ITEM No …9……..

REPORT TO: **HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD – 24 JUNE 2026**

REPORT ON: **TAYSIDE TOGETHER PALLIATIVE CARE MATTERS FOR ALL STRATEGY**

REPORT BY: **CHIEF OFFICER**

REPORT NO: **DIJB31-2026**

1.0 PURPOSE OF REPORT

1.1 The purpose of this report is to present and to seek approval for the Tayside Together Palliative Care Matters For All Strategy

2.0 RECOMMENDATIONS

It is recommended that the Integration Joint Board (IJB):

2.1 Notes and approves the content of the Tayside Together Palliative Care Matters For All Strategy as attached as Appendix 1 to this report.

3.0 FINANCIAL IMPLICATIONS

3.1 None

4.0 BACKGROUND INFORMATION

4.1 The Scottish Government published its National Strategy - Palliative Care Matters for All (2025-2030) in September 2025. The overall aims of the National Strategy are:

> Enabling people and communities – Scotland is a place where people of all ages and their communities can help and support each other to live as well as possible with life shortening conditions, dying, death and bereavement
>
> Strengthening Palliative Care – People of all ages with life shortening conditions and their families and carers receive palliative care, care around dying and bereavement support based on what matters to them.

4.2 Palliative care is delivered across a whole range of settings including at home, in care homes, in acute hospitals, in non-acute or community hospitals and specialist palliative care units or hospices. Palliative care is provided across all age ranges.

4.3 The need for palliative care is growing. People are living longer, often with multiple health conditions, and most will need palliative care at some stage in their lives, whether at diagnosis, during their illness, or when they are dying. Need for palliative care is also increasing among children and young people, and advances in care mean that more children with complex conditions are living into adulthood and requiring ongoing specialist support.

4.4 Following on from the National Strategy, NHS Tayside agreed to develop a Tayside Palliative Care Strategy as a key Corporate Objective for 2025/26 to ensure a focus on delivering the aims of the National Strategy at a local level. Given the range of settings and services where palliative care is provided and the community based interactions with those with life shortening conditions, those who are dying and those who are bereaved, a whole system together approach is key to ensure the delivery of the national aims. The three Tayside Integration Joint

Boards are critical in ensuring strategic planning for services with and for communities ensures a strong focus on working together to improve life, health and care for people of all ages living with life shortening conditions, dying or experiencing bereavement in Tayside.

4.5 The Tayside Strategy has been developed over the course of 2025/26 following the establishment of a Tayside Together Palliative Care Steering Group which has multi service/multi agency representation including the independent and charity sectors and building on the wide ranging experience, knowledge and insight of the Tayside Palliative Care Managed Care Network. The draft strategy has been shared with and discussed at each of the Integration Joint Boards Strategic Planning Groups with the feedback received helping shape the final strategy attached to this report.

4.6 The Tayside Strategy will provide the framework to develop a new target operating model for palliative care across the whole system. Once the Tayside Strategy is published, patients, service users and families and stakeholders will be clear around how they will be supported in Tayside in relation to palliative care, care around dying and bereavement support.

4.7 The strategy is being considered for approval by each of the Tayside Integration Joint Boards and NHS Tayside. Following approval, public facing and accessible versions of the strategy will be published.

5.0 POLICY IMPLICATIONS

5.1 This report has been subject to an Integrated Impact Assessment to identify impacts on Equality and Diversity, Fairness and Poverty, Environment and Corporate Risk. An impact, positive or negative, on one or more of these issues was identified. An appropriate senior manager has checked and agreed with this assessment. A copy of the Integrated Impact Assessment showing the impacts and accompanying benefits of / mitigating factors for them is included as an Appendix to this report.

6.0 RISK ASSESSMENT

6.1 This report has been assessed to identify impacts on strategic risk management. No impact has been identified, either in relation to the strategic risks currently contained within the IJB's strategic risk register or the identification of any additional, emerging risks**.**

7.0 CONSULTATIONS

7.1 The Chief Finance Officer and the Clerk were consulted in the preparation of this report.

8.0 DIRECTIONS

The Integration Joint Board requires a mechanism to action its strategic commissioning plans and this is provided for in sections 26 to 28 of the Public Bodies (Joint Working)(Scotland) Act 2014. This mechanism takes the form of binding directions from the Integration Joint Board to one or both of Dundee City Council and NHS Tayside.

Direction Required to Dundee City Council, NHS Tayside or Both	Direction to:	
	1. No Direction Required	x
	2. Dundee City Council	
	3. NHS Tayside	
	4. Dundee City Council and NHS Tayside	

9.0 BACKGROUND PAPERS

9.1 None

Dave Berry
Chief Officer

DATE: 03 June 2026

Tayside Together Palliative Care Matters for All Strategy

"Working together to improve life, health and care for people of all ages living with life shortening conditions, dying or experiencing bereavement in Tayside"

Right Care, Right Time, Right Place, Right People, Right Experience, Right Outcome

Status:	Draft for consultation
Author:	Tayside Together: Palliative Care Steering Group
Approval:	NHS Tayside and Angus Integration Joint Board (IJB), Dundee IJB, Perth and Kinross IJB
Date:	June 2026
Version:	v.12b

Contents

1. Foreword

Palliative care matters to us all. At some point in our lives, we will either need this support ourselves or for someone we care about. It focuses on what is most important to people, of all ages, living with life shortening conditions, those who are dying, and those who are bereaved.

Good palliative care helps people live as well as possible for as long as possible, supporting comfort and dignity for people and their families and unpaid carers, recognising the distinct role, rights and contributions of unpaid carers throughout life-shortening illnesses. Good care around dying does the same for those who are dying in their last hours, days and weeks of life and in bereavement. We only get one chance to get this right.

The need for palliative care in Tayside is growing. People are living longer, often with multiple health conditions, and most will need palliative care at some stage in their lives, whether at diagnosis, during their illness, or when they are dying. Need for palliative care is also increasing among children and young people, and advances in care mean that more children with complex conditions are living into adulthood and requiring ongoing specialist support.

Meeting this need requires people, families, neighbours, communities and all our services to work together. It also means being more open as a society about death, dying, illness and what matters most.

The Scottish Government's national strategy, "Palliative Care Matters for All" sets out two clear aims: to empower communities to support one another and to strengthen palliative care so people receive support based on what matters to them. Achieving this depends on sustainable, person-centred public services, strong community networks and third sector organisations working side by side.

Across Tayside, there is a strong commitment to fulfil these aims and we have solid foundations to build on. But we know we can and need to do more. Improving palliative care means building on what is good and of most value to people, thinking and working differently when this brings improvement and continually learning and working together into the future.

"Tayside Together: Palliative Care Matters For All" builds on our strengths and on the experiences of people, carers, communities, and professionals. Our goal is to ensure that everyone receives the right care, at the right time, from the right people, in the right place, so that their experience, and the outcome, is the right one. A goal that requires a collective effort.

Together, we will support communities across Tayside to care for one another and ensure that everyone who needs palliative care or care around dying receives it in a way that reflects what matters most to them.

2. Terms Used in National and Tayside Strategies

Term	Definition
Palliative care	Is holistic care of a person of any age living with life shortening conditions and their family, carers and unpaid carers that focuses on what matters to them. It can start from around the time of diagnosis and includes care when someone is dying through to death.
General Palliative Care Service	Palliative care for people of all ages that is provided by many different health and social care staff as part of their usual care of people living with life shortening conditions, wherever they live or have care. General palliative care is sometimes called 'a palliative care approach'.
Specialist Palliative Care Service	Any team or service (NHS or independent hospice service) providing specialist services delivered by a multidisciplinary team of staff who are specialists in palliative care, and sometimes trained volunteers. Specialist palliative care services are for people of all ages wherever they live or have care and is important when the person's care is more complicated and harder to manage. Specialists offer advice and education to staff providing general palliative care.
Care Around Dying	Holistic care of a person of any age who is dying and in the last hours, days or weeks of their life, that focuses on comfort and includes people close to them who are supported into bereavement. Care around dying is a shared social, community and clinical responsibility. We now use the term 'care around dying' instead of 'end of life care' because the older wording causes confusion with palliative care which can be important long before someone is dying.
Compassionate Communities	A broad term that can include a person's own networks of family, friends, neighbours, work colleagues, social or faith/belief groups and others they meet. Some compassionate communities are more organised groups that actively encourage, support and facilitate care for one another, seeing that as everyone's responsibility.
Family, carers and unpaid carers	We mean anyone who is close or important to a person, such as family members, relatives, partners or close friends. We also recognise unpaid carers as individuals (who may or may not be family members) who provide ongoing care and support as part of the person's care team. Unpaid carers are key partners in care and have specific rights under the Carers (Scotland Act 2016) and public services have statutory duties to identify and support them.
Frailty	When a person is living with frailty, their body gradually loses its in-built reserves. This leaves them vulnerable to changes in their health or circumstances and makes it harder to recover from an injury, infection or illness.
Future care planning	Ongoing, shared decision-making that supports people of all ages and their families and carers to manage changes in their life, health and care. Personalised future care plans include what matters to the person and options to guide staff in a health or social care emergency.

Terms Used in National and Tayside Strategies (Cont.)

Term	Definition
Health and Social Care Partnership (HSCP)	HSCPs are partnerships that integrate delegated services provided by Health Boards and Local Authorities/Councils in Scotland. Each partnership is run jointly by the NHS and local authority. HSCPs are directed by their area Integration Joint Boards (see definition below).
Holistic care	Holistic care is person-centred and helps people with managing symptoms, emotional, psychological, social or financial problems, and spiritual wellbeing, regardless of faith or belief.
Integration Joint Board (IJB)	IJBs are a type of Integration Authority and are responsible for planning and commissioning health and social care services for the people living in their areas.
Life-shortening condition	Illnesses or health conditions where health will deteriorate over time and the person will eventually die with these conditions.
Long term conditions	Long term conditions (sometimes referred to as chronic diseases) last a year or longer, may limit what a person can do, and require ongoing medical care. Some long-term conditions become life shortening conditions that cause or contribute to a person's death. These include heart, lung, kidney or liver conditions, neurological conditions, blood vessel (vascular) diseases including stroke, and some types of cancer.
Multidisciplinary team	Groups of health and/or social care staff from different professions or backgrounds who work together to provide care and support for people of all ages, their families and carers.
Realistic Medicine	Realistic Medicine means decisions about a person's care are made jointly between the individual and their care team. It is kind and careful care that delivers better outcomes and experiences for people, supports healthier lives, reduces unnecessary treatments, adverse events and hospitalisations, and uses available resources sustainably.
Specialist Palliative Care Unit	A specialist palliative care unit provides inpatient care from palliative care specialists. This can be in a separate building or be specialist beds within a hospital ward. Sometimes called a 'hospice', it can be run by the NHS or an independent hospice[1] service *1. An independent hospice is a registered charity regulated by Healthcare Improvement Scotland that operates through a combination of charitable and NHS funding to provide specialist palliative care services*

3. Common misunderstandings about palliative and care around dying: what they really mean today

"Palliative care is only for when you are dying."
Palliative care is about living well, not just about dying. It can support people for months or even years, alongside treatment for their illness, helping them manage symptoms, maintain independence, and focus on what matters most to them.

"Palliative care means giving up."
Palliative care is about living with quality, purpose and control. It helps people make informed choices, maintain dignity and stay connected to the people and activities that matter to them. It complements other treatments, not replaces them.

"Palliative care only happens in hospices."
Most palliative care happens in homes, communities, care homes, hospitals and in GP practices, supported by families, neighbours and professionals working together. It includes specialist palliative care services but is not only about specialist palliative care services. It is part of everyday health and social care.

"Talking about care around dying will somehow bring it closer."
Open conversations reduce fear, strengthen relationships, and help people receive the care they want. Talking about death and dying is an important part of living well. Discussing what matters won't change the timing of death and does not impair hope but may provide opportunities to change the experience for the better.

"Care around dying is the same as palliative care."
Palliative care is for anyone with a life shortening condition. It can support people from diagnosis, throughout treatment, during recovery, through to survivorship or when they are dying. **'Care around dying'** describes the holistic care provided in the last hours, days and weeks of life. Care focuses on comfort, dignity and support for the person and those close to them, continuing into bereavement. We use 'care around dying' instead of 'end of life care' to avoid confusion with palliative care, which can be needed much earlier.

"Palliative care is only for people with cancer."

Palliative care may be for people who have cancer, but it is not only for people with cancer. It supports anyone living with a life-shortening condition, including organ failure like heart, lung, kidney or liver disease, dementia, frailty, neurological conditions and many others. It focuses on quality of life no matter what illness a person has.

"Hospices are for when you are dying."

Hospices are Specialist Palliative Care Inpatient Units. They may be run by the NHS or by charities. They support people with life-shortening conditions by helping manage symptoms, offering treatments, and providing care around dying.

People are admitted to a hospice not only when they are dying, but also to help manage difficult symptoms or to support them to return home from another care setting.

"A syringe pump means someone is dying."

A syringe pump (previously known as a syringe driver) can used in palliative care at any stage of a person's illness. It delivers medicines at a fixed rate over a 24-hour period through a fine tube placed under the skin.

These medicines can help symptoms such as pain, nausea and/ or vomiting, breathlessness, anxiety, excess secretions, or other symptoms.

A syringe pump is used whenever this is the best way to give medicines, for example if tablets are not suitable or cannot be swallowed. A syringe pump is not only used when someone is dying, it can be a temporary solution until someone is able to swallow medicines again.

"Palliative care is only the responsibility of specialists."

Palliative care is a shared responsibility delivered by communities, families, health and social care teams, and specialist services working together. It succeeds when the whole system works as one.

4. Introduction

Experiences of illness, caring, dying, death, loss and bereavement affect every one of us. The quality of care and support provided around dying and bereavement has a profound and lasting impact. We know there is only one opportunity to get it right.

Increasing numbers of people are living for many years with life shortening conditions, and more children with complex conditions are living into adulthood. These changing demographics place growing and sustained demands for care and support on individuals, families, communities, and services.

We recognise that many people receiving palliative care are part of families that include children and young people. It is important that support for individuals and families considers the needs of children, including working collaboratively with education services and children's services where appropriate. This helps ensure children receive age-appropriate information, emotional support and continuity, particularly as a person's condition progresses.

The national strategy recognises Scotland's ageing population, increasing numbers of people living with multiple long-term conditions, and the need for public services that are sustainable, preventative and able to deliver effective support within communities now and in the future.

It calls for better integration across hospital, community and specialist services, improved public understanding of life shortening conditions, death and bereavement, and stronger community-led networks to support open conversations and compassionate responses.

These national commitments set the context for Tayside's local strategy, ensuring that our approach aligns with Scotland's ambition for equitable, high quality, coordinated palliative care for people of all ages.

5. Local Context and Challenges

Local Context

Palliative care and care around dying are both social and clinical experiences. While professionally led services provide essential expertise, coordination and safety, people's experiences of illness, dying and bereavement are shaped just as strongly by families, relationships, culture and community life. This strategy therefore recognises palliative care as a shared responsibility across health and social care services, the third sector, communities and people, reflecting a public-health, assets-based approach.

Palliative care in Tayside is delivered through a strong whole-system, multi-disciplinary and multi-agency model, underpinned by a holistic commitment to person-centred support. The system integrates a broad community network of primary care, health and social care services, hospital care, ambulance services, out-of-hours provision, care homes, social care teams, equipment services, and both adult and paediatric specialist palliative care.

This includes a significant contribution from the independent sector, who provide a wide range of care across Tayside, including care at home, community-based services, and care home provision. Independent providers are key partners in delivering both general palliative care and care around dying, particularly within nursing and residential care settings, and play a vital role in supporting people to remain in their communities.

In addition, social care services and care home provision represent a significant strength within the Tayside system and play a central role in the delivery of both general palliative care and care around dying. Across Tayside, care home teams, home care services and wider social care providers support a large proportion of people living with life-shortening conditions, often over extended periods and into the final weeks and days of life. These services provide continuity of care, person-centred support and oversight of daily needs, while working closely alongside families, unpaid carers and health professionals. Their contribution is essential to enabling people to remain in their own homes or homely settings, supporting future care planning, and ensuring coordinated, compassionate care across the whole system.

Within this system, general and specialist palliative care work closely together to provide seamless support. Palliative care is delivered in a variety of care settings by non-palliative care specialist professionals. When needs become more complex specialist teams offer expert assessment, treatment, collaboration, direct care and advice. By working in partnership and through shared learning, people receive the right level of care at the right time, wherever they are cared for.

General Palliative Care

General palliative care in Tayside is delivered across many care settings, such as in a person's own home, a care home, an acute or community hospital. It is provided by a wide range of health and social care professionals, (such as General Practice, community nursing teams, social care, care home teams, improving cancer journey and many more) who support people with life-shortening conditions as part of normal health and social care. They play a central role in the following:

- Identifying and managing symptoms, with regular review of needs
- Supporting future care planning and shared decision-making
- Coordinating care across teams, services and families
- Communicating clearly about what matters to the person
- Providing emotional, practical and information support to individuals, families and unpaid carers, including recognition of carers' own needs
- Enabling people to remain at home where appropriate, with crisis response and reablement when needed
- Avoiding unnecessary or unwanted hospital admissions
- Identifying when inpatient care is needed and beneficial
- Maintaining continuity and personalisation of care across all settings
- Facilitating safe, timely, coordinated discharge home or to community services.

Specialist Palliative Care

Specialist palliative care is provided by NHS or Independent Specialist Palliative Services through multidisciplinary teams with specialist expertise in palliative care, in some settings supported by trained volunteers. It is available to people of all ages, wherever they live or receive care, and is particularly important when needs are more complex or harder to manage. Specialist teams work alongside generalist services, offering direct care, expert advice, support and education to enable high-quality palliative care across all settings.

In Tayside, adult specialist palliative care is delivered across community, hospital and inpatient settings. Services include symptom control clinics, Macmillan Nursing support and day services in each locality. It is provided by an NHS Service, managed through Dundee Health and Socal Care Partnership on behalf Angus, Perth & Kinross Partnerships and NHS Tayside. Inpatient care is provided within Specialist Palliative Care Units within Roxburghe House in Dundee (serving Dundee and Angus) and Cornhill Macmillan Centre in Perth and Kinross, with additional teams based in Perth Royal Infirmary and Ninewells Hospital, including three Acute Palliative Care beds at Ninewells Hospital.

Children's specialist palliative care services are provided in Partnership between NHS Tayside, Children's Hospices Across Scotland (CHAS)

Specialist palliative care includes:

- Managing complex symptoms and clinical situations
- Providing coordinated multidisciplinary assessment, treatment and therapeutic support
- Offering specialist advice and guidance to generalist teams across all care settings
- Delivering inpatient, outpatient, hospital and community-based specialist care
- Providing specialist input to care around dying, including complex physical, psychological, social and spiritual needs
- Supporting families and carers through difficult decision-making, complex care planning and bereavement
- Facilitating seamless transitions between hospital, specialist palliative care units, home and community services
- Providing access to specialist expertise across Tayside, including out-of-hours advice and support.

Third Sector and Partners

Third sector organisations are central to the delivery of palliative care in Tayside, contributing a diverse range of specialist services, community-based support and advocacy. National, regional and local partners work alongside health and social care services to enhance care across all settings, supporting individuals, families and unpaid carers throughout life-shortening illness, dying and bereavement.

These partnerships enable a more responsive, person-centred system of care, combining professional expertise with community networks and local knowledge.

Bereavement and community organisations provide essential emotional support, information and guidance, helping people navigate some of the most difficult stages of life.

As our system develops, we will continue to build and strengthen partnerships across the third sector to ensure support remains inclusive, accessible and responsive to changing needs.

Challenges

Tayside, like the rest of Scotland, is experiencing significant pressures that mean we must collaborate and develop new ways of working. To keep our services strong for the future and respond to people's changing needs, several system-wide challenges must be addressed.

- **Build Proactive Care where possible:** Timely access to palliative care is invaluable to maximise all benefits. Where possible, there is a need to move towards a preventative, proactive model of care that identifies and addresses palliative care needs earlier, delivering the right care, at the right time, in the right place with the right people. This means challenging the myth that palliative care is only for when someone is dying. These principles also apply when reactive care is required, to ensure the right experience and outcome.

- **Aging population:** Tayside's population of around 417,650 is growing and aging, increasing demand for palliative care. With 21.3% of people now of pensionable age and a projected 24% rise in people aged 75+ by 2028, more people are living longer with frailty, dementia and multiple long-term conditions. This trend is particularly evident in rural Angus and Perth & Kinross, placing additional pressure on community-based services and reinforcing the need for a proactive, integrated palliative care system across all settings.

- **Vulnerable and hard to reach groups:** Our strategy recognises that some people face greater barriers to accessing palliative care, and we are committed to reducing these inequalities. This includes people experiencing homelessness, substance use, social isolation or involvement with the justice system (including prison), as well as people from ethnic minority communities, LGBTQ+ individuals, and those who are neurodivergent. Neurodivergent individuals (including those with autism, ADHD and learning disabilities) may experience additional barriers related to communication, sensory environments and navigating services, requiring flexible and personalised approaches.

  We aim to deliver an equitable system of care that respects different lived experiences, cultures and identities, so that palliative care is accessible and responsive to everyone, regardless of background, location or socio-economic circumstances.

- **Shifting the Balance of Care:** We aim to ensure people receive care in the right place, at the right time, based on their needs and preferences supported by professional judgement. For many people, this will involve care at home, while for others hospital or specialist palliative care unit support may be more appropriate at certain points. Supporting people to move between settings, including timely discharge where appropriate, is an established and essential part of care.

  General practice, community nursing and out-of-hours services already play a central role in coordinating and delivering palliative care in the community. This strategy builds on existing practice by strengthening shared decision-making, communication and close working between generalist and specialist teams, so care remains safe, coordinated and responsive as needs change.

  Delivering this approach relies on services working together and making the best use of available resources across the whole system. Continued collaboration between health, social care, voluntary and community partners support sustainable care that reflects both people's needs and the realities of service delivery.

- **Mental Health and Wellbeing:** Palliative care in Tayside is rooted in the four-domain model; physical, psychological, social, and spiritual care. This recognises that serious, life-shortening illness affects every aspect of a person's life and identity. Mental health and emotional wellbeing are therefore integral to palliative care, ensuring support for not only physical needs but also the emotional, relational, and spiritual impact on the person and those close to them.

  We also acknowledge the emotional demands on staff. Regular exposure to suffering and complex decision making can lead to moral distress and moral injury. Supporting staff wellbeing through reflective practice, team support, and psychologically safe environments is essential to sustaining compassionate, high-quality care.

- **Geographical Equity:** Tayside's geography includes urban centres and remote and rural communities. Our aim is to ensure equity so that everyone, regardless of where they live, can access the right care in the right way. This means finding local solutions, so that location never determines the quality of support a person receives.

6. The Landscape of Need: Illness and Experience in Tayside

To plan sustainable services, we need a clear understanding of the disease burden and demographic pressures unique to Tayside. Our approach takes a whole-life perspective, recognising that palliative care needs can begin before birth, including in situations of stillbirth or life-limiting conditions identified in pregnancy, and extend through childhood, adulthood and into old age.

We share a commitment to providing care and support sensitively and collaboratively, ensuring that every family, at any stage of life, receives compassionate, appropriate and well-coordinated support.

6.1 Prevalence of Illness and Clinical Need:

While certain cancers remain life-shortening illnesses and may require both general and specialist palliative care input, the prevalence of non-cancer conditions along with multi-morbidity (more than one illness) is rising.

- **Cancer:** The most prevalent cancers in Tayside are breast, lung, bowel and prostate cancers. Late-stage diagnoses are more prevalent in those who live in the most deprived areas, particularly for lung and colorectal cancers. Palliative care plays an essential role in managing complex symptoms, supporting decision-making and coordinating care, particularly for people with advanced cancer.
- **Multi-morbidity and Long-Term Conditions:** Around 30% of adults live with one or more long-term conditions, with the prevalence of heart failure, Chronic Obstructive Pulmonary Disease and dementia increasing locally. These conditions often involve unpredictable "dips" in health, requiring a more flexible approach. Palliative care is important for improving a person's quality of life by managing symptoms and other issues that can arise during periods of instability.
- **Frailty:** Around 10% of people aged 65+ and 25–50% of those aged 85+ are living with frailty. The level of frailty, whether temporary or more sustained, guides decisions about treatment, recovery and quality of life. Both specialist frailty services and palliative care teams play an important role in supporting resilience, strengthening future care planning and ensuring care and treatments align with what matters most to each person.
- **Children and Young People:** An estimated 450–500 children and young people aged 0–25 in Tayside are living with life shortening conditions. These numbers are likely to rise as advances in neonatal and medical care enable more children with complex conditions to survive into childhood and early adulthood. Children's palliative care is highly specialised and often complex, involving a coordinated network of professionals who support families throughout their journey, including the important transition from paediatric to adult services.

6.2 Specialist Palliative Care Service Activity Trends (2019–2025):

The following summarises trends in Specialist Palliative Care for adults activity across Tayside from 2019 to 2025. This data reflects changes in demand across community, hospital and inpatient Specialist Palliative Care services, illustrating the increasing role and complexity of specialist teams.

In line with increasing need for general palliative care, need for Specialist Palliative Care services has also increased across Tayside:

- Total activity (excluding Dundee community where data was not available) increased by **16%**
- Community activity increased in Perth & Kinross by **31%**, with activity in Angus remaining stable
- Hospital palliative care team activity increased by **13%** (Ninewells) and **11%** (Perth Royal Infirmary)
- Inpatient admissions increased significantly:
    - Roxburghe House: **+32%**
    - Cornhill Macmillan Centre: **+25%**

Overall, these trends point to rising demand and increasing complexity across both community and specialist palliative care settings.

These figures should contain some variation in data completeness across systems, particularly in community data, where activity may be underestimated.

7. Understanding Where People Receive Care Around Dying

People's experiences in the final hours, days and weeks of life are shaped by many factors including their illness, the treatments available, their preferences, the needs of those close to them and the realities of care. Prior to these last weeks of life, most people spend this time at home or in their community, but the final phase of life can be unpredictable. Treatments may or may not work, needs can change quickly and families may feel differently about what feels most safe or comfortable. Our aim is to understand these patterns, support people's preferences where possible and ensure compassionate, coordinated and responsive care in any setting.

Time spent in the community: Looking wider at the last 6 months of life, people who die of expected causes in Tayside spend most of their final months in a community setting. In 2024/25, around 90.8% of the last six months of life was spent outside hospital, with an average of 16.5 days spent in hospital. Reasons for hospital stays during this period are varied, including assessment, treatment, changes in a person's condition or practical arrangements needed before returning home.

Illness can be unpredictable, and appropriate treatments may not always work as expected. As a person's condition changes, their needs may also rapidly evolve and therefore, hospital care may be necessary and appropriate, even when strong community support is in place.

Place of Death: In 2024/25, in Tayside, (excluding traumatic/ external causes):

- 30.1% of deaths occurred at home (1,461 people)
- 21.8% occurred in care homes (1,058 people)
- 31.3% occurred in acute hospitals (1,521 people)
- 6.8% occurred in non-acute/community hospitals (330 people)
- 9.6% occurred in Specialist Palliative Care Units (467 people)

This equates approximately to:

- 1 in 3 deaths occurring in hospital
- 1 in 3 deaths at home
- 1 in 5 deaths in care homes
- 1 in 10 deaths in Specialist Palliative Care Unit settings
- 1 in 20 deaths in community hospitals

These patterns reinforce that care around dying is delivered across the whole system, with the highest demand in home and acute hospital settings, alongside a significant and sustained contribution from care homes and specialist palliative care services.

This distribution highlights the need for a coordinated whole-system response to care around dying, ensuring the right care, in the right place, at the right time across all settings.

Care homes: are a primary setting for delivery of palliative care in Tayside. They support around one in five deaths and care for many people living with frailty and complex needs. This strategy recognises care homes as key clinical partners in providing high-quality palliative care and care around dying.

Specialist Palliative Care Units: Around 1 in 10 expected deaths occur within Specialist Palliative Care Units, delivered by relatively small specialist teams across a limited number of facilities. This concentration of care highlights both the critical role of specialist services and the importance of supporting staff who provide high-intensity care around dying.

Care Around Dying: In last hours, days and weeks of life people's needs and preferences can change significantly and are not always predictable. Some people wish to remain at home, supported by family and community teams, while others may feel more comfortable in hospital or specialist palliative care settings as their condition changes. What matters most is that people and those close to them feel supported, informed, have symptoms managed and they feel confident about the care available to them.

We also recognise the importance of coordinated, integrated and collaborative care around dying in the community, and that achieving a safe, supported and comfortable death at home may be influenced by the availability and configuration of care. Across Tayside and nationally, there is a significant amount of 24/7 care delivered by community and social care services. However, challenges remain in supporting people who require sustained 24-hour support to remain in their own home, particularly where overnight or continuous presence is required.

In practice, this may result in care being delivered through responsive visit-based models in people's homes, or through alternative settings such as care homes when this better meets the level of need. These pressures are felt locally, and many families and unpaid carers continue to provide significant caring responsibility during the final phase of life.

Within this context, the greatest opportunity to support people's wishes lies in ensuring:

- **timely recognition** that someone is entering the last days or weeks of life
- **clear, honest communication and shared decision-making** between professionals, individuals and families
- **responsive community support**, even if services vary locally
- **coordinated care** that is present when needed and unobtrusive when not
- **alternatives** where care at home is not possible to achieve

Our goal is to help people remain at home in their final days if that is their preference and if it can be supported safely. Equally, we aim to ensure that, regardless of place of care or care setting, a person's final days are met with dignity, comfort and compassionate care.

8. Shared Challenges and Systemic Barriers

Tayside must address the "Right Care, Right Place" goal within a complex political and financial environment.

- **Service Variation and Workforce Fragility:** Access to palliative care is inconsistent across Tayside. Workforce pressures are significant across the whole system, including primary care, secondary care, district nursing, care homes and third-sector partners. With an ageing workforce, we must protect staff wellbeing while innovating to ensure service continuity.
- **The "Knowledge Gap":** Public and professional understanding of palliative care is often focused on "the final days or dying", with less awareness of its role in supporting people to live with life shortening conditions. This misperception can lead to inconsistent Future Care Planning and missed opportunities to benefit from timely palliative care.
- **Inequalities:** Some groups in Tayside face barriers to palliative care. People with mental health conditions, learning disabilities, non-cancer illnesses, homelessness, ethnic minorities, cultural minorities or those in the prison system often have poorer access to support or need support in a culturally sensitive way. Rural communities can experience reduced access to service due to distance, while deprived urban areas face higher rates of premature mortality and multi-morbidity.

9. Using Information and Experiences to Improve Care

We will strengthen our understanding of palliative care need, impact and priorities by bringing together information from National Records of Scotland, Public Health Scotland as well as local insights from relevant services and third sector partners.

By connecting this information with an understanding of peoples lived experience, we can identify local gaps in palliative care provision and delivery and focus resource for improvements where they are needed most. This evidence will support future service planning that establishes palliative care as a priority. Public partnerships will be key to this.

Variability in data sources and system limitations highlight the need to strengthen data quality and integration across community and acute services. Improving data accuracy and consistency will be essential to support planning, evaluation and continuous improvement.

10. The Tayside Partnership Commitment

High-quality palliative care in Tayside relies on strong partnerships. People, families and unpaid carers sit at the centre, supported by National Health Service teams, Local Authorities and Social Care services. Voluntary organisations, faith groups and community networks add specialist skills, emotional support and local connection.

General practice plays a central leadership, coordination and accountability role within Tayside's palliative care system. As providers of longitudinal, relationship-based care, GPs are often best placed to identify palliative care needs early, initiate future care planning, coordinate multidisciplinary input and retain oversight of overall clinical management. This leadership role is exercised in partnership with community nursing, specialist services and wider multi-disciplinary teams, ensuring clarity of responsibility while supporting shared decision-making and team-based care.

Compassionate care grows from the confidence, skills and kindness people show one another through illness, dying and bereavement. This is strengthened by voluntary and charitable organisations, alongside the social and spiritual support offered by community and faith groups.

A well informed and supported workforce is essential. By working closely with staff-side representatives, professional bodies and trade unions, staff voices shape service design and their wellbeing is prioritised.

These partnerships reflect the many ways people support one another in formal care settings and communities. Education and training providers help equip teams, while policy makers and Integration Joint Boards provide strategic direction and financial alignment. Health and Social Care Partnerships lead the local planning, coordination and delivery of services, ensuring these priorities are translated into high-quality care.

The experiences and insights that are shared help us learn together and continually improve. Guided by Professional Associations and Regulatory bodies, this Tayside-wide alliance is committed to breaking down silos, sharing data and pooling resources so every individual receives compassionate, seamless and dignified care.

Partner Group	Role in Palliative and Care Around Dying
Families, Carers and Unpaid Cares	Unpaid carers are central to palliative care and care around dying, providing essential emotional, practical and personal support that enables people to remain at home where possible. We use the term *family, carers and unpaid carers* to reflect the range of important relationships in a person's life; however, unpaid carers are a distinct group. Not all carers are family, and not all family members are carers. Unpaid carers are key partners in care, with specific rights under the Carers (Scotland) Act 2016. Public services have a duty to identify and support them. Access to Adult Carer Support Plans, respite and wider supports helps sustain carers, build confidence and reduce distress, while supporting a compassionate, person-centred approach.
Community Services	These include Community Hospitals, GP practices, District Nursing teams, Care Home Teams and health and social care services working across homes and care settings. Their role is to provide ongoing care, symptom management, and coordination close to where people live. Palliative Care services (for both adults and children) work closely and collaboratively within the community to provide expert advice and direct support for those with the most complex needs, enabling people to remain in their preferred place of care.
Hospital Services	These include acute and specialist inpatient services within Ninewells Hospital and Perth Royal Infirmary, along with paediatric services. Together, they provide 24/7 medical oversight and interventions for those requiring hospital care. Hospital Specialist Palliative Care Teams support the wards and teams in both Ninewells and PRI. Specialist in-patient palliative care beds include the Acute Palliative Care beds in Ninewells Hospital as well as Roxburghe Houe and Cornhill Macmillan Centre Specialist Palliative Care Units which provide consultant-led expertise, specialist inpatient beds, and outreach to the wider hospital wards.
Local Authorities & Social Care	These services are critical for "shifting the balance of care." Angus, Dundee, and Perth & Kinross social work teams, along with commissioned providers and commercial partners, deliver the practical care and support required in people's homes. This includes care homes (both Local Authority and independent), which act as the permanent home and place of care for many. Together, these services provide the essential social, emotional, and physical support that allows people to remain in their community and avoid unnecessary hospital admissions.
24/7 Points of Contact Services	The Scottish Ambulance Service, NHS 24/111, Out-of-Hours services and acute front-door teams (such as Emergency Departments and Assessment Units) all act as vital 24/7 points of contact for people whose condition changes. They provide urgent advice, compassionate assessment, clinical support and safe transfer when needed. Working closely with community teams, hospital services and the specialist palliative care service, they help people remain at home where appropriate and ensure that decisions reflect what matters most to the individual and those close to them.

Partner Group	Role in Palliative and Care Around Dying
Voluntary & Charitable Organisations	Marie Curie, Macmillan, and CHAS provide specialist nursing and financial advice. Locally, Tayside benefits from smaller charities (e.g., bereavement support from the Archie Foundation) that enhance statutory provision.
Communities & Faith Groups	Essential for building "Compassionate Communities." These groups address social isolation and their support embraces all perspectives, whether rooted in faith or a secular belief system, ensuring palliative care is a community responsibility, not just a medical one.
Spiritual Care and Bereavement Services	These services provide essential emotional and existential support, addressing the holistic needs of patients, families and staff across all care settings. By offering a supportive presence regardless of faith or belief, they help individuals navigate complex feelings of loss, meaning and peace during life's final stages. Beyond the point of death, they provide access to coordinated bereavement support for families and carers, including universal, targeted and specialist provision delivered through NHS services, commissioned providers, third-sector and community organisations. This support is aligned to national guidance and local pathways, ensuring people can access appropriate help based on their needs, rather than a single provider. These services also play a key role in workforce wellbeing by facilitating reflective spaces and pastoral support for staff, helping to ensure that compassionate care across Tayside is culturally respectful, emotionally sustainable and responsive to the needs of both communities and the workforce.
Education & Training Providers	Includes the Universities of Dundee and Abertay, alongside clinical leads from across our palliative care system workforce. They are vital for the "Workforce Evolution" challenge, ensuring both specialists and generalists have the skills to provide palliative care and care around dying. Palliative Care Specialists across all professions within the Specialist Multi-disciplinary Team deliver education across undergraduate curricula and as an integral part of postgraduate training. This is through clinical placements, representation in examinations, formal education sessions, informal teaching and a variety of other educational opportunities.
Policy Makers & IJBs	The three Tayside Integration Joint Boards act as the commissioners. They are responsible for the strategic oversight of sustainability and delivery of a balanced budget, ensuring that services are designed for future need while remaining responsive to today's challenges.
Professional & Regulatory Bodies	The Care Inspectorate and Healthcare Improvement Scotland ensure that care across all settings remains safe, equitable and of the highest standard.

11. Our Vision and Aims

Our Vision

Tayside is a place where people of all ages with life shortening conditions live as well as possible, where everyone affected by dying, death and bereavement receive compassionate and effective support, and where communities and services are supported to work together to provide timely care based on what matters to people.

Our Aims

Enable People and Communities

Support people, families, carers and communities to live well, talk openly and support one another through illness, dying and bereavement.

Strengthen Palliative Care

Ensure timely, person-centred palliative care, care around dying and bereavement support for people of all ages.

12. Strategy Development

This strategy was developed in partnership across NHS Tayside, the three Tayside Integration Joint Boards, recognising their strategic role and their interface with national policy and Strategic Planning Groups, Health and Social Care Partnerships, primary care services, specialist palliative care services, paediatric palliative services, spiritual care, social care, care homes, ambulance services, third sector, public partners, education providers, local communities and the Tayside Palliative Care Managed Care Network. We would like to thank everyone who contributed to this.

It is shaped by the experiences of people living with life-shortening conditions, families who have experienced bereavement, local evidence and national guidance.

The strategy will be co-owned by NHS Tayside and the Angus, Dundee, and Perth & Kinross Integration Joint Boards, who are jointly responsible for commissioning and developing services. Implementation and monitoring will be managed through the Tayside Annual Delivery Plan, ensuring alignment with regional health and social care priorities.

13. Outcomes and Actions

The Palliative Care Matters for All (2025–2030) national strategy sets out 8 outcomes. These outcomes provide a consistent standard for what high quality, person centred palliative care and care around dying should look like across Scotland.

In Tayside, we are committed to delivering these national outcomes while recognising the progress already made locally and the specific needs of our population. Some national expectations are already being met in Tayside; therefore, our actions focus on sustaining good practice, addressing areas for improvement, and embedding the national aims in a meaningful and proportionate way.

A robust Equality Impact Assessment process will guide our understanding of impact and inequalities, and our design approach will follow the Scottish Approach to Service Design to ensure outcomes are co-created, inclusive and meaningful.

The sections below explain each national outcome, what we want to achieve, what has already been achieved, and the ambition for Tayside. They also show how this work will be delivered locally, ensuring a clear link between national ambition and local action.

Outcome 1. Supportive Communities

Outcome 2. Adult Palliative Care

Outcome 3. Paediatric Palliative Care

Outcome 4. Future Care Planning

Outcome 5. Care Around Dying

Outcome 6. Education and Learning

Outcome 7. Data and Continuous Improvement

Outcome 8. Governance, Leadership and Partnership

Outcome 1: Supportive Communities

What will we do?

We will strengthen the role of communities in supporting people during life shortening conditions, care around dying and bereavement. This includes working alongside community networks, voluntary organisations, faith and belief groups, carers and neighbours to recognise, support and build on existing community assets.

By strengthening the links between communities and formal services, we will help create compassionate, resilient systems of care across Tayside.

Where are we now?

Established Public Health Palliative Care Initiatives:
Active community-led work is already underway through previous projects like Truacanta, which focus on building compassionate communities, EASE programmes and community groups

New Public Health Palliative Care Initiatives:
Developing bereavement aware communities, starting with the introduction of the Bereavement Charter Mark in primary schools across Tayside, a pilot of one school in each locality is successfully underway with the supportive collaboration between Specialist Palliative Care, the Tayside Palliative Care MCN and the Archie Foundation

Resource Development:
Breathlessness management resources have been co-developed through collaboration between the Respiratory MCN and public engagement.

Education and Awareness:
Public Health palliative care work is currently being mapped, including the increased delivery of EASE (End of Life Aid Skills for Everyone) courses to empower people caring for someone who is dying

Charitable Spotlight:
Partnerships with charitable organisations are already in place but can be built further

How will we do this?

We will adopt a public-health and assets-based approach to palliative care, supporting initiatives that build community confidence, skills and openness around death, dying and bereavement.

1. **Build Understanding and Shared Language.** We will achieve this by:

   - **Normalising Conversations:** Supporting community-led initiatives and public health campaigns to encourage open discussion about future care preferences.
   - **Integrated Workforce Training:** Rolling out shared learning frameworks and specific initiatives across health, social care, and the Third Sector to ensure a consistent, confident approach to sensitive conversations.
   - **Accessible Information:** Developing clear, jargon-free resources in multiple formats to help patients and families navigate the care system and understand the support available to them.
   - **Policy Alignment:** Championing palliative care and care around dying awareness into local authority and corporate workplace policies, recognising bereavement and caregiving as significant life events that require compassionate organisational responses.

3. Expand Accessible Information and Community Resources: We will grow community information resources and signpost clearly to trusted national and local supports (e.g. NHS Inform, Good Life Good Death Good Grief, Palliative Care MCN, HSCPs).

4. Strengthen Community Capacity and Support Networks: We will enhance carer support, peer groups, volunteer programmes and charitable partnerships, while supporting community-led projects such as EASE courses, introducing the Bereavement Charter Mark in schools, and conversation initiatives.

5. Embed Compassionate Practice Across Local Systems: We will promote the Bereavement Charter, support schools and community organisations to adopt bereavement-informed approaches, working closely with partners.

Outcome 2: Adult Palliative Care

What will we do?

We will ensure adults with life-shortening conditions are identified early and have equitable, timely access to the right care at the right time, in the right place by the right people for the right experience and right outcome.

Where are we now?

Strong foundations: Tayside has well-established clinical collaboration across general and specialist services, supported by the Tayside Palliative Care Network.

Integrated supportive care models: Consultant-led palliative input is embedded within renal and interstitial lung disease services, improving patient outcomes and experience. Similar approaches are being explored for vascular disease, cancer and neurological conditions.

Unscheduled care: Partnership working with the Scottish Ambulance Service supports people at home, enabling appropriate care or admission with direct access to specialist advice.

Workforce development: Palliative care education is delivered across undergraduate and postgraduate levels, with shared learning strengthening generalist and specialist practice.

Community specialist services: Specialist community teams work across settings (home, clinics, hospital, day care and inpatient services), supporting non-specialists and managing complex cases.

Earlier identification: Work is underway to embed consistent use of tools such as SPICT and the Spectrum of Palliative Care, supported by holistic assessment tools to enable person-centred care.

Co-ordinated leadership: Dundee IJB is the lead partner for Specialist Palliative Care Services, supporting a consistent regional approach.

Care homes: The Spectrum of Palliative Care is being rolled out across care homes, alongside improvements in nutrition and anticipatory prescribing to support care in the last days of life.

How will we do this?

1. Earlier identification and anticipatory planning
We will strengthen early recognition of palliative care needs and ensure this leads to timely action, improving quality of life, supporting choice and reducing avoidable crisis admissions.

2. Empowered people and families
People will receive timely, clear and compassionate information to support informed decisions about their care, enabling them to live and die well in their community.

3. Strong generalist care with specialist support
We will continue to build confidence and capability within generalist teams, with clear pathways for timely access to specialist palliative care when needs become complex. This will be underpinned by shared clinical principles and guidance.

4. Care closer to home
We will support people to receive care as close to home as possible, where safe and appropriate, based on what matters most to them, while balancing clinical need and system capacity.

5. Improved transitions and communication
We will strengthen continuity across in-hours and out-of-hours care through better information sharing, accessible care plans and clear clinical leadership, ensuring care remains aligned with patient preferences during times of crisis.

Outcome 3: Paediatric Palliative Care

What will we do?	We will provide coordinated, age- and stage-appropriate palliative and end-of-life care for children and young people, supporting families to receive care in their preferred place wherever possible. This includes well-planned transitions between settings and into adult services when appropriate.
Where are we now?	**Strategic inclusion:** Paediatric palliative care is now embedded within the Tayside Palliative Care Corporate Objective, ensuring alignment with wider service planning. **Collaborative leadership:** A multi-disciplinary Paediatric Palliative Care Group is established, bringing together clinical, professional and parent perspectives to support service development. **Current provision** • Ward 29 provides inpatient and end-of-life care when needed • Glenlaw House offers high-quality respite care • Specialist nursing support is available across oncology and complex disability services **Partnership working:** Strong links exist with CHAS, the Lothian Paediatric Palliative Care Team and the national advisory service, enabling access to specialist expertise and joint working. **Learning and development:** Ongoing regional and national learning is supporting improved knowledge and practice. **Challenges:** Variation in community capacity and confidence can limit consistency of care and choice around place of care. **Understanding need:** A local database is in development to better understand demand, complexity and gaps, supporting future planning and coordination.
How will we do this?	**1. Improve early recognition and response** We will strengthen awareness and confidence in identifying palliative care needs early, enabling timely, proactive care planning and earlier involvement of key professionals and community services. **2. Strengthen access to specialist expertise** We will promote consistent use of specialist advice, including the national Paediatric Palliative Care Advisory Service, supporting shared decision-making and high-quality care. **3. Develop coordinated transitions** We will implement structured approaches to transitions across hospital, home and community settings, including transition to adult services, ensuring continuity and consistency of care. **4. Enhance family-centred care** We will strengthen partnership working across services, including CHAS, hospital teams and community providers, to deliver coordinated, holistic support, including emotional and bereavement care. **5. Strengthen education and community support** We will work with schools and community partners to improve bereavement-informed practice and support for children and families, building confidence and communication across services.

Outcome 4: Future Care Planning	
What will we do?	Future Care Planning will be a shared, system-wide responsibility. In most cases, plans will be initiated and reviewed by the clinician or team who knows the person best—commonly general practice—triggered by changes in condition, transitions of care or patient preference. People, families and carers will be supported to start or revisit conversations at any stage, reflecting a person-centred, shared decision-making approach (e.g. ReSPECT). Plans will be recorded in shared systems, accessible across all services. Their value will depend on regular review and consistent use to guide real-time care decisions.
Where are we now?	**Established approaches:** ReSPECT and Treatment Escalation Plans (TEPs), supported by the REDMAP framework, are in place to support timely, compassionate, person-centred planning. **Digital sharing:** The Key Information Summary (KIS) is widely used to record and share essential palliative care information, with ongoing work to strengthen use in care homes. **Innovation and improvement:** Research is underway exploring the potential role of AI in enhancing future care planning processes.
How will we do this?	**1. Increase public awareness and engagement** Deliver a Tayside-wide campaign and promote trusted resources to help people understand the value of Future Care Planning. **2. Promote normalising early and ongoing conversations** Encourage discussions to begin early and be revisited regularly as needs and preferences change. **3. Embed Realistic Medicine principles** Promote the use of personalised, clinically informed TEPs aligned with what matters most, avoiding unnecessary or burdensome interventions. **4. Strengthen recording and information sharing** Agree consistent approaches to documentation, including wider use of KIS, to support seamless communication across services. **5. Build workforce confidence and capability** Provide training, tools and support to enable staff to have effective, compassionate conversations with individuals and families.

Outcome 5: Care Around Dying

What will we do?	We will ensure compassionate, coordinated care during the last phase of life, with timely support for families, carers and staff before and after death.
Where are we now?	**National alignment and workforce development:** A Care Around Dying Group is established within the Tayside MCN, aligned to the NES Palliative Care Education Framework and Turas Learn, supporting a skilled and consistent workforce. **Medicines and clinical support:** A Lead Pharmacist and Nurse Consultant are driving improvements in prescribing, supply and administration of medicines, supported by work with HEPMA and pathway development across hospital and community settings. **Supporting policies:** Policies such as Patient and Carer Self-Administration of Subcutaneous Medication enable people to manage symptoms at home, particularly benefiting rural communities. **Bereavement and community approach:** Initial mapping of bereavement support is underway. Programmes such as EASE contribute to a wider public health approach, promoting awareness, conversation and community support around death and dying.
How will we do this?	**1. Develop a whole-system model of care** We will implement a Target Operating Model that ensures seamless, coordinated care across acute, community and specialist services, so care follows the person. **2. Prioritise comfort and goals of care** We will support clear, shared decision-making, enabling a shift toward comfort-focused care and honest, compassionate conversations about dying. **3. Improve access to medicines and equipment** We will strengthen systems for rapid prescribing, supply and administration of medicines, alongside timely access to essential equipment. **4. Support families, carers and staff** We will provide guidance, training and emotional support to those involved before and after death. **5. Strengthen bereavement support** We will expand access to bereavement information, improve signposting and ensure consistent, compassionate support across Tayside.

Outcome 6: Education and Learning	
What will we do?	We will build a skilled, confident, sustainable workforce with equitable access to training, development and wellbeing support.
Where are we now?	• **Tayside Palliative Care Network (MCN) Education Group:** The network already delivers a wide range of co-learning events on dementia, unscheduled care, and non-cancer palliative care. • **Academic Links:** Strong formal ties have been established with the University of Dundee, supporting Master's and PhD level research in palliative care. • **Palliative Care Education and Training (Specialist-Led, System Wide):** The Specialist Palliative Care Service develops, delivers and supports a Tayside-wide palliative care education programme that meets both specialist and general palliative care learning needs. Led by Specialist Palliative Care Practice Educators, this programme is available to all staff and practitioners with a role in palliative care, including NHS staff, social care teams, care homes, voluntary and independent sector practitioners, and community-based roles. Education is delivered through a mix of formal and informal learning, spanning undergraduate, postgraduate and vocational pathways, and is aligned with HSCP workforce development to build confidence, capability and shared understanding across the whole system. A shared learning approach across all we do allows for learning to underpin improvement and ensure expertise from general and specialist palliative care is shared to inform this.
How will we do this?	**1. Strengthen Access to High-Quality Learning Resources.** We will promote the use of the Palliative Care Education Framework 2025 (Turas Learn) and the MCN learning hub. We will signpost staff to trusted free resources such as the Scottish Palliative Care Guidelines and NHS Inform. **2. Embed Palliative Care Education Across All Training Pathways.** Palliative care is already embedded in pre-registration, undergraduate and vocational training. This strategy will strengthen consistency, clarity and quality, ensuring core competencies are clearly defined, proportionate to role and aligned with national education frameworks. This will build confidence, capability and shared understanding from early career stages through to advanced practice. **3. Enhance Local Training and Professional Development.** We will promote and expand local training opportunities across Tayside, supported by the Palliative Care MCN, to ensure a consistent approach to skills development. **4. Support Workforce Wellbeing and Reflective Practice.** We will strengthen wellbeing supports, reflective practice opportunities and responses to moral distress, helping staff feel resilient, valued and supported in emotionally demanding work. **5. Promote Trauma-Informed and Inclusive Practice.** We will promote trauma-informed approaches and ensure staff understand the diverse needs of families and communities, particularly those who may be marginalised or harder to reach.

Outcome 7: Palliative Care Data & Continuous Improvement	
What will we do?	We will use data, feedback and evidence to drive improvement and ensure services reflect population needs and experiences.
Where are we now?	• **Mapping Population Need:** Project support has been recruited specifically to review existing evidence and map data across general and specialist services. • **Baseline Assessments:** Tayside has conducted "Day of Care" audits and is using a Design-Thinking approach to understand service data for adults and children. • **Strategy Response:** The Tayside whole-system response to the national strategy draft was formally commended by the Scottish Government Palliative Care Policy Team.
How will we do this?	**1. Develop a Whole-System Delivery Plan.** We will create a coordinated palliative care delivery plan across NHS Tayside and the HSCPs to guide implementation, improvement and governance. **2. Strengthen Data Infrastructure and Capacity.** We will identify the resource and systems required for high-quality data collection, management and reporting across the whole system. **3. Build Sustainable Population-Level Intelligence.** We will map population need through sustainable dashboards and information systems, enabling equitable planning and resource allocation. **4. Standardise Data and Assessment Tools.** We will agree a core minimum dataset aligned with national requirements and explore development of a comprehensive Palliative and Care Around Dying Assessment. **5. Learn from Experience to Drive Improvement.** We will systematically measure experience, outcomes and feedback, and embed learning from complaints and lived experience, to continually improve services.

Outcome 8: Governance, Leadership & Partnership	
What will we do?	We will strengthen collaborative leadership, accountability and strategic planning for palliative care across Tayside.
Where are we now?	**Corporate priority** Palliative care is established as a Tayside Corporate Objective, with Executive and Non-Executive leadership providing oversight and accountability. **Strategic leadership** The Tayside Together Palliative Care Steering Group (established June 2025) is in place to translate strategy into action across partners. **Governance infrastructure** The MCN provides a strong governance framework, with broad multi-sector representation and clear reporting through Planned Care Integration.
How will we do this?	**1. Executive leadership and national alignment** Maintain clear executive oversight to ensure palliative care remains embedded as core business and aligned with national priorities. **2. Strengthen system-wide leadership** Establish and sustain dedicated palliative care leads across HSCPs, acute services and paediatrics to ensure consistent accountability. **3. Develop robust operational structures** Embed operational groups across HSCPs, NHS Tayside and paediatric services to support delivery and continuous improvement. **4. Strengthen governance framework** Fully embed the Tayside Together governance structure to enable coordinated, system-wide delivery. **5. Enhance partnership working** Strengthen collaboration across health, social care, primary care, care homes, third sector and communities. **6. Co-design with people and communities** Ensure meaningful involvement of people with lived experience, carers and communities in shaping and improving services. **7. Assurance and accountability** Monitor delivery through the Annual Delivery Plan, with formal reporting to NHS Tayside Board and local Integration Joint Boards to ensure transparency and accountability.

14. Delivering the Strategy

This strategy is intended for health and social care professionals, planners, third sector and community partners, while remaining accessible to a wider public audience. To support clarity and shared understanding, language is used consistently across the document, balancing professional terminology with clear and inclusive explanations where appropriate.

Delivering this strategy starts with people, families and unpaid carers, supported by third sector partners, care homes and social care. Success depends on the seamless integration of primary care, ambulance services, specialist palliative care services and inpatient specialist palliative care units across NHS Tayside and the Health and Social Care Partnerships (HSCPs).

Delivery will be supported through a dedicated Palliative Care Delivery Plan. In line with Integration Joint Boards strategic planning approaches, this strategy will not duplicate detailed service-level plans already in place. Instead, it provides overarching strategic direction, with delivery plans and improvement programmes sitting beneath it to drive implementation and monitor progress. These plans will include clear actions, responsibilities, timescales and monitoring arrangements.

Assurance will be provided through established governance routes, including Annual Delivery Plans, Integration Joint Boards and the NHS Tayside Board.

15. Monitoring Progress and Impact

Progress will be reviewed annually ensuring that Tayside remains on track to meet both local needs and national ambitions.

To ensure the highest level of accountability, we are working with a wide range of partners to develop a robust measurement and evaluation framework as a core component of our strategic delivery.

A key part of this framework is making the best use of the Tayside Palliative Care MCN. The MCN brings together local knowledge and service data so that improvements are based on real evidence and responsive to real-time challenges.

The framework will be developed together with a representative group of experts, including colleagues from Public Health Scotland, Healthcare Improvement Scotland and various national networks and collaboratives. By integrating insights from educational institutions and national bodies, we will ensure our measures reflect current best practice in Scotland.

We will measure our success by:

- **Outcome Measures:** Tracking progress against national outcomes, using local service and MCN data to show how Tayside is contributing to Scotland-wide goals.
- **Access and Equity Indicators:** Using population health data to ensure that services are reaching our most deprived and rural communities.
- **Lived Experience:** Prioritising the voices of people, families and carers to measure the quality of care.
- **Workforce Capability and Wellbeing:** Monitoring the health and development of our staff to ensure a sustainable and resilient "whole-system" workforce.

- **Continuous Learning:** Using themes from compliments and complaints to identify issues quickly and improve services.

- **Transparent Governance:** Regular reporting through established governance structures, supported by the MCN, and publishing an annual public summary to support transparency and trust.

16. Conclusion: Our Shared Commitment to Tayside

In Tayside we recognise that palliative care matters to us all. That is why we are committed to working together to strengthen the support available across our communities and services. We know we only get one chance to get this right.

We understand the challenges we face now and, in the future, and we remain both aspirational and realistic in our ambitions. There is work to do. Meeting these challenges will require a societal shift, requiring us to become more open about death and dying and move away from reactive models of care toward proactive, anticipatory support that begins at diagnosis. We will also need to think differently and work differently. It means ensuring that every pound we spend delivers value, so that everyone has access to the right care, at the right time, from the right people, in the right place.

Tayside Together: Palliative Care Matters for All is our unified response. It aligns with Scotland's national vision, but it is rooted in our local strengths.

By recognising palliative care as a key NHS Tayside corporate priority, we are placing it firmly at the centre of our strategic agenda. Our commitment is to build a system that is:

- **Compassionate and Resilient**
- **Equitable and Inclusive**
- **Whole-System Integrated**

By strengthening our professional services and nurturing our community networks, we will ensure that every person in Tayside can face living with a life shortening illness and care around dying with the care and support they deserve.

17. References

Key reference and resources:

1. **Bereavement Charter for Children and Adults in Scotland**
https://scottishcare.org/wp-content/uploads/2024/11/Bereavement-Charter-Guidance-Notes-updated-Nov-23.pdf

2. **Carer Support Needs Assessment Tool (CSNAT) Intervention**
https://csnat.org/

3. **EASE – End of Life Aid Skills for Everyone**
https://www.goodlifedeathgrief.org.uk/plan-illness-ease/

4. **Good Life, Good Death, Good Grief**
https://www.goodlifedeathgrief.org.uk/

5. **Healthcare Improvement Scotland – Ageing & Frailty Standards (2024)** –
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https://www.nhstaysidecdn.scot.nhs.uk/NHSTaysideWeb/idcplg?IdcService=GET_SECURE_FILE&Rendition=web&RevisionSelectionMethod=LatestReleased&noSaveAs=1&dDocName=prod_387557

8. **Palliative Care Learning Hub**
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9. **Palliative Care Matters for All (2025–2030)**
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11. **Palliative Care Strategy - Population Aata and Research: Overview** –
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13. **Scottish Palliative Care Guidelines (Right Decisions)**
https://www.rightdecisions.scot.nhs.uk/scottish-palliative-care-guidelines/

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