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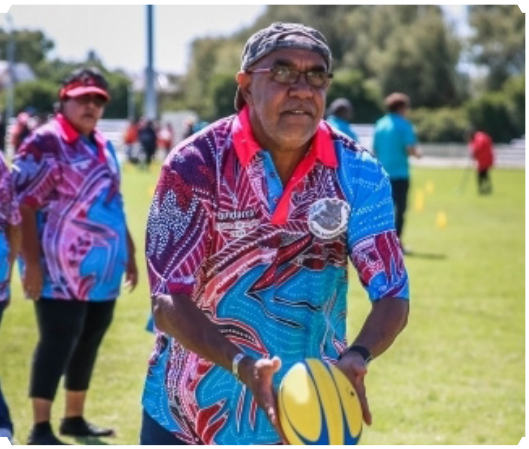
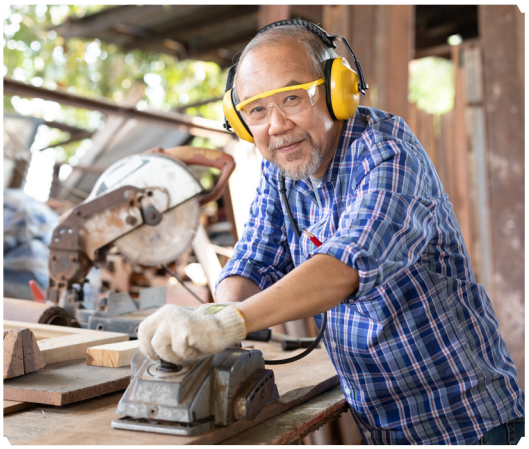
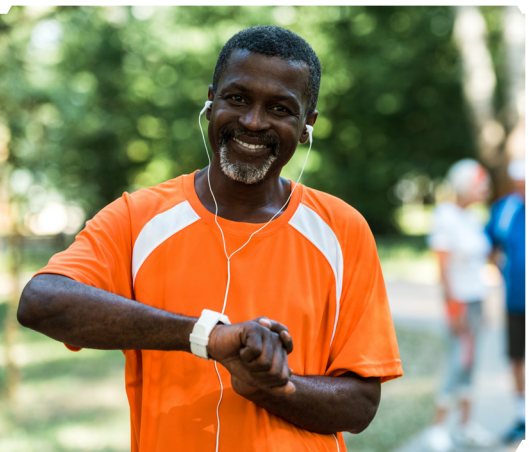
CENTRAL AND
EASTERN SYDNEY
An Australian Government Initiative

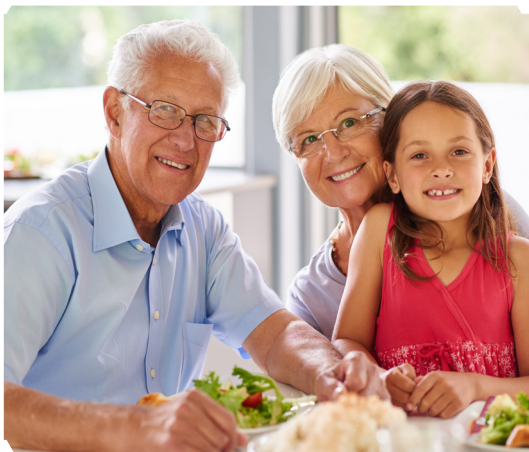
CESPHN
Healthy Ageing Strategy
2023 - 2028







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Executive Summary

Within the Central and Eastern Sydney region people are living longer, and the older population is increasing rapidly. The Central and Eastern Sydney PHN has developed a Healthy Ageing Strategy to empower older people in our region to live more active and fulfilling lives, enabled by inclusive communities, and supported by integrated person-centred health and social services.

Healthy ageing relies on maintaining functional capacity to support wellbeing and social inclusion. Our Strategy acknowledges the key role primary care workers and communities play in health promotion, prevention, and screening initiatives, and assisting to address the social determinants of health and wellbeing. It also recognises the key role older people, or their carers can play when engaged and empowered to participate in managing their own health and wellbeing.

Good health in older age is not distributed equally, either between or within communities, and those most disadvantaged are the ones who most frequently experience poorer health outcomes as they age. To address this, our Strategy incorporates key actions that support diversity and recognise the life experiences of more vulnerable older people in our region and the barriers they face as they age.

Our Strategy aims to increase years of life without disability and reduce the impact of disability for older people in our region as they age. Perhaps the greatest challenge in responding to an ageing society is ensuring a primary care and aged care workforce capable of supporting the needs of all older people. This is why our Strategy focuses on improving system capacity, service integration and care models that support streamlined care. Responding to the challenges of an ageing population requires collaboration and partnership with government and non-government sectors, businesses, the community to achieve the best outcomes for older people. To achieve the strategic vision of this Strategy, CESPHN will work in partnership with local providers and older people – we cannot do it alone and this is why our Strategy incorporates actions to grow these local partnerships.

The key actions in our Strategy will form part of an implementation plan which will provide a basis for monitoring and guiding the success of this Strategy. An annual progress report and update against actions will be provided to the CESPHN Board and communicated to the CESPHN Aged Care Advisory Committee, Community and Clinical Councils throughout the duration of this Strategy.

To be successful CESPHN will do what it does well – we will advocate and grow our partnerships with providers and older people and together build a healthier more inclusive future for older people.

CESPHN Healthy Ageing Strategy

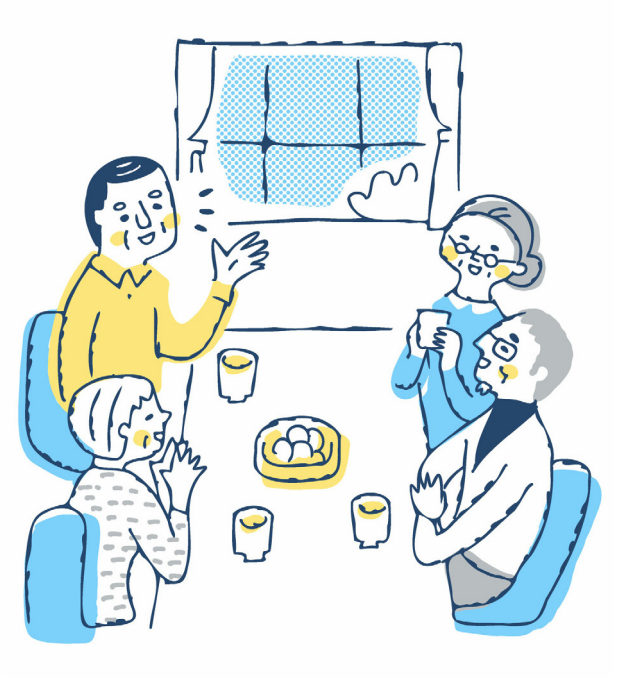
Our Vision

Our vision is to empower older people to lead active and fulfilling lives, enabled by inclusive communities, and supported by integrated person-centred health and social services. We will do this by taking a person-centred system approach that works to:

- Promote health and wellbeing.
- Reduce barriers and improve access to high quality care.
- Improve health system integration.
- Build age inclusive communities.

This Strategy acknowledges the critical role of primary care, community services, local health services, older people, and carers in the role of healthy ageing. CESPHN commits to working collaboratively with local partners to optimise opportunities for older people in our region to lead active and healthy lives.

Older people have diverse needs. CESPHN's Healthy Ageing Strategy will be inclusive with a clear focus on boosting outcomes for those older people experiencing disadvantage.



About CESPHN

The CESPHN region includes Central and Eastern Sydney and the remote Lord Howe Island. Our boundaries align with those of the South Eastern Sydney Local Health District (SESLHD) and Sydney Local Health District (SLHD). CESPHN had a resident population of 1.55 million in 2021 which includes 16,225 Aboriginal people (CESPHN, 2022a).

People are living longer, and the older population is increasing rapidly. Over the next ten years, there will be a 56 per cent increase in the number of older adults in our region – an extra 131,123 people. In 2041 over 365,000 people in our region will be over 65 with almost half of those aged 75+ (CESPHN 2022b).

As we age, the incidence of chronic disease increases, and healthcare expenditure associated with later life increases. Many older adults in our community will have an increased need for community support services, informal care and support from family, caregivers, and other community members. Healthy ageing strategies not only seek to improve the health outcomes and wellbeing of older people but play an important role in reducing excess impacts on services.

Background and Context

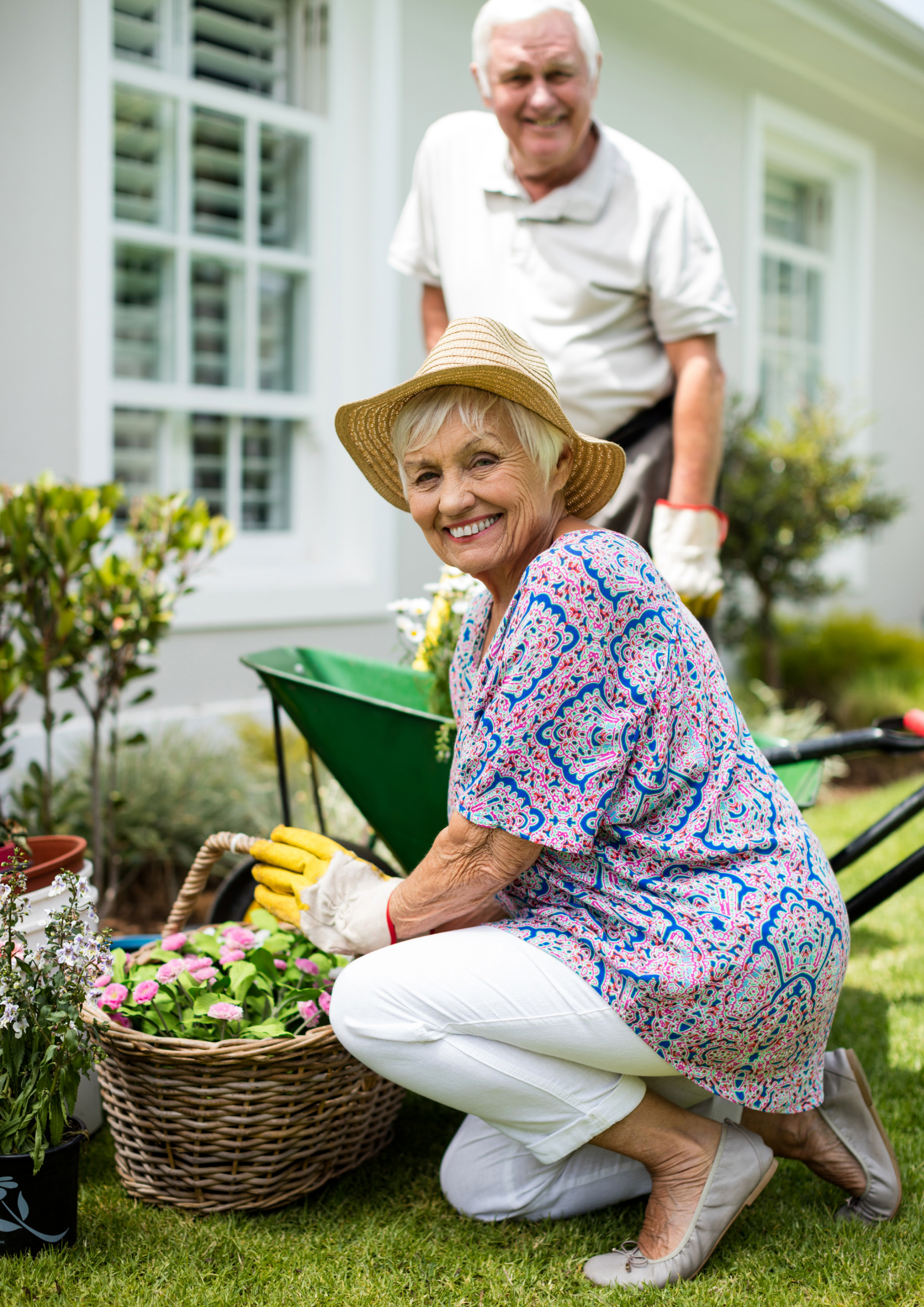
Healthy ageing

The World Health Organisation (WHO) defines healthy ageing as the process of 'developing and maintaining the functional ability that enables wellbeing in older age' (World Health Organisation 2015). This approach recognises that healthy ageing is dependent on creating the environments and opportunities that enable people to be and do what they value through throughout their lives .

The WHO's definition challenges the perception that ageing is a period of inevitable decline and encourages the adoption of strategies that promote the maintenance of health, function and the ongoing participation of older people in their local communities.

[1] Throughout this Strategy, 'older people' refers to people aged 65 and over and Aboriginal and Torres Strait Islander people aged 50 and over.

[2] This strategy acknowledges that everybody has a right to experience healthy ageing.



The CESPHN Healthy Ageing Strategy brings together strategies that aim to improve the effectiveness of primary health care services and supports which will enable older people in the CESPHN region to age well in their place of choice.

Policy Alignment

Our Strategy aligns with the CESPHN Strategic Plan (CESPHN, 2022c), NSW and Commonwealth Government aged care priorities and other key local healthy ageing strategies . Importantly, our Strategy explicitly recognises the impact that social determinants of health have on the ability to age well and access services.

To achieve improved health outcomes and social participation for older people, local services will need to be more strongly integrated and other community partners will need to be engaged by CESPHN. In parallel with the focus of United Nations Decade of Healthy Ageing Plan of Action (2021-2030) and Sustainable Development Goals, we will work with a diverse range of community sectors and stakeholders to improve the lives of older people, their families and the communities in which they live. This includes working with our partners to support environmental and policy change that supports healthy ageing, and the development of health friendly, climate resilient communities.

Importance of Healthy Ageing

Older people's ability to remain healthy as they age is affected by a range of factors including behavioural risk factors, mental and social wellbeing, and biomedical risk factors. Many of these factors are affected by social determinants of health such as socioeconomic status, employment, housing, living environment and social engagement.

While increased life expectancy has increased the number of years lived free of disability for some, it has also increased the risk of increased years of life lived with chronic disease, frailty, memory, and mobility disorders. Factors affecting health in older people are not inevitable and can be ameliorated through initiatives such as early screening and intervention. Our Strategy takes a positive view of ageing and seeks to address barriers that limit the ability of older people to lead full lives.

Acknowledging Diversity

CESPHN's healthy ageing strategy acknowledges our diverse population, changing demographics, the changing expectations of older people and society, and the projected increase in demand for more integrated health care. The Strategy will provide a framework to help improve equitable access to primary care and redefine the role that primary care workers and local communities can play in addressing the factors that impact the most vulnerable older people.

This Strategy will work to drive change in the primary health care sector through the development of more sustainable and equitable person-centred care models that assist older people to age well. Our Strategy provides a platform for new care models built in collaboration with older people, primary care clinicians, local health networks, local health districts, local government, and other partners.

Our Strategy

This Strategy seeks to be innovative and act as a catalyst for change to enable the primary health care sector to develop more sustainable and equitable care models that can assist older people to age well. The CESPHN Healthy Ageing Strategy will develop new care models by working with older people and investing in key health care initiatives. We seek through this Strategy to create the healthcare and the social environments required to meet the needs and expectations of all older people in our community.

[3] Such as local council healthy ageing strategies, Ageing Well in NSW: Seniors Strategy 2021-2031, and key Healthy ageing strategies outlined in the Aged Care Diversity Framework.

CESPHN Role in Heathy Ageing

CESPHN has a strong leadership role in aged care and is well placed to lead and influence healthy ageing in our region. PHNs lead the provision of advice on the primary health needs of their regions and are the central drivers for reform, integration and equitable access across its health and social care system.

As a regional commissioner and trusted system advisor, CESPHN is well positioned to support discussions to reduce service fragmentation and address unmet needs through investment and collaboration with local health networks, local health districts, and other partners such as councils.

CESPHN plays an important role supporting organisation and system change, coordinated primary health care responses to emergencies, designing fit-for-purpose primary care services, and building future workforce capacity and capability to meet the needs of our communities. Our roles in aged care include:

- System coordination and integration
- Regional commissioning
- Primary care system stewardship and management
- Primary healthcare education, training, and workforce development
- Health system transformation and reform (PHN Cooperative 2022)

These enabling roles will assist to drive the success of the CESPHN Healthy Ageing Strategy 2023-2028.

Central and Eastern Sydney Primary Network: Healthy Ageing Strategy

Our Vision

Our vision is to empower older people to lead active and fulfilling lives enabled by inclusive communities and supported by integrated person centre health and social services. Our purpose is to strengthen the recognition and the care provided to older people by:

Strategic Objectives

Promote Health and Wellbeing

Reduce Barriers and Improve Access to High Quality Care

Improve Health System Integration

Build Age Inclusive Communities

Promote Health and Wellbeing

- Health promotion
- Best practice prevention and screening
- Empowering older people to better manage their health
- Increasing participation in healthy lifestyle programs

Reduce Barriers and Improve Access to High Quality Care

- Work to ensure no one misses out
- Advocating for more secure housing options
- People with acute and chronic conditions
- Supporting First Nations people

Improve Health System Integration

- Adoption of digital health technology
- Improving team-based care for older people
- Supporting workforce integration
- End of life care

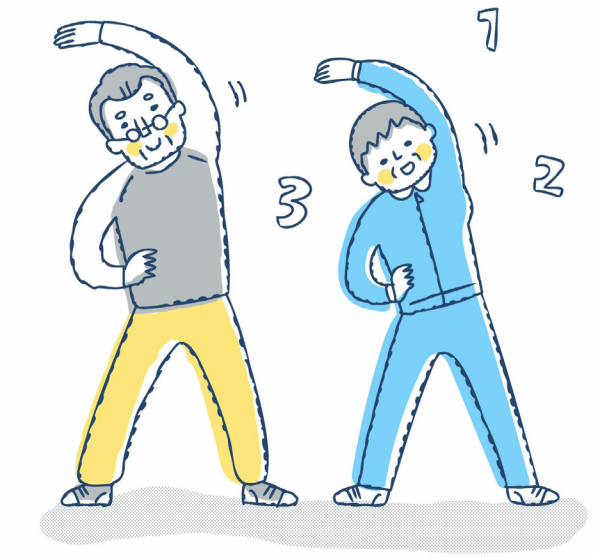
Build Age Inclusive Communities

- Ageing in place
- Age friendly communities
- Recognition and inclusion of diverse communities
- Strengthening regional partnerships

The key objectives of the CESPHN Healthy Ageing Strategy have been aligned to priorities identified by the WHO, local primary care professionals, the CESPHN Strategic Plan, the CESPHN Needs Analysis, and feedback from older people and local services. At the centre of our Strategy are older people, carers and those involved in the delivery of care and support.

Figure One Central and Eastern Sydney Primary Network Healthy Ageing Strategy: Vision

Strategic Objective One: Promote Health and Wellbeing



A range of factors, including behavioural risk factors, mental, and social wellbeing, and biomedical risk factors, affect a person's ability to remain healthy as they age. Increased access to preventative care and early intervention can enable people to address these risk factors, delaying the onset of preventable chronic and complex conditions, and reducing pressure on hospital and aged care systems.

CESPHN will prioritise activities that strengthen health promotion, early detection and screening in primary care, community-based health promotion initiatives, improve health literacy and increase participation in healthy lifestyle programs.

1.1 Health promotion

1.1.1 We will strengthen community-level health promotion activities that address social and cultural determinants of health for our diverse communities.

Key actions:

- Supporting the development and dissemination of healthy ageing and health promotion resources, including the translation of culturally appropriate resources for communities where English is not the first language.
- Connecting older people to health prevention programs that minimise risk behaviours such as smoking, drinking, gambling, and other addictions that impact their health and wellbeing.
- Promote the importance of social connectedness, encouraging and assisting older people, regardless of their age to stay connected to people that matter to them, their family, friends, and community.

1.2 Best practice prevention and screening

1.2.1 We will support screening and early detection actions in primary health care so that fewer people are impacted by preventable diseases and conditions as they age.

Key actions:

- Promote the uptake of 45-49 health checks for people at risk of chronic disease and 75+ health assessments.
- Support general practice with implementation of frailty and dementia screening for their older patients showing signs of early cognitive and functional decline e.g., falls screening and medication reviews for elderly patients taking multiple medicines.
- Support general practice with promotion of cancer screening in line with the national cancer screening program.
- Promote the uptake of vaccination for healthy ageing as per Australian Immunisation Handbook.
- Support general practice with screening for mental health and social isolation and accessing appropriate mental health and suicide prevention services.
- Support comprehensive, coordinated, and readily accessible dental care, including dental health promotion and maintenance, and the early detection of disease.

1.3 Empowering older people to better manage their health

1.3.1 We will work with older members of our communities to improve their health literacy and develop their understanding of common health problems and what can be done about them.

Key actions:

- We will raise awareness of common health problems that affect people as they age and help older people to access and better understand health information that assists them to make choices about their health.
- Work with community partners to deliver education on topics related to healthy ageing that empowers older people to become more active participants in managing their health.
- Develop strategies that improve reach of healthy ageing education into socioeconomically disadvantaged and culturally and linguistically diverse communities.

- Build older peoples' skills and confidence in accessing and understanding their personal digital health information (My Health Record).

1.3.2 We will assist to further develop the skills of the primary care workforce to improve their communication with their older clients and equip them to provide healthy ageing information and resources that can support older people and their carers.

Key actions:

- Ensure older people have better access to the right health information at the right time and that their GPs and primary care workers are supported to successfully implement social prescriptions.
- Work with primary care workers to provide education and training on motivational interviewing and other approaches that support lifestyle modification and behavioural change in older people requiring more complex support. Extend cultural awareness training to GPs and primary care workers and the broader community to ensure our diverse communities receive culturally appropriate care.

1.4 Increasing participation in healthy lifestyle programs

1.4.1 We will support older people in our communities to maintain their physical and mental health through greater access to tailored and affordable healthy lifestyle programs.

Key actions:

- Link individuals to community-based healthy lifestyle education programs that teach older people about healthy diets, nutrition, and the benefits of exercise.
- Promote awareness of programs that assist older people maintain strength, balance and continued engagement with physical activity that can reduce the risk of falls and combat the onset of frailty.
- Partner with providers and local government to support and increase access to affordable physical activity and healthy lifestyle programs to improve physical and mental health and wellbeing.
- Train GPs and primary care workers to better understand their local service environments, including aged and social care service options available, to better enable and increase the likelihood of successful implementation of social prescribing.

1.4.2 Improve access to mental health supports for older people that may be experiencing different levels of stress or anxiety relating to their personal circumstances or situations.

Key actions:

- Support equitable access to best practice, holistic, person-centred mental health stepped care supports for older people living in the community and living in residential aged care facilities.
- Support new models that strengthen community-based care and reduce social isolation and loneliness for older people, models that encourage connections and active engagement of older people in community life.

Strategic Objective Two: Reduce Barriers and Improve Access to High Quality Care

Disadvantage and social isolation have a profound impact on people's health, and how they age. To reduce inequity, this Strategy will focus on improving the lives of older people living with acute and chronic conditions and older people from priority populations including; Aboriginal and Torres Strait Islander peoples, multicultural communities, people with disability, people experiencing homelessness or at risk of homelessness, people who identify as lesbian, gay, bisexual, transgender, intersex and queer (LGBTIQ+), Veterans, Care Leavers and people who have been in contact with the criminal justice system.

2.1 Work to ensure no one misses out

2.1.1 We will strive to improve access to health and aged care services for vulnerable older people in our region to ensure no one misses out on the care they need.

Key actions:

- Work to improve access to GPs, other primary care workers, and aged care services for vulnerable older people, particularly those in residing in lower socioeconomic and disadvantaged regions.
- We will work with our local RACFs and health districts to improve access to a range of high-quality specialist care for their residents, enhancing models of integration.
- Support action that addresses the barriers to accessing health and aged care services
- Advocate to have diversity embedded in the design and delivery of primary health and aged care services.

2.1.2 We will target those older people in our community with diverse characteristics, who are hard to reach, and at greatest risk of poorer health outcomes.

Key action:

- Support GPs and primary care workers and the local community to identify and connect vulnerable older people to health and aged care services (assisting referrals to health services, care finders, My Aged Care, Carer Gateway and NDIS, and other services).

2.1.3 We will support improved linkages and connections between primary health care and other services that provide comprehensive wrap around care for vulnerable older people.

Key actions:

- Work to develop consumer pathways and information and resources that help older people and their health professional to navigate and refer vulnerable older people to aged care, housing, welfare, and legal systems.
- Develop systems and tools that increase social prescribing for older people through development of a service directory that will support older people and their health professionals find the right health and community-based care older people need to age well.

2.2 Adovcating for more secure housing options

2.2.1 We will advocate for more secure housing options for financially disadvantaged older people.

Key actions:

- Support provision of housing assistance to prematurely aged and older people in crisis through the CESPHN care finder network.
- Work with different levels of government to improve access to affordable and secure housing for vulnerable older people.
- Partner with non-government organisations and NSW Housing to develop practical solutions to reduce homelessness.
- Support greater access to housing that enables older people to age in place, where aged care services are either supplied by the housing provider, or through an arrangement with reputable aged care providers.

2.3 People with acute and chronic conditions

2.3.1 We will work to enhance primary care models for the management of acute and chronic health conditions.

Key actions:

- Design and implement new models of care that support early management and support of complex conditions such as dementia and frailty in general practice e.g., use of GP Management Plans and Team Care Arrangements to support older people with chronic conditions.
- Design and implement integrated care strategies with our Local Health District partners that improve and streamline care for older people.
- Support GPs and primary care workers to recognise common mental health conditions such as anxiety and depression that are often present in people who have chronic health conditions. This includes improving access to Older Persons Mental Health services and Behaviour and Psychological Symptoms of Dementia support services for older people in our region with more advanced mental health needs.
- Strengthen referral pathways and linkages between GPs and specialists, and other health providers to ensure older people receive seamless wrap around care services.
- Ensure older people with acute and chronic conditions in socioeconomically disadvantaged areas have equitable access to best practice holistic person-centred models of care that supports management of their acute and chronic conditions.

2.4 Supporting First Nations people

2.4.1 We will engage Aboriginal and Torres Strait Islander people in the design of primary care services that are culturally safe and contribute to Closing the Gap.

Key actions:

- Work collaboratively with local Aboriginal organisations to ensure culturally responsive health and wellbeing services are available to local communities.
- Work to raise awareness amongst GPs and primary care workers of Aboriginal and Torres Strait Islander health and wellbeing services, providing referral and linkage to culturally safe healthy ageing programs.
- Work to build new healthy ageing strategies and approaches that are rooted in a balance of the four elements of Indigenous health, and wellness: the physical, emotional, mental and the spiritual.
- We will continue to work with local stakeholders in our region to develop and implement plans that reduce inequity and improve health outcomes for Aboriginal and Torres Strait Islander peoples.

2.4.2 We will work in partnership with local Aboriginal groups to support delivery of priority health programs.

Key actions:

- Explore initiatives that will support the health and wellbeing of older members of the Aboriginal community.

2.4.3 We will promote the use of existing Aboriginal and Torres Strait Islander health initiatives.

Key actions:

- Promote the use of 715 health checks to ensure Aboriginal and Torres Strait Islander peoples receive primary health care matched to their needs.
- Support local providers to deliver flexible aged care to Aboriginal and Torres Strait Islander people.

Strategic Objective Three: Improve Health System Integration

To ensure our primary care system can meet the challenges of supporting older people in our region to age well, a more integrated and connected approach to care is required to support and empower older people to participate in their own healthcare.

Improved access to care and health information can be accelerated through more integrated team care models and the adoption of new digital technologies that reduce fragmentation and enable ready access to critical health information.

3.1 Adoption of digital health technology

3.1.1 We will work with primary care workers to accelerate the adoption of digital health technologies that improve quality and access to care for older people.

Key actions:

- Support an uplift in primary care IT infrastructure in residential ag Support and train residential aged care facilities with the implementation and use of My Health Record so health information can be easily shared across the health system.

3.1.2 We will strengthen the collaboration and sharing of health information between providers.

Key actions:

- Work to improve the transfer and sharing of key information across the hospital, primary care, and residential aged care sectors.
- Work to significantly increase the health information available to older people, their carers' and their health care teams in My Health Record, empowering older people, and their carers to participate in their own care and the care of their loved ones.

3.1.3 We will review and improve aged care and dementia care clinical referral pathways to support GPs and primary care workers to refer and link older people to necessary specialist care, aged care and other relevant support services.

Key actions:

- Develop, review, enhance and maintain aged care clinical referral pathways (HealthPathways) that support the health and wellbeing of older people.

3.2 Improving team-based care for older people

3.2.1 We will encourage coordinated multi-disciplinary team-based care that sees providers working to their full scope of practice to deliver better health outcomes for older people.

Key actions:

- Advocate for improved systems and funding reform to support GPs and primary care workers to deliver comprehensive team-based care for older people.
- Provide education and training to practices on team-based care models, and how to resource them.
- Respond to planned aged care and Medicare reforms relating to team-based care and assist implementation of new team care initiatives announced in Federal Budget 2023.

3.2.2 We will improve the coordination of care for residents living in residential aged care.

Key actions:

- Continue investing in geriatric outreach models and workforce approaches that support primary care workers to care for residents in aged care facilities.
- Work to develop improved coordination of care between GPs and mental health services to support older people living in residential aged care facilities.

- Assist residential aged care facilities with the adoption of new technology including e-prescribing and telehealth.
- Work with residential aged care facilities to develop after-hours action plans that source the most appropriate after-hours care for residents.

3.3 Supporting workforce integration

3.3.1 We will work toward positioning aged care as a career of choice for health professionals, including medical, allied health, nursing graduates, and aged care workers.

Key actions:

- Work to raise the profile and recognition of primary care workers working in aged care to encourage future potential workers to choose a career path in aged care.
- Advocate for increased remuneration for primary care workers working in aged care to attract and retain staff and improve supply and distribution of GPs and primary care workers.
- Support our GPs, and other primary care workforces to ensure successful and viable business models that put older people at the centre of care and deliver the best outcomes for older people.
- Review barriers and incentives for primary care workers to work to their full scope of practice to build the future aged care workforce.
- Engage with universities to identify and support student placements in aged care (medical, allied health, nursing) which attract and encourage interest in a career in aged care.

3.3.2 We will explore and develop innovative GP-led workforce models that help address key challenges in aged care. Dementia and frailty are significant and growing health and aged issues that are having a substantial impact on the health and quality of life of people with these conditions as well as their family and carers.

Key actions:

- We will improve the knowledge and skills of our GPs and primary care workers and to manage complex health conditions such as dementia and frailty.
- We will develop GP-led models of care specific for dementia and frailty through the introduction of new tools, systems, and pathways that improve care for older people living with dementia and frailty and their family and carers.
- Provide opportunities and training for GPs and practice nurses to work with specialist geriatricians to improve holistic approaches to care, particularly in areas of complex care such as advanced frailty and dementia.

3.3.3 We will explore and develop new community-led models of care that support GPs and primary care workers by assisting social prescribing and navigation to services for older people.

Key actions:

- Implement healthy ageing hubs staffed by workers trained to support GPs and primary care workers through addressing non-medical needs of older people. These workers will do things GPs often do not have the time to do while boosting GP capacity.

3.4 End of life care

3.4.1 We will work to increase community awareness of the benefits of advance care planning and palliative care, and we will work to improve the sharing of advance care plans and treatment plans across the different elements of the health system.

Key actions:

- Work to improve the uptake of advance care plans developed for older people as they age, training our GPs and primary care workers to initiate advance care planning conversations, support people to develop plans and encourage them to upload into My Health Record.
- Work to ensure primary care workers and older people are aware of palliative care service options available to them in our region.

3.4.2 We will support GPs and primary care workers to deliver quality palliative care and end of life care for older people in our community.

Key actions:

- Increase training to GPs and primary care workers to improve the delivery of palliative care and end of life care in the community and residential aged care.

3.4.3 We will educate and support GPs and primary care workers with the introduction of voluntary assisted dying which gives eligible people diagnosed with life-limiting conditions, who are suffering intolerably, an additional end of life choice by allowing them to choose the timing and circumstance of their death.

Key actions:

- Provide GPs and primary health workers with essential information about voluntary assisted dying and training for those health workers who are eligible and choose to participate.

Strategic Objective Four: Build Age Inclusive Communities

Older people want to remain active in their local community and maintain their social networks throughout the ageing process. Supporting older people to stay in their place of choice for longer has a positive impact on their health and wellbeing and prevents early entry into residential aged care.

Opportunities for older people to participate in the development and design of their local community is key to successfully addressing the barriers and enablers to healthy ageing. This Strategy aims to build age inclusive communities and environments to meet the needs and priorities of older people with input from older people using regional planning and co-design processes.

4.1 Ageing in place

4.1.1 We will work to support older people to age in their place of choice with the supports they need.

Key actions:

- Promote older people being at the centre of decisions on where they age. We will support them to make informed decisions based on their health needs and care options.
- Work with aged care providers to support the delivery of home-based care that enables older people to remain living in their own home for as long as possible rather than entering residential aged care.
- Work to increase the adoption of assistive technology that enables older people to continue to live at home longer and delay or prevent the need for long-term care.
- Work with stakeholders (local/state/national agencies) and other community services and private agencies to progress and promote ageing in place initiatives.

4.1.2 We will promote carers' wellbeing and support local carers' programs in our region and look for opportunities to support families and carers in their caring role.

Key actions:

- Support models of home care that provide control to older people and their carers over the care they receive, and how they choose to live.
- Where required, link carers to the Carer Gateway to access the respite and support they need to continue caring for their loved ones.
- Work to improve the image and status of carers by advocating for increased pay and benefits and training opportunities.

4.2 Age friendly communities

4.2.1 We will advocate for communities where older people are included, connected, and actively participate.

Key actions:

- Ensure the rights of older people, their experiences, and needs are recognised during community planning processes.
- Advocate for more age friendly public spaces and services which reflect our diverse communities of older people.
- Ensure that older people with disability are included and able to participate in their local communities with access to the same healthcare and social support activities as other older people.
- Promote positive images of older people in our communications and publicly recognise older people's contributions to their communities.
- Support the development of paid and volunteer workforces that can increase and extend the support to primary and aged care workforces and enable greater participation by older people in social groups.

4.2.2 We will work collaboratively to eliminate any form of elder abuse in our community.

Key actions:

- Raise awareness of elder abuse, as well as prevention and response strategies, and improve referral pathways to assist older people experiencing elder abuse.
- Improve primary care workforce understanding of elder abuse, including skills training on approaches to screening for elder abuse and neglect, and associated risk factors.

4.2.3 Through advocacy we will challenge ageism, leading the way in promoting age friendly communities.

Key actions:

- Encourage compassionate communities that recognise and care for older people during good health and at times of crisis and loss, a task not solely the responsibility of one health and social service, but everyone's responsibility.
- Support intergenerational programs that value the wisdom and knowledge of older people, connecting them with younger generations where the transmission of their knowledge and wisdom can be beneficial to younger generations.
- We will encourage and support the continued growth in intellectual, social, and emotional development of people across their lifespan, breaking down stigmas associated with ageing.

4.3 Recognition and inclusion of diverse communities

4.3.1 We will ensure older people with diverse characteristics and life experiences, their families, carers, and representatives are included in healthy ageing programs, initiatives, and strategies.

Key actions:

- Promote acceptance and inclusion of diverse and more vulnerable older people, such as those from multicultural backgrounds, Aboriginal and Torres Strait Islander people, people who identify as LGBTIQ+, veterans, care leavers and those with dementia.
- Identify and overcome barriers faced by diverse and more vulnerable older people in accessing the health care, the aged care system and participating in community life.
- Ensure older people of multicultural background are not isolated in their local communities because of language and cultural barriers and have access to healthy ageing programs that are responsive to their needs.
- We will work collaboratively with diverse community representatives to assist their members and communities to engage with the broader community tailoring services and activities to be more inclusive of diversity.
- We will work with our local RACFs to provide more opportunities for residents to thrive, supporting innovative models that better meet the needs and wants and enhance the quality of life of their residents.

4.4 Strengthening regional partnerships

4.4.1 We will strengthen alliances between the PHN, local health networks, local health districts, local government, and other partners to strengthen community-based care and services for older people.

Key actions:

- Work together to improve integration of primary and secondary healthcare with local government and community care services.
- Work together to strengthen organisational frameworks that support improved integration between the health, aged care, and disability sectors for the benefit of older people.
- Deliver health promotion initiatives and planning activities with local government and other partners that promote inclusive community health programs.

4.4.2 We will work closely with local government in our region to plan and deliver health related initiatives to meet the environmental needs and priorities of local older people.

Key actions:

- Work with local council to coordinate community-level population health initiatives that address healthy ageing.
- Look for opportunities to co-commission services that improve the lives for older people and accessibility to services in their communities.
- Work with local government to build dementia friendly communities and support people living with dementia and their carers to continue engaging in the activities that are important to them.
- Work with local government to advocate environmental and policy change that leverages climate actions for healthy ageing and the development of health friendly, climate resilient communities

Implementation, Monitoring and Reporting

An Implementation Plan will be developed to support achievement of the CESPHN Healthy Ageing Strategy 2023-2028. This plan will set out CESPHN's actions and commitments for the Strategy across the 5-year period 2023-2028, and responsibility for delivery.

The CESPHN Needs Analysis includes a common set of population health and wellbeing outcome indicators for older people. These indicators will provide the basis for a monitoring and reporting framework that will assess the impact of the CESPHN Healthy Ageing Strategy 2023-2028.

The Strategy and Implementation plan will be updated to reflect any new information, emerging issues, and changes to our environment. Key actions outlined in the CESPHN Healthy Ageing Strategy will also be updated to recognise changing circumstances. A review of CESPHN Healthy Ageing Strategy 2023–2028 will be undertaken in 2026.

An annual progress report and update against actions in the Implementation Plan will be provided to CESPHN Board and communicated to the CESPHN Aged Care Advisory Committee, Community and Clinical Councils throughout the duration of this Strategy.

References

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