



The Palliative Care Outcomes Collaboration

National Outcome Report - January to June 2026

Consult into Residential Aged Care

October 2026

Acknowledgements

Contributions	PCOC wishes to acknowledge the valuable contribution made by the many staff from palliative care services who have spent considerable time collecting, collating and correcting the data and without whose effort this report would not be possible.
Disclaimer	PCOC has made every effort to ensure that the data used in this report are accurate. Data submitted to PCOC are checked for anomalies and services are asked to re-submit data prior to the production of the PCOC report. We would advise readers to use their professional judgement in considering all information contained in this report.
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Suggested citation	Palliative Care Outcomes Collaboration (PCOC) (2026), Consult into Residential Aged Care National Report - January to June 2026. Faculty Science, Medicine and Health, University of Wollongong Australia.

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What is PCOC?

The Australian Palliative Care Outcomes Collaboration (PCOC) is a national palliative care outcomes and benchmarking program. PCOCs primary objective is to systematically improve patient outcomes (including pain and symptom control).

Central to the program is a framework and protocol for routine clinical assessment and response. This works in parallel with a routine point-of-care data collection, capturing clinically meaningful information. PCOC aims to drive improvement in patient outcomes through feedback to individual services and by facilitating service-to-service benchmarking.

The items in the PCOC data collection:

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

The assessment framework incorporates five validated clinical assessment tools:

- Palliative Care Phase
- Palliative Care Problem Severity Score (PCPSS)
- Symptom Assessment Scale (SAS)
- Australia-modified Karnofsky Performance Status (AKPS) and
- Resource Utilisation Groups - Activities of Daily Living (RUG-ADL).

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[Palliative Care Outcomes Collaboration Dataset 2025 Data Quality Statement](#)

What PCOC data tells us about palliative care in Australia

Palliative care improves quality of life - but too many people access it too late or miss out altogether.

1



High-quality care is delivered nationally

People experience improvements in symptoms, distress and function once they receive palliative care.

4



Care often starts too late

For people who die while receiving palliative care, the average time from referral to death is around 8 days

2



Hospitals remain the main entry point to receive care

Most people are referred to palliative care during a hospitalisation, rather than through earlier identification in the community.

5



More people with conditions other than cancer are receiving care

Palliative care is increasingly supporting people with dementia, heart failure and chronic respiratory disease.

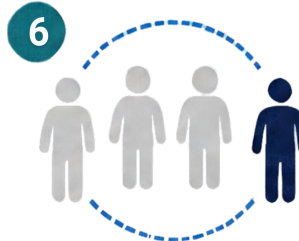
3



Inequities in access remain

Aboriginal and Torres Strait Islander peoples, people in rural and remote areas, and people with non-malignant diagnoses continue to face barriers to care.

6



Many people are missing out

More Australians could benefit from palliative care but are not being identified or referred early enough.

Source: Palliative Care Outcomes Collaboration, National Overview of Patient Outcomes in Australia for 2025, 2026, Faculty of Science, Medicine and Health, University of Wollongong

Introduction

The Australian palliative care sector is a world leader in using routine clinical assessment information to guide patient-centred care and measure patient and family outcomes. Providers of palliative care are commended for their commitment to excellence in delivering evidence-based, patient-centred care by using the routine Palliative Care Outcomes Collaboration (PCOC) assessment framework and contributing patient data toward national outcome measurement and benchmarking. PCOC acknowledges the dedication and willingness of clinicians to improve the care of patients, their families and caregivers. The information collected is not just data - it represents the real-life outcomes of over 60,000 Australian patients each year.

While the focus of this report is on the most recent information relating to January to June 2026, results over the last three years are also presented to highlight achievements and improvement in outcomes. The most recent information corresponds to 42,545 patients, having 52,790 episodes of care and 108,712 Palliative Care Phases from 246 services who provide palliative care in hospital or in the persons home.

How to use this report

The outcomes achieved by your service are compared to national benchmarks. The purpose of benchmarking is to drive quality improvement and palliative care service innovation by providing participating services with the opportunity to compare with other services. PCOC has identified five key strategies for achieving improved patient outcomes. They comprise a set of predisposing, reinforcing and enabling factors that have been associated with patient outcomes. A self-assessment tool is available to help identify gaps and to focus improvement strategies. Information in this report should be considered in the context of these factors. The PCOC suite of audit tools improve consistency and reliability of the PCOC assessments. Auditing reduces variation and helps identify areas for improvement. Audit templates are available for download on the PCOC website.

Please use the following key when interpreting the tables throughout this report

- The item is not applicable
- u** The item was unavailable
- s** The item was suppressed

Table 1: List of services included in this report

Service name	State
Bega Valley Community Health Service Palliative Care	NSW
Broken Hill Health Service	NSW
Buronga Specialist Palliative Care Service	NSW
Calvary Health Care Kogarah	NSW
Coffs Harbour Palliative Care Service	NSW
HammondCare - Greenwich Hospital	NSW
HammondCare - Neringah Hospital	NSW
HammondCare Community Northern Beaches	NSW
HammondCare Community Palliative Care Choices Program	NSW
HammondCare Community Residential Aged Care Inreach	NSW
Hastings Macleay Community Palliative Care Service	NSW
Illawarra Shoalhaven Community Service	NSW
Maitland Dungog Community Palliative Care Service	NSW
Murrumbidgee LHD Palliative Care Service	NSW
Northern Sydney Home Nursing Service	NSW
Palliative Aged Care Supportive Service	NSW
Queanbeyan Community Health Service Palliative Care	NSW
St Vincent's Hospital, Sydney	NSW
Bundaberg Community Palliative Care Service	QLD
Cittamani Hospice Service	QLD
Gordonvale Hospital	QLD
Hervey Bay and Fraser Coast Palliative Care Service	QLD
Ipswich Nursing Service	QLD
Karuna Hospice Services	QLD
Metro South Community Palliative Care Service	QLD
Mt Isa and Surrounds Palliative Care	QLD
Robina Hospital Supportive & Specialist Palliative Care	QLD
St Vincent's Hospital Brisbane	QLD
Toowoomba Hospital	QLD
Townsville University Hospital	QLD

Calvary Community Care SA	SA
Central Adelaide Palliative Service	SA
EFNLHN Palliative Care Service	SA
Northern Adelaide Palliative Service	SA
Port Augusta	SA
Silverchain - South Australia	SA
Southern Adelaide Palliative Services	SA
Tasmania Community North	TAS
Ballarat Hospice Care Victoria	VIC
Banksia Palliative Care Service	VIC
Barwon Health	VIC
Benalla Home Nursing Service	VIC
Cabrini Palliative Care, Malvern	VIC
Colac Area Health	VIC
East Grampians Health Service	VIC
Eastern Palliative Care	VIC
Goulburn Valley Hospice Inc.	VIC
Lower Hume Palliative Care	VIC
Melbourne City Mission Palliative Care	VIC
Mercy Palliative Care - Sunshine	VIC
Moirra Palliative Care Service	VIC
Northeast Health Wangaratta Palliative Care	VIC
Palliative Care South East	VIC
Peninsula Home Hospice	VIC
Portland District Health	VIC
Swan Hill Palliative Care Service	VIC
The Alfred Hospital	VIC
Western District Health Service	VIC
Western Health - Bacchus Marsh	VIC
Wodonga Health Palliative Care Community Service	VIC
Goldfields Regional Palliative Care Service	WA
Great Southern Regional Palliative Care Service	WA
Kimberley Regional Palliative Care Service	WA

Metropolitan Palliative Care Consultancy Service - East Team	WA
Metropolitan Palliative Care Consultancy Service - North Team	WA
Metropolitan Palliative Care Consultancy Service - South Team	WA
Midwest Palliative Care Service (combined)	WA
PaLCATS - Palliative Care After Hours Telehealth Service	WA
Pilbara Regional Palliative Care Service	WA
South West Regional Palliative Care Service	WA
Wheatbelt Regional Palliative Care Service	WA

1 Benchmark Summary

Table 2: Summary of outcome measures

Category	Outcome Measure	Benchmark	Consult into RAC		Benchmark Reference Number
			%	BM Met	
Timely commencement of palliative care					
	Care commencing within two days of the patient being ready	90%	91.5	Yes	1
Responsiveness in managing patients with urgent needs					
	Patients unstable for three days or less	90%	73.0	No	2
Symptoms & problems in the absent to mild range at phase end					
Anticipatory Care <i>when patient symptoms or problems are in the absent to mild range at phase start</i>	Pain (clinician reported)	90%	92.8	Yes	3.1
	Pain (patient reported)		91.7	Yes	3.3
	Fatigue (patient reported)		92.8	Yes	3.5
	Breathing problems (patient reported)		96.5	Yes	3.7
	Family/carer problems (clinician reported)		91.8	Yes	3.9
Responsive Care <i>when patient symptoms or problems are in the moderate to severe range at phase start</i>	Pain (clinician reported)	60%	66.3	Yes	3.2
	Pain (patient reported)		63.8	Yes	3.4
	Fatigue (patient reported)		59.5	No	3.6
	Breathing problems (patient reported)		61.5	Yes	3.8
	Family/carer problems (clinician reported)		61.1	Yes	3.10
Casemix adjusted outcomes (change scores)		Baseline	Score		
Clinician Reported Problems (PCPSS)	Pain	0.0	0.14	Yes	4.1
	Other Symptoms		0.29	Yes	4.2
	Family/Carer Problems		0.26	Yes	4.3
	Psychological/Spiritual Problems		0.26	Yes	4.4
Patient Reported System Distress (SAS)	Pain	0.0	0.37	Yes	4.5
	Nausea		0.23	Yes	4.6
	Breathing Problems		0.29	Yes	4.7
	Bowel Problems		0.30	Yes	4.8

2 Detailed Analysis on Patient Outcomes

2.1 Timely Commencement of Palliative Care

Time from date ready for care to episode start reports responsiveness of palliative care services to patient needs. This benchmark was set following feedback and subsequent consultation with PCOC participants. Service providers acknowledge that, whilst there is wide variation in the delivery of palliative care across the country, access to palliative care should be measured based on patient need rather than service availability. As a result, services operating five days a week (Monday to Friday) are not distinguished from services operating seven days a week (All services are being benchmarked together).

Benchmark 1

This measure relates to the time taken for an episode to commence following the date the patient is available and ready to receive palliative care. To meet the benchmark for this measure, at least 90% of patients must have their episode commence on the day of, or the day following, date ready for care.

Table 3: Time from date patient is ready for care to episode start by setting of care

Time (in days)	Consult into RAC	
	N	%
Same day	3,333	86.9
Following day	178	4.6
2-7	200	5.2
8-14	66	1.7
15+	60	1.6
Average	1.8	-
Median	1	-

Note: Only episodes that started in this reporting period have been included in the table. Episodes where date ready for care was not recorded are excluded from the table. In addition, all records where time from date ready for care to episode start was greater than 90 days were considered to be atypical and were assumed to equal 90 days for the purpose of calculating the average and median time.

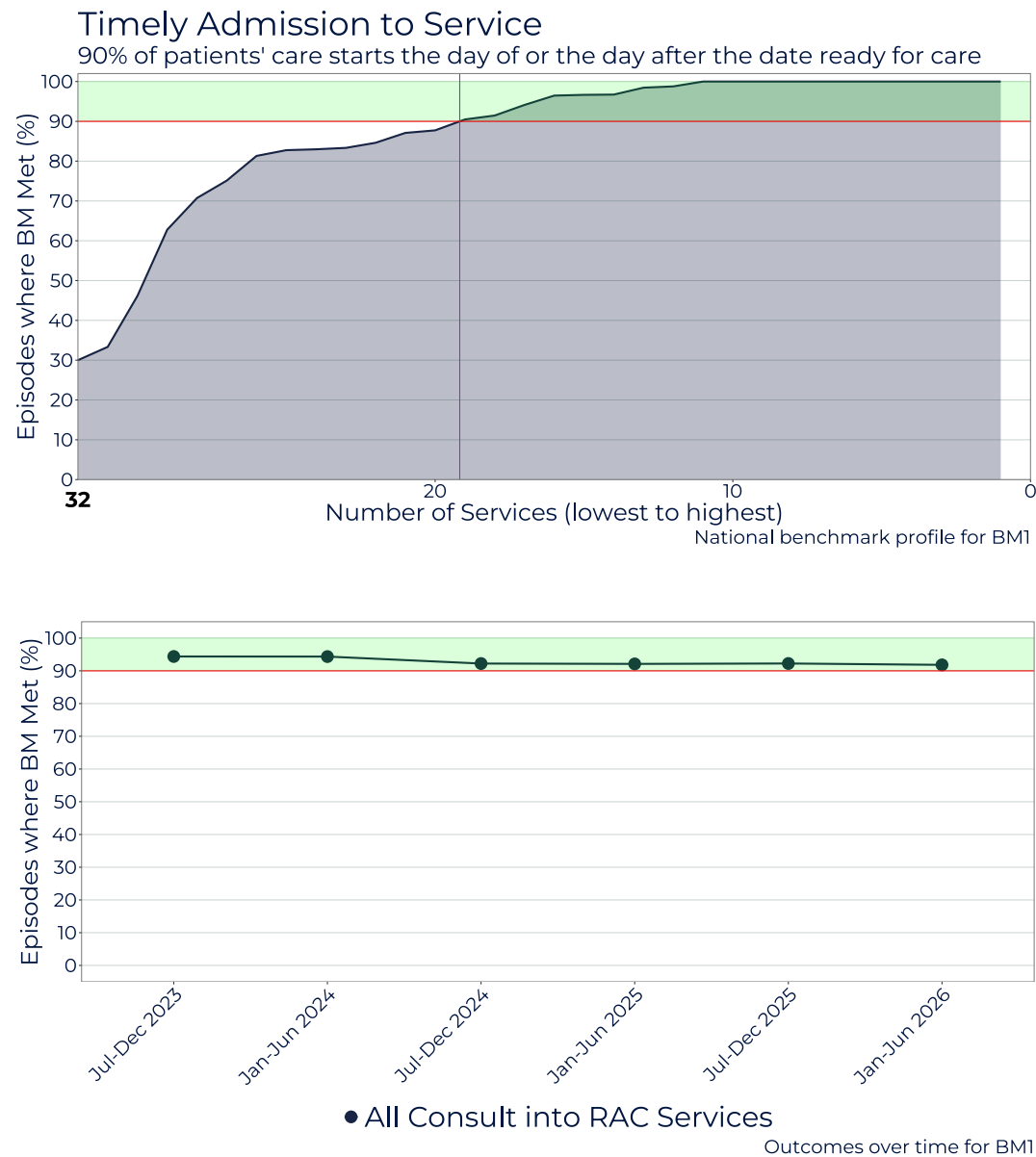


Figure 1: Time from date patient is ready for care to episode start (BM1)

2.2 Responsiveness in managing patients with urgent clinical needs

The unstable phase type, by nature of its definition, alerts clinical staff to the need for urgent changes to the patient's plan of care or that emergency intervention is required. Those patients assessed to be in the unstable phase require intense review for a short period of time.

An unstable phase is triggered if:

- a patient experiences a new, unanticipated problem, and/or
- a patient experiences a rapid increase in the severity of an existing problem, and/or
- a patient's family/carers experience a sudden change in circumstances that adversely impacts the patient's care.

The patient moves out of the unstable phase in one of two ways:

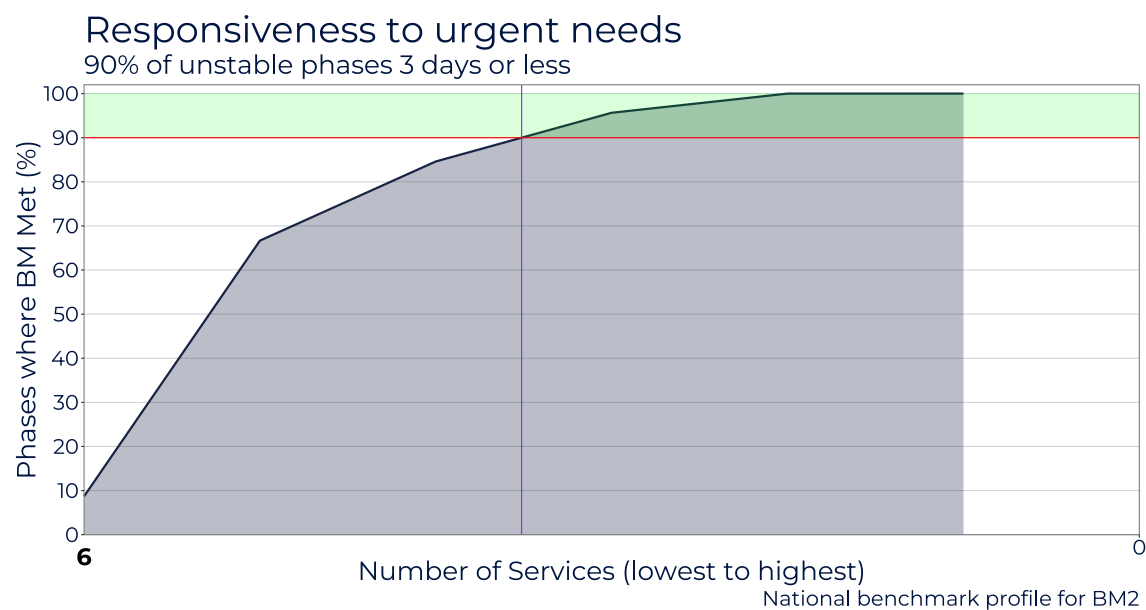
- A new plan of care has been put in place, has been reviewed and does not require any additional changes. This does not necessarily mean that the symptom/crisis has been fully resolved. However, the clinical team will have a clear diagnosis and a plan for the patient's care. In this situation, the patient will move to either the stable or deteriorating phase.
- The patient is likely to die within a matter of days. In this situation, the patient will be moved into the terminal phase.

Benchmark 2

This benchmark relates to the time that a patient spends in the unstable phase. To meet this benchmark, at least 90% of unstable phases must last for three days or less.

Table 4: Time in unstable phase by setting of care

Time in Unstable Phase	Consult into RAC	
	N	%
Same day	61	24.9
1 day	77	31.4
2 days	27	11.0
3 days	14	5.7
4-5 days	15	6.1
6-7 days	9	3.7
8-14 days	19	7.8
15+ days	23	9.4
Total	245	100.0



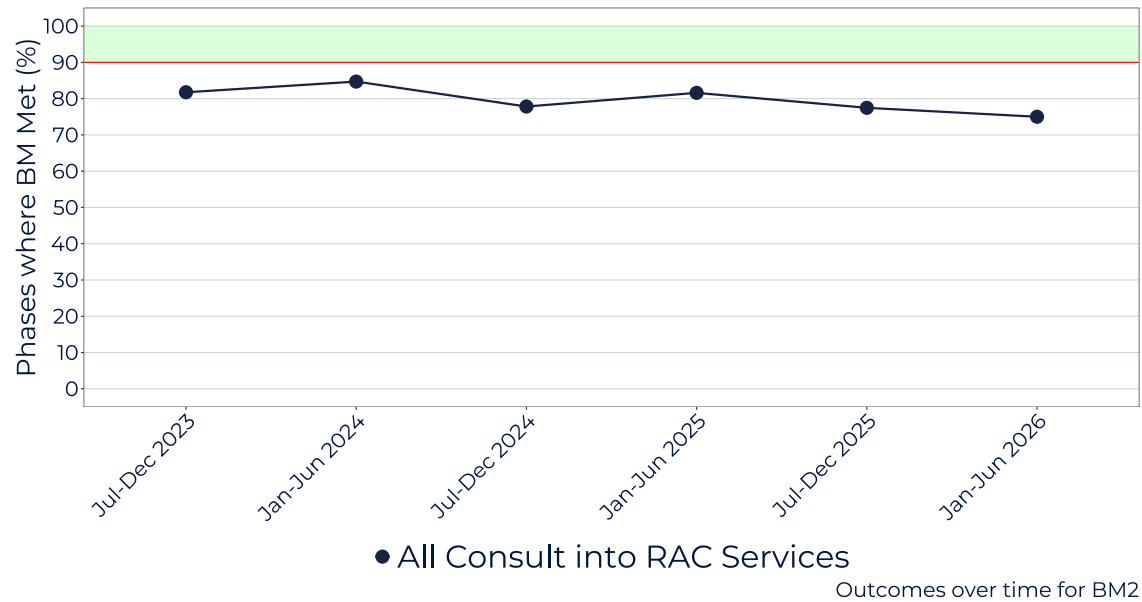


Figure 2: Time in unstable phase (BM2)

2.3 Symptoms & Problems in the Absent to Mild Range at Phase End

The outcome measures presented in this section focus on five symptom and problem areas

- Pain - clinician reported severity
- Pain - patient reported distress
- Fatigue - patient reported distress
- Breathing problems - patient reported distress
- Family/carers problems - clinician reported severity

A positive patient outcome is achieved if the patient and family/carer assessment (using the Symptom Assessment Scale and the Palliative Care Problem Severity Score) has an absent to mild symptom/problem at the end of a Palliative Care Phase. The type of care delivered and the corresponding benchmarks achievement depends on the patients (or family/carer) level of symptom or problem at start of the phase; start scores in the absent to mild range trigger monitoring and review of care plans and are considered anticipatory care, whilst start scores in the moderate to severe range trigger interventions, actions and a change in the patient care plan to respond to needs and are considered responsive care.

Anticipatory Care

The anticipatory care outcome measures and benchmarks relate to patients who have absent or mild symptoms/problems at the start of a phase of palliative care. To meet this benchmark, 90% of these phases must end with the patient still experiencing only absent or mild symptoms/problems. Table 5 summarises the number of patient phases starting with absent to mild symptoms/problems, and the percentage of those ending in the absent to mild range.

Table 5: Achieving absent to mild symptoms/problems at phase end, when absent to mild at start

Symptom/Problem ^a	Consult into RAC	
	N ^b	%
Pain (clinician reported)	4,448	92.8
Pain (patient reported)	4,337	91.7
Fatigue (patient reported)	4,272	92.8
Breathing problems (patient reported)	4,551	96.5
Family/carer problems (clinician reported)	3,020	91.8

a. Phase records must have valid start and end scores for the PCPSS and/or SAS clinical assessment tools to enable outcomes to be measured.

b. N represents the total number of phases starting with **absent to mild** symptoms/problems.

Responsive care

The responsive care outcome measure and benchmarks relate to patients, and/or family/carers, who have been assessed with moderate or severe symptoms/problems at the start of the phase of palliative care. Achieving an absent/mild symptom or problem outcome at phase end has been identified as more clinically challenging. In order to meet this benchmark, 60% of these phases must end with absent or mild symptoms/problems.

Table 6 summarises the number of phases assessed as starting with moderate to severe symptoms/problems and of those, the percentage ending in the absent to mild range.

Table 6: Achieving absent to mild symptoms/problems at phase end, when moderate to severe at start

Symptom/Problem ^a	Consult into RAC	
	N ^b	%
Pain (clinician reported)	558	66.3
Pain (patient reported)	627	63.8
Fatigue (patient reported)	558	59.5
Breathing problems (patient reported)	247	61.5
Family/carers problems (clinician reported)	406	61.1

a. Phase records must have valid start and end scores for the PCPSS and/or SAS clinical assessment tools to enable outcomes to be measured.

b. N represents the total number of phases starting with the symptom or problem rated **moderate to severe**.

On the following pages, the results for the anticipatory and responsive care benchmarks are presented together for each of the five symptom and problem domains. The graphs included compare the outcomes achieved nationally, as well as showing any changes in outcomes over time.

For a guide on how to interpret these graphs, see Appendix E.

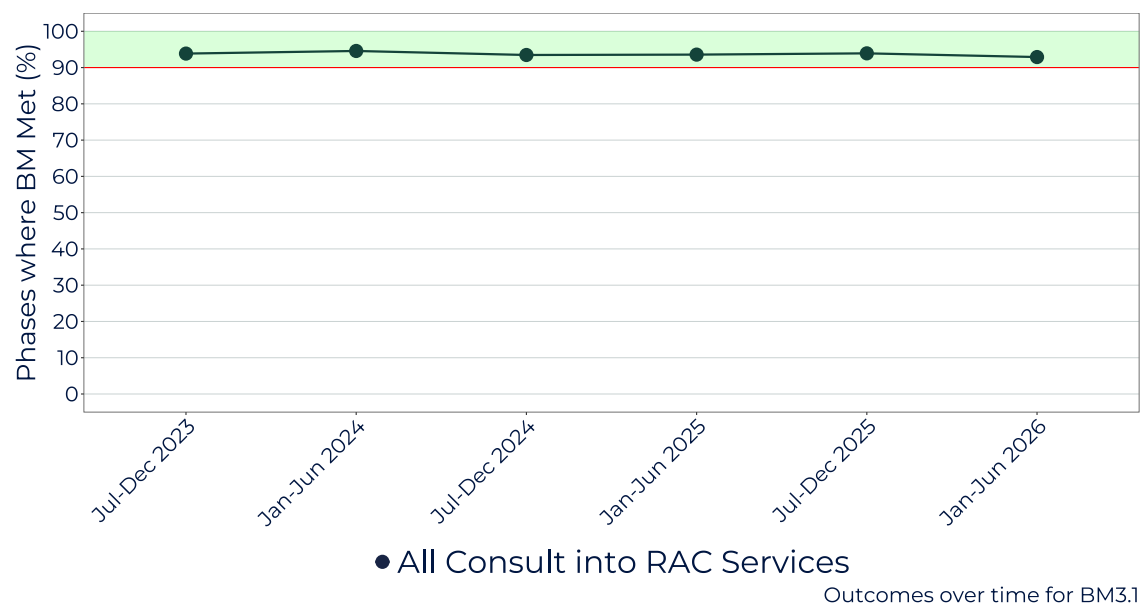
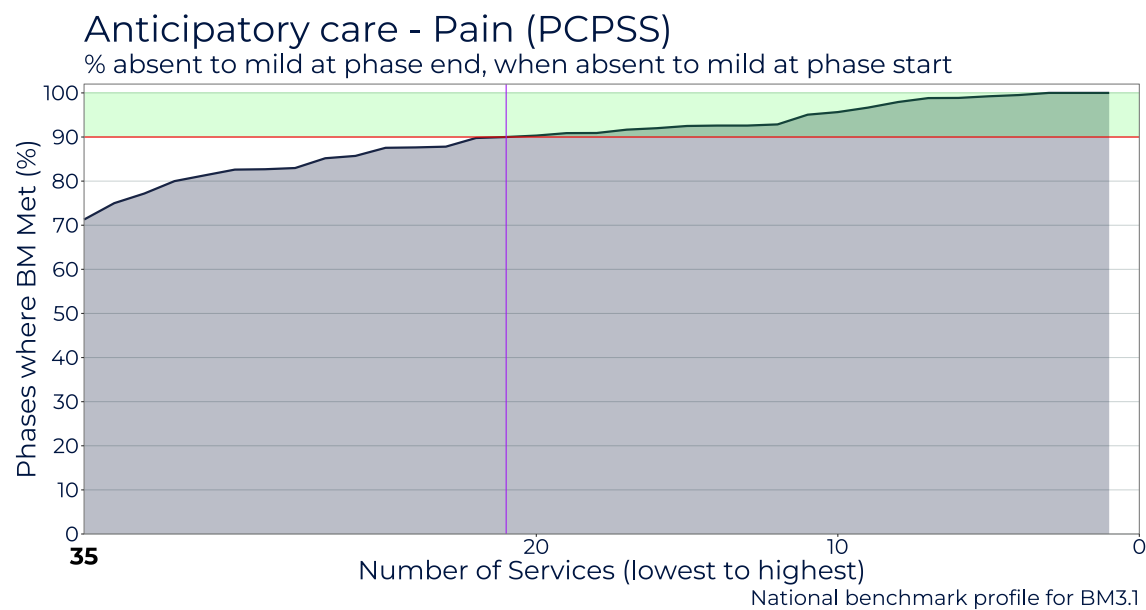


Figure 3: Pain, patients assessed with absent to mild severity at phase end (anticipatory)

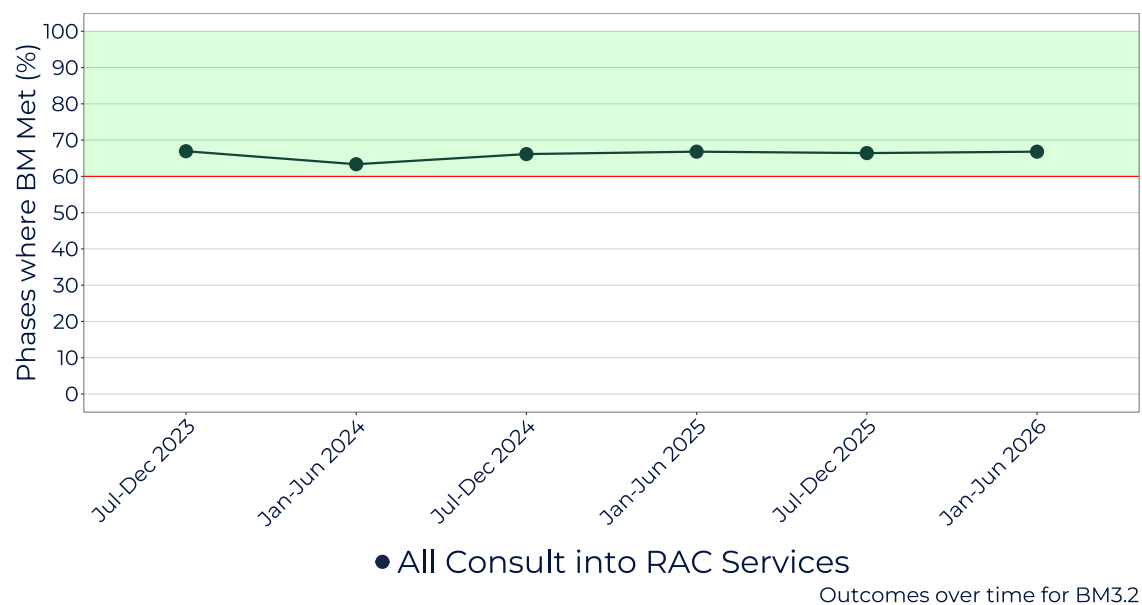
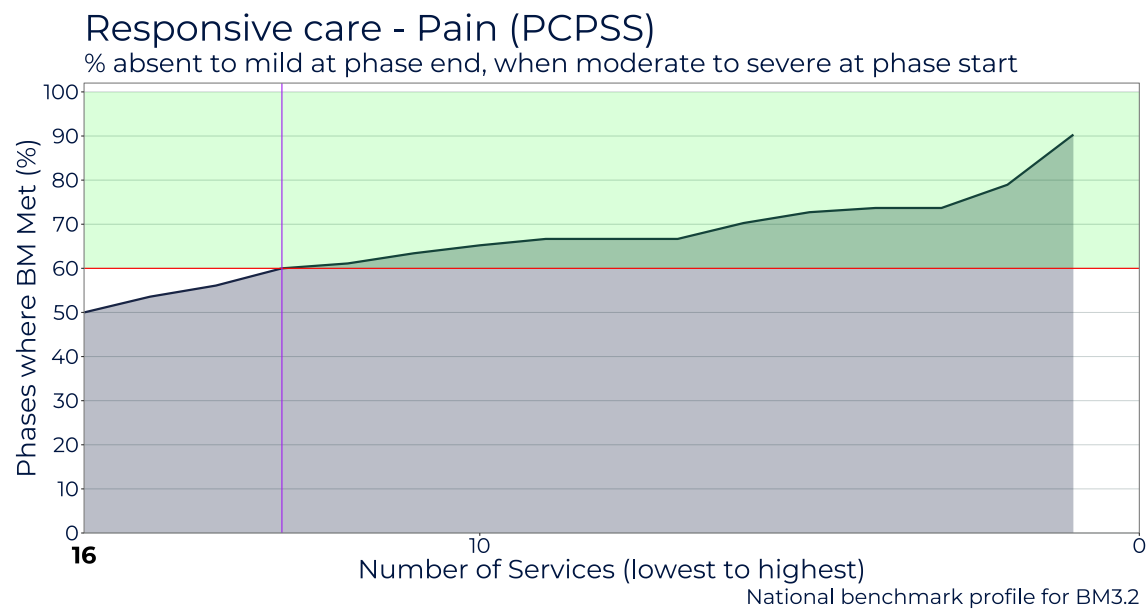


Figure 4: Pain, patients assessed with absent to mild severity at phase end (responsive)

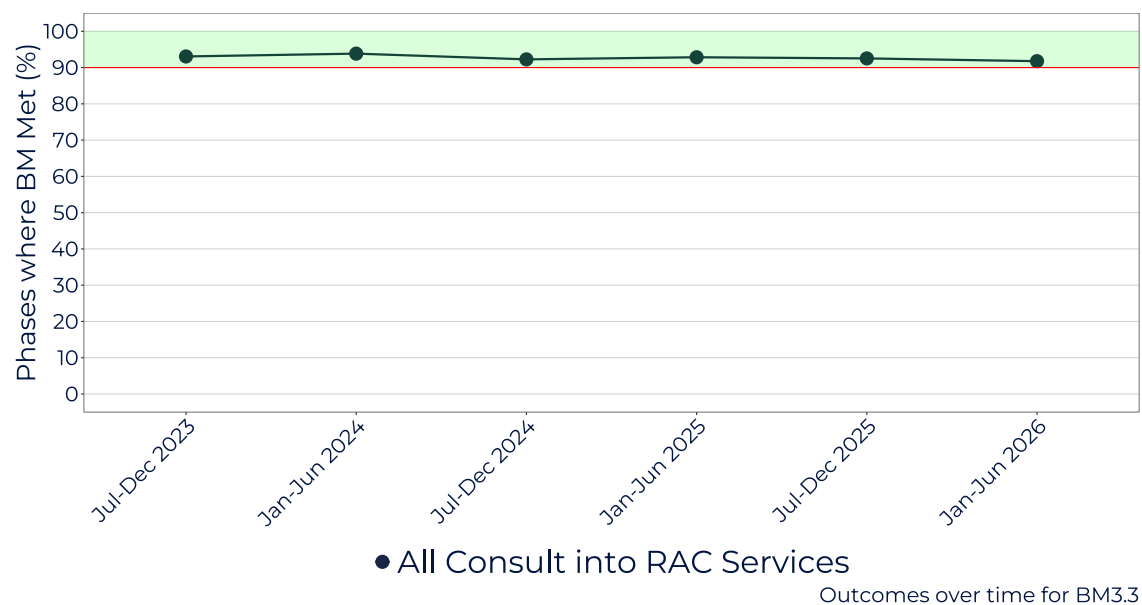
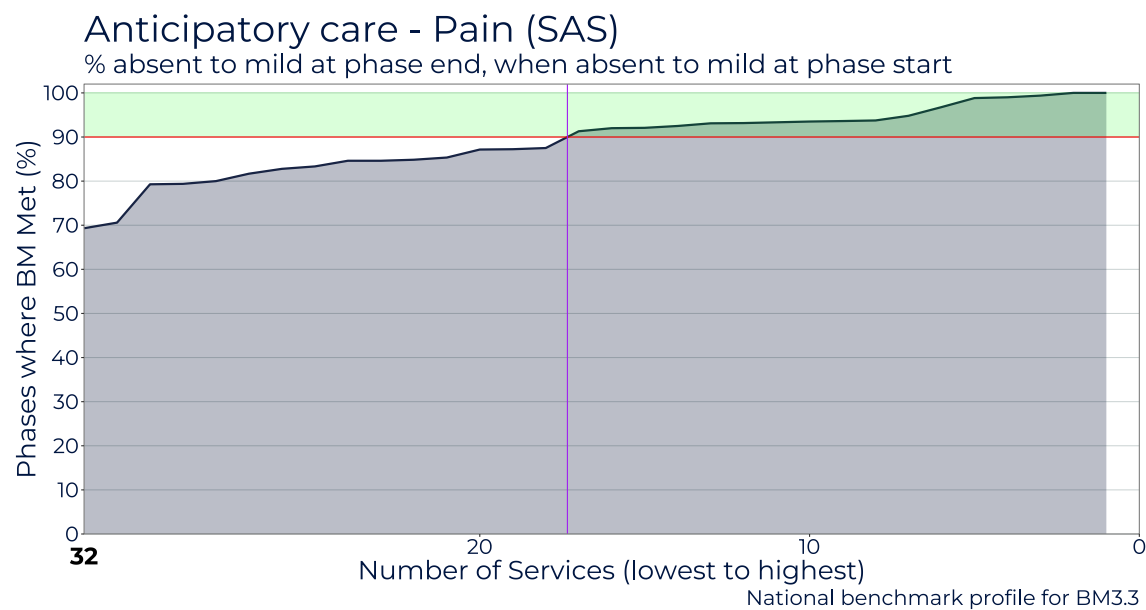


Figure 5: Pain, patients reporting absent to mild distress at phase end (anticipatory)

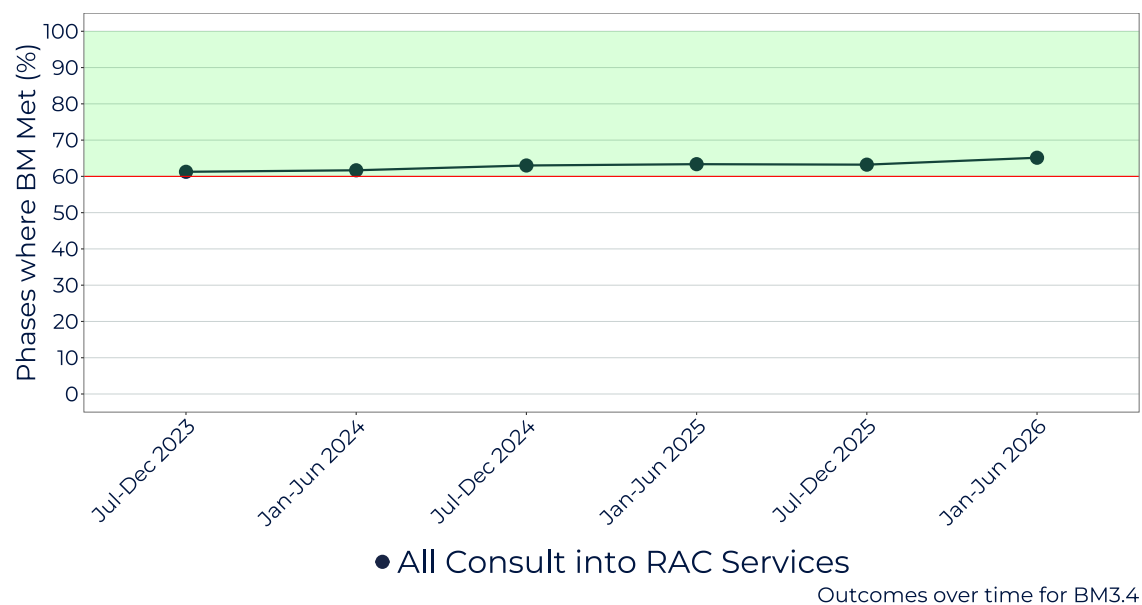
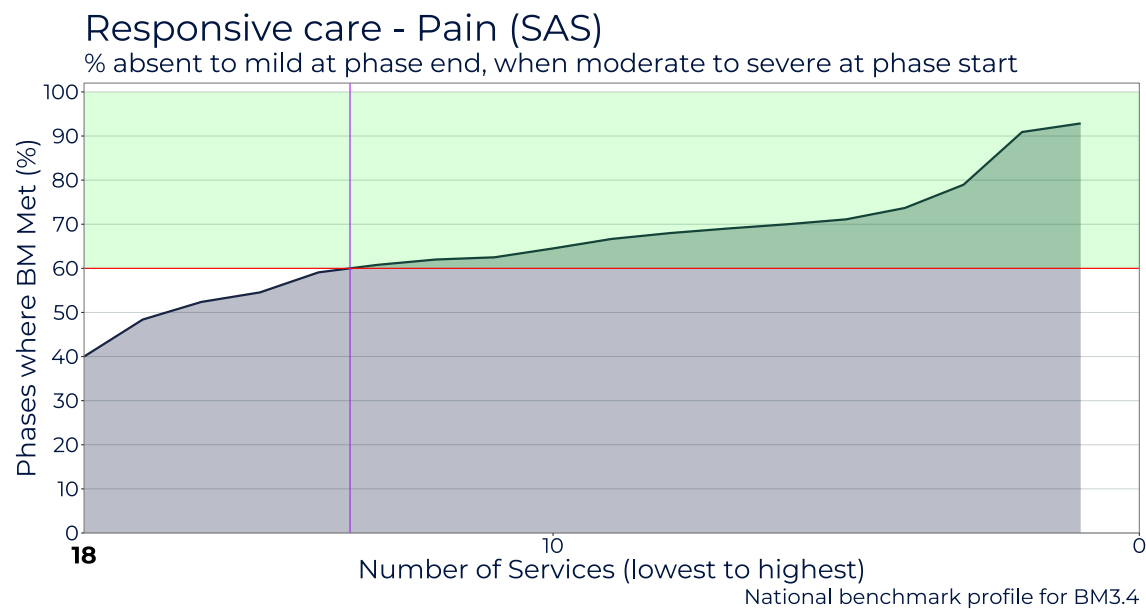


Figure 6: Pain, patients reporting absent to mild distress at phase end (responsive)

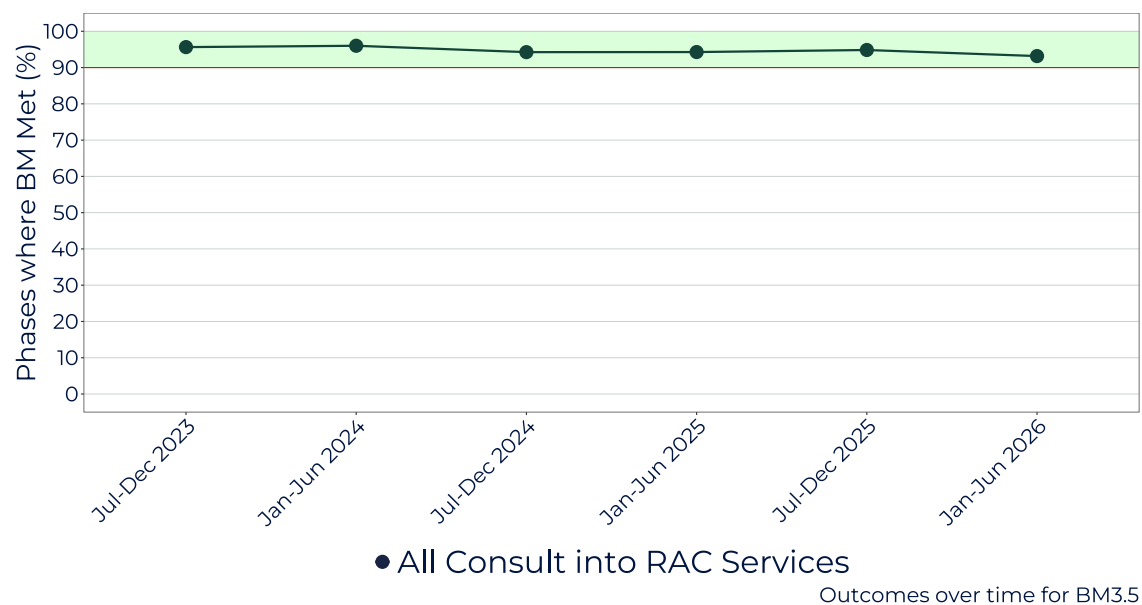
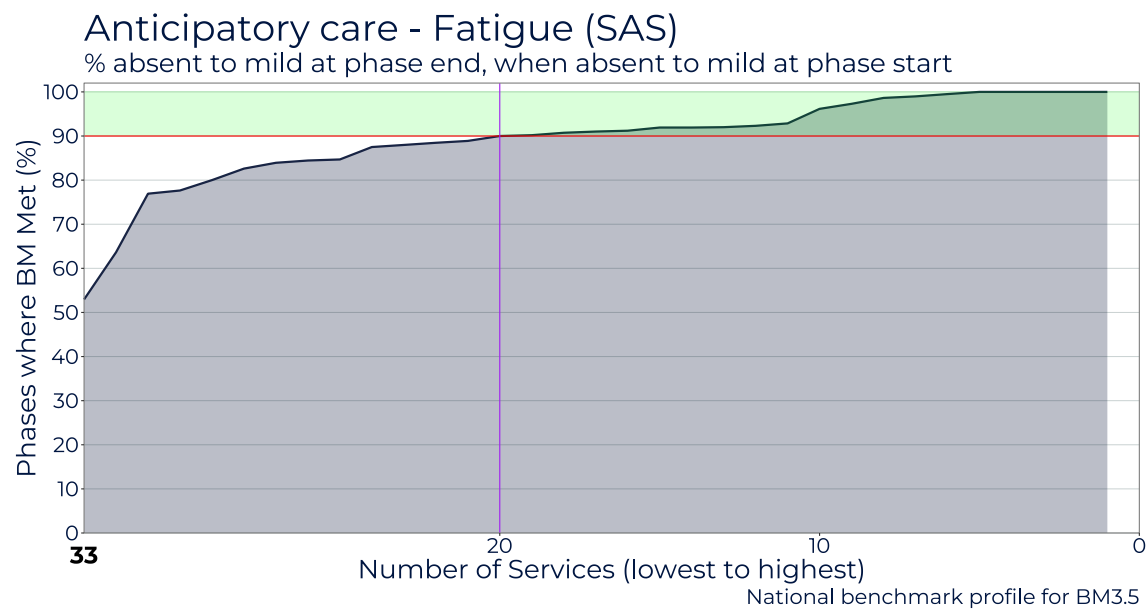


Figure 7: Fatigue, patients reporting absent to mild distress at phase end (anticipatory)

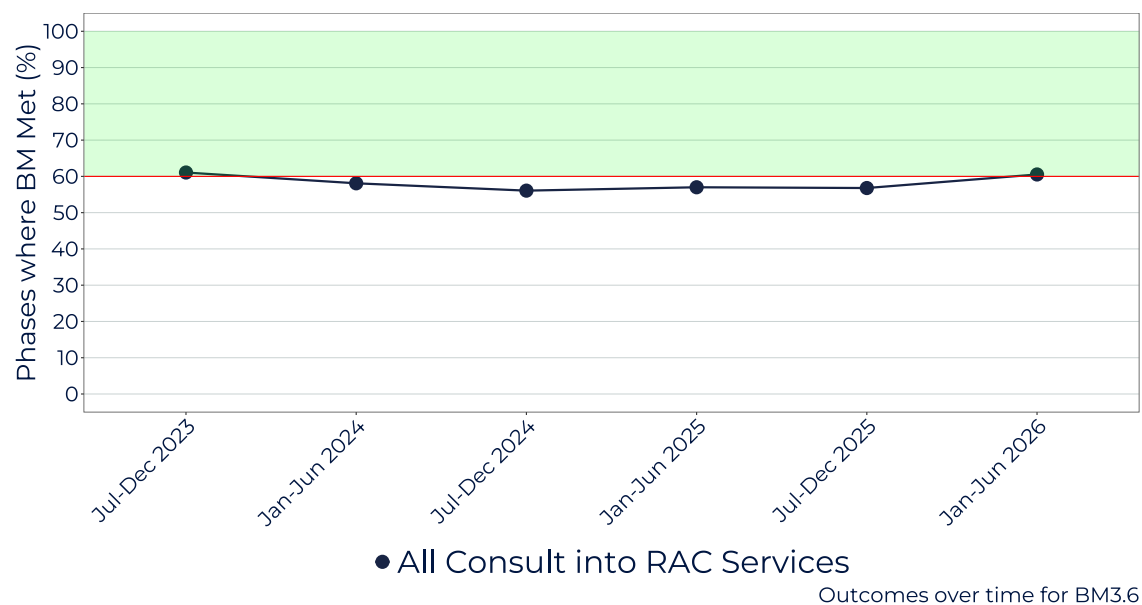
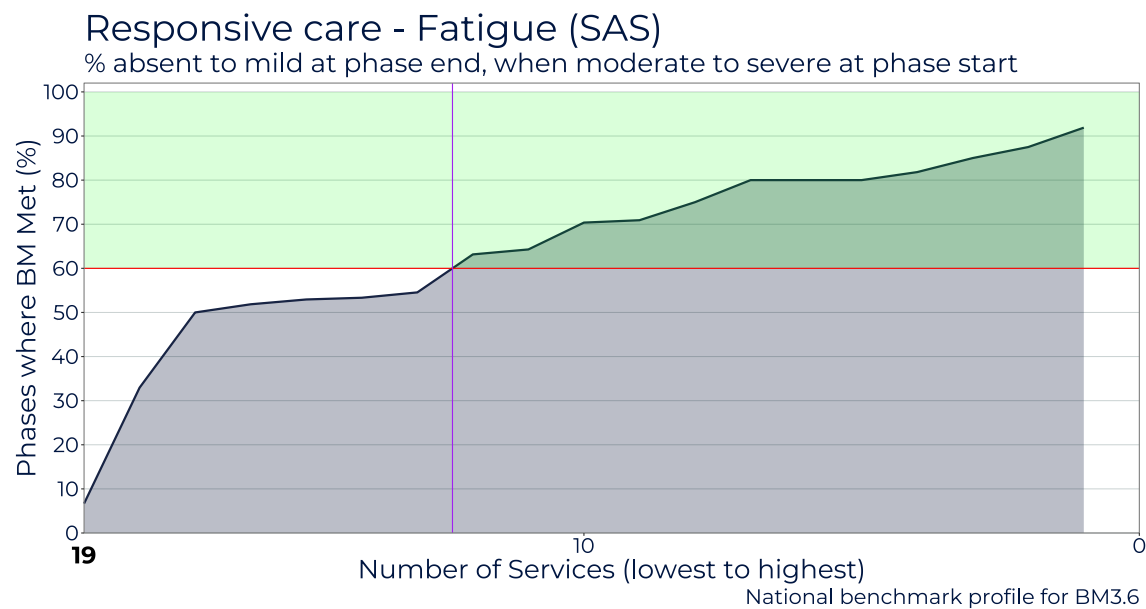


Figure 8: Fatigue, patients reporting absent to mild distress at phase end (responsive)

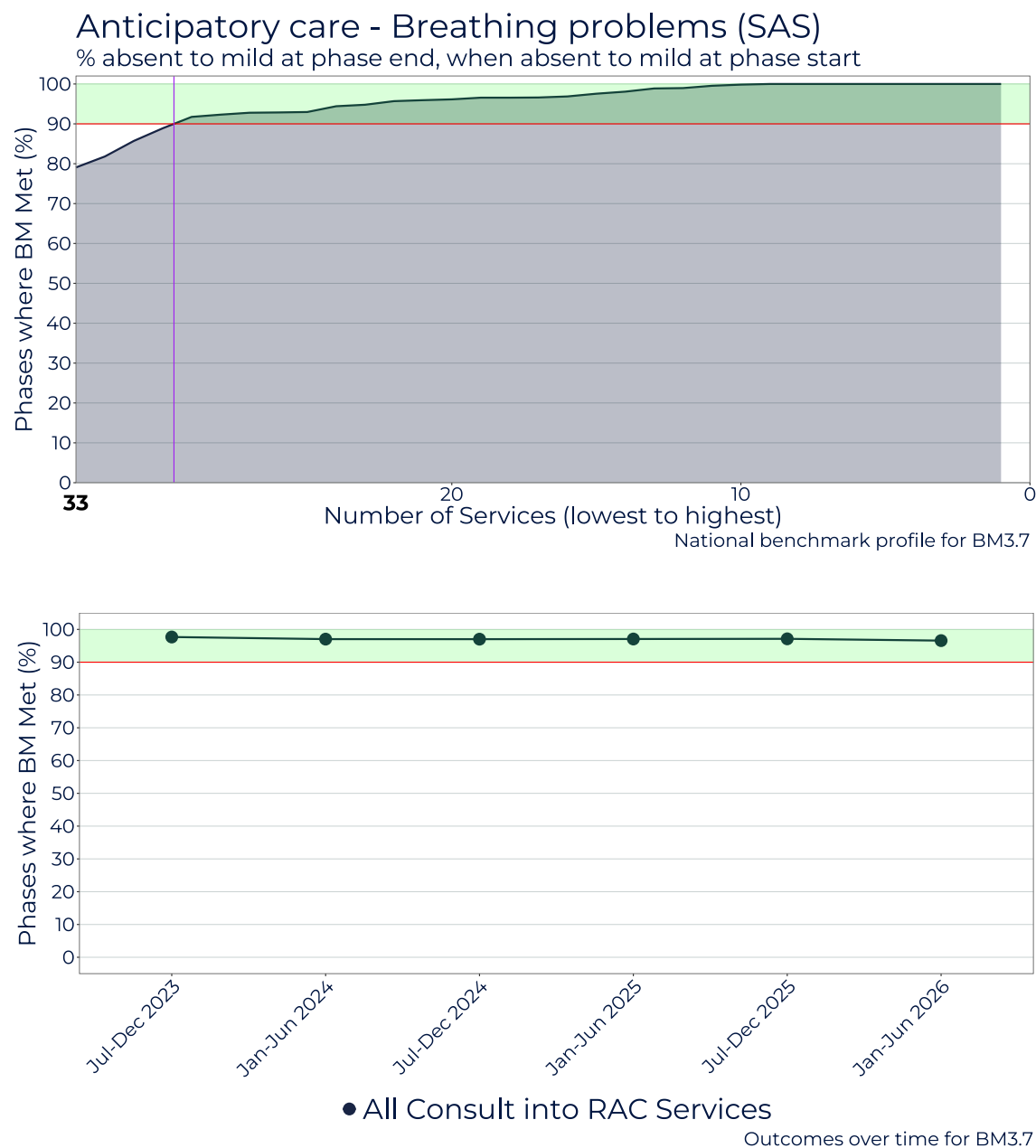


Figure 9: Breathing problems, patients reporting absent to mild distress at phase end (anticipatory)

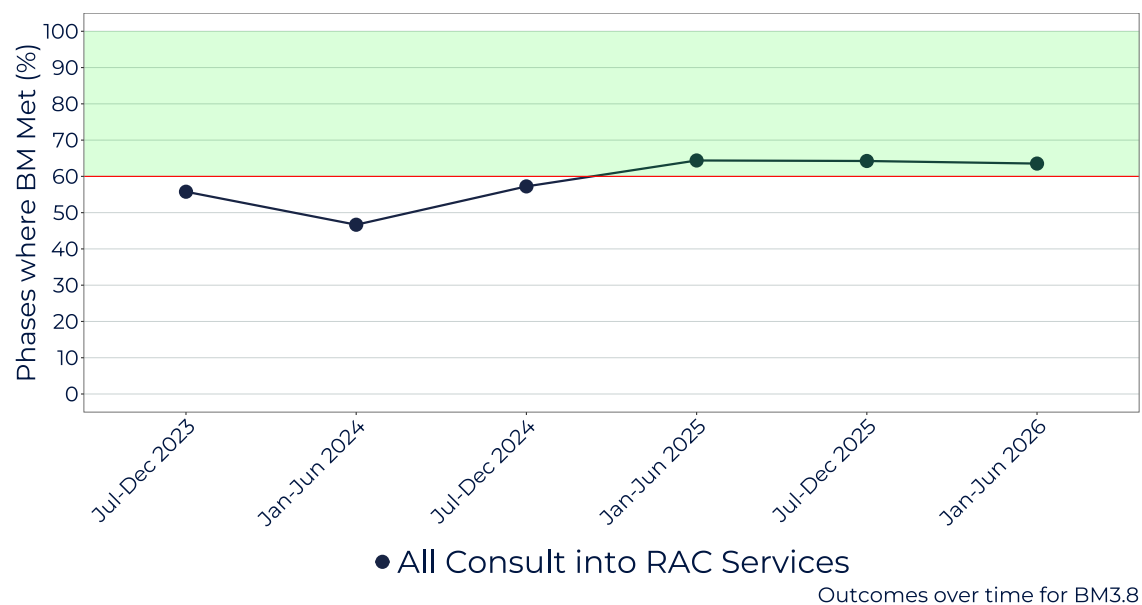
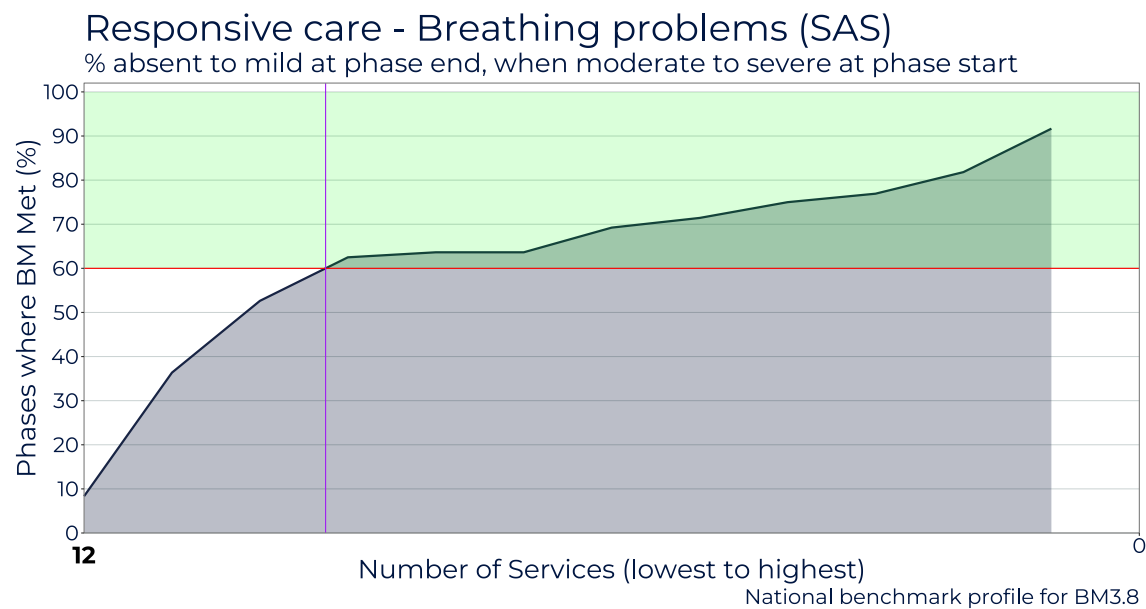


Figure 10: Breathing problems, patients reporting absent to mild distress at phase end (responsive)

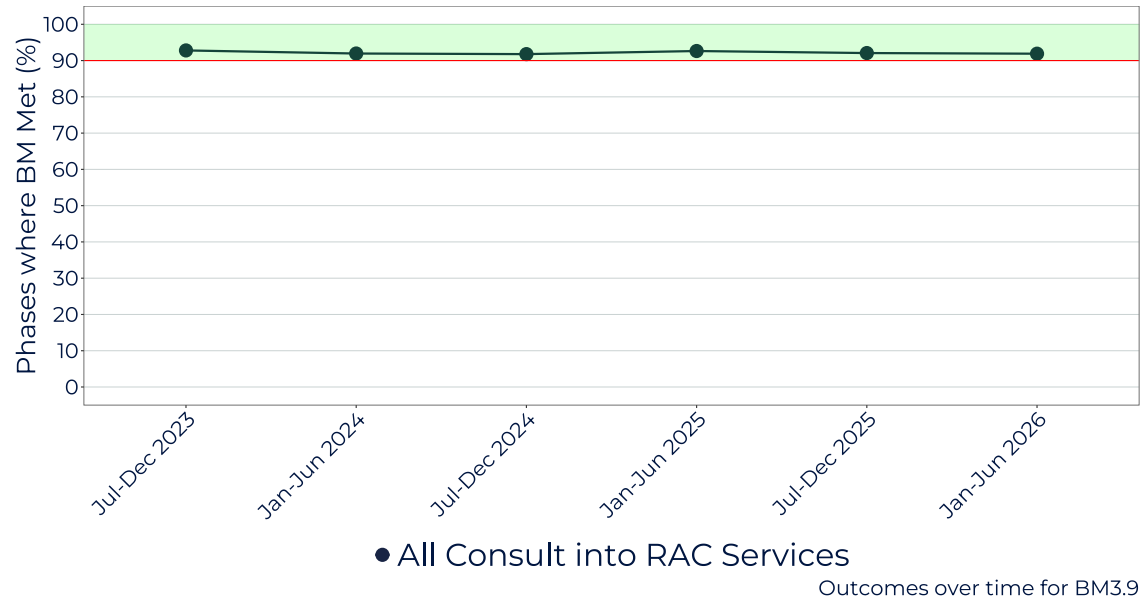
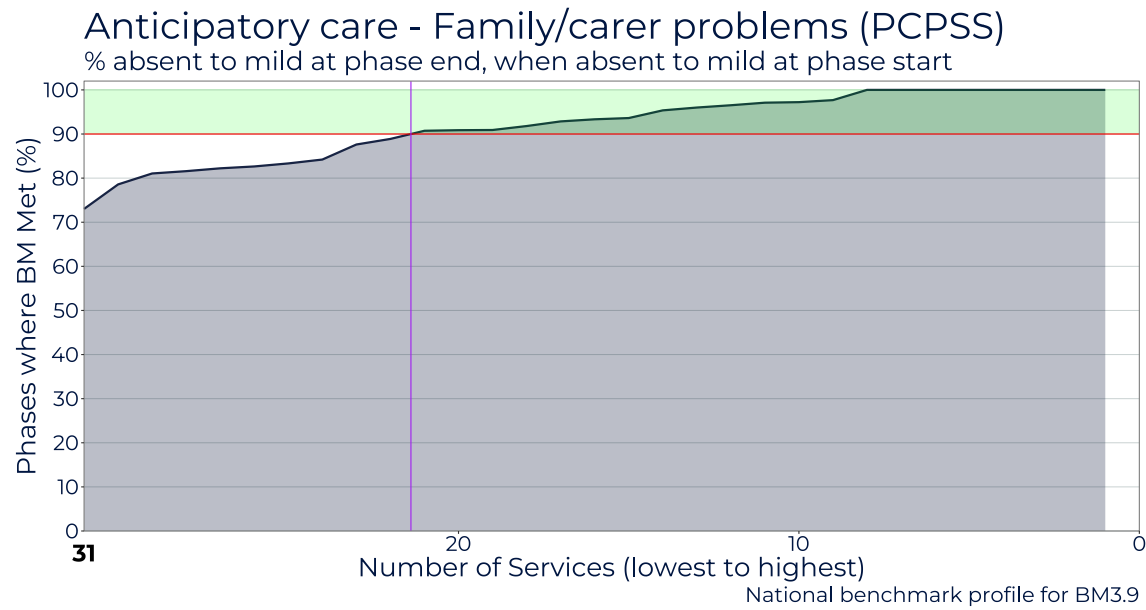


Figure 11: Family/carers problems, family/carers assessed with absent to mild problem severity at phase end (anticipatory)

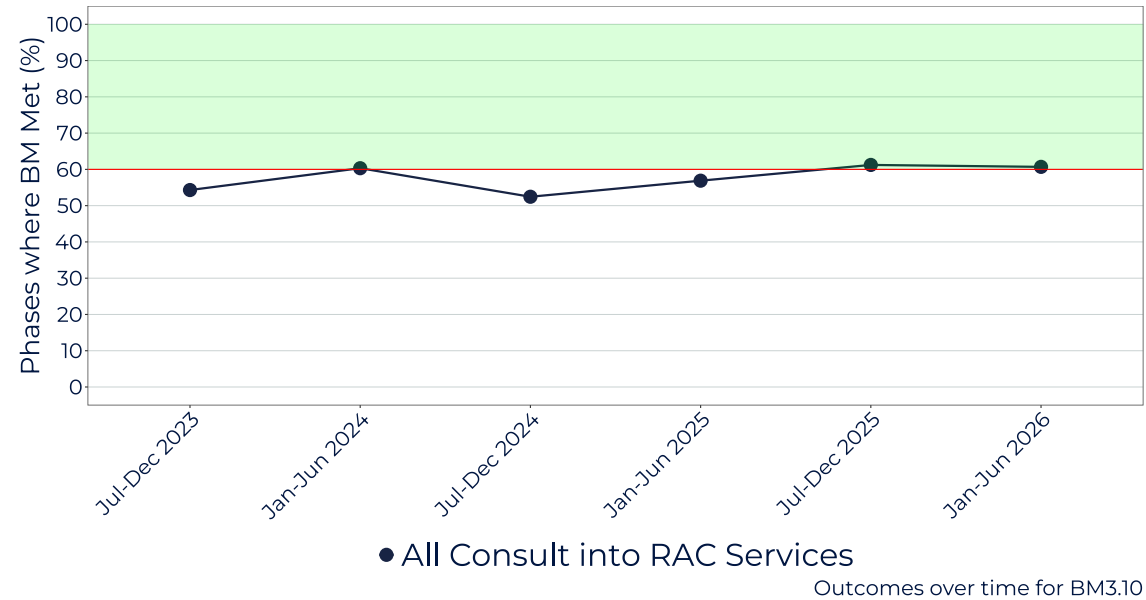
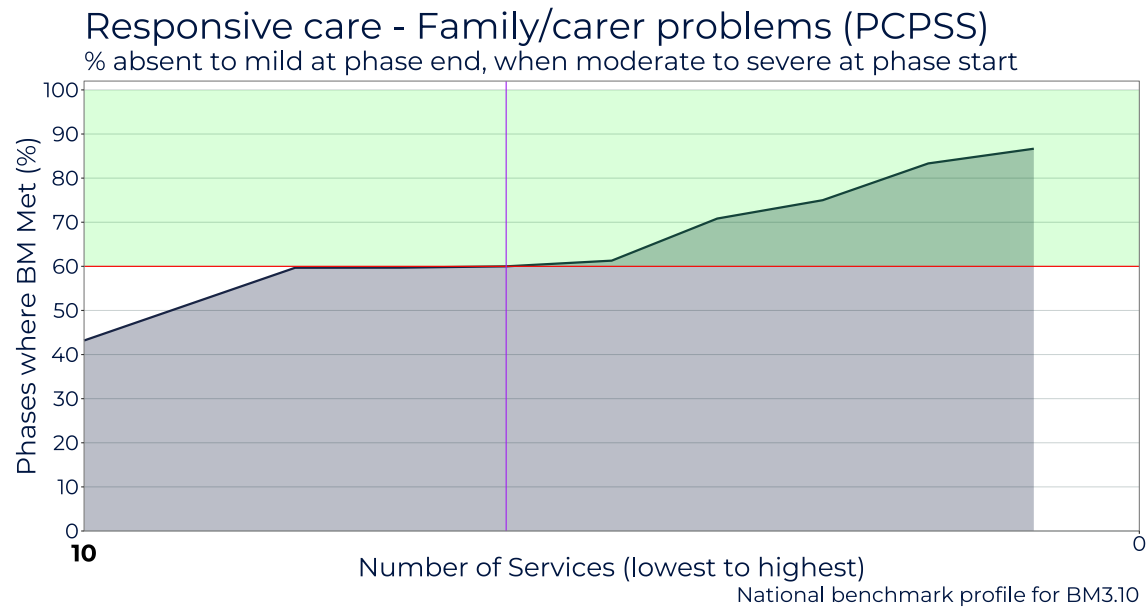


Figure 12: Family/carers problems, family/carers assessed with absent to mild problem severity at phase end (responsive)

2.4 Casemix adjusted outcomes

Outcome measure 4 includes a suite of eight casemix adjusted scores used to compare the change in symptoms for similar patients. Patients in the same phase who started with the same level of symptom have their change in symptom compared to the reference period (January to June 2014).

Table 7: Casemix adjusted outcomes

Clinical Tool	Symptom/Problem	Consult into RAC			
		Casemix adjusted score	Phases included (N)	Phases at or above baseline (N)	Phases at or above baseline (%)
PCPSS <i>Clinician reported severity</i>	Pain	0.14	5,006	3,331	66.5
	Other symptoms	0.29	4,319	3,400	78.7
	Family/carers	0.26	3,393	2,707	79.8
	Psychological/spiritual	0.26	4,842	3,502	72.3
SAS <i>Patient reported distress</i>	Pain	0.37	4,964	3,583	72.2
	Nausea	0.23	4,778	4,374	91.5
	Breathing problems	0.29	4,781	3,997	83.6
	Bowel problems	0.30	4,746	3,962	83.5

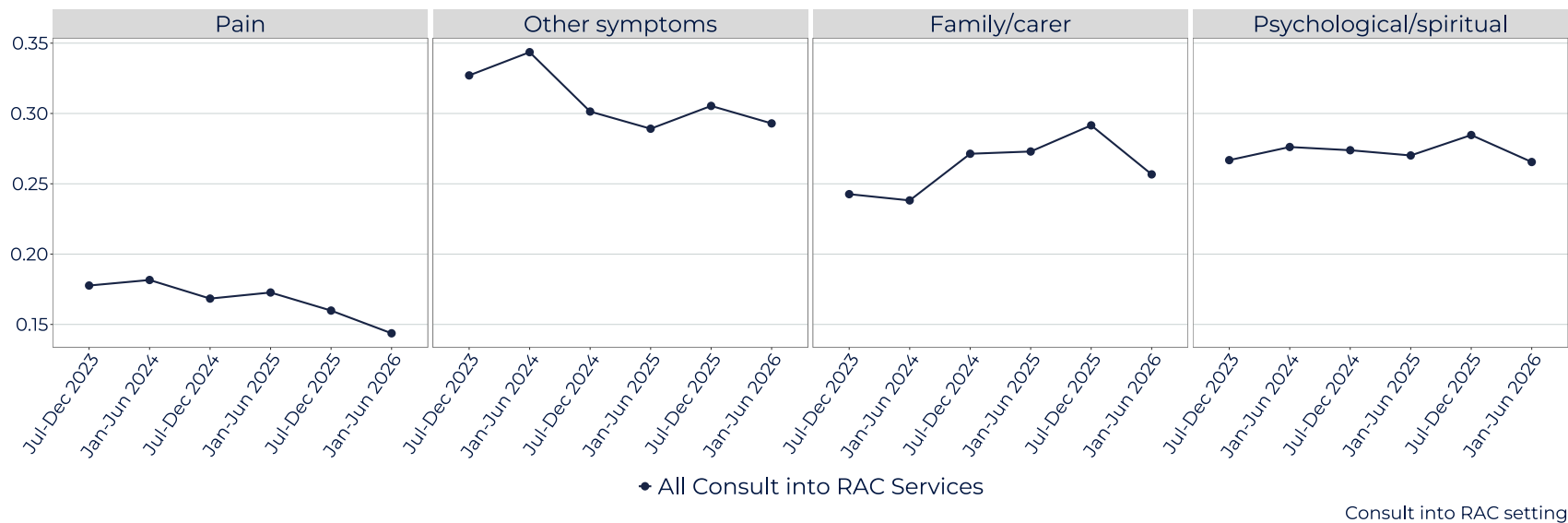


Figure 13: Trends in casemix adjusted outcomes - Palliative Care Problem Severity Score (PCPSS)

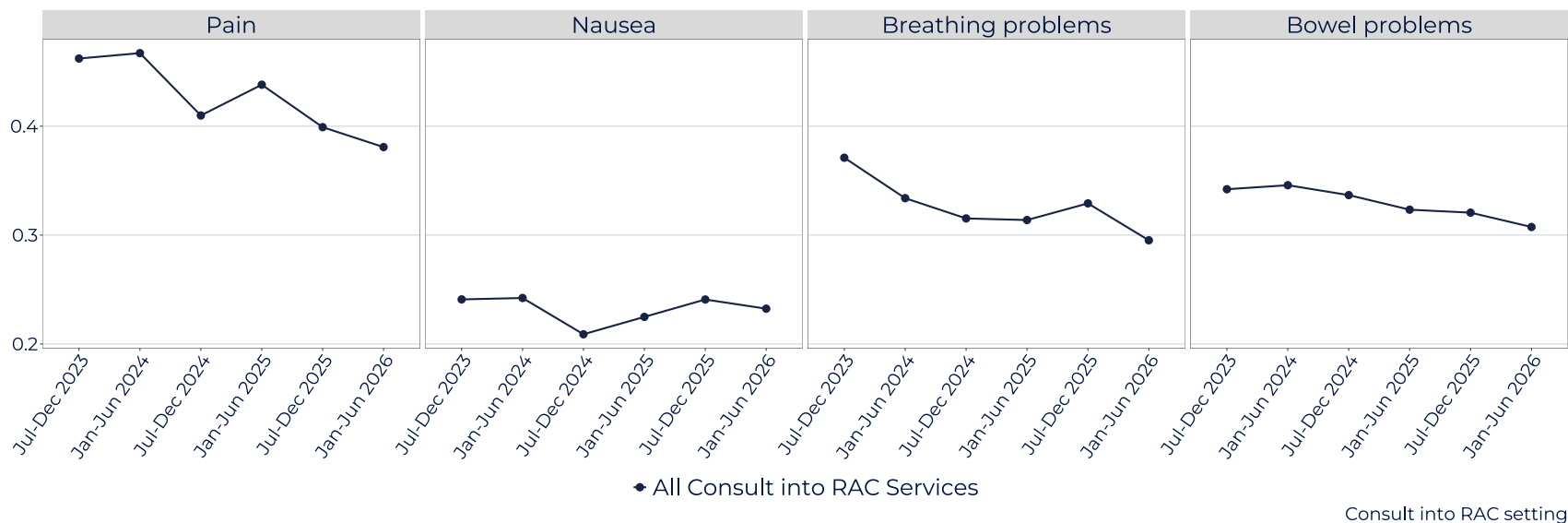


Figure 14: Trends in casemix adjusted outcomes - Symptom Assessment Scale (SAS)

3 Patient characteristics

PCOC defines a patient as a person for whom a palliative care service accepts responsibility for assessment and/or treatment as evidenced by the existence of a medical record. Family and carers are included in this definition if interventions relating to them are recorded in the patient medical record.

Table 8 shows the sex for the patients.

Table 8: Sex

Sex	N	%
Male	1,958	41.5
Female	2,756	58.5
Not stated/Inadequately described/Intersex	0	0.0
Total	4,714	100.0

Table 9 shows the sex for the patients in all participating PCOC services over time.

Table 9: Sex over time

Sex	Jul-Dec 2023	Jan-Jun 2024	Jul-Dec 2024	Jan-Jun 2025	Jul-Dec 2025	Jan-Jun 2026
Male	39.4	39.4	40.4	41.0	41.9	41.5
Female	56.7	57.7	56.4	56.9	58.1	58.5
Not stated/Inadequately described/Intersex	3.9	2.8	3.2	2.1	0.0	0.0
Total	100.0	100.0	100.0	100.0	100.0	100.0

Note: Only episodes starting during the reporting period are included.

Table 10 shows the Indigenous status for the patients in AUS and all participating PCOC services.

Table 10: Indigenous status

Indigenous status	N	%
Aboriginal but not Torres Strait Islander origin	74	1.6
Torres Strait Islander but not Aboriginal origin	3	0.1
Both Aboriginal and Torres Strait Islander origin	7	0.1
Neither Aboriginal nor Torres Strait Islander origin	4,463	94.7
Not stated/inadequately described	167	3.5
Total	4,714	100.0

Table 11 shows the Indigenous status for the patients in your service over time.

Table 11: Indigenous status for AUS over time

Indigenous status	Jul-Dec 2023	Jan-Jun 2024	Jul-Dec 2024	Jan-Jun 2025	Jul-Dec 2025	Jan-Jun 2026
Aboriginal but not Torres Strait Islander origin	1.0	1.3	1.3	1.8	1.7	1.6
Torres Strait Islander but not Aboriginal origin	0.0	0.1	0.0	0.0	0.1	0.1
Both Aboriginal and Torres Strait Islander origin	0.2	0.2	0.1	0.1	0.2	0.1
Neither Aboriginal nor Torres Strait Islander origin	93.7	93.7	94.2	94.2	94.5	94.7
Not stated/inadequately described/Intersex	5.1	4.7	4.4	3.8	3.6	3.5
Total	100.0	100.0	100.0	100.0	100.0	100.0

Note: Only episodes starting during the reporting period are included.

Table 12: Country of birth

Country of birth	N	%
Australia	3,038	64.4
England	370	7.8
India	54	1.1
China	42	0.9
New Zealand	67	1.4
Philippines	11	0.2
Vietnam	13	0.3
South Africa	31	0.7
Malaysia	22	0.5
Italy	225	4.8
Sri Lanka	23	0.5
Scotland	71	1.5
Nepal	0	0.0
United States of America	10	0.2
Germany	40	0.8
All other countries	607	12.9
Not stated	90	1.9
Total	4,714	100.0

a. Cantonese, Hakka, Mandarin, Wu and Min Nan.

b. Bengali, Gujarati, Konkani, Marathi, Nepali, Punjabi, Sindhi, Sinhalese, Urdu, Assamese, Dhivehi, Kashmiri, Oriya, and Fijian Hindustani.

c. Hebrew, Assyrian Neo-Aramaic, Chaldean Neo-Aramaic, and Mandaean (Mandaic)

d. Khmer and Mon.

Table 13: Preferred language

Language	N	%
English	4,277	90.9
Chinese^a	39	0.8
Hindi^b	7	0.1
Arabic^c	10	0.2
Vietnamese^d	11	0.2
Filipino/Indonesian^e	s	s
Tamil/Malayalam^f	s	s
Spanish^g	13	0.3
Greek	55	1.2
Italian	90	1.9
Macedonian/Croatian^h	32	0.7
African languages	s	s
Korean	s	s
Samoan/Tonganⁱ	5	0.1
Australian Indigenous languages	4	0.1
All other languages	110	2.3
Not stated	51	1.1
Total	4,704	100.0

e. Bisaya, Cebuano, Ilokano, Malay, Tetum, Timorese, Tagalog, Acehnese, Balinese, Bikol, Iban, Ilonggo, Javanese, and Pampangan.

f. Kannada, Telugu, and Tulu.

g. Catalan and Portuguese.

h. Bosnian, Bulgarian, Serbian, and Slovene.

i. Fijian, Gilbertese, Maori, Nauruan, Niue, Rotuman, Tokelauan, Tuvaluan, and Yapese.

The tables on the previous page show the country of birth and the preferred language respectively for the patients nationally. To allow for comparison with the broader Australian community the list of country of birth in Table 12 is in descending order of the most frequent country of birth according to the 2021 Census (e.g. India was the third most common country of birth in the 2021 Census). The same approach has been taken with Table 13 (e.g. Arabic was the fourth most frequently spoken language in the 2021 census). All other countries and languages have been grouped together to form the categories 'All other countries' and 'All other languages' respectively.

Table 14 and Table 15 present a breakdown of malignant and non-malignant diagnosis for the patients at the national level. Diagnosis is the principal life-limiting illness responsible for the patient requiring palliative care. Diagnosis was not stated for 35 (0.7%) patients.

Table 14: Principal diagnosis - malignant

Diagnosis	N	% of malignant diagnoses	% of all diagnoses
Bone and soft tissue	12	0.9	0.3
Breast	111	8.1	2.4
CNS	41	3.0	0.9
Colorectal	152	11.2	3.2
Other GIT	119	8.7	2.5
Haematological	108	7.9	2.3
Head and neck	79	5.8	1.7
Lung	192	14.1	4.1
Pancreas	51	3.7	1.1
Prostate	139	10.2	2.9
Other urological	65	4.8	1.4
Gynaecological	50	3.7	1.1
Skin	83	6.1	1.8
Unknown primary	40	2.9	0.8
Other primary malignancy	84	6.2	1.8
Malignant Not further defined	37	2.7	0.8
All malignant	1,363	100.0	29.1

Table 15: Principal diagnosis - non-malignant

Diagnosis	N	% of non-malignant diagnoses	% of all diagnoses
Cardiovascular disease	422	12.7	9.0
End stage kidney disease	125	3.8	2.7
Stroke	96	2.9	2.0
Motor neurone disease	28	0.8	0.6
Alzheimers dementia	632	19.1	13.4
Other dementia	759	22.9	16.1
Other neurological disease	199	6.0	4.2
Respiratory failure	248	7.5	5.3
End stage liver disease	27	0.8	0.6
Diabetes & its complications	28	0.8	0.6
Sepsis	71	2.1	1.5
Multiple organ failure	32	1.0	0.7
Other non-malignancy	389	11.7	8.3
Non-malignant Not further defined	260	7.8	5.5
All non-malignant	3,316	100.0	70.5

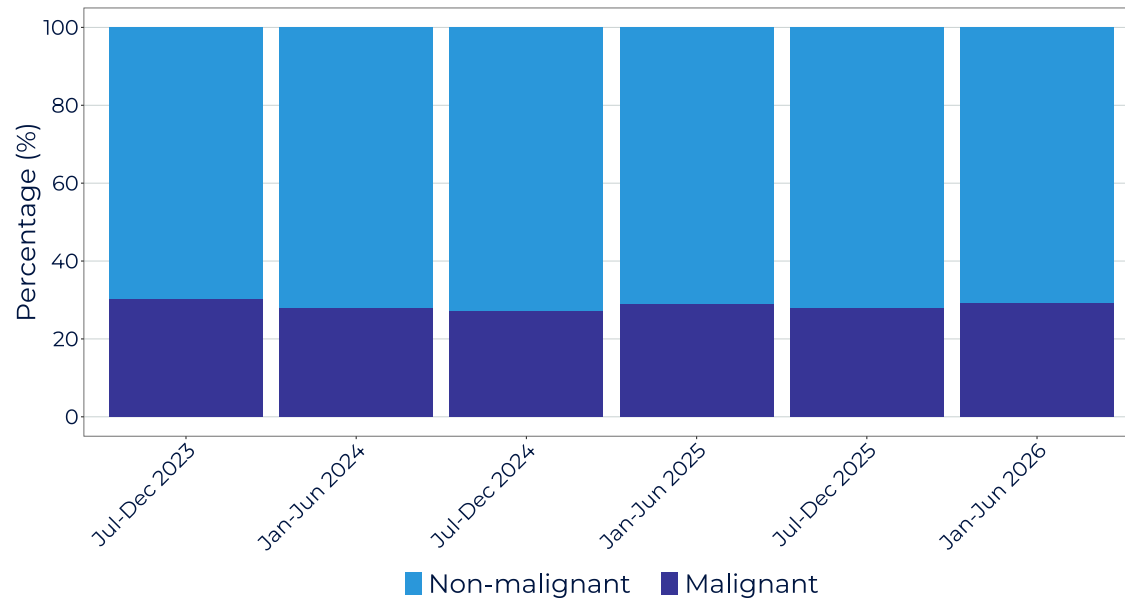


Figure 15: Principal diagnosis over time

4 Episodes of palliative care

An episode of care is a period of contact between a patient and a palliative care service that is provided by one palliative care service and occurs in one setting - for the purposes of this report, either as an inpatient or community patient.

An episode of palliative care starts on the date the comprehensive palliative care assessment is completed using the five PCOC clinical assessment tools and documented in the patient medical record.

An episode of palliative care ends when:

- the patient is formally separated from the current setting of care (e.g. from community to inpatient) or
- the patient dies or
- the principal clinical intent of the care changes and the patient is no longer receiving palliative care.

Table 16 presents the number and percentage of episodes by age group and sex for the patients. Age has been calculated as at episode start.

Table 16: Patient's age by sex

Age	Male		Female	
	N	%	N	%
< 15	0	0.0	0	0.0
15 – 24	0	0.0	0	0.0
25 – 34	0	0.0	0	0.0
35 – 44	s	s	s	s
45 – 54	7	0.3	8	0.3
55 – 64	15	0.7	16	0.6
65 – 74	242	11.7	251	8.8
75 – 84	732	35.5	782	27.3
85 +	1,067	51.7	1,807	63.1
Unknown	0	0.0	1	0.0
Total	2,063	100.0	2,865	100.0

Note: Records where sex was not stated or inadequately described are excluded from the table.

Referral source refers to the facility from where the patient was referred for each episode of care. Table 17 presents referral source by setting of care.

Table 17: Source of referral

Referral source	Consult into RAC	
	N	%
Public hospital – palliative care unit/team	170	4.3
Public hospital - oncology unit/team	18	0.5
Public hospital - medical unit/team	245	6.2
Public hospital - surgical unit/team	15	0.4
Public hospital - emergency department	84	2.1
Public hospital - not further defined	325	8.2
Public hospital - Total	857	21.7
Private hospital - palliative care unit/team	58	1.5
Private hospital - oncology unit/team	s	s
Private hospital - medical unit/team	28	0.7
Private hospital - surgical unit/team	0	0.0
Private hospital - emergency department	s	s
Private hospital - not further defined	42	1.1
Private hospital - Total	128	3.2
Outpatient clinic	20	0.5
General medical practitioner	635	16.1
Specialist medical practitioner	212	5.4
Community-based palliative care agency	62	1.6
Community-based service	35	0.9
Residential aged care facility	1,693	42.9
Self, carer(s), family or friends	170	4.3
Other	131	3.3
Not stated/inadequately described	3	0.1
Total	3,946	100.0

Note: Only episodes starting during the reporting period are included.

Table 18: Referral source over time

Referral source	Jul-Dec 2023	Jan-Jun 2024	Jul-Dec 2024	Jan-Jun 2025	Jul-Dec 2025	Jan-Jun 2026
Public hospital - palliative care unit/team	4.2	3.6	3.8	3.7	3.8	4.3
Public hospital – oncology unit/team	0.4	0.3	0.5	0.6	0.4	0.5
Public hospital – medical unit/team	3.5	3.2	2.7	3.9	6.2	6.2
Public hospital – surgical unit/team	0.1	0.1	0.1	0.2	0.2	0.4
Public hospital – emergency department	0.6	0.9	0.8	1.2	1.9	2.1
Public hospital – not further defined	15.2	14.7	13.4	12.0	11.8	8.2
Public hospital – Total	24.0	22.8	21.3	21.6	24.3	21.7
Private hospital – palliative care unit/team	1.3	1.4	1.6	1.3	0.8	1.5
Private hospital – oncology unit/team	0.2	0.0	0.2	0.1	0.1	0.1
Private hospital – medical unit/team	0.1	0.3	0.1	0.4	0.9	0.7
Private hospital – surgical unit/team	0.0	0.0	0.1	0.0	0.0	0.0
Private hospital – emergency department	0.0	0.0	0.0	0.1	0.2	0.1
Private hospital – not further defined	1.0	2.4	3.2	1.9	1.1	1.1
Private hospital – Total	2.6	4.1	5.2	3.8	3.1	3.5
Outpatient clinic	1.6	0.7	0.9	1.1	0.8	0.5
General medical practitioner	10.7	12.1	12.8	14.8	13.6	16.1
Specialist medical practitioner	5.2	5.7	5.9	5.7	5.2	5.4
Community-based palliative care agency	1.2	0.9	1.2	1.4	1.7	1.6
Community-based service	1.1	0.8	0.7	1.1	1.0	0.9
Residential aged care facility	43.0	42.6	41.9	40.9	42.3	42.8
Self, carer(s), family or friends	3.6	3.8	3.6	3.4	3.6	4.3
Other	7.0	6.2	6.5	6.1	4.1	3.3
Not stated/inadequately described	0.0	0.2	0.2	0.2	0.2	0.1
Total	100.0	100.0	100.0	100.0	100.0	100.0

Note: Only episodes starting during the reporting period are included.

Table 19 gives a summary of the length of episodes for patients.

Table 19: Length of episode (in days) summary by setting of care

Length of episode	Consult into RAC
Average length of episode	31.2
Median length of episode	22

Note: Records where length of episode was greater than 180 days were considered to be atypical and are excluded from the average calculations. Only episodes ending during the reporting period are included.

Table 20 shows a summary of the length of episodes for patients over time.

Table 20: Length of episode (in days) summary over time

Length of episode	Jul-Dec 2023	Jan-Jun 2024	Jul-Dec 2024	Jan-Jun 2025	Jul-Dec 2025	Jan-Jun 2026
Average length of episode	33.3	33.9	31	31.5	28.5	29.4
Median length of episode	24	25	22	23	21	22

Note: Records where length of episode was greater than 180 days were considered to be atypical and are excluded from the average calculations. Only episodes ending during the reporting period are included.

Table 21 details the length of episode. The length of episode is calculated as the number of days between the episode start date and the episode end date. Bereavement phases are excluded from the calculation and episodes that remain open at the end of the reporting period (and hence do not have an episode end date) are also excluded.

Table 21: Length of episode (days)

Length of episode (days)	Consult into RAC	
	N	%
Same day	210	4.8
1 – 2	363	8.2
3 – 4	244	5.5
5 – 7	321	7.3
8 – 14	538	12.2
15 – 21	502	11.4
22 – 30	589	13.4
31 – 60	878	19.9
61 – 90	244	5.5
91 +	514	11.7
Total	4,403	100.0

Note: Only episodes ending during the reporting period are included.

Table 22: How episodes start

Episode start mode	N	%
Admitted from inpatient palliative care	338	8.6
Other^a	3,541	89.6
Not stated/inadequately described	74	1.9
Total	3,953	100.0

Note: Only episodes starting during the reporting period are included.

^a. includes: patient was not transferred from being an overnight patient.

Table 23: How episodes end

Episode end mode	N	%
Admitted for inpatient palliative care	176	4.0
Admitted for inpatient acute care	276	6.3
Admitted to another palliative care service	40	0.9
Admitted to primary health care	1,367	31.0
Discharged/case closure	351	8.0
Death	2,100	47.7
Other	24	0.5
Not stated/inadequately described	69	1.6
Total	4,403	100.0

Note: Only episodes ending during the reporting period are included.

Table 24: How episodes start over time

Episode start mode (%)	Jul-Dec 2023	Jan-Jun 2024	Jul-Dec 2024	Jan-Jun 2025	Jul-Dec 2025	Jan-Jun 2026
Admitted from inpatient palliative care	9.1	9.6	9.7	9.2	9.6	8.6
Other^a	90.2	89.8	89.4	90.0	89.9	89.6
Not stated/inadequately described	0.6	0.7	0.9	0.7	0.5	1.9
Total	100.0	100.0	100.0	100.0	100.0	100.0

Note: Only episodes starting during the reporting period are included.

^a. includes: patient was not transferred from being an overnight admitted palliative care patient.

Table 25: How episodes end over time

Episode end mode (%)	Jul-Dec 2023	Jan-Jun 2024	Jul-Dec 2024	Jan-Jun 2025	Jul-Dec 2025	Jan-Jun 2026
Admitted for inpatient palliative care	6.2	5.6	4.5	3.7	4.3	4.0
Admitted for inpatient acute care	3.6	5.4	5.9	5.7	5.9	6.3
Admitted to another palliative care service	0.4	0.4	0.6	0.9	1.1	0.9
Admitted to primary health care	28.2	28.1	30.9	31.9	31.9	31.0
Discharged/case closure	7.9	8.7	8.4	7.6	8.7	8.0
Death	50.3	48.4	47.8	48.3	45.7	47.7
Other	0.4	0.2	0.6	0.5	0.3	0.5
Not stated/inadequately described	2.9	3.2	1.3	1.5	2.2	1.6
Total	100.0	100.0	100.0	100.0	100.0	100.0

Note: Only episodes ending during the reporting period are included.

5 Profile of palliative care patient assessments

The palliative care profile of patients is determined using five clinical assessment tools which in combination with each other provides a total picture of a patient's trajectory at specific points in time along their journey. These five assessment tools are completed daily for inpatient services, and at each contact for community services. Assessments are reported on admission to the service, at phase change and at discharge from the service. These tools include:

- Palliative Care Phase - an assessment used to identify a clinically meaningful period in a patient's condition. The five Palliative Care Phases are stable, unstable, deteriorating, terminal and bereavement (PCOC does not report on bereavement phases).
- Palliative Care Problem Severity Score (PCPSS) - a clinician rated screening tool to assess the overall severity of problems within four key palliative care domains being pain, other symptoms, psychological/spiritual and family/carer. The scores are 0 - absent, 1 - mild, 2 - moderate and 3 - severe.
- Symptom Assessment Scale (SAS) - a patient (or proxy) rated tool that assesses the level of distress using a numerical rating scale from 0 - no distress to 10 - worst possible distress for seven symptoms (difficulty sleeping, appetite problems, nausea, bowel problems, breathing problems, fatigue and pain).
- Resource Utilisation Groups-Activities of Daily Living (RUG-ADL) - four items (bed mobility, toileting, transfers and eating) to record the level of functional dependence. Domains are scored separately and a total score between 4 and 18 is calculated.
- Australia-modified Karnofsky Performance Status (AKPS) - a measure of overall performance status and ability to perform common tasks relating to activity, work and self care. It is a single score between 0 and 100. PCOC does not report 0 (deceased).

5.1 Phase

The Palliative Care Phase identifies a clinically meaningful period in a patients care. The Palliative Care Phase is determined by a holistic clinical assessment which considers the needs of the patients and their family or carers. The five Palliative Care Phases are stable, unstable, deteriorating, terminal and bereavement (PCOC does not report on bereavement phases). A patient may move back and forth between the phase types based on assessments and clinical care and they may occur in any sequence. See Appendix F for more information on the definition of Palliative Care Phase.

The patients are assessed using the 5 PCOC assessment tools daily in the inpatient units, or at each visit or phone contact in the community, and are reported on admission to the service, at phase changes and at discharge from the service.

Table 26: Number of patient phases by phase type

Phase type	Consult into RAC	
	N	%
Stable	2,700	34.2
Unstable	245	3.1
Deteriorating	3,702	46.9
Terminal	1,247	15.8
Total	7,894	100.0

Note: Bereavement phases have been excluded due to inconsistent data collection and bereavement practices. Bereavement phases are not included in the total phases count.

Table 27: Average phase length (in days) by phase type

Phase type	Consult into RAC
Stable	23.5
Unstable	4.8
Deteriorating	18.2
Terminal	3.0

Note: Phase records where phase length was greater than 90 days were considered to be atypical and are excluded from the average calculations.

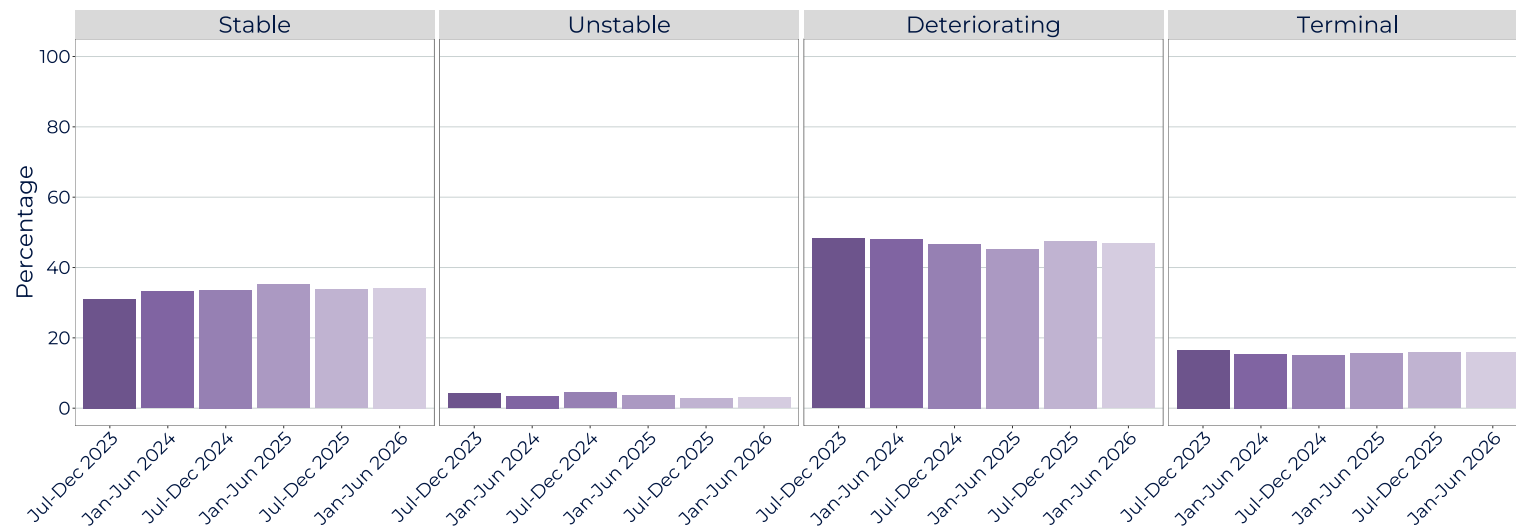


Figure 16: Patient phase profile over time - Consult into RAC setting

Table 28 presents the patients' first phase type for the episode.

Table 28: First phase of episode by setting

Phase type	Consult into RAC	
	N	%
Stable	996	25.2
Unstable	74	1.9
Deteriorating	2,388	60.4
Terminal	495	12.5
Total	3,953	100.0

Note: This table only includes the first phase if the episode has started in the reporting period.

5.2 Palliative Care Problem Severity Score

The Palliative Care Problem Severity Score (PCPSS) is a clinician rated screening tool to assess the overall severity of problems within four key palliative care domains (pain, other symptoms, psychological/spiritual and family/carer). The ratings to assess patients and their family/carer are: 0 – absent, 1 – mild, 2 – moderate and 3 – severe.

Table 29 shows the percentage of phases that were rated absent, mild, moderate and severe at phase start for each key domain.

Table 29: PCPSS at phase start by phase type

Phase type	Problem	Consult into RAC (%)			
		Absent	Mild	Moderate	Severe
Stable	Pain	58.1	39.3	2.5	0.1
	Other symptoms	46.0	51.2	2.7	0.1
	Family/carer	64.4	32.8	2.7	0.0
	Psychological/spiritual	62.5	34.0	3.3	0.1
Unstable	Pain	17.8	27.1	37.9	17.3
	Other symptoms	12.9	27.6	47.1	12.4
	Family/carer	27.8	33.0	33.5	5.7
	Psychological/spiritual	32.1	22.3	38.3	7.3
Deteriorating	Pain	41.2	44.3	13.9	0.7
	Other symptoms	27.3	51.9	19.9	0.9
	Family/carer	46.9	43.5	9.3	0.3
	Psychological/spiritual	40.2	44.4	15.0	0.5
Terminal	Pain	37.7	44.5	16.3	1.5
	Other symptoms	36.0	43.2	19.4	1.5
	Family/carer	64.8	27.1	7.0	1.0
	Psychological/spiritual	33.8	45.8	18.5	1.9

5.3 Symptom Assessment Scale

The Symptom Assessment Scale (SAS) is a patient (or proxy) rated assessment tool and reports a level of distress using a numerical rating scale from 0 - no distress to 10 - worst possible distress. The SAS reports on distress from seven symptoms, these being difficulty sleeping, appetite problems, nausea, bowel problems, breathing problems, fatigue and pain. It provides a clinical picture of these seven symptoms from the patient's perspective. The SAS scores are grouped in Table 30 on the following pages using the same categories as the PCPSS i.e. absent (0), mild (1-3), moderate (4-7) and severe (8-10). Alternative graphical representations of the SAS profile by phase type can be found in Appendix C.

Table 30: Symptom distress at phase start by phase type

Phase type	Problem	Consult into RAC (%)			
		Absent	Mild	Moderate	Severe
Stable	Difficulty sleeping	86.5	12.6	0.9	0.0
	Appetite problems	70.2	27.9	1.8	0.1
	Nausea	92.3	7.1	0.6	0.0
	Bowel problems	82.2	16.2	1.5	0.2
	Breathing problems	78.6	19.3	2.0	0.0
	Fatigue	53.2	42.2	4.4	0.2
	Pain	58.9	37.6	3.4	0.1
Unstable	Difficulty sleeping	64.6	21.7	13.2	0.5
	Appetite problems	49.5	31.2	18.8	0.5
	Nausea	71.0	16.6	10.4	2.1
	Bowel problems	61.4	22.2	13.2	3.2
	Breathing problems	52.6	27.1	18.2	2.1
	Fatigue	32.0	38.5	28.0	1.5
	Pain	18.7	22.0	43.5	15.9
Deteriorating	Difficulty sleeping	81.8	15.5	2.7	0.1
	Appetite problems	54.3	37.9	7.5	0.4
	Nausea	86.2	10.8	2.8	0.2
	Bowel problems	74.4	21.0	4.4	0.2
	Breathing problems	71.7	21.4	6.5	0.4
	Fatigue	37.7	46.6	14.8	0.9
	Pain	42.5	41.9	14.7	0.8
Terminal	Difficulty sleeping	93.1	5.6	1.3	0.1
	Appetite problems	85.7	7.7	5.3	1.3
	Nausea	93.4	4.7	1.9	0.0
	Bowel problems	83.2	13.7	2.5	0.6
	Breathing problems	67.8	23.2	7.7	1.3
	Fatigue	72.6	13.6	10.0	3.9
	Pain	38.2	41.4	19.0	1.4

5.4 Resource Utilisation Groups – Activities of Daily Living

The Resource Utilisation Groups - Activities of Daily Living (RUG-ADL) tool consists of four items to assess the patient's level of functional dependence and give an overall picture of the level of assistance required for patient care. These four items are bed mobility, toileting, transfers and eating. The RUG-ADL items are assessed daily for inpatients, or at each visit or phone contact for patients in the community. The items are reported at admission to the service, when the phase changes and at discharge.

Table 31 summarises the RUG-ADL items at phase start.

Table 31: The Resource Utilisation Groups - Activities of Daily Living (RUG-ADL) at phase start

Item	RUG-ADL assessment at phase start	Consult into RAC	
		N	%
Bed mobility	Independent or supervision only (1)	1,299	17.1
	Limited physical assistance (3)	1,020	13.4
	Other than two person physical assist (4)	1,069	14.0
	Two or more person physical assist (5)	4,226	55.5
Toileting	Independent or supervision only (1)	769	10.1
	Limited physical assistance (3)	1,014	13.3
	Other than two person physical assist (4)	1,389	18.3
	Two or more person physical assist (5)	4,435	58.3
Transfers	Independent or supervision only (1)	811	10.7
	Limited physical assistance (3)	982	12.9
	Other than two person physical assist (4)	1,362	17.9
	Two or more person physical assist (5)	4,443	58.5
Eating	Independent or supervision only (1)	2,291	30.5
	Limited physical assistance (2)	1,770	23.6
	Extensive assistance/total dependence/tube fed (3)	3,452	45.9

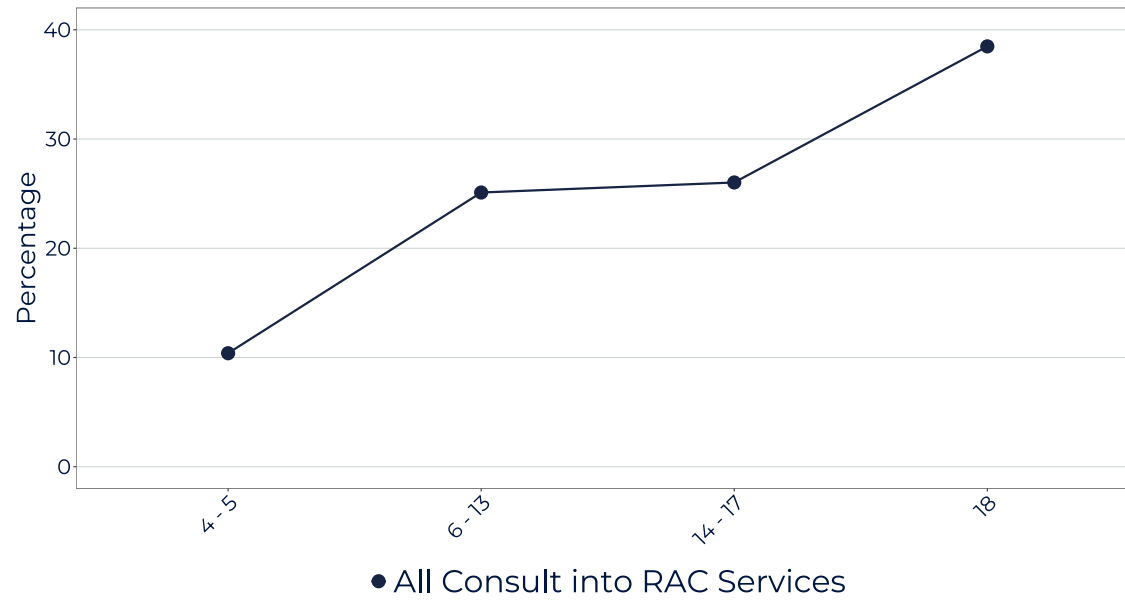


Figure 17: Distribution of patient's RUG-ADL Total at episode start

5.5 Australia-modified Karnofsky Performance Status

The Australia-modified Karnofsky Performance Status (AKPS) is a measure of the patient's overall performance status or ability to perform their activities of daily living. It is a single score between 0 (deceased) and 100 (normal performance, no evidence of disease). For PCOC, patients are assessed from 10 (comatose or barely rousable) to 100. The AKPS is assigned by a clinician based on observations of a patient's ability to perform common tasks relating to activity, work and self-care. It is recorded as part of the five PCOC assessment tools.

Table 32 shows the performance status of patients using the AKPS at phase start.

Table 32: Australia-modified Karnofsky Performance Status (AKPS) at phase start

AKPS assessment at phase start	Consult into RAC	
	N	%
Comatose or barely rousable (10)	825	10.5
Totally bedfast and requiring extensive nursing care (20)	1,979	25.1
Almost completely bedfast (30)	1,184	15.0
In bed more than 50% of the time (40)	1,466	18.6
Requires considerable assistance (50)	1,839	23.3
Requires occasional assistance (60)	317	4.0
Cares for self (70)	35	0.4
Normal activity with effort (80)	17	0.2
Able to carry on normal activity; minor signs or symptoms (90)	5	0.1
Normal; no complaints; no evidence of disease (100)	0	0.0
Not stated/inadequately described^a	227	2.9
Total	7,894	100.0

Note: ^a This may include a small number of phases with AKPS assessment at phase start being Normal activity with effort (80) that have been mapped to an invalid score.

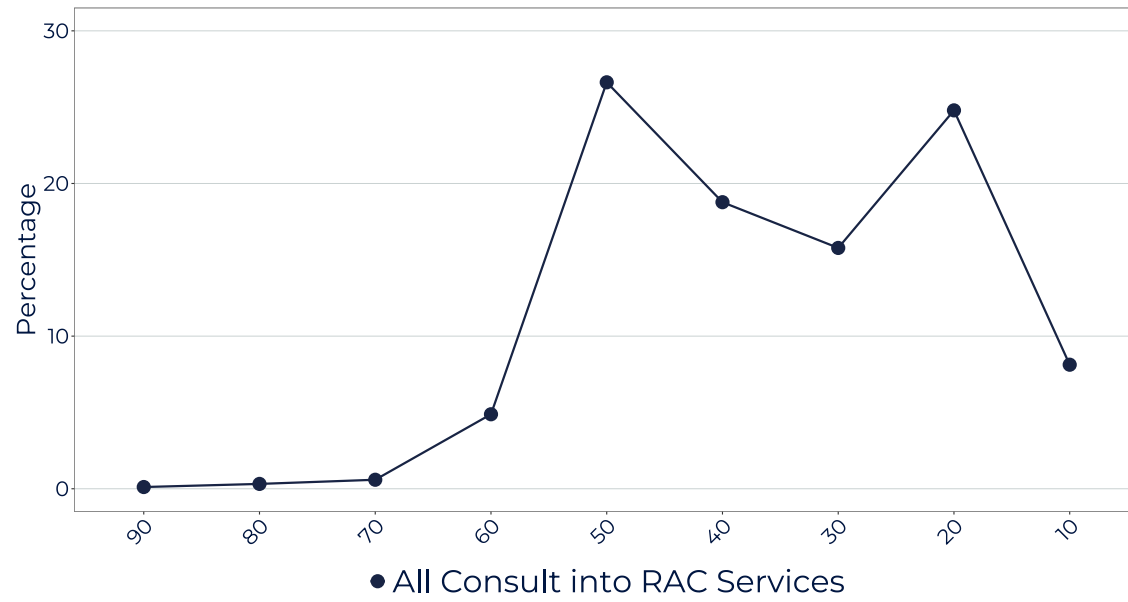


Figure 18: Distribution of AKPS for patients at episode start

Appendices

A Summary of data included in this report

During the reporting period, data were provided for a total of 42,545 patients who between them had 52,790 episodes of care and 108,712 Palliative Care Phases. These total numbers are determined by a data scoping method. This method looks at the phase level data first and includes all phases that ended within the current reporting period. The associated episodes and patients are then determined (Appendix D contains a more detailed explanation of this process). Table 33 shows the number of patients, episodes and phases included in this report.

Table 33: Summary of patients, episodes and phases by setting

	Phase type	Consult into RAC
	Patients (N)	4,580
	Episodes (N)	4,932
	Phases^a (N)	7,894
	Patients (%)	10.8
	Episodes (%)	9.3
	Phases^a (%)	7.3
	Average number of phases per episode^b	1.5

a. Bereavement phases are excluded from this count.

b. Average number of phases per episode is only calculated for closed episodes that started and ended within the reporting period and excludes bereavement phases.

Table 34 shows the number of completed episodes and phases by setting of care for each month in the current reporting period.

Table 34: Number of completed episodes and phases by month

		Jan	Feb	Mar	Apr	May	Jun
Consult into RAC	Completed episodes (N)	721	635	798	734	761	754
	Completed phases (N)	1,273	1,166	1,432	1,359	1,324	1,340

Table 35 shows the number of patients, episodes and phases over time and is reported by setting of care.

Table 35: Number of patients, episodes and phases by reporting period

	Consult into RAC					
	Jul-Dec 2023	Jan-Jun 2024	Jul-Dec 2024	Jan-Jun 2025	Jul-Dec 2025	Jan-Jun 2026
Patients	4,475	4,680	4,715	4,633	5,132	4,580
Episodes	4,821	5,058	5,092	4,965	5,566	4,932
Phases^a	8,008	8,331	8,459	8,081	8,872	7,894
Phases per episode^b	1.6	1.6	1.6	1.5	1.5	1.5

^a. Bereavement phases are excluded from this count.

^b. Average number of phases per episode is only calculated for closed episodes that started and ended within the reporting period and excludes bereavement phases.

B Data item completion

Table 36, Table 37, Table 38 and Table 39 report the rate of data completion. In reviewing the tables the percentage represents the number of valid records as a proportion of the number of records where the data item was relevant. For example, place of death is only required for episodes that end in death - episodes that end in discharge will not have a place of death.

PCOC strongly encourages services to complete and submit the whole data set on every patient as non-completion may result in services being excluded from relevant benchmarking activities or erroneous conclusions being drawn. Low completion of data items may also distort percentages and graphs in some sections.

Table 36: Item completion (%) - patient level

Data item	% completion
Date of birth	100.0
Sex	100.0
Country of birth	98.1
Preferred language	98.9
Diagnosis	99.3

Table 37: Item completion (%) - episode level

Data item	Consult into RAC
Date of first contact	99.1
Referral date	99.9
Referral source	99.9
Date ready for care	96.9
Mode of episode start	98.4
Accommodation at episode start	99.8
Episode end date^a	90.9
Mode of episode end	98.4
Accommodation at episode end	98.9

^a. Episode end date item completion may be affected by open episodes.

Table 38: Item completion (%) - phase level

Data item	Sub-Category (where applicable)	At phase start	At discharge
		Consult into RAC	Consult into RAC
RUG-ADL	Bed mobility	96.5	78.5
	Toileting	96.4	78.8
	Transfers	96.3	78.5
	Eating	95.2	78.4
PCPSS	Pain	97.0	78.8
	Other symptoms	87.0	59.1
	Psychological/spiritual	94.9	77.1
	Family/carer	75.6	44.7
SAS	Difficulty sleeping	92.7	76.7
	Appetite problems	94.0	77.7
	Nausea	93.8	77.3
	Bowel problems	93.3	77.3
	Breathing problems	94.0	77.8
	Fatigue	94.2	77.6
	Pain	96.1	78.4
AKPS	-	97.1	79.1

Table 39: Item completion (%) - phase end

Data item	Consult into RAC
Phase End Reason	98.1

C Profile of patient symptoms and problems

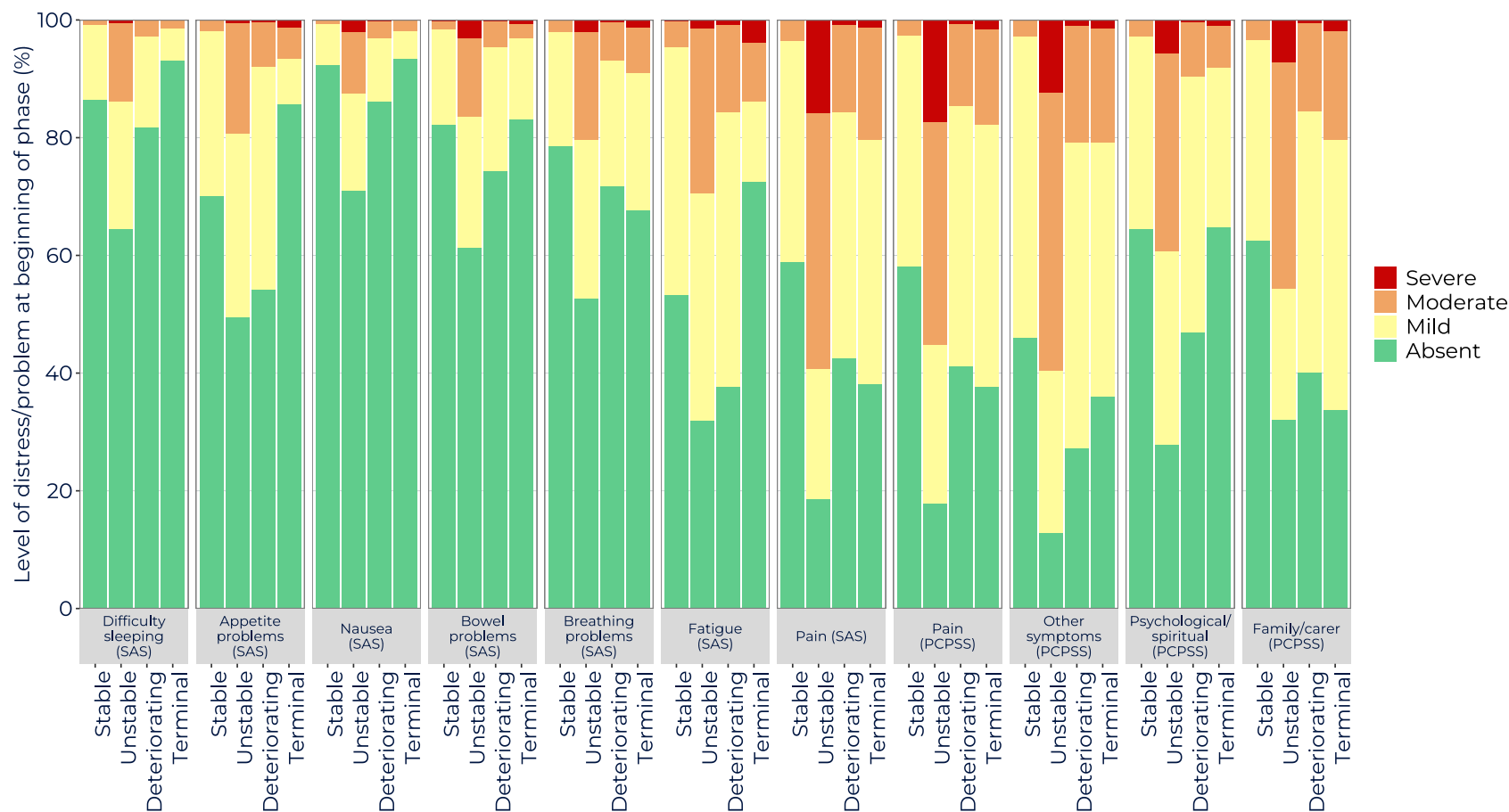


Figure 19: Profile of symptoms and problems by phase type for AUS- consult into RAC setting

D Data scoping method

The method used to determine which data is included in a PCOC report looks at the phase level records first. All phase records that end within the 6 month reporting period are deemed to be in scope and would be included in the report. The episode and patient records associated with these phases are also deemed to be in scope and hence would also be included in the report. Figure 20 below displays four examples to help visualise this process.

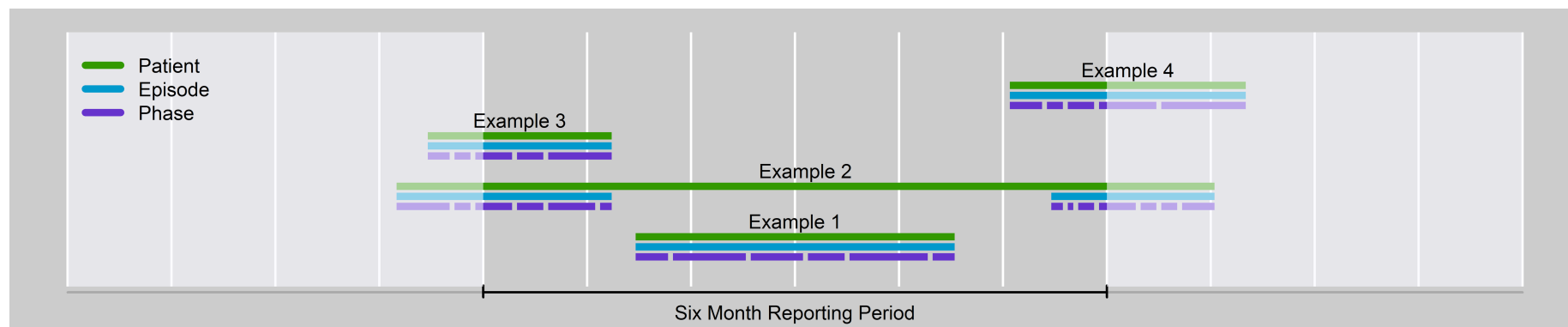


Figure 20: Diagram of the PCOC data scoping method

In Example 1, the patient (represented by the green line) has one episode (represented by the blue line). This episode has six phases (represented by the purple line segments). All six phases would be included in the report as they all end within the reporting period. Hence, the episode and patient would also be in the report.

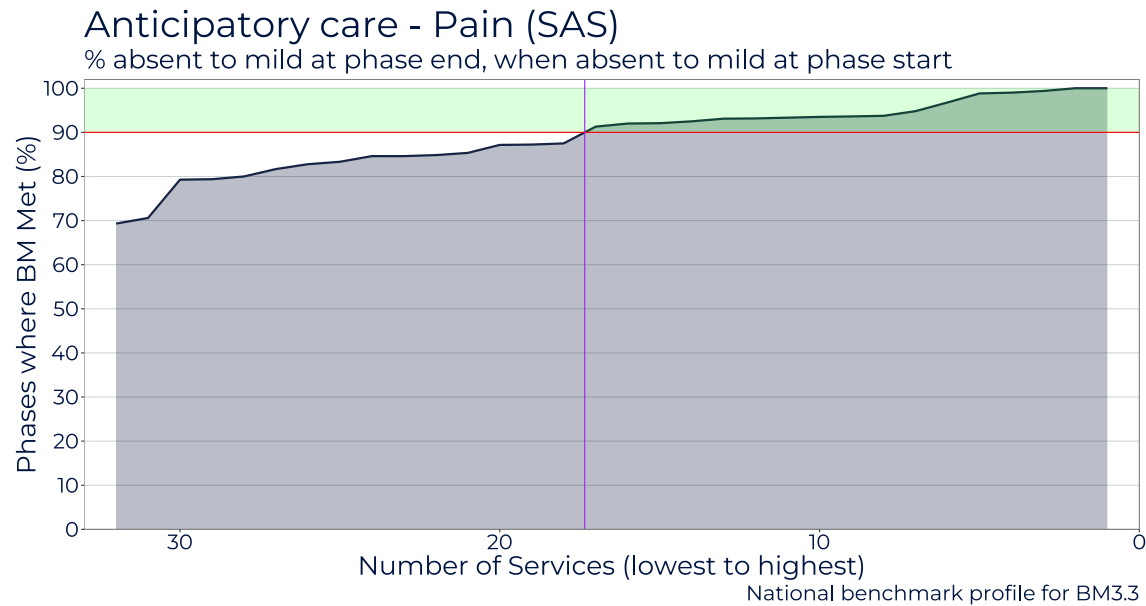
In Example 2, the patient has two episodes – the first having six phases and the second having seven phases. Looking at the phases associated with the first episode, the last four will be included in the report (as they end within the reporting period). The first two phases would have been included in the previous report. For the phases relating to the second episode, only the first three end within the reporting period, so only these would be included in the report. The following four phases would be included in the next report. Both of the episode records and the patient record would also be included in the report.

In Example 3, the patient has one episode and five phases. Only the last three phases will be included in the report as they are the only ones ending within the reporting period (the first two phases would have been included in the previous report). The episode and patient records would be included in the report.

In Example 4, the patient again has one episode and five phases. This time, only the first three phases will be included in the report (the last two phases will be included in the next report). Again, the episode and patient records would be included in the report.

E Interpreting benchmark profile graphs

The national profile graphs present AUS in comparison to all other palliative care services participating in PCOC. In each graph, the gray shaded region describes the national profile for that outcome measure.



- The red line indicates the benchmark for this outcome measure.
- The gray region indicates the national profile. This contains all services across the country that have contributed to this benchmark ordered from the lowest percentage of phases meeting the BM to the highest percentage. The lowest percentage is on the left side of the graph and the highest percentage is on the right side of the graph.
- The green region contains the services that met this benchmark.
- The purple line indicates the number of services that met the benchmark.

F Palliative Care Phase definitions

Phase type	Start	End
Stable	• Patient problems and symptoms are adequately controlled by established plan of care and • Further interventions to maintain symptom control and quality of life have been planned and • Family/carer situation is relatively stable and no new issues are apparent.	• The needs of the patient and/or family/carer increase, requiring changes to the existing plan of care.
Unstable	An urgent change in the plan of care or emergency treatment is required because • Patient experiences a new problem that was not anticipated in the existing plan of care, and/or • Patient experiences a rapid increase in the severity of a current problem; and/or • Family/carers circumstances change suddenly impacting on patient care.	• The new plan of care is in place, it has been reviewed and no further changes to the care plan are required. This does not necessarily mean that the symptom/crisis has fully resolved but there is a clear diagnosis and plan of care (i.e. patient is stable or deteriorating) and/or • Death is likely within days (i.e. patient is now terminal).
Deteriorating	The care plan is addressing anticipated needs but requires periodic review because • Patients overall functional status is declining and/or • Patient experiences a gradual worsening of existing problem and/or • Patient experiences a new but anticipated problem and/or • Family/carers experience gradual worsening distress that impacts on the patient care.	• Patient condition plateaus (i.e. patient is now stable) or • An urgent change in the care plan or emergency treatment and/or • Family/carers experience a sudden change in their situation that impacts on patient care, and urgent intervention is required (i.e. patient is now unstable) or • Death is likely within days (i.e. patient is now terminal).
Terminal	Death is likely within days.	• Patient dies or • Patient condition changes and death is no longer likely within days (i.e. patient is now stable or deteriorating).