SOUTH EAST QLD

FIRST NATIONS HEALTH EQUITY IN ACTION

Inaugural First Nations Health Equity In Action Conference 2021-22

OUTCOME REPORT

29-30 November 2022

Brisbane Convention and Exhibition Centre

Published by the Policy Team, Institute for Urban Indigenous Health on behalf of the SEQ First Nations Health Equity Governance Committee

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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 (eg 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.

Acknowledgement

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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Abbreviations

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

Thanks

The SEQ First Nations Health Equity Governance Committee wishes to acknowledge the contribution of:

- Members of the Conference Organising Working Group – Alison Nelson, Marianna Serghi, Renee Brown and Kerry Skillington (IUIH), Paul Martin (Brisbane North PHN) and Angela Young (CHQ) for planning and development.
- Members of the IUIH Organisational Development and Policy Teams for support on the day.
- All chairs, speakers, workshop convenors, workshop scribes and participants.

Executive Summary

On 29-30 November 2022, the SEQ First Nations Health Equity Governance Committee hosted the **Inaugural SEQ Health Equity in Action Conference** at the Brisbane Convention and Exhibition Centre in Brisbane, Australia. The conference showcased effective service delivery, workforce development and research partnerships 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 conference brought together 192 participants from SEQ Partner Organisations at the board, executive, operational and community levels to understand the elements of success to advance Indigenous-led health service models already underway in SEQ. Delegates mainly comprised representatives from IUIH's partner organisations, including the four Hospital and Health Services (HHSs) in SEQ (Metro North HHS, Metro South HHS, West Moreton HHS, and Gold Coast HHS), Children's Health Queensland, Mater Health, the four Primary Health Networks (PHNs) in SEQ (Brisbane North PHN, Brisbane South PHN, Darling Downs and West Moreton PHN, and Gold Coast PHN), as well as the five CCHSs that form the IUIH Network (ATSICHS Brisbane, Kalwun Health Service, Kambu Health Service, Yulu-Burri-Ba and Moreton ATSICHS).

The Conference exposed participants to:

- The SEQ regional partnership approach to Closing the Gap and its commitments to achieving health equity through implementation of the *SEQ First Nations Health Equity Strategy 2021-31*.
- The need to take a whole of health system approach if we are to effect change *together* to achieve health equity in SEQ.
- An understanding of how to work from Aboriginal Terms of Reference.
- Practical ways of operationalising the aspirations of the *SEQ First Nations Health Equity Strategy.*
- A showcase of effective service models and partnerships, and the identification of opportunities, for innovative scale up and/or replication.
- Unprecedented information about the prevalence of mental illness, mental health service access and gaps, as well as the lived experiences of Aboriginal and Torres Strait Islander people in SEQ.

The conference presented service models that are identified in the *SEQ First Nations Health Equity Strategy* as successful approaches that could be further expanded and/or replicated across SEQ. These include:

- The *Birthing in Our Community* services delivered by the IUIH Network in partnership with Mater Health and Metro South HHS
- The *Better Together Medication Access Program* delivered by Metro North HHS
- Surgical Pathways program delivered by IUIH in partnership with Metro South HHS
- The *Mob Link* care coordination and virtual care service – delivered by the IUIH Network and supporting smooth transition from hospital to community care
- Workforce development models including the IUIH's *Pathways Our Way Academy* and Metro North HHS's *Deadly Start* Program.

A summary of the key themes that emerged in Conference workshops and participant feedback are:

- The need for a system focused approach that integrates care and ensures a smooth transition of people across the healthcare continuum
- The importance of partnerships that respects and utilises the respective strengths of Partner Organisations
- Ongoing community engagement which ensures that the voices of our Aboriginal and Torres Strait Islander communities are reflected in the prioritisation, design and delivery of healthcare services

- The affirmation of a collective commitment to preference Aboriginal Community Controlled organisations in the delivery of First Nations-specific models of care
- A commitment to evidence-based care
- Identification and implementation of service delivery models that brings care closer to home
- Scaling up and/or replicating good practice and service models that have proved successful.

SEQ First Nations Health Equity Governance Committee

Background to conference

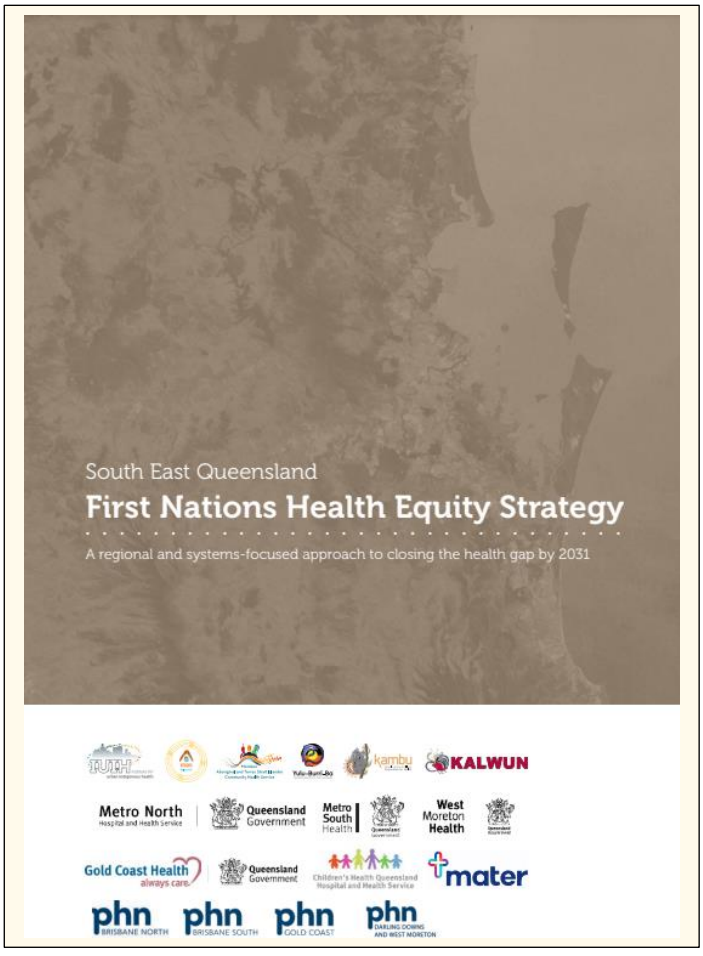
Queensland's Aboriginal and Torres Strait Islander Health Equity Framework

The *Making Tracks Together - Queensland's Aboriginal and Torres Strait Islander Health Equity Framework*[1] 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, 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) 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 region's HHSs, the regional network of CCHSs that comprise the Institute for Urban Indigenous Health (IUIH) and the Primary Health Networks (PHNs) to collaborate on a systems-focused and networked approach to achieving health equity and justice in the SEQ region.



[1] Queensland Health. First Nations Health Equity (website). https://www.health.qld.gov.au/public-health/groups/atsihealth/making-tracks-together-queenslands-atsi-health-equity-framework.

The Regional Strategy's Vision and Six Key Priority Areas

The *SEQ First Nations Health Equity Strategy* can be found on the IUIH website.[2] The six KPAs and their corresponding sub-goals, which align with the priority reform areas of the *National Agreement on Closing the Gap*, are detailed **Appendix 1**.

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)

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 *SEQ First Nations Health Equity Strategy* can be found on the IUIH website.[3]

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. This report records the outcomes from the inaugural SEQ First Nations Health Equity in Action Conference, which focussed on the 2021-22 Year, and was held in November 2022.

Conference overview

On 29-30 November 2022, the SEQ First Nations Health Equity Governance Committee hosted the **Inaugural SEQ Health Equity in Action Conference** at the Brisbane Convention and Exhibition Centre in Brisbane, Australia. The conference showcased effective service delivery and research partnerships 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 conference brought together SEQ Partner Organisations at the board, executive, operational and community levels to understand the elements of success to advance Indigenous-led health service models already underway in SEQ. Delegates mainly comprised representatives from IUIH's partner organisations, including the four HHSs in SEQ (Metro North, Metro South, West Moreton, and Gold Coast), Children's Health Queensland, Mater Health, the four PHNs in SEQ (Brisbane North, Brisbane South, Darling Downs and West Moreton, and Gold Coast), as well as the five CCHSs that form the IUIH Network (ATSICHS, Kalwun Health Service, Kambu, Yulu-Burri-Ba and Moreton ATSICHS).

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

Day 1: Tuesday 29 November 2022

Welcome to Conference: ***Introduction to the SEQ First Nations Health Equity Conference***

Key Note Session: ***Setting the scene for health equity in SEQ from Aboriginal Terms of Reference***

Panel Discussion: ***Building reciprocal relationships for better outcomes***

Concurrent Workshop 1: ***Thinking about community engagement in new***

Concurrent Workshop 2: ***Mental health: The evidence for change***

Day 2: Wednesday 30 November 2022

Panel Discussion: ***Deadly Choices: Maximising community reach to ensure health outcomes***

Concurrent Workshop 1: ***From hospital to home: Integrating care across the health sector for better outcomes***

Concurrent Workshop 2: ***Mob Link: Ensuring a seamless patient journey across primary care and hospital sectors***

Concurrent Workshop 3: ***Economic self-determination: Creating jobs and changing trajectories***

Panel Discussion: ***Partnering for Evidence based birthing outcomes***

Plenary Address*:* ***The role of HHSs/QH in sub-contracting/commissioning to improve health outcomes for Aboriginal and Torres Strait Islander people***

Concurrent Workshop 1: ***The case of chronic disease management: Improving access and outcomes for Aboriginal and Torres Strait Islander people at risk of or living with a chronic disease***

Concurrent Workshop 2: ***Empowering clients and communities: Surgical pathways success***

Concurrent Workshop 3***: Using partnerships to grow a culturally responsive workforce across the health sector***

Closing address: ***Taking the health equity journey forward***

The Conference exposed participants to:

- The SEQ regional partnership approach to Closing the Gap.
- The need to take a whole of health system approach if we are to effect change *together* to achieve health equity in SEQ.
- An understanding of how to work from Aboriginal Terms of Reference.
- Practical ways of operationalising the aspirations of the *SEQ First Nations Health Equity Strategy.*
- A showcase of effective service models and partnerships, and the identification of opportunities, for innovative scale up and/or replication.
- Unprecedented information about the prevalence of mental illness, mental health service access and gaps, as well as the lived experiences of Aboriginal and Torres Strait Islander people in SEQ.

The **Aunty Pamela Mam Oration**, held in partnership between IUIH and the UQ Poche Centre for Indigenous Health, was delivered on the evening of the first day of the conference. This allowed delegates to attend the annual event, which honours Aunty Pamela Mam's legacy of establishing CCHSs in SEQ. The 2022 Oration - *Our Voice. Our Governance. Action on Our Terms of Reference* - was delivered by nationally and internationally acclaimed Cobble Cobble woman from the Barrungam nation in South West Queensland, Professor Megan Davis. Professor Davis spoke on the topic of Constitutional Recognition and the Voice to Parliament.

The conference event **brought together 197 participants** representing a wide range of stakeholders specialising in Aboriginal and Torres Strait Islander health from SEQ. These included Elders, community members, a wide range of health care professionals, policy and technical experts, government representatives, and academics. Conference delegates were invited to ask questions, contribute to presentations, and participate in nine group-based workshops over the two workshop 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, session discussions, breakout discussion-based workshops with Q&A segments, and side meetings. Feedback on the two-day inaugural conference has been very positive on the content, and on the opportunities it provided for networking, shared learning and strengthening intersectoral relationships and working partnerships.

This conference Outcome 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 Outcome Report will be of interest to all stakeholders who seek to advance First Nations Health Equity and Human Rights in Queensland and beyond.

Conference Day 1 – Tuesday 29 November 2022

Welcome to Country

The Welcome to Country was performed by the Nunukal 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** (Chairperson, Institute for Urban Indigenous Health Board of Directors and CEO, Kalwun Development Corporation Ltd) and **David Gow** (Chairperson, Children's Health Queensland (CHQ) HHS Board)

Representing the SEQ First Nations Health Equity Governance Committee, Kieran and David welcomed participants to the Conference 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.

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

Plenary Address: Setting the scene for health equity in SEQ from Aboriginal Terms of Reference

Chair: **David Gow** (CHQ)
Key Note: **Adrian Carson** (CEO, IUIH)

In introducing IUIH's CEO, David Gow considered that by coming together as a group for the two-day conference, *"we are starting to make the progress we have been craving"* to advance health equity reform for equitable health outcomes in SEQ. Gow noted that from what *"we have seen from previous efforts to Close the Gap, that doing more of the same will not work".* Consequently, he pushed conference delegates to work towards integrating a collaborative cross-system approach across the region.

"Systems wide response mean[s] that organisations can learn from each other… address issues that are larger than their scope as an organisation, work together… to deliver on the SEQ First Nations Health Equity strategy." - **David Gow, Board Chair, Children's Health Queensland**

In welcoming delegates to the inaugural *SEQ First Nations Health Equity in Action Conference*, Adrian Carson began by reinforcing the urgency to achieve health equity in SEQ: *"We're not on track to achieve health equity by 2031".* ***"We don't need generational change; we need immediate change."***

He stressed *"The purpose of our approach in SEQ is to accelerate the pace to Close the Gap by 2031".* The *SEQ First Nations Health Equity in Action Conference* "*provides the opportunity to showcase some of our initiatives, and to determine how, not if, to implement them across the system".* IUIH sees the sharing of these initiatives to move quickly on health equity action across SEQ as an *"obligation to our Communities".*

"We do have the ability to achieve significant outcomes for our communities, with initiative, commitment, and resolve. Now is the season for action, now is the time to bring our best ideas and commitments to action."

"Our approach in SEQ won't be easy. We will be tested by pressures in the system, tested by the funding environment, and tested by our communities who are rightly sceptical of another initiative to Close the Gap."

When the COVID-19 pandemic hit Queensland's southeast corner, Carson praised the role of CCHSs, noting that *"our network system was extremely useful and provided unique opportunities to engage with the system, such as engaging with clinicians managing the COVID response in the (mainstream) health system".* He explained how those networks and positive relationships had subsequently grown and strengthened, enabling the IUIH Network to have far greater mutually beneficial engagement with Queensland Health clinicians and policymakers on diverse systems and service quality and safety issues, and to increase the continuum of care at a systemic level.

Carson emphasised the crucial role primary health care must play in preventive health, and the need to strengthen the interface between CCHSs and HHSs, because we *"cannot solely focus on hospital responses".* In turn, he acknowledged that the HHSs must step up and act:

"The time for parochialism of the HHSs is over, now is the season of action."

He highlighted that given the determinants of health account for 30% of the burden of disease we're attempting to close, there is *"need to engage outside of the health system to achieve health equity…The*

social determinants of health [must be of] strong focus." As an example, he pointed out the urgent need for Queensland Health to work with the Child Safety sector to reduce the number of harmful notifications.

In embedding and activating the new *SEQ First Nations Health Equity Strategy*, Carson emphasised the role of multi- and cross-disciplinary leaders and leadership.

"Agreements, MOUs, strategies, plans, royal commissions… these don't reform systems, it is leaders who reform systems."

"It's pretty obvious to me we have a moment in time [that leaders] don't want to squander."

He called for delegates to focus on driving all SEQ leaders to personalise their commitment to achieve Aboriginal and Torres Strait Islander health equity.

"Accentuate attachment of the commitment… Rather than a logo that sits below your signature, do you talk about First Nations when we're out of the room?
That is the ultimate test."

Carson further called for a strong collaborative, cross-system approach. He noted that the fragmented nature of the health system doesn't meet the needs of our people, and this is obvious given "The reason why the gap hasn't closed is because the system hasn't done its job". A collaborative, cross-system approach must also address the competitive nature of service delivery that also undermines access and equity.

"We [must stop getting] caught up with boundaries and logos on shirts… We want to support best care for our Mob, based on what services our Mob choose to access."

"CCHSs, PHNs, HHSs… [we will] not have competition when we're all working complementarily."

He concluded by reminding delegates that when we face challenges in accelerating the pace of implementation of the *SEQ First Nations Health Equity Strategy*, *"we need to recall the commitments we made to our community and to each other"* within that document. In the words of Uncle Les Collins –
"Community control is about what we can do, not what we can't."

Opening Panel Discussion: Building Reciprocal relationships for better outcomes

Chair: **Kieran Chilcott** (Chairperson, IUIH and CEO, Kalwun Development Corporation)

Panellists: **Libby Dunstan** (CEO, Brisbane North PHN); **Dominic Tate** (Executive Director Clinical Services, CHQ); **James Ward** (Director, UQ Poche Centre for Indigenous Health)

Purpose of Opening Panel
The purpose of the Opening Panel is to hear about the ways in which the partnership between SEQ CCHSs, CHQ, Brisbane North PHN and UQ Poche Centre for Indigenous Health have streamlined pathways for First Nations clients to gain access to a range of healthcare services, with pathways providing greater accountability and transparency among partner organisations, government, and, most importantly, for Mob.
Relevant *SEQ First Nations Health Equity Strategy's* Key Priority Areas (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. KPA 6: Strengthening the First Nations health workforce.

Setting the stage for the health equity discussions taking place throughout the conference, the Panel began with a presentation from each of the panellists followed by robust discussion among the panellists and conference participants. Discussion focused on the opportunities, enablers and challenges for collaborative Aboriginal and Torres Strait Islander-led partnerships that support the streamlining of pathways for First Nations clients across the life course to access a range of healthcare services and related supports in SEQ.

Libby Dunstan emphasised the need for PHNs to be a key partner and leader that both champions and drives the implementation of First Nations peoples' access and equity in the SEQ region. She highlighted that although PHNs *"need to acknowledge the principle of self-determination",* there could be no doubt that Aboriginal and Torres Strait Islander health is everyone's business within the PHN: *"We need all of our staff to think about [advancing health equity] and what can they do". She spoke about how "leadership is critical"* not only at the CEO level, but among all staff *"and on a day-to-day basis"* because of the urgency of action needed to advance First Nations peoples' equitable healthcare access in SEQ. For Dunstan, it is crucial that in empowering and working with community controlled organisations to achieve better outcomes, PHNs must engage in shared decision-making and shared approaches because in the Indigenous health space there needs to be *"[an] understanding that PHNs don't always know what's best"*. To this end, she spoke of the collective agreement by PHNs in SEQ to hand administration of Integrated Team Care funding back to the CCHS sector.

"There is an urgency of action. If we keep expecting that things are hard we will never actually change anything… PHNs have an obligation as a key leader in the system to think about what the SEQ First Nations Health Equity strategy says, what Metro North is looking at, and then what is our commitment as a PHN to work with the Community Controlled Health Sector to deliver on that strategy…"

"We are better if we work together. We are really committed to CCHSs, not only in co-design, leveraging new models of care, how we collect data and how we report."

- Libby Dunstan, CEO, Brisbane North PHN

Dominic Tate stated that CHQ *"is on a journey for equity in action"* expressed the need for the CHQ's Board, its Chief Executive, and the whole organisation to deliver on the *SEQ First Nations Health Equity Strategy*. He emphasised the need for humility in the partnership and an understanding that the mainstream health system will not always get things right. Like Libby Dunstan, he emphasised urgency of action: *"It needs to be an accelerated journey to overcome the policy (time) lag"*. Tate pointed to the significance of partnerships and collaborative ideas generation and implementation. He highlighted the importance of increasing shared positions (i.e., rotational roles) among the CHQ and IUIH workforce, including joint orientation and joint training sessions. For Tate, this will break down immediate barriers and accelerate co-learning to improve timely and improved models of culturally responsive care and service delivery. He outlined a number of steps that have already been taken for co-learning to occur. For instance, through the partnership between the IUIH *Mob Link Pathway* and CHQ's Emergency Department. Another example included the CHQ/IUIH *Open Doors Project* where paediatric Ear Nose and Throat specialists are providing a dedicated clinic for Aboriginal and Torres Strait Islander children on Saturdays in partnership with IUIH, to ensure access onto the surgical wait list for First Nations children. Tate noted that the *Open Doors Project* would soon expand to include a dedicated eye health clinic.

"We need to redesign our (healthcare) pathways for Aboriginal and Torres Strait Islander peoples – rather than using current platforms, [redesign] is better."

"Talk is cheap… and partnership agreements are easy. It's action and delivery [that is] the most important".

- Dom Tate, Executive Director Clinical Services, CHQ

James Ward spoke to the core values of the UQ Poche Centre for Indigenous Health being Place, Community, Justice and Knowledge Generation, as well as the Centre and IUIH having common goals and a shared vision. For Ward, there is great need for SEQ to collaboratively work together, *"not just to Close*

the Gap, but we need to change the systems and structures that help to Close the Gap through our research". Ward highlighted that to enable health equity in health outcomes, a co-designed research agenda is essential. Research needed to be *"really respectful of place and the role place has in health outcomes"* as well as integrating relationality, non-hierarchical approaches that *"centres community in our research".* He reminded delegates of the significance of focusing on improving urban Indigenous health given the outputs of Indigenous research and government discourse frequently focus on the health needs and outcomes of remote communities, when *"60% of the gap in health outcomes between Indigenous and non-Indigenous populations is in urban areas".*

"[We] have to eliminate the social determinants of health gradients, eliminate racism, and centre our research in communities, and [our research] has to be action oriented."

– James Ward, Director, UQ Poche Centre for Indigenous Health

Conference delegates questioned how mainstream healthcare staff can be more culturally trained and aware. Panellists responded that key ways involved healthcare worker orientation and spending time with CCHSs and gaining on-the-ground experience. There was agreement that there is strong need to ensure the health workforce in SEQ is well-prepared for when Aboriginal and Torres Strait Islander people present, especially to tertiary care settings.

In the discussion, **Simone Jackson** (CEO, Kambu Health Services that operates in Ipswich and the West Moreton region), raised concern that in the SEQ region ***"we don't have enough community-controlled services [and] we need a sense of urgency".*** Jackson further emphasised the need for *"really strong connectivity"* between all healthcare providers, *"so we don't drop someone through the system, and then we have to work together to pick them up"*.

Day 1, Concurrent Workshop 1. Mental health: The evidence for change

Purpose of Workshop 1: Mental health: The evidence for change
The purpose of the mental health workshop is twofold. First, workshop participants will consider preliminary Aboriginal and Torres Strait Islander mental health prevalence and service access data for SEQ from research conducted by the Queensland Centre for Mental Health Research (QCMHR) at The University of Queensland (UQ). Participants will then discuss the early research findings, and identify opportunities and concerns about accessible, equitable and culturally safe mental health service provision in SEQ particularly for First Nations peoples who form 'the missing middle'.
Relevant *SEQ First Nations Health Equity Strategy's* Key Priority Areas (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 4.13: Jointly develop a SEQ Aboriginal and Torres Strait Islander Suicide Prevention and Aftercare Action Plan.* KPA 5: Working with First Nations people, communities, and organisations to design, deliver, monitor and review health services.

The workshop began with an introduction by **Harvey Whiteford**, Director of the Queensland Centre for Mental Health Research (QCMHR) at UQ. Whiteford reminded that, when it comes to research and data influencing policy, *"It you don't count it, it won't count"* and *"good data is good enough to know where we are starting from and where we are going to"*.

Whiteford was followed by presentations on two research co-designed research projects delivered by **Alize Ferrari** and **Sandra Diminic** (QCMHR) respectively. The first of their kind in Australia, the research projects provide valuable insight into First Nations' mental health prevalence and service access use in SEQ to inform evidence-based planning, funding, and delivery of mental health services for Aboriginal and Torres Straits Islander peoples in the Southeast region. Both research projects are a collaboration between QCMHR and IUIH.

Following the presentations, conference delegates split into nine small groups to discuss:

1. What are your key take-away messages from the presentations?
2. What are the identified gaps? (access and service)
3. How do we use this information to inform the First Nations Health Equity Mental Health Working Group (starting 2023)?
4. How can an HHS/CCHS/PHN collaborative approach respond to service gaps and identified need?
5. How can we use this information to inform our needs assessments and a regional approach to mental health service planning?
6. What can we learn from this example of partners coming together with a shared interest to conduct research that informs service delivery?
7. What are our next steps?

Workshop notes from the nine roundtables were reviewed and synthesised. Key messages from the workshop participants are set out following a summary of the presentations below.

Alize Ferrari presented her research on 'The Staying Deadly Survey – Queensland Urban Indigenous Mental Health Survey' (QUIHMS). Ferrari noted that the QUIMHS project was launched in 2018 and is being conducted in the following four stages: (1) survey establishment (2) pilot study (3) main survey and (4) results dissemination. Research questions include:

- What is the prevalence of selected mental and substance use disorders within a sample of Indigenous Queenslander adults?
- What is the proportion of Indigenous Queenslander adults in treatment for a mental or substance use disorder?
- What type/quality of services are accessed?
- What are the barriers to accessing care?

Data collection occurred from February to October 2022 in the south Brisbane, Moreton Bay, Ipswich and Bayside sub-regions of SEQ. A mixed-methods approach to participants recruitment was taken. The survey was administered to Aboriginal and Torres Strait Islander people by seven trained Indigenous interviewers, with 407 participants finally interviewed and included in the study. Ferrari described the cultural considerations and adaptations integrated throughout the research process. Preliminary data collected show that the prevalence of 'any' mental health or substance use disorder in the last 12 months among participants was reported to be at 46% and that around 49% of participants had accessed a mental health service in the last 12 months. It also showed that around 5.4% of the people had experienced suicidal thoughts in the last 12 months and 57% had experienced the death by suicide of a close friend or family member.

In terms of research implications, Ferrari highlighted that the survey was the first population mental health survey of Indigenous Australians and allows us to better understand demand for mental health service,

with findings having potential to inform service planning. Research findings will also allow us to better understand risk and protective factors to mental disorders and to plan for different combinations of services (by diagnoses, severity and comorbidities). Advice has also been provided to the Australian Bureau of Statistics and Australian Institute for Health and Welfare on the applicability of the QUIMHS methods to national surveys.

Sandra Diminic presented on the IUIH funded 'Indigenous SEQ National Mental Health Service Planning Framework project (ISEQ-NMHSPF Project). The research aims to:

- Analyse mental health services utilised by Aboriginal and Torres Strait Islander people in SEQ.
- Determine the level of required mental health service activity compared to benchmarks established under the National Mental Health Service Planning Framework (NMHSPF).
- Compare current services with targets to identify service gaps and priority areas for planning.

Accounting for certain data limitations, Diminic's preliminary results indicate that compared to non-Indigenous peoples/overall SEQ population, the level of mental health service activity compared to relevant NMHSPF targets for First Nations peoples in SEQ was a similar % NMHSPF target reached for state community mental health service contacts (33% for Indigenous vs 35 for non-Indigenous in 2018) but there was a lower % NMHSPF target reached for inpatient day beds (34% for Indigenous vs 59% for overall population in 2020). Compared to non-Indigenous /overall SEQ population, First Nations consumer rates of service access were found to be the same rate of access to MBS mental health items but should be higher given an estimated need that is double that of the non-Indigenous population. Diminic found there was a significantly lower access to NDIS for primary psychosocial disability (0.03-0.10% of Indigenous population vs 0.17% of overall population), but with a need that is approximately three times higher.

Diminic concluded that: Aboriginal and Torres Strait Islander consumers access a range of clinical and psychosocial mental health supports across different SEQ providers; significant gaps exist across all sectors compared to future NMHSPF targets – especially primary care and community services; and Aboriginal and Torres Strait Islander residents of the West Moreton area have the biggest shortfalls relative to other areas. In terms of inequities in access, Diminic highlighted: access to the MBS among Indigenous peoples in SEQ is comparable to non-Indigenous peoples' access to the MBS despite higher need; access to the NDIS is significantly lower despite higher need – there are a small number of people with big funding packages; and a lower % NMHSPF target was reached for inpatient bed days for Aboriginal and Torres Strait Islander mental health inpatients.

Feedback from workshop participants
Mental Health: The evidence for change

- **More community screening** is needed with non-specialist providers having the skills to provide time-limited help and referral. Include opportunistic for people coming to primary care for other issues.
- A **collaborative approach** in the mental health access and equity space is crucial. Build links between mental health and (i) chronic disease and (ii) disability/developmental disorders.
- **Relationships and communication are key** - slow down and have meaningful conversations.
- **Whole-of-person approach** – avoiding siloed care – is critical.
- Mental health supports for **mob transitioning from prison to community** is crucial.
- Families coming to urban SEQ from rural/remote areas who feel **disconnected from community** and culture, and present with mental health risks.

- Provide mental health supports around people who have already **been exposed to family members that have died by suicide?**
- **Workforce** needs to have the skills to work collaboratively. We need Blak staff offering these services – this should be the focus in recruitment.
- Consider integrating alternative, non-Westernised mental health services for Mob. Delve into **culturally appropriate methods of mental health care and healing**.
- Mainstream services don't realise **what First Nations peoples are eligible for** in terms of mental health supports. Education of mainstream services is required and then that knowledge applied by those services.
- There is a **disconnect between MBS Item numbers and what happens in a consult**, so mental health activity at the primary care level is under-represented because the consult gets claimed as a general consult rather than a mental health consult.
- Don't forget the **importance of qualitative data** – This type of data will really inform us on how it [the quantitative data] should impact on current models, ensure they are culturally responsive.
- **Community needs to know** what mental health support is available and that it is a culturally safe model of care.
- **Concern about the Voice referendum** – will there be negative fallout and trauma impacting on mental health?

Day 1, Concurrent Workshop 2. Thinking about community engagement in new ways

Purpose of Workshop 2: New ways of authentic community engagement
In dispersed urban communities, identifying and engaging with community can seem complex. In this workshop, participants will learn about how tools such as population data and grass-roots community engagement mechanisms can be used to effectively reach out to Aboriginal and Torres Strait Islander peoples in ways that are more authentic and representative than standard approaches. The purpose of the community engagement workshop is twofold.
Relevant *SEQ First Nations Health Equity Strategy's* Key Priority Areas (KPAs)
KPA 2: Increasing access to healthcare services. KPA 4: Delivering sustainable, culturally safe, and responsive healthcare services. *Key Priority Reform Area 4.4: Work together to implement the SEQ Aboriginal and Torres Strait Islander Community Engagement Strategy 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.

The workshop began with an introduction from co-chairs **Simone Jackson** (CEO, Kambu Health) and **Hannah Bloch** (CE, West Moreton HHS) followed by presentations from **Kaava Watson** (Director, Network Development, IUIH) and **Angela Young** (Executive Director, Aboriginal and Torres Strait Islander Engagement, CHQ). Following the presentations, conference delegates split into 12 groups to discuss:

1. What mechanisms do we currently use to collect community feedback and input?
2. How do we analyse and report this data?
3. How do we authentically give voice to First Nations people in SEQ through implementation of the *SEQ Aboriginal and Torres Strait Islander Community Engagement Strategy*?
4. How can we ensure an integrated and collaborative approach whilst still ensuring local input?
5. What are our next steps?

Kaava Watson spoke about how community-control is a practical demonstration of self-determination: *"The ability to exert some control over our own affairs".* He emphasised that community control is essentially a process, a mechanism for the types of health services that mob receive and how they receive them. He emphasised that everyone has a leadership role to play in community engagement: *"We all agree to lead, because that's what is needed".*

Angela Young agreed with Watson that change requires leadership and action, reminding that *"It's so important that we don't lose sight of who we are building these systems for"* and that while it is our responsibility, it is also *"our opportunity to make an impact"* in advancing health equity in SEQ.

"The community has been divided up into different organisations and interest groups. Our community has become fractured, like the system. At its heart, we have to do something we have always done well, and that is turning up for the yarn."

– Kaava Watson, Director, Network Development, IUIH

"Aboriginal and Torres Strait Islander people have a value. And that value hasn't been recognised… We are also consumers and stakeholders – staff members, mums, dads. We are all community." **– Simone Jackson, CEO, Kambu Health**

Feedback from workshop participants

Thinking about community engagement in new ways

- How can we **communicate the outcomes, or performance reporting,** of the *SEQ First Nations Health Equity Strategy* implementation back to community. This is how we build trust. Go back to community with what was said at high-level meetings; **explain to community why you can't do things.**
- Community engagement fatigue. Be clear about the purpose of engagement and ensure clarity around expectations. Community has been engaged and has seen no progress, so there's a lot of mistrust in the healthcare system. **Community wants action** – not talk.
- Acknowledge community engagement **takes time** – it's a long-term process. **Go out to country, hold community meetings**, and **speak to mob face-to-face**. *"Hear the community's heartbeat."* **Encourage safe spaces** for people to be brave and speak out.
- Be **opportunistic in your approach** to engaging with community – gain an understanding from (prior) community feedback - and show that community inputs are appreciated and heard.
- Don't forget **the quiet ones need a voice**. Be aware of power imbalances. The challenge is to **engage the people who are not engaged with the health service**. It is difficult to engage men, especially our young because of the stigma around some topics, e.g., mental health and ensure young voices are heard.
- Identify that **knowledge can come from experience**. A lack of 'formal qualifications' does not translate to being less knowledgeable.
- **Don't always focus on trying to align to existing KPIs**. Understand what outcomes community are looking for. It is important that data doesn't just 'exist and sit there.' If research projects and partners don't gain access to it, they are also blind to what consumers are saying and cannot know of and appropriately address the challenges. **Data must be utilised and meaningfully reported.**

2022 Aunty Pamela Mam Oration, evening session: "Our Voice. Our Governance. Action on Our Terms of Reference."

Aunty Pamela Mam oration given by Cobble Cobble woman Professor Megan Davis

The second annual Aunty Pamela Mam oration was hosted by **Renee Blackman** (CEO, ATSICHS Brisbane) and **James Ward** (Director, Poche Centre for Urban Indigenous Health, UQ). **Uncle Steve Coghill** welcomed participants to Country and a Welcome Honour Dance was performed by the **Wagga Torres Strait Islander Dance Company** of Brisbane, which had performers who were family of Aunty Pam.

Oration participants were also privileged to hear from **Ms Tomasina Ahwang**, Aunty Pam's daughter, who gave a formal welcome and introductory address.

Following the oration, a panel was held to respond to questions from the audience. Panellists sitting alongside Professor Megan Davis included **Renee Brown**, **Kaava Watson (IUIH),** and **Adrian Carson (IUIH)**.

Professor Megan Davis is the Pro-Vice Chancellor Indigenous at UNSW and a nationally and internationally renowned lawyer and expert on constitutional reform for recognition of Indigenous rights. Professor Davis pursues constitutional law and structural reform and feels strongly about the use of the Australian Constitution as an anchor for Aboriginal and Torres Strait Islander people's human rights. Her oration speaks to the Uluru Statement from the Heart and the reforms contained therein.

"I want to talk to the importance of the sequence – Voice, Treaty, Truth – and how that aligns with self-determination and how we need to mobilise now to ensure that the Voice is not about the status quo and that it doesn't end up being about service delivery that we can anchor the right to self-determination in the Australian constitution."

"Our Voice. Our Governance. Action on Our Terms of Reference"

Ten key messages from Professor Megan Davis

The creation and importance of community control is an important story for our people.

"Our people have always spoken up, but the system fails to hear us. And failure to hear our voice and that, at the heart, is a constitutional voice. The contemporary struggle of Voice Treaty Truth that emanated from the Uluru Statement From the Heart is not new in the struggle. It is a continuation of the struggle… Community control is at the very heart of what we think about when we think about the right to self-determination: our governance, our action on our terms".

Self-determination is an action word that is about being independent and not dependent.

"Change doesn't come from the government to the people. Change comes from the people to the country and once, we ran this country."

Where does recognition come from? … Recognition sits on a spectrum of power. On the one end, the weak end, it means symbolism... At the other end … it is substantive.

"In many ways Indigenous peoples have been advocating for recognition of rights since the very early colonial period. Many liberal democracies have different forms of recognition… [But] the language of recognition is very new in Australia although it's very common in the US and Canada …. But what does it mean? Recognition is a complex legal and political term that invites a number of meanings; conceptual multiplicity. It can mean acknowledgement or symbolism; it can also mean a substantial shift in power relations… it can mean the redistribution of public power which is what we're trying to achieve with the Voice to Parliament. It can mean autonomous arrangements, it could mean designated parliamentary seats, it can be an Indigenous parliament, or a treaty… [It] sits on a spectrum of power. On the one end, the weak end, it means symbolism because it cannot compel the state to do something. Or it cannot prohibit the state from doing something… At the other end of the spectrum is the strong form of recognition where it's not symbolic it is substantive, and it can compel the state to do things and it can prohibit the state from doing things. And so recognition sits on that spectrum and Mob [in the Uluru dialogues] rejected the weak form and wanted a more substantive form… the question is where does the Voice to Parliament sit on that spectrum?"

Australia has never actually tried substantive constitutional recognition.

"So treaty is recognition. Land rights is recognition. Native Title is recognition. Constitutional recognition is recognition… The constitution is important because the constitution trumps legislation, it is the highest law in the nation, and it has the force of law and the only umpire to the constitution is the High Court of Australia. So in Australia, the most prominent form of recognition has been Acknowledgement i.e. insertion of explicit symbolic Acknowledgement of Indigenous peoples in a written constitution – and so state governments have most notably taken this up such as [the Queensland constitution] has a symbolic preamble. Symbolism is important but – I would say – it doesn't mean anything. It doesn't do anything. But that is not what we're seeking."

We're seeking substantive change, the recognition of inherent rights. Symbolism is really business as usual.

"There is a proclivity in Australia to pursue agendas for substantive rights for our people in favour of our symbolism. Symbolism is really business as usual. The state based approach to unenforceable Indigenous recognition provisions in [state-level] constitutions has not elicited any change in the lives of First Nations communities, nor has it had any substantive impact. That is why the current recognition process has taken

so long because First Nations people rejected symbolism for First Nations constitutional recognition. The Uluru Statement from the Heart wholly rejected symbolism."

Political change at the state-based level makes state-based treaties vulnerable.

"These state-based treaties may be strong on the rhetoric of treaty but without the overarching legislative power of the Commonwealth Parliament and its financial capacity, they will be nothing like the treaties envisaged by the advocates since the 1970s."

Having a truth and reconciliation commission will not signal that truth telling has occurred…Truth commissions offer much but deliver very little.

"We know the acute failures of the South African process which many people point to. We know that in Canada they've had three Royal Commissions and the process in Canada has had very little impact on the community in terms of Canadians' understandings of the truth of their history …The imported principles and wisdoms about truth telling and truth telling commissions, many of which I've studied at the UN level over 12 years from Colombia to Nicaragua from Finland to Canada… they need to be really cautiously received by our people ... Australia uses truth telling as a can-kicking exercise. We use truth telling as a can-kicking exercise on substantive reform. We use truth telling to avoid the recognition of our peoples' inherent rights. The state loves truth telling because our people give so much to it. But … when truth telling is viewed through a healing lens, it often neglects to talk to the justice element. And the discourse coming out of Canada is that the states co-opting of the language of healing allows the state to avoid engaging in [First Nations] self-determination and justice."

The Uluru approach [to truth telling processes] comes from local people devising local solutions. It should not follow that when our people speak of truth telling in the [Uluru] dialogues that they're talking about a truth commission.

"In the post Uluru environment much potential has been projected onto truth telling. It has been viewed as a soft target by governments and organisations who consider it relatively uncontroversial or at least less controversial than a referendum. Truth telling – as I said – has historically been deployed as a way of avoiding serious structural reform in Australia because governments want to avoid spending political currency on a policy area that cannot elicit either support form a large voting base or donations. …[the] contemporary idea in Australia [is that] you need truth before treaty but the important thing to keep in mind – and this worries me when it comes to Queensland – there is no country in the world that has done truth before treaty."

Voice Treaty Truth – that is the sequencing that is encapsulated in the Uluru Statement from the Heart and nominated in that order and is what is needed.

"Treaty is not a constitutional thing and truth telling is something that our people said in our [Uluru] dialogues said happened every day, every month, every year in community in the work our people do… So there was a complexity to what our people said truth telling might look like."

The Uluru Statement from the Heart is an affirmation of First Nations sovereignty not a negation.

"The Uluru Statement from the Heart carries a simple and powerful message to millions of Australians that First Nations sovereignty was never ceded and never extinguished… In 2017, the delegates of Uluru collectively decided to activate and exercise their unceded sovereignty offering to the Australian people a vision of a transformed future based on structural reform *and* the trilogy of Voice Treaty and Truth…An enshrined Voice to Parliament will not cede our sovereignty. The only people that can cede our sovereignty is us, our Nations, and that is a question for treaties not for a constitutional order that is imposed upon us… We don't need empathy. We just need a hard-headed reform. As Aunty Pam Mam said, we need action. And the Uluru Statement *is* action"

Conference Day 2 – Wednesday 30 November 2022

Opening Panel Discussion. Deadly Choices: Maximising community reach to ensure equitable health outcomes

Chair: **Kaava Watson** (Director, Network Development, IUIH)

Panellists: **Donisha Duff** (Strategic Policy Adviser, IUIH); **Nathan Appo** (Manager *Deadly Choices Partnerships* IUIH); **Simone Nalatu** (Director – Equity, Health & Wellbeing Queensland); **Steve Renouf** (Deadly Choices Ambassador).

Purpose of Conference Day 2 Opening Panel
To comprehensively inform conference delegates of IUIH's award-winning *Deadly Choices* program, and to discuss how that program benefits preventative health strategies and enhances the cultural and social determinants of Aboriginal and Torres Strait Islander people's health at the community and individual level. Expansion of the *Deadly Choices* program through partnerships will also be explored.
Relevant *SEQ First Nations Health Equity Strategy's* Key Priority Areas (KPAs)
KPA 3: Influencing the social, cultural, and economic determinants of health. *Key Priority Reform Area 3.1: Identify and establish cross-agency partnerships to develop regional responses to the determinants of health, particularly with the education, housing, and justice sectors.* *Key Priority Reform Area 3.3: Contribute to Health & Wellbeing Queensland's multi-agency efforts to prevent and address obesity.*

Kaava Watson introduced **Donisha Duff and Nathan Appo** to present, followed by a panel discussion involving the two presenters along with **Simone Nalatu** and **Steve Renouf**. He emphasised the importance of leadership, and the significance of everyone regardless of their role taking responsibility for being a leader to achieve Aboriginal and Torres Strait Islander health equity.

"Leadership needs to exist within all of us. Leaders aren't always the ones standing up the front. Leadership is quite often supporting others, nurturing others in their own journey."

– Kaava Watson, Director, Network Development, IUIH

Donisha Duff and **Nathan Appo** proceeded to present IUIH's *Deadly Choices* program to conference delegates.

Deadly Choices is a well-known brand across Queensland with deep connections to community. The *Deadly Choices* program aims to empower Mob at different life stages to make healthy choices for themselves and their families – to stop smoking, eat good food, and exercise daily. In May 2021, IUIH was awarded a *World No Tobacco Day* global health award from the World Health Organization (WHO) for the *Deadly Choices* initiative.

The four panellists discussed the significance of the *Deadly Choices* program on enhancing the social determinants of health of, for and with First Nations peoples. They collectively discussed how *Deadly Choices* has a number of sporting and other well-known community First Nations Ambassadors who work to increase the reach and impact of Deadly Choices messaging.

"Our Ambassadors and our communities are role models. We have seen a massive shift in this in our community, and how people perceive their health."

To enhance the community impact of the *Deadly Choices* program, they highlighted how *Deadly Choices* Ambassadors generate and solidify community and other stakeholder partnerships in the First Nations preventative health and wellbeing space.

Deadly Choices offers junior and senior healthy lifestyle programs. The session on leadership - being a leader in living a healthy lifestyle – is a *"cornerstone"* educational session in those programs. Duff and Appo outlined how within the SEQ region, identity is difficult for a lot of young children, and *Deadly Choices* programs provide a *"great way for them to connect".* Social media also gives *Deadly Choices* the opportunity to expand its reach on the message of identity and leadership, especially to a younger generation, as well as promote positive public health messages among Mob. All of these initiatives positively impact on the social determinants of health at the individual and community level.

In terms of its state-wide workforce, *Deadly Choices* employs 111 staff with 94% identifying as Aboriginal and/or Torres Strait Islander. Sixty per cent (60%) of staff are also younger than 30 years of age. Consequently, *Deadly Choices* facilitates educational and training opportunities to support many of the program's younger staff with the aim to *"develop skills and capacity to grow in their careers".*

"Deadly Choices is a trusted source of information for our community, a source of respected information."

In 2020, *Deadly Choices* produced 150 healthy messaging videos (social tiles) to enhance the COVID-19 response among First Nations communities. During the COVID-19 lockdown period, videos included healthy cooking demonstrations, videos with medical professionals, and workout videos as part of *Deadly Choices Fit*. *Deadly Choices* messaging and supports are seen at a range of events – golf days, junior netball days, IUIH Network member events – to ensure they have a community focus and community feel. There is also a view to expand a number of events from beyond SEQ to across Queensland and make them a lot larger.

Kaava Watson summarised that *"The exciting opportunity is just how wide Deadly Choices can go, for example into kindies, [and] cancer screening".* He noted that *Deadly Choices* is a *"huge part"* of the IUIH Network's community engagement strategy, which included the Elders Games.

"COVID showed us what was possible when we just get on and do the work."

Day 2, Concurrent Workshop 1. Ways of Integrating Care.
From Hospital to Home: Integrating care across the health sector for better outcomes

Purpose of Workshop 2: Hospital to Home, integrating care across the sector
The COVID-19 pandemic has accelerated or created many new ways of working and collaborating across sectors. In this workshop, we learn and discuss IUIH's Hospital in the Home program and the *Better Together* medication program as examples of how primary and tertiary sectors can work together in an integrated system for better patient outcomes.
Relevant *SEQ First Nations Health Equity Strategy's* Key Priority Areas (KPAs)
KPA 2: Increasing access to healthcare services. *Key Priority Reform Area 2.1: Establish models of care that deliver care closer to home in partnership with and/or subcontracting to, CCHSs e.g., Hospital in the Home, shared specialist clinics.* *Key Priority Reform Area 2.8: Provide free discharge medications to First Nations people leaving hospital.*

The workshop began with an introduction by **Wayne Ah Boo** (General Manager, Corporate Services, IUIH) and presentations from **Libby Dunstan** (CEO, Brisbane North PHN), **Lillian Emery** (Better Together Medication Access, Metro North HHS) and **Halina Clare** (Senior Medical Officer, MATSICHS). Following the presentations, conference delegates split into four groups to discuss:

1. What barriers prevent quality care transitions from tertiary care to primary health care (and back)?
2. How can we overcome these barriers?
3. Are there other ways we can improve these transitions to support clients to achieve better outcomes?
4. What kind of mechanisms can support the governance of these initiatives to ensure action and accountability?
5. What measures can we use to evaluate the impact of new initiatives?
6. What are our next steps?

Workshop notes from the four roundtables were reviewed and synthesised, with some key messages shared by workshop participants presented in the following box.

Feedback from workshop participants
Hospital to Home, integrating care across the health sector

- Make sure you **have the right people at the table**. In terms of clinical governance, it's important to get senior people at the table that community have acceptable trust in.
- It is important to **have champions within organisations** who are dedicated to championing integrated care for Mob.
- It is important that **the voices of the people on the ground**, who are implementing the *SEQ First Nations Health Equity Strategy* and delivering services, are actively sought and heard. Everyone must inform the process.
- **Ensure community is part of the process**. They are the experts in their health, what they do/do not have access to, or want/need.
- Need to **improve trust between services and organisations for integrated care**.
- It is important to ensure we work to **raise community awareness** that Mob Link is not just Brisbane based.
- If there is a situation with a deteriorating patient, there needs to be **understanding among all integrated care providers of a medical escalation pathway(s)**. On the other hand, where there is a clear pathway for escalation, there must be trust, and senior clinicians must demonstrate leadership.
- It is important that **tertiary care providers pick up the phone and speak to the GP when discharging a patient back into GP care**. There needs to be respect for the GP's role and their capability. GPs are specialists in their own right.

- **Demonstrate the effectiveness of the integrated care model and demonstrate the value to patients, to clinicians and the system**. Develop pathway maps, starting at each and every IUIH Network clinic.
- Continue to build the evidence but when reviewing and measuring integrated care success/barriers, **it's about both quantitative and qualitative data and evidence – the qualitative data sets out the experience.**
- It is important to **recognise where the silos are**.

Day 2, Concurrent Workshop 2. Ways of Systematising Care.
Mob Link: Ensuring a seamless patient journey across primary and tertiary sectors

Purpose of Workshop 2: Mob Link and ensuring a seamless patient journey
The transition from primary to tertiary care and back to primary care in the community has many challenges including issues around Discharge Against Medical Advice (DAMA) and revolving doors. The COVID-19 pandemic added challenges and opportunities to expand services that could connect Mob with the right care in the right way at the right time. In this workshop we will discuss and learn about the evolution of IUIH's Mob Link and its expansion as part of the COVID-19 response. As a Queensland Health supported program, we will learn about the ways in which First Nations clients are supported by *Mob Link* in their journey through the health system to ensure access to equitable and ongoing health and social care to meet their needs on their terms, including practical supports that prevent hospital re-admissions.
Relevant *SEQ First Nations Health Equity Strategy's* Key Priority Areas (KPAs)
KPA 5: Working with First Nations people, communities, and organisations to design, deliver, monitor, and review health services. *Key Priority Reform Area 5.2: Improve integrated care by: (i) embedding referrals to Mob Link (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.*

The workshop began with an introduction by co-Chairs **Frank Tracey** (Chief Executive, CHQ) and **Kaava Watson** (IUIH) and presentations from **Sarah Duke** and **Renee Brown** (IUIH).

Mob Link is an IUIH initiative to support Aboriginal and Torres Strait Islander people living in SEQ by linking them with health and social services. By calling 1800 254 354, First Nations people across SEQ can access a variety of health and social support available through the IUIH Network and the broader health system. Services and supports include but are not limited to:

- Virtual Care teams to access acute care 7am-7pm 7 days/week
- IUIH Network clinics for GP services, support for health checks and chronic disease care planning.
- Care coordination for Mob with chronic conditions and access to specialist services and supports to support self-management and quality of life.
- Access to Family Health and Wellbeing services, including antenatal and post-natal services, early childhood developmental programs.
- Referral to IUIH Home Support and other Aged Care community providers including for Regional Assessment Service (RAS) registration and assessment.
- Connection to NDIS assessment and support services.
- Allied Health Services i.e., occupational therapy.
- Hospital and home visits to develop connections, assess needs and provide advocacy.
- Transport to and from medical appointments.
- Legal Aid services.
- Cultural support.
- End of life care support.
- Social support.

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

Renee Brown began by emphasising the need for Mob to have integrated care from primary to tertiary health, and to do this there is a need to create new roles to help people navigate the health system ranging from new clinical roles to new coordination roles.

"We need to focus on the journey walking alongside our people. We need to make sure we aren't focusing on tokenistic measures. Mob Link is about a custodial obligation to our people. The brand is a community owned brand."

– Renee Brown, Interim Manager, Communications and Marketing, IUIH

Both presenters gave practical examples of how Mob Link walks alongside community:

- Anyone can make a Mob Link referral.
- Mob Link can link people into services that the IUIH Network can provide or link into mainstream community services.
- Mob Link coordinators look at family and hospital needs.
- Mob Link staff are "professional trouble-shooters."
- Mob Link can engage community members in *continuity* of and to primary care, which is critical.

Following the presentations, conference delegates split into seven groups to discuss:

1. How can we improve the pathways between primary and tertiary care?
2. What data do we currently have to inform baseline and progress?
3. How do we embed referrals to Mob Link into all SEQ HHSs discharge planning policies and practices?
4. What additional systems or resources do we need?
5. How will we keep ourselves accountable (what kind of reporting do we need)?
6. What are our next steps?

Workshop notes from the seven roundtables were reviewed and synthesised, with some key messages shared by workshop participants presented in the following box.

Feedback from workshop participants

Mob Link and ensuring a seamless patient journey

- **To enable patients to return to community-control care through Mob Link referrals** hospital staff must understand the contribution of community-led primary health care to reducing the burden from hospitals.
- **Promote Mob Link locally among all stakeholders**, including Mob Link's Virtual Care arm and their scope of practice. Communication and marketing are crucial to increase awareness of Mob Link.
- **Mob Link staff can feel like communication is one-way,** the referral out, and they would like to get information or feedback. Two-way communication and sharing of information could be developed or enhanced. For example, is there a way we can check to see what follow-up support the client actually received? This could become a performance measure for Mob Link.
- **Mob Link could in-reach and work with HHS Nurse Navigators** to identify clients that will need Mob Link support on discharge. Better **connections between Mob Link and hospital discharge planners** are needed.
- We need to **combat fragmentation of services by implementing new and innovative models for care**. For example, clinical linking services like Front of House Nurse Practitioners in Emergency Departments to optimize Mob's access to and experience of services. More nurse practitioners are needed in all settings.
- **We need immediate commencement of culturally appropriate care on hospital presentation, and better link back to GPs**. Involve Mob Link/IUIH right away when people identify.
- **Better coordinated transport services and transport options** are required to ensure a 'seamless' patient journey across primary care and the hospital sectors.
- Clarify how jigsaw fits together e.g., nurse navigators, Aboriginal Liaison Officers, Mob Link. What is the role of each service? In which circumstances is it best to bring Mob Link into that system? How can they work together?
- We need to **let go of our traditional ways of working and let go of traditional areas and boundaries and silos** both in the mainstream health sector, and boundaries across PHNs and HHSs.
- We need to also be **addressing institutionalised racism.** Relying on certain staff within the hospital could be perceived as a manifestation of institutionalised racism – how do we make it everyone's responsibility in the hospital to be culturally safe and responsible?

Day 2, Concurrent Workshop 3. Ways of Growing a Culturally Responsive Workforce. Economic Self-Determination: Creating jobs and changing trajectories

Purpose of Workshop 3: Creating jobs and changing trajectories
Over 30% of the Indigenous vs non-Indigenous Health Gap in Australia can be attributed to the social determinants of health such as housing, gender, education, employment and household income. In fact, the largest contributor to the health gap is household income. In addition, workforce pressures across the health system are set to increase exponentially in the next 30 years. In this workshop we will examine and discuss ways in which we can develop a pipeline into careers in health that are both culturally safe and can offer real growth opportunities across the whole health sector.
Relevant *SEQ First Nations Health Equity Strategy's* Key Priority Areas (KPAs)
KPA 6: Strengthening the First Nations Health Workforce *Key Priority Reform Area 6.1: 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 peoples at all HHS workforce levels; a culturally appropriate regional workforce training and employment pipelines 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; partnership with CCHSs for the formal placement of registrars and other clinical staff within CCHS clinics and job sharing arrangements; culturally responsive ways of working; and First Nations workforce representation across all disciplines at levels commensurate with the local population.*

The workshop began with an introduction by co-Chairs **Mike Bosel** (CEO, Brisbane South PHN) and **David Collins** (CEO, Yulu-Burri-Ba) and presentations from **Tracy Hill** (Manager, Pathways Our Way Academy (POWA), IUIH) and **Vivienne Hassed** (Executive Director, Metro North HHS).

The panel discussed the need for a carefully designed pipeline and pathway for Aboriginal and Torres Strait Islander people to be trained and enter the health workforce, which includes wrap around support. This pathway should lead into real jobs and opportunities beyond traineeships. The panel emphasised the importance of a whole of health sector approach so that HHSs and CCHSs are not competing with each other for the same workforce. Several trainees and graduates of the IUIH Pathways Our Way Academy spoke about their journey and their training to employment experience. They described the factors that had helped them stay on track – including, family, having a mentor who walked alongside them, exposure to a range of health careers, and a supportive work environment.

Following the presentations, conference delegates split into two groups to discuss:

1. How can we coordinate pathways for First Nations people into health roles?
2. How many trainees currently exist across the health sector?
3. What barriers stop you from employing trainees?
4. How can these be overcome?
5. How do we maximise existing pipelines, expertise and cultural safety in different parts of the health sector?
6. What could new models look like that optimise community-controlled settings as an incubator?
7. What are our next steps?

Workshop notes from the two roundtables were reviewed and synthesised, with some key messages shared by workshop participants presented in the following box.

Feedback from workshop participants
Economic Self-Determination: Creating jobs & changing trajectories

- **Barriers** to accessing training and employment for First Nations people can include available and affordable place-based housing, a driver's license and identification documentation, low-income levels to access training opportunities, and racism.
- A critical solution to overcome the barriers is **to invest in growing our trainees**, which must include intensive case management and wrap around supports.
- To maximise existing pipelines and the expertise and cultural safety in different parts of the health sector, we need to continue to commit to and embed system wide collaboration and partnerships with existing programs to **expand placement opportunities and job readiness** for trainees.
- **Promote training and employment pathways in schools**.
- **Consider traineeships/cadetships** in health roles, and link into TAFE.

Day 2, Panel Discussion. *Birthing in Our Community Program (BiOC)*

Chair: **Kaava Watson** (IUIH)
Panellists: **Kristie Watego** (BIOC, IUIH); **Wayne Ah Boo** (IUIH); **Maree Reynolds** (Director of Nursing and Midwifery, Mater Health Services); **Liz Wilkes** (Managing Director, My Midwives); **Adrian Carson** (IUIH)

Purpose of Conference Day 2 Late-Morning Panel
Research demonstrates that improving outcomes in birthing sets children up for a healthy life. This requires a cross-sectoral approach, crucial to overcome barriers for First Nations families in birthing settings and spaces. The purpose of this Panel is to learn about the Birthing in Our Community Program (BIOC), in which a partnership between ATSICHS Brisbane, Mater Mothers Hospital and IUIH has produced outstanding outcomes for Aboriginal and Torres Strait Islander babies and their families. Successful, evidence-based outcomes have included BIOC closing the national pre-term birth rate, and almost Closing the Gap altogether in comparison with non-Indigenous pre-term birth rates.
Relevant *SEQ First Nations Health Equity Strategy's* Key Priority Areas (KPAs)
KPA 2: Increasing access to healthcare services. KPA 3: Influencing the social, cultural, and economic determinants of health *Priority Reform Area 3.4: 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 Area 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. KPA 6: Strengthening the First Nations health workforce.

The Panel discussed the history of BiOC, noting the program was established in 2013 by IUIH and ATSICHS Brisbane in partnership with the Mater Mothers' Hospital. Today, BiOC operates out of community-based hubs at Salisbury and Strathpine. Both sites emphasise and facilitate continuity of care. At Salisbury, women who are pregnant with an Aboriginal or Torres Strait Islander baby and are eligible to birth at Mater Mothers' Hospital, have access to their own midwife (provided by the Mater) and to a First Nations family support worker and health team (provided by IUIH and ATSICHS Brisbane) throughout their pregnancy and at birth. At Strathpine, My Midwives provide midwifery services into the BiOC service.

"Timing, opportunity and collectivity – the timing was right to make a change, the opportunity to do something different and step out of the norm, and the collective approach succeeds because of the acknowledgement of the importance of partnerships."

Panel members spoke about BiOC program outcomes *"surpassing mainstream services nationally."* They pointed to the results of a 5-year study quantifying the program's health outcomes published in the Lancet Global Health journal in 2021. That study confirmed 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. In addition to the key finding of the reduced risk of pre-term birth, the study also found that women accessing the program are:

- Less likely to need a Caesarian 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%).

- In a further result, BiOC has not only already exceeded the 2031 Close the Gap Agreement healthy birthweight target (91%) but is delivering optimal birthweights at a better rate than mainstream (92.7% compared to 92.5%).
    - BIOC has also closed the gap in antenatal care and smoking after 20 weeks' gestation.

"There is a lot the mainstream can learn from models like BiOC."

The many advantages of BiOC in enabling health access and equity were highlighted by the panellists. For example, the ability of BiOC families to access transport to attend appointments was viewed as critical. The crucial role of the Family Support Workers was also emphasised, with these workers walking alongside Mum and supporting the family until the child reached 3 years of age.

"BIOC is community-controlled, and family centred."

"Instead of diagnosing, we need to assess the families and build on their strengths."

Maree Reynolds outlined three things that have made a big difference. First, *commitment* among all the partners to co-design to help shape the future and accepting that somethings needed to change. Not only had there been an organisational commitment at the CEO-level, but a personal commitment at all layers and all levels. Second, the *relationship* between the partners – respect for each other as organisations and people. And third, BiOC's research arm through which outcomes have been documented and published.

"Research has been absolutely fundamental [to BIOC] to continuously collect data and review data to see the difference we are making. Research has underpinned the success of the model, for people to believe that a partnership like this will actually work."

– Maree Reynolds, Director of Nursing and Midwifery, Mater Health Services

Other panellists described the collective focus of the program and the partners on the importance of governance, the importance of power being shared (plus receipt of additional funding to strengthen the partnership), as well as the program's integral research arm to strengthen the dissemination of the outcomes and provide the ability to advocate for more funding.

The panellists noted the expansion of BiOC to other parts of SEQ and the commitment to continually evolve the model or care. For example, Yulu-Burri-Ba also has three Family Support Workers to assist Mums and families, with BiOC administration and transport commencing soon. Yulu-Burri-Ba's three clinics each have a room that has been designed for the Mums to attend antenatal clinics, and the Yulu-Burri-Ba team ensures Mums and families can access all the services within those clinics.

"With a joint vision and shared values, we can be really nimble, so we can respond to things and do something differently … We are trying to do the very best for our generation."

Day 2, Plenary Address.

Chairs: **Jim McGowan** (Board Chair, Metro North HHS Board) and **Wayne Ah Boo** (IUIH)
Key Note: **Shaun Drummond** (Director General, Queensland Health)

Consistent with Adrian Carson's Welcome Address and the experience and voices of many conference participants, Shaun Drummond reiterated the need for urgent action to embed the ***SEQ First Nations Health Equity Strategy*** because *"we are not on the trajectory to Close the Gap with our pace of change".*

"It is not about providing the same access, as we will still not Close the Gap. Our challenge is about how we are going to provide far better access to Aboriginal and Torres Strait Islander patients."

Drummond outlined that Queensland Health needed to look at what we are doing together in the acute system for Aboriginal and Torres Strait Islander peoples, but also how Queensland Health services can better connect to other parts of the health system, such as primary healthcare and prevention. Although Queensland Health is primarily involved in secondary prevention (with a much smaller role in primary prevention), Drummond highlighted that Queensland Health has a role to support the parts of the health system that focus on primary prevention beyond Queensland Health auspices, especially CCHSs.

He discussed current and projected health workforce challenges, noting the significant deficits to arise in the next 10 years in the clinical workforce globally and throughout the Australian states and territories, including Queensland. Nationally, there are 30,000 health vacancies in the public health system, while in the United States there are 200,000 nursing vacancies. He raised the World Health Organization's (WHO) concern that although it is anticipated there will be 14 million global health vacancies in the next 10 years, there is simply not a pipeline to create 14 million health workers in the decade ahead. Therefore, with these alarming numbers in mind, Drummond highlighted that by having providers like the IUIH Network who have the greatest connection to community, they can have the greatest outcomes in the face of the current and pending workforce challenges.

"How are we going to have a sustainable workforce, how are we going to maximise the opportunity to have the services provided by the community?"

In response to these complexities, and *"instead of robbing components of the system",* Queensland Health needed to think innovatively about *"how do we connect and use the power of community organisations to deliver healthcare".*

Turning to the need for Queensland Health to subcontract and commission community-controlled organisations to improve health outcomes for Aboriginal and Torres Strait Islander peoples, Drummond

outlined the rules of commissioning from a State Government perspective. First, there is a government commitment that public services should be provided by public service entities – and when those services cannot be provided, public services should be contracted out. Second, the data collection capacities and systems of sub-contracting organisations are important. As 45% of Queensland Health funding comes from the Commonwealth, Queensland Health need to be able to count the patient interactions to report back. Queensland Health also want to understand the impact of the funding.

"We want to be focused on the things that actually make a difference."

Drummond highlighted there will be areas of morbidity and mortality that Queensland Health will be interested in because it is these areas that will have great impact and greatest return, like mental health, cardiology, and cancer services.

One significant challenge in Queensland is the provision of healthcare to older people.

"We have to reset what we do in the health continuum as [healthcare provision to older people] will be a significant issue and will be solved by partnering with community organisations to keep people in the community in a safe and appropriate way."

Drummond then reflected that much policy and planning work between government and community-controlled organisations is urgently required.

Drummond also asked conference delegates to think about how CCHSs can commit to the sustainability of the workforce for the future: *"How do you support workforce vacancies, develop further training, develop capacity?"* He emphasised the need for graduate training, noting that 20% of nursing graduates drop out of the healthcare workforce 2 years post-graduation. In his view, part of the reason for this is *"due to preparation in the undergraduate years".*

"Queensland Health wants all of the partners in healthcare to commit to training staff and building the workforce, essential for sustainability into the future."

Day 2, Afternoon Concurrent Workshop 1. Rethinking Outpatient Services Where it Makes Sense to

The case of chronic disease management: Improving access and outcomes for First Nations peoples at risk of, or living with, a chronic health condition

Purpose of Workshop 1: Outpatient services & chronic disease management
The 'Work It Out' rehabilitation and self-management program was born out of challenges experienced by Aboriginal and Torres Strait Islander people accessing and attending hospital-based rehabilitation outpatient programs. The Indigenous Respiratory Outreach Care program (IROC) is a Queensland Health State-wide Respiratory Clinical Network initiative that aims to take respiratory care closer to home. While initially a rural and remote service, it has expanded to include urban settings. This workshop will describe and discuss the success of these existing programs and identify areas for replication, collaboration and/or expansion into other areas and client groups. For instance, IUIH has received funds from Queensland Health and Metro North HHS to roll-out programs targeting post-acute cardiac rehabilitation and post-acute pulmonary rehabilitation. Such programs will require clear referral pathways between primary and tertiary healthcare services to ensure First Nations clients are able to access care in the community and specialist support as an outpatient.
Relevant *SEQ First Nations Health Equity Strategy's* Key Priority Areas (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: Transition appropriate community-based HHSs to the CCHS sector where possible and as guided by local co-design and service capacity.*

The workshop began with an introduction by co-Chairs **Donisha Duff** (Strategic Policy Adviser, IUIH) and **Michael Cleary** (Acting Chief Operating Officer, Metro South HHS) and presentations from **Katrina Ghidella** (Rehabilitation Programs Manager, IUIH) and **Peter Hopkins** (Executive Director, Heart and Lung Clinical Stream, Metro North HHS).

The panel identified key areas for success, which included: having pathways across the healthcare continuum and between primary and tertiary care, connecting clients with culturally responsive service delivery in community controlled settings, and a one-stop 'under one roof' approach where clients can access a multidisciplinary team for optimal health outcomes.

Following the presentations, conference delegates split into five groups to discuss:

1. How can we expand on existing models and services to improve access, attendance, and outcomes?
2. How do we ensure clear pathways from hospital to community, so clients don't fall through the gaps?
3. How do we ensure both clinical and cultural governance in service delivery?
4. What measures will we use to define success and report on progress?
5. What are our next steps?

Workshop notes from the five roundtables were reviewed and synthesised, with some key messages shared by workshop participants presented in the following box.

Feedback from workshop participants
Rethinking outpatient services and chronic disease management

- **Roll out IROC in other areas**, eg where there are concentrated populations of older people who identify as Aboriginal and Torres Strait Islander.
- Administrative staff need to **follow up appointment cancellations and DAMA with Mob** as a matter of routine. Include discussion on rebooking and barriers to access presented for the client (if any).
- **Referral pathways for the management of chronic diseases** from hospital to community need to be clear e.g., paperwork, handovers, medical history. Do a case conference or warm handover if needed.
- **Safe spaces, referral pathways and processes** that are communicated, embedded and reviewed regularly.
- **Are outpatient spaces safe**? Focus on safe spaces to improve attendance.
- **Report on progress through community feedback –** identify whether DAMA, readmissions or waiting times were reduced, or whether other referrals were generated from the initial appointment. Value and measure the patient's sense of connection to the program or service.
- Identify who is best placed to take **feedback and complaints** through the hospital system.
- It is important to build into new integrated outpatient services with appropriate levels of funding for **evaluation, research and data** for advocacy.
- Close the loop to ensure that when a patient is discharged with instructions, that those instructions go to their GP. **Ensure the GP has received information regarding discharge and treatment.**
- Real benefit of **community members connecting in with Mob Link before entering** the tertiary healthcare system.
- **Provide safety nets in the referral and service access process** – e.g., what happens if a client has declined an outpatient referral service due to acuity. Who follows up and how is that patient's care continued?
- Need to **approach programmatic success through a sustainability lens** – e.g., what's needed for long-term patient and systems referral success?
- We need to **value, and incentivise/reward, time spent on relationship building among service providers** – share learnings between providers, create opportunity for services to connect and share.
- **Ensure referrers, connectors and navigators (i.e., IHLOs) are aware of services**, especially new outpatient services by regularly distributing information on services, including information on service performance.
- We can ensure both clinical and cultural governance in service delivery **by incorporating yarnin' and sharin' models into clinical/program service delivery models** providing opportunity for sharing lived experience and cultural connection.
- Regularly review referral pathways.

Day 2, Afternoon Concurrent Workshop 2. Stitching Care Across the Sector
Empowering clients and communities – surgical pathways success

Purpose of Workshop 2: Stitching Care Across the Sector - Surgical Pathways Success
Accessing eye (cataract) and ear (grommet) surgery for First Nations clients is often a long story of waiting lists and repetition of appointments *to even access the wait list* (e.g., an IUIH-based specialist appointment followed by a Queensland Health specialist appointment). Innovative referral and care models have revolutionised this lengthy and ineffective process and have included partnerships with private hospitals to conduct day surgery procedures with pre-surgery and post-surgery care provided within the IUIH Network. Streamlined models of care not only improve client outcomes but saves the health system significant money. This workshop will outline and discuss the surgical care models and pathways currently used in the SEQ region and explore with workshop participants ways to expand and improve on them.
Relevant *SEQ First Nations Health Equity Strategy's* Key Priority Areas (KPAs)
KPA 5: Working with First Nations people, communities, and organisations to design, deliver, monitor, and review health services. *Key Priority Reform Area 5.1: Build on and replicate effective service delivery partnership models already established in SEQ, including (but not limited to) surgical pathways.*

The workshop began with an introduction by **Trudi Sebasio** (Director, Metro South HHS) and presentations from **Denis Conlon** and **Celia McCarthy** (IUIH)**.**

Following the presentations, conference delegates split into three groups to discuss:

1. How many First Nations people have undergone cataract and grommets surgery in the past 12 months?
2. What (if any) pathways currently exist for First Nations people accessing day surgery?
3. Is there duplication (e.g., seeing a specialist in a community setting then also seeing a specialist at the hospital outpatient clinic) occurring in SEQ?
4. How can we expand on this model to improve access, attendance, and outcomes? In other settings? Across surgical pathways? What ingredients for success do we need to ensure are in place?
5. How will we measure this?
6. What are the next steps?

Workshop notes from the three roundtables were reviewed and synthesised, with some key messages shared by workshop participants presented in the following box.

Feedback from workshop participants

Stitching care across the sector for surgical pathways success

- If we want to decrease duplication, we need to **increase trust in community sector practitioners**, **remove barriers by making community staff employees of hospitals**, and **have in place organisational agreements**.
- To improve access, attendance, and outcomes, **assess the reports of service experience from community against the reports of hospital teams**, increase the frequency of clinics, reduce duplication, implement systemic changes instead of individual-level changes.
- **Have a backup plan** (e.g., locum) to ensure the clinic goes ahead.
- **Ensure all partners are equally invested in the partnership**; have in place a formal agreement.
- **Leadership is needed at the top**.
- We need to **measure return on investment** for these initiatives.
- **Tertiary health needs to have trust in the primary healthcare system** – the patient administration part could be done by IUIH who would then pass this information onto the hospital. This saves duplication and takes away the hierarchy. IUIH knows the client, so knows the level of support required. By constantly asking the client the same questions at different points of service, the clients tell IUIH Network members all the time – *'why do they keep asking the same questions'?* We need a paradigm shift in organisational and workplace culture that has confidence in the other side that is holding the patient.
- We may need to **look towards the private sector**. Private pathways can be very efficient.
- IUIH Network needs to **consider embedding more non-clinical support mechanisms**; non-clinical support is a key aspect of systems efficiency and client happiness and wellbeing as they journey through the surgical pathway.
- Look at the **data for where the largest need is** in SEQ – identify longest wait lists and highest DAMA rates.
- Conduct the more straightforward surgeries to **clear wait times**, and leverage technology to ensure there is clarity between all the systems to reduce duplication with contact with the patient.

Day 2, Afternoon Concurrent Workshop 3. Ways of Growing a Culturally Responsive Workforce

Using partnerships to grow a culturally responsive workforce across the health sector

Purpose of Workshop 3: Ways of Growing a Culturally Responsive Workforce
Partnerships between Queensland Health, the community-controlled sector, training providers and universities enable us a unique opportunity to both grow culturally responsive health providers, as well as increase access to a range of health and specialist services for First Nations people. In this workshop, we will learn about and discuss current and proposed initiatives that aim to grow the Aboriginal and Torres Strait Islander health workforce through training programs designed to support both the clinical and cultural skills of participants.
Relevant *SEQ First Nations Health Equity Strategy's* Key Priority Areas (KPAs)
KPA 6: Strengthening the First Nations Health Workforce *Key Priority Reform Area 6.1: 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 peoples at all HHS workforce levels; a culturally appropriate regional workforce training and employment pipelines 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; partnership with CCHSs for the formal placement of registrars and other clinical staff within CCHS clinics and job sharing arrangements; culturally responsive ways of working; and First Nations workforce representation across all disciplines at levels commensurate with the local population.*

The workshop began with an introduction by co-Chairs **Angela Young** (Executive Director, Aboriginal and Torres Strait Islander Engagement, CHQ) and **Alison Nelson** (Director, Organisational Development IUIH) and presentations from **Richard Mills** and **Chrisdell McLaren** (IUIH), and **Gabrielle Taylor** (Metro North HHS). Key points discussed included ways in which we can approach workforce matters as a whole of health sector; e.g. shared staff, rotations, secondments which both increase Mainstream staff's cultural capacity and provide growth opportunities for Primary Care staff. The risk is that otherwise, we will end up poaching staff or disadvantaging one part of the sector whilst we meet targets in another.

Following the presentations, conference delegates split into ten groups to discuss:

1. How many First Nations staff do you have? Across what roles?
2. How do we currently track and report on representation of First Nations people in our workforce?
3. How can we take a coordinated approach to developing cultural and clinical skills in our health workforce?
4. How do we prevent competition for a finite resource?
5. What are some simple and practical opportunities we could action in the next 12 months?
6. What are our next steps?

Workshop notes from the ten roundtables were reviewed and synthesised, with some key messages shared by workshop participants presented in the following box.

Feedback from workshop participants
Ways of growing a culturally responsive workforce

- Human Resource teams in IUIH and HHSs can track and report on how many First Nations staff are employed in their organisations. Some people choose not to disclose their First Nations status, and this can be a barrier to their engagement.
- To prevent competition for finite resources, **shared or joint positions across systems and services, which promote co-learning**, is a good step forward. Acknowledge and address competition for finite funding and resources, and multiple conflict of interests that may be attached.

- Acknowledge and address **cultural fatigue** of and for First Nations healthcare sector workers.
- **Rotate positions amongst the HHSs and CCHSs in the SEQ region**.
- Health workforce traineeships could have **both community and hospital placements.**
- When staff change or move, there needs to be an **overarching system commitment** to continue staff 'cross over' or shared positions across services.
- On **HHS interview panels**, suggest a member of the IUIH Network sits on the panel as an interviewer to support comprehensive assessment of both clinical and cultural skills of candidate.
- The importance of relationship and network building is so important for overall career building. How do we teach people to do that? Rotation through health systems to build networks and connections? Hot desk systems?
- There is an importance of formalising connections for succession planning.
- Our universities need to integrate cultural safety training into all health and medical education as part of core clinical skills.
- **Redesign health workforce recruitment models** to be more culturally safe.
- Genuinely believe in cultural safety **– appreciate the value of culture and it *not* being 'just a tick and flick.'**
- Offering permanent positions for **stable employment is an outcome that contributes to better health** outcomes.
- **Complete entry and exit surveys to capture what drives individuals moving into and out of healthcare services.**
- Coordinate planning and efforts to provide culturally safe working environments.
- The efforts we've collectively made to date have made a huge increase in the employment of First Nations peoples into the health sector in SEQ.
- Really important need for **cultural mentors** and Aboriginal and Torres Strait Islander leadership.
- Could we increase opportunities for First Nations peoples from rural and remote areas to come to urban regions for training?
- It is crucial that organisational cultures 'within' are not racist. There needs to be **safe spaces to make complaints.**
- Focus on workforce retention.
- HHSs should survey their First Nations staff.
- **Community trust and respect in the workforce** is a part of the building trust with community accessing services.
- New health workforce graduates being work ready – more experience on the floor during studies translating cultural safety theory into practice. How can we increase our support of this?
- Members of the health workforce are on different and non-comparable awards. There are hard conversations when people transfer from one to the other. Need to **work together on salary equity**, particularly around Identified positions.
- **Share talent pools** across organisations. It would be beneficial to shared planned interviews across organisations to see if someone may fit better with another team. Children's Health Queensland is an example of how to do this effectively.
- How do we **put a value on life experience** when the expertise is not necessarily paper-based?
- **Build connector roles** across the system, such as nurse navigator roles, or community navigator roles across organisations.
- **Build on models that work** e.g., BIOC program.
- We need to **remove 'protecting your patch' mentalities** that produce unconscious bias and can reinforce siloed ways of working.

Conference Wrap Up

Taking the Health Equity Journey Forward

Speakers: **Adrian Carson** (IUIH) and **Jim McGowan** (Metro North HHS)

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.

What did participants really enjoy about the conference?

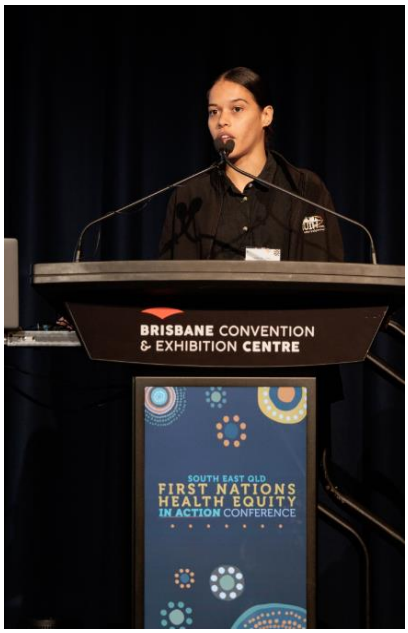
What are the main take-aways from the inaugural SEQ First Nations Heath Equity in Action Conference?

- Actions FAST.
- Personal accountability
- Community led
- Accountability.
- We need to do it yesterday
- Collaborate and share
- Little things can make a big difference
- Red to grow our workforce together across the sector
- We CAN work together
- Build trust
- Localise to our own facility
- We need to communicate with the community at their level
- Know your community
- Go to where the people are
- We need to be more proactive with community engagement specifically with our youth.
- Deliver on our commitment
- Value in co-leadership
- Engage with groups in specific locations based on age
- Report back
- Collaborate for efficiency and keep community at centre
- Engagement is a conversation
- Go to the community to conduct the engagement
- Community engagement needs to be led by community
- To rethink what we do to capture everyone's voice
- Strategies for better integration. To focus on the whole picture rather than immediate outcomes
- Meet community where they are at
- Shared workforce
- Consultation fatigue is a real challenge
- Meet the community where they are
- Just do it
- Trust your role
- Value of partnership positions.
- Proper engagement to where the people are
- Importance of engaging with young people-large part of population whose views really count
- Connecting with young mob
- - we need to meet people at the place they are at.- targeted engagement to reduce the risk of duplication-model- you said, we heard, we did.
- Don't make excuses. Be accountable.
- Collaborative action through strong partnership
- The level of interest in taking action to address health equity
- MobLink uses. Deadly choices program. Working together collectively
- Self determination is key
- Workforce
- Action, effort, commitment and partnership
- Importance of partnerships and collectivity.
- Action now

take-aways continued…

- Commission IUIH to do more
- Networking and listening
- Visibility
- Create systems that talk to each other
- investment in Cultural Integrity across the sector
- Obligation
- Share
- Keep looking at the bigger picture
- Collaboration across organisations
- Put effective actions in place
- Research as an action and research into action
- Share learnings- good and bad
- Follow up on what we can do urgently on priority needs areas
- Encourage sharing of candidates in recruitment pools - someone may not be successful for 1 job but a good fit for another. We need to know about these people.
- Be accountable
- Action speaks louder than words
- Leadership at all levels
- Collaboration. Not competition.
- workforce pipeline rethink
- Lots of work to be done, but it has to be done together.
- Listen
- Data and research collection is paramount
- It actually isn't hard...it is easy to be brave
- Collaboration
- Work better together- with commitment to overcome barriers
- MOBLINK is awesome
- Build and sustain relationships
- Success measures needed
- The system should be equal - no part should be subordinate. Connection and mutuality are key.
- A lot of work to do. Hoping that services will take next steps and action priorities.
- Community led
- How do we hold the CEs accountable for ensuring First Nations family are our first priority?
- First Nations first
- Build strength in our connection with all community health and Qld health. Work together toward a solution/ plan to have a strong pipeline for community
- CHQs talent pool
- Networks
- We need to trust each other to achieve our joint goals
- Importance of expanding community controlled primary health care to meet need
- Lots of good things happening
- Proven models need to be replicated asap. E.g. better access medication
- That by breaking down the barriers between organisations we can make a difference.
- IUIH only collaborates on the Northside
- The urgent need to change and take action
- Action now and commitment to progress. Hold each other to account.
- Feel proud to be part of IUIH
- Personally accountability
- Partnerships need to create action
- Collective and personal accountability
- First Nations lead
- Removal of barriers for equity
- HHS are still not listening
- The wonderful initiatives in place and the opportunities for more.

How do participants plan to commit to achieve First Nations Health Equity in the next 12 months?



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

- Sit and listen
- Start now
- Seek executive support for change
- Words into action
- Build partnerships and collaborate
- Learn more about areas we can expand.
- Have difficult conversations
- Collaborate with HHS
- Share my learnings
- Solutions focussed
- Refocus on health equity
- Collaborate more and share success instead of dwell on differences
- How do we expand our service line - move into new areas
- Build a suite of shared or rotational positions
- Ask questions. Maintain connections across organisations.
- More collaboration
- More collaboration
- Highlight community strengths and self governed models of care
- Make people more aware
- More communication
- Be brave and hold to our ways of being
- Hard conversations on delivery
- Look inwards and outwards.
- Look for opportunities to create training opportunities for First Nations people within our organisation
- Have the hard conversations. Put things into action
- Follow through with collaboration
- Collective action
- More collaboration
- Accountability as key
- Increase First Nations leadership
- Think more of health as a system not component parts
- Nothing. Continue the great work we have started and respect community wishes
- Encourage more partnerships
- Share and collaborate
- Increase program visibility
- Build on and nurture existing partnerships

Strengthen partnerships and collaboration

consider collaborative partnerships

Make team aware of our accountability

Evaluate to gather evidence for our First Nations programs

Understand and implement health equity.

Inspiration and innovation

Empower young ones to see the path through health

Collaboration not parochialism

Progress discharge medications at Gold Coast. Workforce planning for next 12 months

Consider more greatly - connect the system meaningfully

Stay focused on changing the system.

Collaboration across organisations

all presentations were fitting for opening up this important yarn

Advocate for and action community needs with a better understanding

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

First Nations Health Equity *Priority Area 4: Delivering sustainable, culturally safe, and responsive healthcare services*		
National Agreement on Closing the Gap	*Priority Reform 1: Partnership & shared decision-making*	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
	Priority Reform 2: Building Community Controlled Health Services	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
	Priority Reform 3: Transforming Government Organisations	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
	Priority Area 4: Sharing access to data and information at a regional level	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

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	