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

Implementation Plan One 2019-2021

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

Version: 12 June 2019

Contents

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Introduction

The aim of Implementation Plan One is to guide implementation of the *WA End-of-life and Palliative Care Strategy 2018-2028* (Strategy) at both a state and local level. The Strategy was developed over 2015-2018 through extensive consultation with the sector, and launched in May 2018.

The WA Cancer and Palliative Care Network (WACPCN) hosted the *End-of-life and Palliative Care Strategy Implementation Forum 2018* (Strategy Implementation Forum) in September 2018 to consult the sector on implementation of the ten-year Strategy. The outcomes of the Strategy Implementation Forum were detailed in the *Outcomes Report: End-of-life and Palliative Care Strategy Implementation Forum 2018* (Outcomes Report) released in March 2019, and forms the foundation of Implementation Plan One.

The Joint Select Committee (JSC) inquiry into End of Life Choices occurred over 2017-2018. The Report of the Joint Select Committee on End of Life Choices, *My Life, My Choice*, was handed down on 23 August 2018 and made 24 recommendations, of which 12 relate to end-of-life and palliative care.

Implementation Plan One will address the Strategy implementation in-line with the Outcomes Report, and the 12 JSC recommendations relating to end-of-life and palliative care in tandem. Implementation Plan One also takes into account the *Sustainable Health Review: Final Report to the Western Australian Government 2019* (SHR Final Report) released in April 2019.

Development of Implementation Plan One

The WA Cancer and Palliative Care Network (WACPCN), WA Department of Health, led and coordinated the development of Implementation Plan One. The End-of-life and Palliative Care Advisory Committee (EOLPCAC) was the overarching governance group that contributed to its development.

The Strategy Implementation Forum provided the sector opportunity to identify Building Blocks for implementation in the immediate-term, medium-term and longer-term, and suggested actions, leaders and measures of progress. Implementation Plan One was developed with the Outcomes Report and JSC recommendations for end-of-life and palliative care as the foundation. Implementation of the Strategy in-line with the Outcomes Report and the recommendations from the Report of the Joint Select Committee (JSC) on End of Life Choices *My Life, My Choice* will occur in tandem.

The Strategies and Recommendations in the SHR Final Report seek to move away from a predominantly reactive, acute, hospital-based system, to a system with a focus on prevention, end-of-life care, and seamless access to services at home and in the community, along with other areas. “A dignified end of life will become part of community conversations, with greater planning and support for people to have more choices and access to appropriate end of life care” (SHR Final Report). Strategy 3 ‘Great beginnings and a dignified end of life’ of the SHR Final Report aligns with the Strategy’s Priorities and Implementation Plan One to influence cultural change in end-of-life and palliative care via a staged approach. Recommendation 9 of the SHR Final Report to ‘achieve respectful and appropriate end-of-life care and choices’ and its priorities in implementation directly align with Implementation Plan One and include:

- Directions of *My Life, My Choice: Report of the WA Parliament Joint Select Committee on End of Life Choices* progressed for greater use of Advance Health Directives, expansion of successful palliative care models, and patient choices.

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- Use of ‘realistic medicine’ and ‘compassionate communities’ models with individuals, local communities, patients, carers and health professionals to promote and integrate social approaches to dying, death and bereavement in everyday lives.
- Introduction, evaluation and spread of a model for community-based wrap-around services for supporting older people with complex chronic illness and cognitive impairment dementia involving GPs and multidisciplinary services.
- Introduction, evaluation and spread of outreach models to improve linkages between hospital and residential aged care facilities in partnership with primary care based on models such as CARE-PACT in Queensland, building on the current Residential Care Line.

Stakeholders in end-of-life and palliative care were consulted in Implementation Plan One’s development to ensure the actions were achievable and the views of the broader health, community and aged care systems were accurately represented given the responsibility of everyone to implement.

The Vision is to improve the lives of all Western Australians through quality end-of-life and palliative care.

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Overview of Priorities

1

Care is accessible to everyone, everywhere.

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

2

Care is person-centred.

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 taken into account when care is given.

3

Care is coordinated.

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

4

Families and carers are supported.

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

5

All staff are prepared to care.

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.

6

The community is aware and able to care.

I feel supported and empowered to make decisions. My individual preferences are expressed through Advance Care Planning (ACP) and reflected in my end-of-life and palliative care. My community is aware and able to support me and those close to me.

Three-year implementation cycles

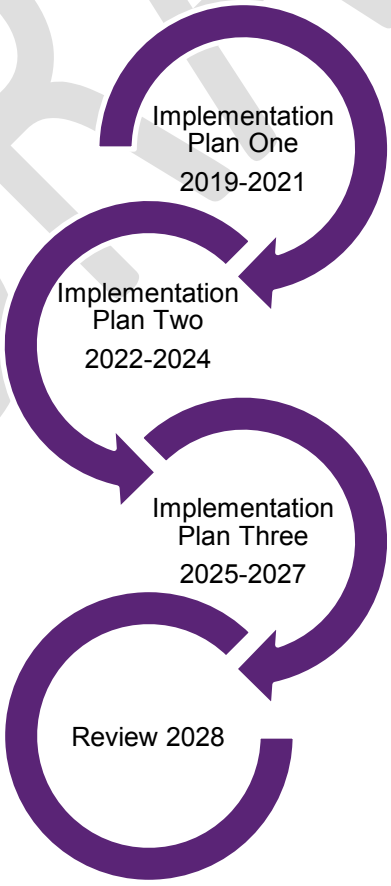
The Strategy is a high-level document providing a ten-year vision for improving the lives of all Western Australians through quality end-of-life and palliative care. The six priority areas require a long-term approach to implementation to achieve culture and population change.

The Implementation Plans will be broken down into three-year time periods, with this being Implementation Plan One. This approach is founded on the end-of-life and palliative care landscape changing with time in relation to people, politics and funding. A phased approach to implementation allows for flexibility given the changing landscape, and facilitates the involvement of future leaders and ideas throughout the Strategy's ten-year life-span.

Implementation Plan One is a guide and allows for flexibility. Implementation Plan One will address the Building Blocks identified for implementation in the immediate to medium-term, with the Building Blocks identified as longer-term addressed in future Implementation Plans.

It does not diminish the importance of Priorities or Building Blocks not identified for Implementation Plan One. Stakeholders may identify other Building Blocks to action within their own systems. These Building Blocks may be addressed by local action and/or raised for immediate-term action to address at future Strategy Implementation Forums and Implementation Plans over the Strategy's ten-year life.

The Strategy Implementation Forum provided the sector opportunity to identify Building Blocks for implementation in the immediate-term, medium-term and longer-term. It is intended that Strategy Implementation Forums will continue with the sector to review implementation progress, provide opportunity for providers to share successes/lessons learnt in implementation, and assist guide the development of future Implementation Plans over the Strategy's ten-year life.



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Statewide responsibilities

The WA Cancer and Palliative Care Network (WACPCN) will lead and oversee the statewide implementation of the Strategy in its role as System Manager, with responsibility for facilitation of actions with statewide impact that do not have a HSP or stakeholder responsibility.

The Minister for Health and/or WA Health is responsible for addressing JSC recommendations 7-18 relating to end-of-life and palliative care (12 recommendations in total). These have been incorporated into Implementation Plan One.

The WACPCN will provide statewide leadership and stewardship, and monitor performance via system-wide trends and data collection.

Local responsibilities

It is intended that Implementation Plan One guides action by Health Service Providers and non-government organisations to address local needs through local action and evaluation plans (including planning and reporting mechanisms). The Strategy and Implementation Plan process allows for flexibility to identify and action areas most relevant to a stakeholder's health system.

HSPs and stakeholders may use the Action Plan Template in Appendix One to prepare and implement an Action Plan aligned to the Strategy and using Implementation Plan One as a guide. It is recommended that Action Plans address each of the six Priorities in the Strategy and outline the actions relevant to their respective health system. This may be done in consultation with the WACPCN on behalf of the Department of Health.

The NSQHS Standards, particularly *Standard 5. Comprehensive Care* that aims to ensure that patients receive comprehensive healthcare that meets their individual needs, and considers the impact of their health issues on their life and wellbeing, aligns with the aims of Implementation Plan One. Important documents for the delivery of high-quality care include the *National consensus statement: Essential elements for safe and high-quality end-of-life care 2015*, and *National consensus statement: Essential elements for safe and high-quality paediatric end-of-life care 2016*. These NSQHS Standards and documents may be relevant when considering, and to guide, implementation in-line with service accreditation.

Implementation Plan One was developed in consultation with HSPs and other stakeholders so that the actions can be brought to reality. These stakeholders are well placed to lead, convene, and coordinate local initiatives to implement the Strategy, making these priorities, their priorities.

WACPCN will support stakeholders to connect and collaborate to enable the provision of an integrated, coordinated and strategic approach to influence policy, purchasing, workforce and planning. Implementation will require the invaluable commitment and collaboration of the WA end-of-life and palliative care community, and other key stakeholders across health, community and aged care services to ensure success. Many systems, services and programs have already progressed local Implementation Action Plans that contribute to implementation in-line with the Strategy Priorities and Building Blocks.

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Overview of Building Block implementation

The following maps the Building Blocks under each of the Priorities, whether it was identified at the Strategy Implementation Forum for immediate, medium or longer-term action, and the Plan to address.

Key		
	Immediate-term and medium-term	Building blocks identified and suggested for implementation in Implementation Plan One
	Longer-term	Building Blocks to be addressed in future Implementation Plans and may require a longer time-frame to action

HSPs and other stakeholders are encouraged to address any Building Block they identify of high importance in their health system.

		Action in	**Plan to address**
Priority One: Care is accessible to everyone, everywhere			
1.	Improve **equity of access**	Immediate-term	Implementation Plan One
2.	Improve access to care for **Aboriginal people**	Longer-term	Local action and future Plans
3.	Improve access to care for **Culturally and Linguistically Diverse communities**	Longer-term	Local action and future Plans
4.	Strengthen care for **children with a life-limiting illness**	Longer-term	Local action and future Plans
5.	Improve access to care for **condition-specific groups** (e.g. people with dementia or those experiencing mental health issues)	Longer-term	Local action and future Plans
6.	Improve access to care for **marginalised groups** (e.g. homeless people and refugees and LGBTIQ communities)	Longer-term	Local action and future Plans
Priority Two: Care is person-centred			
7.	People and their family/carer **co-designing care** with health teams, to include: ▪ culturally respectful and comprehensive care ▪ opportunities to talk about and plan for death, including ACP	Medium-term	Implementation Plan One
8.	Care is **centred on people** and their family/carer	Longer-term	Local action and future Plans
Priority Three: Care is coordinated			
9.	**Strengthened referral pathways** between end-of-life and specialist palliative care teams	Immediate-term	Implementation Plan One
10.	Adequate **resources to support health, community and aged care providers** delivering	Immediate-term	Implementation Plan One

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	end-of-life and palliative care		
Priority Four: Families and carers are supported			
11.	Improved **practical advice and support for families**	Medium-term	Implementation Plan One
12.	Improved **awareness** by health, community and aged care **providers** regarding **family access to bereavement support**	Longer-term	Local action and future Plans
Priority Five: All staff are prepared to care			
13.	Improved health, community and aged care **provider understanding** of end-of-life care, and **appropriate referrals** to specialist palliative care	Immediate-term	Implementation Plan One
14.	The **generalist healthcare workforce** supported and mentored to increase capacity, knowledge and skills	Longer-term	Local action and future Plans
15.	Improved **succession planning** for an ageing workforce	Longer-term	Local action and future Plans
16.	Workforce better equipped to **support an ageing population**	Longer-term	Local action and future Plans
Priority Six: The community is aware and able to care			
17.	Increased **awareness and uptake of ACP**	Longer-term	Local action and future Plans
18.	Improved **public understanding** of end-of-life and palliative care	Immediate-term	Implementation Plan One

Themes

The suggested actions against each building block have been themed according to the following categories:

Funding
Pathways, Models, Policy
GOPC, ACP, CPDP, Clinical Indicators
Education, Champions, Mentoring, Capacity Building
Communication
Navigate health system

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Immediate-term actions

Below are the suggested actions for the Building Blocks identified at the Strategy Implementation Forum for implementation in the immediate-term, recommended measures, and the JSC recommendations that align. The recommended measures can be used to measure progress, or as flags to identify particular actions or Building Blocks that may require higher priority to action in an area's health system. The suggested actions and measures have been taken from the Outcomes Report and from consultation with other divisions and jurisdictions.

Priority **One - Care is accessible to everyone everywhere**

Building Block **1.** Improve **equity of access**

Ranking 1 **Rating** 2.75

Suggested actions	Recommended measures	Aligned JSC recommendations
1. Identify and remedy access gaps: • define access needs of population • who is missing out on specialist palliative care? • do they need it? • is EOL care adequate? • who is missing out on EOL care?	• Analyse data on who did/did not access palliative care – existing data, death reviews • Compare # referrals made to # referrals accepted • Gap between service and national data and funding targets • Data on # deaths and location • Identify appropriate KPIs from PCOC data	10 - unmet demand 14 - activity and spend 9 - pt perspective review of service delivery models and accessibility 7 - inpatient sp pc in northern suburbs 8 - community providers funded to meet demand 13 - Regional pc funded to meet demand 12 - policy development and governance for pc in WACHS
2. Implement strategies that address access gaps in levels of care delivery for services in: • Inpatient Unit • Consultation • Outpatient Clinic • Community • Regional Consultation		
3. Address gaps between State and Federal funding (data) to meet national standards		
4. Identify flexibility in funding models to follow patient		
5. Support roll-out of GOPC to sp pc and EOL care sector to enable shared decision-making (SHR Realistic Medicine)		
6. Address location, access and staffing of inpatient services		
7. Support for the RPCP to continue to build workforce capacity in EOL care in country WA, both financial and governance		
8. Integrate sp pc into formal care pathways e.g. Chronic Obstructive Pulmonary Disease, end stage cardiac, Heart Failure		

The sector identified that a focus is required for:

- Neonatal to paediatric
- Aboriginal Communities
- Mental health
- Disability sector
- Complex patients (expensive and vulnerable)
- Rural and remote

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Priority **Six - The community is aware and able to care**

Building Block **18.** Improved **public understanding** of end-of-life and palliative care

Ranking 2 **Rating** 2.57

Suggested actions	Recommended measures	Aligned JSC recommendations
1. Develop statewide media guidelines for public awareness campaigns for use at local level. Multi-level approach: • apps and flyers • patient stories • forums • online resources – webinar etc. • public debates	• Survey of public awareness and understanding of EOL and sp pc - baseline and follow-up after campaign • Increase in # of ACP conversations, AHDs and common-law directives • Attendance at forums • Increase in # of referrals to sp pc • Increase in # of training • Increase in # of GOPC in health, community and aged care services	11 (11.1) - consistent defn of pc by professionals 11 (11.2) - info and education services to professionals and community on pc 17 (17.2) - educate/health promotion for community on EOL decision making 11 (11.4) - pc info and community hotline 9 - pt perspective review of service delivery models and accessibility
2. Review messages and services for sp pc in hospitals regarding the processes and level provided (less medical and make it specific to patients)		
3. Engage with health insurance providers for improved cover for sp pc and EOL care and aged care facilities		
4. Support Compassionate Communities projects for communities in relation to funding and sustainability (SHR Compassionate Communities)		
Topics for consideration		
5. Develop consistent key messages across the state using Strategy definitions of EOL and PC for: • hospitals and facilities - have conversations; respect family wishes and access • public - sp pc; clear EOL care language; communication about death and dying, expectations to change views and expectations of dying • both: Start conversation earlier: ACP; GOPC; CPDP		
6. Define and navigate the healthcare system for people and their family/carer, including what's involved and available before hospital, and in hospital, including staff, roles and paperwork		
7. Promote public awareness of co-design between a person, their family/carers and their health team		

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8. Raise awareness of out-of-hospital crisis planning, especially emergencies when not in hospital or at home		
Target		
9. Engage with consumer groups		
10. Develop promotional information for community, including: • primary and secondary schools (i.e. via School Health Nurses) • over 55s • aged care		
11. Provide and support education of staff champions in hospitals, facilities and GPs, including promotion of ACP and staff leading by example by having an AHD to be informed and communicate the information		

The sector identified that any information produced would need to be tailored to make it specific to an area, culture, or language.

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Priority **Three - Care is coordinated**

Building Block **10.** Adequate **resources to support health, community and aged care providers** delivering end-of-life and palliative care

Ranking 2 **Rating** 2.57

Suggested actions	Recommended measures	Aligned JSC recommendations
1. Map and address gaps for provider's needs with existing resources with data issues to deliver EOL and PC	• Implementation Plan One completed, Implementation Plans Two and Three developed • Education plan • Billable items with Medicare, IHPA and ABF • Quality pathways and processes in place to support service partnerships	14 - activity and spend 13 - regional pc funded to meet demand 8 - community providers funded to meet demand 7 - inpatient sp pc in northern suburbs 12 - policy development and governance for pc in WACHS 11 (11.1) - consistent defn of pc by professionals 11 (11.2) - info and education services to professionals and community on pc 11 (11.3) - knowledge sharing by sp pc with generalists 11 (11.4) - pc info and community hotline 15 - Educate professionals on right to refuse medical treatment 16 - Educate professionals on right to refuse food and water (includes aged care) 17 (17.1) - Educate professionals curative to non-curative and futile treatment 18 - Guidelines on terminal sedation by professionals
2. Implement ongoing support for GPs in EOL and PC education and networks		
3. Promote billable items for sp pc and EOL care to create data and activity		
4. DOH to advocate for ACP Medicare rebates for GPs and Nurse Practitioners		
5. Advocate and support access to Home and Community Care (HACC) services, particularly for <65 year olds		
6. Assess psychosocial care resourcing – governance, responsibility, funding, service benchmarks		
7. Resource sp pc community providers and inpatient units to meet demand		
8. Investigate and fund stand-by model for sp pc community provider referrals		
9. Address barriers that enable service providers to better work together i.e. communication and IT systems		
10. Support projects that utilise innovative technology to connect teams to teams, and people to teams i.e. TelePalliative Care		
11. Investigate application of a navigator function (SHR Interim Report 2018) and death doulas to connect and support people within the health system		
12. Strengthen pathways, support and education to support aged care deliver EOL care		
13. Review alternative models of service delivery including aged care delivering palliative care e.g. step-down units		
14. Establish and standardise governance committees, including WACHS regional committees, and application of regional governance in metro regions		

Priority **Five - All staff are prepared to care**

Building Block **13.** Improved health, community and aged care **provider understanding** of end-of-life care, and **appropriate referrals** to specialist palliative care

Ranking 3 **Rating** 2.33

Suggested actions	Recommended measures	Aligned JSC recommendations
1. Support (financial/governance) for MPaCCS to continue to build workforce capacity in EOL care in residential care	• Audit of GOPC from sp pc to GP • Evidence of GOPC, ACP resources and CPDP beyond hospitals • Financial incentives in place for GOPC, ACP and CPDP • Staff access to quality clinical education on sp pc and EOL care • Increase in coding for GOPC, CPDP and ACP in hospitals	11 (11.2) - info and education services to professionals and community on pc 11 (11.3) - knowledge sharing by sp pc with generalists 17 (17.1) - Educate professionals curative to non-curative and futile treatment 11 (11.1) - consistent defn of pc by professionals 11 (11.4) - pc info and community hotline 15 - Educate professionals on right to refuse medical treatment 16 - Educate professionals on right to refuse food and water (includes aged care) 18 - Guidelines on terminal sedation by professionals
2. Support roll-out of GOPC, ACP resources and CPDP beyond hospitals to enable shared decision-making (SHR Realistic Medicine)		
3. Re-design funding models to support EOL care activity i.e. financial incentive for GOPC, ACP and CPDP		
4. Improve access to quality clinical education with standardised content and staff release to attend		
5. Enable champions and services to educate sector and leverage the importance of EOL and sp pc within: • NGOs • GPs • public • mental health • Palliative Care WA		
6. DoH to advocate to Commonwealth for greater education in aged care		
7. Utilise and promote Health Pathways (WAPHA) to influence primary care		
8. Process to improve two-way communication of patient information between health services (i.e. hospitals) and primary care (i.e. GPs), particularly at discharge: GOPC, ACP, discharge summary, Outpatient Letter		
9. Support two-way sharing of information between St John Ambulance and providers		
10. Process to improve coordination of services between providers: • Specialist palliative care and GPs • Community and Home and Community Care (HACC) services		
11. Support coders to identify GOPC, CPDP and ACP to support the collection of meaningful data and translate to meaningful action		

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Priority **Three - Care is coordinated**

Building Block **9. Strengthened referral pathways** between end-of-life and specialist palliative care teams

Ranking 3 **Rating** 2.33

Suggested actions	Recommended measures	Aligned JSC recommendations
1. Increase in number of allied health professionals in sp pc, particularly Social Workers	• Increase in # of allied health professionals in sp pc • # and nature of existing referral pathways • Audit # of referrals, appropriateness, patient outcome and ongoing care • Patient/family experience surveys of patient journey • # of re-admissions / failed discharge • # of people dying in hospital following unplanned admission (chronic diseases) • Increased access to funding associated with transfer of info/referral	11 (11.1) - consistent defn of pc by professionals 11 (11.2) - info and education services to professionals and community on pc 11 (11.3) - knowledge sharing by sp pc with generalists 11 (11.4) - pc info and community hotline 10 - unmet demand 14 - activity and spend 8 - community providers funded to meet demand 12 - policy development and governance for pc in WACHS 13 - regional pc funded to meet demand
2. Promote and support ongoing quality staff education: • awareness (timeliness) of palliative care • what services are available and when to refer • how to have difficult conversations		
3. Funding to support care-coordination and referrals – suggest jointly funded by HSPs and NGOs (MOUs)		
4. DoH to advocate for Medicare and ABF to provide financial incentive for transfer of information and referral to sp pc		
5. Design and promote specific referral criteria for specialist pc		
6. Develop centralised referral system and advice for accessing pc services		
7. Utilise and promote Health Pathways (WAPHA) to influence primary care		
8. Design and promote alternative referral pathways to increase access (current sp pc community provider resources limited to terminal phase): • Map existing pathways / services • Strengthen / re-design • Continual improvement / review of referral pathway		

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Medium-term actions

Below are the suggested actions for the Building Blocks identified at the Strategy Implementation Forum for implementation in the medium-term, recommended measures, and the JSC recommendations that align. The recommended measures can be used to measure progress, or as flags to identify particular actions or Building Blocks that may require higher priority to action in an area's health system. The suggested actions and measures have been taken from the Outcomes Report and from consultation with other divisions and jurisdictions.

Priority	**Four - Families and carers are supported**
Building Block	**11.** Improved practical advice and support for families

Ranking 4 **Rating** 1.86

Suggested actions	Recommended measures	Aligned JSC recommendations
1. Establish formal committee of carers groups to strategically plan and coordinate services and tools that improve practical advice and support for families. Committee to: • identify existing resources, gaps and overlap • inform and coordinate services • link in with existing promotion of services and activities	• Establishment of a formal committee • Updates from formal committee on coordination of services to EOLPCAC • Evidence of family/carer access to resources or events • Evidence of family/carer assessment tools in services • Services linking actions to accreditation process and relevant consumer councils	9 - pt perspective review of service delivery models and accessibility 11 (11.1) - consistent defn of pc by professionals 11 (11.2) - info and education services to professionals and community on pc 11 (11.4) - pc info and community hotline 17 (17.1) - Educate professionals curative to non-curative and futile treatment 17 (17.2) - Educate/health promotion for community on EOL decision making
2. Reformat consumer-focused websites to display greater empathy towards carers/families with links/access to practical information and advice		
3. Support access to Compassionate Communities projects for families and carers in the local area (SHR Compassionate Communities)		
4. Promotion of resources and events that aim to explain family and carer role in EOL and PC		
5. Support roll-out of family/carer assessment tools (such as CSNAT and SPICT) including governance, policy and support		

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Priority **Two - Care is person-centred**

Building Block **7.** People and their family/carer **co-designing care** with health teams, to include:

- culturally respectful and comprehensive care
- opportunities to talk about and plan for death, including ACP

Ranking 5 **Rating** 1.71

Suggested actions	Recommended measures	Aligned JSC recommendations
1. Support DOH, HSPs and NGOs to use and/or incorporate co-design of care into area's consumer/carer engagement framework and promote	• # of ACP sessions annually delivered to community • Increase in # of ACP conversations, AHDs and common-law directives • Evidence of focus on consumer / lived experience • Identify indicator for what consumer defines as success & survey on whether these have been achieved (i.e. GOPC patient experience survey) • Patient experience surveys • Evaluation framework for roll-out of GOPC will indicate progress	9 - pt perspective review of service delivery models and accessibility 11 (11.1) - consistent defn of pc by professionals 11 (11.2) - info/education services to professionals and community on pc 11 (11.3) - knowledge sharing by sp pc with generalists 11 (11.4) - pc info and community hotline 15 - Educate professionals on right to refuse medical treatment 16 - Educate professionals on right to refuse food and water (includes aged care) 17 (17.1) - Educate professionals curative to non-curative and futile treatment 17 (17.2) - Educate/health promotion for community on EOL decision making 18 - Guidelines on terminal sedation by professionals
2. Support and promote roll-out of GOPC, ACP and CPDP policies and resources with HSPs, community services, residential care providers and primary care providers to enable shared decision-making (SHR Realistic Medicine)		
3. Support and promote clinician staff development on how to work with families/patients to co-design care and difficult conversations (behavioural change)		
4. Re-design funding models to support co-design of care i.e. financial incentive for GOPC and ACP		
5. Promote use of clinical indicators as assessment tool to identify people for timely care		
6. Support a system that gives GP and sp pc community providers pro-active involvement in the patient journey (prior to inpatient episode)		
7. Education that death is not failure (include multi-cultural sensitive care and awareness for any religion/culture)		
8. Educate community on their involvement in care		
9. Support and promote ACP community sessions and respecting the choice to not to have these conversations		

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Longer-term actions

Action planning was not completed at the Strategy Implementation Forum for Building Blocks identified for implementation in the longer-term. These Building Blocks will be addressed at a local level and in future Implementation Plans.

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Acronyms

ABF	Activity Based Funding
ACP	Advance Care Planning (the process)
AHD	Advance Health Directive (the document)
CPDP	Care Plan for the Dying Person
CSNAT	Carer Support Needs Assessment Tool
defn	definition
DOH	WA Department of Health (WA Health)
EOL	End-of-life care
EOLPCAC	End-of-life and Palliative Care Advisory Committee
GOPC	Goals of Patient Care (Clinical Care Planning document)
GP	General Practitioner
HSP	Health Service Provider
IHPA	Independent Hospital Pricing Authority
info	Information
JSC	Joint Select Committee on End of Life Choices
KPI	Key Performance Indicator
MOU	Memorandum of Understanding
MPaCCS	Metropolitan Palliative Care Consultancy Service
NGO	Non-government organisation
PC	Palliative Care
PCOC	Palliative Care Outcomes Collaboration
PCWA	Palliative Care Western Australia
pt	patient
RPCP	Rural Palliative Care Program
SHR	*Sustainable Health Review: Final Report to the Western Australian Government 2019*
sp pc	specialist palliative care
SPICT	Supportive and Palliative Care Indicators Tool
Strategy	*WA End-of-life and Palliative Care Strategy 2018-2028*
WACHS	WA Country Health Service
WAPHA	WA Primary Health Alliance

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Appendix One – Action Plan template

HSPs, non-government organisations and other stakeholders are encouraged to use the Action Plan Template to prepare and implement an Action Plan for their health system that is aligned to the *WA End-of-life and Palliative Care Strategy 2018-2028* Priorities and Building Blocks, using Implementation Plan One as a guide.

Development of an Action Plan will assist HSPs and other stakeholders to address the Strategy's six Priorities, and work towards the performance measures and ten-year vision to improve the lives of all Western Australians through quality end-of-life and palliative care.

Implementation Plan One provides suggested actions and recommended measures for the Building Blocks identified for implementation in the immediate and medium-term, however stakeholders are encouraged to address any Building Block they identify of high importance in their health system.

The Action Plan template encourages planning against each of the six Priority areas. Stakeholders are encouraged to identify the Building Blocks most relevant to their area and identify the actions, measures, timeline and accountable area that best fits their priorities using the Implementation Plan as a guide. An example is provided below in red.

Priority One: Care is accessible to everyone, everywhere				
BUILDING BLOCK	**ACTION**	**MEASURE**	**BY WHEN**	**ACCOUNTABLE AREA**
Priority Two: Care is person-centred				
BUILDING BLOCK	**ACTION**	**MEASURE**	**BY WHEN**	**ACCOUNTABLE AREA**

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Priority Three: Care is coordinated				
BUILDING BLOCK	**ACTION**	**MEASURE**	**BY WHEN**	**ACCOUNTABLE AREA**
Priority Four: Families and carers are supported				
BUILDING BLOCK	**ACTION**	**MEASURE**	**BY WHEN**	**ACCOUNTABLE AREA**
11. Improved practical advice and support for families	*1. Please complete what action the area's health system will take to achieve this Building Block i.e. reformat consumer-focused websites to display greater empathy towards carers/families with links/access to practical information and advice.*	*1. Evidence of family/carer access to resources or events*		
Priority Five: All staff are prepared to care				
BUILDING BLOCK	**ACTION**	**MEASURE**	**BY WHEN**	**ACCOUNTABLE AREA**
Priority Six: The community is aware and able to care				
BUILDING BLOCK	**ACTION**	**MEASURE**	**BY WHEN**	**ACCOUNTABLE AREA**

DRAFT

This document can be made available in alternative formats on request for a person with disability.

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