

From six to twelve months: how extending the statutory prognostic threshold affected fast-tracked end-of-life benefit access in England and Wales

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Research Article

Keywords: Terminal illness, financial support, policy change, prognosis.

Posted Date: March 22nd, 2026

DOI: <https://doi.org/10.21203/rs.3.rs-8864800/v1>

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Additional Declarations: No competing interests reported.

Version of Record: A version of this preprint was published at BMC Medicine on August 27th, 2026. See the published version at <https://doi.org/10.1186/s12916-026-05148-5>.

Abstract

Background

To evaluate the impact of the 2022 change in prognostic eligibility criteria for the Special Rules for End of Life (SREL) pathway, from an expected death within 6 months to within 12 months, on the number and characteristics of awardees for fast-tracked financial support for people living with terminal illness.

Methods

Interrupted time series analysis of retrospective national government data. Monthly caseload data for Personal Independence Payment (PIP) claims made under the Special Rules for End of Life (SREL) in England and Wales were obtained from the Department for Work and Pensions (DWP) via Stat-Xplore (January 2019 to July 2025). Main outcomes: (1) monthly SREL PIP caseload before and after the change in prognostic eligibility criteria; and (2) trends in award numbers by socio-demographic, geographic, and clinical characteristics.

Results

A total of 2,370,328 cases assigned to PiP were analysed. SREL caseload annual growth significantly accelerated from 4.3% in 2019 to 9.3% after April 2023. Growth was strongest among people with non-cancer diagnoses (from 11.9% to 18.8%) and those at or above state pension age (from an annual decline of 2.6% to an increase of 17.9%). Regional variation was marked, with the West Midlands shifting from an annual decline to a 11.1% increase, and the East of England's growth rate increasing over fivefold. Approximately half of people deemed eligible for SREL under the 12-month criterion are in the last year of life; at the same time, over 200,000 people die each year from a life-limiting illness but are not correctly identified as suitable for referral.

Conclusions

Widening the statutory prognostic threshold increased fast-tracked benefit access, especially for people with non-cancer diagnoses and older adults, but regional and diagnostic disparities persist. Prognosis may not be the best mechanism for determining eligibility because the high level of uncertainty results in large numbers of people receiving SREL benefits when they are not in the last year of life and not receiving benefits when they will die within the last year of life.

Trial registration

Prospective registration on the Open Science Framework on 30th September 2025 (<https://osf.io/avmn8/overview>).

Background

Prognostication is a routine, yet challenging, part of clinical practice. Clinicians are often required to estimate how long a patient is likely to live, and these estimates shape treatment planning, guide conversations about future care, and determine access to specialist services.(1, 2) In practice, prognostic judgements are typically intuitive and framed around whether a patient is likely to die within a defined time period. However, substantial evidence shows that clinicians' prognostic accuracy is poor and inconsistent: particularly for people living with a non-cancer diagnosis, leading to inequities of access to appropriate end-of-life care.(3–5) (6, 7)

Clinicians' prognostic accuracy may have social and economic as well as healthcare consequences. Recent policy debates have heightened scrutiny in the UK, particularly in relation to the Terminally Ill Adults (End of Life) Bill,(8) where survival estimates would play a key role in access to assisted dying. Since 1990, the 'Special Rules for End of Life' (SREL) have fast-tracked financial support for people deemed unlikely to live for more than 6 months.(9)

There are few naturalistic opportunities to evaluate how changes to statutory prognostic rules influence clinical practice and wider outcomes. (10) (9) In April 2022, the UK Government extended the eligibility criteria for SREL from an expected death within 6 months to within 12 months.(11) This was introduced because many people across the country did not receive the financial support they were eligible for, before they died.(12) Evidence suggests that benefits make up around half of the income of working-age households including someone in the last year of life, rising to almost three-quarters among households in the poverty, and financial strain is associated with poorer mental and physical health outcomes.(12–15)

SREL eligibility criteria have important implications for referring clinicians, for referred patients, for patients approaching the end of life who are not referred, and for budget-holders who must finance the additional costs associated with greater eligibility. Despite its importance, we are unaware of any evaluation of these effects to date.

This study aims to address this gap by evaluating changes in the number of SREL beneficiaries before and after the 2022 policy revision. This aim was achieved through the following objectives:

1. Describe and compare the monthly caseload of SREL beneficiaries before and after the expansion of prognostic eligibility criteria.
2. Examine whether changes in monthly caseload differed according to socio-demographic, geographic, and clinical characteristics.

3. Interpret the observed changes in the context of prognostic uncertainty: what is the total number of additional beneficiaries that may be eligible under the new rules, how many are currently receiving SREL, how many are correctly assessed as in the last 12 months of life, and how many are incorrectly assessed?

Methods

The protocol for this study was registered prospectively on the Open Science Framework on 30th September 2025 (Ref: avmn8).(16) This study is reported using the RECORD statement.

Study design and policy context

This study was a retrospective analysis of national government data on financial awards. Specifically, SREL enables expedited access to the higher rate of the Personal Independence Payment (PiP) Daily Living Component, which is approximately £110 per week, plus easier access to the Motability component, which is an additional £77 a week. The SREL requires a clinician's statement that the individual is likely to die within the specified timeframe. This SREL process can materially affect the financial security of people living with terminal illness.

Data source

All data were exported from the Department for Work and Pension (DWP) portal (Stat-Xplore).(17) DWP data describe a range of government benefits and programmes; for this research question, the dataset "PiP from 2019 1 - Caseload by End-of-Life Rule" from the group "PiP Cases with entitlement" was exported. Data was exported from this website on 3rd December 2025.

Outcome measure

The monthly count of caseloads under PiP through the SREL route.

Time unit of analysis

Monthly, before and after the policy implementation in April 2022.

Study period

Data was exported from January 2019 up to July 2025.

Data variables and management

The following data was exported from the platform: Sex (Male, Female), ICD codes (which was later categorised into a binary variable of cancer [ICD codes C00-D48] and non-cancer [all other codes]). We also extracted the Regions and Age (Below or Above pension age) from the platform. The region data included data from England, Wales, Abroad and Scotland; for the primary analysis Abroad and Scotland datapoints were removed as both were felt to be distinct from residents in England and Wales. In recent years, Scotland has introduced replacement benefits for PIP and Attendance Allowance, and data for these new benefits is not available on Stat-Xplore. New claims in Scotland are no longer made to PIP and Attendance Allowance, and existing claimants in Scotland are being moved over to their new system.

Statistical methods

The annual caseload by characteristic was tabulated to give an overview of the dataset. For our first objective, an interrupted time-series (ITS) analysis was completed to assess how the regulation change influenced SREL caseload trends. A one-year implementation phase (April 2022 to April 2023) was assumed in addition to accounting for the potential impact of the COVID-19 pandemic on caseload numbers, spanning from the first lockdown (March 2020) to the end of any COVID-19-related regulations (March 2021). To model the ITS, a Poisson regression models with linear splines was used, incorporating five distinct slopes: before COVID-19, during COVID-19, after COVID-19 but before the regulation change, following the change but during implementation, and post-implementation trends. The model was adjusted for overdispersion by applying a robust variance estimator and added a Fourier term to adjust for seasonality. For our second objective, analyses were stratified by sex, age, ICD code, and location to explore variations in trends across these groups. A comparable ITS model was used for Attendance Allowance caseloads, utilising quarterly data.(18) A sensitivity analysis, including the data from Abroad and Scotland, was completed.

For the third objective, the number of adult deaths annually were identified in England and Wales from statutory data.(19) Then the proportion of these deaths that occur with a terminal illness and the proportion of those decedents interacting with clinicians near end of life, which are both pre-requisites for SREL eligibility, based on survey data, were estimated.(20, 21) For both the 6- and 12-month timeframe, prognostic accuracy literature was then referenced to estimate the number of people correctly referred (i.e. died within the timeframe with SREL), incorrectly referred (did not die within the timeframe but receive SREL) and incorrectly not referred (i.e. died within the timeframe without SREL).(3)

After the analysis, the data was presented and discussed with a stakeholder group. Attendees included policy makers, representation from the DWP, clinicians, academics, and experts by experience. From their expertise, an additional analysis was undertaken of a separate government financial support (Attendance Allowance) which is available through the same SREL process but aimed at people over pension age. Data from the Attendance Allowance was extracted from the Stat-Xplore website on (12th December 2025). A comparable ITS model was used for Attendance Allowance caseloads, utilising quarterly data. Further detail on the analysis can be read Supplementary material 1.

Patient and Public Involvement

A cancer survivor who accessed hospice care discussed the concept of the study prior to the ethical approval and extraction of the data. She helped to inform the research question and in the interpretation of the analysis. She has contributed to the development of this report and is an author on this paper.

Results

Characteristics overall

In total, the data of over 236 million caseloads assigned PiP were extracted from the DWP platform. Approximately 99% of the data was related to the standard route to accessing PiP. Table 1 gives an overview of the total caseload of PiP per year, by sex, diagnosis, and age.

Table 1
Overview of PiP caseload

SREL data								
Year	Standard route total	SREL total*	Sex		Diagnosis		Age	
			Men	Women	Cancer	Non-cancer	Below state pension age	State pension age
			n (%)					
2019	26,080,810	351,761	166,944 (47)	184,813 (53)	308,533 (88)	43,244 (12)	310,392 (88)	41,378 (12)
2020	30,034,256	357,029	170,717 (48)	186,321 (52)	311,101 (87)	45,872 (13)	315,324 (88)	41,705 (12)
2021	32,596,932	350,445	168,083 (48)	182,347 (52)	304,990 (87)	45,467 (13)	301,528 (86)	48,906 (14)
2022	36,265,036	356,951	171,608 (48)	185,331 (52)	310,297 (87)	46,622 (13)	301,175 (84)	55,778 (16)
2023	39,908,871	353,306	171,589 (49)	181,703 (51)	305,884 (87)	47,437 (13)	291,584 (83)	61,726 (17)
2024	42,715,213	374,254	183,322 (49)	190,915 (51)	320,773 (86)	53,514 (14)	305,842 (82)	68,417 (18)
2025†	26,034,169	226,582	111,718 (49)	114,857 (51)	192,059 (85)	34,549 (15)	181,800 (80)	44,791 (20)
Total	233,635,287	2,370,328	1,143,981 (48)	1,226,287 (52)	2,053,637 (87)	316,705 (13)	2,007,645 (85)	362,701 (15)

*Numbers per variable do not always add to totals due to anonymity measures employed by the DWP. Percentages have been calculated from individual variable totals. † 2025 figures are January to July.

Characteristics SREL route

Table 2 describes the annual percentage change and patient characteristics in the monthly SREL PiP caseload at the 5 key timepoints: the baseline, COVID-19, pre-implementation, the implementation period, and after the implementation period. Overall, the caseload of SREL PiP recipients increased from an annual increase of 4% at baseline (in 2019) up to an annual increase of 9% in 2025. There was an annual increase for men and women when comparing data from 2019 (5% men, 4% women) to 2025 (10% men, 9% women). For people with cancer, the annual percentage change increased by 5% from 2019 (3%) and 2025 (8%). For people living a condition other than cancer, the annual percentage change increased by 7%, from 12% in 2019 up to 19% in 2025.

Table 2

Annual percentage change in SREL application awards by sex, ICD codes (cancer vs. non-cancer conditions) and age (below pension age vs. pension age)

	Global	Sex		ICD codes		Age	
		Men	Women	Non cancer	Cancer	Pension age	Below pension age
1	4.3%	4.9%	3.8%	11.9%	3.2%	-2.6%	5.2%
2	-5.4%	-5.0%	-5.7%	-4.4%	-5.5%	11.9%	-7.5%
3	4.1%	4.1%	4.0%	4.6%	4.0%	18.5%	1.9%
4	2.6%	3.9%	1.3%	2.6%	2.6%	14.5%	0.5%
5	9.3%	10.0%	8.5%	18.8%	7.8%	17.9%	7.4%
Footnote: 1. Jan 2019 - Mar 2020 (Baseline/ before COVID-19); 2. Mar 2020 - Mar 2021 (COVID-19); 3. Mar 2021 - Apr 2022 (Between COVID-19 and SREL change); 4. Apr 2022 - Apr 2023 (Implementation period); 5. Apr 2023 onwards (After implementation)							

Table 3 describes the annual percentage change by location. The largest changes in percentage increases are noticeable in the West Midlands (from -2% in 2019 to 11% in 2025), and in the East of England (from 2% in 2019 to 9% in 2025).

Table 3

Annual percentage change in SREL application awards by location

Time point	Location									
	London	East Midlands	East of England	North east	North west	South east	South west	Wales	West midlands	Yorkshire and Humber
1	7.6%	6.0%	1.6%	4.3%	4.6%	5.6%	3.5%	4.5%	-1.8%	6.5%
2	-8.7%	-6.2%	-8.5%	-5.6%	-1.8%	-3.6%	-0.5%	-5.6%	-7.2%	-8.2%
3	3.8%	2.5%	6.3%	7.4%	1.9%	4.3%	5.1%	3.0%	1.8%	6.3%
4	-1.7%	5.9%	0.5%	2.8%	2.9%	5.3%	5.9%	1.8%	3.2%	-0.7%
5	11%	10.7%	8.6%	8.5%	9.6%	10.7%	6.1%	9.0%	11.0%	6.9%
Footnote: 1. Jan 2019 - Mar 2020 (Baseline/ before COVID-19); 2. Mar 2020 - Mar 2021 (COVID-19); 3. Mar 2021 - Apr 2022 (Between COVID-19 and SREL change); 4. Apr 2022 - Apr 2023 (Implementation period); 5. Apr 2023 onwards (After implementation)										

These percentage changes were further reported by monthly percentage changes and can be accessed in Supplementary material 2 and Supplementary material 3.

Primary analysis

The interrupted time series analyses on SREL data (see Fig. 1) indicates that prior to COVID-19 (March 2020), the caseload of PiP was growing annually by 4.3%. After the implementation phase (April 2023) this caseload of PiP had an annual increase of 9.3%; a growth rate 2.17 times pre-COVID-19 rates. During the implementation phase, the number monthly caseload was decreasing by 2.6% per year.

[Figure 1 here]

Figure 1 Interrupted time series analysis on SREL caseloads of PiP.

Variation by gender

The policy led to a two times higher growth rate for men and women, with the visual gap between men and women narrowing in 2025 (see Fig. 2). Before COVID-19, the caseload of PiP for women increased by 3.8% annually, and by 4.9% for men. After the implementation period the award increased at an annual rate of 8.5% for women and 10.0% for men. The post COVID-19-implementation annual rate is 2.26 times higher than the pre-COVID-19 rate and 2.06 times higher for men. During the implementation period, the PiP caseload annual growth rate was 3.9% for men and 1.3% for women.

[Figure 2 here]

Figure 2 Interrupted time series analysis of SREL data stratified by sex.

Variation by region

There was some regional variation regarding the SREL policy change (see Fig. 3). The London region had the highest annual growth rate before COVID-19 (7.6%). In the West Midlands region, the caseloads shifted from an annual decline of -1.8% before COVID-19 to an annual increase of 11.1% after the implementation. In the East of England region, the annual increase was 5.52 times higher after the implementation than before COVID-19. The increase is followed by the Northwest of England region where the annual growth rate was 2.09 times higher after the implementation compared to before COVID-19 annual growth rate. Table 4 describes the ratio of each region.

[Figure 3 here]

Figure 3 Interrupted time series analysis of SREL data, stratified by region.

Table 4
Ratio of change from baseline to post-implementation phase by region

Location	Ratio
West Midlands	-1.78 to 11.07%*
East England	5.52
Northwest	2.09
Wales	1.98
Northeast	1.97
Southeast	1.90
East Midlands	1.77
Southwest	1.71
London	1.43
Yorkshire and the Humber	1.06
*Baseline value was negative (-1.78) so ratio is difficult to interpret	

Variation by disease (cancer and non-cancer)

Before the start of COVID-19, the caseloads assigned PiP increased annually by 11.9% for those with non-cancer diagnoses and by 3% for those with cancer. After the implementation phase, the annual growth for non-cancer conditions was 1.58 time higher than pre-COVID-19, and 2.40 times higher for cancer conditions. Figure 4 demonstrates this change over time, with separate figures by cancer and non-cancer in Supplementary material 4.

[Figure 4 here]

Figure 4 Interrupted time series analysis of SREL data, stratified by disease.

A further analysis was completed looking at the ICD code “Diseases of Nervous System (G00-G99)”. In total, there were 109,959 caseloads recorded under this code.

Table 5
Annual caseload of PiP via SREL route, Diseases of Nervous System (ICD codes G00-G99)

Year	Annual SREL caseloads
2019	15,223
2020	15,964
2021	16,087
2022	16,907
2023	16,813
2024	17,962
2025	11,003
Total	109,959

Before COVID-19, the monthly caseload for PiP through the SREL route increased by 9.7% annually. After the implementation of the policy, the annual growth rate for this group was 1.23 higher than the pre-COVID-19 growth rate (11.9%). See Fig. 5.

[Figure 5 here]

Figure 5 Interrupted time series analysis for “Diseases of the Nervous System (G00-G99)”.

Variation by age (Above and below pension age)

Among pension-age individuals, the caseload shifted from an annual decline of 2.6% before COVID-19 to an annual increase of 17.9% after implementation. Amongst the individual who are below pension age, the annual growth rate increased from 5.2% before COVID-19 to 7.4% after the implementation. The individual graphs, which display these increments in more detail are available in Supplementary material 4. Figure 6 shows the analyses for the policy change

by age group. Where individuals were above the state pension age, the caseload shifted from an annual decline of 2.6% before COVID-19 to an annual increase of 17.9% after the implementation period. For those below state pension age this change from 5.2% before COVID-19 to 7.4% after the implementation period. Individual graphs are available in Supplementary material 5

[Figure 6 here]

Figure 6 Interrupted time series analysis, stratified by pension age group.

The results of the sensitivity analyses, which include monthly percentage change data from both Scotland and other countries, are presented in Supplementary material 6.

After presenting the results to the stakeholder group, an additional analysis of the impact of the SREL change on Attendance Allowance was completed. The complete analysis is presented in Supplementary material 8. The analysis indicates that the SREL policy change did not impact referrals for Attendance Allowance.

Interpretation given prognostic uncertainty

There are approximately 580,000 adult deaths in England and Wales annually. Table 6 describes the number of annual cases. The prevalence and accuracy data has been applied from previously published evidence.

Table 6 Prognostic uncertainty data (data is annual count)		
1. Total death in England and Wales	578,082	
Potential people to identify	6 months	12 months
2. Will die in the timeframe	289,041	578,082
3. 80% die from serious illness, so the total number for SREL in a perfect prognosis is: (80% #1)	231,233	462,466
4. Not everyone will be seen be a GP, so if 80% go at least once in the timeframe to plausibly get referred: (80% #3)	182,452	364,904
5. Total that are not seen by a GP (#3 - #4)	48,781	97,561
Identification by clinicians		
6. Correctly identified and referred (75% #4)	136,839	255,433
7. False negatives (people who were not identified and died) (#4 - #6)	45,613	109,471
8. False positives (people who were recognised who did not die within the predicted timeframe) [†]	199,557	239,468
Total referred for SREL per year	336,396	494,902

† Calculated as: an additional 1,100,000 (#1 *2) people in the last 3 years of life but not last year. If 70% of those people go to the GP (n = 770,000) and accuracy is 75% at 6 months and 70% for 12 months.

After removing deaths without a serious medical illness, accounting for those who do see a GP near end of life, and incorporating prognostic uncertainty, we estimated 336,396 people referred to SREL per year under the 6-month prognostic criterion and 494,902 per year under the 12-month criterion.

Under the 6-month criterion, 136,839 (41%) of referrals will be *ex post* prognostically correct, i.e. the person will die within the timeframe, and 199,557 (59%) incorrect. An estimated 94,934 people will be in the last 6 months of life with a serious illness but not receive SREL; 45,613 attend the doctor but are not identified as approaching end of life, and 48,781 do not see a GP so cannot be referred. Under the 12-month criterion, 255,433 (52%) of SREL referrals will be prognostically correct and 239,468 (48%) will be incorrect. A further 207,033 eligible people (in the last year of life, relevant diagnosis) are not referred to SREL; 109,471 attend the doctor but are not identified as approaching end of life, and 97,561 do not engage with a clinician. The underlying calculations for this data are presented in Supplementary material 9.

Discussion

The annual growth rate of the reported caseload of PIP was 2.17 times higher after the implementation of the SREL rules than the annual pre-COVID-19 rate (a shift from ~ 4% up to ~ 9%). This difference was similar between the genders. Non-cancer diagnoses showed increases in annual growth after the policy change compared with pre-COVID levels, suggesting that broadening the prognostic window has particularly enabled people with non-malignant diagnoses, which often progress more slowly and have less predictable trajectories, to access financial support. Focussing specifically on diseases such as motor neurone disease (MND) or amyotrophic lateral sclerosis (ALS), the pre-COVID rate (~ 9%) compared to the post-implementation data (~ 11%) suggest that the population were already visible to the SREL system, although the policy change has slightly increased growth. Regionally, areas such as the West Midlands and East of England moved from flat or declining caseloads to a growth after implementation, indicating geographical variation in how the new rules have translated into practice.

These results should be considered within the context of broader changes across the DWP as well as national and international events that have altered the financial landscape in the UK. In July 2023, there was a shift to digitalise the process for benefit claims, including the SREL. Prior to this date, forms were submitted by post. Therefore, some of the findings reported in this study could be due to the digitalisation process rather than the policy change itself.

While it might seem unsurprising that lengthening the prognostic timeframe increases the number of people receiving PIP under SREL, this study provides confirmation that policy changes do translate into real-world impact. The process for obtaining financial support mirrors that of accessing specialist palliative and end-of-life care services; both operate under a degree of financial constraints whereby the DWP is responsible for public funds, hospices rely predominately on charitable funding. As a result, application procedures and eligibility criteria that include a prognostic estimate have evolved, in part, to manage these resources (it is notable that the non-SREL route to receiving PIP relies on a lengthy and detailed application process, which significantly restricts access to the benefit, only around half of new PIP claims are accepted by the DWP at the initial application stage).(22) However, such mechanisms may inadvertently perpetuate structural inequities. It has been well evidenced that access to general healthcare is not equitable;(23) and similar disparities exist within specialist palliative care services.(24, 25)

There are important implications from this study for current debate on the Terminally Ill Adults (End of Life) Bill in the UK, which also centres on statutory prognostic thresholds such as “within 6 months” or “within 12 months” of death. In several high-income countries where assisted dying is legal, including Australia, New Zealand and parts of the USA, eligibility commonly requires that death is considered foreseeable within a specified timeframe, often 6 or 12 months. In contrast, other jurisdictions such as Austria, Belgium, Canada, the Netherlands, Spain and Switzerland do not require a prognostic estimate as part of eligibility criteria. In a review of assisted dying legislation in high income countries, the Nuffield Trust highlighted wide variation in how laws have been implemented and noted that eligibility criteria have generally broadened over time rather than becoming more restrictive, particularly in Canada, Belgium and the Netherlands.(26) They also reported that cancer is the most common diagnosis among people accessing assisted dying in these settings. Findings from the present study suggest that changing statutory prognostic criteria can widen access beyond cancer, with people living with non-malignant conditions appearing more likely to receive financial support under the revised SREL rules.

The analysis completed on the prognostic uncertainty highlights the uncertainty of a prognostic estimate as a referral criterion. There was a 137% increase in false negatives (from approximately 46,000 people per year with a 6-month criterion up to 109,000 people with a 12-month criterion) in which people would not be identified as being eligible and therefore would not be referred to SREL. Equally, there was a 20% increase in the number of false positives (from approximately 200,000 people per year with a 6-month criterion up to 240,000 people with a 12-month criterion) where people would incorrectly be identified as eligible and therefore referred to SREL but not die within that timeframe. This evidence will prompt important considerations for policymakers debating how a prognosis-based eligibility criteria might shape patterns of access to assisted dying in the UK-based eligibility criteria might shape patterns of access to assisted dying in the UK.

This study utilised a large volume of monthly data gathered from the Department for Work and Pensions (DWP) spanning a seven-year period, across England and Wales. This enabled a broad inspection of the PiP caseload through the Special Rules for End of Life (SREL) policy change. It is the first study of its kind to report such data. The policy change itself offered a naturalistic observation of the impact of changing a prognostic criterion to access a specific service, in this case, financial support.

Limitations to the data include the lack of nuance around the monthly figures reported. The caseloads refer to the number of individuals that month receiving PiP under the SREL rules; it is unknown, for example, how long they received it for, or indeed how long they lived for. It is not possible to know the severity of their illnesses. Ethnicity data was not available through the platform; therefore, we cannot report the impact of the SREL change to different ethnic minority groups; who we know experience inequities when accessing specialist palliative care services.

Future work should link SREL data with clinical and sociodemographic information to understand who is now being reached, how long they live, and whether existing inequities are narrowing or widening. Economic evaluations are needed to assess the long-term sustainability of a growing SREL caseload and to compare prognosis-based eligibility with need-based eligibility or alternative criteria. Policymakers should consider these findings when reviewing the role of statutory prognostic thresholds in welfare and in any future assisted dying legislation, ensuring that access criteria balance fairness, feasibility and fiscal responsibility.

Declarations

Ethical approval and consent to participate

This study was approved by the UCL Research Ethics Committee on 2nd December 2025 (Ref: 2392). Consent for participation was not required.

Consent for publication

Not applicable.

Competing interests

The authors declare that they have no competing interests

Funding

The study was part funded by: Marie Curie Care (MCCC-FPO-16-U). The funder had no role in the study design; in the collection, analysis, and interpretation of data; in the writing of the report; and in the decision to submit the article for publication. All researchers were independent from the funders and all authors, external and internal, had full access to all of the data (including statistical reports and tables) in the study and can take responsibility for the integrity of the data and the accuracy of the data analysis.

Author Contribution

NW, VV, OM, PM, LL, & LS conceived the initial idea, developed the initial protocol, and obtained ethical approval. NW, CM, JCBA, LL, OM, JT, VV, PM, LS discussed and planned the methodology. NW, JCBA, CM, PM completed the statistical analysis. NW, CM, JCBA, LL, OM, JT, VV, PM, LS discussed and interpreted the data, drafted the manuscript and approved the final report.

Acknowledgement

We would like to thank Dr Matthew Gouldstone and Dr Emily Pikett from the Department for Work and Pensions. We would also like to thank Mr Tom Wardle from Marie Curie.

Data Availability

All data generated or analysed during this study are included in this published article [and its supplementary information files]. All data was accessed from the government portal Stat-Xplore.

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Figures

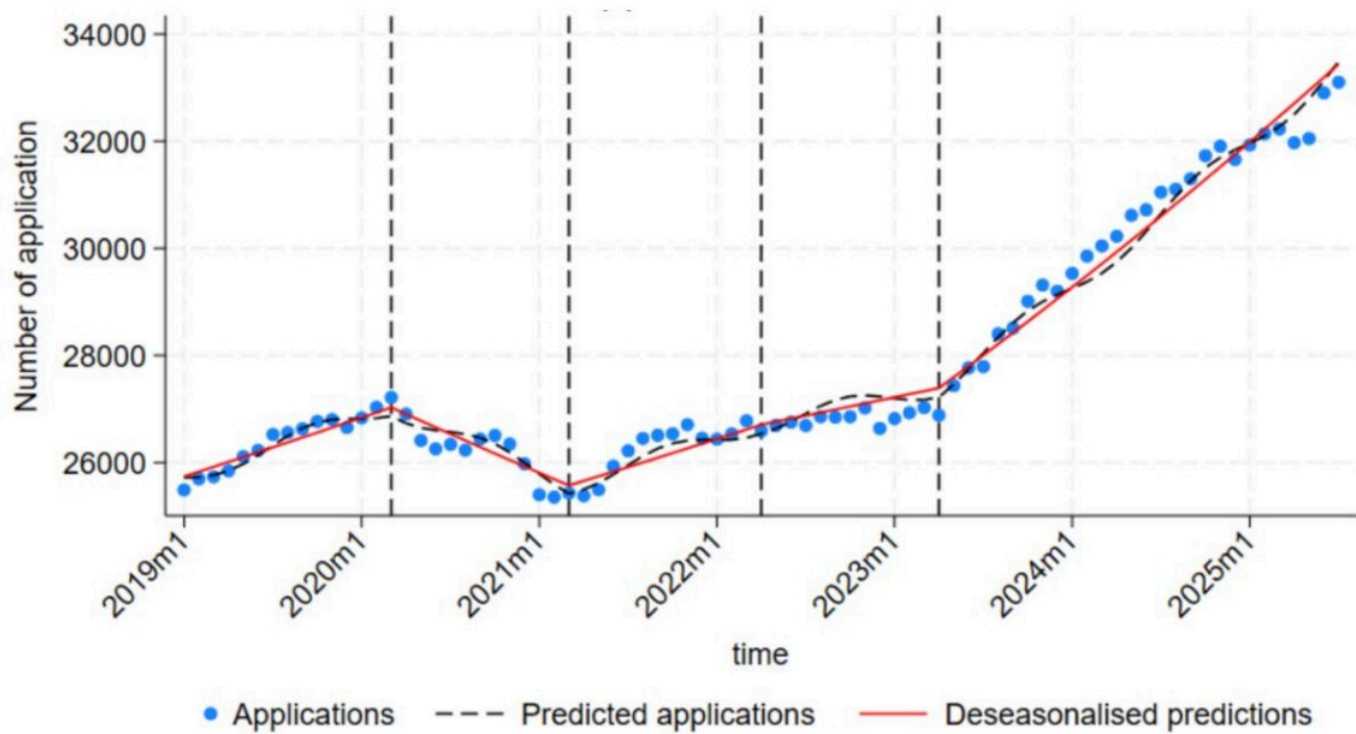


Figure 1 Interrupted time series analysis on SREL caseloads of PiP.

Figure 1

See image above for figure legend.

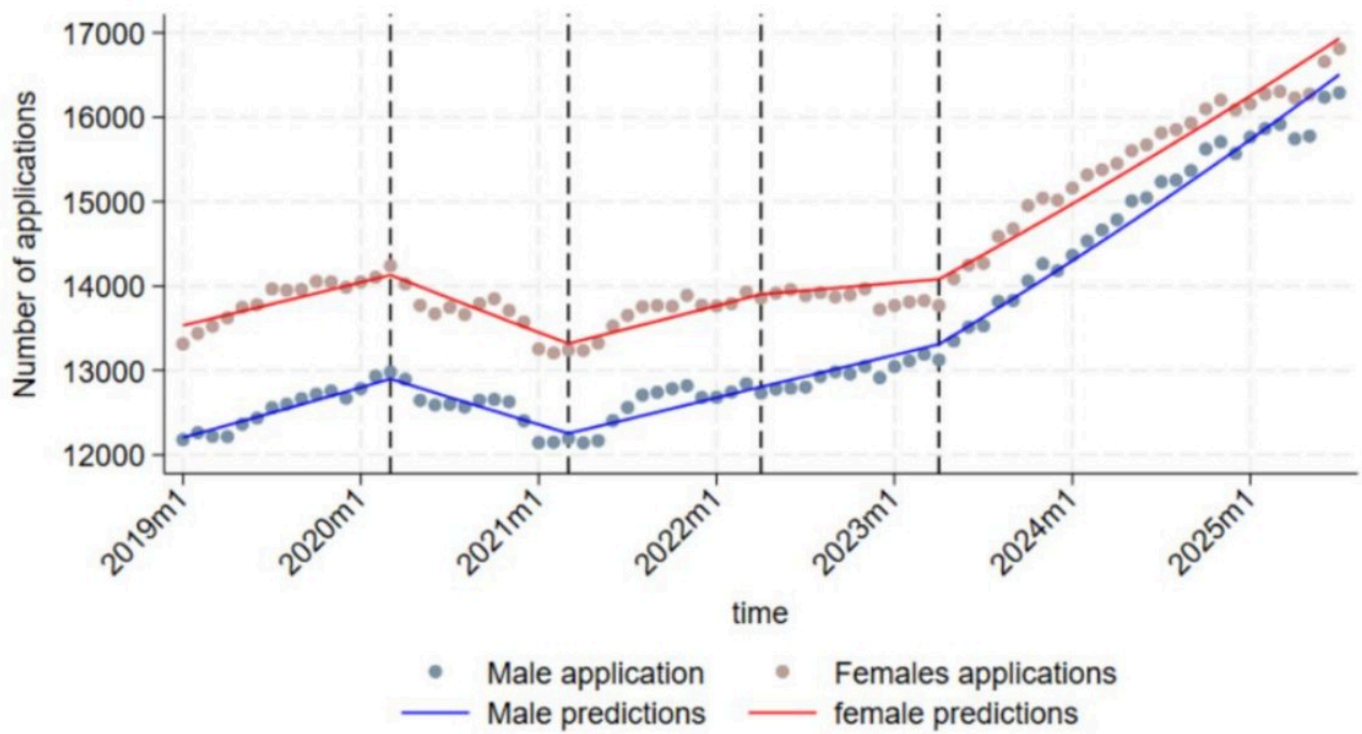


Figure 2 Interrupted time series analysis of SREL data stratified by sex.

Figure 2

See image above for figure legend.

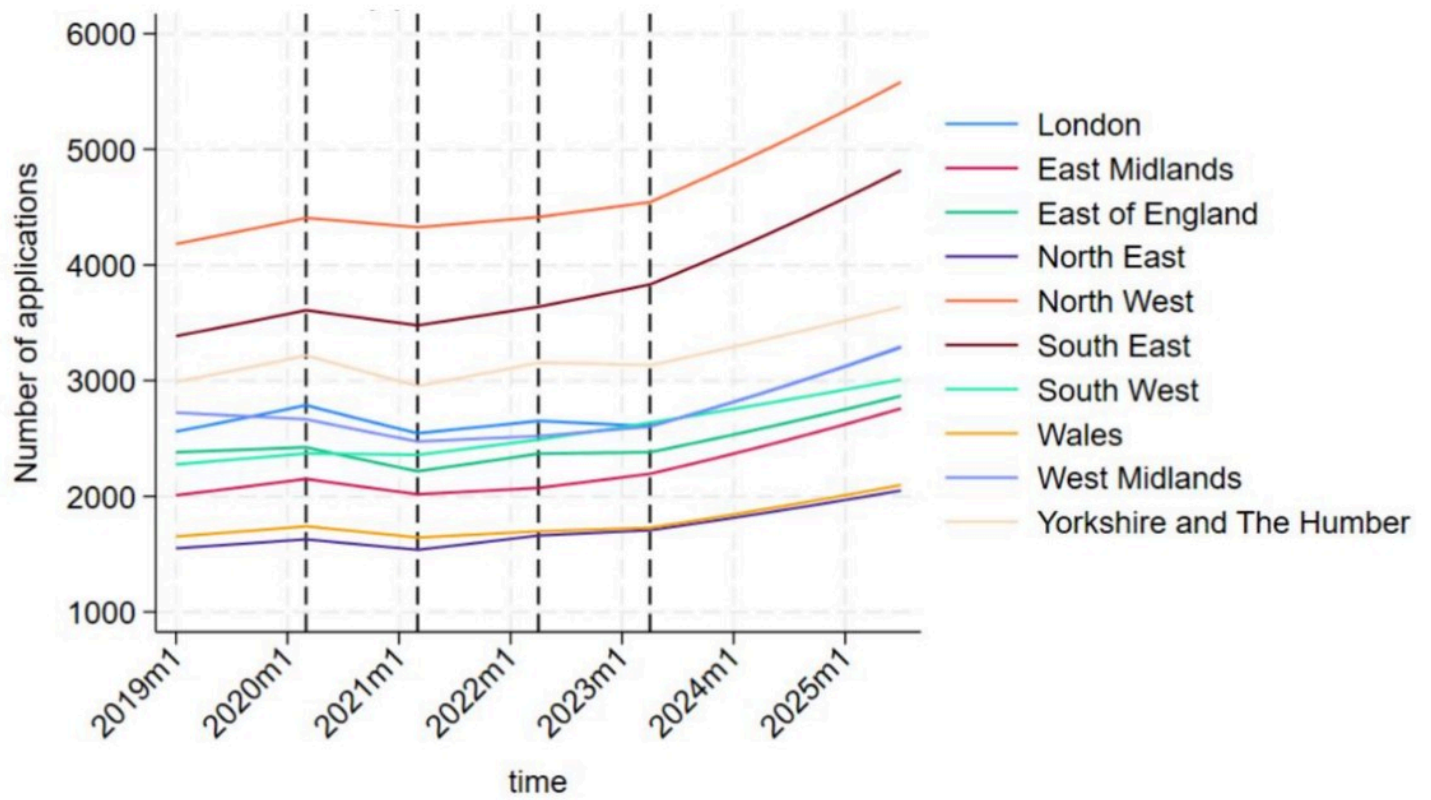


Figure 3 Interrupted time series analysis of SREL data, stratified by region.

Figure 3

See image above for figure legend.

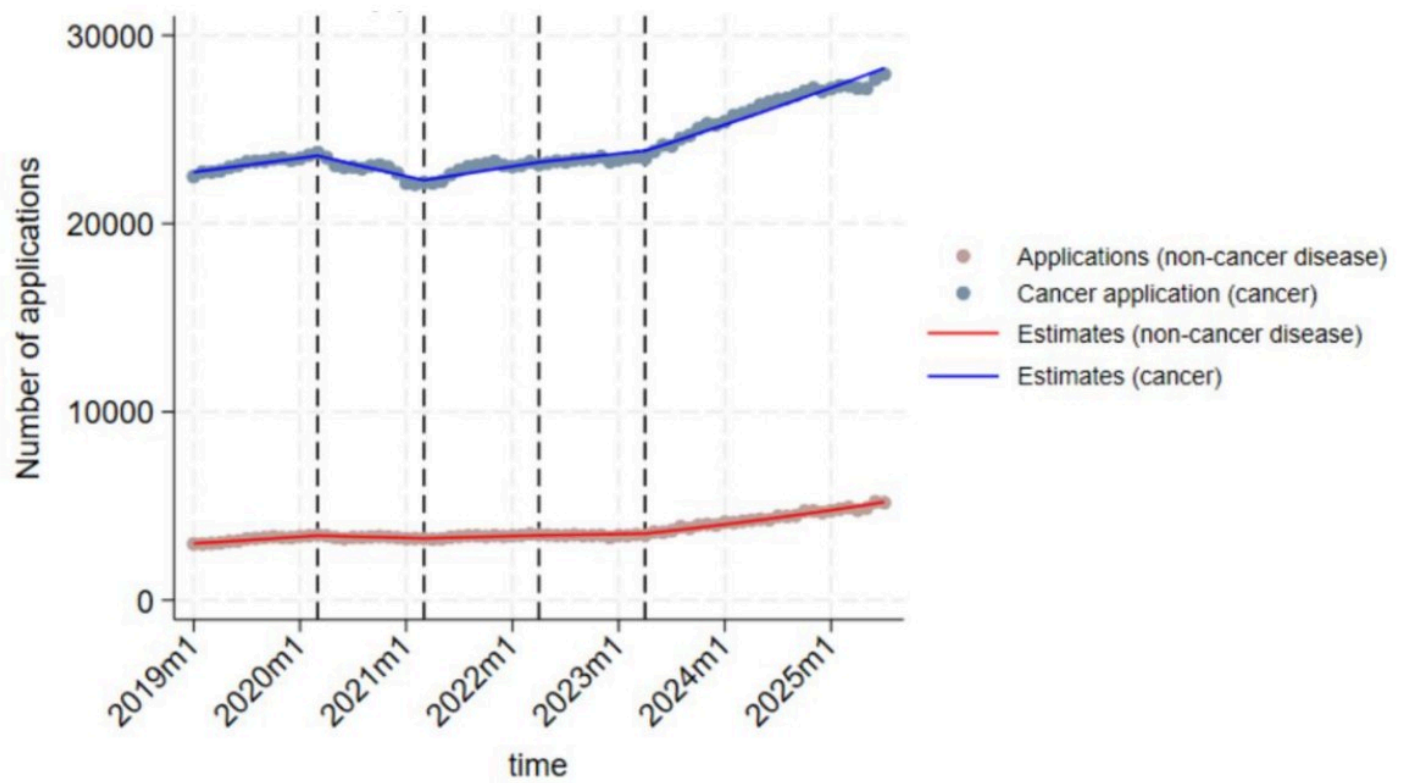


Figure 4 Interrupted time series analysis of SREL data, stratified by disease.

Figure 4

See image above for figure legend.

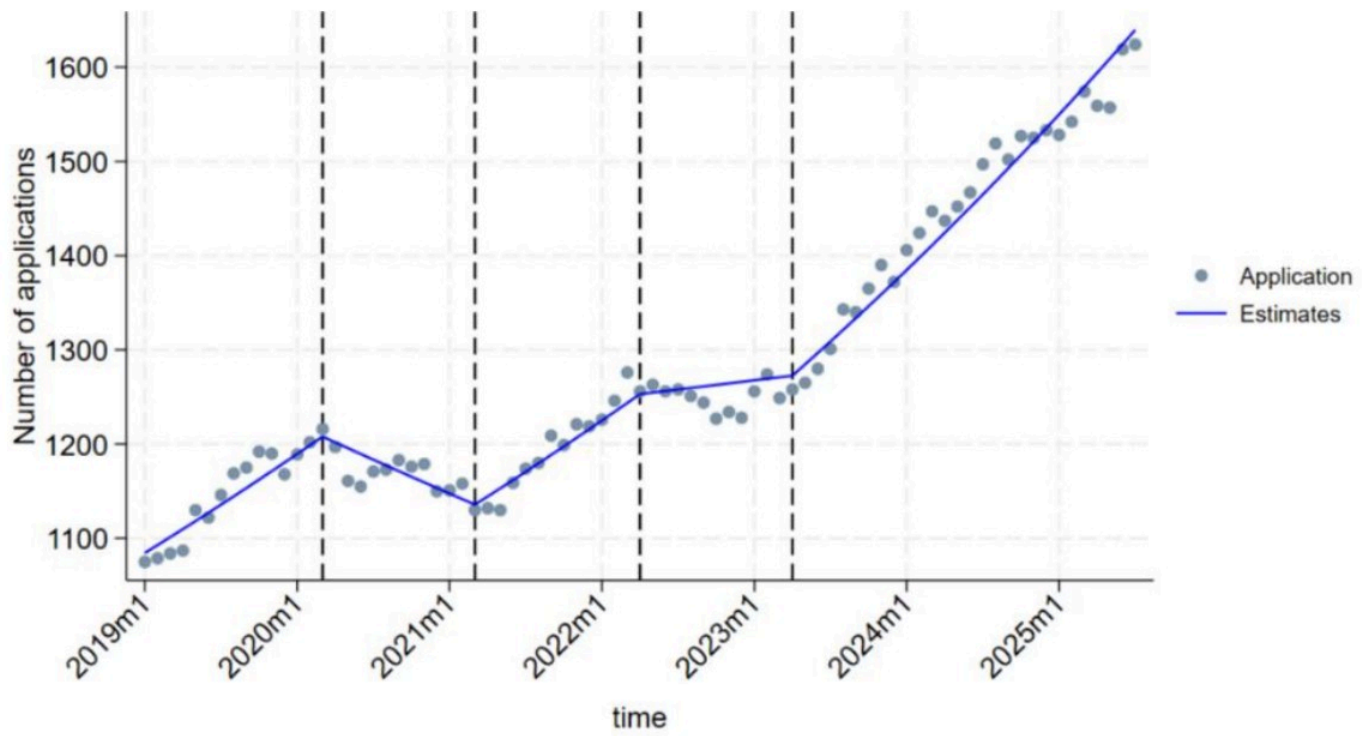


Figure 5 Interrupted time series analysis for “Diseases of the Nervous System (G00-G99)”.

Figure 5

See image above for figure legend.

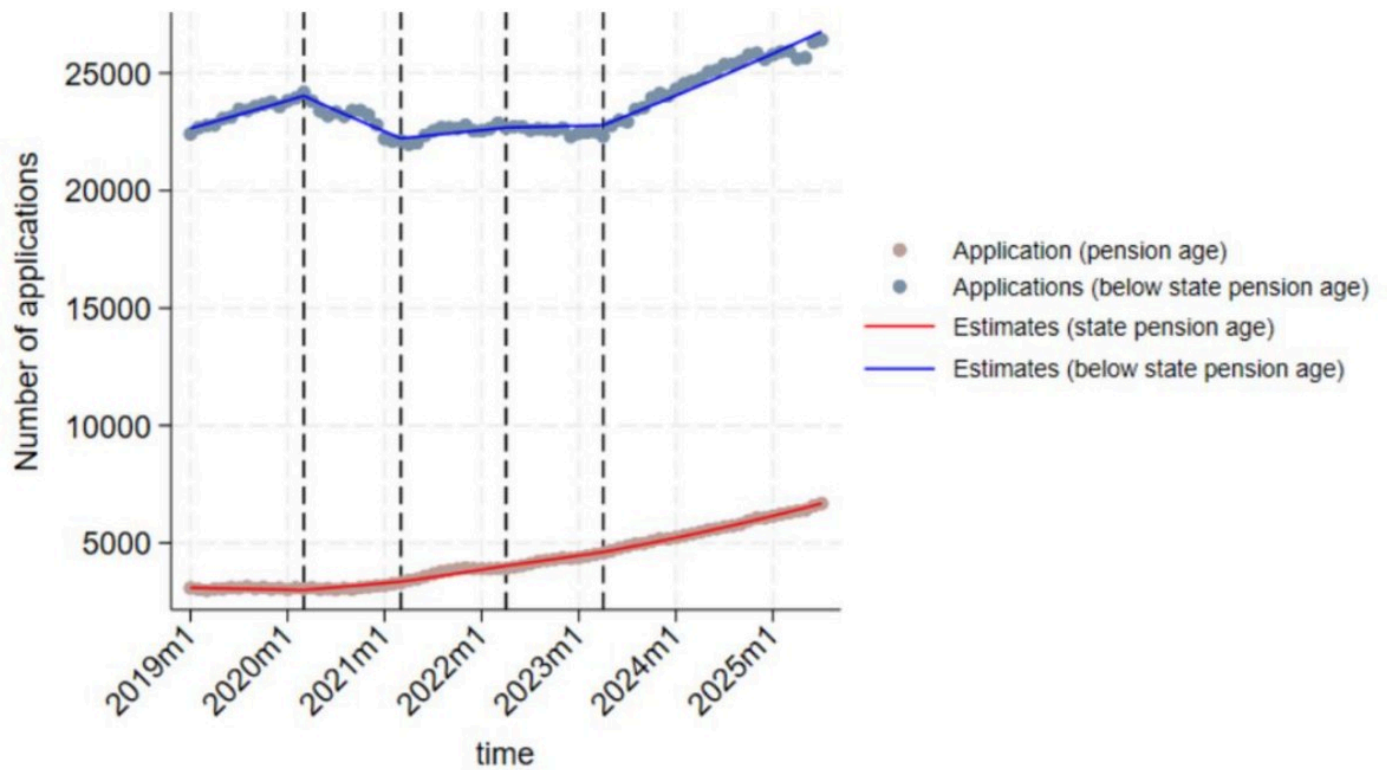


Figure 6 Interrupted time series analysis, stratified by pension age group.

Figure 6

See image above for figure legend.

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