

NHS Greater Glasgow and Clyde	Paper No. 26/140
Meeting:	NHSGGC Board Meeting
Meeting Date:	29 October 2026
Title:	Palliative Care and Care Around Dying Draft Strategy
Sponsoring Director/Manager:	Angela Wallace, Executive Nurse Director
Report Author:	Leanne Connell, Chief Nurse Interface Division Gail Young, Planning Officer

1. Purpose

The purpose of the attached paper is to:

To seek endorsement and approval of the NHS Greater Glasgow and Clyde Palliative Care and Care Around Dying Strategy 2026-2030 and support implementation of the associated delivery programme across NHS Greater Glasgow and Clyde (NHSGGC), Health and Social Care Partnerships (HSCPs), hospices and third-sector partners.

2. Executive Summary

The paper can be summarised as follows:

The NHSGGC Palliative Care and Care Around Dying Strategy 2026-2030 sets out a whole-system vision to ensure that people of all ages with life-shortening conditions, and those important to them, receive high quality, compassionate, person-centred care wherever and whenever it is needed. The strategy aligns with the Scottish Government's Palliative Care Matters for All strategy, NHSGGC corporate priorities, HSCP strategic plans and the Transforming Together programme.

Demand for palliative care is increasing significantly. Across Scotland, approximately 89% of deaths are associated with palliative care need, and this is expected to increase as the population ages and more people live longer with frailty, dementia and complex long-term conditions. Within Greater Glasgow and Clyde an estimated 11,628 people died with palliative care needs during 2024/25, while around 65,000 people are estimated to have experienced bereavement.

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Additionally, more children and young people with life-shortening conditions are surviving into adulthood and requiring longer periods of support.

The strategy recognises that palliative care is not solely care provided in the final days of life. It should be introduced earlier, be centred on what matters to the individual, and encompass physical, emotional, psychological, social, financial and spiritual needs. It also acknowledges significant inequalities in outcomes for people experiencing poverty, deprivation, homelessness, learning disabilities, severe mental illness, substance use disorders and other forms of exclusion.

The strategy has been co-produced with people with lived experience, carers, clinicians, partner organisations, hospices and community representatives. Engagement highlighted the importance of early conversations, coordinated care, access to support, effective symptom management, compassionate communication, workforce capability and improved bereavement support.

Five strategic priorities have been identified:

- Early recognition and planning
- Coordinated, responsive care
- Clear information and support
- Bereavement support
- Skilled and supported workforce

Collectively these priorities support the strategic shift towards prevention, anticipatory care, community-based care and improved experiences for people, families and carers.

3. Recommendations

The NHS Board is asked to consider the following recommendations:

- To endorse and approve NHSGGC Palliative Care and Care Around Dying Draft Strategy for publication
- To note that an implementation and delivery plan will be developed

4. Response Required

This paper is presented for **Approval**.

5. Impact Assessment

The impact of this paper on NHSGGC's corporate aims, approach to equality and diversity and environmental impact are assessed as follows:

- Improve Outcomes for People Positive impact
- Health Quality Care & Experience Positive impact
- Digital First Approach Positive impact
- Sustainability and Value Positive impact
- Supported Workforce Positive impact

6. Engagement & Communications

The issues addressed in this paper were subject to the following engagement and communications activity:

The draft strategy has been developed after significant engagement. This has included:

- Public and service user engagement surveys
- Accelerated Design Event
- Design and Development Group with Strategic Lead representation
- Focus groups with public partners and people with lived experience

7. Governance Route

This paper has been previously considered by the following groups as part of its development:

The draft strategy has been or will be presented at the following the governance forums:

- Primary Care Programme Board 20th August
- Acute SMG 25th August
- HSCP Chief Officers 28th August
- **Corporate Management Team (for approval) 31st August**
- Corporate Staff Partnership Forum (for awareness) 7th September
- Acute Clinical Governance (for awareness) 7th September
- Primary Care (for awareness)
 - Clinical Advisory 2nd September
 - Clinical Governance 17th September
- Board Clinical Governance (for awareness) 19th October
- Area Partnership Forum Workforce 14th October
- **NHS Board (for approval) 29th October**

8. Date Prepared & Issued

Paper prepared on: 13 October 2026

Paper issued on: 21 October 2026

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1. Introduction

The NHS Greater Glasgow and Clyde (NHSGGC) Board is asked to consider and approve the accompanying NHSGGC Palliative Care and Care Around Dying Strategy (“the Strategy”). Planning for the implementation of the Strategy will commence shortly and further approval will be sought ahead of any implementation activities.

2. Background

The Strategy was co-developed with the Design and Development group including representatives from NHS, Health and Social Care Partnerships (HSCPs), independent providers and lived experience representatives. The initial direction for the strategy was shaped by outputs from an Accelerated Design Event held in March 2025.

Five strategic priorities are set out in the strategy. These are as follows:

1. People with palliative care needs will be recognised earlier and we will collectively plan care around you or your child and those who matter to you
2. Care will be well coordinated, easy to access and quick to respond, no matter where you are
3. People can get clear information and support in a way that works for them
4. Everyone can get the right support before and after a bereavement
5. Staff will have the skills and support they need to provide good care

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The Strategy has been approved and/or endorsed by various committees and executive groups ahead of reaching NHS Board, including:

- Primary Care Programme Board
- Acute SMG
- HSCP Chief Officers
- Corporate Management Team
- Corporate Staff Partnership Forum
- Acute Clinical Governance
- Primary Care Clinical Advisory
- Primary Care Clinical Governance Group
- Board Clinical Governance
- Area Partnership Forum Workforce

The Board is now asked to approve the Strategy for publication.

3. Assessment

Demand for palliative care is increasing significantly. Across Scotland, approximately 89% of deaths are associated with palliative care need, and this is expected to increase as the population ages and more people live longer with frailty, dementia and complex long-term conditions. Within Greater Glasgow and Clyde an estimated 11,628 people died with palliative care needs during 2024/25, while around 65,000 people are estimated to have experienced bereavement. Additionally, more children and young people with life-shortening conditions are surviving into adulthood and requiring longer periods of support.

The Strategy recognises that palliative care is not solely care provided in the final days of life. It should be introduced earlier, be centred on what matters to the individual, and encompass physical, emotional, psychological, social, financial and spiritual needs. It also acknowledges significant inequalities in outcomes for people experiencing poverty, deprivation, homelessness, learning disabilities, severe mental illness, substance use disorders and other forms of exclusion.

The Strategy has been co-produced with people with lived experience, carers, clinicians, partner organisations, hospices and community representatives. Engagement highlighted the importance of early conversations, coordinated care, access to support, effective symptom management, compassionate communication, workforce capability and improved bereavement support.

The Strategy aligns positively with each of the NHSGGC Corporate Aims.

4. Conclusions

The Board is asked to endorse and approve the Strategy after which an implementation plan can be developed, aligned with the Board Corporate Aims and the five key priorities of the Strategy.

5. Recommendations

The NHS Greater Glasgow and Clyde (NHSGGC) Board is asked to consider and approve the accompanying NHSGGC Palliative Care and Care Around Dying Strategy for subsequent publication.

6. Implementation

An implementation plan will be co-developed with all relevant stakeholders following the publication of the Strategy.

7. Evaluation

The implementation plan and any actions contained therein will have clear evaluation and measurement plans, aligned with national data work and local intelligence.



NHS Greater Glasgow & Clyde Equality Impact Assessment Tool

Equality Impact Assessment is a legal requirement as set out in the Equality Act 2010 (Specific Duties) (Scotland) regulations 2012 and may be used as evidence for cases referred for further investigation for compliance issues.

Evidence returned should also align to Specific Outcomes as stated in your local Equality Outcomes Report. Please note that prior to starting an EQIA all Lead Reviewers are required to attend a Lead Reviewer training session or arrange to meet with a member of the Equality and Human Rights Team to discuss the process.

Please contact ggc.equality.team@nhs.scot for further details or call 0141 201 4874.

Name of Policy/Service Review/Service Development/Service Redesign/New Service:

Palliative Care and Care Around Dying Strategy 2026–2030

Please tick the relevant box:

- Current Service ☐
- Service Development ☐
- Service Redesign ☐
- New Service ☐
- New Policy ☒
- Policy Review ☐

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Description of the service & rationale for selection for EQIA. (Please state if this is part of a service-wide consideration or is locally driven).

What does the service or policy do/aim to achieve? Please give as much information as you can, remembering that this document will be published in the public domain and should promote transparency.

The Palliative Care Strategy sets out how Greater Glasgow and Clyde will improve palliative care and care around dying for people of all ages, across all settings, at all times, ensuring care is based on what matters to individuals and those important to them.

The Strategy aligns with the Scottish Government's Palliative Care Matters for All (2025–2030) strategy and wider NHSGGC and Integration Joint Board priorities.

The strategy identifies five key priorities:

- Early identification and person-centred care planning
- Equitable, coordinated and responsive care
- Access to information, digital inclusion and community empowerment
- Compassionate bereavement support
- A supported, skilled and resilient workforce

The strategy aims to:

- Improve experiences and outcomes for people with life-shortening conditions
- Ensure equitable access to palliative care across NHSGGC
- Support families, carers and communities
- Improve coordination across services and settings

Expected outcomes include:

- Earlier identification of need
- Improved person-centred care planning
- Reduced inequalities in access and experience

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Why was this service or policy selected for EQIA? Where does it link to organisational priorities? (If no link, please provide evidence of proportionality, relevance, potential legal risk etc.). Consider any locally identified Specific Outcomes noted in your Equality Outcomes Report.

As a public sector body, we are bound by the Equality Act 2010 to have due regard to the equality considerations set out in section 149 when we are exercising our functions.

This Equality Impact Assessment will help us to consider the equality impact of this important policy in a consistent, transparent and accountable way. In doing so it will demonstrate that we have had due regard to the Public Sector Equality Duty. This Impact Assessment will continue to be updated as decisions on drafting and content for the policy are taken.

More specifically, palliative care intersects with our patients, families and carers at a point where care must be truly person-centred and inclusive of the needs of all protected characteristic groups. Omissions, oversights or failure to investigate risks of unintended consequences will leave lasting deficit for patients and their families during a critical period of care and erode trust in the services provided.

Who is the lead reviewer and when did they attend Lead Reviewer Training? (Please note the lead reviewer must be someone in a position to authorise any actions identified as a result of the EQIA)

Name: Gail Young (Planning Officer) / Leanne Connell (Chief Nurse Interface Division)
Date of Lead Reviewer Training: Internal training for team

Please list the staff involved in carrying out this EQIA (Where non-NHS staff are involved e.g. third sector reps or patients, please record their organisation or reason for inclusion)

Staff from NHSGGC, IJBs, the third sector, and independent providers have been involved among others as part of the Design and Development Group. Key contacts including co-chairs, SLWG leads, and others are listed below. A full list of Design and Development Group members is available in Appendix 1.

- Leanne Connell, Chief Nurse Interface Division, NHSGGC (**co-chair**)
- Alexis Chappell, Chief Officer, East Renfrewshire HSCP (**co-chair**)

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- Claire O'Neill, Lead Nurse, CHAS
- Kathleen Halpin, Chief Nurse, East Dunbartonshire HSCP
- Beatrix von Wissman, Consultant in Public Health, NHSGGC
- David Gray, Consultant in Palliative Medicine, NHSGGC / Renfrewshire HSCP
- Laura Kelly, Consultant in Palliative Medicine, NHSGGC / Prince and Princess of Wales Hospice
- Emma Dymond, Consultant in Palliative Medicine, NHSGGC
- Jude Marshall, Deputy Medical Director for Primary Care, NHSGGC
- Lucy Dorrian, Patient Experience Public Involvement Manager, NHSGGC
- Jonathan Downie, Consultant in Paediatric Palliative Medicine, NHSGGC
- Anne Marie Harris, Consultant in Paediatric Palliative Medicine, NHSGGC
- Karen Pirrie, Head of Planning and Improvement, NHSGGC
- Gail Young, Planning Officer, NHSGGC
- Paul Corrigan, Information Officer, NHSGGC
- Ann McLinton, Person Centred Health and Care Programme Manager, NHSGGC

1. What equalities information is routinely collected from people currently using the service or affected by the policy?

If this is a new service proposal what data do you have on proposed service user groups. Please note below any barriers to collecting this data in your submitted evidence and an explanation for any protected characteristic data omitted.

Example: A sexual health service collects service user data covering all 9 protected characteristics to enable them to monitor patterns of use.

Service Evidence Provided:

- HSCP District Nursing services undertake holistic assessments for all patients with palliative care needs admitted to their caseload.
 - Data includes gender, date of birth, ethnicity, religion, preferred language and interpreting requirements, postcode, frailty score, and number of long-term conditions
 - The service also captures key metrics around future care planning conversations, preferred place of death and if preferred place of death was achieved. These key metrics are reported at Board level and monitored locally by operational leads to enable themes and opportunities for improvement.
- Acute HPCTs collect referral information about patients receiving specialist palliative care in hospital
 - Holistic assessment of patients referred to (hospital) palliative care takes place when practical to gather any specific needs that may be relevant to treatment, eg. religion. This will be added to the patients notes. Age and postcode are collected for all referred to hospital palliative care teams.
 - Discharge letter - specific needs of patient may be included when a discharge letter is sent, again religion or other cultural considerations.
- Information is collected differently by independent providers, e.g. care homes and hospices. Aggregated data can be made available to the health board however equalities data is not collected in the same way from one to the next

Possible negative impact and additional mitigating action required:

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Consideration needs to be given to how we collect other equalities data from patients and service users. The lack of comprehensive data on protected characteristics such as race/ ethnicity, sexual orientation, and others will need to be a key focus of any engagement work associated with service change or improvement programmes that stem from this strategy.

2. Please provide details of how data captured has been/will be used to inform policy content or service design.

Your evidence should show which of the 3 parts of the General Duty have been considered. Please tick the relevant box:

- 1) Remove discrimination, harassment and victimisation ☐
- 2) Promote equality of opportunity ☐
- 3) Foster good relations between protected characteristics. ☐
- 4) Not applicable ☐

Example

A physical activity programme for people with long term conditions reviewed service user data and found very low uptake by BME (Black and Minority Ethnic) people. Engagement activity found promotional material for the interventions was not representative. As a result an adapted range of materials were introduced with ongoing monitoring of uptake. (Due regard promoting equality of opportunity)

Service Evidence Provided:

Data around most protected characteristics are not routinely collected by palliative care services. Age and sex of patients and service users are collected, as well as postcodes which give an indication of socio-economic status through SIMD quintiles.

Engagement surveys performed to support and inform this strategy collected standard equalities monitoring information. This information was collected on a voluntary basis and separate from survey responses to allow anonymity for respondents. A rough breakdown is provided in section 4.

Possible negative impact and additional mitigating action required:

The draft strategy emphasises equity of access for all. While research has been done into the intersection of various protected characteristics with the provision of and attitudes to palliative care, specific mitigating actions will be considered when planning any implementation or improvement programmes relating to the strategy.

3. How have you applied learning from research evidence about the experience of equality groups to the service or Policy?

Your evidence should show which of the 3 parts of the General Duty have been considered. Please tick the relevant box:-

- 1) Remove discrimination, harassment and victimisation ☐
- 2) Promote equality of opportunity ☐
- 3) Foster good relations between protected characteristics ☐
- 4) Not applicable ☐

Example

Looked after and accommodated care services reviewed a range of research evidence to help promote a more inclusive care environment. Research suggested that young LGBT+ people had a disproportionately difficult time through exposure to bullying and harassment. As a result staff were trained in LGBT+ issues and were more confident in asking related questions to young people.

(Due regard to removing discrimination, harassment and victimisation and fostering good relations).

Service Evidence Provided:

Evidence used to inform the development of the Palliative Care Strategy includes:

- Scottish Government Palliative Care Matters for All (2025–2030) (Link: [Palliative Care Matters for All: palliative care strategy 2025 to 2030 - gov.scot](#))
- Engagement with over 200 people with lived experience

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- Accelerated Design Event (2025) involving stakeholders and communities
- Marie Curie Evidence on health inequalities and end-of-life poverty (Link: [dying-in-poverty-briefing-2025.pdf](#))
- Engagement Survey responses – please see Section 4 for breakdown.

Possible negative impact and additional mitigating action required:

Nil

4. Can you give details of how you have engaged with equality groups with regard to the service review or policy development? What did this engagement tell you about user experience and how was this information used?

The Patient Experience and Public Involvement team (PEPI) support NHSGGC to listen and understand what matters to people and can offer support.

Your evidence should show which of the 3 parts of the General Duty have been considered. Please tick the relevant box:-

- 1) Remove discrimination, harassment and victimisation ☐
- 2) Promote equality of opportunity ☐
- 3) Foster good relations between protected characteristics ☐
- 4) Not applicable ☐

Example

A money advice service spoke to lone parents (predominantly women) to better understand barriers to accessing the service. Feedback included concerns about waiting times at the drop in service, made more difficult due to child care issues. As a result the service introduced a home visit and telephone service which significantly increased uptake. (Due regard to promoting equality of opportunity)

* The Child Poverty (Scotland) Act 2017 requires organisations to take actions to reduce poverty for children in households at risk of low incomes.

Service Evidence Provided:

As part of our lived experience, patient, carer and public engagement we collected equalities data using the standard equalities capture questions established with EHRT.

Our engagement approach was shared among our own network via the Involving People Network and via our partner organisations that were part of the Design and Development Group and included 3rd sector organisations and charities.

Key themes were gathered throughout the first two phases of engagement via surveys and community events, targeted in locations with low responses to the survey. We shared the engagement routes with carer groups and with local engagement networks. The survey gathered EQIA data as a standard approach to any engagement. Our responses to our EQIA data are voluntary but indicated further work with BME communities, young people under 25 and 3rd sector groups such as Glasgow Disability Alliance would be beneficial for further phases.

While not relating to the draft strategy itself, a programme is underway to design and build a purpose-built paediatric palliative care suite at the RHC site, aligning with the principles of the draft strategy. Engagement work took place with children and families around this through CHAS and the appointed architectural firm, which informed much of the design of the space.

Possible negative impact and Additional Mitigating Action Required:

Further work will be required in identifying and engaging with groups with seldom-heard voices and wider representation across the NHSGGC area population when moving into an implementation phase and proposing any potential improvement programmes.

5. Is your service physically accessible to everyone? If this is a policy that impacts on movement of service users through areas are there potential barriers that need to be addressed?

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Your evidence should show which of the 3 parts of the General Duty have been considered. Please tick the relevant box:-

- 1) Remove discrimination, harassment and victimisation ☐
- 2) Promote equality of opportunity ☒
- 3) Foster good relations between protected characteristics ☐
- 4) Not applicable ☐

Example

An access audit of an outpatient physiotherapy department found that users were required to negotiate 2 sets of heavy manual pull doors to access the service. A request was placed to have the doors retained by magnets that could deactivate in the event of a fire.

(Due regard to remove discrimination, harassment and victimisation).

Service Evidence Provided:

No specific plans have been made so far for changes to physical access to care. If new buildings are proposed to be developed or existing buildings require to be refurbished as part of specific service change relating to this strategy, we will ensure that access audits are undertaken and, where appropriate, engagement with specific groups relating to physical service provision.

Developing digital access to care as part of the strategy will increase options for people living with physical disabilities to connect with health and other professionals from their own homes, reducing the need to travel to places of care where appropriate.

Possible negative impact and additional mitigating action required:

No negative impacts identified at this stage. Many conditions or diagnoses which result in a requirement for palliative care can lead to disabilities, and as such ensuring access for all regardless of ability will be a key component in any improvement programmes resulting from this draft strategy.

6. How will the service change or policy development ensure it does not discriminate in the way it communicates with service users and staff?

Your evidence should show which of the 3 parts of the General Duty have been considered. Please tick the relevant box:-

- 1) Remove discrimination, harassment and victimisation ☐
- 2) Promote equality of opportunity ☐
- 3) Foster good relations between protected characteristics ☐
- 4) Not applicable ☐

The British Sign Language (Scotland) Act 2017 aims to raise awareness of British Sign Language and improve access to services for those using the language. Specific attention should be paid in your evidence to show how the service review or policy has taken note of this.

Example

Following a service review, an information video to explain new procedures was hosted on the organisation's YouTube site. This was accompanied by a BSL signer to explain service changes to deaf service users.

Written materials were offered in other languages and formats. (Due regard to remove discrimination, harassment and victimisation and promote equality of opportunity).

Service Evidence Provided:

- NHSGGC Clear to All Information Policy (Link: [Clear to All - NHSGGC](#))
- NHSGGC Interpreting Service (Link: [Interpreting Services - NHSGGC](#))

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All information leaflets and content for web pages including videos will comply with Clear to All requirements and content will be checked by seeking feedback from people with lived experience. Within palliative care services, interpreters will continue to be sought if required, including for people who require BSL support.

The strategy sets out a person focused approach which will allow people to access services in the ways that are most suitable for them, including their preferences around communication options.

Possible negative impact and additional mitigating action required :

No significant impact anticipated. Any impact on the accessibility of palliative care services is anticipated to be positive, particularly under the key priority of clear information and support for patients and service users.

7. Protected Characteristic

(a) Age

Could the service design or policy content have a disproportionate impact on people due to differences in age?

(Consider any age cut-offs that exist in the service design or policy content. You will need to objectively justify in the evidence section any segregation on the grounds of age promoted by the policy or included in the service design).

If this decision is likely to impact on children and young people (below the age of 18) you will need to evidence how you have considered the General Principles of the United Nations Convention on the Rights of the Child. Please include this in Section 10 of the form.

Your evidence should show which of the 3 parts of the General Duty have been considered. Please tick the relevant box:-

- 1) Remove discrimination, harassment and victimisation ☐
- 2) Promote equality of opportunity ☐

3) Foster good relations between protected characteristics. ☐

4) Not applicable ☐

Service Evidence Provided:

Acute adult HPCT referrals by age band (2024/25):

- Total referrals – **5,348**
- 65+ – 4,077 (**76.2%**)
- 51-64 – 996 (**18.6%**)
- 41-50 – 172 (**3.2%**)
- 25-40 – 88 (**1.6%**)
- 16-24 – 15 (**0.3%**)

Acute paediatric PSPCT accepted referrals by age band (2024/25)

- Total referrals – **72**
- 13+ – 13 (**18.1%**)
- 8-12 – 6 (**8.3%**)
- 3-7 – 9 (**12.5%**)
- 1-2 – 10 (**13.9%**)
- Under 1 – 34 (**47.2%**)

Older people

The numbers above show 65% of adult palliative care referrals accepted are for people aged 65 and over and NRS statistics report 80% of adult deaths in Scotland in 2024 were in ages 65 and over.

The strategy notes that there will be increasing numbers of people living into older years with increasing frailty who will require palliative care for longer periods and the challenge will be to ensure that palliative care continues to be offered to all who would benefit, regardless of age.

Children and young people

Palliative care referrals accepted for children and young people are greatest for babies under one year of age (47%), as in the numbers above. This corresponds to the epidemiology of child deaths in Scotland (2014) report which reported 60% of child deaths being in those under one year, with most of these occurring within the first four weeks of life, with services are already in place.

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The strategy also highlights the increasing young adult population requiring palliative care, with 18% of palliative care referrals accepted being for young people aged 13 and over, and plans will be needed for these young people transitioning into adult services.

Possible negative impact and additional mitigating action required:

Possible negative effect of assumptions around age mitigated as noted above.

(b) Disability

Could the service design or policy content have a disproportionate impact on people due to the protected characteristic of disability?

Your evidence should show which of the 3 parts of the General Duty have been considered. Please tick the relevant box:-

- 1) Remove discrimination, harassment and victimisation ☐
- 2) Promote equality of opportunity ☐
- 3) Foster good relations between protected characteristics. ☐
- 4) Not applicable ☐

Service Evidence Provided:

A person-centred approach is proposed which allows service providers to support people to engage with services, including support with how to access information and support digitally where this is helpful and may reduce the need for people to travel to places of health care.

Where people who are already living with physically limiting disabilities, disabilities that require adjustments for communication support or learning disabilities also require palliative care, their holistic assessment will consider adjustments required to deliver the full package of palliative care according to their current needs.

Possible negative impact and additional mitigating action required:

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The holistic palliative care approach will aim to mitigate any risks of palliative care needs being missed due to pre-existing disabilities. Many conditions or diagnoses which result in a requirement for palliative care can lead to disabilities, and as such ensuring access for all regardless of ability will be a key component in any improvement programmes resulting from this draft strategy.

(c) Gender Reassignment

Could the service change or policy have a disproportionate impact on people with the protected characteristic of Gender Reassignment?

Your evidence should show which of the 3 parts of the General Duty have been considered. Please tick the relevant box:-

- 1) Remove discrimination, harassment and victimisation ☐
- 2) Promote equality of opportunity ☐
- 3) Foster good relations between protected characteristics ☐
- 4) Not applicable ☐

Service Evidence Provided:

Possible negative impact and additional mitigating action required:

No significant impact anticipated. Any impact on people under the protected characteristic of gender reassignment is anticipated to be positive, through the provision of coordinated and respectful palliative care.

The impact of the Supreme Court ruling on biological sex and access to single sex spaces and subsequent EHRC guidance will be adhered to in line with any relevant NHSGGC policies when considering any service change or improvement programmes as a result of this draft strategy.

(d) Marriage and Civil Partnership

Could the service change or policy have a disproportionate impact on the people with the protected characteristics of Marriage and Civil Partnership?

Your evidence should show which of the 3 parts of the General Duty have been considered. Please tick the relevant box:-

- 1) Remove discrimination, harassment and victimisation ☐
- 2) Promote equality of opportunity ☐
- 3) Foster good relations between protected characteristics ☐
- 4) Not applicable ☐

Service Evidence Provided:

Limited relevance – no impact anticipated

Possible negative impact and additional mitigating action required:

Nil

(e) Pregnancy and Maternity

Could the service change or policy have a disproportionate impact on the people with the protected characteristics of Pregnancy and Maternity?

Your evidence should show which of the 3 parts of the General Duty have been considered. Please tick the relevant box:-

- 1) Remove discrimination, harassment and victimisation ☐
- 2) Promote equality of opportunity ☐
- 3) Foster good relations between protected characteristics ☐
- 4) Not applicable ☐

Service Evidence Provided:

Limited relevance – no impact anticipated

Possible negative impact and additional mitigating action required:

Nil

(f) Race

Could the service change or policy have a disproportionate impact on people with the protected characteristics of Race?

Your evidence should show which of the 3 parts of the General Duty have been considered. Please tick the relevant box:-

- 1) Remove discrimination, harassment and victimisation ☐
- 2) Promote equality of opportunity ☐
- 3) Foster good relations between protected characteristics ☐

4) Not applicable ☐

Service Evidence Provided:

- Ethnicity and Palliative Care: we need better data (Link: [Ethnicity and palliative care: we need better data – five key considerations | BMJ Supportive & Palliative Care](#))
- NHS Greater Glasgow and Clyde Anti-Racism Plan (Link: [NHSGGC Anti-Racism Plan April2025 - NHSGGC](#))

Black and Minority Ethnic people in the UK report consistently experiencing lower access to and poorer experiences of palliative and end-of-life care. Data to support this within the NHSGGC area are largely unavailable as race and ethnicity information are not routinely collected from patients or service users.

The priorities within the draft strategy, particularly around clear communication and person-centred care, align with those set out in the NHSGGC Anti-Racism Plan. Any impact on people under the protected characteristic of race is anticipated to be positive, through the provision of coordinated and respectful palliative care.

Possible negative impact and additional mitigating action required:

Nil

(g) Religion and Belief

Could the service change or policy have a disproportionate impact on the people with the protected characteristic of Religion and Belief?

Your evidence should show which of the 3 parts of the General Duty have been considered. Please tick the relevant box:-

- 1) Remove discrimination, harassment and victimisation ☐
- 2) Promote equality of opportunity ☒
- 3) Foster good relations between protected characteristics. ☐
- 4) Not applicable ☐

Service Evidence Provided:

- NHSGGC Spiritual Care Service (Link: [The Spiritual Care Service - NHSGGC](#))

Palliative care as holistic care centred on the person helps people manage a range of issues including their spiritual wellbeing during this time. Care around dying aims to provide holistic care in the last hours, days or few weeks of life, focusing on comfort and supports those close to the person into bereavement. This will include facilitating access to a person's own faith and belief support network or to the NHS GGC Spiritual Care Team if desired.

Possible negative impact and additional mitigating action required:

No negative impact anticipated. Ensuring compassionate, person-centred care to people of all faith groups is a key component of the draft strategy. Engagement with various groups will need to be a key consideration if proposing any service change or improvement programmes aligned with or as a result of this draft strategy.

(h) Sex

Could the service change or policy have a disproportionate impact on the people with the protected characteristic of Sex?

Your evidence should show which of the 3 parts of the General Duty have been considered. Please tick the relevant box:-

- 1) Remove discrimination, harassment and victimisation ☐
- 2) Promote equality of opportunity ☐
- 3) Foster good relations between protected characteristics ☐
- 4) Not applicable ☐

Service Evidence Provided:

- Experiences of palliative care (Link: [Preference for Palliative Care in Cancer Patients: Are Men and Women Alike? - PMC](#))
 - Study found that men's attitudes to and experiences of palliative care are less favourable than women

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Acute adult HPCT referrals by sex (2025):

- Male – **49.2%**
- Female – **50.8%**

Acute paediatric PSPCT accepted referrals by age band (2024/25)

- Total referrals – **72**
- Male – 29 (**40.3%**)
- Female – 38 (**52.8%**)
- Indeterminate – 5 (**6.9%**)

Possible negative impact and additional mitigating action required:

The draft strategy applies to all, regardless of gender. Priorities relating to equity and person-centred care aim to ensure no group is marginalised as a result of their care.

(i) Sexual Orientation

Could the service change or policy have a disproportionate impact on the people with the protected characteristic of Sexual Orientation?

Your evidence should show which of the 3 parts of the General Duty have been considered. Please tick the relevant box:-

- 1) Remove discrimination, harassment and victimisation ☐
- 2) Promote equality of opportunity ☐
- 3) Foster good relations between protected characteristics. ☐
- 4) Not applicable ☐

Service Evidence Provided:

- Marie Curie Palliative and end of life care for LGBTQ+ people (Link: [Palliative and end of life care for LGBTQ+ people | Marie Curie](#))
- Health needs assessment of lesbian, gay, bisexual, transgender and nonbinary people (Link: [Health needs assessment of LGBT .pdf](#))

Possible negative impact and additional mitigating action required:

No significant impact anticipated. Any impact on people under the protected characteristic of sexual orientation is anticipated to be positive, through the provision of coordinated and respectful palliative care.

(i) Socio – Economic Status & Social Class

Could the proposed service change or policy have a disproportionate impact on people because of their social class or experience of poverty and what mitigating action have you taken/planned?

In addition to the above, if this constitutes a 'strategic decision' you should evidence below due regard to meeting the requirements of the Fairer Scotland Duty (2018). Public bodies in Scotland must actively consider how they can reduce inequalities of outcome caused by socioeconomic disadvantage when making strategic decisions and complete a separate assessment. Additional information available from the [Fairer Scotland Duty: guidance for public bodies - gov.scot](#)

Service Evidence Provided:

- Marie Curie Dying in Poverty 2025 Report (Link: [dying-in-poverty-report-2025.pdf](#))
 - Over 100,000 people die in poverty every year in the UK, particularly fuel poverty – approximately 1 in 6
- Macmillan Improving the Cancer Journey (Link: [Improving the Cancer Journey Summary](#))

While palliative and end of life care are free at the point of delivery in Scotland there is suggestion of indirect costs to people receiving palliative care and their families. The strategy states that poverty impacts people in their last year of life, and that in 2024/25 20% of people who died at pension age and 22% to 34% of people who died at working age would have experienced end of life poverty. Scottish Government statistics report 18% of working age adults and 13% at pension age are in relative poverty. This issue may be greater for families with children receiving palliative care, as almost 50% of children in Scotland with a life shortening illness live in the two most deprived SIMD postcode areas, while the Scottish Government poverty statistics March 2026 reported that 21% of children in Scotland are in relative poverty.

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Digital health care has mixed impacts on people living in poverty, with cost savings if communications can take place from home however there may be lower levels of access to the technology and skills required. The holistic approach offered by palliative care services could help to ensure that people have the digital infrastructure and skills required to establish helpful digital communications.

In highlighting these issues, the strategy will focus attention, and it may be helpful to gather information on the support that is available to people and families living in poverty including this in communications at the start of the palliative care journey.

Possible negative impact and additional mitigating action required:

A key focus of the draft strategy is shifting the balance of care to the community. With adequate resources in place, people at end of life should feel empowered to stay at home or in the community without incurring significant costs, particularly when it comes to fuel and bills.

MacMillan Improving the Cancer Journey offers support in some HSCPs for accessing additional benefits and financial help for anyone with a cancer diagnosis.

Increasing cost of living will need to be a key consideration if proposing any service change or improvement programmes aligned with or as a result of this draft strategy.

(k) Other marginalised groups

How have you considered the specific impact on other groups including homeless people, prisoners and ex-offenders, ex-service personnel, people with addictions, people involved in prostitution, asylum seekers & refugees and travellers?

Service Evidence Provided:

Prison Population

The palliative care strategy applies to prison populations through its commitment to equitable, person-centred care across all settings, requiring targeted actions to address structural barriers in custody and disproportionate health need. The most significant equalities risk is loss of continuity at liberation, which must be mitigated

through structured pre-release planning, coordinated referrals, and sustained engagement with community and specialist palliative care services.

- Outcomes for homeless populations (Link: [Holistic health and social care outreach for people experiencing homelessness with recent non-fatal overdose in Glasgow, Scotland: the Pharmacist and third sector Homeless charity worker Outreach Engagement Non-medical Independent prescriber Rx \(PHOENIX\) pilot randomised controlled trial – NHS Scotland](#))
- Cancer rates among homeless population in Glasgow (Link: [jepicomh00180-0058.pdf](#))

Homeless Population

Homeless populations frequently experience poorer health outcomes than housed people. Glasgow has a relatively high homeless population compared to other cities in the UK, with many unhoused people experiencing multiple complications such as substance use, mental health issues, and complex trauma. This often leads to a reluctance to seek healthcare, or an inability to do so. Palliative and end of life care outcomes are impacted by this.

Cancer rates are often higher than average in homeless populations, particularly those of the oral cavity, lungs, and other respiratory tissues. This population is particularly marginalised within healthcare as a whole, and not just palliative care.

Gypsy/Travelling Community

There remain significant barriers to accessing health and social care among gypsy/traveller communities in Scotland and across the UK. National programmes are underway to address this, including Community Health Worker and Carer Support Services through the Minority Ethnic Carers of People Project (MECOPP). These have fostered greater trust in health and social care services, and monitoring shows greater health outcomes for communities served.

- MECOPP services (Link: [Our Services — MECOPP](#))
- Scottish Government Health and Social Care for Gypsy/Traveller Communities (Link: [L Health and social care - Gypsy/Travellers - gov.scot](#))

Possible negative impact and additional mitigating action required:

- Structured pre-release planning for patients in prison with palliative care needs must be prioritised in any implementation plans of this draft strategy
- The implementation of the strategy must align with broader NHSGGC and IJB plans and strategies around health and social care for homeless populations to improve outcomes for these individuals
- Any implementation or improvement programmes aligned to or as a result of this draft strategy should look at gaps in engagement, particularly in those groups listed above.

8. Does the service change or policy development include an element of cost savings? How have you managed this in a way that will not disproportionately impact on protected characteristic groups?

Your evidence should show which of the 3 parts of the General Duty have been considered. Please tick the relevant box:-

- 1) Remove discrimination, harassment and victimisation ☐
- 2) Promote equality of opportunity ☐
- 3) Foster good relations between protected characteristics ☐
- 4) Not applicable ☐

Service Evidence Provided:

Possible negative impact and additional mitigating action required:

9. What investment in learning has been made to prevent discrimination, promote equality of opportunity and foster good relations between protected characteristic groups?

As a minimum include below recorded completion rates of statutory and mandatory learning programmes (or local equivalent) covering equality, diversity and human rights.

Service Evidence Provided:

The national [Palliative Care Education Framework 2025](#) published by Public Services Delivery Scotland outlines the need for equality, diversity, and inclusion in palliative care training.

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Overall GGC compliance for completion of equalities & human rights module was 88% at end of July 2026.

Possible negative impact and additional mitigating action required:

10. In addition to understanding and responding to legal responsibilities set out in Equality Act (2010), services must pay due regard to ensure a person's human rights are protected in all aspects of health and social care provision. This may be more obvious in some areas than others. For instance, mental health inpatient care or older people's residential care may be considered higher risk in terms of potential human rights breach due to potential removal of liberty, seclusion or application of restraint. However risk may also involve fundamental gaps like not providing access to communication support, not involving patients/service users in decisions relating to their care, making decisions that infringe the rights of carers to participate in society or not respecting someone's right to dignity or privacy.

The Human Rights Act sets out rights in a series of articles – right to life, right to freedom from torture and inhumane and degrading treatment, freedom from slavery and forced labour, right to liberty and security, right to a fair trial, no punishment without law, right to respect for private and family life, right to freedom of thought, belief and religion, right to freedom of expression, right to freedom of assembly and association, right to marry, right to protection from discrimination.

Please explain below if any risks in relation to the service design or policy were identified which could impact on the human rights of patients, service users or staff.

Any specific service change as a result of or aligned with this draft strategy will require an EQIA of its own. The draft strategy is high-level and does not propose specific changes or improvement initiatives and as such does not pose any risks as described.

Please explain below any human rights based approaches undertaken to better understand rights and responsibilities resulting from the service or policy development and what measures have been taken as a result e.g. applying the PANEL Principles to maximise Participation, Accountability, Non-discrimination and Equality, Empowerment and Legality or FAIR* (see below).

Engagement took place in three phases

Phase 1 was the discovery phase and gathered lived experience to inform the Accelerated Design Event and the priorities for the draft strategy.

Phase 2 included the Accelerated Design Event itself and the coproduction of the strategy itself alongside lived experience volunteers input.

Phase 3 tested the priorities with the public and refined the definition and what mattered to the public for success measures.

*FAIR is an acronym for the following -

- **Facts:** What is the experience of the individuals involved and what are the important facts to understand?
- **Analyse rights:** Develop an analysis of the human rights at stake
- **Identify responsibilities:** Identify what needs to be done and who is responsible for doing it
- **Review actions:** Make recommendations for action and later recall and evaluate what has happened as a result.

[11.](#) The United Nations Convention on the Rights of the Child (Incorporation) (Scotland) Act 2024 came into force on the 16th July 2024. All public bodies may choose to evidence consideration of the possible impact of decisions on the rights of children (up to the age of 18). Evidence should be included below in relation to the General Principles of the Act. Go to the [full list of articles](#) to be considered for further information.

No Discrimination: Where the decision may have an impact, explain how the EQIA has considered discrimination on the grounds of protected characteristics for children. You may have considered children in each of the EQIA sections and returned relevant evidence.

We coproduced engagement with families who are and have been users of palliative care services both at RHC and at CHAS through different stages in our engagement.

This feedback was core to developing the 5 priorities and also when we cross checked the priorities with our stakeholders.

Best Interests of the child: Where the decision may have an impact, explain how the EQIA has evaluated possible negative, positive or neutral impacts on children. You may find that options considered need to be reframed against the best possible outcome for children.

The five priorities in the draft strategy cover palliative care for adults, children, and young people. Paediatric palliative care services have been key partners in the co-design and development of the strategy, ensuring that the best interests of children and young people are built into the strategy throughout.

Life, survival and development: Where the decision may have an impact, explain how the EQIA has considered a child's right to health and more holistic development opportunities.

No significant impact anticipated. This will need to be considered when proposing any improvement programmes or service change aligned to this draft strategy.

Respect of children's views: Where the decision may have an impact, explain how the views of children have been sought and responded to. You need to consider what steps were taken in Q4 in relation to this.

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Paediatric engagement focussed on engagement with bereaved families on a 1-to-1 basis. This highlighted the importance of continuity of care and considerations of the UNCRC.

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Having completed the EQIA template, please tick the relevant box that you, the Lead Reviewer, perceive best reflects the [findings of the assessment](#). This can be cross-checked via the Quality Assurance process:

Option 1: No major change (where no impact or potential for improvement is found, no action is required) ☐

Option 2: Adjust (where a potential or actual negative impact or potential for a more positive impact is found, make changes to mitigate risks or make improvements) X ☒

Option 3: Continue (where a potential or actual negative impact or potential for a more positive impact is found but a decision not to make a change can be objectively justified, continue without making changes) ☐

Option 4: Full mitigation of identified risk not made, decision to continue without objective justification (Lead Reviewer to provide explanatory note here) ☐

Option 5: Stop and remove (where a serious risk of negative impact is found, the plans, policies etc. being assessed should be halted until these issues can be addressed) ☐

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If you believe your service is doing something that 'stands out' as an [example of good practice](#) - for instance you are routinely collecting patient data on sexual orientation, faith etc. - please use the space below to describe the activity and the benefits this has brought to the service. This information will help others consider opportunities for developments in their own services.

Actions.

From the additional mitigating action requirements sections completed above, please summarise the actions this service will be taking forward or tick the box next to 'No Actions Identified'

Further work will be required in identifying and engaging with groups with seldom-heard voices and wider representation across the NHSGGC area population when moving into an implementation phase and proposing any potential improvement programmes.

Lead: PEPI Team Due 1/4/27

Assess impact of strategy move towards community based care on costs of living for individuals

Lead: Gail Young to take to Implementation group 1/4/27

No actions identified ☐

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Ongoing 6 Monthly Review: please write your 6 monthly EQIA review date:

Lead Reviewer:

Name Claire O'Neill

Job Title Lead Nurse – Palliative Care

Signature Claire O'Neill

Date 24/8/26

Quality Assurance Sign off:

Name Dr Noreen Shields

Job Title Planning Manager

Signature Noreen Shields

Date 3/9/26

Where unmitigated risk has been identified in this assessment, responsibility for appropriate follow-up actions sits with the Lead Reviewer and the associated delivery partner.

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NHS Greater Glasgow & Clyde Equality Impact Assessment Tool
Meeting the Needs of Diverse Communities
[6 monthly review sheet](#)

Name of Policy/Current Service/Service Development/Service Redesign:

Please detail activity undertaken with regard to actions highlighted in the original EQIA for this Service/Policy

Action:

Status:

Completed

Date

Initials

Action:

Status:

Completed

Date

Initials

Action:

Status:

Completed

Date

Initials

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Action:

Status:

Completed

Date

Initials

Please detail any outstanding activity with regard to required actions highlighted in the original EQIA process for this Service/Policy and reason for non-completion

Action:

Reason:

To be completed by

Date

Initials

Action:

Reason:

To be completed by

Date

Initials

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Please detail any new actions required since completing the original EQIA and reasons:

Action:

Reason:

To be completed by

Date

Initials

Action:

Reason:

To be completed by

Date

Initials

Please detail any discontinued actions that were originally planned and reasons:

Action:

Reason:

Action:

Reason:

Please write your next 6-month review date

Name of completing officer:

Date submitted:

If you would like to have your 6 month report reviewed by a Quality Assuror please e-mail to: Alastair.Low@nhs.scot

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Appendix 1: Membership of Design and Development Group

Name	Job Title	Representing
Aimie Holland	Lead Clinical Improvement Co-ordinator	NHSGGC Person Centred Care
Alastair Low	Manager, Equality & Human Rights Team	EHRT
Allan Drummond	Consultant in Acute Medicine	Acute Medicine
Charlene McLaughlin	Change and Development Manager	E-Health
Claire Ireland	Professional Nurse Lead-Older Peoples Services	Glasgow City HSCP
Dawn Allan	Spiritual Care Team Lead	Spiritual Care Service
Elayne Harris	Macmillan Lead Pharmacist Palliative Care	Palliative Care Pharmacist
Fiona Somerville	Interim Professional Nurse Lead	Prison Health care – Primary care/ Police custody
Ioana Stanciu	Service Improvement Officer	Planning & Strategy
Jude Marshall	Deputy Medical Director NHSGGC (Primary Care)	Primary Care / Realistic Medicine
Neil Ritchie		
Pauline McIntyre	Director of Patient and Family Services	Ardgowan Hospice
Scott MacKinnon	Clinical Effectiveness Lead	SAS
Stephanie Pollard	Nurse Team Lead	PEOLC Strategic lead West Dunbartonshire HSCP
Susan Fitzpatrick	Senior Graphic Designer - Communications	
Laura Moore	Chief Nurse - Inverclyde HSCP	PEOLC Strategic lead Inverclyde HSCP
Graham Gardiner	Chief Executive Officer	Ardgowan Hospice
Alexis Chappell	Chief Officer	Co-Chair / East Renfrewshire HSCP
Ann McLinton	PCHC Programme Manager	NHSGGC Person Centred Care
Anne Marie Harris	Consultant	Paediatric Supportive and Palliative Care Team
Barbara Simpson	Lead Nurse Palliative Care	Co-chair Palliative Care acute group
Beatrix Von Wissmann	Consultant - Public Health	Public health
Bridget Johnston	Clinical Professor of Nursing and Palliative Care	Board Bereavement Lead / University representative Palliative Care
Chris Kidson	Consultant Paediatric Intensive Care Medicine	PELiCaN The Paediatric End of Life Care Network
Claire O'Neill	Lead Nurse Palliative Care	NHSGGC Palliative Care / Chief Nurse Acute Services
Claire O'Neill	Chief Nurse	CHAS
David Gray	Consultant - Palliative Medicine	Palliative Care Clinical Lead Acute Clyde
Elaine Hamilton	Lead Nurse Care Home Collaborative	Care Home Collaborative

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Elizabeth Ferguson		
Elizabeth Lochrie	Interim Head of Service (North West Locality)	PEOLC Strategic lead Glasgow HSCP
Emma Dymond	Consultant - Palliative Medicine	Palliative Care Clinical Lead Acute North
Fiona Ralph	Interim Chief Nurse	Chief Nurse (HSCP)
Gail Young	Planning Officer	Planning Representative
Gillian Green	Chief Executive	St. Vincent's Hospice
Graham Whyte		
Gail Winters	Patient representative (GAIL WINTERS)	Public partners Adult and paediatric Palliative Care
Heather Tonner	MacMillan Advanced Nurse Specialist in Palliative Care	Care Home Collaborative
Helen Cadden	Patient representative (HELEN CADDEN)	Public partners Paediatric Palliative Care
Holly McGuigan	Consultant in Palliative Medicine	Ardgowan Hospice
Isabelle Cullen	Clinical Director for East Dunbartonshire HSCP	Clinical Director (OOH)
Jacki Smart	Chief Executive	Accord Hospice
Jane Edgecombe	Consultant - Palliative Medicine	Co-chair Palliative Care acute group
Jennifer Rodgers	Director of Nursing and Family Support	CHAS
John Brown	Director of Finance & Corporate Services	St. Margaret of Scotland Hospice
Jonathan Downie	Consultant in Paediatric Palliative Medicine	Paediatric Supportive and Palliative Care Team
Julie Tomlinson	Chief Nurse East Renfrewshire	PEOLC Strategic lead East Renfrewshire HSCP
Karen Pirrie	Head of Planning and Improvement	Planning Representative
Kathleen Halpin	Chief Nurse	East Dunbartonshire HSCP
Linda Moir	Patient representative (LINDA MOIR)	Public partners Paediatric Palliative Care
Laura Kelly	Consultant - Palliative Medicine	Palliative Care Clinical Lead Acute South
Leanne Connell	Chief Nurse Interface Division	Co-Chair / Interface Division
Liam Herbert	Head of Planning & Strategy	Planning & Strategy
Libby Milton	Associate Director and strategic lead for Marie Curie in Scotland	Marie Curie Hospice Glasgow
Lucy Dorrian	Patient Experience Public Involvement Manager	Patient Experience Public Involvement
Lynsey O'Dwyer	Clinical Team Lead, Community Nursing	PEOLC Strategic lead East Renfrewshire HSCP
Mairi-Clare McGowan	Consultant in Palliative Medicine	St. Vincent's Hospice
Mandy Meechan	Chief Nurse	Paediatric

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Marie Gilchrist	PDN	Chief Nurse adult mental health services
Morag Lynagh	Senior Nurse Manager	West Dunbartonshire HSCP
Neil Mcseveny	Deputy Director of Communications	GGC Communications Team
Nicola Dooley		Staff Partnership/APF
Noreen Shields	Planning & Development Manager - Equality and Human Rights Team	EHRT
Paul Corrigan	Information Officer	NHSGGC Palliative Care
Pauline Robbie	Interim Head of Health and Community Care	PEOLC Strategic lead Renfrewshire HSCP
Phillip Davies	CD for Paediatric sub specialities	Paediatric CD
Rhona Baillie	Chief Executive	The Prince & Princess of Wales Hospice
Sheonad Laidlaw	Transitions Lead	Transitions
Shona Ballentyne	Care Group Lead/Occupational Therapist for Rehab	Occupational Therapy
Susan Watt	Director of Care & Quality	St. Vincent's Hospice
Teresa Merino	Medical Director	St. Margaret of Scotland Hospice
Cathy Miller (Replaced)	Unison	Staff Partnership/APF



Palliative Care and Care Around Dying Strategy for Greater Glasgow and Clyde

Getting Palliative Care and Care Around Dying Right for all People,
of all Ages, Across all Hours and in all Settings

2026 - 2031

Foreword

Chair Foreword:

As Chair of NHS Greater Glasgow and Clyde, I am proud to introduce our Palliative Care and Care Around Dying Strategy 2026-2031. This strategy reflects our shared commitment to ensuring that every person, regardless of age, diagnosis, background or circumstance, receives compassionate, high-quality care when living with a life-shortening condition and as they approach the end of life.

As a Board, we recognise both the opportunities and responsibilities that lie ahead. Demand for palliative care is increasing, inequalities continue to affect people's experiences of illness and loss, and the needs of our population are becoming more complex.

This strategy sets out a clear and ambitious direction for the next five years. Its priorities reflect the importance of early conversations and planning, coordinated care, accessible information, bereavement support and a skilled, supported workforce. Success will depend on all of us working together across organisational boundaries, recognising that palliative care is not the responsibility of any one service, profession or sector, but a collective endeavour.

I would like to thank everyone who has contributed to the development of this strategy and the individuals and families who shared their experiences so openly. Their insight has helped shape a strategy that is grounded in compassion, partnership and a determination to improve care for future generations.

I commend this strategy and look forward to working alongside our partners, communities and staff as we deliver on its ambitions and ensure that people across Greater Glasgow and Clyde receive the care, support and dignity they deserve.

Dr Lesley Thomson KC
Chair
NHS Greater Glasgow and Clyde



Chief Executive Foreword:

Getting Palliative Care and Care Around Dying Right for all People, of all Ages, Across all Hours and in all Settings sets out NHS Greater Glasgow and Clyde's strategic vision for palliative care and care around dying for the period 2026 to 2031. The strategy reflects a commitment to ensuring that people receive compassionate, person-centred care that focuses on what matters most to them and those closest to them.

The strategy has been informed by extensive engagement with people with lived experience, families, carers, staff, partner organisations and communities. Their collective insights have helped identify strengths within current services, areas where improvement is needed and the priorities that matter most for those living with a life-shortening condition or experiencing bereavement.

Five strategic priorities provide the framework for improvement over the next five years. These priorities focus on recognising people earlier and planning care together, delivering coordinated and responsive services, improving access to information and support, strengthening bereavement support, and ensuring the workforce has the skills, knowledge and wellbeing support required to provide high-quality care. Together, they aim to create a more consistent and equitable experience for people and families across Greater Glasgow and Clyde.

Delivering this ambition will require strong leadership, partnership working and shared accountability across health, social care, third sector and community services. It will require a commitment to listening, learning and continuous improvement, while building on existing strengths and expertise across communities and services. Most importantly, it will require a continued focus on the experiences and outcomes of the people who use services and those who care for them.

Through collective effort and collaboration, this strategy seeks to ensure that every person, regardless of age or circumstance, receives high-quality, compassionate palliative care and care around dying when and where it is needed, and that those important to them are supported throughout their journey

Professor Jann Gardner
Chief Executive
NHS Greater Glasgow and Clyde



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Introduction

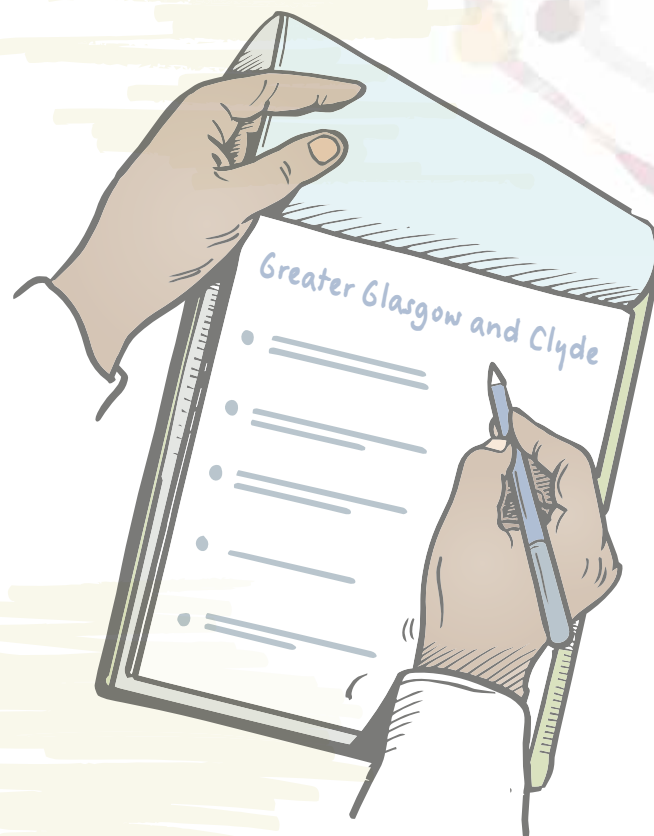
Everyone in Greater Glasgow and Clyde will be affected by life-shortening illness, dying, death and bereavement at some point in their lives. Ensuring people receive high-quality palliative care and care around dying is a shared responsibility across communities, health and care services and wider society.

This co-created strategy sets out how Greater Glasgow and Clyde will improve palliative care and care around dying between 2026 and 2031.

It aligns with national policy (1), local priorities and is driven by the voices of people, families, carers and staff.



Palliative Care Matters for All



Our Purpose

To improve population health through safe, high quality, sustainable, digital-first and innovative services centred on people and communities

Strategic Anchors*

Improved Outcomes for People

High Quality Care and Experience

Digital First Approach

Sustainability and Value

Supported Workforce

Aims

Improve population health and reduce inequalities

Provide the Right Care, Right Time, Right Place

Embed Digital and Virtual Delivery Integral to the Whole System

Ensure Sustainable Service Delivery through Optimising Service Delivery

Build a culture of high-performance, compassion and accountability

*Strategic Anchors = The principles that guide how we make decisions, prioritise resources and assure delivery

Listening, Learning and Transforming Together

1.1 What People Told Us

People consistently told us that high-quality palliative care should be person-centred, compassionate and coordinated.

Children, young people and their families emphasised the need for holistic care, continuity of relationships and support from skilled professionals who know them well.

Palliative Care and Care around Dying

What people with lived experience told us is important

Quality of Life

Prioritising quality of life and what matters most to the individual



Dignity, Respect and Compassion

Upholding dignity, showing compassion and honouring personal wishes



Comfort and Pain Management

Ensuring comfort and effective pain management



Communication and Information

Maintaining clear, honest and open discussions



Family Involvement and Support

Supporting and involving the wider family



Emotional and Psychological Support

Providing empathy and support for patients and families



People with lived experience identified the need for change by highlighting several areas for improvement

Reducing variation in care

Strengthening links between services

Improving communication and coordination

Increasing staff education and awareness

Providing better support for families

Improving access to bereavement services

Ensuring timely access to specialist palliative care expertise

As groundwork for this strategy an Accelerated Design Event in March 2025 brought together people with lived experience, staff and partners to co-design the future of palliative care.

Participants agreed that future services should be

Digitally enabled

Equitable, accessible and compassionate

Supported by strong partnership working, workforce development and robust governance arrangements

1.2 What is Palliative Care?

Palliative care is care of a person of any age living with life shortening conditions and their family and carers that focuses on what matters to them. It can start from around the time of diagnosis and includes care when someone is dying (1).

It is care centred on the person and helps people manage symptoms, emotional, psychological, social or financial problems, and spiritual wellbeing, regardless of faith or belief. This type of care is often called holistic care (1, 2).

Within paediatrics this includes babies, children and young people from before birth through childhood and adolescence until they transition to adult care.

A life shortening condition is any illness or health condition that means a person's health will deteriorate over time and, at some point in the future, they will die with these condition(s) (1).

A person receiving palliative care may also be receiving treatment or interventions with the aim to manage symptoms and/or slow disease or illness progression. This may be referred to as palliative treatment.

Care around dying is an aspect of palliative care. It means holistic care of a person of any age who is dying and in the last hours, days or few weeks of their life that focuses on comfort and includes people close to them who are supported into bereavement.

Palliative care is not limited to the final stages of life. It should be recognised and integrated into care from diagnosis onwards, ensuring that people and those that matter to them receive the right support, at the right time, in the right place.



Appendix 1 includes details on the Spectrum of Palliative Care.

1.3 Population and Palliative Care

The need for palliative care is increasing:

Across Scotland 16,700 children are living with a life shortening condition, with more children surviving into adulthood (3). Adults are living longer with multiple long-term conditions and frailty.

Every week in Scotland 3 children with a life shortening condition will die. In 2024/25 it is estimated that over 11,600 adults in Greater Glasgow and Clyde died with palliative care needs.

Bereavement affects thousands of families, carers and communities every year.

Future services must be designed to meet growing demand across all ages and diagnoses, with particular attention to children transitioning into adult services and increasing numbers of older people living with frailty and complex needs.



1.4 Health inequalities

Health inequalities continue to have a significant impact on how people experience illness, dying and bereavement.

People living in areas of deprivation, people experiencing homelessness, severe and enduring mental illness, learning disabilities, substance use disorders and people living in prison are more likely to experience poorer health outcomes, shorter life expectancy and greater barriers to accessing support.

Poverty can have a profound effect on people in the last year of life and on those who care for them. Financial hardship can increase practical, emotional and social challenges at an already difficult time.

Children living with life-shortening conditions are also disproportionately represented within the most deprived communities.

Reducing inequalities must be central to service planning and delivery to ensure palliative care is accessible, equitable and responsive to the needs of all communities.



1.5 Population Diversity and Palliative Care

Greater Glasgow and Clyde is a culturally and religiously diverse population. People experiencing serious illness, dying and bereavement should receive care that respects their individual beliefs, values, culture and preferences.

Information, services and support should be accessible to everyone, including people who may face additional barriers to care. This includes ensuring appropriate access to advocacy, interpretation services and culturally responsive approaches to care delivery.



People should be confident that palliative care will be personalised, inclusive and respectful, regardless of their background, culture, beliefs or circumstances.

1.6 Where Care Happens

Most people, including children, living with palliative care needs spend the majority of their time at home or within their local community. For adults, this is around 90% of the last 6 months of life.

Some people may also receive care in hospital, particularly when their needs become more complex

People and those that matter to them require care, advice and support across a range of settings. As individuals move between services, effective communication, shared care planning and coordinated working become increasingly important. Ensuring that information about what matters to the person is visible and accessible across services is fundamental to delivering person-centred care.

Understanding where a person wishes to receive care, particularly as they approach the end of life, should be part of routine care planning. Wherever possible, services should work together to avoid unnecessary hospital admissions and support timely discharge when care can be provided more appropriately elsewhere.



People should be able to receive care in the setting that best meets their needs and preferences. Delivering this requires coordinated services, shared information, and strong community-based support that enables people to remain in their preferred place of care.



1.7 Who Provides Palliative Care?

People living with life-shortening conditions spend most of their time at home and in their local communities, supported by family, friends, neighbours, community groups and volunteers, alongside health and social care services.

Palliative care is delivered by professionals across primary care, hospitals, care homes, hospices, community services, prisons, local authorities and independent organisations. For most staff, palliative care forms part of their everyday role and is often described as general palliative care. Meaning palliative care is everyone's business.

Unpaid carers play a vital role and should be recognised and supported in line with the Carers (Scotland) Act 2016.

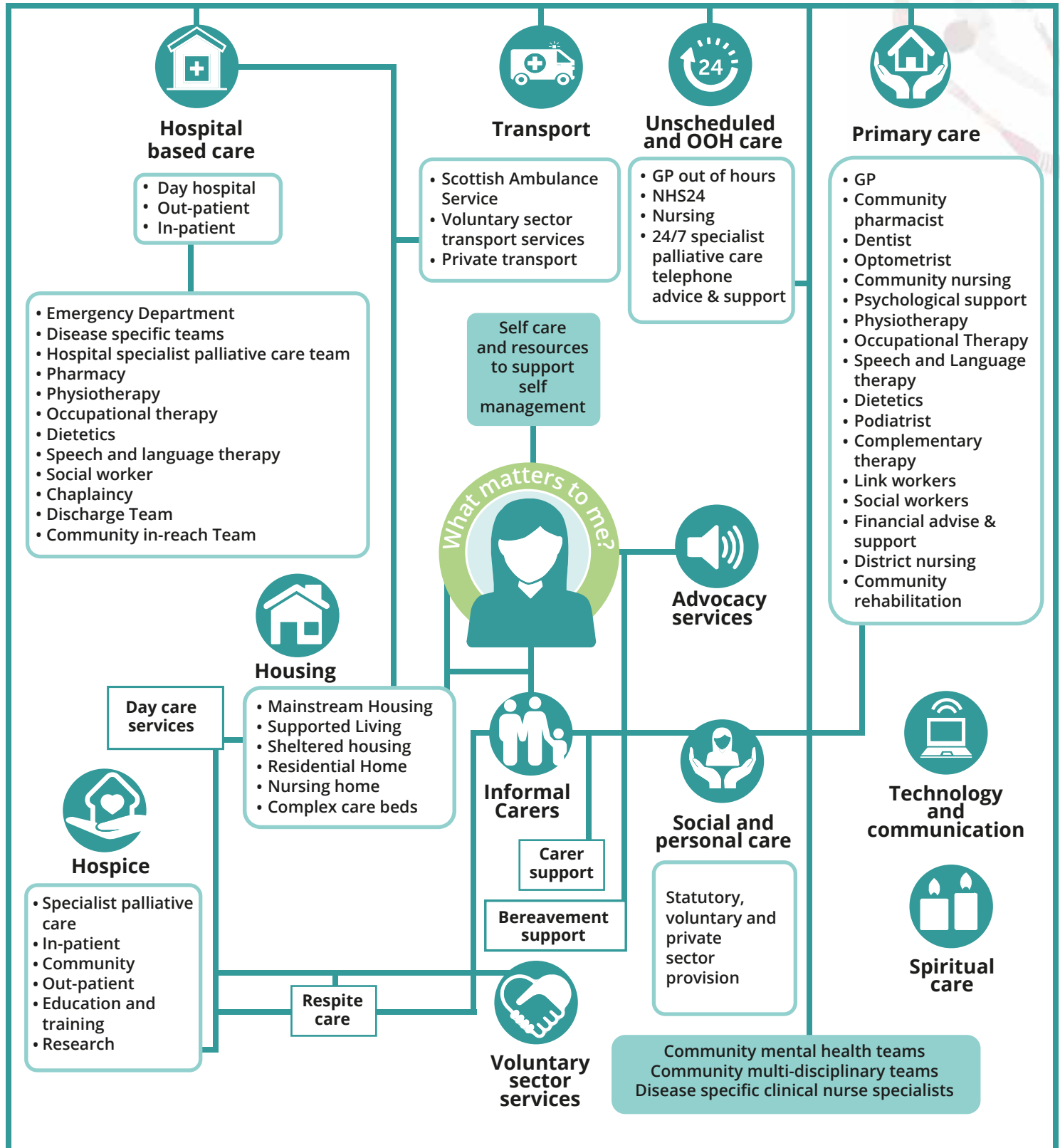
Strengthening compassionate communities and supporting carers must be a central component of our approach to palliative care and care around dying.



Section 1 Defining palliative care, the population who need it, and who provides it

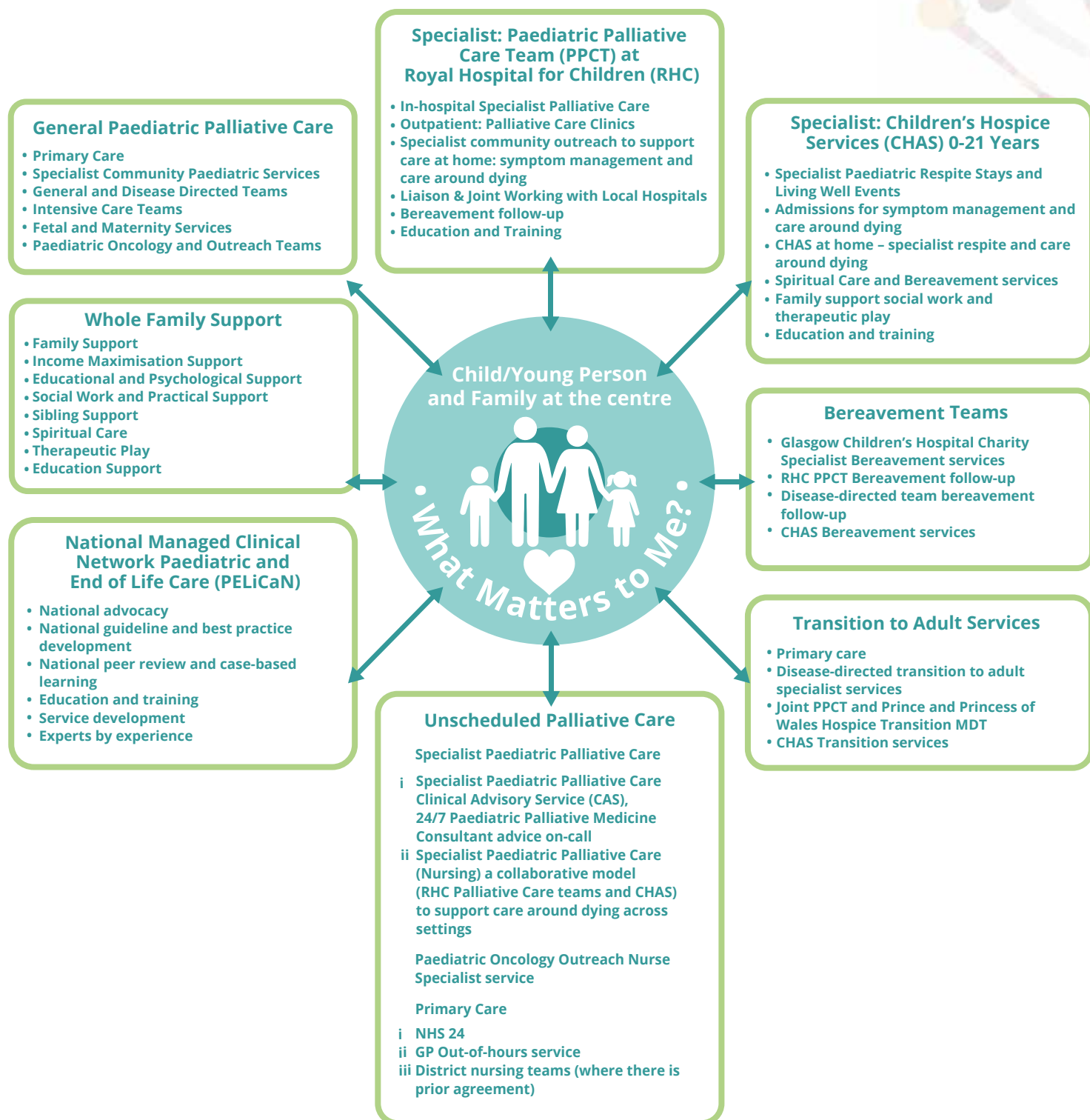
Whole System Map for Adult Palliative and Care around Dying

This whole systems map for adult palliative care and care around dying demonstrates that people in or attending hospital, living at home or in a care home or in other places of care receive palliative care from many different staff and teams.



Whole System Map for Paediatric Palliative and Care around Dying

This whole systems map for paediatric palliative care and care around dying demonstrates that children, babies, young people and their families receive palliative care from many different staff and teams.



Specialist Palliative Care

Most palliative care is provided by the wider health and care workforce.

However, some people require specialist palliative care to support more complex physical, psychological, social or emotional needs.

Specialist palliative care teams provide expert clinical advice, patient and family care, education and support for the wider workforce.

Specialist palliative care services are a vital part of the wider system. Ensuring equitable access to specialist expertise, while strengthening palliative care knowledge across the workforce, will improve experiences and outcomes for people with palliative care needs and those who matter to them.

Emerging evidence suggests that access to specialist support beyond traditional weekday hours can improve care experience.

While services vary between providers and settings, access to specialist palliative care should be equitable regardless of age, diagnosis, location or care setting.

Adult Independent hospices play a fundamental role in the delivery of specialist palliative care across Greater Glasgow and Clyde.

They provide inpatient care, outpatient services, home-based support, bereavement services, education, training and research activity. Children's hospice care is provided by CHAS through their two dedicated hospices.

CHAS also provides specialist care and support in the child's home through the CHAS at Home service.

CHAS provides holistic support services to children aged 0 – 21 years and their families.



Hospital specialist palliative care teams play an essential role, supporting people with complex needs while helping ward and community teams deliver high-quality palliative care and care around dying.

1.8 Workforce – Education, Training and Well-being

High-quality palliative care and care around dying relies on a skilled, confident and supported workforce. As palliative care is delivered across many services and settings, staff from a wide range of professions will encounter people with palliative care needs during their careers. Ensuring they have the knowledge, skills and confidence to provide compassionate, person-centred care is essential.

In 2025, a mapping exercise to review palliative care education and training provision across NHS, Health and Social Care Partnerships, hospices, paediatric palliative care services, universities, colleges was undertaken. The review highlighted a broad range of learning opportunities and reinforced the importance of aligning workforce development with the NHS Education for Scotland (NES) and Scottish Social Services Council (SSSC) Palliative Care Education Framework (2025)

The review also identified opportunities to strengthen coordination and consistency across Greater Glasgow and Clyde. Priorities include ensuring education is available at all levels of practice, embedding palliative care within undergraduate and postgraduate curricula, and strengthening collaboration across organisations to support workforce development.

Well-being

Providing palliative care and care around dying is rewarding but can also be emotionally demanding. Staff need access to effective wellbeing support and a culture that recognises the impact of this work. Prioritising staff wellbeing is essential to sustaining a compassionate workforce and delivering high-quality care.

Achieving our ambition for palliative care requires investment in workforce education, training and wellbeing. Staff should have access to role-appropriate learning, opportunities to develop throughout their careers, and the support they need to deliver compassionate, person-centred care. Workforce support and development will be underpinned by staff governance and partnership working.



Priorities

The priorities within this strategy have been shaped and refined through extensive engagement and collaboration with people with lived experience, families, carers, staff and partners. Together, they respond to the challenges and opportunities identified throughout Section 1 and provide a clear framework for improving palliative care and care around dying across Greater Glasgow and Clyde.

As demand for palliative care continues to grow, we must ensure services are person-centred, easy to access, well-coordinated and responsive. Achieving this will require a collective approach, with health and social care services, hospices, third sector organisations, communities and carers working together to support people wherever they receive care.

Our five strategic priorities set out the changes we will make over the lifetime of this strategy. Each priority is equally important and together they support our ambition to get palliative care and care around dying right for every person, of every age, across all hours and in all settings. A delivery plan will support implementation and provide a framework for measuring progress and impact.

Our Five Strategic Priorities

1

People with palliative care needs will be recognised earlier and we will collectively plan care around you or your child and those who matter to you

2

Care will be well coordinated, easy to access and quick to respond, no matter where you are

3

People can get clear information and support in a way that works for them

4

Everyone can get the right support before and after a bereavement

5

Staff will have the skills, and support they need to provide good care

This section sets out what people can expect to experience care, the actions we will take, and how we will know we are making a difference.



Priority 1:

People with palliative care needs will be recognised earlier and we will collectively plan care around you or your child and those who matter to you

How I or my child and those who matter to me will experience care

I am confident that health and care staff will recognise and help me plan my care needs, or the care needs of my child, if diagnosed with a life-shortening illness.

What we will do

Define and standardise triggers to identify people with palliative care needs early.

Offer future care planning conversations at the earliest opportunity.

Ensure care plans are able to be shared and visible to those who need to see them.

Listen to you and provide clear information on who to contact for support

How we will know it is working

People will feel supported to understand their condition and make plans early, not just at the end of life.

People will feel their health and care teams are aware of their condition and their individual care plan.

Here is a case study to demonstrate when this works well.

Case study 1

A resident living with dementia in a care home was experiencing frequent infections.

On one occasion their health got much worse, very quickly.

Because the Doctor and the Residents Power of Attorney had already talked about what could happen if things got worse, there was a clear plan in place.

Everyone agreed that the most important thing was to keep them comfortable in their home, as was their previously expressed wish.

The care home staff gave antibiotics by mouth to treat the infection and medicine to help with pain.

The resident was able to stay in the care home and died peacefully with their family by their side





Priority 2:

Care will be well coordinated, easy to access and quick to respond, no matter where you are

How I or my child and those who matter to me will experience care

I or my child will know who to contact to meet my or my child's care needs, I or my child will be treated with kindness, dignity and respect. Pain and symptoms will be well managed. My or my child's health and care teams will work together and respond quickly if my needs change.

What we will do

Join up care across services.

Make it clear who to contact and how to get help, develop a single point of access.

Ensure timely access to care, support, equipment and medications when needs change.

Provide consistent, high-quality care across all settings.

How we will know it is working

People will feedback that care is responsive, co-ordinated and kind.

Care opinion feedback demonstrating responsive, co-ordinated person-centred care.

When Mum's health deteriorated, she spent a few days in the hospice where the care she received was top class.

When we knew Mum was near end of life we took her home and the hospice ensured that this transition went as smoothly as possible.

We were supported daily by the amazing community palliative care team from the hospice, the palliative carers and district nursing teams who cared for my Mum in her last days were fantastic.

I will forever be grateful to them for allowing us as a family to be with Mum at home in her final days and make precious memories.

This was her wish and we would not have been able to do that were it not for the amazing teams that deliver care at home to people in Inverclyde at end of life.





Priority 3:

People can get clear information and support in a way that works for them

How I or my child and those who matter to me will experience care

I am able to get information about palliative care in the way I find easiest to access and most helpful for myself or my child. I feel confident to manage my, or my child's, condition with the help of health and care professionals, and I know what supports are available within my community. I feel my community is more aware of palliative care and care around dying, so I (my child) feel "seen" and supported.

Example of good practice

**Managed clinical network PELiCaN
Ambulance/Police Occurrence Markers**

<https://www.nn.nhs.scot/pelican/>

What we will do

Provide simple, easy-to-understand information

Offer information in different formats, not just digital.

Help people get the support they need around money worries.

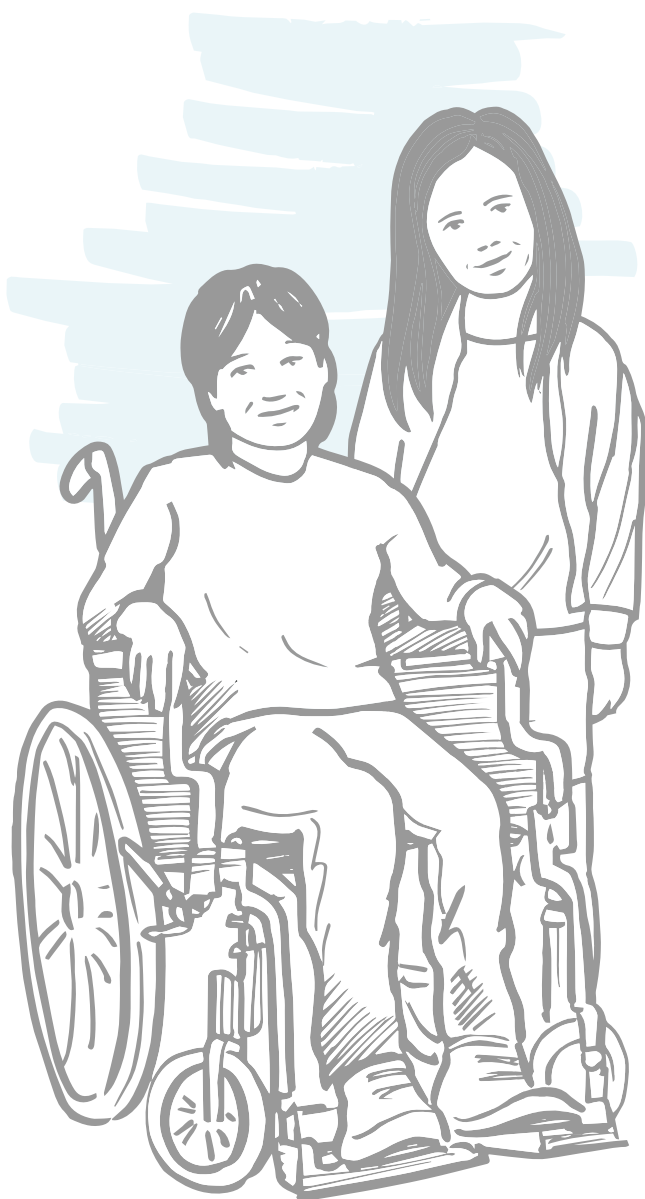
Offer training and advice for people with life-shortening conditions and their carers so they know what to do and where to get help.

Make it clear what support is available and how to access it.

Keep people informed throughout their care, not just at one point in time.

How we will know it is working

Information will be widely available and accessed.





Priority 4:

Everyone can get the right support before and after a bereavement

How I or my child and those who matter to me will experience care

If I suffer a bereavement, I know what support is available and can access this easily if I need it.

What we will do

Offer support early and continue it after a death.

Make sure people know what support is available, when it can help, and how to get it.

Provide different types of support to meet different needs.

How we will know it is working

We will monitor uptake of and satisfaction with bereavement support services.

Bereaved people will feedback that they received support at the right time to meet their needs.

Lived Experience shared by Tracy's daughter

"After my mum died, we asked what would happen and how would we get the death certificate and we were told different things and then the certificate was wrong so we had to get that corrected.

We don't feel like we have had any support after my mum died no one referred us on to bereavement support or knew what happened next".





Skilled & supported workforce

Priority 5:

Staff will have the skills, and support they need to provide good care

How I or my child and those who matter to me will experience care

I am confident that all health and care teams involved in my care, or my child's care, have the training and support they need to provide high quality palliative care regardless of where I am.

What we will do

Ensure staff have the training and skills they need.

Support staff wellbeing in emotionally demanding work.

Create conditions that enable consistent, high-quality care.

How we will know it is working

Staff feedback they have the knowledge, support and skills to deliver palliative care and care around dying.

People with palliative care needs and those that matter to them will feedback that care was high quality, kind and careful.

Example of good practice

Mortality Review: Share and Support Circle

Palliative care can be rewarding, but it can also be hard.

Staff often care for people and families at very sad times.

This can affect how staff feel. The Prince and Princess of Wales Hospice gives staff time each month to meet in a Share and Support Circle.

Staff can talk, listen and support each other.

This helps staff feel heard and cared for, so they can keep giving good care.



3.1 Delivering Change through Collaborative Governance

This strategy recognises that palliative care and care around dying must meet a wide range of needs across all ages, settings and hours of care. Delivering improved outcomes will require organisations to work together with mutual respect, shared purpose and, where appropriate, integrate authority and accountability for palliative care delivery.

Achieving this ambition will depend on effective leadership and collaborative governance.

NHS Scotland describes collaborative governance as:

“When all parties who have an influence in the delivery of healthcare outcomes recognise, understand and respect the needs of each other and work together to integrate or align their arrangements for the governance of the delivery of services and products within the healthcare environment.”

This strategy has been co-created through the Strategy Design and Development Group, with representation from a wide range of partner organisations (Appendix 2). This group co-ordinated the strategy writing groups, feedback and engagement processes.

Following publication, this group will transition into the Collaborative Governance Group for Palliative Care and Care Around Dying.

The Collaborative Governance Group will provide strategic oversight and coordinate implementation of the strategy, through the creation of delivery plans and the provision of a framework for measuring progress and impact.

The NHSGGC Executive Lead for Palliative Care will ensure reporting governance is aligned with Transforming Together Programme.

The work of the Collaborative Governance Group will be underpinned by the Transformation Agenda, recognising palliative care as everyone's business, and will work together to maximise value from public and charitable resources.



Case study demonstrating collaborative governance

Paediatric Care Around Dying - Enabling True Choice for Children and Families.

Across Greater Glasgow and Clyde, families and professionals identified that variability in overnight and weekend support could limit the ability of children to remain at home for their care around dying, even where this was their preferred place of care.

Whilst children with malignancy have long had access to highly specialist 24/7 oncology nursing at home, children with non-malignant conditions have not had reliable out of hours provision, creating an inequity that this work seeks to address.

What did we do differently?

The Paediatric Care Around Dying (PCAD) – Enabling Choice collaborative group brought together NHSGGC RHC (Royal Hospital for Children) Paediatric Supportive and Palliative Care team, Paediatric Oncology Outreach Nursing (POON) team, Children's Hospices Across Scotland (CHAS) and Health and Social Care Partnership (HSCP) partners to design and deliver a reliable model of care. The group united around a shared purpose: to develop a sustainable 24/7 nursing on-call approach that ensures all children and families experience genuine choice for their place of care, no matter where they live or their underlying diagnosis.

Recognising the 'gold-standard' for 24/7 access to paediatric palliative care nursing support, the model builds upon those services currently providing elements of this care and connects nursing teams across organisations. It combines 24/7 specialist

consultant led individualised care planning, a shared 24/7 nursing rota providing overnight telephone support and home visiting when required, and the use of HSCP local knowledge around specific community services to ensure timely and safe responses. Executive leaders from each organisation committed to sponsor the group's Project Initiation Document. Clear governance and oversight structures were established including reporting and escalation routes, focused workstream groups, and a risk register.

Key ingredients are the shared leadership commitment, readiness to work across organisational boundaries, a strong focus on interagency governance, and a willingness of team members to learn and plan together. PCAD provides a clear example of how palliative care systems can work across organisational boundaries to deliver equitable, child-centred care.

3.2 Commissioning

Specialist palliative care services may in some instances be provided by the NHS, but many are also commissioned from third sector partners such as hospices. Some general palliative care services may also be commissioned.

Existing commissioning frameworks and funding arrangements have guided service delivery for many years, but these require review considering changes introduced through the public bodies (Joint Working) (Scotland) Act 2014.

Delivering our shared ambition for palliative care requires strong partnerships between independent hospices, NHS specialist palliative care services, health boards, Integrated Joint Boards and other stakeholders. This strategy recognises the need for sustainable commissioning and funding arrangements that enable hospices and NHS services to work collaboratively and equitably, combining their expertise and resources to meet growing and changing needs. The valuable contribution of both hospice and NHS specialist palliative care services is recognised, and continued support for both sectors is essential to achieving the best outcomes for people and families.

Collectively we will

Commission services based on population need.

Promote equitable access across Greater Glasgow and Clyde.

Maximise value from public and charitable resources.



3.3 Measurement and Assurance

People with palliative care needs and those who matter to them will experience care differently. We will use a shared framework of outcome, quality, experience and performance measures to understand whether this strategy is improving care for people with palliative care needs and those who matter to them.

Outcome measures will be aligned with the strategy delivery plans, key measures will include:

Future Care Planning completion.

Preferred place of care and death achieved.

How people with palliative care needs and those who matter to them experience care

Access to palliative care services.

Workforce education, confidence and wellbeing.

Quality, safety and equity indicators.

We will monitor progress in reducing inequalities and upholding people's rights, including obligations under the UNCRC, alongside any risks and actions identified through the Equality Impact Assessment.

We will support national work to improve palliative care data and outcome measurement, including the use of person-centred outcome and experience measures for adults, children and families.

The Collaborative Governance Group for Palliative Care and Care Around Dying will oversee progress through regular integrated assurance reporting. This will include delivery against the strategic priorities and actions arising from quality, safety and equality reviews.



Our Commitment

Palliative care and care around dying are important to every community. Most of us will, at some point in our lives, experience serious illness, care for someone who is unwell or be affected by bereavement. How we respond during these times matters.

This strategy sets out our shared ambition to work together to ensure people, of all ages, in all settings receive timely, compassionate and coordinated palliative care that reflects what matters most to them.

Through partnership, innovation, compassion and continuous improvement, we will deliver better palliative care and care around dying across all settings, all hours and all communities in Greater Glasgow and Clyde.

By 2030 we want people to be able to say:

I was listened to.

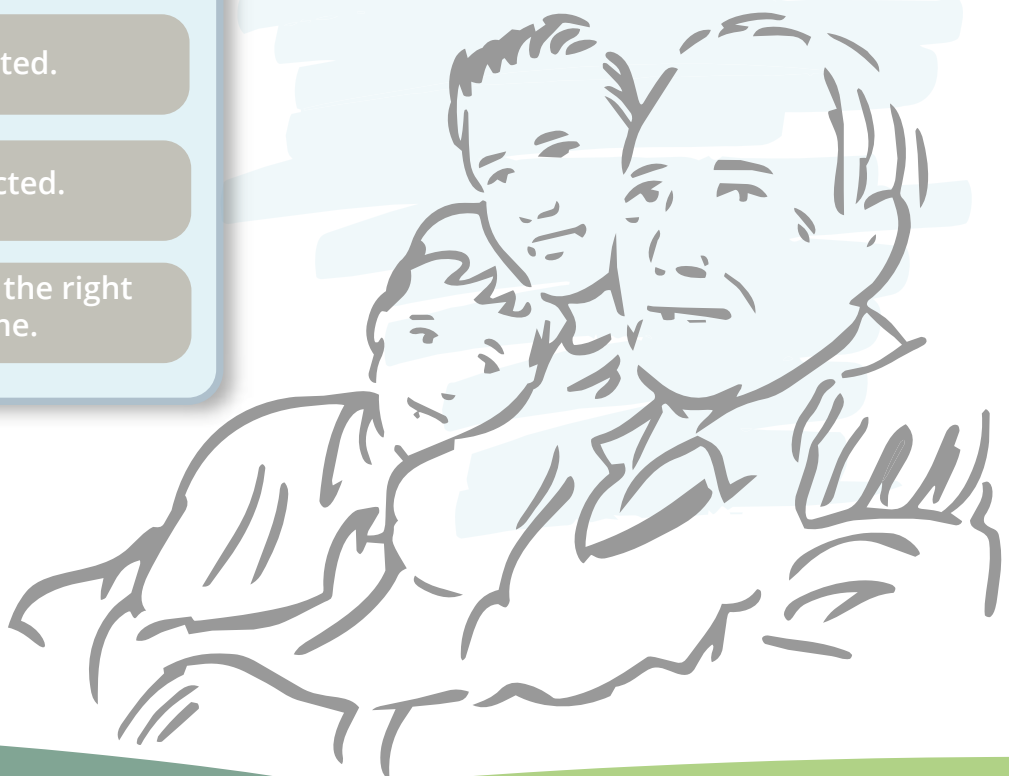
I was treated with dignity and compassion.

I knew who to contact when I needed help.

My care was coordinated.

My wishes were respected.

I received the right care, in the right place, at the right time.



Closing Remarks

"You matter because you are you, and you matter to the end of your life."

Dame Cicely Saunders.

By listening to people across NHS Greater Glasgow and Clyde, we have heard the clear opportunity to change how palliative care and care around dying is designed and delivered for everyone approaching the end of life.

So many people shared their stories and experiences in the hope that we can work together in new, better, bolder and braver ways. Through this strategy and its delivery plan, we commit to doing so.

We will continue conversations and strengthen connections across Greater Glasgow and Clyde, supporting people to have the important discussions around their wishes with loved ones and those important to them.

Understanding these wishes is the key to getting care right, because we never get a second chance and we have heard the clearest of messages that, "The end of life deserves as much beauty, care and respect as the beginning" – Anonymous.

Professor Angela Wallace
Executive Nurse Director

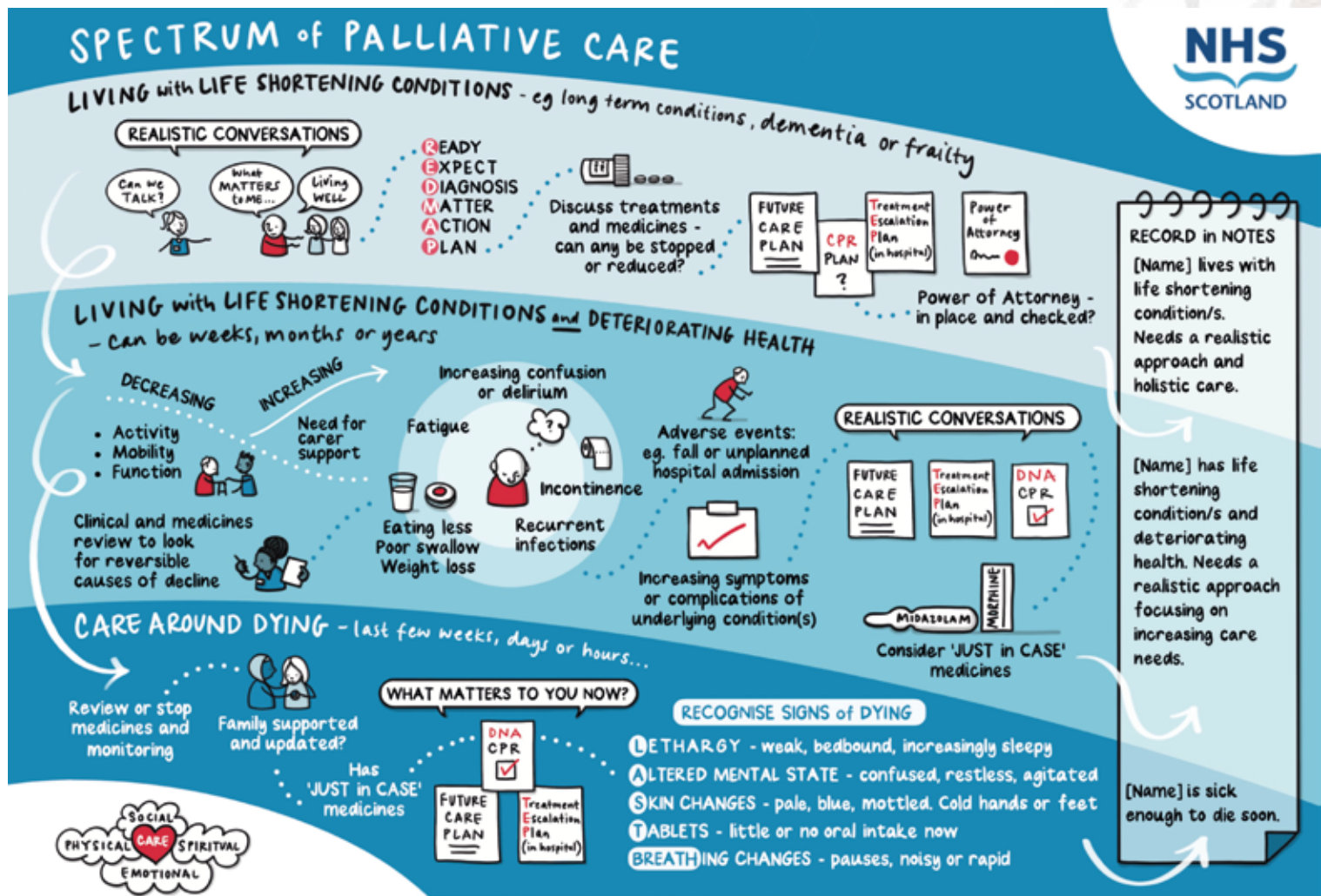


References

1. Palliative Care Matters For All: palliative care strategy 2025-2030 Scottish Government
2. Palliative Care Education Framework 2025 NHS Education Scotland, Scottish Social Services Council.
3. Childrens Hospices Across Scotland Strategic Plan 2024-2028



Appendix 1 - Spectrum of Palliative Care



Plain text version and tools available at <https://spict.org.uk/using-spict/using-spict-sopc/>

Green, R.V, Ward A, Miller S, NHS Forth Valley 2025

The Spectrum of Palliative care demonstrates that palliative care is not limited to the last days and hours of a person's life.

Instead, the image depicts the importance of palliative care through diagnosis and living with a life shortening condition.



Hands in Circle graphic © Crown Copyright Published 10 September 2025

