Scottish Partnership for Palliative Care

Alan Hunter
Assistant Clerk to the Finance Committee
Scottish Parliament

19 June 2014

Dear Alan

Finance Committee Questionnaire on the Financial Memorandum relating to the Assisted Suicide (Scotland) Bill

Thank you for your letter of 15th April requesting that the Scottish Partnership for Palliative Care (SPPC) complete the Finance Committee's questionnaire on the Financial Memorandum relating to the Assisted Suicide (Scotland) Bill. Our response to the questionnaire is appended.

SPPC is a membership organisation and we consult with our members before arriving at positions. Having consulted with members on the Bill we submitted evidence to the Health and Sport Committee, and this letter should be read in conjunction with that evidence (which does not directly address resource issues).

In 2012 we consulted with members on what was, at that stage, Margo MacDonald's proposal for legislation (not the actual Bill). I have appended the section of our response which addresses resource issues. This position, which received the requisite support from our membership, is the basis for our responses in the questionnaire appended.

Best wishes

M Hazelwood

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Appendix 1 – Questionnaire (please also refer to Appendix 2)

1. Did you take part in any consultation exercise preceding the Bill and, if so, did you comment on the financial assumptions made?

   Yes.

2. If applicable, do you believe your comments on the financial assumptions have been accurately reflected in the FM?

   No.

3. Did you have sufficient time to contribute to the consultation exercise?

   Yes.

Costs

4. If the Bill has any financial implications for your organisation, do you believe that they have been accurately reflected in the FM? If not, please provide details.

If the Bill becomes law then it is likely that this will create additional work for SPPC.

5. Do you consider that the estimated costs and savings set out in the FM are reasonable and accurate?

The FM underestimates the training costs for NHS Boards, Local Authorities and hospices. The FM focuses almost exclusively on costs associated with the assessing medical practitioners.

A much more significant cost is the need to provide training for other frontline staff (e.g. nurses, healthcare assistants, social workers) who are likely to be engaged potentially in conversation about assisted suicide. These staff will need to be equipped with the skills to respond appropriately to such enquiries/conversations.

The number of staff needing to be trained is very large. 1 in 3 hospital beds are occupied by people who are in their last year of life. Whilst the numbers of patients wishing to talk about assisted suicide may be small, a very large number of staff need to feel prepared to deal with what will be sensitive, emotionally challenging and highly nuanced conversations.

Section 24 of the FM suggests that these costs can be met from existing budgets. This seems improbable, unless other existing and important training is de-prioritised. There are existing national policies on good end of life care whose implementation is already constrained by the ability to release and access staff for relevant training (e.g. Do Not Attempt Cardio Pulmonary Resuscitation Policy).

In section 37 (Organisations Providing Palliative Care) the FM seems to misunderstand the term "palliative care", implying that palliative care is provided mainly by hospices. Whilst hospices are major providers of specialist palliative care, most palliative care is provided by generalists, in hospitals, care homes or community settings.

Section 37 also makes the assumptions that hospices are opposed to assisted suicide (on religious grounds) and that therefore patients in hospices are likely to be religious and therefore not receptive to assisted suicide, and concludes on this basis that the Bill is therefore unlikely to have any significant cost implication for such organisations. This is extremely flawed logic. Hospices endeavour to support patients and families on an equitable and non-discriminatory basis.

6. If applicable, are you content that your organisation can meet any financial costs that it might incur as a result of the Bill? If not, how do you think these costs should be met?

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7. Does the FM accurately reflect the margins of uncertainty associated with the Bill's estimated costs and with the timescales over which they would be expected to arise?

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Wider Issues

8. Do you believe that the FM reasonably captures any costs associated with the Bill? If not, which other costs might be incurred and by whom?

9. Do you believe that there may be future costs associated with the Bill, for example through subordinate legislation? If so, is it possible to quantify these costs?

Appendix 2 – Response to 2012 Consultation on Proposal for Legislation (resources section)

Q9. What is your assessment of the likely financial implications of the proposed Bill to your organisation? Do you consider that any other financial implications could arise?

There would be a need to provide training for staff who may be working with patients who may want to discuss assisted suicide. This would apply to all health and social care staff working within specialist palliative care as well as to other much larger groups, for example many hospital staff, general practitioners and arguably most care home staff. Nursing staff might be expected to be one of the groups most frequently approached by patients.

This training would be a very significant cost and be difficult to meet within the current financial climate, where training budgets are under pressure and training opportunities restricted.

The process of assessment and prescription, and the vetting, licensing and regulation of facilitators will incur a cost. Any legislation should be clear as to whether these costs are expected to be met by NHS Boards, voluntary organisations, Scottish Government, individuals or others.

There would be a cost to employers and professional bodies who need to develop relevant guidance for staff.

There would be a need to develop appropriate information resources for the general public and this will have a cost. There would be a need to develop appropriate care for the family and friends of people who had committed suicide, which might give rise to additional costs.

Financial savings could accrue to the NHS and Local Government where a person kills them self and therefore does not require further care and/or treatment from the NHS and social work services. There could also be savings from welfare/social security/pension budgets.