

The Prince & Princess of Wales Hospice

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Clinical Strategy

2026 - 2031

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Introduction

The Prince & Princess of Wales Hospice has a long-standing commitment to delivering quality palliative care, symptom management, and end of life care for people in South Glasgow and East Renfrewshire. We also welcome referrals from people outwith our core area and will provide care wherever possible.

Palliative care is an approach to care and support for people living with a life shortening condition and those important to them. In line with the World Health Organisation (WHO) definition and reflected in the Scottish Palliative Care Guidelines and Scotland's Palliative Care Matters for All strategy. Internationally, the WHO defines palliative care "as an approach that improves the quality of life of patients, adults, children, and their families who are facing problems associated with life-threatening illness. It prevents and relieves suffering through the early identification, impeccable assessment and treatment of pain and other problems, whether physical, psychosocial, or spiritual". It focuses on improving quality of life through the prevention and relief of suffering, by early identification, careful assessment and treatment of pain and other distressing symptoms, alongside psychological, social and spiritual support. Palliative care can be provided alongside treatments aimed at managing the illness, from diagnosis onwards, and includes care around death and bereavement support.

A life shortening condition is any illness or health condition that means the person's health will deteriorate over time and, at some point in the future, the person will die with the illness or condition.

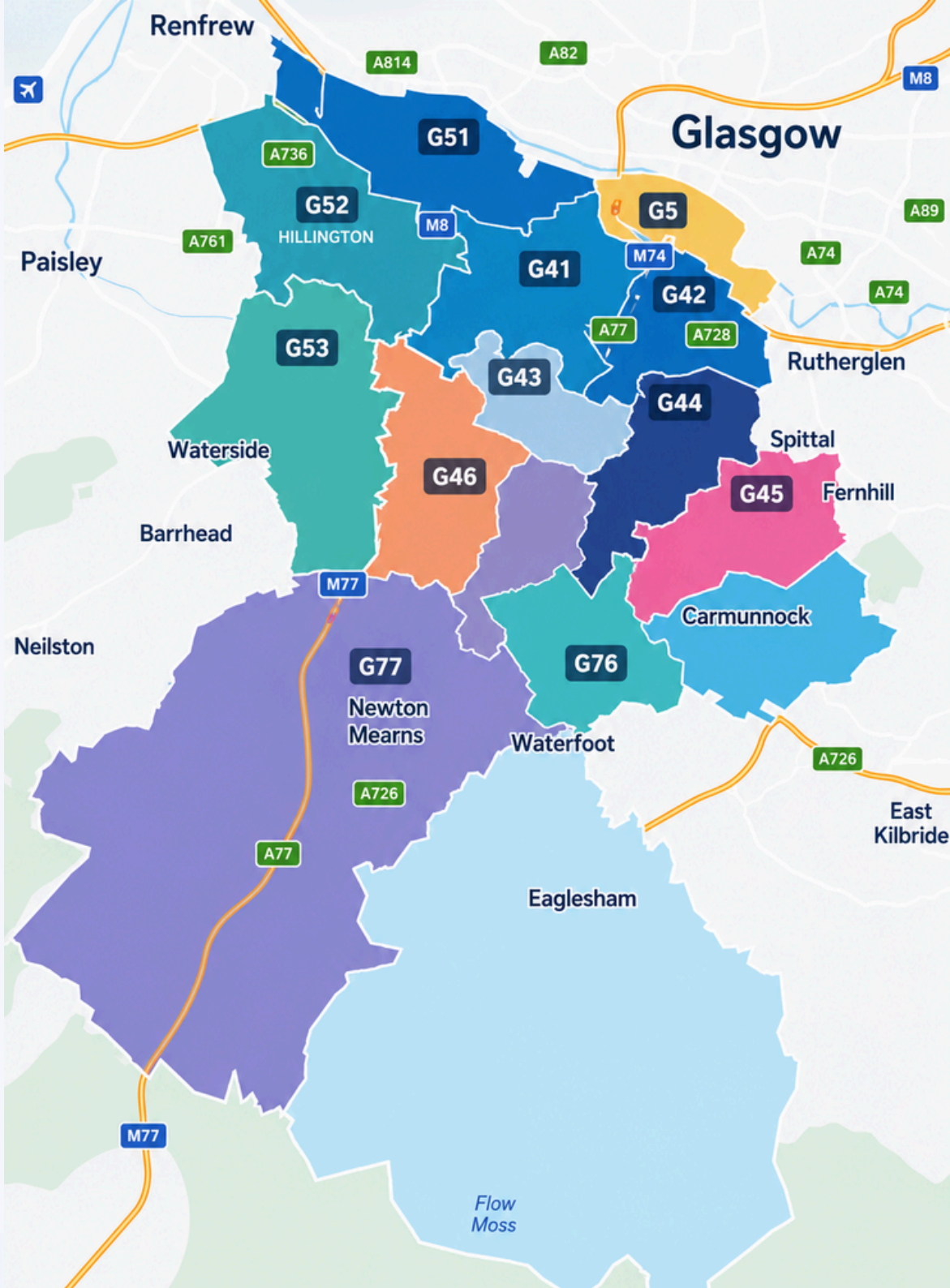
Our mission is to provide high quality clinical, emotional, social and spiritual care for people who have a progressive, life shortening illness and support those close to them. We deliver specialist palliative care through a multidisciplinary team, providing expert assessment and symptom management in the hospice and in the community, and working in partnership with NHS and health and social care colleagues to ensure coordinated care across settings.

We are extremely grateful to our supporters, partners and colleagues whose dedication strengthens the work of the hospice and look forward to your continued support in the coming years.

We look forward to continued connections with our health and social care colleagues to continue to provide high standards of care.

Here for you

The Prince & Princess of Wales Hospice provides specialist palliative and end of life care across the South Glasgow and East Renfrewhsire and surrounding communities, covering the postcode districts G5, G41, G42, G43, G44, G45, G46, G51, G52, G53, G76 and G77.



Our strategic achievements 2023 - 2025

The 2023 – 2025 Clinical Strategy identified five key priority areas:

Priority 1

Supporting patients, families, and carers

- We expanded our Community Service by increasing our outpatient clinics.
- We introduced a Befriending Service to support people experiencing isolation.
- We increased the number of Counselling Sessions for those requiring support pre and post bereavement.
- We introduced a Music Therapist to our Family Support Team.

Priority 2

Tackling inequalities

- We developed a Single Point of Access process to support equitable access.
- We established our Young Adult Service as a core hospice service.
- We expanded our networks through community engagement projects, extending our reach to areas of the population who have not previously engaged with hospice services.

Priority 3

Empowering Communities

- We introduced a new Community Development and Engagement Strategy to develop and create a more informed community.
- We delivered End of Life Care Skills for Everyone (EASE) courses to our community.
- We held grief cafés across our communities.
- We introduced a community choir led by our Music Therapist.
- We introduced Art for Wellbeing classes that are open to our communities.

Priority 4

Supporting the resilience of those who provide care

- We achieved the Scottish Bereavement Charter Mark in recognition of our support to staff who are bereaved.
- We participated in a variety of research projects, expanding our team's ability to participate and contribute to research evidence in palliative care.
- We expanded our student placements to extend the reach of Specialist Palliative Care knowledge.

Priority 5

Embedding and accelerating digital change

- We introduced a new Electronic Patient Record (EPR) system designed to streamline the documentation between NHS Greater Glasgow and Clyde (NHS GGC). This enables a seamless patient journey for patient documentation from acute services, with joint access to patient notes. Acute services have immediate access to our notes enhancing continuity of care across settings.
- We commenced developing activity dashboards to provide rapid and accurate access to clinical data for governance, risk and planning.

Our Impact 2023 - 2025

Young Adult Service



250 Clinical attendances

1,110 Medical attendances

Supporting the wellbeing of young adults aged 16+ and their families.

In-Patient Unit



639 Inpatient admissions

Provides care tailored to individual needs and wishes, supporting with symptom management, treatment and comfort.

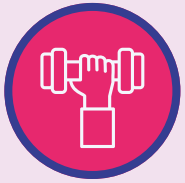
Community Nursing



4,194 Community visits

Provides specialist palliative care at home, helping manage symptoms and offering emotional, social and spiritual support.

Rehabilitation Team



1,220 Assessments and follow-up appointments

Helping people improve independence, mobility and symptom management.

Befriending Service



146 Home visits

Supporting volunteer befrienders to reduce loneliness and social isolation.

Family Support



752 Referrals

Emotional, practical, spiritual and bereavement support for patients, families and carers.

Living Well Hub



2,030 Patient attendances

Supporting wellbeing through therapies, activities and social opportunities.

Creative Arts



2,500 Artist interactions

Helping patients and families express themselves, build confidence and improve wellbeing through creative activities.

Outpatient Clinic Attendance



959 Clinic attendances

192 Medical attendances

Providing specialist outpatient assessment, symptom management and ongoing review, helping patients access expert palliative care while remaining at home.

Our Values

We worked closely with our patients, families, staff and volunteers to understand what matters most to all of us and to define the values that continue to underpin every aspect of care at the hospice.

We believe in:

- Care and compassion for our patients and their families
- Feeling valued as part of the hospice community
- Fairness and integrity
- Dignity and respect
- Striving for excellence

We hold high expectations of our staff and volunteers, investing in their development by providing support, education and guidance to enable delivery of high standards of person-centred care for patients and their families.







How we involved people

To shape the development of this strategy, we held a series of engagement workshops in summer 2025, with staff, volunteers, families, carers, partner organisations, and external stakeholders. In total, 72 participants contributed to the development process. Feedback was highly positive, reflecting appreciation for the opportunity to inform the future direction of our clinical services.

Through collaborative dialogue, we identified the priorities that matter most to our communities. These align closely with the Scottish Government's Palliative Care Matters for All strategy and with ongoing work within NHS Greater Glasgow and Clyde Health and Social Care Partnership. Together, these insights provide a strong and coherent foundation on which to build the key clinical aims and objectives for 2026 - 2031.



Executive Summary

The Prince & Princess of Wales Hospice enters the 2026 - 2031 Clinical Strategy during a time of significant change across Scotland's health and social care landscape. Demand for palliative care is increasing as more people live longer with multiple complex conditions, and as more children and young adults live with lifelong healthcare needs.

This strategy aligns with the ambitions set out in Palliative Care Matters for All, particularly those relating to early identification, equitable access, community capacity building and person-centred care.

We have a strong foundation on which to respond. During the previous strategy period, progress was made in expanding community services, supporting patients and families, tackling inequalities, strengthening staff wellbeing, enhancing education, and embracing digital innovation. The development of a new electronic patient record system and digital dashboards further demonstrates our ability to adapt, collaborate, and lead change across settings.

This 2026 - 2031 Clinical Strategy sets out a clear and ambitious direction to ensure that everyone who could benefit from hospice care can access high standards of quality person centred care when they need it.

There are five clinical aims that will guide our clinical services over the next five years:

Clinical Aim 1: Early identification and equitable access.

People with complex palliative care needs are identified early and referred to our services in a timely way, ensuring everyone has equitable access to the right support and care, when they need it.

Clinical Aim 2: People will receive care that is person-centred.

People are recognised as having preferences and wishes that matter to them. Staff will deliver person-centred care by recognising and responding to each person's preferences, wishes and goals as much as is possible.

Clinical Aim 3: Staff will receive training that will support their learning needs and promote their wellbeing.
Staff are skilled and equipped to guide all aspects of assessment, planning and delivery of high standards of quality care.

Clinical Aim 4: Promote a public health approach to death, dying and bereavement.
People are supported to cope with dying, death and bereavement.

Clinical Aim 5: Develop a digitally enabled 24/7 palliative care model
Digital tools will support people receiving care, staff delivering care and data driven quality improvement.

Together, these aims position us to meet growing need, reduce inequalities, and deliver compassionate, personalised and coordinated care for patients and their families. Success will be demonstrated through strengthened partnerships, improved access for under-represented groups, enhanced digital capability, better staff wellbeing, robust outcome measurement, and greater community involvement in conversations about living and dying well.

As we move into the next five years, our commitment remains clear: to provide the highest quality care for people affected by life shortening conditions, and to work with partners to build a future where every individual receives the care they deserve, when they need it most, and where they want it to be, for both assessment and end of life care.







Clinical Aim 1	**Early identification and equitable access.** People with complex palliative care needs are identified early and referred to our services in a timely way, ensuring everyone has equitable access to the right support and care, when they need it.
What we will do	We will connect with GP Practices and Hospital Palliative Care Teams in our area. Across all services, we will support people and make community connections.
How will we achieve this?	• Review and implement a centralised referral system for specialist inpatient beds, using a system that will display real time data on specialist adult palliative care availability. • Enhance connections with GP Practices and Hospital Palliative Care Teams within our catchment areas to build good connections. • Disseminate daily information to GP Practices and Hospital Palliative Care teams within our catchment area on specialist adult palliative care availability. • Agree and promote referral criteria and referral pathways with referrers. • Promote consistent use of recognised tools to support earlier identification of palliative care need. • Strengthen single point of access/triage and provide feedback to referrers. • Use population health data and service insight to identify communities and groups who are under-represented in hospice care and outreach to these under-represented communities and referrers with low referral rates. • Strengthen collaborative working with NHS GGC services, primary care, community nursing, social care and the third sector to ensure coordinated care across hospice, home, hospital and care home settings. • Support people from the age of 16, to enable earlier engagement with hospice support. • Establish centralised advice lines for people with life shortening illnesses who are known to us and professionals who need specialist palliative care advice out of hours and weekends. • People with life shortening illnesses and carers have access to training to help manage their condition, access support and information and receive guidance. • Review information we ask people to provide to ensure we obtain their views around referral to our services.

Clinical Aim 1	We will know this is successful when:
People and those important to them receive timely, equitable and coordinated hospice care, feel informed and involved in decisions, and can access the right care in the right place at the right time. Earlier identification, effective referral pathways and improved access for underrepresented communities make this possible. Feedback and outcome measures demonstrate continuous improvement and the hospice's contribution to the NHS GGC Palliative and End of Life Care Framework.	



Clinical Aim 2	**People will receive care that is person-centred.** People are recognised as having preferences and wishes that matter to them. Staff will deliver person-centred care by recognising and responding to each person's preferences, wishes and goals as much as is possible.
What we will do	Across all services, we will support people and include those important to them with future care planning, and we will deliver care that is person-centred.
How will we achieve this?	• Alongside the person, we will obtain who and what matters to them most in their daily life. • Obtain a clinical assessment, understand social circumstances including any safeguarding risks, support networks, meaningful engagement/activities, preferences and wishes. As we get to know the person, we will ensure the person is supported to achieve their wishes and preferences and what matters to them, including preferred place of care and death. • Establish if there is a future care plan, check the details recorded are still relevant and update the future care plan as indicated. If the person does not have a future care plan, we will implement this with them and include those important to them. • Ensure staff demonstrate person-centred care through their record keeping demonstrating the person's preferences and wishes. • When reviewing our services, we will include patients and those close to them. Including NHS GGC and community partners as indicated. • Review information we ask people to provide to ensure we obtain their views around person-centred care. • Continue to develop measures to evidence the high standards of person-centred care we provide.

Clinical Aim 2	**We will know this is successful when:**
People consistently receive compassionate, equitable care shaped by what matters most to them and feel listened to, respected and involved in decisions about their care. Their wishes, goals and preferences are discussed, recorded and shared to support coordinated, holistic care and effective symptom management. Feedback and experience inform ongoing improvements in care quality.	



Clinical Aim 3	**Staff will receive training that will support their learning needs and promote their wellbeing.** Staff are skilled and equipped to guide all aspects of assessment, planning and delivery of high standards of quality care.
What we will do	We will nurture a compassionate, learning-focused workplace where staff feel valued, supported and confident to deliver consistently high standards of quality care through education, supervision and wellbeing support.
How will we achieve this?	• Review and establish clinical supervision and wellbeing support. • Provide high-quality learning and development that strengthens skills, confidence and career progression for all staff. • Build a resilient, multidisciplinary workforce, including advanced practice roles. • Use dynamic workforce planning to maintain the right mix of skills and experience and respond flexibly to service demand. • Invest in staff wellbeing through compassionate leadership, psychological safety, and timely access to support after challenging events or activities. • Strengthen cultural competence and inclusive communication to support equitable care and engagement with diverse communities. • Deliver a structured programme of education sessions, including cultural awareness, communication skills and bereavement support. • Supporting our workforce is essential for delivering high quality, compassionate care. • Research group will continue to improve quality, safety, effectiveness and understanding through systematic investigation and evidenced based practice. • Obtain feedback from staff to influence the training calendar.

Clinical Aim 3	**We will know this is successful when:**
People and families experience high-quality, compassionate palliative and end-of-life care delivered by skilled, confident and supported staff. Regular clinical supervision, clear development pathways, learning opportunities, wellbeing support, quality improvement and research strengthen workforce capability, confidence and resilience, supporting excellent care and positive experiences.	



Clinical Aim 4	**Promote a public health approach to death, dying and bereavement.** People are supported to cope with dying, death and bereavement.
What we will do	We will strengthen community understanding, confidence, and engagement through education, partnerships, and open conversations. We will use data, feedback and evidence to improve quality, and share learning. The UK Commission on Bereavement estimates that for every one death five people experience bereavement. Each year in the region of 13,000 people die within the NHSGGC suggesting 65,000 each year will be affected by bereavement.
How will we achieve this?	• Promote a public health approach to conversations about death and dying helps normalise these experiences as part of life, reducing fear, stigma, and isolation. • Normalise conversations about death and dying, supporting communities to become more comfortable and confident to talk about death and dying. • Foster a culture of openness, dignity, and shared responsibility, ultimately improving end of life care and wellbeing for all. • Support patients, families and carers to identify what matters most to live well with a life shortening condition. • Engage people of all ages, and those important to them, in future care planning and shared decision-making as health and care needs change. • Work in partnership with community hubs (for example libraries, schools, and community groups) to reach people we may not normally make contact with. • Deliver grief cafés and EASE courses, and co-create bereavement resources with communities. • Facilitate drop-in sessions at Health Centres, Libraries, Community spaces so that the public can get a better idea of hospice care and services provided. Use this opportunity to explain about legalities such as Power Of Attorney that could help them.

Clinical Aim 4	**We will know this is successful when:**
People, families and communities feel informed, empowered and connected, enabling them to make choices, support one another and engage openly in conversations about death, dying and bereavement. Community development, accessible engagement opportunities and strong partnerships increase participation, build confidence and strengthen people's ability to cope following loss.	



Clinical Aim 5	**Develop a digitally enabled 24/7 palliative care model.** Digital tools will support people receiving care, staff delivering care and data driven quality improvement.
What we will do	By moving to 24/7 access to specialist palliative support, we will give patients, their families and carers, and other healthcare professionals the support, and guidance they need to confidently support people who are ill or dying. The timely provision of information, symptom management, and emotional support will encourage efficiency and innovation, but more importantly, improve equitable access to palliative care to those people and communities currently underserved by the hospice. In this digital era, we must, however, ensure that we take everyone along with us.
How will we achieve this?	• In partnership, explore how digital technology can enhance access to hospice services. • Ensure digital inclusion by providing accessible information and support for those not online. • Further develop a digital dashboard to monitor Key Performance Indicators (KPIs), providing timely data and supporting evidence-based continuous improvement. • Strengthen collaborative working with independent hospices, GPs, District Nurses and other healthcare professionals. • Develop the hospice single point of access to support consistent referral management and information sharing. • Provide patients, families and carers with accessible, timely information and support for living with a life-shortening condition. • Explore opportunities to share our knowledge, skills and experience with health and social care and third sector colleagues. • Support health and social care staff delivering palliative care, end of life care and bereavement support by providing the education and training they need. • Deliver specialist palliative and end of life care education for healthcare professionals, including placement opportunities to increase understanding of hospice care across different settings.

Clinical Aim 5	**We will know this is successful when:**
People and families experience seamless, high-quality and equitable palliative care whenever and wherever they need it. Strong partnerships, shared learning, effective digital systems and population-informed service development improve coordination, address inequalities and strengthen care across the system. People and families actively shape services, and their experiences influence continuous improvement and future developments.	



Monitoring and Evaluation

This Clinical Strategy will be monitored and evaluated through the development of supporting systems and planning in collaboration with clinical leads. A comprehensive action plan will be developed and reviewed by our Clinical Governance Committee on a quarterly basis. An Annual Report will be shared with a Board of Directors for visibility and involvement.



Conclusion

To demonstrate our achievements, an action plan will track progress against the five clinical aims set out in this strategy. A public summary report will be shared, reflecting our commitment to transparency.

Over the past strategy period, we have made significant progress in transforming palliative and end of life care across Glasgow. We have expanded the support we offer, strengthened our presence in local communities, and embraced digital innovation to help us deliver care more effectively. Throughout these developments, our commitment to compassionate, person-centred care has remained at the heart of everything we do. From introducing new therapeutic services and community outreach programmes to creating a single point of access and improved digital dashboards, these achievements reflect the dedication, creativity, and resilience of our staff, volunteers, and partners.

We have built strong foundations by working collaboratively, listening to those we support, and continually learning from experience. The aims of our previous strategy have been successfully delivered, resulting in meaningful improvements for patients, families, and carers. These achievements demonstrate what is possible when we work together with purpose, partnership, and compassion.

As we look ahead to 2026 - 2031, we recognise that health and social care in Scotland is changing, and we are ready to adapt, lead, and innovate. National priorities place greater emphasis on equity, inclusion, prevention, and person-centred care, creating opportunities for us to help shape the future of palliative care locally and nationally.

We will continue listening to our communities, supporting and developing our workforce, and ensuring everyone receives high quality, person-centred care wherever they are and whatever their circumstances. We are confident our services will continue to evolve, remain flexible and inclusive, and stay rooted in the values that define our hospice.

References

Scottish Government
Palliative Care Matters for All: A National Strategy

Scottish Government
Health and Social Care Standards: My Support, My Life

NHS Greater Glasgow & Clyde
Palliative and End of Life Care (PEOLC) Framework

Healthcare Improvement Scotland
Standards for Quality Improvement and Person-Centred Care

Scottish Partnership for Palliative Care (SPPC)
Public Health Palliative Care and EASE Resources

World Health Organization
WHO Definition of Palliative Care

Hospice UK
Future Vision for Hospices



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