



WA Primary Health Alliance PHN PHN Pilots and Targeted Programs Perth North 2024/25 - 2027/28 Activity Summary View

Approved by the Australian Government Department of Health, Disability and Ageing, November 2025



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Activity Metadata

Applicable Schedule

PHN Pilots and Targeted Programs - Perth North

Activity Prefix

PP&TP-GCPC

Activity Number

1000

Activity Title

GCPC - 1000 Greater Choice for At Home Palliative Care Project

Existing, Modified or New Activity

Existing



Activity Priorities and Description

Program Key Priority Area

Aged Care

Aim of Activity

The continuation of the Greater Choices for At Home Palliative Care (GCfAHPC) will run nationally over four years from 2025-2029. The purpose of the grant is to improve and increase access to quality palliative care at home, in the community. The aim is to support people who choose to remain at home to receive palliative care and end-of-life care. The objectives of the Program and this grant opportunity are to:

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

The intended outcomes of the Program and this grant opportunity are to:

- Improve the capacity and responsiveness of services to meet local needs and priorities.
- Improve patient access to quality palliative care services available in the home and improved capacity of carers to support people at home.
- Improve coordination of care for patients, across health care providers and integration of palliative care services in their (PHN) region.

- The GCfAHPC grant will be utilised to build on work undertaken in FY 23/24 and FY 24/25 in PHN North. Our focus for FY 25/26 will include:

- Promoting choice at end-of-life by building community awareness about Advance Care Planning (ACP) through consolidation of activities commenced in FY 24/25 which engaged two peak bodies – Palliative Care WA and LinkWest.
- Improving access to ACP as part of routine health assessments, namely the 75+ and Indigenous Health Assessments (IHA) in general practice.
- Building capacity and capability in general practice to identify patients who may be in their last 12 months of life and who have a high risk of unplanned hospitalisation (improved utilisation of Primary Sense Complexity Report (Report 5)).
- Developing screening processes for general practice to identify patients who may be in the last 12 months of life but who do not meet the criteria for referral to Specialist Palliative Care community services.
- Implementing a Supportive Care model of care in general practice to proactively manage the expected deterioration of patients with an ACG score of 5 with the intention of reducing avoidable ED presentations.

Description of Activity

Background

The Perth North Primary Health Network (PHN) has a population of more than a million Western Australians and spans 2,975 square kilometres. It comprises of inner-city high density living and outer metropolitan suburban and agricultural areas.

Health Needs identified in PNPHN that relate to the GCfAHPC measure include:

- Cancer is the leading cause of disease burden and accounts for one third of fatal disease burden. Some areas have high rates of avoidable deaths from cancer.
- Chronic diseases account for two thirds of disease burden in WA, of which cardiovascular diseases account for a significant proportion.
- Some areas have high levels of demand for after-hours services, including high rates of after-hours GP-type Emergency Department presentations, suggesting unmet community need.
- Some areas in the Perth North PHN have large populations of people born in predominantly non-English speaking countries (21%-26%) and people with poor English proficiency (3%).
- Chronic disease contributes significantly to the differences in life expectancy between Aboriginal and non-Aboriginal people, with the leading cause of death among Aboriginal people being ischemic heart disease.
- There are limited culturally appropriate home palliative care providers, with many older Aboriginal people dying in hospitals or aged care services.
- Some areas have high proportions of older people within priority population groups (including Aboriginal, LGBTIQ+ and multicultural people).
- Nearly 6 in 10 older people using permanent residential aged care in the Perth North PHN have a diagnosis of dementia.

The focus of the PNPHN GCfAHPC activities build on the work completed in the GCfAHPC which was implemented between October 2022 and May 2025. Our approach has been informed by:

- Extensive consultation with key stakeholders.
- Review of the PNPHN Needs Assessment.
- Monthly Community of Practice meetings with general practice employees.
- Monthly Community of Practice meetings with community employees.
- Completion of a Learning Needs Analysis Survey for GPs, Practice Nurses and Nurse Practitioners.
- Completion of the Death Literacy Index tool by community support workers.
- Focus groups.
- Completion of the After Death Audit by a small group of general practices.
- Review of the introduction of new legislation relating to enhanced financial support for people in the last three months of life and the proposed role of GPs (Support at Home).

Rationale

Within PNPHN, specialist palliative care services are provided through a range of hospitals, hospices, and community services. PNPHN has 71 Palliative Care Unit beds which are a mix of public and private beds. Across the Perth metropolitan area, Silver Chain's Community Palliative Care Service supports around 3,500 people with a progressive, life-limiting illness whose needs are complex and whose life expectancy is less than 12 months.

Not all patients referred to the Silver Chain service are eligible for admission. These patients are declined and referred back to their General Practitioner (GP) for ongoing care. If the patient needs greater care than the GP and practice can support, there is a risk that the patient will present to hospital. This risk increases if the person has become housebound as GPs do not routinely provide home-visiting services.

PNPHN has high rates of chronic disease, particularly coronary heart disease and Chronic Obstructive Pulmonary Disease, with areas identified as a hotspot for Diabetes related potentially preventable hospitalisations (PPHs). Cardiac failure was one of the three top PPHs for the PHN. Chronic disease PPHs are statistically significantly higher for Aboriginal populations in PNPHN. The need to increase access to palliative care services has been identified as a priority for the whole PHN.

The generalist nature of primary care providers, competing demands and primary care sustainability issues can be a barrier to the provision of palliative care in the home. There is a need to increase awareness of:

- Advanced care planning (ACP).
- The benefits of palliative care with community and primary care workforce.

There is also a need to assist primary care workforce to identify palliative care needs within their patient cohort and develop a plan of care that reflects the generalist palliative care role.

Roles and responsibilities

WA Primary Health Alliance's (WAPHA's) Primary Care Portfolio, which works across the three WA Primary Health Networks, is responsible for the delivery of the GCfAHPC measure. An executive sub-committee oversees all PNPHN aged care activity including the GCfAHPC to ensure it aligns with funding requirements and guidance, and WAPHA's Strategic Plan 2023-2026.

A team, consisting of an activity lead, project officer and quality improvement coach lead GCfAHPC activities across the three WA PHNs. Each WA PHN contributes to the cost of the team via the available GCfAHPC expansion funds. Activities are costed to the relevant PHN. Project management, place-based integration managers, and practice support employees assist the team. A program logic guides activities.

Key activities

The PHNs Needs Assessment has been updated to include a section on Palliative Care, this information guides the PHNs Greater Choice activities.

Activity 1: Improve community awareness of Advance Care Planning to promote informed choice and future (end of life) planning by consolidating activities delivered through LinkWest and PCWA to build capacity and capability in Community Resource Centres (CRCs) in PNPHN.

This will include:

- Roll-out of ACP foundation training to all CRCs by PCWA.
- A range of community awareness events coordinated by each CRC to enhance understanding of ACP in community.
- ACP information to be promoted by LinkWest on their webpage.
- A small grant will be provided to LinkWest to coordinate this work.
- A small grant will be provided to PCWA to support the delivery of ACP and palliative care awareness training to the staff of the Linkwest Centres in PHN North.

Activity 2: Improving access to ACP to promote informed choice and future (end of life) planning for underserved populations.

This will include:

- Exploring the ACP informational needs of a CaLD community.
- Exploring the ACP informational needs of people newly diagnosed with dementia.

Activity 3: Centres on improving access to ACP through routine health assessments including IHAs in general practice, including:

- Engaging two new general practices to participate in the Palliative Care Champions project and providing a small grant to facilitate work relating to this activity.

- Enhancing ACP capacity and capability of the Quality Improvement (QI) Coaches at WAPHA who support general practice in PNPHN to facilitate the implementation of a systematic approach to the inclusion of ACP in these assessments. This initiative encourages early end-of life planning in an at-risk cohort and will facilitate ACP for patients who are more likely to be diagnosed/have a diagnosis of dementia.
- 0.33 FTE will be funded within the QI Coach to support this increase in scope.
- Introduction of the Australian Modified Karnofsky Performance Scale (Karnofsky Scale) in general practice to support screening for eligibility for the “End of Life Pathway” as per the Support at Home legislation.

Activity 4: Focuses on building capacity and capability related to the generalist approach to palliative care in a small number of general practices.

This includes:

- Provision of a small grant (\$20k per practice) to two general practices to consolidate the work relating to the Palliative Care Champions project completed in FY24/25. This grant will build on the introduction of ACP in routine health assessments and Chronic Disease management plans as well as progress the implementation of a new model which WAPHA has developed called “Supportive Care”.

Activity 5: Concentrates on primary care palliative and EOL care continuous quality improvement (QI) and includes:

- The refinement of QI activities specific to ACP and the generalist approach to palliative care.
- Assisting practices with audits (After Death Audits).
- Activities to improve ACP awareness.
- Utilisation of Primary Sense data (Report 5) to identify patients at high risk of hospitalisation and potentially unmet palliative care needs.
- This work is supported by a dedicated QI Coach (0.33 FTE)

Activity 6: Exploration of the role of community Pharmacists relating to the support of general practice in facilitating ACP and “staying in place”/supportive care. This activity will involve engagement with the peak bodies, community Pharmacists and the Lead Palliative Care Pharmacist for WA.

The GCfAHPC team participates in the national GCfAHPC evaluation and in a range of forums to promote primary care provided palliative care services in the WA palliative care and EOL system and inform service and system improvement.

Needs Assessment Priorities

Needs Assessment

WAPHA Needs Assessment 2025-2027

Priorities

Priority	Page reference
Enable early intervention and monitoring activities to reduce early entry into residential care and support older people in living independently for as long as possible (Metro).	52
Enable access to aged care services that support independent living and healthy ageing at home (Metro).	52
Support people living with dementia and their carers to navigate the aged care system and access appropriate services (Metro).	53
Support primary health care providers (incl. general practices, allied health and aged care services) to effectively manage chronic conditions for older people and promote health ageing at home(Metro)	54



Activity Demographics

Target Population Cohort

Primary care workforce, particularly GPs and general practice employees in their role as “generalist” palliative care providers.

General practice clients living with (advanced) chronic disease whose needs may be better met by a palliative approach to care.

Community members to increase ACP awareness.

Indigenous Specific

Yes

Indigenous Specific Comments

This activity focus includes Aboriginal and Torres Islander populations through the promotion of ACP in IHA’s and the inclusion of culturally appropriate materials to support ACP awareness.

WAPHA will continue to work with our existing partner, the Aboriginal Health Council of WA (AHCWA) to promote awareness of ACP and access to palliative care. We are also interested in developing a relationship with the newly formed National Aboriginal and Torres Strait Islander Palliative Care Association (NATSIPCA).

Coverage

Whole Region

Yes



Activity Consultation and Collaboration

Consultation

The PHN consulted with and continues to engage with a range of stakeholders in the planning and delivery of the Greater Choices for At Home palliative Care measure, including:

- WA GP Panel – Special Interest Group: Care of the older person
- General practitioners and general practice employees
- Palliative Care Australia
- Palliative Care Outcomes Collaborative
- Silver Chain – WA Metropolitan Community specialist palliative Care provider
- WA Health End of Life and Palliative Care Advisory Committee
- WA Health ACP Team
- Advance Care Planning Australia (ACPA)

Collaboration

Collaboration is ongoing with:

- Aboriginal Health Council of WA
- Targeted general practices
- Aged care provider representatives
- Palliative Care WA
- Linkwest
- Program of Experience in the Palliative Care Approach
- Palliative and Supportive Care Education WA.



Activity Milestone Details/Duration

Activity Start Date

09/12/2021

Activity End Date

30/10/2026

Service Delivery Start Date

07/02/2022

Service Delivery End Date

31/10/29

Other Relevant Milestones

Twelve Month Performance Reports

Due 30/09/25, 30/09/26, 30/09/27, 30/09/28, 30/09/29

Activity Work Plan

Due 30/05/25, 30/04/26, 30/04/27, 30/04/28, 30/04/29

Financial Acquittal statement and audited income and expenditure statements Reports

Due 30/09/25 30/09/26, 30/09/27, 30/09/28, 30/09/29

Needs Assessment

Due 15/12/25, 15/11/26, 15/11/27, 15/11/28



Activity Commissioning

Please identify your intended procurement approach for commissioning services under this activity:

Not Yet Known: No

Continuing Service Provider / Contract Extension: Yes

Direct Engagement: No

Open Tender: No

Expression Of Interest (EOI): Yes

Other Approach (please provide details): No



Activity Planned Expenditure

Funding Stream	FY 23 24	FY 24 25	FY 25 26	FY 26 27	FY 27 28	Total
Greater Choice for At Home Palliative Care	\$468,501.03	\$826,403.31	\$339,758.77	\$320,967.00	\$325,451.00	\$2,281,081.11
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