Accounting for the Hospice Business Model in England

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Statement of originality

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"I am indebted to my father for living, but to my teacher for living well"

(Alexander the Great for his teacher, philosopher Aristotle)

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Abstract

This thesis evaluates the viability of palliative and end of life care provision by voluntary hospices in England. Literature on voluntary hospices' management and financial feasibility is fragmented and scattered within and across academic and practitioner discourses. It can still however be consolidated to lay the foundations for developing a study that reveals how charitable income streams, donated to underwrite hospices' activity, are significant relative to Government funding.

Using a mixed methods, inductive approach, I construct a *'descriptive business model'* for hospices which is grounded in analysis of relevant accounting information, and supported by narratives extracted from interviews with senior clinical and non clinical managers from four large and medium sized hospices. The study reveals the strengths and weaknesses of the hospice business model and evaluates its robustness against forthcoming challenges.

The thesis findings highlight the gradual transition from a basic voluntary sector business model, to a complex, highly sophisticated, and institutionalized care establishment, which is sharing many of the characteristics found in large private and public organizations. The sustainability however of the business model is threatened due to its exposure to a number of contradictory forces. Whilst demand for palliative and end of life care going forward is set to increase, due to both demographic and regulatory factors, hospices' voluntary income is highly volatile. Dependency on sustaining a complex network of stakeholder groups to underwrite income, challenges the hospice business model's ability to cope with the anticipated challenges.

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Chapter 1: Introduction

1.1 Background

In its modern form, the term hospice is connected with the provision of palliative care to terminally ill patients. The World Health Organization defines palliative care as:

> *"... an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual"*
>
> WHO (2002:15)

Such care, including sufficient symptom relief of the illness and psychological support for both the patients and their families, can be obtained in hospices (Moore and Naierman, 2002). However, caring for terminally ill people is not something new and efforts have been made to trace back the roots of what is currently known as *'The Hospice Movement'*.

In attempting to discover the roots of '*The Hospice movement'* one comes to the conclusion that in the ancient times *'hospice ideology'* appeared to share or be part of the general principles of care and hospitality of each culture. Milicevic (2002) suggests that the roots of the words hospice, hospital and hospitality are the same, dating as far back as the 4th century A.D. and connects this with the ancient Greek word *'xenodochion'*, which is the place where hospitality is provided.

Institutions with attributes similar to the ones of hospitals or hospices were established in ancient Egypt, India and the Islamic caliphates. Egypt, as early as 2500 B.C. had a well organized system of health care and medical education. Indian literature presents Buddha appointing physicians and building hospitals for the poor whilst Hindu physicians were supposed to perform specific tasks related to both the physical and psychological treatment of their patients. Finally, the idea of humane care in special asylums, especially for the mentally ill, appears to be primarily introduced by Islam (Denice& Walter 1996).

A differentiation in care between temporarily and terminally ill patients appeared to exist in ancient Greece. Based on the Hippocratic tradition a doctor was not allowed to treat incurably sick or terminally ill patients since this was considered to be against the will of gods and the laws of nature (Saunders 1993). On the other hand, patients who were not cured by a doctor or a physician could seek care at a temple to Aesculepius, the god of medicine. There, they could spend the night in the temple *'Aesculepiion'* precincts praying to – in their perception communicating with - god, whilst during the day the priests of Aesculepius were interpreting the patients' dreams and providing them with psychological and physical care. Over time these temples became places were medicine was developed, taught and practiced (Altani 2005).

The first clear differentiation between hospices and hospitals appeared in Roman times and later in Byzantium. A hospital was the place where a guest was received and care was provided to temporarily sick, while a hospice was the place for the permanent habitation for poor, infirm, insane and incurable people. During this period hospitals were developed in the periphery of Roman Empire in order to serve the needs of the garrisoned legions while later under the influence of early

Christianity hospitals and hospices developed within the Byzantine Empire in order to serve the travellers, the poor, and the sick (Saunders 1993, Majno 1975).

Providing care to travellers and soldiers appears to be the reason for the development of hospitals and hospices in Europe during the middle ages, while during the Crusades similar institutions were developed along the way of the Crusaders to the Middle East (Denice& Walter 1996). In response to the wide spread of Leprosy in Europe more than 4,000 houses dedicated to Lazarus were developed in France and Germany to provide care for the sick. Hospices also developed along passes to centres of commerce and pilgrimage with those under the order of St. Bernard at alpine passes to be the most well known.

According to material published by the Hospice Information organisation in 2005, the term hospice was first associated with the care of dying patients in the 19th century in France by Madame Jeanne Garnier. Madame Jeanne Garnier founded the Dames de Calvaire in 1842 and opened the first hospice for the care of dying in Lyon in 1843. The Irish Sisters of Charity introduced the term hospice in Dublin by opening Our Lady's Hospice in 1879. St. Luke's Hospital 1893 and St. Joseph's Hospice in Hackney 1905 were the next units established for the care of dying patients.

The modern hospice movement was initiated by the efforts of Dr Cicely Saunders who established St. Christopher's Hospice in London in 1967. The book of Elisabeth Kubler-Ross *'On death and dying'*, in 1969, brought death to public awareness in the USA causing much public reaction and facilitating the spread of hospices in USA. Due to the efforts of Cicely Saunders and others, the hospice movement has spread out all over the world with various forms from country to country, promoting

primarily a philosophy of care rather than a type of building or service (Milicevic, 2002).

In England, following rapid growth throughout the first three decades after the opening of St. Christopher's Hospice, the hospice sector appears to have entered a maturity stage in its life cycle in terms of its service provision capacity, during the early 00's. With more than 70 per cent of the available palliative care units and 80 per cent of the available beds for adult in-patient care being managed by voluntary sector initiatives, the voluntary sector is still at the forefront of the developments in the country's palliative care field. Hence, in addition to the substantial importance hospices have gained within the society, they also constitute a key ingredient to any Government strategy aimed at improving palliative / end of life care in the country (see Palliative Care Funding Review 2011, Department of Health 2009, Hospice Information 2005).

The rapid development of hospice movement both in England and internationally was followed by an expansion of relevant research work (Monroe & Oliviere 2003, Milicevic 2002, Finlay 2001, Sauders 2001, Clark 1998, Denice & Walter 1996, Saunders 1993, Kubler-Ross 1969). This research contributes to our understanding of the work of the hospice movement covering clinical, social, regulatory, historical, and political challenges facing the sector. On the other hand what has not been investigated in adequate depth is the provision of palliative care as a financial activity.

1.2 Scope of the research

With hospices – particularly in England - relying on various types of income to finance their service provision and expenditure requirements, the question of how to

sustain or even expand voluntary hospices' palliative / end of life care provision in the future remains open (Palliative Care Funding Review 2011, Help the Hospices 2009, Help the Hospices 2001). In the United States, attempts have been made to evaluate hospice movement from an economic perspective. This research, however, did not cover the activity as a whole system or business model and is focused, instead, on cost efficiency issues (Torrens 1985, Brooks 1983, Carney 1981, Bloom & Kissick 1980).

On the other hand, considering the current level of development of hospice movement internationally, as well as, the size and importance for the social wellbeing and Government planning, of the voluntary hospice sector in England, appropriate research by accounting, business, and management academics can be insightful. Internal complexities, discussed within the next sections of this thesis, in conjunction with environmental and demographic pressures facing the sector, also demonstrate a challenge for academics to extend the boundaries of accounting and management literature. This can be achieved through broader analysis of both internal and external factors affecting the sustainability of the voluntary hospices' *'business model'.* Analysis of this kind can also lead to applicable results, through contributing to our knowledge and understanding of the hardships related to managing this particular type of not-for profit organisation.

In this thesis, I employ a middle range, inductive research approach, to evaluate the sustainability of palliative / end of life care provision by voluntary hospices in England and extend the application of accounting business models theory (see Haslam et al 2014, Haslam, et al. 2013, Andersson and Haslam 2012, and Andersson et al. 2010) within the boundaries of voluntary sector organisations. Hence, this thesis contributes to filling a gap on academic theory on both the fields of palliative /

end of life care provision management, as well as, applying a recently developed accounting business models framework of analysis.

1.3 Thesis outline

1.3.1 Chapter 2: The landscape of palliative / end of life care provision by voluntary hospices in England

This chapter is setting the social, clinical, historical, economic, and regulatory context within which voluntary hospices in England develop and operate. To meet its objectives the chapter is organised into three themes. The first theme introduces the concepts and causes of palliative care development that led to the foundation of the modern hospice movement through the work of Dr Cicely Saunders and the establishment of St. Christopher's Hospice. The second theme focuses on the development of the voluntary hospice movement in UK and its role in shaping the palliative care landscape of the country. Finally, the third theme addresses regulatory, governance, and reporting issues, as well as recent developments in Government planning and objectives on end of life care.

1.3.2 Chapter 3: Accounting for Business Models

This chapter helps to inform the thesis' problem definition and provide the theoretical grounding of the research. Literature on business models, which is largely grounded in economics and business strategy, addresses essentially issues relevant to profit generating organisations. In this thesis, I draw upon the work on business models grounded in accounting and the influence of stakeholder relations and stakeholder theory. This opens up the scope for applying a business models investigative framework that combines narratives and numbers as a means to investigate how the 'hospice business model' has evolved and adapted through

interaction with key stakeholders, as well as, how this interaction impacts upon its financial viability and risk.

1.3.3 Chapter 4: Research methodology

This chapter centres on a discussion of the philosophical framework for scientific enquiry considering the paradigms and methods used in social sciences and business and management research. Further on, the discussion focusses the nature of accounting research and theory development in order to identify and evaluate the alternative approaches that could be adopted for the accomplishment of this thesis' objectives. The above consequently lead to the justification of the suitability of a middle range, inductive approach that outlines the structure of the study. Following from that, the discussion focuses on the detailed presentation and application of the methods adopted for the completion of the project.

1.3.4 Chapters 5 and 6: Qualitative Analysis

The analysis of qualitative data aims to enhance our understanding of the voluntary hospices business model and issues relevant to its sustainability. Narratives extracted from interviews with 18 senior clinical and non-clinical managers from four large and medium sized hospices are used to gain further awareness on the following:

- The role of various departments within hospice which allows to evaluate the complexity of their activities.
- The evolution of the hospice movement in England as viewed by key professionals within the sector
- Identify forthcoming challenges for the sector and the case study hospices

- Insight on courses of action taken, planned, or suggested in order to effectively deal with these challenges at both national and locality level

1.3.5 Chapter 7: The Hospice Business Model: Financials and Sustainability

This chapter provides an analysis of relevant financial information focusing on the top 35 hospices in England, as ranked by their total income. Specific attention is paid on the nature of the hospice business model from a financial perspective, whilst accounting for its sustainability in the face of the forthcoming challenges identified in the previous two chapters. The hospice business model has evolved over a period of time and is now more complex than it once was in terms of the stakeholder relations needed to maintain its provision of high quality palliative / end of life care. The argument in this chapter is that the hospice business models' financial viability is challenged because of its increasing complexity and how it has drifted towards new forms of income and activity mix with its stakeholders.

1.3.6 Chapter 8: Conclusions

This chapter summarizes the main points developed within this thesis and highlights its contribution to academic literature on the field of palliative / end of life care provision management, and on the recently developed accounting approach to business models theory. Eventually, the chapter concludes by presenting a number of questions for future research that have occurred in its course.

Chapter 2: The landscape of palliative / end of life care provision by voluntary hospices in England

2.1 Introduction

This chapter sets out the social, clinical, historical, economic, and regulatory context within which voluntary hospices in England have developed and operate. This facilitates identification of the strengths and weaknesses of the hospice business model and contributes to the evaluation of its robustness in the face of foreseeable challenges.

To meet the above objectives this chapter is organised in three key themes:

1. The first part relies mainly on secondary sources (see Sauders et al. 2007) of medical, nursing, social, and historical, literature to introduce the concepts and causes of palliative and end of life care development that led to the foundation of the modern hospice movement through the work of Dr Cicely Saunders and the establishment of St. Christopher's Hospice.

2. The second part focuses on the development of voluntary hospice movement in UK and its role in shaping the palliative care landscape of the country. Issues relevant to the productionist approach to business modelling (see Andersson et al. 2010 and Andersson and Haslam et al. 2012) core aspects, purpose, strategies, infrastructure, organizational structures, operational processes, and policies are identified and revealed to provide an insight and shape the foundation of constructing the voluntary hospices business model. Both primary and secondary sources of literature (see Sauders et al. 2007) are employed in a balanced manner to meet the above objective.

3. The balance in sources of literature changes in the third part of this chapter where further reliance on primary sources of literature i.e. Government or regulatory bodies, and umbrella organizations' publications, relevant population statistics, etc. are required in order to explore the environment within which hospices operate. This part addresses regulatory, governance, and reporting issues, as well as recent developments in Government planning and objectives on end of life care. There is also a shift of focus from UK to England as the study moves towards the main objective of evaluating the business model of English voluntary hospices.

2.2 The early stages of the hospice movement in England: Cicely Saunders and the establishment of St. Christopher's Hospice

Cicely Saunders, born in 1918, is at the forefront of the British and the international development of the modern hospice movement. *"In relation to the evolution of hospice and palliative care, Cicely Saunders was without question the initial charismatic influence"* Twycross (2006:2). It was her vision, ideas, effort and persistence that shaped the principles of the palliative care provision to terminally ill cancer patients both in the UK and internationally (Milicevic, 2002, Sauders 2001, Clark 1998, Denice& Walter 1996, Torrens 1985). Studying her work, motivations, and reasons for establishing St. Christopher's and shaping the principles of palliative care, is a prerequisite to the understanding of how the hospice sector has been developed, both at a medical and governance level.

In 1941 Cicely Saunders began her training as a ward nurse at St. Thomas's hospital caring for war wounded soldiers and later, after completing her degree in Oxford she became a medical social worker (Saunders 1996). Through her experience as a nurse

and social worker she came in close contact with cancer patients, their families and their feeling of devastation due to unrelieved pain in the terminal stages of the disease. *"…in many ways it was the years as Medical Social Worker (or Lady Almoner) from 1947-1951 that helped me to see patients as part of a whole family network, best known as individuals in their own home setting"* Saunders (1999:2).

Her vision for a special home for the terminally ill started to take shape as she was caring for David Tasma in 1948. Tasma's words *"I will be a window in your Home", "I want what is in your mind and in your heart"* and small donation of £500, have been quoted numerous times by both Cicely Saunders and others. Apart from their historic importance those phrases have also been used to indicate the need for adopting a new –for that time - holistic approach to care, which aimed to transform the clinical management of patients suffering pain from advanced cancer (see Twycross 2006, Seymour et al. 2005, Saunders 2000, Clark 1998).

However*, "it took 19 years to build St. Christopher's Hospice around David Tasma's window"* (Saunders 2000:9). Nineteen years that Cicely Saunders devoted to: her own development as a professional, research on pain control, and networking with religious, social, and professional parties in order to develop rapport, increase awareness, establish methodologies, secure funding and built *"…a movement founded on the Judean-Christian ethic, which has shown it can flourish in different cultures…"* (Saunders 2000:8).

Clark 1998 identified three key elements on Cicely Saunders's strategy to promote her ideas and materialise her vision on the establishment of St. Christopher's Hospice and the further development of hospice movement.

> *"First there is an element of personal calling, underpinned by a powerful religious commitment, which provides a motivating force for the work. Second, this is coupled to a concern to promote professional development in the care of dying people, drawing on her experience as nurse, almoner and physician. Third, there are the social networks which are exploited to establish and maintain support for the project, access to which is smoothed by a background in the English upper middle classes."*

(Clark 1998:46)

As part of her professional development and following the advice of surgeon Norman Barrett, Cicely Saunders decided to study medicine when she was 33 years old. At the same time she continued her voluntary work at St. Luke's Home for the Dying Poor. After qualifying as a doctor she took on a clinical research fellowship in St. Joseph's Hospice where she had the opportunity to develop her methodology on symptom relief and pain control using adequate and regular doses of drugs and psychological support to the patient (Clark 1998, Saunders 2000).

> *"The 7 years work there enabled me to lay the foundations of palliative care and raise the money to built St. Christopher's hospice, the first modern research and teaching hospice."*

(Saunders 2000:9)

Publishing her ideas and research findings – around thirty publications between 1958 and 1967 - soon became a major part of her efforts to raise awareness and establish her approach/philosophy on the care of dying within the medical establishment in

Britain and abroad. Following the publishing of her ideas, a series of international lectures broaden the influence of her views and brought her in touch with a wide audience of potential supporters. These facilitated the development of her network of contacts which helped her to access and get the support of key individuals, such as Elizabeth Kubler-Ross who became a leading figure within the American hospice movement and Lord Thurlow who became the first chairman of St. Christopher's Hospice (Clark 2006, Clark 1998).

The first proposal to care for dying patients in a special home was presented to a small circle of like-minded people in 1959. Called *"The Scheme"* a document of 10 pages was presenting Cicely Saunders's ideas and a detailed plan for the development of the home, which, later that year, was named St. Christopher's Hospice. A detailed description of the hospice's facilities, the staffing requirements, the estimated costs and the relationship with the National Health Service (NHS) were all anticipated. By 1960 a group of supporters including Peggy Nuttall, the editor of the *Nursing Times,* Sir Kenneth Grubb, President of the Church Missionary Society, the Bishop of Stepney and others, reinforced support to the development of the hospice movement (Clark 2005, Clark 1998).

Having adopted a charitable status for the new hospice, fundraising became an issue where attention had to be paid to both build St. Christopher's Hospice and maintain the provision of services afterwards. Following a continued programme of grant applications and media appeals, St. Christopher's Hospice attracted the support of major charitable bodies, including the King Edward's Hospital Fund; the City Parochial Foundation; the Nuffield Foundation; the Wolfson Foundation, as well as

the support of individual donors both within and outside the UK (see Clark 2006, The Wolfson Foundation 2005, Clark 1998).

Starting with a building for 54 patients, a 16-bed residential wing for the elderly, a nursery for staff children, a planned bereavement service, and the initiation of home care two years after its opening; St. Christopher's Hospice opened in the summer of 1967. Since its opening it became the benchmark for the development of independent palliative care units and facilitated the expansion of the hospice movement both in the UK and internationally (Sauders 2001).

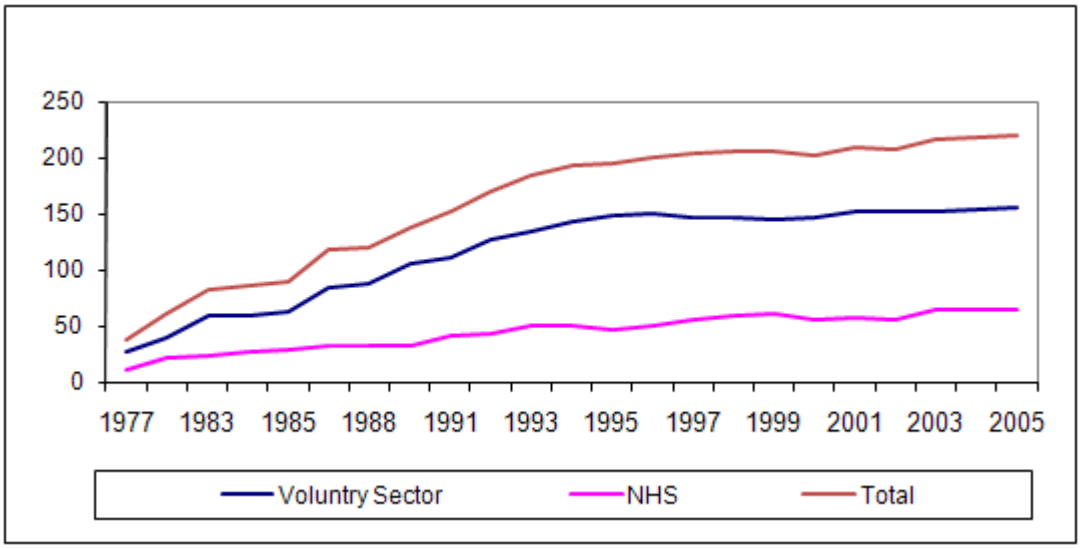
2.3 The development of the hospice voluntary sector in UK

Since the opening of St. Christopher's Hospice the hospice movement more generally experienced rapid growth within Britain. The voluntary sector is still at the forefront of the developments in the country's palliative care field both at a service and research level. More than 70 per cent of the available palliative care units are managed by voluntary sector initiatives, providing around 80 per cent of the available beds for adult in-patient care. The great majority of these hospices are independent, local charities, but large charities like Marie Curie Cancer Care and Sue Ryder as well as the NHS also provide palliative care services (Hospice Information 2005).

Figures 2.1 and 2.2 below demonstrate the growth in palliative care services provision capacity in the form of units – palliative care settings – and beds from late 70s to 2005. They also demonstrate that the hospice sector appeared to enter a maturity stage of its life cycle - as the term maturity is explained by Bender and Ward (2009) - in terms of its service provision capacity, during the early 00's. More

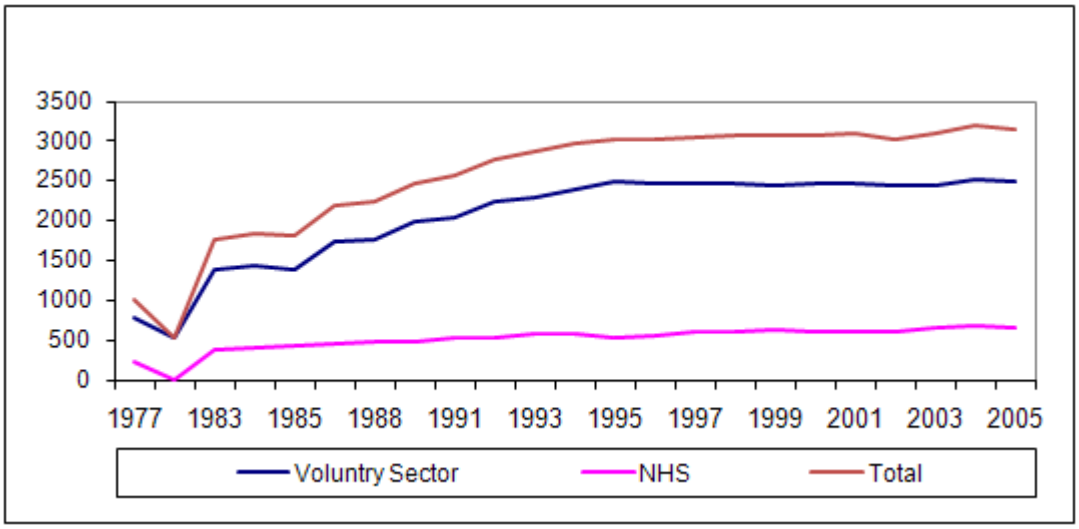
detailed information on service provision for the years up to 2010 is provided on section 2.3.2.

Figure 2.1: Palliative care units for adults in the UK 1977 - 2005



Source: Data found through the Hospice Information centre during 2008

Figure 2.2: Palliative care beds for adults in the UK 1977 – 2005



Source: Data found through the Hospice Information centre during 2008

Even though the development of hospice movement was initiated in the UK by the voluntary sector there is now a closer cooperation with the NHS which manages about 29 percent of in-patient hospices (Palliative Care Funding Review 2011,

Department of Health 2009, and Hospice Information 2005). Cooperation with the National Health Service, through contractual arrangements, had been anticipated by Cicely Saunders even before the opening of St. Christopher's hospice (Clark 1998). In 1987 palliative care was recognized as a service that the state was responsible to provide. However, Government funding has not always reflected this change in terms of the service's status (Help the Hospices 2001).

The vast majority of hospices are independent, *service delivery* voluntary organizations (Handy 1992), governed by trustees and regulated by The Charity Commission. Hence, palliative care services in England are mainly funded through charitable activities and fundraising, with the Government covering, just around one third of the voluntary hospices' expenditure (see table 2.1). However, as palliative care providers, they also have to comply with the relevant Health and Social Care Standards (Palliative Care Funding Review 2011, Help the Hospices 2009, Department of Helath 2002, Care Standards Act 2000).

Table 2.1: Sources of income as a percentage of income in each year for all hospices

	Donations	Legacies	Trading profit	Investment income	Government funding	Dept of Health capital funding	Opportunity & community funds	Sundry
2002	32	23	13	4	25	0	1	2
2003	31	22	14	4	27	0	0	2
2004	30	22	13	3	29	0	1	2
2005	29	22	12	4	30	0	1	3
2006	31	22	11	4	29	0	1	2
2007	33	21	11	4	29	0	0	2
2008	32	21	10	4	27	4	0	2

Source: Help the Hospices 2009 and 2006

Charitable status allowed hospices to develop independently and organize their services based on the needs of the local communities within which they operate.

Though, reliance on non-statutory sources and lack of central planning in terms of need for palliative care resulted to an ad hoc development of services, depending mainly on the vision of the founders. Hence emphasis was initially placed on the care of adult cancer patients (Finlay 2001).

Help the Hospices (2006a) grouped hospices into four bands based on the size of their annual expenditure. Size and expenditure (availability of funds) directly influence hospices' service provision capacity. An example of the level of influence of funding lever is the fact that 87 per cent of the hospices in the lower band do not provide in-patient care and focus mainly on day and/or home care. In 2009 this grouping was adjusted to better reflect the current picture of the sector (Help the Hospices, 2009). This thesis employs this 2006 classification in conjunction with information on each hospices income for sampling purposes as the 2009 changes did not have a material impact on the sample selection.

Table 2.2: Classification of hospices based on size of annual expenditure

	Number of hospices	Percentage of total expenditure	Average expenditure million (£)
Hospices with expenditure more than £4m	23	47	5.8
Hospices with expenditure £3m to £4m	16	20	3.5
Hospices with expenditure £2m to £3m	24	20	2.2
Hospices with expenditure £1m to £2m	18	10	1.6
Hospices with expenditure less than £1m	19	3	0.5

Source: Help the Hospices 2009 and 2006

With regards to service provision, 40 years after the opening of St. Christopher's Hospice, the voluntary hospice sector appears to enter a phase of maturity in terms of developing its clinical role as palliative care provider. The initial focus on providing terminal care to cancer patients has progressively shifted to a more holistic model

adjusting to both domestic and international developments. The current approach anticipates a need to provide palliative care to diverse patient groups and considers diagnosis as the starting point of palliative care provision recognizing a complementary role for palliative care compared to the role of curative treatment (Hospice Information 2005, Finlay 2001, Saunders 2001).

The role of the patient's family and their specific needs also attract more attention and services to support the family both before the death and during the grief period. Additionally, social aspects related to palliative care provision by multidisciplinary teams of carers have been raised and the related research on various approaches of palliative care and end of life care grows continuously (Payne 2006, The National Council for Palliative Care (NCPC) 2006, Seymour et al. 2005, Hospice Information 2005, Addington – Hall et al. 2004, Monroe & Oliviere 2003, Twycross 2006, World Health Organization 2002, Finlay 2001, Saunders 2001, National Council for Hospice and Specialist Palliative Care Services 2000, O'Neill & Fallon 1997, Higginson 1993, Saunders 1993).

2.3.1 Main types of services provided by voluntary hospices

Palliative and end of life care services, provided by voluntary hospices mainly lay within one of the following categories in-patient care, community care, day care, bereavement, and outpatients (see NCPC 2011, NCPC 2006, and Hospice Information 2005). Even though these categories provide a framework which facilitates broad understanding of the service type, when looking at individual hospices one finds diversity in meanings, definitions, processes, capacity, and length of service provision. However, this grouping is necessary to address the

"productionist" (Andersson et al. 2010) aspect of the hospice business model and lay the groundwork for the work developed in chapters four and five.

2.3.2 Inpatient care

Following to a patient's admission inpatient units provide, assessment, symptom management and control, respite and end of life care (Help the Hospices 2006b). The period of care provision varies based on both the patient's condition and illness, as well as on each hospice's capacity (Oliver & Webb 2000, Hicks & Corcoran 1993). Many patients are admitted for short periods of time, in order to deal with a specific problem, until they will be able to return to their home again following their assessment and treatment.

NCPC (2011) recorded 35,333 cases and estimated that during 2009-10 a total of 51,900 patients received inpatient treatment within a palliative care setting. Their average length of stay has been 13.3 days but it is also noted that this varies considerably depending on the patient's condition and the hospice's capacity. Tables 2.3 and 2.4 show the recorded cases of inpatients classified by disease and the percentage increase in admissions from 2008 to 2010.

Table 2.3: Diagnoses of inpatients with a primary diagnosis of cancer

	2009/10		Percentage change from 2008/9	
	New	All	New	All
Lip/Oral/Pharynx	632	738	4	2
Digestive	7,905	9,049	8	9
Respiratory	5,604	6,403	9	10
Breast	2,591	3,179	8	10
Female Genital	1,787	2,124	8	9
Male Genital	1,882	2,204	9	6
Urinary	1,570	1,903	-7	-7
Eye/Brain/Other CNS	919	1,127	7	7
Lymphoid	1,052	1,251	-2	-3
Other (Specified)	1,686	1,917	7	6
Multiple	115	147	-9	-6
Other (non well defined)	1,514	1,918	13	24
Total	**27,257**	**31,960**	**7**	**8**

Source: NCPC (2011)

Table 2.4: Diagnoses of inpatients with a primary diagnosis other than cancer

	2009/10		Percentage change from 2008/9	
	New	All	New	All
HIV / AIDS	11	13	120	117
Motor Neuron	330	465	6	9
Other Neurological	282	484	2	3
Dementia inc. Alzheimer's	112	123	90	71
Heart Failure	239	276	-4	-7
Other Heart Circulatory	277	325	28	30
Chronic Respiratory	497	617	22	30
Chronic Renal	154	173	26	24
All Other Conditions	722	897	-9	-4
Total	**2,624**	**3,373**	**8**	**10**

Source: NCPC (2011)

It is interesting to note the increase from 2008 to 2010 in the number of patients receiving inpatient care by 8% whilst the average length of stay has remained in similar levels 13.8 days during 2008 and 13.3 days in 2010. Additionally, the number of non-cancer patients receiving inpatient care compared to previews years has almost doubled from 5 percent in 2004 to 9.5 percent in 2010 (see NCPC 2011 and Hospice Information 2005). This demonstrates an increasing demand for non-cancer care services which is expected to impact on the cost structure of the business model.

Changes can also be seen on the age profile of inpatients, table 2.5, with the number of patients between 65 to 84 years old increasing from 58% of all cases to 63%. As presented in further depth in a following section, this fact, in conjunction with the ageing population and relevant cancer occurrence statistics, can stretch further the resources of voluntary hospices. This is expected because more people will be within the age group with the highest rate of cancer occurrence hence increasing the demand for palliative care services.

Table 2.5: Age profile of patients receiving inpatient care at 2004 and 2010

Age group	2004	2010
Below 65 years old	33%	36%
Between 65 nad 84 years old	58%	63%
Above 84 years old	9%	1%

Sources: NCPC (2011) and Hospice Information (2005)

2.3.3 Community care

Community palliative care often known as *"hospice at home"* was initiated by St. Christopher's Hospice in 1969. Macmillan Cancer Relief contributed substantially to the development of specialist nursing teams since 1979 through providing funding for the first three years of operation of those teams, the responsibility of subsequent funding lies on the NHS, or, on an independent hospice which is usually responsible for the management and provision of the service from the beginning (Hospice Information 2005).

A large spectrum of care services is covered under the term community care (see NCPC 2011, NCPC 2006, and Hospice Information 2005). NCPC 2011 attempted to categorize these services mainly distinguishing between predominantly advisory services and other types of more sustained care provided in the patient's home. Three

broad categories have been identified, home care, hospice at home, and the combined service.

Home care is seen as a community service based in the patient's home with input from a clinical nurse specialist. Hospice at home refers to provision of community care services based in the patient's home with no input from a clinical nurse specialist. However, it should be noted that the above distinction is arbitrary as there are currently no agreed definitions for either hospice at home or home care. Both services differ widely across hospices in both purpose as well as staffing and delivery mode. Finally, the combined service incorporates elements of both hospice at home and home care elements. The average length of care per patient varies across the three broad service categories. During 2009 -2010 for home care it was 119 days, for hospice at home 61 days, and for the combined service 102 days (see NCPC 2011).

Palliative care service at home is provided in a variety of forms, the hospice community team provides support and advice to the patient's GP and district nurse, who are responsible for managing patients in their own homes or in care homes within the community. Additionally, emotional and practical support is provided to patients and carers (Help the Hospices 2006b). To anticipate the levels of need, community care is organized in a variety of ways including rapid response teams, which offer a high level of specialist support, as well as teams providing less intensive ongoing support to patients (Hospice Information 2005).

Table 2.6 below presents a patient profile based on age and diagnosis using information from the Minimum Data Set (MDS) reports published by the NCPC in 2011 and 2006. Similarly to the case of inpatient care above, there is a considerable increase, as a percentage of recorded cases, in non cancer patients receiving various

forms of community care services. Their number increased from 6 percent of all patients in 2005 to 12 percent in 2010. Contrary to the case of inpatient care service provision, no major changes appear to the age profile of patients receiving community care services during these years apart from a small increase in favour of the oldest group.

Table 2.6: Classification by age and diagnosis of patients receiving community care in 2005 and 2010

		2005	2010
Total number of recorded patients		108,182	112,749
Age group	Below 65 years old	31%	30%
	Between 65 and 84 years old	57%	56%
	Above 84 years old	12%	14%
Diagnosis	Cancer	94%	88%
	Non-cancer	6%	12%

Source: Data found through NCPC 2011 and NCPC 2006

2.3.4 Day care

With a continuously evolving role within hospice services day care enables patients to continue living at home while having access to hospice and palliative care facilities. This involves a wide range of multidisciplinary teams of carers and volunteers and a variety of services are provided. Day care may include the provision of medical and nursing care, emotional, psychological and spiritual support, physiotherapy, occupational therapy, art and music therapies, complementary therapies, peer support, hairdressing, chiropody and beauty treatments, as well as a variety of creative and social activities (Andersson et al. 2009, Help the Hospices 2006b, Hospice Information 2005).

The first day care unit was developed at St. Luke's Hospice in Sheffield in 1975, followed by the Macmillan Continuing Care Unit, Christchurch in 1980. St. Christopher's Hospice and Dorothy House Foundation (now Dorothy House Hospice

Care) in Bath were offering informal day care facilities since 1974 and 1979 respectively (Help the Hospices 2005). During 2010 it was estimated that 22,012 cases of patients received day care services from 149 palliative care settings based on the 2010 MDS report of the NCPC.

Palliative day care, as a service with a multidisciplinary approach, transgresses the boundaries of health and social care providing a range of services and activities Andersson et al. (2009). A number of qualitative studies suggest that there is evidence of increased satisfaction amongst patients in palliative care settings receiving day care services (see Davies and Higginson 2005). It has also been found that patients appreciate the social support and the opportunity to be involved in the activities provided within a day care program. On the other hand, there is still no clear evidence that palliative day care advances symptom control or health-related quality of life (see Andersson et al. 2009 and Norman 2009).

Table 2.7 shows a patient profile based on age and diagnosis using information from the MDS reports published by the NCPC in 2011 and 2006. Similarly to both the cases of inpatient and community care, there is a considerable increase, in non cancer patients receiving various forms of day care services. Their number increased from 9 percent of all patients in 2005 to 16 percent in 2010. Similarly to community care but contrary to the inpatient care, no major changes appear on the age profile of patients receiving community care services during these years apart from a small increase in favour of the oldest group.

Table 2.7: Classification by age and diagnosis of patients receiving day care in 2005 and 2010

		2005	2010
Total number of recorded patients		25,479 in 182 settings	22,012 in 149 settings
Age group	Below 65 years old	35%	35%
	Between 65 and 84 years old	56%	55%
	Above 84 years old	9%	10%
Diagnosis	Cancer	91%	84%
	Non-cancer	9%	16%

Source: Data found through NCPC 2011 and NCPC 2006

2.3.5 Bereavement services

Bereavement is a service provided to a patient's family and/or carers following to the patient's death. Based on the assumption that coping abilities are challenged by a relative's loss through death, bereavement aims to facilitate post death adaptation and reduce complicated grief reactions (Field et al. 2004). This gives rise to a wide range of needs, practical, financial, social, and spiritual, where bereavement support can take the form of written information and advice, telephone support, spiritual and memorial services, one-to-one support, support groups, or even psychiatric treatment for people with complicated grief reactions (Help the Hospices 2006b, NCPC 2006, Hospice Information 2005, Field et al. 2004, Rolls & Payne 2003).

In England, bereavement has been traditionally considered as a private issue. It has been usually dealt with by individuals and their close friends and family members. However, societal changes such as smaller family sizes, and better geographical mobility, have reduced the availability of social support and the motivation of people to confide in close family and friends. Faith and self-help groups as well as national charities such as the Cruse Bereavement Care have historically been the main providers of formal bereavement support Field et al. (2007).

With the exception of psychiatric treatment for individuals with complicated grief reactions, UK health care services have provided limited contribution to bereavement support. On the other hand the hospice movement has recognized the ongoing needs of bereaved relatives since the late 1960s. Most English hospices consider the provision of bereavement support as an integral part of their services. However, there is still very limited consensus on the nature of the services that should be provided and on how they should be allocated or delivered (see Field et al. 2007, Department of Health 2005, Birtwistle et al. 2002).

The combination of the wide range of bereavement related needs with the extended range of service provision capacity among hospices, increased the diversity of services, considered as bereavement related, by different providers. In their survey on the provision of bereavement to adults, by specialist palliative care providers, Field et al. (2004) attempt to standardize the types of services considered as bereavement by asking service providers to report what services they offered from a range of specified activities as well as to disclose information on paid and voluntary staff involvement levels (see table 2.8).

Table 2.8: Bereavement service activities and the involvement of paid and voluntary staff

Service activity	Number of responding services		Involvement of paid staff only		Involvement of voluntary staff only		Involvement of both paid and voluntary staff	
	Number	(%)	Number	(%)	Number	(%)	Number	(%)
One to one support	237	96	82	33	13	5	132	53
Telephone support	223	90	115	46	15	6	95	38
Referral on to other agencies	220	89	163	66	4	2	35	14
Memorial, remembrance or anniversary service	178	72	51	21	6	2	132	53
Written information and advice	181	73	138	56	5	2	43	17
Support group	151	61	42	17	6	2	103	42
Drop in support	107	43	63	25	9	4	36	15
total number of responding services = 248 out of 280, all percentages have been rounded								

Source: Field et al. (2004:572)

For similar reasons NCPC (2006:30) defined a bereavement client *'as one who receives face to face contact after the death of a patient'* for its MDS report. However, the 2011 MDS report appears to adopt a wider approach providing a broader definition of bereavement. Table 2.9 NCPC (2011) shows the contacts for bereavement support that took place during 2009 and 2010 in 131 palliative care settings, as well as the percentage change by type of service. It is noted that complex counselling numbers decreased and that there has been a shift from group to individual support. The number of telephone contacts on the other hand has increased. Overall it appears that estimating accurately the level and type of bereavement services provision is challenging, despite the efforts made up to now to account for these services.

Table 2.9: Contacts in bereavement support 2009 and 2010

	2009	2010	Change	
Phone calls under 10 minutes	25,802	30,216	4,414	17%
Phone calls over 10 minutes	25,590	27,119	1,529	6%
Face to Face Group Not Facilitated	3,769	5,439	1,670	44%
Face to Face Group Facilitated	23,643	19,039	-4,604	-19%
Face to Face Individual Support	32,096	39,253	7,139	22%
Face to Face Individual Counseling	28,176	39,116	10,940	39%
Face to Face Complex	988	313	-675	-68%
Other	7,119	13,115	5,996	84%

Source: NCPC 2011

2.3.6 Outpatient services

Outpatient care is considered any care service provided to patients who are not admitted to a hospice. It can include a wide array of care services ranging from provision of care to medical outpatients, to provision of care to complementary therapy outpatients. This type of care can be provided in a clinic, in the patient's home, in a hospice's outpatient department or in a hospital. An outpatient clinic can

be held occasionally or regularly and it can be attended by one or more patients (NCPC 2011, NCPC 2006, and Hospice Information 2005).

Table 2.10 presents a patient profile based on age and diagnosis using information from the MDS reports published by the NCPC in 2011 and 2006. Compared to any other service outpatient clinics have continuously the highest percentage of patients with diagnoses other than cancer and the dominant age group changes from those between 65 to 84 years old to those below 65 years old. Similarly to all other cases, there is a considerable increase, as a percentage of recorded cases, in non cancer patients receiving various forms of outpatient services. Their number increased from 14 percent of all patients in 2005 to 25 percent in 2010.

Table 2.10: Age and diagnosis classification of outpatients in 2005 and 2010

		2005	2010
Total number of recorded patients		33,137	37,453
Age group	Below 65 years old	49%	49%
	Between 65 and 84 years old	47%	44%
	Above 84 years old	4%	7%
Diagnosis	Cancer	86%	75%
	Non-cancer	14%	25%

Source: Data found through NCPC 2011 and NCPC 2006

2.3.7 Palliative care provision to non-cancer patients

For many years after the opening of St. Christopher's hospice, emphasis was mainly given in palliative care provision to cancer patients (Finlay 2001, Saunders 2001, Franks et al. 2000). The Calman – Hine report, published in 1995, attempted to set out a policy framework for the commissioning of cancer services, highlighting the need for planning in order to direct resources in areas of greatest need. Although the report focused on services for cancer patients, the subsequent Government executive letter stated that its principals apply equally to those for patients with other life-

threatening conditions, including AIDS, neurological conditions, cardiac and respiratory failure.

The significant contribution voluntary hospices make to end of life care and increased choice for patients either in the form of inpatient care or through the hospice at home network is recognized in the Government's End of Life Care Strategy of 2008. Provision of care for a wider range of patient diseases is also stated as an issue to be addressed in the coming years.

> *"In July 2008, following consultation over two years, the Department of Health published its End of Life Care Strategy (the Strategy) which aims to improve the provision of care for all adults approaching the end of their life, including support for their families and carers. The Strategy centres on: Developing specialist palliative care outreach services by encouraging PCTs and hospices to work together to provide appropriate support to all adults in the community, regardless of their condition."*
>
> (National Audit Office 2008:5)

Franks et al. (2000) attempting to assess the general level of need for palliative care in the United Kingdom, suggested that the level of palliative care provision to non cancer patients appears to be insufficient compared both to the demand for palliative care services of that kind, as well as to the level of palliative care provision to cancer patients. Oliver & Webb (2000) as well as Hicks & Corcoran (1993) found that respite and palliative care provision to patients with neurological diseases, such as the motor neuron disease (MND), in hospices is variable.

Despite the fact that specialist palliative care services have been involved in the care of patients with MND since the opening of St. Christopher's Hospice, the specific needs of this patient group in terms of type and duration of care do not appear to be anticipated. As with palliative care for children – which is addressed in detail on the next section, MND patients would benefit mostly from long term provision of palliative care services instead of being provided with just terminal care (Hicks & Corcoran 1993). However, only a minority of hospices appeared to be closely involved in patient care from early stages in the disease process (Oliver & Webb 2000), whereas some institutions appeared to be concerned about accepting patients who may need long term care (Hicks & Corcoran 1993).

The discussion about provision of palliative care to patients suffering from acquired immunodeficiency syndrome (AIDS) has attracted increasing attention over the last two decades. Saunders (2001) pointed out that the focus on cancer treatment delayed the development of hospice services provision to other areas of need, specifically mentioning AIDS as a case in point. However, the requirement to balance between need, available skills and available resources was considered, by Saunders, as a key issue in any further development. Higginson (1993) found that the development of AIDS-specific services was considered uneconomical and referrals were encouraged to existing hospice services. On the other hand, the stigma of AIDS, the high anxiety levels due to lack of effective treatment and insufficient symptom control, as well as homophobic stances had all been proposed as reasons for the development of AIDS specific services (Schofferman 1987). The introduction of highly active antiretroviral therapy (HAART) transformed HIV / AIDS into a chronic rather than a uniformly fatal illness influencing both the type and duration of the required palliative care services.

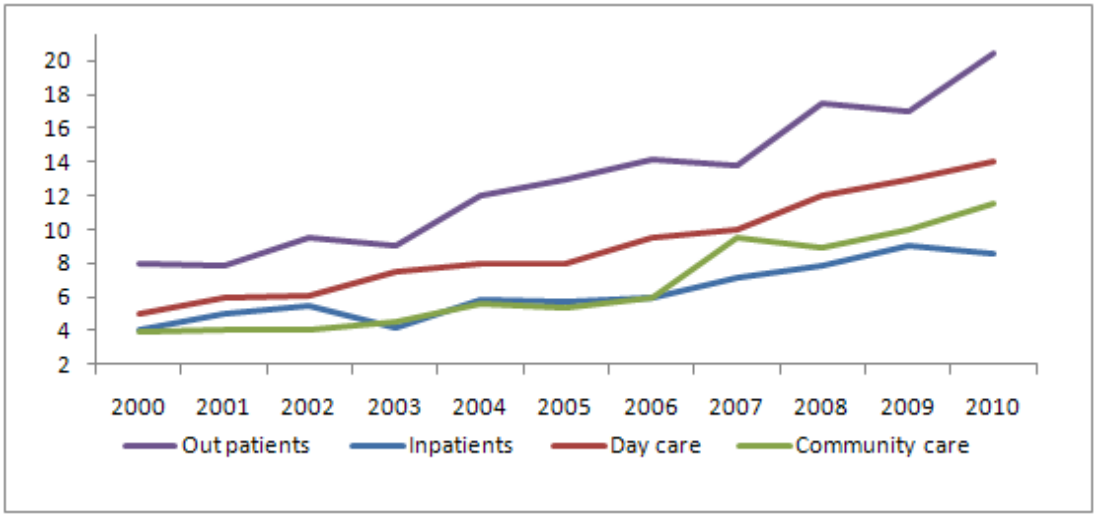
As a result the need to develop AIDS specific hospice services, as well as the need for staff experienced in the management of AIDS related problems has in recent years increased (Easterbrook & Meadway 2001, Stephenson et al. 2000, Rackstraw et al. 2000, Foley & Flannery 1995). Mildmay Hospital in East London, opened in 1987, was the first palliative care service focusing on HIV patients. By 2005, the number of services developed exclusively for HIV / AIDS patients increased to three, providing a total number of 50 beds (Hospice Information 2005).

Comparing relevant data found on the latest MDS report of the NCPC 2011 to its 2006 equivalent and to the information provided about earlier years by Hospice information in 2005 an increase in provision of end of life care services to non cancer patient is becoming clear. The main categories of non cancer diagnoses include HIV / AIDS, Motor Neuron Disease, Other Neurological Diseases, Dementia and Alzheimer, Heart Failure, Chronic Respiratory, Chronic Renal, and others. Even though, medical research in palliative and end of life care addresses issues on the above mentioned diseases (see for example Bausewein et al. 2010, Arcand et al. 2009, and Clemens et al. 2008) it would be beyond the scope of this literature review to provide analysis of further depth on each individual condition. Emphasis is rather focused on the additional challenges brought to the voluntary hospice business model through the widening of its patient base.

Figure 2.3 below provides a graphic presentation of the percentage growth in diagnoses other than cancer between 2000 and 2010 across the four main categories of palliative and end of life care services that have been addressed in the previous section. It is apparent that the number of non cancer patients receiving some form of service has more than doubled over the last decade with outpatients and day care being the services with the sharpest increases in patient numbers. Considering the

upwards trend on provision and demand for these services and the targets of the Government's strategy to widen access to End of life care services for a broader range of patients (see Department of Health 2008 and 2009, Palliative Care Funding Review 2011) the challenge of having to provide a wider range of services to a larger number of people is easily identifiable. Palliative care provision to children and young adults is presented separately on the next section to examine in adequate depth the specific needs and challenges associated with this patient group which in many occasion are different to those of providing care services to adults.

Figure 2.3: Percentage growth in diagnoses other than cancer from 2000 to 2010



Source: NCPC 2011

2.3.8 The development of children's hospices

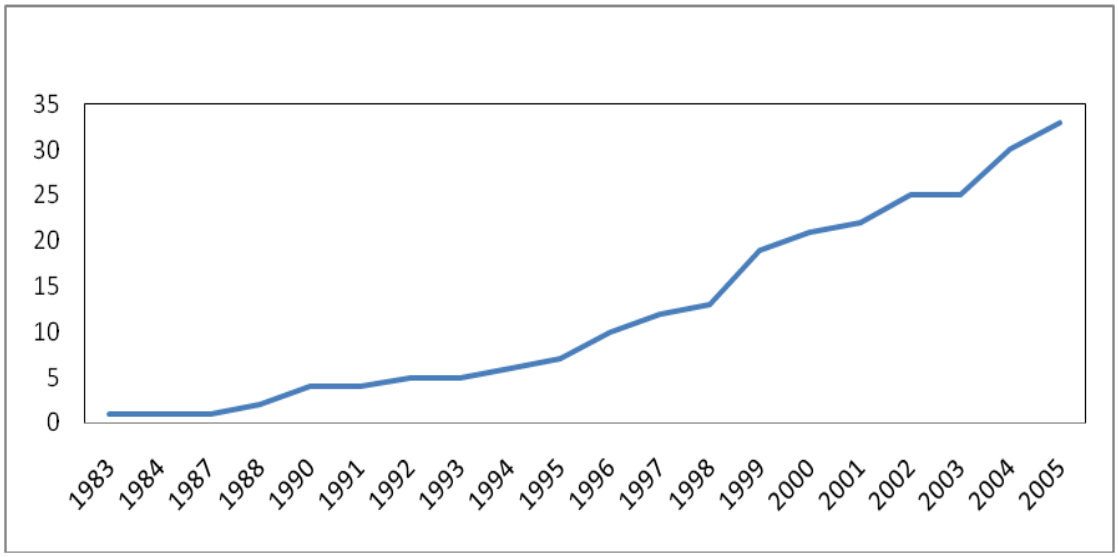
Palliative care provision to children and young adults with life-limiting conditions has also been initiated by the voluntary sector and primarily developed based on the support and needs of local communities. Helen House Children's Hospice (now Helen and Douglas House) was the first children's hospice service in the world opened in 1982 in Oxford. Four more children's hospices opened between the years 1987 and 1991. Since then the provision has been growing with regards to both units

and bed capacity as figures 2.4 and 2.5 below demonstrate (Help the Hospices 2009, Association of Children's Hospices 2006, Hospice Information 2005, Gold 1997).

Sister Frances Dominica is regarded as the leading figure behind the children hospice movement. Trained as nurse she decided to abandon her career for a contemplative life during her early twenties. She took her life vows in 1972 and she was elected to be the Mother Superior of her community at the age of 34 in 1977 (BBC RADIO 2008, Church Times 2007, REACT 2007).

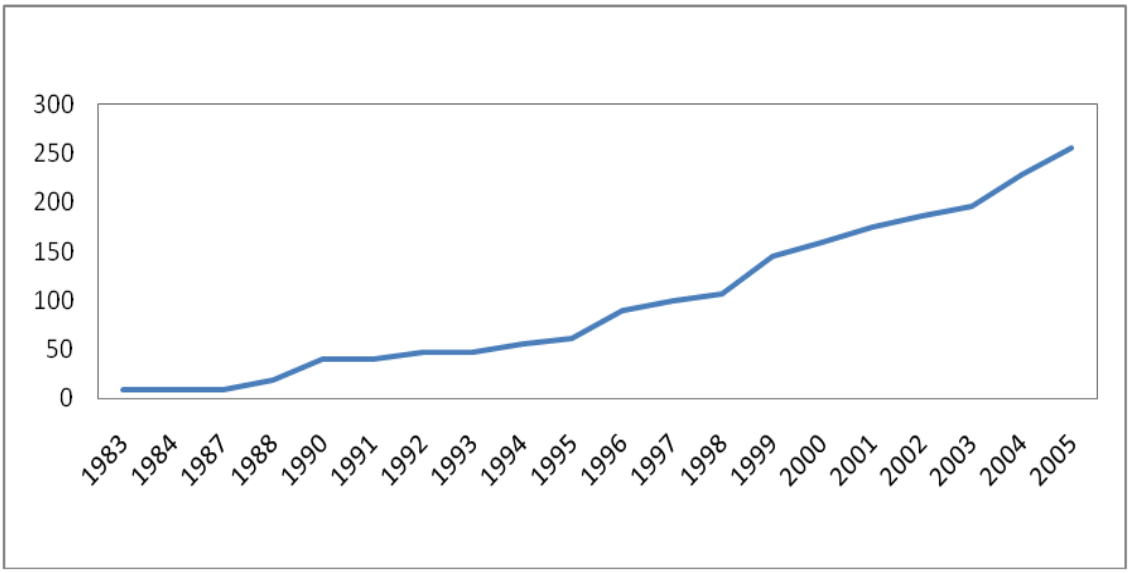
The idea of establishing a home specializing in the provision of respite care to children with life-shortening conditions sprang from Sister Frances' friendship with the parents of a seriously ill girl called Helen. Following surgery for a cerebral tumor the two-year-old was cared for at home in a comatose state. Assisting the parents by taking Helen into her own home from time to time, exposed Sister Frances Dominica to the experiences and the burdens of a family which had to care for a child in need of 24 hour care. In response to that need Helen House was established to provide respite care modelled on that provided within a family setting (Helen and Douglas House 2008, Church Times 2007, Royal College of Nursing RCN 2007). Sister Frances moved on to establish Douglas House, which was opened by HM the Queen in 2004. Douglas House – named under the name of another patient – was founded to provide respite care to teenagers and young adults, up to the age of 40, with life shortening conditions and it was the first hospice of that kind in the world. The requirement for establishing a special type of hospice for that patient category was rooted on the fact that neither children's hospices nor traditional adult hospices were designed to address the patients' particular needs (Helen and Douglas House 2008, Church Times 2007).

Figure 2.4: The growth in palliative care units for children in UK from 1983 to 2005



Source: Data found through the Hospice Information Service during 2008

Figure 2.5: The growth in palliative care beds for children in UK from 1983 to 2005



Source: Data found through the Hospice Information Service during 2008

Palliative care provision to children differs from palliative care provision to adults both in the nature of needs and the time period that care is required (Goldman 1994). World Health Organization (2002) defines palliative care for children as follows:

"Palliative care for children is the active total care of the child's body, mind and spirit, and also involves giving support to the family. It begins when illness is diagnosed, and continues regardless of whether or not a child receives treatment directed at the disease. Health providers must evaluate and alleviate a child's physical, psychological, and social distress. Effective palliative care requires a broad multidisciplinary approach that includes the family and makes use of available community resources; it can be successfully implemented even if resources are limited. It can be provided in tertiary care facilities, in community health centres and even in children's homes."

(World Health Organization, 2002:85)

The aim of a children's hospice is not just that of providing terminal care. Relief care to the patient and practical support to parents may start being provided just after diagnosis and continue even after the child's death in the form of bereavement care for the family (Worswick 1995, Dominica 1987). In contrast to adults' hospices, children's hospices care for children with many different conditions such as complex disorders of which many are neurological in nature, progressive and degenerative leading to a premature death (Farrell 1996). The long term effects of these conditions, as well as the changing developmental needs of the children, can result in families receiving the services of a hospice for many years prior to the child's death. Additionally, the nature of support and care provided requires the services of multidisciplinary care teams. The services provision framework in this case should be able to accommodate both the practical care provided to the child, as well as the

psycho-social implications and the financial hardships for its family (Emond & Eaton 2004, Goldman1994, Thomas 1994, Trapp 1994).

Based on voluntary sector endeavors the children's hospice movement has grown significantly over the last years placing the UK at the forefront of children's hospice care (Association of Children's Hospices 2006, Hospice Information 2005). A large range of specialist children's palliative care services has been developed and research has been employed towards assessing and refining the quality of care as well as anticipating current and future needs and challenges (Association of Children's Hospices (ACH) 2005, Hospice Information 2005, ACH 2004a, Emond & Eaton 2004, Gold 1997, Worswick 1995). The number of children and families who are receiving children's hospice services in the UK is increasing with an average of more than 3,000 children being cared each year. The age range of those children is between five to eleven years old (ACH 2004b).

In spite of the growth of children's hospice services over the last years a gap exists between the supply and the need for palliative care provision to children. Based on ACH 2001, there are at least 15,000 children requiring palliative care in the UK. Evaluating this situation one comes to the conclusion that statutory action is required to further extend the scope and capacity of the children's hospice movement (Rushton 2000). Despite the fact that all the provided services are free to the children and the families who use them, Children's Hospices have to rely essentially on their own fundraising abilities in order to fund the provision of their services. The contribution of the state to palliative care provision for children is limited to around ten per cent, on average, of the total funding required for children hospice services (Help the Hospices 2009, Hospice Information 2005).

2.3.9 The role of umbrella and coordinating bodies within the sector

The rapid increase on the sector's size, the diversity of service capacity and priorities among deferent hospices, the increasing demand for palliative care services and the evolving environmental complexity necessitated the foundation of organisations able to coordinate and represent hospices at national level. Help the Hospices founded in 1984 was established as a national charity supporting the hospice movement. Following to its transformation into a membership organisation in March 2007 Help the Hospices has set out the following objectives in its medium to long term strategy;

> *"1. First and foremost to deliver strategic leadership to our member hospices and to provide them with a national voice*
>
> *2. To provide support for hospice and palliative care organisations, professionals, trustees, volunteers, users and carers*
>
> *3. To raise public awareness of hospices and encourage joint activity on end of life issues*
>
> *4. To contribute to the development of hospice care worldwide"*

(Help the Hospices 2007:2)

In line with its strategic objectives Help the Hospices' role is to support two areas of activity. Firstly, enhancing the frontline activity of voluntary hospices, the organisation is providing support in the form of training, education, information, grant-aid, advice, national fundraising events and activities. Secondly, Help the Hospices expresses and coordinates the voice of its member hospices by, investigating relevant issues, publishing reports and briefings, and by advocating the

cause of the voluntary hospice sector at a statutory and public level (Help the Hospices 2008).

The National Council for Palliative Care (NCPC), following the reorganization of the older National Council for Hospices & Specialist Palliative Care in 2004, is '*the umbrella organisation for all those who are involved in providing, commissioning and using palliative care and hospice services in England, Wales & Northern Ireland'* (NCPC 2008a). Providing a range of services the NCPC aims to facilitate the development of policy proposals for the improvement of palliative care, to influence Government policies in England, Wales and Northern Ireland, and to identify and disseminate good clinical and management practice (NCPC 2008b).

2.4 The stakeholder network and the voluntary hospice sector in England

Following to the development of the hospice voluntary sector, the recognition of palliative care as a service the state has to offer, and the involvement of NHS, the service's provision evolved in to '*a complex whole system'* (Kings Fund 2005:4). Involving a large variety of professions across a range of very different sectors (figure 2.6), modern palliative and end of life care provision is largely commissioned by Primary Care Trusts (PCT) at a regional level. Alongside PCTs, acute trusts, and other voluntary organisations, hospices are called upon to undertake an increasingly demanding role within the wider context of both local needs and national priorities and policies (NCPC 2012, Hospice Information 2005, Kings Fund 2006 and 2005).

Despite their leading role in the country's palliative care field, when viewed at sector level, individual hospices operate within a broad range of diverse standards. Those standards are largely influenced by the level of each hospice's financial autonomy, service provision capacity, the vision and priorities of its founders/trustees and the

relationship – financial dependency/independency – with the local health authority PCT (Ellis 2012, Department of Health 2009, Help the Hospices 2006a, Kings Fund 2005, Finlay 2001). The combination of the above factors largely influences both the choices/options of services individual hospices opt/required to provide and their role and strategic direction within their local health establishment. This leads to a diversity of services provision by different hospices, both at type and length level, as well as to difficulties in defining the exact components on each service. The example of home care (see NCPC 2006) could provide useful inside understanding on this issue.

This final part of the literature review aims to explore the environment within which hospices operate, identify key aspects of the sector's stakeholder network dynamics (see Haslam et al. 2013), and provide the basis upon which the *'hospice business model framework'* will be constructed and evaluated. Hence emphasis is placed on recent developments in Government planning and objectives on end of life care, regulatory, governance, and reporting issues with an impact on the business model's sustainability analysis, as well as relevant statistics on population dynamics and trends. These form the basis of evaluating the expected demand for palliative and end of life care services hospices' will have to provide, and also to identify associated challenges hospices will have to face within the foreseeable future.

2.4.1 Government planning, policy framework and funding

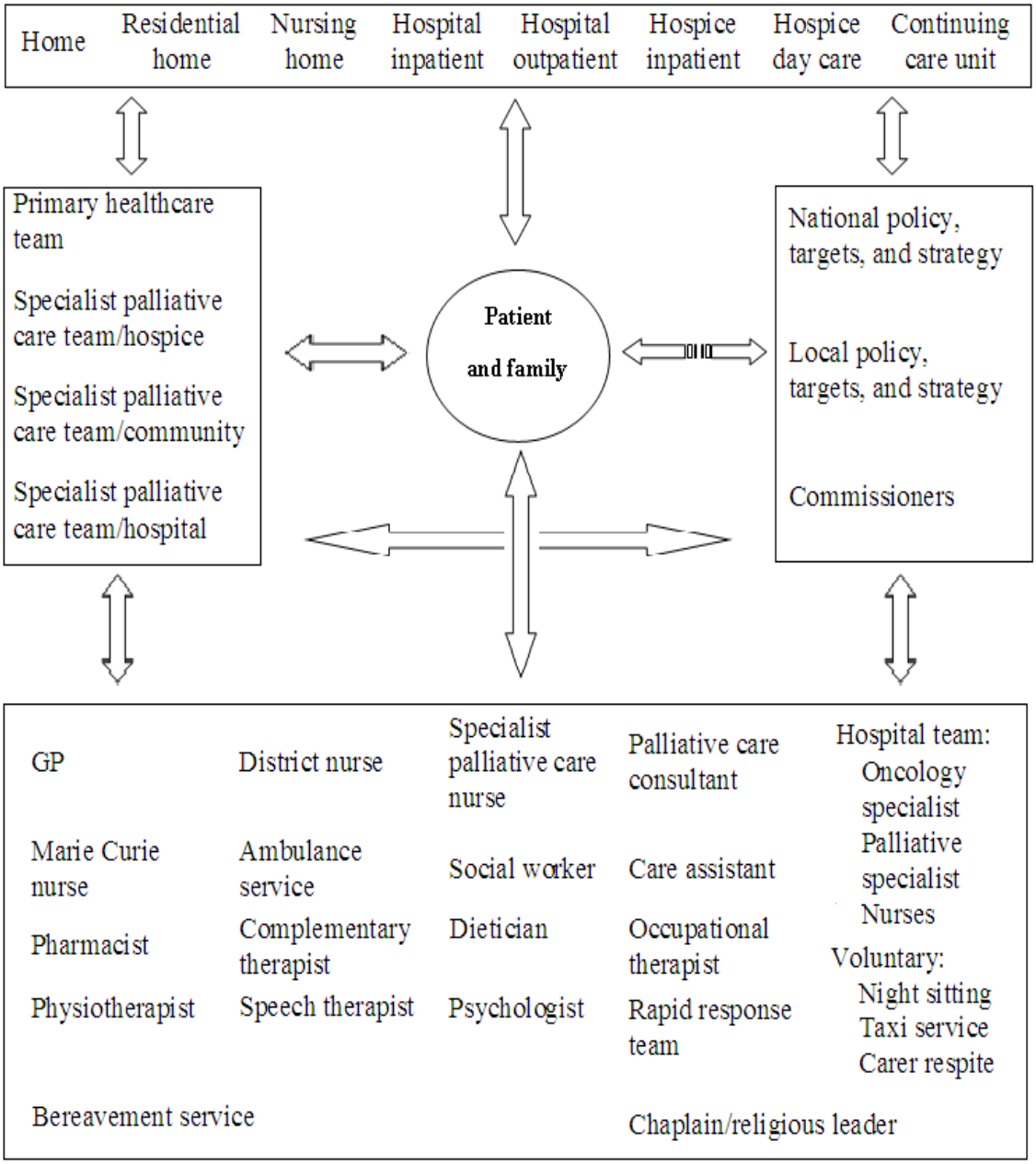
Even though hospice movement was introduced and developed primarily by the voluntary sector the concept of palliative care service provision gradually attracted the interest and was recognised as a necessity by the Government.

> *"Perhaps the greatest achievement of the modern hospice movement is that palliative care is now acknowledged by the state as essential. Indeed, since 1987 all health authorities have had an obligation to develop plans for palliative care in collaboration with the voluntary sector"*

(Help the Hospices 2001:64)

Consequently a series of issues started to arise regarding, policy targets at local and national level, the relationship between NHS and hospices, as well as the commissioning and funding of services (see Ellis 2012, Department of Health, 2012 and 2009, NCPC 2012, Help the Hospices 2008, Hospice Information 2005, Help the Hospices 2001, Finley 2001 and others). Looking into these developments, helps lay the foundation of constructing the hospice business model and developing our understanding of the interdependencies and relationships amongst key stakeholders.

Figure 2.6: Providing palliative care: a complex 'whole system'



Source: Kings Fund (2005:4)

> *"Trustees cannot normally use a charity's funds to pay for services that a public body is legally required to provide at the public expense. However, trustees may use a charity's resources to supplement what the public body provides"*
>
> (Charity Commission 1998:CC37)

During the development of hospice movement, voluntary hospices have gradually become more dependent upon government funding but still cover around 70 per cent of their expenditure from various means of charitable fundraising (Ellis 2012, Palliative Care Funding Review 2011, Theodosopoulos 2011, Help the Hospices 2009, Help the Hospices 2001). A policy framework for the commissioning of cancer services was set out in the Calman–Hine report in 1995, in response to public discussion about the inequalities in cancer care around the country. This report highlighted the need for planning, in order to direct resources to areas of greatest need. The specialist nature of palliative care service provision was also recognised, as well as the need for further development of relevant skills to maintain care quality. Although this report focused on services for cancer patients, the subsequent Government executive letter revealed that its principals applied equally to those patients with other life-threatening conditions. This report introduced a challenge to the cancer centred system of palliative care provision at that time (see Department of Health and Welsh Office 1995). The aim was to increase provision of palliative care to non cancer patients and this was further strengthened through '*The NHS Cancer Plan'* and the *'Manual of Cancer Services Assessment Standards'* in 2000 (see Department of Health 2000a and 2000b). The latter document recognized that the major contribution to palliative care services came from the voluntary sector and thus the report outlined the need for hospices to become more integrated with the NHS. The necessity for agreed national service standards was also included in the report as a condition for Government funding through the NHS.

The *'End of Life Care Strategy'* published by the Department of Health attempted to develop the strategic framework on both commissioning and delivery of palliative

care services. Aiming to widen access, standardize quality, and coordinate provision, the document placed emphasis on the role of PCTs as central coordinating facilities for the commissioning of palliative care at local level (see End of Life Care Strategy 2008). The Government's strategy recognized that the demand for palliative care now delivered to a wider base of patients would require additional resources. It also documented the difficulty of calculating the cost of end of life care in UK, even though palliative / end of life care is presented as a challenge the country could not afford to ignore.

Acknowledging the importance of developing a sustainable system for end of life / palliative care funding, the coalition Government initiated a review in July 2010 which aimed to provide recommendations towards developing a new per-patient funding system. The review was published in 2011 introducing a national payment structure which aimed to cut variations around the country in what the Government pays for and what it does not. Integration of health and social care as well as patient choice has been placed at the heart of the review. Clinical commissioning groups comprising of General Practitioner (GP) practices and other health professionals replacing PCTs under a new structure of end of life care service commissioning (Palliative Care Funding Review 2011, King's Fund 2011).

The new initiative even though welcomed in principle by most involved parties is expected to present providers and commissioners of palliative and end of life care services with a number of challenges.

> *"In order to satisfy the diverse need of individuals at the end of life, as well as those of their families, care can involve a wide range of services, spanning multiple sectors and settings. The significant*

variability in co-ordination between services can result in end-of-life care being disjointed and ineffective, which is often a cause of distress, and this fragmentation of care can make the transition from one provider to another particularly difficult"

(King's Fund 2011:2)

"The review makes a number of bold recommendations about the way care should be funded in the future and we urge the Government to deliver on its promise to reform the patchy and inconsistent funding system for hospice and palliative care in England. However, with NHS funding already under pressure, it is vital that independent charitable hospices and other providers of palliative care are protected during the long transition to a new system. We cannot risk destabilizing the current provision of funding which would have serious implications for people facing the end of life and their friends and family."

(Praill 2011 at: http://www.helpthehospices.org.uk)

Hospices are currently not only required to meet their own internally set governance practices and policies but are also subject to external assessments for example, hospices must meet the regulatory requirements of: the Care Quality Commission (CQC), and care professional regulators, the Charities Commission and complex obligations set into NHS commissioning contracts. In January 2011 the Healthcare Bill was introduced and this envisages a substantial restructuring of the regulatory framework within which healthcare will be commissioned, financed and regulated. The combination of regulatory and organization reforms which will place some GPs

and not all PCT's in charge of NHS commissioning and the financial climate within which these changes are to take place heightens uncertainty for voluntary hospices (see Ellis 2012, Richardson 2012, King's Fund 2011, Praill 2011).

2.4.2 Governance and reporting

The majority of hospices are independent, service delivery voluntary organizations (Handy 1992), governed by trustees who report to the Charity Commission and comply with the relevant Health and Social Care regulations (Palliative Care Funding Review 2011, Help the Hospices 2010, Help the Hospices 2009, Department of Health 2002, Care Standards Act 2000). Charitable status allowed hospices to independently raise funds and organize their services based on the needs of local communities but this reliance on non-Government funding and the fragmented nature of the hospice movement means that there has often been a gap between national planning for the provision of palliative care and locally pursued objectives.

Charities in England and Wales are subject to the regulatory requirements of the Charities Act 1993 (as amended in 2006) which sets the criteria for an organization to be recognized as a charity and ensures the protection of charitable gifts. This is because being a charity secures for the organization a considerable reputational benefit as many people are inclined to offer time and money to a charity in ways that they would be very reluctant to do for a non-charitable institution. Hence regulation ensures that courts and the Charity Commission have recognized powers to intervene in cases where donors' funds have been diverted to non-charitable purposes (Morgan 2010).

In addition to the reputational benefit charities also enjoy various tax advantages which include:

- the right to reclaim tax paid on individual donations under Gift Aid
- no income tax or capital gains tax on investments
- no VAT on press advertising
- no inheritance tax on legacies
- no tax on profits made through charges on the provision of charitable services, under the condition that these profits are reinvested in the long term charitable work of the institution
- reduced business rates on premises used for charitable work

Most charitable organizations in England and Wales are required by legislation to publish financial statements comprising in general by a trustees' annual report, and annual accounts to ensure the accountability of the sector. Charities above the income threshold of £250,000 have to prepare accounts on accruals basis in compliance with the charities Statement of Recommended Practice (SORP). These accounts must include a statement of financial activities (SOFA), a balance sheet, and extensive notes. The SOFA, see table 2.11 for an abbreviated version, is practically an income and expenditure account. Running down the table charities are asked to report: incoming resources, expenditure, transfers and other gains and losses and running across categories income, expenses, gains and losses into unrestricted, restricted or endowment (capital) funds (see Morgan 2011, Theodosopoulos 2011, Morgan 2010, SORP 2005).

Table 2.11: SORP Statement of financial activity

	Unrestricted	Restricted	Endowment
Incoming resources			
By type of income received			
Resources Expended			
By type of activity			
Transfers between funds			
Other gains and losses			
Asset revaluation			
Gains / losses on investments			
Fund balance brought forward			

Source: Theodosopoulos (2011:120)

> *"The classification of incoming resources and resources expended by activity is encouraged for all charities preparing accruals accounts. Smaller charities maybe excused from adopting this approach by legislation recognizing that such information is likely to be less relevant to the users of small charity accounts"*
>
> (SORP 2005: revised paragraph 93)

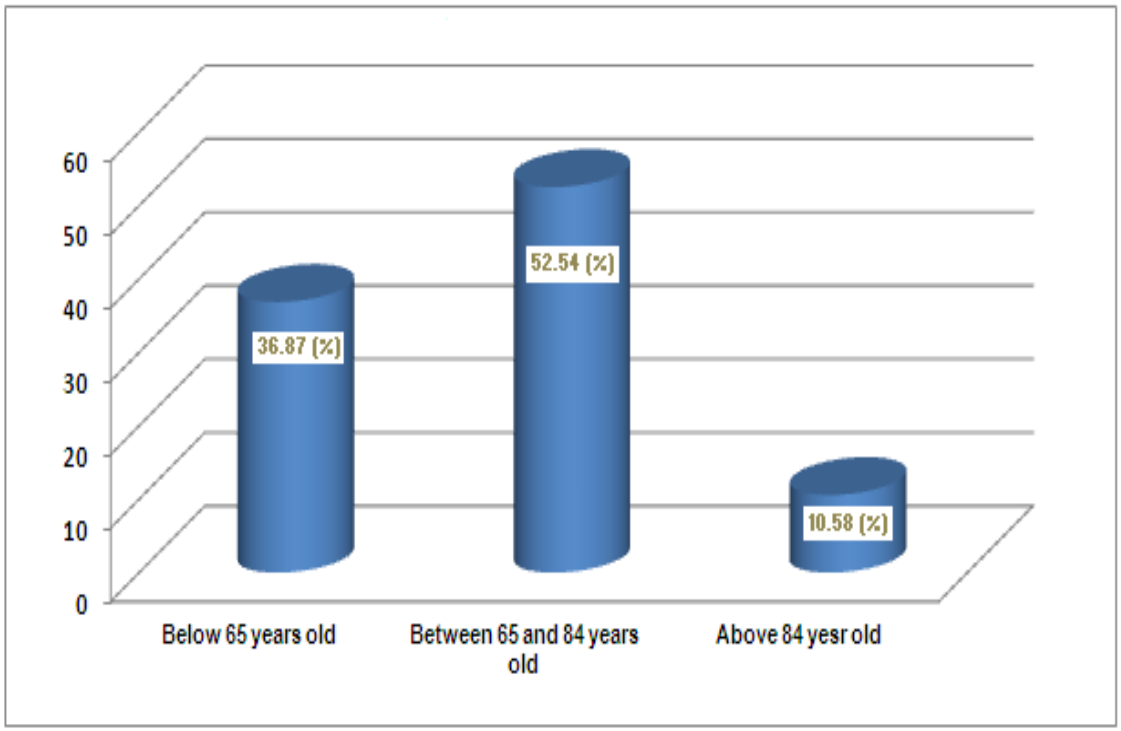
Based on Help the Hospices' 2009 and 2006 analyses of hospices' accounts, the vast majority of voluntary hospices in England and Wales are within those charities that have to fully comply with the provisions of the Charities SORP whilst preparing their annual accounts. Those accounts have to then be publically available and to be filed with the charity commission, hence securing a source of sufficient data for both public scrutiny and - for the case of this study - research purposes.

2.4.3 Population growth and ageing

During 1985-2010 there was an increase of 20 per cent in the number of people ageing 65 and above to 10.3 million or 17 per cent of the total population. Additionally, the number of people aged 85 and above, more than doubled during the same period of time (see UK National Statistics 2012). Given that cancer is a disease of the elderly, see figure 2.7 below, changes in population demographics add to the demand for palliative and end of life care services hence directly increasing the pressure on hospices (see also Theodosopoulos 2011).

> *"Population ageing will continue for the next few decades. By 2035 the number of people aged 85 and over is projected to be almost 2.5 times larger than in 2010, reaching 3.5 million and accounting for 5 per cent of the total population. The population aged 65 and over will account for 23 per cent of the total population in 2035, while the proportion of the population aged between 16 and 64 is due to fall from 65 per cent to 59 per cent."*
>
> (UK National Statistics 2010:
> http://www.statistics.gov.uk/hub/population/ageing/)

Figure 2.7: Incidence rates per 100,000 of population for all cancers excluding non-melanoma skin cancer in UK



Source: Data found through Cancer Research UK in 2012

Apart from issues related to the widening of patient base in need of palliative and end of life care services, demographic factors are imposing additional challenges on the voluntary hospice sector. Population projections show that by 2035 the population aged over 65 will have doubled and if we assume that the incidence in cancer rates per 100,000 of the population remains at current (or slightly lower) levels it is still the case that the demand for palliative and end of life care services from hospices and other providers will almost certainly double. This upwards trend has already been seen on the NCPC 2011 and 2006 reports which has been presented in section 2.3.

2.5 Summary

The literature on voluntary hospices is fragmented and scattered within academic and practitioner discourses addressing a range of issues on palliative / end of life care

provision and the evolution of hospice movement in England and abroad. This chapter provids a review of relevant medical, nursing, social, historical, and regulatory literature, aiming to develop an understanding of the landscape within which hospices operate and contribute their services. However, this literature is not grounded in accounting and management.

To facilitate a grounding of hospices with accounting and business the next chapter reviews literature on business models. This is then used as a framing device within which the researcher for this thesis investigates the sustainability of the voluntary hospice business model. For the scope of this thesis a business models approach is deemed useful even though, there is, so far, no substantive literature on the application of business models theory within non-for profit organizations. A business models approach reveals the significance of stakeholder relations and it can also be informed by relevant accounting disclosures (see Haslam et al 2014, Theodosopoulos 2011). Hence, a business models approach, allows to bring into the framing, narratives from key stakeholders, about how the business model has evolved. Also, reported financials, help to reveal how changes in stakeholder relations impact upon financial viability (liquidity and solvency) of the hospice business model.

Chapter 3: Accounting for Business Models

3.1 Introduction

Having reviewed the development of the hospice movement in UK, as well as, the core characteristics of the voluntary hospice sector, this chapter focuses more specifically on the literature on business models and examines its potential as a framing device for analysis. The chapter is organised into five broad thematic categories. The first of these is concerned with how we frame and conceptualise business models at the level of firm or organisation in terms of resource articulation for value creation and how this value is captured. The second considers how existing business model structures are challenged, degraded or become obsolete through the development of new technologies, innovations, and entrepreneurship.

Within the third section I review how business models can help to frame the tactical and strategic moves of senior management within and outside the boundary of their organisations. The fourth section presents an account of critically reflective views on business models' literature and its role in business and management research. The final section reveals how the concept of the 'business model' is migrating into accounting and analysis of stakeholder relations and how a combination of accounting disclosure about stakeholders relations informs the investigative framework for this thesis.

It is evident that the literature on business models is largely grounded in economics and business strategy addressing essentially issues relevant to profit generating organisations. In this thesis we draw upon the work on business models grounded in accounting and the influence of stakeholder relations and stakeholder theory. This opens up the scope for applying a business models investigative framework that

combines narratives and numbers as a means to investigate how the 'hospice business model' has evolved and adapted through interaction with key stakeholders, as well as, how this interaction impacts upon its financial viability and risk.

3.2 Business Models: Framing and Conceptualizing Business Models

Zott and Amit (2010) suggest that there is a space for developing a conceptual toolkit, based on business models analysis, which would facilitate managers and entrepreneurs in the process of running their organisations.

> *"Given the vital importance of the business model for entrepreneurs and general managers, it is surprising that academic research (with a few exceptions) has so far devoted little attention to this topic. We need a conceptual toolkit that enables entrepreneurial managers to design their future business model, as well as to help managers analyze and improve their current designs to make them fit for the future"*
>
> (Zott and Amit, 2010:217)

The conceptual toolkit for organizing our understanding of business models turns on how a business model makes a viable business proposition. Chesbrough (2010), for example, argues that a business model of a firm can serve a variety of functions but in general it articulates a value proposition. The value proposition of a business model is itself the sum of its parts and these are generally deconstructed into the notion of value creation and value capture. Baden Fuller and Morgan (2010) observe that a business model connects up the *'workings inside the firm'* to elements outside of the firm *'the customer side'* as a way to generate value from the application of

innovation and new technologies. The firm is deploying its own capabilities and resources to generate new products and services which Magretta (2002) characterizes as *'value creating insight'*.

Zott and Amit (2010) highlight the importance of locating a focal firm's value creating initiatives within an activity network where the business model portrays both the internal and external to the firm relationships. This introduces the notion of an architecture that involves establishing and locking in partners through product and service novelty where governance arrangements distribute financial rewards. This framing of business models draws upon resource based theories (Conner and Prahalad 1996, Barney 1991,) of the firm but combines this with a transactions view of the firm where the relationships established by these transactions form an integral part of the value creating process of a business model.

> *"A business model is geared toward total value creation for all parties involved. It lays the foundations for the focal firm's value capture by co-defining (along with the firm's products and services) the overall 'size of the value pie,' or the total value created in transactions, which can be considered the upper limit of the firm's value capture potential"*
>
> (Zott and Amit 2010:218)

Therefore a focal firm's business model is driven by value creating initiatives that involve the deployment and articulation of resources, technologies, and capabilities to generate new innovative products and services. Hereafter, as this involves transactions between the focal firms and other *'partners'* it is the collective efforts or this network that matter in a business model. In addition to value creation a business

model also presents the nature of a focal firm's capacity to capture value. This process of value capture involves defining a firm's location within a value chain, as well as, how this linking up of the focal firm with its suppliers and customers in the transactions network translates into revenue streams, costs, and profit. How and in what ways a focal firm locates itself into a value chain is variable. According to Timmers (1998) this is because the connection between different external partners is complex.

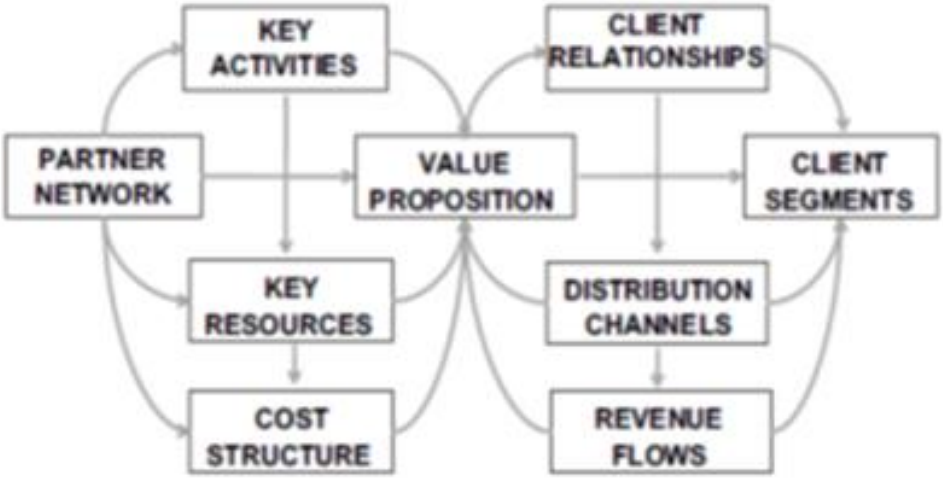
> *"Value chain de-construction means identifying the elements of the value chain, for example as in Porter (1985) who distinguishes nine value chain elements. Namely, as primary elements inbound logistics, operations, outbound logistics, marketing & sales, service; and as support activities technology development, procurement, human resource management, corporate infrastructure"*

(Timmers 1998:4)

Accordingly, value capture is concerned with how the balance between what is financially inside the boundary of a focal firm and what is outside get attuned to displace costs and expenses and secure additional margin. How much margin the focal firm captures from its total value chain depends upon its pricing strategy, relation to distributors and retail network, as well as upon its capacity to out-source and offshore. That is to what extent has a focal firm within its business model sufficient power benefit from price control, customer lock-in, and ability to adjust internal and external cost structure. As Amit and Zott (2010:18) observe *'the business model co-determines the focal firm's bargaining power'* and this facilitates

value capture out of its value creating initiatives. Thus business models are conceptualised, in general as the *'value proposition'* within which a focal firm's resources, deployed for value creating products and services, are located within a partnership network within its value chain. This network secures revenue flows and determines cost structures. Osterwalder's (2005) nine point decomposition of a business model (see figure 3.1) helps to develop our insight on the overall concept.

Figure 3.1: Osterwalder's (2005) nine point decomposition of a business model



Source: http://businessmodelalchemist.com/2005/11/what-is-business-model.html

On the other hand, the importance of technology, innovation, and entrepreneurship, is that these elements of conceptualising business models incorporate a dynamic dimension because they enable adjustments to the value proposition of a focal firm's business model. Consequently, they add complexity in the process of managing organisations as decision makers get concerned with how tactical and strategic moves are executed by managers to implement adjustments to the focal firm's value proposition.

3.3 Business Models: Adaptation and reinvention

Johnson et al (2008:7) observe that *'There are clearly times, however, when creating new growth requires venturing not only into unknown market territory but also into unknown business model territory'*. Johnson et al hence, suggest that it is necessary to consider how and in what ways a focal firm can *'reinvent'* its business model. This is imposed on firms as a result of disruptive changes in technology or new innovative methods in which entrepreneur(s) destabilise existing arrangements within a business model and its value proposition. Examples of activities, where technology and innovation act as a destabilising factor within a focal firm's business model, can be found in areas such as bioscience and information technology. In such areas changes in technology and innovation drive changes in product, process and information exchange, which are the foundation of a business model's value proposition. This is because changes in technology and innovations can broadly change the operating architecture of business models to both degrade and generate new business model opportunities.

For example, Bonaccorsi at al (2006) examine how open source software can recalibrate network relationships between firms in a value chain, not only because development costs are displaced, but also because of prospective information exchanges with other *'users'* within a value network. These often lead new entrepreneurial opportunities within a business model which, in turn, is forcing a reassessment of a business model's viability, based on fitting the firm's available and potential resources against the perceived new opportunity (George and Bock, 2011).

Brink and Holmen (2009) examined the business models of a number of bio-science firms, finding that several of them changed their business models a number of times

and had to undergo at least one period of radical change. Also, whilst technological change is seen as evidence of the complexity of the business model there is also a range of other components in the value proposition which are equally significant and disruptive in terms of the making and re-making of a business model's value propositions. With their work Brink and Holmen (2009) argue that entrepreneurs and managers should pay attention to the development of technical capabilities but also on the development of other business capabilities, such as the development of distribution channels, to secure the value proposition of the bio-pharma business model. In the same line, Onetti et al (2012) extend the business model spatial boundaries to incorporate global linkages and selection of *'value partners'*.

Chesbrough (2007) argues for the necessity of considering a broader concept of *'open innovation business models'* in which the focal firm becomes a much more permeable economic space and boundary in terms of sharing product development with partners. Thus large big-pharmas out-source product development to smaller bio-techs whilst licensing technologies and access to markets modifies their value proposition. Therefore the operating architecture of the business model becomes a place for innovation and recalibration. '*The combination of leveraged cost and time savings with new revenue opportunities confers powerful advantages for companies willing to open their business models'* (Chesbrough, 2007:24). In a later paper Chesbrough (2010) considers the barriers to business model innovation in terms of resistance to change and a lack of entrepreneurial and managerial leadership that are required to experiment and effectuate change to a business model's value proposition.

Sosna et al (2010) reflect on the background and positive drivers of business model innovation in a Spanish dietary products business which is threatened by economic

recession and heightened competition resulting from liberalization. Fiet and Patel (2008) show how the entrepreneurship which drives business model adaption involves a financial risk. Suggesting that knowledge of the reliance of other partners within the business model could help to redistribute risk. The authors also note that business model adaptations, driven by entrepreneurs, need to map out the possibility of risk displacement allowing entrepreneurs *'to notice that resource providers have high market interaction costs and few outside options for negotiating a better deal with others'* (Fiet and Patel, 2008:759).

The static framing of business models needs to be supplemented with a dynamic set of components which stimulate change and initiate a recalibration of focal firm-partner relationships and value proposition. Therefore a focal firm's business model for value creation and capture is disturbed by changes in technology and innovations and these adjust both value creating and capturing opportunities. There is often resistance to change and a lack of managerial creativity and entrepreneurial capacity to absorb and displace risk involved in the evolution and adaptation of a focal firm's business model.

3.4 Strategy, Management and Organisations

Casadesus-Masanell and Ricart (2010) differentiate between the attributes of a business model and those of strategy. Based on their views a business models is seen as a general logic or process employed to deliver value creation and value capture, whilst strategy refers to the choice of a business model and relevant tactics to effectively compete in the market place.

> *"Put succinctly: Business Model refers to the logic of the firm, the way it operates and how it creates value for its stakeholders; and Strategy refers to the choice of business model through which the firm will compete in the marketplace; while Tactics refers to the residual choices open to a firm by virtue of the business model it chooses to employ"*
>
> (Casadesus-Masanell and Ricart, 2010: 196)

An alternative perspective is that business models also embody strategic choices but that the business model itself provides the framework within which *'analysis, testing, and validation of the cause-and-effect relationships that flow from the strategic choices that have been made'* (Shafer et al, 2005:203). Therefore the objective of strategy is to give meaning and direction to the development of a company's business model (Tikkanen et al. 2005). Strategy is seen as being about the choice of a business model and how relevant actions and interventions bring together the value creating and value capturing components of a business model. In many ways Mitzberg and Heyden's use of *'organigraphs'* is a useful summary of this process depicting critical interactions amongst people, products and information (Mitzberg and Heyden 1999).

Strategy is not just about starting a business model for value creation and capture but it is also an ongoing dynamic process which Doz (2010) terms *'renewal'*. That is, business models need to be injected with a sense of *'strategic agility'*. Thus Doz informs us about the *'thoughtful and purposive interplay' on the part of top management between three 'meta-capabilities'* (Doz, 2010:371). These include: Strategic sensitivity, which is the sharpness of perception and the intensity of awareness and attention to strategic developments; leadership unity, which is the

ability of the top team to make bold, fast decisions, without being bogged down in top-level *'win-lose'* politics; as well as, resource fluidity which is the internal capability to reconfigure capabilities and redeploy resources rapidly.

In the same line Yip (2004) supports this notion of ongoing dynamic modifications to a focal firm's existing business model. On the other hand he suggests that these modifications are often subject to routine and that radical strategic adjustments become necessary *'when changes in their environment render their current business models obsolete or when they voluntarily choose to embrace a new business model'* (Yip, 2004:17).

The challenge associated with effectively recalibrating a focal firm's business model is taken up later when I consider the case of hospices in this thesis. Rapid change in market conditions, as well as technical change and information exchange, create additional uncertainties about how and in what ways managers should reconfigure a focal firm's business model. Seelo and Mair (2007) for example, emphasise the importance of timely business model adjustments to cope within changing business environments and criticise aspects of strategic management thinking for being overly focused on stable and mature markets.

> *"An important constraint to the managerial relevance of the RBV (resource based view) is that we know little about how to configure resources to realize their potential to create value in different types of context"*
>
> (Seelo and Mair 2007:52)

Dunford (2010) also emphasises the importance of incremental fine tuning as part of the evolution of a firm's business model and Mason (2008) encourages the notion of a *'soft'* knowledge transfer mechanism through *'communities of practice'* for business model improvement (Mason, 2008).

McGrath, (2010) argues that the majority of business models are established within the limits of a certain set of constraints. Therefore, '*as new technologies and other shifts relax constraints or impose different ones, the opportunities for new models (and the threats to existing ones) increase'* (McGrath, 2010:253). A major challenge is that business models do degrade. According to Bowman and Ambrosini (2000) it is the binding between value creation and value capture that determines the sustainability of a business model. This binding is challenged when the power of the focal firm over its network relationships is deteriorating through a displacement effect. In such times it may be crucial to change into a new business model and phase out one that is challenged, because of the attack of *'strategic innovators',* and degrading (Markides, 2004).

3.5 Business Models: Contested Framing

Ghaziani and Ventresca (2005) suggest, that *'business models'* is a contested terminology for three main reasons. Firstly, public talk about business models is not stable and depends on various cultural developments, changes, and influences across a range of societies. Secondly, it draws from a variety of discourses resulting in differentiation of meaning across different communities. Finally, its use in both historical and current frameworks of use is characterised by significant ambiguity. Nevertheless, although the use of the term '*business model'* is fraught with ambiguity, this promotes a community of interpretation(s).

> *"Competing terms persist even while business model public talk increases dramatically, which it does according to a global meaning and locally tailored usages.... This tension is productive for the cultural order since the same frames are interpreted in ways that facilitate general consensus and community specific interpretations"*

(Ghaziani and Ventresca, 2005: 549)

Zott et al (2011) suggest that the idiosyncratic nature of the literature on business models is its weakness.

> *"Despite the overall surge in the literature on business models, scholars do not agree on what a business model is. We observe that researchers frequently adopt idiosyncratic definitions that fit the purposes of their studies but that are difficult to reconcile with each other. As a result, cumulative progress is hampered"*

(Zott et al 2011:2)

Demil et al (2010) acknowledge similar concerns as those expressed by Zott et al, but argue that this is resulting from the fact that the term *'business model'* is widely used within the sphere of professional practice. Within this context, substantial amount of *'grey literature'* has been produced by consultants, managers, and journalists until the end of the 90s. This, on one hand, made the concept fuzzy, but at the same time it highlighted its potential usefulness for business practice.

The business models' concept is currently populating new discourse spaces including accounting. For example, the accounting profession and relevant institutional bodies which aim to generate relevant information (accounting disclosures) to decision makers, appear to consider the business model concept as a vehicle offering new possibilities for framing corporate financial disclosures (see for example EFRAG, 2013 and IIRC, 2013). Beattie and Smith (2013) use the Intellectual Capital debate concerning business reporting and also argue that managements' reporting of their business model could also help to frame relevant financial disclosures to inform decision makers.

> *"the accounting literature has not forged strong linkages with either the more recent strategy literature or the business model literature, resulting in knowledge residing in disconnected silos"*
>
> Beattie and Smith (2013:252)

Page (2012) also discusses the contested nature and ambiguity around the term *'business model',* suggesting that there is lack of consensus around the meaning of the term and its potential use within the context of financial reporting. This Leisenring et al (2012) argue relates to the difficulty of separating between business-model-based accounting and intent-based accounting.

> *"As far as I am aware there is no generally agreed set of business models for the financial sector. This is not to deny that there are well understood industries and businesses—such as life assurance, pension funds, property investment and so on. But within industries there is a considerable (and sometimes bewildering) range of 'value*

> *propositions' and there are hybrids at the margins of different industries. It follows that managers have a great deal of latitude in describing the business model of particular parts of their organisation, and, as we know, where an inch of latitude exists managers will take a mile, when occasion demands"*
>
> (Page 2012: 4)

Arendt (2013: 396) argues that '*it is time to push the boundaries of the traditional theories to determine their limitations when applied to more complex or social or information-rich contexts'* whilst Zott et al (2011) call for academics to seek to consolidate a business model theory that will be encompassing boundary-spanning activities (performed by a focal firm or others), and focusing on value creation as well as on value capture. There seems to be an opportunity here for academics, practitioners, and policy makers to research around these *'business model themes'* as they can provide an alternative framing for analysis and investigation. A framing that enables to generate critically informed and practically engaged research.

3.6 Accounting for Business Models

Haslam, et al. (2013) conceptualise business models within an accounting framework but take a different perspective to that originated in strategic management literature as well as to that discussed by the professional accounting bodies. The strategy literature on business models emphasises on resource allocation and deployment to generate and capture value, whilst the accounting professional bodies are interested in the way that business models can influence financial reporting.

Haslam et al. (2013) present an alternative framing of a focal firm's business model which is developed based on a reporting entity's stakeholder relationships. Their argument is that a focal firm's business model is structured out of stakeholder relationships that materially define the value proposition of a business model. Dynamic changes in the stakeholder relations within a business model can facilitate or disrupt its value proposition. Haslam et al. (2013) argue that the three primary aspects of a focal firm's business model value proposition are, value creation (product and process innovation and renewal), value capture (recalibration of value chains), and value manipulation (recapitalisation and holding gains).

On the other hand, in relevant management and strategy literature stakeholders are not central to the organising framework even though their role is described and acknowledged. A common thread running through stakeholder theory, as applied to corporations, is the role and contribution of management in both satisfying and integrating the needs of a variety of stakeholders that have a reasonable interest in the organisation. This responsibility of management can be broadly described as *'stakeholder-agency'* or more narrowly as *'shareholder-agency'* (Jensen 1986 and 2002).

Evan and Freeman (1993) argued that a stakeholder theory of the firm should readdress the purpose of the firm in such a way that the interests of the stakeholders are served and coordinated. Freeman defines stakeholders as: *'any group or individual who can affect or is affected by the achievements of the organization's objective'* (Freeman, 1984, p.46). Within this theoretical framework, co-ordination between stakeholders is delivered through legally binding contracts or loose informal relationships which are observed and structured around the mutual benefit of all parties (see Hill and Jones 1992, Freeman and Evan 1990).

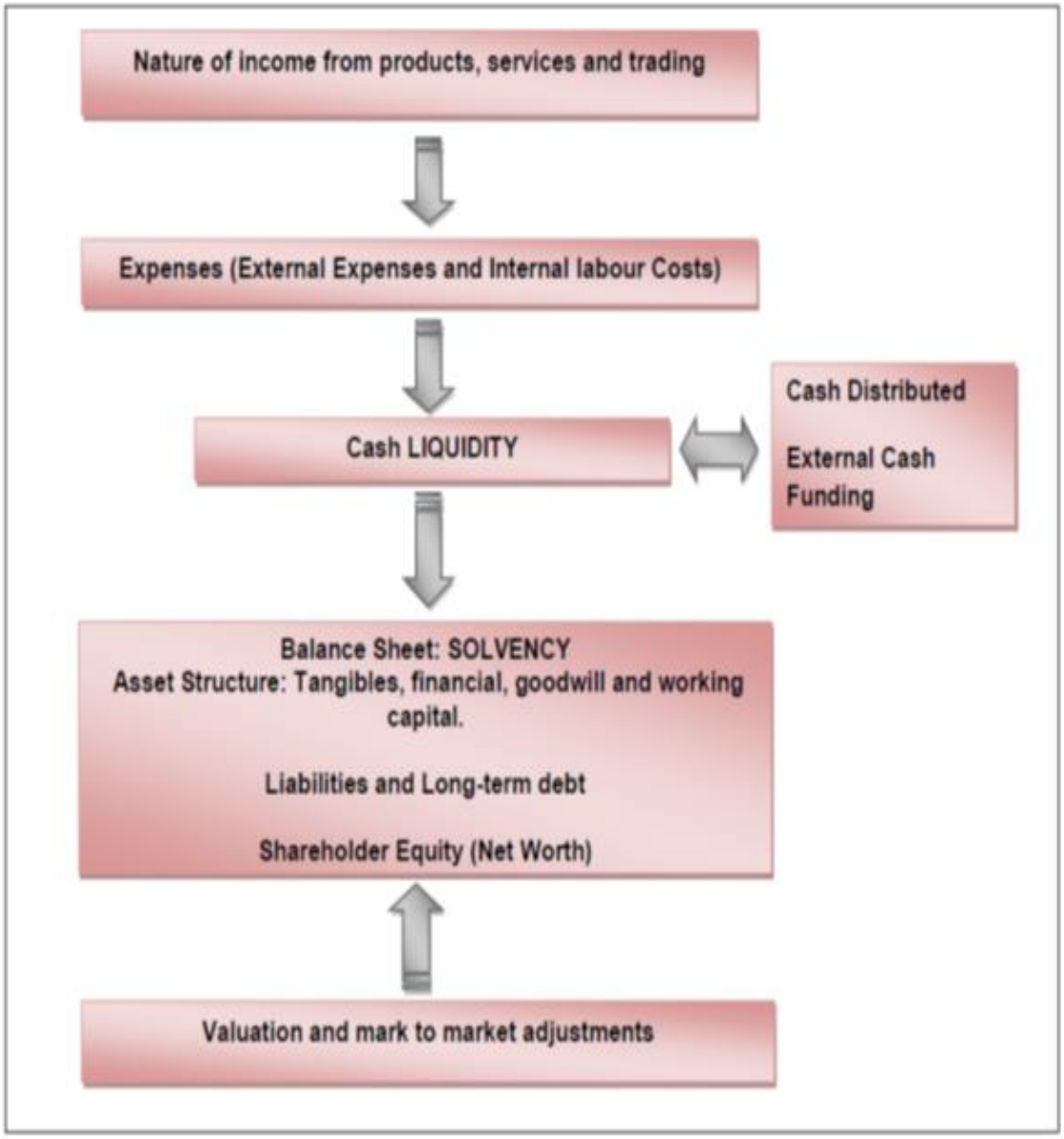
Freeman et al (2004) suggest that a primary concern for an organisation's management is to align several stakeholders' interests. On the one hand the firm is a normative locus for reconciling stakeholder interests and on the other there is an instrumental purpose which is to generate *'outstanding'* performance. Hence, based on their view, stakeholder theory:

> *"Encourages managers to articulate the shared sense of the value they create, and what brings its core stakeholders together. This propels the firm forward and allows it to generate outstanding performance, determined both in terms of its purpose and marketplace financial metrics"*
>
> (Freeman et al 2004:364)

A focal firm's business model, according to Haslam et al (2013) is the result of interactions with a complex network of stakeholders and in return, the information arising from this type of relationships assists to broadly define a focal firm's business model. These interactions produce information that congeals into and impacts upon reported financials even where *'exchange transactions'* or *'contracts'* are absent. For example, stakeholder interactions that may not have material value in terms of an exchange transaction, such as, relationships with advisers, ratings agencies, analysts, consultants, regulatory and professional institutions, are incorporated into the business model framework of analysis. These stakeholder relationships are perceived to materially help to define the nature of a focal firm's business model and also to impact significantly on its sustainability as a value proposition.

The *'value proposition'* of a focal firm's business model should enable it to generate liquidity and solvency though the interactions with its stakeholders. In figure 3.2 below, adopted from Haslam et al (2014) we see liquidity as an outcome of making income from products, services, and asset trading, after deducing all external costs and internal employment costs. Cash from operations (liquidity) is a significant indicator for credit ratings agencies and analysts that are valuing a firm's equity on the stock market. Solvency is the difference between total assets and liabilities and is a measure of net worth. In cases where this net worth is gradually reduced, for example where financial losses are being incurred or assets' values are being written down, the auditors of the organisation may not sign off the accounts as a going concern.

Figure 3.2: Focal Firm's Business Model Value Proposition – Liquidity and Solvency

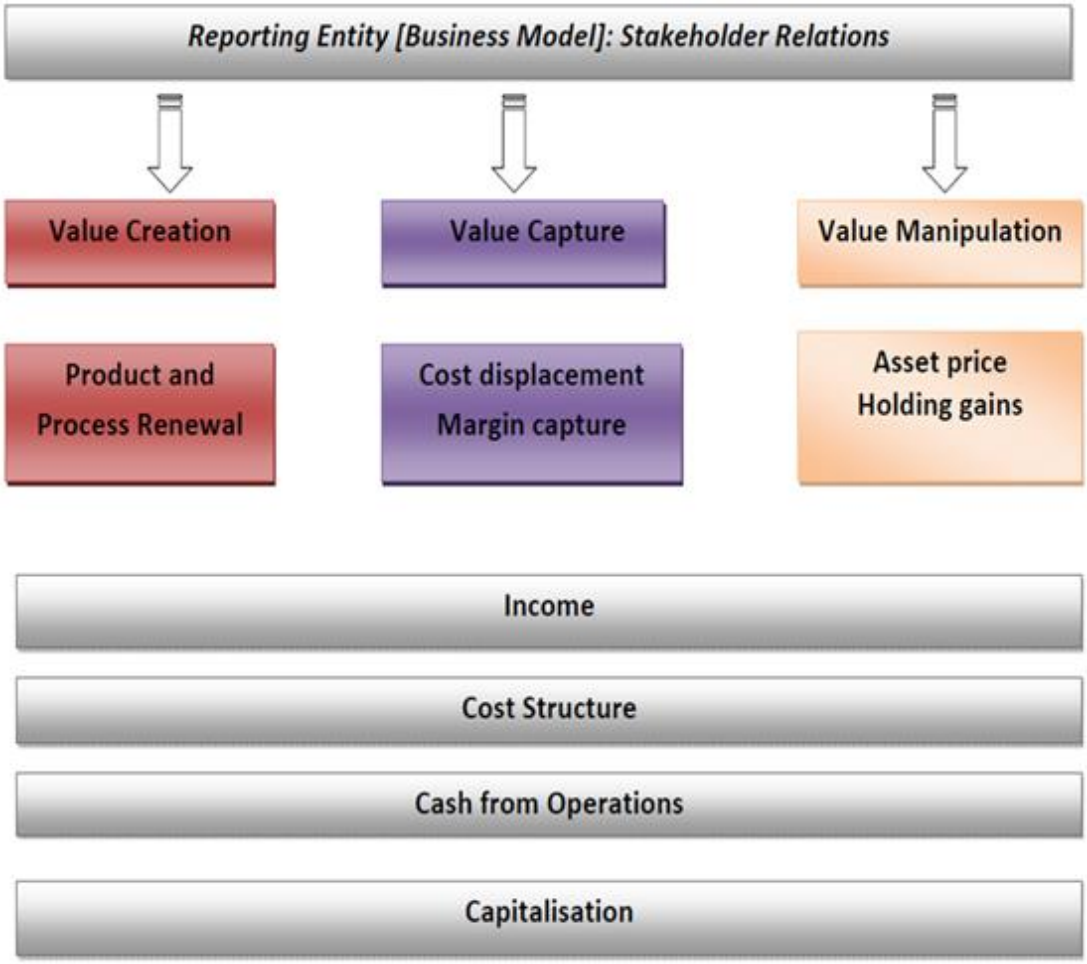


Source: Haslam et al. (2014:10)

In figure 3.3 (see Haslam et al, 2014:13) we see how income, margin, and capitalisations, are the result of stakeholder interactions related with the nature of a particular focal firm's business model value proposition. Consequently, depending on the type of a focal firm's business model, its value proposition will have variable emphasis on value creation, value capture, and value manipulation. Hence, the value proposition is the outcome of stakeholder interactions that are designed to: create,

capture, or manipulate value and these stakeholder relationships, in turn, influence the reporting entity's operating financials: income, cash and balance sheet values.

Figure 3.3: Business Model Value Proposition



Source: Haslam et al. (2014:13)

These aspects of a value proposition are essential for securing financial viability (liquidity and balance sheet solvency) but not all focal firms within a business model appear to be equally focussed on all these aspects of the value proposition. Some business models will be *'burning'* cash in the process of developing new products or services for example a small bio-pharma developing a single new drug (see Andersson et al 2010). Others may operate with relatively thin or robust cash margins, others may rely on generating holding gains through asset prices trades or

revaluations to enhance their financial returns. Haslam et al (2013) describe a range of financial possibilities or a spectrum of business models with different financial typologies that can generally be used to describe a business model's financial operating characteristics (EFRAG 2013; Haslam et al 2013).

Within the Haslam et al (2013) spectrum of typologies, as we see on the left side of table 3.1, business models are *'cash burning',* that is they are raising cash and drawing it down from the balance sheet to cover expenses. As we move to the centre of table 3.1, we come across business models that generate considerable cash surplus and have comparatively low levels of debt financing appearing on their balance sheets. Moving towards the right end, we see business models that generate slim margins through assets traded out of their balance sheets. The later type of business models are often leveraged in terms of their debt to equity ratios. Investment banking, private equity, and real estate investment trusts are good examples of business models located somewhere on the right end of table 3.1. This means that they generate relatively low income and cash margins from their operations and they mainly rely on extracting holding gains from asset trading and revaluations.

Table 3.1: Business Model Financial Typologies

Cash margins weak Balance sheet-Depletion		Cash margins strong Balance Sheet augmentation			Cash margins slim Balance Sheet assets trading and holding gains	
Cash Burn	Cash Burn + income	Cash generative	Strong cash generation	Very strong cash generation	Cash positive	Limited/ restricted cash from operations
Cash from operations negative	Cash from operations neutral	Cash from Operations Positive	Cash from operations strong	Cash from operations very strong	Cash from operations positive holding gains from asset trades strong	Cash from operations limited holding gains from assets very strong
External funding draw down	External funding draw down	External funding + internal surplus	External plus internal funding strong.	Little need for external funding	High levels of debt funding to equity	Very high debt to equity funding ratios
Balance sheet depletion	Some signs of balance sheet augmentation	Balance sheet augmenta-tion	Balance sheet high net worth	Balance sheet strong net worth	Debt to equity ratio high	Debt to equity ratio high

Focal firm located in business model = Operating context and risk variable

Source: Haslam et al (2013:70)

A business models framework of analysis grounded in accounting and analysis of stakeholder interactions, also relies on a change in financial reporting requirements and disclosures. The accounting professional bodies and regulatory organisations however, have been reluctant to expand the functionality of the conceptual framework for financial reporting, that governs financial disclosure, to a broader group of stakeholders. Additionally, when a broader disclosure initiative is considered, it tends to emphasise on *'disclosure to'* rather than *'disclosure about'* stakeholder interactions and their contribution to financial viability and risk. However, Bukh and Nielsen (2010), in their work on health care business models argue that there is considerable added value from communicating the nature of a reporting entity's *'business model'* because this offers a new management technology that can help inform disclosure to stakeholders.

> *"Thus, we perceive the business model as a management technology that helps management communicate and share its understanding of the business logic to external stakeholders, in our case primarily analysts and investors"*
>
> Bukh and Nielsen (2010:11)

The accounting profession and its main regulatory bodies, appear to still, be preoccupied with developing a conceptual framework that can determine the relevance and purpose of financial disclosures by reporting entities. Zeff (1999) delivers a valuable account of the development of the conceptual framework governing financial disclosures for business entities in the US. Zeff observes that in 1966 the American Accounting Association (AAA) published a pioneering

monograph titled *'A Statement of Basic Accounting Theory (ASOBAT)'*. ASOBAT shifted the field of the disclosure away from types of a valuation approach, towards the information needs of investors, specifically for *'decision usefulness'*, emphasising for example on earnings upon which predictions and valuations might be made.

> *"Almost all external users of financial information reported by a profit-oriented firm are involved in efforts to predict the earnings of the firm for some future period. Such predictions are most crucial in the case of present and prospective equity investors and their representatives - considered by many to be the most important of the user groups"*

(AAA, 1966:23)

Zeff (1999) also argues that ASOBAT left the possibility open for firms to report a range of information considered relevant to the needs of the user(s), where users may not simply be investors but also employees and managers. In a later report published by The Trueblood Committee (1973) the use of several measurements to evaluate performance, whilst catering for the needs of a range of user groups, was proposed highlighting also that social goals are no less important than economic goals. However, the conceptual framework that governs financial reporting is still preoccupied with disclosing information to a narrow set of stakeholders *'investors, lenders, and creditors'* (IASB, 2010).

In recent years, the accounting professional bodies have considered the advantages of using a business models framework within which to structure accounting disclosures. However, disclosure to *'investors, lenders, and creditors'* instead of a wider group of

stakeholders appears to still take priority. The Institute of Chartered Accountants in England and Wales (ICAEW) 2010 report on business models in accounting, for example suggest that, in conjunction with elements from the theory of the firm, the concept of *'business models'* can facilitate the provision of appropriate disclosures to those providing capital funding. The ICAEW report also suggests that the type of a firm's business model can potentially determine, whether fair value or historic cost recording of transactions in the balance sheet is more appropriate.

> *"Assumptions about business models have always been implicit in financial reporting standards, as it has always been the case that different businesses will account for the same asset in different ways depending on what its role is within the firm's business model. Questions of cost allocation and revenue recognition for different firms and different sectors are also closely tied to the interpretation of their business models"*
>
> (ICAEW 2010:8)

Therefore, a business model is a mechanism that can help distinguish amongst methods of asset valuation as it takes into account the purpose for which these assets are to be used. If, for example, assets are actively traded they should be *'marked to market'* whilst if they are held for long-term they can justifiably be kept at historic cost. Hence, it is becoming apparent that the views expressed through this ICAEW report on the application of a *'business model'* framework for corporate disclosure is narrowly specified and mainly focused on disclosure to '*investors, lenders, and creditors*'.

In a recent European Financial Reporting Advisory Group (EFRAG, 2013) research report on the role of the business model in financial statements, a definition of the term *'business model'* has been discussed. Additionally, a firm's business model is represented by the way its activities are configured, for example, to what extent are its activities, capital intensive, or whether they rely heavily on R&D expenditures.

> *"Whilst there is no universally defined meaning of the term 'business model', academic literature evidences that the term is increasingly referred to in corporate reporting to describe an entity's activities, its asset configuration (for example, capital intensive or heavy reliance on R&D), and its customers, products and services"*
>
> (EFRAG 2013:10)

The EFRAG (2013) report, hence, focuses mainly on how a business models framework would contribute to modify the *'Conceptual Framework'* that determines the purpose and objectives of financial disclosure. More specifically, how could a business models' approach to financial disclosure impact on the foundational qualitative characteristics of the conceptual framework - relevance and faithful representation – as well as on its secondary aspects - comparability, timeliness, and understandability. Consequently, we observe that this report from the EFRAG is also placing emphasis on how financial disclosures, influenced by the reporting entity's business model, would improve the way in which information is provided to '*investors, lenders, and creditors*'. However, EFRAG's position is also that a business model framework would contribute towards *'cohesiveness'*.

> *"The need to understand an entity's business model is further increased by development of integrated reporting, which suggests that investors need to rely on a cohesive set of information, encompassing more than only financial statements"*

(EFRAG 2013:12)

Similarly, the International Integrated Reporting Council's (IIRC) report of 2013 attempts to define an organisation's business model. This definition mainly relies on the economic theory of the firm, rather than on accounting for stakeholders, as it frames the firm as an activity that transforms inputs to outputs in order to generate value.

> *"An organisation's business model is its chosen system of inputs, business activities, outputs and outcomes that aims to create value over the short, medium and long term"*

(IIRC 2013:14)

In contrast to other professional and regulatory accounting bodies, the IIRC report incorporates the need to report to a broader group of stakeholders. Additionally, it takes the position that a wider group of stakeholders such as employees, customers, suppliers, business partners, local communities, legislators, regulators and policy-makers are interested in the value creating capacity of an organisation.

It is becoming apparent, from the professional and regulatory accounting bodies' reports that the *'business model'*, as an organising concept, is influencing their rational regarding the disclosure of relevant information to stakeholders, whether this is a wider or a narrower group. On the other hand, these reports share a common issue in that they are not developing a strong *'business model'* organising framework to explore how this concept would practically influence the improvement of corporate financial disclosure.

3.7 Constructing the hospice business model

The previous sections have reviewed the literature on business models which is closely attached to a management strategy literature and explaining how firms create and sustain value. The framework presented by Haslam et al (2012) suggests that a firm's business model is the product of complex stakeholder relations and changes to these relationships have an impact upon the viability of the business model under consideration. Hospices are not for profit organisations but they do report their financial accounts as we have seen in section 2.4.2 above. Thus changes in stakeholder relations can impact upon the financial viability of hospices and can also be employed to account for the adaptation and evolution of the hospice business model.

At the centre of the hospice business model are the hospices themselves which are enclosed within a complex web of stakeholder relations. These stakeholder relationships are adapting and evolving and impacting upon individual hospices in a variable way and hence, they have impact upon their viability and sustainability.

In the figure below I construct a simple representation of the hospice business model and stakeholder network. This representation oversimplifies because embedded

within these categories are additional stakeholder networks. For example, within the sphere that contains the income and expenditure patterns, there are complex stakeholder relations surrounding: fundraising activities, legacies made, running lotteries, and making investments, to generate additional income. Similarly, complex arrangements with stakeholders associated with policy and regulations that impact upon the viability of the hospice business model include: changes in health regulations and practices, accounting regulations and financial reporting, pensions and retirement, government policy, and end of life care arrangements.

Hospices internal stakeholder networks include the on-going development of new skills sets of highly trained employees (managerial, administrative and clinical) and the quality of volunteers and their skills and capabilities. The nature of physical facilities and appropriate resources, as well as, the extent they are kept fit for purpose for the care of chronically ill patients, that includes both older and younger generation(s). Mapping out the complex stakeholder relations that constitutes the hospice business model is a useful investigative tool because we can evaluate the extent to which these relationships are changing over time and how they are impacting on the viability of the hospice movement. Our understanding of the hospice business model can be informed by interviews with key actors within the stakeholder network. This can also help in assessing how changes in policy, regulations and needs of the households impact on the financial viability of this business model.

The evolution of the hospice business model is complex because the demands for its services are increasing and the internal and external web of stakeholder relations required to sustain viability have become much more complex and contingent. Thus uncertainties over the employment of highly skilled professionals could act as a

brake to the development of hospices, or introduction of new regulations can put added strain on scarce resources. Also, increased dependency on government funding, whilst stabilising income streams, exposes hospices to different types of risk, for example austerity and cutbacks or value for money initiatives can challenge the 'values' of the hospice movement.

Figure 3.4: A stakeholder schematic of the hospice business model

Source: Author

The business models literature grounded in strategy and often associated with firms that make profit for value: creation, capture, and shareholder interests may not immediately seem to be of relevance as an investigative toolkit, within which to frame an analysis of voluntary hospices. The argument in this thesis is, that the framing of a reporting entity (hospices) business model, within a stakeholder network (see Haslam et al, 2012 and 2014), does provide a useful means by which to investigate the development of hospices and assess the extent to which changes in the relationship with stakeholders, can stress the viability of this essential foundational social activity.

As I will argue in the following chapter, a business model approach to framing this investigation into hospices makes visible the contribution of stakeholders to the viability of the hospice movement. As such their narratives about change and the challenges ahead are a relevant and meaningful investigative resource, as too are the financial reports, because these reveal the extent to which stakeholder arrangements are underwriting or threatening the financial viability of hospices. This thesis therefore explores the hospice business model from a stakeholder perspective where normative values and beliefs are confronted by an instrumental need to make money (Donaldson and Preston, 1995; Freeman et al, 2004; Friedman and Niles, 2002).

3.8 Summary

This chapter provided a review of the literature on business models and evaluated its potential to be used as a framing device for the study. In this thesis, a business model framework of analysis will be utilised. This is grounded in both stakeholder theory and accounting. In contrast to the debate on business models and financial reporting to a narrow group of stakeholders this thesis argues that we need to report about

changes in stakeholder relations and how these are impacting on the financial viability and risk associated with a specific business model. The research is focussed on the hospice business model in the voluntary sector and how this has evolved and adapted and the consequences of this on the financial viability and risk associated with this voluntary sector activity.

The literature on business models, as we have discussed, tends to be located within the corporate domain and is mainly concerned with listed companies rather that voluntary and charitable organisations. However, for this thesis a loose conceptualisation of business models, grounded in accounting, provides a useful means by which to frame a research investigation into the evolution and development of the provision of palliative care by hospices. This is considering and exploring how the nature of stakeholder relations, amongst the reporting hospices, has changed over time and how this impacts on the financial viability of the hospice business model.

Chapter 4: Research methodology

4.1 Introduction

The suitability and intellectual robustness of the research structure as well as the appropriate application of research methods are considered to be the defining factors of a research study's methodological rigour (see for example Smith 2015, Collis and Hussey 2014, Hung 2014, and Saunders et al 2007). With this in mind, this chapter evolves around the discussion of the philosophical framework for scientific enquiry considering the paradigms and methods used in social sciences and business and management research. Further on, the discussion focuses on the nature of accounting research and theory development in order to identify and evaluate the alternative approaches that could be adopted for the accomplishment of the objectives of this thesis.

The above consequently lead to the justification of the suitability of a middle range, inductive approach that outlines the structure of this study. Following from that the discussion in this chapter focuses on the detailed presentation and application of the methods adopted for the completion of the thesis and the complementary contribution of qualitative and quantitative data. Eventually, the chapter addresses the relevant ethical considerations for the research carried out in this thesis.

4.2 The Philosophical framework of scientific research

Russel (1946) in his *'history of western philosophy'* identifies three broad factors, theology, philosophy, and science, known to influence mankind's awareness of the world, as well as, its capacity to respond to fundamental existential questions related to its own being and its ability to know / understand the surrounding universe.

Theology comprises of speculations on matters as to which firm knowledge has so far not been discovered, whilst science appeals to human reason rather than to authority in order to determine what and how we can develop knowledge on various matters. Philosophy according to Russel's view is the *'No Man's Land'* in between the territories of theology and science.

Hung (2014), addressing the role of science in the development of human knowledge from a philosophical perspective claims that philosophy of science is:

> *"... not a set of claims about the material universe nor is it about the supernatural. Rather it is, crudely put, a set of advice, means, and practices to help us see things clearly and to evaluate claims, principles, arguments, and inferences carefully and critically."*

(Hung 2014:1)

Hence, Hung (2014) argues that within the realms of philosophy of science, one is encouraged to study the structure and claims of science and clarify with precision what this claims are, to study and evaluate the methods used and practiced in science, as well as to enquire into the ways science develops or should and could have developed. Through extending our understanding of how science works and knowledge develops, we can *'employ better methods and better formulations'* and consequently *'do better science'* and extend the boundaries of our knowledge.

The conceptions introduced by science in the seventeenth century, as initiated by the contributions of men like Copernicus (1473 – 1543), Kepler (1571 – 1630), Galileo (1564 – 1642), and Newton (1642 – 1727), are considered to have a profound effect on mankind's perspective of the surrounding world, as well as, on the ways we can

get to know and understand it (see for example Chalmers 1982, Kerlinger 1979, Russel 1946).

> *"Almost everything that distinguishes the modern world from earlier centuries is attributable to science, which achieved its most spectacular triumphs in the seventeenth century. The Italian Renaissance, though not medieval, is not modern; it is more akin to the best age of Greece. The sixteenth century, with its absorption to theology, is more medieval than the world of Machiavelli. The modern world, so far as mental outlook is concerned, begins in the seventeenth century."*

(Russel, 1946:484)

Bruwer (1912) whilst arguing for the importance of science for humanity's development and ability to create order in nature, through both understanding the relationships of phenomena and through supplementing them by phenomena caused by humanity's own interventions, defined science as:

> *"the systematic cataloguing by means of laws of nature of causal sequences of phenomena, i.e. sequences of phenomena which for individual or social purposes it is convenient to consider as repeating themselves identically,—and more particularly of such causal sequences as are of importance in social relations"*

(Bruwer 1912:81)

Hence, science can broadly be understood as a logical process, which relies on observation and experiment in order to systematically examine phenomena taking place or affecting the structure and behavior of the physical and natural world. Therefore, scientific research in its various forms aims to surpass description and provide explanation of the phenomena it investigates (see for example Collis and Hussey 2014, Hung 2014, Creswell 2013, Saunders et al 2007, Russel 1946, Bruwer 1912). Kerlinger (1979) defined scientific research as the

> *"... systematic, controlled, empirical, and critical investigation of hypothetical propositions about the presumed relations among natural phenomena."*
>
> (Kerlinger 1979:11)

Shared examples / models of practice that result in universally recognized scientific achievements across several scientific communities constitute the various research paradigms. These in turn are establishing the philosophical framework of practice, which is determining how scientific research is conducted, based on a particular scientific community's traditions, philosophies, and assumptions about the world and the nature of knowledge (Kuhn 2012). Denzin & Lincoln (1994) argue that a paradigm incorporates three fundamental aspects, epistemology, ontology, and methodology. Epistemology is concerned with the theory of knowing and with what can be recognized as evidence. Consequently, epistemology aims to determine how one might discover knowledge about the world by establishing what counts as knowledge, what delineates it as knowledge, and what kind of things count as

evidence Jankowicz (2000). According to Denzin and Lincoln (1994: 99) epistemology poses the questions: *'How do we know the world? What is the relationship between the inquirer and the known?'* Ontology is concerned with our assumptions about the nature of reality demonstrating what we believe about the world. Methodology is addressing issues relevant to the process of the research (Collis and Hussey 2014). Saunders et al (2007:5) define research as '*something that people undertake in order to find out things in a systematic way, thereby increasing their knowledge'*. Consequently, business and management research is a systematic way to find out things about business and management. In the light of these, a research method is:

> *"... a systematic and orderly approach taken towards the collection and analysis of data so that information can be obtained from those data"*
>
> (Jankowicz 2000:209)

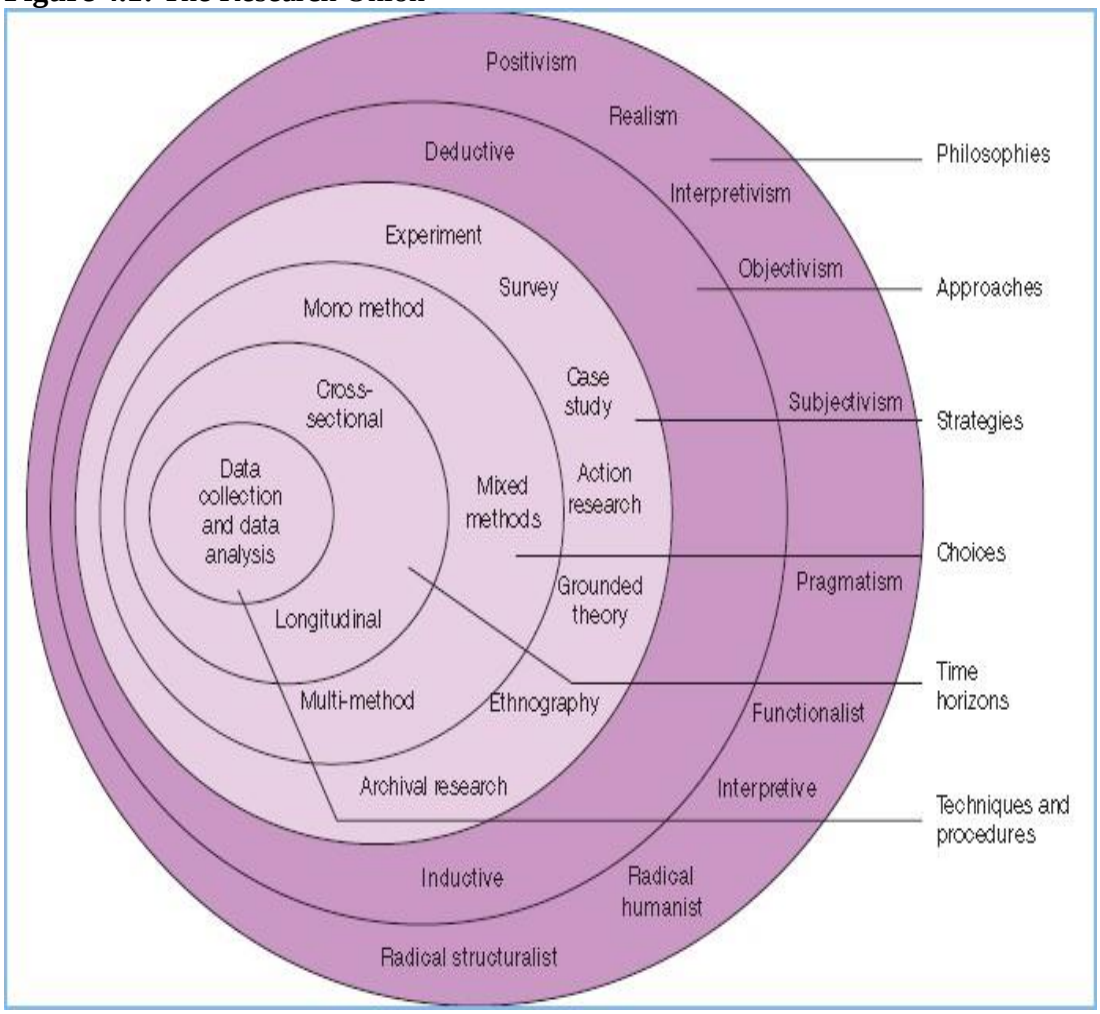
4.3 Paradigms and methods in social sciences and business and management research

Social sciences, *'the scientific study of human society and social relationships'* (see Oxford dictionaries 2013), have been systematically developed, as a distinct branch of scientific research, over the last century. During the initial phase of their growth, social sciences were based on the model of natural sciences, where knowledge is developed through experimentation and vigilant measurement of results. Hence, at its early development, social science research has been shaped by the use of quantitative methods, within a positivist paradigm (Wright 2005, Punch 1988, Jacobson 1966).

However, over the latter half of the 20th century scientific research in social sciences became increasingly multidimensional and embraced a variety of research paradigms. As a result, the development of each new paradigm produced additional debates about alternative research methods that are appropriate for scientific research within its philosophical position (Saunders et al 2007 and 2003, Gray 2004, Burrel and Morgan 1979). Consequently, researchers' views and social interpretations of reality affect their choices of research paradigms and methods and vice versa (Saunders et al 2003).

Hence, it is essential to understand the research approach and strategy chosen compared to alternative approaches when evaluating or developing a research study. In an attempt to summarize the complex range of philosophies and approaches that underpin research methods in social sciences and business research, Saunders et al (2003 and 2007) sketch the research process in what they call a *'research onion'* (see figure 4.1 below). Thus, whilst structuring a research study, a researcher is metaphorically peeling off the onion's layers.

Figure 4.1: The Research Onion



Source: Saunders et al (2007:132)

Collis and Hussey (2014) on the other hand suggests that, as only few researchers nowadays adopt pure forms of a paradigm, positivism and interpretivism can be approached as the two extremities on a continuous line of paradigms that exist synchronously. Whilst a researcher moves along the line, the features and assumptions of one paradigm are progressively substituted by those of the next. The traditional positivist approach to research, originating in the natural sciences, uses a deductive approach to test hypothesis and relationships between variables and considers the researcher to be separate from the context in which the research takes place.

This view, however, has been criticized as inappropriate for research taking place within a range of social settings, where, independently observing repeatable experiments is not feasible. In response to the criticisms of positivism, interpretivism is grounded on the assumption that *'social reality is in our minds, and is subjective and multiple'* (Collis and Hussey 2014:44). This assumption enables a range of subjective interpretations of social phenomena, facilitates analyses that appreciate social dynamics and complexity, and acknowledges that the act of researching social reality has an impact on it (see Smith 2015, Creswell 2013, Saunders et al 2007). Table 4.1 below, adopted from Collis and Hussey (2014), provides a summary of the assumptions of positivism and interpretivism.

Table 4.1: Assumptions of the two main paradigms

Philosophical assumption	**Positivism**	**Interpretivism**
Ontological assumption (the nature of reality)	Social reality is objective and external to the researcher.	Social reality is subjective and socially constructed.
	There is only one reality.	There are multiple realities.
Epistemological assumption (what constitutes valid knowledge)	Knowledge comes from objective evidence about observable and measurable phenomena.	Knowledge comes from subjective evidence from participants.
	The researcher is distant from phenomena under study.	The researcher interacts with phenomena under study.
Axiological assumption (the role of values)	The researcher is independent from phenomena under study.	The researcher acknowledges that research is subjective.
	The results are unbiased and value-free.	The findings are biased and value-laden.
Rhetorical assumption (the language of research)	The researcher uses the passive voice, accepted quantitative words and set definitions.	The researcher uses the personal voice, accepted qualitative terms and limited a priori definitions.
Methodological assumption (the process of research)	The researcher takes a deductive approach.	The researcher takes an inductive approach.
	The researcher studies cause and effect, and uses a static design where categories are identified in advance.	The researcher studies the topic within its context and uses an emerging design where categories are identified during the process.
	Generalizations lead to prediction, explanation and understanding.	Patterns and/or theories are developed for understanding.
	Results are accurate and reliable through validity and reliability.	Findings are accurate and reliable through verification.

Source: Collis and Hussey (2014:46-47)

Reliance on the pure form of a paradigm, positivism or interpretivism and hence on purely quantitative or qualitative methods and data, has traditionally been the norm in social science research. However, dependence on the research question whilst determining appropriate paradigms and methods – pragmatism -, as well as, intentionally combining methods within a research project to develop a broader view of phenomena and cancel out weaknesses of particular approaches – triangulation -, has gained considerable recognition over the last decades (Creswell 2013, Johnson et al 2007, Jick 1979). For example Saunders et al (2007), based on the fact that there is a strong relationship between the method used and the results obtained, argue that:

> *"Since all different techniques and procedures will have different effects, it makes sense to use different methods to cancel out the 'method effect'. That will lead to greater confidence being placed in your conclusions."*

(Saunders et al 2007:147)

4.4 Paradigms and methods in accounting research

Widespread debates are the norm amongst accounting researchers whilst trying to address issues relevant to: what constitutes an appropriate research paradigm for accounting research (see for example: Lukka 2010, Modell 2010, Gaffikin 2007, Beattie and Davie 2006, Lee and Humphrey 2006, Beattie 2005, Riahi-Belkaoui 2004, Mattessich 2003, Laughlin 1999 and 1995, Mouck 1990), the ability of accounting research to inform accounting practice (Moehrle et al 2009, Inanga and Schneider 2005), accounting's theoretical foundations (Smith 2015, Hahn 2007, Hendriksen 1977), and accounting's function as science (Rutherford 2010, Sterling

1975). Inanga and Schneider (2005), for example, argue that accounting research is failing to inform and improve accounting practice and regulation mainly due to luck of a suitable body of known theory upon which hypotheses and/or models could be developed and tested. They also highlight a communication gap between accounting researchers and practitioners, which prevents interaction and limits the ability of research findings to address the professionals' needs. Moehrle et al (2009) however, argue that:

> *"Academics have made countless contributions to the public debate as well as the current state-of-the-art financial accounting. Perusal of any high-profile financial statement analysis or valuation text will reveal countless citations that reinforce the academic contribution."*

(Moehrle et al 2009:413)

This divergence in terms of approaches taken by accounting theorists have led to a multitude of theories being proposed rather than to the development of a comprehensive accounting theory. Hence, labeling accounting as a multi-paradigm science. Hendriksen (1977) for example defined accounting theory as:

> *"a set of broad principles that provides a general frame of reference by which accounting practice can be evaluated and guides the development of new practices and procedures"*

(Hendriksen 1977 in Riahi-Belkaoui 2004:109)

However, considering these divergences the American Accounting Association's Committee on Concepts and Standards (AAACCS) (1977) suggested that:

> *"No single governing theory of financial accounting is rich enough to encompass the full range of user-environment specifications effectively; hence, there exists in the financial accounting literature not a theory but a 'collection of theories' which can be arrayed over the differences in user environment specifications"*

(AAACCS 1977 in Riahi-Belkaoui 2004:108)

More recently, Hahn (2007) observes that in response to the lack of commonly accepted base theory, accounting researchers often rely on, or test, theories drawn from a number of fields of study including economics, finance, sociology, psychology, and organizational behaviour. Following the same line, Smith (2015) argues that accounting researchers do not have much theory, methods, and instruments of their own and hence they are dependent on prior research methods employed in natural and social sciences in order to solve problems, examine relationships, and develop a body of knowledge. This dependence according to Lukka (2010) led to the development of one dominant – primarily in North America – economics based, functionalist, paradigm and two alternative paradigms, the interpretive and the critical, that stem from sociological studies. The functionalist paradigm aims to develop fundamentally rational explanations of social phenomena and law-like regularities that can be tested through the use of empirical data sets. The interpretive paradigm, largely influenced by the work of Burrell and Morgan (1979), acknowledges that the world can be seen as socially constructed and considers the

subjective meanings that individuals associate to things. Finally, the critical paradigm, influenced by various social science thinkers like Marx, Foucault, and Habermas, is based on the assumption that there are well established structural contradictions and clashes in the society of which people need to be informed about and liberated. Beattie (2005) following to an examination of 261 articles published in seven non US accounting journal observed that accounting research in UK

> *"... is characterised by extremely diverse research genres—from the highly quantitative, economics-based, positive US tradition, through to the qualitative, relativist/critical tradition, with all shades in between"*

(Beattie 2005:108)

Riahi-Belkaoui (2004), in the light of Ritzer's (1975) definition of a paradigm in social science, examines the six paradigms for accounting research suggested by the AAACCS (1977) in terms of their respective *'exemplars', 'images of the subject matter', 'theories',* and *'methods and instruments'* (see Riahi-Belkaoui 2004:336). Tables 4.2a and 4.2b below, present an overview of his observations.

Table 4.2a: Competing paradigms in accounting research

Paradigm	**The subject mater**	**Theories**	**Methods and instruments**
Anthropological / inductive	Existing accounting practices and managements attitudes towards those practices	Information economics, Analytical / agency model, Income smoothing / earnings management hypotheses, Positive theory of accounting	Techniques used in: Income smoothing research, Earnings management research, and Positive theory research
True income / deductive	The construction of an accounting theory on the basis of logical and normative reasoning and conceptual rigor, A concept of ideal income based on a method other than historic cost	Price level adjusted accounting, Replacement cost accounting, Deprival value accounting, Net realizable value accounting, Present value accounting	Use of analytic reasoning to justify the construction of an accounting theory or to argue for an asset valuation / income determination model other than historic cost accounting
Decision usefulness / decision model	The usefulness of accounting information to decision models	Different kinds of decision models associated with business decision making, Different economic event that may affect a going concern	Empirical techniques to determine the predictive ability of selected items of information

Source: Riahi-Belkaoui (2004:335-348)

Table 4.2b: Competing paradigms in accounting research

Paradigm	**The subject mater**	**Theories**	**Methods and instruments**
Decision usefulness / decision maker / aggregate market behaviour	The aggregate market response to accounting variables	The efficient market model, The efficient market hypothesis, The capital asset pricing model, The arbitrage pricing theory, The equilibrium theory of option pricing	The market model, The beta estimation models, The event study methodology, The Ohlson's valuation model, The price level balance sheet evaluation models, The models of the relation between earnings and return
Decision usefulness / decision maker / individual user	The individual user response to accounting variables	Borrowed from other disciplines examples include: Cognitive realism in accounting, Cultural relativism in accounting, Behavioural effects of accounting information etc.	Observation techniques, Interviews, Questionnaires, Experimentation
Information / economics	Information is an economic commodity and the acquisition of information amounts to a problem of economic choice	Theory of teams, Traditional economic assumption of consistent, rational-choice behaviour	Analytic reasoning based on statistical decision theory and the economic theory of choice

Source: Riahi-Belkaoui (2004:335-348)

Laughlin (1995) provides an overview of the methodological developments and the debates in accounting research. Starting from the discussion on normative thinking – how things should be – versus the descriptive approach – how things are – he then moves on to analyze the various approaches to accounting research using a three dimensional framework – theory, methodology and change – which is based on the work of Burell and Morgan of 1979. Eventually, he presents his argument on the advantages of what he loosely refers to as a *'middle-range'* thinking which is further clarified on his work of 2004 (see Laughlin 1995 and 2004). This approach is argued to provide a:

> *"more realistic depiction of the social and technical nature of accounting systems design"*
>
> (Laughlin 1995:82)

Humphrey and Lee (2004 and 2006) consider how accounting research has moved from a purely positivist approach to become a more pluralistic field of study. With their work, Humphrey and Lee, attempt to provide a clear acknowledgement, of how the use of qualitative methods has enriched accounting research. They also deliver '*how to'* guidance, to potential accounting researchers, on issues relevant to conducting qualitative research and on the associated challenges.

In summary, this section demonstrates that accounting is a multi-paradigm science, relying on a collection of theories, research approaches, and methods, to advance its body of knowledge. Accounting research is thus a pluralist field of study where a

variety of research approaches are possible. Laughlin (1995) observes that we (the researchers)

> *"... need to argue the merits of their chosen perspective, to defend their position and be equally prepared to be contradicted"*
>
> (Laughlin 1995:77)

4.5 The research approach and methods of this thesis

The primary objective of this thesis, is to evaluate the sustainability of palliative care provision by voluntary hospices in England, using a business models' framework of accounting analysis, as developed within the works of, Haslam et al. (2013), Andersson and Haslam (2012), and Andersson et al. (2010). However, there is a scarcity of relevant literature, on voluntary hospices, within the realms of accounting, business, and management academic research. In this thesis the researcher will employ a business model approach to construct an inductive middle ground approach. This in turn employed to construct a loose conceptualization within which to frame the investigation into the evolution and development of the provision of palliative care by hospices.

Hence, for the purpose of this thesis on hospices, a mixed methods approach is employed that is located somewhere between positivism and interpretivism. A positivistic research approach, as presented on the previous sections of this chapter, tests hypotheses and relationships between variables. Interpretivism or a post-modern approach, on the other hand, rely mainly on narratives and storytelling and tend to avoid the use of numbers. In this thesis the research philosophy is located somewhere

between positivism and interpretivism, on what is often termed a middle ground position which can be both deductive and inductive depending on the objectives of the research (see Collis and Hussey 2014, Sauders et al. 2007, Laughlin 1995 and 2004). Overall, the project is grounded in accounting and supported by narratives extracted from interviews with senior palliative care professionals, from four large and medium hospices. Within the remaining of this section, the researcher explains the role of literature, as well as the nature and application of the research methods employed for the accomplishment of the thesis.

4.5.1 The role of literature

Providing the foundations of a research project is presented as a key aim of the literature review (see for example Sauders et al. 2007, Jankowicz 2000, Glaser 1998). Identifying the main general arguments and themes in the subject area, the main authorities in the field, the common research methods in use and their relevance to the research project, can be of great help in setting the context and defining the gaps the study aims to address. A deductive approach uses literature to identify theories and ideas which the researcher plans to test using relevant data, whilst an inductive approach, explores data to develop theories from them and then associates them with pre-existing literature (see Collis and Hussey 2014, Sauders et al. 2007). Glaser (1998) encourages a wide use of literature in areas both within and outside the boundaries of the research topic, to ensure wide coverage of relevant ideas around the area of interest.

Croft (2010) on his work on the theory of governance processes within the voluntary hospice sector, adopted Glaser's approach to deal with the limited availability of relevant academic literature, within the narrow boundaries of his area of interest.

Despite the plethora of research in palliative and end of life care addressing its clinical, social, historical and political aspects which has been developed over the last decades (see for example Davison 2010, Association of Children's Hospices 2006, Milicevic 2002, Sauders 2001, Clark 1998, Denice & Walter 1996, Saunders 1993, Kubler-Ross 1969), the literature on voluntary hospices *'business elements'* is fragmented and scattered within academic and across practitioner discourses. However, it can collectively reveal some of the challenges facing this sector and assist in constructing and evaluating the sustainability of a relevant business model (Theodosopoulos 2011).

Andersson and Haslam (2012) and Andersson et al (2010) make a distinction between a *'productionist'* and a *'financialized'* scope to the term business model. Under the productionist scope the term is used for a broad range of informal and formal descriptions to represent core aspects of a business which can include purpose, offerings, strategies, infrastructure, organizational structures, trading practices, operational processes, and policies. On the other hand under the financialized scope one adopts a broader perspective, the aims would not be so much process focused even though the core activities of a business would still be taken into account.

Accountants want to evaluate and communicate information relevant to the primary objective of an organisation. Maximisation of shareholders' wealth is the primary objective within a commercial setting Pike and Neale (2008), whilst the maximisation of benefits to beneficiaries, on a broad sense, can be seen as the primary objective within a voluntary / charitable setting (see Nicholls 2009, Landsberg 2004, and Anheier 2000). Hence from an accountant's standpoint identification of strengths and weaknesses would take into account issues relevant to

investment sustainability and risk, market requirements and perceptions, and relevant stakeholders' interests Andersson et al. (2010).

Considering the objective of this thesis, the first chapter of literature review reveals the core activities of hospices and furthers our understanding of the clinical, social, historical, regulatory, and political context within which they developed and operate. This facilitates identification of the strengths and weaknesses of the business model and contributes to the evaluation of its robustness in the face of foreseeable challenges. Considering the theoretical foundations of the thesis the second chapter of literature review is used to review the literature on business models and examine its potential to be used as a framing device for the analysis.

4.5.2 Methods, data, and structure of analysis

Quantitative methods rely on data presented in numerical form or quantified qualitative data, on the other hand, qualitative methods are based on data that cannot be counted and are presented in *'nominal (named) form'* (Collis and Hussey 2014:45) and can be used to find out patterns and trends and to reveal more in-depth information about a particular phenomenon. Miles et al (2014) argue that:

> *"... the careful measurement, generalizable samples, experimental control, and statistical tools of good quantitative studies are precious assets. When they are combined with the up-close, deep, credible understanding of complex real-world contexts that characterize good qualitative studies, we have a powerful mix"*
>
> (Miles et al 2014:43)

Within this thesis a combination of qualitative data, obtained through semi-structured interviews, in conjunction with quantitative data obtained from the annual accounts of the 35 largest in terms of income hospices in England, provide the basis for both structuring a descriptive business model for hospices and identifying its strengths and weaknesses, as well as, the challenges expected to face on the mid to long term future. This analysis is then used to form our assumptions about the business model's sustainability and potential interventions needed to enhance it.

4.5.2.1 The role and structure of qualitative analysis

The analysis of qualitative data aims to enhance our understanding of the voluntary hospices business model and issues relevant to its sustainability. Starting with an analytic induction phase, as defined by Johnson (2004) below, the analysis is founded on critical presentation of inside information obtained through semi structured interviews with 18 senior managers of four voluntary hospices. These type of analysis is deemed necessary to establish the broad frame of the research and complement the findings of the '*fragmented and scattered*' (Theodosopoulos 2011:118) within academic and practitioner discourses literature on the voluntary hospices' *'business elements'*.

> *"... the intensive examination of a strategically selected number of cases so as to empirically establish the causes of a specific phenomenon"*
>
> (Johnson 2004:165)

For the needs of a semi structured interview approach, which allows for in-depth information to be collected, as well as, for ad hoc adjustments to be made, (see Sauders et al. 2007) the questionnaire is organized into six broad thematic categories. Within this context, the participants are asked to answer questions covering: their background and involvement with the hospice movement, their professional views on the development of hospices, their role and the role of their teams within their employer hospice, issues on inter-professional relationships and performance, issues on recruitment, and to provide general feedback on the interview process. To enhance the validity and reliability of findings (see Collis and Hussey 2014) the questionnaire was piloted with the CEO's of two of the hospices involved and two academics. Also all participants were asked for suggestions and feedback at the end of each interview.

Adapting grounded theory procedures (Straus and Corbin 1998) to categorize and present findings in a systematic manner the qualitative analysis is organised into two chapters based on the professional background of the participants. Hence the open coding process results into two units of data. The first unit of data, chapter five, is formed based on the responses of senior clinical staff including four medical and three nursing directors, (or equivalent, as professional titles vary across different hospices due to size and types of provided services), as well as, two senior nurses with managerial responsibilities. The second unit of data chapter six, comprises the responses of non-clinical staff including four fundraising directors, two hospice accountants, one voluntary services manager, one support services manager, and one senior administrator.

Axial coding into thematic categories that emerged through the responses of the participants and the general structure of the questionnaire further disaggregates the data into appropriate quotations extracted from each interview based on their relevance to:

- The participants' background and role in relation to the role of the departments they manage within their employer hospice
- The participants' professional views on the evolution of the hospice movement in England
- The participants professional views on what they see as forthcoming challenges for the sector and their employer hospice
- The participants professional views on courses of action taken, planned, or suggested in order to effectively deal with these challenges at both national and locality level

By the end of the process axial coding incorporates the rearrangement of the findings on each unit and identifies the core elements relevant to the structure, evolution, and challenges to sustainability of the hospice business model. With selective coding identification of foreseeable challenges and the business models' ability to respond are identified as the core category to which the other categories are related.

4.5.2.2 The role and structure of quantitative analysis

Following of Haslam et al. (2013), Andersson and Haslam (2012), and Andersson et al. (2010), the quantitative analysis on this thesis uses data to help structure a descriptive business model for voluntary hospices. Hence, this section provides an

analysis of relevant financial information focusing on the top 35 hospices in England, as ranked by their total income. Based on Help the hospices 2006 and 2009 classifications, I estimate that this group accounts for roughly half of all hospice income in England. Even though this sample is not physically representative of the hospice voluntary sector in England, due to the existence of many small regionally embedded hospices, it still constitutes a financially significant illustration.

Hospices' financial reporting requirements have been examined in detailed in section 2.4.2 of the literature review. There, it was presented that charities above the income threshold of £250,000 have to prepare accounts on an accruals basis and in compliance with the charities Statement of Recommended Practice (SORP). These accounts have to be publically available and to be filed with the charity commission, to secure a source of appropriate data for public scrutiny. For the purpose of this thesis the financial accounts of the top 35 hospices provide a source of valid, reliable, and comparable data used to construct a comprehensive financial database for research purposes. This database constitutes the foundation of the quantitative analysis in this thesis.

The analysis in this section of the thesis, chapter seven, based on a financial review of 35 hospices accounts covering the period 2004 to 2011, focuses on the nature of the hospice business model from a financial perspective and accounts for its sustainability in the face of the forthcoming challenges identified in the chapters five and six. Aggregating the financials for this group, I describe the fundamental features of the hospice business model in terms of trajectory and composition of income and expenditure.

Additionally, this section adopts a case study approach through the detailed examination of three hospices' accounts - Pilgrims Hospice, St Christopher's Hospice, and Trinity Hospice – covering the period 2004 to 2013. With this, I explore variances around the sector's average in terms of specific hospices financial characteristics, risk exposure, and capacity to sustain income and operating surpluses. Additional data from various hospices accounts, such as extracts from their notes to the financial statements, are also used to support the analysis where required.

4.6 Ethical considerations

Research ethics are widely discussed in relevant literature addressing issues relevant to the moral values and principles that constitute the foundation of an appropriate code of conduct (see for example Smith 2015, Collis and Hussey 2014, and Sauders et al. 2007). This code of conduct is seen in relation to the rights of the subjects of a research study or those potentially affected by it. The main areas of interest are focusing on preventing harm to be caused to the participants or the researcher, protecting the dignity of the participants, as well as, securing voluntary participation, anonymity, and confidentiality.

The research undertaken for this thesis has been in accordance to the policy on research ethics of Queen Mary University of London. To ensure that none of the individuals involved in the study is exposed, each participant's job title and the letters A, B, C, and D as a code name for their institutions replace their identities and the identities of their employer hospices. Each interviewee was informed about the voluntary nature of their participation and their option of withdrawing at any point during the interview, at the beginning of the process. Their recorded consents can be

seen on the relevant appendixes and also be available upon request. The quantitative data used for this thesis have been obtained through published financial reports and accounts, of the respective top 35 hospices, filed with the charity commission and thus their use is not posing any confidentiality issue for the institutions included on the sample.

4.7 Summary

This chapter justifies the research approach and the methods employed for the accomplishment of the objective of the thesis, which is to evaluate the sustainability of palliative care provision by voluntary hospices in England, using a business models' framework of accounting analysis. Review of relevant literature considered the philosophical aspects of advancing knowledge within the realms of science with particular emphasis on social sciences, business, management, and accounting research. Accounting has been defined as a multi-paradigm science, relying on a collection of theories, research approaches, and methods, to advance its body of knowledge.

This thesis develops around a middle range, inductive approach, where mixed methods are used to construct, an accounting based, 'descriptive business model' for hospices. The construction of the business model is grounded in analysis of the financial reports of the top 35 hospices' in England, as ranked by their income, covering the period from 2004 to 2011. Additionally, data up to 2013 are used to develop three case studies and reveal discrepancies from the sector's averages in terms of specific financial characteristics, risk exposure, and weaknesses to sustain income and operating surpluses. The project is further supported by narratives extracted from interviews with senior palliative care professionals, from four large

and medium hospices, obtained over a period of three years. Incorporating elements of longitudinal and case based research the study reveals the strengths and weaknesses of the hospice business model and evaluates its robustness against forthcoming challenges.

Chapter 5: Hospice narratives: Perspectives of hospice clinical directors and senior clinical managers

5.1 Introduction

A wide range of indicators demonstrating that the hospice business model has become increasingly complex, during the rapid development of the hospice movement between the late 1970's to middle 2000's, have been revealed on chapter 2 of the literature review. The increasing level of sophistication and complexity of provided care services, in conjunction with the increasing demand for palliative and end of life care lead hospices to gradually rely more on highly qualified clinical personnel instead of volunteers. This fact impacts, on both the movement's ideals and orientation with a shift towards institutionalisation and professionalization. This chapter presents narrative accounts that reflect the views of nine clinical directors across four hospices. Emphasis is placed on the evolution and gradual transformation of the hospice movement and associated challenges for the sustainability of the hospice business model.

5.2 Background and role of the participants

This section examines the professional background of the participants, the time span of their service within a palliative care setting, their motives to join the hospice movement, as well as the key aspects of their role as managers and the role of their teams within their employer hospice.

5.2.1 Background, training, and time of employment within hospices or within a palliative / end of life care setting

A broad spectrum is revealed in terms of the participants' background, level of training, and duration of employment either within a hospice or within a relevant specialty, table 5.1, below, presents the role and the employer hospices of each of the participants. The majority of medical directors joined the hospice movement after a considerable period of employment within the NHS or general practice and they have been employed within the hospice movement for periods ranging from four to 11 years. With one exception, their interest in palliative care was developed during their employment and was not their medical specialty at the start of their careers. On the other hand most nursing directors or senior nurses have been employed in relevant specialties for much longer periods of time and in most cases they have stayed within the hospice sector for periods ranging up to 25 years.

Table 5.1 Roles and employers of the clinical participants

Employer hospice	Interviewee's role	In-text quotation code
Hospice A	Medical Director	HA:MD
Hospice A	Nursing Director	HA:ND
Hospice A	Community Nurse Specialist	HA:CNS
Hospice A	Day Hospice Leader	HA:DHL
Hospice B	Medical Director	HB:MD
Hospice B	Nursing Director	HB:ND
Hospice C	Medical Director	HC:MD
Hospice D	Medical Director	HD:MD
Hospice D	Nursing Director	HD:ND

This diversity in terms of background, level of training, and time of employment within a palliative / end of life care setting, is indicative of the effects of rapid development of the hospice movement and the increasing level of sophistication and complexity of the hospice business model. Following a period of expansion from less than 50 palliative care units in late 1970's to more than 200 by the middle 2000's, as summarised in the literature review, the demand for clinical professionals provided a platform for new specialties to develop and this, in turn, drew clinicians from a range of backgrounds to hospices. The widening of the patient base and the provision of care to non-cancer patients has also increased the demand for specialist clinical professionals which is a topic that we will explore in further depth later in this chapter. The following quotes extracted from interviews give some sense of commitment to and evolution of the hospice business model.

> *"I've been working in this medical specialty for 17 years now but most of that time I haven't been working in hospices I've been working for the NHS so I came to work on the hospice here in 2002 that's about four or five years"*

Hospice A: Medical Director

> *"I've been working at Hospice B for five years now, as a consultant, and over the last 11 months I think it is I've been the medical director. I started off, I trained as a chest and a general physician. I was a consultant for 11 years, but became increasingly disillusioned with what you could do for patients, not being able to solve their problems, because of having to get them out of hospital. And I'd always been interested in palliative care, there's quite a lot of it in respiratory*

medicine. And so after a lot of organization, it took quite a while, I changed to being a palliative care consultant"

Hospice B: Medical Director

"Yes, sure. I've been qualified for… it'll be 20 years next year, as a doctor. I was doing general practice in my general medical training for the first sort of eight years of that, eight, nine years of that. And then I've been involved in the hospice for about, just over ten, nearly 11 years now."

Hospice C: Medical Director

"Four years now, about four and a half years. Well, my background, I always worked medicine, general medicine and I trained there for years, I'm being a staff grade at, you know, like a senior level at general medicine and from my experience seeing patients over at the hospital ward patients with cancer and I found that there is no privacy, there is not much support. These patients, due to the, you know, to the way they work in the hospital and the workload and so on, the doctors and the nurses and everything, I just felt sometimes sorry for these patients and I wanted to help them a bit more if I can. Well, the opportunity came when there was a job in the hospice and... for a locum and I just thought well, I'll go and see what happens"

Hospice D: Medical Director

"In this establishment, since the beginning of December last year, so I'm very new in post. About five months. Before that, I worked for the National Health Service, and I've also worked for the private sector, running nursing homes and for the voluntary sector running care homes, residential care homes"

Hospice A: Nursing Director

"I started working at the original hospice D 25 years ago and it was the beginning, really, of the hospice movement. A lot of areas were looking into setting up small units, where they could look after people with terminal illnesses, and that's how hospice D started."

Hospice D: Nursing Director

"It's collectively about 17 years now. I came to the Hospice in about 92 and I've been here ever since … So, I think about 17 years in, sort of, hospice work and some other time in acute oncology"

Hospice A: Day Hospice Leader

"Okay. I have been working for the hospice now about ten years. Five years on the ward and five years in the community. Apart from that, I've got a general nursing degree which I did before I came to the hospice."

Hospice A: Community Nurse Specialist

5.2.2 Motives to join the hospice movement

The quotes below highlight some of the cultural difference between treating patients within a hospice and treating patients within NHS settings as the main motive for the vast majority of participants to choose a career in hospice movement. '*I found the NHS frustrating and limiting. Because certainly at that time end of life care and care for patients in the end of life, was not a great priority in a big hospital'* (HA:MD). '*... I felt like I can help patients here more, I can give them more time, more support and I feel more satisfaction, you know, by working here than in the hospital ...'* (HD:MD). '*... I went back to hospital and recognized that people were dying very badly in hospital ...'* (HB:ND). ' *... I was working on a very busy medical ward and I found it quite hard that people that were dying were put into a side room and their families didn't get the time I felt warranted the severity of a situation like that ...'* (HA:DHL).

Among a range of personal and professional motivations, revealed by interviewees, is their dedication to provide better quality of palliative and end of life care to patients. This dedication to providing higher quality of care is reinforced by a sense of voluntarism, which secured hospices with a pool of specialist professionals during the start-up and growth stages of the sector. It also helped to form a distinctive identity compared to other forms of care and helped hospices to expand their provision of both chronic health care services and their mission as a charity sector.

However, the sector has entered a maturity stage in terms of its financial and physical resources at a time when, the demand for end of life / palliative care is set to increase and is also becoming embedded into the UK's broader health system. Thus hospices are finding it necessary to attract more specialist clinicians and promote themselves

as employers of choice within a competitive market. This impacts on the type of work and specialist care skills required by clinical staff and we review this in the following section. The quotes extracted below from interviews reveal that whilst the employment market is more competitive clinical staff recount the importance of having a sense of 'mission' and dedication within palliative care.

"Well it was already my medical interest and my specialty but I came to the hospice movement specifically because I found the NHS frustrating and limiting. Because certainly at that time end of life care and care for patients in the end of life, was not a great priority in a big hospital. It's a relatively small area, a relatively dark area, people do not necessarily want to look at it very much, because hospitals on the whole think they are about fixing people, you know making people better. So it's quite a difficult specialty to be in, within a big hospital setting so I was attracted to come to the hospice because this is our business and it is acknowledged and everybody here is comfortable with that."

Hospice A: Medical Director

"It was actually something I wanted to do. When I was a medical student I spent a month working at St. Christopher's Hospice, because at that stage I felt that I wasn't sure how I was going to speak to people who were dying in my everyday work, and I had decided at that stage that at some point in my career I would like to spend a few years working in a hospice"

Hospice B: Medical Director

"I feel... you know, I felt like I can help patients here more, I can give them more time, more support and I feel more satisfaction, you know, by working here than in the hospital. But my, you know, thoughts and my, I guess, about the hospice before I started here, it was totally different from what I think now. I always thought that the hospice is a grim place where people go and die. I never thought of the psychological support or the other aspects, apart from people wanted to die somewhere and that's the hospice. Having come here and been involved much more deeply into that, I think I was very much wrong and I regretted I didn't know about the hospice and how they work before"

Hospice D: Medical Director

"I wanted something which kept me busy, maintained my professional interest from a nursing, medical nursing point of view, but something where I felt I could influence the care that patients receive. And sometimes, as you move into more senior positions in healthcare, you kind of feel you're getting more distant from being able to influence what happens to patients, and for me, I'd heard that this job would be coming up"

Hospice A: Nursing Director

"... I went back to hospital and recognized that people were dying very badly in hospital, did a lot of work in my own time setting up what was

called a Quality Care Interest Group using my knowledge from my hospice time and then decided that I really wanted to specialize in that"

Hospice B: Nursing Director

"... I can tell you exactly, but it's a bit twee really. I was 22 years old and I was working on a very busy medical ward and I found it quite hard that people that were dying were put into a side room and their families didn't get the time I felt warranted the severity of a situation like that. But they should have had more staff time to talk to them. I also think that the communications… I mean, we are… I think that the communications 20 years ago also were very difficult and for patients that were dying there wasn't a lot of the open and the honesty that we have now. So, often people didn't actually know they were dying. So I think I found that quite difficult. And then I had a lecture from a woman who was a nurse in a hospice who talked about hospice philosophy and that was quite important to me. So that was really the deciding factor to move out of the hospital environment and to explore hospice work at that point."

Hospice A: Day Hospice Leader

5.3 Key aspects of the participants' role as managers and the role of their teams

In this section interview narratives are employed to generate an overview of the participants' role within their employer hospice including the role and work of their teams/departments, as well as, their involvement in decision making. These accounts reveal that as the hospice movement has expanded the nature of the organisation

structure involves sophisticated management and control activities on both the medical/clinical side and also on the nursing/care side of the activity. Interview extracts below illustrate the nature of responsibilities held by senior medical and nursing staff. Hence, they reveal considerable variations in terms of role specification, team/department structures, administrative responsibilities, and daily routines, despite the similarities in terms of the participants' position within their employer hospices. The size of each hospice and the relationship with other health/end of life care providers in each region determines the level of a role's complexity, internal and external responsibilities, as well as, the daily duties of the clinicians.

For example, the medical and nursing directors of hospice A, are in charge of a number of well-staffed and structured teams of clinicians across more than one site in the hospice's region. They are supported by a number of full time middle managers and they spend considerable amounts of their working days outside the hospice on a multitude of duties. These duties apart from their "in-house" clinical roles and support to patient's, include providing help to local hospitals, training junior clinicians and university students in palliative care, liaising with the CEO the board of trustees and external bodies to advance the hospice's objectives and strategy, as well as handling their role relevant administrative duties.

As hospices have expanded they have developed more complex organisational structures that include medical Directors, and Nursing Directors who co-ordinate the activities of doctors and nurses over which they have responsibility. Senior clinicians there, spend more of their working days seeing in-patients and managing their teams, compared to the time they spend liaising with external bodies. This observation is very much in line with the views presented on the literature review (see section

2.4.1: Ellis 2012, Department of Health 2009, Help the Hospices 2006a, NCPC 2006, Kings Fund 2005, Finlay 2001) regarding the broad range of diverse standards within which various hospices operate.

> *"So I am the medical director, so I sit on the senior management team with the CEO and the nursing director ... I have then a team of doctors working for me I have a consultant on each of the sites and they are very senior people trained in this specialty and I would say that they all have to one degree or another probably a broader vision than most other employees. So they are people who are naturally interested in bigger questions about the direction of future services and modernizing our practice and so I'm well supported on that. ……. I teach our junior doctors and I teach outside the organization, I teach in the university here so our job is very mixed, the doctors, we do lots of things more junior doctors do more predominantly clinical things, so the more senior doctors have this range of activities, more junior doctors will be predominantly doing more clinical work, that's why it's an interesting job"*

Hospice A: Medical Director

> *"At the moment I'm the senior director. I'm heading the medical team and we've got a team of probably about six or eight doctors who work here through the week. We've got doctors who provide out of hours cover, we've got doctors who help me out on the ward, they are clinical assistants who are all very experienced GPs. ..... I guess, from a medical point of view I'm responsible for the patients in the hospice, in*

the in-patient unit, in the out-patient clinic, and within day therapy, and so the three main services, out-patients, day therapy and in-patient unit"

Hospice C: Medical Director

"Well, my role, I'm a physician first so I'm a clinical person but at the same time I'm the manager also. I manage all the doctors and I'm like the senior clinical person here. ....My role is that... my typical working day would be different when I am management because I might have to go out, attend meetings and courses and so I might be going out more often than other doctors, but most of the time it is in the hospice and it's patient focused, yes"

Hospice D: Medical Director

"My job, if you like, is obviously in terms of the top of the organization, I'm part of the senior management team, which is myself, the CEO and the medical director. I report to the CEO formally, in a line management way, and then the structure underneath myself is that I've got a nurse manager who looks after nursing on this site, in patient nursing, and at the moment, they look after the day hospice, and the same on the other sites of this hospice and then I've also got a nurse manager who looks after the community nursing services across all three sites."

Hospice A: Nursing Director

"I have two teams so, and they are different although they both work in the community. So I have one team that is highly skilled, perhaps I have three teams, but anyway, one team highly skilled nurses, advanced practitioners caring for dying people at home giving specialist advice. The other team, Hospice at Home, give what we call hands-on nursing care at the very end of life, predominantly the last two weeks."

Hospice B: Nursing Director

"I'm the inpatient sister. I look after the inpatient unit, which consists of nine beds. I have a team of nurses under, that work alongside me, they consist of trained nurses and auxiliary nurses, and our job really is to look after the patients that we have in. …We provide symptom control. We have limitation and end of life care, and that's… and support for the family"

Hospice D: Nursing Director

"There are six of us who cover a part of XXXX city and in the community … You would go and do a first visit with the patient and an assessment of what their needs are and what their problems are. And we have … it's an advisory only role, it's not a hands-on nursing role, so it's just advisory and supportive."

Hospice A: Community Nurse Specialist

"I help run the day hospice three days a week here and we run equally on all sites three days a week. …our referrals come from within the

hospice sector. So any member of the multidisciplinary team can refer a patient for day hospice. That's a little bit unique to Hospice A, other hospices do that but one of the ways that we vary is that in other day hospices referrals can be made externally from oncologists or the GP"

Hospice A: Day Hospice Leader

5.3.1 Strategic management and decision making

In most cases participants at directorate level reported involvement in strategic level decision making. The size of the hospice appears also to determine the extent and form of involvement of clinical directors to strategic decisions and target setting. In larger hospices (Hospice A, B and C) medical directors are invited into meetings with the CEO or the board of trustees and the local PCTs to discuss and formulate targets and strategy. Even though senior clinicians still play an important role in strategy development in smaller hospices with simpler and flatter management structures, this is mainly done through internal meetings of the senior management team and submission of proposals or comments on policies and targets.

Involvement of senior management at strategic level in decision making also verified in the literature review (see sections 2.3.2 and 2.4) with regards to the increasing complexity of both individual hospice business models, as well as demands on the palliative care sector's business model as a whole. As hospices are getting larger they move away from the initial simple model of being established by - and following the vision/guidance of - a charismatic individual or a small group of individuals. They gradually evolve into organisations in need of professional management and hence they develop structures and processes similar to those found in complex

organisations of the private or the public sector. This also allows senior management to develop a broader view on strategic issues of management at locality and sector level beyond the day to day operations of their teams. Whilst staff at a lower level within the organisational structure of hospices tend to have local autonomy and control even if they have less input into strategic decision making.

"... I obviously have a strategic role in the organization to be thinking beyond the day-to-day management into broader issues ..."

Hospice A: Medical Director

"In fact, we… I think probably about two, three weeks ago, had a… the whole organization, an away time, where we were looking at the next, you know, five to ten years' worth of strategy. I was there, one of the other consultants was there, so the senior, more senior people get invited to come and put in their experience ... So it's really the more senior people, and I guess it's the medical directors, a big part of the medical director role to think what are we doing in the future."

Hospice B: Medical Director

"... myself, the director for the hospice services, and the Chief Executive are involved in the strategy, in liaison with the PCT, and the various other palliative care network group meetings. So yes, we're involved in that"

Hospice B: Nursing Director

"...we do have, we're part of the management team. We go to, we have a clinical subgroup who decides if there's going to be any changes that may need to be done, and we're also part of the interdepartmental management structure, and that means that we go to the meetings with all the managers within the hospice, and we're part of the human resources team."

Hospice A: Community Nurse Specialist

"... So certainly we're involved in levels that I think it's required. I wouldn't expect to find myself at high managerial level meetings because I think it is important to diffuse information really as opposed to everybody trying to go. But certainly we're involved in relevant policy changes and decision making. Certainly I'm fairly autonomous in running this unit, which is good, absolutely"

Hospice A: Day Hospice Leader

5.4 Towards a more complex business model

A wide range of indicators that the hospice business model is becoming increasingly complex was revealed, when the participants were asked to comment on the evolution of the hospice movement and on any changes they have noticed on its ideals and orientation. The main areas of interest include: organisational change, institutionalisation through the involvement of the Government in palliative and end of life care, a gradual shift towards professionalization and medicalization of palliative/end of life care, and increased complexity and spectrum of care provision. The participants' views on each of these developments and their impact on hospices

vary from scepticism for example on the collaboration with the NHS, to acceptance of the necessity to become more *"business-like"*, and to satisfaction on the ability to provide a wider range of services.

Organisational change in the form of transitioning from being, purely voluntary care settings to becoming, '*a little bit more business-like'* is evident through both the participants' mentioning of it, as well as through their descriptions of the range of activities comprising hospices' service provision and its sustainability. The wider range and the longer duration of the services provided by hospices, require the development of suitable organisational and management structures and recruitment of / reliance on, professional staff rather than volunteers. This consequently leads to the need for additional funding which however is secured through a variety of sources with variable volatility and sustainability characteristics. Hence hospices need to adjust to the requirements of having to interact with an increasingly complex stakeholder network.

The recognition of palliative care as a service the state has to offer and the involvement of the Government through the development of relevant policies, the provision of a percentage of funding to hospices, and the setting of requirements for clinicians training, is an additional driver of transformation, leading the hospice sector towards institutionalisation. '*I think it's having to become… I won't say more professional, I'd probably say more institutionalized, and NHS-ized … And I don't think that's… it has some good features, but actually I think it's something that I'm very suspicious of'* (HB:MD). Hospices have moved away from their initial charitable organisational characteristics and are now positioned within a wider system of care. This is impacting on their independence through, for example, getting

them to assume contractual responsibilities, negotiate on targets, and adjust their service provision in terms of both capacity and quality.

Other changes include the introduction of new types of treatment, increased length of service provision, and the requirement to provide palliative care to non-cancer patients has led to increased complexity and sophistication of care '*... I would say that the way in which the patients have changed and become more complex and their illnesses with co-morbidities, everything, actually it's not an easy option to work in a hospice anymore...'* (HB:ND). This is increasing both the internal complexity of each focal organisation, as well as, the expectations and demand for service provision at sector level.

The evolution/transformation to a more complex model of service provision leads to professionalization and medicalization of the hospice movement and shifts away from the initial voluntary and predominantly nursing based approach to palliative care. '*When I first started ten years ago, on the ward, there were very few treatments given on the ward. There was no, we weren't giving blood transfusions. It was much more low key. It wasn't medicalised as such ...'* (HA:CNS). Training of palliative care clinicians and professional development through specialisation and relevant qualifications is gradually becoming the norm on the sector. Hence, the clinical culture within both individual hospices as well as the whole sector is changing towards more standardisation instead of diversity and inclusiveness. '*Now medical training is very rigid, it follows the same pattern as specialist training in any other specialty, so then it's a very different group of people coming through, it's a little bit more like a sausage machine you get the predictable product at the end. Whilst in the early days we had a wide mixture of people, mostly with very strong personal motivations on this work ...'* (HA:MD). This standardisation though does not lead to

decreased operating costs. As a wider range of activities is now the responsibility of trained professionals, instead of volunteers, hospices have to incur additional costs for recruitment and staff development. On the case of hospices becoming more professional and business like, the following quotes are extracted from interviews with hospice managers.

> *"I think in a sense volunteers are still very important part of our work force but I think perhaps what you are alluding to is a shift in a sense that perhaps the organization is becoming more professionalized and perhaps whereas in the past we had a sort of... its rather a British thing… this sort of charitable amateur well-meaning committed sort of work force we still have a lot of those things but perhaps it becomes a little bit more professionalized and a little bit more businesslike"*

Hospice A: Medical Director

> *"I think it's having to become… I won't say more professional, I'd probably say more institutionalized, and NHS-ized."*

Hospice D: Medical Director

There is also pressure to align hospice management of resources within the policy and regulatory frameworks set by national Government. In addition patient care is also changing because the forms of chronic care have moved on from just cancer care to much more complex treatment and care associated with co-morbidity. This also impacts on the costs of running hospices when more complex care and medications are required to be administered and patients are being admitted at an

earlier stage for their care. Hence requiring additional length of stay and also again inflating costs.

"I think the Hospice Movement is definitely beginning to change, and I think nationally, just from what I've heard, when I've been on the odd conference of what I've read, all Hospices are facing that change in direction, partly because there's kind of Government policy driving that direction, not specifically for hospices, but more generically around healthcare, partly because of the expectations of the public, and new generations expecting things to be done differently and not having the sort of family networks that they've had local to them in the past, the whole world, externally, is changing, and hospices are needing to think how they respond to that"

Hospice A: Nursing Director

"... I would say that the way in which the patients have changed and become more complex and their illnesses with co-morbidities, everything, actually it's not an easy option to work in a hospice anymore, it is really… I don't think it's ever been an easy option, but it's more tough now to nurse in a hospice or other departments that it's ever been"

Hospice B: Nursing Director

"People accepted that they were coming to the end of their life, there was very little treatment that could be given. Now, it's all about chemotherapy, radiotherapy, keep giving them quality by giving them

good pain control, so therefore there's a cost implication of all that, that probably wasn't there when the hospices first moved."

Hospice D: Nursing Director

"we're seeing patients at perhaps earlier stages of their illnesses. We're seeing patients that are receiving what we would have classed then to be quite acute treatments, sort of, radiotherapy, chemotherapy. That perhaps wasn't quite so common I think when I was first aware of hospice movement"

Hospice A: Day Hospice Leader

"There have been a lot of changes, I think, since I started here. When I first started ten years ago, on the ward, there were very few treatments given on the ward. There was no, we weren't giving blood transfusions. It was much more low key"

Hospice A: Community Nurse Specialist

These quotes illustrate that, as far as those involved with hospice care, the business model is becoming more business-like and professional and that the type of care being given to patients has changed. It is not only more complex, but also patients arrive at an earlier stage for their treatment and care and this adds to the cost of providing increasingly complex chronic care pathways for patients.

5.5 Forthcoming challenges and their impact on individual hospices

Having identified the changes and the gradual transformation of the hospice movement from a simple voluntary sector business model into a new more complex form, participants to the interview process were asked to present their views on what they see as forthcoming challenges to the sustainability of palliative and end of life care provision by hospices. The areas attracting most of the participants' attention were related to the ageing of the country's population and the widening of the patient base, a shortage of relevant expertise and the difficulty with recruiting key professionals, and finally a funding constraint that might compromise expected level of service**.** It is the latter concern which we start with in the following section.

5.5.1 Funding of service provision

Securing funding, from reliable and steady sources, to enable hospices cope with the increasing demand for their services and to remain competitive within a demanding recruitment market was mentioned as a core challenge by a majority of interview participants. Government funding through the NHS is seen by most clinicians as a key factor that would help to secure the financial viability of hospices. However, in many responses participants also expressed their concerns over the requirements and conditions that are often attached to this funding. '*The more the NHS funds you, the more they expect from you, but at the same time, they actually want it dirt cheap. So what the PCT would like is to have most palliative care delivered by generalists ... but the specialist units have to have a certain lower level of funding to enable them to provide the services that they do'* (HB:MD)

The potential threat of becoming an extension of the NHS or having to reduce the standards of service quality in order to meet funding targets was a widespread cause

for concern. Participants working for financially stronger hospices appear more reluctant to engage in negotiations for additional NHS funding as they expect it to impose limitations on their independence. '*... there might be a lot of reasons that we might not want to come under Government funding because then we get involved in all the competition for funding with other specialties and we also get involved with huge bureaucracy which is the NHS and that's not very attractive, at the moment we have our independence we are self-determined to some extent ...'* (HA:MD).

On the other hand most hospices have to rely on NHS funding to cover major parts of their expenditure. '*... one of our biggest challenges is getting money and sustaining an adequate amount of money to fund the hospice, because we are a voluntary provider'* (HB:ND). Hence there is no one best way or opinion on a potentially optimal funding scenario to meet the requirements of all hospices in the sector. The ability of individual hospices to raise sufficient funds determines their independence, as well as, their service provision capacity / quality.

With charitable fundraising enabling most hospices to maintain a certain degree of independence a mixture of Government and charitable funding is seen as the most plausible way forward. Charitable funding is currently used to fund the majority (often 70-80 per cent) of palliative/end of life care services. However, most interview participants would expect the Department of Health to decide which elements of palliative care are considered standard for all patients and provide adequate funding to cover them. This would allow hospices to use charitable funding for the provision of any additional services and consequently increase the overall quality of palliative/end of life care for their patients.

"...we are clearly in an unusual position in health-care because of the huge contribution of charitable funding to our services and at the moment locally this is not under threat I mean we are financially in a strong position locally but that's not the case everywhere around the country so some hospices are in trouble financially and ...there might be a lot of reasons that we might not want to come under Government funding because then we get involved in all the competition for funding with other specialties and we also get involved with huge bureaucracy which is the NHS and that's not very attractive at the moment we have our independence we are self-determined to some extent we can spend our money on what we think is important and we are much more flexible organization because we are so much smaller so that's a big issue for the future..."

Hospice A: Medical Director

" .... other places don't have such a big proportion (of NHS funding), and I think what PCTs are looking for, because they're getting directives from above, value for money, and what costs in palliative care is maintaining a big nursing to patient ratio. The more the NHS funds you, the more they expect from you, but at the same time, they actually want it dirt cheap."

Hospice B: Medical Director

"... we get about a third of our… a third of our funding from the PCTs, as you're probably aware, but I mean they're expecting us, want us to do more and more with that amount of money ..."

Hospice C: Medical Director

There is a general position that, whilst hospices need steady funding from Government to remain viable going forward, this also comes at a cost in terms of independence and also a need to generate value for money.

"We have moved now to just from being a charitable organisation to depend on some funding from the NHS and that doesn't come without a price. Always there is pressure to give more time to, you know, record what you do and to try to prove that you're doing the right thing and that takes lots of times and it... you know, from the doctors, from the management especially to structure these things. Yes, the pressure is definitely from outside because we're getting financial support and we have to prove our self"

Hospice D: Medical Director

Although Government funding increases the degree of stability for hospices, this is attached to stringent regulatory and policy initiatives. However, as one interviewer observes below, this Government funding may also not be guaranteed.

" we don't know what's happening for the future with public money, in terms of the way public money is going to be allocated about between

other services and the palliative care, so it's just a big question mark for us"

Hospice A: Nursing Director

A major challenge for hospices is that of maintaining income from the other seventy per-cent of funding sources and these are variable and volatile.

"I think one of our biggest challenges is getting money and sustaining an adequate amount of money to fund the hospice, because we are a voluntary provider"

Hospice B: Nursing Director

"... financially is an obvious one because we are still reliant on fund-raising, the shops, all the things that we rely on to bring revenue, that's it's not guaranteed funds, because it doesn't come from the Government, things like bequests and wills are very variable from year to year."

Hospice A: Day Hospice Leader

In addition to the challenge facing hospices in terms of funding and financial stability interviewees were also concerned with resources and especially recruitment of appropriately skilled personnel.

5.5.2 Recruitment and scarcity of relevant expertise

Recruitment, retention, and training of qualified clinical personnel is considered a major challenge which is already affecting hospices' capacity to provide the desired level of care. '*Okay. Seeing we're talking about staffing, I mean, great plans, the end-of-life care strategy, lots of good stuff in it. But they've starved the people to do it at a general level, let alone at the specialist level'* (HB:MD). Scarcity of relevant skills at national level and variable levels of competition with NHS hospitals and neighbouring hospices at local level impacts adversely on both hospices' operating capacity and financial viability. Training targets set at national level, the wider spectrum of patients and the requirement for longer term provision of service, as well as compensation packages for clinicians, have been mentioned as contributing and / or interrelated factors to hospices' recruitment challenge.

The initial focus on providing palliative care to cancer patients helped hospices to develop adequate expertise at both generalist and specialist level. However, the requirement to widen their patient base challenges the capacity of their existing personnel in terms of available skills and imposes the need for retraining and recruitment of additional numbers of clinicians. '*I think we're finding them a challenge in terms of our knowledge (referring to non-cancer patients). Because although we're, sort of, at end stage, sort of, our skills should be applicable to anybody. It's still concerns, you know, we're not trained as respiratory nurses, we're not trained as, you know, renal nurses. So we're just concerned about that the, sort of, challenges of knowledge and being skilled enough to do it'* (HA:CNS).

Internal training and development of skills has been an alternative used by many hospices but with no input at national level training for specialists, the competition

for recruitment is only expected to increase. '*So I think that's quite tricky ... There are… nationally there are over 100 consultant posts that are unfilled in palliative care. It's that there aren't the people ... So yes, there will be some competition for the specialist registrars that are finishing and ready to be consultants at that stage'* (HB:MD). The setting of training targets at national level by the department of health, on the other hand, does not appear to alleviate the situation. '*workforce is obviously an issue in other areas and that's also not just in this specialty but nationally to do with how the Department of Health is determined to put training numbers in medicine or nursing and so on and of course they are always getting that wrong and we either got too many of one sort of doctor or too few of another sort of nurse'* (HA:MD).

Scarcity of adequately qualified and experienced professionals has already led to competition and developing attractive remuneration packages and this poses the question of how to make working for a hospice an attractive career path. '*Our main competitors are the neighbouring hospices and the neighbouring hospitals but mainly the neighbouring hospices. I remember back two years ago we were fighting over one doctor where to work, we wanted the doctor, we also knew that two other hospices wanted that doctor, so we interviewed the same person, you know, for the three jobs and unfortunately we didn't get her'* (HD:MD) Matching NHS payment scales and providing similar employee benefits is becoming a trend amongst hospices. This however has considerable implications on their expenditure and imposes the need for additional investment in fundraising.

> *"For doctors it's quite difficult to recruit good doctors in palliative medicine there is a shortage of people with sufficient training so the*

fact that we have a full team all my posts are filled that is because we are a good organization. So many hospices around the country will not be able to fill their post with suitably trained people so we are very lucky to have that. Our main competitors will be, well for senior posts it will be nationally people will decide where do I want to live where do I want to work, so we are competing in a national arena for consultants."

Hospice A: Medical Director

There are also problems with recruiting staff that live in close proximity to the hospice and having the right skills mix.

"For more junior people, we are looking for a group of people who live more locally and then it will be difficult to find people with the right skills. So if one of my good senior but not consultant doctors leaves then that will be a very difficult person to replace"

Hospice A: Medical Director

One interviewee observed that the shortage of skilled and well trained staff could compromise the Government's end of life care strategy.

"Okay. Seeing we're talking about staffing, I mean, great plans, the end-of-life care strategy, lots of good stuff in it. But they've starved the people to do it at a general level, let alone at the specialist level ... so I

think the big challenge is going to be the staffing over the next few years. It isn't easy to find what we need to find"

Hospice B: Medical Director

"you know, palliative care becoming a training specialty and people want to be in palliative care, they go from... start off the junior doctors and they go into training. Our main competitors are the neighbouring hospices and the neighbouring hospitals but mainly the neighbouring hospices. I remember back two years ago we were fighting over one doctor where to work, we wanted the doctor, we also knew that two other hospices wanted that doctor, so we interviewed the same person, you know, for the three jobs and unfortunately we didn't get her. Somebody else got her"

Hospice D: Medical Director

"We look for a minimum of a degree for a nurse specialist and they have to have experience in care of dying patients. We'd like them to have a degree that specializes in care of dying patients but we've had to be a little bit more flexible around that and look at their experience as well as their academic qualifications. It's a competitive market full stop because we cover a very rural area here at Hospice B."

Hospice B: Nursing Director

Hospices are spending funds not simply on recruiting but also 'training up' clinical staff to an appropriate level.

> *"I think you'd be… you'd be looking to develop people, yes .... You wouldn't get people with the skills, unless you were very lucky and somebody just moved into the area who'd already worked in a hospice, so you'd be looking at developing people, and that's what we do. We take GPs who are just interested, and we, we train them up"*

Hospice C: Medical Director

Without appropriately trained staff it is simply not possible to maintain hospice services provision.

> *"The one I always go for is about staff, because if anything goes wrong with staff, you can't provide a service, so whether that's from recruitment, retention, training our staff, that whole issue. So if we haven't got staff, we can't provide a service"*

Hospice A: Nursing Director

There is also the problem of maintaining pay differentials relative to the NHS pay structures, because nurses can easily transfer out from hospices into the NHS.

> *"The pay structure, I think, is going to be a lead issue. At the moment, it probably isn't because we're just a little bit low, but I think, at some stage, it will be a big issue if we don't adopt the same pay scale as the*

NHS ... So I think recruitment is going to become more difficult, personally, than it has been"

Hospice A: Community Nurse Specialist

5.5.3 Increasing demand for service provision; patient based and ageing population

Confirming the literature review, interview participants expect considerable increase in demand for palliative / end of life care services in the foreseeable future. Both the ageing of the country's population, as well as the widening nature of the patient base to non-cancer patients will inflate the demand for palliative care services for both in-patient and hospice at home care. This constitutes a significant challenge for the hospice business model which, as we see in chapter 7, is financially stressed and faces the increased challenge of maintaining and expanding its clinical workforce.

Initially hospice care has been positioned around the treatment of cancer patients at the end of their lives and this has influenced both the culture as well as the type of expertise developed within the sector. However, over the latest period of their development and partly due to recent Government initiatives hospices are increasingly required to provide palliative/end of life care to patients with non-malignant conditions. Most participants expressed their concern on hospices' ability to handle the complexity of the conditions new patients bring into the system. '*We're looking at doing non-malignant work, so that's putting a huge increase, that's, you know, doubling potentially the amount of patients that there are going to be, although I'm not convinced whether hospices should be prime movers in non-malignant palliative care, or whether they should just be advisory'* (HB:MD)

The ageing of the country's population in conjunction with the increased number of people living longer with chronic illnesses and hence requiring support for longer periods of time, is also increasing demand and complicates the type of care provision. '*The challenge would be on trying to make places available for those patients, but also to run our policies alongside them'* (HA:DHL). With a finite number of beds available and with restrictions in recruiting additional staff hospices will be in need of substantial investment to upgrade their capacity. This however might not be possible given many hospices' funding constrains and income volatility.

The combination of an ageing population, the widening of the patient base to include non-cancer patients, children and young adults, as well as, the increase in numbers of people living longer with complex health conditions and co-morbidities is expected to double the demand for palliative / end of life care services in the future. This is seen as a major challenge for hospices and their ability to continue providing their services without being forced to compromise quality by either focusing on generalist level services or rely on alternative types of care which are currently perceived as cheaper such as care at home. '*Because the difficulty can sometimes be, particularly from myself in day hospice, that despite the fact that they've got ongoing chronic illnesses the length of their life may actually still be longer than a cancer patient, and therefore can we accommodate places for perhaps periods of years as opposed to periods months?'* (HA:DHL).

Even these alternatives though are viewed with scepticism by some participants for example care at home is cheaper at the initial stages however the cost of it increases dramatically when a patient is in need of 24 hour care at home. '*But yes, patient numbers are going to go up. And there ain't going to be the people to look after them. They want to be looked after at home, which is absolutely fine, and actually,*

on the radio this morning they were saying, you know, it's cheaper to have them at home. Well, it may or may not be cheaper to have them at home by the time you get 24 hour care at home' (HB:MD).

The challenge for hospices is that widening of palliative /end of life care provision coupled with an ageing population will put stress on sustaining the business model.

> *"... in terms of our clinical services the big issues for the future are to do with the ageing population ... with extension of services to patients with illnesses other than cancer which you may have heard a little about. Historically hospice care has been given mostly to patients with cancer at the end of life at least at 90% and yet people are dying from all sorts of other illnesses and having a terminal phase on all sorts of other illnesses. So the question is do we have the right skills and facilities to care for other people and how should we be responding to that challenge but that's a bit clinical issue is about palliative care for non-cancer patients"*
>
> Hospice A: Medical Director

> *"the number of elderly are going to increase dramatically. We're looking at doing non-malignant work, so that's putting a huge increase, that's, you know, doubling potentially the amount of patients that there are going to be"*
>
> Hospice B: Medical Director

"I guess one of the concerns is yes, if you are opening up the services and including other people to refer, that you may be inundated with referrals, and that was always the worry about opening up to non-malignant disease a few years ago, but in reality it doesn't seem to have occurred ... it is a worry, yes, that we've only got a finite number of beds, and there may be… demand may outweigh supply"

Hospice C: Medical Director

The UK Government's end of life care strategy has opened up the possibility of hospices treating and caring for patients with other chronic illness and senior managers suggest they are not ready for this.

"... there are the challenges from having to get involved much more with non cancer patients. It's a Government initiative, again, that, sort of, palliative care should be available to all people, not just cancer patients. So we are having to get involved with, you know, people with lung disease, kidney disease, everything now where they're getting those referrals"

Hospice A: Community Nurse Specialist

"... it's an ageing population. I already mentioned co-morbidities. With the latest End of Life Strategy there's even a bigger push on hospices to open their doors even wider and I'm not sure we're fit for purpose yet for that"

Hospice B: Nursing Director

"Originally when we set up, we were originally just the cancer patients but over the years, palliative care is all about end of life for anybody, not just cancer patients. It could be for heart failure patients, it could be for liver failure patients, it could be…so the doors are opening now for all patients who are end of life, because that's really where palliative care has changed"

Hospice D: Nursing Director

5.6 Sustaining the hospice business model: Interviewee perspectives

In the light of recent developments and the challenges facing hospices in the foreseeable future, participants' opinions were sought about their expectations from, and suggestions on, prospective plans to enhance the business model's sustainability. The necessity and challenges of forming a cohesive movement, the requirement for additional Government support through NHS funding, and the need to educate the public on issues affecting modern hospice services whilst maintaining an appropriate balance between the aspects of care provision and "business" activities, were the most commonly mentioned propositions.

The establishment of hospice movement on voluntary foundations and the ability to generate funds through charitable activities within each hospice's region, resulted in securing a degree of autonomy from central Government planning. On the other hand it led to variable per case commitments depending on the diversity and influence of stakeholder groups within localities. Currently individual hospices appear willing to maintain their autonomy in terms of decision making. This however may no longer be sustainable in the near future as the need to handle common challenges and

collectively respond to Government requirements will impose the need for further collaboration. The development of a cohesive movement, perhaps under an umbrella organisation such as Help the Hospices, appears like a probable future scenario. '*So I think that some hospices will just go down and maybe some others will then see a need for more collaboration more on the sorts of national branding perhaps more unified fundraising ...'* (HA:MD). Considering the increasing demand for palliative / end of life care services, additional Government support through NHS funding was seen as a necessity by all participants if hospices are to maintain their standards of service provision. This however is seen as subject to constant negotiations at both central and locality level. Participants expressed concerns over the requirements set by the NHS for any additional funding resulting in hospices having to compromise in terms of both, their autonomy, as well as, their services type and quality. '*The answer to that is there's some very capable people in the hospice movement, but I don't think they are going to find it very easy trying to negotiate with PCTs, commissioners, anything in the NHS, who… a lot of them play hardball, and they have, of necessity, learned to be quite ruthless in what they can afford ...'* (HB:MD).

Sustainable funding through charitable fundraising is helping hospices to maintain both their desired level of independence, as well as, their standards of service provision. Charitable fundraising however fluctuates dramatically across regions and periods of time. Most participants highlighted the necessity to educate the public on recent developments in palliative care and their impact on hospices as means of encouraging additional donations and support from local communities. '*I think by educating the people outside and giving more information and be open and honest with them ... these challenges by being dependent on NHS and we have to show and prove our self to the public that we're doing more and we deserve... these patients*

deserve more' (HD:MD). This is seen in conjunction with hospices' ability to sustain a viable balance between their care provision and their "business like" promotional activities.

> *"The answer to that is there's some very capable people in the hospice movement, but I don't think they are going to find it very easy trying to negotiate with PCTs, commissioners, anything in the NHS, who… a lot of them play hardball, and they have, of necessity, learned to be quite ruthless in what they can afford, and so any sentiment that gets attached to palliative care, which is a big motivator for everybody, I think, within the hospice movement, of providing quality, commissioners just will say, well, we can't afford it. You know, you provide it if you want it, but we're not paying for it. So I think we've got a lot of catching up to do in management and negotiating, I suspect"*
>
> Hospice B: Medical Director

Even if more secure funding streams are available from Government via the PCT's this comes at the cost of additional regulation and policy interference limiting the independence and autonomy of hospices. One interviewee argues that hospices are thus under an obligation to ensure that PCT's are aware that hospices are delivering value for money. This need to provide value for money justifications to PCTs could become increasingly the case, if Government funding was to secure a greater proportion of an average hospice's income streams.

"... putting pressure on the PCTs and the Government to fund us better. I mean, we get about a third of our... a third of our funding from the PCTs, as you're probably aware, but I mean they're expecting us, want us to do more and more with that amount of money, so I think more money and more grants"

Hospice C: Medical Director

"these challenges by being dependent on NHS and we have to show and prove our self to the public that we're doing more and we deserve... these patients deserve more ..."

Hospice D: Medical Director

"... I think there's a lot of the public which would say, the Government should put more money into hospices. You could say, true, there's a counterargument which says that if they do, you're going to become more and more like the health service in the sense that you're bound by the Government's regulatory and control type systems."

Hospice A: Nursing Director

5.7 Summary

This chapter presented the views of nine hospice clinical directors and senior clinical managers on the development of the voluntary hospice sector in England. These narratives reveal the impact of recent developments on the hospice business model, challenges hospices will face in the near future, and possible courses of action to

enhance the business model's sustainability. Widespread consensus exists amongst the participants regarding the increasing complexity of the hospice business model which impacts on its culture, organisational structure, cost, and future viability. In terms of future developments hospices are at a crossroad where increasing demand for service provision will need to be balanced against income uncertainties.

Upon entering the maturity stage the hospice business model became more complex due to both the type and length of provided services, as well as, the need to interact with an increasingly complex stakeholder network in order to secure funding for their operations. This, in turn, leads to the requirement for recruiting trained clinical professionals whose role is to both deliver palliative / end of life care, as well as, to manage departments and teams of specialists and also take part in strategic planning and management. The profound impact of these developments is a cultural shift from hospices being purely voluntary to becoming more 'business like' and similar in management structure to large profit-making or Government organisations. Recruitment of appropriately skilled clinical professionals, also, constitutes a significant challenge, due to the scarcity of relevant expertise and this, in turn, leads to competition with other hospices and NHS hospitals and hence adds further strains on hospices' budgets, as salary scales are inflated to stay in the game.

Ageing of the country's population and the widening of the patient base, are both considered as major stress factors, for the sustainability of the hospice business model. In recent and in response to relevant Government initiatives, hospices are increasingly required to provide palliative/end of life care services to patients with non-malignant conditions. For hospices this means that they need to develop additional expertise and adjust their organisational and clinical structure to accommodate the needs of non-cancer patients.

Additionally, with increased numbers of people living longer and the ageing of the country's population, the demand for hospice services increases even more. This then raises the need for additional funding to sustain service provision capacity. Interview participants suggest that the combination of the widening of the type and length of provided services, as well as, the ageing of the population could double the demand for palliative/end of life care services over the next few decades. Considering the financial volatility of the business model this would put the business model's sustainability at considerable risk.

Consequently, securing funding from sustainable sources emerges as a major challenge for hospices' managers and trustees if they are to cope with the increasing demand for their services and remain competitive within a demanding recruitment market. Funding through the NHS, even though stable, comes with a range of conditions and may potentially restrict hospices' independence in terms of both types and quality of provided services. Funding through charitable activities on the other hand, even though it safeguards autonomy, places hospices in the middle of an increasingly complex network of stakeholders which in turn results to the requirement for developing more 'business like' operational attributes. On the next chapter we get further insight on that as we see the views of nine non-clinical hospice directors and senior managers.

Chapter 6: Hospice narratives: Perspectives of non-clinical directors and senior non-clinical managers

6.1 Introduction

Their voluntary foundations and reliance on charitable funding led hospices to gradually develop organisational characteristics beyond those found in typical care settings. The necessity to secure large portions of their funding through fundraising and relevant trading activities requires skills found mainly in commercial settings. The initial reliance on volunteers to handle the administrative aspects of the business model became superseded due to the difficulty of managing the associated stakeholder groups and the increased competition for funding. This led to the recruitment of large numbers of commercially minded professionals. This chapter reveals the views of senior non-clinical professionals on the development, challenges, and prospects of the hospice business model.

6.2 Background and role of the participants

This section examines the professional background of the participants, the time span and motives to join the hospice movement, as well as the key aspects of their role as managers and the role of their teams within their employer hospice.

6.2.1 Background, training, and time of employment within hospices

Diversity in terms of background, qualifications, and duration of employment within a hospice is a lot wider in the group of senior non-clinical professionals, compared to senior clinical personnel. Table 6.1, below, shows the role and the employer hospices of each of the participants. Most fundraising directors moved to charity sector after a

career in commercial organisations were they gained variable levels of experience in marketing, sales, advertisement, and management. Finance and accounting professionals joint hospices after substantial employment periods in the corporate sector. With two exceptions the participants had less than five years of working experience in their current roles within hospices.

Table 6.1 Roles and employers of the non-clinical participants

Employer hospice	Interviewee's role	In-text quotation code
Hospice A	Fundraising Director	HA:FD
Hospice B	Head of Fundraising	HB:HF
Hospice B	Support Services Director	HB:SSD
Hospice C	Fundraising Director	HC:FD
Hospice C	Finance Manager	HC:FM
Hospice D	Voluntary Services Manager Fundraising	HD:VSMF
Hospice D	Appeals Coordinator Fundraising	HD:ACF
Hospice D	Hospice Accountant	HD:HA
Hospice D	Senior Administrator	HD:SA

Similarly to the case of clinical professionals, diversity in terms of background is mainly an effect of the rapid development of the hospice movement and the increasing level of complexity of the hospice business model. In addition to providing palliative care services, hospices have to develop administrative capacity to sustain their operations. This necessitated additional investment in recruiting professionals with commercial and fundraising skills. Hospices now employ fundraisers and managers that oversee this activity and the three quotes below reveal the types of backgrounds and skillsets required to fulfil these posts.

"Well, what I said, after my degree, I moved to London to work in television advertising and planning breaks ... and then I moved into research, where I was looking at audience research ... I then moved back to XXXX and started working for a charity down there, running two ambulances, three charity shops and you know, basically looked at the fundraising, and that was my first real experience of fundraising and volunteering"

Hospice A: Fundraising Director

"Well, my main profession was hotels and I studied tourism, actually, and I got into the hotel industry and my career was very much marketing orientated. So I worked for global hotel companies, responsible for their sales teams in the UK"

Hospice B: Fundraising Director

"Okay. I've been here three years, background in consultancy, people development, business development, working with organizations from educational charities, business, etc."

Hospice C: Fundraising Director

Often, voluntary members of staff who become fundraisers, have experience of working within hospices or medical experience and so are able to communicate the values associated with the hospice with regards to its fundraising activities. However,

as we will see later, some members of staff are motivated by the career prospects offered by employment in a hospice and are not simply motivated by 'values'. However, it is striking that in many cases those motivated to work in a hospices have been attracted to this work because of a sense of voluntarism and also their own experience of hospices such as with relatives who have been cared for.

> *" I worked here for about five or six years as a nurse and then left and came back as a therapist for a little while, and then decided to have a career change and came back as Voluntary Services Manager"*

Hospice D: Voluntary Services Manager – Fundraising

> *"I came to the hospice three years ago in December, I think, and my background actually is, well originally I trained as a biochemist and then actually went in and worked for, in sales and marketing for a, in biotechnology for many years"*

Hospice D: Appeals Coordinator – Fundraising

Hospices are also in increasing need of recruiting 'professional staff' involved with managing operations, administrative, and finance functions. This, also, is the outcome of increased business model complexity, but at the same time it can potentially increase complexity further.

"I'm the Support Services Director and I've worked in the charity sector for about 25 years and my time with the hospice has been four years, but before that, I worked for another charity called XXXX, which was a brand new charity, and set up through a project through XXXX University, which is how I got involved with it ... At the same time, it was my responsibility to set up a very brand new institute for these children to be trained in, to recruit the staff and to start all the process and procedures of a charity working. So by the time I left that organization, I was the director of corporate service ..."

Hospice B: Support Services Director

"When I left XXXX I took early retirement when I was 54 and I spent two years working at a school, doing the finance there and then this job came up here and one of the trustees asked me, would I come and look at the work for the hospice. I came here and I work here now on a part-time basis. It's two days a week. I'm responsible for the financial management of the hospice"

Hospice C: Finance Manager

"I've worked in auditing for the last few years. I also was a tutor in a sixth-form College for seven years and then I went back to accountancy about 12 or 13 years ago anyway and I started working for the hospice

here. This is my first job outside of practice … well, accountancy practice and I've been here for five and a half years."

Hospice D: Hospice Accountant

The tension in cultural dynamics, from voluntary to becoming more business like, within hospices, as the business model enters maturity, is becoming apparent through the examination of the backgrounds of our non-clinical professionals. The next section reveals the motives of the interview participants to pursue a career in the voluntary sector.

6.2.2 Motivations associated with those working in the hospice movement

A mixture of motives, ranging from, just seeing hospices as a career prospect and opportunity to utilise skills gained in the commercial world whilst pursuing a career change, to making a conscious choice of contribution through their employment, is revealed in the selection of quotes extracted from interviews below. Even though to a less significant extent compared to clinicians, many of the non-clinical managers were influenced by the hospices' voluntary and care focused culture, in their decision to pursue a career in this sector. A death of a loved one who was admitted to a hospice, a sense of contribution and making a difference, or simply the joy of working within a caring environment were listed by participants as reasons for joining their employer hospice.

However an interesting observation is that the most recently appointed professionals, particularly in fundraising, reported that their motives were predominantly based on career progression and professional criteria. This is in line with our observation in the case of clinical personnel following to the sectors' entering the maturity stage.

Having to cope with more complex challenges, hospices are finding it necessary to attract more specialist professionals, equipped with relevant expertise, in order to sustain their position as leading palliative / end of life care providers.

> *"I went into a library one day, and I thought, I've heard about these Trust Funds. I'm going to find out, I sat down with the books, and just taught myself, and through getting more involved, I then found out about the Institute of Fundraising, and when I left the paper, and went to work for the XXXX, that's when I started going to their conferences, and that's when I started finding out more about people who were doing it professionally, and I realized this could be a real career for me…"*

Hospice A: Fundraising Director

> *"I realized that there were charities and there were paid positions for fundraising, which I hadn't been aware of before. So I decided that's what I wanted to do because I thought it's, I've got a good background, good skills, good experience, it would be nice to bring it into an industry where you actually make a difference. You're not just lining the pockets for other people to make lots of money really. So that, really, was my motivation to get into the charity industry …"*

Hospice B: Fundraising Director

"... the reason, actually, for joining the hospice movement was the job, I guess. It's the job that needed to be done. So I wasn't specifically thinking, I want to join the hospice movement."

Hospice C: Fundraising Director

"I was a student and I enjoyed looking after patients with cancer in my hospital…. So that was my sort of motivation and I didn't really want to go back into general nursing, but for sort of career advancement I wanted to become a ward sister so I needed to stay in the NHS. So I went back to XXXX for about, oh, gosh how many years, five or six years, became a sister and then had my family, so I'd done that and then, when I came back to nursing, I decided that I wanted to come back to a hospice"

Hospice D: Voluntary Services Manager – Fundraising

The motivations driving those working in hospices and helping to raise funds is varied from those motivated to work within a hospice because of its values, to those experiencing the quality of care given to relatives, and finally individuals realising that their skill sets are transferable into the hospice sector.

"Why hospices? That's a very, very personal thing in that many, many years ago when I was 17 my mother died and in those days there was no hospice movement at all, there was actually nothing available to care for people."

Hospice D: Appeals Coordinator – Fundraising

"... because of my wide ranging skills in terms of corporate development and facilities and human resources and finance management, obviously, tried to find something of a similar nature and saw this role, the Support Services Director post advertised in Third Sector magazine and charity journal and came along for an interview of that. And, again, to cut another long story short, was appointed in July 2007 to undertake that role."

Hospice B: Support Services Director

"Well, I have a few relatives who've died of cancer and I've heard a lot about Hospice D. We've been living here for about 20 years and one of my friends and neighbours was the accountant here and she said she was going to leave her job for another job. She'd been here for seven years or something and she said there's a vacancy, if you want to apply, and so I did a lot of research and anyway came for the interview and got the job. So, I was very pleased about it ..."

Hospice D: Hospice Accountant

"I like working in a caring environment. I don't like working in what I call bricks and mortar. I like people and trying to do my best to help people, like our patients, so that's why I like to be here"

Hospice D: Senior Administrator

This section reveals the various motives that encourage people to work for a hospice some of which are not in line with the traditional charitable character of the hospice movement in England. Responding to the increasing complexity of their business model, hospices now recruit people with professional acumen whose motives and approach to work import values and ways of thinking usually found within profit making organisations.

6.3 Key aspects of the participants' role as managers and the role of their teams

This section provides an overview of the participants' role within their employer hospice including the role and work of their teams/departments, and their involvement in decision making.

6.3.1 The role and work of the participants and their teams/departments

Significant variations in terms of how administration and fundraising are organised across different hospices is revealed through the analysis of narratives obtained from interviews with staff. Even in comparable roles, for example, those of the fundraising director, team structures and type of responsibilities allocated to either full time personnel or volunteers vary considerably. In contrast to what was observed in the case of clinical managers, the size of the organisation plays less of an important role in explaining the complexity of the non-clinical organisational structure. Competition for funding with other charities, the hospice's period of existence, and the affluence of the hospice's region, are more influential factors in terms of the trustee's decision to invest in fundraising and administration.

Fundraising, trading income from charity shops, and marketing, activities are organised differently by various hospices depending on the conditions of their locality and the requirements / plans for expansion of their trustees and senior management. This in turn affects accordingly the need for employing professionals instead of relying on volunteers. For example the fundraising director of Hospice A, even though employed by one of the largest hospices in the country has a lot less support in terms of full time staff and middle managers, compared to other smaller hospices. However, fundraising directors in hospices B, C, and D, are in charge of relatively large teams supported by middle managers even though hospices B, C, and D are smaller in size.

> *"Well, at this hospice, this is how it works. There is myself, and a corporate fundraiser, and I now have a marketing and communications coordinator, and a part time fundraising secretary. I report directly to the CEO, and in my team currently, I have the marketing and communications coordinator, the corporate fundraiser, and a fundraising secretary..."*
>
> Hospice A: Fundraising Director

> *"We have four full-time staff, four full-time people, including, with myself, there's five, and we have a placement student, six, and a part-time clerical assistant. So how the department's set up, we have XXXX person who's called a corporate fundraiser. And XXXX person is responsible for the relationships with the local businesses and companies. And she also looks after legacy income and funeral*

directors, that sort of thing. And then she will develop partnerships and relationships with those as well as organizing some events to generate money from those. Then we have XXXX person, who's our community fundraiser."

Hospice B: Fundraising Director

"... my role is Head of Fundraising. And really to, I guess, just to really take on what we need to raise and to look at every single way of how we can raise and maximize what we can do in the area. ..... we've got five shops. So we have shop managers and then the rest are manned by volunteers. .... The lottery, we've got 10,000 members ...We've got three fundraisers and they've got even... well the three of them have got a different focus, but they work very much as a team. So one's focused on the major events, marketing and PR; one's our community events, trying to inspire people to have the coffee mornings and to do whatever they need to be doing, and supporting them. And we've got another lady who looks after business relationships."

Hospice C: Fundraising Director

"we have three fundraisers and two administrators. The fundraisers deal with every form of fundraising out in the community, like a community corporate event, legacies, trusts, trust funds, basically everything - we are the front of the hospice for fundraising"

Hospice D: Appeals Coordinator – Fundraising

Similarly to the case of the fundraising directors, diversity amongst hospices is evident when viewing the roles and work of professionals in finance, support, and administration, of hospices. Again regionally embedded factors appear to be more influential than the size of individual hospices when it comes to various departments' size and complexity.

> *"The Support Service Director's role is simply to provide the person that's responsible for the non-clinical aspects of the organisation. So this role is responsible for human resources, which includes volunteers, management, finance, IT, estates and facilities, catering and housekeeping. So, basically, all the services, the underpinning services for the clinical side of things. I'm able to manage that huge workload, if you like, by having a good set of middle managers over each area. And those middle managers are, if you like, they're qualified people in those areas. For instance, I'm responsible for finance, but I'm not an accountant. My discipline is really HR, but because of my experience, I'm very broad ..."*
>
> Hospice B: Support Services Director

> *"I'm the personal assistant to the hospice director. I arrange meetings. I minute most meetings in this place. I arrange things like AGMs and Light up a Life services that we have outside at Christmas. I do correspondence for the nursing staff. I oversee the reception, make sure that I line manage the two receptionists. My role is varied. There isn't a job description for it really. It's very broad, and, basically, it*

could be anything. I organise stationery, it's all kinds of things. It's really, oh, well, who can do it? I'll ask XXXX person, you know, it's like that. And that's nice because I see everything that's going on in the hospice. I have an overview of it all, which is good"

Hospice D: Senior Administrator

"I'm the finance officer. I work two days a week and that's only really possible because I have three ladies who work for me and are very good at their job. Two of them have been here since the hospice opened and it's a young girl who supports them on the finance side of things. One lady is responsible for the trading company accounts. The other lady is responsible for the hospice accounts. They're full-time employees. My role is really to oversee their work, to do the budget, to meet with the trustees and provide financial reports, to analyse our expenditure, which is an area we think we'd like to look at."

Hospice C: Finance Manager

"the lady who was in my office is my fulltime assistant and then I rely on a whole lot of volunteers to do the bookkeeping for the shops, for instance, and the lottery ... Yes, we're very short of resources, if you like, in the department. I'm very lucky to have very good people who I can rely on but it's a lot of volunteering hours"

Hospice D: Hospice Accountant

Diversity amongst hospices in terms of their non-clinical organisational structures is evident. This is because of a variety of reasons some of which are regionally embedded and some are based on the backgrounds and values of the non-clinical professionals each hospice managed to attract. This constitutes additional evidence of the cultural shift observed when interviewing the clinical professionals. The next section evaluates the non-clinical professionals' involvement in strategy and decision making of hospices.

6.3.2 The participants' involvement in decision making

Variable levels of involvement in strategic level decision making have been reported by the non-clinical participants. Directors of fundraising and accountants are predominantly those involved in strategy and planning whilst managers with administrative or support roles are generally required to only provide an opinion on targets set by the board of trustees. Contrary to the clinical directors, the hospice size does not appear to affect the extent of involvement and input of non-clinical directors in decision making.

The main aspects of contribution of non-clinical directors include financial planning and budgeting to accommodate expansion projects or meet sustainability targets, proposals on new fundraising events, review and optimisation of both clinical and non-clinical activities, and annual target setting. As complexity of the clinical aspects of palliative and end of life care provision increases hospices are also required to develop their non-clinical activities to sustain the business model. This in turn increases the overall internal complexity of hospice management and makes its

organisational structure similar to that found in larger organisations of the private or the public sector.

> *"I've only been here a few months, so at the moment, my focus has been on information gathering, and planning ahead"*
>
> Hospice A: Fundraising Director

> *"I have an income target to raise, we have to raise £2.1 million. So then I have to sit down and write a plan of how I'm going to achieve that, with the input for my team, I'd, obviously, ask them what they, you know, what they feel we could do. And then each month, each team member would have a target and each month, then, we'd have a one-to-one where we review what's happened to the previous month and we outline for the next month"*
>
> Hospice B: Fundraising Director

> *"I sit down, with the finance manager and with the CEO, and realistically look at how we're going to get that money in, and that's the bit that's backwards and forwards because, obviously, that doesn't always match"*
>
> Hospice C: Fundraising Director

"It's mainly day-to-day but if I see a need or somebody asks, they need a new service, then I'll investigate to get a new service. People don't tend to come to me and say we could do with this; I sort of find out that actually we could use volunteers in this or whatever"

Hospice D: Voluntary Services Manager – Fundraising

"More recently we are getting involved in longer term, actually what's happening ... the strategy within the hospice, yes, so yes we would be involved in that as well as focusing on the day to day management"

Hospice D: Appeals Coordinator – Fundraising

"It wouldn't have been in the past, but it will be now. Part of the strategy is that it's been agreed that all departments, mainly the clinical departments, will undertake a review of current practise and that will inform the work of that group. But, at the same time, is they're asking to review it, we're also asking them to look at where it might develop, or how it should develop, in their view, according to the Government's enterprise strategy, according to their experience, according to anything else that they'd come across in their professional lives"

Hospice B: Support Services Director

Apart from the role played by key non-clinical professionals in introducing cultural change within hospices, trustees with experience from other sectors also reshape traditional approaches to strategy and decision making.

"I'm certainly involved as a finance manager in the strategy and the effects that the strategy has on finance. The trustees are in overall responsibility for the financial health of the hospice. There is a finance committee, sub-committee of the trustees. We meet on a three-monthly basis just reviewing progress ... So in as much as the trustees set the overall strategy, they're happy to take the advice of the CEO or myself and the professional managers. Most of the trustees are experienced in various parts of industry. They might have worked in industry before and they'll set the overall tone of where the hospice is going. It was their decision, for example, to extend the hospice. But within that then the management team contribute to the overall decision-making process"

Hospice C: Finance Manager

"Well, at the moment I'm right in it, you know, with this strategy document I'm helping the director to write. I attend all the council meetings, so I'm always aware of what goes on and I'm there, obviously, to help them to give them information… financial information and to help them take decisions, basically. So, I suppose although I don't take the decisions, I'm always… my opinion will be taken into account if they ask me questions during the meeting. My assistant is very good with payroll, so she's the, you know, payroll person. So, she'll be able to cost things but she won't take part in the policy-making or in the strategy. So, I'm the only one, really.

Obviously, you know, there's another two qualified accountants on the trustee board as well"

Hospice D: Hospice Accountant

With larger numbers of professionals required to run the non-clinical aspects of hospices' activities the business model exhibits cultural tension and increased internal complexity. The next section provides a review of the participants' views on the development of the hospice business model.

6.4 The evolution of hospices towards a more complex business model

There is wide spread consensus among the non-clinical participants regarding the gradual transformation of the hospice business model. When asked to comment on the evolution of the hospice movement and on changes they have noticed on its ideals and orientation. Interviewees observe the nature of cultural changes resulting from increased competition for funding among charities, the need to manage expectations of the public, the challenge of increasing their care provision capacity to accommodate the needs of more patients, and the requirement to recruit sufficient numbers of non-clinical professionals with commercial acumen, comprise the main categories of the participants' interests. Increased levels of complexity are observed, as the participants highlight the contrast between the way, hospices used to operate during their earlier stages of development and the way they have to operate in the present.

Structural changes are apparent as hospices become larger, incorporate additional services for patients, and recruit more professionals to sustain their care provision

capacity. '*In fact, the day unit at the hospice I started at was just, you know, a conservatory; they didn't have a proper building. Now it's huge, the one at XXXX hospice and the same here: we started off with five patients and now, you know, 25 years later, we can take 25 each day'* (HD:VSMF) This growth has, in addition to recruiting more clinicians, led to the need for adequate management structures and administrative support teams. Hence shifting the culture of individual organisations from purely voluntary and contribution based, to more structured, professional, and in terms of their non-clinical activities, more market driven and commercial-like.

Increased funding requirements necessitate more sophisticated operating structures and this, in turn, leads to additional investment in fundraising and trading activities. These however are obstructed by the increasing competition with other charities. '*And so we have to be a lot more professional, a lot more aware and a lot more able to present ourselves against other charities when, from my perspective, we're looking for money and we're actually sourcing funds'* (HD:ACF). Consequently, to remain operational within a competitive market, hospices need to sustain a complex network of stakeholder groups to underwrite their varied range of income streams.

Effective management of public relationships and expectations within each hospice's locality is of vital importance for the sustainability of the above mentioned stakeholder network, as hospices also need to be attractive to potential donors, volunteers and supporters compared to other charities. This is challenging due to both out-dated public perceptions, about the way hospices operate, as well as, public scrutiny in terms of allocation of funds between charitable activities and administration. '*...we have to be more business-like, and that's not, I think, what the public actually want to see ... they want responses to their phone calls and their emails, and so on, but what they don't want is for charities to be spending money on*

the administration behind returning those emails and phone calls, and so on' (HA:FD). Therefore as hospices become larger and more professional, continuous efforts through appropriate marketing activities are required to educate the public on their changing operating environment.

> *" what I see as a cultural change here, within this particular hospice anyway ... I think there is a shift happening definitely within the hospice movement, because the charity market in general, from what I've seen, has become more competitive over the years, and I've been fundraising now, crikey, how long? Over ten years now, and you know, it has become a lot more competitive, so we have to be more business like"*

Hospice A: Fundraising Director

The following couple of quotes demonstrate the cultural tension and shift as hospices move towards professionalism to deal with the demands of their current 'business environment'. Hence, traditional values and perceptions originated in the early stages of the hospice movement are under the threat of being compromised as managers and trustees have to act out of necessity.

> *"I think the traditional hospice fundraiser is probably a thing of the past, to be honest. I think what happened before is your fundraising manager or whoever probably had been in the industry or at the same hospice for years. And I think because it's getting very competitive out there, I mean, it is a business at the end of the day. We've got to raise*

money or the hospice doesn't run. I think they're looking for people that have got business skills, really, and commercial acumen ..."

Hospice B: Fundraising Director

"I think it has become more professional but also it has to, has to become because the charity environment, charitable world is very competitive. And so we have to be a lot more professional, a lot more aware and a lot more able to present ourselves against other charities when, from my perspective, we're looking for money and we're actually sourcing funds."

Hospice D: Appeals Coordinator – Fundraising

The tension between the traditional culture of hospices and the need to modernise and become more 'business like' and hence even administratively more complex is also highlighted in the following two quotes.

"You have a mix of the people who are passionate about the cause, enjoying it for the cause, but you also have people who can join the organisation because they have the skills to offer in terms of financial management, or human resource management, or facilities management, or health and safety, which are a natural requirement of any really good business"

Hospice B: Support Services Director

"fund-raising becomes more a priority as the hospice has gone on. We have over 40, nearly 50 people fully employed so there's quite a demand for funds so fund-raising has to get tighter and better ..."

Hospice C: Finance Manager

Within this section, increased competition for funding, the need to manage public expectations, the challenge of increasing hospice care provision capacity, and the recruitment of larger numbers of non-clinical professionals with commercial acumen, have been identified as the main factors driving the hospices business model towards complexity. This increasing complexity is mainly highlighted by the participants by way of a comparison to the way hospices used to operate in their earlier stages of development and the way they have to operate in the present. The next section presents the participants' views on the foreseeable challenges facing the hospice sector.

6.5 Forthcoming challenges and their impact on individual hospices

The increasing cost of service provision in conjunction with the increasing competition for charitable funding is seen as a major challenge for hospices by the non-clinical professionals, when asked to present their views on what they see as forthcoming challenges for the sustainability of the hospice business model in the future. Recruitment is been identified as a challenge in the case of fundraisers but not in other categories of non-clinical personnel. A smaller number of participants also recognised the widening of the patient base and the ageing of the country's population as a potential challenge.

6.5.1 Funding of service provision

Increasing costs to sustain their level of service provision, in conjunction with the increasing demand for palliative / end of life care services and the increased competition for charitable fundraising is seen as the main challenge for the hospice business model by all non-clinical directors. The financial crisis has limited the amounts of funds hospices can raise within their communities and imposed strains on funding provided by the Government. Attempts to identify new sources of charitable income, for example through developing corporate fundraising, have variable success rates for different hospices and in all cases require additional investment in recruitment of experienced professionals.

With a large portion of their expenses being inflexible, for example the salaries of specialist clinicians, hospices are in need of stable sources of funding. Their funding model however is sensitive to a range of environmental conditions. The recent economic downturn, for example, exposed hospices to income uncertainty as Government funding cuts on the NHS limited PCTs ability to provide adequate financial support. '*So, at the moment, of course, the problem is the hospice is in a crisis, the Government has run out of money, they've got to make savings in the NHS, so the NHS passes on the financial cuts, if you like, through the PCT'* (HD:HA).

Charitable fundraising is significantly reliant on individual patterns of giving within various communities and also sensitive to uncertain environmental conditions. Existing donors and supporters, for example, will rarely adjust their contribution to the percentage increase in hospices' annual expenditure required to sustain similar standards of service provision. '*They're used to donating £10. It's their level, if you like. They'll buy £5 worth of raffle tickets and those £5 of raffle tickets every year.*

They don't by £6 the year after and £7 the year after that because our costs are going up. They're contributing at the same level so we have to find more contributors, if you like' (HC:FM). Additionally, securing a sustainable group of donors is also challenging after the recent financial crisis as individuals may not be in a position to continue their support to charities when the level of their own income is uncertain.

Giving individuals tend to spread their donations across various charities from year to year and this makes investment in renewal and expansion of their potential donors' base vital for hospices, if they are to balance the volatility of their income streams. '*... people like to support a charity one year and do something different the next, because they like to feel that their money is being spread around, and that's one of our big challenges ... we need the money year in year out ...'* (HA:FD). This however is restricted by both the size of each hospice's region, as well as, from the existence of other charities aiming to increase their share of supporters. '*there is a little fatigue coming in, particularly when things are hard and lots of people are asking for money'* (HC:FD).

Diversification of their base of donors, through developing links with local businesses to strengthen corporate fundraising, is a way of securing a degree of income stability and a number of hospices are now starting to engage on this type of activity '*... we need to start looking outside of that and really concentrate on the business sectors, and getting people involved and doing things like that, because people only have so much money to give'* (HC:FD). Corporate fundraising however, is not yielding equally distributed and beneficial results for all hospices as it is also reliant on the general economic conditions of deferent regions. '*With the present economic climate it's very difficult for us to attract money from corporates so, and*

that's something that's been in a sort of a decline at the moment' (HD:ACF). The following quotes highlight the challenge to secure funding and cope with increasing service costs further.

> *"Costs go up exponentially. You know, and that's the big thing, that all hospices, I think are faced with ... And, also people like to support a charity one year and do something different the next, because they like to feel that their money is being spread around, and that's one of our big challenges ... we need the money year in year out"*

Hospice A: Fundraising Director

> *"I think the communities which traditionally fund the majority of funding that comes through hospices, you know, you… we need to start looking outside of that and really concentrate on the business sectors…. there is a little fatigue coming in, particularly when things are hard and lots of people are asking for money"*

Hospice C: Fundraising Director

> *"I think that financially at the moment funding and the increasing size of our place and to maintain that in the recession is not easy. It will take a while to recover and hopefully we'll be able to continue our services and not have to cut any services"*

Hospice D: Voluntary Services Manager – Fundraising

"the Government has run out of money, they've got to make savings in the NHS, so the NHS passes on the financial cuts, if you like, through the PCT. They pass it through to the hospices, so we're all in the same boat at the moment, if you see what I mean. It's… I mean, the funding issue is a national issue and should the spending be provided for the care of the dying or should it be funded by… charitably"

Hospice D: Hospice Accountant

To sustain their palliative / end of life care service provision capacity, hospices are faced with increased costs most of which are not flexible and this leads them to make additional investment into fundraising. However, increased competition with other charities and the impact of the general economic conditions within various regions, means that securing adequate funding through charitable activities and fundraising constitutes a major challenge. Moreover, as demonstrated in the next section, recruitment of professional fundraisers can also be a further problem due to scarcity of relevant expertise.

6.5.2 Staff recruitment and skills availability

In addition to the challenge of recruiting and retaining qualified clinical personnel, scarcity of relevant expertise in fundraising is a significant obstacle for most hospices. On the other hand administrative and general support positions are easily filled despite the lower salary structure compared to similar positions in the private sector. Shortage of relevant training programmes and qualifications, competition with other charities to attract experienced professionals, and competition on salary

basis with private sector organisations to attract professionals with potentially transferable skills, are challenging hospices ability to recruit fundraisers at senior level. At the same time the requirement to further develop their fundraising capacity forces hospices to invest in developing internally the required skills on the basis of an individual fitting the requirements in terms of interpersonal skills and commercial awareness.

Competition on salary has also been acknowledged, by non-clinical directors, as a factor limiting many hospices' ability to recruit clinical staff and certain categories of non-clinical professionals (see chapter 5). This drives many hospices to follow the NHS pay scales to secure access to a competitive recruitment pool. '*We want to be able to, when we recruit, make sure we get the same talents and the same abilities that the NHS have and not take on a second tier of clinical staff'* (HC:FM).

> *"We've been struggling to find a consultant in palliative care because there aren't that many of them. So, really they call the shots but… We're getting there but it's taking a long, long time."*
>
> Hospice D: Hospice Accountant

> *"I think there's probably a shortage of doctors, but, so far, at the moment, we're all right, yes. I think perhaps doctors are not as easy to recruit as other members of staff. Nurses, we're usually okay. It might be the one that is a bit more hard."*
>
> Hospice D: Senior Administrator

Equally impactful is competition with private sector organisations, or charities with national cover, which also restricts relatively small hospices' access to highly skilled professional fundraisers, and increases hospices' employment costs. '*I think just from a fundraising perspective, yes, I'm looking for people with sales and marketing skills. These people could be earning a lot more money elsewhere, so what are you ending up with, in a recruitment pool?'* (HA:FD).

Recruitment on the basis of transferable, social, and interpersonal skills frequently becomes an act of necessity for hospices. '*So the decision I made was to actually find people who've got that warmth and have got that quality, and who've got the business skill I mean, it's business, isn't it, really?'* (HC:FD). This however, requires considerable investment in time and training, before individuals can take up the requirements of their new role. The quotes below are good examples of hospices' struggle to attract or develop professional fundraisers with an appropriate skill set.

> *"It's difficult, because I think the voluntary sector in its own right, and again it's my personal opinion, struggles with attracting professionals from the private sector, purely on a salary basis, more than anything else. We have to try and compete to, you know, draw people in. You get people coming to work for the voluntary sector for a lot of different reasons, but one of the main reasons that they don't come is salary, I'm sure of it, and I think we can't compete with that"*
>
> Hospice A: Fundraising Director

> *"The ones that were moving have moved a lot, and it's certainly just kind of indicated. So the decision I made was to actually find people*

who've got that warmth and have got that quality, and who've got the business skill I mean, it's business, isn't it, really?"

Hospice C: Fundraising Director

In the absence of either relevant experience or training, fundraising managers often focus on character traits of prospective employees, upon which they can build and develop the required expertise.

"You need people who are sensitive to the needs of others, and also that they're up to the role and can sort of be fairly self-motivated, self-supporting, because, you know, we haven't got staff to work alongside everybody all the time"

Hospice D: Voluntary Services Manager – Fundraising

On the other hand, for non-clinical or fundraising personnel, such as general support and administrative positions, hospices are managing to recruit despite the lower salary structure they usually offer.

"I think we've been actually quite fortunate that we, there are, yes there are plenty of people out there in actual fact who seem to be willing to, you know, the salaries aren't the best here, so are willing to take the cut in salary and actually come into these roles"

Hospice D: Appeals Coordinator - Fundraising

"It's easy, it's easy, in the type of things I'm looking for. You know, catering staff, cleaning staff, IT, finance, HR. HR just advertised for an administrator, I had 96 applications. Even though we're a rural, if you like, environment, we still had a high element of response. I haven't had any problems"

Hospice C: Finance Manager

Similar to the case of clinical professionals, hospices are faced with increased competition whilst trying to recruit professional fundraisers. This also acts as a limiting factor on their ability to raise funds and requires additional expenditure for training, home grown, employees to meet the standards of a fundraising role. Recruitment of other non-clinical professionals, however, does not appear to be a problem for most hospices. Nevertheless, being faced with the prospects of increasing demand of their services, hospices need to find ways of increasing their administrative and fundraising employment.

6.5.3 Hospices: widening chronic care provision and the ageing population

A number of non-clinical directors highlighted the pressure on hospices from widening of the patient base and the ageing population. The additional complexity attached to treating and caring for non-cancer patients, is expected to impact on hospices employment costs, because there will be additional training and recruitment requirements. Hospices are also expected to be challenged in terms of their assets and resources, which may require further investment and upgrade. These may event

force the need for Government support, if hospices are to meet the expectations outlined in the Department of Health's end of life care strategy.

> *"The fact that we've noticed the complexity of our patients and dependency of our patients getting greater, and, therefore, we need to respond to that the complexity of the conditions, so that they don't just have cancer. So are we going to deal with just cancer patients? Are we going to deal with cancer plus dementia plus something else? What about people with neurological conditions, are we going to help them? So I think we're facing quite key questions at the moment about our own development, about development of our work in the community, which, well, you know, everybody wants to die at home, or do they? So it's been able to look at the development for our service as it is now, look at the demographics, as it's going to be."*
>
> Hospice B: Support Services Director

The adequacy and capacity of specialist skills, developed within hospices, are challenged by the increasing demand for their services due to the ageing population which results in larger numbers of people living with cancer. With their services developed around the care needs of cancer patients, hospices are confronted by the requirement to extend their care provision to new patient groups and this further reinforces the challenge. *'And the other thing is, with the end of life care and the all the sort of proposals of what other patients we might taking other than cancer patients, we could be opening the floodgates, I would imagine, to lots of referrals'* (HD:VSMF)

Hospices' service provision will be stretched by these new additional demands and will require substantial investment in recruitment and development of new premises. '*And, you know, the biggest chunk of our cost is staffing as we've increased… and obviously we need the specialized staff. So it's not just about increasing the beds. You need extra nurses, you need extra doctors, if the clinics get too big'* (HC:FD). Funding for ongoing investment might not become available as many hospices are already financially stretched and operate with restricted reserves.

> *"Well, as you're probably aware, the Government has issued a paper on its end-of-life strategy. I think there's an awareness within Government circles now that the role of the hospice will probably expand because I think they're looking at end-of-life strategy and how people come to the end of their life, what services are needed, how we can provide those services"*
>
> Hospice C: Finance Manager

> *"And the other thing is, with the end of life care and the all the sort of proposals of what other patients we might be taking other than cancer patients, we could be opening the floodgates"*
>
> Hospice D: Voluntary Services Manager - Fundraising

Increased funding requirements, coinciding with income uncertainty, are challenging the sustainability of the hospice business model at a time when Government requires additional contribution through widening of service provision. This consequently

leads to expectations for additional Government support, if hospices are to continue being a key ingredient in any strategy for expanding the provision of palliative / end of life care.

6.6 Securing the hospice business model

This section summarises some of the key points raised by the participants about the evolution of the hospice movement, as well as, how and in what ways the business model is to be sustained. Non-clinical directors discussed these in the form of expectations and suggestions for future courses of action that are required to enhance the business model's sustainability. There was widespread consensus, amongst the interviewees, that hospices will need to adopt a more professional approach to reorganising their fundraising and non-clinical activities. Modelling successful examples, negotiating for better funding conditions with the NHS, as well as, reviewing and adjusting their service provision based on demand and available resources, were also mentioned as either inevitable developments, or potential plans, to reinforce the hospice business model's resilience, in the face of the forthcoming challenges.

In the light of the recent financial crisis and its impact on charitable income streams, participants emphasised the importance for hospices to further invest in developing and professionally organising their fundraising, trading, and non-clinical management activities. '*With the financial pressure that we're under at the moment, and the financial pressures that are ahead of us, I think hospices in general across the board are having to become much, much more professional, particularly within their fundraising'* (HA:FD). The pressing need for additional funding and the

necessity to diversify their income streams is driving hospices towards abandoning the traditional voluntary approach to fundraising.

The contrast between hospices still following the traditional voluntary approach and hospices that have successfully modernised the non-clinical aspects of their business model was extensively discussed by a number of participants. Modernising their non-clinical activities, through benchmarking the cases of successful examples, is seen as inevitable if hospices are to develop and maintain stakeholder networks capable of providing sustainable income streams. Modernisation however requires substantial investment in recruitment of suitable professionals within a completive market.

> *"There's many different levels. You'll know, yourself, if you go around to speak to the hospices, there's very different levels. There's some very switched on, very business focused, know what they're doing, get out there. And there's some very, kind of, still very traditional, you know, a couple of little volunteers trying to do the fundraising and what have you"*
>
> Hospice C: Fundraising Director

Scarcity of resources and income uncertainty led a number of participants to highlight the necessity of analysing the demand for each of the hospices' care services and make adjustments on the basis of what a hospice can afford to offer. '*I think that a review of service provision, as it is, and an analysis of demand of our business, is a good starting point'* (HB:SSD).

"Well, you are being restricted to what you can afford in the future and everything has got an opportunity cost. So, if you decide to, for instance, have extra nurses or extra therapists in the day unit, well, maybe that's so many bedrooms that we won't be able to fund in the future if we decide to have ... So, you've got to decide which direction you go in, either you open the doors to more people or then you increase the care you give to a smaller number of people"

Hospice D: Hospice Accountant

Negotiating better funding conditions with the NHS, as hospices are becoming increasingly embedded in the Government's plans for widening access to end of life care, has also been proposed as a way for hospices to secure a stable source of income. Similarly however to their clinical colleagues, non-clinical directors expressed their concerns over the extent that hospices might have to compromise their autonomy as well as their services' mix and quality. The importance of maintaining hospices' independence whilst negotiating for NHS funding was stressed by a number of participants as vital for the business model's sustainability. This puts additional stress on raising funds from outside of the NHS and from voluntary contributions.

"My target, for example over the next five years, I have to double the voluntary income. That's an awful lot of coffee mornings, and it's not all about coffee mornings, so it's actually looking at the whole portfolio of products, if you like, that we deal with and how we actually make those work for the future ... It's looking for new income streams, it's

looking for how we manage that, and the resource involved in actually generating that income"

Hospice A: Fundraising Director

"... we can actually start thinking about our resources in terms of are we going to continue to be paid through the PCTs and how are we going to ensure that we get proper value for the services we provide and not just, you know, it's going to cost you that, but it's properly analysed and properly paid for"

Hospice B: Support Services Director

The quotation below is a very good example of the tension, within hospices, between negotiating for additional support from the Government or, maintaining their autonomy, revealing widespread concerns over the extent that hospices might have to compromise their services' type and quality, in addition to their autonomy.

"I think the biggest contribution we get is from the PCTs and I think more and more there's an acceptance in the PCTs that they have to provide more cash than they probably want to. And the PCTs have been leant on by the Government to get more involved in hospices. The trustees would say, from this hospice's point of view, we don't... we would like to get to the point where 49.9% of our income is from these PCTs and the remainder of it is from our own resources. That way we're not a Government department. If we're less than 50% funded

then we're happy to say we're independent and we can still do our own things. If we were 99% funded by the PCTs we'd effectively be part of the NHS. We'd just be another department subject to their control. So I think, from our point of view, we'd like to raise more money from the PCTs and get up to this 49% funding but beyond that we want to raise cash ourselves"

Hospice C: Finance Manager

Based on the non-clinical professionals' point of view, to sustain their business model, hospices need to embrace more business like methods in terms of their fundraising and non-clinical activities. Review and adjustment of service provision based on demand and available resources, might occur out of necessity to strengthen the business model's resilience. Negotiating better funding terms with the NHS, to secure more stable income streams, is seen as a way forward by many hospices, but this has the potential to considerably restrict their autonomy.

6.7 Summary

The examination of the non-clinical directors' and senior managers' views on the development, challenges, and prospects of the hospice business model, reveals that complexity has increased considerably. Hospices, are not only challenged by the requirement to increase their service provision in terms of type and quality, but they also have to deal with increased competition for funding. Safeguarding their autonomy, whilst still being in close collaboration with the NHS, also concerns their management and influences individual hospices strategic level decision making.

Recruitment of, much needed, commercially minded, non-clinical professionals, has amplified, in many cases, the cultural shift towards modernisation and reveals the tension between traditional values and the need to secure sustainability. Competition for charitable fundraising and the need for professional resource allocation and management, lead hospices to invest in recruiting professional fundraisers as well as finance and support managers. This gradually leads to the establishment of departments and teams that are not related to hospices' clinical activities. However, scarcity of relevant expertise for fundraisers, in addition to specialist clinical staff, exposes hospices to salary competition with much larger public and private sector organisations.

The need for stable sources of finance drives many hospices trustees and senior managers into closer collaboration with the NHS. This, in turn, threatens hospices' autonomy and many participants highlight the need to establish appropriate levels of Government funding in a way that preserves hospices from becoming an extension to the NHS. Hence, most of the participants suggest that efforts need to be put into both, developing the local relationships with the NHS, as well as, in enhancing efficiency and effectiveness of hospices' own charitable fundraising.

The next chapter of this thesis uses financial information from the 35 largest – in terms of income - hospices in England to construct a financial analysis of the voluntary hospices business model. This is then used to evaluate the resilience of the hospice sector, in the face of the challenges revealed in both this and the previous chapter.

Chapter 7: The Hospice Business Model: Financial Performance and Sustainability

7.1 Introduction

Having considered hospices' transition into a mature and complex business model of care provision and the challenges to its sustainability – increased demand for service provision, increased funding requirements due to increasing operating/recruitment costs, and scarcity of relevant expertise in the recruitment market – this section provides an analysis of relevant financial information focusing on the top 35 hospices in England, as ranked by their total income. Based on Help the Hospices 2006 and 2009 classifications, I estimate that this group accounts for roughly half (47%) of all hospice income in England.

At the top of our list, we have St. Christopher's hospice receiving £19.1 million of income in 2011, and at the bottom of our group, we have St Wilfrid's Hospice (Eastbourne) with an income of £3.5 million in the same year. The remainder of the hospices are thus operating with income levels below £3.5 million, to provide high quality in-patient and day care facilities in addition to hospice at home care services, as well as, family support and bereavement support within their localities.

The analysis in this section of the thesis is based on a financial review of 35 hospices' accounts covering the period from 2004 to 2011. In this chapter, we focus on the nature of the hospice business model from a financial perspective and account for its sustainability in the face of the forthcoming challenges identified in chapters 5 and 6. The hospice business model has evolved over a period of time and is now more complex than it once was in terms of the stakeholder relations needed to maintain its provision of high quality palliative/end of life care. The main argument

in this chapter, boils down to the fact, that the hospice business models' financial viability is challenged, because of its increasing complexity and how it has drifted towards new forms of income and activity mix with its stakeholders.

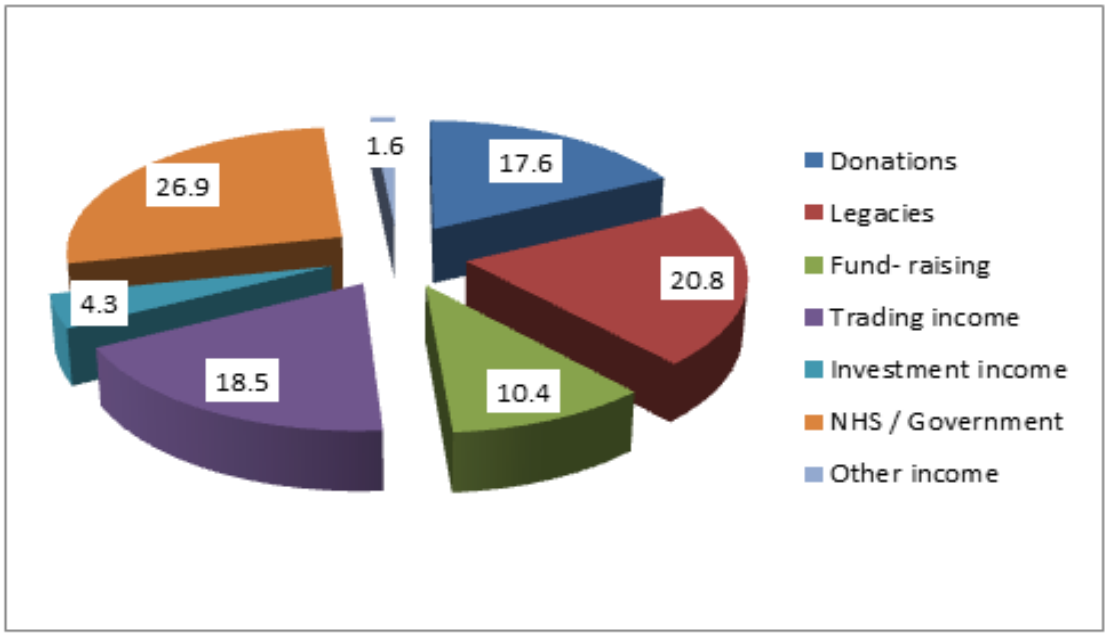
The group of 35 hospices, reviewed in this paper, is therefore, not physically representative of the hospice voluntary sector, where there are many small regionally embedded hospices. The accounts of these smaller hospices cannot be easily traced in a consistent manner and the fragmented inclusion, apart from the increased heterogeneity, of such small hospices would not enhance the analysis significantly. On the other hand, our group of the top 35 hospices constitutes a financially significant sample. Aggregating the financials for this group, it is possible to describe the underlying characteristics of the hospice business model in terms of its trajectory and composition of income and expenditure. Furthermore, detailed examination of three case study hospices accounts - Pilgrims Hospice, St Christopher's Hospice, and Trinity Hospice – covering the period 2004 to 2013 reveal discrepancies from sector's averages in terms of specific financial characteristics, risk exposure, and challenges of sustaining income and operating surpluses. Additional data from various hospices are also used to support the analysis where required.

7.2 Hospices: Fragmented and Volatile Revenue Streams

On the income generation side there are now a range of sources of income that arise out of managing complex stakeholder relationships. These income streams include legacies from a persons' will provisions upon their death, donations made on a regular or irregular basis, specific fundraising activities, income from charity shops (trading), investment income, NHS and Local Authority funding, and other income. This diversity of income streams presents a number of challenges because some of

these account for over 10 per cent of income and can be volatile elements in a hospice's revenue generating capacity (see Figure 7.1).

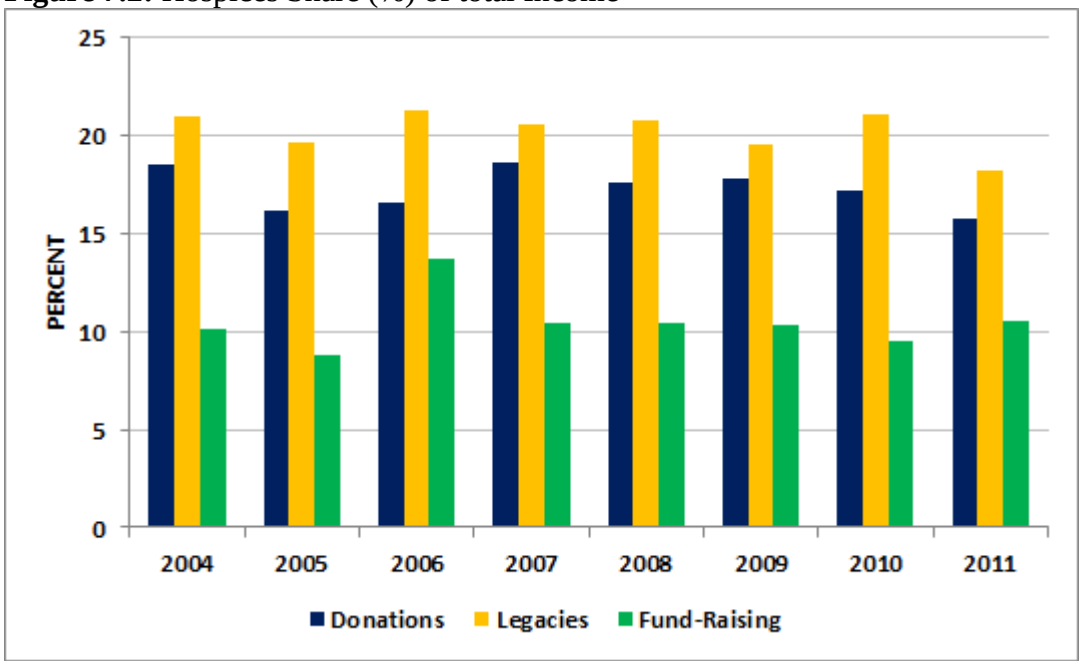
Figure 7.1: Hospices Income Share (%) by Source (2011)



Source: Top 35 Hospices Annual Reports filed at the UK Charity Commission

Figure 7.2, shows three substantial components of an average hospice's income – based on the aggregates of 35 hospices used in this analysis: donations, legacies and fundraising. Legacies and fundraising remain relatively stable at around 20 per cent of total income from 2004 to 2010 but they drop to 18 per cent of total income in 2011. Donations tend to be a little more volatile in terms of year on year fluctuations compared to fundraising and legacies. However, these aggregates conceal considerable volatility in the pattern of year on year income received at the level of individual hospices as figure 7.3 reveals.

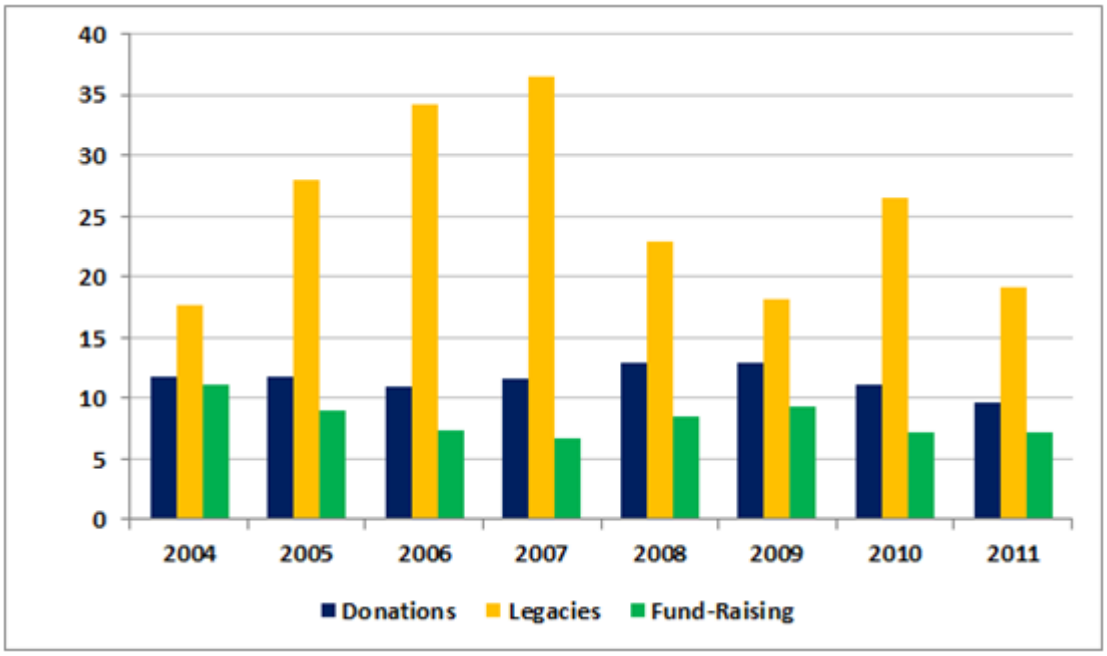
Figure 7.2: Hospices Share (%) of total Income



Source: Top 35 Hospices Annual Reports filed at the UK Charity Commission

Figure 7.3 presents a specific case, which reveals considerable income volatility at Pilgrims Hospice. Legacy income, moves from 36.5 per cent of total income in 2007 to 18.4 per cent in 2009, whilst income from fund-raising might reach 11 per cent of total income in a good year and then down to 7-8 per cent the next year. In a similar fashion, general donations are also not stable year on year and we observe a downward trend in the recent years.

Figure 7.3: Pilgrims Hospice Share (%) of Income



Source: Pilgrims Hospice Annual Reports filed at the UK Charity Commission

In response to this profound volatility and income uncertainty, hospices have sought to modify their business model to incorporate new forms of income generating activities that not only diversify income but also add to its stability. One component of this adjustment to the hospice business model has been the investment in shops that trade donated goods and now make a substantial contribution to the average hospice's income. Hospices generally set up their trading activities into separate limited companies and then consolidate the income from these subsidiaries into their main set of accounts.

> *"St. Rocco's Shops Ltd. is a wholly owned subsidiary of the Hospice. During the year (2013) the company's net income was £613,034 (2012: £603,161). This equates to just over 20% of the total income of the*

Hospice. We have, in addition, generated gift aided donations through our Furniture Shop of £48,175."

(St. Rocco's Hospice Annual Report 2013:10, Charity Commission)

The extract from St Rocco's, a hospice in Warrington Cheshire in England, reveals the challenge of trying to offset income volatility with more regular income from its business model.

"Income from legacies has decreased by £345,383 compared to last year. Although unpredictable, and therefore not relied on, legacy income is always welcome and the Trustees are grateful to those who wish St. Rocco's to benefit from their lifetime savings…. The income from St. Rocco's Shops Ltd increased by £9,873; income from St. Rocco's Promotions Ltd increased by £36,918 and remains a valuable source of regular income from a wide section of the community"

(St. Rocco's Hospice Annual Report 2013:10, Charity Commission)

Table 7.1 reveals that, for our group of 35 hospices in England, the share of trading income in total income remains steady at an average of 20 per cent and the growth rate, in terms of income generated from trading activities in shops runs in line with total income for the hospice sector.

Table 7.1: Top 35 Hospices in England Trading Income Relative to Total Income

	Total Income £000	Trading Income £000	Trading Income as Share Of Total Income	Trading Income Index 2004=100	Total Income Index 2004=100
2004	187,923	35,924	19.1	100	100
2005	211,518	38,931	18.4	108	113
2006	225,340	41,275	18.3	115	120
2007	231,353	45,638	19.7	127	123
2008	261,864	48,424	18.5	135	139
2009	260,520	52,304	20.1	146	139
2010	279,205	57,932	20.7	161	149
2011	300,070	63,995	21.3	178	160

Source: Top 35 Hospices Annual Reports filed at the UK Charity Commission

Another significant source of income for hospices is the one arising out of contracts with local and national health agencies. This, as demonstrated in chapters 5 and 6, adds complexity into the hospice business model because of the need for public sector contracts to deliver value for money and make efficiency savings. Hence, associated performance metrics are being absorbed into the voluntary/charity sector as these contracts require alignment with national regulatory regimes. Significantly, this income stream has also been a stable component of total income and accounts for roughly one-third of total hospice income (see Table 7.2). There is some concern that Government-led efficiency savings may result in more income volatility in the future.

> *"In addition they have seen Government departments and health policy makers wake up to the stark implications of our ageing population. They are aware that some hospices are already being asked to make*

efficiency savings or accept reduced levels of statutory income. These are examples of pressures that are only likely to increase in the future"

(Help the Hospices, 2013:10)

Table 7.2: Top 35 Hospices Income from Government Agencies Relative to Total Income

	Income from Government £000	Income from Government as Share of Total Income
2004	50,299	26.8
2005	67,356	31.8
2006	57,061	25.3
2007	58,937	25.5
2008	70,312	26.9
2009	69,062	26.5
2010	77,626	27.8
2011	90,839	30.3

Source: Top 35 Hospices Annual Reports filed at the UK Charity Commission

7.3 Hospices Cost Structure

Table 7.3 reveals the cost structure of an average hospice from our group of 35 hospices. This reveals that the average hospice out-sources one-quarter of its revenue, to cover external costs, leaving value retained in the hospice of roughly, three-quarters of total revenue received. This is a high retention rate, compared to the average large listed UK firm, which out-sources 60-70 per cent of total income with suppliers. However, like many service intensive activities most of the value that is retained is paid out to cover labour costs. In hospices, this will include administration and management, clinical and nursing support.

Out of the total value retained within an average hospice, approximately 80 per cent is distributed to cover employee expenses and this leaves a cash equivalent of roughly 15-20 per cent of total income. This cash surplus is used to cover the costs of maintaining buildings and sustaining a reserve which a hospice can drawdown where necessary to maintain expenditures on services when income does fluctuate. As the quote below illustrates reserves can be increased or used to draw down funds to cover deficits.

> *"The budget for next year shows a deficit of more than £650,000 to be funded from free reserves, with an increased reserves target of £2.1 million set by the Board."*
>
> (St. Mary's Hospice Annual Report 2013:13, Charity Commission)

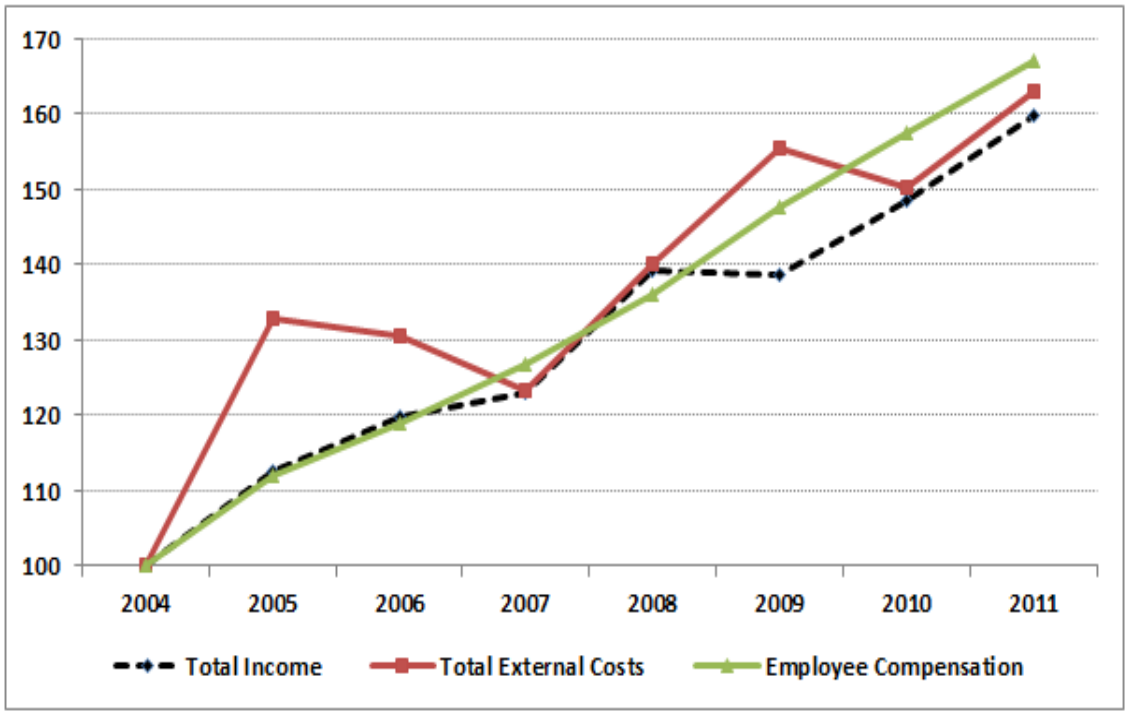
Table 7.3: The Average Cost Structure of the top 35 English Hospices

	Total Income	Total External Costs share of income	Total value retention	Labour Share of Retained Income	Cash Surplus from Income
	£000's	%	%	%	%
2004	187,923	24	76	81	19
2005	211,518	28	72	85	15
2006	225,340	26	74	82	18
2007	231,353	24	76	83	17
2008	261,864	24	76	79	21
2009	260,520	27	73	89	11
2010	279,205	24	76	86	14
2011	300,071	24	76	85	15

Source: Top 35 Hospices Annual Reports filed at the UK Charity Commission

Figure 7.4 below reveals that the growth of both external expenses and internal employment costs has moved ahead of the growth in total income in many hospices. Hence, whilst hospices appear to have managed to increase their income and augment their income generating activities, at the same time they have not managed to keep cost increases in line with the income increase. Hence, many hospices have at times needed to draw upon unrestricted balance sheet reserves or adjust their reserves policies.

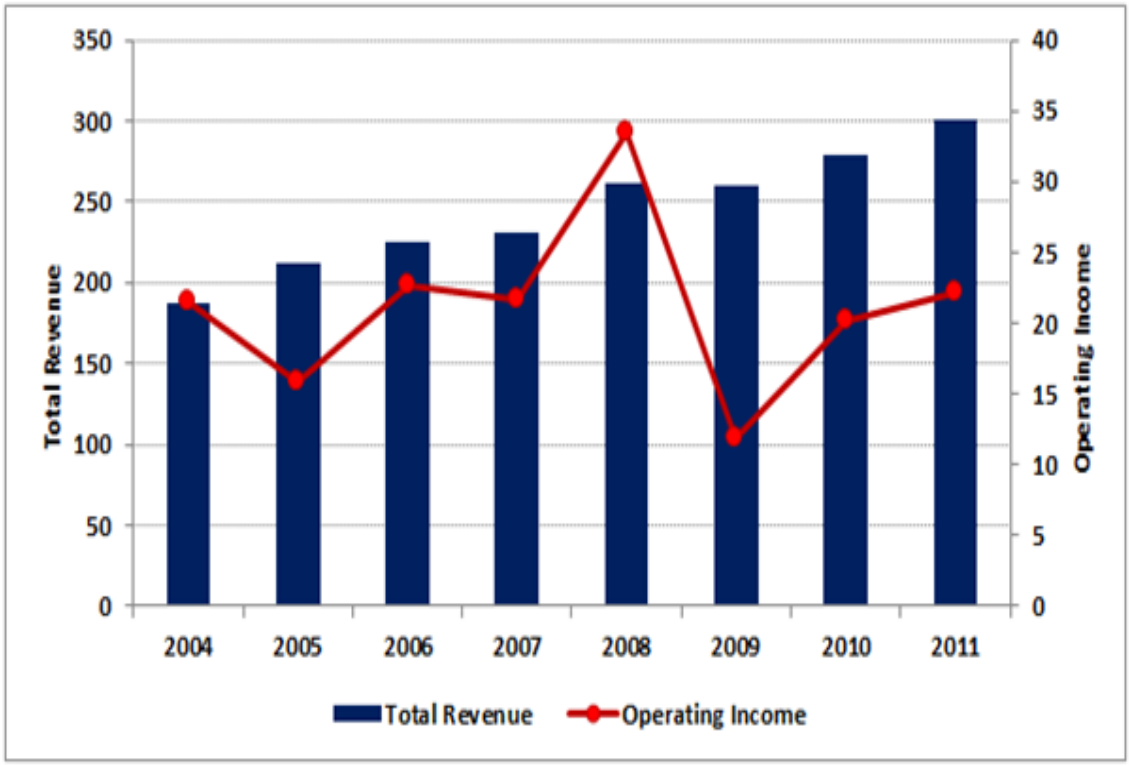
Figure 7.4: Top 35 Hospices Revenue, External and Labour Costs (Growth, 2004=100)



Source: Top 35 Hospices Annual Reports filed at the UK Charity Commission

Although hospices are growing their income they are also committed to maintaining and expanding the provision of services which inflates expenditures. In figure 7.5, we see total revenue steadily increasing but operating income (surplus) remaining at around £25 million.

Figure 7.5: Top 35 Hospices Revenue and Surplus Operating Income £mil



Source: Top 35 Hospices Annual Reports filed at the UK Charity Commission

Despite the slower growth in revenue relative to expenditure, the analysis above indicates aggregate stability in terms of the share of hospices' income derived from various sources. However, this aggregate picture disguises a wide degree of volatility when we consider the finances of individual hospices. For example, table 7.4 below reveals that for St Anne's hospice there is considerable volatility in its revenue. Moreover, as the managers of the hospice are motivated to maintain services, this results in expenditures squeezing residual cash, which, in turn, results in the need to draw down from balance sheet reserves.

Table 7.4: St Anne's Hospice Cost Structure

	Total Income	Total External Costs share of income	Total income retention	Labour's share of retained income	Cash residual
	£000's	%	%	%	%
2004	8,431	14	86	78	22
2005	7,999	19	81	93	7
2006	9,794	9	91	71	29
2007	8,788	35	65	110	-10
2008	9,673	27	73	90	10
2009	10,083	44	56	119	-19
2010	9,449	14	86	86	14
2011	11,066	19	81	77	23

Source: St Anne's Hospice Annual Reports filed at the UK Charity Commission

7.4 Hospices Balance Sheet and Capitalisation

Hospices invest in tangible assets to provide the care facilities used by patients for their treatment and chronic care. These need to be maintained, but also, updated and often this requires new building works that meet new clinical demands and regulatory requirements as we have seen from the interviews in the previous two chapters. Furthermore, as the income from the Government increases, so do the costs to comply, with the increasing number of regulations and relevant policies. However, as the business model for hospices has evolved, considerable investment in other assets is required, such as debtors and stock (associated with shop trading), and cash and investments (associated with the management of reserves).

Table 7.5: Asset Structure of the top 35 Hospices in England

	Tangible assets	Investments	Stocks and debtors	Cash and Deposits	Total
	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's
2004	129,029	88,380	13,342	74,232	304,983
2005	130,982	103,615	14,875	76,913	326,385
2006	140,890	125,632	17,296	84,519	368,337
2007	149,383	139,494	16,162	89,791	394,830
2008	164,404	136,327	19,991	114,152	434,874
2009	188,375	122,417	22,786	97,589	431,167
2010	199,234	145,801	27,993	96,261	469,289
2011	213,258	161,733	27,542	98,904	501,437
	Share of total assets				
2004	43	29	4	24	100
2005	39	32	5	24	100
2006	38	34	5	23	100
2007	38	35	4	23	100
2008	38	31	5	26	100
2009	44	28	5	23	100
2010	42	31	6	21	100
2011	43	32	5	20	100

Source: Top 35 Hospices Annual Reports filed at the UK Charity Commission

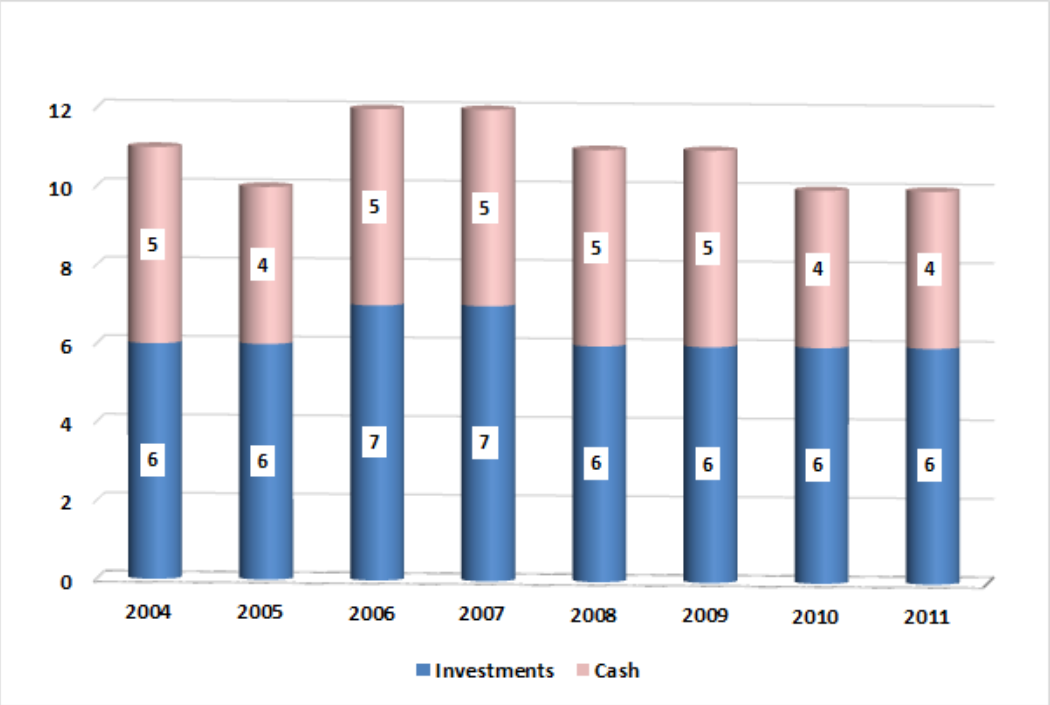
At an aggregate and average level of analysis, the hospice balance sheet asset structure again generates the appearance of financial stability in terms of the share of assets held in tangible assets. In 2004 the share of assets held as cash and investments stood at 53 per cent and this remains at 52 per cent in 2011. These investments and cash deposits reflect the use of reserves that have their equivalent on the liabilities side of the balance sheet, namely, reserves which are set aside for contingencies and specified for future building projects. For example, St Rocco's

hospice has a reserves policy that balances the possibility of uncertain revenues against fixed expenditures.

> *"The Trustees annually review the Reserves Policy of the charity. This review encompasses the nature of the income and the expenditure streams, the need to match variable income with fixed commitments and the nature of the reserves. The review concluded that to allow the charity to be managed efficiently and to provide a buffer for uninterrupted services, a free reserve equivalent to approximately nine months of expenditure should be maintained. During the year the charity's total consolidated reserves increased from £8,853,973 to £8,927,668 of which £4,140,786 is held in tangible fixed assets"*
>
> (St. Rocco's Hospice Annual Report 2013:11 Charity Commission)

Thus, hospices must maintain reserves against uncertainties associated with income and expenditure and also from their investments made, which may or may not inflate in value from one year to the next. At aggregate level, this analysis shows (see figure 7.6, below) that the average hospice tends to maintain reserves in cash and investments equivalent to about a year's worth of total income.

Figure 7.6: Top 35 Hospices Balance Sheet Cash and Investments (Months of total income)



Source: Top 35 Hospices Annual Reports filed at the UK Charity Commission

However this average analysis for the top 35 hospices conceals considerable volatility and variation at the level of individual hospices. Individual hospices are often struggling to sustain income and operating surpluses, maintain sufficient reserves on their balance sheet, and manage exposure to capital market risk. For some hospices, the market value of these investment funds can shift adversely, for example, St Margaret's Hospice (Somerset) in 2013 reported a deficit adjustment on invested funds which was in the region of £445K.

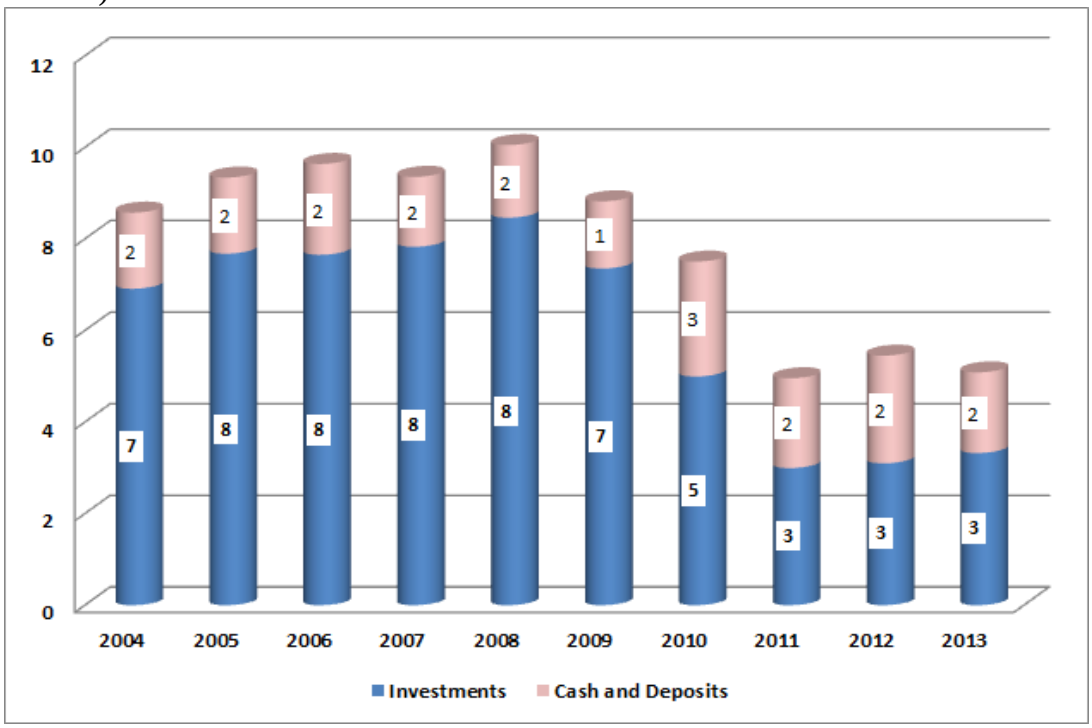
> *"In addition we strive to maintain our investment portfolio, our main reserves, so that we can have confidence when undertaking operational planning. The investment portfolio generated a gain of £309k in the year (2012: £2,042k). Charitable companies are obliged to report gains*

and losses on investments as part of the annual result consequently, we report a total deficit in the year of £445k (2012: £772k surplus)"

(St Margaret's Hospice Annual Report 2013:15 Charity Commission)

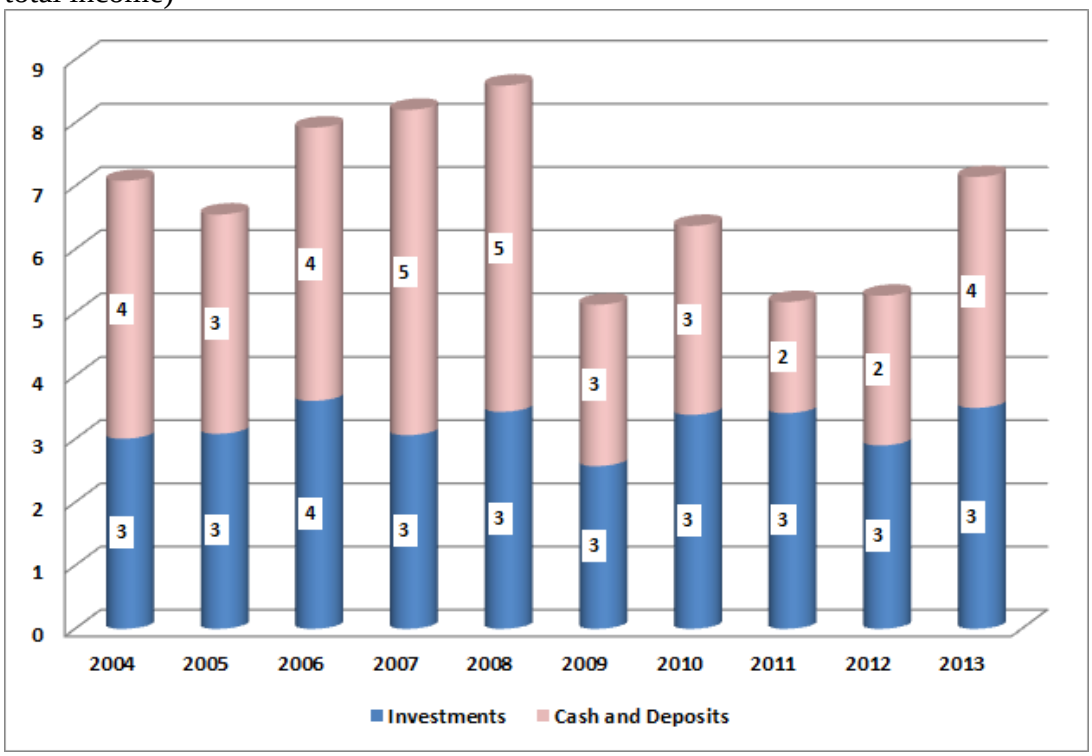
Additionally, as presented on figures 7.7 and 7.8, following to a period of highly volatile income streams and negative operating margins, some hospices are finding their investment and cash reserves depleting and their adequacy of funds in relation to total income squeezed well below that of the average. For example, St. Mary's hospice's balance sheet reserves are sufficient for just about five months and for St. Francis hospice for just about seven months. Hence, at a time when the demand for palliative care going forward is set to increase a hospice like St Marys, can find itself in a very difficult position, with a reducing operating surplus, a drain from cash reserves and losses on investments made in the capital markets.

Figure 7.7: St Mary's Hospice Balance Sheet Cash and Investments (Months of total income)



Source: St Mary's Hospice Annual Reports filed at the UK Charity Commission

Figure 7.8: St Francis Hospice: Balance Sheet Cash and Investments (Months of total income)



Source: St Francis Hospice Annual Reports filed at the UK Charity Commission

This review, of the financial characteristics of the hospice business model, reveals that there are considerable uncertainties and additional risks as the business model, underwriting hospices' financial viability, becomes more complex. Income is volatile, because of the variable nature of these income streams, at a time when expenditures required to preserve the mission of hospices tend to increase steadily. There is also the challenge of sustaining balance sheet reserves that insure against income and expenditure risks and also, provide for sufficient funds to maintain, update, and replace, tangible assets. These reserves are invested in financial assets, which also carry new forms of risk and uncertainty for hospices. In the next section of this chapter we consider these meso-financial characteristics of the hospice business model in more detail through the use of three case studies.

7.5 Case Study one: Pilgrims Hospice

Pilgrims hospice in East Kent is among the relatively large hospices on our sample of 35 in terms of income and expenditure. In 2004 Pilgrims hospice generated around £6 million from various income sources and by 2013 had nearly doubled this to roughly £12 million. Table 7.6 below shows the contribution of the various income streams to the hospice's increase in total income during this period. Donations and legacies account for 29 per cent of the increase in this hospice's funding with trading activities accounting for 31 per cent, and NHS funding from Government a further 29 per cent. Over 60 per cent of this hospice's funding increase for the period 2004 to 2013 has come from trading and NHS/Government funding.

Table 7.6: Pilgrims Hospice change in income 2004-2013

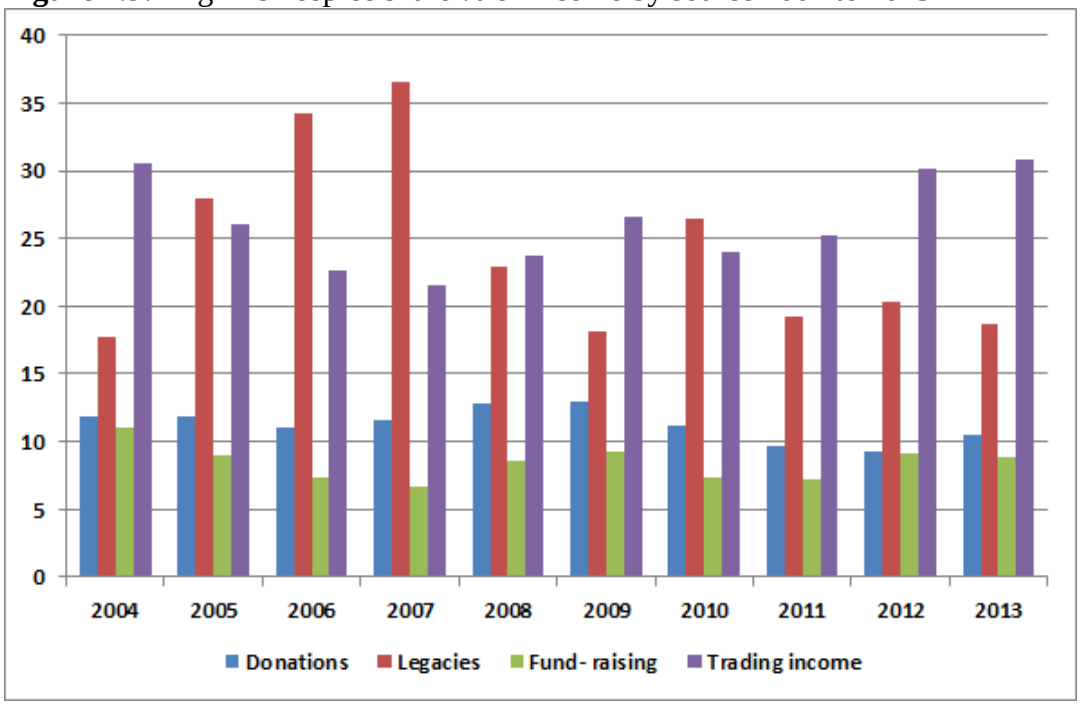
	Change	Share
	£000	%
Donations	535	9
Legacies	1,166	20
Fund raising	387	7
Trading	1,856	31
NHS	1,796	29
Other	164	3
Financing	36	1
Total	5,940	100

Source: Pilgrims Hospice Annual Reports filed at the UK Charity Commission

Even though this overall presentation of the hospice's financial characteristics appears favourable, more detailed examination across the years in figure 7.9 below reveals significant volatility in some of its main income components. In comparison

to our average hospice in section 7.2, Pilgrims hospice appears to rely a lot more on legacies and trading income which however have been a lot more volatile than the average. At peak, trading income accounted for over 30 per cent of total income in 2004 and following a steady decline it scaled again to roughly 30 per cent in 2013. Legacies have in three years peaked at over 35 per cent of total income but in recent years they have consistently accounted below 20 per cent. Donations and fundraising on the other hand have been relatively stable across the years but they only account for roughly 10 per cent, each, of the hospice's total income.

Figure 7.9: Pilgrims hospice share % of income by source 2004 to 2013

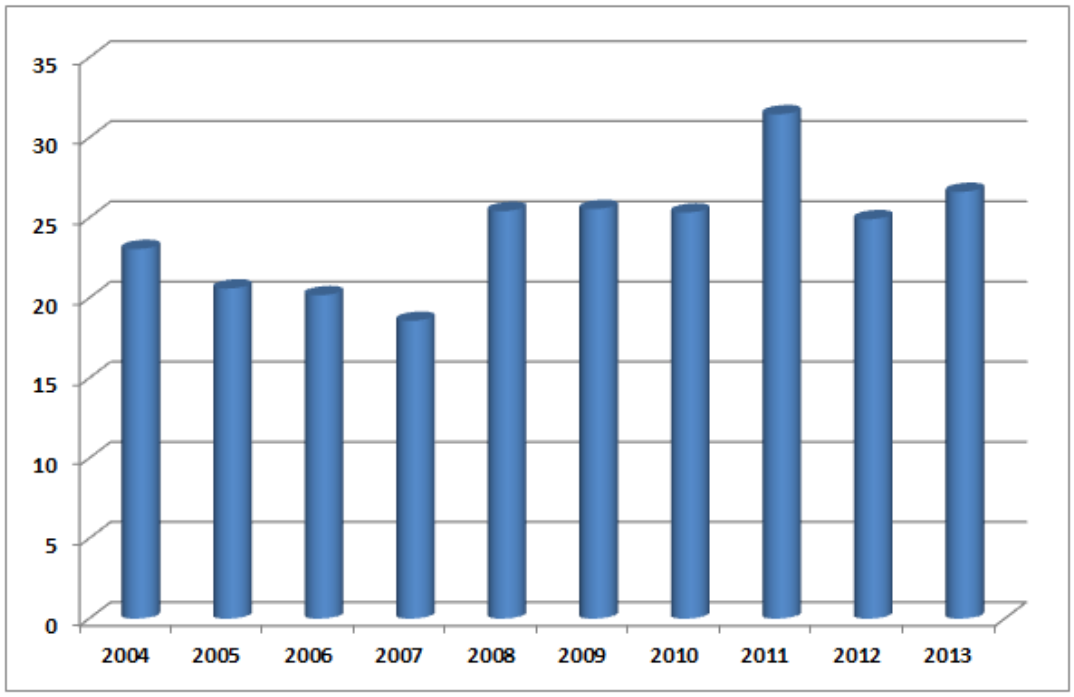


Source: Pilgrims Hospice Annual Reports filed at the UK Charity Commission

Similarly, Government funding has been less volatile and also gently rising during the period 2004 to 2013 from just around 20 per cent of total income to a peak of 30 per cent of total income in 2011 before falling back to 25 per cent of total income in 2013 (see figure 7.10 below). Government underlying income provides security and

locates Pilgrims hospice just slightly below the Government funding patterns of the average hospice seen in section 7.2, without however minimising the risks associated with the hospice's dependency on sustaining a complex network of stakeholder groups, to underwrite its diverse sources of income.

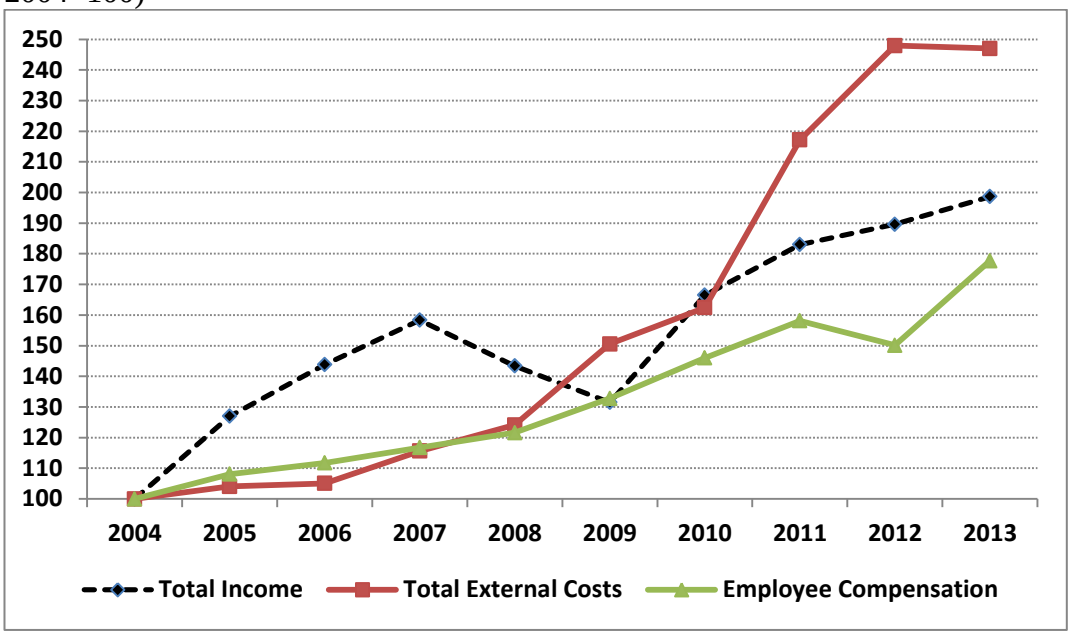
Figure 7.10: Pilgrims hospice NHS/Government funding share % of total income



Source: Pilgrims Hospice Annual Reports filed at the UK Charity Commission

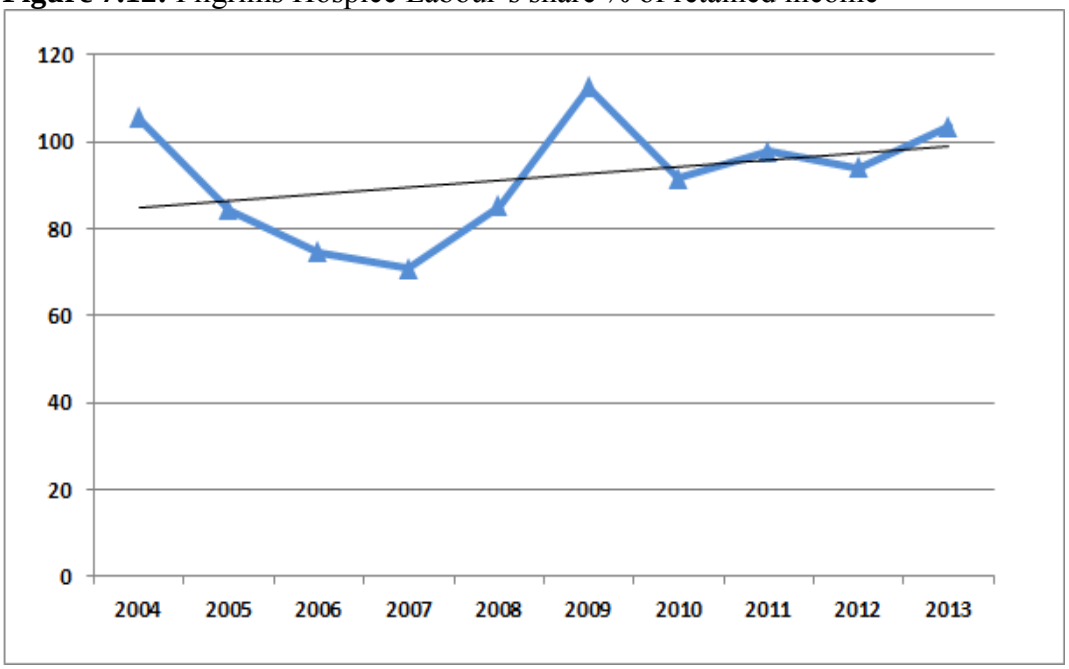
Figure 7.11 reveals, that during the period 2004 to 2013, Pilgrims hospice's external costs have increased at a rate higher to the rate of its revenue growth. This reduced the share of value retained within the hospice from 80 to 60 per cent of income. Also the share of employee expenses in the value retained has also gently increased and at times reached levels above 100 per cent resulting in negative cash flows. In recent years the share of employee expenses in total value retained are consistently at or near 100 per cent as shown in figure 7.12.

Figure 7.11: Pilgrims Hospice Revenue, External and Labour Costs (Growth, 2004=100)



Source: Pilgrims Hospice Annual Reports filed at the UK Charity Commission

Figure 7.12: Pilgrims Hospice Labour's share % of retained income

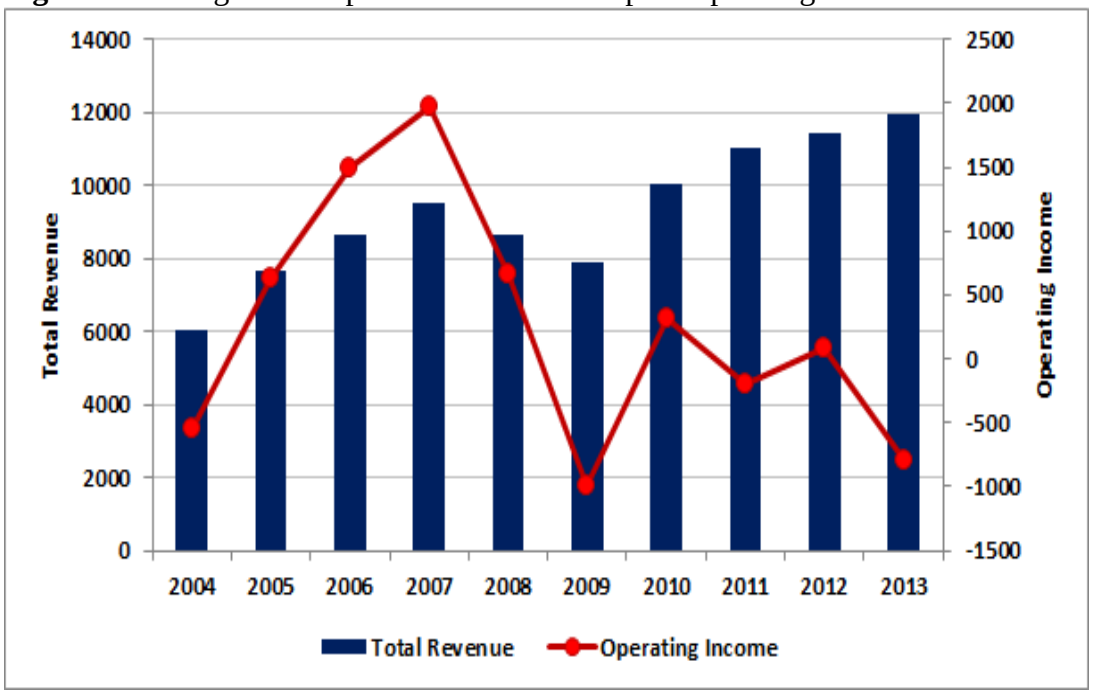


Source: Pilgrims Hospice Annual Reports filed at the UK Charity Commission

Figure 7.13 demonstrates that this disproportionate increase of expenses compared to revenue has squeezed the hospice's operating margins and led to negative cash flows. This in turn reveals that the hospice is finding it difficult to sustain its reserves, which are a contingency for risk and uncertainty over income and expenses. Hence, the trustees have to adjust their reserves policy. Accordingly, in figure 7.14 below we observe a reduction in the hospice's cash reserves to the equivalent of just about a month of total income.

> *"During the year under review the net movement in funds was a deficit of £125k, compared with a deficit of £210k the previous year. However, this included increases in cost of care to our patients and other related costs of Project Invicta which resulted in a deficit before investment gains of £789k compared with a surplus for the previous year of £88k. Whereas this deficit was offset by net gains on investments of £664k, compared to losses of £298k in the previous year, this is a material deficit and reflects the increase in services provided by the charity. Overall this resulted in a small reduction in the reserves. In part due to the continued increase in costs, the trustees have instigated a strategic review"*
>
> (Pilgrims Hospice Annual Report 2013:5 Charity Commission)

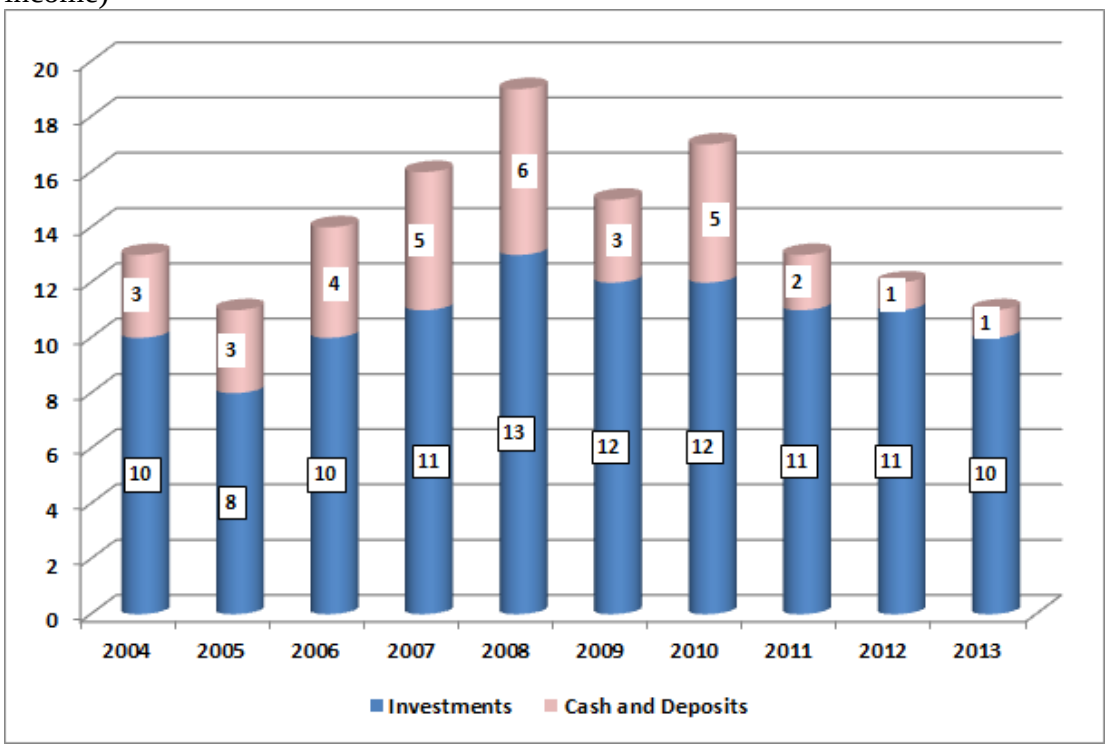
Figure 7.13: Pilgrims Hospice Revenue and Surplus Operating Income £000



Source: Pilgrims Hospice Annual Reports filed at the UK Charity Commission

Regardless of the economic uncertainties it is currently experiencing, Pilgrims hospice appears to be in a slightly safer position compared to the average in terms of available reserves and their capability to keep the employment costs under control. Figure 7.14 shows that there are still invested funds available equal to nearly a year's worth of total income. This practically means that the hospice's ability to sustain their current level of service provision capacity is not under threat in the short term. Their ability however, to cope with forthcoming challenges identified on chapters 5 and 6 – increased demand for service provision, increased funding requirements due to increasing operating/recruitment costs, and scarcity of relevant expertise in the recruitment market – on the long term, is a cause of concern given their current financial trends, as it might be compromised by a lack of available funds.

Figure 7.14: Pilgrims Hospice Balance Sheet Cash and Investments (Months of total income)



Source: Pilgrims Hospice Annual Reports filed at the UK Charity Commission

7.6 Case Study two: St. Christopher's Hospice

St. Christopher's hospice is the first modern hospice established by Dame Cicely Saunders in 1967 and is currently the largest on our sample of 35 in terms of income and expenditure. Located in London it provides palliative care in the boroughs of Bromley, Croydon, Lambeth, Lewisham, and Southwark. In 2004 St. Christopher's hospice generated around £13.5 million from various income sources and by 2013 had raised this by about 30 per cent to just over £17.5 million. Table 7.7 below presents the contribution of the various sources of revenue to the hospice's increase in total income during this period.

Table 7.7: St. Christopher's Hospice change in income 2004-2013

	Change	Share
	£000	%
Donations	971	23
Legacies	-222	-5
Trading	1,283	31
NHS	1,057	26
Other	958	23
Financing	103	2
Total	4,150	100

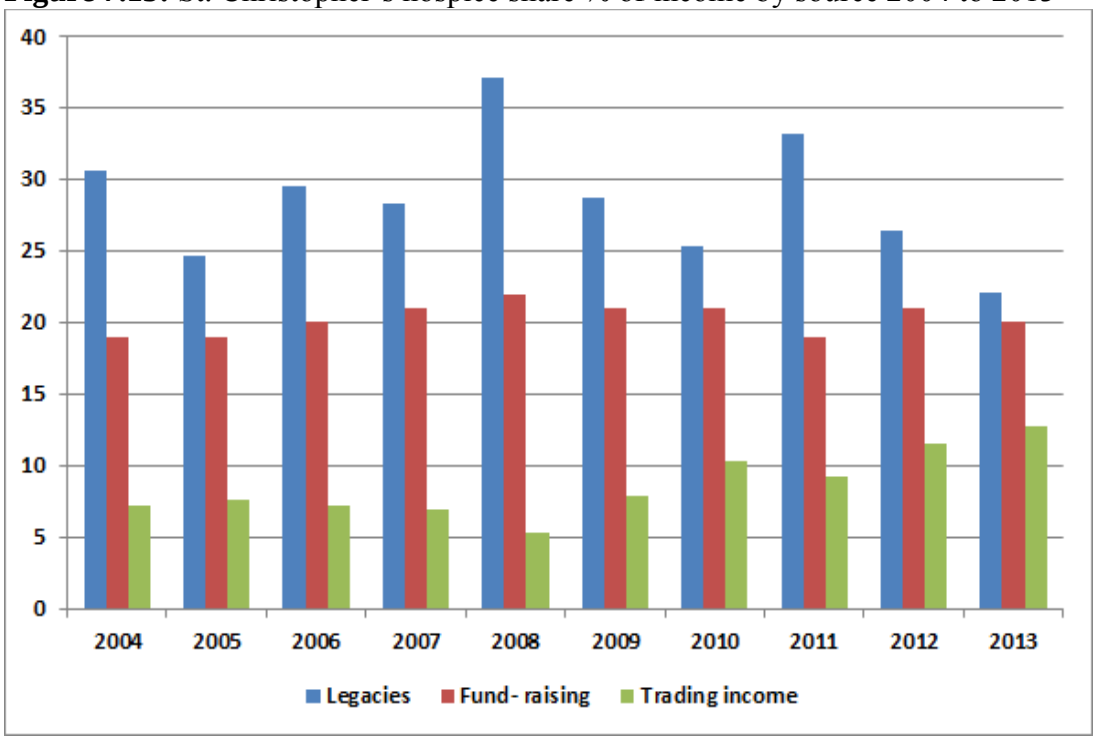
Source: St. Christopher's Hospice Annual Reports filed at the UK Charity Commission

Donations, include fundraising, as no separate data have been available for all years, account for 23 per cent of the increase in this hospice's funding with trading activities accounting for 31 per cent, and Government funding for a further 25 per cent of the increase. Provision of education and training services, which have been a core component of both the hospices *'other'* sources of income and its strategy to promote the modern hospice movement have contributed another 23 per cent of the increase.

> *"St Christopher's extends its teaching and influence nationally and internationally through extensive programmes of education and research. Every year over 7,000 health and social care professionals attend our Education Centre courses and outreach programmes. The Education Programme offers a wide range of courses and training in Palliative and End of Life Care."*
>
> (St. Cristopher's Hospice 2013, available at: http://www.stchristophers.org.uk/hospiceoverview)

Similarly to Pilgrims hospice, trading activities and Government funding have been the main drivers for the hospice's increase in revenue over the period 2004 to 2013, accounting together for 57 per cent of it. Legacies, on the other hand, have been very volatile (see figure 7.15 below) and were down by 5 per cent in 2013 compared to 2004, following a steady downwards trend since 2008. Fundraising and donations put together have been relatively stable contributing an average of 20 per cent on the hospice's revenue per year across the period.

Figure 7.15: St. Christopher's hospice share % of income by source 2004 to 2013

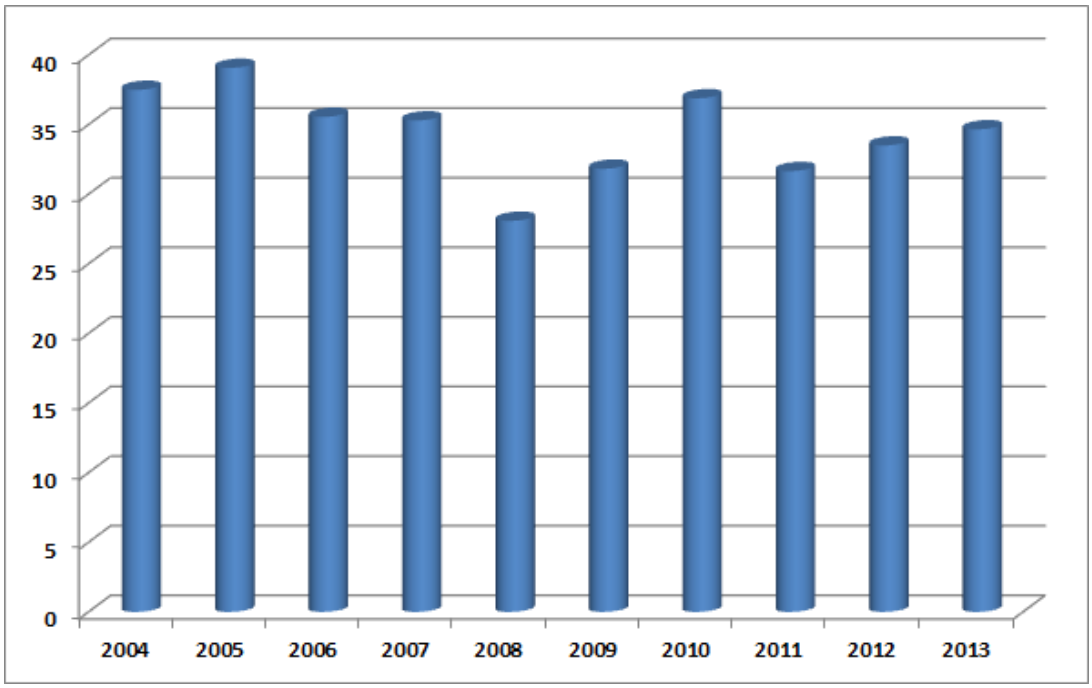


Source: St. Christopher's Hospice Annual Reports filed at the UK Charity Commission

Figure 7.16 demonstrates that Government funding through the NHS has also been reasonably stable and mainly within 30 to 35 per cent of the hospice's annual income during the period 2004 to 2013. This locates St. Christopher's hospice on just around the average Government funding patterns seen in section 7.2. In conjunction with the

fairly stable patterns on most other sources of the hospice's income, apart from the legacies, steady NHS funding justifies a perception of safety when we evaluate the hospice's sustainability. However, we still observe the necessity to sustain a complex network of stakeholder groups, to help finance the hospice's ability to maintain palliative / end of life care services.

Figure 7.16: St. Christopher's hospice NHS/Government funding share % of total income

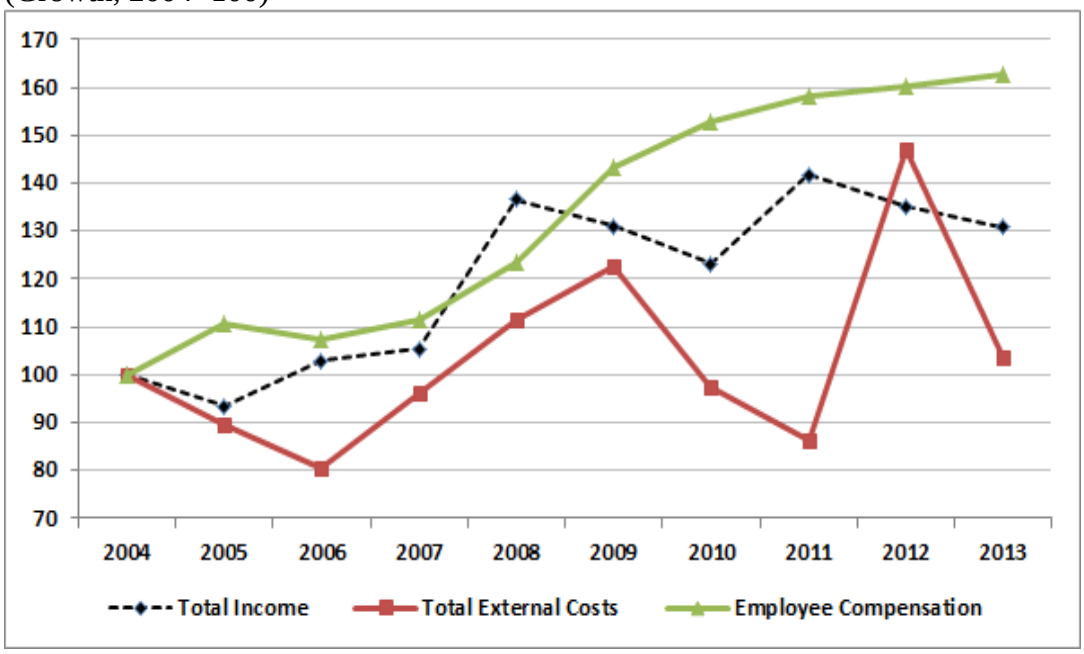


Source: St. Christopher's Hospice Annual Reports filed at the UK Charity Commission

In figure 7.17, we observe that even though external costs have been kept under control during the period 2004 to 2013, employment costs have increased at a rate much higher to the rate of its revenue growth. In combination with a declining income growth rate from 2008 onwards, the share of employee expenses in the value retained has reached levels very close to a 100 per cent (Figure 7.18). This trend, of expenses increasing faster compared to income, means that St. Christopher's hospice

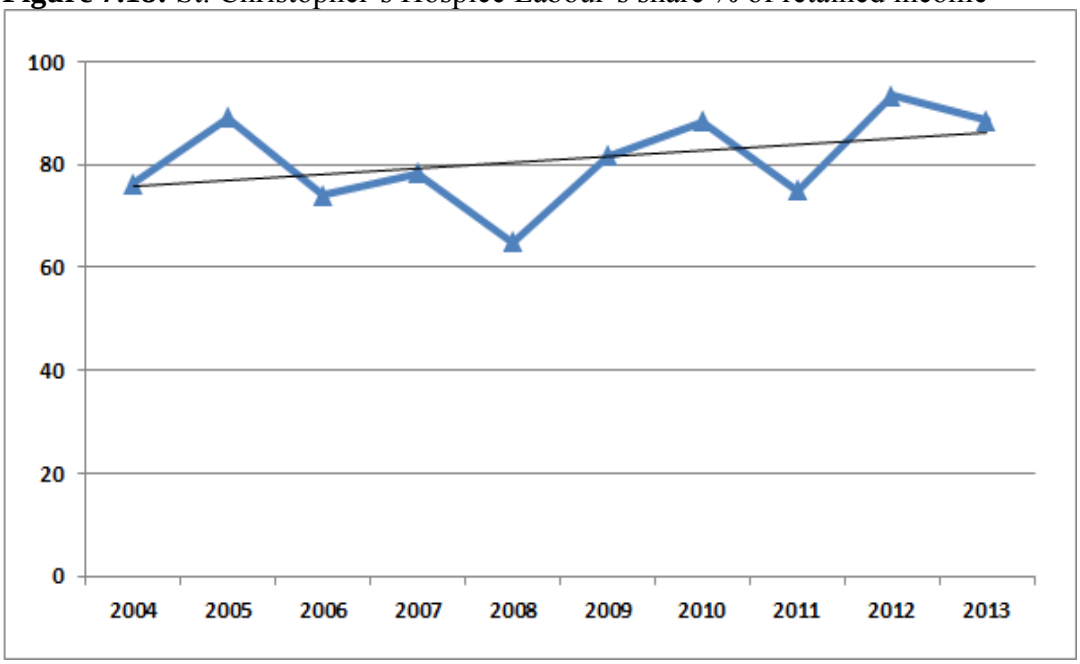
cannot generate sufficient free cash resources to invest in further development of its service provision capacity.

Figure 7.17: St. Christopher's Hospice Revenue, External and Labour Costs (Growth, 2004=100)



Source: St. Christopher's Hospice Annual Reports filed at the UK Charity Commission

Figure 7.18: St. Christopher's Hospice Labour's share % of retained income

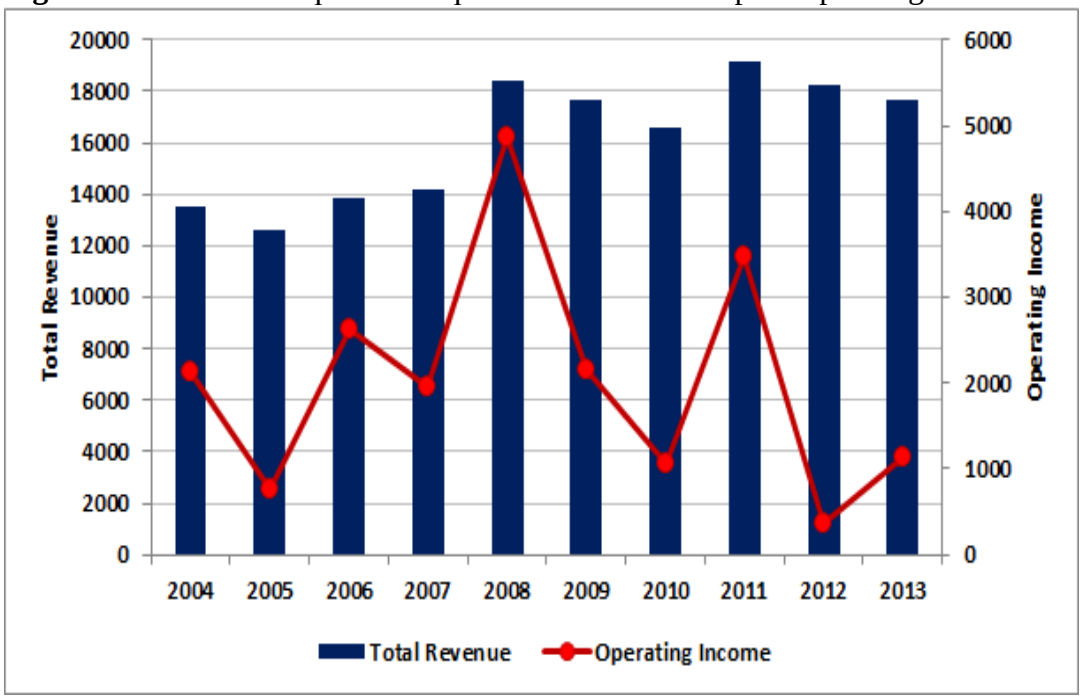


Source: St. Christopher's Hospice Annual Reports filed at the UK Charity Commission

Figure 7.19 reinforces this previous point as we observe the impact of expenses increasing and resulting in just marginally positive operating income. St. Christopher's hospice may also find it difficult to sustain and potentially expand its capacity without making use of its reserves in the foreseeable future as this quote from the 2013 annual report notes:

> *"At 31 March 2013 St. Christopher's Hospice Group had free reserves of f11,393k (as defmed by SORP 2005) covering 34 weeks' running costs. The Board has decided to designate part of the unrestricted general funds to cover the cost of the ward refurbishment and as a result the free reserves have reduced by 12 weeks from the prior year."*
>
> (St. Christopher's Hospice Annual Report 2013:23 Charity Commission)

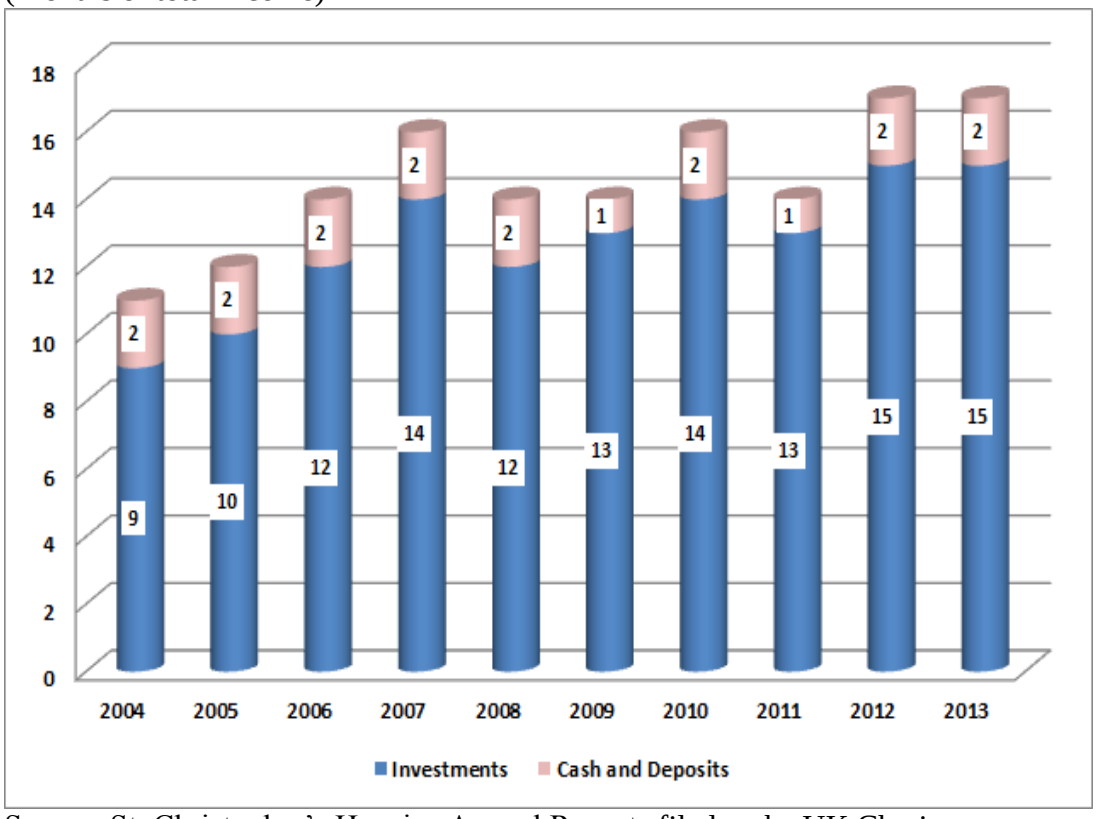
Figure 7.19: St. Christopher's Hospice Revenue and Surplus Operating Income £000



Source: St. Christopher's Hospice Annual Reports filed at the UK Charity Commission

On the other hand, St. Christopher's hospice also appears to be in a safer position compared to the average hospice in terms of sustaining current levels of service provision capacity. Regardless of the financial uncertainties it is currently experiencing, figure 7.20 shows that there are still invested funds available equal to 15 months' worth of total income. Hence, the hospice's ability to sustain their current level of service provision capacity is not under threat in the immediate short term.

Figure 7.20: St. Christopher's Hospice Balance Sheet Cash and Investments (Months of total income)



Source: St. Christopher's Hospice Annual Reports filed at the UK Charity Commission

7.7 Case Study three: Trinity Hospice

Trinity hospice is among the smaller hospices on our sample of the top 35 in terms of income and expenditure and is the local hospice for Blackpool, the Fylde and Wyre at the North West of England. In 2004, Trinity hospice's total income from various sources was just above £4 million and by 2013, it grew by approximately 70 per cent to just over £7 million. The share of each of the various revenue sources to the growth of the hospice's income is presented on table 7.8 below.

Table 7.8: Trinity Hospice change in income 2004-2013

	Change	Share
	£000	%
Donations	359	13
Legacies	131	5
Fund raising	128	4
Trading	588	21
NHS	1,696	59
Other	0	0
Financing	-35	-2
Total	2,867	100

Source: Trinity Hospice Annual Reports filed at the UK Charity Commission

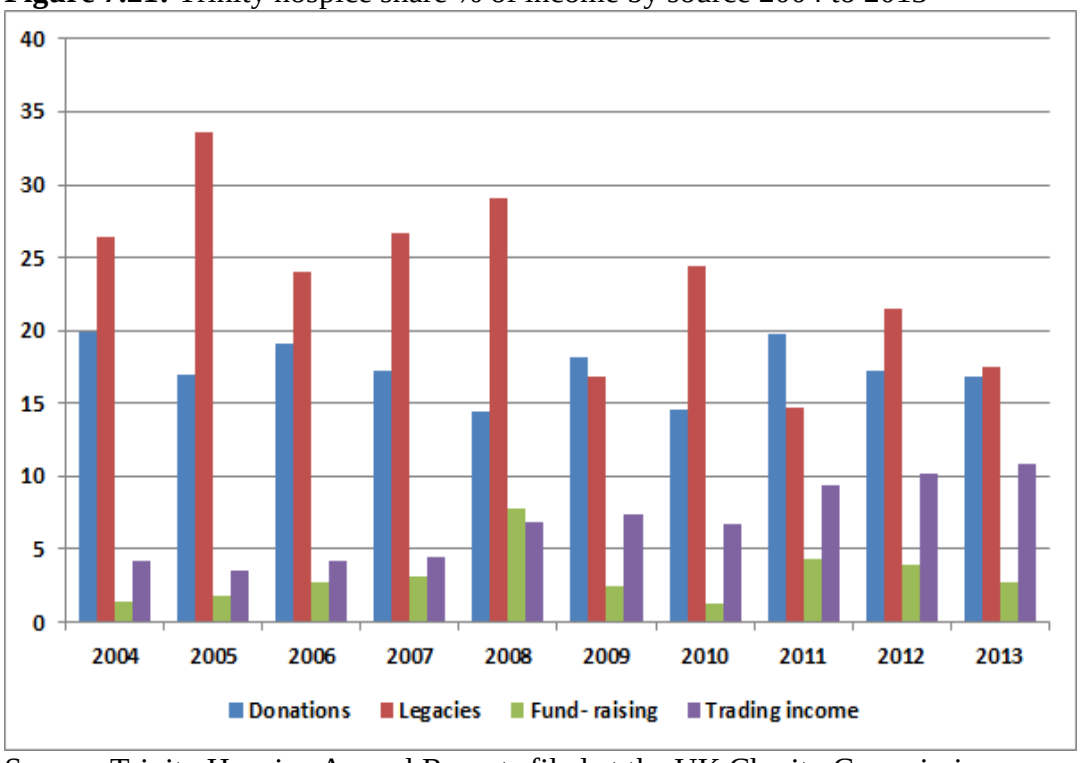
Considerable reliance on Government funding and trading income is becoming apparent as these two sources account for 80 per cent of the hospice's growth in total income over the period. Donations and legacies together account for 18 per cent of the growth. Whilst investment income has been in decline compared to the period before 2009. A significant risk is noted in the accounts, as it is possible that Government funding could decline and this will add additional stress on the overall

financing. In 2013 two non-recurrent income receipts helped to maintain growth in overall income.

> *"The Charity's income, from all sources, increased by £597,845 (9%) from £6,440,819 to £7,038,664. This was due in the main to two non-recurrent receipts from the PCT and Blackpool Council, and an increase in income from Trinity Trading. Voluntary income decreased by 3% from 2012 compared with the average charity seeing a 20% reduction in this period. Trinity Hospice Trading income increased by over £100,000 with three new shops opening during the year. An additional shop is planned for the coming year subject to location."*

(Trinity Hospice Annual Report 2013:8 Charity Commission)

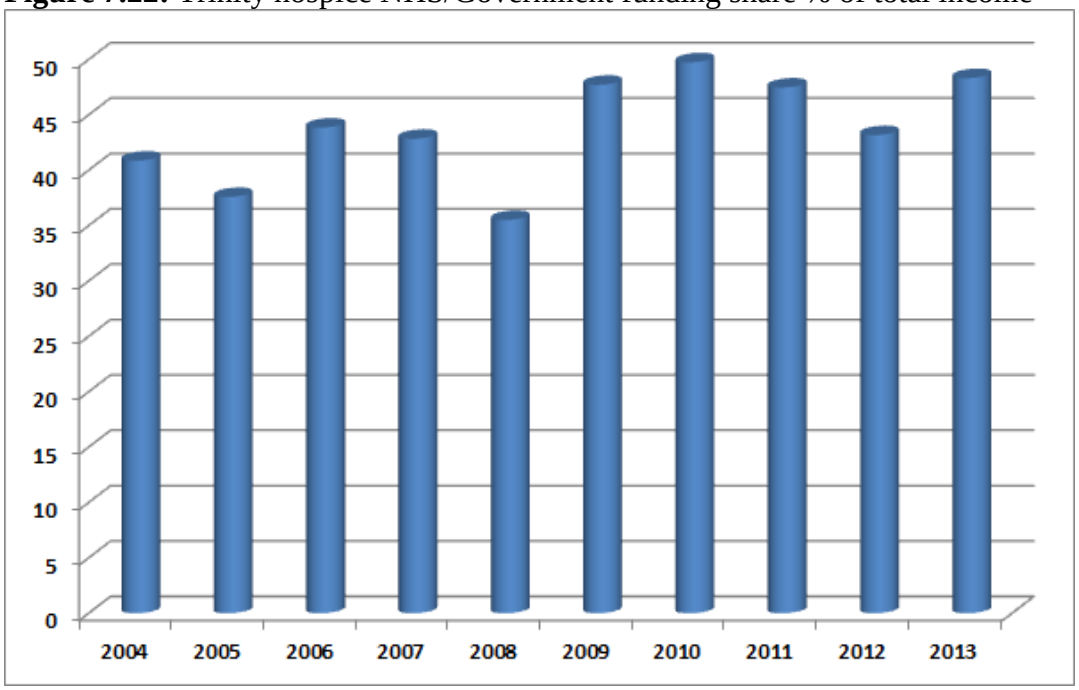
Figure 7.21: Trinity hospice share % of income by source 2004 to 2013



Source: Trinity Hospice Annual Reports filed at the UK Charity Commission

Figure 7.21 shows Trinity hospice's income, other than Government funding, across the period 2004 to 2013. Legacies' contribution to revenue has consistently deteriorated from nearly 35 per cent in 2005 to below 20 per cent in 2013. Donations have been fluctuating between 20 and just below 15 per cent, whilst fundraising has also been volatile and at times below 5 per cent of total income. The only stable growing source of income has been funding from trading activities, which has been more than doubled in recent years, but it is still only accounting for just over 10 per cent of total revenue compared to an average hospice's 25%. Hence, the hospice's capacity to replace Government funding which currently constitutes nearly 50 per cent of total income (see figure 7.22) through increasing income from other sources appears to be problematic.

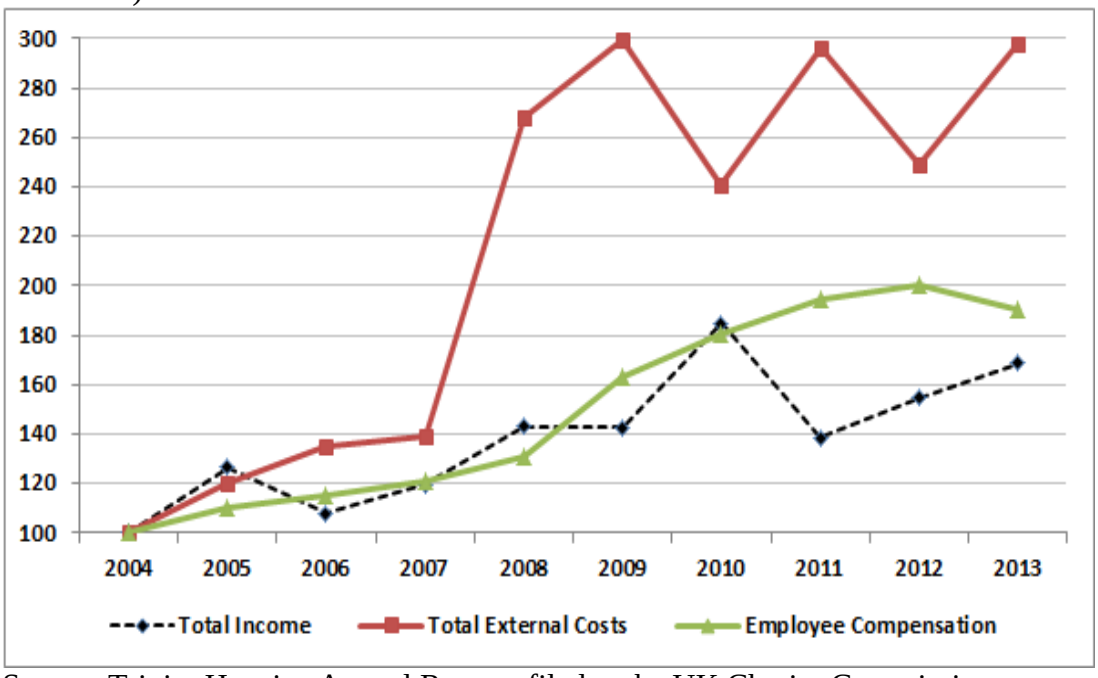
Figure 7.22: Trinity hospice NHS/Government funding share % of total income



Source: Trinity Hospice Annual Reports filed at the UK Charity Commission

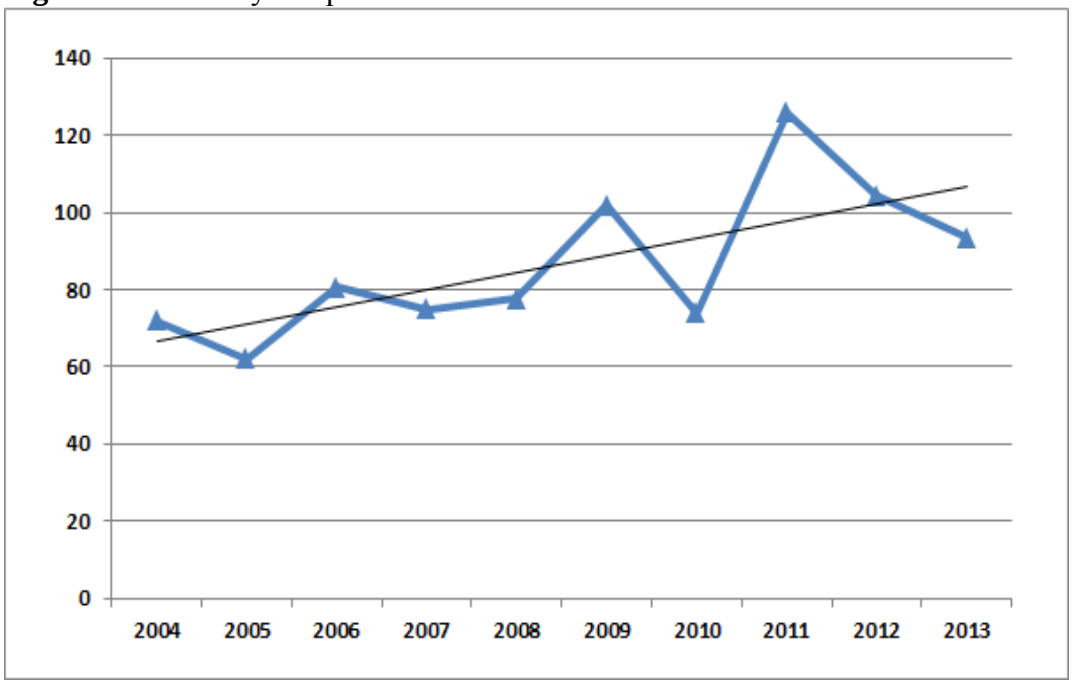
In addition to the risks associated with Trinity hospice's ability to generate sustainable income, an examination of its expenditure patterns reveals further pressures on its capability to sustain its service provision capacity. Figure 7.23 demonstrates that during the period 2004 to 2013 both its external and labour costs have increased at rates considerably higher than the rate of its revenue growth. Therefore, the value retained within the hospice has been considerably reduced from 85 to just over 70 per cent. At the same time as figure 7.24 shows employee expenses have often exceeded total value retained and this has had a negative impact on cash surplus.

Figure 7.23: Trinity Hospice Revenue, External and Labour Costs (Growth, 2004=100)



Source: Trinity Hospice Annual Reports filed at the UK Charity Commission

Figure 7.24: Trinity Hospice Labour's share % of retained income



Source: Trinity Hospice Annual Reports filed at the UK Charity Commission

The results of this increase in expenses relative to total income, as we see in figure 7.25, had a detrimental effect on Trinity hospice's operating margins leading to the generation of negative cash flows in recent years. These underlying trends suggest that the hospice will find it difficult to augment its reserves, which are a contingency required to cover uncertainties. Additionally, the risk of not being able to sustain an effective recruitment strategy due to lack of funding increases and this, in turn, limits considerably the hospice's capability to maintain and expand its service provision capacity.

> *"The tough financial position meant a second year of pay freezes for staff, including Directors. Trustees are fully aware of the pressure this puts on employees at a time of significant cost of living increases, and are committed to a fair pay award in 2013. However, this can only*

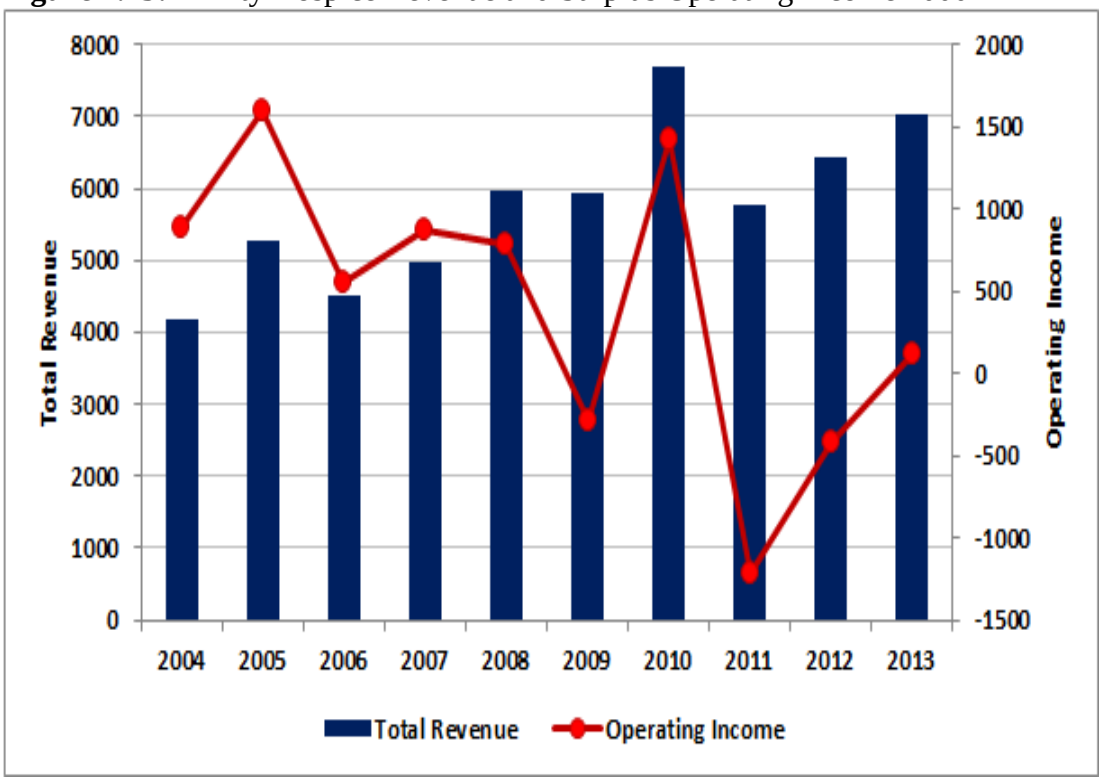
happen if we continue to make considerable progress towards a financially sustainable future, as set out in Trinity's business plan."

(Trinity Hospice Annual Report 2012:18 Charity Commission)

"The tough financial position meant another year of pay freezes for staff, including Directors."

(Trinity Hospice Annual Report 2013:19 Charity Commission)

Figure 7.25: Trinity Hospice Revenue and Surplus Operating Income £000



Source: Trinity Hospice Annual Reports filed at the UK Charity Commission

This is becoming apparent if we examine the employment data of the hospice presented on table 7.9. Contrary to Pilgrims hospice and St. Christopher's hospice that have increased the number of their employees over the last years (based on comparable data from the hospices' annual reviews) Trinity hospice's medical and general clinical staff numbers have been in decline. This shows that the hospice was not only unable to recruit new clinicians but also lost some of its staff members due to funding restrictions that made it impossible to match remuneration packages offered by competing organisations, as the quote below demonstrates.

> *"Although difficult decisions have had to be taken, the way our staff have faced up to the changes has been a credit to their professionalism and commitment. It is sad when staff who have given many years of loyal service take the opportunity to move on, but the manner in which everyone has pulled together to support their colleagues has ensured that the service provided to our patients and their families has remained as good as ever."*
>
> (Trinity Hospice Annual Report 2013:19 Charity Commission)

Table 7.9: Trinity Hospice average number of employees on full time equivalent basis

	2013	2011
Management	4	5
Medical directorate	24	30
Clinical directorate	72	80
Resources directorate	26	31
Fundraising directorate	19	10
Total	145	156

Source: Trinity Hospice Annual Reports filed at the UK Charity Commission

On the other hand, the necessity to invest additional resources to generate income has led to the recruitment of more fundraising staff. Hence, income uncertainty has led to a diversion of resources from the primary objective of providing palliative / end of life care. This in turn, as we have seen in chapters five and six is adding to the complexity of the business model and also to its contradictory forces.

> *"Staff recruitment has been restricted to posts that would improve income generation, or that were critical to continuing appropriate levels of patient care. Considerable opportunities have been taken over the past year to realize efficiency savings."*
>
> (Trinity Hospice Annual Report 2012:18 Charity Commission)

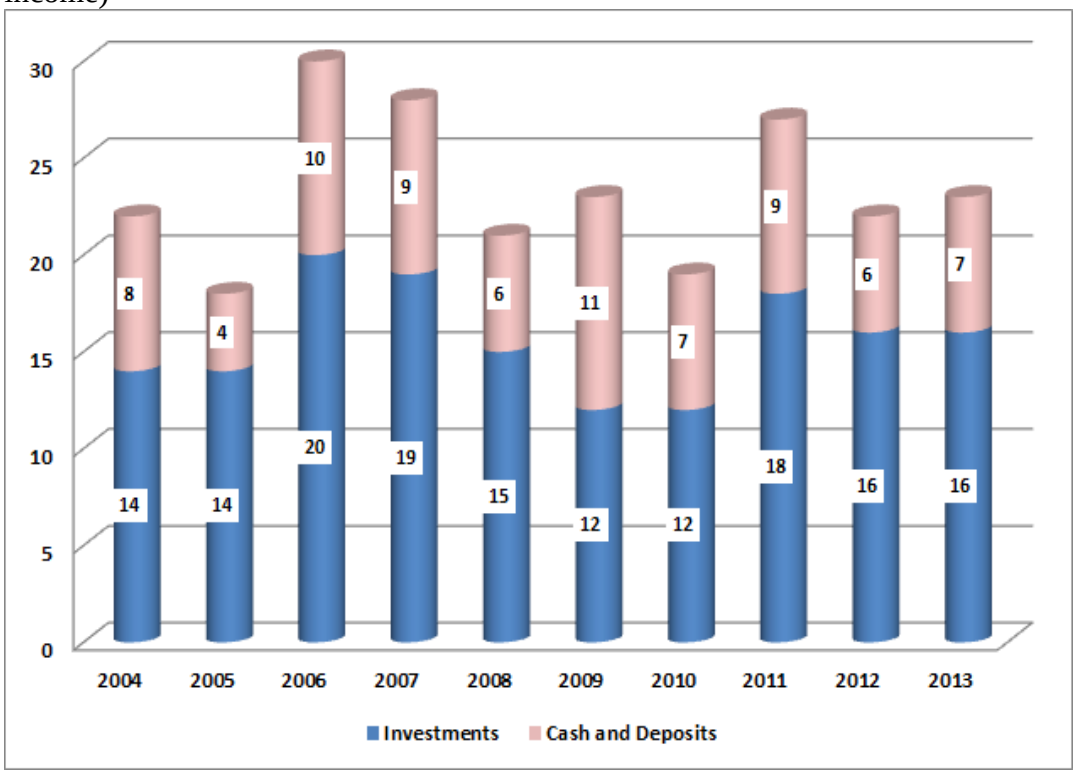
> *"Staff recruitment has been restricted to posts that would improve income generation, or that were critical to continuing appropriate*

levels of patient care. Considerable opportunities have been taken over the past year to realize efficiency savings."

(Trinity Hospice Annual Report 2013:19 Charity Commission)

Trinity hospice's income uncertainties appear to also influence it reserves strategy. Figure 7.26 reveals that there are substantially more funds kept in reserve in the form of investments, compared to the average hospice, even though the return on these funds is lower than it was in 2003. Albeit these funds provide a cushion of security against threats in the short term this hospice is forced to adopt a very conservative reserves policy at a time when investment in medical / clinical staff retention and development is required if it is to expand service provision.

Figure 7.26: Trinity Hospice Balance Sheet Cash and Investments (Months of total income)



Source: Trinity Hospice Annual Reports filed at the UK Charity Commission

7.8 Summary

In this chapter, we reviewed the hospice business model and the extent to which this is financially stressed. We have highlighted the vulnerability of hospices to income volatility from donations, legacies, and trading income in addition to the impact of weak financial market conditions that have reduced holdings gains on invested funds. Hospices thus share many of the financial characteristics of a private sector business model especially their exposure to uncertain income streams and variable capital market conditions. Hospices also receive Government funding through the NHS commissioning agencies which traditionally accounts for one third of hospice income but it too is not stable and varies considerably across different hospices.

The pattern of hospice income is volatile and this forces hospice managers and trustees, who are motivated to maintain or extend palliative care, to 'invest' in fundraising and income generating capacity and this tends to drive expenditure ahead of income. Thus reserves are required to not only cover a possible shortfall in income but to accrue possible investment holding gains that can then be used to finance the cost of capital projects like new buildings and replacement facilities. Hospice trustees allocate a substantial share of these reserves into investment funds but this has amplified financial risk and uncertainty in recent years.

There are wide variations in hospices' operating cost structures and thus ability to sustain surplus funds carried forward each year. Our analysis reveals that hospices have generally increased their operating expenses, for example, for fundraising or running shops in addition to staff directly involved in extending palliative care. Hence, hospices are found to be exposed to a variety of contradictory forces

including revenue and income volatility, expenses running ahead of income to preserve care services and investment volatility from changes in capital market valuations. Dependency on sustaining a complex network of stakeholder groups to underwrite income, challenges the hospice business model's ability to cope with the anticipated challenges of increased demand for service provision, increased funding requirements due to increasing operating/recruitment costs, and scarcity of relevant expertise in the recruitment market.

Chapter 8: Conclusions

This thesis evaluates the sustainability of palliative / end of life care provision by voluntary hospices in England and extends the application of accounting business models theory (see Haslam, et al. 2013, Andersson et al. 2010, and Haslam et al. 2010) within the boundaries of voluntary sector organisations. Hence, this thesis fills a gap in the academic literature in both the fields of palliative / end of life care provision management, as well as, on the recently developed accounting approach to business models which tends to focus on corporate profit generating sectors.

Using a middle range, inductive approach, to construct a 'descriptive business model' for hospices, the study reveals the strengths and weaknesses of the voluntary hospices' business model and evaluates its robustness against forthcoming challenges. The findings highlight the gradual transition from a basic voluntary sector business model to a complex, highly sophisticated, and institutionalized care establishment, sharing many of the characteristics found in large private and public organizations.

8.1 Literature, theoretical framework, and research approach

The literature on voluntary hospices is fragmented and scattered within academic and practitioner discourses but it collectively reveals the challenges facing this sector. Specifically, how the provision of hospice palliative / end of life care has changed over time in response to patient needs and regulatory conditions such that now eighty percent of specialist palliative care beds in England are located in voluntary hospices (Department of Health 2008 and 2009). It also helps to develop our understanding of the landscape of palliative / end of life care provision in England and the role

hospices play as a key ingredient on any Government's strategy to sustain or improve it.

The modern hospice movement arises out of the work of Dr Cicely Saunders who established St. Christopher's Hospice in London in 1967 promoting primarily a philosophy of care (Milicevic 2002, Denice and Walter 1996, Saunders 1993). Hospices, for the first time, provided a holistic approach to care, which aimed to transform the clinical management of patients suffering pain from advanced cancer (Twycross 2006, Seymour et al. 2005, Saunders 2000, Clark, 1998). Initially, the emphasis was on caring for adult, terminally ill, cancer patients during the final stage of their lives.

However, the provision of palliative care services has progressively extended to cover more patient groups in need of longer periods of care including, children, HIV, and patients with neurological disease. In turn, this broader demand for palliative care changed the nature and the cost of the service provided by hospices (WHO 2002, Finlay 2001). Patients with motor neuron disease, for example often require long-term provision of palliative care services instead of just terminal care (Oliver and Webb 2000, Hicks and Corcoran 1993). The demand for palliative care from patients suffering from acquired immunodeficiency syndrome (AIDS) has also increased and Saunders (2001) notes that the focus on cancer delayed the development of hospice provision to other areas of need. As a result, the need for developing AIDS specific hospice services, as well as the need for staff experienced in the management of AIDS related problems has increased (Easterbrook and Meadway 2001, Stephenson et al. 2000, Foley and Flannery 1995).

Apart from issues related to the widening patient base in need of palliative / end of life care services, demographic factors are imposing additional challenges on the voluntary hospice sector. The population of the UK is ageing, during 1985-2010 there was an increase of 20 per cent in the number of people ageing 65 and above to 10.3 million or 17 per cent of the total population. Given that cancer is a disease of the elderly changes in population demographics will add to the pressure for palliative / end of life care (see UK National Statistics 2012).

From an organisational perspective most hospices are independent, service delivery voluntary organizations (Handy 1992), governed by trustees and regulated by The Charity Commission. Hence, palliative care services in England are mainly funded through charitable activities and fundraising, with the Government covering, just around one third of the voluntary hospices' expenditure. Consequently, individual hospices operate within a broad range of diverse standards. Those standards are largely influenced by the level of each hospice's financial autonomy, service provision capacity, the vision and priorities of its founders/trustees and the relationship – financial dependency/independency – with the local health authority PCT (Ellis 2012, Department of Health 2009). Although Government funding is, on average, one-third of their income hospices integrate into the complex structure of the National Health Service and are subject to Government policy and regulatory initiatives. Hospices contribute to the provision of patient choice and capacity for palliative / end of life care provision and help to ease pressure on acute hospitals.

Therefore, despite the fact that hospices are charities, they appear to share many characteristics of the corporate profit-generating sector in terms of their need to raise

funding for their service provision. At the same time, the increasing level of sophistication and complexity of provided care services, in conjunction with the increasing demand for palliative and end of life care, encouraged hospices to develop more complex management structures, similar to those found in large private or public organisations. This is considerably increasing the complexity of the hospice business model.

Despite its usefulness in developing an understanding of the clinical, social, historical, economical, and regulatory landscape of palliative / end of life care provision, current literature on hospices is not grounded in accounting and management. The literature on business models, which is initially grounded in economics and strategy, has been used as a framing device to help conduct research within profit-making organisations (see Onetti et al 2012, George and Bock 2011, Amit and Zott 2010, Chesbrough 2010, Osterwalder's 2005). A key argument of this thesis is that business models literature can also be a useful framing / investigative device for non for profit organisations. The arguments for this are that it allows to bring into the framing narratives from key stakeholders about how the business model has evolved. It also allows to utilize reported financials to consider how changes in the business model impact upon financial viability (liquidity and solvency) and new forms of risk (Haslam, et al. 2013).

This thesis develops a middle range, inductive approach, where mixed methods are used to construct a 'descriptive business model' for hospices. Integrating elements of longitudinal and case based research this thesis reveals the strengths and weaknesses of the hospice business model and evaluates its sustainability against

forthcoming challenges. Relevant literature on hospices and interviews with senior palliative care professionals, from four large and medium hospices, are employed to reveal and evaluate these challenges.

8.2 Qualitative analysis

Interviews with 18 clinical and non-clinical directors reveal the transition into a more complex business model. They also help to identify increased demand for service provision, increased funding requirements due to increasing operating / recruitment costs, and scarcity of relevant expertise in the recruitment market, as the main anticipated challenges for the business model's sustainability in the foreseeable future. Organisational change in the form of transitioning from being, purely voluntary care settings to becoming, "more business-like" is evident through the range of activities comprising hospices' service provision and its sustainability, as the two quotes below indicate.

> *"I think it's having to become… I won't say more professional, I'd probably say more institutionalized, and NHS-ized … And I don't think that's… it has some good features, but actually I think it's something that I'm very suspicious of"*

Hospice B: Medical Director

> *"... I think there is a shift happening definitely within the hospice movement, because the charity market in general, from what I've seen, has become more competitive over the years"*

Hospice A: Fundraising Director

The wider range and the longer duration of the services provided by hospices, require the development of suitable organisational and management structures and recruitment of / reliance on, professional staff rather than volunteers. This consequently leads to the requirement of additional funding which however needs to be secured through a variety of sources with variable volatility and sustainability characteristics. Hence, the complexity of the business model and its reliance on a wider network of stakeholders to secure income streams increase even further.

> *"When I first started ten years ago, on the ward, there were very few treatments given on the ward. It was much more low key. It wasn't medicalised as such ..."*

Hospice A: Community Nurse Specialist

> *"Now, it's all about chemotherapy, radiotherapy, keep giving them* (the patients) *quality by giving them good pain control, so therefore there's a cost implication of all that, that probably wasn't there when the hospices first moved."*

Hospice D: Nursing Director

> *"fund-raising becomes more a priority as the hospice has gone on. We have over 40, nearly 50 people fully employed so there's quite a demand for funds so fund-raising has to get tighter and better ..."*

Hospice C: Finance Manager

The increasing cost of service provision in conjunction with the increasing competition for charitable funding is seen as a major challenge for hospices. Recruitment of suitably trained/qualified clinical personnel and fundraisers has been identified as a major challenge for hospices. Shortage of much needed relevant expertise directly affects hospices' capacity to provide the desired level of palliative and end of life care.

> *"I think one of our biggest challenges is getting money and sustaining an adequate amount of money to fund the hospice, because we are a voluntary provider"*

Hospice B: Nursing Director

> *"We want to be able to, when we recruit, to make sure we get the same talents and the same abilities that the NHS have and not take on a second tier of clinical staff"*

Hospice C: Finance Manager

It also often leads to competition on salary basis with neighbouring hospices, hospitals, and - in the case of fundraisers - private sector organisations, which adversely impacts on both hospices' operating capacity and financial viability.

> *"I think just from a fundraising perspective, yes, I'm looking for people with sales and marketing skills. These people could be earning a lot more money elsewhere, so what are you ending up with, in a recruitment pool?"*

Hospice A: Fundraising Director

Considerable increase in demand for palliative and end of life care services, due to the widening of the patient base to non-cancer patients and the ageing of the country's population, is also threatening the sustainability of the current standards of care provision. With their services developed around the care needs of cancer patients, hospices are confronted by the requirement to extend their care provision to new patient groups and this further reinforces the challenge.

> *"the number of elderly are going to increase dramatically. We're looking at doing non-malignant work, so that's putting a huge increase, that's, you know, doubling potentially the amount of patients that there are going to be"*

Hospice B: Medical Director

> *"and the other thing is, with the end of life care and the all the sort of proposals of what other patients we might be taking other than cancer patients, we could be opening the floodgates, I would imagine, to lots of referrals"*

Hospice D: Voluntary Services Manager - Fundraising

This increase in demand for service provision constitutes a significant challenge for the hospice business model which is already under financial stress and with limited capacity to expand through increasing its clinical workforce due to the aforementioned scarcity of suitable expertise.

"and, you know, the biggest chunk of our cost is staffing as we've increased… and obviously we need the specialized staff. So it's not just about increasing the beds. You need extra nurses, you need extra doctors, if the clinics get too big"

Hospice C: Fundraising Director

Being in close collaboration with the NHS, whilst maintaining their autonomy as separate charitable institutions, also concerns their management and influences individual hospices decision making at strategic level.

"there might be a lot of reasons that we might not want to come under government funding because then we get involved in all the competition for funding with other specialties and we also get involved with huge bureaucracy which is the NHS and that's not very attractive, at the moment we have our independence we are self-determined to some extent"

Hospice A: Medical Director

"We have moved now to just from being a charitable organisation to depend on some funding from the NHS and that doesn't come without a price. Always there is pressure to give more time to, you know, record what you do and to try to prove that you're doing the right thing and that takes lots of time"

Hospice D: Medical Director

"The more the NHS funds you, the more they expect from you, but at the same time, they actually want it dirt cheap. So what the PCT would like is to have most palliative care delivered by generalists…"

Hospice B: Medical Director

Overall, the interviews with the hospices' directors revealed that upon entering a maturity stage the hospice business model becomes more complex. This is because of both the type and length of provided services and due to the need to interact with an increasingly complex stakeholder network in order to secure funding to sustain the hospices' service provision capacity. Consequently, hospices are not only challenged by the requirement to increase their service provision in terms of type and quality, they also have to deal with increased competition for funding.

8.3 Financial Performance and Sustainability

The analysis of financial information from the accounts of the largest 35 hospices in the country helps to construct the financial aspect of the business model. It also reveals the volatility of hospices' income as opposed to their steadily increasing expenses. Additionally, examination of three case study hospices' accounts - Pilgrims Hospice, St Christopher's Hospice, and Trinity Hospice – covering the period 2004 to 2013 reveals divergences from the sector's averages in terms of specific financial characteristics, risk exposure, and weaknesses to sustain income and operating surpluses. This analysis highlights the vulnerability of hospices to income uncertainty. Hence, their dependency on sustaining a complex network of stakeholder groups to underwrite their diverse income streams is becoming apparent.

In 2004 the top 35 hospices in England had generated about £188 million income and by 2011 this had grown by nearly 60 per cent to £300 million. At the same period Pilgrims hospice achieved 83 per cent income growth from £6 million to £11 million, St. Christopher's hospice achieved 42 percent income growth from £13.5 million to just over £19 million, and Trinity hospice achieved 38 per cent income growth from just over £4 million to about £5.8 million. Table 8.1 below shows the contribution of the various income streams to each of the hospices' increase in total income during this period.

Table 8.1: (%) change in income by income stream 2004-2011

	Average hospice	Pilgrims hospice	St. Christopher's hospice	Trinity hospice
Donations	11.2	7.0	19.0	19.4
Legacies	13.8	21.0	39.3	-15.4
Fund raising	11.4	2.6	0.0	11.7
Trading	25.0	19.0	14.2	22.7
NHS	36.1	41.6	17.7	64.6
Other	2.7	8.2	9.6	0.0
Financing	-0.2	0.6	0.2	-3.0
Total	100	100	100	100

Source: Top 35 Hospices Annual Reports filed at the UK Charity Commission

In addition to the noticeable difference in terms of growth dynamic, amongst the average hospice – top 35 hospices' average performance - and each of the three case study hospices, detailed examination of comparable financial data reveals considerable volatility and variation at the level of individual hospices. Average analysis conceals the variable impact of the different revenue streams on each hospice's income growth over the period. Government funding and trading activities, for example, were the driving force behind the income growth of Trinity hospice whilst St. Christopher's hospice relied more on income from donations and legacies.

Pilgrims hospice, on the other hand, that achieved the highest income growth over the period, appears to sustain a better balance across its various sources of income. This analysis also exposes that individual hospices need to rely on different mixes of stakeholder networks to underwrite their costs a fact that increases the business models' complexity.

In table 8.2 we see that Government funding received directly from the Department of Health or from PCT contracts traditionally accounts for just about one third of hospice income. On aggregate level this provides a sense of security and stability. However, Government funding too is not a stable long-term source of finance and is variable across different hospices in the sector. The value of NHS contracts year on year can fluctuate and PCT contracts with hospices tend to be short-term and generally for one year. This makes it possible that government funding could decline and this can add substantial stress on the remaining components of income, a fact that, in turn, can put a hospice's capacity for palliative / end of life care provision at considerable risk.

Table 8.2: NHS/Government funding share % of total income

	Average hospice	Pilgrims hospice	St. Christopher's hospice	Trinity hospice
2004	27	23	37	41
2005	32	21	39	38
2006	25	20	36	44
2007	25	19	35	43
2008	27	25	28	36
2009	27	26	32	48
2010	28	25	37	50
2011	30	31	32	47

Source: Top 35 Hospices Annual Reports filed at the UK Charity Commission

Examination of the top 35 hospices' cost structure reveals that an average hospice uses about one quarter of its income to cover external costs. The remaining three quarters are retained and used to cover labour costs and develop cash reserves for risk mitigation. Tables 8.3 and 8.4 however, indicate that this aggregate analysis disguises considerable variances at individual hospice level and provides a misrepresenting picture of stability.

Table 8.3 shows the external costs' share of total income for an average hospice and for each of the three case study hospices. The average hospice's performance in terms of keeping external costs under control, over the period from 2004 to 2011, is stable and consistent. On the other hand, at individual hospice level of analysis we observe that only St. Christopher's hospice manages to, consistently, keep external costs under control. Conversely, Pilgrims and even at a larger extent Trinity hospice's external costs' share of total revenue has increased considerably in recent years.

Table 8.3: Total external costs share % of income

	Average hospice	Pilgrims hospice	St. Christopher's hospice	Trinity hospice
2004	23.6	26.7	25.9	14.8
2005	27.8	21.9	24.8	14.1
2006	25.7	19.5	20.2	18.6
2007	23.6	19.5	23.7	17.2
2008	23.7	23.1	21.1	27.8
2009	26.5	30.6	24.2	31.1
2010	23.8	26.1	20.4	19.3
2011	24.1	31.7	15.8	31.7

Source: Top 35 Hospices Annual Reports filed at the UK Charity Commission

Comparative analysis of the labour's share of retained income, in table 8.4 below, demonstrates similar findings as with the case of the external costs above. Contrary to the example of our constructed average hospice, where labour costs appear to be kept in balance and at around 85 per cent of retained income, two of our case study hospices have, more than one times in recent years, seen their labour costs exceeding their retained revenue. This, in turn, has led to using cash kept in reserves for the coverage of operating expenses.

Table 8.4: Labour's share % of retained income

	Average hospice	Pilgrims hospice	St. Christopher's hospice	Trinity hospice
2004	80.6	105.4	76.3	71.9
2005	85.1	84.2	89.1	62.1
2006	82.2	74.6	73.9	80.6
2007	82.9	70.8	78.2	74.9
2008	78.9	85.2	64.8	77.7
2009	89.2	112.5	81.6	101.9
2010	85.8	91.6	88.3	74.0
2011	84.9	97.8	75.0	125.9

Source: Top 35 Hospices Annual Reports filed at the UK Charity Commission

Table 8.5 demonstrates that operating margins of both the average and the case study hospices have dramatically deflated in recent years. This reveals that the growth of hospices' operating expenses has continuously been running ahead of the growth of their revenues as has also been observed in chapter 7 above. There are wide variations in hospices operating cost structures and thus ability to sustain surplus funds carried forward each year. The analysis on this thesis reveals that hospices have generally increased their operating expenses, for example, for fundraising or running shops in addition to staff directly involved in extending palliative care. This

led expenditure to, at times, run ahead of income. Consequently, hospices' trustees need to operate a reserves policy as part of good governance and risk management.

The pattern of hospice income is volatile and this forces hospice managers and trustees, who are motivated to maintain or extend palliative care, to "invest" in fund raising and income generating capacity. This has the potential to force expenditure ahead of income. Thus reserves are required to not only cover a possible shortfall in income but to accrue possible investment holding gains that can then be used to finance capital investment projects such as new buildings and replacement facilities. However, the choice of many hospice trustees to allocate a substantial share of their reserves into investment funds, has amplified financial risk and uncertainty in the years during and shortly after the financial crisis.

Table 8.5: Operating margins 2004-2011

	Average hospice	Pilgrims hospice	St. Christopher's hospice	Trinity hospice
2004	11.4	-9.1	15.8	21.3
2005	7.5	8.2	6.1	30.4
2006	10.0	17.3	19.0	12.2
2007	9.4	20.8	13.7	17.4
2008	12.8	7.7	26.3	13.3
2009	4.5	-12.6	12.1	-4.8
2010	7.2	3.2	6.4	18.5
2011	7.3	-1.8	18.1	-21.1

Source: Top 35 Hospices Annual Reports filed at the UK Charity Commission

Table 8.6 shows that, at aggregate level, the average hospice tends to maintain reserves in cash and investments equivalent to about a year's worth of total income. This policy however, is not consistent across the sector and it depends on both decisions made at strategic level by each hospice's trustees, as well as, on the

specific financial conditions faced by individual hospices. Pilgrims hospice and St. Christopher's hospice, for example, appear to maintain reserves at levels similar or slightly above the average, whilst Trinity hospice maintains reserves equivalent to more than two years of total income.

Table 8.6: Reserves in Cash and Investments (Months of total income)

	Average hospice	Pilgrims hospice	St. Christopher's hospice	Trinity hospice	St. Mary's hospice
2004	11	13	11	22	8
2005	10	11	12	18	9
2006	12	14	14	30	9
2007	12	16	16	28	9
2008	11	19	14	21	10
2009	11	15	14	23	8
2010	10	17	16	19	7
2011	10	13	14	27	4

Source: Top 35 Hospices Annual Reports filed at the UK Charity Commission

On the other hand, adverse financial conditions have forced a number of other hospices, within the sample of the top 35, to make extensive use of their reserves. This increases the risk of not being able to sustain their service provision capacity even on the short term. For example, a hospice like St. Marys above can find itself with a reducing operating surplus, a drain from cash reserves, and losses on investments made in the capital markets, at the same time that demand for palliative / end of life care service provision within its locality, increases.

An additional indicator of the adverse consequences of income volatility can be hospices' weakening financial performance during the recent financial crisis. Analysis of their financial accounts shows that many hospices from this sample of the top 35 were struggling to maintain their cash reserves as their expenses did run ahead of income. Hospice managers (and trustees) were motivated to extend their

income generating activities, for example, investing in more shops to boost trading income and recruit employees whose job is to increase funding so as to maintain palliative care services. However, during the same period, employment expenses and external contracted service costs have run ahead of income. Consequently, many hospices were forced to draw down cash reserves and adjust their reserves strategy.

In summary, the analysis of financial information from the accounts of the largest 35 hospices in the country, helped to construct the financial aspect of the hospice business model. It also revealed differences between aggregates and individual hospices demonstrating the volatility of hospice income streams, cost structures, and balance sheet capitalisation. It also drew attention to the vulnerability of hospices to income uncertainty from donations, legacies, and trading, in addition to the impact of adverse financial market conditions which cause fluctuations in holdings gains/losses on invested funds.

The hospice business model depends on sustaining a complex network of stakeholder groups to underwrite a varied range of income streams, which are then deployed to sustain or extend palliative care services. The recent financial crisis stressed the hospice business model at the same time that the public sector business model was in crisis. A similar conjuncture in the future may considerably threaten to restrict the growth in palliative / end of life care capacity at a time when the demand for it is increasing.

Therefore, I argue that hospices share many of the financial characteristics of a private sector business model, especially their exposure to uncertain income streams.

Managers and trustees are motivated to maintain their capacity to generate income to either sustain or increase palliative care provision within their communities. However, this often drives internal and external expenses ahead of income forcing hospice managers and trustees to draw down and deplete free cash reserves.

8.4 Findings and recommendations for future research

This thesis provided an account of the evolution of the hospice business model in order to evaluate its sustainability. This account reveals complexity and instability in the stakeholder relations that define the activity of delivering hospice palliative /end of life care. This complexity adds to the difficulty of sustaining and growing the hospice business model to meet the challenges of an ageing population within which more will need palliative / end of life care.

The UK Government's end of life care strategy draws upon the capacity and additional choice provided by charitable voluntary hospices in England. However, the fate of this state-voluntary sector policy intersection depends on the stability of the hospice business model in the medium to long-term future. On the other hand, the contradictory forces embedded in an increasingly complex stakeholder network threaten the sustainability of the hospice business model. This establishes a paradox that whilst demand for palliative and end of life care going forward is certain to increase, due to both demographic and regulatory factors, the vulnerability of the hospices' business model generates a conjuncture that threatens to restrict the growth in palliative and end of life care capacity at a time when it will be increasingly needed.

The research account developed within this thesis and the dissemination of its findings, through a paper publication in a classified as 'internationally excellent' academic journal, one international and two national academic conferences, have laid the foundations for further academic research on this, crucially important for the public benefit, segment of the voluntary sector. Three areas of particular interest have attracted the author's interest due to their importance being highlighted by the interview participants and due to the absence of appropriate academic research.

Issues around the potential to develop homogeneity in terms of services provided by hospices across the country and the funding of these services have been discussed in practitioner literature and Government reports (see for example King's Fund 2011, NCPC 2011, Palliative Care Funding Review 2011). However, no evidence has been found within the accounting and management literature of research aiming to address the issue and evaluate its potential impact on hospices service provision capacity and financial sustainability. Despite the associated challenges, due to the current state of many regionally embedded and focused hospices, this area could provide numerous opportunities for impactful research in collaboration with both hospices' umbrella organisations and the department of health.

The analysis in this thesis revealed differences between aggregates and individual hospices' financials, highlighting the volatility of hospice income streams, cost structures, balance sheet capitalisation, and reserves policy. This issue can be further investigated to identify regional demographic factors influencing a hospice's financial performance and risk exposure as well as the impact of each factor to a hospice's sustainability. This can lead to the development of a management tool

allowing hospices' managers and trustees to improve their financial planning and evaluate with relative accuracy forthcoming challenges.

Eventually, no evidence of the existence of a suitable and comprehensive performance measurement framework within any of the involved hospices was found during the interviews process. In most cases, hospices were relying on either performance matrixes introduced by managers with experience on the privet sector and the NHS or on models required by local palliative care commissionaires to determine funding for services. Further research to develop appropriate performance measurement methods, in conjunction with the determination of regional demographic factors influencing a hospice's performance presented above, would help hospices to both optimise internal management processes, as well as to negotiate better funding terms with palliative / end of life care commissionaires.

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Appendixes

Appendix 1: Adjusted Statements of Financial Activity – Top 35 Hospices in England

St Christophers Hospice (2004 to 2013)

Source: Hospice's Annual Reports filed at the UK Charity Commission

	Donations	Legacies	Fund- raising	Trading income	Sub total	Investment income	NHS / Government
	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's
2013	3556.00	3907.00	0.00	2250.00	9713	496.00	6116.00
2012	3820.00	4820.00	0.00	2113.00	10753	442.00	6111.00
2011	3657.00	6339.00	0.00	1767.00	11763	402.00	6054.00
2010	3521.00	4217.00	0.00	1708.00	9446	401.00	6126.00
2009	3776.00	5086.00	0.00	1398.00	10260	1140.00	5623.00
2008	3980.00	6848.00	0.00	980.00	11808	993.00	5174.00
2007	2951.00	4026.00	0.00	979.00	7956	781.00	5018.00
2006	2810.00	4097.00	0.00	991.00	7898	622.00	4932.00
2005	2450.00	3101.00	0.00	956.00	6507	559.00	4919.00
2004	2585.00	4129.00	0.00	967.00	7681	393.00	5059.00

Other income	Total Income	Total External Costs	Total income retention	Exployee Compensation	Depreciation	Operating income	Cash from Operations
£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's
1319.00	17644	3621	14023	12410.00	489.00	1124.00	1613
935.00	18241	5132	13109	12228.00	523.00	358.00	881
900.00	19119	3019	16100	12078.00	559.00	3463.00	4022
631.00	16604	3401	13203	11666.00	481.00	1056.00	1537
641.00	17664	4279	13385	10933.00	301.00	2151.00	2452
447.00	18422	3897	14525	9416.00	256.00	4853.00	5109
459.00	14214	3368	10846	8487.00	410.00	1949.00	2359
417.00	13869	2815	11054	8174.00	243.00	2637.00	2880
605.00	12590	3133	9457	8431.00	262.00	764.00	1026
361.00	13494	3495	9999	7629.00	231.00	2139.00	2370

Pilgrims Hospice (2004 to 2013)

Source: Hospice's Annual Reports filed at the UK Charity Commission

	Donations	Legacies	Fund- raising	Trading income	Sub total	Investment income	NHS / Government
	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's
2013	1246	2235	1053	3692	8226	300	3184
2012	1061	2314	1039	3434	7848	322	2845
2011	1060	2118	800	2785	6763	295	3466
2010	1115	2652	730	2407	6904	260	2539
2009	1023	1436	737	2106	5302	374	2023
2008	1110	1975	736	2053	5874	341	2195
2007	1110	3486	641	2048	7285	374	1771
2006	957	2960	636	1959	6512	287	1747
2005	907	2136	685	1993	5721	244	1575
2004	711	1069	666	1836	4282	264	1388

Other income	Total Income	Total External Costs	Total income retention	Exployee Compensation	Depreciation	Operating income	Cash from Operations
£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's
249	11959	3977	7982	8265	506	-789	-283
400	11415	3992	7423	6983	352	88	440
490	11014	3496	7518	7355	366	-203	163
319	10022	2615	7407	6790	297	320	617
216	7915	2424	5491	6177	312	-998	-686
222	8632	1998	6634	5657	310	667	977
101	9531	1861	7670	5430	259	1981	2240
111	8657	1691	6966	5197	272	1497	1769
105	7645	1675	5970	5027	318	625	943
85	6019	1610	4409	4651	307	-549	-242

Trinity the Hospice in the Fylde (2004 to 2013)

Source: Hospice's Annual Reports filed at the UK Charity Commission

	Donations	Legacies	Fund- raising	Trading income	Sub total	Investment income	NHS / Government
	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's
2013	1186.00	1232.00	189.00	763.00	3370	267.00	3401.00
2012	1114.00	1383.00	253.00	655.00	3405	255.00	2781.00
2011	1139.00	853.00	249.00	541.00	2782	254.00	2744.00
2010	1121.00	1880.00	94.00	515.00	3610	263.00	3835.00
2009	1082.00	999.00	147.00	437.00	2665	445.00	2839.00
2008	865.00	1733.00	463.00	411.00	3472	379.00	2121.00
2007	856.00	1328.00	157.00	225.00	2566	283.00	2136.00
2006	862.00	1083.00	125.00	189.00	2259	267.00	1973.00
2005	898.00	1774.00	94.00	189.00	2955	340.00	1985.00
2004	827.00	1101.00	61.00	175.00	2164	302.00	1705.00

Other income	Total Income	Total External Costs	Total income retention	Exployee Compensation	Depreciation	Operating income	Cash from Operations
£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's
0.00	7038	1844	5194	4861.00	220.00	113.00	333
0.00	6441	1542	4899	5119.00	199.00	-419.00	-220
0.00	5780	1836	3944	4966.00	194.00	-1216.00	-1022
0.00	7708	1494	6214	4599.00	187.00	1428.00	1615
0.00	5949	1856	4093	4173.00	209.00	-289.00	-80
0.00	5972	1662	4310	3351.00	167.00	792.00	959
0.00	4985	861	4124	3092.00	165.00	867.00	1032
0.00	4499	838	3661	2951.00	159.00	551.00	710
0.00	5280	744	4536	2820.00	112.00	1604.00	1716
0.00	4171	620	3551	2554.00	108.00	889.00	997

The Princess Alice Hospice (2001 to 2011)

Source: Hospice's Annual Reports filed at the UK Charity Commission

	Donations	Legacies	Fund- raising	Trading income	Sub total	Investment income	NHS / Government
	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's
2011	1635.00	2846.00	728.00	4025.00	9234.00	118.00	1768.00
2010	1336.00	2034.00	916.00	3445.00	7731.00	106.00	1758.00
2009	1212.00	1904.00	828.00	2909.00	6853.00	354.00	1736.00
2008	1177.00	2009.00	528.00	2593.00	6307.00	371.00	1676.00
2007	1199.00	2498.00	554.00	2415.00	6666.00	390.00	1617.00
2006	1779.00	2234.00	523.00	2137.00	6673.00	515.00	1622.00
2005	740.00	1696.00	492.00	2020.00	4948.00	540.00	1522.00
2004	829.00	4068.00	470.00	1938.00	7305.00	290.00	1370.00
2003	973.00	3049.00	320.00	1855.00	6197.00	213.00	981.00
2002	912.00	3421.00	396.00	1674.00	6403.00	295.00	852.00
2001	884.00	1584.00	343.00	1583.00	4394.00	188.00	822.00

Other income	Total Income	Total External Costs	Total income retention	Exployee Compensation	Depreciation	Operating income	Income retention	Cash from Operations
£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's
176.00	11296.00	2580.00	8716.00	7639.00	574.00	503.00	8716.00	1077.00
125.00	9720.00	1883.00	7837.00	6979.00	529.00	329.00	7837.00	858.00
114.00	9057.00	3739.00	5318.00	6693.00	493.00	-1868.00	5318.00	-1375.00
182.00	8536.00	2593.00	5943.00	6044.00	502.00	-603.00	5943.00	-101.00
82.00	8755.00	2191.00	6564.00	5489.00	519.00	556.00	6564.00	1075.00
85.00	8895.00	1597.00	7298.00	4907.00	505.00	1886.00	7298.00	2391.00
141.00	7151.00	1637.00	5514.00	4440.00	128.00	946.00	5514.00	1074.00
65.00	9030.00	2774.00	6256.00	4066.00	198.00	1992.00	6256.00	2190.00
80.00	7471.00	1962.00	5509.00	3485.00	143.00	1881.00	5509.00	2024.00
63.00	7613.00	1462.00	6151.00	3241.00	163.00	2747.00	6151.00	2910.00
85.00	5489.00	1396.00	4093.00	2870.00	161.00	1062.00	4093.00	1223.00

St. Ann's Hospice (2002 to 2011)

Source: Hospice's Annual Reports filed at the UK Charity Commission

	Donations	Legacies	Fund- raising	Trading income	Sub total	Investment income	NHS / Government
	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's
2011	1840.00	2635.00	1056.00	986.00	6517.00	239.00	3665.00
2010	1951.00	1703.00	1071.00	885.00	5610.00	250.00	3573.00
2009	1862.00	2111.00	1324.00	818.00	6115.00	423.00	3419.00
2008	1726.00	1700.00	1297.00	749.00	5472.00	455.00	3419.00
2007	1427.00	1737.00	1245.00	581.00	4990.00	434.00	3227.00
2006	1381.00	3010.00	1122.00	526.00	6039.00	387.00	3146.00
2005	1589.00	1623.00	835.00	515.00	4562.00	343.00	2829.00
2004	1607.00	2318.00	835.00	398.00	5158.00	275.00	2748.00
2003	1246.00	1311.00	823.00	336.00	3716.00	241.00	2394.00
2002	1142.00	1354.00	809.00	313.00	3618.00	312.00	2212.00

Other income	Total Income	Total External Costs	Total income retention	Exployee Compensation	Depreciation	Operating income	Income retention	Cash from Operations
£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's
645.00	11066.00	2093.00	8973.00	6922.00	361.00	1690.00	8973.00	2051.00
16.00	9449.00	1352.00	8097.00	6944.00	329.00	824.00	8097.00	1153.00
126.00	10083.00	4427.00	5656.00	6744.00	310.00	-1398.00	5656.00	-1088.00
327.00	9673.00	2590.00	7083.00	6385.00	254.00	444.00	7083.00	698.00
137.00	8788.00	3051.00	5737.00	6300.00	233.00	-796.00	5737.00	-563.00
222.00	9794.00	912.00	8882.00	6315.00	180.00	2387.00	8882.00	2567.00
265.00	7999.00	1483.00	6516.00	6048.00	192.00	276.00	6516.00	468.00
250.00	8431.00	1220.00	7211.00	5650.00	310.00	1251.00	7211.00	1561.00
403.00	6754.00	2873.00	3881.00	5270.00	281.00	-1670.00	3881.00	-1389.00
276.00	6418.00	2452.00	3966.00	4819.00	292.00	-1145.00	3966.00	-853.00

St. Margaret's Hospice Somerset (2003 to 2011)

Source: Hospice's Annual Reports filed at the UK Charity Commission

	Donations	Legacies	Fund- raising	Trading income	Sub total	Investment income	NHS / Government
	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's
2011	1769.00	2828.00	377.00	2683.00	7657.00	124.00	2394.00
2010	1727.00	1734.00	352.00	2389.00	6202.00	147.00	2144.00
2009	1658.00	2089.00	363.00	2138.00	6248.00	160.00	1653.00
2008	2166.00	3080.00	339.00	1832.00	7417.00	275.00	2187.00
2007	1758.00	2631.00	292.00	1727.00	6408.00	234.00	1415.00
2006	1282.00	2695.00	282.00	1640.00	5899.00	184.00	1292.00
2005	1054.00	1180.00	279.00	1469.00	3982.00	191.00	1349.00
2004	1350.00	846.00	277.00	1472.00	3945.00	167.00	1292.00
2003	1793.00	1224.00	272.00	1305.00	4594.00	211.00	975.00

Other income	Total Income	Total External Costs	Total income retention	Exployee Compensation	Depreciation	Operating income	Income retention	Cash from Operations
£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's
0.00	10175.00	2205.00	7970.00	6607.00	1136.00	227.00	7970.00	1363.00
0.00	8493.00	1829.00	6664.00	7019.00	472.00	-827.00	6664.00	-355.00
0.00	8061.00	1879.00	6182.00	6241.00	410.00	-469.00	6182.00	-59.00
0.00	9879.00	3233.00	6646.00	6065.00	394.00	187.00	6646.00	581.00
8.00	8065.00	1687.00	6378.00	5238.00	394.00	746.00	6378.00	1140.00
11.00	7386.00	1737.00	5649.00	4478.00	226.00	945.00	5649.00	1171.00
93.00	5615.00	1423.00	4192.00	4037.00	255.00	-100.00	4192.00	155.00
47.00	5451.00	1366.00	4085.00	3370.00	252.00	463.00	4085.00	715.00
8.00	5788.00	1130.00	4658.00	2567.00	105.00	1986.00	4658.00	2091.00

Loros Hospice (2003 to 2011)

Source: Hospice's Annual Reports filed at the UK Charity Commission

	Donations	Legacies	Fund- raising	Trading income	Sub total	Investment income	NHS / Government
	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's
2011	291.00	1881.00	3243.00	2020.00	7435.00	111.00	2828.00
2010	2153.00	5556.00	1229.00	1896.00	10834.00	71.00	2871.00
2009	2002.00	1379.00	1187.00	1738.00	6306.00	171.00	2867.00
2008	1818.00	898.00	1239.00	1813.00	5768.00	145.00	3297.00
2007	1508.00	912.00	1221.00	1751.00	5392.00	99.00	2494.00
2006	1408.00	2224.00	1177.00	1535.00	6344.00	184.00	2438.00
2005	1438.00	1174.00	1144.00	1536.00	5292.00	190.00	2331.00
2004	1496.00	2021.00	1112.00	1444.00	6073.00	99.00	2092.00
2003	1149.00	1310.00	925.00	1388.00	4772.00	83.00	1843.00

Other income	Total Income	Total External Costs	Total income retention	Exployee Compensation	Depreciation	Operating income	Income retention	Cash from Operations
£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's
730.00	11104.00	3207.00	7897.00	6308.00	497.00	1092.00	7897.00	1589.00
453.00	14229.00	3187.00	11042.00	5669.00	525.00	4848.00	11042.00	5373.00
0.00	9344.00	2910.00	6434.00	5521.00	585.00	328.00	6434.00	913.00
0.00	9210.00	2694.00	6516.00	5393.00	530.00	593.00	6516.00	1123.00
0.00	7985.00	2438.00	5547.00	5031.00	481.00	35.00	5547.00	516.00
0.00	8966.00	2263.00	6703.00	4894.00	424.00	1385.00	6703.00	1809.00
0.00	7813.00	2169.00	5644.00	4411.00	395.00	838.00	5644.00	1233.00
0.00	8264.00	1943.00	6321.00	4028.00	412.00	1881.00	6321.00	2293.00
0.00	6698.00	1708.00	4990.00	3349.00	363.00	1278.00	4990.00	1641.00

St. Mary's Hospice (2003 to 2011)

Source: Hospice's Annual Reports filed at the UK Charity Commission

	Donations	Legacies	Fund- raising	Trading income	Sub total	Investment income	NHS / Government
	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's
2011	290.00	882.00	842.00	807.00	2821.00	357.00	3493.00
2010	333.00	798.00	645.00	489.00	2265.00	68.00	2711.00
2009	414.00	1039.00	734.00	576.00	2763.00	171.00	2393.00
2008	379.00	1058.00	691.00	475.00	2603.00	180.00	1817.00
2007	488.00	953.00	966.00	479.00	2886.00	155.00	1674.00
2006	428.00	1077.00	575.00	425.00	2505.00	126.00	1614.00
2005	425.00	1173.00	699.00	345.00	2642.00	96.00	1545.00
2004	435.00	1041.00	608.00	335.00	2419.00	72.00	1442.00
2003	484.00	645.00	515.00	281.00	1925.00	80.00	1056.00

Other income	Total Income	Total External Costs	Total income retention	Exployee Compensation	Depreciation	Operating income	Income retention	Cash from Operations
£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's
233.00	6904.00	1357.00	5547.00	4869.00	262.00	416.00	5547.00	678.00
79.00	5123.00	404.00	4719.00	4401.00	234.00	84.00	4719.00	318.00
21.00	5348.00	1325.00	4023.00	4020.00	205.00	-202.00	4023.00	3.00
30.00	4630.00	1056.00	3574.00	3804.00	192.00	-422.00	3574.00	-230.00
29.00	4744.00	776.00	3968.00	3531.00	199.00	238.00	3968.00	437.00
13.00	4258.00	592.00	3666.00	3338.00	187.00	141.00	3666.00	328.00
5.00	4288.00	737.00	3551.00	3007.00	188.00	356.00	3551.00	544.00
1.00	3934.00	664.00	3270.00	2646.00	182.00	442.00	3270.00	624.00
5.00	3066.00	948.00	2118.00	2425.00	177.00	-484.00	2118.00	-307.00

Compton Hospice (2003 to 2011)

Source: Hospice's Annual Reports filed at the UK Charity Commission

	Donations	Legacies	Fund- raising	Trading income	Sub total	Investment income	NHS / Government
	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's
2011	662.00	950.00	789.00	2690.00	5091.00	250.00	3097.00
2010	756.00	1057.00	263.00	2715.00	4791.00	214.00	2797.00
2009	971.00	1334.00	204.00	2596.00	5105.00	394.00	2246.00
2008	1122.00	1299.00	203.00	2388.00	5012.00	345.00	1878.00
2007	1016.00	1001.00	200.00	2237.00	4454.00	276.00	1775.00
2006	720.00	1034.00	188.00	2033.00	3975.00	209.00	1763.00
2005	883.00	1032.00	0.00	1908.00	3823.00	175.00	1543.00
2004	1066.00	917.00	0.00	1744.00	3727.00	104.00	1769.00
2003	869.00	836.00	0.00	1568.00	3273.00	80.00	1444.00

Other income	Total Income	Total External Costs	Total income retention	Exployee Compensation	Depreciation	Operating income	Income retention	Cash from Operations
£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's
124.00	8562.00	2018.00	6544.00	5313.00	258.00	973.00	6544.00	1231.00
212.00	8014.00	1533.00	6481.00	5320.00	657.00	504.00	6481.00	1161.00
176.00	7921.00	1549.00	6372.00	5068.00	412.00	892.00	6372.00	1304.00
142.00	7377.00	1464.00	5913.00	4796.00	251.00	866.00	5913.00	1117.00
164.00	6669.00	1354.00	5315.00	4510.00	200.00	605.00	5315.00	805.00
135.00	6082.00	1246.00	4836.00	4082.00	188.00	566.00	4836.00	754.00
623.00	6164.00	1216.00	4948.00	4243.00	183.00	522.00	4948.00	705.00
283.00	5883.00	1147.00	4736.00	3644.00	194.00	898.00	4736.00	1092.00
318.00	5115.00	1027.00	4088.00	3502.00	184.00	402.00	4088.00	586.00

Douglas Macmillan Hospice (2003 to 2011)

Source: Hospice's Annual Reports filed at the UK Charity Commission

	Donations	Legacies	Fund- raising	Trading income	Sub total	Investment income	NHS / Government
	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's
2011	863.00	1364.00	1419.00	2254.00	5900.00	186.00	2971.00
2010	697.00	862.00	1328.00	2107.00	4994.00	188.00	2095.00
2009	439.00	1511.00	1371.00	1888.00	5209.00	270.00	1994.00
2008	429.00	898.00	1463.00	1756.00	4546.00	260.00	2125.00
2007	1124.00	988.00	1055.00	1654.00	4821.00	172.00	1799.00
2006	460.00	1134.00	1777.00	555.00	3926.00	156.00	1768.00
2005	410.00	829.00	1739.00	493.00	3471.00	129.00	1741.00
2004	427.00	817.00	1378.00	470.00	3092.00	111.00	2016.00
2003	443.00	360.00	1240.00	404.00	2447.00	158.00	1533.00

Other income	Total Income	Total External Costs	Total income retention	Exployee Compensation	Depreciation	Operating income	Income retention	Cash from Operations
£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's
0.00	9057.00	1689.00	7368.00	5961.00	281.00	1126.00	7368.00	1407.00
0.00	7277.00	1547.00	5730.00	5446.00	271.00	13.00	5730.00	284.00
0.00	7473.00	1653.00	5820.00	5243.00	265.00	312.00	5820.00	577.00
0.00	6931.00	1426.00	5505.00	4630.00	237.00	638.00	5505.00	875.00
0.00	6792.00	1317.00	5475.00	4561.00	207.00	707.00	5475.00	914.00
0.00	5850.00	1242.00	4608.00	3987.00	207.00	414.00	4608.00	621.00
0.00	5341.00	1163.00	4178.00	3672.00	197.00	309.00	4178.00	506.00
0.00	5219.00	1153.00	4066.00	3364.00	173.00	529.00	4066.00	702.00
0.00	4138.00	464.00	3674.00	2972.00	173.00	529.00	3674.00	702.00

Havens Christian Hospice (2003 to 2011)

Source: Hospice's Annual Reports filed at the UK Charity Commission

	Donations	Legacies	Fund- raising	Trading income	Sub total	Investment income	NHS / Government
	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's
2011	2762.00	1155.00	1258.00	1466.00	6641.00	133.00	1848.00
2010	2519.00	1942.00	1131.00	1300.00	6892.00	173.00	1820.00
2009	2847.00	422.00	1069.00	1163.00	5501.00	259.00	1987.00
2008	2581.00	1334.00	936.00	1114.00	5965.00	369.00	1432.00
2007	2600.00	753.00	754.00	1089.00	5196.00	144.00	1347.00
2006	1919.00	711.00	721.00	1088.00	4439.00	128.00	969.00
2005	2227.00	1164.00	201.00	1105.00	4697.00	75.00	924.00
2004	1891.00	655.00	100.00	1171.00	3817.00	23.00	926.00
2003	1775.00	327.00	30.00	1135.00	3267.00	38.00	561.00

Other income	Total Income	Total External Costs	Total income retention	Exployee Compensation	Depreciation	Operating income	Income retention	Cash from Operations
£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's
0.00	8622.00	2824.00	5798.00	5425.00	96.00	277.00	5798.00	373.00
0.00	8885.00	2666.00	6219.00	5100.00	95.00	1024.00	6219.00	1119.00
0.00	7747.00	2408.00	5339.00	4588.00	117.00	634.00	5339.00	751.00
0.00	7766.00	3348.00	4418.00	3445.00	117.00	856.00	4418.00	973.00
0.00	6687.00	2609.00	4078.00	3733.00	126.00	219.00	4078.00	345.00
0.00	5536.00	1983.00	3553.00	3425.00	115.00	13.00	3553.00	128.00
0.00	5696.00	1778.00	3918.00	3001.00	337.00	580.00	3918.00	917.00
0.00	4766.00	1181.00	3585.00	3049.00	146.00	390.00	3585.00	536.00
0.00	3866.00	1151.00	2715.00	2709.00	140.00	-134.00	2715.00	6.00

North London Hospice (2003 to 2011)

Source: Hospice's Annual Reports filed at the UK Charity Commission

	Donations	Legacies	Fund- raising	Trading income	Sub total	Investment income	NHS / Government
	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's
2011	2045.00	1025.00	0.00	1684.00	4754.00	235.00	2281.00
2010	1757.00	955.00	0.00	1421.00	4133.00	334.00	1284.00
2009	1879.00	1213.00	0.00	1270.00	4362.00	437.00	1267.00
2008	3059.00	895.00	0.00	1227.00	5181.00	419.00	1453.00
2007	1573.00	961.00	0.00	1080.00	3614.00	354.00	1239.00
2006	1509.00	1213.00	0.00	968.00	3690.00	319.00	1231.00
2005	1295.00	323.00	0.00	886.00	2504.00	279.00	1200.00
2004	1369.00	1229.00	0.00	818.00	3416.00	236.00	947.00
2003	1369.00	1229.00	0.00	818.00	3416.00	236.00	947.00

Other income	Total Income	Total External Costs	Total income retention	Exployee Compensation	Depreciation	Operating income	Income retention	Cash from Operations
£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's
0.00	7270.00	1453.00	5817.00	4603.00	226.00	988.00	5817.00	1214.00
0.00	5751.00	1347.00	4404.00	4391.00	217.00	-204.00	4404.00	13.00
0.00	6066.00	1282.00	4784.00	4156.00	231.00	397.00	4784.00	628.00
0.00	7053.00	1215.00	5838.00	3947.00	187.00	1704.00	5838.00	1891.00
0.00	5207.00	1231.00	3976.00	3516.00	161.00	299.00	3976.00	460.00
0.00	5240.00	1015.00	4225.00	3144.00	143.00	938.00	4225.00	1081.00
0.00	3983.00	1017.00	2966.00	3084.00	140.00	-258.00	2966.00	-118.00
0.00	4599.00	838.00	3761.00	2707.00	123.00	931.00	3761.00	1054.00
0.00	4599.00	838.00	3761.00	2707.00	123.00	931.00	3761.00	1054.00

St. Catherine's Hospice Lancashire (2003 to 2011)

Source: Hospice's Annual Reports filed at the UK Charity Commission

	Donations	Legacies	Fund- raising	Trading income	Sub total	Investment income	NHS / Government
	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's
2011	666.00	942.00	1700.00	860.00	4168.00	64.00	1886.00
2010	568.00	1609.00	1737.00	816.00	4730.00	87.00	1371.00
2009	1026.00	550.00	1814.00	841.00	4231.00	271.00	1243.00
2008	554.00	752.00	1714.00	821.00	3841.00	300.00	1203.00
2007	553.00	668.00	1466.00	797.00	3484.00	166.00	1160.00
2006	608.00	815.00	1463.00	732.00	3618.00	147.00	1142.00
2005	477.00	723.00	1697.00	764.00	3661.00	126.00	1221.00
2004	431.00	166.00	1410.00	540.00	2547.00	81.00	764.00
2003	433.00	355.00	1331.00	455.00	2574.00	81.00	718.00

Other income	Total Income	Total External Costs	Total income retention	Exployee Compensation	Depreciation	Operating income	Income retention	Cash from Operations
£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's
106.00	6224.00	1830.00	4394.00	3569.00	261.00	564.00	4394.00	825.00
75.00	6263.00	2076.00	4187.00	3357.00	211.00	619.00	4187.00	830.00
39.00	5784.00	1616.00	4168.00	2859.00	135.00	1174.00	4168.00	1309.00
53.00	5397.00	872.00	4525.00	3210.00	144.00	1171.00	4525.00	1315.00
31.00	4841.00	1481.00	3360.00	2821.00	140.00	399.00	3360.00	539.00
27.00	4934.00	1801.00	3133.00	2663.00	154.00	316.00	3133.00	470.00
62.00	5070.00	1612.00	3458.00	3038.00	149.00	271.00	3458.00	420.00
64.00	3456.00	1055.00	2401.00	2192.00	109.00	100.00	2401.00	209.00
32.00	3405.00	1064.00	2341.00	1989.00	105.00	247.00	2341.00	352.00

Rowcroft Hospice (2003 to 2011)

Source: Hospice's Annual Reports filed at the UK Charity Commission

	Donations	Legacies	Fund- raising	Trading income	Sub total	Investment income	NHS / Government
	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's
2011	424.00	1106.00	879.00	1012.00	3421.00	199.00	1771.00
2010	537.00	2202.00	805.00	860.00	4404.00	159.00	1935.00
2009	161.00	1872.00	917.00	788.00	3738.00	302.00	1558.00
2008	129.00	1756.00	805.00	727.00	3417.00	434.00	1404.00
2007	407.00	2718.00	456.00	710.00	4291.00	307.00	1433.00
2006	462.00	2278.00	337.00	698.00	3775.00	282.00	1257.00
2005	303.00	1796.00	270.00	661.00	3030.00	288.00	1268.00
2004	326.00	1016.00	196.00	657.00	2195.00	249.00	1086.00
2003	301.00	1144.00	157.00	646.00	2248.00	262.00	712.00

Other income	Total Income	Total External Costs	Total income retention	Exployee Compensation	Depreciation	Operating income	Income retention	Cash from Operations
£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's
174.00	5565.00	1327.00	4238.00	4451.00	1317.00	-1530.00	4238.00	-213.00
105.00	6603.00	1177.00	5426.00	4197.00	517.00	712.00	5426.00	1229.00
37.00	5635.00	1311.00	4324.00	4235.00	347.00	-258.00	4324.00	89.00
34.00	5289.00	1276.00	4013.00	4029.00	343.00	-359.00	4013.00	-16.00
47.00	6078.00	1348.00	4730.00	3807.00	433.00	490.00	4730.00	923.00
51.00	5365.00	1261.00	4104.00	3528.00	316.00	260.00	4104.00	576.00
115.00	4701.00	1130.00	3571.00	3095.00	334.00	142.00	3571.00	476.00
90.00	3620.00	936.00	2684.00	2714.00	261.00	-291.00	2684.00	-30.00
77.00	3299.00	748.00	2551.00	2336.00	258.00	-43.00	2551.00	215.00

St.Catherine's Hospice W.Sussex (2003 to 2011)

Source: Hospice's Annual Reports filed at the UK Charity Commission

	Donations	Legacies	Fund- raising	Trading income	Sub total	Investment income	NHS / Government
	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's
2011	1524.00	1223.00	1096.00	1576.00	5419.00	22.00	2640.00
2010	1207.00	2378.00	1197.00	1531.00	6313.00	37.00	2748.00
2009	1192.00	1396.00	1144.00	1414.00	5146.00	124.00	1437.00
2008	1119.00	1336.00	954.00	1365.00	4774.00	162.00	1518.00
2007	1112.00	1300.00	958.00	1236.00	4606.00	130.00	1183.00
2006	832.00	750.00	1074.00	1167.00	3823.00	98.00	1188.00
2005	1448.00	1442.00	695.00	1168.00	4753.00	132.00	912.00
2004	1410.00	931.00	716.00	1101.00	4158.00	67.00	738.00
2003	1227.00	617.00	709.00	1074.00	3627.00	66.00	669.00

Other income	Total Income	Total External Costs	Total income retention	Exployee Compensation	Depreciation	Operating income	Income retention	Cash from Operations
£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's
33.00	8114.00	1891.00	6223.00	5614.00	124.00	485.00	6223.00	609.00
31.00	9129.00	2043.00	7086.00	5262.00	130.00	1694.00	7086.00	1824.00
54.00	6761.00	1937.00	4824.00	4375.00	141.00	308.00	4824.00	449.00
50.00	6504.00	1921.00	4583.00	4104.00	128.00	351.00	4583.00	479.00
117.00	6036.00	1914.00	4122.00	3586.00	127.00	409.00	4122.00	536.00
141.00	5250.00	1866.00	3384.00	3262.00	144.00	-22.00	3384.00	122.00
73.00	5870.00	1633.00	4237.00	3240.00	163.00	834.00	4237.00	997.00
73.00	5036.00	1358.00	3678.00	3127.00	184.00	367.00	3678.00	551.00
27.00	4389.00	1249.00	3140.00	2971.00	191.00	-22.00	3140.00	169.00

St. Gemma's Hospice (2003 to 2011)

Source: Hospice's Annual Reports filed at the UK Charity Commission

	Donations	Legacies	Fund- raising	Trading income	Sub total	Investment income	NHS / Government
	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's
2011	2128.00	2028.00	468.00	2197.00	6821.00	184.00	2670.00
2010	1626.00	1228.00	471.00	1961.00	5286.00	126.00	2202.00
2009	1363.00	1326.00	749.00	1798.00	5236.00	286.00	2111.00
2008	1367.00	1454.00	623.00	1608.00	5052.00	317.00	2542.00
2007	1422.00	1867.00	416.00	1479.00	5184.00	226.00	2129.00
2006	1209.00	1246.00	452.00	1215.00	4122.00	194.00	1943.00
2005	1284.00	1576.00	72.00	997.00	3929.00	153.00	2053.00
2004	1191.00	993.00	97.00	852.00	3133.00	111.00	1816.00
2003	1217.00	1013.00	159.00	662.00	3051.00	114.00	1455.00

Other income	Total Income	Total External Costs	Total income retention	Exployee Compensation	Depreciation	Operating income	Income retention	Cash from Operations
£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's
122.00	9797.00	1777.00	8020.00	6300.00	493.00	1227.00	8020.00	1720.00
164.00	7778.00	1648.00	6130.00	5919.00	287.00	-76.00	6130.00	211.00
148.00	7781.00	1740.00	6041.00	5555.00	279.00	207.00	6041.00	486.00
123.00	8034.00	1681.00	6353.00	5149.00	254.00	950.00	6353.00	1204.00
187.00	7726.00	1538.00	6188.00	4910.00	379.00	899.00	6188.00	1278.00
111.00	6370.00	1312.00	5058.00	4433.00	217.00	408.00	5058.00	625.00
126.00	6261.00	984.00	5277.00	3993.00	202.00	1082.00	5277.00	1284.00
88.00	5148.00	965.00	4183.00	3572.00	208.00	403.00	4183.00	611.00
74.00	4694.00	746.00	3948.00	3058.00	210.00	680.00	3948.00	890.00

St. Francis Hospice (2003 to 2011)

Source: Hospice's Annual Reports filed at the UK Charity Commission

	Donations	Legacies	Fund- raising	Trading income	Sub total	Investment income	NHS / Government
	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's
2011	2296.00	1361.00	0.00	1403.00	5060.00	64.00	2706.00
2010	1777.00	1956.00	0.00	1165.00	4898.00	68.00	2357.00
2009	2127.00	1434.00	0.00	1099.00	4660.00	146.00	2031.00
2008	1573.00	1560.00	0.00	1106.00	4239.00	193.00	1971.00
2007	1417.00	1961.00	642.00	1095.00	5115.00	170.00	1729.00
2006	1169.00	1367.00	441.00	1076.00	4053.00	116.00	1730.00
2005	736.00	1272.00	446.00	1053.00	3507.00	104.00	1716.00
2004	821.00	966.00	442.00	1047.00	3276.00	91.00	1577.00
2003	953.00	747.00	366.00	1016.00	3082.00	133.00	1105.00

Other income	Total Income	Total External Costs	Total income retention	Exployee Compensation	Depreciation	Operating income	Income retention	Cash from Operations
£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's
218.00	8048.00	2220.00	5828.00	5728.00	202.00	-102.00	5828.00	100.00
193.00	7516.00	1867.00	5649.00	5272.00	231.00	146.00	5649.00	377.00
166.00	7003.00	2213.00	4790.00	5226.00	251.00	-687.00	4790.00	-436.00
153.00	6556.00	1570.00	4986.00	4868.00	204.00	-86.00	4986.00	118.00
130.00	7144.00	1494.00	5650.00	4385.00	262.00	1003.00	5650.00	1265.00
121.00	6020.00	1248.00	4772.00	4037.00	141.00	594.00	4772.00	735.00
111.00	5438.00	1305.00	4133.00	3757.00	144.00	232.00	4133.00	376.00
97.00	5041.00	1146.00	3895.00	3391.00	158.00	346.00	3895.00	504.00
70.00	4390.00	1039.00	3351.00	3162.00	112.00	77.00	3351.00	189.00

St. Giles Hospice (2003 to 2011)

Source: Hospice's Annual Reports filed at the UK Charity Commission

	Donations	Legacies	Fund- raising	Trading income	Sub total	Investment income	NHS / Government
	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's
2011	721.00	996.00	186.00	4437.00	6340.00	62.00	3292.00
2010	1048.00	911.00	201.00	4075.00	6235.00	82.00	2645.00
2009	958.00	1523.00	529.00	3444.00	6454.00	468.00	1872.00
2008	1389.00	804.00	589.00	3254.00	6036.00	442.00	2181.00
2007	2043.00	539.00	419.00	3168.00	6169.00	348.00	1651.00
2006	715.00	1278.00	389.00	3072.00	5454.00	281.00	1584.00
2005	545.00	1293.00	506.00	3088.00	5432.00	216.00	1741.00
2004	546.00	687.00	455.00	3080.00	4768.00	133.00	1618.00
2003	498.00	610.00	372.00	2941.00	4421.00	107.00	1415.00

Other income	Total Income	Total External Costs	Total income retention	Exployee Compensation	Depreciation	Operating income	Income retention	Cash from Operations
£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's
115.00	9809.00	3230.00	6579.00	6041.00	365.00	173.00	6579.00	538.00
35.00	8997.00	2841.00	6156.00	5373.00	171.00	612.00	6156.00	783.00
692.00	9486.00	2851.00	6635.00	4955.00	163.00	1517.00	6635.00	1680.00
381.00	9040.00	2474.00	6566.00	4584.00	154.00	1828.00	6566.00	1982.00
289.00	8457.00	2318.00	6139.00	4463.00	113.00	1563.00	6139.00	1676.00
329.00	7648.00	2202.00	5446.00	4460.00	118.00	868.00	5446.00	986.00
24.00	7413.00	1942.00	5471.00	4157.00	133.00	1181.00	5471.00	1314.00
32.00	6551.00	1865.00	4686.00	3543.00	142.00	1001.00	4686.00	1143.00
26.00	5969.00	1805.00	4164.00	3173.00	148.00	843.00	4164.00	991.00

St. Luke's Hospice (2003 to 2011)

Source: Hospice's Annual Reports filed at the UK Charity Commission

	Donations	Legacies	Fund- raising	Trading income	Sub total	Investment income	NHS / Government
	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's
2011	1360.00	0.00	795.00	1258.00	3413.00	88.00	2698.00
2010	1621.00	0.00	806.00	1167.00	3594.00	87.00	2688.00
2009	1110.00	0.00	919.00	916.00	2945.00	274.00	3035.00
2008	1953.00	0.00	995.00	828.00	3776.00	274.00	3352.00
2007	1353.00	0.00	953.00	777.00	3083.00	190.00	2315.00
2006	1409.00	0.00	860.00	787.00	3056.00	175.00	2132.00
2005	1825.00	0.00	871.00	738.00	3434.00	146.00	2091.00
2004	1594.00	0.00	912.00	711.00	3217.00	136.00	2035.00
2003	1508.00	0.00	904.00	549.00	2961.00	149.00	1921.00

Other income	Total Income	Total External Costs	Total income retention	Exployee Compensation	Depreciation	Operating income	Income retention	Cash from Operations
£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's
133.00	6332.00	2106.00	4226.00	4347.00	316.00	-437.00	4226.00	-121.00
343.00	6712.00	2227.00	4485.00	4806.00	215.00	-536.00	4485.00	-321.00
271.00	6525.00	2030.00	4495.00	4647.00	194.00	-346.00	4495.00	-152.00
224.00	7626.00	1779.00	5847.00	4393.00	764.00	690.00	5847.00	1454.00
150.00	5738.00	1157.00	4581.00	4174.00	143.00	264.00	4581.00	407.00
172.00	5535.00	1238.00	4297.00	4074.00	119.00	104.00	4297.00	223.00
119.00	5790.00	1244.00	4546.00	3970.00	108.00	468.00	4546.00	576.00
127.00	5515.00	1216.00	4299.00	3659.00	112.00	528.00	4299.00	640.00
103.00	5134.00	1094.00	4040.00	3406.00	92.00	542.00	4040.00	634.00

St. Michael's Hospice Hastings (2003 to 2011)

Source: Hospice's Annual Reports filed at the UK Charity Commission

	Donations	Legacies	Fund- raising	Trading income	Sub total	Investment income	NHS / Government
	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's
2011	633.00	1792.00	874.00	645.00	3944.00	19.00	1808.00
2010	908.00	657.00	1063.00	640.00	3268.00	15.00	1889.00
2009	742.00	1001.00	1629.00	825.00	4197.00	115.00	1131.00
2008	613.00	669.00	1403.00	843.00	3528.00	169.00	1311.00
2007	743.00	1545.00	1312.00	899.00	4499.00	106.00	966.00
2006	634.00	997.00	1281.00	851.00	3763.00	77.00	929.00
2005	641.00	835.00	259.00	793.00	2528.00	113.00	856.00
2004	373.00	1085.00	1148.00	817.00	3423.00	62.00	613.00
2003	435.00	1031.00	1006.00	742.00	3214.00	67.00	525.00

Other income	Total Income	Total External Costs	Total income retention	Exployee Compensation	Depreciation	Operating income	Income retention	Cash from Operations
£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's
270.00	6041.00	1015.00	5026.00	3205.00	131.00	1690.00	5026.00	1821.00
11.00	5183.00	1138.00	4045.00	3724.00	139.00	182.00	4045.00	321.00
9.00	5452.00	1696.00	3756.00	3901.00	155.00	-300.00	3756.00	-145.00
10.00	5018.00	1465.00	3553.00	3628.00	142.00	-217.00	3553.00	-75.00
9.00	5580.00	1151.00	4429.00	3310.00	140.00	979.00	4429.00	1119.00
8.00	4777.00	1276.00	3501.00	3114.00	157.00	230.00	3501.00	387.00
447.00	3944.00	764.00	3180.00	2968.00	134.00	78.00	3180.00	212.00
259.00	4357.00	1065.00	3292.00	2782.00	134.00	376.00	3292.00	510.00
246.00	4052.00	961.00	3091.00	2464.00	110.00	517.00	3091.00	627.00

St. Luke's Hospice Plymouth (2003 to 2011)

Source: Hospice's Annual Reports filed at the UK Charity Commission

	Donations	Legacies	Fund- raising	Trading income	Sub total	Investment income	NHS / Government
	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's
2011	1544.00	1046.00	539.00	2122.00	5251.00	69.00	2420.00
2010	1625.00	1033.00	506.00	1678.00	4842.00	64.00	1933.00
2009	1357.00	1280.00	472.00	1415.00	4524.00	92.00	1799.00
2008	1277.00	1103.00	447.00	1307.00	4134.00	82.00	2144.00
2007	1106.00	792.00	408.00	1223.00	3529.00	48.00	1342.00
2006	1072.00	609.00	396.00	1043.00	3120.00	68.00	1180.00
2005	773.00	820.00	427.00	802.00	2822.00	72.00	1111.00
2004	822.00	1084.00	480.00	705.00	3091.00	64.00	1005.00
2003	561.00	985.00	506.00	605.00	2657.00	30.00	790.00

Other income	Total Income	Total External Costs	Total income retention	Exployee Compensation	Depreciation	Operating income	Income retention	Cash from Operations
£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's
331.00	8071.00	2085.00	5986.00	5459.00	379.00	148.00	5986.00	527.00
310.00	7149.00	1661.00	5488.00	5077.00	316.00	95.00	5488.00	411.00
326.00	6741.00	1608.00	5133.00	4903.00	303.00	-73.00	5133.00	230.00
314.00	6674.00	1358.00	5316.00	4600.00	270.00	446.00	5316.00	716.00
343.00	5262.00	1206.00	4056.00	3848.00	291.00	-83.00	4056.00	208.00
260.00	4628.00	1104.00	3524.00	3652.00	293.00	-421.00	3524.00	-128.00
54.00	4059.00	1013.00	3046.00	3207.00	280.00	-441.00	3046.00	-161.00
53.00	4213.00	890.00	3323.00	2830.00	252.00	241.00	3323.00	493.00
47.00	3524.00	823.00	2701.00	2420.00	251.00	30.00	2701.00	281.00

St. Peter's Hospice Bristol (2003 to 2011)

Source: Hospice's Annual Reports filed at the UK Charity Commission

	Donations	Legacies	Fund- raising	Trading income	Sub total	Investment income	NHS / Government
	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's
2011	1151.00	1540.00	474.00	5799.00	8964.00	353.00	1907.00
2010	1293.00	1695.00	273.00	5891.00	9152.00	398.00	1579.00
2009	1356.00	1587.00	445.00	5346.00	8734.00	483.00	1476.00
2008	1186.00	2110.00	414.00	5058.00	8768.00	532.00	1604.00
2007	1113.00	1520.00	374.00	4856.00	7863.00	518.00	1273.00
2006	1024.00	1936.00	387.00	4628.00	7975.00	334.00	1261.00
2005	959.00	1362.00	305.00	4291.00	6917.00	288.00	1235.00
2004	993.00	1692.00	292.00	3937.00	6914.00	218.00	1116.00
2003	862.00	939.00	343.00	3097.00	5241.00	220.00	804.00

Other income	Total Income	Total External Costs	Total income retention	Exployee Compensation	Depreciation	Operating income	Income retention	Cash from Operations
£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's
159.00	11383.00	2742.00	8641.00	7591.00	541.00	509.00	8641.00	1050.00
164.00	11293.00	3553.00	7740.00	7456.00	658.00	-374.00	7740.00	284.00
128.00	10821.00	3116.00	7705.00	6971.00	586.00	148.00	7705.00	734.00
93.00	10997.00	2901.00	8096.00	6477.00	596.00	1023.00	8096.00	1619.00
97.00	9751.00	2710.00	7041.00	6202.00	535.00	304.00	7041.00	839.00
115.00	9685.00	2620.00	7065.00	5847.00	481.00	737.00	7065.00	1218.00
119.00	8559.00	1840.00	6719.00	5971.00	446.00	302.00	6719.00	748.00
101.00	8349.00	2331.00	6018.00	4829.00	395.00	794.00	6018.00	1189.00
89.00	6354.00	1842.00	4512.00	4223.00	333.00	-44.00	4512.00	289.00

St. Barnaba's Hospice Sussex-Worthing (2003 to 2011)

Source: Hospice's Annual Reports filed at the UK Charity Commission

	Donations	Legacies	Fund- raising	Trading income	Sub total	Investment income	NHS / Government
	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's
2011	1420.00	3775.00	3333.00	1654.00	10182.00	319.00	2426.00
2010	1007.00	4229.00	2559.00	1706.00	9501.00	350.00	1720.00
2009	1116.00	4658.00	2118.00	1360.00	9252.00	748.00	1556.00
2008	1324.00	3105.00	1738.00	1301.00	7468.00	704.00	1613.00
2007	1010.00	2593.00	1262.00	1160.00	6025.00	508.00	1712.00
2006	869.00	2859.00	1008.00	1097.00	5833.00	412.00	1278.00
2005	754.00	2557.00	775.00	1068.00	5154.00	345.00	983.00
2004	1969.00	2782.00	1872.00	0.00	6623.00	484.00	580.00
2003	1093.00	2366.00	1529.00	0.00	4988.00	345.00	390.00

Other income	Total Income	Total External Costs	Total income retention	Exployee Compensation	Depreciation	Operating income	Income retention	Cash from Operations
£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's
41.00	12968.00	2774.00	10194.00	6597.00	317.00	3280.00	10194.00	3597.00
325.00	11896.00	2669.00	9227.00	6064.00	312.00	2851.00	9227.00	3163.00
48.00	11604.00	2305.00	9299.00	5530.00	297.00	3472.00	9299.00	3769.00
39.00	9824.00	1856.00	7968.00	5315.00	356.00	2297.00	7968.00	2653.00
37.00	8282.00	1447.00	6835.00	4655.00	353.00	1827.00	6835.00	2180.00
55.00	7578.00	1433.00	6145.00	4333.00	348.00	1464.00	6145.00	1812.00
51.00	6533.00	1300.00	5233.00	3804.00	351.00	1078.00	5233.00	1429.00
84.00	7771.00	1040.00	6731.00	3427.00	154.00	3150.00	6731.00	3304.00
21.00	5744.00	920.00	4824.00	3718.00	150.00	956.00	4824.00	1106.00

The Martlets Hospice (2003 to 2011)

Source: Hospice's Annual Reports filed at the UK Charity Commission

	Donations	Legacies	Fund- raising	Trading income	Sub total	Investment income	NHS / Government
	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's
2011	1317.00	525.00	1074.00	1371.00	4287.00	54.00	1944.00
2010	1322.00	1491.00	1005.00	1122.00	4940.00	58.00	1550.00
2009	1003.00	1060.00	342.00	1714.00	4119.00	74.00	1252.00
2008	670.00	864.00	333.00	1613.00	3480.00	110.00	1813.00
2007	624.00	954.00	223.00	1279.00	3080.00	106.00	1346.00
2006	700.00	515.00	251.00	1133.00	2599.00	86.00	1859.00
2005	526.00	942.00	231.00	937.00	2636.00	90.00	1086.00
2004	461.00	472.00	205.00	868.00	2006.00	72.00	1390.00
2003	440.00	591.00	152.00	657.00	1840.00	105.00	1261.00

Other income	Total Income	Total External Costs	Total income retention	Exployee Compensation	Depreciation	Operating income	Income retention	Cash from Operations
£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's
13.00	6298.00	1918.00	4380.00	4526.00	121.00	-267.00	4380.00	-146.00
58.00	6606.00	1804.00	4802.00	4245.00	114.00	443.00	4802.00	557.00
42.00	5487.00	1310.00	4177.00	4274.00	101.00	-198.00	4177.00	-97.00
132.00	5535.00	1729.00	3806.00	3716.00	83.00	7.00	3806.00	90.00
21.00	4553.00	1134.00	3419.00	3380.00	88.00	-49.00	3419.00	39.00
27.00	4571.00	1358.00	3213.00	2993.00	102.00	118.00	3213.00	220.00
46.00	3858.00	836.00	3022.00	2864.00	87.00	71.00	3022.00	158.00
58.00	3526.00	914.00	2612.00	2542.00	113.00	-43.00	2612.00	70.00
23.00	3229.00	837.00	2392.00	2173.00	107.00	112.00	2392.00	219.00

Trinity Hospice Clapham (2003 to 2011)

Source: Hospice's Annual Reports filed at the UK Charity Commission

	Donations	Legacies	Fund- raising	Trading income	Sub total	Investment income	NHS / Government
	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's
2011	1950.00	1276.00	278.00	2818.00	6322.00	99.00	2852.00
2010	1386.00	1165.00	465.00	2649.00	5665.00	124.00	2834.00
2009	1712.00	1214.00	488.00	2208.00	5622.00	207.00	2714.00
2008	2084.00	2213.00	1759.00	1890.00	7946.00	293.00	2680.00
2007	1841.00	976.00	1062.00	1819.00	5698.00	171.00	2727.00
2006	1536.00	462.00	550.00	1721.00	4269.00	196.00	2731.00
2005	1543.00	554.00	154.00	1789.00	4040.00	211.00	2675.00
2004	1596.00	1155.00	156.00	1752.00	4659.00	203.00	2722.00
2003	1474.00	1300.00	159.00	1621.00	4554.00	155.00	2305.00

Other income	Total Income	Total External Costs	Total income retention	Exployee Compensation	Depreciation	Operating income	Income retention	Cash from Operations
£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's
200.00	9473.00	2220.00	7253.00	5921.00	590.00	742.00	7253.00	1332.00
150.00	8773.00	2004.00	6769.00	5888.00	587.00	294.00	6769.00	881.00
45.00	8588.00	1867.00	6721.00	5459.00	355.00	907.00	6721.00	1262.00
53.00	10972.00	1720.00	9252.00	5198.00	309.00	3745.00	9252.00	4054.00
36.00	8632.00	1714.00	6918.00	5391.00	632.00	895.00	6918.00	1527.00
44.00	7240.00	1756.00	5484.00	5394.00	312.00	-222.00	5484.00	90.00
32.00	6958.00	1632.00	5326.00	5294.00	277.00	-245.00	5326.00	32.00
6.00	7590.00	1869.00	5721.00	4863.00	225.00	633.00	5721.00	858.00
38.00	7052.00	1561.00	5491.00	4410.00	236.00	845.00	5491.00	1081.00

St. Oswald's Hospice (2003 to 2011)

Source: Hospice's Annual Reports filed at the UK Charity Commission

	Donations	Legacies	Fund- raising	Trading income	Sub total	Investment income	NHS / Government
	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's
2011	865.00	1239.00	2298.00	1401.00	5803.00	59.00	4039.00
2010	1076.00	1460.00	2216.00	1362.00	6114.00	51.00	2370.00
2009	1179.00	1720.00	1832.00	1314.00	6045.00	171.00	2199.00
2008	1043.00	1047.00	1664.00	1302.00	5056.00	304.00	2608.00
2007	1092.00	848.00	1608.00	1301.00	4849.00	209.00	2053.00
2006	934.00	732.00	1387.00	1280.00	4333.00	158.00	1722.00
2005	992.00	626.00	1042.00	1204.00	3864.00	225.00	1633.00
2004	1203.00	563.00	678.00	1035.00	3479.00	155.00	1346.00
2003	1499.00	721.00	586.00	851.00	3657.00	149.00	1229.00

Other income	Total Income	Total External Costs	Total income retention	Exployee Compensation	Depreciation	Operating income	Income retention	Cash from Operations
£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's
72.00	9973.00	2588.00	7385.00	5840.00	242.00	1303.00	7385.00	1545.00
61.00	8596.00	3028.00	5568.00	5482.00	304.00	-218.00	5568.00	86.00
41.00	8456.00	2632.00	5824.00	5478.00	238.00	108.00	5824.00	346.00
41.00	8009.00	2018.00	5991.00	4880.00	254.00	857.00	5991.00	1111.00
31.00	7142.00	2005.00	5137.00	4509.00	239.00	389.00	5137.00	628.00
31.00	6244.00	1681.00	4563.00	4334.00	238.00	-9.00	4563.00	229.00
28.00	5750.00	1410.00	4340.00	3753.00	226.00	361.00	4340.00	587.00
23.00	5003.00	1159.00	3844.00	3091.00	133.00	620.00	3844.00	753.00
51.00	5086.00	1095.00	3991.00	2495.00	70.00	1426.00	3991.00	1496.00

Butterwick Hospice (2004 to 2011)

Source: Hospice's Annual Reports filed at the UK Charity Commission

	Donations	Legacies	Fund- raising	Trading income	Sub total	Investment income	NHS / Government
	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's
2011	766.00	451.00	1617.00	839.00	3673.00	0.60	1732.00
2010	458.00	361.00	1522.00	717.00	3058.00	0.20	1313.00
2009	499.00	840.00	1471.00	648.00	3458.00	6.00	1384.00
2008	568.00	405.00	1504.00	621.00	3098.00	9.00	1848.00
2007	402.00	453.00	1537.00	620.00	3012.00	13.00	942.00
2006	896.00	270.00	1342.00	605.00	3113.00	13.00	1238.00
2005	623.00	364.00	1301.00	553.00	2841.00	9.00	1106.00
2004	648.00	236.00	1313.00	526.00	2723.00	1.00	1082.00

Other income	Total Income	Total External Costs	Total income retention	Exployee Compensation	Depreciation	Operating income	Income retention	Cash from Operations
£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's
17.00	5253.60	1435.60	3818.00	3330.00	175.00	313.00	3818.00	488.00
25.00	4210.20	1365.20	2845.00	3110.00	168.00	-433.00	2845.00	-265.00
19.00	4672.00	1418.00	3254.00	3121.00	146.00	-13.00	3254.00	133.00
88.00	4835.00	1288.00	3547.00	2940.00	147.00	460.00	3547.00	607.00
57.00	3798.00	1189.00	2609.00	2869.00	125.00	-385.00	2609.00	-260.00
49.00	4176.00	1349.00	2827.00	2667.00	108.00	52.00	2827.00	160.00
32.00	3725.00	1256.00	2469.00	2441.00	107.00	-79.00	2469.00	28.00
40.00	3549.00	1149.00	2400.00	2167.00	116.00	117.00	2400.00	233.00

St Wilfrid's Hospice South Coast (2004 to 2011)

Source: Hospice's Annual Reports filed at the UK Charity Commission

	Donations	Legacies	Fund- raising	Trading income	Sub total	Investment income	NHS / Government
	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's
2011	1225.00	2765.00	45.00	1241.00	5276.00	157.00	993.00
2010	1169.00	2508.00	59.00	1129.00	4865.00	241.00	634.00
2009	1104.00	1448.00	0.00	1047.00	3599.00	336.00	533.00
2008	1268.00	1874.00	0.00	909.00	4051.00	376.00	528.00
2007	1135.00	1112.00	0.00	764.00	3011.00	354.00	502.00
2006	953.00	1248.00	0.00	772.00	2973.00	262.00	499.00
2005	872.00	1185.00	0.00	15.00	2072.00	503.00	529.00
2004	718.00	964.00	0.00	47.00	1729.00	419.00	414.00

Other income	Total Income	Total External Costs	Total income retention	Exployee Compensation	Depreciation	Operating income	Income retention	Cash from Operations
£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's
52.00	6478.00	1480.00	4998.00	3832.00	81.00	1085.00	4998.00	1166.00
51.00	5791.00	1260.00	4531.00	3593.00	66.00	872.00	4531.00	938.00
183.00	4651.00	1556.00	3095.00	3214.00	51.00	-170.00	3095.00	-119.00
518.00	5473.00	869.00	4604.00	2903.00	26.00	1675.00	4604.00	1701.00
108.00	3975.00	813.00	3162.00	2764.00	56.00	342.00	3162.00	398.00
125.00	3859.00	843.00	3016.00	2603.00	64.00	349.00	3016.00	413.00
119.00	3223.00	879.00	2344.00	2234.00	43.00	67.00	2344.00	110.00
64.00	2626.00	666.00	1960.00	2068.00	51.00	-159.00	1960.00	-108.00

St Barnabas Hospice Lincolnshire (2004 to 2011)

Source: Hospice's Annual Reports filed at the UK Charity Commission

	Donations	Legacies	Fund- raising	Trading income	Sub total	Investment income	NHS / Government
	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's
2011	570.00	533.00	689.00	480.00	2272.00	152.00	4586.00
2010	385.00	1473.00	544.00	520.00	2922.00	142.00	2806.00
2009	347.00	831.00	506.00	336.00	2020.00	314.00	2341.00
2008	382.00	1099.00	447.00	363.00	2291.00	279.00	2759.00
2007	327.00	695.00	383.00	430.00	1835.00	178.00	1899.00
2006	340.00	534.00	353.00	350.00	1577.00	173.00	2035.00
2005	285.00	498.00	319.00	332.00	1434.00	170.00	1745.00
2004	256.00	215.00	356.00	359.00	1186.00	130.00	1812.00

Other income	Total Income	Total External Costs	Total income retention	Exployee Compensation	Depreciation	Operating income	Income retention	Cash from Operations
£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's
0.00	7010.00	1414.00	5596.00	4134.00	164.00	1298.00	5596.00	1462.00
0.00	5870.00	1069.00	4801.00	3453.00	152.00	1196.00	4801.00	1348.00
0.00	4675.00	877.00	3798.00	3148.00	115.00	535.00	3798.00	650.00
0.00	5329.00	921.00	4408.00	2948.00	116.00	1344.00	4408.00	1460.00
6.00	3918.00	687.00	3231.00	2782.00	77.00	372.00	3231.00	449.00
5.00	3790.00	712.00	3078.00	2590.00	71.00	417.00	3078.00	488.00
5.00	3354.00	628.00	2726.00	2416.00	90.00	220.00	2726.00	310.00
4.00	3132.00	626.00	2506.00	2143.00	101.00	262.00	2506.00	363.00

St Wilfrid's Hospice Eastbourne (2004 to 2011)

Source: Hospice's Annual Reports filed at the UK Charity Commission

	Donations	Legacies	Fund- raising	Trading income	Sub total	Investment income	NHS / Government
	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's
2011	674.00	1329.00	0.00	608.00	2611.00	205.00	614.00
2010	592.00	1245.00	0.00	519.00	2356.00	289.00	557.00
2009	607.00	1335.00	0.00	480.00	2422.00	525.00	516.00
2008	481.00	2283.00	0.00	421.00	3185.00	369.00	487.00
2007	467.00	1478.00	0.00	395.00	2340.00	331.00	481.00
2006	508.00	2136.00	0.00	401.00	3045.00	230.00	622.00
2005	457.00	1846.00	0.00	439.00	2742.00	242.00	648.00
2004	345.00	1239.00	0.00	345.00	1929.00	207.00	363.00

Other income	Total Income	Total External Costs	Total income retention	Exployee Compensation	Depreciation	Operating income	Income retention	Cash from Operations
£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's
11.00	3441.00	832.00	2609.00	2787.00	110.00	-288.00	2609.00	-178.00
9.00	3211.00	855.00	2356.00	2762.00	103.00	-509.00	2356.00	-406.00
12.00	3475.00	937.00	2538.00	2690.00	102.00	-254.00	2538.00	-152.00
28.00	4069.00	701.00	3368.00	2501.00	97.00	770.00	3368.00	867.00
17.00	3169.00	845.00	2324.00	2364.00	91.00	-131.00	2324.00	-40.00
0.00	3897.00	922.00	2975.00	2239.00	87.00	649.00	2975.00	736.00
0.00	3632.00	972.00	2660.00	2352.00	104.00	204.00	2660.00	308.00
1.00	2500.00	661.00	1839.00	1588.00	70.00	181.00	1839.00	251.00

Severn Hospice (2004 to 2011)

Source: Hospice's Annual Reports filed at the UK Charity Commission

	Donations	Legacies	Fund- raising	Trading income	Sub total	Investment income	NHS / Government
	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's
2011	1436.00	1060.00	1521.00	1707.00	5724.00	215.00	2759.00
2010	1286.00	1679.00	1445.00	1215.00	5625.00	203.00	2597.00
2009	1480.00	1918.00	1176.00	1065.00	5639.00	310.00	2976.00
2008	1456.00	1198.00	1172.00	964.00	4790.00	259.00	1933.00
2007	1663.00	884.00	1103.00	832.00	4482.00	263.00	1659.00
2006	1150.00	1597.00	1068.00	718.00	4533.00	224.00	1594.00
2005	714.00	1082.00	1002.00	719.00	3517.00	145.00	1457.00
2004	712.00	943.00	897.00	701.00	3253.00	99.00	1217.00

Other income	Total Income	Total External Costs	Total income retention	Exployee Compensation	Depreciation	Operating income	Income retention	Cash from Operations
£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's
10.00	8708.00	1899.00	6809.00	5909.00	352.00	548.00	6809.00	900.00
1.00	8426.00	1729.00	6697.00	5149.00	332.00	1216.00	6697.00	1548.00
134.00	9059.00	1708.00	7351.00	4532.00	314.00	2505.00	7351.00	2819.00
185.00	7167.00	1457.00	5710.00	4116.00	193.00	1401.00	5710.00	1594.00
108.00	6512.00	1248.00	5264.00	3828.00	183.00	1253.00	5264.00	1436.00
97.00	6448.00	1182.00	5266.00	3414.00	173.00	1679.00	5266.00	1852.00
91.00	5210.00	709.00	4501.00	3095.00	159.00	1247.00	4501.00	1406.00
101.00	4670.00	991.00	3679.00	2641.00	135.00	903.00	3679.00	1038.00

St Helena Hospice (2004 to 2011)

Source: Hospice's Annual Reports filed at the UK Charity Commission

	Donations	Legacies	Fund- raising	Trading income	Sub total	Investment income	NHS / Government
	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's
2011	617.00	1135.00	1084.00	855.00	3691.00	227.00	2305.00
2010	692.00	1002.00	884.00	757.00	3335.00	204.00	1820.00
2009	692.00	1002.00	884.00	757.00	3335.00	204.00	1820.00
2008	800.00	1190.00	669.00	721.00	3380.00	293.00	2082.00
2007	1398.00	1097.00	582.00	680.00	3757.00	274.00	1501.00
2006	1079.00	764.00	593.00	619.00	3055.00	250.00	1434.00
2005	796.00	1295.00	586.00	609.00	3286.00	202.00	1472.00
2004	606.00	464.00	501.00	585.00	2156.00	201.00	1371.00

Other income	Total Income	Total External Costs	Total income retention	Exployee Compensation	Depreciation	Operating income	Income retention	Cash from Operations
£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's
275.00	6498.00	1426.00	5072.00	4238.00	168.00	666.00	5072.00	834.00
274.00	5633.00	1259.00	4374.00	4044.00	163.00	167.00	4374.00	330.00
274.00	5633.00	1259.00	4374.00	4044.00	163.00	167.00	4374.00	330.00
174.00	5929.00	1227.00	4702.00	3680.00	157.00	865.00	4702.00	1022.00
165.00	5697.00	1051.00	4646.00	3436.00	152.00	1058.00	4646.00	1210.00
162.00	4901.00	1017.00	3884.00	3391.00	111.00	382.00	3884.00	493.00
189.00	5149.00	995.00	4154.00	3137.00	116.00	901.00	4154.00	1017.00
190.00	3918.00	981.00	2937.00	2858.00	124.00	-45.00	2937.00	79.00

The Pasque (Keech) Charity Hospice (2004 to 2011)

Source: Hospice's Annual Reports filed at the UK Charity Commission

	Donations	Legacies	Fund- raising	Trading income	Sub total	Investment income	NHS / Government
	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's
2011	2176.00	302.00	668.00	2452.00	5598.00	21.00	1898.00
2010	2740.00	382.00	492.00	1969.00	5583.00	15.00	1384.00
2009	1854.00	425.00	1073.00	1446.00	4798.00	147.00	135.00
2008	1187.00	332.00	1462.00	1228.00	4209.00	176.00	167.00
2007	969.00	287.00	1229.00	1256.00	3741.00	109.00	287.00
2006	805.00	244.00	964.00	1172.00	3185.00	116.00	145.00
2005	862.00	523.00	893.00	1166.00	3444.00	103.00	161.00
2004	862.00	523.00	893.00	1166.00	3444.00	103.00	161.00

Other income	Total Income	Total External Costs	Total income retention	Exployee Compensation	Depreciation	Operating income	Income retention	Cash from Operations
£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's
0.00	7517.00	2213.00	5304.00	4613.00	384.00	307.00	5304.00	691.00
0.00	6982.00	2472.00	4510.00	4636.00	322.00	-448.00	4510.00	-126.00
44.00	5124.00	529.00	4595.00	4046.00	209.00	340.00	4595.00	549.00
60.00	4612.00	471.00	4141.00	3566.00	184.00	391.00	4141.00	575.00
30.00	4167.00	530.00	3637.00	3306.00	173.00	158.00	3637.00	331.00
10.00	3456.00	746.00	2710.00	3133.00	174.00	-597.00	2710.00	-423.00
11.00	3719.00	623.00	3096.00	2828.00	181.00	87.00	3096.00	268.00
11.00	3719.00	623.00	3096.00	2828.00	181.00	87.00	3096.00	268.00

The Dorothy House Foundation (2004 to 2011)

Source: Hospice's Annual Reports filed at the UK Charity Commission

	Donations	Legacies	Fund- raising	Trading income	Sub total	Investment income	NHS / Government
	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's
2011	1611.00	1823.00	0.00	2526.00	5960.00	222.00	2317.00
2010	1492.00	2629.00	0.00	2322.00	6443.00	185.00	1946.00
2009	1451.00	1636.00	29.00	2068.00	5184.00	314.00	1966.00
2008	1306.00	2825.00	26.00	1872.00	6029.00	262.00	2087.00
2007	2018.00	963.00	0.00	1683.00	4664.00	194.00	1764.00
2006	1351.00	954.00	0.00	1481.00	3786.00	175.00	1728.00
2005	1236.00	493.00	0.00	1391.00	3120.00	146.00	1627.00
2004	1236.00	493.00	0.00	1391.00	3120.00	146.00	1627.00

Other income	Total Income	Total External Costs	Total income retention	Exployee Compensation	Depreciation	Operating income	Income retention	Cash from Operations
£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's
0.00	8499.00	1803.00	6696.00	5856.00	217.00	623.00	6696.00	840.00
0.00	8574.00	1647.00	6927.00	5073.00	136.00	1718.00	6927.00	1854.00
0.00	7464.00	1518.00	5946.00	4592.00	152.00	1202.00	5946.00	1354.00
0.00	8378.00	1399.00	6979.00	4059.00	135.00	2785.00	6979.00	2920.00
0.00	6622.00	1296.00	5326.00	3541.00	130.00	1655.00	5326.00	1785.00
0.00	5689.00	1243.00	4446.00	3269.00	129.00	1048.00	4446.00	1177.00
0.00	4893.00	1350.00	3543.00	3032.00	129.00	382.00	3543.00	511.00
0.00	4893.00	1350.00	3543.00	3032.00	129.00	382.00	3543.00	511.00

Myton Hamlet Hospice (2004 to 2011)

Source: Hospice's Annual Reports filed at the UK Charity Commission

	Donations	Legacies	Fund- raising	Trading income	Sub total	Investment income	NHS / Government
	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's
2011	2276.00	1701.00	1412.00	1026.00	6415.00	50.00	1967.00
2010	1686.00	1223.00	1051.00	1075.00	5035.00	78.00	1788.00
2009	2915.00	994.00	634.00	950.00	5493.00	253.00	1521.00
2008	1971.00	760.00	607.00	911.00	4249.00	353.00	1706.00
2007	1320.00	1125.00	609.00	914.00	3968.00	286.00	1371.00
2006	1699.00	951.00	9168.00	611.00	12429.00	246.00	1335.00
2005	1170.00	1219.00	498.00	939.00	3826.00	188.00	1317.00
2004	1073.00	481.00	465.00	934.00	2953.00	137.00	1092.00

Other income	Total Income	Total External Costs	Total income retention	Exployee Compensation	Depreciation	Operating income	Income retention	Cash from Operations
£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's	£ 000's
0.00	8432.00	2292.00	6140.00	5319.00	419.00	402.00	6140.00	821.00
0.00	6901.00	2322.00	4579.00	4408.00	308.00	-137.00	4579.00	171.00
0.00	7267.00	1717.00	5550.00	4078.00	133.00	1339.00	5550.00	1472.00
0.00	6308.00	1905.00	4403.00	3811.00	142.00	450.00	4403.00	592.00
0.00	5625.00	1487.00	4138.00	3335.00	153.00	650.00	4138.00	803.00
0.00	14010.00	9606.00	4404.00	3308.00	158.00	938.00	4404.00	1096.00
0.00	5331.00	1268.00	4063.00	2940.00	171.00	952.00	4063.00	1123.00
0.00	4182.00	1252.00	2930.00	2501.00	178.00	251.00	2930.00	429.00

Appendix 2: Adjusted Balance Sheets – Top 35 Hospices in England

St Christophers Hospice (2004 to 2013)

Source: Hospice's Annual Reports filed at the UK Charity Commission

	Tangible assets	Investments	Stocks & debtors	Cash and Deposits
	£ 000's	£ 000's	£ 000's	£ 000's
2013	5974.00	21767.00	2450.00	3477.00
2012	6443.00	22369.00	2028.00	2563.00
2011	6945.00	21185.00	2368.00	1854.00
2010	7244.00	19360.00	1613.00	2205.00
2009	7011.00	18602.00	2418.00	2162.00
2008	3740.00	18310.00	1118.00	3332.00
2007	3773.00	16000.00	918.00	1839.00
2006	4010.00	13703.00	293.00	2117.00
2005	4253.00	10772.00	520.00	2091.00
2004	4129.00	10031.00	403.00	2073.00

Creditors	Net Assets	Unrestricted Funds	Designated Funds	Other Funds
£ 000's	£ 000's	£ 000's	£ 000's	£ 000's
-1250.00	32185.00	11985.00	17336.00	2864.00
-1856.00	31061.00	15699.00	12786.00	2576.00
-1618.00	30703.00	15048.00	13707.00	1948.00
-1832.00	27240.00	13272.00	12656.00	1312.00
-2921.00	27272.00	11223.00	13927.00	2122.00
-2142.00	24358.00	10652.00	11613.00	2093.00
-2026.00	20504.00	10797.00	8691.00	1016.00
-1506.00	18617.00	9881.00	7292.00	1444.00
-1537.00	16099.00	9449.00	5715.00	935.00
-1301.00	15335.00	9187.00	5040.00	1108.00

Pilgrims Hospice (2004 to 2013)

Source: Hospice's Annual Reports filed at the UK Charity Commission

	Tangible assets	Investments	Stocks & debtors	Cash and Deposits
	£ 000's	£ 000's	£ 000's	£ 000's
2013	11,378.00	9,920.00	481.00	957.00
2012	11,135.00	10,154.00	301.00	1,135.00
2011	10086.00	10041.00	686.00	2255.00
2010	9953.00	9811.00	620.00	3932.00
2009	9925.00	7977.00	2101.00	2237.00
2008	9249.00	9246.00	574.00	4186.00
2007	9248.00	8472.00	720.00	4250.00
2006	9232.00	7353.00	920.00	2819.00
2005	9453.00	5339.00	781.00	1739.00
2004	9594.00	4939.00	316.00	1629.00

Creditors	Net Assets	Unrestricted Funds	Designated Funds	Other Funds
£ 000's	£ 000's	£ 000's	£ 000's	£ 000's
-1055.00	21676.00	10,252.00	11,378.00	43.00
-916.00	21801.00	10,620.00	11,135.00	43.00
-1047.00	22011.00	11912.00	10086.00	13.00
-2561.00	21747.00	11622.00	9953.00	172.00
-2662.00	19578.00	9387.00	9925.00	266.00
-959.00	22296.00	12485.00	9249.00	562.00
-1089.00	21601.00	12322.00	9248.00	31.00
-686.00	19638.00	10390.00	9232.00	16.00
-395.00	16917.00	7451.00	9453.00	13.00
-407.00	16071.00	6086.00	9594.00	391.00

Trinity the Hospice in the Fylde (2004 to 2013)

Source: Hospice's Annual Reports filed at the UK Charity Commission

	Tangible assets	Investments	Stocks & debtors	Cash and Deposits
	£ 000's	£ 000's	£ 000's	£ 000's
2013	5011.00	9315.00	196.00	4069.00
2012	4965.00	8404.00	525.00	3465.00
2011	5098.00	8463.00	455.00	4385.00
2010	5205.00	7478.00	884.00	4499.00
2009	5334.00	5760.00	155.00	5671.00
2008	5176.00	7449.00	1235.00	3205.00
2007	5307.00	7940.00	278.00	3720.00
2006	4669.00	7244.00	682.00	3584.00
2005	4691.00	6147.00	767.00	1606.00
2004	2887.00	4827.00	280.00	2643.00

Creditors	Net Assets	Unrestricted Funds	Designated Funds	Other Funds
£ 000's	£ 000's	£ 000's	£ 000's	£ 000's
-1730.00	16850.00	14357.00	0.00	2493.00
-1600.00	15753.00	13193.00	0.00	2560.00
-2171.00	16229.00	13599.00	0.00	2630.00
-1128.00	16936.00	14190.00	0.00	2746.00
-3116.00	13805.00	11022.00	0.00	2783.00
-1504.00	15561.00	12278.00	0.00	3283.00
-2109.00	15136.00	12279.00	0.00	2857.00
-2255.00	13924.00	10554.00	450.00	2920.00
-969.00	12242.00	9356.00	0.00	2886.00
-308.00	10329.00	8605.00	500.00	1224.00

The Princess Alice Hospice (2001 to 2011)

Source: Hospice's Annual Reports filed at the UK Charity Commission

	Tangible assets	Investments	Stocks & debtors	Cash and Deposits
	£ 000's	£ 000's	£ 000's	£ 000's
2011	7483.00	6568.00	1480.00	2349.00
2010	7842.00	6339.00	1282.00	947.00
2009	8248.00	5426.00	454.00	1189.00
2008	8348.00	7489.00	817.00	1189.00
2007	8732.00	7623.00	1281.00	1115.00
2006	7050.00	2519.00	762.00	8413.00
2005	2121.00	2100.00	913.00	10743.00
2004	1664.00	1877.00	2773.00	8602.00
2003	3080.00	1472.00	2708.00	5509.00
2002	2971.00	1824.00	2873.00	3256.00
2001	3027.00	2049.00	1229.00	1793.00

Creditors	Net Assets	Unrestricted Funds	Designated Funds	Other Funds
£ 000's	£ 000's	£ 000's	£ 000's	£ 000's
-1762.00	16018.00	918.00	14136.00	964.00
-895.00	15515.00	669.00	13898.00	948.00
-1131.00	15186.00	506.00	13742.00	938.00
-789.00	17054.00	133.00	15959.00	962.00
-1084.00	17659.00	1272.00	15477.00	910.00
-1544.00	17101.00	1148.00	15026.00	927.00
-563.00	15215.00	513.00	13776.00	926.00
-548.00	14269.00	4676.00	8673.00	920.00
-393.00	12277.00	4108.00	4427.00	3742.00
-429.00	10396.00	3138.00	3483.00	3775.00
-363.00	7635.00	3301.00	974.00	3360.00

St. Ann's Hospice (2002 to 2011)

Source: Hospice's Annual Reports filed at the UK Charity Commission

	Tangible assets	Investments	Stocks & debtors	Cash and Deposits
	£ 000's	£ 000's	£ 000's	£ 000's
2011	5278.00	5364.00	307.00	3542.00
2010	4875.00	5233.00	319.00	2683.00
2009	4867.00	3852.00	283.00	3234.00
2008	4611.00	5102.00	232.00	4363.00
2007	4600.00	5795.00	407.00	2392.00
2006	4630.00	5935.00	232.00	3441.00
2005	4558.00	5022.00	404.00	2705.00
2004	4657.00	4634.00	327.00	2780.00
2003	4903.00	4040.00	446.00	1981.00
2002	5104.00	5096.00	379.00	1895.00

Creditors	Net Assets	Unrestricted Funds	Designated Funds	Other Funds
£ 000's	£ 000's	£ 000's	£ 000's	£ 000's
-776.00	12577.00	2715.00	9185.00	677.00
-8001.00	10887.00	1622.00	8734.00	531.00
-687.00	10063.00	2182.00	7325.00	556.00
-1825.00	11462.00	2542.00	8354.00	566.00
-589.00	11017.00	1023.00	9730.00	264.00
-666.00	11814.00	1793.00	9896.00	125.00
-1465.00	11223.00	3243.00	7746.00	234.00
-1447.00	10947.00	3239.00	7341.00	367.00
-1668.00	9697.00	3712.00	5771.00	214.00
-1099.00	11367.00	11135.00	0.00	232.00

St. Margaret's Hospice Somerset (2003 to 2011)

Source: Hospice's Annual Reports filed at the UK Charity Commission

	Tangible assets	Investments	Stocks & debtors	Cash and Deposits
	£ 000's	£ 000's	£ 000's	£ 000's
2011	9377.00	4971.00	759.00	1170.00
2010	10004.00	4640.00	951.00	224.00
2009	10056.00	4312.00	403.00	634.00
2008	7420.00	7435.00	188.00	2011.00
2007	5426.00	6260.00	271.00	2545.00
2006	5537.00	5691.00	61.00	2264.00
2005	5688.00	4549.00	75.00	875.00
2004	5780.00	4046.00	55.00	2139.00
2003	3971.00	3555.00	213.00	2709.00

Creditors	Net Assets	Unrestricted Funds	Designated Funds	Other Funds
£ 000's	£ 000's	£ 000's	£ 000's	£ 000's
-1375.00	14352.00	477.00	9561.00	4314.00
-1461.00	13855.00	254.00	9561.00	4040.00
-2000.00	13405.00	-219.00	9561.00	4063.00
-1462.00	15591.00	2236.00	9561.00	3794.00
-383.00	14119.00	2825.00	8801.00	2493.00
-629.00	12924.00	5144.00	7621.00	159.00
-212.00	10974.00	4872.00	6046.00	56.00
-1316.00	10704.00	10631.00	0.00	73.00
-555.00	9893.00	9838.00	0.00	55.00

Loros Hospice (2003 to 2011)

Source: Hospice's Annual Reports filed at the UK Charity Commission

	Tangible assets	Investments	Stocks & debtors	Cash and Deposits
	£ 000's	£ 000's	£ 000's	£ 000's
2011	9529.00	2235.00	2348.00	6435.00
2010	9893.00	1900.00	4702.00	3114.00
2009	9368.00	1647.00	1401.00	1697.00
2008	8918.00	2075.00	1895.00	2573.00
2007	9037.00	2126.00	1743.00	455.00
2006	9040.00	1427.00	2484.00	360.00
2005	6083.00	0.00	985.00	4450.00
2004	5536.00	0.00	818.00	4148.00
2003	4990.00	0.00	518.00	2978.00

Creditors	Net Assets	Unrestricted Funds	Designated Funds	Other Funds
£ 000's	£ 000's	£ 000's	£ 000's	£ 000's
-1113.00	19433.00	16277.00	408.00	2748.00
-1497.00	18112.00	14850.00	436.00	2826.00
-1258.00	12855.00	10041.00	465.00	2349.00
-2428.00	13033.00	10765.00	494.00	1774.00
-791.00	12569.00	10757.00	523.00	1289.00
-911.00	12400.00	10531.00	552.00	1317.00
-641.00	10877.00	8930.00	581.00	1366.00
-462.00	10039.00	8218.00	610.00	1211.00
327.00	8158.00	6305.00	638.00	1215.00

St. Mary's Hospice (2003 to 2011)

Source: Hospice's Annual Reports filed at the UK Charity Commission

	Tangible assets	Investments	Stocks & debtors	Cash and Deposits
	£ 000's	£ 000's	£ 000's	£ 000's
2011	3795.00	1723.00	556.00	1129.00
2010	3311.00	2133.00	478.00	1071.00
2009	3032.00	3277.00	238.00	655.00
2008	2873.00	3266.00	274.00	612.00
2007	2944.00	3095.00	370.00	604.00
2006	3035.00	2716.00	295.00	704.00
2005	3122.00	2744.00	191.00	594.00
2004	3176.00	2266.00	154.00	545.00
2003	3331.00	1586.00	246.00	466.00

Creditors	Net Assets	Unrestricted Funds	Designated Funds	Other Funds
£ 000's	£ 000's	£ 000's	£ 000's	£ 000's
-483.00	6719.00	2408.00	1687.00	2624.00
-691.00	6303.00	2544.00	1665.00	2094.00
-988.00	6215.00	2879.00	1228.00	2108.00
-608.00	6417.00	3070.00	1379.00	1968.00
-174.00	6838.00	3248.00	1553.00	2037.00
-150.00	6600.00	3234.00	1478.00	1888.00
-192.00	6460.00	3225.00	1293.00	1942.00
-134.00	6007.00	2796.00	1214.00	1997.00
-135.00	5493.00	2140.00	1255.00	2098.00

Compton Hospice (2003 to 2011)

Source: Hospice's Annual Reports filed at the UK Charity Commission

	Tangible assets	Investments	Stocks & debtors	Cash and Deposits
	£ 000's	£ 000's	£ 000's	£ 000's
2011	3514.00	5065.00	173.00	5928.00
2010	2198.00	4385.00	248.00	5224.00
2009	2684.00	2493.00	381.00	4997.00
2008	2774.00	2874.00	290.00	5147.00
2007	2586.00	3280.00	364.00	3946.00
2006	2534.00	3009.00	217.00	3360.00
2005	2552.00	2229.00	875.00	2257.00
2004	2877.00	1507.00	407.00	2808.00
2003	2971.00	1125.00	265.00	1808.00

Creditors	Net Assets	Unrestricted Funds	Designated Funds	Other Funds
£ 000's	£ 000's	£ 000's	£ 000's	£ 000's
-2364.00	12316.00	5582.00	5500.00	1234.00
-1004.00	11050.00	5001.00	5648.00	401.00
-1020.00	9536.00	4151.00	5034.00	351.00
-1492.00	9593.00	3915.00	5124.00	554.00
-1012.00	9164.00	3877.00	5009.00	278.00
-738.00	8382.00	3867.00	4436.00	79.00
-528.00	7384.00	3554.00	3752.00	78.00
-876.00	6722.00	3767.00	2248.00	707.00
-575.00	5594.00	2651.00	2342.00	601.00

Douglas Macmillan Hospice (2003 to 2011)

Source: Hospice's Annual Reports filed at the UK Charity Commission

	Tangible assets	Investments	Stocks & debtors	Cash and Deposits
	£ 000's	£ 000's	£ 000's	£ 000's
2011	4319.00	3148.00	512.00	2191.00
2010	3851.00	1649.00	365.00	3133.00
2009	3723.00	142.00	619.00	4551.00
2008	3517.00	159.00	564.00	4541.00
2007	2870.00	166.00	316.00	4502.00
2006	2451.00	174.00	311.00	4114.00
2005	2582.00	178.00	253.00	3514.00
2004	2574.00	213.00	199.00	3329.00
2003	2490.00	213.00	199.00	2870.00

Creditors	Net Assets	Unrestricted Funds	Designated Funds	Other Funds
£ 000's	£ 000's	£ 000's	£ 000's	£ 000's
-739.00	8777.00	452.00	7682.00	643.00
-586.00	7157.00	129.00	6340.00	688.00
-636.00	6842.00	-140.00	6253.00	729.00
-654.00	7209.00	516.00	5944.00	749.00
-468.00	6085.00	370.00	4307.00	1408.00
-363.00	5462.00	305.00	4337.00	820.00
-251.00	6276.00	1319.00	3846.00	1111.00
-364.00	5950.00	1348.00	3904.00	698.00
-351.00	5421.00	1891.00	2991.00	539.00

Havens Christian Hospice (2003 to 2011)

Source: Hospice's Annual Reports filed at the UK Charity Commission

	Tangible assets	Investments	Stocks & debtors	Cash and Deposits
	£ 000's	£ 000's	£ 000's	£ 000's
2011	4181.00	4927.00	883.00	208.00
2010	3810.00	5000.00	1261.00	107.00
2009	3850.00	4150.00	694.00	396.00
2008	3899.00	3700.00	234.00	356.00
2007	4063.00	2600.00	230.00	407.00
2006	4137.00	2600.00	131.00	593.00
2005	4184.00	2500.00	242.00	35.00
2004	4480.00	750.00	252.00	599.00
2003	4528.00	0.00	180.00	945.00

Creditors	Net Assets	Unrestricted Funds	Designated Funds	Other Funds
£ 000's	£ 000's	£ 000's	£ 000's	£ 000's
-910.00	9110.00	1985.00	764.00	6361.00
-1104.00	8836.00	1414.00	7422.00	0.00
-875.00	7812.00	1169.00	6638.00	5.00
-862.00	7178.00	1226.00	5944.00	8.00
-766.00	6321.00	1188.00	5074.00	59.00
-1309.00	6102.00	1142.00	4878.00	82.00
-673.00	6089.00	901.00	5217.00	-29.00
-572.00	5509.00	875.00	4572.00	62.00
-533.00	5120.00	885.00	4197.00	38.00

North London Hospice (2003 to 2011)

Source: Hospice's Annual Reports filed at the UK Charity Commission

	Tangible assets	Investments	Stocks & debtors	Cash and Deposits
	£ 000's	£ 000's	£ 000's	£ 000's
2011	5703.00	8927.00	677.00	2459.00
2010	5292.00	9259.00	561.00	1222.00
2009	5379.00	6973.00	949.00	1149.00
2008	4689.00	8766.00	623.00	1898.00
2007	3873.00	7630.00	528.00	2625.00
2006	3906.00	6176.00	355.00	3669.00
2005	3976.00	4929.00	286.00	3004.00
2004	3966.00	4331.00	288.00	3368.00
2003	3966.00	4331.00	288.00	3368.00

Creditors	Net Assets	Unrestricted Funds	Designated Funds	Other Funds
£ 000's	£ 000's	£ 000's	£ 000's	£ 000's
-1435.00	16330.00	8498.00	6298.00	1534.00
-1379.00	14955.00	8537.00	6248.00	170.00
-1037.00	13413.00	7396.00	4600.00	1417.00
-801.00	15175.00	7804.00	4600.00	2771.00
-756.00	13899.00	8360.00	4600.00	939.00
-716.00	13389.00	7889.00	4600.00	900.00
-787.00	11408.00	6902.00	3600.00	906.00
-731.00	11223.00	6702.00	3600.00	921.00
-731.00	11223.00	6702.00	3600.00	921.00

St. Catherine's Hospice Lancashire (2003 to 2011)

Source: Hospice's Annual Reports filed at the UK Charity Commission

	Tangible assets	Investments	Stocks & debtors	Cash and Deposits
	£ 000's	£ 000's	£ 000's	£ 000's
2011	4854.00	176.00	262.00	4913.00
2010	4228.00	164.00	212.00	4945.00
2009	3754.00	155.00	158.00	5977.00
2008	2711.00	0.00	94.00	4894.00
2007	2310.00	1672.00	104.00	2058.00
2006	2371.00	1474.00	96.00	2633.00
2005	2437.00	1230.00	30.00	1938.00
2004	2368.00	1100.00	94.00	1404.00
2003	2351.00	922.00	66.00	1219.00

Creditors	Net Assets	Unrestricted Funds	Designated Funds	Other Funds
£ 000's	£ 000's	£ 000's	£ 000's	£ 000's
-894.00	9311.00	6910.00	100.00	2301.00
-813.00	8737.00	6332.00	642.00	1763.00
-1932.00	8113.00	5289.00	1045.00	1779.00
-733.00	6965.00	4452.00	1200.00	1313.00
-432.00	5713.00	4883.00	150.00	680.00
-1357.00	5218.00	4422.00	100.00	696.00
-1032.00	4602.00	3890.00	0.00	712.00
-757.00	4209.00	3480.00	0.00	729.00
-597.00	3961.00	3215.00	0.00	746.00

Rowcroft Hospice (2003 to 2011)

Source: Hospice's Annual Reports filed at the UK Charity Commission

	Tangible assets	Investments	Stocks & debtors	Cash and Deposits
	£ 000's	£ 000's	£ 000's	£ 000's
2011	1506.00	4835.00	549.00	2074.00
2010	2342.00	6133.00	1023.00	1167.00
2009	2131.00	4783.00	648.00	1854.00
2008	1734.00	2628.00	313.00	5474.00
2007	1453.00	5956.00	475.00	2433.00
2006	1599.00	5720.00	373.00	1874.00
2005	1724.00	4947.00	292.00	1381.00
2004	1965.00	4609.00	259.00	1076.00
2003	2103.00	4204.00	349.00	886.00

Creditors	Net Assets	Unrestricted Funds	Designated Funds	Other Funds
£ 000's	£ 000's	£ 000's	£ 000's	£ 000's
-515.00	8450.00	4366.00	3356.00	728.00
-852.00	9813.00	2595.00	6624.00	594.00
-902.00	8514.00	2602.00	5664.00	248.00
-1129.00	9020.00	3329.00	5605.00	86.00
-648.00	9668.00	2969.00	6307.00	392.00
-554.00	9012.00	8506.00	0.00	506.00
-438.00	7907.00	7599.00	0.00	308.00
-496.00	7414.00	7056.00	0.00	358.00
-224.00	7319.00	7018.00	0.00	301.00

St.Catherine's Hospice W.Sussex (2003 to 2011)

Source: Hospice's Annual Reports filed at the UK Charity Commission

	Tangible assets	Investments	Stocks & debtors	Cash and Deposits
	£ 000's	£ 000's	£ 000's	£ 000's
2011	2383.00	5131.00	1309.00	2669.00
2010	2485.00	3666.00	1031.00	3409.00
2009	2592.00	3228.00	590.00	1416.00
2008	2548.00	3944.00	154.00	1336.00
2007	2404.00	3656.00	159.00	1444.00
2006	2462.00	3463.00	144.00	922.00
2005	2200.00	2763.00	312.00	1077.00
2004	2242.00	2017.00	147.00	897.00
2003	2292.00	1630.00	93.00	667.00

Creditors	Net Assets	Unrestricted Funds	Designated Funds	Other Funds
£ 000's	£ 000's	£ 000's	£ 000's	£ 000's
-1587.00	9906.00	5915.00	2284.00	1707.00
-1359.00	9232.00	5561.00	2238.00	1433.00
-676.00	7150.00	3540.00	2308.00	1302.00
-507.00	7475.00	3776.00	2343.00	1356.00
-441.00	7222.00	3650.00	2381.00	1191.00
-517.00	6475.00	2923.00	2439.00	1113.00
-429.00	5922.00	2792.00	2189.00	941.00
-490.00	4812.00	1786.00	2227.00	799.00
-543.00	4139.00	1228.00	2280.00	631.00

St. Gemma's Hospice (2003 to 2011)

Source: Hospice's Annual Reports filed at the UK Charity Commission

	Tangible assets	Investments	Stocks & debtors	Cash and Deposits
	£ 000's	£ 000's	£ 000's	£ 000's
2011	5030.00	3863.00	302.00	4404.00
2010	4928.00	3583.00	310.00	3154.00
2009	4986.00	2792.00	379.00	2974.00
2008	4975.00	3428.00	346.00	3135.00
2007	4510.00	2962.00	202.00	3150.00
2006	4737.00	2838.00	195.00	1818.00
2005	4724.00	1568.00	176.00	2216.00
2004	4823.00	1129.00	72.00	1366.00
2003	4769.00	767.00	334.00	891.00

Creditors	Net Assets	Unrestricted Funds	Designated Funds	Other Funds
£ 000's	£ 000's	£ 000's	£ 000's	£ 000's
-1961.00	11638.00	4772.00	6390.00	476.00
-1746.00	10229.00	3753.00	6307.00	169.00
-1565.00	9567.00	3722.00	5792.00	53.00
-1804.00	10081.00	4145.00	5825.00	111.00
-1578.00	9247.00	3902.00	5190.00	155.00
-1313.00	8276.00	2730.00	3096.00	2450.00
-1192.00	7491.00	1999.00	3035.00	2457.00
-1088.00	6303.00	1223.00	2536.00	2544.00
-967.00	5793.00	978.00	2230.00	2585.00

St. Francis Hospice (2003 to 2011)

Source: Hospice's Annual Reports filed at the UK Charity Commission

	Tangible assets	Investments	Stocks & debtors	Cash and Deposits
	£ 000's	£ 000's	£ 000's	£ 000's
2011	3857.00	2287.00	1394.00	1180.00
2010	3978.00	2119.00	723.00	1872.00
2009	4163.00	1502.00	859.00	1489.00
2008	4250.00	1875.00	757.00	2818.00
2007	3893.00	1823.00	560.00	3063.00
2006	3268.00	1808.00	874.00	2168.00
2005	3345.00	1398.00	926.00	1571.00
2004	3465.00	1263.00	478.00	1713.00
2003	2803.00	1001.00	409.00	2226.00

Creditors	Net Assets	Unrestricted Funds	Designated Funds	Other Funds
£ 000's	£ 000's	£ 000's	£ 000's	£ 000's
-456.00	8262.00	662.00	4944.00	2656.00
-445.00	8247.00	542.00	5014.00	2691.00
-477.00	7536.00	178.00	4551.00	2807.00
-1051.00	8649.00	230.00	5644.00	2775.00
-399.00	8940.00	567.00	5508.00	2865.00
-260.00	7858.00	414.00	5115.00	2329.00
-255.00	6985.00	387.00	4610.00	1988.00
-267.00	6652.00	278.00	4335.00	2039.00
-361.00	6078.00	261.00	3757.00	2060.00

St. Giles Hospice (2003 to 2011)

Source: Hospice's Annual Reports filed at the UK Charity Commission

	Tangible assets	Investments	Stocks & debtors	Cash and Deposits
	£ 000's	£ 000's	£ 000's	£ 000's
2011	12893.00	763.00	967.00	4389.00
2010	12439.00	755.00	816.00	4408.00
2009	7601.00	811.00	715.00	8547.00
2008	5443.00	1271.00	802.00	8590.00
2007	4632.00	3508.00	293.00	5713.00
2006	3257.00	3463.00	684.00	5037.00
2005	3358.00	2964.00	341.00	4622.00
2004	3216.00	2297.00	207.00	4216.00
2003	3253.00	2016.00	222.00	3094.00

Creditors	Net Assets	Unrestricted Funds	Designated Funds	Other Funds
£ 000's	£ 000's	£ 000's	£ 000's	£ 000's
-1725.00	17287.00	11067.00	0.00	6220.00
-1321.00	17098.00	11547.00	0.00	5551.00
-1371.00	16303.00	10441.00	0.00	5862.00
-1096.00	15010.00	9337.00	0.00	5673.00
-831.00	13314.00	8740.00	0.00	4574.00
-745.00	11695.00	8512.00	0.00	3183.00
-969.00	10316.00	7061.00	0.00	3255.00
-1034.00	8903.00	5814.00	0.00	3089.00
-796.00	7789.00	4567.00	0.00	3222.00

St. Luke's Hospice (2003 to 2011)

Source: Hospice's Annual Reports filed at the UK Charity Commission

	Tangible assets	Investments	Stocks & debtors	Cash and Deposits
	£ 000's	£ 000's	£ 000's	£ 000's
2011	3233.00	2916.00	201.00	1264.00
2010	3364.00	2336.00	415.00	1921.00
2009	3362.00	2991.00	288.00	1954.00
2008	3210.00	3281.00	568.00	1788.00
2007	3055.00	3369.00	246.00	1054.00
2006	2964.00	3248.00	88.00	1039.00
2005	3055.00	2857.00	89.00	681.00
2004	3135.00	2116.00	251.00	509.00
2003	3113.00	1851.00	214.00	2396.00

Creditors	Net Assets	Unrestricted Funds	Designated Funds	Other Funds
£ 000's	£ 000's	£ 000's	£ 000's	£ 000's
-957.00	6657.00	6657.00	0.00	0.00
-1007.00	7029.00	6902.00	0.00	127.00
-1135.00	7459.00	7330.00	0.00	129.00
-995.00	7851.00	7691.00	0.00	160.00
-487.00	7236.00	7074.00	0.00	162.00
-502.00	6837.00	6655.00	0.00	182.00
-355.00	6328.00	6143.00	0.00	185.00
-341.00	5670.00	4642.00	0.00	1028.00
-2729.00	4844.00	3793.00	0.00	1051.00

St. Michael's Hospice Hastings (2003 to 2011)

Source: Hospice's Annual Reports filed at the UK Charity Commission

	Tangible assets	Investments	Stocks & debtors	Cash and Deposits
	£ 000's	£ 000's	£ 000's	£ 000's
2011	1867.00	145.00	1850.00	3813.00
2010	2268.00	131.00	663.00	3465.00
2009	2406.00	69.00	697.00	2683.00
2008	2681.00	128.00	487.00	3131.00
2007	2615.00	118.00	391.00	3320.00
2006	2682.00	111.00	812.00	1920.00
2005	2533.00	323.00	1031.00	1312.00
2004	2550.00	330.00	590.00	1836.00
2003	2277.00	42.00	351.00	2177.00

Creditors	Net Assets	Unrestricted Funds	Designated Funds	Other Funds
£ 000's	£ 000's	£ 000's	£ 000's	£ 000's
-269.00	7406.00	7399.00	0.00	7.00
-817.00	5709.00	5699.00	0.00	10.00
-355.00	5500.00	5204.00	0.00	296.00
-593.00	5834.00	5181.00	0.00	653.00
-372.00	6072.00	1536.00	4140.00	396.00
-437.00	5088.00	799.00	3846.00	443.00
-406.00	4794.00	1947.00	2546.00	301.00
-558.00	4748.00	2180.00	2563.00	5.00
-542.00	4304.00	2005.00	2299.00	0.00

St. Luke's Hospice Plymouth (2003 to 2011)

Source: Hospice's Annual Reports filed at the UK Charity Commission

	Tangible assets	Investments	Stocks & debtors	Cash and Deposits
	£ 000's	£ 000's	£ 000's	£ 000's
2011	4024.00	1052.00	549.00	1633.00
2010	3174.00	991.00	535.00	1622.00
2009	3378.00	774.00	462.00	1377.00
2008	3513.00	782.00	555.00	1590.00
2007	3561.00	888.00	368.00	906.00
2006	3394.00	1198.00	329.00	769.00
2005	3492.00	977.00	242.00	1187.00
2004	3665.00	842.00	159.00	1596.00
2003	3554.00	607.00	214.00	1556.00

Creditors	Net Assets	Unrestricted Funds	Designated Funds	Other Funds
£ 000's	£ 000's	£ 000's	£ 000's	£ 000's
-1182.00	6076.00	306.00	3905.00	1865.00
-471.00	5851.00	298.00	4103.00	1450.00
-452.00	5539.00	108.00	3968.00	1463.00
-658.00	5781.00	159.00	3978.00	1644.00
-316.00	5405.00	272.00	3716.00	1417.00
-306.00	5383.00	433.00	3860.00	1090.00
-288.00	5610.00	287.00	4160.00	1163.00
-318.00	5944.00	169.00	4517.00	1258.00
-352.00	5579.00	41.00	4428.00	1110.00

St. Peter's Hospice Bristol (2003 to 2011)

Source: Hospice's Annual Reports filed at the UK Charity Commission

	Tangible assets	Investments	Stocks & debtors	Cash and Deposits
	£ 000's	£ 000's	£ 000's	£ 000's
2011	4145.00	9368.00	929.00	710.00
2010	3810.00	6604.00	1450.00	1744.00
2009	4770.00	5326.00	842.00	973.00
2008	4818.00	5832.00	440.00	3050.00
2007	4469.00	5970.00	474.00	757.00
2006	4489.00	5204.00	499.00	1102.00
2005	4624.00	4430.00	240.00	586.00
2004	4638.00	4176.00	356.00	355.00
2003	4612.00	3445.00	315.00	0.00

Creditors	Net Assets	Unrestricted Funds	Designated Funds	Other Funds
£ 000's	£ 000's	£ 000's	£ 000's	£ 000's
-2330.00	12822.00	9777.00	2339.00	706.00
-1965.00	11643.00	2102.00	6925.00	2616.00
-1092.00	10819.00	600.00	7881.00	2338.00
-2342.00	11798.00	1718.00	7895.00	2185.00
-622.00	11048.00	1535.00	5990.00	3523.00
-711.00	10583.00	1290.00	5797.00	3496.00
-609.00	9271.00	419.00	5667.00	3185.00
-815.00	8710.00	234.00	5258.00	3218.00
-1027.00	7345.00	-539.00	4789.00	3095.00

St. Barnaba's Hospice Sussex-Worthing (2003 to 2011)

Source: Hospice's Annual Reports filed at the UK Charity Commission

	Tangible assets	Investments	Stocks & debtors	Cash and Deposits
	£ 000's	£ 000's	£ 000's	£ 000's
2011	21585.00	9217.00	398.00	6288.00
2010	15516.00	6244.00	389.00	11644.00
2009	11210.00	5134.00	424.00	10646.00
2008	9393.00	7040.00	686.00	8352.00
2007	7330.00	9487.00	567.00	5989.00
2006	7560.00	9425.00	244.00	3817.00
2005	6793.00	7618.00	74.00	2666.00
2004	7053.00	5577.00	76.00	2822.00
2003	1736.00	4274.00	4583.00	1176.00

Creditors	Net Assets	Unrestricted Funds	Designated Funds	Other Funds
£ 000's	£ 000's	£ 000's	£ 000's	£ 000's
-2718.00	34770.00	12834.00	21591.00	345.00
-2645.00	31149.00	10628.00	19159.00	1362.00
-769.00	26645.00	7879.00	17448.00	1318.00
-535.00	24936.00	14641.00	9500.00	795.00
-379.00	22995.00	14640.00	8000.00	355.00
-400.00	20647.00	14215.00	6000.00	432.00
-327.00	16824.00	12845.00	3500.00	479.00
-394.00	15134.00	12642.00	2000.00	492.00
-254.00	11515.00	5938.00	3900.00	1677.00

The Martlets Hospice (2003 to 2011)

Source: Hospice's Annual Reports filed at the UK Charity Commission

	Tangible assets	Investments	Stocks & debtors	Cash and Deposits
	£ 000's	£ 000's	£ 000's	£ 000's
2011	2408.00	268.00	433.00	2029.00
2010	2029.00	260.00	651.00	2389.00
2009	2012.00	275.00	324.00	2040.00
2008	2063.00	461.00	238.00	2108.00
2007	1977.00	0.00	502.00	2257.00
2006	2036.00	0.00	104.00	2526.00
2005	2069.00	0.00	234.00	2324.00
2004	2068.00	0.00	193.00	2163.00
2003	2129.00	0.00	156.00	2135.00

Creditors	Net Assets	Unrestricted Funds	Designated Funds	Other Funds
£ 000's	£ 000's	£ 000's	£ 000's	£ 000's
-603.00	4374.00	1457.00	0.00	2917.00
-502.00	4665.00	1950.00	0.00	2715.00
-428.00	4223.00	1480.00	0.00	2743.00
-448.00	4420.00	1546.00	0.00	2874.00
-322.00	4413.00	1565.00	0.00	2848.00
-204.00	4462.00	1582.00	0.00	2880.00
-283.00	4343.00	1363.00	5.00	2975.00
-151.00	4272.00	1466.00	5.00	2801.00
-104.00	4316.00	1644.00	0.00	2672.00

Trinity Hospice Clapham (2003 to 2011)

Source: Hospice's Annual Reports filed at the UK Charity Commission

	Tangible assets	Investments	Stocks & debtors	Cash and Deposits
	£ 000's	£ 000's	£ 000's	£ 000's
2011	11552.00	1822.00	441.00	2934.00
2010	11776.00	1749.00	347.00	1955.00
2009	11754.00	1420.00	349.00	1732.00
2008	8168.00	1920.00	629.00	3995.00
2007	4494.00	3101.00	320.00	1438.00
2006	3924.00	2938.00	486.00	1077.00
2005	3614.00	2558.00	399.00	1690.00
2004	3379.00	2257.00	563.00	2126.00
2003	3305.00	1957.00	281.00	1738.00

Creditors	Net Assets	Unrestricted Funds	Designated Funds	Other Funds
£ 000's	£ 000's	£ 000's	£ 000's	£ 000's
-898.00	15851.00	15060.00	257.00	534.00
-767.00	15061.00	11776.00	3126.00	159.00
-818.00	14437.00	11710.00	2455.00	272.00
-684.00	14028.00	6276.00	4470.00	3282.00
-446.00	8906.00	4314.00	2937.00	1655.00
-575.00	7849.00	3185.00	3924.00	740.00
-554.00	7706.00	3571.00	3614.00	521.00
-623.00	7703.00	3716.00	3379.00	3987.00
-511.00	6770.00	2929.00	3455.00	3841.00

St. Oswald's Hospice (2003 to 2011)

Source: Hospice's Annual Reports filed at the UK Charity Commission

	Tangible assets	Investments	Stocks & debtors	Cash and Deposits
	£ 000's	£ 000's	£ 000's	£ 000's
2011	10844.00	1952.00	874.00	3146.00
2010	9877.00	1446.00	1064.00	2611.00
2009	9285.00	999.00	1300.00	3621.00
2008	7660.00	1293.00	683.00	5015.00
2007	7439.00	1398.00	699.00	4483.00
2006	7583.00	1298.00	726.00	3866.00
2005	6789.00	1056.00	577.00	4889.00
2004	6866.00	934.00	386.00	4660.00
2003	6805.00	767.00	652.00	3880.00

Creditors	Net Assets	Unrestricted Funds	Designated Funds	Other Funds
£ 000's	£ 000's	£ 000's	£ 000's	£ 000's
-1230.00	15466.00	7687.00	0.00	7779.00
-805.00	14074.00	7613.00	0.00	6461.00
-1346.00	13858.00	7421.00	0.00	6437.00
-567.00	14084.00	7463.00	0.00	6621.00
-654.00	13365.00	7894.00	0.00	5471.00
-567.00	12906.00	7401.00	0.00	5505.00
-609.00	12702.00	5721.00	900.00	6081.00
-571.00	12275.00	5394.00	918.00	5963.00
-575.00	11530.00	4107.00	1836.00	5587.00

Butterwick Hospice (2004 to 2011)

Source: Hospice's Annual Reports filed at the UK Charity Commission

	Tangible assets	Investments	Stocks & debtors	Cash and Deposits
	£ 000's	£ 000's	£ 000's	£ 000's
2011	2771.00	7.00	342.00	552.00
2010	2422.00	11.00	435.00	486.00
2009	2471.00	1.00	383.00	1115.00
2008	2211.00	1.00	537.00	900.00
2007	2354.00	1.00	430.00	697.00
2006	2344.00	2.00	304.00	824.00
2005	2345.00	2.00	295.00	795.00
2004	2363.00	0.01	268.00	427.00

Creditors	Net Assets	Unrestricted Funds	Designated Funds	Other Funds
£ 000's	£ 000's	£ 000's	£ 000's	£ 000's
-833.00	2835.00	33.00	51.00	2751.00
-918.00	2433.00	247.00	51.00	2135.00
-1191.00	2778.00	670.00	0.00	2108.00
-946.00	2703.00	609.00	0.00	2094.00
-1333.00	2149.00	781.00	0.00	1368.00
-1038.00	2435.00	1058.00	0.00	1377.00
-1169.00	2268.00	1055.00	0.00	1213.00
-842.00	2216.00	19.00	0.00	2197.00

St Wilfrid's Hospice South Coast (2004 to 2011)

Source: Hospice's Annual Reports filed at the UK Charity Commission

	Tangible assets	Investments	Stocks & debtors	Cash and Deposits
	£ 000's	£ 000's	£ 000's	£ 000's
2011	2243.00	7857.00	773.00	2022.00
2010	2384.00	6516.00	1219.00	1937.00
2009	2398.00	4599.00	708.00	1041.00
2008	2323.00	5585.00	346.00	2404.00
2007	2519.00	5575.00	210.00	2043.00
2006	2556.00	5533.00	766.00	796.00
2005	2586.00	4833.00	673.00	367.00
2004	2612.00	4573.00	410.00	348.00

Creditors	Net Assets	Unrestricted Funds	Designated Funds	Other Funds
£ 000's	£ 000's	£ 000's	£ 000's	£ 000's
-331.00	12259.00	1378.00	10850.00	31.00
-830.00	10885.00	1254.00	9600.00	31.00
-327.00	8419.00	8245.00	144.00	30.00
-256.00	10401.00	5201.00	4750.00	450.00
-237.00	10109.00	5489.00	4600.00	20.00
-179.00	9470.00	7457.00	2000.00	13.00
-106.00	8355.00	6319.00	2000.00	36.00
-92.00	7851.00	7851.00	0.00	0.00

St Barnabas Hospice Lincolnshire (2004 to 2011)

Source: Hospice's Annual Reports filed at the UK Charity Commission

	Tangible assets	Investments	Stocks & debtors	Cash and Deposits
	£ 000's	£ 000's	£ 000's	£ 000's
2011	5207.00	2807.00	569.00	3977.00
2010	3502.00	2421.00	565.00	4432.00
2009	3403.00	1442.00	746.00	3626.00
2008	2808.00	1747.00	513.00	3699.00
2007	2554.00	1806.00	345.00	2671.00
2006	2527.00	1586.00	375.00	2393.00
2005	2547.00	1370.00	189.00	2198.00
2004	2021.00	1279.00	315.00	2370.00

Creditors	Net Assets	Unrestricted Funds	Designated Funds	Other Funds
£ 000's	£ 000's	£ 000's	£ 000's	£ 000's
-719.00	11840.00	4868.00	5200.00	1772.00
-566.00	10355.00	4872.00	4500.00	983.00
-542.00	8677.00	4667.00	3000.00	1010.00
-258.00	8509.00	3985.00	3500.00	1024.00
-161.00	7215.00	3105.00	3500.00	610.00
-137.00	6744.00	4628.00	1500.00	616.00
-200.00	6104.00	3982.00	1500.00	622.00
-199.00	5787.00	3157.00	2000.00	630.00

St Wilfrid's Hospice Eastbourne (2004 to 2011)

Source: Hospice's Annual Reports filed at the UK Charity Commission

	Tangible assets	Investments	Stocks & debtors	Cash and Deposits
	£ 000's	£ 000's	£ 000's	£ 000's
2011	2394.00	7146.00	838.00	1089.00
2010	1838.00	8600.00	497.00	732.00
2009	1896.00	9584.00	516.00	125.00
2008	2047.00	8675.00	292.00	996.00
2007	2105.00	8309.00	237.00	945.00
2006	2148.00	8154.00	501.00	1034.00
2005	2039.00	6620.00	448.00	506.00
2004	1813.00	6039.00	634.00	469.00

Creditors	Net Assets	Unrestricted Funds	Designated Funds	Other Funds
£ 000's	£ 000's	£ 000's	£ 000's	£ 000's
-322.00	11145.00	841.00	10139.00	165.00
-233.00	11433.00	758.00	10615.00	60.00
-178.00	11942.00	508.00	9567.00	1867.00
-141.00	11870.00	508.00	9353.00	2009.00
-166.00	11430.00	924.00	8419.00	2087.00
-344.00	11493.00	1238.00	7620.00	2635.00
-244.00	9370.00	670.00	6416.00	2284.00
-171.00	8784.00	841.00	5891.00	2052.00

Severn Hospice (2004 to 2011)

Source: Hospice's Annual Reports filed at the UK Charity Commission

	Tangible assets	Investments	Stocks & debtors	Cash and Deposits
	£ 000's	£ 000's	£ 000's	£ 000's
2011	6888.00	880.00	856.00	8387.00
2010	6961.00	381.00	888.00	7534.00
2009	7061.00	157.00	1040.00	6570.00
2008	6688.00	275.00	941.00	4747.00
2007	4980.00	0.00	578.00	4867.00
2006	2686.00	741.00	1140.00	4524.00
2005	2549.00	1588.00	812.00	2262.00
2004	2447.00	971.00	303.00	2105.00

Creditors	Net Assets	Unrestricted Funds	Designated Funds	Other Funds
£ 000's	£ 000's	£ 000's	£ 000's	£ 000's
-1453.00	15558.00	4882.00	10484.00	192.00
-753.00	15011.00	4394.00	10557.00	60.00
-1127.00	13701.00	3670.00	9978.00	53.00
-1036.00	11314.00	9505.00	1597.00	212.00
-512.00	9913.00	8066.00	1751.00	96.00
-424.00	8666.00	6634.00	956.00	1076.00
-376.00	6834.00	5652.00	876.00	306.00
-356.00	5469.00	4880.00	552.00	37.00

St Helena Hospice (2004 to 2011)

Source: Hospice's Annual Reports filed at the UK Charity Commission

	Tangible assets	Investments	Stocks & debtors	Cash and Deposits
	£ 000's	£ 000's	£ 000's	£ 000's
2011	4857.00	4993.00	489.00	2680.00
2010	4219.00	3818.00	321.00	2014.00
2009	4219.00	3818.00	321.00	2014.00
2008	4228.00	2729.00	509.00	3617.00
2007	4331.00	3146.00	347.00	2904.00
2006	3428.00	3712.00	347.00	982.00
2005	2996.00	3132.00	452.00	1478.00
2004	3027.00	2896.00	511.00	529.00

Creditors	Net Assets	Unrestricted Funds	Designated Funds	Other Funds
£ 000's	£ 000's	£ 000's	£ 000's	£ 000's
-2222.00	10797.00	553.00	7530.00	2714.00
-416.00	9956.00	682.00	7005.00	2269.00
-416.00	9956.00	682.00	7005.00	2269.00
-1753.00	9329.00	685.00	6283.00	2361.00
-1712.00	9017.00	972.00	5738.00	2307.00
-186.00	8282.00	1144.00	5507.00	1631.00
-237.00	7820.00	1019.00	5561.00	1240.00
-279.00	6684.00	511.00	5165.00	1008.00

The Pasque (Keech) Charity Hospice (2004 to 2011)

Source: Hospice's Annual Reports filed at the UK Charity Commission

	Tangible assets	Investments	Stocks & debtors	Cash and Deposits
	£ 000's	£ 000's	£ 000's	£ 000's
2011	7230.00	101.00	306.00	1855.00
2010	7272.00	96.00	484.00	1312.00
2009	6879.00	69.00	338.00	2222.00
2008	4762.00	93.00	240.00	3648.00
2007	4609.00	104.00	381.00	3233.00
2006	4720.00	92.00	443.00	2739.00
2005	4869.00	74.00	348.00	3108.00
2004	4869.00	74.00	348.00	3108.00

Creditors	Net Assets	Unrestricted Funds	Designated Funds	Other Funds
£ 000's	£ 000's	£ 000's	£ 000's	£ 000's
-776.00	8716.00	1846.00	6481.00	389.00
-781.00	8383.00	1774.00	6367.00	242.00
-719.00	8789.00	604.00	6540.00	1645.00
-417.00	8326.00	3902.00	0.00	4424.00
-563.00	7764.00	3822.00	0.00	3942.00
-509.00	7485.00	3839.00	0.00	3646.00
-451.00	7948.00	4293.00	0.00	3655.00
-451.00	7948.00	4293.00	0.00	3655.00

The Dorothy House Foundation (2004 to 2011)

Source: Hospice's Annual Reports filed at the UK Charity Commission

	Tangible assets	Investments	Stocks & debtors	Cash and Deposits
	£ 000's	£ 000's	£ 000's	£ 000's
2011	6156.00	9331.00	1216.00	628.00
2010	5828.00	9436.00	222.00	415.00
2009	5861.00	5812.00	907.00	512.00
2008	5830.00	5407.00	1421.00	180.00
2007	5583.00	3354.00	480.00	604.00
2006	4368.00	2945.00	905.00	154.00
2005	3399.00	3027.00	284.00	327.00
2004	3399.00	3027.00	284.00	327.00

Creditors	Net Assets	Unrestricted Funds	Designated Funds	Other Funds
£ 000's	£ 000's	£ 000's	£ 000's	£ 000's
-1115.00	16217.00	7442.00	5520.00	3255.00
-720.00	15181.00	6917.00	5238.00	3026.00
-520.00	12572.00	4719.00	4777.00	3076.00
-657.00	12181.00	6351.00	2696.00	3134.00
-568.00	9454.00	3881.00	2789.00	2784.00
-583.00	7788.00	1914.00	1953.00	3921.00
-453.00	6584.00	2464.00	2571.00	1549.00
-453.00	6584.00	2464.00	2571.00	1549.00

Myton Hamlet Hospice (2004 to 2011)

Source: Hospice's Annual Reports filed at the UK Charity Commission

	Tangible assets	Investments	Stocks & debtors	Cash and Deposits
	£ 000's	£ 000's	£ 000's	£ 000's
2011	10023.00	2199.00	491.00	2363.00
2010	10106.00	2033.00	1091.00	1321.00
2009	8931.00	1771.00	313.00	3115.00
2008	5126.00	2061.00	396.00	5272.00
2007	3747.00	2304.00	368.00	5362.00
2006	3556.00	2132.00	118.00	5067.00
2005	3632.00	1771.00	119.00	4119.00
2004	3725.00	1453.00	166.00	3147.00

Creditors	Net Assets	Unrestricted Funds	Designated Funds	Other Funds
£ 000's	£ 000's	£ 000's	£ 000's	£ 000's
-1847.00	13230.00	13094.00	0.00	136.00
-1795.00	12757.00	12624.00	0.00	133.00
-1737.00	12393.00	6524.00	0.00	5869.00
-1313.00	11542.00	7415.00	0.00	4127.00
-512.00	11270.00	8442.00	0.00	2828.00
-376.00	10497.00	8265.00	0.00	2232.00
-423.00	9217.00	6882.00	0.00	2335.00
-373.00	8118.00	6082.00	0.00	2036.00

Appendix 3: Indicative questionnaire used for the semi-structured interviews with hospices clinical and non-clinical managers

Introduction

Introduction of my self and the project

Dear XXX would you like to tell me a few things about your background and your involvement with hospice movement?

How long have you been with the hospice movement?

What was that motivated you to join hospice movement?

Professional views on hospice movement

Have you noticed any changes in the ideals and the orientation of hospice movement during the period you are actively involved with it?

What you think motivated people to join hospice movement when you started?

Do you think these motives remain the same or you are finding differences between now and then?

Do you think the fact that hospice movement enters maturity is changing people's attitudes and motives to assist or volunteer and how?

Which are you considering to be the main challenges that hospice movement is facing now or will face the near future? Challenges could be both internal and external.

How you think hospice sector should respond to these challenges?

How you think these challenges are going to affect XXX hospice?

Is there any action plan in place in order to deal with these issues effectively?

What would you propose on this topic?

Role and team description

Would you like to talk to me about your role and the role of your team within XXX hospice?

Are you personally, or your team getting involved in the process of target setting, long term management and the overall policy creation of the hospice, or you are focusing mainly on the day to day management?

Would you like to describe to me how your team is organised and managed? (Team structure staff involvement on decision making)

Would you like to describe a typical working day for you and your team?

Are you aware of differences between, the way your team in XXX Hospice is working and the way similar teams are working in other hospices? Would you like to give me examples of differences and similarities?

Are you using any method to measure the performance of your team? Would you like to describe it to me?

What would you consider as the main challenges in the process of measuring personnel performance within a hospice?

Would you suggest any specific topics one should take into account whilst trying to measure the performance of teams similar to yours and the performance of hospice personnel in general?

Do you believe that your team is, or could be involved in the process of creating financial value for the hospice and if yes how?

Inter-professional relationships

Are the members of your team working in cooperation with members of other teams or they are primarily working on an independent basis?

Do you believe your team members would prefer working on a different basis?

Do you think that the voluntary nature of the hospice movement assisted in decreasing the impact of inter-professional working obstacles among carers?

How the movement towards professionalism within hospices would affect inter-professional relationships?

Recruitment

Would you like to give me some information about your recruitment policies and your criteria for hiring new members on your team?

Are you looking for specific skills and how easy it is for these skills to be found?

Would you suggest that the recruitment market is competitive and why, whom you consider to be the main competitors?

General feedback

Did you enjoy this conversation would you like to indicate three strong and three weak points of the interview process?

Would you like to suggest areas of interest relevant to your profession that you feel they were not covered in adequate depth?

Would you like to suggest some improvements on the approach or the content of the interview?

Would you like to participate in a similar interview in the future?

Appendix 4: Interviews with clinical directors and senior clinical personnel

Interview with the Medical Director of Hospice A:

Speaker key

IV: Interviewer

IE: Interviewee

IV: Before we will start with the interview itself, I will have to let you know about the ethics and confidentiality policy of the University. You can be assured that any kind of information you will provide within the interview is going to be kept confidential, whichever information out of it we publish is not going to carry your name or the name of the institution you are working for. If at any time you find out that you don't feel comfortable answering a particular question you can just say that you don't want to answer this question, or if you feel at some point that you want to interrupt or stop the interview process, you can just feel free and ask for that. We have done the introduction and now I would like to ask you a few things about your background and your involvement on hospice movement, how many years you have been involved in this sort of activity.

IE: I've been working, this medical specialty for 17 years now but most of that time I haven't been working in hospices I've been working for the NHS so I came to work on the hospice year in 2002 that's about four or five years

IV: What motivated you to join hospice movement?

IE: Well it was already my medical interest and my specialty but I came to the hospice movement specifically because I found the NHS frustrating and limiting. Because certainly at that time end of life care and care for patients in the end of life, was not a great priority in a big hospital. It's a relatively small area, a relatively dark area, people do not necessarily want to look at it very much, because hospitals on the whole think they are about fixing people, you know making people better. So it's quite a difficult specialty to be in, within a big hospital setting so I was attracted to come to the hospice because this is our business and it is acknowledged and everybody here is comfortable with that. Also because we provide such excellent service and care, and then other colleagues in the healthcare are very interested in being friends with us. It changes the dynamic a lot because we have some independent funding and because we have some independence on how we use our

resources, and because we have a lot of beds and so on, and then we are in so powerful position in health care so all these were things that attracted me to come here.

IV: Have you noticed any changes in the orientation of hospice movement over the last years for example in the past it was mainly based on volunteers now some people are saying that it is moving towards professionalism here you seen anything like that.

IE: I think in a sense volunteers are still very important part of our work force but I think perhaps what you are alluding to is a shift in a sense that perhaps the organization is becoming more professionalized and perhaps whereas in the past we had a sort of... its rather a British thing… this sort of charitable amateur well-meaning committed sort of work force we still have a lot of those things but perhaps it becomes a little bit more professionalized and a little bit more businesslike so there is some shift but what we don't want to do is to lose these qualities of this earlier model because it does bring important things to our service so people's commitment is important to us so people are committed to this organization over and above compared to a normal job and that's important to us.

IV: Do you think the motivation of the people is changing as well, like people were motivated because of their own good will, their will to help to provide something good for good cause in the past, can you see this thing happening nowadays or these motives are not the same anymore?

IE: I think those motives are still strong, particularly I think people also want respect for their professional skills and a competitive salary and all those other things as well and so there is some shift perhaps, but I think those motivations are still a very important part of what makes a hospice.

IV: Would you relate this change is in the motivation with the fact that hospice movement is entering the maturity level nowadays?

IE: To some extent yes, I think so I mean certainly from a medical point of view the pioneering doctors in hospices were unusual people, interesting people, who haven't somehow fitted into standard career pathways. Now medical training is very rigid, it follows the same pattern as specialist training in any other specialty, so then it's a very different group of people coming through, it's a little bit more like a sausage machine you get the predictable product at the end. Whilst in the early days we had a wide mixture of people, mostly with very strong personal motivations on this work, so that has changed as well, in medicine particularly, in the medical aspect.

IV: Now I'm going to ask you some things about challenges that the hospice sector is going to face now and in the future. Which are you considering the main challenges for the whole movement and maybe for your profession in specific to be right now and within the next 10 to 15 years? The challenges that I am referring to can be both internal and external to the hospice sector, internal could be recruitment related issues, and centralized governance of the whole sector, or decentralized governance of the whole sector, and external could be related to the regulation, or financial, or the ageing of the population, increased demand for services etc.

IE: Where to start, financially that is your primary interest we are clearly in an unusual position in health-care because of the huge contribution of charitable funding to our services and at the moment locally this is not under threat I mean we are financially in a strong position locally but that's not the case everywhere around the country so some hospices are in trouble financially and that's going to be a challenge then that is the question about well how much of this is appropriate if in fact we think that palliative care and hospice care should be available to all patients with appropriate need then why isn't the Department of Health paying for it you now like it pays for every other element of care and in a sense I think it would be a bit strange if that wasn't the case at some point in the future but somehow the Department of here needs to decide which elements of palliative care are if you like standard and should be available to patients and then pay for it and then the charity is left to do the fruity bits the nice bits if they so desire but at the moment charitable money is paying for core services and there is no clear intention of the government to change that and that's a big issue for the future how that will go and obviously there might be a lot of reasons that we might not want to come under government funding because then we get involved in all the competition for funding with other specialties and we also get involved with huge bureaucracy which is the NHS and that's not very attractive at the moment we have our independence we are self-determined to some extent we can spend our money on what we think is important and we are much more flexible organization because we are so much smaller so that's a big issue for the future. In terms of our clinical services the big issues for the future are as you say to do with the ageing population to do with extension of services to patients with illnesses other than cancer which you may have heard a little about historically hospice care has been given mostly to patients with cancer at the end of life at least at 90% and yet people are dying from all sorts of other illnesses and having a terminal phase on all sorts of other illnesses. So the question is do we have the right skills and facilities to care for other people and how should we be responding to that challenge but that's a bit clinical issue is about palliative care for non-cancer patients. Work force wise I mean locally we are in strong position because we are tacked out just far

enough from London so our workforce doesn't have any much choice on where to work if you understand me so that put us in relatively strong position but workforce is obviously an issue in other areas and that's also not just in this specialty but nationally to do with how the Department of Health is determined to put training numbers in medicine or nursing and so on and of course the always getting that wrong and we either got too many of one sort of doctor or too few of another sort of nurse. Certainly I think there will be shortage of nurse specialists who are quite an important part of our work force. So workforce issues are interesting and not all in our control because it depends on national level decisions about training. Internally we have issues about modernizing our workforce and their approach to work and perhaps getting a bit more work out of them they have a comfortable working life here which is fine which is good but probably we should be a little bit more efficient as an organization but probably this applies to most organizations they could be more efficient than they are really turn to the good patterns and streamline the way we work what we do and to get the most of the resources that we have for the patients and families which all this is all about. So these are the sorts of things that come in mind.

IV: I would like to talk about hospice sector related issues would you consider better for hospices to standardize some services and centralize the governance of the sector or it could be better to keep it flexible.

IE: That's an interesting question I think because of the way that hospices have grown up historically a motivated person in a small town I want to build a hospice for our town there is very little desire for those organizations to give up their autonomy however if the outturn activities for somewhat for some of them seem then they might take a brave decision to collaborate more. But on the whole the decision-making is not very rationale because it is based on local commitments and local people and it might be rational to collaborate but I'm not sure that that would prevail. So I think that some hospices will just go down and maybe some others will then see a need for more collaboration more on the sorts of national branding perhaps more unified fundraising. I mean all those things will obviously be in our interest probably but am not sure that individual hospices around the country will necessarily make sensible decisions around that. This is a really exceptional hospice run by a really wise group of people that’s not applying everywhere that's very variable.

IV: Is it that sometimes people are focusing more on what they think hospice is all about instead of what it is required for a hospice to stand up?

IE: There is an interesting tension, as we already talked about, between running a business and running a place of care and love and death isn't it, there is a huge tension

between those two things. Some hospices run very much to businesses and they don't look enough at the other issues, some run much more as a sort of social community, supporting, loving place and they don't look enough at the business. So that balance is the key and it's very variable into different organizations.

IV: How you think the sector should respond to this sort of challenges?

IE: I don't know how the sector will respond, I mean I think, as I've said I think some hospices might have to close because they will become non viable financially probably, and then I guess there will be opportunities for other organizations then to grow and perhaps one would see the future one outcome might be there will be a lot fewer bigger hospices running the services over a wider area. It's a bit like what we already do as you know being three units is quite unusual being as big as we are is quite unusual so maybe more of that will happen. I am sure we will continue to rankle with the Department of Health about funding for ever, and they will continue trying not to pay for it as long as they possibly can. They never have any money to it, they never get themselves sorted, but I guess I would see inevitably a shift towards more Department of Health funding overtime, particularly if we do broaden the range of patients that we are looking after so if we are looking after a broader range of patients and a bigger number of patients I would expect funding to follow that.

IV: How you think that this challenges will affect this hospice specifically, and are you aware of any action plan in order to deal with issues like that. Like the ageing population your demand to provide more services the volatility of your income and what would be your personal proposal on the best way to deal with this kind of challenges?

IE: I think we are already dealing with them rather well, because this is a very well-run organization we have our… financially we are strong we've got good investments and we've got good cushion for some of the fluctuations and although we had some gloomy financial forecasts during the past years they haven't counter the issue that we have been very strong in terms of fundraising. I think we are very, very well. We are starting from a very good place to deal with the future. We also have good relationships with the NHS locally, I do think that even if we did get into financial difficulties we have some basis to negotiate with the NHS for more funding because we are valued by them locally and we have a very good working relationship. We are already big so we are already in a sense where… I think in the position where other hospices might have to move towards, we are already there because you're already big. I suppose there is a question of whether we are trying to get bigger and that's something that has been … is muted from time to time should we perhaps consider extending farther and getting one or two units into West Kent. I can see there is value in

collaborating in certain areas we are already doing that in human resources we already share our human resources department with a hospice in West Kent they use our skills and pay us a certain amount of money for that and you can see that might be sensible. Maybe we only need one HR Department for all the hospices in Kent maybe we only need one finance department, you know if you're paying people high skilled people a big salary then each little hospice doesn't want to have to do that so I see room for collaboration in finance and HR, perhaps in IT. Whether you merge your services clinically perhaps it's a different issue and you have to look at this things separately perhaps you can merge the business aspects of the organization possibly and keep the clinical separately I don't know but these are things for the future. But then you think… you know the reason I came to work here, is because we are well set up we have big capacity to take on more work already within our current workforce and with our current bed situation I think the other element that I am interested in is research in the sense that I think that any growth on clinical work needs to be based on research. How to do it properly, not just it could be a good idea to care for people with Parkinson's disease, but actually to find out what they need, and do our services feet and so on so. In a sense we need to manage the growth on our clinical services by being sure that it is based on research evidence.

IV: Now, I would like to move on a little bit on more specific things are related to your role and your team's role would you like to talk to me about these two things about yourself and your team within this hospice what are you doing are you getting involved in the process of target setting for the whole hospice is your staff getting involved in this process or your people are just focusing on day-to-day management of issues and things. I want a general description of your role and your team and how it's structured and managed.

IE: So I am the medical director, so I sit on the senior management team with Steve and Paula that you have already met, so I obviously have a strategic role in the organization to be thinking beyond the day-to-day management into broader issues. I have then a team of doctors working for me I have a consultant on each of the three sites and they are very senior people trained in this specialty and I would say that they all have to one degree or another probably a broader vision than most other employees. So they are people who are naturally interested in bigger questions about the direction of future services and modernizing our practice and so I'm well supported on that. Further down the hierarchy perhaps some of my doctors are more committed to day-to-day clinical practice but that's very appropriate to their role, because that's their job, it is to run the unit so there is a good mixture on the doctor team of people who have a broader vision and people who get on with the daily work. We certainly have a strong voice in the organization as doctors, they need us. So if I have an issue about something I would expect to be listened to, quiet

seriously if we had something we want, we think it's important, we are certain that people will take note of our views it will be significant.

IV: Would you like to describe a typical working day for yourself and your team speaking as a system?

IE: My day is…and the days of the consultants, the senior doctors, will be a mixture of clinical work so we all do clinical work, myself included, and that would be seeing patients in the ward, seeing patients in the hospital, because we all have jobs that are being linked into the acute hospital or see patients as out- patients or in the day hospice. So we or all are doing a good portion of clinical work and the administration that is associated with the clinical work and we might go in visit patients at home as well. And then we will all have administrative tasks and we will be representing our group in various subgroups in the organization to do with education, clinical governance, whatever, and we all have time for providing education which we have a set amount we have to do each year. I am teaching as well, I teach our junior doctors and I teach outside the organization, I teach in the university here so our job is very mixed, the doctors, we do lots of things more junior doctors do more predominantly clinical things, so the more senior doctors have this range of activities, more junior doctors will be predominantly doing more clinical work, that's why it's an interesting job because it has loads into it.

IV: Are you aware of the differences between, the way your team in this hospice works and the way similar teams are working in other hospices?

IE: No I mean according to my experience and meeting up with colleagues from other organizations I suspect the pattern is similar for doctors in hospices. Some hospices will obviously be much smaller organizations, will have fewer doctors, and they may not have as much time for some of the work outside clinical work, because clinical work in a way takes first priority because the patients are there you know we have to care for them. So smaller organizations may strangle a bit more with some of the other staff we have the time for the other staff.

IV: Are you using any method to measure the performance of your team and if yes would you like to describe it to me?

IE: Well we have simple clinical data collection so numbers so we know how many patients are coming in to the service how many patients coming into the units how many of those go home how many die so we've got a lot of data basic activity data really. We have quite a well-developed audit program in the organization so that's the type of clinical data

we are collecting. We've got a program of audit running in the organization so various topics will be picked up specifically for attention and then we will reflect on our practice in that area and see if there are any recommendations for change so this sort of things that might be audited …. There might be a range of things it might be our use of strong opioids medicines, it might be mattresses, are the mattresses in need of repair, it might be organizational issues... All sorts of things we would audit if we had areas we wanted to investigate more deeply. In terms of clinical evaluation we don't routinely use any tool which looks at the patients and how successful we are in improving their situations, obviously we are doing that as part of our work every day, but we don't have a formal assessment tool for that.

IV: In terms of individual doctor?

IE: No we don't keep information like that not formally.

IV: So there is no system for quashing, this area.

IE: So I wouldn't be able to say Dr X, exactly what they are doing each week no.

IV: What you think that is the main challenges when somebody is trying to measure the productivity of a doctor within palliative care?

IE: The first problem is going to be the perceived threat that this person thinks you are on their case you know. The second thing would be there are so many issues to do with courtesy witnesses difficult to measure so if you're looking at an orthopedics' surgeon you can count how many patients does he see in outpatients how many operations did you do in how many of these operations did the patient get an infection I mean these are easy things to count aren't they. It's more difficult to count here for instance of the outcome is not when the patient dies so in some ways that's not very positive. We have very good satisfaction data, having said that we do do annual satisfaction surveys and that's always very high and we have loads of positive feedback so satisfaction is high. I'm not really answering your question am I? The barriers to monitoring the activity of a particular doctor…. I mean you could do it… you could monitor how many out patients see, how many in patients they meet, how many patients are still on the ward around you could do accounting game but to assess the quality of what they are doing that is more complicated particularly because there is not one person determining the outcome for the patient. The care we give here is very multi-professional so loads of different people feeding in doctors, nurses counselor, chaplain etc. So even if you good menstrual the improvement of the patient you wouldn't be

able to say who is responsible for that because it's a team effort. That's an interesting question.

IV: So you would think that it's not just doctors that are getting involved it's better to consider something on the broader level with in the hospice.

IE: Yes it's very much holistic care so you need to look at quality across a range of measures including psychological issues, communication, anxiety, as well as perhaps physical symptoms.

IV: Would you like to add any other specific topics one should take into account whilst trying to measure the performance of teams similar to your words and the performance of hospice personnel in general?

IE: No, I mean I think you can do a counting exercise that's one element of it, it is the number of patients at different settings that has been dealt with there are various tools to look at… to assess the quality of symptom management. There are tools that exist and then you can take a snapshot of that one time point and then you get a snapshot of another time point as it improved. But you have to remember that in the meantime the patient might well have an illness which is in fact getting worst. So these measures although of some use are not straightforward. You can demonstrate that palliative care input does improve people's symptoms, but as I said it's not as easy as in other clinical areas it might be.

IV: Would you say that it would be a lot better to measure individual productivity on a longer period of time … like in a corporate environment it might be broken down in an hour - you should be able to produce this much within one hour or within one day. Your view looks like a day wouldn't be enough it could well be that we need to measure it on a weekly or two weeks basis and make the averages in order to see that … okay this specific doctor is always above the average whilst the specific doctor is always below the average.

IE: True, yes any system that you could have, should have that time element in it.

IV: The last question of this section is … do you believe that your team is, or could be, involved in the process of creating financial value for the hospice and if yes how?

IE: I'm not sure I know what that means, creating financial value … I mean…hmm.

IV: This could be related with income coming through patients or income being saved through more efficient use of resources or anything else that you could possibly suggest.

IE: Yeah, I mean I think we are implicit in donations from patients is the fact that there are specialist doctors here giving high quality service so that could be part of the reason for income generation that people give donations and legacies. But you wouldn't be able to separate out the doctor bit of that but nevertheless it would be a component of that. In terms of efficiency as I have indicated before I think we could be more efficient. Most of the doctors who work here choose to work here because they like to involve themselves with patients and families and they like to have time to do their job to a good standard, and that's good that's we want. But yes my feeling is that we could be more efficient with the time we've got, the doctors could process more patients in the time available. They are not wasting time but it could be more… tight.

IV: Thanks … and what about the admissions of hospices that you would get an income coming for specific admonitions of patients.

IE: Yes, if we had income tightened to the number of admissions, well that would obviously sharpen us up a bit, wouldn't it, and then we would have an incentive to get more patients in. But we do try to use our resources to the best of our ability anyway, I mean because we have a duty to do that anyway, even if it's not the case that an admission comes with a tariff still people are giving us money to care for patients we should care for as many as we can.

IV: Do you find that your team is getting involved with these two specific areas, income inflow or income saving?

IE: They are getting involved with income inflow but just by verge of what they do so they are not going out raising money it is just through the service they give. In terms of outflow I guess I am the one in the team who cares about that rather than most of the other doctors.

IV: The next topic is inter-professional relationships, your team with other teams. You already told me that your team-members are working in cooperation with members from other teams within the hospice. Do you believe that they like it to be like that, or you believe that they would be in favor of working on more independent basis?

IE: Okay that's interesting; actually I'm in theory responsible for all the other clinicians in the organization so all the once that are not nurses I am responsible for so counselors chaplains etc and I would say that for the most part the doctors are very committed to multi-professional working again that's why they choose to come and work in this environment if they didn't like multi-professional working then they would be mad to come and work here

because that's so marks part of what we do. Part of it depends on individual relationships of course do I like this person who is also social worker let's say but I think all our doctors have a great deal of respect for other professions. They can see the benefits of that style of working for the patients, if you work in that collaborative way with other disciplines you get a better quality of care for patients and their families and doctors sign up for that.

IV: Do you think that, you already said that basically, the voluntary nature and care orientation of the hospice movement is assisting in decreasing the obstacles in the areas that different professions are interacting or cooperating?

IE: It's not without its difficulties but the principle I think is agreed as we need to work in a multi-professional way.

IV: What would you consider the main difficulties from a doctor's point of view?

IE: At working in a team like that, well doctors tend to like to be in charge so they might want to work with the team provided that the team makes the same decision that they would make. They don't like it if it goes another way. They tend to be a bit controlling, that's sort of our professional training I think, so we probably have to fight against that a bit, that's one problem. Another problem is obviously you when you have a weak member of the team; I mean that's always difficult or someone you are finding it difficult to get on with, that's just human beings you know normal staff so I guess those are the sorts of problems yeah.

IV: Going back to the recruitment are there any specific policies that you are applying any criteria that you are setting for hiring somebody in this hospice?

IE: Yes for our doctors yes, depending on particular posts there are all sorts of different grades for doctors. We have very specific criteria for each grade so for senior doctors, consultants, they have to be have to complete specific training in this area. For the next tier of doctors we would also expect them to have a lot of experience in this specialist area. Then for some of the junior doctors obviously they won't have experience and some will be here to obviously learn the specialty, to be trained. So depends on the level of doctor we have specific criteria for each level.

IV: How often these criteria get reviewed or updated?

IE: Each time a post becomes vacant don't forget we are only 15 doctors in the organization permanently. It's not common for a post to become vacant I mean the other thing about hospices is that they have a very stable workforce we do any work. So every time a post becomes vacant I will be reviewing the criteria and also I will be talking with

colleagues from the NHS to make sure that we remain on the level with other doctors at the NHS that we require the same sort of standards.

IV: Do you think that the fact that your doctor your profession is allowing you more flexibility in choosing people?

IE: No, probably less, well I don't know I can't comment on nursing. The criteria for its grade of doctor are quite specific.

IV: So up to certain level you know what you're looking for it's not something that you need to think about it and design a strategic model for recruiting the right people it's people with skills that we want to find and get them in.

IE: Depending on which grade you're trying to fill a gap, the structure is quite clear yes.

IV: Do you think that the employment market is competitive and whom would you consider their main competitor or for hospices in general and this hospice in specific?

IE: For doctors it's quite difficult to recruit good doctors in palliative medicine there is a shortage of people with sufficient training so the fact that we have a full team all my posts are filled that is because we are a good organization. So many hospices around the country will not be able to fill their post with suitably trained people so we are very lucky to have that. Our main competitors will be, well for senior posts it will be nationally people will decide where do I want to live where do I want to work, so we are competing in a national arena for consultants. For more junior people, we are looking for a group of people who live more locally and then it will be difficult to find people with the right skills. So if one of my good senior but not consultant doctors leaves then that will be a very difficult person to replace.

IV: So this is not because of competition in the market it's the specific skills that you are missing.

IE: They don't exist … there is a lack of people who got the training.

IV: Okay now we are going to the final part of it I would like to ask you for some feedback first of all did you enjoy the conversation we had and then we would you like indicate three strong and three weak points of the whole process?

IE: Yeah I mean it's fine, it's interesting, I mean I talk a lot about this thing because I have a strategic responsibility I think about and I talk about this sort of thing quite a lot so that's fine and as you can tell I can talk a lot. I think yeah I'm not totally clear on what you

want to get out of the interview so whether you asked the right questions or not it is hard for me to say. Some of them I suppose, I think, if I knew about the questions beforehand I might he have been more useful to you but on the other hand as I said because I thinking at this level most of the time I don't think I missed out something too important hopefully not. I don't think I'd have any other comments about the interview it has been fine.

IV: Thank you very much, is there any possible improvements that you would like to suggest on the approach or the content of the interview?

IE: I think it would be whether you feel it would be worthwhile to get the people know the questions ahead of time you know you may not want to do that whether you want someone to have thought out their answers or whether you are more interested in the intermediate response. But some of the questions you are asking about future challenges to the area, to the specialty, they are quite big questions, there is lots of stuff in there and if some has the chance to thing about them beforehand they could bring out more things perhaps.

IV: What I'm afraid with this specific kind of questions is that if I will give you time and give time to people of similar level to yours most of you will do the same kind of research and most of you will come up with this same type of answers, whilst what I want to do in the end is assess each individual's awareness on these issues.

IE: I see, I understand, so that's valid then the approach you take is absolutely right in that case.

IV: And one last question would you be willing to participate in a similar interview in the future maybe not with exactly the same questions but with things that might come up by then.

IE: Yes I'm quite happy to do that, I think, I mean, the overall project will be valuable, I mean the results you will get so yes I will be happy to be part of it in the future.

IV: Thank you very much for that.

Interview with the Medical Director of Hospice B:

Speaker key

IV: Interviewer

IE: Interviewee

IV: Before we will start with the interview itself, I will have to let you know about the ethics and confidentiality policy of the University. You can be assured that any kind of information you will provide within the interview is going to be kept confidential, whichever information out of it we publish is not going to carry your name or the name of the institution you are working for. If at any time you find out that you don't feel comfortable answering a particular question you can just say that you don't want to answer this question, or if you feel at some point that you want to interrupt or stop the interview process, you can just feel free and ask for that. Are you ready to start?

IE: I'm ready to start. I am.

IV: [Overtalking], yes, that's great. Would you like to tell me a few things about your background and your involvement with the hospice movement? I would be looking mainly in how long you have been with the hospice movement in general, and then what motivated you to join the hospice movement?

IE: Okay. I've been working at Hospice B for five years now, as a consultant, and over the last 11 months I think it is I've been the medical director. I started off, I trained as a chest and a general physician. I was a consultant for 11 years, but became increasingly disillusioned with what you could do for patients, not being able to solve their problems, because of having to get them out of hospital. And I'd always been interested in palliative care, there's quite a lot of it in respiratory medicine. And so after a lot of organisation, it took quite a while, I changed to being a palliative care consultant.

IV: That's interesting. Any particular thing that made you feel like getting into hospices? Was it something that you wanted to do, or it was just a career change at some point of your life?

IE: It was actually something I wanted to do. When I was a medical student I spent a month working at St. Christopher's Hospice, because at that stage I felt that I wasn't sure

how I was going to speak to people who were dying in my everyday work, and I had decided at that stage that at some point in my career I would like to spend a few years working in a hospice.

And in those days it was very easy to make the change. A lot of hospices that was how they got their medical staff. That people at the end of their hospital careers changed. Then all the organisation of medical training changed, and it became much more difficult, but it was really coming full circle to what I'd always intended to do.

IV: That's interesting. You've done quite some time with the movement now, have you noticed any changes in the ideals, the orientation of people within the movement? Do you think it is becoming a little bit more professional compared to what it used to be, and how do you think this affects people's attitudes?

IE: I think it's having to become… I won't say more professional, I'd probably say more institutionalised, and NHS-ised. Not that there's such a word. Because as the government pays more interest, more attention to end-of-life things, so it's looking to organise the whole of the NHS, it's delivery of end-of-life, and we get caught up in that. And I don't think that's… it has some good features, but actually I think it's something that I'm very suspicious of, having worked so many years entirely in the NHS, I have a fairly low opinion of what happens when the NHS gets hold of something, because it has to meet financial targets, and it dumbs down what services are on offer.

And I think the hospice has to get involved, but I think it's very difficult to keep far enough away that we don't get dumbed down, that we don't get pulled down in the, in the meantime.

IV: That's interesting. What about people that are joining the hospice movement nowadays, are you getting people with a professional attitude, a career-oriented approach to things, or are you still get people who really want to devote themselves in palliative care? Do you think that people's motives nowadays are similar to what they used to be at the time that you joined the hospice movement?

IE: Okay. I think a mixture of that. I think a lot of people do feel very motivated to do hospice work in particular, because there are other ways of earning a living, in medicine or nursing or whatever. I think one of the things, certainly in medicine, is junior doctors are now… there are more opportunities than there used to be, to, on their rotations, they all have to be part of a medical rotation if you're just qualifying, or if you're a specialist registrar.

By the time you get to be a specialist registrar, you've actually chosen to do palliative medicine, but in… lower down than that, you may find yourself doing four months palliative medicine that you didn't necessarily chose to do, but you wanted to do the other things that were in that leg of the rotation. So I think we do see people coming through medicine who are not as motivated. And I still… I'm not convinced that it's necessarily a good thing to do palliative medicine unless you've knocked around a bit, and got a bit older, and had a bit more life experience. So they do sometimes feel very young and naïve, about life in general.

IV: I think even some [overtalking]. If we were to shift a little bit, our conversation, while still related to staffing issues, but make it a little bit broader. What is the main challenges that you expect hospice movement to deal with in the near future? Or it is dealing with right now?

IE: Okay.

IV: Both at the sectors level, whole hospice movement, and maybe at the hospice level. Both external and internal.

IE: Okay. Seeing we're talking about staffing, I mean, great plans, the end-of-life care strategy, lots of good stuff in it. But they've starved the people to do it at a general level, let alone at the specialist level. Obviously here we're looking to provide specialist palliative care, and people are being send on courses left, right and centre, so that's time away from seeing patients and such like. We're starting to see waiting lists filled up for patients being seen in… by the community team. We usually have some sort of a waiting list for in-patient care, and part of that's the number of beds, but that's also partly related by the number of staff there are to man the beds or to admit the patients.

And I think people may spend a period of time in palliative care, either on a nursing or a medical front, but there is a small, much smaller pool of people who are… who have the aptitude to do it longer term. And so I think the big challenge is going to be the staffing over the next few years.

IV: That's interesting. What about funding, and what about the demand for specialist palliative care services? Can you see those two things conflicting with each other?

IE: Yes. I think at the moment we're quite lucky here, because about a third of our funding is NHS. Other places don't have such a big proportion, and I think what PCTs are looking for, because they're getting directives from above, value for money, and what costs in palliative care is maintaining a big nursing to patient ratio. The more the NHS funds you, the more they expect from you, but at the same time, they actually want it dirt cheap. So

what the PCT would like is to have most palliative care delivered by generalists so that… from primary care, and actually much of it can be delivered from primary care, but the specialist units have to have a certain lower level of funding to enable them to provide the services that they do.

IV: Do you see patient numbers increasing in the future?

IE: Yes.

IV: Or…?

IE: Yes. And we're told -- and I believe it -- that we… the number of elderly are going to increase dramatically. We're looking at doing non-malignant work, so that's putting a huge increase, that's, you know, doubling potentially the amount of patients that there are going to be, although I'm not convinced whether hospices should be prime movers in non-malignant palliative care, or whether they should just be advisory.

But yes, patient numbers are going to go up. And there ain't going to be the people to look after them. They want to be looked after at home, which is absolutely fine, and actually, on the radio this morning they were saying, you know, it's cheaper to have them at home. Well, it may or may not be cheaper to have them at home by the time you get 24 hour care at home.

IV: How do you think hospices should respond to these challenges? Hospices are adequately equipped in terms of management expertise and perhaps lobbying expertise, if we can use this word?

IE: Okay. Loving as in how we approach patients?

IV: I mean lobbying.

IE: Oh lobbying? Right. I'm with you. Okay. The answer to that is there's some very capable people in the hospice movement, but I don't think they are going to find it very easy trying to negotiate with PCTs, commissioners, anything in the NHS, who… a lot of them play hardball, and they have, of necessity, learned to be quite ruthless in what they can afford, and so any sentiment that gets attached to palliative care, which is a big motivator for everybody, I think, within the hospice movement, of providing quality, commissioners just will say, well, we can't afford it. You know, you provide it if you want it, but we're not paying for it. So I think we've got a lot of catching up to do in management and negotiating, I suspect.

IV: I see. Let's pull things a little bit more into your own, your own thing now. Would you like to tell me if you think about what you're doing, what is your team or teams doing in Hospice B?

IE: Okay. Well, it depends at what level you're looking at, what grade of doctor you're looking at, because the consultants and, we have one associate specialist, who… a big proportion of our job is actually outside the hospice, working in the hospitals, but we still come with the Hospice B name attached, so in one sense it's flying the flag.

Within the hospital, and in the hospice, basically there are junior doctors, there's a very junior doctor, an FY2, who's in their second year after qualifying. There is between one and three specialist registrars who have chosen to specialise in palliative care, and they are… they come attached to the various consultants here to learn, but they may well be in any of the departments. Then we have a volunteer retired GP who works on the in-patient unit. We have two GPs who come in and provide sessions, one session and a two sessions a week, and then we have two GPs who work in the day hospice.

So a lot, a lot of different backgrounds and skills and levels of experience, both of life, medicine and palliative care in particular. So what we do, basically, one of our main this is look after the patients on the in-patient unit. And then we also support and provide advice to the community team, so our equivalent, they've got their own nurses. The day hospice, lymphoedema, although they're very self-sufficient, so we have very little input in there. And basically, Uncle Tom Cobley and all. A big, as I say, a big part of our thing is also providing support to hospitals.

IV: All right. So you, are you personally or your team getting involved in the process of long term management or long term targets, I think, or you set the targets, set the targets or… what are we going to be doing with things next month, year, five years? At Hospice B, how is the decisions made? Do you have an input there? And then does your team have an input on what you will transfer, or it's the other way around? Is it somebody coming and saying to you things? And you spread the word to your team? How it goes?

IE: In fact, we… I think probably about two, three weeks ago, had a… the whole organisation, an away time, where we were looking at the next, you know, five to ten years worth of strategy. And I was there, one of the other consultants was there, so the senior, more senior people get invited to come and put in their sixpence, and for those that weren't

there at a senior level, then that's been fed back to them, the sort of things that we were talking about.

And there's no doubt, from my mind, actually part of my role is that if people have got ideas then I will feed that into senior management team. On the whole, the most junior doctor, the FY2, will comment on a day to day basis, what's happening, but isn't really in the situation where they're thinking strategy. The SPRs are supposed to be learning about management, but it's very much a theoretical thing, like have them sit in at meetings, so on the whole I don't think they… they may have some ideas, but they're not really thinking way ahead.

They see some of the problems, some of them, which is good. And you can talk to them about what they think might be solutions. So it's really the more senior people, and I guess it's the medical directors, a big part of the medical director role to think what are we doing in the future.

IV: Sounds interesting. If I am, can reckon your words correctly, then it is like a particular level, it is a contribution, there is an involvement, and when it comes to people below you, then this, the process work, you will be assigning to them what to do.

IE: Largely. And it's… I mean, it's not just people at my level passing things up, because the bottom line is we are employed by the hospice, and there is room for consensus decision making about strategy, but there will come a point when we are told this is what we're going to do, and as employees of the hospice we have to do that. You know, you may or may not agree with it, but that's part of employed, isn't it?

IV: Are you… of any differences between your team in Hospice B is working and teams in other hospices are working? Are you more or less doing exactly the same thing as other hospices do, or different?

IE: Yes, more or less. I mean, there's… you work in different areas, and so your population may be different, the needs may be different. There may be differences in ethnic make-up, and therefore that brings its own differences and challenges. But on the whole, you're basically doing the same sort of stuff.

IV: Yes. The question is looking for the way you're structuring things.

IE: Okay.

IV: Do you think there is a similar approach among all hospices or there are differences there?

IE: There are differences, because there are some hospices that don't actually have consultants, and therefore that makes a bit of difference on how they function. If they're functioning on GP input and such like, they're not functioning at a specialist level, they're not training doctors in the same way because you have to be a consultant to have specialist registrars, and… so there are differences at that level.

I guess we're all facing the same problems, strategically. How to get enough money to provide the services we think we ought to. Or we would like to.

IV: How do you manage performance?

IE: Are we measuring performance? I guess -- do you mean within the medical team?

IV: Yes.

IE: We're probably not measuring it that much. There's the day to day seeing what people go, how they perform. There are, I suppose there's… we have an appraisal system working, so that the consultants and the GPs have an annual appraisal, which is done in-house by a mixture of me and one of the other consultants. And the junior doctors, the specialist registrars have their goals that are set, educational goals basically, and are not appraised in the sense of, you know, how many patients have they seen. We don't do that. They keep records of it for their education stuff. And then the FY2 gets educational supervision, but, again, there aren't numbers kept, or anything like that.

IV: Having problems in terms of the process of measuring performance in your profession?

IE: There's always… well, how do you measure quality? Because what we're really interested in… people measure numbers, and, you know, here are you in this we're sitting in, there's a lot we've… collecting, looking at statistics and bits and pieces happening in this office. So you could measure numbers like that, but do we measure quality? We have, you know, satisfaction surveys and all that sort of stuff we've put in place, but in terms of measuring do we give a good service, that's really the only way that we do it, and I actually think it's quite good, well, it's the bottom line. There you go. It's very different to the NHS though.

IV: Are you working with people from other teams, and are your team members working with other professionals

IE: Within the hospice?

IV: And you can talk, yes.

IE: All the time. Because we meet at the common point, which is the patient or the family, so we do quite a lot. All the time we're working with the nurses, whether it's on in-patient unit or the community team or in day hospice.

IV: How is the relationship there?

IE: On the whole, actually, we do work together very well. I think most of the people who come into palliative care are not big egos, otherwise they'd be in something more glamorous. So on the whole, everybody is very well motivated. They're supportive. There are days when you have spats, you know, and you disagree over how you manage something, or emotions are running high because you've got a difficult patient, and that spills over and people have spats, but we work pretty well together, actually.

IV: That's good. Would you like to tell me a few things about your recruitment policies, and your criteria for hiring new members on your team?

IE: Okay. New members as in new positions, or actually replacing people?

IV: Both.

IE: Okay. We have… in terms of replacing people, we have… I think it's standard how you recruit FY2s and specialist registrars. And specialist registrars actually get allocated to us. We take part in their selection, and there's the interview, we're always doing interviews. Ditto the FY2s, but that's all organised via Queens [?] because they're on a rotation from there. Higher up, the GPs -- we'd love to recruit some GPs at the moment. Not many people want to do it. Basically, some of that is knowing someone who would be interested, and then doing some sort of interviewing process to check that they're the right… got the right attitudes and such like.

At consultant level, we're in the process of doing that at the moment, a replacement, where you have to comply with certain regulations from the College of Physicians, and then obviously employment law for… interviewing and appointing. In terms of new posts, that depends on being a need that is acknowledged by the organisation, which is largely run through the Chief Executives. But also there being funding for that, and so that's partly why we have posts, or it makes it easier having posts between hospitals and the hospice, because they pay for the sessions that they have, and therefore that means that the hospice gets concessions that it really needs, without having to commit a whole time person or, you know, part time person.

IV: Do you think that the market for the skills that you are looking is competitive, or it is easy to find what you need to find?

IE: It isn't easy to find what we need to find. I'm not sure that that's necessarily because -- I think it's just there aren't that many people out there who are… have the aptitude and are either trained or are prepared to have some training. So I think that's quite tricky.

IV: So there is not kind of people being there and having being able…

IV: There's not another organisation in the area that's… like would be able to choose and the criteria would be who's going to pay me better, where am I going to get better working conditions?

IE: The competition isn't that big. There are… nationally there are over 100 consultant posts that are unfilled in palliative care. It's that there aren't the people. If you want to stay within the particular area, then there maybe a bit of competition. We're about, in the West Midlands, to see, I think, it's either four or six new consultant posts advertised in 2008/2009. So yes, there will be some competition for the specialist registrars that are finishing and ready to be consultants at that stage. But in terms of the person coming in for the post, well, they can do very well, thank you. But we're wonderful to come and work for.

IV: That's good. I'm going to ask you some things about the whole process, the interview process. Have you enjoyed the conversation we've had? Is there anything you would like to add, any strong, weak points, what we have missed?

IE: No, I'm happy to wrap it for England. I've had a very nice half hour. I will pontificate as much as you like, there's nothing particularly I think that I need to add.

IV: Let's make it a little bit for difficult for you. Is there anything that you feel we didn't cover in adequate depth?

IE: Not particularly, no. I think that what I was expecting to… no, I'm very happy.

IV: And any improvements that you would like to suggest?

IE: To the interview?

IV: Yes.

IE: No.

IV: To the contents?

IE: No, it's absolutely fine. I think the only thing I would say is for someone who's very clinically focused, discussing… well, no, I suppose… discussing the strategy is quite interesting, but it's something that I'm learning to get to grips with. Having only been in the post, the medical director post for under a year.

IV: It see what you mean.

IE: If you'd talked to the previous incumbent, she probably would have been very, very… lots of interesting ideas, I'm sure.

IV: Would you like to participate in a similar interview in the future?

IE: I could do that.

IV: Let's see… is it possible to give me your email address.

Interview with the Medical Director of Hospice C:

Speaker key

IV: Interviewer

IE: Interviewee

IV: Before we will start with the interview itself, I will have to let you know about the ethics and confidentiality policy of the University. You can be assured that any kind of information you will provide within the interview is going to be kept confidential, whichever information out of it we publish is not going to carry your name or the name of the institution you are working for. If at any time you find out that you don't feel comfortable answering a particular question you can just say that you don't want to answer this question, or if you feel at some point that you want to interrupt or stop the interview process, you can just feel free and ask for that. Would you like to tell me a few things about your background, and your involvement with the hospice movement?

IE: Yes, sure. I've been qualified for… it'll be 20 years next year, as a doctor. I was doing general practice in my general medical training for the first sort of eight years of that, eight, nine years of that. And then I've been involved in the hospice for about, just over ten, nearly 11 years now. I was a GP in a local nearby town for about three years, and when I was, while I was doing that I enjoyed the palliative care aspects of my job, and wanted to move into palliative care. So I applied for a job here and got the job. Ten years ago. I've been here since.

IV: So it looks like you're one of the oldest members of staff here?

IE: Yes. Oldest in many… more ways than one.

IV: Yes, yes. So 11 years with the hospice. You must have seen many things. What was the main motives of people to join hospice movement at that time?

IE: For me or for everybody?

IV: We can start with you, then generalise.

IE: I guess personally I just enjoyed… I took a lot of… a lot from and got a lot of sort of positive comments when looking after people who are dying of cancer and long term

illnesses, and found it very rewarding, when I was a GP. But I had limits to my knowledge, and limits to how much I could do, and I wanted to do more, really. So that was how it started for me. I think probably hospice, for other people, I think it, I think sometimes it seems people think it's just about sitting and looking after people and, you know, comforting people, and you don't realise how… how it's changed and how it's eventuated, but going back sort of ten, 12 years, people, okay, maybe with the same intentions I did, people had an interest in it, but wanted to further themselves and improve their knowledge and I think that's what drew people into it.

IV: Can you see any notion of volunteerism, ten years ago? And wanted to contribute mainly rather than acting as professionals.

IE: I think so, I think there was a lot more -- people wanted to, sort of, yes, just look after people and help. Yes, yes. But I think now it's… it's kind of changed a bit now. It's a bit more… more professional and more structured. But yes, probably, yes.

IV: Do you think that the hospice sector, the hospice movement, is entering a maturity state?

IE: Has it reached a maturity stage?

IV: Saying maturity we mean it started with loads of enthusiasm, collected loads of happy to help people, but not necessarily having the professional skills required to get the job done. And nowadays, can you say that it's growing big enough to attract people of a different type, like…

IE: I think… yes, I think so, yes. I think it's still changing a lot, it's evolving and still, and… and got new challenges now, compared to the challenges when I started in the hospice. Especially with the, sort of, challenge of, well, funding I guess as well, and treatments are more expensive, and staff are more expensive, and the building's more expensive. But also the actual people who look after, the patients we look after, and the diseases we look after are different, and with more challenges and not just traditional cancer. It's more non-malignant diseases as well, which is a big change.

So yes, I think it's more, it's seen in a better light now. Because, I mean, palliative medicine's only been a speciality for 1987 till now, so it's not very long, in terms of medicine. I think in the nursing… nursing-wise it's becoming more of a specialism, more accepted specialism, rather than just a… somewhere where people go just to see some years out.

IV: That looks interesting. And as we start thinking about challenges, if you had to summarise the challenges that the hospice movement is facing now, and is going to be facing in five years time from now, how would you summarise them?

IE: Challenges now, I think, the big challenge now is to be involved with the end-of-life care strategy, and to… to get that up and running working better in the community and in the hospitals. And I guess also trying to… trying to get across our message to the other professionals not involved in the hospice movement to refer people with other diseases, so to encourage more people with heart failure, and COPD, and other lung diseases, or kidney failure, or whatever it may be, getting those people to refer people and to give them more guidance.

In five years time I guess it'll probably be similar, really. I think the challenges will remain the same. Still trying to get people to refer people earlier rather than later, and trying to get them to see the hospice and the palliative care as running alongside the normal acute hospital care and GP care, not being a sort of either/or but running in association with, and running parallel. But people can dip in and dip out from the palliative care opinions, don't have to take over the entire care of the patient, we can actually just give advice and then be used again at a later date. So trying to, yes, work better with our consultant colleagues.

IV: What about the demand for palliative care services? Can you see it increasing up to a level that the current establishment is not going to be adequately [overtalking].

IE: I think so, eventually. Yes. I think so. I mean, what we've done here, obviously, we're just in the middle of building a new out-patient block, and we're going, we're increasing by one extra bed. But I guess one of the concerns is yes, if you are opening up the services and including other people to refer, that you may be inundated with referrals, and that was always the worry about opening up to non-malignant disease a few years ago, but in reality it doesn't seem to have occurred.

I guess too that the flipside of that is if you can up-skill the general physician, and general GPs and the generalists with more knowledge, then they can look after more of the generic general palliative care issues, and leave us for the more specialist issues. But it is a worry, it is a worry, yes, that we've only got a finite number of beds, and there may be… demand may outweigh supply.

IV: How do you think this… the challenges reflect on this hospice in particular?

IE: The excellence?

IV: These challenges, the challenges we mentioned.

IE: Oh, the challenges.

IV: Of the hospice movement. How can you see them reflecting in this hospice? Is it… what I mean by that … there are hospices where in it may be that, even though the rest of the country is facing financial difficulties, financial constraints, they still can be creating income to renew these assets, architect, structured [inaudible] because they don't really see it as a challenge as they don't have the money to deal with it.

IE: Yes.

IV: What about this hospice?

IE: I think it will be a challenge, because we're not in a particularly financially wealthy area, I mean, within XXX's and XXX. It's a relatively poor area, with a lot of, a lot of disease, so I think it will be a challenge. A lot of the money that paid for our new block has come from a government grant, over £50 million from the year before. We've had contribute sort of 400,000 on top of that, so we're getting… with the financial situation globally, a lot of our assets will have reduced. So the challenges are there, and… but I think we've got a very… a very astute Chief Executive financially, who has a financial background, so personally, I think, you know, with the expansions in the fundraising department, and more push that way, I think we'll be okay financially, but I think it is a worry, yes. But I've got confidence in our Chief Executive.

IV: You'll have to excuse me, if we bring the conversation back to the hospice movement in general now. If you had to make suggestions about how the hospice sector should respond to these challenges, what kind of suggestions would you make?

IE: Financial challenges?

IV: Well, financial challenges, disease challenges, treatment challenges. Everything that we mentioned earlier on. We have taken… opened up to new kinds of disease, new kinds of diseases, we have an aging population, which means that the demand will go higher, how do you think things should be coordinated amongst the different [overtalking].

IE: Yes, yes. Just… putting pressure on the PCTs and the government to fund us better. I mean, we get about a third of our… a third of our funding from the PCTs, as you're probably aware, but I mean they're expecting us, want us to do more and more with that amount of money, so I think more money and more grants and… the lottery could help us more, if we could get any help from the lottery.

Yes, I think that's where the pressure's got to go, into trying to get us more money from the PCTs.

IV: Can you see the hospice movement being in the position of doing something like that?

IE: I think so, yes. I think there's…

IV: Do they have coordination there?

IE: In theory, yes. I mean, it probably isn't there in practice at the moment. All the hospices seem to work fairly independently. But there is an association for chief executives of all the hospices, I know that, and I know our Chief Executive is in touch with the other chief executives from the other hospices. So in theory, there could be pressure put that way, but I guess everyone kind of… all the hospices want more money for themselves. That's a problem. But I guess in theory, but I'm not sure that's being coordinated at the moment.

IV: Let's bring things now to your own role, and the role of your team within the hospice. Would you like to tell me a few things about what you do, and what your team is doing?

IE: Sure, yes. At the moment I'm the acting medical director at Hospice C, so I'm the senior director. In the next few months that will change because there's going to be a new consultant starting here, but at the moment I'm heading the medical team and we've got a team of probably about six or eight doctors who work here through the week. We've got doctors who provide out of hours cover, we've got doctors who help me out on the ward, they are clinical assistants who are all very experienced GPs.

We've got a team of… a highly professional team of nurses, and we've got the full range of other professions including occupational therapy, physiotherapy and holistic and creative therapy. Social work access, we have got a social worker in the hospice. We've got a pastoral team headed by one of your local vicars. We've got pharmacy input. So we have a whole team of people, and I, I guess, from a medical point of view I'm responsible for the patients in the hospice, in the in-patient unit, in the out-patient clinic, and within day therapy, and so the three main services, out-patients, day therapy and in-patient unit.

IV: How do you manage all your team?

IE: How do I manage my team? I try and be… I try and encourage people, try and encourage people to be proactive, I try and give people a chance to develop and give them confidence to make decisions. Also while allowing them to come to me for further advice,

but I try and let people get on with it, really, as much as I can. Knowing that I'm there and available for further advice if needed.

Try and encourage people to do further education and courses, and improve their own educational skills, and trying… from the good team working and open to everybody in putting them… and I don't… I try not to lead, sort of, by top down, and telling people what to do. I try to encourage people to develop and to contribute and I listen to everybody's opinion. But obviously ultimately someone has to be responsible, and that… at the moment, that's me.

IV: That looks good. Is it you personally, or any members of your team, that are getting involved with target setting or strategy development for the hospice?

IE: Yes, yes. I think myself, the director for the hospice services, and the Chief Executive are involved in the strategy, in liaison with the PCT, and the various other palliative care network group meetings, and looking at a for the north-west, and for the local ICM. So yes, we're involved in that. But the, yes, mainly the three people I mentioned.

IV: Is there any kind of typical working day for your team?

IE: I guess if I'm… on the days I'm on the ward, which at the moment is most days, and yes, we… we meet, we have a meeting at 9 o'clock, a handover for the pass, we pass over information from the night before, or the weekend as it is today. Throw some ideas around about who… who's in, inform me about people who have died, we go through a list of referrals and organise admissions accordingly, and then the other calls that happened over the weekend from the community or the hospital, we go through those, and then pass those on to relevant organisations, or the hospital team, or community management team, and liaise directly with those teams about patients if we're worried about them.

If we've got a host of referrals we contact the referrers and try and get an update as to how the people are, and then within that day I go around and see all the patients, either with the nurses or without, depending on availability, and then feedback to the nurses. We have a handover again at about 2 o'clock when the early staff go off and the late staff come in. Go through the patients again, then I feedback formally as to what I've done in the morning, and then often there's another doctor around, and they might take over in the afternoon, and I might to out-patient clinic or go to multi-disciplinary team meeting, or whatever it may be. But that, that kind of thing. And then I'm around on the ward again near the end of the day to mop up any problems or issues.

IV: Well, that's looks interesting. Are you aware of the way similar things are working in different hospices? Are there any differences or any similarities between the way you are getting the job done here?

IE: I mean, it's hard to know. I mean, I did… when I first started, ten years ago, I did go around all the hospices and spent about two or three months going around visiting other places, and they were all… everyone seemed to do fairly much a similar thing. We were a bit unusual in that I'm on the ward a lot of the time and I'm the senior doctor. Most of the time the senior doctors involved in other things, and they have more junior doctors on the ward, so I guess we have that.

At the moment it's quite good, because I'm quite experienced to be on the ward all the time, so I guess that's good for the patients, but maybe not always the best use of my skills, and that's the way it is at the moment. But that may change in the future. But I think we do it a fairly standard way, fairly traditional model really. It seems to work for us.

IV: Are you using any method to measure the performance of your team?

IE: All team members have an IPR, an appraisal done annually, and appraisals within that 12 months. The medical have all, all but two have been appraised, and were appraised annually. So yes, that kind of thing, yes.

IV: Do you think that it easy to measure performance in a… on the whole, or do you have challenges there?

IE: I think it is challenging, it is a challenge to measure, and obviously we're measuring internally, so that always makes it a bit easier to run it, by yourself, inside. There's nobody from outside measuring us, apart from if you have an external appraisal, which we would do, but I think there are challenges within that, yes. It's just… we are kind of self-governing, in a way, aren't we? The Health Care Commission obviously appraise the hospice and are available, you know, they externally appraise us, and we meet all their criteria and conform to all their requirements. I guess that's… we do what we have to do.

IV: Do you believe that your team is doing it already or could be somehow involved in the process of creating financial value for the hospice? And if yes, how?

IE: Sorry, just say that again?

IV: Is your team already involved in creating financial value for the hospice?

IE: Right.

IV: Or if not, how do you think your team could be involved in creating financial value?

IE: In terms of the fundraising and things, you mean, or…?

IV: It could be both in terms of fundraising, it could be in terms of cost monitoring, it could be in ways that I cannot even think of.

IE: No, no, no. I think it's… I mean, the team… I think we get value for money from the team, but I think it's a very difficult job, you know, mentally, to work in this environment. We only have a few patients compared to the hospital, in terms of the number of beds, but obviously they're very complex patients with lots of complex family issues and complex patient issues. In terms of staff, financial value in terms of fund raising, I don't think that's part of their role, really.

But obviously I guess if you look after people well and patients are looked after well, then families tend to donate more money, so you could look at it from a financial point of view, which is not necessarily what we do as the health care professionals, but I know in terms of fundraising it's important, isn't it? You look after patients well, patients tend, or relatives then tend to want to raise money for the hospice. So, and then you get more legacies, and so on and so forth. So I think, yes, I think the staff contribute in that way very well.

IV: We will come back to this area. Are your team members working in cooperation with members of other teams, or they are primary working independently?

IE: We… we have a regular integrated, sort of, like, an interface meeting on a Tuesday afternoon between the hospital palliative care team and the community management and the nursing team and our team on a weekly basis, so we do do that regularly, yes. And we are in the area with them most days, probably, of out-patients. So we do work as an integrated… in an integrated fashion. I'm sure it could be more integrated, we've got three separate teams, who are all paid for differently, and, you know, there's no integration… like staff members don't move about between the teams, or they have in some units, people are interchangeable. We don't do that. But some of the integration is limited. But there is integration there, yes.

IV: Do you think members of your team like that, or would like more of that?

IE: I think so, yes. I think it's the way it is, because I guess we are, we're not NHS are we? I mean, non-NHS staff go working in the NHS, it's not… not that easy logistically to do it, but I guess there could be more integration between the hospital team and the community team, because they're both employed by the NHS, so… but again, people are

comfortable in the role they're in, and they don't always want to swap over into another team. For lots of different reasons.

IV: Are there any conflicts between your team members and members of other teams when they are working together, or are the voluntary nature of organisations helping for conflicts to be resolved?

IE: I don't think there's any major conflicts between the teams. I think the three teams generally work very well together. Maybe not, as I said, as integrated as they could be. But there's no major conflicts there. I mean, apart from the fact… everyone, yes, the teams, the two other teams, apart from us, are also very busy and very stretched. And yes, there… generally, no, I think the teams get on very well. I don't think there's any particular conflicts between the teams. I think there might be conflicts within each team.

But I haven't been working with the team, so I don't know, but I… I enjoy working… I did, a few years ago I did go work with the palliative care team one half day a week at the hospital. I really enjoyed that, and I think that built some bridges between the teams. And I got on very well with the staff in the team, and I think that's always a good thing. And I liaise with the nurses upstairs, I work fairly closely with them. They come down and ask for advice regularly, and again, without, you know, I have a lot of respect for them as well, so… I think things work pretty well.

IV: Bringing back the financial valuation, do you think that a better cooperation or… it seems with, I guess, with people from the fundraising department would help the members of your team to become more useful in this area, or you would be helping them in doing their work better if you were letting them know certain aspects of the type of job you are doing?

IE: I think, I think things have improved over the last few years. I think a few years ago we had… the head of fundraising wasn't particularly, didn't work particularly closely with the clinical teams at all. There was a hospice, and then there was fundraising, and they were quite separate. And I think over the last few years, I mean, we got a new head of fundraising, and I think that has, that has changed. And I think there is a good relationship between the clinical teams and the fundraising department.

So I think it has improved. I'm sure there's always room for improvement. The two teams are quite separate, but I guess they are quite separate teams, aren't they? And… but I think there's always room for improvement, but I think things have certainly changed a lot, for the better, over the last few years with the, you know, with the people who are now in post. There are sort of, they have meetings between fundraising and the clinical staff regularly. I

see the fundraising people in the managers meeting every couple of months, and we have… yes, we have quite a good rapport. So I think things have improved.

IV: That's very interesting. Thinking about recruitment now. Would you like to give me some information about recruitment policies that are in place with regards to hiring somebody for your team?

IE: For the medical team?

IV: Yes.

IE: Recruiting people is very hard. One of the problems we face on the medical side is that the pay that the hospice offers doesn't correspond to the NHS pay. And we can't compete with the NHS scales. So for example a GP could do a half-day at a surgery as a locum and make three, £400. If they work here they might make 100, £120. So financially we can't compete. So we have to recruit people when, if they're interested in working here they have to want to work here. They have to be interested in palliative care, and want to improve their knowledge, so they can then take it back to their practise, or they have to be very good people who want to do it and are not bothered about the money.

We do pay people obviously, but corresponding, you know, it doesn't correspond to how much they could earn as a GP. So that is a problem, and that's what we've faced from day one. And I say for myself, you know, if I was a GP, I'd probably make an extra 30% on top of… extra on my salary. But I don't work here primarily for the money, I work here because I enjoy the work and find it very rewarding.

But financially, obviously, at the end of the day, people want paying for what they do. So recruiting GPs to work here is very difficult, and has always been so. And I'm sure it will always continue to be difficult. So you have to wait for that person who says, oh, I quite fancy working at a hospice to ring us up and then getting them in. But it is, you know, obviously, as the years go by, there are less people, because I presume we've got most of the people who want to work here already. So then you're waiting for new GPs to come into the area who want to work here.

It's a sad reflection on general practise, I think, that we only have, in the whole of XXX's, there's sort of 70 GPs and we've only got two GPs in XXX's who work here. Which is, you know, they only work here part time, obviously, but it's a sad reflection on general practise that there are people here that don't want to help out. But that's, that's just the way it is. So recruitment is difficult. So probably it is [overtalking].

IV: Looking for specific skills when you are recruiting, and [overtalking] that it is difficult, so is it easier to recruit skills or develop skills?

IE: I think you'd be… you'd be looking to develop people, yes. Yes. I mean, the GPs are in… what we, I mean, what we do is if we're looking for someone, we would speak to all the local GP surgeries, send out fliers, maybe put something in the British Medical Journal, to recruit, to attract people, but we tend to send out fliers for GPs in XXX and XXX and then you get a couple of people ring, and then you don't hear anything back.

You wouldn't get people with the skills, unless you were very lucky and somebody just moved into the area who'd already worked in a hospice, so you'd be looking at, [unclear], developing people, and that's what we do. We take GPs who are just interested, and we, we train them up. We have them here for sort of four, five or six sessions which we pay for, to educate them, and to, to… yes, to improve them before they start. But it's an ongoing process, obviously, once they start here, because it's, you know, I mean, we're all learning as the years go by.

IV: Looks like the medical team in every single one of the hospices, with the exception of one hospice, all the rest of the hospices say they're going to have to update, they have the same problems as you have, yes.

IE: Yes.

IV: So the main competitor in your job market is the NHS? What about other charities around?

IE: Who compete with us? Or to get doctors? I mean, I… I think mainly it's just… I mean, most of our doctors who work here are GPs, so, you know, their GP locum rates are so high now that that's our main problem. I think if people do have spare sessions, and that, you know, the hospice, at the end of the day, only has a finite amount of money, so… but it is difficult. You do rely on those very motivated people who really want to do it, because they want to know about it. And unfortunately they are few and far between. I mean, it's better than it used to be, because I think a lot of doctors used to do it, but did it voluntarily. But nobody does that anymore, so I don't know, there might be some… I know a lot of doctors do it voluntarily. For no money at all, so… but that takes some doing.

IV: Let me ask you for some general feedback now. Did you enjoy the conversation, or are there any weak points or strong points or…?

IE: No, no. I think some of the… the financial value questions are a bit confusing, but we got there in the end. No, no, no. They're fine, yes. It's good.

IV: Would you like to suggest any areas of interest relevant to your profession that you feel were not covered in adequate depth?

IE: No, no.

IV: Any general improvements on the approach or the content of the interview?

IE: No, no, it's very… good questions, yes. Well asked.

IV: And would you like to participate in a similar interview in the future?

IE: Yes, no problem.

IV: That's wonderful. Thank you very much.

IE: That's okay. Yes.

IV: Thanks.

Interview with the Medical Director of Hospice D:

Speaker key

IV: Interviewer

IE: Interviewee

IV: Before we will start with the interview itself, I will have to let you know about the ethics and confidentiality policy of the University. You can be assured that any kind of information you will provide within the interview is going to be kept confidential, whichever information out of it we publish is not going to carry your name or the name of the institution you are working for. If at any time you find out that you don't feel comfortable answering a particular question you can just say that you don't want to answer this question, or if you feel at some point that you want to interrupt or stop the interview process, you can just feel free and ask for that. Do you feel comfortable to continue with the interview?

IE: Yes, that's fine.

IV: Thank you very much.

IE: I hope I can answer your questions because I'm not much into finance.

IV: It's general nature questions, so there will not be any issue with that. Would you like to tell me a few things about your background and your involvement with the hospice movement?

IE: Well, my background, I always worked medicine, general medicine and I trained there for years, I'm being a staff grade at, you know, like a senior level at general medicine and from my experience seeing patients over at A&E and hospital ward patients with cancer and I found that there is no privacy, there is not much support. These patients, due to the, you know, to the way they work in the hospital and the workload and so on, the doctors and the nurses and everything, I just felt sometimes sorry for these patients and I wanted to help them a bit more if I can. Well, the opportunity came when there was a job in the hospice and... for a locum and I just thought well, I'll [unclear] and see what happens. And from that day, you know, I feel... you know, I felt like I can help patients here more, I can give them more time, more support and I feel more satisfaction, you know, by working here than in the hospital. But my, you know, thoughts and my, I guess, about the hospice before I started

here, it was totally different from what I think now. I always thought that the hospice is a grim place where people go and die. I never thought of the psychological support or the other aspects, apart from people wanted to die somewhere and that's the hospice. Having come here and been involved much more deeply into that, I think I was very much wrong and I regretted I didn't know about the hospice and how they work before, like other issues, it's not just a dying place, it's a happy place.

IV: So that looks really good. How long have you been with the hospice movement in general?

IE: Four years now, about four and a half years.

IV: Four and a half years. Have you noticed any changes in the ideals and the orientation [?] of hospice movement during the period you are actively involved with it?

IE: Sorry, can I... can you repeat that?

IV: Have you noticed any changes in the ideals and the orientation of the hospice movement during the period you are actively involved with it? What I mean by that, when hospices started, it was a lot more a voluntary based movement. Now it looks as if they are moving towards more professional model. Have you noticed any changes like that during your involvement [overtalking]?

IE: Absolutely. I've just been here, as I said, about four years and in that four years, things moved a lot, you know. I started here within the hospice as volunteer and... or charitable, with very, very little support from the NHS or from the government in this area. However, I think that changes happen when you provide other things, for instance, when we started improving our self, providing more services, then I found out that we attracted more funding from the NHS and from the local PCTs and things to, you know, definitely. Now, now all our performance is recorded and, you know, documented and things so we can, you know, present it that we're doing stuff more than what we should do, and for that [?] that these patients deserve to be looked after better and get the money from somewhere else, just not charitable.

IV: That looks good. What do you think... what do you think motivated people to join hospice movement when you started? And once you will tell me that, do you think that these motives remain the same nowadays or you are finding differences in the motives of people to join hospice movement nowadays?

IE: I'm not very clear about your question again. In what... in what way do you want me to say that?

IV: You told me that the motives you had, what motivated you to work for the hospice was the fact that you were not feeling that comfortable with the kind of support hospitals were providing.

IE: Absolutely.

IV: So it was a lot more of an emotional choice, something voluntary. There might be a case that people nowadays are motivated by exactly the same emotions that you have been motivated, or there might be a case that people say [unclear] profession, it became a specialisation nowadays.

IE: Yes, I understand now. Yes, absolutely. I told you that, because I think, because coming from a background medicine which is the most, most [unclear] speciality, you know, in the hospital, working in A&E and the medical admission unit, I'd seen these patients and when they needed more support, it's not that we didn't like to support them, it was that it wasn't available for them. That's what really motivated me as a person, you know, looking at how... trying to help these patients, and I really tried in the hospital, I tried, you know, I probably was one of the doctors who used the Macmillan nurses, they knew me very well because I always contact them, trying to get help and advice for them to help these patients. Starting from A&E, don't wait for the patient to go to the wards and after a week or two then contacting them, so I'd start these patients, you know, these Macmillan services from the start. Definitely one of the things also urged me and made me make up my mind to join the hospice movement is... is palliative care is done not just on the sidelines, becoming speciality and it's becoming all evidence based and all, you know, in terms of guidelines and things, how to do... how to work, which is... which is... most of the doctors will need that in their practice, rather than just an open ended one, and that will make me more confident in joining it definitely. Other thing is that, you know, I sometimes felt ashamed of myself, looking at the people here and helping help the hospice and I never thought of giving a penny to the hospice. I gave to charities and I come from background of Iraq, and Iraq went through disasters and disasters and I help always, but coming here has just made me feel like how, you know, how generous these people are and how they help the hospice and they need... really, I do more things just, you know, trying to help in any way I can.

IV: Do you think that the fact that hospice movement is entering maturity now is changing people's attitudes and motives to assist or help or, or to volunteer and how does this maturity of the sector affect people's approach to hospice movement?

IE: Definitely. I can... I can tell, you know, from my experience as a doctor and talking to patients, I think, yes, we have moved so, so far away, you know, we're better now, we think we're better now but unfortunately our patients and the people, the lay people, they don't understand that, and all of them thinks we take here is the patient come with the name hospice and they think that's coming here to die and that's it, not going anywhere, and I think education is missing there, educating the people on how fast we're moving. I think we're doing things faster than what the public knows and all come from really education and information, and I think we're lacking that, you know. We are not very clear to the public on where we are now and in our site, in our hospice, we try and go fast through day care to going to fund raising to, you know, to involve even local and I'm involving GPs and things of what we are about and how people can use our services when they're not dying or... you know, so a hospice is not just for dying people, a hospice is for people who are just in the start of journey of cancer and can be helped, you know, in a way, you know, helping people to come and use our services rather than just waiting for the end.

IV: With regards to people supporting the hospice either financially or as professionals, can you see, can you identify any changes there?

IE: Oh yes. I think, yes, people think that we do more and especially with patients, and I can tell you, I feel that patients are being more supported, the patient definitely. I think the hospice finance done better [unclear] hospice movement. In the past, I remember although excuse me, I'm not very financial but in the past when... if I wanted to buy something for the best of the patient, I would have thought 100 times because where I get the money from, is it worth it, is it going to be cost effective and things. I still think now but I'm not worrying about the money now because I know if I didn't get it from here, I know, you know, people will... they're out there doing fund raising that will support it, as long as they know what it's for. So definitely, I think it's changed a lot and it's for the best.

IV: That's very good. Thinking things a little bit more on the challenges side. Which are you considering to be the main challenges that the hospice movement is facing now or is going to face in the near future? And what do I mean when I say challenges? Challenges can be both internal, risks relating to the fact that you are not this hospice only but hospices in general are growing bigger and this might affect your recruitment policy, your management structure or the overall sector's governance, and they can be external challenges as well. It can be new regulation imposed on hospices, there might be financial pressures, it

might be the ageing population, it might be the demand for new services, but at this point I want you to give me things that you consider to be challenging in the near future, both from an internal to the hospice sector approach as well as an external to the hospice sector approach.

IE: What I can confidently say to you is one of the big challenges I've faced here, [unclear] organisation face here, is the one question which I always wanted to answer, what we have now. Because we've got staff who have been working for the hospice for years, for 20 years, I don't know how long before I here and these staff, they looked at the hospice in early days to different from now, and one of the challenges I am facing now is how to convince these people to move forward and be what we are now. They're... I can find resistant, you know, disagreement and upset sometimes the way we want to try things here. So in our last clinical meeting actually I raised I think one question, if it could be answered, you know, the staff, you know, will be much more happier to what we are now. Are we still a hospice or are we a specialist palliative care unit? And that makes much difference, you know, to the staff attitudes towards where we are now. Yes, and it needs a lot of education and convincing and working together with these staff to show them the benefit of what we are now, but unfortunately some staff are older age and, you know, they've been working 20 years in an old hospice, sort of, you know, very homely, like, it's very difficult to move and I think that's one of the most challenges, you know, the most important challenge I face here as an inside[?]. Outside there is a lot but I can tell you one of the ones you... you just gave me an example is the... is the pressure. We have moved now to just from being a charitable organisation to depend on some funding from the NHS and that doesn't come without a price. Always there is pressure to give more time to, you know, record what you do and to try to prove that you're doing the right thing and that takes lots of times and it... you know, from the doctors, from the management especially to structure these things. Yes, the pressure is definitely from outside because we're getting financial support and we have to prove our self. Not that we didn't prove our self before but I think that's become almost, you know, backs our policies, our guidance, our documents, all has got to be changed because lots of [unclear] income [unclear] coming in, we have to show that doing, you know, and that takes time also and effort.

IV: Now I'm going to ask two questions. One is how you think that the sector should respond to these challenges, which means you identified some external challenges to the sector as a whole, like all the hospices [overtalking]

IE: Yes, absolutely, they're all...

IV: The other one is going to be how you think that St Rocco's is doing with regards to these challenges. Is there any action plan made or are you aware of something or you see that is generated or customer generated which is going to deal with these problems in the near future? But let's go to the first questions first.

IE: Which was?

IV: How do you think the hospice sector, the sector as a whole, should respond to these challenges?

IE: That's a very difficult one because different hospices are different way of working and even the area where they work are different.

IV: Do you perceive that its diversity as a weakness of the sector? I'm using the word sector which means a market [unclear] and it might be a little bit arbitrary to apply it to charitable organisations but what I see an outsider is a large group of organisations trying to provide the same type of service, but what I'm finding out as I'm moving on with my research is that different hospices do things in different ways. Do you see this as a strength or as a weakness?

IE: I think... I think I see it as a doctor, as a physician I think it's a strength but you know, because I look at the benefits coming from... for the patient which is great now. It might not be a positive for the management, might not [unclear] for the financial side, but I think... I think as a physician I look at what the patient getting, are getting better service now and for me that's a positive thing.

IV: How patients are getting better services by the fact that different hospices are providing... are doing the same thing in different ways?

IE: Yes. Well, we all provide almost much the same cares, type of care but some of us will provide more and some of us will... can provide more, you know, depending on your financial situation. I think form looking at this as a positive. I gave you an example before we started this interview, you know, about how patients now, you know, rather than being in a hospital and going through a very bad experience, they can be here since the beginning of their journey with cancer without going through all that horrible time and they'll be supported in a better way. I think that's a very positive... It's costing the hospice a lot, I think the way we're moving, we're accepting patients even earlier in their disease, they're not dying so we have to keep them for longer and look after them for longer but that's so that... you know, they're benefitting from it. It might be a lot of financial pressures on us but I think that's very positive. I personally see that movement towards becoming more... some

people call it hospitalised. It's not hospitalised but more open services, more improved, I think it is a positive thing. But like I say, maybe the management will think okay, we have to think of different strategies, we're not... you know, I don't know how they think but as a physician I think it is positive.

IV: Are there any situations, if you had somebody who is sort of gathering [?] or advising the whole sector, all the hospices in England and he was to ask you a question about what you think we should do to respond to the situation we are facing now, what would be a recommendation from your side?

IE: It's very difficult. One recommendation I think educating the people, you know, educating the public and... because the public look at this all happening very fast and they don't understand it. I think by educating the people outside and giving more information and be open and honest with them, I think, you know, people will not see it as a threat. But I might be wrong [unclear].

IV: No. Now, how do you think that the challenges we were talking about earlier on are going to affect St Rocco's hospice and are you aware of any action plan in order to deal with the issues you are facing now or you expect to face within the next two, three, five years?

IE: Well, the [unclear] started facing, I said, these challenges by being dependent on NHS and we have to show and prove our self to the public and to [unclear] that we're doing more and we deserve... these patients deserve more and we already started taking action plan, is one of the projects I started and, you know, with the help of the hospice management that... through this electronic record, patient electronic record which we can record every activities we do and people look at that, and so the nurse is looking after the patient, oh we spend lots of time with relatives, comforting relatives, trying to sort their problem, because it's really the patient coming [unclear], they don't come by their own. All this was... in the past was lost because there is nothing to record about how much time we spend with the relative, how much we spend ordering, you know, investigation and things for these patients, or looked at how much patients you've got in the hospice, about 200 a year, oh that's not a lot. How much time and effort spent with these patients to prove to the public we deserve that money, to prove to the government that we're doing more and one of the action plans we've taken is to go electronic record to record every single conversation, every single intervention. All the work we do outside, inside is there and when people ask us we'll be confident to say that look, this is what we've got now and this is why we need this money, rather than just talking for people who want... now people are more educated and more organised and they want evidence for what you do. You can't just say oh I'm making that patient very well. You need a proof of that, what you've done for that patient, and that's one

of the... I know there's lots of things going to come and we need to do more but as a start, I think that's a very good action we take... we took and I think it... we can see the benefit now even with just being one year now through it, but even now we see the benefit with the government because we are very confident to say that... what we have done and that's what we're going to do and this is the proof of we doing it and the PCT [?] are always starting to think yes, you know, you deserve more.

IV: That's very nice. Now we are going to talk a little bit about your role and the role of your team within this hospice. Would you like to talk to me about your role and the role of your team within St Rocco's hospice, what are you doing [unclear] people are helping you, how is your team structured?

IE: Well, my role, I'm a physician first so I'm a clinical person but at the same time I'm the manager also. I manage all the doctors and I'm like the senior clinical person here. Unfortunately, at the hospice we haven't got a consultant yet so my position is the most senior so all the difficulties, all the, you know, the clinical... the clinical physicians come to me, so I work hard [?], you know, so my four... I work eight sessions so my four sessions will be clinical, direct patient contact and seeing patients and on the other four sessions my work will be advisory and doing management stuff regarding the policies, guidelines, building bridging with the outside community and with the other organisations to help this hospice movement to go forward. You said your role within the team, you know, well, of course, we all... in a hospice you can't work by your own, you have to be through... you know, working within a team because hospice movement or that's more [?]... the first aim of the hospice is the holistic approach to the patient so it's not just medical, it is psychological, it's family, social, religious so you have to work with other people when assessing patients and yes, we work altogether with nursing, with the chaplain, with the family support team, with the physio OTs, altogether, you know, to help the patient get through what they're going through. I think we are, you know, maybe other people [unclear], I think the clinical team is the spine of the hospice and without the dedication and the effort and the commitment of this team, nurses and doctors, I think there would be no hospice. So I basically see it as a core service and it's what we do that will help the hospice to get more funding.

IV: Are you personally, or your team, getting involved in the process of setting strategy or the long term management policy creation of the hospice, or you are focusing mainly on day to day management issues?

IE: Definitely no. We're focusing on targets and, you know, future guidance and future governance, definitely and the team is big part of that, because like I said, I can't do it by my

own. We have to work together to reach these targets and we have to set up [unclear] targets and without the team working...

IV: Is it you setting the targets or the senior management setting the targets...

IE: Not really.

IV: **...**and your team is following?

IE: No. It is the clinical things that... I pass it to the management, I recommend it to the management and then we work together to see if it's achievable or not. Like I said, without them involvement, or without them helping I can't set a target and try to achieve it. It will not happen. It's usually the targets come from the clinical team and then I'll pass it to the management and that's how...

IV: Yes, it's very good. Would you like to describe to me how your team is organised and managed? And what I mean by that, describe the team structure and you have already described the staff involvement of decision making, you told me that they do help you in decision making issues.

IE: Absolutely.

IV: But how is your team structured?

IE: Okay. How is the team structured? I'll start from, you know, from the nursing staff. We've got nurses and then we've got doctors, the nurses will have a manager which is... well, they call them sisters and this hospice has got three sisters, four sisters, and these are the people who, you know, discuss, you know, take the ideas or the feeling of these nurses and because they are the patient contact and what they see is what will benefit the patient, what we should be looking to improve and then I'll be looking at the management of the doctors side and what do we feel that we can help the patient. We always have a clinical meeting, when we meet. I'm the doctor's manager, they're the nursing manager and we've got the matron which is their, you know, the nursing overall manager and we have a meeting between our self to decide about these targets. However, in clinical, in clinical position we have what's called multi disciplinary meeting every week which is the different professional involved, doctors, nurses, family support [unclear].

IV: How many doctors do you have here?

IE: We've got five doctors now.

IV: Five doctors. And you are responsible for them five all?

IE: Yes.

IV: That's very good. Is it different specialities or [overtalking]?

IE: Sorry, five is including me so...

IV: Five is including you.

IE: Including me so I'm, you know, yes, I'm managing four doctors, yes.

IV: You're managing four doctors. Is there a diversity on their specialities or you are focusing on something in particular?

IE: No, there's not. Them... you know, we all almost like general practitioners. There are three GPs, general practitioners and one of [?] my other colleagues, we have come from medical background but we all work here as focusing on, yes, palliative medicine, you know, palliative care, so I wouldn't say that's diversity actually. It is good to have doctors, the GPs here, because they're also the people in the community. They look after families and things and they can help us to build our targets and set our targets because they see them from different side.

IV: Very good. How is a typical working day for your team, and I mean the doctors team, staying in the hospice, going out?

IE: Well, most of the time staying in the hospice but we do go out to see patients in the community and that happens, you know, once a day only. We... you know, depends on how many patients there need our help. Say, for the time being, we are full, we haven't got any beds, empty beds so if the patient needed admission but we didn't have bed, we'd be going out to see that patient, to see if we can help them at home. But a typical working day is looking after the inpatient, outpatient under the unit [unclear] here, any extras we go out and see them. My role is that... my typical working day would be different when I am management because I might have to go out, attend meetings and courses and so I might be going out more often than other doctors, but most of the time it is in the hospice and it's patient focused, yes.

IV: Are you aware of any differences between the team in this hospice works and the way similar teams are working in other hospices?

IE: I think there are always differences depending how... again, we come to the financial position of the hospice, how much you can afford where unfortunately doctors are very expensive resources, okay. We do lots of... our team, I know, we do lots of goodwill, we do

like on calls for free, you know, we don't ask for payment because we love our job and we try to help the hospice anyway we can. I think we are very fortunate and lucky that we've got hospices, got the money and we've got very good, high qualified doctors and we've got no problems. Some other hospices I know that they work as a session based and they might have some sessions not covered so the patient will not get 24 medical on, you know, on call care. Yes, there are differences but I think not big differences, all depends on the financial position of the hospice. If they had, you know, [unclear], if they had that, you know, I think they would be the same like us. However, saying that, we still need, you know, I'm not saying that we are... we are 100% covered and we don't need any more doctors but for the time being we try to do our best with what we've got. Probably in the future I'm sure there'll be, you know, some more support and more doctors, you know, to make it even better.

IV: Are you using any method to measure the performance of your team? And if yes, would you like to describe it to me? In plain management words, how do you know that your teams members are getting their work done or how much work is getting done by your team members?

IE: Okay. Again, I'll go and say that by introducing the electronic records, I can see if we reach targets, looking how many patients we could, say, finish consultation, that's something, looking at our stay at the hospice, how long the patients stay before these problems have been sorted. Are we getting behind or are we getting... comparing our self to the national figures? I think appraisals, that's another way, I would like to say that I can, as a physician and I manage doctors, appraisals is the one way I can, you know, measure my team's work as doctors by seeing what they've achieved, what they want to achieve, what are the difficulties and how can make it better. Yes, I would say as a physician that the appraisals is the way and it works. Maybe with a nurse, it's different, you know, you need, you know, reaching targets and that's all recorded in the system. I can see how much... what's our performance now.

IV: What's the difficult part of measuring personal performance within a hospice?

IE: Yes. Lots of difficulties I would say. We haven't got, you know, unfortunately, it's not like when you work in the hospital, we haven't got very structured appraisal system and this is all new coming. Hospice only used to have doctors who were popping in and out, just as a help, you know, goodwill. Now things have changed and like I said, if you want to measure performances and see if you reach targets, you have to make sure that things done properly. We didn't have a structure, a system for appraisals. It depends on your personal, really, effort whether you want to do it and I think we've moved a long way since I've

started here and trying to... I think when you [unclear] efforts, we've got some of the doctors here been nine years and they never had appraisal here as in part of the hospice and trying to introduce the system and make them feel like it is as much as they work in the hospital or as a GP, they need to be appraised here. Yes, setting a system which everybody will be happy and follow. It's not... and convincing people it's not checking on them, it's trying to work together how make things better. I think that's one of the challenges, because you know, I think people, some of them are more senior than me and it's very hard for me, you know, to go and criticise them or just say where you went wrong, but trying to convince them that it is a matter of, you know, working together to see how can we help each other to get better performance.

IV: Would you suggest any specific topics that should be taken into account when somebody is trying to measure performance of teams similar to yours?

IE: I don't know. I don't understand. You know, not I don't understand but I...

IV: If you had to advise me, I'm going to... I'm coming here and asking you, you know, I'm going to be monitoring four, five, ten doctors and 20, 30 nurses a week in a hospice but I have no idea about their work. How am I going to know that their work is getting done, if I had to make a breakdown of system with boxes that should be ticked off, what would these boxes should have inside? What would be the five, ten key things that I should be looking for as a manager in order to know that my staff is working properly and that things are running well?

IE: Well, I think if I... if it was me, I think I would... team building is, would be in the top of my list, you know, trying to work, you know, to pick up from difference places, difference... and trying to make them feel like it's one family, one team working together. That would be my one thing, important thing to me. And then make them feel... maybe the second thing is make them feel they can trust you and you are trusting them, you know, building this trust between yourself and you are not there to criticise them or to check on their performance, rather they are there to help them. And I feel like team building is one of the very important things in the hospice.

IV: Well, that looks interesting. So you wouldn't recommend a standardised breakdown, task approach, where I would be looking for one, two, three, four, five things that this person did over the course of the day?

IE: That's appraised... that's part of the appraisal, like I said, you do that in their appraisal, they... this is what you expect them to do and this is what they've done and then

you look at why they've not done the something or what they've done very good. That's how I appraise people, you know. As a doctor, you're supposed to do all these things and these are what you've done.

IV: Is this coming with a formal document or it is...?

IE: Yes, there is a formal... we build our... you know, we made our own formal document for appraisals, you know, each person was expected, you know, to do and what they've done and how to make things better and work together, yes. That's appraisal and it's... it doesn't have to be yearly, we do it every six months sometime, you know, depends if... I'm watching what's going on and if I feel like this person probably got some struggles there from their performance, then I'll ask them for appraisal even earlier.

IV: Yes, it's very good. I would be asking you now what is included on this document but this would extend the length of our conversation a lot. Let's go to next question. Do you believe that your team is or could be involved in the process of creating financial value for the hospice and if yes, how?

IE: I think yes, definitely. My team can, you know, I think we do that now. How... the way to do it, to say it is... I would say if we're setting targets, realistic targets and if the team would be directing us, that way we can achieve them much more easier and then we can get, you know, you know, we're promising the government this and that and if we set these targets within the team and then works toward it then we are achieving them much more easier, then we're getting more financial support.

IV: That's very interesting. Are the members of your team working in cooperation with members of other teams or they are primarily working on an independent basis?

IE: No, we all work together, definitely. Clinical team is not separated from finance, is not separated from fund raising. Actually, lots of our nurses and doctors, they do just things for fund raising, they're appearing in photos, coming and doing a party or something to raise money, actually individual people, including my daughter, like other nurses' children, they're doing just a jump or cake sale or something, you know, so we work altogether, definitely.

IV: Do you think that your team members like that or that they would prefer to work on an independent basis?

IE: No. No, I think they would like that and they're very supportive. Somebody comes with an idea, they're more than willing to, you know, to participate.

IV: Doctors in different establishments tend to adopt a more professional approach and they usually tend to work on their own or to see themselves as the decision maker of the team [?] they are working on, which causes friction with other health professionals. It looks like this is not as strong with the hospice movement as with other places. Why? Do you think...?

IE: I think, yes, it's a very good point. Yes, definitely. It's one of the things I challenged first coming here. I see myself as a senior doctor and I make the decision and they will... and that's how it works in the hospital. The nurses would be waiting for you to make the decision and, you know, they will give [?] whatever you say. Coming here it was a bit different, you know. Here is that you have to listen what other people say and you can't work the same way. I feel the nurses... I feel that making decision... Some decisions have to be made independently and these are pure, pure medical decisions, like what medication you're going to give this patient but as an overall management of these patients, I wouldn't be able to work in a hospice in that way, because the people who are in the most contact with the patient are the nurses, the, you know, the other staff. I can't just come by, see the patient once, half an hour, you know, trying to help them with all the sort [?] that they're going through. I don't know whether [?] I answered your question or not, but I think no, I wouldn't be able to work as I've worked somewhere else in the hospital or make a decision by myself.

IV: We noticed earlier on that the hospice sector is moving towards professionalism a lot more compared to being purely voluntary in the past. Do you think that this movement towards professionalism is going affect the inter professional relationships?

IE: I think it does, it does, but again it comes with what's the people understanding within the hospice of professionalism. It doesn't mean you're going to work by yourself. I think if they understand what you mean by this professionalism and where you're coming from, not just bossing them and giving them order. Yes, there will be always friction but I think, like I said again, by education and explaining yourself things, much easier in the hospice than in the hospital, definitely.

IV: That's very good. Now we are going to talk a little bit about recruitment policies. Would you like to give me some information on recruitment policies and criteria for hiring new members of your team, and I'm mainly referring to the team of the doctors rather than...?

IE: Well, our recruitment policy is like anywhere, it's there is a vacancy, there will be a job description and there will be, you know, a commitment and, well, the doctor's duty and

then it will... goes to advertisement. Usually we go for local advertisement rather than national, and if we didn't get any local candidate then we'd probably go national. We do our advertising in websites, in the NHS website and we use the national advertising in the British Medical Journals in the past. However, we depend on, most of the time, on our relationship with other doctors, our relationship with the hospital team, with the local GPs. If we know somebody who really interested and, you know, we approach them that there is something coming up, are you interested? But the procedure is... it's all the same. It goes through advertisement and it is a peer [?]... a peer interview, you know, the candidate and they have to just present to us that they're fit for taking the post and proper interview with all professional involved in that interview, including a consultant from the hospital to assess these doctors. So it's like anywhere else. It wasn't like that before but I think things moved a lot now and it's all coming professionalism, yes. And I think it's a good way, I think you, you know, by looking at the background of that doctors, by looking deeply into their performance, getting references from somewhere, you'll be sure that we've taken the right person.

IV: Are you looking for specific skills when you are hiring people, and how easy it is for you to find these skills?

IE: Well, we will always be looking for somebody who is, you know... It's not easy to work in a hospice and working with patient with advanced cancer, so I think, you know, you need somebody who likes to do that, you know. It's not a job, just a job, a paid job, so we're looking for somebody who really interested and show us why they're interested and where they're coming from [?]. And their knowledge also, that's very important to us and yes, team work, that's the thing. You can't work in a hospice by your own. How I make sure of [unclear] from the application, from the CV, from reference and I'll be asking specific question in interviews to see [unclear] in situation and see what's their response to that.

IV: And how is the recruitment market in your area? Is it competitive or it is easy for you to find and recruit people?

IE: No, it is very competitive and I don't think it's easy at all. We've been trying for recruiting, you know, more doctors but we haven't managed to. Yes. It is all depend on the, you know, the system, the NHS system's changed, now especially, you know, palliative care becoming a training speciality and people want to be in palliative care, they go from... start off the junior doctors and they go into training. In my days, it was different, it had [?] lots of people around who are doing other specials and they being [unclear] and it would be easy to bring [?] them in. Nowadays it's not that easy, you have to a proper training before you get

into the speciality. Yes, it's very competitive and I don't think there are many palliative medicine doctors around anyway.

IV: Who is your main competitor in this area? Who else is hiring?

IE: I think there is the neighbouring hospice and the neighbouring hospitals. Outside that, [unclear] also but mainly the neighbouring hospices. I remember back two years ago we were fighting over one doctor where to work, we wanted the doctor, we also [unclear] hospice wanted [?] doctor, so we interviewed the same person, you know, for the three jobs and unfortunately we didn't get her. Somebody else got her.

IV: We are very close to finishing. I just need some general figures [?] from you. Did you enjoy your conversation? Would you like to indicate some strong and some weak points of the interview process?

IE: I think it was good. It's very relaxing, I didn't feel like under pressure. However, some of these terms, financial aspects and you know, financial targets, this is not my speciality and I found it sometimes difficult to put it in a proper word. I do understand what you need but as a physician, as a medical background, probably I wouldn't be able to put it in the right words for you. But now, I didn't feel like I'm interrogated or... I felt very relaxed and I enjoyed actually talking about it, because I think, you know, it's [unclear] that you need to do.

IV: That's very good. Thank you very much. Any strong or weak points? Any suggestions that you would like to make?

IE: Shorter questions. There's lots of them. There are too many of them. Can you make them shorter?

IV: I will try my best next time. Any ideas of interest [unclear] to your profession but you don't feel were covered in adequate depth?

IE: Not really. I think you covered most of the aspects you need to, you know, I think what the hospice need to know and what the people outside need to know. I would say you covered most of the things. There will always be things, you know, which are general or very personal or very speciality, you know. I think we've got all... I think that you, no, you covered most of thoughts we had.

IV: Would you like to suggest any improvements on the approach or the content of the interview?

IE: I think I would have like more information about what you're going to talk about before I sit with you. What I've been told is that you're visiting the hospice and you wanted just to speak to people. I didn't know that research project and you know, search process and you know, there'll be... particular question will be asked. Then I would have made sure we have a quieter place and then, you know, my thoughts would have been more organised. That's the only thing. I didn't know that it's a research and then specific questions, I thought it's just talking about the hospice and what we do here.

IV: That's very interesting, very interesting suggestion. The reason I kept it like that was because after the first stage there will be a second phase of interviews. At the first stage, I just wanted to get what comes out of people's mouths, what they tell yourself and things.

IE: I think for me as a... Yes, I think for me as a doctor, I've got other commitments. I wasn't... you know, it would have been better for me to organise the time, in the proper time and not sitting here, you know, people coming in and out and interrupting your thoughts and if I knew that it's a proper, you know, like a chat rather than just a friendly chat, that definitely would have made a difference to the whole [overtalking].

IV: The type of information you will be providing. That's a good suggestion. I will take this into account. Would you like to participate in a similar interview in the future?

IE: Yes.

IV: That's good. Thank you very much.

IE: Can I just say something before you finish?

IV: Yes.

IE: Can I have a record of what you... what you're going to say, you know? Can I have a record of what... our interview there written?

IV: Yes, of course. You mean access to research outcomes?

IE: No. What the interview... you know, when you're going to write the...

IV: The [unclear]?

IE: Yes. You know, you're going to listen to the tape and you know, somebody's going to have to, you know...

IV: Yes, I can give you the whole interview as recorded but you mean your interview?

IE: Yes, my interview. Yes.

IV: I am obliged not to give you [overtalking].

IE: No, I want my interview and I will be very interested to see... of course, I would like to see your research outcomes because that will help us also. I don't feel like I've wasted my time, you know, I feel like I've got something out of it, just helpful to our patient and our organisation so definitely I want to see the outcomes, yes.

IV: Actually, once I will... I will try to send it via email. If not, I will ask for your address and send you either a USB with your interview or a CD with the interview [unclear] file.

IE: Yes, absolutely. If that's all right. Yes.

IV: Thanks a lot. Thanks a lot, that was...

IE: You're welcome.

Interview with the Nursing Director of Hospice A:

Speaker key

IV: Interviewer

IE: Interviewee

IV: Before we will start with the interview itself, I will have to let you know about the ethics and confidentiality policy of the University. You can be assured that any kind of information you will provide within the interview is going to be kept confidential, whichever information out of it we publish is not going to carry your name or the name of the institution you are working for. If at any time you find out that you don't feel comfortable answering a particular question you can just say that you don't want to answer this question, or if you feel at some point that you want to interrupt or stop the interview process, you can just feel free and ask for that. So, you already made the introduction and you told me about your background, it's not very specific on palliative care…

IE: No.

IV: It's nursing, and you have been with Hospice Movement for how long?

IE: In this establishment, since the beginning of December last year, so I'm very new in post. About five months.

IV: What about before that?

IE: Before that, I worked for the National Health Service, and I've also worked for the private sector, running nursing homes and for the voluntary sector running care homes, residential care homes.

IV: Is it mine or…? And what was the motivation for you to join the Hospice sector, is it financial, personal motivation?

IE: No, it's professional, and personal, as you mentioned, I'd say. What was happening to me at the time, the NHS was restructuring it's whole work force anyway, I'd also moved house, so I was living quite a long way from where I worked, and what I was looking for, having had a number of short term jobs over the past few years, at quite sort of senior levels, I wanted something which kept me busy, maintained my professional interest from a nursing,

medical nursing point of view, but something where I felt I could influence the care that patients receive. And sometimes, as you move into more senior positions in healthcare, you kind of feel you're getting more distant from being able to influence what happens to patients, and for me, I'd heard that this job would be coming up, so I try to apply before the advert, and Pilgrim said, you will have to wait for the advert, so I kept my eyes open and fortunately one day saw the advert and applied, thinking that I wouldn't be successful, particularly because I haven't got the specialist palliative care background, but fortunately for me I was, so here I am.

IV: It's good, it looks like a new turn in life.

IE: Absolutely. Indeed, you're right.

IV: Would you like to give your Hospice Movement in general, I know that your background is not really Hospice Movement but I guess from your [unclear] experience.

IE: Well, I think, if I probably wear my nursing hat, my preconceived understanding of what the Hospice Movement would be about would be that it encompasses all the things that, nurses, certainly when I first started nursing, which was 1982, would see to be fundamental to good nursing, and a lot of which people, I think the public and for nurses themselves feel has been kind of lost, or at least eroded in part, in other healthcare establishments. So for me, the Hospice Movement, in my mind, and I think it's been proven since I've been here, still encompasses values and morals and ethical kind of standards, and very good multi-disciplinary work, which for me, is key, and doesn't always happen elsewhere in the way that you might like to see it. So that's my kind of global concept of what a Hospice is about, and what it brings to a patient. I suppose aside from that, I've got quite a burning desire around the fact that a hospice, when it started, was around care for patients with cancer, and certainly when I first came here, and I've always had in my mind, you know, this level of care, and quality of care, can't possibly be something morally that we can only offer to some people, and therefore there's this need that anybody whose facing the end of their life, or a limited life span, should have access at the right points in time to this level of care, rather than leaving to die in a hospital bed, maybe in a ward that's not as environmentally friendly as it might be, both for them and their relatives, or equally to help someone who might choose to die at home or spend their last days, and that we should be able to broaden our service base to meet the needs of those people, and you've probably already picked up from CEO that that's a big strategy for us in the future, so quick an exciting time. If we could achieve that, then …

IV: You [unclear] more than half of [unclear]

IE: You can see you've got the old bifocals now.

IV: That's [unclear] I think. So, the first question was about the orientation and the ideals of the Hospice Movement with it's, mainly its governed by now, [unclear] do you think that the Hospice Movement is changing a little bit towards professionalism, or you can still see the same ideals and the same principles exactly what they used to be?

IE: I think that partly depends on the definition of professionalism, which we won't get into, but for my terms of reference, I think the Hospice Movement is definitely beginning to change, and I think nationally, just from what I've heard, when I've been on the odd conference of what I've read, all Hospices are facing that change in direction, partly because there's kind of government policy driving that direction, not specifically for hospices, but more generically around healthcare, partly because of the expectations of the public, and new generations expecting things to be done differently and not having the sort of family networks that they've had local to them in the past, the whole world, externally, is changing, and hospices are needing to think how they respond to that. So that answer is definitely yes. I think that's a bigger challenge to the issue of professionalism, because partly it means that all or our staff will need to have a think about what that means for them, at times when, certainly with all the medical and therapy and nursing professions, their own organising bodies are asking them to think about what their job is about, what their roles are about, you know, how they move forward, particularly when resources are always limited, no matter where you work. What I would hate to see, I think we've still got all those professional values, and that they predominate, and the worst case scenario would be that we move forward and meet the challenge of change, but lose some of our professional values that I referred to earlier, because if we do that, there isn't anything that sets us apart from all that other type of healthcare that I just mentioned, which doesn't feel at the level of quality that I think we should, and do, provide. So it's quite a challenge.

IV: It's certainly a challenge [unclear] one more thing that, moving towards professionalism, might be the opposite thing of relying mainly on the ability of some people, or the will of some people to [unclear] and this is where I would like an answer from you, like do you think that people are still motivated to [unclear] do you think that this idea is sort of changing, and more and more people are training in the Hospice Movement, because they see it as a job or as a profession, and how do you think this is going to carry on in the future?

IE: Sure, yes. I think at the moment, people aren't motivated to volunteer, what it feels to me is that most people do end up volunteering, that's people that come to the hospice, do so on the back of an experience associated with the hospice, so they may have lost a loved one, or had a friend who's been in the care of the hospice, and that's why they come to volunteer here, maybe a couple of years later, and stay for a number of years. So I think there's always an element of that that will be there. I think in the longer term, what's probably more difficult to understand, from a whole society point of view, is, are the generations to come going to be as geared up to volunteering for good causes in their entirety? For example, lots of volunteers in the past, and even now, have been women who've been at home, who've raised children, whereas the future is more women who work who don't have the time to commit, or don't feel they have the time to commit, so there's that change in society which could impact on volunteers that might come forward, even if people want to come forward, so I think that could be a gap for us in the future. But it feels like, once people have had experience here, been on the receiving end of care, for example, that they always seem to say, I want to give something back, and however small or great that time might be, at the moment, they seem to do it, so I think it's a question mark for the future.

IV: So that agree, you can see hospices relying more and more on professional …

IE: Or paid people. Paid people, I think that's a risk for us, in financial terms, because if our volunteers weren't here, now, I don't know how much it would cost us to cover what they do, and a lot of what they do is raise money for us, so it's a double whammy, if they weren't able to do that.

IV: This is where I'm going to [unclear] right now, which are you considering to be the main challenges, not just for Pilgrim's Hospice, but for Hospice Movement as a sector, now and in the foreseeable future, these challenges could be either internal, like sector governance, or recruitment problems, volunteerism versus professionalism, which we already covered, or they could be external challenges, in regulation, financial problems, demand for more services, the ageing population of the country, which of these things are you considering as being the main challenges that the Hospice Movement would have to deal with?

IE: The one I always go for is about staff, because if anything goes wrong with staff, you can't provide a service, so whether that's from recruitment, retention, training our staff, that whole issue. So if we haven't got staff, we can't provide a service, so that has to be a key challenge for us in the future, and one of the examples I would share with you again, from a nursing perspective on that, and I was talking to CEO about it this morning, we've

currently got a good nursing workforce who do what they do well, who've been been here for a good number of years, totally committed and motivated to Pilgrim's and the type of work that they do. When they retire, and we've got quite a few who potentially will retire over the next couple of years, nurses that might want to come and work in the Hospice Movement who have been more recently trained, trained with a different set of thinking and values and their training experience with different [unclear] and a challenge for us will be, how do we make the Hospice an attractive career option for them, to come and work here, so they see it as trendy and sexy and the place to be, or do they see it as a Cinderella service and somewhere to go when the acute world gets too tough, or do they prefer Accident and Emergency and Intensive Care Unit, and why do they prefer that, if they do? So that's an unknown quantity for us. The other big challenge, and again, I'm sure CEO's raised this one, but it's generically around finance, because we've got part public finance from the Health Service as it were, the predominantly voluntary donations, and I think that's very different from people paying their taxes every month, because at the end of the day, we pay our taxes, and we might moan about our taxes and that we might not get good value for money, or we're fed up with services, but when people donate money voluntarily, they literally take it out their wage packet or pocket each month and give it, so if they stop giving that, that's, well, we wouldn't be here, and equally so, we don't know what's happening for the future with public money, in terms of the way public money is going to be allocated about between services and the unpalliative [?] care, so it's just a big question mark for us. People, risk, and challenge, money, risk and challenge, I think are probably the two predominant things.

IV: What about the demand for Hospice services for people?

IE: Yes, I think the demand is a difficult one to assess, in the sense that we know there's a potential for more demand, because, demographically, we know that more people are living longer with more complex life limited diseases, so there's no cure for them, they might have Parkinson's disease, they might have cancer, they might have a rheumo [?] disease, they might have heart failure, so their condition is going to continue to deteriorate and they're our future potential customers, if you like. I think at the moment, out there in the general public world, those types of potential patients wouldn't even think or know about accessing Hospice services, so in a sense, we haven't opened the flood gates to test that demand, and we're about to start to do that, with the appointment of a new consultant medical post around non cancer patients, so again, it's a bit of an unknown quantity, but I think for me, a particular issue around how people live in the future, is we know that there's going to be more, and already is, more people living alone without family networks or social support networks, and there's a question about what role do we play there, because if those people want to stay home, how do we, along with other organisations and colleagues, help

them achieve their wish, so that's the other big, probably the third area, but again, quite untested from that point of view.

IV: How do you think the Hospice sector, as a whole, should respond to these issues, these challenges?

IE: I've got a heart response and a head response, and my heart response, which I shared with all the staff when I first came here, was once you see how this place operates and what it does, you feel like you want everybody who said they're going to be a patient for anything, even if it's having their ingrowing toenail removed, to come here and have it done, because it just feels that this is what everyone should receive if they're unwell or needing to recover. Obviously that's not what we do. So I think, in terms of a Hospice response, one of the things we're actually starting to do is undertake a review of our services, which are predominantly community based, so we've got a day Hospice on each of our three sites, and we've got a team of clinical nurse specialists who work in the community with the support of an [unclear] disciplinary team, visit patients in their own home, but I think the patients we're potentially working with is really the tip of the iceberg in terms of what we could do. So we want to look at what we're currently doing now, what might be needed for the future, and think about where our boundaries might be for the future and how we can work with other people outside of hospice, and do we need to be doing anything differently, or do we need any services to be new services, which we include with our existing services, or change entirely, to deliver more of the care to that wider population base that I've referred to, with our patients that have things other than cancer.

IV: So, you would suggest more for Hospice A, and the Hospice sector in general, to, first of all, try and map, measure, what kind of services they are offering, how they are offering these services and then measure the expected demand for Hospice service in the future.

IE: Exactly.

IV: Usually on such a basis, [unclear] respond to whatever they will do.

IE: I think the most difficult debate in that as well is about, and it's always been there in the Hospice Movement, it's what should the government fund, and one of the dangers is, and I think our Trustees would say this, that if we tried to do everything, all of the time, that in theory, one could argue should be funded by the government through the Department of Health or Social Services, then that maybe shouldn't be our role, because most of our money is publicly donated, therefore why are people paying taxes, so there's a danger that we could

start to do things that really should be funded through a different route, and I think that's a constant source of discussion and tension and one that we need to keep our eye on the ball with really.

IV: So maybe as Hospice Movement, as a whole, people should start negotiating with the government about the kind of services that Hospice Movement is offering to people or not?

IE: Yes.

IV: Do you think this could be useful, to formalise, to make uniform sort of services that hospices in general are offering, or you think that this is not applicable in any [unclear] care?

IE: That's a very good question. On the one hand, I could say yes, for a number of reasons, for financial reasons, so that patients nationally would understand exactly what hospices can and can't provide and all those sorts of issues. Where the answer would be no, for example, would be, well if local people are giving publicly their local money, they should have a say in what you provide, and there might be local nuances around their, what they want in their communities, as well as what the local need would really dictate, so different socio-economic groups, or demography, so therefore you could argue, it shouldn't be standardised, and that the more debate you might have with the government about all of those things, may end up as being hospices in a compartment that then becomes inflexible around what, what level of control you've got within your own organisation in terms of what you can deliver for people, and I know that there's a lot of people that would also argue, and I think there's a lot of the public which would say, the government should put more money into hospices. You could say, true, there's a counterargument which says that if they do, you're going to be come more and more like the health service in the sense that you're bound by the government's regulatory and control type systems. So if the government started to say, okay, we will fully fund all the hospices, which I am sure they never will, but we will fully fund all the hospices, with that, we know would come a whole range of targets and a whole load of bureaucracy, which would then probably erode some of those values and professional issues that really come to the fore and make the Hospice what it is. I sit on the fence with it, probably because I've not been around in the organisation long enough to form a view of my own, but I can see those arguments.

IV: So practically, you would say like, there should be a standardising process to a certain extent, but hospices should still keep a certain level of flexibility around the kind of services they are providing, based on their local needs?

IE: Absolutely, if it's going to be truly accountable, if we're going to provide a truly accountable service to our public, who give us the money that they do and the energy that they do and the time that they do, then we need to retain that element of how we respond.

IV: So, now I will ask you some questions mainly related on your role and the role of your team.

IE: Okay, yes.

IV: Would you like to give me a general description of what you do and what your team does within Pilgrim's Hospice and how your team is organised and managed, and whether you personally, or members of your staff, are getting involved with target setting and planning [unclear] process for the hospice, or you are mainly focussed on day to day issues, [unclear].

IE: Okay, well my, [unclear] my post is a nursing director as you know, and I come into post in December having followed my predecessor, who had been in post since there was one Hospice site, so my predecessor had done a lot of good work to set all the foundations and get nursing to where it's got to, she's been excellent, a kind of tough act to follow. My job, if you like, is obviously in terms of the top of the organisation, I'm part of the senior management team, which is myself, the CEO and the medical director, you're meeting the medical director, aren't you, yourself? And I report to CEO formally, in a line management way, and then the structure underneath myself is that I've got a nurse manager who looks after nursing on this site, in patient nursing, and at the moment, they look after the day hospice, and the same on the XXX site and the XXX site, and then I've also got a nurse manager who looks after the community nursing services across all three sites. It's quite, it's a small team of middle managers, if you like, who, particularly on the in patient and day Hospice side, by default, because they're there all the time, have a real challenge in terms of very frontline role, but equally so from my perspective, pulling on their kind of input, all the time really. So as ever, that middle place is one of the most challenging places to be, I think in any organisation, because you get upward pressure, downward pressure, sidewards pressure. My responsibilities are obviously around nursing, but I think particularly with my post, what I understand the senior management team and trustees to want is somebody who's responsible, not just for the here and now, but looking ahead. So more of that thinking in a strategic way to think where do we need to be, how do we get there, and how do I try and kind of pick nursing up and take it with us in our journey. And that's quite a challenge, particularly in this organisation and I would say for most hospices, given that values base, and that very traditional professionally centred base, which has not yet begun to face the

challenges that all professions are facing in healthcare, which is that workforce and the external changes that we've talked about.

My managers on the sites, and my community manager, are all very experienced nurses, all of them except the one who's been within the organisation for a good number of years, and so has got lots of experience and specialist palliative care, as well as nursing, and my expectations of them, for the future, already are, and will continue to be, different from what my predecessor expected. I think that's partly to do with the changing culture in the organisation, but in particular for me, it's about devolving some responsibility and authority, closer to the patient, which I think has to happen, and it hasn't been like that in the past. So they're going through a whole, as I am too, learning experience. Part of that is around fact finding about their particular area of responsibility, whether it's around what management information and data there might be to help them make decisions, setting parameters for their decision making, so that they don't need to feel they need to keep coming back to the centre of senior management team before they can take action. I think that's, you know, a point that a number of organisations go through in their evolution really, and even if that wasn't really being driven by external changes in the financial world that we live in, I think by the very nature of the fact that when Pilgrim's started, it was one Hospice on one site, and maybe a centralised model works very well, but as the Hospice has grown onto three sites, and has become more diverse, a central model really just doesn't stack up, and causes more frustrations than anything else.

So I think that's the biggest thing that I'm going to be, kind of help people through the next couple of years really, and obviously, that has an impact, you know, on all of the nurses and all of the multi-disciplinary team really, because it's about doing things differently and different training requirements, different developmental requirements and all those sorts of things.

IV: How would you describe a typical working day for your team and yourself, how is the system working, from the top to the bottom?

IE: Okay, well my working day is fortunately very varied and diverse, which I enjoy. I guess at the moment, probably because of the length of time I've been in post and the point at which nursing is at, my work is predominantly around managing the here and now, rather than the long term. So if I described it, from a statistical point of view, I'd probably say, on a daily basis, it's more about 80% here and now and next week, and 20% five years' time. Although that 20% is always going on up here in my mind, and I think over a period of time, I'd like to see that balance the other way round, so that most of the nurse managers are managing to address the 80%, with my support and help as and when needed, and that

enables me, the 80% to kind of support CEO and Medical director more, on the future, I think there's a transitionary phase, in that there's quite a bit around nursing that we need to explore and consider, because we haven't developed nursing in the way that we could do, and I'm not saying that we have to go in that direction, but I increasingly think it's the right direction of travel for us. So my working day might be a range of things, such as, participating in, or leading certain meetings, some of them are around regular things that happen as part of the organisational framework, so whether it's about governance, whether it's about quality in practice, those sorts of things. Quite a lot, at the moment, is around here, and I do that all of the time anyway, so I might just be going to make a cup of coffee, and what I do is pick up things on route, which gives me a feel for the heat in the system and where nurses are at and what the current issues are. I try to, by going into different meetings, and or by talking to some patients as and when I can, feel for what the patient experience is, and obviously there's a whole range of work that goes on behind the scenes around things like audit and patient experience and patient surveys, which supplement or otherwise, my instinctive kind of feeling about what's going on. I try to get to all of the sites, when I came into post, my plan was to go to all of them at least once a week, that's not happening, but I do keep in touch with the mangers, pretty much on a daily basis, and we have regular one to one meetings, as well as a regular manager's meeting every month, which is part business, part blue sky thinking about the future. And in fact, tomorrow, we've got a manager's meeting, which we've sectioned the whole day aside, and we're going to do some of that forward thinking, which is partly education and coaching for them, but partly about future plans. Quite a lot of my time at the moment is taken up with staffing issues, which are predominantly human resource matters, so a bit of pouring oil on trouble waters when people are feeling stressed and agitated, and that's usually anxiety about here and now in the future. Partly some real issues, and for example I heard a grievance that a member of staff had, I've been investigating a complaint that came in, that are few and far between for us, but obviously need to be done in a timely way, and as I say, for the future, what I want to do is more of the planning ahead, than the reactive. At the moment, it's less proactive than it should be, but I think that probably reflects my kind of [unclear]

IV: Are you using any measures to measure the performance of your staff, of your people, and at which level, are you just using it for your middle managers, or you are going down the bottom measuring individual performance?

IE: I think formal measurement, in a whole number of ways, we're not good at, and we need to get better at. And again, it's a bone of contention, because I think performance measurement, or performance management, all right, stop me when you need to, is, certainly from our values base, perceived to be a management thing, whereas really it's everyone's

business, because if you don't know where you're at, how do you move forward. So I think we've got quite a challenge around instilling that culture.

We, in theory, have got an appraisal system, so every year, personal appraisal, in theory, for every member of staff, with objective setting, and on the back of which, training and development needs are identified etc, and that's through the line management route. However, we know it doesn't work, we know it's fallen over year after year after year, and it's intermittent and inconsistent, so it doesn't serve it's purpose in any shape or form. And our HR manager who, you might be meeting, I'm not sure, is doing some work on a new appraisal system, which needs to come with training for appraisals and appraising, which we're trying to kick off, I think it's May, June time.

The challenges for, and that should be for everybody, the challenges for my managers around that will be time, if you're going to do it properly, you need, either you invest in it or you don't really, I think the structure that we've got within the organisation as a whole is quite imbalanced in terms of numbers of people reporting to certain people. So, if you look at my role, in theory, there's four people that report to me, formally, so that's fine, for appraisal setting and objective setting. I think CEO Alter, I think he has about 16 people directly reporting to him, which is not fine, and in the nursing fraternity, we really haven't worked through much lower than the nurse managers, who really formally reports to who. That's not clearly defined, and at this moment in time, even if we clearly defined it in a way which would fit with an objective and appraisal setting process, in terms of our hierarchy, there would still be at the bottom end, too many people reporting into too few people. So we need to re-look at, and we're currently doing that anyway. It's something about roles and functions, and who's taking responsibility for what.

IV: [Unclear] we are talking about making the groundwork first, and let everybody know what he or she should do, and on a ladder space, assess the targets that you are setting, and how much, let's say, it can be [unclear] per day, when it comes to the low levels that people who are actually doing the day to day job, and you would say that this is under development, this is an area that you are trying to work on.

IE: Yes.

IV: This is good. What do you consider as the main challenges, not that much the time element and the reporting element, but both on line level, you consider as the main challenges for [unclear] performance within a Hospice and after that, how this could be combined as a whole, you know, to provide a good reporting profile to senior management?

IE: I think one of the main challenges at the front line would be, I suppose I'd call it, getting buy in from front line staff, to the fact that that type of reporting and performance management and assessment type of framework should even be there, because what the front line would see, is that all those sorts of things are about bureaucracy, and all they do is take time away from patients. So at the lowest denominator, in terms of our staffing hierarchy, anything that isn't to do with hands on care for patients, is considered pretty worthless.

IV: That's where I would like to put the emphasis on this question, or which are the areas that you can measure per nurse, or per day, or per hour, if you would try to break down the person's schedule, the person's daily schedule, to asses that person, not this manager, this nurse is doing here of his job well, and how good you assess that this person knows what his job is and what [unclear] of his team, department and the whole Hospice is?

IE: At the moment, we don't and we can't, is the true answer, and I think what we need to try and do is, define, even at very basic levels, some, even if there was three, objective measures that we could start to define that type of basis on, and in fact, Medical directorwas talking to CEO and I recently about a hospital in London, who have literally done almost a time, well, they have done, a time in motion type study, on nurses. So for example, standing there with a clipboard making notes of everything that nurses do, and out of that, they've defined how much time nurses spend walking backwards and forwards to pick things up out of cupboards, you know, so it's a productivity type of thing, from which you can measure a whole range of things, whether it's value for money, or efficiency or all those sorts of things, but at the moment, we don't do anything like that.

IV: Based on your general background in nursing, what you think could be measured on a nurse's ward, per day, and which are the main indications?

IE: I think for the Hospice Movement, it would be useful to be able to measure a whole range of things, but something that will be meaningful for staff as well, would be about measuring patient contact time, because that's what the nurses see as valuable. I think we need to start to measure the contributions, somehow, and I don't know how the contribution that nurses make towards areas such as multi-disciplinary team type meetings, record keeping, communication and liaison with external agencies, so you know, time spent on the phone talking to GP surgeries, or social workers. They're the things, they're quite difficult to assess, and they're all part of a nurse's day, but they tend to get overlooked. So it's quite a large chunk, certainly of what qualified nurses will do, which is perceived as being not enough time delivered directly with a patient, and yet without all of that, the patient's experience would be different, they might not be discharged as quick as they might be otherwise be discharged, or something else might go wrong. But it's difficult to define how

much time and energy and effort goes into that, and what impact it has on the patient's overall care and experience. So it's quite easy, for example, to count the number of baths that happen in a week, and how much nursing time that might take, or how many dressings nurses might do in a week, and how much time that might take, all those other things, and I think if we can get to that point, although there will be a great deal of pain to get nurses through understanding why that might be useful to know about, one of the things that frustrates nurses a lot is that they're unable to demonstrate to their colleague, who are not nurses, including the senior management team, how they spend their time and what they do and what contribution they make. So for example, if nurses are sat in a handover discussing patients, what everybody else sees are nurses sitting down having a cup of tea. That's not what's happening.

IV: How do you think that, at this point exactly, would be, let's say, [unclear] for you to pass this performance measurement by asking them to say, to give you some areas that would make their job presentable?

IE: Yes, yes, what I'm trying to do at the moment is talk to them at every opportunity about trying to get a better science into nursing thinking, it could be something that certainly doctors are much better at, it's more of a quantity type of analysis, which nurses are not generally trained in, and not generally coached in, and as I say, they see it as management things, you know, anything with numbers or data is not useful, but I think that's, and I think that's not just hospice, I mean that tends to be nursing generically. And as I say, in the longer term, I think nurses for the future will probably come out of their training with a slightly different view on that, but coming back to the starting point, we'd love to have some of that, but we don't want that to be at the expense of, but the other things we don't want to lose [?] that's the challenge.

IV: What is the comparison now between your team at Pilgrim's Hospice and singular teams working in other hospices, do you think you are working from the same way or different way, would you be able to give me, let's say, three similarities and three differences, compared to the next, different hospice?

IE: Yes, I've probably not had enough experience to answer your question, in real terms, all I've understood is, I mean, many years ago I did some bank work myself within a hospice, but that wouldn't kind of give me enough to compare, it was when I was first a staff nurse and too many years ago. I've spoken to a number of peer colleagues in other organisations just by telephone, I've visited one, I shall be visiting another one next week, which is a London based hospice, whereas with a Kent based hospice, or very different sizes. I think there is a significantly large enough area to say that there's a lot of similarity in terms

of the way nurses work in the Hospice Movement. Around that, I think there are what I would call, outlier hospices, those who probably push the margins and the boundaries a bit more than others. Sometimes because they had a different starting point, so for example, some hospices started with a community service and didn't have any beds at all, and therefore, their community services might be perceived to be a bit further developed, because that's where their growth areas were, and then their beds came second. I think if you're in a Hospice where the beds came first, and maybe the community part came second, then there's a difference there. I think as well, a Hospice is quite a medicalised model of care, and here, I would say the medical model is very predominant, and the trustees are, as far as I understand, took a decision some years ago to invest in that model, and have done so, and to very good effect and benefit to patients. Now, other hospices, where I've spoken to a peer colleague, they might be different in that there's not been that investment quite so much in a medical model, and what I tend to find there is that sometimes, nursing developments are a bit further ahead than we might be at, and say for example, it might be the nurse who can discharge a patient, whereas here it wouldn't be a nurse who discharges a patient, the doctor would be the kind of key person for discharge. So I think it probably depends on the starting point. It probably depends on the leaderships in the organisation and what the culture of that organisation is, and in part, it depends on the kind of regulatory standards and best practice standards that everyone tries to work towards and adhere to.

So as I say, overall, I think there's a generic kind of baseline, which we tend to find everywhere, with some outlying kind of experiences and practices, but not as diverse as what you might find in a healthcare setting generically.

IV: Let's go for the interprofessional relationships there are at Pilgrim's Hospice now, are the members of your team working in co-operation with members of other teams?

IE: Yes, my experience of here is, judging by my past experiences in other organisations, that the whole concept of this multi-disciplinary working to the benefits of patients is excellent, the level of discussion and liaison, I actually think, within multi-disciplinary teams, there's a lot of challenge going on, you know, a lot of agreements and disagreements and discussion, I think MDTs would say, we need to challenge each other more, multi-disciplinary teams, but, from my experience, the level of challenge is much more than I've ever seen, and out of that good things come. So I think, what I observe is, everybody getting a good say, a fair say, able and confident to raise whatever issues they need to raise, and all centred around the patient. I don't think that's necessarily how the MDTs see it, but that's because they've only got their experienced to draw on, and so they think they can always do better, which is a complete…

IV: [Unclear] Do you think that they will like multi-disciplinary process, or do you think that they prefer to work more independently?

IE: No, well, from a nursing perspective, they're totally committed to multi-disciplinary teams for two reasons. One is, for what I call the right reason, and the other is, the right reason is, because that's the best outcome for the patient, it's a multitude of skills and expertise that are driving that. The reason that I sometimes think it's for the wrong reason, and a couple of nurses have said it to me recently when I've pushed them on what they need, and it's still this concept of, well, if the doctor backs me on the decision I've made, then if something goes wrong, the doctors back me and therefore I won't be in trouble, and that's a fallacy within nursing.

IV: So you can see somehow nurses feeling inferior to doctors, maybe this is not the right wording, or nurses not feeling confident enough to take responsibility for their own job, and therefore looking forward to be with somebody else.

IE: And although sometimes they feel frustrated in that, and that manifests as saying, we're not recognised as much as we should, we not valued as much as we should be, but there's also a level of comfort in the place they're in, because if you're held to account, you're on your own, and the place they're in makes them feel as if, it will be the doctor that's held to account, which it never would be of course, because each nurse is accountable to their public and their Nursing Midwifery Council who's their governing body. So I'm beginning to throw some pebbles in the water, if you like, about that concept in their minds, which they find challenging, and they can't give me answers.

IV: So, based on what you said, [unclear] answer the next question is yes, like you do think that the very nature of the work and the environment of the Hospice Movement is facilitating to avoid inter professional conflicts and influences, inter professional reaction [unclear] co-working people?

IE: Yes, because it's there for a good reason.

IV: That's true, we talked a little bit about the recruitment, there is one more thing before we go to recruitment, can you see if your team getting involved in the process of providing financial value to the hospice?

IE: Like do you mean in terms of demonstrating their value?

IV: This could be both demonstrating their value, but it could be at the same time, like if you are getting a patient in, and this patient is going to be followed by x amount of money, is

it your team that could do something about that, [unclear] getting involved in this process, or [unclear] there might be ways of doing the job of the team in a way that could facilitate either getting more people in, or getting the same people in using less resources, so all this area of things is increasing financial value, either [unclear]

IE: I would say yes, if you ask the nurses, they would say, no, that's nothing to do with them, and they wouldn't necessarily, at this stage, realise or understand the part they play in that. Even if they realised it and understood it, they would probably feel a bit uncomfortable with it, because they wouldn't see themselves as, if you like, potential income generators or people that would need to give much thought to, making sure there was value for money. They do understand, we need to spend money wisely, and be transparent in that, but that all comes second to the 110% they need to give to a patient on that day. So they don't see it as an integral part of what they do. But clearly, they're critically involved in the whole process.

IV: How are you generating this kind of income, based on your point of view?

IE: One of the things that's been happening recently, I think you will probably be familiar with this new payment system, Payment By Results, and the chaos that it's currently in. But one of the strategies that the trustees and senior management team have driven over recent years is around trying to increase the occupancy of our beds, and that has been steadily increasing. One of the things that needed to happen to enable that was that the whole team, nurses and others, needed to become much more flexible in being able to admit patients. There was an unwritten law from years ago, which went, we cannot admit more than two patients a day Monday to Friday, and everyone was wedded to that cause, for good reason, when you could carry on, where you could have four or five beds empty all the time. Now, financially, that's not a good thing, but also from the patient perspective, if there's somebody out there who needs to come in, and we've got a bed on the team, they need to come in, you know, to get the money, they need to come in. So, what the teams have been working on, is trying to overcome that unwritten rule about only two admissions per day Monday to Friday, and there are days now, for example, where we might admit four patients in a day, if we've got four beds, and if there's a need. Now, without you telling me that we're going to admit four patients in a day, I will probably walk down the stairs here, and I would know if we were going to get four patients in on that day, because I would feel the level of tension walking along the corridor. But there's been good achievements in that, the nurses certainly see it as added pressure, added stress, added workload, but in terms of value for money, having the beds full, doing the right thing for the right people, that has to be the way forward. From a patient need point of view, we wouldn't want to know there was

someone out there needing our services who couldn't come in because we only allowed two patients to come in each day, because that doesn't stack up either.

IV: How look, on an average basis, they staying here, and if you will, would you be able to give me a number, like an average number per day, how many patients are staying in the hospice?

IE: Yes, Claire's the guru on facts and figures, so she would probably have them in her head, but I think average length of stay in terms of days, is probably two weeks, two to three weeks. There are occasions where we've had somebody who's been here for months, for various different reasons, be they inappropriate or appropriate, [unclear] and that's a minority. In terms of admissions, again, I don't know off the top of my head the average figures, but certainly every week there are admissions. I wouldn't say at this stage we have admissions every day, but the throughput and turnover in patients is increasing. Obviously for the nurses as well as multi-disciplinary team, regardless of whether someone goes home or someone dies, there's an increased, as patients turn over more quickly, there's an increased component of the care after death as well that happens, or, at the point of discharge, to enable that discharge. So they're the sort of things that the nurses experience as a result of that change, and it means they have to be more flexible in the way they work.

IV: I see. We already spoke about, what are you expecting from the new people that you are going to be recruiting in the future, do you have any specified policies and criteria in terms of recruiting nurses in Pilgrim's Hospice, and are you looking for specific skills to acquire [unclear]

IE: I mean, there's a range of things around recruitment and retention that we've already got, be it from basics of job descriptions and person specifications, through to recruitment and retention policies for complements and new staff employee handbooks, which lay out all of the different parameters of what are our current policies and procedures that support employees at work, and the employer [unclear] What we have got to do is completely revise all the job descriptions, because they're too out of date now, and get everybody signed up to their new job descriptions, and that's even for the here and now, that's before we think about what we need for the future. One of the key things for us, and at the moment, what we've actually got is a kind of framework around nursing which suggest that, you know, if you join the organisation, and then you're thinking about wanting to progress to the next grade of nurse, or become a ward sister, or you know, further along the line, then you will have needed to achieve this, this or this, in education terms. That goes from internal courses to MSC degrees. What's not clear about the future is, number one, the Nursing Midwifery Council are still doing work and making statements, or not making enough statements, on

what they're defining as advanced clinical practice, and where would our nurses fit into that framework, so we need to keep our eye on the ball with professional regulatory guidance and advice. But I think it's also becoming clear that, in terms of future around other patients that we might look after, what we currently, either commission or provide for education for our nursing staff and for others, might need to be different, might need to be more, or different entirely, or mix and match as both. So that will need to be built in, in terms of the requirements we'll be either looking for in people we recruit, or people that we develop once they're here. So, and there might be other things that we're missing at the moment.

IV: So in fact, there are things that you are looking for to get from the job market?

IE: Yes.

IV: Specific areas.

IE: Yes, there are now.

IV: It's just that haven't been put into, they haven't conceptualised …

IE: Yes, and they haven't been future proofed, if I can use that word, so they might stack up [unclear] out to a certain extent, but we haven't looked forward yet. That's part of our service review, and review of our current education, sort of department, about what do we need for the future?

IV: Do you think that the recruitment market is competitive, is it difficult for you to get the kind of people you want, and is it costly, what's the main thing that you would promote, your recruitment strategy?

IE: Right, well, for nurses, at the moment we don't have a problem, and we've got people who would want to come and work here. And on that basis, certainly when I speak to [unclear] in HR, they will always say to me, well, that's good enough isn't it? What really concerns me about that is, that I think we might be digging ourselves a hole for the future, in that, and you're probably aware of this, certainly in the Health Service, all the medical careers have been through this process, they're called modernising medical careers, and the consultants have got new contracts and GPs have got different working hours and we all know, from the newspapers and the press that that's gone badly wrong in financial terms from the government's perspective. The same thing has happened in the NHS for nurses, and everybody else, for that matter, so whether you're in catering or therapists, whatever you are, if you're not a medic in the NHS, everybody went through this gruelling bureaucratic process called, Agenda for Change. Some hospices have gone through the same process, and

one of the outcomes was, their pay bill significantly increased, hence at Pilgrim's, there was a decision taken not to go down that route, and that stacks up financially, now. It doesn't stack up in the nurse's mind, because they feel they're losing out in terms of what their NHS colleagues might have, both financially, and in terms of a concept of modernisation. So for nursing, we still call people, D Grade, F Grade, which is that old NHS clinical grading system, which now no longer exists. So one of the troubles we will have in the future is, it's difficult to measure a system against another system when they're two different systems of pay. In addition to that, new nurses, when they start to arrive, who have only ever known Agenda for Change, Agenda for Change is a pay system, will say, well, what's this clinical grading business, it's a bit Florence Nightingale, you know, it's old and it's old fashioned, it's not modern. It's also difficult to see, I mean, certainly all clinical nurses in the NHS, what tended to happen with that pay structure was, managers who didn't have hands on clinical roles, pay went down, so that I had a job as a manager in the NHS, and I went down in my grading when that process come in. The frontline staff, who work with patients, went up. So it kind of re-dressed that balance between [unclear] pay going up here and the frontline people's pay becoming more disproportionate. But, it is the case, that in the Hospice world, those who have gone the Agenda for Change route, have got a much bigger pay bill, so I think we're in danger, as time goes on, of becoming more disparate with NHS pay, and that's something I kind of flagged up to CEO, as well as being perceived to be a bit old fashioned.

How would we, in terms of our recruitment, what would we sell ourselves on? What we try to sell ourselves on, and we haven't had to do a lot of nursing recruitment at all recently, but just thinking if we were, and what we try to say to our own nurses about well, you might be a bit less well paid than your NHS counterpart, but, the but tends to be, better working environment, which it no doubt is, free car parking, for those that need to park, it's true a lot of NHS staff do have to pay now. We would say that we go for things like flexible working hours and good training and education and those sorts of things, but really, I think that begins to wear a bit thin, in that all organisations who are perceived to be good employers and working within the law of employment, have to be providing those sorts of opportunities for people, whether it's flexible working, flexible retirement, those sorts of things. So I think maybe the things we've championed ourselves on in the past, and prided ourselves on…

IV: Are coming due.

IE: Yes.

IV: There might be [unclear] also.

IE: Exactly.

IV: I see, and it looks like your [unclear] your main competitor in the job market, [unclear] that you've been able to pay better salaries to people.

IE: Yes, or there wouldn't, I mean, we would also argue things like better staffing better teamwork, better [unclear] and I think all that is true, but just, you know, if you said that to nurses, they would just raise their eyebrows.

IV: Now, it's time to ask for your evaluation of the interview process I've put you through for the last hour and this sort of stuff, did you enjoy discussing with me and would you be able to indicate like, three strong and three weak areas of the whole process, do you think that there are cases that we haven't gone therefore [unclear]

IE: I think, it's a fascinating process, and I really wish you luck with it, and I think CEO did mention that we might be able, at a future date, to see your product, and that would be really interesting, I would be fascinated.

IV: I will do that for you.

IE: That would be excellent. I thoroughly enjoyed it personally, because I like talking a lot, as you gathered, but it also gives me a chance, as a newcomer, to kind of just sit down and reflect on what I really think, which in a busy day, you tend not to do, so there's a spin off for me in this, because I've had a chance to think about some things I wouldn't otherwise have done. I think all of your questions are going to give you so much information, and I've been wondering who your poor typist is going to be for your transcribing, I'm just thinking about the amount of data that you're going to end up working with, and again, I commend you for what you're going through in terms of process of your PhD and how you're going to put all of this together, I'd be fascinated to hear the end point. I really don't see, in terms of the weak areas, I think the only weakness is probably in terms of my newness in post won't have given you maybe as much input as what probably I could have done in another year's time, if you were asking me the same set of questions. But hopefully, the other people that you will meet have had a lot longer in post and so maybe there might be something that comes out of that which might even be useful, or would cover maybe the kind of gaps, in terms of the view that I've been able to share back.

IV: Would you like to suggest any improvement or things that could be addressed on a different way?

IE: No, not at all, I think it's been a good process.

IV: Thank you very much.

IE: I did my nursing degree at the University of Hertfordshire…

IV: Excellent, which campus?.

IE: It was a long time, it's a much bigger place now, than what it was.

IV: Now its College became bigger and bigger, so also they gathered all the campuses in Hatfield, and they only left the Law School in St Albans

IE: Right, because I was at Hatfield, the Hatfield site.

IV: Yes, not great town but good university.

IE: Yes, exactly.

IV: Would you like to participate in a similar in the future?

IE: Yes, absolutely.

IV: Not exactly with the same questions, but …

IE: Yes, if there's anything that comes from it, I'd be delighted.

IV: That's great! Thank you very much.

IE: Pleasure to meet you, and I do wish you luck!

IV: Thank you so much.

Interview with the Community Palliative Care Team Manager of Hospice A:

Speaker key

IV: Interviewer

IE: Interviewee

IV: Before we will start with the interview itself, I will have to let you know about the ethics and confidentiality policy of the University. You can be assured that any kind of information you will provide within the interview is going to be kept confidential, whichever information out of it we publish is not going to carry your name or the name of the institution you are working for. If at any time you find out that you don't feel comfortable answering a particular question you can just say that you don't want to answer this question, or if you feel at some point that you want to interrupt or stop the interview process, you can just feel free and ask for that.

IE: No problem. Thank you for that.

IV: You're welcome. And would you like to, first of all a few things about you around your involvement with the hospice movement, and this would include how long with, how long you have been with hospices, how long have you been with this hospice in particular and what it was that motivated you to join the hospice movement.

IE: Okay. I began nursing in 1983, so about 25 years nursing experience plus. I've always had an interest in cancer, even before I became a nurse and before, just before I became a nurse or went onto my training my mum died when I was 18. And that was a pretty horrific thing for my family; it broke my family up, we, it just dissipated us. Mum was the thing that kept us all together. But before mum had been ill I'd had an interest in cancer, so all through my nurse training I focused on cancer patients and was particularly interested in how we helped them and how we made them better or not, and how we cared for them when they weren't going to get better.

Shortly after finishing my nurse training, I'd say within two years of qualifying as a nurse, I worked at XXX as a night nurse on the inpatient unit and I loved it, but I had a baby and that was that. I've not really had a massive career break, only ever maternity leave, but after I had my daughter I went into paediatric nursing - so a complete different area. However, my interest in caring for dying people was there still so I moved back to the general side of

nursing and I did district nursing, believing that that was the way that I would go forward. That didn't work so I went back to hospital and recognised that people were dying very badly in hospital, did a lot of work in my own time setting up what was called a Quality Care Interest Group using my knowledge from my hospice time and then decided that I really wanted to specialise in that. So 1995 went into XXX Hospice, as ward sister then ward manager and then came to Hospice B, still here.

IV: So the motive was related to your family's experiences?

IE: Initially, yes. I wanted to make the dying experience better for other families.

IV: Do you think that many people that work with [?] the dying were motivated by similar factors as you or…?

IE: Not everyone, but I do believe that there is an element of people that work in a hospice that are doing it for something for themselves. They may not admit that, but actually there's an awful lot you get back from giving to a hospice. So if people perhaps have had a lot of loss or maybe personal relationship difficulties you can get a great deal of love back from caring for the dying - but that's not research or evidence based, that's just my own opinion.

IV: This is what we are looking for, basically. Have you noticed any shift of motivation nowadays? Have you noticed any change? For example, when the hospice movement started it was voluntary based, primarily, nowadays it is entering the maturity state so it is becoming a career. People are, some people start taking themselves as professionals or seeing themselves as professionals. Can you see this change?

IE: Very much so; I would agree with that. And the other bit that I would also say is that a lot of people think that coming and working in a hospice is and easy game because you've got lots more staff and lots more time to do things. And I would say that the way in which the patients have changed and become more complex and their illnesses with co-morbidities, everything, actually it's not an easy option to work in a hospice anymore, it is really… I don't think it's ever been an easy option, but it's more tough now to nurse in a hospice or other departments that it's ever been.

IV: Can you see it being a challenge for hospices?

IE: A challenge?

IV: Yes, or an opportunity.

IE: I think it depends on how you resource it, because unless areas are properly resourced with staff then it can become more or a challenge and a disappointment when you aren't delivering the holistic approach of nursing care that you believe you should be. Or having that time to be with the dying patients is hugely important. And if that's slipping away from the clinicians and the nurses they'll get frustrated, so it's not, it then becomes a disappointing experience and you're not meeting the expectations not only of yourself as a professional but in what the dying people and their families are expecting of you.

IV: If you had to evaluate the challenges for the hospice movement as a whole, for example, we mentioned already that it is entering maturity as it grows big and fast, what these challenged would be? Would it include anything related to sector governance? Would they be just external challenges such as age of the population, more patients coming in, or there would be other challenges as well in terms of management, resource allocation?

IE: I think one of our biggest challenges is getting money and sustaining an adequate amount of money to fund the hospice, because we are a voluntary provider. However, nursing staff, clinicians, occupational therapists, we're not cheap, and therefore investment in staff, be that just in numbers of staff as well as their training is hugely important. If staff don't feel that they are able to do their jobs well then morale drops, they become very dissatisfied. They're working in a highly emotive arena. They've got to feel good about what they're doing. So our challenge I see is to engage with our local hospitals, our local trusts, to ensure that we get sufficient resources in order to meet the care needs of the aging, it's an aging population. I already mentioned co-morbidities. With the latest End of Life Strategy there's even a bigger push on hospices to open their doors even wider and I'm not sure we're fit for purpose yet for that.

IV: I see what you mean. So you sort of identified challenges both inside the sector and outside the sector.

IE: Absolutely, yes.

IV: And funding is becoming a major issue.

IE: Yes.

IV: What about Hospice B? Which of these particular challenges do you think will be coming [?] for the hospices [unclear] in the future in the next five years or so?

IE: Can you just say that first bit again? Which…?

IV: We mentioned some challenges about the hospice movement in general; which of them do you think would be the determining factor in the hospice's strategy for the next five years.

IE: The determining factor? I have to say money because without that some of our ideas can't possibly go ahead.

IV: I see what you mean. Now, I [unclear] bring things to your own role [several unclear words] would you like to talk to me about what you're doing and what your team is doing within Hospice B?

IE: I have two teams so, and they are different although they both work in the community. So I have one team that is highly skilled, perhaps I have three teams, but anyway, one team highly skilled nurses, advanced practitioners caring for dying people at home giving specialist advice. The other team, Hospice at Home, give what we call hands-on nursing care at the very end of life, predominantly the last two weeks. So they support patients, their families and people like district nurses and social services with the practical hands-on elements of nursing care at the very end of life. And I also have an administration team, as well.

IV: That's wonderful. And are you getting involved in long term target setting? Or your work is mainly day to day management?

IE: We have lots of long term target setting and I've had an away day with my nurse specialist team. I haven't had an away day with my Hospice at Home team, but we have a vision of what we should be doing. What we haven't got is money, okay?

IV: I see what you mean. And what about targets that are set for you, are you getting involved on that scale?

IE: Yes.

IV: If you had to describe the management style to me it would be more of a flat management style?

IE: We try to make it as flat as possible, but obviously there are some layers - but we have made it as flat as we can, yes.

IV: This is great. And you told me already that your team is managed in a similar way, so you are making it, you are keeping it flat and you are open to everyone's ideas?

IE: Yes, I have team, that's all.

IV: Would you like to describe a typical working day of yourself and a typical working day of your team?

IE: Okay, for myself I can never come in and know exactly what I'm going to be doing that day because situations can arise that will need my immediate attention. For example, a letter from a patient's relative, a distressed letter on Monday, a meeting at the request of people externally to the organisation that was hugely important to the future of our services, and I have to accommodate that. So I may have my own agenda but I have to respond to the demands around me, so it can be chaotic and I rarely get blocks of time when I can concentrate on my work. So at the moment I'm working one day a week at home in order to get some space to do that, otherwise 14 hours in a day [?] easily, that's without the post and that's without other people wanting to come and see me because a problem has arisen.

For my team, for the nurse specialists they will spend about 40% of their time giving telephone advice, receiving or giving. They will spend another 40% of their time probably out visiting patients and 20% of their time writing that all up and communicating with other people internally, maybe working on audits, teaching. The Hospice at Home team will spend I would say 90% of their time out in the community caring for patients and about ten to 20% of their time in the management, sort of documentation of. And the admin team never stop, they are… that phone starts ringing, 80 to 100 calls a day, they don't have a minute to breathe.

IV: I see what you mean. Do you think that similar teams in other hospice are working in the same way as your team is working here, or there are differences in the ways?

IE: I think there are possibly differences. I think that we have experienced and increased demand for our services which we haven't been able to match with resources, and we need to look at how we're responding. But what we can't stop is the phone ringing and we can't stop the referrals coming in. We have no control over that.

IV: I see. And you think that this applies to every single hospice possibly or…?

IE: I think, I think to some degree, but possibly we are feeling it more here because of the work that we've been doing engaging with our local communities so they know about our services. And it will get more because of the End of Life Strategy push.

IV: Are you using any specific methods to measure the performance of your team?

IE: We do some data collection but we're in a transition phase at the moment of computer systems so that's proved… giving us some teething problems. The other methods

of measure that we use personal is through an appraisal system and targets and an action plan is set at each appraisal and then we have a review and we see how people are doing on those reviews. I would say to you that in my teams I, there is not one member of the team that is not functioning well above high standard.

IV: It's like you have a quality [? quantity] of experience of this work so the next questions may be, you might be the best person I could ask it up to now. What's the main challenge in the process of measuring personnel performance? We think a hospice in particular and [several unclear words].

IE: The main challenge?

IV: How do you know that I do my job well?

IE: Because I know when it's not done - that would be the easiest way to say it. When we come to… I'm very aware of every member of my team and what they're doing and how they're doing it. I will ask for things for a certain date; if I'm not getting it I will go back to them. They may give me a reason why, maybe they've got, veered off on another priority for someone else, but it's rare that that happens mainly because they will inform me. If they're struggling with a deadline date or anything, they will come to me and say, I'm really struggling, can I have another two weeks? And that's fine, as long as we communicate; communication is key.

IV: If I had to start a new hospice tomorrow and I'm probably inexperienced, I was hiring you to run my nursing department and I'm asking for your advice, how am I going to measure the performance of the nurses in this hospice? If you would, if you were to come there then it would be for me but if you were not to come there and you just had to develop a model, how would it be?

IE: There are lots of models and tools available at the moment. In the National Health Service they have what they call KF Extra framework which is a series of competencies for every post that is banded. Here at Hospice B we try to implement the Royal College of Nursing competencies for palliative care. I would say to you they are not the best measured, but that's a personal opinion. My better measure is the job description and if I can assure myself looking at that person's job description that they are fulfilling each element of that then I know. So if I were advising you the quick and sharp way would be to use your job description, and then you may want to introduce something along a KF Extra competency framework.

IV: This sounds great. What about the relationships between your team and other professionals within the hospice? Is your team working in isolation or they have to interact with loads of other professionals?

IE: They have to work with every department in the hospice and there are some tensions between certain departments. And I used to manage the inpatient unit and the day hospice here so I'm [inaudible] aware of both sides of the thing. The problem I think is when you work in your own department you become very blinkered to what may be happening elsewhere. And when you don't have an understanding of other departments' roles it's easy to be critical or not understand and we know we've got some work to do on bridging that, particularly between the inpatient and the community team.

IV: This is good. Do you think your personnel is happy with that?

IE: Very happy; they raised it themselves at an away time. Our problem is because we're persistently running under establishment of staff we haven't got the capacity to go and work, what we'd like to do is spend regular time, each person going and working with their colleagues on the inpatient unit and we'd like them to come and have a day with us. But we haven't got that slack, you know, people are working to the absolute limit, so there is no capacity to do that at the moment.

IV: Do you think that the in the past before people started viewing themselves as professionals first of all rather than volunteers things were easier, most things?

IE: Yes I think there was a, historically there was a family feel to the hospice movement. And as the hospice movement and hospices as individual departments, units have grown people feel that sense of moving away from a family and more distance. So you could look at the hospice as an analogy as a core family, and then you're expanding that family and how families move away from each other.

IV: I see what you mean, so the more professionals they feel so the less attached they become to other professionals inside the organisation.

IE: Yes.

IV: What about your recruitment policies? Would you like to give me some information about that? And you told me you are involved in recruitment, so what is your criteria for hiring new members of your, of your team?

IE: Well, whenever a vacancy arises… and I have to tell you that in the two years I've been with the community team I've never had a full team itself. As soon as I recruit

somebody leaves or retires, you know, there are genuine reasons for moving on, as well. We have… we look at that vacancy and we determine, myself, and then I advise the nursing director do I want to fill like with like or do we need to do something different? And you look at everything that's going on in your service and what the demands are of your service before you make that decision. Then we have to complete a request to fill the vacancy which goes to our HR department and then we process that. We would attach a job description, the salary range, where you want the job advertised, everything like that, but I never just recruit without thinking about what do I want to do with that.

IV: So you would describe it as an active process, a dynamic process, not something you would say is structured and you know what you are looking for before you will start recruiting people?

IE: Because we have a vision, we have a strategy, yes, for our department of how we're going to work. However, there are some structures and processes that we have to comply with that are part of the hospice way of working, which is fine. They're good structures and processes, they're not negative, and it helps keep everything track-able and auditable, because it's a very expensive process to recruit.

IV: So my understanding is that even though there are structures and policies you have to recruit people and what type of people you are looking for, they are flexible enough to allow you to make your choices, even to change roles, to change…?

IE: Yes because I'm a budget holder and therefore I can, I can, not choose but I can recommend how I'd like to spend that money.

IV: This is good. Are you looking for specific skills and how easy it is for you to find these skills or these [unclear]?

IE: Very hard, it's very, very… which is why I think we've had so, such as tough time recruiting. We look for a minimum of a degree for a nurse specialist and they have to have experience in care of dying patients. We'd like them to have a degree that specialises in care of dying patients but we've had to be a little bit more flexible around that and look at their experience as well as their academic qualifications.

IV: This looks good. Is there a competitive market for these types of skills in the particular area?

IE: It's a competitive market full stop because we cover a very rural area here at Hospice B. My colleagues in similar roles, say in Birmingham and Solihull, don't have such

problems because they're very close to major hospitals with a cohort of staff there looking for opportunities. And we are, because we're in a village we haven't got any major hospitals right on our doorstep, we have less sort of feeder routes to our nurse specialist roles.

IV: Whom would you consider to be your main competitor in this market? You said that there are no hospitals, there are not many hospices around, so if I was an employee and I had to choose and I want somewhere close in this region, who would I have to choose between, Hospice B and…?

IE: It depends where you live because if you live in the north you would go to either Macmillan XXX Unit or you would to go XXX Macmillan, which is in XXX. If you live more over to the west you would look at XXX House. If you look to the east, I'm not sure what's over there, I think it's XXX so there might be XXX and to the south you've got an NHS hospice of XXX and then you're touching XXX and XXX, but it's a considerable distance. One of the reasons I moved to Hospice B is because I was getting up at half past five in the morning to travel to south Birmingham for my job because I live near here, so it's not easy.

IV: I see what you mean. If you considered salary…?

IE: Salary is a big issue and I think at the moment there is a general belief among my clinical nurse specialist team that Hospice B do not pay as well as the NHS/other hospices. If they paid, if we paid more than other hospices or the NHS we may attract people to travel, possibly, we may.

IV: That's very interesting.

IE: How are we doing for time?

IV: [Several unclear words] this is great. I would like to ask you some general feedback on the interview now. Have you enjoyed the conversation that we've had?

IE: Yes!

IV: And would you like to give me three strong points, like points that you particularly liked and perhaps three points that you didn't really…?

IE: Oh, that's hard. I think it's always useful to have the opportunity to talk about what you know through experience and knowledge of your job. Not everything has to be research based and I think we don't give enough merit sometimes to the value of what people like myself, although I am an academic, you know, myself, I also recognise that that's just one

arm, one way of bringing information to decision making. It's much bigger than that and you need to look at the whole evidence base. So just talking through, a lot of what I said to you I know but I couldn't prove with a research paper unless I had lots of time to do lots of research and evidence based practice. And that I think is a weakness for the hospice movement in terms of having time, [?] but my nursing director and chief exec know that I'm very passionate about the lack of research and evidence based practice in the hospice movement and particularly with cancer. So I feel as if I haven't answered your question really in that, the three things, but I haven't found everything difficult about the process, thank you.

IV: This is good. Do you think that there would be something more that I could ask, I could include on the questionnaire, something that we didn't get in [several unclear words]?

IE: What's your outcome? What are you hoping to achieve? What's the title of your study?

IV: I've looking for hospice management, funding and finances [several unclear words] other factors [unclear].

IE: Okay. Are you interviewing any sort of fund raising type people?

IV: Yes.

IE: So no, I don't think, I don't think… you're hearing clinician perspective, management perspective, as I have a dual role. You're obviously looking at people who are, the ones that raise the money, that get some of the money in for us, so I don't know what else you could do. You're doing HR, as well, aren't you? You're seeing our support services director. You're getting a lot of different opinions there. There's a lot of history to the hospice movement and there are many people who have worked here for 25 years since it began, and it might be interesting to have interviewed someone who was here from day one.

IV: This would have been great. So any improvements of the…?

IE: Any improvements?

IV: Yes, that I could possibly…?

IE: For this? No, not at all.

IV: Would you like to participate in something I am doing in the future?

IE: Possibly, yes. **IV:** Thank you so much.

Interview with the Nursing Director of Hospice D:

Speaker key

IV: Interviewer

IE: Interviewee

IV: Before we will start with the interview itself, I will have to let you know about the ethics and confidentiality policy of the University. You can be assured that any kind of information you will provide within the interview is going to be kept confidential, whichever information out of it we publish is not going to carry your name or the name of the institution you are working for. If at any time you find out that you don't feel comfortable answering a particular question you can just say that you don't want to answer this question, or if you feel at some point that you want to interrupt or stop the interview process, you can just feel free and ask for that. Are we comfortable with this arrangement?

IE: Yes,

IV: That's okay for you? That's great. So for the first question would you like to tell me a few things about your background and your involvement with the hospice movement, how long have been with the hospice movement?

IE: I started working at the original Hospice D 25 years ago and it was the beginning, really, of the hospice movement. A lot of areas were looking into setting up small units where they could look after people with terminal illnesses and that's how St. Roccos started. It actually started five years before that with a small fundraising group who were trying to raise the money to start the original hospice and look for their holding. It was set up by two local GPs and some people within the community. They started raising money on a voluntary capacity and they bought their first building, which was an old vicarage, for £25,000 and that was approximately about 27 years ago. That hospice, I was employed at the hospice at the time. We had nine patients and I'd originally had a background in working in accident and emergency but, looking back from when I was a student nurse, I always had a tendency to look after people who were at the end of the their life and felt there was a need, outside the acute setting, where people could be looked after with terminal illness. And that really is what attracted me to the original advert for the hospice.

At the time there was lots of small hospices in towns like Warrington that decided to set up their own unit, mainly because they felt the acute setting, the NHS, didn't cater for patients who didn't want to go into hospital to die, they didn't necessarily want to stay at home to die, so they decided to set up this very small unit. It consisted of nine beds, no other facilities at all and just looking after nine patients. We had part time GPs who did it on a voluntary, in a voluntary capacity as part of their GP role. We had, it was felt that the nursing staff couldn't be run with volunteers because you have to have a certain amount of commitment – volunteers could only do it as when they needed it – so they decided to employ the nursing staff on a paid basis, on a salary basis and I think, at the time, we had one secretary. And that's... and a cleaner and a cook, and that was it when we first started.

As the hospice... and I think we got a small grant from the NHS at the time and as we realised, as we opened, over the years, we realised that it wasn't just looking after patients, nursing them at the end of life, it was leading up to that, it was giving the family support while they were, sort of, entering the phase of the terminal illness. So that's really how I started. And, I've been here ever since. I've seen a lot of changes. It's a big business now.

IV: You've more than covered all the previous questions, and I'm getting some really good information there. Now, let's move onto how professional is the hospice movement in general. You said that you have noticed many changes. What about changes in the ideals and really the intention of the hospice movement during the period that you are actively involved with it?

For example, we can use, you told me a few things about volunteers, and you told me that within this hospice, from the very beginning, you decided that it was of absolute importance to have professional nurses, within the setting.

How is it nowadays? How it used to be here and at other hospices, and how it looks nowadays? Are you finding other hospices are moving a little bit more professionally nowadays, or is it still the same idea as it used to be?

IE: I think if you look at why hospices were set up, it was all about people in their dying phase of their illness. Now, it's about palliative medicine, and palliative medicine at the time is, now has become a branch of medicine, so when people are dying, it's all about what you can do with them in that phase of their illness, so it's almost become a speciality, so it's all about how you can give them quality of life, and by doing that, you have to…it's about the medication. It's about the treatment, it's about working with other areas within the medical field, where they…people don't necessarily accept end of life nowadays, than when

hospices first started. People accepted that they were coming to the end of their life, there was very little treatment that could be given.

Now, it's all about chemotherapy, radiotherapy, keep giving them quality by giving them good pain control, so therefore there's a cost implication of all that, that probably wasn't there when the hospices first moved. Also, as well I think people accepted that they were going in a hospice to die, that's not the case these days. It's all about keeping, giving them quality of life towards the end of life, and with that is obviously the professionalism, the change of people's qualifications, updating in new medical, new treatments, and also as well it's about, it's not just about the nursing side of it. It's about what you can give that patient.

You give them family support, which we've got a family support unit, which consists of social workers, bereavement counsellors, and they support the patient and the family while they're actually going through this phase of the illness. It's not about coming in as an inpatient. It's about day care. Patients can come to the hospice, or day care, they may come in for one day a week, so we can monitor their illness. The doctors we have now are no longer part time. They're paid professionals, they're here every day, they cover us seven days a week, and it's become much more medicalised, whereas when it first started, it was very much the nursing side of the patient. Whereas now, those are the big changes really.

IV: What do you think motivates people to join the hospice movement, when you started, regardless of volunteer or professional?

IE: I think a lot of it is because obviously end of life is very emotive. In a hospital, you probably felt things have changed. They have very good care in hospitals now, people look at … originally home was the place where everybody, people tended to die. People's lives have changed. They haven't got the families around them now to look after them. Families move on. You know, in certain cases, so they haven't got the family to look after them within their own environment. They do not find a hospital ward where there's lots of things going on, an ideal place for a patient to be at the end of their life. They felt that a hospice movement would be able to give them the dignity, the environment that they needed to make it a place where people could die comfortably really.

The volunteers are obviously like-minded people who probably are professionals or have been professionals, and they come in and do it as they can't commit themselves fully as a paid job, but would like to come in for a couple of hours a week, to do things like flowers and make drinks for relatives. They make drinks, they help to give the patient's meals out, so in a way, they do it, a non-paid job but the jobs that they do that help the nurses be able to give all the care and the time that patients need at the end of their life.

IV: Do you think that there are any changes in the mode for volunteers and professionals between nowadays and back when you started with the hospice movement?

IE: I think as far as professionals are concerned is that I think nursing has changed. I think, if I look back a long time ago, when I started in nursing, nurses these days are quite, more technologically minded than when we…we've moved on people who've been in nursing a long time. I think sometimes when you look at the nurses of today, it was a risk when you came into nursing in a hospice, many years ago, because you weren't quite sure of the financial implication, because it was a charity, so you weren't quite sure. You didn't get the benefit, if you like, the NHS benefits, when you came into the hospice movement. In some ways, you took a risk really, but the risk has paid off because the hospice movement has moved on. It's had to move on to survive.

It's got bigger, each hospice has got bigger. It's added to the services, so that the money that comes in from, into the charity has had to increase to keep the hospice movement going. As far as volunteers are concerned, I think their motives are still very much the same. They're obviously very interested. They want to give the time, and they don't commit themselves to a paid job, but they can come in as and when they need to, and they're a very valued member of the organisation. Because they do many things. On the ward, I've just mentioned the things on the ward, but outside the hospice, they're the ones that really help to bring the money in, the funds in.

IV: Interesting. If we focus a bit more on the challenges that the hospice movement is facing, what do you think is going to be the main challenge for the hospice movement now or in the near future, and we are talking about challenges, both internally like maturity risk or equipment risk, or external challenges, like regulations or [unclear], documentation, need to provide more services? What do you see as upcoming challenging points, within the next five years?

IE: I think the cost, the cost really because it's a very expensive service, and we're very fortunate that we are a very well-supported charity, but the local population will bring the money into the hospice, but obviously financially out there, people haven't got the money to give to us, as a voluntary contribution, so I think the cost. Also the fact that the hospice movement, as far as providing services has got to move on, to keep going, because you've got to be providing the services that people expect at end of life. You've got to be providing the therapy services that we do, the day care, the family support and all our staff are paid at the same rates as the NHS.

You have to do that to keep your recruitment levels, although you can say that we're on a par salary wise of the NHS, so that's always been something that the hospice has been able to do, to pay the salaries, but in the future, and I think you've got to do that, to keep the professionalism of the staff, and to get the right quality of staff. We've never had a problem with recruitment. At times, we may have had maybe not as many applicants for a job as what…that fluctuates a little bit, but on the whole, staff recruitment and staff staying here, we've had very little movement. I've been here 25 years. A lot of our staff have been here, a long time really.

IV: That's good, so summarising the challenges, you might cite cost, coming from the fact that you need to increase service quality, and capacity, and you said, it's a little bit of external issue, because the market or society?

IE: Yes, I think society, I mean, the way that this hospice was carried on was because we've been able to move on. We've been able to go from a nine bedded, converted vicarage to this building that we have here, which we've got ten beds. We've only got ten beds, because our inpatient capacity, we've never felt the need to increase, but our day care, we've increased. We've just built a new day care, and we've just built accommodation for the community McMillan nurses to be on site, the community palliative care team are going to be on site.

We've just built a new education facility, so to do all that, you've got to have, you've got to attract, you've got to have the facilities, to be able to increase the facilities for the patient, so in other words, for education. Education wide, we're educating people, that they're able to come in here and learn about palliative care, day care as far as day care facilities are concerned. We've just built a whole new day care. We've a therapy unit, with relaxation rooms, with a craft area. I don't know if you've been around the hospice, but I can show you the new facilities afterwards, but it's increasing these services, because if you increase your services, you're providing more people in the community, and by providing more people in the community, they respond by giving you money as donations.

The more people you treat within their end of life, they may not necessarily come into the hospice to die, but we may have treated them in day care, and then it sounds quite mercenary, but they will give you money back of donations for looking after their care, or they will support you when you're having a fundraising event in the community, and the community as a whole, companies, they will use us as a fundraising exercise within the building, within an organisation, and that will add, gives the feel good factor basically.

IV: That looks good talking about patients. Is it a particular focus on one patient group, like cancer patients, or you are providing the service to other patients as well?

IE: Originally when we set up, we were originally just the cancer patients and then within a short space of time, we realised that there were other illnesses that we would have to provide for, and we chose patients like motor neuron disease and other unusual terminal illnesses. We had to be very mindful that we didn't open the gates, so there would be too many patients for us to provide care for, but over the years, palliative care is all about end of life for anybody, not just cancer patients. It could be for heart failure patients, it could be for liver failure patients, it could be…so the doors are opening now for all patients who are end of life, because that's really where palliative care has changed.

IV: Are you seeing this as a challenge? For example, if you had to take somebody with HIV, would this require additional staff? Would this require additional equipment or money?

IE: No, you treat everybody as if they could be an HIV patient as a nurse, because you don't know, you do know that the patients that have HIV, as a nurse in whatever you do, everybody is a potential, so you treat them, when you go about your care for them, because obviously you've got to care for them. As nurses as well, it's one of those things that really is in…we don't get an awful lot of HIV patients, because there's a facility in Liverpool and they tend to be treated by their medical team, so they tend to go there, but we have had HIV patients in, but it's not a problem.

IV: How do you think that the hospice sector should respond to the challenges you mentioned earlier on, but I want to start it slightly differently. We talked about Hospice D and the challenges you face here. Is there any action plan on your side? Do you feel that the management team, yourself, you're part of it, adapting to a proactive approach to overcome challenges, like increasing costs or more patients to care for? Or, you feel like there is going to be a reactive approach, to that, if something happens, then we are going to do something else?

IE: I think we always have had a strategy and so therefore we have a five year strategy, or a three year strategy, whichever it is, and we look at what we're going to do. The management works very closely. The hospice itself, the majority of the staff are paid, but we have a board of trustees who are voluntary, and they oversee what's happening. If the hospice can move forward in certain areas. You know, they have to stay or they feel that we can't afford to do that.

The big project, and we've been here 11 years, in this hospice and this was a purpose built, so we went from a building that cost 25,000 probably about 25 years ago, to this building, that probably cost us about 2.5 million, I think, and we've just had another new extension, which is over the 2.5 million, which obviously is coming to the end, but we'd been planning that probably five years, so we've always got a way forward. The same as, at the moment, the big thing is increase our beds, but at the moment we've decided to stay with the ten beds we have, because we're looking at an outreach service, where we can actually go and support district nurses to look after patients in their own homes, so a district nurse, the community nurses who are PCT, they look after the patients, but we will support them in their role, so that patients can stay at home, if that's what they want to do.

So, the challenges are really that I don't think it can stand still. You've always got to be looking ahead of how you can improve, because that is how you get people to use your service. If we even stayed in the nine bedded unit in a very small vicarage, we wouldn't have survived, because you wouldn't have been providing the service for as many people as what we do now.

IV: Interesting, do you think that the challenge that St. Roccos is facing can be generalised to the hospice movement, and how do you think that hospices as a sector should respond to these type of challenges?

IE: I think all hospices are finding it difficult, because obviously fundraising, and I think you're speaking to one of our fundraisers, they will tell you that that fluctuates dramatically really. You know, people have got money, they can give money. The general is that if you're looking after patients, you get funds back again. I mean, we're very lucky, because we're very fortunate that we live in an area that our charity is very focused. It's within the town, people are very…they favour us. They will want to give money, but other areas are not so fortunate. We live in quite a, I wouldn't say an affluent area, but we've got a very mixed population.

We've got quite an area where the houses, we've got a very poor area of the town. I think in some areas, if you take our hospice in the north to somewhere, a retirement hospice in the south, where you know, people have got a lot of money, and they'll give a lot of money for donations, it's a much more increase, rather than with us here, we sort of, I think the way we survive is really we've got a very good board of trustees, who've been able to support us, and been able to see that we can progress, and we've been able to progress, and I think that's why we've been successful really.

IV: So, you would recommend the same model across the hospice sector, or you think that a generalised model cannot be applicable, because of difference in local?

IE: I think it differs in different areas really. I can only speak of the staff who've worked here, that I feel that we've been supported, and we've been able to increase our services, because of the model we have. I'm not saying we've not had problems along the way. You know, over the years, we may have had problems with the structure, if you like. It's not really being at the top of the trustees. They've always, but they're people who they may have been solicitors, teachers, accountants. They're the ones that they do it in their own time, but they're very astute, is suppose in how they see the hospice, whether we can actually say, we can go ahead with this new build or not. But, you know, I'm not really part and parcel of that, all I know really is that as a nurse, we're always very well supported, and that's it.

IV: Would you like to talk to me about your role and the role of your team within this hospice?

IE: I'm the inpatient sister. I look after the inpatient unit, which consists of nine beds. I have a team of nurses under, that work alongside me, they consist of trained nurses and auxiliary nurses, and our job really is to look after the patients that we have in. The patients that come in, come in on a short term. We are classed as a short term unit, so if patients come in, then we have to look that they're going to be able to move them on, so obviously all patients are individuals but patients aren't here for months on end, that we have to look to that. With only having ten beds, and there's a movement. Patients can come in in the short term. We provide symptom control. We have limitation and end of life care, and that's…and support for the family.

IV: Are you or anybody on your team involved in the process of target setting, or long term management or policy creation, or your task is predetermined, and you know what you have to do, day in, day out?

IE: We have a policy for anything, a policy for…most things are covered by a policy these days, aren't they? So, we do have, we're part of the management team. We go to, we have a clinical subgroup who decide if there's going to be any changes that may need to be done, and we're also part of the interdepartmental management structure, and that means that we go to the meetings with all the managers within the hospice, and we're part of the human resources team. Matron is, who is there. We do have an influence in what actually, the changes within, at management level, although we are still nurses. Our main job is that we are still nurses.

IV: How is your team organised and how is it managed?

IE: We have a rota, and we do, we have obviously, we have a day staff and a night staff separate. We don't do internal rotation, we don't do days and nights, and we have it that we have to have so many trained staff on one shift, and we do three shifts a day. So, we do quarter past seven till three, and that is where the main things, the main tasks, sort of, for the patient in the mornings, the medicines, things like that. So, the main things are done in the morning, that's the heavy shift. The evening shift, again we can have up to six or seven nurses on in the morning, and that consists of four trained and three untrained. In the evening, we have four staff on, which is usually three trained up to qualified nurse, and on untrained, and then at nights, we have two trained and one untrained, but we can increase the numbers if we have high dependent patients. We have a bank of nurses that we can increase the numbers if we need to.

IV: If you have to describe a typical working day for you and your team, how easy could that be? Is there such a thing as a typical working day for you, or it is a constantly changing situation?

IE: It constantly changes, because obviously the changes are the patients really, but a typical working day is at quarter past seven we come in. We take over from the night staff. We have a half an hour handover, which they actually tell us if there's been any changes during the night, any changes in the patient, if there's been any deaths, if there's been any relatives that have had to come in, and the doctors normally start about between eight and nine. We have a handover for them and then we really just then start the care of the patients, supporting, some of the patients may be able to look after themselves. Some patients need all care. In some cases, you may have a patient who is at the end of life. It's quite imminent, and it's supporting them. It may be that you have patients that are going home and you're organising ambulances or appointments, or going for treatments, so they more or less are the same really. I mean, some days are busier than others, if you've got…patients have died during the night. You're having to bring the relatives back, and deal with all the certificates and things, then that go along with the patient's death.

IV: Are you aware of any differences between the way your team at Hospice D is working, and the way similar teams are working in other hospices?

IE: Yes.

IV: Or do you think it's all the same?

IE: I think, some hospices are much more medically, specialist units. I mean, we're verging on the specialist unit. We have patients that come in for blood transfusion, for taps and things like that. It's not all about nursing care, it's about active treatment when they're coming in. Some of the bigger hospices obviously are much more active, patients coming in and out and treatments and things, so it depends on the size of the hospice really. We're much more active than what we were when we first started.

IV: Yes, moving over to performance measurement now. Are you using any tools to measure the performance of your team, and if yes, would you like to describe this to me? Or, do you think that the management uses any method to measure your performance?

IE: Right, what we're doing at the moment is we've just gone onto a computer system, called System One, and what we do, what that will enable us to do. We did it, we did, it's all about numbers really, isn't it? It's how many patients you nurse and what percentage of beds you've got occupancy and how many patients are in and out over a specific time, so…and I think that really is for the management to be able to measure, to the PCT really, because we get a grant from the PCT, and it's all about at one time, it was just a grant, whereas I think now it's more and more what are we doing to get that grant?

Are we doing blood transfusions? How many patients are coming in? How many admissions we've had, so I think it's coming into it, because of the money that we get from the PCT, because we do get a small, in comparison to how much it costs. Catherine will be able to tell you that in finance, but it's all about what we're actually doing, as far as occupancy and things like that. Occupancy doesn't always tell you what actually the activity on the ward, because it could say that we've got seven beds left, with patients in, but we could have two patients that are booked to come in, or we could have had two patients that have died, so a patient who has died, there's still an awful lot to do around that patient.

They may not be in a bed, but it's dealing with relatives, getting death certificates, arranging appointments for them to register the dead, and supporting them, so it's not always sometimes about how many patients you've got in. It's about the other activity that can go along with those.

IV: So, I assume that you are finding it challenging to measure personal performance within a hospice, or you think it can be as straightforward as it looks?

IE: As a nurse?

IV: Yes.

IE: It is challenging, because I think it's a very, it's quite a stressful environment at times, and therefore it's measuring, and also measuring your own personal things that are going on with your lives, with being able to come to work and deal with the things that, every day you're dealing with death, every day you're dealing with loss, it's not your loss. It's a very fine line, I always say, when you are a nurse in a hospice, that you can get too close sometimes to what's going on on the ward, and it can affect you, as a person. You know, the stress levels, but I think that sometimes is about, sometimes you can identify with a situation, and it may be a very similar situation to your own, and therefore you have to be very careful emotionally.

I think we're a very good organisation at looking after our team. We make sure that we've got all the best beds, the best mattresses, the right chairs, the right lifting equipment, things like that. I think if you do, as a manager, look after your staff, then their job as nurses, they don't actually think, oh, this bed is broken. You know what I mean? You have to be on top of the things, so that it makes coming to work a pleasure, rather than a chore really.

IV: If you had to report to somebody what your team did during the course of a week or a month, what would you be reporting back to this person? How would you, what would be evidence that your team has been doing great, or that your team has not been doing great, but if we try to quantify that, if we try to leave the emotional and the idealistic approach out. I'm coming here from this, saying you have this much money from me. Tell me what you are doing day in, day out and tell me how you are imagining it?

IE: I think palliative care is very emotive, what we do every day is quite emotive really, but I think the comments that we make, the support we get, if we weren't doing a good job, we wouldn't have been here 25 years on, because we wouldn't have had the support we've had, and I think the support that we have is because people are very aware of the job that we do. In fact, you know, in how we look after patients, how we support them in every way.

It's not just about them coming in, as an inpatient. It's supporting the family, it's supporting them in their bereavement. It's supporting the families in their bereavement. It's about them being able to come to day care from the length of time they come in for day care, and it's not just about patients. It's about the whole family. And, I think people appreciate that. When you go into an acute environment, it's very easy not to think of the family. You know, the patient comes in, in bereavement it's very easy to, when a patient dies in hospital, they're not necessarily supported in the…the relatives are supported in their bereavement, whereas in a hospice, we're able to do that.

I think as well is that they've got choice when they come in. The patients, they appreciate that and that again is appreciated when they go home. It doesn't cost them anything to come in. We don't charge them anything to come in, but very often you'll get a donation, you'll get an in memory of. You don't do it for those reasons, but you do get it back, because of that. You know, if the patient has died, very often people give donations in memory of that person, and those donations will be given to the hospice.

IV: If a friend of yours, another nurse was to go to another hospice, and her task was to manage a day similar to yours. How, what would be your advice for her, with regards to how to manage her things? Which are the things you should pay attention for helping to be effective?

IE: I think you've got to respect your team. And, you've got to, they've got to have your respect as well. It's a two way thing. I think they've got to know that you will support them, and you will…they've obviously got a job to do, but when times are tough, you'll give them the extra ten minutes to go to a break. Other times, they may not get a break, because you're too busy on the ward. It's a lot of give and take really, I think as a manager. It's an ongoing thing. You can't be…sort of it being firm but knowing that the jobs are getting done. Making decisions with them, getting them to be part of the team. You know, if there's any major decisions taking place. We have a big thing about a smoking room. We have hospices where they didn't have to get rid of their smoking rooms for patients. We have an area where patients can go to smoke. When the smoking ban came in, it was all about patients had to go outside of areas to smoke. They couldn't smoke within the building, and it was do we get rid of our smoke room, do we not? And, it wasn't my decision. It was taking the decisions of all that staff, from everybody in the hospice, the nursing staff, is this something that we should do or not?

The comments that came back were very mixed, and the decision was, no for the time being, we'll leave it, because it was too much of a big decision. There were too many people that were for and against, that you didn't really want to rock the boat, because of that decision, and I think it's just letting them know that they're just as important as what I am, even though I might be in charge of a unit. They've got a job to do and their job, it doesn't matter whether they work one day a week, or five days a week. Their job is just as important.

IV: I see. Let's go to deal with more inter-professional relationships now. I guess that the members of your team are working in cooperation with members of other teams. They are not just working on their own, are they?

IE: No, we work with the medical team, we work with the admin team. We work with the domestic team, everybody, because it's all interlinked really. We work with the…we don't work alongside the fundraising team, but they're very aware of what we do. Obviously the family support team and day care, because we all interlink with each other really.

IV: Do you think that your team members like that, or do you think that they would rather be working on their own?

IE: You can't work on your own in such a small environment really, because you know, sort of the domestics. They have to come in and clean the rooms, they have to make our meals, they have to…even going up to the fundraisers really. You know, we have relatives that may come in and they want to give a donation, so you're interlinking with them all the time, so it's not an isolated area. Nowhere is isolated, really you've got to work alongside one another, because that's how a small organisation ticks really.

IV: Do you think that the nature of the hospice movement is assisted in increasing the impact of inter-professional working? There has been some papers mentioning difficulties with between nurses and doctors, working in the same environment in a high stress conditions, sometimes frictions might be in the place. For you, is it a condition that these things are not in place within hospices, do you think that this is because of the voluntary nature of the activity, and how do you think that this movement towards professionalism will affect the inter-professional relations?

IE: In this hospice, all the doctors have paid jobs, all the nurses are paid jobs. The voluntary are the, apart from the voluntary coordinator, who organises all the voluntary people that come in, she's paid. We obviously have differences of opinions, I think at times, and sometimes with volunteers, they can come in and sometimes feel a little bit unappreciated sometimes, but I think a lot of that is sometimes you can be very busy in what you're doing, and therefore can sometimes forget that this person has come in, and they've been making the tea all afternoon. You think, you know, I suppose sometimes it can make them feel a little bit unappreciated really. But, I think again you've got to look at why somebody's come in as a volunteer. In my eyes, a volunteer shouldn't be coming in if every five minutes, every few minutes you've got to be stopping and thanking them for what they're doing. They've come in here for a purpose, and just accept that we're very appreciative of what they do. I mean, obviously medic, because the medical staff are paid and the nursing staff are paid, you've obviously got professional opinions, and sometimes they may not, but it's working together for what the best for the patient at the end of the day.

IV: Let's move to recruitment now. Would you like to give me some information about your recruitment policies and your criteria for hiring new members of your team?

IE: As a nurse, the recruitment policy is that if we have a vacancy, we will appoint, we will recruit, we will advertise. We tend to advertise and ask for palliative care experience as a nurse. It's not always essential, it depends on the role. It's very much about when you interview, is obviously having the qualifications and whether you feel that person will fit in with the team. With it being a very small team, I think that's quite important really, that when you're recruiting, you've obviously got to get the right person with the right qualifications, but you've also got to think about them fitting in quite a small unit, really, and working along shifts with them, with the staff that we already have. We don't always have a problem recruiting. We look at our…we call our nursing members an establishment, and every so often, we've got to look at our establishment, because as the work changes, sometimes you need to increase those numbers, and so far, if we put a proposal in, we've been able to recruit for the positions.

IV: Are you looking for specific skills when you are hiring somebody, and how easy is it for this hospice in this area to find these skills?

IE: I think if you're looking for somebody in a management role now, you're asking for somebody with a palliative care degree, because that is really just goes along with it. When I first started, it was just an interest in palliative care, so obviously for people who've been here a long time, it's through experience as much as any nursing qualification. For the untrained staff, you want somebody that's obviously got an interest and shows potential. All our, the unqualified staff that we have here, and they're what you may call carers, we call them auxiliary nurses, and then there's that have got a basic training, but they're working now towards a qualification, but they're not registered nurses, so they can't do the drugs, and they can't do the medicines and things like that. But, all the time you're really looking for somebody that you think has got an interest in palliative care, and they have got motivation really.

IV: How easy is it for you to find these type of people in this area? Is it easy or a highly competitive market? For example, I've got interviews from three hospices up till now. One of them told me that now it's absolutely in this area, it's trying to find people and they said, we don't get involved with each other. We are looking for different skills and there are loads of nursing graduates around, so it's really easy for us. We don't even have to pay the same salaries as the NHS pays. I've had other cases where people found that the hospices were finding it very challenging, to get people with the right type of qualities, because the market for hospices around, but there are not that many graduates.

IE: I think it depends. At the moment, over the last two vacancies, we've not had a problem. We pay the same as the NHS, and we also have a pension scheme, and if anybody comes from the NHS, they can bring their pension with them, and we will support them in that, so I think that's a positive. At the moment, you know, there's the NHS really. I think there are people who are a little bit unsettled within that environment and therefore will apply for jobs. Some people come for the wrong reasons. They'll apply for the wrong reasons, you know? They think it's a nice little job. You've only got ten patients to look after. It will be a nice place to work, but it's a little bit more than that really.

We've not had a problem, we don't seem to have a problem with recruitment. I think one of the things is that we don't advertise very often, and therefore if you don't advertise very often, if you're advertising on a regular basis, people think there's something wrong there, whereas if you don't advertise that regularly, and also people, we take student nurses here, we take medical students and we take student nurses, so a lot of our student nurses, they come in as students in the training, they have an interest in palliative. They pick up an interest in palliative care, and therefore when they're training, they will work towards the qualifications to be able to apply for jobs here, and our last two recruitment for trainers has come from students that have been here in the past.

IV: It looks like there is not much competition in this area, like you can find what you want?

IE: No.

IV: You couldn't see somebody as a competitor to you, in the job market or the hiring market?

IE: Not really, no.

IV: That's very good. Let me ask you some kind about the interview process itself now. Did you enjoy the conversation, first of all?

IE: Yes.

IV: Would you like to indicate if you strong or a few of the points in the whole interview process?

IE: No, I think it's been fine. I think it's been fairly general really, and quite interesting, going back. I think because I've worked here a long time, and within the hospice movement at the beginning, you can see the big changes, not so much in the fact that we've still got the same amount of patients, but what you have to go through to support those still ten patients,

and I think from your point of view, when you're looking at the finance around supporting a hospice, that area, if I can see how it does cost. It's an expensive service, because of what we have to do as a hospice, to keep updated, and to keep people supporting us, how we've had to increase from what we started to what we are now. And, I think that really… I think palliative care has changed, and because of the change of end of life care, palliative care, whatever you want, whatever you call it, and because of people's perceptions overall as a community, as a nation, as a world really, that really is what people…people don't accept the fact that they're coming to the end of their life. There's a lot more now about they want the quality, they want the time, they want all those things really. They don't accept end of life, like the same as what they did a long time ago.

IV: That's true. Would you like to suggest any areas of interest on your profession that you feel was not covered in adequate depth with this interview?

IE: No, that's fine.

IV: Any improvements that you would like to suggest, on the approach of the conference, or the interview?

IE: No, it's fine because the other people that you will be seeing, they'll obviously be able to fill you in in their areas, like the fundraiser, different areas. We all have a different view of what actually goes on, all the ultimate aim is looking after the patient at the end of the day.

IV: That's really encouraging, thank you very much. Would you like to participate in a similar interview in the future, if necessary?

IE: I don't mind. I quite enjoyed it actually.

IV: Thanks a lot.

IE: Do you want to look around?

IV: I would love to.

Interview with the Community Nurse Specialist of Hospice A:

Speaker key

IV: Interviewer

IE: Interviewee

IV: Before we will start with the interview itself, I will have to let you know about the ethics and confidentiality policy of the University. You can be assured that any kind of information you will provide within the interview is going to be kept confidential, whichever information out of it we publish is not going to carry your name or the name of the institution you are working for. If at any time you find out that you don't feel comfortable answering a particular question you can just say that you don't want to answer this question, or if you feel at some point that you want to interrupt or stop the interview process, you can just feel free and ask for that.

IE: Okay, fine.

IV: And having done the introduction, I would like to tell me a few things about your background; what you are doing and what your team does.

IE: Right, background in terms of working here?

IV: General background. Your personal, general background. How long have you been with the hospice movement, [unclear]…

IE: Okay. I have been working for the hospice now about ten years. Five years on the ward and five years in the community. And, at the moment, I'm studying to do my masters in specialist, in palliative care and supportive care at Kent University. I'm near the end of that. I'm just about to do my dissertation, so that's starting soon. And apart from that, I've got a general nursing degree which I did before I came to the hospice. And I've done just study days appropriate to the work and what I'm doing, so that's where I am at the moment.

IV: And what was the main motivation for you to join the hospice movement?

IE: I think where I was working before, it was on a cancer ward, general medical ward, but we had a lot of, sort of, cancer patients. And we used to get the consultants from the hospice come over and, you know, sort of, do an assessment and then whether or not they

were going to, sort of, go into the hospice or be referred. So I got to know the consultant and I got to, sort of, look at some of the work that they were doing, and I just felt, at that time, that I would like to, then, move on from the specialist, sort of, active treatment of cancer patients on to the palliative side. So I, sort of, came not really knowing very much about it because I think it was quite new. It had only been… I'd worked in [unclear] in the hospice, it had only been open there about a year, so it was, sort of, I think it was very new and never really had much to do with this one here. So it was, kind of, you know, just see what it is and whether or not it suited me, but it just seemed the time to move from active treatment to palliative, so I've been here ten years.

IV: It looked like a difference.

IE: Yeah. It's different and it's a much more enjoyable working environment, really, as well, from a hospital environment.

IV: And it looks like you are among the few people who have some time to spend within the hospice movement who are not saying that they joined because of the will to involve themselves with something. It was a professional decision.

IE: It was, yes.

IV: It wasn't that much voluntary, it's more something that pushed [?] you through [?].

IE: Yes, I think, yes. I've, sort of, I've never been somebody that has a career plan and never known where I want to go. I always think something will turn up. As is say, the, sort of, involvement from the hospice and the acute sector just made me think about, well, that's a different path to follow and, you know, I might like to try that. And so as we came, just as a taster, to see whether it was what I wanted and I've been here ever since. So, yes.

IV: We'll be looking for your professional views on the hospice movement in general right now. Actually, have you noticed any changes in the ideals and orientation of the hospice movement during the period that you are actively involved with it? Moving from voluntary to professional is what could be an example, but there could be more things than that.

IE: There have been a lot of changes, I think, since I started here. When I first started ten years ago, on the ward, there were very few treatments given on the ward. There was no, we weren't giving blood transfusions. It was much more low key. It wasn't medicalised as such, I think. You know, there's much more medicalisation, I think, of hospice and palliative care now than there was. Patients, you know, we give blood transfusions. We do an awful

lot more than we used to; it was much more low key. And it was much towards the end of life, I think, when I first started. And they're giving referrals now, so people are being referred early, you know, when they've got cancer, so we're getting much more involved in, you know, sort of, treatment options and, you know, when they're still having chemotherapy and still having treatment and supporting them through that. So I think… and it's been, sort of, a move from government as well, with, you know, sort of, palliative care starts earlier on the journey and it's opening up to more people. So it's becoming much more the professional movement than I think a voluntary movement. We're all having to do, you know, sort of, courses and gain professional qualifications, which have only been, probably the last five years that everybody's been encouraged to do things like the masters. You know, before that it was, it wasn't, they weren't qualifications so much. So it has become much more professional, you know. It's much more acceptable now.

IV: I see. What do you think motivated people to join the hospice movement when you started? And how do you think this change is affecting the motives of people to either stay or join or go out of the hospice movement nowadays? You think it's the same old [?] [unclear]?

IE: I think it is. I think people generally tend to, sort of, come to hospice and palliative care because they want to maybe, sort of, help people more. I know that sounds silly, but in a hospital situation, you know, it's a much busier place and you don't follow people through. People come in and they go home and you don't know what happened to them and you don't, sort of, see what goes on and it's a much more pressurised situation. So I think people come to the hospice maybe because they figured it's much more, especially nurses, it's much more nursing than you get in a hospital situation, you know. It's much more hands-on nursing, it's much more supportive and care than it was in the hospital. But as I say, I think things are changing and it's becoming, it's not quite like that anymore on the wards anyway. You know, you are doing more things and the nursing situation here used to be a much higher percentage of nurses to patients, so you could actually get more involved. You were doing a lot of psychological and psychosocial support as well as general nursing care and you had the time to spend with patients. I do know that they think that that's being ebbed away now, you know, you actually haven't got the time that you used to have. But I think it's still different. I think people still tend to stay here a lot longer. That's an ambulance I think. I think people still stay at the hospice for a lot longer, for lots of different reasons. From a, sort of, a purely personal and selfish point of view, it's a much nicer working environment. You haven't got the same stresses as you have in the NHS. And despite, you know, sort of, time being, sort of, ebbed away, you haven't got as much time to spend with patients, you still have more time than you do in the nursing, in that situation. So I think it's just

something that grabs you, you know, the way that you can get involved with patients and families much more and I think it does attract people differently to hospital, so people do tend to stay a lot longer. I'm not alone to have been here this long. I think people have been here 15 years and even the girls who started two or three years ago, there's no sign of, sort of, moving. They're happy in this situation.

IV: What's the [unclear] process now? Do you think the changes we were talking about have any effect, not on the professional side, but on the people who want to assist on a voluntary basis the hospices? And how it affects and if it does affect.

IE: I think volunteering has changed as well from the perspective… when the hospice first started. I think volunteers used to do an awful lot more than they do now. But that's because it has become a much more professional movement. There are things, you know, there things they're not allowed to do anymore. There are criteria that have to be met and it's all, sort of, training that they have to go through. And I think we're noticing, as well, that we're not getting as many young people in the volunteering as we would like maybe. It is an older, sort of, volunteer workforce, if you like. I mean, we still couldn't survive without them, because they do so much. But I think we are trying, actively, to encourage younger people to volunteer. I think we have a special, sort of, person that's been employed to try to recruit young volunteers now, because we are noticing that we're not getting them. And I think it's just an age thing that, you know, sort of, people think of hospice and they think of death and dying still and maybe they don't think that's for them. But I think we're trying to encourage younger people now.

IV: That's good. I'm going to ask you a question which is going to be a little bit [unclear] now. It's about challenges that the hospice movement is facing now or it might be facing in the future. What kinds of challenges do you think these will be and could you describe to me both in general to the cycle of things like risk severity and too much [unclear] percent [?], or the recruitment of people, or to the certain [?] [unclear]. Or there could be external challenges such as regulation, increased regulation, financial issues, [unclear] population, the demand for new palliative care service. Which of those things are things that you would think about possibly?

IE: I think, first, there's the community team, there are the challenges from having to get involved much more with non cancer patients. It's a government initiative, again, that, sort of, palliative care should be available to all people, not just cancer patients. So we are having to get involved with, you know, people with lung disease, kidney disease, everything now where they're getting those referrals. And I think we're finding them a challenge in terms of knowledge. Because although we're, sort of, at end stage, sort of, our skills should

be applicable to anybody. It's still concerns, you know, we're not trained as respiratory nurses, we're not trained as, you know, renal nurses. So we're just concerned about that the, sort of, challenges of knowledge and being skilled enough to do it. And also, in terms of time management, you know, the more referrals we have coming in, there's still the same number of us to cope with those referrals and we're having to see more patients. So we're spreading ourselves a little bit thinner. Our role has changed in much more of a… that's less supportive, maybe, than they used to be because we haven't got the time to go in and just give psychological support and just be there with people. We're, sort of, much more about going in, sorting things out, withdrawing and, sort of, what we call painting people, taking them off our list because they don't have any problems. And, sort of, maybe crisis management much more than it used to be. So our role has changed and I think role is going to keep changing in that way.

And we're concerned, we wonder about the financial issues in that, sort of, the hospice movement was traditionally set up for cancer patients, and that's what it's always been portrayed as. So there is the worry, you know, sort of, if we start opening our doors to everybody, whether or not the people that supported us initially with financial donations would see that maybe as taking away the service from them. Because most people who support us financially have people with cancer in here, you know, so it's very close to their heart. And if you, sort of, you know, you're open to everybody else, will they see that as well, you know, they don't need to provide us with funds if they don't want to because we're, sort of, not for them anymore, we're for everybody. Will they think we're getting funds from elsewhere? So I think, financially, we're just concerned about how that would go as well.

And, again, as I say, it's the changes that we know that there's going to be lots of changes in our team because they're doing a review of the community services at the moment, and whether or not we need to change how we're working. And looking at 24 hour cover, you know, on-call cover, which is going to be something new for us and whether that would be us that do it or, you know, sort of, employ different people to do it. And just how our team's going to change. Because there are lots of problems out there in the community, but whether it's us that plug the holes or the NHS that plugs the holes, and there are, sort of, doubling [?] up the services sometimes, you know, sort of, us and the community matrons in the community are now doing a lot more work with palliative care. They're asking us about the possibility of prescribing, so we can go in and prescribe the medication to patients. But we have concerns about how that's going to work in terms of us prescribing, GPs prescribing, nurses prescribing. You know, is it going to be too complicated? We don't have access to the NHS computer, so we wouldn't know from the GP records, you know, what's, any complications with medicines and things. So it's going to be much more involved and there

are a lot of, sort of, taking us down different roads and it's changing and I'm not really quite sure how it's going and how it's going to affect us.

IV: This seems mainly related to your own team experience.

IE: Yeah, clinical practise with our own team, yes. I think that's probably the way that… there's been a lot more, sort of, input into the community service now. I think the impression you get with the hospice, it's up and running, we've got three hospices and, you know, that's been looked at and been, sort of, now the gaps are seen in the community. So I think it's, sort of, it's spreading, you know. They're telling their view now to us and how we're working, so I think we can see lots of changes. And lots of it is coming from, you know, sort of, government led initiatives, not just from within.

IV: What about the whole hospice movement? Can you see here specific challenges for the future because of all these changes?

IE: I think so. I think it's… whether or not there will be more, sort of, government money, I think, is the big thing. Because whatever changes happen within the hospice movement, as long as we're a voluntary sector, we, sort of, maybe struggle financially, but we're expected to provide a lot more services. But part of us doesn't really want government money, because the more government money, the more you have to operate under their system and do, you know, hey have much more control over what you do. But I think financially, it may be quite hard. I think a lot of hospices have been struggling financially, raising the money that they need to carry on. So it's, I think, finances could be a big problem in the future.

IV: How do you think the hospice should respond to these challenges? The hospice movement, not Hospice A?

IE: I think, there, it is becoming much more of a cohesive movement than it used to be. I think, you know, individual hospices used to, you know, you used to have a hospice here and a hospice there and they never used to talk to each other because it was such a voluntary sector and wasn't so organised. But I think now we have got a lot more organised and we are all talking to each other. We have a national, you know, sort of, hospice movement and there will be set plans in motion as a unit rather than as an individual. And I think that's probably the way forward is that we have to become much more of a cohesive hospice movement and not individual hospices, you know, and work forward that way and plan that way. And I think make ourselves known a lot more. I think people, the public view of a hospice is still as it used to be. It's a place where people come to die and the only time the

hospice gets involved is when somebody's at the end of their life and not really realising how much quicker we get involved with patients and, sort of, what we do and how we can carry forward with them and be with them for a longer period of time. So I think it's trying to get that over to people and get away from the old view of it, you know, in one door and out the other because people die and then you get involved. So it's trying to promote ourselves. And I think hospice, maybe we need to change the name, you know, rather than hospice, calling ourselves palliative are. Because I think hospice, that word, has that connotation for people. It just means death. And no matter how much you try to tell people that's not what we're about now, they just see that and I think maybe we need to drop the word hospice. Maybe we need to start talking about ourselves as palliative care services, so people see it as a different, you know, different thing.

IV: So we are talking about re-branding.

IE: I think re-branding, yes. I think trying to get away from hospice as it was and re-branding as something that starts earlier and sees people through a journey.

IV: And how do think these challenges are going to affect Hospice A? Are you aware of an action plan [unclear]?

IE: No, I'm not aware of an action plan. I know that they are, I mean, we do have a hierarchy, you know. People, sort of, looking at things and I know that in terms of our service and, sort of, taking on new patients and how we're going to change, we've just set up a steering group of, you know, sort of, about a dozen people to look at where the gaps in the service are and how we should change. And that's going to be about a year's worth of work, I think. And we will have representatives from our team on that steering group, so we'll have some input as to what we're doing. And then at the end of that, we'll come up with a plan of where we think we need to take our service. So it's quite, sort of, compartmentalised. I know that they are always looking at, sort of, changes that need to be made. And I think we had a lot of changes because we have a lot of new people arriving, sort of, management… I mean, CEO, hasn't been here well, probably a couple of years now, but it seems… And so he's, sort of, maybe changed things, you know. We have a new broom [?] there, you know, he's come in and looked and seen what we need to do and changed a few things. We've got a new clinic nursing director who's now in the process of looking and seeing what needs to be changed. So I think we're all a little bit, sort of, a lot of change is coming up, we don't really quite know what yet. Everything is just being looked at at the moment.

IV: I would like to move a little bit on what you're doing and what your team is doing. Would you like to talk with me about your own personal role and the role of your team with you responsibilities?

IE: There are six of us who cover a part of East Kent and in the community. We have four people who have their own caseloads, based on GP surgeries and two of us occupy what they call a rover's post, so between two other nurses, we take up the slack. If they are busy, we will take referrals from them and we will go out and do other visits for them if they're really busy. So we're, sort of, helping them out rather than having our own, sort of, major [?] caseload, although we do have a small caseload. We see the majority of patients referred to the hospice, actually, coming, sort of, via… with every referral that comes in, comes to our team first. So I think Lynne said there are about 100 referrals, across three sites there are about 100 referrals a month, so you would see that many first visits. You would go and do a first visit with the patient and an assessment of what their needs are and what their problems are. And we have [unclear]… it's an advisory only role, it's not a hands-on nursing role, so it's just advisory and supportive. And from there we would look at, sort of, symptom control issues, we would look at any, sort of, financial problems that they have. Any, sort of, other social problems they might have and the help that they have and we would, then, be a liaison role between, sort of, the GP, district nurse, social worker and all the other agencies out there and try to, sort of, arrange things. We advise GPs or suggest medication changes to GPs, if that was necessary. And, sort of, we can liaise with the hospital consultants as well. So we sit very much in the middle of everybody else try to just pull things together for people.

And how long we see them is really dependent upon their needs and it's a clinical judgement that we have. You know, if we see somebody and they have symptom control issues and we make medication changes, we'll go and follow up and see how that's worked. And whilst all the issues are resolved, we would then stop seeing them and, sort of, tell them just to contact us if there was a problem. I think Lynne was saying that it's about 80 to 90 patients a month that we lose through death, but it leaves about 500 across all three sites that we're seeing on a regular basis and people are coming in and out of that all the time and changing.

We have access to day hospice, so a lot of our patients we would do a referral to come to day hospice. If they settled in day hospice and didn't have any other needs, we would then step back and just leave it with day hospice. And, as I say, we sometimes will do one visit and then pend [?] them because they don't have any needs. Sometimes we'll see them right through to death if they're that, you know, they're referred later [?]. But we do tend to, much more now, sort of, dip in and out of people's care. See if they can get things resolved and, sort of, step back and either they or somebody else contacts us to say they've got more

problems, can we go back in again. And so we, sort of, juggle really with so many different patients. We do also have a, sort of, a teaching role in terms of, you know, passing on education to other services like district nurses. Not specifically formal teaching, but, you know, informal teaching when we're seeing them, so we can then pass on, sort of, knowledge and try to, sort of, encourage them to use those skills as well. And our own educational needs; we're all, sort of, encourage to do courses and things like that, yes.

IV: Is anybody from your team or yourself getting involved in the process of target saving [?] for the hospice or around policy creation of the hospice? Or your team is mainly focusing on day-to-day issues [unclear]…

IE: Well, actually, we have a team leader which was Keith, who I think you saw. He's our team leader and, as a team leader, he has regular meetings with our line manager, so any issues. And also he does attend the management meetings, clinical managers meetings. So we are, sort of, catching forward and he does have some, you know, sort of, input into those because of his position. So we do have a little bit of input, but we don't get involved to a great extent, but our views are, you know, sort of, taken and we are much more involved than we used to be. Maybe probably about four or five years ago, we were never involved in anything. It was much more of a hierarchy for management system than it is now. It's much a much more involved management system now. it, sort of, filters down whereas years ago, decisions were made and we were told and you had no input into it whatsoever. But it has changed. It's a much better, sort of, management system now.

IV: This is good. You've already told me how your team is organised and [unclear] you have a team leader and [unclear]… to decision making. And I think you've covered these questions, but I was about to ask you to describe the typical working day for you and your team, but you have already described this [unclear] before. I would like to ask now if you are aware of any differences with the way your team is working here in Hospice A and teams working in other hospices.

IE: I think we all work slightly… As I say, our role is just an advisory role, we don't do any, sort of, hands-on nursing. There are teams that we know that would do what they call hospice at home, so they will go and they will set up syringe drivers for patients and get much more involved in that kind of thing. Whereas we, if we want a syringe driver set up we have to go through a GP and get district nurses to come and do that. So we don't have any, sort of, clinical input in that way and I know that other teams do. There's a team, a hospice team, sort of, further up in West Country who actually do much more setting up syringe drivers and that kind of thing, so have that clinical input. I think there are lots of different teams that we've found and we know that they're probably going to have to change.

And I think in terms of referrals, everybody works slightly different. I know there are some teams, if they get busy, they will block, they will say they can't take anymore and they have a waiting list of patients that they have to see. Whereas we just take patients, we never, sort of, put a block on how many patients. We just try to, sort of, fit them in and work around it. So I think there are differences. Quite a lot of differences.

IV: So will you suggest that strategy [?] for teams similar to your team? There is not, like, a defined strategy used by all the hospices or [inaudible]…

IE: [Overtalking] No, and I think everybody works differently. And I think there's a big difference between, that we find as well, is that because most clinical, and especially from the community, the Macmillan nurses who, you know, charity, cancer charity, and we are not Macmillan nurses, and I think that's a difference as well. So, for us, we're outside of that and maybe we don't, we find that quite hard sometimes. Because I think Macmillan is very good at supporting their nurses and so we don't have access to anything Macmillan does. And we always seem to be in competition with Macmillan, in terms of, you know, sort of, financial as well. Because everybody knows if you talk to anybody about cancer nurses, everybody knows who a Macmillan nurse is, and we lose a lot of, we, I know it sounds awful, but we do lose a lot of our donations to Macmillan because everybody thinks that we're Macmillan nurses, that's who they're expecting. And I think that Macmillan is a nationwide charity and their nurses all work to a specific, sort of, way of working, so we are different in that way as well.

IV: I see. Do you think that the job you are doing, day in day out, is getting measured by somebody? Have you been asked to do specific things like… Do you have the sense that somebody is watching the job you're doing, giving information from this?

IE: Only statistically.

IV: … to other people, like…

IE: Only statistically. I mean, we have to do our statistics every month of, you know, sort of, how many visits we'd seen. And that's really all that's recorded is the terms of the visits that we've seen and any meeting that we've attended with GPs or any other meetings that we've had. Nobody, there aren't… there doesn't appeal to be anything else, whether there is, I don't know, but there doesn't appear to be anything else. We do have meetings with our director, like the one, you know, just to look at case [unclear] views [?] and how we're doing with our cases and how we're, you know, sort of, coping with the patients. But there are no other things that I'm aware of.

IV: Do you think that it could be easy or difficult for somebody to measure your job, measure the job you are doing in terms of productivity? And would you say that this would be useful for you and the hospice as an organisation?

IE: I think it would be very useful, but I'm not sure that it can be done. Because there is so much that we do that would be hard to put down really. As I say, our statistics are only on the visits that we do and. There are lots of other things, there are telephone calls, there are all sorts of other things that we do that is just probably quite hard to measure. I don't know, to actually, sort of, do a time and motion on our job or to actually… everything that we do would be quite hard, I think. I don't know how you would actually physically put it down. Because there are telephone calls to patients, district nurses and all sorts of other little things, you know, like, I'm not sure. The day seems to go so quickly with things happening, but I'm not sure all of it is measurable. But it would be interesting if it could be and I think it would be interesting to find exactly how long we spend doing things. I mean, paperwork is a huge part of the job, you know, writing everything up that we do. Making sure documents are up-to-date and all the different paperwork that you have to put together, you know, so, I mean, that's quite a large proportion of the time that we use. And it would be interesting to find out, but I'm not sure how.

IV: Do you think that it could help you to get some sort of guidance [unclear]…

IE: [Overtalking] I think it could, I think it could. I think it would be, because I don't think any of us really know what we do. I mean, I know that sounds silly, but we don't know what we do. We just know, we just, you know, you're doing the job and there are so many different facets of it that sometimes there maybe things that you're doing that you're not aware, that, you know, sort of, how long they'll take you to do and different aspects of it. It would be good to actually be able to say well, this is what you do, this is your part, you know. How long you spend doing the clinical part of it. How long you spend doing the liaison part. How long you spend on education or whatever. It would be very interesting to find out, yeah. I think it would help, you know, sort of, looking at how many of us there are and how to develop the role. And maybe when new members of staff are coming in, sort of, what educational needs they have as well.

IV: So you've already suggested specific topics. What to take into account when trying to measure performance for your team. [Unclear]… taking a lot of challenges. Are any of your team getting involved or could be involved in a way in the process of creating financial value for the hospice. This could be present in various different ways like financial value from incoming patients, [unclear] by a certain amount of money. Or financial value by working, operating on a more efficient manner using the same resources for more people. Or

using less resources for the same amount of people and other things that you could possibly be able to think of.

IE: I think in terms of patients coming in and money following patients, again, I mean, the big thing is this donation going to the Macmillan [unclear] and parading ourselves and making ourselves known out there, because we are losing donations because of that. We do know that because of cheques coming in. In terms of, sort of, what we could do, I think, probably, introducing, sort of, a paperless, you know, sort of, IT, you know, so that we didn't have to write, physically write lots of notes. We could actually be condensing time that we're using and writing things up. If we could have laptop computers, then everything could go on there and we'd have access to things, so that way we'd be using it. And also because if we're looking at… we do weekend working and we have to actually physically come in to the office and spend eight hours here because we haven't got paperless records, so we have to be here to have access to the notes. Whereas it would probably be more effective, I think, to have us on call rather than have us paid to sit in an office eight hours a day. Whether or not you get any phone calls or you don't. Whether or not you have to go out or you don't, we're here. So I don't think that's probably very cost effective. I think there would be a better way of doing it. And, again, if you're looking at doing evening covers and night time cover, you need the technology, I think, before you can do it. Because, otherwise, you're wasting a lot of money and time really. People, sort of, sitting there with sometimes nothing happening, so I think that could be much more cost effective than it is.

IV: So you really could see, for example, that you are getting involved in cash and flow [unclear], promoting…

IE: In the hospice, yes.

IV: … the hospice as a brand name. And you could add financial value if your job was organised a little bit better, broken down, very organised and get some IT support.

IE: Yes.

IV: This is great. So now we'll move on to inter professional relationships. Are you working in cooperation with members of other teams or you're primarily working independently?

IE: We're working, obviously, with the in-patient team. We have support; we have a meeting every Wednesday with the doctor and all the other, sort of, social work counsellor and chaplain. We know every week to look at patient review patients. We have a liaison nurse at the hospital who comes over, again, every Wednesday to our meetings here, so we're

able to hear about our patients that are in hospital and hear about any new referrals that she's going to be making. We've worked very closely with her. We worked with the district nurses. And with the non cancer patients, we're trying to build up a much closer working relationship with the, you know, the specialist teams of nurses and doctors. So they're trying to build up close relationships with everybody. So we don't work totally in isolation.

IV: But it's not like if we had to give it in a percent, on a scale, would it be 50 :50 or 60 : 40.

IE: Probably 70 : 30. Very much more on our own than…

IV: 70 : 30. So maybe you are working, sort of, independently [unclear]… to other [unclear]… in hospices.

IE: [Overtalking] Yes.

IV: That's good. Do you think that your team members would prefer to work on a different basis? Like to cooperate more with other things or interact more with other hospice professionals?

IE: Yes, we would. I mean, we actually feel that in terms of our team, that we would prefer it. We would like our own, sort of, social worker or our own counsellor and our own doctor as part of our team, rather than having to borrow them from the wards. Because it creates a conflict of, you know, sort of, just trying to get the time. And we, sort of, feel that we actually need, even if it's just a part-time, two days a week, access to, you know, these people and to enable us to, sort of, ask for a visit with a doctor or a counsellor or a social worker to go and see our patients. If we knew we had them and we could access them, it would be far easier than trying to fight with the in-patient unit to get the time. So we would like, we would prefer that and we think that would be better. We've started working a lot more closely with GPs than we used to, because of those meetings that GP surgeries set up, you know, which we are involved with as part of the palliative care unit. So it's all beginning to come together, but I think in terms of needing more, other professionals, it's from within that we feel we need much more, we need more. Doctors' support and others.

IV: So you team would like, wouldn't see obstacles or conflicts in integrating with other teams, interacting with other teams?

IE: No. I think it would, you know, I think we'd probably work quite well.

IV: Is this because they're only speaking of what the situation is in terms of care as a whole, is that wherever there is interaction of different professionals, there are conflicts there as well. Palliative care is a lot better compared to other places, you know. Somehow, people who are working for palliative care organisations, they're cooperating, [unclear]… doctors and nurses and social workers. But yourself [?] in areas, different palliative care and there have been conflicts, professional conflicts with people trying to protect the [unclear]…

IE: [Overtalking] Yes.

IV: … sectors and… Let's go to recruitment issues now. Do you feel like there is any recruitment strategy or policy? Do you think that are certain criteria people are looking for when they are hiring people for your team or when they are transferring people to your team?

IE: We are… it's very much been an internal, sort of, transfer to our team. People have tended to come from the ward [?] bases [?] that we know and then they get promoted internally into the team. We haven't really had any strategy up until just lately, actually, because we're in the process where a lot of people are getting to retirement age, so we need to look at how we're going to recruit. And so we are trying to look at having a rotational post from the ward in our team to get them used to what we do, to try to help training with them, so that they are, then, able to, if they feel that it's for them, apply for any jobs that come up. We don't know if there's going to be a, sort of, a freeze on posts at the moment. But people retiring, they're not necessarily going to be replaced because of this review of community services. And they don't know what is going to end up in a year's time, so they don't want to employ people, you know, sort of, into a post. It may not be there in the future. So that's concern, just a little bit, as to how that's going to go. We also, I mean, in terms of people coming to work for us, we are quite concerned in terms of, sort of, I know it sounds very, sort of, mercenary, but pay because we're falling behind on the NHS pay, the way that it's changed out there. So we're not actually getting as much pay as the NHS, so we think that will prevent, maybe, outsiders wanting to come to work for us at some stage because they will be on a lower pay scale and we have that concern. But, at the moment, they're looking at recruiting and how we're going to do it. And so the internal rotation process, we think, will be a good idea to train people on the ward.

IV: Would you be looking for specific skills if you were in charge of hiring people? And how easily do you think these skills can be found in this area?

IE: It's difficult really. I mean, I think if you're recruiting to our team, I think people need to have palliative care backgrounds anyway. I think they need to have had some

experience of palliative care, whether it's in a hospice or working in the community as part of a palliative care, sort of, you know, sort of nursing team. I think that you do need a palliative care background, not just coming straight from acute sector into, sort of, LT community team. Because it's a different way of working and we're working at different goals for people and different, sort of, criteria for people. It's different to the acute sector, so we feel, I feel that you would need palliative care experience. So that could, obviously, limit the number of people that were appropriate to apply. I don't necessarily think that you need community experience, you know, in terms of having been a district nurse, because I think you can learn that. You can learn the palliative care part of it as well, but I think it's much more involved and it's much harder to come in with no palliative care experience. But then, as I say, that does, kind of, limit you to just internal recruitment the whole time, because there isn't much out in the community, other than us that do this sort of palliative care.

IV: Do you think that the recruitment market is competitive for somebody who wants to hire people to perform specific tasks related to your team? Like, is it, again, I'm thinking, is it easy to gain people? And, if it's not easy, then why? Is it because we have competition with the NHS space where [unclear]… me or other hospices around are providing better working environments. What interferes [?] there?

IE: I think, I mean, in terms of other hospices, we're probably in a fortunate position as we are, you know, the only hospice in East Kent. That means if you want to work in palliative care in a hospice in East Kent, it's Hospice A or nowhere. The pay structure, I think, is going to be a lead issue. At the moment, it probably isn't because we're just a little bit low, but I think, at some stage, it will be a big issue if we don't adopt the same pay scale as the NHS. Maybe especially within our grading, sort of, the G grading that we are, sort of, the higher end of the pay scale. I think, up until now, people have [unclear]… but it's a much nicer working environment, so money isn't always the be all and end all. You know, if you're under less pressure, it's less stress because of the working environment, then money, maybe, doesn't matter quite so much. But I think the way things are going, the stress levels are beginning to come into this work, so you, then, are looking at remunerations. And I think people will query if there's quite a big drop. And also the difficulty with the hospice as well is that you are deskilled when you come to the hospice in terms of on the wards, using and, sort of, canulating, giving intravenous antibiotics, that kind of thing, you don't use anymore. And out in the community, if we don't go along the nurse prescribing route and don't actually take that up, a lot of the community nurses are prescribing. And, therefore, that's one thing that they're going to have to leave behind when they come to us, so they're going to lose the skill. And I think that might be a little bit difficult because you are in a position, and it has been for a long time, that if you come to the hospice and you stay for any

length of time, it's difficult to move on, which might be why people stay here so long because you've lost a lot of skills that you used to have, so you, therefore, couldn't get an equivalent to the job and grade outside of the hospice movement, because you wouldn't have those skills to go with it anymore. So I think recruitment is going to become more difficult, personally, than it has been.

IV: And now I would like you to evaluate the whole process. Did you enjoy the conversation and would you like to indicate three strong and three weak points of the whole process?

IE: In terms of, sorry, three strong in terms of?

IV: Did you like the conversation for a start?

IE: Yes.

IV: And in terms of the structure, any area related to the conversation we've had together. Would you feel like there were areas that were covered? Areas that were not covered? Things that you didn't like about the interview. Things that you like about the interview, [unclear]… thing.

IE: Yes. I mean, no, it's fine. I've enjoyed it. I think, for me, and this is just, sort of, organisational, again, I wasn't aware until yesterday I think or Monday that I was seeing you, so it was, kind of, you know, it, sort of, oh, gosh, what's it going to be and I only had the information yesterday, I think, about what you were looking at. So I wasn't, I probably feel that I wasn't as prepared as I should have been. And so I wasn't, you know, and I was, but apart from that, I think you've covered most things. I don't think there is anything that I don't think has been covered.

IV: Is there anything that you think could be improved? The approach or the content of the interview.

IE: No. I think, as I say, I mean, probably whether just a bit more information about what you were looking for maybe. As I said, when they first, sort of, said you were looking at financial and whatever, I was, like, gosh, I'm not going to know any of those answers. So maybe just to have, prior to seeing you, a bit more background about what it was that you were hoping to, sort of, cover within the interview systems. There weren't things that I was aware of. I was aware that I wouldn't know if you know rather than, sort of, oh, gosh, what's he going to ask, you know. If I'm going to have to, sort of, say I don't know all the time, that would be the only thing, I think, just a bit more information beforehand.

IV: Yes, this could be useful. Basically, I am looking for financial issues but what most of the accountants are doing or most of the consultants are doing is they are doing some [unclear] organisation or [unclear] or whatever. And they are trying to apply a certain model that they created or they've been working with regardless of the internal limits of the system. What I need to find out first is to see how the hospice centre is working and get adequate depth there in order to be able to present it as a financial activity. Because every single time that you are going outside Hospice A, there is some cost. To affect Hospice A and make you willing to do this, so there is some value created and some value not wasted but sacrificed for people to operate. Unless we will see what motivates people, unless we will see how people are working, like just sitting on their desk and reading [unclear], it's not going to be possible to say that okay, now I have problem [unclear]… of the cost [unclear]. This is why I want to go through your job first and then come back to my main finance areas. Would you like to participate in a similar interview in the future? Maybe with slightly different questions?

IE: Yes, that would be fine, I'd be happy to do that.

IV: Thank you very much.

Interview with the Day Hospice Leader of Hospice A:

Speaker key

IV: Interviewer

IE: Interviewee

IV: Before we will start with the interview itself, I will have to let you know about the ethics and confidentiality policy of the University. You can be assured that any kind of information you will provide within the interview is going to be kept confidential, whichever information out of it we publish is not going to carry your name or the name of the institution you are working for. If at any time you find out that you don't feel comfortable answering a particular question you can just say that you don't want to answer this question, or if you feel at some point that you want to interrupt or stop the interview process, you can just feel free and ask for that. Okay? So, starting I would like to say… to learn some things about your background and your involvement with the hospice movement.

IE: Okay. Well, I've been working… prior to coming over to Ashford this hospice, I'd been working at XXX Hospice A and I've done, sort of, two stints of employment there and it's collectively about 17 years now. I spent some time there way back in 86 for three years and then I went back to the hospital and did some acute oncology, some more training and then I came back to the Hospice A in about 92 and I've been here ever since. So partly over at XXX Hospice and then came over here almost six years ago to set up this day hospice. So, I think about 17 years in, sort of, hospice work and some other time in acute oncology.

IV: Yes, that's quite a broad experience. What motivated you to join the hospice movement?

IE: I can tell you exactly, but it's a bit twee really. I was 22 years old and I was working on a very busy medical ward and I found it quite hard that people that were dying were put into a side room and their families didn't get the time I felt warranted the severity of a situation like that. But they should have had more staff time to talk to them. I also think that the communications… I mean, we are… I think that the communications 20 years ago also were very difficult and for patients that were dying there wasn't a lot of the open and the honesty that we have now.

So, often people didn't actually know they were dying. So I think I found that quite difficult. And then I had a lecture from a woman who was a senior [unclear] and a nurse in a hospice who talked about hospice philosophy and that was quite important to me. So that was really the deciding factor to move out of the hospital environment and to explore hospice work at that point.

IV: Have you noticed any changes in the ideals the hospice movement since you started, like, any move towards professionalism, standards [unclear] of things?

IE: I think there have been changes, to be honest. I think… I think that some of it is that when I, sort of, started many years ago a lot of the emphasis was very much about perhaps terminal care predominately. I think we have moved much more into the realms of palliative care. And I think therefore we're seeing patients at perhaps earlier stages of their illnesses. We're seeing patients that are receiving what we would have classed then to be quite acute treatments, sort of, radiotherapy, chemotherapy. That perhaps wasn't quite so common I think when I was first aware of hospice movement. I think also from the voluntary sector we actually use volunteers greatly now as we did do then. They've always made up a large percentage of hospice team, I think a necessity from a funds point of view. But the roles of the volunteers may have changed slightly with legislation and we actually use them on the ward as, sort of, assistants to the nurses.

So they will probably do more physical work with patients and actually having more direct patient contact when I was first, sort of, introduced to the hospice and that certainly has been something that with moving and handling and now legislation and perhaps data protection, that perhaps we'd not seen volunteers as directly involved in patient care. Although I would hasten to add that down here in the day hospice volunteers have… a large percentage of their time is spent very much in contacts with patients, really. Although again, they're not encouraged to do physical actions with patients, i.e., help them into a wheelchair. So there have been changes certainly, absolutely.

IV: The next questions are about comparing the motivation of people who were starting when you first joined the hospice movement with the motivations today. Do you think that the motives for people to join the hospice movement are becoming different now, like, for some [unclear] to get the patient out. Is it mainly the professional or the palliative care nowadays and what was happening a few years ago?

IE: I think… I think again that does vary a little bit person to person. But I think certainly 20 years ago in palliative care or in hospice setting when I moved into that, I think you were seeing nurses perhaps who were older, slightly older, who'd maybe got quite a lot

of experience in other fields. Because I think it was then certainly an area then that nurses in younger stages of their training perhaps didn't want to feel they were staying in a hospice for long periods of time. It perhaps wasn't considered too healthy to be spending many years in a hospice. And I think because we weren't dealing with many acute interventions it could be perhaps perceived as somewhere you would only want to spend a short period of time before moving onto other acute areas of training.

So I think the nature of palliative care moving, for example, the fact that bloods are taken routinely now in a hospice and that didn't tend to be a daily occurrence 20 years ago. But nurses were involved in venipuncture actually, taking blood and camulating [?] and those things weren't happening 20 years ago. But they are much more aware on a daily basis now. So I think… I think the nurse's role has altered in some respects and therefore the drive to come into palliative care will have changed because of that. However, I think also it's only my opinion and not… that's not necessarily based on research, that there's a certain amount of dissatisfaction amongst the health service as well. And I think that that can sometimes actually encourage a nurse, a qualified nurse to look to an area of work where she might get more job satisfaction, where she might feel that her role has… is appreciated more.

So I think there are other factors involved and some of that I think is bound to be about the drive with the health service as well not being quite as satisfactory as it used to be. I think… I think from the point of view of motivation it's quite a difficult one really because I can only speak from experience and I think sometimes motivation… there will be peaks and troughs. I think what I'm… what I'm used to seeing is that there will be times when nurses are less motivated than others. I think some of that is the nature of the work we do in palliative care I have to say, because I think it's… it can be accumulative we're in quite an emotional environment as you can imagine, predominately a lot of our work is if not with dying people and immediately people who are facing inevitable mortality and I think the knock-on effect of that is that will have effects on people's morale and on their emotions. So I do… I do believe that there will be peaks and troughs motivationally because of that.

I think the changes in nursing generally also has an effect on that, in that 20 years ago there was perhaps less pressure for nurses to continue studying to enhance their role, to pay to remain on the register. So I think there are other things aside from palliative care that are purely linked with nursing as opposed to working in this setting that perhaps could also effect a nurse with motivation. I think generally I see very good motivation here and I'm always still very impressed with how motivated people are. I think… I think there's a lot of team discussion. I think the fact that we have things like a multidisciplinary team meeting, a community team meeting, and the value of each member of the team is important. And I

very much believe that's everybody, volunteers, the housekeeping team, because I think everybody contributes to a patient's care. And I do think that can motivate each other, so I think there's self-motivation that goes on within the team and team spirit if you like, is extremely important. But I think there will understandably be changes on an individual basis, absolutely.

IV: So practically you wouldn't connect the fact that the hospice movement is changing towards a more professionally set standardised organisation, let's call it like that, has any affect on the motives of the people to come and work for hospices?

IE: I think obviously I can only speak really from myself and colleagues perhaps who I know as opposed to more generally. I think… I think… I'm sure that there will be factors, I think we're in an organisation that's ever changing. We're equally in an organisation that's still only partly funded by the government and therefore we're still very much reliant on fundraising and charitable money. So I think there's… within some palliative care settings it may be that people feel more vulnerable from the point of view of their continued employment. I think we're very lucky here in that we are kept abreast of information and I think that can… that can help with de-motivation if you are informed and made aware of decisions. But I think also… I think there's bound to be a certain amount of anxiety if you like, linked to the, sort of, organisation that we work to.

I think from a change point of view it's very hard. I think if people do find that they're de-motivated they tend to leave and they tend to think, well, perhaps I've seen too many changes and that's it, I've had enough time. And I think that's sensible perhaps because we're in an ever changing field. We've moved from an area where we're predominately looking after people who are imminently dying. There wasn't such pressure on the beds. We weren't dealing perhaps from a financial point of view in such an acute way. And now we are moving along those lines and I think… I think changes are inevitable and it's a case of… personally if I'm kept informed about them I feel I can cope with them and deal with them and take them onboard and analyse them more than if we weren't. And luckily here we are, pretty much, so…

IV: That's good. So practically are you viewing the hospice movement as a whole, not just Hospice A or specific hospices. If I was asking you to give me a percentage, just out of your experience doesn't matter if it's based on research. How many people would you tell me that 20 years ago joined the hospice movement having similar motives to you? Based mainly on job satisfaction, I will volunteer to help, goodwill, and not on, I'm going to get some better money or it looks like a more stable job or whatever. And the same percentage nowadays, do you think people in the past worked mainly for the voluntary side why

nowadays the hospice movement, the hospice sector is well established people are starting to mainly view it as a career maybe or something like that?

IE: I wouldn't think there'll be huge changes personally. But I would imagine that there was perhaps a higher percentage way back of people that joined it purely on the job satisfaction basis, possibly volunteers as well. Although I think there are probably less changes from a volunteer perspective than a professional perspective. But certainly from a professional… nurses, possibly doctors as well. I would imagine that at least 70% to 80% of people joined for those reasons 20 years ago. And I think certainly it's what kept them in position even more because the joining is always difficult, you're not sure if it's going to be what you expected it to be, a field like this. But I think it's certainly a high percentage of people stayed in post for those reasons. I would imagine that that percentage is probably less now, although I wouldn't say hugely less, I mean, perhaps 60%, 70% of people.

It may well be now that there's certain group of nurses that are dissatisfied with the NHS that would be drawn to palliative care that wouldn't have been initially. And two, it might be that there's a desire to actually work in an environment like this to accrue experience for a period of time and then move on. And I think those are more likely to be the changes which may drop it 10%, 15%. But I still think the higher percentage comes from the fact that people are drawn to this level of work because of the nature of what we do and what we achieve.

IV: Now, thinking again of the hospice movement sector, which are you considering to be the main challenges which the sector is going to face in the near future or is currently facing? And I would like you to think of both internal and external challenges. Internal challenges to the sector could be risks related to the maturity of the sector itself, risks related to their equipment, challenges related to the sector of governance, government bodies or organisations, versus flexible and independent policy making [unclear]. And external challenges would be the new regulation, financial challenges, the demand for more and new services and the aging of the British [?] population.

IE: Well, if we deal with the external ones first it's thinking about those more prevalently. I think the external ones will come from things like the NICE guidelines, things like our payment by results. I think there'll be… the percentage of money that the government has provided hospices in the past perhaps is a fairly standard amount each year mainly to actually be justified in the future. And therefore we may actually be finding ourselves if you like, having to think about our service almost in accordance with what are we going to get money for, i.e., we may be expected to see patients receiving more blood transfusions to accrue a certain amount of money.

So I think… I think there's a possibility that our service will be reviewed generally to decide how much financial input will be awarded to it. So I think certainly that's something externally. I think also the challenges will continue on professionals. There'll be… there'll be a, kind of, need for nurses to actually provide themselves with more education to higher levels. And I think for the aging population of nurses that may be a deciding factor that makes them think, well, I may decide I don't wish to go down that route whatever age I am. So I think that's the external challenges what will, sort of, always be there.

IV: I'm talking about the aging population of the country and not the aging population of the [unclear].

IE: Oh, I see. Sorry, yes. With the aging population of the country, I mean, I went to a lecture two or three years ago in [unclear], it was quite an eminent, sort of, professor in our country was talking. And he was very hopeful that we may not even see cancer becoming the biggest problem, but the aging population and chronic illnesses would always be and I think there's a significant possibility that people will, because of the age they're living to, have more chronic illnesses, their needs will be greater. And so we could see our beds filled, certainly for longer periods of time and not necessarily that most of our patients will be older, but the factor is with an aging population it's continuing care. If it's not met by the hospice we'll have to look at further avenue's of care for this aging population, that may mean that beds are actually filled longer as a social point of view as opposed to a medical point of view. Where do we place some of this population? Where are the funds coming from? And if they can't be cared for at home, alternative places.

So I do think there's a possibility beds could be if you like, blocked, for want of a better word, on occasion because of an aging population. And the requirements of the health service generally will be phenomenal with a population that's aging. I think from the point of view of recruitment, we already recognised that from a volunteer sector we've got for example here an aging population in drivers. Most people who drive tend to volunteer when they've perhaps retired themselves. So what tends to happen is you have great waves of volunteers that are ready to leave together and whether we can actually encourage younger drivers or replacements is always a factor. Myself… part of our service is about transportation, we're extremely reliant on people volunteering to be drivers and people volunteering, so…. But again I think there are positives linked in with that because I think we're now looking at the fact that volunteering in itself should be part of work experience, should be recognised on a C.V. and actually I think if we move along those lines it may be that we can attract younger volunteers into the sector. So I think not that it's all negative, but I think there are certainly changes from that point of view. Internally, I'm just trying to…

trying to think originally and bring myself back to the point, Grigorios. Just remind me again internally where we're at.

IV: What, kind of, challenges do you think that the sector is going to be dealing with in the near future now that the sector is getting bigger, well established, there might be a need for more [unclear] government grants or anything that you could consider as a challenge for the hospice movement and could come internally…

IE: Yes.

IV: Or externally. Externally it's mainly the government…

IE: Yes.

IV: And the environment.

IE: Yes.

IE: Internally it's the way you are doing the job [?], the way hospices are cooperating.

IE: Yes. I mean, we've got three hospices here, so perhaps that's a bigger challenge for us all under one umbrella really. We've not only… financially is an obvious one because we are still reliant on fund-raising, the shops, all the things that we rely on to bring revenue. But we haven't just got one hospice to fund, we've got three, so in many ways it's a taller order. I think accumulatively bed wise, we've got about 56 beds under the Pilgrim, so that's quite a lot of funding to find. I think we've got an extremely good fundraising team but I think the finances will always be variable and will always be a challenge for the future. I'm sure that will have already been said to you, that's it's not guaranteed funds, because it doesn't come from the government, things like bequests and wills are very variable from year to year. So I think the financial challenge internally will always be there for our organisation.

I think from the point of view of the other factor that we're aware of is that perhaps we are likely to see more non-cancer patients as well in our organisation and I think they bring about a certain amount of new challenges for us. It's always been felt that palliative care quite rightly should be accessible for anybody who's dying and not just somebody with terminal cancer. Although the reality is in most hospices in this country, beds are filled with people with cancer, it's an extremely high percentage. It tends to be that we've tried to promote palliative care but in some sectors we find it harder to bring on board the speciality if you like, for example, end-stage cardiac disease doesn't tend to be the, sort of, patients we see very regularly. Although I quite agree with the philosophy of palliative care when it is for somebody that's terminally ill actually doesn't change very much, the symptoms may

vary a little but the care should actually be the same and certainly the family care and the support that relatives have is definitely the same. We're seeing a growing number of non-cancer patients, for example motor neurone disease, Parkinson's disease. I've got a lady with a heart condition as well. But it's still a relatively small percentage.

The challenge would be one trying to make places available for those patients, but also to run our policies alongside them. Because the difficulty can sometimes be, particularly from myself in day hospice, that despite the fact that they've got ongoing chronic illnesses the length of their life may actually still be longer than a cancer patient, and therefore can we accommodate places for perhaps periods of years as opposed to periods months? So, I think that's a challenge in itself but certainly not an insurmountable one, certainly one that we should be taking on and addressing. So I think it's to work with other specialities in the community, liaison nurses, other consultants, so that they're very much aware of us as a service for non-cancer patients. And I personally believe it would balance quite a lot of inequity. I think if you're dying, you're dying, and in actual fact everybody deserves that level of care and I would quite agree that there is a certain amount of privilege linked to having cancer. It sounds awful but because the service is actually more phenomenal than it is for somebody with a more chronic condition.

So I think that those are challenges for us. Certainly ourselves, we're trying to make links with motor neuron disease specialists, trying to… education will be a challenge because of that, because perhaps a lot of our speciality in the past has been linked around cancer and I think we will there have to take onboard new education needs, challenges, resources, equipment, to meet those needs. But I think they're important to do.

IV: How do you that think hospice sectors will respond to these challenges? The hospice as a sector. The whole movement.

IE: The whole movement. Well, I think, you know, there's a case that sometimes we don't like change really, you know, I think we tend to, sort of… nobody particularly likes change. And I think there might be a fear amongst the movement generally that our beds are going to be flooded with non-cancer patients and that we're going to be looking after people with lots of chronic illnesses and that that will bring about more social problems, perhaps more physical dependency, that the ratio of our staff might be imbalanced because of that.

So I think most of the work we've always been… done and researched has been on the types of patients we've always looked after. But I… so I imagine there will be a certain amount of anxiety. I know that when we've looked at it here there's always been questions, well, will we be able to facilitate that amount of service? Will our services stretch that far if you like?

Will it open flood gates to many other patients? In our experience that hasn't been the case. But I think… I think it's important from the point of view that we meet those anxieties with knowledge really. And certainly here it's encouraging that we're going to be taking on a new consultant who's going to be actually, sort of, partly researched based and looking into those things. So I think it should be researched and looked into. But I think there is understandably anxiety, probably about the swamping of resources more than anything; can we meet that challenge really realistically?

IV: How do you think the services are going to affect the [unclear] at Hospice A? And are you aware of any action plan in place in order to be able to deal with these issues effectively and do you have any specific proposals on this topic? Things you consider as important to be done?

IE: I think… I think… sorry, I've already backtracked and said, I know we're going to be employing a new consultant, sort of, 50% ours here and 50% at the university. And I know part of that role will be certainly to research non-cancer [unclear]. Look into the requirement, the need locally. I think we've already done quite a lot of work with the Motor Neuron Society, our… one of our hospice doctors is linked in monthly with them. So I think certainly from one condition, motor neuron disease, we've perhaps put in a certain amount of research and work. I think from my point of view, from a day hospice point of view and perspective, I think the day hospice service is very… it's a moveable feast and I that think we could adapt to new challenges depending on the patients that we need to at the time. I think it's… the service is very possible to be adapted to non-cancer patients and I think we should… we should continue to obviously look at that. We've got… I'm going to be heading from a day service perspective, a service review coming up that's going to last several months.

But it will… one of the areas we will explore will certainly be the non-cancer element. What can we do? What service can we provide? How broadly can we provide it? And I would expect us then to be liaising with specialist nurses in the community, making links really, within the community so that they're aware of the service we have to offer. They could come and have an overview. I think we need to be realistic, we shouldn't… we shouldn't be thinking we can offer everything; we need to be realistic about our services. But I think there's certainly plenty of scope there to be… to be offering a very wide service to cancer and non-cancer patients.

IV: I would like us to move on now to more specific things related to your role and to the role of the team within the hospice. Would you like to talk to me about it, what about yourself and about what the day hospice thinks?

IE: Yes. I love talking about the day hospice because… you'll have to stop me. I help run the day hospice…

IV: Are you threatening me?

IE: No, I promise. I wouldn't do that. I help run the day hospice three days a week here and we run equally on all three sites three days a week. And we try to offer… a rough guide is maximum patients is 20 patients a day. So each site can facilitate up to 60 patients in day hospice. Now, it doesn't mean we always run on full occupancy because the nature of our patients mean that we'll always have patients that are ill or have hospital appointments, having treatments, so we never run a full occupancy for those very reasons, and the fact that we're dealing with ill people. But our referrals come from within the hospice sector. So any member of the multidisciplinary team can refer a patient for day hospice. That's a little bit unique to Hospice A, other hospices do that but the many ways that we vary is that in other day hospices referrals can be made externally from oncologists or the GP.

We don't do that here and it's always been felt that if a patient accesses any element of the hospice service they should be able to get the whole package, i.e., the physiotherapist, the counsellor, the medical teams. So it tends to be a more rounded service that we offer people. So a patient will be referred to me and I offer an assessment visit then of about an hour… stop making me laugh. You'll have to edit that bit. Of about an hour and I encourage them to bring their family in, have a look around. We try and make this very informal because for many people it's their first time in a hospice, very frightening, very daunting. Some of them might never have considered they were as ill as that, and so equally by me suggesting the day hospice they might think, am I much iller [?] than I thought I was. So part of my role is getting over that and actually explaining to people that, no, this is about a social environment but it's also medically based, we can keep an eye on your symptoms and we have a large team that do that.

We have myself, there's a nurse and we have another staff nurse here. And we tend to speak to the patients each week, have an overview of their symptoms, how they're feeling. We have some issues about pain control, symptom management, we run breathlessness [?] groups, we can refer to the physio. So it's, kind of, about balancing their symptoms from a medical point of view. We then offer diversional therapy which might be in the form of art, sorts of crafts, graph gardening projects, woodwork projects, computer on the internet, all sorts of things really. And we bring people in specifically to do that, that are trained to do that. That's very optional. I'm very keen that people, patients, don't think the day hospice is purely about making things. It is a bit scary in itself really, especially if you can't make anything, you know, that they can come and they choose what they want from the service.

We've got the complimentary therapist who does aromatherapy, reflexology, massage. And then we can link in to every member of the multidisciplinary team, people like the physiotherapist, the chaplain, the counsellor, the social worker, the medical teams. So as you can imagine already, just by coming one day a week not only can we, kind of, medically overview people, but we can also offer social interaction, we can offer counselling from a psychologist.

So we're hoping that their whole needs are met, their physical, psychosociological wellbeing, their religious needs if possible. The chaplain offers a service here once a month. So just by visiting, the hope is to balance symptoms for patients to keep them at home as long as possible. It also provides respite for the carers, that's the other very important thing. If you're the person, Mrs. Jones or Mr. Smith looking after your family member seven days a week, 24 hours a day, just coming to the day hospice one day a week for six hours actually can be quite a lifeline for people, even if it's going to have their hair done or going to lunch with a friend, it's extremely important just to give them a break. We offer them a regular weekly slot and we do provide transportation, so our volunteer drivers will go and collect people and bring them home. If their mobility doesn't allow for that, which some of our chronic patients wouldn't, then we can look into ambulance service and other services.

So as much as possible we then produce an individual package for people with their individual goals. We access them regularly every three months and on occasion if people are balanced, they're symptoms are stable, we do discharge them from the service. It tends to be… most patients tend to end up becoming unwell and not able to attend for those reasons. But certainly there are patients that plateau if you like, and that we're able to discharge from this service, but certainly we refer at any times possible. So a lot of fun down here Grigorios, a lot of fun down here. Lots of laughter, very positive environment. Patients come and they do whatever they want to really, within reason, so long as it's legal. And it's a positive environment, patients gain a lot of support from each other. So if you felt quite isolated or lost your hair from chemotherapy, it's a very good environment for people to feel supported, be able to talk about things. They don't have to be the wife or the mother or the husband, they can just be whatever they want to be on that day. And that's actually quite a relief for people really that are ill. So it's a very positive environment.

IV: So yes, the next thing has got to do with yourself or your team getting involved on the decision making, the target setting and the policy creation of the hospice, or the opposite to that is managing your day to day issues.

IE: Yes.

IV: Are you getting involved on…?

IE: Yes, I do. I mean, I run this unit so I'm usually involved. I have a local managers meeting here which is when heads of department meet. And then I'm kept up to date with any other significant changes within the hospice. I'm usually… a representative of day hospices is required on most working parties or significant policy changes, so certainly if there will be an element of day hospice involved, for example a service review, I'm heading that. Coming up in the near future we've got a patient user group happening to decide on our new information user booklet. So certainly we're involved in levels that I think it's required. I wouldn't expect to find myself at high managerial level meetings because I think it is important to diffuse information really as opposed to everybody trying to go. But certainly we're involved in relevant policy changes and decision making. Certainly I'm fairly autonomous in running this unit, which is good, absolutely.

IV: I think you already told me about how your team is organised and how your team is managed. So we can move on. And…

IE: Tell me if I talk too much. You're allowed to.

IV: No. Come on. I'm here to make you talk too much. This is my…

IE: Don't worry, that doesn't take a lot.

IV: And I think that you already described a typical working day for… but from the patient's perspective…

IE: Yes.

IV: How is a typical working day for you, yourself and for one of your team members? Not that much patient's side, just your side.

IE: Yes. Well, we… we work on… I work four days a week and the team is here three days a week that runs the day hospice. And we're here from about half past eight in the morning and we're here till five o'clockish approximately, because there's obviously preparation work before patients arrive and there's record keeping, there's computerising, pall care [?] statistics, as well as obviously the preparation of the environment and the clearing up. A lot of our work around the patients being here is liaising with the community. We often… because we are what we call the, key worker for many of our patients, some of our work will be around phoning district nurses, phoning GPs, the oncology unit. So it's liaising with relevant people in the community. It might also be about phoning family members. If patients are too ill to come here then that involves work load as well on our part

because we have to know why they haven't attended. Is there anything that's needed from us? And we have to record all of this down in many ways.

So I try on a personal basis also to try to be able to have time to be available if volunteers or the team members need to, kind of, discuss any issues, talk about things. I'd like to think that 70% of my day is planned and 30% is unplanned. The reality is that it may be the other way around and that in actual fact quite a lot of the day with the nature of the work we do is unplanned. Somebody could come in and say they need to discuss something and it's important that time's made. We also have quite a presence on the ward. We attend meetings. We visit patients on the ward. So there will be phoning new referrals. A lot of our work whilst the patients are here is linked to the patients, either side of that there's a lot of other things that need to be achieved as well.

IV: Are you aware of differences between the way your teams are doing their job in this hospice and other similar teams are doing the same job in other hospices? Would you just point out some key examples of this?

IE: I think from the hospices that all Hospice A, we probably work with quite a lot of clarity. We try and have…I mean, obviously there'll be small differences but I think some of the things we might do in this hospice that they don't do in other hospices is we coordinate a carers day as well once a month. So that's actually aimed at any carers of hospice patients, we offer that service once a month. We try to put information talks in that. It's aimed at being supportive as well as informative, and lunch. And we coordinate that service as well and that may be unique to us here. We also run a pamper day here, which is a delightful service that we've, kind of, researched, put a lot of work into and raised the funds for. And that's… we aim to run that three or four times a year for carers and for patients across all three hospices and that's very much unique to us. So we coordinate that here as well independently. I think from the point of view of… it will be hard without having the knowledge of the other hospices if there were any other specifics that the team do here that they don't in other places.

IV: Excellent. Let's go on to the other one now. Are you using any methods to measure performance of the members of your team?

IE: We do an annual appraisal. And so all team members will be appraised annually. We've a fairly standard appraisal form really. From the volunteers perspective I don't do appraisals and their role really would be about individually accessing it on an ongoing process. So I would address any issues that were needed to with volunteers, in a very positive manner. But I would also… I would also try and highlight things that volunteers did

well and we would try and perhaps have a little bit of in-house training. I might spend some time talking about perhaps chemotherapy, so to give them some medical awareness of the, sorts of, things that our patients were experiencing.

There isn't really… I wouldn't be responsible for volunteers technically, our administrator would. Staff-wise it tends to be purely an appraisal. As well as the fact that we here have team meetings probably four or five times a year and that would be a very open meeting that I would encourage staff to talk about anything they thought would be good, positive to make changes. We have a very open team working relationship and we would have… I would be encouraging of them, airing any concerns they had on a regular basis. But certainly in the way of an official review would only be in the form of an appraisal annually.

IV: Basically there is nothing like measuring people's performance, individual's performance on a daily or weekly basis?

IE: Not really, no.

IV: There hasn't been any attempt to break down the job into pieces and then reconstruct it in a way that could give you as team leader the opportunity of watching how the job is getting done, who is doing how much and so on. This, sort of… this, kind of information?

IE: I think that I run quite a relatively small team in many ways. It's another staff nurse, another nurse who works under quite a structured job description really. And that would be reviewed periodically, but that wouldn't be specific to my team member. And then a diversional therapist, and again we may review, small chance of that. But it wouldn't tend to be broken down in the way you've described, not in my experience, no. So I think formal status tends to be about what we see and how we work on a daily basis. Absolutely.

IV: What would be the most difficult things whilst trying to measure the performance of people doing the job that your team are doing? What would you find challenging to measure?

IE: I think in more recent years the biggest challenges would be the roles that are peripheral from our primary role. So I think our main role is perhaps quite straightforward, as a day hospice leader, as a day hospice staff nurse. I think in more recent years we've seen quite a lot of peripheral roles attached to those, so to become link nurses and trainers, to be on working parties, to be part of patient user groups, to coordinate things like the carers day. And I think we are finding that there are additions to the original role that provide challenges. And they're mostly challenges on a time basis really. It's really finding the time to achieve those roles as successfully as you would want to really and I think that's probably,

certainly from my perspective and I think there's ever increasing demands on the day hospice as well to change and I think those in itself provide challenges on the team members as well.

IV: So basically what you're saying to me is that if there is one thing that makes it difficult for you to measure people's performance is the fact that they have to multitask.

IE: Yes. Definitely.

IV: And so from your point of view it could be better if you would have time to measure things beyond your period of time?

IE: I think that's right, because I think… I think the multitasking linked with the original role is fine because I think we expect to multitask. You can be dealing with one patient and certainly have another concern in your head and be thinking, planning your day from the perspective of our original job. I think it's when you're actually trying to bring in almost quite a different role into that working day that will be quite hard and I think… I think probably as you say, actually looking and overviewing that over a period of time will be more helpful than trying to do it on daily basis really. And that would probably need a little bit of research, how many hours you'd actually dedicated to perhaps one of the specific roles or… and making some, sort of, records linked with it.

IV: Are there any specific things that you would consider that's measured on the activities that your team's undertaking on a daily, weekly, monthly basis that could give you an outline of how an individual is performing compared to the rest of the members of the team?

IE: It's a tricky one really. I don't think because two… my other two significant team members have completely different roles, so I certainly…. I wouldn't be able to compare or make comparisons because their roles are completely different. I think from the point of view of… from the nurse's point of view down here we could only measure that really in the way… on a daily basis according to how many patients arrive. So I think a lot of our work is changeable, it's not static, because we may have 20 patients due to arrive and perhaps six don't come, well that would change the working day quite significantly. Equally we could have half of those patients arrive very ill and that would change the working day significantly. So I think the fact that those common factors aren't static would make it quite hard to overview it in many ways really, and as I say because certainly the other two team members roles are completely different. You certainly couldn't make any measureable comparisons with their roles.

IV: Do you believe that your team is already getting involved or it could be involved in the process of creating financial value for the hospice?

IE: Oh definitely. I really do. Sorry, were you going to say a bit more then?

IV: No. I was about to say something but…

IE: I interrupted. Sorry.

IV: It was good.

IE: I really do. Because I think we do… we have quite an awareness here from a fundraising point of view. And for example just small things like we get heavily involved in our annual summer fair which is about fundraising. We equally try from a point of view of our equipment levels and our stock to look into what we can borrow, beg, steal. Stealing, I obviously underline that as a metaphor, we're not really stealing things obviously.

IV: I trust not.

IE: Absolutely. But we do… we are very much aware as a charity that we can… that we use equipment if we can gain it… somebody might hypothetically phone up and say, I've got all this art equipment, is it any use to you? So we are very good from that prospective. Also… things like our pamper day, we went out, we did two or three fashion evenings ourselves, which was a lot of extra work to raise the money for that. So I think we have quite a good overview of the fundraising. I'm not necessarily sure it's part of our role. I think we do it from the point of view of knowing how important it is to provide the service. I don't necessarily say that there's time put into our role to allow for it. But I think we have a good overview and have participated.

IV: Do you think that you are helping the branding process of Hospice A and the hospice movement in general and [unclear] and these patients are coming and some of these patients are followed by a certain amount of money, either from government organisations, hospital, whatever. This is one case. There is another category of patients coming in and there is a potential of bringing money, a will or donations from them or their families. Can you see your team playing a role in these three areas, like, branding, money coming here instead of going to somebody else's charity, and donations or government or whatever funding through your contact with the patients or any other people?

IE: I mean, I think not necessarily directly, because I think…I think patients will make donations here because they are pleased with the service. And I think part of that is definitely due to the team because they feel satisfied with the service and are happy to make donations.

And from my point of view, all I would be encouraging of patients is that yes, we do have collecting pots and small denominations of money goes in those. And I would be encouraging when I'm asked by patients, which I regularly am, and their relatives, what are the charges for this service? And I make them aware there are no standard charges but that we are very pleased and very grateful to receive any donations.

So I think I would be encouraging from that perspective. I think I'd be uncomfortable if I started to think the team were discussing legacies and wills and I certainly wouldn't want to be seeing that happening because I would perhaps feel uncomfortable about on a personal basis. I think it's important that people come here and from a professional perspective we treat them and offer a service and that shouldn't involve the discussion of money. As I say, I think what we see and which I'm happy to say we acknowledge is that if people wish to make small donations on the day for services they receive, i.e., as I say we have a pot in the hairdressing room if they have their hair done and they wish to make a small donation. But I wouldn't be comfortable with starting to talk about wills. I would very much point that in the direction of the administration if somebody asked to discuss making provision for their will, I would point that in our administration in the right department rather than perhaps take that onboard ourselves. I think… I think otherwise from a funding point of view we probably don't have anything directly to do with funding down here. Other than that I think we try to have awareness of the costings of the unit and the requirements that's needed, which is good to be aware of, but…

IV: Yes, of course. It looks like you're doing quite a lot though.

IE: Yes. I think so. [Unclear] hardest working member of the team.

IV: Let's move onto the [unclear] question. Are the members of your team working in corporation with members of other teams within the hospice or they're primarily working on an independent basis?

IE: No. We're very much linked very much with other teams. We've got a small team down here and we work on a daily basis around each other, but we're very much linked to other teams. Our nurse manager is responsible for us as nurses. The complementary therapist is very much under the medical directors. So we're very much linked to other teams really, yes. I think it's very important that we are for support, but also for recognition of what the service does, so yes.

IV: Do you think that the team members are enjoying it or would they like to [unclear] a bit more or maybe [unclear]?

IE: No. I think… I think they enjoy being part of a bigger team because most… most of us hospice professionals value the support that a team can offer in the work that we do. I tend to think that we run our unit in a daily basis reasonably autonomously and I think that's important to feel equipped to do that. I think we need to feel confident in running this unit on a daily basis ourselves. But I think we equally need to know where we go to for our advice and our information and our backup, because we need it as well, so…

IV: Who do you think the voluntary major [?] of hospice movement is facilitating the multidisciplinary work team? Because compared to other organisations like hospitals, you can see the amount of people coming from different professions that work in teams that there is some conflict there. Doctors for example, tend to view themselves as leaders of the team or some people are feeling that their opinion is not taken into account. Based on what you've told me, here these things are minimal compared to other places. Do you think that it is the voluntary nature of the job? Of the movement, of the different elements?

IE: I think there's probably different elements, to be honest. I think it's a combination of things. I think very much… the example you give, I think is a good one, really. I think a consultant in a hospital can appear a little bit more difficult to relate to about a patient. Certainly here I think we'd have… nobody would have any qualms about discussing a patient in depth with a medical consultant or director at all and I think very much what we do is about communication, and therefore I do think… I wouldn't say we're perfect at it. I think we'd all like to think we did everything perfectly and we certainly aren't. But I do think that we probably have high levels of communication and opportunities and I do think that spreads right across our working perspective including the volunteer sector really.

IV: How about recruitment? We've already said some things but I would like to make it a little bit more specific now. Do you know if there are any specific recruitment policies or do you… are you setting specific criteria when you're about to hire a new person, a new team member?

IE: I'm not sure of any new recruitment policies particularly. Certainly I would be involved in part of a panel, an interview panel for anybody significant to my team and we would… that would be a panel though; it would never be one person. And I think our recruitment policies tend to… tend to now be overviewed a little bit more rigorously because we've got a very upfront human resources department. And I think there's been some work done into recruitment policies and job descriptions, that's probably positive really.

So I think there are probably changes because of having that department and that resource available to us, which is probably important. Certainly from my own perspective I wouldn't be involved in the changing of recruitment and policies. But certainly I would be involved in interviewing and selecting a new team member for the team.

IV: Are you usually looking for specific skills when you're hiring somebody? And how easy it is for these skills to be found?

IE: I think we probably are. I think when we advertise for people we're not necessarily expecting to see people with palliative care experience. But I think we… some of it is based around their previous training and previous work they've done, because I think certainly we would… we would… we would be pleased to see anybody that's had relevant palliative care or experience or in similar fields really. But equally I think quite a lot of it is based on an interview as well. Because I think we are seeing shortages of qualified nurses coming forward and therefore it's important that we recognise that we can also train personnel on-site as well. And that if somebody hasn't had relevant experience but does come across with a very general interest and enthusiasm, that the training we provide on-site should be significant to bring them to required levels, so…

IV: Do you believe that the recruitment market is competitive? And whom do you consider as the main competitor of this market for hospices?

IE: I think we probably have difficulties occasionally with, kind of, grading and wages and things because I think as an independent… part of the independent sector, I think we… our organisation obviously tries to run in line with the, sort of, grading that nurses particularly see themselves. That may be a dilemma at times I'd imagine because we're there are only a certain amount of financial resources available. But I think we can probably compare fairly favourably. I think our biggest… our biggest opposition if you like, would be the hospital, I imagine, although the community does actually attract huge amounts of staff as well. So I think… I think it's a case of, you know, those would be the opposition if you like. Not necessarily other hospices, because people in this area, we've only the three so we tend to… if that's what's somebody's looking for we would probably be the people they would contact, so…

IE: Between ourselves, each other or each hospice or with the hospital?

IV: Anything. Anything you [unclear] if you want to hire somebody and you're looking to the market. How easy is it to find this person and what are your difficulties to persuade

him to come and work for your team instead of going and working for the hospital or another hospice or whatever?

IE: I think… I think… I mean, I think it probably does produce a certain amount of difficulties but I'm not sure that's purely because of competition from other organisations like a hospital. I think some of that is because of the nature of what we have to offer. It's perhaps not what everybody would consider a desirable field to work in. So I think there's that factor as well. I think also from the point of view of wages, I think people will look at pay scales, and will look at those. And perhaps if there's more money involved that will be a deciding factor for somebody. If we weren't able to match that pay scale that may be a deciding factor for not coming here. But I think predominately there tends to seem… I can only speak from the example of when we tried to recruit flexi-nurses and we weren't very lucky on that occasion. But I think it's variable. I think there are also peaks and troughs in the employment, kind of, organisation that sometimes work fine we'll have several people apply for one post and on other occasions not so. And that can be quite variable really.

IV: Now I would like to ask you for some general feedback on the whole process. Did you enjoy the conversation we had and would you like to indicate three strong and three weak points of the interview process?

IE: Yes. It was a wicked conversation, Grigorios.

IV: Thank you very much.

IE: Sorry if I talked too much. I apologise. I made you very late.

IV: That's all right.

IE: I apologise. Three strong points I think are from you're very… will we talk about that, you're very encouraging to… and explains the points very well so that I think I was quite clear on mostly what you were asking me and that's brilliant because it can be that you're not entirely certain what you've been asked. So that's very good that you're very relaxed and allow the person to speak, somebody like myself who speaks a lot, without interrupting. So that's very a very strong point. And, you know, you're very pleasant, you haven't asked me to prepare you a meal before we've done it or whatever, so…

IV: I was about to ask that.

IE: Oh yes. That's the weak point now. So no, I felt relaxed during the interview and not threatened, if that's a strong point. From a weak point of view, not very much really, except that I probably… there where certain areas that weren't specific to me so that I perhaps

wasn't able to answer in as much detail as I would have because those areas are perhaps not as pertinent. But you made it very clear that I could say at any point about not answering or that I didn't know. So if it appears, you know, a bit flimsy it may be that there are areas that I haven't as much information in. But apart from that and the fact that now I'll have to do all my work tomorrow instead of today because I've been interviewing with you.

IV: That's great. So that's a small disadvantage

IE: Is that what you reckon. And obviously the fact that you encourage a huge pay increase is a plus from my point of view.

IV: Well, the next question. Would you suggest any areas of particular interest to your team, your job, your own that you feel were not covered in adequate depth, and how do you think they will be covered better on a similar or future interview?

IE: I think really it does very much depend on what you're trying to achieve from the interview really, Grigorios, because I think you can go down many different routes and day hospice is quite a specific unit. So certainly you can look at what benefits it… we think it brings specifically to patients. How we're trying to achieve it. So I think there are many other routes to take. But I think in many ways that depends on what you want to overview really. So I think it's better to be focused really.

IV: Yes. Based on accessing the individual hospice and the contribution of your team as the financial management activity. Do you think that these areas work out?

IE: Yes, I do. Yes, I do.

IV: Yes. Okay. Are there any improvements that you would like to suggest on the approach or on the content of the interview?

IE: I think it's important to bring doughnuts next time. Are you familiar with doughnuts?

IV: Yes, quite a lot. I think that this is quite…

IE: I think if you provide a plate of doughnuts, apart from the fact they're messy and it takes time, it's important, yes. But apart from that, no.

IV: Oh okay. Thank you so much.

IE: You're very welcome.

IV: And one more thing. Would you like to participate in a similar interview in the future? Maybe with some different questions, but [unclear] in other interviews?

IE: Yes. That would be fine.

IV: Thank you very much.

IE: You're very welcome. No problem.

Appendix 5: Interviews with: non-clinical directors and senior non-clinical personnel

Interview with the Fundraising director of Hospice A:

Speaker key

IV: Interviewer

IE: Interviewee

IV: Before we will start with the interview itself, I will have to let you know about the ethics and confidentiality policy of the University. You can be assured that any kind of information you will provide within the interview is going to be kept confidential, whichever information out of it we publish is not going to carry your name or the name of the institution you are working for. If at any time you find out that you don't feel comfortable answering a particular question you can just say that you don't want to answer this question, or if you feel at some point that you want to interrupt or stop the interview process, you can just feel free and ask for that. The questions I'm going to ask you are more or less what you have seen on the email already, so mainly I'm interested in the work you are doing. What your team is doing? How you are managing people? Your general background knowledge of hospice, your background, as you already said, academic background, education. Where you are coming from. These kinds of things. What I would be looking for here is to have a little bit, a few things about your background, and how you got involved with hospices? What was the main motivation for you to drive you here?

IE: Gosh, right. Well, what I said, after my degree, I moved to London to work in television advertising and planning breaks, planning out into the breaks of ITV, and then I moved into research, where I was looking at audience research. You know, who was watching what at what time? And, how much we could feasibly charge them, for the air space. I then moved back to Plymouth and started working for a charity down there, running two ambulances, three charity shops and you know, basically looked at the fundraising, and that was my first real experience of fundraising and volunteering, and how we could develop that, so that was quite good fun.

Then, I moved from there into hotel marketing, and from there into press advertising, and from there, back to animal charities, where I worked for the Barn Owl Trust and I was looking very much at their fundraising and how that worked, which was majority Trust fundraising, and it was there that I met my last boss, you know, through the Institute of Fundraising, at one of their conferences, and I said to him, did he have any positions

available? Because I'd quite liked to go and work for him, because he was quite an inspirational character, and anyway, that was when he said, yes. There would be something coming up, keep my eyes peeled, and I applied for a job as a manager working for him.

And, ended up working my way up within that hospice, from fundraising manager to Director of Funding, so it was quite an exciting time, because I got to experience a whole host of fundraising. I was looking at, I ran a Lottery. We were doing majority community fundraising, but we also developed our corporate fundraising, which I headed up and yes, it was a very exciting time. I was there three and a half years, and then I saw this position advertised, and I'd taken my last hospice, where I wanted it to be, over the time that I was there, and this opportunity came up, and my family are living in Kent, so it was a great opportunity for me to move back home, closer to my family.

And, it was a great opportunity, because this is three times the size of my last hospice, and there are some huge opportunities here for generating more income, so it was quite exciting, thinking I could use the skills and the techniques that I'd learnt down in Plymouth up here, to implement them here. So, it's a great opportunity to be here.

IV: How did you decide to move to fundraising and this. Were there any? Did you know anything about those things before you started, or it was just that you met somebody in a conference, and you decided to work for him?

IE: No, this started back when I moved back down to Plymouth. I left London, purely because I got fed up of being in the big city. I wanted to move back to the West Country, and that's when I basically went back and started working as a florist, and volunteered for this charity, and through the volunteering, they said, would I like to manage one of the shops? And, then I ended up managing all of their shops, and the charity in its own right, which was great, and that's where I discovered fundraising, because up until then, you know, I hadn't done any real volunteering, other than the bits and pieces you do at school, but I'd never actually been a proper volunteer, or done any proper fundraising outside of school or organised environments, so yes, so I learnt from scratch.

I went into a library one day, and I thought, I've heard about these Trust Funds. I'm going to find out, I sat down with the books, and just taught myself, and through getting more involved, I then found out about the Institute of Fundraising, and when I left the paper, and went to work for the Barn Owl Trust, that's when I started going to their conferences, and that's when I started finding out more about people who were doing it professionally, and I realised this could be a real career for me, so yes.

IV: So, you mean you entered it as a career, after you started as a volunteer, and then you started considering it as a career, as a professional business?

IE: Yes.

IV: The next question is going to be about both yourself, your own views and the people who are, the views of the people that you are cooperating with, within the hospice movement. It is about their motivation. How…what do you think motivates people to come and work for a hospice? Nowadays, and what do you think motivated people to work for hospices a few years ago? Can you see any changes there?

IE: Yes. There's definitely a trend that you can see. It's still early days yet. I mean, I didn't come to work for the hospice, because I'd had experience of hospice care, because I haven't. I haven't had anyone in a hospice, I haven't…I see what we do now, but like I said, I'm a professional, so I came here for the job, because I wanted to be a fundraiser, and I knew that working for the hospice was going to be a good career move, because of the variety of fundraising that I could get involved in, and like I said, my last boss was quite an inspirational character locally, and I actually wanted to work with him and learn from him, so that was quite a draw for me.

You find, when you speak to people, I think, within the hospice environment, that people who've worked here for years and there are quite a few. Retention tends to be quite high, from what I've seen. They've come here and for the love of the work and the place, but then there are other people who come in, who you know, are here just for the job. I suppose it depends what level you're at and what you're actually doing.

IV: Can you see the hospice movement as a whole changing from a voluntary based institution to something more professional, more mature? Basically, are hospices attracting more professionals than what they attract volunteers, nowadays, compared to what they were doing in the past?

IE: It's interesting you should say that because we're going through what I see as a cultural change here, within this particular hospice anyway, and it's…one of the proposals that I'm putting forward to our trustees in a few month's time is around investing in fundraising, and actually taking it more seriously, and making sure we have the staff with the right skill sets, in order to take us where we need to be.

My target, and sorry, I know I'm talking just about fundraising with this, but it's quite a good example. With the financial pressure that we're under at the moment, and the financial pressures that are ahead of us, I think hospices in general across the board are

having to become much, much more professional, particularly within their fundraising. My target, for example over the next five years, I have to double the voluntary income. That's an awful lot of coffee mornings, and it's not all about coffee mornings, so it's actually looking at the whole portfolio of products, if you like, that we deal with and how we actually make those work for the future.

It's looking for new income streams, it's looking for how we manage that, and the resource involved in actually generating that income, and I think there is a shift happening definitely within the hospice movement, because the charity market in general, from what I've seen, has become more competitive over the years, and I've been fundraising now, crikey, how long? Over ten years now, and you know, it has become a lot more competitive, so we have to be more business like, and that's not, I think, what the public actually want to see. Yes, they want the same level of service that they would expect from your utilities companies, for example. You know, they want responses to their phone calls and their emails, and so on, but what they don't want is for charities to be spending money on the administration behind returning those emails and phone calls, and so on.

They're very focused on how much pence in each pound goes on administration, and yet administration is still…we need that in order to respond to people, so it's a bit of a catch 22. How do you deliver the service which you should be able to deliver, but at the same time, do that without being seen to spend lots of money on administration or paid for services [?], and I think that's quite a challenge, because again, particularly as a local charity, and from a local perspective, when people phone up and speak to you, they think you know them, because you are local. What they don't see is that in fact this particular hospice, we're actually rather large, and we couldn't possibly know everybody. Case in point. I had a letter yesterday, saying there is a funeral and this lady was one of our supporters, and some flowers via the florist, or come and attend the service, so I went to a funeral yesterday, but I didn't know who this lady was. The people that I spoke to within the organisation didn't know who she was. It turns out after conversations that I had at the funeral, that she was one our volunteers in one of our shops, and that indicates to me that you know, we have this massive network of support and of people, which is fantastic, but we don't at the moment have the resource in this hospice to know who all these people are, and to be able to have that proper, two-way communication that people are expecting, because we just haven't had that investment to be able to do that.

IV: You feel a little bit like doing both the job of a director and a secretary at the same time?

IE: Oh yes. Well, at this hospice, this is how it works. There is myself, and a corporate fundraiser, and I now have a marketing and communications coordinator, and a part time fundraising secretary, but that's about it, and that's…we are one of the largest hospices in the country.

IV: Given that all the rest of your team is volunteers?

IE: Yes. We are very, very fortunate, and this is where the catch 22 comes in. We have ten volunteer fundraising groups who are fantastic. They do a brilliant, brilliant job, and some of them have been fundraising since we started, since before we started. They've been going for 25 years, and they have seen the hospice grow from an idea to a building, to this big, big organisation, but the understanding behind where we'd need to go next, needs to be worked on, because with the best will in the world, what they're doing is fantastic and it's great, and it keeps us at the level we're at today, but if we need to double this income over the next five years, we've got to do some different things, and it's going to mean investing, because we can put out an appeal to bring in more volunteers, but there's only so many hours in my day to help support these people.

IV: I can understand that, and if you carry on what you've done up till now, you [unclear] in the end, so…

IE: Absolutely.

IV: This looks good. So, it looks like you would support a more professional approach, both on this hospice and on the hospice movement in general?

IE: Yes.

IV: That people should start taking it a little bit more seriously, like it is not just the idea anymore. It is not just a public support anymore. We have to manage our own, we have to identify some things that we can do and work on them, and if we have the resources available to invest in that?

IE: Yes.

IV: Are you involved with the overall fund management of the hospice at all?

IE: How do you mean?

IV: The financial planning, and general income, or are you just focusing on fundraising, because you are involved in with the Trustees [?] or general?

IE: We have a meeting in May with the Trustees, where I will be presenting to them a plan, a strategy for the next five years, based on their overall organisational expenditure needs over five years, because I have their five year plan. What I need to do now is to look at ours, and where in the past fundraising has just been a term for events, and the volunteer groups, I'm trying to get the understanding that fundraising actually encompasses far more than that. It crosses over all the different areas, and actually there are bigger opportunities in some of the other areas. One of the things I'm particularly looking at is our database, because we have an income database, where people input information on donations and so on, but there's been no proactive direct marketing from this database, and this is a goldmine, as far as I'm concerned. This is where our money will be coming from.

But, I need to look, validate, first of all, validate the data that we already have on there. Then, I need to look at the resources we have to actually put the data on there, the resources we're going to need to actually get that data out in a manageable format, and then actually looking at, okay, so creatively what are we going to do with this? How does this fit with our overall portfolio of income generation products, if you like? And, manage that whole process and lead it, and we've made a start. We've started reviewing our current database as it is, and we have a group of people who are users, who are looking at it and going, okay, this is what this particular database can do, but if we got this database, it could do X, Y and Z, so that's…we've seen two databases now, which is kind of good, so we're looking at the functionality and where we can go forward with things.

I've also been trying to create a bit of hype around the online side of things. We've created a Facebook page, and we're looking at…one database yesterday were saying that we could interface directly with our websites, so donations online, we can afford to move away from third party providers, and actually link straight through, so there's some huge possibilities going on. What I'm trying to do is keep a mix of some real good, short term hits, if you like, to prove that what we're looking at works. So, we bring that money in, we gain people's trust and they're then looking for the next thing that we're going to be doing, and at the meantime, bringing in some longer term bits and pieces, so people can see, it's win, win, win all the way.

IV: This is great, and it's good that you are adopting a very positive approach to things. You didn't put in any challenges up till now, any problems up till now. All that we're talking about is things that you want to do and how things will be better after that, which I think is a great mentality when you are doing this type of job.

IE: Yes. I get accused of being a bit too enthusiastic sometimes, but on the whole, you've got to be forward thinking. You've got so many different people to take with you. I

mean, I have three organisations in one, effectively. I mean, the Trustees see this hospice as being one organisation based on three sites. You go onto each of the sites, and they see it as, well, we're the hospice here. We're the hospice there. It's very hard for them to see it as one organisation over three sites, so you have to take three groups of people with you, wherever you go, and then you've also got the added complication of different groups fundraising for their individual hospices, so it's…you've got to be like this.

You have to be positive, you have to be enthusiastic, because you've got to take all these people with you, and you have to show them where these opportunities are. It's too easy sometimes, I think, to just close down and get the blinkers on, and just look at your one area, and think, okay, yes. I'm doing okay with this bit here. I don't want to worry about the rest of it, but my job is to look at the rest of it, and to make it less scary for people, I think.

IV: Are you getting involved at all with money coming from government organisations, like hospitals or institutions?

IE: No, that's CEO's ball. Yes, that's not mine. He deals…

IV: CEO has to deal with this?

IE: Yes, CEO deals with that, yes. I deal with at the moment, like I said, until we have the meeting in May, when we actually make some decisions about what I'm actually going to be doing. At the moment, I just deal with the volunteer groups, the friends scheme and the corporate fundraising. Any other bits and pieces that come along, but I don't officially look after the donations administration, which is the database stuff, and the legacies and things, but because my work crosses over these areas, I am getting involved, and because I have flagged this up as a major opportunity for this organisation, I know that if the decision is made in May, yes, go forth and multiply, it's going to happen, so it's quite positive about that.

IV: It looks like you are getting involved on a target setting process?

IE: Yes.

IV: But, how is it working? Is it like you're proposing the targets and your Trustees are either accepting or rejecting them, or they are putting some targets in place, and you're going about them in the end?

IE: What they've worked on is a five year budget, if you like, and what they are predicting is what level of expenditure they need in five year's time. My job then is to look

at that overall target, and break that down into realistically, CEO, what are we going to expect from the NHS? Fine, okay, that leaves us with X and then we can break it down from there. So, at the moment, I have a ballpark figure to go for, which is double the fundraising income. What I'm working with CEO very closely on now is, sorry, am I allowed to mention names? Your confidentiality thing?

IV: It's not a problem. We can keep those names out, I can keep all the names out.

IE: Sorry, I just realised, so yes, there is that, you know, we are working very, very closely on actually getting some realistic targets together, and working towards that.

IV: Excluding CEO, the financial side of it, are you getting involved in the overall process of management? Like, for example, do you have managers of other departments approaching you about their expenditures, about the internal resource allocation within the hospice, or this is nothing to do with you?

IE: No, the only people that I cross over with outside of my team, is on a marketing level. Because I've taken over the responsibility for the marketing of the hospice, both internally and externally, my marketing communications coordinator is working on an internal communications project, for example, and she deals with all the written literature that goes out from the different departments and so on.

So, there's a lot of crossover there. With regards to expenditure as such, the only expenditure that I share with anyone is the Lottery, and that's on our advertising budget, but again, we're having a discussion about that next week, because I personally don't think we should be spending money on advertising, when I know I can get it for free, but I need to talk to him about that, because if it's going to adversely impact on his membership, and his recruitment, then we need to look at alternative ways of upping that, or moving that expenditure out of my budget into his. I don't know. But, it's not…if that answers your question?

IV: It's good to get all this information. My purpose here, here are some questions written, but these are only a guide for me, and we have already gone far out of the framework, but it's still very, very interesting. My overall target is to get you to speak.

IE: You don't have any problems there. It's getting me to shut up that's the problem.

IV: Like I said, who wants to do this? Let's talk about a little bit more about your team now. How is it organised? How many people do you have there? Are there any people below you? Are you reporting to somebody else, excluding CEO?

IE: No, I report directly to CEO, and in my team currently, I have the marketing and communications coordinator, the corporate fundraiser, and a fundraising secretary, who is part time. I also have the friend's secretary , who is part time. She's on a temporary contract at the moment on a bank basis, but we're working on that. I also, I've been working more closely with the donations administrator, and she has a temp who comes and works for her, and because of the database projects. Whether that will change in May or not is part of the decision they need to make in May. If you want me to tell you what my plans are, I'm quite happy to share.

IV: That would be great.

IE: I'd like to develop a supporter relations department, within my team. A supporter relations team within my department, rather. And, I'd like to recruit a supporter relations manager, who comes in and manages the previous donations administrator, or that role, rather than maybe not the person, but the role. We change the donations administrator job title to supporter relations administrator, it's still an administrator's role, so we basically have two administrators working for the supporter relations manager, who reports to me.

And, I think that will give us enough scope to be able to develop some of our fundraising, looking at our donors on our database. Sorry, I do this because I refer to my database as a pyramid. We're constantly moving people up the pyramid, so there's a lot of work around that that needs doing, so that's one side of things. The other side of things, we're looking at major donors, and trust fundraising. We haven't done any investment in that. I have a volunteer who comes in for two hours a week, most weeks, not all weeks. And, sends out trust applications on our behalf. Also the corporate fundraiser gets involved on doing the trust applications as well.

Currently, we bring in about 100K a year. I think we could probably double that if we had someone working on it on a part time basis, so looking to pitch for a 16 hour a week post for trusts and from that will also come some major donor work as well. We're looking to outsource some prospect research. I've got someone coming in next week to talk to me about actually prospecting the database, looking at potential opportunities, people we could contact, and then I'll be working very much on making sure, we find out who's who. Who knows who? You know, so we can get some peer to peer asks going on, so we can work up some projects. We can actually have a serious Investors in the Hospice programme up and running, so looking at that. Looking at trusts.

The next area, as I said I have a corporate fundraiser, and what I'd like to do is to combine corporate and community fundraising, because there is…there are grey areas. There are a

lot of crossover. The way I see corporate fundraising, you've got three asks. You've got the philanthropic ask, which is where you go and you speak to the owner, the MD, you say, hey, give us some cash. Maybe not quite like that, but that's your pure philanthropic ask. Where they give you a donation to offset against their tax and their corporation tax, etc.

Great. You've then got your sponsorship asks, where you go to the marketing department, and say, give me some money. Shall we show your logo at our event? You pay for the production of this. We'll do that, you know? So, it's those cause related marketing, sponsorship, kind of asks that go through that side of things. Then, you've got employee fundraising, which is community fundraising in essence, where you're getting them to sell an Easter bunny on the reception desk, or get them all to do some team building events reversal or whatever it is, Christmas bells, that's the employee side of things.

Now, if we amalgamated what we do with the community with the groups and the collecting cans and all those bits and pieces, and added that in with the corporate stuff, it actually dovetails quite nicely. And, our corporate fundraiser at the moment, who is placed in Thanet, actually does an awful lot of community fundraising, so just to change the scope of the post slightly from being supposed focused on corporate, which is not what she's been doing, actually makes it a lot easier to manage, because with the big philanthropic asks at the top of the ladder, with the MDs and the owners and so on, actually what we could do is get the community fundraisers to flag up these possibilities, to myself or the major donor trust person, and then we work on the hospice ambassadors and the right people, the trustees, the senior managers, to actually go out and do those asks, from the corporates who would potentially be major donors or have their own trust funds, etc, so there's a lot of crossover there.

So, that's the plan, and where I'd like to go. At the moment, like I said, we've got one person in post currently in Thanet, which is great. I'm proposing we recruit here in Canterbury, so we have one person in Canterbury, because we have a very, very strong group in Ashford, so I'm not too worried geographically about Ashford yet. I need to warm up the Trustees and the organisation to the thought of investing in fundraising anyway, so we're going in politically with a lower ask. You know, gets the supporter relations in, because that's an easy, quick hit to prove that we can do it. Get the trust, get this money in. We've got to recruit here in Canterbury, because the group we have here in Canterbury, the Chairman is retiring at the end of this year, and if I don't have someone in place here, there is no way, there will be no proactive fundraising going on in Canterbury, and we can't afford to lose any ground or market share that we have in this area, because we're already struggling with other appeals that are going on.

For example, the Cathedral have their big capital appeal running, to Save Canterbury Cathedral. You've also got the Milo [?] Theatre have just launched their big appeal as well, so we've got to keep our market share here, and that means we have to compete, so we need resource in this area. The only other new thing that's come up, that has actually been agreed is, please tell me if this isn't relevant and not useful. We've just put out an advert last week for a youth fundraising coordinator. This was the Young Volunteers Development Officer post, which we had three years funding for. She left before Christmas, and I went to CEO and said, can we use the money slightly differently, and can I have it in my department? And, we worked up a job description, slightly changed the role, so that it's more fundraising focused.

So, that we can actually attract somebody with the skill set of the fundraiser, because we want this post to focus across all the bases, across the whole area, on bringing in young people from schools, colleges, and universities to come and work with us, and actually, you know, put on their own events, generate their own money, and just get involved, so the other side of that coin is they will be charged with creating and supporting this group of hospice ambassadors, who I will be able to tap into. The major donors and trust person will be able to tap into, and we can use across the whole organisation.

Provided my plan goes ahead in May, and we are successful, and we get these short term hits and so on, that does leave the door open for a year, two years down the line, getting another fundraiser in, in Ashford, so that we've now got a more coherent team structure. When you're talking about structures within hospices, we are very, very under resourced here, paid staff wise, I feel, coming from another hospice in another part of the country, where I had 15 staff. We're very, very under resourced here and it's how do we actually redress that balance, or do we need to, to achieve what we need to achieve? There's the other question.

IV: This is true, but it's always up to what you can exactly prove, because it's forward looking but working to present to people about your targets. If you will show a way and the target you have, it's not easy for you to get what you want out of them.

IE: Yes.

IV: And, we are now talking about expanding your team basically, but how are you measuring the performance of your team, or how is it measured by the hospice? Do you have, how do you know that your people are doing a good job, basically? Just results at the end of the year, or you have a different process?

IE: No, it will be a mixture of soft and hard targets. I'm looking at setting objectives that I want people to achieve throughout the year, and there will be a mix in there of for example, the youth fundraising coordinator. I mean, obviously once they get up and running, I would be expecting to see an increase in the amount of money coming in from different schools and colleges, through their activity. So, you would measure, well, I would measure that person very much on their activity, how many talks have they organised? How many schools have they been to see? How many visits have they organised for schools to come here? It's that real mix of their activity targets, versus the actual hard financial targets as well, because the only way I think you can see, if you're flogging a bit of a dead horse. If they've gone and done so many talks and visits, and nothing has come back from that, you start asking questions as to, are they asking…are they giving the right messages across? Why aren't people responding to this? Is it because people don't want to respond to this? Or, is it, maybe we need to change our approach? You can then start, you know, problem solving from day one, with both the soft and hard targets, so yes, I would expect to be looking at things like this on a monthly basis. How are you getting on? What's happening and so on?

IV: That's great, so you are describing the role that you will create and at the same time, you're describing the measures that you will take to make sure that the person you will get in will work there.

IE: Yes.

IV: This is good, what about existing measures? How are you measuring the performance of the people you already have below you now? Both at the bottom level, a volunteer up to maybe your level, the whole team?

IE: I've only been here a few months, so at the moment, my focus has been on information gathering, and planning ahead. I haven't actually got too involved with what's been going on, because what I've been wanting to get a feel for is how people work, what sorts of things are coming up. What sorts of problems are coming forward, and from that, I'm actually, from taking a more, not sedate view, but a more passive stance, I think, it's been interesting, because you're seeing things as they are, and you're then able to add that into your overall planning and so on. I mean, I have introduced monthly reports, and that was in the last few weeks. I have actually said to the guys, okay. I actually want you to start giving me reports now, telling me just activity. What have we been up to? What are you planning to do? Just look back, look ahead, simple as that. So, that will be a measure that I'll have introduced.

I actually had an objective setting session with the marketing and communications coordinator, because that was quite an easy one to do, with the corporate fundraiser, because I know we've got this change coming up. I've been a bit more reluctant to actually go in there and say, okay, here are your objectives, or let's discuss this. Where do we want to go? What do we want to do? Because we are going to be having…I need to be having a more sensitive discussion around actually, you know, what sort of fundraising do you actually want to be doing, and the organisation probably needs to be looking at this. Is that something you are comfortable with, because we're going to need to start broaching this subject now, so that we're not, if the decision goes ahead in May, we're not actually dumping someone with a change like that. That doesn't work. If we can warm people up, I think that would be a good thing, yes. I mean, it's not going to be huge for her anyway, because it is what she's currently doing. It's just if she's got ideas as to where she wants to be doing stuff…so yes, it's…

IV: Get people to contribute to your idea, and approaching the change that your ideas?

IE: Yes, I totally believe that's the best way forwards. The same thing with the database, and what we're trying to do there. The donations administrator currently, okay, I don't directly line manage this lady, but I'm the first person who has actually understood what she's talking about. She said, since I've been here, she said, it's so nice to be part of the team, and I said, well…officially speaking, you're not, but I'm more than happy for you to come along, and we've actually this week, you know, I've just got the go ahead to actually have a team meeting, where I'm just going to pull everyone together, regardless of who line manages them and say, okay guys. We work on the income generation, the fundraising side for this, and I'd like you to come together and we'll just chat about what we're doing, and share information with each other, and I think it's making a difference definitely.

IV: You have the ability to cover more than five questions at one go. This is amazing.

IE: I'm so sorry, I ramble, so…

IV: Don't feel sorry it. It's exactly what I need. You have worked in another hospice as well, how were things there, from a professional perspective?

IE: How do you mean?

IV: How were things organised? If you were to compare this hospice to the other hospice, are there any differences or does there exist something like a formula, like hospice fundraising?

IE: Okay. Gosh, my last hospice, differences.

IV: Also clarities, or?

IE: I'm trying to think where to start really, because there's some huge differences, some huge similarities. When I went to work there, the Director of Funding that my predecessor there, very charismatic gentleman and very well known locally. Absolute rubbish line manager, you know, not very good with the old people management, but he was very good at presenting the vision, and getting people on board with things, which I think is really important in a leader anyway. And, that's what he was doing. He actually had all the nuts and bolts there for a good department. He took me on to manage the team, and actually do the people management side of things. There are two community fundraisers there, who work alongside each other, who hated each other, so I had to manage that very awkward relationship, and that was a real challenge.

I was also given the Lottery, and that…the Lottery manager had died a year or so previously. It was being run by the Lottery administrator, who then handed in his retirement, about the time, just before I started, so he was off, so I had the whole thing, and I was just me. Then, I was given the admin team within a month, so you know, that was an admin manager, who left, and two admin administrators, and then one of them left, so I've basically had to build the whole thing from scratch, so when you talk about differences. The feeling of the board down there was very much, yes, we need to invest in fundraising. We need to do this and that, but the big difference between the two hospices, to get some perspective on this, is they only had about six month's worth of money in reserves. This post has got 18 months worth of money in reserves. This is a much, much richer organisation, so the pressure isn't there, as such. You know, it's not as much as it was in my last hospice, so there is time here to think about where we want to go and what we want to do, and there's a very realistic approach to what we can feasibly achieve.

I think when you're under pressure, in that sort of environment, it's very hard to give yourself the time to work on your plans, and actually implement the things you need to implement, and I think there is…it's hard to be realistic about what can be achieved as well, and I think that's a challenge. It's a huge challenge. So, yes, I don't know if I've answered your question.

IV: Can we explore it a little bit more?

IE: Yes.

IV: What kinds of people are contributing to your, or what kind of people are putting money into this business?

IE: This hospice?

IV: This hospice and the other hospice, if there are differences?

IE: Yes, your vast majority of money comes from people who have had experience of what you do, and whether that be through donations and flowers at a funeral, tribute funds, right up to legacies. The vast majority will be people who have had experience of what you do. Then, you've got the other sector, because we did a survey on this, at my last hospice, and I know it's pretty much the same across all of them, just through talking to people. And, asking people on events, why are you doing this? It's a good way of finding out where your support actually comes from. A lot of people, I would say the vast majority, it's thanks for the care giving for someone they know. Other reasons for people giving to you are down to they just want to know that you're there. They don't want to know anything else about you, they just want to know that you're there. It's like an insurance payment, you know? They just want to know that you're there. Other people, you're local and you're a worthy cause. It's hospice, that's fine, you know, and a lot of that comes through the amount of coverage you have in the press and then the media. It's all down to how many times your name is seen, people can trust in you and think, yes, that's worth spending my money locally. Yes, those are your main reasons.

IV: And, do you think the approach that was taken at the previous hospice, on getting these people closer was a little bit more professional compared to the hospice here, or?

IE: Yes, well, they had the resource down there. Well, we had the resource down there. I mean, I developed, as I mentioned, I was given the admin team, who previously were just administering donations. The admin manager left, one of the administrators retired, and we'd just had a big database, Razor's Edge, put in, so nobody knew how to use the database really well. We didn't understand it, and then my boss left within, I think he was with us for about three months, six months I think I worked with him for at the end.

It was like, there you go, you take over. Okay. So, I became the Head of the Department, but it was an interesting time, very interesting time, because I had to learn Razor's Edge from scratch. There was one point, because to make matters worse, I can't believe I actually went through all of this, but the lady that was there, as the administrator, had to go into hospital for a major operation, so she was out of action for three months, so I had three months of me, sat there on that database, trying to work it out, and I took on two new

administrators, and one of them, the Chief Exec asked me to take on. She was an ex nurse, so we had to train her up from scratch.

Another one came in with skills and experience that I'd interviewed, and yes, there was one Christmas. We were just sat there, and I spent quite a few evenings there until eight, nine at night, just putting stuff in the database, just to get my head around it, and the scope of it, and it was a crazy, crazy time and I'm losing track of what the question was about now, but you're talking about the professional bit behind the fundraising. But, what I did was I took that team from being one administrator to being a donor development team, and we created a whole identity, and we created trust across the organisation. One of the first jobs I gave them, I took this administrator and I gave her the carrot of, okay, you could be this manager and manage this, create your own team and actually manage this database, but I need you to produce X, Y and Z. This is where we need to be, and what she ended up doing. We worked on together very closely. We did, we created a memory or fundraising programme, because the biggest, one of the biggest complaints that we got, and this is this bit about being a sponge and sitting back and just seeing how things work without getting involved too early on, is you get to see what comes back in, and I was seeing people complaining, internally about letters that were being sent out willy nilly, and you know, been sent out to people who had already died, etc.

So, obviously one of the things we needed to tackle was this internal mistrust of fundraising, so we called it donor development and we'll do some stuff around that. And, we called a meeting with all the, well, we had a focus group first, with a couple of the Trustees and a few of the volunteers, a few of the people that we knew, pulled them together and said, look guys. We're thinking about doing this. What do you think? What would you say? When's the best time to contact someone after they've lost someone? How long should we leave it? What sorts of things should we ask? What can we write? What words do we use? What pictures do we use? You know, and we threw it at them, and we got back some really interesting responses. Then, we went and had a meeting with the people internally, who were twitchy about us writing to people, so we had the Chaplain in there. We had some of the patient family services teams, the social workers, nurses, we had a real, multi-disciplinary team meeting, sat down, did a presentation.

Guys, this is what we're thinking about doing. These are all the different things that we could put into place. What do you think? Where are we…where can we go wrong here? What would you do differently, and it was brilliant, because they then took all of that, and said, we'll just change that, and we could do this, and what about that? Yes, okay, we're happy with that, and from that, we actually got the mailing lists of the next of kin from the

community teams and so on, and that trust that meant that we were able to start doing some real, proper, direct marketing with the trust of the organisation behind us, and this team, because they led that, they gained the identity that they needed in order to have the credibility to make that actually happen. From there, they set up several initiatives, for example we had a blue release, which you can't do as a charity these days. It's littering, it's [unclear], blah, blah. And, I've inherited this thing, and this thing generated nearly 20K a year. Couldn't just not do it because of the money, but it was a case of, what are we going to do? How are we going to make this different?

Again, we bounced it around as an idea, in the focus group, did a boat trip instead. This team led that thing, because it was a memorial event, they led that, they made it a part of the open programme. Then, the mailing planner that they had, we got from the multi-disciplinary meeting and the focus group meetings that actually we wait three months after someone has died before we then contact them and say, you know, would you like to set up a tribute fund in memory of your loved one? So, we set up tribute funds, we did a book of names, they led the light up a life side of things, and they generated an awful lot of money, so…yes, there's lots of scope there.

IV: What about this hospice here? Do you think that getting involved is related in many way with other things? Other departments? How is that communication here? Are you getting the same kind of feedback as you used to get, maybe from the medical or the nursing side, or the Chaplain side? Do you have the option of doing these kind of meetings of interaction with other people as you used to have in the past?

IE: Funnily enough, this morning I've been invited to one of the multi-disciplinary team meetings here, just to meet the guys here, and I have been, I've volunteered on different areas on the other sites, spent time on the inpatient unit, spent time with the different staff, so I've actually gone out and made myself known, so people know who I am, which is kind of helpful, but with the communications side of things, we haven't done anything formally. Like I said, I've come into an organisation where it's very reactive not proactive. We've not actually gone out there properly, as a fundraising team, and said, okay we are going to generate X and we're going to do it this way, so…it's new ground to be broken.

IV: Is this because of the convenience of a steady income stream from somewhere, or because of money that came at some point and they are still there?

IE: This organisation has always had great support from the volunteers, and they've always had high levels of legacies, and money coming in from different events. Long may that go on, but it's that Women in Prayer thing. You know, it's at the moment, we're

coasting quite nicely. The money is coming in, that's great, but do we carry on like that, or do we actually say, no. Hey, hold on a minute. We need to actually get some programmes in place, so we can estimate quite confidently that we are going to bring in X, Y and Z, especially if we start spending more money, which is where we are going. There's no way you can't. I mean, costs go up exponentially. You know, and that's the big thing, that all hospices, I think are faced with.

IV: Why do you think that costs are getting larger nowadays? That imposes more costs to the hospice?

IE: You've got the rising cost of living, which is a given, that's very unlikely that that's going to change. You've also got increased legislation, so you need people there to actually do the bean counting and the making sure that everything is legal and above board, so that costs money. Fundraising is a classic. That's another one that's become more regulated. We now have to…I've got a piece of paper on my desk that I need to deal with this afternoon. We have to do returns to the Fundraising Standards Boards, you know? We have to comply with the latest Gambling Commission and Charities Act stuff, so there's loads of stuff that we need to be on top of, and…

IV: If it's not the trust, it's this Commission who is regulating? Are there more things?

IE: We've got the Healthcare Commission as well. That's the biggie, that's the one that regulates the standards of care, and I've seen the reports that we have to do for them, and you know, it's not a do it in five minutes job. It takes time. I think that's got a lot to do with it as well. And, there's also the fact that could the NHS fund us better than they do currently? Would we want them to?

IV: This is another issue. Would you want them to fund? I know that there are some hospices who do have this to take place, and there are some hospices where there is loads of money from the NHS. The question is, what's the relationship with the NHS going to be, if you will get…you certainly as a sector, need to get more money by the government, but they will have to come in such a way that will secure your independence.

IE: Absolutely. It's an interesting question. I asked the volunteers, because when you talk about fundraising, they go, you've got a big job. I say, yes. What if we had more money from the NHS though, what do you think? It's really interesting what people say to you. The general feeling is they don't want it. They want to make sure that we're always going to be here, and that we'll have enough money to do what we need to do, but they don't want to be tied to the NHS telling us what to do. They like the choice really.

IV: How would you see it, right now, the picture is, like, loads of independent hospices acting on an independent basis, well, the hospice is in place but with not a big power to organise or interfere in anything. How would you see the creation of an organisation that would be receiving maybe a certain amount of funding by the government and do some fundraising and so on, which would be working on a suggestion level, but a little bit more actively. It would be an advisory provider, a solutions provider, and at the same time it would be like a centre of planning for the sector as a whole? Do you think that this would work for hospices?

IE: Help the Hospices recently went to being a membership organisation. That happened last year, I think, which gives us as independent hospices a little bit more control over their strategy and their planning and where they go. I know my last boss was very involved in Help the Hospice, she was actually a Trustee, and it's interesting because I went to David [?] and I got to know them and tried to find out a bit more about them, just from the fundraising side. What their plans were and so on, because you hear all sorts of things from other directors of fundraising, who are saying, they're stamping on our toes. They're getting money for this, blah, blah and yet actually when you look at it from the other side of the coin, they do tie in some of the national companies that we wouldn't normally ever get access to, and they do, the money does come back around again, because they do put money into training grants, so if I wanted to do a course, they'd be more than likely to pay 50% of my course fees, because you can apply for that sort of thing, but…I don't know.

Hospices are an incredibly, this is my personal opinion, hospices are incredibly proud of their independence. To then try and have an umbrella organisation does tend to go against the grain of a lot of people, I think, but at the same time, there are benefits to that. So, I don't know. I was working on a committee with Help the Hospices, which was made up of other fundraising directors across the country, and we were looking at corporate fundraising. You know, getting these national campaigns together, and actually how can, how hospices help facilitate that, and one of the outcomes from that committee was Light up a Life, and actually trying to get a coherent national branding to something which makes so much money, but you know, again, I come here, and we've got Trees of Love, but interestingly enough, what we do here raises less money than what I raised down in Plymouth in one hospice. And, that's because it's not been a fundraising event here. It started as a fundraising event, and then went to being a bereavement services led event, and now it's going back to hopefully being a fundraising event. If we want to collect more money.

IV: It looks very interesting. So, you do not see hospices accepting the idea of getting an umbrella organisation, unless it is loose enough to allow them their own independence, and to allow them their own ways at a local level. At the same time, there are so many hospices whom we visit nowadays, their financial levels are not looking that good. What can you say? How can you see things working in the sector?

IE: I would like to…

IV: Apart from the regulatory side of it, the population and hospices need to provide services to other patient groups, apart from cancer nowadays, and they think you are doing something for them.

IE: We are, we have a consultant coming in, so that will make a difference, and again, that's part of one of our marketing objectives, is to increase referrals from non-cancer diagnoses, to help, so that's quite huge. It's difficult, because I think the voluntary sector in its own right, and again it's my personal opinion, struggles with attracting professionals from the private sector, purely on a salary basis, more than anything else. We have to try and compete to, you know, draw people in. You get people coming to work for the voluntary sector for a lot of different reasons, but one of the main reasons that they don't come is salary, I'm sure of it, and I think we can't compete with that, because you do have that, the job satisfaction that you get is, I think, higher than what you get in the private sector, and that is why a lot of people come, but does that attract the best candidates all the time? I don't know. I think just from a fundraising perspective, yes, I'm looking for people with sales and marketing skills. These people could be earning a lot more money elsewhere, so what are you ending up with in a recruitment pool? I don't know.

IV: And, you can apply this to the hospice sector as a whole?

IE: Well, have you come across the Agenda for Change? Have you interviewed hospices that have been through Agenda for Change?

IV: Not yet, but I have some [unclear] and my supervisor has done specific work, not for the Agenda for Change, but a specific thing on the Agenda for Change.

IE: Yes, because that's an interesting thing, because we went through that in my old hospice, and I personally felt that fundraisers got a bad deal out of it, because it was very much geared at the medical side. Basically we went through the whole thing, of analysing every single job, going through physical and emotional efforts, mental efforts that you put into your role for all the different areas. I had to get my entire team to rewrite all their job descriptions following this, the criteria for the Agenda for Change, and from that the team,

the HR team had put together the salary scales and bandings that we were all going to go into, and they assessed all of our jobs, and which band we're going to go in.

It was, I think, slightly unfair because of the medical input that was in there. And, how you can assess a fundraiser against a medical secretary is another matter, but it was an interesting process, and it does flag up the inequalities, I think, across the board, but we did that because we wanted to make sure that we were able to attract people, nurses of the same calibre as the NHS across the hospice, and that there was no inequalities for them. When you're talking about the admin and the support staff, there was quite a bit of an inequality, and it's how do you actually tackle that, and here, we did…as far as I'm aware, this hospice didn't go through Agenda for Change. When it comes to pay scales, I've just been through it with one of my staff, and we reviewed their job, come up with a recommendation, take it to the Chief Exec, and you can take it to the Remuneration Committee, which is made up of Trustees and then they come back with a decision. So, it's interesting, yes. I got off the point.

IV: Let's go back to, it's too early for you to talk to me about recruitment policies here. It looks like you're now trying to establish something like that. Let's talk about qualities when you're recruiting people? What are you really looking for? You told me that you want people with marketing skills. Anything more than that? Any background to activities, hospices, or you would prefer to get people in from the private sector? How or what do you expect them to work, once they will come in? What will you be looking out of that?

IE: It depends what role it is. I mean, transferable skills are great, and I've taken on people in the past with transferable skills, who've come, who've seen the job, thought it was interesting and applied for it, and you know, once you get chatting, they realise actually their skills are totally transferable. We had one lady I've recruited once, in my old place, who had come from a manufacturing background, but the work that she'd been doing on her, the charity committee side of things within that manufacturing base, totally transferable. When you talk about what qualities do you look for? Again, it depends what post you're looking for, but if you're looking for a fundraiser, you're looking for someone who's a bit of a social chameleon, a little bit thick skinned, and has that outgoing, positive attitude, and with every job, in the job description you have the role description and then in the person spec, you actually list down what you want there.

IV: You spoke about competition in the market? In which form is this competition coming? Who is your main competitor in terms of personnel, who would you be losing?

IE: Our main competition locally, if you're looking at people who have a career in the voluntary sector, we've got the Cathedral Appeal, a bit of Marlow appeal, there's Dimelsa House [?], which is the Children's Hospice. Are you talking purely in recruitment terms, or are you talking in recruitment donors as well?

IV: For the time being for recruitment terms.

IE: For staff?

IV: Yes, your staff, and then we can go to donors as well.

IE: Yes, I would say those would be the main ones locally. People with transferable skills.

IV: Is it easy or difficult for you to get the people you are looking for?

IE: I don't know that.

IV: You haven't found it?

IE: We went to advert last week, you see, so here, in this area, being you know, again I'm getting used to the demographics of this area. I don't know. I will see what the response is to this advert that I've put out, and that will give me a feel for it. I know in the West Country, it was quite hard to recruit the right people, and I knew everyone anyway through my network at the Institute, so it was a case of if the position came up, I'd know who to go and speak to, to say, do you know anyone who might be interested? Who could be available? And, you've got a real mix as well, when you advertise, because I used to advertise locally, and that would give you a really interesting mix of people, but it would depend on what level you were doing it. Again, as I said, I recruited two people with totally transferable skills, and they hadn't actually considered becoming professional fundraisers until I took them on, and they actually made fantastic fundraisers, and their careers are going to be great. They are real rising stars, the pair of them.

Yes, that is, again I have a background in developing people internally. I had the administrator, I built up to be a manager, so yes, and the nurse who came over to work as well as an administrator, so yes, skills can be taught, definitely. I think it's about identifying potential, and if someone is willing and has that enthusiasm and basic attitude then you are able to mould that and work with that, I think, but again it's that whole initial process of not imposing on people, but just seeing what goes on, and seeing how they react in different situations, which gives you the feel for would they or wouldn't they? Then, you plant seeds and see what grows.

IV: What about competition in terms of donors now? How would you expect your fundraisers to approach them and how are your competitors approaching them? Do you have identified key things, key areas where you can, maybe I'm not using the right words there, so that I can get what you want to get out of people?

IE: Like I said, this organisation has been very reactive and not very proactive when it comes to gaining new people, and even with people who want to, who come to us red hot, saying, have some money. We're not actually converting it that tax efficiently. There is so much opportunity for tidying up a lot of our procedures and so on, but again, we haven't had the resource to do that, so it's a case of, we need that investment in order to generate more money. And, get our messages across a bit more clearly.

I think with the competition locally, okay, let's look at it in different types of channels, different marketing channels. With direct marketing, everyone gets about three or four pieces of junk mail a day. The way we, I hope we will be countering that in a future, is we will be looking at direct marketing through direct mail, but it will be fairly targeted from this database, from actually analysing that, having the team on board, to be able to make sure that we're targeting the right people with the right messages and keeping our response rates quite high.

So, I'm not suggesting we do cold mailings of people we don't know. I'm suggesting we mail to people we do know, but we mail more effectively. I'm not suggesting we use the telephone at the moment, and that's something I know that they're exploring with the Lottery, and I know that that's something we're looking at doing with cold audiences. I've done that before in my previous organisation, and that does tend to work, but it's expensive, and you need to…there's a breakeven point you need to hit before you start actually gaining money from that. You've also got, so I'm not suggesting that currently. Because the Lottery are doing it.

You've also got face to face recruitment, again I think that is probably a little bit too aggressive for us at the moment, and again you know, all the figures that I've looked at, all the predictions I've looked at, when I've looked at this from my previous organisation, you need at least a year running in order to bring in the big bucks, and I think we've got a much cheaper and easier hit to make first, before we need to start considering something else. I think that's quite a drastic way of fundraising. It's also very controversial, and I think we've got other ways, softer ways that we can use first and see where we get to with that.

So, that's direct marketing and where I think our competition lies. I know for a fact that Help the NHS are hitting people locally very hard on telephones, and I know because I

know someone who works for them, so you know, I know there's quite a bit going on there, and that's quite difficult. I know XXX Children's Hospice are doing a lot of work locally as well. They have a very, they've got 25 paid fundraisers, or something, I've been told. Whether that's true or not, I don't know. They are competition, because they cover our geographic area, but I don't know if you've been told this, but the adult hospices have their territories marked out, so we don't compete with each other, which is great, because we can work together, and say, did this work for you? Oh yes, what about trying this? That's really nice.

Children's Hospices, because they cover the adult hospice area, and it's a similar type of ask. It's just children rather than adults, it is quite heavy competition. The Air Ambulance is another big one locally, that people tend to like supporting, from what I've seen. And, again they've got very strong Lottery and they've got a very strong name. People do like to do bits and pieces with them, so it's quite difficult competing with them. And, also people like to support a charity one year and do something different the next, because they like to feel that their money is being spread around, and that's one of our big challenges. Is we need the money year in year out, so how do you actually…

IV: Get that?

IE: Yes, how do you get that message across without seeming to be greedy, and that's quite a challenge. I'm trying to think what else? I know the Lifeboats are strong locally because we're very, we've got quite a lot of coastline around us, so that's quite a big one for us locally as well. Other channels, other ways of getting the message out there, like I said, the community fundraising. We're very, very strong in that. I'm not to worried about that. Yes, I think that's just about answered your question.

IV: It looks like you are well aware of the competition in your area.

IE: Yes.

IV: Do you think that this is important for your type of job? Do you think…?

IE: Yes, very much so. For example, one of the local papers, they work very closely with a charity that they actually host, which is for children, and they do three or four events a year, and we get half the money. No, we get 70% of the money, and they get another percentage of the money, it's a split thing, but we don't have to do too much of that, because we just turn up on the day, a few volunteers help out and then we get the cheque, which is great. There's pros and cons. The pros for us are we're not resourcing our paid staff wise, so it's quite hard for us to do any of the work anyway. So, actually from our

point of view, it's quite a good thing, but at the same time, it's also a bad thing, because all those people who go to those events, we don't actually know who they are, so they could be going to that event, doing it for us. Thinking, I'm raising money for the hospice, and actually we don't get to thank them, or you know, engage them and bring them closer to us, and actually get them on our database, and then start communicating with them.

We have no contact like that, so one of the things I'm looking at is do we carry on receiving the money from these events as it is, or do I go back and try and renegotiate to get more involved, maybe take a smaller cut of the money, but actually then get a longer term gain from it? So, there's something around that. I'm not too worried about it at the moment, but it's something to really look at over the next few years, and the other thing is with the media players. A lot of them, we've got a big event that we're putting on this year in Deal, and we're saying, this is our event. We are funding, we've gone out and got the sponsorship to fund the event, so every penny raised goes to the Hospice, but we're doing all the administration, all the work behind it, and when we went to some of the media players, they were saying, oh, can you do our charity?

Sorry, but we haven't got the support from them that we would have had otherwise, so there seems to be a shift in the marketplace generally to people wanting to have the shared event thing, because you know, we are a very strong local brand. The Hospice is the Hospice. Everyone thinks, Hospice, great, here's money, fine. There's other charities that don't have the same luxury of having that high level of awareness, and so on. And, it seems to me that you know, there are people out there that want us to work together, which is all very well and good, but what concerns me is it's down tot that donor and what they want, and it's the individual's choice as to where that money goes, and it's how do you cater for that?

If we are to go down the route of doing these joint events, which is great, something that works quite nicely as part of the portfolio, but my concern is, is those people who are raising money, because it's the Hospice, are they actually getting what they want and what they think they're getting, and that's my concern, and that's what we need to clear up, because the way marketing seems to be shifting anyway is it is much, much more about the individual driving it. It's not about the organisation driving it, as it has been in the past, and it's how do we as a voluntary organisation, cater for that without having to spend loads of money on sophisticated CRM systems, etc. Do you see where I'm coming from? We have to do this, as professionally as possible, but on the tightest of shoestring budgets, and it's how do we actually make that work, you know?

IV: Is there anything else that you'd like to say? Do you think that we left something that has not been covered in relation to your Hospice movement, your team, anything that you would like to put in? Maybe what were you expected to be asked?

IE: No, we've probably covered most things.

IV: Do you think it was enjoyable? Did you like the interview process?

IE: I love talking about my work, so…I do. I think it's really important that people try and understand what we're trying to achieve, and I think the more transparent we are, the better in a lot of respects, because it's very hard when you're dealing with people and their perceptions of things, and a lot of people think that a Hospice is a place where people come to die, and that's it, and blah, blah.

That is not the case, so the more opportunities I have to say that it's not, the better, as far as I'm concerned, because I've seen people come into Hospices absolutely terrified, thinking that's it, and that's awful, because one guy I went to see once, who wanted to talk to me about giving us some money. He was on the inpatient unit, and he said, I was just talking to him about his experience, and he said, well, when I came here, I was terrified. But, it was so stupid, because actually this is like a five star hotel. I'm having a whale of a time, and I want everybody to know. You know, not to be scared, and I think we've still got so much ground to cover, and again, going back to this thing about us being a professional organisation with professionals, you know? I'd love people to, you know, I get this all the time, I'd love people to actually respect what I'm trying to do.

One guy said to me the other night, when he asked me what I did, and I said, oh, I'm a fundraiser, he said. What? It's your full time job. And, I went, yes, actually I'm really proud of it. I work for my money and it's a great job. There's a lot of work to be done, and a lot of people still don't understand that, and I think it's such a shame, because you know, we ultimately are responsible for a few million pound budget, and we're turning over 7.5 million at the moment, we're looking at turning over 9.5 million in five years. That's a lot of money, and we are charged as management with the stewardship of that money, and I think it is all but right to have these conversations, to raise that awareness, so that people do get behind us, and go yes, okay, guys you've got our support. How can we help you do it better?

How can we assist you? A classic example, this afternoon, I'm off to Kent University to have a chat to their team about a business case for something that we want to put together, or one of our volunteers has come to us with, and it's a very risky event. It's going to

involve big financial input from us, if we are going to go ahead with it, but potentially very big return. Question is, have we covered everything? Because I wrote two sides of A4 of questions for my volunteer, saying have you thought about this, have you thought about that? What about this, what about that? I need all of these questions answered, because otherwise I'm not going to back you on it, because I will not be comfortable not knowing what we're going to do with this, that and the other.

And, so we're going to go to the university this afternoon, to sit down with their academics, and go, right, we're having a chat here. Okay, have we missed anything? Have we covered anything? Is there anything else? And, that's what I like to see, is us working in the community with other members of the community and people taking us seriously, going okay guys. What about this? And, if someone was to come to us and say, hey guys. You know, I've had a great idea for generating some income, what do you think? That would be my dream. That would make my job a lot easier.

IV: That's great, so you are doing, from one perspective, it's important, both in terms of the possibility and in terms of your own reward outlook, not the money you're making, but going for practical purpose, is it? Is this motivating you or motivating your staff more?

IE: I think my biggest motivation and my staff's biggest motivation is the scope of what we're able to do. You don't take this job to just do your job description. It doesn't work like that, I'm afraid. Yes, that's important. Don't get me wrong, but you always end up getting dragged into other bits and pieces, and being the part of the Hospice, and charities in general, from my experience of working with the three big charities I've worked for, you get to get involved with other areas, and maybe that's just because I've worked for very small, local charities and medium sized, local charities, and now a large sized, local charity, but you know, you do get dragged into other stuff, and that's great, because you then feel totally…you know, totally a part of what's going on, and I don't know. It's…I love it, like the variety is something I've not experienced in the private sector. You know, I have the ability to go and get involved and that's great, and just fundraising in its own right. It's such a creative job.

You know, you get to think of these wonderful ideas, and work with people with wonderful ideas and make those ideas a reality, and that's just great. You know? It's a very inspiring place to work, it really is, and when you get together with other fundraisers as well, then that's even better, because you just…sometimes I get to go on these great conferences, where you just meet other people who are doing what you do, in other parts of the country, and oh my God, it's great just to chew the cud with them.

IV: And, getting the feeling that you are not alone.

IE: Yes, because you're not alone. You're not alone at all, and it's wonderful, and there is that. I mean, I've been to conferences where you know, they do the arms and rah rah, we're changing the world thing. And, you are in your own little way, and the greatest thing, whenever you get, and we've had this, where you send out application forms and people apply to work for you, and you say, why do you want to work for a hospital? To make a difference. It's so corny, but…it's true. It does make a difference, and you see that when you talk to patients and you bump into people who are raising money for you, and they turn around to you, and they say, yes, I'm doing this because…then you hear their story and you think, yes, actually that's great.

When I worked with the animals, I'll never forget. One day I picked up a stray cat that was just part of the job, picked up a stray cat in the ambulance, and the poor thing has broken it's pelvis. How, I don't know. It was on a bit of wasteland, and you know, I dread to think what it had been through, whether it had been a car accident, or it had been kids or what, but just that…you know, getting that cat into the basket, taking it to the vets, and although it was the end of the life for the cat, the fact that I knew that I helped speed that cat out of its pain just made the difference, and how you put that in words without it sounding corny is another matter. As a marketing person, you'd think I'd have sussed that by now, but…it never happened.

IV: It is interesting, and it gives you this type of reward. There was recently in a conference organised by the Cooperative, the retail…

IE: They're a fantastic company.

IV: They were presenting the company structure, how they are doing things differently, and you could see that these people were really proud of what they were doing.

IE: Yes.

IV: They were able to look in your eyes and say, of course we have to do some things that are not totally ethical, like sell this type of product and this type of product, because of…but you could see that on the overall side of their job, they were totally proud of the company that they were working for, of how this company is operating, how do they feel that they contribute to the society and people's lives, and you could see the difference between this type of people and the really stressed type of city person.

IE: Yes. You talk to people sometimes and they say, you've done the whole thing, and they say, what do you do? You tell them about what you do, and you say, I work here, and blah, blah, and then you go, and then they turn around to you and say, what do you do then? I just do this, and that's it. It is different.

IV: It is something else, a kind of psychological reward to this.

IE: Absolutely, and you get to have the best conversations with people as well, especially as a fundraiser, because you can always turn around to someone and say, what do you do? I'm a fundraiser, yes okay. So, what's the maddest thing you've ever done? Okay, there was that time I walked over hot coals. Or the time I got dressed up as a Koala Bear, or the time… And, that's always good value, so yes.

IV: Would you like to maybe make any suggestions on how we could make this interview process better?

IE: No, not really. You did it all fine, did the whole get to know you bit, and then got the tape out. That was super, that was fine.

IV: Would you like to be interviewed on a similar subject in the future again?

IE: Sorry?

IV: Would you like to participate in a similar interview again? Do you think it would be interesting for you?

IE: Like I said, I'll talk until the cows come home, so I don't mind at all, you know?

IV: This is great.

Interview with the Fundraising director of Hospice B:

Speaker key

IV: Interviewer

IE: Interviewee

IV: Before we will start with the interview itself, I will have to let you know about the ethics and confidentiality policy of the University. You can be assured that any kind of information you will provide within the interview is going to be kept confidential, whichever information out of it we publish is not going to carry your name or the name of the institution you are working for. If at any time you find out that you don't feel comfortable answering a particular question you can just say that you don't want to answer this question, or if you feel at some point that you want to interrupt or stop the interview process, you can just feel free and ask for that.

IE: Yes, that's fine.

IV: That's wonderful. Would you like to tell me a few things about your background and your involvement with the hospice movement? We could start on what you used to do before and then how long you have been working with hospices and what was the main motivation for you to start?

IE: Well, my main profession was hotels. And I studied tourism, actually, and I got into the hotel industry and my career was very much marketing orientated. So I worked for global hotel companies, responsible for their sales teams in the UK. And then, it would have been about the end of 2004, I decided that I'd had enough. I'd got to where I'd wanted to get to in my career and there was a restructure going on within the organisation I was in. So it gave me the opportunity to say that I'd like to take redundancy and get out, so I did that and took a year off. And in that year, then, I started to do some training in counselling. And it was from that that I realised that there were charities and there were paid positions for fundraising, which I hadn't been aware of before. So I decided that's what I wanted to do because I thought it's, I've got a good background, good skills, good experience, it would be nice to bring it into an industry where you actually make a difference. You're not just lining the pockets for other people to make lots of money really. So that, really, was my motivation to get into the charity industry. Then I started to look around for jobs and I

wanted to either work for a cancer charity or a children's cancer charity. They were my two, sort of, focuses. So I went to work for CLIC Sargent, which is the UK's leading children's cancer charity. And I went in there, what I wanted to do, because I'd never done charity before, I wanted to go in at the bottom to learn the charity industry, basically. So I went in there as a community fundraising manager to cover the North West, North Wales and the Midlands. And I learned, in two years there, all the, really, all the basics and the main things to do with fundraising. And then I decided I wanted to go back into management, then, and I wanted a more local charity, because I was travelling a lot with that job. And then this position at Hospice B was advertised, head of fundraising, so it was perfect.

IV: That will explain it. Do you find many people like you nowadays in the hospice movement or are you finding out that you have to cooperate with people with 20 or ten or long years of experience?

IE: Yes. I think there's a bit of a shift now. I think charities in general and hospices fall into that. Fundraising, I probably look for people with a bit of commercial background. Because I think the traditional hospice fundraiser is probably a thing of the past, to be honest. I think what happened before is your fundraising manager or whoever probably had been in the industry or at the same hospice for years. And I think because it's getting very competitive out there, I mean, it is a business at the end of the day. We've got to raise money or the hospice doesn't run. I think they're looking for people that have got business skills, really, and commercial acumen. Yes, I think that's where they're veering towards.

IV: How do you think this approach affects the hospice movement nowadays? It looks like hospices are entering into a maturity stage. Do you think it has a positive impact from your point of view?

IE: I think you have to have a balance. I don't think you can get everybody from outside the hospice. And I think, certainly, on the clinical side, it has a much greater impact because of the specialist skills that are needed on the clinical side. From a fundraising element, it's very different working in a non profit sector to the profit sector because you're dealing with volunteers. And it's not the same as in business where you're dealing, maybe one of your clients, you can have a contract. They have to deliver what you're saying. That doesn't happen in the charity world. I mean, a volunteer can promise to do something, but they're within their rights to say I haven't got the time to do it. So it's a completely different environment. So you have to be careful that you don't recruit everybody who maybe comes from a cutthroat industry into something like here in the fundraising perspective, because it

would take time for them to get to know how to work with volunteers and supporters. It's very, very different and they could alienate people, you know.

IV: I see what you mean. If we [unclear] now the hospice movement and the main challenges it is facing right now. What kind of challenges would you be able to identify for the future?

IE: Well, from a fundraising, because I'm looking at it purely from fundraising. I mean, the current economic downturn the country's experiencing, that's obviously going to have an impact. Average donations are probably going to go down. People that maybe were going to do some fundraising or make donations might decide not to. Because I think that's the biggest challenge, to be honest. I think, as a hospice, as a local charity, what I've noticed the difference between Hospice B to CLIC Sargent, you've actually physically got a building here. You can actually see where the money's going. That actually helps you a lot more than when you work for a national charity where you haven't got anything visible or physical in a local area. In fact, that works against you.

IV: What about management? And not just people's management, the resource allocation management? Do you think the hospice movement, in general, has the skills and expertise necessary to go through?

IE: What do you mean? Sorry.

IV: We're looking at challenges and bringing it into resource allocation. Taking into account that, most likely, we have been hearing an increasing demand of the quality of care services. Do you think that the hospice movement is in a position to deal with it?

IE: From the palliative care side?

IV: Yes. But thinking in your fundraising expertise. If you have an increase in the people who are going to ask for hospice help, then you need to be able to either increase your resources and allocate more resources in order to cover the demand, or to manage the resources you already have.

IE: Yes, I think it's managing effectively what you've got. Because here, the fundraising department's already gone through a restructure. They've seen that there was a need to change and invest in fundraising. Prior to me coming onboard, and take it back a year before that, so we're talking about 2000, what are we now? Eight, seven, six, 2006, there would have only been one, two, three, there would have been possibly three, four people in the department with, kind of, specific roles, but not specific, specific. And then to move it

forward, because, obviously, the management and the trustees within Hospice B recognised that we're building a brand new in-patient unit and the costs are going up of the hospice, so we have to raise more income through the fundraising department. They decided to invest in the fundraising department and, actually, bring more people in. So we are now, and also, we were able to restructure the department, so that we have people focusing on specific income segments, so that we could maximise those income segments. So we've actually probably gone through that, where some hospices might only be looking at that now, that's already happened here. So I would say that we have the resources, it's down to me, as a manager, to manage those resources effectively.

IV: That looks interesting. What about your team now? Would you like to give me a team description? What kind of projects you're undertaking?

IE: Yes. We have four full-time staff, four full-time people, including, with myself, there's five, and we have a placement student, six, and a part-time clerical assistant. So how the department's set up, we have Linda Bridges who's called a corporate fundraiser. And Linda is responsible for the relationships with the local businesses and companies. And she also looks after legacy income and funeral directors, that sort of thing. And then she will develop partnerships and relationships with those as well as organising some events to generate money from those. So, recently, we did a Make a Will Week, where we got local solicitors to give us their services for free. And then people were invited to make a will and make a donation to us, because they weren't paying the solicitor for the will. With the local companies, we did Bring a Pound to work, so everybody brought a pound to work in the company. So she'd run those events, as well as develop the partnerships. And then legacy income for her is probably going to come in at just under a million this year, so she'd managed all of that.

Because it's a long process, the legacy. From notification to when you actually get the money, there's a lot to it. Then we have Sarah, who's our community fundraiser. She actually does all the events, our own events, so she works on life, well, she doesn't, she does the solstice walk and if we do an abseil or a sponsored walk or something like that, that we organise ourselves, she does that. Then Lynne looks after all the collecting cans that we have out in the area and also the merchandise that we sell as well. And she looks after what we call our friends groups, which are groups of fundraisers. She would also go out to do talks to various groups and organisations and check presentations. Then Anne, sort of, oversees the administration side of the office and our computer system and our database, which is [unclear], so she's actually manage all of that. She also looks after regular giving, which is where you make a donation every month. And she does golf events as well. And

then we've had, for the second year this year, a student placement from Aston University. So Martin's with us this year and he gets involved from a marketing and administration point as well. So he does all different projects for us really, but, at the moment, he's helping with Light up a Life, but he creates our posters for us and does our main campaigns, that sort of thing. And then we have a part-time clerical assistant.

IV: That's very good. Is it yourself or the members of your team getting involved into long term planning, decision making, target setting for the hospice?

IE: That would be me, yes. I would be involved in that and then I'd sit down with them to get their input into it.

IV: And how is it working really? Is it that people are allocating targets for you and then you then are transferring them to the team?

IE: Yes. So I have an income target to raise, we have to raise £2.1 million. So then I have to sit down and write a plan of how I'm going to achieve that, with the input for my team, I'd, obviously, ask them what they, you know, what they feel we could do. And then each month, each team member would have a target and each month, then, we'd have a one-to-one where we review what's happened to the previous month and we outline for the next month.

IV: It looks like a little bit more hierarchical when it comes to fundraising, like the real world.

IE: It looks like?

IV: It looks like business environment.

IE: Yeah, yeah.

IV: We tend to say the real at the university, for example.

IE: Well, that's, I think that's very much what my background is, so I haven't, I still manage my team as I managed the sales team in the hotel industry. Because, at the end of the day, I have a revenue target to raise, so I don't see that being any different in this world to the commercial world. Because we've still got achieve it. Because it is pointless people just going off and doing stuff and they've got no accountability, because they could be doing the wrong thing or we're not raising the money. And each month, then, we'll review our figures, where we are and where we think we're going to be, because if I have to set up

another event or something like that, so that we reach our target, then, you know, we'd have to introduce that.

IV: So if I'm taking your words well, it is your measuring performance based on achieving targets and this is the outcome?

IE: Yes.

IV: You don't have another mechanism to measure performance within your team?

IE: Well, it's not just… It's finance but also personal development as well. It's not all target driven. I mean, we would invest, for example, in the team for the future as well. So if there was, say, Linda maybe wanted to get more, because she had no fundraising background, we would like to send her on various courses for the future, knowing that, you know, if she wanted to grow in that job or whatever, then we would actually have her developed into that. But it's very much, I mean, at the end of the day, for us, we have to raise the money, so you've got to have the revenue as the target really. It's very different to the palliative care side where the care of the patients is utmost. Ours is raising the money to care for those patients. But part of it, as well, it isn't, it's not just target driven, though, because we are very much, we're the face of the community as well. So if we're not out there talking to people, getting awareness of Hospice B hospice, then you're not going to get the money at the end of the day. So it's money, but it's also being the face of Hospice B out in the community.

IV: I see. I don't know if this question is particularly applicable to you, but do you think it is difficult to measure performance of people within your team?

IE: Not for me, probably, because it's a bit different in fundraising I think, yeah.

IV: And what about inter professional relationships? Are your team members interacting or working at all alongside other groups of people within the organisation?

IE: Yes. Because we get the staff involved in our fundraising events. We need the staff to promote our events as well, so we work very closely with them. The volunteers, for example, within the hospice, will often come and volunteer at our events. And so, yes, there's a good, you know, there's a good… I feel, as a fundraising team, you have to get all the staff on board really, because they're your best spread the word, as well as going out into the community, so it's important that fundraising is seen as approachable and we work with other people. I mean, we have very close relationships with the specific departments like finance, because all donations come through our office and then they go to finance for

processing. So that relationship is crucial. We have a very good relationship with Barn Farm, for example, the Sutton Coldfield Centre. Again, because we work very closely there at that team. And, yes, so, in general, the team would work. And, I mean, like, Lynne, for example, she's worked or volunteered for this hospice for 20, since it opened, 25 years. She's part of the team, so everybody knows her. So, you know, it's good to have people like that, because you get the support of other people, then.

IV: That's interesting. Are there any standards for your recruitment policies? Are there any specific things that you are looking for? Is it just up to you or are there structural procedures to recruit people in the fundraising team?

IE: It depends on the position really. For example, the part-time position that we've recently recruited, that was down to, I mean, everything comes via the human resources department. So an ad will go out, they'll put the ad together, but we're, obviously, I'd okay the ad with them or put it together with them. The job spec will be put together between the human resources team and myself. Or, subject, again, to the position, Peter Holliday would, obviously, have some input into it as well. And then we'd go out and advertise and then, like, with the part-time position, there was no need for anybody else to interview. At that level I could just interview for that position. But if we're interviewing for a fundraiser, as we are actually interviewing for a trust fundraiser at the moment for the Capital Appeal, then Kathy's involved as well as myself and Laura. And Peter may well be involved in those positions. So, subject to what level it is will be subject to who gets involved.

IV: Are you looking for specific skills and how easy is it for you to find specific skills and qualities in people in this area?

IE: It depends, again, on the position that you're recruiting for. I mean, the general skills of a fundraiser would be someone that is very approachable. Good interpersonal skills, good communication skills and who is used to talking to people and going out to people or doing presentations, that sort of thing. Because that's not easy to do if you've never done anything like that. And then on the skill level, it will depend, then, on how much organisation is involved in it. There's a level of literacy subject to, you know, what you expect them to do within… So, yes, it's all different. But personality is probably key in fundraising as well as a good skill level; you have to have the right personality as well. And so far, I mean, everybody's local, so there haven't been, I've only recruited one person since I've been here, so we've never actually gone out to recruit a fundraising position, so I couldn't really comment if that's easy to do here or not really.

IV: Okay, so you're covering the next question because the next question was about how easy it is to find in this area. Is it a very competitive area, competitive market or you can easily get…?

IE: From a charity perspective, there aren't many charities based in this area. You'll have a coverage, all the national charities will have a coverage, but a lot of the national charities may well either be based in Birmingham, or Stoke maybe, or people will work from home. The nearest here is Sutton, you've got the National Children's Home, they've got their office there. But, other than that, there are no real main local charities, so I don't know if that would impact. If we went out to recruit, I mean, for the trust fundraiser that we're recruiting at the moment, that's a very specialised job, trust fundraising, so we haven't had many applications for that, but that's, I think, because of the nature of the job. You wouldn't expect it, to be honest.

IV: Let me ask you some questions about the interview itself. Did you enjoy the conversation? Would you like to indicate the strong or weak points of the interview process?

IE: No, no, it was fine. It was easy to answer the questions and they were all clear.

IV: Is there anything that you feel like we didn't go into an adequate depth? Anything that you would like to add, information that you would like to…?

IE: Probably fundraising is very different to maybe other people that you're interviewing, so it's whatever you're wanting to get out of it, I suppose. So, from my perspective, I suppose, rather than the hospice movement, I'm looking more just at this hospice rather than the movement itself. So I don't know if that, you know, if maybe other members of the team who've had more to do with the hospice movement, would be able to answer some of those questions a bit more detailed for you.

IV: Some of them did, but, actually, the hospice movement is in a transition period right now. It is becoming more mature and more professional, and this has both positive and negative impacts. So during, within this area, any person in the hospice movement is a great interviewee.

IE: Oh, I see, yes.

IV: And any improvements on the content or the nature of…?

IE: No. I thought they were good questions because you're covering quite a… you're looking at the individual who you're speaking to, you're looking at their background as well

and how the team works, but also their views on, you know, the various disciplines. So, yes.

IV: Thank you very much. Would you like to participate in similar interviews in the future?

IE: Yes, I don't mind at all.

IV: Thank you very much. Thanks a lot.

Interview with the Fundraising director of Hospice C:

Speaker key

IV: Interviewer

IE: Interviewee

IV: Before we will start with the interview itself, I will have to let you know about the ethics and confidentiality policy of the University. You can be assured that any kind of information you will provide within the interview is going to be kept confidential, whichever information out of it we publish is not going to carry your name or the name of the institution you are working for. If at any time you find out that you don't feel comfortable answering a particular question you can just say that you don't want to answer this question, or if you feel at some point that you want to interrupt or stop the interview process, you can just feel free and ask for that. Are you happy with this procedure? Would you like to carry on with the interview?

IE: Yes. Goodness, goodness, yes. I'm happy.

IV: Well, that's good let's go on with your own background.

IE: Yes.

IV: How did you get informed with the hospice movement, what were you doing before that?

IE: Okay.

IV: How long have you spent here? What was the motive for you to enter the hospice movement?

IE: Okay. I've been here three years, background in consultancy, people development, business development, working with organizations from educational charities, business, and home ecs. And the reason, actually, for joining the hospice movement was the job, I guess. It's the job that needed to be done. So I wasn't specifically thinking, I want to join the hospice movement. I was thinking there is a situation that needs attention, and it's probably for the best if you can do it. And so I just made the decision to join.

IV: It was mainly a professional attitude, or an emotional?

IE: Probably 80% professional, 20%, I think, being involved with other charities, to actually build… to put in what you can do and see the difference, and it actually goes and makes a difference. That does help. It is nice to know, and it helps, I think, helps everyone when they know what they're doing and that everything goes where it should be going, and you can actually see the end result. But the biggest chunk is professional, to be honest.

IV: Did you find, in fact there are many people like you, showing you the hospice movement nowadays, or are things the same as they used to be maybe five, six, or ten years ago? Or if you care… less formal care as nowadays and a lot more professionals here in the job nowadays?

IE: I think, probably, a mix. I mean I know that… speaking from IT, they're all professionals. So they…and it's very hard to find good fundraisers, so I've kind of… didn't even try and find fundraisers when I was looking for fundraiser, kind of, and people with people skills, because it's all about people, isn't it? Everything we do is about people, and we're enthusiastic, and where… can get that notion of connection with someone, and they see the work they're doing. You know, we have a lot of fun as well. To me, professionals… I want professionals on IT, but with a heart they can balance. And we still have fund tiers. Fund tiers plan have actually been on a bit of a journey with us, because we've had that much change. We've gone from being a kind of very community-led organisation to doing the little coffee morning as well. I mean, we're still doing that, but our focus is on the high end of stuff, so we've had to have quite a little hand-holding journey with the volunteers, but we still have volunteers.

IV: That was interesting. So if you're assuming it's saying [unclear] of the hospice movement that you are actively involved with it?

IE: Yes. To me, I'm… when I joined… me, personally, when I joined, I like to understand and know as much as I can about an environment. And, really then, I just kind of take what I need to know and kind of get focused. And certainly from this organisation, we've gone from an organisation that was very safe and kind of followed maybe two years behind general trends. I don't want to belong to that sort of environment. I like to kind of lead. So, you know, if that's what we're doing now and other hospices are getting in touch with us and finding out what we're doing and from talking to other hospices, the… I'd say, pretty much all of them have got… certainly on my level, if I'm talking with… to people doing the same job as me, they're all professional people who are… who kind of know what they need to do and not really kind of sitting backsides. So it's been a massive

change. They've had to, they've had to because other charities now this… I think with hospices, there's misconceptions because people have… if you come in a hospice, usually it's cancer-related. You've got McMillan's teams based here, and so you've got all the national charities giving the message of what they need to have, and people could get confused and think that, because there's a McMillan team here, because their loved one had cancer or what have you, if they give to cancer to research, they're giving to the hospice and what have you. So I think the hospice movement have had to really stand up and say, no, actually, they're independent. We need your pennies more than anyone. And really need to stand up and counted.

IV: Well that was very interesting. So the other question here, what do you think motivated people to join hospice movement when you started? But this is mainly a thing to people with much more experience in hospice movement than what you have. What I would like to do is rephrase this question and say, what are the differences between your motives and the people who you have already found in the hospice movement when you joined?

IE: Okay. What are the motives?

IV: Yes.

IE: Are we talking volunteers, staff, or both?

IV: Both.

IE: Okay. Because there is quite a mix. It's really, I think, on a deep level, we've all got exactly the same thing. I would hope, on a deep level, right from the heart that we all want to try and get to… try and make the best… raise the hospice in the best possible profile. And, you know, we've got a lot of volunteers in the country because they've lost someone at the hospice. Probably the biggest majority of volunteers have come to us because they've lost someone. And they've… really, whether it's part of the grieving or after the grieving, they've wanted to come and give something back, because of the help and support they had. So it's a quite difficult one, really. I think actually, one of the things I was looking at when I joined here was to try and understand volunteers and their motives for giving time, and what actually was behind that and what they received from it. That was one of my little researches I was looking to do. And it was inconclusive, because there was a different reason for everyone.

Some people volunteered because they could, because they had the skill sets. Some people because they had the contacts. Some people because they had the money, the time to be

able to do that. Some people because they care passionately about what we do. Some people volunteer not so much caring about what we do, but eventually came to care. So there was so many different matters and so many different motives that I gave up. I just thought I'm going in circles. And I just thought, you know what? This is what we've got, and this is what we've got to work with. But from a staffing point of view, certainly the staff that I inherited and the new staff that have come along, they've… the motive hasn't always been because it's a hospice. It's been more about the job. And we find that, in all honesty, in relation to the events we do and what we're trying to do because it's probably, I'd say, about 10% of the staff here are quite happily involved in what we do and get involved in what we do. The others just literally want to come in and do the job and go home, which is a fair comment, isn't it? Did that answer that?

IV: I think so, yes. And now for, we sit back a little bit and see with the times the hospice movement is facing right now, and with finances a huge part of the hospice movement to face in the near future, let's say for five years, both internal to the circle and external to the circle, how would you summarize these challenges?

IE: Honestly, the current finances and financial situation, I think the challenges are, thinking about it, I mean, I actually see them as opportunities which, I would say, that would be my guess. But the challenges are, I think, for us to, as any organisation, is to be fair on what you are and don't try to be anything else. And trying, you know, kind of be strong in what you are, but be very focused on who you're asking money from, because I think the communities which traditionally fund the majority of funding that comes through hospices, you know, you… we need to start looking outside of that and really concentrate on the business sectors, and getting people involved and doing things like that, because people only have so much money to give. And there is a little fatigue coming in, particularly when things are hard and lots of people are asking for money. There is a definite charity fatigue. So the… I guess, the challenges are to really kind of to your own identity, be focused, but really be identifying other sectors of what… or how you can generate. And really kind of keep them on top of what people want to do to raise money. People clearly don't want to attend events any more. It… they want to get involved and do something, which is going to push them and challenge them. So it's kind of, you know, maybe working together with other charities or other hospices, and putting together these events. And really just kind of, to a degree, ignore what's going on but be very focused on where you're going on.

IV: That's interesting. Is there a regulation in place? Anything that makes your life easy or makes your life difficult as a fundraiser?

IE: No. It's certainly not as if… the regulations that are in place are to help, I mean, to help the public and there to help us, so no. I think… I'm trying to think if there's anything that makes it easier. No, because they're quite clear. I think when we're putting together our fundraising strategy, it's quite clear, I think, sometimes we have differences of what, maybe, the volunteers would like to get involved with as opposed to what we do. And our challenge is really to find… I've got a team of three fundraisers, and they're going to be spending their time. I need to make sure we get the most out of what they're spending the time on. So I think a lot of the regulations actually help us be very clear. And when we were trying to manage that relationship with volunteers and with other fundraisers, it actually… it's actually quite helpful because, you know, some of the things that people would like to be doing a lot of the time, you know, with certain regulations you can't, because you're only allowed to do so many collections and so many, you know, not national but big local events. So they're actually quite helpful for us, because it makes things a little bit more clearer when you're trying to resolve. But no, I can't think of anything. I'm trying to… because our fundraisers… we have shops, craft shops, and we have lottery, and we do have… we do a lot of events. And so no, I think everything that's in place is good. And as a charity. I mean, we do have a duty, don't we? I mean, we're taking money off of people, and I think we have a duty to follow the guidelines and also to be very transparent in what we're doing.

IV: Can you see any reason to be [unclear] for hospice services? And, if yes, how is this affecting your work?

IE: Yes, I can, definitely. I think the… well, as you can tell just by looking at trends and the way things are and the way people are but, you know, yes. That unfortunately is our life and that's a fact of it. It's about people, you know, they seem to be getting very poorly and need the service in the families, and what's the second part of the question, sorry?

IV: How is this increasing demand affecting your work?

IE: Well, it did… massively in the effect that the, honestly, on the service side of things, it's obviously specialized stuff that you need for that. And, you know, the biggest chunk of our cost is staffing as we've increased… and obviously we need the specialized staff. So it's not just about increasing the beds. You need extra nurses, you need extra doctors if the clinics get too big. And so that is a challenge for us, and also, we have these same conditions of BNHS. We have to, because otherwise, we would never keep staff, and staff

are on the nursing side of things. So, you know, we're kind of an independent part, funded by the NHS, but we're attracting NH staff… NHS staff to perform on a service. So it is a challenge for us, and it will continue to be so, and I think, you know, really, as a fundraising team, we're kind of maxed out on what we can do, because, you know, we sit and we manage our time, and we look at what the big events we're doing, but [unclear] seeing them, what we can get to in an area like this, and we increase on staff and we need to… there will come a stage where we'd really need to look at what we do. So I think, massively in the future, that is something I… maybe, a probability that you just have to… another hospice would have to be built somewhere to cover demand. I think you'd have a limit on what you can do.

IV: It looks like… there's a thinking in place in how to respond to this [unclear] hospice. Do you have the same feeling about if you think the perceptive level… do you think that there is a service in place to deal with increasing demand and to deal with the challenges that you've mentioned?

IE: Yes. I mean, we… I think we set up and plan everything. So I think the PCTs here have just changed, so they've changed our area. So, yes, I think… I don't know. Have you chatted with area yet?

IV: Yes.

IE: Yes, so you had the chat with Neil. Well, I think because, on the clinical side… now, I probably see not that much of the clinical side, because I'm… well, why I just doing what needs to be done? But I think there are definite plans, but I think with the NHS, obviously that's very much driven by the NHS, isn't it? On the sites of the hospice and the funding and what happens, because they're newly merged, and they tend to work on the three year cycle, I think, don't they?

IV: I think.

IE: I mean, they change and what have you. So I don't know. We, I mean, we… you can see it, and we've anticipated and we've talked about building and they're increasing, but a lot, a lot of thought will need to be given to that, because we're not in a very cash rich area here. It's no… I mean, you need to look…I mean, have you had a little wander round? I mean, we cover two areas, but they've probably got the highest incidence of cancer-related deaths and stuff as well. It's just a link into the… got the overall… St. Ann's is an old mining town, very little industry there and what have you. So it would cause a massive problem if we did increase too big.

IV: Yes.

IE: But the… if we were going to do it, we would plan it, we would look at it, and we would find a way. We just have to find extra funding. It would be more grant funding, and probably NHS funding would have to happen.

IV: Can you see anything being done at sectors level, like all the hospices together?

IE: To provide the service?

IV: To provide the service or to lobby for funding, or to provide knowhow in terms of fundraising, in terms of allocation of financing and associates?

IE: I think, I mean, that would be great if that's the way things happened. I think as… and it may be down to research like this that would help to make things happen, in all honesty. Because I know certainly being from personal experience, there's many different levels. You'll know, yourself, if you go around to speak to the hospices, there's very different levels. There's some very switched on, very business focused, know what they're doing, get out there. And there's some very, kind of, still very traditional, you know, a couple of little volunteers trying to do the fundraising and what have you. So I think, I think that would be great. I think Help the Hospices, obviously, probably see part of their role as maybe doing that. I don't, I don't know if they do. Are you speaking to Help the Hospices? Have you spoke to Help the Hospices?

IV: Yes.

IE: Yes. I don't know if that's how they see it, but I know we've tried to do things as a group, and to me, that's not been successful. But I think when the climate comes and the situation comes where there's kind of real possibilities of hospices, perhaps, not being multifunctional, you know, it's kind of like that. I think there'd come a stage where, really, you'd have to kind of… you'd hopefully get someone inspirational in each of the hospices to go, like, let's approach these together. Because, you know, there's… I guess there's odd ones to fall on the funding, but, you know, it's an essential service full stop, isn't it? And, you know, the NHS doesn't… couldn't provide it in this way, doesn't provide it in this way, so. But that… in an ideal world, that would be great. But I think, where hospices are at the moment, it'll be a little while I'll probably be a long time until...

IV: Let's go to a bit to, now, your own role and the role of your people. Would you like to talk to me about what you're doing and what is your team doing with the Hospice C?

IE: Yes, sure. Well, my role is Head of Fundraising. And really to, I guess, just to really take on what we need to raise and to look at every single way of how we can raise and maximise what we can do in the area. And that's really to have as much diversity, so that a lot of people have a choice. Whoever wants to give has a choice. But also, alongside that, is to maintain the hospice in the public eye and really to try and get some sort of emotional attachment to the hospice, to people, to make them aware and really get them kind of involved in what we do. So it's kind of double-edged, really. It's [unclear] to raising money and really me and the team are the faces of the hospice. Because hopefully the majority of people will get to know about the hospice is through us, not through personal experience. And so really I'm kind of… I do a lot of the planning, and it tends to work for an 18 month plan, really on events. Look at the community, what sort of events we need to be doing, the cross-section of people, so we try and get a mix of women's events, main events, fun events, family events, and really balancing that out with the staff I've got, the team I've got to make sure. Well, we've got five shops. So we have shop managers and then the rest are manned by volunteers. Shops are good because they're in the community, so you've got your recycling a little bit on there, and they're also able to get the message of what we're doing. The lottery, we've got 10,000 members so, again, we're able to hit the community and do what we do in their pound a week, and have a chance to win a couple of grand, which is a nice weekend if you will, a little… have a little holiday or something. And the team fundraise.

We've got three fundraisers and they've got even… well the three of them have got a different focus, but they work very much as a team. So one's focused on the major events, marketing and PR; one's our community events, trying to inspire people to have the coffee mornings and to do whatever they need to be doing, and supporting them. And we've got another lady who looks after business relationships, so she's out in businesses and getting them to do the dress-down phase and to do set up, you know, adding a little charity function to the business. So we're… they work very much as a team as well. So, you know, if there's an event, if there's an event, we all turn up, and, you know, we make people feel as welcome as we can. We let people have a bit of fun. We help… let people realize what we do, but in a very appropriate way to that audience and then, hopefully, people come back wanting more from us, which seems to work.

IV: That looks interesting.

IE: Yes.

IV: Are you personally your... in your opinion, in general, getting involved in the process of target setting, and I'm getting to vote on the long-term hospice issues of policy creations, types of development? Or are you mainly being given targets to facilitate?

IE: We work very much as a team. That's really my style, to work as a team. So when we're putting together the fundraising strategy, we kind of… we're… some events we're going to do, and there's other events we're looking at doing. A lot of what we do is we go and research what it is, but we will agree a target on those. So we would look through them. What do we need to raise on this? It's going to take us three months to put this on. What do we need to raise? Who's the audience? How are we going to raise that? Is that feasible? Is that possible? And then we agree on that as a team, and then that's the targets for what we're doing. So we do, very much, very target driven, because I have to… if it's a great event and it's going to cost us, I don't know, £10,000 to put on, but we're going to raise £15,000. Well, we can't do that, because it's not worth it. You know, if it took two months to do we raise £5,000, it costs us too much risk to do that, because it might not happen. But it's… so it's kind of really looking at stuff.

But I like to get the whole team involved, because then it's not me saying, we need to raise this. It's that as a team we're saying, okay, we're committed to doing this, so let's do everything we can. If we don't raise what we're looking to raise, I mean, after every events or anything we do, we sit and we really analyse, and we say, okay, what did we miss? Did we not get people there? Did we not get the message? Were we not focused enough? Or do we do this again, or do we just scrap it and put it down as a bad experience? So we're constantly working on that, which the team work quite well for it, but it's not a… I mean, I've done a lot of training in the past with sales people, and I think, you know, I'm not… I don't think it's the right environment to give each individual, this is your target, and this is what you need to be doing, specifically on… so much work is cross based, the team working together on it, and I think it's… a lot of what we do is [unclear], because you don't know the impact you have. Because a conversation I might have with someone when I walk out there might suddenly come into a £1,000 donation somewhere on the line, but you can't, you can't monitor on that and kind of work out where that came from. So I get the whole… achieve with the different sections, really, to buy into what we said we were going to do, what we need to do if we're to keep the hospice open. And then we've just asked for their feedback, and we regularly check in on that just to say how are we doing? We're down on this, what can we do? Do we need to put another event in? Do we need to do this to build it up? So it's just…

IV: That looks very good. So it looks like we think the team, the management strategy, is flat. But what about the relationship of your team and the hospices management? And you are as a fundraising manager in charge of fundraising, getting targets from the CEO of trustees, or you are involved with the process where the targets are developed?

IE: Yes. I'm involved, very much involved, really and we… when we're looking at budgets, we have a process, or we have an achievement process, where we… where the different heads of the hospices give, like, the costs and projects of what they need for that year. We gather all of that together, and then I sit down, with Ed and with Neil, and realistically look at how we're going to get that money in, and that's the bit that's backwards and forwards because, obviously, that doesn't always match. It didn't match, I mean, it didn't match last year of what we need to raise to what we could physically raise. Because you've got to look if you've got… I don't know if you've got ten people and you're asking them to raise, I don't know, £500,000, and they've only ever raised £200,000, you need to think, well, how on earth are we going to get that £300,000? What are we going to do? How can we do it? Can we do it? And where that's my job, is to sit and backwards and forwards with the… and then we take that to the trustees, once we've kind of happy that it, all… it balances as much as it can be with… it has to be realistic. Because what I can't do is give my team unrealistic targets, because they're going to be on the floor before they even start. And, you know, they're really motivated, they really care about what they're doing, and if you're saying, well, we need to do this. Well, we know we're not going to do this, but we have to do it because that's what we've got to do. It's no good for anyone, is it? So really, my, I guess, my job is to make sure what I agree to can be done.

IV: I think you have covered this question up to a sufficient level, but do you think there is such a thing as a typical working day for you and your team members?

IE: I mean, it gets to… no is the answer, probably, because it depends on events and campaigns. I mean, at the moment, it's the Christmas campaign, and we would… last week, for instance, we had… I don't know… two major services, so we were kind of working until 9:00 at night for two nights. And we had a trip out to Langley [?] Christmas concert thing on… so we had three nights in a row which were really long. So no typical days as such, which is probably the beauty, as it probably suits the people who do that form of fundraising. I think the other guys who are doing the admin and the lottery and stuff, they have far more, kind of, structure to their days, but I think now it's about people, it's about events. So fundraisers manage their own diary. They could have an event in a day. They could be talking to someone about doing their own event. They could be at a school,

doing assembly with children. And certainly, from my point of view, that meeting is all in the office or attending somewhere. So no, that's the beauty of the job, I think, and that's what suits the people who work in the fundraising side because certainly it wouldn't be for me to go in and have this set day. And, you know, it's quite funny because every time you do think you've got a set day, you think, okay, I'm in the office all day today. So I'll do a little list, I'll get to all my stuff, and you usually by about 9:30, it doesn't happen. Okay, so that's a long way of answering no, wasn't it? Now listen to this. I'm turning into Neil.

IV: You think there's a difference between the way you're doing the job here and the way similar things are doing the same tasks in other hospices? You're, more or less, doing the same as other people do?

IE: I think so. I think the hospices I've tended to be in touch with, I think it's a bit like, kind of… you kind of only know the certain people, don't you, that tend to be pretty much like you, so the hospice volunteers. The ladies who run that are kind of quite inspirational. I must say that. But, you know, the… they volunteered really well, so there's other people out, kind of, being in contact with, and I think I, in the nicest possible way, I'm not really that interested in finding out how they run their way, because… it sounds harsh, doesn't it? It's not harsh, just realistic. If I'm giving up the amount of time I have to kind of share and look at different ideas, I need to make sure it's going to be where I'm going to take something from it. And, I guess, just by listening, you kind of make a quick judgement about whether… is your time best spent there or there? So I kind of gravitate towards people I think I'm going to actually learn something from. So, hopefully, I think, I think, more and more, I think people I've got to know, they're running it really well.

IV: How are you measuring performance of your team members? Are you using any particular method, or…?

IE: We have a system called Dernaflex [?] which monitors, sort of, every bit of revenue that comes through goes through [unclear] so we have two systems. One on… the lottery is a separate one, so that's quite straightforward and very typical to get together. The Dernaflex, every bit of money comes through, whether it's ten pence, £10,000, what have you, goes into the system. So you can see and you can link back into events and what's happening. But I have regular meetings. I have a weekly meeting with the team on the fundraising side. And what they'll also do is kind of an analysis of, you know, what's happening, ticket sales, and what is coming through. So we regularly check it and then, from that, I have a monthly meeting with Neil with the, with the council meeting, if you like, with how we're doing and what we're doing, and we respond to that as well. So if

we… if you… if it's not looking a good month, you know, we'll kind of look and see if, do we need to do anything or do we sit back and not panic just yet?

IV: What's your main tool in the course of measuring the strengths of formats and fundraising? For example, you said the one by which you've started to catch onto your peers as well. Is it easy to break down the tasks that identify who has done what and how successful this person has been where?

IE: Yes. It's fairly, I mean, for all of our events, we take… we have a lead. So with all the fundraisers, we'll take a lead so they have ultimate responsibility for that event, although they're using the full teams. So that is helpful because you can then… you've got someone to take responsibility, I guess, rather than people, you know, that seeing that things haven't been done. I think, on the measuring and the effectiveness, the staffing is never a problem, I think. The… you know, it's all down to the message, the focus, and being able to respond and say… and I'm kind of… every event, I'm there anyway, and I kind of… I'm the background. I'm like a sponge and I've just watching and observing and then, if anything needs to change, we change it there and then so we can move someone very quickly. If there is a mistake, it's a genuine mistake, because the team are really good and we've… they're really trying and, sometimes, things go wrong, so if you… we really kind of go through it.

Problems sometimes with volunteers, that's a difficult one to navigate sometimes, because you've got volunteers who don't want to do it in such a way. Sometimes, you have volunteers who, if there is a problem, they get tied down in discussing the problem with, perhaps, somebody's complaining as opposed to saying, you know what, we're trying to do our best. Let's not, let's not, you know, don't let it spoil the night. Let's do something else or let's do something different. So that's quite delicate. Sometimes I've had to, kind of, take someone away and have a little chat, and try and get them to see what we're doing and to… but we kind of… we know it well enough now to try and… and we know the characters well enough now to try and put what needs to happen in certain places and try and keep an eye on things and to try and manage it as best we can. So there's only a few little, tiny hiccups that we know of. But we don't kind of… I mean, we're volunteers, as you've probably heard from the hospices, you know, the attitude is we're grateful for… we are, for all the help We try and involve them in the meetings so they can see what we're trying to do. We try and get them as involved as possible. But if they are not fully in, or we think they're going to spoil the tone of the night, we'd have to try and manage them to a different, a different event or a different place too. So.

IV: Well, that looks good. Is [unclear] getting in touch with other members of the hospice, are your team members working together with groups of other things with resource from other things?

IE: Yes. It's a work in motion, and I think it's something we're always working on. I think we've got a couple… you know, if there's any events… we've got a couple of events going on, so we get involved with the day therapy, and we've done a launch of a new build, and we've got that. So we went round the… so we're trying to, you know, work closely. I'd say they're, pretty much, in close teams. We're trying to work with the nursing team. It has to be, I think, it has to be when there's something appropriate. I mean, we did look at ways of trying to integrate when there wasn't any real focus, you know, just trying to have a meetings and to get everyone together, and we thought, no, when there's something really specific to do. It's more fun with active sets. Yes. It's…

IV: Are you getting involved with doctors or nurses or…?

IE: They are, from the view that they're attending events we do, so that we have, like a It's a Knockout event, and the doctors and nurses put a team in. And then they were with us and it was great fun and we were having a laugh. But the actual nursing stuff? No.

IV: Do you think that meeting the nursing staff, with… of what you were doing, but exchanging experiences with the nursing staff, would enhance the ability of your team to generate financial value, or could it be able to somehow insight from the nurses, the ability to create financial value for the hospice?

IE: It depends on the individual. That's my answer, because I think some of the nurses just want to nurse, and I think that's clear. And I think, you know, we've tried. We tried the setting up a committee on the… getting someone from the nurses to come and join a fundraising group with us, and we're actually about to re-launch that, actually. One of the nurses is going to come and join us on a fundraising group to try and take that message back. I think, as opposed to some of the fundraising coming into the nursing, if we had someone actually from the nursing who came into fundraising and then took it back to their colleagues and what have you. Mixed response, really, because I think some people purely just want to nurse and they're not really interested in how we make… in the nicest possible way, they're not really interested in how we make that money, although their impact on nursing and how they look after a patient, automatically helps us. So I think it is a difficult one. Something that we're always look at to try. And, I mean, I work quite closely with XXX… and I don't know if you spoke with XXX today, XXX, and I work quite closely with her. And if we need to do anything with, you know, we'll… we know what to do, so

we're always looking at ways to try and enhance. But, I mean, certainly for my team, itself… I mean we, one of my fundraisers has come from… her husband was in the hospice, so she's kind of got that understanding of how they care and what's happened from first-hand experience. Which, you know, is, you know, without a doubt, it's part of her passion for what she's doing. I still think the other two who are younger, still very much see the full level. So I think they're able to give that emotional bit over to people who are looking to raise money. Some of the nurses are great, and some of them are still great but they don't want anything to do with fundraising.

IV: Do you think that your team members like working with members from other teams? Or they would prefer to work on and autonomous basis?

IE: From the point of view of the hospice?

IV: Yes.

IE: I think if there's any… if there's a benefit and we can get the experience from them and it's going to help and make what we do extra special. I think there's no problem with who you work with. I think it's, if I work with other teams, it's not actually going to… it's going to [unclear], if you like, and it's going to prevent them from moving on as quickly as they're going to do, then they prefer to work on their own.

IV: Nice.

IE: I think, and it's, I guess, it's like anything. If there's a purpose and a benefit, great, but if it's for the sake of doing it, not great.

IV: That looks nice. I would like to ask something about recruitment now.

IE: Yes.

IV: Are there any recruitment policies in place? Are there any criteria that you here want to hear about if you're about to hire a new member of your team?

IE: Yes. I mean, certainly, we've done quite a lot of recruitment, but we, obviously, have job descriptions and job specifications, so if we need someone, we have to work from that. And we do have a policy. We've got an HR departments, so they will handle all the recruitment, but they'll handling all the advertising and the gathering of the CVs and then I'm responsible for the recruitment for anything to do with fundraising, and Chris would be referred to for hospice services.

IV: Are you looking for specific skills? Earlier on you said you were looking for people skills, you're not going really looking for qualified fundraisers?

IE: There are none in the area. I think that's… I mean, I get lots of [unclear], you know, kind of looking for experience fundraising. It's… what I've found in the area are either very good and very happy where they are and they're not interested in moving. The ones that were moving have moved a lot, and it's certainly just kind of indicated. So the decision I made was to actually find people who've got that warmth and have got that quality, and who've got the business skill I mean, it's business, isn't it, really? So if you've got that warmth and you can get on with people and you're able to talk and you're organized and you're quite inspirational, you can raise funds. So, you know, the whole team were not fundraisers, but the whole team now are very good fundraisers.

IV: That looks good.

IE: I guess myself included. I mean, I wasn't a fundraiser, and I came into, you know, and it really wasn't for the fundraising skills they wanted me for. It's the business skills and to be able to make sense of what we were doing. But you can't find… or I don't know if you… I don't think you can, probably… maybe in the London way a little bit more so, but when you come out to these different regions, very difficult.

IV: So you would say that they could market these competitive in this area?

IE: I think, in general, I think recruitment to find good candidates is hard for any sector. That's nice and positive. I think it's very hard to find. You will find up to probably 20 applications, you may find one or two decent candidates.

IV: And do you think these candidates have loads of functions as well if they were not becoming fundraisers, for example, would this prevent them from becoming fundraisers for someone else in the area?

IE: Yes, because they've got those skills. Yes. They could literally… a good fundraiser in this area could potentially work anywhere they wanted.

IV: So if…

IE: Don't tell the team that.

IV: If you can examine the positive situation compared to other parts of the hospice, what I've got up to now is that, in several markets for recruiting other kinds of specialists, is it not that competitive? If you can find work you want, it's no question of finding what the

complication, if we can limit competition base… what it looks like for the fundraising, things are getting more difficult, isn't it?

IE: Yes. It's… I mean, for the first time in three years, I've got a full team. I mean, I've literally… I was recruiting for one of the fundraisers for nine months, and I've seen people, and they just weren't suitable. So I said, no, we have to readvertise. You'll have to readvertise it. There is no point investing in someone when you know they're going to stay or they're not going to be up for the job. So it took a long time. And the lady I actually took on after a year, that I developed her into the business side because I've… again, alongside that, I was probably looking for a business fundraiser. And I think I was getting a reputation for being very fussy with high standards, but it was kind of… there was no point, because I've… this is so important to what the organization is, it's best not having anyone and us trying to do the work until we find the right person. So yes.

IV: That's good. Now we are about to complete, so I would like to ask for something that's about the way I've conducted the interview. Did you like it? Did you enjoy the conversation we've had?

IE: Yes. Yes, it's good.

IV: Are there any strong areas or weak areas? Any suggestions you would like to make, if I had to ask you, for example, very strong facts about discussion but weak parts of our interview process, what would it be?

IE: Okay. Of course. About the question, or about your questioning?

IV: About my question about the interview in general, about kinds of…

IE: No, I think it flowed. It's relevant. It's thought provoking, which is quite good, because you don't often think, do you? So you had me thinking about things which I just do naturally. I think, yes, I think it's fine, it's fine. Hopefully you got the information you need.

IV: Do you think that there are anything… that there is anything that we didn't cover in too depth related to your area of expertise?

IE: I guess if you… I don't know if this will be relevant to your thing, but it would be quite interesting to… no, it's hospice, isn't it? But I was going to say other charities, because that's my… I can actually see any sort of competition for what we do with the other hospices, because there's a, there's a really… a lovely working relationship for now. I mean, things might change in the future as things get more and more difficult, but there's

kind of a gentleman's agreement, if you like, that people kind of stick to their own areas, and there's a lot of sharing of information goes on. So it's, you know, if I'm thinking about doing something, someone else is already doing it. I can go over and have a chat and have a cup of tea, and we can discuss and I'll give them all the information. And we're the same. We invite anyone in and show them what we do. And… but I guess the… how they're impacted by other charities, because that's the big one that's the competition, and, you know, big charity. They've got national budgets, they've got a lot of money and they spend a lot of things on it, and really, they've left us behind on that side of things. My response to that is I don't try and be like them. I ignore them and just keep focused on what we do. It'd be quite interesting to see how other charities… if they are, indeed, affected by them. But you need to keep it specific, because you could go on forever, couldn't you? You could, couldn't you? You could ask questions. You'd end up with, like, you might as well give up a whole week and come and stay here.

IV: Well, we will see. It might be a good motive for me to do things like that. Would you like to suggest improvements in the approach or the content of the interview?

IE: No, that's fine. That's good.

IV: Do you think it is applicable to your needs?

IE: Yes. Yes. No, that's… the questions you asked are what we ask of ourselves. We we're looking at this strategy and we're looking… when we take that step at us, what we should be asking and looking at really, they're the sort of questions that we…

IV: Thank you very much. Would you like to participate in a similar interview in the future?

IE: Yes, up here? That's no problem.

IV: Thank you. That's very good

Interview with the Voluntary Services Manager - Fundraising of Hospice D:

Speaker key

IV: Interviewer

IE: Interviewee

IV: Before we will start with the interview itself, I will have to let you know about the ethics and confidentiality policy of the University. You can be assured that any kind of information you will provide within the interview is going to be kept confidential, whichever information out of it we publish is not going to carry your name or the name of the institution you are working for. If at any time you find out that you don't feel comfortable answering a particular question you can just say that you don't want to answer this question, or if you feel at some point that you want to interrupt or stop the interview process, you can just feel free and ask for that. Are you happy with that?

IE: Yes, that's fine.

IV: So would you like to tell me a few things about your background and your involvement with the hospice movement?

IE: You want to know about my background, yes. I've been involved with Hospice D for about 25 years off and on. Before that I was involved with another hospice in Manchester where I was a nurse – that's XXX Hospice – for two years. And then they started to think about having one in XXX so I was involved in the very first sort of steering committee that they had, deciding on fundraising and where we were going to have the hospice, and actually involved with the planning of the original hospice, which was an old house, and adapting that for care, for caring for patients.

Then I took a bit of time out after all that because I was having a family and I carried on with my professional career at the hospital, and then I carried on fundraising and supporting it. I became a trustee for 12 to 18 months, but I didn't really feel that was for me, and then in the 1990s I became a staff nurse here when my family were grown up a little bit more. I worked here for about five or six years as a nurse and then left and came back as a therapist for a little while, and then decided to have a career change and came back as Voluntary Services Manager. And I have done four years in this position now.

IV: What was motivating you to join the hospice movement, what was it?

IE: I was a student and I enjoyed looking after patients with cancer in my hospital in Birmingham, and did a sort of postgraduate course in Manchester at Christie Hospital. And while I was there I had a placement at St Anne's Hospice and I really felt that there was where I should be in the hospice, because the nursing care is so good, the whole family and the whole patient. So that was my sort of motivation and I didn't really want to go back into general nursing, but for sort of career advancement I wanted to become a ward sister so I needed to stay in the NHS. So I went back to Warrington for about, oh, gosh how many years, five or six years, became a sister and then had my family, so I'd done that and then, when I came back to nursing, I decided that I wanted to come back to a hospice.

IV: That looks very interesting. Now we are going to move onto your professional views on the hospice movement in general. Have you noticed any changes in the ideas and the orientation of hospice movement during the period you were actively involved with it?

IE: Yes, I mean 25 years ago, 30 years ago, it was very much the last resort for patients, but now things are happening far earlier in their disease; the disease seems to becoming more chronic so people can often live for longer with it, so they're coming in and out, whereas, especially when I worked at XXX, people came in and not that many seemed to go home. They came in, we had the symptoms controlled quite often and they were really quite poorly at the time and ended up dying there. But things have changed quite a lot and day-care was only just starting off then. In fact, the day unit at the hospice I started at was just, you know, a conservatory; they didn't have a proper building. Now it's huge, the one at XXX. And the same here: we started off with five patients and now, you know, 25 years later, we can take 25 each day. Yes, a lot of changes in day-care.

IV: That's very interesting. Are these changes affecting the level of professionalism within hospices? Do you think that there is a move towards professionalism instead of a voluntary based movement a few years ago?

IE: Yes. I think we don't have volunteer nurses anymore; we have lots of volunteers but we don't have volunteer nurses. All our nurses are paid for and the nurses are encouraged to do more professional qualifications, get degrees and things, so yes, the emphasis has changed slightly. There's more education.

IV: So it's whole people kind of view, palliative care aspect area, as well as the way to contribute to the society.

IE: For instance, when I went from St Anne's to the hospital over the road, the matron there or whoever interviewed me said, well, you need to come and work here because you need to do some proper nursing. So it wasn't regarded as the proper thing, but actually the hospice had got it right: they're doing the proper nursing, in my opinion. They're doing the very excellent nursing care and if the hospitals could learn from here, I think...

IV: Good. What do you think motivated people to join the hospice movement 25 years ago when you started?

IE: I think it tended to be the nurses that really wanted to give very excellent care and get involved. It didn't really attract people who wanted a busy surgical ward or operating theatres or accidents and emergency. It attracted the nurses that wanted to do the very best for the patients and the hospice movement allows people to have the time to do that and in a busy general hospital that's not always possible, especially in the last 15 years.

IV: That's interesting. Do you think that this model has remained the same nowadays that you are finding differences in the mentality of people that join the hospice movement nowadays compared to 20 years ago?

IE: Yes, I think the nurses are different; the trained nurses are different. But I think that's to do with the way student nurses are now recruited and trained, degree programmes, and they're looking for the more academic nurses than the nurses that perhaps wouldn't have got into university. Because the nursing qualification now, you have to go through university; all those years ago you didn't, so therefore the entry requirements, they were looking for different people. And I think that's a shame, that they've lost a lot of that really.

IV: Do you think that it's a fact that hospice movement enters maturity, this is related to professionalism that we were talking about earlier on, it's changing people's attitudes and motives to assist as volunteers and how easy it is to recruit volunteers or nurses or whatever it is nowadays?

IE: We don't really have a recruitment problem here. If we advertise, we get a lot of applicants for most positions, nursing and volunteers. I don't have to struggle to find volunteers; I'm very fortunate.

IV: You say you're very fortunate. Maybe if you try to see the hospice movement in general, can you see people having your position in other hospices having problems with volunteers?

IE: Not really. I think, because I network with other volunteer managers in the northwest particularly, and no, compared to other charities, other organisations, I think the local hospice does well for volunteers if they've got a good reputation, and I'd imagine that most of them have.

IV: That's very good. Now I'm going to ask you two questions about challenges that the hospice movement is facing or is expected to face in the near future. Which are you considering to be the main challenges which are going to occur for the hospice movement? They can be both external, like government imposed financial cuts, aging population, and they can be internal as well, like overgrowth of the sector governance, non-hospice governance, but overall sector governance and coordination between hospices?

IE: I think that financially at the moment funding and the increasing size of our place and to maintain that in the recession is not easy. It will take a while to recover and hopefully we'll be able to continue our services and not have to cut any services. At the moment we seem to be growing but, you know, that will be. And the other thing is, with the end of life care and the all the sort of proposals of what other patients we might taking other than cancer patients, we could be opening the floodgates, I would imagine, to lots of referrals. And whether we cope with being able to take everybody that is referred, I would doubt it very much because of the size of the place. And the way the staff have been trained, it's very different looking after certain types of patients, and that might have a knock-on effect with our funding, because if we suddenly start to take lots of patients who haven't got cancer, will our people who donate to us still give us the money for that?

IV: That looks very interesting. How do you think hospices at sector levels should respond to these challenges?

IE: Well, I think we're doing it cautiously; I think we're doing it, that the actual taking new referrals, we're taking a few people but we're not just saying we take everybody, because we wouldn't cope.

IV: Is this applicable to every hospice in the country?

IE: I don't know.

IV: If you had to deal with these problems and you were to have some advisory tools to help the hospice organisation, what would you propose in order to deal with the financial pressure and the increasing demand for private care services, the government requirements?

IE: I don't know because that's not really my remit. It would be sort of the clinical staff that decided on that really. It wouldn't be within my remit. I don't know how. I suppose you'd have to state your objectives and say this is what we do for now and we've got to consolidate some of those. But I don't know because if it was the local authority saying, well, we're not going to give you the funding if you don't take certain patients, then that's obviously got to be negotiated.

IV: And now bringing things to Hospice D how do you think these challenges are affecting Hospice D or are they going to affect it in the near future? Is there any action planning today in order to deal with these issues affecting you?

IE: Well, we're just finalising our strategy and meeting to discuss funding vehicle, NHS XXX PCT. So I presume a lot of it will depend on the outcome of those two things.

IV: Now we are going to move on and start looking a little bit more specifically for Hospice D and more specifically about your role within the hospice. Would you like to talk to me about your role and the role of your team within this institution?

IE: Yes. I work 30 hours a week and I have an assistant who works 16 hours a week, and that really is my paid team. But I have 550 volunteering roles that we fill and so that's filled with about 400 people because some people do two roles. So there's a lot of volunteers and I actually manage the voluntary services, as well as the volunteers, so that's implementing new services, making sure they're all running and everything's okay, recruiting where I need to, all the training, personnel side of things, allocating people, the rotas, support and ongoing training and difficult situations, complaints and things like that.

IV: So it will be actually be talking about your role, not...?

IE: Yes, I haven't got a large department, although, yes, we manage all those people. It's not sort of a daily one-to-one management.

IV: Are you personally getting involved in the courses of target setting, long-term management and overall policy creation, or you are focusing mainly on day-to-day activities? Is it that the targets are coming from above and you're trying to meet them, or it is that there is an interactive process where you put your proposals forward if it's a large meeting and you stand a chance of amending certain policies?

IE: It's mainly day-to-day but if I see a need or somebody asks, they need a new service, then I'll investigate to get a new service. People don't tend to come to me and say we could do with this; I sort of find out that actually we could use volunteers in this or whatever. I

don't have targets as such because I just have to keep it all ticking over. The targets I set are sort of just for me really, to sort of increase numbers of this, that and the other, but I don't have any set by my boss, no.

IV: That's interesting. There was a question here about how you team is organised and managed, etc, but it is you and another person so we are interested in that. Would you like to describe it, if you can, a working for you and your team?

IE: My day is a very reactive day. I can't ever plan what exactly I'm going to do because I will think like today I'm going to arrange this and sort this, but the telephone rings an awful lot in here, lots of emails every day from volunteers or other people enquiring about it. People will turn up and want to know about volunteering and they expect to see somebody there and then. The charity shops will ring up with a problem, which could be getting in the car and going down there, or it could be, you know, I'll refer that to somebody else or whatever. We're always having people phoning in sick or whatever and so you have to cover the shifts, and so we manage the rotas. I do quite a lot of interviewing of new volunteers and we have to CRV applications for the ones that work here, take references up and arrange training for them.

And that's sort of a training and induction programme and then the training session with experienced volunteers as well. I also do support sessions, so last week, for instance, we had all our voluntary drivers in for the evening, so it's all the admin of inviting people in and then thinking of the content of the evening, running the evening and catering for the evening, all that stuff. And then the ones that couldn't come, so then it's putting everything that was said down on paper. And at the moment we're just tightening up on all our procedures for volunteer drivers for insurance and all that sort of thing, [unclear] coming to me, keeping on top of things like that. I do quite a few references for people who were volunteers in the past who are looking for work.

What else do we do? I also sit on the HR support, the HR subcommittee, interdepartmental meeting, so Health & Safety Subcommittee, the shop's [unclear] because there's volunteers in the shops. I also get tied up with other things that are actually not a lot to do with my job, but because we're a small management team, like writing and maintain the website, which isn't part of my role but it's something I've ended up doing. If we've got a big event on, I find all the volunteers for that, so every year we do a midnight walk so I find 180 volunteers and everyone briefing and given a jacket and putting them, allocating them on the route and things like that. So that's all something that we do. This weekend we've got a marathon going on so we're finding new volunteers for that. Somebody else wants some furniture

shifting from one place to another because somebody's left some stuff for us, so it's finding volunteers who will be willing to do that.

And what else do I do? Oh, gosh. At the moment we do all the CRVs for all the staff and volunteers. The ISA, this new Independent Safeguarding Authority's coming in, so that's something that we've got to write policies for and procedures and things like that. We're always updating our paperwork and our application process and have got online applications there, which is good. We've had an increase in applications since we've gone online. What else? Volunteers often want sort of to meet together to do things, so we facilitate that sort of thing, emotional support for volunteers working with patients as well. Training for people on reception and lately I've had a lot of companies want to come and do a day's work with us, a teambuilding thing. Next week I've got 25 coming from a drug company so I've got to organise that and make sure that they're going to be supervised by somebody so they're going to be painting corridors, selling Christmas cards, doing a makeover in the shop, all sorts of things, gardening.

So it's actually tying all that together, giving them a tour throughout the hospice and making sure the risk assessments are done, and then they can get on with it, take photographs of them, give them a tour at the end of the day and then send the photographs and thank-yous to them afterwards. I produce a monthly newsletter to all the volunteers, so that's to go out every month, and we update our recruitment literature quite frequently, as well as the website and I give talks to WIs and various places as and when required. I don't have to go and seek those anymore because we've got plenty of applications coming in, so I don't have to do it... I respond to requests for that; I don't actually have to go out and seek them. I haven't done that for a while because I've not needed to.

IV: If you had to compare your work, the work of your team in Hospice D with the work of similar teams that work in other hospices, what would be the similarities and what would be the differences there?

IE: The similarities are we all have the same problems with certain volunteers. People have their own motivations for volunteering and sometimes that's not quite the motivation you think it's going to be. So we all have the sort of volunteers like that. We all seem to get involved in lots more than just helping with volunteers and we all seem to never actually get everything ticked off in a day or a year, there's always more to do, because I think resource wide we're doing a huge job with a small amount of people and I think that's maybe the nature of volunteering is that people think it doesn't need a lot of managing because they're volunteers. But actually they need an awful lot of time put into them and that's because you're talking about 500 and something people.

IV: That's interesting. And what about differences?

IE: Differences: everybody does things slightly differently. Some hospices don't have a set of volunteer drivers; they don't do that, they don't have people doing certain things. And they're all in a different management structure; everyone seems to have a different structure. Some people are way down the line and other people are quite high up in the management team, depending on how that team is, and that can make a big difference because they don't have the freedom that I have to make decisions and do things. They have to ask their boss who has to ask their boss and it has to go to a committee and I don't have that problem. If I think something's good, I can go ahead and do it. My immediate boss is the Director, so I don't have to jump through hoops to get anything done, I can just go ahead and do it, so I've got quite a lot of autonomy in how I arrange my days, my time, everything. I'm never questioned as to, you know, where have you been today because I might be working in the evening, you know, spectacle.

IV: That's very good. Are you using any methods to measure the performance of your team, and by saying your team now I mean volunteers?

IE: What's really difficult is I couldn't possibly do like an appraisal on everybody because, you know, just to get round and see them all once a year is very, very difficult because they all work odd hours, odd times and things. So what I've done twice now is send a sort of postal assessment form, you know, what's your motivation for doing it, are you happy, is there anything that could be changed, that sort of thing, and that gives me an idea of what's happening.

But, you see, not everybody will fill those in and the responses are huge [?]. I try and see as many as I can on an informal basis, but volunteers I find don't want to come and sit in an office and tell me, you know, how they want to develop; most volunteers want to do this as a sort of extra thing to whatever else they're doing in their lives, so their motivation is that they're giving something. They don't feel they need to get something back from it. They do; they get enormous benefits from it. So I don't do a formal appraisal. We do count up the number of hours done every year as best we can, which isn't always easy because a lot of people do more than they say they're doing; they do extra bits that are never sort of counted.

And we do measure that against the minimum wage, just how much we're saving with the hospice. The minimum wage isn't a good guide because, you know, we could have accountants and people doing stuff voluntarily for us and they're basing it on the minimum wage. But also we wouldn't replace every single volunteer with a paid member of staff if it was the other way around. Volunteers are sort of doing vital stuff but they're also doing

extra stuff, which is different, so it's really hard to actually measure performance. I think if the departments are happy and when the volunteers can't come for any reason they miss them, then obviously they are working well because they're part of the team.

IV: If you had to give me a small number of obstacles in measuring volunteers' performance within the hospice, what would this be like, one, two, three?

IE: Numbers of it all. The availability of people; people in the shops... the volunteers in the shops that we have don't particularly want to come in to do anything like that. I have to go out to the shops; but there's different volunteers every day in every shop, so that's quite a task as well. So numbers, the reluctance of people to fill things in or be assessed because this is volunteering, this is not work. And what else? Lack of time really, because I'm very busy doing everything else.

IV: Would it be of any help to you if a generalised template was in place, like a KPI template, key performance indicator template, or you don't find it much applicable in the case of volunteers?

IE: Not really, not really. I don't think it would. Most of them are doing between two and four a week, so to measure that is really difficult.

IV: I see. Well, that's really the answer here, so [unclear] I do feel like asking the question, do you really think your team is or could be involved in the process of creating financial value for the hospice and, if yes, how?

IE: Yes. I don't know how. I mean by giving the figures every year to, you know, Catherine or [unclear], they can see the value that they're getting. But I don't know – what was the question – I don't know...?

IV: Do you believe that your team is or could be involved in the process of creating financial value for the hospice?

IE: I just think we are, but I don't know how we'd create it. I mean, we just are.

IV: Like are the volunteers going out for fundraising, for example?

IE: Yes, we do have fundraising volunteers.

IV: One is this and one is replacing people who would be paid to do jobs like a sales assistant. It does create value.

IE: Oh, well, we do that all the time. That's just what we do.

IV: These are the type of things that …

IE: Yes, that's why we're here. We have fundraising volunteers, we have people working here that we couldn't do without, you know, bookkeepers; we have all sorts of people like that. We have one receptionist who's paid and one volunteer and it's too much work for one person to do that reception; they need a volunteer. So instead of having another receptionist, we have a volunteer on a rolling programme. That's what they do. Over 96% of our patients who come for day-care come with a volunteer driver who drives them in their own car, so that we're not having the cost of taxis and ambulances and things; the patients are not bearing that, we're not bearing it, but some of them claim expenses but not many of them. So, yes, we're saving a huge amount of money. So I think creating makes it sound like it's something new, but it's what we're doing all the time.

IV: It's just that I'm looking for areas where you are saving costs

IE: Right, that's what...

IV: The end financial value by saving costs and you might create financial value by generating more money for the hospice. So you're able to both of them. Now a few things about inter-professional relationships. Are the members of your team – and again I'm referring to yourself and the volunteers – working in cooperation with members of other teams, or you tend to primarily work on your own?

IE: I have to work with everybody else because the whole thing wouldn't work if we didn't cooperate with everybody and there's no way...

IV: Do you believe that your team members would prefer to work on a different basis, like working on their own, being delegated a task etc?

IE: Well, they are really. If they're set in an area that's what they do, but some of them do lots of different roles at different times. So, yes.

IV: Do you think that the voluntary nature of the hospice movement assists in decreasing the inter-professional working obstacles like, you know, like nurses and doctors sometimes are finding it a little bit difficult to cooperate when loads of stress is around, or a volunteer being in exactly the same job as a paid member of staff, it might cause a little bit of friction? Do you think that the nature of the hospice movement is helping to get keep these things at a low level?

IE: A low level because everybody respects everybody. The volunteers respect the staff and the staff respect the volunteers, because they couldn't do their job without them. I think

what has changed is that some volunteers who used to like sit and chat to staff for a long time can't do that anymore because the staff are much busier than they used to be. There isn't as much time in the day for sort of... we've all got time for people but not as much just sitting and chatting with them. So I've had one or two leave because the ward has got busier and maybe their motivation isn't what it should be. They come in for a bit of a chat with the nurses and, you know, but that's not a bad thing. I mean that's a good thing that the hospice is busier and seeing more patients, so that's okay.

IV: Do you think that this good relationship might be affected by a potential movement to each professional group within hospices?

IE: I don't think so. I think you've just got to keep communicating and bringing them along and see the changes that are positive.

IV: Would you like to give me some information about your recruitment policies and your criteria for... it's not exactly hiring but getting new members of your team?

IE: We are on do-it.org which is a volunteering national website. We've got Kirsty at the Volunteer Centre; we occasionally put things in the paper and have quite a good response from them. All the local high schools know about us because they tend to send their young people here for experience if they're going into medicine or nursing or whatever, and word does get round that way. As I say, I used to do a lot of talks; I don't do as many now. We've got the website which I think has been a real plus for us and we have various leaflets and things, volunteering leaflets that we send out.

And I would say that most days we get enquiries about volunteering, people who just want to know. We've got a reputation in Warrington for being good at looking after volunteers and efficient, because some places I think you can reply and it's months before you hear anything. But we always respond on the day or the next couple of days after we've had an application, even if it's to say we're processing it; we do get back to people so I think that's a positive thing. Recruitment, people will state on their application form what they're interested in or they will say they'd like to chat about it, so then they will come in and we'll talk about the different options.

On the website I have a list of vacancies, current vacancies, so that we don't get too many people applying for one thing, but people don't always see that; they just think, oh, yes, that's what I want to do. And then we get references and I will then interview people for working in the hospice. In the shop we get references and the shop managers do the interviews because it's more relevant to them. And it depends; sometimes people might be suitable but

we have to put them on a waiting list because there isn't a vacancy. I probably take on more people than I decline; I usually try and find something for most people. The people that often don't quite make it are often the ones that can't get references, who aren't quite serious about it, they've just applied and so naturally they fall by the wayside. But most people have been in, they've had a look around and they've got an idea and tend to want to come and do something here and do stay with us, so that's quite good.

IV: That looks interesting. So on the specific qualities, what skills are you looking for when you are interviewing the volunteers or to get someone?

IE: Somebody who's doing it for the right reasons. Most people want to do it because they've had a personal experience and they want to give something back to the hospice and you just have to be careful to take them at the right time. You can't take somebody who's newly bereaved; they wouldn't cope with that. They might be all right in the shops but they wouldn't be coping in this environment because it's too close to home. So you've got to take that into account. Obviously, you've got to be careful on personalities that you don't put very loud noisy people in with people who are quite poorly.

You need people who are sensitive to the needs of others, who've got a general sort of caring role or, if they go into an office, that they're obviously computer literate and who are capable of the demands of the role, but also that they can be discreet and confidential about matters because it's really important here. And also that they're up to the role and can sort of be fairly self-motivated, self-supporting, because, you know, we haven't got staff to work alongside everybody all the time. So anybody that needs a lot of support wouldn't manage here very well; they'd need to be working as a part of a team perhaps in the hospice garden or something.

IV: You told me already that it's easy for you to recruit volunteers so I guess that the market is not competitive in this area.

IE: There are lots and lots of charities in the area but we don't seem to have a problem with attracting the right people.

IV: That's good. Who is your main competitor for example?

IE: Disability Partnership have lots of volunteers, but there again they send a lot to us as well for a different volunteering experience. We're the only big one really in the town; other people, there's all the other sort of charities like British Heart Foundation, Save the Children, the NSPCC, the Peace Centre and John Holt Cancer people – they're a fairly new one. Yes, there's just the main, the usual charities, but local charities we're the biggest local one.

IV: Thank you. Now we have come to some feedback on the interview process. Did you enjoy the conversation?

IE: Mm hmm, yes, it makes you think about what you're doing really. I'm usually too busy for that.

IV: That's one of the comments I usually get. Would you like to indicate the strong and the weak points of the interview process?

IE: The questions are fairly straightforward. It went a lot quicker than I thought it was going to. I mean it has taken a while but it sort of went quickly. I actually enjoyed looking at what I actually do. There's probably a lot I haven't told you about, but yes.

IV: Thank you. Would you like to suggest any areas of interest relevant to your profession, your role, that you feel they were not covered adequately?

IE: I can't think at the moment but I'm sure there will be some that I'll think about tonight.

IV: You can send me them. Would you like to suggest any general improvements in the approach or the content of the interview?

IE: No, that's fine, it's okay.

IV: Would you like to participate in a similar interview in the future?

IE: I don't mind

IV: Thank you very much, thanks a lot.

Interview with the Appeals coordinator - Fundraising of Hospice D:

Speaker key

IV: Interviewer

IE: Interviewee

IV: Before we will start with the interview itself, I will have to let you know about the ethics and confidentiality policy of the University. You can be assured that any kind of information you will provide within the interview is going to be kept confidential, whichever information out of it we publish is not going to carry your name or the name of the institution you are working for. If at any time you find out that you don't feel comfortable answering a particular question you can just say that you don't want to answer this question, or if you feel at some point that you want to interrupt or stop the interview process, you can just feel free and ask for that. Would you like to continue with the interview?

IE: Yes, that's fine.

IV: That's great. So XXX, would you like to tell me a few things about your background and your involvement with the hospice movement?

IE: Yes. I came to the hospice three years ago in December, I think, and my background actually is, well originally I trained as a biochemist and then actually went in and worked for, in sales and marketing for a, in biotechnology for many years. In the event of the birth of my children I actually decided that I did quite a bit of consultancy work that I would actually go back, use this field I have but perhaps in a different route and decided that I would like to work in the hospice movement. And the skills are transferable, sales and marketing into fund raising directly, so we're just dealing with a different sort of client group but all the skills are the same really. So that is… I'm mainly here and I concentrate on events, so I'm an event fundraiser and actually organise all, most of the events, well all of the events for the hospice and the objective is to raise as much money from as many different target groups of people as possible.

IV: That is very interesting. What was the motive for you to join the hospice movement? Why hospices?

IE: Why hospices? That's a very, very personal thing in that many, many years ago when I was 17 my mother died and in those days there was no hospice movement at all, there was actually nothing available to care for people. So that actually left quite a mark on me, that the hospice movement I think does such a splendid and wonderful job in an area when lots of people are floundering and can't… you know, are really struggling and the hospice movement step in and actually supports and help people, both the patient and also the relatives.

IV: That looks very interesting. Have you noticed any changes in the ideals and the orientation of the hospice movement during the period you're actively involved with it?

IE: Sorry, could you repeat that, any…?

IV: Any changes in the ideals and the orientation of the hospice movement in general during the period you are actively involved with it?

IE: Not in the three years, other than the fact it's moving forward. It is advancing all the time so it's not… it's evolving all the time; it's not standing still. There's… it hasn't changed direction, I think the idea is still the same, and also to spread the word as well to it and to work with other professionals in the policy of care.

IV: Even though you started three years ago the motives you presented were related to the same types of motives people had many, many years ago when the hospice movement was a lot more voluntary basis. Do you think that nowadays the hospice movement if becoming more professional and how this motivates or de-motivates people to get involved with hospices?

IE: Yes I think it is, yes, so in the past when it started it was voluntary and people were doing it with no expectation, true expectations I think of getting anything for themselves out of it. I think now, I think it has become more professional but also it has to, has to become because the charity environment, charitable world is very competitive. And so we have to be a lot more professional, a lot more aware and a lot more able to present ourselves against other charities when, from my perspective, we're looking for money and we're actually sourcing funds. I think in the care it's giving it's probably the same level of attention has always been there, but we probably are more professional, more up to date, more connected from a profession basis to the other resources from an actual, the front of a hospice. We are more professional, which might put some people off, but also it means we're probably reaching out to a bigger audience, we're probably attracting a lot more people. And I don't think it has actually, it may have put some people off who prefer the more basic stuff but I

think a lot more people, I think we're just reaching out to a lot more people not only with our patient care but also with the message we give for the existence of Hospice D. So, you know, encouraging people to help us and to volunteer for us.

IV: I think you have answered the following question, as well, was do you think the fact that hospice movement enters maturity is changing peoples' attitudes and motives to assist and volunteer and how. I think we have covered this one well. I'm going to move on asking a few things about challenges, first of all about the hospice movement and secondly about Hospice D Hospice in particular. What are you considering to be the main challenges that hospice movement, the whole sector, is facing now or will face in the near future? And what I mean by challenges, it can be both internal challenges like maturity risks, recruitment, centralised or decentralised sector governance and they might be external risks like new regulations or policies imposed by the government, financial issues, aging population, demand for new services. But I don't want just examples, I want your views what you consider as a big challenge with the hospice sector and a big challenge coming outside of the hospice sector.

IE: I think I can only speak for fundraising, so I think for us I think it's very… the internal challenge is to keep the momentum going, because we're always having to create new ideas and new ways to actually raise money. And the running costs of the hospital are £2 million a year at the moment so we have to, although we don't raise that full amount we've still got to come up with ways to pull in that money from the population, so we've got to be very creative. I think the challenges are, as I've just mentioned previously, lots of other competitive charities; they are all, everybody's aiming for the same amount of money. With the present economic climate it's very difficult for us to attract money from corporate so, and that's something that's been in a, sort of a decline at the moment. So what we spend our time doing is looking at specific target audiences externally and trying to encourage sponsorship and support from those people. And it's not always finance, money, it can actually be in kind, it can be the gift of time. But for us the challenge is mainly the external economic climate because people have less money to give and so we've got to find new ways of asking, getting them to give that.

And then, you know, internally it's just to be actually creative enough to be able to come up with new ideas that will attract people and also maintain the people that we already have. So they're the two things we're looking at, at the moment, is reaching as many people as possible but also holding onto the people, the supporters that we do have.

IV: And I guess you consider these are challenge [?] both for the hospice sector as well as for your own hospice?

IE: Yes and also in this particular environment, in Warrington for instance, we actually have there are a number of new charities that have actually come up in, recently, and they do compete with us, so it's also we've got to work very hard to keep our profile high.

IV: From your point of view do you see other charities as competitors or…?

IE: Yes, from a finance point of view. I mean, not obviously in the work that they do, we would obviously respect all the work they do, but if we're all looking for the same... because we only have our funding for us, fundraising can only come from a small geographical area and we can't step outside that. We're stuck within that area for our funding, therefore anyone who comes into that particular area is actually looking for funding from those people as well so, yes, from a financial point of view they are competitors.

IV: I understand and respect that; this is my view as well, but we have a very similar background, so… how do you think the hospice sector should respond to these challenges? And now I'm talking about every hospice, not just Hospice D Hospice, so if you were to be put in that, a fundraising advisor to the sector, an umbrella organisation such as Help the Hospice, for example, what would be your proposal in order to deal with the situation at the sectors' level?

IE: Big question! I think it's a case of raising, keeping the profile very high, for everyone to keep the profile high but also to take care of the people that we have and the support. I think you can't say thank you enough and it's actually looking after the people - your main supporters, your main donors - for everyone. I think you really have to consolidate all that area and make it, hold on to them and I think that's really what I would suggest most people have to do in this climate. But also to perhaps branch out and look at areas that we're, they're not targeting at present and actually go out to address these areas.

IV: That's good. Now, how do you think these challenges are going to affect Hospice D Hospice? Is there any action plan in place in order to deal with the issue effectively or is there anything that you would like to propose for Hospice D Hospice on this case? And we are moving from the sector's level…

IE: Okay. That is something within this department we're aware of and it is something we have been looking at. We have obviously personnel constraints in what, you know, we haven't got enough personnel here, the sort of resource basically to do that. But it something we are, have actually been looking at and have been trying to address and are actively moving forward trying to address those areas, so we kind of have that in place but it's quite a lose framework.

IV: And what would you suggest in order to make it more effective?

IE: To make it more effective I probably think we should, we probably should have a plan like a three, five year plan, a fundraising plan for exactly where we're going and be slightly more proactive rather than reactive. So for me it would be a strategy forward, yes, like a three year plan.

IV: That looks good. Now we are moving on to general and the role of your team. Would you like to talk to me about your role and the role of your team within Hospice D Hospice?

IE: Yes so the team, actually we, there's different functions here so within Hospice D we have in this department, we have three fundraisers and two administrators. The fundraisers deal with every form of fundraising out in the community, like a community corporate event, legacies, trusts, trust funds, basically everything - we are the front of the hospice for fundraising. The administrators, every single piece of money comes through this department, that comes in comes through this department that we raise, so we actually do all the, well from all the income generation it's actually all taken through this department and actually booked through here. We handle all the cash and we also are the front that we write to everyone and we also do all the marketing from, fundraising marketing, so quite a lot of the marketing from the whole of the hospice from this one department. We also interact with every single department here, we work very closely and because we're also, we're the front position for bereaved relatives who come in with donations we work very closely with bereaved relatives. A lot of the people who support us are bereaved relatives anyway so we're, have quite, very close links with the relatives but not necessarily the patients. Does that answer your question?

IV: Yes. Are you personally or your team getting involved in the process of target setting, local management and your role for the strategy [?] of the hospice or you are focusing mainly on day to day management issues?

IE: More recently we are getting involved in longer term, actually what's happening, [?] the strategy within the hospice, yes, so yes we would be involved in that as well as focusing on the day to day management.

IV: Would you like to describe to me how you have been, this [?] organised and managed you've done that already, but now I want to place some more emphasis on staff involvement for decision making. Is it that your team is reporting to you and then you pass this to management or it is like when there is a new policy to be made you or someone else

of your team are always participating from the early stages? It is this type of activities that I'm looking for.

IE: Yes we actually work, we work very closely as a team actually, so there's a lot of team decisions so [several unclear words] because we're very small we have to, you know, we have very few resources, we do operate as a team so a lot of decisions are made as a team. So I think we have [inaudible] senior management and whatever or whatever else is going on as a team point of view, but also individually we have quite a lot of autonomy as well to do with [unclear], to make decisions on our own. So it's both, works both ways really because, you know, we have a lot of, you know, each person has quite a lot of decision making power.

IV: And how does this affect the hospice's policies?

IE: I think because the relationships of this, from this department and the other departments we actually probably do confer with other departments before we would take decisions, so we are very sensitive to the hospice and what other departments are doing. And anything we decide to do would actually be done in conjunction or with reference to other departments and in discussion with them. So, for instance we, Light up a Life which is a new, big, not new but it's just coming up at Christmas, that's something which is a big fundraising event but it's also a very emotional event with a service for a lot of bereaved relatives, so there are two sides of that. So we, that's something that has to be handled very delicately so we actually work very closely with probably every other department within the hospice to organise that particular event, so even though it is a fundraising event.

IV: I guess if I was to ask you to describe me a typical working day for you and your team, would you be in a position to describe something like that? Or it is a kind of constant change, constantly evolving with new things?

IE: Yes, it's a constant change, so it depends really what we have on. At the, at the minute we've got three events planned in the next two weeks so it's sort of we're very busy, we're all doing lots of different things. So it really depends, you know, when and where we're at really. But yes, I don't think any day is the same, really.

IV: That's interesting. Are you aware of differences between the way your team at Hospice D Hospice is working and the way that similar teams are working in other hospices?

IE: Yes, so we actually do communicate with other hospices a lot and we are aware of it. I mean, we're quite unusual here in that all the money comes through the department; in lots of other hospices that would be in accounts, not within fundraising. So there are differences

like that, there are differences in roles, there are differences in, we're quite a small fundraising department compared with a lot of other hospices, as well, and quite a few of the other hospices have different, you know, functions, structures as well. So yes, we are aware how we differ.

IV: Are you using any method to measure the performance of your team?

IE: No, none other than actual appraisals but, with milestones, I suppose, but the, in a way we're measured by how much we raise, so we do have targets actually. So we do have targets that we are, you know, try to achieve in fundraising so, yes, in revenue.

IV: What would you consider as the main challenges in the process of measuring personnel [? personal] performance for this particular part of hospice activity?

IE: I think the number of variables in anything that we do so if we're, for instance, running an event or we're opening up Christmas Shop or, I don't know, sending out a mailing asking for raffle tickets, the number of variables of any one event or anything we do are so great that it's quite hard to actually control - variables that are out of our control, I mean. So it's very difficult work to monitor so and make them an individual performance in that respect because, I don't know, you can do a mailing and then there's a mail strike and it all falls flat, you know, so it's not the… or the credit crunch and we're trying to, we have targets set and with the credit, you know, at the moment then obviously that affects… But generally because we all work as a team that the challenges really, because no one person is ever responsible for any one result, it's all the team.

IV: That's interesting. Can you say things, specific topics that should be taken into account when somebody's trying to measure performance of singular things within hospices? What would be two or three or five qualities that you would be advising me to look for if I was to take a similar role in another hospice?

IE: I think you'd probably look at…

IV: Or if I was about to hire somebody new?

IE: Yes, well I think quite a lot of it I suppose is starting with passion which is a passion to actually be motivated by the charity, so by the hospice movement, and to actually want to be part of it and want to do it. And the ability to be a good team player, a good all-rounder, I think, and to be self-motivated. But also things like good organisational skills and creativity. Does that answer your question?

IV: Yes. The next question is whether you believe that your team is or could be involved in the process of creating financial value for the hospice and if yes, how, but I guess that we can cancel this question now. So now we're going to move on, the inter-professional relationships. Are the members of your team working in cooperation with members of other teams or they are primarily working on an independent basis?

IE: Both because they, we actually work within all, with all the teams in the hospice. And we also work outside with lots of different people, as well, so we work as the interface between the hospice and outside. So yes, we work with all departments, actually interface with all departments.

IV: Do you believe your team members would prefer working on a different basis?

IE: No, I believe that they actually… that's part of the job and that's part of the attraction of the job, that it's very varied and they actually have that ability to be part of that and especially work within it. And also be outside it and represent it, be ambassadors for it outside.

IV: Do you think that the voluntary nature of the hospice movement assisted in decreasing the impact of inter-professional working obstacles?

IE: Sorry, repeat that, in…?

IV: When you get people from different teams working together there might be some frictions in place, because sometimes it appears that people are speaking in different languages. You speak money, they speak care, for example. Do you think that the voluntary nature of the hospice movement is helping to reduce potential frictions or obstacles from, relating with different team members, with members from different teams?

IE: I don't know that it reduces it; I don't know that I would say, if I would say it reduces it. I think the fact that we have such a huge number of volunteers makes, definitely makes an impact on the way everybody operates here because they're very greatly valued, the volunteers, and they actually have quite a, play a major role in the hospice. So, I mean perhaps they do lessen any friction between departments because they're in every department and they do link all the departments together, the volunteers. But they're also well respected and without the volunteers the hospital couldn't exist, so I do think that, yes the voluntary nature maybe, yes maybe it does actually reduce because people think, oh gosh, if they're going to give it for free, their time for free [unclear], I think maybe it does think well I, you know, let's try harder, people try harder, all try harder on… I don't know.

IV: Well, let's move a little bit on the recruitment. Are there any recruitment policies? Are you setting any criteria for hiring new members in your team? And this can be both an informal level, like things that you're looking for off the record, or there could be particular policies in place, particular boxes to be ticked off when you're about to hire someone in your team.

IE: To be honest, in this department the biggest criteria has to be that they fit in with the team so that, so whatever they're bringing, the major criteria is that they can work as a team and that because we do work, the nature of the work, we've to work so closely together.

IV: Does it mean that you are not looking for a specific skill set when you are getting somebody?

IE: We are looking for… I mean it depends on the job really, whether it be a fundraiser, administrator, different roles, and for every role it would be a different, slightly different skill set. So certain roles require more public speaking, require more outgoing personalities, whereas other roles would require people to be more analytical, more studious, more happy to be, take a back seat - so there's a mix role. Again I think it goes to the passion; that they really have to be quite passionate because we are frontline, so they would have to be quite passionate about the hospice unit and Hospice D.

IV: How easy it is for you to find these skills on the market?

IE: I think we've been actually quite fortunate that we, there are, yes there are plenty of people out there in actual fact who seem to be willing to, you know, the salaries aren't the best here, so are willing to take the cut in salary and actually come into these roles. So we've actually been, I think been very successful. We do seem to manage. There do seem to be a lot of people. We don't struggle to hire.

IV: That's good. So you wouldn't say that the market is competitive, even though you have a number of charities around who most likely be looking for the same type of individuals to be their fundraisers? There is no much of competition to hiring people for this particular job?

IE: You see, I don't think they actually… there aren't very many… even though it's competitive there aren't, within the area of Warrington there aren't that many roles in say fundraising. So even with the competitive charities together there are, there are far more people out there, basically, who would like to… yes

IV: Who would like to…? It works like that with the fundraising part of the market [?]. You might be one of the most fortunate managers in this but not just in this hospice but with other hospices that I can compare with. Now we are towards the end of the interview. I'm only going to ask some general feedback on the whole process. Did you enjoy our conversation? And would you like to indicate three strong and three weak points of the interview process?

IE: Yes, I did enjoy it and it was quite thought provoking. I think it would be, it might be interesting to have the questions before to think the answer through, because some of them I may actually I could have said something more about that. So some of the questions would perhaps require a bit more thought. Other than that I think they, you know, I think the questions are comprehensive, actually.

IV: Are there any areas of interest relevant to your profession that you feel they were not covered in adequate depth and some little things that we could have drawn a little bit farther?

IE: No, I think you perhaps had an understanding of fundraising, get the feel, I get the feeling that perhaps you understand fundraising a bit, the nature of it, so that came over quite well. So no, I think that, no I think you covered, I think within the context of the hospice, you know, our position, I think that, you know, the part that fundraising plays, I think you've actually probably covered it very well with your questions.

IV: Thanks a lot. So are there any general improvements that you would suggest on the approach or the content of the interview or…?

IE: No, only in the, as I said, it might be nice to read the questions beforehand so you had a chance to prepare.

IV: Thank you. I've had this comment from other people, as well. It's interesting because when I wrote this questionnaire I wanted to keep it aside and just get into peoples' offices and get their views on this without letting them too research based things like that, because what I had in my mind is that if I give the time to think about it you might get caught into searching for the answer and I could come up with ten, 20, 40, 50 people giving me exactly the same answer to each question. Would you like to participate in a similar interview in the future if…?

IE: Yes that's fine, yes.

IV: Thank you very much for that - that was interesting. So yes, and it was…

IE: Thank you. Nice to meet you.

Interview with the Support Services Director of Hospice B:

Speaker key

IV: Interviewer

IE: Interviewee

IV: Before we will start with the interview itself, I will have to let you know about the ethics and confidentiality policy of the University. You can be assured that any kind of information you will provide within the interview is going to be kept confidential, whichever information out of it we publish is not going to carry your name or the name of the institution you are working for. If at any time you find out that you don't feel comfortable answering a particular question you can just say that you don't want to answer this question, or if you feel at some point that you want to interrupt or stop the interview process, you can just feel free and ask for that. Are you happy to be interviewed today?

IE: Yes, I am.

IV: Good. So, let's start. Would you like to tell me a few things about your background and how long you have been with the hospice movement and what was it that motivated you to join the hospice movement in the first place?

IE: Okay. My name's Cathy Butt. I don't need to say that, actually, do I? But I'm the Support Services Director and I've worked in the charity sector for about 25 years. And my time with the hospice has been four years, but before that, I worked for another charity called Foundation for Conductive Education, which was a brand new charity, and set up through a project through Birmingham University, which is how I got involved with it. Because, at the time, I was working in the Education Department at the university. And we set up a four year project to take ten teachers to Hungary to train them in this method of conductive education. And we ware also directed… we weren't directed, we were also asked to set up an institute in this country where those teachers could then come back and train and teach children with cerebral palsy and adults with Parkinson's Disease and multiple sclerosis, to give them the skills to overcome their disabilities. And that project, to cut a long story short, turned into a much bigger charitable event in that the charity was set up and it went from strength to strength. And we ended up putting four tranches of students through Hungary and lots of children and adults and their families went to Hungary, and that was my

responsibility to turn all that over, that big social exercise. At the same time, it was my responsibility to set up a very brand new institute for these children to be trained in, to recruit the staff and to start all the process and procedures of a charity working. So by the time I left that organisation, I was the director of corporate service.

My passion is, actually, was, actually, very much related to that cause. However, I decided to leave that organisation at a time when the Chief Executive was just retiring, he was the person that set the whole thing up, was retiring and I'd been with him, working on this project for charity, for such a long time, but perhaps it was a natural time for me to do something else. And there were other circumstances around that which decided me to move on. Because of my wide ranging skills in terms of corporate development and facilities and human resources and finance management, I, obviously, tried to find something of a similar nature and saw this role, the Support Services Director post advertised in Third Sector magazine and charity journal and came along for an interview of that. And, again, to cut another long story short, was appointed in July 2007 to undertake that role. Do you need any more on me?

IV: So you would say that your motives were mainly professional motives?

IE: They were mainly…

IV: Part of your career, not something that attracted you specifically to the hospice movement.

IE: Yes, at that time, yes. Definitely, I wanted to work in another charity, but it matter particularly whether it was the hospice movement or children. It was more a career move.

IV: During the first years of the hospice movement development, there were a lot more people coming in because of what the hospice movement was standing for. And it was a lot more of an amateur environment rather than a professional environment. Nowadays, if you are okay with what I say, of course, you can dispute that.

IE: I don't, actually, I agree with it.

IV: Now, my feeling is that it gets to a transition stage where more professionals are coming in. Would you be able to confirm that? Have you found more people are joining the hospice movement with similar motives to yours or you can still see the vast majority of people following some, let's call them traditional ideas, of the hospice movement.

IE: I think, just from my experience in setting up a charity in the mid 80s and that this hospice started around the same time, the mid 80s, meant the hospice movement, I know,

goes beyond that, but, from my experience, I mean, there are two organisations, I would say that there is a natural development that goes on within young [?] charities and a cause that I could see reflected in this hospice as well as hospice there. An organisation with a very different objective, i.e. working with disabled children. But the same emotions and motives are there in terms of a passion behind a cause. And I could see from my experiences in both organisations, how those organisations have developed and grown. And very much, and it can happen on an ad hoc basis, i.e. responding to passion, responding to changes in environment and legislation, just, sort of, bolted on. But they get to a certain age in their development where, quite naturally, I believe, they have to become more businesslike. And, as a result of that, you have a mix of the people who are passionate about the cause, enjoying it for the cause, but you also have people who can join the organisation because they have the skills to offer in terms of financial management, or human resource management, or facilities management, or health and safety, which are a natural requirement of any really good business. So, there you go.

IV: Do you think that this is changing people's attitudes within the organisation as well? Are you able to get as many volunteers, for example, as the past or things are becoming more businesslike?

IE: I think probably there's going to be a transitional phase, which I think this organisation is probably in, where you've still got the people who joined the organisation 25 years ago and still understand why they joined it and the basic needs of that organisation at the time. But I think people who, perhaps, join it now, excuse me, will join on the clinical side of things because they'd experienced or they want to specialise in end of life care and, therefore, want to become specialists in palliative care. And I can see how that is changing, that people will specialise, say, in clinical careers or specialise, and, therefore, you will have that passion in the clinical staff. I think with paid staff, you'll get more and more people joining the organisation because it's a career move, it's a job, whether they get hooked into the big passion around the organisation. It's probably a personal thing. In terms of volunteers, I think you will always have those that have experienced the care of the hospice and have joined it because of that. I truly believe that that will be maintained.

Recruiting volunteers, I think, is a different matter in that even though somebody might have experienced care, either directly or indirectly, through the hospice and then want to come and volunteer, may very much now depend on their own personal needs. Whether they want to carry on working at 65, beyond 65, because the majority of the volunteers are older people. We don't get that many younger volunteers, even though we've tried. And so people are having to continue to work longer and needing their finances longer and the ability to

work longer at 65, I think, means that our volunteer base may change. And then, therefore, this organisation, particularly, are trying to look at how we might recruit younger volunteers.

IV: I see what you mean. Viewing things now from the challenges that the hospice movement is facing, and we can mention both internal challenges and external challenges, what do you think the main challenges will be in the near future? First of all at the sector's level, and, secondly, at Hospice B level.

IE: What was the first one, sorry?

IV: At the sector's level, at the movement's level.

IE: And then within the … I think the sector level is… I think the challenges are being driven by… at the moment, the government's attitude to end of life care and what… how they ought to handle it and where they're directing their funding, through things like the Darzi, the NHS review through the Darzi Report, and the government's End of Life Strategy, I think that's probably influencing the movement very much. I think at the hospice level, I think those things still apply, but I think we then need to respond. We might not necessarily respond to the national view, but we might take, for instance, the fact that we've noticed the complexity of our patients and dependency of our patients getting greater, and, therefore, we need to respond to that the complexity of the conditions, so that they don't just have cancer. So are we going to deal with just cancer patients? Are we going to deal with cancer plus dementia plus something else? What about people with neurological conditions, are we going to help them? So I think we're facing quite key questions at the moment about our own development, about development of our work in the community, which, well, you know, everybody wants to die at home, or do they? So it's been able to look at the development for our service as it is now, look at the demographics, as it's going to be. Take into account the government's or the national movement's strategy, and then try and fit what we think is happening locally into those. And so the key question at the moment, I don't know the answer, actually.

IV: So you say you don't know the answer. Do you have a view how the hospice sector should respond to that or how Hospice B should respond to that? Is it the case of lobbying for more funding, for example? Is it the case of including resource allocation management? What would be…

IE: Okay. I think, from the hospice point of view, I'd rather, probably, take it from that because I think that's probably where I'm more confident speaking about that. I think that a review of service provision, as it is, and an analysis of demand of our business, is a good

starting point. And to see whether we feel that, for instance, we should develop our community, our work out in the community. Or whether we should be looking at an in-patient unit and sectoring that for people with special needs or just cancer; generalising or specialising. And I think once we've done that sort of analysis of our current provision and looking at our demand, we can actually start thinking about our resources in terms of are we going to continue to be paid through the PCTs and how are we going to ensure that we get proper value for the services we provide and not just, you know, it's going to cost you that, but it's properly analysed and properly paid for. I think the referrals systems we need to be thinking more about how they work and collaborations with partnerships with other groups, potentially, MND society, Parkinson's Disease Society, dementia, those sort of groupings. So we're up and that might create more demand, more resources to be able to do that. And so, I've forgotten the answer now. So I think, you know, I think that a, sort of, review required to meet what's going on nationally, but also to look at what's going on locally. And so that's why we have resource needs.

IV: That's good. Now I'd like to take the conversation a little bit more into your own role and your team's role. Would you like to talk to me about your role and the role of your team within Hospice B?

IE: Okay. The Support Service Director role is simply to provide the person that's responsible for the non clinical aspects of the organisation. So this role is responsible for human resources, which includes volunteers, management, finance, IT, estates and facilities, catering and housekeeping. So, basically, all the services, the underpinning services for the clinical side of things. I'm able to manage that huge workload, if you like, by having a good set of middle managers over each area. And those middle managers are, if you like, they're qualified people in those areas. For instance, I'm responsible for finance, but I'm not an accountant. My discipline is really HR, but because of my experience, I'm very broad. What was the question again?

IV: Don't worry. It is your technical part, your own and the role part of your team within Hospice B. You think you do very, very well after that.

IE: Okay. So if I take each sector, yes, everyone is managed properly by a qualified middle manager. And what I would say is that as I've in the post four years, that all of those sectors have either undergone a review and an improvement and are more professional. Or they're in the process of being reviewed and looked at, and that can hurt sometimes because, you know, the old way of working, potentially, doesn't necessarily fit the new way of working. And so people who've been here a long time can sometimes be put out by, you know, changes to practise and things. but the idea has been to review practise and

procedure, policy and procedure, and to build teams to actually provide a service that underpins everything. And we've not got to the point three years in, in some of those change circumstances, where we're reviewing and we're looking at departmental strategies. But that's quite difficult because that really needs to drop out of a whole organisation strategy, which we don't really have in place at the moment.

IV: You don't have in place a whole organisation strategy?

IE: No.

IV: Would you like to give me a little bit more information? Are you referring to the structural strategy that doesn't exist?

IE: I'm referring to what I would consider to be a document which tells me what this organisation's about, where it wants to go, how it plans to do that. So what its ambitions are, what its goals are, what the action plans are behind that, even if it's three, five years. When I first came in 2004, I asked to see the business plan, and I was given one side of A4 with some points on, which was just the philosophy of the organisation. There's nothing wrong with that, but there was nothing, I didn't fee, that underpinned it in terms of where we were going and how. And it's only now, this year, and only very, very recently this year, that this organisation is actually addressing that. very seriously, I have to say, in that trustees have agreed to set up a trusty workforce. They haven't met yet. They meet next week for the first time.

IV: That looks very interesting. Is your view or your team's view taking into account this process?

IE: It wouldn't have…

IV: How is this formulated?

IE: It wouldn't have been in the past, but it will be now. Part of the strategy is that it's been agreed that all departments, mainly the clinical departments, will undertake a review of current practise and that will inform the work of that group. But, at the same time, is they're asking to review it, we're also asking them to look at where it might develop, or how it should develop, in their view, according to the government's enterprise strategy, according to their experience, according to anything else that they'd come across in their professional lives. And we're asking them to put forward a case. And where, I believe, in the past, the departments have evolved, I don't think they've evolved as a coherent whole for this hospice. So we've been successful and our different areas of work have grown, but it's dependent on

who's the line manager and who can shout the loudest and who can persuade senior management and trustees that theirs is one to go forward or requires the extra resources. So, for instance, community work and our team in the community has developed and hospice at home have developed quite rapidly over the last couple of years, but not with a view to looking at how it links in to day hospice or into the IPU up to discharge and admission. And now I think that will happen, which I think is really healthy. So we're working on it.

So in terms of my own teams, I think what we've been able to do is actually, up to a point, say okay, we're three years in to being like this and the system's better, but we want to improve that, dump that or we'd be able to respond to that, so we can be more proactive rather than reactive of groups. And in the main, that is working. One blip is, again, with the new IPU being built, without a strategy, knowing how that's going to be managed or worked or, you know, what it's going to provide for, and ditto with that and our centre in Sutton Coldfield, that's, sort of, a bit the same. We can't be saying okay, we need ten more cleaners or we need X more cooks or, actually, we're going to need a much bigger ATAR [?] team, because we're going to be recruiting, you know, even if it's a temporary workforce planning issue. you can tell them it's being addressed properly.

IV: That's the basis for a new governance to take place and that is just closing your eyes in front of a problem.

IE: Absolutely. I feel angry with that comment.

IV: [Laughs] Are you aware of the differences between the way your team is working here and similar things are working in other hospices? And when I say work, I mean the difference would be in the length of your thing. Your team might just not exist on a different or another hospice. Your work might be overtaken on its [unclear] department for you. Or it might be exactly a concern of yours working and very soon where are you going to a different way. Are you aware of what is happening in other hospices?

IE: Yeah. Yes, yes, I am. Not necessarily in all aspects, but there are various local forums that have been set up. For instance we have a support services forum and we have an HR forum within the, sort of, West Midlands region. And we meet, we are able to discuss things like, say, the support service forum met a couple of weeks ago and we were talking about patient nutrition and patient meals and catering service. And, yes, I heard the voices of five of the hospices saying they had this many cooks and this is the way they operated with hospitality and this is what patient meals are put together. These were the chimings of the great staff to do comparative work, especially, you know, and we are, currently, undertaking a review of our catering service. So, yeah, brilliant just to be able to listen and hear how

other people are working. The other way, besides these forums, is often we'd help the hospice's training sessions. Because you are mixing with like minded people who are wanting to, you know, we're all, basically, the same topic, that an awful lot of value in being able to network and just to listen to other people. And, you know, you come back with an awful lot of good stuff. Training courses, and last week the St Anne's Hospice health and safety, you know, it related to their experience of health and safety, listening how other people do it, listening to other questions, you know. So it does inform. So I think that, probably, from my point of view, is a good opportunity to learn from each other and to be able to change our own practise side of things.

IV: It's interesting to hear. Have you spotted any differences in the way you're approaching the things here and the way other hospices or in similar things?

IE: Yeah, slightly. Well, for instance, take health and safety, I know of two or three hospices that, I mean, health and safety, from my perspective in this organisation, is a key topic to prime, to, sort of, you know, a health and safety environment, you know, we are liable, hugely liable. And we don't have, because I'm not it, I'm responsible for it, but I don't have a qualification in health and safety, I've loads of experience and go to lots of little courses and stuff, but today, I think there needs to be somebody who has that key responsibility. Well, people, other organisations, have gone that step further and, yes, they have a health and safety officer, how they manage it is slightly different. But, you know, as I say, they are doing it in a different way. They've taken the big step to saying yes, this is a huge responsibility, this needs to be addressed in that way. That's just an example, you know. Yeah, I mean, the catering, in the same way members of staff working, when we built that really, you know, next question, that sort of thing. Facilities as well.

IV: Are you using a method to measure the performance of your team.

IE: You mean benchmarking?

IV: Benchmarking, core targets or in terms of performance measurement and HR

IE: In terms of HR, HR and finance are the only ones who are doing it. We are, you know, turnover and absence, numbers of people absent and training, numbers of people going through training at any one time and what levels of training. So, yes, in HR, we are collecting data and sharing that with our trustees. Not necessarily benchmarking in defence of the hospices yet. Ditto with the finance, again, collecting data and sharing that. Not just normal reporting, but collecting data. And I'm not talking about clinical data here, because, I mean, it isn't my patch, what I do is produce a KPI, a set of KPIs for the board on a quarterly

basis and I just manage the numbers that come in for the clinical side of things, just in terms of managing, putting them onto paper. But in terms of the HR element and the finance element, yeah, we are doing that. But I wouldn't necessarily say we were benchmarking against other organisations at the moment, certainly on the non clinical side of things. It's time.

IV: What are the challenges in the measuring of personal performance within the hospice?

IE: Do you mean staff and their abilities?

IV: Staff and their abilities. The very nature of the work that you are doing in here. Maybe this is not exactly applicable to your case, maybe you have some things to measure.

IE: You mean skills of clinical staff and think like that?

IV: Skills, how they improve and how they apply these skills. How many people they see could be one thing. What kinds of problems they have dealt with and how effectively they have gone through it? How much resources, how many resources, how was the cost of the visit or this kind of…

IE: Just give me the question again, then.

IV: Are there any challenges when you are trying to measure personal performance within the hospice?

IE: I think we have the means here to be able to measure it. I'm not saying, therefore, that the systems were set up to measure it. Though I think because we have annual appraisal and training needs analysis, we can actually gather the information of who needs what. As an organisation, we take the responsibility and the need to up-skill and keep people skills moving and responding to their particular environment very seriously, and there's definitely a budget to do that. There's a committee that meets every year to look at applications for higher education, university modules, courses, etc. What I wonder whether is that possibly there isn't an evaluation of all of that in terms of how they are then using their skills. How they, you know, how is that being measured in terms of performance. I suppose it's being measured by a lot of them will move on within their environment, i.e. get promotion because they've got the skills to do it. Or they get rewarded for it, but the measurements are, kind of, put there or not, I don't know. I'm not sure that I've answered that properly, but [unclear]…

IV: Every single person has given different answers to that, so don't worry. Did you believe that your team is or could be involved in the process of creating financial value for the hospice? And if yes, how?

IE: I suppose we do that and non clinical services, you know, financial value. Are we talking here… Just say the question again for me.

IV: Do you believe that your team is, or could be, involved in the process of creating financial value for the hospice?

IE: What do you mean exactly by that? Like selling our services or actually being more efficient?

IV: There are two approaches to that. One is either [unclear] at all with bringing money into the organisation. If not, are there any steps that you think could be taken in order to use less money from the organisation?

IE: Not since when I started doing this one, then, isn't there? I think me, personally, my angle in the organisation, the budgeting process is a good one for making people look at their resources and how they use them. And also what sort of income can be generated from their work. I suppose from that point of view, we can suggest efficiencies through the budgeting process. In terms of income, income generation, I don't think my sector has much influence on that.

IV: Are the members of your team working with people from other points within the organisation? Do you have to liaise with doctors, nurses or fundraisers?

IE: I suppose, by the very nature of the fact they are services, yes, they are. I mean, for instance, IT will get involved with all sectors of the organisation, like going to the patients and someone who wants to have a computer at their bedside, you know. Okay, it's not set up like that at the moment, but, you know, if somebody comes in and wants IT facilities, yes. Or, you know, we've got a new patient record system coming, so IT is out there. IT are influencing everything, HR is influencing everything, so someone's pension or their pay or absence of discipline, HR's involved in all sorts of things, finance, expenses, you know, there's an involvement down there. Our housekeeping staff, stewards, they can't, you know, light bulbs, leaking taps, the whole lot.

IV: What do you think, do you feel, are you giving, do you have the feeling that they respond positively to interaction?

IE: Absolutely.

IV: Do you think that the fact that they get work in different hospices is helping that? Or would you complain?

IE: Yes, most definitely. The catering, I would say the staff who are near the interface, the service, do so because it's a hospice environment and do so in a way they work because it's a hospice environment. For instance, zero, virtually, absence rate in stewards. Ditto with housekeeping. And then not with, sort of, long term sickness. So people are very dedicated to their service. But they, perhaps, wouldn't be if they work in a factory down the road or something like that, yes. I'm not so sure, one step removed, i.e. in the HR Department or the Finance Department. Maybe IT are a little bit more…

IV: So you don't hear of any inter professional conflicts there?

IE: No.

IV: That's wonderful. Something about recruitment now. Do you have any specific recruitment policy in place? Or, if not, do you have a guidance on recruitment?

IE: Yes. We have a recruitment policy and procedure, yes. Are you meaning any, sort of, we have a recruitment policy procedure, which is an HR document, which will, you know, this is the starting process. We go through it, we do it like this. But a bit different to a policy on, you know, how are we going to sell our service, which I think could be seen more as PR.

IV: And I was…

IE: You're talking…

IV: Are you looking for specific skills when you're having somebody for team?

IE: Yes. I mean, various skills, obviously, depending on the team I'm going for.

IV: Is it easy to find the skills in this area or it is a competitive market?

IE: It's easy, it's easy, in the type of things I'm looking for. You know, catering staff, cleaning staff, IT, finance, HR. HR just advertised for an administrator, I had 96 applications. Even though we're a rural, if you like, environment, we still had a high element of response. I haven't had any problems.

IV: That's interesting. And now I'd like to…

IE: I also don't have many people leave.

IV: That's great, that's good. A low staff turnover.

IE: Yes.

IV: Okay, I would like to have for some general feedback. First of all, did you enjoy the conversation?

IE: Yes. I'm a bit tired, I'll agree, but I suspect you are as well. It's quite interesting.

IV: Would you suggest, would you indicate any strong or weak points of the interview process?

IE: Strong points is that the interviewer has made the interviewee feel comfortable and safe and confident about their approach. The interviewer has been very helpful in terms of clarification if there's been any uncertainty and no other problems. What was the other one?

IV: Weak points, or, if not weak, at least something that could be improved?

IE: No, it was great.

IV: And something that you would like… information you gave me, maybe it impacts on something related to your area of specialisation or I didn't get it in adequate depth? Something that you would like to add?

IE: I was aware that the youth volunteers needs to be a specific question. I know you asked about volunteers and about their, you know, the ease of getting volunteers. And perhaps I didn't answer it in a way that could have been, but it possibly, you know, how we use them, what sort of percentage use across the board is, in terms of, you know. In answer to that I would have said, you know, hugely on reception, hugely on transport and the management of them being difficult, that sort of thing.

IV: Would you like to participate in a similar interview in the future?

IE: Yes, that should be fine. As long as it's just the topic I know.

IV: Thank you very much.

Interview with the Finance manager of Hospice C:

Speaker key

IV: Interviewer

IE: Interviewee

IV: Before we will start with the interview itself, I will have to let you know about the ethics and confidentiality policy of the University. You can be assured that any kind of information you will provide within the interview is going to be kept confidential, whichever information out of it we publish is not going to carry your name or the name of the institution you are working for. If at any time you find out that you don't feel comfortable answering a particular question you can just say that you don't want to answer this question, or if you feel at some point that you want to interrupt or stop the interview process, you can just feel free and ask for that. Would you like to carry on with the interview?

IE: Yes, fine. No problems for me.

IV: Thank you very much. So would it be possible to tell me a few things about yourself and your background and your involvement with the hospice movement?

IE: Okay, yes. Well, I joined Hospice C approximately two years ago. I'm now 61 and retired. I retired from my previous job which was working for XXX in XXX. They produce glass, manufacturing glass. I'd been with them since I left school, basically. That was my entire career.

When I left XXX I took early retirement when I was 54 and I spent two years working at a school, doing the finance there and then this job came up here and one of the trustees asked me, would I come and look at the work for the hospice. I came here and I work here now on a part-time basis. It's two days a week. I'm responsible for the financial management of the hospice.

The hospice is split into two separate companies, the hospice itself and a trading company. Trading company are, which is a fund-raising part of the hospice, responsible for both areas, basically, financial aspects of both areas. The attraction to the hospice was, I had my arm twisted to come along and see them. At the time, the current… my predecessor, the finance executive was leaving and he was leaving fairly quickly so they wanted someone to come

and help out. He worked on a full-time basis and when I came to the hospice I said, yes, I'd like to help but I didn't want to work full-time. They were happy with that because it saved them some cost. You know, you've got three days… I work two days and do the same job the guy, the previous guy did in five and [unclear]. Do you want me to explain the set-up? The set-up is basically myself and three people who work for me.

IV: So what was the primary motivation for you to come here? It was something you always had a feeling about working for a hospice or it would be more like reflecting to your life and you decided that this is something that you chose to do.

IE: I think that's true. When I finished full-time employment when I was 54, I decided then I would only do the things that appealed to me, that I wanted to do. I enjoyed working at the school. I've enjoyed working here. I don't feel as if I'm way too tired. I want to carry on working not because I need to financially, because I'd like to give something back, work for either a charity or something that appealed to me, something I could identify with. Personally, my family don't have any experience of the hospice. It's not a case of I have a parent in the hospice or I have a loved one who went through the hospice system and I wasn't exposed to them that way. It's purely having been here and met the people, seen what they do. The work appeals to me and I'm enjoying the work tremendously.

IV: That's good. Do you have any interaction with the [unclear] in the hospice movement?

IE: I'm part of a management team in the hospice itself so I meet with all the other managers on a monthly basis. There's also an area finance group. We meet every three or four months and that's the finance officers from other hospices in the area – by the area I mean the North-West of England. We had a meeting about four, five weeks ago where we met at Lancaster and other finance executives from other hospices meet and we compare notes and talk about the things that are happening in our hospice and we pass on best practise to another hospice; how did you do that, we've got a problem here – that kind of interaction. And that's a very good meeting, very useful meeting and includes hospitals from as far as North Wales and as far south as Cheshire and up as far as, I think the furthest one is Carlisle so it's quite a broad area. So I meet with those people on a regular basis.

IV: While you're interacting with these people, what, have you noticed any comments about their motives, why did they join the hospice movement, how they became hospice professionals and any comments of their views on why people join hospices nowadays?

IE: Because it's finance, first of all, we're not volunteers in the sense that we're professional people, we've been through the… we've qualified as finances and accounts and whatever it is so we've had a life other than the hospice movement. It's not a case of a youngster joining, qualifying as an accountant and joining a hospice. Most of them tend to be 40s, 50s and that way they've had experience in other walks of life and gravitated to the hospice for various reasons. Some is a case of having, as I say, a loved one that has gone through the hospice movement, died in a hospital or whatever it is and then people want to get involved in it. Others want to be involved in charities of one sort or another and the hospice is a charitable movement. It's hard to say, really. I think you'd have to speak to individuals. Everyone will have a story why they got involved and how they got involved. I don't think there's any sort of common factor to us all to say that we all joined because of X.

IV: Looks like over the years, as the sector is [unclear] people tend to view things in a more professional manner compared to a more, a volunteer's attitude that people were coming with in the past. Have you seen something like that, have you discussed about issues like that?

IE: What's happening with Hospice C is that we opened ten years ago. This is our tenth anniversary today and you're absolutely right. Most hospices start off as a good idea and a group of enthusiastic volunteers. In the case of Hospice C, the idea, the concept of the hospice was the brainchild of Lady Pilkington and a group of like-minded people. She drove the original desire to build a hospice on the site we're on now, which was bought in her early days of fund-raising. I think what happened then is that as the hospice has aged it's become more mature, it's found it's place in society, it's found its niche, if you like, its role in the area. But it's very much in the early days, it wasn't here before, there was no hospice. We know there's a demand for it but how big is the demand? What's the nature of the demand? Is it just inpatient bed care or is it day therapy sessions? Are there other things you can provide?

And I think you start off initially with a very small [unclear] as funding starts. As the hospital's been accepted into the community, people are more aware of where we are. The PCTs have taken on board that there is such a thing as a local hospice. Their funding has increased. They're bringing to us ideas of what they would like the service to be that we provide. We've expanded the services we're providing to day therapy. There's, we actually visit patients at home. These have all been the sort of new services that have developed. These have been in response to demand, if you like. We found a need for the service so I think there's more like that as you go through your life of your hospice.

Also, fund-raising becomes more a priority as the hospice has gone on. We have over 40, nearly 50 people fully employed so there's quite a demand for funds so fund-raising has to get tighter and better. We've got a fund-raising set-up which is the trading arm. We've had six shops. We've now opened two new shops this year so that's expanding because we need the funds. So there's that kind of development as the hospice has moved forward.

IV: If we have to consider the challenges that both Hospice C as well as the hospice movement in general is facing now and it is going to face in the near future, how would you summarise these challenges? Is it mainly fund-raising, is it mainly the demand increasing, demand for the hospice's services? If you've got to give me a summary of your own view, three internal and three external challenges for the next five years, what would you give me?

IE: Well, as you're probably aware, the Government has issued a paper on its end-of-life strategy. I think there's an awareness within Government circles now that the role of the hospice will probably expand because I think they're looking at end-of-life strategy and how people come to the end of their life, what services are needed, how we can provide those services. As a finance guy… You're probably better talking to XXX about that. He's on the clinical side. As a finance guy, my main priority is fund-raising or the health, the financial health of the hospice so every year, for example, something like 30% of our income is from the PCT. The rest of it we have to raise ourselves. On the cost side, we've adopted the agenda for changes and our pay rates are linked to the NHS scales so we pay NHS rates. That means our cost on average each year expanding by about £70,000. We have to find another £70,000 a year so my top priority is how we raise those monies.

We have a professional fund-raiser who you'll speak to later, Julie. She has her remit. The team's more and more professional. I think the idea of the volunteer fund-raiser who has a charitable coffee morning, those kind of things and great and they still happen. They provide us with an awful lot of income but we're getting more to the point where we need to approach corporations, charitable trusts to get donations from them because their donations are much higher than the public. So it's more we need to tap into that kind of market and make sure financially, going forward, you have the funds to do what the hospice wants to do. We're currently building an extension which is costing over £1 million. £600,000 of that was a grant from the Department of Health but we have to find the 400,000 which is coming out of our reserves. So there's that kind of interaction, if you like. As a finance man, my top priority is the financial health of the hospice.

IV: How you see the going – both for this hospice and for the hospice sector in the future – is it going to be easier or more difficult to raise funds compared to what it used to be? Do

you have increasing competition for fund-raising or do you think that the more people are getting aware of the hospice movement, the more they are willing to contribute?

IE: I think the biggest contribution we get is from the PCTs and I think more and more there's an acceptance in the PCTs that they have to provide more cash than they probably want to. And the PCTs have been leant on by the Government to get more involved in hospices. The trustees would say, from this hospice's point of view, we don't… we would like to get to the point where 49.9% of our income is from these PCTs and the remainder of it is from our own resources. That way we're not a government department. If we're less than 50% funded then we're happy to say we're independent and we can still do our own things.

If we were 99% funded by the PCTs we'd effectively be part of the NHS. We'd just be another department subject to their control. So I think, from our point of view, we'd like to raise more money from the PCTs and get up to this 49% funding but beyond that we want to raise cash ourselves. Now, the pressures on raising cash are tremendous. We're about recession. That's a two-edged sword. We don't quite have a feel for it yet, whether the structure will be much better because we're in recessionary times, the same as the one that people will use charity shops more, or whether donations will continue at the same level. People haven't got the cash, they can't make a donation or donate as much as they did last year.

What we find with the donations is that we have a tree of lights ceremony, for example, and someone will donate £10. Next year, they'll say, I'll donate £10. They're used to donating £10. It's their level, if you like. They'll buy £5 worth of raffle tickets and those £5 of raffle tickets every year. They don't by £6 the year after and £7 the year after that because our costs are going up. They're contributing at the same level so we have to find more contributors, if you like. The people who traditionally support us will give us so much and they'll find a level that they're happy to contribute that. Beyond that we've got to come up with new events and new fund-raisers, approach a new organisation. Two years ago we came up with a moonlight walk which was very successful and we raised £60,000. We ran the walk this year and we think we've raised about £70,000.

But those kind of events have a period when they play up or get to a point where the moonlight walk has had its day. We've run it for four or five years, we have to replace that with something else and yet keep the income stream. So it's just pressure, pressure, pressure any one feels. What we have found, one good bit that we find is that because we've been going ten years now, the legacy income's increasing. In the early days we'd get very few legacies. Now we find we're being remembered in people's wills because we think that

what's happened is life, the wife or husband has been to the hospice, perhaps died in the hospice. Their partner survives and goes on for another five, ten years, whatever, into old age and then they die and that's when we're left a legacy because they remember the treatment they had in the hospice, they remember the service we provided. So we've found over the last four, five years legacy income is increasing quite dramatically and we think that's a factor of the fact we've been open ten years now.

IV: That looks interesting but would you like to bring things a little bit more to your own thing now? How is it organised, how many people you have there and what your office individual as a team?

IE: Yes. As I say, I'm the finance officer. I work two days a week and that's only really possible because I have three ladies who work for me and are very good at their job. Two of them have been here since the hospice opened and it's a young girl who supports them on the finance side of things. One lady is responsible for the trading company accounts. The other lady is responsible for the hospice accounts. They're full-time employees. My role is really to oversee their work and also to get involved in [unclear] exercises, to do the budget, to meet with the trustees and provide financial reports, to analyse our expenditure, which is an area we think we'd like to look at. We keep looking at maintenance. That's starting to cause us a little bit of concern, again because we've been open ten years.

We find the building is now getting to the point where we're spending more on maintenance so we've recently introduced a new maintenance report which is really just saying maintenance costs is over x. We helped to find out, you know, where are we spending it? As I said, with legacies, we used to just accept legacies happening. Now we do a legacy report where we look at it and find out where the legacy is coming from, whether a particular solicitor has been more proactive in getting legacy income for us. We have one, for example, who's very supportive of the hospice so when he's working to make out a will for a person, he'll suggest, would you like to make a donation to charity, how about the local hospice? And we think that's starting to grow through.

So my role is basically responsible for budget, to make sure the finances are in order. It's a budget going forward for the next year and that budget goes to the trustees who'll accept or reject or look at it and change it, together with the CEO. We're constantly managing costs to see where we can save money, where we need to spend money, what the position is going forward for at least one year – difficult to go much beyond that. We do the annual accounts. We have a… The annual accounts are actually done for us by a company called Leafless Pottiford [?] who are our accountants. They'll come in and I'll liaise with them to make sure

they haven't any problems. The accounts information then received, the ledger's kept at stage so we do stage which they take and provide the annual accounts from.

We have our own in-house payroll system so we don't use a payroll agency. We pay the staff ourselves and again, we use SAGE for that, SAGE payroll. So in all, it seems to work, be working quite well. The worry was that, as I said, my predecessor worked five days a week and I dropped the job down to two days a week and we thought then, would it be enough? It seems to be working quite well and I think that's down to the people who work for me because they're very good at the job they do.

IV: It looks interesting. Are you personally, your team getting involved in the personal target-setting and long-term management, overall policy creation? Are you getting involved in strategic issues of the hospice, strategic decision making or it comes mainly from the trustees and you follow what you're asked to follow?

IE: I think we're involved with it. I'm certainly involved as a finance manager in the strategy and the effects that the strategy has on finance. The trustees are in overall responsibility for the financial health of the hospice. There is a finance committee, sub-committee of the trustees. We meet on a three-monthly basis just reviewing progress. So, sorry. Just go through the other parts of your question again once.

IV: I was asking, were you getting involved in long-term management or policy creation? The main idea of this question was to identify how flat or how structured the governance is. If you have to position yourself and your team somewhere, how would you be viewing yourself; as a contributor to the policy creation or as a person who is receiving his orders and has to meet targets being set by somebody else, by people above you?

IE: I think the trustees are very mindful of the fact that they have professional people working for them now, senior on the professional team of managers so they do consult with us on management strategy and they're happy to take our input into the strategy. An example would be the way we contribute to the strategies. I mentioned earlier, we had a plan which we need to raise £400,000 to add to the 600 that we've been given as a grant. Now, we have investments, £800,000 worth of investments and the trustees said, well, we'll sell some of the investments, which we've done. So I've sat down and said, we thought about it and it's a bad time to sell investments because the market's very low. It's a good time to get a loan because interest rates are very low, if you can get a loan. So we came up with a strategy saying, well, should we be selling our investments or should we get a loan? So we've done some work, on financially what would be the benefit of us borrowing money rather than selling investments.

If we borrow money and we pay three or 4% interest rate, we pay an arrangement fee. So we've costed all of that against our investments to find out how much it would be to service the loan for three years and give our investments time to recover. And we find that if investment go up by 3% a year, we're better off hanging onto the investments because it's the worst possible time. So inasmuch as the trustees set the overall strategy, they're happy to take the advice of the CEO or myself and the professional managers. Most of the trustees are experienced in various parts of industry. They might have worked in industry before and they'll set the overall tone of where the hospital is going. It was their decision, for example, to extend the hospice. But within that then the management team contribute to the overall decision-making process.

IV: Would you like to describe me a typical working day for you and your team? You said earlier on that you were only working two days a week so how are things working these two days and how are things working the other three days?

IE: Oh, I'm paid for two days a week but what I do is I work four mornings.

IV: Ah.

IE: And XXX came up with the idea. I've played around my hours to find what suits people best. I find if I work two days, two full days, then I'm out of the office too much those three days when I'm not here, for consultations, to speak to, whatever. So if I work four mornings I'm here four days a week, if only in the morning, I find that's much better because people can come to me if there's a problem. Then I'll meet them tomorrow morning, okay, not in the afternoon but there's not too big a delay between a problem and coming in with a solution.

As I say, I'm very lucky inasmuch as the staff I have are very experienced and they tell me what to do a lot of the time! So I don't find the work schedule too onerous, to be honest, and it's comfortable, two days a week, and it's helped save the hospice £20,000 by moving down. There are probably things that we would like to do that I don't find… For example, there's a lot of meetings, a lot of group meetings. I talked about the finance group. We meet quarterly. There are other hospices and XXX bank belongs to some having some sort of event or there's some sort of group meeting they want to have. I very often turn those down because I find that takes up a day of my week and unless I can show I get benefit from them… I think if I worked five days a week I would get more involved in that side of things.

But we haven't seen that as a disadvantage yet and, to be honest, I do do some work at home, which everybody does, I think. When we do the budget, which is just after Christmas, that's quite a busy time. I start making some… I'll actually come in three days that week. It's totally up to me. What I want to do is do the job in as little time as possible for my own benefit and for the hospice's benefit because they don't have to pay the cost.

IV: I see what you mean.

IE: Just to add to that, we find that we, three days of work, there's only one of those who works full-time. The other two have this part-time in/out sort of basis. That's quite common in the hospice movement because you want the expertise but you don't want to pay the costs. You'll find that when people talk to you about the fund-raisers there are three or four people there who work three days a week or two days a week or four mornings. It's very flexible working, it's what suits the individual and what suits the hospice.

IV: I see. Are you aware of differences between the way your team or hospice is working and the way similar teams in other hospices are working?

IE: Again, there's a couple that have come up. As I say, we adopted agenda for change where we pay national health rates. Some, a lot of hospices haven't done that. What else can I think of? Can't think of anything offhand, how other hospices work dramatically different to us. You find most hospices have some sort of fund-raising arm, whether that's part of the overall… And when I've been to one or two meetings I've found that they have, in their shops they'll have part-time people or volunteers only. Each of our shops has a professional manager so you'll find each hospice is in a different stage of development, I think, and they've got slightly different ways. The overriding priority for everyone is to reduce costs and raise as much money as possible but some of them have done it by sticking with the volunteer route. Others have decided, like ourselves, to have a mix of volunteers and a mix of professionalism and some have gone seriously professional, like the really big organisations; British Heart Foundation and people like that have quite a big set-up.

IV: Okay. I'm going to ask you a few things now about performance measurement and it will cover both your own team's performance and the overall performance measurement techniques that the hospice is using. Are we…? Do you have any particular way of measuring performance for your team and for the hospice in general and if yes, is it possible to describe it?

IE: We do have a key performance strategy. It's probably, the HR lady's probably the best person to present it. We have appraisals each year, we are appraised and we set… not so

much targets. It's very difficult in finance to have a target because basically, because of the nature of what we do in finance, we want to... We want to do the accounts, we want to do it properly, we want to do them accurately but they don't fundamentally change from year to year. The nature of what the three ladies do, for example, is the same.

As I say, we produce reports and we'll do ad hoc exercises to look at certain areas of finance but beyond that and beyond making sure that we have sufficient cover… Each of the ladies, for example, learns various aspects of the other lady's job so that we're not too compartmentalised. The hospice in general; our performance is basically tasked to not make a loss. We don't want to lose money! We want to keep tight control on cost so the CEO's priority with me is to make sure that we're on top of them and we do that with monthly reports, comparisons against budget. That kind of man agreement's going on all the time. The budget exercise is very important because that's when you look at your strategy for the new year and you've got what have you done right, what can you do next year and what's the financial cost of that?

We're currently looking, for example, at security, initially that we pay £50,000 for overnight security at the hospice. We're looking to see whether we can avoid paying this and change the system so we have a canvas on site, we have lockdown on any part of the areas. So we're considering different areas. We've also done some work on the budget. Insurance, the cost per bed, what it costs us to provide a bed, what it costs us to provide outpatient therapy for each patient for each day, for each hour, whatever. We've done some work on that and we've come up with… I can give you a copy of the work we've done on… We reanalysed all our costs and come up with a… I think XXX has the copy of this. It's something to take away and look at.

They are aware of this because one or two of the PCTs are going to payment by results. They want to, instead of giving you a grant, a quarter of a million pounds as they do normally, they want to say, well, how many patients do you treat a year, we will give you £500 per bed per night for the services you provide, provided they're fully used. We know our bed occupancy rates. We know day therapy attendance rates. We allow for three days of day therapy and two patients per day, that kind of thing. So we've done some work in that. It's early days yet and we're hoping to come up with a model that we can perhaps pass to other hospices that we know locally. So now that we've done this, how do you compare…? Since the early days, we covered rates, obviously. We're not sure of how did we recover our costs or add new costs, how did we apportion those over the various services we provide? That's very much argumental, you know, arguably could be your IT costs. We come up with the idea of 50 computers for 50… These computers take up a 50th of the IT costs, those kinds of

things. So it's cost recovery rates we're looking at now and finding the best way of apportioning those costs.

IV: We will move now to inter-professional relationships. I don't know whether it will be applicable but is your team working closely with other teams, other professionals within the hospice?

IE: Not the three ladies who work for me. Basically, they maintain the accounts. There is a monthly management meeting with our managers to make sure that we're all aware of what's happening in other areas of the hospice so that I'm not completely behind that box. I find out what's happening downstairs with the patients and those kind of things. So there is that exchange of information.

IV: Do you believe that your statement that you referred to working different days is a little bit more important with what is happening?

IE: I don't… I think that we are quite involved. Don't forget, we're quite a small organisation. We only have ten beds on this site. Everybody knows what's going on. There are only something like a dozen people in administration, including the three ladies I have. It's more a case of a big organisation where you need to develop a system for that exchange of information. It happens naturally. It happens in people knowing what's happening down on the floor. It's just not an issue, really. Sometimes we worry about the link between ourselves and the trading company because they're off-site. They're in a different set-up, they're in St. Helen's but even there, there's plenty of personnel each day recording. They take the donations that we receive and we say what's been going on here. The lady I work for, her husband works at the trading company so there's that constant… It's not a big organisation, it's not an issue.

IV: Do you think that the voluntary nature of the hospice is assisting the interaction of managers?

IE: Sorry. Can you just repeat that question; the voluntary nature…?

IV: The voluntary nature of the hospice – you have covered this question already but just to get some things on there. The voluntary nature of the hospice movement; is it assisting your interaction with other members of the hospice? You have private sector experience. How is [unclear] here compared to there?

IE: I think you've got to tread carefully because you're dealing with volunteers at times. And in the early days of this hospice everybody was a volunteer, there were very few paying

people and as more and more employees have come into it, you have to be careful that you don't get a sense of resentment from the volunteers. You have to be very conscious that they're giving up their time and not being paid so that if they're working along… For example, we're currently doing an exercise on Gift Aid. We're not happy with the level of Gift Aid we've had so we're chasing [unclear] donations we've had in the past which haven't been Gift Aided. We've got a lady who comes in to help us on that, volunteering and the mail shots and what have you. And I think the professionals who are working with the volunteers have to be grateful for their contribution. They have to be forever saying to the volunteers how big a difference they make and how valued they are and not forget that they aren't being paid, we are.

Because we are being paid. What we try and do is work various of the work we do in the hospice, even something like the canteen ladies; they will have one or two volunteers who come to help. We have volunteer drivers so they're not on the clinical side of things. We have volunteers in the shops working alongside paid professionals in the shop. It seems to work very well but sometimes there can, if you're not careful, there can be resentment that, you know, you're being paid to do this, I'm not. So you have to be grateful for any contribution they give and very often they're making that contribution because they identify with what the hospice does and they may have had a relative through the hospice and want to give them… So we're very grateful for that.

IV: That looks good. Are there any equivalent policies in place when you're hiring people? I don't think that here you had new people in your team lately.

IE: No, not each time. We have a professional HR lady works three days a week and there is a recruitment policy. I don't know if you were to speak to her… But we have to follow normal procedures for employing people whenever we do, there has to be an interview and an application form. We very often do CRB checks because we're working with vulnerable people so anybody in the hospice has to have a CRB check, who comes in as an employee. There's a whole raft of recruitment information that that lady could give you as to how we go about it but personally, I've never been involved in that.

IV: Are you aware of people looking for specific skills and how would you see the recruitment market for the hospice in this area? Is it comparatively easy to find the skills that you need or not really?

IE: The main area of recruitment probably be nocturnal staff and as I said, we pay rates similar to the NHS which stayed with what they call their agenda for change, their pay scales. One or two hospices that haven't done that pay slightly less because they pay what

they can afford to pay, basically. We've decided to stay with agenda for change because we don't want to have that issue, we want to be able to recruit. We want to be able to offer the same rates that the NHS can issue the same pool.

We want to be able to, when we recruit, make sure we get the same talents and the same abilities that the NHS have and not take on a second tier of clinical staff. In other areas, fund-raising is always a… We had three professional fund-raisers but there's no professional qualification for fund-raisers. You can't say, you know, you must have your fund-raising degree so when you recruit a fund-raiser it's very much a case of that person's personality, that person's enthusiasm has to come out. Unless you're picking up somebody who's worked at fund-raising before, they're very often people who've never done fund-raising who want to try – and they're very often very good at it because they're enthusiasts and they've got a lot of ideas. But there's no – like accountancy, you can say, are you a qualified accountant? Yes. Then you're accepting a certain level of person, you know that they've achieved certain things in their life. There's one or two jobs where – canteen staff, for example, they have to have hygiene certificates and everything like that. No, I think it's those kind of issues; depends on the job you're trying to fill. We don't have difficulty recruiting people.

IV: That's good. Let's move on to the last section of the interview now and it is [unclear] what they would like from you. Did you enjoy the conversation and would you like to make any suggestions, any weak points of the interview process?

IE: No, it's been very interesting. I've either gabbled on and said too much… Basically, no. I think you [unclear] but some of the areas like the HR, you'd be better speaking to the HR lady. The trustees; it may be if you could speak to one of the trustees, that'd be a great idea, to find out what their feeling is for how the hospice has been run, how it's movements were, and speaking to the CEO and speaking to other people so you'll get a broad feeling. It's more than I expected, actually. I didn't think it would be this detailed.

IV: Thank you. Any areas of interest in your planning maybe of a little bit more related to your professional expertise that you feel that were not covered in great depth?

IE: No. I think you've given me the opportunity to explain… Because accountancy is such a structured profession, the accounting role in the hospice is identical to the accounting role in industry. You do a budget, you do the monthly reporting, you do the annual accounts and you can do that with any organisation as an accountant. You know this yourself. So no, accountancy's very much the area where my speciality is and obviously that's well covered by what you've asked.

IV: Right. Would you like to participate in another interview in the future?

IE: Yes, I'm quite happy to.

Interview with the Hospice Accountant of Hospice D:

Speaker key

IV: Interviewer

IE: Interviewee

IV: Before we will start with the interview itself, I will have to let you know about the ethics and confidentiality policy of the University. You can be assured that any kind of information you will provide within the interview is going to be kept confidential, whichever information out of it we publish is not going to carry your name or the name of the institution you are working for. If at any time you find out that you don't feel comfortable answering a particular question you can just say that you don't want to answer this question, or if you feel at some point that you want to interrupt or stop the interview process, you can just feel free and ask for that. Do you feel comfortable with that?

IE: Yes.

IV: Very good. So, would you like to tell me a few things about your background and your involvement with the hospice movement?

IE: Okay. Well, my background, I have a degree in economics and then I took all the accountancy exams in Belgium. I part-qualified in Belgium because we came over to this country. So, I carried on… I worked for Coopers & Lybrand in Brussels before coming here and I got a transfer to Liverpool office here as an internal auditor and I've worked in auditing for the last few years. I also was a tutor in a sixth-form College for seven years and then I went back to accountancy about 12 or 13 years ago anyway and I started working for the hospice here. This is my first job outside of practice… well, accountancy practice and I've been here for five and a half years.

IV: That's interesting.

IE: Yes.

IV: What was the motive for you?

IE: What was the... sorry?

IV: The motive? Why did you start? Why did you join the hospice movement?

IE: Well, I have a few relatives who've died of cancer and I've heard a lot about Hospice D. In XXX, when… We've been living here for about 20 years and one of my friends and neighbours was the accountant here and she said she was going to leave her job for another job. She'd been here for seven years or something and she said there's a vacancy, if you want to apply, and so I did a lot of research because when I'm applying for a job, I really just and anyway came for the interview and got the job. So, I was very pleased about it.

But, to be honest with you, I never realised… Because I'd never been in a hospice before, I never realised what kind of caring environment this is. It's not like a hospital at all and I must admit the ethos of the hospice has really grown on me and I'm very proud to work for this hospice. It's my best job ever. Really. I could get much better money elsewhere but I really like my job here. I'm very proud of it. And I have a lot… What's good also is that the hospice movement is not… We are not competing against each other. All the hospices are trying to help each other, in the Northwest anyway, and I chair the Northwest Finance Group for all the Northwest hospices and we exchange an awful lot of information on a daily basis.

Like, for instance, today I was asking for a job description for an Information Officer and so I just sent it around the Northwest and I get whatever I get back. You know, I've had about three job descriptions back so far that I can give to her as examples, so to help her. So, we help each other a lot. Like there's no competition for fundraising. So, that's really useful because you can feel a bit isolated because basically you have nobody else to talk finance with, apart from the Treasurer, if you see what I mean. But, of course, the trustees are non-executive, so, you know, they don't have a hands-on approach at all. I'm here on a day-to-day basis and I've got to get on with things and, you know, you try also… You're always aware of finance, so you want to find information as quickly as possible, so the best is to ask your counterpart in other hospices. So, that's what I do.

IV: That's absolutely true. So, ideals within the hospice. Have you noticed any changes in the ideals and the orientation of the hospice movement during this period of time? You told me that you have contact with professionals from other hospices, with accountants from other hospices. If you had to see not this hospice but all the hospices, do you think that nowadays they are exactly what they used to be a few years ago? Can you see any changes?

IE: From the financial point of view… Is that what you're asking me, yes?

IV: Yes.

IE: …I think we're all going through the same issues or problems but not at the same time. Sometimes, because our funding also depends on the PCT, you know… I'm sure you know. I'm also a non-executive of XXX Primary Care Trust. I'm the only chair there, so I've got a foot in both camps. But because we're all dependent on PCT funding and various PCTs are not at the same stage in the country, hospices will, if you like, live through or experience the same, for instance, funding decree but at various times, not all at the same time. We're all quite different but we experience the same trends at different times, if you see what I mean. So, at the moment, of course, the problem is the hospice is in a crisis, the government has run out of money, they've got to make savings in the NHS, so the NHS passes on the financial cuts, if you like, through the PCT. They pass it through to the hospices, so we're all in the same boat at the moment, if you see what I mean. It's…

I mean, the funding issue is a national issue and should the spending be provided for the care of the dying or should it be funded by… charitably like [unclear] and, more to the point, children's hospices are… don't receive any funding from the Department of Health, which is unethical, you know, so, you know… So, I think… I mean, there is definitely a hospice movement with Help the Hospices up there on top but I think also that the Northwest hospice movement is very strong. That's what other hospices from outside seem to say. We seem to stick together and we're quite homogenous. We have regular meetings, whether it's for HR or Finance or with chairs and the chief exec. So…

IV: That's very good. Can you see the hospice movement adapting a more professional view of themselves instead of being amateur and like a lot more on a voluntary basis? Can you see it becoming really more of a professional issue?

IE: Definitely, yes. Absolutely. I think… I mean, to compete with other charities who are also getting more and more professional, we've got to, definitely, and get more qualified people and fulltime people, definitely, in all areas.

IV: How will this professionalism affect people's attitudes when they hear about the growing hospice movement?

IE: Well, I think it works both ways. I think as an employee I think it helps you to work better and more efficiently since you work with more… better qualified people or more professional people. It makes you also more proud to work for this institution or organisation. From the outside you are seen as a more efficient organisation also. Donors,

for instance, they see that we are not squandering their money and that we are using it efficiently. So, I think it's a win-win situation, really.

IV: If I were to ask you about the main challenges of the hospice movement…

IE: The main…?

IV: …challenges, like problems or issues, that the hospice movement as a whole sector is facing now or it will face in the near future, which ones would you mention as potential challenges, and I'm looking for both internal to the sector, like maturity risks or recruitment problems, governance of the sector, centralised with the hospice, for example, given a lot more power or decentralised. And then there might be these internal possible challenges. There might be a number of external challenges, like government regulations, financial pressures, ageing of population, demand for more services in palliative care. Which do you consider to be the main challenges that the hospice movement in this country is going to face within the next two to five years?

IE: It would have been good to have the questions in advance. I think people's expectations are rising and, for instance, the NHS now has dramatically reduced the waiting times in the last two years. They are trying now to boost the quality of care. The quality of care in a hospice, for instance, has to be excellent and everyone, of course, would like to have this quality of care but… if it's affordable or not and can the country basically afford to provide that to everyone or should it funded charitably?

Now, in this hospice, we mainly deal with cancer patients. Now, why not deal with also other patients who are also at the end of their life and maybe who are suffering? So, I think, you know, if you open the palliative care to other patients than cancer patients, I think that there's going to be a huge funding problem. But, on the other hand, why not? Given expectations are going to, you know, be… either have to be managed or they have to be disappointed. So, to me that's one big problem or challenge for the future. The risks… I mean, you talked about management risks and so on. I think, you know, risks would have to be managed and wherever you are, in whichever institution you are, you always have to manage the risks that, you know, you are going to face and… I mean, at the moment obviously one of the big ones is the economic climate because it affects our funding so much. That's it, really. I mean, if I had more time to think about it, I would probably say a bit more.

IV: Based on what comes up in your mind. How do you think the hospice circle should respond to these challenges?

IE: Well, interestingly, I'm just working on the strategy at the moment, our four-year strategy, and you have choices to make with the assumptions that you take for forecasting your income. Well, you are being restricted to what you can afford in the future and everything has got an opportunity cost. So, if you decide to, for instance, have extra nurses or extra therapists in the day unit, well, maybe that's so may bedrooms that we won't be able to fund in the future if we decide to have… For instance, we have an issue with the ambulance service. It's slow etc., so the patients can't come here when we want them because it's not an emergency.

So, we are thinking about maybe buying a vehicle and, you know, having… and staffing it, basically. So, that would come at an opportunity cost. So, you've got to decide which direction you go in, either you open the doors to more people or then you increase the care you give to a smaller number of people. It's a question of a decision from the Board with the trustees, I think, and they need to be aware of, I think, what is required in the country, what is required very locally and what other hospices are doing as well so they don't… they're not sort of… they're in sync with what other hospices do.

IV: Do you feel that board or an organisation like Help the Hospices would help co-ordinate the sector better or do you think that being secluded would be a very good idea?

IE: It's interesting because I think on the one hand Help the Hospices can help the hospices, obviously, with some… putting pressure on the government in certain areas, for instance, for us. So, each individual hospice doesn't have to make that better because it's impossible, we don't have the resources. So, that's good. But, on the other hand, we are very local and the local people want to relate to their local hospice. They don't really relate to Help the Hospices. So, it's got two levels, if you like. On the national level we… it's good to have an organisation like Help the Hospices to push and put pressure on the government to whatever – have more gift aid, scrap the VAT or whatever, or be able to reclaim all the VAT from, you know, all our expenses or that type of thing. But, on the other hand, this industry don't really care about that. They care about what goes on here in Warrington, they don't care what goes on in London or wherever or in Birmingham. So, there are two levels and I think at the moment it's working well but I'm not 100% sure that if Help the Hospices launched a campaign nationally, the people in XXX, for instance, would respond to it.

IV: I see. How do you think these challenges are going to affect Hospice D? And you told me already that there is an action plan in plan for here.

IE: Strategy, yes.

IV: What would you include there in order to deal with the challenges you mentioned to me earlier on – financial pressures, services? What would you propose on these issues?

IE: Well, what I'm doing at the moment is the assumption of funding and explain what I've included in my costing and I think the best thing to do is to try and minimise the risks that are present in the strategy, for instance, and one of them if, for instance, to go and see our PCT and try and put on paper, you know, three-year agreements, for instance, and that's what's going to happen next week on Thursday, for instance. So, from Thursday onwards I'll be able to… instead of having assumptions on that particular line, I'll be able to put some real figures because we know that we've secured that line of funding, for instance. Once we've done that we can decide on… You know, again, I said, you know, we'll have to decide on which developments we want to go for and everything will have an opportunity cost, so from then on we can… It's really trying to narrow… Because people don't like uncertainty, so it's narrowing the uncertainty and trying to manage it and manage the risk.

IV: That's good. A few things now about your role and your team description? Would you like to talk to me about your role and mainly about the role of your team? Is there anybody else working with you or is it just you in the accounts department?

IE: No, the lady who was in my office is my fulltime assistant and then I rely on a whole lot of volunteers to do the bookkeeping for the shops, for instance, and a lottery bookkeeper also and I just rely on… Yes, we're very short of resources, if you like, in the department. I'm very lucky to have very good people who I can rely on but it's a lot of volunteering hours.

IV: Are you personally…? Yes, you are but how are you or your team getting involved in the process of target-setting, long-term management and overall policy creation of the hospice?

IE: Well, at the moment I'm right in it, you know, with this strategy document I'm helping the director to write. I attend all the council meetings, so I'm always aware of what goes on and I'm there, obviously, to help them to give them information… financial information and to help them take decisions, basically. So, I suppose although I don't take the decisions, I'm always… my opinion will be taken into account if they ask me questions during the meeting.

IV: Who else is involved there? Is it the doctors, is it the nurses, is it…?

IE: Yes. The council meetings… So, the trustees are chosen for their experience and qualifications. So, we try and have a wide variety of experienced people in various fields.

Like we like to have a lawyer or a solicitor, of course we have two doctors, we have a nurse, we have two accountants, we have a or a priest, we have two people from the NHS… I'm just trying to think… We have a police officer… an ex-police officer who's just retired, somebody from the council… We try and have various organisations involved as well and at the meetings we have a senior medical officer, the matron, myself plus whoever else needs to be present. One of the sisters, so one of the nurses, from either the inpatients or the day units would be present also.

IV: That's very good. Would you like to describe to me how your team is organised and managed? Like you told me that it is you who makes the decisions .and then it is one fulltime assistant plus a number of volunteers. Now, when it comes to strategy or decision-making, what I'm meaning with this question is with the doctors, for example, usually, even though there is a medical director or there is a which is exchanging ideas and various ideas are getting for policy creation. What about your team? Apart from you, is there anybody else contributing to the strategy development?

IE: My assistant is very good with payroll, so she's the, you know, payroll person. So, she'll be able to cost things but she won't take part in the policy-making or in the strategy. So, I'm the only one, really. Obviously, you know, there's another two qualified accountants on the trustee board as well.

IV: Are you aware of differences between the way your team in Hospice D is working and the way similar teams are working in other hospices?

IE: My team in finance or the management team?

IV: Or you as a financial professional here. Like you told me that you are getting involved with.

IE: Yes.

IV: Is this or are there hospices that use an accountant, a bookkeeper as an accountant and he's not much involved with the strategy of the hospice?

IE: Okay. Well, it depends on who you're talking about because we… All the hospices are so different, even the management structures in the… The internal management structures are very different. So… But, yes, I think my equivalents, if you like, are involved in the strategy, of course. You know, you've always got to financial… Everything has got financial implications. So, yes, they are also involved and… But we organise the departments very differently and, of course, I inherited… I mean, I came here five and a half

years ago and inherited the department how it was and, you know, it's not really up to me to start changing everything. So, the hospice, as it is at the moment it's like the titles are very… well, we have certain titles whereas the other hospices, they have a director of this and a director of that and it's just a… it's very local, if you like. Each hospice is run differently. But, of course, yes, we all have involvement in the strategy.

IV: When it comes to performance measurement, are you using any particular methods for that? And I will not only ask you about your team, I will ask about the entire hospice. How do you measure performance here?

IE: Well, to be honest, that's an issue that needs to be addressed. To me there is not enough performance management. We are a very nice and caring organisation but sometimes I think some strict guidelines are missing and we could do with better… I can't find the words but harmonisation and treat everybody the same. You know?

IV: The standardisation of activities or…?

IE: Yes, activities or, you know, performance management and return to work interviews, for instance, sickness, absence, that sort of thing, the management of all that.

IV: Are there any records of that or…?

IE: Oh, yes, there are records but it's just the way various departments manage these issues that are different. So, there's no standardisation, no harmonisation, I feel.

IV: What makes it difficult to measure personal performance in the hospice? Do you think it's difficult or do you think that it is just people never cared about it, so it's just not in place?

IE: No, I think for… What's difficult to assess, I think, is the amount of care that you give somebody. How can you assess the amount of love that's given from a nurse to a patient, for instance, or the amount of warmth? You know, that's very difficult to assess. I mean, you can measure the time, for instance, that a nurse has spent next to a patient but is that a good measure? In finance, of course, it's much easier. You know, it is how many reports have you produced and have you met all your deadlines and have you signed all your returns and so on? So, it's easier because, of course, we deal with figures mainly rather than people. Have all the employees been paid at the end of the month? Whilst I think on that side it's… On the nursing side or the medical side it's more difficult. How many errors have doctors made? I don't know. Were their errors or not? Because these patients are at the end of their life anyway, so, you know, should they perhaps try to prolong their life

longer or not? So, I think it's difficult to measure the performance of the staff in an institution like ours.

IV: Would you suggest any specific topics that should be taken into account when somebody is trying to measure performance within a hospice? If you had to… If you would be asked tomorrow to go and make a [unclear] table of key points for performance measurement within the hospice, what kind of things would you include there?

IE: I think from my point of view, from a financial point of view, of course, it's meet the budget because we can't run at a loss, for obvious reasons. Maybe something like the number of day unit attendances or the number of contacts between therapists and patients in a day or in a week or in a month or whatever. The number of patients that went through the inpatients unit, the length of stay of patients because we've got to decide whether we are a specialist palliative care unit or just palliative care unit or continuing care etc. There are various categories. Number of times the trustees meet I think is important. Are they aware of what goes on or do…? They're not hands-on but they should be aware of, you know, the challenges and so on, so health risk management and so on. Also maybe the amount of contact with other organisations that work in… that work along us, for instance Social Services or the PCT or the MacMillan nurses or other hospices to see what they do and comparing… Be aware of what goes on around us. Be aware of your environment. That's what I would do as a measurement also, as a KPI.

IV: Were there perhaps more things like how would you measure the performance of a doctor or a nurse or…?

IE: Let me think about that one. That's not my area. I know what kind of performances they use in the NHS but this is quite different, in a hospice. And, of course, patient satisfaction is difficult to get because of the nature of our patients but I think we could get patient satisfaction surveys or, you know, questionnaires or asking people if they are happy. Especially it would be much easier, of course, in day unit rather than inpatients but, I mean, some patients… They don't all die here, some go home, so they could give some feedback. I think that would be a good way of assessing, you know, nursing or medical care.

IV: Are the members of your team working in co-operation with members of other teams or are they primarily working independently?

IE: In silo? No, I mean, we've got to work together. I mean, when you pay somebody, they've done some overtime and there are questions and, you know… I mean, there's always people coming around in our office for the payroll, for instance. There's always

something going around or, you know, such and such has changed or about and didn't get her money last month and so you… There are a lot of contacts with other departments, well, especially from my point of view recently, especially with the strategy. I went to talk to all the departments. We were talking about this, well, sort of patient transport service because we are not happy with the ambulance where I've got to assess how many… who's going to man it, who's going to drive it, what kind of qualified person do we need on this vehicle, what kind of vehicle and so on, how are we going to depreciate it and that sort of thing? So, we've got to talk to everyone. There is a lot of interaction.

IV: Do people like it that way?

IE: Yes, I do. Yes, I think it's very… Yes, I've done working on my own, you know, and I find it very boring with figures. I mean, it's nice to be on your own and quiet for a while but I think it's very useful to talk to others because you… I think you learn much more by interacting with other strangers rather than being in your office on your own or reading e-mails or whatever.

IV: Do you think that the voluntary nature of the hospice movement assisted in decreasing the impact of inter-professional conflicts?

IE: Say that again.

IV: With different people from different teams working together there might be some sort of frictions, such as the problems between them or some lack of understanding but you describe the teamwork in this place as a very good thing which works very well. Do you think this goes with the nature of the work, goes with the voluntary basis of the hospice movement or not?

IE: I mean, don't get me wrong, we don't always get on. We don't always agree. But I think at the end of the day probably because it's such a place we're all proud to work. We think about what are we here for first, well, we're here for the patients, so we've tried to do what is good for the patient or what is better for the patient first. So, we take a decision in… with the patient at the forefront of our thoughts, if you like. So, yes, I suppose working for a charity is probably… will help. And when you see how… It's very humbling to see all the volunteers giving their time or money or expertise or whatever for free. It's very humbling and you feel… well, if you're, for instance, upset or whatever, you think, well, look at them, they are giving all this for us, we better get on with it and stop worrying about myself and you get on with it. I think it helps.

IV: What if hospices will adapt a more professional approach? Do you think that performance will get better or not that good with regards to inter-professional teamwork?

IE: I think it can only be a good thing. We do have issues, though, with the fundraising for shops, for instance, because all our charity shops are run by volunteers only except one and it's a furniture shop. Because you need lifting, handling and so on, we decided to employ people there, so have a more professional approach, if you like, and that created a lot of friction but with time and explanation…

IV: Friction with who?

IE: With the volunteers because they don't want to spend any money on wages in the shops, you see. They want all the money to go for the hospice, not in somebody's pocket as an employee. But, I mean, you can't run a furniture shop just with… I was going to say have the same volunteers that would go in another shop because you've got the lifting. There's health and safety you've got to bear in mind. Yes? And also we… I mean, the premises are much larger, much more expensive. You've got to heat the premises. Everything is more expensive in that shop because obviously furniture is bigger than garments or clothing.

So, we need a van to transport all this furniture to and from the donors and to the people who've bought it. So, you need something. Things like that created a lot of friction. But I think if you can prove that the investment that you make by, for instance, having more paid staff, it's paying off because the turnover is higher and the traffic is higher. But then you need professional people to be able to deliver that. I think it can only be a benefit to have more professional people or better qualified people.

IV: Now let's look into recruitment. Would you like to give me some information about your recruitment policies and your criteria for hiring new people, either of your team in the accountancy department or the hospice in general?

IE: No, I don't think I could talk very articulately on that. I'm… I know in the near future we're going to recruit somebody, an information officer, my team but I've never recruited so far, apart from volunteers, so I can't really… I've never recruited anyone at the hospice, so I'd rather not… I don't know. Sure, we've got a recruitment policy, it's all written down and it's in the staff handbook as well but I'll get to that when I'm involved in a few weeks' time.

IV: Would you suggest that the recruitment market is competitive in this area? Are you finding it easy to get people in, like…

IE: Yes.

IV: …accountants or doctors or nurses? Do you think it's easy or do you have problems with competitive organisations?

IE: We've been struggling to find a consultant in palliative care because there aren't that many of them. So, really they call the shots but… We're getting there but it's taking a long, long time. So, that's a bottleneck. Nurses, no problem. Having said that, I mean, XXX is a sort of heavily… densely populated area but… with lots of jobs. We found in the hospice there's a very low turnover and when we want to recruit we usually find a lot of very good candidates, so… because of the reputation of the hospice.

Not all hospices are in the same position, I know, because, for instance, hospices more in the Lake District where the population is much less dense, it's difficult to find, for instances, a specialist in, I don't know… specialist therapists, for instance, or… You know? Or more towards Yorkshire, I know they had difficulties in recruiting a particular kind of person but I can't remember what. So, we… No, I don't think we've ever had any problems, except with this consultant.

IV: Now I'm going to ask for some general feedback about the interview process itself. Did you enjoy the conversation?

IE: I did, yes. Yes.

IV: Would you like to indicate three strong and three weak points of the interview process?

IE: One, I didn't know it was going to be an interview. I thought I would be showing you things but that's okay. I didn't realise you were going to record me. I… Depending on what you want, of course, but I think it would have been helpful to have the questions in advance. Otherwise very professional, very professionally prepared, obviously. I feel at ease, no problem, thank you. And I'm just very happy to help and I'm very proud… As you can see, I'm very proud to work here and I'm happy to help anyone. If you want to contact me, that's… you know, with pleasure...

IV: Thank you.

IE: …and I'll try and do my best.

IV: Would you like to suggest any areas of interest relevant to your profession that you feel were not covered in adequate depth?

IE: Again, I could have done with that question before. On the one hand I think the third sector is treated with preference to the industry, if you like, because we can get benefits and that sort of thing. Yes? On the other hand, I feel we're penalised in various areas, for instance, the VAT. So, if I could campaign for it, you know, I would campaign for total VAT input claim back and that sort of thing for hospices because, I mean, we have over £2 million expenses every year and £25,000 every year go… are lost in VAT that we can't claim back. So, it's a lot of money, really, I find. So, differences of treatment, you see, between charities and the industry. I'm sure once you've gone, I'll think, gosh, I should have said this, that or the other.

IV: Any other improvements you would like to suggest on the approach or the content of the interview?

IE: No, it's fine. No. How did we get to know you? Is it through XXX?

IV: It is… Yes

IE: I see. Right, okay.

IV: Thank you very much.

IE: You're welcome.

Interview with the PA to director of Hospice D:

Speaker key

IV: Interviewer

IE: Interviewee

IV: Before we will start with the interview itself, I will have to let you know about the ethics and confidentiality policy of the University. You can be assured that any kind of information you will provide within the interview is going to be kept confidential, whichever information out of it we publish is not going to carry your name or the name of the institution you are working for. If at any time you find out that you don't feel comfortable answering a particular question you can just say that you don't want to answer this question, or if you feel at some point that you want to interrupt or stop the interview process, you can just feel free and ask for that. Are you comfortable with continuing?

IE: Yes, that's absolutely fine, yes.

IV: Thank you very much. So would you like to tell me a few things about your own background and your involvement with the hospice movement? This could cover things like what motivated you to get into the hospice movement in the first place. How long have you been with the hospice movement? General information about you.

IE: Okay. I joined the hospice 14 years ago.

IV: 40?

IE: 14, one, four, 14. And I was then in the fund raising department. It was different than it is now because we worked in the old hospice, not this lovely new building. So I worked for fundraising. I was the appeals director's secretary. I worked for him for about four or five years and then I got sideways promotion, if you like, and I worked for the hospice director. And I've been working for various different directors for the past ten or 11 years, something like that. I like working in a caring environment. I don't like working in what I call bricks and mortar. I like people and trying to do my best to help people, like our patients, so that's why I like to be here.

IV: That looks very interesting. So that I have a … with the hospice movement, have you noticed any changes in the ideals and the orientation of the entire hospice movement?

IE: I notice that from this particular hospice, we have got bigger. The care to the patients remains the same and it always will, but we have got more people here, more staff, more departments, and that's because we've got to try and help more patients, so physically we need to get bigger.

IV: What do you think motivated people to join the hospice movement when you started?

IE: Maybe they felt like I did; they wanted to work somewhere where they can care for somebody or do good for people. Working for what I call bricks and mortar, it's very, it's not as friendly, it's not as caring. This place is a very caring place. We look out for each other as well as the patients and their families. We care for one another, and that's a nice feeling, to know you've got that support.

IV: That looks good. So it looks like people, at that time, were adapting a lot more a voluntary approach to their work?

IE: Yes.

IV: Do you think these motives remain the same nowadays or do you get the impression that the whole movement is adapting to a more professional approach?

IE: I think it's a very professional organisation. But I think people want to work in hospices for many, many reasons. Very often it's maybe because they've lost somebody themselves to cancer, so they want to give something back, so they might go back as a volunteer or they might be a paid member of staff; it's about giving back. There are lots of reasons why people want to be involved with hospices, wherever they are.

IV: Do you think that the fact that the hospice movement is entering the maturity stage, is becoming larger, is changing people's attitudes and motives to assist or to volunteer?

IE: No. I think it remains the same. I think people will always want to help, they'll always want to volunteer. And for many reasons, like I've said just now. You know, they've lost somebody or… Nearly everybody knows somebody that's either got a diagnosis or has died with cancer or another of the illnesses. So I think hospices are very special and they'll always be that. And it's mainly because of the people that work here, whether it's paid or voluntary. Yes, we all want the same thing and we all strive to make sure that it stays that way.

IV: That's very good. Which are you considering to be the main challenges that the hospice movement is facing nowadays or that the hospice movement is going to face in the

near future? And challenges can be both internal, like growing too large, for example, or recruitment problems or adapting to centralised approach to the sector's management. By sector I mean the entire, all the hospices of the country. And it can be external as well. There can be challenges because of new regulations or requirements by the government. It might be financial problems or the [unclear] the population of the country or the demands for new services. If you had to give me a couple of internal challenges, possible problems for the future, and a couple of external, what would they be?

IE: I think finance is one. We rely on money from the local population, so there is a risk that we don't get enough money to keep this building going, if you like. We get money from the PCT, but it's a struggle, possibly, maybe in the future as well, that we can keep going. And all hospices feel the same, they have the same problems. But Warrington public are very good. They do support us tremendously, but I think in the background, there's always that little bit of worry.

IV: So you are mainly focusing on finance?

IE: I think we will always get volunteers, we will always have staff. Staff want to come here, every time we put an advert in the Guardian, we get numerous people applying because they see it as a very attractive place to work.

IV: How do you think the hospice sector should respond to the challenge you mentioned, the finance issue? And now we are talking, again, about the entire sector, then I will make another question for Hospice D.

IE: I think the trustees of Hospice D are doing their utmost to try and get as much money from the PCT as it can. In fact, there are meetings next week to try and secure a grant for next year that will ensure that we can pay our doctors and our nurses and all the other staff. So there are always ongoing discussions. You know, it's always in the back of people, you know, our directors and our trustees' minds, that it could be a risk, it could be a problem in the future. But they are on the case, if you like. Does that answer your question? I'm not sure that it does.

IV: You answered the next question, but I will get you back onto the first one. Like, if I was to get you at a managerial level within an organisation which is responsible for the entire sector, for every single hospice in this country, and you've seen from the view that for various reasons, there might be financial constraints. How would you respond to that? What would be your way out of it? Not just for Hospice D, but for the entire sector, the financial pressures.

IE: I suppose you'd have to prioritise. I'm not sure that I understand what you're getting at, but I presume they would have to prioritise what was essential. And an essential, always in a hospice, is patient care and we might have to have some cutbacks on other stuff. But nursing staff, doctors and the ancillary staff and then maybe the key people, make sure, I mean, at most, it's the patient care which is the priority for all hospices.

IV: Now we are going to move a little bit more to your own role and your description. There is no team, but what about you? What's your role within the hospice?

IE: I'm the personal assistant to the hospice director. I also do a little bit of work for Beth, typing that kind of thing. I arrange meetings. I minute most meetings in this place. I arrange things like AGMs and Light up a Life services that we have outside at Christmas. I do correspondence for the nursing staff. I oversee the reception, make sure that I line manage the two receptionists. My role is varied. There isn't a job description for it really. It's very broad, and, basically, it could be anything. I organise stationery, it's all kinds of things. It's really, oh, well, who can do it? I'll ask Jenny, you know, it's like that. And that's nice because I see everything that's going on in the hospice. I have an overview of it all, which is good.

IV: Are you personally involved in the process of target setting?

IE: No. That would be the director and the accountant, who you'll see next.

IV: Are you aware of any methods used to measure performance within the hospice?

IE: We have appraisals and I've actually got an appraisal pack. That measures performances between staff, year on year. I'm not sure that we measure against each other, because we all do different jobs. There aren't two people the same, except for the nursing staff, so there isn't another of me and there isn't another of XXX. But performance is measured year on year. Line managers measure their staff.

IV: What would you consider as the main challenge in the process of measuring personnel performance within a hospice?

IE: Explain.

IV: What makes it difficult to measure performance within a hospice? Like how do you know that a nurse is doing her job or his job the way they should do it or a doctor or fund raiser?

IE: Right. Well, fund raising has targets to meet, so they would, their performance would be to make sure that they raise so much money in a year. My target, if you like, is to make sure that I do the minutes for a meeting, I type them up, they're checked and then sent out at a given time. I have targets to meet that way. I have to arrange meetings, I have targets to arrange all these meetings throughout the year, that kind of thing. Nurses are monitored each day by the sister in charge. So she would, you know, as she's going round she would make, you know, she would check to make sure that nurses are doing things as they should be doing. And it's all documented. But that's how that's obtained.

IV: Let's move on now with the professional relationships. How do you see the cooperation between members of different groups?

IE: Within the hospice?

IV: Within the hospice.

IE: In different departments?

IV: Different departments or like doctors working with nurses. Doctors and nurses supporting the fundraising events. The quality of supporting different groups. I guess there is much of inter professional team's build-up.

IE: There is.

IV: Do you think it works well?

IE: It does. It does here, in this place is does, yes. There's a lot of respect for our volunteers because this place wouldn't exist without our volunteers. We have lots of volunteers out in the shops raising money, in the lottery raising money or here. The doctors work closely with the nurses, and, again, there's a lot of respect. There are boundaries, obviously, but we all work very well together. We can all cooperate, we all help one another. So I don't think there are any difficulties. I mean, there might be some personal issues occasionally, as always, but, generally, I think we all work extremely well helping one another. And that's because it's this place and we know that we have to work together. We have to work side by side, otherwise the care, it would spill out to the care of the patients, and that is the main priority here. Do you understand, yes?

IV: I can see what you're trying to say. Do you think that it is the voluntary nature of the hospice movement which is helping to get people working together in a better way compared to people in a different establishment?

IE: I think the volunteers, as I say, we couldn't manage without our volunteers in every aspect within the hospice. But it's because of the time that they give freely that makes us, sort of, humble, I guess, that they're giving up all this time, so that we can do our job, so that patients get cared for. I keep coming back down to that because that's really what it's all about. But we couldn't work without each other. We need everybody. It's like the pieces of a jigsaw and we all fit together, you know, to make this whole.

IV: That looks very good, that looks very good. Do you think that this good relationship might be affected if hospices approached a more professional attitude?

IE: I think we are very professional here. And I think we've got very professional people that don't overstep any boundaries. And that's how we do it. You know, we've all got our boundaries, but, equally, we work alongside everybody. We all help everybody. We all have a role, but, equally, we can help different departments as and when.

IV: Now I'm going to ask some questions about recruitment. Are there any specific recruitment policies and any specific criteria for hiring new people or new members of different things?

IE: When we decide we need a new member of staff, a proposal is put to our human resources group and then this is agreed or disagreed. When it's been agreed, at the moment, we've advertised for a senior shop manager. I do the recruitment, so I put the advert in the Guardian, Warrington Guardian. I send out the packs, you know, the job description and information about the hospice and that goes out. And then we arrange an interview date, so I arrange all the interviews, and then certain members of staff will be on the interview panel. They'll do that. So there is structure to how we do it and I'm quite involved with the admin side, if you like, and that's how we do our recruitment. But it all goes through a sub-group to be approved.

IV: Are you looking for specific skills and how easy is it for these skills to be found?

IE: Usually we get what we wanted. We recently advertised for a maintenance engineer, and we had 70 or 80 applications, all with good skills. So, of course, you've got to read them all and then you shortlist and interview and, hopefully, you pick the right person. But, yes, we've never not been able to find a person that we wanted.

IV: Is the recruitment market competitive for you or not? How are other people looking to hire people with singular skills? Is this causing you any problems? Not for administration personnel, but when it comes to doctors, nurses?

IE: I think there's probably a shortage of doctors, but, so far, at the moment, we're all right, yes. I think perhaps doctors are not as easy to recruit as other members of staff. Nurses, we're usually okay. It might be the one that is a bit more hard.

IV: Now I would like some general feedback on the interview process itself. Did you enjoy your conversation or would you like to indicate any strong or weak points on the interview process?

IE: No, it was fine.

IV: Thank you. Would you like to suggest any areas of interest relevant to your profession that you feel were not covered in adequate depth?

IE: No, I think you did... I mean, you asked about me, you've asked about the hospice volunteer work, you've covered everything that I'm aware of.

IV: Would you like to suggest any improvements on the approach or the content of the interview?

IE: No. It was well thought out and well structured.

IV: Would you like to participate in a similar interview in the future, if necessary?

IE: Yes, I don't mind, yes. I don't know how helpful I've been, but…

IV: It's been helpful, it is helpful. What I'm looking for is the use of different people within hospices. And the more people I interview and the more hospices that are getting engaged, the more I will be able to structure an overall picture. Thank you very much!