Funding and Commissioning: Using the Evidence

Wednesday 14th May 2025
Big Conversation

HospiceUK

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Welcome and introductions

Annette Alcock, Director of Programmes
Hospice UK

HospiceUK

Housekeeping

Please keep your mic muted unless you are asking a question

Please note that the presentations (excluding the Q&A) are being recorded.

The recording and slides will be shared with you after the event, and we'll notify you by email

Please use the Chat function to ask any questions

AI bots are not permitted in these meetings and will be removed

Agenda

10:00	Welcome and introductions	**Annette Alcock**, Director of Programmes Hospice UK
10:05	Public expenditure on people in the last year of life	**Sarah Scobie**, Deputy Director of Research Nuffield Trust
10:25	An Introduction to Community Currency Models	**Gary Stinson**, Payment Development Manager NHS England
10:45	Getting outcomes to work well for you and your team	**Professor Fliss Murtagh**, Professor of Palliative Care & Director of the Wolfson Palliative Care Research Centre
11:00	Q&A	**All**
11:25 – 11:30	Close	**Annette Alcock**, Director of Programmes Hospice UK

Public expenditure on people in the last year of life

14 May 2025

Lisa Cummins, Sophie Julian, Theo Georghiou, Gayathri Kumar, Sarah Scobie

Health Economics Unit

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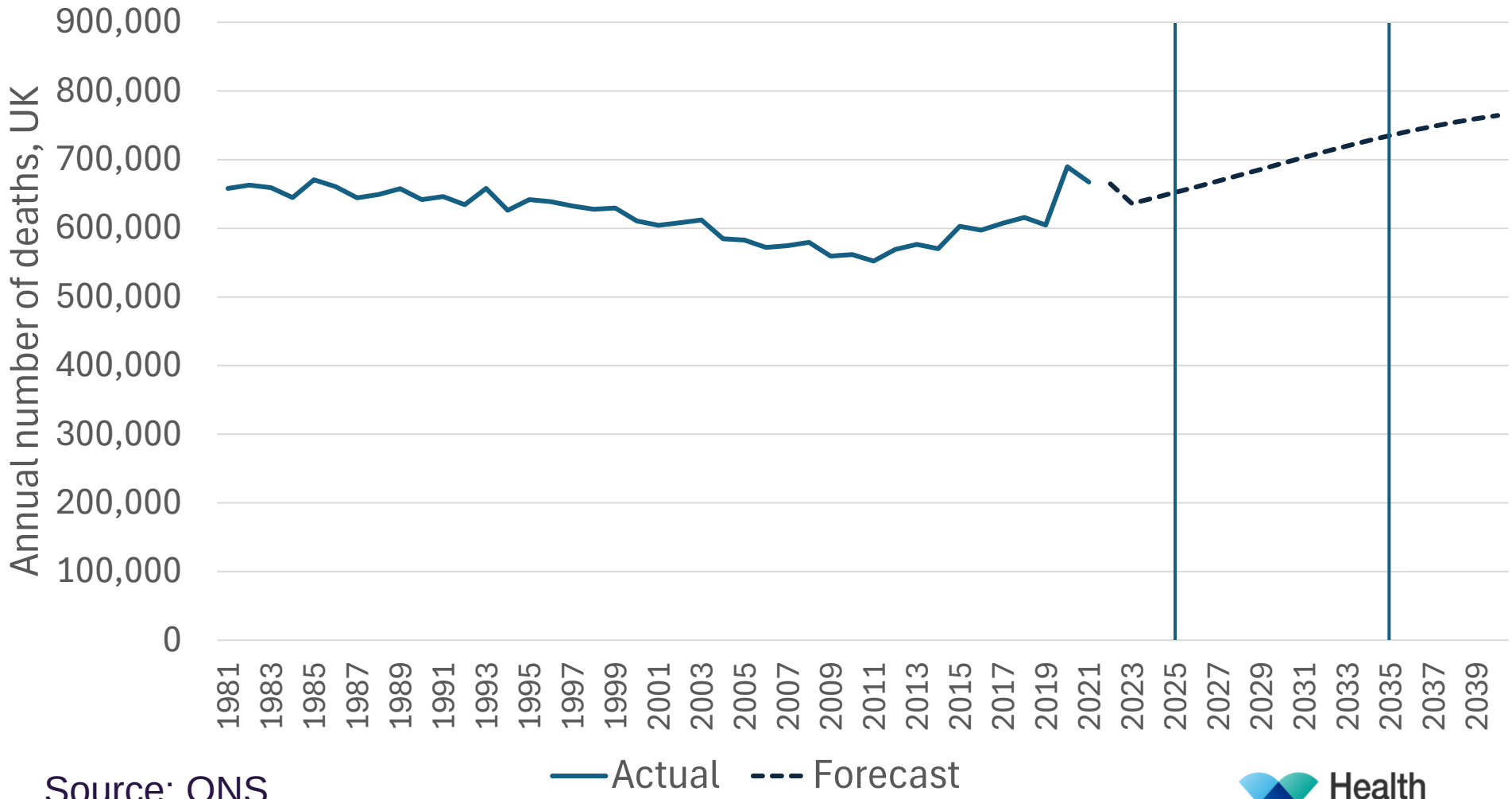
By 2035 there will be 13% more deaths



Source: ONS

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Research aims

Little evidence on public expenditure for people in their last year of life.

Critical gap in evidence available to decision makers to make the best possible use of public funds and get care and support right.

To address this gap, we estimate how much the UK spends on people in the last year of life across health care, social care and social security

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Findings for the UK

How much public expenditure is spent on people in the last year of life in the UK in 2022?

£22.1 billion in total

We estimate that, in 2022, at least **£22.1 billion*** of public expenditure was spent on adults in the last year of life

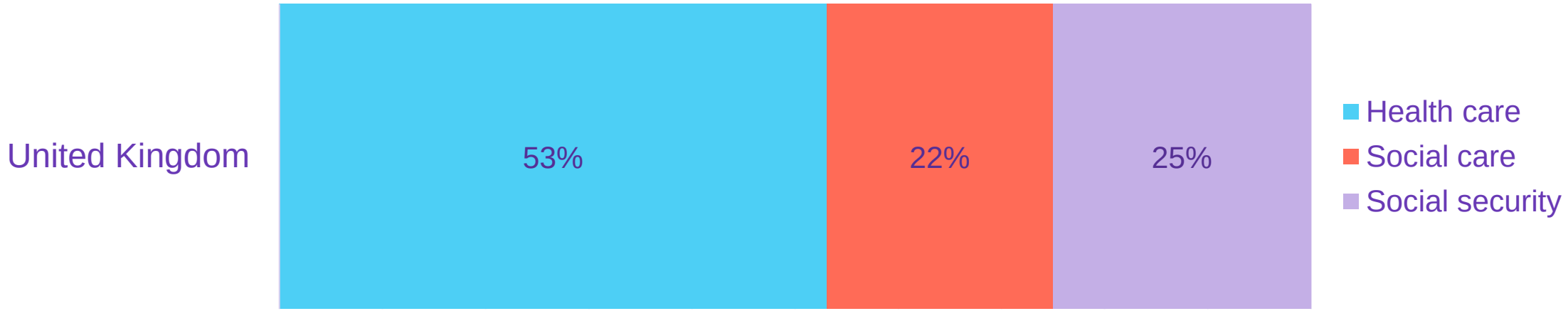
£33,960 per person

This amounts to **£33,960 per adult who died**

*UK public expenditure on health care, social care and social security for people aged 18 or older in the final year of life, in 2022, to £22.1 billion (95% credible interval £22.0 billion to £22.3 billion).

How is public expenditure distributed?

Over **half (53%)** was spent on health care **(£11.7 billion)**; **22%** social care **(£4.8 billion)**; **25%** social security payments **(£5.5 billion).**



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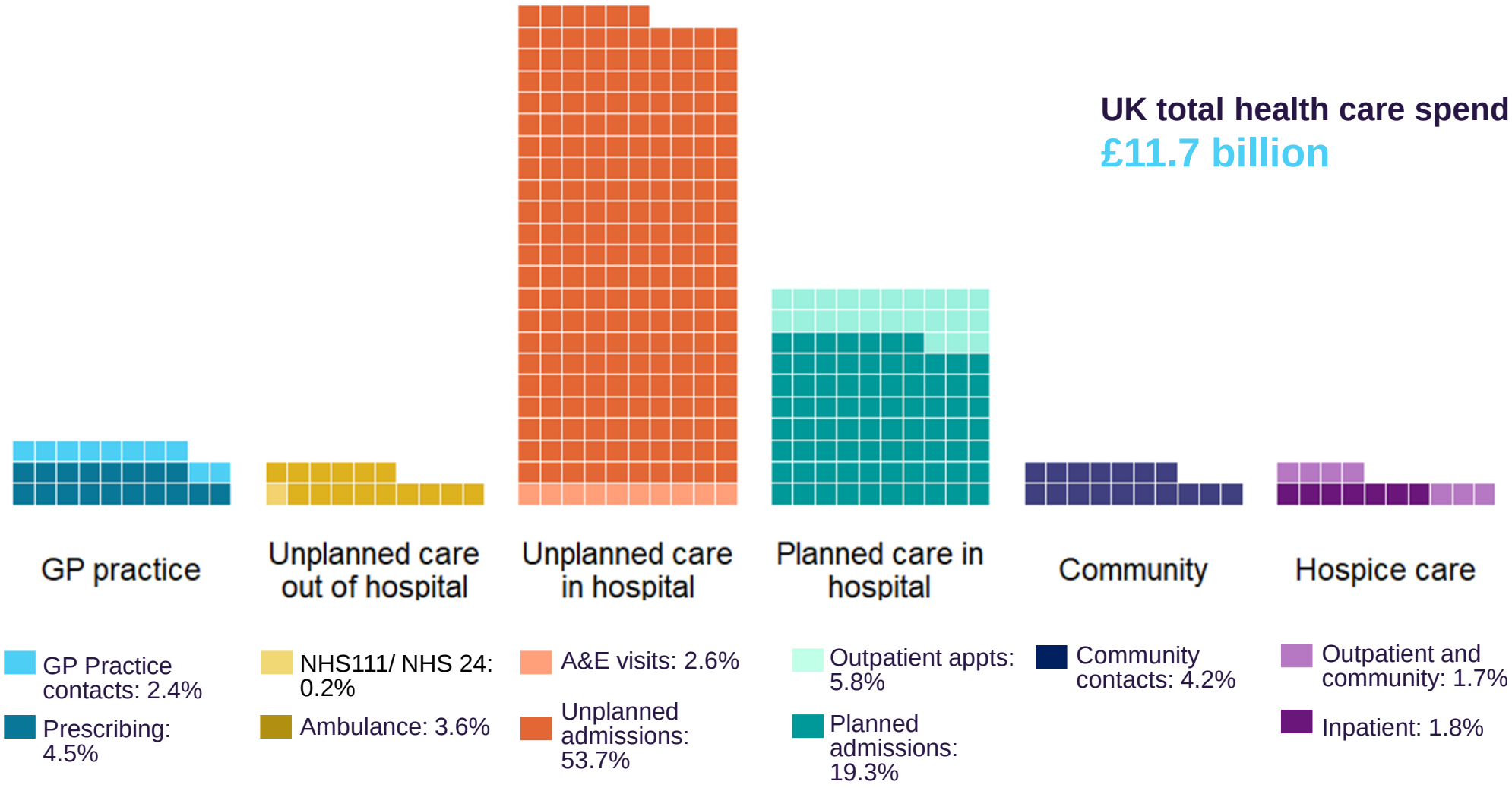
UK health care spend

UK total health care spend:
£11.7 billion



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Relative to all health care spend (England only)

	Last year of life total, £m (cash)	Total estimated sector spend, £m (cash) 2022/23 *	Last year of life as % England total
GP primary care	£ 237	£ 11,510	2.1%
Community prescribing	£ 418	£ 9,780	4.3%
Community healthcare	£ 432	£ 9,270	4.7%
Ambulance/111	£ 389	£ 3,580	10.9%
Acute healthcare	£ 7,637	£ 80,750	9.5%

https://www.nuffieldtrust.org.uk/resource/where-does-the-nhs-money-go

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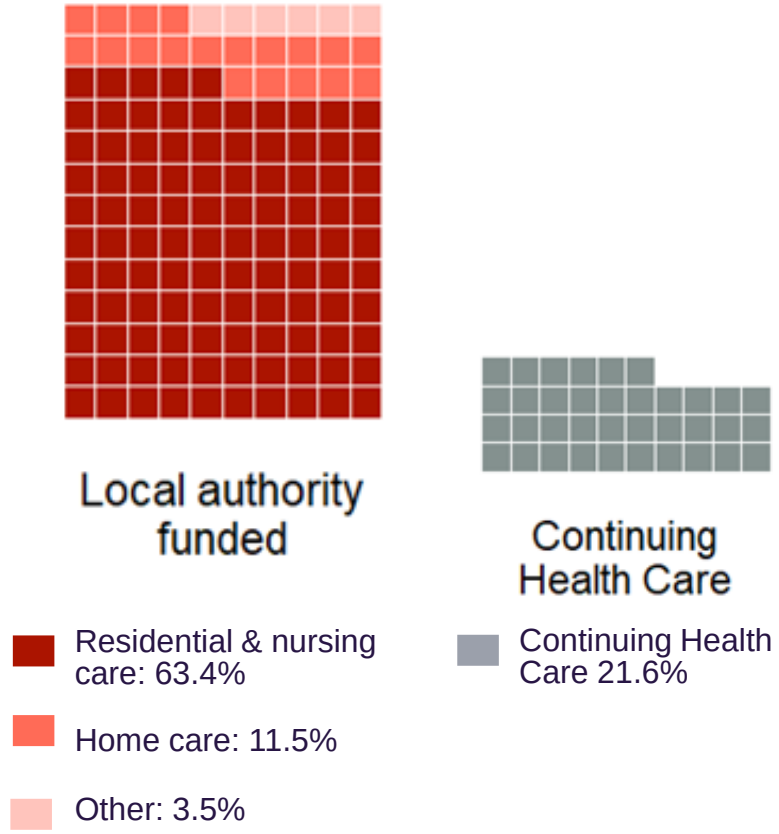
Hospice expenditure

	UK
Charitable spend on service £millions	940.6
Public expenditure £millions	**413.6**
% public	**44%**
Total expenditure per person who died	£1,443
Public expenditure per person who died	**£ 634**

Source: Hospice UK. Data provided by independent hospices. Financial year 2021/22.

UK social care spend



Total social care spend:
£4.8 billion

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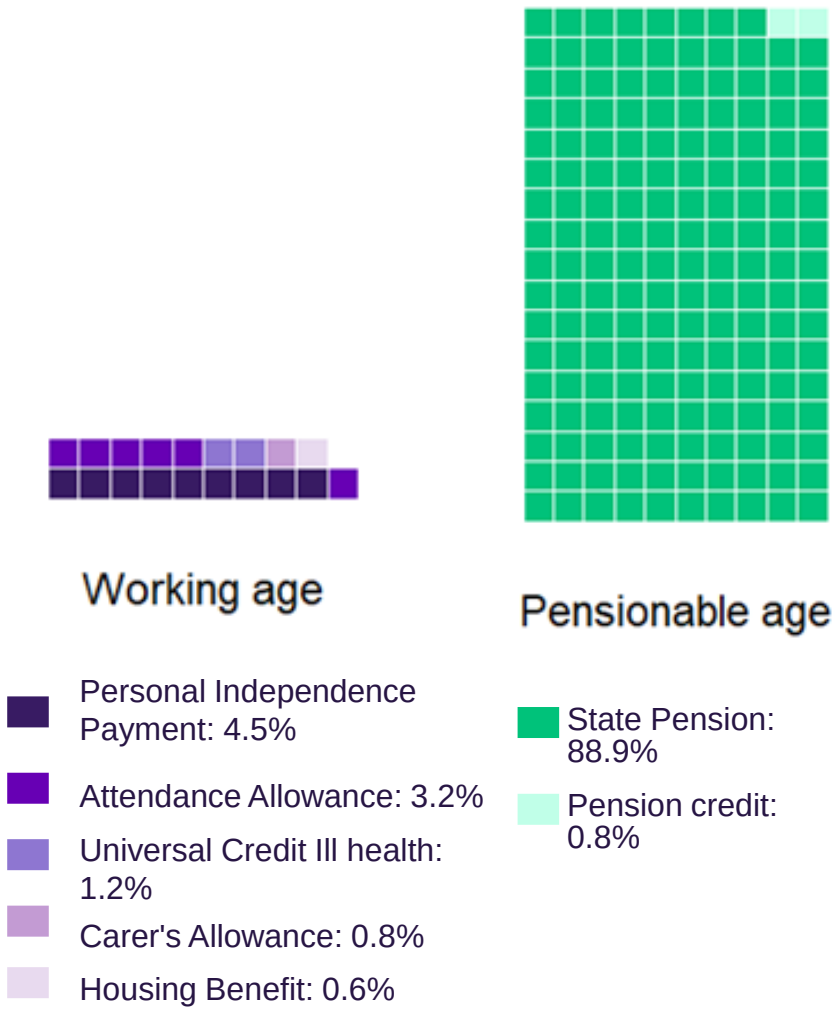
UK social security spend



Total social security spend:
£5.5 billion

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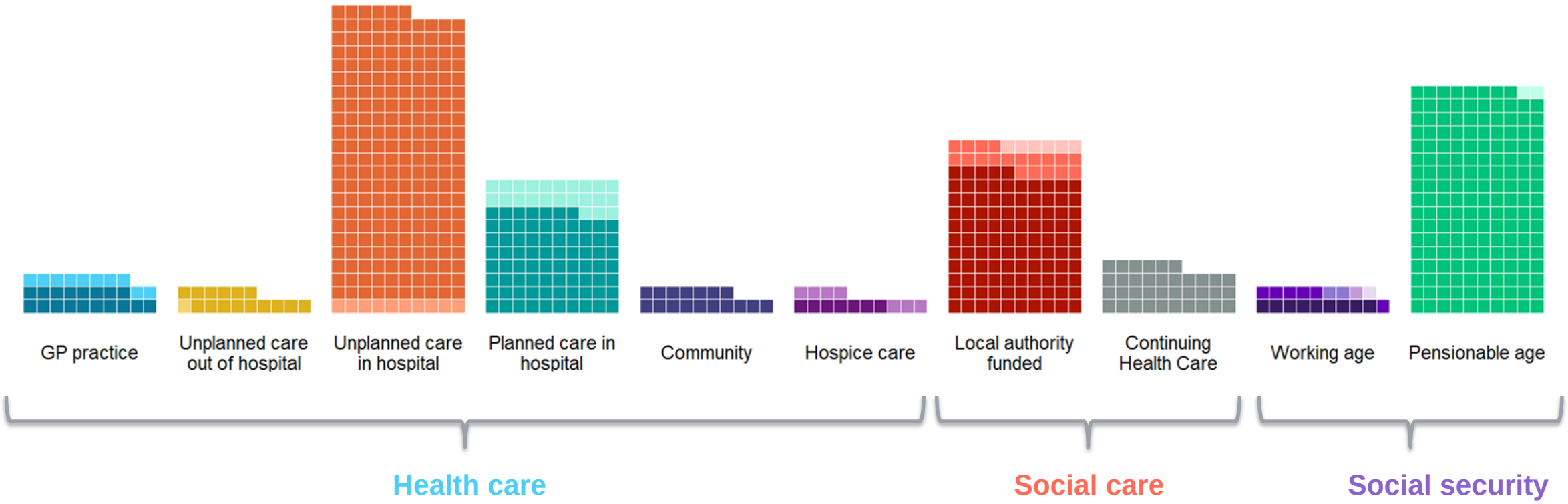
Components of expenditure UK



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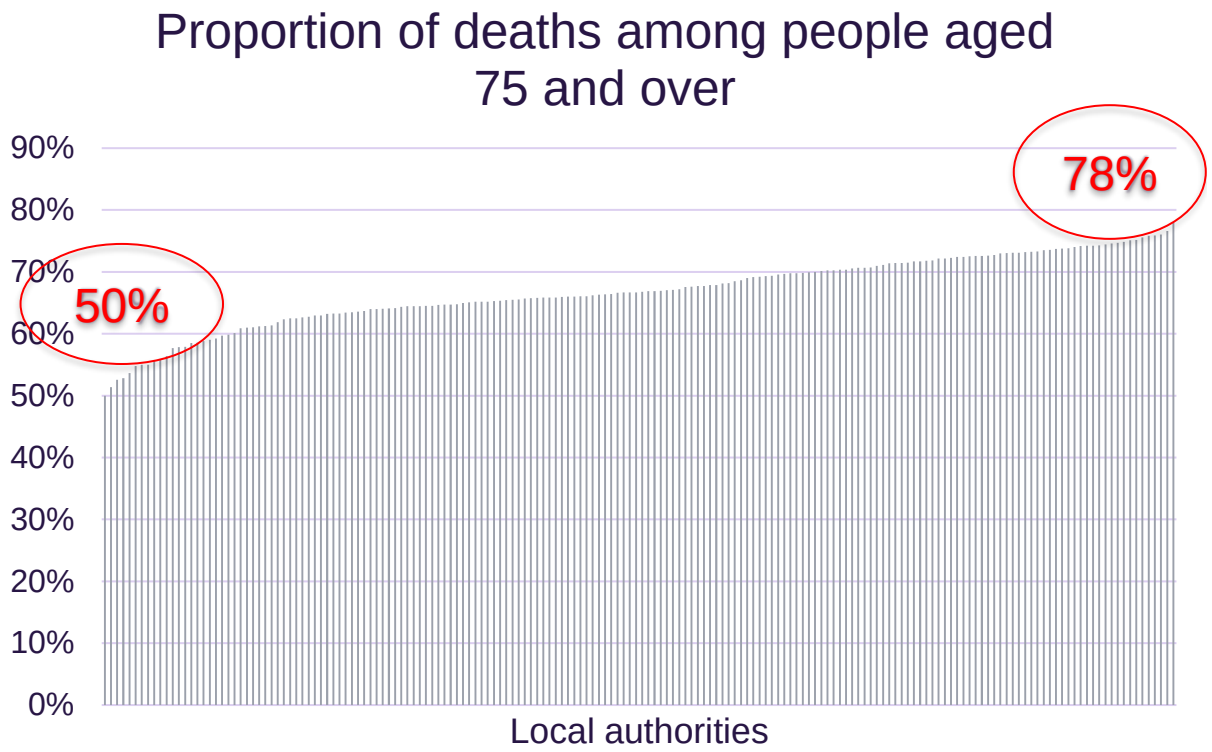
Key messages

- Insufficient focus from policy makers on people at the end of life
- Hospital spend continues to dominate health care spend
- Health and care inequality a key consideration for improving end of life care



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Full report

Cummins L, Julian S, Georghiou T, Kumar G, Scobie S (2025)

Public expenditure In the last year of life, Marie Curie

https://www.mariecurie.org.uk/document/public-expenditure-in-the-last-year-of-life-report

Scobie S and Georghiou T (2025) “Why is it so difficult to estimate expenditure on health and care at the end of life?”, Nuffield Trust

https://www.nuffieldtrust.org.uk/news-item/why-is-it-so-difficult-to-estimate-expenditure-on-health-and-care-at-the-end-of-life

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An Introduction to Community Currency Models

Gary Stinson
Payment Development Manager
NHS England

14/05/2025

Agenda

- Background
- What are currencies?
- Programme Timeline
- Publication of 2025/26 NHS Payment Scheme
- 2026/27 and beyond
- Support and Guidance

Background

Since the introduction of a much more transparent approach to paying for acute health services through the use of consistent units of care known as currencies, it has been an ambition to develop currency models for Community Care, Mental Health Care and Ambulance services.

The absence of these models in community services has led to a lack of useable evidence which has meant that:

1. Providers struggle to understand care in a consistent way.
2. There is a lack of evidence to support commissioning decision making.
3. Lack of standardisation creates a barrier to collaboration and benchmarking.

How do we define the term “Currency”?

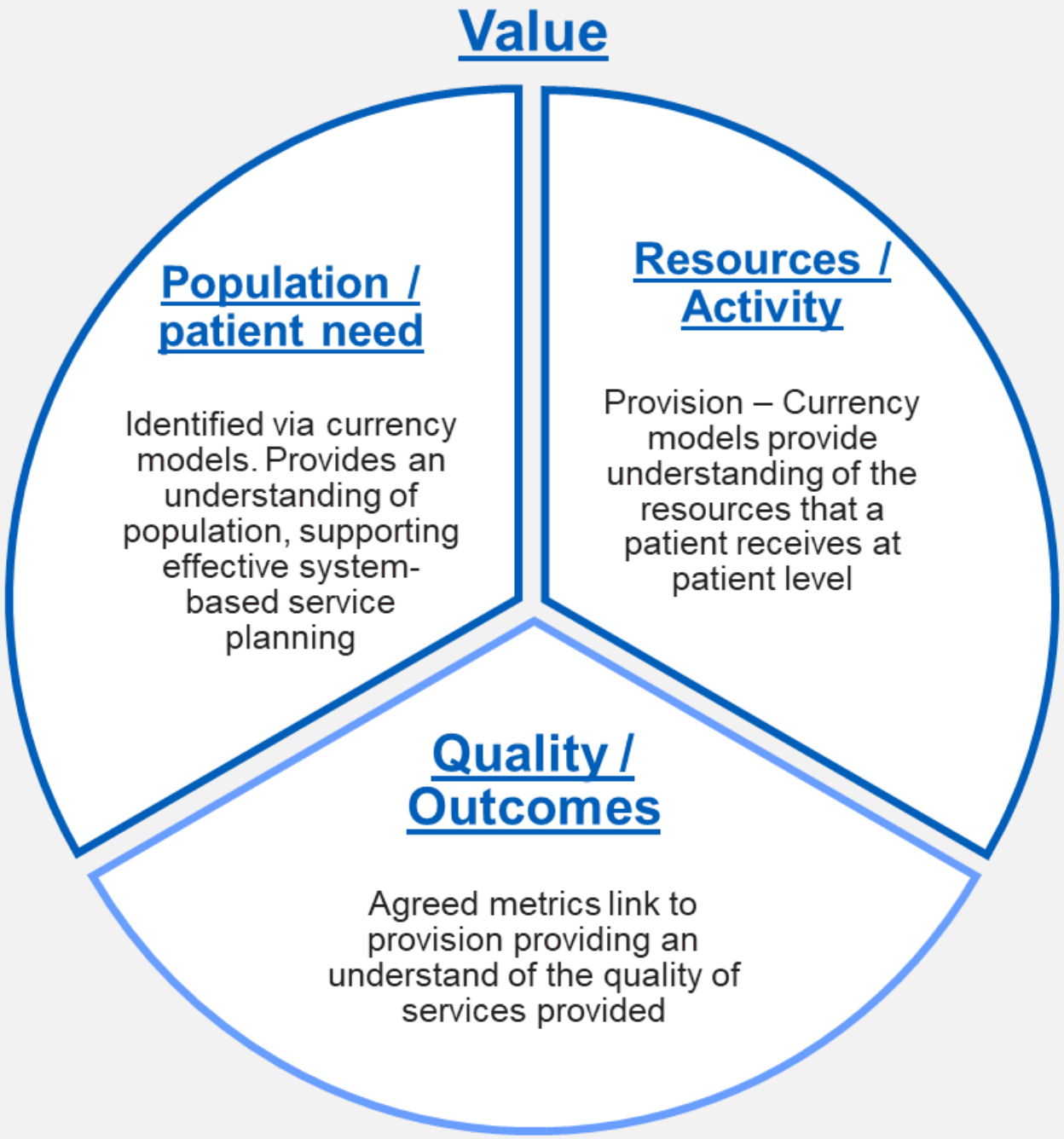
What a currency is:

- A way of grouping patients’ activities into units that are clinically similar and have broadly similar resource needs and costs.
- Each unit of currency must be evidence-based and analytically identifiable, but most importantly it must be clinically meaningful.
- The currency must be rooted to the care the patient receives and be practical to implement.
- A currency model provides a structured way to classify a population based on specific attributes such as needs.

What a currency is not:

- Currency models are often mistaken for a price or a tariff.
- A currency can be used to support payment by providing a standardised methodology for understanding a patient and their care needs.
- We expect that currency models developed will support commissioning discussions and service planning as part of an evidence base and alongside other supportive tools.

Our vision is for currency models - to be a tool for understanding the value of care for clinicians, commissioners, policy



How do we identify the population or patient need?

1. Identifying the patient within the population
2. Understanding the needs and/or complexity of the patient
3. Tracking the patient's journey or trajectory over time

How do we identify resources and activity?

1. Allocate activity and resources to the units reflecting the support provided to the patient to meet the identified need.

2. Activity/resource needs to be identifiable through existing data and can be allocated to the unit easily both locally and nationally.

Using outcome measures

1. Measures should be consistently measurable and available for use on a national basis where possible.

2. Measures support an understanding of the success of supporting the needs of the patient.

Development Timeline

Our mission is for currencies to be used as a tool to understand and improve patient outcomes

We are Here

2017 - 2019

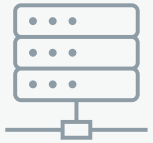
Development of community currencies began in 2017 with 5 models initially developed and published by NHS England for testing in 2019.

2021/22 - 2024/25

Models shared as developed with a Soft Launch of population wide models in June 2024.

2025/26

Currencies to be published for use alongside 2025/26 NHS Payment Scheme.



2026/27

Further support and guidance, along with expanded ICB and provider expectations.

Beyond 2026/27

Development and implementation continues with further requirements set out in 2026/27.

2025/26 NHS Payment Scheme

In April we published the latest NHS Payment Scheme, which governs transactions between providers and commissioners of secondary healthcare.

The Payment Scheme sets out –

- Full guidance relating to the development and implementation of currency models for community health services.
- What ICBs should expect from 2025/26 onwards
- What providers should implement from 2025/26 onwards

Alongside this guidance, resources has been produced and shared on FutureNHS, with an offer of further engagement and support through 2025/26.

Currency Models

- Long Term Conditions
- Short Term Interventions
- Frailty
- Last Year of Life
- CYP Disabilities and Long-Term Conditions
- CYP Short Term Interventions
- CYP Palliative and End of Life Care
- Wheelchairs

Currency models guidance can be found here.

What does this mean for Integrated Care Boards?

1. ICBs should expect providers to begin collecting currency related data as part of standard practice and using this data as defined above. Commissioners should begin to request currency related data as part of day-to-day working within local systems.

2. ICBs should begin to use currency models as part of planning processes across system and as part of processes to evaluate services provision against the needs of local populations. Using standardised data to aid collaboration.

3. ICBs should consider currency models for Community Services when reviewing when reviewing API fixed payments – moving towards evidence-based decision making for commissioning.

What does this mean for providers?

1. Providers should ensure that the data items required to populate each currency model are collected and stored locally. Key data fields are set out on FutureNHS. As per design, all data items can be submitted to national data sets, providers should ensure that this data is provided within current national data submissions.

2. Providers should begin to use currency data locally to support the planning of existing services and future care provision to understand population-based needs and how these needs can be met in collaboration with other local teams/providers.

3. Providers are required to use of currency models and associated data on a day-to-day basis as part of local benchmarking.

4. Providers should use currency information as an evidence base to underpin and support an evidence-based approach to commissioning and contracting.

2025 / 2026 – Other Highlights

NHS trusts are required to submit costs for Community Currency Models for the 2024/25 National Cost Collection.

Further engagement throughout the year, aimed at raising awareness of the models across organisation structures.

Continued development of guidance and support tools. Stakeholders asked to suggest what support they may require.

Opportunities to collaborate/learn from each other using FutureNHS.

How does this align with Hospices?

Currencies provide a standardised methodology for understanding a patient, tracking care provided and understand outcomes.

The models were developed by clinicians and subject matter experts to support parity

Currency models provide evidence on complexity and changes in patient needs which may place financial pressure on a provider or system.

- This methodology has merit irrespective of provider type and supports a wider movement to evidence-based commissioning.
- This also supports collaboration – including understanding populations for a neighbourhood approach.
- Currency related data will be increasingly used to support movement of services/patients across traditional setting boundaries.

- The underlying data is collected by many providers already – however a there is no consistent national picture for policy making and funding discussions.
- It could be argued that this lack of nationally available information is a blocker to evidence-based funding.

Beyond 2025/26 - Highlights

Continue development of currency models. Focus on Long Term Conditions and CYP models

Expand guidance on how currency model will support future payment and movement of services into community settings.

How can currencies and payment support reduction in waiting lists?

How will neighbourhood approaches be funded and how can currencies support this process?

FutureNHS Platform

You are welcome to sign up for our FutureNHS Workspace, our primary point of contact for currencies, guidance and queries.
Currency Models, Support and Guidance

Currently available tools and support –

- FAQs
- Currency model guidance
- Case studies
- Grouping Methodologies
- Introduction to… guides
- Links to published guidance

In development –

- SQL code to support currency extraction
- National statistics based on national submissions
- Further guidance

Suggestions –

- Communities of Practice – collective learning
    - Implementation of models
    - Use of software
    - System pioneers

Thank you.

For questions, please contact
Gary.Stinson@nhs.net

Getting outcomes to work well for you and your team

Fliss Murtagh, Professor of Palliative Care,
Wolfson Palliative Care Research Centre, Hull York Medical School

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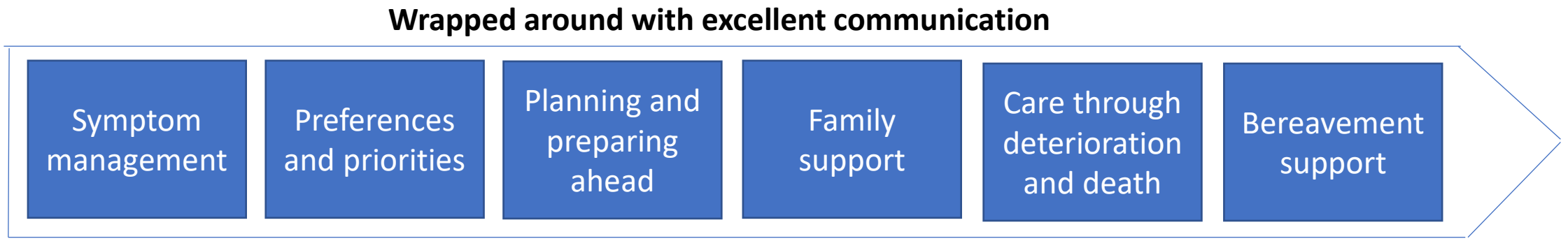
Palliative and end of life care

How can we comprehensively assess, follow through, and **demonstrate** what we do (and don't) achieve for individuals and families in our comprehensive, multidisciplinary, and multi-domain practice?



How can we do so when our patients face serious illness with often unavoidably poor outcomes?

Overview

1. What to measure?
2. When to measure it?
3. How to use this data?

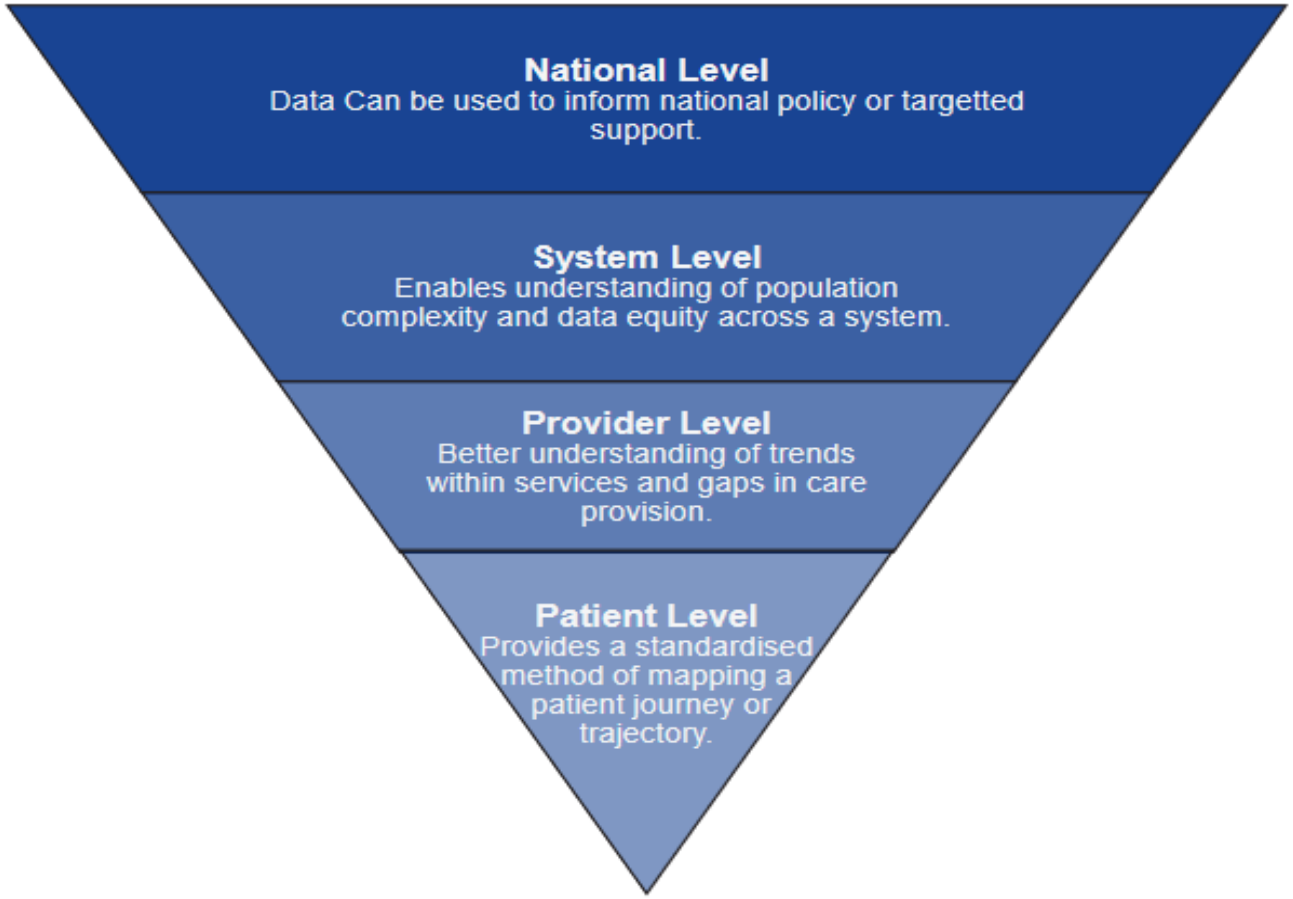
What to measure - what is the patient-level data you need?

https://www.datadictionary.nhs.uk/

- **Personal and demographic data**
  - Age, sex, ethnicity, main diagnosis, secondary conditions or co-morbidities
- **Social and personal circumstances data**
  - Marital status, deprivation status (derive from postcode), lives alone or not
- **Care event and screening activity**
  - Episode start and end – derive episode length
  - Services received – as a minimum: inpatient and homecare (outpatient, therapies)
  - Referral information and episode results, including place of death (and preferred)
- **Scored outcome assessments … see next slides**

Patient-level data can be used to build …

Fig. 1 How can data be grouped for various uses



Scored outcome assessments

- **Palliative Phase of Illness**
  - Australian modified definitions (good reliability)
- **Functional status**
  - **Australia-modified Karnofsky Performance Scale**
  - reliable, in cancer & non-cancer, more discriminatory than ECOG or WHO
- **[Problem severity scale**
  - Integrated Palliative care Outcome Scale IPOS
  - Valid, reliable, sensitive to change, brief
  - Patient and proxy versions]

These measures are now in use by 76% of UK hospice and palliative care teams

What is palliative Phase of Illness?

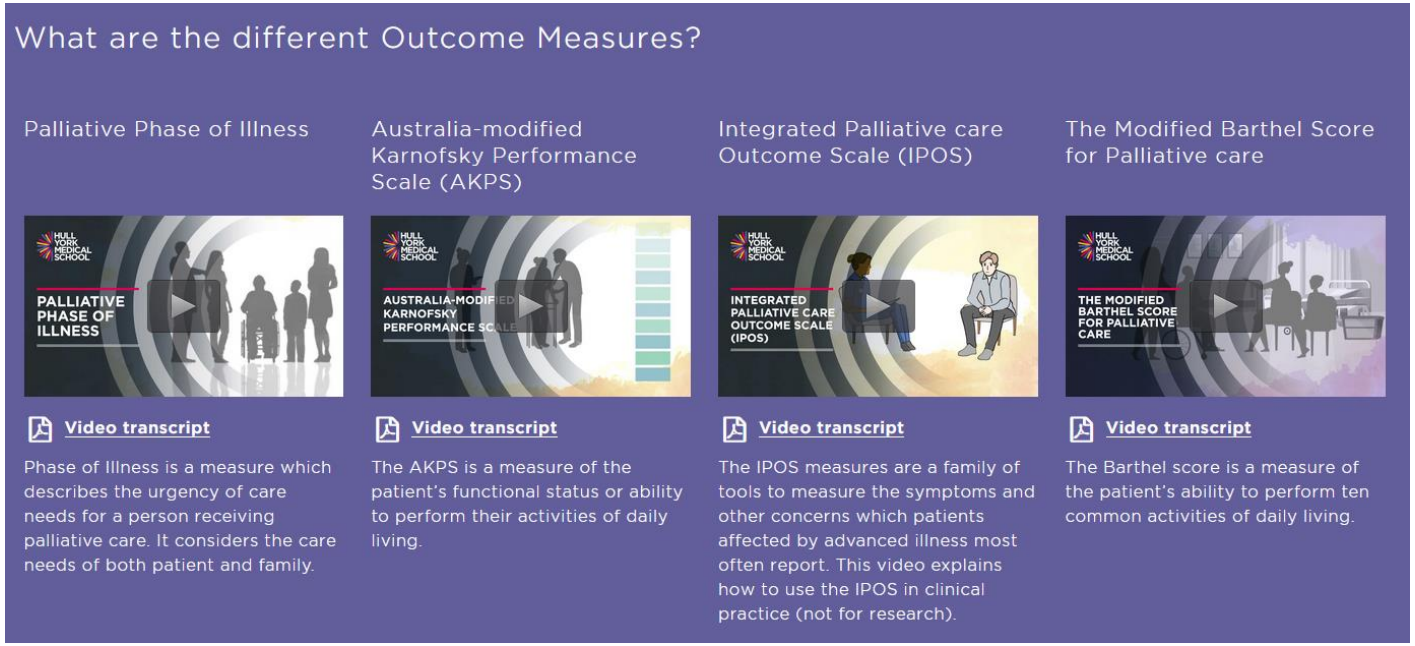
Training here:
www.hyms.ac.uk/research/research-centres-and-groups/wolfson/resolve/access-resolve-training-resources

Based on the urgency of the current plan of care:

- Stable
- Unstable
- Deteriorating

Apart from:

- Dying or Terminal
- Deceased (Bereaved)



Based on proximity to death or after death

Masso et al. Palliative Care Phase: Inter-rater reliability and acceptability in a national study. Palliative Medicine. 2014
https://journals.sagepub.com/doi/full/10.1177/0269216314551814

What is AKPS?

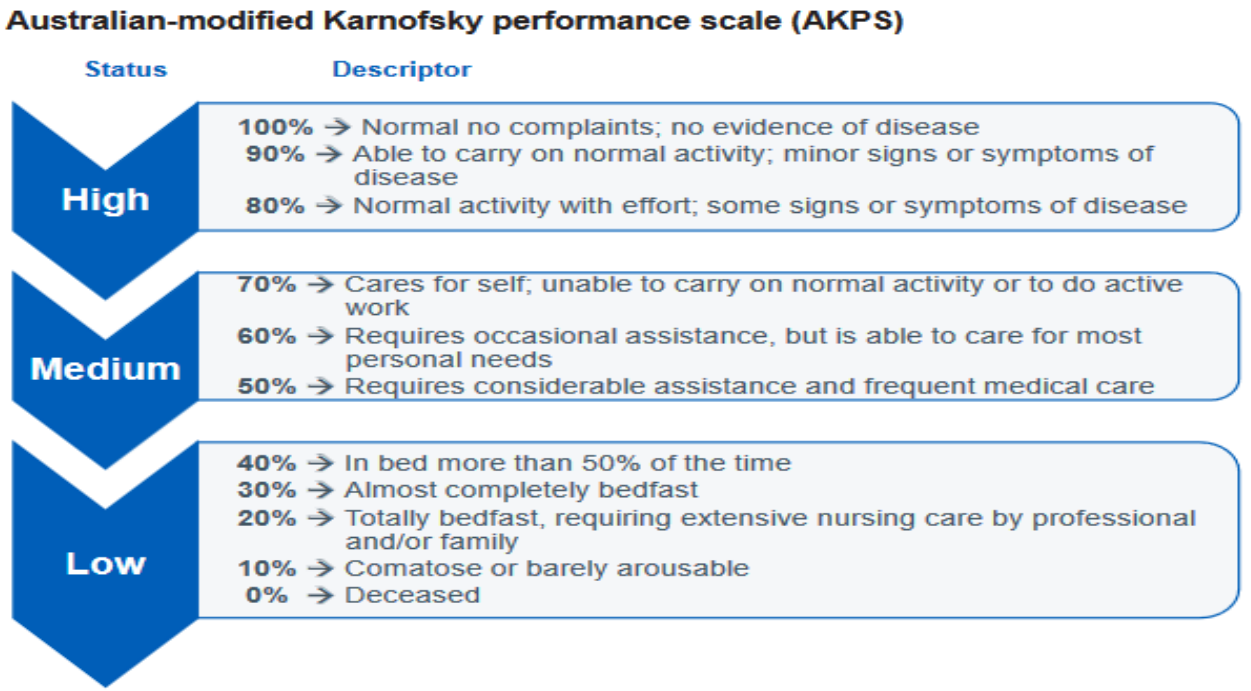
Abernethy et al. The Australia-modified Karnofsky Performance Status (AKPS) scale. BMC Palliative Care. 2005. https://pubmed.ncbi.nlm.nih.gov/16283937/

A measure of functional status:

- Australia-modified Karnofsky Performance Status
- 1 item/11 options

Training here:
www.hyms.ac.uk/research/research-centres-and-groups/wolfson/resolve/access-resolve-training-resources

AKPS ASSESSMENT CRITERIA	SCORE
Normal; no complaints; no evidence of disease	100
Able to carry on normal activity; minor sign of symptoms of disease	90
Normal activity with effort; some signs or symptoms of disease	80
Cares for self; unable to carry on normal activity or to do active work	70
Able to care for most needs; but requires occasional assistance	60
Considerable assistance and frequent medical care required	50
In bed more than 50% of the time	40
Almost completely bedfast	30
Totally bedfast and requiring extensive nursing care by professionals and/or family	20
Comatose or barely rousable	10
Dead	0



Additional measures which are very useful (IPOS)

Q1. What have been the patient's main problems over the past 3 days?

1. _____
2. _____
3. _____

Q2. Please tick one box that best describes how the patient has been affected by each of the following symptoms over the past 3 days?

	Not at all	*Slightly*	*Moderately*	*Severely*	*Over-whelmingly*	*Cannot assess (e.g. unconscious)*
Pain	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐
Shortness of breath	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐
Weakness or lack of energy	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐
Nausea (feeling like you are going to be sick)	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐
Vomiting (being sick)	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐
Poor appetite	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐
Constipation	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐
Sore or dry mouth	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐
Drowsiness	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐
Poor mobility	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐

Over the past 3 days:

	Not at all	*Occasionally*	*Sometimes*	*Most of the time*	*Always*	*Cannot assess (e.g. unconscious)*
Q3. Has s/he been feeling anxious or worried about his/her illness or treatment?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐
Q4. Have any of his/her family or friends been anxious or worried about the patient?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐
Q5. Do you think s/he felt depressed?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐

	Always	*Most of the time*	*Sometimes*	*Occasionally*	*Not at all*	*Cannot assess (e.g. unconscious)*
Q6. Do you think s/he has felt at peace?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐
Q7. Has the patient been able to share how s/he is feeling with his/her family or friends as much as s/he wanted?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐
Q8. Has the patient had as much information as s/he wanted?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐

	Problems addressed/ No problems	*Problems mostly addressed*	*Problems partly addressed*	*Problems hardly addressed*	*Problems not addressed*	*Cannot assess (e.g. unconscious)*
Q9. Have any practical problems resulting from his/her illness been addressed? (such as financial or personal)	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐

Training here:

www.hyms.ac.uk/research/research-centres-and-groups/wolfson/resolve/access-resolve-training-resources

Additional measures which are very useful (CFS)

- The Rockwood Clinical Frailty Score
- See https://www.bgs.org.uk/sites/default/files/content/attachment/2018-07-05/rockwood_cfs.pdf
- K. Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489-495

Clinical Frailty Scale

	1	**Very Fit**	People who are robust, active, energetic, and motivated. They commonly exercise regularly and are among the fittest for their age.
	2	**Well**	People who have no active disease symptoms but are less fit than category one. Often, they exercise or are very active occasionally, e.g. seasonally.
	3	**Managing Well**	People whose medical problems are well controlled but are not regularly active beyond routine walking.
	4	**Living with Very Mild Frailty**	Previously "Vulnerable," this category marks early transition from complete independence. While not dependant on others for daily help, often symptoms limit activities. A common complaint is being "slowed up", and/or being tired during the day.
	5	**Living with Mild Frailty**	These people often have more evident slowing, and need help in high order IADLS (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation, medication, and housework.
	6	**Living with Moderate Frailty**	People who need help with all outside activities and with keeping house. Inside, they often have problems with stairs, need help bathing and might need minimal assistance (cuing, standby) with dressing).
	7	**Living with Severe Frailty**	Completely dependent for personal care, from whatever cause (Physical or cognitive). Even so, they seem stable and not at high risk of dying (within - 6 months).
	8	**Living with very Severe Frailty**	Completely dependent for personal care and approaching the end of life. Typically, they could not recover even from a minor illness.
	9	**Terminally Ill**	Approaching the end of life. This category applies to people with a life expectancy <6 months, who are not otherwise evidently frail.

When to measure outcomes data and what this gives you

1. Phase, AKPS, IPOS (and CFS?) at first assessment
2. Monitor Phase of Illness daily or at contacts
3. Re-measure AKPS and IPOS at first (and subsequent) Phase change
4. Be sure to capture Phase, AKPS and IPOS close to episode end, discharge or death

- Understanding of complexity and casemix at start of episode
- Data needed for the Last Year of Life currency
- Data on your outcomes: to demonstrate impact

1. When to measure IPOS and what this gives you

- Data needed for the Last Year of Life currency
- Being able to demonstrate the impact of care – to the team, to the leads and managers, to the commissioners, to fundraisers/public
- Can use palliative Phase, AKPS, IPOS to improve team communication – both internally, and to externally to facilitate better integrated care with eg GPs, DNs, community nurses, hospitals
- Supporting new and junior staff in comprehensive and holistic assessments and follow ups (use IPOS to support dialogue)

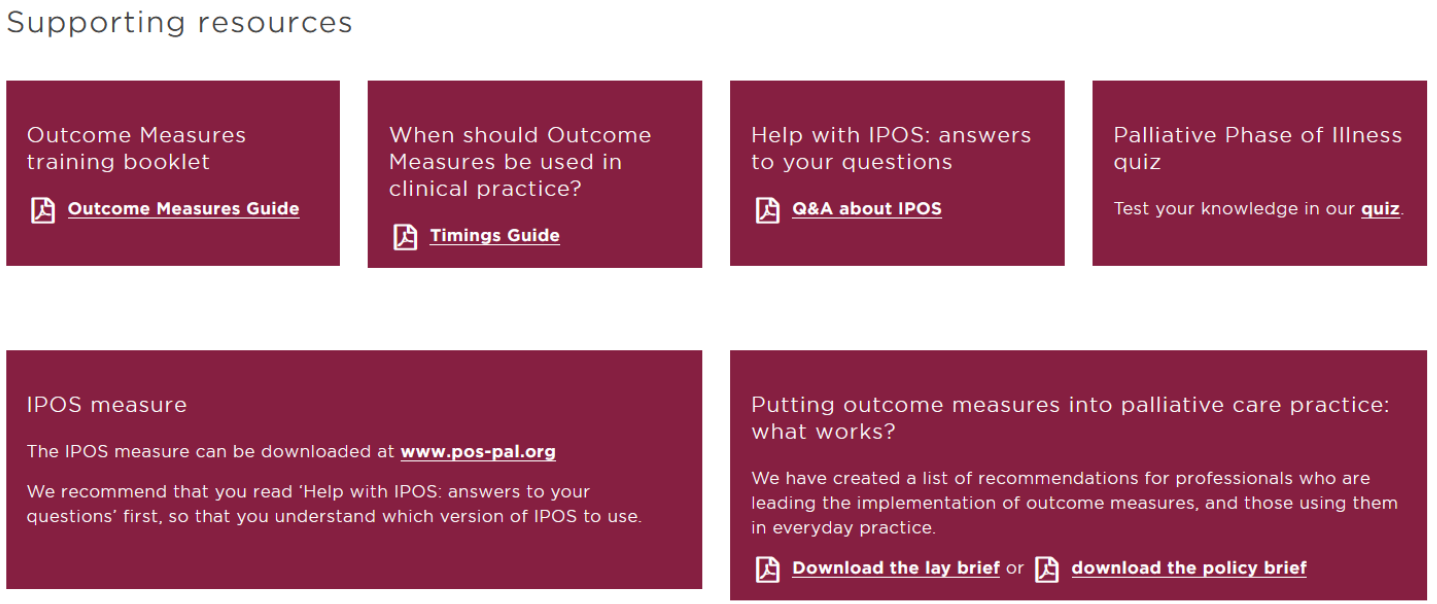
2. When to measure IPOS and what this gives you

- Prioritising referrals and weekend work, especially when busy of short staffed
- Improving/standardising clinical reviews and handovers
- New service development – an inbuilt way to monitor if a new service or a service development brings benefit or not
- Business intelligence – to inform and underpin any business case for resources or funding
- To measure casemix and complexity at start of episode – strong links here to work on Safer Staffing and informing staffing levels for effective delivery and safety of care

Using outcome measures with patients

- Phase of Illness and AKPS are staff measures
- IPOS: some patients want to /are able to engage; others not
- Measures can be completely and ‘invisibly’ integrated into holistic assessment by staff
- Most helpful if staff see IPOS as opening dialogue, and used to monitor and improve care

Training resources here: www.hyms.ac.uk/research/research-centres-and-groups/wolfson/resolve/access-resolve-training-resources



Main successes applying outcome measures

Widespread clinical use of the core individual-level outcome measures – palliative Phase of Illness, AKPS, IPOS - in the UK and beyond

UK Community of Practice in partnership with Hospice UK – recently clinical and data

Considerable **iterative** learning about use and implementation of outcome measures, based on dialogue between people with experience of advanced illness, practitioners and researchers

Prototype Outcomes Registry established

- Outcomes reporting for participating sites established
- Beginning to look at comparative outcomes

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Thank you

fliss.murtagh@hyms.ac.uk

Full report on complexity and casemix available at

https://www.ncbi.nlm.nih.gov/books/NBK597740/

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Questions and Discussion

HospiceUK

Hospice UK data collation 2025

Every year, Hospice UK collates, analyses and shares data about hospice services. This forms a key part of our work fighting for hospice care for all who need it, for now and forever.

This year we are asking our members to respond to the following surveys by **30th June 2025**.

more details

Activity and patient demographic data

HospiceUK

more details

Workforce data collation

HospiceUK

Feedback Survey

Funding and Commissioning: Using the Evidence - Big Conversation 14 May 25

Please consider sparing a few minutes to answer this survey, so that we can continue to improve future Big Conversation events:

https://forms.office.com/e/Vy2nNJWbB9

Thank you

HospiceUK

Our Big Conversation events are supported by:

MDDUS
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