PALLIATIVE CARE (SCOTLAND) BILL

EXPLANATORY NOTES

(AND OTHER ACCOMPANYING DOCUMENTS)

CONTENTS

1. As required under Rule 9.3 of the Parliament’s Standing Orders, the following documents are published to accompany the Palliative Care (Scotland) Bill introduced in the Scottish Parliament on 1 June 2010:
   • Explanatory Notes;
   • a Financial Memorandum; and
   • the Presiding Officer’s Statement on legislative competence.

A Policy Memorandum is printed separately as SP Bill 50–PM.
EXPLANATORY NOTES

INTRODUCTION

2. These Explanatory Notes have been prepared by the Non-Executive Bills Unit on behalf of Gil Paterson MSP, the member in charge of the Bill. They have been prepared in order to assist the reader of the Bill and to help inform debate on it. They do not form part of the Bill and have not been endorsed by the Parliament.

3. The Notes should be read in conjunction with the Bill. They are not, and are not meant to be, a comprehensive description of the Bill. So where a section or schedule, or a part of a section or schedule, does not seem to require any explanation or comment, none is given.

SUMMARY AND BACKGROUND TO THE BILL

4. The Bill seeks to give legislative effect to the Scottish Government’s intentions in Living and Dying Well: a national action plan for palliative and end of life care in Scotland (“the Living and Dying Well strategy”) which aims “to ensure that good palliative and end of life care is available for all patients and families who need it in a consistent, comprehensive, appropriate manner across all care settings in Scotland.”

5. To do this the Bill amends the National Health Service (Scotland) Act 1978 (“the 1978 Act”). The 1978 Act imposes a number of duties on the Scottish Ministers in relation to the provision of health services in Scotland. Section 1 of the Act provides that it is the duty of the Scottish Ministers to “promote a comprehensive and integrated health service designed to secure…the improvement in the physical and mental health of the people of Scotland, the prevention, diagnosis and treatment of illness and for that purpose to provide or secure the effective provision of services in accordance with the provisions of this Act…” One of the Bill’s objectives is to raise the priority of palliative care services in line with the Living and Dying Well strategy by creating a specific duty on the Scottish Ministers to provide or secure palliative care for all persons diagnosed with a life-limiting condition and their family members according to their reasonable needs.

6. The Bill also sets up reporting arrangements which require the Scottish Ministers to report annually on the provision of palliative care. The Bill specifies indicators with the aim that the quality of care provided can be monitored.

7. The Bill consists of two sections. Section 1 adds a new Part (Part IIIA: Palliative care) and a new schedule (Schedule 9A: Reporting and indicators) into the 1978 Act. Part IIIA sets out the requirements for the provision of palliative care by the Scottish Ministers. Section 2 provides for commencement of the Bill and sets out the short title.

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COMMENTARY ON SECTIONS

Section 1: Palliative care

8. Section 1(2) of the Bill sets out the duties of the Scottish Ministers, including the duty to report to the Scottish Parliament. Section 1(3) makes provision to provide for the Parliamentary procedure to be followed in relation to the Scottish Ministers’ powers to make subordinate legislation under the Bill. Section 1(4) makes provision for new Schedule 9A to the 1978 Act which lists the indicators that are required to be reported upon.

Section 1(2)

9. Section 1(2) amends the 1978 Act to bring in new Part IIIA which includes new sections 48A to 48C.

New section 48A: Duty to provide palliative care

10. Section 48A places a duty on the Scottish Ministers to provide or secure the provision of palliative care for persons who have been diagnosed with a life-limiting condition and their family members based on the reasonable needs of such persons.

11. “Palliative care” is defined in section 48C and reflects broadly the definition used by the World Health Organisation (WHO). Rather than list illnesses which would attract palliative care services the Bill utilises “life-limiting condition”, a term used in the Living and Dying Well strategy. Section 48C defines “life-limiting condition” as a condition, illness or disease which is progressive and fatal and the progress of which cannot be reversed by treatment. The Bill does not require diagnosis of a specific life-limiting condition.

12. In relation to persons with a life-limiting condition, section 48C defines palliative care as treatment which controls and relieves pain, discomfort or other symptoms caused by or related to a life-limiting condition with the intention of improving quality of life. Section 48C provides that palliative care also includes psychological, social or spiritual help and support. Help and support in this regard could include the provision of stress management courses, access to a hospital chaplaincy services or the provision of bereavement counselling.

13. The Bill covers within its definition of “palliative care” help and support for family members. Under section 48C this covers psychological, social or spiritual help and support to assist family members in dealing with the fact that their relative has a life limiting condition and the consequences of that condition.

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2 The World Health Organisation’s definition of palliative care describes, “an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.” For the full definition see: http://www.who.int/cancer/palliative/definition/en/

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14. The meaning of “family member” is defined in section 48C and includes parents, children and grandparents as well as uncles, aunts, nieces, nephews, great aunts and great uncles and spouses. “Civil partners” and “cohabitants” are also included in the definition of family member and are further defined in section 48C.

15. Section 48A provides that palliative care should be provided according to the reasonable needs of persons with the life-limiting condition and family members. The use of “reasonable needs” clarifies that the duty to provide care is bound by what is reasonable for any individual to receive. In other words the Scottish Ministers’ duty is to provide a palliative care service to all relevant people, but only to the extent that it meets the particular and reasonable needs of those individuals.

16. Section 48A(2) sets out that the Scottish Ministers are not required to provide, or secure the provision of, treatment, help or support where there is already a duty on another person to do so. This ensures that the Scottish Ministers duty to provide or secure the provision of palliative care under subsection (1) does not interfere with other persons’ duties to provide treatment, help or support which could amount to or be viewed as palliative care services.

New section 48B: Reports to the Scottish Parliament

17. Subsection (1) of section 48B requires the Scottish Ministers to lay annually before the Scottish Parliament a report covering that year. The “reporting year” is defined in section 48C as the period beginning with the day on which this Bill comes into force and ending on 31 March and each successive year ending on that date.

18. Subsection (2) introduces Schedule 9A (see paragraphs 26 to 41 of these notes) which sets out the information on which the Scottish Ministers are required to report under subsection (1), certain requirements as to the content of the report and the provision of information to compile the report.

19. Subsections (3), (4), (5) and (6) detail the Scottish Ministers’ powers to modify the terms of Schedule 9A.

20. Subsection (3) provides the Scottish Ministers with powers to modify the indicators in Schedule 9A. In terms of subsection (3)(a) the Scottish Ministers may add a new indicator or alter an existing one. It also provides that an indicator added by the Scottish Ministers can itself be subsequently altered. Subsection (3)(b) provides for the subsequent removal of an indicator, but only one that has been added by the Scottish Ministers under subsection (3)(a).

21. Subsection (4) provides the Scottish Ministers with powers to modify the requirements set out in paragraphs 5 or 6 of Schedule 9A. In terms of subsection (4)(a) the Scottish Ministers may alter a requirement. It also provides that a requirement altered can itself be subsequently altered. Subsection (4)(b) provides for the subsequent removal of any part of a requirement, but only one that has been altered by the Scottish Ministers under subsection (4)(a).

22. Subsection (5) provides the Scottish Ministers with powers to modify definitions in paragraph 7 of Schedule 9A. In terms of subsection (5)(a) the Scottish Ministers may add a new
definition or alter an existing one. It also provides that a definition added can itself be
subsequently altered. Subsection (5)(b) provides for the subsequent removal of a definition, but
only one that has been added by the Scottish Ministers under subsection (5)(a).

23. Subsection (6) provides the Scottish Ministers with powers to modify requirements in
relation to indicators altered or added under subsection (3)(a). Subsection (6)(b) provides for the
subsequent removal of requirements in relation to indicators, but only applies to the requirements
that have been added by the Scottish Ministers under subsection (6)(a).

New section 48C: Interpretation of Part IIIA
24. This section contains definitions of terms used throughout the Bill.

Section 1(3)
25. Section 1(3) of the Bill amends section 105(2A) (orders, regulations and directions) of
the 1978 Act so that orders made by the Scottish Ministers under new section 48B(3) are subject
to affirmative resolution procedure.

Section 1(4)

Schedule 9A: Reporting and indicators
27. Schedule 9A is introduced by new section 48B and prescribes the content of the annual
report which the Scottish Ministers are required to lay before the Scottish Parliament.

28. Indicator 1 requires information to be provided on the number of persons with a life-
limiting condition who have received palliative care and the number of family members who
have received palliative care.

29. Indicator 2 requires information on the average time it takes for persons diagnosed as
having a life-limiting condition to receive a first assessment of their palliative care needs and
also the longest time it has taken for a first assessment.

30. Indicator 3 requires information on the average time it takes for persons with a life-
limiting condition whose palliative care needs have been assessed to receive palliative care for
the first time and also the longest time it has taken for such care to be first received.

31. Indicator 4 requires information on the number of persons who are in receipt of palliative
care who have received a community care assessment. Paragraph 7 defines “community care
assessment” as an assessment carried out by a local authority under section 12A (duty of local
authority to assess needs) of the Social Work (Scotland) Act 1968 (c.49). Under section 12A
local authorities have to assess the care needs of anyone to whom they have a duty or have a
power to provide, or secure the provision of, community care services.
32. Indicator 5 seeks information on the proportion of carers, caring for a person with a life-limiting condition, who have received a carer’s assessment. Paragraph 7 defines “carer’s assessment” as an assessment carried out by a local authority under section 12AA (assessment of ability to provide care) of the Social Work (Scotland) Act 1968. A carer assessment identifies whether carers may have community care needs of their own.

33. Indicator 6 requires information on the place and cause of death of any person with a life-limiting condition who has received palliative care. Paragraph 5 develops the information required by indicator 6. Information provided needs to be sub-divided to show the number dying in hospital, in a hospice, in accommodation provided by a care home service, a private address and in any place other than these places. Paragraph 7 defines a “care home service” by reference to section 2(3) of the Regulation of Care (Scotland) Act 2001 (asp 8). This is therefore a service which provides accommodation, together with nursing, personal care or personal support, for persons by reason of their vulnerability or need. It does not include a hospital, a public, independent or grant-aided school, an independent health care service or any service which has been excepted by regulations made by the Scottish Ministers.

34. Indicator 7 requires information on the number of persons who have been in receipt of palliative care and died at their preferred place of death, where such a preference has been recorded in the patient’s medical records.

35. Indicator 8 requires information on the number of persons who have died in hospital despite expressing a preference to die elsewhere, where, such a preference has been recorded in the patient’s medical records. In such cases, reasons must be given to explain why a person who has been in receipt of palliative care died in hospital despite having expressed a contrary preference. Paragraph 6 develops the information required by indicator 8. This falls into three categories: “unexpected change in symptoms” (paragraph 6(a)); “inability to relieve pain” (paragraph 6(b)); and “any other reason” (paragraph 6(c)), in which case the reason must be stated in the report. Paragraph 6 requires the total number to be provided for each of these categories.

36. Indicator 9 requires information on the nature of the psychological, social and spiritual help and support given to persons with a life-limiting condition and their family members.

37. Indicator 10 requires information to be provided on the number of persons with a life-limiting condition who have received palliative care and the number of family members who have received palliative care who have completed a survey conducted by or on behalf of the Scottish Ministers or Health Boards giving their views on the standard of palliative care.

38. Indicator 11 requires the Scottish Ministers to report on the number of persons who have received education and training in providing palliative care. This may include staff from a range of disciplines who provide palliative care.

39. Paragraph 2 places a duty on Health Boards to provide the Scottish Ministers with such information as they require for the purposes of preparing the report required under section 48B. The Scottish Ministers may set time limits for the provision of the information.
40. Paragraph 3 stipulates that the information supplied in respect of each indicator should cover the whole of Scotland and each Health Board area.

41. Paragraph 4 confirms that nothing in the Act authorises the disclosure, by the Scottish Ministers, of information from which any person, living or deceased, could be identified.

Section 2: Commencement and short title

42. The Act comes into force on Royal Assent.

FINANCIAL MEMORANDUM

INTRODUCTION

43. This document relates to the Palliative Care (Scotland) Bill introduced in the Scottish Parliament on 1 June 2010. It has been prepared by the Non-Executive Bills Unit on behalf of Gil Paterson MSP, the member in charge of the Bill, to satisfy Rule 9.3.2 of the Parliament’s Standing Orders. It does not form part of the Bill and has not been endorsed by the Parliament.

44. Over 55,000 people die in Scotland each year. As well as controlling pain palliative care focuses on other symptoms. It applies a holistic approach to meeting the physical, practical, social, emotional and spiritual needs of patients and their families facing progressive illness and bereavement. At present there is a wide variation in the provision of palliative care across Scotland, whether due to differing priorities, funding or staffing shortages, or the criteria used to determine individuals’ need for such care.

45. The objective of the Bill is to secure access to palliative care in Scotland for everyone with a progressive life-limiting condition and their family members, as set out in the Living and Dying Well Strategy. The proposal aims to secure this by:

- placing the Scottish Ministers under a statutory obligation to provide palliative care for those with life-limiting conditions and their family members; and
- setting up reporting arrangements so that the nature and quality of care provided can be monitored by the Scottish Ministers and the Parliament.

46. These reporting arrangements will require the Scottish Ministers to report on the provision of palliative care in relation to a number of key indicators. The Scottish Ministers will be required to lay an annual report before the Parliament which compiles the information

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4 Palliative and end of life care in Scotland: the case for a cohesive approach, Scottish Partnership for Palliative Care, May 2007, para 2.1, page 13
submitted by the Health Boards to enable the Parliament to scrutinise, compare and contrast the delivery of palliative care services nationwide.

47. The provisions of the Bill complement the intentions of the Scottish Government’s Living and Dying Well strategy. More information on this can be found in the Policy Memorandum.

48. In order to understand what costs may result from the Bill it is useful to examine the costs of the Government’s Living and Dying Well strategy, which seeks to deliver palliative care to all with life-limiting conditions and their family members (including taking account of care being provided at the moment and how it is being delivered).

49. In addition with regard to the costs associated with reporting the information required by the Bill it is useful to consider what information is already being collected by Health Boards.

COSTS ON THE SCOTTISH ADMINISTRATION

50. In 2008 the Scottish Government published its strategy for ensuring that palliative and end of life care can be available to all persons in Scotland with life-limiting conditions. The Living and Dying Well strategy seeks to ensure that palliative care services becomes a practical reality for all requiring such care and is applicable to all geographical areas of Scotland. The strategy says that: “It seeks to establish a single, comprehensive approach to the provision of palliative care that will be embedded across Scotland”.

51. Many with life-limiting conditions will already be in receipt of palliative or end of life care. The Living and Dying Well strategy seeks to ensure this access to care will continue. Critically, it aims to extend the provision of palliative care to all requiring such care, regardless of diagnosis, age or geography.

Generalist palliative care

52. Audit Scotland found that palliative care associated with primary care and more general acute care was undertaken by generalists and that these costs were more difficult to determine because it was embedded in the existing work of many staff in health and social care. Information on the cost of generalist care is not centrally held.

53. In order to extend the provision of palliative care to all with life-limiting conditions, the Living and Dying Well strategy places considerable emphasis on delivering the strategy through increased provision of generalist palliative care. The Scottish Government has made additional funding available. In particular £3 million per year has been made available to the Directed Enhanced Service to support improvements in generalist palliative care for all.

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6 Living and Dying Well: a national action plan for palliative and end of life care in Scotland, foreword http://www.scotland.gov.uk/Publications/2008/10/01091608/0
7 Parliamentary Written Question S3W-30385
54. To facilitate this increased role for generalists, the Living and Dying Well strategy recognises the need for increased training of generalist staff in palliative and end of life care. The Living and Dying Well strategy indicates that NHS Education for Scotland will develop a national education plan\(^8\) for generalist staff which will facilitate and support the delivery of improved palliative care in all settings and for the diversity of the Scottish population.

55. In response to a written question from the member, the Deputy Minister for Health advised that a £500,000 development funding was provided in 2008-09 for use centrally and to support NHS boards in the development of delivery plans. Further additional funding of £120,000 in 2008-09 and £500,000 in 2009-10 was made available to support implementation of the plan, to ensure that generalist palliative care was supported and to ensure the development of care in community based settings\(^9\).

56. Therefore funding of £1.12 million has already being directed towards ensuring the provision of universal palliative care to those in need can be met over and above current funding for generalists to provide palliative care.

**Specialist palliative care**

57. At present there are 63 palliative care specialists working in Scotland.\(^10\) The availability of specialist care also varies significantly across Scotland and different areas have different models. For example, the number of specialist staff per 100,000 people ranges from 4.1 in NHS Ayrshire and Arran to 7.3 in NHS Greater Glasgow and Clyde and 11.2 in NHS Highland\(^11\). According to the Audit Scotland review of palliative care, in 2006/07 £59 million was spent on specialist palliative care in Scotland\(^12\). Of this figure, £32.8 million was provided through public funding.\(^13\) This figure relates to specialist care provided through specialist teams by the NHS and specialist care commissioned from hospices.

**Number of people needing palliative care services**

58. There is a lack of information about the number of people currently receiving palliative care.\(^14\) It is therefore difficult to estimate how much it will cost to deliver the Living and Dying Well strategy.

59. It is therefore helpful to consider the cost associated in delivering the UK Government’s End of Life Care Strategy for England\(^15\) which was published in July 2008. That strategy seeks

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\(^9\) Written Parliamentary Question, Gil Paterson MSP, S3W-30385

\(^10\) NHS Scotland Workforce Information, Excel sheet: HCHS Medical and Dental Staff by speciality, Table HCHS staff by speciality, gender and contract type. [http://www.isdscotland.org/isd/5896.html](http://www.isdscotland.org/isd/5896.html)


\(^14\) Written Parliamentary Question, Gil Paterson MSP, S3W-30382

\(^15\) End of Life Care Strategy - promoting high quality care for all adults at the end of life, Department of Health
to deliver on similar objectives to those set out in the Living and Dying Well strategy. In the document the UK Government committed to increase expenditure on end of life care by £88 million in 2009/10 and by £198 million in 2010/11\(^\text{16}\).

60. Reflecting on the fact that 500,000 people\(^\text{17}\) die each year in England as compared to 55,000 in Scotland it is therefore possible to deduce that the funding required to support the Living and Dying Well strategy will be 11% of that required to support the English strategy. This would suggest for Scotland expenditure of £9.68 million in year one and £21.8 million in the second year.

61. The Scottish Government is already seeking to deliver its Living and Dying Well strategy and has already directed additional funding toward the delivering of the strategy, in particular in relation to increasing the provision of generalist palliative care which would provide for palliative care for all with life-limiting conditions. The Bill does not add to the services required under the Living and Dying Well strategy and as a consequence has no financial consequences in relation to delivery of care.

Margins of uncertainty

62. It should be recognised that there is a considerable margin of uncertainty about the costs of delivering palliative care under the Living and Dying Well strategy due to:

- the absence of information about the provision of palliative care by generalists;
- the absence of information about the number of people currently in receipt of palliative care; and
- the lack of certainty about how many more people would be eligible to receive palliative care as a consequence of the Living and Dying Well strategy.

Cost of collecting performance indicators

63. The Bill does not require the setting up of a database, but Scottish Administrations have previously established databases to facilitate information collection. For example, following enactment of the Management of Offenders etc. (Scotland) Act 2005 a standardised database was introduced which provides UK wide, searchable intelligence for the registration and management of violent and sex offenders (ViSOR). The Scottish Executive provided £375,000\(^\text{18}\) to the Scottish Police Service to establish this database.

64. Similarly under the Tobacco and Primary Medical Services (Scotland) Act 2010 the Scottish Government established a database to register tobacco retailers. It offered the following funding in support of the Bill:

- £7,500 to set up database

\(^\text{16}\) National Council for Palliative Care
http://www.ncpc.org.uk/download/newsroom/pressReleases/Funding_Survey_PR.pdf
\(^\text{17}\) http://www.dyingmatters.org/news/13
\(^\text{18}\) The Management of Offenders etc. (Scotland) Act 2005 (asp14), Financial Memorandum, para 123.
These documents relate to the Palliative Care (Scotland) Bill (SP Bill 50) as introduced in the Scottish Parliament on 1 June 2010

- £44,000 first year running costs for staff etc.
- £10,000 running costs for database each year thereafter (staff etc.)

65. Given that most Health Boards are already collecting the information which will require to be reported to the Parliament (see paragraphs 71 to 74), collection costs will largely relate to the collation of any such information. On the basis of the examples above, it is anticipated that costs will range in the first year from £51,500 to £375,000, but are likely to be closer to the former, given the number of locations involved and the nature and the amount of information to be held. Once in place, it is expected that costs in future years will be less and the figure of £10,000 annual running costs is considered a reasonable assumption.

COSTS ON LOCAL AUTHORITIES AND OTHER PUBLIC BODIES

Local authorities

66. There are not expected to be any direct costs upon local authorities resulting from the Bill. The main burdens will fall, in the first instance, upon the Scottish Ministers.

Health Boards

67. The Bill in itself will not precipitate any additional costs for Health Boards. In the first instance the duty to provide, or secure the provision of, palliative care is placed on the Scottish Ministers. Scottish Ministers may, of course, delegate functions to Health Boards under section 2 of the National Health Service (Scotland) Act 1978 (c.29). That, along with any cost implications for Health Boards, would be a matter for them. Having said that, as discussed above, the Bill provides a statutory basis for the intentions of the Scottish Government’s Living and Dying Well strategy. As with the Bill, the strategy seeks to provide for palliative care to be available to all with a life-limiting condition and their family members. It is therefore clear that the Scottish Government is already seeking to deliver this aim and as a consequence providing sufficient funding for that purpose.

68. According to Audit Scotland, the cost of specialist palliative care in 2006/07 was approximately £59 million with just over half provided by Scottish Administration (see paragraph 57). The overall cost of delivering palliative care, however, was unknown. Audit Scotland’s report noted that the cost of generalist care is unclear but recognised that it is a significant part of the existing work of many staff in health and social care.

69. As noted at paragraph 56 of this Memorandum, additional funding has been made available by the Scottish Government in order to enable delivery of the aims set out in the Living and Dying Well strategy.

70. It is also a key feature of the Living and Dying Well strategy that where appropriate, palliative care will be delivered in the community. To deliver the strategy and thereby the Bill, the focus is likely to be on enabling generalists to deliver palliative care. In this regard, the

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Scottish Government has already taken steps to ensure that generalists are properly trained to provide this care.

Collection of information on the provision of palliative care

71. Health Boards already collect a significant amount of information relating to delivery of palliative care services through the use of recognised tools which facilitate the assessment and review of care of those with palliative care needs. These include for example the use of:

- Quality of Outcomes Framework Palliative Care Register;
- the Gold Standards Framework;
- the Liverpool Care Pathway for the Dying Patient;
- the Scottish Patients at Risk of Readmission and Admission;
- the Single Shared Assessment; and
- Indicator of Relative Need.

72. Guidance on the Minimum Information Standards for Assessment and Care Planning for all Adults\(^{20}\) has recently been circulated to all local authorities, Health Boards and Community Health Partnerships. The Guidance is supported by developments in education and technology which facilitate the safe and effective sharing of data to support the delivery of person centred care. There are many other general tools used and records kept which will generate information relevant to the Bill’s indicators.

73. Standardising, capturing and collating this information will, however, require some additional funding to implement. No information is available on how much is currently spent annually on the collection of performance indicators by Health Boards\(^ {21}\) and how much is spent in relation to compliance with the Gold Standards Framework in Scotland\(^ {22}\). As such, while recognising that there will be small additional costs, it is difficult without any central information to estimate what these will be. It is anticipated these minimal costs could be absorbed by Health Boards.

74. Primary collection costs will fall on the Scottish Administration (see paragraphs 50 to 65).

COSTS ON OTHER BODIES, INDIVIDUALS AND BUSINESSES

Voluntary sector

75. To date, the primary providers of palliative care have been the voluntary sector. In 2006/07, the majority of specialist palliative care beds (250 beds) and 72 per cent of day care

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\(^{21}\) Written Parliamentary Question – S3W-31410

\(^{22}\) Written Parliamentary Question – S3W-31411
These documents relate to the Palliative Care (Scotland) Bill (SP Bill 50) as introduced in the Scottish Parliament on 1 June 2010

places were provided by voluntary hospices\(^{23}\). The voluntary sector has also supplied 44\(^{\%}\)\(^{24}\) of the funding necessary to provide palliative care.

76. The Living and Dying Well strategy anticipates increased demand will be met through generalist palliative care and increased care in the community. It thus follows that there will not be a significantly increased demand upon the voluntary sector.

POTENTIAL SAVINGS

77. A recent study by Thomas J Smith and J Brian Cassell, published in the “Journal of Symptom and Pain Management”, drew the following conclusions on the costs arising from the provision of palliative care:

“Although palliative care is rarely profitable by itself, palliative care in hospitals is associated with significant reductions in per diem costs and total costs, and can generate substantial savings to the health system by “cost avoidance”. Palliative care alongside usual care in recent randomized outpatient trials has maintained or improved the quality of care while generating substantial cost savings. The data are mixed about the impact of palliative care consultation on inpatient length of stay and are related to local patterns of care, consultation, and assumption of control of the course of care. In collecting and presenting the data to administrators and others, we have found that the simplest approach is the most effective—for example, presenting a few clinical outcomes alongside cost-saving data.”\(^{25}\)

78. A study by the Centre for Entitlement in the USA demonstrated savings that could be made by extending the provision of palliative care:

“Approximately 1.5\(^{\%}\) of all hospital discharges (30,181,406/year for all payers) are currently managed by palliative care services, just under 453,000 patients annually. Average cost savings estimated from the literature are, conservatively, $2,659 per patient, for an overall savings of $1.2 billion possible currently. Building on the research evidence, cost savings from coordinated palliative care could reach more than $37 billion over ten years.”\(^{26}\)

79. It is expected therefore that comprehensive, coordinated, cohesive and consistent delivery of palliative care as required by the Living and Dying Well strategy will deliver benefits to those in receipt of such care, as well as benefiting the public purse.


\(^{25}\) http://www.jpsmjournal.com/article/S0885-3924(09)00528-4/abstract

\(^{26}\) Centre for Entitlement Reform – September 2009
PRESIDING OFFICER’S STATEMENT ON LEGISLATIVE COMPETENCE

80. On 1 June 2010, the Presiding Officer (Alex Fergusson MSP) made the following statement:

“In my view, the provisions of the Palliative Care (Scotland) Bill would be within the legislative competence of the Scottish Parliament.”
These documents relate to the Palliative Care (Scotland) Bill (SP Bill 50) as introduced in the Scottish Parliament on 1 June 2010

PALLIATIVE CARE (SCOTLAND) BILL

EXPLANATORY NOTES

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