Health Needs Assessment – Palliative Care

Darling Downs and West Moreton PHN

December 2025

phn DARLING DOWNS AND WEST MORETON
An Australian Government Initiative

Local Integrated Primary Health Care

Acknowledgment of Country

Darling Downs and West Moreton PHN acknowledges the Aboriginal and Torres Strait Islander peoples as the Custodians of the lands across which we work. We pay my respect to Elders past, present and emerging, and commit to a future with reconciliation and renewal at its heart.

We recognise that the concepts of land, family and spirituality are directly linked to Aboriginal and Torres Strait Islander peoples' physical and mental wellbeing.

We respectfully acknowledge the resilience and wisdom of Aboriginal and Torres Strait Islander peoples as one of the world's longest-lasting cultures and recognise our responsibility to contribute towards a more equitable and culturally safe primary care system.

This Health Needs Assessment – Palliative Care was developed as a part of Greater Choice for At Home Palliative Care – An Australian Government Initiative. While the Australian Government Department of Health has contributed to the funding of this material, the information contained in it does not necessarily reflect the views of the Australian Government and is not advice that is provided, or information that is endorsed, by the Australian Government. The Australian Government is not responsible in negligence or otherwise for any injury, loss or damage, however arising from the use of or reliance on the information provided herein.

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Abbreviations

- ABS – Australian Bureau of Statistics
- ACD – advance care directive
- ACP – advance care planning
- AIHW – Australian Institute of Health and Welfare
- CAEOL – Care at the End of Life
- DD – Darling Downs
- DDH – Darling Downs Health
- FTE – full-time equivalent
- GP – general practitioner
- HNA –Health Needs Assessment
- LGA – local government area
- LGBTIQA+ – lesbian, gay, bisexual, transgender, gender diverse, intersex and queer
- MASS PCEP – Medical Aids Subsidy Scheme Palliative Care Equipment Program
- PBS – Pharmaceutical Benefits Scheme
- PCOC – Palliative Care Outcomes Collaboration
- PHIDU – Public Health Information Development Unit, Torrens University
- PHN – Primary Health Network
- RACGP – Royal Australian College of General Practitioners
- RACH – residential aged care homes
- SA2 – Statistical Areas Level 2
- SPACE – Specialist Palliative Care in Aged Care
- SPaRTa – Specialist Palliative Rural Telehealth
- VAD – voluntary assisted dying
- WM – West Moreton
- WMH – West Moreton Health

Introduction

Palliative care is about helping to support the quality of life of anyone with a life-limiting illness, as well as supporting carers, family and friends during this period. Whether provided by a specialist facility, general healthcare organisation, or community teams, palliative care is an important part of the healthcare journey.

Palliative care can ensure that physical needs including relief from pain and discomfort are managed at the end-of-life, and can also be part of meeting psychosocial or spiritual needs. Person-centred palliative care should be matched to the person's values and beliefs and grounded in their place among family, friends and community.

In the Darling Downs and West Moreton region, palliative care is provided by a range of specialist and general healthcare practitioners and support workers. In this Health Needs Assessment, we explore what else can be done improve our services and meet the needs of our community members who are at the end of their lives, along with their carers, family and friends.

Lucille Chalmers

Chief Executive Officer
Darling Downs and West Moreton PHN

Executive summary

About this Health Needs Assessment

The Darling Downs and West Moreton Primary Health Network (the PHN) have developed this regional Health Needs Assessment (HNA) on Palliative Care to examine the healthcare needs of people in our region and the gaps that must be addressed to meet those needs. The HNA aims to identify service gaps and key issues to inform and establish joint regional priorities.

This Palliative Care Health Needs Assessment requires ongoing collaboration between the PHN and its healthcare partners to identify all joint regional priorities across the Darling Downs and West Moreton regions to ensure we are meeting the palliative and end-of-life care needs of the communities we serve.

Methodology

The HNA used evidence-based methodology to understand needs and determine priorities. The process was conducted according to the PHN Program Needs Assessment Policy Guide.[1]

The assessment explored key questions around three main themes:

- **Community:** What are the community needs for palliative care in our region (numbers of people, regional distribution, types of care)?
- **Services:** What palliative care services are available in the region, and how well do they meet community needs?
- **Workforce:** What are the palliative care workforce capacity and capabilities in the region, and how well do they meet community needs?

Several main data sources were used to develop the assessment:

- Australian Institute of Health and Welfare.[2]
- Palliative Care Outcomes Collaboration Program.[3]
- Palliative Care Queensland.[4]
- Joint Regional Needs Assessment 2025-2028 - Darling Downs and West Moreton PHN, Darling Downs Health, West Moreton Health.[5]
- Health Needs Assessment - Darling Downs and West Moreton PHN.[6]
- Local research, including hospitals and health service data and regional service mapping conducted as part of the Palliative Care Pathways Project and development of the Joint Regional Older Persons Strategy.
- Consumer research, including regional outreach, TALK ABOUT Older Persons community research campaign, and Death Literacy Index evaluations.

1. Department of Health, PHN program needs assessment policy guide 2021, Australian Government, Canberra 2021, accessed 22 October 2025.
2. Australian Institute of Health and Welfare (AIHW), Palliative care services in Australia, AIHW, Canberra, 2025, accessed 22 October 2025.
3. Australasian Health Outcomes Consortium, About PCOC, University of Wollongong, n.d., accessed 22 October 2025.
4. Palliative Care Queensland, Patient outcomes in palliative care reports, 2025, accessed 22 October 2025.
5. Darling Downs and West Moreton PHN, Darling Downs Health, West Moreton Health (2025). Joint Regional Needs Assessment 2025-2028. https://www.ddwmphn.com.au/uploads/attachments/Joint-Regional-Needs-Assessment-2025-28.pdf
6. Darling Downs and West Moreton PHN. (2025) Health Needs Assessment. www.ddwmhna.com.au. Accessed 22 October 2025.

The Darling Downs and West Moreton region

In 2022, the population of the Darling Downs and West Moreton region was estimated to be 606,588.[7] The region is one of the fastest growing areas in Australia and is predicted to grow by 20% by 2030.

The responsibility for understanding the health needs and supporting the provision of services to meet these needs in the region is shared between the PHN, Darling Downs Health and West Moreton Health and the five Aboriginal Community Controlled Health Organisations in the region:

- Carbal Medical Services
- Cherbourg Regional Aboriginal and Islander Community Controlled Health Service (CRAICCHS)
- Goolburri Aboriginal Health Advancement Company Limited
- Goondir Health Services
- Kambu Aboriginal and Torres Strait Islander Corporation for Health (Kambu Health).

The region covers 99,000 km^2 and spans 12 local government areas (LGAs). The major communities in the region are Ipswich and Toowoomba, plus the surrounding communities located in the Lockyer Valley, Scenic Rim, Somerset, South Burnett, Cherbourg, Southern Downs, Goondiwindi and Western Downs. The region also includes parts of the Banana Shire and Brisbane LGAs.

Health needs across the region

The region's population is growing rapidly, and the proportion of older residents is also growing. The need for palliative care is higher among older age groups – by 2026–27, demand for specialist palliative care is expected to increase by 44% in the Darling Downs, and by 52% in West Moreton.[8]

The local health system aims to deliver high-quality and coordinated care but faces challenges in responding to the diversity of needs of the population. Some groups of Australians and communities in the region face additional barriers in accessing appropriate health and palliative care. These include people living with disabilities, Aboriginal and Torres Strait Islander peoples, people from multicultural backgrounds, people living in rural and remote locations, people who identify as LGBTIQA+, and veterans.

The size of the region and remoteness of some of its communities create challenges for delivering palliative care services. Palliative care is provided by a range of public and private health services and supported by general practitioners, other specialists and other healthcare professionals. Support for palliative care in the home and in residential aged care homes (RACH) varies widely across the region.

7. Public Health Information Development Unit (PHIDU), *Social Health Atlas of Australia 2023*, based on ABS 3235.0 Population by Age and Sex, Regions of Australia, 30 June 2022, Torrens University, Sydney, 2023.
8. Darling Downs and West Moreton PHN, Darling Downs Health, West Moreton Health (2025). Joint Regional Needs Assessment 2025-2028. https://www.ddwmphn.com.au/uploads/attachments/Joint-Regional-Needs-Assessment-2025-28.pdf

Strengths and challenges

What is working well

- **Coordination to meet patient needs:** In some areas and organisations, coordination helps to maximise the use of resources and ensure care matches patient need.
- **Community outreach:** Some outreach services, including information and education initiatives, provide effective care and improve understanding of palliative care options. Over the past 3 years, Queensland Health specialist palliative care services have increased their capacity and scope of services available in the region, due to ongoing workforce funding from Palliative Care Reform.
- **Productive collaboration:** Care at the End of Life (CAEOL) Collaboratives are operatoinal across both regions, working on developing workforce and information networks to improve palliative care services.
- **Workforce development:** West Moreton CAEOL Collaborative developed a framework that provides freely available education programs, courses, tools and local regional contacts in the key knowledge areas required by different professional groups who may be involved in the delivery of palliative care services.
- **Knowledge sharing through technology:** Some initiatives have been developed to improve the accessibility of information; for example, the PHN has developed online knowledge resources for health professionals and community members.
- **Education and training opportunities:** Some workshops, education and training opportunities have been developed to improve capacity and confidence in health professionals to provide palliative care and end-of-life care, across the region, including:
    - twice yearly Palliative Care Study days at Toowoomba Hospital (free to attend)
    - palliative care education sessions at Darling Downs GP Symposium
    - RACGP Toowoomba Education Training Day.

  These training opportunities have been developed in collaboration with public and private palliative care services in the region, PHN, PallConsult, SPaRTa, and Palliative Care Queensland.
- **Ongoing assessment:** Benchmarks and assessment by the Australian Palliative Care Outcomes Collaboration aim to improve patient outcomes through feedback to services.
- **24/7 clinician-to-clinician hotline:** Within the West Moreton region this service provides specialist guidance to clinicians managing palliating clients across home and supported-living environments. This is a great after-hours option that provides support when whenever it is needed. This is a greatly valued option as most palliative services are funded for in-hours support only.

What could be better

- **Service accessibility:** Accessibility to services varies widely across the region, with rural and remote areas in particular need of increased access.
- **Service coordination:** Stakeholders have highlighted that coordination and communication are still areas to be improved.
- **GP engagement:** Improve GP interest and/or participation in palliative care and shared care models earlier so patients have adequate time to plan and prepare with families and carers.
- **Palliative care in the home:** Options for palliative care to enable persons to stay in their own home at the end of life are limited in the region.
- **Advance care planning:** Although Queensland residents have high rates of engagement in advance care planning, stakeholders flagged it as an issue for many regional residents, especially priority populations.
- **Grief and bereavement support services:** Access to ongoing needs-based grief and bereavement support services for patients and their families across the region.

- **Cultural awareness and sensitivity:** Culturally sensitive care is a key challenge for the high proportion of Aboriginal and Torres Strait Islander residents and residents from culturally and linguistically diverse backgrounds in the region.
- **Data:** Collection of consistent data to support planning is made more challenging because of the range of settings in which palliative care occurs. Additionally, there is a lack of interoperability of data systems with client management systems.
- **Age-specific needs:** Support for people under 65 could be strengthened, particularly in enabling end-of-life care within the home, due to limited funded community programs. There are also significant challenges in accessing specialist palliative care services for paediatric and neonatal patients and their families living in the region.

Opportunities and priorities

The HNA has identified the following needs and these will be addressed in future Activity Work Plans, based on the evidence and with the aim of building on what is working well and addressing what could be better:

- increased access to palliative care to match changing community demographics
- improved coordination of palliative care across services
- increased understanding of palliative care and how it can be accessed
- increased support for palliative care in the home
- improved delivery of patient-centred culturally sensitive palliative care
- ongoing training and support to ensure a skilled palliative care workforce.

The needs are being addressed through effective regional strategies and action plans which reflect and support international, national and state priorities.

These are:

- The Stronger for Life-Joint Regional Older Persons Strategy 2025-2030
- Darling Downs Care at the End-of-life Action Plan2025-2026
- West Moreton Care at the End-of-life Action Plan 2024-2027
- Joint Region Health Needs Assessment 2025.

Palliative care in the region

Definition and importance of palliative care

Palliative care is holistic care that helps people nearing the end of their life to live as well as possible for as long as possible. The World Health Assembly defines palliative care as '*an approach that improves the quality of life of patients (adults and children) and their families who are facing the problems associated with life-limiting illness, through the prevention and relief of suffering by means of early identification and correct assessment and treatment of pain and other problems, whether physical, psychosocial or spiritual.*'[9]

Palliative Care Australia defines palliative care as '*person and family-centred care provided for a person with an active, progressive, advanced disease, who has little or no prospect of cure and who is expected to die, and for whom the primary goal is to optimise the quality of life.*'[10]

The Australian National Palliative Care Strategy says '*The types of palliative care and support that may be needed by an individual, their families and carers will vary and may include one or more formal and informal supports, including:*

- *specialist palliative care*
- *social, spiritual, cultural, community relationships and organisations*
- *community, disability, aged and social services*
- *grief and bereavement support*
- *general practice and primary care*
- *other specialist medical, nursing and allied healthcare.*'[11]

Best-practice palliative care is designed to suit the needs and values of the person and their carers, family and friends, including respecting and supporting cultural considerations. Carers, families and friends are welcomed as partners in best-practice care.

Although palliative care is often seen as a concern of older people, palliative care may be required at any age. The needs of children and young people, and their parents and families, are often quite different from those of people facing the end-of-life at a much older age. Similarly, although palliative care is often regarded as relating to cancer, palliative care may be required for a wide variety of life-limiting illnesses. People with differing illnesses will have differing physical, psychosocial and spiritual needs over various timeframes.[12]

Stages of care

Patient care along the illness trajectory ideally transitions smoothly from chronic disease management to palliative care. There are several phases to palliative care:[13]

- Palliative approach when the person is at risk of dying (less than 12 months, timing uncertain) involves advance care planning and person-centred care based on need.
- End-of-life care when the person is likely to die soon (medium term, timing uncertain) focuses on providing increased services and support for the person's physical, emotional, social and spiritual issues as they approach death.
- Terminal care when the person is dying (short term, likely hours, days or a week) aims to make the person as comfortable as possible. This phase extends to after-death care and bereavement support for family.

9. World Health Assembly, Strengthening of palliative care as a component of comprehensive care throughout the life course [PDF 158KB], Sixty-seventh World Health Assembly, Geneva, 24 May 2014, accessed 22 October 2025.
10. Palliative Care Australia, What is palliative care?, Palliative Care Australia, Canberra, 2025, accessed 17 November 2025.
11. Department of Health, National palliative care strategy 2018, Australian Government, Canberra, 2019, accessed 22 October 2025.
12. Department of Health, National palliative care strategy 2018.
13. Royal Australian College of General Practitioners (RACGP), Prompts for end-of-life planning framework, RACGP, Melbourne, 2024, accessed 25 November 2025.

People with progressive chronic illness have three typical illness trajectories, which intersect differently with the stages of palliative care (Figure 1):[14]

- cancer (short decline)
- organ failure (intermediate with acute episodes)
- dementia and frailty trajectory (gradual dwindling).

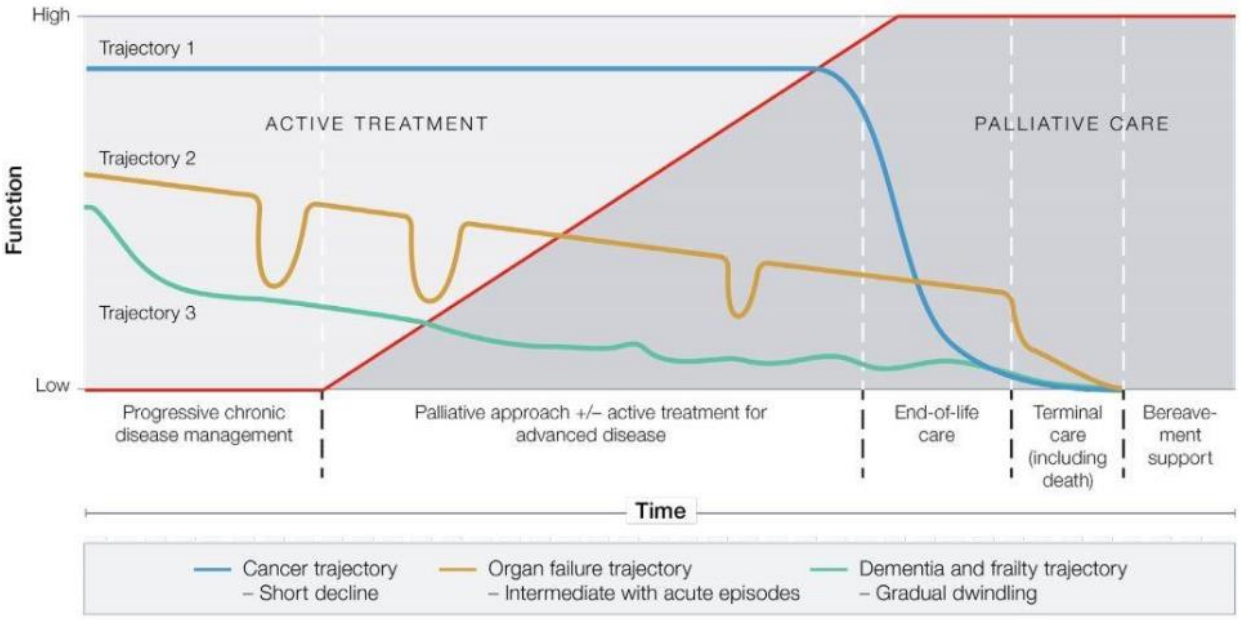


Figure 1: Typical illness trajectories and palliative care phases towards the end of life

Source: RACGP, 'RACGP aged care clinical guide (silver book): Part A – palliative and end-of-life care', RACGP, Melbourne, 2025, accessed 25 November 2025.

Benefits of palliative care

Palliative care plays a vital role at the end of life for many Australians, improving quality of life for individuals and the carers, family and friends supporting them. Recent research by the Australian Institute of Health and Welfare (AIHW) points to the positive impact and power of palliative care:[15]

- The overwhelming majority of palliative care patients report better outcomes with pain and symptom management and psychological and spiritual needs after palliative care intervention.
- The overwhelming majority of families and carers of people with a life-limiting illness felt their own problems improved or remained low with support from palliative care services.
- People receiving palliative care have been shown to have fewer hospitalisations, shorter lengths of stay when they are hospitalised, and reduced visits to emergency departments.[16] Those receiving palliative care at home have been shown to have increased quality of life and reduced need for hospital-based care,[17] providing cost savings for the health system.[18]

14. RACGP, RACGP aged care clinical guide (silver book): Part A – palliative and end-of-life care, RACGP, Melbourne, 2025, accessed 25 November 2025.
15. AIHW, Palliative care and health service use for people with life-limiting conditions, AIHW, Canberra, 2024, accessed 22 October 2025.
16. Palliative Care Australia, The economic value of palliative care and end-of-life care, Palliative Care Australia, Canberra, 2017, accessed 22 October 2025.
17. B McNamara, L Rosenwax, K Murray and D Currow, 'Early admission to community-based palliative care reduces use of emergency departments in the ninety days before death', Journal of Palliative Medicine, 2013, 16(7):774–779.
18. Palliative Care Australia, The economic value of palliative care and end-of-life care.

Gaps in care

Across Australia, improvements are widely needed to improve access to and understanding of palliative care. Based on 2019–20 data, it is estimated that:[19]

- 80% of all expected deaths in Australia each year need palliative care – that is 4 in 5 people with illnesses including cancers, kidney failure, liver failure, dementia and heart disease.
- 62% of all people who need palliative care did not receive specialist palliative care.
- People with dementia and heart disease are least likely to receive specialist palliative care, while people with cancer are most likely.
- Those in major cities are more likely to receive timely specialist palliative care than those in rural and remote areas; in some of these communities only around 15% of people with a life-limiting illness received timely palliative care.

This HNA examined the provision of and gaps in palliative care in the Darling Downs and West Moreton region, looking at three key areas: community, services, workforce. The assessment starts with the community as the driver of demand for services, which in turn drives the need for the workforce.

19. AIHW, Palliative care and health service use for people with life-limiting conditions.

Community needs for palliative care

The palliative care HNA asked the question: **What are the community needs for palliative care in our region?**

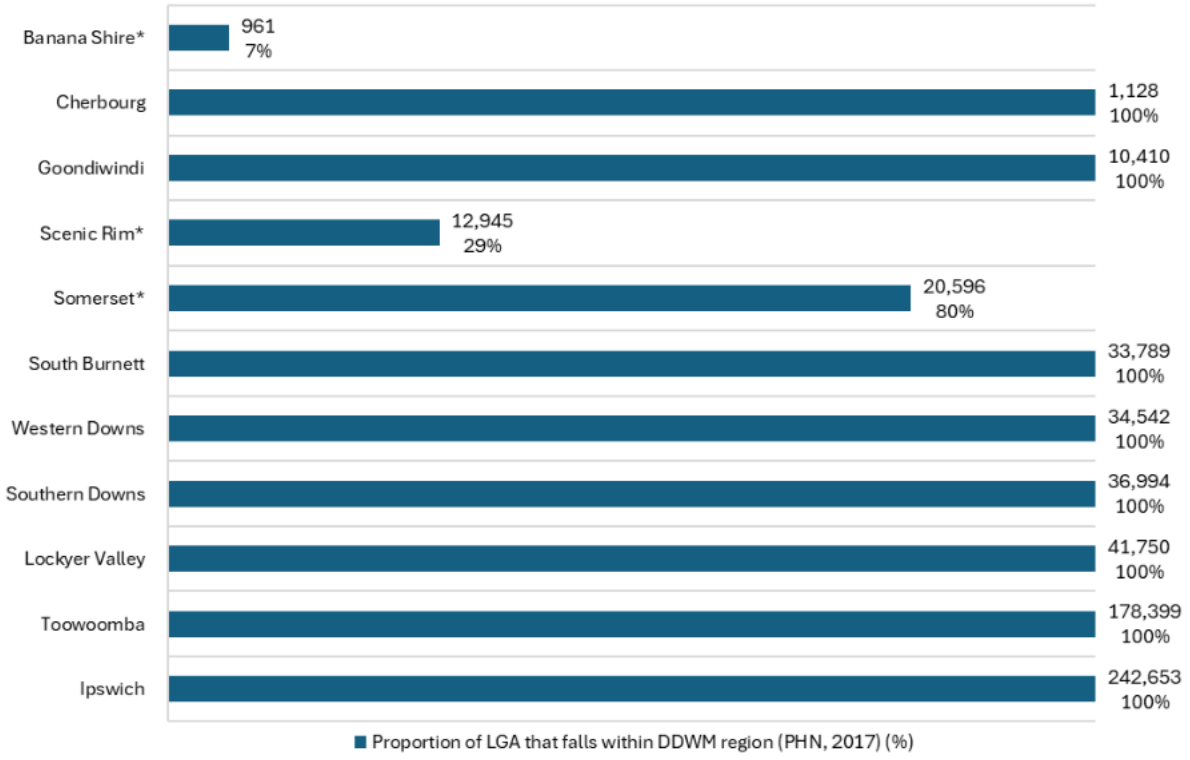
Population profile

In 2023, the population of the Darling Downs and West Moreton region was estimated to be 632,000.[20] Our region is one of the fastest growing areas in Australia and the population is predicted to grow by 40% by 2041 to about 885,000 people.

In the Darling Downs, the population grew at an average annual rate of 1.6% between 2010 and 2020 and is expected to continue growing at a rate of 0.7% per year over the next 25 years.[21] The population of West Moreton is expected to double by 2036; the rapid growth in population will require more palliative care services to meet the demand.[22]

The Darling Downs and West Moreton region includes urban, regional, rural and remote settings. A significant challenge for delivering palliative care services in Darling Downs and West Moreton is the size of the region and remoteness of some of its communities (see Table 1 and Figure 2). The region covers 99,000 km^2 and spans 12 LGAs (some of which do not fall entirely within the region).

Table 1: Population by LGA



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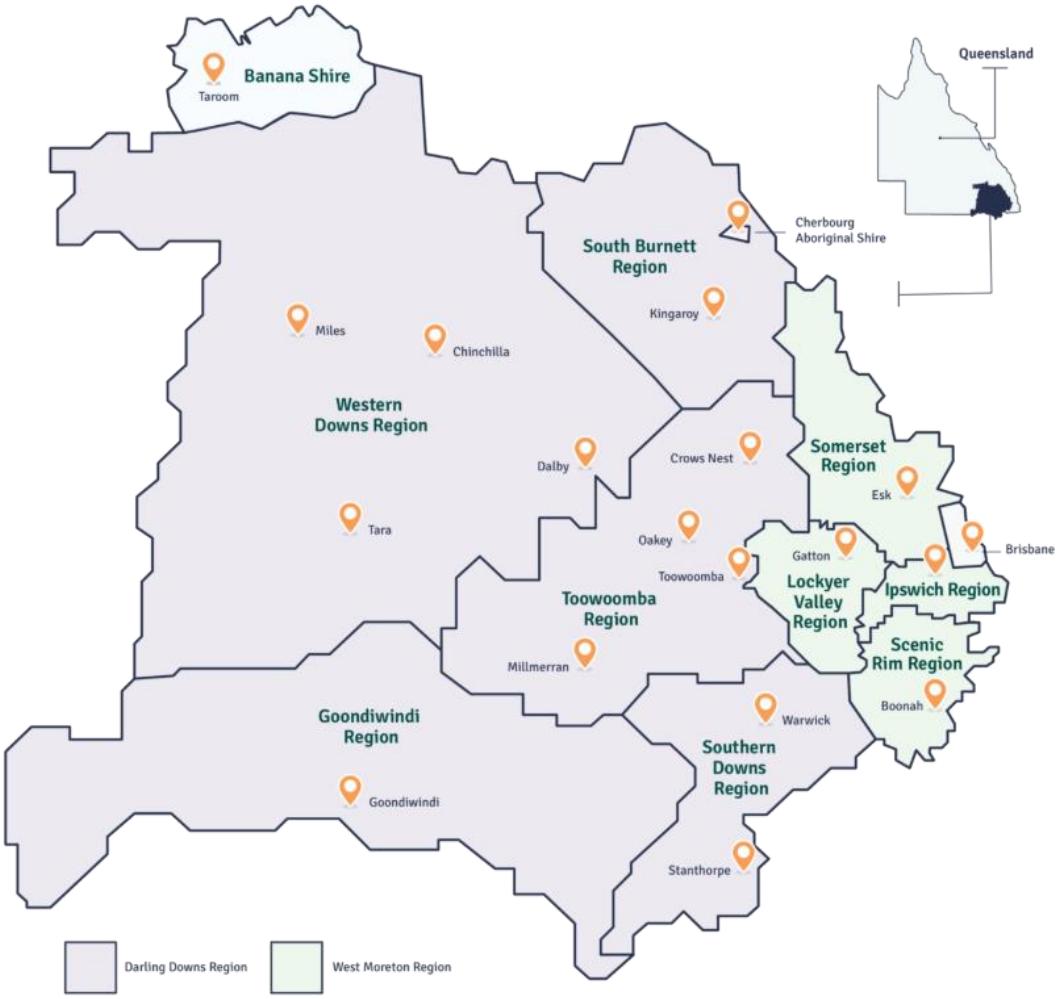
Source: Australian Government Department of Health and Aged Care, Primary Health Networks (PHN) (2017) – concordance files – Local Government Areas (2021). Released 26 September 2023. Accessed at www.health.gov.au/resources/publications/primary-health-networks-phn-2017-concordance-files-local-government-areas-2021?language=en. *Lake Manchester/England Creek is the only area within the Brisbane LGA that falls within the DDWM region but has no residents (ABS Population by SA2), so has been excluded.

20. Darling Downs Health and West Moreton Health, Darling Downs and West Moreton joint regional needs assessment 2025–28.
21. C Hope, Palliative care in the Darling Downs and West Moreton region: a desktop review, Darling Downs and West Moreton Primary Health Network, Toowoomba, 2021.
22. C Hope, Palliative care in the Darling Downs and West Moreton region: a desktop review.

Figure 2: The Darling Downs and West Moreton region

Source: Darling Downs Health and West Moreton Health, Darling Downs and West Moreton Joint Regional Needs Assessment 2025–28, Darling Downs and West Moreton Primary Health Network, Toowoomba, 2025.



Age profile and care needs

The proportion of Australians aged 65 and older continues to grow: from 15% of the population in 2017 to a predicted 22% by 2057. The number of older people in the region is growing steadily. In 2024, there were 111,470 senior persons in the region (58,289 females and 53,181 males), with the largest proportion living in the urban areas of Toowoomba and Ipswich.[23] By 2030, adults aged 65 and older will make up 18% of the Darling Downs and West Moreton population, with the fastest increase among those aged 85 and over (Figures 3 and 4).[24]

23. Regional Health Collaborative, *Joint regional older persons strategy: stronger for life*, Regional Health Collaborative, Toowoomba, 2025.
24. Darling Downs and West Moreton Primary Health Network, *The health and care needs of older Australian in the region with additional challenges – Care Finder Program*, Darling Downs and West Moreton Primary Health Network, Toowoomba, 2023.

Figure 3: Population of older people by LGA

Source: Public Health Information Development Unit (PHIDU), Torrens University, Social Health Atlas of Australia, 2025.

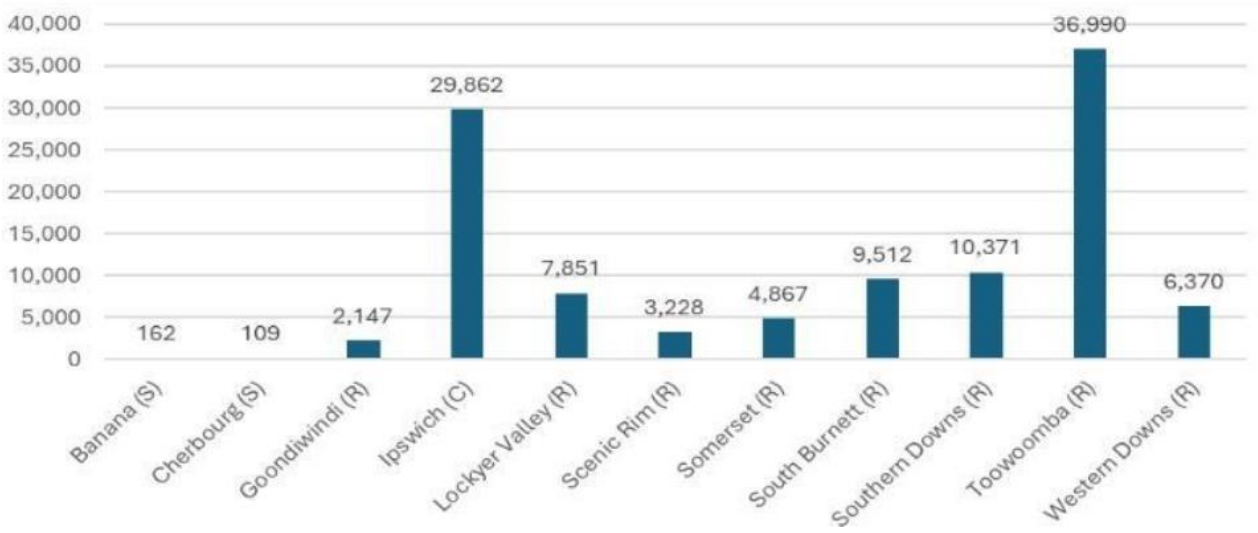
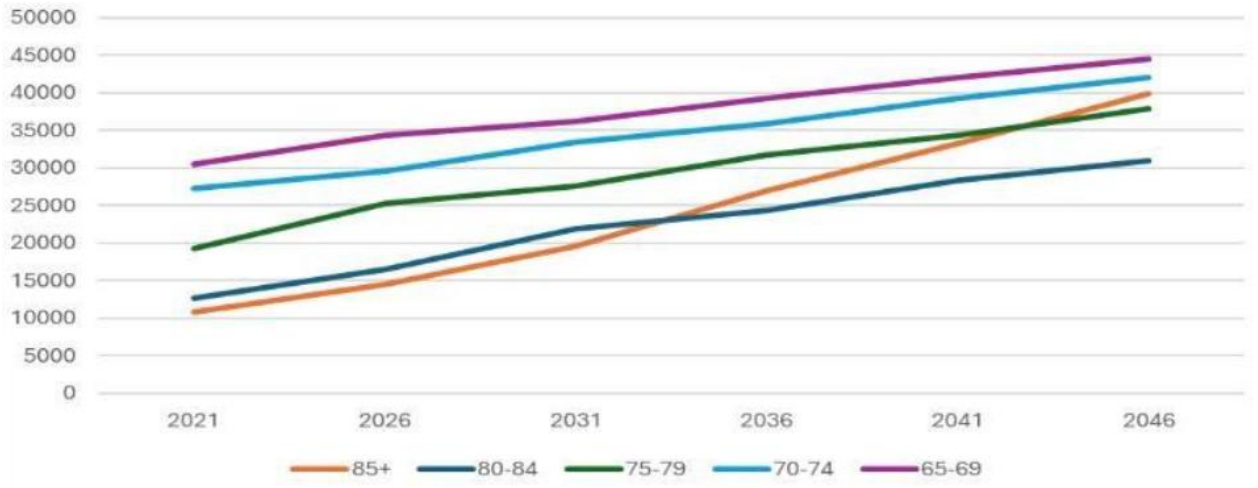


Figure 4: Projection of older persons population from 2021 to 2046 by age group

Source: Queensland Government Population Projections, 2023.



The need for palliative care is higher among older age groups. Given the population is ageing, demand for palliative care will grow. By 2026–27, demand for specialist palliative care is expected to increase by 44% in the Darling Downs, and by 52% in West Moreton.[25] The older age group (85 years and over) are at higher risk of chronic conditions, dementia, and complex health needs, which makes end-of-life and palliative care more complicated and limits care options.

As part of the development of the Joint Regional Older Persons Strategy, engagement workshops, surveys, and community-led discussions were undertaken to explore what ageing well means from the perspective of older people, their families and carers across Darling Downs and West Moreton. Findings relevant to palliative care are that:[26]

- retaining independence and autonomy in decision-making about health, care, and daily life is important
- long-term relationships with general practitioners (GPs) are important
- friendly and welcoming healthcare staff are highly appreciated
- services close to home are important.

25. Darling Downs and West Moreton PHN, Darling Downs Health and West Moreton Health, *Joint Regional Needs Assessment 2025–28*.
26. Regional Health Collaborative, *Joint regional older persons strategy: stronger for life 2025-2030*.

Palliative care needs and services differ according to the age of the person receiving care, their prognosis and their individual needs Service provision should be designed to ensure all people receiving palliative care can live as well and fully as possible, irrespective of where they live palliative care services should also be designed to support family and other carers.

Socio-economic status

The Darling Downs and West Moreton region experiences a greater rate of socio-economic disadvantage than Australia and Queensland. Within the region, Cherbourg, South Burnett and Somerset have the highest proportion of people experiencing relative disadvantage: a higher risk of low household income, unemployment, lower levels of education, limited internet access and increased healthcare needs. A total of 46.1% of households in the region are low-income.[27]

Dividing the PHN region into five socio-economic areas highlights a clear relationship between disadvantage and palliative care use. The lowest area accounts for 52.6% of admitted patient palliative care and 55.4% of non-admitted service events. The lowest two areas combined account for 80.4% of hospital admissions for palliative care and 83.5% of non-admitted palliative service events.[28] This shows that people living in more disadvantaged areas have a higher palliative care needs and use more services, underlining the importance of targeted planning and resource allocation to ensure equitable access to end-of-life care.

Health profile

The health profile of the Australian population is changing: the number of people who die each year is expected to rise substantially over the next 50 years, more people will have complex co-morbidities that need to be managed, and more people will die from chronic progressive diseases.[29] These changes will increase the demand for high-quality palliative care and end-of-life care services to meet the needs and expectations of people with a life-limiting illness and their families, carers and other support people.

The Darling Downs had 2,199 registered deaths in 2019 and has a higher crude death rate (per 1,000 population) compared with Queensland. The 5 highest causes of death in the Darling Downs are cardiovascular disease (29%), cancer (27%), coronary heart disease (13%), respiratory disease (10%) and stroke (7%).[30]

West Moreton has around 1,500 registered deaths per year. The 5 highest causes of death in West Moreton are cancer (31.1%), cardiovascular disease (26.6%), coronary heart disease (11.9%), respiratory disease (10%) and injury and poisoning (7.4%).[31]

A high proportion (59–68%) of older Australians in the region have 1 or 2 chronic conditions.[32] Musculoskeletal problems, cardiovascular diseases, mental health and diabetes are the most commonly reported chronic conditions among older Australians in the region. Of those older people in the region who regularly attend a local GP:[33]

- 52% have one or two conditions recorded
- 22% have three or more conditions recorded
- 20% do not have a chronic condition recorded.

The challenges in responding to comorbidity include ensuring coordination of services, managing multiple medications and ensuring effective communication between services.

27. Darling Downs Health and West Moreton Health, Darling Downs and West Moreton Joint Regional Needs Assessment 2025–28.
28. AIHW, 'Palliative Care Services in Australia'.
29. AIHW, National palliative care and end-of-life care information priorities (PDF 892KB), Report produced by the Australian Institute of Health and Welfare in collaboration with the Palliative Care and End-of-Life Care Data Development Working Group, AIHW, Canberra, 2022, accessed 22 October 2025.
30. Hope, Palliative care in the Darling Downs and West Moreton region: a desktop review.
31. Hope, Palliative care in the Darling Downs and West Moreton region: a desktop review.
32. Darling Downs and West Moreton Primary Health Network, The health and care needs of older Australian in the region with additional challenges – Care Finder Program.
33. Regional Health Collaborative, *Joint regional older persons strategy: stronger for life*.

Priority populations

Some groups in the region face additional challenges with health and palliative care:[34]

- People with a profound or severe disability may have complex healthcare needs. Some 7.4% of the region's population lives with a profound or severe disability (compared with 6.3% for Queensland and 6.0% for Australia). About 19.5% of older Australians in the region have a profound or severe disability.[35] Cherbourg LGA reported the highest proportion of older Australians with profound or severe disability.
- Aboriginal and Torres Strait Islander people have a higher likelihood of health problems than non-Indigenous people. Compared with non-Indigenous residents, health-adjusted life expectancy is 11.8 years lower for Aboriginal and Torres Strait Islander residents in the Darling Downs, and 8.3 years lower for Aboriginal and Torres Strait Islander residents in West Moreton.[36] The region has a high proportion of older Aboriginal and Torres Strait Islander people. In 2021, there were 4,339 Aboriginal Elders (55+ years) living in the region. This group represented 4.3% of the total senior population and 11.3% of all Aboriginal and Torres Strait Islander people in the region. The highest proportion of Elders lived in Cherbourg (86.8%) followed by Goondiwindi (4.4%) and the Western Downs (4.3%).[37]
- People from culturally and linguistically diverse backgrounds may require language support and cultural awareness to meet their healthcare needs. Some 8.9% of the region's residents were born in non-English speaking countries.[38] Within the region, Lockyer Valley, Banana and Ipswich LGAs reported the highest rates of people born overseas reporting poor English proficiency.
- Rural, regional and remote communities have limited access to healthcare, community and at-home services. Australia has five remoteness classes: major cities (good access to services), inner regional (access to services in urban centres), outer regional (some access to services in regional centres), remote (poor access to services) and very remote (very poor access to services).[39] The proportion of regional LGAs in the different classes are as follows:
    - Banana – 87.9% outer regional, 12.1% remote
    - Cherbourg – 100% inner regional
    - Goondiwindi – 95.2% outer regional, 4.8% remote
    - Ipswich – 95.6% major cities, 4.4% inner regional
    - Lockyer Valley – 100% inner regional
    - Scenic Rim – 18.6% major cities, 80.4 inner regional, 1.0% outer regional
    - South Burnett – 65.3% inner regional, 34.7% outer regional
    - Somerset – 97.1% inner regional, 2.9% outer regional
    - Southern Downs – 64.3% inner regional, 35.7% outer regional
    - Toowoomba – 97.9% inner regional, 2.1% outer regional
    - Western Downs – 53.3% outer regional, 40.4% inner regional, 6.3% remote
- Lesbian, gay, bisexual, transgender, gender diverse, intersex and queer (LGBTIQA+) people often experience health inequalities and barriers to accessing primary care services. No data is currently available to estimate the number of LGBTIQA+ people in the region. However, consultation with community members in the region indicated that older LGBTIQA+ people experience difficulties accessing healthcare.
- People with learning disability or low literacy face barriers to accessing healthcare because of difficulties in understanding the health system and available support.
- Veterans may require specialised care services. There are about 1,400 veteran pensioners in the region; Somerset and South Burnett LGAs have the highest proportion of veteran pensioners.

34. Darling Downs and West Moreton Primary Health Network, The health and care needs of older Australian in the region with additional challenges – Care Finder Program.
35. PHIDU, 'Social Health Atlases: data workbooks – Data by Primary Health Network (including Local Government Areas, 2021 ASGS), published September 2025', PHIDU, Torrens University, Sydney, 2025, accessed 1 November 2025.
36. Darling Downs Health and West Moreton Health, Darling Downs and West Moreton joint regional needs assessment 2025–28.
37. Regional Health Collaborative, Joint regional older persons strategy: stronger for life.
38. Darling Downs Health and West Moreton Health, Darling Downs and West Moreton joint regional needs assessment 2025–28.
39. Australian Bureau of Statistics (ABS), Remoteness areas, ABS, Canberra, 2025, accessed 20 November 2025.

Service needs in palliative care

The palliative care HNA asked the question: What palliative care services are available in our region, and how well do they meet community needs?

Regional service profile

In the past few decades, palliative care has become available within almost every healthcare setting. It is also available in specialist hospices and provided in the home, often by carers supported by home-based outreach services from public, private or not-for-profit agencies.

In 2022–23 in the PHN region, expenditure on admitted patient palliative care totalled $19,837,247 and expenditure on non-admitted patient palliative care totalled $6,729,509 (in each case, representing 3.3% of total Australian expenditure).[40]

Darling Downs

The Darling Downs has a range of public and private palliative care services.[41]

These include:

- admitting rights and specialist palliative care inpatient consulting service at Toowoomba Base Hospital
- specialist palliative care outpatient clinics and an outreach team provided by Toowoomba Hospital Specialist Palliative Care Service
- Specialist Palliative Care in Aged Care setting (SPACE) service, provided by Toowoomba Hospital Specialist Palliative Care Service.

Community palliative care in the Darling Downs is mainly medically managed in a GP (primary care) model. Support and advice from specialist palliative care physicians can be accessed through the Toowoomba Hospital Palliative Care Services, or through the Gold Coast–Toowoomba Specialist Palliative Rural Telehealth (SPaRTa) service in rural areas.

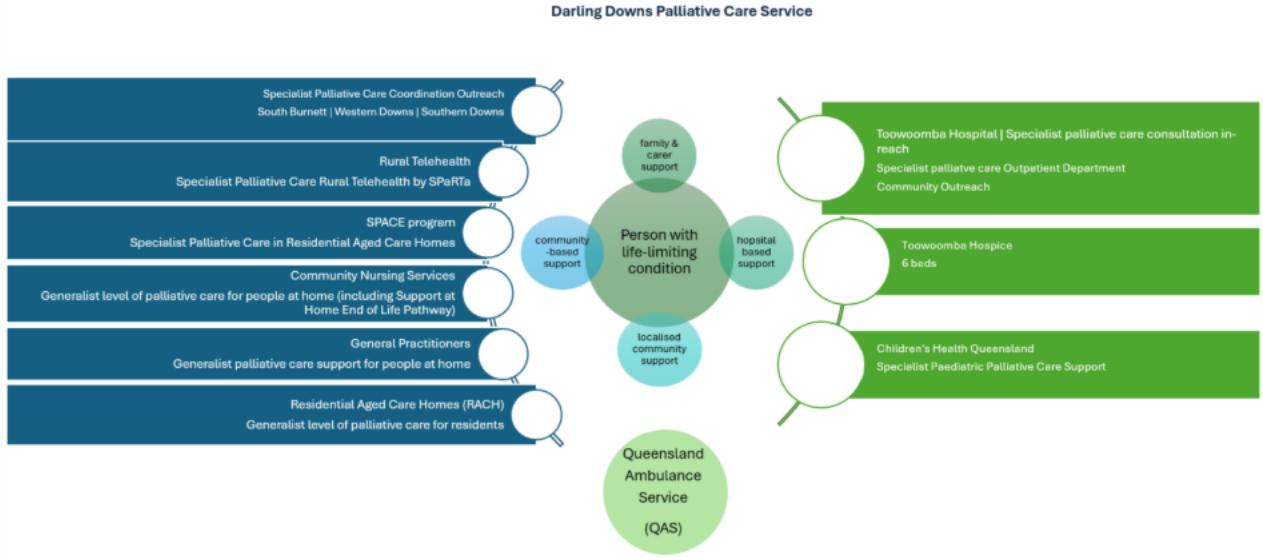
Palliative care in the home is provided through community nursing services, which are funded by statewide funding (Bluecare Rural and Remote Palliative Care Community Program); palliative care scripting (from the Toowoomba Hospital palliative care service) or through community sources such as the new aged care Support at Home program End of Life pathway, and the National Disability Insurance Scheme. Community palliative care in rural and remote areas of the region is coordinated by senior palliative care nurses based in South Burnett, Western Downs and Southern Downs. These regions are also supported by the Gold Coast-Toowoomba Specialist Palliative Care Rural Telehealth Service (SPaRTa).

There are 49 RACHs in the Darling Downs. Palliative care in residential aged care is supported by the Queensland Health–funded Specialist Palliative Care in Aged Care (SPACE) program.

The Darling Downs region palliative care services ecosystem is summarised in Figure 5.

40. AIHW, 'Palliative care services in Australia'.
41. Hope, Palliative care in the Darling Downs and West Moreton region: a desktop review.

Figure 5: Darling Downs Palliative Care; Source – Darling Downs and West Moreton PHN, 2025.



West Moreton

West Moreton also has a range of palliative care services.[42]

These include:

- inpatient beds across Ipswich Hospital, Ripley Satellite Hospital and Ipswich Hospice
- specialist paediatric palliative care provided via face-to-face visits and telehealth from Children's Health Queensland Paediatric Palliative Care Services.

West Moreton Health has developed a suite of community palliative care services, including a specialist palliative care outreach team to provide people in the last three months of life with care at home.

Each of the rural hospitals in West Moreton Health have community outreach that includes palliative care. These services are supported by face-to-face services and telehealth from the West Moreton Palliative Care Team at Ipswich Hospital.

Outpatient clinics are run from Ipswich Hospital, Ripley Satellite Hospital and each rural hospital. Ipswich Nurses provides palliative care for people living with disabilities in an integrated service model with West Moreton Hospital, and also works with the Children's Health Queensland Paediatric Palliative Care Services to provide day-to-day nursing and carer support.

Palliative care in residential aged care is supported by Ipswich Nursing Service and the SPACE program is also operating in West Moreton. There are 16 RACHs in West Moreton.

The West Moreton palliative care services ecosystem is summarised in Figure 6.

42. Hope, Palliative care in the Darling Downs and West Moreton region: a desktop review.

Figure 6: West Moreton Palliative Care; Source – Darling Downs and West Moreton PHN, 2025

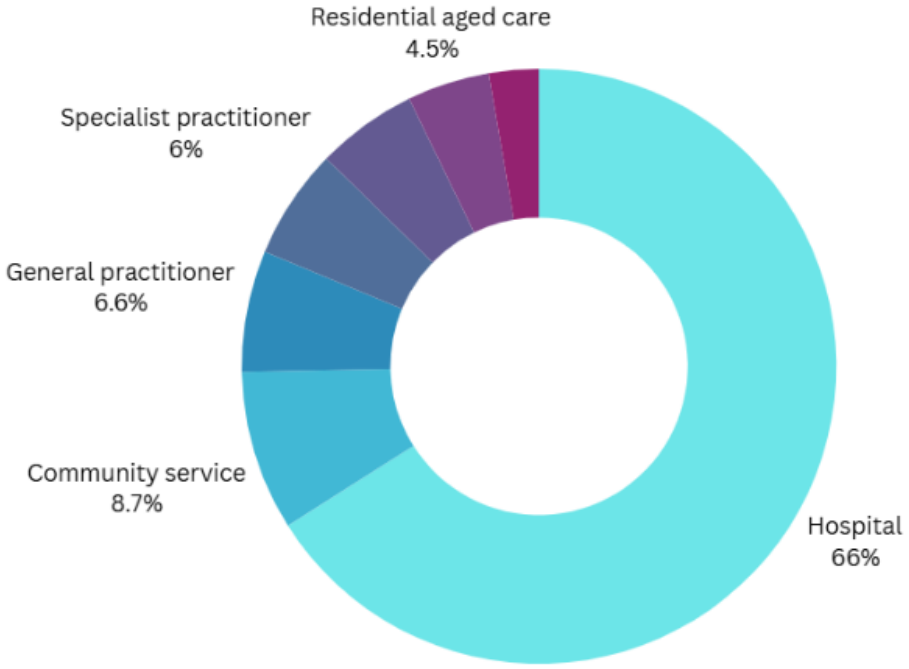
Types of care and support

Along with the broader services profile, examining specific areas of care and specific programs helps to provide a complete picture of palliative care in our region.

Referrals and hospitalisations

The Palliative Care Outcomes Collaboration (PCOC) aims to improve palliative care outcomes though improved data and feedback to services (see Ongoing assessment).[43] PCOC data show the number of annual referrals to palliative care has doubled over the past 10 years among the organisations participating in PCOC. Hospitals are the largest source of referrals to palliative care, followed by community services and GPs (Figure 7).

Figure 7: Referrals to palliative care in Australia, 2014–2024

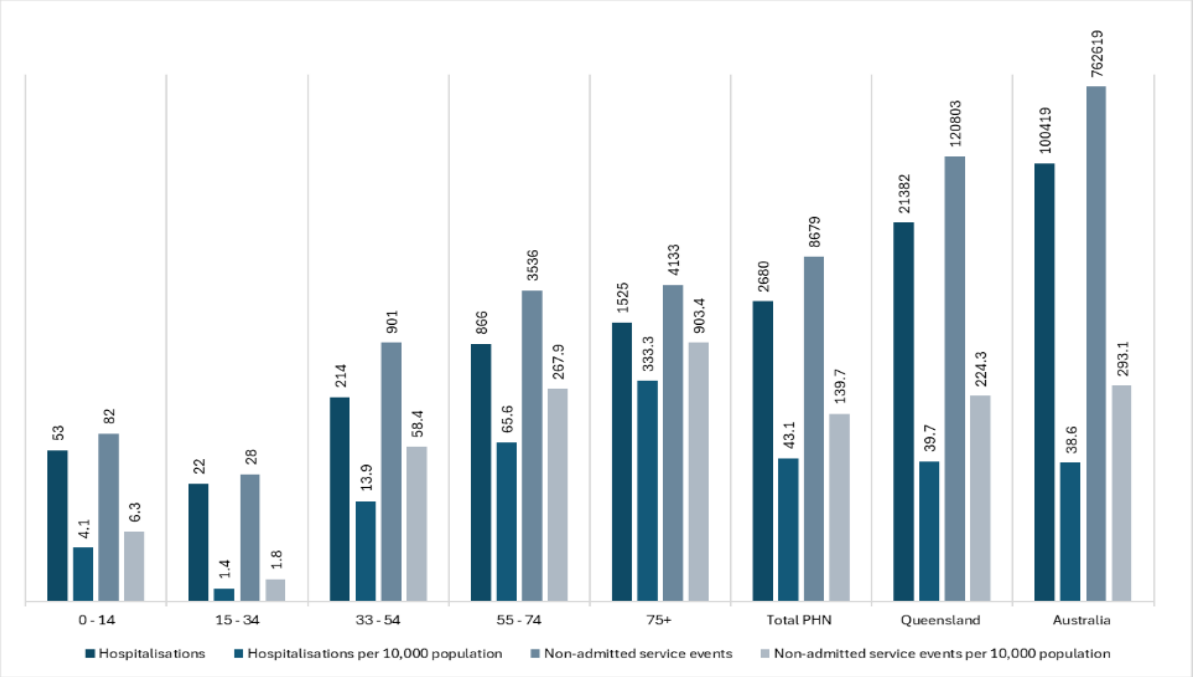


Source: Palliative Care Outcomes Collaboration, *National overview of patient outcomes in Australia,* 2025.

43. Palliative Care Outcomes Collaboration (PCOC), About PCOC, PCOC, University of Wollongong, 2025, accessed 17 November 2025.

The PHN has a higher rate of palliative care hospital admissions than Queensland or Australia (43.1 per 10,000 population versus 39.7 and 38.6, respectively). The region also has a much lower rate of non-admitted service events (139.7 per 10,000 population versus 224.3 for Queensland and 293.1 for Australia) (Table 2).[44] The data suggest that Darling Downs and West Moreton rely more heavily on hospital admissions for palliative care rather than community-based palliative care services.[45]

Table 2: Darling Downs and West Moreton Primary Health Network, palliative care hospital admissions and non-admitted service events, by age



Source: AIHW,(2022-23), Palliative care services in Australia', Admitted patient palliative care data, table 6; Non-admitted patient palliative care data, table 1, PHN palliative care services data, table 1, AIHW, Canberra, 2025, accessed 22 October 2025.

Residential aged care homes

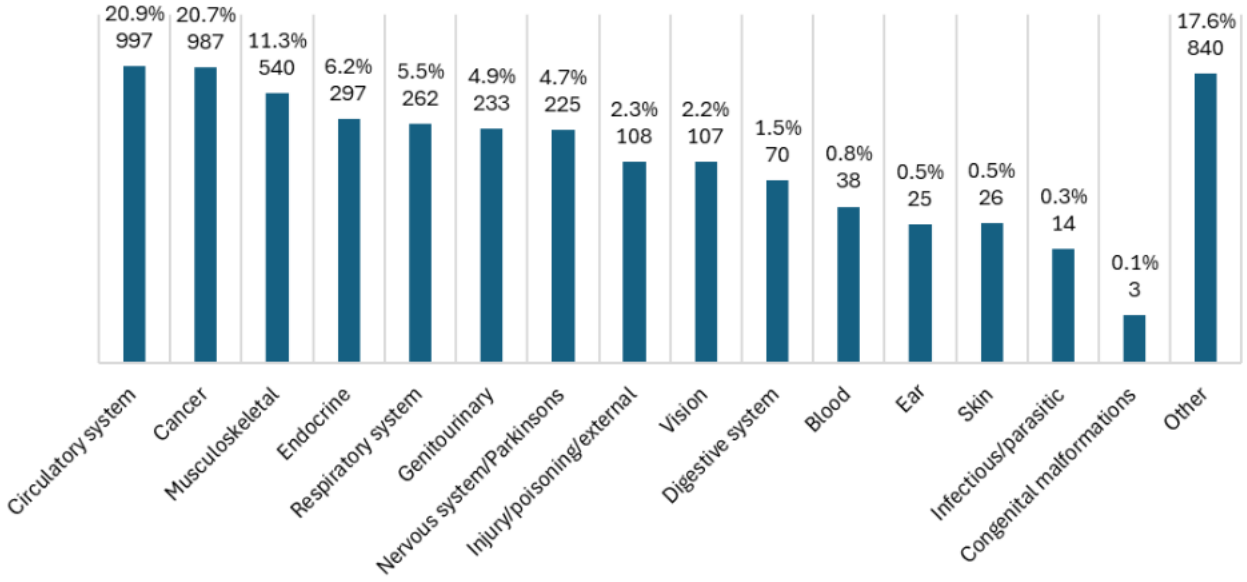
Palliative care often takes place in RACHs, which may have a specialist palliative care physician or nurse, or may involve a community palliative care service.[46] In 2021–22 in Australia, there were 245,965 people living in RACHs (158,306 females and 87,659 males); 4829 of these were receiving palliative care (2633 females and 2196 males). Overall, in 2021–22, 66,641 people were admitted to an RACH. Of these, 2415 (3.5%) were admitted for palliative care.[47]

Caring for palliating residents is a collaborative effort, with GPs, Registered Nurses, SPACE, SPARTA or PallConsult all playing important roles in supporting residents and their families. GPs and hospitals typically provide the palliative diagnosis, while the care team works together to develop a care plan and put supports in place, ensuring families remain informed and involved. However, Residential Aged Care Homes (RACHs) face specific challenges that can impact palliative care delivery, including limited data collection and information-sharing systems, gaps in workforce skills and knowledge, difficulties accessing medication scripts from external palliative care providers, and delays caused by medications being supplied through Brisbane-based pharmacies.

The most common disease diagnoses of people receiving palliative care in RACHs are circulatory system diseases, cancer, musculoskeletal diseases and endocrine diseases (Table 3). The most common mental and behavioural disorder diagnoses are dementia and depression, mood and affective disorders and bipolar disorder (Table 3).

44. AIHW, (2022-23) 'Palliative care services in Australia'.
45. Regional Health Collaborative, Joint regional older persons strategy: stronger for life.
46. Department of Health, Disability and Ageing, Where is palliative care provided?, Australian Government, Canberra, 2024, accessed 22 October 2025.
47. AIHW, (2021-22), Palliative care services in Australia'.

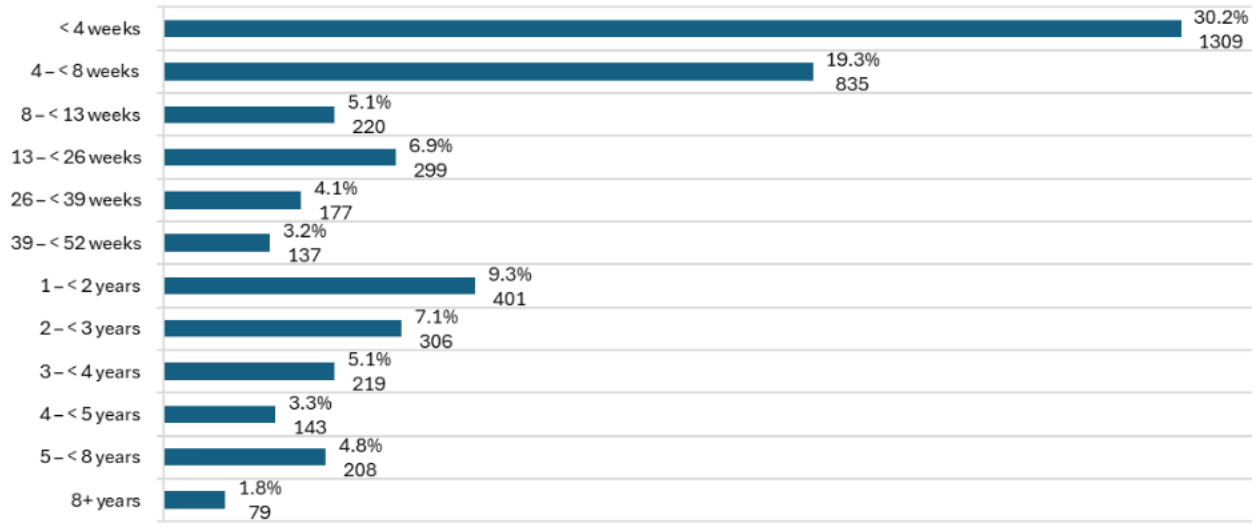
Table 3: People receiving palliative care in an RACH, by first medical diagnosis and first mental or behavioural disorder



Source: AIHW, (2021-22), Palliative care services in Australia', Palliative care for people living in residential aged care data, table AC.2, AIHW, Canberra, 2025, accessed 22 October 2025.

Palliative care is for people with life-limiting illnesses and 95.4% of exits from care are because of death. A further 2.2% move to other residential care, 0.6% return to the community and 1.0% move to a hospital.[48] Almost half of persons receiving palliative care in a RACH have a length of stay less than eight weeks (Table 4).[49]

Table 4: Length of stay in a RACH in Australia



Source: AIHW, (2021-22), 'Palliative care services in Australia', Palliative care for people living in residential aged care data, table AC.3, AIHW, Canberra, 2025, accessed 22 October 2025.

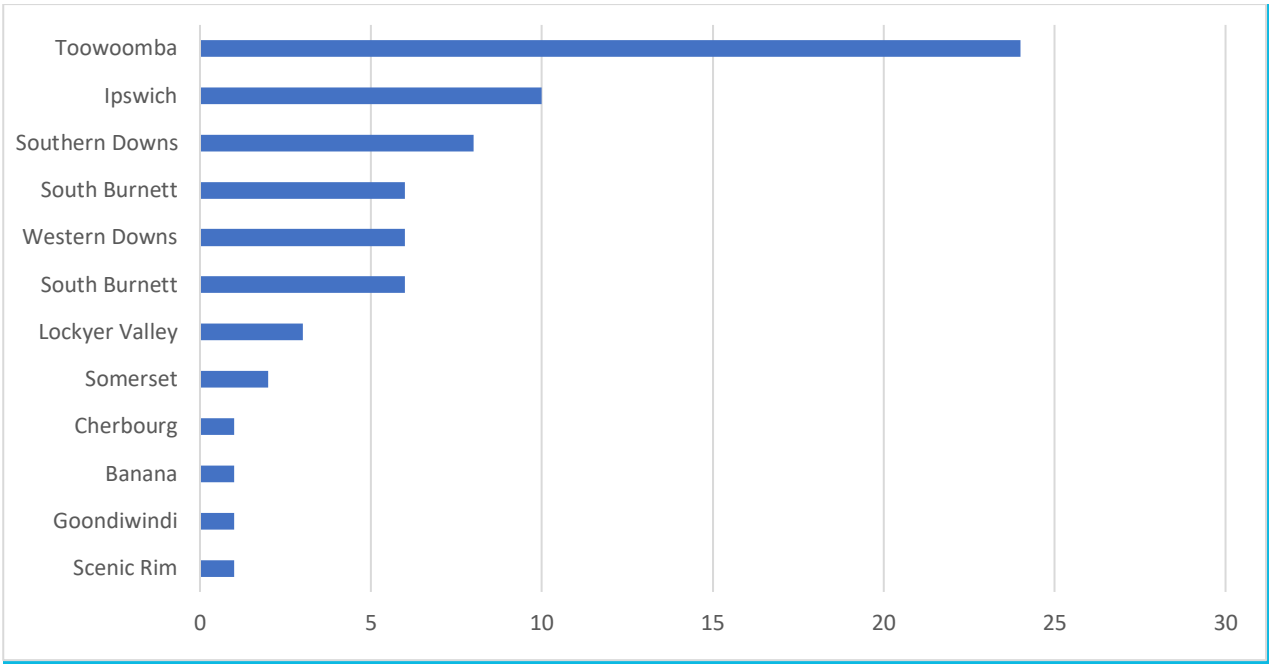
***"Residential aged care has become more acute, residents are coming in to die. The average length of stay seems to be 2 years – in the past it was 7 years."* – former RACH manager**

48. AIHW, (2021-22), 'Palliative care services in Australia'.
49. AIHW, (2021-22), 'Palliative care services in Australia'.

In 2021–22, there were **68 RACHs** across the Darling Downs and West Moreton region. These had an average occupancy of 87%, with an average length of stay of 30 months. This is an average of 3,611 older people residing in permanent RACHs at any one time in the region.[50]

In 2025, there are now **63 RACHs** across the region, which together provide 4,151 RACH beds. Facilities include private and public facilities, large corporate and stand-alone aged care homes, and multipurpose sites.

Table 5: Government RACHs location by LGA



This means there are:

- 48 RACHs Darling Downs
- 15 RACHs West Moreton

Advance care planning

The Royal Australian College of General Practitioners (RACGP) describes advance care planning or an Advance Care Plan (ACP) as a process where a person:[51]

- discusses their values and healthcare preferences with their family, friends and healthcare team
- can choose a 'medical decision-maker' to make decisions for them if they lose capacity to make or communicate their own values and care preferences or decisions
- can document a formal, written values statement and/or instructional advance care directive (ACD) to help ensure the person's preferences are respected.

ACP documents record decisions and preferences for future medical treatment and personal care, in case an individual becomes unable to make or communicate these decisions themselves. A recent study has found that digitally accessible ACP documents reduce hospital use (emergency department visits, hospital and intensive care unit admissions) and costs in the last 6 months of life.[52]

50. Regional Health Collaborative, Joint regional older persons strategy: stronger for life.
51. RACGP, RACGP aged care clinical guide (silver book): Part B – advance care planning, RACGP, Melbourne, 2025, accessed 25 November 2025.
52. I Scott, L Reymond, X Sansome and H Carter, 'Association of advance care planning with hospital use and costs at the end of life: a population-based retrospective cohort study', *BMJ Open*, 2024, 14(11):e082766.

An ACP has been shown to:[53]

- improve adherence to patients' preferences for care that is consistent with their beliefs and values
- improve personal and family satisfaction with care, and reduce family members' anxiety, depression and stress
- improve ongoing and end-of-life care
- reduce unwanted interventions and non-beneficial transfers to acute care.

An ACP is ideally discussed early, when patients are well and have the capacity to anticipate, discuss and plan for preferred treatment when they become too ill or cognitively impaired to express their wishes.

However, most Australians are not fully prepared for future healthcare decisions. Only 35% of Australian adults54 are aware of ACPs, 19% have discussed their future healthcare with someone else, 13% have formally appointed a substitute decision-maker, and 6% have completed an ACD.[55]

Key barriers to advance care planning include:

- lack of knowledge,
- perceived irrelevance, and
- practical hurdles.

The main reasons for lack of advance care planning or having an ACP in place were:

- not knowing where to start (29%),
- trusting family or friends to know what they want (27%),
- believing they are too young (27%), and
- uncertainty about future health (24%).[56]

RACGP recommends that an ACP is included as part of Older Person's health assessments (for those aged 75 years and over) and during management of progressive chronic disease, early dementia or frailty.[57] It should also be a consideration at key events such as diagnosis of a life-limiting illness or entry into a RACH. Forms and requirements for advance care plans vary between states and territories; further information and forms can be found at Advance Care Planning Australia.

In the Queensland ACP system, completed ACP documents can be uploaded to the ACP Tracker, a digital tool that provides health professionals with real-time access to ACP documents including:

- enduring powers of attorney
- statement of choices
- advance health directives
- Queensland Civil and Administrative Tribunal decisions
- revocations
- other documents.

53. RACGP, 'RACGP aged care clinical guide (silver book): Part B – advance care planning'.
54. Children can complete an ACP, but it is not legally binding; (Queensland Government, Statement of choices forms for children and young people under 18, Queensland Government, Brisbane, 2025, accessed 22 October 2025.
55. Advance Care Planning Australia, Advance care planning prevalence in Australia 2025, Advance Care Planning Australia, Brisbane, 2025.
56. Advance Care Planning Australia, Advance care planning prevalence in Australia 2025.
57. RACGP, 'RACGP aged care clinical guide (silver book): Part B – advance care planning'.

The documents can be accessed by registered health professionals across care settings, including Queensland Health Hospitals and Health Services, primary care and general practice, RACHs and Queensland Ambulance Service.

The 2025 study of ACP prevalence in Australia found that ACP engagement varied considerably by location. 'Residents of Queensland and South Australia had the highest rates of engagement, were more likely to have been appointed as a substitute decision-maker and to have discussed preferences for future healthcare. Residents from these states also had the highest ACD completion rates.'[58] However, prevalence also varied between regions and groups; for example, people from culturally and linguistically diverse backgrounds were less likely to have engaged in ACP, regional residents were more likely to have had ACP discussions with family members, and metropolitan residents were more likely to have uploaded ACDs to My Health Record.

From July 2014 to September 2025, the Queensland Statewide Office of Advance Care Planning received 231,161 ACP documents; in 2025, an average of 3782 documents have been received each month.[59] A total of 30,478 ACP documents have been received from the Darling Downs and West Moreton region since 2014, and an average of 516 documents a month were received in 2025. However, not all documentation is successful; from July to September 2025, 1762 ACP documents were uploaded but 10% (175) were incomplete and 7% (119) were duplicates.

The ACP Tracker is well used by practitioners in the region. From July 2024 to June 2025 the tracker was consulted 1341 times from within the region; 59% of tracker launches were by nurses, 39% by medical practitioners, and 1% by pharmacists and optometrists.

ACP documents can also be uploaded and viewed on the national My Health Record system. This system provides a secure online summary of an individual's health information, including medical history, allergies, medications and immunisation records, which can be accessed by the individual and all authorised healthcare providers. From October 2024 to September 2025, ACP upload rates for the Darling Downs and West Moreton region were the lowest in Queensland (36 uploads and 15 views); this is an area for future focus.

The 2025 prevalence study had 2 recommendations to improve ACP uptake and use:

- **Improve awareness:** Investment is needed to increase awareness of ACP across all sectors of the population.
- **Increase support:** Many people would benefit from assistance to navigate the processes. ACP can be complex, especially if legal documents are involved.

These recommendations are being successfully pursued in various ways in the region (see Community outreach).

It is also important to understand that all activities associated with advance care planning, including where hospital and health services, the PHN or other groups have implemented communities of practice and/or undertaken intensive community engagement, directly align to the GCfAHPC objectives by identifying and supporting people's individual choices to die at home. Advance Care Plans ensure the person retains ownership of the care they wish to receive at the end of their life, at the right time and in the right place and improves access to care at home or in a primary care or community setting.

58. Advance Care Planning Australia, Advance care planning prevalence in Australia 2025.
59. Statewide Office of Advance Care Planning, 'Statewide advance care planning activity reporting; dashboard results for Darling Downs and West Moreton, September 2025', 2025. Queensland Government, Brisbane.

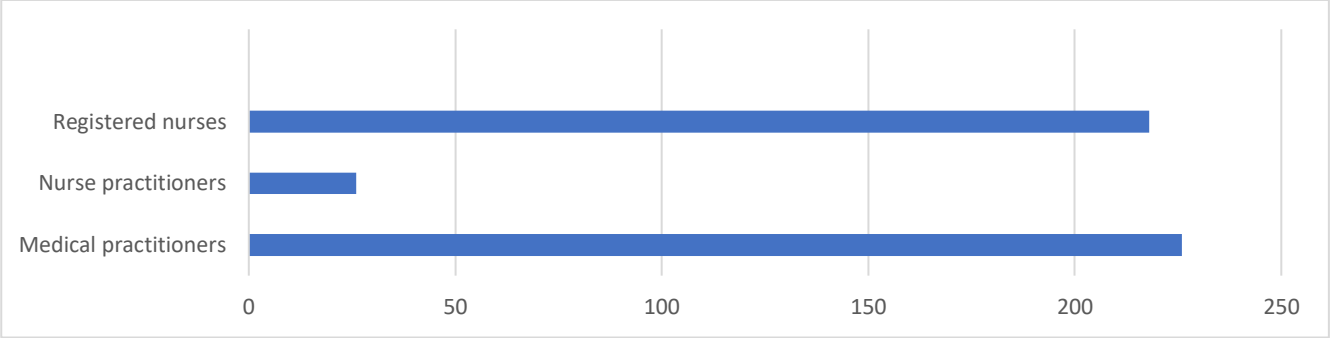
Voluntary assisted dying

Voluntary assisted dying (VAD) became legal in Queensland from 1 January 2023. The option of VAD can give patients with a life-limiting illness the ability to control the timing of their death (should they so choose and when strict criteria are met).

VAD services in Queensland are still in their formative stages. At a state level the 2024-2025 Voluntary Assisted Dying Annual Report identified that from 1 July 2024 to 30 June 2025, 2,039 people had a first assessment. In the same period, 1,072 people received assistance to die through administration of a voluntary assisted dying substance (either by self-administration or practitioner administration). This represents approximately three per cent of the 38,630 total deaths in Queensland.[60]

- There is a **coordinating doctor** who has completed mandatory training and has been approved as an authorised Voluntary dying Doctor. They can support throughout the whole process from completing the first assessment to assisting you to make you administration decision, prescribing the VAD substance through to acting as your administering doctor.
- A **consulting doctor** is an eligible doctor who has completed the mandatory training and has been approved as an authorised voluntary assisted dying doctor they will conduct a consulting assessment.
- An **administering doctor or nurse** will normally be the coordinating doctor, however the role can be transferred to another eligible doctor, nurse practitioner or registered nurse who has completed the mandatory training.[61]

Table 6: Authorised practitioners between 1 July 2024 to 30 June 2025 [61]



Between 1 July 2024 and 30 June 2025, there were 470 authorised Voluntary Assisted Dying practitioners in Queensland. Just under half (48 per cent) are medical practitioners, and the remaining 52 per cent are nurse practitioners and registered nurses (Table 6).

60. Table 2: Authorised practitioners between 1 July 2024 to 30 June 2025
61. Queensland Voluntary Assisted Dying Review Board. (2025). *Voluntary assisted dying annual report 2024–2025*. Queensland Government. URL

Table 7: Palliative Medicine Physicians

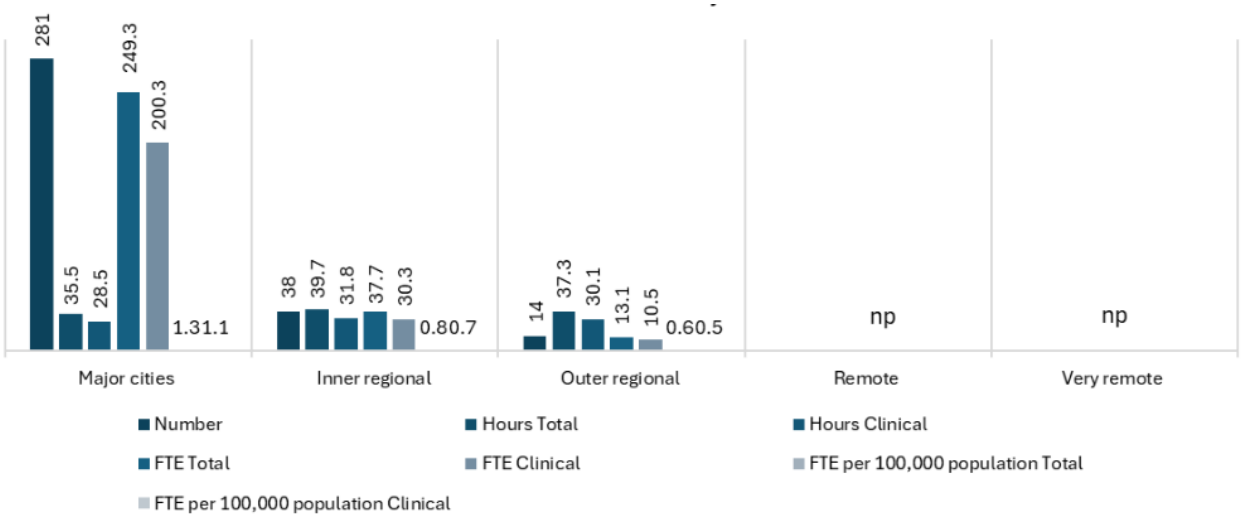
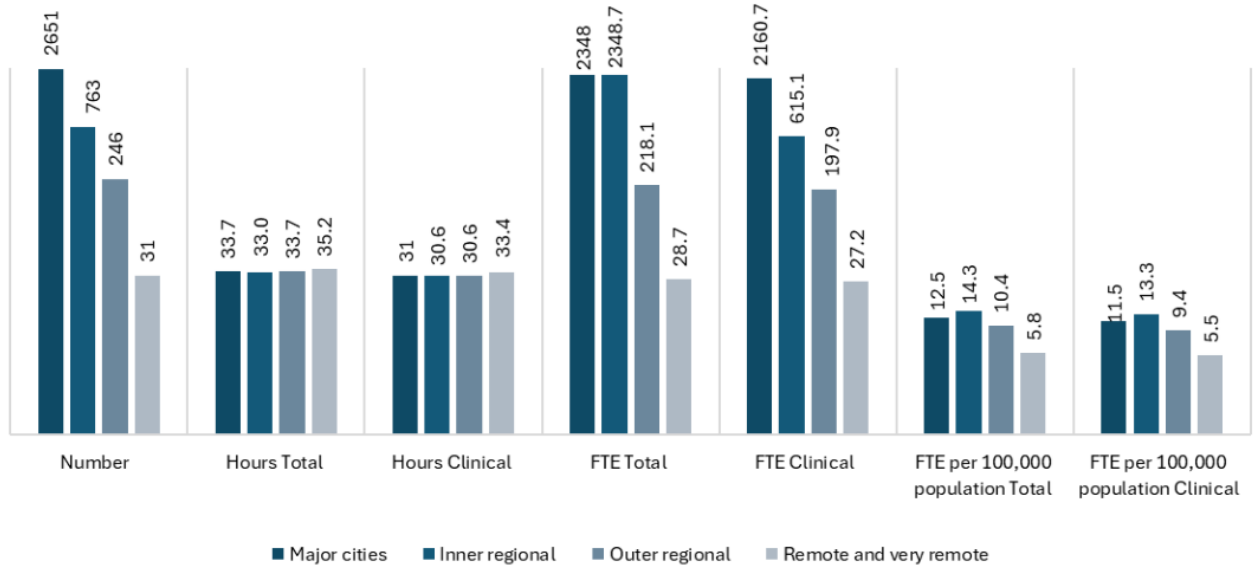


Table 8: Palliative Care Nurses



Darling Downs Health has established a dedicated VAD team made up of medical, nursing and allied healthcare professionals. The team provides a phone and email service to connect health practitioners to a VAD clinical nurse consultant who can then make contact with a patient interested in VAD. Some aspects of the process can be managed via telehealth, but legislation requires face-to-face interaction for other parts of the process. VAD service staff will travel to anywhere in the region. The team have helped eligible people with life-limiting illnesses access the program, and provided education and support on the process from eligibility, request and assessment, through to administration and post-death support.

West Moreton Health has developed a specialised Voluntary Assisted Dying (VAD) service to support patients, their support people and clinicians across the region. Located on the Ipswich Hospital campus, the service provides in-reach to all admitting West Moreton Health facilities and outreach to people in the community, including Residential Aged Care Facilities (RACFs), private hospitals and individuals at home. WM VAD also provides education and in-services to all health care workers across these settings including GP clinics.

Through WM VAD Connect, patients living in the West Moreton catchment can:

- be introduced to authorised VAD practitioners, and
- receive coordinated support throughout the entire VAD process.

The establishment and expansion of VAD services in Queensland, including coordinated multidisciplinary teams, authorised practitioners, telehealth support and outreach into homes, RACFs and community settings, directly align with the GCfAHPC objectives by enabling the right care at the right time and in the right place, strengthening access to high-quality, coordinated end-of-life care at home and in the community, and building workforce capability and integration across primary, community and specialist services.

Greater Choice for At Home Palliative Care Program – An Australian Government initiative

Most people receiving palliative care prefer to stay at home (which may be a RACH) if possible. However, pain, nausea, complex medical needs, and the ability and availability of family or carers can mean hospital or hospice care is needed.[62]

The Greater Choice for At Home Palliative Care Program – was launched with 11 PHNs as a pilot program by the Australian Government Department of Health and Aged Care in 2017. The pilot program was evaluated in 2020 and found to have facilitated the establishment of networks between PHNs, local stakeholders, community members and service providers. The program was expanded to include all 31 PHNs from 2021.

A 2023 national evaluation of the program found *'PHNs are on track with implementing program activities against their activity work plans… with sustained collaboration across all 31 PHNs. PHNs have delivered a range of program activities demonstrating that the program is enabling a diversity of offerings that meet local needs.'*[63]

The Darling Downs and West Moreton PHN developed an activity work plan for 2021–25 that focused on education and integration of care with the support of three new positions (a project coordinator and two regional palliative care program officers).[64]

Activities included:

- **Referral pathways:** Improving coordination and communication between services, across organisational boundaries and between public and private sector providers.
- **Collaboration and awareness:** Building on the existing West Moreton Regional Care at the End-of-Life Knowledge Framework.
- **Models of care:** Identifying and supporting uptake of new or existing models of care among healthcare providers.
- **Planning and management:** Increasing health sector awareness and uptake of ACP across the region.
- **Access to information:** Developing the region into a compassionate community, building capacity to care for people approaching the end of life.
- **At-home support:** Increasing patient/carer awareness and uptake of ACP across the region.
- **Community and professional awareness:** Achieving equitable access to quality at-home palliative care for all members of the community, regardless of age, diagnosis, location, disability status, socio-economic status or social circumstances.
- **Cross-collaboration for service providers:** Improving health professional and stakeholder networks across the region.

62. Australian Government Department of Health, Disability and Ageing, 'Where is palliative care provided?'.
63. Scyne Advisory, National evaluation of the Greater Choice for At Home Palliative Care Program, Department of Health and Aged Care, Canberra, 2023.
64. Darling Downs and West Moreton Primary Health Network, *Greater Choice for At Home Palliative Care activity work plan 2021/22–2024/25,* Darling Downs and West Moreton Primary Health Network, Toowoomba, 2021.

To ensure engagement and participation, the program has been identified as a shared priority within the Joint Regional Older Persons Strategy in collaboration with the two regional Hospital and Health Services, all five Aboriginal Medical Services and community stakeholders. Multimodal education and engagement have been central to how the PHN works with priority populations and communities, with strong participation and pre- and post-evaluation outcomes demonstrating impact (see Community outreach).

Informed by the GCfAHPC guidelines, implemented activities, community engagement, establishment of end-of-life and palliative care collaboratives in both the Darling Downs and West Moreton regions highlights the commitment to improving access to palliative care at home across and in partnership with our health and hospital systems and community service providers, supporting dignity of choice for people who choose to die at home, and utilising data to support continuous improvement of provision of services across sectors.

Medication

Delivery of palliative care often involves a complex mix of medicines. Across Australia in 2023–24, 78.9% of Pharmaceutical Benefits Scheme (PBS) Palliative Care Schedule prescriptions were for pain relief, 9.4% were for gastrointestinal symptoms, 9.2% for neurological symptoms, and the balance for psychological symptoms and respiratory symptoms.[65]

In 2023–24, 44,278 prescriptions were written for PBS Palliative Care Schedule medicines for 13,549 people in the PHN.[66] Effective and safe medication management requires coordination between different carers. In 2023–24, in Queensland, 89.7% of PBS Palliative Care Schedule medicines were prescribed by GPs, 1.6% by palliative medicine specialists and 8.7% by other clinicians.[67] For neurological and psychological symptoms, the rate of prescription by general practitioners drops relative to other clinicians, but general practitioners are still responsible for more than 70% of such prescriptions.[68]

The 2023–24 rates of PBS palliative care-related prescriptions per 100,000 population show that the region has a higher than national average rate of prescribing pain relief medications, including a higher than average rate of opioid prescribing.[69] There could be a range of underlying factors that contribute to this – the region records a significantly higher proportion of palliative care delivered in hospital settings (Referrals and Hospitalisations) compared with the national average. This is likely contributing to higher rates of opioid use, as hospital-based palliative care typically manages more acute and complex symptoms and relies more heavily on strong analgesia to stabilise pain. Limited referral to palliative care early in the disease trajectory also means that pain management often occurs later, when symptoms are more severe and require stronger medication.

The region's higher levels of comorbidity and clinical complexity (Health Profile) increase the need for more intensive symptom control. At the same time, the limited availability of community-based palliative care and gaps in after-hours support make it difficult for families to manage care at home. As a result, patients are more likely to present to hospital, where opioid administration is standard practice for managing complex or uncontrolled pain.

Together, these factors suggest that strengthening community palliative care capacity, improving early referral pathways, and addressing after-hours workforce gaps may help reduce avoidable hospital presentations and support timelier, coordinated pain management in the community.

In 2022–23, 270 people in the PHN received a total of 2850 MBS-subsidised palliative medicine attendance and case conference services provided by palliative care physicians or specialists. This represents a rate of 43.4 people per 100,000 population (compared with a national rate of 53.5) and 458.7 services per 100,000 population (compared with a national rate of 255.0).[70]

65. AIHW, 'Palliative care services in Australia'.
66. AIHW, 'Palliative care services in Australia'.
67. AIHW, 'Palliative care services in Australia'.
68. AIHW, 'Palliative care services in Australia'.
69. AIHW, 'Palliative care services in Australia'
70. AIHW, 'Palliative care services in Australia'.

In 2022–23, 259 people received a total of 2,521 palliative medicine attendances by a palliative medicine physician or specialist (approximately 9.8 per person) in the PHN. Of these, 257 people were attended in a consulting room or hospital and 2 were in other settings. Attendances were provided at a rate of 41.6 people per 100,000 population, and a rate of 406.2 services per 100,000 population.[71]

In 2022–23, 118 people received a total of 326 palliative medicine case conferences involving a palliative medicine physician or specialist (approximately 2.8 per person) in the PHN. Of these:

- a community case conference was organised and coordinated for 85 people
- a community case conference was attended for 10 people (12 services)
- a discharge case conference was organised and coordinated for 29 people (33 services)
- a discharge case conference was attended for 17 people (31 services).

Case conferences were provided at a rate of 18.9 people per 100,000 population, and a rate of 52.5 services per 100,000 population.[72]

Complexities that exist in the pharmacological side of palliative care within our region highlights a higher need for access to medications within the community and primary health care settings. Ensuring at all stages the safe and appropriate care and management of palliative symptomatology, and allowing for available technologies that will support flexible and responsive palliative care at home, including in the after-hours space, helps reinforce the need for quality palliative care at home.

Equipment

The Queensland Medical Aids Subsidy Scheme Palliative Care Equipment Program (MASS PCEP) provides medical equipment to patients on a loan basis for up to 6 months.[73] It is available to eligible persons of all ages with a palliative condition and approaching the end of life. The purpose of the program is to support persons at the end of life to remain at home by:

- providing continence aids and oxygen to help maintain quality of life
- providing daily living (such as bathing or sleeping equipment) and mobility aids (such as wheelchairs, walking frames or ramps) to reduce dependence and support engagement in functional tasks, either independently or with assistance.

MASS PCEP operates through a prescriber model. Approved prescribers, in consultation with the patient or nominated support person, submit an application on their behalf.

It is pertinent to know that communication from Queensland Health, July 2025, advised the Queensland MASS program is undergoing review in order to strengthen and improve its impact and effectiveness in its continued support of people requiring aids and equipment to live with dignity and independence. Whilst the health, disability and aged care sectors continue to evolve through current reforms, this review is an opportunity to ensure MASSs continued sustainability, specifically, in this instance, of those people with life-limiting conditions.

Linking directly to the GCfAHPC objectives, equipment allows people receiving end-of-life or palliative care in the home to access the necessary support they require and increase functional safety for themselves and their carer/s. Ensuring the right supports/care in the right place complements the reduction of unnecessary hospitalisations.

71. AIHW, 'Palliative care services in Australia'.
72. AIHW, 'Palliative care services in Australia'.
73. Queensland Health, Guidelines for Palliative Care Equipment Program, Queensland Government, Brisbane, 2025.

Workforce needs in palliative care

The palliative care HNA asked the question: **What are the palliative care workforce capacity and capabilities in our region, and how well do they meet community needs?**

Workforce profile

The Queensland Government has committed $171 million from 2021–22 to 2025–26 to strengthen palliative care across Queensland; it is expected that the Queensland specialist palliative care workforce will increase by 87% across Queensland over the funding period.[74]

The following figures are drawn from the Australian Institute of Health and Welfare (AIHW) Palliative Care Services in Australia workforce data.[75]

In 2022, there were 334 palliative medicine physicians employed in Australia, providing a workforce of 301.3 full-time equivalent positions (FTE) or a clinical workforce of 242 FTE (0.9 per 100,000 population). Two-thirds were female; none were Aboriginal or Torres Strait Islander persons. Of the 334 palliative medicine physicians, 310 were clinicians, 10 administrators, 8 researchers or academics and 6 teachers or educators.

In the same year, there were 3692 palliative care nurses employed, providing a workforce of 3258.7 FTE or a clinical workforce of 3011.9 FTE (11.5 per 100,000 population). More than 90% were female. Fifty-two (<2%) were Aboriginal or Torres Strait Islander persons. Of the 3692 palliative care nurses, 3487 were clinicians, 88 administrators, 64 teachers or educators, 42 researchers or academics and 11 in other roles.

In Queensland, there are 63 palliative medicine physicians employed – 1.1 FTE per 100,000 population or 0.9 FTE clinical per 100,000 population (compared with 1.2 and 0.9, respectively, for all of Australia).

There are 678 employed palliative care nurses in Queensland – 11.5 FTE per 100,000 population or 10.4 FTE clinical per 100,000 population (compared with 12.5 and 11.5, respectively, for all of Australia).

For healthcare in general, for every 100,000 residents in the Darling Downs and West Moreton region, there are:[76]

- 106.9 GPs (2022), compared with 127.8 for Queensland
- 328.8 total medical practitioners (2022), compared with 434.5 for Queensland
- 1314.6 total nurses (2022), compared with 1,500.9 for Queensland.

74. Queensland Health, Queensland Palliative and End-of-Life Care Strategy 2022, Queensland Government, Brisbane, 2022, accessed 22 October 2025.
75. AIHW, 'Palliative care services in Australia'.
76. Darling Downs and West Moreton Primary Health Network, *Darling Downs and West Moreton joint regional needs assessment 2025–28*.

Various state and federal workforce resources and training programs are available to support palliative care in the region:

- PallConsult is a Queensland Health service designed to boost the ability of local healthcare teams to deliver palliative care. The service provides advice hotlines and education and monitoring sessions for clinical staff.[77]
- End of Life Direction for Aged Care provides information, guidance, and resources to health professionals and aged care workers on palliative care and ACP.[78]
- The Palliative Aged Care Outcomes Program aims to improve the outcomes of all Australians in RACHs with a particular focus on those who are approaching the end of their life.[79]
- The Program of Experience in the Palliative Approach helps health professionals to deliver palliative care by providing training in clinical placements in specialist palliative care services and interactive workshops.[80]
- The Pharmaceutical Society of Australia has developed the ASPIRE Palliative Care Foundation Training Program to help equip pharmacists with the foundation knowledge and skills needed to provide palliative care support through the quality use of medicines.[81]

Workforce distribution

- Most palliative medicine physicians and nurses work in major cities (Table 6). Direct access to specialist care in remote areas can be limited.

Table 9: Palliative physicians and care nurses in Australia by region

Group	Remoteness areas	Number	Hours Total	Hours Clinical	FTE Total	FTE Clinical	FTE per 100,000 population Total	FTE per 100,000 population Clinical
Palliative medicine physicians	Major cities	281	35.5	28.5	249.3	200.3	1.3	1.1
	Inner regional	38	39.7	31.8	37.7	30.3	0.8	0.7
	Outer regional	14	37.3	30.1	13.1	10.5	0.6	0.5
	Remote	np	np	np	np	np	np	np
	Very remote	np	np	np	np	np	np	np
	Total	334	36.1	29.0	301.3	242.0	1.2	0.9
Palliative care nurses	Major cities	2,651	33.7	31.0	2,348.7	2,160.7	12.5	11.5
	Inner regional	763	33.0	30.6	662.2	615.1	14.3	13.3
	Outer regional	246	33.7	30.6	218.1	197.9	10.4	9.4
	Remote and very remote	31	35.2	33.4	28.7	27.2	5.8	5.5
	Total	3,691	33.5	30.9	3,257.7	3,000.9	12.5	11.5

np = not published due to small numbers, confidentiality or data quality concerns.
Source: AIHW, 'Palliative care services in Australia', Palliative care workforce data, table 4, AIHW, Canberra, 2025, accessed 22 October 2025.

77. Queensland Health, About PallConsult. Queensland Government, Brisbane, 2025, accessed 18 November 2025.
78. Department of Health, Disability and Ageing, End of Life Direction for Aged Care (ELDAC), Australian Government, Canberra, 2025, accessed 19 November 2025.
79. Department of Health, Disability and Ageing, Palliative Aged Care Outcomes Program (PACOP), Australian Government, Canberra, 2025, accessed 19 November 2025.
80. Department of Health, Disability and Ageing, 'Palliative Aged Care Outcomes Program (PACOP)', Australian Government, Canberra, 2025, accessed 19 November 2025.
81. Pharmaceutical Society of Australia, 'ASPIRE palliative care foundation training program', Pharmaceutical Society of Australia, 2025, accessed 18 November 2025.

Work settings

The Australian palliative care workforce is mainly based in hospitals, RACHs or hospices (Table 7).

Table 10: Palliative physicians and care nurses in Australia by work setting

Group	Work setting	Number	Hours Total	Hours Clinical	FTE Total	FTE Clinical	FTE per 100,000 population Total	FTE per 100,000 population Clinical
Palliative medicine physicians	Hospital	234	36.6	29.4	213.8	172.0	0.82	0.66
	Other community healthcare service	38	33.8	27.2	32.1	25.8	0.12	0.10
	Outpatient service	25	36.0	32.2	22.5	20.1	0.09	0.08
	Private practice (sole or group)	18	38.4	34.9	17.3	15.7	0.07	0.06
	Tertiary education facility	7	39.1	12.9	6.8	3.0	0.03	0.01
	RACH	6	34.0	32.3	5.1	4.9	0.02	0.02
	Other[(a)]	6	24.2	8.7	3.6	3.0	0.01	0.01
	Total	334	36.1	29.0	301.3	242.0	1.16	0.93
Palliative care nurses	Hospital	1,880	34.4	32.5	1,701.3	1,610.0	6.54	6.19
	Community healthcare service	941	32.9	30.4	814.4	752.7	3.13	2.89
	Hospice	532	32.3	30.0	452.1	420.1	1.74	1.61
	Residential healthcare home	76	33.0	28.2	66.0	56.5	0.25	0.22
	Outpatient service	75	34.9	31.9	68.9	63.1	0.26	0.24
	Tertiary education facility	25	33.8	5.7	22.2	3.7	0.09	0.01
	Other government department or agency	25	37.0	24.3	24.3	16.0	0.09	0.06
	Private practice (independent or other)	22	28.1	22.2	16.3	12.8	0.06	0.05
	GP practice	8	31.3	29.8	6.6	6.3	0.03	0.02
	Other[(b)]	108	30.5	21.4	86.6	60.8	0.33	0.23
	Total	3,692	33.5	30.9	3,258.7	3,001.9	12.53	11.54

(a) For palliative medicine physicians, 'Other' includes 'Other government department or agency', 'Other educational facility' and 'Other'.
(b) For palliative care nurses, 'Other' includes 'Other educational facility', 'Commercial/business service', 'Correctional services', 'Aboriginal Community Controlled health service', 'Defence forces' and 'Other'.
Source: AIHW, Palliative care services in Australia', Palliative care workforce data, table 6, AIHW, Canberra, 2025, accessed 22 October 2025.

Strengths and challenges

What is working well

Increased state funding and a dedicated strategy for palliative care, along with ongoing national support, are providing a strong basis for improvements in palliative care (see National and state priorities). In the region, some services and collaborations are working well to maximise the access to and effectiveness of palliative care resources. Using these as examples to guide actions across the region will be important to meet the increasing palliative care needs of the community and continuously improve the quality, consistency and outcomes of palliative care.

Coordination to meet patient needs

In some organisations in the region, an integrated model of care is used to ensure the setting of palliative care is determined based on patient needs and acuity.[82] In West Moreton, 25 inpatient beds across Ipswich Hospital and Ipswich Hospice are jointly managed, with patients directed to the most appropriate setting. This approach could be more widely used across the region to ensure inpatient beds are used most effectively.

Palliative care in residential aged care is well supported in West Moreton. Ipswich Nursing Service has been delivering consultation and education services to the RACHs in Ipswich since 2016. The SPACE program works in an integrated model with Ipswich Nursing Service to share workload and prevent duplication. One of the strengths of the program is the continuity of care it provides, with the after-hours service enabling clinicians who already have relationships with residents to continue their care outside normal hours. This is crucial, as it supports informed decision-making and allows clinicians within the RACHs to seek timely advice during the after-hours period, resulting in fewer hospital presentations.

Community outreach

Community palliative care service delivery has been a focus of West Moreton Health for several years, which has resulted in a comprehensive community service portfolio.[83] West Moreton Health operates a specialist palliative care outreach team which includes nurse practitioners to provide people in the last 3 months of life with care at home. The outreach service is supported by up to 12 palliative care hospital-in-the-home beds which ensure people can remain at home even if they require complex symptom management. Each of the rural hospitals in West Moreton Health (Esk, Boonah, Laidley and Gatton) have community outreach that includes palliative care. These services are supported by telehealth from the West Moreton Palliative Care Team at Ipswich Hospital.

In the Darling Downs, Toowoomba Hospital Palliative Care Service operates specialist palliative care outpatient clinics and an outreach team which provides coordination for palliative care. Community palliative care in the Darling Downs is predominantly managed by GPs, with support and advice from specialist palliative care physicians at Toowoomba Hospital or accessed through the SPaRTa service in rural areas. Community palliative care in rural and remote areas of the region is coordinated by senior palliative care nurses based in South Burnett, Western Downs and Southern Downs.

In 2019, Ipswich Hospice Care established its first nurse practitioner service in the community. As with the inpatient services, West Moreton Health and Ipswich Hospice work in an integrated model to ensure there is no duplication of service provision and to simplify referral pathways. Ipswich Hospice also delivers palliative care specifically for people with disability.

82. Hope, Palliative care in the Darling Downs and West Moreton region: a desktop review.
83. Hope, Palliative care in the Darling Downs and West Moreton region: a desktop review.

West Moreton is one of very few areas in Queensland that has a substantive ACP team. Based at Ipswich Hospital, this team provide ACP services anywhere in West Moreton, including in hospitals, community settings, RACHs and prisons. Several successful initiatives in information and education outreach have also been conducted across the Darling Downs and West Moreton Region:

- Printed resources, including ACP information sheets, toolkits and checklists, have been co-designed and disseminated to the community.
- Elder Care Journals were co-designed with Elders at Kambu Health. The project engaged Elders to identify culturally appropriate approaches to end-of-life care education and support for Aboriginal and Torres Strait Islander peoples. The journal helps Elders manage their health, including appointments, blood sugar and blood pressure tracking, and includes sections on ACP, dementia, palliative care, and VAD. It also supports service provider understanding.
- 'Dying to Know' initiatives were delivered in retirement villages in the region, using a 'train the trainer' model to ensure sustainability. Twenty community workshops were also delivered across Scenic Rim, Lockyer, Somerset and Ipswich.
- A 'Death Expo' was held in Toowoomba in October 2025 to bring together health professionals and community members to encourage conversations around death, dying, grief and end-of-life planning. Sessions were held on ACP, funeral planning, grief support, palliative care, VAD and cemeteries. The expo also featured interactive exhibition booths where attendees could speak with professionals in palliative care, grief counselling, funeral services, aged care, end-of-life doulaship and legal/financial planning.

Productive collaboration

Our region has developed some effective collaborations between organisations involved in palliative care. The West Moreton Care at the End of Life (CAEOL) Collaborative was established in 2018 by stakeholders who provide care at the end of life. This includes West Moreton Health, the PHN, University of Southern Queensland, Queensland Ambulance Service, Ipswich Hospice and representatives from the aged care, disability and private hospitals sectors in the region. Palliative Care Queensland and Ipswich City Council also have representatives on the CAEOL Collaborative. The Collaborative's aim is to address gaps in capacity and capability to provide quality care at the end of life in the West Moreton region. It supports initiatives in the areas of:

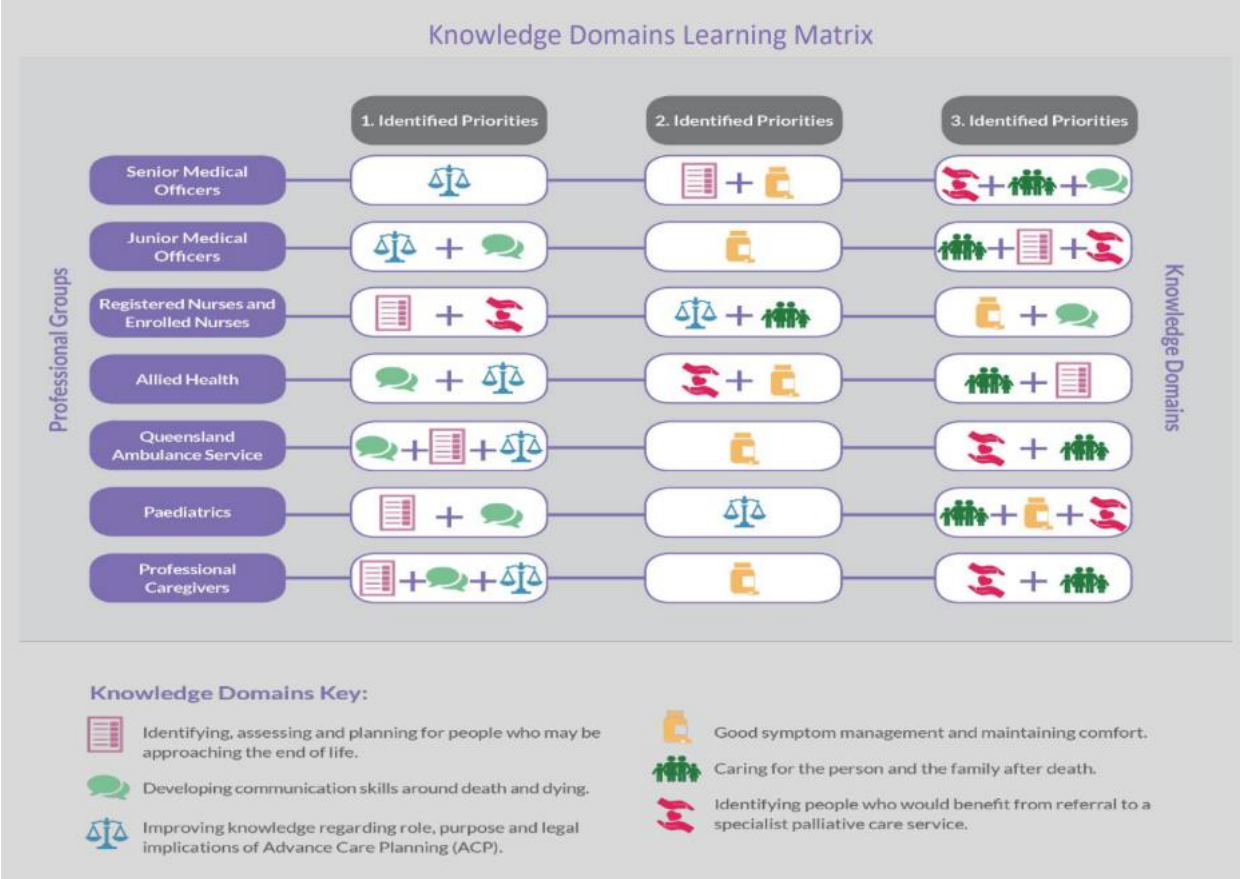
- workforce education and development
- community development
- research and innovation.

Following on from the success of the West Moreton CAEOL Collaborative, the Darling Downs CAEOL Collaborative was established in June 2022 by the PHN as part of the Australian Government's Greater Choice for At Home Palliative Care program. The Collaborative develops partnerships across government and non-government services to optimise systems, processes, and outcomes for people living with life-limiting illness in the Darling Downs community.

Workforce development

The quality of palliative care depends on a suitably knowledgeable and skilled workforce. The PHN supported the West Moreton CAEOL Collaborative to develop a knowledge framework to guide health professionals and professional caregivers who provide palliative care. The framework is a user-friendly, hyperlinked guide to role-specific and freely available education programs, courses, tools and local regional contacts for medical professionals, nurses, allied health clinicians, and Queensland Ambulance Service, paediatric and professional caregivers. The framework was based on a needs analysis that identified the key knowledge areas required by different professional groups who may be involved in palliative care (see Figure 8). It has been widely shared and implemented throughout the region.

Figure 8: The knowledge domains of the West Moreton CAEOL Collaborative knowledge framework



Source: West Moreton CAEOL Collaborative.

Table 11: Knowledge domains of the West Moreton CAEOL Collaborative knowledge framework

Knowledge Domains Learning Matrix							
	Senior Medical Officers	Junior Medical Officers	Registered Nurses Enrolled Nurses	Allied Health	Queensland Ambulance Service	Paediatrics	Caregivers
Identified level of Priority x Professional Group: 1 - 3							
Identifying, Assessing and planning for people who may be approaching the end of life	2	3	1	3	1	1	1
Developing communication skills around death and dying	3	1	3	1	1	1	1
Improving Knowledge regarding role, purpose and legal implications of Advance Care Planning	1	1	2	1	1	2	1
Good symptom management and maintaining comfort	2	2	3	2	2	3	2
Caring for the person and family after death	3	3	2	3	3	3	3
Identifying people who would benefit from referral to a specialist palliative care service	3	3	1	2	3	3	3

The West Moreton Care Collaborative Symposium, held biannually for health professionals in the region, has also supported improvements to palliative care. Recent topics have included:

- ageing ahead of time
- enhancing palliative care in the community
- health literacy and emergency preparedness for seniors
- dementia diagnosis and post-diagnosis support for older persons.

The Symposium have been well attended with the 2025 symposium having 85 attendances with a wide range of health professionals from a variety of backgrounds including GP's, Registered Nurses, students and community providers.

The West Moreton Care at the end-of-life Collaborative (WMCEOL) and Darling Downs End of life Collaborative have delivered a broad range of Courageous conversations and last aid training session across the region. Courageous Conversations is a training program that equips health professionals with the skills and confidence to have clear, compassionate discussions about death, dying, and end-of-life care with patients and their families. Whilst Last aid is a community education program that builds death literacy by teaching people the basic principles of palliative care, end-of-life support, and how to provide compassionate care for someone who is dying.

An evaluation of the WMCEOL delivery of Courageous Conversations workshops using pre- and post-surveys found that the 86 participants showed a 32% increase in confidence, 45% increase in knowledge, and 75% implementation of learnings. The participants were a broad professional group from acute, community, mental health, rural and RACH settings, representing medical, nursing, paramedic, caregiving, and allied health professions.

Knowledge sharing through technology

The region covers 99,000 km^2 and has a mix of urban, regional, rural and remote communities. This can present challenges for both the workforce and community members to access information about palliative care services. The PHN has developed online knowledge resources for health professionals and members of the community, including:[84]

- GPs in a Pod clinical podcast series, which enables GPs to access knowledge from experts on various topics in short episodes, on various platforms and where convenient, including, for example, while driving; episodes relevant to palliative care have included:
    - Episode 17 on advance care planning, which aired on 22 October 2024 and had 56 listens.
    - Episode 23 on voluntary assisted dying, which aired on 14 January 2025, and had 67 listens.
- West Moreton CAEOL Collaborative website which provides information on local health services, community services, and support organisations and groups for people with a life-limiting illness, as well as their family, carers and health professionals.
- Darling Downs HealthPathways and West Moreton HealthPathways websites that provide evidence-based clinical information for health professionals:
    - a repository of GP symposium presentations
    - an online education webpage linking to the PHN and external resources
    - an interactive online community of practice (hosted through Project ECHO) focused on knowledge sharing to improve delivery of care to older persons
    - a PHN Virtual Library that includes key publications and an online directory of PHN commissioned services (PHN Services Library), including palliative care services and initiatives (e.g., Ipswich Nurses).

Ongoing assessment

The Palliative Care Outcomes Collaboration (PCOC) is a national palliative care outcomes and benchmarking program funded by the Australian Government Department of Health, Disability and Ageing.[85] PCOC's primary objective is to improve patient outcomes (including pain and symptom control). PCOC collects and analyses information from palliative care services across Australia to help the services understand if the care they provide is effective and appropriate to the needs of patients and their families and carers. Central to the program is a framework and protocol for routine clinical assessment and response. This works in parallel with routine point-of-care data collection, capturing clinically meaningful information.

PCOC aims to drive improvement in patient outcomes through feedback to individual services and by facilitating service-to-service benchmarking. The items in the PCOC data collection:

- provide clinicians with an approach to systematically assess individual patient experiences
- include routine patient-reported outcome measures relating to symptom distress
- define a common clinical language to allow palliative care providers to communicate with each other, facilitate the routine collection of nationally consistent palliative care data for the purpose of reporting and benchmarking to drive quality improvement at service, state, territory and national levels.

84. Darling Downs and West Moreton Primary Health Network, Darling Downs and West Moreton Primary Health Network [website], n.d., accessed 30 October 2024.
85. Australasian Health Outcomes Consortium, Outcome report: patient outcomes in palliative care – January to June 2025, PCOC, Wollongong, 2025, accessed 22 October 2025.

Case study: Performance against benchmarks

The Australian Palliative Care Outcomes Collaboration (PCOC) is a national palliative care outcomes and benchmarking program that aims to improve patient outcomes.

Ipswich Nursing Service measures palliative care performance against the PCOC benchmarks, which include timely commencement of palliative care, responsiveness to urgent clinical need, and effective control of symptoms. The service has three palliative care programs: palliative care at home, palliative care in RACHs and palliative care for children. PCOC data shows that, between January and June 2025, Ipswich Nursing Service provided palliative care to 198 people. The median age of the person receiving care was 88 years and the mean age was 87.3 years. There were more males than females in the 65–74 age group, and more females than males in the 75–84 and 85+ age groups. During the period, 202 episodes of care were delivered. The median length of a care episode was 66 days and the mean length of a care episode was 46.9 days.

Of all patients receiving palliative care services from Ipswich Nursing Service between January and June 2025, 14.1% were born in a country other than Australia, 1% were Aboriginal or Torres Strait Islander people and 0.5% preferred a language other than English. PCOC is a valuable quality improvement tool for the Ipswich Nursing Service and there are opportunities to use this tool in other organisations, such as RACHs, in the region.

Source: PCOC National Overview of Patient Outcomes in Australia, 2014 to 2024, and Ipswich Nursing Service PCOC dashboard.

What could be better

Identifying key areas for improvement, along with effective collaboration built between the HNA partners, will support the improvement of palliative care in our region.

Service accessibility

Access to palliative care is an Australia-wide issue. AIHW research found that in the last year of life, 2 in 5 (41%) of the population in need of palliative care received specialist palliative care and 94% consulted with a GP; 1 in 2 (54%) had consultations with other specialists. Most specialist palliative care was received around 15 days before death. Current evidence suggests at least 3 to 4 months of specialist palliative care provides the maximum benefit.[86]

Recent research found that access to healthcare services in general varies across the region and feedback from older people highlighted a lack of services – many organisations have staff shortages, so they are unable to provide access to the services that are needed.[87] This deficit is mirrored in palliative care. The aged care workforce is under severe strain, and the lack of workers is an issue for regional organisations, especially in rural and remote areas.[88]

As noted previously (see Population profile), rural and remote areas in the region have limited access to palliative care services, however this has somewhat improved in some areas, since statewide funding of 7-day palliative care community service provider, Blue Care Rural and Remote Program was commenced in the Darling Downs region.

The Palliative Care Pathways Project consulted with stakeholders who deliver specialist and generalist palliative care across the Darling Downs region to map 4 journeys of patients identified as having palliative care needs.[89] One rural community care nurse reported patients have no other option than to be admitted to the local hospital because there is no 24/7 support available from care providers to enable them to remain at home leading up to and at the end of life.

86. AIHW, Palliative care and health service use for people with life-limiting conditions.
87. Darling Downs and West Moreton Primary Health Network, The health and care needs of older Australian in the region with additional challenges – Care Finder Program.
88. Darling Downs and West Moreton Primary Health Network, The health and care needs of older Australian in the region with additional challenges – Care Finder Program.
89. Darling Downs and West Moreton Primary Health Network, DDH Palliative Care Pathways Project final report 2023, Darling Downs and West Moreton Primary Health Network, Toowoomba, 2023.

Research also highlighted that older people may require additional support to navigate aged care and the healthcare system,[90] including palliative care systems. Community members told us:

"There's a lack of funding for palliative care. I don't feel there is enough beds in any of the hospitals." **– Community member**

"Aboriginal Health Workers are only around during the day. But our needs don't stop when the sun goes down. We need 24/7 support, especially in palliative care or hospitals." **– Community member**

Some accessibility issues are around access to palliative medications. While PallConsult (see Workforce profile) and the Specialist Palliative Care in Aged Care program (see Regional service profile) provide valuable support to regional healthcare professionals, prescriptions cannot be obtained through these programs and must be separately sourced through GPs. Some rural and remote RACHs have limited stock of palliative medications and need to order these from pharmacies in Brisbane, which results in delays and an inability to support with pain management.

Service coordination

Although there have been some positive examples of effective coordination in our region (see What is working well), gaps in coordination and communication between services and organisations is still an issue for many areas and patients. Healthcare coordination and communication of care is recognised as critical to high-quality care, supported by national standards and frameworks.

Drawing on conversations with older residents, the assessment of the health and care needs of older Australians in the region with additional needs highlighted the following challenges:[91]

- lack of sharing of concise medical information from health professionals to patients; some people are having a hard time understanding the plan for their healthcare, such as changes to medications and multiple referrals as part of a care team.
- some health professionals not knowing enough about other services within their region that could assist older people's health.
- feeling that health professionals are not relaying information to other health professionals.

While this research applied to healthcare in general, it echoes challenges faced in palliative care. Communication issues flagged in recent research include difficulties in obtaining discharge summaries from hospitals and with contacting GPs for end-of-life prescribing.[92] There is also a lack of uptake of the Palliative Aged Care Outcomes Program in regional RACHs due to lack of interoperability and competing priorities.

90. Darling Downs and West Moreton Primary Health Network, The health and care needs of older Australian in the region with additional challenges – Care Finder Program.
91. Darling Downs and West Moreton Primary Health Network, The health and care needs of older Australian in the region with additional challenges – Care Finder Program.
92. Darling Downs and West Moreton Primary Health Network, DDH Palliative Care Pathways Project final report 2023.

Palliative care in the home

Assessments completed for the Joint Regional Older Persons Strategy[93] and proposed Greater Choice for At Home Palliative Care program[94] identified the main challenges for providing quality palliative care at home in the region:

Darling Downs

- **Rurality:** Sixteen per cent of the population live in outer regional or remote areas, making it very difficult to provide palliative care and end-of-life care in the home (see remoteness classifications for the region in Priority populations).
- **Workforce:** The consultation with stakeholders undertaken by the PHN indicated that recruiting and maintaining an adequately skilled workforce in the region is challenging. This includes the GP workforce. A particular challenge is that there is an ageing GP workforce within rural areas, with limited options to attract workforce into the area.
- **Fragmented models of care:** The specialist palliative care team at Toowoomba Base Hospital provide services to Toowoomba and surrounds only. Community and Rural Health are responsible for palliative care in the rural clusters, each having a palliative care coordinator. Consultation with service providers indicated there is little planning or integrated care delivery for palliative care across the region.
- **Growing older persons population:** See Age profile and care needs.

West Moreton

- **Population growth:** The population growth projections are the highest in Queensland, with the population expected to more than double by 2041. This is particularly so in the population aged 65 years and older.
- **Low socio-economic status:** In 2016, 61.2% of the population were in the 2 most disadvantaged quintiles of Socio-Economic Indexes for Areas.
- **Rurality:** While almost 71% of the population live in the Ipswich conurbation, the remaining almost 30% live in the rural areas of the region. However, as this area is designated 'inner regional' there is no access to SPaRTa telehealth services, creating further burden on the specialist palliative care team.

Advance care planning

Although ACP has a higher uptake in Queensland than in other states (see Advance care planning), regional stakeholders still highlight that more could be done to encourage ACP use.[95] Stakeholders identified concerns regarding the amount of people who were at the end of life with no evidence of ACP discussions having been initiated, and held that there is a need for ACP to become standard practice across service delivery.

Feedback from the community highlighted that they find the ACP process complicated, with lots of steps to go through. This means that documentation is often left incomplete, making it harder for people to receive the care they want at the end of life. Additionally, some service providers noted that, while many people in an RACH have an ACP, it may not have been reviewed or updated in some time. Improving the quality of these records will help ensure everyone's wishes are accurately understood and respected. Through consultation the community told us:

They (ACPs) are a good idea, less stress for the family when the time comes.
– Community member

We need a bit more help to sit down and go through it properly.
Don't just give us a brochure and expect us to know what to do.
– Community member

93. Regional Health Collaborative, Joint regional older persons strategy: stronger for life.
94. C Hope, Greater Choice for At Home Palliative Care proposed program, Darling Downs and West Moreton Primary Health Network, 2021.
95. Darling Downs and West Moreton Primary Health Network, DDH Palliative Care Pathways Project final report 2023.

Cultural awareness and sensitivity

The Darling Downs and West Moreton regions have a diverse and growing population, with a high proportion of Aboriginal and Torres Strait Islander peoples and a significant number of residents from Multicultural and refugee background. To ensure services and staff have the cultural awareness and appropriate approaches it is important to ensuring equitable and accessible healthcare, including palliative care, for these groups.

Cultural beliefs, practices and end-of-life requirements

Aboriginal and Torres Strait Islander peoples, Multicultural communities and people from a refugee background bring unique perspectives and traditions to illness, dying, death and bereavement. Many groups have specific rituals and practices, which may include extended family involvement, spiritual or religious rites, gender-specific care preferences, and culturally determined expectations of privacy, communication and decision- making. End-of-life spiritual practices, such as prayer, sacraments, cleansing rituals, singing chanting or the presence of specific faith leaders may be essential for individuals and families[96]. Many cultural and religious groups hold particular beliefs about the body, afterlife, and acceptable post-death practices.

These may include washing or anointing rituals, restrictions on who may touch the body, requirements for same-day or next-day burial, limitations on autopsy, or specific expectations about cremations. Respecting these practices is essential for cultural safety, dignity and trust at end of life. It is important not to rely on assumptions or stereotypes and ask individuals and families what matters to them remains central to culturally safe palliative care. It is important that palliative care respects and accommodates these needs.

Additionally developed by Palliative Care Australia may be needed to enable palliative care staff to provide appropriate care and support. Multicultural palliative care guidelines developed by Palliative Care Australia may be needed to enable palliative care staff to provide appropriate care and support.

Barriers to access for Multicultural and Aboriginal and Torres Strait Islander communities

Feedback from regional stakeholders has identified that under-served populations such as Aboriginal and Torres Strait Islander peoples and people from a Multicultural communities including refugee background continue to experience barriers to accessing palliative care. These can lead to late services, unmet needs and preventable distress.

Commonly reported barriers include:

- Low English proficiency, limited health literacy and limited digital literacy.
- Small social networks and reduced exposure to mainstream health and aged care systems.
- Fear of services, lack of trust, and concerns about cultural safety.
- Previous negative experiences, discrimination or communication breakdowns.
- Stigma, loneliness, depression and isolation (particularly among older migrants.)
- Lack of Culturally safe aged care and palliative care options.[97]

Research shows that older people from multicultural backgrounds frequently feel isolated and unsupported due to limited English, reduced access to culturally specific services and uncertainty about how to navigate the system.[98] This reflects the broader experiences of migrant groups.[99]

96. Palliative Care Victoria, Culturally & linguistically diverse people, Palliative Care Victoria, East Melbourne, 2025, accessed 20 November 2025.
97. Darling Downs and West Moreton Primary Health Network, DDH Palliative Care Pathways Project final report 2023.
98. Darling Downs and West Moreton Primary Health Network, The health and care needs of older Australian in the region with additional challenges – Care Finder Program.
99. Australian Refugee Health Practice Guide, Older people, Foundation House, Brunswick, 2025, accessed 20 November 2025.

Specific needs of Aboriginal and Torres Strait Islander peoples

Consultation with Aboriginal and Torres Strait Islander health providers identified gaps that can impede and disadvantage Aboriginal and Torres Strait Islander people.[100]

These include:

- The need for a holistic approach to health and the need to deliver sensitive health information in a culturally sensitive way.
- Cultural safety was raised as a concern; one Aboriginal and Torres Strait Islander Health Worker reported a lack in cultural competency and understanding of the needs of Aboriginal and Torres Strait Islander people.
- These issues may result in delayed referrals, reluctance to engage with palliative care, and poorer experiences for patients and families.

The region's ageing multicultural and refugee population brings additional considerations for palliative care delivery. Our PHN region's refugee communities are growing as the advantages of refugee settlement outside Australia's major capital cities are experienced by regional communities. Toowoomba is a recognised Humanitarian Settlement Program (HSP) location and Refugee Welcome Zone with approximately 500 refugees being settled in the community each calendar year. The Ipswich Region is not classified as an official HSP location however due to housing affordability and availability refugees are being settled in the area. Ipswich official settlement rates are included in the Logan HSP data.

Older migrants and refugees often face:

- Substantial barriers to full social and community participation, including language limitations, low digital literacy, and unfamiliarity with Australian Health systems.
- Practical, social and emotional isolation, as well as stigma, depression and loneliness.
- Strong resistance to residential aged care home due to cultural differences, fear, misunderstanding or past trauma.

Implications for the palliative care system

To ensure the region's palliative care system meets the needs of all communities, including Aboriginal and Torres Strait Islander, multicultural and refugee populations, the following improvements are required:

- Strengthened cultural safety training for the workforce, including cultural competence, trauma-informed practice, religious literacy and understanding of refugee health.
- Enhanced partnerships with Aboriginal Medical Services, multicultural agencies, refugee services and faith-based organisations.
- Improved service pathways that incorporate interpreters, community connectors and culturally specific models of care.
- Early engagement and advance care planning conversations delivered in culturally accessible settings.
- Models of care that minimise re-traumatisation and acknowledge complex trauma histories.

100. Darling Downs and West Moreton Primary Health Network, DDH Palliative Care Pathways Project final report 2023.

Data

The need for palliative care is increasing with a growing and ageing Australian population. Meeting this need will require long-term planning and investment; information on community needs and service gaps is essential to underpin development.

Although there have been some advances in palliative care information, recent research has found that there are limited consistent, national data with full coverage of jurisdictions and care settings.[101] The collection of palliative care data is made more challenging because of the range of settings in which palliative care occurs.

Accessing and coordinating health data to support palliative care in Queensland can be challenging due to the fragmented nature of information systems across hospitals, primary care, community organisations, and national digital platforms. While public hospitals use systems such as The Viewer and the ieMR, GPs, ACCHOs, refugee health services, and NGOs often operate separate practice systems that do not automatically interface with each other or with state systems. This fragmentation makes it difficult to build a complete picture of a person's health history, advance care plans, or cultural and psychosocial needs. This is particularly true for Aboriginal and Torres Strait Islander peoples and people from refugee backgrounds who may have multiple care providers or gaps in previous documentation. Additional barriers such as inconsistent data sharing, varying consent processes, limited integration with My Health Record, and concerns about privacy or mistrust of institutions can further complicate timely, culturally safe palliative care planning.

The *National palliative care and end-of-life care information priorities* report[102] identified priorities for collecting and improving palliative care data:

- people with a life-limiting illness, including patient-reported experience measures and patient-reported outcome measures
- families and carers, including identifying who is providing care and the needs of carers
- workforce, including capacity of the workforce and future workforce requirements
- service and system planning and design, including unmet need and demand for palliative care
- service delivery and integration, including care at home and in the community and ease of access, coordination and transition between services
- understanding and awareness of palliative care.

101. AIHW, National palliative care and end-of-life care information priorities.

Opportunities and priorities

Context

Regional actions in palliative care take place in the context of broader international and national strategies, priorities and support.

International context

In 2014, the World Health Assembly adopted a resolution to urge member states to 'develop, strengthen and implement, where appropriate, palliative care policies to support the comprehensive strengthening of health systems to integrate evidence-based, cost-effective and equitable palliative care services in the continuum of care, across all levels, with emphasis on primary care, community and home-based care, and universal coverage scheme'.[103]

Also in 2014, the Executive Board of the World Health Organization published policy directions recognising the need for palliative care and end-of-life care to be provided 'in accordance with the principles of universal health coverage' and for palliative care to be offered by all health systems.[104] WHO has continued to provide information and resources to support the development of palliative care, including guides for planners and managers.[105]

National priorities

The Australian Government has a long history of support for palliative care, beginning with funding from the 1990s for the National Palliative Care Projects. The projects have included research, clinical education, benchmarking, training materials and assessment tools.

The first National Palliative Care Strategy was endorsed in October 2000 by the Australian Health Ministers' Advisory Council. In 2010, the second National Strategy, Supporting Australians to Live Well at the End of Life, was launched with the endorsement of health ministers, following significant consultation with the sector. In 2016, the Australian Government commissioned an evaluation of the 2010 National Strategy. The current (2018) strategy was developed based on the findings of the evaluation and extensive consultation with more than 200 individuals and organisations.[106]

The vision of the National Palliative Care Strategy is that 'People affected by life-limiting illnesses get the care they need to live well'. The seven goals of the strategy are:

- **Understanding:** People understand the benefits of palliative care, know where and how to access services, and are involved in decisions about their own care
- **Capability:** Knowledge and practice of palliative care is embedded in all care settings
- **Access and choice:** People affected by life-limiting illnesses receive care that matches their needs and preferences
- **Collaboration:** Everyone works together to create a consistent experience of palliative care across care settings
- **Investment:** A skilled workforce and systems are in place to deliver palliative care in any setting
- **Data and evidence:** Robust national data and a strong research agenda strengthen and improve palliative care
- **Accountability:** National governance of this strategy drives action.

Established in 1998, Palliative Care Australia is the Australian peak body for palliative care. The Palliative Care Australia Roadmap 2022–2027[107] sets out key priorities to ensure high-quality palliative care is available for all who need it, where and when they need it. The priorities include investment, support for carers, workforce, awareness campaigns about death, dying and palliative care, data and research, and palliative care in aged care.

102. AIHW, National palliative care and end-of-life care information priorities.
103. World Health Assembly, Strengthening of palliative care as a component of comprehensive care throughout the life course'.
104. World Health Organization (WHO), *Strengthening of palliative care as a component of integrated treatment throughout the life course*, WHO Executive Board 134th session, Provisional agenda item 9.4, 2013.
105. WHO, 'Palliative care' [fact sheet], WHO, Geneva, 2025, accessed 27 October 2025.
106. Department of Health, *National Palliative Care Strategy 2018*.
107. Palliative Care Australia, Palliative care Australia roadmap 2022–2027, Palliative Care Australia, Canberra, 2022, accessed 22 October 2025.

State priorities

The Queensland Government has committed $171 million from 2021–22 to 2025–26 to strengthen palliative care across Queensland. The vision of the current (2022) Queensland Palliative and End-of-Life Care Strategy is that 'Queenslanders with a life-limiting illness and their families receive equitable, compassionate, and high-quality palliative care that meets their individual needs, preferences, and goals at the end of life.'[108]

The Queensland strategy's seven goals are:

- **Access to quality services:** People with a life-limiting illness can access high-quality, efficient and integrated palliative care services, at the right time and in the right place.
- **Information about care:** People with a life-limiting illness, their families and carers receive information that enables and supports them to make informed choices about palliative and end-of-life care.
- **Individual needs and preferences:** People with a life-limiting illness receive compassionate and high-quality care that is aligned to their preferences and is respectful of their culture, age, identity, and emotional and spiritual needs.
- **Support for families and carers:** Families and carers receive timely and compassionate support while caring for people with a life-limiting illness and during bereavement.
- **Skilled workforce:** Care is delivered by a skilled, supported, and multidisciplinary workforce that is accessible for people with a life-limiting illness, their families and carers.
- **Data and research:** Research and performance data are used to continually improve palliative care policy settings and services.
- **Governance and advocacy:** state governance of this strategy drives action, accountability, and sustainability of funded services.

Regional needs and priorities

This HNA has identified specific regional needs, drawing on the evidence base as well as analyses of what is working well and what could be better. The needs are being addressed through effective strategies and action plans which reflect and support the international, national and state priorities. The priorities and aims for each are identified below:

Stronger for Life: Joint Regional Older Persons Strategy 2025-2030,[109] which has the following focus areas and actions under its *Supporting dignity of choice for care at the end-of-life* section:

Collaboration:

- Refresh and develop a regional end-of-life and palliative care joint HNA to inform prioritisation and drive joint approaches to end-of-life and palliative planning.

Community development:

- Increase community death literacy and knowledge around ACPs so communities and families can plan and talk early about end of life and are prepared for the realities of what death looks like.
- De-medicalise and destigmatise death and dying where safe and appropriate; bring end of life back to the community as a natural part of life.
- Provide education sessions and clear information about end-of-life options, including VAD, to communities; develop support to identify grief and bereavement options within the community and explore additional options.

108. Queensland Health, Queensland Palliative and End-of-Life Care Strategy 2022.
109. Regional Health Collaborative, Joint regional older persons strategy: stronger for life.

Skilled and capable workforce:

- Support RACHs, GPs, pharmacists and ambulance services to enable home or community deaths.
- Provide education sessions and clear information about end-of-life options, including VAD, to GPs.
- Improve primary care capacity to identify palliative needs early and refer; develop dementia-inclusive palliative pathways, stronger GP engagement and consistent information sharing.
- Focus on rural primary care as there are limited specialist supports available rurally.

Culturally responsive and person-centred approach:

- Embed culturally responsive palliative practices and safe inclusive spaces for end-of-life care.
- Enhance practices and provide interpreter support and culturally appropriate resources, enabling 'dying on Country' where chosen.

Innovation and impact:

- Use digital devices, telehealth and software to enhance end-of-life care within RACHs; this includes continuous quality improvement and outcomes programs, better access and visibility to care plans and patient info through the Viewer and My Health Record.
- System navigation, coordinated care and transitions.
- Build knowledge and enhance options for people in rural areas to access end of life services.

Darling Downs Care at the End-of-life Action Plan[110]

- Increase the capacity and understanding in the community about care at the end of life.
- Improve access to in-home care at the end of life for people in the Darling Downs region.
- Improve coordination and integration of services for people approaching end of life in the Darling Downs region.
- Improve the capability, capacity, and responsiveness of services to meet end-of-life care needs in the Darling Downs region.
    - Build stronger partnerships with GPs to ensure consistent communication and earlier referrals.
    - Improve the capability of RACHs and reduce unnecessary hospital transfers.
- Ensure rural communities have equitable access to supports that allow dying at home.

West Moreton Care at the End-of-life Action Plan[111]

Education and workforce development:

- Regional palliative care passport to improve communication regarding clinical care of palliative care patients in West Moreton.
- Education sessions for non-government organisations, community services and GPs to improve knowledge and understanding of non-specialist clinicians and service providers regarding care at the end of life in West Moreton.
- Place-based local networks to improve coordination of care for people approaching end of life in West Moreton.
- Community development:
- Community-facing end-of-life care and pathways to improve communication regarding clinical care of palliative care patients in West Moreton.
    - Community workshops and group hub to increase community capacity to care for people approaching end of life in West Moreton through addressing death literacy.
- Research and innovation.

110. Darling Downs Care at the End of Life Collaborative, Darling Downs Care at the End of Life Action Plan 2025–27, 2025.
111. West Moreton Care at the End of Life Collaborative, West Moreton Care at the End of Life Action Plan 2024–27, 2024.

ADAPTS research project to increase community capacity to care for people approaching end of life in West Moreton through addressing death literacy.

In this section, the identified needs are mapped to the national and state strategies and regional action plans. The identified needs are:

- increased access to palliative care to match changing community demographics
- improved coordination of palliative care across services
- increased understanding of palliative care and how it can be accessed
- increased support for palliative care in the home
- improved delivery of patient-centred culturally sensitive palliative care
- ongoing training and support to ensure a skilled palliative care workforce.

Increased access to palliative care to match changing community demographics

The evidence shows that the need for palliative care is increasing rapidly in the Darling Downs and West Moreton region. Improving accessibility will involve various actions that both build on what is working well and improve what could be better. Actions include increasing options for care in RACHs, expanding digital health supports, and building on community outreach to improve options for rural and remote communities.

Alignment with national and state strategies and regional action plans

National Palliative Care Strategy

- Access and choice – people affected by life-limiting illnesses receive care that matches their needs and preferences.
- Capability – knowledge and practice of palliative care is embedded in all care settings.
- Data and evidence – robust national data and a strong research agenda strengthen and improve palliative care.
- Accountability – national governance of this strategy drives action.

Queensland Palliative and End-of-Life Care Strategy

- Access to quality services – people with a life-limiting illness can access high-quality, efficient and integrated palliative care services, at the right time and in the right place.
- Data and research – research and performance data are used to continually improve palliative care policy settings and services.
- Governance and advocacy – state governance of this strategy drives action, accountability, and sustainability of funded services.

Joint Regional Older Persons Strategy

- Collaboration – refresh and develop a regional end-of-life and palliative care joint HNA to inform prioritisation and drive joint approaches to end-of-life and palliative planning.

Darling Downs Care at the End-of-life Action Plan

- Improve the capability, capacity, and responsiveness of services to meet end-of-life care needs in the Darling Downs region.
- Improve the capability of RACHs and reduce unnecessary hospital transfers.

West Moreton Care at the End-of-life Action Plan

- Research and innovation – ADAPTS research project to increase community capacity to care for people approaching end of life in West Moreton through addressing death literacy.

Improved coordination of palliative care across services

Coordination and communication between healthcare professionals and services improves the experiences of patients and carers and reduces risk. It is also an important way in which the use of resources is optimised, to meet the growing need for palliative care.

Developments in this area will build on existing strengths in coordination between organisations, on the CAEOL Collaboratives, and on the partnership between the PHN, West Moreton Health and Darling Downs Health. Improved coordination will be supported by successes in knowledge sharing and community outreach.

Alignment with national and state strategies and regional action plans

National Palliative Care Strategy

- Capability – knowledge and practice of palliative care is embedded in all care settings.
- Collaboration – everyone works together to create a consistent experience of palliative care across care settings.

Queensland Palliative and End-of-Life Care Strategy

- Access to quality services – people with a life-limiting illness can access high-quality, efficient and integrated palliative care services, at the right time and in the right place.

Joint Regional Older Persons Strategy

- Innovation and impact – use digital devices, telehealth and software to enhance end-of-life care within RACHs; this includes continuous quality improvement and outcomes programs, better access and visibility to care plans and patient info through the Viewer and My Health Record.

Darling Downs Care at the End-of-life Action Plan

- Improve coordination and integration of services for people approaching end of life in the Darling Downs region.
- Build stronger partnerships with GPs to ensure consistent communication and earlier referrals.

West Moreton Care at the End-of-life Action Plan

- Education and workforce development.
- Regional palliative care passport to improve communication regarding clinical care of palliative care patients in West Moreton.
- Place-based local networks to improve coordination of care for people approaching end of life in West Moreton.

Increased understanding of palliative care and how it can be accessed

Understanding the options available for palliative care, including ACP and VAD, is important to ensure persons at the end of life receive the support and medical treatment they want.

However, the need to increase understanding is not just about the community – a more informed health workforce, especially in primary care, is important to be able to provide appropriate information to patients and to direct them to available services.

Alignment with national and state strategies and regional action plans

National Palliative Care Strategy

- Understanding – people understand the benefits of palliative care, know where and how to access services, and are involved in decisions about their own care.
- Capability – knowledge and practice of palliative care is embedded in all care settings.

Queensland Palliative and End-of-Life Care Strategy

- Information about care – people with a life-limiting illness, their families and carers receive information that enables and supports them to make informed choices about palliative and end-of-life care.

Joint Regional Older Persons Strategy

- Community development.
- Increase community death literacy and knowledge around ACPs so communities and families can plan and talk early about end of life and are prepared for the realities of what death looks like.
- De-medicalise and destigmatise death and dying where safe and appropriate; bring end of life back to the community as a natural part of life.
- Provide education sessions and clear information about end-of-life options, including VAD, to communities; develop support to identify grief and bereavement options within the community and explore additional options.
- System navigation, coordinated care and transitions — build knowledge and enhance options for people in rural areas to access end-of-life services.

Darling Downs Care at the End-of-life Action Plan

- Increase the capacity and understanding in the community about care at the end of life.

West Moreton Care at the End-of-life Action Plan

- Community development.
- Community-facing end-of-life care and pathways to improve communication regarding clinical care of palliative care patients in West Moreton.
- Community workshops and group hub to increase community capacity to care for people approaching end of life in West Moreton through addressing death literacy.
- Education and workforce development – education sessions for non-government organisations, community services and GPs to improve knowledge and understanding of non-specialist clinicians and service providers regarding care at the end of life in West Moreton.

Increased support for palliative care in the home

Most people with a life-limiting illness would prefer to die at home, rather than in a hospital. Enabling this requires medical and community support for the person and their carers, family and friends. Regional actions will be needed, alongside improvements in care coordination, to deliver the supports needed.

Alignment with national and state strategies and regional action plans

National Palliative Care Strategy

- Access and choice – people affected by life-limiting illnesses receive care that matches their needs and preferences.

Queensland Palliative and End-of-Life Care Strategy

- Access to quality services – people with a life-limiting illness can access high-quality, efficient and integrated palliative care services, at the right time and in the right place.

Joint Regional Older Persons Strategy

- Skilled and capable workforce – support RACHs, GPs, pharmacists and ambulance services to enable home or community deaths.

Darling Downs Care at the End-of-life Action Plan

- Improve access to in-home care at the end of life for people in the Darling Downs region.
- Ensure rural communities have equitable access to supports that allow dying at home.

West Moreton Care at the End-of-life Action Plan

- Research and innovation – ADAPTS research project to increase community capacity to care for people approaching end of life in West Moreton through addressing death literacy.

Improved delivery of patient-centred culturally sensitive palliative care

Patient-centred care is care that is aligned to the needs and preferences of the individual. End-of-life attitudes, beliefs and preferred practices vary across cultures. Patient-centred care principles therefore require palliative care to be delivered in culturally appropriate ways. The Darling Downs and West Moreton region has a high proportion of Aboriginal and Torres Strait Islander residents and residents from culturally and linguistically diverse backgrounds and these residents require palliative care to be discussed and delivered through culturally safe environments and practices.

Alignment with national and state strategies and regional action plans

Queensland Palliative and End-of-Life Care Strategy

- Individual needs and preferences – people with a life-limiting illness receive compassionate and high-quality care that is aligned to their preferences and is respectful of their culture, age, identity, emotional, and spiritual needs.
- Support for families and carers – families and carers receive timely and compassionate support while caring for people with a life-limiting illness and during bereavement.

Joint Regional Older Persons Strategy

- Culturally responsive and person-centred approach.
- Embed culturally responsive palliative practices and safe inclusive spaces for end-of-life care.
- Enhance practices and provide interpreter support and culturally appropriate resources, enabling 'dying on Country' where chosen.

Ongoing training and support to ensure a skilled palliative care workforce

Underpinning all palliative care services is the healthcare workforce. It is important to ensure the palliative care workforce in the region has the skills and support needed to continue to deliver high-quality care.

Alignment with national and state strategies and regional action plans

National Palliative Care Strategy

- Investment – a skilled workforce and systems are in place to deliver palliative care in any setting.

Queensland Palliative and End-of-Life Care Strategy

- Skilled workforce – care is delivered by a skilled, supported, and multidisciplinary workforce that is accessible for people with a life-limiting illness, their families and carers.

Joint Regional Older Persons Strategy

- Skilled and capable workforce.
- Provide education sessions and clear information about end-of-life options, including VAD, to GPs.
- Improve primary care capacity to identify palliative needs early and refer; develop dementia-inclusive palliative pathways, stronger GP engagement and consistent information sharing.
- Focus on rural primary care as there are limited specialist supports available rurally.

Darling Downs Care at the End-of-life Action Plan

- Improve the capability, capacity, and responsiveness of services to meet end-of-life care needs in the Darling Downs region.

Implementation Action Plan

As part of the Joint Regional Older Person Strategy, this implementation plan identifies the needs, actions, priorities, and outcomes to support planning across the region, specifically focusing on end-of-life care. This plan will act as a guide for partners to address gaps identified through the HNA.

Click HERE to download a copy.

Implementation Action Plan - Supporting Dignity of Choice for Care at the End-of-Life

Need	Strategic Themes	Activities	Partnerships	Outputs	Outcomes	Measures	Year
Low death literacy leaves families ill prepared, resulting in distress and challenges at end-of-life.	**Community development**	▪ Enhance community death literacy and knowledge around advance care planning: ▪ increase community death literacy so communities and families can plan and talk early about end-of-life and are prepared for the realities of what death looks like ▪ build the communities knowledge, utilisation and review of advance care planning. **This can be achieved through:** ▪ engaging in community setting ▪ peer to peer educators/ navigators re-advanced care plans, sorry business, dying to know days.	WMCC, DDCC, HHS, PHN, AMS, QAS, community, PCQ and Office of Advanced Care Planning.	▪ Events held, materials distributed. ▪ Peers trained.	▪ Increase death literacy awareness. ▪ Increase in peoples wishes being followed as a result of having advanced care plans completed.	▪ Number of completed advanced care plans. ▪ DLI scores. ▪ Post event surveys.	2026 onwards
Diverse cultural needs around death and dying not being fully met, workforce feeling ill prepared.	**Skilled and culturally responsive workforce**	▪ Embed culturally responsive palliative practices and safe inclusive spaces for end-of-life care. ▪ embed culturally safe palliative practices, interpreter support and culturally appropriate resources ▪ enabling 'dying on country' where chosen. Where this is not possible explore ways to support more culturally safe inclusive spaces.	WMCC, DDCC, HHS, AMS, QAS, community, MC partners, WMMCHWC and RACHs.	▪ Co-planning and co-design completed. ▪ Cultural resources identified or developed. ▪ Staff training delivered. ▪ Cultural spaces developed.	▪ End-of-life care can reflect dignity, choice and cultural needs. ▪ Increase in available resources to support dignity and choice for culturally diverse communities.	▪ Consumer feedback. ▪ Post event surveys. ▪ Additional/ expanded language resources.	2027 onwards
Late primary care referrals and poor planning.	**Skilled and capable workforce /prevention, early identification and intervention**	▪ Enable primary care - improve primary care capacity to identify palliative needs early and refer, dementia inclusive palliative pathways, stronger GP engagement and consistent information sharing. ▪ Primary focus needs to support rural primary care as limited specialist supports.	Primary care, PHN, QAS, WMCC, DDCC, HHS, AMS, community, RACHs, Pall Consult, ELDAC, ASPIRE-PSA and pharmacists.	▪ Training modules delivered. ▪ Referral pathways established. ▪ Dementia inclusive resources distributed.	▪ Earlier referrals: more coordinated planning; reduce crisis presentation.	▪ Date of referrals to SPACE prior to death. ▪ Uptake of training delivered. ▪ Health Pathways accessed.	2028 onwards

Implementation Action Plan - Supporting Dignity of Choice for Care at the End-of-Life

Need	Strategic Themes	Activities	Partnerships	Outputs	Outcomes	Measures	Year
Late primary care referrals and poor planning.	**Skilled and capable workforce /prevention, early identification and intervention**	▪ Enable primary care - improve primary care capacity to identify palliative needs early and refer, dementia inclusive palliative pathways, stronger GP engagement and consistent information sharing. ▪ Primary focus needs to support rural primary care as limited specialist supports.	Primary care, PHN, QAS, WMCC, DDCC, HHS, AMS, community, RACHs, Pall Consult, ELDAC, ASPIRE-PSA and pharmacists.	▪ Training modules delivered. ▪ Referral pathways established. ▪ Dementia inclusive resources distributed.	▪ Earlier referrals: more coordinated planning; reduce crisis presentation.	▪ Date of referrals to SPACE prior to death. ▪ Uptake of training delivered. ▪ Health Pathways accessed.	2028 onwards
Over medicalisation of death, loss of dignity and choice.	**Community development /skilled and capable workforce**	▪ De-medicalise and destigmatize death and dying where safe and appropriate. ▪ Bring end-of-life back to the community as a natural part of life. ▪ Support RACHs, GPs, Pharmacists and Ambulance services to enable more home or community deaths.	WMCC, DDCC, HHS, AMS, QAS, community, MC partners, WMMCHWC, university/ colleges, Care at end-of-life and PCQ.	▪ Community education sessions. ▪ Shared care protocols for home and community care.	▪ Increase home/ community deaths where preferred. ▪ Reduction in unnecessary hospitalisation.	▪ After death audit. ▪ Post event surveys. ▪ Utilisation and distribution of caring @ home resources.	2026 onwards
Fragmented care in RACHs and limited visibility of places.	**Innovation and impact**	Utilise digital devises, telehealth and software to enhance end-of-life care within RACHs. This includes: ▪ CQI and outcomes programs - map opportunities to implement the Palliative Aged Care Outcomes Program (PACOP) within RACHs to support continuous quality improvements and benchmarking. ▪ Better access and visibility to care plans and patient info through the Viewer and My Health Record.	WMCC, DDCC, HHS, AMS, PHN, QAS, Community, MC partners, WMMCHWC, Primary care, RACHs, Pall Consult.	▪ PACOP implemented on facilities. ▪ Digital tools training delivered.	▪ Better continuity of care. ▪ Increased skills of workforce. ▪ Embedded CQI process.	▪ Number of RACH utilising PACOP.	2026 onwards
Families lack timely access to grief and bereavement support.	**Community capacity and development**	▪ Work with DDCC and WMCC to better understand need and co-design ways to address the gaps around grief and bereavement experience of those left behind.	WMCC, DDCC, PHN, community organisations and NGOs.	▪ Understand need. ▪ Map services. ▪ Support referral pathways.	▪ Families and service providers have better access to support.	▪ Delivery of a grief and bereavement service mapping document and recommendations for enhancement at a local level.	2028 onwards
Low awareness and misconceptions about VAD and end-of-life options.	**Community development /skilled and capable workforce**	▪ Provide education sessions, clear information about VAD and palliative care engaging GPs and community.	WMCC, DDCC, HHS, AMS, PCQ, QAS and community.	▪ Education sessions delivered. ▪ Material distributed.	▪ Increase knowledge of legal options.	▪ Number of GPs and community members participating in VAD sessions. ▪ Uptake of VAD across the region.	2026 onwards

Implementation Action Plan - Supporting Dignity of Choice for Care at the End-of-Life

*** Glossary of abbreviations:**

AMS – Aboriginal Medical Services
DDCC – Darling Downs Care Collaborative
ED – Emergency Department
HHS – Hospital and Health Services
HNA – Health Needs Assessment
MCH – Multicultural Health
MOU – Memorandum of Understanding
PACOP - Palliative Aged Care Outcomes Program
PCQ – Palliative Care Queensland
PHN – Darling Downs and West Moreton Primary Health Network
QAS – Queensland Ambulance Service
RACH – Residential Aged Care Homes
VAD – Voluntary Assisted Dying
WMCC – West Moreton Care Collaborative

Closing summary

This Palliative Care Health Needs Assessment has highlighted ongoing gaps and challenges across the region. We are seeing limited data, around paediatric palliative care and palliative care needs outside the older population which makes it hard to truly understand demand, service delivery and whether people can access the care they need.

There are also ongoing accessibility barriers for several priority populations right across the region. In many cases the people who face the greatest risks are the least visible in the data. This affects the region's ability to plan effectively, deliver culturally appropriate care and ensure services are easy to navigate and are responsive.

A consistent theme throughout this assessment was the importance of ongoing workforce development. Strengthening capability across the region, especially in culturally safe and trauma-informed care. This will be vital to improving the experiences and outcomes of individuals, families and communities accessing palliative and end-of-life care services.

While these challenges are significant, this Health Needs Assessment shows strong alignment with national, state and regional priorities. Stakeholders expressed strong support for collaboration, particularly through the Strong for life- Joint Regional Older Persons Strategy 2025-2030 and other shared initiatives.

Overall, this Health Needs Assessment provides a solid foundation for the next steps. By addressing data gaps, enhancing workforce capability, improving accessibility, working collaboratively to enhance the palliative and end-of-life care for all people in the Darling Downs and West Moreton region.

phn
DARLING DOWNS
AND WEST MORETON

An Australian Government Initiative

E: info@ddwmphn.com.au

P: 07 4615 0900

W: www.ddwmphn.com.au

Darling Downs Office

Level 1, 162 Hume Street
(PO Box 81),
Toowoomba QLD 4350

West Moreton Office

Level 5, World Knowledge Centre,
37 Sinnathamby Boulevard,
Springfield Central QLD 4300

Local Integrated
Primary Health Care

ABN 51 605 975 602