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An Australian Government Initiative

Gold Coast Health always care

KALWUN

Palliative Care Needs Assessment

December 2025

Acknowledgement of Traditional Custodians

Jingeri. We acknowledge the Traditional Custodians of the land in which we work, live and grow, the Kombumerri, Wangerriburra, Bullongin, Minjungbal and Birinburra peoples, of the Yugambeh Language speaking nation. We also pay our respects to Elders past, present and emerging.

Contributions

This document was developed in partnership between Gold Coast Hospital and Health Service, Gold Coast Primary Health Network, Kalwun Development Corporation, and Queensland Ambulance Service. Many organisations, groups, and individuals contributed their guidance, expertise, and lived experience to the development of the Gold Coast Joint Regional Needs Assessment. The authors acknowledge and extend gratitude for the time and effort spent contributing to this project, and the commitment to ensuring a shared understanding of our community's needs.

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GCPHN has reviewed the findings of the 2025 Palliative Care Needs Assessment and used these insights to inform the development and refinement of the Greater Choices for At Home Palliative Care Program Logic. The Program Logic reflects the identified needs, priorities, and service gaps across the Gold Coast region and guides the implementation of activities to strengthen access to coordinated community-based palliative care. To support transparency and broader sector planning, the GCPHN Greater Choices for At Home Palliative Care Program Logic is included as an appendix. As program implementation progresses and the needs of the region evolve, the Program Logic may be refined to ensure it continues to reflect emerging priorities and evidence.

Greater Choice for At Home Palliative Care – an Australian Government initiative.

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Key Terminology

ACRONYM	DESCRIPTION
ACP	Advance Care Planning
ACSQHC	Australian Commission on Safety and Quality in Healthcare
AKPS	Australia-modified Karnofsky Performance Status
AIHW	Australian Institute of Health and Welfare
BEACH	Bettering the Evaluation and Care of Health
FTE	Full Time Employee
GP	General Practitioner
GCHHS	Gold Coast Health and Hospital Service
GCPHN	Gold Coast Primary Health Network
RACH	Residential and Aged Care Home
VAD	Voluntary Assisted Dying

TERM	DEFINITION
Palliative care-related hospitalisations	A hospitalisation where palliative care was a component of the admitted patient care. These can be divided into 2 groups: • *Primary palliative care hospitalisations*: recorded care type of palliative care • *Other palliative care hospitalisations*: recorded diagnosis of palliative care, but the care type is not recorded as palliative care
Non-admitted patient palliative care services	Services wherein the primary clinical purpose or treatment goal is to optimise the quality of life of a patient with an active and advanced life-limiting illness. These can be divided into: • *Primary palliative care service event*: non-admitted patient care service event with a recorded care type of palliative care. • *Medical consultation for palliative care*: non-admitted patient care service event with a recorded Tier 2 non-admitted service type as palliative care in medical consultations. • *Allied health and/or clinical nurse specialist intervention for palliative care*: non-admitted patient care service event with a recorded Tier 2 non-admitted service type as palliative care in allied health and/or clinical nurse specialist interventions. • *Palliative care related service events*: broader category that that encompasses all/any non-admitted service event identified as palliative care either by care type, by Tier 2 clinic type, or both.
Medicare subsidised palliative medicine attendance	Palliative medicine attendance and case conference services provided by palliative medicine physicians or specialists that are claimed under specialist palliative care MBS item numbers subsidised under the Medicare Benefit Schedule (MBS).

1. KEY FACTS

- Demand for palliative care is rising due to an ageing population and increasing prevalence of chronic illness.
- From 2020-21 to 2023-24, the number of palliative care hospitalisations on the Gold Coast rose by 34% (compared to a 19% increase recorded nationally).
- In 2023-24, Gold Coast region had a significantly lower rate of outpatient palliative care events, compared to national averages.
- Despite the preference for home-based palliative care of many patients, the majority of deaths still occur in hospitals due to limited-service capacity, workforce shortages and funding constraints.
- There are significant workforce shortages among specialised palliative physicians and palliative care support staff across Australia. However, by 2026, Queensland's palliative care workforce is projected to grow by 87%, and Gold Coast by 55%.
- GPs have limited involvement in delivering palliative care due to systemic barriers such as inadequate renumeration, time limitations, and restricted access to specialist resources, highlighting the need for improved training, defined responsibilities and integrated care models.
- Delayed Advance Care Plan (ACP) discussions and low community awareness highlight gaps in education and promotion.
- There has been an increased emphasis on palliative care policies, strategies, and programs at both national and Queensland levels, aimed at strengthening community-based palliative care through improved service integration, workforce capability, access and quality of care, while seeking to address known system barriers including workforce shortages, resource constraints and inequitable access.
- Hospice care capacity in the region, and more broadly, is limited, highlighting a critical gap in palliative care services.

2. PRIORITISED NEEDS

1) Insufficient integration of care models, funding mechanisms and capacity for the provision of community based palliative care.
2) Strengthen and grow the palliative care workforce with a focus on recruitment, retention, and training to meet projected demand increases.
3) Limited uptake and implementation of Advanced Care Plans.
4) Limited GP capacity and variable levels of confidence in providing palliative care within aged care settings, particularly in after-hours.
5) Limited sense of cultural safety within palliative care for meeting needs of patients of culturally and linguistically diverse backgrounds, and First Nations peoples.
6) Insufficient resources and guidance for families and carers in navigating care systems.

3. INTRODUCTION

1.1 Definition

The Australian Commission on Safety and Quality in Healthcare (ACSQHC) defines palliative care as **care specifically tailored to assist with the effects of life-limiting illness**[1]. It distinguishes palliative care from the broader concept of 'end-of-life care' which typically refers to the final 12 months of life, while palliative care can occur episodically over an extended period.

Palliative care involves early identification, assessment and treatment of pain and other physical, psychosocial, and spiritual considerations. Palliative care is not limited to any specific condition; it can be delivered at any stage of illness, can accompany curative treatment, and can be provided in any health care setting (e.g. neonatal units, pediatric services, general practices, acute hospitals, residential and community aged care services and general community services)[2].

Specialist palliative care services comprise multidisciplinary teams with specialised skills, competencies, experience and training to deliver complex palliative care needs to patients. They operate through specialist inpatient consulting services, specialist inpatient settings, hospices and community-based specialist services.

2.1 Royal Commission into Aged Care Quality and Safety

In 2018, the Australian Government launched the **Royal Commission into Aged Care Quality and Safety**, which examined palliative care in the aged care sector, and provided key recommendations[3]:

- Compulsory palliative care training for aged care workers,
- Comprehensive sector funding specifically including palliative care and end-of-life care,
- A review of the Aged Care Quality Standards to regulate high quality palliative care in residential aged care,
- Access to multidisciplinary outreach services, and
- A new Aged Care Act that includes the right to access palliative care and end-of-life care.

Several of these recommendations have since been implemented, however, the calls for workforce training in palliative care, comprehensive sector funding and the integration between health and aged care systems remain outstanding. These gaps pose ongoing challenges to deliver consistent, high-quality palliative care across all settings[4].

Backed by the Queensland Government's investment of approx. $171 million, the **Queensland Health Palliative Care Strategy (2022-2025)** seeks to strengthen palliative care by[5]:

- Developing a new Palliative and End-of-Life Care Strategy,
- Growing Queensland Health's frontline specialist palliative care workforce,
- Investing in community-based services to meet local needs,
- Enhancing palliative care digital services and telehealth support,
- Delivering 24/7 secondary consultation for palliative care practitioners, and
- Providing education and advocacy about dying, death and advance care planning.

[1] Australian Commission on Safety and Quality in Health care (2023*). National Consensus Statement: Essential elements for safe and high-quality end-of-life care*
[2] Australian Institute of Health and Welfare. (2025). *Palliative care services in Australia: Overview*.
[3] Royal Commission into Aged Care Quality and Safety (202*). Aged Care Quality and Safety Final Report*.
[4] Office of the Inspector-General of Aged Care (IGAC) (2025). *2025 Progress Report*.
[5] Queensland Health (2022). *Palliative and End-of-Life Care Strategy*.

4. SERVICE DEMAND

Demand for palliative care services is increasing due to the ageing population and the increase in the prevalence of cancer and other chronic diseases. Dementia is the most common, and rapidly increasing primary diagnosis within palliative care events, doubling from 8% in 2014 to 17% in 2024[6].

Private and public hospitals are the largest referrers to palliative care, accounting for around 2/3 of all referrals. The number of referrals from each referral source has more than doubled in the last decade, while the percentage of each referral source over time has remained relatively consistent over time.

Nationally, there has been a 46% increase in palliative care-related hospitalisations between 2015 and 2024[7]. Similarly, in Queensland, the number of palliative care-related hospitalisations has doubled between 2020 and 2024.

National reports state that while 70% of Australians prefer to die at home, fewer than 15% do, with most deaths occurring in hospitals or residential aged care facilities[8].

This reflects systemic barriers such as limited home-based service capacity, workforce shortages and funding constraints[9]. Research highlights that achieving this shift requires integrated, multidisciplinary care, improved coordination through Primary Health Networks, and financial incentives to support home-based palliative care[10].

5. PALLIATIVE CARE SETTINGS

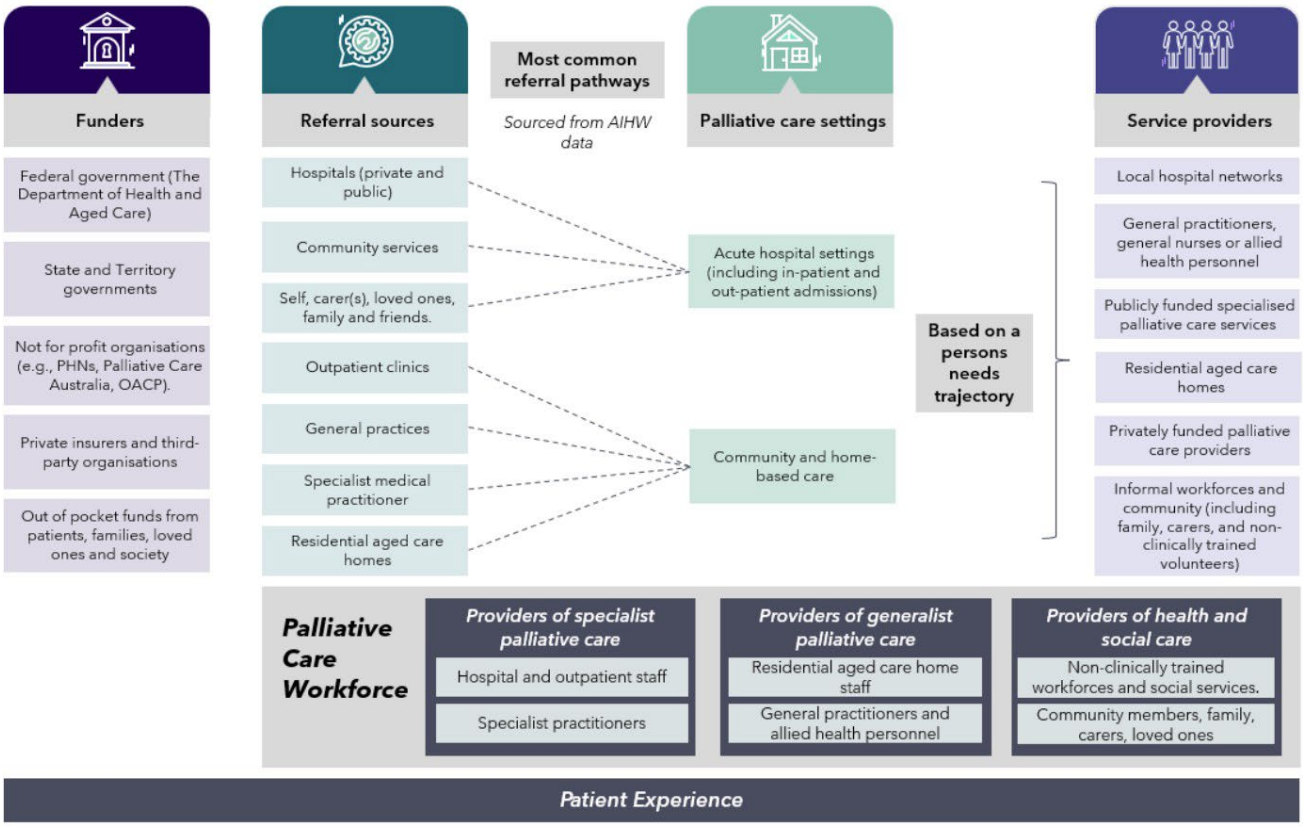
Palliative care services in Australia are provided in a range of settings, including:

- Public and private hospitals,
- Outpatient hospital services,
- Palliative care consultations,
- General practices,
- Residential aged care homes, and
- Patients' homes.

Figure 1 outlines the Australian Palliative care services system.

[6] Palliative Care Outcomes Collaboration (2025). *National Overview of Patient Outcomes in Australia*. University of Wollongong
[7] Australian Institute of Health and Welfare (2025) *Palliative care services in Australia*, AIHW, Australian Government
[8] Swerissen, H and Duckett, S. (2014). *Dying Well.* Grattan Institute.
[9] Scyne Advisory. (2025). *Evaluation of the Greater Choice for At Home Palliative Care Program: Baseline Report.* Australian Government, Department of Health
[10] Herrmann, A., Carey, M., Zucca, A., Boyd, L., & Roberts, B. (2019). General practitioners' perceptions of best practice care at the end of life: a qualitative study. *BJGP Open*, *3*(3).

FIGURE 1: AUSTRALIAN PALLIATIVE CARE SERVICES SYSTEM



Source: Australian Government Department of Health. (2025). Evaluation of the Greater Choice for At Home Palliative Care Program: Baseline Report.

5.1 Public and private hospitals

Palliative care provided in public or private hospitals includes care for admitted patients who receive palliative care provided during all or part of the episode of care. These hospitalisations include:

1) *Primary palliative care hospitalisations* with a recorded care type of palliative care
2) *Other palliative care hospitalisations* with a recorded diagnosis of palliative care, but the care type is not recorded as palliative care.

The 2025 Australian Institute of Health and Welfare (AIHW) report *Palliative care services in Australia* provides the latest available data on palliative care provided in hospital settings in 2023-24[7].

National data shows:

- Most palliative care-related hospitalisations were by patients aged 75+, with a median admission age of 77 years.
- The average length of stay was 11 days, which was twice the duration of hospitalisations for other reasons.
- 3% of all palliative care hospitalisations were by First Nations patients.
- More than half (55%) of hospitalisations ended with the patient dying in hospital.
- Cancer was the most common principal diagnosis of palliative care hospitalisations (40%).
- Most common non-cancer diagnoses included cerebrovascular disease, septicaemia, influenza, pneumonia, and other ill-defined causes.

Data for the Gold Coast region shows:

- There were 2,179 palliative care related hospitalisation; of those, almost half (n=1,001) had a primary diagnosis of cancer.
- 68% of the hospitalisations were by patients aged 75+.
- Compared to the national average, Gold Coast had a higher percentage of primary palliative care hospitalisations (70% vs 54%), and a lower percentage of other palliative care hospitalisations (30% vs 46%).
- From 2020-21 to 2023-24, palliative care hospitalisations on the Gold Coast rose by 34% (from 3,253 to 4,358), compared to a 19% increase recorded nationally.

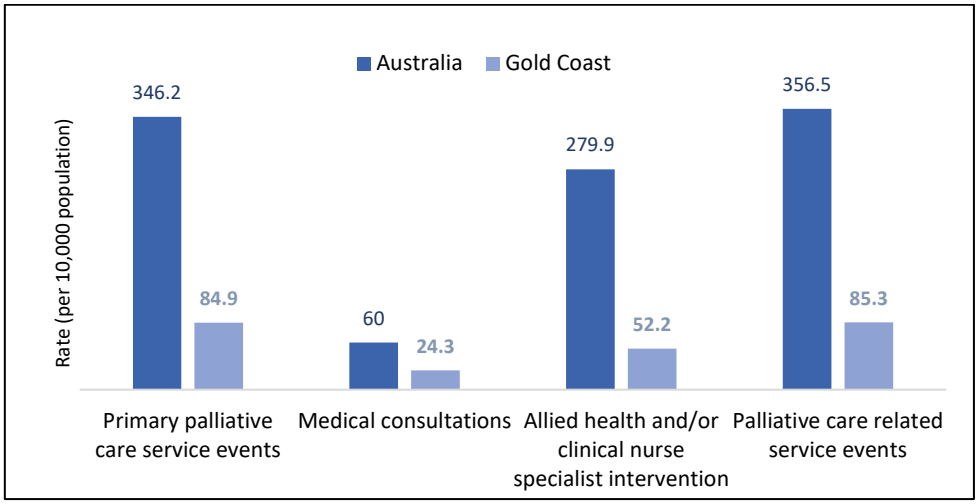
5.2 Outpatient hospital services

Outpatient hospital services refer to treatment or consultation provided in the public hospital system without hospital admission.

In 2023-24 there were 1.0 million outpatient palliative care-related services provided in Australia[7]:

- Over one in three referrals originated from hospitals,
- 72% of services were delivered off the hospital campus, and
- Around 3% of services were provided to First Nations patients.

FIGURE 2: REGIONAL NON-ADMITTED PALLIATIVE CARE RELATED EVENTS, 2023-24



Source: Australian Institute of Health and Welfare. (2025). Palliative services in Australia.

- Gold Coast region had a much lower rate across all types of palliative care related events provided outside of hospitals, compared to national averages (Figure 2).
- The degree of this difference ranged from 2.5-fold (medical consultations) to 4.2-fold (palliative care related service events).

1.3 Palliative care consultations

Palliative care consultations comprise medicine attendance and case conference services provided by palliative medicine physicians or specialists, which are claimed under Medicare Benefits Schedule (MBS) item numbers.

In 2023-34, 70,400 palliative care consultations were provided nationally by palliative medicine physicians/specialists. 85% of these were provided in consulting rooms or hospitals, 3% in other settings and 12% for case conferences[7Error! Bookmark not defined.].

The number of MBS-subsidised palliative medicine services has declined between 2018-19 to 2023-24, with an average annual decrease of 5%.

Data for Gold Coast shows:

- A total of 1,267 palliative care consultations were provided in 2023-24.
- Palliative medicine case conferences were the most common type of service (rather than attendance based).
- Average number of services provided per patient (1.9) was much lower than the Queensland (4.7) and national rate (4.9).

1.4 General practices

GPs play a critical role in palliative care, but their understanding of what constitutes palliative care varies widely with care requirements differing across settings[11]. Their role spans continuity of care, symptoms and pain management, care planning, and coordination with multidisciplinary teams[12]. A 2019 qualitative study that explored Australian GP views on best practice in palliative care described it as care that is proactive, holistic, and responsive to patient and family needs[Error! Bookmark not defined.]. However, barriers such as inadequate remuneration, time constraints, and limited specialist resources, particularly in rural areas, hinder effective delivery.

There is **limited data available on palliative services delivered by GPs**. This can be attributed to the lack of nationally consistent, routinely collected primary healthcare data collection that enables reporting on the provision of palliative care by GPs. Secondly, there are no palliative-care specific MBS items that can be used by GPs and therefore, it is likely that GPs use other MBS items such as chronic disease management and home visit items when providing patients with palliative care.

While somewhat dated, results from the Bettering the Evaluation and Care of Health (BEACH) study provide the most comprehensive insights into the GP clinical activity data, drawing on 1.8 million GP-patient encounter records from 1998 to 2016. Regarding palliative care, the study found[7]:

- 1 in 1,000 GP encounters were palliative-care related (6 per 1,000 population),
- 9 out of 10 palliative care encounters were for people aged 65+, and 5% were for those aged under 55,
- 1.3% of all GP palliative care-related encounters were by First Nations patients, and
- Females accounted for more GP palliative care-related encounters (53%) than males (47%).

Another study that evaluated GP experience in undertaking the Advance Project (national palliative care initiative in Australia, aimed at equipping health professionals in general practice, primary care, and aged care settings with practical tools and training to better support end-of-life care) revealed that the program increased awareness and confidence among practitioners in advance care planning

[11] Coulton, C., & Boekel, C. (2017). *Research into awareness, attitudes and provision of best practice advance care planning, palliative care and end of life care within general practice*. Department of Health.

[12] van Gaans, D., Erny-Albrecht, K., & Tieman, J. (2022). Palliative care within the primary health care setting in Australia: a scoping review. *Public Health Reviews*, *43*, 1604856.

(ACP) and palliative care. Initiatives like this demonstrate that structured tools, team-based approaches, and PHN support can embed advance care planning into routine practice[13].

To meet the growing demand and patient preferences for home-based care, reforms are needed to clarify GP roles, strengthen education, improve funding models, and enhance collaboration across the health system.

1.5 Residential aged care homes

The 2021-22 national data shows that the people requiring palliative care accounted for 2% of all permanent residential care residents, and 3% of all new admissions[7]. Of those:

- 55% were women, however, as a proportion of all RACH residents, men were 1.5-times more likely to be requiring palliative care than women,
- 78% were aged 80 years and over,
- 21% had cancer listed as the first condition on their appraisal, and
- 50% exited RACH within 8 weeks of admission requiring palliative care.

1.6 In patient's home

Palliative care services available at patient's home include medical and nursing support for symptom management and medication, allied health input such as physiotherapy and social work, emotional and spiritual care, provision of equipment and aids, respite for carers, and bereavement support for families[14]. The access to home palliative care is usually via GP, specialist or hospital referrals, or through Aged Care pathways and Pal Assist helplines.

The cost of home palliative care through public palliative care services is funded by state and federal governments with possible out-of-pocket costs for GP gap fees, non-PBS medications, equipment hire, private nursing and complementary therapies. The End-of Life Pathway under the Support at Home program provides up to $25,000 over 12 weeks covering nursing, personal care and home help. Eligibility includes being 65+ (or 50+ for Aboriginal/Torres Strait Islander people) with a prognosis of ≤3 months confirmed by a doctor and an AKPS score of 40 or less (which indicates frailty)[15].

Data on home-based palliative care is limited, making it hard to measure the service use.

Significant systemic challenges have been highlighted across multiple domains:

- Access to palliative care remains inequitable, with rural and remote communities, non-cancer patients, and underserved populations such as First Nations peoples and culturally diverse groups facing particularly significant barriers[16].
- Funding limitations, such as the 3-month cap under the Support at Home program, fail to accommodate variable illness trajectories.
- Workforce shortages and inadequate workforce training hinder the integration and availability of services, leaving carers experiencing high stress due to limited support and resources[17].

[13] Nagarajan, S. V., Lewis, V., Halcomb, E. J., Rhee, J., Tieman, J., & Clayton, J. M. (2022). Australian general practice experiences of implementing a structured approach to initiating advance care planning and palliative care: a qualitative study. *BMJ open*, *12*(3), e057184.
[14] Queensland Government (2017*). Care at Home*. Delivering for Queensland, Queensland Government.
[15] Australian Government (2025). *End-of-Life pathway: Support at Home*. Department of Health, Disability and Ageing.
[16] Australian Department of Health. (2019). *Exploratory Analysis of Barriers to Palliative Care*. Australian Healthcare Associates.
[17] Miller, E. M., & Porter, J. E. (2021). Understanding the needs of Australian carers of adults receiving palliative care in the home: A systematic review of the literature. *Sage Open Nursing*, *7*, 2377960820985682.

- The fragmentation within the system further disrupts the continuity of care, leading to unnecessary hospital transfers and poor coordination between services.

A 2025 Queensland study compared palliative care arrangements between patients with private health insurance and a standard community palliative care cohort[18].The study found that Medibank-insured patients more frequently reported a preference for a home death, had significantly shorter contacts with palliative services, and were more likely to die at home These results highlight the potential benefit of enhanced palliative care support at end of life with in-home nursing assistance and allied health interventions.

Many programs and initiatives have been introduced in Australia in recent years to support the rising demand for palliative care in patients' homes through carer support resources, telehealth utilisation (for patients residing in rural and remote locations) and enhancing cultural safety. Some of these initiatives include:

- **Greater Choice for At Home Palliative Care Program** strengthens coordination through Primary Health Networks by linking GP's, specialists, and community services, promoting advance care planning and carer support, and funding local projects to raise awareness and improve access to home-based care[Error! Bookmark not defined.].
- **The Quality Use of Community Palliative Care Medicines Project** aims to increase access to quality and timely end-of-life care for patients who choose to be cared and, if possible, die in their preferred place[19].
- **End-of-Life Pathway** supports older people diagnosed with 3 months or less to live who want to remain at home. It covers nursing, personal care, equipment and respite for home-based palliative care[15].
- **Medical Aids Subsidy Scheme (MASS)** offers free or subsidised equipment for home palliative care patients[20].
- **caring@home:** Website that aims to increase access to quality and timely end-of-life care for home-based patients by developing practical and evidence-based resources and providing associated education for health professionals[21].
- **PalAssist**: Statewide free telephone and online service that provides advise, emotional support and links to local home care providers[22].

[18] Eu, D., Fischer, A., Griffin, A., Lancaster, M., & Good, P. (2025). Dying at home: a prospective comparative study of home death rates in a private health insured palliative care community program. *Internal Medicine Journal*, *55*(5), 777-783.
[19] Palliative Care Australia. (2025). *Quality Use of Community Palliative Care Medicines Project.*
[20] Queensland Government. (2025). *Medical Aids Subsidy Scheme*. Queensland Health.
[21] The State of Queensland. (2025). *Caring@home*. Queensland Government.
[22] Queensland Government. (2025). *PalAssist: About us*.

6. WORKFORCE

The palliative care workforce comprises various health professionals, including specialist palliative medicine physicians, nurses, GPs, pharmacists, other medical specialists (such as oncologists and geriatricians), support staff, other health workers, and volunteers.

In 2023, there were 358 palliative medicine physicians (335 FTE) and around 3,900 palliative care nurses (3,500 FTE) employed in Australia[7]:

- 64% of physicians and 92% of nurses were women,
- 75% of physicians and 49% of palliative care nurses worked in hospital settings,
- There were 7 paediatric palliative medicine physicians in Australia, accounting for 0.2% of all physicians with a primary speciality of paediatrics and child health, and
- Over the last 10 years, the number of palliative medicine physicians grew at a much steeper rate (5.0% annual growth) than palliative care nurses (0.8% annual growth).

Currently, no data is available on the palliative care workforce specific to the Gold Coast region.

The 2025 *Palliative Care Workforce: Challenges and Opportunities Report* [23] outlines the demand for the growth of palliative care workforce between 2021 and 2026, based on demographic trends, rising complexity of care, and policy goals for equitable access and service expansion. The required 87% increase statewide (and 55% for Gold Coast to reach 47 FTE) will require a significant number of additional medical practitioners, nurses, allied health professionals, First Nations workforce, and administrative officers working in palliative care.

Importantly, these figures represent modelled service need rather than guaranteed workforce supply. Actual growth in workforce will depend on education and training capacity, recruitment and retention strategies, and sustained investment to translate these targets into a real workforce pipeline.

A recent workforce survey by Palliative Care Australia showed that most primary care professionals view palliative care as a core responsibility, with 81% agreeing GPs should discuss palliative care, 96% emphasising early discussions, and 93% supporting early access to care following diagnosis of a life-limiting condition[24]. However, inadequate renumeration and funding remain major barriers for GPs to deliver care as the rising demand for palliative services is not supported by the current MBS arrangements. Workforce shortages, funding and resource constraints are impacting on the quality of care for people with life-limiting illnesses, requiring an urgent reform to sustain primary care involvement in palliative care[25].

7. PRESCRIBED MEDICATIONS

Prescription medication is an important component of palliative care. These medications are defined as clinically relevant for patients with active, progressive and advanced diseases for whom the prognosis is limited and the focus of care is quality of life. These medications typically involve:

- analgesics for pain relief,
- anti-epileptics to treat seizures,

[23] Queensland Health. (2021). *Specialist Palliative Care Workforce Plan*. Queensland Government.
[24] Palliative Care Australia. (2025). *The case for improved renumeration of palliative care in primary care.*
[25] Palliative Care Australia. (2025). *Australia's palliative care workforce: Challenges and opportunities.*

- psycholeptics to treat psychological symptoms,
- anti-inflammatory and anti-rheumatic products to treat inflammation, and
- drugs for constipation.

The national data on palliative care-related prescribing in 2023-24 indicates[7Error! Bookmark not defined.]:

- there were 1.4 million palliative care-related prescriptions provided to 474,000 people,
- between 2016-17 to 2023-24, the number of palliative care-related prescriptions increased by 59%, while the number of people receiving these medications declined by 4%,
- number of prescriptions per person increased from 1.8 to 3.1 over this period,
- people aged 65+ accounted for 63% palliative care-related prescriptions,
- pain relief accounted for 79% of palliative care-related prescriptions, and
- GPs issued 90% of these prescriptions.

In Gold Coast region, 36,931 prescriptions were issued to 12,813 people in 2023-24.

8. PROGRAMS IMPLEMENTED ON THE GOLD COAST

Several programs focusing on increasing the understanding and uptake of palliative care services have been implemented in the Gold Coast region in recent years including:

8.1 Greater Choices for At Home Palliative Care

The Greater Choices for At Home Palliative Care (GCfAHPC) program provides funding for coordinating palliative care through PHNs and aims to enhance access to timely, high-quality and flexible coordinated palliative care services at home and in the community. PHNs work on improving care coordination, enabling early palliative referrals, providing resources for local collaboration and strengthening community and carer support by working with hospitals and the communities[26].

At Gold Coast PHN, activities under the GCfAHPC program include[27]:

- *Workforce support*: Supporting GPs, nurses, carers, Aboriginal workers, and allied health workers to complete palliative care training through scholarships.
- *Facilitate bereavement workshops*: For education of RACH staff on how to cope with grief and loss supported by partner Change Futures.
- *Health literacy resource booklet*: Distribution of ACP consumer guide to raise awareness and support consumers to discuss and plan end of life which was promoted through a series of local events involving GPs, practice managers, nurses and RACH and aged care workforce.
- *Stakeholder engagement:* distribution of news and information related to palliative care through online newsletters and other communication channels.

[26] Australian Government. (2025). *Greater Choice for At Home Palliative Care Program*. Department of Health, Disability and Ageing.
[27] Scyne Advisory. (2025). National Evaluation of the GCfAHPC Program: Midpoint Activity Catalogue. Australian Government.

8.2 Specialist Palliative Care in Aged Care

The Specialist Palliative Care in Aged Care (SPACE) program aims to improve access to specialist palliative care for residents in residential aged care homes. Implemented initially across Queensland HHSs between 2020 and 2024, the program provided specialist nurse-led support for residents and built capacity of GPs and aged care staff to deliver complex end-of-life needs[28]. The SPACE program is now funded permanently with state and federal funding allowing a smaller but ongoing service to be delivered moving forward.

Implementation of the SPACE program reports a positive impact with improved symptom control, reduced transfers to hospitals, and increased resident deaths in their place of choice. There has also been an improvement in capability and confidence of residential aged care providers to provide safe and culturally sensitive, high-quality end-of-life care[29]. An increase in Advance Care Planning documentation was observed, helping reduce hospital admissions and costs while promoting greater use of community-based palliative care.

8.3 Palliative Care Foundation Training Program for Pharmacists

ASPIRE is a training program developed by the Pharmaceutical Society of Australia to equip pharmacists with foundational knowledge and skills to support palliative care through safe and quality use of medicines. Available nationally and thus to Gold Coast pharmacists, the program aims to upskill pharmacists to support palliative care such as symptom management, medication rationalisation, grief and bereavement support, and advance care planning[30].

8.4 Residential Aged Care Support Service

The Residential Aged Care Support Service (RaSS) program provides a single point contact for RACHs providing care to residents with acute health care needs. It operates in partnership with Gold Coast Health, GCPHN, and GPs providing in person and online support (telephone and telehealth) from experienced clinical nurse consultants supported by specialist doctors[31]. Staff provide clinical support such as IV therapies, mobile X-rays and acute care needs for end-of-life care. The RaSS program, along with strong integration with SPACE and PallConsult programs has been found to reduce unnecessary ED presentations and provide support in advance care planning and after-hours care[32,33].

[28] Queensland Government. (2025). Specialist Palliative Care in Aged Care (SPACE) Project. Clinical Excellence Queensland.
[29] Queensland Government. (2022). SPACE Evaluation Report: Baseline. Clinical Excellence Queensland.
[30] Pharmaceutical Society of Australia. (2025). *ASPIRE: Palliative Care Foundation Training Program for Pharmacists*.
[31] Queensland Health (2019). *Residential Aged Care Facility Support Service (RaSS).* Queensland Government.
[32] Gold Coast Health (2021). *Program keeps Gold Coast elderly out of hospital.* Queensland Government.
[33] Queensland Health. (2025). *RaSS consultant contacts for GPs and QAS paramedics.* Queensland Government.

9. CONSULTATIONS

In the development of this Needs Assessment, consultations were held with a range of key stakeholders, including the Gold Coast Aged and Palliative Care Steering Group, GCH Clinical Council, GCPHN Community Advisory Council, and the Primary Care Partnership Council (PCPC).

Some were held as part of preparing the 2024-2026 Joint Regional Needs Assessment (co-developed by GCPHN, GCH, Kalwun and QAS), and some were organised in November 2025 to further inform the development of this specific document, as well as Joint Regional Older Persons Strategy.

Consultations found that the palliative care in the Gold Coast region, and more broadly, faces a number of significant challenges. Summary of main findings is presented in Table 1, with more details from individual consultations provided below.

TABLE 1: SUMMARY OF PALLIATIVE CARE CONSULTATION FINDINGS

Theme	Findings
Workforce & Staffing Shortages	Persistent shortages in RACHs and home care; limited after-hours coverage.
Access & Navigation Challenges	Difficulty accessing timely home support, after-hours care, and medication; families struggle to navigate fragmented systems; cross-border funding gaps add complexity.
GP Engagement & Clinical Governance	Limited GP involvement in palliative care; low uptake of training programs; inadequate remuneration and time constraints.
Education & Advance Care Planning (ACP)	ACP conversations often delayed until crisis; low community understanding; staff lack confidence; need culturally safe, earlier, and normalised ACP processes.
Funding & Service Fragmentation	Underfunding and siloed services create inequities, delays, and stress; hospice beds mostly privately funded; compliance burdens discourage flexibility.
Family & Community Support	Heavy reliance on family carers for in-home care; gaps for socially isolated patients; volunteers reduce isolation, but NGO engagement is limited; community wants holistic, compassionate care.
Training & Capability Building	Staff need more confidence in symptom management and end-of-life communication; balancing mandatory training with palliative care skills remains a challenge.

9.1 Palliative And Aged Care Committee (November 2025)

The Palliative and Aged Care Committee has been established to provide the GCPHN and GCHHS with access to a range of service providers and community members, related specifically to aged and palliative care. Main findings include:

- Shortage of RACH beds and increased demand for beds post-COVID.
- High complexity patients are not accepted by RACHs.
- Need for culturally safe models; posters are not a substitute.
- Acknowledgement of Commonwealth–State planning and upcoming dementia-specific units.
- Challenges with urgent home care package upgrades.
- The other big issue with aged care in hospitals is that patients are kept in bed, which makes them worse. RACHs can often manage this much better.
- Funding is the problem - the difference between hospitals and RACHs.
- Northern NSW patients frequently access Gold Coast services. Lack of cross-border funding alignment. Some NSW pathways are inaccessible to QLD clinicians and vice versa.
- There is a strong need for communication and navigation support.
- Generational education in advance care planning is needed.
- ACP should begin earlier in life and needs review over time.

9.2 Joint Regional Older Persons Strategy (October 2025)

Joint Regional Older Persons Strategy (JROPS) is a partnership between Gold Coast Health, GCPHN, Kalwun Health Service, and QAS, with the aim of developing a unified regional approach to older person care, reducing duplication and improving health outcomes.

The JROPS consultation was facilitated by a consultancy ImpactCo. The consultation was undertaken via community focus groups (3), sector workshops (3), 1:1 structured interview with sector (6), partners workshop (1) and surveys (2).

Consumers provided 25 responses and members of the sector provided 16 responses.

Main themes identified by the **community, older people and carers:**

- People want choice and control over their end-of-life care, including where they die.
- Care must be personalised, compassionate, and aligned to individual values.
- Families want better communication and involvement in decision-making and care planning.
- There is a need for simple, flexible care models that reduce the burden on families and carers.
- Access to timely medication, symptom control and pain management needs to be improved.
- The experience of end-of-life care must be more dignified and humane.
- Community members want more education on palliative care and advance care planning — what it means, how to prepare, and what supports are available.
- People want better connection to social, emotional, cultural and spiritual supports.

Main themes identified by the **aged care and community providers**:

- Staff need more training and confidence in palliative approaches, symptom management and end-of-life communication.
- Teams want easier access to clinical advice, decision support and specialist palliative care.
- There is a need for after-hours support to reduce stress and avoid unnecessary hospital transfers.
- Providers want simple, usable pathways and escalation processes for end-of-life care.

Main themes identified by the **system partners** (PHN, GCHHS, Kalwun, QAS):

- Advance Care Planning needs to be normalised earlier, not left until crisis moments.
- Care must be culturally safe, especially for First Nations peoples and CALD communities.
- GPs require more support and education on changes in palliative care practice and pathways.
- Partners want to better support older people to die outside of hospital, where appropriate and aligned with patient goals.
- Technology (telehealth, virtual consults, digital ACP access) should be used to strengthen response and coordination.

Stakeholders identified a number of **system gaps** impacting palliative care in the Gold Coast region:

- Fragmented communication across providers causes distress and delays.
- Families often experience difficulty navigating services, especially after hours.
- There are inequities in access between large and small RACHs, and between metro vs semi-rural parts of the Gold Coast.
- Not all older people have ACPs, and existing ACPs are not consistently accessible across GPs, RACHs, hospitals and QAS systems.

9.3 Primary Care Partnership Council (PCPC) (September 2025)

The PCPC is a governance and collaboration forum under GCPHN that brings together a broad range of primary care providers and stakeholders, including general practice, aged care, community health, and NGOs, to discuss emerging health issues and sector priorities. Main themes included:

- High-quality end-of-life care should honour patient wishes, minimise hospitalisations, and prioritise comfort, dignity, and family involvement.
- Access to preferred care settings, such as publicly funded hospice and palliative care, is essential, but staffing limitations restrict availability.
- Providing wraparound supports in home or aged care settings can reduce hospital transfers and enable dignified care by empowering staff.
- Early, honest, and culturally sensitive conversations about death support compassionate, high-quality end-of-life care.
- Although most Australians prefer to die at home, current supports are insufficient due to reliance on elderly family carers and workforce shortages.

- Death is often stigmatised and hidden in Australian culture, though community interest in holistic approaches is growing (e.g., death doulas, death cafés, living funerals).
- Hospice services on the Gold Coast are limited, with most beds reliant on private funding; palliative care investment is primarily focused on hospitals.
- Voluntary Assisted Dying (VAD) is legally available but not always accessible in preferred locations.
- Advance Care Planning (ACP) is underutilised, sometimes overridden by family, and staff/facilities lack confidence to act due to legal risks and documentation burdens.
- There is a need for earlier and normalised ACP conversations, such as during age 75 health checks and retirement planning, along with assistance to complete legally acceptable ACPs.
- Dementia care adds complexity and requires a dedicated strategy for end-of-life care.
- Aged care providers may hesitate to keep residents at home due to inadequate staffing, fear of complaints, and risk of penalties, despite clinical appropriateness.
- Ambulance and hospital protocols tend to default to life-prolonging interventions, even when these conflict with care wishes, due to risk management and compliance pressures.
- Paperwork, compliance demands, and system inefficiencies discourage flexible, person-centred end-of-life care.

Recommendations developed by PCPC:

- Education and guidance for both clinicians and the community on the importance of having early family discussions around care and planning.
- Access to assistance to complete an effective ACP due to the specific nature of the information required for a legally accepted ACP.
- Consider opportunities to advocate for a shift from hospital-centred models to person-centred, community-based approaches that respect individual wishes, reduce avoidable hospitalisation and provide accessible dignified hospice and home supports.

10. Service system in Gold Coast region

Key observations:

- Specialist palliative care services are highly centralised, with inpatient, outpatient and consultation services primarily located at Robina Hospital and Gold Coast University Hospital.
- Community, primary care and NGO services are distributed across the Gold Coast, but capacity, capability and scope of care vary, particularly between specialist and generalist providers.
- The system relies heavily on generalist providers (GPs, aged care and community services) to manage care outside hospital settings.
- Strengths:
    - Integrated bereavement support provided through Gold Coast Health with established referral pathways into community services.
    - Consultative specialist outreach (hospital and community-based) supporting care coordination and clinical advice.
    - Multiple funding streams available to support home-based palliative care (NDIS, CHSP, Home Care Packages).
    - Presence of a local hospice service, providing terminal care close to tertiary hospital services.
- Gaps:
    - No ongoing specialist palliative care service embedded in RACHs, with previous in-reach capability having ceased at the end of the funded project.
    - Limited specialist inpatient and hospice bed capacity, increasing reliance on community, aged care and generalist services.
    - Restricted access to specialist community services for RACH residents, contributing to potential hospital transfers.
    - Limited local paediatric palliative care capacity and not standalone, though no current concerns have been raised regarding the ability to match demand).

Services	Number	Distribution	Capacity discussion
GCH Inpatient Facility (Specialist Palliative Care)	1	Robina Hospital	• One public purpose-built 20 bed palliative care unit is available at Robina Hospital, with a further 4 palliative care beds at Gold Coast University Hospital. • The Palliative care unit is not a long-term facility, and some patients may be discharged to more appropriate care including the generalist services and RACHs or the private hospice.
GCH Specialist Palliative Care in Aged Care	1	Robina Hospital	• Project providing in reach support to upskill RACH staff to improve capability. • Funded from 2020 to 2024.

Services	Number	Distribution	Capacity discussion
GCH Community Service	1	Gold Coast wide	• The Community Service team provide a consultative service in patients' homes and provide support to the GP and other teams when necessary. There are no services currently to RACH (nursing homes or hostels).
GCH Bereavement Services	1	Gold Coast wide	• When a palliative care patient passes away, the family and significant others receive follow up consultations by a Social Worker, Chaplain, Community Nurse or Medical Officer. • Ongoing support is arranged as needed through other community services.
GCH Consultation and Liaison Service (Specialist Palliative Care)	1	Gold Coast University Hospital	• Symptom assessment, support and management advice, family support, case/ family conference, care planning, triage admissions and discharge advice.
GCH Outpatient/Community Facility (Specialist Palliative Care)	2	Robina and Gold Coast University Hospital	• Assessment and ongoing management via outpatient clinics and home visits. • Liaison with GPs and community nurses.
GCH Inpatient Facility (Children's Palliative Care Service)	1	Gold Coast University Hospital	• Works closely with Children's Health Queensland. • Not a standalone service, staff are shared across multiple services.
BlueCare, Ozcare and Anglicare (funded by Gold Coast Heath)		Gold Coast wide	• Complex nursing and personal care, and support to help patient stay at home, including post-death support. • Other NGOs including Aquamarine Care, RSL Life Care at Home Kalwun Home and Community Care provide limited services.
Hopewell Hospice	1	Arundel	• Eight beds located near GCUH, it's often used for terminal care (one non-private bed available).
Aged care service providers	Numerous	Gold Coast wide	• Numerous aged care providers across the Gold Coast region provide generalist palliative services, but not specialist palliative care support. • This can include domestic and personal care, home maintenance, equipment, social support, clinical services, respite, and counselling.

Services	Number	Distribution	Capacity discussion
General practitioners	889*	Gold Coast wide	• GPs play a critical role in coordinating care and making referrals, identifying and assessing palliative care needs pain management, medication management, bereavement support and advance care planning.
At home palliative care service providers	Various	Gold Coast wide	• A number of providers across the Gold Coast region provide at-home palliative care services, working closely with health professionals and family members. • The in-home palliative care services offered are pain and symptom management, medication monitoring, advance care planning nutritional support, mobility assistance, bereavement support, and counselling through personal carers, nursing and allied health professionals. • Most of the services provided are private but can be covered under NDIS, Commonwealth Support Program (CHSP) or under government funded Support at Home and Home Care Packages.

*As at 3/12/2025

11. Appendix

Greater Choices for At Home Palliative Care - Program Logic

Aim: To improve equitable access to coordinated, high-quality, culturally safe palliative and end-of-life care at home and in community settings, and to strengthen the capability of primary care, aged care and community providers to support people to receive care and die in their preferred place where appropriate.

Specific objective(s):

- Establish and maintain effective regional governance and collaboration mechanisms.
- Strengthen primary care and aged care workforce capability.
- Support general practices to identify and manage palliative care needs earlier.
- Increase awareness and consistency of Advance Care Planning (ACP) across the region.
- Enable the development of compassionate community and volunteer capacity.
- Improve equity and cultural safety in palliative care access and delivery.

Needs ***What is the specific problem or issues that this program/activity will address?***	**Inputs** ***What resources do we have?***	**Outputs (Activities)** ***What will we do?***	**Outputs (Participation)** ***Who will we target? Who else is involved and what is their role?***	**Outputs** ***What will be the direct products of the program/ activities? E.g. types, levels, targets of services to be delivered.***	**Outcomes Short Term (1st year)** ***What are the expected benefits/changes as a result of the program?***	**Outcomes Medium Term (2-5 years)** ***What are the expected benefits/changes as a result of the program?***	**Outcomes Long Term (5+ years)** ***What is the expected impact in the long term?***
The Gold Coast Primary Health Network Palliative Care Needs Assessment (2025) identifies that demand for palliative care in the region is increasing due to population ageing and rising prevalence of chronic and complex illness, while service capacity and system integration remain insufficient to meet demand. The Needs Assessment highlights fragmentation across health, aged care and	**Australian Government GCfAHPC funding:** • $1,292,934 million 2025–2029 (funded to end FY 2028–29) **Policy, Plans, Frameworks, Strategies, Reports:** • Greater Choice for At Home Palliative Care grant opportunity guidelines – GO7548 • Pilots & Targeted Programs Schedule	**System coordination and engagement** • Facilitate and participate in regional governance and advisory groups (e.g. Palliative and Aged Care Committee and Queensland & Northern Territory PHN Greater Choices for At Home Palliative Care Community of Practice). • Contribute to regional planning activities that strengthen coordination of care across settings.	**Target participants** • Primary care providers (GPs, practice nurses, allied health) • Residential aged care providers • Community and specialist palliative care services **Other stakeholders** • Hospital and Health Service • Non-government and community organisations • Advisory and governance groups • PHN staff	• Number of Palliative and Aged Care Committee meetings facilitated • Number of participants in Palliative and Aged Care Committee meetings • Number of joint planning or partnership meetings held with Gold Coast Health and key stakeholders • Number of Queensland & Northern Territory PHN Greater Choices for At Home Palliative Care Community of Practice meetings attended	Increased knowledge, skills and confidence of the health, aged care and community workforce in palliative care Increased knowledge of palliative care pathways, roles and referral options Increased awareness of Advance Care Planning and	Increased capability of primary care, aged care and community providers to deliver palliative care in community settings Increased uptake of Advance Care Planning and earlier end-of-life discussions Increased community and volunteer	More people receive palliative care in their preferred place, including at home where appropriate Improved coordination and integration of palliative care across services Improved experiences of care for people with life-limiting illness,

Needs ***What is the specific problem or issues that this program/activity will address?***	**Inputs** ***What resources do we have?***	**Outputs (Activities)** ***What will we do?***	**Outputs (Participation)** ***Who will we target? Who else is involved and what is their role?***	**Outputs** ***What will be the direct products of the program/ activities? E.g. types, levels, targets of services to be delivered.***	**Outcomes Short Term (1st year)** ***What are the expected benefits/changes as a result of the program?***	**Outcomes Medium Term (2-5 years)** ***What are the expected benefits/changes as a result of the program?***	**Outcomes Long Term (5+ years)** ***What is the expected impact in the long term?***
community services, which contributes to poor coordination, difficulty navigating services, and avoidable hospital transfers, particularly for patients and carers managing care at home. There is a recognised need to strengthen workforce capability and capacity, including improving training, confidence and engagement of general practitioners, nurses, allied health and aged care staff, particularly in providing palliative care in community and residential aged care settings and after-hours. The Needs Assessment also identifies low uptake of Advance Care Planning and the need for earlier conversations, improved community awareness and support to complete and implement Advance	• 2018 Gold Coast Regional Palliative Care Plan • Gold Coast Palliative Care Health Needs Assessment 2025 • Gold Coast Joint Regional Needs Assessment 2024 to 2026 • The National Palliative Care Strategy 2018 **Resources:** • GCPHN staff • Established governance structures, including the Palliative and Aged Care Committee and working groups • Partnership with Gold Coast Health • Relationships with primary care, aged care, community care providers	**Workforce capability and capacity building** • Provide scholarships opportunities for GPs, nurses and other health professionals. • Commission education and training in palliative care for aged care and primary care providers. • Facilitate evaluation activities to measure changes in knowledge, confidence and skills.	**Target participants** • General practitioners and practice nurses • Residential and community aged care staff • Allied health professionals **Other stakeholders** • Change Futures • Training providers • Hospital and Health Service • PHN staff	• Number of scholarships awarded • Number of scholarship recipients completing education • Percentage of participants completing post-training evaluation • Number of education and training activities delivered • Number of health professionals participating in palliative care education and training • Percentage of participants reporting increased knowledge, skills or confidence following training	death literacy among providers and community members Increased awareness of culturally safe and inclusive approaches to palliative care	participation in supporting people at end of life Improved access to culturally appropriate and responsive palliative care	families and carers A more capable and sustainable workforce and community supporting end-of-life care
		General practice engagement and support • Promote practical tools, pathways and resources that support early identification of palliative care needs. • Facilitate opportunities for collaboration and knowledge sharing between general practice and specialist and community providers.	**Target participants** • General practitioners • Practice nurses • Practice managers **Other stakeholders** • Training providers • PHN staff	• Number of resources or pathway tools promoted to general practices through GP and Practice News. • Number of General Practice focused education or engagement activities delivered • Number of General Practice staff participating in training or education activities • Percentage of participating General Practice staff reporting increased confidence in providing palliative care.			

Needs ***What is the specific problem or issues that this program/activity will address?***	**Inputs** ***What resources do we have?***	**Outputs (Activities)** ***What will we do?***	**Outputs (Participation)** ***Who will we target? Who else is involved and what is their role?***	**Outputs** ***What will be the direct products of the program/ activities? E.g. types, levels, targets of services to be delivered.***	**Outcomes Short Term (1st year)** ***What are the expected benefits/changes as a result of the program?***	**Outcomes Medium Term (2-5 years)** ***What are the expected benefits/changes as a result of the program?***	**Outcomes Long Term (5+ years)** ***What is the expected impact in the long term?***
Care Planning documentation effectively. In addition, there is a need to improve community awareness, carer support and access to culturally safe care, as families often experience difficulty navigating services and some population groups face additional barriers to accessing appropriate palliative care. Despite strong community preference to receive end-of-life care at home, most deaths still occur in hospital, reflecting limitations in community-based service capacity, workforce availability and coordinated care models.	• Relationships with First Nations, culturally diverse and community organisations • Communications channels, stakeholder networks and community engagement platforms • Monitoring, evaluation and reporting systems • Existing regional service pathways and collaboration mechanisms	**Advance Care Planning (ACP) awareness and death literacy** • Promote ACP awareness through distribution of *Planning your future care today* booklet and consumer and provider resources. • Participate in community events and relevant health promotion activities. • Collaborate with the Office of Advance Care Planning and GCHHS Advance Care Planning Service to promote consistent messaging. • Participate in Statewide Office of Advance Care Planning Clinical Advisory Group to support quality improvement.	**Target participants** • Community members • Older people and people with chronic or life-limiting illness • Health care professionals **Other stakeholders** • Hospital and Health Service • City of Gold Coast • Community organisations and local groups • PHN staff	• Number of *Planning your future care today* (print or digital) resources distributed • Number of communication and promotional activities delivered (newsletters, campaigns, website updates) • Number of community engagement events attended • Number of Statewide Office of Advance Care Planning Clinical Advisory Group meetings attended			

Needs ***What is the specific problem or issues that this program/activity will address?***	**Inputs** ***What resources do we have?***	**Outputs (Activities)** ***What will we do?***	**Outputs (Participation)** ***Who will we target? Who else is involved and what is their role?***	**Outputs** ***What will be the direct products of the program/ activities? E.g. types, levels, targets of services to be delivered.***	**Outcomes Short Term (1st year)** ***What are the expected benefits/changes as a result of the program?***	**Outcomes Medium Term (2-5 years)** ***What are the expected benefits/changes as a result of the program?***	**Outcomes Long Term (5+ years)** ***What is the expected impact in the long term?***
		Volunteer and compassionate community development • Support development of Gold Coast Compassionate Communities model. • Support recruitment of Compassionate Communities Coordinator for the Gold Coast region. • Strengthen partnerships with community organisations and volunteer networks. • Support initiatives that build volunteer capability in palliative care. • Promote compassionate community approaches that support patients, carers and families.	**Target participants** • People with advanced or life-limiting illness living in the Gold Coast PHN region • Family members, carers, and informal supports • People experiencing grief and bereavement **Other stakeholders** • Volunteer organisations • Community organisations • Local groups • Compassionate Communities Australia • Kindness Company • Hospital and Health Service • Compassionate Communities Working Group • PHN staff	• Locally tailored Compassionate Communities model and framework developed within project timeframe • Number of training and capacity-building sessions delivered • Number of community members, volunteers and organisations participating in training • Community capability-building tools and resources developed and disseminated • Percentage of participants reporting increased knowledge or confidence in supporting people at end of life			

Needs ***What is the specific problem or issues that this program/activity will address?***	**Inputs** ***What resources do we have?***	**Outputs (Activities)** ***What will we do?***	**Outputs (Participation)** ***Who will we target? Who else is involved and what is their role?***	**Outputs** ***What will be the direct products of the program/ activities? E.g. types, levels, targets of services to be delivered.***	**Outcomes Short Term (1st year)** ***What are the expected benefits/changes as a result of the program?***	**Outcomes Medium Term (2-5 years)** ***What are the expected benefits/changes as a result of the program?***	**Outcomes Long Term (5+ years)** ***What is the expected impact in the long term?***
		Culturally safe and equitable access • Engage with First Nations organisations and culturally diverse organisations where appropriate. • Promote culturally appropriate resources and education. • Support activities that improve awareness, knowledge, and confidence in delivering culturally safe care.	**Target participants** • First Nations peoples • Culturally and linguistically diverse communities • Priority and underserved populations **Other stakeholders** • Kalwun • Multicultural Communities Council Gold Coast • Change Futures • Training providers • PHN staff	• Number of culturally appropriate resources promoted • Number of engagement activities undertaken with First Nations or culturally diverse organisations • Number of workforce participants attending culturally safe palliative care training • Percentage of participants reporting increased knowledge and confidence in providing culturally safe care			

Assumptions:	**External factors:**
• *Workforce capacity exists to participate in training.* • *Partner organisations remain engaged.* • *Community providers continue to deliver services locally.* • *Consumers are willing to engage.*	• *Workforce shortages and turnover.* • *Health system reforms and funding changes.* • *Demand growth due to ageing population.* • *Policy changes in aged care and home care.* • *Public health events or system pressures.*

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