hospiceUK

Peering over the Precipice

A toolkit for hospices to survive and thrive

Acknowledgements

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We also wish to thank those who contributed case studies: Angela Jordan, Chief Executive of Prospect Hospice, Swindon; Peter Hartland, Chief Executive of St Luke's Hospice in Sheffield; Tina Swani, Chief Executive of Birmingham St Mary's Hospice; Heather Richardson and Shaun O'Leary, Joint Chief Executives of St Christopher's Hospice; Mike Palfreman, Chief Executive of Haven House Children's Hospice, and Sue McGraw, Chief Executive of St John's Hospice, Lancaster.

This toolkit is published as part of Hospice UK's Good Governance programme of support for hospice trustees, boards and senior teams.

Published by Hospice UK in November 2017.

Contents

Foreword

The idea for this toolkit originated from a single phone-call from a hospice in financial difficulty. The hospice was indeed peering over the precipice, and immediate rescue action was needed to avoid the failure of the charity. Everyone involved learned a huge amount from this experience, and we were keen to share this learning across the sector. Shortly afterwards we developed a series of financial sustainability measures to help us identify those hospices that might face future financial issues in order to help boards ask the right questions and make timely plans.

We realised that the financial resilience of many hospices has been gradually eroding over many years due to a challenging funding environment, increasing demand and rising costs of regulation and service provision. It's the classic boiling frog scenario – how do you know when the water is too hot when the temperature has been slowly rising, and what do you do about it? This is exactly the question that this toolkit aims to address. We want to give hospice boards and executives the means to diagnose future risks and the tools to make robust plans and support the changes that need to be made. In developing this toolkit, we were delighted to work with the Centre for Charity Effectiveness at Cass Business School to run an Open Space workshop where over 60 participants brought their experience, insights and knowledge to identify some of the key signs of risk, and actions that hospice boards and senior teams might take together to address those risks.

The hospice movement has always been dynamic and innovative, and by continuing to harness those characteristics we will continue to provide high quality hospice care to those who need it for generations to come.

Tracey Bleakley
Chief Executive
Hospice UK

Section 1: Introduction

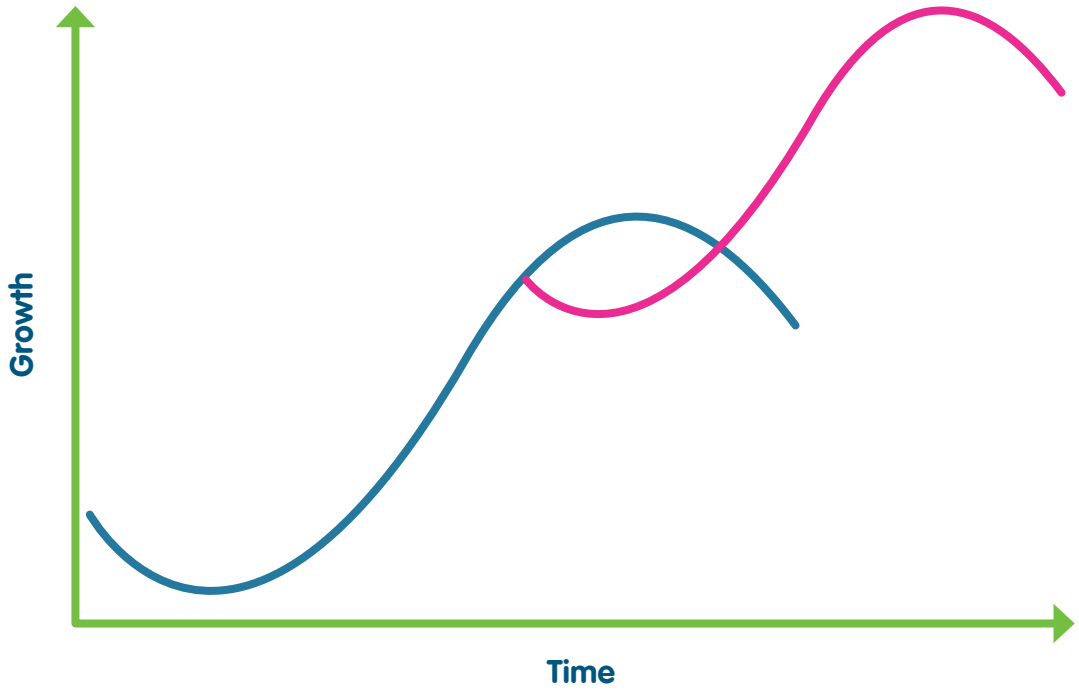
1.1 The purpose of this toolkit

It is clear from anecdotal evidence that we seem to be at a pivotal point in the life of the hospice sector, and that for the majority of hospices the business model that has served so well in the past and the assumptions made about the business of running a hospice may no longer be valid in future. There is growing polarisation between those organisations that are effective and those that are failing – it is much less possible for organisations in the charity sector to merely survive: increasingly thrive or fail seems to be the reality. Settling for the status quo is unlikely to be the right option and inaction is likely to lead to decline and crisis. Reinvention of both the hospice sector and of individual hospices is the only sustainable solution.

The purpose of this toolkit is to support hospices to respond to these challenges, and provide a range of resources to enable hospice boards and senior staff to consider what they need to do to go beyond survival and to thrive in an increasingly challenging and markedly different external environment.

The approach in this toolkit is based on organisation 'lifecycle' theory. Charles Handy introduced the metaphor of "sigmoid curves of reinvention" and builds on this in his book 'The second curve'[1]. A sigmoid curve (the blue line below) is 'the line of all things human' and can be applied to organisations (and products and services). It begins with a period of investment, moving into trial and experiment, resulting in growth, until the curve inevitably peaks and begins its descent and decline.

Figure 1: Charles Handy's second curve



(1) Handy C. The Second Curve: Thoughts on reinventing society. London: Random House, 2015.

First curve success can be built upon by reinvention, but the second curve (the red one), says Handy, has to start *before* the first curve peaks: you need to reinvent before the downturn, even if this seems counterintuitive. According to Handy, it's much harder to reinvent or turnaround once you've lost momentum, once times are hard, morale is low, and investment resources are running out. He sees the second curve as our opportunity to "redeem ourselves, and to show that we have learnt from the past in order to create a better future". The overriding message is that *you can't stand still*.

This toolkit offers you a range of tools to:

1. work out where you are on the curve
2. take action to keep fit and reinvent to survive and thrive
3. work out the best next steps if your organisation is on the decline.

1.2 How we developed the toolkit

The process to develop this toolkit was kick-started at an open space workshop called *Peering over the Precipice*, organised by Hospice UK and facilitated by the Centre for Charity Effectiveness (Cass CCE) at Cass Business School in September 2016. Over 60 hospice trustees, senior staff, staff from Hospice UK and from Cass CCE took part. Much of the structure and content of this toolkit emerged from the work of this group.

Participants developed an analysis of the challenges, opportunities and threats facing hospices, and then explored the root causes of the difficulties faced by many in the sector. There was no shortage of ideas in the room about the diverse and plentiful range of opportunities that exist for hospices to improve their impact, reinvent their business models and strengthen their capacity and capability to deliver high quality services. A very clear message emerged from this exploration and analysis: *the solutions to the challenges and thus the future of individual hospices and the sector lie in the hands of those responsible for their governance, leadership and management*.

1.3 How to use this toolkit

We have seen from other sectors that the organisations that thrive are those where boards and senior staff work together to explore, adapt and change. So the audience for this toolkit is the board and senior team together: the **top team**. It might be useful for both the chair and chief executive to discuss how the toolkit could be used to stimulate strategic thinking and improvements to governance and management. There is a range of materials that could be used in board meetings, senior team meetings or away days.

We expect you will want to read the whole toolkit to get a sense of the content, look in some detail at **section three** to work out where your hospice is on the 'curve', and then dip down into the other elements according to your needs. In the longer term we hope that you will revisit the different sections, according to need.

Section two looks at tools to explore the drivers of change in the external environment, how they will impact on your hospice, and what your response could be.

Section three contains a series of tools to help you conduct a 'healthcheck' to assess your hospice's present state – where you are on the curve.

Section four looks at a spectrum of possible responses according to where you are on the

curve: get even fitter to move up the curve; reinvent to take advantage of the momentum; or think about next steps/turnaround if you are on the downward slide.

Section five summarises the key themes and learning points.

Each section has a mix of materials to help you explore the topic:

- **Tool:** something practical that can be used by the board and senior staff and to explore challenges together.
- **Worksheet:** a guide through the steps you can take together to achieve a practical result to help bring insights, focus or prioritise.
- **Board conversation piece:** some guidance for boards about useful questions to consider with the senior team, how to tackle the topic in board meetings etc.
- **Signposts to useful resources:** specific to the topic. We have provided hyperlinks for those using this toolkit as an interactive pdf, and those using a hard copy of the toolkit should be able to trace the resources by searching online.

The toolkit also features a number of **hospice case studies** to illustrate the kinds of situations that hospices have had to address and what has worked for others.

Section 2: Drivers of change and their implications

If we understand the drivers in the external environment (trends and forces) and their implications we will be better able to take positive steps to deal well with them, and with a little foresight, better prepare ourselves to take advantage of opportunities and decide the optimum allocation of resources to particular areas of activity in the future. There is an established link between top teams that constantly keep their eye on the external environment, anticipate likely future events and have regular conversations about possible future scenarios, and organisations that go beyond survival to *thrive*.

2.1 Hospice external environment analysis

This section contains an overview of how to do a PESTLE analysis, how to turn this information into something useful to explore future strategic options, some questions for trustees to ask, and some signposts to where you can find out more.

Participants at the *Peering over the Precipice* workshop in September 2016 developed the following list of *drivers* (outer circle) and their *implications* (inner circle). Their conclusion was that the hospice sector is potentially facing a 'perfect storm' of forces that provide both opportunity and significant threat, and that those hospices which are to survive and thrive for the benefit of their patients, service users and local communities need to take action to change their business models and start to do things differently. Bear this thinking in mind as you develop your own PESTLE analysis.

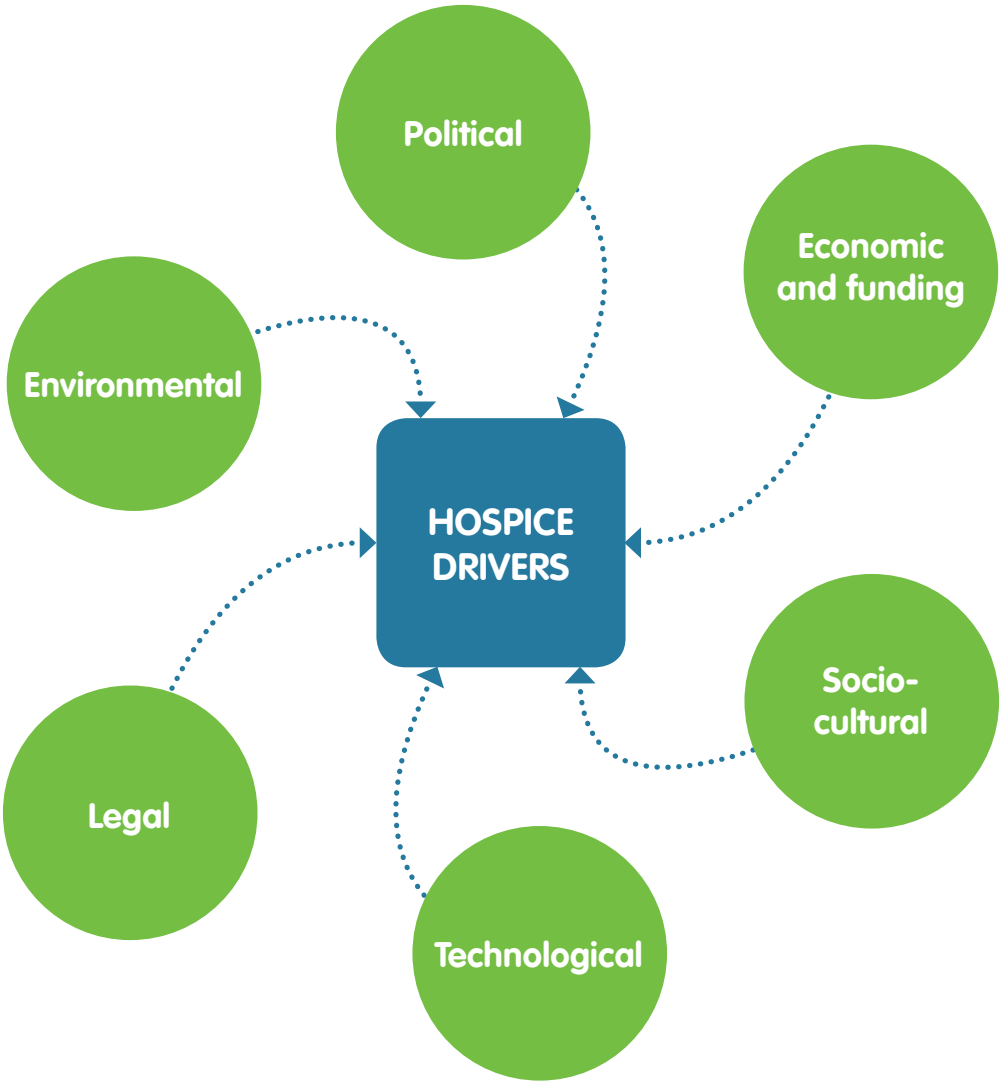
Figure 2: drivers of change for hospices identified at *Peering over the Precipice* workshop, September 2016

2.1.1 Tool: Hospice PESTLE

PESTLE is a framework to help scan the external environment to better understand what drivers (trends and forces) might need to be taken into account as part of strategic decision making. PESTLE is an acronym to help you categorise different kinds of external drivers and make sure you don't miss anything in your analysis:

- **P**olitical
- **E**conomic
- **S**ocial
- **T**echnological
- **L**egal
- **E**nvironmental

Figure 3: PESTLE analysis framework



How to use this tool:

- Get a group of people together who have different roles, perspectives and mindsets – this will help strengthen thinking and enable you to explore new and different questions.
- Start with the mission for your hospice and the things you have to do well, then ask "given what we have to achieve now and in the future, what external drivers (trends and forces) could impact on us, creating either opportunities or threats?"
- Think about these drivers under each of the PESTLE headings. The headings are just there as an aid to getting ideas out – there's no need to worry about where something sits – if it's big, it needs to be part of your analysis!

- Go for broad analysis as well as deep:
  - How will these drivers affect statutory funders/commissioners, donors, strategic partners and other stakeholders? What does that mean for your hospice?
  - What about other players – what different forces could impact on them? (Eg a commercial organisation with shareholders might be impacted by different drivers than you.)
  - What other drivers might affect patients and their families and carers?
- Consider the relationships between drivers. Looking at how two or more interact or play against each other might tell a different story compared to looking at them one by one (eg an increasing desire to die at home; growth in SMART technology).
- Select three or four drivers that will have the greatest potential for opportunity or threat, and do more work on them to consider options for either maximising opportunity or mitigating threat (see the worksheet).

2.1.2 Worksheet: Impact analysis: What, So what, Now what?[2]

Sometimes people just do a PESTLE analysis and stop once they've got a list of drivers – they stop at **'What?'**

To turn the list into a useful analysis, once you have identified the drivers that you want to explore in more detail, ask yourselves: **'So what?'**

- So what might be the impact on the organisation?
- What new challenges, threats and risks might emerge?
- What opportunities might there be for improving effectiveness and impact?

Once you've considered the implications, the final question is **'Now what?'** When you generate options to tackle what might happen and what you might do to build on opportunities and to mitigate threats. It's important to open up thinking by asking the 'So what' question, before you close things down to consider strategic options and action.

Use the impact analysis worksheet on the next page to explore the **'So what'** implications.

And then turn to **'Now what'** should we do about it: covered in the rest of this toolkit, and especially section four.

(2) Copeman C and Griffith M. Looking out. London: NCVO, 2007.

IMPACT ANALYSIS WORKSHEET								
	How could each driver affect your organisation? What opportunities does this create?							
	External				Internal			
Your 3-4 key Drivers	**Patients, families, carers** and their needs	**Funders, Commissioners** and their priorities	**Local communities**	**Relationships** and influence	**Workforce** (paid and volunteer) and trustees	**Your work** (services and activities)	**Governance** (including accountability and evaluation)	**Systems, Skills, Technology** (new treatments, comms, admin, management)
Driver 1								
Driver 2								
Driver 3 etc.								

2.1.3 Case study: Wigan and Leigh Hospice PESTLE analysis, April 2017

POLITICAL

- Change in government and subsequent policy
- BREXIT uncertainties
- Effects of devolution in regions
- Uncertainty around NHS commissioning arrangements
- Future of the NHS
- Future for social care
- Development of STPs – where will this lead?
- Competition in healthcare
- Over-regulation
- Right to die
- Greater reliance on the third sector to deliver statutory services
- Keeping end of life care on the political agenda – competing priorities

ECONOMIC

- Statutory funding 'flat-lining' / reducing as percentage of costs
- Lack of mandated funding mechanism
- NHS QIPP agenda – expecting 'more for less'
- Competition for statutory support
- Competition for 'donor pound'
- Charity fatigue and loss of confidence in sector
- Austerity / lack of growth in economy
- Wage costs increasing (plus impact of Living Wage)
- Challenges of recruiting well trained staff (including impact of BREXIT)
- Costs of implementing / abiding by burgeoning regulations
- Low returns on cash investments
- Volatile stock markets
- Potential impact of personal health budgets
- Balancing reserves with spending requirements
- Pressure on value of estates impacting on legacies

SOCIAL

- Ageing population
- Increased complexity of patient population
- Increasing demand for end of life services
- Dementia 'time bomb'
- Proliferation of 'unhealthy lifestyle' diseases
- Effects of social deprivation
- Reaching the 'hard to reach' in society
- Lack of social care impacting on length of stay
- Rise in care home residence
- Fragmented familial structures
- Reduction in informal carers due to family demands
- 'Blame' culture affecting attitudes to risk
- Consumer / 'Baby Boom' society – higher expectations
- Consumer choice – balancing 'needs' and 'wants'
- Challenges of engaging with population about end of life issues
- Dispelling hospice myths – 'a place you go to die'
- Increasing numbers of charities
- Reducing volunteer pool as people delay retirement
- Capacity within volunteer community to take on challenging roles, eg trustees

TECHNOLOGICAL

- Advances in medical treatments on patient complexity
- Electronic patient record systems and data sharing
- Challenges of cross-database integration and data sharing
- Opportunities for delivery of remote care via technological solutions
- Challenges of technology at the patient interface
- Remote devices allowing patients to live safely at home
- Opportunities around training and development
- Opportunities around efficient multidisciplinary communication
- Developing systems to record / report on outcome-based measures and KPIs
- Impact of social media – positives and negatives
- Meeting expectations of donors / supporters across multiple interfaces
- Challenges of managing multiple data sets
- Implications of data protection legislation
- Cost of technological advances
- Speed of change
- Security implications around electronic data

LEGAL

- Increasing burden of regulation – CQC, Charity Commission, Gambling Commission etc.
- Blurring of professional boundaries – NMP; drugs off-licence etc
- Patients 'demanding' their rights
- Right to die agenda – euthanasia, physician-assisted suicide etc
- Issues around mental capacity and 'best interest' decisions
- Deprivation of Liberty Safeguards
- Equality and diversity agenda
- Increasing vulnerability of hospice / employees to litigation
- Fundraising regulation

ENVIRONMENTAL

- Focus on saving energy and use of new technologies to reduce carbon footprint
- Recycling through hospice shops
- Impact on environment of vehicles used to deliver community services
- Greater pollution from traffic problems

2.1.4 Board conversation piece: external environment

Ideally boards will take an in-depth look at the external environment and its implications once a year, and supplement or update this at each meeting by considering any new intelligence that provides insights about the future strategic landscape, opportunities and threats. Some questions to ask might be:

- What trends aren't we watching that could creep up on us?
- What's so uncertain that we're not really thinking about it?
- What's our foresight track record like? How can we get better at it?
- Which drivers and their implications are within our control to tackle, and which aren't? What should our tactics be for each?
- Who can we call in to give us their best guess about the uncertainties we face?
- How can we best allocate our resources to deal with certainties and uncertainties?
- When will things firm up enough to put on the risk register?
- When will things firm up enough to change our plan?
- Do we have a collective view about whether and how our funds should be used to prop up shortfalls in statutory funding? And what we will do if the funding situation gets worse?
- What are other hospices in our locality doing and how might this affect our future?

2.1.5 Signposts: external environment

Useful general information: The NCVO Road Ahead 2017: a review of the voluntary sector's operating environment (free to NCVO members).

The links between effective leadership and analysing the external environment: BCG Perspectives (2011) The Five Traits of Highly Adaptive Leadership Teams by Roselinde Torres and Nneka Rimmer.

The Hospice UK website including Transforming Hospice Care, Hospice UK's strategy 2017-2022 and the resources produced by the Commission into the Future of Hospice Care.

The next section contains tools to help you assess your hospice's present state of health: to understand where you are on the curve, and give you insights into how fit you are to respond to the opportunities and threats in the external environment.

Section 3: Hospice healthcheck – understanding your present state

This section is designed to help you carry out a 'hospice healthcheck' to assess your hospice's present state of health by looking at both the factors critical to success and the risks the hospice faces, and using this knowledge as the basis for strategic decisions.

3.1 Factors critical to success

It's important to develop an in-depth understanding of what hospices need to do well in order to survive and thrive. This isn't just about the tangible aspects of the business model, but also the intangible aspects such as culture, behaviour and morale. The analysis will help you judge your hospice's present state, work out what to focus on to improve capacity and capability, and understand your fitness to respond to the drivers in the external environment.

The section offers:

1. an 'internal healthcheck' – an exploration of the factors critical to success – the things a hospice has to do well
2. a discussion of the behaviours that ensure effective board decision-making
3. some tips to help 'spot the ostrich' and have the courage to challenge colleagues. Not picking up or ignoring the signs that things aren't going well is seen as a major contributor to decline, so to be fit and successful we need to be alert with 'heads up'.

3.1.1 Tool: Internal healthcheck

This framework enables a thorough review of internal capabilities and processes as the basis for setting an action agenda for strategic development.

How to use this tool:

Use it to stimulate discussion and explore your hospice's fitness in each of the areas of capability. You could use it at a board/senior team away day for example. Make sure you prioritise rather than produce a long list of things to improve! Use the external environment analysis in section two to help prioritise: what are the factors *most critical* to our success given the external challenges we face?

INTERNAL HEALTHCHECK TOOL	
External perspective – rate how well you:	Comments
Meet patient and family/carer needs and aspirations	
Meet the needs of the local community (including different demographic groups within the community)	
Meet statutory funder/commissioner needs	
Meet donor and other funder needs	
Meet the needs and expectations of other partners and stakeholders	
Influence policy and practice locally, actively engage in the health and care economy	
Get external recognition for the work of the hospice	
Are accountable and transparent in dealing with the community	
Know and shape what others think of the hospice and how they see hospice and end of life care	
Are active in and engaged with other organisations to build sector capacity, increase reach and address unmet need	
Understand the drivers and forces in the external environment and how these will impact on the work of the hospice in the future	

Strategy and impact – rate how well you:	Comments
Achieve your desired impact, evaluate your services/ initiatives and can systematically evidence your outcomes using robust quantitative and qualitative measures	
Periodically carry out strategic reviews to ensure you are doing the right things and doing them right	
Develop scenarios to understand the range of future potential opportunities and possibilities	
Communicate core values to shape an effective culture both within and beyond the hospice including to those who carry out work on your behalf	
Use the ideas and insights of the local community, staff, volunteers, patients, service users and their families to shape strategy and services	
Use the strategy to guide your work (minimise reactive or unplanned growth)	
Adapt to respond to changing need	
Link high-level goals with the front line work of the organisation	

INTERNAL HEALTHCHECK TOOL	
Leadership – rate how well you:	Comments
Link governance and executive direction, and have a top team (especially chair and chief executive) that collaborate to add value	
Communicate what is important – internally and externally	
Do what you say you will, and how you say you will do it	
Perform as a team (across, up/down the organisation)	
Exercise power and resolve conflict	
Align people (staff and volunteers) towards achieving the Mission	
Management practice – rate how well you:	Comments
Practise effective governance, including ensuring regular board renewal and review	
Delegate authority to ensure appropriate levels of participation and use of discretion, and check how these have been applied	
Use comprehensive management information to enable in-depth understanding of the drivers of performance and make informed decisions	
Acquire and allocate financial resources; have a broad income base (not reliant on a limited number of sources)	
Understand costs, overheads and the business model	
Use all resources to build future capacity	
Leverage collaboration to secure new and varied capital	
Manage resources such as IT and premises	
Understand and manage risk, and link this to the reserves policy	
Evaluate against an outcomes framework linked to your strategy	
Manage performance with a focus on results, outcomes and impact	
Recruit, retain and develop the right people	
Run core services and develop new services that respond to need	

INTERNAL HEALTHCHECK TOOL	
Quality governance (including quality and safety of care) – rate how well you:	Comments
Promote a quality-focussed culture and agenda, and engage with patients, staff and key stakeholders to check out the reality	
Put quality at the heart of the strategy, and ensure sufficient resources to have full and proper insight and oversight	
Have the right knowledge, skills and confidence on the board and at each level of the organisation to ensure delivery of the quality agenda	
Have clear roles, accountability and processes to ensure quality governance	
Analyse, interrogate and challenge quality information to ensure its integrity	
Promote a commitment to continuous quality improvement	
Learning and growth – rate how well you:	Comments
Stimulate creativity and improvise	
Enable experimentation, testing new ideas, prototyping and learning from the results	
Motivate and inspire at all levels	
Reach out beyond organisational boundaries to contribute to and participate in wider knowledge sharing	
Match tasks with the necessary skills required and build capacity for the future	
Manage change	
Manage knowledge, and use this to learn and improve	
Involve and include different kinds of people with different mindsets, perspectives and backgrounds	

3.1.2 Worksheet: Getting board behaviour right for effective decision-making

Effective board behaviour is most readily apparent at board meetings, when trustees interact to make decisions that set the course for the hospice. This worksheet sets out a checklist for trustees to use to ensure their approach and behaviour drives high-quality decision-making.

When exploring the papers in preparation for the board meeting, think about how you can:

- focus on asking better questions
- consider the future and longer term implications (perhaps carrying out some research of your own to build knowledge about specific topics)
- frame issues and find meaning: explore *why*…?
- switch your brain on to critical thinking: 'the art of analysing and evaluating thinking with a view to improving it'
- tap feelings and insights as well as analyse and be rational
- get rid of impediments such as:
  - being certain you're right
  - not wanting to be wrong
  - social loafing[3]
  - groupthink[4].

In the meeting itself:

- focus on sense-making, framing and asking questions and engage in real dialogue – listen with the intent to understand
- be curious and ready to build on what others have said: create new ideas together
- speak up to share ideas and challenge positions (including the attractive status quo!).

Question for the chair and chief executive to explore together:

- How can we create a culture and group dynamic that enables trustees to fully engage and participate in meetings?
- How can we harness the diversity of background, experience and opinion on the board to generate the best discussions and decisions?

(3) People exerting less effort to achieve a goal when they work in a group than when they work alone

(4) People feeling conformity and harmony make for better decisions than does challenge. A group is especially vulnerable to groupthink when its members are similar in background, when the group is insulated from outside opinions, and when there are no clear rules for decision-making.

3.1.3 Case study: Prospect Hospice, Swindon

Prospect Hospice provides a broad range of end of life care services across Swindon and North East Wiltshire. The hospice has an outstanding local reputation and is committed to ensuring that the patients and families we care and support receive an exceptional level of support towards the end of their lives as well as helping to influence and enhance best practice in end of life care with other providers.

Why the hospice needed to improve

Whilst operating on a sound basis and with a robust financial portfolio, the trustees of Prospect Hospice wanted to ensure that their approach, systems and processes in governance were fit for the demanding future, and they therefore welcomed a programme of board development.

What Prospect Hospice did

Prospect Hospice engaged with Cass Business School through the board effectiveness review offered as part of Hospice UK's Good Governance programme. A full governance review was conducted during 2016 involving trustees and management of the hospice. The report of the review findings and recommendations was presented to trustees by the conducting consultant. Using the recommendations, the trustees designed a programme of developments and have been working to achieve the ambitions of their programme. The trustees undertook to build a more balanced set of skills through board retirements and recruitment, with scrutiny of the charity operations gaining more depth as a result. The standard of report presentation from the leadership team is now more robust, in anticipation of this higher and broader level of scrutiny.

There has been a tangible shift from time spent on operational matters to greater strategic scrutiny and discussions at board meetings; the board are consequently more fully engaged or now driving on long term strategic ambition.

What might have previously been considered 'silo' working of the board committees has been managed by the addition of a chairmen's teleconference in advance of the quarterly round of meetings. It plans for every topical aspect of operations, risk or governance scrutiny to get addressed by at least one meeting.

What they learned

Angela Jordan, Prospect chief executive says:

> "The skills required of trustees now are likely to change as we progress through the hospice's five year plan, with increasing complexity in the care we will provide, a growing and older population, and uncertain political and statutory landscape, more cost to run existing services and the need to design new services and redesign others for maximum efficiency and reach. Having trustees who recognise and understand the need to start planning now for this future to continue to govern well is vital. In tandem with significant management developments, Prospect Hospice is on a firm footing to deal with the future."

Tim Willis, Chairman of the Board of Trustees says:

> "The Board Development Programme offered the opportunity for trustees to consider the purpose of their role and their effectiveness as a board, and as chair it opened discussions into how we could improve our working together for the good of Prospect Hospice. We were pleased that most of the outcomes of the review were not a total surprise, and we are taking forward discussions and recommendations at board and committee level. Not only do we have a five year plan for the hospice, we also have a long-term plan for the board."

3.1.4 Board conversation piece: surely we can't be ostriches?

Denial is the first stage of crisis. How can we recognise the signs, 'out' the ostriches who have their heads in the sand, and become a more successful, more alert and open board and organisation?

How to spot an ostrich...

- I don't tell anyone that I don't really understand the finances.
- I don't tell anyone that I don't really understand all our services and what we do.
- I don't tell anyone that I don't really understand patient and service user need and the potential for end of life care.
- I don't tell anyone that I don't understand what is meant by population needs or unmet need.
- I don't tell anyone that I don't really understand the components of care quality.
- I don't really understand about fundraising or getting the business model right.
- I don't stop people when they talk about things I don't understand.
- I'm a bit worried that we're not doing the right things but I don't want to rock the boat.
- I'm a bit worried we're doing the wrong things, but I don't want to rock the boat.
- I don't want to rock the boat.
- I don't know how best to rock the boat.

How to rock the boat...

1. Find an ally:

- Someone who also looks uncomfortable during board meetings.
- Someone who also looks like they want to say something but aren't quite doing it.
- This is about getting moral support, not creating a clique or plotting!

(Avoid those who talk the whole time, never listen, those who always agree with those who talk the whole time and never listen, and those who obviously haven't read their papers.)

2. Make a plan; work with your ally to:

- Focus on the perfect outcome: what does good look like? It might be simply 'the majority realising that we are being ostriches and need to get a grip of what's really going on'. Don't aim too high for this first courageous leap!
- What steps do we need to go through to create this perfect outcome?
- Where does the chair stand in all of this? Will they be an enabler or barrier?

- Who might other allies be? Can we cluster different people into groups? Eg
  - » intellectual or social loafers (those who never have their own view and always take the easy route)
  - » deniers (those who have fooled themselves into thinking things will get better if we just wait);
  - » bombasts (those who think they know it all, but might be wrong)
  - » unengaged (those who have brains but have switched them off).
- What arguments would most persuade different groups?
- How far off getting a critical mass are we?
- Which group should we focus on first to build the critical mass?

3. Get some evidence:

- Work out what information you need to form a case/argument to persuade.
- Gather evidence, seek out the views of experts, other trustees, staff.
- Work out what you know and what this tells you.
- And what you don't know, and what this tells you.

4. Build a rationale or mini-case:

- We are worried about this...because of this...
- We don't know enough about this....and feel we should know more because...

5. Support each other to be courageous:

- What's the best that could happen?
- What's the cost of not being courageous?
- What would patients and their families say if they knew that we knew something was wrong and kept quiet?
- What's the worst that could happen?

6. Speak out:

- Use an established agenda slot, not AOB.
- Preferably a slot which is early on the agenda, when people are feeling fresh; ideally one that is on the topic of performance.
- If you feel there is the danger of your views being misquoted, ask the secretary to record your exact words in the minutes.

What to do if you can't speak out

You could talk in private to the chair – use the annual trustee review/appraisal process if you have one, or request a one-to-one meeting. Have a discussion with the chair about how different views and perspectives can be better aired. If the chair's style is part of the problem, consider talking to the vice-chair or chief executive instead.

If none of these conversations are possible or they don't have any effect, then ultimately you may want to resign (though you'll still be liable for decisions made in your tenure).

3.1.5 Signposts on factors critical to success

A simple healthcheck framework: NPC What makes a good charity? by Iona Joy and Ruth Gripper.

A more sophisticated framework: Business Model Canvas Alexander Osterwalder, at http://www.canvaniser.com

Resources specifically for chairs of charities: Association of Chairs.

Resources specifically for charity treasurers: The Honorary Treasurers Forum.

3.2 Performance management

The focus in this part is on how well the board collects performance information and has regular conversations with a view to improving results. Performance conversations focus on results against expectations for the *organisation as a whole*, for *teams* including the board, and for *individuals*. This approach enables action to be taken when performance is not as expected, and is crucial to both surviving and thriving.

3.2.1 Tool: Key performance indicators: dashboard pick'n mix

What are the indicators that we should keep our eye on, that provide a picture of the whole system, that alert us when things are going well and not so well, and that enable us to make informed decisions about the future?

Whilst KPIs and thus your dashboard should be aligned closely to your strategy and are therefore unique to your hospice, it is possible to offer a selection of indicators that could be relevant to any hospice, whatever its strategy. Some example *core indicators* are shown in Figure 4, along with some examples of *strategy specific indicators* – ones which would only be relevant in certain hospice contexts. See this as a 'pick'n mix' from which to draw the indicators that are important to your hospice and strategy. It is also very useful to look at trends over time, comparing indicator data across the years and setting stretching targets for year-on-year improvements.

Figure 4: Example key performance indicators

IMPACT

Core

Activity

Number of new patients/users:

- IPU
- Community
- Day
- Bereavement support

Number of core hours:

- IPU
- Community
- Day
- Bereavement support

Average IPU bed occupancy

Average length of stay (days)

Strategic examples

Results against Commissioner contract, eg:

- Number of inpatients cared for
- Number of bed days
- Number of community patients/users

% of non-cancer patients/users

% of BAME patients/users

Admissions to IPU outside normal hours

QUALITY

Core

Patient safety

Number of medication errors
Number of patient falls
Number of incidents reported
Number of accidents reported
Number of 'near misses' reported
Number of reportable incidents/accidents
Number of complaints
Number of compliments

Patient/carer experience

% meets needs and preferences
Comfort/welcome
Timeliness
Place
Voice to shape

Strategic examples

OACC Outcome Measures

% patients per service showing improvement in scores for each symptom/concern covered by the IPOS outcome measure

% reporting improvements in quality of life and positive impact of service received through the Views on Care outcome measure

% that would recommend the service

Number and % of nurses trained to prescribe

Number and % of staff studying for relevant qualifications

Number and % of staff studying for higher degrees (Masters, PhD)

Number of publications by staff

Number of conference posters accepted

Number of conference abstracts/presentations made staff

Number of external conferences/educational events attended by staff

COMMUNITY ENGAGEMENT AND AWARENESS

Core

- % increase in social media activity and reach
- Number of items of positive media coverage
- Number of items of negative media coverage
- Number of external events attended by hospice representatives
- Number of external organisations engaged with by hospice
- Number of people attending hospice events

Strategic examples

- Number of new collaborations/partnerships with other organisations
- Number of new people trained to offer community befriending
- Number of volunteers offering community befriending through the hospice
- Number of people supported through community befriending initiatives
- Number of people attending education courses run by hospice
- % positive evaluation/satisfaction responses of those attending courses run by hospices
- % public awareness of choice at end of life
- % donor satisfaction
- % Commissioner satisfaction

PEOPLE

Core

- Staff turnover (you may want to analyse by clinical and non-clinical, or by dept)
- Volunteer turnover
- % staff reporting positive morale (staff survey)
- % volunteers reporting positive morale (volunteer survey)
- % staff sickness absence
- % volunteer sickness absence
- % staff completing mandatory training
- % staff appraisals completed

Strategic examples

- New volunteer recruitment
- % increase in new volunteers
- Vacancies (by dept/role)
- Time taken to recruit (by dept/role)
- Staff age profile
- Volunteer age profile

FINANCIALS

Core

- Liquidity / quick ratio
- Unrestricted reserves
- Cashflow forecast
- Operating surplus/deficit
- Income against budget for key sources
- Income source return on investment ratios
- Fundraising ratio

Strategic examples

- Cost of bank/agency staff
- Cost, overheads and contribution by each service area

Variance analysis, trends and projections: keeping your eye on the ball

(The whole bouncing ball, not the wrong ball, an old ball, a bit of the ball, or a static ball!)

Merely reporting performance results as a static indicator or measure isn't enough. It is *performance against expectations that really matters* (results against budget, compared with local and national standards, against previous results/years etc.) *followed by having conversation about the implications*. From this comparative analysis we can *develop a picture of what the indicators are telling us*, explain variances, and explore what the patterns mean for the future as well as the past. Dashboards should show historical and comparative data and contain projections based on the trend.

3.2.2 Worksheet: Regular performance conversations about the things that matter

In addition to focussing performance conversations on the breadth of the business model, it will be helpful to put feedback loops in place to explore the causal factors of decline[5], and determine how strong your hospice is in each of these areas:

CAUSAL FACTORS OF DECLINE	
In order of frequency of citation as main cause; a typical crisis situation has six or seven.	
Internal	
Poor governance and management	Incompetency and lack of interest are common characteristics in the leadership of failing organisations. Ineffective boards, making poor decisions about resource allocation and control. Failure to lead and manage change. Lack of management depth at the level below the chief executive.
Inadequate financial control	Poor systems of proper financial control. A lack of data about income, costs, overheads, and cash. Financial data poorly presented so that it is not understood by the whole board. Poor budgetary control: over-centralisation is a common symptom. Lack of working capital management (inadequate planning).
High cost structure	Management style and organisation culture and structure. Centralised bureaucracies are cost ineffective and inefficient, giving rise to low productivity and slow/uninformed decision making. Operating inefficiencies more generally are features of those in decline: low staff productivity, poor planning, lack of adequate maintenance, out of date premises layout, office procedures etc.
Poor marketing	Lack of responsiveness to customers/key stakeholders (eg patients, donors and statutory funders/commissioners). Lack of market research/knowledge of customer/stakeholder needs; reliance on assumptions. Lack of promotional material or use of outdated material. Weak or non-existent new service development, including income generation products.
One-off capital or revenue projects	Big projects that go wrong because costs are underestimated and/or revenue is overestimated are often the 'last straw'.

(5) Adapted from Slatter S and Lovett D, Corporate turnaround. Suffolk: Penguin, 1999.

CAUSAL FACTORS OF DECLINE	
In order of frequency of citation as main cause; a typical crisis situation has six or seven.	
Mergers/ acquisitions	Crisis can be driven by merging with/acquiring poor organisations and not taking real costs, and the cost of change, into account. Then/or by not being able to turn them round to health – poor post acquisition management, including culture clash, drives crisis.
Financial policy	A high debt: equity ratio (high gearing). A very conservative financial policy – prolongs the slow decline phase. The use of inappropriate financing sources, eg borrowing short-term money (including 'raiding reserves') to invest in long-term projects. Being over cautious, eg having reserves of many months and not investing these in sustainable ways of improving patient care. Poor decision making – using short-term money to invest in the long-term, eg creating new posts when a one-off legacy arrives.
Inertia and confusion	Distressed organisations are characterised by a failure to make decisions and make things happen. Inappropriate structures and processes, lack of defined accountabilities.
External	
Changes in market demand	Not paying attention to changing 'customer' need. Being slow to adapt and remodel.
Competition	New entrants into the marketplace... Who bring new approaches and different cost structures... Sometimes subsidising to gain market share.

Whilst the research on which this is based is generic and almost certainly did not include non-profit organisations, there is strong evidence that a crisis is most likely to occur when an organisation is already weakened by poor governance and management, lack of control and inefficiency. When such an organisation is 'hit' by change in demand, some threat from the external environment or one-off events such as a big project or acquisition, it cannot cope, is slow to adapt and respond, and ultimately fails.

3.2.3 Case study: Birmingham St Mary's Hospice

Birmingham St Mary's Hospice was established in 1979. Initially running 28 beds, a 24-hour community palliative care service, and a 20 place day hospice, the organisation has introduced changes over the years in response to changing need. A significant change was the expansion into community development through its Compassionate Communities programme initiated in 2008. The hospice's vision is for a future where the best experience of living is available to everyone up to and including the end of life.

It now costs around £7.5 million per year to run the hospice and its wide range of services. The hospice employs over 200 staff, has around 360 volunteers and 16 charity shops including two boutiques and a furniture store.

Why the hospice needed to change

The period between 2011 and 2013, when the primary care trusts dissolved and the clinical commissioning groups (CCGs) were initiated, signalled a very different way of working with the hospice's commissioners. There was greater impetus for partnership working and during this time Birmingham St Mary's Hospice was awarded full funding for a new Hospice at Home service: a first for the hospice.

This change in the commissioning climate highlighted the gaps in both capacity and expertise that the hospice needed to fill to respond to service redesign and partnership working. In response, the board approved a proposal for a Service Design Lead.

Another driver for change was the need to respond to Birmingham's hugely culturally diverse population along with growing numbers of older people living in social isolation. This change was due to the growth of the local elderly population; more people living longer with dementia at the end of life; many young people surviving childhood with long-term, life-limiting conditions; and too many people dying in hospital when they would rather be at home.

It was clear to key leads at the hospice that the current service models would become unsustainable and not provide value for money. This was brought sharply into focus by the launch of NHS England's 'Five Year Forward View' in which plans were published to close the £30 billion gap between available funding and people's future healthcare needs by 2021. In spite of these factors, it took a financial threat to create the leverage for change to reshape services and transform the hospice's ways of working to meet growing demand in a constrained economy and with a changing population.

By November 2014 it was recognised that the level of financial risk was increasing. The hospice had a risk-based reserves level of around £2.6 million at the time, which was around £500,000 over and above the reserves policy. The financial year previously had delivered legacy income in excess of £1.7 million. This had been climbing since 2003 when legacies had dipped to around £600,000. Between September and November 2014 there had been virtually no legacy income.

At the same time, the three contracting CCGs were starting a procurement process for end of life and palliative care. Furthermore, the hospice had begun changes to the fundraising team that were anticipated would slow income for up to two years before accelerating income growth.

A financial reforecast identified that all these factors could result in a year end deficit of over £1 million with a year-on-year ongoing loss.

What the hospice did

To contain the risk, the hospice launched a programme called 'Back to Balance'. All vacancies were scrutinised before any recruitment was initiated; this slowed down spend.

All clinical leads were brought together to assess which services could make savings and create greater value for money:

- The 20 place day hospice service, running four days a week, had recently been reviewed, demonstrating ineffective use of specialist staff time and dwindling patient numbers. The model was not popular to all in need.
- The inpatient unit was staffed for 21 beds although demand was consistently less than this, apart from a few days a year.

- A Change Team was initiated to look at new ways of working. This was followed by a workshop of all middle managers (Business Development Team) tasked to deliver a proposal for change to the chief executive.

The proposal was a powerful route to change as the team recognised that to meet demand externally the hospice needed to influence external integration of services across the system. The proposal made clear that hospice teams needed to become much more integrated internally in order to influence external service integration. From this point, a Service Redesign Team was set up to lead a full redesign and integration of services.

The hospice also changed some budgeting principles for legacies by only budgeting amounts that were in the legacy pipeline. This reassured staff but created greater challenges in balancing the budget.

Communication was improved. Morale had taken a significant dip during 'Back to Balance', so briefings were used to launch the new projects and were attended by 98 per cent of staff. The briefings were a turning point in staff and volunteer morale and refocused people on a new vision and future for the hospice.

An internal governance review had improved reporting and the way documents were presented to the board. However, an external review by CASS Business School through the Hospice UK Board Development Programme supported more strategically-focussed board meetings allowing time for debate and questioning. Trustee walkabouts were introduced to engage the board more closely in what was happening on the ground and to keep them better informed about the impact of change on hospice services.

The results

A number of collaboration events effectively engaged the hospice with two CCGs, who consequently deferred their tender processes. Effective partnership work led to the hospice participating in a successful bid with the one CCG that did go out to tender. A case for change was submitted to two CCGs outlining a transformation programme, resulting in one-off funding of £750,000 and a commitment to ongoing Hospice at Home funding as part of contractual baseline.

Savings of 10 per cent were achieved within 12 months enabling redirection of funds to new services. Morale started to improve and a recent staff survey has demonstrated that 95 per cent of staff are committed to the hospice's strategy. In addition, the hospice has received a 'staff engagement' award for the highest level of staff engagement across 10 other benchmarked charities.

What did the hospice learn?

The emotional reaction to change was significantly underestimated. Whilst communication was heightened this did not sufficiently address growing fears and feelings of bereavement during change.

Working contracts were too inflexible which meant that jobs in one team were technically identified as 'at risk' even though jobs were available in other service areas. The initiation of a formal HR process only served to reinforce employees' fears. This approach would not now be necessary with our new more flexible contracts.

Whilst it was not intended to lose good staff, some staff leaving unblocked resistance to change. This included some leadership roles, which, in turn empowered innovators to surface.

The development from this point was significant. Unexpected leaders came to the surface. The medical team were instrumental in providing support to others managing less well with change; however, this placed overwhelming demands on some highly conscientious leaders.

Investment in change-making roles such as a Service Design Lead and a Head of Quality and Service Improvement have been essential for change and provided assurance on service quality.

Empowering middle managers to draft solutions was key. However, a great deal of extra support was needed to help them develop financially viable business plans. Staff had been insulated from the external environment, which made small changes seem large. They now have more exposure to some of the difficult choices being made in context and with knowledge of the external factors. The new 'one team' approach is also developing staff beyond their comfort zones, so they are not only more skilled and effective, they are also more flexible in their approach.

The hospice now puts clinical services and patient stories top of the board agenda. This includes a section on a future view of hospice care, plus a strategic document of the month between board meetings, to ensure the board maintains awareness of threats and opportunities in the external environment and acts with greater understanding. The hospice is testing inclusion of a 'leadership narrative' at board meetings delivered by an executive director or trustee to give insight into each other's life and leadership influences, with a view to creating greater trust and a more open board environment.

There is no such thing as over-communication. It is vital to remain a compassionate and listening employer during change, even when the most difficult decisions are being made.

3.2.4 Board conversation piece: strengthening the top team

The importance of effective governance, leadership and management is a constant theme in this toolkit. This conversation piece is designed to stimulate conversation to strengthen the top team of the hospice, ie the board and senior team.

The *Peering over the Precipice* workshop in September 2016 came up with some warning signs that a top team may be in decline and the organisation may be vulnerable:

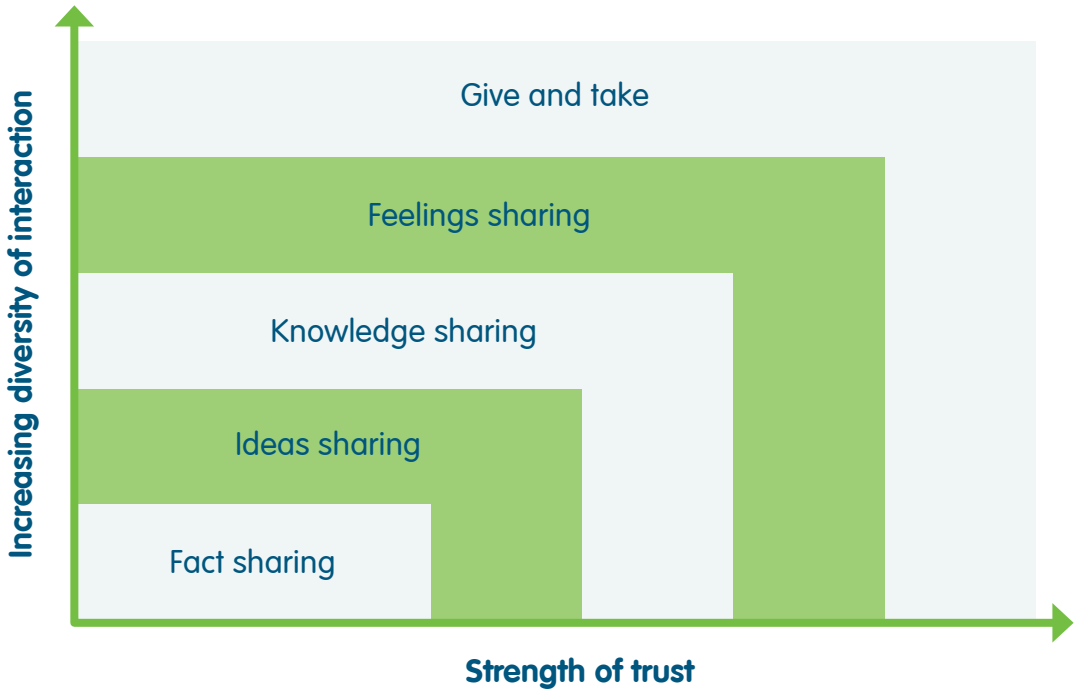
- Board breaking into factions, not talking about the issues or not resolving conflict.
- Board business often done outside of formal meetings.
- Board not challenging the chief executive.
- Chief executive or trustees resisting challenge, evading open discussions about difficult issues.
- Chair and chief executive relationship too cosy.
- Chair and chief executive relationship too distant, lacking in trust.
- Chair or chief executive dominates meetings and decision-making.
- Trustees too involved in operational issues.
- Trustees in post for too long.

Board not clear on appetite for risk – seen as risk averse.

- Lack of trust between the board and senior staff.
- Complacency: not seeing the warning signs, or hoping for improvements without really having a plan.

Hiland 2006[6] helps us consider how increasing the diversity of interaction between members of the top team will build trust: if you start with fact sharing and move up the diversity scale, sharing ideas, then knowledge, then feelings – leading to more give and take – then trust will grow. The more you do this, the greater the trust.

Figure 5: five types of interpersonal dynamics



- What steps can your top team take to build and strengthen trust?
- How can you create safe and appropriate situations to build the top team as a vibrant, healthy, trusting team, sharing feelings and give and take?

Another way of exploring the top team relationship is to consider the approach the board takes to support and challenge. In Figure 6, the top right quadrant is seen as the place to be! Where is your board?

(6) Hiland M (2006). Effective board Chair - executive director relationships: not about roles. *The Nonprofit Quarterly*. Winter, pp49-50.

Figure 6: board approach to support and challenge

Cass CCE have run masterclasses for Hospice UK members (as part of the Good Governance programme) on Building Better Hospice Governance, as well as Building Better Governance seminars for the wider charity sector. Ideas to better understand and improve the quality of the top team relationship that have emerged from these include:

- Emphasis on reviewing governance practice at least annually: using a mix of formal and informal, internal and external approaches, and at both individual and collective board performance.
- Having some trustee-only meetings at the end of a board meeting so that the board can talk about issues that inhibit their effectiveness.
- Regular whole top team bonding opportunities – social time together.
- Discussion about boundaries and what effective support and challenge looks like.
- Formal structures for regular board, trustee and chief executive appraisal or performance review; seeking feedback from a range of sources to inform these.

3.2.5 Signposts to improve performance

Hospice UK and Cass CCE good practice guides on a range of governance topics:

- Hospice board recruitment and selection
- Appraisal of hospice boards and trustees
- Effective board meetings in your hospice
- Board involvement in hospice strategy and planning
- Quality governance for your hospice

- Developing a dashboard for your hospice
- Developing a balanced scorecard for your hospice
- Board reports that add value to your hospice

Information on how to manage reserves effectively: Sayer Vincent 'Beyond Reserves'

More on managing overheads: The Bridgespan Group's Nonprofit Starvation Cycle.

3.3 Risk management

3.3.1 Tool: Risk appetite

Section 3 is all about 'exploring the present state' of your hospice. In this final part, we aim to encourage a greater shared understanding of risk, looking both at the organisation's appetite for risk, and how risk is governed and managed.

Boards need to be aware of and consider the possibility that they might be holding organisations back by their aversion to taking risks. It's a tough and challenging balancing act. Without doubt those organisations that survive and thrive will be those that differentiate more explicitly between the areas where only very low risk is tolerated, and those areas where more risk can be accepted in order to enable growth in impact, so long as there are plans in place to mitigate and learn.

Risk appetite is an expression of the amount of risk an organisation is willing to seek or accept in pursuit of its long term strategy. Top team discussions about risk appetite are vital, and should be part of regular strategic discussion at both board and senior team meetings.

One approach is based on the work of Edinburgh University's risk management committee[7]:

1. Develop a set of risk areas relevant to your future strategy (see example below).
2. Decide on your attitude to risk in each area: what the tolerance levels are and how this will affect your ability to deliver your strategy. Be bold where you need to be bold to improve care, develop new services, extend reach and get the business model right. Ensure compliance, safety and excellence in other areas.
    - Be clear on those areas where you will not compromise and have no appetite for risk, and why.
    - Be clear what your minimum standards are (eg specific quality standards or financial indicators).
    - Be clear where you will tolerate greater risk and why.
    - Explore the trade-offs (eg accepting greater risk to reputation in order to pioneer new services to reach under-served communities or create real additional patient benefit). For example, you will want to be very careful around care quality but initiatives such as having volunteers who are lone working to support people with cognitive impairment in their own homes (as some hospices are doing to deliver the Namaste programme) will involve some risk, but with proper checks and controls can vastly improve care for individuals and their carers.

(7) Adapted from Edinburgh University risk appetite approach http://www.ed.ac.uk/governance-strategic-planning/governance/university-committees/court-committees/risk-management-committee

3. Document your rationale and communicate it so that everyone appreciates the logic and motivation: your intent, the culture you seek to create, and the checks and balances in place to ensure learning.
4. Determine how you will monitor and review the decision to make sure it remains relevant.
5. Decide on escalation procedures should new intelligence change the logic.

RISK APPETITE FRAMEWORK										
Risk areas	Low ← willingness to take risks → High									
	1	2	3	4	5	6	7	8	9	10
Reputation	■	■	■	■						
Compliance	■	■	■							
Care quality	■	■	■							
Financial		■	■	■						
Staff, volunteers, culture		■	■	■	■	■				
New models of care and clinical practice				■	■	■	■	■	■	
New types of income stream			■	■	■	■	■			
Different ways of engaging with local community				■	■	■	■	■		

Remember, this is just an example – yours will be different!

3.3.2 Worksheet: Risk management

This sample risk register[8] illustrates the breadth and depth required to ensure that risk is understood, assessed, and managed. It relies upon an organisation-wide system of controls and alerts to ensure events at the front line are connected up, patterns studied, criteria adjusted, learning applied. The risk register should be a dynamic, living document, rebalanced as the organisation learns, as new risks are identified, as the context changes and risks grow or recede.

A risk management programme would:

1. Identify risks: all hazards that could arise from activities
2. Evaluate the risks according to their likelihood (probability) and the degree of loss/liability (impact)
3. Determine how the risks might best be managed:
   - avoided (and consider the cost of not doing the activity exposing the risk)
   - controlled or reduced (such as by introducing policies and procedures)
   - financed (to cover the cost of eventual liability).

Figure 7: Example hospice risk register

Person undertaking RA	Source of risk (eg Cont Ass, Incident, Risk assessment, etc,	Department/area	Summary/description of hazard	Date of assessment	Likelihood (probability)	Consequence (severity)	Risk score	Controls currently in place	Plans for implementing any additional controls required	Who is responsible for implementing plan and by when?	Actual date of review	Rescored likelihood (probability)	Rescored consequence (severity))	What is the residual risk and is it acceptable? If not, what is the plan?
Financial and business risks														
Strategic risks														
Service risks														
Workforce related risks														
Information risks														
Risks related to premises														
				Score range										
			Low risk	0	7									
			Medium risk	8	15									
			High risk	16	25									

- What's on your risk register?
- How often is it updated?
- Who is involved in compiling and discussing it?
- How well do your controls and mitigation plans reduce risks to acceptable levels?
- Do operational staff know what is expected of them to mitigate the risks that have been identified?
- Do you report movement in the RAG rates to the board on a quarterly basis?

3.3.3 Case study: St Christopher's Hospice

St Christopher's has been in operation for 50 years, serving a population of 1.5 million people in South East London. The services we provide are broad including inpatient and outpatient care, community based palliative care, and care coordination for people at the end of life. Our income is drawn from statutory sources, voluntary giving and some commercial activities including trading and a private personal care agency.

Over the last two years we have worked hard to strengthen and make more sophisticated our approach to risk management. In part this is simply a response to the environment in which we are working – one that is subject to increasing regulation, legislation and accountability. It is also a response to our growing awareness of current and potential weaknesses in our processes and systems that are inevitable as a result of growth in recent years – in terms of the range of services on offer and the number/range of users, the premises we use and our workforce. The reality of this was bought into sharp focus for us when in 2016 we were faced with a historical and serious charge related to health and safety. It was, arguably, a situation in which any hospice could have found itself but was sobering nonetheless.

Our response to these threats has been incremental but focused. We began by fortifying our structures supporting quality governance. To do this we intensified the link between the committee overseeing this work and the board of the hospice; we increased the number of sub committees engaged in identifying and managing risks on the ground, and strengthened their leadership by offering additional training to their chairs. We clarified our expectations of the reports that they produce, working towards consistent and transparent documents that describe the full range of risks on a regular basis. In addition, we have started to establish clear links between risk assessments generated within the organisation, incident reports and the corporate risk register that is used by the senior managers and board to identify those of greatest concern to the organisation. The risk register is reviewed at least six monthly and more often in response to emerging risks by the senior managers in the organisation, with related reports to the board. It is used by the board and the senior management team to inform how we prioritise investment of time and money.

We are constantly improving these processes and plans that address ongoing or emerging risks. We realise that we cannot afford to be complacent in these regards. As a result of the case brought against us last year there is a shared concern and real commitment across the organisation to identify and manage risks that could harm the organisation. The corporate challenge now is to maintain a balance between this important work whilst simultaneously nurturing a creative approach to, and a responsive service for, all who seek our help. In terms of possible lessons for other hospices, we would highlight the importance of investing sufficiently in the structures (including dedicated staff), processes and systems to ensure quality of services and management of related risk – even if this takes resource from direct care. It is not a luxury but a necessity if hospices are to keep people safe, meet expectations and be effective in their work.

3.3.4 Board conversation piece: risk from board to the front line

The board sets the risk strategy of the organisation, as well as being accountable for how risk is managed and controlled. Whilst it is usual for risk management to be given greater attention by a board committee, and for risk registers to come to the board periodically, it may be useful for the whole board to also explore the extent to which its intentions regarding risk are embedded in the reality of what actually happens at the front line:

- How do we know that our appetite for risk is taken into account when new projects are started?
- How do we ensure that staff and volunteers understand where we will not compromise and where we are more likely to tolerate risk?
- How do we know that those acting on our behalf in the wider community (such as fundraising agencies) understand and comply with our risk management strategy?
- How can we be both careful and diligent, whilst also creating a culture where people will try things out, experiment, feel they have our permission to explore and push boundaries for the people we support?
- How can we have open conversations about things we don't do too well, to enable us to learn without creating a blame culture?
- How do we know we have the right people to stretch and challenge our assumptions, bring in new perspectives so that we get the balance of risk and reward right for our organisation and beneficiaries?
- How can we make ourselves aware of issues of which we are currently unaware?

3.3.5 Signposts: risk

The Institute of Risk Management: guides on risk management; look for the special work done for charities in 2015.

Sayer Vincent guide: Rethinking risk: Beyond the tick box, published in partnership with Charity Finance Group.

3.4 Where are you on the lifecycle curve?

In working through this section together, you will have developed a view about the present state of health of your hospice – where are you on the lifecycle curve (Figure 1)?

- You might be consolidating after a period of uncertainty and on the up, but still with a list of things to do to have even greater impact.
- You might have such a long list of things to do that you may have peaked! Where you are on the downward curve is important: reinvention/turnaround gets much more difficult as you travel down the slope.
- You may be mid-way through reinvention – changing how you do things, but with huge potential for greater impact.
- You may be feeling really good about the impact you're having and your capacity and capability to do more: it's time to reinvent!
- If you're saying "actually things are just OK and they'll get better soon" then revisit the board conversation piece: "Surely we can't be ostriches"!

In the next section, we turn to considering the range of possible responses according to where you are on the curve.

Section 4: A menu of responses

This part explores a spectrum of responses. If you feel your hospice is fit for its future then the first two parts will help you focus on keeping up the good work: identifying ways of getting even fitter, and then ways of reinventing the organisation to remain fit, healthy and relevant in the longer term.

The final part provides signposts to action when your analysis has revealed that your hospice is some way from being fit, and on the decline. Here the action required is much more about either turning decline/crisis around or making a graceful exit.

4.1 Get fitter and prevent decline

The *Peering over the Precipice* workshop in September 2016 identified a range of different ways hospices can maintain their focus on getting fitter and preventing decline:

- Improve operational effectiveness by service redesign: doing things differently, focussing on quality, creating more cross-team collaboration (such as multidisciplinary team working), standardising processes where there are inconsistencies, understanding outcomes and focussing on those things which have the greatest impact for patients and the community, sharing back-office or other functions such as education with other hospices.
- Improve operational efficiency by process improvement: doing things better; improving productivity; reducing costs by taking them out or doing things more efficiently; outsourcing back office services; apportioning overhead so that you properly price the services you contract for; controlling supplier prices.
- Raise more income by seeking out new sources, with a focus on ensuring return on investment for each new source and investing in the instruments that bring greater return.
- Some key messages were:
  - Really understand your financial drivers – how much your services actually cost.
  - Have confidence to say no when the price from statutory funders/commissioners is too low.

This part looks at three aspects of getting fitter:

- understanding your portfolio of services and the business model
- reinvigorating income generation
- hospices collaborating together to improve effectiveness and efficiency.

4.1.1 Tool: Business Model Matrix Map

This Business Model Matrix Map is a way of looking at your activities to assess both impact and sustainability of the portfolio. A sustainable business model can be seen as having both a relevant and impactful portfolio of activities, along with sufficient working capital (funds to continue operations) to meet the needs and activities of the organisation and to grow impact over the medium to longer term.

To determine sustainability, Bell, Masaoka and Zimmerman[8] encourage non-profit organisations to look at how their whole portfolio of activities works together, and map the Mission Impact and Financial Return of all activities (products, services, campaigns and revenue generation activities).

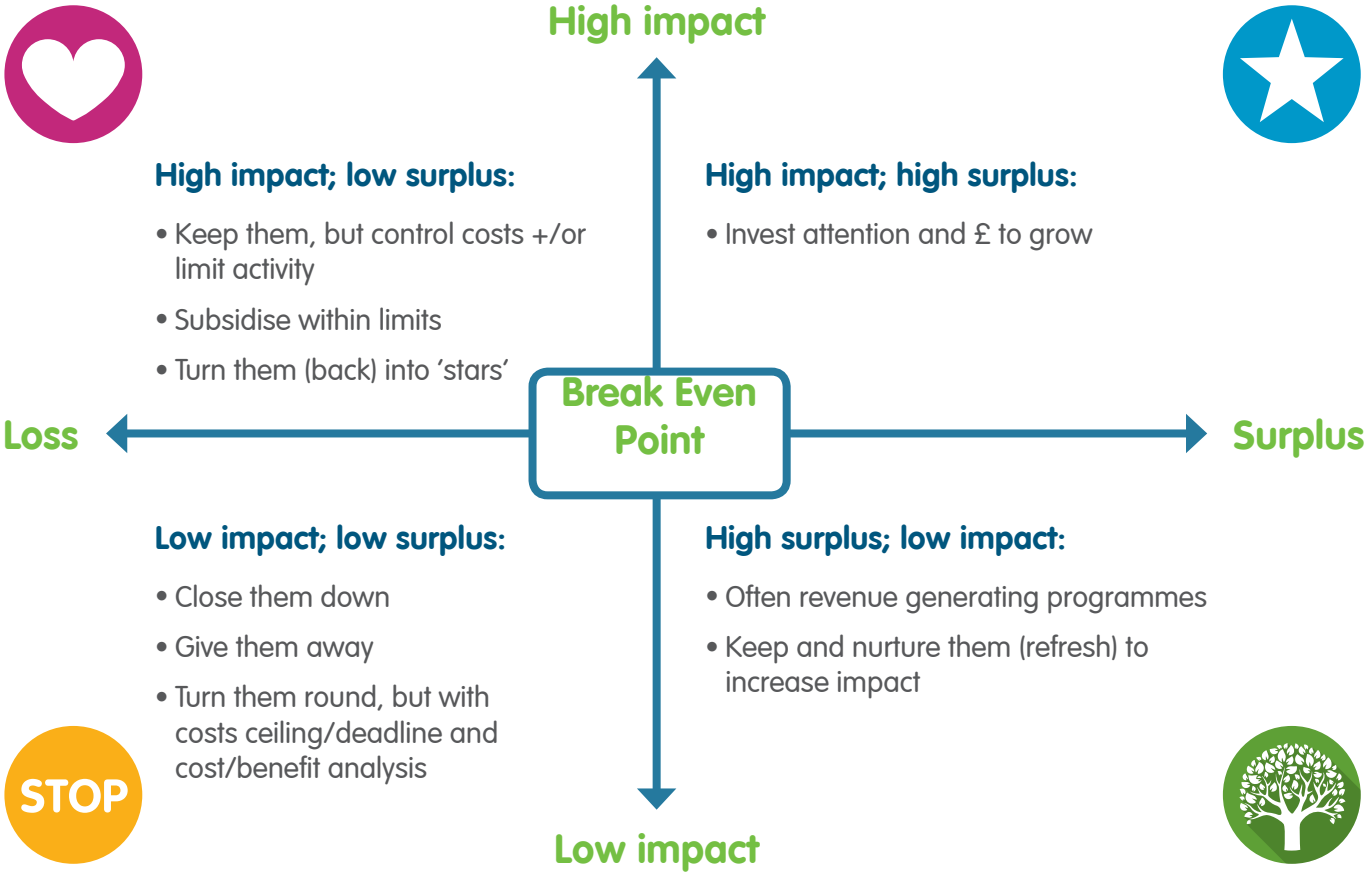
In Figure 8, the horizontal axis is about **Profitability** (BEP = Break Even Point). This is seen as revenue minus costs for each activity (including accurately apportioned overheads). For hospices (and other charities) profit or surplus is about creating funds to improve outcomes and impact, and invest in the future.

The vertical axis is **Mission Impact** where activities can be given a ranking against a selection of criteria:

- fit with Mission
- excellence in terms of quality
- scale of impact (numbers); depth of impact (in terms of change for the beneficiary)
- filling important gap (FIG)
- community-building
- leverage of other benefits (use data as evidence where possible, but the best guess of a diverse group is good enough).

You can use your own criteria too.

Figure 8: Profitability and impact business model matrix



(8) Bell J, Masaoka J, Zimmerman S. Nonprofit sustainability: making strategic decisions for financial viability. San Francisco: Jossey Bass, 2010.

How to use this tool:

1. Draw up a Business Model Matrix Map for all of your activities and services.
2. Use a 'bubble' for each activity; make the size of the bubble relative to the cost of each activity (to spotlight where resources are going).
3. Determine each activity's level of Mission Impact and Profitability.
4. Then evaluate how you can make your portfolio of activities more impactful and sustainable.

Your model will be in balance if there are enough high surplus/low impact activities to subsidise low surplus/high impact ones.

You may also be alerted to things you need to wind down or redesign. To withdraw a service can be very challenging, but propping up activities that don't contribute to Mission Impact and make a loss (bottom left) is not in the long term interest.

4.1.2 Worksheet: Revitalising income generation

The ideas in this worksheet come from participant group work at the *Peering over the Precipice* workshop in September 2016 and provide a series of suggestions to revitalise your fundraising and income generation:

1. Actions to revitalise your income generation approaches:

- Form a working group and develop an action plan. Make sure it is not just made up of fundraisers or senior managers – make it a hospice-wide mixed group – in terms of roles, seniority and background – to get a variety of perspectives.
- Establish a baseline and be very clear about what issues you want to address and your intended outcomes.
- Seek feedback from key stakeholders including patients, families, and donors. Seek input to really understand your local market; consider investing in some well-facilitated focus groups.
- Analyse the return on investment from each of your income generation approaches. What is delivering the greatest return on investment? And what the least? This kind of analysis can help you to understand and break the link with fundraising activities which may be long-standing but are not (sufficiently) profitable.
- Have the reinvention debate: explore untapped sources, do different things.
- Ensure your senior team accepts collective responsibility for income generation.

2. How to generate more income:

- Exploit existing opportunities more effectively – openness and courage are key.
- Do not expect the fundraising team to come up with all the ideas – harness ideas from the whole hospice community.
- Find new sources: invest time and money in investigating new sources and involve your finance team and others beyond the fundraising team in stress testing them to decide which to actively pursue.

- Ensure effective communication of need – develop clear communications about the needs which would be unmet if the hospice didn't exist, or had to reduce/withdraw services. Also ensure you have clear messages about how the hospice is addressing the need or plans to fill the gap, and evidence of the impact of your activities.
- Seek out examples of good practice, both across the hospice sector and beyond. What can you learn from these? How can you adopt and/or adapt such approaches?
- Work with other organisations, eg lawyers for legacies, financial advisors who advise on donating shares tax-efficiently.
- Engage with local corporates; hold business breakfasts, get local corporates in for breakfast, a tour and to listen to a speaker on a topic of interest. Invest time in building your relationships with local companies.
- Develop high net worth individuals (HNWIs) as major donors; hold Chair/trustee brunches with HNWIs.
- All of these activities need the support of the senior team. The fundraising director may not always be the best person to attend events or speak on behalf of the organisation – sometimes it might be the finance director or a clinician: match the person delivering the message to the audience.
- Throw out challenges to staff to come up with new proposals for raising significant amounts of money.
- Challenge assumptions that "something will turn up" without the need to adopt new, more proactive fundraising approaches – something won't just turn up!

3. Tracking progress

- Be very clear about goals and outcomes: set SMART targets and objectives: "We will have raised x by y".
- Be clear that the amount raised means the net amount, after deducting all costs: it can be tempting for fundraisers to report on gross income figures rather than net!
- Ensure that in addition to money raised, other outcomes from income generation activity are analysed, understood, and communicated internally, eg this campaign attracted x new donors or was supported by a new sponsor. Relationship-building is an important part of fundraising.
- Use data and analyse it.
- Carry out local and national benchmarking: what do others do, and what do they achieve? How does your hospice compare? What can you learn from such analysis? What can you learn from other organisations, especially those willing to share data, insights and experiences?
- Take remedial actions if your milestones are not reached, eg cost saving steps if money not raised.
- Keep 'checking in' with the rest of your organisation; keep providing/asking for feedback; take temperature; make sure everyone feels engaged and positive; minimise destabilisation.
- New sources – how long do you allow experimentation? Do you take more risk once you're in a crisis?

4 Communications

- Ensure there is an internal and external communications strategy in place both to inform and to facilitate feedback on changes.
- Build a narrative that makes the link between monies raised and services provided – this is valuable internally as it will help to support a fundraising culture across the organisation as well as externally.
- Encourage staff to promote fundraising through social media. Peer-to-peer communications can be more effective than advertising, but provide clear social media guidelines and training to avoid problems.
- Give careful consideration to your messaging, ensure you are always truthful and be wary of creating uncertainty around your brand or putting your reputation at risk. For example, if you **repeatedly** say "if we don't have enough money we will have to close services" then you risk being seen as scaremongering or 'crying wolf' and may undermine your own credibility.
- Think carefully about what to do where there are in fact significant reserves. You may need to explain the legal requirements and/or be clear if they are earmarked for a significant development. Or perhaps you should consider spending some of the reserves?
- Think about how creative your fundraising communications are. Too many photos of cheque presentations can give the message that the hospice is doing well and does not need money. Try and focus on the difference the money will make with a great case study: "because of this money, x will happen".

4.1.3 Case study: Haven House Children's Hospice

Haven House Children's Hospice is based in North East London and today provides care for over 300 life limited children and young people every year.

In 2008, Haven House experienced financial difficulties resulting in a number of cutbacks and redundancies. By Spring 2011, financial stability had been restored, at least to a degree but, due to lack of resources, the organisation was operating at a bare minimum of care staff and morale was poor amongst staff and volunteers.

The charity's annual income was just below £2 million of which almost half was from statutory sources (a ratio significantly higher than the children's hospice average). Nonetheless it was apparent that, in comparison with other children's hospices operating in areas of similar size and demographics, Haven House was achieving significantly less awareness and voluntary income than it should have been.

With the full support of the Board, the following steps were taken to address the problem:

- A governance review was undertaken through the Hospice UK Board Development Programme by Cass Business School, and the recommendations implemented, eg to provide greater diversity to the board and to implement separate board committees for different areas of work including income generation.
- Comprehensive research was undertaken of comparable hospice fundraising performance to establish benchmarks and examples of good practice.

- After some early staff changes, time and money was invested in raising profile in the local media and in recruiting more, skilled fundraising staff.
- A Database Manager was recruited to ensure more accurate recording and analysis of our supporter data.
- The whole Income Generation and Marketing team were engaged in creating ideas and a plan for the hospice's 10th birthday year in 2013.
- Greater integration and team building opportunities were sought to bring the fundraising, care and support services staff closer together as 'one team'.
- Haven House joined the Local Hospice Lottery (recognising that the time and costs of starting their own lottery were not feasible).
- The hospice started participating in the annual staff survey offered by Birdsong through Hospice UK, in order to provide an anonymous reflection of staff satisfaction.
- In 2014/5, with the input of all staff, families, volunteers and other stakeholders, Haven House launched Vision 2020, a five-year strategy with ambitious targets for growth in services and income.
- That same year the board and SMT approved proposals to re-expand retail – an area that had been allowed to wither.

Today the charity has a total gross income of more than £3.4 million within which fundraising has more than doubled its net contribution. Haven House now has a wholly new board, with much wider expertise and diversity, and having continued with the annual Birdsong staff survey every year, last year achieved record scores both for Haven House and against hospice and charity sector averages. Haven House has also been a member of CHaL (Children's Hospices across London) and has taken a leading role in CHaL being selected as the Blackrock Charity of the Year which grossed £800,000+.

4.1.4 Board conversation piece: getting fitter

Questions to ask ourselves:

- How can we use reserves more effectively?
- Who else can we learn from?
- How could our corporate supporters be used to open our eyes to different and better ways of working?
- How can our patients, their families and carers be better involved in shaping and improving services?
- How can we listen and learn from our local communities and engage them in shaping our work and services?
- How can our staff and volunteers be stimulated to help us think differently about increasing effectiveness and efficiency?
- How can we give more freedom to staff and volunteers to allow them to develop new and improved ways of working?
- How can we track progress for all of our effectiveness and efficiency projects to make sure we are investing in the things that will really make a difference?
- How can we learn from evaluation findings, and evidence about outcomes and impact (of our own services and elsewhere), to inform and improve what we do?

4.1.5 Signposts: getting fitter

Portfolio analysis using social purpose and financial impact: 'Organised Abandonment Grid'[9].

Maximising impact whilst reducing waste: LEAN Enterprise Institute.

Hospice UK works in partnership with the Cicely Saunders Institute, King's College London, to support increased understanding and use of the OACC suite of Palliative Care Outcome Measures. Some resources about OACC and outcome measures are on Hospice UK's website, and a new Community of Practice was launched in July 2017.

Both NPC and NESTA have a range of useful resources about evaluation and impact measurement on their websites.

4.2 Reinvent the business model

It was acknowledged at the start of this toolkit that maintaining the status quo is unlikely to be a sustainable option. It may not even be enough just to focus on driving greater effectiveness and efficiency into your business model: changes in the external environment may drive you to find completely different ways of doing your traditional work, or even to do radically new things to meet changing needs and respond to constrained resources. This section offers some approaches to getting the reinvention conversation going:

- A way of looking at growth and reinvention options, and then consider how you might work with others to deliver them
- Change management techniques to make sure you take people with you on the journey
- A closer look at mergers as a way of both achieving greater impact and improved sustainability

4.2.1 Tool: Ansoff's grid

Ansoff's grid is a tool to help decide how and where to grow impact in a very beneficiary focussed way. It helps compare and contrast options to reinvent the way you do things and achieve the Mission in new and different ways.

How to use this tool:

The first step is to identify all your current services/products (including income generation products) and their markets so that you understand the breadth and depth of what you do, and for whom. Then consider potential options for expansion using the matrix which encourages you to think about new services/products, new markets and unmet need. Useful questions might be:

- How can we get greater impact by doing what we do differently or better? Or by ceasing to do some of the things we do that don't meet the needs of our beneficiaries?
- How can we grow our impact by taking what we currently do well and offering it to new groups/markets? (market development)
- What services and products do patients, families and carers need that we don't currently provide? (service/product development)
- What challenges does society face that we have the capability to help resolve? (diversification)

(9) Boschee J. Keep or Kill? Score your programs. *Nonprofit World*, Vol 21, No.5, Sept/Oct 2003.

Figure 9: Ansoff's grid

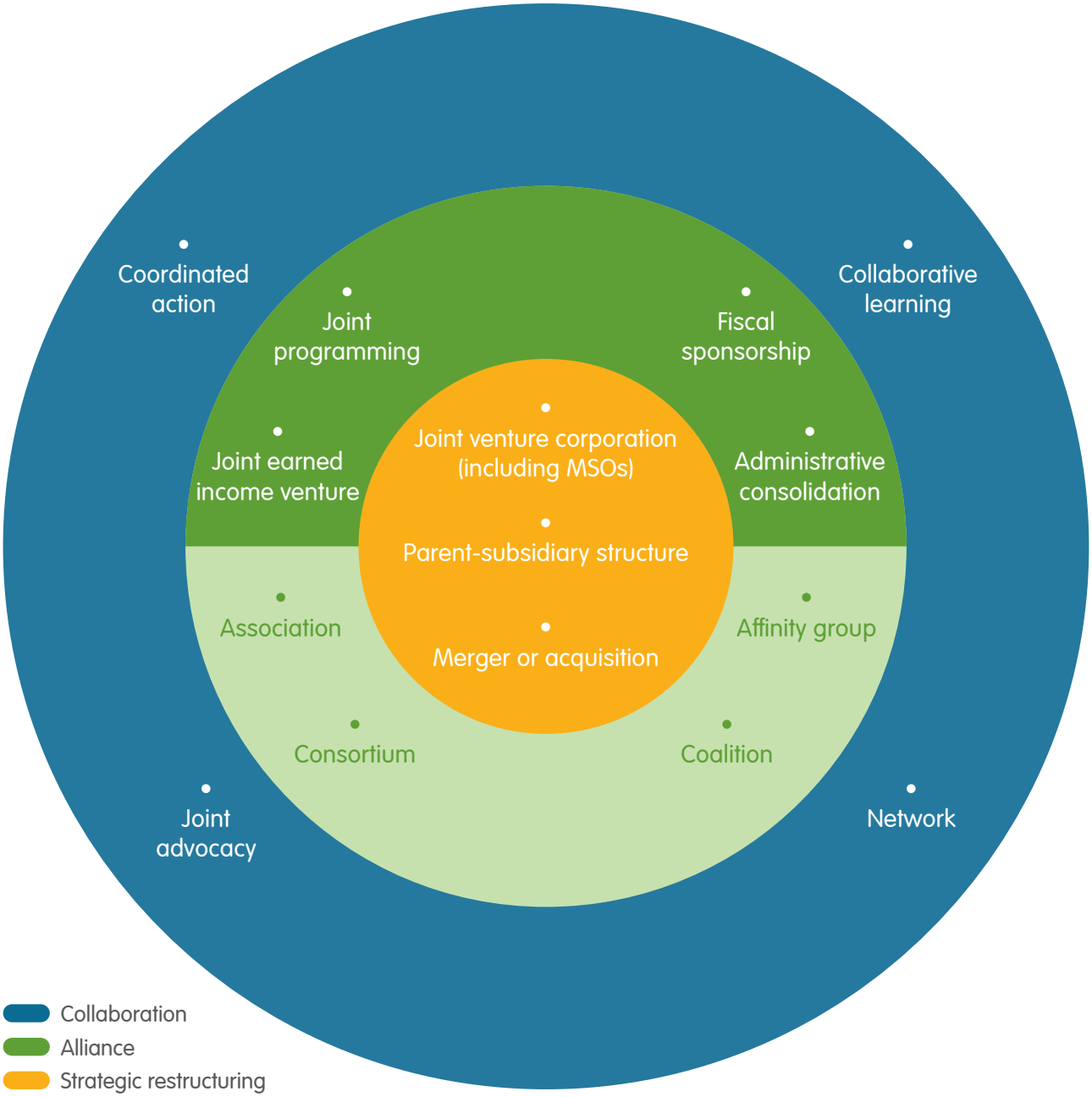
Once you have developed a range of options you then need to consider the associated costs, benefits and risks for each option.

One way of potentially having greater impact and reducing risk is to consider working with other hospices or strategic partners such as housing associations, other health charities etc. to achieve your growth or reinvention strategy. There are many examples from across the hospice sector:

Growth strategy	Examples of the potential for working with others
Market penetration (including improving effectiveness and efficiency)	• Different referral partner offering new ways to for patients to access our support • Co-ordinated action to apply for joint funding or jointly bid for tender opportunities • Gain greater understanding by learning from another organisation providing different services to your patients • Joint procurement to achieve better prices from suppliers • Joint venture to share cost, risk and reward in income generation • Joint venture to grow impact, eg Hospice Education Alliance • Staff rotation between hospice and NHS • Shared posts with NHS, other hospices, other charities etc. • Shared services: facilities, pharmacy, HR, IT, finance • Learning collaborations between hospices
Market development	• Merger or acquisition of an organisation in a different geographical area • Joint venture or collaborative learning with an organisation already working with your target group
Product development	• Merger or acquisition of an organisation specialising in new/different services • Joint venture with them to pool risk and reward
Diversification	All of the above!

David la Piana[10] captures these opportunities in his collaborative map:

Figure 10: La Piana's Collaborative Map



Piana's model distinguishes between:

- **Collaboration** = co-ordinated action with mutual benefit
- **Alliance** = a more formal, structured partnership, doing business together in a joint
- **Strategic Restructuring** = a structural change or the creation of a new entity

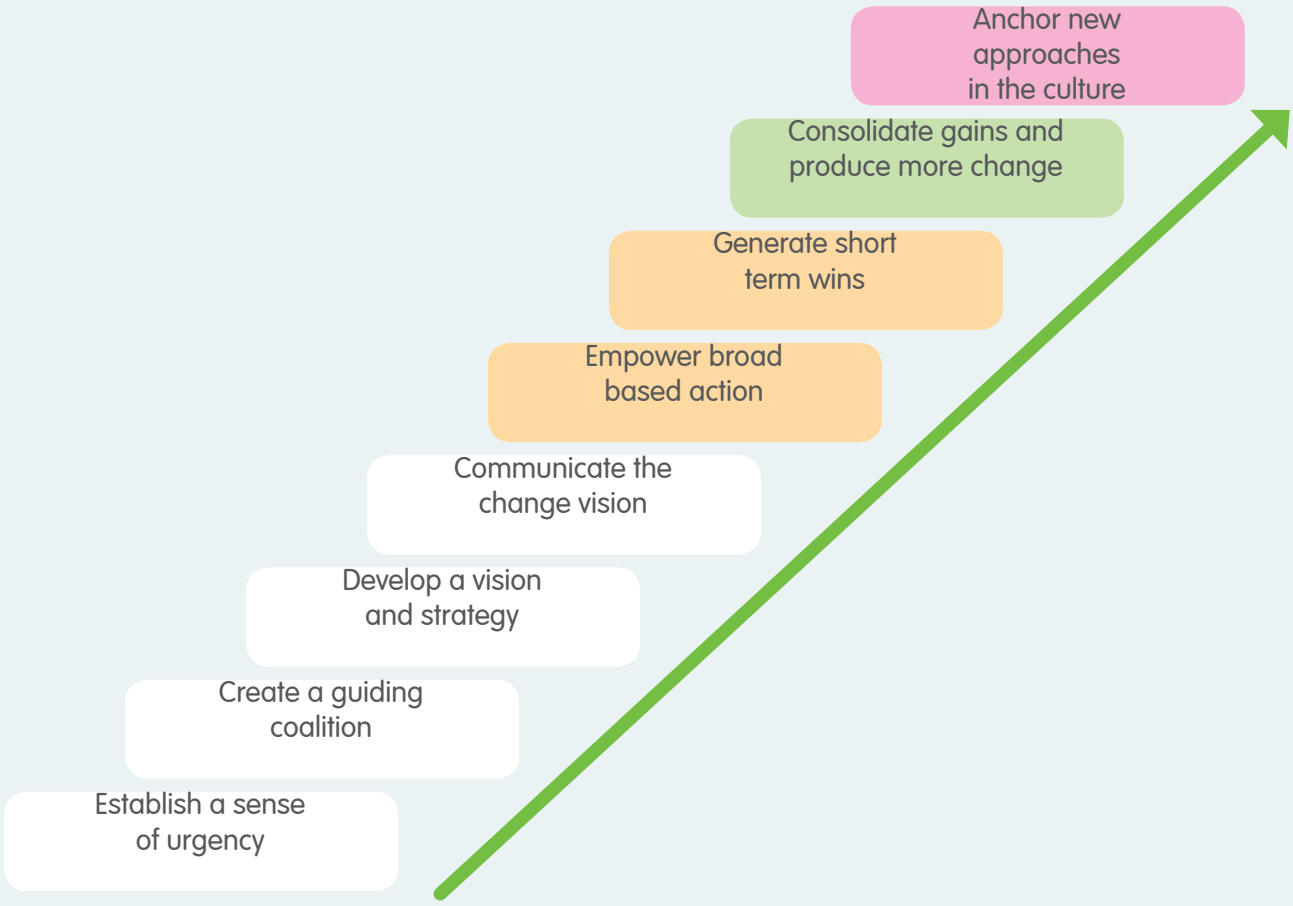
It is important to note that there are always the costs of collaboration to consider: for example the cost of change, professional fees, dips in productivity as people learn, or as some leave the organisation. Collaboration takes time and requires investment to get alignment and integration, and for the change to be embedded into the culture.

(10) La Piana Consulting: http://lapiana.org/insights-for-the-sector/insights/collaboration-and-strategic-restructuring/collaborative-map

4.2.2 Worksheet: Change management – taking people with you, building ownership

John Kotter[11] provides us with a step by step structure for large-scale change programmes:

Figure 11: Kotter's large-scale change process



(11) Kotter J. Leading strategic change. HBSP, 1996.

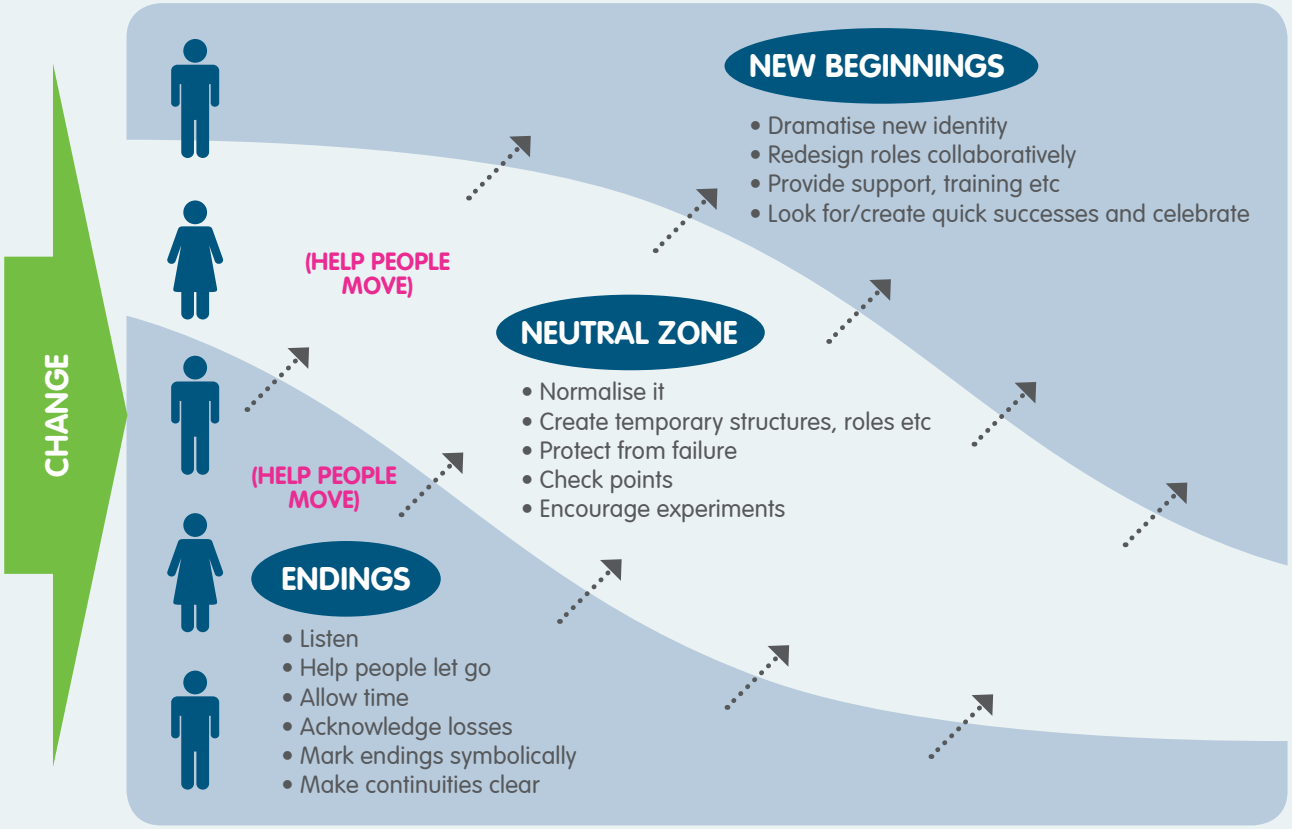
KOTTER'S LARGE-SCALE CHANGE MANAGEMENT PROCESS		
In order of frequency of citation as main cause; a typical crisis situation has six or seven.		
Steps	Approaches	Think about the actions you would take
Establish a sense of urgency	Make sure key stakeholders are onboard and have strong and consistent views about the need to change. Evidence the need to change. Celebrate past achievements and departure!	
Create a guiding coalition	Get a group of stakeholders together to guide the change and give them authority to act: be clear on the change mandate.	
Develop a vision and strategy	Establish a positive and engaging vision of what the changed organisation will look like. Then be clear about the transition steps.	
Communicate and change vision	This should be a mix of 'what', 'why' and 'how'…as well as a bit of 'who'. Constant, consistent and clear.	
Empower broad based action	Get everyone involved at all levels. Use change agents or 'network leaders' to ensure alignment.	
Generate short term wins	Get some early recognisable successes promoted and publicised.	
Consolidate gains and produce more	Build on the momentum, create a critical mass of support	
Anchor new approaches in the culture	Make sure the change is deeply rooted by fixing it into the culture –'start using the present tense'. Celebrate arrival!	

Tammy Tawadros from Cass CCE has produced a useful summary of why classic change efforts fail:

- They are too rational and overlook the emotional aspects
- They concentrate on the processes and procedures and not enough on the people
- They fail to take account the interconnectedness of different parts of the organisation

Tammy has developed a summary of how to manage the 'people elements': helping people to move, based on William Bridges[12] ideas about managing transitions:

Figure 12: Managing transitions



Signs of unmanaged transitions

Guilt
Resentment
Anxiety
Self absorption
Stress

(12) Bridges W. Managing transitions, 1995 and 2002 and http://www.wmbridges.com/books/books-mt_chpt_2.html

4.2.3 Case study: St Luke's Hospice, Sheffield

St Luke's Hospice, Sheffield was a founding hospice of the modern hospice movement, opening in 1971.

Why the hospice needed to change and improve

St Luke's reached a critical situation in 2008, facing a huge financial deficit of nearly £1 million per year, with fear of closure within three years – compounded by ageing and failing facilities, isolation from the local healthcare sector, lack of professional practices and processes, and the need to renew governance and management.

What St Luke's hospice did

To address this situation, St Luke's embarked on a change programme organisation-wide, at all levels and in all services, over five years. The hospice started an immediate financial recovery plan based on difficult discussions with NHS funding bodies, a refocus and reduction of services in some areas, and a reinvigoration of governance, management and organisational attitude and culture. Finances were stabilised. A properly resourced plan for income generation was developed. Key messages were addressed. Efficient, effective and joined up working was promoted. A business plan to improve facilities was created and implemented. Clinical management and delivery programmes were renewed. St Luke's became known for innovation and quality, a place where change happens, with class-leading facilities. The hospice renewed its brand and values, and focussed outward as a 'community organisation.'

What they learned

The outcomes of the changes that St Luke's made are that, after three years of real pain, the charity has grown again in every way. St Luke's now cares for more patients annually than ever before. Whilst NHS funding fell from 35 per cent to 26 per cent of income (with no monetary increases in seven years), the hospice's self-generated net income doubled. St Luke's is now a vital part of the local healthcare sector, and recently received a CQC 'outstanding' rating. And the new systems and processes that St Luke's has introduced, together with their care facilities, attract national attention.

Peter Hartland, chief executive, says:

> "We've learned that an uncompromising focus on who we're here for, and what is best for them – now and in future – is the vital mindset. We know that change is never-ending, the next crisis is around the corner, but we have to be ready for it!"

4.2.4 Board conversation piece: getting familiar with the 'M' word!

Explore the barriers to successful merger and seek to improve the chance of success; use this as a way of checking out your willingness and preparedness for merger:

EXPLORING THE BARRIERS TO MERGER		
Barriers	Implications	What can we do?
Fear of loss of identity and independence	• 'Take-over' type language is unhelpful • Depends on who makes the approach and their motivation	• Have clear parameters and explicit expectations around brand, name, retention of key services • Think hard about how to minimise any negative impact on supporter base: sell the benefits to patients and the community, be clear about what is remaining the same, consider whether to have two brands sitting side-by-side rather than a new joint brand
Egos and self interest	• Emotional attachments can get in the way • People with a high stake (often related to power and self esteem) can block and resist • Founder syndrome can prevail	• Keep an open mind until the shape and scope of the new organisation is known (form follows function) • Avoid early appointments • Keep a clear focus on beneficiaries and how merger would enable you to improve services, reach more people, increase impact
Putting together two cultures	• Often cited as the biggest barrier to successful merger • •Affects how people work together • How decisions are made • How success is viewed • How people deal with change • Pockets of resistance	• Really understand both cultures before the journey starts • Establish a joint vision, shared values and language • Have non-negotiables around shared values and protection of beneficiary interests

4.2.5 Signposts: reinvention

To explore social investment by charity boards, see Big Society Capital: Get Informed.

Eastside Primetimers have produced the Good Merger Guide to help not-for-profit organisations explore options for merger.

Charity Commission publication on mergers.

BCG's e-publication Transformation: delivering and sustaining breakthrough performance offers tips and techniques to getting transformation right.

Hospice UK Collaboration Toolkit, produced as part of the Commission into the Future of Hospice Care.

4.3 Turnaround from crisis or make a graceful exit

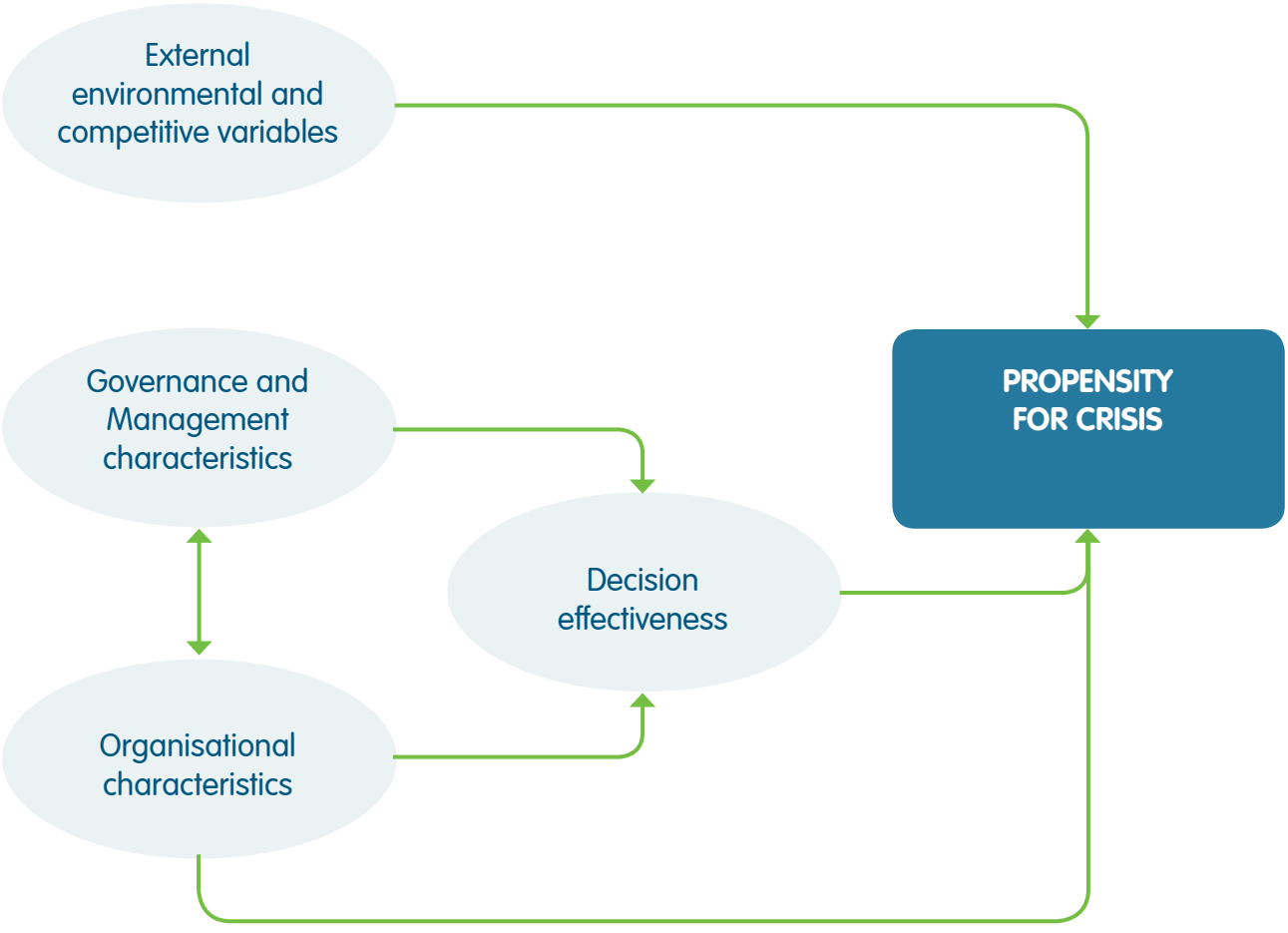
Whilst the focus of this toolkit is on surviving and thriving we can't ignore the fact that many charities, including hospices, are under immense pressure in the current climate, and some are in decline and approaching crisis. This section looks at generic turnaround strategies, some signposts and the option of making a graceful exit

The dilemma that many charities find themselves in is that trading whilst insolvent in order just to survive is not a long term option, nor are trustees fulfilling their fiduciary responsibilities when they decide to do this and indeed they may be at risk of being proven negligent. If the basic business model is out of balance, crisis will happen, and it's much harder to turnaround when you're in severe decline.

4.3.1 Generic turnaround strategies[13]

A series of causal factors interact with each other to affect the propensity for crisis. It is these characteristics and the resulting effectiveness (or ineffectiveness) of decisions that are the focus of turnaround strategies:

Figure 13: Factors affecting decision effectiveness



(13) This section adapted from Slatter S and Lovett D. Corporate turnaround. Suffolk: Penguin, 1999.

Turnaround approaches can help organisations in decline or crisis. These are focussed on managing the immediate crisis and tackling the more deep-rooted systemic issues, whilst rebuilding stakeholder confidence (local community, local statutory funders/commissioners, acute hospitals, GPs, other professionals, the media etc.) to get a secure footing for the future. Below are some generic steps, but it will be important to decide which are appropriate and tailor these to each individual context:

GENERIC APPROACHES TO ACHIEVING TURNAROUND	
1. Crisis stabilisation	• Take control • Cash management • Asset reduction • Short term financing • First step cost reduction
2. Leadership	• Change of chief executive • Change of other senior management • Change of Chair and/or other trustees
3. Stakeholder support and managing reputation	• Communications to keep key external stakeholders on board and manage the reputation • Communications to help staff and volunteers engage and understand the process • Communications with patients, families and service users
4. Strategic focus	• Redefine core business • Divestment and asset reduction • Service/product/market refocusing • Downsizing • Outsourcing • Investment
5. Organisational change	• Structural changes • Key people changes • Improved communications (internal and external) • Building commitment and capabilities • New terms and conditions of employment
6. Critical process improvements	• Improved income generation and marketing • Cost reduction • Quality improvements • Improved responsiveness • Improved information and control systems • Improved efficiency • Service redesign
7. Financial restructuring	• Refinancing/renegotiating contracts • Asset reduction

Characteristics of successful turnarounds: doing more, even more vigorously

- Management changes – particularly the appointment of a new chief executive and/or finance director.
- Improved financial control systems.
- Driving for a performance-oriented culture.
- An understanding that cost-reduction strategies alone will not lead to a successful turnaround, indeed redundancies can hinder recovery (you lose talent, people left get demotivated etc.).
- Improved marketing and communications.
- Improved income generation activities.
- Process and structural improvements.

4.3.2 Case study: St John's Hospice Lancaster and South Lakes

St John's Hospice in Lancaster opened in 1986; at the time it was fully funded by the local Health Board. For 30 years, legacy income was abundant and, even though statutory funding eventually reduced to 30 per cent, money was never an issue. But by 2012 the hospice had a £568,000 deficit and had received poor feedback from the CQC regarding individualised record keeping.

What did the hospice do?

A new chief executive was appointed with a remit to raise money, raise awareness and raise quality. The chief executive joined the governing body of the CCG as a lay member, analysed the key strategic intentions of all local commissioners (health and social care) and presented these to the hospice board.

The hospice chairman stood down and a new chair was elected. The incoming chair's focus was on governance and quality. The board carried out a review of trustees' skills, and there was a 50 per cent turnover of trustees in 18 months. The board held 'Blue Sky Thinking' sessions using materials produced by the Commission into the Future of Hospice Care.

A thorough review of board governance was conducted including sub-committee structures. An integrated governance committee was established and a Governance Handbook, (including a scheme of delegated authority) developed.

The chief executive invited all staff to a personal one-to-one meeting and listened to their thoughts and fears. The hospice involved staff in implementing 'quick financial wins'. The 'keepers of the old culture' began to leave.

Internal communications were improved with the introduction of team briefings, a revised induction process, development of a staff forum and a team newsletter. The Chair and chief executive jointly led team briefing sessions for all staff and all shifts, including those working nights.

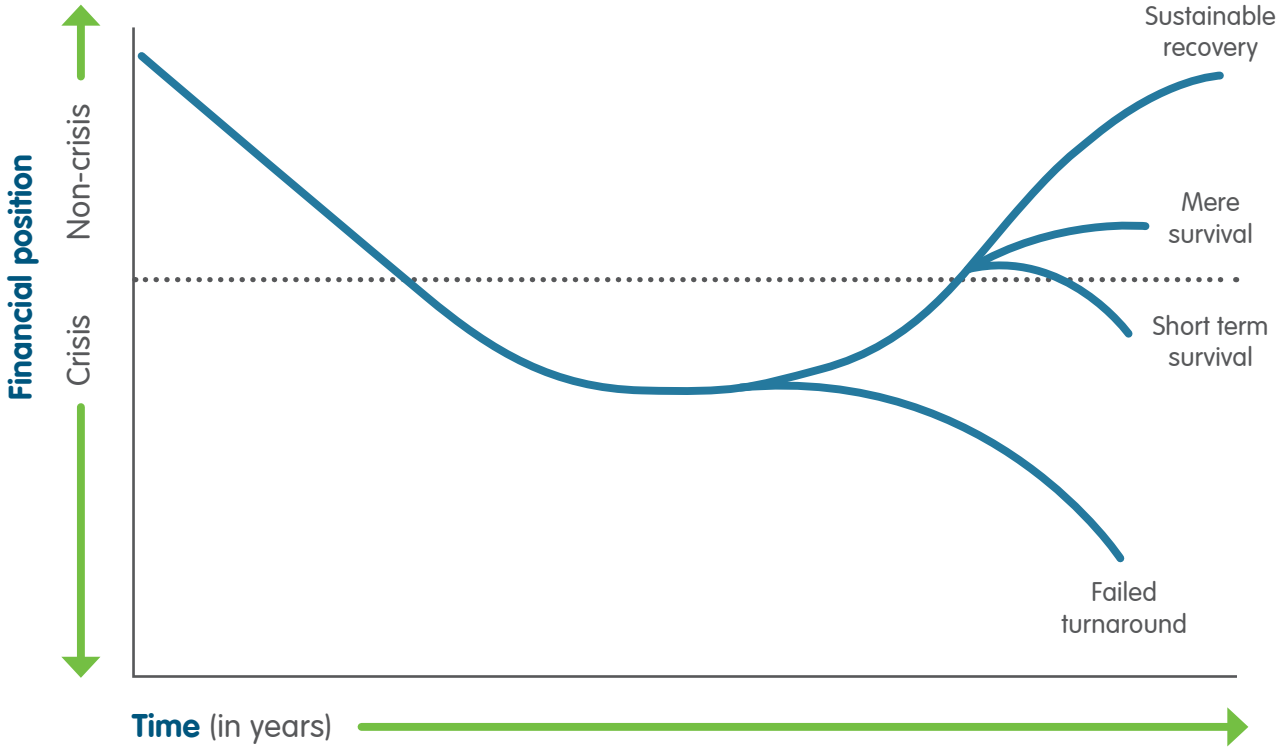
St John's chair joined the Hospice UK Board. The chief executive and chair attended Hospice UK's Partners in Success programme (part of the Good Governance programme) run specifically for hospice chairs and chief executives to explore and strengthen their working relationship together. The hospice conducted a review of their medical structure, and a consultation and review of nursing teams.

The hospice ran a number of intense media campaigns. In year one, they ran a campaign called 'Driving Hospice Care' to promote Hospice at Home and buy new vehicles. In year two, St John's ran 'Save our Hospice for Future Generations' galvanising community support with a compelling 'call to action' campaign. And in year three they ran a 30th anniversary 'Hospice Angels' campaign, to fund an additional Hospice at Home nurse in South Lakeland. The hospice also focused on social media: in 2013 they had 1000 Facebook 'likes', by 2016 this had grown to more than 8,000.

Three years on, St John's hospice has recorded a significant financial surplus and was recently judged 'Outstanding' by the CQC.

4.3.3 Board conversation piece: can we ensure sustainable recovery?[14]

Figure 14: types of recovery situation



The goal of a turnaround effort is *sustainable* recovery. Some questions that might help focus the mind on the right next steps if your hospice is in decline or even in crisis are:

- Are we up for the effort we will have to take to turn our organisation round?
- Would we have a better chance of survival by merging with another hospice? And why would they want to merge with us? What can we offer?
- What is in the best interests of our service users and our local community?
- Is the cost of turnaround greater than the likelihood of sustainable recovery? Do we have the resources to invest in recovery sufficient to make it sustainable?
- Is the prospect of mere survival or short term survival good enough? What do we need to do to ensure sustainable recovery?

(14) Slatter S and Lovett D. Corporate turnaround. Suffolk: Penguin, 1999.

4.3.4 Signposts: turnaround

Charity Commission guidance on managing difficulties and insolvency.

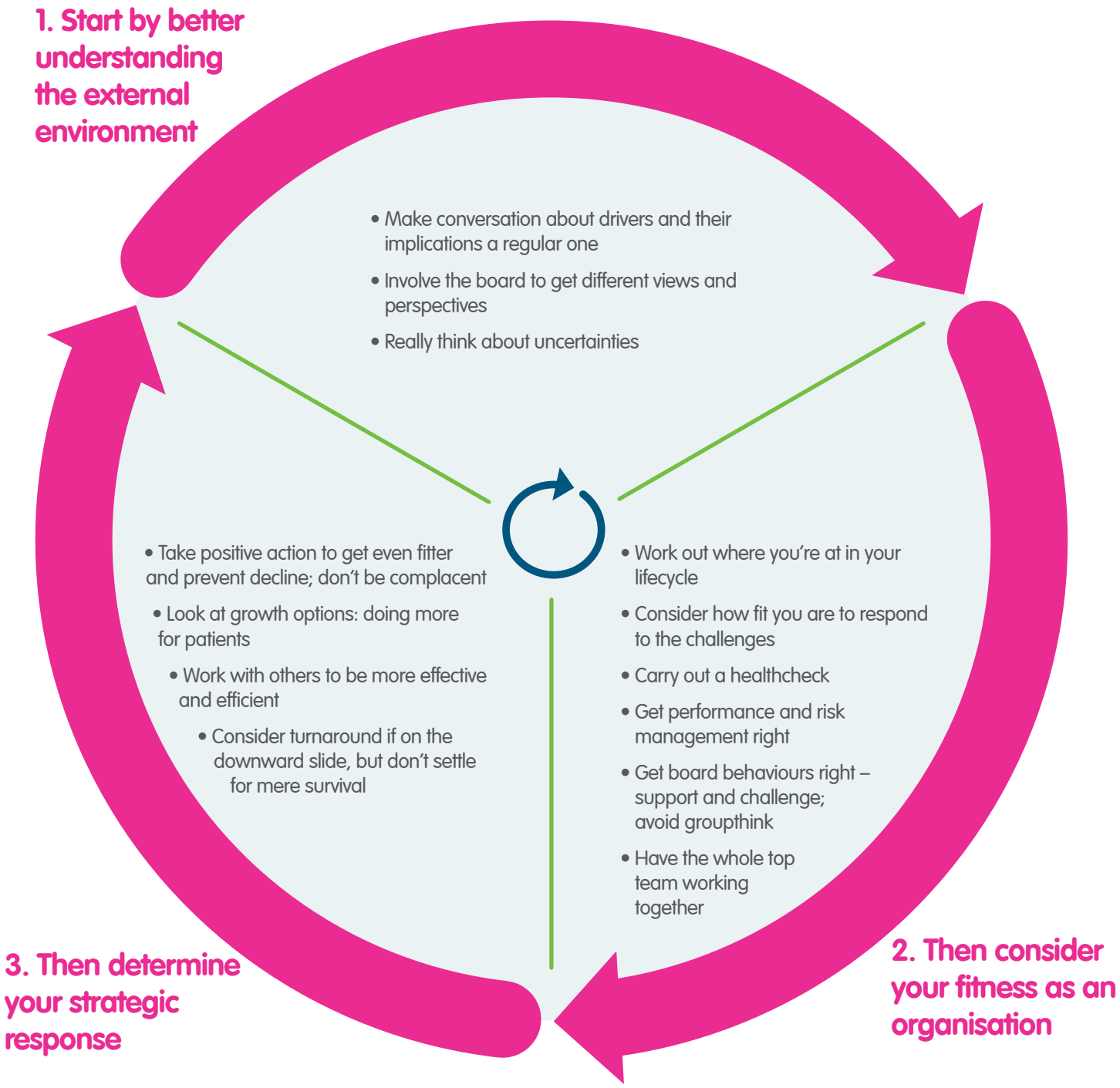
NCVO and the Charity Finance Directors Group (CFDG) offer a free insolvency helpline.

Get in touch with Hospice UK if you feel you are in difficulties and require a sounding board or external support – you can contact any member of the senior team.

Section 5: Key themes in summary

We hope that you've seen from your exploration of the toolkit that how you respond to the challenges in the external environment is a matter for your board and senior staff to shape and develop together. There are a number of tools that can help, and some questions and further research that will help you get greater depth to your thinking, and a more considered response. Exploring the external environment, considering your fitness to respond, and determining the most appropriate response is an ongoing top team conversation if you are to make the maximum impact for your beneficiaries and add value to your local community:

Figure 15: key themes in the Peering over the Precipice toolkit



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