NHS England

2026/27 NHS Payment Scheme

Community Currency Models Guidance

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1. Introduction

1.1 Background

Community services cover a diverse and often varying range of care. Community services are often defined by what they are not. Although services in different organisations may share a name, they frequently have different professional definitions and modes of delivery across England. The development of community currencies presents an opportunity to focus on needs-based systems of service design, delivery, and payment.

Community currencies have been developed as part of a detailed and highly collaborative process, bringing together varied stakeholders and experts to support the delivery of a robust and useful set of currency units which aim to segment community care based on patient needs and complexity and methods of delivery, and to understand the impact of this care on the patient, and where relevant, their carers and family.

The Community Currency Models are patient segmentation tools that allow providers and systems to plan, fund, benchmark and improve their services in a more evidence-based way. Currency models are a key lever for achieving parity of esteem with the acute sector, with better outcomes reporting and robust costing to demonstrate value for money and improve the quality of care for patients. The currency models aim to support system-based collaborative working based on national policy ambitions, creating a common understanding of care provision and providing a standardised evidence-base which can support effective and equitable funding models.

In 2025/26, the currency models were published alongside the NHS Payment Scheme 2025/26. Signalling the use of these currency models by providers and commissioners, the currency models were also implemented within the National Cost Collection (NCC) 2024/25. Throughout 2025/26, NHS England continued to develop and enhance the currencies based on our iterative approach. In 2026/27 the currency models published in this document have been expanded to cover wider community care provision and our tools and support have expanded.

1.2 What is a Currency?

A currency is a way of grouping patients or care activities into units that are clinically similar and have broadly similar resource needs and costs. Each unit of currency must be evidence-based, analytically identifiable and clinically meaningful. The currency must be rooted to the care the patient receives and be practical to implement.

A currency is often confused with a price or a specific payment model, however these terms are not interchangeable. A currency refers to grouping healthcare activities into units of similar resource and clinical need. A price refers to a value assigned to a unit of currency or bundled package of care as part of a funding mechanism. Appropriate valuation is identified via costing processes, which themselves support clinical, operational, and financial improvement processes, as well as planning and funding arrangements.

Currency models can be used within systems to ensure service provision meets the needs of patients in a local health economy. This means currencies are a crucial enabler for transitioning to population and place-based commissioning. Currencies can also inform service development and re-design, thus ensuring the money spent provides best value for patient populations and reimburses providers fairly for the work they do.

Integrated Care Boards (ICBs) and providers should increasingly use the community currency models to support service development, benchmarking, planning, and funding discussions over the coming years, following improvements to data quality and the development of suitable depth and breadth within the currencies.

Further information can be found in An Introductory Guide to Currencies, available on Futures.

1.3 Currency Development

Development is based on a number of key principles:

- Currency models place patients at the centre and should be developed to support an understanding of the value of care delivery. The models will align the needs and complexity of patients, with service delivery and measures of outcomes.
- Currency models should be driven by available data wherever possible, minimising additional data burden for providers who meet their current national data submission obligations.
- Currency models should segment based on needs and complexity. Iterative development and implementation should support the sector to implement models at pace and see value from their use.

The Community Currency Models have been developed with the input of working groups led by clinicians, finance and data teams and subject-matter experts. NHS England will continue to develop granular patient-level currency models based on an iterative implementation approach, focussing on where currency models can delivery the most impact.

To learn more about the development process, please visit our Futures Workspace and see Introduction to the Community Currency Models. This document sets out development principles, the aims of the work and the benefits of implementation.

1.4 What does this mean for providers?

- 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 the Futures workspace. 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.
- 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.
- Providers are required to use of currency models and associated data on a day-to-day basis as part of local benchmarking.
- Providers should use currency information as an evidence base to underpin and support an evidence-based approach to commissioning and contracting.

1.5 What does this mean for commissioners?

- 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.
- 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.
- ICBs should consider currency models for Community Services when reviewing when reviewing API fixed payments (see the NHS provider payment mechanisms supporting document).

2. Community Currency Models

The community currency models are designed to segment patients into populations of similar patient groups, or groups receiving similar types of care and with similar needs. There are multiple levels to the currency models, these levels may be useful to different stakeholder groups for differing purposes. A key design element of these models was to develop a scalable resource, the same data can be used to understand a single patient, and can be grouped then to understand a service, population group, provider or ICB footprint, all the way to national data level.

To support users to populate the community currency models, a methodology has been developed with three main stages. An accompanying Grouping Methodology has been developed to show the specific data items needed to segment provider or system data. This section describes the three main steps to segmenting, beginning with age, then population groups, and where available, into granular currency units.

2.1 Step 1 - Age

Patients are initially segmented by age to split the Children and Young People (CYP) and adult populations. The adult population can be defined by those patients who are referred to a community service after their 18th birthday.

The CYP population is defined as patients referred prior to their 18th birthday, however it is understood that some patients will remain in CYP services beyond their 18th birthday where it is clinically appropriate to do so, these patients would remain within CYP currency units.

The currency model recognises that as a young person reaches adulthood this can also be a point of change within the care they receive from community services. Some care will transition to be supported by primary care services. Some care will transition to adult services. This can be captured within national data and can support a better understanding of the needs and complexity of children during this time.

2.2 Step 2 – Population

Patients are then segmented by their population, this takes into account the service in which the patient is receiving care, as well as other factors to group less population specific measures such as district nursing. In this section, each population is defined along with detail on services included within the population. By following this methodology all patients should fall into at least one population group. Patients can fit into multiple groups where they meet multiple population definitions, in these cases care will be split into relevant categories using the Grouping Methodology.

2.2.1 Adult Population Groups

Management of Long Term Conditions (Adults)

This population group segments patients who require specialist services to support them to live at home with a pre-existing long term health condition. In previous years these patients were included within a broader Long Term Conditions currency model which has now been split between management and preventative care.

The NHS Data Dictionary defines a long term condition as, ‘A Long-Term Physical Health Condition (also known as a Chronic Condition) is a health problem that requires ongoing

management over a period of years or decades and is one that cannot currently be cured but can be controlled with the use of medication and/or other therapies'.

Patients in this population may be receiving care from one of the following defined services:

- Continence, bladder and bowel
- Respiratory (inc. Home Oxygen)
- Diabetes
- Tissue viability and wound care
- Lymphoedema
- Heart failure
- Cardiology
- Neurological conditions

Patients may also be supported by district nursing teams and integrated multi-disciplinary teams.

Prevention of Long Term Conditions (Adults)

This population group segments patients who require support focussed on preventing health issues from worsening. In previous years these patients were included within a broader Long Term Conditions currency model which has now been split between management and preventative care.

Patients in this population may be receiving care from one of the following defined services:

- Occupational therapy
- Nutrition and dietetics
- Speech and language therapy
- Physiotherapy

Patients may also be supported by district nursing teams and integrated multi-disciplinary teams.

Frailty (Adults)

This population group segments patients who require support focussed on their frailty needs.

Frailty can be considered as a long term health condition characterised by loss of physical, emotional and cognitive resilience as a result of the accumulation of multiple health deficits. Frailty is progressive, typically erodes functional, cognitive and/or emotional reserves and increases vulnerability to sudden loss of independence and adverse health outcomes following a comparatively minor stressor event such as an acute infection or injury. While severe frailty can be comparatively easy to recognise and diagnose, lesser degrees of frailty may be more difficult to differentiate from normal ageing.

Patients may be supported by district nursing teams and integrated multi-disciplinary teams, to by other specific frailty related provision.

A detailed model has been developed which segments this population further, please see Section 2.3.2.

Last Year of Life (Adults)

This population group segments patients who are identified as in their last 12 months of life and are receiving palliative or end of life care.

The patient group covers a range of conditions and multi-morbidities and different methods for identification may be used dependent on local services and patient choice. A patient can be identified if they have a progressive disease, and as a consequence of that disease, the patient's clinician would not be surprised if the patient were to die within 12 months. It is accepted that due to the variable nature of progression, a patient could live longer than 12 months whilst receiving palliative and end of life care, this would not exclude the person or their care from this population.

Patients may be supported by end of life care and palliative care services, as well as district nursing teams and integrated multi-disciplinary teams.

A detailed model has been developed which segments this population further, please see Section 2.3.3.

2.2.2 CYP Population Groups

Long Term Conditions and Disabilities (CYP)

For the Long Term Conditions and Disabilities population group, patients will meet at least one of the definitions set out below:

1. The World Health Organisation of disability, "An umbrella term, covering impairments, activity limitations, and participation restrictions. An impairment is a problem in body function or structure; an activity limitation is a difficulty encountered by an individual in executing a task or action; while a participation restriction is a problem experienced by an individual in involvement in life situations."
2. The Department of Health definition of Long Term Condition, "A long-term condition (LTC) is a condition that cannot, at present, be cured but is controlled by medication and/or other treatment/therapies. LTCs are not just a health issue they can have a significant impact on a person's ability to work and live a full life". The Royal College of Paediatrics and Child Health comments: "Many long-term conditions develop during childhood; these children are more likely to develop mental health conditions and should be supported to navigate the transition from child into adult health

services". With the examples given of asthma, epilepsy, diabetes, cancer and disability / additional learning needs.

Through development it was agreed that organisations also refer to a condition lasting more than a period of 12 months as an indicator that it may be a long-term condition.

Patients in this population may be receiving care from one of the following defined services:

- Continence, bladder and bowel
- Respiratory (inc Home Oxygen)
- Diabetes
- Tissue viability and wound care
- Cardiology
- Neurological conditions
- Occupational therapy
- Nutrition and dietetics
- Speech and language therapy
- Physiotherapy

Patients may also be supported by Community Paediatrics Services, Children's Community Nursing Services, district nursing teams and integrated multi-disciplinary teams.

End of Life Care (CYP)

The End of Life Care Model identifies patients receiving palliative and end of life care support. Patients in this group may also be receiving care as part of another population group and potentially by multiple provider organisations.

Patients may be supported by Community Paediatrics Services, Children's Community Nursing Services, district nursing teams and integrated multi-disciplinary teams.

2.2.3 All-Age Population Groups

Short Term Interventions (Adults and CYP)

Short Term Interventions currency model segments patients receiving care not directly linked to a long-term condition or disability. This is often episodic planned care provided via targeted and specialist services.

Patients in this population may be receiving care from one of the following defined services:

- Community musculoskeletal (MSK) Care
- Podiatry
- Audiology
- Phlebotomy
- Dentistry
- Community rehabilitation

Patients may be supported by Community Paediatrics Services (CYP only), Children's Community Nursing Services (CYP only), district nursing teams (all-age) and integrated multi-disciplinary teams (all-age).

Equipment (Adults and CYP)

The Equipment population group identifies patients who require support from equipment services provided within the community. Services are split into three distinct groups:

- Appliances and Equipment
- Prosthetics
- Wheelchairs

Neurodevelopment (Adults and CYP)

The Neurodevelopment population group identifies patients with needs related to neurodevelopmental assessments and support. Information on this population group and currencies can be found in Section 2.3.1.

Intermediate Care (Adults and CYP)

This population group identifies patients receiving therapy-led support for people to recover and retain function, as well as specialist pathways. This could include:

- Crisis Response Intermediate Care Service
- Reablement Intermediate Care Service
- Home-based Intermediate Care Service
- Community Bed-based Intermediate Care Service

Public Health (Adults and CYP)

This population group identifies patients receiving public health funded services. This could include:

- Health Visiting
- Public Health and Lifestyle
- Treatment Room Nursing
- School Nursing Service
- Weight Management Services

Other Community Care (Adults and CYP)

Other services not grouped into the above populations will group to the Other Community Care population. This may include services which are not consistently commissioned nationally or could be provided in a community setting in some areas, but another setting within other areas.

Please see the Grouping Methodology for how current service codes map to this population. A full list of currency units can be found in Annex A.

2.3 Step 3 - Detailed Currency Models (Where Appropriate)

The currency development process for community has been iterative by design, focussing on the prioritisation of currencies where they have the most impact. All care can be segmented to a population and service level, supporting an understanding of the overall needs of the population. We have also developed more granular currency models for some of these populations. Development on this basis allows the programme team to identify national policy priorities and focus delivery on these areas. In future we will continue to develop granular models on this basis.

Each model set out below sets out a methodology to segment from the population/setting level. Further information on each of these models can be found on the Futures workspace.

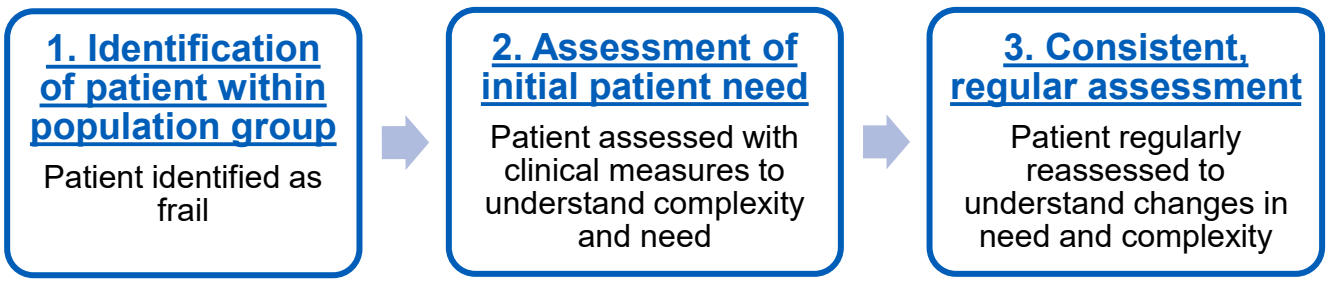
2.3.1 Attention-Deficit/Hyperactivity Disorder (ADHD) & Autism

Guidance has been developed and published alongside the NHS Payment Scheme 2026/27 for ADHD services and Autism assessments. Please see the Attention-Deficit/Hyperactivity Disorder (ADHD) & Autism Payment Guidance Supporting Document published as part of the NHS Payment Scheme.

2.3.2 Frailty Currency Model

The Frailty Currency Model is a population-based model which places the patient at the centre. The model is designed to stratify the needs of patients into categories and structure regular assessments of patients to understand their progress and trajectory. The model aims to provide a consistent approach to understanding the delivery of high-quality care for patients living with frailty.

The Frailty model has three key components:



The Frailty model uses the Clinical Frailty Scale to support identification of relevant patients, and to measure the patient's trajectory on a regular basis. If a patient's CFS score has reduced between assessments, they are categorised as "recoverable". If their CFS score

has stayed the same, they are “stable” and if it has increased they are “progressive”. Therefore, assessment on first contact, then on a regular locally agreed basis (e.g. every 6 weeks) segments patients into one of 12 currency units:

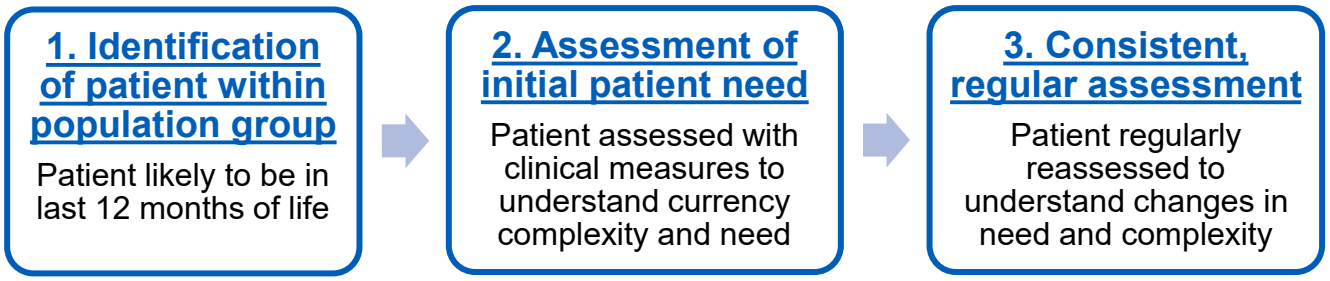
- Very Mild Frailty – Recoverable
- Very Mild Frailty – Stable
- Very Mild Frailty – Progressive
- Mild Frailty – Recoverable
- Mild Frailty – Stable
- Mild Frailty – Progressive
- Moderate Frailty – Recoverable
- Moderate Frailty – Stable
- Moderate Frailty – Progressive
- Severe Frailty – Stable
- Severe Frailty – Progressive
- Severe Frailty – End Stage

For more information on how the Adult Frailty currency model works please visit our Futures workspace.

2.3.3 The Last Years of Life Currency Model

The Last Year of Life (LYOL) Currency Model is a population-based currency model which places the patient and their family/carers at the centre. The model is designed to stratify the needs of patients into categories based on their own needs, but also their environment, and the needs of carers and those important to them. The model aims to provide a consistent approach to understanding the delivery of high-quality palliative and end of life care.

The LYOL model has three key components:



The currency model uses two widely recognised, clinically validated assessment methodology to understand the complexity of the patient, the needs of the patient, their family and carers, and the effect of the patient’s home or local environment:

1. **Palliative Phase of Illness** which describes the urgency of care needs for a patient receiving palliative care. The model provides a holistic view of needs and complexity, including family, carers and local environment.

2. **Australian-modified Karnofsky performance scale (known as AKPS)** is a measure of the patient's functional status or ability to perform their activities of daily living. AKPS is scored by clinical staff, and offers a 11-point scale, from 100% (representing full physical function) down to 0% (when the patient has died) in steps of 10%. It is based on observations of a patient's ability to perform common tasks relating to activity, work, and self- care. Lower numbers indicate reduced functional ability.

A combination of these measures is used to define patients in stable, unstable or deteriorating phases. For patients at the dying phase, only the patient's Phase is used. The final unit is Deceased; this is to ensure initial signposting and family/carer support is included. There are 11 currency units in total:

- **Stable** Phase of Illness & **High** AKPS
- **Stable** Phase of Illness & **Medium** AKPS
- **Stable** Phase of Illness & **Low** AKPS
- **Unstable** Phase of Illness & **High** AKPS
- **Unstable** Phase of Illness & **Medium** AKPS
- **Unstable** Phase of Illness & **Low** AKPS
- **Deteriorating** Phase of Illness & **High** AKPS
- **Deteriorating** Phase of Illness & **Medium** AKPS
- **Deteriorating** Phase of Illness & **Low** AKPS
- **Dying** Phase of Illness
- **Deceased** Phase of Illness

For more information on how the Adult Last Year of Life currency model works please visit our Futures workspace.

2.3.4 Children and Young People Currency Model

The currency model for CYP is based on the overall needs and complexity of a child or young person, segmenting patients into currency units based on the number of SNOMED CT defined needs. The needs are defined within a Terminology Set developed by the Royal College for Paediatrics and Child Health (RCPCH), split into four main categories;

- Underlying health conditions
- Family reported needs
- Technology dependencies
- The need for round the clock care

All patients will have underlying health conditions and/or family reported needs. Where technological dependencies and/or round the clock care needs are identified, this will increase the complexity of need and therefore be recorded separately within the model.

The model includes nine units:

- Low need
- Medium need
- Medium need with technological dependencies
- Medium need with round the clock care
- Medium need with technological dependencies and round the clock care
- High Need
- High need with technological dependencies
- High need with round the clock care
- High need with technological dependencies and round the clock care

2.3.5 Children and Young People – End of Life Currency Model

Similarly to the adult equivalent model, the End of Life Currency model aims to stratify patients based on their needs and complexity, whilst also including the patients family, carers and local environment.

The CYP model uses the same Phase of Illness assessment methodology to segment patients, aiming to understand the Phase a patient is in as a way of understanding the level of support needed as a patient's care plan changes.

The currency model has five currency units:

- Stable Phase of Illness
- Unstable Phase of Illness
- Deteriorating Phase of Illness
- Dying Phase of Illness
- Deceased

For more information on how the Children & Young People's Last Year of Life currency model works please visit our Futures workspace.

3. Data, Tools and Guidance

3.1 Using Local Data to Derive the Currency Models

The currency models have been designed with the intention of reducing additional data burden as much as possible. Providers who meet their current national data collection and submission obligations should find that the majority of data items are already collected.

To support users to understand the data items that are required for the currencies, a Grouping Methodology has been developed which sets out the specific data items, and how they map to the relevant currency models. This is available on the Currency Models, Support and Guidance Futures Workspace. Instructions for use are also provided.

3.2 Data Quality Framework

As part of NHS England's commitments set out in the NHS Community Health Services Data Plan, a Data Quality Improvement Framework for Community Health Services has been developed.

The framework is designed to be transformative for CHS data, improving the quality of data at all levels to foster a culture of data driven decision making, ultimately leading to better patient outcomes and a more efficient and effective NHS. This supports the NHS 10 Year Health Plan's ambition to shift care from hospitals to community settings, by enabling better data driven planning and delivery of services closer to home.

Specifically, the Framework sets out clear definitions and goals for providers in terms of local data capture and submission to national data sets, clear requirements for providers to meet, and how success will be assessed. The Framework is part of a multi-year improvement drive which will be reviewed during 2026-27 based on progress.

3.3 Tools to Support the National Cost Collection

To support the use of the currency models and the National Costing Collection process, the team have developed SQL-based tools to derive the currency units. This was piloted for the 2024/25 National Cost Collection and will be expanded this year. The team are also aiming to share data reports based on national activity and cost data during 2026/27. Please join the Future NHS Workspace for news and updates.

For tools to support data collection, please visit our Futures Community Currency Workspace.

3.4 Further Guidance

Additional guidance is available on the Futures workspace, including further information on the development of the currency models, Frequently Asked Questions and contact information for the development team.

Further information on the benefits of using the currency models, and how the models can be used on a wider basis beyond the costing and commissioning of care is also available. The team continue to expand the guidance available - feedback is appreciated.