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

WA Health's strategy for Advance Care Planning education and awareness raising: For health professionals and the community

Prepared by the Advance Care Planning Team of the End-of-Life Care Program Team, WA Health

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Background

The End of Life Care (EOLC) Program within the WA Department of Health was tasked with implementing the recommendations from the My Life My Choice report by the Joint Select Committee on End-of-Life Choices, and the subsequent Ministerial Expert Panel on Advance Health Directives: Final Report (August 2019). Specifically, the Advance Care Planning (ACP) project addresses the recommendations related to ACP and consists of 4 key workstreams:

- Workstream 1: Revising the Advance Health Directive (AHD) template
- Workstream 2: Health Professional Education and Awareness regarding ACP
- Workstream 3: Community Education and Awareness regarding ACP
- Workstream 4: Development of an Advance Health Directive Register.

In 2021, Workstreams 2 and 3 focused on developing high level strategies to outline WA's approach to ACP awareness raising, training and education for health professionals and the community. Following the development and consultation process, this final document is referred to as *WA Health's strategy for Advance Care Planning education and awareness raising: for health professionals and the community (the Strategy)*.

Purpose and aim

The ACP project aims to enable more Western Australians to effectively engage in advance care planning. Specifically, it aims to address Priority Six of the WA End-of-Life and Palliative Care Strategy 2018–2028 which states:

The community is aware and able to care.

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

The Strategy suggested the required building blocks for ACP are:

- **Increased awareness and uptake of ACP** - The general public has a better understanding of the value of ACP, including how to:
  - have conversations about preferences for care
  - access and complete relevant forms
  - make ACP available to health, community and aged care providers
  - advocate for appropriate care.

The purpose of the Strategy is to outline WA Health's approach to ACP awareness raising, training and education for health professionals and the community.

Development process

The draft strategies (later to become the Strategy) were developed following a desktop scan of local, interstate and international education, training and awareness raising materials. Existing ACP strategies and policies from other jurisdictions were also reviewed. This information, along with the recommendations from the Ministerial Expert Panel on AHDs were used to draft the high-level strategies.

The strategies were released for broad consultation via an online survey on the WA Health Citizen Space Consultation Hub between 21 September to 23 October 2020 and received 77 responses.

A broad range of stakeholders were invited to participate in the consultation including consumers and carers, community organisations, Government departments/ areas, health and allied health professionals and professional

bodies, health services across all settings, aged care providers, WA Health Service Providers, peak/advocacy organisations, legal services and educational institutions.

The feedback from the consultation was incorporated into the Strategy and circulated amongst a small group of key stakeholders for final input before being submitted to the End-of-Life Care Program Steering Committee, for approval.

For more details on the consultation and the findings, please see the *High-level strategies for health professional and community education and awareness raising of Advance Care Planning: Consultation report.*

Implementation

The Strategy provides a holistic view of what is required in WA in regard to ACP education and awareness raising. Although the Strategy will primarily be used by WA Health to guide their activity over the next couple of years, it may also be a useful resource for other key ACP organisations and services to identify potential areas for action. It is recognised that there are a number of key stakeholders that are already working in this space and making great progress towards achieving the desired outcomes. A number of these key stakeholders are mentioned within the document but it is recognised there are more. WA Health's intention is to build on and complement this work where possible, play a role in coordination to avoid duplication of efforts and to address some of the areas where there are currently gaps. As such, WA Health's role will vary between the strategies from leading, to supporting, partnering or monitoring.

Further research and planning is required to develop a detailed implementation plan(s) in order to prioritise areas for action and to determine how the strategies and activities will be resourced and actioned.

Summary of WA Health's strategy for Advance Care Planning education and awareness raising

AIM – Increase awareness and uptake of ACP

Health professionals and the community have a better understanding of the value of ACP, including how to: have conversations about preferences for care, access and complete relevant forms, make ACP available to health, community and aged care providers and advocate for appropriate care.

Area of focus & outcomes	PROMOTION	RESOURCES	EDUCATION AND TRAINING	MONITORING & EVALUATION	IMPLEMENTATION
	Everyone routinely talking about future care planning with a values-based focus. Death is considered a natural process.	ACP resources are consistent, widely available and useful to all.	A skilled workforce to support shared care decisions. All individuals can develop an ACP. ACP interactions are culturally and socially appropriate.	Show the approach to ACP is consistent with WA End-of-Life and Palliative Care Strategy 2018–2028.	Systems & processes clarify the role of different setting and people in ACP. ACP is systematically incorporated in health services.
Strategies	• Influence state and national agendas. • Communication plan for ACP promotion. • Multi-media awareness campaign. • Promote ACP at relevant points of contact with health, aged care and social services.	• Review existing resources - retain, revise or create. • Review WA Health policies relevant to ACP. • Develop online tool to support completion of ACP documents. • Identify resource needs of population groups.	• Implement sustainable education/ training to achieve consistent understanding of ACP. • Create structures that make professional development easily available and build ACP education into curricula. • Support local clinical communication education. • Ensure coordinated approach to community workshops. • Develop engagement strategy to increase uptake in priority populations.	• Develop a WA ACP Implementation Plan that supports Priority Six of the WA End-of-Life and Palliative Care Strategy 2018–2028. It will include strategies to increase awareness and education.	• Establish an 'Office of Advance Care Planning' within WA Health. • Build systems and processes into existing structures to improve care coordination relating to ACP.
Activities	• Connect with interstate/ national activities. • Link to NSQHS and Aged Care Quality Standards. • Share positive stories. • Utilise existing organisations. • Participate in ACP Week and Dying to Know Day.	• Clarify roles of different sectors and professions. • Clarify preferred method for education/ training. • Create centralised location for ACP information. • Use a codesign approach.	• Collaborate with education providers to promote availability of and access to training. • Consider volunteer facilitators and train-the-trainer programs. • Develop standardised training course content.	• Develop implementation plan that considers: ○ access to resources ○ concordance with AHDs ○ usability of AHDs • Adopt continuous improvement approach informed by data.	Office of ACP will: • Assist with reviewing completed AHDs • Respond to initiatives and actions at state/ national level that impact on ACP • Ensure coordinated ACP education approach.

DRIVERS - My Life My Choice report by the Joint Select Committee on End-of-Life Choices, Ministerial Expert Panel on Advance Health Directives: Final Report (August 2019)

WA Health's Strategy for Advance Care Planning education and awareness raising

**It is recognised there are a number of key stakeholders already working in this space. WA Health's intention is to build on and complement this work where possible, play a role in coordination to avoid duplication of efforts and to address some of the areas where there are currently gaps.*

Area of focus	Outcomes	Strategy	Possible implementation activities	*Related current activity/key stakeholders in WA/ interstate/ international
PROMOTION - *Normalise advance care planning*	• Consumers and healthcare professionals are routinely talking about future care planning and recognising different cultures and experiences, with a values-based focus.	• Ensure early and continual advance care planning (ACP) and person-centred, values-based care planning is on state and national health policy documents and social care agendas to promote discussion and awareness of ACP.	• Identify key state and national committees to provide regular reports and updates regarding advance care planning activities. • Align, connect and collaborate with activities/initiatives in other states, as well as nationally, to maximise opportunities for promotion for ACP. • Link ACP activities to National Safety and Quality Health Service (NSQHS) Standards (Standard 5 - Comprehensive Care, and Standard 8 - Recognising and Responding to Acute Deterioration); and Aged Care Quality Standards (Standard 1 - Consumer Dignity and Choice, Standard 2 - Ongoing Assessment and Planning with Consumers, and Standard 3 - Personal Care and Clinical Care) wherever relevant.	
	• Death is considered a natural process – the conclusion of the life cycle and not a 'failure' of care.	• Develop a communication plan to promote the importance and benefits of ACP across all sectors (i.e. health services, community health and social services, residential aged care facilities, primary care practices, prisons, legal services and community groups) using a mix of public relations, networking events and stakeholder engagement.	• Collect and share consumers' and healthcare professionals' positive/uplifting stories. • Include regular updates of ACP activities and resources in service/ organisation communication channels i.e. newsletters, social media. • Utilise existing groups/ organisations to promote ACP and Advance Health Directives (AHDs) to the community and to health professionals. • Participate in National Advance Care Planning Week and national Dying to Know Day. Consider grants for local grassroots organisations to develop activities in line with	• Palliative Care WA (PCWA) workshops • Cancer Council WA • End-of-Life Direction for Aged Care (ELDAC) • ACP Consortium via PCWA • Office of the Public Advocate (OPA) community education sessions for Enduring Power of Attorney (EPA), Enduring Power of Guardianship (EPG) and AHDs. • Death Café

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			these events that involve a range of people from the community. • Link in with activities through community networks/groups and local governments such as community centres (e.g. attend seniors' sessions), faith communities, multicultural networks within local governments.	• Compassionate Communities networks • Build on work already done through Advance Care Planning Australia.
		• Design and deliver a multi-media awareness campaign – that promotes both ACP and AHDs and differentiates between them.	• Design a broad health promotion campaign building on storylines from the 'You only die once campaign': o with different phases running from 2021 – 2023 • Include TV, radio, print, social media advertisements and promotion, including ethnic radio and community language materials. • Include more diversity in mainstream campaigns and consider specific strategies to reach high risk vulnerable community members e.g. Residential aged care facilities. Ensure targeted messages are developed using a co-design approach with representatives from the priority populations. Ensure representation on relevant planning/ reference groups.	• "You only die once" campaign – PCWA • WA Health End-of-Life Care Media campaign (2021) • Dying to talk – Palliative Care Australia
		• Ensure engaging in ACP conversations and the completion of AHDs is considered and promoted to individuals at all relevant points of contact with health, aged care and social services.	• Identify key points of contact to raise ACP and determine how ACP can be routinely incorporated and how the completion of AHDs can be promoted. Consider additional human resource and training requirements. For example: o Age specific checks o As part of ongoing management of life long conditions i.e. through comprehensive cancer centres, chronic illness support services (e.g. MSWA). o At check-ups with specialists (e.g. oncologist appointments)	

Area of focus	Outcomes	Strategy	Possible implementation activities	*Related current activity/key stakeholders in WA/ interstate/ international
			○ Incorporate ACP conversations and documentation into routine practice on or after admission to home-based or residential aged care. • Support the development of ACP Consumer Facilitators to support completion of the ACP documents and AHD by patients/residents. • Consider coordination from key community organisations. • Consider non-health related points of contact (e.g. providing ACP information through funeral directors when people are purchasing funder packages in advance).	
RESOURCES – *accessible information and tools to support ACP*	• ACP and AHD resources are consistent, widely available and useful to all.	• Review existing ACP and AHD resources and tools available in WA to determine what needs to be retained, revised or created.	• Evaluate the uptake of the current ACP e-learning package and revise if appropriate. • Ensure consistent communication about the roles of acute, community and primary care sectors, and different professions, in ACP and approaches. • Determine the preferred method for education and training materials for different sectors and settings. Encourage simulation-based learning, scenario-based training and on-the-job learning from skilled experienced staff – to help clinicians build their confidence and skills in this area. • Create a centralised location to access all ACP and AHD resources, information regarding ACP education events and resources ordering. • Consider development of a list of practitioners skilled in ACP that could be made publicly available.	• E-learning • End-of-Life and Palliative Care Training and Education Hub • WA Health resources • PCWA resources (e.g. Dying to Talk cards) • OPA resources • Citizens Advice Bureau • Cancer Council • HealthPathways WA • Alzheimers WA • Goals of Patient Care resources • COVID-19 resources • Existing resources from professional bodies (e.g. RACGP guidelines - Aged care clinical guide, Silver Book - Part A)

Area of focus	Outcomes	Strategy	Possible implementation activities	*Related current activity/key stakeholders in WA/ interstate/ international
				• Central AHD Register being developed by the ACP Project Team. • CareSearch e-learning • A clear path to care – SA Health • ACP Australia (e-learning package for health professionals and consumers, videos and webinars with scenario based learning materials) • Dementia Australia • End-of-Life Essentials • The Advance Project
		• Review WA Department of Health policies relevant to ACP.	• Review clinical handover policies to ensure advice around ACP and AHD is covered. • Support Health Service Providers to review discharge policies to ensure ACP and AHD are effectively communicated between care settings, particularly to those providing services in the community to vulnerable populations. Consider the role of My Health Record in achieving this. • Identify similar documentation and combine education resources where appropriate i.e. Goals of Patient Care.	• Training Centre in Subacute Care (TRACS) WA education for Goals of Patient Care. • *TRACS is likely to be aged care focussed. Identify providers for education for health service providers and other providers.
		• Development of online interactive tool to support people to complete values statement and treatment decisions.	• Finalise revised AHD and central AHD register to determine best approach to the online interactive tool. Ensure value statements are able to be linked to My Health Record. • Provide hard copies of all relevant online resources for those who prefer this format.	• Prepare to Care in USA • My Values website in Victoria

Area of focus	Outcomes	Strategy	Possible implementation activities	*Related current activity/key stakeholders in WA/ interstate/ international
		• Identify the resource needs of population groups.	• Identify and develop resources and cultural tools (using co-design) to increase ACP access to priority populations including: ○ Aboriginal communities (including specific needs of different kinship groups) ○ People experiencing disadvantage ○ Culturally and linguistically diverse (CaLD) communities ○ People with mental illness ○ People with disability (noting the range of needs based on the type of disability) ○ Older people. • Ensure resources are available in multiple languages. • Ensure resources are available in various formats (e.g. booklets, videos, Auslan videos, cartoons, audio podcasts, easy read / plain English versions to facilitate supported decision making, resources for those with vision impairment, face to face education for some groups such as Aboriginal elders etc.)	• PCWA, People with Disability WA, Health Consumers' Council and consumers with disability project to develop a tailored approach to education for people with disability. • ACP Australia culturally relevant information and CALD resources in 15 different languages.
EDUCATION AND TRAINING – *A prepared workforce and community*	• The healthcare and support staff workforce are skilled in communicating and working with patients and families to make shared decisions about care. • Individuals in WA can develop an advance care plan, no matter where they reside	• Implement sustainable systems for the education, training and mentoring of health professionals and support staff to achieve a consistent understanding of ACP competencies.	• Promote a consistent system-wide approach to ACP training based on agreed roles across hospital (acute and non-admitted care settings), community and primary care sectors (e.g. acute hospitals could have a greater focus on identifying patients who would benefit from ACP, having pre-cursor discussions (e.g. Goals of Patient Care) and routinely including this information and recommendations in discharge; routine outpatient appointment are potentially an appropriate environment for ACP which could have targeted strategies; proactive identification of patients in primary care for ACP; routine ACP for all people admitted to residential aged care).	• Education and Training Hub being developed by End-of-Life Care Team. • Health Professionals Education and Training Framework by End-of-Life Care Team. • Metropolitan Palliative Care Consultancy Service (MPaCCS) • OPA service provider education sessions for EPA, EPG and AHDs.

Area of focus	Outcomes	Strategy	Possible implementation activities	*Related current activity/key stakeholders in WA/ interstate/ international
	in WA, their ethnicity or socioeconomic status. • ACP interactions are culturally and socially appropriate.		• Develop the infrastructure to support trained staff to effectively access and deliver ACP and clinical communication training (e.g. access to a portal which provides an overview of all ACP and AHD training available). • Review existing ACP training materials and promote implementation in appropriate settings. • Develop standardised training course content, as required. • Recruit skilled staff interested in facilitating training, providing time and support for facilitators to be trained and to deliver training within Health Services in a sustainable way. Consider ways to enable them to provide on-the-job coaching in this area. Explore their role as ACP champions at hospital sites. • Consider the inclusion of ACP in annual training programs delivered by Health Service Provider Education/Development Units. • Investigate opportunities to embed ACP training into mandatory requirements, if appropriate. • Maintain a team of advanced communication trainers and professional actors (for media campaigns). • Evaluate facilitators and training quality, and support facilitators to ensure sustained quality and skill. • Consider the benefits of introducing ACP clinics. • Consider introduction of key performance indicators (KPIs) for Health Service Providers for ACP training, that measure the quality of ACP training as well as the uptake and compliance.	• Hospital study days (e.g. Royal Perth Hospital Palliative Care Study Day Oct 2020) • Guidelines for a Palliative Approach to Aged Care in the Community (COMPAC) • ACP Australia provides: ○ Learning Management System with 11 modules ○ webinars ○ 2-3 hour web based training aimed to improve ACP communication skills ○ 3 hour train the trainer webinar ○ resources for educators to incorporate ACP into health professionals and support worker curriculum.

Area of focus	Outcomes	Strategy	Possible implementation activities	*Related current activity/key stakeholders in WA/ interstate/ international
		• Create structures and processes that make professional development easily available to health care professionals and support staff, and other relevant professions tailored to their level of practice, and with incentives for individuals to complete (e.g CPD points).	• Provide readily available evidence-based advanced clinical communication training. • Build partnerships and collaborate with education providers and key organisations to promote availability of and access to training to improve uptake, particularly in primary care. • Investigate opportunities to embed ACP training in mandatory requirements. • Investigate opportunities to assign professional development points and/or key performance indicators (KPIs) to ACP training. • Review availability of training for: ○ Legal practitioners ○ Aged care workers ○ Community support workers ○ Volunteers.	• Palliative and Supportive Care Education (PaSCE) • The Advance Project - toolkit and training package to support general practices to implement a team-based approach to ACP • Cancer Council WA Clinicians Communication Program • ELDAC
		• Develop a structure on which education providers can build ACP education into curricula, including a tool to facilitate evaluation and assessment.	• Identify and liaise with education providers to review and revise ACP related curricula and embed relevant ACP competency framework into relevant curriculum for health and support worker higher education programs (including undergraduate and postgraduate university courses, vocational courses and orientation programs in health care facilities).	• End-of-Life Law for Clinicians (ELLC) • End-of-Life Essentials Education Modules • Palliative Care Curriculum for Undergraduates (PCC4U) • Advance Care Planning Aus Education Capability Framework
		• Support the delivery of ACP and clinical communication education locally.	• Support Health Services in the development of infrastructure, processes and policies to maximise the value of the training and make it easier for Health Services to deliver training locally. • Develop a train-the-trainer programme to train facilitators locally.	
		• Ensure a coordinated approach to the delivery of	• Review current community education and identify any gaps, duplication of efforts and	• PCWA face-to-face workshops

Area of focus	Outcomes	Strategy	Possible implementation activities	*Related current activity/key stakeholders in WA/ interstate/ international
		community ACP workshops and presentations for the general population.	opportunities to increase the spread and uptake. • Create a centralised location to access all ACP education events and information (as in 'Resources' above). • Consider the role of trained volunteer facilitators, local councils, community organisations (Mature Adults Learning Association, U3A, Seniors Centres) and social media in promoting ACP messages to the general population. • Ensure messages are also targeted towards unpaid carers as they often play a role in guiding people through ACP.	• OPA community education sessions.
		• Develop an engagement strategy to increase ACP uptake in priority populations including: ○ Aboriginal communities ○ People experiencing disadvantage ○ CALD communities ○ People with mental illness ○ People with disability ○ Older people ○ People in rural, regional and remote areas.	• Identify the need and develop ACP education and training programs and content (using co-design) targeting consumers in priority populations. • Design specific training and education materials to support health professionals to undertake ACP with priority populations including: ○ Aboriginal communities ○ People experiencing disadvantage ○ CaLD communities ○ People with mental illness ○ People with a disability ○ Older people ○ People in rural, regional and remote areas.	
MONITORING AND EVALUATION – *care is based on evidence and what matters to consumers, health*	• Measurement and evaluation show the approach to ACP is consistent with Priority Six of the WA End-of-Life and Palliative	• Develop a WA ACP Implementation Plan that supports Priority Six of the WA End-of-Life and Palliative Care Strategy 2018–2028. It will include (but not be limited to) –	• Establish a diverse Reference Group to oversee the development of the implementation plan. Consider establishing relevant expert advisory groups (e.g. medico-legal organisations, professional regulators).	• Planned reporting against Sustainable Health Review (Strategy 3 - Great beginnings and a dignified end-of-life). • Link with Metropolitan Health Service Board key

Area of focus	Outcomes	Strategy	Possible implementation activities	*Related current activity/key stakeholders in WA/ interstate/ international
professionals and providers	Care Strategy 2018–2028 – the community is aware and able to care.	strategies to increase awareness and education regarding ACP and AHDs in WA.	• Undertake broad consultations and adopt a co-design approach in the development of the implementation plan. • Include a measurement approach and take baseline measures. • Adopt a continuous improvement approach informed by the ongoing collection/supply of Health Service Provider data that measures the completion of AHDs. • Implementation plan will consider: ○ use of website to capture feedback on access to resources online. ○ creating a system to capture/document when health professionals and care workers complete ACP professional development ○ monitoring concordance with treatment outcomes, not just ACP completion ○ follow-up evaluation of participants in education workshops ○ measuring the usability of AHDs (i.e. where clinicians able to interpret them) ○ collaboration with primary care and residential care facilities on data extraction.	performance indicator (KPI) reporting and evaluation. • Link with monitoring and evaluation of End-of-Life and Palliative Care Strategy (Priority 3 and 5). • Data from specialist palliative care services. • Monitor AHD upload to My Health Record. • Gold Standard Framework (GSF) Centre in End-of-Life Care • ACP Australia is developing a national toolkit to assist Health Services to audit and improve practices relating to ACP, linking with the National Safety and Quality Health Service Standards.
IMPLEMENTATION *– supporting a coordinated consistent approach to ACP*	• Systems and processes clarify: ○ how ACP can be undertaken across different health and care settings. ○ the roles that different people and organisations can play in the	• Establish an 'Office of Advance Care Planning' within WA Health.	• 'Office of ACP' will: ○ Assist with reviewing completed AHDs to ensure they have been completed as required, from a legal and clinical perspective. ○ Respond to strategies, initiatives and actions at a state and national level that impact on ACP (e.g. embedding ACP in National Standards). ○ Advise on review of complaints incidents associated with ACPs, especially in the event of sentinel event.	• Link in with work of organisations already working to engage and build relationships with consumers and community members (e.g. PCWA, Primary Health Networks) • ACP Australia provides a free National Advisory Service • Queensland Office of Advance Care Planning

Area of focus	Outcomes	Strategy	Possible implementation activities	*Related current activity/key stakeholders in WA/ interstate/ international
	ACP process and provide.		○ Ensure a coordinated approach to ACP education activities. ○ Ensure consumer enquiries are answered (this role may be outsourced as required to avoid duplicating existing consumer services in the community). ○ Engage and build relationships with consumers, their families and carers and consumer organisations outside of WA Health that could support the societal and cultural change required (e.g. primary care organisations, Aboriginal Community Controlled Health Organisations) ○ Requires close links with Department of Justice, OPA and State Administrative Tribunal (e.g. in relation to Enduring Power of Guardianship).	• Advance Care Planning: Roles and responsibilities in Advance Care Planning • NSW Advance Planning for Quality Care at End-of-Life - Action Plan 2013–2018
	• ACP is systematically incorporated within health services.	• Build systems and processes into existing structures to improve care coordination relating to ACP.	• Health Services work collaboratively with primary and community sectors to improve care coordination around ACP and AHDs. • Health services use quality audits to inform and improve the advance care planning system.	

Appendix 1: Ministerial Expert Panel on Advance Health Directives Recommendations for Consumers

Recommendation 1 – The scope of a new approach

1.1 A new approach to community awareness and education should encompass and coordinate measures promoting:

- The concept of 'having the conversation' about serious illness and death;
- Advance care planning; and
- The statutory instruments.

Recommendation 2 – Strategic planning

2.1 The State Government should mandate the Department of Health to lead the development and delivery of a community awareness and education strategy.

2.2 The Department of Health should co-design the proposed strategy with relevant government and non-government stakeholders.

Recommendation 3 – Audiences

3.1 The proposed community awareness and education strategy should incorporate initiatives:

- Addressed to the community as a whole;
- Specifically targeting priority groups including older people, people in regional areas, people experiencing disadvantage, Aboriginal people and people from culturally and linguistically diverse communities; and
- Targeting individuals at 'key points', including the 75-year-old health check and at diagnosis with a life-limiting condition or neurodegenerative disease.

3.2 Measures targeting priority groups should be developed and delivered in close collaboration with relevant stakeholders including carers, service providers, the Office of the Public Advocate and advocacy bodies.

Recommendation 4 – Funding

4.1 The proposed community awareness and education strategy should be:

- Supported by ongoing dedicated funding, to be sought and allocated in line with standard Government budgetary processes; and
- Designed to leverage other resourcing opportunities, including those associated with the Commonwealth and the private sector.

Appendix 2: Ministerial Expert Panel on Advance Health Directives Recommendations for Health Professionals

Finding 1: The ability of health professionals to support advance care planning and apply the treatment hierarchy is influenced by a number of structural factors that are not primarily related to education but are addressed in the recommendations of the Joint Standing Committee's report, elsewhere in this report or both. Health services can support individual health professionals to discharge their responsibilities in relation to advance care planning, including adherence to decisions documented in the statutory instruments, by examining relevant processes and policies, particularly in relation to clinical handover and discharge communication.

Recommendation 5 – A new approach to the education of health professionals

5.1 The State Government should mandate the Department of Health to lead the development and delivery of a strategy for educating health professionals about advance care planning, the treatment hierarchy and the statutory instruments.

5.2 The Department of Health should develop and deliver the strategy in partnership with relevant stakeholders including professional bodies, tertiary institutions, aged care providers and Commonwealth agencies.

5.3 The strategy should focus on opportunities to embed consistent information within existing education and training systems including academic curricula and professional development processes.

5.4 The State Government should provide funding to support the development and delivery of the strategy.

Recommendation 6 – Target audiences

6.1 Education for health professionals should:

- Recognise the diversity of roles and educational requirements that exist under the broad umbrella of 'health professionals' and other relevant service providers; and
- Give initial priority to general practitioners, acute sector health professionals and health professionals working with people with life-limiting conditions or neurodegenerative diseases including dementia and/or in aged care.

Recommendation 7 – Structuring the content

7.1 The proposed education strategy for health professionals should consider educational needs across the following stages of the advance care planning process:

- Initiating discussion about advance care planning;
- Assisting patients to make advance care plans, including the statutory instruments; and
- Applying the treatment hierarchy and implementing decisions documented in statutory instruments.

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