The case and model for Progressive Collaboration between Hospices

Why Darwin was right!

Brian Mansfield, Trustee, Dorothy House
Wayne de Leeuw, CEO, Dorothy House

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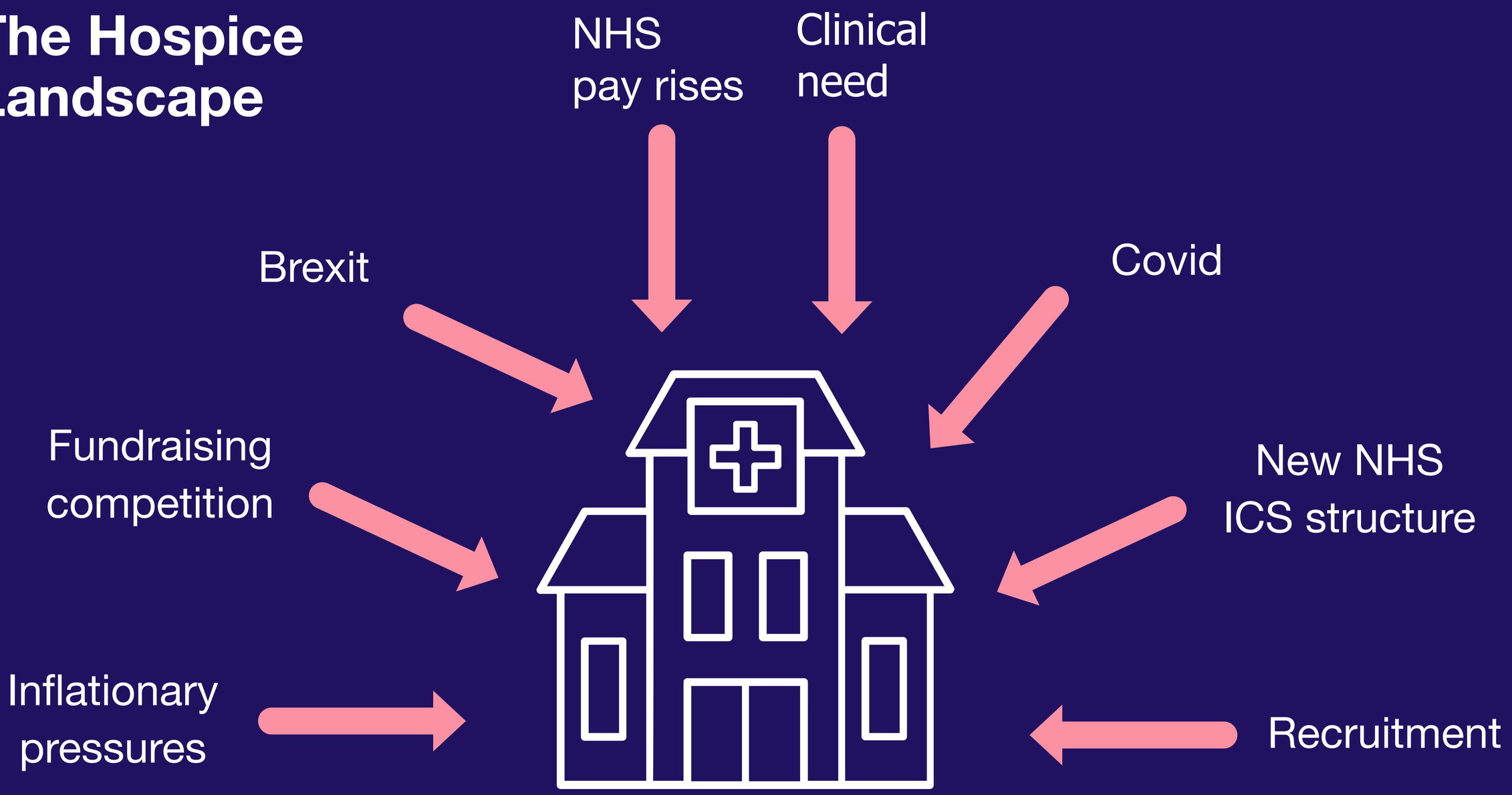
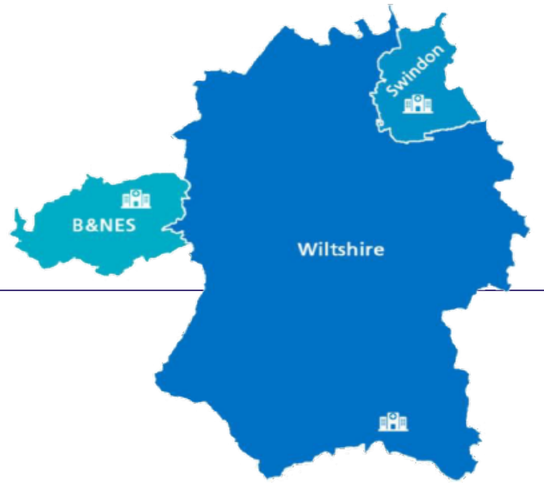
The Hospice Landscape



The New ICS Landscape



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Our Vision

"Working together to empower people to lead their best life"

The BSW Landscape-

BSW CCG
Bath & North East Somerset Council
Swindon Borough Council
Wiltshire Council
Great Western Hospital Foundation NHS Trust
Royal United Hospitals Bath NHS Foundation Trust
Salisbury NHS Foundation Trust
Avon & Wiltshire Mental Health Partnership NHS Trust
Wiltshire Health & Care
Virgin Care
94 GP practices
Dorothy House Hospice
Prospect Hospice
South Western Ambulance
Medvivo
Wessex Local Medical Committee
West of England Academic Health Science Network
Health Education England
3 Health and Wellbeing Boards
Healthwatch

BSW Integrated Care System	
Neighbourhood	24 neighbourhoods (PCNs) with populations ranging from 26,000 to 60,000
Place	3 Places with registered populations of: - B&NES 205,000 - Swindon 239,000 - Wiltshire 494,000
System	One system with a combined population of 940,000 and a joint budget of £1.6bn. At this level strategic planning and decisions can be made for the benefit of everyone as well as having an overview of system finance and performance.

The Four Dimensions of Hospice Capability

1. Clinical
2. Commercial
3. Community
4. People & Leadership

The Four Dimensions of Hospice Capability

Commercial

1. Do you regularly review clinical and non-clinical KPI's for operational impact and efficiency to assist decision making at the Board?
2. Is your retail offer delivering significant (25%+) contribution?
3. Is your brand well understood and consistently communicated internally and externally?
4. You have right level of NHSE funding and have the influence and capability to monitor and challenge this as need/systems change?
5. Do you have a diverse portfolio of income streams, including a pot of innovative and new ideas coming through and are able to share risk (and reward) on new ventures?

Clinical

1. Do your recruitment and retention strategies mean that your clinical teams are at full establishment and empowered to deliver the best possible care?
2. Do you have robust internal training programmmes to "grow your own" and empower staff and volunteers to be the best that they can possibly be?
3. Does ready access to live data on local "population health" and need drive decision making and the use of your services?
4. Is your digital capability as good as it can be, allowing for the sharing of patient records and decision making swiftly between multiple partners within the system and ensuring staff and volunteers are enabled and empowered?
5. Are you "CQC ready" and feel that the organisation is ready for the new inspection framework as part of the wider NHSE system?

Community

1. Do you actively engage with all relevant organisations who share your aims across your community managed through the use of a CRM system?
2. Is your Volunteering body strong and supportive of the organisation?
3. Are your services consistent across your geography?
4. Are you certain that the "voice" of your community, including the people who use your services, informs what services are delivered, where and how?
5. Are you "co-developing" services/roles in partnership with your community e.g. through the application of Asset Based Community Development (ABCD)?

People and Leadership

1. Do you have strong, authentic and open leadership?
2. Is your strategic plan coherent and understood across the organisation and wider system?
3. Are your Governance policies, procedures and practices top drawer?
4. How good is your People Management? Do you have an Employee Value Proposition?
5. You have adequate in-house speciality knowledge to effectively lead large scale project management and/or org development?

How do you rate yourselves?

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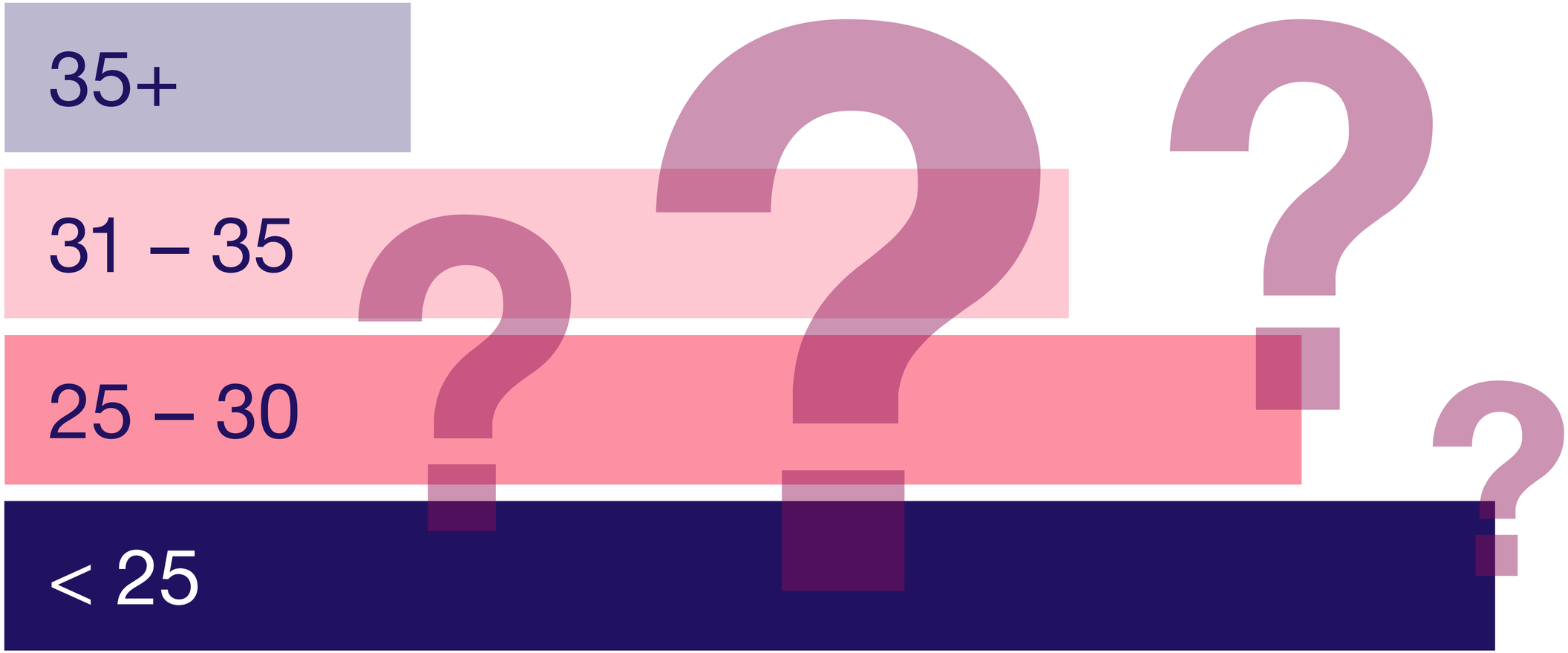
Overall

40

The Four Dimensions of Hospice Capability: Poll Results



The case for collaboration

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- Consolidation is both likely and probably desirable to improve economies and maintain service standards
- Collaboration allows learning while exploring deeper affiliation
- The changing NHS Commissioning landscape expects consistency of provision and collaboration by geography

The problem with Commercial Language...

HOSTILE TAKEOVER

Empire Building

Culture clash

Dawn Raid

TANKS ON THE LAWN

ASSET STRIPPING

Loss of identity

Why did we call it “Progressive Collaboration”?

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- Softens the language
- Encourages dialogue over dominance
- Shows a pathway for engagement
- Only progresses if everyone wins
- No lead party

A Model of Progressive Collaboration

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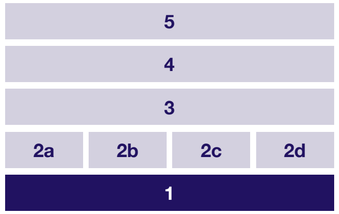
Level 5	Full Merger with Unified Brand			
Level 4	Full Merger with Independent Trading Brands			
Level 3	Federated Approach			
Level 2	a. Formal Collaboration	b. Sub-Contracting	c. Purchasing/ Funding Consortia	d. Back-Office Integration
Level 1	Opportunistic Collaboration			

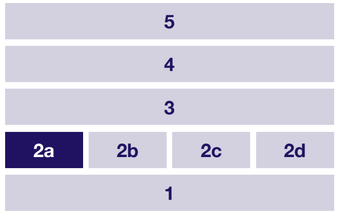
A Model of Progressive Collaboration



Level 1: Opportunistic Collaboration

- One-off instances of support between Hospices (clinical/back office, managerial, fundraising etc.)
- No sharing of strategic information or payment for support/services
- No contracting for ongoing provision
- Might act as foundation for further collaboration or unification especially for geographical ambiguities

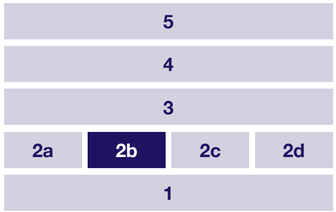
A Model of Progressive Collaboration



Level 2(a): Formal Collaboration

- Specific areas of collaboration in line with each party’s strategic and operational aims
- Pricing mechanism agreed and public may remain unaware of joint activity
- Contracted for a fixed period
- Useful in joint retail shops, shared roles, training & consultancy, joint fundraising and events

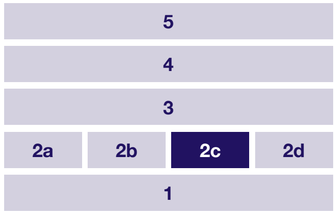
A Model of Progressive Collaboration



Level 2(b): Sub-Contracting

- Where services are sub-contracted from one Hospice to another as part of a larger agreement
- DH delivering IT infrastructure support to hospices in the region

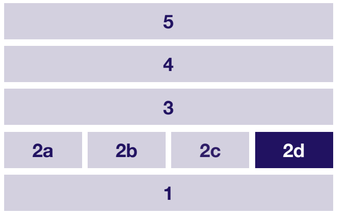
A Model of Progressive Collaboration



Level 2(c): Purchasing/Funding Consortia

- Two or more Hospices jointly procure products/services e.g. medical supplies, utilities, IT
- Joint funding and grant applications
- Combined purchasing power; headcount reduction and shared expertise
- No change in legal or operating model

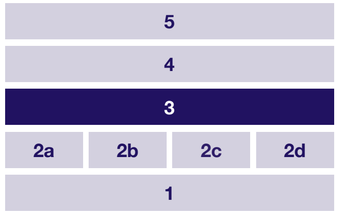
A Model of Progressive Collaboration



Level 2(d): Back-office integration

- Hospices formally unite all operating procedures and systems
- Individual legal entities and public facing brands are maintained
- Long-term commitment to achieve cost-savings, scale economies, shared best practice and unified standards
- Timetable agreed at outset to ensure commitment
- Could cover IT, HR, Finance, Clinical Processes etc

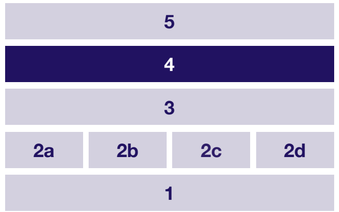
A Model of Progressive Collaboration



Level 3: Federated Approach

- Hospices within geographies (or beyond!) speak with a “single voice”, under the banner of one central organisation
- Consolidation of key roles across the Federation allowing for greater professionalisation and higher standards
- Established standards, governance frameworks and policies adhered to by all participants
- Procurement and Funding economies to drive efficiencies
- Centralised leadership but Board Governance at individual Hospice level
- The brand of each Hospice remains strong with local presence and voice
- Operates like a Schools Trust

A Model of Progressive Collaboration



Level 4: Full Merger with Independent Trading Brands

- Formal and legal merger
- Trading brands maintained for community engagement and fundraising
- Potential for an Alliance brand e.g. “Part of the Wessex Hospice Group”
- Substantial cost, clinical and strategic benefits

A Model of Progressive Collaboration

5			
4			
3			
2a	2b	2c	2d
1			

Level 5 : Full Merger with Unified Brand

- As Level 4 but indidivdual brands are unified
  e.g. Age UK formed from Help the Aged and Age Concern
- Re-branding costs re-couped from cost efficiencies
- Likely one organisation “leads” the merger managerially/strategically

Benefits of Progressive Collaboration

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- Creates friendly, consistent language for Boards to engage in exploratory chats
- Encourages shared best-practice raising standards for all
- Low-risk and develops only if benefits all
- Allows “cultural dating” to see if Values align
- Conversations can begin at different points and progress at different paces
- Protects pubic facing brands until decided otherwise (if ever!)
- Show Commissioners a plan/vision for shared patient care and consistency

Why our experience says this is a good thing

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“

If hospices want to ensure and influence: equitable access to palliative and end of life care, sustainable funding for their care from the NHS and that they have a (valued and important) role in the new Integrated Care System, it is an imperative that hospices find ways to truly collaborate and speak with a single voice across the system!

Tracey Cox

Why our experience says this is a good thing

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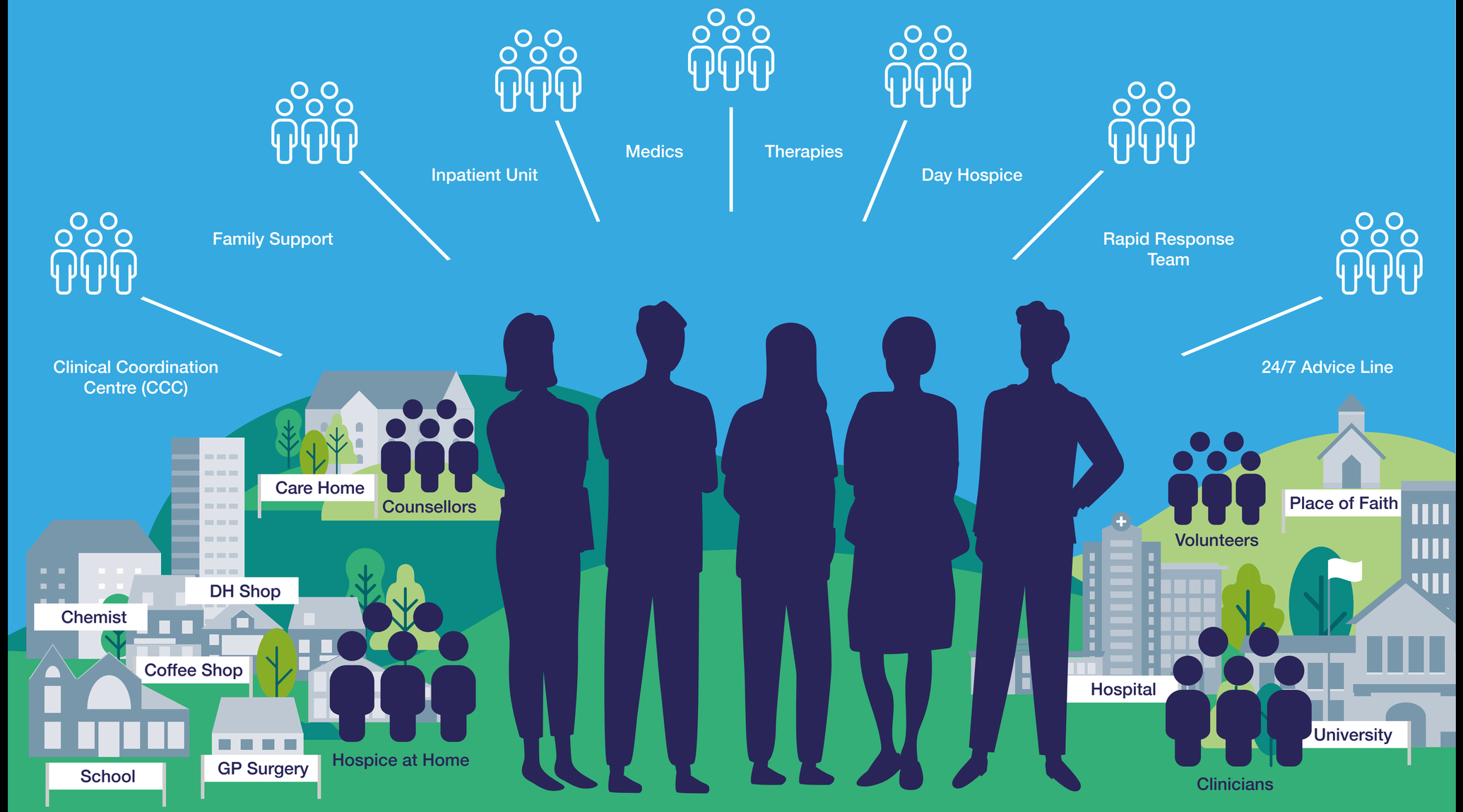
- Strategic
- Tactical
- Pragmatic



Dorothy House Community Care Team

Community Support Assistant (CSA) | Registered Nurse (RN) | Clinical Nurse Specialist (CNS) | Clinical Lead | Community Engagement and Volunteer Coordinator

Trustees – What can we do?

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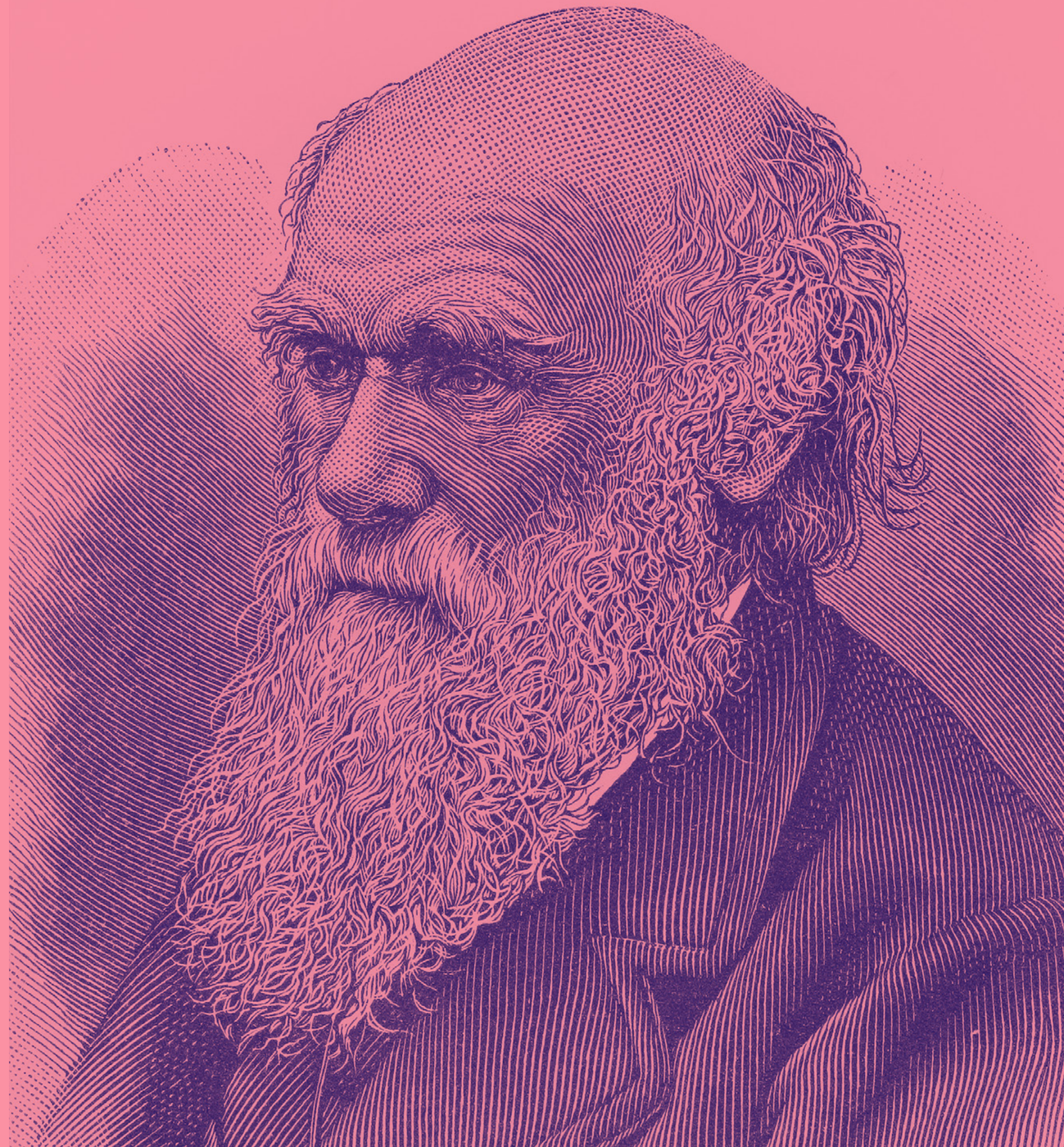
- Introduce the Model and language and open the discussion internally and with local Hospices
- Challenge “turf defenders” especially those protecting their roles
- Define your ‘red lines’ openly
- Understand what you bring to and what you need (strategically) from collaboration
- Invite perspective from Commissioners

Why was Darwin right?

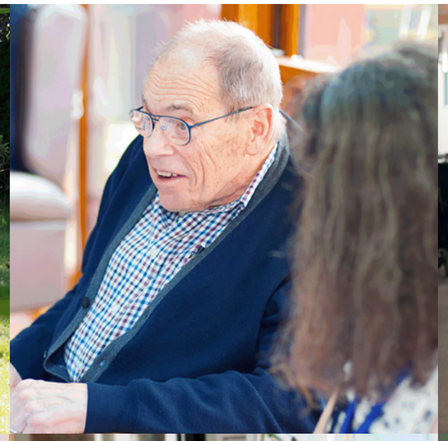
“

It is not the strongest of the species that survives, not the most intelligent that survives. It is the one that is more adaptable to change.

Charles Darwin







Quiet Zone







BATH RU





geologist

Q&A

Thank you

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