Joint Regional Older Persons Strategy 25-30

Stronger for Life

REGIONAL HEALTH COLLABORATIVE

A partnership to improve healthcare in the Darling Downs and West Moreton Region

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List of abbreviations and acronyms

ACP	Advance Care Planning
AGES	Acute Geriatric Evaluation Services
AIHW	Australian Institute of Health and Welfare
AMS	Aboriginal Medical Services
CGA	Comprehensive Geriatric Assessment
COP	Community of Practice
COTA QLD	Council on the Ageing Queensland
CQI	Continuous Quality Improvement
DDCC	Darling Downs Care Collaborative
DDHHS	Darling Downs Hospital and Health Service
DDWM	Darling Downs and West Moreton
Dept of HDA	Department of Health, Disability and Ageing
DLI	Death Literacy Index
ECHO	Extension for Community Healthcare Outcomes (tele-mentoring model)
ED	Emergency Department
FY	Financial Year
GEDI	Geriatric Emergency Department Intervention
GOLD	Geriatric Outreach to Live in Dignity
GP	General Practitioner
HHS	Hospital and Health Service
HNA	Health Needs Assessment
JROPS	Joint Regional Older Persons Strategy 2025-2030
LGAs	Local Government Area(s)
MCH	Multicultural Health
MDT	Multidisciplinary team
MOUs	Memoranda of Understanding
NGO	Non-Government Organisation
PHN	Darling Downs and West Moreton Primary Health Network
PHIDU	Public Health Information Development Unit
QAS	Queensland Ambulance Service
QLD	Queensland
RACH / RACHs	Residential Aged Care Home(s)
RHC	Regional Health Collaborative
RASS	Residential Aged Care Support Service
UTI	Urinary Tract Infection
VAD	Voluntary Assisted Dying
WMCC	West Moreton Care Collaborative

Acknowledgement of Country

Stronger for Life acknowledges the Traditional Custodians of the lands on which we live, work and gather. We pay our respects to Aboriginal and Torres Strait Islander Elders past and present, and extend that respect to emerging leaders.

We recognise that connection to Country, waterways, culture, family, and spirituality are central to the physical, mental, social, and cultural wellbeing of Aboriginal and Torres Strait Islander peoples.

We honour the wisdom, leadership, and ongoing contributions of Elders and communities in preserving, sharing, and passing on cultural knowledge about ageing, care, and community.

Stronger for Life is committed to walking alongside Aboriginal and Torres Strait Islander peoples to support health, wellbeing, and cultural strength through every stage of the ageing journey.

Foreword

Older people are at the heart of our families and communities — and they have a fundamental right to live with purpose and dignity.

With an ageing population across the Darling Downs and West Moreton region, we are presented with both a responsibility and an opportunity to ensure our health system can efficiently and sustainably provide care for our community members as they grow older.

Stronger for Life lays the path to achieving our vision of a future-fit health system that enables older people to age well, on their own terms.

This Strategy is grounded in the lived experiences and voices of older people and those who provide care. The actions laid out within this Strategy are based on a place-based and person-centred approach, prioritising core themes of choice, independence and dignity.

We acknowledge that the experiences of older people in their healthcare journey have become more complex, particularly at the interface between primary care, community, residential aged care homes, and hospital settings.

Stronger for Life will work across the system to enable better-coordinated transitions and timely access to services that are closer to home. This is fundamental to supporting the wellbeing and dignity of older people, and relieving pressure on their caregivers and families.

We extend our sincere gratitude to our partners across the health, community and aged care systems for their role in shaping this Strategy, and their ongoing work to enable people in our region to age well.

The implementation of this Strategy is underpinned by a strong governance structure that connects place-based collaboratives, working groups, and Regional Health Collaborative oversight to ensure strong stewardship and accountability over the implementation of this Strategy.

With the support of our cross-system partners, Stronger for Life is our coordinated investment in a sustainable health system for everyone.

Lucille Chalmers

Chair - Regional Health Collaborative

CEO - Darling Downs and West Moreton PHN

About the Regional Health Collaborative

The Regional Health Collaborative (RHC) is a health system partnership in the Darling Downs and West Moreton region.

RHC was established in 2024 to enable the governance and practical collaboration needed to meaningfully partner on joint strategic priorities for the region. In partnership, the RHC develops solutions to shared priorities that can be more effectively addressed with a cohesive, joined-up approach.

Read more about RHC at:
ddwmphn.com.au/RHC

Governance

The RHC Governance includes chief executive representation from:

Australian Government

phn DARLING DOWNS AND WEST MORETON An Australian Government Initiative

West Moreton Health | Darling Downs Health

Queensland Government

HCQ HEALTH CONSUMERS QUEENSLAND

kambu Aboriginal and Torres Strait Islander Corporation for Health

CRAICCHS

Goolburri

Carbal Medical Services

goondir health services

REGIONAL HEALTH COLLABORATIVE
A partnership to improve health care in the Darling Downs and West Moreton Region

Our region

The Darling Downs and West Moreton PHN region is large and diverse, geographically and demographically. At around 99,000 km^2, our region spans 12 local government areas (LGAs):

- Toowoomba
- Ipswich
- Lockyer Valley
- Scenic Rim
- Somerset
- South Burnett
- Cherbourg
- Southern Downs
- Goondiwindi
- Western Downs

Our region also includes communities located in the Banana Shire and Brisbane LGA. We support healthcare in urban, regional, rural and remote settings, all with their unique challenges.

With a diverse population of around **610,000 people**, our region is one of the fastest growing areas in Australia and predicted to grow by 17% to 2030[1].

1. PHIDU, Social Health Atlas of Australia (2025)

Major public hospitals

West Moreton	Darling Downs
1	1

Rural health services

West Moreton	Darling Downs
4	12

Private hospitals

West Moreton	Darling Downs
2	6

Residential Aged Care Homes

West Moreton	Darling Downs
16	47
9 Ipswich 4 Lockyer Valley 2 Somerset 1 Scenic Rim	22 Toowoomba 6 South Burnett 9 Western Downs 3 Goondiwindi 7 Southern Downs

Across West Moreton and Darling Downs

4,151 RACH beds

173 general practices

5 Aboriginal community controlled health organisations

Geographical snapshot

6.5% Aboriginal and Torres Strait Islander population

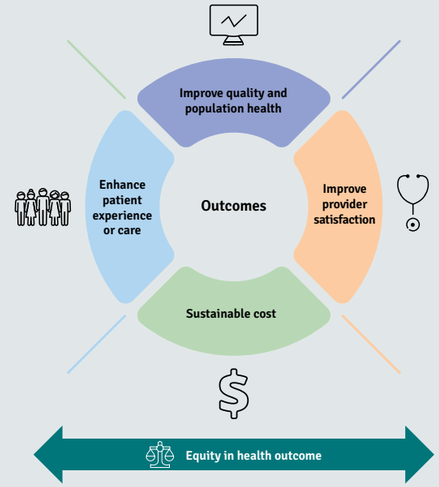
17% of people in our region are aged 65 years or older

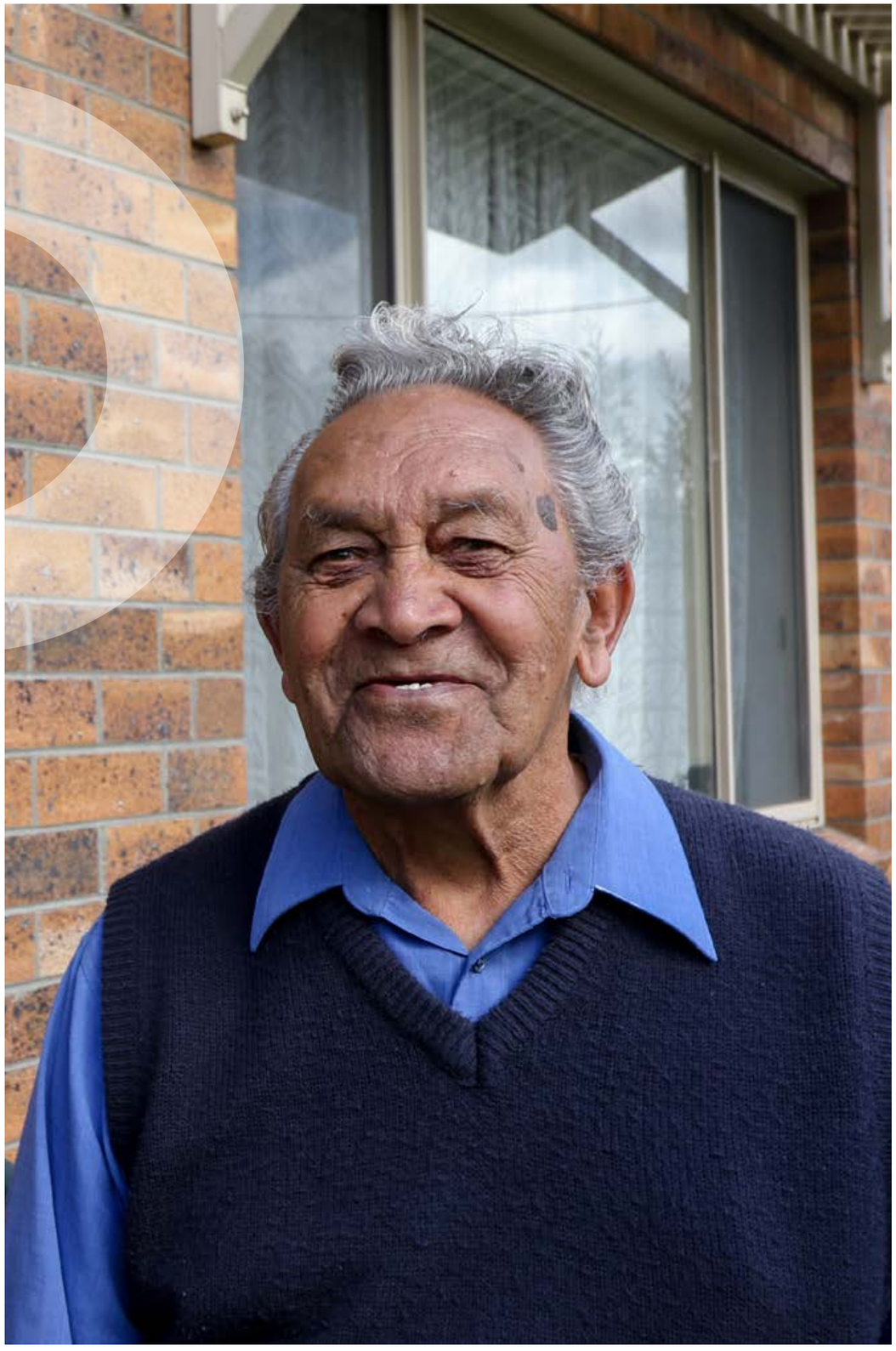
53,181 males aged 65 or older

58,289 females aged 65 or older

Quintuple aim

The Quintuple Aim framework for healthcare systems is being widely adopted across Australia as the primary framework for assessing the impact of state and federally funded health services. It is used to address health inequities and centres our innovation and improvement efforts on priority communities and populations.





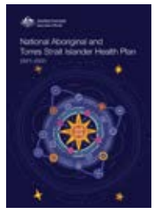
Strategic alignment

Stronger for Life is aligned with key national, state and regional activities.

The Royal Commission into Aged Care Quality and Safety - 2021

Download

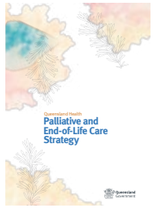
The final report in 2021 identified systemic failures and made 148 recommendations leading to a government-led reform agenda focused on improving quality, safety, sustainability, workforce and governance through measures like increasing funding, mandatory care minutes, and a new Aged Care Act.



National Aboriginal and Torres Strait Islander Health Plan - 2021 - 2031

Download

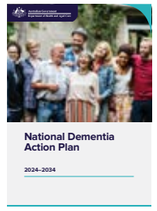
This plan is shifting the way governments work with Aboriginal and Torres Strait Islander peoples to achieve better outcomes and drives the development of Aboriginal and Torres Strait Islander health policies, programs and initiatives.



Queensland Health Palliative and End-of-life Care Strategy - 2022

Download

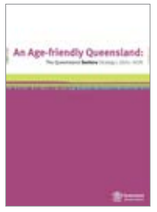
The Palliative and End-of-ife Care Strategy guides the Queensland government's additional invention in palliative and end-of-life care. There are 44 actions to enable, strengthen and connect Queensland's palliative care services.



National Dementia Action Plan - 2024-2034

Download

The National Dementia Action Plan 2024-2034 is Australia's national dementia policy framework that sets out a plan for continuing to improve the lives and care of people living with dementia in Australia over the next ten years.



An Age Friendly Queensland: The Queensland Seniors Strategy - 2024-2029

Download

This Strategy supports the needs and aspirations of all people to age well in a place that is right for them, to be included and contribute to their communities, to enjoy their independence and to be respected and feel valued.

Voluntary Assisted Dying - 2023

Download

The Voluntary Assisted Dying Act 2021 (the Act) was passed in September 2021 and became available to eligible Queenslanders on 1 January 2023.

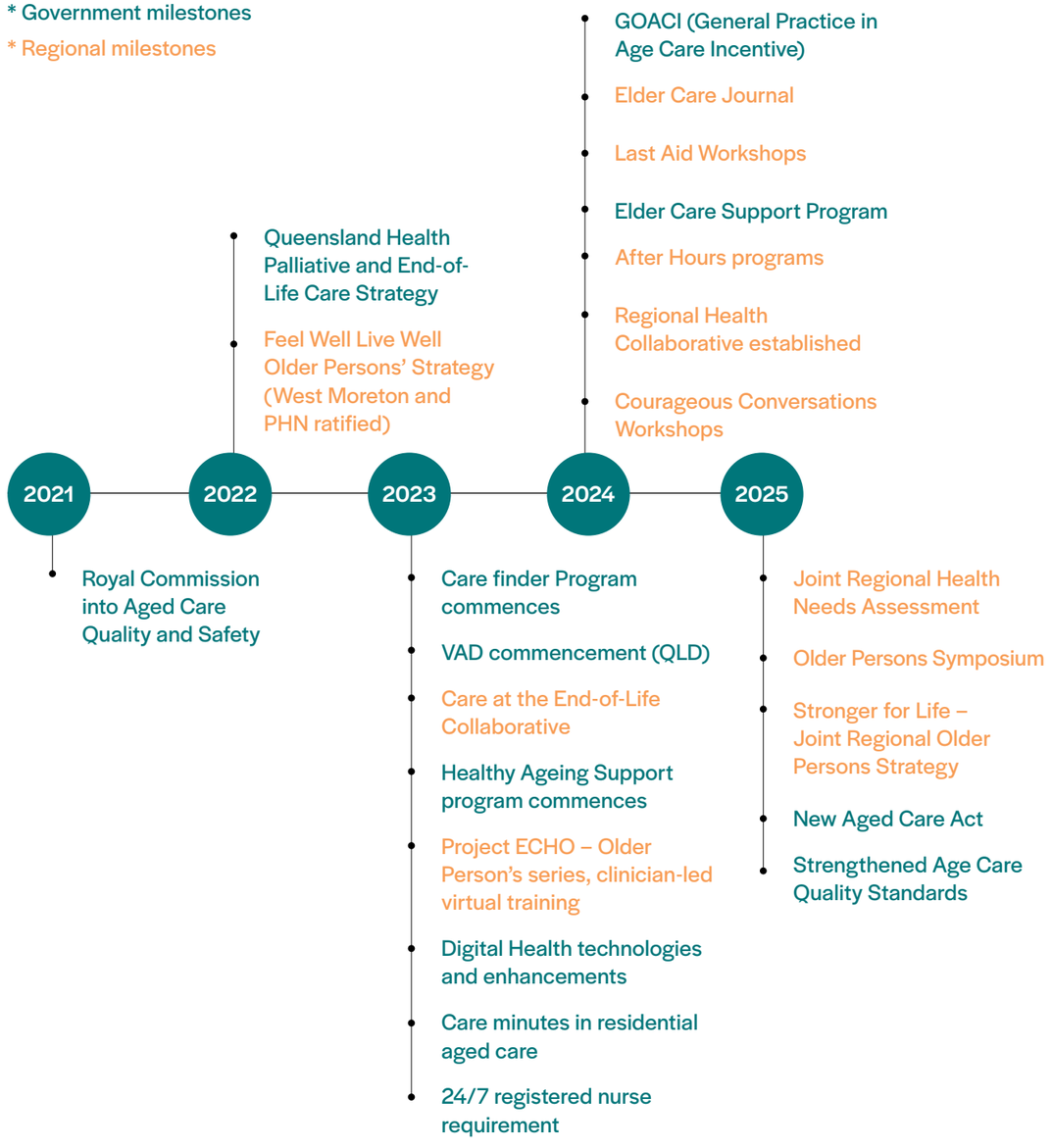
Building on strong foundations

Stronger for Life builds upon important, collaborative achievements and connections established through Feel Well, Live Well – Older Persons Strategy, which was developed in partnership between the PHN, Darling Downs Health and West Moreton Health in 2021.

Feel Well, Live Well delivered strong outcomes in a time of major sector change. With the establishment of the Regional Health Collaborative (RHC), Stronger for Life continues and extends the path for this important work, with a strong commitment from all partners to prioritise the needs of older people across the region.

Timeline of significant events and achievements

* Government milestones
* Regional milestones



Spotlight on existing joint activities

Elder Care Support Program

Across our region Aboriginal Medical Services, including Goolburri, Goondir, CRAICCHs and Carbal, are delivering the Elder Care Support Program.

Elder Care Support helps Aboriginal and Torres Strait Islander Elders and their families and carers to access education and information, including My Aged Care, navigation of assessment processes, advocating on behalf of Elders with Assessors and providers, and ongoing support to access and connect to aged care services.

Voluntary Assisted Dying (VAD) Darling Downs Health

Since the VAD law took effect in Queensland on 1 January 2023, Darling Downs Health's dedicated VAD team, made up of medical, nursing and allied healthcare professionals, have helped eligible people with life-limiting illnesses access the program, and provided education and support on the process from eligibility, request and assessment, through to administration and post-death support.

The VAD team have been instrumental in supporting health professionals and community build awareness of the options available to them at the end of life whilst also delivering the service.

Older Persons-Project ECHO Series

Since 2021, the PHN in partnership with West Moreton Health, has utilised the Project ECHO teleconference guided practice model to develop the Older Persons series.

Between 2021 and 2024 a total of 939 participants attended and topics included; elder abuse, hoarding, ageing and housing, caregiver burden, Residential Aged Care Home (RACH) transition and social isolation and loneliness.

Looking ahead FY25/26 Project ECHO will introduce a new season with initial sessions sharing information on the new 'Support at Home' program.

GOLD Program West Moreton Health

The Geriatric Outreach to Live in Dignity (GOLD) service provides a Comprehensive Geriatric Assessment (CGA) for older people, alongside education and support in outpatients and at-home settings in the Ipswich and surrounding rural area.

The service aims to provide complex healthcare for vulnerable and frail elderly people living in the community and improve their quality of life.

Somerset Assist

Somerset Assist was developed as a need emerged through the West Moreton Care Collaborative, who then worked with community members and stakeholders to co-design solutions.

Somerset Assist is a place-based innovative self-managed aged care provider partnering with Mable and Trilogy Care to utilise local supports and provide a local response to local needs.

Somerset Assist supports those older people with an allocated Home Care Package in the Somerset region to access the services they need in the home and community and harness the ability to navigate the aged care system.

Supporting Older People, People with Complex Care Needs and/or Palliative Care

The PHN commissions Ipswich Nurses which operate in the West Moreton area. Ipswich Nurses offer a Nurse Practitioner-led clinical care service that is delivered in RACHs.

This initiative aims to enhance the quality of life and clinical outcomes for residents in RACHs and thereby reduce avoidable hospital admissions and presentations to emergency departments, in turn alleviating pressure on RACHs, GPs and Health and Hospital Services.

Acute Geriatric Evaluation Services (AGES)

The AGES team at Toowoomba Hospital support older people to get the right support during care. A team of doctors, nurses, pharmacists and other health professionals offer assistance in:

- Hospital - Emergency Department Geriatric Emergency Department Intervention (GEDI).
- Residential Aged Care Homes - Residential Aged Care Support Service (RASS).
- Within the community.

Health intelligence

Community voice

Community voice is crucial to the successful implementation of the Stronger for Life Strategy. Throughout the development of this Strategy, engagement workshops and activities occurred across the region to understand community perspective and needs.

Through this collaborative approach older people with lived experience - inclusive of Aboriginal and Torres Strait Islander Elders and multicultural communities - were able to share their personal insights about what ageing well means to them.

Common themes:

- Feeling valued and having the ability to continue to contribute to their community and family.
- Having secure housing and homes and the financial means to ensure that security.
- Being able to be on Country, or return to Country at the end of their lives.
- Retaining their independence and autonomy in making decisions for their own lives, health and care needs.
- Recognition of their status as elders in their family and community, and position as knowledge and keepers of tradition and cultural practices, and the respect they hold within the family and extended family unit.

TALK ABOUT – Ageing Well

From May to June 2025, we talked about what it means to age well.

121
online survey responses

79
participants in community led discussions in Nanango, Ipswich, Toowoomba, Coominyah and Cherbourg.

This is what we heard from the community:

6/10
was the average rating given by these participants and their overall experience with health services in the region.

Long-term relationships with GPs are important.

Friendly and welcoming healthcare staff are highly appreciated.

Close to home services are important.

87%
say pharmacists explain treatments clearly and provide trusted advice.

46%
say they feel it takes too long to access care.

38%
say the cost of healthcare is hard to management, and bulk-billing is becoming harder to find.

31%
reported mobility concerns, with those living rurally sharing that lack of transport is a compounding issue to mobility.

Data-informed community insights

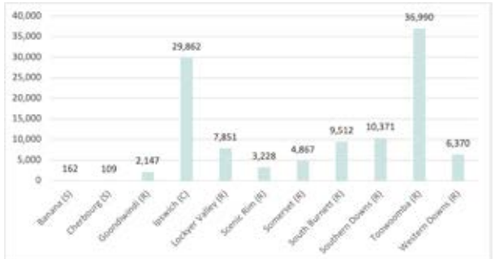
Where older people live

In 2024, of the 111,470 senior persons in the region, the largest proportion lived in urban areas of Toowoomba and Ipswich.

In 2021, there were 4,339 Aboriginal Elders (55+ years) living in the region. This group represented 4.3% of the total senior population and 11.3% of all Aboriginal and Torres Strait Islander peoples in the region.

The highest proportion of Elders lived in Cherbourg (86.8%), followed by Goondiwindi (4.4%) and the Western Downs (4.3%).[2]

Population of older people by LGA



Source: PHIDU, Social Health Atlas of Australia, 2025

Residential Aged Care Homes (RACHs)

In 2021-2022, there were 68 Residential Aged Care Homes across the region who had an average occupancy of 87%, with an average length of stay of 30 months.[3]

This accounts for an average of 3,611 older people residing in permanent aged care at any one time across the region. Currently, the region's 64 RACHs include a cross-section of private and public facilities, large corporate and standalone aged care homes, and nine multi-purpose sites.

An evaluation by Nous reported that 80% of residents lose their regular GP upon entering a RACH raising challenges around GP accessibility and continuity of care.[4]

Social insights

Volunteering: In 2021, 15.4% of senior persons (65+) participated in volunteer activities.[5]

Unpaid care: 11.6% of older people provided unpaid assistance to a person with a disability, health condition, or due to old age.[6]

Age pension: In 2022, 65,935 people received the Age Pension, representing 63% of the total senior population aged 65 and over.[7]

Senior health card holders: 9,219 people held a Seniors Health Care in 2022, accounting for 8.8% of the senior population.[8]

Homelessness support: In 2022, 275 people aged 50-59 years and 195 people aged 60 years and over accessed Specialist homelessness programs.

Chronic disease

With an increase in the prevalence of chronic conditions and an increasing ageing population, there is correlated evidence of increased pressure on our health services and system.

To manage this, focused attention must be paid to earlier intervention and preventative health measures to relieve the burden of healthcare across our region, including the need for increased multi-disciplinary care.

Living with chronic conditions

Of those older people who regularly attended a local GP:

- 52% have 1 or 2 conditions recorded
- 22% have 3 or more conditions recorded
- 20% do not have a chronic condition recorded.

Older people with rising risks

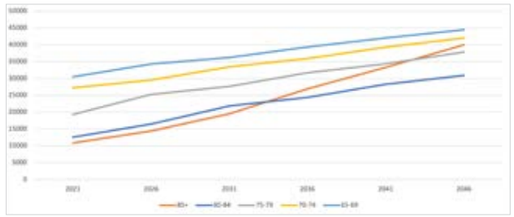
Of those older people who regularly attended a local GP in the Darling Downs and West Moreton region:

- 37,877 (32%) were healthy
- 40,189 (34%) were at risk
- 26,502 (22%) were rising risk.
- 13,841 (12%) were high risk.

2. PHIDU, Social Health Atlas of Australia, (2025) 3. AIHW, Older People, (2021-2022). 4. General Practice in Aged Care Incentive – Monitoring and Evaluation Framework, Aug 2024). GPACI Nous Evaluation Report.pdf 5. ABS, Census of population and housing, (2021) 6. ABS, Census of population and housing, (2021) 7. PHIDU, Social Health Atlas of Australia, (2023) 8. PHIDU, Social Health Atlas of Australia, (2023).

Growing older persons population

Projection of senior persons population from 2021 to 2046 by age group



Source: Queensland Government Population Projections, 2023

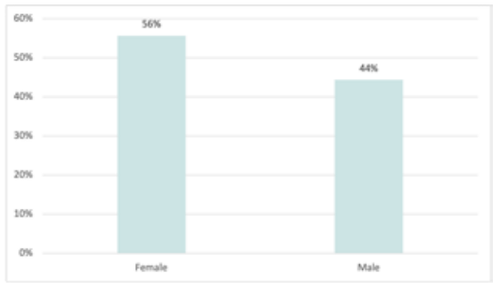
Whilst there are consistent growth rates across all age brackets, the 85+ group has the highest increase. As a region we need to ensure that health, aged care and supportive services take into consideration the more complex health needs of this group like dementia, arthritis and potential accessibility issues when developing infrastructure and interventions to support ageing communities.

Dementia

Dementia Australia report there is an estimated 433,300 Australians living with dementia and this is projected to increase to around 812,500 by 2054. Nationally, there are recognised data gaps in dementia insights, particularly around prevalence.

Within the Darling Downs and West Moreton PHN region, it is estimated the number of Australians living with dementia in 2023 was 9,404. Further breakdown of the data by gender indicates 38.5% are men, and 61.5% are women.[9]

Senior persons with dementia conditions



Source: GP Database, 2025

Older people with high behavioural support needs (e.g. as a result of a mental illness or dementia) often have great difficulty in securing a residential aged care bed if they have complex interacting disabilities.[10]

GP data indicates that the region has high proportions of older people with increasing levels of health risk. More than two-thirds of the senior population are experiencing, or are at risk of experiencing, poorer health, mobility and wellbeing as they age. This highlights the need to shift from reactive responses to proactive, preventative models of care when implementing the Strategy.

Planning within this Strategy aligns with population risk, with a focus on stronger early intervention and education.

Palliative care

The region generally exhibits relatively high palliative care hospitalisation rates across most age groups compared to other regions of Australia.

Service access: The region records the highest hospitalisation rate for the 35-54 age group among all listed PHNs. In contrast, the region has a relatively low rate of palliative care service access (139.66 per 10,000 people). This is significantly below the national average (293.13) and lower than most other PHNs.

Overall insight: The data suggests that Darling Downs and West Moreton rely more heavily on hospital admissions for palliative care compared to community-based palliative care services, which appear to be less frequent than in many other regions and nationally.

Future needs: By 2026-2027, the need for specialist palliative care services is expected to increase by 44% in the Darling Downs, and 52% in the West Moreton region.[11]

9. AIHW, Australians Living with Dementia in 2023, (2023). 10. (Ref: The National Aged Care Advocacy Program Presenting Issues – Report 5 July 2024 – June 2025 and DDH RACH Reference Group) 11. Queensland Health, 2019

Priority populations

As our primary focus, the older persons population is inclusive of several intersecting priority populations and communities. As a joint health system, we understand and recognise the numerous priority populations within our region and the importance of ensuring their inclusion across the aged care system and overall Stronger for Life Strategy.

Older people living with Dementia or other cognitive impairments

The number of people with dementia is expected to double by 2058 (AIHW 2024). Older people, living with changing cognition or cognitive impairment and/or dementia, require focused support to access healthcare that allows them to retain their independence in daily living at home and in the community for as long as possible. Where necessary the ability to access higher, more specialised support is available as their health and living needs change.

Aboriginal and Torres Strait Islander peoples

Aboriginal and Torres Strait Island peoples make up 6% of the total population in our region, and within this population, Elders make up 11.3% of all Indigenous people. This Strategy seeks to build equity through addressing systemic barriers and implementing culturally safe and responsive care across the health and aged care system.

Multicultural communities including refugees and asylum seekers

People born overseas, including those from refugee and asylum seeker backgrounds, make up 26.3% of our total population with larger communities in Ipswich and Toowoomba urban areas. Older people from multicultural backgrounds may require better access to language support, culturally safe and appropriate health and aged care. Additional consideration needs to be given to supporting trauma-informed care for those from a refugee background.

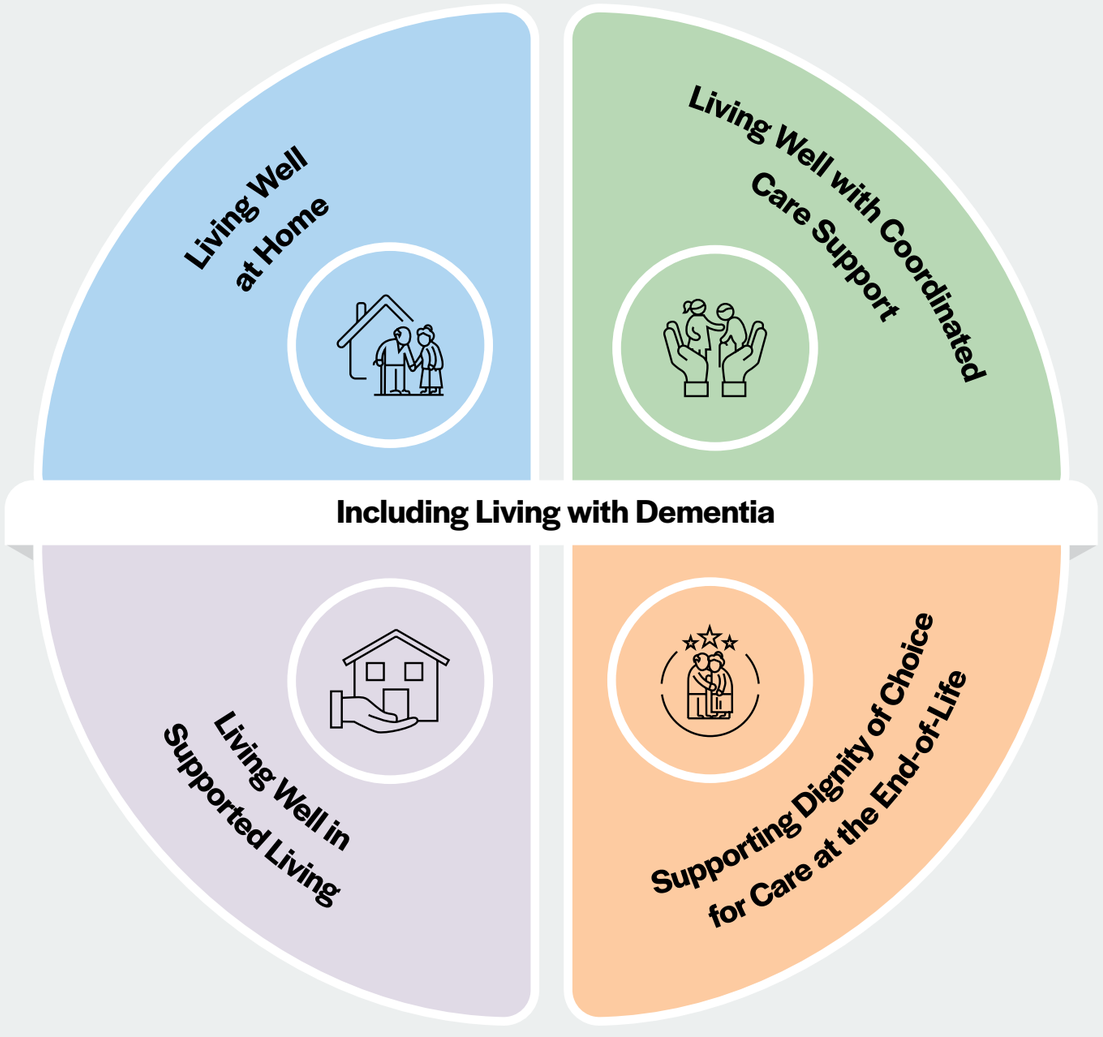
Rural, regional and remote communities

Improvement of access to services and resources to increase or maintain health status for those people living rurally/remotely who have limited access to health care, community and at-home services. Integration of existing place-based services helps to support the local community where older people live.

Strategic pillars

These pillars are the foundation on which Stronger for Life is developed. Using a life course approach, these four pillars provide structure for how we will support people throughout their ageing journey.

These four distinct pillars cover diverse experiences of ageing, from living independently at home, through to dying with dignity and care – ensuring the system can respond flexibly and effectively to the changing needs that arise throughout the ageing journey.



Living Well at Home

All older people are able to live well in their own home, community and on Country, by being able to access the necessary primary health care, community and at-home services they require that optimises self-determination and independence.

Living Well with Coordinated Care Support

Working alongside older people to enhance the support they need in navigating the aged care system and ensuring that those with increasing or more complex health needs receive comprehensive, coordinated care across our health and aged care systems.

Living Well in Supported Living

All older people living within an assisted living or Residential Aged Care Home receive the quality care and support they need and deserve to continue to live and age well.

Supporting Dignity of Choice for Care at the End-of-Life

Ensuring people retain their right to choose the type of palliative and end-of-life care they want to receive, in the place they choose, at the end of their life, that supports not only the person with a life-limiting illness but their family and carers, including:

- Education of care needs when supporting someone in the home.
- Preparedness and connection to ongoing support.
- Enhancing dignity of choice and dying well.

Strategic themes

Through the review, exploration, and design process, several recurring themes emerged as priorities. These themes build on the foundations of the Strategy, guiding efforts to drive system change and deliver better care and support for people as they age.

The six priority themes are:

Prevention and early intervention:

Strengthening proactive approaches to support health and wellbeing across the life course.

System navigation and coordinated transitions:

Ensuring people experience seamless and supported care journeys.

Skilled and culturally responsive workforce:

Building capability to deliver safe, inclusive, and individualised care.

Dementia-inclusive practice across the continuum:

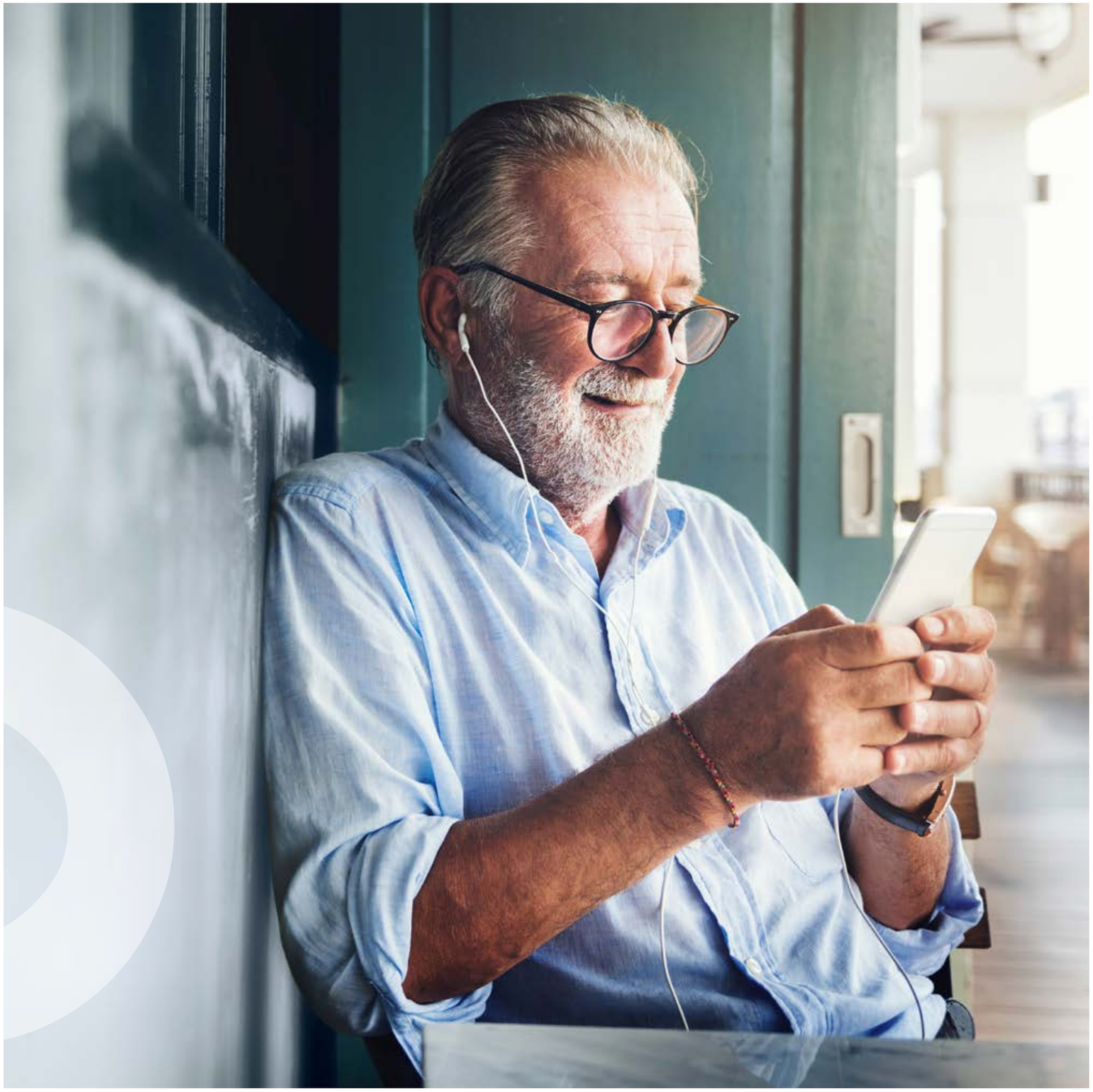
Embedding dementia awareness, supports, and pathways at every stage.

Innovation and impact:

Exploring and delivering new models, approaches, and partnerships that drive measurable improvements.

Community capacity and development:

Enabling communities to play an active role in shaping and supporting healthy ageing.



Enablers of success

For this Strategy to make a real difference in the lives of people as they age, certain conditions need to be in place. These are the 'enablers of success', the things that create the right environment for change to happen and for good ideas to come to life.

By keeping a close watch on these enablers, working together, supporting the workforce, and strengthening health intelligence. We will ensure the Strategy remains responsive, sustainable, and centred on what matters most to older people and their communities.

Monitoring progress will be key, and the Strategy will deliver a 12-month report back to the community on the progress to support with transparency and accountability to the community and stakeholders.

Collaboration

Workforce

Health Intelligence

Collaboration

Good outcomes for older people happen when services, communities and governments work side-by-side. Strengthening both informal and formal relationships will help us move toward a more connected health and care system.

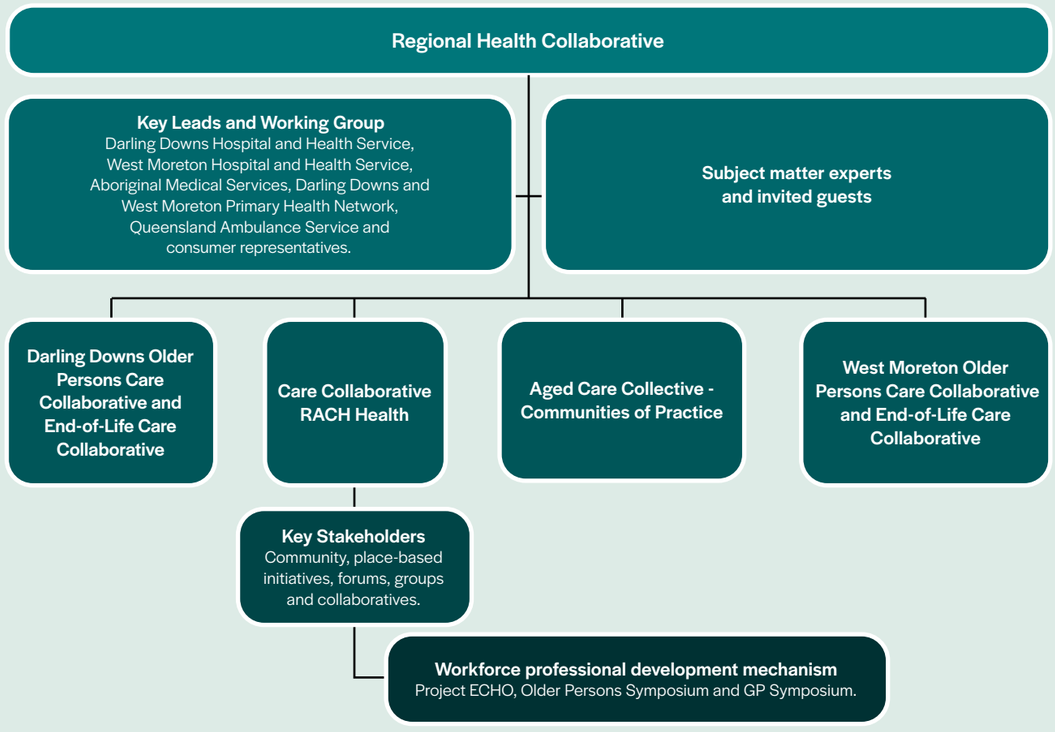
A clear governance structure will enable collective decision-making and coordinated action, guided by those with subject matter expertise and local knowledge. Local collaboratives will bring people together around place-based and thematic priorities, through the Older Persons Strategy Working Groups.

The Strategy will align with the broader RHC governance structures, while intentionally connecting existing groups to ensure the Strategy is embedded well at all levels of community and the service system.

Governance supports broad regional and deeper local representation including local councils, community members, and health and community service providers.

This will be delivered by:

- Creating regular opportunities for networking and shared learning.
- Partnering on projects that tackle big, complex issues together.
- Hosting symposiums to share what's working and to spark innovation.
- Listening to older people in their communities in ways that are meaningful and engaging for them including world cafe's, forums, yarning circles, Elders groups and older person's collaboratives.



Workforce

The people who care for older persons are at the heart of this Strategy. Sustaining and supporting this workforce is especially important in our region, where high turnover and reliance on temporary staff are a reality.

We will explore innovative, team-based approaches and strategies to ensure people can work to the top of their skills and training, in the context of our broad geographical reach and workforce shortages.

The Strategy responds to this through a range of activities:

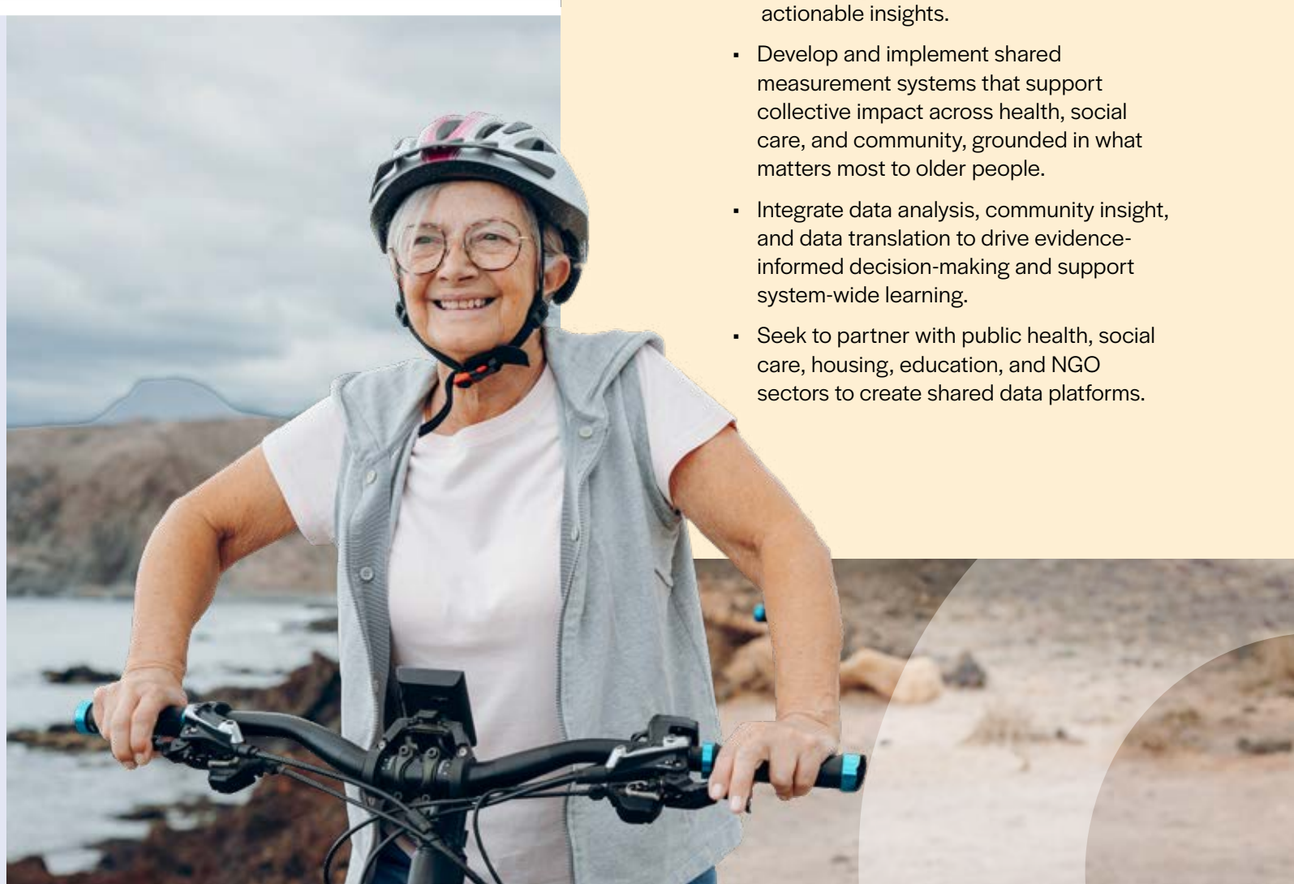
- Incorporating structured and regular opportunities for clinical and managerial involvement in Strategy implementation.
- Exploring locality-based, multi-disciplinary teams that bring together nurses, allied health, GPs, Aboriginal health workers, and care coordinators.
- Trialling new workforce models such as shared workforce and nurse practitioner-led care.
- Targeted training in areas like dementia, falls, and frailty management.
- Encouraging job-sharing and cross-role understanding to build trust across the workforce.
- Strengthening the region's value proposition as a destination of choice for working with older people through attraction, engagement and retention activities across relevant sectors.

Health intelligence

Shared knowledge and insights help us design better connected care. Having sound quantitative and qualitative data informed by lived experience, spanning hospital, primary, aged, and community care, ensures evidence-based and well-informed decision-making that enables high-quality, responsive, timely, and equitable services.

We will achieve this by:

- Strategic collaboration of cross-sectoral health intelligence to enable place-based, integrated, and equity-driven care through high-quality, localised, and actionable insights.
- Develop and implement shared measurement systems that support collective impact across health, social care, and community, grounded in what matters most to older people.
- Integrate data analysis, community insight, and data translation to drive evidence-informed decision-making and support system-wide learning.
- Seek to partner with public health, social care, housing, education, and NGO sectors to create shared data platforms.



Living Well at Home - Community Voice

We heard people as they age want to stay in their homes as long as possible. There is a need for support that is flexible, person-centred and reduces the burden on family caregivers.

> *My role in the community as I get older, I am expected to support others I need to participate and contribute.*
>
> **— Anyuon**

> *Good Health, cheat death, staying healthy for my family.*
>
> **— Mike**

> *We want care, but we want to decide what that care looks like. Let us choose the tasks and how it works in our home.*
>
> **— Community member**

> *Being healthy, having a house having money to go back to country and having the ability to get around is important.*
>
> **— Rodger**

> *Good support would allow me to have enough care to stay in my own home until I died.*
>
> **— Community member**

Living Well at Home

Enablers

Collaboration

Workforce

Health Intelligence

What success looks like:

- Earlier detection of health risks; reduced avoidable ED admissions over time; shift to strength-based and preventative mindset.
- Increase in community-facing holistic responses to ageing. Increased quality of life and connection.
- Earlier identification and proactive management of acute conditions.
- Greater dementia awareness, reduced stigma and increased community capacity.
- Proactive self-advocacy and navigation from individuals' families and carers.
- Sense of being valued and having agency.

Focus	Measuring success
Early identification and intervention » Identify and embed clear referral pathways so people receive timely follow-up care. » Increase community knowledge and use of preventative health assessments, including: 75+ Health Assessment, 45–49 Check, Chronic Condition Plans, Frailty Index, Cognition Screens.	Number of completed preventative health assessments. GP and health service data on early detection and reduced avoidable ED admissions.
Build health literacy and shared decision-making for older people, carers, and families Activities include: » Peer knowledge sharing on Advance Care Planning. » Dementia, and carers support. » Elders Journals for community engagement and reflection. » Disaster preparedness tools (QR codes, brochures, radio, social media).	Pre- and post-event surveys and community feedback on self-agency, preparedness, and confidence.
Dementia-Inclusive Practice Across the Continuum » Reduce stigma and misinformation around dementia through awareness campaigns. » Collaborate with Dementia Australia and primary care to showcase good practices and build community capacity. Activities include; Project ECHO, podcasts, media releases, events and community engagement.	% of participants reporting improved understanding after attending event. Feedback from people with dementia and carers on their experience of being supported locally.
Culturally responsive and person-centred approach » Shift focus from illness to overall wellbeing, quality of life, and purpose. » Promote access for at-risk populations, integrate social prescribing, and include lived experience input in training materials. » Deliver multidisciplinary team care that focuses holistically on wellbeing rather than deficits.	% increase of priority populations accessing services. Increase in participation in community or social connection programs.
Explore targeted strategies » Support older people to manage their health and prevent conditions such as UTI's, cellulitis and falls.	ED presentations admissions for acute conditions.

Living Well with Coordinated Care Support - Community Voice

Coordination across services, trusted relationships, consistency in workforce and cultural safety are key to ensuring people retain their ability to live well at home, aided with clear information and increased navigation support for families.

We need more of our own mob caring for us. Someone who understands our ways, who we don't have to explain ourselves to. That would make a big difference.

— Community member

Need to be better informed on what you can get in terms of assistance.

— Community member

We rely on our families to make the calls because it's all too hard to figure out.

— Community member

Good support, personalised person-centred care.

— Community member

Living Well with Coordinated Care Support

Enablers

Collaboration

Workforce

Health Intelligence

What success looks like:

- Greater community confidence in navigating the aged care system.
- Increased access to services for older people and priority populations communities.
- Improved awareness of care options and alternatives.
- Increased culturally responsive practices, tools and workforce.

Focus	Measuring success
System Navigation, Coordinated Care and Transitions » Commission navigation services for those that require additional assistance. Delivering community education to older people and families on navigation of the aged and healthcare system, options beyond hospital and GP, virtual ED, telehealth explained in plain language and co-design of community material with community. » Strengthening digital integration and co-ordinated care, in and out of hours so older people experience safe, timely and coordinated transitions.	Quarterly reporting, Post event surveys and recorded number of people attending. Reduced hospital transfers from RACHs and community settings. My Health Record registration and usage. Documented After Hours care plans in place and routinely used.
Skilled and culturally responsive and person-centred approach » Increasing advocacy and culturally inclusive care, navigation and assessment, access to face-to-face My Aged Care for priority groups, and utilising “Good Spirit, Good Life” for Aboriginal and Torres Strait Islander Elders. Expanding culturally responsive care and telehealth supports, and workforce professional development in culturally safe practices. » Embed Age-Friendly Communities approach across commissioned providers and health services safe practices.	Uptake of “Good Spirit, Good Life” tool. Number or % of priority populations engagement in services. Professional development participation rates. % of participants who reported care was culturally responsive. Number of commissioned services meeting age-friendly criteria. Consumer satisfaction surveys, % of those accessing service identify as 55/65+.
Innovation and Impact » Advocating solutions for the unintended impacts of policy and red-tape to Governments and decision-making partners through evidence-based intelligence.	Number of position papers or proposals delivered.

Living Well in Supported Living - Community Voice

There is a need for improved quality of services in residential and supported living, especially around specific care needs (e.g., dementia capability). Strategies to ensure cultural appropriateness and ways to address workforce shortages are also needed for people to age and live well in supported living accommodation.

The nursing homes need to employ more staff... They are doing three minute showers and rushing feeding.

There is no time.

— Community member

My regular GP of more than 30 years will not visit me in the RACH, I have to go to him which only works if I have family to take me there.

— RACH resident

It challenging when a GP goes on leave we once had one go for two months and we had no one to write up scripts.

— Former RACH manager

Mum was in a severe dementia unit... Staff did not display knowledge of living with dementia. Many hours of the day she sat in front of the TV.

— Community member

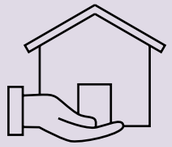
Residential aged care has become more acute, residents are coming in to die. The average length of stay seems to be two years. In the past it was seven years.

— Former RACH manager

Ideally, it would be great to get the GP visit regularly or when I need them.

— RACH resident

Living Well in Supported Living



Enablers

Collaboration

Workforce

Health Intelligence

What success looks like:

- Earlier intervention, reduce social isolation and improved health outcomes.
- Increase collaboration and shared problem solving.
- Improved social connection and mental wellbeing for residents.
- Increase in co-ordinated care and improved health outcomes.
- Increased confidence of resident's utilising digital health platforms of care.
- Increased culturally responsive workforce.

Focus	Measuring success
Prevention, Early Identification and Intervention » Commissioning services and implementing supports that enhance residents' wellbeing (volunteer programs, digital connections, peer support, mental health and wellbeing programs).	Number/s of residents participating in wellbeing activities. Pre and post satisfaction surveys. Uptake of digital connection programs.
Collaboration » Establishing and co-delivering RACH collective action groups (DD + WM) to jointly identify and deliver key priorities and projects, and enhancing information sharing across health providers, including GPs, pharmacists, digital health, AGES, and palliative care.	Number of actively engaged RACHs in collective forums or individual engagements. Number of joint projects delivered.
Innovation and Impact » Co-design and pilot nurse-led models linking RACHs and primary care: Enable full scope of practice and multidisciplinary care. » Increase engagement between GPs and RACHs.	Hospital admissions of those enrolled. Number of GP's and RACH's actively participating in the program. Service provider surveys. Increase in MyMedicare enrolment for older persons year on year. Number of GP's claims for enrolled persons.
Skilled and culturally responsive workforce and person-centred approach » Identifying and responding to priority needs, including digital health, afterhours care, dementia, advance care plans and clinical handovers.	Numbers attending professional development activities. Post event surveys.
Innovation and Impact » Explore opportunities to co-commission complex behavioural support models.	Number of proposals delivered and MOUs.

Supporting Dignity of Choice for Care at the End-of-Life - Community Voice

Community Definition: We heard the call from community and stakeholders to demedicalise ageing and the end-of-life, in favour of community centred care that is culturally safe and accessible, and ensuring community is equipped to make informed decisions.

(ACP) To guide you and your family when nearing end and can't speak for self – their wishes are understood.

— Community member

They (ACP) are a good idea, less stress for the family when the time comes.

— Community member

Lack of funding for palliative care... Don't feel there is enough beds in any of the hospitals.

— Community member

Aboriginal Health Workers are only around during the day. But our needs don't stop when the sun goes down. We need 24/7 support - especially in palliative care or hospital.

— Community member

We just need a bit more help to actually sit down and go through it properly. Don't just give us a brochure and expect us to know what to do.

— Community member

Supporting Dignity of Choice for Care at the End-of-Life

Enablers

Collaboration

Workforce

Health Intelligence

What success looks like:

- Shared understanding and priority of the needs of the region relating to end-of-life care.
- Community have increased death literacy and are empowered to share wishes with family and professionals.
- Increase in completed Advanced Care Plans and wishes being followed in end-of-life care choices with dignity.
- Care at the end of life is culturally safe and responsive to the community.
- Community and professionals' area aware of all choices available at end of life and are seeking support early.
- Grief and bereavement options and pathways are embedded well and families feel supported.
- Digital technologies are utilised to enhance care options and deliver of end of life care choices.
- People living in rural areas and can receive high quality end-of-life care.

Focus	Measuring success
Collaboration » Refresh and develop regional end-of-life and palliative care joint Health Needs Assessment to inform prioritisation and drive joint approaches to end-of-life and palliative planning.	Delivery of Joint Health Needs Assessment action plan.
Community development » Increase community death literacy and knowledge around ACP's so communities and families can plan and talk early about end of life and are prepared for the realities of what death looks like.	Number of Completed Advanced care plans. DLI scores . Post Event surveys.
Community development/skilled and capable workforce » De-medicalise and destigmatize death and dying where safe and appropriate. Bring end-of-life back to the community as a natural part of life. Support RACHs, GPs, Pharmacists and Ambulance services to enable home or community deaths. » Provide education sessions and clear information about end-of-life options including VAD to GPs and community. Support to identify grief and bereavement options within the community and explore additional options.	Review and reflect on experiences of families. Post event surveys. Utilisation and distribution of caring@home resources. Delivery of a grief and bereavement current state map and develop recommendations for enhancement at a local level, Number of GPs and Community members participating in VAD sessions, uptake of VAD across the region.
Culturally responsive and person-centred approach » Embed Culturally responsive palliative practices and safe inclusive spaces for end-of-life care. » Enhancing practices, interpreter support and culturally appropriate resources, enabling 'dying on country' where chosen.	Consumer feedback. Post event surveys.

Focus	Measuring success
Skilled and capable workforce/prevention, early identification and intervention » Improve primary care capacity to identify palliative needs early and refer, dementia inclusive palliative pathways, stronger GP engagement and consistent information sharing. » Key focus on rural primary care as there are limited specialist supports available rurally.	Date of referrals to Specialist Palliative Age Care programs prior to death. Uptake of training delivered. Health Pathways accessed.
Innovation and impact » Utilise digital devises, telehealth and software to enhance end-of-life care within RACH's. This includes CQI and outcomes programs, better access and visibility to care plans and patient info through the Viewer and My Health record.	Number of RACH utilising Palliative Aged Care Outcomes program. Number of RACH registered for My Health Record.
System navigation, co-ordinated care and transitions » Build knowledge and enhance options for people in rural areas to access end of life services.	Number of community sessions held, post survey feedback. Increased Health Pathway utilisation. New Health Pathways developed.

Underpinning our work and tracking our progress

To support implementation, the Strategy will be underpinned by needs assessments, more granular plans, tools and frameworks that to ensure transparency, and strengthen accountability.

Monitoring and review frameworks will be further developed and made available as the Strategy is implemented.

REGIONAL HEALTH COLLABORATIVE

A partnership to improve healthcare in the Darling Downs and West Moreton Region