1. Marie Curie welcomes the Health and Sport Committee’s inquiry into 2018-19 Budget and how it impacts on health and social care spending, priorities and outcomes.

2. Marie Curie provides care and support to over 8,000 people living with a terminal illness and their families every year in Scotland. We provide a range of services to deliver this care including our two hospices in Edinburgh and Glasgow, as well as our nursing services, which are delivered in 31 local authorities in Scotland. These services are delivered in partnership with local Health and Social Care Partnerships and NHS Boards, who commission us to do this work.

3. Our services are supported through a mixture of statutory funding, as well as our voluntary fundraising income. Without statutory funding we would not be able to deliver the services that we do.

4. Our response to this inquiry will relate to the need for further investment in palliative care resources, and the other services and support that are needed to enable people to receive that care.

5. Palliative care aims to treat or manage pain and other physical symptoms. It will also help with any psychological, social or spiritual needs. Treatment will involve medicines, therapies, and any other support that specialist teams believe will help their patients. It includes caring for people who are nearing the end of life. This is called end of life care. It can be delivered in acute and specialist settings including hospitals and hospices, as well as in general settings in the community through GP practices and in people’s own homes.

6. Investment in palliative care and services that can support people living with a terminal illness can play a key part in enabling the Scottish Government to achieve its ambitions to shift the balance of care from the acute to the community, as well as achieve its National Health and Wellbeing Outcomes, and its vision that “By 2021, everyone in Scotland who needs palliative care will have access to it.”

7. As well as introducing its bold vision for palliative care for all that need it, the Scottish Government has also continued to highlight palliative care in other key policy and delivery documents as well as made it a priority for the new Health and Social Care Partnerships.

8. In the Scottish Government’s Health and Social Care Delivery Plan the Government committed to “doubling the palliative and end of life provision in the community, which will result in fewer people dying in a hospital setting”².

9. The Scottish Government has also listed palliative and end of life care provision as a key priority in a letter relating to all Chief Officers of Integration Authorities regarding the Draft Budget 2017/18 (15 December 2016). The letter states that Integration priorities are to: “Increase provision of good quality, appropriate palliative and end of life care, particularly in people’s own homes and communities and also, where appropriate, in hospices, so that people who benefit from such care access it.”

10. At present, around 56,000 people die every year in Scotland, of which it is estimated that 46,000 will need some form of palliative care. However, evidence suggests that nearly 11,000 people do not get the care they need when terminal ill and at the end of life³. This is a substantial gap, which must be bridged if the Scottish Government is to deliver on its vision for care for all.

11. However, no additional or specific financial resource has been committed to palliative care services locally to support the delivery of these various commitments and priorities relating to palliative care. Integration Joint Boards (IJBs) have been asked to find this resource from within existing budgets. We would like reassurance that IJBs are recognising these commitments. They should be able to demonstrate how they deliver their palliative care services to ensure they are meeting the needs of their communities and bridging the gap between those that receive the palliative care they need and those that do not.

12. A recent Nuffield Trust report highlighted that Scotland, like other UK countries, has struggled to move care out of the hospital and into the community⁴. The Nuffield report also highlights that Scotland’s NHS is facing financial difficulties, with a need for greater savings than in other UK countries.

13. Difficult decisions will need to be made in order to invest in community and primary care services, which will ultimately lead to savings in the acute setting, as more people stay at home to receive their care and the risk of emergency and unplanned hospital stays are reduced. We believe that palliative care can play a significant role in helping shift care from the acute to community settings and to contribute to efficiency savings in health spending in acute settings.

14. At present, there is a limited evidence base for the economic value of palliative care. However, the research that has been done suggests that investing in palliative care services, both in specialist and community settings, can lead to savings in hospitals.

15. Based on calculations in the Palliative Care Funding Review for England, extending ‘specialist and core’ palliative care services to those that would benefit could result in net

savings of £4.2 million in Scotland⁵. These figures are based on costs for extending palliative care by £16.8 million in Scotland leading to estimated savings of £21 million in Scotland (nearly 7,000 fewer hospital deaths). While these estimates exclude the full costs of community based support, including care from GPs, district nurses and others, the evaluation of the Marie Curie Nursing Service highlighted below suggests that these costs are not likely to differ substantially between those in receipt and not in receipt of specialist palliative care.

16. An evaluation of the Marie Curie Nursing Service in England, found evidence of lower total care costs for someone receiving the Marie Curie service compared to a similar individual in receipt of usual end-of-life care. This study identified overall healthcare savings of around £500 per person, taking into account the cost of hospital care, community and primary healthcare and social care, as well as the costs of providing the Marie Curie Nursing Service⁶.

17. Although these two separate estimates cannot be readily combined or compared they both support the view that the costs of extending palliative care may be largely, or even completely, offset by savings from reducing the number of people that die in hospital who do not want to be there and can be discharged with proper support.

18. There is also evidence to show that palliative care services do reduce the amount of hospital admissions, A&E admissions and hospital stays that a patient will experience, particularly in the last months of life. They are also increasingly likely to die in their preferred place of death, which for many is their home or in the community. For example, a recent service evaluation of the Marie Curie Hospice at Home Service in Fife found patients supported by the Marie Curie experienced significantly fewer admissions to hospital (27% compared to 40% of similar patients who did not receive the Marie Curie service) and experienced significantly fewer A and E attendances (3% compared to 12). Overall, patients supported by the Hospice at Home model of care spent 24% fewer days in hospital compared to similar patients not receiving Marie Curie services.

19. Social care is an integral part of palliative care. It can mean the difference between being able to stay at home, get out of hospital, remain connected to families and communities, living the life people want to with some element of independence and control, and dying the way they want to. Last year we launched Dying to Care: A report into social care at the end of life⁷. We highlighted that there needs to be significant time and resource invested into redesigning social care processes and provision to ensure that the right people are in the right place at the right time to deliver better outcomes for people in their communities. This should include a focus on earlier interventions, staff support, better planning and better co-ordination and communication across and between services.

20. We believe that the 2018-19 Budget should consider further investment in social care services in order to support people to live at home, and to help shift the balance of care.

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from acute settings to the community. Only with genuine investment and additional resource will Scotland be able to ensure that people get the care they need at home in a way that meets their needs from the point of that need.

21. Investing in palliative care, and those services that ensure that palliative care can be delivered can support the Government achieve its priorities, as set out in the National Performance Framework and meet the National Health and Wellbeing Outcomes. There is also enough evidence to suggest that palliative care services both in acute and community settings can contribute to the wider debate on how to make efficiency savings in public spending on health and social care.

22. We would urge all those with responsibility for palliative care to ensure that they understand the palliative care needs of their local populations, but also they are investing in the right balance of palliative care services in both the community and acute settings. This should include consideration of additional financial resource in order to ensure everyone gets the care that they need.