Northern Queensland Primary Health Network

Palliative Care Health Needs Assessment

December 2025

Disclaimer

Funding Acknowledgement

Greater Choice for At Home Palliative Care – an Australian Government initiative.

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Executive Summary

This Health Needs Assessment (HNA) is Northern Queensland Primary Health Network's (NQPHN's) report to the Australian Government Department of Health, Disability and Ageing on delivery of the Greater Choices for At Home Palliative Care (GCfAHPC) program in the NQPHN region. It summarises progress to date and the evidence base to guide planning to 30 June 2029.

Evidence sources include a desktop review, analysis of publicly available datasets (including AIHW), a stakeholder survey (40 responses), and targeted provider interviews (late 2025). Delivery to date has focused on community engagement (Compassionate Communities/Community Connectors), education and networking, the Good Life, Good Death Expo (with Palliative Care Queensland), and workforce development through PEPA.

Key findings

- Demand is increasing: 2,850 palliative care-related hospitalisations in 2023–24 (~12.6% of Queensland), rising since 2020–21.
- Need is concentrated in older cohorts: 14,293 non-admitted primary palliative care service events for people aged 55+ in 2023–24.
- Cancer remains a major driver: 38% (n=1,092) of palliative care-related hospitalisations in 2023–24 included cancer as the principal diagnosis.
- Workforce shortages are the primary constraint, limiting home visiting, after-hours coverage and respite—most acute in rural and remote areas.
- Pathways and coordination remain variable, highlighting the need for stronger integration across primary care, hospitals, aged care and community providers.

Based on the HNA evidence, six priority areas were identified along with 10 key needs for the region (Appendix A). The six priority areas are:

- Workforce capacity and development.
- Access in regional, remote, and very remote areas.
- Enhancing palliative care in residential and facility-based settings (including residential respite services).
- Community education and awareness.
- Ongoing development and promotion of inclusive palliative care for diverse communities in the NQPHN region.
- Service mapping across the NQPHN.

The 10 needs set out in Appendix A will guide GCfAHPC work planning and monitoring through to 30 June 2029. Addressing these needs will require coordinated action across primary care, specialist palliative care, hospital and health services, aged care providers and community partners. Over the remainder of the program, NQPHN will focus on strengthening a connected and resilient palliative care system aligned to the program's four objectives—supporting delivery of the right care, at the right time, in the right place.

Overview

The Greater Choice for At Home Palliative Care (GCfAHPC) program was established as a pilot by the Department of Health, Disability and Ageing (DHDA) in 2017-18. Initially, it was piloted with 11 Primary Health Networks (PHNs) across Australia, and due to its success, was extended to all 31 PHNs in 2021-22 for a four-year period. In 2025, the program was funded for an additional four years, through to 2028-29.

The program has four key objectives.

- Improve awareness (workforce and community) and access to safe, quality palliative care at home and support end-of-life care systems, and services in primary health care and community care.
- Enable the right care, at the right time, and in the right place to reduce unnecessary hospitalisations.
- Generate and utilise data to support continuous improvement of services across sectors.
- Use available technologies to support flexible and responsive palliative care at home, including after hours.

The intended outcomes of the program include:

- Improved capacity and responsiveness of services to meet local needs and priorities.
- Improved patient access to quality palliative care services available in the home and improved capacity of carers to support people at home.
- Improved coordination of care for patients across health care providers and the integration of palliative care services in our region.

The research into palliative care in Australia provides clear evidence that most people, >70% wish to die home, or in a homelike environment, surrounded by family and friends – peacefully, pain free with high quality medical care, personal needs accommodated, and their spiritual needs met. Unfortunately, <20 % of people will experience that ‘ideal’ death (Swerissen, 2014). Most people ~51% will die in hospitals, ~30 - 35% will die in RACHs, or similar, the balance (estimated to be 14 - 17%) dying at home, or on Country.

The research into death/dying and palliative care at the end of life in Australia mirrors that found across the world. Whilst research shows that more than 75% of people wish to die at home, or on Country, only about 14 – 17% achieve this outcome (Swerissen, 2014).

Whilst all involved in palliative care do their best for those dying in these environments, for most of those patients their death does not often align with what most have in mind for themselves. Many of these people will die in hospitals (or similar) often surrounded by strangers, in less-than-ideal situations, far from where they had hoped (Swerissen, 2014).

In Australia, from 2015-16 to 2023-24 there has been a 46 per cent increase in palliative care hospitalisations, specific to admitted patient palliative care.

Methodology

This needs assessment was managed by NQPHN's Greater Choice for At Home Palliative Care (GCfAHPC) project team and the Population Health Manager. The below steps were followed for this iteration:

- Desktop analysis of existing strategic documents specific to palliative care.
- Quantitative analysis of publicly available datasets sourced from the Australian Institute of Health and Welfare.
- Survey to understand current needs of the region related to palliative care (including data analysis and summary).
- Interviews with key stakeholders across our region.

The methodology adopted is by no means comprehensive, however, it does provide insight into the project to date, and importantly, what is required of the NQPHN project team over the next four years.

Limitations of this report

Some of the limitations identified via this process included:

- A tight submission deadline limited stakeholder engagement needed to understand health and service needs.
- Limited granular-level datasets specific to palliative care.

Overview of our region

The Northern Queensland Primary Health Network (NQPHN) region spans an area of 510,172 square kilometres, making it the second largest Primary Health Network in Queensland. The region includes 31 local government areas (LGAs), each with a varied population and distinct health needs. Communities within the NQPHN region range from inner and outer regional to remote and very remote settings, with each facing unique health disparities and priorities (QGSO, 2024).

Within the NQPHN region, the following four Hospital and Health Services (HHSs) deliver public health care:

- Torres and Cape HHS
- Cairns and Hinterland HHS
- Townsville HHS
- Mackay HHS.

The demographic makeup of the region features Aboriginal and/or Torres Strait Islander peoples, culturally diverse groups, and a significant aging population, all of which shape the region's health landscape. Social determinants – including income, education, and environmental conditions – play a vital role in influencing health outcomes across the NQPHN region.

Sociodemographic insights

Estimated resident population

The region's estimated population is 734,595, with 16.1 per cent aged 65 years and older. Aboriginal and Torres Strait Islander people make up 10.8 per cent of the population, which is notably higher than Queensland's state average of 4.6 per cent. Additionally, 15.1 per cent of residents were born overseas, and 8.5 per cent originate from countries where English is not the primary language. About 3.8 per cent of the population live in remote areas, while 3.6 per cent reside in extremely remote locations (QGSO, 2024).

Projected population

Population forecasts offer a glimpse into how the region's future size and age structure may develop, based on assumptions about fertility, mortality, and migration trends (ABS, 2024). By 2046, the region's population is expected to reach 909,807, growing at an average annual rate of one per cent, which is slightly below Queensland's projected rate of 1.4 per cent. As the population increases, there will be greater demand for health services and other factors that influence health outcomes.

The Townsville LGA is projected to have the largest population in 2046, while the Cairns LGA is expected to experience the fastest growth. In contrast, some LGAs – specifically Flinders (-1.2 per cent), Hinchinbrook (-0.9 per cent), Etheridge (-0.6 per cent), and Croydon (-0.6 per cent) – are anticipated to see a decline in population, reflecting the aging demographics in these areas (QGSO, 2024).

Population by age

Most people in the region are between 25 and 64 years old (52.3 per cent), which suggests potential workforce challenges as there being more working-age individuals transitioning into older age than younger people entering the workforce. Within the region, the Northern Peninsula Area LGA has the highest proportion of children aged 0–14 years, at 34.8 per cent. The Isaac LGA, on the other hand, has the largest share of residents aged 15–64 years, with 72.0 per cent.

As the number of older adults continues to rise, so does the need for health services. Currently, 16.1 per cent of the region's population is aged 65 years and above. Among this age group, males and females are almost equally represented, with 49.8 per cent male and 50.2 per cent female. Notably, a greater proportion of Aboriginal and Torres Strait Islander individuals aged 65 years and over are female (55 per cent) compared to male (44 per cent).

The Hinchinbrook LGA has the highest percentage of residents aged 65 years and over at 29.1 per cent, followed by the Tablelands LGA at 26.5 per cent, and the Burdekin LGA at 23.9 per cent. Additionally, 55.4 per cent of older adults who require assistance are female, while 44.6 per cent are male (QGSO, 2024).

Country of birth and proficiency in spoken English

In the NQPHN region, 15.1 per cent of residents were born overseas, with 8.5 per cent coming from countries where English is not the primary language, which is higher than Queensland's state average of 12.5 per cent. Nearly 11 per cent of people from culturally and linguistically diverse (CALD) backgrounds speak a language other than English at home.

At the local level, the Cairns LGA has the highest proportion of overseas-born residents at 22.3 per cent. The Cairns LGA (13.5 per cent), Mareeba LGA (10.4 per cent), and Douglas LGA (10 per cent) have the largest shares of people born in non-English speaking countries. The median age for those born overseas in a non-English speaking country is 43.1 years, compared to 41.2 years for Queensland overall (QGSO, 2024).

People living with long term health conditions

In our region, 26.3 per cent of people have at least one chronic health condition, which is lower than the Queensland state average of 32.9 per cent. More men (69 per cent) than women (31 per cent) reported living with one or more long-term health issues. At the local level, the Hinchinbrook LGA (33.4 per cent), Burdekin LGA (30.1 per cent), and Tablelands LGA (29.7 per cent) have the highest proportions of residents with multiple chronic conditions.

The most frequently reported long-term health issues are mental health conditions – including depression and anxiety – at 8.2 per cent, followed by arthritis at 8.1 per cent. Other common conditions include asthma (7.1 per cent), diabetes (4.6 per cent), heart disease (4 per cent), and cancer (2.8 per cent). People aged 55 years and older are more likely to report having one or more chronic health conditions (QGSO, 2024).

People with disability

According to the Census of Population and Housing, 5.4 per cent of people in the NQPHN region have a profound or severe disability compared to six per cent in Queensland overall. Amongst children aged 0–14 years who require assistance, 31.8 per cent are female and 67.8 per cent are male. For those identifying as Aboriginal and/or Torres Strait Islander and needing assistance, 47.9 per cent are female and 51.6 per cent are male.

At the local government area level, the Hinchinbrook LGA has the highest proportion of residents with a profound or severe disability (8.3 per cent), followed by the Cassowary Coast LGA (6.8 per cent), and the Burdekin LGA (6.6 per cent) (QGSO, 2024).

Leading causes of death

For the NQPHN region, coronary heart disease was identified as the leading cause of death in 2022 followed by dementia, including Alzheimer's disease (AIHW, 2022).

Rank	Cause of death (ICD-10)	Number of deaths
1	Coronary heart disease	2,551
2	Dementia, including Alzheimer's disease	1,759
3	Lung cancer	1,453
4	Cerebrovascular disease	1,233
5	Chronic obstructive pulmonary disease	1,089

Palliative care services

The Royal Australian College of General Practitioners (RACGP) defines palliative care as an approach that shifts focus from life prolonging treatment to a focus on quality of life across a person's physical, emotional, social, and spiritual world as they approach death (RACGP, 2025).This concept must be considered when understanding palliative care services across the NQPHN region.

A key investment in palliative care with significant impact on the palliative care sector across northern Queensland is the Queensland Government's *Palliative and End-Of-Life Care Strategy* which prioritises that all Queenslanders have access to high quality palliative care and end-of-life support. It aims to strengthen the healthcare system by ensuring that care is culturally safe, person-centred, equitable, and accessible to all (Health, Palliative and End-of-Life Care Strategy, 2022). Queensland Health's *Specialist Palliative Care Workforce Plan 2021-22 to 2025-26* has resulted in a Specialist Palliative Rural Telehealth Service (SPaRTa), a specialist multidisciplinary clinical telehealth service with an emphasis on providing consultation and clinical advice to clinicians managing end-of-life care for rural and regional patients. The Specialist Palliative Care in Aged Care (SPACE) project provides similar support to residential aged care homes (RACHs) (Health, Queensland, 2022)

As part of this reform, community based palliative care services have been commissioned to increase access to community based palliative care for regional and remote Queenslanders. This service is being delivered by BlueCare and aims to complement existing services to provide person-centred care for individuals residing in designated health service areas, three of which are in the NQPHN area. Additional state-based initiatives further enhance the sector including the First Nations Palliative Care project, Telehealth Paediatric Palliative Care Service, the Statewide Office of Advance Care Planning, and PallConsult which provide hotlines, education, mentoring, and resource development for Queensland clinicians providing palliative care (Health,Queensland, 2022).

Torres and Cape Hospital and Health Service

The Torres and Cape Hospital and Health Service (TCHHS) provide a unique palliative care service developed to respond to the specific challenges of the region. The Pop-Up Palliative Care Service

(PUPS) operates a multidisciplinary service that includes Aboriginal and Torres Strait Islander Health Workers. They aim to support patients in returning to the community, enabling end-of-life care at home, or on Country when appropriate, while also assisting those who may transition back into residential aged care homes.

Whilst all other HHS regions in the NQPHN footprint received additional community-based palliative care services, delivered by BlueCare, for regional and remote Queenslanders the TCHHS did not receive this (Health, Queensland, 2022). Palliative care services ranked third as a service gap in the TCHHS region, indicating that staff shortages remain a barrier (HWQ, 2025).

Cairns and Hinterland Hospital and Health Service

The Cairns and Hinterland Hospital and Health Service (CHHHS) provide multidisciplinary community palliative care to individuals living within a 45-kilometre radius of Cairns. Outside this radius, SPaRTa provides specialist telehealth multidisciplinary services support. To address the growing demands of services, CHHHS have identified an expansion of palliative care services that include models to enable people to palliate at home, where possible. This has been identified for the Tablelands (East) to Kuranda Statistical Area, Level 3 (SA3) region and Innisfail to Cassowary Coast SA3 region (CHHHS, 2022). Like the Mackay and Townsville HHS regions, BlueCare community palliative care services work closely with SPaRTa to provide in-home services to those in the rural and remote areas of the CHHHS region (Health, Queensland, 2022). Palliative care services were ranked second as a service gap in the Cairns and Hinterland HHS region (HWQ, 2025).

Queensland Health's SPaRTa and the SPACE project supports the 21 RACHs in the CHHHS region.

Townsville Hospital and Health Service

The Townsville Hospital and Health Service (THHS) delivers community-based palliative care to individuals living within a 45-kilometre radius of Townsville. These services include a mix of medical and allied health services, bereavement, and volunteer support services. Outside this 45-kilometre radius, SPaRTa provides specialist telehealth multidisciplinary services. The Townsville HHS was one of the areas identified for additional community palliative care under BlueCare, with services reaching into some of the regional areas of the catchment. Access to palliative care and end-of-life support services is an issue, especially in rural and remote areas across the Townsville HHS region. Additionally, an unavailability in hospice facilities and the limited capacity and capability of existing RACHs to provide palliative care was identified (THHS, 2021).

There are currently 20 RACHs within the THHS region who have access to specialist palliative care clinicians via SPaRTa and the SPACE project (Health, Queensland, 2022).

Mackay Hospital and Health Service

The Mackay Hospital and Health Service (MHHS) provide community palliative care services to those living within a 45-kilometre radius of Mackay. These services include a mixture of medical and allied health practitioners and bereavement supports. Individuals living outside the 45-kilometre radius, receive specialist telehealth multidisciplinary services from SPaRTa, which is based out of the Townsville HHS. The Mackay HHS regions was one of the areas identified for additional community palliative care under BlueCare. Limited availability of palliative care services, particularly rural areas has been identified for the Mackay HHS region (MHHS, 2025).

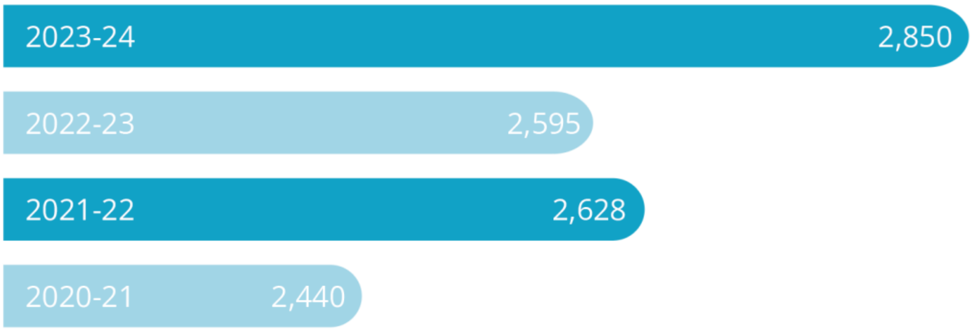
There are 12 residential aged care homes located within the Mackay HHS region, supported by Queensland Health's SPACE project, to improve palliative care for residents of aged care homes (Health, Queensland, 2022).

Palliative care-related hospitalisations

Palliative care-related hospitalisations refer to episodes of admitted patient care where palliative care was a component of the care provided during all or part of the episode (AIHW, 2025).

In 2023-24, there were a total of 2,850 palliative care-related hospitalisations across our region. A consistent increase in the number of hospitalisations has been observed over the last few years (as seen in Figure 1).

Figure 1. Total number of palliative care-related hospitalisations in the NQPHN region, 2020-21 to 2023-24



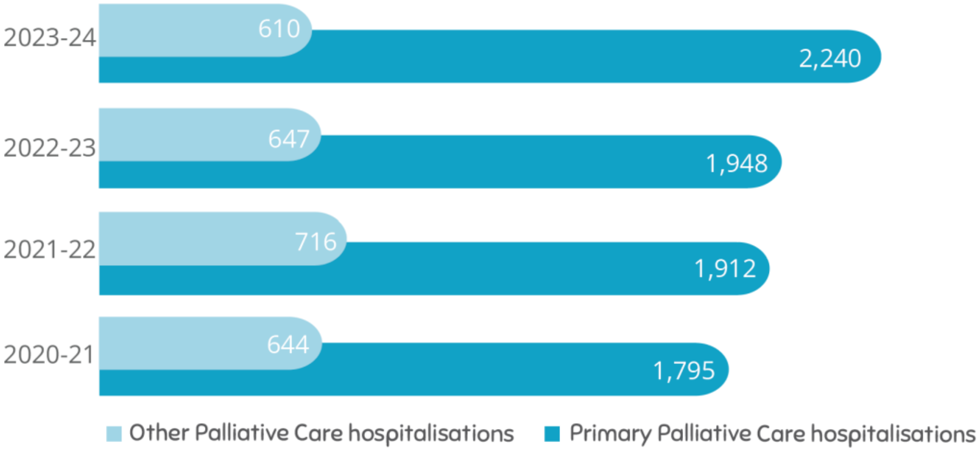
Palliative care-related hospitalisations by type

These palliative care-related hospitalisations can be divided into two groups, depending on how they are identified in the hospital data:

- Primary palliative care hospitalisations: Hospitalisations with a recorded care type of palliative care.
- Other palliative care hospitalisations: Hospitalisations with a recorded diagnosis of palliative care, but the care type is not recorded as palliative care.

A higher number of primary palliative care hospitalisations were reported in comparison to other palliative care hospitalisations for our region between 2020-24. A consistent increase has been observed in the number of primary palliative care hospitalisations over this period (Figure 2).

Figure 2. Total number of palliative care-related hospitalisations by type, NQPHN region, 2020-21 to 2023-24



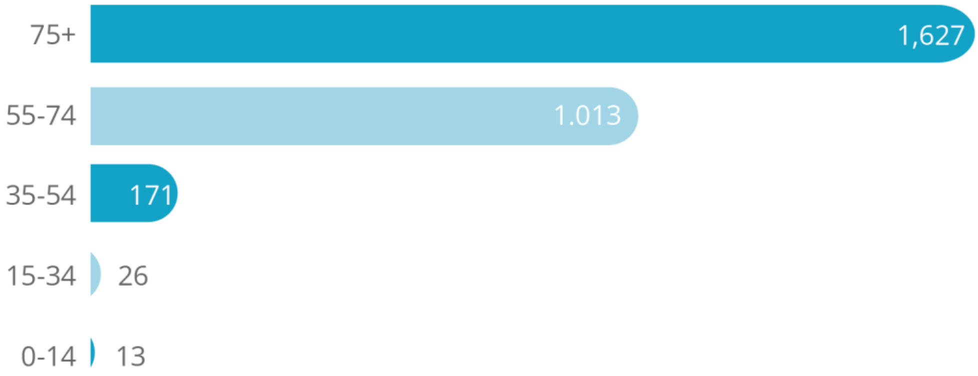
Palliative care-related hospitalisations by diagnosis

Of the total number of palliative care-related hospitalisations, 38 per cent (n=1,092) were due to cancer as the principal diagnosis in the 2023-24 period for our region.

Palliative care-related hospitalisations – admitted patients

In 2023-24, the number of hospitalisations for admitted patient palliative care within the NQPHN region was 2,850 (~12.6 per cent of the Queensland state total). A higher number of hospitalisations was observed among those 55 years and older in our region.

Figure 3. Number of palliative care-related hospitalisations (admitted) by age group, NQPHN region, 2023-24



Palliative care-related service events

Palliative care-related service events refer to non-admitted patient care service events where the primary clinical purpose or treatment goal is the optimisation in the quality of life of a patient with an active and advanced life-limiting illness.

For our region, nearly 16,545 palliative care-related non-admitted patient primary palliative care service events were reported in the 2023-24 period. Those aged 55 years and older had a higher number of service events (n=14,293) for our region while a smaller number of service events were reported for those aged 35-54 years (n=1,745).

Figure 4. Number of palliative care-related non-admitted patient primary palliative care service events, by age group, 2023-24

MBS-subsidised palliative medicine attendance and case conference services

In 2023-24, Medicare Benefit Schedule (MBS)-subsidised palliative medicine attendance and case conference services, provided by palliative medicine physicians/specialists within our region, included 1,339 services provided, at an average of 2.9 services per person. Of these:

- most of the services were palliative medicine attendances (n=1,328)
- 460 people received these services within our region
- those aged 55 years and older received a higher number of MBS-subsidised palliative medicine attendance and care conference services.

At a national level, the number of MBS-subsidised palliative medicine attendance and care conference services has declined with an average annual decrease of 4.9 per cent (AIHW, 2025).

Figure 5. Number of MBS-subsidised palliative medicine attendance and care conference services by age group, NQPHN, 2023-24

Palliative care-related prescriptions

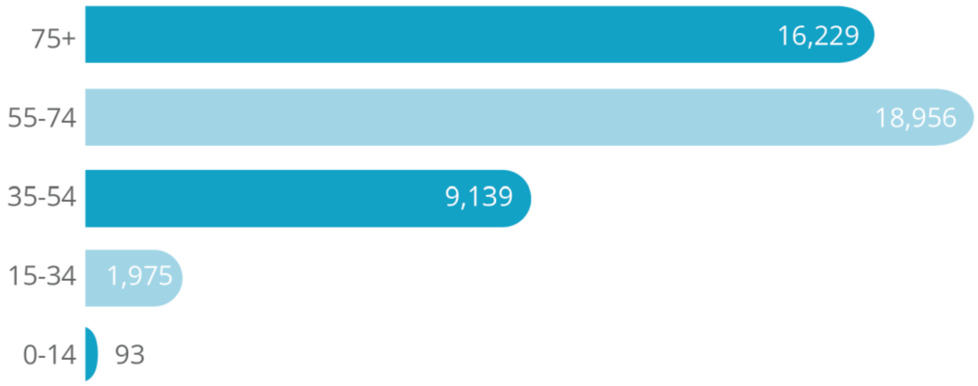
In 2023-24, across our region, 46,392 palliative care-related prescriptions were provided to 15,566 people, equating to three prescriptions per person. Of these, 85 per cent of the palliative care-related prescriptions were for pain relief.

Nationally, the number of palliative care-related prescriptions has increased by 59 per cent, while the number of people dispensed with palliative care-related prescriptions declined by 4.1 per cent (AIHW, 2025).

Figure 6. Proportion of palliative care-related prescriptions by medication group, NQPHN region, 2023-24

The number of palliative care-related prescriptions was highest among those aged 55 years and older across our region in 2023-24 at about 3.4 prescriptions per person (AIHW, 2025).

Figure 7. Number of palliative care-related prescriptions by age group, NQPHN region, 2023-24



Survey findings

Northern Queensland Primary Health Network (NQPHN) ran a survey targeting service providers across the region to provide feedback and insights around the Greater Choice for At Home Palliative Care (GCfAHPC) program.

A total of 40 responses were received. Of these, the highest number of responses were from the Cairns and Hinterland Hospital and Health Service (HHS) region (n=18) with the least number of responses collected from respondents in the Torres and Cape HHS region (n=3).

Respondents mainly included nurses working in palliative care service delivery. Other respondents consisted of general practitioners, allied health professionals, and community workers and members.

Many respondents chose home-based care (n=17) as the type of palliative care service they provided across the NQPHN region, followed by community support services (n=14).

Current availability of services

Survey respondents rated the current availability of services on a scale from one (lowest) to five (highest). Most responses clustered around ratings of two, three, and four. Rating three was the most common response, indicating that many participants feel the availability of palliative care services is moderate – neither poor nor excellent (n=15). Several other respondents rated availability as below average, highlighting concerns about access and adequacy (n=10).

Barriers

The most frequently cited barriers to delivering palliative care are a lack of resources, limited awareness among patients and providers, a lack of education and training, staffing shortages, and insufficient funding. These issues are consistently mentioned across responses and represent the main challenges to effective service delivery. Geographical challenges, especially in rural and remote areas, were repeatedly mentioned as limiting access.

- **Staffing shortages:** This was the most frequently cited barrier by most respondents, leading to limited-service availability, longer wait times, and reduced capacity for home visits or after-hours care. A survey respondent shared that “carer support very difficult to obtain in my regional town due to mainly staffing shortages”.
- **Insufficient funding:** Directly affecting the ability to hire staff, provide training, and maintain or expand services. Funding gaps were more pronounced in rural and remote areas.
- **Lack of resources:** This included a shortage of equipment, medications, and education materials. Respondents noted delays in accessing necessary supplies, especially in remote areas.
- **Limited awareness or understanding:** Amongst providers this was around the referral processes and palliative care pathways, while patients and their families were unaware of available palliative care services or how to access them.
- **Geographical and access challenges:** Distance and remoteness limited access to services, especially for home-based care and respite. Telehealth is not always a viable option due to connectivity issues.
- **Education and training gaps:** The need for more local, face-to-face training for staff was stated by respondents. Lack of training for support workers, family caregivers, and volunteers was also mentioned.

- System and process issues: Respondents stated that care was fragmented due to lack of integration across services and inconsistent documentation. It was also noted that there were siloed service provision and duplicity of information.
- Cultural and community specific barriers: Respondents mentioned the need for culturally safe care, especially for Aboriginal and Torres Strait Islander communities and people with disabilities. This included a lack of tailored resources and training for these groups, specifically.
- Other notable barriers included:
  - time constraints for staff, especially when urgent equipment or medication is needed
  - emotional and spiritual support needs for patients and families are sometimes unmet
  - stigma and legal/ethical concerns around medication used at end of life which may act as a barrier to nurses administering and doctors prescribing.

Most common needs of patients and families

Survey respondents stated the following as the most common needs of patients and families they worked with:

- pain management
- emotional and spiritual support
- caregiver support and respite
- information and education
- advanced care planning and legal support
- access to services and equipment
- equity of access and culturally safe care.

Additional services needed to support palliative care in the community

- Expanded home-based and community support: Respondents stated that more home-based care services and in-home clinical support, especially after-hours, would allow patients to remain at home and reduce hospitalisations.
- Respite care: For families and caregivers, including culturally safe respite options in rural and remote areas.
- Timely provision of equipment and medication: For symptom management and to support families without delays.
- Ongoing professional development and education: On symptom management, end-of-life care, and culturally appropriate practices.
- Better collaboration and communication: Between primary care, aged care, hospitals and palliative services.
- Shared clinical platforms and documentation systems: To ensure seamless care and information sharing.
- Culturally safe training: For health workers and resources for families.
- Tailored services: For Aboriginal and Torres Strait Islander communities and other diverse groups.

- Increased community education: About palliative care options, referral pathways, and available services. This will help support patients and families to navigate the system and access care when needed.
- Increased availability of face-to-face services: Given telehealth services are limited in remote areas due to connectivity.

Collaboration of palliative care providers

Most respondents rated the availability and collaboration of palliative care services in the region as moderate (ratings of 3 out of 5), and a majority are interested in participating in future discussions or focus groups. However, many are unsure if the program has made a noticeable difference so far.

Improve collaboration among palliative care providers

- Many respondents suggested holding regular meetings, forums, or roundtable discussions for service providers to share updates, changes, and best practices. These meetings would help build relationships, clarify roles, and foster a sense of shared purpose.
- Shared platforms would help all providers involved in a patient's care to access up-to-date information, reducing duplication and improving handover.
- Respondents suggested improving communication channels across all levels of care as this would help ensure timely and coordinated care.
- Strengthening interprofessional collaboration between all key stakeholders and not just the health sector.
- Clarity around the roles and responsibilities of different providers in palliative care would help increase collaboration and communication.

Training and resources

While most respondents agreed that they had adequate training and resources to provide effective palliative care (n=27), a smaller proportion of respondents stated they did not.

The smaller cohort of respondents made the below suggestions to improve training and resources for effective palliative care.

- Local on-site training opportunities: Respondents noted that most training is only available in major cities, making access difficult for regional staff and carers.
- Education for all staff levels and carers: Respondents stated a lack of basic introductory training for all staff, including assistant and support workers, not just nurses and doctors. Family members and informal carers also need education and resources to better understand palliative care and end-of-life care.
- Specialised and advanced training topics: Respondents requested more training on specific clinical topics such as pain management, anticipatory prescribing, symptom management, and having difficult conversations with families.

Progress of program has made a noticeable difference

Most responses were mixed, with some stating the GCfAHPC program has made a noticeable difference, while others felt the impact was limited or unclear. Respondents recommended:

- more frequent and visible engagement in the community

- increased education and training, especially in rural and remote areas
- enhanced collaboration and communication between all service providers
- greater support for general practice and community-based care
- more culturally safe and inclusive services.

Other Findings

Previous needs assessments

The previous NQPHN Greater Choice for At Home Palliative Care (GCfAHPC) Needs Assessment (2022) highlighted that some groups have difficulty accessing quality palliative care, appropriate to their needs, including:

- people who identify as lesbian, gay, bisexual, transgender, or intersex (LGBTI)
- people from culturally and linguistically diverse (CALD) backgrounds
- Aboriginal and/or Torres Strait Islander peoples.

NQPHN's Joint Regional Needs Assessment 2025 – 28 highlighted Australia's ageing population growth and an increase in the prevalence of chronic conditions and the need for improved palliative care services, in addition to:

- the limited availability of palliative care services across the NQPHN region
- rural and remote areas lacking suitable palliative care services.

Interviews

Insights from four interviews conducted with palliative care service providers aligned closely with survey findings. The need for greater collaboration across the sector was identified as a strong theme. Participants raised concerns about the recent introduction of The End-of-Life Pathway, with the support at home program under aged care reforms highlighting the need for clearer guidance and targeted palliative care training for the community aged care workforce. Staff shortages, particularly in rural and remote areas, were cited as a barrier for providing in-home support. Specific challenges in the TCHHS region included significant issues with equipment provision due to geographic constraints. Respite services were also flagged as a critical need, with current options being extremely limited, often leaving admission to a local health service or hospital as the only alternative.

GCfAHPC project activities summary

In 2025, a series of activities were implemented across the NQPHN region as part of the Greater Choices for At Home Palliative Care (GCfAHPC) project. Through these activities, feedback highlighted a need for more locally based providers and community connectors, indicating the need for local connection and collaboration across the entire sector.

As part of these activities, education and networking sessions were held throughout the NQPHN region, bringing together professionals from across the palliative care workforce. The education sessions covered topics around paediatric palliative care, culturally appropriate end-of-life care, advanced care planning, and specialist palliative care services. During this time, the need for additional education and training sessions across other areas within our region was suggested.

Through the Program of Experience in the Palliative Approach (PEPA) program, seven staff were trained in the NQPHN region. These participants reported finding value in the experience, all expressing that their practice was altered as a result of the training, with learnings shared amongst their respective workplaces. Additional opportunities have been identified for extending the offerings to the aged care sector through PEPA Aged Care, and to Aboriginal and Torres Strait Islander workforce through the Indigenous Program of Experience in the Palliative Approach (IPEPA).

Conclusion

This Greater Choices for At Home Palliative Care Project Needs Assessment highlights both the progress and ongoing challenges in the delivery of high-quality, accessible palliative care across the NQPHN region. While initiatives such as Compassionate Communities, expanded training, and increased service integration have strengthened local capacity, persistent barriers remain – particularly in workforce shortages, resource limitations, and service coordination, especially in rural and remote areas. Moving forward, a continued focus on collaboration, culturally safe care, community engagement, and data-driven decision-making will be essential to ensure that all individuals receive person-centred palliative care, wherever they live.

Over the next four years the Greater Choices for At Home Palliative Care project will focus on the four key objectives of the program by:

- Developing a detailed service map of palliative care services across the NQPHN region.
- Strengthening and expanding Compassionate Communities groups by enhancing their skills and resources.
- Expanding PEPA training opportunities and identifying additional strategies to support residential aged care homes in maintaining high-quality palliative care.
- Continuing networking and professional development activities.
- Actively engaging and working with key stakeholders involved in service delivery across our region.
- Facilitating/providing opportunities for the use of technology in palliative care service delivery.
- Capturing high-quality data to guide informed decision-making.

Appendix A: List of needs identified for NQPHN Region

The below list of palliative care needs was identified from survey findings, limited datasets, and stakeholder engagement. A total of 10 needs were identified for our region based on stakeholder feedback, including service providers, carers, etc.

Priority	Issue/s	Need/s	Expected outcome
Workforce capacity and development	Staffing shortages are the most frequently cited barrier, limiting service availability, respite options, home visits, and after-hours care.	Train more staff, especially in rural and remote areas; upskilling for general practitioners (GPs), nurses, and the aged and community care workforce. Exploration of sustainable workforce models.	Reduced hospitals transfers, more choice for death at home or on Country, and the right care, at the right time for individuals, and their carers.
	Limited education and capacity building opportunities for GPs, practice nurses, and the broader palliative care workforce, especially in rural and remote areas.	Ongoing professional development and education on symptom management and medications, end-of-life care, and palliative care practices.	Strengthened connections between primary and specialist services, upskilling, and an improvement in the recognition of palliative care needs.
	Limited awareness or understanding amongst some service providers around referral processes and pathways.	A stakeholder engagement series with a view to establish collaborative palliative care groups in each HHS region, ongoing networking and professional development, exploration of information sharing systems for seamless referrals, and a roll out of PEPA and iPEPA training.	Strengthened connections between services, upskilling of staff, improved recognition of palliative care needs, and more timely referrals.
	Education and skill enhancement for providers intending to provide new End-of-Life Pathways under aged care reforms.	Engagement with the community aged care sector, and ongoing networking and professional development opportunities to upskill community based aged care providers.	Strengthened connections between services, upskilling of staff, improved recognition of palliative care needs, and more choice for holistic care at home or on Country.

Priority	Issue/s	Need/s	Expected outcome
Access in regional, remote, and very remote areas	Limited home-based and community palliative care, especially outside major centers; limited access to respite care and equipment.	Exploring opportunities to facilitate local solutions to fill service gaps, including respite for carers.	Reduced hospitals transfers, provision of more choice for holistic care at home or on Country.
	Limited access to palliative care services due to distance and remoteness, with telehealth not always viable due to connectivity issues	Exploration of emerging technology to provide access to specialist/general care and local solutions for service gaps.	Reduced hospital transfers, provision of more choice for holistic care at home or on Country, and enhanced reach for current specialist palliative care teams.
Enhancing palliative care in residential and facility-based settings (including residential respite services)	Building capacity for person-centred palliative care within residential and facility-based settings.	Linking with SPACE and other palliative care specialist programs, skill enhancement for residential and facility-based care workforces, and exploration of emerging technology to support palliative care.	Provision of person-centred end-of-life care in residential and facility-based settings, resulting in fewer hospital transfers where avoidable.
Community education and awareness	Enhancing community capacity, knowledge, and skills for end-of-life care.	Reinvigorating Compassionate Community Connector networks, providing community information, and education activities for all aspects of end of life, including advanced care planning and bereavement supports.	Communities who are empowered to make end-of-life decisions, have the skills and knowledge to support each other and access services, if required.
Ongoing development and promotion of inclusive palliative care for diverse communities in the NQPHN region	Person-centered, culturally safe palliative care options for diverse communities, including CALD communities, Aboriginal and Torres Strait Islander peoples, LQBTQI communities and individuals with a disability.	Relationship building and partnerships with peak bodies, local groups, and other key stakeholders, and education and capacity building initiatives within the community and palliative care sector.	Increased choices and access to inclusive, person-centered and culturally safe in home or on Country palliative care.
Service Mapping across NQPHN	Increased understanding of service gaps, duplication, and service barriers across all aspects of end-of-life care provision, including community aged care services.	Stakeholder forums, engagement, and collaboration. Desktop review and resource creation.	Clearer referral pathways for individuals, less service duplication, and a more thorough understanding of service gaps for future needs assessments.

Program Logic Table – 10 Identified Priority Areas (Needs)

This program logic table translates the 10 needs identified in Appendix A into a logic model (activities → outputs → outcomes). It is intended to support work planning for the GCfAHPC project through to June 2029 and can be refined as implementation details (owners, resourcing, baselines) are confirmed.

#	Priority area	Need Appendix A)	Key activities / strategies (from document)	Outputs	Short-term outcomes (0–12 months)	Medium-term outcomes (1–3 years)	Long-term outcome / impact (by 2029 and beyond)	Suggested measures
1	Workforce capacity and development	Train more staff (especially rural/remote); upskill GPs, nurses, and community care workforce; explore sustainable workforce models.	Deliver training and education opportunities; expand PEPA/IPEPA placements; targeted upskilling for rural/remote workforce	Training sessions delivered; participants trained (GPs, nurses, community care providers); PEPA/IPEPA placements completed.	Increased confidence/knowledge in palliative care and symptom management; improved recognition of palliative care needs.	Improved service capacity (home visits/after hours); improved continuity of care; fewer avoidable escalations.	Reduced hospital transfers; more people able to die at home/on Country with right care at right time.	# training sessions; attendance by discipline/location; pre/post training self-assessment; PEPA/IPEPA numbers; palliative care-related hospitalisations trend.
2	Workforce capacity and development	Ongoing professional development on symptom management/medications, end-of-life care, and palliative care practices.	Provide ongoing PD (forums/dinners); promote use of HealthPathways and other technologies; education on end-of-life processes.	PD calendar: resources shared; HealthPathways promotion activities.	Increased capability in anticipatory prescribing/symptom management; improved end-of-life care processes.	Stronger primary–specialist linkages; improved timeliness/quality of community-based management.	Right care in right place; improved patient/carer experience; reduced unnecessary hospitalisations.	Number of PD events/year; participant feedback; HealthPathways usage (visits, time, topics searched); clinician-reported practice change.
3	Workforce capacity and development	Stakeholder engagement series to establish collaborative palliative care groups in each HHS; explore information sharing systems; roll out PEPA/iPEPA.	Establish and administer 4 HHS-based collaboratives; develop Terms of Reference; hold regular meetings; conduct member satisfaction survey.	4 collaboratives established; ToR agreed; meetings held; shared actions/initiatives identified.	Improved connectedness and pathway awareness; improved communication between providers.	More coordinated care; clearer referral pathways; reduced duplication/fragmentation.	More cohesive palliative care system; fewer admissions; improved outcomes for patients/carers.	Collaboratives established (Y/N); meetings; attendance; member satisfaction; documented pathway improvements; hospital admission trends.
4	Workforce capacity and development	Upskill providers delivering End-of-Life Pathways and strengthen service navigation and referral knowledge across community-based care settings.	Engage relevant sector stakeholders; develop/offer training aligned to End-of-Life Pathways; connect providers with specialist support.	Engagement sessions held; training modules delivered; participation metrics.	Improved preparedness of participating providers for end-of-life pathways; improved referral/navigation knowledge.	Improved delivery of holistic care in home and community settings; reduced crises/escalations.	More choice for care at home/on Country; improved quality end-of-life care across sectors.	# engagement/training sessions; attendance; confidence surveys; documented pathway use; provider feedback.

5	Access in regional, remote, and very remote areas	Facilitate local solutions to fill service gaps, including respite for carers.	Explore and develop opportunities to fill service gaps; build knowledge; include respite carer options; connect with community providers.	Gap analysis/ engagement notes; potential local service models identified; respite options mapped (where available).	Improved visibility of local service options; initial service improvements trialed.	Expanded access to home-based care/ respite options outside major centers.	Reduced hospital transfers: more people supported to die at home/on Country in rural/remote areas.	# local solutions trialed; respite availability indicators; patient/carer feedback; transfer-to-hospital rates from rural/ remote areas.
6	Access in regional, remote, and very remote areas	Explore emerging technology to provide access to specialist/ general care; develop local solutions for gaps where telehealth is limited by connectivity.	Explore technology-enabled models; work with services to address connectivity constraints; leverage SPaRTa where applicable.	Technology options assessed; pilot(s) implemented (To be confirmed); guidance/ resources produced.	Improved clinician access to specialist advice; improved patient access where feasible.	Improved reach of specialist palliative care teams; more timely support for remote patients.	Reduced hospital transfers; more equitable access to palliative care across geography.	# technology assessments/ pilots; clinician uptake; connectivity barriers logged; service reach metrics; avoidable hospitalisations trend.
7	Residential and facility-based settings (incl. residential respite)	Link with specialist programs (e.g., SPACE) and other supports; build workforce capability in residential and facility-based settings; explore technology to support palliative care.	Work with residential and facility-based providers; develop training with SPACE/ PallConsult/PEPA/IPEPA; mentoring/telehealth support options.	Provider engagements: training delivered; specialist support linkages established.	Increased workforce knowledge/confidence in residential/facility-based settings; improved symptom management and end-of-life planning.	More people able to receive end-of-life care in place where appropriate; fewer transfers near end of life.	Improved quality and person-centered end-of-life care in residential and facility-based settings.	Provider participation; pre/ post confidence; transfers near end of life; proportion able to be cared for in-place; family feedback (where available).
8	Community education and awareness	Reinvigorate Compassionate Community Connector networks; provide community information and education (ACP, bereavement supports, etc.).	Re-establish/grow Community Connectors; deliver community events (including the Good Life, Good Death Expo in partnership with Palliative Care Queensland); provide ACP workshops; develop palliative care website resources.	# connector sessions; # participants; events/ workshops delivered; Good Life, Good Death Expo(s) delivered (e.g., Mackay June/ July 2026; Townsville Oct 2026 TBC); public and professional attendance; information distributed (e.g., ACP); CPD sessions delivered (where applicable); resources produced/ updated.	Improved death literacy and awareness of services/referral pathways; increased ACP engagement.	Stronger community support networks for carers/ families; improved navigation of services.	Communities more empowered to support dying people; increased ability for people to die at home/on Country where preferred.	Community Connector participation and feedback; ACP workshop numbers; website resource usage; GLGD Expo measures: public attendance; professional attendance (GPs, nurses, other); formal feedback/learning capture; engagement indicators (e.g., questions from the public); information distributed; exhibitor feedback; questionnaires (e.g., death literacy / Statement of Choices).

9	Inclusive palliative care for diverse communities	Relationship building/ partnerships with peak bodies and local groups; education/ capacity building to improve inclusive, culturally safe options (CALD, Aboriginal and Torres Strait Islander peoples, LGBTQI, disability).	Engage with CALD communities, LGBTQI communities, disability groups; develop/adapt resources; provide culturally safe training.	Partnerships established; tailored resources produced; engagement activities delivered.	Improved cultural safety and awareness across workforce; improved access to information/ resources for diverse groups.	Improved equity of access and patient experience across diverse communities.	Increased choice and access to inclusive, culturally safe in-home/ on Country palliative care.	Partnerships; tailored resources; participation by community groups; feedback from diverse communities (To be confirmed); equity indicators (To be confirmed).
10	Service mapping across NQPHN	Stakeholder forums/ engagement/ collaboration; desktop review and resource creation to understand gaps/duplication/ barriers and improve pathways.	Map all palliative care services; understand focus/capacity; cross-reference mapping findings with HNA; pursue engagement opportunities.	Service map produced; directory/ resources created; gaps/duplication documented; pathway improvements identified.	Clearer visibility of services and referral options; reduced duplication of information.	Clearer referral pathways; improved coordination; better targeting of future initiatives.	More integrated palliative care system; improved access and efficiency; improved ability to plan beyond 2029.	Service map completion (Y/N); update frequency; services mapped; user feedback; documented pathway changes; duplication reduction examples.

Acronyms

Term	Definition
CALD	Culturally and Linguistically Diverse
CHHHS	Cairns and Hinterland Hospital and Health Service
DHDA	Department of Health, Disability and Ageing
GCfAHPC	Greater Choices for At Home Palliative Care
GPs	General practitioners
HHS	Hospital and Health Service
iPEPA	Indigenous Program of Experience in the Palliative Approach
LGA	Local Government Area
LGBTI	Lesbian, Gay, Bisexual, Transexual, and Intersex
MBS	Medicare Benefits Schedule
MHHS	Mackay Hospital and Health Service
NQPHN	Northern Queensland Primary Health Network
PC QLD	Palliative Care Queensland
PEPA	Program of Experience in the Palliative Approach
PHN	Primary Health Network
PUPS	Pop Up Palliative Care Service
RACH	Residential Aged Care Home
SPACE	Specialist Palliative Care in Aged Care
SPaRTa	Specialist Palliative Rural Telehealth Service
TCHHS	Torres and Cape Hospital and Health Service
THHS	Townsville Hospital and Health Service

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e: support@nqphn.com.au
w: nqphn.com.au

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