Shared action plan checklist

This checklist aims to assist agencies to work together, plan, deliver and review services provided to people with complex needs.

	Key elements or principles	Achieved (yes or no)	Actions
1	Is there provision to identify the service coordination of initial needs if required?		
2	Are there multiple needs/multiple services/other agencies?		
3	Is there difficulty coordinating appointments or managing health needs?		
4	Is there an agreed way of explaining the benefits of coordinating services to the person (including people with CALD background)?		
5	Is there a system between services to decide how information is shared, when and with whom?		
6	Has the consent process been fully explained to the person?		
7	Is there an agreed process to nominate an agreed worker?		
8	Is this type of work clearly defined and included in a worker's position description?		
9	Are needs and risks identified holistically, including, where appropriate, those of carers, children and animals?		
10	Does the assessment cover all elements – clinical, social, psychological, welfare and lifestyle?		
11	Are equipment requirements or other needs identified?		
12	Is the action plan designed with and for the person and shared with carers, if appropriate, and with the person's consent?		
13	Does the action plan address how the person might live with the condition (practically, socially as well as medically)?		
14	Are all existing service/action plans taken into account when developing a community plan?		
15	Are the issues prioritised according to the person's current situation?		
16	Does the action plan document self-management support strategies, where appropriate?		

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17	Are the action plan goals written in the person's own words?		
18	Do proposed actions take into account all available information?		
19	Are the actions realistic and achievable?		
20	Does each action of the action plan clearly state who is responsible?		
21	Have referrals for other services been discussed, and consent given by the person?		
22	Do all professionals undertaking action planning have access to up-to-date evidence and information, including a service directory?		
23	Are there processes and support tools in place to ensure regular reviews of proposed actions?		
24	Are changes documented?		
25	Does the review process include a means of indicating improvement?		
26	Are there processes in place for regular collaborative meetings?		
27	Have agreed pathways of service delivery been established and documented across and within agencies?		
28	Are end-of-life plans included as part of the action planning process, where appropriate?		
29	Do the professionals from different organisations, individuals and carers work as a single response team?		
30	Do all participants in the action plan have access to a copy, either print or electronic form, including the person?		
31	Are there systems in place to ensure communication and feedback between one another?		
32	Are there processes in place to ensure reassessment if there is a change in the person's health or service status?		
33	Is there a well documented process for re-entry into any service system?		
34	Is the action planning process led/endorsed from strategic levels throughout the organisation/s?		