Government of **Western Australia**
WA Country Health Service

A GLOBAL LEADER IN RURAL AND REMOTE HEALTHCARE

WA Country Health Service Palliative and End-of-Life Care Strategy

2024–28

The Palliative Care Program has engaged local artists in each region to create and design artwork for regional specific palliative care educational resources. The art pieces tell a cultural story of the love and support needed during the journey of palliative and end-of-life care and symbolise the overall message of the importance of quality of life during this journey, along with the need for community and connection to country.

About the artists

My name is Merinda Churnside, I am a female Aboriginal artist from the Pilbara. My connection to the Pilbara is through both my parents as my mother connection is to Roebourne as she is a Ngarluma Woman. And my Dad's connection is to Martuthunira mob. I have been an artist for as long as I can remember. My heart is a canvas and brings out my potential and passions in art and creating masterpieces.

My name is Janet Paddy. I am a Nyarngumarta, Banjima also connected to the Ngarluma and Yindjibarndi mob. My skin group is Milanka and my clan/tribe name is Pirntarl. I have been an artist for more than four years and have been capturing my stories through my artwork. I have found this to be a source of expressing my culture through art and portraying family stories and telling our history.

Acknowledgements

WACHS acknowledges the Aboriginal people of the many traditional lands and language groups of Western Australia (WA). It acknowledges the wisdom of past and present Aboriginal Elders 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 this state. 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.

Using the term — on country

For the purposes of this document, on country represents a term used by Aboriginal people referring to the land to which they belong and their place of Dreaming.

Using the term - cultural security

Cultural security is the provision of programs and services by the health system that will not compromise the legitimate cultural rights, values and expectations of Aboriginal people. To be culturally secure, programs and services need to:

- identify and respond to the cultural needs of Aboriginal people.
- work within a holistic framework that recognises the importance of connection to country, culture, spirituality, family and community.
- recognise and reflect on how these factors affect health and wellbeing.

Please note: Aboriginal people should be aware that this publication may contain images or names of deceased persons in photographs or printed material.

Glossary of terms

Definitions of a number of health terms used in this document are in the glossary on page 24.

Contents

WA Country Health Service Strategic Priorities

> *Palliative care staff, words cannot thank-you enough for your compassion, caring and professionalism, to allow Beth to achieve her end-of-life journey in her own home. She died peacefully, without pain or fear, holding my hand in the home she loved.*
>
> *Patient's carer*

Message from the Board Chair

Every person in country WA has a right to access palliative care when and where they need it.

Since 2019, WA Country Health Service (WACHS) has significantly improved equity of access to quality palliative and end-of-life care for regional communities through the $39.7million WACHS Palliative Care Program (the Program). The Program has successfully developed specialist and generalist palliative care services in more locations, enabling complex care both at home and within our WACHS facilities. This care provision has extended from neonates through to the very elderly, and their families and friends. Special attention has been paid to underserved populations and to providing care to Aboriginal people.

The ***WACHS Palliative and End-of-Life Care Strategy 2024 – 28*** (the Strategy) has been developed in consultation with consumers, clinicians, regional communities, Aboriginal Community Controlled Health Organisations, and service partners. It expands on the Program's recent priorities including:

- building the palliative care multidisciplinary workforce capacity
- growing our Aboriginal health workforce.
- promoting a WACHS culture where 'everyone is prepared to care'
- providing more care options at home
- integrating local and virtual service options
- strengthening clinical governance

It aligns with the Sustainable Health Review, Parliamentary Joint Select Committee recommendations into end-of-life choices and palliative care from 2018 and 2020 and builds on the work already undertaken in the WA Department of Health's *End-of-Life and Palliative Care Strategy 2018-2028.* This ten-year vision seeks to improve the lives of all Western Australians through quality end-of-life and palliative care.

WACHS palliative care services must leverage emerging digital innovations to keep pace with regional growth, and demographic shifts. We need to gather and use data to inform the development of our services. We also must meet consumers' growing expectations of how information is shared with them and connected across the organisations with whom we partner in providing care.

We are committed to providing a seamless experience for people and their families and carers across the continuum of their lives and changing care needs. High quality palliative care throughout WACHS involves all settings from home to hospital. Delivering place-based care for people with life-limiting illness requires partnerships across non-palliative care specialist disciplines, health system partners, General Practice, allied health, homecare providers, volunteers, carers and community members.

To provide the best possible quality of life for a person, we also understand our care needs to be person-centred and integrated with the support that comes from their broader network of friends, neighbours, schools, groups and clubs. As such the Strategy supports the roll-out of the Compassionate Communities model by WA Health and integration within local government public health plans.

We recognise improvement cannot be achieved alone and we look forward to working in partnership with consumers, communities and healthcare partners over the next five years, transforming this Strategy into action.

DR NEALE FONG

BOARD CHAIR
WA COUNTRY
HEALTH SERVICE

The WACHS specialist palliative care workforce has grown from 30.1 FTE (June 2019) to 99.95 FTE (June 2023).

What is palliative care and end-of-life care?

The differences in the way terms are used across the world can be confusing. Throughout the *WACHS Palliative and End-of-life Care Strategy 2024-28* the following terminology is used:

Palliative care is care that improves the quality of life of people, including their family/carers, facing problems associated with life-threatening illness, through the prevention and relief of suffering. Palliative care recognises the uniqueness of the person and the importance of their family/carers. It maximises their quality of life through managing physical, social, financial, emotional and spiritual distress.

Generalist Palliative Care is care provided to people living with a life-limiting condition, their families/carers by healthcare providers who are not specialist palliative care providers. Essential team members include nurses, allied health professionals, Aboriginal health workers and liaison officers and pharmacists. The medical management may be undertaken by a wide range of doctors including GPs, physicians, paediatricians, psychiatrists, and surgeons. These health professionals are 'generalists' with respect to palliative care, notwithstanding that many of them are specialists in their own discipline.[1]

Specialist palliative care is the care undertaken by palliative care teams/services with recognised qualifications or accredited training in palliative care. Their role includes providing consultation services to support, advise, educate, and mentor other clinical teams to provide end-of-life and palliative care and/or providing direct care to people with complex palliative care needs.

End-of-life is the timeframe during which a person lives with, and is impaired by, progressive, advanced or incurable illness, frailty or old age, even if the prognosis is ambiguous or unknown. Those approaching end-of life are considered likely to die during the next 12 months.

End-of-life care is care needed by people who are likely to die in the next 12 months. During this period, people may experience fluctuations in their condition and require support from family, carers and health services.

End-of-life choices are when people consider and make decisions about their preferences for how they will be cared for. These choices may include ceasing life-prolonging treatment (such as chemotherapy or dialysis); deciding what kinds of medical treatment they may consent to as part of their advance care planning (such as resuscitation, transfer to Perth hospitals); accessing voluntary assisted dying; or deciding on their preferred place of death. Supporting patients with end-of-life choices conversations can help ensure that care is compassionate, respectful and aligned with the values and wishes of the patient.

Terminal care is the care of a person in the last days or weeks before they die.

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

Building on the pillars of the Palliative Care Program 2019 to 2023

Background to the Palliative Care Program

In 2018, the Joint Select Committee End-of-Life Choices report, *My Life, My Choice*,[2] highlighted inequity of access to quality palliative care services for rural and regional Western Australians.

WACHS received funding by the Department of Health (DOH) to establish the $39.7 million Palliative Care Program. The Program's aim was to provide the best possible palliative care services closer to home for regional families.

In 2019 the Program commenced the 'Program of work' (refer to Figure 1), this aligned with the WA End-of-Life and Palliative Care Strategy 2018-2028.[3] The Program organised the work into four key priorities referred to as 'Pillars of the Program': expanding workforce to accommodate need (Pillar 1); improving clinical and program governance (Pillar 2); new innovative service models including TelePalliative Care (Pillar 3) and supporting patients and families to remain at home for as long as possible (Pillar 4).

What the Program has achieved?

Improved consumer experience our consumers praised the high quality, compassionate care provided by WACHS specialist palliative care (SPC) services.

Improved equity of access to high-quality palliative care in WA country regions through strengthened clinical governance processes and an expanded workforce model.

Expanded specialist palliative care services were provided by broadening the scope of the SPC multidisciplinary teams (MDT). The MDTs have a more diverse range of disciplines, including allied health and Aboriginal health liaison officers (AHLO), and new and innovative roles which include spiritual care practitioners and counsellors, to name a few. The new and expanded SPC services provide increased consultations to hospitals, residential care and for people who reside in the community.

Telepalliative care services have been enhanced through the commencement of new services by telehealth modalities, including Palliative Care After-Hours Telehealth Service (PalCATS) and TelePalliative Care in the Home (TPCITH). PalCATS has provided support to staff and built capacity for the generalist workforce and increasing the reach to SPC for people in the regions.

Palliative Care Support Packages (PCSP) support people to receive care at home for as long as possible, and who may wish to die at home. Approximately 74 per cent of services provided were for personal care and domestic assistance for up to a six-week duration, and in some circumstances longer.

Figure 1: What we have achieved – WACHS Palliative Care Program 2019-2023

	PILLAR 1	PILLAR 2	PILLAR 3	PILLAR 4
STRATEGIC INITIATIVE	**EXPANDING THE REGIONAL SPECIALIST PALLIATIVE CARE MULTIDISCIPLINARY TEAMS (MDTs)**	**IMPROVING CLINICAL AND PROGRAM GOVERNANCE**	**EXPANDING TELEHEALTH AND INNOVATIONS IN MODELS OF CARE**	**DELIVER COMMUNITY PALLIATIVE HOMECARE PACKAGES**
ACTION DELIVERED	**Each region now has an operational leadership team across medicine and nursing:** • Specialist Palliative Care consultants • Palliative Care Nurse Coordinators (Senior Registered Nurses). **Within the regions, SPC multidisciplinary teams are now operational in 18 District hubs and include:** • Expanded team of nurses • Palliative Care GPs • Social workers • Aboriginal Health Liaison Officers (AHLOs) • Administration officers. **Other pilot programs developed to expand the MDT include:** • Spiritual Care Practitioner in the Great Southern • Palliative care counselling service in the South West • Allied Health service in the South West.	• Data governance and reporting is consistent in all regions using the management system electronic Palliative Care Information System (ePalCIS). • Embedding the Palliative Care Outcome Collaborative clinical tools to routinely collect patient and carer outcomes to guide clinical care, benchmark against like services and progress quality improvement. • Strategic Operational Clinical Committee (SOCC) established. Several new clinical roles have been established to support governance: • Palliative Care Clinical Director (2019) • Coordinator of Nursing-Palliative Care (2019) • Palliative Care Lead Pharmacists (2022) • PalCATS Nurse Manager • Coordinator Aboriginal Palliative Care AHLOs.	• Palliative Care Afterhours Telehealth Service (PalCATS) provides central after-hours support to all WACHS sites including aged care from the WACHS telehealth hub (Command Centre) using high-definition video consultation. • Tele-Palliative Care in the Home is supported by training and research to continue to build the culture and capacity of the WACHS SPC workforce. • Tele-Palliative Care in the Home provides SPC support via videoconferencing (iPads) during the terminal stages of life for people who wish to die at home.	• Access to home support care services for people with end-of-life needs providing personal care, respite care, home help, medication prompts, meals and food preparation and social support. • Palliative Care Support Packages (PCSP) provide up to six weeks of support with possible extension at the week four review. These packages support people who choose to stay at home when there are no other options to access services, and support them to die at home. A streamlined person-centred approach with appropriate governance has been developed. **Between 17 February 2020 and 30 December 2022, 259 Palliative Care Support Packages were approved.**
OUTCOME/ BENEFITS	WACHS can provide specialist palliative care services closer to where people live. **The WACHS specialist palliative care workforce has grown from 30.1 (June 2019) to 99.95 (June 2023)**	A centralised clinical and program governance model was established to utilise outcome data, current evidence and best practice standards to improve care quality and coordination for country people.	Providing integrative palliative care services utilising innovative telehealth models that are workforce efficient.	• Person-centred approach to providing support with end-of-life needs for people to die in their preferred setting, home. • Promotes hospital avoidance. • Improved partnerships with non-government home care providers.
IN DEVELOPMENT	Clinical supervision models are developing across the MDTs.	• Nurse Practitioner JDF/ Framework • AHLO Competency Framework • Standardising ABF rules project • Clinical Nurse Educator / Specialist Palliative Care.	Expansion of PalCATS to palliative care patients/ carers in their own homes and who are known to the regional teams and identified as requiring after hours community support from PalCATS.	• Patient Care Assistance to deliver care in remote regions (casual). • To streamline and improve process relating to PCSP.

In 2017-18, **1,547** people were referred to palliative care services in WA Country Health.
This number increased to **2,122** in 2022-23.
There were **1,687** active palliative care patients on May 29, 2023.

The need to improve palliative care services

Opportunities for the future

It should be acknowledged that although much work has been done, there is still more to be done to improve equity of access to high-quality palliative care for WA country people, especially in remote communities.

The Palliative Care Program Evaluation Report has identified key areas of service improvement and we will focus on implementing strategies to address these within this Strategy. Some of these include:

Equity of access - will be improved through a continued focus on meeting the needs of geographically dispersed population groups, especially those people with complex care needs and underserved populations. The continued expansion of TelePalliative Care services and innovative service delivery models will provide after-hours support to the workforce.

Quality of care and consumer experience will be captured as routine practice through a consistent, streamlined and inclusive process across all WACHS regions. The use of an 'agreed' consumer satisfaction tool will have an improved capacity to capture cultural representation and will be consistently and methodically utilised across regions.

Training and workforce strategies will focus on a more structured approach to addressing gaps and variations in expertise, knowledge and skills, that are required to provide safe and equitable provision of SPC by our MDTs.

Data quality improvement will require developing and standardising business rules for data entry, and ensure consistent processes and training are in place for regional staff so service activity is captured correctly. Consideration will be given as to how data information should be incorporated into the digital medical record (DMR) and electronic medical record (EMR) rollout.

Innovative partnerships with all key service providers are crucial if we are to address the challenges experienced by our consumers, especially as people transition across services and sectors. Consumer engagement and a commitment to authentic co-design is essential.

Planning for the future

WACHS recognises there are challenges in the provision of healthcare as our population ages and more people live longer with chronic conditions and complex needs, resulting in greater demand on hospital and community-based health services.

In regional WA, the expected population of people 65 and older will increase by 3.5 per cent annually, reaching 122,000 by 2031.The demand for palliative care services is already expanding, yet the workforce, including volunteers and carers required to provide this care, is declining.[4]

Given the association between aged care and palliative care among older West Australians, particularly those in residential care, meeting the palliative care needs of an ageing population within available workforce and infrastructure presents a challenge.

As such, it is a priority of this Strategy to strengthen care pathways and partnerships for people coming towards the end of their life and integrate innovative technologies such as telepalliative models of care to increase capacity and service sustainability.

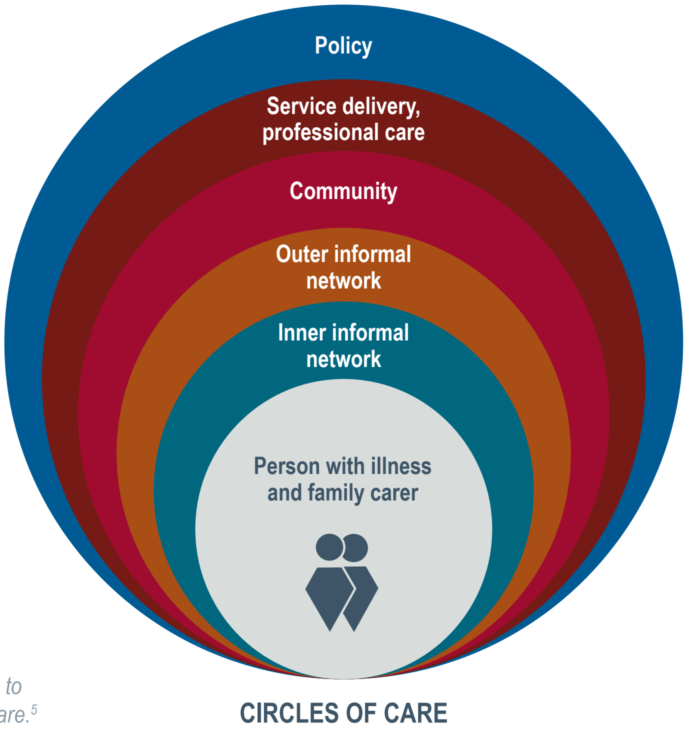
The 2019 *Sustainable Health Review (SHR)* Final Report recognised the need to do more to respect people's choices in end-of-life care across a sustainable whole-of-health system. Sustainability can be achieved in palliative and end-of-life care by adopting a public health model that integrates hospital, primary and community services with informal care networks through a process of active consumer co-design[5] (Figure 2).

This approach builds capacity to deliver person-centred, culturally secure care where the person chooses and supports transitions across community and hospital-based services. The public health approach requires cooperation across organisations and policy and practice changes WACHS-wide and within each regional area.

Public Health approach to palliative and EOL care

ENABLERS

- Digital and assistive technologies: Telehealth, equipment
- Advanced Care Planning
- Education and training programs
- Compassionate communities and social network enhancement
- Not-for-profit organisations and other NGOs



INTEGRATION OF SERVICES

- Disability sector, NDIS
- Aged care sector
- Specialists palliative care
- Generalist palliative care
- Disease specific clinics
- Primary care and allied health care

Figure 2: Public Health approach to palliative and end-of-life (EOL) care.[5]

Palliative care and end-of-life care in country WA

High quality palliative care recognises that as people's needs vary, so too will the healthcare they require.

Palliative Care Australia has developed a conceptual model that captures this approach based on the complexity of needs over time.[6] WACHS has adapted this into a Framework that illustrates how we deliver end-of-life and palliative services, aligned to the WA End-of-Life and Palliative Care Strategy 2018-2028, and it is a central concept within this Strategy.

The *WACHS End-of-Life and Palliative Care Service Delivery Framework (Appendix 3)* describes people's care needs as straight forward and predictable, of intermediate complexity and/or variable, or highly complex and/or persistent, and recognises that these needs are likely to change over time. This Framework encompasses family and carers and describes how the provision of services responds to changing needs into bereavement.

As care is often delivered by many providers across multiple settings, there are challenges ensuring people are empowered with the information required to navigate the care continuum. There are difficulties ensuring resources are responsive to changing needs and coordinating them across settings. The staged transition of the DMR, EMR and My Health Record will improve coordination.

Specialist palliative care (SPC) is provided within multidisciplinary teams across hubs concentrated around regional centres and towns. The teams consist of Aboriginal health liaison officers (AHLOs), administration staff, allied health, doctors, and nurses who provide specialist care as well as expertise and support to the generalist workforce. The teams provide integrated care and assist in connecting people and their families and carers to services locally, and if required, to metropolitan services.

Impacts on specific population groups

Aboriginality: Aboriginal people experience a greater burden of health conditions earlier in life which can lead to premature onset of age-related conditions and disability. Aboriginal people tend to access palliative care later, often only in the last days to weeks of their life. Approximately 11 per cent of the population WACHS serves are Aboriginal people, with this proportion varying around the WA regions from three per cent in the South West to 49 per cent in the Kimberley.

Older persons: Approximately one in four older Australians live in rural and remote communities. Some of these communities have fewer aged care services and facilities compared to metropolitan areas. Approximately 81 per cent of people in residential aged care services have a diagnosis of dementia.

Non-cancer groups: These include people with progressive organ failure and neurodegenerative disease and are underrepresented in the population of people referred to palliative care services.

Underserved populations: This includes diverse population groups including, but not limited to: Aboriginal people; carers and families; culturally and linguistically diverse (CaLD) people; lesbian, gay, bisexual, transgender, intersex people (LGBTQI+); financially and socially disadvantaged people; refugees; migrants; people experiencing homelessness; those with criminal convictions or in prison; veterans; those with rare diseases; and adolescents.

Paediatrics: Care of dying children is intensive work and bereavement is a complicated process. Care includes parents, siblings, grandparents, other family members, carers and school and work communities.

Snapshot: Palliative Care

IN AUSTRALIA

Deaths in 2022

190,939

1/3 were due to the leading causes of death

Ischaemic Heart Disease

Dementia *Including Alzheimer's Disease*

Covid-19

Cerebrovascular Disease

Lung Cancer

DEMENTIA

Dementia is the leading cause of death among older people (75+)

89 *years*

Median age of DEATH FROM ALZHEIMER'S DISEASE

Currently

451

NEW CASES of Dementia each day

By 2056

650

NEW CASES of Dementia each day

WA COUNTRY STATS

Country people referred for palliative care in 2012–22

2,138

11%

were Aboriginal

88%

Aboriginal People aged 55+ have a CHRONIC CONDITION

55%

of Aboriginal People aged 55+ have THREE OR MORE CHRONIC CONDITIONS

Of people receiving palliative care in country WA between January and June 2023:

64% **had a CANCER DIAGNOSIS**

36% **NON-CANCER DIAGNOSIS**

WHO CAN BENEFIT FROM PALLIATIVE CARE?

Worldwide, it is estimated palliative care could be relevant for:

90% of deaths due to CANCER

35% of deaths due to HEART FAILURE

80% of deaths due to COPD

50% of deaths due to LUNG DISEASE

80% of deaths due to DEMENTIA

PLACE OF DEATH IN AUSTRALIA

70% *of Australians say they would prefer to die at home*

In 2019

51% **DIED IN HOSITAL** *~80,000*

30% **DIED IN RESIDENTIAL AGED CARE**

15% **DIED AT HOME**

5% **OTHER/UNSPECIFIED**

VIRTUAL CARE

Telehealth appointments in 2021–22

16,260

95% **Telephone**

5% **Telehealth videoconference**

PALCATS

1,058 *occasions of service for*

335 *individuals*

(April 2022 – May 2023)

Vision: A global leader in rural and remote healthcare

Mission: WACHS provides equitable access to innovative, high quality palliative care services that improve the end-of-life experience for people and their loved ones/carers living with a progressive life limiting illness.

WACHS palliative care and end-of-life care priority areas

The *WACHS Palliative and End-of-Life Care Strategy 2024-28* describes the way in which palliative care and end-of-life care services should be experienced by people in regional and remote WA.

It aligns with national strategies and is underpinned by best practice and purposefully builds upon the WA *End-of-Life and Palliative Care Strategy 2018-2028.*[3] The Strategy is a ten-year vision that seeks to improve the lives of all Western Australians through six state-wide priority areas (Figure 3).

OVERVIEW OF PRIORITIES

1 **Care is accessible to everyone, everwhere.**
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 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 where 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 skillful 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.

Figure 3: WA End-of-life Palliative Care Strategy 2018-2028 – Priorities 1 to 6

Priority 1

CARE IS ACCESSIBLE TO EVERYONE, EVERYWHERE

Equitable access to palliative care and referral earlier in the disease process leads to better outcomes and improved quality of life for people with life-limiting illness and their family/carers.

Outcomes are improved for WA country people and their families/carers through:

- Access to timely, equitable and seamless palliative care services that best meet their needs.
- Receipt of specialist palliative care when required.
- Receiving care that is respectful and culturally secure.

The use of innovative technologies such as TelePalliative Care, PalCATS, telemedicine apps and other digital platforms support palliative care in hard-to-reach communities (refer Appendix 4).

OUTCOMES

- New care pathways and research projects foster earlier referral to palliative care services for people in their disease process to improve outcomes.
- Strengthening partnerships and collaboration with internal and external stakeholders addresses challenges experienced by palliative care consumers.
- Sustainable funding models to support people dying at home are developed, outlining the costs associated with providing SPC in more remote communities and for people with complex care needs.
- Optimal, co-designed paediatric palliative care pathways improve access and offer a consistent approach to palliative care for babies, children and adolescents across WACHS.
- The quality and safety of SPC services delivered in the community are audited against national Palliative Care Standards.
- Access to SPC services 24/7 through the deployment of a mobile and agile workforce improves access for Aboriginal people, remote communities and other populations with inequitable access.

Priority 2

CARE IS PERSON-CENTRED

Every person has unique needs and their preferences about end of-life care are based on their life experiences, personal resources, values, culture, and spirituality.

Outcomes are improved for WA country people and their families/carers through:

- Receiving care that considers all the dimensions of a person's physical, psychological, spiritual, cultural and social needs.
- Receiving care that recognises that these needs can change and is responsive to these changes.
- Receiving care that is comprehensive, seamless, safe and culturally respectful across the continuum of care, including into bereavement.
- Receiving opportunities to talk about and plan for death including advance care planning and end-of-life choices.
- Experiencing care that is person-centred and always includes family/carers who are actively involved in shared decision-making.

OUTCOMES

- A WACHS palliative care psycho-social-spiritual framework provides a comprehensive approach to meeting the holistic needs of consumers, their families and/or carers.
- Increased uptake of Advance Care Planning (ACP) by improving the capture of ACP documents including standardisation of routine data collection and the continuous review of quality improvement processes.
- A palliative care room baseline audit conducted across WACHS hospitals quantifies the unmet need and guides future service and infrastructure planning.
- An infrastructure and funding plan informs decision-making and enables the implementation of palliative care room upgrades, equipment and furniture requirements across WACHS regions.

Priority 3

CARE IS COORDINATED

Continuity and coordination of care is central to improving the experience of people with a life-limiting condition.

Outcomes are improved for WA country people and their families/carers through:

- Access to SPC earlier in the disease process.
- Receiving timely care, when, where and how they choose, whenever possible.
- Experiencing seamless and coordinated care.
- A shared care approach from primary care and SPC services.

OUTCOMES

- Defined, person-centred pathways for condition-specific groups improve care navigation, embed advance care planning, and focus on care coordination and referral.
- Strengthening the coordination of care and earlier referral to SPC services as patients transition between services. (Refer to Figure 4).
- Timely access to equipment to support palliative care at home is available in regional WA.
- Standardisation of processes and business rules for how existing information systems are used to routinely record agreed metrics, including simplified use of WebPAS clinic codes. The plan will accommodate integration with the electronic medical records (EMR) and digital medical records (DMR) implementation.
- Support is provided for the rollout of innovative technologies and enhanced communication systems like My Health Record and other statewide systems to improve communication/coordination as people transition across settings.

Priority 4

FAMILIES AND CARERS ARE SUPPORTED

Meeting the physical, psycho-spiritual, social, cultural and financial needs of someone during their palliative care can be challenging and tiring.

Outcomes are improved for WA country people and their families/carers through:

- People receiving the appropriate support, irrespective of the care setting.
- Staff directing and/or referring family/carers to services that provide education, information and supportive care.
- Increasing awareness of the need for respite care and understanding how to access services.
- Access to timely bereavement support services.

OUTCOMES

- Respite care options available through WACHS and local partnerships are expanded and include better access to palliative care support packages, access to day respite and inpatient multi-day stay in residential care, hospitals or community services.
- WACHS supports expansion of the Compassionate Communities model in regional WA through stronger collaborations and participation in initiatives led by local government, civic groups, and community organisations that build the communities' capacity to support people at the end of their life.
- WACHS works with service partners and communities to better understand the significant impacts of financial stress associated with providing care for country patients at home and develops consumer co-designed solutions.
- Bereavement pathways that use screening tools for complex grief, care before death, consistent follow-up after death, referral pathways and access to telehealth psychological support are developed across regional WA to embed consistent processes and strategies for WACHS.
- Routine audit and quality improvement activities are undertaken WACHS-wide through a consistent approach to family experience surveys and include an improved capability to capture cultural background to ensure representativeness.
- Embedding Palliative Care Outcomes Collaborative (PCOC) assessment tools and quality improvement processes consistently across WACHS services ensure high-quality, evidenced-based care.

Hilda is 78 years old

She lives in an aged care home that is part of a WA Country Health Service (WACHS) Multi-Purpose Service (MPS) in regional WA.

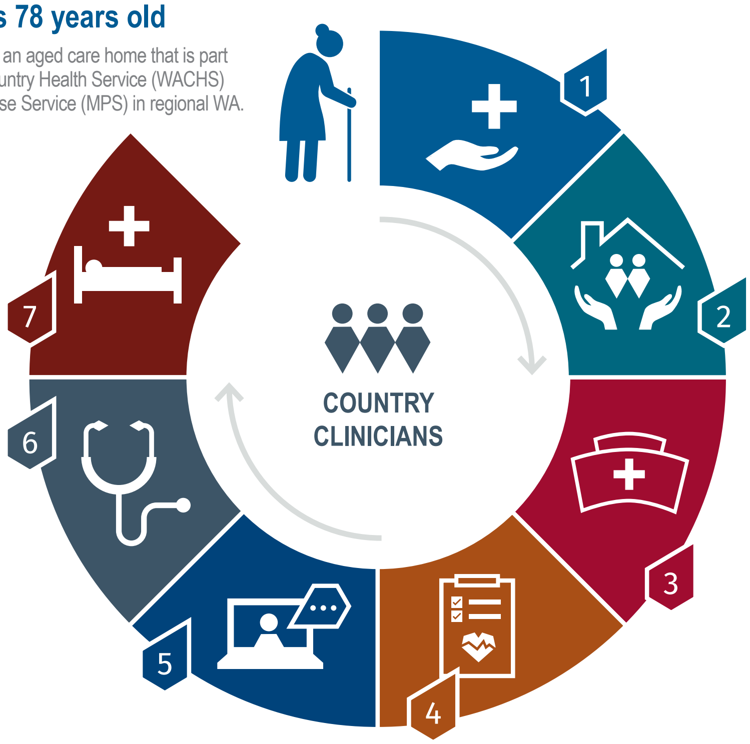


Figure 4: Older person's journey of integrated care with generalist and specialist palliative care teams

1 Hilda has cardiac failure, emphysema and stage four breast cancer. She has recently deteriorated, and her family are very worried. Hilda's daughter Joan lives in Perth and is actively engaged in her care. Joan is keen to know what the plan is to manage Hilda's pain and deterioration.

2 The staff in Hilda's aged care home have identified her deterioration, guided by the Supportive and Palliative Care Indicators Tool (SPICT) criteria. This prompts a referral to the regional specialist palliative care (SPC) multi-disciplinary team (MDT).

The regional SPC team reviews Hilda and works with the staff and GP caring for Hilda to improve symptom management. Joan and the SPC team discuss how to respect Hilda's wish to receive all her care in the aged care home.

The team also provides MPS staff with the contact for Palliative Care Afterhours TelePalliative Service (PalCATS) who can review afterhours. The regional SPC team check in on Hilda in person or via telehealth regularly over the next few weeks.

3 On a Saturday evening the aged care nurse contacts PalCATS for advice concerning Hilda's increasing pain and to reassure her family. Hilda, the local GP, aged care staff and family all consent to the PalCATS referral for senior nurse review.

4 The regional SPC team have already provided the following documents to PalCATS: medication chart, summary of medical history, recent observations, Advance Care Plan and Residential Goal of Care form.

5 The aged care home is telehealth-enabled and PalCATS nurses review Hilda and have a 'face-to-face' with her family via telehealth. Hilda is now likely to die in the coming days, and the care plan is updated to reflect this.

6 PalCATS sends their assessment to the GP, the regional SPC team and the aged care team to review the plan and follow-up with a phone call.

The family feels reassured and supported with the plan. The PalCATS team suggests local bereavement services and refers the family to social work within the regional SPC team, who follow-up with Joan and staff at the MPS site on the Monday morning, following handover from PalCATS.

Hilda dies comfortably in the aged care facility a few days later, in line with her end-of-life wishes.

7

OUTCOME

Access to SPC locally and via telehealth supported Hilda's wish to have optimal symptom and terminal phase management at the aged care facility. She and her family received an integrated, comprehensive approach to support her in her final days and into the family's bereavement.

The aged care nursing staff received support and education from the regional SPC team and PalCATS over the weekend, which increased their confidence to provide quality end-of-life care.

Priority 5

ALL STAFF ARE PREPARED TO CARE

Not all people with a life-limiting illness need care by specialist palliative care.

General practitioners or specialists in other disciplines can provide compassionate care, manage symptoms, support advance care planning and address psycho-social and spiritual needs.

SPC is required when patient care is complex. It's important to recognise the role other professionals play in caring for people with straight forward and predictable needs and to support and strengthen their capability (Appendix 3).

Outcomes are improved for WA country people and their families/carers through:

- WACHS's workforce understanding the benefits of timely palliative care.
- WACHS's workforce knowing how to provide compassionate palliative and end-of-life care appropriate to a person's individual needs and knowing when to refer for SPC.
- All relevant WACHS clinicians initiating and reviewing Goals of Patient Care with patients and their family/carers to increase their understanding and utilisation of advance care planning, Advance Health Directives and Enduring Power of Guardianship.
- SPC teams having access to professional development opportunities.

OUTCOMES

- A sustainable, agile workforce that is supported across all regions by an expanded TelePalliative Care service, empowered through strong preceptorship and mentorship programs that grow teams locally and retain them. These SPC teams consider expanded roles for:
    - non-regulated health workers
    - junior clinician placements for allied health students
    - graduate nurse placements
    - junior doctor roles
    - nurse practitioner candidacy roles
- and strengthen links with universities and TAFEs.
- A targeted recruitment and retention plan for SPC staff, with streamlined consistent recruitment processes across WACHS to employ staff in a timelier manner.
- A coordinated education and training program develops skilled regional SPC teams across regions and a standardised approach to robust collection and reporting of training outcome data. An existing Skill Capability Framework for the SPC nursing workforce is used and existing palliative care education and training resources are adapted for the local workforce needs.
- Existing palliative and end-of-life training resources are promoted to the WACHS workforce through WACHS's learning and development services.
- Strengthened governance relationships between Comprehensive Care committees and SPC teams promote safe and high quality care provided at the end-of-life by generalists in WACHS acute care facilities.
- Audit and quality improvement activities are undertaken in all SPC teams and include the ongoing audit of GoPC with a focus on quality of discussion and documentation.

Priority 6

THE COMMUNITY IS AWARE AND ABLE TO CARE

Empowered consumers and caregivers know where and how to access resources to support them during end-of-life care.

Outcomes are improved for WA country people and their families/carers through:

- Improving understanding about dying, bereavement and relevant legislation and/or policies relating to advance care planning and voluntary assisted dying.
- People being empowered to better plan for their care and respond to changes as the need arises.
- Self-referral to available community resources as required.

OUTCOMES

- Strengthening partnerships with agencies who promote health and death literacy programs and early discussions about end-of-life and dying well, will help combat community misconceptions about the role of palliative care e.g. Healthy WA, Compassionate Communities.
- Carers and volunteers within the local community are supported to access training opportunities provided by cross-sector service providers e.g. Certificate 3 from Carers WA.
- Community-based palliative care champions are identified to work alongside SPC to promote community understanding about palliative care services and how to access them. This may be of particular importance in remote communities where culturally appropriate information and awareness is needed.
- The public health palliative care model is strengthened through innovative partnerships with local civic organisations and institutions including Compassionate Communities. Models such as the Connectors Program are embedded within Chronic Disease Programs across regional WA.

Next steps

Successfully implementing the ***WACHS Palliative and End-of-Life Care Strategy 2024-2028*** will rely on collaborative efforts, strong partnerships, active involvement and capable communities.

An implementation plan will guide the delivery and monitoring of WACHS-wide actions in the Strategy.

Regional palliative care clinical service plans will guide the local implementation of the Strategy within their own context, workforce, available resources and changes required to meet community needs.

Strong governance and performance monitoring by WACHS palliative care leaders will oversee Strategy implementation, identify improvement opportunities and consider how they will be progressed.

Coordinated support at executive levels and strong communication will be essential to the rollout of the Strategy along with including people with life-limiting illness and their families/carers in a co-design model.

Appendix 1

GLOSSARY OF TERMS

Term	Definition
Access to	Refers to "timely use of personal health services to achieve best outcome".[7]
Aboriginal Health Liaison Officer (AHLO)	Provide palliative care expertise, education and supports the delivery of palliative care that upholds the traditions and customs for Aboriginal people living in regional WA.
Aboriginal Health Worker	A collective term for Aboriginal people working in the healthcare sector as a collective group, regardless of their employment stream.
Advance care planning (ACP)	A 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. "ACP documents" is a catch-all term to include documents that result from advance care planning. This includes Advance Health Directives and Advance Care Plans and Appointment of Enduring Guardian(s).[4]
Bereavement	Broadly encompasses the entire experience of family members and friends during and after death as they learn to adjust to life without their loved one.[5]
Carer	Someone who provides unpaid care and support to family members and/or friends who are living with a disability, mental health challenge, long term health condition (including a chronic condition or terminal illness), and alcohol or other drug dependency, or who is frail aged. Young Carers are carers aged between 8-24 years old.[6]
Community care	Care provided by health professionals outside of a hospital setting.
Cultural safety	Determined by Aboriginal individual families and communities. Culturally safe practice is the ongoing reflection of health practitioner knowledge, skills, attitudes, practising behaviours and power differentials in delivering safe, accessible, and responsive healthcare free of racism.[7]
Interdisciplinary team	Team members from different disciplines working collaboratively, with a common purpose, to set goals, make decisions and share resources and responsibilities. A team of clinicians from different disciplines, together with the patient, undertake assessment, diagnosis, intervention, goal setting and the creation of a care plan. The patient, their family and carers are involved in any discussions about their condition, prognosis, and care plan.
Life-limiting illness	Refers to where an illness is unlikely to be cured and will likely cause death at some stage in the future.
Multidisciplinary team	Refers to an approach that involves team members working independently to create discipline-specific care plans that are implemented simultaneously, but without explicit regard to their interaction.[8]
Model of care	Broadly defines the way healthcare services are arranged and delivered to people across various settings.
TelePalliative Care	The model of care utilising digital technology platforms to deliver end-of-life and palliative care services.
Voluntary Assisted Dying	Involves a process to access medication and enable a person to legally choose the manner and timing of their death. The term 'voluntary assisted dying' emphasises the voluntary nature of the choice of the person and their enduring capacity to make this decision.

Appendix 2

STRATEGIC INITIATIVES AND CRITERIA FOR SUCCESS

***Types of Measures: Key performance Indicator (KPI), Supporting Indicator (SI), Milestone (M)**

Directions	Key performance measures or indicators	Target (what we aim to achieve)	Timeframe	Type of measure
Priority 1 ***Care is accessible to everyone, everywhere***	**Develop an Aboriginal model of care to facilitate earlier referral and increased access to culturally secure palliative care**			
	Models of care developed with consumer co-design (including stakeholders from all regions).	• Models of care developed.	2025	M
		• 100% of regions implement the agreed model of care.	2026	M
	Increasing referral rates and the proportion of people referred earlier.	• Baseline referral rates (to SPC and AHLO specifically) and timing of referral established.	2026	SI
		• Increased referral rates for Aboriginal people, proportionate to population.	2025	SI
		• >50% of referrals for Aboriginal people occur more than three months before death.	2028	KPI
	Increase opportunities for engagement with Aboriginal people and families regarding experience of care.	• Baseline satisfaction with care established.	2026	SI
		• >80% of Aboriginal people and families are satisfied with care.	2028	KPI
	All SPC staff complete regionally specific cultural awareness training on a biannual basis.	• 100% of current WACHS SPC staff have completed regional specific cultural awareness training within the last 24 months.	2025	M
	Community palliative care outreach models facilitate provision of high-quality care that meets patient needs.			
	Provide 24/7 access to palliative care expertise, through a combination of in-person and telepalliative care (PalCATS and telepalliative care in the home (TPCITH).	• 100% of regions provide 24/7 access.	2026	M
		• Baseline uptake of telepalliative care is established in all regions (PalCATS and TPCITH).	2026	SI
		• Increased regional uptake of telepalliative care proportionate to population and availability of local services.	2028	KPI
		• Increase uptake of telepalliative care in the home in all regions.		
		• 90% of patients in the SPC service for >3 weeks will have a documented SPC MDT plan.	2026	KPI
	PCOC outcome measures meet WACHS benchmark, within 10% of national benchmarks.	• Meets or within 10% of PCOC national benchmarks for timely access to palliative care.	2027	KPI

Appendix 2

STRATEGIC INITIATIVES AND CRITERIA FOR SUCCESS

***Types of Measures: Key performance Indicator (KPI), Supporting Indicator (SI), Milestone (M)**

Directions	Key performance measures or indicators	Target (what we aim to achieve)	Timeframe	Type of measure
Priority 1 ***Care is accessible to everyone, everywhere***	**Develop a model of care to improve access and standardise the approach to palliative care for babies, children and adolescents**			
	Models of care developed with consumer co-design (with stakeholders from all regions).	• Models of care developed.	2025	M
		• 100% of regions implement the agreed model of care.	2028	SI
		• Baseline referral rates established.	2025	KPI
		• Increased referral rates for babies, children and adolescents.	2028	KPI
	Increase opportunities for engagement with families and carers regarding experience of care.	• Baseline satisfaction with care established.	2026	SI
		• >80% of families and carers are satisfied with care.	2028	KPI
	All SPC staff complete Quality of Collaborative Care Australia (QuoCCA) paediatric palliative care training.	• 90% of current WACHS SPC staff have completed designated paediatric palliative care training and/or e-learning modules within the last 24 months.	2025	KPI

Appendix 2

STRATEGIC INITIATIVES AND CRITERIA FOR SUCCESS

***Types of Measures: Key performance Indicator (KPI), Supporting Indicator (SI), Milestone (M)**

Directions	Key performance measures or indicators	Target (what we aim to achieve)	Timeframe	Type of measure
Priority 2	**Patients are actively involved in shared decision-making and advance care planning**			
Care is person centred	Patients entering palliative care services without an existing ACP/ AHD have opportunity to discuss and formalise future care planning using a shared decision-making approach.	• 100% patients without existing documentation are offered opportunity to document preferences for care.	2026	M
	Patients with existing ACP/AHD have opportunity to review documentation and update as required using a shared decision-making approach.	• 100% patients with existing documentation are offered opportunity to review preferences for care.	2026	M
		• Review VAD Board report and examine the reporting rates for First Requests as compared with expected rates for the population and compared with metropolitan-based services.	2026	M
	Increase the availability of advance care planning documentation when needed for clinical decision-making			
	Standardisation of routine data collection for AHD /ACP across all regions.	• Standardised business rules for data collection are developed.	2025	M
		• All regions implement a WACHS standardised approach to recording presence of ACP/AHD documentation.	2026	M
	Routine upload of ACP/AHD to My Health Record.	• 100% of patients providing consent have their ACP/AHD uploaded to their My Health Record.	2028	KPI
	Improved access to psycho-social-spiritual care for patients (see priority 4 for bereavement care for family/carers)			
	Develop palliative care and end-of-life psychosocial-spiritual framework.	• 100% of SPC hubs have a referral pathway based on local service provision.	2026	M
	Embed screening tools to identify psycho-social-spiritual needs of patients.	• Patients are referred to relevant services based on screening outcomes.	2026	M
	Reduced psycho-social-spiritual-distress among palliative care patients			
	PCOC measures for psychological/ spiritual problems meet WACHS benchmark of within 10% of national benchmarks.	• Meets or within 10% of PCOC national benchmarks.	2027	KPI
	Establish protocol for audit of patient reported experience.	• >80% of patients are satisfied with care.	2028	KPI

Appendix 2

STRATEGIC INITIATIVES AND CRITERIA FOR SUCCESS

*Types of Measures: Key performance Indicator (KPI), Supporting Indicator (SI), Milestone (M)

Directions	Key performance measures or indicators	Target (what we aim to achieve)	Timeframe	Type of measure
Priority 3 ***Care is coordinated***	**Defined pathways for end-of-life care for people with dementia**			
	Increased access to end-of-life and palliative care services for people with dementia.	• Pilot study to assess impact of integration of palliative care with dementia care services on family/caregiver outcomes.	2028	M
	Regional coordination / navigation and connectors			
	Country residents are connected to available services across the continuum of care e.g., Compassionate Communities and Connectors Programs.	• Documented pathways, processes, and relevant information tools for consumers and WACHS staff to access cross-sector services.	2026	M
	Equipment available for palliative care services			
	Increased access to essential equipment so people can be cared for at home.	• WACHS-wide documented and agreed process for transport and logistics equipment and inventory.	2026	M
	Use of digital technology to improve care coordination			
	Improved care coordination of people who access multiple services & providers through use of technology across various care settings.	• Rollout of EMR/DMR as per statewide schedule. • Upload of essential documentation to My Health Record (ACP/AHD, discharge summaries, care plans).	2028 2028	M M

Appendix 2

STRATEGIC INITIATIVES AND CRITERIA FOR SUCCESS

***Types of Measures: Key performance Indicator (KPI), Supporting Indicator (SI), Milestone (M)**

Directions	Key performance measures or indicators	Target (what we aim to achieve)	Timeframe	Type of measure
Priority 4 ***Families and carers are supported***	**Improved access to psycho-social-spiritual and bereavement care for family/carers**			
	Develop bereavement care and referral pathways as part of the psycho-social-spiritual care framework.	• 100% of SPC hubs have a referral pathway based on local service provision.	2026	M
	Embed screening tools to identify psycho-social-spiritual and bereavement of families/carers.	• Families are referred to relevant services based on screening outcomes.	2026	M
	Reduce family/carer psycho-social-spiritual-distress including into bereavement			
	PCOC measures for family/carer problems meet WACHS benchmark of within 10% of national benchmarks.	• Meets or within 10% of PCOC national benchmarks.	2027	KPI
	Establish protocol for audit of family reported experience measures.	• >80% of families/carers are satisfied with care.	2028	KPI
	Expand options for respite to support patients and families			
	Develop partnerships with local services to introduce more options for community, residential care and hospital-based respite.	• Increased options for respite are available. • Increased uptake of respite care options.	2027	M
	Build community capacity to support people at end-of-life			
	Support expansion of Compassionate Communities through formalised partnerships and cross-sector collaboration.	• Communities are supported and have more capacity to provide responsive care to people and families.	2028	M
	Solutions to address financial stress among family/carers providing care in the home			
	Co-design solutions for addressing family/ carer financial stress through strong collaboration with service partners and community.	• Family/carer are supported to provide care at home through collaborative service models tailored across regions.	2028	M

Appendix 2

STRATEGIC INITIATIVES AND CRITERIA FOR SUCCESS

*Types of Measures: Key performance Indicator (KPI), Supporting Indicator (SI), Milestone (M)

Directions	Key performance measures or indicators	Target (what we aim to achieve)	Timeframe	Type of measure
Priority 5	**Increased access to online palliative care education to support and upskill generalist workforce**			
All staff are prepared to care	Development and/or expansion of current programs within My Learning to meet palliative care training needs of the generalist workforce.	• Increased uptake of online generalist palliative care education program within My Learning.	2026	KPI
		• Capture demographics details of staff completing online modules, including region and role.	2026	SI
	Scope minimum mandatory training requirements for all generalist staff and explore feasibility.	• Minimum palliative care training requirements identified. Feasibility of introducing minimum mandatory requirements identified.	2025	M
	Efficient acquisition of required skills for workforce in SPC			
	Development and/or implementation of a capability matrix and training framework detailing required competencies for the SPC workforce (including AHLOs and nurse practitioners).	• All regions implement the capability matrix to identify training needs among new and existing staff.	2025	M
	Training is evaluated to demonstrate key outcomes.	• Evaluation demonstrates achievement of training objectives (knowledge, skills and competencies).	2026	KPI
	Workforce capacity and sustainability			
	Develop WACHS workforce plan and model based on local service need for each region. Workforce plan considers: succession and remuneration plan, training needs analysis, staff required to support virtual models of care and a model for medical governance across all providers of care.	• Workforce plan developed and implemented in all regions.	2026	M
	Create PCA positions as required.	• PCA positions established and defined.	2025	M
	Develop associated training and capability framework for PCAs.	• Capability matrix developed and flexible training options identified.	2026	M
	Conduct gap analysis for availability of home-based support throughout all WACHS regions for inclusion in workforce planning.	• PCAs provide palliative care support to people in the community where a private provider is not available.	2026	KPI

Appendix 2

STRATEGIC INITIATIVES AND CRITERIA FOR SUCCESS

***Types of Measures: Key performance Indicator (KPI), Supporting Indicator (SI), Milestone (M)**

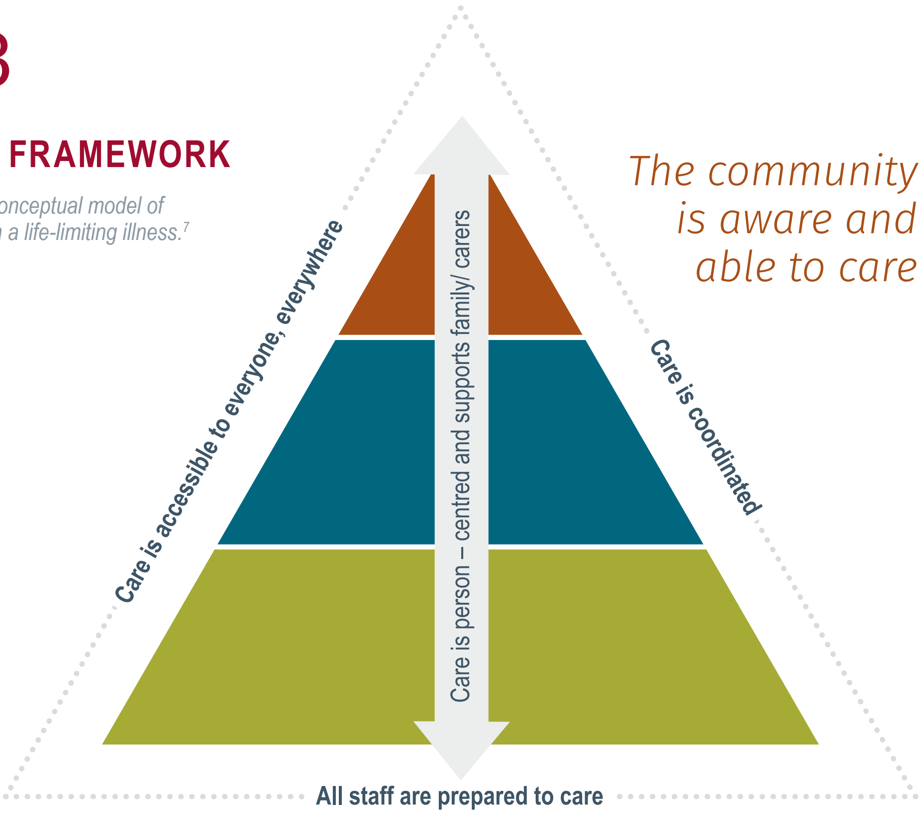
Directions	Key performance measures or indicators	Target (what we aim to achieve)	Timeframe	Type of measure
Priority 5 ***All staff are prepared to care***	Agile workforce models that are scalable and can be mobilised across WACHS.	• FTE within each region remains consistent.	2028	KPI
		• Baseline self-sufficiency established in each region.	2025	SI
		• Self-sufficiency is improved by approximately ≥5% in each region over four years.	2028	KPI
	Targeted recruitment and retention of SPC staff.	• Annual workforce retention ≥80%.	2026	KPI
	Palliative Care clinical supervision / mentorship program developed for all disciplines.	• 100% of regions implementing palliative care clinical supervision / mentorship program.	2024	KPI
		• VAD trained medical practitioners available across WA country.	2025	KPI

Directions	Key performance measures or indicators	Target (what we aim to achieve)	Timeframe	Type of measure
Priority 6 ***Community is aware and able to care***	**Programs to raise awareness of health and death literacy for people in regional and remote communities**			
	Develop community engagement plan outlining strategies to raise community awareness of palliative care.	• Engagement plans developed for all regions (e.g. – Number of resources developed, forums held, public awareness campaigns).	2026	SI
		• Implement and monitor success of engagement plans.	2027	KPI
	Collaborate with service partners to increase community and stakeholder awareness.	• Number of forums held in partnerships monitored.	2027	KPI
	Community-based palliative care champions identified and recruited to promote community understanding of palliative care services.	• Establish community's baseline understanding of palliative care service and how to access services.	2026	SI
		• Number of community champions recruited in each region monitored.	2028	KPI
	Formal training opportunities are promoted to carers and volunteers.	• Carers and volunteers are trained to provide care.	2028	M

Appendix 3

WACHS CONCEPTUAL FRAMEWORK

Adapted from Palliative Care Australia's conceptual model of need within the population of patients with a life-limiting illness.[7]



PERSON-CENTRED NEEDS

Significant complexity

Care being entirely directed and/or delivered by SPC

Increasing complexity

Care plan needing SPC input at times as needs fluctuate

Straight forward and predictable

Care plan in place that meets needs

SERVICE PROVIDERS

Specialist palliative care senior clinicians are very present in the person's care. This includes a palliative medicine specialist, senior nurses and allied health. May include referral to other specialist WACHS services, e.g. psychiatry, or shared care planning with metro–based services, e.g. paediatric specialist palliative care.

Specialist palliative care team staff come in and out of a person's care as directed by need. This may include a WACHS palliative care GP and all other members of SPC team.

Primary care, inpatient teams and Aboriginal Medical Services staff etc provide medical, nursing and psychosocial / spiritual care.

SUPPORT RESOURCES FOR COUNTRY PEOPLE INCLUDE:

- **Community networks, WACHS Command Centre, private regional hospitals and hospices, Royal Flying Doctor Service (RFDS), St John Ambulance, other specialist health services and metropolitan-based services, not-for-profit organisations, Palliative Care WA and other patient/peer support organisations.**

COMPLEXITY OF CARE MAY INCLUDE:

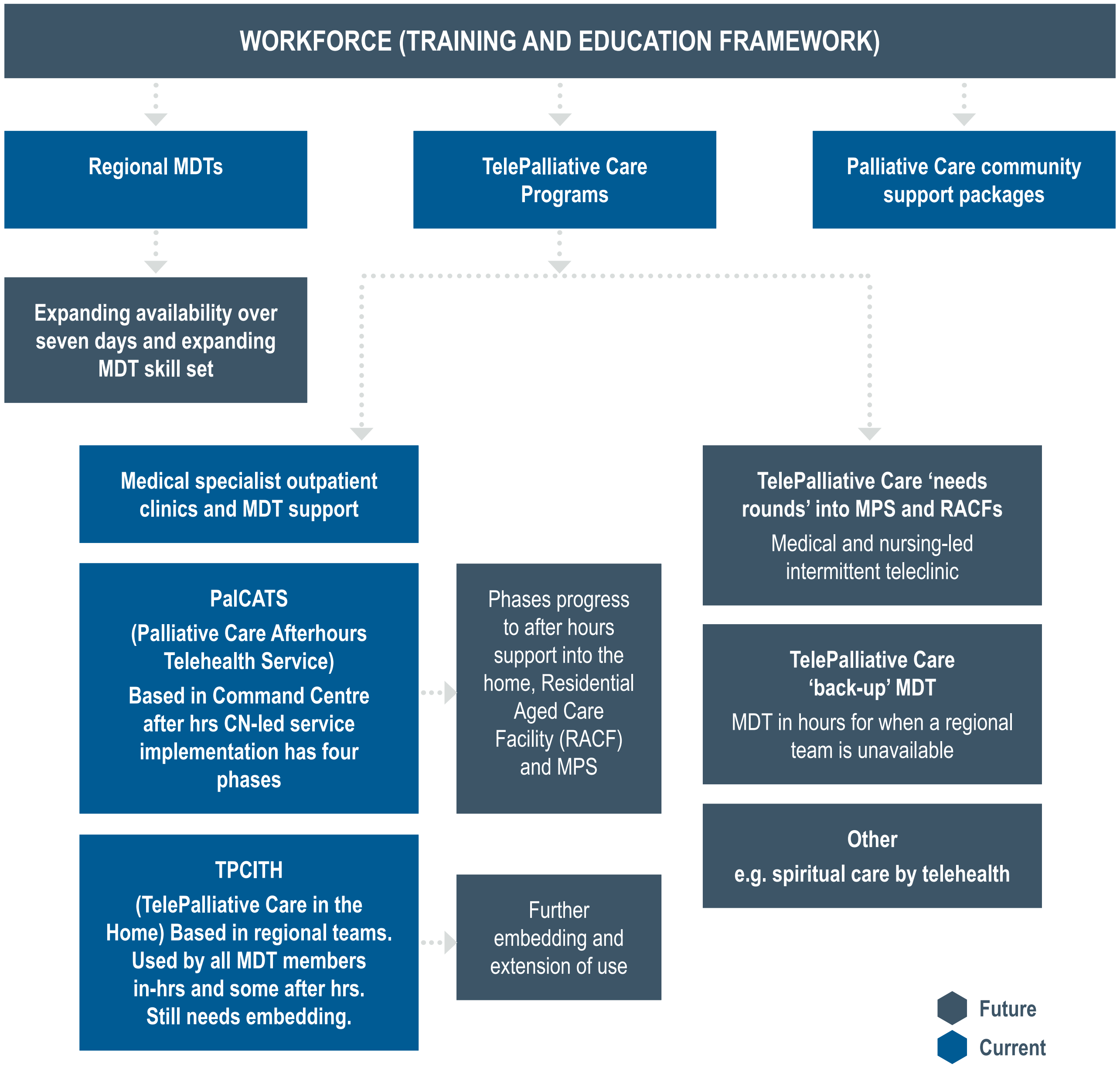
- Multiple symptoms
- Severe symptoms
- Significant psychological / emotional or spiritual distress
- Significant family or caregiver distress
- No carer available
- Uncertain illness trajectory
- Rapidly progressive illness
- Multi-morbidity
- Social isolation or remote location for care
- Multiple adverse social determinants of health
- Young age
- Complex or high dose medication regimes
- Complex nursing care
- Cultural complexity
- Previous trauma
- Homelessness
- Delirium

Appendix 4

WACHS PALLIATIVE MODEL OF CARE

WACHS PALLIATIVE MODEL OF CARE

Governance (funding/policies/performace monitoring)



WORKFORCE (TRAINING AND EDUCATION FRAMEWORK)

Regional MDTs

TelePalliative Care Programs

Palliative Care community support packages

Expanding availability over seven days and expanding MDT skill set

Medical specialist outpatient clinics and MDT support

PalCATS

(Palliative Care Afterhours Telehealth Service)

Based in Command Centre after hrs CN-led service implementation has four phases

Phases progress to after hours support into the home, Residential Aged Care Facility (RACF) and MPS

TPCITH

(TelePalliative Care in the Home) Based in regional teams. Used by all MDT members in-hrs and some after hrs. Still needs embedding.

Further embedding and extension of use

TelePalliative Care 'needs rounds' into MPS and RACFs

Medical and nursing-led intermittent teleclinic

TelePalliative Care 'back-up' MDT

MDT in hours for when a regional team is unavailable

Other

e.g. spiritual care by telehealth

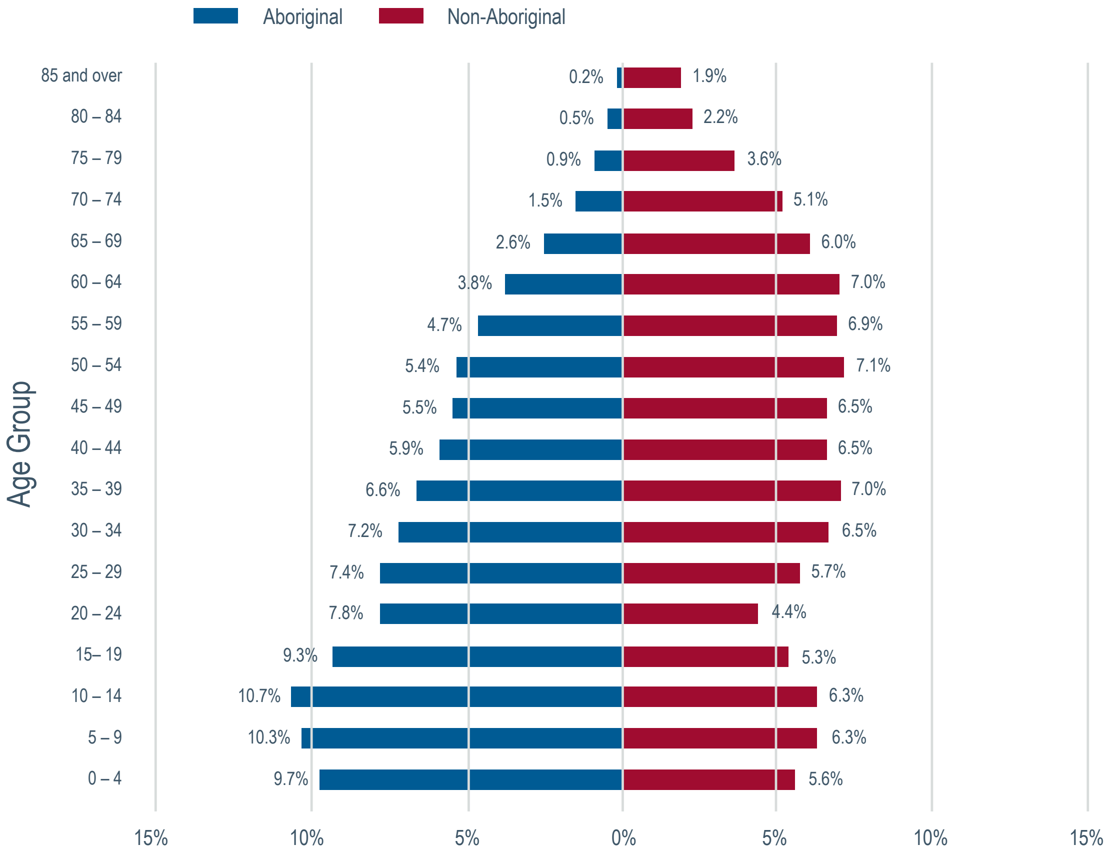
⬢ Future

⬢ Current

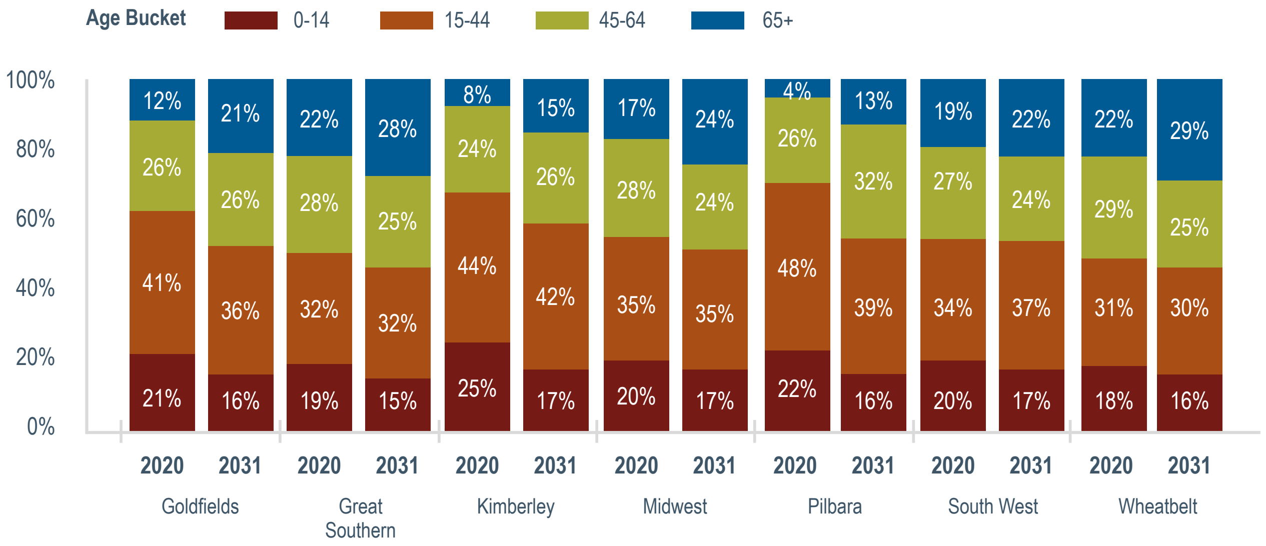
Appendix 5

POPULATION PROJECTIONS

WACHS AGE DISTRIBUTION (%) BY ABORIGINALITY, 2022



PROPORTION OF POPULATION BY AGE GROUPING AND WACHS REGION, 2020 VERSUS 2031



Appendix 6

PALLIATIVE CARE NEED

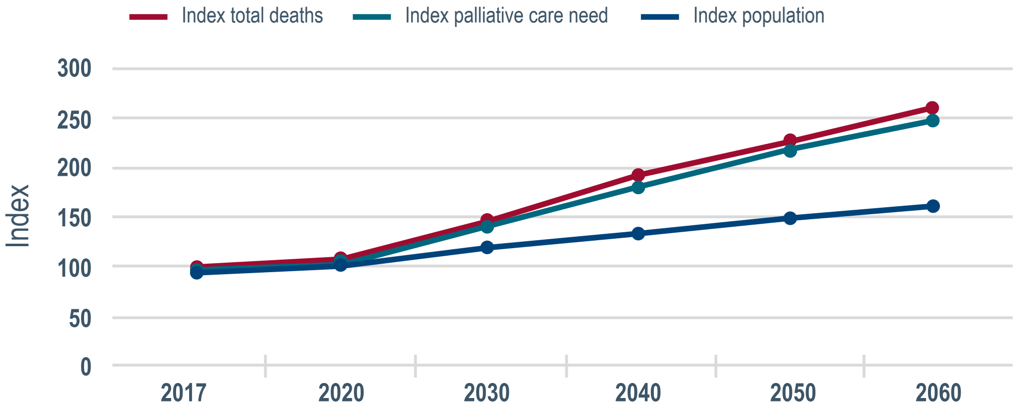
THE INCREASING NEED FOR PALLIATIVE CARE [12]

In 2017, 15 per cent of all Australians were aged 65 years and over. Of the 160,000 deaths in 2017, 82 per cent were aged in this cohort. With expectations that 8.2 million individuals aged 65 and over will be added to the population by 2060 (approximately 20 per cent of the estimated population in that period), death will become increasingly prevalent in Australian society.

Following the method from Sleeman et al., combined with WHO mortality projections, KPMG estimate that between now (2019) and 2060:

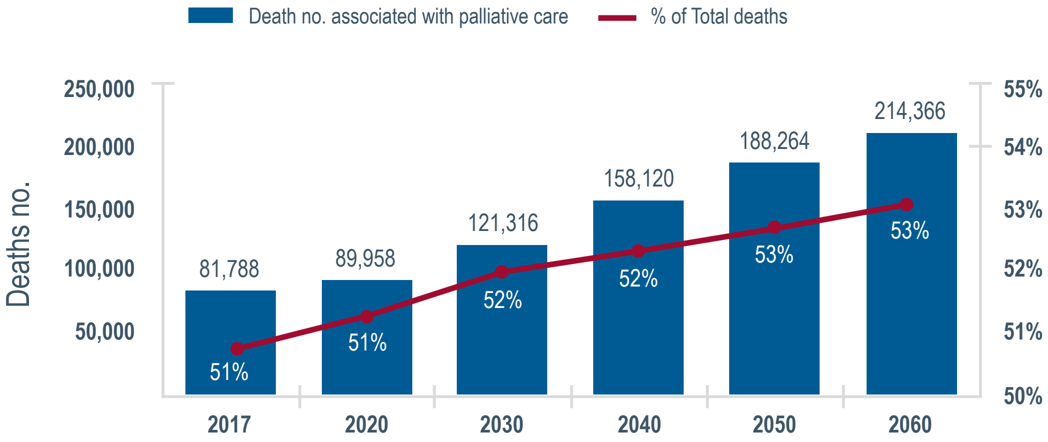
- The population will increase by 60 per cent to 40.5 million individuals;
- Total deaths will surge by 135 per cent to 400,000, of which 214,000 will require palliative care services.
- Need for palliative care will grow faster than both the population and total deaths

GROWTH IN THE ESTIMATED POPULATION, TOTAL DEATHS AND PALLIATIVE CARE NEED (2017–2060)



Sources: KPMG analysis (2019), ABS cat. no.3303 2018

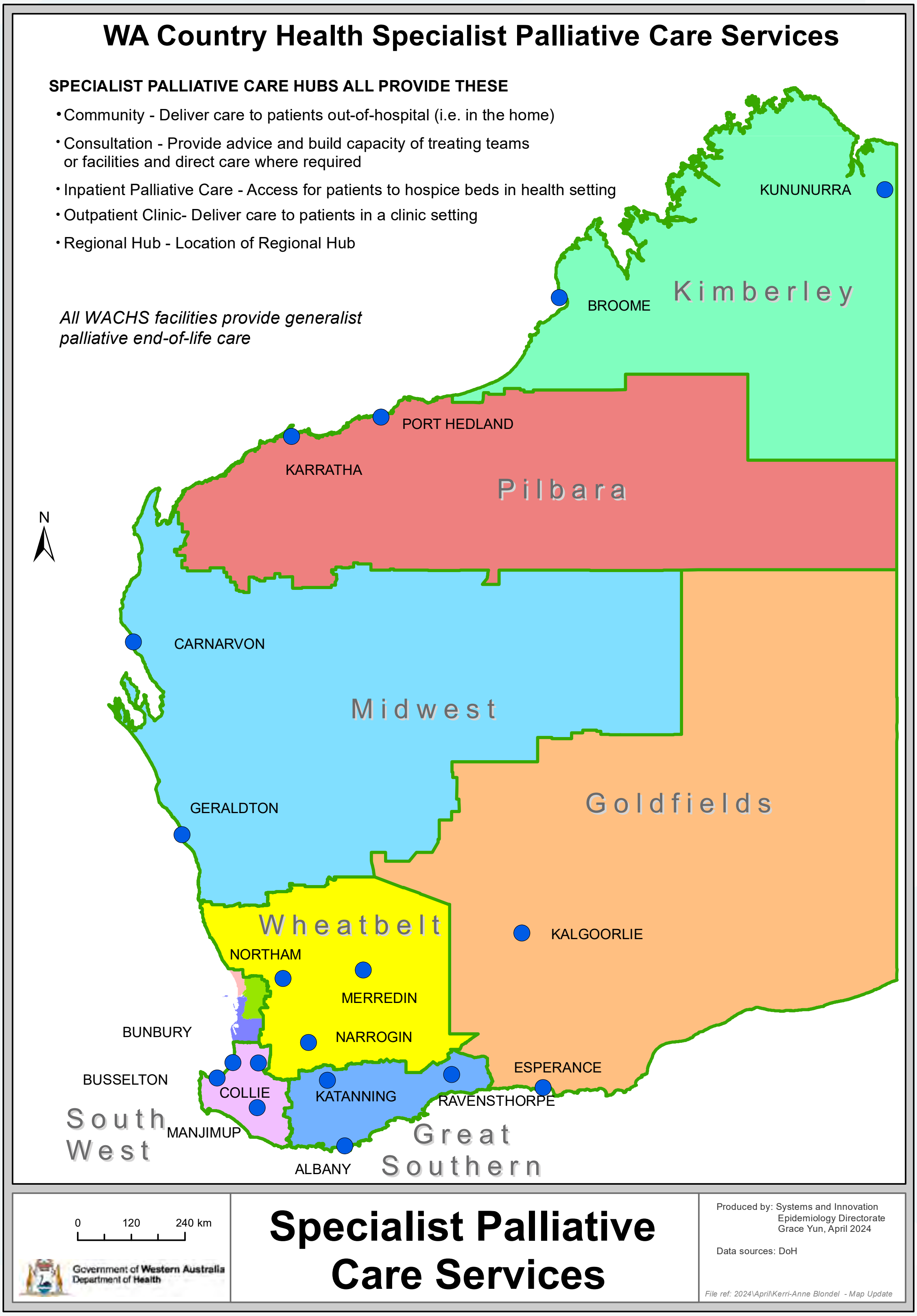
ESTIMATES OF NEED FOR PALLIATIVE CARE IN AUSTRALIA 2017–2060



Source: KPMG analysis (2019), Sleeman et al. (2019)

Appendix 7

SPECIALIST PALLIATIVE CARE SERVICES IN WACHS



WA Country Health Specialist Palliative Care Services

SPECIALIST PALLIATIVE CARE HUBS ALL PROVIDE THESE

- Community - Deliver care to patients out-of-hospital (i.e. in the home)
- Consultation - Provide advice and build capacity of treating teams or facilities and direct care where required
- Inpatient Palliative Care - Access for patients to hospice beds in health setting
- Outpatient Clinic- Deliver care to patients in a clinic setting
- Regional Hub - Location of Regional Hub

All WACHS facilities provide generalist palliative end-of-life care

Specialist Palliative Care Services

Produced by: Systems and Innovation
Epidemiology Directorate
Grace Yun, April 2024

Data sources: DoH

File ref: 2024\April\Kerri-Anne Blondel - Map Update

Appendix 8

KEY STRATEGY AND PLANNING CONTEXT

The WACHS Palliative and End-of-Life Care Strategy 2024-2028 aligns with several national, state and WACHS strategies and frameworks that support and strengthen country health services including:

WACHS

- WACHS Strategic Plan 2019-2024
- WACHS Clinical Services Plans
- WACHS Cancer Strategy 2017-2022
- WACHS Health for Older People 2022-2027
- WACHS Kidney Health Strategy 2019-2024
- WA Country Digital Innovation Strategy 2019-2022
- WACHS Aboriginal Health Strategy 2019-2024
- WACHS Consumer and Community Engagement Strategy 2021-2026
- WACHS Research and Innovation 2019-2024
- WACHS Voluntary Assisted Dying Position Statement
- WACHS Disaster Preparedness

State

- WA Health Clinical Services Framework 2014-2024
- Western Australian Paediatric Strategy for End-of-Life and Palliative Care 2021-2028
- WA Health Digital Strategy 2020-2030
- WA Government response to the Joint Select Committee on End-of-Life Choices Report - 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
- WA Aboriginal Health and Wellbeing Framework 2015-2030
- Aboriginal End-of Life and Palliative Care Framework
- WA Sustainable Health Review (SHR) Final Report - Strategy 3, Recommendation 9
- Carers Recognition Act 2004
- End-of-Life Framework (A state-wide model for the provision of comprehensive, coordinated care at end-of-life in Western Australia)
- Government of WA, Climate Health WA Inquiry: Final Report, November 2020

National

- National Quality and Safety Health Service Standards NSQHS Standards (second edition)
- National Palliative Care Strategy 2018
- National Safety and Quality Health Services Standards – Second edition
- The National Framework for Advance Care Directives 2021
- National Palliative Standards for All Health Professionals and Aged Care Services 2022
- National Consensus Statement: Essential elements for safe and high-quality end-of-life care

International

- World Health Assembly Resolution 67.19 – Strengthening pf palliative care as a component of care throughout the life course.

Strategic Plan 2019-24
WA Country Health Service

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Appendix 9

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