Government of **Western Australia**
Department of **Health**

Implementation Plan Two 2025-2028 (IP2) - draft for consultation

WA End-of-Life and Palliative Care Strategy 2018-2028

Version: 22 September 2025

Classification: Official

Acknowledgement of Country and People

The WA health system acknowledges the Aboriginal people of the many traditional lands and language groups of Western Australia. It acknowledges the wisdom of Aboriginal Elders both past and present and pays respect to Aboriginal communities of today.

Using the term Aboriginal

Within WA, the term Aboriginal is used in preference to Aboriginal and Torres Strait Islander, in recognition that Aboriginal people are the original inhabitants of WA. Aboriginal and Torres Strait Islander may be referred to in the national context and Indigenous may be referred to in the international context. No disrespect is intended to our Torres Strait Islander colleagues and community.

Contents

[*Note: further acknowledgements, foreword, executive summary and appendices to be included in final version*]

Overview

Our vision is to improve the lives of all Western Australians through quality end-of-life and palliative care

Implementation Plan Two 2025-2028 (IP2) outlines how the Western Australian health system and partnered organisations can action the priorities and building blocks of the WA End-of-Life and Palliative Care Strategy (2018-2028) (the strategy). IP2 builds on Implementation Plan One 2020-2022 (IP1) and aligns with other statewide end-of-life and palliative care frameworks and pathways released subsequent to the strategy.

The strategy provides the statewide direction for end-of-life and palliative care and recognises that people are at the centre of their care, and that their values, preferences and choices should drive the care and services they receive. Policymakers, executives, health professionals, educators, researchers and the wider community all play important roles in ensuring that people, their families and carers have access to high-quality, evidence-based end-of-life and palliative care, support and services.

Terminology

The term 'palliative care' is referred to in this document as the concept or approach to care, not as the multidisciplinary specialty or service itself. The definitions used in the strategy and implementation plans are outlined in the definitions section of this document.

The changing landscape

The population of WA is changing in line with national and international trends. The population is ageing, and with this, the number of people living with chronic, progressive conditions is increasing. The top 5 leading causes of death in Australia in 2023 were ischaemic heart disease, dementia, cerebrovascular disease, lung cancer and chronic lower respiratory disease.[1] In 2024, dementia was also reported to be the leading non-malignant condition requiring palliative care,[2] and the number of Australians with dementia is projected to more than double by 2058.[3]

The estimated need for palliative care in Australia is expected to grow faster than that of both the population and total deaths between 2019 and 2060.[4] Between 2022-23, there were 101,000 palliative care-related hospitalisations across Australia, a 37% increase from 2015-16.[5] Figure 1 (below) highlights the key end-of-life and palliative care statistics.

In this context, the WA Department of Health (the department) recognises the continued importance of advance care planning and has increased resources available to people who wish to complete advance care planning documents, including Advance Health Directives. Health professionals in acute, community and residential aged care settings have a range of options to document advance care planning and goals of care discussions to ensure the person's values and preferences are known and the care provided aligns with their wishes.

Since the strategy and IP1 were published, the *Voluntary Assisted Dying Act 2019* came into effect and now provides eligible people in WA with an additional choice in their end-of-life care. Voluntary assisted dying (VAD) operates within a comprehensive legal framework and is overseen by robust governance and reporting. It also protects clinicians who have conscientious objections to VAD.

Eligible people who access VAD in WA have progressive, life-limiting illnesses, such as cancer or neurological conditions,[6] and VAD enables them to legally choose the manner and timing of their death. From 2023-2024, nearly 84 per cent of people requesting and found eligible to access VAD in WA had received palliative care,[6] highlighting VAD as an integrated component of end-of-life care for those who choose to access it.

Although generalist and specialist palliative care services in WA aim to provide high quality end-of-life and palliative care, we must continue to seek innovative solutions to manage the increasing demand for services and commit to strengthening the way end-of-life and palliative care are delivered for those who need it.

Figure 1: End-of-life and palliative care snapshot in Australia [*note: graphic design to be completed*]

Top 5 leading causes of death in Australia in 2023[1]				
1. Ischaemic heart disease	2. Dementia	3. Cerebrovascular diseases	4. Lung cancer	5. Chronic lower respiratory diseases
Insert infographic	*Insert infographic*	*Insert infographic*	*Insert infographic*	*Insert infographic*

Place of death for people under palliative care services in 2023[7]		**Deaths per year in WA in 2024**[8]
Insert infographic	69% died in hospital 18% died at home 11% died in a residential aged care home 2% not stated	18,303

Access to palliative care services

Number of Australians who accessed palliative care services in 2022-2023[5]

Out of 101,000 palliative care related hospitalisations:

- 3 in 5 (60%) were for people aged 75 and over
- Less than 1 in 10 (8%) were for people aged under 55
- 2,800 hospitalisations were for Aboriginal and Torres Strait Islander people.

Top 3 pathways of referral to palliative care in WA in 2024[7]

Referral to inpatient services		**Referral to community services**	
	1. Public hospital 2. Community palliative care services 3. Private hospital		1. Public hospital 2. General practice 3. Private hospital
Insert infographic		*Insert infographic*	

Top 5 diagnoses accessing palliative care in 2023 in Australia[2, 7]

Malignant conditions (63.4%)	1. Lung 2. Colorectal 3. Other gastrointestinal tract 4. Pancreas 5. Breast	Non-malignant conditions (36.6%)	1. Respiratory failure 2. Dementia 3. Cardiovascular disease 4. End-stage kidney disease 5. Stroke
Insert infographic		*Insert infographic*	

Voluntary assisted dying in WA[6]

Since 2021, there have been:

- 2,260 first requests to access VAD
- 737 VAD deaths.

Development of Implementation Plan Two

The department's End-of-Life Care Program (EOLCP) developed IP2 by building on progress since launching the strategy and applying learnings from IP1. Since IP1 was released there has been increased emphasis on the role of the community in end-of-life and palliative care and the importance of supporting families and carers beyond a person's death. IP2 also incorporates recommendations from reviews and reports published since the release of IP1, including the Independent review – Consumer perspectives of palliative care service models,[9] key national and state strategies, frameworks and reviews, and WA health service end-of-life and palliative care strategies. Figure 2 provides an overview of the strategy and IP2 alignment with national and state legislation, strategies and frameworks.

IP2 also incorporates stakeholder perspectives from the June 2023 forum: End-of-Life Care Collaborative Forum – A dignified end of life: Progress and Possibilities. More than 160 people attended the forum, which identified key implementation priorities. Participants included consumers, carers and health professionals, along with researchers and representatives from health services, specialist and community palliative care services, residential aged care, primary and tertiary health care, government and peak bodies.

Work towards the strategy has continued since IP1, reflected in output from the collaborative forum and highlighted in the case studies included throughout IP2. Further consultation was undertaken with a wide range of stakeholders in September 2025 before the finalisation and launch of IP2 in [Month] 2025.

Figure 2: Strategic alignment of the WA End-of-Life and Palliative Care Strategy 2018-2028, IP1 and IP2 [*Note: graphic design to be completed*]

National

- Aged Care Diversity Framework (2017)
- National Palliative Care Strategy 2018 and Implementation Plan 2020-2022
- National Safety and Quality Health Service Standards – Second edition (updated 2021)
- National framework for advance care planning documents (2021)
- National Consensus Statement: Essential elements for safe and high-quality end-of-life care (2023)
- National Palliative Care Standards for Specialist Palliative Care (2024) and for All Health Professionals and Aged Care Services (2022)
- National Dementia Action Plan 2024-2034
- The Paediatric Palliative Care National Action Plan (2024)
- *Aged Care Act (2024)* (expected to commence 1 November 2025).

Western Australian

- *Guardianship and Administration Act 1990*
- My Life, My Choice report of the Joint Select Committee on End of Life Choices (2018)
- WA End-of-Life and Palliative Care Strategy 2018–2028 and Implementation Plan One 2020 – 2022
- East Metropolitan Health Service End-of-Life and Palliative Care Strategy Implementation plan (2019 – 2024)[10]
- *Voluntary Assisted Dying Act 2019*
- Ministerial Expert Panel on Advance Health Directives (2019)
- Sustainable Health Review (2019)

- Palliative Care in Western Australia – Progress Report of the Joint Select Committee on Palliative Care in Western Australia (2020)
- Aboriginal End-of-Life and Palliative Care Framework (2021)
- Western Australian Paediatric Strategy for End-of-Life and Palliative Care 2021 – 2028 and Optimal Paediatric Palliative Care Pathway (2021)
- End-of-Life and Palliative Care for People with Dementia Framework (2021)
- WA Country Health Service Palliative and End-of-Life Care Strategy (2024-2028)
- Review of the *Voluntary Assisted Dying Act 2019* (2024)
- Framework for bereavement support after an expected death in WA (2025).

How to use Implementation Plan Two

The EOLCP is responsible for monitoring the performance of the IP2 against the wider strategy. It plays an active role in facilitating collaboration amongst key stakeholders and the community to implement the plan through influencing policy, purchasing, workforce and planning. The EOLCP encourages stakeholders to continue to progress local, health service and community-level initiatives that are relevant to their community and patient needs and support the strategy and IP2. It also recommends that stakeholders continue to use the action plan template in appendix 2 if suitable.

The intention is for IP2 to inform, complement and support other relevant statewide service models and frameworks including the WA Cancer Plan (2020-2025),[11] Kidney Supportive Care model of service (*in development*) and WA Dementia Action Plan (*in development*).

IP2 highlights some of the work health services and community organisations have done or are undertaking to improve end-of-life and palliative care outcomes.

> *“Palliative care is so important and when you've had good palliative care it makes a huge difference to your experience. But it’s not just the patient… the family cope better when there’s a palliative care team involved.”*
>
> *Independent review – Consumer perspectives of palliative care service models* [9]

Caring for people with diverse needs and priority populations

An essential part of delivering high quality person-centred care is understanding the unique experiences and diverse needs of people receiving end-of-life and palliative care, and their families and carers.[12]

People from priority populations are more likely to have complex needs, exposure to psychological trauma, experience higher levels of unmet healthcare needs and adversity in health outcomes compared to the general population. This extends to end-of-life and palliative care outcomes.[13] People from priority populations also face barriers and challenges in accessing health care and other community services.

The following population groups have been identified in IP2 as priority populations warranting specific consideration in relation to end-of-life and palliative care services in WA:

- Aboriginal people
- people from culturally and linguistically diverse (CaLD) backgrounds (including new migrants)
- people experiencing socio-economic disadvantage (including people experiencing homelessness)
- children and young people
- older people living in residential aged care homes (RACHs)
- people living in regional, remote and rural areas
- people living with disability
- people living with cognitive impairment, including dementia
- people living with mental illness
- people who are lesbian, gay, bisexual, transgender, intersex, queer and other sexuality, gender and bodily diverse people (LGBTIQA+).

People from priority populations may also experience intersectionality. Intersectionality describes how different aspects of a person's identity, such as gender, sexual orientation, ethnicity or socio-economic status, can expose them to overlapping forms of discrimination and marginalisation.[14] It is important that intersectionality is considered when providing end-of-life and palliative care to priority populations.

In this document, priority populations refers to the groups listed above. Specific population groups will be explicitly mentioned where relevant to a particular outcome, action and/or measure.

Implementing Priority 1: care is accessible to everyone, everywhere

Priority 1
Care is accessible to everyone, everywhere

"We are so fortunate to have [the] support and care from a palliative [care] nurse in [our] region." [15]

Consumer experience

I have access to good quality end-of-life and palliative care, regardless of who I am, or how I live my life.

Strategy building blocks

- Improve equity of access
- Improve access to care for Aboriginal people
- Improve access to care for culturally and linguistically diverse communities
- Strengthen care for children with a life-limiting illness
- Improve access to care for condition-specific groups (e.g. people with dementia or those experiencing mental health issues)
- Improve access to care for people with diverse care needs and priority populations.

Outcomes

- People living in WA with life-limiting illness will have access to timely, respectful and inclusive end-of-life and palliative care if required:
    - regardless of age, illness, ethnicity or background
    - in their place of choice
    - in metropolitan, regional, rural or remote WA
    - irrespective of their end-of-life choices.
- The specialist palliative care workforce will be able to meet the demand for services across the state.
- People from priority population groups can access care that is respectful and appropriate and includes their families and carers where relevant.
- Palliative care services for children living with and dying from a life-limiting illness will be guided by the Paediatric Strategy for End-of-Life and Palliative Care and the Optimal Paediatric Palliative Care Pathway to meet the needs of the child and their family.
- Health (including primary care), community and aged care providers will be able to demonstrate greater capability, understanding and application of end-of-life care principles, supported by:
    - access to education and resources to enable appropriate assessment and care for people, their families and carers

- a greater understanding of holistic care needs at end-of-life, including beliefs and values
- access to culturally appropriate consumer information in a variety of formats and languages to suit the diverse needs of people and their families and carers, including access to interpreter services.

Recommended actions

Service provision

- Improve access to timely specialist palliative care services by:
    - having systems in place that support early and consistent identification of palliative care needs
    - supporting earlier referrals to community-based and hospital-based specialist palliative care where appropriate
    - supporting options for self-referral
    - understanding and addressing barriers to access
    - designing welcoming environments and models of care to support priority populations.
- Support projects, pathways and services that allow people who want to, to remain at home while receiving palliative care services.
- Encourage and support increased provision of palliative care by primary care providers, including those visiting RACHs.
- Continue to use existing technology to improve access to palliative care, particularly in regional WA.
- Promote the use of tools to identify people with deteriorating health who would benefit from earlier access to specialist palliative care, goals of patient care discussions or end-of-life interventions.
- Ensure equitable access to VAD for those who want it, regardless of place of care.
- Access to VAD aligns with the Access Standard[16] which includes how the state intends to facilitate access to VAD for regional residents.

Service models

- Seek to improve current end-of-life and palliative care service models to respond to changing and increasing demand, emerging issues and service delivery gaps.
- Promote and support the inclusion of end-of-life and palliative care in models of care for people with life-limiting illnesses.
- Continue to collaborate with community, consumers and carers to inform service model planning and reviews.

Care coordination

- Integrate palliative care into formal care pathways for those with advancing life-limiting illness to encourage timely access and avoid crisis referrals.
- Promote and support early referral to Aboriginal Health Liaison Officers, where available and appropriate, to improve access and support the provision of culturally appropriate palliative care.

Bereavement

- Refer to the service considerations for Priority 1 in the Framework for bereavement support after an expected death in WA.[17]

Workforce

- Promote consistent messaging across sectors to build health professionals' understanding of the benefits of early referrals to palliative care.
- Advocate for specialist palliative care workforce that can meet the increasing demand for services in WA, including bereavement support.
- Support access to VAD by:
    - streamlining access to the WA VAD Approved Training
    - increasing health professionals' understanding of VAD and the referral process.
- Develop and support Aboriginal Health Liaison Officer roles that specialise in end-of-life and palliative care and ensure their availability in a range of healthcare settings.

Recommended measures

What will we have that we don't have now?
What will it look like?

Service provision

- Collection and/or analysis of available state-level data related to access and referrals to specialist palliative care by location and priority group.
- Examples of how the experience of people receiving palliative care, particularly priority populations, is informing service provision planning, delivery and review.
- Increasing numbers of people remaining at home while receiving palliative care services.
- Projects and initiatives that demonstrate support for primary care practitioners in providing quality palliative care.
- Increased use of new and existing technology to improve access to palliative care in WA.
- Better use of clinical indicators and assessment tools to support earlier referrals.

Care coordination

- New or updated care pathways for people with life-limiting illness, including frailty.
- Increased options for referring Aboriginal people to Aboriginal Health Liaison Officers or equivalent roles.

Workforce

- Enhanced specialist palliative care workforce across the state, including specialist allied health professionals.
- Increased number of VAD practitioners by location.
- Increased understanding of the VAD referral process by health professionals.
- Increased number of Aboriginal Health Liaison Officers and health practitioners specialising in end-of-life and palliative care.

[Placeholder - Priority 1 in action – examples from Western Australia]

Implementing Priority 2: care is person-centred

Priority 2
Care is person-centred

> *“Mum’s death and dying was… exactly as she wanted it to be.”* [18]

Consumer experience

I am seen as an individual, and I have the opportunity to be involved in honest discussions with those important to me about my care. My values, culture and spirituality are respected and considered when care is given.

Strategy building blocks

- People and their families and carers co-designing care with health teams, to include:
    - culturally respectful and comprehensive care
    - opportunities to talk about and plan for death, including advance care planning.
- Care is centred on people and their families and carers.

Outcomes

- People and their families and carers will:
    - have the confidence and be supported to participate in advance care planning and document their decisions
    - have sufficient information and be supported to make informed decisions on end-of-life choices, including VAD.
- Services will work together to deliver person-centred care in the person’s preferred location, wherever possible.
- Improve communication between the healthcare team and people receiving end-of-life and palliative care, and their families and carers.
- Health (including primary care), community and aged care providers will have the capability and capacity to anticipate and respond to the changing needs and preferences of people, their families and carers.
- Increased uptake of quality goals of care and advance care planning discussions to ensure the person’s end-of-life preferences are known.
- Palliative care assessments and plans are available if required to document agreed care.

Recommended actions

Service models and provision

- Continue to promote tools and resources for health professionals that support person-centred assessment and care planning including integration of VAD.
- Support service models and pathways that facilitate high quality, person-centred palliative care including for those people who wish to access VAD.
- Promote service models and pathways that incorporate advance care planning, goals of patient care and Advance Health Directive documents.
- Continue to use digital solutions to store and share goals of care and advance care planning documents across all care settings and services in real time, so information about people's preferences for care is readily available.
- Incorporate consumer perspectives on end-of-life and palliative care service delivery into service improvements.

Education

- Increase use of the End-of-life and Palliative Care Education and Training Framework as a tool to identify learning needs and opportunities across all services providing care for people approaching end of life.
- Continue to provide training and education opportunities for all health professionals, care workers and volunteers to support person-centred care.
- Strengthen communication skills required to have effective goals of care and advance care planning discussions, including supported decision-making.

Bereavement

- Refer to the service considerations for Priority 2 in the Framework for bereavement support after an expected death in WA.

Recommended measures

What will we have that we don't have now?
What will it look like?

Service models and provision

- Increased completion rates and availability of goals of care and Advance Health Directive documents.
- Increased electronic storage and sharing of advance care planning documents (based on available state and national data).
- Increased use of person-centred, holistic assessment and care planning tools by health professionals.
- High levels of patient and carer satisfaction with end-of-life care regardless of place of care or death.

[Placeholder - Priority 2 in action – examples from Western Australia]

Implementing Priority 3: care is coordinated

Priority 3
Care is coordinated

> *"The GP was amazing at liaison and remained constantly in touch and available for advice, visits and assistance, even when [a community service] took over."* [9]

Consumer experience

I receive the right care at the right time, in the right place, from the right people. My care occurs within a coordinated and collaborative approach, enabling care to be delivered seamlessly.

Strategy building blocks

- Strengthened referral pathways between primary care, community, aged care and specialist palliative care service providers in the delivery of end-of-life care
- Adequate resources to support health, community and aged care providers delivering end-of-life and palliative care.

Outcomes

- People, their families and carers will be supported to transition between services, across all sectors.
- Quality of life for people, their families and carers will be improved through:
    - an inter-disciplinary and coordinated approach to care, incorporating allied health services where relevant
    - strengthened communication and collaboration between health (including primary care), community and aged care providers and specialist palliative care teams at all stages of care
    - appropriate referrals to specialist palliative care.
- The specialist palliative care workforce supports the general healthcare workforce to build their capacity to deliver palliative care.
- People are supported by care navigators and connectors where available to support access and delivery of palliative care services.
- Patient clinical information is accessible across services where appropriate, and through relevant digital solutions.
- The use of innovative technology, including an increased uptake of digital solutions, will connect people, and their families and carers to all teams providing their care.

Recommended actions

Care coordination

- Continue to improve care coordination and transition between services, through collaboration between specialist palliative care services, primary care, allied health

and other health professionals including facilitating multidisciplinary (MDT) meetings and case conferencing.
- Continue to promote the involvement of primary care in the planning and coordination of palliative care, supported by use of relevant Medicare Benefits Schedule items.
- Support initiatives that provide coordinated care for older adults.
- Ensure consistent storing and sharing of documents, including advance care planning via digital platforms to improve continuity of care.
- Facilitate timely sharing of clinical information with VAD practitioners with the person's consent, and timely access to assessment, following a request to access VAD, regardless of place of care.
- Support young adults and their families to transition safely and smoothly from paediatric to adult services.

Service models

- Continue to explore alternative models of service, such as the use of telehealth and e-prescriptions, to improve coordinated care, particularly for those living in regional WA.
- Further develop pathways between virtual healthcare initiatives and palliative care services to support emergency department and hospital avoidance.
- Ensure health services put in place and adhere to local policies, processes and statewide guidance for correct identification and storage of advance care planning documents to allow ease of retrieval.

Bereavement

- Refer to the service considerations for Priority 3 in the Framework for bereavement support after an expected death in WA.

Recommended measures

What will we have that we don't have now?
What will it look like?

Care coordination

- Evidence of increased collaboration between specialist palliative care services, primary care and other health professionals (for example, increased MDT meetings and case conferences).
- Increase in claims against relevant palliative care Medicare Benefits Schedule item numbers.
- Increased satisfaction and/or experience measures of children and their families transitioning from paediatric to adult services.

Service models

- Increased utilisation of alternative models of service, such as telehealth and e-prescriptions, to support coordinated care.
- Increased number of palliative care patients accessing virtual healthcare initiatives.
- Documented processes and pathways for bereavement services depending on level of care required.
- Increased awareness of and compliance with relevant local policies and statewide guidance for identification and storing advance care planning documents.
- Collection of data on number of people accessing VAD within services.

[Placeholder - Priority 3 in action – examples from Western Australia]

Implementing Priority 4: families and carers are supported

Priority 4
Families and carers are supported

"The service enabled us to care for Dad all the way through, at home, even helping us to care for his body after he passed away." [9]

Consumer experience

Those close to me and caring for me are supported and involved in my care. Contributions made by family and carer are recognised and valued by those providing my care, including their need to be supported during and after my death.

Strategy building blocks

- Improved practical advice and support for families
- Improved awareness by health, community and aged care providers regarding family access to bereavement support.

Outcomes

- Families and carers will have practical advice and support about:
    - accessing hospice, respite, specialist palliative care, financial support, and timely and appropriate bereavement support
    - advocating for their loved one's preferences through advance care planning.
- Health professionals, including primary care and community providers, have the:
    - skills and resources to identify and monitor family and carers' needs from the point of diagnosis of progressive, life-limiting illness through to bereavement
    - knowledge of and access to referral systems for local, community and non-specialist palliative care organisations.
- Health professionals will coordinate bereavement support for families and carers, including:
    - having access to evidence-based carer assessment tools, including bereavement assessment
    - understanding the potential for complicated family grief in bereavement, and the importance of timely identification and intervention
    - having access to information about available bereavement support and services.

Recommended action

Education

- Continue to promote resources, services and education to support families and carers to care for a person receiving end-of-life and palliative care.
- Provide additional support for families and carers on VAD, including:
  - accessing VAD and guidance on supporting a loved one during the process and into bereavement
  - appropriate information on the role of the appointed contact person.

Care coordination

- Families and carers are supported to attend family meetings, case conferences and MDT meetings when appropriate.

Service models and provision

- Develop and strengthen care pathways to facilitate access to psychosocial, respite and bereavement support for families and carers, including support from volunteers.
- Ensure information on end-of-life and palliative care for families and carers is accessible and easy to locate from the point of diagnosis of a life-limiting illness.
- Promote tools and resources for health professionals to identify the needs of families and carers.
- Explore new approaches to support families and carers and address identified gaps, including:
  - developing new resources and updating existing resources (particularly for priority populations)
  - trialling new support services
  - opportunities to provide more respite and homecare services.
- Provide opportunities for families and carers to be involved in the development and review of services and resources.
- Increase access to social workers in community palliative care services.

Bereavement

- Refer to the service considerations for Priority 4 in the Framework for bereavement support after an expected death in WA.

Recommended measures

What will we have that we don’t have now?
What will it look like?

Education

- New resources, information and education sessions for families and carers on palliative care and end-of-life care, including bereavement and advance care planning.
- Increased advice and support for bereaved families and carers.
- Increased support for families and carers of people accessing VAD.

Service provision and models

- Evidence of family and carer involvement in developing and reviewing resources and support services that they access.
- Increased access to social workers in community palliative care services.
- Care and/or referral pathways for practical advice, information and support for bereaved families and carers.
- Improved options for psychosocial support and respite for families and carers.
- Increased use of family and carer assessment tools by health professionals.

[Placeholder - Priority 4 in action – examples from Western Australia]

Implementing Priority 5: all staff are prepared to care

Priority 5
All staff are prepared to care

“We couldn't fault the staff in their care for Mum in the last 48 hours [of her life], or with my sister and I in supporting our emotional needs.” [18]

Consumer experience

Wherever and whenever I am cared for, all staff involved in my care have expertise, empathy and compassion. All staff provide confident, sensitive and skilful care before, during and after my death.

Strategy building blocks

- Improved health, community and aged care provider understanding of end-of-life care and appropriate referrals to specialist palliative care
- The generalist workforce is supported and mentored to increase capacity, knowledge and skills in the provision of end-of-life and palliative care
- Improved succession planning for an ageing workforce
- Workforce is better resourced to support end-of-life and palliative care for an ageing population.

Outcomes

- Health (including primary care), community and aged care providers will:
    - increase their knowledge and understanding of end-of-life and palliative care
    - be skilled in facilitating conversations about palliative care, advance care planning and goals of care with people, their families and carers
    - be confident to support people, their families and carers at end-of-life through to bereavement support
    - know when, why and how to refer people to specialist palliative care.
- The person’s treating team will be supported to provide integrated end-of-life and palliative care in partnership with primary, community, aged care and specialist palliative care services.
- The specialist palliative care workforce will:
    - have ongoing access to quality education and training opportunities
    - be resourced adequately to mentor and share their knowledge and expertise with generalist providers
    - be supported to develop recruitment and retention strategies within their workforce.
- Palliative care volunteers will have access to ongoing education and training opportunities.

Recommended action

Education

- Provide education, training and resources in line with the End-of-Life and Palliative Care Education and Training Framework for all staff who care for people with end-of-life and palliative care needs.
- Provide education to medical practitioners on identifying when a person is approaching end-of-life and may benefit from specialist palliative care.
- Provide education to health professionals on their rights and obligations in relation to VAD.
- Continue to engage and work with RACHs and aged care services to increase:
  - awareness, preparation and use of advance care planning and goals of care
  - workforce capability through training, education and mentoring.
- Ensure education, training and resources for health professionals and volunteers are:
  - available in flexible modes of delivery and various formats
  - relevant to current and emerging issues
  - informed by the latest evidence-based practice
  - subject to evaluation and continuous improvement.

Service models and provision

- Continue to promote, implement and align activities to the End-of-Life and Palliative Care Education and Training Framework.
- Staff are supported to attend and complete education and training activities that will upskill them in end-of-life and palliative care.
- Advocate for having end-of-life and palliative care training included in inductions for health professionals.

Bereavement

- Refer to the service considerations for Priority 5 in the Framework for bereavement support after an expected death in WA.

Workforce

- Explore and support initiatives that aim to increase the palliative care workforce and strengthen its capability, including:
  - strategies to attract and retain workers
  - professional development and training opportunities
  - initiatives to support the workforce’s wellbeing and self-care.
- Continue to advocate for:
  - sustainable funding for palliative care registrar training positions across public, private and community sectors.
  - Advanced practice allied health roles in palliative care, including pharmacists.
- Continue to promote clinical palliative care champions across all settings.

Governance

- Provide guidance on the future composition and strategic direction of the palliative care workforce, including succession planning.

Recommended measures

What will we have that we don't have now?
What will it look like?

Education

- Available education, training and resources align with the End-of-Life and Palliative Care Education and Training Framework.
- Increased numbers of health professionals and care workers participating in education and training in end-of-life and palliative care.
- New models of education and training sessions piloted.
- Evaluation of education and training activities, and evidence of ongoing improvements.

Workforce

- Evidence of palliative care workforce initiatives.
- Bereavement support is increasingly considered in specialist palliative care staffing models and clinical workload.

[Placeholder - Priority 5 in action – examples from Western Australia]

Implementing Priority 6: the community is aware and able to care

Priority 6
The community is aware and able to care

> *"[It was most helpful when] friends and neighbours just dropped by to help normalise my life after spending over 3 weeks in hospital."* [9]

Consumer experience

My individual preferences are expressed through advance care planning and those close to me know my preferences. My community is aware and able to support me and those close to me.

Strategy building blocks

- Increased awareness and uptake of advance care planning.
- Improved public understanding of end-of-life, palliative care and VAD.

Outcomes

- The general public will have a better understanding of the value of advance care planning, including how to:
    - initiate conversations about treatment and care preferences with family, carers and their healthcare team
    - access and complete advance care planning documents
    - share advance care planning documents with relevant providers, including via the use of digital platforms.
- Priority populations and people with diverse needs will have access to information and education about advance care planning that meets their needs.
- People, their families and carers will be able to:
    - clearly identify and document their goals of care with the support of health, community and aged care providers
    - identify and advocate for care that is consistent with their goals of care.
- The wider community will have a better understanding of the benefits of timely end-of-life and palliative care, including:
    - normalising death and dying
    - what is end-of-life care and palliative care
    - how to access palliative care services
    - normalising VAD as an end-of-life choice and how to access it.

Recommended action

Education

- Increase public awareness of:
  - death literacy, grief and bereavement
  - end-of-life, palliative care and associated services
  - accessing and completing advance care planning documents, including goals of care
  - VAD as an end-of-life choice.
- Continue to:
  - provide up to date end-of-life, palliative care and advance care planning consumer resources
  - facilitate and support community awareness events.
- Explore new approaches to support priority populations, including developing new resources and education sessions, in partnership with community groups.
- Ensure new resources and education sessions are informed by consumers, families and carers.
- Ensure consistent messaging and language for end-of-life, palliative care, advance care planning and VAD across all sectors.

Partnerships

- Strengthen relationships with community organisations, including those in regional, rural and remote WA, to increase awareness of end-of-life and palliative care.
- Explore opportunities to collaborate with peak bodies and organisations to promote end-of-life, palliative care and advance care planning for people living with a life-limiting illness.
- Support services that increase the community's participation in advance care planning conversations and the completion of documents.
- Support a public health palliative care approach, working with communities to improve people's experience of death, dying and bereavement.

Bereavement

- Refer to the service considerations for Priority 6 in the Framework for bereavement support after an expected death in WA.

Recommended measures

What will we have that we don't have now?
What will it look like?

Education

- Increased public awareness of:
  - death literacy, grief and bereavement
  - end-of-life, palliative care and VAD and associated services.
- Consumers, families and carers inform the development of new resources and education sessions.
- Evaluate the usefulness and effectiveness of end-of-life and palliative care resources.

Partnerships

- Strengthened relationships with community organisations and peak bodies for people living with a life-limiting illness.
- Increased awareness and support for the compassionate communities model.

[Placeholder - Priority 6 in action – examples from Western Australia]

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Acronyms

ACP	Advance care planning
CAHS	Child and Adolescent Health Service
CaLD	Culturally and linguistically diverse
EOLCP	End-of-Life Care Program
IP1	Implementation Plan One
IP2	Implementation Plan Two
LGBTIQA+	Lesbian, gay, bisexual, transgender/gender diverse, intersex, queer, asexual and more
MDT	Multidisciplinary team
NGO	Non-government organisation
PCWA	Palliative Care WA
RACH	Residential aged care home
RASS	Regional Access Support Scheme
RCL	Residential Care Line
Strategy (the)	WA End-of-Life and Palliative Care Strategy 2018-2028
SWCNS	Statewide Care Navigator Service
the Department	Department of Health Western Australia
VAD	Voluntary assisted dying
WA	Western Australia
WACHS	WA Country Health Service
WAPHA	WA Primary Health Alliance

[Note: Acronyms include those used in case examples and may not appear in this version]

Definitions

Advance care planning

A voluntary process of planning for future health and personal care whereby the person's values, beliefs and preferences are made known to guide decision-making at a future time when that person cannot make or communicate their decisions.

Advance Health Directive

An Advance Health Directive is a legal document completed by an adult with full legal capacity which contains decisions regarding future treatment. It specifies the treatment(s) for which consent is provided or refused under specific circumstances.

Bereavement

Bereavement is the state of loss when someone close to an individual has died. How people experience this loss can vary from one person to the next, and with the circumstances of the death.

End-of-life

End-of-life is the timeframe during which a person lives with, and is impaired by, a life limiting or fatal condition, even if the prognosis is ambiguous or unknown. Those approaching end-of-life will be considered likely to die during the next 12 months.

End-of-life care

End-of-life care is care needed for people who are likely to die in the next 12 months due to progressive, advanced or incurable illness, frailty or old age. During this period, people may experience rapid changes and fluctuations in their condition and require support from a range of people, including health services, as well as family and carers.

Families and carers

For the purpose of this document, the term 'families and carers' recognises that family comes in very different forms and diversity must be positively responded to. According to the Carers Recognition Act 2004, "a carer is someone who provides unpaid care and support to family members and friends who have disability, mental illness, chronic condition, terminal illness or general frailty. Carers include parents and guardians caring for children."

Life-limiting illness

A life-limiting illness is an active, progressive or advanced disease that has little, or no prospect of cure, and the person is likely to die from the disease at some point in the future.[18] Examples of life-limiting illnesses include dementia, neurological conditions, cancer, renal disease, other chronic conditions and frailty.

Grief

Grief is a normal, natural and inevitable response to loss. It can affect every part of life, including thoughts, behaviours, beliefs, feelings, physical health and relationships with others. Grief may occur before the death related to the losses already occurring such as not being able to do usual activities together, and after the death from the death itself as well as flow on losses by not having that person in one's life anymore.

Palliative care

Palliative care is an approach that improves the quality of life of individuals, their families and carers facing problems associated with life-threatening illnesses/conditions, through the prevention and relief of suffering. Palliative care recognises the person and the importance and uniqueness of their family and carer. It serves to maximise the quality of life and considers physical, social, financial, emotional, and spiritual distress. Such distress not only influences the experience of having a life-limiting illness but also influences treatment outcomes.

Person-centred care

Person-centred care is an approach to health care that involves treating each person respectfully as an individual human being and not as a condition to be treated. It involves seeking out and understanding what is important to the person and their families and carers.[19]

Specialist palliative care

Specialist palliative care is undertaken by a professional palliative care team or service with recognised qualifications or accredited training in palliative care. The role of the specialist palliative care services includes providing consultation services to support, advise, educate and mentor specialist and non-specialist teams to provide end-of-life and palliative care and/or to provide direct care to people with complex palliative care needs.

Voluntary assisted dying

Voluntary assisted dying involves a process to access medication and to enable a person to legally choose the manner and timing of their death. VAD is available to adults in WA who have a terminal illness and meet specific criteria. It is provided only by clinicians that have undergone the approved training.

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