FIRST PEOPLES HEALTH EQUITY STRATEGY 2022 – 2025

CONSULTATION DRAFT 7 MARCH 2022

[Graphics Placeholder]

Queensland Government

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Terminology
Throughout the Strategy, the term First Peoples, is used interchangeably for 'First Nation People' 'First Nations', 'Aboriginal peoples and Torres Strait Islanders', and 'Aboriginal and Torres Strait Islander peoples.' We acknowledge First Peoples' right to self-determination and respect the choice of First Peoples to describe their own cultural identities which may include these or other terms.

Glossary

APUNIPIMA	Apunipima Cape York Health Council
ATSICHHO	Aboriginal and Torres Strait Islander Community Controlled Health Organisation
CHHHS	Cairns and Hinterland Hospital and Health Service
CYLC	Cape York Land Council
GP	General Practitioner
GURRINY YEALAMUCKA	Gurriny Yealamucka Health Service
HHS	Hospital and Health Service
LANA	Local Area Needs Assessment
MAMU	Mamu Health Service
MULUNGU	Mulungu Aboriginal Corporation Medical Centre
NQLC	North Queensland Land Council
PHN	Primary Health Network
QAIHC	Queensland Aboriginal and Islander Health Council
RFDS	Royal Flying Doctor Service
SA2	Statistical Area Level 2
SA3	Statistical Area Level 2
SEIFA	Socio-Economic Indexes for Areas
TCHHS	Torres and Cape Hospital and Health Service
WUCHOPPEREN	Wuchopperen Health Service

Acknowledgement

The Cairns and Hinterland Hospital and Health Service (CHHHS) acknowledge Aboriginal peoples and Torres Strait Islanders as this country's First Nations people. *We recognise First Nation people and communities as traditional and cultural custodians of the lands on which we work to provide safe and quality health services. We pay our respect to Elder's past, present and emerging.*

We deeply respect the rich, diverse, and enduring cultures of First Peoples as amongst the longest surviving cultures in the world. We recognise the importance of First nation leadership in all matters that effect the vitality of First Peoples, Communities, and their Institutions.

We also acknowledge the deep pain and intergenerational suffering that colonisation has had on the health and wellbeing of First Nation peoples. We accept our responsibility and accountability to continue to build and sustain a system of health care that free from all forms of racism and delivers significantly better health outcomes for the First Peoples of these lands.

A special thanks to First Nation staff, consumer's and community members, traditional owner groups, Aboriginal Community Controlled Health Organisations and the many other people and groups who have contributed to the development of our inaugural Health Equity Strategy for First Peoples.

We commit to doing all that we can to honour the voices of First Peoples and the strategies and actions contained in this Strategy, to continue to build the trust and confidence First Peoples have of us and our alliances to deliver to you our best possible care.

Message from the Chair and Chief Executive, HHS

[Placeholder]

Statement of Commitment

We acknowledge. We commit. We promise.

A strength of Far North Queensland's health system, and in particular the Cairns and Hinterland region, is the essential and varied elements that make up a vibrant, resourceful, and innovative health sector.

This simple statement embodied in a complex composition of government, non-government, public and private primary, including First Peoples leadership through Aboriginal and Torres Strait Islander Community Controlled Health Services, secondary and tertiary health care, requires acting in unison to deliver improved access, leading to better health outcomes for First Peoples.

While each health service has a distinct role to play, we know the power of purposeful partnerships, that this Strategy relies upon. We accept that it is courage, conviction and determination of the Hospital and Health Service, working in tandem with First Peoples, their health and other community owned and operated institutions, which will provide the best chance of accelerated progress and outcomes.

The Health Service affirms its unreserved recognition of Aboriginal peoples and Torres Strait islanders as First Peoples of this area; supports the pursuit of self-determination; accepts the diversity of First peoples' cultures and respects traditional knowledge holders; and local decision making.

As a prelude to the legislative requirement for a Health Equity Strategy the many and varied health leaders embarked on joint health planning, in recognition of the need for an agreed approach to improving health outcomes, resulting in a regional health plan, 2019-2022.

The welcomed legislative and regulatory Queensland Government instruments Hospital and Health Boards Act (2011) and accompanying Hospital and Health Boards (Health Equity Strategies) Amendment Regulation 2021 (the Regulation) expanded and brought discipline and standardisation to the pre-existing will and free spirit of health care providers. Notably, and for the first time, the regulation requires traditional owner groups and other health entities, such as Health and Wellbeing Queensland, as prescribed stakeholders to be part of the co-design endeavour, in prioritising health equity and addressing racial discrimination and institutional racism. We acknowledge and support that systemic and sustainable health equity reform can only be achieved through the genuine inclusion of, and partnership with, Aboriginal and Torres Strait Islander peoples at every stage.

Background

Towards Health Equity in Cairns and Hinterland Hospital and Health Service…….

From 2018 the Aboriginal and Torres Strait Islander Health Unit has been executing a two-staged re-positioning of internal resources to realise strategies targets towards health equity which included activities to:

- Increase the Indigenous workforce.
- Achieve 80% compliance with mandatory cultural capability training.
- Implement Policies and Procedures aimed at improving health care access for First Peoples.
- Increase formalised partnerships with Aboriginal Community Controlled Health Organisations (ACCHOs).
- Implement actions to reduce Discharge Against Medical Advice (DAMA) and Potential Preventable Hospitalisation (PPH) rates for First Nations peoples.
- Introduction of a CHHHS Health Equity for Aboriginal and Torres Strait Islander Patients Policy.
- Convene a regional health planning partnership event with sector stakeholders, October 2018. Emergence of Stronger Mob, Living Longer Working Group and Far North Queensland Aboriginal and Torres Strait Islander Peoples Health Plan.
- Lead and support the development and implementation of the Stronger Mob, Living Longer Regional Health Plan.
- Cairns and Hinterland Analytical Intelligence (CHAI) Aboriginal and Torres Strait Islander Health Dashboard launch, January 2019.
- Memorandums of Understanding and Collaborative Service Agreements with ACCHOs, 2019.
- Development of inaugural Aboriginal and Torres Strait Islander Health Annual Report in March 2020.

In recognition of the significant gap in health outcomes for First Peoples and communities, our aim is to become leaders in improving health outcomes for First Peoples. The Stronger Mob, Living Longer Plan was developed as a companion multilateral plan aligned to the CHHHS Clinical Services Plan and together these plans created the foundation for greater integration and coordination of care across the acute and primary health care environments. Deliberate action was taken to redress the previous siloing of First Peoples health within the system by deliberately consolidating First Peoples leadership and re-alignment of specific programs to ensure continuing service development approaches to achieving accessible, high quality, culturally capable integrated health care for First Peoples.

In February 2020 progress was delayed due to the emergence of the COVID-19 Pandemic, which resulted in a shift of health sector attention and resources. The previous partnership efforts were strong foundations to maintain a leadership presence and collective approach to designing COVID-19 responses.

In July 2020 the Regional Health Partnership terms of reference were refreshed and the Working Group was re-ignited. From July 2020 – May 2021 (eleven months) there were of bursts of activities to accelerate the groups desire and focus towards achievement of goals within the Plan. Some of the resulting regional initiatives included:

- Connecting Your Care Projects: Care Coordination, Priority Dashboard and Central Referrals.
- Development of a regional data set.
- Patient Transport and Accommodation Hub Model development.
- Working Group developed sector response to National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021 – 2031.

These activities aligned with the CHHHS Strategic Plan 2018-2022; CHHHS Clinical Services Plan 2018-2022; and CHHHS FY20-21 Operational Plan. This uniform approach provides another critical building block in the CHHHS Health Equity foundation, which works across the region to enable accessible, high quality, culturally capable integrated health care for First Peoples.

"Closing the Gap is where equity (giving Indigenous people what they need) meets equality (treating Indigenous people fairly)".

Dr Murty Mantha MD FRACP

Our Vision

'Galvanise a renewed and shared agenda to improve Aboriginal peoples' and Torres Strait Islander peoples' health outcomes, experiences, and access to care across the health system.'[1]

Our Goal

'Improve access to care, health and wellbeing outcomes and experiences, and eliminate health inequalities and equalise the life disparity experienced by First Peoples.'

Principles

Person Centred	*Care will be delivered to First Peoples and will consider and be informed by them and their specific needs, culture, and health goals.*
Integrated and Connected	*Develop formal, mutually beneficial partnerships with Prescribed Stakeholders to co-design care pathways for seamless care provision and reduce service duplication. This approach will support a more targeted approach to health service resourcing and delivery, with connectedness to social services as important in the achievement of improved health outcomes.*
Recognising and Respecting Culture	*We recognise and respect the traditional culture and practices of individuals, families and communities; with outcomes and aims based on the preferences, needs and values of the patient, their family and community.*
Commitment and Accountability	*Define and agree roles and responsibilities of health service providers to ensure accountability and a meaningful commitment to delivering this Strategy. This commitment should be visible, measurable, and continuously communicated and demonstrated to Prescribed Stakeholders.*
Accessible	*Support First Peoples to access timely, culturally safe and appropriate health care, as close to home as possible where safe and sustainable to do so. This includes consideration of technology, extended / alternative delivery hours, alternative workforce models (which supports the increase of First Peoples employment in health services) and culturally appropriate policies and processes.*
Equitable	*Ensure equity of access and quality of health outcomes for First Peoples, meaning access to health services is fair, just, and responsive to the patient, their family and community needs. This includes providing choice of who, how, what and where services are accessed, with patients empowered to manage their own health.*

Priorities

The six (6) Key Priority Outcome Areas have been co-designed in consultation with the Prescribed Developmental Stakeholders. The activities are the locally informed solutions to health system issues such as structural and systemic inequities, barriers to service access, workforce capability and the provision of culturally safe and capable health services.

Figure 1. CHHHS First Peoples Health Equity Strategy Key Priority Outcome Areas

About CHHHS

Regional Summary

Approximately 12% of the population within the Cairns and Hinterland region are Aboriginal people and Torres Strait Islanders. The total estimated population of Cairns and Hinterland is 259,230 people. Cairns and Hinterland geographical area covers Cairns to Tully, west to Croydon and north to Cow Bay, and one (1) discrete Aboriginal Community: Yarrabah. CHHHS includes six (6) Statistical Area Level 3 (SA3) regions (Cairns North, Cairns South, Innisfail-Cassowary Coast, Port Douglas-Daintree, Tablelands (East)-Kuranda and Far North).[4]

Figure 2. Percentage of First Peoples who reside outside of Cairns North and Cairns South SA3 regions.

Of the 6 SA3 regions in CHHHS, 44% of the First Peoples population reside outside of the Cairns North and Cairns South region.

We also consider the Aboriginal people and Torres Strait Islanders who access our service from the neighbouring Torres and Cape Hospital and Health Service (TCHHS), approx. 69% of their population. This increases the number of Aboriginal people and Torres Strait Islanders accessing health services within Cairns and Hinterland Hospital and Health Service (HHS.

Throughout Cairns and Hinterland Hospital and Health Services there are two (2) Aboriginal and Islander Community Controlled Peak representative bodies (Northern Aboriginal & Torres Strait Islander Health Alliance and Queensland Aboriginal and Islander Health Council) and five (5) Aboriginal and Islander Community Controlled Health Organisations.

Cairns and Hinterland health facilities includes:

- Seven (7) Hospitals
- Nineteen (19) Primary/Community Health Centres
- Eighty (80) General Practice Clinics

Since March 1994 North Queensland Land Council (NQLC) has represented Traditional Owner constituents Native Title submissions. To date NQLC have successfully supported fifty-five (55) native title consent determinations. Through these determinations numerous land use agreements have been developed to ensure maximum benefit to the traditional owners of their region. All of the Traditional Owner groups are Aboriginal.

Figure 3. Health Partners within CHHHS

Estimated and projected resident population

The estimated resident population of CHHHS in 2019 is 259,230 people and is projected to grow to 306,634 people by 2031. The area with the highest anticipated growth is Gordonvale – Trinity (within the Cairns South SA3 area), with a projected annual growth of 6.8% from 2021 to 2031.[4]

Just under 12% of the population of the CHHHS identify as First Nations peoples, compared to the state average of 4.6%.[4]

The Australian Bureau of Statistics (ABS) estimates and projections of Aboriginal and Torres Strait Islander Queenslanders indicate that, at 30 June 2031 Queensland's Aboriginal and Torres Strait Islander population is projected to number between 302,093 and 315,585 persons.[5]

For the Indigenous Region (IREG) of Cairns-Atherton the projected population increase at 30 June 2031 is 39,466 persons.[6]

Service Profile

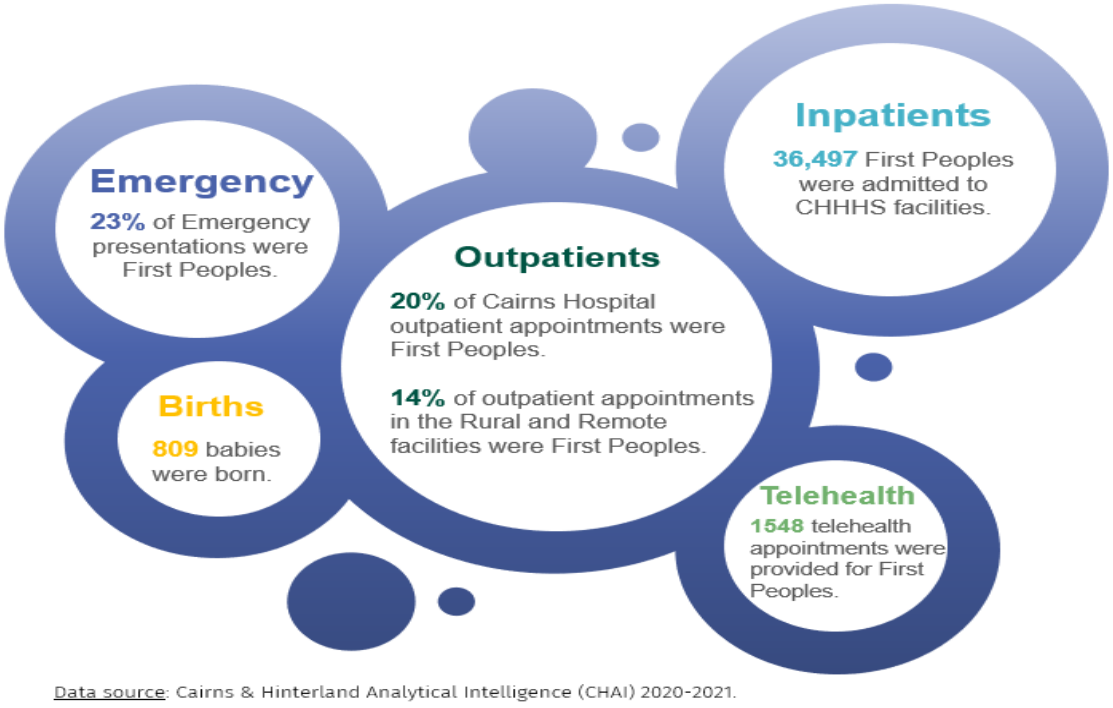
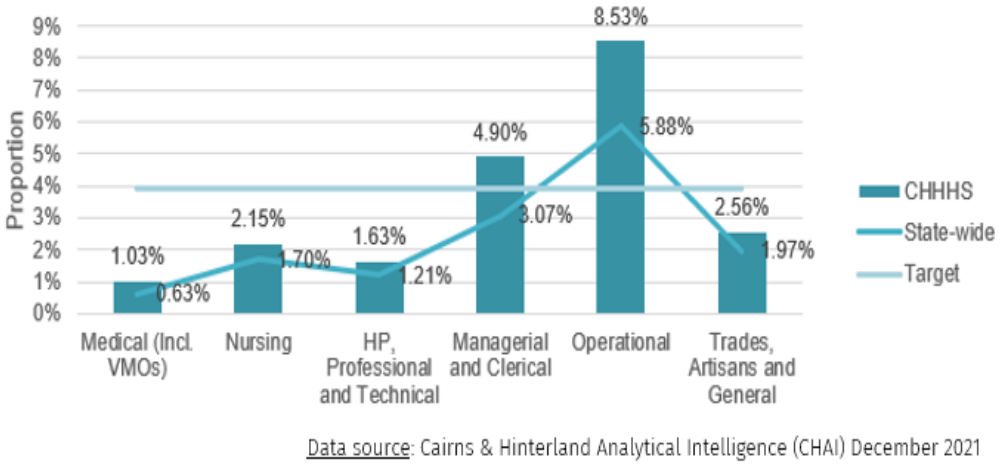


Figure 4. First Peoples service access and activity for CHHHS 2020-2021

The First Nations age standardised separation rate is more than 2x the population separation rate in Cairns South, and more than 3x the population separation rate in Port Douglas – Daintree. For First Nations people the top 3 reasons for overnight admissions are respiratory, obstetrics and gastroenterology. The top 3 same day admission for First Nations people in the CHHHS are for renal dialysis, obstetrics, and chemotherapy.[4]

CHHHS Workforce Representation by Stream



The proportion of CHHHS workforce who identify as Aboriginal people and/or Torres Strait Islanders is currently 3.5%, with a 40% gap in the completion of voluntary identification across the workforce domains.

Figure 5. CHHHS First Peoples workforce representation

Social determinants

The social determinants of health for First Nations people are far worse within the CHHHS, including low income, severely crowded (and crowded) dwellings and limited access to vehicles and internet access.[4]

Socio-economic profile.

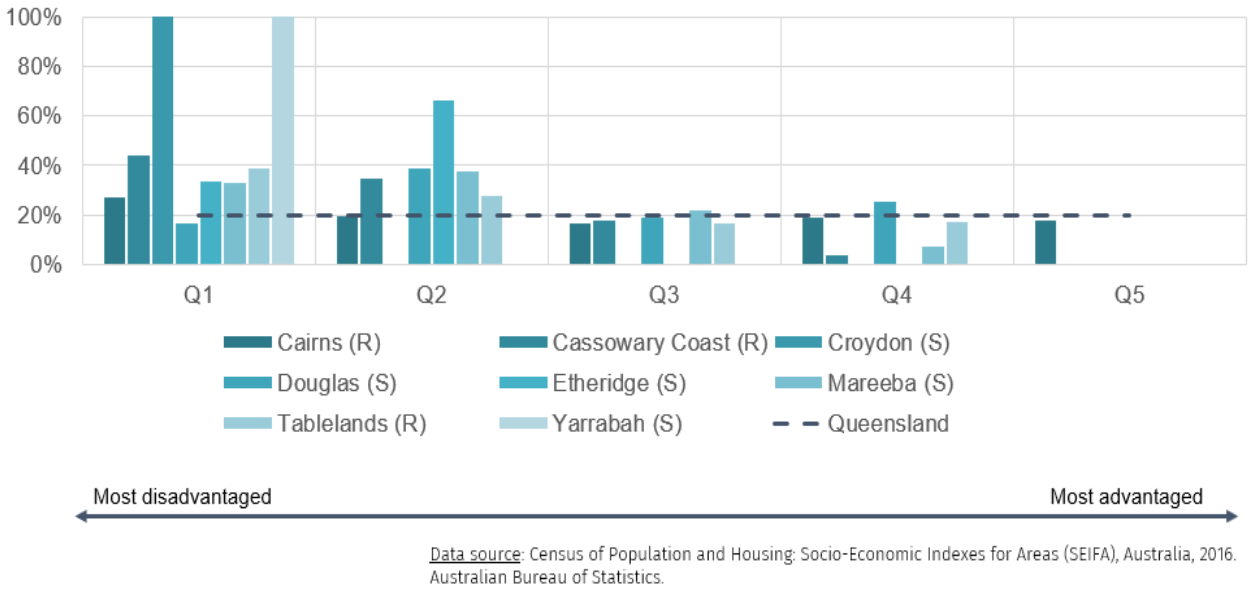


Figure 6. CHHHS Socio-economic profile.

The proportion of the total population in the lowest Socio-Economic Indexes for Areas (SEIFA) quintile is 23%.

The top 5 most disadvantaged SA2s in the HHS by proportion of First Peoples are Yarrabah, Manoora, Manunda, Westcourt – Bungalow and Innisfail.[4]

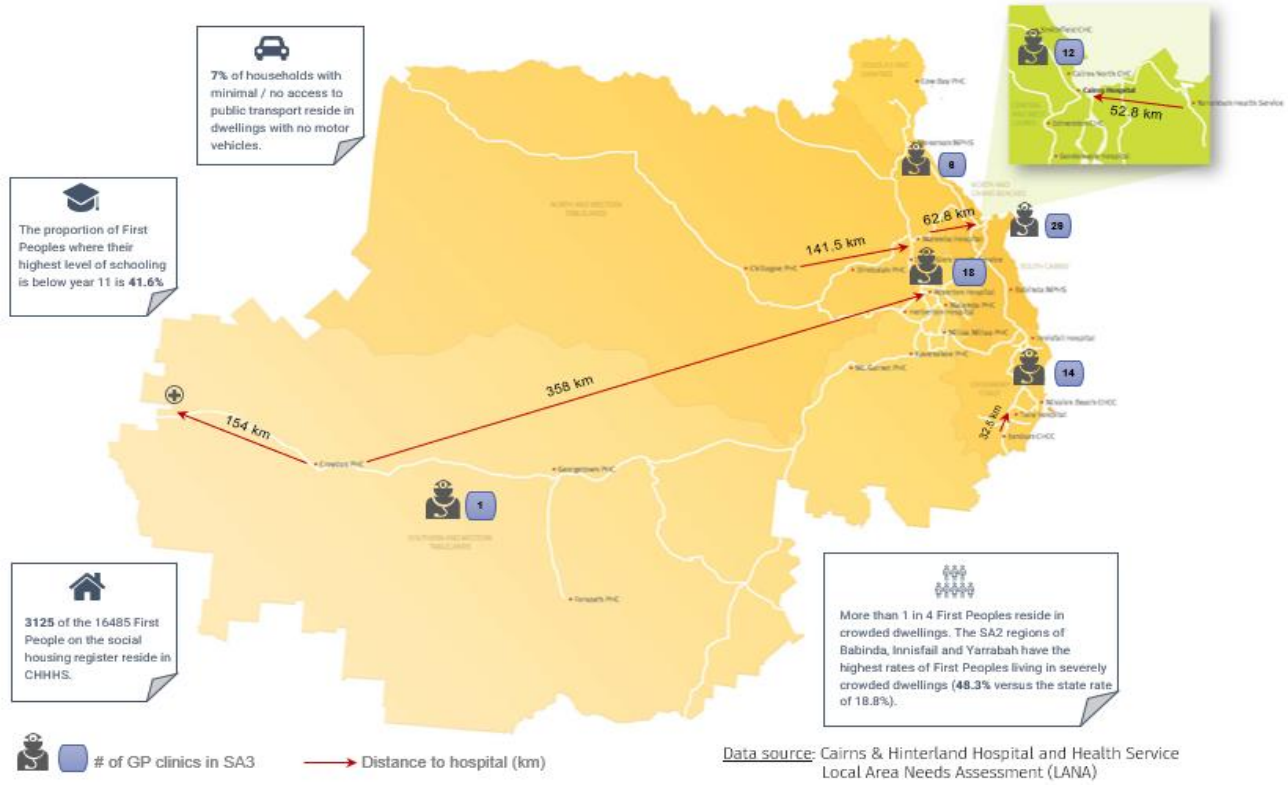


Figure 7. CHHHS service map with impacting social determinants of health

According to the Accessibility Remoteness Index of Australia, the SA3 regions within CHHHS are classified as outer regional, remote, and very remote designated areas. The total area covered is 141,600km^2, which is approximately 8% of the total Queensland area.

Age Distribution

For First Peoples, the age distribution in the CHHHS is skewed slightly towards the older ages when compared to the state distribution. 17.7% of First Peoples are aged 50+, 2.0% higher than the Queensland proportion. The top three SA2 areas with the highest proportion of older First Peoples aged 50+ (relative to the First Peoples population of the SA2) are: Babinda (29.1%, 112 people), Cairns City (27.8%, 299 people) and Freshwater – Stratford (27.1%, 42 people).[4]

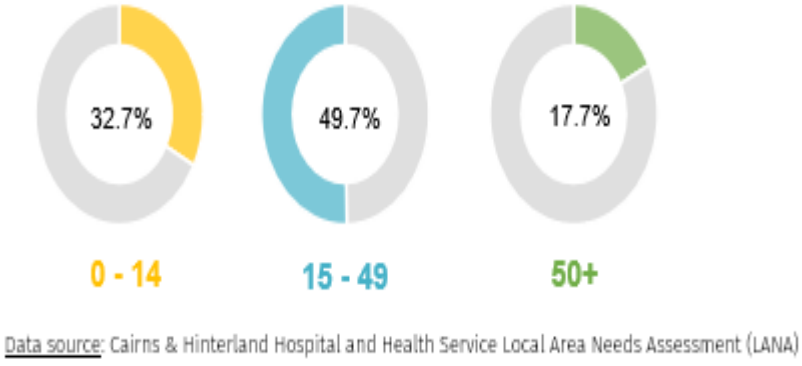


Figure 8. Age distribution of CHHHS First Peoples 2019

Health Status

The CHHHS First Peoples cohort experiences higher preterm birth rates, higher low birthweight rates, higher end-stage kidney disease prevalence rates, higher acute rheumatic fever/rheumatic heart disease rates, higher rates of sexually transmitted infections and higher rates of vaccine preventable potentially preventable hospitalisations. There are certain Indigenous Areas (IARE) with significantly higher premature mortality for cancer, circulatory system diseases, respiratory system diseases and diabetes within the CHHHS.[4]

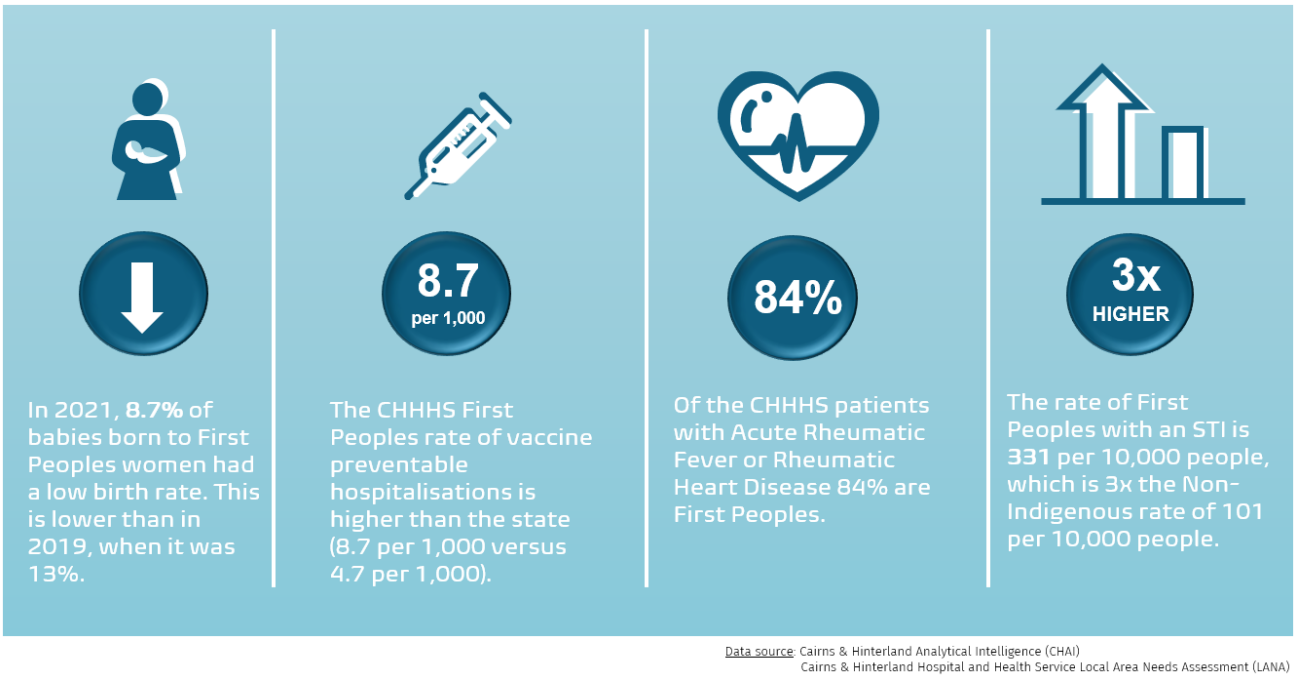


Figure 9. CHHHS Health Status

Gap in Life Expectancy

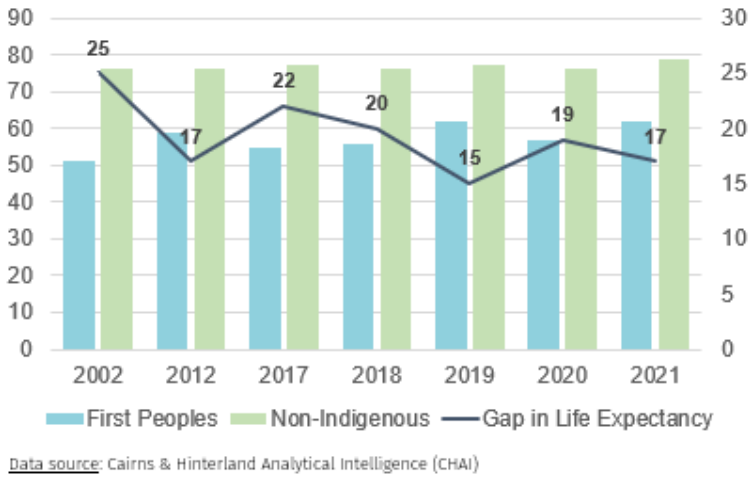


Figure 8. CHHHS Life expectancy gap

Chronic disease burden

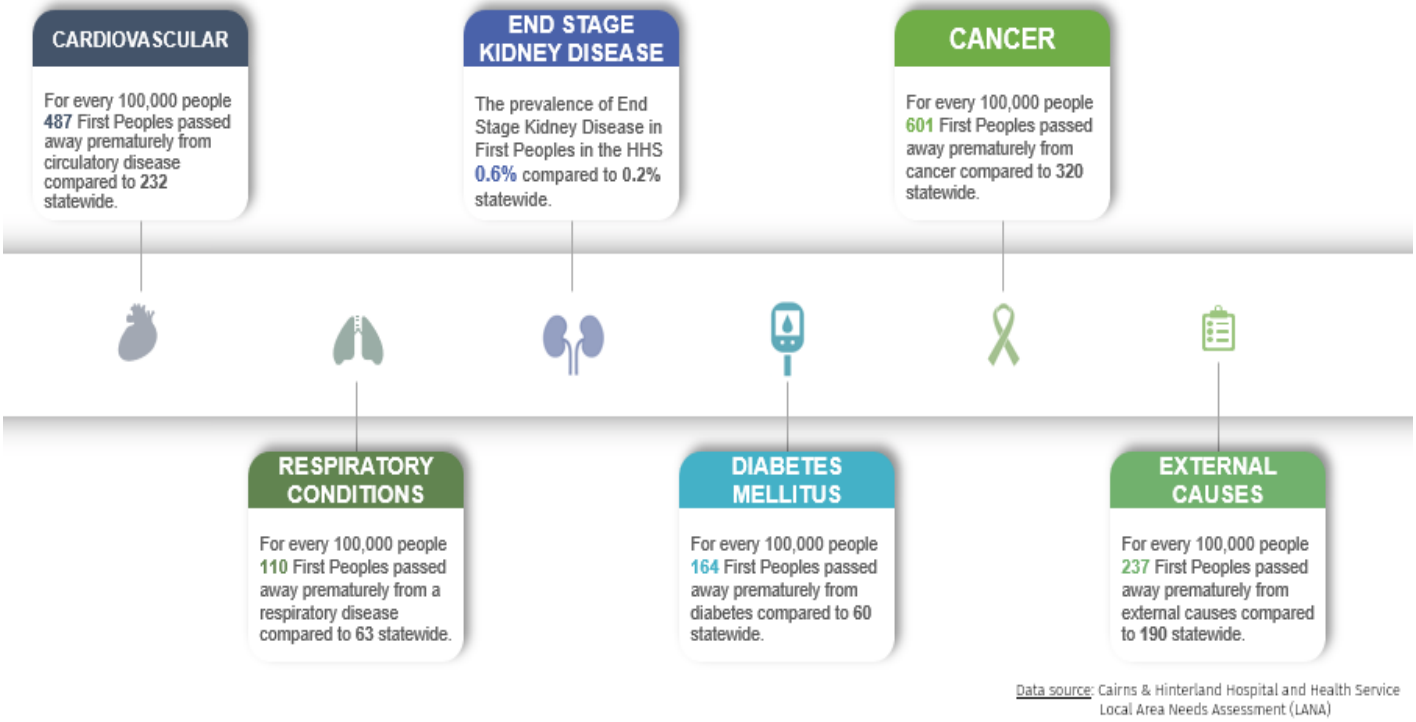


Figure 9. Burden of disease for First Peoples in CHHHS

The prevalence of some conditions is more than double the state average in CHHHS IREA regions for diabetes, respiratory conditions, circulatory system diseases and cancer. The rate of rheumatic heart disease is 39x higher among First Nations persons compared to non-First Nations people. The rate of end stage kidney disease prevalence for First Nations people is 7.0x the non-First Nations prevalence.[4]

Cultural determinants

Within the Cairns and Hinterland region are the Kuku Yalanji in the north (Mossman), Tagalaka in the west (Croydon), and Girramay in the south (Tully) and all other tribes and clans therein, including the diaspora of Torres Strait Islanders and other first peoples who have made this region their home.

It is widely acknowledged that the Cultural determinants of family, kinship and community, language, art, dance, song, hunting and gathering, Country and place, cultural identity and self-determination originate from and promote a strength-based approach and are protective factors that influences First Peoples health and wellbeing.

Family, Kinship and Community

First Peoples have strong family and cultural values which operate within our immediate and extended family constructs. First Peoples kinship and community structures are complex and dynamic eco systems, which define where people fit in their family and the broader community.

These structures incorporate and define First Peoples obligations and behaviours towards each other and extend from the immediate family unit to the extended family and community, and include but are not limited to:

- Family and Elder stewardship responsibilities
- Lore and cultural connection to Country
- Child rearing and support
- Care of elderly or frail family members
- Teaching language, ancestry, cultural practices, and protocols
- Teaching others about social norms

Country and Place

Pre-colonialism First Peoples lived in a harmonious and sustainable way with the land. Everything that was needed to survive was gathered and provided by land and sea, i.e., food, clothing, tools, weapons, ceremonial objects. First Peoples knowledge of their Country was primarily recorded and transferred verbally from generation to generation. First Peoples spirituality is intrinsically linked to their Country and importantly the culture (language, dance, song) associated to their Country.

Cultural Identity

The Health Service undertakes regular audits to assess the quality of its completeness of cultural identity in its hospital admissions and separations. The Health Service has a 99.78% rate of completeness and aims to maintain and strengthen the quality of its identification processes towards 100% completeness.

While there are identification options of Aboriginal but not Torres Strait Islander, Aboriginal and Torres Strait Islander, Torres Strait Islander but not Aboriginal, or unknown/not stated, the health service is yet to accommodate First Peoples tribal groups in its health records.

Recently, The Meriba Omaskar Kazin Kazipa Act 2020 recognises the long-held tradition of Torres Strait Islander traditional adoption. The implications of this in health care and information held on medical records is yet to be fully understood.

In short, there is more we must do in cooperation with First Peoples to make space for cultural forms of identification.

Self-Determination

Self-determination has been at the heart of First Peoples fight for justice, not only in health, but in land and sea, economics, education, and all other social and cultural determinants.

The clearest manifestation of self-determination is the model of comprehensive primary health care that has been developed by Aboriginal and Torres Strait Islander Community Controlled Health Services over 50 years in Australia and just over 40 years here in Far North Queensland.

Self-determination is distinguished from self-agency in that self-determination is generally accepted as a collective process of First Peoples determining for themselves health care which is for the people, by the people.

"Health to Aboriginal [and Torres Strait Islander] peoples is a matter of determining all aspects of their life, including control over their physical environment, of dignity, of community self-esteem, and of justice. It is not merely a matter of the provision of doctors, hospitals, medicines or the absence of disease and incapacity."[3]

(Source: National Aboriginal Health Strategy, 1989)

Individual agency is where the health system applies a patient-centred care approach ensuring the patient and their family or significant others are informed and making decisions for themselves, not by health care providers. While there are exceptions, other decision makers, under law, the general principle and practice of the patient being the centre of their own care is paramount to the trust and confidence Aboriginal peoples and Torres Strait Islanders have, or don't have, in the Health Service. We must do all that we can to ensure people, as patients, are in the decision-making seat.

Our Partnering Arrangements

With the emergence of COVID-19 and associated outbreaks co-designing the Strategy with Prescribed Developmental Stakeholders presented consultation and engagement challenges. To mitigate community transmission and maintain the safety throughout the consultation and engagement phases COVID-19 rules were strictly adhered to.

At Cairns and Hinterland Hospital Health Service, health equity for First Peoples is already a priority of our strategic and operational plans. The introduction of Legislation provided the opportunity for increased focus and action towards achieving health parity for First Peoples.

Our consultation and engagement approach were focused on the lived health experiences of everyday people, and included First Peoples' Staff, Consumer's, Communities, Traditional Custodians/Owners, and Aboriginal Community Controlled Health Services. Prescribed Stakeholders were provided with information about the Health Equity Legislation, Hospital and Health Services obligations, health data, and the Strategy Key Priority Outcome Areas.

The co-designed approach is aligned to IAP2's Spectrum of Public Participation. In working with the Prescribed Development Stakeholders, we were intent on:

- Providing a phased engagement and consultation approach with prescribed stakeholders on What Health Equity Is? and the draft strategy.
- Obtaining First Peoples feedback on health system issues and solutions.
- Creating culturally safe, non-judgmental, and impartial environments and opportunities for First Peoples to share their health system experiences; describe their health needs; and share solutions.
- Accurately hearing and recording First Peoples feedback about their local community context, history and culture, and synthesizing their commentary into Health Equity goals.
- Authenticating the Health Equity Strategy with First Peoples.
- Engaging and consulting with First Peoples in a respectful and authentic way to establish enduring relationships.
- Providing defined pathways for Stakeholders to contribute ideas and feedback on systemic health barriers.

While consultation sessions were unable to be delivered to the Land Council groups prior to the draft strategy being developed, Traditional Owners attended community consultation sessions and provided feedback.

INCREASING IMPACT ON THE DECISION

	INFORM	CONSULT	INVOLVE	COLLABORATE	EMPOWER
DEVELOPMENT STAKEHOLDERS PARTICIPATION GOAL	Provide Development Stakeholders with balanced and objective information to assist them in understanding the Legislated Health Equity requirements, and health system alternatives, opportunities and/or solutions.	Obtain Development Stakeholders feedback on health system analysis, alternatives and/or decisions.	Work directly with Development Stakeholders throughout the co-creation the Hospital and Health Service Health Equity Strategy to ensure that Stakeholder aspirations and concerns are reliably understood and authenticated.	Partner with Development Stakeholders in co-creation decision aspects of the Health Equity Strategy, including the development of alternative or preferred solutions.	Place final decision making, validation and endorsement of the Hospital and Health Service Health Equity Strategy in the hands of the Development Stakeholders.
HOSPITAL AND HEALTH SERVICE PLEDGE TO STAKEHOLDER	We will keep you informed.	We will keep you informed, discuss with you, listen to and acknowledge your aspirations and concerns, and provide feedback on how Developmental Stakeholders input influenced decision-making.	We will work with Development Stakeholders to confirm that your aspirations and concerns are clearly reflected in the Health Equity solutions developed and provide feedback on how your input influenced decision-making.	We will call upon Development Stakeholders advice and innovation in co-creating Health Equity solutions and incorporate your advice and recommendations into decision-making to the maximum extent possible.	We will implement what you decide.

Figure 10. CHHHS IAP Consultation matrix

Finalisation and endorsement of the Health Equity Strategy by the Regulation's prescribed stakeholders and the Chief Aboriginal and Torres Strait Islander Health Officer is expected by 30 April 2022.

Governance

The CHHHS Board and Executive *(Tier 1)* will be accountable for the effective leadership, implementation and compliance of the Health Equity Strategy as defined in the Regulations.

Following CHHHS Health Equity Strategy endorsement, discussions will commence with Prescribed Stakeholders to establish the CHHHS Health Equity Council *(Tier 2)*, Diagram 1,and will be responsible for ensuring:

- co-design, co-implementation and co-review of the Implementation Plan, and;
- visibility, assurance, and performance of health equity activities are maintained within agreed timelines.

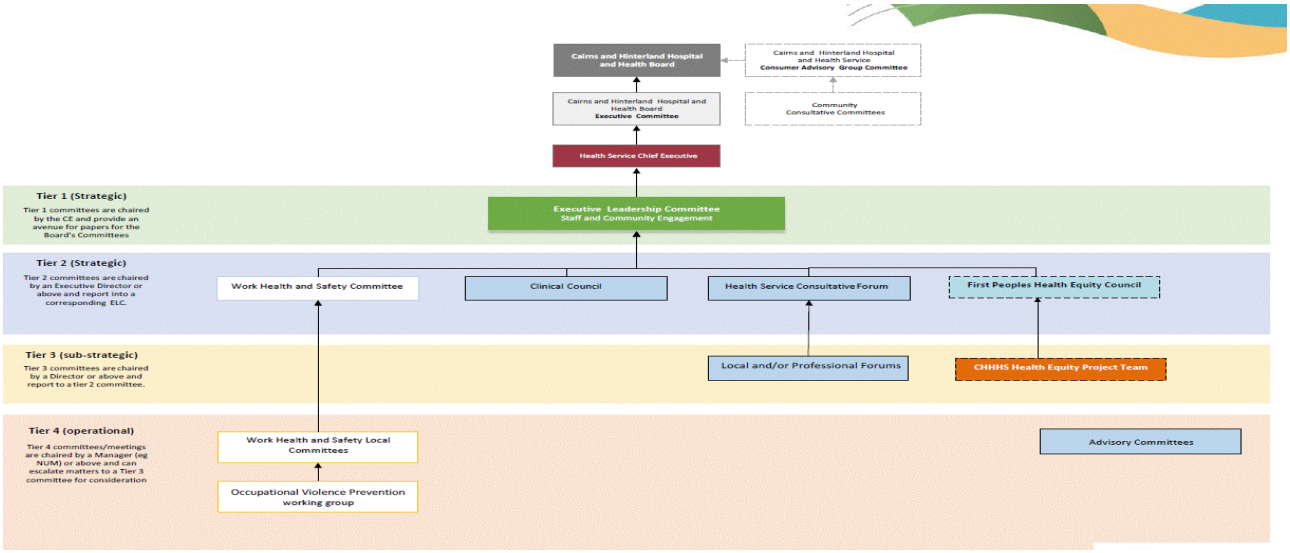


Figure 11. Proposed CHHHS First Peoples Health Equity Governance Committee

The governance committee will be comprised of representatives from the Prescribed Development and Implementation Stakeholders who will be responsible for endorsing the co-design, co-implementation, and co-review of the Strategy.

Performance, Monitoring and Review

The Health Equity Strategy and Implementation Plan will be reviewed annually, to update and adapt as targets are met and activities are embedded as core components of business, and also to refresh and capture emerging priorities within the evolving health environment. Progress against key performance indicators will be reported bi-annually.

Successful delivery of strategic outcomes will require the collective commitment and effort of our workforce to champion and deliver upon the strategies and their associated actions.

Our Key Priority Outcome Areas

Improving health and wellbeing outcomes

What will we do	What will we see
Identify patients with priority health needs requiring comprehensive health care plans (prevention, early identification, and effective management of complex chronic conditions).	Improved outcomes of complex chronic conditions for First Peoples that demonstrate the ability to achieve closing the gap in life expectancy within a generation.
Deliver comprehensive, culturally safe, and responsive Hospital and community based pre and post maternal and early childhood services.	Improved pre and post maternal and early childhood outcomes by providing early parenting support in hospital and community to First Peoples women including but not limited to: nutrition, breast feeding and immunization.
Suicide and self-harm levels in First Peoples communities are identified and monitored to facilitate planned responses.	Enhance capacity of primary health care and mental health services to identify and assess suicidal behaviour, self-harm, and the cumulative risks of suicide to support implementation of appropriate approaches to interventions and follow up.

Actively eliminating racial discrimination and institutional racism within the service

What will we do	What will we see
Promote to consumers how to report all avenues instances of discrimination and institutional racism to the HHS and external agencies.	Improve the reporting of instances of racial discrimination and institutional racism within the service.
Undertake annual independent audits to measure and monitor institutional racism and apply a social justice lens across all that we do.	Establish a baseline against which to monitor and report on reduction of racial discrimination and institutional racism within the service. Results can be made publicly available.

Increasing access to healthcare services

What will we do	What will we see
Establish an integrated approach to seamless care through the care coordination service centre: – Across all key service areas increase the delivery of telehealth or care closer to home – Explore the expansion of specialist services i.e., mental health and renal services across rural and remote primary health care services (have a look at the RRS ambulatory plan and see what can be leveraged from it) – For the specialist services that are not included in the initial care coordination service look at, review, and amend the communications with patients that improving processes for timely access to specialist outpatients' appointments	Establishment of new integrated and seamless MoC which operate across the health sector: Connecting Your Care Projects: Care Coordination, Priority Dashboard and Central Referrals.
Renewed focus on promotion, prevention and public health services for Aboriginal and Torres Strait Islander peoples.	Identification and development of a flexible, best practice primary prevention model, designed to meet the needs of First Peoples.
Develop a process with PTSS is meeting the needs of eligible patients ensuring consistency and access support.	Establishment of a business model to deliver accessible, culturally appropriate, and safe, flexible, short- and long-term transport and accommodation options which meet the needs of First Peoples.
Expand models of care in renal, emergency department and select rural sites for Aboriginal and Torres Strait Islander Health Practitioners (A&TSIHP).	Models of Care and service provision are designed to provide culturally safe, appropriate and accessible services First Peoples populations.
Establish processes with a view to identifying service efficiencies to increase First Peoples access to CHHH Services: - 'Waiving' of co-payments for pharmaceuticals dispensed for First Peoples across CHHHS. Review of Public Health Services.	First Peoples are able to readily access essential services.

Influencing the social, cultural, and economic determinants of health

What will we do	What will we see
Establish purposeful partnerships with regional lead agencies (education-MAPS, housing, employment, etc) to improve social cohesion and to support the cultural strengths and employment of First Peoples.	Establishment of a partnership within 6 months of implementing the Strategy that supports and leverages improvements of the broader social determinants of health for First Peoples.

Delivering sustainable, culturally safe, and responsive healthcare services

What will we do	What will we see
Develop and implement a support model for Aboriginal and Torres Strait Islander Health Workers, Health Practitioners and Hospital Liaison Officers staff professionally including governance structure within their designated streams and roles. CHHHS will develop an A&TSI workforce strategy in conjunction with professional groups plans to include Aboriginal and Torres Strait Islander Health Workers, Hospital Liaison Officers, Health Practitioners and Support services staff.	Increase in First Peoples representation within CHHHS workforce to create parity with estimated population rate.
Embed institutional cultural capability: - Explore the delivery modes and engagement methods of CCP for all staff (is this part of orientation, an additional iLearn program or externally provided). - Implement a culturally appropriate space within the health service facilities for clinical yarning to improve patients health literacy, and develop a short iLearn program on increasing clinical yarning capability for staff.	Delivery of culturally safe, appropriate and accessible services for the Aboriginal and Torres Strait Islander population through all clinical service models.
Develop and introduce on-country palliative care program and explore how Voluntary Assisted Dying align with this.	HHS fosters the practice of 'advanced care yarning' and family case conferencing – involving patients, their carers and families in decisions about culturally appropriate end-of-life decisions.
Explore the establishment of a Hospital Inpatient Team Assist Service for First Peoples that can be contacted after hours.	

Working with First Nations peoples, communities, and organisations to design, deliver, monitor, and review health services

What will we do	What will we see
Establish an Elders in residence (VIP) initiative.	Identify and invite First Peoples Elders to provide expert cultural advice, mentorship and education.
Review all MOUs and collaborative agreements with AICCHOs to ensure they are contemporary and meeting the needs of communities.	Partnered approach with First Peoples to agreement making.

Implementation

Once the CHHHS First Peoples Health Equity Strategy is endorsement, an Implementation Plan will be developed in partnership with Prescribed Stakeholders. It will describe the HHS key actions, outcomes, targets, resourcing requirement, accountability and health sector partnering arrangements.

Supporting resources will be developed to assist HHS teams to explore how to translate and incorporate the Strategy into operational business activities.

Sources

[Placeholder]

References

[Placeholder]