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CENTRAL QUEENSLAND,
WIDE BAY, SUNSHINE COAST

An Australian Government Initiative

Ageing Well in our Region: A Healthy Ageing Strategy 2022 - 2027

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External Acknowledgements: We would like to thank and acknowledge the time, expertise and advice provided by the Reference Advisory Group, established for the development of this Strategy.

Acknowledgements: The PHN acknowledges the traditional Custodians of the land on which we work and live, and recognise their continuing connection to land, waters and community. We pay our respect to them and their cultures; and to Elders both past and present.

The PHN pays its respects to LGBTIQ leaders, elders and trailblazers who have worked to support the improved health and wellbeing of their communities. We celebrate the extraordinary diversity of people's bodies, genders, sexualities, and relationships that they represent.

Foreword

I am delighted to present the Central Queensland, Wide Bay, Sunshine Coast PHN *Ageing Well in our Region: A Healthy Ageing Strategy 2022 – 2027.* This document outlines our PHN's strategic vision, to ensure that as people age, they have value in the community and are empowered to live the life of their choice.

Servicing a population of 976,789 covering 12 Local Government Areas, our region is home to diverse communities that are ageing and growing rapidly. Older people make a significant contribution to our society, economically, socially and intellectually as mentors, leaders and skilled workers and volunteers. Health is fundamental to being able to live well, age well and continue to participate in family and community life.

To achieve our vision, action is needed to foster healthy ageing and enable people in our communities to maintain their physical, cognitive and social functional ability for as long as possible. Through the four strategic priority areas identified in this document, we aim to assist people to stay healthy, well and independent throughout their lives, ensure adequate care is accessible and contribute to a progressive, sustainable and equitable aged care system.

This strategy represents a great opportunity to improve the health outcomes for older people in our region and achieve greater coordination and integration of efforts in older people's health across the health continuum, life-course and the spectrum of primary health care.

I am delighted with the collaborative effort, from our partners and stakeholders across our local community, Queensland and Australia to develop this strategy and agreed approach moving forward. This strategy is a key step in our organisational commitment to ongoing continuous improvement as we seek to build age-friendly communities and transform systems to meet primary and preventative healthcare needs for older people in our region.

I look forward to seeing this strategy come to life, and the improved health outcomes as a result, as we strive to improve the lives of older people, their families and their communities.

Pattie Hudson
Chief Executive Officer
Central Queensland, Wide Bay, Sunshine Coast PHN

February 2022

Glossary

ACCHOs	Aboriginal Community Controlled Health Organisation
ACP	Advance Care Planning
ACRRM	Australian College of Rural and Remote Medicine
ADA	ADA Australia (Age and disability advocates)
ADHA	Australia Digital Agency
AGPA	Australian General Practice Accreditation Limited
AMA	Australian Medical Association
AMS	Aboriginal Medical Service
CALD	Culturally and linguistically diverse
CHSP	Commonwealth home support program
COAG	Council of Australian Governments
COTA	COTA Australia
COTA QLD	COTA Queensland
CQID	Central Queensland Indigenous Development
CQU	Central Queensland University
DAA	Dietitians Association Australia
DTA	Dementia Training Australia
ECEC	Early Childhood Education Centres
ELDAC	End of Life Direction for Aged Care
ESSA	Exercise & Sports Science Australia
GEDI	Geriatric emergency department intervention
GERI	Geriatric specialist department
GPs	General Practitioners
HHS	Hospital and Health Service
HWQ	Health Workforce Queensland
ITC	Integrated Team Care
LASA	Leading Age Services Australia
LGA	Local Government Area
LGBTIQ+	Lesbian, gay, bisexual, transgender, intersex and queer
MH	Mental health
NDIS	National Disability Insurance Scheme
NGO	Non-Government Organisation
OCAP	Office of Advance Care Planning
OPAN	Older Persons Advocacy Network
PEPA	Program of Experience in the Palliative Care Approach
PHC	Primary Health Care
PHN	Primary Health Network
QAS	Queensland Ambulance Service
QUAC	Queensland Aids Council
RACF	Residential Aged Care Facility
RACGP	The Royal Australian College of General Practitioners
RAQ	Relationships Australia Queensland
RASS	Residential Aged Care Facility Support Service
SCHI	Sunshine Coast Health Institute
SCUH	Sunshine Coast University Hospital
SPACE	Specialist Palliative Care in Aged Care project
UN	United Nations
USC	University of the Sunshine Coast
WHO	World Health Organisation
Central Queensland Wide Bay Sunshine Coast PHN teams:	
PHN CST	Commissioned Services Team
PHN MHAODs	Mental Health, Alcohol & Other Drugs team
PHN PHC	Primary Health Care team
PHN HPIT	Health Planning and Intelligence Team
PHN Comms	Communications
PHN GPLO	General Practitioner Liaison Officer

Contents

1. Executive Summary

The Central Queensland, Wide Bay, Sunshine Coast Primary Health Network (PHN) region is home to diverse communities that are growing and ageing rapidly. People are living longer and this presents many new rich opportunities for both individuals and societies. Together, our challenge is to foster healthy ageing and enable people to maintain their physical, cognitive and social functional ability for as long as possible into their older age.

The World Health Organisation and the UN Decade of Healthy Ageing emphasised that fundamental shifts are required not only in the actions we take but in how we think about age and ageing.[1] In response to this, the PHN in collaboration with our communities, partners and stakeholders, have developed the *Ageing well in our region: A Healthy Ageing Strategy 2022 – 2027*. Our vision is that: ***"As people age, they have a valued place in community, are healthy, active, resilient and connected and are empowered to live the life of their choice."***

Using a life-course and functionality approach, the Strategy provides a framework to achieving this vision and responding to the needs of our communities through the action plan.

The actions within the plan are presented under four Strategic Priority Areas:

1. People stay healthy, well and independent throughout their lives
2. People with acute and chronic conditions live well with the care they need when they need it as close to home as possible
3. Equitable access to systems for long term care and respectful end of life is available for people that need it
4. The aged care system is progressive, sustainable and equitable through integrated and continuous system improvement

In setting out this Strategy and action plan, we emphasise the need for a whole-of-society response, working together and in collaboration across sectors and agencies to transform systems and build age-friendly communities. Older people themselves are at the centre of this plan, which brings together governments, agencies, providers, professionals, academia, and the private sector to improve the lives of older people, their families and their communities.

Implementing the action plan requires collective action, and the plan therefore identifies key players and those best placed to be the lead agency. Where the plan contains areas of work and priority that are outside of the PHN's immediate scope and/or resources as a lead agency, it articulates the PHN's role as a support or partner in these pieces of work.

Ultimately the plan has two goals:

- internal to guide our work and prioritisation within our programs and projects; and
- external to provide a consistent framework that can be a shared direction and intent by leaders, partners and stakeholders.

2. Strategy on a page

Ageing well in our region: A Healthy Ageing Strategy 2021 - 2028

Vision:
" As people age, they have a valued place in community, are healthy, active, resilient and connected and are empowered to live the life of their choice"

The actions will be implemented under four strategic priority areas

Underpinning principles:
Intrinsic value; Empowering and patient centred; Respecting autonomy; Contribution & participation; Equity; Diversity; Progressive health system

Strategic priority 1

1.1 People are physically and mentally healthy and well, have healthy lifestyles, and are resilient throughout their lives and into older age
1.2 People are engaged and participate in society and are socially connected throughout their lives and into older age
1.3 Communities are age-friendly and encourage positive ageing, and enable people to age respectfully and to fully participate in their communities
1.4 People age in their place of choice with the supports they need (if needed) and experience emotional, financial and housing security
1.5 Older people are health literate, able to actively manage their health, access information and make informed health decisions, and are well-supported in accessing and navigating systems and care into older age

Strategic priority 2

2.1 Best practice promotion and early detection actions are provided so that fewer people are affected by preventable conditions or frailty as they age
2.2 People with acute and chronic conditions are health literate to actively manage their health and existing conditions and navigate services to meet their care needs as they age
2.3 People with acute and chronic conditions have equitable access to best practice holistic person-centred models of care that support their physical and mental health and social needs, including assessment, triage/referral, integrated care, discharge planning, rehabilitation strategies and follow up support as they age
2.4 Health and care services are culturally safe and staff are culturally competent and respect cultural preferences and differences
2.5 Workforces that support older people with long-term conditions, including health, home and community support services, as well as family and other informal carers, collaborate and have skills, competencies and resources they need to provide quality and person-centred care and support
2.6 Transition pathways are efficient and seamless (hospital to 'home' or residential care; home to residential care, etc.) and older people have access to support and rehabilitation while they transition and to meet their changing care needs

Strategic priority 3

3.1 Older people with high and complex needs are able to live as independently and actively as possible with access to integrated care and support where their needs are known
3.2 Older people with high and complex needs and their carers have information and freedom to make informed choices about their care, have care plans in place and know that health care workers understand and support their wishes
3.3 Families and carers (paid and unpaid) have the support, information and training they need to assist older people with care needs, including dementia, and are supported in caring for their own health and wellbeing
3.4 Health care, aged care and support teams respond to older people's goals, care and cultural needs at the end stages of life and the experiences of their family, caregivers and friends so people die feeling as comfortable and safe as possible in their place of choice

Strategic priority 4

4.1 Healthy ageing outcomes are defined and monitored, and programs evaluated to ensure quality health care for older people in the PHN region
4.2 The PHN is known for challenging cultures associated with ageism and leading the way in promoting healthy ageing outcomes in the primary health care sector
4.3 Primary health care systems are oriented around intrinsic capacity and functional ability, and foster integration and multi-sectoral action in the health sector and across agencies
4.4 Sustainable and appropriately qualified age care workforce exists to support our ageing population into the future and raising the profile and recognition of people who work in aged care will help potential workers choose aged care as a career pathway

Enablers:
Governance; Relationships and alliances; Health and system intelligence; Investment and financing; Freedom to innovate

3. Purpose and Scope

3.1 Overview and Purpose of Strategy

The Central Queensland, Wide Bay, Sunshine Coast PHN (the PHN) services a population of 976,789 covering 12 Local Government Areas including Banana, Central Highlands, Gladstone, Livingstone, Rockhampton, Woorabinda, Bundaberg, Fraser Coast, North Burnett, Gympie, Noosa and Sunshine Coast Regional Councils.

The PHN region is home to diverse communities that are ageing and growing rapidly. Together, in collaboration with our communities, partners and stakeholders, the PHN has developed the *Ageing Well in our Region: A Healthy Ageing Strategy 2022 – 2027* (the Strategy). The development of an overarching Strategy for older people, grounded in the concept of healthy ageing, is an opportunity to improve the health outcomes for older people in our region and achieve greater coordination and integration of efforts in older people's health across the health continuum, life-course and the spectrum of primary health care. In developing the Strategy, we also recognise the need for a whole-of-society response, working together and in collaboration across all sectors and agencies to transform systems and build age-friendly communities.

The Strategy:

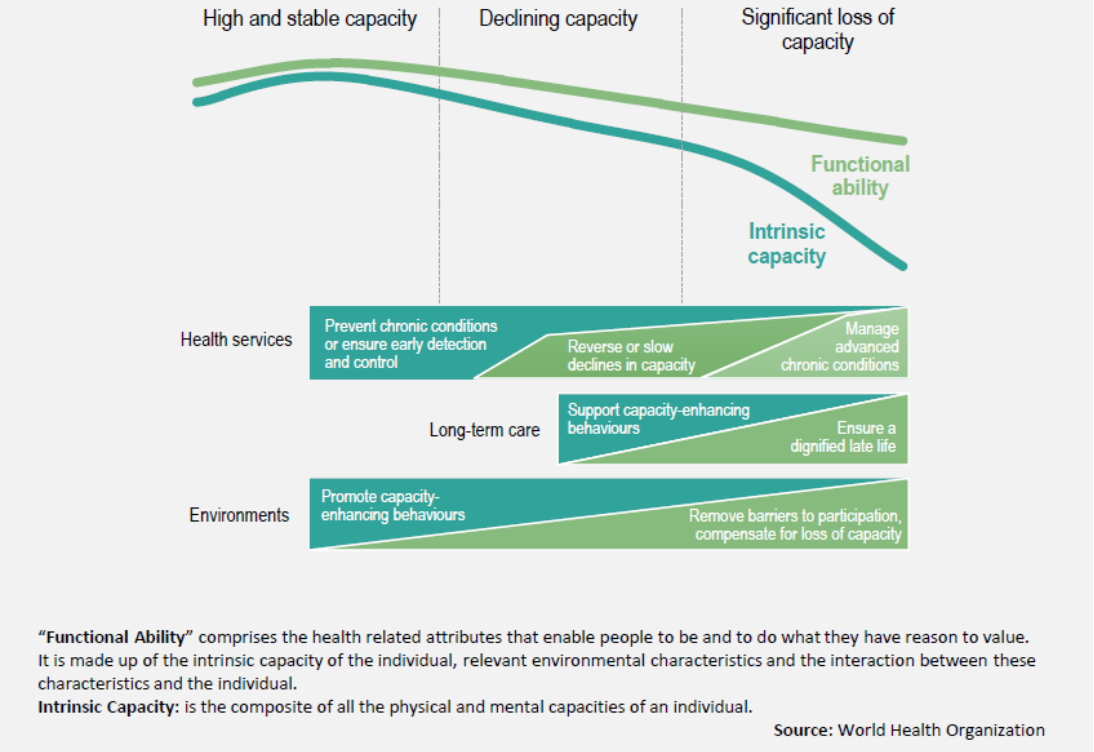
- articulates a vision, objectives, and principles for the strategic planning of health services and activities to meet the needs to age healthily in the PHN catchment;
- identify the strategic priorities and actions for the health and wellbeing of older people that will be operationalised in the PHN Operational and Activity Work Plans;
- provide a framework for responding to national and state policy and health sector reform;
- identify future opportunities for improving health outcomes for older people to enable agile responses as new funding, research or partnership opportunities arise;
- provide a consistent framework and shared direction and intent for use by critical leaders, partners and stakeholders within the region.

3.2 Scope

The Strategy articulates the strategic priority areas, key goals and broad actions for the PHN for the next five years, 2022 – 2027. The *Ageing Well in our Region: A Healthy Ageing Strategy 2022 - 2027* (the Strategy) is grounded within the concept of healthy ageing, and adopts the definition and approach of the World Health Organisation in applying 'functionality' to defining healthy ageing[1] (Figure 1, also see Appendices 1 and 2).

Healthy ageing is described as the process of developing and maintaining the functional ability that enables wellbeing in older age, and reflects the ongoing interactions between an individual and the environments we inhabit.[1] The scope of the strategy is therefore defined as healthy ageing, to encompass a functional life-course approach in which to view health and wellbeing as people age.

Figure 1. Public health framework for healthy ageing (WHO)[1]



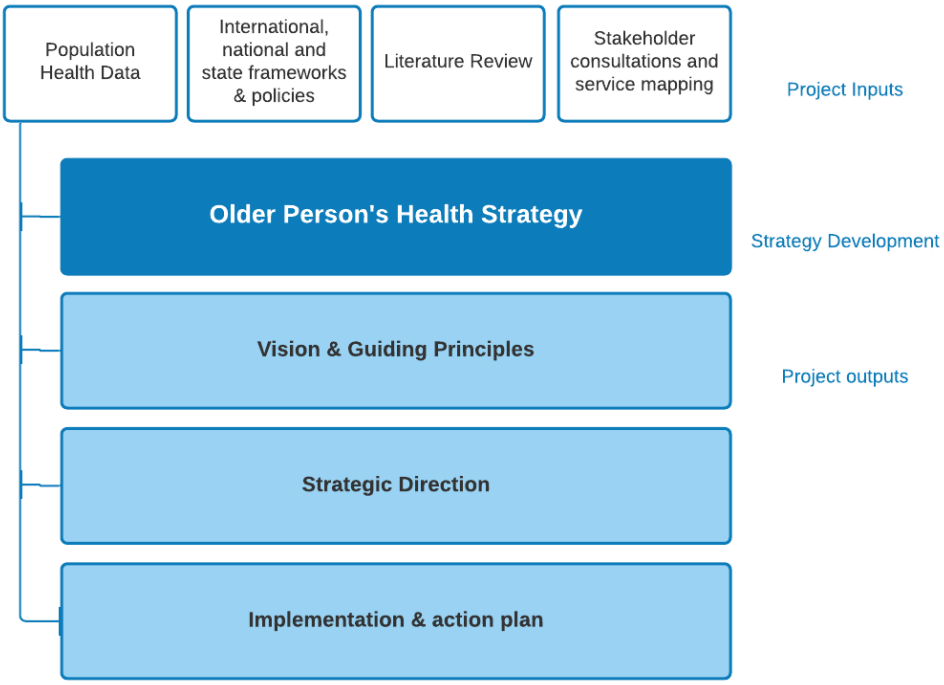
3.3 Methodology to developing the Strategy

Development of the Strategy was informed by a review of relevant international, national and state policies and frameworks; local population health needs analyses; relevant research evidence and literature; and understanding local needs through purposeful engagement and relationships with our communities and stakeholders. This was considered within the context of the existing work and the remit of the PHN, as well as the broader aged care context including the Council of Australian Governments (COAG) health reform agenda and the Royal Commission into Aged Care Quality and Safety.[2]

The following methodology was undertaken in the development of this Strategy:

1. Review of the existing international, national and state frameworks and policies (Appendix 1) and the current system and service landscape (Appendix 2)
2. Literature review to understand determinants of and indicators for healthy ageing and best practice/evidence-based strategies (Appendix 2 and 4)
3. Review of secondary health and social population data to characterise the population and assess determinants and indicators of health across the region (Appendix 3)
4. Consultation with internal and external stakeholders and community to understand needs/perceptions and gaps and potential actions (Appendix 3)
5. Synthesis of health needs and issues of healthy ageing across the region to identify strategic priority areas and objectives (Section 4)
6. Setting the vision, key principles, priority themes and goals; identifying options for action to deliver services and activities across the region to meet community needs; and creating an action plan to prioritise and monitor the delivery of these actions (Section 5).
7. Developing key performance indicators and measures (based on logic modelling) to inform operational planning, implementation, evaluation and monitoring (Appendix 5).

Figure 2. Inputs and Outputs of the *Ageing Well in our Region: A Healthy Ageing Strategy 2022 - 2027*



4. The Strategy – Our vision and priorities for action

4.1 Vision

The *Ageing Well in our Region: A Healthy Ageing Strategy 2021 – 2028* is aligned to the PHN's overarching Strategic Plan[3] to build healthier communities through primary health outcomes and the vision, objectives and broad actions articulated in this Strategy will contribute to the PHN's overarching strategic vision: 'Healthy, resilient, connected communities – country to coast.'

The vision of this Strategy is:

"As people age, they have a valued place in community, are healthy, active, resilient and connected and are empowered to live the life of their choice."

4.2 Guiding principles

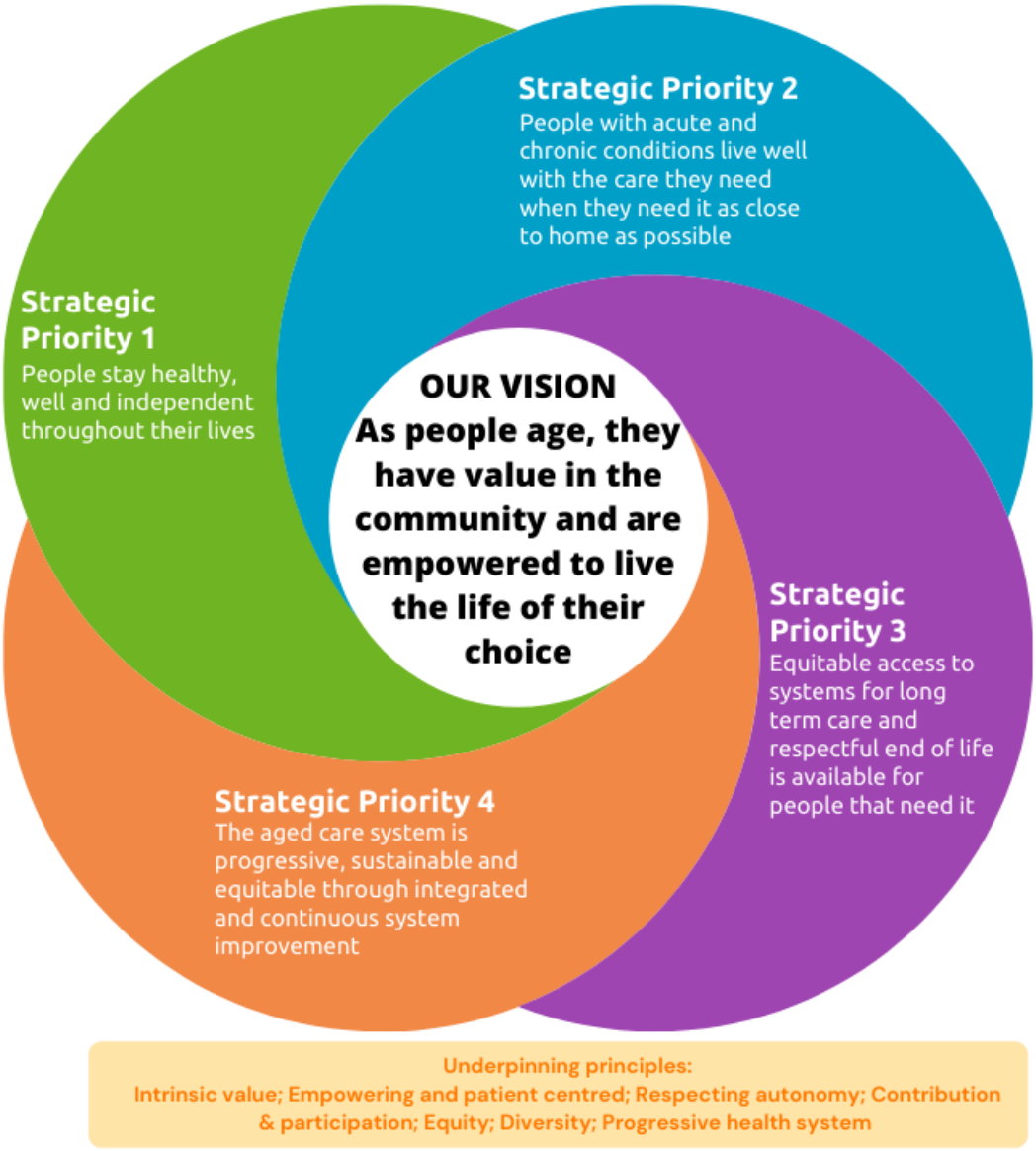
There are seven underpinning principles guiding our decisions and implementations of actions. These are:

"Intrinsic value" and cultivating a valuing mindset	• Older people are of intrinsic value to society; • Challenging the devaluing mindset/culture and shifting from a 'burden' view; • Celebrating and valuing the bravery, determination and resilience of seniors (and their continuing contributions).
Empowering, inclusive and patient centred	• Involving older people in deciding the services they need/want and in decision making/service design/society at large; • Validating needs of older people WITH them.
Valuing and respecting a person's autonomy	• Supporting/promoting a person's autonomy and confidence to apply self-agency • Respecting the choices they make for their own health
Co-design, contribution and participation	• Older persons' genuine participation in solution design is actively sought and valued; • Older persons' voice is imperative across the continuum of service engagement and experiences
Equity and equitable access and outcomes	• Tackling health inequalities should be at the core of action; target least advantaged, most vulnerable, marginalised; • Universal health coverage • Equity of access to care and services and of the workforce across the more regional, rural, remote communities of the PHN region
Diversity and uniqueness of individuals	• Embracing diverse characteristics and life experiences of individuals • Recognising and celebrating diversity and culture, including Aboriginal and Torres Strait Islander culture, ethnicity and gender diversity
Responsive, accountable and progressive health system	• Underpinned by shared approaches to collaborative practice, policy and commitment to evidence based / best practice • Ensuring equitable access to quality and safe care and coordinated & seamless service delivery

4.3 Strategic priority areas

The actions under this Strategy are presented under four Strategic Priority Areas:

1. People stay healthy, well and independent throughout their lives
2. People with acute and chronic conditions live well with the care they need when they need it as close to home as possible
3. Equitable access to systems for long term care and respectful end of life is available for people that need it
4. The aged care system is progressive, sustainable and equitable through integrated and continuous system improvement



The following section describes the intent and importance of each Strategic Priority Area and the goals we are aiming to achieve.

Strategic Priority 1
People stay healthy, well and independent throughout their lives

Why it is important

Health is fundamental to being able to live well, age well and continue to participate in family and community life. Older people make a significant contribution to our society, economically, socially and intellectually as mentors, leaders and skilled workers and volunteers.

Ageing well is not just about preventing ill health and disability. It is also about maximising physical and mental health and wellbeing, independence and social connectedness as people age. This includes empowering people to be health smart (health literacy) and to plan for the future and active ageing, ensuring that support and care is accessible and close to home, improving the social and environmental factors that influence health and creating age-friendly communities.

The actions under this priority area aim to enable older people to continue to be active, engaged and enjoying life.

What we want to achieve

1.1 People are physically and mentally healthy and well, have healthy lifestyles, and are resilient throughout their lives and into older age
1.2 People are engaged and participate in society and are socially connected throughout their lives and into older age
1.3 Communities are age-friendly and encourage positive ageing, and enable people to age respectfully and to fully participate in their communities
1.4 People age in their place of choice with the supports they need (if needed) and experience emotional, financial and housing security
1.5 Older people are health literate, able to actively manage their health, access information and make informed health decisions, and are well-supported in accessing and navigating systems and care into older age

Strategic Priority 2
People with acute and chronic conditions live well with the care they need when they need it as close to home as possible

Why it is important

For older people with acute and chronic conditions, their diseases may have become established and they may be experiencing declining capacities. A functionality focus (rather than a disease focus) is still applied, with actions focussing on minimizing the impacts of these conditions on a person's overall capacity by helping to stop, slow or reverse declines in capacity. Ensuring people are able to access the level of care at the right place and right time is important to being able to live well, which includes being able to navigate the complexities of the aged care system.

Therefore, we will focus on improving the three main parts of the journey for older people – prevention and early intervention; management of acute and chronic conditions and maintenance/improvement of functionality; and ensuring there are supported discharges and rehabilitation in the community. To achieve this, we need holistic integrated, safe and quality care delivered by an engaged, sustainable and valued workforce (both informal and informal). In addition, service providers and staff need to understand older people's cultural and other preferences, and be committed to working with individuals, families, providers, and community leaders to get the best outcomes possible for individuals.

What we want to achieve

2.1 Best practice promotion and early detection actions are provided so that fewer people are affected by preventable conditions or frailty as they age
2.2 People with acute and chronic conditions are health literate to actively manage their health and existing conditions and navigate services to meet their care needs as they age
2.3 People with acute and chronic conditions have equitable access to best practice holistic person-centred models of care that support their physical and mental health and social needs, including assessment, triage/referral, integrated care, discharge planning, rehabilitation strategies and follow up support as they age
2.4 Health and care services are culturally safe and staff are culturally competent and respect cultural preferences and differences
2.5 Workforces that support older people with long-term conditions, including health, home and community support services, as well as family and other informal carers, collaborate and have skills, competencies and resources they need to provide quality and person-centred care and support
2.6 Transition pathways are efficient and seamless (hospital to 'home' or residential care; home to residential care, etc.) and older people have access to support and rehabilitation while they transition and to meet their changing care needs

Strategic Priority 3

Equitable access to systems for long term care and respectful end of life is available for people that need it

Why it is important

Older people with high and complex needs are one of the most vulnerable groups in society and may have, or are at high risk of, significant losses in capacity. Here we focus on the provision of long-term care that enables an older person to maintain a level of functional ability consistent with their basic rights, fundamental freedoms, and human dignity.

We need to ensure that older people of all ethnicities are health literate and can access culturally-appropriate services including home and respite care, long-term residential care, mental health and other healthcare services. Dementia is a particularly prevalent long-term condition in older age, and an important priority.

Support workers, carers and family members make up a large part of the workforce for people with high and complex needs. We particularly acknowledge the role of informal carers (such as families, friends and volunteers) and that the recognition and support of these carers is even more vital when their loved ones become frailer.

We also need to ensure that people at the last stages of their life are in control of their care, and that their preferences are well understood and adhered to as much as practicable by those involved in their care.

What we want to achieve

3.1 Older people with high and complex needs are able to live as independently and actively as possible with access to integrated care and support where their needs are known

3.2 Older people with high and complex needs and their carers have information and freedom to make informed choices about their care, have care plans in place and know that health care workers understand and support their wishes

3.3 Families and carers (paid and unpaid) have the support, information and training they need to assist older people with care needs, including dementia, and are supported in caring for their own health and wellbeing

3.4 Health care, aged care and support teams respond to older people's goals, care and cultural needs at the end stages of life and the experiences of their family, caregivers and friends so people die feeling as comfortable and safe as possible in their place of choice

Strategic Priority 4

The aged care system is progressive, sustainable and equitable through integrated and continuous system improvement

Why it is important

The health system and aged systems operate in a complex and dynamic environment. Our approaches to the health and care of older people need to change at multiple levels. The health system needs to work with other sectors to take joint action on the social, environmental, cultural and economic determinants of people's health. Good housing and transport, for example, are critical to keeping people well in their own communities.

The health system faces some significant workforce challenges, including recruitment and sustainability of a qualified workforce. Workforce disparities exist across our regional, rural and remote communities compared to more metropolitan areas, and each community faces their own unique workforce challenges. Overall, as people live longer with long-term conditions and complex needs, either at home or in aged residential care, we will increasingly need to support and develop the skills of our formal (paid) and informal (unpaid carers e.g. spouses, families, volunteers) workforces.

The PHN's role as a primary health care leader is to bring together partners and stakeholders, to facilitate integration and to drive system improvement. Together we need to challenge ageist cultures and raise the profile of the age care workforce as a speciality and discipline of value.

What we want to achieve

4.1 Healthy ageing outcomes are defined and monitored, and programs evaluated to ensure quality health care and outcomes for people as they age in the PHN region

4.2 The PHN is known for challenging cultures associated with ageism and leading the way in promoting healthy ageing outcomes in the primary health care sector

4.3 Primary health care systems are oriented around intrinsic capacity and functional ability, and foster integration and multi-sectoral action in the health sector and across agencies

4.4 Sustainable and appropriately qualified age care workforce exists to support our ageing population into the future and raising the profile and recognition of people who work in aged care to support aged care as an important career pathway

5. The Action Plan

5.1 Development of the action plan

To achieve the PHN's vision for the healthy ageing of our older people, an action plan has been established. The strategies in the action plan draw on consultation with community and stakeholders including health care providers, local hospital and health services and other agencies (refer to Appendix 3) and evidence from the literature about what is effective for improving and promoting health and wellbeing of people throughout their lifetime and as they age (Appendices 1, 2 and 4), as well as policy frameworks to align with the directions of the healthy ageing agenda (Appendix 1).

In setting out the action plan, we emphasise the need to work in collaboration across sectors and agencies. Many actions within the plan require collective action, and the plan therefore identifies various key players and those best placed to be lead and support agencies on specific actions.

It is intended that actions identified in the action plan will be developed and implemented over the next five years, with some long-term strategies that will be implemented beyond five years. The Strategy will be reviewed annually to inform annual planning and updated to reflect changes in need, priority and opportunity.

Actions
Within each strategic priority area there are actions to be undertaken to achieve the goals.

Toolkit / action device
Methods to achieve each action have been identified based on the current context of where initiatives are at. Actions have been identified as:

- Advocacy – urging through debate, evidence and innovation; leading the way in health system transformation and reform
- Provide – operational, management and functional activities delivered in 'business as usual' activities (e.g. through PHC function); PHC education, training and workforce development; PHC system stewardship and management (quality)
- Procurement – project planning (including co-design) and subsequent procurement of programs, services or activities
- Partnership & collaboration – collaboration with internal or external bodies; system coordination and integration
- Planning – planning (including master planning, regional planning), strategy and policy development
- Business development/Innovation
- Investigation – further investigation research or feasibility opportunities

Priority
The timing of actions has also been identified through a prioritisation process using the following criteria:

Criteria	Description
Accessibility and equity	• Will the action address the need/s of those who need it most?
Evidence based	• Known / likelihood to be effective; also recognizing we can be involved in contribute towards evidence base including evaluation
Readiness / support	• Identify relevant and appropriate partnerships or stakeholders (including right skills, resources, assets) • Community support exist / relevance

	• Other resourcing – what is available (human, financial, assets) and when is it available. Priorities are subject to budget allocation, both Department funding and additionally or externally sourced funding.

Based on this prioritisation, actions in the plan are specified as:

- Ongoing (business as usual or continuing or enhancing current practices/ projects/ investments)
- Short (within 1-2 years)
- Medium (within 2-5 years)
- Long (beyond 5 years)

5.2 Operationalising the action plan

Operationalising actions

The actions in this Action Plan will be delivered over the next 1 – 5 years. Key players and lead agencies have been identified for each action. Where actions are led by partners external to the PHN in our community, the PHN's role is as a partner or to provide support or facilitation. Roles of key players are defined as:

- Lead: lead agency / responsible
- Partner: key collaborator, not necessarily the lead agency
- Support: through resourcing, knowledge sharing, advisory; value adding to action e.g. training
- Facilitate/Drive: facilitating partnerships, engagement or co-design etc.; brokerage; driving investigation or planning

The Action Plan also identifies strategies where additional funding (beyond existing resources such as Department of Health funding for PHN work) may need to be sourced, where partnerships need to be established or strengthened, as well as a range of research opportunities. In that sense, some actions may be considered more 'aspirational' where resourcing and partnerships will be required first.

For the PHN, it is intended that actions will operationalised in Implementation Plans and subsequent project plans or incorporated into business as usual functions within existing work/projects. The Action plan will serve as a regional strategy or framework for use by and engagement with key stakeholders and lead organisation with responsibility to improve the outcomes and choices for older people across the region to inform priority future investment considerations of the PHN with stakeholders.

It is important to emphasise that older people need to be at the centre of all actions in the Action Plan. The voice of the consumer is crucial in operationalising these actions, and will be achieved through the active involvement and participation of older people in the design of solutions, services and programs. This includes involving the family and carers (including adult children) as initiating or managing support for older adults.

Important considerations – Equity and priority groups

The PHN is committed to improving the health and wellbeing of all residents living throughout the region. While the Action Plan includes strategies that will support all people to achieve healthy ageing outcomes through universal approaches, it is important to consider additional cultural and environment aspects that create barriers to healthy ageing and accessing appropriate care. Therefore, **a focus on equity (and equity of access) for priority population groups** within the older population should remain at the fore of operational planning and implementation of the actions within this Strategy, particularly for the PHN region which covers wide ranging and diverse populations of differing cultures, social standing and residential location.

Within the PHN population, there are priority population groups within the older population that face considerable health disparities and challenges and inequities in relation to accessing services. This includes people with disabilities, people who identify as LGBTIQ+, cultural and linguistically diverse people, care leavers, and our first nations people. As the PHN region covers regional, rural and remote localities, equity of access to care and services for these communities is also a priority. In addition, consideration may be needed for men, farmers/people on properties and people in the more regional, rural and remote areas who have previously not been able to obtain ready access to services and are stoic or have sceptism or resistance about accessing services.

Complexities around **aging in place and what that means to people** is also important to consider in implementing these strategies. Geographically speaking, in many regional, rural and remote regions, people perceive a need or in some cases are required to move, to access these services, meaning that ageing in place of choice is not able to be achieved. Examples may include Aboriginal and Torres Strait Islander people nearing end of life wanting to return to Country; or people no longer able to live in a town where they have lived for all of their life are having to relocate due to lack of family support or access to services or facilities. Ageing in place of choice should also consider the type of residence for example, people staying in their homes or in units with appropriate care or having appropriate access to independent living facilities, RACFs, hospices and palliative care facilities; or people having to move from properties/farmland into town to receive appropriate care.

Another consideration is to **involve "adult children" of older people and the next generation** of older people as key stakeholders or in key actions. This next generation of people are often at the core of planning for older age, or leading, initiating or managing services for their parents and as such they need to be literate and engaged in knowing where to start in healthy ageing, how to navigate systems or what services are available to themselves or the older person that they are caring for. Therefore, building the capacity of, involving and supporting this stakeholder group in the development and implementation of actions will be a key enabler to improving healthy ageing and access outcomes.

To support these considerations, strategies in the Action Plan should be considered in context of emerging work and supporting policies and frameworks for vulnerable populations. For example, Roadmap for Improving the Health of People with Intellectual Disability , the Aged Care Diversity Framework, Working with Stolen Generations and Forgotten Australians (Also see Appendix 1). In addition, as described in Appendix 1, the aged care reforms falling out of the Royal Commission into Aged Care Quality and Safety will be implemented during the life of this Strategy – the reforms will change how older people access aged care and health care, how aged and health care is delivered, who by and how it is funded, and people's ability to navigate a changing system. The Healthy Ageing Strategy and strategies within is therefore a living document, that requires ongoing monitoring and review to ensure directions and investments continue to reflect community needs and priorities.

5.3 Measuring success and progress

Measuring progress of actions as they are being implemented and ensuring that outcomes achieved are those that matter to people will form an important part of operationalising this Strategy. A full list of indicators and logic models specific to each strategic priority area is provided in Appendix 5 and has been developed to provide additional context and support for the PHN and partners as they operationalise these actions and develop subsequent plans.

5.2 Action Plan

Strategic Priority 1: People stay healthy, well and independent throughout their lives

Action no.	Strategy (high level) and action	Who responsible / key players (e.g. lead, support etc.)[1]	Method (for PHN)	Priority *(short, medium, long)*
People are physically and mentally healthy and well, have healthy lifestyles, and are resilient throughout their lives and into older age				
1.1.1	**Support and invest in strategies targeting people at risk of chronic conditions to build self-agency, health literacy and enable people to live healthy lifestyles/reduce risk factors, such as through:** ***1)*** **Continuing to support the My Health for Life program** *(state funded initiative - a free six month program for individuals at risk for developing chronic conditions)* **2)** **Continuing to invest in the Rural Primary Health Service program** to support access to allied health services and supports	Diabetes Qld / Heart Foundation (funder) **PHN PHC team (contractor/lead activity)** **PHN CST team (Lead)** Health providers / agencies (commissioned)	Provide Procure	Ongoing / Short Ongoing
1.1.2	**Continue to deliver PHN Mental Health Stepped Care services to provide mental health services for people in our region** (prioritising older people) and explore opportunities to meet gaps in mental health service provision across levels of prevention for older people, including: *Ongoing* - Undertake mapping to understand the local MH service landscape for older people - Continue to deliver Stream 1 (low risk/ people needing connection or for grief/loss) - Continue to deliver Stream 3 (MH In Reach program to RACFs) *Short term* - Explore opportunities to address and meet gaps in mental health service provision for older people (including psychogeriatric services, provision in home care services)	**PHN MHAODs team (Lead)** Stepped Care providers (commissioned)	Procurement	Ongoing and Short

[1] Refer to page 17 – definitions of roles

Action no.	Strategy (high level) and action	Who responsible / key players (e.g. lead, support etc.)[1]	Method (for PHN)	Priority *(short, medium, long)*
	- Explore opportunities to deliver more universal low intensity community-based mental health promotion initiatives targeting older people to combat social isolation and other risk factors associated with mental health			
1.1.3	**Support strategies that empower people to actively plan for healthy ageing, ageing/aged care needs and maintaining QOL into older age, such as:** *Short term* - Continue to support (& evaluate) the Healthy Ageing Collaborative on the Fraser Coast - Support the delivery (in partnership with Public Trustee or other peak bodies) public awareness programs to increase understanding and uptake of legal planning documents (including advance health directives, understanding of rights including voluntary assisted dying) *Medium term* - Explore collaboration opportunities with General Practices, local government, neighbourhood centres or other organisations to deliver local programs for community members to live well and support and empower them in planning for and advocating for their future and for their ageing/aged care needs	**Peak bodies e.g. OCAP, ELDAC, Public Trustee (lead/partner)** Local government / NGOs / Neighbourhood Centres and ACCHOS and Indigenous NGOs / Aged care providers (Lead/partners) COTA Queensland (lead/partner/facilitate) PHN – CST Team, Comms, PHC team (partner/support/facilitate)	Partnership & Collaboration Provide	Short - Med
1.1.4	**Work/partner with local governments, organisations and NGOs to support delivery of local physical activity and other healthy lifestyle programs (especially where these are lacking) that are free or low cost for all ages and preference types** *Ongoing - Short* - Support and promote existing activities and programs *Medium* - Explore opportunities to partner to understand service gaps and needs - Explore opportunities to support and enhance and and/or facilitate delivery of new programs in localities where these are lacking or where there is identified need	**Local Government (Lead)** PHN CST Team – CC or OPH portfolios (support) HHS, RACFs (Facilitate /Integration) Peak bodies (e.g. ESSA) (partner) Allied health providers (partner/support)	Partnership & Collaboration Investigation Provide	Short - Medium
1.2	People are engaged and participate in society and are socially connected throughout their lives and into older age			
1.2.1	**Support, promote and build on existing local programs that provide social engagement and participation opportunities, and foster capacity building and peer support among older people, including:** - Identify at the local level what is available and accessible for local people	**PHN MHOADs and CST (Lead, facilitate)** in partnership with Local Government	Partnership & Collaboration	Short

Action no.	Strategy (high level) and action	Who responsible / key players (e.g. lead, support etc.)[1]	Method (for PHN)	Priority *(short, medium, long)*
	- Promote existing programs and resources to GPs and other health professionals, care planners/providers (RAS/ACAT Assessors, Home Care Providers, Aged Care Navigators/Care Finders, and Carers Gateway, Neighbourhood Centres etc.) and to community; and support referral pathways and linkages into those programs - Explore opportunities with local governments across our 12 LGAs to enhance existing (or develop new) initiatives and programs for local people in their communities - Explore opportunities to promote and support these type of programs in key settings such as RACFs and respite care facilities etc. across the region *Note this may also align/links with the Care Finder program Action 2.2.1, and Social prescribing under Action 1.4.1*	Partners: Communities; Local Government; NGOs and community based organisations/providers; RAQ; Neighbourhood Centres		
1.2.2	**Explore opportunities to support and invest in intergenerational health promotion and social support initiatives that address social isolation/loneliness and promote the value and contribution of older people through intergenerational connection within families and networks**: *Ongoing - Short* - Continue to fund the Moving Moments program, an intergenerational playgroup - Support and promote the intergenerational model being delivered by USC Gympie and Cooinda *Medium* - Explore opportunities for PHN to support and enhance existing intergenerational programs and/or facilitate delivery of new programs - Support the delivery of community-led initiatives that facilitate intergenerational connection and valuing older people - Advocate to state government to encourage early learning centres and preschools etc to incorporate intergenerational activities as part of core business - Partner with stakeholders to support/encourage younger people/adults to volunteer or undertake student placements with aged care services and organisations/programs that provide support to older people – e.g., community visitors programs, volunteering with Aged Care CHSP and HCP package providers, and with RACFs	**Leads/Partners: ECEC Peaks; Education Qld; Playgroup Qld; USC Gympie/Cooinda; Early years facilities; Schools; playgroups, Community Visitors program, local home care providers, Residential aged care facilitie.** **PHN MHAODs and CST teams** (Facilitate/drive co-design; Support); PHN Business Development	Procurement (Moving Moments) Partnership & Collaboration (& Investigation) Business Development Advocacy	Medium
1.2.3	**Explore opportunities to promote <u>carers'</u> wellbeing and social connection experiences particularly among informal family/in-home carers or similar of high need individuals** (such as through digital connection models, peer support and community of practice models, carers support models*).	**Lead/Partners: Wellways; Universities; Carers Qld**	Procurement Partnership & Collaboration	Medium

Action no.	Strategy (high level) and action	Who responsible / key players (e.g. lead, support etc.)[1]	Method (for PHN)	Priority *(short, medium, long)*
	*Note – see Aged Care Reform – Support for Informal Carers	Other key partners/facilitators (settings based): Neighbourhood centres, meeting points e.g. U3A PHN CST or MHAODs teams (Facilitate/drive co-design; Support) ; PHN Business development Other partners/support: Services Australia		
Communities are age-friendly and encourage positive ageing, and enable people to age respectfully and to fully participate in their communities				
1.3.1	**Work/partner with local governments and other local agencies to develop age- and dementia-friendly communities** • Develop and strengthen local-level partnerships with local government and other stakeholders • Support development of local government level 'age friendly' strategies and plans • Influence & advocate for creating built environments (including provision of infrastructure, footpaths, public amenities, parks & open spaces, public transport etc) and urban developments that are conducive to health and ageing • Facilitate and/or support collective actions* to improve cognitive, physical, social and environmental factors of healthy ageing * collective actions refers to 'working together in a coordinated way towards a common goal/objective'	**Local governments (lead)** Partners: PHN CST Team and HPIT; HHS; Universities; Developers / urban planning; Other local agencies	Advocacy Partnership & Collaboration	Medium
Older people age in their place of choice with the supports they need (if needed) and experience emotional, financial and housing security				
1.4.1	**Support development and implementation of locally specific referral pathways for GPs and other health professionals for identifying and referring people in need of housing and other social supports (e.g. aged care supports, financial services), and deliver capacity building activities on pathways as well as skills such as cognitive behavioural therapy (CBT) and motivational interviewing** Strategies may include:	**PHN PHC team (Partner/facilitate/drive)** with GPLOs and MHAODs support Partners: HHS My Aged Care / RAS assessors, and local	Provide	Short

Action no.	Strategy (high level) and action	Who responsible / key players (e.g. lead, support etc.)[1]	Method (for PHN)	Priority *(short, medium, long)*
	- Mapping to identify existing supports (such as financial counselling, housing support, existing resources such as Health Compass series) – note align with MHAOD mapping currently being undertaken - Updating Health Pathways to reflect above - Supporting primary health care providers in understanding referral processes and requirements to ensure effective and quality referrals to My Aged Care and other aged care services. - Delivering capacity building activities for GPs and other health professionals around social prescribing and on the referral pathways and options available, as well as screening for loneliness and building other skills such as CBT and motivational interviewing - Partner to explore and support development and implementation of social prescribing models, pathways and systems for general practice and other PHC health professionals *Note this may also align/links with the Care Finder program Action 2.2.1*	agencies and providers that deliver aged care and home care services (such as through CHSP) Training bodies / universities / colleges (partner/support) PHN Clinical Council (support) Department of Communities, Housing and Digital Economy (Qld Gov) Services Australia		
1.4.2	**Deliver a range of strategies to improve awareness and referral pathways for older people experiencing elder abuse or family & domestic violence**, including: • Partner with Relationships Australia Queensland (RAQ) to develop elder abuse referral pathways; support RAQ to develop early screening tools for providers, organisations and aged care workers/workforce to use • Promote the Elder Abuse Helpline and promote and support providers and professionals to increase knowledge and access additional training as opportunities arise	**RAQ (Lead)** DV Connect (partner) Older Women's Network Qld (partner) PHN MHAOD & PHC Teams (partner/provide) OPAN (support)	Provide Partnership & Collaboration	Short
1.4.3	**Deliver strategies to improve awareness, understanding and skills of primary health care professionals about elder abuse, risk factors, responding to elder abuse etc., through:** • Promoting and encouraging OPAN training for Health and Aged Care professionals and community • Participating as a member of the Sunshine Coast Elder Abuse Prevention Network (SCEAN) and collaborating to provide education / awareness session to for Health and Aged Care professionals • Exploring opportunities to link with community-based agencies or programs to deliver Life Style Cafés that provide awareness sessions	**Leads/key players:** **RAQ (support/lead)** **ADA (support/lead)** **OPAN (partner/lead)** Local agencies (neighbourhood centres, community respite centres etc.) (partner) PHN PHC or CST (Support/partner/linkage)	Provide	Medium

Action no.	Strategy (high level) and action	Who responsible / key players (e.g. lead, support etc.)[1]	Method (for PHN)	Priority *(short, medium, long)*
Older people are health literate, able to actively manage their health, access information and make informed health decisions, and are well-supported in accessing and navigating systems and care into older age				
1.5.1	**Work collaboratively with key stakeholders and partners to support delivery of a range of strategies to enable conversations and decisions around individuals' health care and choices** that impact them now and into their futures (including Advance Care Planning), by: *Ongoing* - Promoting common resources and a common shared language - Continuing to work with local RACFs and the Office of Advance Care Planning QLD to support the embedding of evidence-based Advance Care Planning (ACP) processes into routine clinical care. *Short* - Partnering with/supporting Palliative Care QLD, the Office of Advance Care Planning and other community organisations to support those ageing in the community settings. - Partnering with/supporting local agencies such as RAQ, peak bodies and local government to deliver talks/community forums to carers and families around relevant topics such as how to have hard conversations with older people, voluntary assisted dying, advance care planning etc. - Supporting collaborative efforts of individuals, clinicians, aged care providers, families to advocate for the person's rights in the aged care system	**OACP (lead)** **RAQ (lead)** PHN (Facilitate partnerships; support) Other partners: COTA QLD; Community geriatrics; GPs SPACE; Local Governments; Carers organisations; Seniors legal services	Partnership & Collaboration Procurement	Ongoing - Short
1.5.2	**Deliver strategies that support individuals' health literacy and specifically in being empowered to self-manage their own health and wellbeing and live a healthy lifestyle** including physical activity, nutrition, lifestyle behaviours (smoking, alcohol), cognitive health, sexual health and oral/dental health, as well as their understanding of their right to make decisions and take risks. This may include: - Investing in capacity building of GPs and other health professionals, care staff, home care providers and family & friends, to support peoples wellness and reablement - Supporting and/or deliver strengths-based approaches and initiatives that encourage healthy lifestyle behaviours at all ages to support healthy ageing and prevent chronic diseases, with a particular focus in 40s - Partner to develop community-based health literacy strategies/programs for older people their families and carers (PHN & HHS)	**Lead/Partners:** **Peak and professional bodies** PHN PHC team (drive/support) with Comms Other partners: Local government, universities, NGOs	Provide	Short

Action no.	Strategy (high level) and action	Who responsible / key players (e.g. lead, support etc.)[1]	Method (for PHN)	Priority *(short, medium, long)*
1.5.3	**Work with the Australian Digital Health Agency to explore, promote and support the uptake of the My Health Record system** (including uploading of advance care plans) throughout the residential aged care and community care space.	**PHN – CST and PHC team (lead)** ADHA (support) *Others TBD with upcoming funding / opportunities. Note – collaboration opportunities may exist with existing programs through the Be Connected program and funding (Federal Government)*	Provide	Short - Medium
	Note – Action 2.2.1 (Care Finder Program) also addresses accessing information and services and support for digital literacy			

Strategic Priority 2: People with acute and chronic conditions live well with the care they need when they need it as close to home as possible

Action no.	Strategy (high level) / action/s	Who responsible / key players (e.g. lead, support etc.)	Method (for PHN)	Priority *(short, medium, long)*
Best practice promotion and early detection actions are provided so that fewer people are affected by preventable conditions or frailty as they age				
2.1.1	**Support GPs and other health care providers to undertake relevant health checks at 45+ and 75+ years** (all population) **and as indicated for those with chronic conditions and in the provision of resources and care plans** - Provide support and information to GPs and providers on best practice for health checks - Provide/promote resources to PHC professionals for supporting individuals with a chronic condition to be proactive and self-manage their health, such as Chronic Disease Action Plans (prepared by GPs) *Note that this action also links with programs such as My Health for Life (under Action 1.1.1), and supporting health literacy, healthy lifestyle behaviours and self-management (under 1.5.2)	**PHN - PHC team / GPLOs (Lead)** HHS (partner/support)	Provide	Ongoing - Short
2.1.2	**Commission early intervention and monitoring activities to support healthy ageing and reduce early entry into residential care** (including screening and risk assessment, frailty management, models of care such as MDT, virtual) ***Note –*** *this action links with Action 2.3.4 (FFP/Active at home program)*	**PHN CST Team (Lead)** with PHC team / GPLOs support HHS (partner/support)	Procurement Provide	Short
2.1.3	**Promote screening of all people at clinically indicated ages for risk factors for dementia and frailty** including cardiovascular risk by GPs and general practice nurses, including: - Advocate/request RACGP to consider frailty score or other appropriate measure in the health assessment guidelines - Work closely with GPs and PHC sector to build capacity in identifying dementia, mental health and associated risk factors and support use and uptake of screening tools, including cognitive screening tools and subjective assessments - Encourage promotion and prevention advice for healthy ageing as part of the screening and assessment process	**PHN PHC team (Lead)** with GPLO support HHS (partner/support)	Provide	Short
2.1.4	**Partner with older people/Elders, community and partners to explore feasibility of a 'Wellbeing Checks / Community Check-in' program or model** in rural and remote communities to reach/access hard to reach older people to provide connection as well as access to social and health services/care (through screening and referral/linkages)	**PHN CST or MHOADs Team – (Lead/facilitate - backbone to bring partners together)** HHS (partner/support)	Partnership & Collaboration Procurement (long term actions)	Med - Long

Action no.	Strategy (high level) / action/s	Who responsible / key players (e.g. lead, support etc.)	Method (for PHN)	Priority *(short, medium, long)*
		Partners: Local Government / community hubs / Neighbourhood Centres; RAQ; PHN; COTA QLD; USC / CQU / SCHU (& utilising students in evaluation); Other health providers Eg. CQID		
People with acute and chronic conditions are health literate to actively manage their health and existing conditions and to navigate and access services to meet their care needs as they age (functionality focus (rather than diseases) / Intrinsic capacity across spectrum of functionality)				
2.2.1	**Work collaboratively with COTA to provide vulnerable senior Australians who need specialist aged care support, access to 'Community Care Finders'** to provide face to face assistance to access and navigate aged care services, health and community supports through the Care Finder program	**COTA (national lead)** **PHN (Lead)** Other partners/ stakeholders: COTA Qld; Centrelink- DHS; Community providers and organisations; HHS; Local government; Services Australia; PHC providers	Partnership & Collaboration	Short
2.2.2	**Explore and implement strategies to address travel and transport barriers to access**	**Leads:** **Local government;** **Neighbourhood Centres / community hubs; NGOs;** PHN CST Team (support) HHS (facilitator) Other partners:	Investigation (Planning; Partnership & Collaboration)	Medium

Action no.	Strategy (high level) / action/s	Who responsible / key players (e.g. lead, support etc.)	Method (for PHN)	Priority *(short, medium, long)*
		Department of Transport and Main Roads		
	Note – also see Action 1.5.2 for strategies relating to health literacy, these could be broadened to also include people with chronic conditions as a target group			
People with acute and chronic conditions have equitable access to best practice holistic person-centred models of care that support their physical and mental health and social needs as they age, including assessment, triage/referral, integrated care, discharge planning, rehabilitation strategies and follow up support				
2.3.1	**Invest in and improve access to services for older people in regional, rural and remote areas, through:** - Use national, regional and local data to inform and improve access to PHC services. - Continue to commission the RPHS program in North Burnett, Discovery Coast and Central Qld, and work with these providers to address barriers to access especially for older people (*note – also links to Action 1.1.1*). Consider further expansion into other locations of need. - Continue to commission Discovery Coast Community Nurse contract (to address MAC packages gap) - Work with Local Government and other agencies in engaging with communities to understand local barriers to accessing services and identify locally- and community-led solutions	**PHN CST team (Lead)** Partners: Queensland Health Local providers COTA Queensland, Home Care Providers (eg CHSP and HCP). Local Government (support/involve)	Procurement	Ongoing
2.3.2	**Continue to contribute to the Roundtable Partnership discussions and working in partnership with ACCHOs and community to support the appropriate roll out and delivery of the Integrated Team Care (ITC) program and other initiatives** *ITC is a program designed to support access to services for Aboriginal and Torres Strait Islander people (including older people) with chronic conditions and complex needs*	**ACCHOs, Community, Roundtable Partnership (Lead/Partner)** PHN CST Team (Facilitate; support)	Procurement	Ongoing
2.3.3	**Support RACFs to ensure residents have equitable access to clinical supports where local care is not available, or patients are unable to travel, through:** - Supporting RACFs to ensure they have the appropriate facilities, equipment and training to enable on-site telehealth care for residents - Supporting RACFs to link with HHS, primary care providers for direct Telehealth support, and supporting general practices to provide support and consultations to RACF residents and staff via telehealth	**PHN CST Team (Lead) with PHC team support** RACFs (partner) HHS and general practices (support/partner)	Procurement	Short

Action no.	Strategy (high level) / action/s	Who responsible / key players (e.g. lead, support etc.)	Method (for PHN)	Priority *(short, medium, long)*
	- Supporting collaborative efforts of individuals, clinicians, aged care providers, families to advocate for the person's rights in aged care ** Also links with Actions 4.4.1 and 3.1.1*			
2.3.4	**Co-design and deliver a multidisciplinary home-based and/or community-based falls prevention programme/s (FFP)*** with a focus on Wellness, Reablement and Restorative Care, targeting people from middle age and into older age, and consider sustainability of any programs delivered. (Primary aim of FPP is to improve musculoskeletal health / prevention of frailty and falls, self-efficacy and capacity, reducing risk of fall or reducing harm from a fall, as well as assessment and screening) Actions may include: *Ongoing* - Continue to commission the Active at Home program in community and home-based settings - Continue to support the pilot program in Fraser Coast and scoping a multidisciplinary team model in the Sunshine Coast *Medium* - Support the establishment of new programs or building on/enhancing and/or expanding existing programs that aim to improve musculoskeletal health and reduce risk of falls - Support HHS and community referral pathways for falls assessments, home modification assessments, medication/pharmacology management, and appropriate onward referral.	**PHN CST or AH Team (Lead)** Potential partners: Community health or Home Care providers, HHS/nurse navigators, pharmacy, GPs, RAS/ACAT assessors(involvement) Exercise & Sports Science Australia (ESSA) Universities and/or SCHI (research support) Brisbane North PHN (Active at Home)	Partnership & Collaboration Procurement	Medium (note – Active at home and pilot program are current/ ongoing)
2.3.5	**Form a collaboration between PHN, general practice, QAS, HHS to develop and deliver a 'Frequent Flyers' project that includes:** *Short* - Using health service data to identify frequent flyers who are older and understand presenting conditions and factors surrounding presentations *Medium* - Co-designing solutions for managing/supporting older people in the community setting and their health condition outside of hospital (e.g. mechanisms to refer to GPs; Co-responder type models of care)	**QAS (Lead)** PHN (Partner) HHS (Partner) General practitioners (involve/support)	Partnership & Collaboration	Short - Med

Action no.	Strategy (high level) / action/s	Who responsible / key players (e.g. lead, support etc.)	Method (for PHN)	Priority *(short, medium, long)*
2.3.6	**Partner with both private-public entities to explore new (or existing) models of care that support prevention, management and rehabilitation for older people with chronic and long-term conditions.** Key considerations for progressing planning of this strategy: - Identify and understand health need and issues, considering prevalence data of communities/localities and service mapping data - Solutions and models of care to be locally-led and consider principles of holistic care, affordability, provision of integrated and multidisciplinary care	**SCHI / Universities; HHS (Leads)** PHN CST Team (Partner) Allied health professionals, specialists (involve)	Partnership & Collaboration Investigation	Long
Health and care services are culturally safe and staff are culturally competent and respect cultural preferences and differences				
2.4.1	**Support and enhance cultural appropriateness, competency and safety of services and supports for Aboriginal and Torres Strait Islander older people, including:** - Promote and support the uptake of the PHN cultural competency training program to all commissioned providers and PHC sector - Deliver the PHN cultural competency training program to home care organisations, providers and RACFs across the region - Support and enhance holistic models of care that are appropriate for Aboriginal and Torres Strait Islander older people and their families to support healthy ageing and to support aging in place (such as returning to Country)	**PHN CST/ITC and PHC teams (Lead)** ACCHOs, AMSs (Partner)	Provide	Medium
2.4.2	**Develop (or identify existing) and deliver a culturally and linguistically safe training package for our commissioned service providers and the PHC sector more broadly** that includes recognition of, and responds to, diversity among older people *(including CALD, people with disability, people who identify as LGBTIQ+).*	PHN CST team (Lead) Partners: Multi Cultural Peaks LGBTIQ+ Peaks etc	Investigation (Provide – long term action)	Med - Long
Workforces that support older people with long-term conditions, including health, home and community support services, as well as family and other informal carers, collaborate and have skills, competencies and resources they need to provide quality and person-centred care and support				
2.5.1	**Educate and build the capacity of the PHC workforce (GPs, NPs, aged care, RACFs allied health, home care workers etc. etc.) on the role of frailty and functionality as an indicator of poor health in older people**. Other topic areas also include elder abuse, social issues, medication/deprescribing, ACP/planning, dementia management, quality communication, compassion fatigue/empathy *Ongoing* - Partner to develop and deliver a suite of webinars in older persons health topics for GPs across the region (in progress) *Short*	**PHN (Drivers/facilitate) – PHC team and OPH team, MHAOD team** **Aged Care and Consumer peaks to be critical partners and/or take lead in the delivery**	Provide Procurement	Ongoing – Short

Action no.	Strategy (high level) / action/s	Who responsible / key players (e.g. lead, support etc.)	Method (for PHN)	Priority *(short, medium, long)*
	- Promote awareness of functionality (see Action 4.3.2 – Drive reform of PHC to focus on intrinsic capacity of older people across all forms of functionality) - Partner to deliver specific training packages or support in RACFs to build capacity of staff around topics including wound care, continence, mental health identification etc. - Promote Dementia Behaviour Management Advisory Service (DBMAS), Severe Behaviour Response Teams (SBRTs), Dementia Training Australia to GPs, residential aged care facilities and community service providers, Home Care providers, Independent Support Workers and NDIS - Partner to deliver training packages / forums and/or community of practice (and potentially a sustainable collaboration model) that bring the different disciplines together	**supported by PHN to provide access and priority for PHC Workforce** Partners: HHS; PHN Clinical Council; DTA; RACFs; GPs; PHC providers		
2.5.2	**Explore ways to improve vaccination uptake for the aged care workforce** - Understanding the barriers to uptake of vaccinations - Codesign strategies and solutions to address the barriers identified and support uptake of vaccinations among the primary health care workforce including aged care staff to address vaccine hesitancy (including culturally appropriate support and information) - Continue to support the promotion of awareness of the risks and importance of vaccinations for the aged care workforce	**PHU (Lead)** PHN PHC team and CST team (Support)	Partner/Provide Investigation	Ongoing
2.5.3	**Support GPs and other health professionals to improve timely referrals to My Aged Care (MAC), Care Finders, Carer Gateway and NDIS**, including: • Deliver specific education and capacity building for GPs, other health professionals and community workers (to focus on referrals for social and functional needs not clinical/medical condition) • Update Health Pathways to better support GPs to refer into MAC, NDIS and other services **note – this action also links/aligns with action 2.5.1, as functional need should be a focus of referrals	**PHN – PHC team (lead)** RAS/ACAT (involve/support) GPs and health professionals (involve/support)	Provide	Short
2.5.4	**Support/facilitate local communities to plan, develop and deliver local workforce solutions, targeting workforce solutions in areas of greatest need/gap, such as:** - Support/facilitate community-led solutions, workforce models and mechanisms that attract, recruit and build local workforces (e.g. local 'grow your own' models, opportunities immersion / growth and development, virtual models, extending scope of practices etc.) - Support development of the Indigenous MH workforce through: o Partnering/working with QUAC to increase workforce and uptake o Supporting/working with Indigenous mental health and counselling services (such as supporting Gallang Place with the roll out of their Workforce development strategy)	**Local communities (lead)** PHN CST and PHN Teams (support/facilitate) – PHN may also lead initial planning Other partners: COTA Qld, Local Government; HWQ; ACCHOs; Other peak	Partnership & Collaboration	Short

Action no.	Strategy (high level) / action/s	Who responsible / key players (e.g. lead, support etc.)	Method (for PHN)	Priority *(short, medium, long)*
		bodies e.g. QUAC; NGOs		
2.5.5	**Promote the aged care workforce as a speciality and a discipline of value and support career pathways in aged care sector and for professions working with older people** through: *Medium* - Engaging with individuals, education institutions and healthcare providers to reinforce that 'healthy ageing begins early' and importance of healthy lifestyles and habits. - Partnering with education sectors and the PHC sector in advocacy and cohort building strategies that aim to ignite the thirst for learning, support passion for being in aged care and address compassion fatigue etc. of new and existing workforce (Aged care support workers, home care/aged care staff, nurses, GPs) o For example, supporting USC Gympie in the delivery of their USC Campus Strategy and the development of the USC Healthy Ageing Hub project - Supporting Indigenous people to uptake roles / career pathways into aged care through promotion and advocacy, and supporting ACCHOs to develop workforce - Considering and exploring innovative ways in rural and remote communities to build local aged care workforce in communities that have limited access to home care package service provision	**Leads:** **COTA QLD,** **Peak bodies, employer, and union organisations** **ACCHOs** **Universities and educators** PHN CST Team (Support) and Executive	Advocacy Partnership & Collaboration Business development/ Innovation	Medium
Transition pathways are efficient and seamless (hospital to 'home' or residential care; home to residential care, etc.) and older people have access to support and rehabilitation while they transition and to meet their changing care needs				
2.6.1	**Partner with HHS to develop and trial an 'early supported discharge' models** (between patient, HHS and PHC), where the person, their family or carers, HHS clinical care team, nurse navigators, GP and other people or services who will be involved in providing on-going support in the home and community are involved in the discharge planning and development of a care plan. *Examples from NZ include START team in Waikato and CREST team in Canterbury DHB*	**HHS (Lead)** **PHN HPIT and PHC Team (Partner/lead)** Universities and research bodies (Support) Involve: HHS staff (Clinical, Nurse navigators); Short Term Restorative Care, Transition Care Program and ACAT staff; GPs; Family	Partnership & Collaboration Investigation	Short

Action no.	Strategy (high level) / action/s	Who responsible / key players (e.g. lead, support etc.)	Method (for PHN)	Priority *(short, medium, long)*
2.6.2	**Extend the scope of PHN in-reach mental health services to RACFs** to include providing support to people who are transitioning into long term residential care, grief & loss counselling (e.g. social worker FTE) and explore sustainability solutions to ensure long term sustainability of the program	**PHN MHAODs team (Lead) and Business development** RACFs Commissioned service provider/s	Procurement	Medium

Strategic Priority 3: Equitable access to systems for long term care and respectful end of life is available for people that need it

Action no.	Strategy (high level) / Action/s	Who responsible / key players (e.g. lead, support etc.)	Method (for PHN)	Priority *(short, medium, long)*
Older people with high and complex needs are able to live as independently and actively as possible with access to integrated care and support where their needs are known				
3.1.1	**Work with RACFs, GPs and the HHS to co-design solutions that support and increase PHC in-reach services into RACF** (PHC services like GP, MH etc.). such as: *Ongoing* - Continue to undertake stakeholder engagement to determine locally relevant and achievable strategies to improve access to Primary Health Care - Continue to facilitate discussions between facility management, visiting GPs, QAS, pharmacy and other visiting clinicians within individual facilities to create solutions - Support GPs to access MBS billing items, as well as identifying advocacy and reform opportunities to Federal Government – links with Action 4.4.1 *Potential short term solutions* - Co-design and deliver local based solutions / models - Promote alternate services which offer General Practice support to RACF residents in areas where local providers are lacking or at capacity - Support/enhance/expand RASS into RACFs - Implement models such as adapting the 'GywSI Model' (GP with Special Interest) for increasing GP workforce into RACFs - Partner with RACFs to ensure they have comprehensive out-of-hours care plans and arrangements in place *Note – also aligns with Action 2.6.2*	**PHN CST team (Lead) with PHC and GPLO support** Partners: RACFs; GPs; HHS; PHN Clinical Council; Peak bodies (RACGP, ACRRM etc.)	Partnership & Collaboration Potentially procurement	Short
3.1.2	**Work collaboratively across the health care system to support effective clinical handover and communication between primary and acute/secondary care** through: *Ongoing* - Continuing to deliver the Clinical handover *Yellow Envelope* trial on the Sunshine Coast, and consider the feasibility of scaling the program up across	**HHS (lead)** **PHN (lead)** RACF (partner) ADHA (partner / support)	Partnership & Collaboration	Ongoing – Short

Action no.	Strategy (high level) / Action/s	Who responsible / key players (e.g. lead, support etc.)	Method (for PHN)	Priority *(short, medium, long)*
	the PHN. *The Yellow Envelope is a paper-based tool which to assists residential aged care facilities (RACFs) and acute care services to transfer quality resident/patient information in a timely manner.* *Short* - Supporting medication management in residential aged care facilities (RACFs) and the adoption of the National Residential Medication Charts (eNRMCs) - Promoting the adoption and use of My Health Record in RACFs, GPs and Hospitals - Supporting digitalisation of the transmission of electronic transfer of care information between different care settings (and upskilling / capacity building of staff to utilise these systems)	Peak bodies e.g. Pharmaceutical Society of Australia (Partner / support)		
3.1.3	**Explore strategies to better provide and integrate GPs and Geriatric specialist care for older people, such as through:** - Establishing and/or promoting local helpline type services to better link GPs to GERI support when they need it - Provision of GP education in specific topics of geriatric care - Ensuring Health Pathways are up-to-date with local referral pathways and clinical information	**PHN PHC Team (lead/facilitate)** with HPIT support for evaluation **HHS (lead/partner)** Partners: GPs; PHN Clinical Councils; GPLOs	Investigation	Ongoing – Short
3.1.4	**Work with RACFs, HHS and other key partners to explore developing and implementing an integrated, evidence-based model for screening, assessing, managing and supporting older people with behavioural and psychological symptoms of dementia and other mental illness** by: a) Supporting the workforce to utilise agreed cognitive screening tools to enable early diagnosis, timely and appropriate management, and supporting referral pathways b) Exploring feasibility non-hospital based models of care and support and facilities such as memory clinics (long term action) and models/strategies to build capacity of RACF staff and families to better support/manage loved ones	**Leads: HHS; RACFs** **PHN CST team (Drive/ facilitate co-design), Business development** Partners: Thompsons Institute; Dementia Australia; Queensland Health; Peak bodies	Partnership & Collaboration	Med – Long
3.1.5	**Explore opportunities to improve access to assistive technologies and local support for older people with disabilities or with restrictive functional capacity**	**PHN Business Development (drive exploration component)** Partners: NDIS; Supported living agencies; Allied health providers; Vision Australia and other key organisations	Investigation	Medium – Long

Action no.	Strategy (high level) / Action/s	Who responsible / key players (e.g. lead, support etc.)	Method (for PHN)	Priority *(short, medium, long)*
3.1.6	**Explore co-designing and piloting a Hospital in the Nursing Home (HiTNH) model of care in residential aged care facility** to support and build capacity of facilities and their staff to care and manage clients within the home (to reduce unnecessary transfers)	**Clinical Excellence committee (Lead)** PHN (facilitate / support) Partners: HHS; RACFs; Peak Bodies; Queensland Health	Investigation Partnership & Collaboration	Long
	Also see Actions 2.5.3, 1.4.1 and 1.4.2 for other strategies to strengthen and improve referral pathways and follow up			
Older people with high and complex needs and their carers have information and freedom to make informed choices about their care, have care plans in place and know that health care workers understand and support their wishes				
	See Action 1.5.1 for strategies to enable conversations and decision making around heath care and choices; and see Actions under Strategic Priority Areas 1 and 2 around health literacy and navigation			
Families and carers (paid and unpaid) have the support, information and training they need to assist older people with care needs, including dementia, and are supported in caring for their own health and wellbeing				
3.3.1	**Support the development of nationally-consistent aged care and dementia referral pathways using the Health Pathways platform** to support health professionals to provide advice, referrals and connections for senior Australians into local health and aged care services. Including the development of: a) dementia specific Health Pathways with guidance from Dementia Australia, for use by clinicians during consultation b) consumer-focused dementia support pathway/resources which will detail support available for people living with dementia, and their carers and families. **Continue to enhance and promote health pathways for dementia to support primary care providers** to manage symptoms and conditions and when needed integrate with other community and hospital services. *Links with Action 3.1.4	**PHN CST team and PHC team (Lead)** with HPIT support for evaluation Dementia Australia (support)	Provide	Short
3.3.2	**Work with Dementia Training Australia to provide training and education on dementia** to PHC workforce (including carers, general practice and the aged care workforce including CHSP, HCP, Respite, RACF and Independent Support Wokers) and community	**DTA (Lead)** PHN (support/partner)	Procure	Short
Health care and support teams respond to older people's goals, care and cultural needs at the end stages of life and the experiences of their family, caregivers and friends so people die feeling as comfortable and safe as possible in their place of choice				
3.4.1	**Partner with our 3 HHS Specialist Palliative Care in Aged Care (SPACE) teams to provide resources, linkages, and education to RACFs** with the aim of working	**HHS (lead)** PHN CST team (partner, support, facilitate)	Partnership & Collaboration	Ongoing

Action no.	Strategy (high level) / Action/s	Who responsible / key players (e.g. lead, support etc.)	Method (for PHN)	Priority *(short, medium, long)*
	toward a coordinated and sustainable approach to enhancing the end of life experience for those at end of life within the residential aged care setting	RACFs (partner) Existing resources through ELDAC, PallConsult (Metro South HHS) and Qld Health		
3.4.2	**Promote the advance care planning and enduring power of attorney initiatives and information to primary health care professionals across the region via PHN communication channels,** including GP Matters, PH Matters, RACF forums, GPLO networks and forums, Health Pathways etc.	**PHN – PHC team (Lead)** with CST and Comms support Office of Advance Care Planning (support/partner) Seniors Legal Services (support/partner)	Provide	Ongoing
3.4.3	**Continue to support the development, implementation and sustainability of Compassionate Communities models across our PHN**, , including: - Partnering to provide training and education for community members who wish to be a part of the model - Partnering to facilitate an ongoing Community of Practice for community connectors, and - Leading consultation and processes to work toward embedding the model as a sustainable community asset *Compassionate Communities are a core part of public health approaches to palliative care, end of life care and bereavement. The term describes communities which play a much stronger role in the care of people at end of life, their families and their carers, through illness, dying, death and bereavement. The Community Connectors model facilitates this through activating everyday citizens to draw upon their knowledge of local services and groups to be able to "signpost" people and families experiencing end of life and facilitate dialogue about dying and death.*	**PHN CST team (Lead / facilitate)** Partners: Lead Connectors – community members; The Groundswell Project HHS physicians and specialists, Hospice and community care palliative care providers, home care workers (support) Training providers/Peaks (such as OACP, PEPA, ELDAC, COTA Qld) (support and training)	Procurement	Ongoing
3.4.4	**Work with the HHS to deliver programs which allow clinicians with and role/interest in end-of-life care the opportunity to expand their knowledge and skills in the palliative approach**. This should also include specific upskilling on caring for Indigenous people in a culturally responsive manner at end of life.	**HHS (Lead)** Program of Experience in the Palliative Approach (Support/Partner) PHN (support/partner) Other partners: GPs; ACCHOs	Procurement Partnership & Collaboration	Ongoing

Action no.	Strategy (high level) / Action/s	Who responsible / key players (e.g. lead, support etc.)	Method (for PHN)	Priority *(short, medium, long)*
		Existing resources through ELDAC, PallConsult (Metro South HHS) and Qld Health		
3.4.5	**Support trauma-informed aged care services, to ensure that people and their families have respectful and dignified end of life care and experiences, including:** - Creating culturally safe trauma-informed care (or use existing resources) - Scoping the availability of local resources and activity in the grief and bereavement space, including bereavement pathways that support family, carergivers and friends after the loss of a loved one - Identifying potential partnerships to promote the availability of these resources and opportunity to build upon existing resources where equity gaps are noted.	**Indigenous partners, churches, CALD groups (Lead)** PHN (support/facilitator) and Qld Palliative Care Clinical Network (newly formed)and Qld PHN Pall Care Community of Practice Partners: USC/university; Peak bodies for CALD and LGBTIQ+ Australian Centre for Grief & Bereavement (support)	Partnership & Collaboration Investigation	Short – Med
3.4.6	**Partner with and support hospices and hospice establishment committees across our region to provide access to patient centred, coordinated care for individuals at end of life in communities** through supporting care coordination, integration, workforce development, training and community involvement.	**Hospice establishment committees and Hospices (lead)** PHN CST PAL team (partner, support, facilitate) Community (partner)	Partnership & Collaboration Procure	Ongoing – Short *Noting actions from committee may be longer term*

Strategic Priority 4: The aged care system is progressive, sustainable and equitable through integrated and continuous system improvement and the aged care sector and workforce is valued and recognised

Action no.	Strategy (high level) / Action/s	Who responsible / key players (e.g. lead, support etc.)	Method (for PHN)	Priority *(short, medium, long)*
Healthy ageing outcomes are defined and monitored, and programs evaluated to ensure quality health care for older people in the PHN region				
4.1.1	**Use data to inform ongoing planning and targeted investment**, by: - Developing key indicators for assessing healthy ageing across the region and develop processes for ongoing monitoring, evaluation and improvement of routine care delivered with older people. - Undertaking key data collection activities with regional and local stakeholders to better understand the diversity and their common needs, attitudes, opinions, solutions.	**PHN (Lead)** Queensland Health (partner) Local Government (Partner) Department of Health	Provide	Short
4.1.2	**Contribute to the evidence base and build a strong research culture and identity in care of older people through enhance existing and build new partnerships with universities, research institutes, hospital partners, service providers and older people their carers and family to build.** **Actions may include:** a) Undertaking evaluation activities of individual programs and communicating findings to add to the evidence base b) Partnering with universities and other training organisations to provide PHC staff training in skills related to research and quality improvement c) Supporting engagement between research groups and older consumers and their carers to inform research priorities, design and conduct and assist in public dissemination of findings d) Supporting involvement of older people, their carers and family in the co-design of service improvements. * note – Action a) requires establishing processes and mechanisms internally at PHN to communicate and disseminate findings (publications, presentations, media etc.)→ Link to PHN Research Strategy and to Comms ** Note – these actions also require governance relating to ethics approval etc.	**Universities (Lead)** PHN (partner) with support from PHN research collaborative COTA Qld (support)	Provide or Partner	Ongoing Short term / high priority
4.1.3	**Drive localised research opportunities which have breadth and depth to comprehensively inform healthy ageing agenda**, including the roles of council, state, federal, non for profits, charities, universities, peak bodies, and other social and community groups. Prioritised research needs arsing from this Strategy include:	**Universities (Lead)** **SCHI (Lead)** PHN (partner) Other partners/support: COTA Qld	Partnership & Collaboration	Ongoing/short

Action no.	Strategy (high level) / Action/s	Who responsible / key players (e.g. lead, support etc.)	Method (for PHN)	Priority *(short, medium, long)*
	• Age-friendly communities; enablers and barriers to healthy ageing • Models that address social participation and social isolation (intergenerational models/program, programs for hard to reach people, social prescribing models) • Social wellbeing and connection for informal home carers including family • Innovative models of service delivery or solutions to address barriers to accessing services and programs and social connections such as digital literacy and technology; care navigator/linker roles focussing on digital health • Developing innovative data driven solutions for managing and supporting people in community settings outside hospital • Models of integrated care that support preventative and management for older people with chronic and long-term conditions such as holistic group-based rehab programs across chronic conditions • Multidisciplinary home-based and/or community-based falls prevention programme/s or models of care (that aim to improve musculoskeletal health / prevention of frailty and falls, self-efficacy and capacity, reducing risk of fall or reducing harm from a fall etc.) • In-reach mental health services and models of care for residential aged care facilities • Non-hospital models of care for managing and supporting older people with behavioural and psychological symptoms of dementia and other mental illness • Early supported discharge of patient models • Healthy ageing Indicators and data linkage	Local Governments NGOs Primary health care providers		
The PHN is known for challenging cultures associated with ageism and leading the way in promoting healthy ageing outcomes in the primary health care sector				
4.2.1	**Inform and influence policy at all levels of government, strategy and processes** to continually improve health and wellbeing outcomes and care for older people and support integrated health systems and services - Advocate for policies that drive population health approach to physical activity and healthy lifestyles - Influence and advocate for appropriate provision of infrastructure in urban planning, design and development to support healthy ageing - Review internal organisational HR processes within PHN for older workers to ensure flexible work arrangements such as part-time positions, in partnership with other government agencies.	**PHN Executive in partnership with Peak bodies (ESSA, DAA) (Lead)**	Advocacy	Ongoing - Short

Action no.	Strategy (high level) / Action/s	Who responsible / key players (e.g. lead, support etc.)	Method (for PHN)	Priority *(short, medium, long)*
4.2.2	**Support active participation of older people in the design of the health sector by including older people, their families and carers in the planning, design and delivery of initiatives, services and actions in this Strategy, including:** - Developing a consistent approach and framework for PHN to enable this to happen in practice - Mapping existing seniors groups and consumer groups that PHN can link into	**PHN Executive, CST and HPIT Team (lead)** COTA (support)	Provide	Short
Primary health care systems are oriented around intrinsic capacity and functional ability, and foster integration and multi-sectoral action in the health sector and across agencies				
4.3.1	**Work collaboratively with key partners and stakeholders to develop a united strategic action plan for falls** (for example working with HHS, Local Government and other key stakeholders to develop a whole of region Falls Strategy) and support roll out of new and current local initiatives (current initiatives include the Falls Prevention Service Referral Pathway initiative led by the Fraser Coast Falls Collaborative and the Lifestyle Cafes with Active at Home).	**PHN HPIT and CST Team (drive/facilitate/partner)** **HHS (lead/partner)** Local and State Government (lead/partner)	Partnership & Collaboration	Long (current initiatives – ongoing)
4.3.2	**Drive reform of PHC to focus on intrinsic capacity of older people across all forms of functionality** with a focus on upstream prevention that integrates social and health outcomes holistically and across the lifespan - Drive change and build capacity of the PHC sector in adopting strength-based approaches to functionality, wellness and reablement (focusses on what works, what we can do, maintaining/improving function, addresses ageism such as removing use of language such as frail/vulnerable that creates stigma and devalues people) - Support / upskill the PHC sector and workforce in skills such as motivational interviewing, strength-based approaches to care, as well as working with education institutions to ensure accreditation processes reflect these skills and emphasis multi-disciplinary approaches to health care for older people - Engage with and advocate to education institutions of disciplines such as urban planning and development to reinforce role of built environments in supporting functionality and enabling active healthy ageing in community	**PHN Executive & senior leadership team (lead)** In partnership and/or through peak and professional bodies PHC sector (including general practice, allied health, pharmacy, home care, RACFs, community services)	Advocacy Provide	Medium
4.3.3	**Continue to facilitate the palliative care interagency forums to create an opportunity for broader collaboration** between health sectors and peak organisations who provide services, education, training and resources in	**PHN CST Team (lead/facilitate)** HHS (support) Peak bodies/training (support)	Provide Partnership & Collaboration	Ongoing

Action no.	Strategy (high level) / Action/s	Who responsible / key players (e.g. lead, support etc.)	Method (for PHN)	Priority *(short, medium, long)*
	Palliative and End of Life care and for shared learnings across the 3 HHS areas within our PHN. Members of these forums will provide advice and support for the coordination of palliative care across primary, secondary, tertiary and community health services to support at home palliative care for those that choose it			
4.3.4	**Continue to facilitate the PHN led RACF forums to create an opportunity for collaboration and shared learnings** between residential aged care providers, HHS support services (ie. RASS/GEDI), training services, and peak bodies. These forums should provide: - a community of practice between RACFs - a platform for residential and community aged care providers to discuss needs and challenges - an opportunity for RACFS to network/gain support. - a platform for the PHN to be able to provide updates and test ideas for commissioning/project work with frontline workers in the Older Person's Health space. - An opportunity for HHS's, state based services, national peaks and other key players to provide updates on referrals, training and support available for RACF workforce.	**PHN CST Team (lead/facilitate)** HHS (support) Peak bodies/training e.g. COTA Qld (support)	Provide Partnership & Collaboration	Ongoing
4.3.5	Continue to attend meetings of the Levels of Government Healthy Ageing Action (LOGHAA) on the Sunshine Coast to map healthy ageing activity across government sectors and identify opportunities for collaboration, co-designing and resource sharing.	**SCHHS and Local government (lead/facilitate)** PHN CST team (partner)	Partnership & Collaboration	Ongoing - short
Sustainable and appropriately qualified age care workforce exists to support our ageing population into the future and raising the profile and recognition of people who work in aged care will help potential workers choose aged care as a career pathway				
4.4.1	**Advocate to the Federal and State governments for change in wages and workforce support for the aged care workforce/sector (including the home care sector like cleaning, allied health services, general practice in RACFs etc.)** - Work with peak bodies and agencies such as AMA, AGPAL, RACGP, Universities to inform and influence policy at all levels of government. - Advocate for the Australian Federal Government to review funding models, MBS billing and relevant industry awards and update Australian	**PHN Executive (lead/partner & advocate)** Partners: Universities and educators (partners/supports/leads); Peak bodies (allied health: DAA, ESSA etc.; Medical: AMA, AGPAL,	Advocacy	Short - Med

Action no.	Strategy (high level) / Action/s	Who responsible / key players (e.g. lead, support etc.)	Method (for PHN)	Priority *(short, medium, long)*
	government policies to ensure remuneration is equitable, reflects the complexity of care and is more attractive. - Identify, understand and promote the role and value of self-regulated allied health professionals such as exercise physiologists and dietitians for supporting healthy and active lifestyles and re-enablement and work with peak bodies to strengthen their role in support healthy ageing for their discipline	RACGP etc., Aged care: LASA, COTA QLD etc.); ACCHOs		
	See Action 2.5.5 under Strategic Priority 2 for strategies to promote the aged care workforce as a speciality and a discipline of value and support career pathways in aged care sector. Also see Action 2.5.4 - for strategies for targeting workforce shortages in areas of need (under Strategic Priority 2)			

Wish-list

The following actions were identified during consultation and research. While these are out of the immediate scope for this Strategy, they are listed here as additional opportunities and considerations for the future:

1. Training and capacity building opportunities around mental health and wellbeing for older people to relevant stakeholders including all carer types (especially community based, volunteers and informal workforce/carers)
2. Initiatives or opportunities that provide mental health support and social connection for residents in residential aged care
3. Community-led strategies and initiatives focussing on learning in the third age
4. Community development approaches to address housing insecurity and homelessness issues locally
5. Opportunities and initiatives that enable people to increase safety, accessibility and liveability of their homes as they age
6. Creative communication / health communication messaging, as well as to promotion of local services through effective and preferred communication mediums and methods
7. Development of shared workforce strategy between secondary/acute and primary health sectors (to enable a sustainable workforce and support workforce management)
8. Establishment of a specific regional strategy for capacity building and support of informal (unpaid) workforce (family, volunteers)
9. Supporting existing initiatives and/or exploring new opportunities to address technology / digital literacy barriers to access and support improving digital literacy and confidence
10. Supporting earning in the third age initiatives including advocacy opportunities for supporting older workers in the health workforce

6. Appendices

Appendix 1: Strategic context and alignment

1.1 PHN Strategic context

The health and wellbeing of older people is identified as a key priority in the PHN Strategic Plan 2021[1] (www.ourphn.org.au), with a vision to build healthier communities through connecting older people to services that keep them healthy and active at home. The PHN currently commission a range of health activities and services to improve health outcomes for older people across the various funding schedules we receive.

However, significant developments across the sector continue to have further implications and relevance for these efforts. At the national level, a key acknowledgment of the recent Aged Care Royal Commission was that more investment was needed to ensure senior Australians were treated with respect, care and dignity and had access to quality care as they aged. While the Royal Commission's Final Report[2] recognised the effort of nurses and carers, it further highlighted the current challenges faced by aged care services. The report also highlights the essential role of person-centred approaches that support older people to manage their health and wellbeing and to engage effectively with the health and aged care sectors when required.

The Government, using the report's recommendations as a roadmap to reform, has thus committed to transforming aged care, investing an additional $17.7 billion to improve quality care and increase viability in the sector, by which PHN's will play a key role.

The national five year – five pillar aged care reform plan addresses:

1. Home care – at home support and care based on assessed needs including investments in home care packages, home care and respite services and support for navigating the aged care system
2. Residential aged care services and sustainability – improving service suitability that ensures individual care needs and preferences are met
3. Residential aged care quality and safety – improving access to and quality of residential care
4. Workforce – growing a bigger, more highly skilled, caring and values-based workforce;
5. Governance – new legislation and stronger governance

This context provides a significant opportunity for PHNs to deliver coordinated responses to enhance integration of health and aged care services within their regions and to contribute to improvements in the health and wellbeing of older people.

1.2 Broader Policy Context

Understanding the implications of the current demographic shift, as well as the epidemiological transition, is crucial to societies preparing to serve an ageing population. In response, a number of international, national and state policy documents and frameworks have been developed around the world, which have informed the development of this Strategy (see Figure 2).

International - The Decade of Healthy Ageing

With the COVID-19 pandemic impacting older persons more severely, this has highlighted the seriousness of existing gaps in policies, systems and services. Thus, a decade of concerted global action on healthy ageing has been urgently prioritised internationally to ensure that older people can fulfil their potential in dignity and in a healthy environment.

The United Nations General Assembly declared 2021-2030 the Decade of Healthy Ageing[3], creating a global collaboration of governments, civil society, international agencies, academia, the media, and the private sector to improve the lives of older people and their communities. The main strategy is based on previous guidance from the WHO[4] and addresses four areas for action: age-friendly environments, combatting ageism, integrated care, and long-term care.

National – Improving Aged and Palliative Care
As aged care services are a Commonwealth Government responsibility, there is a significant body of national policies and strategies governing this sector.

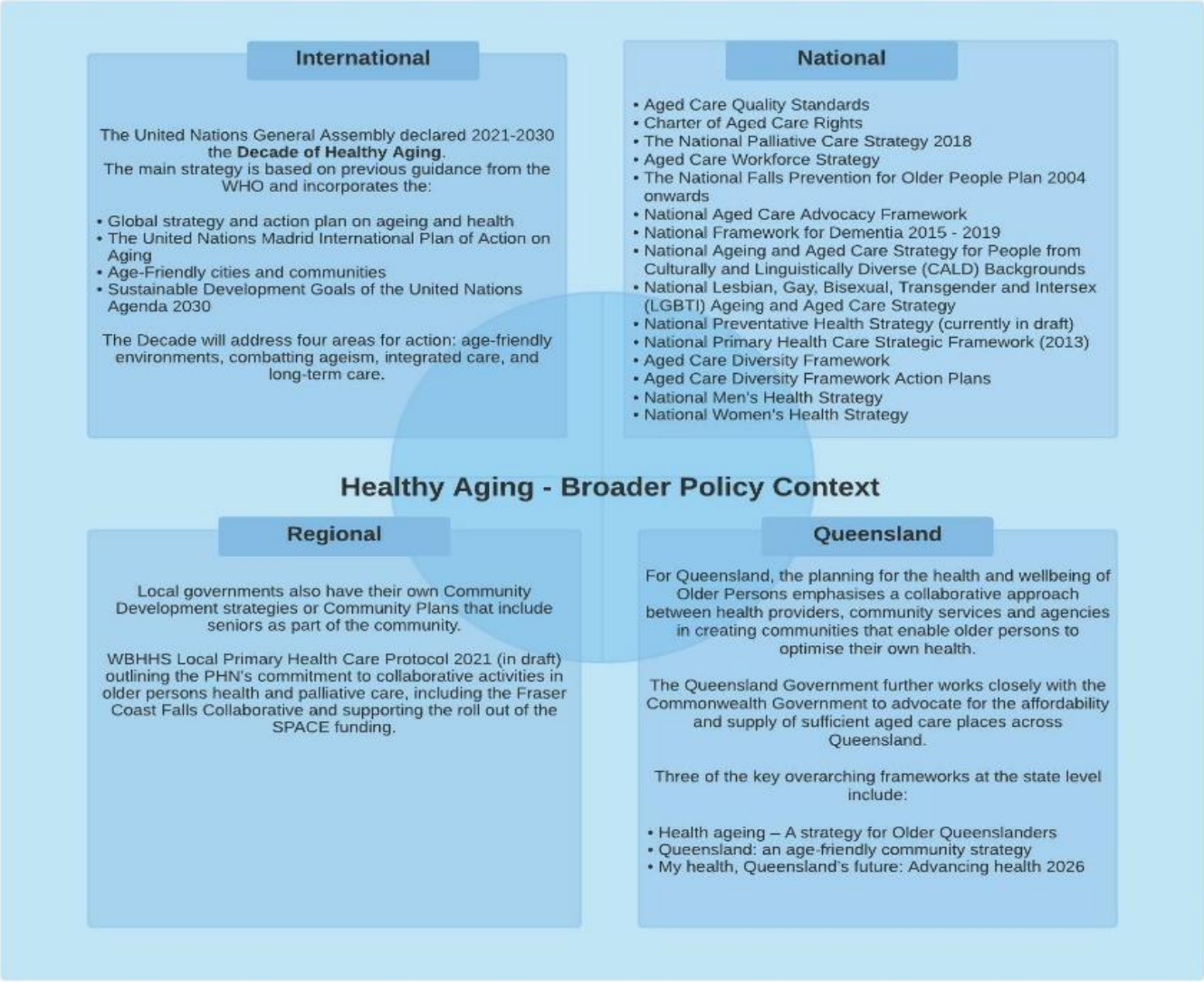
In addition, the National Men's Health Strategy[5] and the National Women's Health Strategy[6] both identify healthy ageing as a priority area, aiming to provide a gender-specific approach to health activities and to guide the development of new and innovative policies and approaches addressing the specific health needs of men and women in Australia. The Strategies work in tandem with each other and acknowledge the different biological and societal factors that impact women's and men's health and wellbeing, aiming to strengthen and improve national approaches for both.

Queensland – Creating age-friendly communities
For Queensland, the planning for the health and wellbeing of Older Persons emphasises a collaborative approach between health providers, community services and agencies in creating communities that encourage and enable older persons to optimise their own health.

The Queensland Government further works closely with the Commonwealth Government to advocate for the affordability and supply of sufficient aged care places across Queensland. Three of the key overarching frameworks at the state level include: Health ageing – A strategy for Older Queenslanders [7]; Queensland: an age-friendly community strategy [8]; My health, Queensland's future: Advancing health 2026 [9]

Regional / Local policy context
At the local level, local governments have their own Community Development strategies or Community Plans that include seniors as part of the community. The Hospital and Health Services (HHS) also have local and regional plans that provide direction for action in aged care, such as the WBHHS Local Primary Health Care Protocol 2021 (in draft) which outlines the PHN's commitment to collaborative activities in older persons health and palliative care, including the Fraser Coast Falls Collaborative and supporting the roll out of the SPACE funding.

Figure 2. Summary of broader policy context



Appendix 2. Context and strategy framing

2.1 The PHN region context

The Central Queensland Wide Bay Sunshine Coast PHN is home to a diverse and large footprint, servicing a population of over 976, 789 people[1] and covering twelve local government areas, varying across a diverse geographic region of 161,108km².

In terms of older persons, the proportion of the population aged 65 years or over for the PHN region was 21% as of 30th June 2020, higher than the state-wide average of 16%. Furthermore, more than 20% of the population were aged 65 years or over in seven out of twelve local government areas (LGAs). Additionally, population projections in the region indicate a growth rate higher than the state average in the over 65 years age group, with the number of older people residing in the PHN area forecasted to double to 300,000 by 2036.

Thus, with a growing and ageing population, regional health care providers are seeing an increasing number of older people presenting for health care with many receiving care for complex conditions and, in many cases, more than one—referred to as co-morbidities. Likewise, many older people accessing health care are frail and are particularly vulnerable to rapid deterioration of health.

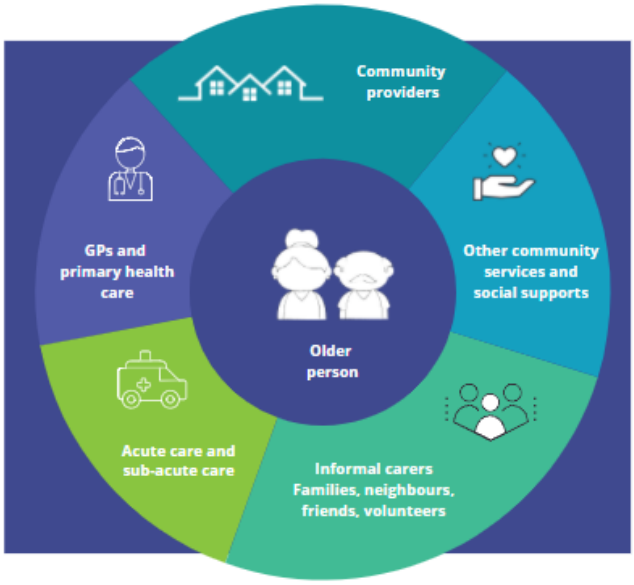
2.2 System and service landscape

The consumer journey in the aged care system spans across primary care, community and hospital service settings, as well as the community and social sector (Figure 3). The role of carers, and in particular informal carers including family and volunteers is a crucial piece of the puzzle, and will continue to be an important component of the aged care system relied on into the future.

Whilst the region has a comprehensive range of public, private and non-government health and aged care services available, the services are not distributed equally and the mix and breadth do not always align with local health need. The health service system is challenged by increasing demand for services, shared and often differing boundaries between sectors (local government, health, education), competing policy reform agendas, different funding models, poor service relationships, workforce shortage issues, service duplication and fragmentation and increasing costs. In addition, the PHN region covers a large geographical footprint, with many diverse rural and remote communities as well as diverse ethnic and culturally linguistic populations.

PHNs are embedded within their local communities to act as planners, commissioners, and integrators for primary health care services for their region.[2] PHNs have a particular focus on vulnerable populations – the people most likely to miss out on the opportunity to access and engage with health and aged care services due to having fewer resources. This places PHNs in a strong position to contribute to improving consumer journeys into, within, and between the health and aged care systems for those most in need .[2,3]

Figure 3. System and service landscape of aged care in the PHN region



Underpinning the work of PHNs to support the system and service landscape are a number of key enablers.[2,4] These enablers are also relevant in the delivery of this Strategy, and include:

1. Governance – Effective and inclusive governance that facilitates a coordinated approach from planning to evaluation
2. Relationships and alliances – Ensuring relationships within and across sectors, and all levels of government, business and community
3. Health and system intelligence – Embedded data to support commissioning, drive continuing quality improvement and demonstrate consumer experience and outcomes
4. Investment and financing – Adequate investment that leverages existing funding and reflects the integrated nature of care
5. Freedom to innovate – Autonomy to adapt system elements to meet regional need, consumer expectation, reduce barriers and eliminate perverse incentives

2.3 A framework for defining and addressing health and wellbeing of older people

A significant challenge for most contemporary health systems around the world is adapting to meet the needs of ageing populations. While increased longevity positively reflects improved life expectancy outcomes, the phenomenon itself has significant impacts for the health system and wider community services sector.

In Australia, “older persons” are often defined as people aged over 65 years for non-Indigenous or 55 years for Aboriginal and Torres Strait Islander people. However, this definition, with its emphasis on chronological age, fails to acknowledge the diversity of experience that defines the navigation of the later years of life.

Older people are by no means a homogenous population group, nor do they become 'old' at an exact point or in the same way. Whilst some older people remain both physically and mentally independent, others are impacted by long-term or chronic health conditions or disabilities, with these needs complicating as they age. Others may develop conditions and become dependent later in life, due to cognitive and physical decline, or conditions such as dementia.

We therefore recognise that as people age, care requirements often become more complex and the likelihood of having multiple chronic illnesses, frailty and disabilities grows. Healthy ageing is therefore the process of developing and maintaining the functional ability that enables wellbeing in older age. Functional ability includes the intrinsic capacity of the individual (both mental and physical) and reflects the ongoing interactions between an individual and the environments they inhabit.

Defining health and wellbeing of older people in the context of the PHN and population planning therefore requires applying a whole-of-society approach to healthy ageing. This involves applying a life-course lens to health and wellbeing, with a greater emphasis on preventative health and addressing the social determinants of health.[5] Communities also need to be strengthened to provide integrated services and supports to older adults that are tailored to individual needs.[5]

Furthermore, healthy ageing is not simply defined as the absence of disease but is influenced by a range of environmental, social and behavioural factors. Health care that considers and manages the complex needs of older age in an integrated way has been shown to be more effective than services that simply react to specific diseases individually.[5] Approaches based on functioning can also be useful in framing a public-health response to population ageing.

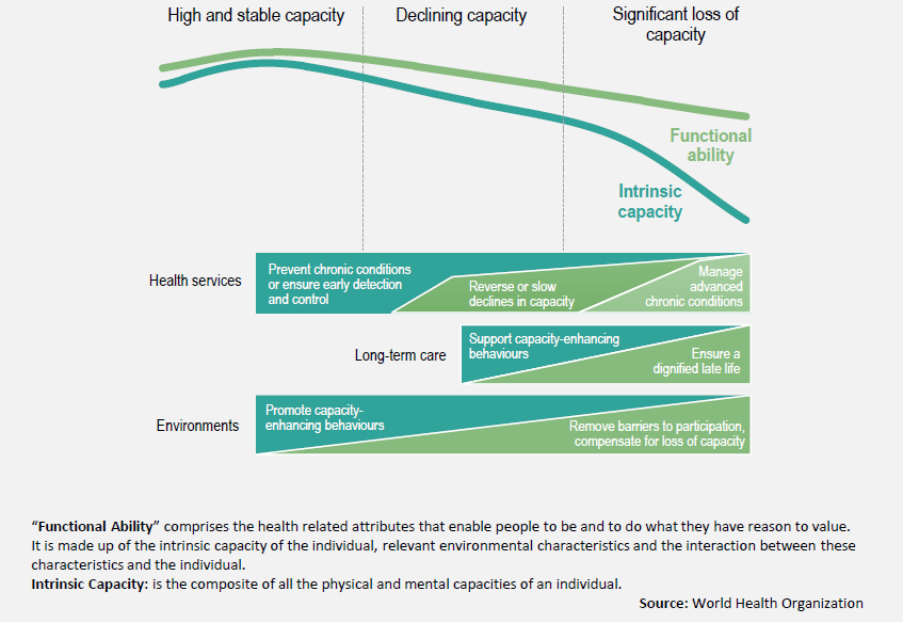
Therefore, in developing the *Ageing well in our region: A Healthy Ageing Strategy 2021 – 2028,* we have applied a functional life-course approach in which to view ageing and health and wellbeing of older people and in which to frame our responses and actions.

A functional life-course approach

The World Health Organisation has developed a public-health framework for healthy ageing which provides a lens to inform public-health response and actions.

- The framework considers health from the perspective of an older person's trajectory of functioning rather than the disease or comorbidity they are experiencing at a single point in time.
- It is couched within the understanding of the role of the wide-ranging contextual factors and environmental influences that impact health (and health in older age)[5,6]
- It also considers the concept of diversity, meaning there is no 'typical older person' and the variability we see in people in older age is a result their own unique interaction with the environments they have experienced across their lives, and the accumulation of those experiences over time that influence into older age.

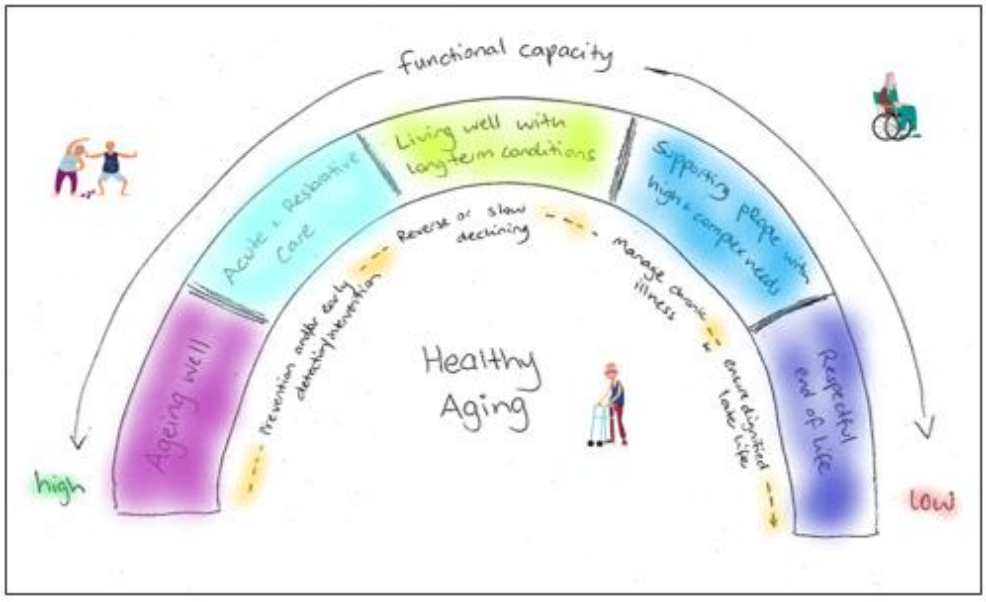
Figure 4. Public health framework for healthy ageing (WHO)[5]



The WHO framework can be applied to the Primary Health Care (PHC) context as a means for the PHN to frame ageing and how we might address the needs of older people in our communities and achieve optimal outcomes. PHC, as defined by WHO and UNICEF, addresses the broader determinants of health and focuses on the comprehensive and interrelated aspects of physical, mental and social health and wellbeing.[7] It provides whole-person care for health needs throughout the lifespan, not just for a set of specific diseases. PHC ensures people receive quality comprehensive care - ranging from promotion and prevention to treatment, rehabilitation and palliative care - as close as feasible to people's everyday environment.

The following illustration (Figure 5), demonstrates how the functional life-course approach and WHO framework can be applied to the PHC system context, along the continuum from health promotion and disease prevention to treatment, rehabilitation and palliative care. This framework forms the basis of this Strategy to inform strategic action.

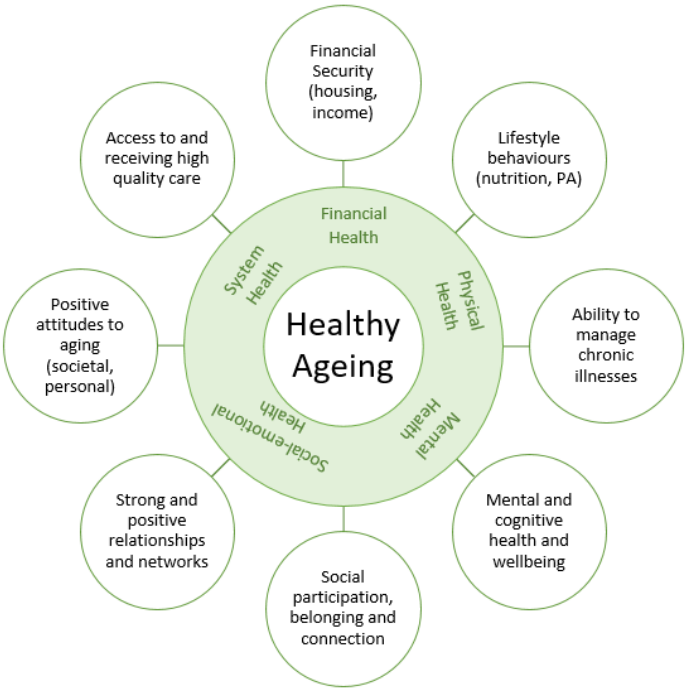
Figure 5. Applying the WHO framework to the Primary Health Care context



2.4 Determinants and indictors of health and wellbeing in older age

A literature review was undertaken to identify the indicators of health and wellbeing for older people, and the determinants (or causes) of poor health and wellbeing outcomes for this population group. There are a number of factors or 'ingredients' that contribute to healthy ageing outcomes. Key themes have been categorised under 5 overarching domains of health: physical, mental, social-emotional, financial and system health and were used as the basis for understanding the local needs of healthy ageing across the region.

Figure 6. Indicators of healthy ageing / "ingredients" for successful healthy ageing



Physical Health

Although ageing is associated with grade accumulation of molecular and cellular damage resulting in **biological changes**, it is important to note that this is not necessarily linear or consistent.[5] Exposure to a range of positive and negative environmental **influences across the life course** can influence the development of other health characteristics, such as chronic conditions, diseases, injuries and broader geriatric syndromes.[5] Further, healthy ageing is not necessarily a disease-free state but a focus on managing the increased risk of **multi-morbidity** (multiple chronic conditions). The impact of multi-morbidity on an older person's capacity, health-care utilization and costs of care is often significantly greater than what might be expected from the summed effects of each condition.[8]

Lifestyle behaviours across the life course likewise have a significant impact on healthy ageing outcomes. For instance, recent studies have shown that older adults who engage in high levels of total **physical activity** in later life have greater likelihood of ageing successfully ten years later.[9]

There is also a strong link between **good nutrition** and health outcomes for older people with healthy dietary patterns, such as the Mediterranean diet, associated with improved quality of life across a number of domains.[10] Nutrition has also been shown to be a factor in reducing the development of frailty syndrome in older adults[11] as well as the reducing incidences of cognitive decline.[12] There is also an emerging consensus that saturated fats and trans–fatty acids, as well as a **low**er **quality of sleep** throughout mid-life, may increases the risk of developing dementia.[13]

Mental Health

In later life, isolation, social connectedness, support mechanisms, and participation are all strong determinants of mental, social and emotional wellbeing and cognitive function. With dementia the second biggest leading cause of death in Australia, determinants that increase the risk of it developing include depression[14], family history of the disease, intellectual disability as well as comorbid and mixed pathologies[15]. Further, there is a well-established link between higher levels of education and a lowered risk of Alzheimer's dementia[15], with low occupational complexity conversely associated with a higher risk of developing dementia in later life.[16]

In addition, links between adverse mental health and certain medical conditions have been established, with adverse cardiovascular profile[15, 17], head trauma[15, 16, 17], stroke[16], epilepsy[16], and hearing loss[18] all increasing risk. Furthermore, frailty[19] and impaired mobility[20] can also adversely impact mental health, as well as unresolved childhood stress and trauma.[16]

Social-Emotional Health

Closely connected to mental health, healthy social-emotional wellbeing in later life is significantly influenced by **strong and positive relationships and networks**. One of the biggest threats to social-emotional wellbeing is isolation and loneliness, which has a comparable risk factor for all-cause morbidity and mortality as smoking, lack of exercise, obesity and high blood pressure.[21, 22, 23] In addition, loneliness has been associated with decreased resistance to infection, cognitive decline and mental health conditions such as depression and dementia.[21]

Social isolation is further associated with **increased risk of elder abuse,**[5, 24, 25] with several dimensions contributing to its prevalence. Isolation renders elders more vulnerable to exploitation for psychological, emotional and physical reasons, and further allows abusive behaviour to often go undetected. Other risk factors include cognitive impairment and other forms of disability, as well as previous traumatic events, interpersonal and domestic violence and the perpetrator being in a position of financial, emotional or relational dependence.[5, 24, 26] Although prevalence data in Australia is lacking, the incidence of elder abuse continues to be a growing concern.[27]

Unsurprisingly, a strong social network and contact with family and friends thus often leads to higher scores of self-rated health, psychological well-being and life satisfaction for older persons.[28] Moreover, positive social connections result in lower incidence of major depressive symptoms and disorders, improved sleep quality and increased psychosocial wellbeing.[29] Thus, social participation has been described as the **'cornerstone' of successful ageing in place** among older adults, and especially for those in rural areas.[29, 30] Additionally, volunteering as a specific form of participation similarly has positive associations with healthy ageing, improving perceived health, life satisfaction, positive mood and reduced mortality levels among older adults.[29]

It is also important to recognise the impact of life transitions (e.g. retirement, relocation, death of friends/partner) on social relationships for older persons, which can impact support mechanisms, social participation and overall health. In developing a public-health response to ageing, it is important not just to consider approaches that ameliorate the losses associated with older age, but also those that may reinforce recovery, adaptation and psychosocial growth.[5]

Financial Health

Financial resources, including income and wealth, is an economic health asset important to healthy ageing.[28, 31] For example, insecure housing (e.g., renting vs owning own home) and being without car increases the risk of poor health, including reduced functioning, self-reported negative health and reduced life satisfaction outcomes.[31]

Further, it is recognised that multiple diseases increase the burden and cost of transportation, medication and the ability to lead a healthy lifestyle.[32] Affordability is a common issue facing older persons and can often be compounded by multi-morbidity requiring high health care use.[33]

System Health

Healthy ageing is reliant on older persons being able to readily access and receive high quality care. Much of the literature emphasises the need for better integration between health and social services,[34] addressment of workforce issues and improvements across quality and safety.

With access to and the usage of health care positively associated with improved health needs and outcomes, the **4 As of accessibility** detail the requirements of best service practice[32] below:

- **Availability and accommodation of services** including supply and demand; workforce capacity; wait times; after-hours services and appointments. Geographical location can also greatly influence availability or services[33]
- **Accessibility** including access to transport[33]
- **Affordability** including cost of services and ability to pay[32]
- **Acceptability** including cultural competency, inclusivity and actions against ageism

Appendix 3. Population data and community consultation

3.1 Health and social data

Our region is characterised by an ageing population. In general, most older people are living longer and in good health. However, some people continue to have poorer health and fewer opportunities for social and economic engagement.

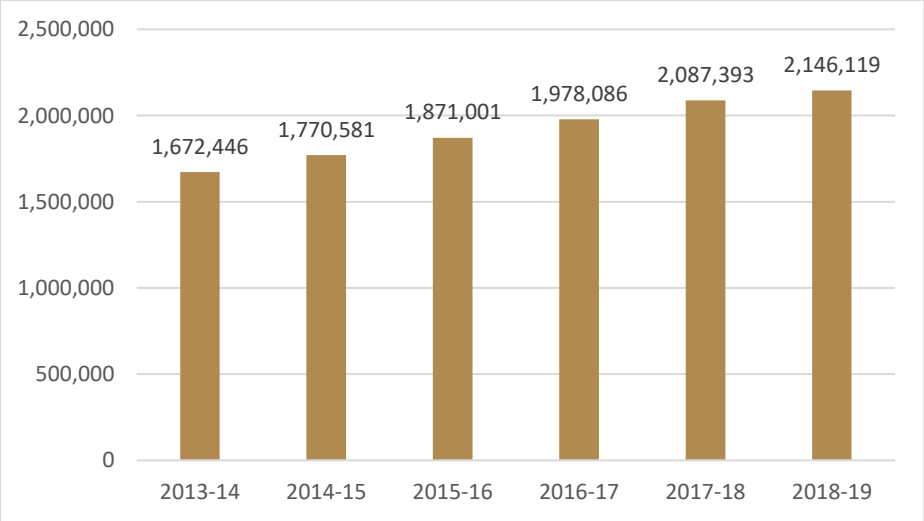
- Highest proportion of population of people aged 65 years and above is in Fraser Coast LGA (29%), Noosa LGA (26%), North Burnett LGA (25%), Gympie LGA (25%) and Bundaberg LGA (25%) while highest number of people aged 65 and above is in Sunshine Coast LGA (67, 050) followed by Fraser Coast (29,694) and Bundaberg (23,104).[1]
- The largest growth in older persons is anticipated to be in the Central Queensland area, with the population over the age of 65 projected to double (99%) and the population over the age of 85 expected to triple from 2016 to 2036. In the Wide Bay area, the population over the age of 65 is projected to increase 70% from 2016 to 2036.[2]
- At March 2021, 69% of those aged 65 years and over in the PHN region were receiving the Age Pension. Wide Bay region had highest proportion (76%) of 65+people receiving the age pension followed by Central Queensland (67%) and Sunshine Coast (65%).[3]

Table 1. Summary of key health and social characteristics and relevant population data

Health and social characteristic	Data
Ageing population	• The region has an ageing population that is expected to continue to increase by over a third in the next 15 years. At June 2020, there were an estimated 190,000 people aged 65+ years which is expected to grow to around 300,000 by 2036.[1] • The proportion of older people in the region is higher than the state average. At June 2020, 21% of the population were 65+ years compared with 16% across Australia. [1]
People are living longer	• Men can expect to live to around 81 years and women to around 85 years.[4]
Older people make a significant contribution to society	• 1 in 5 older people want to contribute to their communities and volunteer their time.[5] • 1 in 8 older people are in paid work or students.[5] • 1 in 5 older people provide care, with 1 in 3 of them being the primary carer.[5] • 1 in 7 older people provide unpaid childcare.[5]
Social determinants impacting on health	***Socio-economic disadvantage*** • 1 in 5 people aged 55+ years report age is a major barrier to finding a job or getting more hours of paid work.[6] • 2 in 3 older people live in low-income households (less than $756 per week). • 2 in 3 rely at least in part on the Age Pension and 1 in 10 has a Senior's Health Card for extra support.[7] • 1 in 4 live in poverty ***Housing & homelessness*** • People aged 55+ years represent almost 1 in 5 of the homeless population.[5] • 1 in 6 of all homeless people on Census night were aged 55 or over, which is an increase of 49% over the last decade[5] ***Ageism*** • 1 in 3 people aged between 55 and 64 years say they have experienced discrimination because of their age.[8] ***Accessibility, inclusivity and connectedness*** • Many communities are not easily accessible for older people.[9] • 1 in 5 older people were socially isolated prior to COVID; with older people in care facilities tending to be most at risk.[6] • Between 2% to 8% of older people are thought to experience elder abuse.[6] • 1 in 2 older people have low to no digital literacy; 3 in 4 are digitally disengaged, including in the use of online banking.[6]
Mental and social-emotional health	• 1 in 5 older people have a mental illness.[5] • The number of people with dementia is projected to double in the next 15 years, from 13,700 in 2016 to 27,000 in 2030.[5]

	• Older people are especially vulnerable to social isolation: research reveals that prior to the COVID-19 pandemic, one in five older Australians were socially isolated and that this was the major cause of loneliness and social exclusion amongst the elderly[6]
Physical health and functionality	• 3 in 4 older people have a long-term health condition; 3 in 10 have 3 or more.[10] • The greatest causes of health burden for older people are from heart disease, neurological conditions (e.g. dementia) musculoskeletal conditions (e.g. arthritis, back pain), and respiratory conditions (e.g. lung disease, lung cancer).[5] • 1 in 2 older people have some form of disability; for 1 in 5 it is severe affecting everyday activities requiring care.[11] • 1 in 2 older people who are primary carers of family members have some form of disability themselves and are often socially isolated.[6] • 3,700 older people in the region are frail and 14,200 are pre-frail which is expected to increase by about 20% over the next decade.[5] • Older Aboriginal and Torres Strait Islander people experience poorer health and have higher rates disability than other Australians of the same age: being almost 3 times more likely to need help with self-care, mobility or communication.[12]
Service usage and increasing demands on services	• GP attendances by older people have increased by 22% in the last 5 years across the region (prior to COVID) (Figure 6)[13]. • The number of GP visits to residential aged care facilities increased by 30% over the last 5 years.[14] • There were almost 80,000 emergency department presentations by older people across the region in 2018/19.[15] • 2 in 5 of all hospitalisations are for older persons which have increased by 29% in the last 5 years across the region (prior to COVID).[16] • 1 in 20 older people live in care accommodation; and 1 in 4 older people aged 85+ years.[17] • 3 in 10 older people use aged care services; 3 in 4 use in home care services.[17] • Residential aged care places per capita in the region are less than Australian average; 64 compared with 74 places per 1,000 population aged 70+ years.[18]
Impact of COVID	• Mental health (particularly loneliness, depression and anxiety): 1 in 10 older people reported experiencing high or very high levels of psychological distress in June 2021[19] • Physical health (through loss of fitness and mobility)[20] • Rental stress (social housing and private market) risking homelessness[20]
Priority groups	• Within the Aboriginal and Torres Strait Islander population in the PHN, 15.3% of Aboriginal and Torres Strait Islander people are aged 50 years and older[1] • Older people who identify as LGBTIQ+[21] • Older people from culturally and linguistically diverse backgrounds[21,22] • Older people living in rural and remote communities[22] • Vulnerable people in community including veterans, widows/singles, people with disabilities and people in residential aged care[21]

Figure 7. Numbers of GP attendances by people 65+ years have increased across the region by 22% in the last 5 years



3.2 Consultation – what is our community telling us

During July to August 2021, a broad community and stakeholder consultation process was undertaken. The purpose of the engagement and consultation was to gain an understanding of the key needs and issues facing our seniors across the region, as well as what is most important to people to support healthy ageing and what opportunities exist to improve outcomes for seniors. This feedback and insights were invaluable in developing this strategy and the Action Plan - as hearing and understanding what is important to people as they age will shape what we do and focus on.

A number of community and stakeholder engagement activities were undertaken including:

- Semi-structured interviews with key stakeholders representing a broad range of organisations and service areas across the health and social sectors
- Online survey of providers and community members (disseminated via interagency networks consisting of community organisations, service providers, home care providers, residential aged care providers, social workers and allied health professionals, and community members)
- Facilitated discussion with a community-based Seniors Advisory Group
- Interviews and discussions with internal PHN staff and teams
- Informal conversations and emails received from a number of individual seniors in our various communities

The development of the Strategy was also informed by an external Reference Group (advisory body) made up of experienced and qualified experts representing health and social sectors and geographical locations.

Data from these consultations were triangulated with the secondary data (population and health and social data) as well as existing sources of consultation data including the PHN Community and Stakeholder surveys (Reference/hyperlink), and cross-referenced against the themes from a literature review.

Summary of the consultation data

The overarching resonating message is the fundamental concept of "**valuing our older people**". Through our consultation and engagement processes, it was evident that ageism exists at many levels and across many domains. A societal/cultural negative view of ageing and a "devaluing" view of older people unfortunately permeates Australian society, and challenging this mindset needs to remain at the fore of as we implement this Strategy.

One participant summarised: *"Older persons make up a significant population in our community ….. Our culture needs to ensure they are seen as an integral part of the community and not seen as a burden. Our Community needs to show respect for the contribution older persons provide." (Online survey participant)*

In additional to the underpinning concept of 'value', the top themes from the consultation were:

1. Meaningful participation in community/society and importance of social connectedness
2. Maintaining functionality (physical, social and emotional, mental and cognitive)
3. Being able to age in place of choice surrounded by age-friendly places & spaces
4. Ease of access to services and supports
5. Supply of services to meet need and addressing gaps in provision
6. Workforce (formal and informal) - support, capacity and supply
7. Integration and patient centred care

Meaningful participation and social connectedness

Consultation with our seniors and stakeholders highlighted the important social and intellectual capital that exists in older people. Being able to contribute meaningfully to their families, community and society as a whole is important to the seniors in our region. Seniors emphasised the experience, intellectual and social capital they have to offer, and expressed desires to be able to pass on their knowledge and experience to the younger generations.

Being able to remain active in the community and to continue to grow and learn is also important, as was eloquently expressed by one senior: *"I want what I can learn and do - leading to meeting new people, getting to know people better, being interested in the world and all things – being alive to living." – quote from one of our Seniors, Central Qld*

Social connection is a key indicator for positive healthy ageing and mental wellbeing, and isolation of seniors was an issue raised during consultation. In many cases, there are many local opportunities available such as social groups, community activities or events (such as U3A, card groups, men's sheds etc.), but being aware of what these are and how to access them (or how to support people to access them) was often discussed. Intergenerational connection and learning was also highlighted as important, both in relation to passing down knowledge and also in contributing to feelings of social connectedness.

Maintaining functionality

Maintaining functionality into older age was also of key importance both to older people themselves and the people and service providers who support them. Maintaining physical functionality included being able to stay as mobile and independent as possible, as well as reducing risk of frailty.

Stakeholders also spoke about the importance of providing solutions and support across the spectrum of care including prevention, early intervention and through to management/maintenance and provision of care for complex needs, as well as building the capability of people to be able to self-manage their health in a proactive way.

Mental health and cognitive functionality was also a key sub-theme. Dementia was a particular area of concern, and many people expressed a need for capacity and resources, both at the community and provider level, to be able to identify and support people with dementia.

Ageing in place of choice / Age friendly places & spaces

Being able to age in community and in place of choice can be complex, and a number of issues and factors that impact on people's ability to do so were identified during the consultation process. This included (in additional to social connectedness):

- Having good financial and housing security – there was concerns around people's true understanding of their financial situation or ability to access to adequate income sources to live well, as well as an increasing worry around rising levels of homelessness.
- Being able to modify the home and receive varying levels of assistance in the home as a person's needs increase was also identified as a need, in order to help them maintain independence and remain in their homes long term or as long as possible.
- Planning for the future (including financial management, advance care planning, retiring from driving etc.) was highlighted as important enablers to supporting people to age where and how they choose. In addition, stakeholders also shared how many people do not plan for ageing/aged care needs so they often present straight to RACFs in crisis rather than planning for their needs and receiving appropriate care in the home (& care that increases as needs increase), before progressing to RACFs.
- Age-friendly communities (including physical environment) - Some participants noted that poor community

infrastructure can make ageing in the community more difficult and can reduce people's mobility. Well-maintained community infrastructure such as footpaths and activities supported or funded by council are important to people as they age.

Ease of access

A key perception from many stakeholders and community members was that healthy ageing outcomes are influenced by a persons' access to services and supports. Ease of access to health and support services was extremely important to older people. The complexity of the health and aged care system was raised, and for many navigating the system was a key concern – including access to information, understanding what's available, and completing the applications/paperwork.

Many community and stakeholders also spoke about the complexities associated with using digital technologies to access health and services for older people. Issues discussed included digital literacy including skills, confidence and willingness to use technology; whether support exists (family or external) to help people access and use technology; a persons' actual access to it (in some cases, people do not have internet or devices at all); and the impact of a persons' health such as their vision and hearing on being able to successfully engage with technology.

"[With] everything being on line we find a lot of seniors still don't have mobile phones/computers and either don't want to [or are] unable to and unless they have family/friends to help they slip through system." (Quote from online survey)

Barriers to access were also discussed, with access to transport was the most frequent concern raised by participants. Some communities, particularly rural and regional areas, have limited or no public transport and when older people stop driving, transport can become a major problem. This impacts on their independence, their ability to easily access services and supports, and can also be a critical cause of isolation. The cost and inconvenience of arranging transport also is challenging for many.

Supply of services to meet need / gaps in provision

Access to health and support services was a concern for many community members and stakeholders. For some, the main problems were waiting times and availability of services. Areas of particular concern or in short supply included:

- Home-care Packages
- Primary health care services in rural / regional communities, especially GPs but also specialists
- Primary health care services (in particular GPs and mental health services) in residential aged care facilities
- Promotion / prevention programs in community
- 'Specialist care' services in community

Workforce (formal and informal) support, capacity and supply

Issues around the workforce centred on need for increased support, skills and capacity and addressing workforce shortages. This was in relation to both the formal (paid) workforce and the informal (family, volunteers, unpaid) workforce. Many stakeholders emphasised the

crucial role of the informal workforce in supporting people as they age, and the importance of providing adequate support and resources as they will continue to be a heavily relied on workforce into the future.

Key issues discussed were:

- Workforce shortages in the aged care sector (which impact on supply) and challenges associated with recruiting and even more so retaining staff.
- Inconsistencies in the quality of care received, which was linked to issues such as compassion fatigue and lack of support. Consumers also spoke of a need and desire for a health culture of 'caring', which is closely connected with the perceptions of feeling valued.
- Need for upskilling / capacity building of the aged care workforce (both the formal/paid and also the unpaid workforce).

A cross-cutting theme over the issues above was the concept of 'valuing the workforce' and a need to recognise the aged care sector as a speciality and discipline of value. Many felt the current aged care system is not geared towards valuing older people. Comments included that current funding models and industry awards are inequitable, aged care work (including home care sector) is under-resourced and current remuneration doesn't reflect the complexity of care. This in-turn impacts on recruitment and retainment of qualified staff as well as encouraging early career pathways, as other areas of the health system are financially more attractive.

Integration and patient centred care

Many stakeholders highlighted a need for better joined up care across teams and disciplines as well as across services and agencies. In addition, many people talked about this importance of providing and receiving holistic care and older people themselves expressed a desire for a seamless journey in accessing the services and supports needed to age well and age in place.

Stakeholders and providers across the health and social sector identified various opportunities where pathways between care providers could be strengthened. This included: referral pathways and improved referral and communication mechanisms between health services; clearer linkages and pathways between health services and support/social services (such as housing support, financial counselling etc.); and referral pathways to prevention and health promotion programs.

There was also a need identified to support smoother transitioning between acute care and community (home, supported living or residential care), as well as supporting people including emotionally and mentally with the transition from home into residential care.
It was also felt that more could also be done to improve integration between social and health sectors, and a recognition that healthy ageing spans across the lifetime and all aspects of society. Therefore a unified systems approach across different sectors and different levels of government and non-government is needed to truly achieve healthy ageing outcomes for our region.

Appendix 4. Effective approaches to healthy ageing

A high-level literature review was undertaken to identify effective population approaches to healthy ageing. The review focused on empirical and grey literature (including policies and strategies by health and other relevant authorities) at a systematic, meta-analyses or other review level. Literature on healthy ageing is considered in its infancy with more comprehensive research required to fully understand the range of actions required [1].
Approaches found effective in healthy ageing included those that were [1-4]:

- multi-disciplinary, collaborative partnerships and co-design with relevant stakeholders from across government and society
- based on theory and/or evidence addressing the underlying protective and risk factors of healthy ageing
- sustainable, particularly in terms of cost and accessibility, and
- responses that address gaps and key objectives of what is to be achieved.

Recommended actions to address healthy ageing fell under the pillars [1-4]:

- Healthy sustainable age-friendly environments
- Place-based approaches
- Person-centred focus
- Use of volunteers
- Self-directed/professional-led approaches
- Combatting ageism
- Integrated care
- Long-term care

Key enablers to ensure the success of actions included ensuring [1]:

- Engagement with older people
- Effective governance and leadership and accountability mechanisms across sectors, including building capacity of stakeholders
- Connecting stakeholders across sectors and disciplines to leverage resources, share learning and experience, advocate for/support policy and action
- Strengthening research, data and innovation to better understand healthy ageing to inform and drive appropriate action

A summary of the effective evidence-based approaches to healthy ageing is provided in the table below. These, along with the policy guidance and stakeholder consultation has informed the development of the actions in the Action Plan.

The following table provides a summary of effective evidence based approaches to healthy ageing.

Theme	Effective approaches
Building the intrinsic capacity of older adults	• Awareness raising of the role of the environment on health and wellbeing [5]; • Learning self-compassion as a modifiable psychological skill [6]; • Creating positive self-perceptions of ageing and perceived control [7]; • Health literacy and self-managing health and wellbeing (with support of multidisciplinary and person-centred care by health professionals), comprehensive health assessments, coordinating care for multiple chronic diseases, medication reviews, age-appropriate self-management programs and clear communication by health professionals [2]; • Family violence and elder abuse strategies such as raising community awareness, addressing risk factors, educating health professionals and multidisciplinary interventions [2]
Maintaining and enhancing physical function	• physical activity initiatives [8, 9], including: o in younger age and in the workforce [10], o volunteer-led physical activity interventions [11-13], o community based group interventions [14], o ehealth interventions for self-management [15], o exercise prescriptions [15], o other self-care programs [16]; • Reducing sedentary behaviour through awareness raising, making activity enjoyable, convenient and habitual and evidence-based interventions [17]; • Nutritional initiatives [9, 18], including in younger age [10, 12] and into retirement [19] using supplements and environmental and organisational **interventions** [20]; • Use of creative communication media to promote healthy lifestyle behaviours and messages [21]; • Non-pharmaceutical interventions for pain management, including acupressure, acupuncture, guided imagery, qigong, periosteal stimulation, and Tai Chi [22, 23];

	• Interventions to minimise, prevent and reverse frailty, including client-centred group-based **interventions** based on health psychology and that include physical exercise, or multicomponent (exercise, cognitive, nutrition, social) **interventions** [24].
Maintaining and enhancing cognitive function	• Brain and cognitive reserve/brain maintenance activities [9, 25], including face-to-face and technology-based lifestyle interventions [26]; • Regular physical exercise programs [27]; and, supporting spirituality practices, including enabling **practices** [28].

Maintaining and enhancing psychological and social function	• Social and participation programs, including
	  ○ arts and humanities [29],
	  ○ community-based programs [30],
	  ○ collaborative partnership approaches, involving older adults in planning, implementation and evaluation of programs, addressing local needs, using existing resources and volunteers [2, 9], and
	  ○ programs in care settings, including upskilling carers [31];
	• Use of technology for social connection, including developing systems and basic digital skill development programs for caregivers and older people, creating smart homes as interactive living environments [32, 33]; and, building collaborative partnerships with stakeholders to address mental wellbeing;
	• Using an integrated and multidisciplinary approach; taking a holistic view of active ageing; involving older people in the process; addressing the needs of specific target group, providing training and support for staff and volunteers [2]

Diagnostic assessments	• Assessment of healthy ageing of older adults by nurses [34], using mobile applications as diagnostic tools for **aging** disorders such as mild cognitive impairment [35] and integrated assessment tools [36]; • Use of behaviour change **techniques**, social interaction, tailoring of **interventions**, booster sessions, and multi-component and multi-professional team approach to **intervention** design and delivery [3, 4, 37, 38]; • Prescribing and reviewing of medication [39] and medication adherence [9]; • Planning for life changes, such as mobility [40], transition to retirement, including digital health coaching [41] and volunteering as "structured" means of making a meaningful contribution in society [42] and other transition programs [43, 44]; and, • Adherence to screening [9]
Addressing age discrimination	• Community awareness of age discrimination, challenge discriminatory age norms and stereotypes, change discriminatory institutional and societal practices and regulations [7, 45]
Attending to specific conditions	• Comprehensive fall prevention approaches, including GPs [46], strength and balance exercise and physical activity [47], reducing medications, addressing vision impairment and home hazards [2]; • Oral health and tooth retention [48]; • Transport-related injuries, including awareness raising and self-management of risk, improving pedestrian safety [2]; • Sexual health and safe sex practice strategies, including targeting service providers to promote sexual health and promoting supportive and inclusive practice for aged care residents and for LGBTI older people accessing health and aged care services [2]; • Awareness raising of risks associated with alcohol [9], including interventions across the life course [49], treatment programs that are person centred and specific to older people, online self-help programs, early intervention programs targeting risky behaviours, brief education programs [2]; and, • Chronic disease self and assisted management [2]
Creating supportive environments that cater for older people's needs	• Life space mobility and accessibility [50] and physical environmental attributes in communities [51]; and, • Collaborative approaches age friendly communities that engage multiple stakeholders, empowering older people and engaging them throughout the whole process, addressing local needs and using multiple interventions, and embedding theory and evidence-based interventions [2].
Providing age-friendly integrated care	• Upskilling practice nurses to work in the community on strengthening accountability, use of innovative care models and coordinating services through partnerships [52] and use of nurse-led approaches to healthy ageing [53]; • Upskilling allied health professionals in aged care, including occupational therapists [54, 55]; use of risk stratification to inform proactive, anticipatory and integrated care [56]; • IT-supported care pathways for managing chronic conditions, including diabetes [57], and mobile (m)health using person-centred, biopsychosocial approach that considers multi-level determinants of health care, collaborative partnerships and governance frameworks [58]; • Equity of services for priority groups, including LBGTQ [59, 60]; service delivery models at the end of life that integrate social, and welfare services across the care continuum focusing on needs and likelihood of benefits [61];

	• Upskilling about dementia including awareness raising, reducing stigma, and clarifying misunderstandings of the illness [62] and training programs on quality care, including lifestyle programs [63]; • Uptake of vaccinations [9], including models of how they are administered [64]; models of home support to people with dementia and their carers [65]; • Explicit inclusion of older people service delivery and in the design of policy and services [66]; identifying and advocating for policies or potential entry points for action that could serve to reduce inequities [67]; and • Upskilling carers to support older people's healthy lifestyles, including the use of multi-media computer-assisted instruction [68]

Appendix 5. Logic models, key performance indicators and measures

The following program logics and list of indicators for each strategic priority area provides a framework and context for the actions in the Action Plan. Together, the logic models and the indicator tables (Part A) provide guidance on the types of outcomes and indicators of relevance to inform operational planning, implementation and monitoring of activities. The logic models demonstrate where actions fit within the healthy ageing strategy and how each action contributes to healthy ageing outcomes. The indicators table provides measurable indicators and potential data sources that could be used to measure progress and outcomes along the way. A process evaluation framework (Part B) has been provided to provide guidance for staff in developing their evaluation plans

Part A – Logic Models and Indicator tables

Strategic Priority 1

Needs	Responses			Outcomes		
	Inputs	**Actions**	**Outputs**	**Short term**	**Medium term**	**Long term**
Healthy and well populations of all ages have intrinsic capacity to plan for later life and maintain and enhance their physical, social and mental wellbeing, functional ability and autonomy • Financial, housing and personal security • Healthy lifestyle • Mental and cognitive wellbeing • Social engagement, networks and supports • Positive attitudes toward ageing • Access to high-quality integrated social and health care • Age in place	• PHN teams/budget • PHN commissioned service agencies • HHSs (SC, WB, CQ) • Indigenous agency partners and stakeholders (e.g. ACCHOS, NGOs) • Peak body partners and stakeholders (e.g. Heart Foundation, Diabetes Qld, OCAP, ELDAC, Public Trustee) • Government partners and stakeholders (e.g. DoH, local government, Dept of Communities, Housing and Digital Economy) • Community partners and	• Chronic disease prevention and early intervention strategies • Local free/low-cost physical activity and healthy lifestyle programs • PHN mental health Stepped Care services • Social engagement and participation programs • Community intergenerational and social support initiatives • Health literacy strategies	Public awareness campaigns (e.g. of available local programs; older people's awareness of local programs and services; health seeking behaviour and participation in programs Chronic disease health promotion/prevention programs, local physical activity/healthy lifestyle programs, and health literacy programs; older people's awareness, knowledge, attitudes, skills, self-efficacy in health behaviours (e.g. physical activity, nutrition, alcohol consumption), self-care, and cognitive activities (e.g. reading, writing, puzzles) Stepped care mental health services; older people's participation in programs; knowledge, self-efficacy and skills to manage psychological health Social connectedness/intergenerational programs; older people's participation in programs; awareness, knowledge, attitudes, self-efficacy in social activities/community Digital literacy support and access programs; older people's participation in programs and ability to access care; knowledge, attitudes, self-efficacy in digital technology RACF social engagement programs; residential aged care residents' participation in programs; awareness, knowledge, attitudes, self-efficacy in social activities Partnerships…	Older people's increase availability and choice of support programs Older people's health seeking behaviour Older people's digital literacy to navigate and access necessities and care Older people's health literacy to self-manage health, make informed decisions, and navigate and access care Older people's participation in health behaviours (e.g. physical activity, nutrition, alcohol consumption), self-care (e.g. psychological care), and cognitive activities (e.g. reading, writing, puzzles) Older people's biomarkers and other risk factors in healthy range (e.g. cholesterol, blood sugar, markers of psychological and social health) Older people's ability to build/maintain relationships Older people's perceived sense of contribution, role and identity Older people's perceived sense of potential for personal growth (e.g. learn, grow, make decisions)	Health conditions Resilience Quality social supports and networks Emotional security free of abuse (family and age-related) Financial security Housing security Personal security Independence/ autonomy Intrinsic capacity (mental/ physical) Functional ability Live in place Ageist/ age-friendly societal culture	Health status - social, mental, physical Meaning of life Quality of life Efficient and sustainable aged care system

	stakeholders (e.g. neighbourhood centres) • RACFs • USC • Other stakeholders	• PHC professional awareness and referral pathways (e.g. housing, elder abuse, social support) • PHC professional strategies encouraging care choice conversations with patients	PHC professional awareness campaigns (e.g. elder abuse, local programs); PHC professionals' awareness of healthy ageing issues PHC education programs (e.g. behaviour change techniques, chronic disease prevention, screening/ assessments, healthy lifestyle, elder abuse and social supports); PHC professionals' knowledge, attitudes, self-efficacy, skills; Advanced Care Planning in routine clinical care Referral pathways (e.g. housing, financial, loneliness, domestic abuse); PHC professionals' awareness, knowledge, attitudes, self-efficacy, skills and practice in referring patients to required care Partnerships…	Older people's exposure to and availability of holistic care options Older people's health screening, assessments, care plans and referrals to care Older people health seeking behaviour for care (e.g. financial, emotional) Older people's biomarkers and other risk factors in healthy range (e.g. cholesterol, blood sugar, markers of psychological and social health) Older people have fewer unmet needs (health and social), barriers to care, quality care experiences, choice Provider quality care experiences	Holistic, integrated, effective age care services/ programs Age-friendly competent workforce Built and social environments of communities are supportive of healthy ageing Older people's perceived sense of security/ safety, confidence and independence to get out and about	
		• Healthy ageing and end of life planning	Public awareness campaigns and education programs (e.g. legal care plans, healthy ageing, conversations and decisions about care choices); older people's and their families' awareness, knowledge, attitudes, skills, self-efficacy in planning for healthy ageing (e.g. care plans, finances, retirement) Partnerships…	Older people's and their families' planning for healthy ageing and acting on those plans (e.g. care plans, finances, retirement)		
		• Family carers' wellbeing and social connection strategies	Family carer social support and wellbeing programs; carers of older people's awareness, knowledge, attitudes, self-efficacy and participation in social activities/ community and self-care activities Partnerships…	Carers of older people's increase availability of support programs Carers of older people's ability to build/ maintain relationships Carers of older people's health literacy and participation in care self-manage		
		• Age- and dementia-friendly community initiatives	Age- and dementia-friendly community activities; stakeholders' awareness, knowledge, attitudes, self-efficacy and participation in establishing age- and dementia-friendly community activities; partnerships and funding for action; actions delivered	Increase in public and professional discussion and activity related to age- and dementia-friendly communities		
		• My Health Record promotion	My Health Record system awareness and access support programs; older people's and stakeholders' awareness, knowledge,	Increase in availability of support for accessing My Health Record		

			attitudes, skills to sign up to My Health Record Partnerships…	Older people's registration on My Health Record Older people have fewer unmet needs (health and social), barriers to care, quality care experiences, choice		

How will measure success and progress (KPIs and measures)

Domain[2]		KPI / Indicator	Suggested measure (data source)	Related goal
Determinants of health	**Health behaviours**	Increase in the proportion of older people who are health literate	• Changes in health literacy across domains (Healthy Literacy Survey, ABS)[3] • Changes in perceived participation in decision making, autonomy and control (Adult Social Care Outcomes Toolkit)[4]	1.5
		Increase in the proportion of people who have the awareness, knowledge, attitude, skills (and other relevant behaviour change constructs) to actively engage in good health behaviours (e.g. physical activity, healthy eating, alcohol consumption, safe sex)	• Changes in health behaviour awareness, knowledge, attitude, skills (to be developed)	1.1, 1.5
		Increase in the proportion of older people who have the knowledge, confidence, attitude and skills to use, and who use, technology and digital platforms to access services and information	• Change in knowledge, confidence, attitude and skills to use technology (to be developed) • Changes in technology use by older people and carers – prevalence of use, by type of technology; reasons for use; reasons for not using internet (ABS survey)[5]	1.1, 1.5
		Increase in the proportion of older people (and other age groups) who are meeting health guidelines for health behaviours (e.g. physical activity, healthy eating, alcohol consumption)	• Changes in health behaviours (National and State Health Surveys; ABS, QH CHO report; other validated instruments of health behaviours)[6,7]	1.1, 1.5
		Increase in the proportion of older people who are aware of locally accessible health and social programs of interest	• Changes in awareness (to be developed)	1.1, 1.5
		Increase in the proportion of older people having recommended screening and health assessment checks, including dental check ups	• Changes in screening participation rates (Cancer screening AIHW)[8] • Changes in health assessment rates (Health assessment Dept of Health)[9]	1.1, 1.5
		Increase in the proportion of people who have the knowledge, attitude, skills to actively engage, and who participate, in societal and social activities and other personal growth activities (e.g. employment, training, volunteering, community social activities, with family/ friends) Increase in the proportion of older people who participate in cognitive activities	• Changes in knowledge, attitude, confidence and skills to participate in society and other social activities (to be developed) • Changes in employment and formal training rates of people 65+ years (ABS Labour Force)[10] • Changes in unpaid care, volunteering, and community and social engagement rates of people aged 65+ years (e.g. contact with people outside household; ABS General Social Survey; Volunteer Aust)[11] • Changes in reading books or other cognitive activities (e.g. writing, puzzles) 3 or more times a week (AIHW)[12]	1.2, 1.5
		Increase in the proportion of people who have the knowledge, attitude, skills to actively engage, and who participate, in planning for their future and healthy ageing (e.g. finances, retirement, end-of-life/care)	• Changes in knowledge, attitude and skills to plan for their future (to be developed) • Changes in end-of-life plans , and other retirement and healthy ageing plans (to be developed)	1.5
		Increase in the proportion of people registered with health care system supports (e.g. My Health Records, end of life plans)	• Changes in health care system registered users (Digital Health; Dept of Health)[13,14]	1.5

[2] Australia's Health Performance Framework. Australia's health performance framework - Australia's health performance framework - Australian Institute of Health and Welfare (aihw.gov.au)
[3] https://www.aihw.gov.au/reports/australias-health/health-literacy
[4] Berry HL, Rodgers B, Dear KBG. Preliminary development and validation of an Australian community participation questionnaire: types of participation and associations with distress in a coastal community. Soc Sci Med. 2007;64(8):1719–37
[5] - Disability, Ageing and Carers, Australia: Summary of Findings
, 2018 ABS, March 2018 Use of information technology by people with disability, older people and primary carers | Australian Bureau of Statistics (abs.gov.au)
[6] AIHW Older Australia at a glance, Behavioural risk factors - Australian Institute of Health and Welfare (aihw.gov.au)
[7] Qld Health Full 2020 Chief Health Officer report | Queensland Health
[8] AIHW, Cancer screening programs: quarterly data, Summary - Australian Institute of Health and Welfare (aihw.gov.au)
[9] Department of Health | Health assessment for people aged 75 years and older
[10] ABS Labour Force, Australia, September 2021 | Australian Bureau of Statistics (abs.gov.au)
[11] AIHW Volunteers - Australian Institute of Health and Welfare (aihw.gov.au)
[12] AIHW Older Australia at a glance, Mental & social wellbeing - Australian Institute of Health and Welfare (aihw.gov.au)
[13] Digital Health Statistics | Australian Digital Health Agency
[14] Dept of Health Advance care planning | Australian Government Department of Health

		Increase in the proportion of people with a positive attitude toward ageing	• Changes in people's positive attitudes toward ageing (Australian Human Rights Commission)[15]	1.2, 1.3, 1.5
	Biomedical factors	Increase in the proportion of people who have biomarker scores in the healthy range (e.g. cholesterol, blood pressure, blood sugar, healthy weight)	• Biomarkers (e.g. BMI, blood pressure, cholesterol)	1.1, 1.5
	Socioeconomic factors	Increase in the proportion of people experiencing financial and housing security into older age	• Change in people living in poverty (Australian Council of Social Service)[16] • Change in homeless rates (Census Population and Housing data)[17] • Change in perceived feeling of financial and housing security (Social Housing Register[18])	1.1, 1.4
	Environments	Increase in the number of LGAs/communities actively engaging/investing in age-/dementia-friendly community activities Increase in the number of LGAs/communities with 'healthy'-scoring liveability measures across domains Increase in the proportion of people who feel comfortable and safe to get out and about and get around their community to do daily chores	• Change in LGA/communities participating formally in activities evidenced in formal partners, policies and/or delivery of actions (to be developed) • Change in perceived liveability rating scores (PlaceScore)[19] • Benchmarked objective liveability/ age-friendly community indicator scores (e.g. walkability, public transport, social infrastructure and services, employment, food, housing, and public open space (Australian Urban Observatory liveability indicators; Queensland Health Healthy Places Healthy People, World Health Organisation Age-friendly indicators)[20] [21]	1.3
		Decrease in the proportion of older people who report experiencing age discrimination as part of daily life, including employment, healthcare	• Changes in older people's experience of age discrimination (Australian Human Rights Commission)[22]	1.2, 1.3, 1.5
		Increase in the proportion of PHC professionals who have the awareness, knowledge, skills, and deliver services to patients, to support ageing well (e.g. behaviour change techniques, referral pathways and local programs, chronic disease prevention, elder abuse and other social and mental supports)	• Change in awareness, knowledge, skills and behaviours of PHC professionals (to be developed)	1.1, 1.5
		Increase in the proportion of PHC professionals with positive clinical experiences	• Change in clinician experience score across domains (to be developed)	1.1, 1.5
		Increase in the number of strategies and programs available to people to support healthy ageing (e.g. chronic disease prevention, mental health, social participation, intergenerational, healthy lifestyle, technology support, care planning support, health literacy)	• Change in program numbers, reach, participation, quality and participant/ provider satisfaction (to be developed; refer to process evaluation indicators)	1.1, 1.5
		Positive societal cultural shift in attitudes towards the value of and contribution made by older people	• Changes in society's positive attitudes toward ageing (Australian Human Rights Commission)[23]	1.5
		Increase in the proportion of older people with unmet health and social needs and quality care experiences; barriers for service use; choice of services; person-centred care; not experiencing ageism in healthcare system	• Changes in client experience scores across domains (to be developed)	1.5
		Increase in the proportion of older people ageing in place	• Change in place of residence (Australian Productivity Commission)[24]	1.3

[15] Australian Human Rights Commission Face the facts: Older Australians | Australian Human Rights Commission
[16] Australian Council of Social Service Poverty and inequity Data – Poverty and Inequality (acoss.org.au)
[17] https://www.aihw.gov.au/reports/older-people/older-australia-at-a-glance/contents/diverse-groups-of-older-australians/people-at-risk-of-homelessness
[18] Social Housing Register: https://www.data.qld.gov.au/dataset/social-housing-register
[19] PlaceScore Home - Place Score
[20] RMIT Australia. New digital platform maps liveability in our major cities. (2020). Available from: https://www.rmit.edu.au/news/all-news/2020/feb/digital-platform-maps-liveability
[21] World Health Organization. (2007). Global age-friendly cities: a guide. World Health Organization. Available from: https://apps.who.int/iris/handle/10665/43755
[22] Australian Human Rights Commission Face the facts: Older Australians | Australian Human Rights Commission
[23] Australian Human Rights Commission Face the facts: Older Australians | Australian Human Rights Commission
[24] Australian Productivity Commission Housing Decisions of Older Australians - Productivity Commission (pc.gov.au)

		Increase in the reach and quality of partnerships to plan for, deliver and evaluate the coordination of initiatives on healthy ageing	• Change in partnership qualities (Vic Health Partnerships Tool)[25]	1.1-1.5
Health Status	**Overall health status**	Increase in the proportion of older people who rate their health as very good or excellent by age group Increase in the proportion of older people who have intrinsic capacity (physical, mental)	• Change in self-rated health status (AIHW)[26] • Change in intrinsic capacity scores (WHO)[27]	1.1-1.5
	Meaning in life	Increase in the proportion of older people who feel they have a role/ identity/ contribute Increase in the proportion of older people who perceive potential for personal growth (e.g. to learn, grow, make decisions)	• Change in role identity/ contribution/ potential for growth (to be developed)	
	Physical wellbeing	Decrease in rates of potentially preventable hospitalisations Decrease in rates of potentially avoidable deaths Decrease in the proportion of older people who fell within the last 12 months/ with falls-related injury/ hip fracture Decrease in the proportion of older people with complete tooth loss Decrease in the incidence of preventable health conditions among older people (and/or hospitalisations or other service utilisation) Decrease in the rate of frailty by age	• Change in preventable disease incidence rates – selected cancers, sexually-transmitted diseases, end-stage kidney disease, heart attacks, injury, type 2 diabetes (AIHW)[28]	1.1, 1.3, 1.4, 1.5
	Social wellbeing	Increase in the proportion of older people who experience quality social connections Increase in the proportion of older people who feel able to build and maintain relationships and possibility for enjoyment	• Changes in having people living outside the household who could provide support (AIHW[29];General Social Survey[30]; Australian Community Participation Questionnaire (ACPQ)[31]; ICEpop CAPability measure for Older people (ICECAP-O)	1.2, 1.3
	Mental wellbeing	Decrease in the proportion of older people experiencing psychological distress Decrease in the proportion of people who rate their physical and mental health as not good over the last 4 weeks Decrease in the proportion of older people with diagnosed mental health disorders, including dementia (and/or hospitalisations or other service utilisation) Increase in the proportion of older people with adequate emotional support and security Increase in the proportion of older people who score positively to meaning of/satisfaction with life metrics	• Change in psychological distress (ABS)[32] • Change in people who rate their physical and mental health as not good in the past 30 days • Mood & emotional health via the Medical Outcomes Study Questionnaire Short Form (SF-36)[33]	1.1, 1.5

[25] Vic Health Partnerships Tool The partnerships analysis tool (vichealth.vic.gov.au)
[26] Australia's health 2018, Self-assessed health status - Australian Institute of Health and Welfare (aihw.gov.au)
[27] WHO MergedFile (who.int); Microsoft PowerPoint - 2017 12 02 WHO Berlin healthy ageing measures Ritu Sadana updated 16 9 format distribution.pptx (crn-i.org)
[28] AIHW Health status: Health conditions - Australia's health performance framework - Australian Institute of Health and Welfare (aihw.gov.au)
[29] AIHW Older Australia at a glance, Mental & social wellbeing - Australian Institute of Health and Welfare (aihw.gov.au)
[30] Australian Bureau of Statistics. General Social Survey: Summary Results, Australia. (2021). Available from: https://www.abs.gov.au/statistics/people/people-and-communities/general-social-survey-summary-results-australia/latest-release
[31] Flynn TN, Chan P, Coast J, Peters TJ. Assessing quality of life among British older people using the ICEPOP CAPability (ICECAP-O) measure. Applied Health Economics and Health Policy. 2011;9(5):317–29.
[32] ABS/AIHW Health status: Wellbeing - Australia's health performance framework - Australian Institute of Health and Welfare (aihw.gov.au)
[33] Ware JE, Sherbourne CD. The MOS 36-item short-form health survey (SF-36): I. Conceptual framework and item selection. Med Care. 1992;30(6):473–83

	Functional ability	Decrease in the proportion of older people who have limitations in 1 or more 5 basic activities/needs of daily living Increase in the proportion of older people who perceive they have autonomy to move around	• Change in assistance in activities of daily living (ABS Census Population and Housing; DSS Survey of Disability, Ageing and Carers[34]; WHO[35])	1.1, 1.5

[34] Disability, Ageing and Carers (Survey of) (abs.gov.au)
[35] WHO Microsoft PowerPoint - 2017 12 02 WHO Berlin healthy ageing measures Ritu Sadana updated 16 9 format distribution.pptx (crn-i.org)

Strategic Priority 2

Needs	Responses			Outcomes		
	Inputs	**Actions**	**Outputs**	**Short term**	**Medium term**	**Long term**
People with acute and chronic conditions live well with the care they need when they need it as close to home as possible • Management of conditions • Supported discharge and rehabilitation • Social support and engagement • Mental and emotional wellbeing • Holistic integrated and safe quality care • Sustainable and valued healthy ageing workforce • Cultural and other preference considerations • Cross community and sector collaboration • Care coordination and case managment	• PHN teams/budget • PHN commissioned service agencies • HHSs (SC, WB, CQ) • Indigenous agency partners and stakeholders (e.g. ACCHOS, NGOs) • Peak body partners and stakeholders (e.g. COTA) • Government partners and stakeholders (e.g. DoH, local government) • Community partners and stakeholders (e.g. neighbourhood centres) • RACFs • Other stakeholders	• Health checks (e.g. age-relevant) • Early intervention and monitoring activities • Screening (e.g. dementia and frailty) • Wellbeing/community check in programs • Assistance programs to navigate and access age care services • Local service access strategies	PHC health check programs (e.g. age-relevant), screening and referral programs (e.g. dementia, frailty, My Aged Care, NDIS, frailty, functionality, elder abuse, social support, mental health) Early intervention and monitoring programs; older people's awareness, knowledge, attitudes, skills, self-efficacy in health behaviours (e.g. physical activity, nutrition, alcohol consumption, cognitive activities) Wellbeing/community check in programs Age care assistance programs Local service access activities Partnerships…	Older people's exposure to and availability of holistic care Older people's health screening, assessments, care plans and referrals to care Older people health seeking behaviour for care (e.g. dementia, frailty, My Aged Care, NDIS, frailty, functionality, elder abuse, social support, mental health) Older people's participation in health behaviours (e.g. physical activity, nutrition, alcohol consumption, cognitive activities) Older people's biomarkers and other risk factors in healthy range (e.g. cholesterol, blood sugar, markers of psychological and social health) Older people's health literacy to manage conditions, make informed decisions, and navigate and access care management Older people have fewer unmet needs (health, social, cultural), barriers to care, quality care experiences, choice, coordination of care Provider quality care experiences	Preventable/ avoidable health conditions Multimorbidity Quality social supports and networks Emotional security Financial security Housing security Personal security Independence/ autonomy Intrinsic capacity (mental/ physical) Functional ability Frailty Live in place of choice, including delayed need for residential age care Holistic, integrated, effective age care services/ programs	Health status - social, mental, physical Meaning of life Quality of life Efficient and sustainable aged care system
		• PHC professional capacity building strategies (e.g. intrinsic capacity, frailty and functional ability) • Health worker referral pathways promotion (e.g. My Aged Care and NDIS) • Aboriginal and Torres Strait Islander cultural competency strategies • CALD competency strategies	PHC professionals/health worker/ carer educational programs (e.g. cultural competency, compassion, literacy, wound care, continence, care management planning, frailty, functionality, dementia, elder abuse, social support, medication, mental health, referral pathways); PHC professionals'/health workers'/ carers' awareness, knowledge, skills Partnerships…	Older people's exposure to and availability of holistic care options Older people's management of acute and chronic disease (and other concerns) Older people's health-seeking behaviour for and attendance at integrated holistic care management Older people have fewer unmet needs (health, social, cultural), barriers to care, quality care experiences, choice, coordination of care Provider quality care experiences		

		• Home-/community-based fall prevention programs • Models of integrated care • Service access for older people in rural areas strategies • Integrate Team Care program • Aboriginal and Torres Strait Islander models of care	Home-/community-based falls prevention programs Integrated community and rural-outreach models of care (e.g. PHC, ITC, Aboriginal and Torres Strait Islander mental health services, aged care) Patient transition pathways (e.g. hospital to home) Partnerships, including Round Table	Older people's exposure to and availability of holistic care Older people's screening, assessments and referrals Older people's health literacy to manage conditions and access care management Older people's health-seeking behaviour for and attendance at integrated holistic care management Older people's management of acute and chronic disease (and other concerns) Older people's biomarkers and other risk factors in healthy range (e.g. cholesterol, blood sugar, muscle strength, psychological wellbeing) Fewer unmet needs (health, social, cultural), barriers to care, quality care experiences, choice, coordination of care Confidence to live independently with fewer falls-related insecurities Older people have fewer unmet needs (health, social, cultural), barriers to care, quality care experiences, choice, coordination of care	Age-friendly competent workforce	
		• Early supported discharge models	Early discharge models; older people's timely transitions from hospital care to home	Older people's availability of holistic care in home environment Older people's management of acute and chronic disease (and other concerns) Older people have less deconditioning from hospital care and able to return to healthy behaviours Confidence to live independently with their condition Older people have fewer unmet needs (health, social, cultural), barriers to care, quality care experiences, choice, coordination of care Provider quality care experiences		

		• RACF mental health in-reach services • RACF clinical support services in • RACF competency building strategies in health ageing (e.g. cultural competency, compassion, literacy, wound care, continence, care management planning, frailty, functionality, dementia, elder abuse, social support, medication, mental health)	RACF services (e.g. mental health, clinical support) RACF education programs (e.g. cultural competency, compassion, literacy, wound care, continence, care management planning, frailty, functionality, dementia, elder abuse, social support, medication, mental health); RACF carers' awareness, knowledge, skills and behaviours in healthy ageing Partnerships…	RACF residents' availability of holistic care RACF residents receive screening, assessment, referrals, care (e.g. age-related, My Aged Care, NDIS, frailty, functionality, dementia, elder abuse, social support, mental health) RACF residents' health-seeking behaviour RACF residents' management of acute and chronic disease (and other concerns) RACF residents have fewer unmet needs (health, social, cultural), barriers to care, quality care experiences, choice, coordination of care Provider quality care experiences		
		• Frequent ED flyer project	Community models of care; older people's awareness, knowledge, attitudes, self-efficacy in health seeking behaviours Partnerships…	Older people's availability of community care options Older people's management of acute and chronic disease (and other concerns) Older people treated in community for relevant conditions as needed; ED freed up Older people have fewer unmet needs (health, social, cultural), barriers to care, quality care experiences, choice, coordination of care Provider quality care experiences		
		• Age care workforce vaccination uptake strategies	Aged care workforce vaccination programs; workforce awareness, knowledge, attitudes, behaviours Partnerships…	Aged care workforces' exposure to and availability to vaccinations Age care workers vaccination rate Less transmission of infectious diseases to older people Provider quality care experiences		
		• Local workforce solution strategies • Promotion of age care as a career pathway	Workforce development programs; understanding of local workforces; local partnerships and activities Aged care career promotional campaigns, including Aboriginal and Torres Strait	Available age care workforce in communities to meet the needs of older people Cultural shift in the view of aged care as a career More people training and working in aged care		

			Islander; workforce and community awareness and attitude toward aged care Partnerships…			
		• Transport strategies to overcome barriers to access	Transport programs; understanding of local workforces; local partnerships and activities	Age-appropriate transport options coordinated with care services Older people's access to care Older people have fewer unmet needs (health, social, cultural), barriers to care, quality care experiences, choice, coordination of care		

How will measure success and progress (KPIs and measures)

Domain[36]		KPI / Indicator	Suggested measure (data source)	Related goal
Determinants of health	**Health behaviours**	Increase in the proportion of older people with acute or chronic conditions who are health literate in managing their health condition	• Changes in health literacy across domains (Healthy Literacy Survey, ABS)[37] • Changes in perceived participation in decision making, autonomy and control (Adult Social Care Outcomes Toolkit)[38]	2.1, 2.2
		Increase in the proportion of older people with acute or chronic conditions (or risk factors) who are actively managing their condition	• Changes in condition management behaviours (to be developed)	2.2, 2.3
		Increase in the proportion/number of older people having screening and health assessment checks, including routine age-related assessments and other assessments (e.g. frailty, functionality, dementia, elder abuse)	• Changes in screening participation rates (Cancer screening AIHW)[39] • Changes in health assessment rates (Health assessment Dept of Health)[40]	2.1, 2.3
		Increase in the proportion of older people utilising rehabilitation and other support services to manage their acute or chronic condition	• Change in reported behaviours (to be developed) • Change in care plans (MBS)	2.2, 2.3, 2.6
		Decrease in the proportion of older people with fall-related insecurities and implementing practices to prevent falls	• Changes in falls attitudes and practices (to be developed)	2.1, 2.2
		Increase in the proportion of older people accessing care/support packages in need of them (e.g. My Aged Care and NDIS)	• Changes in system registered users (Digital Health; Dept of Health)[41,42]	2.3
		Increase in the proportion of older people having recommended screening and health assessment checks, including dental check ups	• Changes in screening participation rates (Cancer screening AIHW)[43] • Changes in health assessment rates (Health assessment Dept of Health)[44]	2.1
	Environments	Increase in the proportion of care workers who have undertaken formal training and/or accredited in healthy ageing-relevant topics (e.g. dementia, frailty), and see working with the aged as a valued profession	• Changes in training/accreditation (to be developed) • Changes in attitudes about aged care as a profession	2.5, 2.6
		Increase in the proportion of PHC professionals who have the awareness, knowledge, skills, and deliver services to patients, to manage acute/chronic conditions and their holistic needs, and age well (e.g. frailty, functionality, dementia, elder abuse and other social and mental supports)	• Change in reported awareness, knowledge, skills and behaviours of PHC professionals (to be developed) • Change in care plans proportions for diagnosed conditions provided by GPs (MBS data[45])	2.1, 2.3, 2.5, 2.6
		Increase in the proportion of PHC professionals supporting people with acute and chronic conditions who are culturally competent	• Change in competency level (or completed training; to be developed)	2.5, 2.6
		Increase in the proportion of PHC professionals with positive clinical experiences associated with managing the care of people with acute or chronic conditions, including feeling as though they are equipped to work with older persons issues	• Change in clinician experience score across domains (to be developed)	2.4, 2.5, 2.6
		Increase in the number of programs, services, transition pathways available to people with acute or chronic conditions by geographic area	• Change in program numbers, reach, participation, quality and participant/ provider	2.3

[36] Australia's Health Performance Framework. Australia's health performance framework - Australia's health performance framework - Australian Institute of Health and Welfare (aihw.gov.au)
[37] https://www.aihw.gov.au/reports/australias-health/health-literacy
[38] Berry HL, Rodgers B, Dear KBG. Preliminary development and validation of an Australian community participation questionnaire: types of participation and associations with distress in a coastal community. Soc Sci Med. 2007;64(8):1719–37
[39] AIHW, Cancer screening programs: quarterly data, Summary - Australian Institute of Health and Welfare (aihw.gov.au)
[40] Department of Health | Health assessment for people aged 75 years and older
[41] Digital Health Statistics | Australian Digital Health Agency
[42] Dept of Health Advance care planning | Australian Government Department of Health
[43] AIHW, Cancer screening programs: quarterly data, Summary - Australian Institute of Health and Welfare (aihw.gov.au)
[44] Department of Health | Health assessment for people aged 75 years and older
[45] MBS: Medicare Benefits Schedule (MBS) data collection - Australian Institute of Health and Welfare (aihw.gov.au)

		and rurality (e.g. rehabilitation, integrated models of care, community-based falls prevention strategies) Number of innovative models of care implemented	satisfaction (to be developed; refer to process evaluation indicators)	
		Increase in the proportion of older people with acute and chronic conditions with met health, social and cultural needs, quality care experiences, no barriers for service use; choice of services; person-centred are; not experiencing ageism in healthcare system Average/median number of people with an acute or chronic condition saw to management their condition Increase in the proportion of older people with acute and chronic conditions who felt they had one health professional coordinating the management of their care Decrease in the proportion of older people with acute and chronic conditions who report transport as a barrier to accessing services of need Increase in the proportion of older people with care plans for their acute or chronic conditions	• Changes in client experience scores across domains (to be developed) • Changes in experience ratings (ABS)[46]	2.3, 2.4, 2.5, 2.6
		Increase in the proportion of older people transitioning back to their place of residence as recommended after an acute or chronic condition hospital stay Increase in proportion of patients returned home Length of stay in hospital compared with recommended Emergency department and hospitalisation rates	• Hospital and emergency department administration data (AIHW[47])	2.6
		Proportion of aged care workers who are vaccinated by type	• Change in vaccination rates (AIHW)[48]	2.5
		Net growth in aged care training and workforce	• Change in training and workforce rates (AIHW)[49]	2.5
		Increase in the reach and quality of partnerships to plan for, deliver and evaluate the coordination of services for older people	• Change in partnership qualities (Vic Health Partnerships Tool)[50]	2.1-2.6
Health Status	**Overall health status**	Increase in the proportion of older people with acute or chronic conditions who rate their health as very good or excellent by age group Decrease in the proportion of older people in residential aged care by age group Increase in the proportion of older people who have intrinsic capacity (physical, mental)	• Change in self-rated health status (AIHW)[51] • Change in rates of residential aged care (AIHW)[52] • Change in intrinsic capacity scores (WHO)[53]	2.1-2.6

[46] ABS Patient Experiences in Australia: Summary of Findings, 2019-20 financial year | Australian Bureau of Statistics (abs.gov.au)
[47] AIHW: National Hospitals Data Collection* - Australian Institute of Health and Welfare (aihw.gov.au)
[48] AIHW Residential aged care worker COVID-19 vaccination rates map | Australian Government Department of Health
[49] AIHW Welfare workforce - Australian Institute of Health and Welfare (aihw.gov.au)
[50] Vic Health Partnerships Tool The partnerships analysis tool (vichealth.vic.gov.au)
[51] Australia's health 2018, Self-assessed health status - Australian Institute of Health and Welfare (aihw.gov.au)
[52] AIHW Aged care - Australian Institute of Health and Welfare (aihw.gov.au)
[53] WHO MergedFile (who.int); Microsoft PowerPoint - 2017 12 02 WHO Berlin healthy ageing measures Ritu Sadana updated 16 9 format distribution.pptx (crn-i.org)

	Meaning in life	Increase in the proportion of older people with acute or chronic conditions have feel they have a role/ identity/ contribute Increase in the proportion of older people with acute or chronic conditions who perceive potential for personal growth (e.g. to learn, grow, make decisions)	• Change in role identity/ contribution/ potential for growth (to be developed)	2.1-2.6
	Physical wellbeing	Decrease in rates of potentially preventable hospitalisations Decrease in the proportion of older people with multimorbidity Decrease in rates of potentially avoidable deaths Decrease in the proportion of older people who fell within the last 12 months/ with falls-related injury/ hip fracture Increase in survival rates of people diagnosed with cancer Decrease in rate of unplanned hospital readmission rates Decrease in the incidence of preventable health conditions among older people Decrease in the rate of frailty by age group	• Change in preventable disease incidence rates – selected cancers, sexually-transmitted diseases, end-stage kidney disease, heart attacks, injury, type 2 diabetes (AIHW)[54]	2.1-2.6
	Social wellbeing	Increase in the proportion of older people with acute or chronic conditions who experience quality social connections Increase in the proportion of older people with acute or chronic conditions who feel able to build and maintain relationships and possibility for enjoyment	• Changes in having people living outside the household who could provide support (AIHW[55];General Social Survey[56]; Australian Community Participation Questionnaire (ACPQ)[57]; ICEpop CAPability measure for Older people (ICECAP-O)	2.2, 2.3
	Mental wellbeing	Decrease in the proportion of older people with an acute or chronic condition (and their family carers) experiencing psychological distress Decrease in the proportion of older people with an acute or chronic condition with diagnosed mental health disorders (and/or hospitalisations or other service utilisation) Increase in the proportion of older people with an acute or chronic condition with adequate emotional support and security Increase in the proportion of older people with an acute or chronic condition who score positively to meaning of/satisfaction with life metrics	• Change in psychological distress (ABS)[58] • Change in people who rate their physical and mental health as not good in the past 30 days • Mood & emotional health via the Medical Outcomes Study Questionnaire Short Form (SF-36)[59]	2.1-2.6
	Functional ability	Decrease in the proportion of older people who have limitations in 1 or more 5 basic activities/needs of daily living	• Change in assistance in activities of daily living (ABS Census Population and Housing; DSS Survey of Disability, Ageing and Carers)[60]	2.1-2.6

[54] AIHW Health status: Health conditions - Australia's health performance framework - Australian Institute of Health and Welfare (aihw.gov.au)
[55] AIHW Older Australia at a glance, Mental & social wellbeing - Australian Institute of Health and Welfare (aihw.gov.au)
[56] Australian Bureau of Statistics. General Social Survey: Summary Results, Australia. (2021). Available from: https://www.abs.gov.au/statistics/people/people-and-communities/general-social-survey-summary-results-australia/latest-release
[57] Flynn TN, Chan P, Coast J, Peters TJ. Assessing quality of life among British older people using the ICEPOP CAPability (ICECAP-O) measure. Applied Health Economics and Health Policy. 2011;9(5):317–29.
[58] ABS/AIHW Health status: Wellbeing - Australia's health performance framework - Australian Institute of Health and Welfare (aihw.gov.au)
[59] Ware JE, Sherbourne CD. The MOS 36-item short-form health survey (SF-36): I. Conceptual framework and item selection. Med Care. 1992;30(6):473–83
[60] Disability, Ageing and Carers (Survey of) (abs.gov.au)

		Increase in the proportion of older people who perceive they have autonomy to move around		

Strategic Priority 3

Needs	Responses			Outcomes		
	Inputs	**Actions**	**Outputs**	**Short term**	**Medium term**	**Long term**
People in need of long-term care • Autonomy and functional ability • Rights, freedom and dignity • Health literacy • Culturally competent care • Capable and competent workers, carers (formal/ informal), family • Health and welfare of informal carers • Care preferences and control, including in end stages of life • Mental wellbeing • Social networks and supports • Access to high-quality integrated, holistic care • In place of choice with needs being met • Undervalued aged care workforce • Care management, coordination	• PHN teams/ budget • PHN commissioned service agencies • HHSs (SC, WB, CQ) • Indigenous agency partners and stakeholders (e.g. ACCHOS, NGOs) • Peak body partners and stakeholders (e.g. RACGP, ACRRM, Dementia Aust) • Government partners and stakeholders (e.g. DoH, NDIS) • RACFs • USC • Other stakeholders	• Dementia training and education - PHC • Advanced care planning promotion • Palliative care capacity building activities - clinicians • Cultural competency training • End-of-life care capacity building activities - RACF	PHC/RACF/clinician/in/formal carers awareness/education programs (e.g. dementia, advanced care planning, palliative care, cultural competency, end-of-life care); PHC/ RACF/ clinician/ in/formal carers' awareness, knowledge, skills and practices in healthy ageing issues Partnerships…	Older people in need of long-term care's screening, assessment, referrals, advanced care plans, care of need (e.g. dementia, advanced care planning, palliative care, end-of-life care) Informal carers feel competent and supported in providing care to older people Older people in need of long-term care's needs and wishes are known by providers Older people in need of long-term care's needs (including cultural) are attended to and coordinated Older people in need of long-term care and their families have fewer unmet needs (health, social, cultural), barriers to care, quality care experiences, choice, coordination of care Older people in need of long-term care feel goals, care and cultural needs are supported, including at end stages of life Older people in need of long-term care and families have a respectful, dignified end of life care experiences Older people need of long-term care have perceived sense of contribution, role, identity Older people in need of long-term care have a perceived sense of relative autonomy Provider/carer and family quality care experiences	Quality social supports and networks Relative independence/ autonomy Live/die in place of choice Relative intrinsic capacity (mental/ physical) Relative functional ability Live in place of choice Preventable/ avoidable and prolonged hospitalisations Older people have respectful, dignified end of life care experiences Holistic, integrated, effective age care services/ programs Age-friendly competent workforce	Health status - social, mental, physical Meaning of life Quality of life Efficient and sustainable aged care system
		• Assessment and management - dementia, mental health • Referral pathways - aged care and dementia • Clinical handover and communication strategies between primary/secondary care • Dementia models of care	Assessment and care management programs (e.g. dementia, mental health); PHC professionals' awareness, knowledge, attitudes, self-efficacy, skills and practice in assessment and coordination and referral of care of patients Referral pathways for aged care issues (e.g. dementia); PHC professionals' awareness,	Older people in need of long-term care's assessment, care plans and coordination, and referrals (e.g. dementia, mental health) Older people in need of long-term care and their families' health literacy to make informed care decisions and care plans, and navigate and access care Older people in need of long-term care health seeking behaviour		

		• Provision and integration of GP and specialist care • Community-based end-of-life care services	knowledge, attitudes, self-efficacy, skills and practice in referring patients to care Clinical communication programs between carers across sectors; PHC workers' awareness, knowledge, attitudes, self-efficacy, skills, practice in communicating patient care Integrated care models across PHC/ specialists; RACFs/ acute, other care Dementia models of care Community-based end-of-life care models Partnerships…	Health workers and carers of older people in need of long-term care are aware of care needs and patient wishes Older people in need of long-term care and their families have fewer unmet needs (health, social, cultural), barriers to care, quality care experiences, choice, coordination of care Older people in need of long-term care and families feel goals, care and cultural needs at end stages of life are supported Provider/carer and family quality care experiences		
		• RACF PHC in-reach service delivery • Hospital in nursing home models of care	PHC services for RACF residents Hospital in nursing home models of care Partnerships…	RACF residents' availability of holistic care in home environment RACF residents' assessment, care plans and coordination, and referrals RACF residents' health seeking behaviour RACF residents' management of conditions RACF residents have less deconditioning due to extended hospital care RACF residents have fewer unmet needs (health, social, cultural), barriers to care, quality care experiences, choice, coordination of care Provider/carer and family quality care experiences		
		• Compassionate Communities models • Hospice partnerships • Trauma-informed age care models • Assistive technologies and local support -	Compassionate Communities models Hospice models of integrated care Trauma-informed aged care models	Families and friends of people in end stages of life are aware of, linked with, and seek, social support and networking with peers Families and friends of people in end stages of life feel supported		

		people with a disability/ restrictive function	Assistive technologies and local support programs	Older people in need of long-term care's screening, referrals and utilisation of services and supports of need Older people in need of long-term care and their families' health literacy to make informed care decisions and care plans, and navigate and access care Older people in need of long-term care and their families have fewer unmet needs (health, social, cultural), barriers to care, quality care experiences, choice, coordination of care Provider/carer and family quality care experiences		

How will measure success and progress (KPIs and measures)

Domain[61]		KPI / Indicator	Suggested measure (data source)	Related goal
Determinants of health	**Environments**	Increase in the proportion of older people in need of long-term care (or their family) who are health literate to make informed care decisions and care plans, and navigate and access care	• Changes in health literacy across domains (Healthy Literacy Survey, ABS)[62] • Changes in perceived participation in decision making, autonomy and control (Adult Social Care Outcomes Toolkit)[63]	3.2
		Increase in the proportion of older people in need of long-term care who are having recommended screening and health assessment checks, including for social and mental wellbeing needs	• Changes in health assessment rates (Health assessment Dept of Health)[64]	3.1, 3.2
		Increase in the proportion of older people in need of long-term care who actively engage in social activities (e.g. community social activities, with family/ friends)	• Changes in knowledge, attitude, confidence and skills to participate in society and other social activities (to be developed)	3.1
		Increase in the proportion of older people in need of long-term care accessing care/support packages in need of them (e.g. My Aged Care and NDIS)	• Changes in system registered users (Digital Health; Dept of Health)[65,66]	3.1, 3.2
		Increase in the proportion of older people in need of long-term care living/dying in place of choice	• Change in place of residence (Australian Productivity Commission)[67] • Place of death aligning with care plan (TBD)	3.2, 3.4
	Health System	Increase in the proportion of PHC professionals and RACF workers who have the awareness, knowledge, skills to support people in need of long-term care (e.g. advanced care planning. Dementia, end-of-life, cultural competency)	• Change in awareness, knowledge, skills and behaviours of PHC professionals (to be developed)	3.1, 3.4
		Increase in the proportion of PHC professionals and other support carers with positive clinical experiences for caring with people in need of long-term care and end of life	• Change in clinician experience score across domains (to be developed)	3.2, 3.4
		Increase in the proportion of PHC professionals supporting people in need of long-term care who are culturally competent	• Change in competency level (or completed training; to be developed)	3.3, 3.4
		Increase in the number of services and strategies (assessment, referrals) available to support people in need of long-term care, including in RACFs (e.g. mental health, social participation, care planning support, health literacy)	• Change in program numbers, reach, participation, quality and participant/ provider satisfaction (to be developed; refer to process evaluation indicators)	3.2, 3.4
		Increase in the proportion of informal carers of people in need of long-term care or at the end of life (family members) that are screened for mental wellbeing, are aware of support services available and seeking support	• Change in screening and referral behaviour toward people with long-term health need carers (to be developed) • Change in social connectedness and social networks (having people living outside the household who could provide support (AIHW[68];General Social Survey[69]; Australian	3.3

[61] Australia's Health Performance Framework. Australia's health performance framework - Australia's health performance framework - Australian Institute of Health and Welfare (aihw.gov.au)
[62] https://www.aihw.gov.au/reports/australias-health/health-literacy
[63] Berry HL, Rodgers B, Dear KBG. Preliminary development and validation of an Australian community participation questionnaire: types of participation and associations with distress in a coastal community. Soc Sci Med. 2007;64(8):1719–37
[64] Department of Health | Health assessment for people aged 75 years and older
[65] Digital Health Statistics | Australian Digital Health Agency
[66] Dept of Health Advance care planning | Australian Government Department of Health
[67] Australian Productivity Commission Housing Decisions of Older Australians - Productivity Commission (pc.gov.au)
[68] AIHW Older Australia at a glance, Mental & social wellbeing - Australian Institute of Health and Welfare (aihw.gov.au)
[69] Australian Bureau of Statistics. General Social Survey: Summary Results, Australia. (2021). Available from: https://www.abs.gov.au/statistics/people/people-and-communities/general-social-survey-summary-results-australia/latest-release

		Increase in the proportion of informal carers of people in need of long-term care or at the end of life (family members) that feel socially connected with quality support networks, and mentally well Increase in the proportion of informal carers of people in need of long-term care who feel they have adequate knowledge and skills to care for their loved one Increase in the proportion of informal carers of people in need of long-term care who feel their needs were met by care/support teams at the end stages of life and with quality experiences	Community Participation Questionnaire (ACPQ)[70]; ICEpop CAPability measure for Older people (ICECAP-O)) • Change in mental wellbeing (psychological distress (ABS)[71]; rate their physical and mental health as not good in the past 30 days; SF-36[72]) • Change in care knowledge and skills (to be developed) • Change in carer experience scores, across domains (to be developed)	
		Increase in the proportion of older people with long-term health needs that do not have unmet health and social needs and have quality care experiences	• Changes in client/family experience scores across domains (to be developed)	3.2, 3.4
		Increase in the proportion of families of/ older people in need of long-term care that experience respectful and dignified end of life care experiences	• Changes in client experience scores across domains (to be developed)	3.4
		Increase in the proportion of older people (and/ or their family) who feel care plans and needs (including cultural) are understood and supported by carers Increase in the proportion of older people (and/or their family that feel goals, care and cultural needs are supported at end stages of life, including cultural needs	• Change in unmet needs and care plans (AIHW)[73]	3.4
		Increase in the proportion of older people in need of long-term care who felt they had one health professional coordinating the management of their care	• Change in care coordination (AIHW)[74]	3.1, 3.4
		Increase in the reach and quality of partnerships to plan for, deliver and evaluate the coordination of services for older people in need of long-term care	• Change in partnership qualities (Vic Health Partnerships Tool)[75]	3.1-3.4
		Increase in the proportion of older people in need of long-term are who have care plans in place	• Change in care plans (MBS)	3.2
Health Status	**Overall health status**	Increase in the proportion of older people with long-term health needs who have intrinsic capacity (physical, mental)	• Change in intrinsic capacity scores (WHO)[76]	3.1-3.4
	Meaning in life	Increase in the proportion of older people in need of long-term care that feel they have a role/ identity/ contribute Increase in the proportion of older people in need of long-term care who perceive potential	• Change in role identity/ contribution/ potential for growth (to be developed)	3.1-3.4

[70] Flynn TN, Chan P, Coast J, Peters TJ. Assessing quality of life among British older people using the ICEPOP CAPability (ICECAP-O) measure. Applied Health Economics and Health Policy. 2011;9(5):317–29.
[71] ABS/AIHW Health status: Wellbeing - Australia's health performance framework - Australian Institute of Health and Welfare (aihw.gov.au)
[72] Ware JE, Sherbourne CD. The MOS 36-item short-form health survey (SF-36): I. Conceptual framework and item selection. Med Care. 1992;30(6):473–83
[73] AIHW Health of older people - Australian Institute of Health and Welfare (aihw.gov.au)
[74] AIHW Coordination of health care - Australian Institute of Health and Welfare (aihw.gov.au)
[75] Vic Health Partnerships Tool The partnerships analysis tool (vichealth.vic.gov.au)
[76] WHO MergedFile (who.int); Microsoft PowerPoint - 2017 12 02 WHO Berlin healthy ageing measures Ritu Sadana updated 16 9 format distribution.pptx (crn-i.org)

		for personal growth (e.g. to learn, grow, make decisions)		
	Physical wellbeing	Decrease in rates of potentially preventable hospitalisations among people in need of long-term care Decrease in rates of potentially avoidable deaths among older people in need of long-term care Decrease in the rate of frailty by age among older people in need of long-term care	• Change in potentially preventable hospitalisations (AIHW)[77]	3.1-3.4
	Social wellbeing	Increase in the proportion of older people in need of long-term care who experience quality social connections Increase in the proportion of older people in need of long-term care who feel able to build and maintain relationships and possibility for enjoyment	• Changes in having people living outside the household who could provide support (AIHW[78];General Social Survey[79]; Australian Community Participation Questionnaire (ACPQ)[80]; ICEpop CAPability measure for Older people (ICECAP-O)	3.1-3.4
	Mental wellbeing	Decrease in the proportion of older people in need of long-term care experiencing psychological distress Increase in the proportion of older people in need of long-term care with adequate emotional support and security Increase in the proportion of older people in need of long-term care who score positively to meaning of/satisfaction with life metrics	• Change in psychological distress (ABS)[81] • Change in people who rate their physical and mental health as not good in the past 30 days • Mood & emotional health via the Medical Outcomes Study Questionnaire Short Form (SF-36)[82]	3.1-3.4
	Functional ability	Decrease in the proportion of older people in need of long-term care who have limitations in 1 or more 5 basic activities/needs of daily living Increase in the proportion of older people in need of long-term care who perceived to have autonomy to move around	• Change in assistance in activities of daily living (ABS Census Population and Housing; DSS Survey of Disability, Ageing and Carers)[83]	3.1-3.4

[77] AIHW Health status: Health conditions - Australia's health performance framework - Australian Institute of Health and Welfare (aihw.gov.au)
[78] AIHW Older Australia at a glance, Mental & social wellbeing - Australian Institute of Health and Welfare (aihw.gov.au)
[79] Australian Bureau of Statistics. General Social Survey: Summary Results, Australia. (2021). Available from: https://www.abs.gov.au/statistics/people/people-and-communities/general-social-survey-summary-results-australia/latest-release
[80] Flynn TN, Chan P, Coast J, Peters TJ. Assessing quality of life among British older people using the ICEPOP CAPability (ICECAP-O) measure. Applied Health Economics and Health Policy. 2011;9(5):317–29.
[81] ABS/AIHW Health status: Wellbeing - Australia's health performance framework - Australian Institute of Health and Welfare (aihw.gov.au)
[82] Ware JE, Sherbourne CD. The MOS 36-item short-form health survey (SF-36): I. Conceptual framework and item selection. Med Care. 1992;30(6):473–83
[83] Disability, Ageing and Carers (Survey of) (abs.gov.au)

Strategic Priority 4

No program logic is presented for priority 4. Goals and actions under this priority theme are considered enablers of actions across the strategy.

KPIs

KPI / Indicator	Related goal
Healthy ageing outcomes are defined and monitored to support the strategy	4.1
All healthy ageing actions are evidence-based	4.1
All healthy ageing strategy actions/programs are evaluated for quality (process evaluation) and outcomes (impact and outcome evaluation)	4.1
Number of projects and/or partnerships of an innovative or research nature	4.1
Healthy ageing strategy governance, communication and planning processes (including reporting and monitoring) are established and regularly monitored	4.1
Proportion of key stakeholders by type that are aware of the healthy ageing strategy, relevant healthy ageing actions impacting directly on their profession, and are actively working in partnership with the PHN in progressing its actions	4.1, 4.2
Number and type of input provided to policy influencing healthy ageing	4.2
Engagement strategy established that ensures all relevant healthy ageing actions have the input of older people	4.2
Healthy ageing actions of the PHN are centred on increasing intrinsic capacity and functional ability of older people	4.3
Increase in the reach and quality of internal and external partnerships to plan for, deliver and evaluate the coordination of services and actions for older people	4.2, 4.3
Increase in number of multi-sector actions and partners and co-designed programs to progress healthy ageing	4.3
Aged care workforce meets aged care needs of communities	4.4
Aged care is perceived by community as an important workforce	4.4

Part B: Process evaluation framework

Below is a process evaluation framework based on that of Bauman and Nutbeam[84] to assess the implementation of a program. The purpose of presenting the framework is to provide staff with the range of factors to consider when deciding on what to assess a part of their process evaluation in developing their evaluation plans. The table below provides themes, questions and broad indicators that may be used to prompt thinking about how to assess the reach, quality and participation in a program to determine whether the program is being implemented as planned and reasons for deviations. Knowledge gained from process evaluation is intended to be used to re-design or modify a program so it is being rolled out as well as it can be. Process evaluation and ensuring a program is running optimally should always be completed before assessing or evaluating program impacts or outcomes and is vital in improving the program quality.

Theme	Process indicator/s
1. Exposure/awareness *i.e. Who is, and is not, aware of the program or elements of the program?* *(People will not participate in a program unless they are aware of it.)*	
(a) Awareness *e.g. Do the target group, and staff or stakeholders, recognise the program or elements of the program?*	• Proportion and characteristics of the target population and relevant stakeholders who are aware of the initiative and its key components
2. Participation/reach/quality *i.e. What are the program participation rates?*	
(a) Participation rates *e.g. Who in the target group are, or are not, participating in the program?*	• Proportion and characteristics of the target population who are participating in the initiative compared with intended
(b) Participant satisfaction *e.g. Are participants satisfied with various aspects of the project –relationships with participants, activities, and content?*	• Level of participant satisfaction with the initiative, its components and implementation *(Considerations:* • *Level of comfort, feeling listened to/understood, friendliness of other participants, staff interest/ approachability/ sincerity* • *Convenience/comfort/adequacy/accessibility of venue, timing, cost* • *Topics relevant/interesting, presented in interesting ways, pace, complexity vs ease, things left out/not covered sufficiently)*
(c) Quality *e.g. Are project components of quality – content, activities, facilitators, and group leaders?*	• The level of quality of the initiative and its components *(Considerations:* • *Degree to which facilitators work/communicate with participants, friendliness, interest, ability to communicate/be understood, organisation/ directiveness, attention to detail, capacity to foster group* • *Attraction, comprehension, acceptability, personal, persuasion* • *Readability)*
(d) Stakeholder engagement *e.g. Are staff or stakeholders engaging in the program or elements of the program?*	• Number/proportion of stakeholders by type participating in/delivering the initiative as intended
3. Delivery *e.g. Are activities being implemented as planned? If not, why not?*	
(a) Session delivery *e.g., How many sessions are being delivered, where? How are sessions being delivered? Are they complete?*	• Extent to which the initiative is being delivered as planned • Types of deviations in implementation from what was planned and reasons why
4. Context/influencing implementation factors *e.g. What settings and contexts were programs delivered in?*	
(a) Impacts on participation and delivery *e.g. What factors influence program delivery – social, environmental, cost and other? What problems and barriers are reported by staff?*	• Factors positively and negatively affecting participation by target population and stakeholders in the initiative • Factors positively and negatively affecting delivery of the initiative by those responsible

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