



The Palliative Care Outcomes Collaboration

National Outcome Report - January to June 2026

Inpatient and Non-admitted Setting

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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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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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.

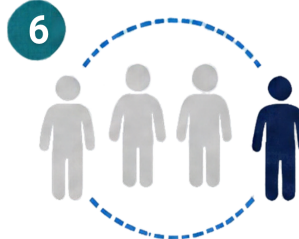
3



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.

Inpatient data include care provided in palliative care wards and through consult-liaison services. Meanwhile, non-admitted data include care provided in private residences, through specialist palliative care consultations in residential aged care facilities (RACFs), and in outpatient clinics.

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

1 Benchmark Summary for AUS

Table 1: Summary of outcome measures by setting of care

Category	Outcome Measure	Benchmark	Inpatient		Non-admitted		Benchmark Reference Number
			%	BM Met	%	BM Met	
Timely commencement of palliative care							
	Care commencing within two days of the patient being ready	90%	96.7	Yes	84.3	No	1
Responsiveness in managing patients with urgent needs							
	Patients unstable for three days or less	90%	86.7	No	80.1	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%	91.3	Yes	85.8	No	3.1
	Pain (patient reported)		90.7	Yes	84.6	No	3.3
	Fatigue (patient reported)		93.3	Yes	83.2	No	3.5
	Breathing problems (patient reported)		96.1	Yes	93.0	Yes	3.7
	Family/carer problems (clinician reported)		93.6	Yes	84.8	No	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%	64.2	Yes	57.8	No	3.2
	Pain (patient reported)		62.3	Yes	54.4	No	3.4
	Fatigue (patient reported)		62.6	Yes	46.2	No	3.6
	Breathing problems (patient reported)		62.1	Yes	50.2	No	3.8
	Family/carer problems (clinician reported)		59.2	No	50.7	No	3.10
Casemix adjusted outcomes (change scores)		Baseline	Score		Score		
Clinician Reported Problems (PCPSS)	Pain	0.0	0.10	Yes	-0.03	No	4.1
	Other Symptoms		0.27	Yes	0.04	Yes	4.2
	Family/Carer Problems		0.24	Yes	0.07	Yes	4.3
	Psychological/Spiritual Problems		0.24	Yes	0.08	Yes	4.4
Patient Reported System Distress (SAS)	Pain	0.0	0.29	Yes	-0.08	No	4.5
	Nausea		0.20	Yes	-0.01	No	4.6
	Breathing Problems		0.31	Yes	0.07	Yes	4.7
	Bowel Problems		0.31	Yes	0.05	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 2: Time from date patient is ready for care to episode start by setting of care

Time (in days)	Inpatient		Non-admitted	
	N	%	N	%
Same day	21,946	91.8	14,980	79.0
Following day	1,170	4.9	999	5.3
2-7	686	2.9	1,777	9.4
8-14	51	0.2	633	3.3
15+	60	0.3	562	3.0
Average	1.2	-	2.7	-
Median	1	-	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.

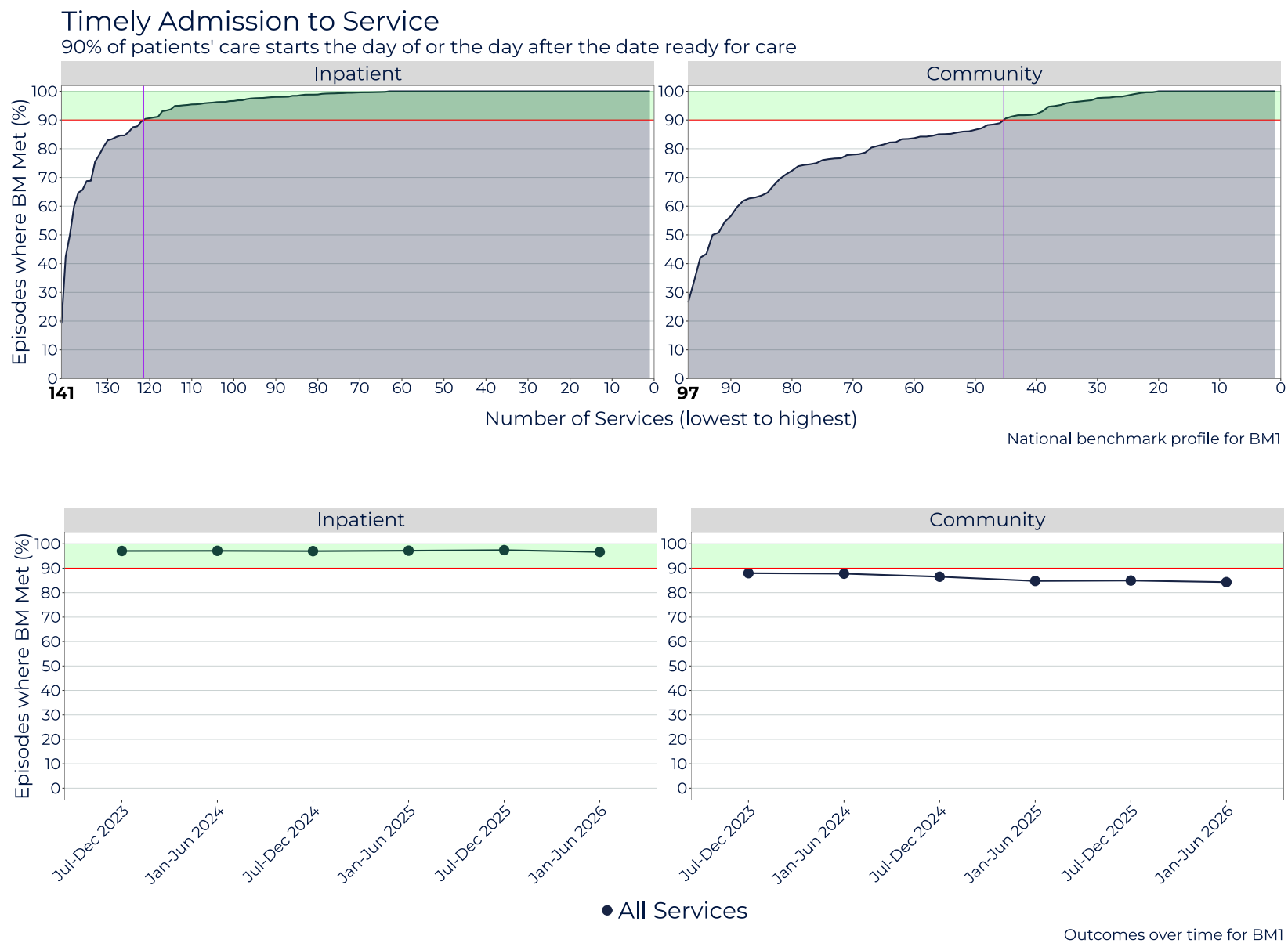


Figure 1: Time from date patient is ready for care to episode start (BM1)

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

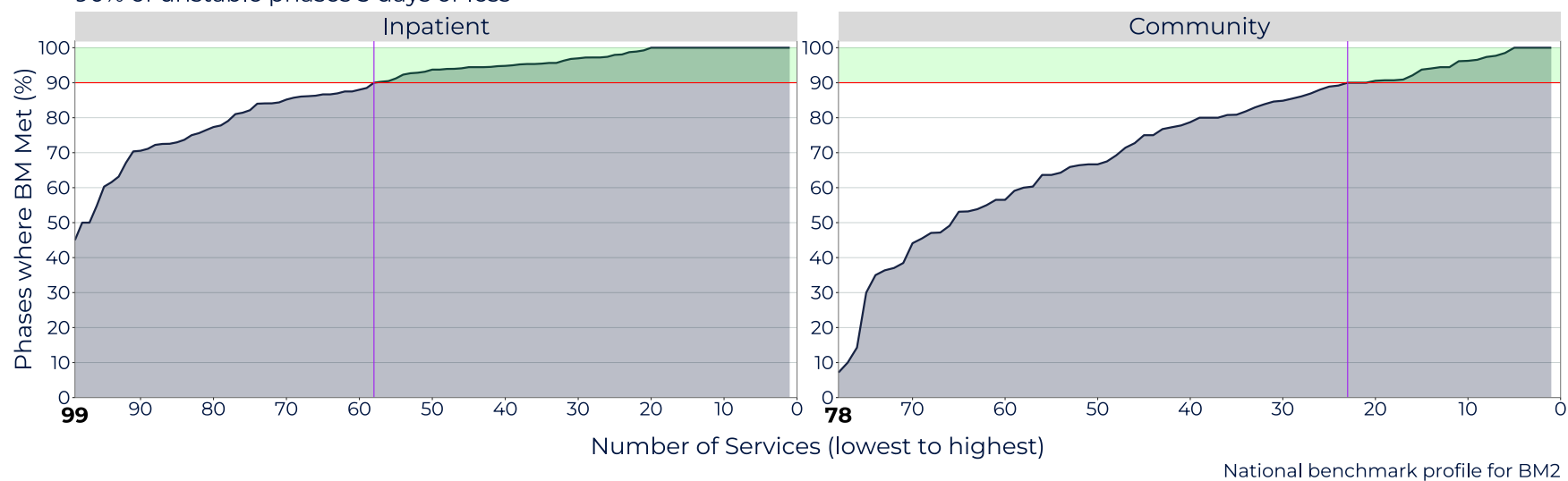
This benchmark relates to the time that a patient spends in the unstable phase. To meet this benchmark, at least 90% of unstable phases must last for three days or less.

Table 3: Time in unstable phase by setting of care

Time in Unstable Phase	Inpatient		Community	
	N	%	N	%
Same day	597	9.1	1,425	33.0
1 day	3,427	52.2	1,359	31.4
2 days	1,080	16.5	437	10.1
3 days	587	8.9	244	5.6
4-5 days	453	6.9	231	5.3
6-7 days	199	3.0	181	4.2
8-14 days	165	2.5	195	4.5
15+ days	53	0.8	251	5.8
Total	6,561	100.0	4,323	100.0

Responsiveness to urgent needs

90% of unstable phases 3 days or less



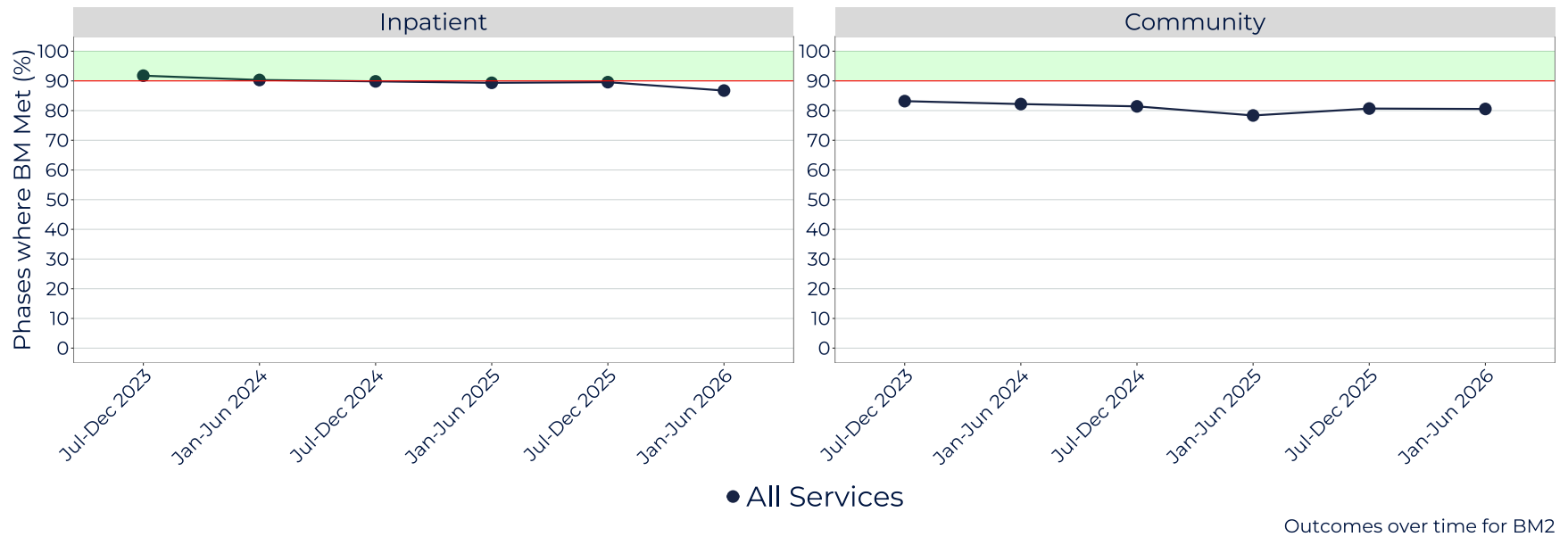


Figure 2: Time in unstable phase (BM2)

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/carer 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 4 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 4: Achieving absent to mild symptoms/problems at phase end, when absent to mild at start

Symptom/Problem ^a	Inpatient		Non-admitted	
	N ^b	%	N ^b	%
Pain (clinician reported)	28,199	91.3	30,873	85.8
Pain (patient reported)	24,928	90.7	30,545	84.6
Fatigue (patient reported)	26,015	93.3	27,602	83.2
Breathing problems (patient reported)	28,103	96.1	32,510	93.0
Family/carer problems (clinician reported)	28,173	93.6	28,079	84.8

^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/carer, 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 5 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 5: Achieving absent to mild symptoms/problems at phase end, when moderate to severe at start

Symptom/Problem ^a	Inpatient		Non-admitted	
	N ^b	%	N ^b	%
Pain (clinician reported)	6,168	64.2	6,829	57.8
Pain (patient reported)	6,036	62.3	7,634	54.4
Fatigue (patient reported)	4,709	62.6	9,251	46.2
Breathing problems (patient reported)	2,721	62.1	4,009	50.2
Family/carer problems (clinician reported)	3,516	59.2	6,246	50.7

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.

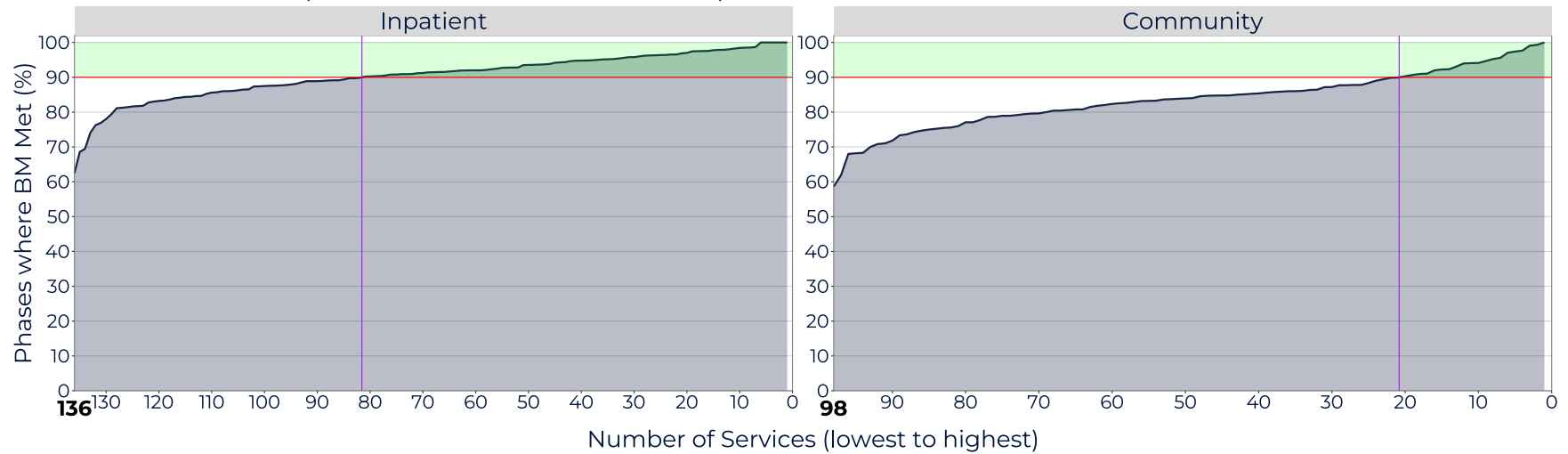
b. N represents the total number of phases starting with the symptom or problem rated **moderate to severe**.

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.

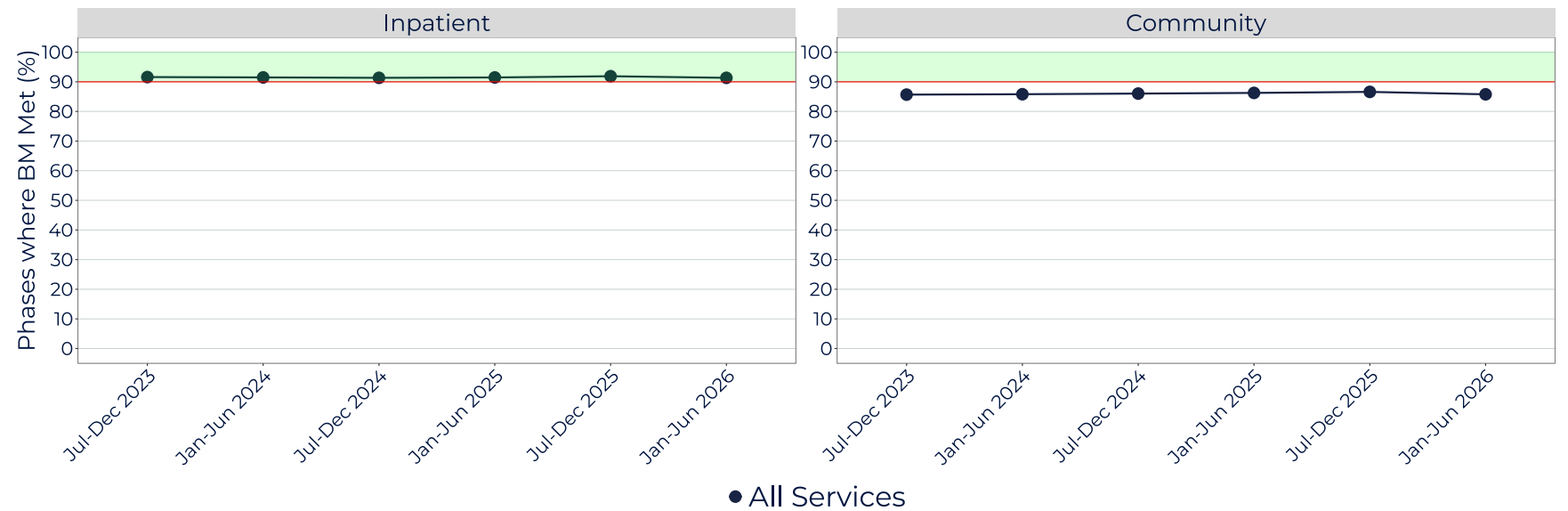
For a guide on how to interpret these graphs, see Appendix E.

Anticipatory care - Pain (PCPSS)

% absent to mild at phase end, when absent to mild at phase start



National benchmark profile for BM3.1



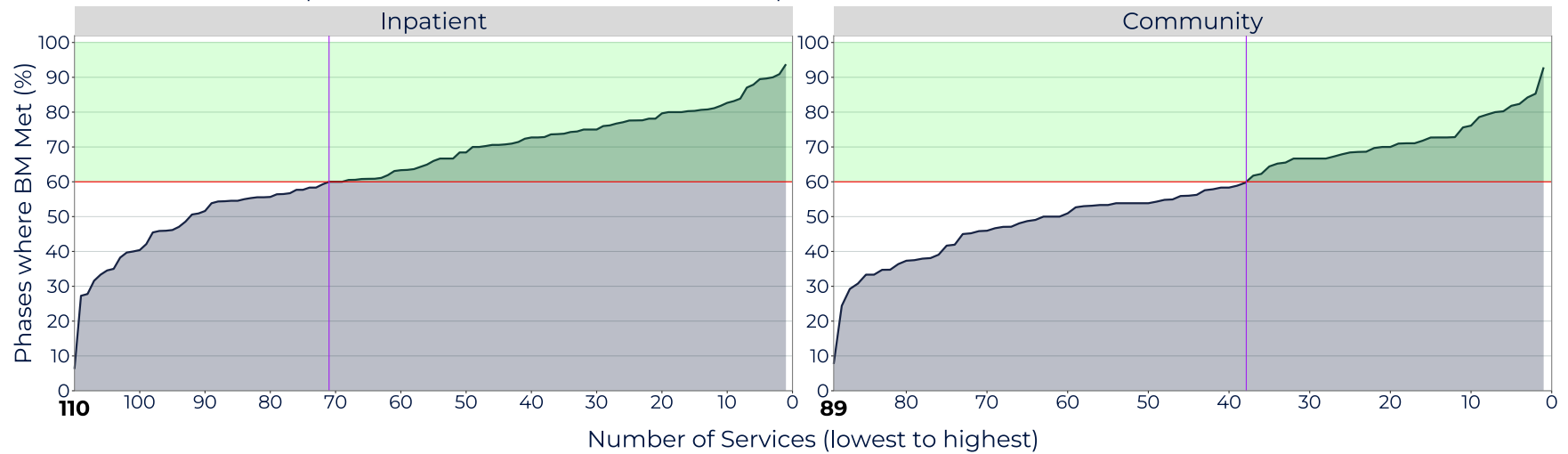
• All Services

Outcomes over time for BM3.1

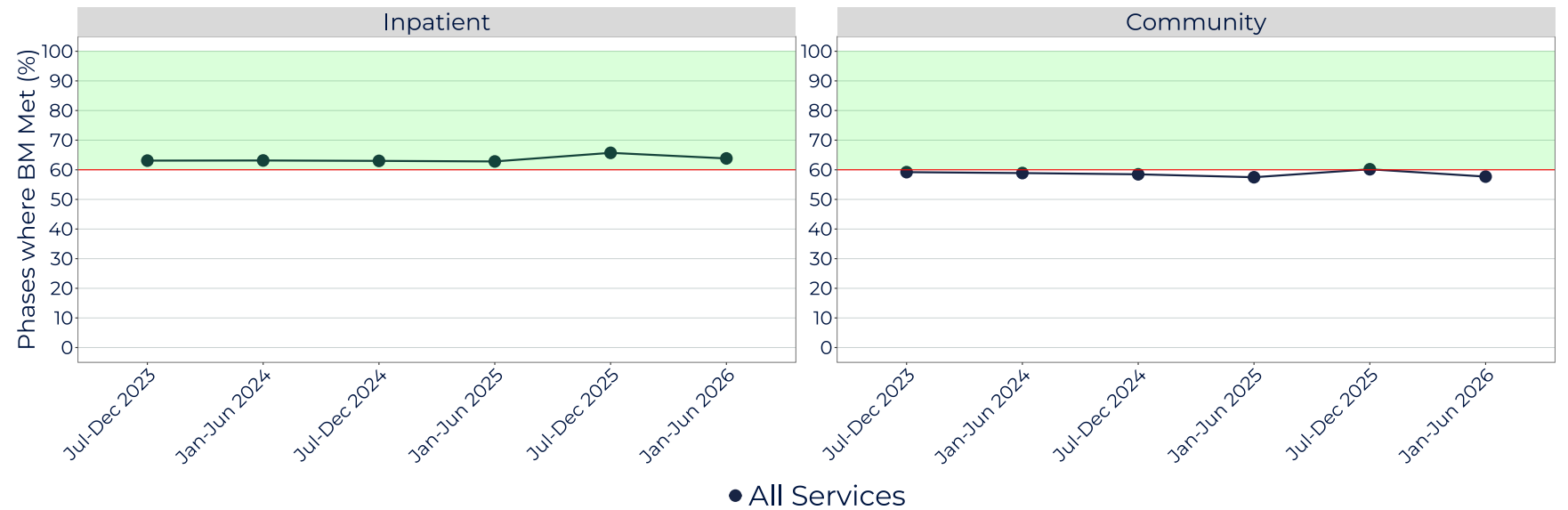
Figure 3: Pain, patients assessed with absent to mild severity at phase end (anticipatory)

Responsive care - Pain (PCPSS)

% absent to mild at phase end, when moderate to severe at phase start



National benchmark profile for BM3.2



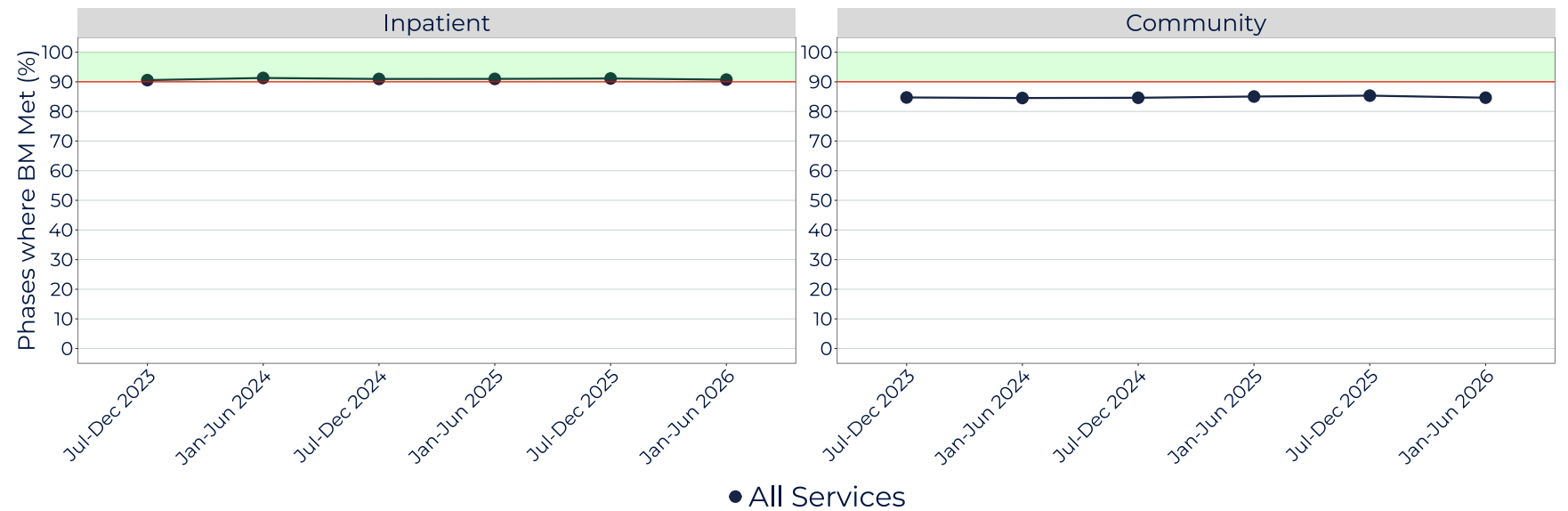
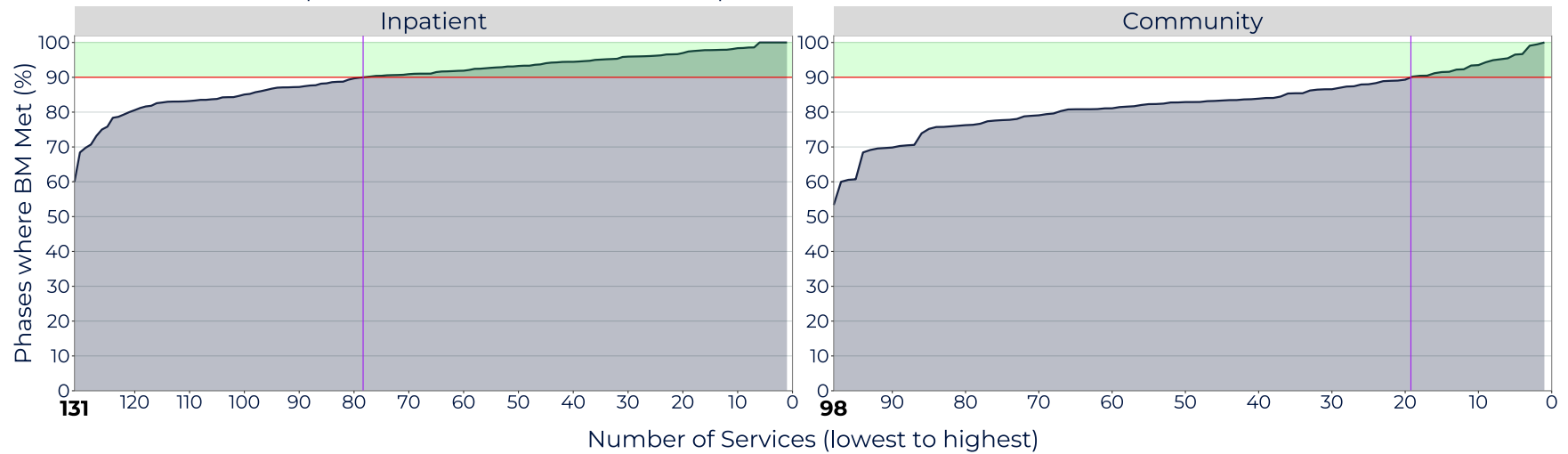
• All Services

Outcomes over time for BM3.2

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

Anticipatory care - Pain (SAS)

% absent to mild at phase end, when absent to mild at phase start

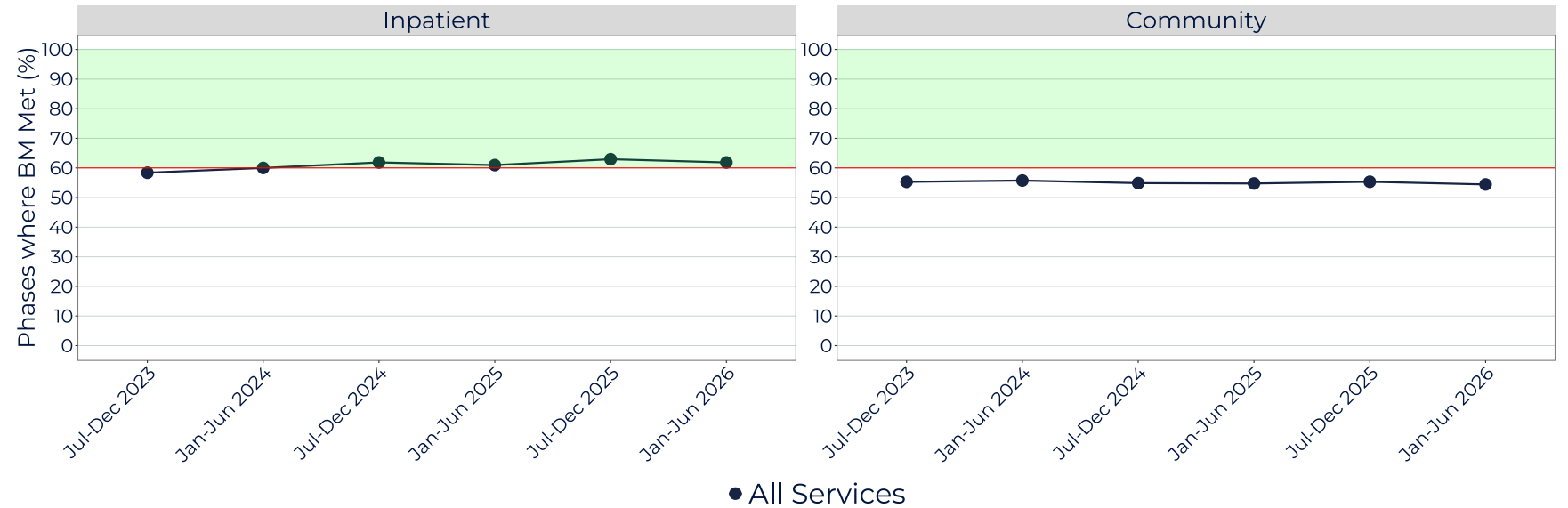
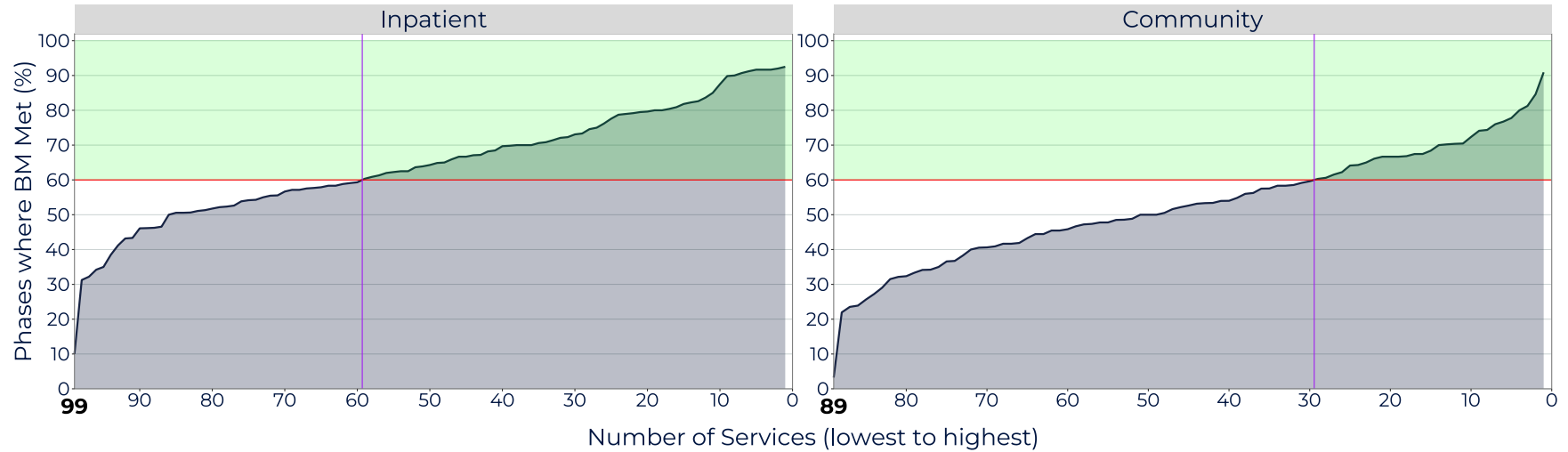


Outcomes over time for BM3.3

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

Responsive care - Pain (SAS)

% absent to mild at phase end, when moderate to severe at phase start

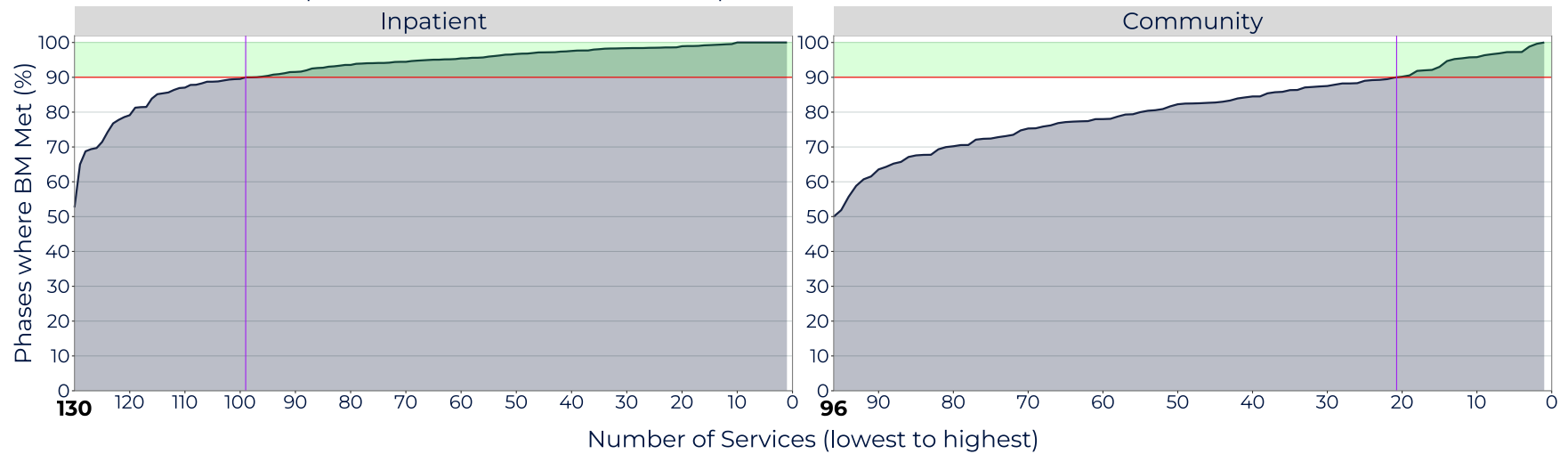


Outcomes over time for BM3.4

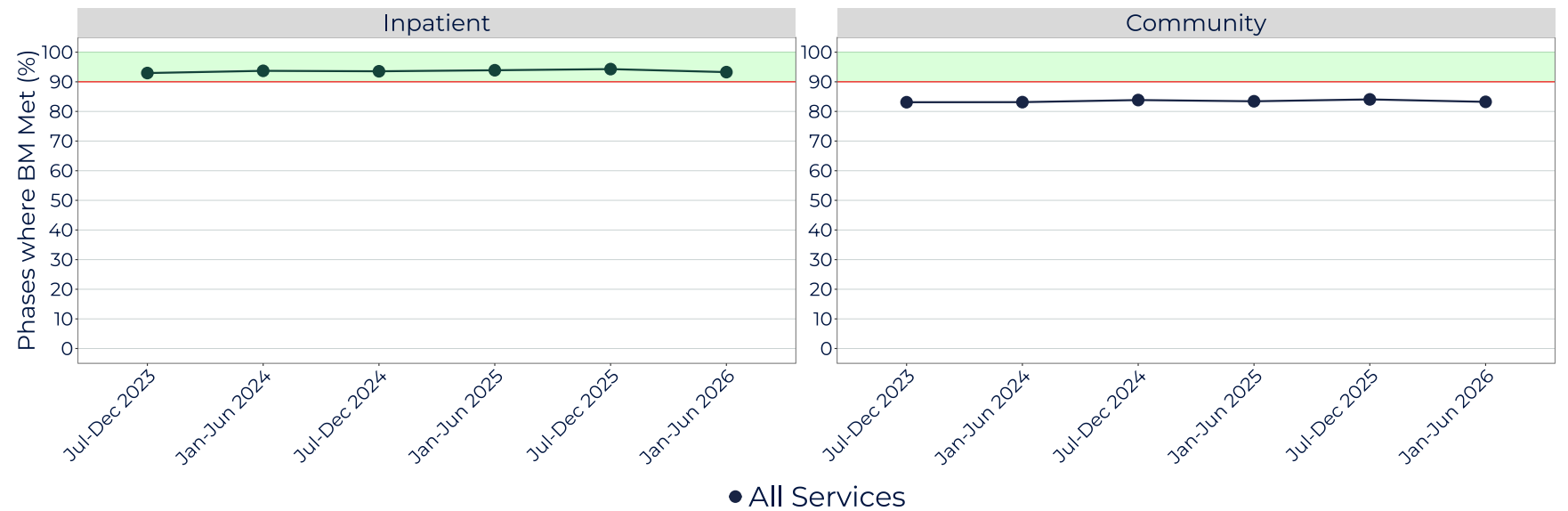
Figure 6: Pain, patients reporting absent to mild distress at phase end (responsive)

Anticipatory care - Fatigue (SAS)

% absent to mild at phase end, when absent to mild at phase start



National benchmark profile for BM3.5

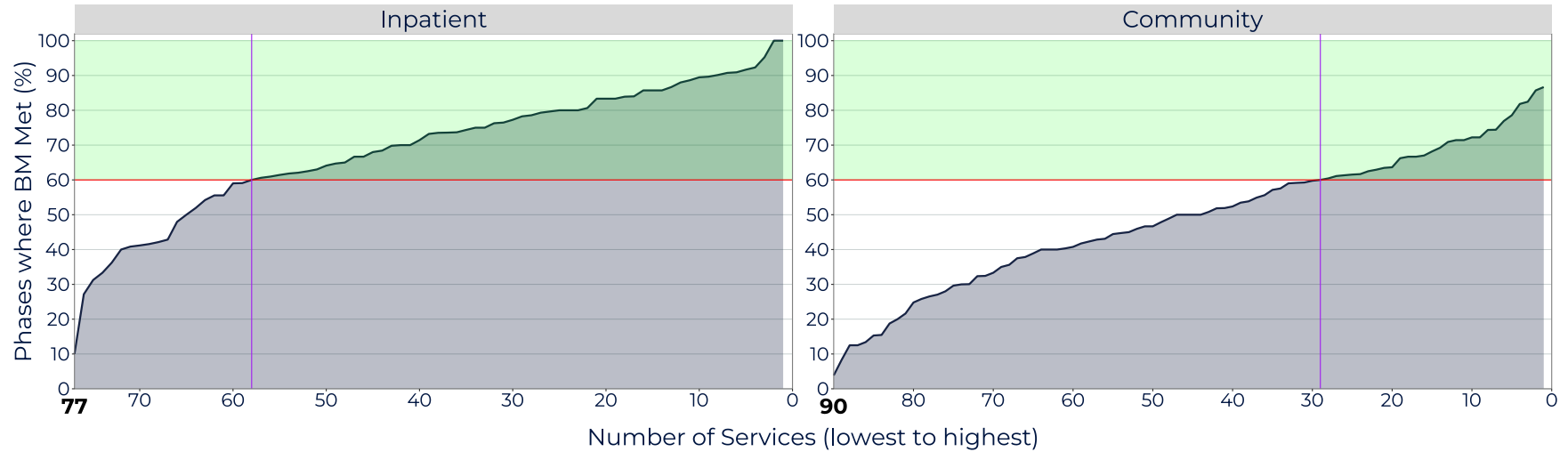


Outcomes over time for BM3.5

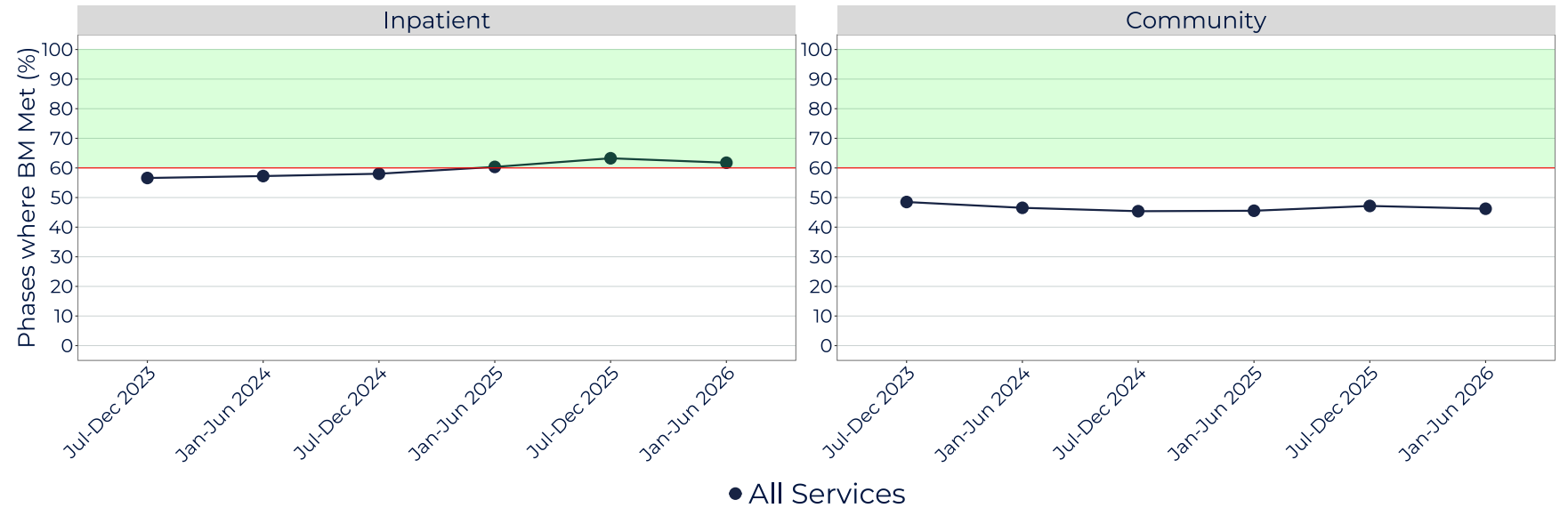
Figure 7: Fatigue, patients reporting absent to mild distress at phase end (anticipatory)

Responsive care - Fatigue (SAS)

% absent to mild at phase end, when moderate to severe at phase start



National benchmark profile for BM3.6

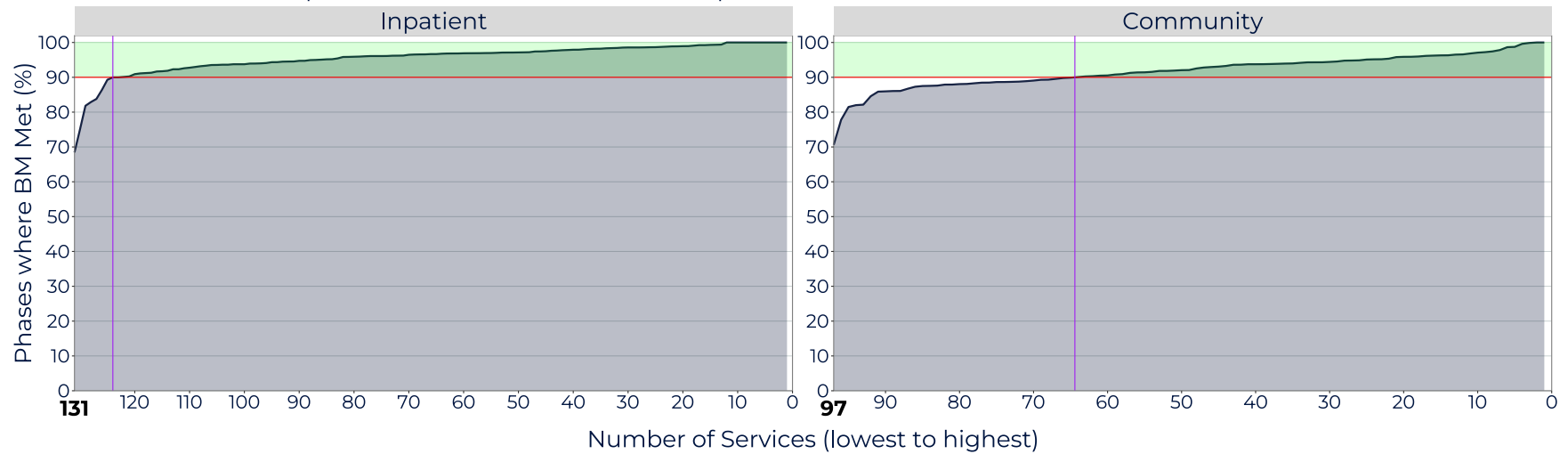


Outcomes over time for BM3.6

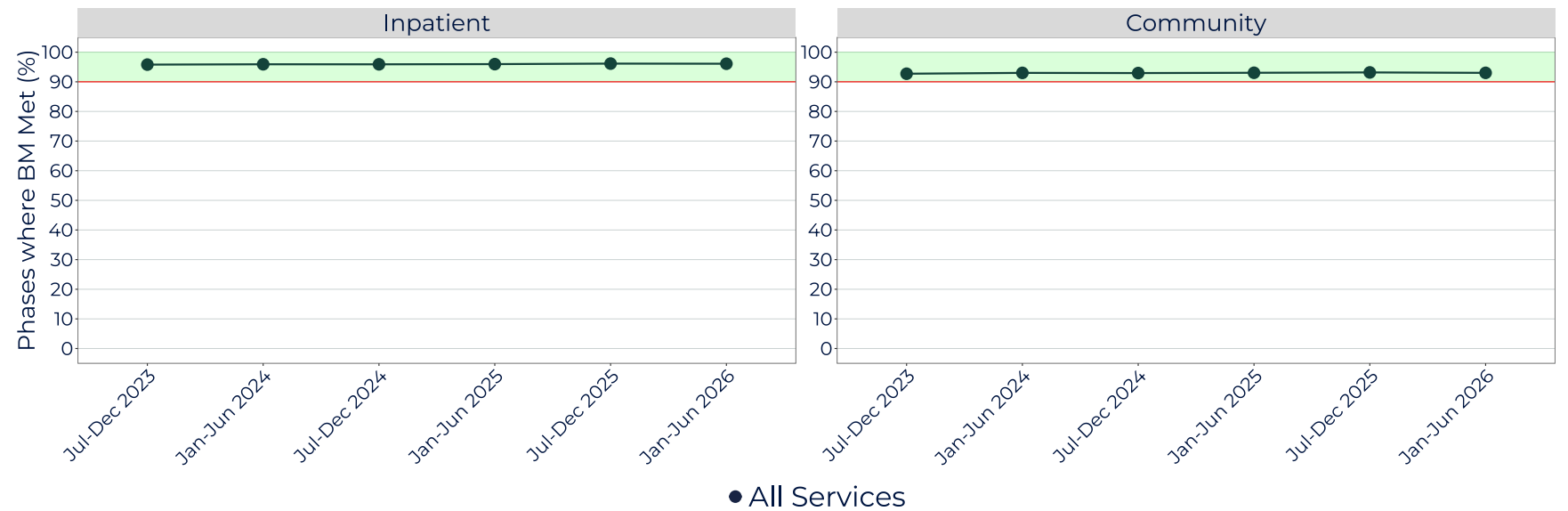
Figure 8: Fatigue, patients reporting absent to mild distress at phase end (responsive)

Anticipatory care - Breathing problems (SAS)

% absent to mild at phase end, when absent to mild at phase start



National benchmark profile for BM3.7



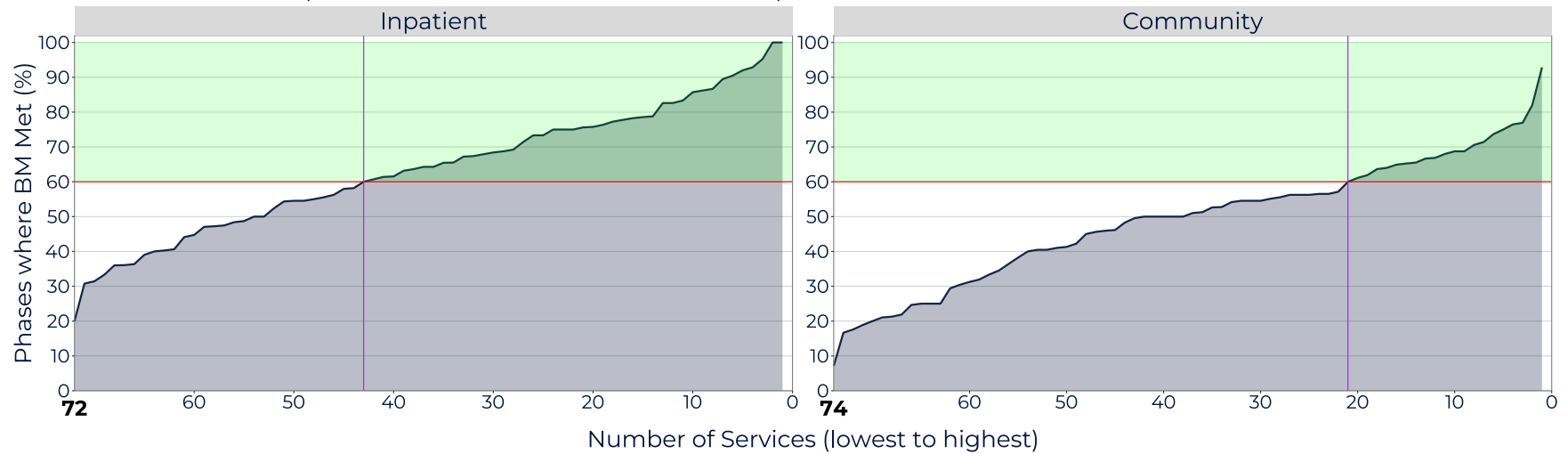
• All Services

Outcomes over time for BM3.7

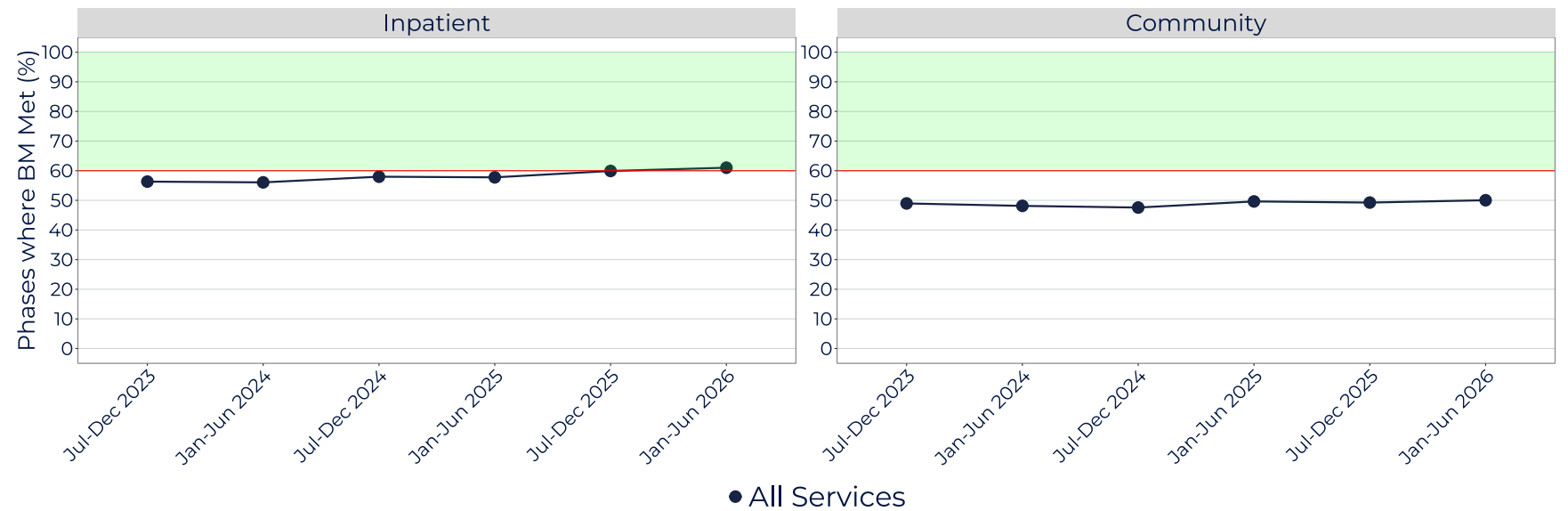
Figure 9: Breathing problems, patients reporting absent to mild distress at phase end (anticipatory)

Responsive care - Breathing problems (SAS)

% absent to mild at phase end, when moderate to severe at phase start



National benchmark profile for BM3.8

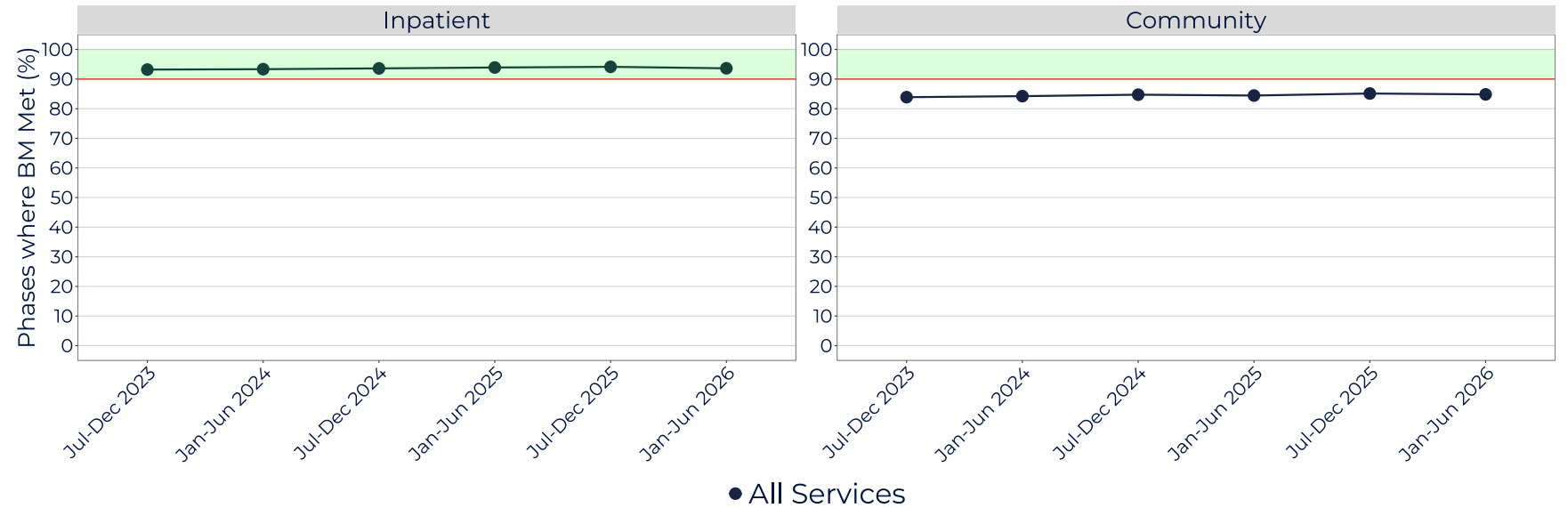
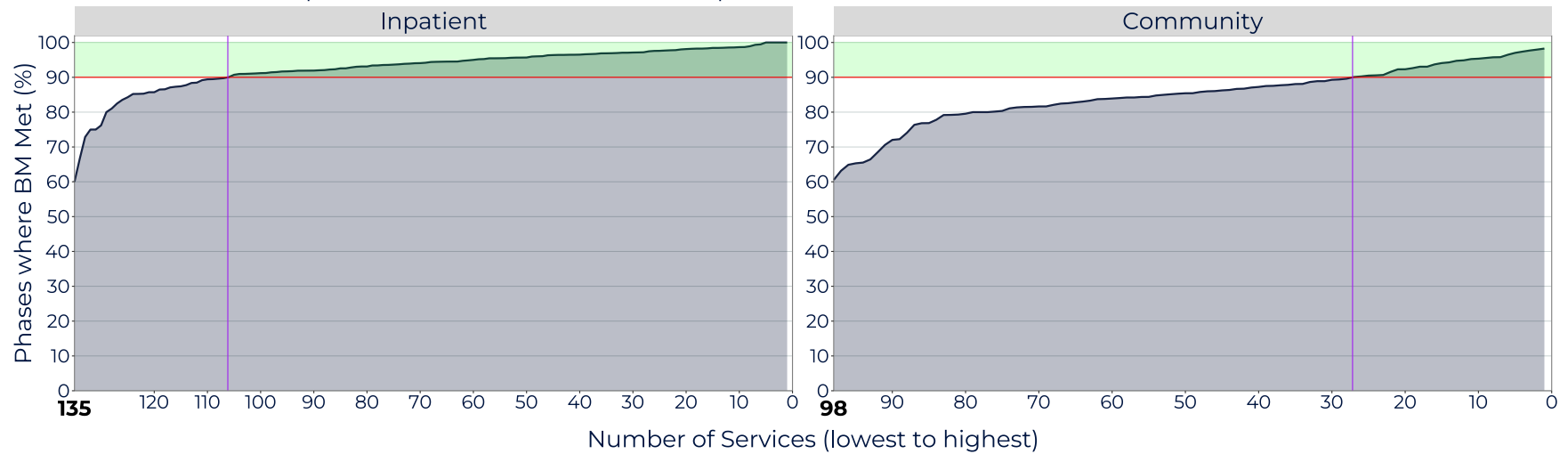


Outcomes over time for BM3.8

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

Anticipatory care - Family/carer problems (PCPSS)

% absent to mild at phase end, when absent to mild at phase start

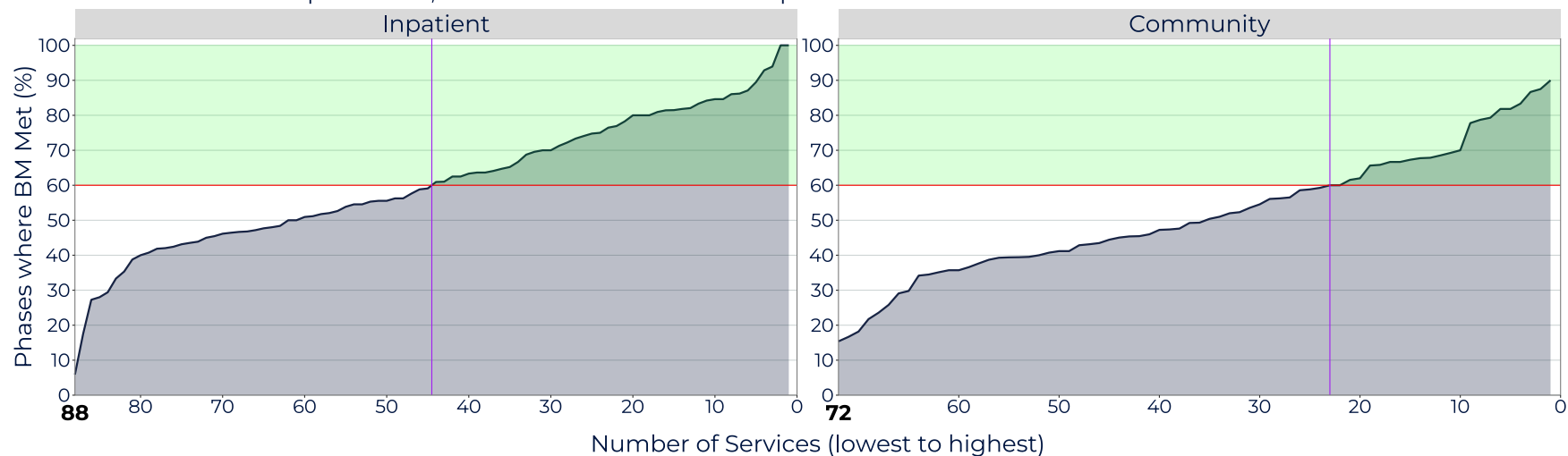


Outcomes over time for BM3.9

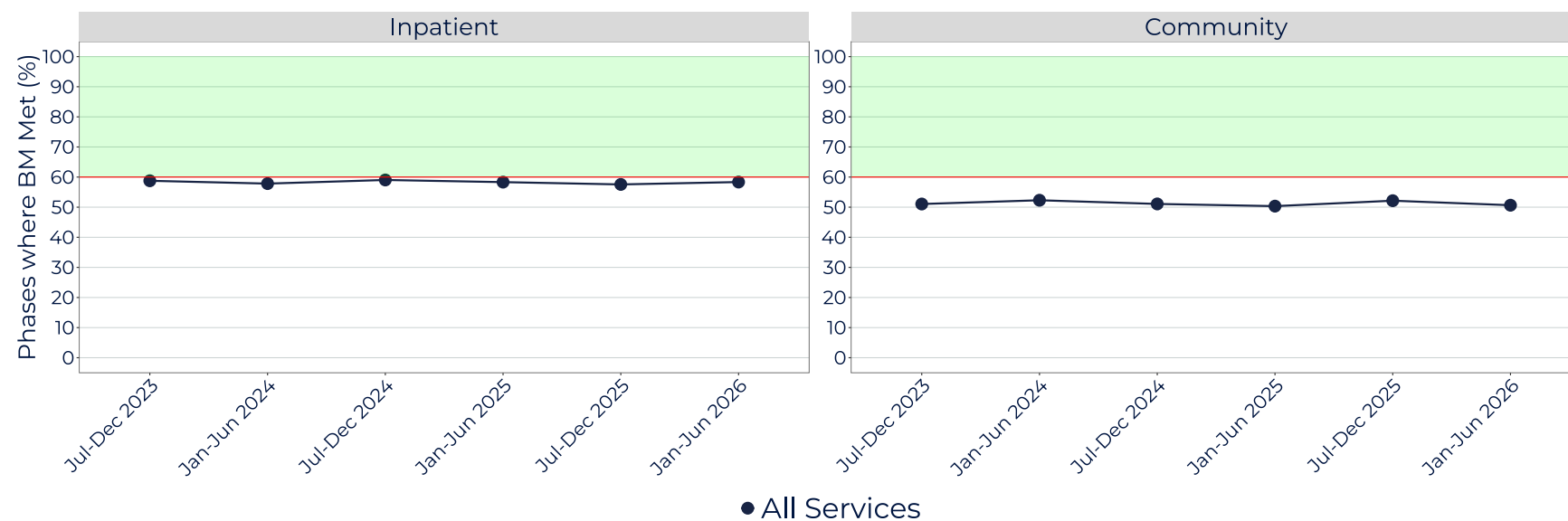
Figure 11: Family/carer problems, family/carer assessed with absent to mild problem severity at phase end (anticipatory)

Responsive care - Family/carer problems (PCPSS)

% absent to mild at phase end, when moderate to severe at phase start



National benchmark profile for BM3.10



• All Services

Outcomes over time for BM3.10

Figure 12: Family/carer problems, family/carer 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 6: Casemix adjusted outcomes

Clinical Tool	Symptom/Problem	Inpatient				Non-admitted			
		Casemix adjusted score	Phases included (N)	Phases at or above baseline (N)	Phases at or above baseline (%)	Casemix adjusted score	Phases included (N)	Phases at or above baseline (N)	Phases at or above baseline (%)
PCPSS <i>Clinician reported severity</i>	Pain	0.10	34,367	21,352	62.1	-0.03	37,702	20,633	54.7
	Other symptoms	0.27	33,356	25,330	75.9	0.04	36,555	23,913	65.4
	Family/carer	0.24	31,557	24,216	76.7	0.07	34,214	23,109	67.5
	Psychological/spiritual	0.24	34,097	23,605	69.2	0.08	36,757	20,991	57.1
SAS <i>Patient reported distress</i>	Pain	0.29	30,964	20,817	67.2	-0.08	38,179	22,382	58.6
	Nausea	0.20	30,705	27,166	88.5	-0.01	36,602	29,290	80.0
	Breathing problems	0.31	30,735	25,033	81.4	0.07	36,429	25,768	70.7
	Bowel problems	0.31	30,652	24,974	81.5	0.05	36,172	26,279	72.7

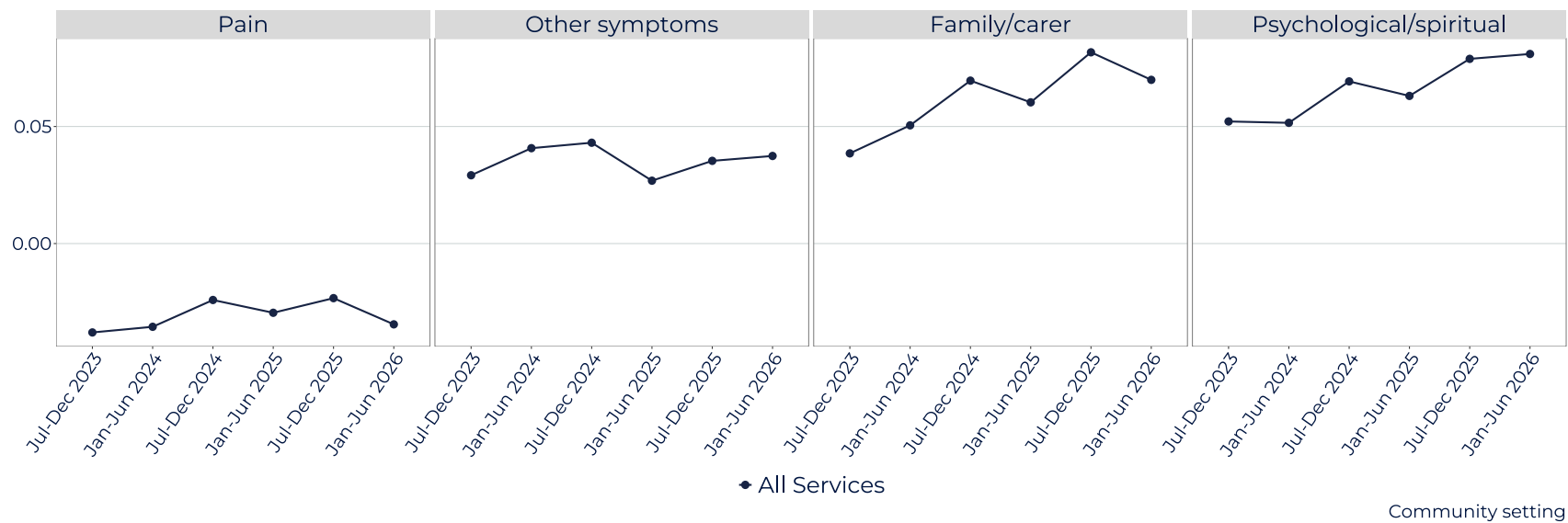
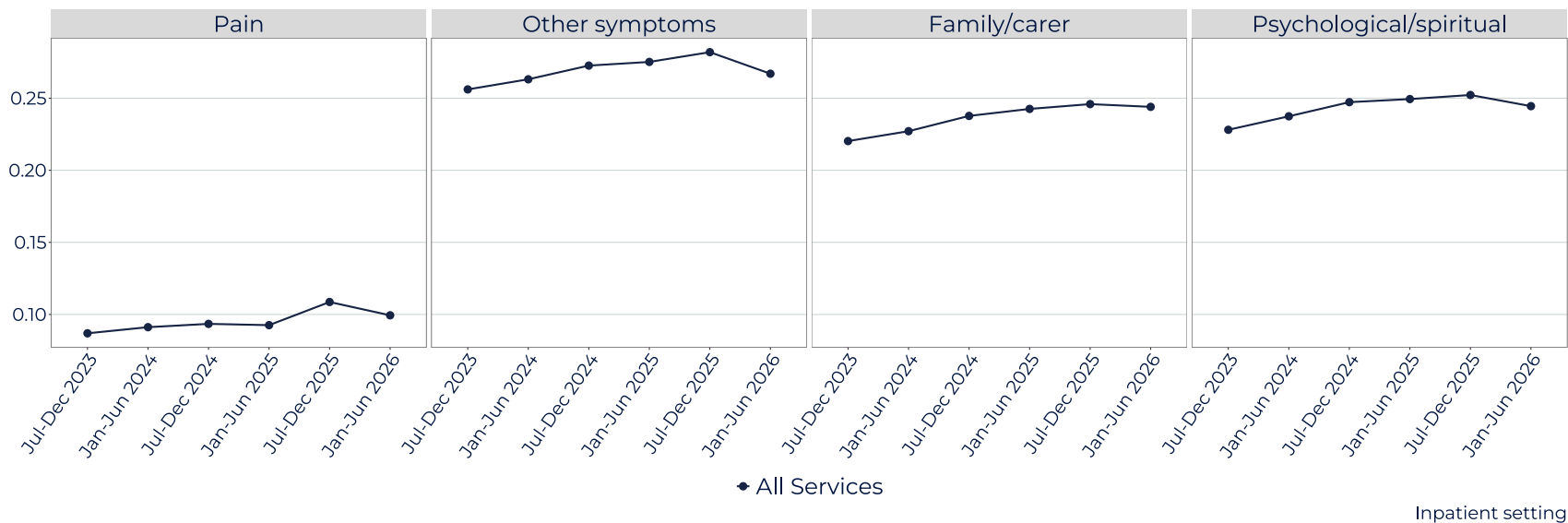


Figure 13: Trends in casemix adjusted outcomes - Palliative Care Problem Severity Score (PCPSS)

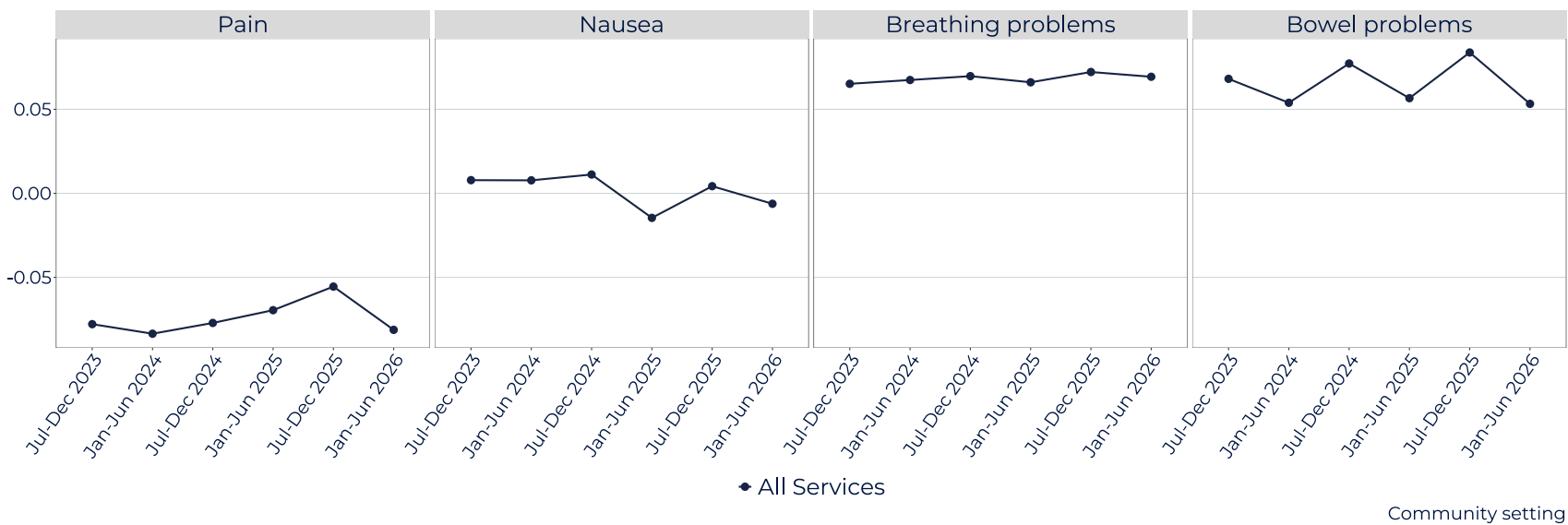
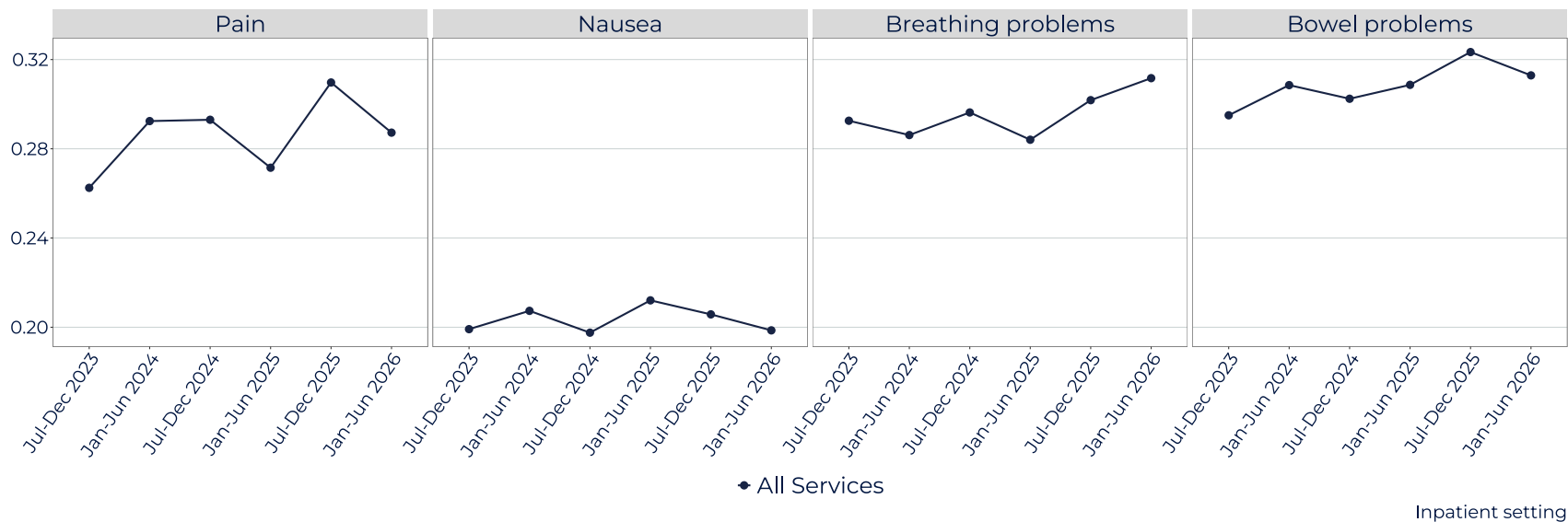


Figure 14: Trends in casemix adjusted outcomes - Symptom Assessment Scale (SAS)

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 7 shows the sex for the patients of all participating PCOC services.

Table 7: Sex

Sex	N	%
Male	21,571	50.7
Female	20,967	49.3
Not stated/Inadequately described/Intersex	7	0.0
Total	42,545	100.0

Table 8 shows the sex for the patients in all participating PCOC services over time.

Table 8: Sex over time

Sex	Jul-Dec 2023	Jan-Jun 2024	Jul-Dec 2024	Jan-Jun 2025	Jul-Dec 2025	Jan-Jun 2026
Male	50.8	50.7	50.4	50.6	50.3	50.7
Female	47.4	47.8	48.2	48.3	49.7	49.3
Not stated/Inadequately described/Intersex	1.8	1.5	1.4	1.1	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 9 shows the Indigenous status for the patients in AUS and all participating PCOC services.

Table 9: Indigenous status

Indigenous status	N	%
Aboriginal but not Torres Strait Islander origin	925	2.2
Torres Strait Islander but not Aboriginal origin	51	0.1
Both Aboriginal and Torres Strait Islander origin	57	0.1
Neither Aboriginal nor Torres Strait Islander origin	40,271	94.7
Not stated/inadequately described	1,241	2.9
Total	42,545	100.0

Table 10 shows the Indigenous status for the patients in AUS over time.

Table 10: 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	2.1	2.2	2.2	2.2	2.3	2.2
Torres Strait Islander but not Aboriginal origin	0.1	0.1	0.1	0.1	0.1	0.1
Both Aboriginal and Torres Strait Islander origin	0.1	0.2	0.2	0.2	0.2	0.1
Neither Aboriginal nor Torres Strait Islander origin	94.6	94.3	94.8	94.6	93.8	94.7
Not stated/inadequately described/Intersex	3.1	3.2	2.8	2.9	3.7	2.9
Total	100.0	100.0	100.0	100.0	100.0	100.0

Table 11: Country of birth

Country of birth	N	%
Australia	26,903	63.2
England	2,677	6.3
India	400	0.9
China	763	1.8
New Zealand	974	2.3
Philippines	275	0.6
Vietnam	354	0.8
South Africa	242	0.6
Malaysia	171	0.4
Italy	1,397	3.3
Sri Lanka	157	0.4
Scotland	478	1.1
Nepal	17	0.0
United States of America	103	0.2
Germany	433	1.0
All other countries	6,490	15.3
Not stated	711	1.7
Total	42,545	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 12: Preferred language

Language	N	%
English	37,364	87.8
Chinese^a	860	2.0
Hindi^b	174	0.4
Arabic^c	411	1.0
Vietnamese^d	279	0.7
Filipino/Indonesian^e	77	0.2
Tamil/Malayalam^f	23	0.1
Spanish^g	198	0.5
Greek	591	1.4
Italian	576	1.4
Macedonian/Croatian^h	369	0.9
African languages	30	0.1
Korean	53	0.1
Samoan/Tonganⁱ	68	0.2
All other languages	769	1.8
Not stated	640	1.5
Total	42,545	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 11 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 12 (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 13 and Table 14 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 1,276 (3.0%) patients nationally.

Table 13: Principal diagnosis - malignant

Diagnosis	N	% of malignant diagnoses	% of all diagnoses
Bone and soft tissue	350	1.4	0.8
Breast	1,872	7.2	4.4
CNS	662	2.6	1.6
Colorectal	2,656	10.3	6.2
Other GIT	2,580	10.0	6.1
Haematological	1,911	7.4	4.5
Head and neck	1,301	5.0	3.1
Lung	5,007	19.4	11.8
Pancreas	2,039	7.9	4.8
Prostate	1,605	6.2	3.8
Other urological	1,205	4.7	2.8
Gynaecological	1,322	5.1	3.1
Skin	959	3.7	2.3
Unknown primary	805	3.1	1.9
Other primary malignancy	1,332	5.2	3.1
Malignant Not further defined	245	0.9	0.6
All malignant	25,851	100.0	60.9

Table 14: Principal diagnosis - non-malignant

Diagnosis	N	% of non-malignant diagnoses	% of all diagnoses
Cardiovascular disease	2,046	13.3	4.8
End stage kidney disease	1,211	7.9	2.8
Stroke	810	5.3	1.9
Motor neurone disease	419	2.7	1.0
Alzheimers dementia	1,151	7.5	2.7
Other dementia	1,543	10.0	3.6
Other neurological disease	810	5.3	1.9
Respiratory failure	2,519	16.3	5.9
End stage liver disease	408	2.6	1.0
Diabetes & its complications	81	0.5	0.2
Sepsis	836	5.4	2.0
Multiple organ failure	471	3.1	1.1
Other non-malignancy	2,661	17.3	6.3
Non-malignant Not further defined	452	2.9	1.1
All non-malignant	15,418	100.0	36.3

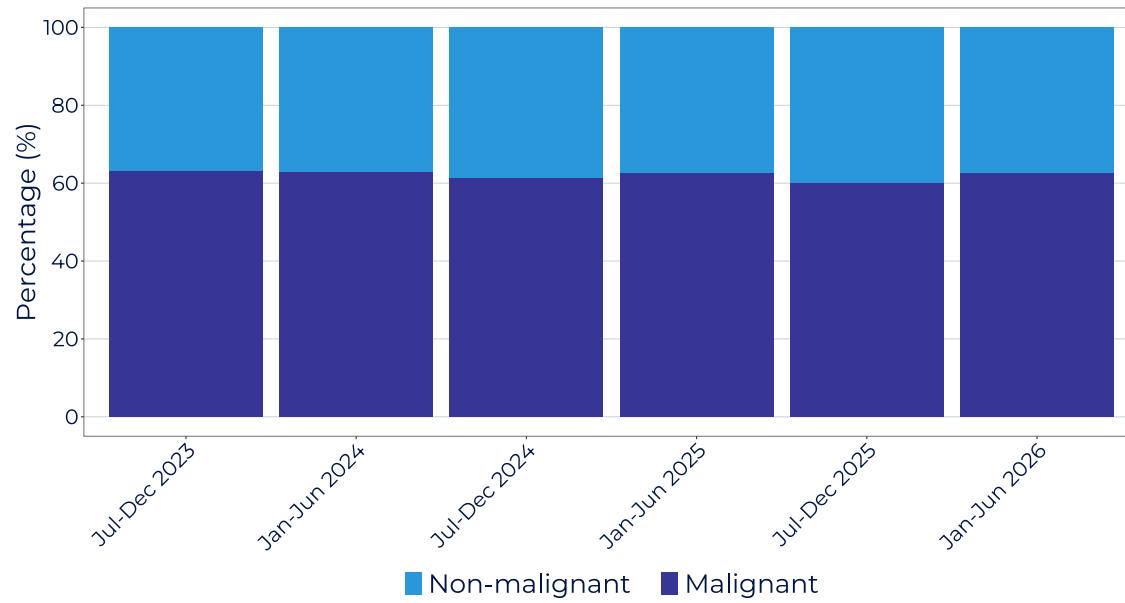


Figure 15: Principal diagnosis over time

Table 15 shows the breakdown of patient deaths nationally for the reporting period. All inpatient deaths are reported in the hospital/hospice category while the non-admitted deaths are reported in the private residence and residential aged care facility categories.

Table 15: Place of death

Place of death	N	%
Private residence	2,809	15.3
Residential aged care facility	2,067	11.2
Hospital/hospice	12,943	70.4
Not stated/inadequately described	564	3.1
Total	18,383	100.0

Table 16 shows the place of death for the patients in all participating PCOC services over time.

Table 16: Place of death over time

Place of death	Jul-Dec 2023	Jan-Jun 2024	Jul-Dec 2024	Jan-Jun 2025	Jul-Dec 2025	Jan-Jun 2026
Private residence	17.6	16.9	15.9	15.2	14.4	15.3
Residential aged care facility	11.5	12.1	11.5	11.6	11.5	11.2
Hospital/hospice	69.1	69.2	70.6	70.1	71.4	70.4
Not stated/inadequately described	1.8	1.8	2.0	3.1	2.7	3.1
Total	100.0	100.0	100.0	100.0	100.0	100.0

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

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 non-admitted 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 non-admitted 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 17 presents the number and percentage of episodes by age group and sex for the patients at the national level. Age has been calculated as at episode start.

Table 17: Patient's age by sex

Age	Male		Female	
	N	%	N	%
< 15	14	0.1	17	0.1
15 – 24	99	0.4	57	0.2
25 – 34	124	0.5	139	0.5
35 – 44	406	1.5	588	2.3
45 – 54	1,159	4.3	1,266	4.9
55 – 64	3,040	11.3	2,842	11.0
65 – 74	5,731	21.3	4,824	18.6
75 – 84	8,130	30.3	7,040	27.2
85 +	6,630	24.7	7,749	29.9
Unknown	1,523	5.7	1,402	5.4
Total	26,856	100.0	25,924	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 18 presents referral source by setting of care.

Table 18: Source of referral

Referral source	Inpatient		Non-admitted	
	N	%	N	%
Public hospital – palliative care unit/team	2,310	9.4	1,651	8.5
Public hospital - oncology unit/team	2,872	11.7	968	5.0
Public hospital - medical unit/team	8,209	33.6	1,263	6.5
Public hospital - surgical unit/team	1,017	4.2	76	0.4
Public hospital - emergency department	1,627	6.6	182	0.9
Public hospital - not further defined	2,520	10.3	5,048	25.8
Public hospital - Total	18,555	75.8	9,188	47.1
Private hospital - palliative care unit/team	167	0.7	523	2.7
Private hospital - oncology unit/team	525	2.1	170	0.9
Private hospital - medical unit/team	484	2.0	91	0.5
Private hospital - surgical unit/team	40	0.2	4	0.0
Private hospital - emergency department	62	0.3	9	0.0
Private hospital - not further defined	143	0.6	716	3.7
Private hospital - Total	1,421	5.9	1,513	7.8
Outpatient clinic	105	0.4	249	1.3
General medical practitioner	193	0.8	2,548	13.0
Specialist medical practitioner	500	2.0	2,006	10.3
Community-based palliative care agency	2,708	11.1	474	2.4
Community-based service	32	0.1	265	1.4
Residential aged care facility	70	0.3	1,745	8.9
Self, carer(s), family or friends	229	0.9	530	2.7
Other	387	1.6	818	4.2
Not stated/inadequately described	267	1.1	195	1.0
Total	24,467	100.0	19,531	100.0

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

Table 19 shows the referral source for the patients in all participating PCOC services over time.

Table 19: 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	9.0	8.8	8.6	8.8	8.4	9.0
Public hospital – oncology unit/team	7.6	7.3	7.1	7.5	7.8	8.7
Public hospital – medical unit/team	20.7	19.1	19.8	19.6	21.7	21.5
Public hospital – surgical unit/team	1.9	2.1	2.2	2.2	2.4	2.5
Public hospital – emergency department	3.7	4.0	3.8	4.1	4.3	4.1
Public hospital – not further defined	16.8	16.5	15.2	17.3	18.4	17.2
Public hospital – Total	59.7	57.8	56.7	59.5	63.0	63.0
Private hospital – palliative care unit/team	2.2	2.3	3.8	1.7	1.0	1.6
Private hospital – oncology unit/team	2.5	2.6	2.6	2.1	1.3	1.6
Private hospital – medical unit/team	1.8	1.6	1.9	1.8	1.3	1.3
Private hospital – surgical unit/team	0.2	0.1	0.2	0.1	0.1	0.1
Private hospital – emergency department	0.3	0.3	0.3	0.2	0.2	0.2
Private hospital – not further defined	2.1	2.6	2.5	2.3	2.1	2.0
Private hospital – Total	9.1	9.5	11.3	8.2	6.0	6.8
Outpatient clinic	1.1	0.8	0.9	1.1	0.9	0.8
General medical practitioner	6.4	6.4	5.9	6.3	6.2	6.2
Specialist medical practitioner	5.0	5.4	5.6	5.9	5.5	5.7
Community-based palliative care agency	8.4	8.6	8.3	8.2	7.7	7.2
Community-based service	0.7	0.8	0.6	0.8	0.7	0.7
Residential aged care facility	4.2	4.5	4.3	4.1	4.4	4.1
Self, carer(s), family or friends	1.5	2.0	2.3	1.7	1.6	1.7
Other	3.6	3.5	3.6	3.7	3.1	2.7
Not stated/inadequately described	0.4	0.4	0.8	0.6	0.8	1.1
Total	100.0	100.0	100.0	100.0	100.0	100.0

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

Table 20 gives a summary of the length of episodes for patients nationally.

Table 20: Length of episode (in days) summary by setting of care

Length of episode	Inpatient	Non-admitted
Average length of episode	8.5	38
Median length of episode	4	27

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 shows a summary of the length of episodes for patients in all participating PCOC services over time.

Table 21: 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	21.6	22.8	21.5	22.2	20.7	21.5
Median length of episode	9	9	9	9	8	9

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 22 details the length of episode by setting. 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 22: Length of episode (days)

Length of episode (days)	Inpatient		Non-admitted	
	N	%	N	%
Same day	2,466	10.0	1,411	6.2
1 – 2	6,198	25.0	1,428	6.3
3 – 4	3,999	16.2	1,171	5.2
5 – 7	3,807	15.4	1,631	7.2
8 – 14	4,158	16.8	2,629	11.6
15 – 21	1,778	7.2	1,998	8.8
22 – 30	1,079	4.4	1,947	8.6
31 – 60	963	3.9	3,778	16.7
61 – 90	183	0.7	1,830	8.1
91 +	117	0.5	4,801	21.2
Total	24,748	100.0	22,624	100.0

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

Table 23: How inpatient episodes start

Episode start mode	N	%
Admitted from community^a	15,835	64.7
Admitted from another hospital	3,376	13.8
Admitted from acute care in another ward	3,179	13.0
Change from acute care to palliative care - same ward	845	3.5
Other^b	431	1.8
Not stated/inadequately described	801	3.3
Total	24,467	100.0

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

a. includes: admitted from usual accommodation, admitted from other than usual accommodation.

b. includes: change of sub-acute/non-acute care type and other categories.

Table 24: How inpatient episodes end

Episode end mode	N	%
Discharged to community^a	7,170	29.0
Discharged to another hospital	1,980	8.0
Death	12,943	52.3
Change from palliative care to acute care^b	248	1.0
Change in sub-acute care type	161	0.7
End of consultative episode - inpatient episode ongoing	1,111	4.5
Other	468	1.9
Not stated/inadequately described	667	2.7
Total	24,748	100.0

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

a. includes: discharged to usual accommodation, discharged to other than usual accommodation.

b. includes: change from palliative care to acute care - different ward, change from palliative care to acute care - same ward.

Table 25: How inpatient 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 community^a	63.6	63.3	60.5	60.2	64.1	64.7
Admitted from another hospital	15.4	14.8	14.6	15.1	14.3	13.8
Admitted from acute care on another ward	14.1	15.5	17.5	16.4	15.2	13.0
Change from acute care to palliative care - same ward	3.9	3.0	3.2	4.1	3.4	3.5
Other^b	1.7	2.2	2.0	2.2	1.6	1.8
Not stated/inadequately described	1.2	1.1	2.2	2.0	1.5	3.3
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: admitted from usual accommodation, admitted from other than usual accommodation.

b. includes: change of sub-acute/non-acute care type and other category.

Table 26: How inpatient 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
Discharged to community^a	29.9	28.3	28.8	27.7	27.3	29.0
Discharged to another hospital	6.9	6.6	6.3	7.2	7.6	8.0
Death	52.3	53.9	53.2	54.2	54.2	52.3
Change from palliative care to acute care^b	1.0	1.2	1.2	1.0	1.2	1.0
Change in sub-acute care type	0.7	0.8	0.7	0.6	0.7	0.7
End of consultative episode - inpatient episode ongoing	5.8	5.3	5.5	5.1	4.6	4.5
Other	1.4	1.7	2.1	1.9	2.0	1.9
Not stated/inadequately described	2.0	2.2	2.2	2.4	2.3	2.7
Total	100.0	100.0	100.0	100.0	100.0	100.0

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

a. includes: discharged to usual accommodation, discharged to other than usual accommodation.

b. includes: change from palliative care to acute care - different ward, change from palliative care to acute care - same ward.

Table 27: How community episodes start

Episode start mode	N	%
Admitted from inpatient palliative care	6,048	31.0
Other^a	12,542	64.2
Not stated/inadequately described	941	4.8
Total	19,531	100.0

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

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

Table 28: How community episodes end

Episode end mode	N	%
Admitted for inpatient palliative care	5,945	26.3
Admitted for inpatient acute care	5,996	26.5
Admitted to another palliative care service	355	1.6
Admitted to primary health care	2,179	9.6
Discharged/case closure	1,698	7.5
Death	5,440	24.0
Other	206	0.9
Not stated/inadequately described	805	3.6
Total	22,624	100.0

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

Table 29: How non-admitted 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	29.4	29.8	30.6	29.0	29.3	31.0
Other^a	69.6	67.1	65.7	67.2	66.9	64.2
Not stated/inadequately described	1.0	3.0	3.7	3.7	3.8	4.8
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 30: How non-admitted 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	27.9	25.4	25.4	24.5	24.7	26.3
Admitted for inpatient acute care	23.2	26.4	27.2	27.6	27.2	26.5
Admitted to another palliative care service	1.7	0.9	1.3	1.5	1.6	1.6
Admitted to primary health care	8.7	8.8	9.4	9.9	10.2	9.6
Discharged/case closure	7.5	8.3	7.8	7.7	8.0	7.5
Death	28.0	26.2	25.1	24.9	24.2	24.0
Other	0.9	0.8	0.9	1.4	0.9	0.9
Not stated/inadequately described	2.0	3.3	2.9	2.4	3.2	3.6
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 non-admitted 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 31: Number of patient phases by phase type and setting of care

Phase type	Inpatient		Non-admitted	
	N	%	N	%
Stable	13,669	25.5	22,038	40.1
Unstable	6,561	12.2	4,323	7.9
Deteriorating	21,137	39.4	24,566	44.6
Terminal	12,321	22.9	4,097	7.4
Total	53,688	100.0	55,024	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 32: Average phase length (in days) by phase type and setting of care

Phase type	Inpatient	Non-admitted
Stable	6.1	22.9
Unstable	2.2	3.7
Deteriorating	4.6	14.9
Terminal	2.0	2.7

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

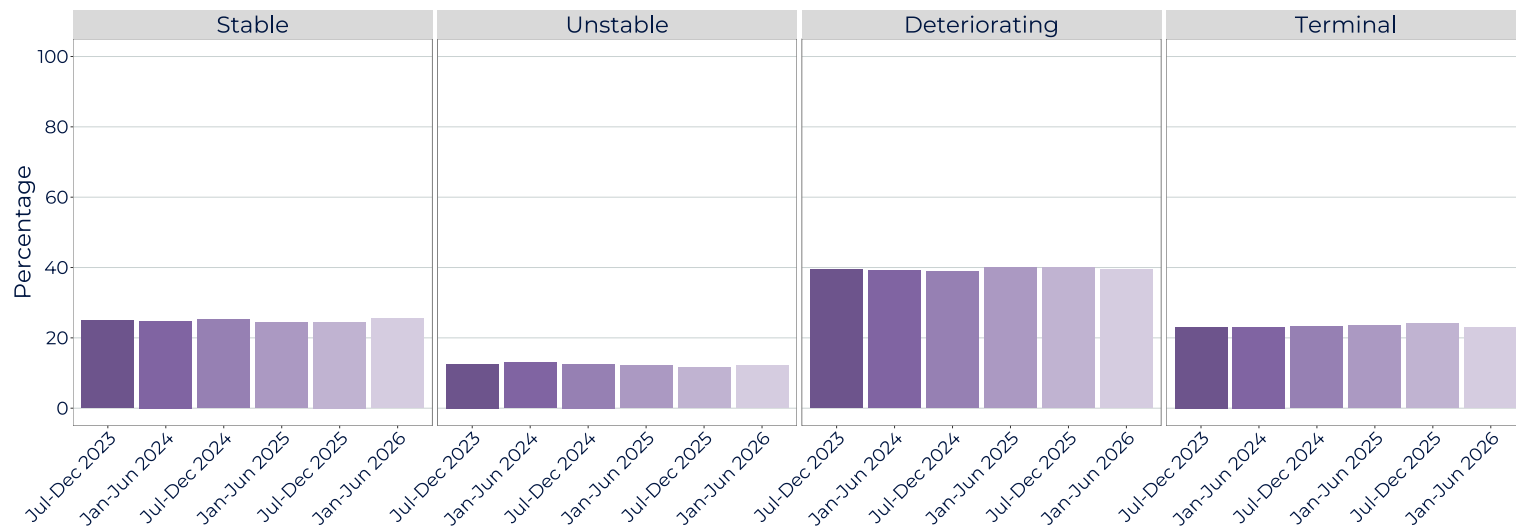


Figure 16: Patient phase profile over time - inpatient setting

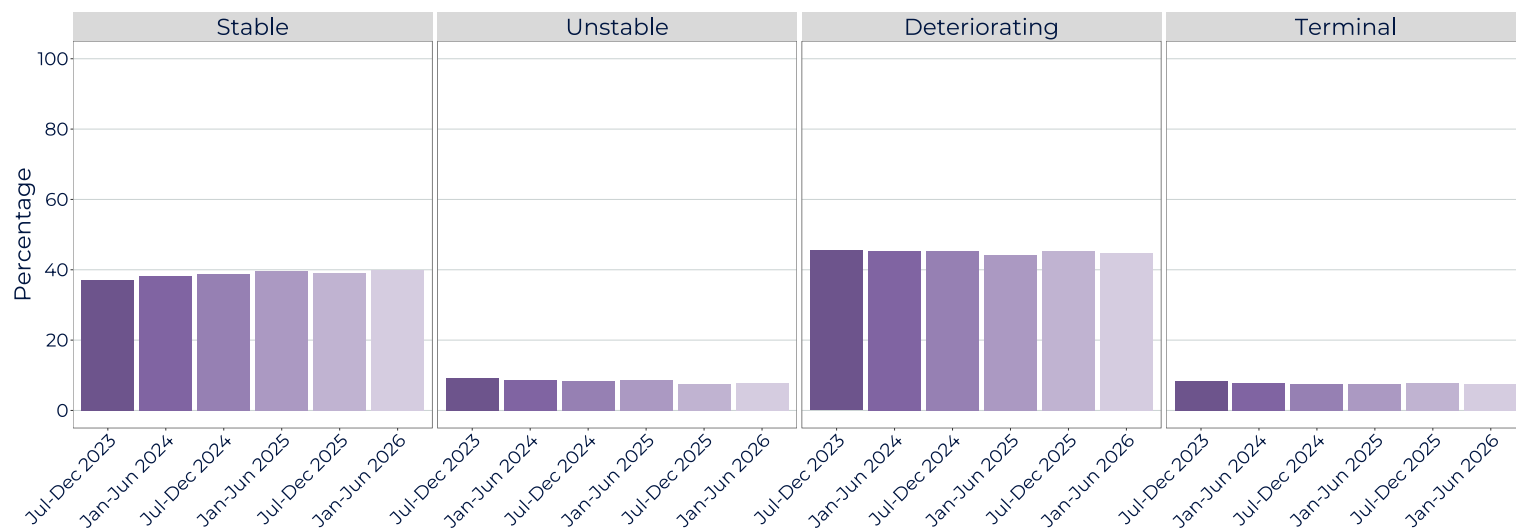


Figure 17: Patient phase profile over time - non-admitted setting

Table 33 presents the patients' first phase type for the episode nationally.

Table 33: First phase of episode by setting

Phase type	Inpatient		Non-admitted	
	N	%	N	%
Stable	4,220	17.3	7,441	38.1
Unstable	3,793	15.5	881	4.5
Deteriorating	12,456	50.9	10,330	52.9
Terminal	3,991	16.3	876	4.5
Total	24,460	100.0	19,528	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 34 shows the percentage of phases that were rated absent, mild, moderate and severe at phase start for each key domain for all participating PCOC inpatient services.

Table 34: PCPSS at phase start by phase type - inpatient setting

Phase type	Problem	Inpatient (%)				Non-admitted (%)			
		Absent	Mild	Moderate	Severe	Absent	Mild	Moderate	Severe
Stable	Pain	53.8	39.5	6.3	0.4	44.8	50.3	4.8	0.1
	Other symptoms	45.8	47.5	6.5	0.2	26.4	66.6	6.8	0.1
	Family/carer	63.8	32.4	3.5	0.3	50.3	45.3	4.3	0.1
	Psychological/spiritual	67.0	28.7	4.0	0.2	47.7	46.1	5.8	0.3
Unstable	Pain	28.5	35.3	28.5	7.7	17.4	29.4	36.0	17.1
	Other symptoms	22.9	42.0	29.5	5.5	7.7	26.9	48.8	16.5
	Family/carer	42.8	38.2	16.8	2.2	21.9	41.2	32.1	4.8
	Psychological/spiritual	49.2	33.8	14.5	2.4	20.3	34.7	37.1	7.8
Deteriorating	Pain	38.8	41.9	17.9	1.4	29.1	47.9	21.8	1.1
	Other symptoms	29.5	48.1	21.1	1.3	11.0	52.2	35.7	1.2
	Family/carer	48.2	41.0	10.1	0.7	29.8	54.7	15.1	0.5
	Psychological/spiritual	47.2	39.7	12.2	0.9	25.7	51.3	21.9	1.0
Terminal	Pain	45.3	39.8	13.3	1.6	34.7	44.5	18.9	2.0
	Other symptoms	41.8	40.3	16.0	1.9	27.6	43.4	26.1	3.0
	Family/carer	66.9	26.3	6.0	0.8	52.3	35.3	11.3	1.1
	Psychological/spiritual	38.3	43.8	16.0	2.0	19.1	46.4	31.5	3.0

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 35 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 35: Symptom distress at phase start by phase type

Phase type	Symptom	Inpatient (%)				Non-admitted (%)			
		Absent	Mild	Moderate	Severe	Absent	Mild	Moderate	Severe
Stable	Difficulty sleeping	82.4	14.8	2.6	0.2	72.8	23.8	3.3	0.2
	Appetite problems	78.7	18.6	2.4	0.3	62.0	34.5	3.3	0.2
	Nausea	86.9	11.4	1.6	0.1	83.7	15.1	1.2	0.1
	Bowel problems	75.8	20.5	3.4	0.3	72.1	24.7	2.9	0.2
	Breathing problems	77.1	19.3	3.3	0.3	61.6	32.6	5.5	0.2
	Fatigue	55.3	37.6	6.5	0.5	29.8	56.5	13.1	0.6
	Pain	53.9	38.0	7.4	0.6	44.9	48.2	6.6	0.3
Unstable	Difficulty sleeping	67.4	21.5	9.5	1.5	49.1	27.9	19.7	3.4
	Appetite problems	61.2	28.6	9.2	1.1	41.1	35.6	21.2	2.1
	Nausea	71.1	17.6	9.3	1.9	59.5	20.3	15.7	4.5
	Bowel problems	61.3	26.1	11.2	1.4	51.1	25.9	18.1	5.0
	Breathing problems	64.7	21.7	11.1	2.4	48.1	27.6	18.7	5.7
	Fatigue	36.4	39.9	21.5	2.3	18.7	35.2	39.1	7.1
	Pain	28.4	34.9	28.6	8.1	17.4	26.2	38.5	17.9
Deteriorating	Difficulty sleeping	75.8	18.2	5.5	0.5	64.3	27.4	7.8	0.5
	Appetite problems	69.9	24.1	5.4	0.6	47.2	42.1	10.2	0.5
	Nausea	78.7	15.6	5.1	0.6	72.9	21.2	5.6	0.4
	Bowel problems	69.9	23.1	6.4	0.6	61.5	29.4	8.6	0.6
	Breathing problems	65.2	23.7	10.2	0.9	53.5	32.8	13.0	0.8
	Fatigue	42.3	39.9	16.3	1.4	19.6	48.5	29.9	2.0
	Pain	38.8	40.4	19.2	1.6	30.4	45.1	22.9	1.6
Terminal	Difficulty sleeping	91.0	6.6	2.1	0.3	84.3	11.4	3.8	0.5
	Appetite problems	92.7	5.2	1.2	0.9	83.6	10.0	5.0	1.3
	Nausea	93.3	5.0	1.5	0.2	85.7	10.0	3.8	0.5
	Bowel problems	89.0	8.8	2.0	0.2	78.2	16.6	4.6	0.6
	Breathing problems	66.1	23.1	9.5	1.4	62.9	25.3	10.1	1.7
	Fatigue	74.9	17.3	6.5	1.4	64.3	16.8	15.4	3.5
	Pain	47.8	37.1	13.7	1.4	37.8	40.3	19.9	2.0

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 36 summarises the RUG-ADL items at phase start for inpatient and non-admitted patients.

Table 36: The Resource Utilisation Groups - Activities of Daily Living (RUG-ADL) at phase start by setting of care

Item	RUG-ADL assessment at phase start	Inpatient		Non-admitted	
		N	%	N	%
Bed mobility	Independent or supervision only (1)	14,550	28.0	31,671	60.7
	Limited physical assistance (3)	7,500	14.5	6,227	11.9
	Other than two person physical assist (4)	5,888	11.4	4,297	8.2
	Two or more person physical assist (5)	23,936	46.1	9,947	19.1
Toileting	Independent or supervision only (1)	9,624	18.6	26,464	50.7
	Limited physical assistance (3)	9,211	17.8	8,946	17.1
	Other than two person physical assist (4)	7,669	14.8	6,012	11.5
	Two or more person physical assist (5)	25,362	48.9	10,786	20.7
Transfers	Independent or supervision only (1)	9,427	18.2	25,567	49.1
	Limited physical assistance (3)	9,098	17.5	9,549	18.4
	Other than two person physical assist (4)	7,379	14.2	5,919	11.4
	Two or more person physical assist (5)	25,951	50.0	10,995	21.1
Eating	Independent or supervision only (1)	21,450	41.5	34,132	66.1
	Limited physical assistance (2)	10,366	20.1	8,644	16.7
	Extensive assistance/total dependence/tube fed (3)	19,855	38.4	8,858	17.2

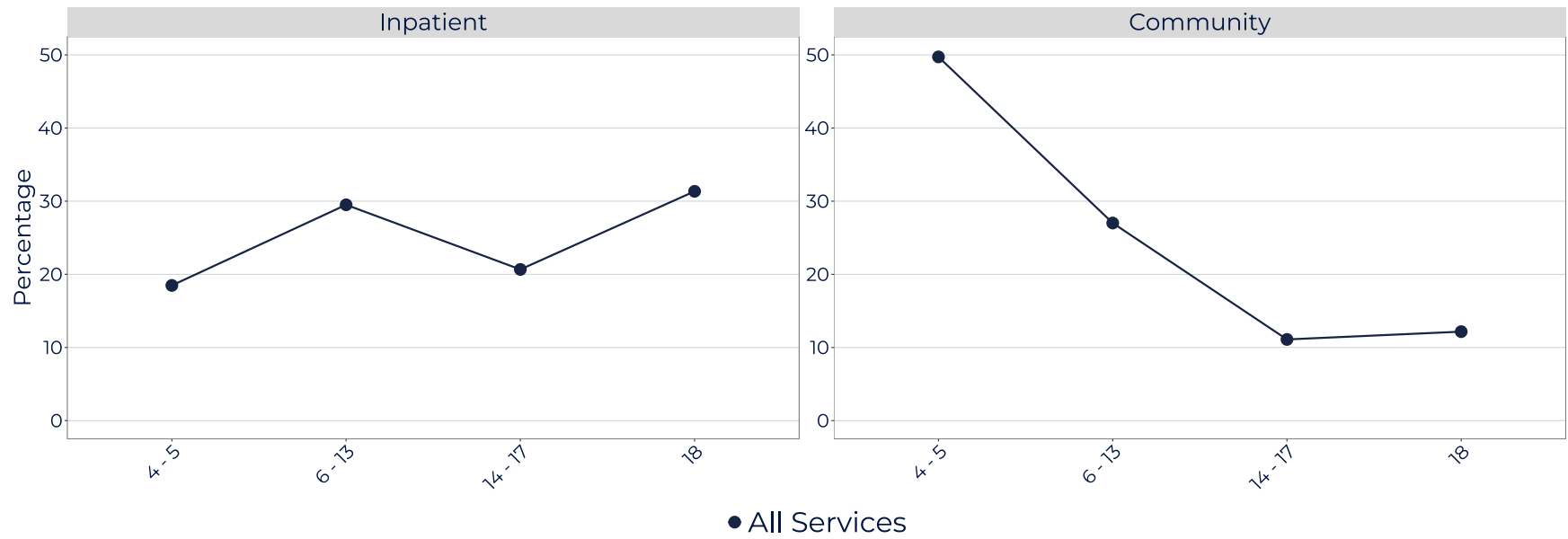


Figure 18: Distribution of patient's RUG-ADL Total at episode start

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

Table 37: Australia-modified Karnofsky Performance Status (AKPS) at phase start by setting of care

AKPS assessment at phase start	Inpatient		Non-admitted	
	N	%	N	%
Comatose or barely rousable (10)	6,701	12.5	1,921	3.5
Totally bedfast and requiring extensive nursing care (20)	14,168	26.4	5,986	10.9
Almost completely bedfast (30)	7,639	14.2	4,774	8.7
In bed more than 50% of the time (40)	10,221	19.0	10,002	18.2
Requires considerable assistance (50)	6,625	12.3	12,961	23.6
Requires occasional assistance (60)	3,943	7.3	10,920	19.8
Cares for self (70)	1,310	2.4	4,830	8.8
Normal activity with effort (80)	379	0.7	1,144	2.1
Able to carry on normal activity; minor signs or symptoms (90)	115	0.2	228	0.4
Normal; no complaints; no evidence of disease (100)	28	0.1	9	0.0
Not stated/inadequately described^a	2,559	4.8	2,249	4.1
Total	53,688	100.0	55,024	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.

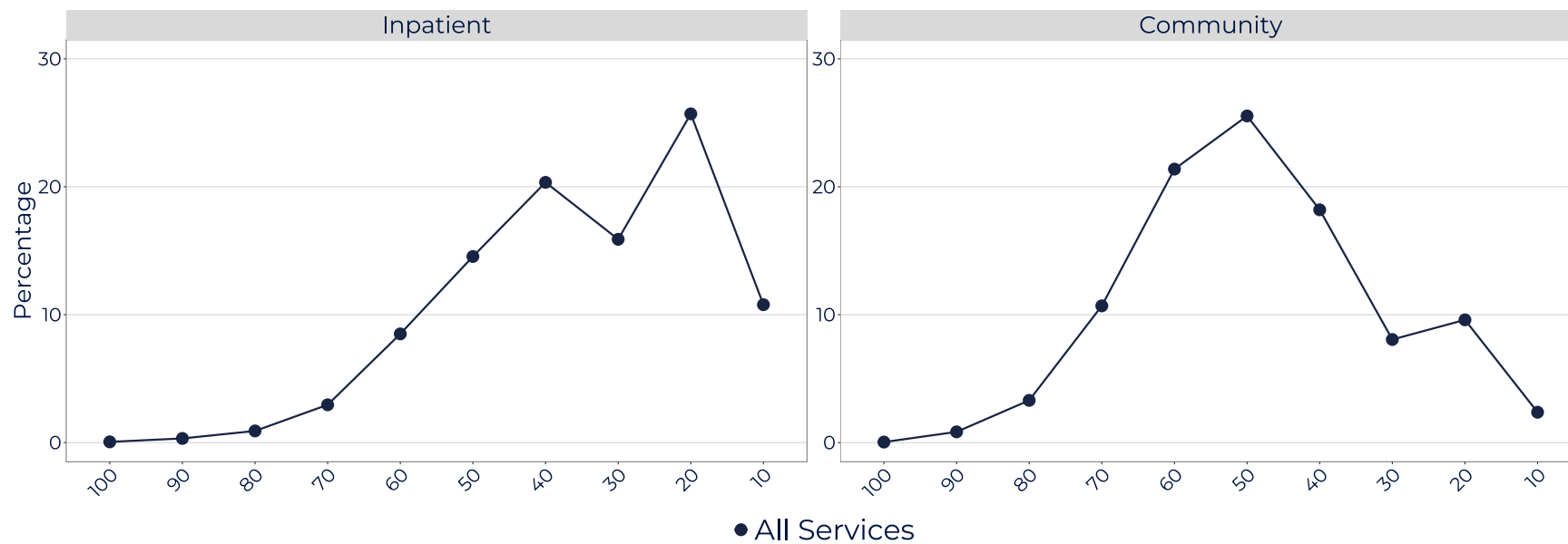


Figure 19: Distribution of AKPS for patients at episode start

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 38 shows the number of patients, episodes and phases included in this report, for all participating PCOC services nationally.

Table 38: Summary of patients, episodes and phases by setting

Phase type	Inpatient	Non-admitted	Total
Patients (N)	21,786	22,252	42,545
Episodes (N)	25,555	27,235	52,790
Phases^a (N)	53,688	55,024	108,712
Patients (%)	51.2	52.3	100.0
Episodes (%)	48.4	51.6	100.0
Phases^a (%)	49.4	50.6	100.0
Average number of phases per episode^b	2.1	1.9	2.0

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

Table 39: Number of completed episodes and phases by month and setting

Setting		Jan	Feb	Mar	Apr	May	Jun
Inpatient	Completed episodes (N)	4,090	3,923	4,318	4,020	4,312	4,085
	Completed phases (N)	8,972	8,776	9,550	8,667	9,351	8,372
Non-admitted	Completed episodes (N)	3,667	3,530	4,054	3,685	3,906	3,782
	Completed phases (N)	9,017	8,784	9,768	8,894	9,349	9,212

Table 40 shows the number of patients, episodes and phases over time and is reported by setting of care.

Table 40: Number of patients, episodes and phases by setting and reporting period

	Inpatient						Non-admitted					
	Jul-Dec 2023	Jan-Jun 2024	Jul-Dec 2024	Jan-Jun 2025	Jul-Dec 2025	Jan-Jun 2026	Jul-Dec 2023	Jan-Jun 2024	Jul-Dec 2024	Jan-Jun 2025	Jul-Dec 2025	Jan-Jun 2026
Patients^a	20,475	19,549	20,930	20,198	22,373	21,786	20,196	20,495	20,874	21,413	22,444	22,252
Episodes	24,512	23,364	24,971	23,921	26,366	25,555	24,059	24,585	25,487	25,812	27,416	27,235
Phases^b	52,507	50,373	54,093	51,474	55,295	53,688	52,937	53,561	52,845	52,229	55,608	55,024
Phases per episode^c	2.1	2.1	2.1	2.1	2.1	2.1	2.1	2.0	1.9	1.9	1.9	1.9

a. Patients seen in both settings are only counted once in the total column and hence numbers/percentages may not add to the total.

b. Bereavement phases are excluded from this count.

c. 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 41, Table 42, Table 43 and Table 44 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 41: Item completion (%) - patient level

Data item	% completion
Date of birth	94.6
Sex	100.0
Country of birth	98.3
Preferred language	98.8
Diagnosis	97.0

Table 42: Item completion (%) - episode level, by setting of care

Data item	Inpatient	Non-admitted	Total
Date of first contact	98.6	98.7	98.6
Referral date	100.0	99.5	99.7
Referral source	98.9	99.2	99.0
Date ready for care	97.8	97.2	97.5
Mode of episode start	96.7	95.6	96.2
Accommodation at episode start	99.1	96.9	97.8
Episode end date^a	98.2	85.5	91.6
Mode of episode end	97.3	96.4	96.9
Accommodation at episode end	98.2	97.7	98.0
Place of death	100.0	90.6	97.2

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

Table 43: Item completion (%) - phase level, by setting of care

Data item	Sub-Category (where applicable)	At phase start			At discharge		
		Inpatient	Non-admitted	Total	Inpatient	Non-admitted	Total
RUG-ADL	Bed mobility	96.6	94.8	95.7	61.9	47.7	53.4
	Toileting	96.6	94.9	95.7	62.8	47.9	54.0
	Transfers	96.6	94.6	95.6	61.8	47.7	53.5
	Eating	96.2	93.8	95.0	61.7	47.3	53.2
PCPSS	Pain	95.6	95.5	95.5	64.0	48.3	54.7
	Other symptoms	93.1	93.1	93.1	62.3	45.2	52.2
	Psychological/spiritual	95.0	94.0	94.5	63.3	47.5	53.9
	Family/carer	90.2	88.9	89.6	56.1	40.9	47.1
SAS	Difficulty sleeping	85.3	91.9	88.6	51.4	45.6	47.9
	Appetite problems	85.3	93.2	89.3	51.4	46.2	48.4
	Nausea	85.5	93.8	89.7	51.5	46.7	48.7
	Bowel problems	85.4	93.1	89.3	51.4	46.2	48.3
	Breathing problems	85.8	93.6	89.7	51.6	46.8	48.7
	Fatigue	85.4	94.0	89.8	51.5	47.0	48.9
	Pain	86.8	95.9	91.4	51.5	48.3	49.6
AKPS	-	95.2	95.9	95.6	61.1	49.1	54.0

Table 44: Item completion (%) - phase end, by setting of care

Data item	Inpatient	Non-admitted	Total
Phase End Reason	99.0	98.2	98.6

C Profile of patient symptoms and problems

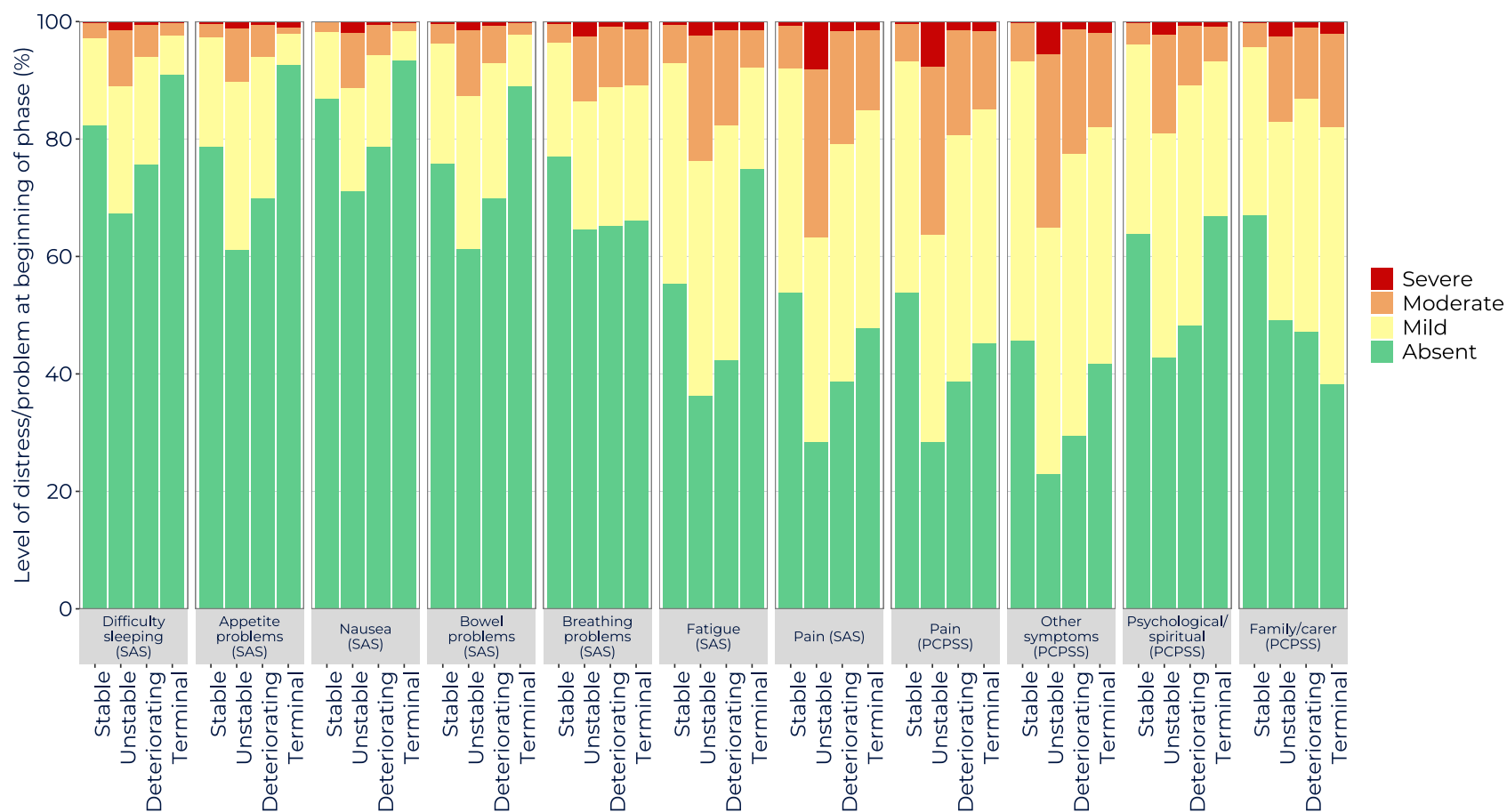


Figure 20: Profile of symptoms and problems by phase type for AUS- inpatient setting

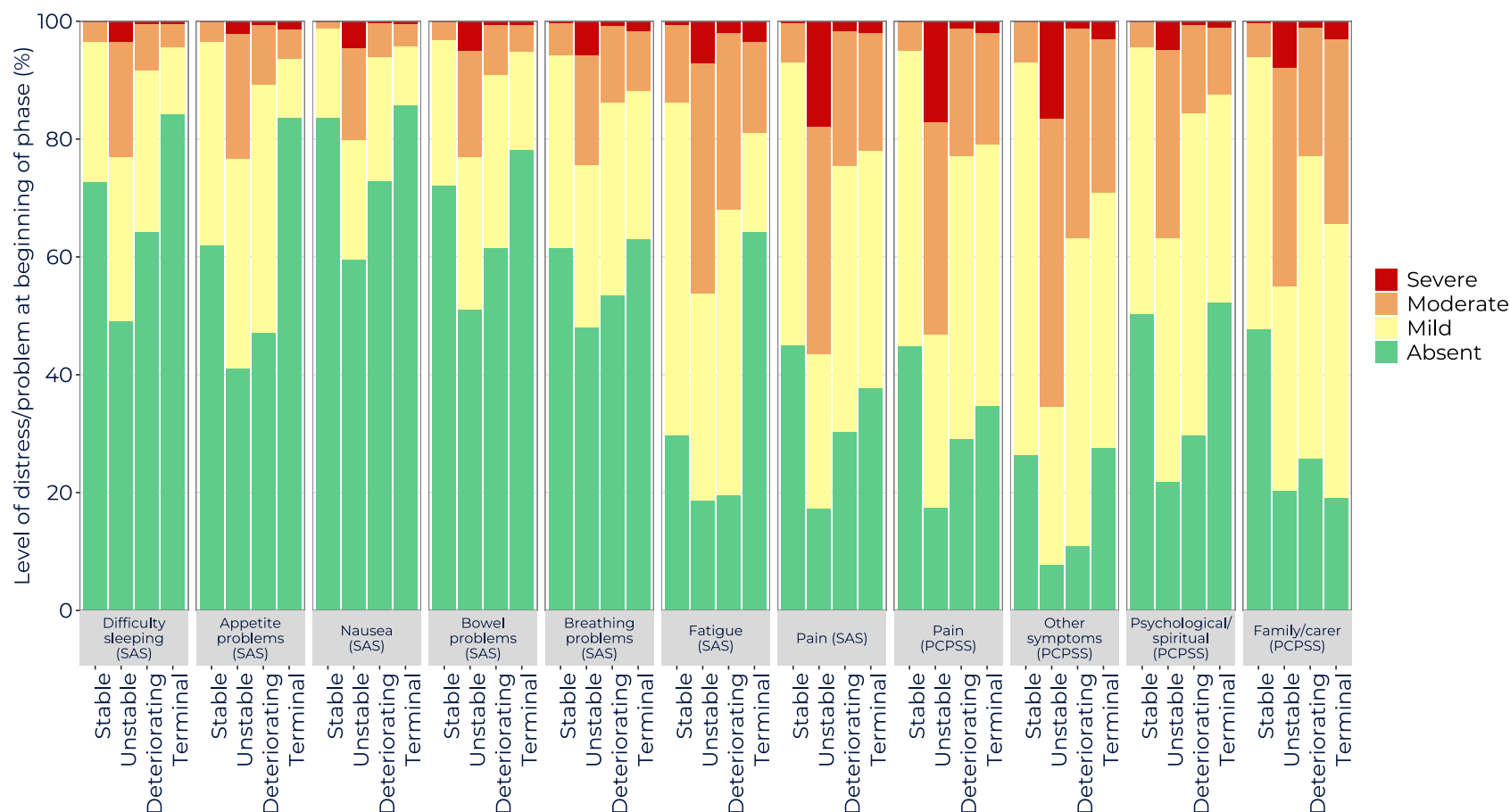


Figure 21: Profile of symptoms and problems by phase type for AUS- non-admitted setting

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 22 below displays four examples to help visualise this process.

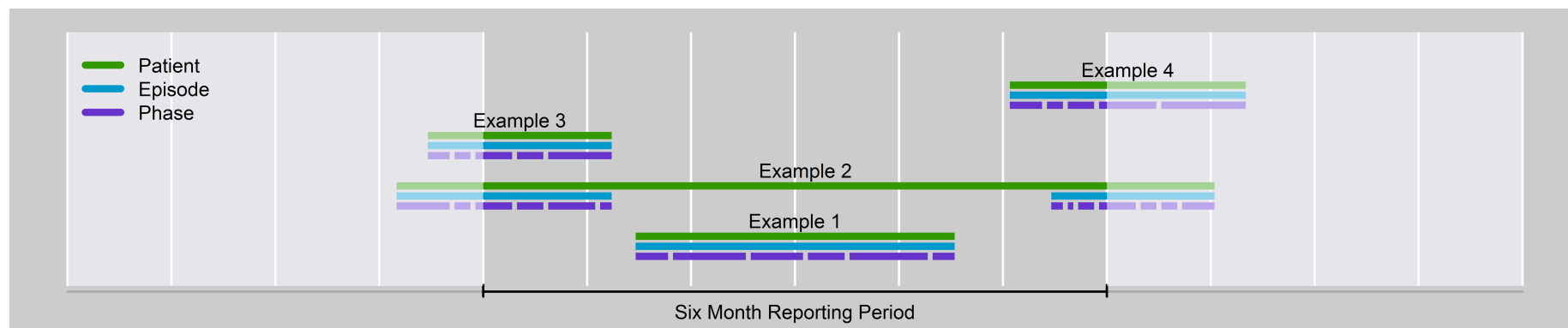


Figure 22: Diagram of the PCOC data scoping method

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.

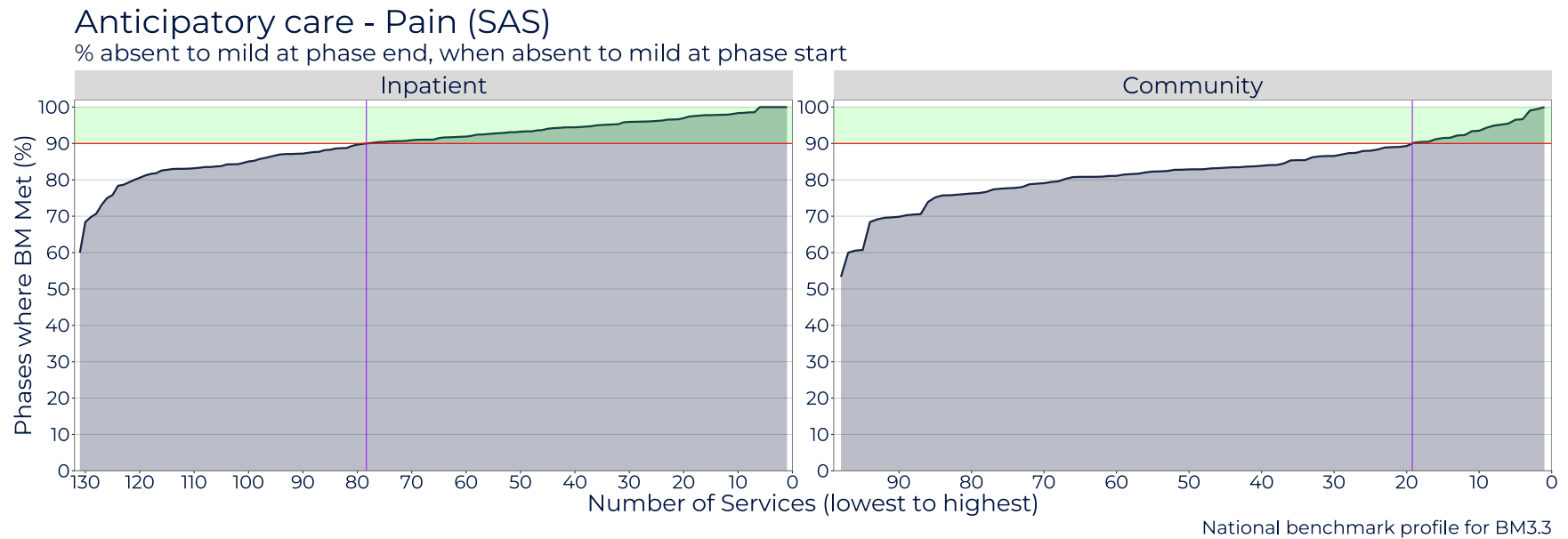
In Example 2, the patient has two episodes – the first having six phases and the second having seven phases. Looking at the phases associated with the first episode, the last four will be included in the report (as they end within the reporting period). The first two phases would have been included in 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).