

ICB contracts for CHC Fast Track

Hospice UK Big Conversation
12 May 2026

Housekeeping



Please keep your mic muted unless you are asking a question



Please note that the presentation (excluding the Q&A) is being recorded



The recording and slides will be on the Big Conversation website after the event



Please use the Chat function to ask any questions as we go along



AI bots are not permitted in these meetings and will be removed

Agenda

14:00	Welcome & Introductions	Annette Alcock , Director of Programmes, Hospice UK
14:05	Greenwich Care Partnership: CHC Fast Track	Jon Devlin , Director of Partnerships, Greenwich & Bexley Community Hospice
14:35	Hospice Rapid Access Service: The Funding Model	Louise Bryan , CEO, Havens Hospices
15:05	Q&A	All
15:25	Hospice UK updates	Annette Alcock , Director of Programmes, Hospice UK
15:30	Close	Annette Alcock , Director of Programmes, Hospice UK

**COMMUNITY
HOSPICE**

For the people of
Greenwich & Bexley

Greenwich Care Partnership: CHC Fast Track

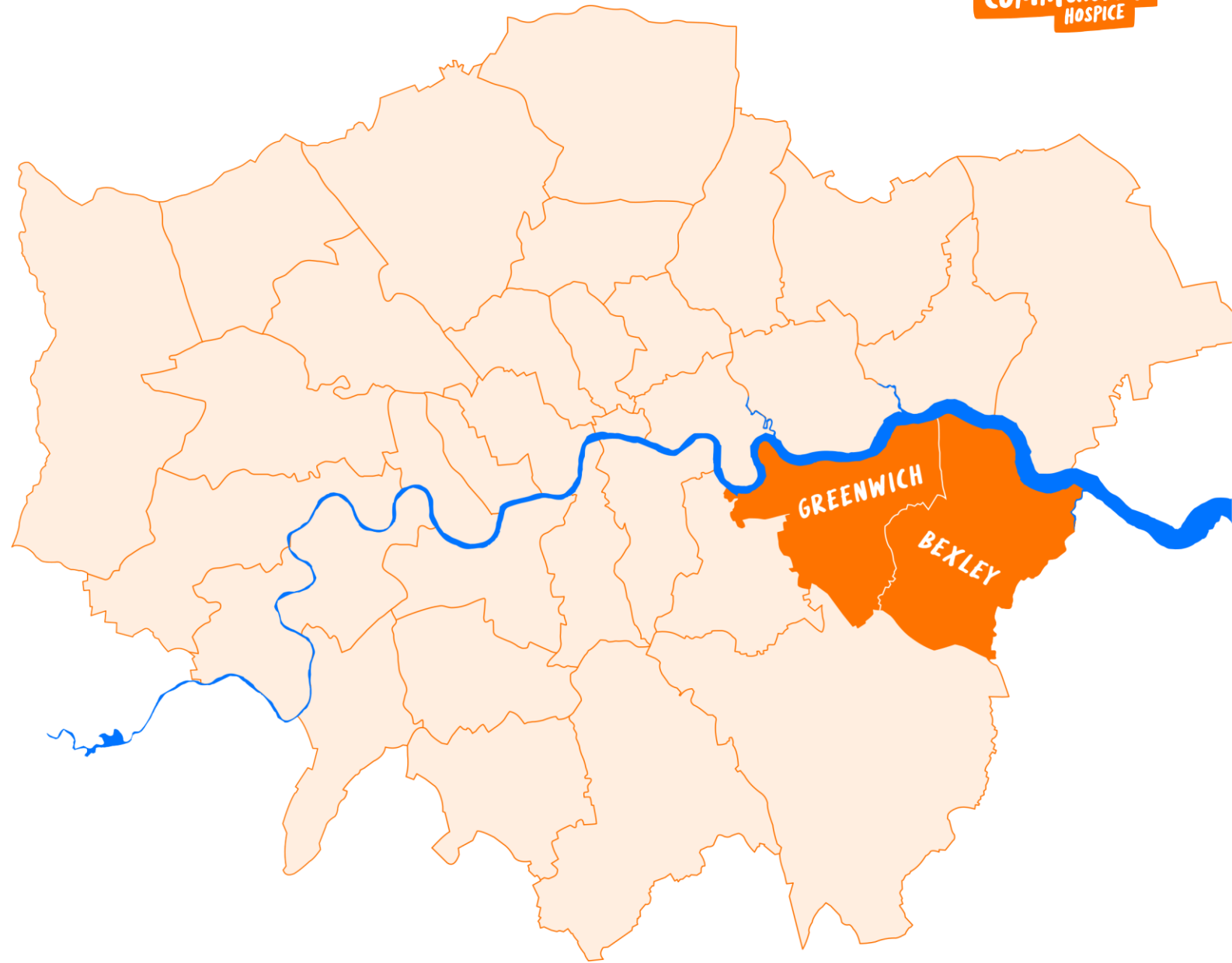
Jon Devlin – Director of
Partnerships

May 2026



Who we are

The Community Hospice is the adult hospice delivering care to the people of the London Borough of Bexley & the Royal Borough of Greenwich in South East London.



About the Community Hospice



The Community Hospice serves ~550,000 people across two boroughs in South East London – the London Borough of Bexley and the Royal Borough of Greenwich. With 296 staff (192.6 FTE) and approximately 40% NHS funding via a 3+2 year SEL ICB contract, we are one of the most system-integrated hospices in the country.

OUR SERVICES

- Inpatient Unit (13 beds)
- Community CNS teams
- Hospital In-Reach (QEH & LGT)
- Greenwich Care Partnership
- Virtual Ward (14 beds)
- ANP in ED pilot
- Compassionate Neighbours

OUR SCALE

~550,000

population served

296

headcount (192.6 FTE)

~3,000

individuals seen per year

OUR COMMISSIONING

~40%

NHS-funded — high for the sector

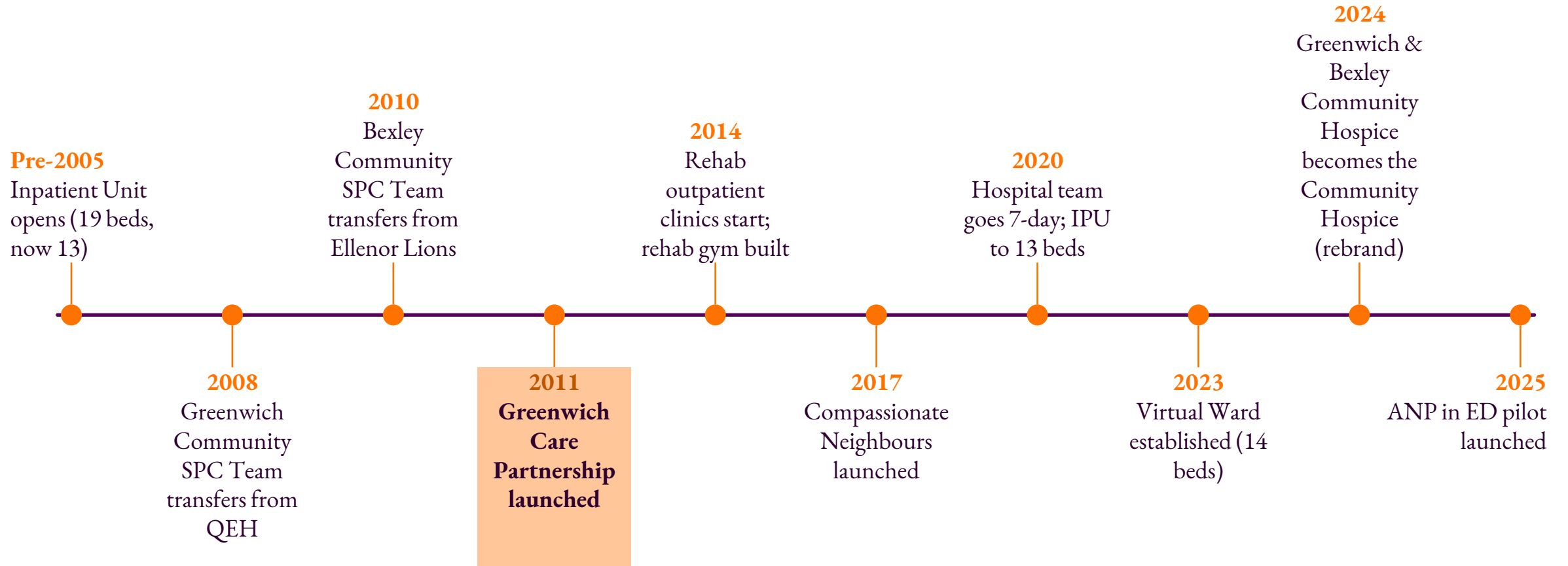
3+2 year

NHS Standard Contract with SEL ICB

Prime contractor

for the Greenwich Care Partnership

How Our Services Developed



Overview of Service Model



	At the Hospice	Community	Hospital (QEH, Woolwich)	Remote	
High Intensity	<p>Inpatient Unit 13 beds · 24/7; symptom management; end-of-life care. 49 HC / 31.7 FTE</p>	<p>GCP: Overnight Rapid Response nursing overnight 1:1 night-sitting (Marie Curie) <i>Greenwich only</i></p>	<p>GCP: CHC Fast Track Coord nurses (GBCH) Package delivery <i>Greenwich only</i> GCP: 21 HC / 12.5 FTE</p>	–	<p>Virtual Ward 14 beds (7 per borough) Daily clinical contact 4 HC / 4.1 FTE</p>
Medium Intensity	<p>MDT Social work; Counselling · Chaplaincy; Consultant medicine. Medical: 16 HC / 4.9 FTE Psych & Social: 4 HC / 3.7 FTE</p>	<p>Community CNS ~700 caseload; 08:00-18:00 core hrs; 24/7 telephone advice 24 HC / 20.5 FTE</p>	<p>Hospital SPC QEH Woolwich · LGT 11 HC / 7.8 FTE</p>	<p>ANP in ED (Pilot) Embedded in ED Dec 25 – Mar 26 Continuation sought</p>	
Low Intensity	<p>Wellbeing & AHPs Physio · OT · Groups Rehab: 5 HC / 4.8 FTE</p> <p>Outpatient Clinics Charitable trust funded; Eltham Community Hospital & the Hospice site.</p>	<p>Compassionate Neighbours 209 volunteers 400+ people supported Com Dev: 5 HC / 3.0 FTE Volunteering: 4 HC / 2.5 FTE</p>	<p>Care Home Support Training & education Specialist advice to staff In-reach support</p>	–	

How Our Services Are Funded



~40% NHS-funded — high relative to sector, reflecting the breadth and integration of our commissioned services

Service	Funder	Funding Model	Key Detail
Community CNS, IPU, Hospital SPC, MDT	NHS SEL ICB	Annual block contract	Core contract — Commissioner Requested Services status
Greenwich Care Partnership	NHS SEL ICB	Annual block contract	GBCH lead; Oxleas + Marie Curie as delivery partners. Greenwich only
Virtual Ward (14 beds)	NHS SEL ICB	Recurrent commissioned	Contingent on national virtual ward programme continuing
ANP in ED Pilot	LGT NHS Trust	Time-limited grant	Dec 2025–Mar 2026; continuation via SELICS funding to further test model
Outpatient Clinics	Charitable trust	2-year grant	Not NHS commissioned; no statutory funding
Compassionate Neighbours	Mixed	Trust grants + fundraising	National programme, local delivery; not in NHS contract

Rows 1–3: NHS Standard Contract (3+2 year) | Rows 4–6: grant-funded or charitable income

Origins of the Greenwich Care Partnership

1 2008–2010 Marie Curie Delivering Choice Programme

A national programme that examined how end-of-life care was being delivered locally — providing the evidence base and catalyst for change across South East London.

2 Review of End-of-Life Care Across SEL

Comprehensive review of all stakeholders involved in delivering end-of-life care — mapping existing services, identifying gaps in provision, and understanding unmet need across the boroughs.

3 Agreed a Local Vision

Stakeholders came together to agree a shared vision for coordinated, patient-centred end-of-life care — with the hospice at its centre, working alongside NHS and voluntary sector partners.

4 Greenwich: The Only Borough to Commission

Of all the SEL boroughs involved in the review, **Greenwich were the only borough to commission the outputs of the report** — translating the vision into a funded, operational service model.

5 2012 GCP Established — Hospice as Prime Contractor

Three organisations commissioned: **Greenwich & Bexley Community Hospice** (prime contractor), **Oxleas NHS Foundation Trust**, and **Marie Curie** — delivering the Greenwich Care Partnership.

Greenwich Care Partnership: Service Components

Four integrated service components commissioned in Greenwich through the GCP partnership model

Palliative Care Coordination Centre (PCCC)



- Delivered by **the Community Hospice**
- Clinical admin team with RN available
- Care coordination — single point of contact
- Arranges CHC Fast Track nursing home placements (brokerage function only)
- Extended hours access
- **2.8 WTE (+ clinical admin)**

Rapid Response



- Delivered by **Oxleas** and **Marie Curie**
- Rapid response nursing out of hours: 18:00–08:00
- 24-hour coverage on weekends & bank holidays

Planned Night Visits



- Delivered by **Marie Curie**
- Overnight care: 22:00–07:00
- HCA providing 1:1 night-sitting support
- Enables patients to remain at home overnight

Hospice at Home



- Delivered by **the Community Hospice**
- CHC Fast Track packages
- Delivered by **hospice HCAs**
- Personal care & symptom support at home
- Delegated authority — no NHS commissioning delay
- **10.0 WTE + bank**



Contract & Funding

- **2024: all contract lines consolidated** — GCP, Greenwich spec and Bexley spec merged into a single contract
- GCP is **nominally fully NHS-funded**, as is hospital activity and anything we have bid for from other funds
- Other elements of care are subsidised by charitable income
- **Risk share:** block contract — margin being eroded by inflation but has generally covered its costs

Managing Demand

- **Peaks and troughs** — some months significantly busier than others; demand is inherently variable
- Managed through a flexible workforce model:
 - Bank staff pool to scale up at peak
 - Part-time staff with flexible hours
 - Rotation of staff with the inpatient unit to manage overall demand across the organisation
- Removes NHS commissioning bottleneck — care in place within 48 hours
- Gives hospice strategic leverage — not just a delivery sub-contractor

What It Means for Patients & the System

~325

CHC FT referrals / year
(3-year average)

0.9 days

avg referral to care starting

~40%

referrals from hospital
(~55% internal / community)

11.7%

of referrals die in hospital
(3-year average)

All figures are 3-year averages (2023/24 – 2025/26) · ~976 total referrals over the period

For the System

- Single referral pathway for palliative care
- ~40% referrals from hospital (SPC team with discharge coordinator); ~55% internal (community / virtual ward)
- Reduces bed-days and avoidable admissions
- Accountability sits with one provider

For Patients & Families

- Care starts within **0.9 days** of referral — many same-day
- **76% achieve preferred place of death** outside hospital
- One team, not multiple agencies
- Seamless transition from hospital to home
- End-of-life support from experienced specialist nurses

How Referrals Flow

Hospital referrals (~40%) come via our **embedded SPC team** at QEH Woolwich and LGT, which includes a discharge coordinator within the team. Internal referrals (~55%) come from our own community CNS caseload, virtual ward, or inpatient unit — patients already known to us who need CHC Fast Track packages arranged.

1 Formal NHS Contract

- 3+2 year NHS Standard Contract with SEL ICB — unusual for the hospice sector
- Four core services hold Commissioner Requested Service (CRS) status, secured during CCG-to-ICB transition
- CRS status means services cannot be decommissioned without formal consultation process
- Contract covers services delivered by partners (Oxleas, Marie Curie) under GBCH as lead contractor

2 Deep System Integration

- Members of local Health & Wellbeing Boards in both boroughs
- Active in system-level silver command: strategic and operational groups
- Invested relationships with elected members and local authority leadership
- Embedded in acute trust pathways — 50% of community referrals originate from hospital teams

3 ~40% NHS-Funded

- Higher than many hospices — reflects scope of commissioned services, not just a standard community grant
- Some services (GCP, hospital) were historically funded at ~100% by NHS; now consolidated under a risk-share arrangement
- Remaining 60% from charitable income, grants, and fundraising — but the NHS share anchors our financial position

What This Model Has Enabled

System-Level Presence

Delivering across the full range of SPC settings gives us **legitimacy to be part of system-level conversations**. Regular contact with key operational, strategic & commissioning colleagues across **ICB, local authority, community trust, acute trust & voluntary sector**.

Where We Sit

- Health & Wellbeing Boards (both boroughs)
- "Home First" strategic & operational groups
- RESPLENDENT (silver command fortnightly)
- Acute trust steering groups

This positions us to access non-recurrent funding to trial new initiatives — **folded into our core contract by variation if successful:**

NHS Winter Funding

Non-recurrent funding secured to bolster capacity over winter pressure periods.

Additional social worker + ANP

SPC OT

Specialist palliative care occupational therapist co-located with the community OT team.

Integrated into community services

ANP in ED Pilot

Advanced Nurse Practitioner embedded in ED — identifying palliative patients at point of admission.

Diverts unnecessary admissions

Virtual Ward

14-bed hospital-at-home model — acute-level monitoring at home (7 per borough).

4 HC / 4.1 FTE

For Further Information



Jon Devlin

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[Connect on LinkedIn](#)

Thank you



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Greenwich & Bexley



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Hospice Rapid Access Service

The Funding Model

Louise Bryan CEO

Havens Hospices

HSJ



**PARTNERSHIP
AWARDS 2025**

#hsjpartnershipawards

PROUD TO BE A WINNER

Best Not for Profit Working
in Partnership with the NHS



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- Initial funding proposal not fit for purpose
- Delivering care without financial risk
- A model where care is never delayed by funding.

**Instead of asking the ICB to solve the problem of
'underfunding' we built them a model to enable them to
deliver *'fair funding'***



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Where does this funding sit within the system?

HRAS contract

- Funds the **service and capacity**
- Enables rapid response
- Covers system-level demand
- Regular structured assessments every four weeks
- Enhanced care - emotional and wellbeing support

CHC Funding

- Funds **individual patient care packages**
- Based on assessed need
- Applied case-by-case

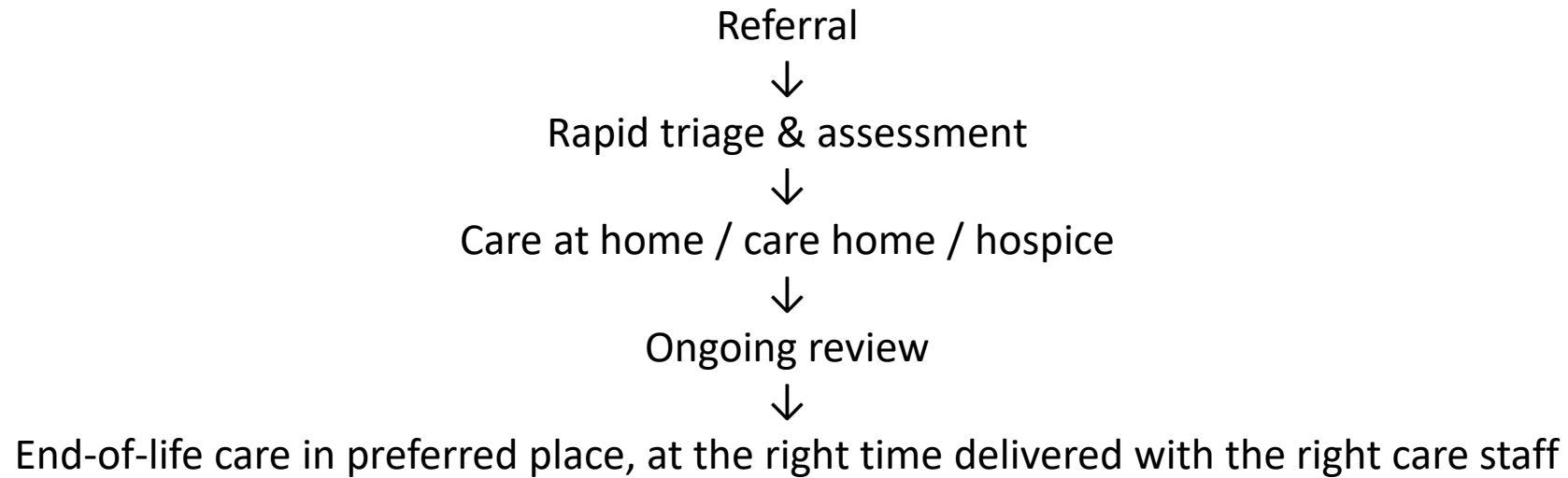
This contract enables care to start immediately



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How does the service work?



A flexible, responsive model = a financial challenge



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What the HRAS Service has delivered (August 2023 – March 2026)

Bed-Based Care activity

- **100,886 patient bed nights delivered**
- *Contract expectation: 42,000 bed nights*
- **140% more than expected**

Domiciliary Care activity

- **742,124 hours of care delivered**
- *Contract expectation: 610,493 hours*
- **22% more than expected**

Service Outcomes

- **75%** referrals responded to within 24 hours
- **80%** preferred place of death achieved
- **£4m** system efficiency achieved



The Starting Point

Commercial Perspective

- significant financial uncertainty sat with the hospices
- activity and demand risk being absorbed through charitable funds

The Environment Has Changed

- Hospices are operating in deficit and using reserves

A charity funding a statutory service from reserves felt wrong



Externally – one single provider

- One clinical lead
- One finance lead
- One reporting structure

Underneath - Three Independent Hospices

- Independent governance
- Separate but identical contracts
- Local delivery
- MOU



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The Risk

The Proposed Funding Model Relied On *Estimates*:

- referral activity
- length of stay
- place of care

These were all outside hospice control

- The indicative dataset was difficult to validate
- Uncertainty around future demand

Risk of Financial Pressure and Service Failure



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Turning Risk into a Solution

Our Approach

- Work with the ICB

What We Did

- Modelled activity at different demand levels
- Demonstrated multiple outcomes

What Made This Possible

- Open and constructive relationships
- Solve the problem together
- Transparency from both sides

Shifting the conversation from *'this is too risky'* to *'this is workable'*



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The Three-Part Funding Model

1 – Fixed Costs

Funded in advance

2 – Expected Variable Costs

Funded in advance - based on estimated activity data provided by ICB

3 – Top-Up Funding

A reconciliation process monthly in arrears

The funding flexes with activity



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Why did we need Part 3

- Demand was uncertain and likely to be underestimated
- Higher activity or longer stays would exceed the proposed funding
- Could force referral restriction

Important Point

Fairness for both parties - also protects the ICB if activity is lower



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Part 3 – The Variable Cost Reconciliation

Actual full cost of services delivered
minus
Advance funding received

Example (FY 25/26)

- Actual bed night delivery **+163%** & Actual domiciliary care hours **+42%**
- Actual cost of services delivered: **£20.5m**
- Less advance funding: **£11.5m**
- Additional funding: **£9m (subject to capped rates)**



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Inflation Protection

Annual Review Process

- Fixed costs annual uplift in line with AfC
- Hospice bed night rate annual uplift in line with AfC
- Domiciliary care staff costs and agency costs reimbursed in full providing they do not exceed the agreed average hourly cost cap
- Domiciliary cap annual uplift in line with NLW increase

Important Protection

- Care home costs are reimbursed at full pass-through cost



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Delivering Efficiency

Capped Rates

- Hospice bed night rate
- Domiciliary care hourly cap
- Care home expected average rate

Financial Impact reported (August 2023- March 2026)

- Full expected cost at agreed capped rates: **£50m**
- Actual hospice full delivery cost: **£46m**
- **£4m system efficiency achieved**



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Reporting Success

Monthly Finance Report

- Requests top-up funding
- Demonstrates activity-driven costs
- Reports against capped rates

Demonstrates Efficiency

- Domiciliary care delivery @£4 per hour below agreed cap
- Care homes: average nightly rate @£6 below expected level

Our Approach

- Designed reporting around what the ICB needs to show upwards
- “Cut-and-paste ready to use” reporting

Make it easy for the system to demonstrate value and success



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The Big Question - Is the HRAS service Fully Funded? – No

Because hospices choose to:

- deliver enhanced care
- provide additional staffing
- support services beyond specification

Hospice costs reflect:

- hospice choice

Some overheads are underfunded:

- system/partner engagement time
- referrals team

For HRAS funding - Don't confuse underfunding with local choices about enhanced care



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Final Thoughts

- This financial model supports care at the right place at the right time which is tailored to the individual, reviewed and adjusted regularly as needs change.
- It supports uncertain activity, fast access, lower system cost and protects hospice finances.

What we did

- Identify and explain the risk
- Model the sensitivities
- Accept what is **'fundable'** and what is **'hospice choice'**
- Design a better funding model
- Offered the ICB a workable **solution** instead of a **problem** and **built a strong commissioner relationship**

Closing Message

- Use your finance team alongside your care leaders to prepare for funding discussions
- Help shape solutions that work for both sides

Instead of asking the ICB to solve the problem of *'underfunding'* build them a model to enable them to deliver *'fair funding'*

Hospice UK National Conference 2026

Scan here for
more details



Liverpool Experience Campus (formerly the ACC), 16 - 18 November 2026

Hospice UK Membership survey

Feed back on Hospice UK as a membership body, and help us review our progress in delivering our strategy.

We want to hear from as many people as possible who work in a Hospice UK member organisation, so please share with your colleagues and trustees.

Survey deadline is 30 June.

Take part
here



Big Conversations

The Big Conversations series comprises webinars, workshops, and roundtables that enable our members to:

- learn more about key issues
- share knowledge and experience to inform our work
- discuss problems and solutions with peers
- get practical guidance to move work forward

Next event:

10th June workshop - Outcome measures: making it work in clinical practice, 11:30 - 13:00

Scan Me



Stay up to date



Scan me

Our [Member Update page](#) is updated regularly so you can keep up with our key work and priorities from week to week.

The page is hidden from the public and will not come up in web searches, so we'd recommend bookmarking it!

Feedback Survey

Please consider sparing a few minutes to answer this survey, so that we can continue to improve future Big Conversation events:

<https://www.surveymonkey.com/r/LY3N38F>



Thank you