Our Guiding Principles

Final report
February 2023

Queensland Government

Acknowledgement

Torres and Cape Hospital and Health Service acknowledge and respect the Traditional Owners of the land on which we live and work and recognise their continuing connection to the land and community which we serve. We pay respect to them, their culture, and their Elders past, present, and future.

We would also like to acknowledge the cultural authority and wisdom of all Aboriginal and Torres Strait Islander Peoples and communities that contributed to the contribution of Our Guiding Principles.

Our Guiding Principles on a page

Our Guiding Principles explain what good healthcare should look and feel like for our patients. They underpin and inform how all decisions and matters relating to service delivery are made.

1 Healthcare that is community-centred

We place community at the centre of everything we do

2 Healthcare that embeds primary health and health promotion

We embed the principles of primary health and support health promotion within our communities

3 Healthcare that is responsive to need and culture

We adapt our services to respect the nuances and different cultural needs of our communities

4 Healthcare that is strengths-based

We focus on and celebrate the positive outcomes and strengths of the communities that we support

5 Healthcare that has equitable access

We ensure that we provide everyone with safe, effective, accessible, affordable and apppopriate access to health care

6 Healthcare that is holistic and collaborative

We treat and consider patients holistically, and strive to provide access to wraparound, complimentary and multidisciplinary care

Contents

1. Introduction and background

The Torres and Cape Hospital and Health Service (TCHHS) is a public health service provider in far north Queensland operating across four hospitals and 31 primary healthcare centres. TCHHS was established in 2014 as a result of a merger between two previously distinct health services - the Torres Strait and Northern Peninsula Health Service and the Cape York Health Service.

Following the merger of the Torres Strait and Northern Peninsula Health and the Cape York Health services, TCHHS identified a need to unify how services were delivered across its catchment, while honouring the existing Torres Model of Care.

It engaged external consultants Impact Co. to develop a set of guiding principles (referred to as 'Our Guiding Principles') to support this. The project's purpose was to engage extensively with staff and community members to identify and articulate key principles for how healthcare should be delivered across the region. For more about the approach to undertake the development of Our Guiding Principles, see page 9.

The Torres Model of Care

The Torres Model of Care was developed by, and for, the communities of the Torres Strait Islands and Northern Peninsula area in 1994.

The aim of the Torres Model of Care was to address poor and deteriorating health outcomes of the region.

The model included working on the social determinants of health in a holistic manner and proposed changes in the governance, management structures and service delivery mechanisms that were previously in place, with a focus on Indigenous governance and care provided as close to the home as possible.

The development of the TCHHS Guiding Principles does not seek to replace or replicate the Torres Model of Care. Rather, it is seen as an opportunity to bring important elements of Torres Model of Care back into the focus of the HHS and allow for elements that work well to be leveraged across the entire catchment.

Alignment of our Guiding Principles

The Our Guiding Principles project aligns with other key strategic work currently underway at TCHHS. This work compliments several national and Queensland Government Strategies, as shown on the diagram on page 7.

About the TCHHS region

Within the unique TCHHS geographic, demographic, and socioeconomic context, the development of Our Guiding Principles was seen as a necessary step to assist the HHS in achieving its vision – to lead connected healthcare to achieve longer, healthier lives.

TCHHS operates in a geographically vast and culturally diverse part of Australia, servicing around 28,000 people, with approximately 68.7% of the population identifying as Aboriginal and/or Torres Strait Islander. The TCHHS catchment area is 130,238 km2, approximately 8% of Queensland. All communities within the TCHHS catchment qualify as remote or very remote.

Some statistics relating to the demographics and outcomes of the region are below.

- 76% reside in a very remote location, and the remainder, 24%, reside in a remote location
- Rates of vaccine-preventable related admissions are 2.8x higher than the QLD average
- There are higher levels of chronic disease related hospitalisations overall for people living in TCHHS areas compared to the Queensland rate.
- About 85% of the population are in the lowest socioeconomic (SEIFA) category
- For further information on TCHHS demographics and outcomes refer to the TCHHS Local Area Needs Assessment 2022 Summary Report.

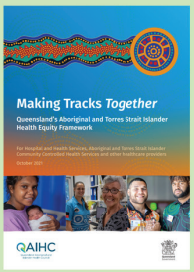
National strategies

Queensland Government strategies

Unleashing the Potential 2020

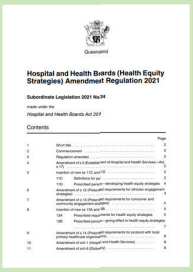
Advancing Health 2016 - 26

Making Tracks Together Health Equity Framework 2021 - 31



Better Care Together 2022-27

Statement of Commitment 2019



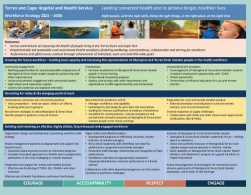
Health Equity Strategies Regulation 2021

TCHHS strategies and plans

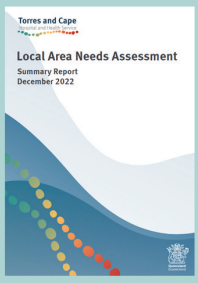
Strategic Plan 2019-23

Clinical Services Plan 2019-29

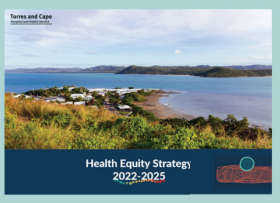
Workforce Strategy 2021-26



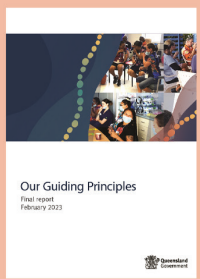
Local Area Needs Assesment 2022



Health Equity Strategy 2022-25



TCHHS Our Guiding Principles



Our Guiding Principles 2023

Next steps

Revision of TCHHS strategies and plans

Opportunities for service improvement based on Our Guiding Principles

2. What is a guiding principle?

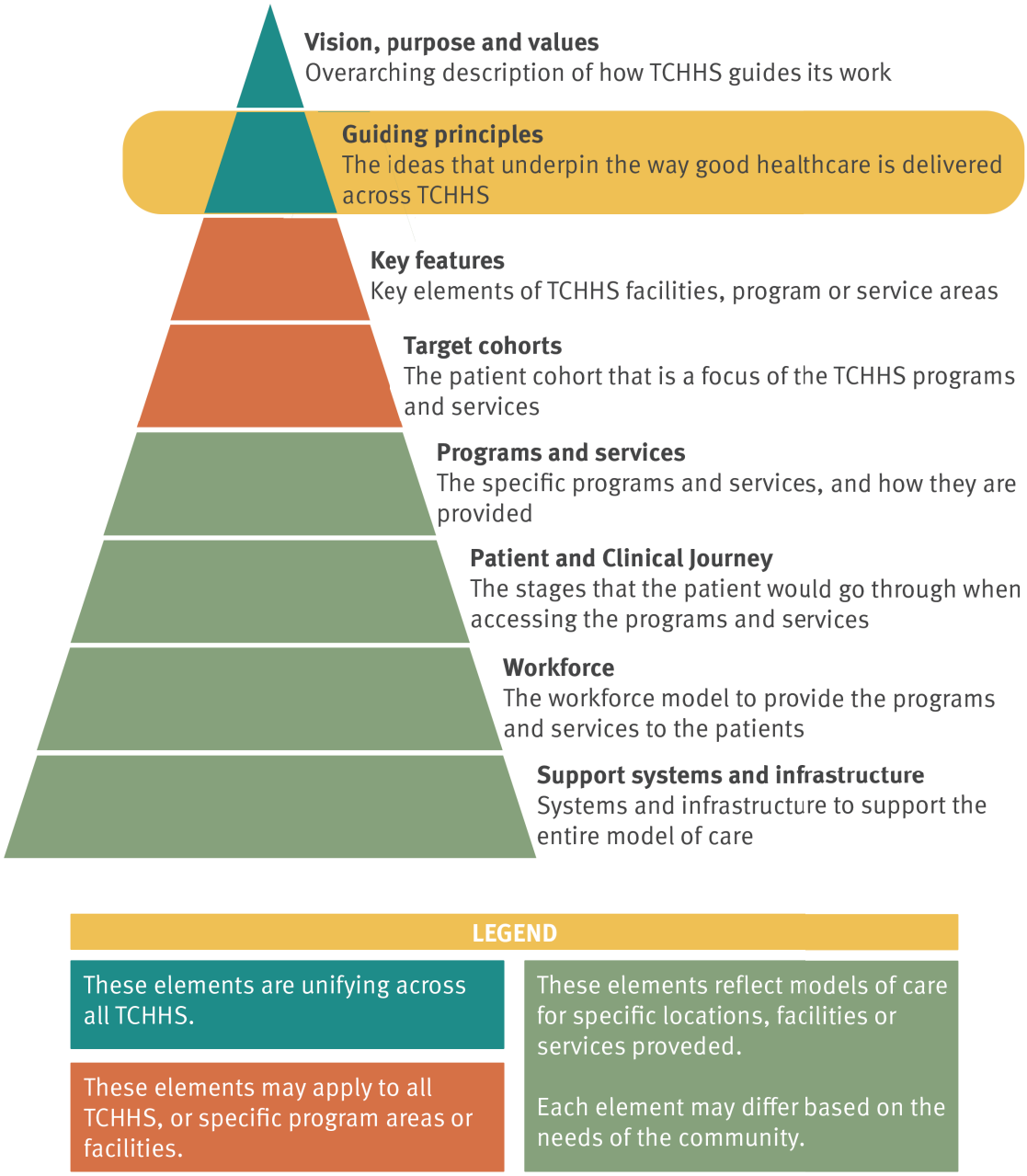
A Guiding Principle is a concept or value that underpins and provides a strong influence when making a decision, considering a matter or developing a solution.

Our Guiding Principles explain what good healthcare should look and feel like for patients and should therefore be used to underpin all decisions and matters relating to how healthcare is designed and delivered by TCHHS.

This report aims capture and inform many aspects of operations - from workforce planning, and programs to patient journeys and experience.

The diagram below overviews the key features generally included in a health service's Model of Care and where the Guiding Principles sit organisationally.

Where the Guiding Principles sit in the TCHHS model/s of care



What about the Torres Model of Care?

It is worth noting that the Torres Model of Care includes many features within this diagram. The purpose of Our Guiding Principles is not to replace the Torres Model of Care but to reinforce key aspects of the Torres Model of care as principles.

3. Developing Our Guiding Principles

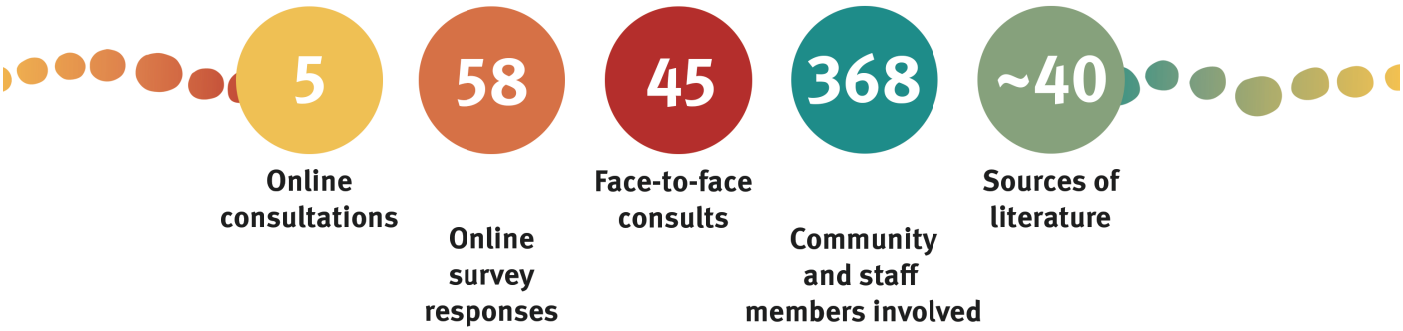
Developing Our Guiding Principles has been a bottom-up approach. This approach has prioritised the voices of the TCHHS community, including community members, staff, patients, partners, and other stakeholders.

A large number of consultations were held throughout the TCHHS catchment to hear from as many people as possible about what they thought "good healthcare should look and feel like".

Using the ideas of what "good healthcare looks and feels like", the project team were able to identify common themes across the different locations, facilities, and stakeholders.

These themes were then synthesised into a set of draft Guiding Principles. Community members, staff, patients, partners, and other stakeholders were then provided the opportunity to validate and provide feedback on the draft Guiding Principles.

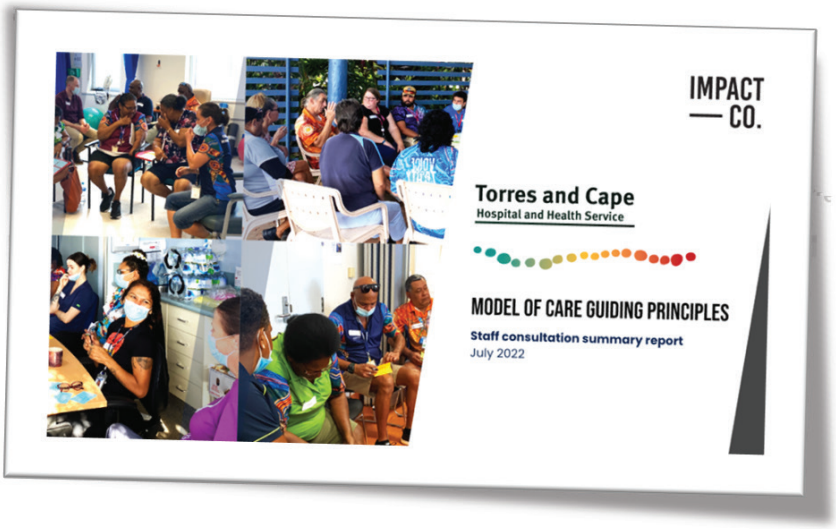
The following pages provide further details on how Our Guiding Principles were developed.



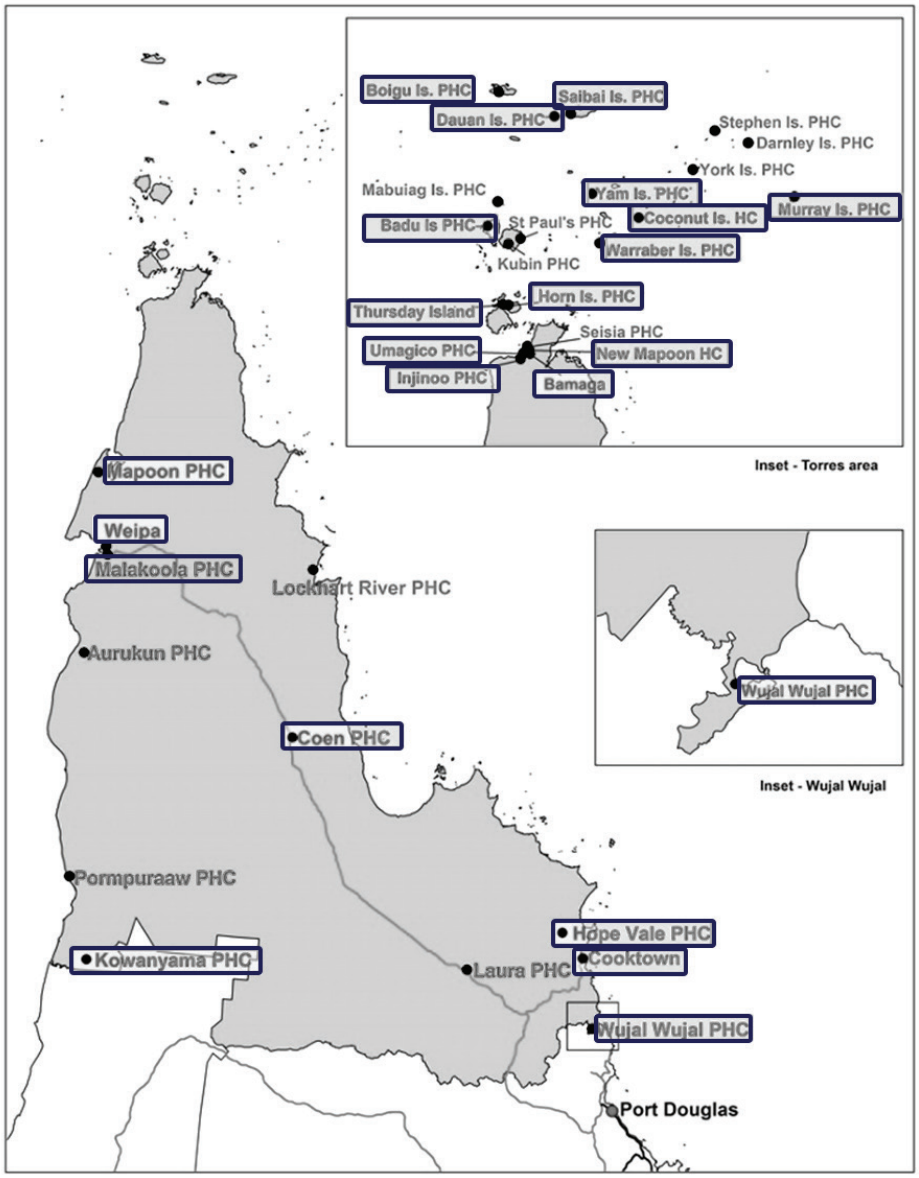
Developing Our Guiding Principles: consultation and research in numbers:

Note that the distinction between community and staff members was not made, as in many cases, staff members are community members and provide advice and input as community members.

Validating what we heard from staff: the summary report



Where consultations were held: a map of locations visited by the project team



Timeline of developing Our Guiding Principles

January 2021 to May 2021	**Project kick-off**	The Project Team kick started the project in 2021 by meeting with the Project Steering Committee, the original Authors of the Torres Model of Care and the TCHHS Clinical Council. The project team also commenced a literature review of Australian and international Indigenous Models of Care.
May 2021 to July 2021	**Meeting with staff**	The Project Team started meeting with staff, with an online forum and several online consultations.
June 2021	**Meeting with the CAC**	A two-day workshop was held with the TCHHS Consumer Advisory Committee (CAC), where the Project Team worked with the CAC to understand what 'good healthcare would look and feel like' for their communities. The CAC also provided the project team with information on how best to consult with their communities.
August 2021 to March 2022	**Project on hold**	As a result of COVID-19 outbreaks across Australia, the Model of Care Guiding Principles project was put on pause for around 6 months.
May 2021 to June 2022	**Face-to-face consultations**	The Project Team travelled across Cape York, the Torres Strait Islands and NPA to undertake consultations with staff members and stakeholders to understand what "good healthcare" looks like to their patients and communities.
July 2022	**Validation of input**	The staff output report was circulated to staff for validation in July 2022. This was an opportunity for all staff to let us know if the themes that were captured, were correct
July 2022 to November 2022	**Face-to-face community consultations**	The Project Team travelled across Cape York, the Torres Strait Islands and NPA to undertake consultations with community members and stakeholders to understand what "good healthcare" looks like to them.
November 2022	**Project changes name**	In November 2022 the TCHHS Board and Project Steering Committee formally endorsed the change of project name to Our Guiding Principles. This reflected strong community feedback and better aligns the output to TCHHS's overall strategies.
December 2022	**Presenting and endorsing the final Guiding Principles**	In December 2022, the Project Team travelled to Cairns to present the final Our Guiding Principles to TCICA and TSIRC, and to get final endorsement from the CAC and TCHHS Board.
February 2023	**Our Guiding Principles Final Report**	The final Principles was released for staff, community, and stakeholders.

4. Our Guiding Principles

The following section provides a detailed overview of the six guiding principles identified through extensive consultation and validation with community members, staff, and stakeholders.

Evidence of why and how the guiding principle was identified is provided for each guiding principle. Further details as to what that guiding principle may look like in practice are also provided, along with direct quotes from those who participated in consultations.

The six guiding principles and their details often overlap. This is intentional, as all guiding principles should be considered collectively to inform how TCHHS should deliver healthcare.

It should also be noted that the six guiding principles are meant to be high-level and not directly dictate how services are operationalised.

The six Guiding Principles are:

1. Healthcare that is **community-centred**
2. Healthcare that embeds **primary health and health promotion**
3. Healthcare that is **responsive to need and culture**
4. Healthcare that is **strengths-based**
5. Healthcare that has **equitable access**
6. Healthcare that is **holistic and collaborative**

1) Healthcare that is community-centred

Placing community at the centre of services means designing and delivering hospital and healthcare around the needs of individuals and the community.

Treating a person and their community with dignity and respect, involving them in all decisions about their health and working with them collaboratively will be the centre of everything that TCHHS does. This provides a foundation for all other Guiding Principles to be achieved.

The TCHHS community and staff have told us that:

Community empowerment leads to cultural safety

- Services delivered to communities need to consider the nuanced needs of community members and the broader communities themselves, recognising that the individuals and communities across TCHHS' are non-homogenous, even if they might be near one another.
- Stronger community involvement will help to increase the cultural safety, appropriateness, and acceptance of services as the service recipients will have played a role in informing their design.
- Governance and management structures in the Torres Strait Islands through the Torres Model of Primary Healthcare were identified by community as a strength of the model, and emulating this would further drive Self Determination within the communities that TCHHS supports.
- For the community and TCHHS to work together better, all parties must be held accountable.
- Trust and relationships are critical
- Local staff members bring a deeper understanding of a community's specific geographical and cultural nuances, allowing them to deliver tailored and responsive care to the community's needs.
- These staff members have strong community networks that help make healthcare more accessible. It was identified that these relationships could be leveraged to encourage people to access and understand the necessary healthcare services and resources, particularly ones focused on prevention and early intervention.
- Staff continuity was highlighted as critical, as building trust and rapport takes time. Community members identified that they are more likely to open up to someone they are familiar with. This is particularly important for visiting staff not based in the community.
- Aboriginal and/or Torres Strait Islander Healthcare Workers and Practitioners often go above and beyond the scope of their roles to support the local community. This includes supporting individuals to navigate other service systems (e.g., housing) and undertaking unpaid work after-hours (e.g. local Aboriginal and/or Torres Strait Islander Healthcare Workers and Practitioners are usually the first port of call for local Aboriginal and/or Torres Strait Islanders when there is an emergency).
- Staff at TCHHS who do not identify as Aboriginal and/or Torres Strait Islander reinforced the importance of Aboriginal and/or Torres Strait Islander Healthcare Workers and Practitioners in delivering services and building trust with individuals.
- Staff must be visible in the community and be seen to embed themselves in the community (particularly staff who are outside the local community). For this reason, community members believe outreach (i.e. proactively taking healthcare services to community members) to remote communities needs to be a fundamental way of working that underpins how services are delivered to the local community (in addition to centre-based appointments).

> *To engage with community; you need to understand and speak the language.*
> – Community member

Evidence has shown us that:

Community-driven design, delivery and governance are central to the success of healthcare in Aboriginal and/or Torres Strait Islander communities. Inherent to this approach are the concepts of Self-Determination, shared responsibility for health, collaborative practice and the inclusion of education and prevention activities across the care continuum.[1] This ensures the participation of communities, families and individuals in health decisions and activities.[2]

What mechanisms can enhance local and Aboriginal and/or Torres Strait Islander Leadership, Governance and Capacity?

There are various mechanisms that TCHHS may use. Some examples used elsewhere and, in the past, include Local Community Boards and Cultural Protocol Committees. Mechanisms closer to the community will respond more to community needs and provide better pathways for local leadership.

This approach has also been described as 'bottom-up', highlighting how conventional hierarchies and bureaucratic structures are reversed to allow communities power, autonomy and decision-making ability. A community-driven approach allows community members and stakeholders to participate more actively in governance and advisory roles.

> *You need the mindset of community.*
> – Staff member.

Community-driven approaches consider the extended kin networks, connections to Country and other collective or different understandings of wellbeing that are critical to Aboriginal and/or Torres Strait Islander communities.[3]

> *If the HHS is led by the community, it should automatically be culturally appropriate.*
> – Staff member.

In practice, this looks like services that are responsive to individual and community needs, such as flexible approaches and comfortability to change things at short notice (such as appointment times) or hosting appointments in environments that make the individual or family feel comfortable (such as in people's homes, schools, playgrounds or on Country).[4]

> *Good healthcare looks like happy families, living culturally and making deadly choices.*
> – Community member.

There is also evidence that appropriate local and Aboriginal and/or Torres Strait Islander governance and leadership structures must underpin health systems in rural and remote areas. This means substantial community input into all aspects of the planning and provision of primary and other health services through regional governance structures, which considers any existing Aboriginal and/or Torres Strait Islander community-controlled governance structures.[5]

Governance and management structures of the Torres Model of Primary Healthcare

An Indigenous management structure was implemented throughout the health service to facilitate the integration of clinical, corporate and community governance requirements into service activities and ensure appropriate health activities and sustainability of health services.

[1] Bulloch, H., Forgarty, W. & Bellchambers, K, Aboriginal Health and Wellbeing Services: Putting community-driven, strengths-based approaches into practice, The Lowitja Institute, Melbourne, 2019.

[2] Ibid.

[3] Ibid.

[4] McMillan F, Kampers D, Traynore V, Dewing J. 'Person centred care as caring for Country: An Indigenous Australian experience,' International Journal of Social Research and Practice 9:2, 162.

[5] Wakerman, J., & Humphreys, J. S. "Better health in the bush": Why we urgently need a national rural and remote health strategy. Medical Journal of Australia, 210(5), 202-203, 2019.

What we aspire for this to look like in practice: Healthcare that is community-centred

Local and Aboriginal and/or Torres Strait Islander Leadership, Governance and Capacity

- Community members actively drive and inform how TCHHS services are designed, planned and delivered. Engagement with local communities is authentic and proactive, where consultation feedback is acted upon. This is supported by various mechanisms, such as Community Boards and Cultural Protocols Committee.
- Aboriginal and/or Torres Strait Islander leadership and management in Aboriginal and/or Torres Strait Islander communities
- Staff respect the experience and knowledge that individuals and communities possess.
- There is mutual trust between staff, individuals and the community.

Listening to community

- Clinics and health facilities are empowered. They can adapt and respond to community needs as they arise, without being burdened by too many layers of bureaucracy and management.

Working with community

- There is shared accountability between TCHHS and the other organisations that it works with to deliver positive outcomes for the community.

2) Healthcare that embeds primary health and health promotion

TCHHS is uniquely positioned to support, drive and embed primary healthcare and health promotion through its network of primary care centres and multipurpose facilities.

While acute and subacute care are vital services provided by TCHHS, many chronic health conditions and other health needs within the TCHHS catchment are preventable, with early intervention being able to prevent conditions from deteriorating to the acute setting.

Allocating resources to prevention and early intervention

Diabetes was raised as a common example of a chronic condition where current resources were focused on the condition's management rather than its prevention. While some of the services visited, such as on the outer island services, had Diabetes Nurse Educators and Practitioners regularly attending to provide support, it was noted that there were not sufficient resources allocated to healthy eating or nutrition initiatives at the same locations.

The TCHHS community and staff have told us that:

- There is a strong consensus that there needs to be a greater focus on prevention and early intervention in the way healthcare is delivered. There is frustration among communities engaged that many of the health issues experienced can be prevented.

> *Good healthcare starts with primary prevention and awareness.*
> – Staff member.

- Health promotion and building health literacy was highlighted as inextricably linked to empowering Self-Determination. Community members can make more informed decisions by having greater knowledge about health and wellbeing. Greater knowledge will also help to address the stigma that exists towards accessing certain types of services e.g., mental health, social and emotional wellbeing and men's health.
- Experience from long-term staff noted that there had been examples and times throughout history where primary health, prevention and promotion activities were better supported and resourced - aligning more strongly with the Torres Model of Primary Healthcare.
- Health promotion activities provided by and to community should be supported by adequate resourcing, reflecting the extensive need in the community. When there are limited on-the-ground resources, staff often focus their time and effort on providing treatment. They don't have the additional capacity to focus on other important initiatives such as health promotion and community engagement.
- Staff are often overwhelmed dealing with the acute end of healthcare, rather than preventative care, exacerbated by staffing and workforce challenges.

> *We used to do more home visits when I worked in health.*
> – Community member

Evidence has shown us that:

A focus on primary healthcare and prevention, particularly in Aboriginal and/or Torres Strait Islander communities, provides various benefits, including economic benefits. The WHO describes that these benefits are derived through the potential for primary healthcare to improve health outcomes, health system efficiency and health equity.[6]

They state that primary care can:

- Improve population health in terms of life expectancy, all-cause mortality, maternal,

infant and neonatal mortality as well as mental health outcomes.[7]

- Reduce total hospitalisations, avoidable admissions, and emergency admissions and hospitalisations.
- Improve equitable access to healthcare and equitable health outcomes.

> *Good healthcare is the power to make informed decisions about interventions which promote positive health outcomes.*
> – Staff member.

Economic benefits of primary healthcare in Aboriginal and/or Torres Strait Islander communities have been calculated to save as much as AU$3.95–11.75 in hospital costs, in addition to other health benefits for individuals, for every $1 invested.[8] These potential benefits are reflected by the current high rate of avoidable hospitalisations,[9] where Northern Queensland has higher rates of potentially preventable hospitalisations than the state average.[10]

6 World Health Organisation. Building the economic case for primary healthcare: a scoping review, 2018 https://www.who.int/docs/default-source/primary-health-care-conference/phc---economic-case.pdf?sfvrsn=8d0105b8_2

7 Ibid.

8 Thomas, S. L., Zhao, Y., Guthridge, S. L., & Wakerman, J. 'The cost-effectiveness of primary care for Indigenous Australians with diabetes living in remote Northern Territory communities,' Medical Journal of Australia, 200(11), 658-662; Alford, K. A. (2015). Indigenous health expenditure deficits obscured in Closing the Gap reports. Med J Aust, 203(10), 2014.

9 Hutchison, A., Ambrose, S., Glover, J., & Hetzel, D. 'Atlas of avoidable hospitalisations in Australia: ambulatory care-sensitive conditions,' Commonwealth of Australia, 2007.

10 Duckett S, Griffiths K. 'Perils of place: identifying hotspots of health inequalities,' Melbourne: Grattan Institute, 2016.

What we aspire for this to look like in practice: Healthcare that embeds primary health and health promotion

- Primary healthcare and health promotion activities being a key part of the services that TCHHS delivers, or partners with other organisations to deliver. These programs and services focus on prevention, are offered on an ongoing basis, are embedded within the community and are not once-off.
- Embedding primary health and health promotion aims to keep people healthy and well, and outside of the acute setting where possible.
- Acute and subacute service delivery that effectively links individuals with primary and community care post-discharge.
- Services and programs in primary healthcare and health promotion will be:
  - Designed in partnership with local communities
  - Targeted at emerging health trends
  - Based on evidence and demonstrated through positive community outcomes
  - Grounded in being long-term outcomes-focused
  - Delivered with other community partners, such as schools or other local service providers
  - Delivered proactively rather than reactively
  - Delivered out in the community not just in the clinic

3) Healthcare that is responsive to need and culture

The TCHHS catchment includes a significant proportion (approximately 66%) of Aboriginal and/or Torres Strait Islander communities, as well as non-Aboriginal and/or Torres Strait Islander communities.

There are different cultures, protocols and needs in these different communities and providing good healthcare means taking a proactive approach to responding to these individual needs and cultures.

COVID-19 initiatives were flexible and responsive to community need

During COVID-19 vaccination rollouts, there were localised, and culturally appropriate approaches taken to maximise vaccine uptake. This included offering vaccines out of hours when the weather was cooler and through outreach rather than exclusively at the health centres. These approaches were highly successful and demonstrate how outcomes can be achieved using flexibility and the expertise of the local staff.

The TCHHS community and staff have told us that:

Culture

- There are many different cultures across the TCHHS catchment. This includes Aboriginal and/or Torres Strait Islander, and other cultures. Culture across TCHHS' catchment is not homogenous, and a one size fits all approach does not work.
- Visiting health staff who are culturally aware and trusted by the local community were often contrasted against visiting/locum health staff who made little effort to understand the local culture or respect it.
- Cultural appropriateness is more than just being 'appropriate'. It is about cultural sensitivity, cultural accessibility, cultural responsiveness, cultural awareness, cultural support, and cultural proactivity.
- Some community members prefer to engage with health staff of a particular gender. For others, this preference may be cultural lore. Not having diversity in the gender of health staff can act as a barrier for community members accessing healthcare. This was identified as a challenge for some of the men who visited as there are very few male health staff based or visiting the communities in TCHHS' catchment.

> *They got to trust you or they won't come to you next time.*
> – Staff member.

Need

- TCHHS would be better placed if communities and individual health facilities had the autonomy to adapt and respond to community needs as they arise, without being burdened by too many layers of bureaucracy. In addition, if TCHHS staff were empowered to deliver services in a way that meets the service needs and preferences of communities, even if it may not be the 'standard' way to provide services, there would likely be better outcomes for the community.

> *Services should be what community needs and wants, not just fitting government requirements.*
> – Community member.

- Wait times for appointments have been identified as being long and inappropriately scheduled, leading to individuals needing more appointments or being left out-of-pocket.
- The importance of privacy and confidentiality was reinforced during the consultations.

Evidence has shown us that:

Culture

The most common characteristic of successful Aboriginal and/or Torres Strait Islander primary

healthcare service delivery models has been found to be a deep focus on culture.[11]

Despite the enormous benefits biomedicine has brought to the world, there is a recognition that it has limitations.[12] One of these limitations is biomedicine's focus on illness. This is juxtaposed with Aboriginal and/or Torres Strait Islander understandings of health that go beyond 'treating the disease' to 'working towards reclaiming a sense of balance and harmony in the physical, psychological, social, cultural and spiritual elements of a person's life.'[13]
Traditional culture and practices can be incorporated into healthcare by implementing a holistic model of care and a holistic approach to sickness and wellbeing.

> *Good healthcare addresses the culture barriers to deliver healthcare.*
> – Staff member

Need
Tailoring service and program elements to individual and community needs has been essential to obtaining better outcomes through creating healthy lifestyle changes and increasing screening for conditions such as diabetes and heart disease.[14]

[11] Harfield, S. G., Davy, C., McArthur, A., Munn, Z., Brown, A., & Brown, N. 'Characteristics of Indigenous primary healthcare service delivery models: a systematic scoping review,' Globalisation and health, 14(1), 1-11, 2018.

[12] Bulloch, H., Forgarty, W. & Bellchambers, K. 'Aboriginal Health and Well-being Services: Putting community-driven, strengths-based approaches into practice,' The Lowitja Institute, Melbourne, 2019.

[13] Mackean, T. 'A healed and healthy country: understanding healing for Indigenous Australians,' The Medical Journal of Australia, 190(10), p. 522, 2009.

[14] Power, T., East, L., Gao, Y., Usher, K., & Jackson, D. 'A mixed-methods evaluation of an urban Aboriginal diabetes lifestyle program,' Australian and New Zealand Journal of Public Health, 45(2), 143-149, 2021.

What we aspire for this to look like in practice: Healthcare that is responsive to need and culture

- Healthcare delivery that is effective and achieves positive outcomes for the communities that TCHHS support, in the acute, subacute and primary care settings.
- Community members actively drive and inform how TCHHS services are designed, planned and delivered. Input from the community is respected, and feedback mechanisms are fit-for-purpose for community members.
- Clinics and health facilities are empowered and have the autonomy to adapt and respond to community needs as they arise without being burdened by too many layers of bureaucracy and management. This may include financial delegation provided to middle management to allow for flexibility to enable TCHHS services to meet the needs of their local community.
- Behaviour and actions of staff (such as respecting Lore, Sorry Business and other customs), the type of TCHHS services that are provided (such as the provision for bush medicine), and the physical design of facilities (such as incorporating cultural art) recognise the importance of Aboriginal and/or Torres Strait Islander culture.
- Staff understand individual community nuances and the different cultural needs of communities across the TCHHS catchment and adapt service delivery approaches accordingly.
- Services always maintain the privacy and confidentiality of individuals
- Services that take into consideration the unique needs of individuals, for example,
    - Travel that is organised with sufficient notice and considers the context of the region. Overnight stays are avoided, and alternative family caring arrangements are respected.
    - Flexible mechanisms are adopted to support individual recalls and follow-ups e.g. not relying on text messages when this may not work for some individuals

4) Healthcare that is strengths-based

TCHHS staff and community highlighted the importance of adopting a strengths-based approach to engaging with the community and delivering healthcare.

The TCHHS community and staff have told us that:

- Language used within the community should not reinforce the 'deficit narrative' that accompanies Aboriginal and/or Torres Strait Islanders. For example, the terminology for an individual not attending an appointment is called a Fail to Attend (FTA). This phrasing places culpability on individuals for 'failing' to meet an expected standard. The TCHHS community shared that this phrasing does not recognise the many factors contributing to missing an appointment, which may be due to a lack of transport, family commitments, or short notice before the appointment.
- Culture and community are assets to health and wellbeing. When communities feel like health services respect their culture, this contributes to a good healthcare experience.
- Focusing on the outcomes and the positive changes observed in the community is preferable to deficit-focused statistics and narratives.

> *Good healthcare is adults engaging with each other in a positive way.*
> – Staff member.

Evidence has shown us that:

Strengths-based approaches are an essential pillar of effective healthcare systems in Aboriginal and/or Torres Strait Islander communities and have emerged as a response to the deficit discourse that often surrounds those communities. 'Deficit discourse' refers to discourse that represents people or groups in terms of deficiency, absence, lack or failure. It describes discourse that narrowly situates responsibility for problems with the affected individuals or communities, overlooking the larger socio-economic structures in which they are embedded. Deficit discourses about Aboriginal and/or Torres Strait Islander peoples are not exclusive to the health context and encompass other social determinants of health such as employment and education.[15]

While there is limited documented evidence of the connection between deficit discourse and outcomes, specifically in the Aboriginal and/or Torres Strait Islander context, comparable studies in other contexts demonstrate the pervasive effects of deficit discourses.[16] Anecdotally, Aboriginal and/or Torres Strait Islander peoples have described the individual and adverse outcomes experiences because of this.[17]

Existing strengths-based healthcare in the Torres and Cape

There are several health initiatives that have used a strengths-based approach, by leveraging culture and community through partnering to design and deliver particular programs. A standout example from consultations was the sexual health education program developed in consultation with Education Queensland, Queensland Health and the Torres Strait Island Regional Council. The program was developed with extensive community consultation that enabled a tailored program to be created for each island, ensuring cultural appropriateness.

Strengths-based approaches on the other hand have been demonstrated to support positive outcomes among different communities. There are several different strengths-based approaches, including:

- Cultural appropriateness - this includes the tailoring of programs, resources and healthcare to include and celebrate cultural aspects of indigeneity.
- Social determinants of health and ecological theories - this includes recognising the structural factors and conditions influencing health and wellbeing.
- Protective factors - this includes non-physical and non-medical elements that counteract or mitigate the effects of adversity.

- Empowerment - this includes focusing on Self-Determination and abilities rather than limiting factors such as poor physical health.[18]

There is strong alignment between the strengths-based approaches outlined above and the other Guiding Principles identified.

[15] Fogarty W, Lovell M, Langenberg J and Heron M. 'Deficit Discourse and Strengths- based Approaches: Changing the narrative of Aboriginal and/or Torres Strait Islander health and wellbeing,' The Lowitja Institute, May 2018

[16] Fforde C, Bamblett L, Lovett R, Gorringe S and Fogarty B. 'Discourse, Deficit and Identity: Aboriginality, the race paradigm and the language of representation in contemporary Australia,' Media International Australia Vol 149, 162 – 173

[17] Ibid.

[18] Fogarty W, Lovell M, Langenberg J and Heron M. 'Deficit Discourse and Strengths- based Approaches: Changing the narrative of Aboriginal and/or Torres Strait Islander health and wellbeing,' The Lowitja Institute, May 2018

What we aspire for this to look like in practice: Healthcare that is strengths based

- Staff apply a strengths-based, culturally appropriate lens to understand the different factors impacting a person's life.
- Deficit-based views and approaches to client interaction and engagement with services are avoided. This includes the removal of the use of the term FTAs.
- All staff are aware of the impact of unconscious bias and actively seek ways to reframe thinking and language to a strengths-based perspective.
- TCHHS supports the use of non-physical and non-medical elements in healthcare that counteract or mitigate the effects of adversity (i.e. enhancing the protective factors of individuals such as their employment and housing status).

5) Healthcare that has equitable access

TCHHS supports some of Australia's most remote and isolated communities. Equitable access and delivery of services are critical to helping close the gap and improve health outcomes for many communities.

The TCHHS community and staff have told us that:

- Safe, effective and affordable healthcare should be seen as a right everyone should have access to, regardless of where they live.
- Access to critical health services is essential. There were a number of key service gaps identified during the consultations. This includes (but is not limited to):
    - Dental services / oral health
    - Social-emotional and wellbeing
    - Ophthalmologist
    - Gynaecologists
    - Allied Health
    - AOD counsellors
    - Diabetes Nurse Educators

Note: This list of service gaps identified above represents what was identified during the consultation process and is not meant to be exhaustive.

- There is variation in the available service infrastructure across the different communities in TCHHS' catchment. Staff and community members recognised that the remote nature of a number of the communities makes it challenging for the same service infrastructure to be made available in every community, but at the same time highlighted this (and the limited frequency of visiting health services discussed previously) as a critical barrier to accessing the required healthcare services. For example, when engaging with staff across the Torres Strait Islands, it was consistently reinforced that as a lot of the teams/services are physically based on Thursday Island (e.g., the Health Promotion Team), which inadvertently leads to a greater focus on supporting the Thursday Island community and not the other islands.
- Difficulty in accessing services was also identified to have significant flow-on impacts on other aspects of a person's life (in addition to having a direct impact on their health and wellbeing). For example, when community members have to pay significant out-of-pocket costs to travel, it substantially impacts their financial wellbeing.

The challenges to accessing dental services in the Torres region

Dental services were identified as notable examples of where equitable access is not being achieved. This was highlighted by the fact that there is 1 dentist and limited staff for 14 communities (across the Torres region). Many remote communities do not get to see a dentist for over two years, and the system relies on individuals to self-fund travel to access dental services. This delays interventions and increases preventable oral health and other chronic conditions across the population. Anecdotally dental staff reported conditions worsening particularly among young children over the course of their employment at TCHHS.

- Communities that are more difficult to access/ remote feel that they are not being prioritised and that their communities are being forgotten.
- Some Aboriginal and/or Torres Strait Islander community members felt a lack of trust towards TCHHS due to experiences of racism and discrimination in the past.

> *There's a stigma. People are still scared to see a doctor.*
> – Community member

- Visiting health services should recognise people working in remote communities and ensure that services are accessible to them. For example, it was noted that visiting health services were often in communities during working hours on weekdays, making it difficult for working people to access those services.

Evidence has shown us that:

Equitable accessibility is a complex concept that is not limited to the physical locations of services but can be defined as the opportunity to reach and obtain appropriate healthcare services in situations where there is a need.[19]

Some of the barriers to access and engagement with health services in Aboriginal and/or Torres Strait Islander communities include unwelcoming hospital or healthcare settings, lack of appropriate or affordable transport, mistrust of mainstream healthcare, a sense of alienation, and inflexible treatment options.[20] This has resulted in an overall reluctance for many communities to attend services and receive care.[21]

There is also evidence that poor communication from health providers and a lack of Aboriginal and/or Torres Strait Islander staff at health services exacerbates the problem and highlights underlying racism.[22]

Equitable access to healthcare can be achieved when barriers to the below are removed:

- Approachability - this focuses on the ability of individuals to recognise a need for healthcare and whether a healthcare service is known to exist. This step is reinforced by health literacy and health promotion activities that enable community members to identify when they need a service and which service they should access.
- Acceptability - this focuses on the ability of individuals to freely seek out services and the appropriateness of those services to abide by social and cultural norms. This step acknowledges that there can be resistance and hesitation from Aboriginal and/or Torres Strait Islander community members to access services due to previous experiences and/or feelings of threat by perceived social distances and power imbalances between the individual and the service provider.
- Availability and accommodation - this focuses on the physical barriers to accessing services. Strategies to remove these barriers can include individual transport and providing services locally where possible.
- Affordability - this focuses on the economic barriers to accessing services.
- Appropriateness - this focuses on the extent to which care provided meets the needs of the communities they serve.

> *Community members should be getting the right treatment at the right place at the right time.*
> – Staff member.

Accessibility must be considered holistically to maximise access to healthcare services, particularly for Aboriginal and/or Torres Strait Islander communities.

Patients leaving without medical advice

Research shows that Aboriginal and/or Torres Strait Islander individuals are discharged against medical advice (DAMA) at a much higher rate than other individuals. Underlying reasons may relate to feelings of isolation, not being listened to and respected, fear of procedures, and associations of their experience with past traumatic experiences in similar institutions. Preventing discharges against medical advice (DAMA) requires an understanding of the individual's perceptions of their hospitalisation and treatment. Having Aboriginal and/or Torres Strait Islander Health Workers and Practitioners can help build rapport, communicate effectively, and form a trusting relationship with the individuals. They can also bridge communication gaps by acting as translators as they share the same linguistic and cultural backgrounds as the people they are supporting.

[19] Levesque, J. F., Harris, M. F., & Russell, G. 'Patient-centred access to healthcare: conceptualising access at the interface of health systems and population,' International Journal for Equity in Health, 12(1), 1-9, 2013

[20] Durey, A., McEvoy, S., Swift-Otero, V., Taylor, K., Katzenellenbogen, J., & Bessarab, D. 'Improving healthcare for Aboriginal Australians through effective engagement between community and health services,' BMC Health Services Research, 16(1), 1-13, 2016

[21] Shahid S, Finn L, Thompson SC. 'Barriers to participation of Aboriginal people in cancer care: communication in the hospital setting,' Medical Journal of Australia, 190:574–9, 2009

[22] Durey, A., McEvoy, S., Swift-Otero, V., Taylor, K., Katzenellenbogen, J., & Bessarab, D. 'Improving healthcare for Aboriginal Australians through effective engagement between community and health services,' BMC Health Services Research, 16(1), 1-13, 2016

[23] Shaw, C. 'An evidence-based approach to reducing discharge against medical advice amongst Aboriginal and/or Torres Strait Islander individuals' Deeble Institute for Health Policy Research, Vol 14, 2016

[24] Shaw, C. 'An evidence-based approach to reducing discharge against medical advice amongst Aboriginal and/or Torres Strait Islander individuals' Deeble Institute for Health Policy Research, Vol 14, 2016

What we aspire for this to look like in practice: Healthcare that has equitable access

- An evidence-informed approach to resource allocation, for example, needs-based funding, ensures that resources are provided where they are most needed.
- Communities have equal access to TCHHS services, regardless of location.
- Communities are aware of the TCHHS services available, and how to access them.
- Services are delivered as close to home as possible (this may involve the use of technology). Where this is impossible, individuals, their families, and/or support persons are comprehensively supported to travel to the necessary service delivery location.
- Decisions around individual care are transparent, and staff ensure that individuals understand the care provided to them.
- Services that are easy to navigate with seamless individual journeys.
- Services that are timely.

6) Healthcare that is holistic and collaborative

TCHHS provides a range of services to diverse communities, offering the HHS an opportunity to collaborate across teams and external services to drive better outcomes for the community.

The TCHHS community and staff have told us that:

- Poor health outcomes are often the consequence of poor social determinants of health which are often not treated holistically. The following have been identified as drivers that have contributed to poor health outcomes in TCHHS communities:
    - High cost of living.
    - Lack of fresh and affordable fruit and vegetables.
    - Lack of local employment opportunities.
    - Limited housing options, which leads to issues around overcrowding.
    - Limited social and other activities, often exacerbated by a lack of local employment options and limited infrastructure in community.
    - Lack of local employment opportunities.
- The importance of collaboration and partnership between services to meet the holistic needs of community members was strongly supported and encouraged by community. Some communities reported this was done well, while others identified room for improvement.

> *TCHHS should see us as another vehicle to help deliver services.*
> – Staff member.

- There is a strong desire from stakeholders in the education sector to work more closely with the health system, particularly to embed health promotion (e.g. healthy habits/lifestyle and healthy eating) at an early age.
- There is a strong desire from other health and wellbeing services in the region to work collaboratively as partners rather than as competitors. These health and wellbeing services believe that collaboration across the spectrum of service delivery and operations will drive efficiencies, break down barriers to access and ultimately support better outcomes.

> *We would love to be able to co-locate with TCHHS.*
> – Community member

Evidence has shown us that:

Holistic approaches to healthcare are essential to providing services outside the mainstream biomedical approach, which tends to focus on illness and compartmentalise health and wellbeing. This can therefore exclude the wider social determinants of health and may overlook structural inequalities that promote or hinder good health.[25]

> *You've got to know your population health and your social determinants.*
> – Staff member.

Social determinants of health, as defined by the World Health Organisation (WHO) are the non-medical factors in a person's life that influence their health outcomes. Below is a list of examples of social determinants of health that can influence health equity in positive or negative ways:

- Income and social protection
- Education
- Unemployment and job insecurity
- Working life conditions
- Food insecurity
- Housing, basic amenities and the environment
- Early childhood development
- Social inclusion and non-discrimination
- Structural conflict
- Access to affordable health services of decent quality.[26]

Partnership with schools presents a valuable opportunity for health outcomes

Collaboration with local schools was identified as presenting an important opportunity to

- Increase health literacy
- Deliver effective health promotion
- Deliver health screening (eg: Rheumatic Heart Disease)
- Build trust in the health service from an early age
- Establish pathways for traineeships into employment at the health service

There was a significant appetite for collaboration demonstrated by school stakeholders, community stakeholders and TCHHS staff interviewed. However, it was also identified that local schools and TCHHS services are often not adequately resourced for establishing effective and long-term partnerships.

WHO estimates, through numerous studies, that the social determinants of health account for between 30 – 55% of health outcomes. This highlights that addressing these factors is fundamental for improving health and reducing longstanding inequities in health.[27]

There is also evidence of the outcome benefits of collaboration and partnerships in an Aboriginal and/or Torres Strait Islander context. For example, Queensland's Deadly Kids Deadly Future Program is jointly implemented by Queensland Health and the Commonwealth Department of Education to improve the hearing of Aboriginal and/or Torres Strait Islanders by reducing the rates of otitis media. An evaluation in 2015 found a reduction in presentations of chronic suppurative otitis media in 0-4-year-olds and 5 - 14-year-olds from 2009 - 2013.[28]

> *Community can tell when the services aren't working together well.*
> – Community member.

[25] Bulloch, H., Forgarty, W. & Bellchambers, K. 'Aboriginal Health and Well-being Services: Putting community-driven, strengths-based approaches into practice,' The Lowitja Institute, Melbourne, 2019

[26] World Health Organisation. Social Determinants of Health 2021 ‹https://who.int›

[27] Ibid.

[28] Cited in Fogarty W, Lovell M, Langenberg J and Heron M. 'Deficit Discourse and Strengths- based Approaches: Changing the narrative of Aboriginal and/or Torres Strait Islander health and wellbeing,' The Lowitja Institute, May 2018

What we aspire for this to look like in practice: Healthcare that is holistic and collaborative

- Services take into consideration the needs of individuals in a holistic manner (including considering the social determinants of health), appreciating the complexity of their situation and the context.
- Services leverage multidisciplinary teams, where all staff work together in the best interest of individuals.
- Services are integrated internally within TCHHS and externally with external partners to meet the holistic needs of the community - ensuring that there is no duplication or unnecessary competition between services.
- Individuals and family/community are involved in care planning and making key care decisions, if and when desired.
- TCHHS works in a whole-of-government and whole-of-community approach to improve the health outcomes for the community. This means TCHHS will actively collaborate with agencies, partners, community and other stakeholders (such as education) to address all the determinants of health at a population level, with a particular emphasis on health promotion, food and housing.
- TCHHS plays an active and vocal role in advocating important strategic policy decisions and priorities across the social determinants of health that impact the health of its communities, ensuring that they take into consideration the unique needs of its communities.

5. Enablers

The following section provides an overview of some of the enablers identified by community, staff and stakeholders needed to achieve and support Our Guiding Principles.

These enablers are not an exhaustive list but rather the most prominent and important. These enablers will also likely link to other strategies and plans that TCHHS and Queensland Health have in place or are working on.

The enablers are linked to each of the guiding principles they relate to.

	Guiding Principle					
	1	2	3	4	5	6
1. Workforce Strengthening the Aboriginal and/or Torres Strait Islander Health Workforce,[29] especially for the Aboriginal and/or Torres Strait Islander communities that TCHHS operates in, through proactive employment of local community members, including in management positions, providing training opportunities and clear career pathways. This will enhance the sustainability of TCHHS' workforce, supporting continuity in staffing and helping to build relationships and trust with local communities. This will also help to strengthen the cultural safety of services. This will enable TCHHS and its staff to: • Place community at the centre of the service (1) • Help focus on primary care and embed health promotion (2) • Be responsive to the different local needs and cultures (3) • Provide strengths-based healthcare (4) • Work towards equitable access to healthcare (5) • Provide healthcare that is holistic and collaborative (6)						
2. Professional development Building staff capacity through targeted professional development opportunities, including (but not limited to) providing all staff, new and locum staff with comprehensive cultural training/induction. Training and development should be an ongoing focus of TCHHS to ensure that staff are effectively equipped to deliver high-quality care to individuals in an empathetic, safe and non-judgemental manner. This will enable TCHHS and its staff to: • Place community at the centre of the service (1) • Help focus on primary care and embed health promotion (2) • Be responsive to the different local needs and cultures (3) • Provide strengths-based healthcare (4) • Work towards equitable access to healthcare (5) • Provide healthcare that is holistic and collaborative (6)						

[29] Aboriginal and/or Torres Strait Islander Health Workforce is the term used throughout this document as it refers to Aboriginal and/or Torres Strait Islander people working in the healthcare sector as a collective group, regardless of which professional stream and/or classification they are employed under; meaning it is inclusive of cleaners, gardeners, drivers, administrative officers, senior executives, doctors, nurses, allied health professionals, Aboriginal and/or Torres Strait Islander Health Workers and Aboriginal and/or Torres Strait Islander Health Practitioners.

3. Partnerships

Developing strong partnerships with other local, community, health and non-health organisations is critical to support the achievement of the TCHHS guiding principles.

These partnerships may include Apunipima, Royal Flying Doctors Service, local Health Action Teams, Justice Networks and Education Queensland/ schools.

This will enable TCHHS and its staff to

- Place community at the centre of their operations (1)
- Work towards equitable access to healthcare (5)
- Provide healthcare that is holistic and collaborative (6)

4. Decision-making

Devolving more decision-making to local staff to enable greater responsiveness and support self-determination at the local/community level.

This should involve training to upskill staff and build their own capability.

This will enable TCHHS and its staff to:

- Place community at the centre of the service (1)
- Help focus on primary care and embed health promotion (2)
- Be responsive to the different local needs and cultures (3)
- Provide healthcare that is holistic and collaborative (6)

5. Reporting

Providing regular, more targeted and visible reporting on community needs and outcomes to staff and the community through capturing localised data and outcomes.

This will make TCHHS and its staff accountable to the communities they serve.

This will enable TCHHS and its staff to:

- Place community at the centre of the service (1)
- Help focus on primary care and embed health promotion (2)
- Be responsive to the different local needs and cultures (3)
- Work towards equitable access to healthcare (5)

6. Integration

Removing any internal siloes, through effective processes and structures to communicate and share information between staff and teams within TCHHS and focusing on the needs of the individual.

This will help to support the functioning of multidisciplinary care teams.

This will enable TCHHS and its staff to:

- Help focus on primary care and embed health promotion (2)
- Be responsive to the different local needs and cultures (3)
- Work towards equitable access to healthcare (5)
- Provide healthcare that is holistic and collaborative (6)

7. Data and knowledge sharing Improving the systems and ability to collect and share data, resources and knowledge with external partners and agencies - particularly with organisations supporting the same individuals. This will create efficiencies and break down barriers to care and access. This will enable TCHHS and its staff to: • Be responsive to the different local needs and cultures (3) • Work towards equitable access to healthcare (5) • Provide healthcare that is holistic and collaborative (6)						
8. Funding Supporting a funding structure that prioritises funding of services supports and programs to the communities that are most in need (i.e. needs-based funding). This includes a focus on preventative services. This includes the funding of support services such as travel for dental individuals to access care. This will enable TCHHS and its staff to: • Place community at the centre of the service (1) • Help focus on primary care and embed health promotion (2) • Be responsive to the different local needs and cultures (3) • Work towards equitable access to healthcare (5)						

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