



## VIEWS AND REVIEWS

### ACUTE PERSPECTIVE

# David Oliver: £25m for hospices won't go far

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Last month the prime minister pledged a one-off payment of £25m (€28m; \$31m) to boost hospices and palliative care services.<sup>1</sup> Boris Johnson's words were warm and supportive, hinting at more money soon. But was this more than a gesture?

Certainly, the pledge is there in a Number 10 press release,<sup>2</sup> including some positive reaction from the health secretary and charity chief executives at Hospice UK and Thames Hospice. Within a day of Johnson's announcement, however, the chair of NHS Clinical Commissioners told the *Health Service Journal* that the £25m would come from ringfencing existing NHS budgets, inevitably at the expense of other cash starved services.<sup>3</sup> Not new money after all, then.

Hospice UK recently conducted a survey on the current state of the hospice sector.<sup>4,5</sup> Some 73% of respondents had seen the funds they received from clinical commissioning groups frozen or cut, although their own costs were rising. One in three had been forced to cut services, and around half had delayed or cancelled plans to develop or expand them.

For financial context, the total NHS budget was around £125bn for 2017-18.<sup>6</sup> But Hospice UK's figures concluded that, in 2016-17, only 33% of hospice funding in England (about £350m) came from government, the rest coming from charity.<sup>7</sup> But why are hospices still "charitable," in a country with a national health service famously free at the point of delivery and funded from general taxation? It's a historical anomaly stemming from the separate origins of the hospice movement,<sup>8</sup> which surely needs to be tackled with more than token announcements of small redirections of funding.

In palliative medicine, specialist nurse practitioners and their colleagues in multidisciplinary teams have much to be proud of. Hospices don't just provide end-of-life care during final admissions but act as support hubs, venues for respite admissions, and places for symptom control.<sup>7,9</sup>

They're part of a wider palliative care ecosystem that also entails support from specialist clinical teams for end-of-life care in patients' own homes, including care homes. Palliative care services also provide support for hospital inpatients nearing the end of life.<sup>10</sup> With over 500 000 deaths a year, that specialist input is not possible for everyone who needs it, whether dying at home, in a care home, or in hospital. NHS England's *Atlas*

*of Variation in End of Life Care*<sup>11</sup> and the Royal College of Physicians' audit of end-of-life care in hospital<sup>12</sup> have both shown geographical variations in our ability to support people dying out of hospital, palliative care for those who die in hospital, and availability of specialty support between regions and gaps in provision generally.<sup>13 14</sup>

Despite all of this, in 2015 the Economist Intelligence Unit ranked the UK first of 80 countries on an "end-of-life care index." It cited as principal factors the strength of the hospice movement and greater integration of palliative care with the NHS than in most of the world's healthcare systems.<sup>15</sup>

The National Survey of Bereaved People<sup>16</sup> has consistently shown that hospice care offers the best experience for families of dying people and the best symptom control. Nearly half of us will die in hospital when the time comes, but few people choose hospital as their preferred place of death when asked.<sup>7</sup>

The case for more investment in staff, capacity, and capital upgrades seems irrefutable. What could be more important than our one chance to get death right?<sup>17</sup>

This situation surely needs urgent redress, and, while the announcement of more funding is welcome, £25m of non-recurring investment is chickenfeed next to the scale of the problem.

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