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

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

Implementation Plan Two 2026–2028 (IP2)

health.wa.gov.au

Acknowledgement of Country and people

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

Using the term Aboriginal

Within Western Australia, the term Aboriginal is used in preference to Aboriginal and Torres Strait Islander, in recognition that Aboriginal people are the original inhabitants of Western Australia. 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.

Produced by the End-of-Life Care Program, WA Department of Health 2026

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Acknowledgements

The WA End-of-Life and Palliative Care Strategy Implementation Plan Two 2026-2028 (IP2) is the result of input from a significant number of individuals and organisations involved in the support and care of people in Western Australia living with a life-limiting illness. This includes consumers and carers, health professionals, researchers and representatives from health, community and aged care services, specialist and community palliative care services, primary care, government, non-government organisations and peak bodies.

We sincerely thank all the people involved in the consultation process that led to the development of IP2. We acknowledge the individual consumers, carers and health professionals who provided their own insights, either in respect to their lived experiences, or through caring for people and their families and carers.

We would also like to thank everybody who participated in the End-of-Life Care Collaborative Forum – A dignified end of life: Progress and Possibilities in June 2023, either in person or virtually to help inform the development of IP2.

End-of-Life Care Program, Department of Health Western Australia

Foreword

I am pleased to introduce the WA End-of-Life and Palliative Care Strategy Implementation Plan Two 2026–2028 (IP2) that reconfirms our commitment to placing people facing end-of-life, their families and carers at the centre of care. IP2 provides the WA health system and partnered services with an outline to guide the planning, delivery and evaluation of end-of-life and palliative care that aligns to the WA End-of-Life and Palliative Care Strategy 2018–2028 (the strategy).

IP2 reaffirms that delivering high quality, best practice end-of-life and palliative care requires collaboration between all sectors of the WA health system to ensure people receive individualised, coordinated and integrated care, and are supported to participate in decision-making about their care, in the setting they prefer, with the people they want beside them. IP2 builds on the recommended actions and outcomes from earlier years and recognises the significant changes that have taken place since the strategy was released including the implementation of voluntary assisted dying legislation. IP2 also aims to address current and future challenges for the sector, including an ageing population, increasing rates of dementia diagnoses and specialist palliative care workforce challenges.

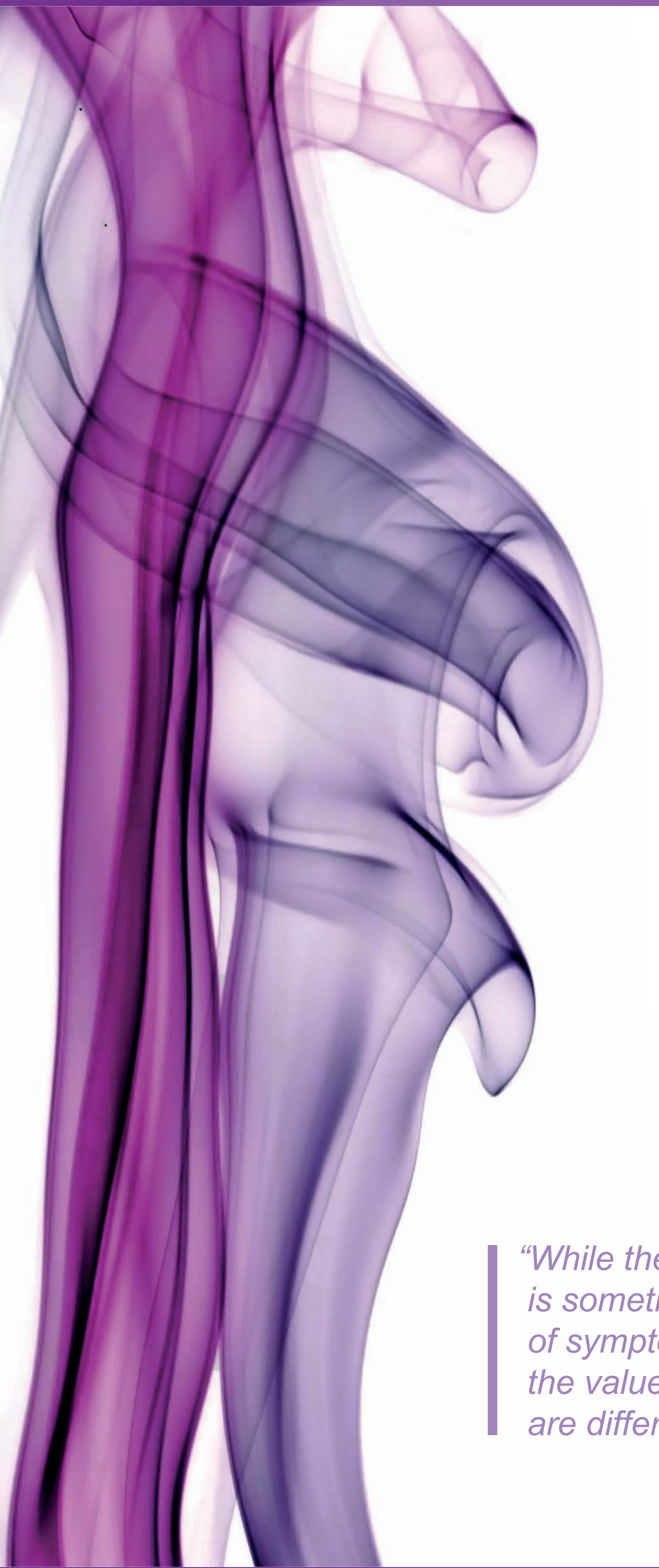
We are increasingly seeing the positive impact that advance care planning and goals of care conversations can have for the person, their family and their health care team. There is no 'right time' to have these sometimes difficult conversations, but we know that early conversations about death and dying between people, their family and their healthcare team result in care that is more aligned with the person's preferences. It is equally important that family members and carers have access to the information and support they need throughout the person's life, and after their death.

Everyone within the WA health system and its valued partners have a role to play in improving people's awareness of and access to end-of-life and palliative care. We must work together to ensure that people from vulnerable, marginalised and under-represented populations are not missing out on services they would benefit from.

I would like to acknowledge the contributions, time and expertise provided by individual staff, consumers, carers and representatives to inform the development of IP2. This engagement and collaboration ensures that we as a health system continue to strengthen end-of-life and palliative care through the strategy, implementation plans and supporting frameworks.

Dr Shirley Bowen

Director General
Department of Health Western Australia



> *"While the inevitability of death and dying is something that we all share, the impact of symptoms, the effects of treatment and the value we place on quality of life, are different for all of us."*

Executive summary

End-of-life and palliative care aims to improve the quality of life of people facing life-limiting illness, their families and carers, and help them to live and die well through the prevention and relief of suffering. The demand for end-of-life and palliative care in Western Australia is growing as the population ages and the number of people living with chronic, progressive conditions increases.

The WA End-of-Life and Palliative Care Strategy 2018–2028 (the strategy) provides a strategic statewide direction for end-of-life and palliative care and places people at the centre of their care. The strategy is supported by implementation plans that outline how the WA health system and partnered organisations can action the priorities the strategy sets out:

1. Care is accessible to everyone, everywhere
2. Care is person-centred
3. Care is coordinated
4. Families and carers are supported
5. All staff are prepared to care
6. The community is aware and able to care

Implementation Plan 2 2026-2028 (IP2) builds on Implementation Plan 1 2020–2022 and aligns with other statewide end-of-life and palliative care frameworks and pathways that were released since the strategy. IP2 was developed through a review of progress against Implementation Plan 1, consultation with key stakeholders via a collaborative forum and online survey, and informed by recommendations from contemporary reviews and reports.

IP2 reiterates that the WA health system must continue to strengthen the way it delivers end-of-life and palliative care to those who require it, and how it measures its benefits. This includes providing optimal access to end-of-life and palliative care services across the lifespan, ensuring priority populations are not disadvantaged in accessing care, and addressing emerging public health, health care and community issues. The community need access to information and support to enable them to participate in advance care planning and make informed decisions about end-of-life, including their end-of-life choices. This includes exploring access to voluntary assisted dying should they wish to do so.

Core to the success of the strategy and IP2 is the implementation and evaluation of local initiatives by end-of-life and palliative care stakeholders to support the building blocks and recommended actions. IP2 highlights some of the local initiatives presented at the collaborative forum, that reflect the priorities of the strategy, and demonstrate the commitment from stakeholders to make holistic, person-centred care a reality for people in WA. Health service providers, private service providers, specialist and community palliative care services, aged and community care, primary healthcare, peak bodies and the wider community all play an important role in ensuring that people, their families and carers have access to high-quality, evidence-based end-of-life and palliative care, support and services.

Overview

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

Implementation Plan Two 2026–2028 (IP2) outlines how the Western Australian health system and partnered organisations can action the priorities and building blocks of the WA End-of-Life and Palliative Care Strategy (2018–2028) (the strategy). IP2 builds on Implementation Plan One 2020–2022 (IP1) and aligns with other statewide end-of-life and palliative care frameworks and pathways released subsequent to the strategy.

The strategy provides the statewide direction for end-of-life and palliative care and recognises that people are at the centre of their care, and that their values, preferences and choices should drive the care and services they receive. Increasingly, people express a wish to be cared for and to die at home, however, this requires sufficient availability and capability of both informal and formal care and services, including specialist palliative care services when needed.

While the Department of Health's (the department) End-of-Life Care Program (EOLCP) is responsible for monitoring the strategy and IP2, and evaluating their impact on end-of-life and palliative care; policymakers, executives, health professionals, educators, researchers and the wider community all play a role in ensuring that people, their families and carers can access high-quality, evidence-based end-of-life and palliative care.

Terminology

The term 'palliative care' is referred to in this document as the concept or approach to care, not as the multidisciplinary specialty or service itself. The terms used in the strategy and implementation plans are outlined in the definitions section of this document. IP2 acknowledges that both generalist palliative care provided by health and aged care teams, and specialist palliative care services are vital to realising IP2 and achieving the outcomes of the strategy.

The changing landscape

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

The estimated need for palliative care in Australia is expected to grow faster than that of both the population and total deaths between 2019 and 2060.[4] Between 2022–23, there were 101,000 palliative care-related hospitalisations across Australia, a 37 per cent increase from 2015–16.[5] Figure 1 (below) highlights the key end-of-life and palliative care statistics in WA and nationally that inform IP2.

With more Australians' seeking treatments for complex chronic disease and care at end of life, there is a greater need for people to prepare for future health care decisions. Currently only 6 per cent of Australians have recorded their future treatment decisions and health care preferences, while 13 per cent have formally appointed a substitute decision maker.[6] In this context, the department recognises the continued importance of advance care planning and has increased resources available to people who wish to complete advance care planning documents, including Advance Health Directives. Health professionals in acute, community and residential aged care settings have a range of options to document advance care planning and goals of care discussions to ensure the person's values and preferences are known and the care provided aligns with their wishes.

Since the strategy and IP1 were published, the *Voluntary Assisted Dying Act 2019* came into effect and now provides eligible people in WA with an additional choice in their end-of-life care. Voluntary assisted dying (VAD) operates within a comprehensive legal framework and is overseen by robust governance and reporting. It also protects clinicians who have conscientious objections to VAD. Eligible people who access VAD in WA have progressive, life-limiting illnesses,[7] and VAD enables them to legally choose the manner and timing of their death. From 2024–2025, nearly 85 per cent of people requesting and found eligible to access VAD in WA had received palliative care,[7] highlighting VAD as an integrated component of end-of-life care for those who choose to access it.

Recent national aged care reform recognises older people living at home with life-limiting illnesses need additional support at the end-of-life, in addition to palliative care services they may be receiving. In November 2025, the End-of-Life Pathway commenced under the Australian Government's Support at Home program and is available to older people who are eligible for aged care services and assessed as having 3 months or less to live. While this may offer additional time-limited support for older people who wish to die at home, there will be implementation challenges that require action at a state level if it is to be a positive change for older people and their families.

The WA Health Workforce Strategy 2034 acknowledges the workforce challenges across the WA health system.[8] Implementing the recommended actions throughout this document requires recruitment and retention of experienced and knowledgeable specialist palliative care staff. Although generalist and specialist palliative care services in WA aim to provide high quality end-of-life and palliative care there must be a system-wide commitment to manage the increasing demand for services, respond to emerging trends in the sector and commit to strengthening the way end-of-life and palliative care are delivered for those who need it.

Figure 1: End-of-life and palliative care snapshot

Top 5 leading causes of death in Western Australia (2024)[1]

1. Dementia (including Alzheimer's disease)
2. Ischaemic heart diseases
3. Malignant neoplasm of trachea, bronchus and lung
4. Cerebrovascular diseases
5. Chronic lower respiratory diseases

Place of death for patients receiving palliative care in Western Australia (PCOC data 2025)[9]

60.2%	died in hospital or hospice
20.2%	died at home
16.5%	died at a residential aged care home
3.1%	not stated

Life expectancy in Western Australia[10]

Non-indigenous

81.2 years

84.3 years

Aboriginal and Torres Strait Islander

68.9 years

72.6 years

Access to palliative care

Number of Western Australians who have accessed palliative care in 2023–24[5]

- **9,512** palliative care-related hospitalisations
- **131,821** service events for non-admitted primary palliative care patients

Palliative care-related hospitalisations in Australia 2023–24[5]

Out of **107,500** palliative care-related hospitalisations in Australia:

- **3 in 5 (59%)** were for people aged 75 and over
- **1 in 10 (8.4%)** were for people aged under 55
- **3,100 (2.9%)** hospitalisations were for Aboriginal and Torres Strait Islander people

Top 3 sources of referral to palliative care services in Western Australia[9]

Inpatient

1. Public hospital
2. Community palliative care services
3. Private hospital

Community

1. Public hospital
2. General Practice
3. Specialist medical practice

Top 5 diagnoses of people accessing palliative care in Western Australia (PCOC data 2025)[9]

Malignant conditions

1. Lung
2. Gastrointestinal tract (other)
3. Colorectal / Pancreas
4. Prostate
5. Breast

Non-malignant conditions

1. Non-malignancy (other)
2. Respiratory failure
3. Dementia (other)
4. Cardiovascular disease
5. Alzheimer's dementia

Advance Care Planning in Australia[6]

33%

of Australian adults have undertaken a form of advance care planning

6%

of Australians have completed an Advanced Health Directive or equivalent document

13%

of Australians have formally appointed a substitute decision maker

Voluntary Assisted Dying in Western Australia[7]

Between July 2021 and June 2025, there have been:

2,816 first requests to access VAD

1,219 VAD deaths

Development of Implementation Plan Two

The EOLCP developed IP2 by considering the current policy context, reflecting on progress since the launch of the strategy in 2018 and IP1 in 2020 and identifying areas for improvement.

IP2 incorporates recommendations from reviews and reports published since the release of IP1, including the Independent review – Consumer perspectives of palliative care service models[11], key national and state strategies, frameworks and reviews, and WA health service end-of-life and palliative care strategies. Figure 2 provides an overview of IP2 alignment with national and state legislation, strategies and frameworks. Since IP1 was released there has been an increasing emphasis on the role of the community in end-of-life and palliative care, social approaches to dying, death and bereavement and the importance of supporting families and carers beyond a person's death.

The EOLCP hosted a forum in June 2023: End-of-Life Care Collaborative Forum – A dignified end of life: Progress and Possibilities, to identify key implementation priorities for IP2. More than 160 people attended the forum, including consumers, carers and health professionals along with researchers and representatives from health services, specialist and community palliative care services, residential aged care, primary and tertiary health care, government and peak bodies. The forum highlighted the work by health services and community organisations being undertaken to improve end-of-life and palliative care outcomes in line with the strategy's priorities, and these examples are included throughout IP2.

Further consultation was undertaken with a wide range of stakeholders in October 2025 using an online survey before the finalisation and launch of IP2 in 2026.

Figure 2: Strategic alignment of the WA End-of-Life and Palliative Care Strategy 2018–2028, IP1 and IP2

National

- Aged Care Diversity Framework (2017)
- National Palliative Care Strategy 2018 and Implementation Plan
- National Safety and Quality Health Service Standards – Second edition (updated 2021)
- National framework for advance care planning documents (2022) and National guidelines: using My Health Record to store and access advance care planning and goals of care documents (2021)
- National Consensus Statement: Essential elements for safe and high-quality end-of-life care (2023)
- National Palliative Care Standards for Specialist Palliative Care (2024) and for All Health Professionals and Aged Care Services (2022)
- National Dementia Action Plan 2024–2034
- The Paediatric Palliative Care National Action Plan (2022)
- Aged Care Act (2024)

Western Australian

- Guardianship and Administration Act 1990
- My Life, My Choice report of the Joint Select Committee on End of Life Choices (2018) (see Appendix 1)
- WA End-of-Life and Palliative Care Strategy 2018–2028 and Implementation Plan One 2020–2022
- East Metropolitan Health Service End-of-Life and Palliative Care Strategy Implementation plan (2019–2024)[12]
- Voluntary Assisted Dying Act 2019
- Ministerial Expert Panel on Advance Health Directives (2019)
- Sustainable Health Review (2019)
- Palliative Care in Western Australia – Progress Report of the Joint Select Committee on Palliative Care in Western Australia (2020)
- WA Health Digital Strategy 2020–2030
- Aboriginal End-of-Life and Palliative Care Framework (2021)
- Western Australian Paediatric Strategy for End-of-Life and Palliative Care 2021–2028 and Optimal Paediatric Palliative Care Pathway (2021)
- End-of-Life and Palliative Care for People with Dementia Framework (2021)
- WA Country Health Service Palliative and End-of-Life Care Strategy (2024–2028)
- Review of the Voluntary Assisted Dying Act 2019 (2024)
- WA Health Workforce Strategy 2034
- Framework for bereavement support after an expected death in WA (2025)

Caring for people with diverse needs and priority populations

An essential part of delivering high quality, holistic person-centred care is understanding the unique experiences and diverse needs of people receiving end-of-life and palliative care, and their families and carers.[13]

People from priority populations are more likely to have complex needs, exposure to psychological trauma, experience higher levels of unmet healthcare needs and adversity in health outcomes compared to the general population. This extends to end-of-life and palliative care outcomes.[14] People from priority populations also face barriers and challenges in accessing health care and other community services.

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

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

People from priority populations may also experience intersectionality. Intersectionality describes how different aspects of a person's identity, such as gender, sexual orientation, ethnicity or socio-economic status, can expose them to overlapping forms of discrimination and marginalisation.[15] It is important that intersectionality is considered when providing end-of-life and palliative care to priority populations.

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

> *"Palliative care is so important and when you've had good palliative care it makes a huge difference to your experience. But it's not just the patient... the family cope better when there's a palliative care team involved."*

Independent review – Consumer perspectives of palliative care service models[11]

How to use Implementation Plan Two

Realising the outcomes in the strategy requires all stakeholders in all sectors across WA to work towards IP2 when planning, delivering and evaluating end-of-life and palliative care in WA.

The EOLCP is responsible for monitoring the strategy and IP2, and evaluating their impact on end-of-life and palliative care. It will use IP2 to:

- promote collaboration amongst key stakeholders and the community to implement the actions
- influence statewide policy and inform procurement and contracting of aligned projects and initiatives
- advocate for additional workforce where there is need and help inform clinical service planning.

Health service providers (HSPs) continue to fund and deliver specialist palliative care services across the WA health system to meet the needs of their patients and communities and can use IP2 to:

- inform their own strategies and implementation plans
- inform their specialist palliative care service provision and workforce development
- guide service redesign and quality improvement initiatives.

Specialist palliative care services and associated non-government organisations (NGOs), aged care and community providers can use IP2 to:

- align services and improvement initiatives relevant to their community and patient needs to achieve the priority outcomes and recommended actions.
- Complete the action plan template in Appendix 2 if suitable.

Policy makers are encouraged to use the strategy and IP2 to inform, complement and support related statewide service models and frameworks, for example, the WA Kidney Supportive Care model of service (in development) and the WA State Dementia Action Plan (in development).

Priority 1

Care is accessible to everyone, everywhere

> *“We are so fortunate to have [the] support and care from a palliative [care] nurse in [our] region.”*[16]

Consumer experience

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

Strategy building blocks

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

Outcomes

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

Recommended actions	Stakeholder(s)
Service provision • Support projects, pathways and services that allow people who want to, to remain at home while receiving palliative care services. • Provide information to palliative care services about the End-of-Life Pathway available under the Support at Home program for eligible older people who are receiving care at home, and monitor the Pathway's implementation locally. • Monitor the occupancy of and demand for inpatient palliative care beds and hospices in WA and respond to emerging gaps in coverage. • Promote timely access to palliative care medications across all care settings. • Promote the use of tools within non-specialist services to help identify people with deteriorating health who would benefit from a palliative care approach, earlier access to specialist palliative care, goals of patient care discussions and/or end-of-life interventions.	EOLCP, Department of Health
• Improve access to timely specialist palliative care services by: - having systems in place that support early and consistent identification of palliative care needs - supporting earlier referrals to community-based and hospital-based specialist palliative care where appropriate - supporting options for self-referral - understanding and addressing barriers to access - designing welcoming environments and models of care to support priority populations. • Encourage and support increased provision of palliative care by primary care providers, including those visiting RACHs. • Continue to use existing technology to improve access to palliative care services, particularly in regional WA. • Support equitable access to VAD for those who want it, regardless of place of care. • Align access to VAD with the Access Standard,[17] which includes how the state intends to facilitate access to VAD for regional residents.	All stakeholders

Recommended actions	Stakeholder(s)
Service models • Scope, review and collaborate with existing services for people who are homeless or at risk of homelessness to improve palliative care provision. • Collaborate with the Older Adult Community Integrated Care Hubs that connect older adults to services, supports and resources in the community, to support palliative care engagement and integration. • Promote and support the inclusion of end-of-life and palliative care in models of care for people with life-limiting illnesses.	EOLCP, Department of Health
• Seek to improve current end-of-life and palliative care service models to respond to changing and increasing demand, emerging issues and service delivery gaps. • Continue to collaborate with community, consumers and carers to inform service model planning and reviews.	All stakeholders
Care coordination • Integrate palliative care into formal care pathways for those with advancing life-limiting illness to encourage timely access and avoid crisis referrals. • Promote and support early referral to Aboriginal Health Liaison Officers, Aboriginal Health Practitioners and qualified interpreters where available and appropriate, to improve access and support the provision of culturally appropriate palliative care.	HSPs, health, aged care and community services
Bereavement • Refer to the service considerations for Priority 1 in the Framework for bereavement support after an expected death in WA.[18]	All stakeholders

Recommended actions	Stakeholder(s)
Workforce • Promote consistent messaging across sectors to build health professionals' understanding of the benefits of providing early information about, and referrals to palliative care. • Advocate for specialist palliative care workforce that can meet the increasing demand for services in WA and respond to future projected demand, including offering bereavement support and support for those who wish to explore access to VAD. • Support access to VAD by: - reducing administrative and logistical obstacles for practitioners accessing the WA VAD Approved Training - Developing education materials to increase health professionals' understanding of VAD, the referral process and their professional obligations following a first request. • Support initiatives that allow health professionals to work to the full scope of their practice.	EOLCP, Department of Health
• Develop and support Aboriginal Health Liaison Officer and Aboriginal Health Practitioner roles that specialise in end-of-life and palliative care and ensure their availability in a range of healthcare settings.	EOLCP, Department of Health, HSPs

Recommended measures

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

Service provision

- Collection and analysis of available state-level data related to accessing palliative care and supporting services, and referrals to specialist palliative care by location and priority group.
- Examples of how the experience of people receiving palliative care, particularly priority populations, is informing service provision planning, delivery and review.
- Increasing numbers of people remaining at home while receiving palliative care services.
- Analysis of available state-level data on use of the End-of-Life Pathway under Support at Home Program.
- Projects and initiatives that demonstrate support for primary care practitioners in providing quality palliative care.
- Increased use of new and existing technology to improve access to palliative care in WA.
- Better use of clinical indicators and assessment tools to support earlier referrals.
- Increased number of pharmacies stocking National Core Community Palliative Care Medicines List medicines.

Care coordination

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

Workforce

- Enhanced specialist palliative care workforce across the state, including specialist allied health professionals.
- Increased number of VAD practitioners available throughout the state.
- Increased understanding of the VAD referral process by health professionals.
- Increased number of Aboriginal Health Liaison Officers and Aboriginal Health Practitioners specialising in end-of-life and palliative care.
- Examples of successful expanded scope of practice initiatives being implemented in end-of-life and palliative care sectors.

Priority 1 in action

WA Country Health Service Aboriginal palliative care workforce

WA Country Health Service (WACHS) Palliative Care Program established specialist positions to support local and culturally safe palliative care for Aboriginal people. These roles included a State Coordinator Aboriginal Health Worker and Aboriginal Health Liaison Officers. Since the establishment of these roles, there are:

- increased referrals for Aboriginal people due to better awareness, acceptance, cultural safety and navigation assistance
- increased support and advocacy for the voice of Aboriginal people and their wishes for their end-of-life journey
- strengthened collaboration with multidisciplinary teams (MDT) and external stakeholders for shared community care
- more opportunities to demystify cultural barriers, myths and beliefs by sharing two-way clinical yarning and culturally appropriate resources
- development of palliative care resources that honour Aboriginal cultural values, traditions, and spiritual beliefs surrounding end-of-life care and bereavement.

WA Country Health Service Palliative Care Afterhours Telehealth initiatives

Since 2022, access to care is transforming across all WACHS regions through expansion of specialist palliative care teams coupled with digital enablement including PalCATS (after-hours telehealth nursing), PalDOCS (after-hours medical support) and Tele-Palliative Care in the Home, ensuring palliative care patients and families in regional areas are continuously supported. Digital enablement is also facilitating in-reach of specialist palliative care services into private RACHs and WACHS aged care homes (multi-purpose service sites). The services have helped identify people with palliative care needs not already known to specialist palliative care services.

The Telehealth initiatives are making care accessible by connecting patients / residents, families, carers and healthcare professionals with senior palliative care nurses and doctors, via video consultation after hours, offering clinical advice, psychosocial support, and upskilling of healthcare providers to ensure people receive the right care, at the right time, in the setting of their choice. These initiatives can reduce the likelihood of people being transferred away from their home and community while receiving specialist services, and at the end-of-life.

Voluntary Assisted Dying Statewide Care Navigator Service

The VAD Statewide Care Navigator Service (SWCNS) plays a critical role in supporting people across WA with the option to explore VAD as an end-of-life choice. The SWCNS was established in 2021 and supports anyone involved with VAD in WA, including people wishing to access VAD, their families and carers, members of the community, health professionals and service providers.

The SWCNS has supported over 4,000 new referrals and assisted over 2,900 people and their support networks to explore VAD across every region of WA through patient-driven, person-centred care. The service provides face-to-face care where needed for the person, their family, carers and supporting health professionals, wherever they are in WA with 33 per cent of new referrals arising from regional areas.

The SWCNS helps operationalise the Access Standard and manages the Regional Access Support Scheme (RASS). The scheme primarily supports travel of a trained VAD practitioner to a patient where there is no local provider available and supports regional practitioners to complete the WA VAD Approved Training and deliver this care in their local communities promoting greater awareness and regional capacity to provide timely care. There have been 605 requests to utilise the RASS, with 365 patients receiving care from practitioners willing to travel to them. The SWCNS works closely with health professionals and helped establish and support a network of VAD practitioners across every region of WA.

Priority 2

Care is person-centred

"Mum's death and dying was... exactly as she wanted it to be."[19]

Consumer experience

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

Strategy building blocks

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

Outcomes

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

Recommended actions	Stakeholders
Service models and provision • Continue to promote tools and resources for health professionals that support holistic, person-centred assessment and care planning, including integration of VAD. • Support service models and pathways that facilitate high quality, holistic, person-centred palliative care including for those people who wish to access VAD. • Promote services, service models and pathways that facilitate effective advance care planning conversations and completion of documents: - earlier in a person’s illness, particularly for people diagnosed with dementia - in home or community settings where practical - at appropriate times, preferably when the person is medically stable and comfortable.	EOLCP, Department of Health
• Incorporate consumer perspectives on end-of-life and palliative care service delivery into service improvements. • Continue to use and improve digital solutions to store and share goals of care and advance care planning documents across all care settings and services in real time, so information about people’s preferences for care is readily available. • Promote the use of My Health Record to the community as an option to store advance care planning documents. • Audit advance care planning processes, documentation and alignment of a person’s end-of-life preferences for care with actual care.	EOLCP, Department of Health, HSPs, health and aged care services, NGOs
Education • Continue to fund and support training and education initiatives that will help all health professionals, care workers and volunteers to deliver holistic, person-centred care.	EOLCP

Recommended actions	Stakeholders
• Facilitate access to education and training for all health professionals, care workers and volunteers that will support the delivery of holistic, person-centred care. • Provide education and training opportunities to strengthen health professionals' communication skills that will support effective end-of-life choices, goals of care and advance care planning discussions, including supported decision-making.	HSPs, health and aged care services, NGOs
Bereavement • Refer to the service considerations for Priority 2 in the Framework for bereavement support after an expected death in WA.	All stakeholders

Recommended measures What will we have that we don't have now? What will it look like?
Service models and provision • Increased completion rates of advance care planning and goals of care documents. • Increased digital storage and sharing of advance care planning documents within state and national digital platforms. • Improved compliance with filing of Advance Health Directive documents in health records across WA Health. • Increased use of person-centred, holistic assessment and care planning tools by health professionals. • High levels of patient and carer satisfaction with end-of-life care regardless of place of care or death.

Priority 2 in action

Patient experience – little things make a big difference

Murdoch Community Hospice has implemented a range of initiatives to support person-centred care. These initiatives include:

- foldaway beds in each room for family members to stay overnight with their loved one
- a flat that can be used by any out-of-area families
- an outdoor area with BBQ and children's play facilities that the person and their families are encouraged to use for get-togethers or parties
- outdoor gardens for wandering and spending time together
- meals for patients and boarders with a menu offering nutritious meals that can be ordered at a time that is suitable
- availability of two cuddle beds that can enable both the person and family member to be able to lie together and experience close physical contact and reduce the sense of loneliness and isolation.

For the wellbeing of patients and their families, there is a music therapist who provides music and songs, improving mood and reducing stress and anxiety. Every Friday afternoon is happy hour where the patients can have an alcoholic drink, approved by the doctor. Patients and their families through the day centre “Footprints” can access complementary therapies, companionship, art therapy and assistance in making memory boxes for their loved ones.

The Thrive Council is a peer-nominated group of caregivers who implement new initiatives to improve patient safety and their experiences.

Advance care planning support service

The Advance Care Planning Support Service (ACPSS) run by Palliative Care WA has been funded by the WA Department of Health since January 2025.

The service offers a range of support options for WA community members, including:

- Advance Health Directive document support workshops
- One on one support to complete ACP documents at offices around Perth
- One on one support at home (referral required)
- One on one support by online methods or telephone.

In the 5 months from 1 February 2025 to 30 June 2025, a total of 258 people were helped by the ACPSS.

In that time, the service has been very well received. One participant said:

> *“I am secure in the knowledge that the people close to me and caring for me, know my wishes in the event that I cannot make those decisions for myself.”*

Another commented:

> *“The at-home help gently guided me to accurately complete the Advance Health Directive, and I now feel confident about my advanced care.”*

Priority 3

Care is coordinated

> *"The GP was amazing at liaison and remained constantly in touch and available for advice, visits and assistance, even when [a community service] took over."*[11]

Consumer experience

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

Strategy building blocks

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

Outcomes

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

Recommended actions	Stakeholders
Care coordination • Continue to improve care coordination and transition between services, through collaboration between specialist palliative care services, non-specialist health services, WA Health virtual services, primary care, allied health, community and aged care including facilitating multidisciplinary (MDT) meetings, discharge planning meetings and case conferencing. • Promote the involvement of primary care in the planning and coordination of palliative care, supported by use of relevant Medicare Benefits Schedule items. • Improve communication and collaboration between specialist palliative care, aged care and community sectors to support coordinated care for older adults, including integration with Older Adult Community Integrated Care Hubs. • Consistent storing and sharing of documents, including advance care planning via digital platforms to improve continuity of care. • Facilitate timely sharing of clinical information with VAD practitioners with the person’s consent, and timely access to assessment, following a request to access VAD, regardless of place of care. • Support young adults and their families to transition safely and smoothly from paediatric to adult services. • Teams / individuals involved in the care of the person and their family have access to up-to-date specialist palliative care service delivery information and other supporting information about palliative and end-of-life care.	All stakeholders
Service models • Review models of care navigation used in other jurisdictions and specialities to determine potential benefits for WA. • Further develop pathways in all care settings that improve continuity of care between virtual healthcare initiatives and specialist palliative care services to support emergency department and hospital avoidance.	EOLCP

Recommended actions	Stakeholders
• Continue to explore alternative models of service, such as those that make use of technology, to improve coordinated care, particularly for those living in regional WA. • Establish and adhere to local policies, processes and statewide guidance for correct identification and storage of advance care planning documents to allow ease of retrieval by all health professionals when required.	HSPs, health and aged care services
Bereavement • Refer to the service considerations for Priority 3 in the Framework for bereavement support after an expected death in WA.	All stakeholders

Recommended measures What will we have that we don't have now? What will it look like?
Care coordination • Evidence of increased collaboration between specialist palliative care services, primary care and other health professionals (for example, increased MDT meetings and case conferences). • Increase in claims against relevant palliative care Medicare Benefits Schedule item numbers. • Increased satisfaction and/or experience measures of children and their families transitioning from paediatric to adult services.
Service models • Increased availability of alternative models of service, such as telehealth and e-prescriptions, to support coordinated care. • Increased number of palliative care patients accessing virtual healthcare initiatives. • Documented processes and pathways for bereavement services depending on level of care required. • Increased awareness of and compliance with relevant local policies and statewide guidance for identifying and storing advance care planning documents. • Ongoing collection and review of data on number of people accessing VAD within services.

Priority 3 in action

WA Primary Health Alliance Case Coordinator project

The WA Primary Health Alliance (WAPHA) established the Case Coordinator project in 2023 that aims to optimise the primary care and end-of-life care coordination for people living in metropolitan RACHs. Through funding from the National Partnership Agreement for Comprehensive Palliative Care in Aged Care, WAPHA commissions aged care organisations to employ dedicated registered nurse Case Coordinators onsite.

The role of the Case Coordinator is to:

- optimise RACH staff capability to deliver quality palliative care with a focus on recognising and responding to deterioration
- develop systems and processes to ensure primary and palliative care coordination between general practice and RACHs that is effective and sustainable.
- optimise RACH staff capability to coordinate case conferencing aided by the promotion of Medicare Benefits Schedule guidance.

This project was successfully piloted in 2023-24 and demonstrated:

- optimised identification and management of unmet palliative care needs using the Palliative Care Outcomes Collaboration program
- optimised case coordination and referral processes to specialist palliative care services
- improved uptake of advanced care planning processes
- a reduction in the number of resident transfers to hospital that did not require admission.

The project continues into 2026.

WACHS Residential Goals of Care in RACHs

WACHS was funded by the Department of Health to develop and trial a goals of care document, similar to the form used in acute hospitals, that was appropriate for use with older people living in RACHs. The resulting Residential Goals of Care (RGoC) form is designed to support shared decision-making between health professionals, residents and their families to establish ceilings of care and goals of care in the context of end-of-life.

WACHS aged care staff were supportive of the initiative as a way to improve person-centred care at end-of-life and adopted the RGoC form to sit alongside other ACP documents for their residents to provide supplementary information. One of the clear benefits of the RGoC form is the ability to integrate the form into ACP processes in RACHs, as it can be used to complement ACP documents or to record a resident's wishes when they no longer have capacity to complete ACP documents. The RGoC form continues to be implemented statewide with the support of the Department of Health.

Priority 4

Families and carers are supported

> *"The service enabled us to care for Dad all the way through, at home, even helping us to care for his body after he passed away."*[11]

Consumer experience

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

Strategy building blocks

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

Outcomes

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

Recommended actions	Stakeholders
Education • Provide information about VAD for families and carers including: - guidance on accessing VAD and supporting a loved one throughout the process, including bereavement care - clear information on the responsibilities and role of the appointed contact person. • Support and promote new education, training and resources that will benefit families and carers from priority populations.	EOLCP
• Promote resources, services and education to support families and carers to care for a person receiving end-of-life and palliative care. • Develop new resources, services and education sessions that will support families and carers from priority populations.	HSPs, health, aged care and community services, NGOs
Care coordination • Families and carers are supported to attend family meetings, case conferences and MDT meetings when appropriate.	HSPs, health and aged care services
Service models and provision • Information about end-of-life and palliative care for families and carers is accessible and easy to locate from the point of diagnosis of a life-limiting illness. • Promote tools and resources for health professionals that identify the needs of families and carers. • Advocate for increased access to social workers in community palliative care services.	EOLCP
• Develop and strengthen care pathways to facilitate access to psychosocial, respite and bereavement support for families and carers and support options for self-referral.	All stakeholders

Recommended actions	Stakeholders
• Explore new approaches to support families and carers, such as Compassionate Communities and other community-based volunteer programs, that aim to reduce carer burnout. • Provide opportunities for families and carers to be involved in the development and review of services and resources.	All stakeholders (cont.)
Bereavement Refer to the service considerations for Priority 4 in the Framework for bereavement support after an expected death in WA.	All stakeholders

Recommended measures

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

Education

- New resources, information and education sessions for families and carers on palliative care and end-of-life care, advance care planning and bereavement.
- Number of new resources, information and education sessions developed for / with priority populations
- Increased advice and support for bereaved families and carers.
- Increased information available for families and carers of people accessing VAD.

Service provision and models

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

Priority 4 in action

Kalamunda Day Hospice

(Part of the East Metropolitan Health Service)

At Kalamunda Hospital, the Day Hospice offers a supportive, community-focused space for people with a life-limiting illness who are receiving palliative care at home. Operating 3 days a week, the service provides meaningful activities, social connection and specialised care that helps hospice attendees reconnect with community and regain a sense of participation in everyday life. It also helps their carers by giving them a break.

The Day Hospice opened in 2022 and is a free service. The service is staffed by a multidisciplinary team of nurses, allied health professionals and dedicated volunteers.

The program is designed to support people's physical, emotional, social and spiritual wellbeing while also offering practical education, guidance and respite for families and carers. Staff work closely with participants to help them stay involved, build confidence and connect with the agencies that can best support them.

The service also provides education about advance care planning, helping individuals and their loved ones understand their options, communicate their wishes and ensure their preferences are respected throughout their end-of-life journey.

This video provides the patient perspective of the Day Hospice.

Child and Adolescent Health Service

CAHS is expanding the practical advice and support available to newly bereaved families in WA with the appointment of a Bereavement Coordinator based at Perth Children's Hospital. Bereavement support is important because it validates feelings and normalises the grief process. It helps families develop coping strategies and provides practical guidance. The key initiatives are:

- Bereavement bags for parent/carers and siblings. The service has created information bags that contain resources about understanding grief, understanding how grief impacts children, parenting other children while grieving and where to go for support in WA. The sibling bags contain activities to help children remember their sibling, learn how to understand their grief, story books and grief journals.
- Peer parent mentor support for newly bereaved parents/carers. Bereaved parents and carers can receive training and supervision to become mentors for newly bereaved parents. The mentors provide a unique connection and understanding to newly bereaved mothers and fathers as they have also experienced the death of a child.
- Directory of WA support services for grief and bereavement. A directory is available with information and contact details of community support groups across WA that can assist families after the death of a child.

- Community network. The bereavement coordinator has facilitated the development of a WA Community Network of service providers who support families after the death of a child. There are currently 18 members who meet on a regular basis to understand what support is currently available to support grieving WA families, identify gaps in services and explore ways to provide responsive grief and bereavement services. This collaboration is also important to ensure a smooth transition for families from the Hospital to community services.

Priority 5

All staff are prepared to care

> *"We couldn't fault the staff in their care for Mum in the last 48 hours [of her life], or with my sister and I in supporting our emotional needs."*[19]

Consumer experience

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

Strategy building blocks

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

Outcomes

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

Recommended actions	Stakeholders
Education • Review the End-of-Life and Palliative Care Education and Training Framework to ensure it is contemporary and inclusive of end-of-life options and priority populations. • Provide up to date education and training resources to services and organisations about end-of-life, palliative care, advance care planning and VAD. • Ensure education, training and resources are available to support quality end-of-life and palliative care for people from priority populations and staff from services that support them (e.g. community workers, interpreters). • Continue to engage with and support initiatives in RACHs and aged care services to increase: - knowledge, preparation and use of advance care planning and goals of care - workforce capability through training, education and mentoring.	EOLCP

Recommended actions	Stakeholders
• Provide education and training in line with the End-of-Life and Palliative Care Education and Training Framework for all staff who care for people with end-of-life and palliative care needs. • Promote interdisciplinary education opportunities that can improve care coordination across different disciplines, services and settings. • Provide education to medical practitioners that will help them to identify when a person is approaching end-of-life, discuss their end-of-life care options and support appropriate referrals to specialist palliative care. • Provide education to health professionals on their rights and obligations in relation to VAD. • Provide education, training and resources that are: - available in flexible modes of delivery and various formats that will accommodate the diversity of the health, community and aged care workforce - relevant to current and emerging issues - reflective of evidence-based practice and current legislation - supportive of holistic, person-centred care - subject to evaluation and continuous improvement.	All stakeholders
Bereavement • Refer to the service considerations for Priority 5 in the Framework for bereavement support after an expected death in WA.	All stakeholders

Recommended actions	Stakeholders
Workforce • Explore and support initiatives that aim to increase the palliative care workforce and strengthen its capability, including: - strategies to attract and retain workers - professional development and training opportunities - initiatives to support the workforce's wellbeing and self-care. • Develop an evidence base for specialist palliative care workforce modelling and planning that can inform clinical planning and can advocate for: - sustainable funding for palliative care registrar training positions across public, private and community sectors - advanced practice allied health roles in palliative care, including pharmacists - bereavement support as a part of specialist palliative care staffing models and / or as a recognised part of the clinical workload.	EOLCP, Department of Health
• Continue to identify and support clinical palliative care champions across all settings. • Staff are supported to attend and complete education and training activities that will upskill them in end-of-life and palliative care. • Advocate for inclusion of end-of-life and palliative care training in inductions for health professionals.	HSPs, health and aged care services

Recommended measures

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

Education

- Available education, training and resources align with the End-of-Life and Palliative Care Education and Training Framework.
- Increased numbers of health professionals, volunteers and care workers participating in education and training in end-of-life and palliative care.
- Number of new models of education and training sessions piloted and evaluated, and how many primarily relate to priority populations.
- Evaluation of education and training activities, and evidence of ongoing improvements.

Workforce

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

Priority 5 in action

Clinical deterioration education

The Residential Care Line (RCL) developed an education package on clinical deterioration for RACH staff which has helped to improve their assessment skills and empowered them to recognise clinical deterioration in residents. To date 3,201 clinical staff across 294 RACHs (including country RACHs) have been provided with education between September 2022 and June 2025. In addition, a focus on assessing frailty using the Rockwood Frailty Scale tool has been incorporated into everyday business in the RCL service. This has helped to prompt immediate discussions with RACH staff about ACP. Most importantly, RCL forums included collaboration with other community-based palliative services.

In the same period, RCL identified 108 service events that required end-of-life discussions, 95 service events that required ACP discussions and 219 occasions where RCL requested or referred directly to community-based specialist palliative care services. The RCL syringe driver loan scheme has also been used in 135 episodes, provided alongside education at the bedside.

WA End-of-Life and Palliative Care Education and Training Framework and CareSearch

The EOLCP collaborated with CareSearch to develop an interactive end-of-life and palliative care education and training framework for WA.

The digital resource is designed specifically to support WA health professionals and other staff who care for people at the end of their life and / or who are referred to specialist palliative care services. This includes health professionals and other staff working in primary care, hospital, community and aged care services.

The interactive framework builds on the End-of-Life and Palliative Care Education and Training Framework launched in 2022.

Health professionals can use the interactive framework to:

- identify their learning needs
- create an interactive personal learning matrix and learning plan
- explore learning pathways tailored to their profession and workplace setting
- easily access relevant WA Health end-of-life and palliative care guides and resources.

Priority 6

The community is aware and able to care

> *“(It was most helpful when) friends and neighbours just dropped by to help normalise my life after spending over 3 weeks in hospital.”*[11]

Consumer experience

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

Strategy building blocks

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

Outcomes

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

Recommended actions	Stakeholders
Education • Deliver and support initiatives that increase public awareness of: - death literacy, grief and bereavement - end-of-life, palliative care and associated services - advance care planning and goals of care documents - VAD as an end-of-life choice. • Provide up to date end-of-life, palliative care and advance care planning consumer resources. • Promote consistent messaging and language for end-of-life, palliative care, advance care planning and VAD across all sectors.	EOLCP, Department of Health
• Explore new approaches to support priority populations, including developing new resources and education sessions, in partnership with community groups. • Develop new resources and education sessions informed by consumers, families and carers.	All stakeholders
Partnerships • Support services that increase the community's participation in advance care planning conversations and the completion of documents. • Promote a public health palliative care approach, supporting community initiatives that integrate social approaches to dying, death and bereavement.	EOLCP, Department of Health
• Strengthen relationships with community organisations, including those in regional WA, to increase awareness of end-of-life, palliative care and advance care planning.	All stakeholders
Bereavement • Refer to the service considerations for Priority 6 in the Framework for bereavement support after an expected death in WA.	All stakeholders

Recommended measures

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

Education

- Increased public awareness of:
    - death literacy, grief and bereavement
    - end-of-life, palliative care and VAD and associated services
    - advance care planning and goals of care documents.
- Evidence of consumers, families and carers informing the development of new resources and education sessions.
- Evaluate the usefulness and effectiveness of end-of-life and palliative care resources.

Partnerships

- Strengthened relationships with community organisations and peak bodies for people living with a life-limiting illness.
- Increased awareness and support for the Compassionate Communities model and other community-based initiatives.

Priority 6 in action

Compassionate Communities

From 2022 to 2024, the Department of Health funded several local governments across WA to implement a range of activities to support the Compassionate Communities initiative.

South West: The South West Compassionate Communities Network partnered with the City of Bunbury to develop a Compassionate Bunbury Charter. The charter was endorsed by the City of Bunbury in June 2023, recognising that local government, individuals, families, neighbourhoods, workplaces, schools, community, faith based, voluntary and other organisations and services all play a part in talking about death, dying and illness and providing compassionate support throughout ill health, during death and in bereavement. The charter is accompanied by a toolkit which outlines practical actions that can be undertaken individually and collectively.

The City of Bunbury is the custodian, or holder of the charter, on behalf of the community. The charter has led to a number of initiatives including the development of educational material (for example, Be a compassionate friend in time of need); a compassionate workplace initiative supported by the South West Development Commission and the Bunbury Geographe Chamber of Commerce and Industry; and the Compassionate Bunbury Mayoral Awards which are presented by the Mayor each year on World Compassionate Communities Day (1 November).

Kalamunda: Kalamunda Compassionate Communities is about creating compassionate and caring neighbourhoods who support each other to help build strong, connected and happy communities to live, play and die in. One of the Community's first initiatives was the 3-month artist in residency at the Kalamunda Hospital's Palliative Care Unit, where the artist recorded people's stories and portrayed them as the person they were, a wonderful legacy and memory not just for the families but for the people portrayed before they passed.

A more recent initiative was the Legacy Lantern Ceremony, first held in 2024 and again in 2025. As the sun set, lanterns were released, carrying hopes and memories across the water. The gentle sound of a harpist created an atmosphere of peace and reflection as the lanterns drifted together into the night. The video can be found here: Legacy Lantern Ceremony 2025.

A committed team of volunteers will guide Kalamunda Compassionate Communities into the future. In partnership with the Perron Institute and Compassionate Communities Australia, and with support from a Lotterywest grant, a citizen activation training program and an online resource hub will be developed. These tools will be made available to organisations across Western Australia, empowering them to establish their own Compassionate Connector programs and nurture more caring, connected communities.

Stirling: The City of Stirling established the Leave a Legacy project, and ran workshops to support the community to embrace a Compassionate Communities approach to caring, ageing, dying and grieving. The workshops targeted specific community groups, including men, volunteers, older people groups (seniors / autumn clubs) Aboriginal and culturally and linguistically diverse people. The workshops focussed on different topics including support for carers, understanding grief and advance care planning.

The City partnered with specialist providers such as Palliative Care WA, Act Belong Commit and the Grief Centre of Western Australia to conduct workshops and are also embedding Compassionate Communities into its Age Friendly Strategy.

Advance care planning community education workshops

During the 2024–25 financial year, Palliative Care WA has delivered 111 in-person or online community education workshops on advance care planning (ACP) and palliative care to 2,533 participants across WA.

These free ‘My Future Care’ workshops aim to encourage ACP conversations, increase engagement in the process and improve palliative care and death literacy within WA communities.

Some of the workshops are ‘safe space’ workshops that cater specifically for people with a chronic condition or terminal illness or for their family or friends who care for them. This approach allows people in vulnerable situations to feel more comfortable sharing questions and concerns with those in similar circumstances.

Workshops are delivered in metropolitan Perth as well as selected regional areas and are delivered in a variety of venues from community centres to aged care villages. They are delivered to several priority groups, including people with culturally and linguistically diverse backgrounds, people experiencing cognitive decline, people with disabilities, Aboriginal people, people living with life-limiting conditions such as cancer and motor neurone disease, and the LGBTIQA+ community and carers.

Positive feedback has included:

> *“The workshop has given me confidence to go ahead with my older age planning.”*
>
> *“A wonderful, heartful and engaging workshop, well delivered and with a real respect for everyone present.”*

References

1. Australian Bureau of Statistics. Causes of death, Australia Canberra (AU) 2024. [Internet] [cited November 2025]. Available from: https://www.abs.gov.au/statistics/health/causes-death/causes-death-australia/latest-release#australia-s-leading-causes-of-death
2. Rand J FT, Redwood L, Draper K, Hartati A, Kaltner M, Mastroianni F, Beric E, McPherson A, Pidgeon T, Auret K, Clark C, Yates P and Clapham S. National Overview of Patient Outcomes in Australia. Wollongong (NSW): Palliative Care Outcomes Collaboration, Faculty of Science, Medicine and Health, University of Wollongong; 2025 [cited August 2025]. Available from: https://www.uow.edu.au/australasian-health-outcomes-consortium/pcoc/reports/.
3. Australian Institute of Health and Welfare. Dementia in Australia. Canberra: Australian Institute of Health and Welfare, 2024. [Internet] [cited September 2025]. Available from: https://www.aihw.gov.au/reports/dementia/dementia-in-aus/contents/population-health-impacts-of-dementia/prevalence-of-dementia.
4. Palliative Care Australia and KPMG. Investing to save: The economics of increased investment in palliative care in Australia. Canberra (AU): Palliative Care Australia and KPMG; 2020 [cited August 2025]. Available from: https://palliativecare.org.au/publication/kpmg-palliativecare-economic-report/.
5. Australian Institute of Health and Welfare. Palliative care services in Australia. Canberra (AU): Australian Institute of Health and Welfare; 2025. [Internet] [cited August 2025]. Available from: https://www.aihw.gov.au/reports/palliative-care-services/palliative-care-services-in-australia/contents/admitted-patient-palliative-care/distribution-palliative-care-hospitalisations.
6. Advance Care Planning Australia. Advance care planning prevalence in Australia 2025. Melbourne (AU): Advance Care Planning Australia; 2025 [Internet] [cited November 2025]. Available from: https://www.advancecareplanning.org.au/
7. Voluntary Assisted Dying Board Western Australia. Voluntary Assisted Dying Board Annual Reports. Perth, Western Australia: Department of Health; 2025 [cited November 2025]. Available from: https://www.health.wa.gov.au/Reports-and-publications/Voluntary-Assisted-Dying-Board-Annual-Report.
8. Department of Health Western Australia. WA Health Workforce Strategy 2034. Department of Health; 2024 [cited November 2025]. Available from: https://www.health.wa.gov.au/~/media/Corp/Documents/Reports-and-publications/workforce-strategy-2034/workforce-strategy-2034.pdf.
9. Auret K, Clapham S, Draper K, Futcher T, Pidgeon T and Rand J. Patient Outcomes in Palliative Care – Western Australia State report, January to June 2025. Palliative Care Outcomes Collaboration, Faculty of Science, Medicine and Health, University of Wollongong; 2025 [cited November 2025]. Available from: https://documents.uow.edu.au/content/groups/public/@web/@chsd/@pcoc/documents/doc/uow279818.pdf

10. Australian Bureau of Statistics. Aboriginal and Torres Strait Islander life expectancy. [Internet] [cited November 2025]. Available from: https://www.abs.gov.au/statistics/people/aboriginal-and-torres-strait-islander-peoples/aboriginal-and-torres-strait-islander-life-expectancy/latest-release.

11. Aoun, S. Independent review – Consumer perspectives of palliative care service models. Perth (AU): Perron Institute; 2020 [cited August 2025]. Available from: https://www.health.wa.gov.au/-/media/Files/Corporate/general-documents/End-of-Life/PDF/Independent-review-Consumer-perspectives-of-palliative-care-service-models-summary-report.pdf.

12. East Metropolitan Health Service. End-of-Life and Palliative Care Strategy Implementation Plan 2019–2024. Perth, Western Australia; 2019 [cited August 2025].

13. Australian Institute of Health and Welfare. National Palliative Care and End-of-Life Care Information Priorities. Canberra (AU): Australian Institute of Health and Welfare; 2022 [Internet] [cited August 2025]. Available from: https://www.aihw.gov.au/getmedia/17b82c56-83ff-45dc-be93-392bc5669fab/national-palliative-care-and-end-of-life-care-information-priorities.pdf.aspx

14. Australian Government Department of Health. Exploratory Analysis of Barriers to Palliative Care: Summary policy paper. Australia: Department of Health, Disability and Ageing; 2019 [cited August 2025]. Available from: https://www.health.gov.au/sites/default/files/documents/2020/01/exploratory-analysis-of-barriers-to-palliative-care-summary-policy-paper.pdf.

15. Victorian Government. Understanding intersectionality 2021 [Internet] [cited August 2025]. Available from: https://www.vic.gov.au/understanding-intersectionality.

16. User paprikaet87. "Dedication of palliative nurse" Care Opinion Australia 2022 [Internet] [cited August 2025]. Available from: https://www.careopinion.org.au/84644.

17. Department of Health. Access Standard. Department of Health; 2019 [cited August 2025]. Available from: https://www.health.wa.gov.au/~/media/Corp/Documents/Health-for/Voluntary-assisted-dying/Access-Standard.pdf.

18. Health Networks, Department of Health. Framework for bereavement support after an expected death in WA. Perth, Western Australia: Department of Health; 2025 [cited August 2025]. Available from: https://www.health.wa.gov.au/~/media/Corp/Documents/Health-for/End-of-Life/Framework-for-bereavement-after-death.pdf#:~:text=Framework%20for%20bereavement%20support%20after%20an%20expected%20death,bereaved%20families%20and%20carers%20after%20an%20expected%20death.

19. Aoun S. National Partnership Agreement: Comprehensive Palliative Care in Aged Care – WA Deep Dive Impact Evaluation. Perth (AU): Perron Institute; 2024 [cited August 2025]. Available from: https://www.perroninstitute.org/wp-content/uploads/2025/02/WA-NPA-CPCiAC-deep-dive-impact-evaluation-Dec24_Full-Report.pdf.

20. Government of Western Australia. *Carers Recognition Act 2004*. Department of Communities; 2004 [cited September 2025]. Available from: https://www.legislation.wa.gov.au/legislation/statutes.nsf/law_a9247.html.
21. Palliative Care Australia. National Palliative Care Standards for Specialist Palliative Care Providers 5.1 Edition 2024. [Internet] Australia; 2024 [cited November 2025]. Available from: https://palliativecare.org.au/national-palliative-care-standards-for-specialist-palliative-care-providers-5-1-edition-2024/
22. Department of Health, Disability and Ageing. What is palliative care? 2025. [Internet] [cited August 2025]. Available from: https://www.health.gov.au/topics/palliative-care/about-palliative-care/what-is-palliative-care.
23. Australian Commission on Safety and Quality in Health Care. Person-centred care, 2025. [Internet] [cited August 2025]. Available from: https://www.safetyandquality.gov.au/our-work/partnering-consumers/person-centred-care.
24. Government of Western Australia. Joint Select Committee on End-of-Life Choices Report My Life, My Choice. Department of Health; 2018 [cited August 2025]. Available from: https://www.health.wa.gov.au/~/media/Files/Corporate/Reports%20and%20publications/End%20of%20life/End-of-Life-My-Life.pdf

Acronyms

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

Definitions

Advance care planning

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

Advance Health Directive

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

Carers

A carer as a person who provides ongoing care, support and assistance to a person with disability, a chronic illness (which includes mental illness) or who is frail, without receiving a salary or wage for the care they provide.[20]

End-of-life

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

End-of-life care

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

Family

For the purpose of this document, the term 'family' includes people that the person identifies as family. Family may or may not include biological relations, and may include people who joined the family through marriage or other relationships, as well as family of choice and friends. Diversity in family and identification of family must be respected and positively responded to.[21]

Generalist palliative care

Generalist palliative care is care provided to people living with a life-limiting condition, their families and carers by healthcare providers who are not specialist palliative care providers. Medical management of the patient may be undertaken by a wide range of doctors, including GPs, physicians, surgeons, paediatricians and psychiatrists. These health professionals are 'generalists' with respect to palliative care, notwithstanding that many of them may be specialists in their own discipline.

Life-limiting illness

A life-limiting illness is an active, progressive or advanced disease that has little, or no prospect of cure, and the person is likely to die from the disease at some point in the future.[22] Examples of life-limiting illnesses include dementia, neurological conditions, cancer, renal disease, other chronic conditions and frailty.

Palliative care

Palliative care is an approach that improves the quality of life of individuals, their families and carers facing problems associated with life-limiting illnesses, through the prevention and relief of suffering. Palliative care recognises the person and the importance and uniqueness of their family and carer. It serves to assess and treat pain and other problems, whether psychical, psychosocial, cultural or spiritual. It offers a support system to help patients live as well as possible until death, enhances quality of life and may positively influence the course of illness.[21]

Person-centred care

Person-centred care is an approach to healthcare that involves treating each person respectfully as an individual human being and not as a condition to be treated. It involves seeking out and understanding what is important to the person and their families and carers, and prioritises the satisfaction of spiritual, existential, social, cultural and psychological needs to the same extent as physical needs.[21, 23]

Specialist palliative care

Specialist palliative care is undertaken by multidisciplinary teams whose substantive work involves consultative and ongoing care and support for people with a life-limiting illness, their carers and family. Specialist palliative care professionals would be expected to have recognised qualifications, specialised skills, competencies, experience and / or accredited training in palliative care. The role of the specialist palliative care services includes providing consultation services to support, advise, educate and mentor specialist and non-specialist teams to provide end-of-life and palliative care and/or to provide direct care to people with complex palliative care needs.

Voluntary assisted dying

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

Appendices

Appendix One

End-of-life and palliative care recommendations of the My Life, My Choice Report of the Joint Select Committee on End-of-Life Choices and alignment to Priorities[24]

No.	Recommendation
7	The Minister for Health should facilitate the establishment of an inpatient specialist palliative care hospice providing publicly funded beds in the northern suburbs of Perth.
8	The Minister for Health should ensure that community palliative care providers, such as Silver Chain, are adequately funded to provide for growing demand.
9	WA Health should conduct an independent review, from a patient's perspective, of the three models of palliative care in Western Australia: inpatient, consultative and community. The review should examine the benefits and risks of each model and the accessibility of each across the state as well as the admission criteria for hospice care.
10	WA Health should implement a process to determine the unmet demand for palliative care and establish an ongoing process to measure the delivery of palliative care services with the aim of making those services available to more Western Australians.
11	To improve understanding of palliative care in Western Australia, WA Health should: • establish a consistent definition of palliative care to be adopted by all health professionals • provide comprehensive, accessible and practical information and education services about palliative care to health professionals and the community • encourage knowledge sharing by palliative care specialists with their generalist colleagues • establish a palliative care information and community hotline.
12	The Minister for Health should prioritise policy development and improved governance structures for the delivery of palliative care by WA Country Health Services.
13	The Minister for Health should ensure regional palliative care be adequately funded to meet demand.

No.	Recommendation
14	Once a consistent definition of palliative care has been established by WA Health in accordance with Recommendation 11, the Minister for Heath should appoint an independent reviewer to audit: • The level of palliative care activity actually provided in Western Australia's hospitals and compare it against the level of recorded palliative care activity. • The actual spend by WA Health on palliative care on a year-by-year and like-for-like basis, across all aspects of palliative care provision, including community service providers, area health services (including WA Country Health Services) and delineating between inpatient, consultancy and community care.
15	WA Health should provide ongoing professional development for all health professionals – beyond undergraduate training – about the right of a patient to refuse medical treatment. WA Health should also specifically amend the Consent to Treatment Policy to provide comprehensive information in relation to a competent patient's absolute right to refuse medical treatment.
16	WA Health should provide ongoing professional development – beyond undergraduate training – for all health professionals regarding the absolute right of a competent patient to refuse food and water. Training should also include those working in aged care.
17	WA Health should provide ongoing professional development – beyond undergraduate training – for health professionals about the transition from curative to non-curative end of life care and effective discussions with patients and families about futile treatments. WA Health should consider how it might effectively educate the community about end of life decision-making and implement appropriate health promotion in this area.
18	WA Health should provide specific guidelines on the use of terminal sedation by health professionals for patients at the end of life. These guidelines should include an agreed name and definition of the treatment. As per any other medical treatment, the requirement for informed consent must be clear. The treatment must be specifically noted in the medical record as 'terminal sedation'.

Priority	Strategic alignment to the My Life, My Choice Report recommendations
Priority 1: Care is accessible to everyone, everywhere	7, 8, 9, 10, 12, 13, 14
Priority 2: Care is person-centred	9, 11.1, 11.2, 11.3, 11.4, 15, 16, 17.1, 17.2, 18
Priority 3: Care is coordinated	7, 8, 10, 11.1, 11.2, 11.3, 11.4, 12, 13, 14, 15, 16, 17, 18
Priority 4: Families and carers are supported	9, 11.1, 11.2, 11.4, 17
Priority 5: All staff are prepared to care	11.1, 11.2, 11.3, 11.4, 15, 16, 17, 18
Priority 6: The community is aware and able to care	9, 11.1, 11.2, 11.4, 17

Appendix Two – Action Plan template

Stakeholders are encouraged to use this template to prepare and implement an action plan for their health system or service that is aligned to the WA End-of-Life and Palliative Care Strategy 2018–2028 priorities and the building blocks of IP2.

Developing an action plan will assist stakeholders to address the Strategy's priorities and work towards the performance measures.

Stakeholders are encouraged to prioritise the building blocks most relevant to their area and identify the related actions, measures, timelines and areas of accountability.

Please note that examples are provided below in italics.

Building block	Action	Measure	By when	Accountable area
Priority One – Care is accessible to everyone, everywhere				
Improve equity of access.	*Provide Telehealth sessions for people living in regional, rural and remote WA.*	*Number of Telehealth sessions provided and held.*		
Priority Two – Care is person-centred				
People and their families and carers co-designing care with health teams, to include opportunities to talk about and plan for death, including advance care planning.	*Provide training sessions for health professionals on how to have effective advance care planning conversations.*	*Number of training sessions held and number of attendees at each session.*		

Building block	**Action**	**Measure**	**By when**	**Accountable area**
Priority Three – Care is coordinated				
Strengthened referral pathways between primary care, aged care and specialist palliative care service providers in the delivery of end-of-life care.	*Increase collaboration with GPs through MDT meetings and case conferences.*	*Number of MDT meetings/case conferences scheduled and held.*		
Priority Four – Families and carers are supported				
Improved practical advice and support for families.	*Increased availability of resources for families and careers.*	*Number of wards/clinical areas where resources for families and carers are available.*		
Priority Five – All staff are prepared to care				
Improved health, community and aged care provider understanding of end-of-life and appropriate referrals to specialist palliative care.	*Promote the use of clinical indicator tools to help health professionals identify when a person needs specialist palliative care.*	*Number of wards/clinical areas using clinical indicator tools.*		

Building block	**Action**	**Measure**	**By when**	**Accountable area**
Priority Six – The community is aware and able to care				
Improved public understanding of end-of-life and palliative care.	*Host a community event for National Palliative Care Week.*	*Number of event attendees.*		

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

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