



The Palliative Care Outcomes Collaboration

South Australia 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.
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Contents

1 Benchmark Summary for SA Services	3
2 Detailed Analysis on Patient Outcomes	4
2.1 Timely Commencement of Palliative Care	4
2.2 Responsiveness in managing patients with urgent clinical needs	6
2.3 Symptoms & Problems in the Absent to Mild Range at Phase End	8
2.4 Casemix adjusted outcomes	21
3 Patient characteristics	25
4 Episodes of palliative care	33
5 Profile of palliative care patient assessments	45
5.1 Phase	46
5.2 Palliative Care Problem Severity Score	52
5.3 Symptom Assessment Scale	54
5.4 Resource Utilisation Groups – Activities of Daily Living	57
5.5 Australia-modified Karnofsky Performance Status	59
Appendices	61
A Summary of data included in this report	61
B Data item completion	63
C Profile of patient symptoms and problems	66
D Data scoping method	67
E Interpreting benchmark profile graphs	69
F Palliative Care Phase definitions	70
G Quality Improvement Guide	71

List of Tables

1	List of SA Services included in this report	2
2	Summary of outcome measures by setting of care	3
3	Time from date patient is ready for care to episode start by setting of care	4
4	Time in unstable phase by setting of care	7
5	Achieving absent to mild symptoms/problems at phase end, when absent to mild at start	9
6	Achieving absent to mild symptoms/problems at phase end, when moderate to severe at start	10
7	Casemix adjusted outcomes - inpatient setting	21
8	Casemix adjusted outcomes - non-admitted setting	22
9	Sex	25
10	Sex for SA Services over time	25
11	Indigenous status	26
12	Indigenous status for SA Services over time	26
13	Country of birth	27
14	Preferred language	27
15	Principal diagnosis - malignant	29
16	Principal diagnosis - non-malignant	30
17	Place of death	32
18	Place of death for SA Services over time	32
19	Patient's age by sex	34
20	Source of referral	35
21	Referral source for SA Services over time	36
22	Length of episode (in days) summary by setting of care	37
23	Length of episode (in days) summary for SA Services over time	37
24	Length of episode (days)	38
25	How inpatient episodes start	39
26	How inpatient episodes end	39
27	How inpatient episodes start for SA Services over time	40
28	How inpatient episodes end for SA Services over time	40
29	How non-admitted episodes start	42

30	How non-admitted episodes end	42
31	How non-admitted episodes start for SA Services over time	43
32	How non-admitted episodes end for SA Services over time	43
33	Number of patient phases by phase type and setting of care	46
34	Average phase length (in days) by phase type and setting of care	47
35	First phase of episode by setting	49
36	PCPSS at phase start by phase type - inpatient setting	53
37	PCPSS at phase start by phase type - non-admitted setting	54
38	Symptom distress at phase start by phase type - inpatient setting	55
39	Symptom distress at phase start by phase type - non-admitted setting	56
40	The Resource Utilisation Groups - Activities of Daily Living (RUG-ADL) at phase start by setting of care	57
41	Australia-modified Karnofsky Performance Status (AKPS) at phase start by setting of care	59
42	Summary of patients, episodes and phases by setting	61
43	Number of completed episodes and phases by month and setting	62
44	Number of patients, episodes and phases by setting and reporting period	62
45	Item completion (%) - patient level	63
46	Item completion (%) - episode level, by setting of care	64
47	Item completion (%) - phase level, by setting of care	65
48	Item completion (%) - phase end, by setting of care	65

List of Figures

1	Time from date patient is ready for care to episode start, SA Services compared to all services (BM1)	5
2	Time in unstable phase, SA Services compared to all services (BM2)	8
3	Pain, patients assessed with absent to mild severity at phase end (anticipatory)	11
4	Pain, patients assessed with absent to mild severity at phase end (responsive)	12
5	Pain, patients reporting absent to mild distress at phase end (anticipatory)	13
6	Pain, patients reporting absent to mild distress at phase end (responsive)	14
7	Fatigue, patients reporting absent to mild distress at phase end (anticipatory)	15
8	Fatigue, patients reporting absent to mild distress at phase end (responsive)	16

9	Breathing problems, patients reporting absent to mild distress at phase end (anticipatory)	17
10	Breathing problems, patients reporting absent to mild distress at phase end (responsive)	18
11	Family/carer problems, family/carer assessed with absent to mild problem severity at phase end (anticipatory) . . .	19
12	Family/carer problems, family/carer assessed with absent to mild problem severity at phase end (responsive) . . .	20
13	Trends in casemix adjusted outcomes - Palliative Care Problem Severity Score (PCPSS)	23
14	Trends in casemix adjusted outcomes - Symptom Assessment Scale (SAS)	24
15	Principal diagnosis over time for SA Services	31
16	How episodes end for SA Services over time - inpatient setting	41
17	How episodes end for SA Services over time - non-admitted setting	44
18	Patient phase profile over time - inpatient setting	48
19	Patient phase profile over time - non-admitted setting	48
20	Alluvial plots showing referral source by first phase type – Inpatient setting	50
21	Alluvial plots showing referral source by first phase type – Non-Admitted setting	51
22	Distribution of patient’s RUG-ADL Total at episode start	58
23	Distribution of AKPS for patients at episode start	60
24	Profile of symptoms and problems by phase type for SA Services- inpatient setting	66
25	Profile of symptoms and problems by phase type for SA Services- non-admitted setting	67
26	Diagram of the PCOC data scoping method	68

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.

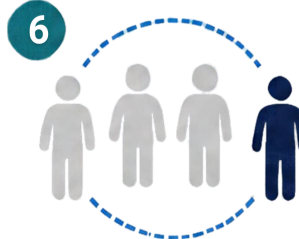
3



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.

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 SA Services included in this report

Service name	Setting of care
Adelaide Hills Palliative Care	Community
Barossa Palliative Care	Community
Calvary Community Care SA	Community
Calvary Health Care Adelaide (Mary Potter Hospice)	Inpatient
Central Adelaide Palliative Service	Community
Central Adelaide Palliative Service	Inpatient
EFNLHN Palliative Care Service	Community
Fleurieu Palliative Care	Community
Limestone Coast LHN Specialist Palliative Care Service	Community
Noarlunga Hospital	Inpatient
Northern Adelaide Palliative Service	Community
Northern Adelaide Palliative Service	Inpatient
Port Augusta	Community
Port Augusta	Inpatient
Royal Adelaide Hospital	Inpatient
Silverchain - South Australia	Community
Southern Adelaide Palliative Care Consult	Inpatient
Southern Adelaide Palliative Services	Community
Southern Adelaide Palliative Services	Inpatient
Whyalla Palliative Care Service	Community
Whyalla Palliative Care Service	Inpatient
Yorke Peninsula Palliative Care	Community

1 Benchmark Summary for SA Services

Table 2: 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%	96.4	Yes	93.2	Yes	1
Responsiveness in managing patients with urgent needs							
	Patients unstable for three days or less	90%	87.7	No	84.4	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%	90.6	Yes	84.9	No	3.1
	Pain (patient reported)		89.3	No	86.6	No	3.3
	Fatigue (patient reported)		89.7	No	83.0	No	3.5
	Breathing problems (patient reported)		95.4	Yes	92.2	Yes	3.7
	Family/carer problems (clinician reported)		91.3	Yes	82.0	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%	47.7	No	45.4	No	3.2
	Pain (patient reported)		52.2	No	41.6	No	3.4
	Fatigue (patient reported)		59.3	No	42.2	No	3.6
	Breathing problems (patient reported)		49.5	No	39.6	No	3.8
	Family/carer problems (clinician reported)		59.6	No	42.9	No	3.10
Casemix adjusted outcomes (change scores)		Baseline	Score		Score		
Clinician Reported Problems (PCPSS)	Pain	0.0	-0.06	No	-0.17	No	4.1
	Other Symptoms		0.19	Yes	-0.05	No	4.2
	Family/Carer Problems		0.21	Yes	-0.02	No	4.3
	Psychological/Spiritual Problems		0.20	Yes	-0.07	No	4.4
Patient Reported System Distress (SAS)	Pain	0.0	-0.09	No	-0.29	No	4.5
	Nausea		0.19	Yes	-0.05	No	4.6
	Breathing Problems		0.20	Yes	-0.08	No	4.7
	Bowel Problems		0.30	Yes	-0.10	No	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' care starts the day of or the day after the date ready for care.

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

Time (in days)	Inpatient				Non-Admitted			
	SA Services		All Services		SA Services		All Services	
	N	%	N	%	N	%	N	%
Same day	890	91.3	21,946	91.8	1,184	89.8	14,980	79.0
Following day	50	5.1	1,170	4.9	45	3.4	999	5.3
2-7	35	3.6	686	2.9	71	5.4	1,777	9.4
8-14	0	0.0	51	0.2	9	0.7	633	3.3
15+	0	0.0	60	0.3	9	0.7	562	3.0
Average	1.1	-	1.2	-	1.7	-	2.7	-
Median	1	-	1	-	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.

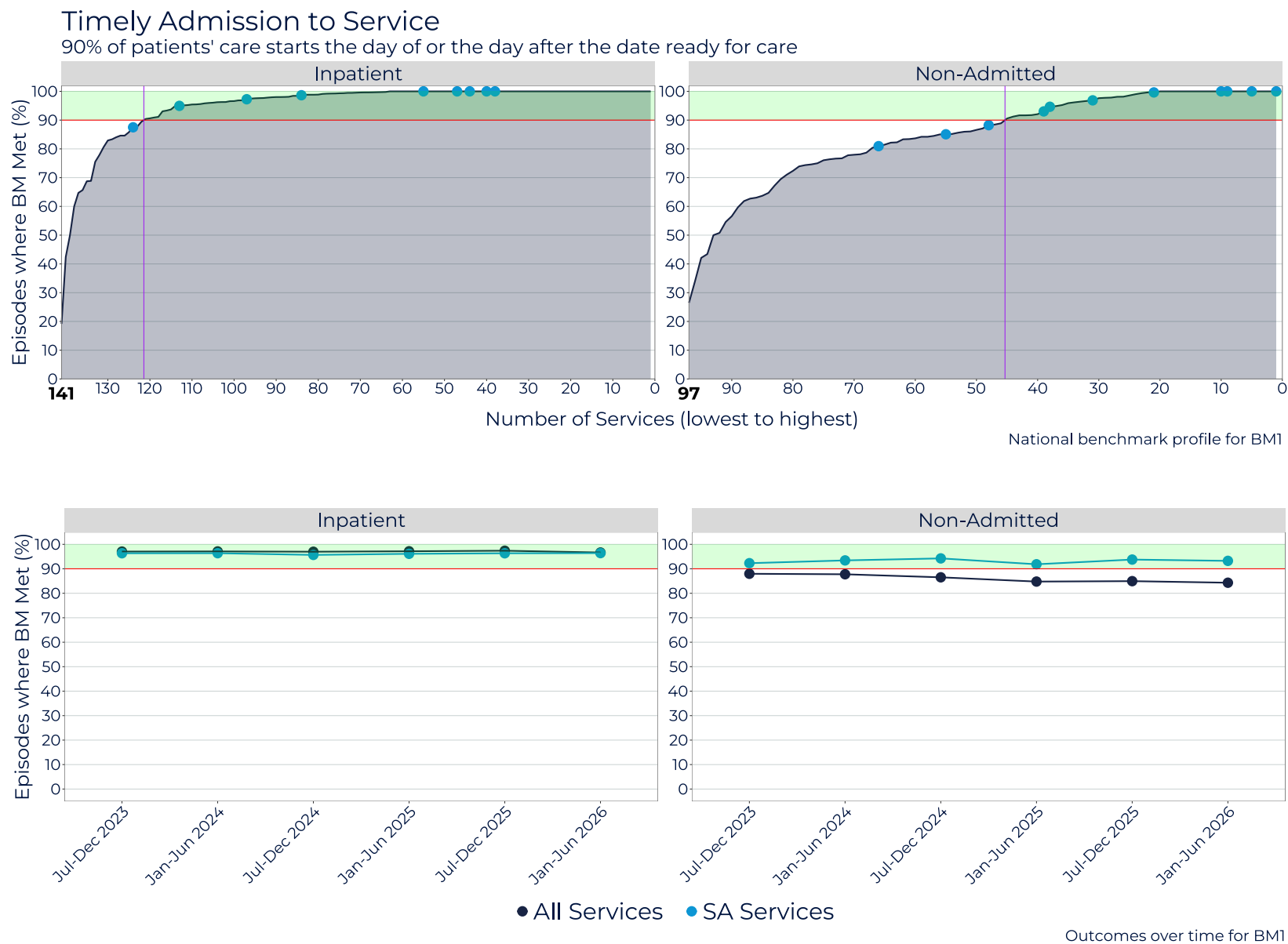


Figure 1: Time from date patient is ready for care to episode start, SA Services compared to all services (BM1)

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

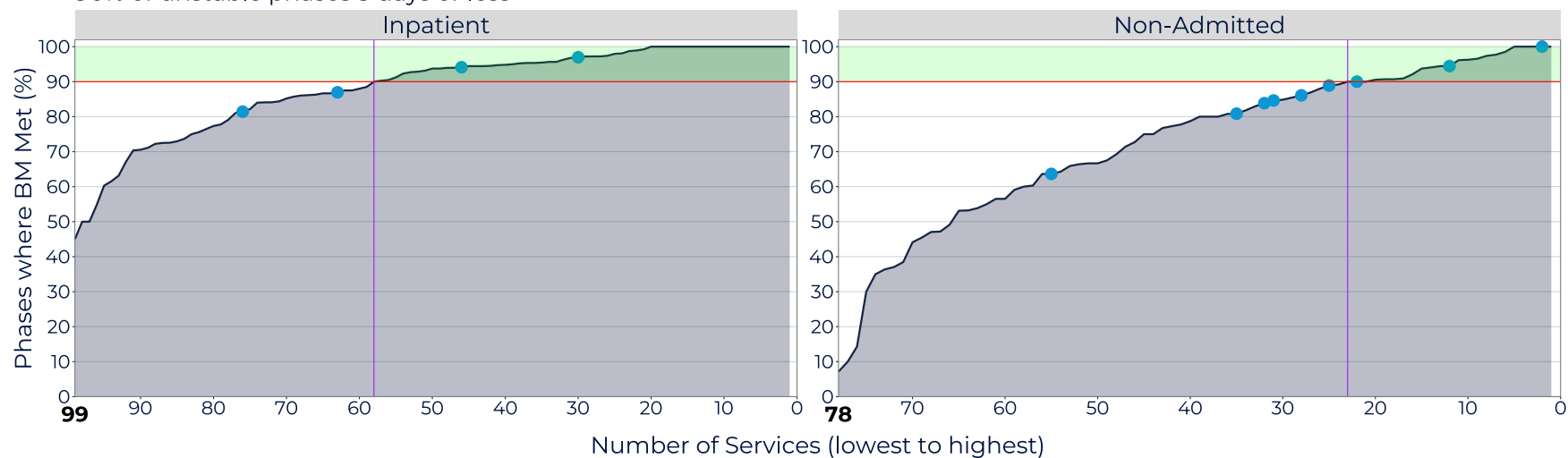
This benchmark relates to the time that a patient spends in the unstable phase. To meet this benchmark, at least 90% of unstable phases must last for three days or less.

Table 4: Time in unstable phase by setting of care

Time in Unstable Phase	Inpatient				Non-Admitted			
	SA Services		All Services		SA Services		All Services	
	N	%	N	%	N	%	N	%
Same day	30	20.4	597	9.1	166	28.2	1,425	33.0
1 day	69	46.9	3,427	52.2	229	38.9	1,359	31.4
2 days	26	17.7	1,080	16.5	63	10.7	437	10.1
3 days	11	7.5	587	8.9	38	6.5	244	5.6
4-5 days	11	7.5	453	6.9	37	6.3	231	5.3
6-7 days	s	s	199	3.0	14	2.4	181	4.2
8-14 days	s	s	165	2.5	17	2.9	195	4.5
15+ days	0	0.0	53	0.8	24	4.1	251	5.8
Total	147	100.0	6,561	100.0	588	100.0	4,323	100.0

Responsiveness to urgent needs

90% of unstable phases 3 days or less



National benchmark profile for BM2

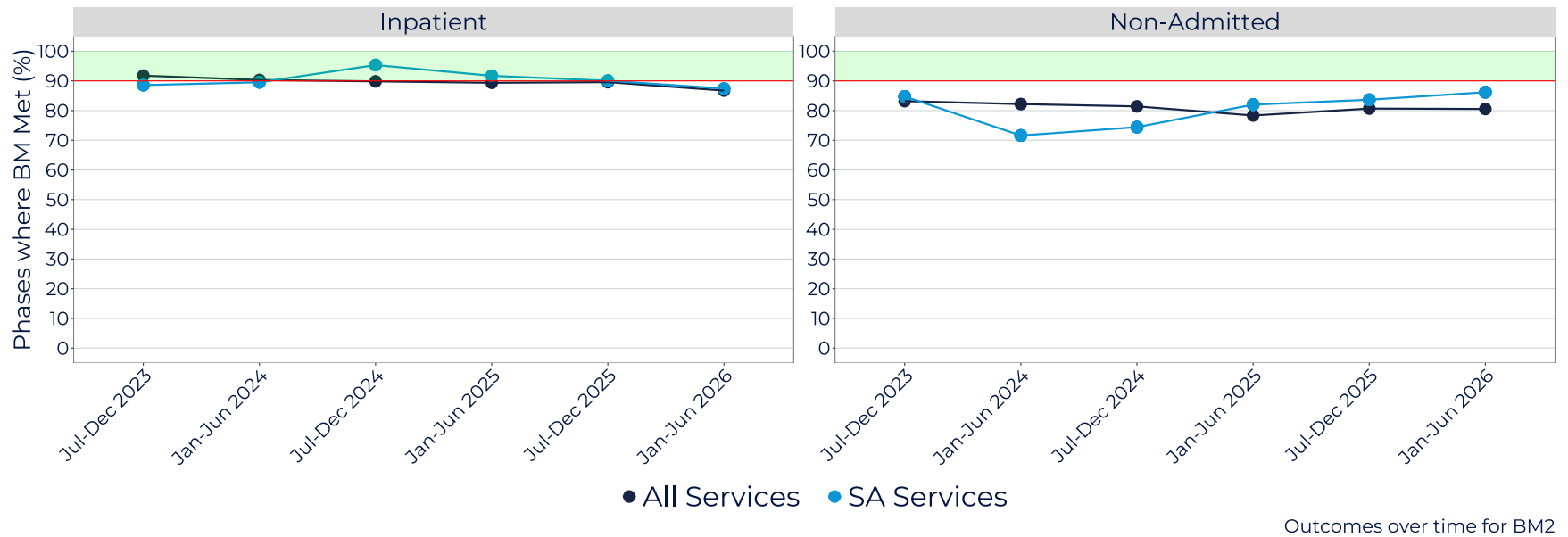


Figure 2: Time in unstable phase, SA Services compared to all services (BM2)

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	Inpatient				Non-Admitted			
	SA Services		All Services		SA Services		All Services	
	N ^b	%	N ^b	%	N ^b	%	N ^b	%
Pain (clinician reported)	873	90.6	28,199	91.3	2,418	84.9	30,873	85.8
Pain (patient reported)	805	89.3	24,928	90.7	2,349	86.6	30,545	84.6
Fatigue (patient reported)	848	89.7	26,015	93.3	2,048	83.0	27,602	83.2
Breathing problems (patient reported)	967	95.4	28,103	96.1	2,466	92.2	32,510	93.0
Family/carer problems (clinician reported)	895	91.3	28,173	93.6	2,256	82.0	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 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	Inpatient				Non-Admitted			
	SA Services		All Services		SA Services		All Services	
	N ^b	%	N ^b	%	N ^b	%	N ^b	%
Pain (clinician reported)	243	47.7	6,168	64.2	710	45.4	6,829	57.8
Pain (patient reported)	251	52.2	6,036	62.3	694	41.6	7,634	54.4
Fatigue (patient reported)	214	59.3	4,709	62.6	870	42.2	9,251	46.2
Breathing problems (patient reported)	111	49.5	2,721	62.1	462	39.6	4,009	50.2
Family/carer problems (clinician reported)	114	59.6	3,516	59.2	613	42.9	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.

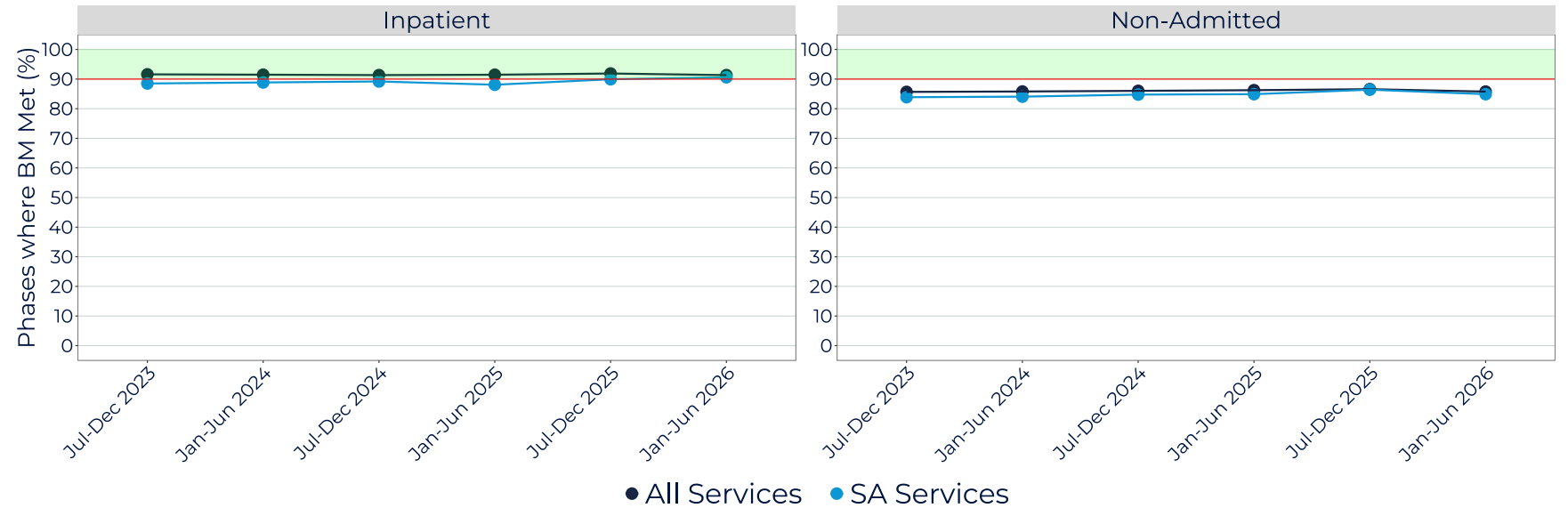
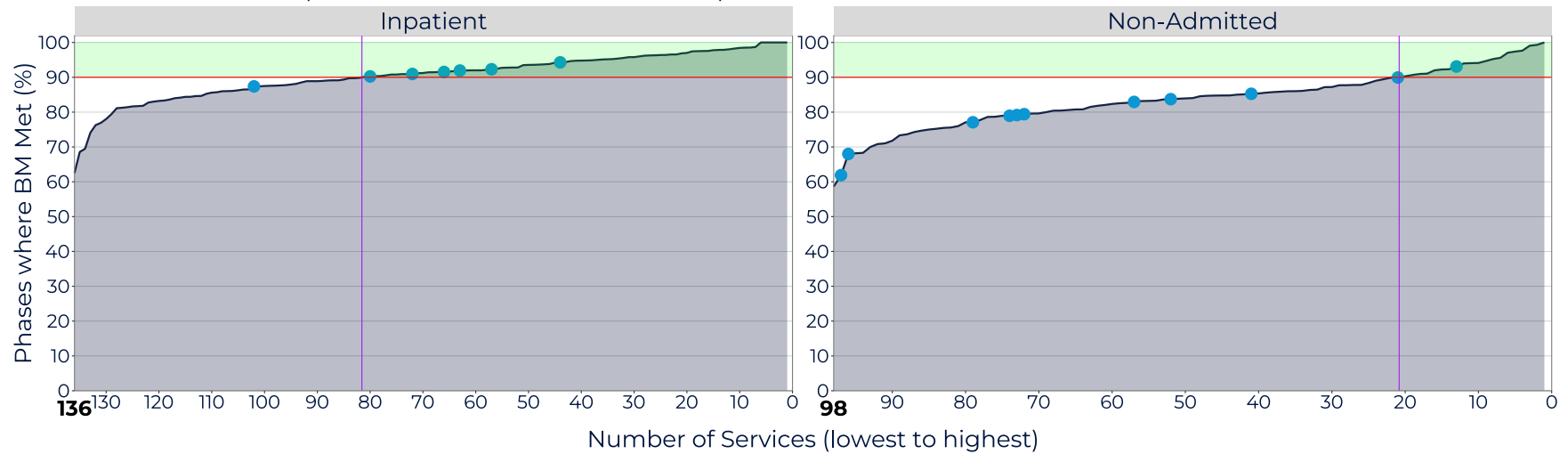
b. N represents the total number of phases starting with the symptom or problem rated **moderate to severe**.

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 by SA Services to those of other individual services 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

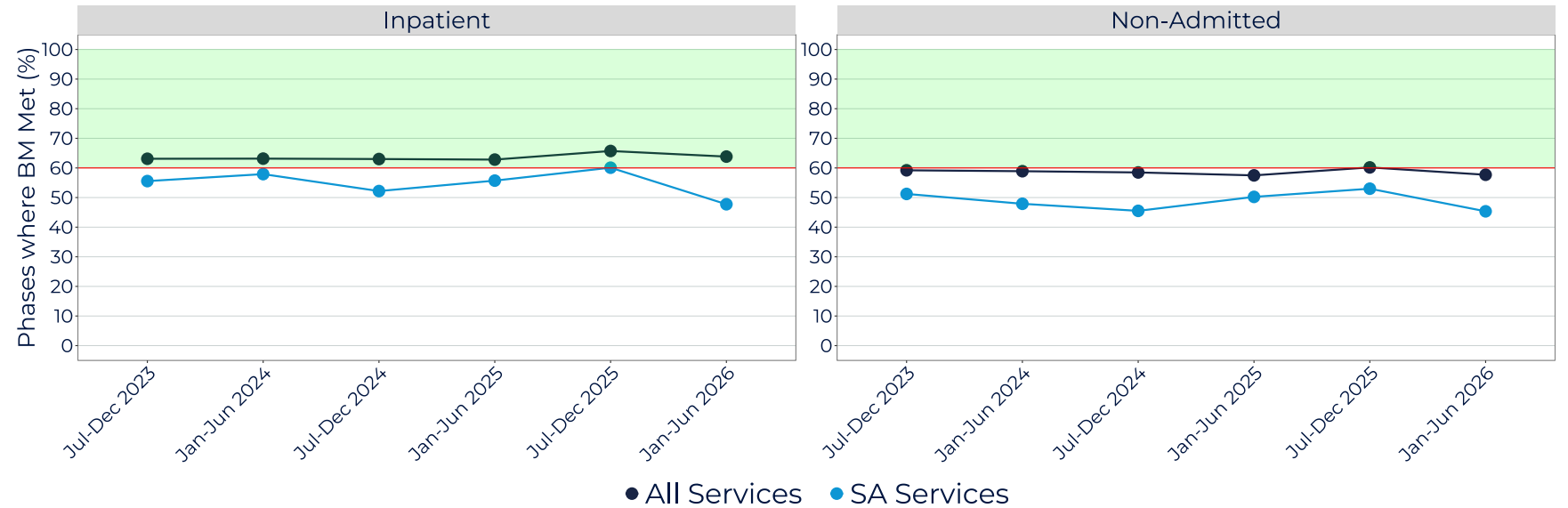
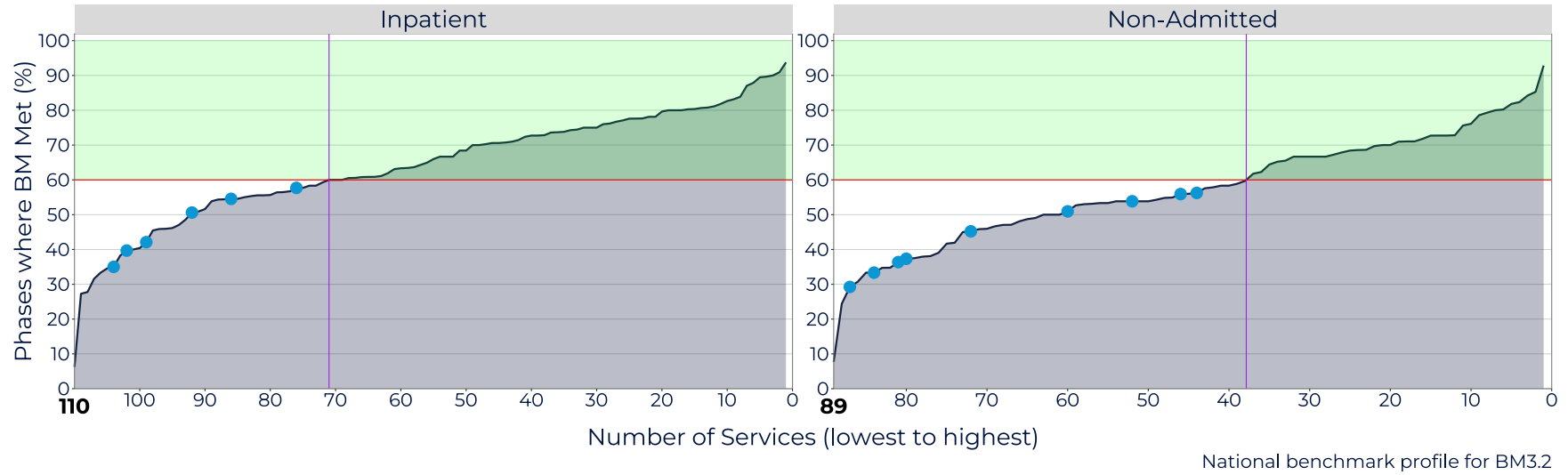


Outcomes over time for BM3.1

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



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

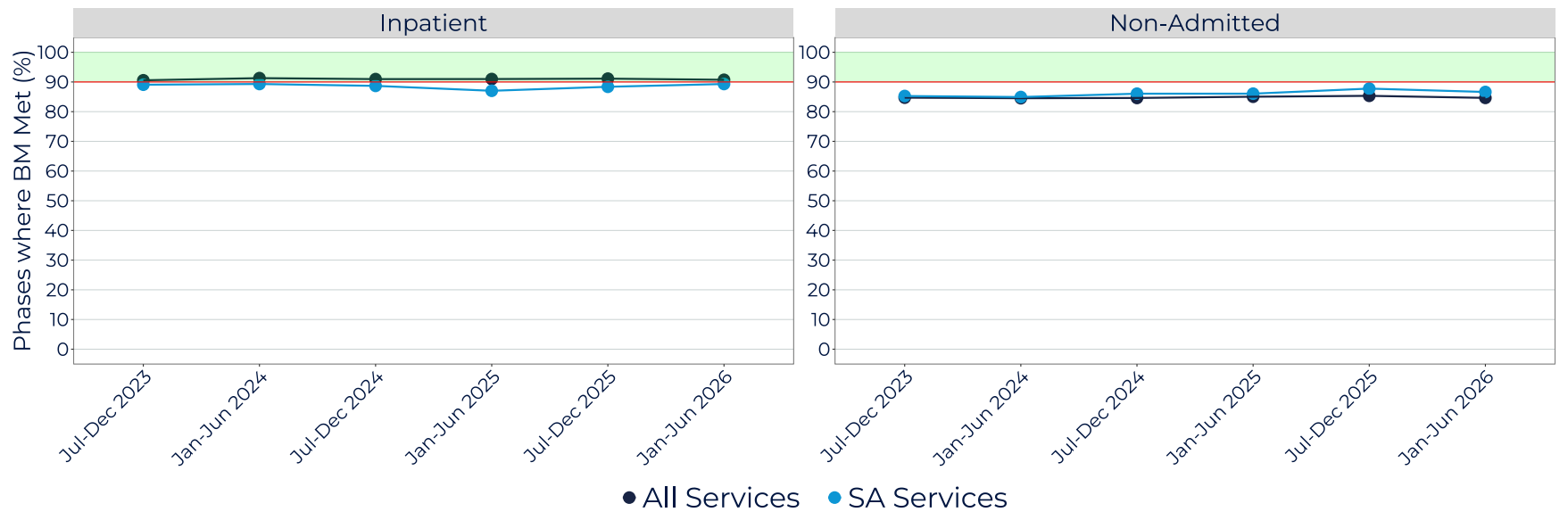
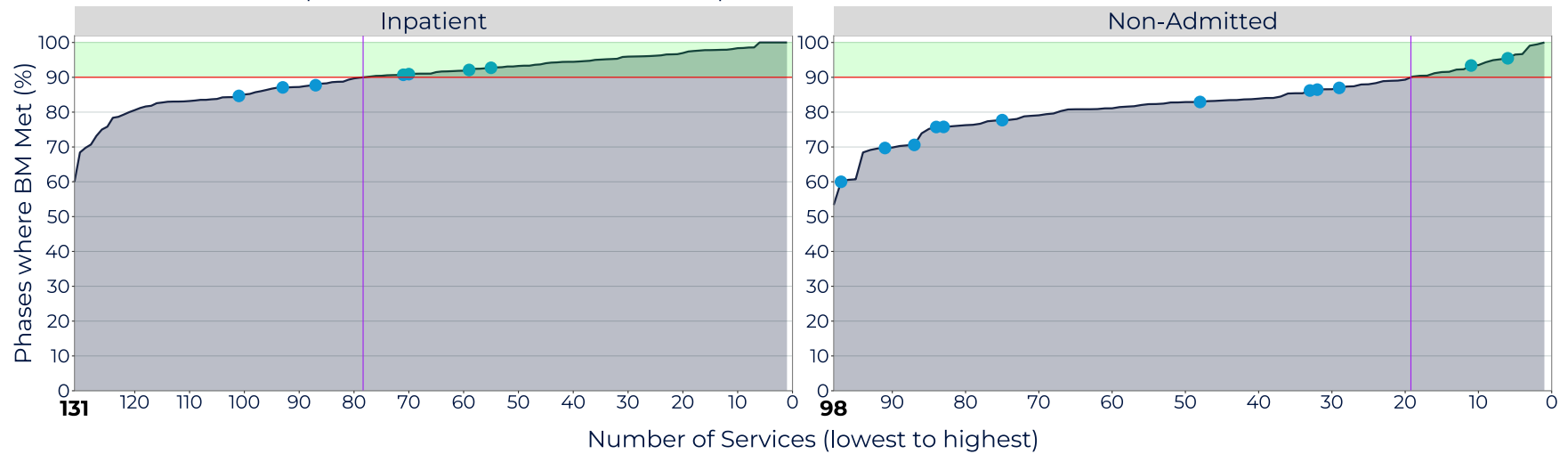
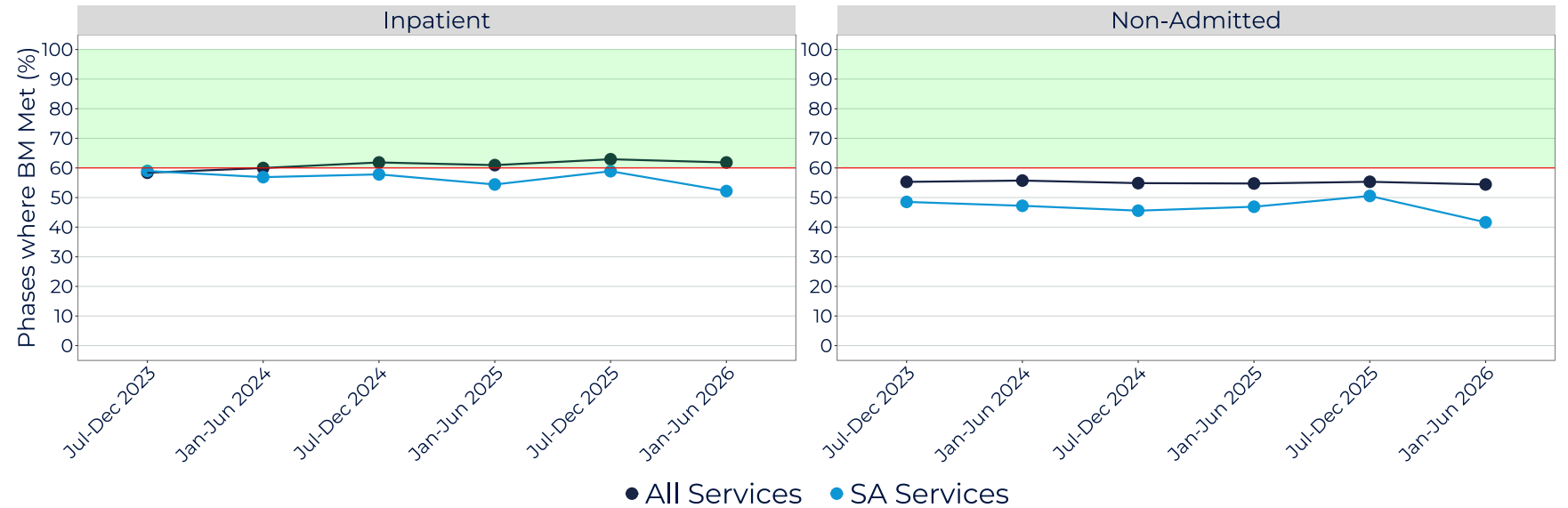
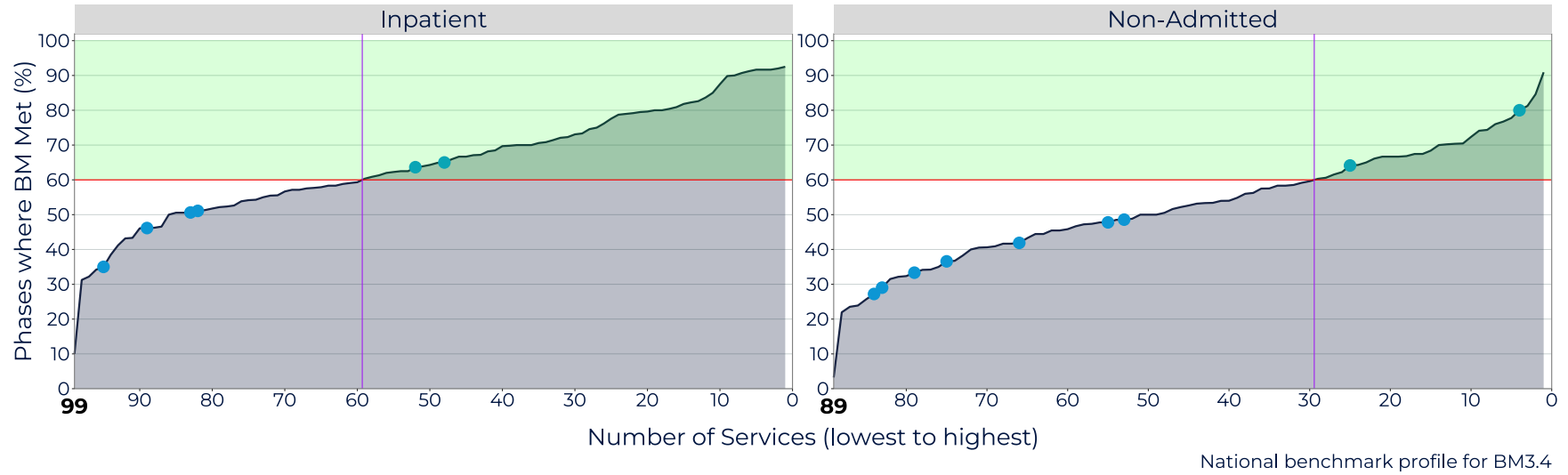


Figure 5: Pain, patients reporting absent to mild distress at phase end (anticipatory)

Responsive care - Pain (SAS)

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

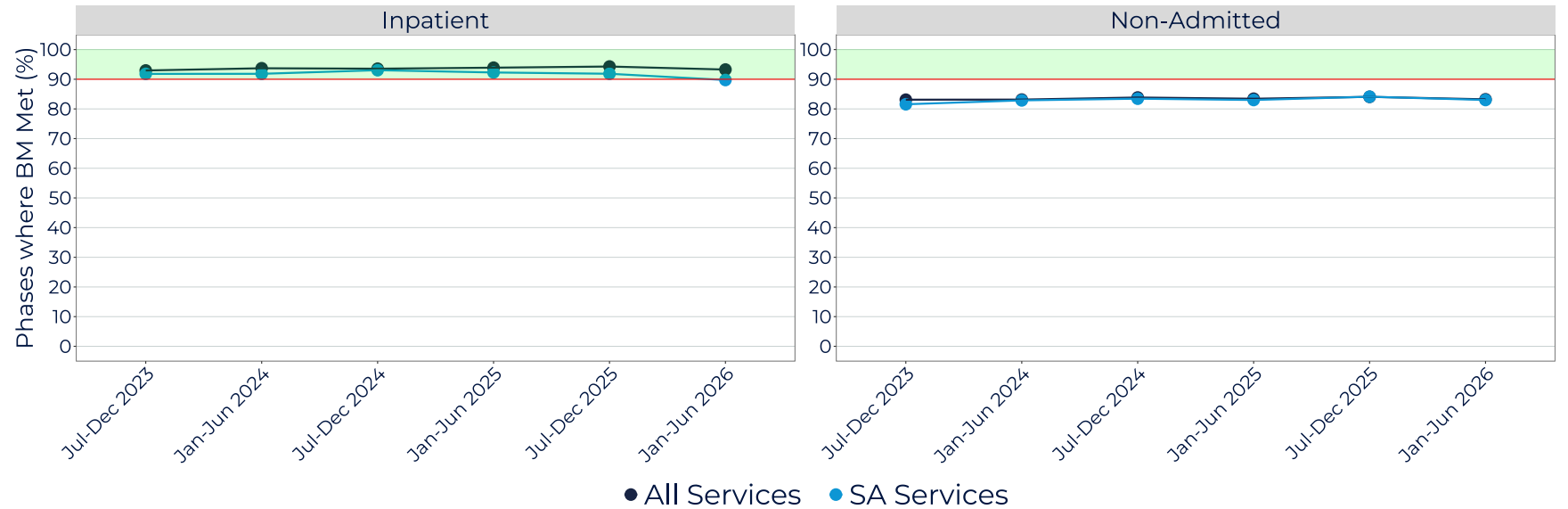
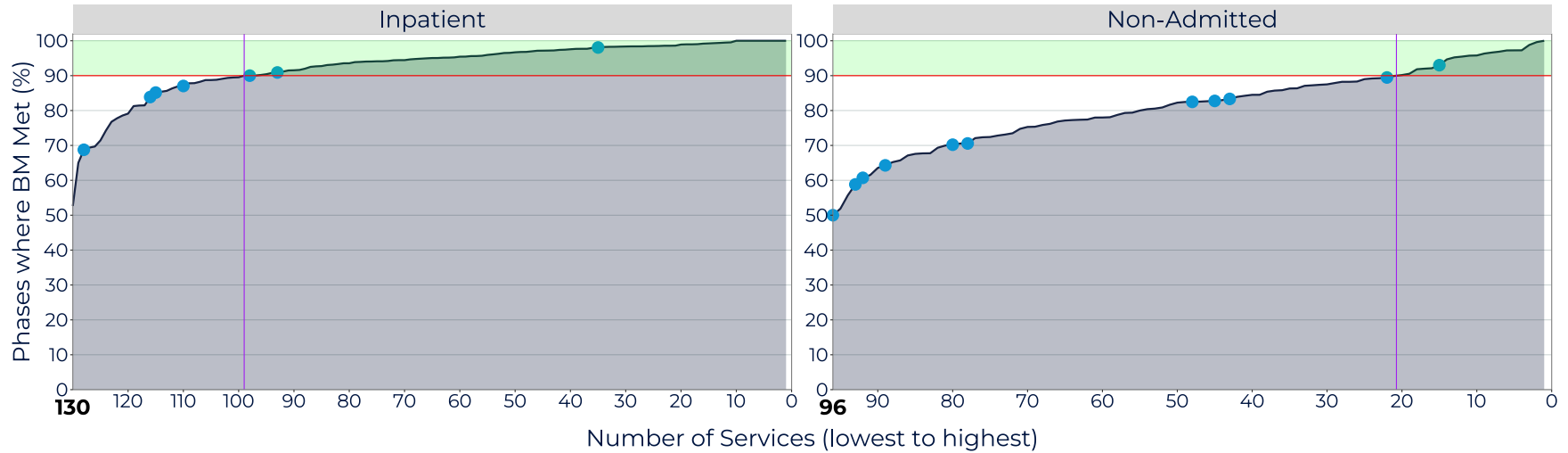


Outcomes over time for BM3.4

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



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

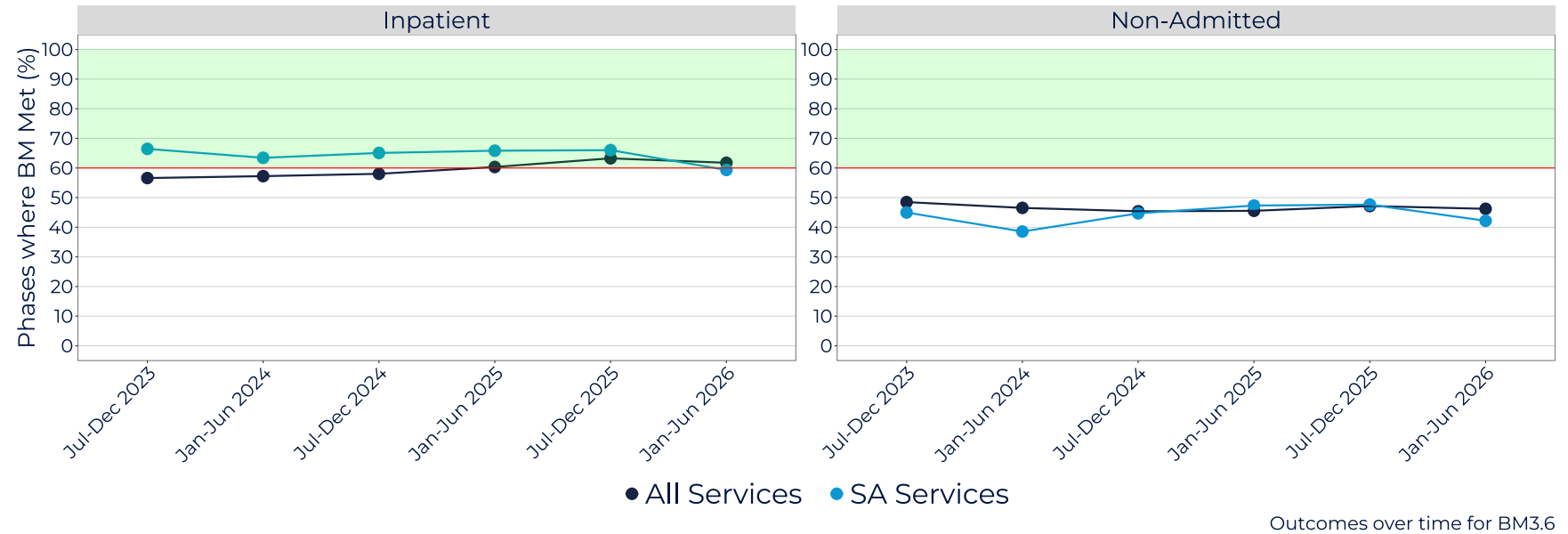
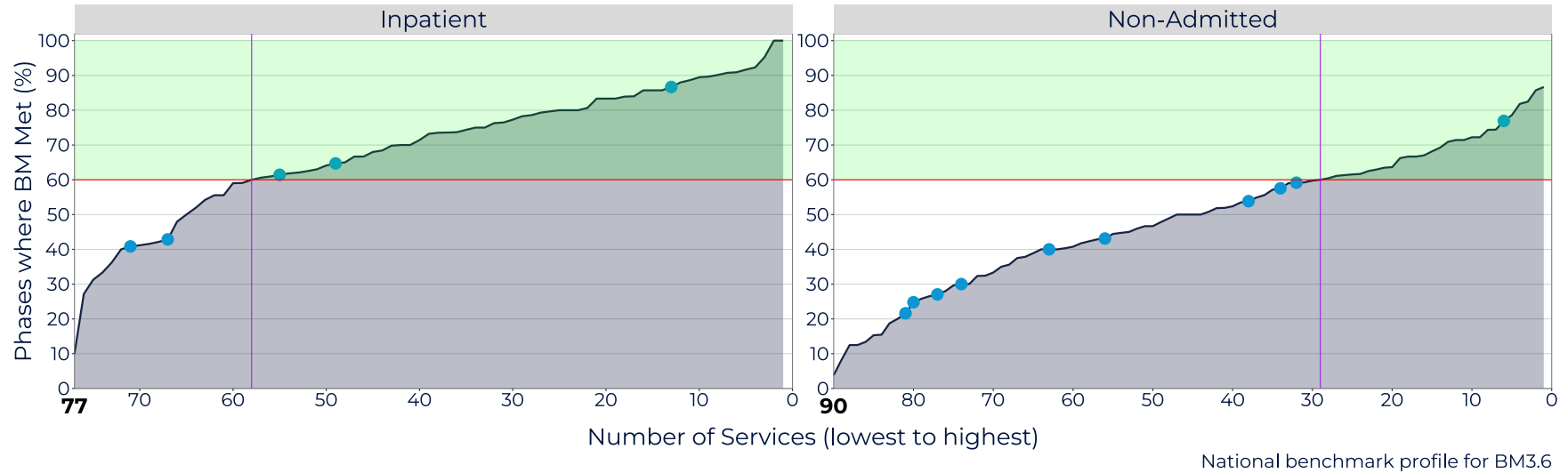
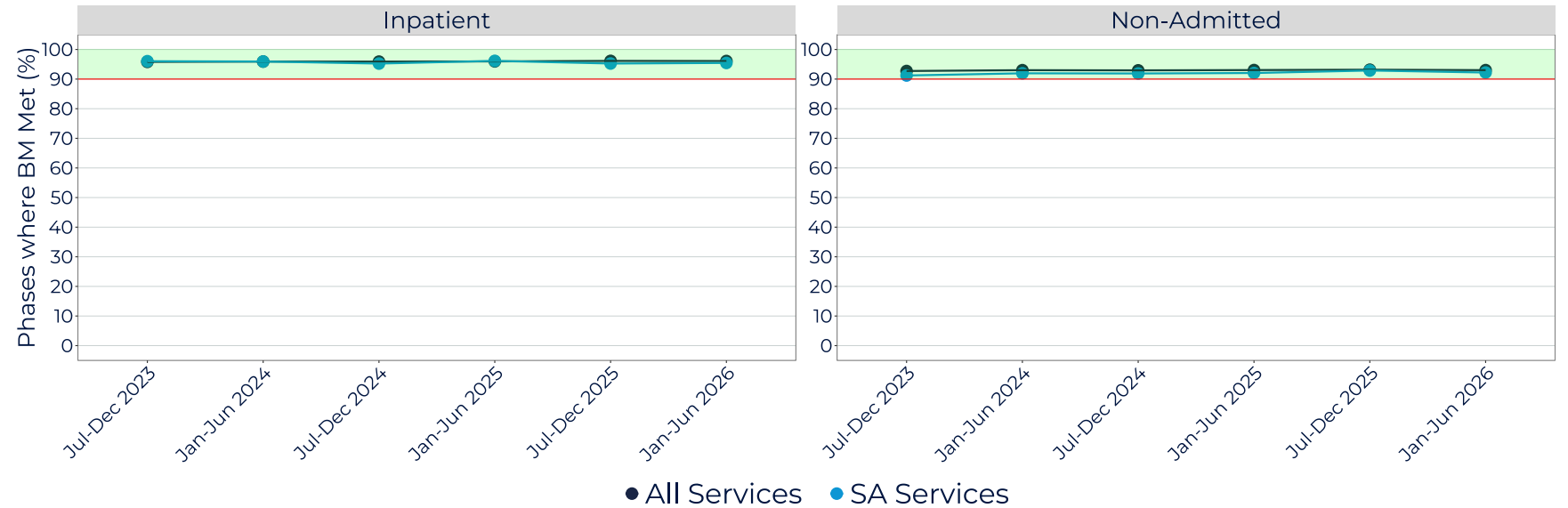
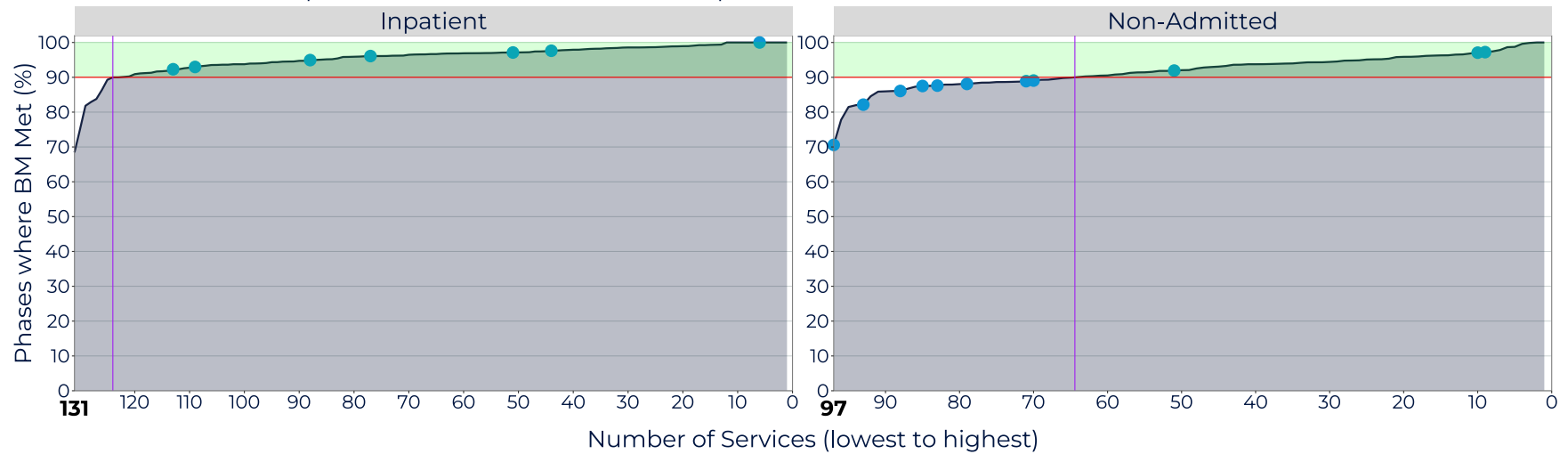


Figure 8: Fatigue, patients reporting absent to mild distress at phase end (responsive)

Anticipatory care - Breathing problems (SAS)

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

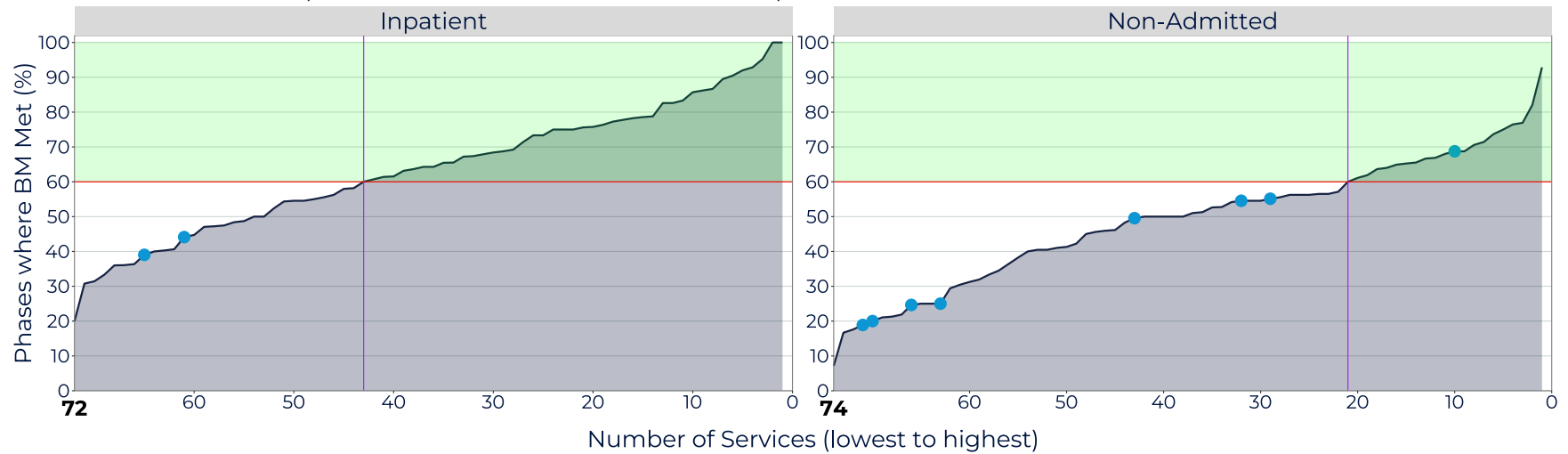


Outcomes over time for BM3.7

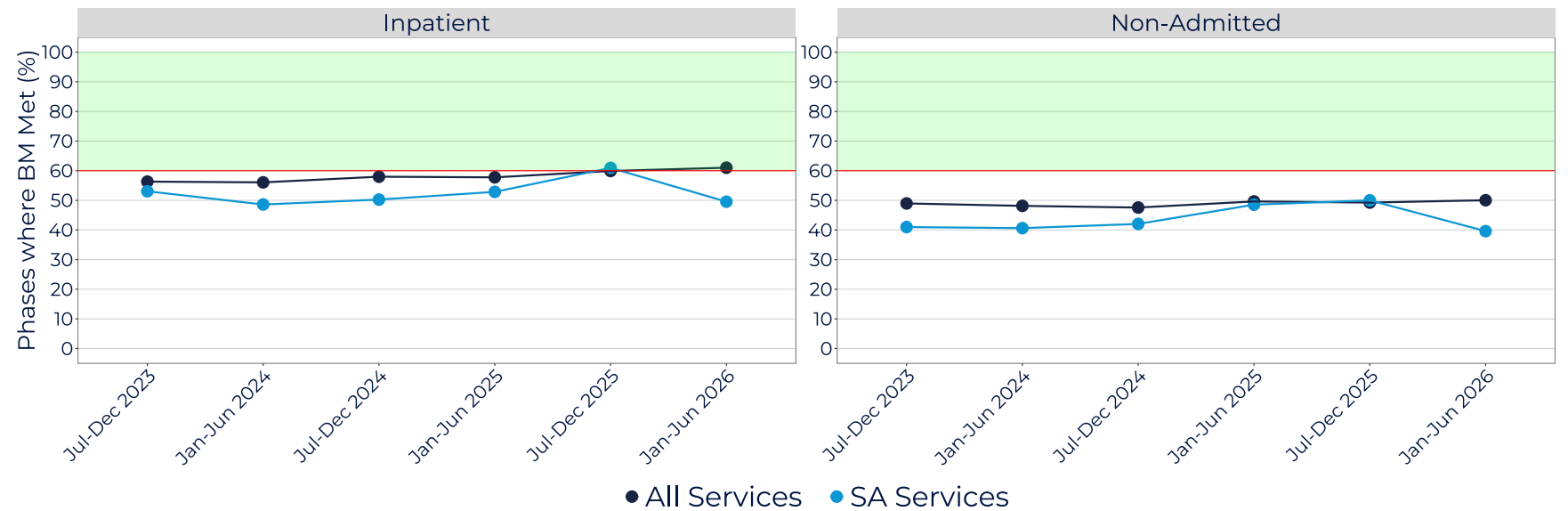
Figure 9: Breathing problems, patients reporting absent to mild distress at phase end (anticipatory)

Responsive care - Breathing problems (SAS)

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



National benchmark profile for BM3.8

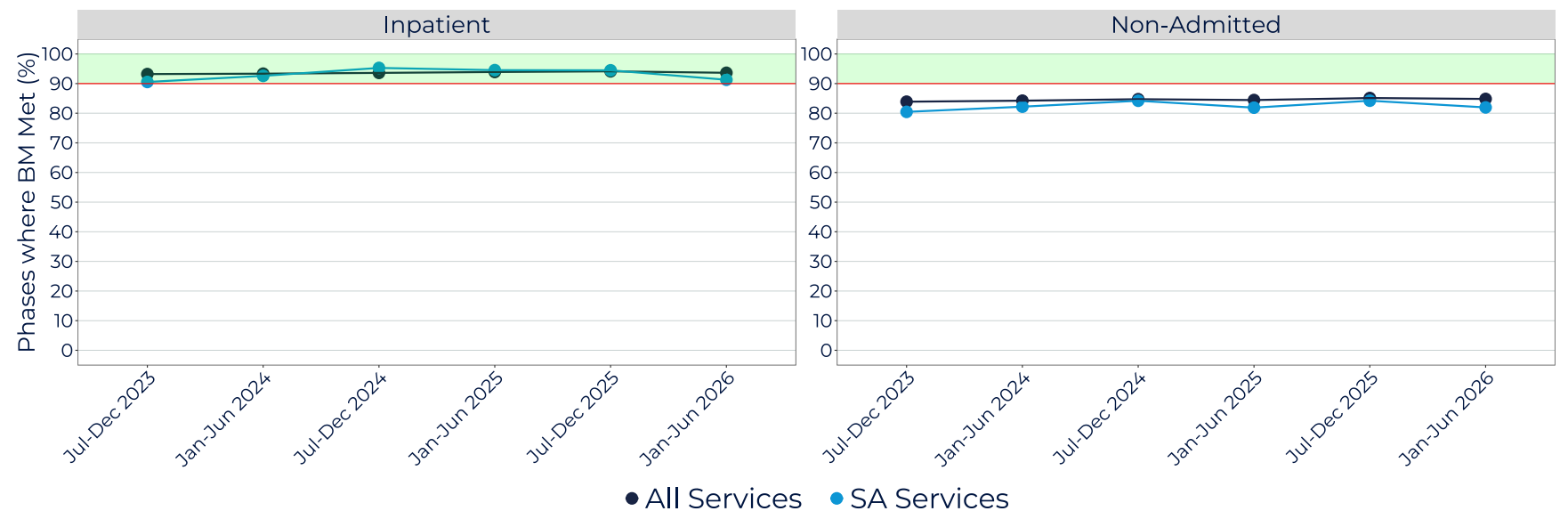
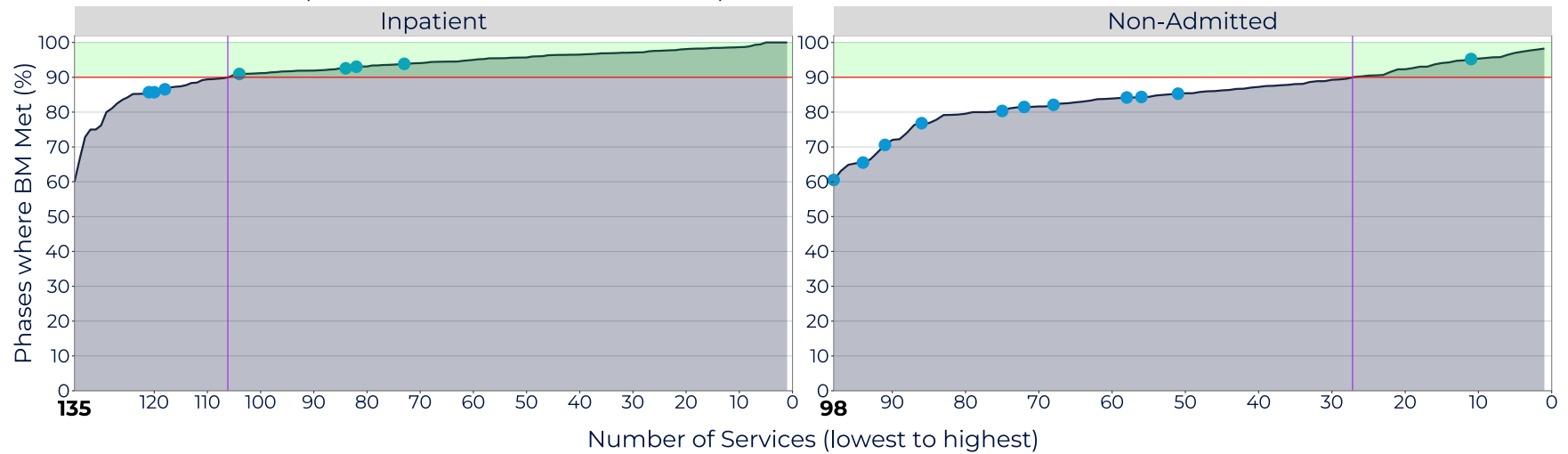


Outcomes over time for BM3.8

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

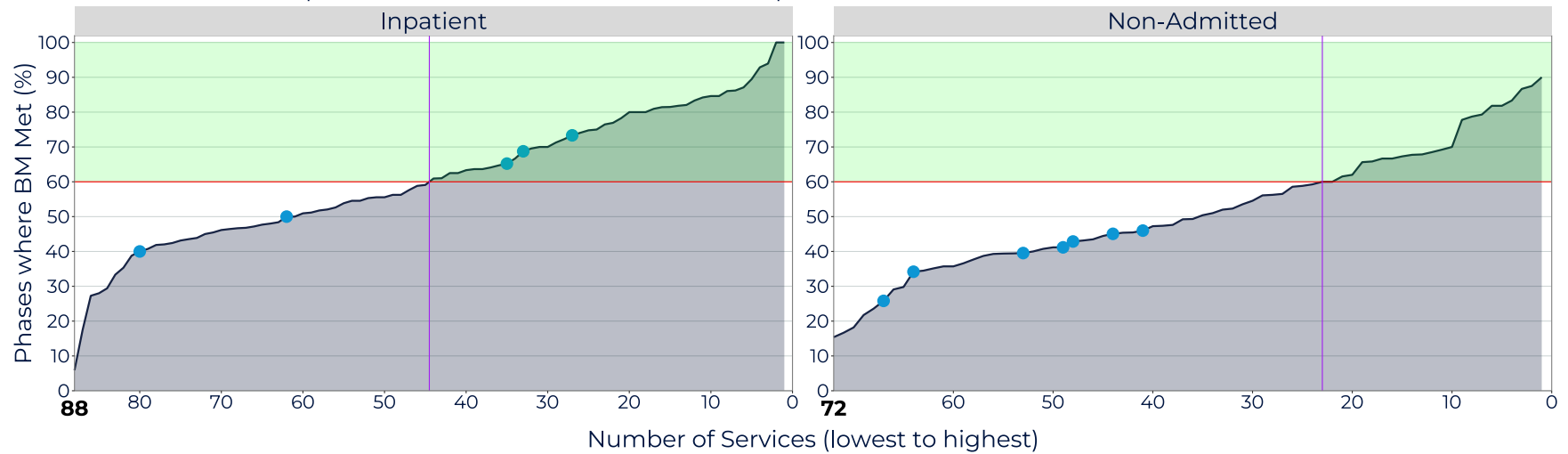


Outcomes over time for BM3.9

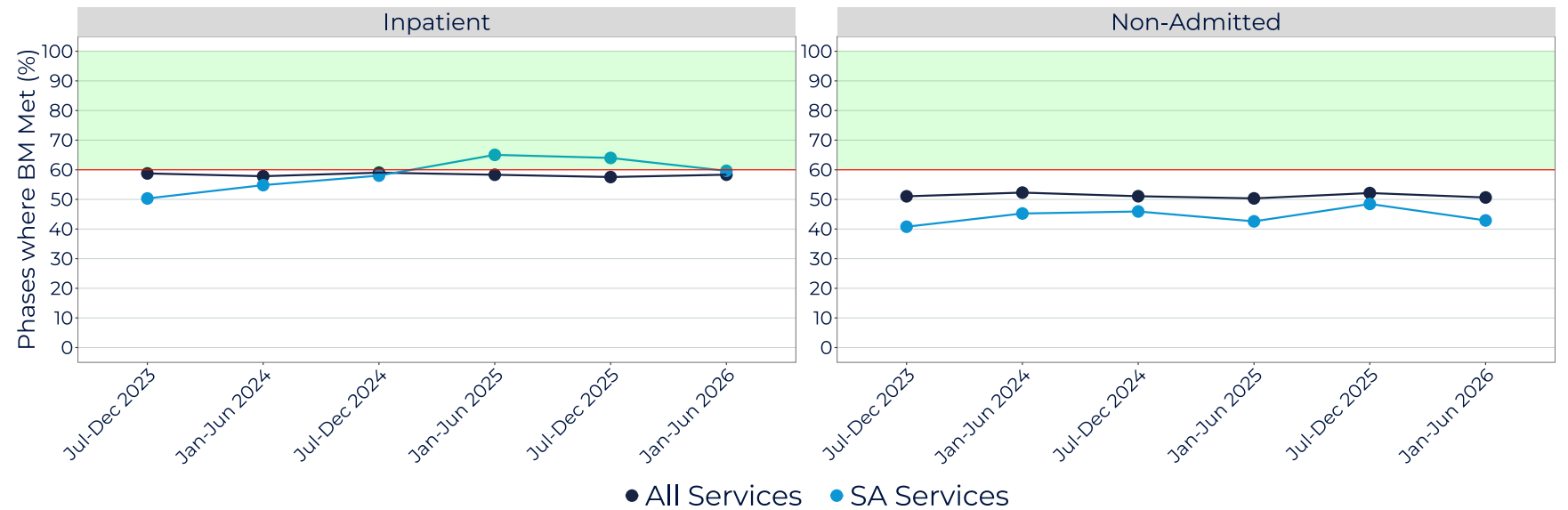
Figure 11: Family/carer problems, family/carer assessed with absent to mild problem severity at phase end (anticipatory)

Responsive care - Family/carers problems (PCPSS)

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



National benchmark profile for BM3.10



Outcomes over time for BM3.10

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 - inpatient setting

Clinical Tool	Symptom/Problem	SA Services				All Inpatient Services			
		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	-0.06	1,116	503	45.1	0.10	34,367	21,352	62.1
	Other symptoms	0.19	1,120	826	73.8	0.27	33,356	25,330	75.9
	Family/carer	0.21	994	749	75.4	0.24	31,557	24,216	76.7
	Psychological/spiritual	0.20	1,106	680	61.5	0.24	34,097	23,605	69.2
SAS <i>Patient reported distress</i>	Pain	-0.09	1,056	584	55.3	0.29	30,964	20,817	67.2
	Nausea	0.19	1,060	962	90.8	0.20	30,705	27,166	88.5
	Breathing problems	0.20	1,062	815	76.7	0.31	30,735	25,033	81.4
	Bowel problems	0.30	1,050	869	82.8	0.31	30,652	24,974	81.5

The Casemix adjusted scores are calculated relative to a baseline reference period. A Casemix adjusted score:

- **greater than 0** means that on average your patients' outcomes were **better than similar patients** in the reference period
- **less than 0** means that on average, your patients outcomes were **worse than similar patients** in the reference period
- **equal to 0** means that on average, your patients outcomes were **about the same as similar patients** in the reference period

Table 8: Casemix adjusted outcomes - non-admitted setting

Clinical Tool	Symptom/Problem	SA Services				All Non-Admitted Services			
		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	-0.17	3,128	1,324	42.3	-0.03	37,702	20,633	54.7
	Other symptoms	-0.05	3,038	1,981	65.2	0.04	36,555	23,913	65.4
	Family/carers	-0.02	2,853	1,824	63.9	0.07	34,214	23,109	67.5
	Psychological/spiritual	-0.07	2,975	1,270	42.7	0.08	36,757	20,991	57.1
SAS <i>Patient reported distress</i>	Pain	-0.29	3,043	1,577	51.8	-0.08	38,179	22,382	58.6
	Nausea	-0.05	2,898	2,244	77.4	-0.01	36,602	29,290	80.0
	Breathing problems	-0.08	2,909	1,788	61.5	0.07	36,429	25,768	70.7
	Bowel problems	-0.10	2,865	1,799	62.8	0.05	36,172	26,279	72.7

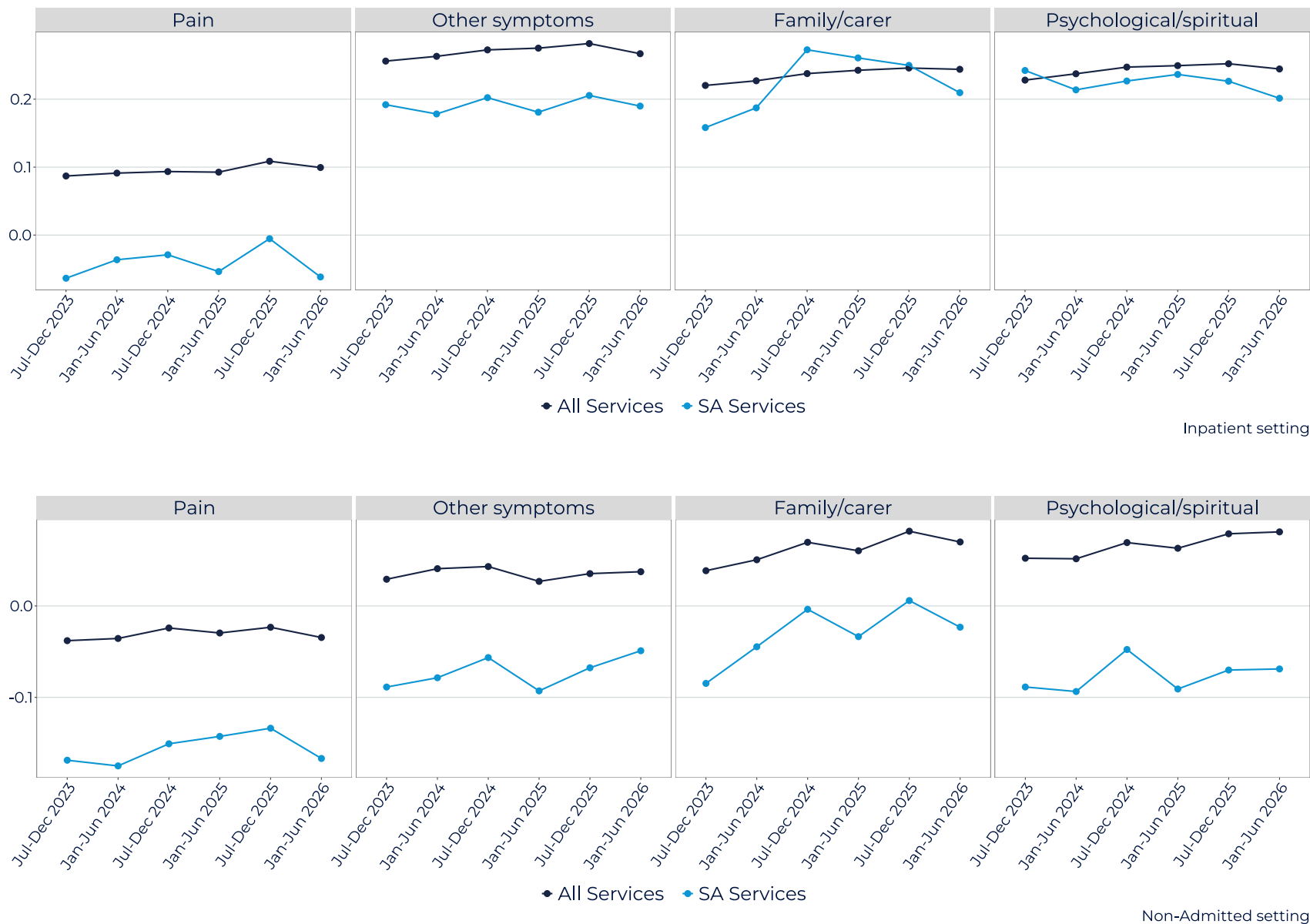


Figure 13: Trends in casemix adjusted outcomes - Palliative Care Problem Severity Score (PCPSS)

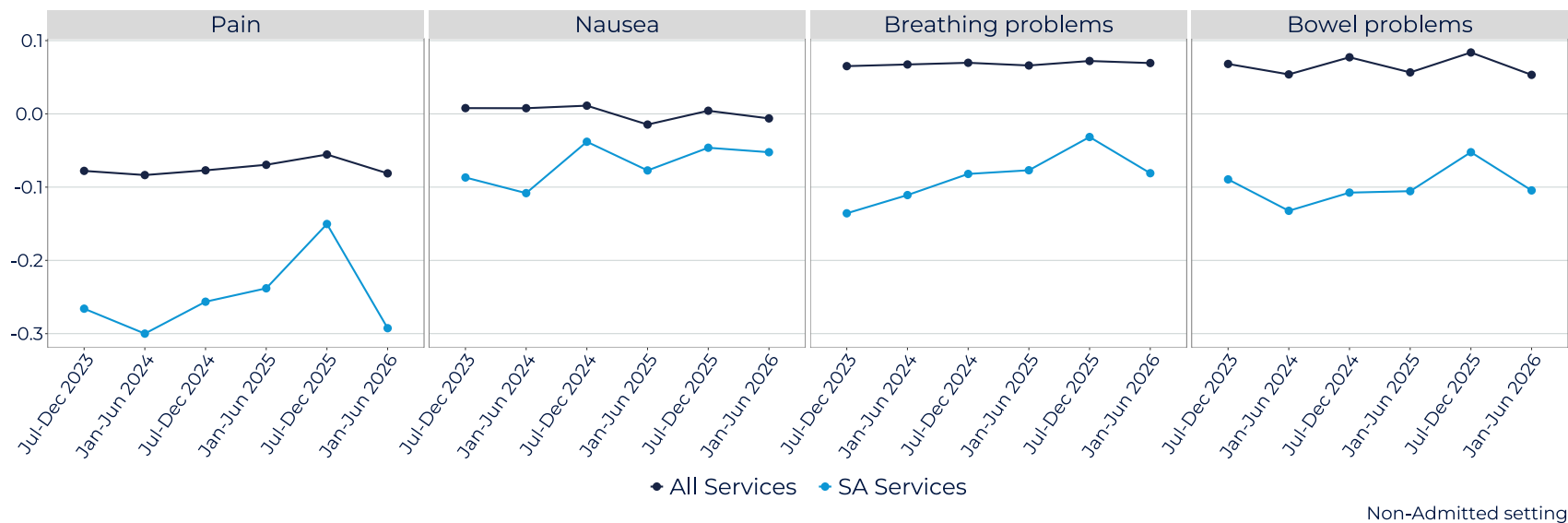
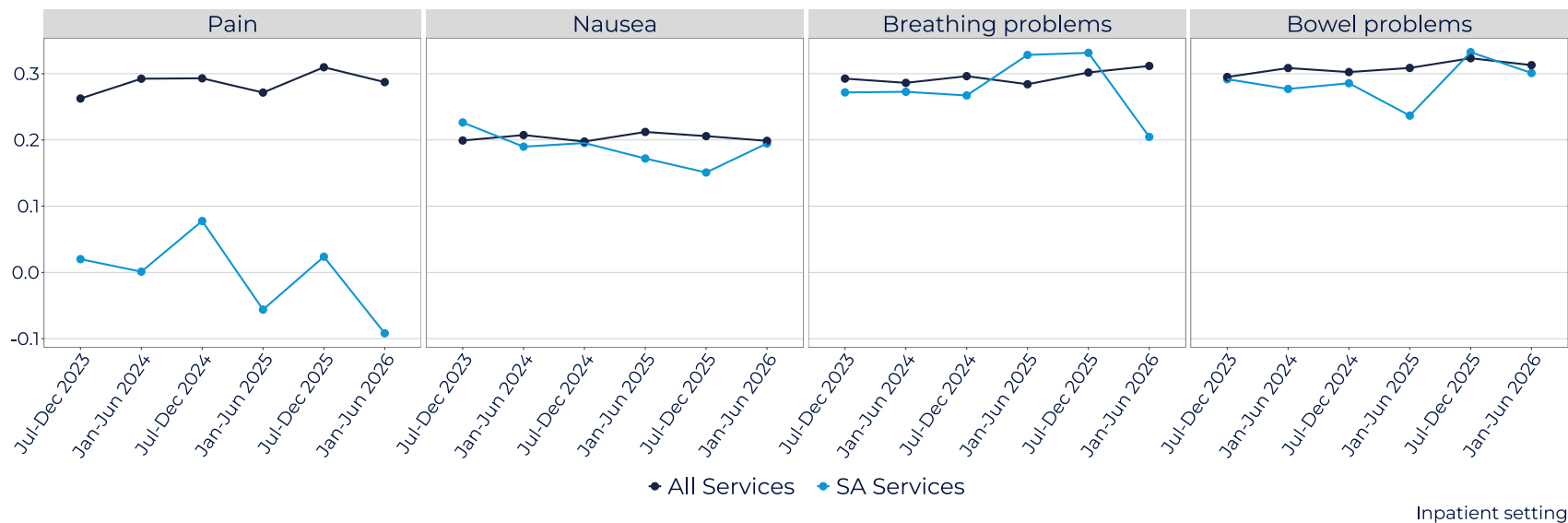


Figure 14: Trends in casemix adjusted outcomes - Symptom Assessment Scale (SAS)

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 9 shows the sex for the patients in SA Services and all participating PCOC services.

Table 9: Sex

Sex	SA Services		All Services	
	N	%	N	%
Male	1,311	51.1	21,571	50.7
Female	1,247	48.6	20,967	49.3
Not stated/Inadequately described/Intersex	6	0.2	7	0.0
Total	2,564	100.0	42,545	100.0

Table 10 shows the sex for the patients in SA Services over time.

Table 10: Sex for SA Services over time

Sex	Jul-Dec 2023	Jan-Jun 2024	Jul-Dec 2024	Jan-Jun 2025	Jul-Dec 2025	Jan-Jun 2026
Male	54.1	53.3	52.1	51.5	51.4	51.1
Female	45.8	46.6	47.8	48.5	48.6	48.6
Not stated/Inadequately described/Intersex	0.1	0.2	0.1	0.0	0.0	0.2
Total	100.0	100.0	100.0	100.0	100.0	100.0

Table 11 shows the Indigenous status for the patients in SA Services and all participating PCOC services.

Table 11: Indigenous status

Indigenous status	SA Services		All Services	
	N	%	N	%
Aboriginal but not Torres Strait Islander origin	39	1.5	925	2.2
Torres Strait Islander but not Aboriginal origin	0	0.0	51	0.1
Both Aboriginal and Torres Strait Islander origin	4	0.2	57	0.1
Neither Aboriginal nor Torres Strait Islander origin	2,418	94.3	40,271	94.7
Not stated/inadequately described	103	4.0	1,241	2.9
Total	2,564	100.0	42,545	100.0

Table 12 shows the Indigenous status for the patients in SA Services over time.

Table 12: Indigenous status for SA Services 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	1.7	2.0	1.4	1.6	1.2	1.5
Torres Strait Islander but not Aboriginal origin	0.0	0.0	0.0	0.0	0.0	0.0
Both Aboriginal and Torres Strait Islander origin	0.1	0.2	0.0	0.1	0.0	0.2
Neither Aboriginal nor Torres Strait Islander origin	94.9	94.4	95.4	94.6	79.9	94.3
Not stated/inadequately described/Intersex	3.3	3.4	3.1	3.7	18.9	4.0
Total	100.0	100.0	100.0	100.0	100.0	100.0

Table 13: Country of birth

Country of birth	SA Services		All Services	
	N	%	N	%
Australia	1,559	61.0	26,903	63.2
England	264	10.3	2,677	6.3
India	12	0.5	400	0.9
China	14	0.5	763	1.8
New Zealand	20	0.8	974	2.3
Philippines	14	0.5	275	0.6
Vietnam	36	1.4	354	0.8
South Africa	20	0.8	242	0.6
Malaysia	8	0.3	171	0.4
Italy	111	4.3	1,397	3.3
Sri Lanka	s	s	157	0.4
Scotland	43	1.7	478	1.1
Nepal	s	s	17	0.0
United States of America	s	s	103	0.2
Germany	52	2.0	433	1.0
All other countries	371	14.5	6,490	15.3
Not stated	33	1.3	711	1.7
Total	2,557	100.0	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 14: Preferred language

Language	SA Services		All Services	
	N	%	N	%
English	2,133	83.5	37,364	87.8
Chinese^a	12	0.5	860	2.0
Hindi^b	8	0.3	174	0.4
Arabic^c	6	0.2	411	1.0
Vietnamese^d	26	1.0	279	0.7
Filipino/Indonesian^e	s	s	77	0.2
Tamil/Malayalam^f	s	s	23	0.1
Spanish^g	s	s	198	0.5
Greek	21	0.8	591	1.4
Italian	30	1.2	576	1.4
Macedonian/Croatian^h	9	0.4	369	0.9
African languages	s	s	30	0.1
Korean	0	0.0	53	0.1
Samoan/Tonganⁱ	0	0.0	68	0.2
Australian Indigenous languages	3	0.1	63	0.1
All other languages	151	5.9	769	1.8
Not stated	156	6.1	640	1.5
Total	2,555	100.0	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 in SA Services and nationally. To allow for comparison with the broader Australian community the list of country of birth in Table 13 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 14 (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 15 and Table 16 present a breakdown of malignant and non-malignant diagnosis for the patients in SA Services and at the national level. Diagnosis is the principal life-limiting illness responsible for the patient requiring palliative care.

Diagnosis was not stated for 186 (7.3%) patients in SA Services and was not stated for 1,276 (3.0%) patients nationally.

Table 15: Principal diagnosis - malignant

Diagnosis	SA Services			All Services		
	N	% of malignant diagnoses	% of all diagnoses	N	% of malignant diagnoses	% of all diagnoses
Bone and soft tissue	20	1.2	0.8	350	1.4	0.8
Breast	116	6.8	4.5	1,872	7.2	4.4
CNS	54	3.1	2.1	662	2.6	1.6
Colorectal	152	8.8	5.9	2,656	10.3	6.2
Other GIT	182	10.6	7.1	2,580	10.0	6.1
Haematological	151	8.8	5.9	1,911	7.4	4.5
Head and neck	97	5.6	3.8	1,301	5.0	3.1
Lung	297	17.3	11.6	5,007	19.4	11.8
Pancreas	162	9.4	6.3	2,039	7.9	4.8
Prostate	97	5.6	3.8	1,605	6.2	3.8
Other urological	89	5.2	3.5	1,205	4.7	2.8
Gynaecological	74	4.3	2.9	1,322	5.1	3.1
Skin	68	4.0	2.7	959	3.7	2.3
Unknown primary	57	3.3	2.2	805	3.1	1.9
Other primary malignancy	64	3.7	2.5	1,332	5.2	3.1
Malignant Not further defined	38	2.2	1.5	245	0.9	0.6
All malignant	1,718	100.0	67.1	25,851	100.0	60.9

Table 16: Principal diagnosis - non-malignant

Diagnosis	SA Services			All Services		
	N	% of non-malignant diagnoses	% of all diagnoses	N	% of non-malignant diagnoses	% of all diagnoses
Cardiovascular disease	110	16.7	4.3	2,046	13.3	4.8
End stage kidney disease	62	9.4	2.4	1,211	7.9	2.8
Stroke	10	1.5	0.4	810	5.3	1.9
Motor neurone disease	32	4.8	1.2	419	2.7	1.0
Alzheimers dementia	62	9.4	2.4	1,151	7.5	2.7
Other dementia	35	5.3	1.4	1,543	10.0	3.6
Other neurological disease	41	6.2	1.6	810	5.3	1.9
Respiratory failure	127	19.2	5.0	2,519	16.3	5.9
End stage liver disease	29	4.4	1.1	408	2.6	1.0
Diabetes & its complications	6	0.9	0.2	81	0.5	0.2
Sepsis	12	1.8	0.5	836	5.4	2.0
Multiple organ failure	21	3.2	0.8	471	3.1	1.1
Other non-malignancy	100	15.2	3.9	2,661	17.3	6.3
Non-malignant Not further defined	13	2.0	0.5	452	2.9	1.1
All non-malignant	660	100.0	25.7	15,418	100.0	36.3

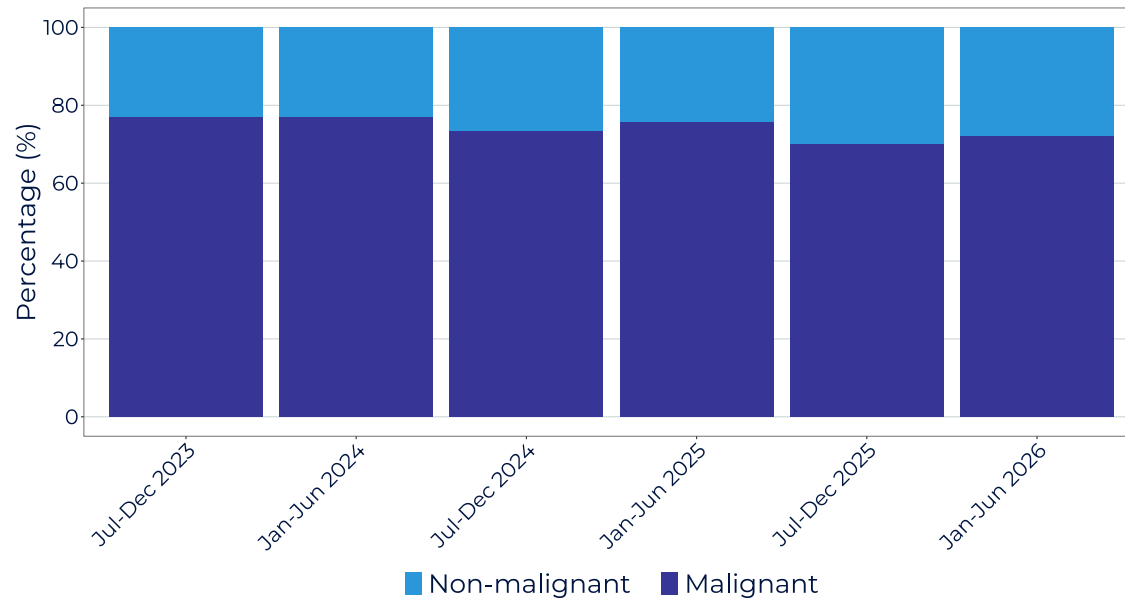


Figure 15: Principal diagnosis over time for SA Services

Table 17 shows the breakdown of patient deaths in SA Services and 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 17: Place of death

Place of death	SA Services		All Services	
	N	%	N	%
Private residence	286	26.0	2,809	15.3
Residential aged care facility	83	7.5	2,067	11.2
Hospital/hospice	720	65.5	12,943	70.4
Not stated/inadequately described	11	1.0	564	3.1
Total	1,100	100.0	18,383	100.0

Table 18 shows the place of death for the patients in SA Services over time.

Table 18: Place of death for SA Services 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	37.8	35.5	34.5	28.6	27.9	26.0
Residential aged care facility	4.8	4.2	4.5	6.2	5.8	7.5
Hospital/hospice	54.2	58.7	57.8	62.5	65.3	65.5
Not stated/inadequately described	3.2	1.6	3.2	2.7	1.0	1.0
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 19 presents the number and percentage of episodes by age group and sex for the patients seen by SA Services and at the national level. Age has been calculated as at episode start.

Table 19: Patient's age by sex

Age	SA Services				All Services			
	Male		Female		Male		Female	
	N	%	N	%	N	%	N	%
< 15	0	0.0	0	0.0	14	0.1	17	0.1
15 – 24	5	0.3	0	0.0	99	0.4	57	0.2
25 – 34	11	0.7	s	s	124	0.5	139	0.5
35 – 44	17	1.0	42	2.8	406	1.5	588	2.3
45 – 54	57	3.5	62	4.1	1,159	4.3	1,266	4.9
55 – 64	181	11.0	193	12.7	3,040	11.3	2,842	11.0
65 – 74	291	17.8	281	18.4	5,731	21.3	4,824	18.6
75 – 84	494	30.1	360	23.6	8,130	30.3	7,040	27.2
85 +	336	20.5	329	21.6	6,630	24.7	7,749	29.9
Unknown	247	15.1	258	16.9	1,523	5.7	1,402	5.4
Total	1,639	100.0	1,525	100.0	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 20 presents referral source by setting of care.

Table 20: Source of referral

Referral source	Inpatient				Non-Admitted			
	SA Services		All Services		SA Services		All Services	
	N	%	N	%	N	%	N	%
Public hospital – palliative care unit/team	20	2.0	2,310	9.4	55	3.5	1,651	8.5
Public hospital - oncology unit/team	s	s	2,872	11.7	98	6.3	968	5.0
Public hospital - medical unit/team	41	4.1	8,209	33.6	51	3.3	1,263	6.5
Public hospital - surgical unit/team	s	s	1,017	4.2	14	0.9	76	0.4
Public hospital - emergency department	s	s	1,627	6.6	s	s	182	0.9
Public hospital - not further defined	605	60.6	2,520	10.3	496	31.7	5,048	25.9
Public hospital - Total	666	66.7	18,555	75.8	714	45.7	9,188	47.1
Private hospital - palliative care unit/team	s	s	167	0.7	s	s	523	2.7
Private hospital - oncology unit/team	59	5.9	525	2.1	9	0.6	170	0.9
Private hospital - medical unit/team	32	3.2	484	2.0	s	s	91	0.5
Private hospital - surgical unit/team	s	s	40	0.2	0	0.0	s	s
Private hospital - emergency department	s	s	62	0.3	0	0.0	9	0.0
Private hospital - not further defined	13	1.3	143	0.6	35	2.2	716	3.7
Private hospital - Total	104	10.4	1,421	5.8	44	2.8	1,509	7.7
Outpatient clinic	s	s	105	0.4	32	2.0	249	1.3
General medical practitioner	s	s	193	0.8	130	8.3	2,548	13.0
Specialist medical practitioner	s	s	500	2.0	90	5.8	2,006	10.3
Community-based palliative care agency	171	17.1	2,708	11.1	132	8.4	474	2.4
Community-based service	s	s	32	0.1	155	9.9	265	1.4
Residential aged care facility	16	1.6	70	0.3	48	3.1	1,745	8.9
Self, carer(s), family or friends	s	s	229	0.9	29	1.9	530	2.7
Other	s	s	387	1.6	22	1.4	818	4.2
Not stated/inadequately described	42	4.2	267	1.1	167	10.7	195	1.0
Total	999	100.0	24,467	100.0	1,563	100.0	19,527	100.0

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

Table 21 shows the referral source for the patients in SA Services over time.

Table 21: Referral source for SA Services 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	4.0	4.2	3.2	4.4	2.6	2.9
Public hospital – oncology unit/team	3.0	4.5	4.1	4.3	1.6	3.9
Public hospital – medical unit/team	5.1	4.8	5.0	3.5	3.3	3.5
Public hospital – surgical unit/team	0.3	0.3	0.3	0.1	0.1	0.6
Public hospital – emergency department	1.2	0.8	0.9	0.6	0.6	0.2
Public hospital – not further defined	38.6	35.3	35.2	34.1	40.7	42.5
Public hospital – Total	52.2	49.9	48.7	47.0	48.9	53.6
Private hospital – palliative care unit/team	1.1	0.7	0.4	0.4	0.1	0.1
Private hospital – oncology unit/team	3.2	4.0	3.0	3.7	2.4	2.6
Private hospital – medical unit/team	0.9	1.4	1.3	1.3	1.0	1.4
Private hospital – surgical unit/team	0.0	0.1	0.2	0.1	0.0	0.0
Private hospital – emergency department	0.1	0.2	0.0	0.0	0.0	0.1
Private hospital – not further defined	2.1	1.5	1.5	2.1	1.8	1.9
Private hospital – Total	7.4	7.9	6.4	7.6	5.3	6.1
Outpatient clinic	0.3	0.3	0.3	0.6	0.5	1.3
General medical practitioner	5.4	5.2	5.2	5.2	4.4	5.1
Specialist medical practitioner	1.4	2.6	2.9	2.8	2.1	3.5
Community-based palliative care agency	25.1	23.6	23.0	23.0	19.4	11.7
Community-based service	1.5	4.2	3.3	4.2	3.9	6.1
Residential aged care facility	0.9	0.8	0.9	1.0	2.2	2.5
Self, carer(s), family or friends	2.4	2.1	1.6	1.1	0.9	1.2
Other	0.8	1.2	2.0	2.1	2.3	0.9
Not stated/inadequately described	2.5	2.1	5.7	5.3	10.0	8.1
Total	100.0	100.0	100.0	100.0	100.0	100.0

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

Table 22 gives a summary of the length of episodes for patients in SA Services and nationally.

Table 22: Length of episode (in days) summary by setting of care

Length of episode	Inpatient		Non-Admitted	
	SA Services	All Services	SA Services	All Services
Average length of episode	8.4	8.5	36.7	38
Median length of episode	4	4	22	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 23 shows a summary of the length of episodes for patients in SA Services over time.

Table 23: Length of episode (in days) summary for SA Services 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	28.1	28	29.8	29.6	23.2	25.1
Median length of episode	13	13	16	14	9	10

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 24 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 24: Length of episode (days)

Length of episode (days)	Inpatient				Non-Admitted			
	SA Services		All Services		SA Services		All Services	
	N	%	N	%	N	%	N	%
Same day	75	7.4	2,466	10.0	185	11.7	1,411	6.2
1 – 2	276	27.1	6,198	25.0	82	5.2	1,428	6.3
3 – 4	172	16.9	3,999	16.2	80	5.0	1,171	5.2
5 – 7	158	15.5	3,807	15.4	113	7.1	1,631	7.2
8 – 14	169	16.6	4,158	16.8	185	11.7	2,629	11.6
15 – 21	82	8.1	1,778	7.2	128	8.1	1,998	8.8
22 – 30	39	3.8	1,079	4.4	125	7.9	1,947	8.6
31 – 60	38	3.7	963	3.9	243	15.3	3,778	16.7
61 – 90	8	0.8	183	0.7	126	7.9	1,830	8.1
91 +	s	s	117	0.5	318	20.1	4,801	21.2
Total	1,017	100.0	24,748	100.0	1,585	100.0	22,624	100.0

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

Table 25: How inpatient episodes start

Episode start mode	SA Services		All Inpatient Services	
	N	%	N	%
Admitted from community^a	493	48.3	15,835	64.7
Admitted from another hospital	101	9.9	3,376	13.8
Admitted from acute care in another ward	260	25.5	3,179	13.0
Change from acute care to palliative care - same ward	97	9.5	845	3.5
Other^b	10	1.0	431	1.8
Not stated/inadequately described	60	5.9	801	3.3
Total	1,021	100.0	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 26: How inpatient episodes end

Episode end mode	SA Services		All Inpatient Services	
	N	%	N	%
Discharged to community^a	154	15.1	7,170	29.0
Discharged to another hospital	18	1.8	1,980	8.0
Death	720	70.7	12,943	52.3
Change from palliative care to acute care^b	18	1.8	248	1.0
Change in sub-acute care type	72	7.1	161	0.7
End of consultative episode - inpatient episode ongoing	22	2.2	1,111	4.5
Other	s	s	468	1.9
Not stated/inadequately described	15	1.5	667	2.7
Total	1,019	100.0	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 27: How inpatient episodes start for SA Services 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	44.3	49.2	44.7	40.8	58.5	48.3
Admitted from another hospital	15.5	12.6	15.6	14.1	11.4	9.9
Admitted from acute care on another ward	26.0	26.0	27.3	30.6	23.7	25.5
Change from acute care to palliative care - same ward	3.8	4.1	2.7	3.3	3.1	9.5
Other^b	2.2	1.6	1.2	0.7	1.4	1.0
Not stated/inadequately described	8.1	6.5	8.5	10.5	1.9	5.9
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: admitted from usual accommodation, admitted from other than usual accommodation.

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

Table 28: How inpatient episodes end for SA Services 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	19.1	21.4	20.9	20.3	18.2	15.1
Discharged to another hospital	0.8	0.8	1.0	1.3	0.8	1.8
Death	66.9	66.7	69.0	70.6	69.1	70.6
Change from palliative care to acute care^b	1.5	1.3	1.8	0.7	1.2	1.8
Change in sub-acute care type	5.9	6.0	4.9	3.4	6.2	7.1
End of consultative episode - inpatient episode ongoing	1.3	2.1	0.8	1.1	2.0	2.2
Other	0.5	0.1	0.1	0.1	0.1	0.1
Not stated/inadequately described	3.9	1.6	1.6	2.6	2.4	1.5
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.

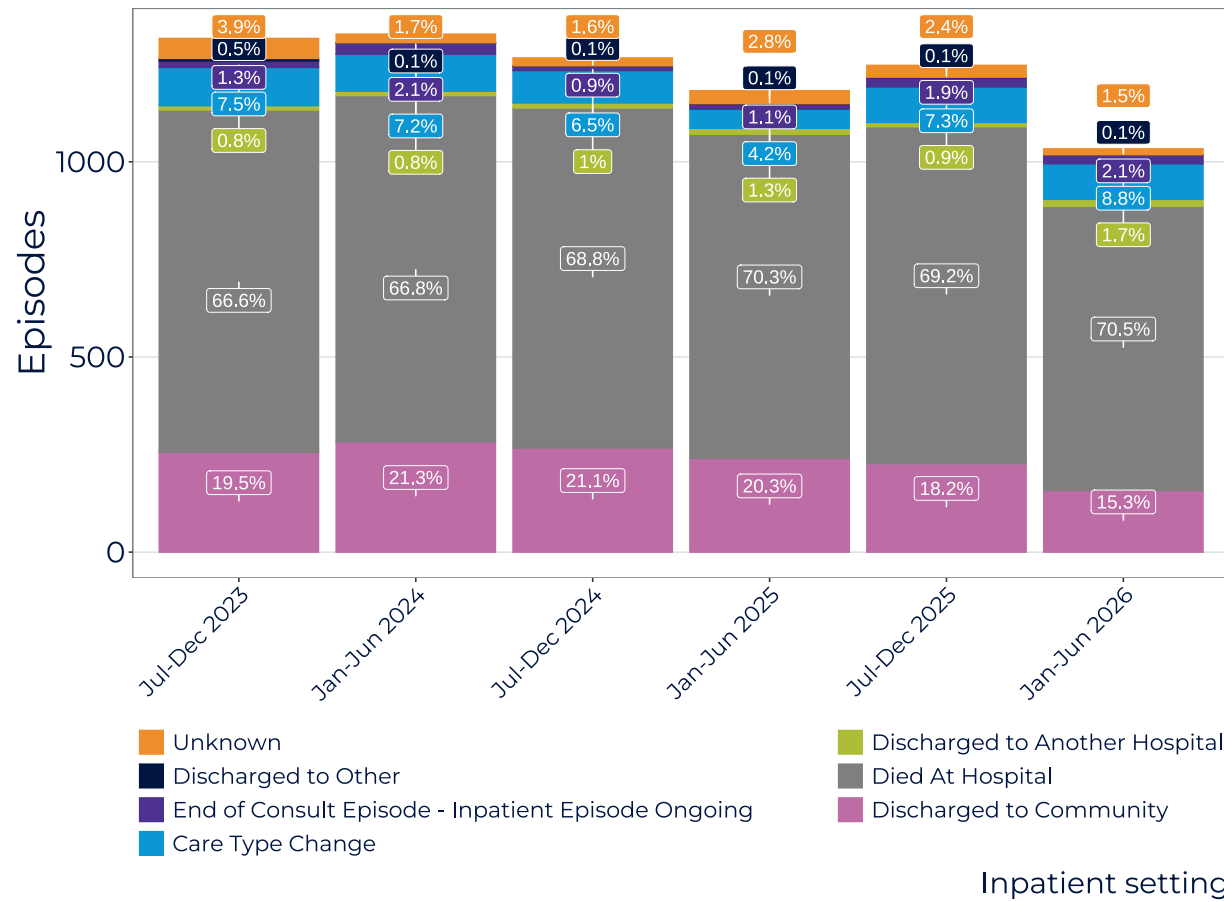


Figure 16: How episodes end for SA Services over time - inpatient setting

Table 29: How non-admitted episodes start

Episode start mode	SA Services		All Non-Admitted Services	
	N	%	N	%
Admitted from inpatient palliative care	68	4.3	6,048	31.0
Other^a	1,136	72.3	12,542	64.2
Not stated/inadequately described	367	23.4	941	4.8
Total	1,571	100.0	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 30: How non-admitted episodes end

Episode end mode	SA Services		All Non-Admitted Services	
	N	%	N	%
Admitted for inpatient palliative care	179	11.3	5,945	26.3
Admitted for inpatient acute care	436	27.5	5,996	26.5
Admitted to another palliative care service	9	0.6	355	1.6
Admitted to primary health care	50	3.2	2,179	9.6
Discharged/case closure	89	5.6	1,698	7.5
Death	380	24.0	5,440	24.0
Other	17	1.1	206	0.9
Not stated/inadequately described	425	26.8	805	3.6
Total	1,585	100.0	22,624	100.0

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

Table 31: How non-admitted episodes start for SA Services 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	8.5	9.6	11.9	8.3	5.2	4.3
Other^a	88.0	84.4	77.3	79.8	79.7	72.3
Not stated/inadequately described	3.5	6.1	10.8	12.0	15.2	23.4
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 32: How non-admitted episodes end for SA Services 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	14.0	17.6	18.0	17.3	14.3	11.3
Admitted for inpatient acute care	25.1	27.8	30.1	33.6	26.9	27.5
Admitted to another palliative care service	0.6	0.9	0.7	0.7	0.4	0.6
Admitted to primary health care	2.7	2.8	3.7	3.0	3.6	3.2
Discharged/case closure	10.5	11.5	11.4	14.3	10.0	5.6
Death	34.4	30.4	28.9	25.8	26.6	24.0
Other	1.9	1.1	1.5	1.4	1.1	1.1
Not stated/inadequately described	10.9	8.0	5.7	4.0	17.2	26.8
Total	100.0	100.0	100.0	100.0	100.0	100.0

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

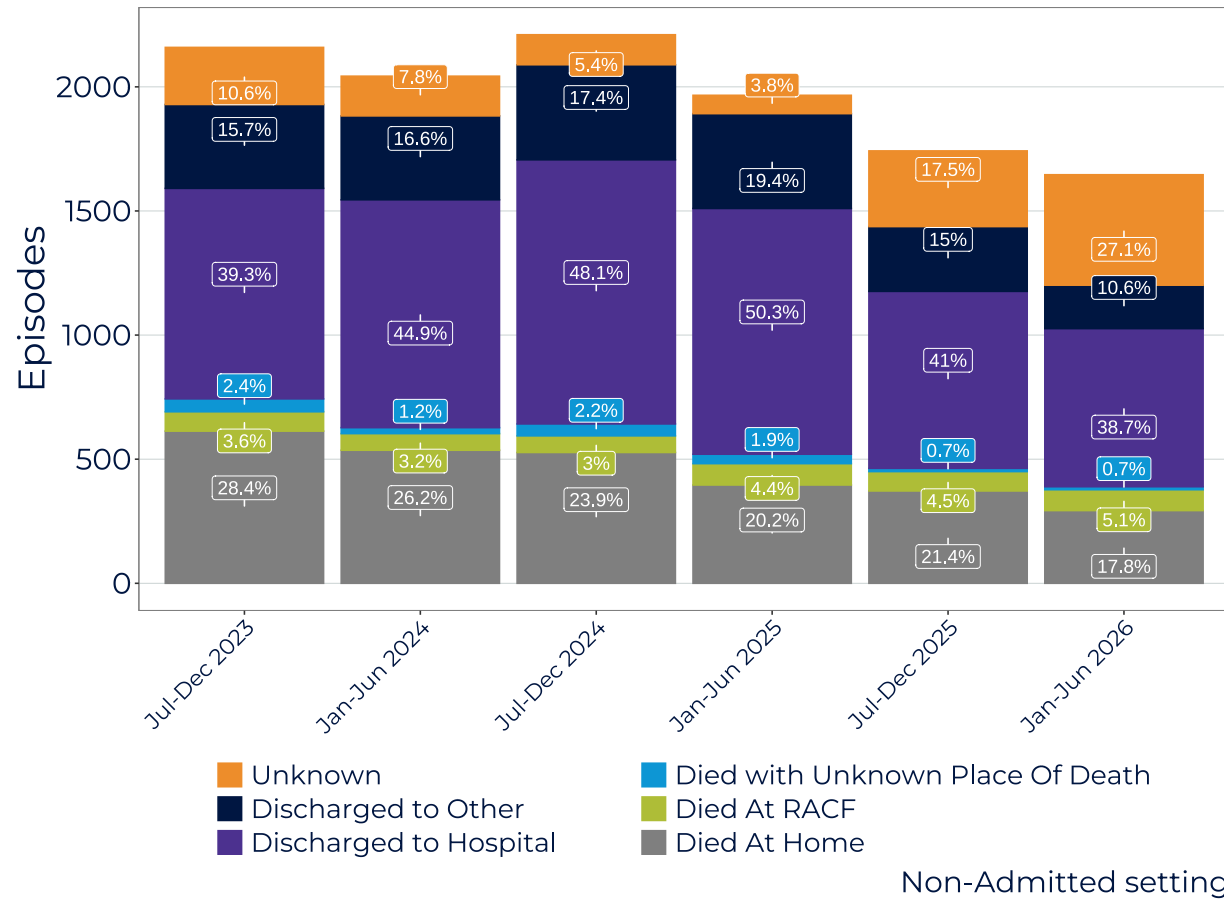


Figure 17: How episodes end for SA Services over time - non-admitted setting

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 patient's 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 non-admitted settings, and are reported on admission to the service, at phase changes and at discharge from the service.

Table 33: Number of patient phases by phase type and setting of care

Phase type	Inpatient				Non-Admitted			
	SA Services		All Services		SA Services		All Services	
	N	%	N	%	N	%	N	%
Stable	154	7.9	13,669	25.5	1,238	28.7	22,038	40.1
Unstable	155	8.0	6,561	12.2	588	13.6	4,323	7.9
Deteriorating	901	46.5	21,137	39.4	2,114	49.0	24,566	44.6
Terminal	728	37.6	12,321	22.9	371	8.6	4,097	7.4
Total	1,938	100.0	53,688	100.0	4,311	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 34: Average phase length (in days) by phase type and setting of care

Phase type	Inpatient		Non-Admitted	
	SA Services	All Services	SA Services	All Services
Stable	5.0	6.1	21.3	22.9
Unstable	1.9	2.2	3.0	3.7
Deteriorating	6.7	4.6	18.5	14.9
Terminal	1.9	2.0	2.5	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.

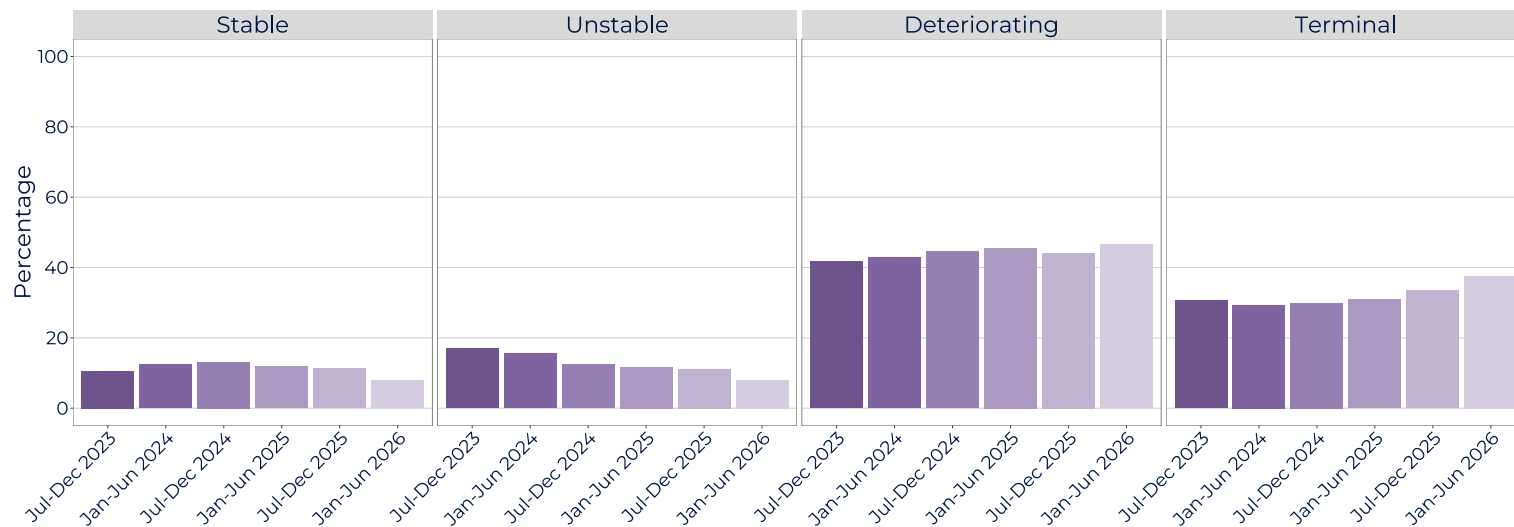


Figure 18: Patient phase profile over time - inpatient setting

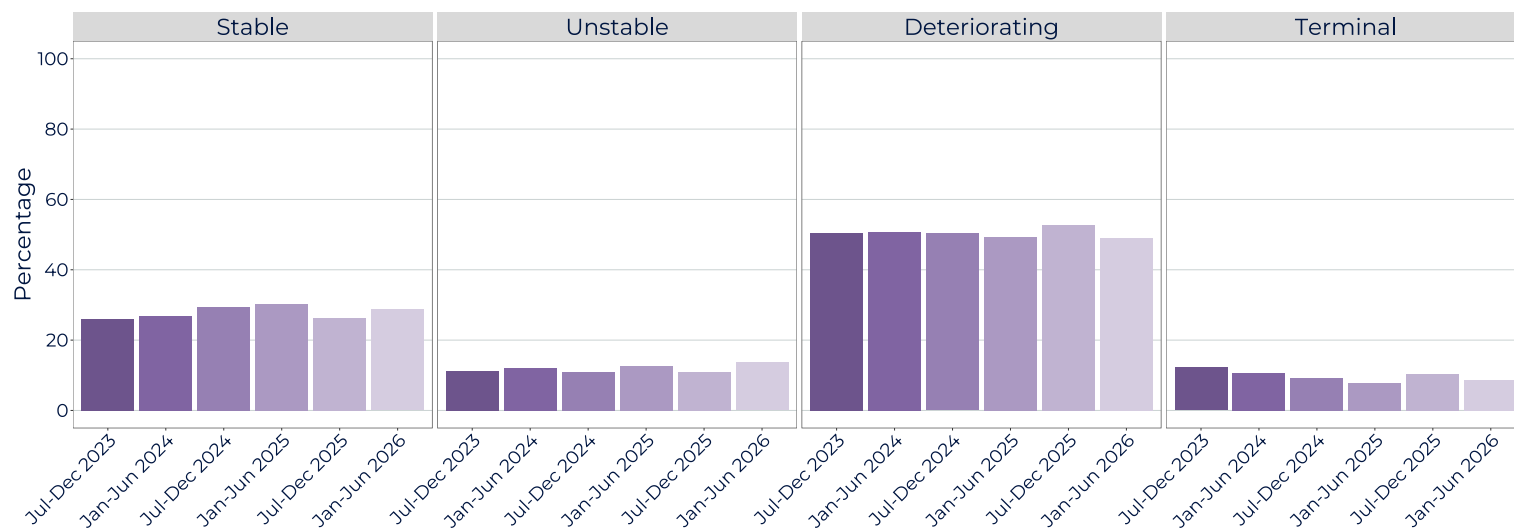


Figure 19: Patient phase profile over time - non-admitted setting

Table 35 presents the patients' first phase type for the episode, both for SA Services and nationally. The first phase of the episode allows you to understand the type of patient, complexity and urgency of patient/family needs.

Table 35: First phase of episode by setting

Phase type	Inpatient				Non-Admitted			
	SA Services		All Services		SA Services		All Services	
	N	%	N	%	N	%	N	%
Stable	21	2.1	4,220	17.3	409	26.1	7,441	38.1
Unstable	111	10.9	3,793	15.5	101	6.4	881	4.5
Deteriorating	692	67.8	12,456	50.9	989	63.0	10,330	52.9
Terminal	197	19.3	3,991	16.3	71	4.5	876	4.5
Total	1,021	100.0	24,460	100.0	1,570	100.0	19,528	100.0

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

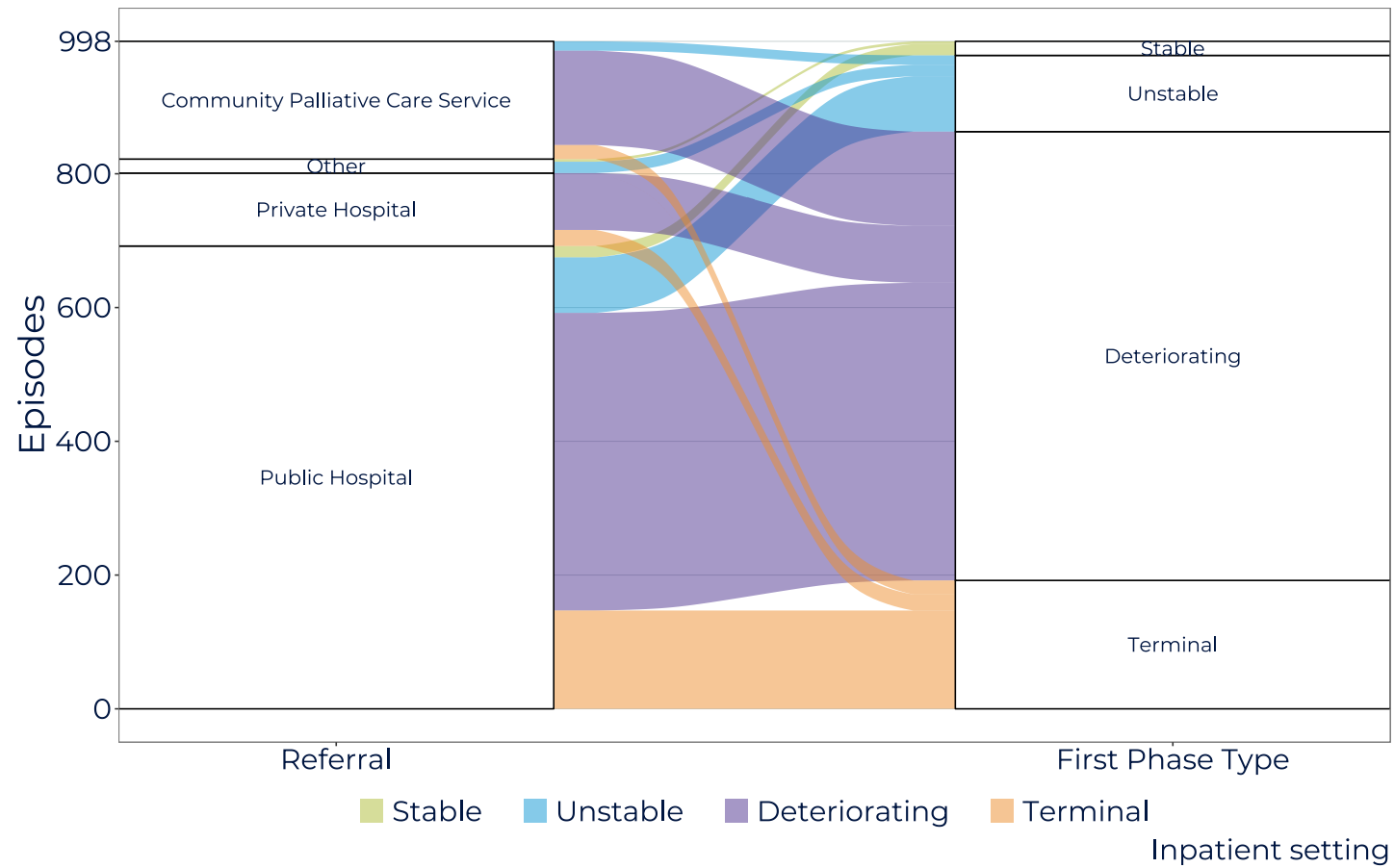


Figure 20: Alluvial plots showing referral source by first phase type – Inpatient setting

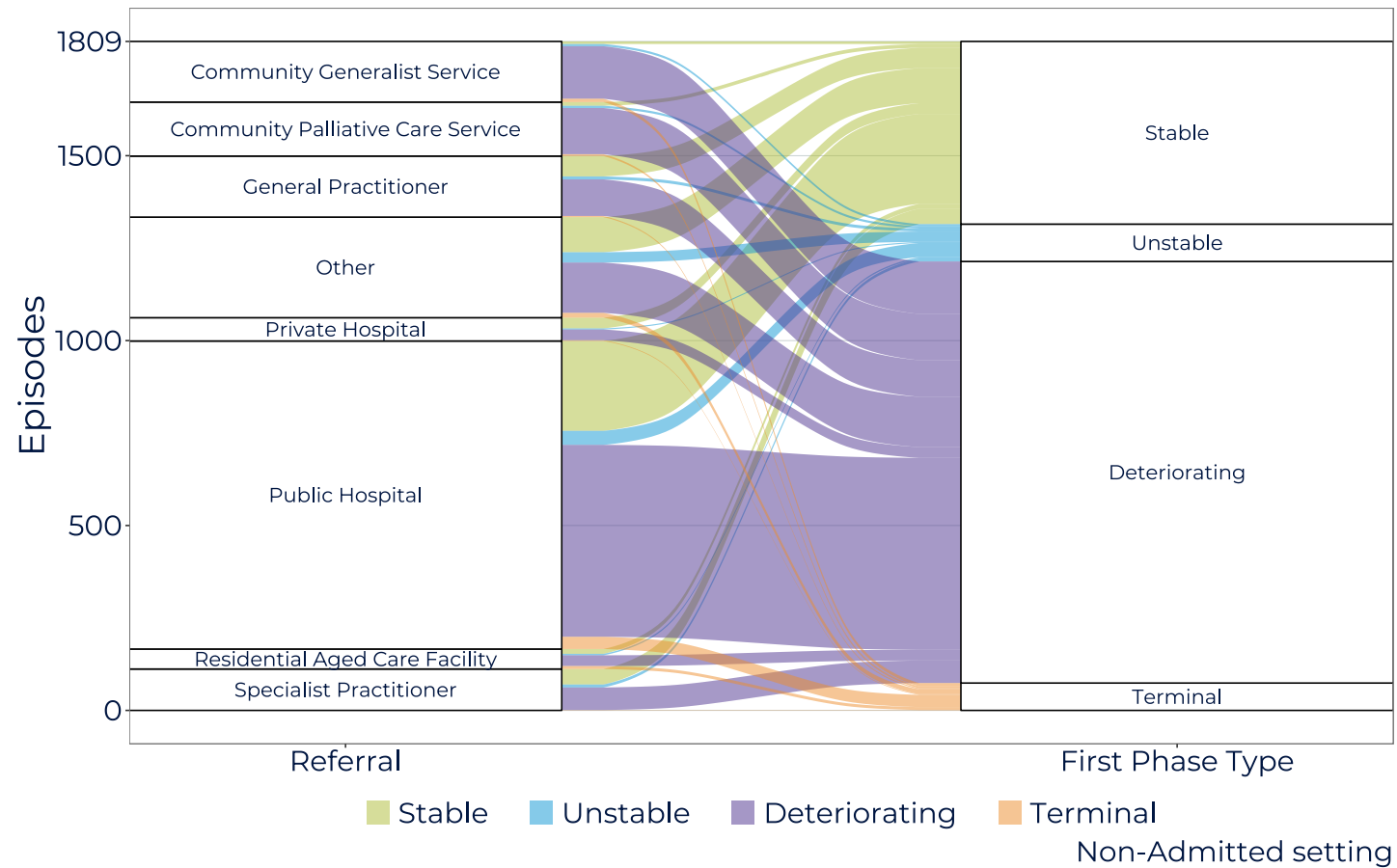


Figure 21: Alluvial plots showing referral source by first phase type – Non-Admitted setting

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 36 shows the percentage of phases that were rated absent, mild, moderate and severe at phase start for each key domain for SA inpatient setting of care compared to all participating PCOC inpatient services. Table 37 shows the same for SA non-admitted setting of care compared to all participating PCOC non-admitted services. Alternative graphical representations of PCPSS profile by phase type are shown in Appendix C.

Table 36: PCPSS at phase start by phase type - inpatient setting

Phase type	Problem	SA Services (%)				All Services (%)			
		Absent	Mild	Moderate	Severe	Absent	Mild	Moderate	Severe
Stable	Pain	51.0	41.1	7.3	0.7	53.8	39.5	6.3	0.4
	Other symptoms	53.6	43.0	3.3	0.0	45.8	47.5	6.5	0.2
	Family/carer	63.0	34.2	2.1	0.7	63.8	32.4	3.5	0.3
	Psychological/spiritual	71.9	26.6	1.6	0.0	67.0	28.7	4.0	0.2
Unstable	Pain	17.4	25.5	35.6	21.5	28.5	35.3	28.5	7.7
	Other symptoms	16.9	26.4	47.3	9.5	22.9	42.0	29.5	5.5
	Family/carer	24.5	42.2	32.7	0.7	42.8	38.2	16.8	2.2
	Psychological/spiritual	42.9	32.3	21.8	3.0	49.2	33.8	14.5	2.4
Deteriorating	Pain	31.6	49.3	17.1	1.9	38.8	41.9	17.9	1.4
	Other symptoms	24.5	56.9	17.7	0.9	29.5	48.1	21.1	1.3
	Family/carer	41.8	48.7	8.8	0.7	48.2	41.0	10.1	0.7
	Psychological/spiritual	45.2	44.0	9.9	1.0	47.2	39.7	12.2	0.9
Terminal	Pain	29.9	53.3	14.5	2.3	45.3	39.8	13.3	1.6
	Other symptoms	32.5	49.7	16.3	1.4	41.8	40.3	16.0	1.9
	Family/carer	58.2	34.9	6.7	0.3	66.9	26.3	6.0	0.8
	Psychological/spiritual	40.5	45.9	12.1	1.5	38.3	43.8	16.0	2.0

Table 37: PCPSS at phase start by phase type - non-admitted setting

Phase type	Problem	SA Services (%)				All Services (%)			
		Absent	Mild	Moderate	Severe	Absent	Mild	Moderate	Severe
Stable	Pain	29.4	63.3	7.3	0.1	44.8	50.3	4.8	0.1
	Other symptoms	15.7	76.0	8.2	0.1	26.4	66.6	6.8	0.1
	Family/carer	37.1	57.2	5.6	0.1	50.3	45.3	4.3	0.1
	Psychological/spiritual	39.1	54.5	6.2	0.2	47.7	46.1	5.8	0.3
Unstable	Pain	12.2	33.3	34.3	20.3	17.4	29.4	36.0	17.1
	Other symptoms	3.8	24.5	53.7	18.0	7.7	26.9	48.8	16.5
	Family/carer	10.2	40.1	43.8	5.9	21.9	41.2	32.1	4.8
	Psychological/spiritual	12.8	35.0	44.1	8.1	20.3	34.7	37.1	7.8
Deteriorating	Pain	19.5	57.8	21.7	1.0	29.1	47.9	21.8	1.1
	Other symptoms	6.6	61.0	31.3	1.1	11.0	52.2	35.7	1.2
	Family/carer	16.1	66.6	17.1	0.3	29.8	54.7	15.1	0.5
	Psychological/spiritual	19.4	60.3	19.6	0.7	25.7	51.3	21.9	1.0
Terminal	Pain	21.7	58.3	18.3	1.7	34.7	44.5	18.9	2.0
	Other symptoms	16.9	51.4	27.7	4.0	27.6	43.4	26.1	3.0
	Family/carer	34.3	48.2	15.7	1.8	52.3	35.3	11.3	1.1
	Psychological/spiritual	11.2	49.4	33.9	5.5	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 38 and Table 39 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 38: Symptom distress at phase start by phase type - inpatient setting

Phase type	Symptom	SA Services (%)				All Services (%)			
		Absent	Mild	Moderate	Severe	Absent	Mild	Moderate	Severe
Stable	Difficulty sleeping	76.9	18.9	4.2	0.0	82.4	14.8	2.6	0.2
	Appetite problems	83.9	12.6	3.5	0.0	78.7	18.6	2.4	0.3
	Nausea	93.8	4.9	1.4	0.0	86.9	11.4	1.6	0.1
	Bowel problems	77.6	20.3	2.1	0.0	75.8	20.5	3.4	0.3
	Breathing problems	78.9	18.4	2.7	0.0	77.1	19.3	3.3	0.3
	Fatigue	47.2	47.9	4.9	0.0	55.3	37.6	6.5	0.5
	Pain	52.4	40.7	6.2	0.7	53.9	38.0	7.4	0.6
Unstable	Difficulty sleeping	55.2	27.3	17.5	0.0	67.4	21.5	9.5	1.5
	Appetite problems	52.8	31.7	14.8	0.7	61.2	28.6	9.2	1.1
	Nausea	64.8	20.7	11.0	3.4	71.1	17.6	9.3	1.9
	Bowel problems	57.2	27.6	13.8	1.4	61.3	26.1	11.2	1.4
	Breathing problems	61.8	22.9	12.5	2.8	64.7	21.7	11.1	2.4
	Fatigue	26.4	42.4	29.9	1.4	36.4	39.9	21.5	2.3
	Pain	14.6	28.5	38.2	18.8	28.4	34.9	28.6	8.1
Deteriorating	Difficulty sleeping	68.6	25.1	5.4	0.8	75.8	18.2	5.5	0.5
	Appetite problems	60.1	32.1	7.3	0.5	69.9	24.1	5.4	0.6
	Nausea	79.3	14.9	5.3	0.5	78.7	15.6	5.1	0.6
	Bowel problems	67.3	24.8	7.0	0.9	69.9	23.1	6.4	0.6
	Breathing problems	62.3	27.1	9.5	1.2	65.2	23.7	10.2	0.9
	Fatigue	27.3	51.2	20.4	1.1	42.3	39.9	16.3	1.4
	Pain	30.3	48.5	19.6	1.6	38.8	40.4	19.2	1.6
Terminal	Difficulty sleeping	88.6	8.8	2.4	0.1	91.0	6.6	2.1	0.3
	Appetite problems	91.6	6.8	1.5	0.1	92.7	5.2	1.2	0.9
	Nausea	93.0	5.3	1.5	0.3	93.3	5.0	1.5	0.2
	Bowel problems	85.1	10.9	3.8	0.1	89.0	8.8	2.0	0.2
	Breathing problems	64.0	25.8	10.0	0.3	66.1	23.1	9.5	1.4
	Fatigue	60.3	25.4	13.3	1.0	74.9	17.3	6.5	1.4
	Pain	32.5	50.5	16.5	0.4	47.8	37.1	13.7	1.4

Table 39: Symptom distress at phase start by phase type - non-admitted setting

Phase type	Symptom	SA Services (%)				All Services (%)			
		Absent	Mild	Moderate	Severe	Absent	Mild	Moderate	Severe
Stable	Difficulty sleeping	56.8	36.4	6.6	0.3	72.8	23.8	3.3	0.2
	Appetite problems	54.0	39.3	6.4	0.3	62.0	34.5	3.3	0.2
	Nausea	82.4	15.4	2.0	0.2	83.7	15.1	1.2	0.1
	Bowel problems	57.5	37.4	4.5	0.6	72.1	24.7	2.9	0.2
	Breathing problems	51.1	38.5	9.8	0.6	61.6	32.6	5.5	0.2
	Fatigue	17.0	62.4	19.2	1.4	29.8	56.5	13.1	0.6
	Pain	32.7	54.7	12.3	0.3	44.9	48.2	6.6	0.3
Unstable	Difficulty sleeping	33.1	32.0	31.3	3.7	49.1	27.9	19.7	3.4
	Appetite problems	32.1	41.3	24.6	2.0	41.1	35.6	21.2	2.1
	Nausea	56.3	26.9	14.5	2.3	59.5	20.3	15.7	4.5
	Bowel problems	39.3	33.9	22.5	4.3	51.1	25.9	18.1	5.0
	Breathing problems	33.1	36.2	23.3	7.3	48.1	27.6	18.7	5.7
	Fatigue	11.9	37.4	44.8	5.8	18.7	35.2	39.1	7.1
	Pain	12.8	33.6	35.9	17.6	17.4	26.2	38.5	17.9
Deteriorating	Difficulty sleeping	50.4	38.0	11.3	0.3	64.3	27.4	7.8	0.5
	Appetite problems	39.6	46.4	13.2	0.8	47.2	42.1	10.2	0.5
	Nausea	69.5	25.0	5.1	0.5	72.9	21.2	5.6	0.4
	Bowel problems	50.2	39.0	9.7	1.1	61.5	29.4	8.6	0.6
	Breathing problems	40.3	42.2	16.8	0.7	53.5	32.8	13.0	0.8
	Fatigue	10.4	54.5	33.3	1.9	19.6	48.5	29.9	2.0
	Pain	22.2	55.2	21.1	1.5	30.4	45.1	22.9	1.6
Terminal	Difficulty sleeping	69.2	22.3	7.5	0.9	84.3	11.4	3.8	0.5
	Appetite problems	79.8	13.9	4.4	1.9	83.6	10.0	5.0	1.3
	Nausea	80.8	13.0	5.3	0.9	85.7	10.0	3.8	0.5
	Bowel problems	69.4	24.7	5.3	0.6	78.2	16.6	4.6	0.6
	Breathing problems	48.5	37.7	10.8	3.1	62.9	25.3	10.1	1.7
	Fatigue	53.4	23.4	20.3	2.8	64.3	16.8	15.4	3.5
	Pain	24.3	56.1	18.4	1.2	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 non-admitted patients. The items are reported at admission to the service, when the phase changes and at discharge.

Table 40 summarises the RUG-ADL items at phase start for inpatient and non-admitted patients.

Table 40: 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			
		SA Services		All Services		SA Services		All Services	
		N	%	N	%	N	%	N	%
Bed mobility	Independent or supervision only (1)	361	19.0	14,550	28.0	2,439	59.8	31,671	60.7
	Limited physical assistance (3)	245	12.9	7,500	14.5	595	14.6	6,227	11.9
	Other than two person physical assist (4)	221	11.6	5,888	11.4	333	8.2	4,297	8.2
	Two or more person physical assist (5)	1,078	56.6	23,936	46.1	714	17.5	9,947	19.1
Toileting	Independent or supervision only (1)	267	14.0	9,624	18.6	2,068	50.8	26,464	50.7
	Limited physical assistance (3)	240	12.6	9,211	17.8	750	18.4	8,946	17.1
	Other than two person physical assist (4)	279	14.6	7,669	14.8	498	12.2	6,012	11.5
	Two or more person physical assist (5)	1,122	58.8	25,362	48.9	757	18.6	10,786	20.7
Transfers	Independent or supervision only (1)	244	12.8	9,427	18.2	2,004	49.1	25,567	49.1
	Limited physical assistance (3)	254	13.3	9,098	17.5	817	20.0	9,549	18.4
	Other than two person physical assist (4)	254	13.3	7,379	14.2	482	11.8	5,919	11.4
	Two or more person physical assist (5)	1,155	60.6	25,951	50.0	778	19.1	10,995	21.1
Eating	Independent or supervision only (1)	686	36.2	21,450	41.5	2,344	57.7	34,132	66.1
	Limited physical assistance (2)	323	17.0	10,366	20.1	1,020	25.1	8,644	16.7
	Extensive assistance/total dependence/tube fed (3)	886	46.8	19,855	38.4	696	17.1	8,858	17.2



Figure 22: 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 41 shows the performance status of patients using the AKPS at phase start.

Table 41: Australia-modified Karnofsky Performance Status (AKPS) at phase start by setting of care

AKPS assessment at phase start	Inpatient				Non-Admitted			
	SA Services		All Services		SA Services		All Services	
	N	%	N	%	N	%	N	%
Comatose or barely rousable (10)	334	17.2	6,701	12.5	164	3.8	1,921	3.5
Totally bedfast and requiring extensive nursing care (20)	658	34.0	14,168	26.4	520	12.1	5,986	10.9
Almost completely bedfast (30)	277	14.3	7,639	14.2	474	11.0	4,774	8.7
In bed more than 50% of the time (40)	267	13.8	10,221	19.0	1,040	24.1	10,002	18.2
Requires considerable assistance (50)	182	9.4	6,625	12.3	940	21.8	12,961	23.6
Requires occasional assistance (60)	117	6.0	3,943	7.3	614	14.2	10,920	19.8
Cares for self (70)	35	1.8	1,310	2.4	271	6.3	4,830	8.8
Normal activity with effort (80)	12	0.6	379	0.7	66	1.5	1,144	2.1
Able to carry on normal activity; minor signs or symptoms (90)	0	0.0	115	0.2	9	0.2	228	0.4
Normal; no complaints; no evidence of disease (100)	s	s	28	0.1	0	0.0	9	0.0
Not stated/inadequately described^a	55	2.8	2,559	4.8	213	4.9	2,249	4.1
Total	1,937	100.0	53,688	100.0	4,311	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 23: 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 42 shows the number of patients, episodes and phases included in this report - both for SA Services and all participating PCOC services nationally.

Table 42: Summary of patients, episodes and phases by setting

	Inpatient		Non-Admitted		Total	
	SA Services	All Services	SA Services	All Services	SA Services	All Services
Patients (N)	910	21,786	1,845	22,252	2,564	42,545
Episodes (N)	1,060	25,555	2,115	27,235	3,175	52,790
Phases^a (N)	1,938	53,688	4,311	55,024	6,249	108,712
Patients (%)	35.5	51.2	72.0	52.3	100.0	100.0
Episodes (%)	33.4	48.4	66.6	51.6	100.0	100.0
Phases^a (%)	31.0	49.4	69.0	50.6	100.0	100.0
Average number of phases per episode^b	1.8	2.1	1.9	1.9	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 43 shows the number of completed episodes and phases by setting of care for each month in the current reporting period for SA Services. This table allows SA Services to identify any significant change in the number of episodes and phases during the reporting period.

Table 43: Number of completed episodes and phases by month and setting

Setting		Jan	Feb	Mar	Apr	May	Jun
Inpatient	Completed episodes (N)	167	149	195	162	182	165
	Completed phases (N)	326	293	370	296	350	303
Non-Admitted	Completed episodes (N)	253	225	292	254	291	270
	Completed phases (N)	703	687	775	657	755	734

Table 44 shows the number of patients, episodes and phases for SA Services over time and is reported by setting of care. It allows you to identify any significant changes in volume over a three-year period and may assist in understanding changes in service delivery or model of care.

Table 44: 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	1,125	1,133	1,091	1,041	1,076	910	2,166	2,153	2,236	2,145	1,862	1,845
Episodes	1,353	1,356	1,280	1,225	1,262	1,060	2,406	2,379	2,525	2,413	2,144	2,115
Phases^b	2,746	2,789	2,661	2,514	2,514	1,938	4,642	4,607	4,738	4,710	4,248	4,311
Phases per episode^c	2.0	2.0	2.1	2.1	2.0	1.8	2.0	1.9	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 45, Table 46, Table 47 and Table 48 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 45: Item completion (%) - patient level

Data item	SA Services	All Services
Date of birth	82.6	94.6
Sex	99.8	100.0
Country of birth	98.7	98.3
Preferred language	93.9	98.8
Diagnosis	92.7	97.0

Table 46: Item completion (%) - episode level, by setting of care

Data item	Inpatient		Non-Admitted		Total	
	SA Services	All Services	SA Services	All Services	SA Services	All Services
Date of first contact	95.7	98.6	87.5	98.7	90.2	98.6
Referral date	99.9	100.0	96.8	99.5	97.8	99.7
Referral source	96.0	98.9	91.4	99.2	92.9	99.0
Date ready for care	95.7	97.8	87.3	97.2	90.1	97.5
Mode of episode start	94.3	96.7	79.8	95.6	84.7	96.2
Accommodation at episode start	99.6	99.1	95.6	96.9	96.5	97.8
Episode end date^a	97.5	98.2	77.8	85.5	84.4	91.6
Mode of episode end	98.5	97.3	73.0	96.4	82.8	96.9
Accommodation at episode end	96.2	98.2	86.1	97.7	91.1	98.0
Place of death	100.0	100.0	96.9	90.6	98.9	97.2

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

Table 47: 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	
		SA	All Services	SA	All Services	SA	All Services	SA	All Services	SA	All Services	SA	All Services
RUG-ADL	Bed mobility	98.3	96.6	94.7	94.8	95.8	95.7	79.6	61.9	46.7	47.7	57.1	53.4
	Toileting	98.5	96.6	94.5	94.9	95.7	95.7	79.9	62.8	49.7	47.9	59.3	54.0
	Transfers	98.4	96.6	94.7	94.6	95.8	95.6	79.6	61.8	46.5	47.7	57.0	53.5
	Eating	97.8	96.2	94.2	93.8	95.3	95.0	79.6	61.7	46.4	47.3	56.9	53.2
PCPSS	Pain	97.6	95.6	95.5	95.5	96.1	95.5	79.2	64.0	45.5	48.3	56.2	54.7
	Other symptoms	97.6	93.1	92.6	93.1	94.1	93.1	79.2	62.3	45.0	45.2	55.8	52.2
	Psychological/spiritual	96.7	95.0	91.1	94.0	92.9	94.5	79.2	63.3	44.6	47.5	55.6	53.9
	Family/carer	91.1	90.2	88.4	88.9	89.2	89.6	68.4	56.1	44.1	40.9	51.8	47.1
SAS	Difficulty sleeping	93.3	85.3	89.9	91.9	91.0	88.6	77.3	51.4	40.8	45.6	52.4	47.9
	Appetite problems	93.3	85.3	90.8	93.2	91.6	89.3	77.3	51.4	41.0	46.2	52.5	48.4
	Nausea	94.1	85.5	90.9	93.8	91.9	89.7	78.1	51.5	41.5	46.7	53.1	48.7
	Bowel problems	93.6	85.4	90.3	93.1	91.3	89.3	77.3	51.4	41.0	46.2	52.5	48.3
	Breathing problems	94.7	85.8	91.0	93.6	92.1	89.7	77.7	51.6	42.7	46.8	53.8	48.7
	Fatigue	94.1	85.4	91.0	94.0	92.0	89.8	77.3	51.5	41.7	47.0	53.0	48.9
	Pain	94.4	86.8	93.4	95.9	93.7	91.4	77.7	51.5	43.9	48.3	54.7	49.6
AKPS	-	97.2	95.2	95.1	95.9	95.7	95.6	78.1	61.1	47.8	49.1	57.4	54.0

Table 48: Item completion (%) - phase end, by setting of care

Data item	Inpatient		Non-Admitted		Total	
	SA Services	All Services	SA Services	All Services	SA Services	All Services
Phase End Reason	96.0	99.0	83.4	98.2	87.3	98.6

C Profile of patient symptoms and problems

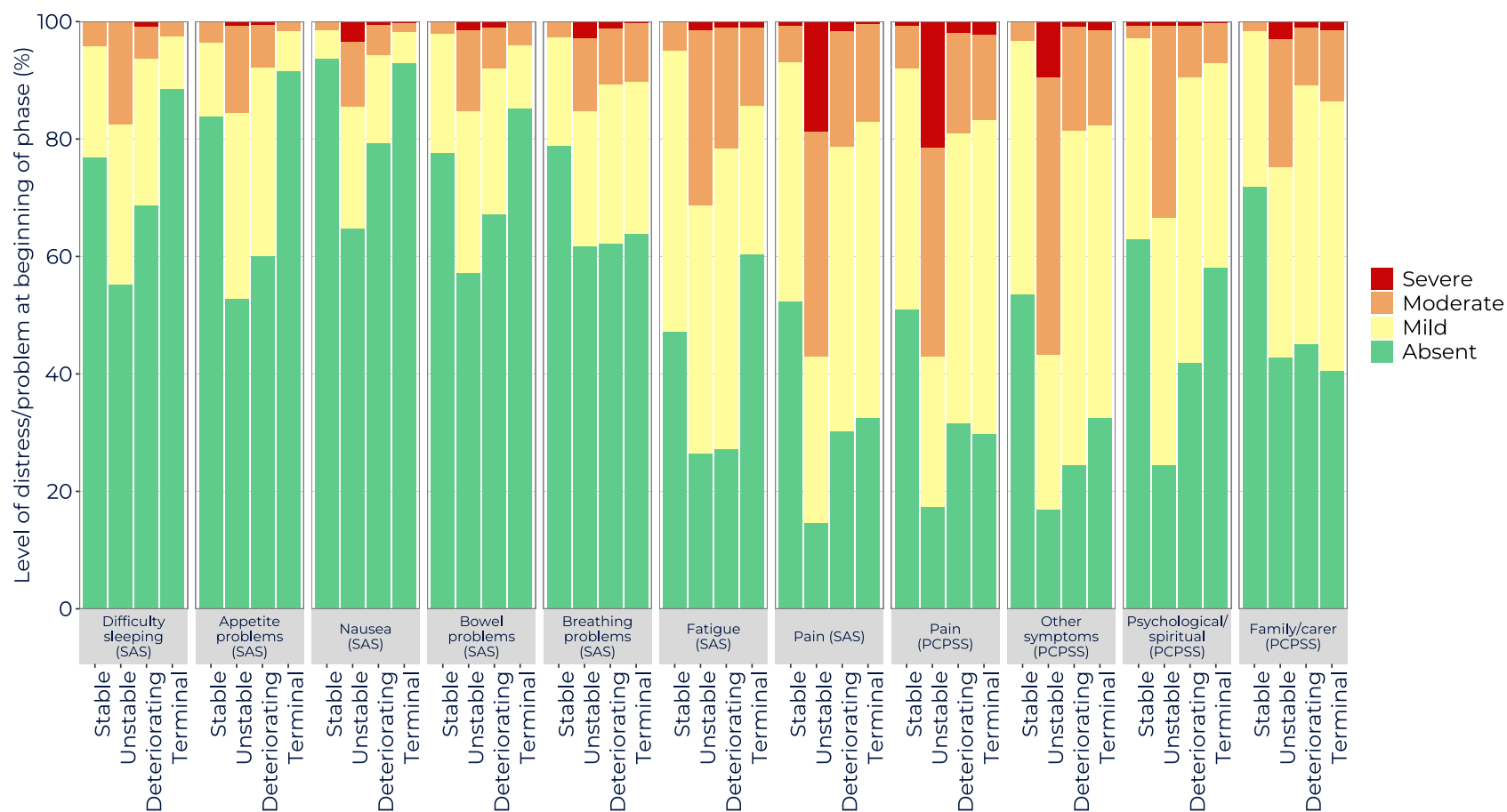


Figure 24: Profile of symptoms and problems by phase type for SA Services- inpatient setting

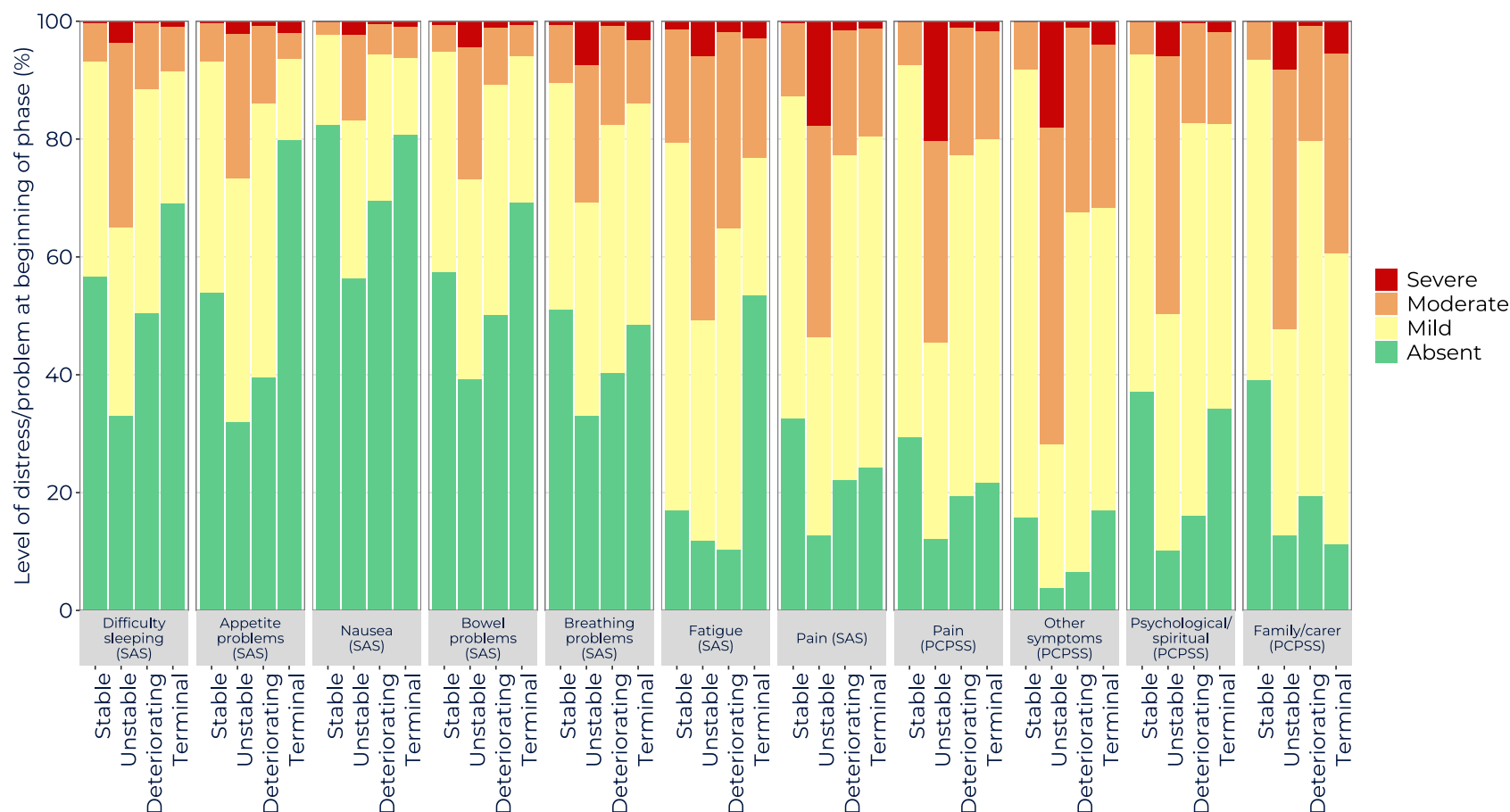


Figure 25: Profile of symptoms and problems by phase type for SA Services- non-admitted setting

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 26 below displays four examples to help visualise this process.

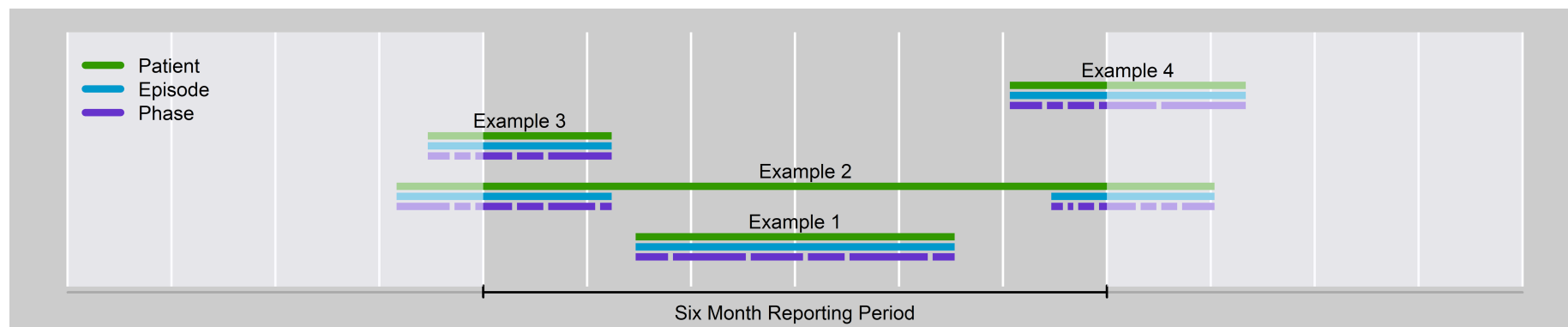


Figure 26: Diagram of the PCOC data scoping method

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.

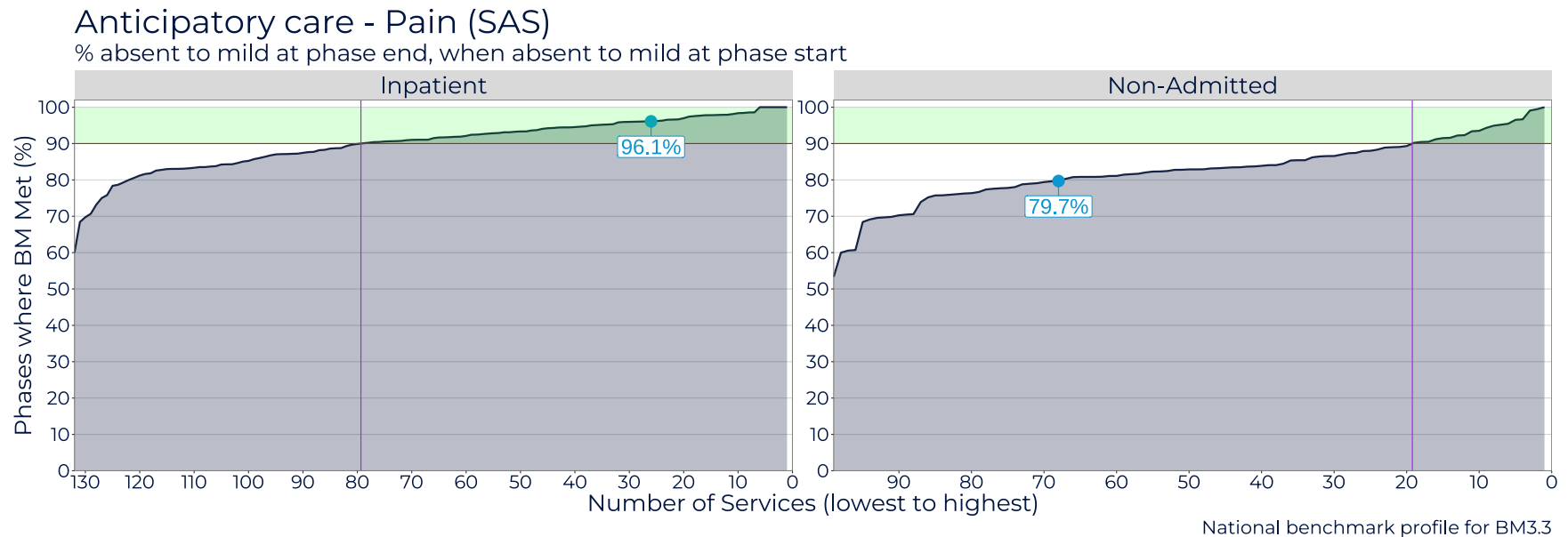
In Example 2, the patient has two episodes – the first having six phases and the second having seven phases. Looking at the phases associated with the first episode, the last four will be included in the report (as they end within the reporting period). The first two phases would have been included in 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 figures used in this interpretation guide are only examples and do not show any real data. The national profile graphs present your service 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.



- Inpatient SA Services are represented by blue dots on the left figure.
- Non-admitted SA Services are represented by blue dots on the right figure.
- 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 • 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).

G Quality Improvement Guide

This guide is designed to help services and organisations identify opportunities for quality improvement within their Outcome Reports. It is intended for use alongside the PCOC Quality Improvement Guide for Services and is particularly useful for clinicians and managers responsible for applying PCOC data to drive improvement efforts.

When reviewing your report with your team, keep in mind that PCOC Benchmarks are aspirational and that meaningful quality improvement is a gradual process. This guide includes a step-by-step checklist to support teams in interpreting outcome data and pinpointing areas for targeted QI activities.

Instructions for use	
Gather relevant team members to complete this checklist. It is recommended that one to two QI activities are selected for each reporting period (bi-annual). Refer to the list of useful resources within this guide and the key reflection questions to help guide the review.	
Table / Figure	Process check ☐ QI activity ☐
Table 2 Summary of outcome measures by setting of care.	☐ How do your results compare against the state and national outcomes and benchmarks? How do you account for the difference? ☐ Have your areas identified for improvement from previous reports resulted in better outcomes this report? ☐ Consider which symptoms or problem area benchmarks continue to be a challenge for your service, given your patient cohort and referral source(s), as you read your report. This may inform which service processes might be changed, to improve patient outcomes.
Table 3 Figure 1 Time from date patient is ready for care to episode start by setting of care.	☐ If you meet this BM at 100%, do you think it is accurate that your service does a comprehensive PCOC assessment on all patients within 48 hours of the patient being ready and available to receive care? A patient is ready for care, when they can accept an offer of care from the service. For example, for inpatient services, if a patient would accept an offer of a bed today, they are ready for care today. ☐ If the patient is not available for assessment, does your service have a process for recognising the date a patient is ready for care has changed? ☐ If you do not meet the benchmark, consider addressing barriers, implementing, or reviewing triage processes. ☐ If you do not think it is accurate, review the definitions of date ready for care and how this information is recorded. ☐ If you do not meet this benchmark, consider how your IT system supports the recording of assessments and if improvements are required.

Table 4 Figure 2 Time in unstable Phase.	☐ Are patients moved out of the unstable phase, with unresolved moderate or severe symptoms? This could be indicated by meeting Benchmark 2 Responsiveness of care but not meeting some of the individual responsiveness Benchmarks for responsiveness of care. ☐ Are patients in an unstable phase reviewed daily? What is your procedure for managing patients in unstable phase? Is it followed? Consider a case review using your supplementary data. ☐ Do you think your team is assessing and changing phase correctly? ▷ If you do not meet the benchmark, consider implementing priority patient review process for review triage, case discussions and handover, based on patients in unstable phase. You may also consider a file audit. ▷ If there has been a significant increase in benchmark performance, consider if this is due to an improvement in performance e.g. responding more quickly to severe symptoms, or due to a process change.
Table 5 Anticipatory Care Benchmark.	☐ Does your service have processes to prevent problems escalating for common symptoms associated with the primary diagnosis? ☐ Does your service have anticipatory prescribing processes? ☐ Does the review of patients include carer education and planning for the preferred place of care and death? ☐ If a patient does not have a carer, what is the process to ensure they can report / escalate issues? How are patients without a carer flagged in your processes? ▷ If you do not meet the benchmark, consider implementing an anticipatory care process for patients in the deteriorating and terminal phase, to actively prevent scores escalating. ▷ Introduce a patient without a carer flagging process, to ensure their escalation of care needs are identified.
Table 6 Responsive Care Benchmark.	☐ What is your process for responding to patients with moderate to severe scores? ☐ How well are patient needs responded to, according to the PCOC Assessment and Response protocol? For example, are phases being changed / ended, when patients still have moderate to severe scores? ☐ Do moderate and severe scores trigger referrals, intervention, or review? ▷ Consider a case review for patients with severe pain and family/carers issues, utilising the moderate to severe symptoms tabs in the supplementary data spreadsheet. ▷ If you do not meet the benchmark, implement, or review your service escalation plan for patients with moderate and severe symptoms.
Tables 7, 8 Figures 13, 14 Casemix Adjusted Outcomes.	☐ Based on your performance in the last outcome report, what symptoms/problems are not improving? ☐ Are there any symptoms that are lower than the national average? Patients that do not meet these benchmarks have larger increases, or less improvement in the level of severity/distress than those in the reference period. ☐ Are there areas where you are consistently not meeting the benchmark e.g. bowel problems? Investigate why this might be. Is it a staff skills issue? ▷ Consider reviewing your symptom management processes. ▷ Consider undertaking a team learning needs assessment, to identify and address staff knowledge gaps. ▷ Consider reviewing supplementary data and auditing the care provided to several patients who did not meet the BM to determine whether the quality of the care provided could be improved.

Tables 11, 12 Indigenous Status.	☐ Consider what proportion of data is not stated / inadequately described. Why is this data not being asked / collected and recorded? Are your results representative of the population you provide care for? If not, why not? ☐ Review your outcomes dashboard. Compare your results with the state average. Could there be unmet need? ▷ Consider asking the question training and / or cultural awareness training for all staff. Also see Gwandalan National Palliative Care Project ▷ Consider whether intake processes or assessment forms/templates need to be revised to always include questions about whether patients identify as Aboriginal or Torres Strait Islanders. ▷ Consider working with local Aboriginal and/or Torres Strait Islander services/community members to improve referral pathways. ▷ Consider a community population mapping activity with your PHN and review access pathways.
Table 13 Country of birth.	☐ Are your results representative of the populations you provide care for? Are there barriers for diverse groups to access your service? ☐ What is your referral acceptance criteria? Are there unintended consequences for some populations? Who is missing out on care? ▷ Consider a non-admitted population mapping activity with your PHN, or other appropriate bodies, to review access pathways, acknowledging that the social determinants of health impact on population access to health services generally. ▷ Review Census data for the area that you serve to identify underserved populations.
Table 14 Preferred language.	☐ Country of birth is likely to inform preferred language. Consider whether this aligns with the data in Table 13. Are patients asked about their preferred language and provided with language specific resources? Do you provide SAS information in different SAS Translations ? ▷ Introduce a process when the identification of a preferred language (other than English) triggers the provision of resources in the preferred language, for the patient, carer, and family.
Tables 15, 16 Principal diagnosis – malignant, non-malignant.	☐ Are there specific diagnoses that account for more referrals than others? Why? Does your symptom prevalence align with common symptoms of your most prevalent malignant conditions? E.g. Lung cancer and breathlessness. If not, why not? ☐ Are there conditions that are under-represented? Consider expected causes of death in Australia. Who is missing out on accessing your care? ☐ Review 'other primary malignancy' and 'not further defined' rates. Does this account for a significant proportion of your results? What are these 'other' conditions and are they accurately recorded? ▷ Consider a file audit review for patients recorded as; other primary condition, not further defined. Undertake training to address knowledge gaps. Contact a PCOC Improvement Facilitator to request this bespoke data.
Table 20 Referral Source.	☐ Do your referral sources reflect your service model and setting of care? ☐ Which sources are under or overrepresented in your referral data? ☐ Refer to your Outcomes dashboard. Are there established trends between referral source and episode phase start? Can this help with service provision? ▷ Reach out to you PHN/ local palliative care consortia/Community of practice and explore a referral source collaboration QI activity. ▷ Meet with inpatient referral sources to improve referral pathway linkages, for inpatient / consult services. ▷ Consider what type of patient (e.g. phase type and / or diagnosis) come from each referral source.

Tables 22, 23, 24 Length of episode.	☐ Is the length of episode long enough, to allow you to create therapeutic relationships with patients? Are referrals timely? ☐ Has the episode length changed over time? If so, why? ▷ Review your 'deaths within three days of episode start' supplementary data to identify possible pathways for earlier referral. ▷ Consider how users of your service access your service, identify any barriers, and consider a QI activity to improve ease of access.
Figures 16, 17 How Episodes End.	☐ This displays how episodes end over time for your service. The vertical axis displays the number of episodes, and each column represents the proportion of episode end type, classified by color. "Discharge to Other" includes discharge home, discharge from a non-admitted service or discharge from a consult service (and remaining in hospital). The reason for this type of discharge is often due to the patient no longer requiring (or wanting) the level of specialist palliative care that the setting provides. "Unknown" includes the episode end modes 'not recorded' and 'other'. Open episodes have been omitted. ▷ What percentage of your non-admitted episodes are ending in 'Discharge to Inpatient' and inpatient episodes are ending in 'Discharge to Other'? ▷ Review your supplementary data to see if discharges are due to unmet need/ uncontrolled symptoms. Is there an opportunity for QI?
Table 33 Figures 18, 19 Phase type.	☐ This table represents the patient and/or family/carer needs of your service. How do the needs of your patients/ family/carers compare to all services nationally? ▷ If the data does not reflect your teams time spent on supporting these needs, check that phases are being assessed accurately according to definitions. Note that the unstable phase can be triggered by severe family / carer problems.
Table 34 Phase length.	☐ Consider the average length of each phase at your service compared to national figures. Is your phase length longer or shorter? If your phases are longer for unstable and deteriorating phase, this may indicate that care plans are taking longer to be effective in reducing symptoms/problems. Is the Assessment and Response protocol being followed? Is your team phasing correctly? ▷ Undertake a team skills and knowledge survey and address identified staff needs, for example, clinical skills development, phasing education or implementation of an escalation of care protocol. ▷ Reach out to your Improvement facilitator for additional support.
Table 35 First phase of episode by setting.	☐ This table represents needs at admission to your service. How do these needs compare against services nationally? Does this seem accurate? ☐ Does phase type at admission reflect your service model e.g. Unstable for consult services? ▷ Conduct a file review to understand whether these phases align with the severity of symptoms/problems on admission. Introduce a process or staff training, to address the discrepancy. ▷ Meet with inpatient referral settings of care to improve referral pathway linkages and awareness of your service admission criteria.
Figure 21 Alluvial plot of Referral Source by First Phase Type.	☐ The left-hand side shows the referral source with the height of the box representing the volume of referrals. Similarly on the right-hand side, the size of the boxes represents the proportion of first phases. The referral source is then linked to the first phase phase of an episode with coloured lines/bands representing phase type (see key below, and box on the right-hand side). ☐ Does phase type at admission by referral source reflect your service model? ▷ Is the percentage of phase at episode start expected? ▷ Should referral type be considered at intake/triage?

Table 36, 37 PCPSS at phase start by phase type.	☐ Does the severity of scores align with phases as per the PCOC Assessment and Response protocol? ☐ How does the severity of scores for your patients compare to those for all services? ► Conduct a file audit on patients with severe PCPSS scores and the corresponding phase recorded. Is your team phasing correctly? Consider whether the assessment and response protocol is followed, as documented in the patient notes. Address issues found in team assessments or processes.
Table 38, 39 Symptom distress at phase start by phase type.	☐ Does the level of symptom distress align with phases as per the PCOC Assessment and Response protocol? Is your team phasing correctly? ☐ How does the level of symptom distress of your patients compare to those for all services? ► Conduct a file audit on patients with severe SAS scores and phase. Assess whether the assessment and response protocol were followed, in the patient notes. Address issues found in team assessments or processes. For example, staff education around phasing and applying the Assessment and Response protocol.
Table 40 Figure 22 RUG - ADL.	☐ Do most of your patients have RUG ADL score of 10 or more at admission? Are your referrals timely, given your setting of care, model of care and service type? ► Consider the impact of proportion of patients with a RUG - ADL score of 10 or more on admission, considering resources required and type of care provided (e.g. equipment needs, staff requirements).
Table 41 Figure 23 AKPS at phase start by setting of care.	☐ Do most of your patients have AKPS scores below 50 at admission? Are your referrals timely, given your setting of care, model of care and service type? ► Consider the impact of proportion of patients with AKPS of less than 50 on admission on the resources required and type of care provided (e.g. symptom management vs. end-of-life care). ► Reach out to you PHN/local palliative care consortia/Community of practice and explore a timeliness of referral collaboration QI activity or engage in a project around the value of palliative care with referring teams / sources.
Tables 45, 46, 47, 48 Data item completion.	☐ Does your service type explain the missing data? ☐ Is your service using the suite of tools at point of care? ☐ Who in your team is responsible for entering data? Is this an IT system and / or administration process issue? ► Identify in your team processes, from referral receipt until discharge. What assessment and collection points are missed? ► Consider introducing a routine check for PCOC item completion. ► If there are IT system issues, work with your IT team to resolve the issues before the next submission.