**Implementation Plan One (2020-2022) of the**

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

**Action plan template**

This template can be used to develop a Local Action Plan aligned to the Strategy’s priorities and building blocks. Stakeholders are encouraged to prioritise the building blocks most relevant to their area and identify the related actions, measures, timelines and areas of accountability.

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| **Priority One – Care is accessible to everyone, everywhere** |
| **Building block** | **Action** | **Measure** | **By when** | **By whom** |
| Improve equity of access.Improve access to care for Aboriginal people.Improve access to care for CALD communities.Strengthen care for children with a life-limiting illness.Improve access to care for condition-specific groups.Improve access to care for marginalised groups. |  |  |  |  |
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| **Priority Two – Care is person-centred** |
| **Building block** | **Action** | **Measure** | **By when** | **By whom** |
| People and their families/ 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/carers. |  |  |  |  |

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| **Priority Three – Care is coordinated** |
| **Building block** | **Action** | **Measure** | **By when** | **By whom** |
| Strengthened referral pathways between end-of- life and specialist palliative care teams.Adequate resources to support health, community and aged care providers delivering end-of-life and palliative care. |  |  |  |  |

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| **Priority Four – Families and carers are supported** |
| **Building block** | **Action** | **Measure** | **By when** | **By whom** |
| Improved practical advice and support for families.Improved awareness by health, community and aged care providers regarding family access to bereavement support. |  |  |  |  |
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| **Priority Five – All staff are prepared to care** |
| **Building block** | **Action** | **Measure** | **By when** | **By whom** |
| Improved health, community and aged care provider understanding of end-of-life care, and appropriate referrals to specialist palliative care.The generalist healthcare workforce supported and mentored to increase capacity, knowledge and skills.Improved succession planning for an ageing workforce.Workforce better equipped to support an ageing population. |  |  |  |  |

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| **Priority Six – The community is aware and able to care** |
| **Building block** | **Action** | **Measure** | **By when** | **By whom** |
| Improved public understanding of end-of-life and palliative care.Increased awareness and uptake of Advance Care Planning. |  |  |  |  |