



Healthy Ageing Framework

2025 - 2028

COORDINARE -
South Eastern
NSW PHN





Acknowledgement to Country

COORDINARE- South Eastern NSW PHN acknowledges the Traditional Owners and Custodians of the lands across which we live and work.

We pay our respects to Elders past, present and emerging, and acknowledge Aboriginal and Torres Strait Islander peoples' continuing connection - both physical and spiritual - to land, sea and sky.

About the artwork

This artwork was painted by Walbunja woman Loretta Parsley, a Traditional Custodian of Yuin country with a strong connection to the south east coast of NSW.

The artwork is in the form of a cultural map and depicts the South Eastern NSW PHN region.

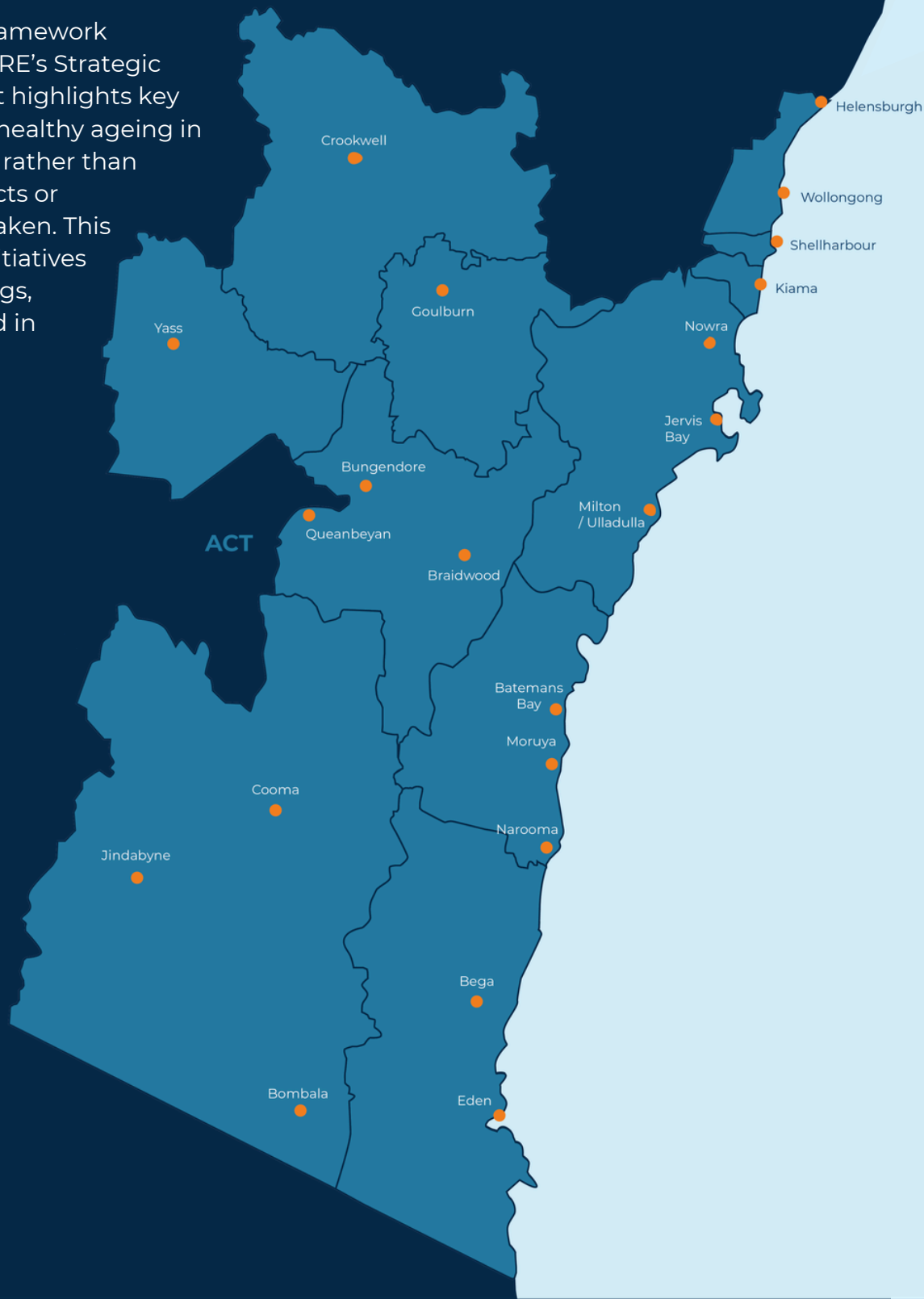
The areas in the artwork are defined by local government territories and include 12 places of significance: Wollongong, Shellharbour, Kiama, Shoalhaven, Jervis Bay, Eurobodalla, Bega Valley, Snowy/Monaro, Queanbeyan, Goulburn/Mulwaree, Yass Valley and Upper Lachlan Shire.

Introduction

COORDINARE is dedicated to fostering healthier communities. We focus our efforts on those who face the biggest inequities. To do this, we collaborate with the community, general practices and other stakeholders to design solutions that make it easier for people to get the health care they need.

Our goal is that people in our region lead healthier lives as they age and get support when they need it by reducing the complexity and inequity of accessing care in the community.

This Healthy Ageing Framework aligns with COORDINARE's Strategic Directions 2024-2027. It highlights key focus areas to support healthy ageing in our local communities, rather than detailing specific projects or initiatives to be undertaken. This framework supports initiatives across a range of settings, including care provided in the community and in residential aged care recognising both as important home environments.



Purpose

To enhance our ability to have a positive impact on health and social challenges that currently prevent people in our region from leading healthy lives as they age by:

Clearly identifying the problems we are trying to solve

Targeting where we invest our time, funding
and effort based on good evidence

Focusing on priority groups and reducing health inequity

Building on and creating synergies with existing activities

Enabling partnerships and collaboration by being clear about
our focus and what they can expect from us

Avoiding activities that duplicate existing initiatives,
add unnecessary complexity or fragment the regional health
and support system

The Framework aims to provide guidance on what to consider in any work we do, including enhancements to existing services, new services or proposals, and evaluation.

The Framework should be used alongside the Commissioning Framework.

Why we need a Healthy Ageing Framework

South Eastern NSW has an ageing population, with the number of older people continuing to increase. Many people are living longer, but not always healthier lives. Attitudes about ageing well need to shift to encourage prevention and earlier planning.

- Getting older brings a range of significant life changes such as retiring, changes in relationships and living arrangements, becoming a carer, changes to physical and mental health and grief and loss.
- People aged 65+ years and Aboriginal people 50+ years are significant users of local health services. For some people as they age, their care needs become more complex, and many people have multiple health conditions or disability.
- Mental health support is not always tailored to the needs of older people and not everyone has natural support networks.
- Accessing quality care can be difficult due to costs, distance and transport issues, long wait times, workforce shortages and unmet needs.
- Navigating health and support systems is complex and time-consuming for individuals and their carers.
- Social issues like loneliness, isolation, housing stress, and poverty further affect older people's health.
- There are significant inequities in care access and health outcomes. Only 6.8% of Aboriginal peoples are aged 65 years and over compared to 22.4% of non-Aboriginal people.

A summary of some key data about our, region, workforce and community insights are available below:



**Region
data**

**Aged care
services
data**

**Community
insights**

Priorities

Our priorities to support people in our region leading healthier lives as they age are:

Improving access to services such as mental health, alcohol and other drugs, chronic conditions, after hours and urgent care - especially for priority groups.



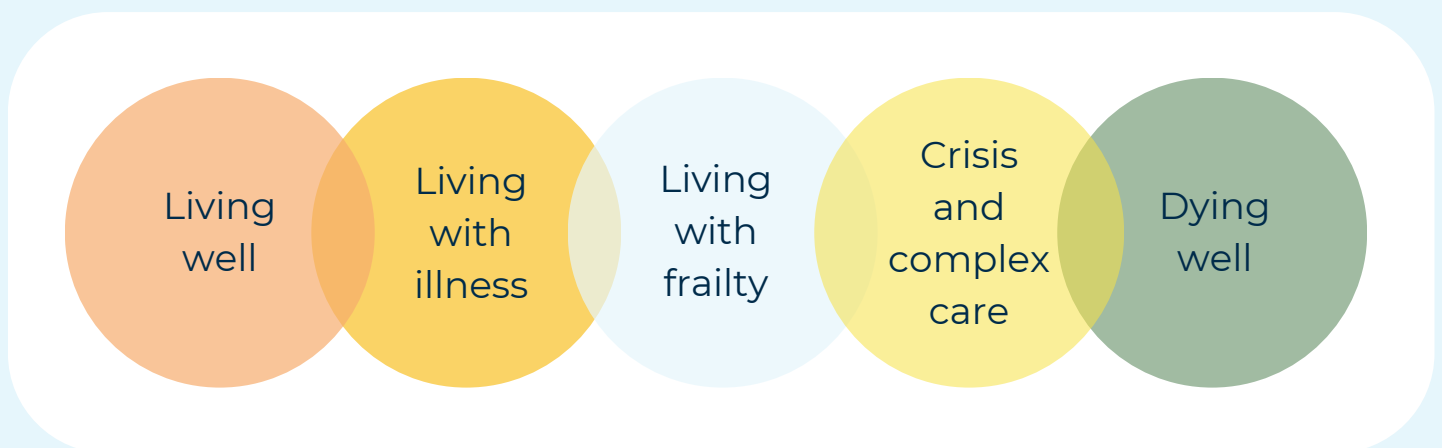
Fostering health across the lifespan, addressing the social determinants of health, increasing prevention activities, and improving community resilience and social connectedness.

Strengthening linkages between primary care and the broader health system. We support general practice and commission coordination and navigation services that guide individuals through their health care journey.

What healthy ageing looks like

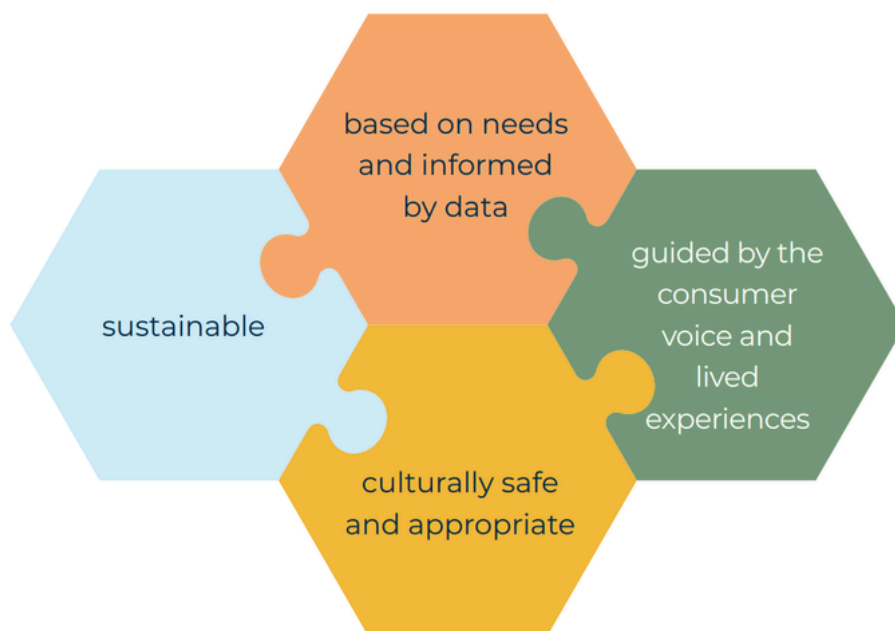
Healthy ageing is about recognising ageing as a natural and individual journey and supporting people to maintain their physical and mental wellbeing, stay socially connected, and lead fulfilling lives with choice and independence.

Some conditions associated with ageing such as frailty can be prevented, delayed, or managed. People need a continuum of services that assist them to maintain their health, functional capacity, dignity and control. This should include access to services across domains of care from preventive care through to palliative care, noting not all older people will need to access all domains of care.

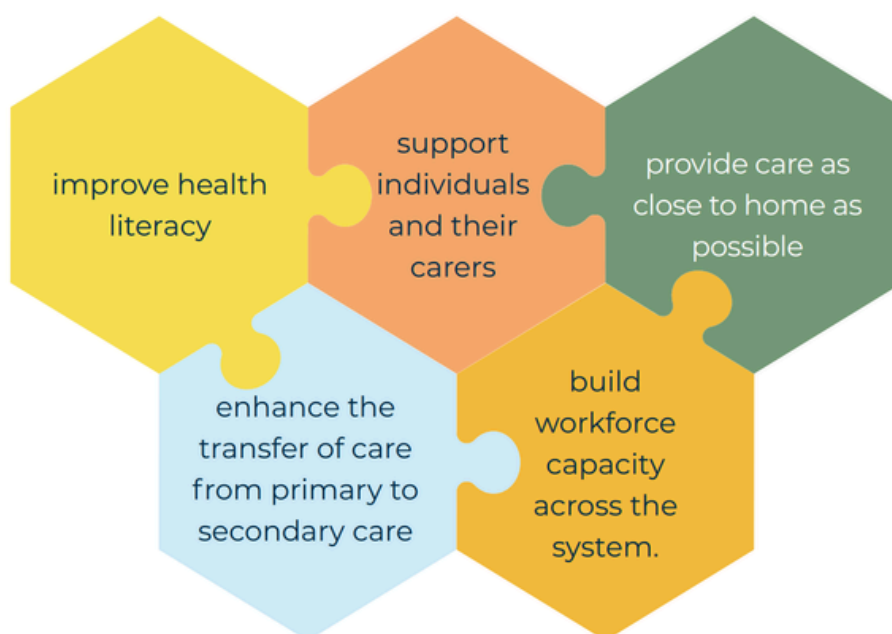


Our approach

We are dedicated to collaborating to develop initiatives and commission services that are:



All our work aims to:



Our focus areas

When considering healthy ageing activities to support or commission, we will consider how well they fit under our strategic priorities. For an activity to be supported it should help us achieve one or several of the following focus areas.



1. Accessible care

- 1.1 Enhance existing programs and services across the domains of care to benefit older people.
- 1.2 Increase focus on prevention and future planning for people aged 45-64 years in key areas such as brain health through modifiable behaviors that reduce the risk of poor health later in life.
- 1.3 Design services and systems to reduce additional barriers and poorer health outcomes experienced by some people in our region including Aboriginal peoples, lesbian, gay, bisexual transgender, queer, intersex (LGBTQI+) people culturally and linguistically diverse (CALD) people, people who are homeless or at risk of homelessness, people on low incomes and rural/regional residents.

Key objectives

- Increased data collection and analysis about the needs of people aged 45-64 years in South Eastern NSW to better understand their needs as they transition into older age.
- Increased investment in prevention and early intervention initiatives on conditions that have the highest impact on health and quality of life including frailty, dementia, cardiovascular disease, lung disease, mental health and suicide prevention.
- Increased engagement with specific groups in our community to improve access to services.
- Future health planning activities (such as planning to age conversations, advance care planning, home care planning) embedded in general practice and appropriate commissioned services.



2. Systemised care

- 2.1 Partner with local health and community services to simplify and better connect services and support for people and their carers.
- 2.2 Workforce capability uplift in understanding and addressing the needs of older people in primary and allied health care.
- 2.3 Coordinate efforts and develop holistic models of care to address behavioral risk factors and social determinants of health that have the greatest impact on healthy ageing.
- 2.4 Share data across services and networks to better understand people's experience and to see whether it is improving.

Key objectives

- Joint planning across health services to improve sharing of health information and increase the level and cohesiveness of care provided in the community.
- Reduced travel burden on older people and their carers through increased referrals closer to home and virtual health care initiatives.
- Increased capacity across primary care, allied health and mental health services to meet the specific needs and goals of older people.
- Integrated palliative and end of life services.

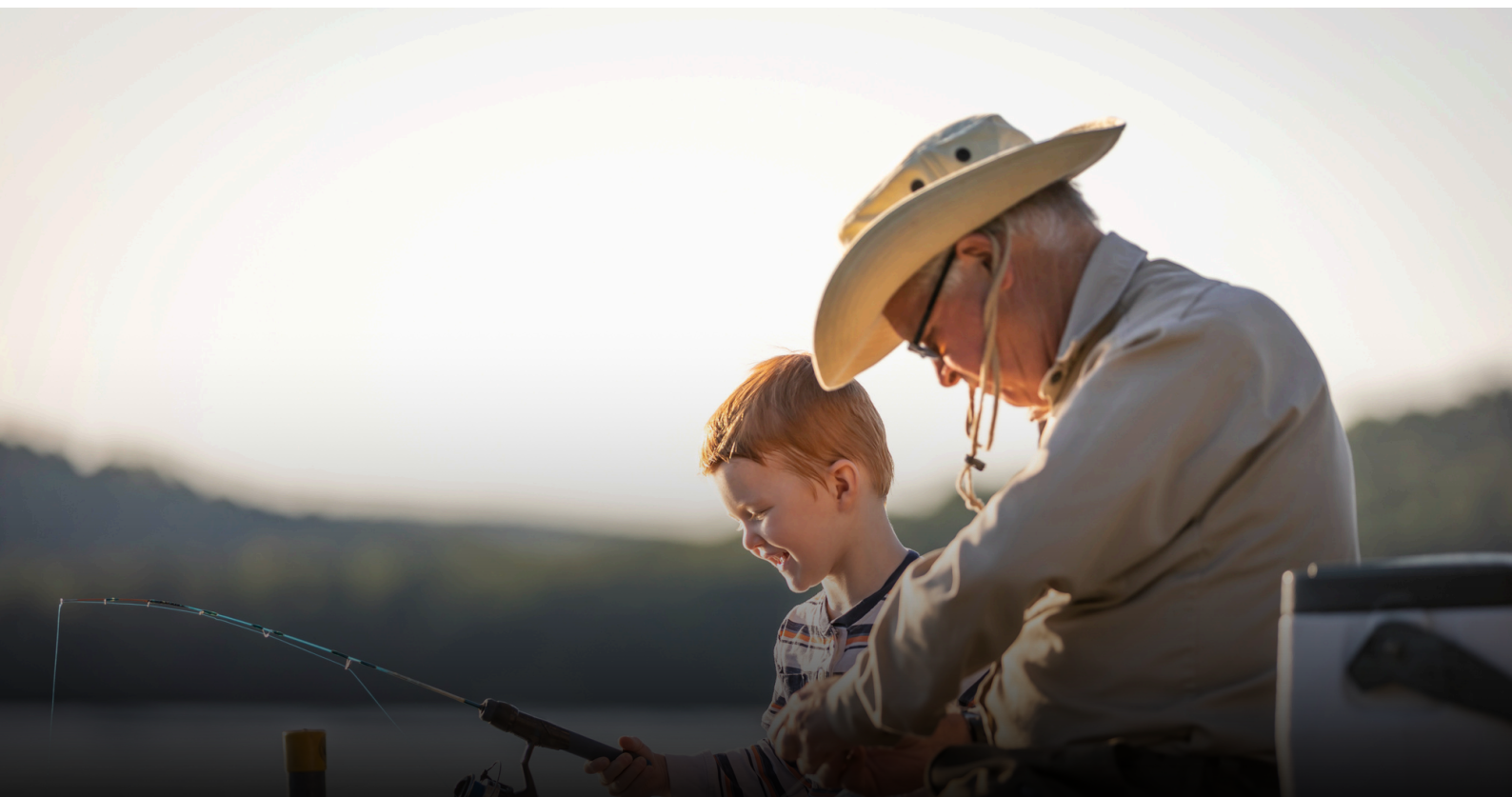


3. Activated community

- 3.1 Support community and individual participation in health and wellbeing across the lifespan including normalising conversations about ageing well and dying well.
- 3.2 Work with community and service partners to emphasise that individuals can improve their health and well-being through physical activity, good nutrition and social connection.
- 3.3 Reduce stigma around ageing, including for dementia and mental health, to shift attitudes that impact on help seeking and quality care.

Key objectives

- Implement a system for continuous community feedback to strengthen the voice of older people in our commissioning processes.
- Increased engagement with community and peer support groups, consumers, and carers.
- Increased percentage of people who have a plan in place for their future health needs and are accessing assessment services in a timely way.



The Framework in practice

The annual report will include an update on the following key measures to see what change is being achieved over time:

- percentage of people accessing primary care health assessments (75+, Aboriginal and Torres Strait Islander health check)
- percentage of people who have an advance care plan in place
- percentage of Aboriginal people aged 65+.



Proposals to support healthy ageing should include a reference to which focus area and key objectives it supports and clearly identify how the proposal meets the needs of people in our region facing additional barriers to care and poorer health outcomes

Proposals should be informed by existing research, data, and input from internal and external stakeholders, and where relevant, consider participation in community and general practice research to strengthen localised knowledge on healthy ageing. Early collaboration across directorates is essential to integrate diverse expertise and perspectives.

An up-to-date overview of our work will be maintained to create greater opportunities for alignment between initiatives both internally and with external partners and stakeholders.

A report to our advisory councils and Board will be provided annually on our work towards Healthy Ageing in South Eastern NSW.

Developing this Framework

This Framework has been informed by several key sources and perspectives to ensure it reflects both best practice and the unique needs of our region. This includes:

- *Royal Commission into Aged Care Quality and Safety*
- *Positive ageing Australian Government Department of Health and Aged Care*
- *Ageing well in NSW: Seniors Strategy 2021-2031 NSW Government (2020)*
- *PHN Cooperative White Paper: Supporting Healthy Ageing the Role of PHNs (2022)*
- *Needs Assessment 2022/23-2024/25*
- *Needs Assessment Snapshot: Ageing - Supplement to Needs Assessment 2024/25-2026/27*
- *Population Health Profile: South Eastern NSW, COORDINARE - South Eastern NSW PHN (last updated: September 2024).*

Advice and insights have been provided by our Clinical Councils, Community Advisory Committees, and Aboriginal Health Council to shape this Framework. A consumer survey was conducted to provide a preliminary view of the needs and aspirations of people in our communities about ageing.

