

Appendix A: Identifying the evidence

This scoping review followed the proposed six stages advised by Arksey and O’Malley (2005) and Levac and colleagues (2010), as well as guidance and commentary on scoping reviews (Colquhoun and others., 2014; Peters and others., 2015; Tricco and others., 2018). The stages included:

1) **Defining the research question:** we worked with NHS England/ Improvement to identify this research question: What evidence exists on the costs of specialist level palliative care delivered in the community?

2) **Identifying relevant studies:** The review team conducted the searches in partnership with a subject area librarian. We initially only included reviews in the Cochrane Library from 2000 onwards, and then single studies from any of the following databases Embase, MEDLINE, HMIC, Social Policy and Practice from 2010 onwards. We then searched references of the included texts, relevant systematic reviews from three published overviews (Bainbridge and others 2016, Brereton and others 2017, and Luta and others 2021), as well as on 10 websites of health charities and policy organisations, and complemented all of the approach above with interviews with key stakeholders to identify possible case studies.

3) **Selecting the evidence:** Duplicate records were removed prior to screening. To facilitate screening, guidelines were developed around the inclusion and exclusion criteria (see Table A1). Articles were reviewed against inclusion and exclusion criteria in two stages: (i) titles and abstracts, and (ii) full texts. The first reviewer (RH) examined all texts and the second reviewer (SK) examined a 10% subset at both stages applying the inclusion/exclusion criteria. The two reviewers (RH, SK) met to discuss their decisions and resolve discrepancies. Based on these discrepancies, amendments were made to the guidelines to improve clarity.

Table A1: Eligibility criteria

Theme	Criteria
Costs	Articles were included if they described or analysed costs using any approach, including CBA, CEA, CUA. Where no analysis of costs was carried out the study was excluded.
Specialist level	Articles were included if they examined the costs of specialist level palliative care (SLPC) services in the community for adults and children and young people, where the definition of SLPC aligned with the national service specifications.

Community setting

Articles were included if they included any form of community-based SLPC delivered in any out of (acute) hospital setting, including within social care settings. However, it should be noted that some specialist teams that work in community settings are employed by acute providers. Some studies also described outpatient units as community settings.

Geography

The review of reviews examined international evidence from high-income countries, while the single studies focused on UK-based evidence.

Language

Only studies published in English were included.

Publication type

Both academic or grey literature were included, and commentaries or opinion pieces were excluded.

4) **Charting the data:** Data was extracted from all relevant evidence across a range of categories including: author and year of publication, patient group, intervention (e.g. setting, service, list of specialist characteristics), and any cost-related findings (see Tables B1 and B2). Full text extractions were carried out by two reviewers (RH and SK).

5) **Collating, summarising and reporting the results:** Thematic analysis was used to organise findings.

6) **Consulting with stakeholders:** to validate findings and further develop analysis and interpretation, we brought emerging results to NHSE/I Commissioning and Costing steering group at three time points, once for their comments on the planned evidence search approach, emerging findings and the near-final draft of the output for commissioners.

Appendix B: Evidence examined

Table B1: Summary of international reviews

Review (no. of studies covering costs/service use)	Aim	Patient population	Intervention	Comparator	Key findings related to costs
Bajwah and others, 2020 Systematic review (13/42)	To assess the effectiveness and cost-effectiveness of hospital-based specialist palliative care (HSPC) compared to usual care for adults with advanced illness and their unpaid caregivers/families.	Includes some patients who receive HSPC at home	SLPC to inpatients in acute care hospitals, outpatients or patients receiving care from hospital outreach teams at home	Usual care, defined as inpatient or outpatient hospital care without specialist palliative care input at the point of entry into the study, community care or hospice care provided outside of the hospital setting	Of 13 studies reporting costs of SLPC, nine studies found no difference between SLPC and usual care and two studies favoured SLPC over usual care. Note that the reviewers suggested the quality of the evidence assessed using GRADE was very low to low, downgraded due to a high risk of bias, inconsistency and imprecision. There was also an emphasis on hospital-based studies (30/42) – with only a few delivering hospital at home.
Candy and others, 2011 Systematic review (6/18)	To identify the current evidence on (1) the effectiveness, including cost-effectiveness, of hospice care in hospices, in a patient's home and in nursing homes and (2) the experiences of those who use and those who provide such services.	Patients with a variety of cancer and non-cancer diagnoses in the final phases of terminal disease and family caregivers or family members.	SLPC/PC in a dedicated hospice facility; SLPC/PC at home, in a nursing home or other care facility in the community.	"conventional care services" or usual generalist care for comparative studies	Patients receiving hospice care at home had lower healthcare utilisation (mostly due to costly hospital admissions). The strength of this evidence, however, was limited because few of the findings originated from RCTs – and narrow costing perspectives were used. It should also be noted that there were no cost savings for hospice care for patients with certain diseases, in particular for diseases where survival length was more uncertain (Gozalo and others, 2008; Pyrenson and others, 2004). Nevertheless, the benefits identified for patient and family in terms of increased care satisfaction and other outcomes such as symptom management may well justify the added monetary costs.

Datla and others, 2019 Systematic review and narrative synthesis (13/23)	To identify the evidence in relation to palliative care for people with symptomatic heart failure	People with symptomatic heart failure	Multi-disciplinary palliative care in community or hospital, or through outpatient consultation	Usual care	There was a reduction in health care resource use, namely hospital visits in 7/23 studies (all in community settings) and overall costs in 4/23 studies (all in community settings). The review supports the approach of multi-disciplinary multi-component generalist palliative care with specialist care intervention for complex or persistent concerns for people with advanced heart failure (but trials did not identify who would benefit most from specialist palliative referral).
Finlay and others, 2002 Systematic review with qualitative meta-synthesis and quantitative meta-analysis (43)	To assess whether there was an effect of palliative care teams.	Not clearly stated, although adults mentioned in included tables.	Palliative care teams / subgroups of teams in hospital, home and hospice (not defined)	Usual generalist care for comparative studies. Conventional care.	Specialist palliative care teams have advantages in terms of reducing hospital admissions and length of hospital stays. Home hospice reduces costs. Irrespective of type of intervention, there were lower costs for the home care group.
García-Pérez and others, 2008 Narrative review (2/6)	To assess & synthesise evidence on the effectiveness and cost effectiveness of specialised palliative care for terminally ill patients, comparing different organisational models with one another.	Adults (18 years and older) with terminal illness included in a palliative care programme.	Specialised palliative care programmes (i.e. Full palliative care team; Telephone palliative care team; In patient and home hospices and specialist palliative care unit).	Comparing different organisational models of specialised palliative care provision with each other.	No specific model of specialised palliative care was more effective or cost effective than others with regard to symptom control, quality of life, emotional support and satisfaction. Despite challenges in study quality, SLPC models are associated with cost savings, due to a reduction in inpatient stays. Home telemedicine visit was cheaper than a traditional in-person visit because of decreased travel (Doolittle and others 2000).

Gaertner and others, 2017 (3/12)	To assess the effect of specialist palliative care on quality of life and additional outcomes relevant to patients in those with advanced illness.	Adult (age ≥18) inpatients and outpatients with advanced illness	Intervention(s) unclear, but minimum requirements for specialist palliative care included the multi-professional team approach	Standard care	Of the three studies that examined costs it was found that: neither the average mean costs per day nor expenses for hospice care differ between SLPC and standard care (Greer and others, 2015). In the study of Rabow and others (2004), no differences were reported in the mean charge per patient for all medical centre services. While in Gade and others (2008) mean health costs per patient were significantly lower for SPC versus standard care (SLPC standard care: -\$7,483, P=0.001) while hospitalization costs did not differ.
Gardiner and others, 2018 A systematic review with narrative synthesis (10)	The aim of this study was to review evidence on the costs of specialist and generalist palliative care in the UK, and to explore different approaches used for capturing activity and unit cost data.	Adults aged 18 years or more	A comprehensive package of palliative care incorporating specialist and/or generalist elements.	Unclear	The studies display significant variation in their estimates of the cost of palliative care, therefore it was not possible to present an accurate aggregate cost of palliative care in the UK. The majority of studies explored costs from a National Health Service perspective and only two studies included informal care costs. Approaches to estimating activity and costs varied. Particular challenges were noted with capturing activity and cost data for hospice and informal care.
Gomes and others, 2013 Systematic review, meta-analysis and narrative synthesis (7/23)	To quantify the effect of home palliative care services for adult patients with advanced illness and their family caregivers	Participants aged 18 years or older in receipt of a home palliative care service, their family caregivers, or both	A team delivering home palliative care 1) for patients with a severe or advanced disease or their caregivers 2) aiming to support patients and family caregivers, and enable them to stay at home 3) providing specialist or intermediate palliative/hospice care and 4) providing comprehensive care	Home palliative care vs usual care, home vs hospital palliative care	Lower costs for home-based group compared with usual care (18 to 35%). Institutional and non-institutional costs, medications costs and in 1 study, informal care costs, were reported. Evidence on cost-effectiveness is moderate.

Haun and others, 2017 Systematic review of RCTs (4/7)	To compare effects of early palliative care interventions versus treatment as usual/standard cancer care on health-related quality of life, depression, symptom intensity, and survival among adults with a diagnosis of advanced cancer	Adults with advanced cancer	Early palliative care interventions (including specialist) across a range of settings	Usual oncological care	Four studies evaluated interventions delivered by specialised palliative care teams, and the remaining studies assessed models of co-ordinated care. Reviewers suggested they found no evidence that specialised palliative care teams (as part of integrated care) are superior to those providing a generic palliative care approach (co-ordinated care). In addition, cost utility of early palliative care remains unclear at this point.
Higginson and others, 2003 Systematic review using meta-regression and meta-synthesis (15 papers from 14 studies /44)	To determine the effectiveness of palliative and hospice care teams (PCHCT),	Patients with a progressive life-threatening illness and their caregivers (defined as family, friends, or significant others).	Palliative and hospice care teams (PCHCT) defined as two or more health care workers, at least one of whom had specialist training or worked mainly in palliative or hospice care. PCHCT were home care, hospital-based combined home/hospital care, inpatient units, and integrated teams.	Usual care was routine community and general hospital/oncology services.	The results are heterogeneous and lack important methodological detail, thereby excluding detailed meta-analysis. However, there was some evidence to suggest substitution effects between hospital and home care, thus reducing the number of inpatient days, and hence costs of health care. Differences in length of hospitalisation explained most of the variance in cost. Note that only three studies adopted a societal perspective when analysing the costs of care, and only two studies attempted to assess the costs to patients and families.
Higginson and others, 2010 Systematic review (40)	To determine whether specialist palliative care teams (SPCTs) improve outcomes for patients with advanced cancer and their caregivers, in terms of improving symptoms and quality of life and/or reducing the emotional concerns of family caregivers.	Patients with advanced cancer and family carers	Specialist palliative care in a community, hospital (inpatient/outpatient), and /or hospice setting.	Usual care (present or historical). Usual care comprised conventional community and general hospital/oncology services.	SLPC teams show benefit for patients with cancer in hospital, home or inpatient services. Significant benefits exist in terms of improving pain and symptom control, satisfaction, anxiety and health care outcomes (i.e. reduced hospital admissions and length of stays). Some studies indicated lower costs. High level of evidence that home, hospital, and inpatient specialist palliative care significantly reduced hospital admissions.
Jess and others, 2019 (4/39)	To review and synthesize current evidence regarding the use of	Various patient groups	Specialist level palliative telemedicine	Usual care	Video consultations give rise to cost-savings for adult palliative care providers when the video technology replaced outpatient consultations at

	video consultations in general and specialized palliative care to various patient groups.				the hospital or health care professionals' home visits to rural patients. Specialist telemedicine enabled palliative care professionals to notice patients' physical progress or regression such as weight loss or blushing, as well as their mental state, for example, if they had delirium or anxiety'. Bensink and others (2009) also focused on the provider perspective and found that video consultations in paediatric palliative care were more expensive than home visits, albeit the estimated costs were based on a sample of metropolitan families living close to the hospital.
Leclerc and others, 2014 Systematic review (3/4)	To determine the effectiveness, harms and adverse effects of the interdisciplinary team approach to providing end of life palliative care to adult patients and their home caregivers compared to other approaches.	In-patients or community dwelling patients aged 18 or over with stage III or IV cancer or a terminal condition with a prognosis of a year or less to live who received care in any setting.	Interdisciplinary teams or interventions delivering care in the home	A group that did not receive care from an interdisciplinary team.	Patients were less likely to visit the emergency department (2/4 studies) or be hospitalised (3/4 studies).
Luckett and others, 2013 Systematic review and meta-analysis (5/10)	To compare the effect of Specialist Palliative care Services (SPCSs) providing home nursing vs. other models of service delivery on rates of home deaths.	Patients with life limiting illnesses; receiving nursing care exclusively at home.	Interventions delivering nursing care exclusively in the home rather than only through a day hospital or inpatient services.	An alternative that did not include access to home nursing.	Overall, authors suggested that there was inconclusive evidence that community SPCSs offering home nursing increase home deaths without compromising symptoms, quality of life or increasing costs. When studies measured symptoms/quality of life or costs, these outcomes either favoured SPCSs offering home nursing or did not differ between interventions. Studies that analysed costs showed a similar pooled effect to all studies combined, providing preliminary evidence for the cost-effectiveness of SPCSs including home nursing.

Mathew and others, 2020 Systematic review (1/5)	To describe and critically appraise economic evaluations of palliative care models and to identify cost-effective models in improving patient-centred outcomes.	Any population group receiving palliative care services	Home-based palliative care	Usual care	One study examined costs (Higginson and others 2009). Home-based palliative care for individuals affected with multiple sclerosis and their caregivers is cost-effective. The study plotted the cost differences between the intervention groups against the differences on outcome from the Palliative Care Outcome Scale (POS-8) and the Zarit Carer Burden Inventory (ZBI). Palliative care was cost saving for both outcomes.
Rabow and others 2013 Systematic review (4)	To assess the evidence of the impact of non-hospice outpatient palliative care services (defined as including specialty consultations and co-management in clinics, homes, or residential living facilities)	Patients with late stage chronic obstructive pulmonary disorder (COPD), CHF and cancer; advanced cancer and metastatic non-small cell lung cancer and their family caregivers.	Outpatient palliative care services for terminally ill patients (i.e. in outpatient clinics, primary care clinics; in home or via telephone).	Usual care which included usual primary care and usual oncology care. Usual care was not described.	Outpatient palliative care services can reduce health care utilization & costs and lengthens survival in lung cancer patients.
Shepperd and others, 2021 Systematic review (3/4)	To see if the provision of end-of-life home-based care reduced the likelihood of dying in hospital and what effect this has on patients' and caregivers' satisfaction and health service costs,	People aged 18 years and over	Multidisciplinary end-of-life home-based care (which included specialist palliative-care nurses, family physicians, palliative-care consultants, physiotherapists, occupational therapists, nutritionists and social care workers)	Hospital or hospice-based care	There was a reduction in total health service cost of 18– 30% for participants receiving end-of-life care at home (Brumley 2007; Hughes 1992). Grande 1999 (UK-based, but MDT of nurses and nurse aides only) and Hughes 1992 (US-based) reported data on the use of healthcare services (very low-certainty evidence). One study reported total costs including VA hospital, private hospital, nursing home, outpatient clinic, home care and community nursing (Hughes 1992), and reported little difference in total costs (home-based home care: mean cost USD 3479; usual care: mean cost USD 4249). None of the studies reported costs to the participants or the caregivers.

Smith and others, 2014 Comprehensive literature review (46)	To identify studies that investigate the cost or resource use implications or cost-effectiveness of a 'palliative care intervention' to some type of comparator or control.	Limited information was provided about study population. Where stated, cancer & non-cancer patients with advanced illness	A range of hospital-based, home-based and hospice care models of palliative care	A range of models described in various ways as usual care; conventional care or non-PC hospital-based care.	Palliative care is most often less costly than comparators. Palliative care has a mixed impact on resource utilisation. Smith and others's (2014) more detailed findings, which focus on the costs of palliative care concur with these reviews, indicating that, in most cases, palliative care is consistently found to be significantly less costly than comparator models. However, Smith and others (2014) acknowledge that their findings are based on variable cost data that often fails to consider out of pocket expenses or informal care costs. The evidence base for cost-effectiveness is very limited as Smith and others (2014) report on only one cost-effectiveness study, the results of which are conclusions that the cost-effectiveness of palliative care has not been rigorously assessed.
Sutherland and others, 2020 Systematic review (34)	To identify all potentially relevant research about video consultations in palliative care	Paediatric or adult palliative care patients with any diagnosis	Palliative telemedicine (including SLPC)	Any comparison – such as usual care, outpatient care, or telephone advice	The international evidence appears to support video consultations for palliative care (including SLPC) as effective, accessible, acceptable and cost-effective.
Thomas and others, 2006 Systematic review of RCTs (23)	To identify and analyse all published RCTs that focus on the organization of EOL care provided to persons who are terminally ill, near death, or dying.	Terminally ill people near death, or dying, including patients with advanced cancer. Close family members were included in 1 study	Dedicated Community Teams (described in various ways)	Routine or standard care usual EOL care; customary Veterans Affairs post discharge Care; conventional care; standard home care or to office care	Authors suggest cost data was inconclusive, suggesting “whether community or home-based care is more cost effective or not remains unclear. It is possible that RCTs to date have not adequately measured the total costs of health care and so underestimate the cost savings associated with home care and home deaths” (p.287). Three studies, two of which assessed Veterans Affairs home-based EOL care services, reported higher costs for EOL care in comparison with conventional care. Two further studies found no differences between palliative and conventional care, while two more studies reported lower costs for palliative care.
Zimmerman and others, 2008	To systematically examine the evidence for the effectiveness of specialized palliative	Population with mixed diagnoses including cancer, Chronic Obstructive	A specialized palliative care service was defined as a service of professionals that	Usual care in a variety of settings. Standard hospital, hospice, or home care.	Although limited cost data exist, Zimmerman and others (2008) found that that SLPC models are associated with cost savings, due to hospital costs (although this review also reports that

Systematic review (22)	care in improving quality of life, satisfaction with care, and economic cost.	Pulmonary Disorder (COPD), Congestive Heart Failure (CHF) Motor Neurone Disease & AIDS	provides or coordinates comprehensive care for patients with a terminal illness.		home and hospice care costs increased when patients were referred to a palliative care programme) (Zimmerman and others 2008). Little evidence for benefit with regard to quality of life, symptom control and patient satisfaction or cost. However, specialized palliative care (SPC) consistently improves family satisfaction with care.
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Table B2: Individual studies based in the UK

Reference	Aim	Patient population	Intervention	Comparator	Key findings related to cost
Evans and others, 2021	To evaluate the impact of the short-term integrated palliative and supportive care intervention for older people living with chronic noncancer conditions and frailty on clinical and economic outcomes and cost-effectiveness	Older people with chronic noncancer conditions and frailty living at home or in a care home	SIPScore: specialist community palliative care integrated with district and community nursing and general practice	Usual primary and community health care and social care providers	The baseline costs were slightly higher in the control group compared with intervention with the main difference being higher informal care costs in the control. At 12-week follow-up, total costs were similar with informal care costs remaining higher in control.
Moore and others, 2017	To (1) understand how the intervention operated in nursing homes in different health economies; (2) collect	People aged 65 years and over with advanced dementia at two nursing homes	'Compassion intervention' - Two core components: facilitation of an integrated, multidisciplinary	Not specified	The cost of the ICL role for six-months was £18,255. This included activity across both nursing homes as well as travel time.

	preliminary outcome data and costs of an interdisciplinary care leader to facilitate the intervention; (3) check the intervention caused no harm		approach to assessment, treatment and care; and education, training and support for formal and informal carers. Distinguishing feature is the intervention is coordinated by an interdisciplinary care leader (ICL) who scopes local practice and identifies key personnel to support end of life care.		
Noble and others, 2015	To evaluate the Midhurst Macmillan Specialist Palliative Care Service (MMSPCS)	The service receives referrals for patients served by 19 general practices, with an estimated population of 155 000	A medical consultant-led multi-disciplinary team, reconfigured as a community service following the closure of a Sussex hospital - modelled on Motala hospital-based home	Patients' use of healthcare services for last 12 months of life contrasted across three study groups: patients using Midhurst service, patients using local hospices and patients	Found that while each patient referred to the Midhurst service may incur cost to the commissioners of £1900, the prevention of costs of secondary care activity is around £6000 per patient. The total costs in last year of life were substantially lower when referral was made either before or after the first inpatient stay regardless of whether referral made

			care programme in Sweden.	not known to have used either.	to a hospice or the Midhurst service.
Noyes and others, 2013	To develop an evidence-based and costed commissioning exemplar for children's palliative care.	Children and young people age 0–19 years with complex health and palliative care needs as defined by Together for Short Lives. ¹	Children's palliative care divided into three categories: specialist palliative care services (care delivered by specialist providers such as specialist in-patient facilities); core palliative care services and universal palliative care services.	Not specified	The estimated annual total cost of current children's palliative care was £5.5 million which included hospital/ hospice services, community and specialist nurse teams and continuing care. Hospice services, including end-of-life care, respite care for families and bereavement support, account for 45% of total palliative care costs. Continuing care packages for children with palliative care needs (bespoke care packages if child's needs not met by existing service provision), which include equipment, consumables, nurse and social worker support, were the second largest cost (37%).
Pattenden and others, 2012	To determine if a collaborative palliative care intervention for patients with advanced heart failure made it more likely that patients would be cared for	Patients could be referred to the service by British Heart Foundation Heart Failure Specialist Nurses (HFSNs), district nurses, community matrons and GPs when they	Intervention delivered by Marie Curie Cancer Nurses (MCCN) and HFSNs working alongside cardiologists, consultant	Convenience sample identified retrospectively by HFSNs from their service caseloads - selected all	The intervention was associated with reduced costs and increased benefits but there was considerable uncertainty around incremental cost-effective ratios. Costs were calculated based on secondary care admissions with a principal diagnosis of heart failure -

¹ See Together for Short Lives (2018) A Guide to Children's Palliative Care, Fourth Edition.

	and died in their place of choice, and to investigate its cost-effectiveness	met the following criteria: NYHA classification III or IV ² ; considered in the last year of life; repeated hospital admissions; difficult physical/psychological symptoms despite optimal therapy; in need of extra care or support and willing to have the service.	geriatricians, district nurses and GP. Services included: self-management education and advice to patients/ their carers; symptom management; medication and psychological support.	NYA Level III and IV patients who would have been considered eligible for a palliative care service.	outpatient, primary and community care costs were not available so focussed on secondary care.
Sonola and others, 2013	To understand the strategies used to deliver care-coordination effectively; examine barriers and facilitators to successful care coordination; and identify lessons in how care coordination can best be supported in terms of planning,	Patients with advanced dementia living at home, and their carers	Provides care co-ordination, palliative care and support to; service consists of a consultant in old-age psychiatry, several specialist nurses and a dementia social worker.	Not specified	The authors estimated the value of hospital admissions avoided as a result of providing palliative care at home – this was derived from a commissioning tool produced by the Department of Health to help determine the savings associated with a primary care-based dementia service (Department of Health, 2011). This estimated a potential saving of £10,983 per person for each emergency hospital admission avoided.


² NYHA classification system is a 'disease severity' classification system based on self-reported symptom load, disability and quality of life. Class III criteria include "a marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes fatigue, palpitation, or dyspnoea". Class IV is defined as "Unable to carry out any physical activity without discomfort. If any physical activity is undertaken, discomfort is increased."

	organisation and leadership.				
Spiro and others, 2020	To establish the day-to-day costs of Hospice at Home care of patients judged to be within three months of end-of-life and reference these to in-hospital care costs	Available for any patient with a life-limiting diagnosis requiring specialist palliative care services towards the end of his or her life	A 24-hour Hospice at Home service offering specialist care at home through a combination of planned and responsive visits by teams of nurses and healthcare assistants. ³	An inpatient specialist palliative care bed	<p>The highest daily cost was £578.10 due to 2-hour GP visit and the lowest was under £5 for 30 mins of formal care provision (lowest amount provided on a single day).</p> <p>Patients who died during data collection had higher cost service use. Formal carers/ social; services provided highest number of contacts at 47% of all visits made (but only 11% of total care cost), hospice staff 25% and district nurses 17%. People in the last days of life had more visits from GPs/ district nurses. GP cost accounted for 14% of overall costs but only 5% of visits. Overnight provision by Marie Curie/ Macmillan was 14% of total costs but only 2% of visits.</p> <p>Sixsmith and others (2017) noted that the cost of care of the service, per person/per night, was on average £195. This compares with the national average of a bed per day for inpatient specialist palliative</p>

³ A summary evaluation report of the Sixsmith, Ward and Youell (2017) study is available at: rennie-grove-night-service-evaluation.pdf (renniegrove.org).

					care at £397 (Sixsmith and others, 2017).
Yi and others, 2020	To compare health and social care costs, quality and their drivers in the last 3 months of life for older adults across countries	Patients aged >65 years who had accessed (<1 contact) a participating palliative care team and died 4–10 months prior to the survey date.	Palliative care services grouped and included: services from a dedicated palliative care unit (e.g. within specific units in hospitals or inpatient hospices), from specialist palliative care teams, dedicated or specialist nurses (e.g. Macmillan/ Marie Curie).	Not specified	<p>In England, of total care costs, community care costs were 9% and 16% for cancer and non-cancer respectively. Hospital costs accounted for 79-88% of total care costs across England, US and Ireland. Sensitivity analysis using English unit costs confirmed patterns driven by service use.</p> <p>Being aged >80 and experiencing financial difficulty was associated with being in highest 10% in all countries. The number of co-morbidities was not associated with higher care costs.</p>

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