

Palliative Care Connect *Evaluation in brief*

Palliative Care Connect (PCC) is a Commonwealth-funded pilot operating in South Australia since October 2023 and extended through to June 2026. It was established to address long-standing gaps in how people with life-limiting illness, their families, carers, and the professionals supporting them navigate palliative and end-of-life care across a fragmented, health, aged care and community systems.

The evaluation found that PCC has delivered consistently high-quality support at some of the most difficult moments in people's lives and it is beginning to influence how the broader system functions. Early system-level contributions indicate potential for broader impact if the model continues.

The pilot brings together two palliative care navigation services (the PCC Statewide Navigation Service, and the PCC Aboriginal Navigation Service), a Bereavement Navigation Service, a central information Website, the Healthy End of Life Planning (HELP) app, short-term bereavement counselling, and palliative care volunteering coordination.

The evaluation makes clear that the functions PCC performs are real, valued and currently unmet elsewhere in the system.

Palliative Care Connect

Snapshot summary of PCC in numbers

Combined:

1,363 episodes of care
2,023 people supported



PCC Website:

47,985 total users
average of 1,919 per month

97,369 total views
average 3,895 per month

HELP app:

113 active Networks
average of 7.2 new networks
per month

Palliative Care Connect Statewide Navigation Service:

931 episodes of care
average of 32 per month

Regional Navigation Service:

119 episodes of care
average of 7.9 per month

Palliative Care Volunteering SA service:

600 enquiries received

Bereavement groups and individual bereavement counselling:

156 people supported

Bereavement Navigation Service:

263 episodes of care
average of 11.4 per month

Aboriginal Navigation Service:

50 episodes of care
average of 2.2 per month

486 from individuals

114 from organisations

Bereavement counselling:

63 people supported

Bereavement groups:

93 people supported

Key findings

- ✓ PCC fills a gap not addressed elsewhere in the system, providing navigation and psychosocial support that individuals, families and clinicians are otherwise left to manage during diagnosis, deterioration, and bereavement.
- ✓ Impact is strongest at the individual and family level, with consistent improvements in understanding, confidence, emotional containment, and ability to access appropriate services.
- ✓ PCC Navigation works because it is relational, trusted and time-limited, rather than transactional or ongoing case management. Trust is the primary mechanism that enables disclosure, engagement, and informed decision making.
- ✓ The model has achieved high reach and sustained use, with steady growth over the pilot period driven by referrals and establishing relationships.
- ✓ User experience and satisfaction are consistently high with people describing PCC support as clear, knowledgeable, compassionate and available when it is most needed.
- ✓ The PCC Aboriginal Navigation Service is effective by operating with cultural safety, sustained presence and relationship -first practice.
- ✓ Early system level contributions are emerging, including improved care coordination, clearer referral pathways, and reduced pressure on general practice, aged care and acute services.

Why navigation matters

- ➔ Without trusted navigation, system complexity becomes a barrier to care
- ➔ Earlier understanding and engagement improves decision making and coordination, reducing crisis driven care and inappropriate service use.
- ➔ Relational navigation addresses gaps created by workforce and capacity constraints, supporting clinicians and services rather than duplicating their roles.
- ➔ Culturally safe end of life support requires time, trust and continuity.

Implications

If continued PCC is well positioned to consolidate and extend its impact, strengthen system-level coordination, and embed navigation as a core support alongside clinical care across health, aged care and community sectors.

If ceased individuals, families and clinicians lose a trusted point of orientation and support. The referral pathways built over the last 3 years will dissipate and the burden of coordination will revert to carers, palliative patients or stretched frontline workers.

Recommendation

- ➔ It is recommended that PCC be continued beyond the pilot period, with a focus on consolidating and scaling its navigation function as a core system support alongside clinical palliative care. The evaluation demonstrates that PCC fills a gap not met elsewhere in the health, aged care, and community system, delivering clear and consistent benefits for individuals, families and frontline services.
- ➔ Continuation of PCC will preserve and build on the trust, referral pathways, and culturally safe practices established over three years, and enable PCC to strengthen its emerging system-level contributions. The infrastructure and navigation workforce developed will also be maintained.
- ➔ Ceasing the service would result in the loss of a proven and trusted function, at a time when demand for end of life support continues to grow and system capacity remains constrained.