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WEST MORETON

Darling Downs and West Moreton PHN
and West Moreton Health

Older Person's Health and Wellbeing Strategy

phn DARLING DOWNS AND WEST MORETON
An Australian Government Initiative

West Moreton Health

Local Integrated Primary Health Care

Contents

The mighty Bunya

The design for this strategy is based on the journey of a local Bunya tree that grows in the Bunya Mountains to the west of Yarraman. It acknowledges that if a tiny seed is given the correct nurturing and support, over time, it can flourish into a vibrant and resilient Bunya tree which produces Bunya nuts that hold great knowledge to pass on to the next generation.

Much like the journey of older Australians in our region, with the correct nurturing and support, people can flourish into healthy, vibrant and resilient older people.

Acknowledgement

Acknowledgement of Country

Darling Downs and West Moreton PHN and West Moreton Health wish to acknowledge Australia's Aboriginal and Torres Strait Islander peoples as Custodians of this land.

We pay our respects and recognise their unique cultures and customs and honour their Elders past, present and emerging.

Mental health acknowledgement

We would also like to take this opportunity to acknowledge those who are living with mental health conditions, and those providing care for people with mental health conditions.

Disclaimer

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Joint message from Darling Downs and West Moreton PHN and West Moreton Health

West Moreton is the fastest-growing region in Queensland (in relative terms) and our population is ageing rapidly. By 2026, our general population is forecast to grow by 30 per cent (to 419,000 people), while the portion of people aged 65 and older is expected to increase by 50 per cent (to more than 60,000 people). Added to this, our culturally diverse population of older persons is dispersed across urban, suburban and rural settings.

Acknowledging this growth and diversity, West Moreton Health (WMH) and the Darling Downs and West Moreton PHN have a shared goal of supporting older persons to stay well and socially connected in their preferred place of residence. Our organisations have committed to developing and maintaining a culture of partnership and collaboration to achieve this vision.

As part of this commitment, WMH and the PHN have jointly developed an Older Person's Health and Wellbeing Strategy (2021–2026). This strategy has been developed through extensive consultation with a range of stakeholders, including consumers, their families, and carers. It will guide the way community, primary and secondary healthcare providers plan and deliver health services that support older persons to stay healthy, connected, and at home. Additionally, this strategy recognises the crucial role of family and carers in supporting our older people to live well and feel well.

Hannah Bloch
Interim Chief Executive
West Moreton Health

Lucille Chalmers
Chief Executive Officer
Darling Downs and West Moreton PHN

Messages from members of our community

The following feedback has been provided by members of the West Moreton community.
You mentioned you most liked services that:

- listened to you
- helped you access the care you need
- like one-stop-shops and those with transport services
- helped you make decisions about your health.

You would like to see...

- a greater focus on prevention including
- exercise, balance, and nutrition
- more help to manage health needs, such as education
- more services closer to home, such as visiting professionals or telehealth options
- more support to continue living at home as you age.

What is liked about our services?

- quality care
- kindness and respect
- assistance with reminders and follow-up appointments
- timely response to enquiries
- location in your local community
- after hours access.

You also would like to see...

- timely and clearer communication from your health care providers
- reduced wait times and costs, such as more bulk billing and public health services
- more support for your carer
- more allied health services, such as mental health and occupational therapy.

"As an old person I like to say, you do not know what it is like to be old until you are old."

"Caring properly and adequately for older people at a time of a growing aging population is an urgent need and I am just so pleased to see a constructive effort being made to meet that need."

"Training carers for aged people is important for me. This is more so when functionality and capability of thinking and acting are in decline. I have witnessed carers, even aged health carers, express a negative attitude to their charges when they regard their work as a chore and sometimes neglectful way the tasks of the so-called chore are done. I may be getting ahead of myself here, but I think that we need to create more opportunities for extended and quality training for health care."

"Family and carers need to be more involved in the diagnosis, treatment and communications."

West Moreton - the health of our region

- The West Moreton region is one of the fastest growing areas in Queensland. By 2026 it is predicated 65% more people aged 65 or older will be living in the region when compared to 2018. This is the highest projected relative increase in Queensland for this age group.
- The growth of the population and residents aged 65+ in West Moreton is expected to increase by 65% by 2026 and reach 671,694 by 2041.
- The West Moreton community is culturally and linguistically and economically diverse, encompassing both metropolitan and rural settings:
    - 18% of the population are born overseas.
    - Residents' top places of origin include New Zealand, England, the Philippines and India. The top five non-English languages spoken at home for West Moreton are Samoan, Indo Aryan language, Southeast Asian Austronesian languages, Vietnamese and Chinese languages.
- 64.5% of people in the region are disadvantaged.
- The socio-economic indexes for areas are a summary of social and economic conditions of geographic areas. In 2016, up to 33.7% of the population was in quintile 1, the most disadvantaged measure, and 27% in Quintile 2, the second most disadvantaged marker.
- 5% of people in the West Moreton region identify as Aboriginal and Torres Strait Islander.
- 5.9% require assistance for profound/severe disability.

In a recent survey of older persons in our community...

- 3 in 4 rated their own health as good to excellent.
- More than 50% said they are working with their GP on their care needs like diabetes, heart disease and/or lung conditions.
- 2 in 5 said they get enough exercise, and 1 in 4 had a healthy weight.
- 80% of people needing support said they would like to continue living in their current home.

Overall, a rating of 5.9 out of 10 was scored for health services in our region.

Predicted future state

- Emergency department presentations will be 23,250 for persons aged 70+ by 2026/27. This is an increase from 13,763 presentations in 2017-18.
- By 2026-27, 118,975 bed days will be needed for persons aged 70+ (36% of total predicted activity) and 43,355 inpatient separations (29% of total predicted activity). This is an increase from 60,320 beds and 19,942 separations in 2017-18.

Our strategy

Introduction

- West Moreton Health (WMH) and Darling Downs and West Moreton PHN have committed to a culture of partnership and collaboration. The WMH and PHN Older Person's Health and Wellbeing Strategy (2021-2026) has been developed to guide the way we plan and deliver community, primary and secondary health services to support older people to stay healthy, connected and at home. Additionally, the strategy recognises the important role families and carers play in helping to keep our older population healthy, happy, and fulfilled.

Strategy development approach

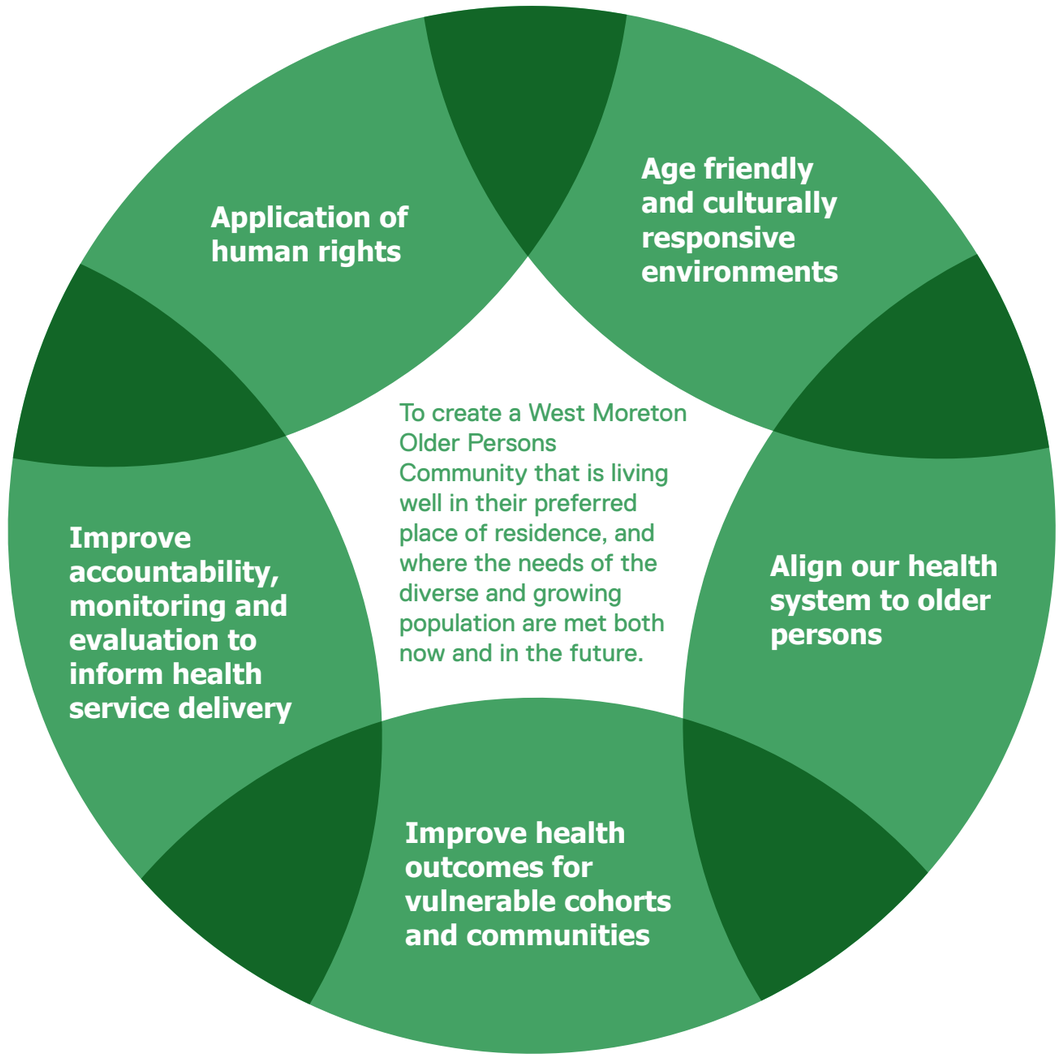
- The WMH and PHN Older Person's Health and Wellbeing Strategy (the strategy) has been developed following extensive consultation with a range of stakeholders including consumers, their family, and carers. In developing the strategy, the current state was examined, the ideal future position was defined, and the required direction to achieve the vision was determined.

Where are we now?	What do we need to do to get there?	Where do we want to be?
The demand for West Moreton older person services and the rising incidence of medical and social complexity is accelerating at a rate that exceeds our capacity to deliver without change. National and regional impacts of the COVID-19 pandemic. **Health system** Can be challenging to navigate, including My Aged Care. The responsibility for the management of older persons in the community is not always clearly defined. Instances of disconnected care across services impacting transitions of care, opportunities for improved integration and communication and opportunities to improve governance and accountability. Opportunities to increase locally based services in the community and in rural locations. Recommendations from the Royal Commission into Aged Care Quality and Safety report finalised – consumers reporting instances of bias relating to age. Opportunities to increase knowledge and skills to support the care of older persons and increase health literacy of consumers, family and their carers. Services often organised around a disease based, curative model with frequent use of high-cost, reactive and bed-based care. Improve processes to support early identification of needs for older persons, to enable appropriate referral and access to appropriate services across our services underpinning this with a self-management/family carer model. Plethora of evidence-based research with capacity challenges to implement practice change.	Application of human rights in all interactions. Ensure age friendly environments with age friendly and culturally responsive practices across all WMH and PHN health services. This includes respecting and adhering to patient choice regarding their health care. Align the WMH and PHN health system to the older persons we serve. Improve healthcare outcomes for vulnerable cohorts and communities and investment in innovative community models. Improve accountability, monitoring and evaluation to inform health service delivery.	A West Moreton Older Persons Community that is living well in their preferred place of residence, and where the needs of the diverse and growing population are met both now and, in the future.
Develop and implement a shared strategy across community, primary and secondary age care sectors.		

Strategy overview

Vision

The strategy has been developed to achieve a vision, "to create a West Moreton Older Persons Community that is living well in their preferred place of residence, and where the needs of the diverse and growing population are met both now and, in the future,". Ensuring older persons are supported to live well in their home has been strongly identified as the preference of our region's older people. The below schematic graphically represents the agreed strategy to achieve the vision.



Priority direction areas

To achieve the strategy, the priority direction areas identified are:

- Application of, and respect for human rights within all services provided by WMH and the PHN.
- Age friendly and culturally responsive environments and practices within all health contexts.
- Align the WMH and the PHN health system to the older persons we serve through:
    - ◊ Access to services that provide older-person-centred shared care based on the maintenance of functional ability.
    - ◊ Provision of improved, innovative, and sustainable services delivered locally wherever possible.
    - ◊ Assurance of a positive, sustainable, and appropriately trained health workforce.
    - ◊ Increased health literacy and improved access to information for older persons, their family, and carers.
- Improve healthcare outcomes for vulnerable cohorts and communities.
- Improve accountability, monitoring and evaluation to inform health service delivery.

An action plan to support achievement of the strategy priority direction areas is detailed within this document.

Core strategy enablers

Across our region, our strategy will be successfully enabled through consideration and optimisation of the following key enablers.

Information, Communication and Technology (ICT) and Digital Health	The vision as outlined in the "Digital Health Strategic Vision for Queensland 2026", is to advance healthcare for our consumers, clinicians, and the community through digital innovation.
Knowledge Translation (KT)	Building KT capability of clinicians within our community, primary and secondary older persons health services will support research moving from the laboratory, the research journal, and the academic conference into the hands of people and organisations who can put it to practical use.
Culture (supportive of older persons) and Strong Leadership	Leadership, partnership and stronger relationships between health organisations and clinicians will support the realisation of outcomes and actions outlined within the strategy.
Ongoing Collaborative Participation	Continued participation in the West Moreton Older Persons Care and Care at End of Life Collaboratives, provides WMH and the PHN with opportunities to advocate for and support change outside of either organisation's control and contribute to a whole of system health care and wellbeing vision.

To enable the strategy, it is acknowledged that further work will be required in partnership to operationalise the agreed direction, and which will include project and change management.

Alignment to other strategies, plans and frameworks

WHO World Report on Aging and Health 2015

National Health Reform (2020-2025)

Queensland Govt Priorities including Unite and Recover

Queensland's Strategy for Healthy Aging for Older Queenslanders (2019-2026)

West Moreton Health (WMH) Strategic Plan 2021-25

Darling Downs and West Moreton PHN Strategic Plan 2021-2023

WMH Strategic Workforce Plan

WMH Equity Framework

WMH Older Persons Care Framework

Darling Downs and West Moreton PHN Plan for Older People's Care

WMH Clinical Services Plan

WMH and Darling Downs and West Moreton PHN Older Person's Health and Wellbeing Strategy (this document)

Other enabling plans

Health Services Operational Planning

Divisional/Business Operational Planning

Enabling PHN plans and strategies

- Older Persons Care Collaborative Action Plan
- Care at the End of Life Collaborative Action Plan

Action plan

The following action plan will guide the development and delivery of healthcare across the community, primary and secondary services of WMH and the PHN to support the achievement of the strategy priority direction areas.

Human rights are about everyone, and they are very important for older people in Australia. We are all entitled to the enjoyment of human rights without discrimination of any kind, including discrimination based on our age.

There are certain human rights and freedoms that are particularly relevant to older people, including the right to:

- an adequate standard of living including access to adequate food, clothing and housing
- the highest possible standard of physical and mental health
- be safe and free from violence
- be free from cruel, inhuman or degrading treatment
- privacy
- family life.

Some of the human rights problems faced by older people in Australia include: access to appropriate and adequate aged care facilities and health care; abuse – including financial, physical and psychological abuse of elderly people; homelessness, poor living standards; and barriers in accessing government services and other opportunities to participate in community/public life.

Age friendly environments play an important role in determining the physical and mental capacity across a person's life course and into older age. Environments also impact how well people adjust to loss of function and other forms of adversity that may be experienced at different stages of life, particularly in later years. Both older people and the environments in which they live are diverse, dynamic, and changing. In interaction with each other they hold incredible potential for enabling or constraining healthy ageing. Age friendly environments encompass the entire context in which older persons live including transport, housing, labour, social protection, information and communication, as well as health care services and long-term care. It is always important to remember that older persons have a right to make choices and take control over a range of issues, including where they live, the relationships they have, what they wear, how they spend their time and whether they undergo treatment or not

Culturally responsive environments refers to health care services that are respectful of, and relevant to, the health beliefs, health practices, culture and linguistic needs of diverse populations and communities.

Action plan legend

Gain agreement	A
Develop	D
Communicate	C
Implement	I
Maintain	M
Review	R
Update	U
Evaluate	E
For actioning	✔

Application of human rights and age friendly and culturally responsive environments and practices					
We will:	**2022**	**2023**	**2024**	**2025**	**2026**
1.1 Review recommendations from the Royal Aged Care Commission into Aged Care Quality and Safety.	R				
1.2 Establish a baseline measurement report for application of human rights and age friendly and culturally responsive environments and practices within our community, primary and secondary services.	D				
1.3 Develop and implement an action plan to ensure application of human rights in all interactions and age friendly, culturally responsive environments. The action plan should include an agreed suite of age friendly and culturally responsive principles of practice and enable review and updates of existing policies, procedures, guidelines, practices, and training. This to include workforce training in application of the human rights act regarding older persons.	D C	I	E U	C I	E
1.4 Include education on application of human rights, age friendly and culturally responsive environments and practices in all orientation training programs and develop and deliver targeted training and in-services.		✔	✔	✔	✔
1.1 Develop measured and tangible outcomes for evaluation purposes.		✔	✔	✔	✔

Deliverables

1. Report: baseline measurement and collated data on the application of human rights and age friendly and culturally responsive environments and practices across our services.
2. An action plan for implementation across community, primary and secondary health services.
3. Updated policies, procedures, guidelines, and practices etc.
4. Targeted training on human rights and age friendly and culturally responsive environments and practices.
5. Regional Collaboratives are engaged in the delivery of consumer education materials

Success will look like...

1. Improved performance between 2022 to 2024 and then again in 2026 on application of human rights and enhanced physical environments which comply with the design principles of caring for older and diverse people.

Align health system to older persons: Access to services that provide older-person-centred shared care based on the maintenance of functional ability					
We will:	**2022**	**2023**	**2024**	**2025**	**2026**
2.1 Develop a consolidated map of older persons services (including community activities to assist with social prescribing) for the West Moreton region and publish for community, primary and secondary services to access as a single source of truth. This includes ongoing maintenance of HealthPathways.	D	✓	M	✓	M
2.1 Assess service gaps and identify opportunities for change.	✓		✓		✓
2.3 Advocate for services where gaps are identified (in partnership), utilising the West Moreton collaboratives and other existing channels to engage local, state, and federal governments.	✓		✓		✓
2.4 Gain agreement across WMH and PHN community, primary and secondary health services to use one consistent, risk screening and assessment toolkit (including behavioural and psychological symptoms of dementia and other mental illness) to enable integrated care plans that aim to optimise functional ability. This tool to accommodate differing contexts including older persons mental health.	A	I	E U	I	E
2.5 Develop and implement a template for a single WMH and PHN system-wide care plan for older persons based on functional ability and in codesign with the community, older persons, their family, and carers. This includes training and a process for care plans to be timely shared with all care providers within and across service settings and with older people, their family and carers.	D C	I	E U C	I	E
2.6 Develop and implement interdisciplinary models of care and care pathways across settings and care providers in codesign with the community, older persons, their family, and carers. Consider: • Barriers to accessing services (for example, wait times, out of pocket expenses, transition between services, transport, domestic assistance, medical monitoring and mental illness). • Person-centred care based on functional ability. • Patient flow. • Workforce interactions – consider creating service structures that foster care by multidisciplinary teams. • Information sharing and care coordination – implement strategies to share real-time information between providers in a standardised way. Consider communication with older persons, their family, and carers. • Shared care model optimised across primary and secondary health contexts.	D I	E U	I	✓	E
2.7 Develop clinical guidelines across community, primary and secondary health services to optimise trajectories of intrinsic capacity – this is to ensure early intervention when it is identified that capacity is starting to deteriorate. Update existing guidelines so that their impact on capacity is clear.	D U C	I	E U C	I	E

Deliverables

1. Current consolidated West Moreton older persons services map.
2. An agreed risk screening and assessment toolkit for use across our services.
3. WMH and PHN system-wide care template, based on older persons functional ability.
4. Interdisciplinary models of care, supporting person-centred care based on functional ability.
5. Clinical guidelines for use across our services to optimise trajectories of intrinsic capacity.

Success will look like...

1. Increased number of interdisciplinary services codesigning models of care and enhanced services with the community.
2. Community, primary and secondary services all participating together to achieve a shared care plan whilst using a consistent set of risk screening and assessment tools.
3. Increased proportion of older people, their family and carers consulted and supported to participate in and better understand their care.
4. Increased use of early intervention services.

Align health system to older persons: Provision of improved, innovative and sustainable services, delivered locally wherever possible					
We will:	**2022**	**2023**	**2024**	**2025**	**2026**
3.1 Proactively identify opportunities to base new and existing services in local communities, rather than in hospital settings.	✓	✓	✓	✓	✓
3.2 Increase care that is preventative, proactive, and focused on maintaining independence and the preservation of functionality ability. Promote early intervention and assessment of: • Smoking cessation, alcohol consumption, diet, pain relief and physical activity at key points across the lifespan – this is to support reduced chances of developing chronic conditions including heart and kidney disease. • Hearing and sight impairments to alleviate risk of accidents and isolation which leads to reduction in physical and social activities. • Oral hygiene to prevent dental disease for older people. • Nutrition and hydration for health. • Osteoporosis. • Dementia. • Cancer screening. • Older Person's Mental Health. • Care of carers, and associated services. • Elder abuse and domestic violence. • Falls and continence. • Frailty.	✓	✓	✓	✓	✓
3.3 Increase utilisation of GP Management Plans and Team Care Arrangements for those with identified needs and develop hybrid models with the WMH hospitals. Enhancement of existing hybrid models such as Me Care.	✓	✓	✓	✓	✓
3.4 Review outpatient services identifying opportunities for: • Better value and innovative models. • Increased own source revenue to support reinvestment for patients and the community. • Expansion of mix and breadth of services aligning with local catchment needs for older people. • Services provided at the Ipswich Hospital to be delivered in the West Moreton community service environment.	✓				
3.5 Review existing models of care, clinical care pathways, clinical guidelines and processes, and procedures. Identify opportunities for improvements in: • Innovation, with a focus on better system performance, preventable hospitalisation, reduced length of stay and a sustainable health care system such as: ◊ Extending successful models for improved primary health care including Geriatric Emergency Department Intervention (GEDI) to support consumers presenting with mental health challenges. ◊ Growing the capacity of hospital in the home services to enable older people to access medical, nursing, allied health, and rehabilitation services in their home.	✓				
3.6 Review recommendations from the Royal Aged Care Commission into Aged Care Quality and Safety. Develop an action plan for community, primary and secondary health services to support implementation of relevant recommendations.	R	D I	E U	I	E
3.7 Promulgate end of life care with accelerating advanced care planning incorporating outcomes associated with the voluntary assisted dying act.		✓	✓	✓	✓

Deliverables

1. Innovative models of care.
2. Action plan to implement Royal Aged Care Commission into Age Care Quality and Safety recommendations.

Success will look like...

1. Increased services available outside of hospital setting.
2. Increase in access to care that is preventative, proactive, and focused on the preservation of functionality ability
3. Innovation maturity.
4. Continued collaboration with clinical and statewide older persons networks.

Align health system to older persons: Assurance of a positive, sustainable, and appropriately trained health workforce						
We will:	**2022**	**2023**	**2024**	**2025**	**2026**
4.1 Partner with educational institutions to increase the focus of age friendly and culturally responsive principles and practices in relevant undergraduate, graduate and post graduate programs.	✓				
4.2 Review recruitment protocols to ensure inclusion of value-based competencies such as interpersonal skills respectful to the aging process, recognising older persons care as a speciality area requiring specific skill sets.	✓				
4.3 Review and update recruitment and retention strategies to ensure a capable and sustainable older persons workforce.		✓			
4.4 Design and implement an ongoing structured education curriculum across the region, accessible to all community, primary and secondary older persons health services and which includes: • Person-centred care principles and implementation in practice: Operationalising the concept of intrinsic capacity in clinical settings to enable reorientation of clinical practices away from the disease-based, curative model approach towards a more effective person-centred approach based on maintaining functional ability. • Usage of the agreed risk screening and assessment toolkit. • Usage of the system-wide care plan template and communication processes. • Knowledge and skills to address the specific health care needs of our older patients in our region. • Dying with dignity and palliative care. • Digital health literacy. • Knowledge Translation: applying evidence-based research to improve older persons health and strengthen our health care system.	D	I	E U	I	E
4.5 Enable staff to work across sectors to strengthen relationships across the service system and to better understand the capacity and capabilities within different service settings.	✓	✓	✓	✓	✓
4.1 Ongoing rollout of Project ECHO: Older Persons Educational Series.	✓	✓	✓	✓	✓
4.1 Establish GP Preceptorship Programs - building capability in primary care.	✓	✓	✓	✓	✓
4.8 Develop and implement, with input from a broad range of staff within community, primary and secondary older persons services, one workforce engagement survey to be used by all to better capture experiences, opinions, and preferences.	D I	E I	E I	E I	E I
4.9 Provision of consumer feedback to inform health education programs and recruitment strategies	✓	✓	✓	✓	✓

Deliverables

1. Updated recruitment and retention strategies.
2. Structured education curriculum for use across the community, primary and secondary older persons health services.
3. Staff with work experience opportunities in other sectors.
4. Ongoing Project ECHO: Older Persons Educational Series.
5. Preceptorship Programs.
6. Workforce engagement survey.

Success will look like...

1. Increased proportion of aged care providers participating in and completing a structured education curriculum that provides skills to deliver older person-centred care and the knowledge and skills to address the specific health care needs of our older patients.
2. Increased knowledge and skills to implement evidence-based research and increased innovation and change.
3. Increased awareness of the capacity and capabilities of age care providers in other sectors.
4. Improved workforce satisfaction and engagement.

Align health system to older persons: Increased health literacy and improved access to information, including access to the Human Rights Act, for older persons, their family, and carers.					
We will:	**2022**	**2023**	**2024**	**2025**	**2026**
5.1 Develop a partner portal in codesign with the community, older persons, their family, and carers to improve access to information regarding healthy behaviours, health conditions and services for older people, their families, and carers.	D C	I	E U C	I	E U C
5.2 Increase educational opportunities for older persons, their family, and carers. This includes educational symposiums specifically for this cohort (a minimum of two per calendar year), this to also include adhoc regional opportunities to connect with the community.	✓	✓	✓	✓	✓
5.3 Utilise the West Moreton Older Persons Care Collaborative, the WMH Consumer and Community Advisory Council and the PHN Advisory Group to develop strategies to support older persons to self-manage through peer support.	✓	✓	✓	✓	✓
5.4 Provide older persons, their family and/or carers with a plain language patient-held referral summary, including the appointment details if known or likely waiting period and alternative care options.	✓	✓	✓	✓	✓
5.5 Provide older persons, their family and/or carers with a plain language patient-held discharge summary with follow-up appointments that enable discussions with specialist regarding complex care needs.	✓	✓	✓	✓	✓
5.6 Promote assistive technology that supports older people to remain living independently in their own home. Partner with community providers who deliver education on using technology to increase digital literacy of older persons living in our region.	✓	✓	✓	✓	✓
5.7 Research peer to peer influence software and tools to support communication with consumers and to send appropriate, timely educational resources. Develop a business case for change to improve health literacy and improved access to information for consumers, their family, and carers, using available technology.	R	D C	I	E U C	I
5.8 Investigate innovative ways to optimise GP Smart Referrals.	✓	✓	✓	✓	✓

Deliverables

1. Partner portal and other tools/software to support improved health literacy and communication.
2. Educational symposiums for older persons, their family, and carers.

Success will look like...

1. Consumers accessing the partner portal to support their health needs.
2. Reduction in reported instances of unclear referral information and reasons for service presentation.
3. Reduction in reported instances of no discharge information available for patients by GPs and other care providers.
4. Increased digital literacy of older persons in our region (less reported instances of technology usage being a barrier).

Improve health outcomes for vulnerable cohorts and communities					
We will:	**2022**	**2023**	**2024**	**2025**	**2026**
6.1 Work in partnership with our regional collaboratives and other agencies, to identify and implement strategies for older people to increase access to preventative and early intervention in wellness and primary care settings who: • are homeless and require services • require support to navigate advocacy, legal, financial, and social care service systems • require support to maintain social connectivity.	✓	✓	✓	✓	✓
6.2 Support better access to the aged care system for vulnerable populations through service navigation or care coordination solutions.	✓	✓	✓	✓	✓
6.3 Evaluate service availability and effectiveness for the following groups with an intent to identify health care improvement opportunities: • Aboriginal and Torres Strait Islander • Culturally and Linguistically Diverse (CALD), including refugees • consumers living in isolation • Lesbian, Gay, Bisexual, Transgender, Queer/Questioning (LGBTQ) consumers • correctional centre consumers (including the impact of an increase in correctional centres within the region and an aging population within the prison system) • older consumers living with dementia • those with experience in Institutional environments during childhood • elder abuse and domestic violence.	E				
6.4 Develop an action plan based on findings, secure required approvals and funding and implement.		D C	I	E U C	I

Deliverables

1. Evaluation of current services available to vulnerable consumers.
2. Action plan to improve health outcomes.

Success will look like...

1. Vulnerable consumers have increased access to services to improve their health outcomes.

Improve accountability, monitoring and evaluation to inform health service delivery						
We will:		**2022**	**2023**	**2024**	**2025**	**2026**
7.1	Develop a shared position across community, primary and secondary health services on metrics, measures, and analytical approaches for maintaining functional ability and healthy ageing.	D I	E U	I	✓	E
7.2	Adapt information systems to collect, analyse and report data on intrinsic capacity and functional ability.	✓	✓	✓	✓	✓
7.3	Use the data to inform relevant system changes (for example, early access to memory clinics, exercise physiologists, podiatrists, dentists, dieticians).		✓	✓	✓	✓
7.4	Develop with input from older persons, their family, and carers, one patient experience tool to be used by all community and primary health services across West Moreton to better capture experiences, opinions, and preferences. Utilise statewide PREMs data to improve care models for WMH.	D I	E	E	E	E
7.5	Engage the West Moreton Older Persons Care Collaborative networks to determine which strategic actions they can support and monitor.	✓				
7.6	Empower the community groups across WMH and the PHN to monitor specific actions of their choice.	✓				
7.7	Monitor and evaluate the progress of the strategy and the related actions through the WMH Partnership Committee.	✓	✓	✓	✓	✓
7.8	Deliver yearly comprehensive reports to the Executive Leadership Committee of both organisations to outline progress and achievements.	✓	✓	✓	✓	✓
7.9	Provide a communication that is disseminates the strategy across the region.	✓	✓	✓	✓	✓

Deliverables

1. An agreed set of metrics, measures, and analytical approaches for healthy ageing.
2. Data on intrinsic capacity and functional ability.
3. Patient experience tool across community and primary care settings and use of PREMs data across WMH.
4. Yearly strategy progress reports.

Success will look like...

1. Improved patient experiences.
2. Monitoring and evaluating the functional ability of older persons in our care and using available findings to provide appropriate and timely care in the right setting.
3. Awareness across our organisations and the community of the shared strategy.
4. Visible accountability of the strategy.
5. Regional awareness of the strategy impact across the regional.
6. Ongoing input and monitoring of the Strategy provided by the regional Collaboratives.

Glossary

Term	Definition
Environments	Environments include the home, community and broader society, and all the factors within them such as the built environment, people and their relationships, attitudes and values, health and social policies, the systems that support them and the services that they implement. Being able to live in environments that support and maintain one's intrinsic capacity and functional ability is key to healthy ageing.
Functional ability	Having the capabilities that enable all people to be and do what they have reason to value. This includes a person's ability to: • meet their basic needs • learn, grow, and make decisions • be mobile • build and maintain relationships • contribute to society. Functional Ability = Intrinsic Capacity + Environments.
Intrinsic capacity	Comprises all the mental and physical capacities that a person can draw on and includes their ability to walk, think, see, hear, and remember. The level of intrinsic capacity is influenced by several factors such as the presence of diseases, injuries, and age-related changes.
PHN	Primary Health Network. Darling Downs and West Moreton PHN is one of 31 Primary Health Networks across Australia funded by the Commonwealth Department of Health to improve primary health care (health care delivered outside of a hospital setting). This strategy has been developed in partnership with the Darling Downs and West Moreton PHN and West Moreton Health.
WMH	West Moreton Health Hospital and Health Service (West Moreton Health) provides public hospital, health and wellbeing services to more than 312,000 people across the Somerset, Scenic Rim, Lockyer Valley and Ipswich communities, from Esk in the north, Gatton to the west, Springfield and Ipswich in the east, and Boonah to the south.

Notes

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phn
DARLING DOWNS
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An Australian Government Initiative

West Moreton Health

Local Integrated
Primary Health Care