Healthcare Improvement Scotland | Inspections and reviews
To drive improvement

Unannounced Inspection Report: Independent Healthcare

Service: The Prince & Princess of Wales Hospice, Glasgow

Service Provider: Prince & Princess of Wales Hospice

6-7 July 2026

NHS SCOTLAND

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1 Progress since our last inspection

What the service had done to meet the recommendation we made at our last inspection on 3-4 May 2022

Recommendation

The service should ensure a process is in place to check mattresses and have designated staff to carry out these checks. This should be part of the service's infection prevention and control audit programme.

Action taken

A regular programme of checking mattresses was now in place. This was included as part of the infection prevention and control audits carried out by the nursing team.

2 A summary of our inspection

Background

Healthcare Improvement Scotland is the regulator of independent healthcare services in Scotland. As a part of this role, we undertake risk-based and intelligence-led inspections of independent healthcare services.

Our focus

The focus of our inspections is to ensure each service is person-centred, safe and well led. We evaluate the service against the National Health Services (Scotland) Act 1978 and regulations or orders made under the Act, its conditions of registration and Healthcare Improvement Scotland's Quality Assurance Framework. We ask questions about the provider's direction, its processes for the implementation and delivery of the service, and its results.

About our inspection

We carried out an unannounced inspection to The Prince & Princess of Wales Hospice on Monday 6 and Tuesday 7 July 2026. We spoke with a number of staff, patients and families during the inspection. We received feedback from 61 staff members through an online survey we had asked the service to issue for us during the inspection.

Based in Glasgow, The Prince & Princess of Wales Hospice is an independent hospital (a hospice providing palliative care/end of life care).

The inspection team was made up of two inspectors.

What we found and inspection grades awarded

For The Prince & Princess of Wales Hospice, the following grades have been applied.

Direction	*How clear is the service's vision and purpose and how supportive is its leadership and culture?*
Summary findings	**Grade awarded**
The hospice's core values were displayed throughout the hospice. An ethical leadership charter helped to provide an open and transparent leadership approach. Strategic plans detailed improvements that had taken place, such as the development of new services, and future planned improvements. Key performance indicators were used to regularly measure performance and improvements implemented in the hospice. The board of trustees met regularly and were clearly involved in all of the hospice's governance groups, as were external advisors.	✓✓✓ Exceptional
Implementation and delivery	*How well does the service engage with its stakeholders and manage/improve its performance?*
Information about the hospice, and relevant external support services, was available for patients and families. A communication strategy demonstrated the importance of feedback from patients, families and staff to help develop and improve the service. Events were held regularly to help improve staff wellbeing. A community development and engagement strategy aimed to empower and support a more informed community about palliative care. Appropriate policies and processes were in place to support staff to deliver safe, compassionate and person-centred care. Patient assessment and consultation was thorough. Staff were appropriately recruited. A proactive approach was in place for managing risk and improving processes. This included a comprehensive audit programme. An extensive maintenance register was in place. Staff were given the opportunity to lead on improvement projects. A large number of volunteers helped support the day-to-day running of the hospice. A volunteer role had been developed to help address isolation and loneliness for patients in the inpatient unit.	✓✓✓ Exceptional

Results	*How well has the service demonstrated that it provides safe, person-centred care?*
Summary findings	**Grade awarded**
The environment was modern and bright, clean and well maintained. Appropriate infection prevention and control processes were in place ensuring a safe environment. Patient care records were completed fully. We saw an ongoing process of open communication between staff and the senior management team. Staff told us they felt valued and supported. Both the single point of access service and the young adult transition service were expanding in patient numbers and staff recruitment to deal with demand. Patients and families spoke highly of their experiences, and felt involved in planning their care.	✓✓✓ Exceptional

Grades may change after this inspection due to other regulatory activity. For example, if we have to take enforcement action to improve the service or if we investigate and agree with a complaint someone makes about the service.

More information about grading can be found on our website at: Guidance for independent healthcare service providers – Healthcare Improvement Scotland

Further information about the Quality Assurance Framework can also be found on our website at: The quality assurance system and framework – Healthcare Improvement Scotland

What action we expect Prince & Princess of Wales Hospice to take after our inspection

The actions that Healthcare Improvement Scotland expects the independent healthcare service to take are called requirements and recommendations.

- **Requirement:** A requirement is a statement which sets out what is required of an independent healthcare provider to comply with the National Health Services (Scotland) Act 1978, regulations or a condition of registration. Where there are breaches of the Act, regulations or conditions, a requirement must be made. Requirements are enforceable.
- **Recommendation:** A recommendation is a statement which sets out what a service should do in order to align with relevant standards and guidance.

This inspection resulted in no requirements and no recommendations.

We would like to thank all staff at The Prince & Princess of Wales Hospice for their assistance during the inspection.

3 What we found during our inspection

Key Focus Area: Direction

Domain 1: Clear vision and purpose	Domain 2: Leadership and culture
How clear is the service's vision and purpose and how supportive is its leadership and culture?	

Our findings

The hospice's core values were displayed throughout the hospice. An ethical leadership charter helped to provide an open and transparent leadership approach. Strategic plans detailed improvements that had taken place, such as the development of new services, and future planned improvements. Key performance indicators were used to regularly measure performance and improvements implemented in the hospice. The board of trustees met regularly and were clearly involved in all of the hospice's governance groups, as were external advisors.

Clear vision and purpose

The hospice provides specialist palliative care and support for people aged 16 years and over living with life-limiting conditions and their families. This was both as an inpatient service as well as supporting people in their homes within the Glasgow and East Renfrewshire area. A wide range of services were provided, including:

- inpatient services
- young adult transition service
- outpatient clinics
- community services
- living well hub
- befriending services
- family support, and
- art services.

The aim of the hospice was to 'achieve the best quality of life possible in whatever time remains for the patient. Where it may not be possible to add days to lives, we aim to add life to days.'

The hospice had identified five core values. These were:

- care and compassion for patients and families
- feeling valued as part of the hospice community
- fairness and integrity
- dignity and respect, and
- striving for excellence.

These core values were displayed throughout the service. This included on digital information screens at reception, noticeboards throughout the building, including in public areas, the website, the desktops on all hospice computers and as part of staff's electronic email signatures.

A number of strategic plans were in place, including:

- a clinical strategic plan
- wellbeing and resilience strategy
- community development and engagement strategy, and
- communication strategy.

The outcomes from the clinical strategic plan from 2023–2025 were available on the website. These included the expansion of the outpatient clinics and the development of a single point of access service. This allowed all new patient referrals to the hospice to be assessed equally through the same process.

The current clinical strategic plan for 2026–2028 was in draft form and referred to the increase in demand for palliative care in the future. The new strategic plan had five main aims, including early identification of people requiring palliative care and ensuring equitable access to the hospice's services.

The hospice had developed a number of key performance indicators. These were in line with the strategic plans and demonstrated an ongoing review of the main strategies. This included a key performance indicator of when all new referrals were reviewed once received, and when all GPs were contacted about the admission, discharge or death of a patient. The key performance indicators were reviewed every 3 months and were included as part of the regular clinical governance committee meetings. The information obtained was reviewed by the clinical team, the senior management team and the board. This information was shared with staff, supporting an open and transparent leadership approach.

- No requirements.
- No recommendations.

Leadership and culture

The hospice staff comprised a range of clinical and non-clinical staff, including:

- medical and nursing staff
- social work
- housekeeping staff
- chaplain
- physiotherapists, and
- volunteers.

Board members and external advisors were actively involved with all governance committees, including the clinical governance committee and medicine management committee. Regular meetings were held for each individual committee and discussions included risk management updates, medicine management updates and workforce development. There were detailed minutes for every meeting and associated actions attached for both meetings. Board members met every 2 months, and minutes and actions were also in place for these meetings.

A daily safety brief was attended by representatives from all departments, and this highlighted any updates and issues in the hospice and wider community. A morning multidisciplinary hospice bed meeting discussed inpatients, community patients and potential patients to be admitted to the hospice, as well as reviewing patient activity for the day. We attended a bed meeting and saw a thorough discussion took place involving all in attendance. Actions identified during both the safety brief and the bed meeting were documented and acted on.

The chief executive officer regularly updated staff on issues that may concern them. For example, recent updates had included the financial situation of the hospice and planned changes in the senior management team due to staff retirement in the next few months.

Appropriate staff had the opportunity to attend a managers training day throughout the year. Topics discussed included 'compassionate leadership'. An 'inspiring leadership' course was available to more senior staff and was run in collaboration with NHS Greater Glasgow and Clyde and other hospices in the Glasgow area.

There was a clear governance structure and defined lines of reporting and accountability. An effective leadership structure was in place through the senior management team who managed the day-to-day running of the hospice. Senior managers were visible every day and carried out daily leadership walkrounds. This involved speaking with staff to understand any pressures or challenges staff were experiencing at that time.

An 'ethical leadership' charter available on the website set out the expectations of all leaders in the organisation. This was with a view to developing a strong, open workplace culture.

All staff we spoke with told us they felt supported in their roles. They felt confident that the management team was visible, approachable, and would listen to and act on their concerns and ideas.

Staff told us through our online survey:

- 'Positive leadership throughout the organisation. We have a CEO who leads by example.'
- 'Senior leadership gives the organisation a clear sense of direction and is committed to providing high quality, compassionate care.'

- No requirements.
- No recommendations.

Key Focus Area: Implementation and delivery

Domain 3: Co-design, co-production	Domain 4: Quality improvement	Domain 5: Planning for quality
How well does the service engage with its stakeholders and manage/improve its performance?		

Our findings

Information about the hospice, and relevant external support services, was available for patients and families. A communication strategy demonstrated the importance of feedback from patients, families and staff to help develop and improve the service. Events were held regularly to help improve staff wellbeing. A community development and engagement strategy aimed to empower and support a more informed community about palliative care. Appropriate policies and processes were in place to support staff to deliver safe, compassionate and person-centred care. Patient assessment and consultation was thorough. Staff were appropriately recruited. A proactive approach was in place for managing risk and improving processes. This included a comprehensive audit programme. An extensive maintenance register was in place. Staff were given the opportunity to lead on improvement projects. A large number of volunteers helped support the day-to-day running of the hospice. A volunteer role had been developed to help address isolation and loneliness for patients in the inpatient unit.

Co-design, co-production *(patients, staff and stakeholder engagement)*

The hospice's website provided detailed information on the services available. A wide range of information leaflets was also available throughout the hospice. Along with information about the hospice services, links were provided to external services within the Glasgow area, for example links to carer support and who to contact if concerned about a vulnerable adult. Patient and family experiences could be read on the hospice website.

A communication strategy highlighted internal and external methods of keeping in touch with patients, families and staff. For example, an electronic weekly newsletter was sent to all staff and volunteers, and digital information screens were used throughout the hospice to provide information about the services available. This included information about a nursing development programme and the development of an inpatient volunteer companion role with the aim of reducing isolation and loneliness to those in the inpatient unit. Feedback from patients and families was communicated through a 'you said, we did' process which could be found on the digital information screens and on general

noticeboards. Suggestions and complaints forms were available throughout the hospice and these could be posted anonymously into dedicated suggestions boxes.

Patients and families had the opportunity to complete a 'current care' feedback form while they were using the hospice services. A 'post service survey' form was sent out to families and carers 6 weeks following the death of their loved one giving them an opportunity to feedback about their experience. The information received from patients, families and staff was regularly reviewed and themes were developed. These were presented at board meetings, senior management meetings and staff forums.

A community development and engagement strategy aimed to develop a more supportive and informed community in relation to death, dying and loss. The strategy included introducing people in the community to hospice services, empowering people to address the subject of death, and directing families and carers to suitable community resources. An 'end of life aid skills for everyone' course (EASE) had been developed in collaboration with the Scottish Partnership for Palliative Care. This short educational course was available to the public to help build confidence and skills in relation to death and dying.

The hospice had regular contacts with a wide number of external partners and groups, including:

- The Health and Social Care Alliance Scotland group - providing support to practitioners in the south of Glasgow with the issues of death, dying and loss.
- Glendale Woman's cafe - a series of workshops for women with south Asian backgrounds exploring the issues of death, dying and loss.

Community development action plans were in place demonstrating involvement with external partners, for example GPs, district nurses and spiritual leads in Glasgow.

Feedback raised from patients, families, staff and external partners was compiled and formed part of the service's quality improvement plan. Examples of improvements made as part of feedback included communication skills training for staff and an opportunity for people to meet every week in the social areas in the inpatient unit for tea and cake.

A staff wellbeing and resilience strategy had been developed. This aimed to support staff to stay well and healthy in work. The strategy was communicated through staff forums and senior management teams. A wide range of staff

activities was available, recognising that staff may need support in the workplace. A ‘fun Friday’ event was often held that involved complimentary therapies, and buffet treats for staff. Staff health and wellbeing were supported throughout the hospice.

Staff had access to supervision, helping to provide them with an opportunity for reflection and development, and to help ensure consistent practice. The lead for collaborative training and education held a monthly ‘sharing circle’ for staff to attend and be able to discuss anything they felt they needed support with.

Regular staff forums were held where staff had the opportunity to put forward improvement ideas for the hospice, giving them a voice in the running of the service. For example, a member of the senior nursing team had recently developed a check-in/check-out process for nursing staff working in the inpatient service. This gave staff an opportunity to voice how they were feeling at the beginning and then again at the end of a shift. Processes were also in place for staff to speak on a one-to-one basis with a senior member of staff if necessary.

Various staff rewards were available, particularly focusing on thanking staff as a group rather than individuals. However, staff birthdays were celebrated, and staff received shopping vouchers at Christmas. At 5 years’ service, staff received 2 additional days annual leave, and at 25 years’ service they would be offered lunch with the chief executive officer or vouchers.

Staff completed a staff survey every year. The results of the 2025 survey showed that over 97% of staff enjoyed their job in the hospice. An overview of the staff survey results was available on the website.

Staff who completed our online survey told us:

- ‘There are opportunities to bring things of note or requiring change or improvement through the staff forum and our weekly staff meetings.’
- ‘It is a welcoming organisation where people genuinely care about both patients and each other.’
- ‘We deliver a very high-quality patient-centred service which focuses significantly on the living well and befriending aspect of hospice and palliative care.’
- ‘The standard and practice of care within the organisation is outstanding.’

    - No requirements.
    - No recommendations.

Quality improvement

We saw that the hospice clearly displayed its Healthcare Improvement Scotland registration certificate and was providing care in line with its agreed conditions of registration.

The hospice fully understood Healthcare Improvement Scotland's notification process and the need to inform Healthcare Improvement Scotland of certain events or incidents occurring in the service.

The hospice had a wide range of up-to-date policies and standard operating procedures which staff could access through the staff intranet. These included policies for:

- access referrals and admission
- infection prevention and control
- medicine management
- health and safety
- whistleblowing (detailing how staff could raise concerns about patient safety and/or practice in the service), and
- duty of candour.

A clear process of recording and investigating incidents and accidents was in place. The incident would first be recorded on paper and then transferred onto an electronic tracker system where a checklist was completed. This detailed the necessary steps involved in the specific incident, for example duty of candour or reporting to Healthcare Improvement Scotland. Each incident was fully investigated, and all incidents were reported at the clinical governance meetings. Any improvements implemented formed part of the service's quality improvement plan. Lessons learned and improvements were shared with staff at the regular staff forums.

Information about how to make a complaint was easily accessible in the service and on the website. This information included options to make a complaint either by email or telephone, and provided information and contact details for Healthcare Improvement Scotland as an alternative route to complain. A review of complaints received in the last 2 years carried out by the hospice showed a thorough process of investigation and learning outcomes. We were told that this same process of investigation and communication was also often carried out if negative feedback, but no formal complaint, was received from patients and families. The learning outcomes of complaint investigations were raised at all levels including at board meetings and staff forums.

A duty of candour policy was in place. Duty of candour is where healthcare organisations have a professional responsibility to be open and honest with patients when something goes wrong. The hospice's annual duty of candour report was published on the website. Clinical staff had been trained in duty of candour.

Effective processes and procedures ensured the environment was safe with appropriate infection prevention and control processes in place. These were carried out in line with the hospice's infection prevention and control policy. This policy took account of national infection prevention and control guidance, and described the precautions in place to prevent patient and staff from being harmed by avoidable infections. These precautions included hand hygiene practice, the use of personal protective equipment (such as disposable aprons, gloves and face masks), and the management of laundry, sharps and clinical waste.

We noted that the medicine management policy was in the process of being reviewed. NHS Greater Glasgow and Clyde's pharmacy team supported the hospice with ordering and storing medicines.

The pharmacy team carried out regular audits on:

- medicine management
- prescription practices, and
- the storage and disposal of medicines.

The pharmacy team was also involved in staff induction and in training clinical staff in medicine management, including single-nurse drug administration. Nursing staff trained in this can administer some medicines (which normally require two members of staff) on their own. We saw clinical staff completed medicine management-based training every year as part of their mandatory training requirements. The hospice was part of a wider hospice medicine management group involving other hospices in the Glasgow area. These were educational sessions, and included reviewing policies and guidelines to ensure consistency across services. These meetings took place every 3 months. Staff told us that these were positive training sessions.

Patient care records were stored electronically (on a password-protected secure system) and some paper chart documents were kept in folders at the bedside. This new electronic record keeping system had been introduced into the hospice this year and was in line with those used at other hospices in the Glasgow area. Electronic patient care records allowed sharing of, and easy access to, other community and hospital admission information about the

hospice's patients. The hospice was registered with the Information Commissioner's office (an independent authority for data protection and privacy rights) to make sure confidential information was managed safely.

We saw evidence that patients and families were involved in care planning. Care plans were in place within 24 hours of admission and reviewed at least once a week, including:

- what was important to the patient
- oral and nutritional assessment
- pain assessment
- pressure area (skin) assessment
- risk of falls, and
- any spiritual requirements.

The hospice took part in benchmarking (comparing) its incidence of falls, pressure ulcers and controlled drug medicine incidents (medications that require to be controlled more strictly, such as some types of painkillers) with Hospice UK. This is a national charity that supports organisations that provide palliative and end-of-life care. This information was compared to other similarly sized services throughout the UK and provided learning opportunities for staff.

A staff recruitment process was in place. Designated human resource staff were responsible for all recruitment support. Appropriate background checks were obtained for staff, including:

- Disclosure Scotland Protecting Vulnerable Groups (PVG) updates
- identification checks
- evidence of qualifications
- immunisations, and
- two references.

Practicing privileges is where staff are not employed directly by the provider but are given permission to work in the service. Some staff were employed by an NHS board but worked in the hospice under a practicing privileges contract. We saw a thorough process in place to carry out appropriate checks for these members of staff. Senior hospice staff had a good relationship with NHS human resource teams, ensuring regular communication between the organisations.

The hospice's lead for collaborative training and education supported staff to develop in the hospice. We saw evidence of training and further learning for different levels of staff development. They also provided training to staff external to the hospice to help grow the knowledge base around palliative care in the wider community and worked closely with other hospices across Scotland to share knowledge. Some examples of this included:

- advanced training for staff in how to communicate with patients and families
- an online course about caring for people with dementia in care homes, and
- palliative care update days with the other hospices in the Glasgow area.

A programme of mandatory training was available through an NHS online education system, with a mix of online and face-to-face training provided. This including training on:

- infection prevention and control
- manual handling
- basic life support, and
- public protection and safeguarding.

Managers were supported to oversee the training compliance of their teams. We saw evidence of high compliance rates across both clinical and non-clinical areas.

All staff completed an induction process and received a staff handbook. A yearly appraisal process was in place where staff developed objectives to support their professional development. One-to-one meetings every 2 months between staff members and their individual managers had recently been introduced.

The hospice had approximately 700 volunteers who helped run the hospice. They provided support in different ways, such as welcoming and signposting visitors in the main foyer, supporting the running of the hospice cafe, and interacting directly with patients in the clinical and the living well areas. Recruitment checks were in place for each volunteer, including Disclosure Scotland checks where required. Volunteers completed an induction programme. They told us they felt supported in their role and all staff were approachable.

- No requirements.
- No recommendations.

Planning for quality

The clinical governance committee oversees quality, safety and effectiveness in the hospice, providing assurance through audit, risk management, incident review, policy development, patient and family feedback, and continuous improvement activity.

The director of operations oversees all non-clinical services in the hospice. We saw evidence of an extensive maintenance register which included both in-house maintenance schedules and schedules with all contractors for the hospice. This included gas, boiler, oxygen, electrics and gardens. Daily checks were carried out by the housekeeping staff, which included daily water flushing regimes.

A risk management group met every 2 months to discuss and oversee all matters related to risk, in line with the hospice's risk management strategy. A comprehensive risk register was in place with a range of clinical and non-clinical risk assessments, including:

- fire risk assessment
- legionella (a water-based bacteria) risk assessment
- patients' skin integrity and prevention from pressure ulcers, and
- potential for injury in patients at risk of falls.

An extensive clinical audit programme included:

- medicine management
- patient care records
- development of pressure ulcers, and
- the referral process.

Audit results are shared with staff in a number of ways, including through the staff intranet and at staff meetings.

Senior nursing staff carried out regular audits of infection prevention and control, and patient care. This had informed a comprehensive quality improvement action plan. This included actions around:

- inpatient unit mattress compliance
- care planning
- hand hygiene, and
- the care environment.

A non-clinical audit programme included:

- water safety
- food hygiene, and
- health and safety.

The hospice's quality assurance and improvement strategy had been developed in line with the national Health and Social Care Standards. The clinical governance committee, which included board members, met every 2 months and was responsible for overseeing the strategy. The quality improvement plan was a 'live' document and was a regular agenda item for the clinical governance committee. All issues raised through audit, feedback, complaints and incidents were part of the quality improvement plan alongside new planned projects and processes For example, supporting healthcare assistants to carry out uncomplicated clinical procedures.

The hospice's business continuity plan included a detailed plan of how to respond in the event of a failure occurring in the building, and how patients and families would continue to be supported in the event of a system failure.

- No requirements.
- No recommendations.

Key Focus Area: Results

Domain 6: Relationships	Domain 7: Quality control
How well has the service demonstrated that it provides safe, person-centred care?	

Our findings

The environment was modern and bright, clean and well maintained. Appropriate infection prevention and control processes were in place ensuring a safe environment. Patient care records were completed fully. We saw an ongoing process of open communication between staff and the senior management team. Staff told us they felt valued and supported. Both the single point of access service and the young adult transition service were expanding in patient numbers and staff recruitment to deal with demand. Patients and families spoke highly of their experiences, and felt involved in planning their care.

Every year, we ask the service to submit an annual return. This gives us essential information about the service such as composition, activities, incidents and accidents, and staffing details. The service submitted an annual return, as requested. As part of the inspection process, we ask the service to submit a self-evaluation. The questions in the self-evaluation are based on our Quality Assurance Framework and ask the service to tell us what it does well, what improvements could be made and how it intends to make those improvements. The service submitted a comprehensive self-evaluation.

The environment was clean, organised, well maintained and free from clutter. Housekeeping staff were up to date with infection prevention and control training and cleaning methods. We saw cleaning taking place during our inspection and noted that general cleaning was carried out at least twice a day. Equipment had 'clean' stickers attached to show the date and time the item was cleaned and by whom. Housekeeping staff used appropriate chlorine-based cleaning products for sanitary fixtures and fittings. All cloths and mops were single use only. Additional information on cleaning products was available for all staff to view in the sluice areas, including information on correct dilution of chlorine-based solutions for cleaning different bodily fluids. All patient bedrooms had cleaning schedules which were completed daily. The hospice had a large laundry facility where all linen was laundered at appropriate temperatures. The machines were maintained in line with national disinfection requirements. Personal protective equipment was readily available throughout the service with additional stock located in ward store cupboards.

We reviewed four patient care records and saw that a thorough process of assessment and consultation took place. This included a plan for the patient's preferred place of care and where they wished to die. Nationally recognised assessment tools were used to determine a patient's current physical condition and abilities. This helped to make sure that patient assessments were consistently carried out. We saw evidence in the patient care records of:

- patient's contact details
- GP and next of kin contact details
- power of attorney in place where applicable, and
- consent to treatment and sharing of information.

As part of their twice daily review of medicines administered, a 'blank box' patient care audit was carried out by members of the clinical team. This ensured that routine patient medicines had been given to patients.

We attended a weekly patient multidisciplinary team meeting. This was attended by a range of staff involved in the care and support of patients and families. This was an opportunity for staff to discuss aspects of support the patient and their family may require and to assess the patient's condition. The multidisciplinary team included:

- inpatient staff
- rehabilitation service staff
- doctors
- patient and family support team, and
- senior management.

We reviewed five staff files and saw that staff were recruited appropriately. Staff recruitment information was stored in the human resources electronic system. A tracker was held by the human resource team to allow all PVG and disclosure checks to be kept up to date.

We spoke with the team involved with the single point of access service and saw how this was developing to ensure all new referrals go through an equitable process. Staff numbers in this team had expanded recently as the project developed.

The young adult transition service provided ongoing palliative care and support for young adults moving from child palliative care to adult services. The hospice held a weekly hub for young adults to attend, giving them access to music and art therapy, and an opportunity for ongoing clinical assessment. The young adult's carers also attended, giving them the opportunity to form supportive

relationships with others. We noted that this young adult service is the only one available in Scotland and is one of four in the UK. We saw that an ongoing strategy was in place for further development of this service and a framework to involve other Scottish hospices in providing support for young adults in their area. We were told that most Scottish hospices were interested in being involved. This project had been supported and funded by Hospice UK. We spoke with the staff involved and found they were enthusiastic about future opportunities for development and that additional staff had been recruited to join the team.

The decoration throughout the hospice provided a modern, yet homely, non-clinical environment. The environment in the inpatient unit was peaceful. Designated spaces for patients, families and staff allowed for reflection and privacy. From their bedroom, patients and families could access private outdoor space.

The hospice cafe was open to the public, and we saw this was a busy environment. There was also the opportunity for external organisations, charities, or social groups to hire rooms or facilities within the hospice building. The hospice could then provide catering for these events, if required. This helped to provide valuable financial resources to the hospice.

Patients and families that we spoke with told us:

- 'This is an absolutely amazing place, I never feel pressured to make a decision. I feel fully informed of the plans and treatment available.'
- ‘I can ask questions.’
- 'There is nothing that could be improved on.'
- 'I tease the staff, we have a laugh, they are great.'

Staff we spoke with told us they enjoyed their job and felt supported. One staff member told us they felt ‘empowered’ working in the hospice. Staff who completed our online survey told us:

- 'People work well together, treat each other with respect. Staff are encouraged to support one another and contribute ideas to help improve the service.'
- ‘I feel lucky to be part of our team, I feel there is a positive culture. This extends throughout the hospice; it is a pleasure to be a part of this service.’
- ‘Brilliant place to work positive attitude.’

    - No requirements.
    - No recommendations.

Appendix 1 – About our inspections

Our quality assurance system and the quality assurance framework allow us to provide external assurance of the quality of healthcare provided in Scotland.

Our inspectors use this system to check independent healthcare services regularly to make sure that they are complying with necessary standards and regulations. Inspections may be announced or unannounced.

We follow a number of stages to inspect independent healthcare services.

Before inspections

Independent healthcare services submit an annual return and self-evaluation to us.

We review this information and produce a service risk assessment to determine the risk level of the service. This helps us to decide the focus and frequency of inspection.

Before

During inspections

We use inspection tools to help us assess the service.

Inspections will be a mix of physical inspection and discussions with staff, people experiencing care and, where appropriate, carers and families.

We give feedback to the service at the end of the inspection.

During

After inspections

We publish reports for services and people experiencing care, carers and families based on what we find during inspections. Independent healthcare services use our reports to make improvements and find out what other services are doing well. Our reports are available on our website at: **www.healthcareimprovementscotland.org**

We require independent healthcare services to develop and then update an improvement action plan to address the requirements and recommendations we make.

We check progress against the improvement action plan.

After

More information about our approach can be found on our website: [The quality assurance system and framework – Healthcare Improvement Scotland]

Complaints

If you would like to raise a concern or complaint about an independent healthcare service, you can complain directly to us at any time. However, we do suggest you contact the service directly in the first instance.

Our contact details are:

Healthcare Improvement Scotland
Gyle Square
1 South Gyle Crescent
Edinburgh
EH12 9EB

Email: his.ihcregulation@nhs.scot

You can read and download this document from our website.
We are happy to consider requests for other languages or formats.
Please contact our Equality and Diversity Advisor on 0141 225 6999
or email his.contactpublicinvolvement@nhs.scot

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