



# **WNSW PHN Palliative Care Needs Assessment**

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2026-2029

**phn**  
WESTERN NSW

An Australian Government Initiative

## Acknowledgement of Country

Western NSW Primary Health Network (WNSW PHN) acknowledges the Traditional Custodians of the lands on which we live and work. We recognise and respect the enduring connection that Aboriginal and Torres Strait Islander peoples have to Country, waterways, land and skies.

We pay our deepest respects to Elders past and present and extend that respect to all Aboriginal and Torres Strait Islander peoples. We acknowledge the strength, resilience and cultural wisdom of Aboriginal communities and commit to working in genuine partnership to improve health and wellbeing outcomes across our region.



**Artwork title:** *Maradhal-Yandhul-Giriya* (Wiradjuri: Past-Present-Future)

**Artist:** Nathan Peckham, 2021

The piece symbolises a cultural and physical journey – one that mirrors the ongoing work of WNSW PHN to build connection, understanding and shared commitment across all communities we serve.

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## Executive Summary

Australians are living longer, and most older people prefer to die in their usual place of care. However, only 15% die at home, while 51% die in hospitals and 29% in residential aged care <sup>1</sup>, a pattern that has remained unchanged for a decade. Achieving a “good death” requires enabling choice and ensuring that preferred settings are adequately resourced with medical, psychological, and physical supports.

Between 2023 and 2025, Western NSW Primary Health Network (WNSW PHN) undertook a supplementary Palliative Care Needs Assessment (PCNA) under the Greater Choice for At Home Palliative Care (GCfAHPC) program funded by the Department of Health, Disability and Ageing. The assessment aimed to identify service gaps, capture stakeholder experiences, and explore opportunities to improve palliative care delivery in primary health settings across the region. This work aligns with the National Palliative Care Strategy (2018), NSW Health’s End of Life and Palliative Care Framework (2019–2024), and evidence supporting integrated, person-centred care.

The PCNA used a mixed methods approach, including a review of key literature and policy documents, quantitative health and service data, 23 stakeholder interviews and a survey of 28 professionals across diverse palliative care roles. Findings reveal systemic challenges such as workforce shortages, geographic isolation, fragmented service pathways, and inequities in culturally safe care for Aboriginal communities.

The PCNA has identified 16 priority needs, including 4 First Nations specific needs, for action from the WNSW PHN for 2026-2029. This PCNA is a primary resource in the effective planning and delivery of the GCfAHPC program for WNSW PHN to provide the evidence base required to respond to regional palliative needs within the catchment.

In considering the next steps for WNSW PHN to respond to the identified needs, the needs were considered against 3 overarching areas for action:

1. Championing person centred care
2. Connecting the care teams
3. Supporting the palliative care workforce

This assessment underpins WNSW PHN’s commitment to operationalising practical, coordinated strategies that improve access, equity, and quality of palliative care across Western NSW—ensuring services respect individual preferences and enhance quality of life.

Enhancing palliative care services in for our First Nations communities requires a culturally sensitive, well-resourced approach encompassing direct service delivery and education with strong carer, family, Aboriginal kinship and community engagement in order to address the many barriers to successful intervention. It is important that the PHN prioritise our most at risk communities, including First Nations communities, and explore all options within our scope to reduce the inequality in health outcomes between Aboriginal and Torres Strait Islander people and non-Indigenous Australians. All identified needs apply to both Aboriginal and non-Aboriginal community

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<sup>1</sup> Australian Bureau of Statistics. (2021). Classifying place of death in Australian mortality statistics, 2019 (ABS Cat. No. 3303.0.55.005). Canberra, ACT: ABS. Retrieved from <https://www.abs.gov.au/statistics/research/classifying-place-death-australian-mortality-statistics>

members across the region and the PHN will therefore respond to the needs according to each community taking into account culturally sensitive and relevant approaches.

## WNSW PHN Identified Palliative Care Needs

The following priority needs were identified for the PHN and are presented below. The needs have not been through a prioritisation process and are not presented in a particular order. The identified needs apply to both Aboriginal and non-Aboriginal people across the region (needs 1-12). Aboriginal people in our region experienced additional cultural and communication barriers and a further 4 needs identified for action (needs 13-16). The PHN will therefore respond to the needs according to each community considering culturally sensitive and relevant approaches.

1. People in WNSW have difficulty accessing timely palliative care medical assistance and medications after hours.
2. Residential aged care facilities lack access to palliative care nurses to provide prompt review and support for deteriorating residents.
3. Patients receiving palliative care experience delays in care and misunderstanding of the care required due to poor communication between palliative care teams and general practitioners (GPs).
4. Patients experience delays in receiving palliative care services due to delays in referrals and stigma surrounding the use of palliative care services.
5. Patients in WNSW, particularly in remote areas, experience difficulties accessing timely consultations for palliative care services and prescriptions for palliative care medications.
6. Families often lack the support and resources they need when caring for loved ones at home, leading to additional stress.
7. Patients, their families and their carers face additional barriers to accessing palliative care support services due to the complexity navigating healthcare systems (e.g., NDIS).
8. Patients in rural and remote areas of WNSW have limited access to specialist palliative care services due to lack of palliative care specialists in these areas.
9. Poor health and death literacy among patients, families, and healthcare workers leads to delayed care, increased pain and suffering, poor quality care and increased frustration for these cohorts.
10. Patients and their families and carers experience confusion and unnecessary distress due to frequent changes in end of life (EOL) care plans by medical practitioners.
11. Patients experience unnecessary or avoidable hospital trips for issues that could be managed effectively at home or in residential aged care facilities due to lack of GP consultations in the home and at residential aged care facilities, GPs reluctant to prescribe S8 medications for palliative end of life and feel they lack access to palliative care specialists.
12. Patients, families and carers receive insufficient holistic care to address broader psychosocial and emotional needs due to services and support that focus too heavily on medical needs alone.
13. First Nations people, kin and communities in WNSW experience barriers in accessing care and support for palliative care due to understanding of cultural engagement, trust and cultural safety.
14. First Nations communities in Western NSW report barriers accessing culturally safe palliative care and end-of-life support, in the community and in RACHs

15. First Nations health professionals and clinicians in WNSW experience barriers in accessing support and education in palliative care.
16. First Nations services and ACCHOs in WNSW experience barriers in accessing training, education and resources to deliver culturally safe palliative care due to lack of authentic engagement and culturally appropriate resources and tools

## Introduction

### Greater Choice for At Home Palliative Care Program (GCfAHPC)

The Greater Choice for At Home Palliative Care (GCfAHPC) Program (the Program) has been established “to improve awareness of local palliative care options and to coordinate and facilitate access to palliative care services at home” and in the community<sup>2</sup>.

Between 2025–26 and 2028–29, a total of \$40.08 million was committed by the Commonwealth Government nationally across all 31 Primary Health Networks (PHNs) to enhance palliative care services. This funding aims to improve access to safe, high-quality palliative care delivered at home, with the broader goal of reducing unnecessary hospitalisations. The Western NSW PHN has participated in the GCfAHPC program since 2018 with the inception of the Shared Health and Advance Care Record for End of life choices Project. This program implemented a shared Palliative Approach across Far West and Western NSW. Resources developed under that program of work are still in use.

The GCfAHPC initiative is designed to raise awareness of palliative care among both the healthcare workforce and the wider community, while also strengthening primary and community care systems. It seeks to ensure that individuals receive timely and appropriate care in their preferred settings. Additionally, the program focus is on using data to drive continuous improvement.

The objectives of the program are to:

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

To meet the GCfAHPC Program planning objectives, this palliative care needs assessment (PCNA) was conducted by WNSW PHN during 2023-2025 to determine the key issues affecting the delivery of palliative care in primary health settings across the aged care and health sectors within the region. The PHN gathered information from community members with lived experience and from service providers and clinicians about their palliative care experiences, their identified needs, the education required and opportunities for service improvement.

The World Health Organization (WHO) states “*Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual*”<sup>3</sup>.

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<sup>2</sup> Department of Health and Disability and Ageing (AU). Primary Health Networks (PHN) program expansion of the Greater Choice for At Home Palliative Care (GCfAHPC) measure: grant opportunity guidelines [Internet]. Canberra (ACT); 2021.

<sup>3</sup> World Health Organization. Palliative care: fact sheet [Internet]. Geneva: WHO; 2020 Aug. Available from: <https://www.who.int/news-room/fact-sheets/detail/palliative-care>

Palliative care services are 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 treatment goal is to optimise the quality of life.

End-of-life (EOL) care is distinct from palliative care and is defined as care provided to a person with an incurable illness or whose death is imminent, typically during the final 12 months of their life<sup>4</sup>. EOLC is the care given to people and their families who are facing the end of their life.

EOLC is an important part of palliative care<sup>5</sup>. A patient can receive palliative care at any stage of their illness. Patients can also continue treatment for their illness whilst receiving palliative care.

There is evidence to show that people are living longer, and most older people have a preference to die in their usual place of care<sup>6,7,8</sup>. Priority, therefore, is for models of palliative and EOL care to be designed for residential aged care (RAC) and home settings<sup>6</sup>.

The ability to die in a preferred place is an important condition of a 'good death'<sup>7</sup>. Up to 70 per cent of Australians say they would prefer to die at home, but few (15%) do so<sup>9</sup>. Around half of us (51%) die in a hospital and another 29 per cent die in residential aged care homes (RACH)<sup>10</sup>. These outcomes have barely changed in the past ten years.

To support more people living in community to die at home, a considerable investment is required beyond the acute sector, to provide appropriate service and support for patients and their families who take on a considerable amount of caregiving. Along with a choice in place of death, there is the need for confidence that the place is adequately and safely resourced with medical, psychological and physical supports. Understanding these needs in more detail is required to address the current needs gaps for our communities.

Recent funding increases for palliative care services in the community are visible. This includes increases in funding for hospital outpatient clinics, community-based clinics and patients' homes<sup>11</sup>. Providing additional funding for services also reflects a commitment by service providers to deliver quality person-centred care. This means care is offered; where the person wants it to be; delivered in a timely manner; is holistic in approach; by trained professionals working collaboratively in a coordinated manner.

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<sup>4</sup> Australian Institute of Health and Welfare. National palliative care and end-of-life care information priorities [Internet]. Canberra (ACT): AIHW; 2021. Available from: <https://www.aihw.gov.au/getmedia/17b82c56-83ff-45dc-be93-392bc5669fab/national-palliative-care-and-end-of-life-care-information-priorities.pdf.aspx>

<sup>5</sup> Australian Government Department of Health and Aged Care. What is palliative care? [Internet]. Canberra (ACT): Commonwealth of Australia; 2024. Available from: <https://www.health.gov.au/health-topics/palliative-care>

<sup>6</sup> Bone AE, Evans CJ, Etkind SN, Sleeman KE, Gomes B, Aldridge M, et al. Factors associated with older people's emergency department attendance towards the end of life: a systematic review. *Eur J Public Health*. 2019;29(1):67-74.

<sup>7</sup> Nysæter, T.M., Olsson, C., Sandsdalen, T. *et al.* Preferences for home care to enable home death among adult patients with cancer in late palliative phase – a grounded theory study. *BMC Palliat Care* **21**, 49 (2022). <https://doi.org/10.1186/s12904-022-00939-y>

<sup>8</sup>Zaman, M, Espinal-Arango, S, Mohapatra, A, Jadad, A.R, (2021), 'What would it take to die well? A systematic review of systematic reviews on the conditions for a good death?' *The Lancet Healthy Longevity* Zimmerman

<sup>9</sup> Swerissen, H and Duckett, S, (2014) *Dying Well*, Grattan Institute ISBN: 978-1-925015-61-https://grattan.edu.au/report/dying-well/

<sup>10</sup>Australian Bureau of Statistics (2021), *Classifying Place of Death in Australian Mortality Statistics*, ABS Website,

<sup>11</sup> Independent Health and Aged Care Pricing Authority. Annual report 2024–25 [Internet]. Sydney (NSW): IHACPA; 2025. Available from: <https://www.ihacpa.gov.au/ihacpa-annual-report-2024-25>

## Our Region

### WNSW PHN Population<sup>12</sup>

The total estimated resident population (ERP) of the WNSW PHN in 2021 was approximately 314,000, with 90.5% living in Western NSW Local Health District (WNSWLHD) and 9.5% living in Far West Local Health District (FWLHD). The region is highly dispersed, and although it accounts for only 3.9% of the New South Wales population, it spans almost 55% of the state's geographic area.

The WNSW PHN regions covers 27 Local Government Areas (LGAs). However, population distribution is uneven: 45.5% of residents live in just three LGAs—Bathurst, Dubbo Regional and Orange—all within the Western NSW Local Health District (LHD). In contrast, the Far West LHD comprises five LGAs, with 59.5% of its population concentrated in the Broken Hill LGA. This uneven distribution contributes to significant disparities in services and infrastructure between larger, more densely populated regional centres and smaller, sparsely populated rural and remote communities.

### Aboriginal people and communities within our region

The presence of many Aboriginal people and communities within the WNSW PHN contributes to the unique cultural character of the WNSW PHN population.

In 2021, the estimated resident Aboriginal population for the WNSW PHN region was approximately 45,420, representing 14.5% of the region's total population. This is significantly higher than the portion across NSW, where Aboriginal people accounted for 4.2% of the state population.

Across the WNSW PHN region, the highest numbers of Aboriginal residents are found in larger towns and major regional centres including Dubbo, Orange, Bathurst, Parkes, Broken Hill, and Mid-Western Regional. Several smaller LGAs in the region also have notably higher proportions of Aboriginal people. These include Brewarrina (63%), Central Darling (48%), Coonamble (44%), Bourke (41%), and Walgett (32%).

WNSW PHN is also home to important farming and pastoral communities. These communities are uniquely affected by issues including geographical isolation, socioeconomic challenges, mental health issues, and limited access to healthcare services.

### Social Determinants and Geographic Remoteness<sup>12</sup>

WNSW PHN has communities with geographic remoteness and social determinants that put its residents at greater disadvantage for health outcomes compared to other communities across NSW and Australia. As presented in table 1 below, many LGAs in region have high rates of socio-economic disadvantage, low educational attainment, low employment and low income. These factors increase the risk of chronic disease and poorer health outcomes and influence ability to afford and access services.

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<sup>12</sup>Western NSW Primary Health Network. Health needs assessment 2024/25 to 2026/27 [Internet]. Orange (NSW): WNSW PHN; 2024. Available from: <https://wnswphn.org.au/about-us/publications-achievements>

Table 1: Measures of socioeconomic disadvantage and remoteness by jurisdiction, 2021

2021						
LGA	IRSD <sup>1</sup>	ARIA + <sup>2</sup>	Education (≤ Year 10) <sup>3</sup>	Poor English & born OS <sup>3</sup>	Low Income <sup>3#</sup>	Unemployed <sup>1</sup>
	(Decile <sup>4</sup> )	(Remoteness)	(ASR/100)	(%)	(%)	(%)
Balranald* (FW)	4	Outer Regional	34.1	2.1	50.5	3.1
Bathurst Regional	7	Inner Regional	34.1	0.4	44.3	4.1
Blayney	6	Inner Regional	38.4	0.1	46.2	4.4
Bogan*	5	Remote	40.8	0.2	48.5	3.2
Bourke*	3	Very Remote	35.8	0.1	43.5	2.7
Brewarrina*	1	Very Remote	43.5	0.6	65.6	7.1
Broken Hill* (FW)	2	Outer Regional	45.7	0.2	56.1	5.5
Cabonne*	8	Inner Regional	35.5	0.2	46.2	2.6
Central Darling* (FW)	1	Very Remote	44.3	0.0	64.6	7.4
Cobar	5	Remote	40.4	0.3	41.0	3.2
Coonamble	1	Remote	39.9	0.0	57.1	6.7
Cowra	3	Inner Regional	41.6	0.3	60.5	5.1
Dubbo Regional	6	Inner Regional	37.0	0.4	44.5	3.6
Forbes	5	Outer Regional	38.6	0.2	54.0	3.8
Gilgandra	3	Outer Regional	40.3	0.0	59.7	4.8
Lachlan*	3	Remote	38.7	0.3	57.8	5.4
Mid-Western Regional	5	Inner Regional	39.5	0.2	48.4	4.0
Narromine	4	Outer Regional	37.8	0.0	54.1	4.4
Oberon	5	Inner Regional	37.0	0.5	47.8	3.5
Orange	7	Inner Regional	36.1	0.6	42.4	3.5
Parkes	3	Outer Regional	41.2	0.3	52.7	5.2
Unincorp* (FW)	NA	Very Remote	30.4	0.0	42.2	3.1
Walgett	2	Remote	32.6	0.6	62.0	6.7
Warren*	4	Outer Regional	34.7	0.0	52.6	4.5
Warrumbungle	2	Outer Regional	35.4	0.1	63.0	6.1
Weddin	4	Outer Regional	38.0	0.0	62.9	4.7
Wentworth (FW)	5	Outer Regional	32.4	0.4	51.5	4.3
<b>WNSW PHN</b>	<b>NA</b>	<b>NA</b>	<b>37.7</b>	<b>0.4</b>	<b>49.0</b>	<b>4.1</b>
<b>NSW</b>	<b>NA</b>	<b>NA</b>	<b>27.9</b>	<b>4.0</b>	<b>40.8</b>	<b>4.9</b>

LGA=local government area, IRSD=index of relative socio-economic disadvantage, ARIA+=accessibility/remoteness index of Australia +, ASR=age- standardised rate, FW=Far West Local Health District, NA=Data not available, WNSW PHN=Western NSW Primary Health Network.

<sup>1</sup>ABS Census, 2021

<sup>2</sup>Hugo Centre for Population and Migration Studies, University of Adelaide <sup>3</sup>Public Health Information Development Unit, Torrens University Australia <sup>4</sup>Where 1=most disadvantaged and 10=least disadvantaged.

\*WNSW PHN portion only for PHIDU data; all Lachlan LGA for ABS & Hugo Centre data

<sup>#</sup>Quality of Education data rated as 'Poor' by PHIDU

Source: Western NSW Primary Health Network. Health needs assessment 2024/25 to 2026/27 [Internet].

Orange (NSW): Western NSW Primary Health Network; 2024. Available from: <https://wnswphn.org.au/about-us/publications-achievements/>

## Palliative Care Related Health Characteristics

The two leading causes of death in WNSW PHN and NSW were circulatory diseases and malignant neoplasms (cancer) accounting for 40% deaths in each jurisdiction over this period. Respiratory conditions were the third leading cause of death in all jurisdictions. Diabetes and dementia, including Alzheimer disease were the next greatest cause of death<sup>13,14,15,16</sup>.

These conditions highlight the need for coordinated end-of-life and palliative care, given their chronic nature and likelihood of deterioration before death. Early coordination between primary care providers, specialist teams managing these conditions, and palliative care services, will support higher quality care, including pain and symptom management, during the late stages of illness and end of life.

The median age at death for WNSW PHN males, females and all residents was two years less than that of their NSW counterparts. Further, the median age at death of WNSW PHN male residents was six years less than their female counterparts.

The median age at death for all residents was lowest in Central Darling (63 years) and Brewarrina (71 years), and highest in Forbes and Parkes (82 years). For males, median age at death was lowest in Central Darling (63 years) and Brewarrina (70 years) and highest in Forbes and Gilgandra (80 years) and higher than that for NSW males.

For females, median age at death was lowest in Central Darling (65 years) and Brewarrina (73 years) and highest in Cabonne and Bogan (86 years and higher than that for NSW females).

Lower median ages of death for communities in WNSW highlights the need for earlier intervention and engagement with palliative care services and likely points to more chronic conditions that are poorly managed or have delayed interventions and treatment in these communities.

## Workforce Distribution

National data published by the Australian Institute of Health and Welfare (AIHW, 2023)<sup>17</sup> found that over four in five specialist palliative medicine physicians and approximately three quarters of palliative care nurses worked within the Modified Monash Model (MMM) metropolitan locations of MMM1 and MMM2 with workforce density declining as remoteness increases<sup>18</sup>. Table 2 below shows rates of specialist palliative medicine clinicians and palliative care nurses compared to all medical specialist and all nurses by remoteness. The data shows that rates of medical specialists per 100,000 population decline as remoteness increases. For palliative care specialists, inner regional and outer regional have lower rates than major cities, but remote and very remote are not shown as

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<sup>13</sup> Australian Institute of Health and Welfare. Deaths in Australia: leading causes of death [Internet]. Canberra (ACT): AIHW; 2025. Available from: <https://www.aihw.gov.au/reports/life-expectancy-deaths/deaths-in-australia/contents/leading-causes-of-death>

<sup>14</sup> Australian Bureau of Statistics. *Causes of death, Australia 2024* [Internet]. Canberra (ACT): ABS; 2024. Available from: <https://www.abs.gov.au/statistics/health/causes-death/causes-death-australia/latest-release>

<sup>15</sup> NSW Ministry of Health. *Deaths in NSW: causes of death data* [Internet]. Sydney (NSW): HealthStats NSW; 2024. Available from: <https://www.healthstats.nsw.gov.au/topic-overview/Deaths>

<sup>16</sup> Australian Bureau of Statistics. Australia's leading cause of death on the brink of change: media release [Internet]. Canberra (ACT): ABS; 2024. Available from: <https://www.abs.gov.au/media-centre/media-releases/australias-leading-cause-death-brink-change>

<sup>17</sup> Australian Institute of Health and Welfare. *National palliative care measures* [Internet]. Canberra (ACT): AIHW; 2024. Available from: <https://www.aihw.gov.au>

<sup>18</sup> Australian Government Department of Health and Aged Care. *Modified Monash Model (MMM)* [Internet]. Canberra (ACT): Commonwealth of Australia; 2025. Available from: <https://www.health.gov.au/topics/rural-health-workforce/classifications/mmm>

data is suppressed due to small numbers. For all nurses, the same trend is not observed, with rates being more stable across remote areas. Rates for palliative care nurses are however similar to palliative medicine specialists with the highest rate in major cities and decreasing significantly as remoteness increases.

Table 2: Rates of specialist palliative medicine clinicians and palliative care nurses compared to all medical specialist and all nurses by remoteness

Remoteness areas	FTE per 100,000 population – Clinical	FTE per 100,000 population – Clinical
	<i>All employed specialist medical practitioners</i>	<i>Palliative medicine physicians</i>
Major cities	159.9	1.1
Inner regional	90.3	0.7
Outer regional	71.1	0.5
Remote	66.7	*n.p.
Very remote	32.8	*n.p.
<b>Total<sup>(a)</sup></b>	<b>138.3</b>	<b>0.9</b>
	<i>All employed nurses and midwives</i>	<i>Palliative care nurses</i>
Major cities	1,158.8	11.5
Inner regional	1,122.1	13.3
Outer regional	1,090.8	9.4
Remote and very remote	1,194.8	5.5
<b>Total<sup>(a)</sup></b>	<b>1,147.5</b>	<b>11.5</b>

Source: National Health Workforce Data Set. PCSiA Palliative Care Workforce data tables 2024.

\* Not published

As a result, regional and remote areas experience comparatively lower access to locally based specialist palliative care clinicians than metropolitan areas<sup>19</sup>.

WNSW PHN experiences very low rates of services delivered by palliative care specialist physicians. In 2023, WNSW PHN had the 5th lowest rate of palliative care attendance and case conference services provided by a specialist palliative medicine specialist of all PHNs in Australia. The rate of services in WNSW PHN was 30.5 per 100,000 population, compared to the highest rate in Brisbane North PHN (730.7 per 100,000), lowest rate in Northern Territory PHN (11.4 per 100,000) and the national rate of 264.1 per 100,000 population<sup>19</sup>. These rates are likely lower in specific communities across the WNSW PHN region.

<sup>19</sup> Australian Institute of Health and Welfare. *Specialist palliative care use for older people receiving aged care* [Internet]. Canberra (ACT): AIHW; 2025. Cat. no. HWI 139. Available from: <https://www.aihw.gov.au/getmedia/77158c61-496d-4735-8975-16f480caa3f6/specialist-palliative-care-use-for-older-people-receiving-aged-care.pdf>

In 2023, WNSW PHN had the 4th highest rate of primary palliative care hospitalisations (32.5 per 100,000 population) for all PHNs and significantly higher than the national rate of 19.9 per 100,000 population<sup>19</sup>. Having higher rates of hospitalisations is often an indication that patient needs are not being met in the community. These rates highlight the need for greater support for patients in WNSW through primary care and specialist access in the community.

Western NSW Local Health District (WNSW LHD) covers a geographic area of approximately 247,000 square kilometres, while Far West New South Wales Local Health District (FWNSW LHD) spans approximately 194,949 square kilometres<sup>20,21</sup>. Combined, these districts cover a vast geographic area of approximately 441,949 square kilometres and service a total population of approximately 310,422 residents<sup>20,21</sup>. The combined large geographic area and dispersed population presents ongoing challenges for workforce distribution and palliative care team service coverage<sup>19</sup> (Australian Institute of Health) WNSW and FWNSW Local Health Districts are located within MMM 3 to MMM 7 and are considered regional, rural or remote palliative care workforces<sup>18</sup>. Palliative care specialist teams in WNSW LHD are based in Orange (MMM3) Bathurst (MMM3), Dubbo (MMM3) Lachlan (MMM4) and Mudgee (MMM4) hospitals. Palliative care teams in FWNSW LHD are based in Broken Hill (MMM6) and Buronga (MMM6)<sup>18,21</sup>. Orange base hospital currently has two palliative beds and has plans for a palliative care expansion program in early 2026 to increase the number of palliative care beds to five<sup>22</sup>.

In Far West NSW, workforce distribution is further constrained by remote and very remote (MMM6 - MMM7) geographical areas and small community population sizes<sup>20</sup>. The specialist palliative care teams provide care through a combination of face-to-face and virtual services. FWNSW LHD partners with other health professionals across the district, such as general practitioners to ensure that people receiving palliative care and carers can access palliative care support at home and in hospital. These teams typically include a small multidisciplinary workforce, including palliative care nurses, doctors, Aboriginal health practitioners, allied health providers such as dietitians, occupational therapists, physiotherapists, social workers and bereavement counsellors and volunteers. The ongoing reliance on visiting and locum clinicians reflects the difficulty of recruiting and retaining specialist clinicians in remote and very remote clinical settings. NSW Health workforce initiatives in FWNSW, such as allied health education and clinical student placement programs, aim to strengthen future workforce supply sustainability and improve recruitment pathways.

WNSW LHD Specialist Palliative Care Service uses a consultancy model for care, supporting general practitioners and inpatient hospital teams to provide palliative and end of life care<sup>21</sup>. The service operates under a nurse led model, supported by palliative medicine clinicians, allied health, Aboriginal health staff, and volunteers. Liaison with metropolitan specialist palliative care services when required, assists to address complex patient care needs<sup>21</sup>. Education and training for primary care doctors and nurses on palliative and EoLC maintains and increases competency in managing care in the inpatient, aged care and community settings<sup>21</sup>.

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<sup>20</sup> Far West Local Health District. *Palliative care* [Internet]. Sydney (NSW): NSW Government; n.d. Available from: <https://www.nsw.gov.au/departments-and-agencies/fwlhd/services/palliative-care>

<sup>21</sup> Western NSW Local Health District. *Palliative care* [Internet]. Sydney (NSW): NSW Government; n.d. Available from: <https://www.nsw.gov.au/departments-and-agencies/wnswhd/services/palliative-care>

<sup>22</sup> NSW Health. *News release* [Internet]. Sydney (NSW): NSW Government; 2026 Mar 16. Available from: [https://www.health.nsw.gov.au/news/Pages/20260316\\_01.aspx](https://www.health.nsw.gov.au/news/Pages/20260316_01.aspx)

However, the AIHW reports that existing national workforce datasets capture only specialist palliative medicine physicians and palliative care nurses and do not comprehensively quantify the contribution of general practitioners, allied health professionals, Aboriginal health workers or other clinicians who provide a palliative approach as part of broader roles<sup>19</sup>. As a result, there is limited counts of the palliative care workforce limiting the ability to quantify workforce distribution in FWNSW and WNSW given the consultancy model of care.

Non-clinical support workers can also provide holistic palliative care, including end-of-life doulas<sup>23</sup>. Preparing the Way, an End of Life Doula registered training organisation estimates 15 people in the WNSW PHN footprint have completed End-of-Life Doula training<sup>24</sup>. Preparing the Way have suggested End of Life Doulas are an emerging local workforce providing practical, emotional, social, spiritual and informational support before, during and after death. Their work may include helping people explore wishes and options, supporting conversations and planning, assisting families to feel more confident and informed, offering companionship and continuity, and helping communities respond in more compassionate and death literate ways complementary to clinical staff and services<sup>24</sup>.

Overall, workforce distribution across Western NSW and Far West NSW is characterised by limited locally based specialist capacity. The limited specialised workforce and geographic barriers create a reliance on generalist and multidisciplinary teams, and virtual care models to achieve person-centred palliative care. These structural workforce distribution challenges directly influence access to timely and equitable palliative care for patients and families within the WNSW PHN area.

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<sup>23</sup> Palliative Care Australia. *End of life doulas and palliative care* [Internet]. Canberra (ACT): Palliative Care Australia; 2024. Developed in collaboration with Flinders University. Available from: <https://palliativecare.org.au/resource/end-of-life-doulas-and-palliative-care/>

<sup>24</sup> H. Callanan, personal communication, 27 March 2026

# Approach and Methodology

## The Palliative Care Needs Assessment (PCNA)

The PCNA process sought to align itself with a number of key guiding and policy documents, current literature, quantitative data sources and qualitative data. Particular attention was given to our most vulnerable communities. This document will inform and provide evidence for future palliative care in primary health care planning for WNSW PHN.

The WNSW PHN PCNA was conducted in the following six phases:

### 1. Literature Review

A literature review was conducted including international and Australian literature, national and state policy and guidance documents. The literature was analysed to identify priority issues, common themes and alignment with PHN and GCfAHPC priorities.

### 2. Quantitative Data Review

Quantitative data from publicly available data sets and published documents were collected and analysed to determine priority needs for palliative care patients, families, carers and clinicians. Where local data was available at the WNSW PHN population level, this was used to provide local context and priorities. These data sources are summarised in Summary of Identified Needs, Table 3. Triangulated Palliative Care Needs (pgs.23-34).

### 3. Qualitative Data Review

The PCNA process included significant consultation engagement to support the understanding of needs relevant to the WNSW PHN population. Interviews were held with 23 palliative care service providers and users across the WNSW PHN and a survey of 28 service providers across all local Government areas (LGAs) in Western and Far Western Local Health District (LHD).

In 2023 the WNSW PHN Palliative Care team conducted 17 unstructured interviews with stakeholders to gather their insights into current service gaps in the provision of palliative care in our footprint. All participants were interviewed on a voluntary basis. The interviews were conducted by a skilled health professional or project officer.

Confidentiality of responses was ensured through the de-identification of the respondents in any reporting formats. In view of the sensitive nature of the subject matter, all participant interviews were conducted with respect, care and consideration.

The de-identified data from the interviews was analysed into themes and key insights using AI assisted technology (ChatGPT). The deidentified open-ended data was further analysed using AI (ChatGPT) and summarised to identify key priority areas, educational topics, local needs, positive outcomes of service improvements, and the potential recipients of these improvements.

In 2024, a survey canvassing the opinions of palliative care service providers and from within a range of health care settings in palliative care was conducted. The survey focused on the needs identified during interviews and asked respondents to prioritise and offer recommendations for addressing these needs.

The 15 Question survey was open from 1 December 2023 until 31 January 2024. The survey was distributed to all PHN Palliative care contacts in the WNSWPHN data base.

#### **4. List of Needs**

Following the completion of the qualitative data review, 12 priority needs were identified and a further 4 Aboriginal specific needs. The needs were developed through the synthesis of evidence collected through the literature, quantitative and qualitative data sources. The needs emerged through the methodical, stepwise evaluation of the evidence and describe the priority issues that face the population. No additional prioritisation process was undertaken to rank the 16 needs, so the final needs in Table 1, are presented with the 12 overarching unprioritized needs first then the four specific Aboriginal needs last.

#### **5. Triangulation**

Supporting evidence was mapped against each need to assess the frequency, strength, local relevance, GCfAHPC alignment and PHN alignment. This process allowed the PHN team to assess the overall strength of evidence from all sources for each identified need.

#### **6. Next Steps**

Once 12 needs were identified and evidence was triangulated to support their validity and alignment with GCfAHPC and PHN priorities, the WNSW Palliative Care team grouped the needs into 3 overarching categories for action:

1. Championing person centred care
2. Connecting the care teams
3. Supporting the palliative care workforce

These categories for action were aligned with the PHN's, ability to impact the needs under the Greater Choice for At Home Palliative Care Program (GCfAHPC) Grant Opportunity Guidelines.

## Policy and PHN context

### WNSW PHN 2025-2028 Core Health Needs Assessment

In 2025 WNSW PHN published its Health Needs Assessment (HNA)<sup>12</sup>. It sought to identify the key areas of focus for the PHN to improve the health and wellbeing of the population.

The HNA highlighted systemic challenges that are impacting people's access to health care in general and, in turn, quality palliative care across the WNSW PHN region. These include the persistent inequities for Aboriginal people, including gaps in culturally safe care, limited locally designed services, and insufficient understanding of Aboriginal patients' needs. Similarly, chronic disease prevalence, socioeconomic disadvantage, geographic isolation, and low health literacy all intensify the complexity of palliative care needs. Recognition of these barriers emphasised the importance of coordinated models of care, integrated service pathways, and preventative approaches that delay deterioration and support earlier palliative care engagement.

Many of the identified social and environmental determinants identified within the report; housing, transport, financial strain, social isolation, and limited access to services, also influence people's ability to receive timely, continuous, and dignified palliative care. Supporting and developing programs which mitigate these determinants will also positively impact the provision of palliative care services delivered in WNSW PHN.

The HNA further underscored workforce shortages, mental health vulnerabilities, and limited timely access to care; each of which has direct implications for palliative service delivery. Overextended rural and remote health staff, gaps in specialist skills, and the absence of outreach services impede equitable palliative care, particularly for geographically isolated communities.

Rising alcohol and other drug use, co-occurring gambling harm, and increasing rates of mild-to-moderate mental illness require palliative care services to be flexible, trauma-informed and well-integrated with psychosocial and addiction supports.

Addressing palliative care needs requires alignment with national and state priorities, research evidence and demographic data, therefore this PCNA relies on the same system-wide solutions recommended in the HNA:

- strengthened stakeholder collaboration
- investment in culturally appropriate and community-led models
- improved service integration and coordination
- stigma reduction
- innovative approaches to achieving timely, affordable and locally accessible care for all people across the region.

### Policy Alignment

The needs assessment considered three key areas of national and state palliative care policy.

### *The National Palliative Care Strategy 2018*<sup>25</sup>

The national strategy provides a unified framework for improving palliative care across Australia. It is designed for use by all levels of government, organisations, and individuals to ensure that “*people affected by life-limiting illnesses get the care they need to live well.*”

It provides Guiding Principles of:

1. Care is person-centred.
2. Death is recognised as a natural part of life.
3. Carers are supported and valued.
4. Services are accessible to all.
5. Everyone has a role in palliative care.
6. Care is high quality and evidence-based.

To support the strategy, a five-year Implementation Plan was released in 2020, outlining key action areas:

- Improve access to palliative care, especially for underserved populations.
- Enhance collaboration and coordination across services.
- Promote the use of advance care planning to support shared decision-making.
- Establish consistent national data collection and public reporting mechanisms.

### *End of Life and Palliative Care Framework 2019-2024, NSW Health*<sup>26</sup>

The NSW Health End of Life and Palliative Care Framework 2019-2024 Framework outlines the state’s vision and strategic direction for improving palliative care and EOL services. It emphasises collaboration between services, individuals, families, and carers to ensure care is accessible, high quality, and person-centred.

The vision is for “All NSW residents, along with their families and carers, have access to the best possible palliative and EOL care, tailored to their individual needs. The framework promotes dignity, respect, and quality of life at the centre of care”.

The Priority Areas are:

1. Person-centred care – respecting individual preferences, values, and beliefs.
2. Support for families and carers – recognising their role and ensuring they receive appropriate support.
3. Access to skilled care providers – ensuring competent care is available across all settings.
4. Coordinated and integrated care – improving communication and continuity across services.
5. Equitable access – ensuring all people can access quality care regardless of location or background.

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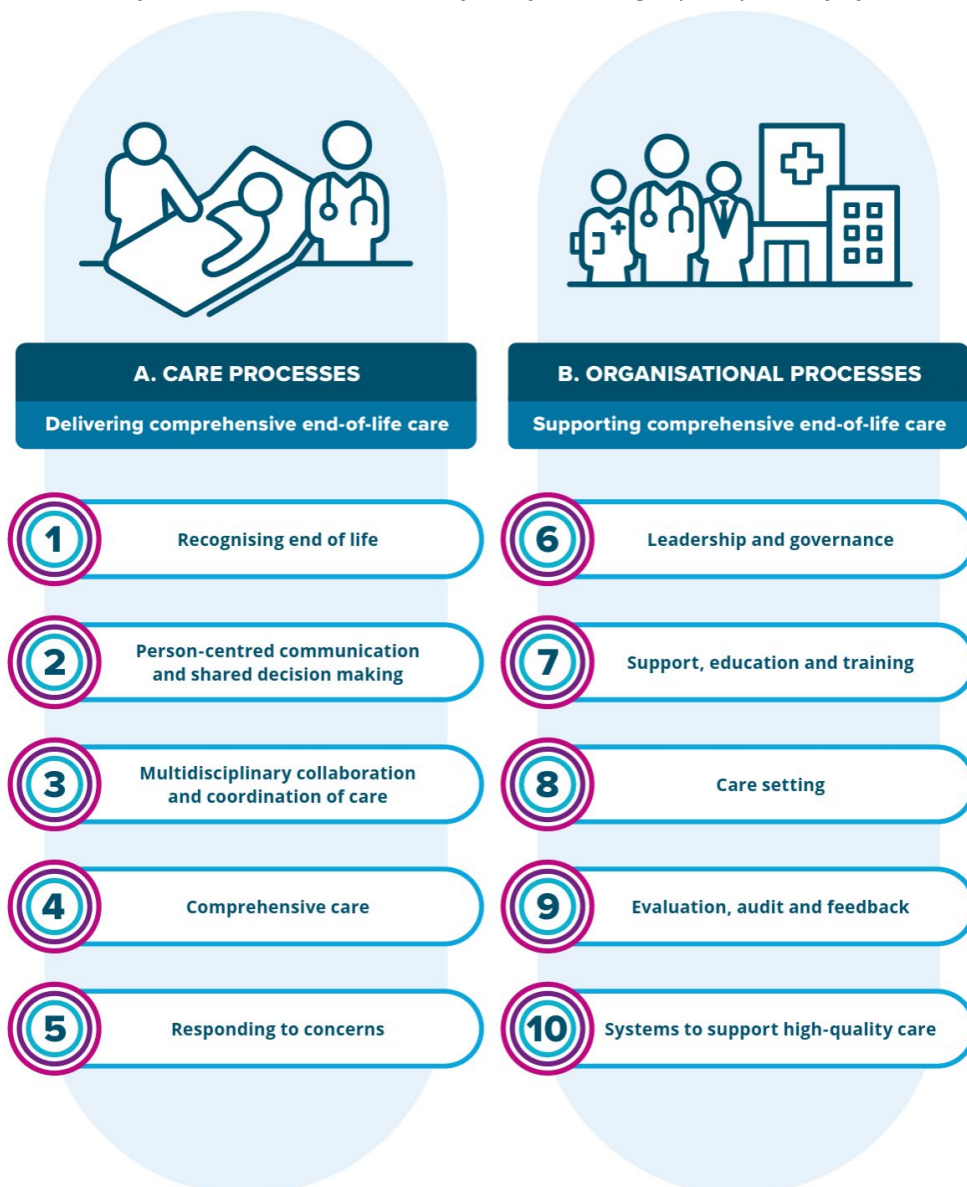
<sup>25</sup> Australian Government Department of Health and Aged Care. *National palliative care strategy 2018* [Internet]. Canberra (ACT): Commonwealth of Australia; 2018. Available from: <https://www.health.gov.au>

<sup>26</sup> NSW Ministry of Health. *End of life and palliative care framework 2019–2024* [Internet]. Sydney (NSW): NSW Health; 2019. [End of Life and Palliative Care Framework 2019-2024](#)

*National Consensus Statement: Essential elements for safe and high quality end of life care*<sup>27</sup>

The 2023 National Consensus Statement, released by the Australian Commission on Safety and Quality in Health Care, outlines the core elements required to deliver safe, high-quality EOL care across all healthcare settings both clinical and community. The essential elements are designed to apply universally, regardless of a person's clinical condition. However, the statement also recognises that specific population groups may have unique needs, which are addressed within the framework (see Figure 1 below).

Figure 1: Overview of the 10 essential elements for safe and high quality end-of-life care



Source: [Essential elements for safe and high-quality end-of-life care National Consensus Statement](#), Australian Commission on Safety and Quality in Health Care

<sup>27</sup> Australian Commission on Safety and Quality in Health Care. *National consensus statement: essential elements for safe and high-quality end-of-life care* [Internet]. Sydney (NSW): ACSQHC; 2015. Available from: <https://www.safetyandquality.gov.au/publications-and-resources/resource-library/national-consensus-statement-essential-elements-safe-and-high-quality-end-life-care>

## Summary of Identified Needs

Each of the 16 identified needs in the PCNA emerged from the evidence reviewed throughout the process. These unprioritised needs are listed below in Table 3 with the evidence source, alignment to GCfAHPC priorities, the WNSW PHN’s current or planned activities and opportunities to address the need and the relevant outcome measures and timeframes. The table is followed by a summary of the evidence from each of the sources (literature review, policy documents, quantitative sources and qualitative sources).

Table 3. *Triangulated Palliative Care Needs*

Identified Palliative Care Need	Supporting Evidence	Alignment with GCfAHPC	Current and proposed PHN Activities	Outcome Measures and Timeframe
1 People in WNSW have difficulty accessing timely palliative care medical assistance and medications after hours	<ul style="list-style-type: none"> <li>Stakeholder interviews</li> <li>Survey recommendations</li> <li>EOL care rapid review (2022)</li> <li>AIHW MBS data</li> </ul>	Improve access to safe, high-quality palliative care delivered at home, including strengthening after-hours services	<p>Work with GP and Residential Aged Care Homes (RACHs) through education and support to use existing Commonwealth funded palliative care programs and HealthPathways; PHN support and promotion of the Aged Care Outreach Service (ACOS) program (working with WNSW LHD);</p> <p>Electronic Palliative Approach Framework (ePAF) to support GPs and other palliative care clinicians to better understanding of medication information.</p>	<p>In 2026 – 2029: continue to provide clinician palliative care medication education opportunities and resources from a variety of sources. Measure with clinician survey feedback; survey and interview community members on their palliative experience, use data from reputable data sources i.e. AIHW MBS data.</p>

Identified Palliative Care Need	Supporting Evidence	Alignment with GCfAHPC	Current and proposed PHN Activities	Outcome Measures and Timeframe
2 Residential aged care homes lack access to palliative care nurses to provide prompt review and support for deteriorating residents	<ul style="list-style-type: none"> <li>Stakeholder interviews</li> <li>EOL care rapid review (2022)</li> <li>ARIIA review (2020)</li> <li>AIHW workforce data</li> </ul>	Enhance community-based and RACH capacity to deliver care in place and prevent avoidable hospital admissions.	Promotion and development of GP-RACH Connection Hub (on WNSW PHN website) connecting GPs and RACHs; RACH webinars with LHD; PACOP training for RACH nurses, paramedics, allied health, GPs.	<p>Measure usage of the GP-RACH Connection Hub and improved GP access in RACHs.</p> <p>Commencing in 2026, support RACHs, services and other clinicians with access to PACOP training and support for RACH implementation initially, with a view to expanding to community aged care services providing the EOL Palliative Packages from 2027-2028.</p> <p>Measure improvement using PACOP outcomes data and stakeholder survey and interview.</p>
3 Patients receiving palliative care experience delays in care and misunderstanding of the care required due to poor	<ul style="list-style-type: none"> <li>Stakeholder interviews</li> <li>Survey recommendations</li> <li>EOL care rapid review (2022)</li> </ul>	Improve coordination and integration of primary health care services for people with life-limiting illnesses	PHN palliative care team collaboration with Practice Support Development Team; consult with community to better understand what is needed to support co-design of solutions with GPs.	Commencing in 2026 and within 2 years strengthening coordination between care teams by supporting and promoting the adoption of standardised, best practice communication tools e.g.

Identified Palliative Care Need	Supporting Evidence	Alignment with GCfAHPC	Current and proposed PHN Activities	Outcome Measures and Timeframe
communication between palliative care teams and general practitioners GPs	<ul style="list-style-type: none"> <li>NSW Health End of Life and Palliative Care Framework 2019-2024</li> </ul>			PACOP. Measure improvement using PACOP outcomes data, and clinician survey feedback.
4 Patients experience delays in receiving palliative care services due to delays in referrals and stigma surrounding the use of palliative care services	<ul style="list-style-type: none"> <li>Survey recommendations</li> <li>Exploratory Analysis of Barriers to Palliative Care (2019)</li> <li>WNSW PHN Core HNA (2025-2028)</li> </ul>	Improve awareness of palliative care options and facilitate earlier, timely access to services at home	GP education and support; Education of community including Dying to Know events; My Care Future - advanced care planning and community palliative education initiative.	Commencing in 2026, and within 2 years, improve care teams connections to access and use localised referral pathways e.g. Health Pathways and ePAF measure using usage rates, clinician feedback.  Provide community with access to timely palliative care information and measure outcomes using participant Death Literacy Index (DLI) and surveys.
5 Patients in WNSW, particularly in remote areas, experience difficulties accessing	<ul style="list-style-type: none"> <li>WNSW demographic data</li> <li>Stakeholder interviews</li> </ul>	Improve accessibility and leverage technology to support flexible, responsive care models, including telehealth in	GP education and support; Work with GP education and support to use HealthPathways; Electronic Palliative Approach	Continue ongoing PHN accredited education for clinicians with measures from participant feedback.

Identified Palliative Care Need	Supporting Evidence	Alignment with GCfAHPC	Current and proposed PHN Activities	Outcome Measures and Timeframe
<p>timely consultations for palliative care services and prescriptions for palliative care medications</p>	<ul style="list-style-type: none"> <li>Survey recommendations</li> <li>AIHW workforce data</li> </ul>	<p>geographically dispersed regions</p>	<p>Framework (ePAF) to support GPs and other palliative care clinicians; Quality Use of Community Palliative Care Medicines Project (QUM).</p>	<p>Measure usage and feedback on usage of HealthPathways and ePAF.</p> <p>Continue to promote the utilisation of existing and new resources and measure usage.</p> <p>Provide additional support for the QUM i.e. Four Medications Program with pharmacy and GPs to increase the availability and usage of palliative care medications in community.</p> <p>Measure outcomes annually using MDS data and clinician and community surveys from 2026.</p>
<p>6 Families often lack the support and resources they need when caring for loved ones at home, leading to additional stress.</p>	<ul style="list-style-type: none"> <li>Stakeholder interviews</li> <li>Survey recommendations</li> <li>AIHW national palliative care data</li> </ul>	<p>Support individuals and families to care for themselves in the community, reducing avoidable hospitalisation</p>	<p>Publication of local palliative care services directory electronically and hard copy. Promote and distribute directory broadly to support availability of the resource and other palliative information</p>	<p>From 2026, publish local palliative care services directory resource from website and promote to local clinicians. Measure directory electronic access and print usage and provide feedback mechanisms. From 2025 to 2029 deliver</p>

Identified Palliative Care Need	Supporting Evidence	Alignment with GCfAHPC	Current and proposed PHN Activities	Outcome Measures and Timeframe	
			<p>from GPs and other trusted sources.</p> <p>Provide community education opportunities such as Dying to Know Days to improve understanding and use of palliative care and support pathways.</p>	<p>targeted education to community to measure improved understanding using DLI scores exceeding baseline in specific domains, and stakeholder feedback surveys and interviews.</p>	
7	<p>Patients, their families and their carers face additional barriers to accessing palliative care support services due to the complexity navigating the healthcare systems (e.g., My Aged Care, NDIS)</p>	<ul style="list-style-type: none"> <li>Stakeholder interviews</li> <li>WNSW PHN Core HNA (2025-2028)</li> </ul>	<p>Improve care coordination and integration across services, particularly for people at risk of poorer health outcomes.</p>	<p>Education and information for community across multiple platforms about navigating complex systems, with regular review of programs beyond the initial implementation including Dying to Know events; adapt learning from the care finder program that can be applied; publication of palliative care directory of resources.</p>	<p>Commencing in 2026 and ongoing until 2029, provide targeted education to support families and carers.</p> <p>Measure using participant feedback, stakeholder surveys and interviews.</p>
8	<p>Patients in rural and remote areas of WNSW have limited</p>	<ul style="list-style-type: none"> <li>Stakeholder interviews</li> <li>AIHW MBS data</li> </ul>	<p>Increasing accessibility and quality of primary palliative care services</p>	<p>Prioritise rural and remote GPs for GP education for referrals; consultation with</p>	<p>From 2026, link each GP with a regional specialist palliative physician; provide linkages to</p>

Identified Palliative Care Need	Supporting Evidence	Alignment with GCfAHPC	Current and proposed PHN Activities	Outcome Measures and Timeframe	
	<ul style="list-style-type: none"> <li>AIHW workforce data</li> <li>WNSW PHN Core HNA (2025-2028)</li> <li>WNSW demographic data</li> </ul>	in underserved and rural populations.	palliative specialist units and community on how to better connect with services; identify targeted education opportunities to support GPs.	<p>information and palliative advisory support; provide GPs with targeted education to build confidence managing palliative care plans.</p> <p>Measure change through clinician participation surveys, interviews, and surveys of carers and families.</p>	
9	<p>Poor health and death literacy among patients, families, and healthcare workers leads to delayed care, increased pain and suffering, poor quality care and increased frustration for these cohorts</p>	<ul style="list-style-type: none"> <li>Survey learning needs</li> <li>Survey recommendations</li> <li>Exploratory Analysis of Barriers to Palliative Care (2019)</li> </ul>	<p>Improve awareness of local palliative care options among the community and workforce, strengthening informed decision-making and advance care planning</p>	<p>Support targeted education and engagement activities promoting understanding of palliative care, advanced care plans and EOL care, as well as educating care staff in having timely, clear and compassionate conversations about palliative care.</p> <p>Continue to provide community Dying to Know Day events; My Care Future - advanced care planning and community palliative</p>	<p>Commencing in 2026 and continuing until 2029 strengthen the death literacy of community members and health workers. Measure improvement with DLI scores exceeding baseline, participant surveys.</p>

Identified Palliative Care Need	Supporting Evidence	Alignment with GCfAHPC	Current and proposed PHN Activities	Outcome Measures and Timeframe
			initiative; and resources i.e. publication of PHN palliative care service directory.	
10 Patients and their families and carers experience confusion and unnecessary distress due to frequent changes in EOL care plans by medical practitioners	<ul style="list-style-type: none"> <li>Stakeholder interviews</li> <li>Survey recommendations</li> <li>EOL care rapid review (2022)</li> <li>National Palliative Care Strategy (2018)</li> </ul>	Enhance quality, continuity and shared decision-making in community-based palliative care	Palliative care collaboration with primary health care providers through access to accredited education; engaging with PACOP to support clearer language and greater understanding in care planning; connecting community clinicians (e.g. pharmacists and other allied health) to palliative education and resources.	By 2028-2029 improve consistency in EOL planning across care teams by supporting the adoption of standardised, best practice communication tools used consistently across health sectors. Measure improvement by clinician uptake and feedback, stakeholder surveys, interviews with families.
11 Patients experience unnecessary or avoidable hospital admissions for issues that could be managed effectively at home or in RACHS due to lack of GP	<ul style="list-style-type: none"> <li>Stakeholder interviews</li> <li>EOL care rapid review (2022)</li> <li>ARIIA review (2020)</li> <li>WNSW palliative care data</li> </ul>	Reduce potentially preventable hospital attendances and admissions through strengthened community and primary care delivery.	<p>Provide GPs with information, supports and additional education as needed to access specialist support to better support palliative patients at home.</p> <p>Provide access to Palliative Aged Care Outcomes Program</p>	2026-2029 provide GPs with palliative resources to support improved GP consultations and palliative care planning. Measure with clinician and community surveys and interviews.

Identified Palliative Care Need	Supporting Evidence	Alignment with GCfAHPC	Current and proposed PHN Activities	Outcome Measures and Timeframe
<p>consultations in the community or in RACHs; some GPs are reluctant to prescribe S8 medications for palliative end of life and feel they lack access to palliative care specialists.</p>	<ul style="list-style-type: none"> <li>AIHW palliative care data</li> </ul>		<p>(PACOP) to support the connection between palliative care specialists and GPs to manage patients at home; with additional support for Aboriginal Community Controlled Health Organisations (ACCHOs) for care of patients in RACHs.</p> <p>Use interviews and surveys to better understand the specific barriers and opportunities for GPs to provide support at home, prescribe palliative medications and accessing specialist advice.</p>	<p>From 2026, provide GPs access to PACOP education. Measure improvements with reduction in RACH and community palliative hospital transfers and improved communication with RACH staff and community surveys.</p> <p>In 2026-2027 interview local GPs and palliative specialist physicians to understand the barriers and opportunities to provide palliative care at home for patients. Identify opportunities and develop recommendations for implementation commencing 2027-2028.</p>
<p>12 Patients, families and carers receive insufficient holistic and culturally appropriate care to address broader psychosocial and</p>	<ul style="list-style-type: none"> <li>Stakeholder interviews</li> <li>Exploratory Analysis of Barriers to Palliative Care (2019)</li> </ul>	<p>Person-centred, culturally safe, high-quality palliative care delivered in preferred settings, particularly for vulnerable populations.</p>	<p>Provide GP education and support to address the holistic needs of patients; including cultural safety training for GPs and promote opportunities for both Aboriginal and CALD online courses; promote free</p>	<p>In 2026-2027 increase the ability of clinicians to respond to the holistic and cultural needs for palliative patients, families and carers.</p> <p>Measure using clinician training survey feedback and increased</p>

Identified Palliative Care Need	Supporting Evidence	Alignment with GCfAHPC	Current and proposed PHN Activities	Outcome Measures and Timeframe
emotional needs due to services and support that focus too heavily on medical needs alone.			online palliative care training for clinicians; consulting with community; develop learnings from the My Care Future – First Nations ACP pilot for implementation.	use of a holistic palliative care plans. Survey and interview patients, families and carers to measure improved care experience.
13 First Nations people, kin and communities in WNSW experience barriers in accessing care and support for palliative care due to a lack of understanding about cultural engagement, trust and cultural safety.	<ul style="list-style-type: none"> <li>Stakeholder interview</li> <li>2019 Analysis of Barriers to palliative care</li> </ul>	Improve access to culturally safe, person-centred high-quality palliative care delivered in preferred settings, particularly for vulnerable populations.	Support First Nations people and kin to access relevant information and supports (i.e. caring@home symptom management support), and authentic engagement with key stakeholders. Design suitable Aboriginal community education events. I.e. My Care Future First Nations Pilot Model; and information sessions.	<p>By 2028 improve access to family centred and culturally appropriate palliative care for First Nations patients, carers and kin by strengthening workforce capability through cultural safety education.</p> <p>Measure improved clinician skills and confidence to support holistic, culturally safe documentation through reviews, surveys and interviews.</p>
14 First Nations communities in Western NSW report	<ul style="list-style-type: none"> <li>Stakeholder interview</li> </ul>	Reduce potentially preventable hospital attendances and	Support clinician access to high quality Aboriginal cultural safety training, both face to	Commencing in 2026, strengthen clinician access to training from SWNSW PHN, and

Identified Palliative Care Need	Supporting Evidence	Alignment with GCfAHPC	Current and proposed PHN Activities	Outcome Measures and Timeframe
<p>barriers accessing culturally safe palliative care and end-of-life support, in the community and in RACHs.</p>	<ul style="list-style-type: none"> <li>2019 Analysis of Barriers to palliative care</li> </ul>	<p>admissions through strengthened community and primary care delivery.</p>	<p>face and online, to build cultural sensitivity and trust.</p> <p>Identify resourcing and support issues to prioritise and develop solutions.</p> <p>SWNSW PHN to participate in authentic engagement with key stakeholders (i.e. Elders and ACCHOs) and work with them to identify and further understand barriers and misunderstanding of palliative care supports and collaborate on potential solutions.</p> <p>Use consultations and the My Care Future- First Nations pilot project to inform culturally appropriate education for community to increase death literacy.</p>	<p>other Commonwealth funded providers on cultural safety training for palliative care.</p> <p>Measure improvement through participant surveys.</p> <p>Measure changes for each Aboriginal community around palliative care and end of life planning using an instrument such as the DLI or an equivalent Aboriginal approved assessment tool.</p> <p>Use a stakeholder survey or interviews to determine if there has been a reduction in the cultural barriers.</p>
<p>15 First Nations health professionals and clinicians in WNSW</p>	<ul style="list-style-type: none"> <li>Stakeholder interviews</li> </ul>	<p>Improve coordination and integration of primary health care</p>	<p>Support ACCHOs and Aboriginal health professionals to access</p>	<p>By 2028-2029 assess Aboriginal health professional workforce barriers, capacity and service</p>

Identified Palliative Care Need	Supporting Evidence	Alignment with GCfAHPC	Current and proposed PHN Activities	Outcome Measures and Timeframe	
	<ul style="list-style-type: none"> <li>2019 Analysis of Barriers to palliative care</li> </ul>	services for people with life-limiting illnesses.	<p>appropriate palliative care education and supports.</p> <p>Engage authentically with key stakeholders to; develop a deeper understanding of their issues; continue cultural safety training for mainstream clinicians; and consult with community; utilise My Care Future - First Nations ACP pilot outcomes to provide insights.</p>	<p>gaps. Identify priority areas and potential technological and workforce development solutions to improve access to palliative care for First Nations communities.</p> <p>Document using Aboriginal health professional workforce assessment tools and recommendations for implementation.</p>	
16	<p>First Nations services and ACCHOs in NSW experience barriers in accessing training, education and resources to deliver culturally safe palliative care due to lack of authentic engagement and culturally</p>	<ul style="list-style-type: none"> <li>Stakeholder interview</li> <li>2019 Analysis of Barriers to palliative care</li> </ul>	<p>Person-centred, culturally safe, high-quality palliative care delivered in preferred settings, particularly for vulnerable populations</p>	<p>Support ACCHOs to access palliative care information, training and supports.</p> <p>Consult with First Nations communities and refer to evidence from the My Care Future pilot project and other relevant sources, to better understand the language and communication barriers for First Nations patients, families and carers. In consultation</p>	<p>Commencing in 2026 improve culturally safe communication. Measure improvements by service uptake, improved stakeholder feedback and changes in DLI or an equivalent Aboriginal approved assessment tool.</p>

Identified Palliative Care Need	Supporting Evidence	Alignment with GCfAHPC	Current and proposed PHN Activities	Outcome Measures and Timeframe	
	appropriate resources and tools.			with those communities develop strategies for the culturally safe delivery of education and resources for community such as the completion of ACDs.	

## Literature Review

Literature reviews provide a robust opportunity to connect identified needs with existing evidence and explore academic findings that can inform and support the development of local strategies. For this document 3 sources of information were considered.

### *End of Life care in hospital a review of the literature*<sup>28</sup>

In 2021, The Australian Commission on Safety and Quality in Health Care (the Commission) engaged Flinders University's Research Centre for Palliative Care, Death and Dying (PCDD) to undertake a rapid review of the literature to provide an update of the current evidence base that could inform a revision of the Consensus Statement.

The review identified five broad themes relating to best practice processes for EOL care:

1. Organisational readiness:  
Having access to appropriate physical spaces for the delivery of care, such as privacy and spaces to provide culturally responsive care; organisational systems such as presence of policies and guidelines, organisational readiness to manage care of the dying.
2. Person-centred care:  
Considering individuals and specific needs groups such as culturally and linguistically diverse (CALD), poor health literacy; tailored care.
3. Clinician capacity and capability:  
Clinician factors such as bias, readiness and attitude towards delivering end-of-life care; training and education in end-of-life care.
4. Supporting families in care;  
Involvement of family in care, including valuing their personal knowledge.
5. Bereavement support:  
Routine bereavement practices including creating memories, formal counselling and follow-up care.

### *End of Life Care in Community and Aged Care settings in Australia*<sup>29</sup>

In 2022, the Commission engaged the Research Centre for PCDD at Flinders University to undertake a rapid review of the Palliative Care Literature. This rapid review aimed to identify research evidence on the effectiveness of EOL care interventions and practices delivered in residential aged care and community settings.

Main themes across the literature:

1. Collaborative or integrated care initiatives
2. Community-based programs
3. Home-based care
4. Residential aged care

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<sup>28</sup> Research Centre for Palliative Care, Death and Dying, Flinders University. *Rapid review of the literature on end-of-life care* [Internet]. Adelaide (SA): Flinders University; 2021.

<sup>29</sup> *the literature on end-of-life care in aged care and community settings* [Internet]. Adelaide (SA): Flinders University; 2022. Commissioned by the Australian Commission on Safety and Quality in Health Care. Available from: [https://www.safetyandquality.gov.au/sites/default/files/2023-03/rapid\\_review\\_of\\_the\\_literature\\_on\\_end-of-life\\_care\\_in\\_aged\\_care\\_and\\_community\\_settings\\_-\\_final\\_-\\_march\\_2023.pdf](https://www.safetyandquality.gov.au/sites/default/files/2023-03/rapid_review_of_the_literature_on_end-of-life_care_in_aged_care_and_community_settings_-_final_-_march_2023.pdf)

5. Structured approaches to EOL goals of care discussions and advance care planning
6. Interventions to reduce community-hospital transfers
7. Primary care involvement in EOL care
8. Dementia-specific interventions:
  - a. Namaste care
  - b. Other dementia-focused interventions
9. Interventions with a positive effect on communication
10. Interventions for symptom control and patient quality of life
11. Practices to reduce aged care staff stress
12. Digital innovations
13. Other considerations:
  - a. Special populations
  - b. Access to medicines, anticipatory prescribing, and deprescribing
  - c. Organisational readiness for change

### *Palliative Care and End of Life in aged care settings<sup>30</sup>*

In 2020, Aged Care Research and Industry Innovation Australia (ARIIA) conducted a literature review to support improved knowledge and practice in palliative and EOL care within aged care settings. The review informed the development of short evidence-based themes to guide care providers.

The analysis enabled mapping of current services, identification of practice gaps, and recognition of barriers and enablers to quality care. Four major themes emerged:

- Advance care planning
- Acute care transfers
- Staff training and education
- Communication at end of life

Additionally, the review highlighted a lack of systematic evidence regarding bereavement care and underscored the importance of self-care for staff involved in EOLC.

### *Palliative Care Issues Report on Aboriginal and Torres Strait Islander Peoples<sup>31</sup>*

Exploratory Analysis of Barriers to Palliative Care Issues Report on Aboriginal and Torres Strait Islander Peoples is provided by the Australian Government Department of Health, Disability and Ageing (16). The national report released in September 2019 (Australian Health Care Associates) identified multiple barriers to palliative care for Aboriginal and Torres Strait Islander people in accessing palliative care services:

Individual and Family Barriers:

1. Lack of understanding and awareness about palliative care and fear of Western healthcare systems.

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<sup>30</sup> Australian Research Institute for Innovative Aged Care (ARIIA). *Scoping review summary: palliative care and end of life in aged care settings* [Internet]. Wollongong (NSW): ARIIA; 2022. Available from: <https://www.ariia.org.au/knowledge-implementation-hub/palliative-care-and-end-of-life>

<sup>31</sup> Australian Government Department of Health. *Exploratory analysis of barriers to palliative care: issues report on Aboriginal and Torres Strait Islander peoples* [Internet]. Canberra (ACT): Commonwealth of Australia; 2019 Sep. Available from: <https://www.health.gov.au/resources/publications/exploratory-analysis-of-barriers-to-palliative-care-issues-report-on-aboriginal-and-torres-strait-islander-peoples>

2. Language and communication barriers:
  - Limited English proficiency and lack of interpreter.
  - Difficulties in translating medical terminology and cultural differences in understanding health and disease.
  - “Cultural shyness” and reluctance to discuss death.
3. Kinship and caring dynamics:
  - Importance of family roles and responsibilities in care, with challenges like distance, isolation, and cultural differences.
  - Reluctance to administer medication due to cultural beliefs or fear of blame.
4. Cost: Financial barriers related to travel, equipment, and care.

#### Community and Cultural Barriers:

5. Cultural differences in beliefs about health, illness, and dying, such as the idea that "cancer is contagious" or beliefs in curses and payback.
6. Spiritual and traditional practices that may not align with mainstream palliative care, like the importance of “dying on country” or spiritual ceremonies.

#### Health Professional Barriers:

7. Referral issues: Delayed or lack of referrals to palliative care, particularly for younger patients and those in rural areas.
8. Lack of cultural awareness among health professionals, leading to difficulties in providing culturally competent care.
9. Fear of cultural misunderstanding among non-Indigenous health professionals.

#### Organisation/Service-side Barriers:

10. Lack of available services in remote areas, with geographical isolation making it difficult to access palliative care.
11. Inappropriateness of mainstream palliative care services for Aboriginal and Torres Strait Islander people, including logistical and cultural barriers.
12. Workforce issues: Shortage of trained Aboriginal and Torres Strait Islander palliative care workers and inadequate staff in remote areas.

### Quantitative Data Sources

National and PHN level quantitative data was used to help identify the palliative care needs of local populations, anticipate future demand and guide where services and resources should be placed. It also supports targeted prevention efforts and helps reduce health inequalities by highlighting vulnerable groups.

#### *AIHW Palliative Care Quantitative Data Insights*

As the Australian population ages, the number of people dying from chronic diseases with complex needs is increasing. In Australia the number of expected deaths from chronic illness is predicted to double by 2050<sup>25</sup>.

The majority of the last year of a person’s life is spent at home, interspersed with visits to their doctor and/or a hospital specialist, visits to hospital (emergency department or an admission) and

potentially, admission to residential aged care or a hospice. They may or may not see specialist palliative care (SPC) services<sup>32,33</sup>.

### Demographics & Trends <sup>22 23 34</sup>:

- Deaths from chronic diseases are rising; expected to double by 2050.
- Most people (60-70%) prefer to die at home however over half die in hospitals, and about a third in residential aged care (34%)<sup>9</sup>.

### Costs & Utilisation:

- WNSW PHN has a significantly lower rate of 30.5 per 100,000 population for specialist palliative care medicine services compared to the national rate of 364.1 per 100,000 population.
- Hospital care in the last year of life is significantly more expensive than care in the home.
- NSW spent ~\$188M on admitted and ~\$80M on non-admitted palliative care in 2021-22.
- WNSW PHN has one of the highest rates of palliative care hospitalisations nationally.<sup>35</sup>
- WNSW PHN ranks 12th nationally for non-admitted palliative care service events.

### General Practice & Aged Care:

- Limited data from GPs due to lack of specific MBS items.
- Only 2% of aged care residents had documented palliative care needs, via the Aged Care Funding Instrument (ACFI).
- 34% of aged care residents die within 12 months of admission.

### Workforce

- Nationally there are 335 palliative medicine physicians and 3,700 nurses (full-time equivalent), mostly in major cities<sup>36</sup>.
- 75% of physicians and 49% of palliative care nurses work in hospitals.
- NSW has 119 palliative medicine physicians (108.4 FTE), equating to 1.3 FTE per 100,000 population - comparable to the national rate of 1.2 FTE. It also has 1,037 palliative care nurses (965.8 FTE) equating to 11.8 FTE per 100,000 population, slightly lower than the national figure of 12.5 FTE (in 2022).
- At Orange hospital there are currently 2 beds within a specialist palliative care space, with funding under the World Class End of Life Care Program (NSW Government) providing 3 additional beds by the end of 2025.
- There is no localised palliative care workforce data currently available.

## Quantitative reports

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<sup>32</sup> Australian Institute of Health and Welfare. *The last year of life: patterns in health service use and expenditure* [Internet]. Canberra (ACT): AIHW; 2022. Available from:

<https://www.aihw.gov.au/reports/life-expectancy-deaths/health-service-use-and-expenditure-in-the-last-year-of-life>

<sup>33</sup> Australian Institute of Health and Welfare. Palliative care overview [Internet]. Canberra (ACT): AIHW; 2024. Available from:

<https://www.aihw.gov.au/reports/palliative-care-services/palliative-care-overview>

<sup>34</sup> Australian Institute of Health and Welfare. *Palliative care services in Australia* [Internet]. Canberra (ACT): AIHW; 2025. Available from:

<https://www.aihw.gov.au/reports/palliative-care-services/palliative-care-services-in-australia/data>

<sup>35</sup> Palliative Care NSW. Annual report 2023–24: Guidance Service [Internet]. Sydney (NSW): Palliative Care NSW; 2024. Available from:

<https://palliativecarenewsw.org.au>

<sup>36</sup> Australian Institute of Health and Welfare. Palliative care service in Australia [Internet]. Canberra ACT AIHW; 2024 Available from

<https://www.aihw.gov.au/reports/palliative-care-services/palliative-care-services-in-australia/contents/palliative-care-workforce>

*Palliative Care NSW Guidance Service<sup>37</sup> Launched in 2022 to support public and professionals.*

- The report included data collected in 2023 from January to December.
- The service received 357 calls in 12 months; 30-37% were from regional areas.
- 67% of calls were from family members including carers and 27% from health professionals.
- Majority of calls were from carers seeking understanding of palliative care and how it operates, who and where to refer for services, support and symptom management.

*Go Gentle Australia: Voluntary Assisted Dying (VAD)<sup>38</sup>*

- VAD has been legal in NSW since November 2023.
- High uptake in regional areas accounting for 65.2% of all assessments.
- In NSW, First Nations people account for 2.5% of total assessments.
- Across Australia, 71-86% of VAD patients had accessed palliative care.
- Nearly 50% of participants have died at home compared to 14.8% of the general population.

## Qualitative Data Sources

In 2023, the WNSW PHN palliative care team conducted 17 stakeholder interviews. Analysis identified 10 key themes, which informed the design of a subsequent survey conducted in 2024. In August 2025, a supplementary group interview with six providers in the Far West Local Health District was undertaken to further inform the survey.

Following the collation of the qualitative and the quantitative data from the 2024 survey, 12 priority palliative care needs were identified. These 12 needs were linked to the current literature, supporting the development of a catalogue of needs for palliative care service improvement in our region.

## Stakeholder Interviews

The goal of the 2023 and 2025 stakeholder interviews was to identify key palliative care needs in the region. Participants were also asked to propose potential solutions to the barriers or challenges they experienced.

Stakeholders included:

- Rural GP (1)
- RACH managers
- Registered nurses delivering palliative care
- Carer Gateway Program Officer
- NDIS worker
- Aboriginal Health Chronic and Complex Care Officer (1)
- Allied health professionals
- Family members and/or carers

August 2025 interviewed stakeholders in the Far West region included:

- Palliative care consultant

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<sup>37</sup> Palliative Care NSW. *Annual report 2023–24: Guidance Service* [Internet]. Sydney (NSW): Palliative Care NSW; 2024. Available from: <https://palliativecare.nsw.gov.au/wp-content/uploads/2024/12/2023-24-Annual-Report-PCNSW.pdf>

<sup>38</sup> Go Gentle Australia. *State of voluntary assisted dying in Australia and New Zealand* [Internet]. Sydney (NSW): Go Gentle Australia; 2024 Aug. Available from: <https://www.gogentleaustralia.org.au> <http://www.gogentleaustralia.org.au/>

- Advance care planning project officer
- Palliative care nurse practitioner
- Palliative Care CNC
- Director of Palliative Care Services FWNSW
- Aboriginal health worker, cancer and palliative care

Based on a review of the 17 initial interview data, the following 10 themed areas of needs were identified:

1. Strengthen communication
  - Between doctors, families, and other stakeholders.
  - Ensure care staff, clinicians and families, have a clear understanding of what a patient wants for all aspects of their care.
  - Improved consistency and clarity for advance care planning.
2. Improve access to medications
  - Identifying solutions to improve timely access, especially during weekends.
  - Medication shortages are impacting treatments and patient outcomes.
3. Address workforce challenges
  - RACHs and some GPs refer to palliative specialists for issues that could be managed in primary care.
  - Shortage of experienced GPs in rural areas.
  - Reliance on registrars disrupts continuity of care.
  - GP engagement inconsistent; practice nurses are a more stable workforce.
  - Geographic isolation makes service delivery challenging.
4. Proactive assessment and monitoring
  - Emphasising early identification and recognition of patient/resident deterioration.
  - Continuing and enhancing the Palliative Care Outcomes Program (PACOP).
5. Emotional and psychological support
  - Increasing the availability of emotional support services for patients and families.
6. Education and training
  - Enhancing education of nurses, practice nurses and GPs.
  - Current training for health staff in palliative care is insufficient.
  - Lack of GP confidence or engagement.
  - "EOL care is everyone's business."
7. Physical environment needs
  - Lack of dedicated palliative care rooms within aged care facilities and hospitals for family support. Families need accommodation to stay overnight with loved ones.
  - Providing comfortable environments for patients.
8. Support for caregivers
  - Emotional and practical support needed for caregivers.
  - Guidance throughout the palliative and end of life process.
9. Cultural sensitivity and competence
  - Importance of culturally sensitive approaches, especially for Aboriginal people.
  - Need for a culturally competent workforce.

- Culturally appropriate ACP resources.
10. Comprehensive support services
- Increased allied health involvement in palliative care.
  - Advocacy for 24/7 access to palliative care nurses.

In 2024, an interview with an Aboriginal health worker in chronic and complex care highlighted the following needs::

- **Cultural sensitivity and trust:**  
Aboriginal people often prefer to stay at home and die on country rather than in hospitals, partly due to historical mistrust of medical institutions. There is a need for healthcare providers to respect and understand cultural preferences, and non-Indigenous workers need training in cultural sensitivity.
- **Lack of resources and support:**  
There is a significant shortage of hands-on healthcare workers in the community. More staff, especially those with an understanding of Aboriginal culture, are needed to ensure adequate palliative care and to help with sensitive topics like legal and EOL planning.
- **Education and awareness:**  
There is a need for more education and open discussions about palliative care, especially regarding the importance of planning for EOL care. Many Aboriginal families are unaware of the options and services available until it's too late.
- **Family-centred care:**  
Family plays a central role in caregiving, and it's important to provide support not only to those who are dying but also to the caregivers, particularly younger family members who may need emotional or mental health support.
- **Access to allied health services:**  
Clear communication about the roles and responsibilities of various service providers is crucial to avoid confusion and overwhelming families. Integrated care is vital, but coordination needs improvement.
- **Hospital care challenges:**  
Many people in Aboriginal communities avoid hospital care due to negative experiences, preferring home-based care whenever possible. There is a need for more comprehensive home-care services that respect the individual's wishes and cultural needs.
- **Resource constraints in rural areas:**  
In rural areas like Dubbo, palliative care is often limited, with some regions lacking essential services. More outreach and mobile care units are needed to improve service delivery in remote areas.
- **Mental health and emotional support:**  
Supporting the emotional well-being of family caregivers, especially those in younger generations, is essential. This includes ensuring that caregivers have access to counselling and coping mechanisms during challenging times.

### Aboriginal Health Outcomes

These 8 items, identified during the interview, align with the barriers identified in the 2019 Exploratory Analysis of Barriers to Palliative Care<sup>31</sup> as follows:

#### Individual and Family Barriers

- Family centred care
- Hospital care challenges
- Family Mental health and emotional support

#### Community and cultural barriers

- Cultural sensitivity and trust
- Lack of resources and support
- Education and awareness

#### Health Professional Barriers

- Lack of resources and support
- Access to allied health services -
- Hospital care challenges -
- Resource Constraints in rural areas
- Mental health and emotional support

#### Organisation/Service-Side Barriers

- Language and communication

### Service Provider Survey

The survey was completed by 28 respondents with some respondents working across multiple healthcare settings, refer Table 4 below.

Table 4: Summary of Survey Respondents

Health care setting	Number of respondents
Primary Care	11
Aged Care	11
Hospital	8
Allied Health	5
Community Care	5
Other	1

Respondents were asked to recommend improvements for palliative care in the region. These recommendations included expanding after-hours access to nurse practitioners, streamlining medication access, particularly on weekends and public holidays and enhancing interdisciplinary communication through standardised protocols and regular team meetings. The importance of early

referrals to palliative care and the integration of advanced care planning (ACP) into everyday medical care were also emphasised, alongside community education to reduce stigma and promote understanding of palliative care. Additional recommendations focused on providing tailored, holistic support to patients and families and establishing feedback mechanisms to ensure continuous service improvement.

The respondents identified 9 key areas for education:

1. Symptom management
2. Pain management
3. Communication skills
4. EOL care planning
5. Interdisciplinary team collaboration
6. Psychosocial and spiritual care
7. Care for specific populations
8. Ethical and Legal issues
9. Public education on palliative care

All LGAs within WNSW PHN were represented by at least one respondent, with the exception of Wentworth LGA.

Survey respondents prioritised the greatest issue within palliative care as:

1. Greater access to palliative care services
2. Increased palliative care education and skills
3. Earlier referral into palliative care
4. Timely access to medications
5. Increased health and death literacy amongst families and patients

## Next steps for WNSW PHN

The voices and experiences captured through the WNSW PHN PCNA provide valuable insight into the current state of palliative care in our communities. This section considers how these perspectives can shape responsive, culturally safe, and person-centred strategies moving forward.

### Categories for Action

The 16 identified palliative care needs have been aligned with 3 main overarching categories for action:

1. Championing person centred care
2. Connecting the care teams
3. Supporting the palliative care workforce

These categories for action were considered against the PHN's ability to impact the needs under the Greater Choice for At Home Palliative Care Program funding guidelines.

The PCNA provides a strong evidence base for strategic planning for the PHN Palliative Care team from 2026-2029, ensuring initiatives align with community needs for maximum impact. The data gathered through this comprehensive review of local providers, service users and relevant literature will directly inform the PHN's future palliative care planning. It will guide efforts to address priority areas within the PHN's remit, focusing on where the greatest impact can be achieved.

In addition, the PHN is committed to engaging in meaningful and culturally safe consultation with First Nations communities. This will support the identification and resolution of barriers to effective service delivery, ensuring that care is informed, respectful, and responsive to cultural needs.

The list of education topics provided by respondents will be used to inform our General Practice Education and other community and service provider education activities provided by the PHN. This list was also used to generate topics for the Palliative Care in RACH's webinar series 2025 provided by the WNSWLHD and hosted by the PHN Palliative Care team.

### Evidence for Current WNSW PHN Palliative Care Activities

WNSW PHN currently undertakes several activities to support patients, families, carers and clinicians across the region to improve their outcomes and experiences. This needs assessment provides evidence to inform and support these activities, ensuring that resources and activities are directed to areas of greatest need, as well as providing evidence to plan and undertake future activities across the region.

The current activities undertaken by the WNSW PHN palliative care team are:

- **Electronic Palliative Approach Framework (ePAF):**  
An online resource to help GPs and other primary health and community health clinicians to understand better palliative care medication and options available to patients.
- **Dying to Know events:**  
Health and death literacy education events held for service providers, clinicians, carers, community and patients to improve their understanding about what palliative and EOL care are, what services, resources and support are available and connecting people in the community and across services.

- My Care Future Project Peer Support (including a pilot model for First Nations) – promoted through GP practices:  
Advanced care planning and community palliative education initiative to improve advanced care planning for patients. This includes a pilot model to test whether the current model is culturally appropriate for Aboriginal patients in the region.
- RACH palliative webinars with LHD:  
Education webinars on a variety of palliative care topics, held in partnership with the Western NSW LHD, to support RACHs to improve care delivered to residents at end of life.
- GP education events:  
The palliative care team collaborates with the education team delivering two palliative care continuing professional development (CPD) accredited education sessions annually to general practitioners.
- Consultation, engagement and co-design events:  
Collaborate with other teams across the PHN to incorporate education into other programs, including allied health, mental health, chronic disease and community pharmacy.
- GP-RACH connection hub (on WNSW PHN website) connecting GPs and RACHs:  
A webpage on the WNSW PHN website that helps connect GPs with RACHs to increase and improve the delivery of GP care to residents in RACHs.
- Palliative care service directory of resources:  
A resource is in development to provide information about all palliative care services, resources and support available across the region.
- Engagement with the Palliative Aged Care Outcomes Program (PACOP):  
Further support and engagement with PACOP to improve clear language and greater understanding in care planning; connecting community clinicians (eg GPs, RACH RNs, paramedics, pharmacists and other allied health) to education.
- Alignment and support of Aged Care Outreach Service (ACOS):  
Working with WNSW LHD to support the ACOS model in WNSW.

For more information about the WNSW PHN programs go our website: [wnswphn.org.au](http://wnswphn.org.au) or email [agedcare@wnswphn.org.au](mailto:agedcare@wnswphn.org.au)

Underpinning all activity from the PCNA commitment to the delivery of services that recognises and includes the unique needs of our First Nations communities, addressing the many barriers that impact access to the health care system, and in turn resulting in improved health outcomes for these communities. Enhancing the health outcomes of First Nations communities requires a commitment to supporting their unique needs through authentic engagement with key stakeholders. This involves developing and implementing strategies that are identified through meaningful consultation and endorsed by the communities in which they are applied. Such an approach promotes improved health outcomes, greater autonomy, and strengthened community empowerment. Conversely, adopting a one-size-fits-all model or perpetuating barriers that limit access to services undermines these objectives and inhibits genuine progress.

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