AGEING WELL IN OUR REGION:

A healthy ageing strategy

2022 - 2027

phn
CENTRAL QUEENSLAND, WIDE BAY, SUNSHINE COAST

An Australian Government Initiative

Foreword

AGEING WELL IN OUR REGION:
A HEALTHY AGEING STRATEGY 2022 – 2027

I am delighted to present the Central Queensland, Wide Bay, Sunshine Coast PHN *Ageing well in our region: A healthy ageing strategy 2022 – 2027* (the strategy). This document outlines our strategic vision, to ensure that as people age, they have value in the community and are empowered to live the life of their choice.

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.

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. Achieving our vision and goals requires the commitment, participation and collaboration of many people across health, social and other systems in partnership with NGOs, communities, older people and their families. It was recognised, in development of this strategy, that a whole of-society response was required, working together and in collaboration across all sectors and agencies, which the PHN is only one small player. There is also already so much great work underway that we can build on in collaboration.

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

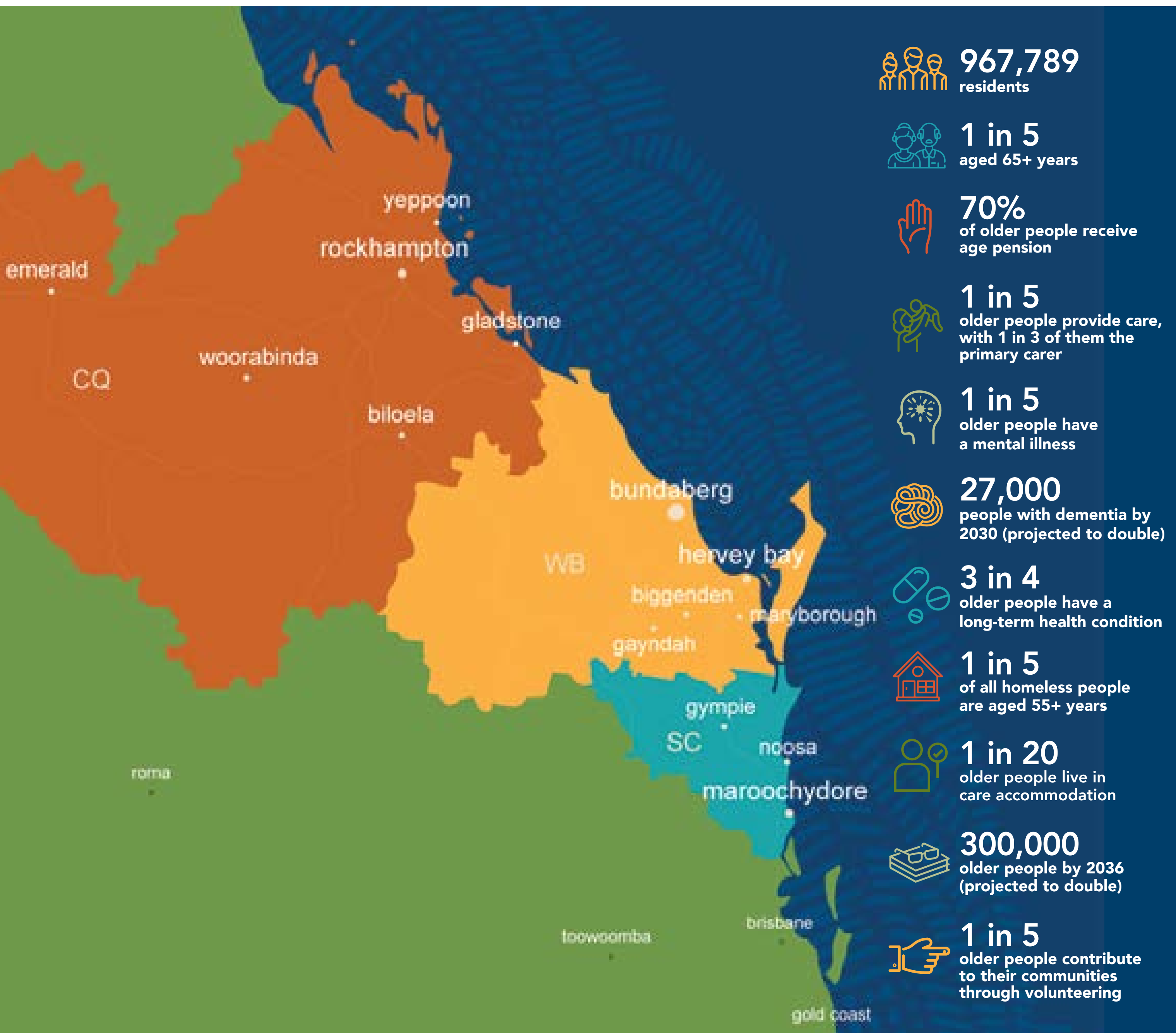
February 2022

Acknowledgments

Sunshine Coast Health Network Ltd acknowledges the Traditional Custodians on the land on which we work and live, and recognises their continuing connection to land, waters and community. We pay our respects to them and their cultures; and to Elders past, present and emerging.

The PHN pays 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.

Our region



Central Queensland, Wide Bay, Sunshine Coast Primary Health Network (PHN) is an independent not for profit commissioning agency funded by the Australian Government Department of Health to improve health outcomes across the region.

The strategy is an opportunity to consolidate actions needed across sectors to improve health outcomes for older people and achieve greater coordination and integration of efforts impacting on healthy ageing across sectors, health continuum, life-course and the spectrum of primary health care.

We are committed to working together with our communities, partners and stakeholders to improve health outcomes for older people, and to access and receive the right care in the right place at the right time.

Strategy scope

This strategy is grounded within the concept of healthy ageing and outlines the broad actions for the next five years.

Healthy ageing is 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 they inhabit across their lifespan.

The strategy:

- Articulates the vision, principles and goals to inform health planning, other care services and activities for healthy ageing in the PHN catchment.
- Identifies the strategic priorities and actions required by many agencies to achieve positive health and wellbeing outcomes for older people.
- Provides a framework for responding to national and state policy and health sector reform for the region.
- Identifies future opportunities for improving healthy ageing outcomes for older people to enable agile responses as funding, research or partnership opportunities arise.
- Provides a consistent framework, and shared direction and intent to be lead by critical leaders, partners and stakeholders across the region.

UNDERPINNING PRINCIPLES

Intrinsic value	Respecting autonomy	Equity and diversity
Empowering and patient centred	Contribution and participation	Progressive health system

Goals and actions

The following action plan identifies the key goals and actions for each priority area to achieve our vision for our older people. They will be used to inform operational planning and co-commissioning opportunities.

The action plan emphasises the need to work collaboratively across sectors and agencies. Many of these actions require collective engagement with communities, older people and their families.

Actions with this icon represent the PHN as a lead role. Other actions will require the leadership of other agencies and community groups.

A copy of full strategy is available LINK

Strategic priority 1: Goals

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.

Actions

SHORT TERM

- Support and invest in strategies targeting people at risk of chronic conditions
- Continue to deliver PHN Mental Health Stepped Care services
- Promote and build on local programs that provide social engagement and participation opportunities
- Support development and implementation of referral pathways to identify and refer people in need of housing and other social supports
- Improve awareness and referral pathways for older people experiencing elder abuse or family and domestic violence
- Enable conversations and decisions around individuals' health care and choices
- Support individuals' health literacy

SHORT-MEDIUM

- Promote and support the uptake of the My Health Record
- Support strategies that empower people to actively plan for healthy ageing and end of life
- Support delivery of free or low-cost local physical activity programs and healthy lifestyle programs

MEDIUM

- Explore opportunities to support and invest in intergenerational health promotion and social support initiatives
- Promote carers' wellbeing and social connection experiences
- Partner to develop age-friendly and dementia-friendly communities
- Improve skills, awareness and understanding about elder abuse and risk factors

Strategic priority 2: Goals

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.

Actions

SHORT TERM

- Support health care providers to undertake health checks at 45+ and 75+ years and for those with chronic conditions
- Commission early intervention and monitoring activities to support healthy ageing
- Promote screening at clinically indicated ages for risk factors for dementia and frailty
- Support RACFs to ensure residents have equitable access to clinical supports
- Build primary health care (PHC) workforce capacity on the role of frailty and functionality as an indicator of poor health
- Support health professionals to improve referrals to My Aged Care, Care Finders, Carer Gateway and NDIS
- Work collaboratively with COTA Queensland to provide access to Community Care Finders
- Support/facilitate local communities to plan, develop and deliver local workforce solutions
- Partner with HHS to investigate development of an early supported discharge model

SHORT-MEDIUM

- Form a collaboration between PHN, general practice, Queensland Ambulance Service, and Hospital and Health Service to co-design a Frequent Flyers project

MEDIUM

- Co-design and deliver multidisciplinary home and/or community-based falls prevention programs
- Support and enhance cultural appropriateness, competency and safety of services and supports
- Extend the scope of PHN in-reach mental health services to residential aged care facilities (RACFs)
- Explore and implement strategies to address travel and transport barriers to access
- Promote the aged care workforce as a speciality and a discipline of value, and support career pathways

MEDIUM-LONG TERM

- Explore feasibility of a Wellbeing Checks / Community Check-in program or model
- Deliver a culturally and linguistically safe training package for commissioned service providers and PHC

LONG-TERM

- Partner with private-public entities to explore new (or existing) models of integrated care that support prevention, management and rehabilitation for people with chronic conditions

ONGOING

- Improve access to services for older people in regional, rural and remote areas
- Continue to support delivery of the Integrated Team Care program
- Explore ways to improve vaccination uptake for the aged care workforce

Strategic priority 3: Goals

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 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.

Actions

SHORT TERM

- Support and increase primary health care in-reach services into RACFs
- Support effective clinical handover and communication between primary and acute/secondary care
- Explore strategies to better provide and integrate GPs and geriatric specialist care for older people
- Develop nationally-consistent aged care and dementia referral pathways
- Explore opportunities to improve access to assistive technologies for older people with disabilities
- Work with Dementia Training Australia to provide training and education to PHC workforce
- Partner to provide access to patient centred, coordinated care for individuals at end of life in communities
- Support trauma-informed aged care services through resources and information
- Collaboratively develop and implement a model to support older people with behavioural and psychological symptoms of dementia
- Explore feasibility of a Hospital in the Nursing Home model of care in residential aged care facility

ONGOING

- Promote the advance care planning initiatives
- Continue to support the development and implementation of Compassionate Communities models
- Provide resources and education to RACFs to enhance the end-of-life experience in residential aged care
- Deliver programs that expand knowledge and skills in the palliative approach

Strategic priority 4: Goals

4.1 Healthy ageing outcomes are defined and monitored, and programs evaluated to ensure quality health care and outcomes for older 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 will help potential workers choose aged care as a career pathway.

Actions

SHORT-TERM

- Use data to inform ongoing planning and targeted investment
- Inform and influence policy at all levels of government, strategy and processes
- Support active participation of older people in the design of the health sector
- Partner to build a strong research culture and identity in care of older people
- Partner to drive localised research opportunities to inform healthy ageing agenda

MEDIUM-LONG

- Drive reform of PHC sector to focus on intrinsic capacity of older people across all forms of functionality
- Advocate for change in wages and support for the aged care workforce/sector
- Collaborate to develop a united strategic action plan for falls

ONGOING

- Continue to facilitate the palliative care interagency forums
- Continue to facilitate RACF forums for collaboration and shared learnings
- Continue to attend the Levels of Government Healthy Ageing Action

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