) Room B1	**Staying Deadly Hubs – Establishing community controlled specialised multidisciplinary mental health and AOD hubs in partnership** **Chairs:** Angela Young (CHQ) and Dr Harvey Whiteford (UQ/WMHHS) **Presenters:** Dr Carmel Nelson (IUIH), Rayno Potgieter (IUIH) and Emma Foreman (WMHHS) Room B2	**Connecting to Support Mob in their surgery journey** **Chairs:** Frank Tracey (CHQ) and Donisha Duff (MSHHS) **Presenters:** Nami Hirano (IUIH), Celia McCarthy (IUIH), Caroline Harvey (IUIH) and Edwina Powe (MNHHS) Room B3
The new Cardiac and Pulmonary Services for First Nations people have been operating for 12 months. This includes both outreach of specialist services from the HHSs and establishment of multidisciplinary rehabilitation programs within the Institute for Urban Indigenous Health (IUIH) Network. This has brought care closer to home and enabled a culturally responsive service delivery model. Learn from this presentation and hear how it is already being replicated to other specialist areas.	Last year's conference presented research from two co-designed mental health projects. The first of their kind in Australia, the projects provided valuable insight to mental health prevalence and service access in SEQ to inform the planning, funding and delivery of mental health services for urban Indigenous people. This year, hear about a partnership approach to establishing community controlled mental health hubs to address identified needs and service gaps and support people living with mental health issues to stay deadly.	Accessing surgery for Aboriginal and Torres Strait Islander clients is often a story of long wait lists and repetition of appointments. Clients can then struggle to access follow-up appointments and rehabilitation. In this presentation you will hear about innovative models which have impacted on access to surgery and post-operative rehabilitation. Learn about models that stitch up care pathways across the primary/hospital interface and use the respective strengths of partner organisations to support patients through the patient journey.

Time			
10:30am	**MORNING TEA**		
11:00am	**Workshop:** Collaborating to expand opportunities for multi-disciplinary rehabilitation models	**Workshop:** Staying Deadly Hubs – Establishing community controlled specialised multidisciplinary mental health and AOD hubs in partnership	**Workshop:** Exploring ways to better support Mob in their surgery journey: what can you do?
12:00pm	**LUNCH**		
12:45pm	**Panel Yarn: Engaging with our communities to achieve more together** **Learnings from the Qld Murri Carnival - First Nations Health Equity Activations** **Chair and Facilitator:** Kaava Watson (IUIH) **Panel:** Dallas Leon (IUIH), (MSHHS), (WMHHS), Wyomie Robertson (CHQ), Philip Whap (MNHHS), Belinda Charles (ATSICHSB) Room: Boulevard Auditorium		
1:15pm	**Plenary Session: Addressing Issues of racism and discrimination in our health systems – Are we ready?** **Chair:** Kaava Watson (IUIH) **Panel:** Keryn Ruska (IUIH) and Scott McDougall (Human Rights Commission) Room: Boulevard Auditorium		

Time	Room B1	Room B2	Room B3
2:00pm	**Addressing Racism and discrimination in our health services: where are we up to?** **Chairs:** Kaava Watson (IUIH) **Presenters:** James Ward (UQ Poche), Angela Young (CHQ), Aunty Mary Graham Room B1	**Community Engagement in Partnership** **Chairs:** Wayne AhBoo (Moreton ATSICHS) and Hannah Bloch (WMHHS) **Presenters:** Laurie West (Kalwun) and Kristy Hayes (GCHHS) Room B2	**Progress and outcomes in improving the pathway between hospital and home** **Chairs:** Michael Cleary (MSHHS) and Dom Tait (CHQ) **Presenters:** Camille Anlezark (IUIH), Darsha Beetson (CHQ), Oliver Walker (MNHHS) Room B3
	General consensus is that actions speak louder than words. So how do we move beyond campaigns to true action and transformation of our systems to be more culturally safe? In this presentation we will show snapshots of campaigns and initiatives currently underway to implement a regional anti-racism campaign. But even more importantly, we will discuss what systems and processes are required to be in place before an anti-racism campaign can be rolled out.	Engaging with our communities in a coordinated and connected way is critical to the success of the First Nation's Health Equity Strategy. We need to move beyond tokenistic and individualistic approaches to well-coordinated approaches across governance, organisational and individual levels. This presentation will highlight community engagement which has taken place as part of the Murri Carnival as well as the approach being taken on the Gold Coast to ensure community engagement happens in a coordinated and integrated way.	The transition from primary to tertiary care and back has many challenges including issues around DAMA and revolving doors. In this session you will learn about the evolution of Moblink and its expansion in the past 12 months. As a QH supported program, learn about the ways in which clients are supported by Moblink in their journey through the health system to ensure access to ongoing health and social care to meet their needs, including practical supports that prevent re-admissions. Data showing referrals to Moblink over the past 12 months and stories that illustrate the impact of these referrals will be shared.
2:45pm	**Workshop:** Implementation strategy and systems and processes. This workshop will provide an opportunity to plan next steps.	**Workshop:** Improving the ways in which we engage with our Aboriginal and Torres Strait Islander communities	**Workshop:** Improving the patient journey across primary care and hospital. Planning the next 12 months.
3:15pm	**Closing Address: Taking the Health Equity Journey forward** **Chairs:** Jim McGowan (MNHHS Board Chair) and Kieran Chilcott (IUIH Board Chair) **Speaker:** Haylene Grogan (QH) Room: Boulevard Auditorium		
3:45pm	**AFTERNOON TEA (Final Gathering)**		