HEALTHY NORTH COAST

Healthy Ageing Strategy

2023 - 2027

phn NORTH COAST
An Australian Government Initiative

Healthy North Coast is an independent, not-for-profit organisation proudly delivering the PHN Program in North Coast NSW. We are committed to improving the health of our communities through quality primary health care. The PHN program is an Australian Government initiative.

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HNC23015

Healthy North Coast acknowledges the Traditional Custodians of the lands across our region, which include the Githabul, Bundjalung, Yaegl, Gumbaynggirr, Dunghutti and Birpai nations. We pay respect to Elders past, present and on their journey. We recognise these lands were never ceded and acknowledge the continuation of culture and connection to land, sky and sea. We acknowledge Aboriginal and Torres Strait Islander Peoples as the first peoples and honour the rich diversity of the world's oldest living cultures.

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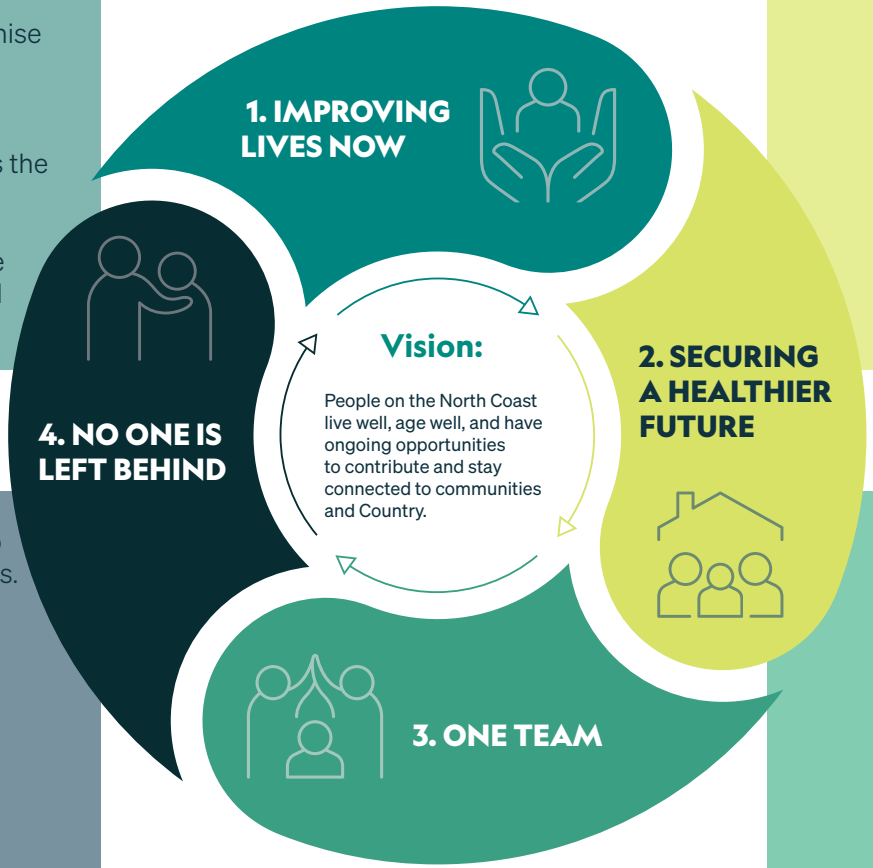

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Strategy Enablers:

To implement the strategy and translate these priorities and actions into outcomes, the following enablers are required: engaging with the voices of older people, joint planning, partnerships and governance, strengthening data, research and innovation, digital health technology and systems, capable workforce, and financial sustainability.

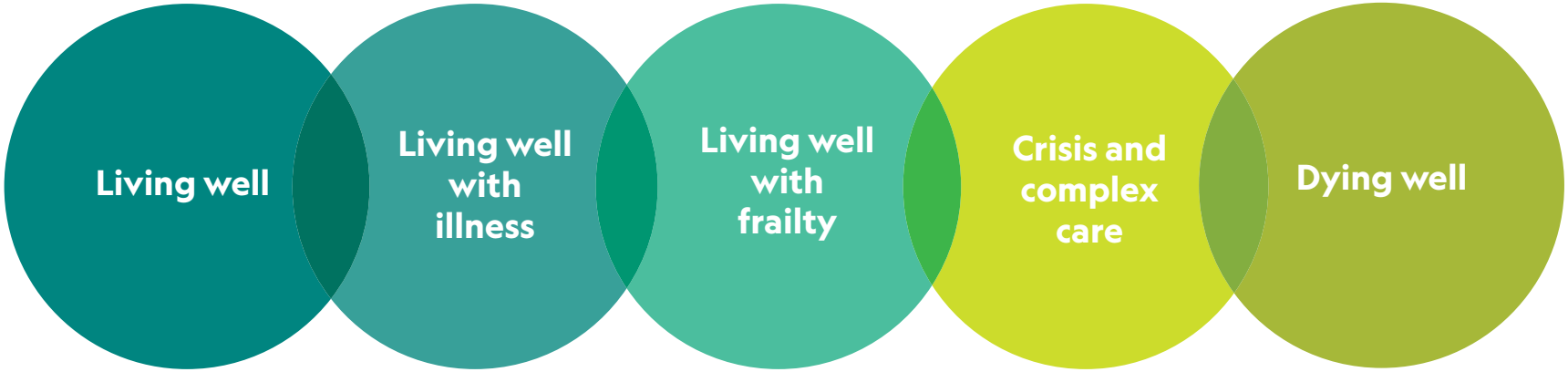
Executive summary

Healthy North Coast has developed the Healthy Ageing Strategy with the vision 'People on the North Coast live well, age well, and have ongoing opportunities to contribute and stay connected to communities and Country.' Healthy ageing is not just planning supports and services for older people, it is about all of us planning for healthy ageing. The actions in the strategy will contribute to healthy ageing across the life course by increasing health literacy, improving access, quality, continuity and integrating services. Coordinating efforts across different sectors improves efficiency and effectiveness, reduces duplication, and enables a whole-of-system approach to improving health outcomes for older people.

This Healthy Ageing Strategy has been developed with a population health approach and focuses on wellness, independence, and enablement. The purpose of the strategy is to improve population health outcomes and direct investment towards evidence-informed healthy ageing initiatives as new funding, research or partnership opportunities arise.

Healthy North Coast has taken a value-based healthcare approach considering the five domains of care (Figure 1). This approach focuses on living well, or to one's optimal best, across the domains with integrated primary, acute and aged care services from prevention and early intervention through to palliative care.

Figure 1: Five Domains of Care[1]



Value-based healthcare approaches move the key focus of care from activity to achieving outcomes. The aim is to improve the quality and effectiveness of health care and doing this in the most efficient way. It is underpinned by the quadruple aim (Figure 2).

Figure 2: Quadruple Aims of Healthcare[1]

Patient experience of care

Safe, accessible and effective care with a key focus on the needs of the patient.

Provider delivery of care

Improving the experience of care through quality improvement and leadership.

Population health

Improving access and inequities and addressing the health needs for Healthy North Coast.

Efficiency of care

Providing the best care efficiently.

By adopting a value-based approach, clinicians, networks and organisations work together on joint regional plans and have shared goals and governance. These partnerships will embed integration of services and pathways for older people through a whole-of-system approach and promote evidence-informed service development to address identified gaps. This approach will enhance people's experience and population health outcomes, reduce cost, and foster a satisfied workforce. Delivering value-based healthcare involves achieving outcomes that matter to people.

To best meet the needs of the Healthy North Coast region through planning, commissioning and collaborating, a system, population and individual-level approach has been taken. Defining the Healthy Ageing Strategy with a consideration of these levels will assist in identifying gaps, prioritising needs, and targeting strategies at the appropriate level. This is consistent with the quadruple aim and system thinking approaches and will enable the identification of monitoring indicators and outcome measures.

Different levels of government have policy responsibility for planning for an ageing population. The Australian Government has responsibility for key areas impacting ageing policy, including primary health, aged care, National Disability Insurance Scheme, and income support. The NSW Government has responsibility for hospitals, some community health services, Multipurpose Services (MPS), health promotion, transport, social housing, and justice. Councils are responsible for community infrastructure, facilities, and programs to meet the local needs of an ageing population,

including footpaths, parks, and community centres.

These different and overlapping areas of responsibility can contribute to system fragmentation and disconnected care. This Strategy aims to address this by taking a collaboration, systems and partnership approach encompassing joined-up supports and services for our communities.

This strategy has been developed with the voice of older people at its heart. Community consultation occurred from 2019 to the present. There will be continuing community consultation and stakeholder engagement to embed the voice of the consumer and build shared direction throughout the implementation of
the Strategy.

Several factors or enablers need to be considered for implementation, as they will contribute to the translation of the priorities and actions into outcomes. These include:

Engaging with the voices of older people throughout design and implementation to ensure they are influencing decision making as well as being service beneficiaries.

Joint planning, partnerships and governance between health and other sections are critical to improving the health and wellbeing of older people.

Strengthening data, research, and innovation.

Ability to age in the right place, including ability to access services.

Digital health technology and systems to support a connected and integrated service network for consumers and carers, reducing or removing service access barriers experienced by priority target populations.

Capable workforce.

Financial sustainability – the ageing population affects both health expenditure and revenue.

Healthy North Coast undertakes a wide range of activities to support the priorities, which are built into the action plan. These activities include:

Health promotion and disease prevention

Health literacy

Improving access and quality of primary and aged care services

Regional planning and commissioning

Supporting workforce education, training, and development

Increasing integration and coordination of health and aged care services and

Supporting evidenced-based practice and practice-based evidence across primary and aged care.

The priorities that will deliver the vision of the Healthy Ageing Strategy are grouped into four areas:

Priority 1. Improving lives now

GOAL: People live well and age well, exercising choice, and participating in family and community life as desired

Why is it important?

People across the Healthy North Coast region are living longer, though not necessarily healthier, more active lives. As people age, they are more likely to experience multiple health conditions at the same time. We want people to experience the benefits of these extra years of life in good health so they can continue to do what is important to them, participate in family life, remain socially connected and be involved in the community.

Conditions commonly associated with ageing, such as chronic disease, frailty, dementia and depression, can complicate the normal ageing process. The increasing longevity and proportion of older adults who live with chronic conditions will exert pressure on the healthcare system for the provision of more appropriate care, including the availability of reliable health information. We need to work with older people and people moving towards older age to enhance their capacity and capability to access information, exercise choice, self-manage, navigate the health and aged care systems and access services at or closer to home.

People want to die comfortably at home or in a home-like environment, with minimal pain and suffering, supported by family and friends and effective services.[3] A good death gives people dignity, choice, and support to address their physical, personal, social, and spiritual needs. We need to support people to die well by promoting the importance of end-of-life planning.

Carers play a significant role in supporting families and friends as they age. Carer roles can require a lot of time and energy and are associated with poor physical and mental health.[4] The need for carers will increase as our population ages, and we need to support people to maintain their own health and wellbeing.

What do we want to achieve?

People can access information and services that enable choice and maximises self-management.

People are supported to create and maintain meaningful connections.

People live at their optimal best across the continuum of ageing.

People are supported to die well.

Carers are supported in their carer role while maintaining their own health and wellbeing.

See Appendix 6 Action Plans, page 39

Priority 2.
Securing a healthier future

GOAL: People are healthy, well, and independent with good quality of life now and into the future

Why is it important?

More people are living full and productive lives well into old age. Living a healthy lifestyle earlier in life will give you a better chance of staying healthy as you get older. Meaningful engagement and social interactions throughout our lives can have a positive impact on health and wellbeing. For a healthier future we need to prevent disease, promote health, maintain intrinsic capacity and enable ability.

The most important basic needs of older adults, beyond health and social support, are financial security, adequate housing and a safe environment. Creating communities that are more age friendly can contribute to the wellbeing of older people.

Promoting good health and healthy behaviours across the life course can prevent or delay the development of chronic disease and can support independence and community engagement. Enabling people to learn and plan, throughout life, to prepare themselves for all stages and to cope with chronic illness and injuries is essential, particularly planning for their future health and care needs.

Health literacy, which is how people access, understand, and use health information to benefit their health, is important because it affects capacity to make decisions, to take action to manage our health and health care. People with low health literacy are more likely to have worse health outcomes and poorer health behaviours.[5]

We need to work with our partners in government, council, and community organisations to develop solutions that promote healthy living, challenge ageism, create age-friendly environments and assistive technology for ageing in place and strengthen early intervention to prevent chronic health issues.

Ageism can have a negative impact on people's health and wellbeing. Negative stereotypes, prejudice and discrimination toward older people can reduce their physical and mental health, increasing their care needs, reducing their quality of life, and contributing to negative health outcomes.

What do we want to achieve?

People have their basic needs (housing, finances, and personal safety) met.

People stay healthy and well, engaging in healthy behaviours.

Ageing and end of life is normalised.

See Appendix 6 Action Plans, page 42

Priority 3.
One team

Why is it important?

As people age, many will experience chronic illness, disability and/or physical or cognitive decline and subsequently have higher health care needs and costs. We have increasing demands for health care by the growing number of older people in our region.

To address these increasing health care demands, a coordinated team-based approach to care delivery is needed. Integrated care, or the provision of well-connected, effective, and efficient care that takes account of a person's health and social needs[6], is particularly important for people with complex and long-term conditions, including those with chronic conditions, frail older people, people with disability and those at the end of life. It helps them manage their own health, keeping them healthy, independent, and out of hospital for as long as possible.

Many older people visit multiple providers, which means they are at increased risk for fragmented care. Integrated care has the potential to improve the quality of care for older people, service users and carers by ensuring all services are well coordinated around their needs. As part of an integrated care model, we need to support the ongoing adoption and implementation of innovative virtual care services across the region.

A key element in moving towards a more integrated system is improving the continuity of care through the use of data. Data tends to sit in silos and do not follow the patient through their care journey. Connecting these data silos through linked data enables the patient to be viewed holistically, with a greater understanding of the patient and subsequently driving improved quality of care.

We need to invest and build partnerships to collaborate on service planning, population health, regional commissioning, and shared service delivery. Strong evidence-informed examples such as Integrated Care Partnerships[7] in the United Kingdom provide a platform to explore improved integration, investment and collaboration.

Workforce is a key aspect of integrated care. A workforce engaged in providing integrated care is wide and diverse, performs as "one team" and facilitates a more coordinated approach. This coordination enables more joined-up and person-centred care.

What do we want to achieve?

Regional collaborations and partnerships that are responsive to population health needs.

People experience joined-up care.

Virtual care is normalised and improves access and health outcomes across the region.

Sustainable and capable primary and aged care workforce.

See Appendix 6 Action Plans, page 43

Priority 4.
No one is left behind

Why is it important?

'Leave no one behind' is a central promise of the United Nations Sustainable Development Goals and aims to reduce the inequities and vulnerabilities that leave people behind and undermine their potential[7]. Key dimensions of inequity are ethnicity, nationality, age, disability, sexuality, education, employment, and socio-economic status. Inequities compound across the life course with early life conditions and experiences driving outcomes in older age.

There are several priority target populations in the North Coast region, including Aboriginal and Torres Strait Islander peoples, people from culturally and linguistically diverse backgrounds (CALD), lesbian, gay, bisexual, transgender, intersex, queer + people (LGBTIQ+) and people living in rural and isolated areas.

As well as these priority target populations, there are those who are living with conditions of higher prevalence, such as dementia. Dementia is forecast to increase in the region by 2058, with Tweed cases forecast to grow by 91% and Ballina by 68%.[9]

Our region has a high proportion of Aboriginal people (6%), which is nearly three times higher than NSW (2.1%), with Kempsey (12.9%) having a rate almost six times higher. Healthy ageing is a significant health intervention for Aboriginal people due to the earlier onset of chronic diseases.[10]

The Royal Commission into Aged Care Quality and Safety found that people receiving aged care, particularly those in residential aged care homes, do not always receive the health care they need.[11] The report identified the need for more programs that provide services that are culturally safe for Aboriginal and Torres Strait Islander peoples, people from CALD backgrounds, refugees and LGBTIQ+ communities. Furthermore, it highlighted the need for better support so that all older people have access to information and can navigate the aged and healthcare systems, as well as access preventative care and early intervention.

We need to better understand the needs of these cohorts in our region, particularly the wider determinants of health and how they contribute to health and wellbeing, ensuring that these groups have the same opportunities and options for healthy ageing that are available to all older people. Equitable health and aged care systems require service availability for all people based on need. Services need to be appropriate and inclusive for older people in these priority target populations.

What do we want to achieve?

Services are flexible and responsive to the needs of priority target populations.

Aboriginal and Torres Strait Islander peoples age well, enabled by spiritual, physical and mental wellbeing and connections to person, place and culture.

The wider determinants of health are addressed.

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Appendices
1. Background

The Healthy North Coast region is facing a rapidly ageing population driven by increasing life expectancy, declining birth rate and increased regional migration of middle-aged people and retirees (Figure 3). This has implications for the future of our healthcare system, the provision of community and aged care services and the quality of life and wellbeing of the population. Older people contribute significantly to our communities – as family members, elders, mentors, leaders, skilled workers and volunteers. Good health is fundamental to being able to live well and age well, enabling older people to contribute socially, culturally and economically to their community.

Our current health system and disease-focused model of care is not yet well-equipped to support our growing, ageing population. This model does not suit older people who often have multiple chronic conditions and more complex needs. Older people must navigate a complex system and often require higher levels of healthcare resources. An integrated model of care, centred around the person's needs and care experience will ensure resources are used more efficiently. The disease-oriented approach can obscure individual characteristics such as access to services and cultural safety, particularly for priority target populations.

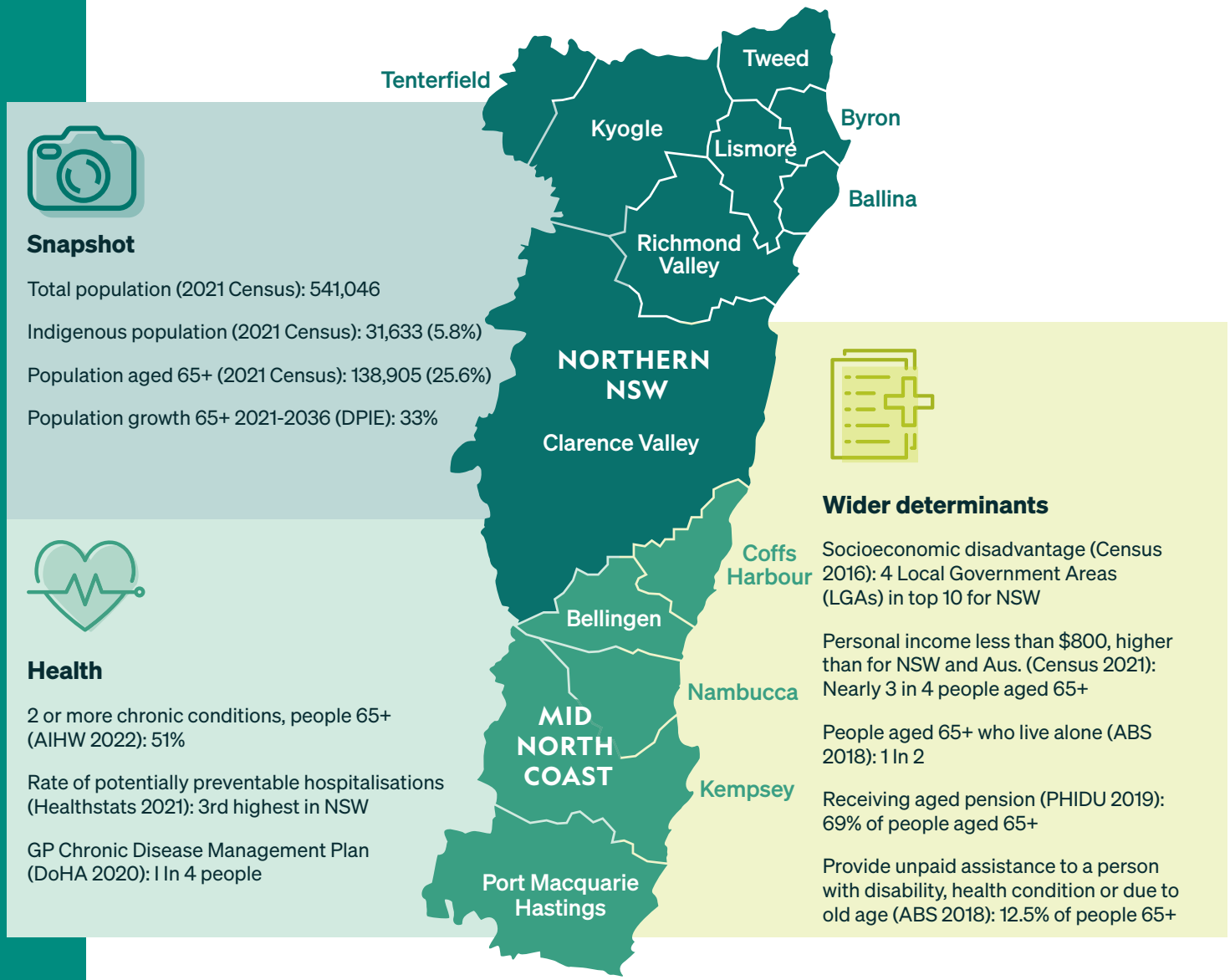
Healthy North Coast began work on the development of a Healthy Ageing Strategy in 2019. Community consultation and a literature review informed the development of an Ageing Systems Dynamic Model in collaboration with the Sax Institute. Healthy North Coast worked with ARTD Consultants in 2021 to complete an intergenerational report into community perceptions of healthy ageing. Codesign with stakeholders, including older people, their families and carers, service providers, clinicians, and the general community, was undertaken in Ballina and Coffs Harbour in late 2022, focusing on the ageing journey (see Appendix 4 for further details and emerging themes).

A systems-thinking approach has been adopted in the design of the Strategy. This approach allows us to explore the characteristics and interconnectivity at a system, population and individual level to improve understanding of how outcomes emerge from these interactions. Efforts are needed at all levels to support healthy ageing (see Appendix 2). By taking a systems-thinking approach through the lens of the quadruple aim, we were able to prioritise initiatives to support our vision for healthy ageing across our footprint.

Healthy ageing is a lifelong process, starting when we are born. Through health promotion and prevention activities it is possible to add not only years to life but also life to years.

The World Health Organisation (WHO) defines healthy ageing as "the process of developing and maintaining the functional ability that enables wellbeing in older age", with functional ability being more than just physical but the "health-related attributes that enable people to be and do what they have reason to value."[12]

Figure 3: Snapshot of the Healthy North Coast Region



Our regional *Health Needs Assessment* identifies key issues and primary healthcare priorities across Healthy North Coast region, including:

- The North Coast population is comparatively older than the NSW and Australian populations.
- North Coast residents are living longer and with more chronic conditions.
- An ageing population is increasing the demand for health and aged care services.
- Older people with multi-morbidity have complex health and support needs, requiring integrated, responsive, and scalable services.
- Some rural LGAs experience relatively more socio-economic disadvantage and are at a greater physical distance from major health infrastructure.
- Digital health service models could reduce service access barriers experienced by priority target populations.

The Strategy has been informed by priorities identified in international, national, state, and local policies (Figure 4). Key healthy ageing priorities across all levels of government are age-friendly environments, integrated care, challenging ageism, inclusive communities, joint planning, improving health literacy and value-based healthcare.

Figure 4: Healthy Ageing Policy Context

International	National
UN Decade of Healthy Ageing 2021-2030	National Health Reform Agreement 2020-2025
UN Sustainable Development Goals	Royal Commission into Aged Care Quality and Safety
	National Palliative Care Strategy 2018
	National Safety and Quality Health Service Standards

State	Regional
Ageing Well in NSW: Seniors Strategy, 2021-2031	Healthy North Coast Strategic Plan
NSW Regional Health Strategic Plan 2022-3032	Healthy North Coast Health Needs Assessment
NSW Carers Strategy: Caring in NSW 2020-2030	Local council community development and ageing plans

An ageing population is driving changes to how health and ageing services are planned and delivered and will also drive changes to how communities evolve to meet the needs and preferences of the people that live in those communities. Aged care is one of the seven National PHN priority areas; however, the focus of this area is much broader than just aged care. The following outcomes for this priority area include:

- older people can access primary healthcare services that meet their needs, including self-care in the home
- older people are supported to enjoy a greater quality of life
- fewer preventable hospitalisations for older people

The *Royal Commission into the Aged Care Quality and Safety* final report, Care Dignity and Respect, calls for fundamental and systemic aged care reform with 148 recommendations[11].

Healthy North Coast has received funding to address several areas that affect aged care residents, forming key short-term deliverables of the Strategy, including:

- access to GPs and allied health providers in residential aged care homes (RACHs)
- unnecessary hospital transfers
- telehealth care for aged care residents
- enhanced out-of-hours support for residential aged care homes
- dementia pathways to support assessment and referral
- early monitoring and identification of health needs to support people to live at home
- local health and other care providers are supported to deliver *coordinated, effective and appropriate* care to older people
- local healthcare systems provide coordinated, quality care to older people[13]

For people on the North Coast to live well, age well and have ongoing opportunities to contribute and be connected to community and Country, we need to:

- improve lives now
- secure a healthier future
- become one team of health and social services
- ensure that no one is left behind

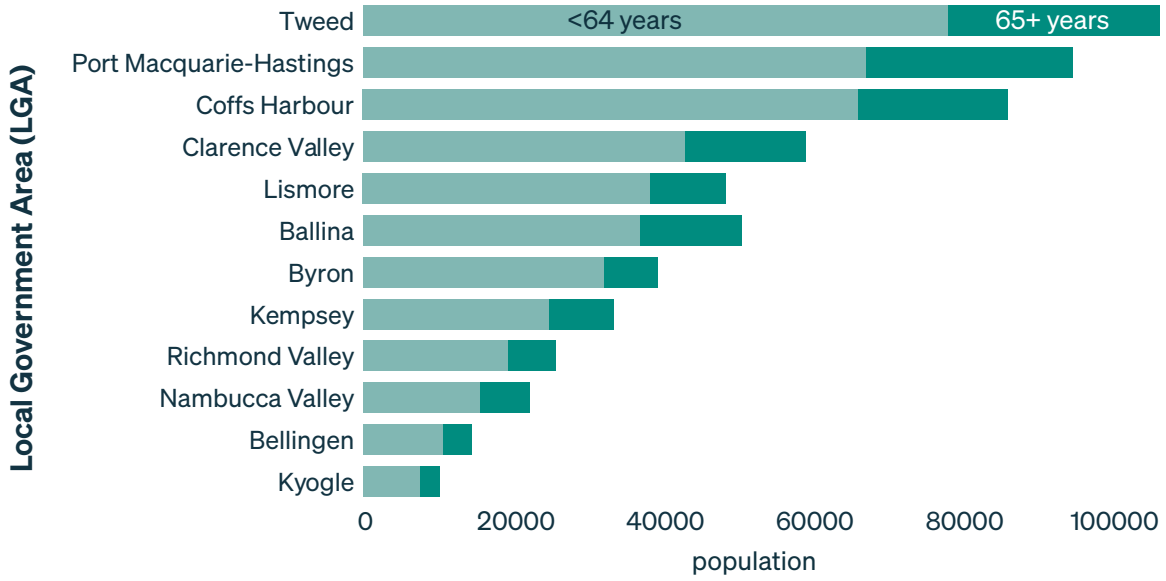
Appendices
2. Demographics

The Healthy North Coast region has a total population of 541,046 persons, covering twelve LGAs (Figure 5). The population is growing and ageing, with the total population projected to increase to 580,270 by 2036 and 1 in 2 people aged over 50 years.[14]

Already, 1 in 4 people across the region are aged 65+ years compared to less than 1 in 6 people in both NSW and Australia.[15] Healthy North Coast has nearly 10% of all people aged 65+ in NSW even though we only have 7% of the NSW population. Nambucca Valley has the highest proportion of the population aged 65+ at 30%, with Port Macquarie the next highest at 29% (Figure 5). Byron has the lowest proportion of people 65+ years at 19%, which is still higher than the NSW total proportion of 17.6%.

Figure 5

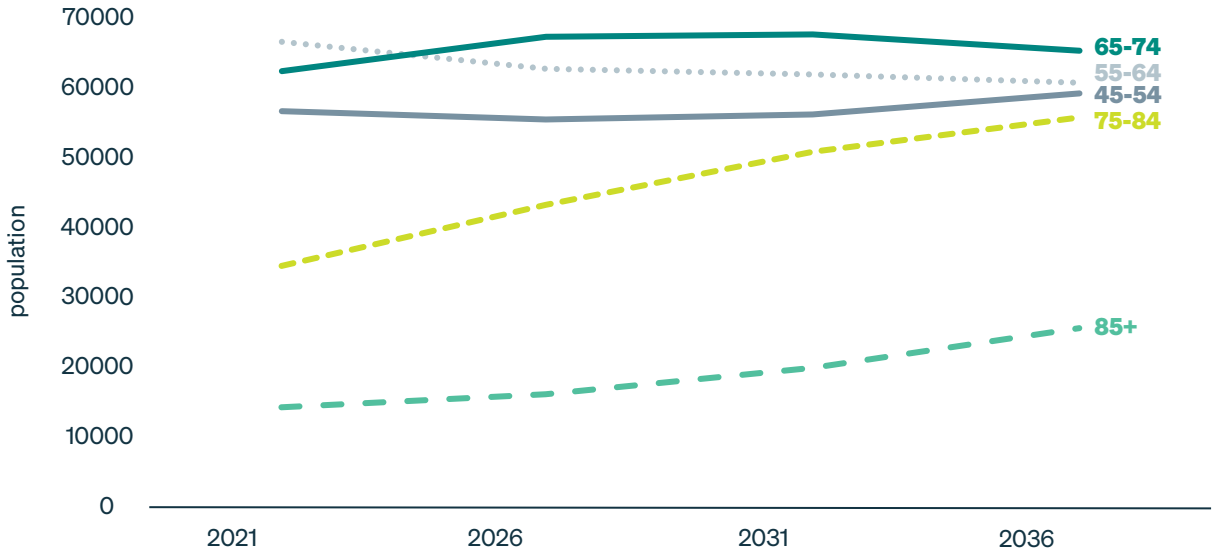
The highest number of people aged 65 years and over are in Tweed and Port Macquarie-Hastings, reflecting that these LGAs have the largest overall population and the largest towns/regional cities.



There is no typical older person, and the support needs of a person aged 65 years are likely to be significantly different from a person aged 75 years or 85 years. The number of people aged 65+ across the Healthy North Coast region is projected to increase to almost 1 in 3 by 2036 with the largest growth in the 85+ age group (figure 6).[16] This higher ageing population has implications for healthcare, walkable and wheelable communities across the region and is likely to result in an ageing workforce.

Figure 6

The **65-74 age** group begins to decrease from 2031, and the **85+ age** group has the largest growth over time.



SOURCE: DPE 2022

Across the Healthy North Coast region, 6 in 100 people identify as Aboriginal and Torres Strait Islander, compared to 3 in 100 in Australia.[17] The Aboriginal population exhibits quite different demographics to the non-Aboriginal population, generally is younger, and growth in the older population is slower than in the non-Aboriginal population. The proportion of Aboriginal and Torres Strait Islander peoples aged 50 years and over varies across the Healthy North Coast region and is higher than the NSW average (Figure 7). Due to the disparities between Aboriginal and non-Aboriginal people, Aboriginal people tend to have a shorter life expectancy and increased chronic illness at a younger age than non-Aboriginal people.[18]

Figure 7

All Healthy North Coast LGAs have a higher proportion of Aboriginal and Torres Strait Islander peoples aged over 50 years than for NSW.

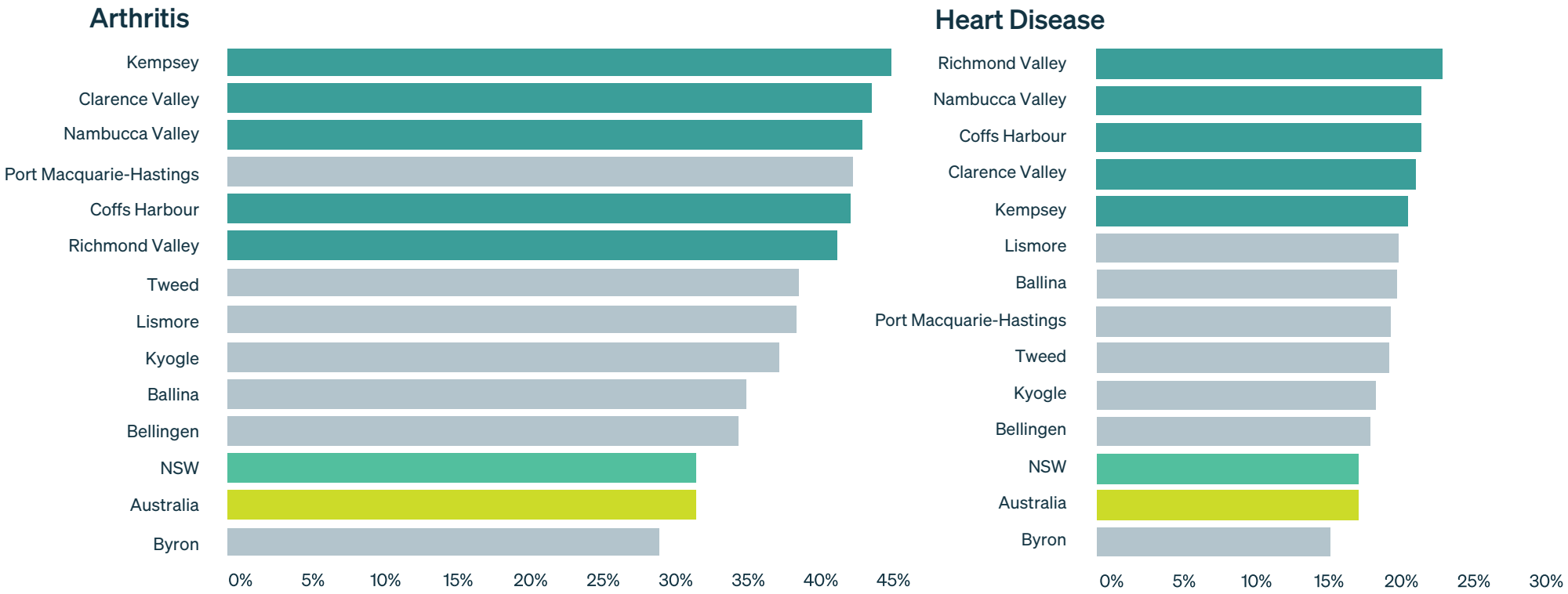
SOURCE ABS 2021

The net migration of all people to the region is 4,500 per annum, with an increase of people who move to the region in retirement. Some local retirees have the means to successfully manage an independent retirement and enjoy their later years with minimal health and social sector support until they are very old. Others face significant social disadvantage. Many move to be closer to family, while others have left family behind so may have less support.

Chronic conditions are an ongoing cause of substantial ill health, disability, and death across the Healthy North Coast region, making them a priority for intervention. Chronic conditions have complex and multiple causes and, once developed, they generally require long-term management. Many people with chronic conditions experience multimorbidity (the presence of two or more chronic conditions), and this becomes more common with age. In our region, 1 in 2 people aged 65+ years have two or more chronic conditions (compared with 1 in 10 for the 15–44-year age group).[19] People aged 65+ years in the Healthy North Coast region have a higher incidence of arthritis and heart disease than NSW and Australia (Figure 8).

Figure 8

Clarence Valley, Kempsey, Nambucca Valley, Richmond Valley and Coffs Harbour LGAs have a higher proportion of people aged 65 years+ who have arthritis (left) and/or heart disease (right).

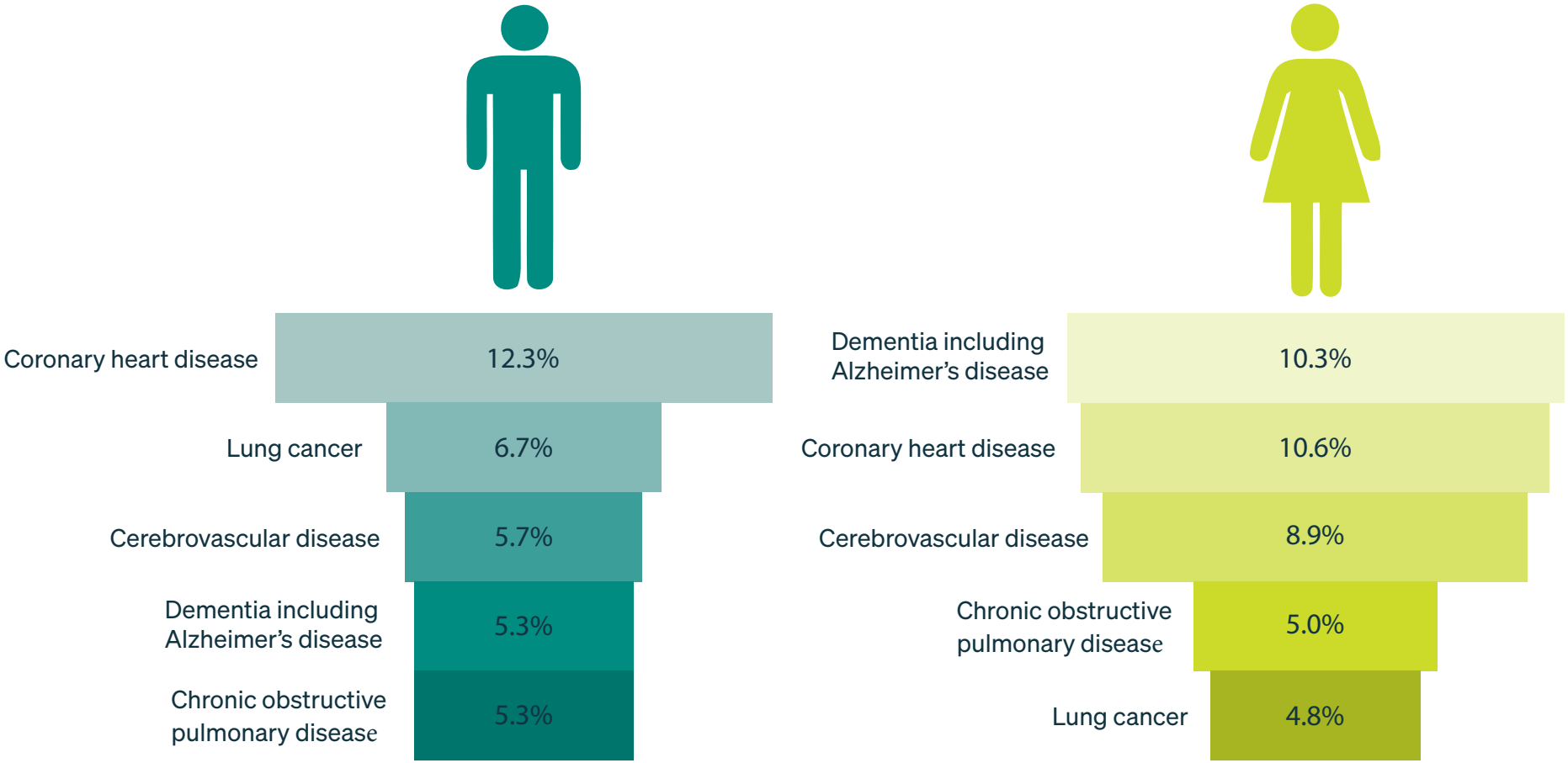


SOURCE: ABS 2021

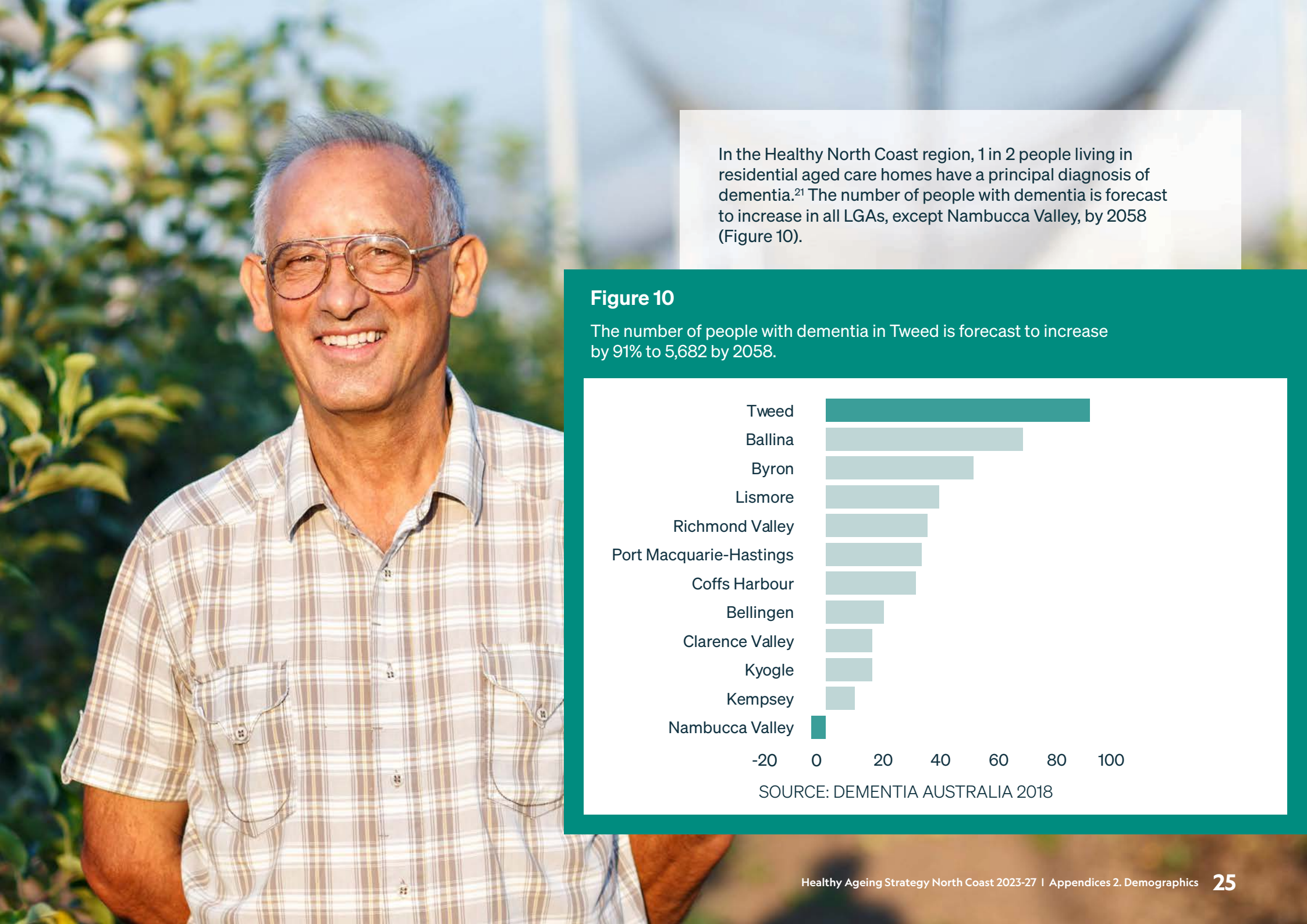
Dementia is a condition associated with ageing. Dementia was the second leading cause of death across the Healthy North Coast region from 2016 to 2020 (Figure 9). Tweed had the highest number of people with dementia in 2021, consistent with its high number of ageing residents, however, Coffs Harbour and the surrounding LGAs of Nambucca, Bellingen and Kempsey had the highest rates of hospitalisation for dementia.[20]

Figure 9

For every one death for males caused by dementia, including Alzheimer's, there are two deaths for females caused by dementia, including Alzheimer's, across the region.



SOURCE: MORT BOOKS 2022



In the Healthy North Coast region, 1 in 2 people living in residential aged care homes have a principal diagnosis of dementia.[21] The number of people with dementia is forecast to increase in all LGAs, except Nambucca Valley, by 2058 (Figure 10).

Figure 10

The number of people with dementia in Tweed is forecast to increase by 91% to 5,682 by 2058.

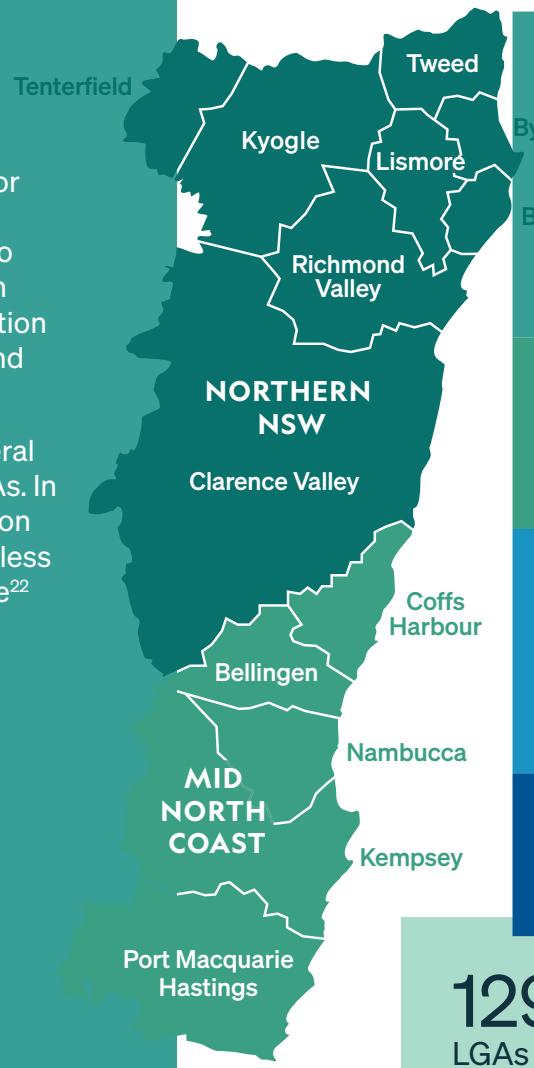
SOURCE: DEMENTIA AUSTRALIA 2018

With an ageing population and an increasing prevalence of chronic diseases, the demand for palliative care and end-of-life services across the Healthy North Coast region will continue to increase, and this should be considered a high priority. Many people with a life-limiting condition should have the opportunity to be cared for and die at home, where it is possible to do so.

The Healthy North Coast region includes several relatively advantaged and disadvantaged LGAs. In 2021, one-quarter of the North Coast population was in the most disadvantaged quintile, while less than 10% were in the most advantaged quintile[22] (Figure 11).

Figure 11

Greater than 8 in 10 people in Kyogle, Richmond Valley, Nambucca and Kempsey LGAs are in the most disadvantaged quintile.



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Lowest LGA Score in AU

HNC PHNs (with a selection of "adjacent" LGAs in NSW)							
Percentile AU	2021 LGA Name	Score	Rank HNC	Rank State	Rank AU	Lowest SA 1 Score	Highest SA 1 Score
7	Fairfield	814		1	35	508	1108
11	Walgett	888		5	56	591	1113
13	Kempsey	903	1	6	67	461	1069
13	Cumberland	904		7	68	657	1120
17	Canterbury-Bankstown	917		10	90	412	1168
17	Nambucca	920	2	11	91	711	1070
17	Tenterfield	920		12	93	743	1064
18	Kyogle	921	3	13	96	771	1029
19	Richmond Valley	924	4	14	99	551	1064
19	Liverpool Plains	926		15	103	781	1057
24	Cessnock	939		25	127	480	1135
24	Clarence Valley	940	5	26	130	669	1104
25	Moree Plains	940		27	133	419	1130
41	Cobar	965		45	221	900	1073
41	Lismore	966	6	46	224	616	1110
42	Berrigan	966		47	225	812	1107
45	Temora	972		55	244	880	1061
45	Coffs Harbour	972	7	56	246	651	1114
46	Carrathool	973		57	251	920	1089
52	Armidale Regional	980		66	281	485	1114
52	Bellingen	981	8	67	283	861	1075
53	Port Stephens	982		68	287	701	1118
54	Eurobodalla	985		72	295	782	1137
55	Port Macquarie-Hastings	985	9	73	297	652	1128
55	Dubbo Regional	985		74	299	517	1124
58	Maitland	988		77	313	489	1174
58	Tweed	989	10	78	314	768	1149
59	Wagga Wagga	989		79	318	499	1142
75	Newcastle	1012		97	406	372	1148
76	Ballina	1015	11	98	411	406	1133
77	Snowy Monaro Regional	1020		99	421	853	1124
78	Byron	1021	12	100	423	871	1094
78	Upper Lachlan Shire	1022		101	427	918	1124
99	Woollahra	1110		129	542	1015	1162

129
LGAs in NSW

547
LGAs in AU

1117
Highest LGA Score in AU

SOURCE: ABS 2023

Appendices
3. Older People's Needs at a System, Population, and Individual Level

Older People's Needs at a System, Population, and Individual Level			
Level	**System/Structure**	**Population/Equity**	**Individual/experience**
Objectives	Building strong structures for the integration of healthcare and wellbeing services across Healthy North Coast communities	Population health approaches to ensure equitable access to culturally appropriate services	Ensuring healthcare is patient-centred and focussed on what matters to patients
Focus	• Place-based planning • Networks • Clinical Advisory Councils • Partnerships to address broader ageing issues and social determinants of ageing well • Collaboration • Walkable wheelable communities • Aged Care System Reform • Strategy documents e.g., Age Well in NSW	• Population health assessments • Health needs assessments • Collaborative and strategic commissioning • Monitoring and evaluation • Workforce planning • Provider experience and satisfaction • Intergenerational activities	• Health literacy • Death literacy • Palliative care and end-of-life planning • Patient-reported outcomes • Personalised health plans and goals • Shared decision-making • Patient-reported experiences • Coordinated care • Joined up and integrated care across the care continuum • Support to manage specific health conditions (identified through population health and health needs assessments)

Older People's Needs at a System, Population, and Individual Level			
Level	**System/Structure**	**Population/Equity**	**Individual/experience**
Key activities	• Workforce assessment and planning for current and future needs • Include workforce diversity in planning to better address the needs of all community groups • Provide professional development opportunities in healthy ageing • Develop education and resources on healthy ageing and effective care for illness, as well as working effectively with people who experience historical trauma, ageism and institutional discrimination in the healthcare system • Ongoing education in gerontology and nurse practitioners (LHD and primary care) • Use partnerships to develop multidisciplinary teams that can address the health needs of older people in a holistic way	• Positive ageing campaigns and ones to address discrimination and stigma experienced by community groups who don't necessarily have trust in healthcare (LGBTIQ, people with a disability, Aboriginal and Torres Strait Islander peoples, refugees, people experiencing mental health issues) • Health promotion – wellbeing and healthy lifestyle • Screening services • Community groups and programs • Identify and target populations that are at high risk for age-related health issues – i.e., chronic conditions, dementia, falls, specific population groups, and socioeconomic factors • Develop targeted interventions designed to improve their health outcomes • Develop (co-create) health resources/ literacy for older people and clinicians to support informed choices • Explore opportunities to participate in community events, such as age expos and community groups, to share resources, health promotion activities and identify what matters to people • Collect and analyse data to monitor progress and improvements in outcomes	• Where gaps are identified in physical access to care, work with partners (GPs, LHD) to enhance virtual care. This may include check-ups, education sessions on healthy ageing and tracking sickness, monitoring chronic disease progression and using assisted tech (falls pendants, etc). Virtual care can facilitate continuity of care • Explore options to work effectively with frail older people • Establish processes for regular medication reviews for older people • Map older people's journeys in the healthcare sector to identify and address gaps, ensuring streamlined, coordinated, and comprehensive care across GPs, specialists and acute care • Provide resources to empower and enable older people to self-manage chronic conditions where appropriate • Develop strategies for people in mid-life years to plan for healthy ageing

Appendices
4. Strategy Enablers

The translation of vision, priorities and outcomes into action needs to be supported by strategy enablers:

Engaging with the voices of older people

The voices of older people are to be prioritised in all their diversity to ensure they are influencing decision-making processes regarding older person's health and wellbeing. Continuing partner, stakeholder and community consultation is needed to ensure the voice of older persons is present as the strategy moves into detailed program development and service planning.

Joint planning, partnerships and governance

Healthy ageing requires cross-sector collaboration; the health system cannot achieve the goals of healthy ageing alone. The wider determinants of health often lie outside the health system. Consequently, partnerships between health and other sectors are crucial to improving the health and wellbeing of older people. Healthy North Coast will continue to progress partnering with key stakeholders and community organisations to collaboratively understand needs, plan, commission services and evaluate outcomes. With efficient and effective governance that facilitates a coordinated approach from planning through to evaluation.

Strengthening data, research, and innovation

Data collection and analysis are critical to the success of the Healthy Ageing Strategy. Both output and outcome measures are needed to ensure activities are continuing to track progress toward expected outcomes and address current and emerging needs. Data collection and analysis are also essential to support research and innovation.

Ability to age in the right place

Ageing in place is a key element of the quality of life of older people. The home is the main element of life quality for older people. Factors contributing to ageing in the right place are a safe home environment, income, support from family and significant others, social connection with the community and access to services. The ability to age in place has been linked to people's sense of identity.

Digital health technology and systems

Digital health technology tools are needed to support a connected and integrated service network for consumers and carers, enabling real-time shared information between providers, consumers and carers working as a team. Digital health solutions can reduce or remove service access barriers experienced by disadvantaged and priority target populations.

Capable Workforce

A capable, diverse, and appropriately resourced and supported workforce is a critical enabler of achieving healthy ageing objectives. A diverse workforce provides access to different perspectives by bringing together people of different experiences, cultures, and backgrounds who can bring different or unique solutions to problems or opportunities. Building the capability of the workforce to deliver evidence-informed, safe, and quality care for older people is a significant challenge facing the health sector. Changes to the nature and skills of the future workforce will be required due to the impact of technology and a forecast move to community-based integrated care.

Financial sustainability

The increasing ageing population affects both health expenditure and revenue. Greater investment in earlier intervention can slow the level of demand for health and aged care services.

Appendices
5. Consumer Consultation

As part of the development of the Healthy Ageing Strategy, Healthy North Coast undertook consultation with several different groups across the region. Healthy North Coast prioritised this engagement with the community to understand the perspectives and needs of community members, strengthen collaboration and work with communities to help shape the programs and services people need across the lifespan.

The workshop activities focussed on the ageing journey and potential concepts and solutions to address some of the identified needs. These activities provided valuable insights for further development of concepts for new services or supports for older people.

A series of interviews and focus groups with people aged in their early 20s to their 80s was undertaken, with assistance from the ARTD consultancy team, to answer the question:

> What is the North Coast vision for healthy ageing?

Community perceptions explored included maintaining quality of life, functionality, and independence into the future, planning to age, and the future state of ageing. Thinking back to when they were 50, participants were asked to consider the things that kept them healthy and well. The themes within their responses are intertwined (with multiple responses within each category), illustrating the holistic nature of health and wellbeing.

Healthy North Coast engaged the Sax Institute in 2021 to develop a system dynamics model (SDM) to test innovative healthy ageing initiatives and scenarios intended to improve health outcomes for older people across the north coast community. The SDM was designed to determine what combination of initiatives are likely to achieve the biggest improvements in population health outcomes. Six models were built:

> wraparound primary care for multi-morbidities
>
> rural digital specialist care
>
> positive ageing campaign
>
> co-housing, healthy communities
>
> Aboriginal housing

The modelling revealed significantly reduced hospital costs from the wraparound primary care for multi-morbidities and rural digital specialist care models. The Aboriginal housing model was the only other model able to be measured against hospital costs which supported reduced costs. To enable the SDM to function as a decision-support tool, the SDM required further investment in modelling changes, rigorous assessment of evidence (both research and practice-informed), determining what works, what needs to be adapted to fit the local context, and developing a short-list of prospective programs.

There were several limitations in relation to the qualitative data collected. The COVID-19 pandemic added to the complexity of accessing consumers in the region, particularly our priority target populations, including rural and remote, financially disadvantaged people, carers and residents of Aged Care Homes. Further information is needed from the Aboriginal and Torres Strait Islander communities in relation to financial concerns, what health concerns worry them most, how rural living impacts on them and what planning for ageing could look like for older Aboriginal and Torres Strait Islander peoples.

Several key themes emerged from a synthesis of the consultation:

1. Planning to age
2. Staying healthy and active
3. Accessing health services
4. Access to age-friendly environments
5. Awareness and understanding of palliative care and end-of-life

Key themes
1. Planning to Age

When discussing planning to age, accommodation was top of mind for North Coast residents. This included staying in the family home, downsizing as family circumstances change, or finding secure accommodation. Financial security and retirement were mentioned by over half of North Coast residents. Planning for changes to health was mentioned by about one-third of participants.

Concerns were raised about housing affordability and suitability, availability of transport and access to shops. Participants talked about social connectedness, highlighting the need for older people to create and maintain connections and join community groups.

Family was a common theme among participants in terms of planning to age, having dialogue with, planning with, and having support from family. The issue of uncertainty around planning to age was discussed, highlighting information gaps, a diverse interpretation of "ageing" and health literacy among older people.

"I'm really hoping the move [to town] will do that, because I will have more options for things to do in the community. More places to go, more activities that you can attend. And I'm thinking perhaps that might make a fair bit of difference." (Female, 64 years, Kundabung)

Key themes
2. Staying Healthy and Active

Many issues were discussed in relation to the theme of staying healthy and active as people age. The need to remain physically active was highlighted, and participants raised the need for appropriate and inclusive opportunities for older people to access and undertake physical activity as well as the variety and cost of activities.

While many North Coast residents mentioned being content and grateful with their lives, over a third of North Coast residents sought more social connection – with family, friends, community, or activities – this was the one thing they would change to improve their health and wellbeing. Community and social connection (both retaining connections and building new ones) were highlighted in terms of staying healthy and active, with volunteering opportunities, cultural connection and the limitations imposed by stigma all mentioned. Participants emphasised the need to provide opportunities that address barriers to access, i.e., providing fully supportive social/community opportunities, including facilitating awareness, access, transport and a variety of options.

Participants recalled keeping physically active, keeping mentally active through volunteering and or work, staying socially active and maintaining family as the activities that kept people healthy and well. Preventive approaches contributing to remaining healthy and active were highlighted, including education about exercise, chronic illness and falls.

"I guess it is a daily decision to keep well as much I can. For me, that's a holistic approach, every part of my life is included in that. Keep mentally well, physically, spiritually, emotionally. So, I think that ageing well has got very much to do with a day-to-day investment in it. It doesn't happen by chance, it's an investment into the future. It starts now, it starts every day." (Female, 53 years of age, Mid North Coast)

Key themes
3. Accessing Health Services

Better access to health care and health procedures were mentioned by about one-third of people. The need for transport was raised by many, and how a lack of transport can impact on quality of life. Awareness of available services, accessibility issues (service affordability and availability) and poor referral processes were all seen as potential barriers to accessing health services. The lack of availability of GPs, the need for earlier diagnosis and referrals, targeted services and support for those living with chronic illness, and the need for a focus on holistic, integrated care.

Digital and virtual technology was mentioned in relation to accessing services, with the need for the technology to be older person friendly and access to equipment and connectivity seen as a barrier. Some people were reluctant to use virtual technologies as solutions to isolation and to healthcare; it was acknowledged that during COVID-19 lockdowns, the ability to talk to GPs over the phone had worked for some and not others.

"The postcode you live in-in Northern NSW there is a huge disparity between services provided to people in the coastal areas versus people that live in the west of the district." (Health professional, Northern NSW)

Key themes
4. Access to Age-Friendly Environments

Participants talked about access to age-friendly social and general living needs, highlighting both provider and community capacity to support access. They highlighted the lack of home care providers as a potential barrier to service access as well as the need for community understanding and capacity to facilitate access for older people. Several respondents considered the built environment as closely related to an accessible community. This includes increasing accessibility and safety through more seniors' parking, pedestrian access, wheelchair access, paved footpaths and street lighting. Access to green spaces, places to exercise and moderating development were also highlighted.

Key themes

5. Awareness and Understanding of Palliative Care and End-Of-Life

Discussions around the need to normalise death, dying and palliative care included starting and having conversations about death and dying, reducing stigma of accessing services and increasing awareness and understanding. The issue of planning for death was raised, highlighting the importance of early Advanced Care Planning (ACP) discussions and uploading to My Health Record to increase accessibility.

One theme included a lack of clarity around what palliative care is, the stigma linking palliative care and imminent death, and the need to raise awareness, including the potential for campaigns or facilitated opportunities for discussion. Another theme was about early diagnosis, referrals and information, highlighting the confusion that people experience on the trajectory of diagnosis to dying. Understanding the services, supports and options available was a theme raised by many, including the role of General Practitioners and community connectors and a general lack of information in this space. The need for increased supports and services was raised, particularly support to keep people at home if that's what they desire.

The need for specific services and resources to support carers in their role was discussed as was the need for stronger connections and better integration between providers in the palliative care and end-of-life space.

"It'll happen we just have to. Something will trigger it and we'll get it done because my wife and I have to do it together pretty much and it is a bit of work but it's important especially when you have a house, and you have four children and you have a house basically. Like what happens if something happens to me tomorrow and someone needs to get into my computer or my phone." (Consumer, aged 59, Coffs Harbour)

"Informal caregivers often have difficulties caring for the patient in their home, particularly related to administering medications, manual handling, and managing their own psychological wellbeing and burnout related to being responsible for these demanding tasks." (Carer, workshop participant, Coffs Harbour)

Aboriginal and Torres Strait Islander peoples

Aboriginal Elders reported being happy connecting with children, family, a place to call home and community. This was important both now and into the future. Better access to social activities and transport (accessibility for wheelchairs or community transport) and better access to the National Disability Insurance Agency and medical services were also considered important.

A focus group was conducted with Aboriginal and Torres Strait Islander peoples from the Healthy North Coast region. The participants in the focus group worked within Aboriginal health and/or aged care and have experience with how Aboriginal peoples in the community use the services available and their understanding of what is important to older Aboriginal peoples. One of the key themes from the focus group was the importance of social connectedness. Social connectedness was considered vital and could be supported through health education groups or other cultural/social groups. It was considered important that some of the activities be inclusive of other family members, for example, Elders.

Housing was another theme, in particular, housing that supports generations living together in some families and communities. Participants expressed a need for timely repairs to homes to ensure safety. Family caring for family is quite common in Aboriginal communities and financial support for carers was considered to be helpful. Another theme was transport, which was considered to be vital to allow people to remain independent and have access to health care, shopping and social activities, particularly for those in the more remote regional areas.

"I think we as Elders, we are the land. You treat me right, I'm your elder. We forget that respect goes both ways. If we want our younger people to respect us, we've gotta respect them. That's where we learn from hey." (Aboriginal Elder)

Appendices
6. Action Plans

Improving lives now
Action plan (How, Who, Output/Outcome)

No.	How (high-level strategy and action)	Who	Output/Outcome
1.1	**People can access information and services that enable choice and maximise self-management**		
1.1.1	Work with key stakeholders to ensure people have the information (including digital) they need to be active participants in their health and wellbeing, making informed healthcare decisions and planning to age.	Lead: HNC Collaborators: ACP Australia, local councils, COTA NSW, RACHs, LHD, Carers NSW, Tech Savvy Seniors	Output: number of activities and events Outcome: older people have increased levels of health and digital literacy and are better able to navigate the system
1.1.2	Undertake place-based service planning and develop targeted programs and services to improve information and access.	Lead: HNC Collaborators: LHDs	Output: number of targeted navigation services, local service plans completed Outcome: consumer-reported improvement in service access experience, increased referrals to health and aged care services
1.1.3	Support people to access after-hours primary care services.	Lead: HNC (PCA Program Team) Collaborators: primary health	Output: number of after-hours GP services provided Outcome: reduced potentially preventable hospitalisations of older people
1.1.4	Wellbeing of older people is included in disaster management planning.	Lead: HNC Collaborators: LHDs, home care providers, residential aged care providers, emergency services, advocacy groups e.g., COTA	Output: resources and tools are developed and shared with older people, advocates Outcome: local disaster management plans developed, collaborative disaster management planning and preparedness testing
1.2	**People are supported to create and maintain meaningful connections**		
1.2.1	Work with stakeholders to promote social connectedness and intergenerational programs, such as the promotion of volunteering, joining local clubs, recreational activities, cognitive activities	Lead: HNC (Healthy Communities Team) Collaborators: commissioned services	Output: increased enrolment of older people in healthy ageing programs/activities offered by community organisations Outcome: improved quality of life and wellbeing
1.3	**People live at their optimal best across the continuum of ageing**		
1.3.1	Review existing or develop new HealthPathways to increase usage and improve management of chronic conditions, disability, and frailty.	Lead: HNC (Healthy Communities Team) Collaborators: LHDs, GPs, HNC (Primary Care Impact and Partnerships team)	Output: increased HealthPathways usage Outcome: multi-disciplinary planning & service delivery, increased referrals to health and support services

Improving lives now

Action plan (How, Who, Output/Outcome)

No.	How (high-level strategy and action)	Who	Output/Outcome
1.3.2	Work with GPs to improve the effectiveness of chronic disease management programs and plans.	Lead: HNC Collaborators: GPs, research partner	Output: research project (survey) Some clarification Outcome: reduction in hospitalisations for people with chronic disease management plans
1.3.3	Work with consumers, home care services and allied health to support living independently through improving access to home modifications, assistive technologies and low-cost exercise programs	Lead: Aged Care Assessment Team and HNC Collaborators: home care service providers, allied health	Output: number of home modifications completed or smart home technologies installed Outcome: delayed/prevented residential aged care home admission
1.3.4	Explore with partners to design and trial programs designed to deliver services to people living with long-term complex health and support needs.	Lead: HNC (Healthy Communities Team) Collaborators: LHD, GPs, allied health, homecare, RACH	Output: pilot programs/trials of support programs (or similar) as agreed with all partners Outcome: reduced potentially preventable hospitalisations of older people
1.3.5	Work with RACHs and other partners to co-design strategies that increase access to primary health care in RACHs (in-reach).	Lead: HNC and RACH Collaborators: Primary healthcare, aged care	Output: range of primary healthcare services available in RACHs; rate of MBS services provided by primary care providers in RACH per residential aged care place Outcome: older people have access to primary healthcare services that meet their needs
1.3.6	Connect people living with dementia and their carers to access specialist services.	Lead: HNC Collaborators: Dementia Support Australia	Output: number of health and aged care services adopting local dementia pathways Outcome: people living with dementia are supported to remain living at home
1.4	**People are supported to die well**		
1.4.1	Promote the importance of palliative care and end-of-life planning.	Lead: HNC (Healthy Communities Team) Collaborators: HNC (Primary Care Impact and Partnerships Team), GPs, LHDs, Centre for Grief and Bereavement, RACHs	Output: number of Advanced Care Plans (ACPs) developed Outcome: participant self-reported experience with advanced care planning
1.4.2	Support access to person-centred, high-quality palliative and end-of-life care at the right time, in the place of choice.	Lead: HNC Collaborators: GPs, LHD, RACHs, NGOs, home care services	Output: development of place-based palliative care and end-of-life care plans Outcome: people have access to contemporary palliative and end-of-life care in the setting of their choice
1.4.3	Support uptake of Advanced Care Planning in primary and aged care.	Lead: HNC and RACH Collaborators: Advanced Care Planning Australia, GPs, aged care	Output: increased uptake of ACPs Outcome: older people are better planned for end-of-life

Improving lives now

Action plan (How, Who, Output/Outcome)

1.4.4	Trial Compassionate Communities model within the region.	Lead: HNC Collaborators: Community	Output: Compassionate Communities trial developed and implemented Outcome: older people have better experiences at end-of-life
1.5	**Carers are supported in their caring role, while maintaining their own health and wellbeing**		
1.5.1	Work with other organisations to support carers to navigate the health and aged care system and promote carer wellbeing and social connection.	Lead: HNC Collaborators: LHD (nurse navigation teams), My Aged Care, Carers Australia	Output: carers can access the support and information they need Outcome: carer self-reported effectiveness of navigation services

Securing a healthier future

Action plan (How, Who, Output/Outcome)

No.	How (high-level strategy and action)	Who	Output/Outcome
2.1	**People have their basic needs (housing, finances, and personal safety) met**		
2.1.1	Develop a strategic advocacy plan to influence healthy ageing across the life course and age-friendly places and spaces.	Lead: HNC Collaborators: local council, LHDs, primary health, RACHs, homecare, community groups, peaks	Output: strategic advocacy plan developed and implemented Outcome: successful joint funding applications, changes in the built environment conducive to health and ageing
2.2	**People are supported to create and maintain meaningful connections**		
2.2.1	Work with partners to develop health and wellness promotion programs/ activities focussing on improving population health outcomes across the life course.	Lead: HNC Collaborators: LHDs (health promotion teams), NSW Ministry of Health (Health Education & Training Institute)	Outputs: number of health promotion wellness programs developed Outcome: improvement in modifiable risk factor rates
2.3	**People live at their optimal best across the continuum of ageing**		
2.3.1	Work with partners to support people to confidently plan for ageing and end of life.	Lead: HNC Collaborators: GPs, family/significant others, social workers/counsellors, legal and financial services	Outputs: increased uptake of ACPs Outcome: people are well-planned for ageing and end of life
2.3.2	Work with community to change the narrative around ageing by challenging ageism.	Lead: HNC (Healthy Communities Team) Collaborators: council, LHDs, peaks, home care services, community groups	Outputs: develop a positive ageing campaign Outcome: raise awareness in community about positive ageing
2.3.3	Explore with partners challenging ageism and age-based discrimination.	Lead: Peak bodies Collaborators: HNC, LHD, council	Outputs: positive ageing campaigns, advocacy Outcome: increased involvement of older people in community-based activities
2.3.4	Invest in healthy ageing programs that deliver better population outcomes now and into the future.	Lead: LHD and HNC Collaborators: primary health, RACHs, secondary health, specialists, service providers, Aboriginal Community Controlled Organisations, palliative care services, home care	Outputs: evidence-based, innovative healthy ageing models of care are identified and developed Outcome: regional commissioning is being undertaken with joint planning and joint governance, leading to better outcomes for older people

One team

Action plan (How, Who, Output/Outcome)

No.	How (high-level strategy and action)	Who	Output/Outcome
3.1	**Regional collaboration and partnerships that are responsive to population health needs**		
3.1.1	Invest in and build our relationships with key stakeholders through formal and informal structures.	Lead: HNC Collaborators: LHDs, council, primary health, Aboriginal Community Controlled Organisations, peak bodies, culturally specific services and other service providers	Outputs: relationship management plan, number of healthy ageing initiatives jointly planned, implemented & evaluated Outcome: relationships developed and maintained with agreement around shared priorities and ways to address them
3.1.2	Actively work with LHDs to jointly plan, problem-solve, and design shared care models.	Lead: LHDs and HNC Collaborators: primary health, RACHs, secondary health, specialists, service providers	Outputs: develop collaborative service models with LHDs Outcome: trial integrated service delivery with LHD; MOU, joint regional plans, governance practices and structures
3.1.3	Regional commissioning.	Lead: HNC and LHD Collaborators: NSW Ministry of Health, other PHNs, NGOs, ACCHOs	Outputs: collaborative commissioning trial Outcome: improved health and health equity across our region
3.1.4	Build leadership capability to lead the regional transformation and reform of health delivery across boundaries.	Lead: HNC and LHDs Collaborators: primary health, RACHs	Outputs: build trust, creating greater opportunities for connection and collaboration Outcome: cross-sectoral collaborations to deliver integrated services. Mobilising people to undertake collaborative action for service transformation
3.2	**People experience joined up care**		
3.2.1	Support an integrated health information system. including real-time sharing of clinical information across care boundaries, virtual healthcare and remote monitoring and care.	Lead: HNC and LHD Collaborators: aged care services, primary health, specialists	Outputs: increased registration with My Health Record Outcome: Improved sharing of clinical information; older people experience fewer barriers to care and have an increased experience of care. Older people do not have to repeat personal or medical information data/health information sharing; increased use of digital health technologies
3.2.2	Undertake key data collection activities with regional and local stakeholders to better understand and communicate the diverse voices of the older person.	Lead: HNC Collaborators: older people, their families, and carers, LHD, primary health, priority target populations	Outputs: Community Engagement Framework. Understanding individual needs and preferences across different population groups and provide support; developing a collaborative data plan with key health partners Outcome: the voice of community embedded in all that we do; health services are flexible and responsive to different older priority communities' needs data; collaborative service planning, outcomes monitoring, and outcomes measurement is used to drive investment in healthy ageing activities

One team

Action plan (How, Who, Output/Outcome)

No.	How (high-level strategy and action)	Who	Output/Outcome
3.3	**Virtual care is normalised and improves access and health outcomes across the region**		
3.3.1	Investigate and trial digital health models, particularly for people living with limited mobility, in rural locations, in residential aged care, or accessing after-hours services.	Lead: HNC Collaborators: GPs, primary health, RACHs, specialists	Outputs: education, infrastructure Outcome: people living in rural and remote locations have access to health services: people living in RACHs can access GPs/specialists through digital technology
3.4	**Sustainable and capable primary and age care workforce**		
3.4.1	Build capacity and capability of the primary health and aged care workforce to ensure the workforce is sufficient in number, geographically distributed and is fit for purpose now and into the future.	Lead: HNC Collaborators: GPs, other primary health providers, Aboriginal Controlled Community Organisations, LHD, Rural Doctors Network, University Centre for Rural Health	Outputs: updated Health Workforce Trends Report; sector learning needs identified; number of learning/clinical resources developed/ shared Outcome: primary health and aged care workforce continues to grow; participant feedback regarding learning needs, learning resources, clinical resources

No one is left behind

Action plan (How, Who, Output/Outcome)

No.	How (high-level strategy and action)	Who	Output/Outcome
4.1	**Services are flexible and responsive to the needs of priority target populations**		
4.1.1	Develop a Community Engagement Framework targeting priority populations.	Lead: HNC Collaborators: peak and local organisations representing priority groups; consumers	Output: development of the Community Engagement Framework, associated tools Outcome: HNC and stakeholders respectfully engage with priority target populations
4.1.2	Undertake collaborative regional/place-based planning to identify where our priority target populations are located and their diverse health needs.	Lead: HNC, LHDs Collaborators: community organisations, councils, home care providers, aged care providers, consumers	Output: local plans to address the specific health needs of priority target populations are developed Outcome: improvement in population health outcomes for priority target populations
4.1.3	Work with primary health, aged care, and commissioned services to embed trauma-informed practice, mental health services and cultural competency.	Lead: HNC Collaborators: NGOs, GPs	Output: increased cultural competency of primary and aged care and commissioned services Outcome: improved access to culturally safe services when needed
4.1.4	Enhance the provision of plain language health information tailored to the needs of priority target populations.	Lead: HNC Collaborators: LHD	Output: plain language or multiple language health information is developed Outcome: older people can become active partners in their health and care
4.1.5	Explore multidisciplinary approaches to identify and support older people at risk of or experiencing abuse and its consequences.	Lead: HNC Collaborators: community organisations, OPAN, primary health, carefinders, aged care	Output: Primary health and aged care services access practical screening tools to identify abuse Outcome: older people receive social support to reduce the negative impacts of elder abuse
4.2	**Aboriginal and Torres Strait Islander peoples age well, enabled by spiritual, physical, and mental wellbeing and connections to person, place and culture**		
4.2.1	Undertake an Aboriginal Health Needs Assessment (AHNA) to identify priority needs for this population in the region.	Lead: HNC and AMSs Collaborators: ACCHOs, Aboriginal community	Output: AHNA completed, as a result of comprehensive engagement with local community and stakeholders undertaken Outcome: partnerships built, strengthening community involvement in decision making, better use of resources
4.2.2	Work with communities to build on identified community strengths to develop strategies to address health priorities and community aspirations for health and wellbeing.	Lead: HNC Collaborators: ACCHOs, AMS	Output: culturally appropriate strategies addressing wider determinants of health and wellbeing are developed Outcome: emerging needs are identified, and service models are adapted to embrace those needs. Indigenous engagement principle central to the design and delivery of programs and services
4.2.3	Work with partners to design and deliver culturally appropriate healthy ageing programs and services that address issues related to chronic disease.	Lead: HNC and ACCHOs Collaborators: AMS, LHD	Output: culturally appropriate ageing programs are developed Outcome: Aboriginal people are more health literate and can access culturally appropriate chronic disease services

No one is left behind

Action plan (How, Who, Output/Outcome)

No.	How (high-level strategy and action)	Who	Output/Outcome
4.3	**Carers are supported in their caring role, while maintaining their own health and wellbeing**		
4.3.1	Support partners to develop initiatives that better address the physical and wider determinants of health (e.g. transport, mobility, housing, etc).	Lead: HNC Collaborators: NGOs (Care and Support sector), government, council	Output: older people have improved access to the services and supports they need that address the physical and wider determinants of health Outcome: different housing models developed which provide older people with the access they need to health and support services for healthy ageing
4.3.2	Support primary health workforce to identify social isolation needs and refer to appropriate services.	Lead: HNC Collaborators: primary health, NGOs	Output: social prescribing programs expanded; number of referrals to social connectedness services Outcome: older people recognise triggers for loneliness and social disconnection and seek support

Acronyms

Term	Meaning
ABS	Australian Bureau of Statistics
ACCHOS	Aboriginal Community Controlled Health Organisations
ACP	Advanced Care Planning
AIHW	Australian Institute of Health & Welfare
AMS	Aboriginal Medical Service
CALD	Culturally and Linguistically Diverse
COTA NSW	Council on the Aging NSW
GP	General Practitioner
HNC	Healthy North Coast
LGBTIQ+	Lesbian, gay, bisexual, transgender, intersex, queer +
LGA	Local Government Area
LHD	Local Health District
NGO	Nongovernment organisation
OPAN	Older Persons Advocacy Network
PHN	Primary Health Network
RACH	Residential aged care home
UN	United Nations
WHO	World Health Organisation

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