

# Accounting for hospices: Palliative care at risk

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## Abstract

This paper is based on a presentation given at the British Accounting and Finance Association 46th Annual Conference in 30 March to 1 April 2010 at Cardiff City Hall.

This article is concerned with how the Government's end of life care strategy seeks to draw upon the capacity and additional choice provided by voluntary charitable hospices in England. Constructing a hospice financial business model we consider the extent to which the policy intersection outlined in the Governments End of Life Care Strategy between Primary Care Trust (PCT) commissioning and the contribution of voluntary hospices is robust or fragile going forward.

Voluntary hospices, Charity accounting SORP<sup>1</sup>, hospice business model

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<sup>1</sup> The Statement of Recommended Practice (commonly referred to as the SORP) is issued by the Charity Commission and the Office of the Scottish Charity Regulator (OSCR) and basically gives instructions as to how charities are expected to report their activities, income and expenditure and financial position in their annual report and accounts. <http://www.oscr.org.uk/SORPCommittee.stm>. For the purpose of this paper we are employing SORP 2005 updated July 2008

## 1. Introduction

This article is concerned with the provision of palliative care services in England by voluntary charitable hospices. The literature on voluntary hospices is fragmented and scattered within academic and practitioner discourses but collectively this reveals the challenges facing this sector. Specifically, how the provision of hospice palliative 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 (NHS, 2008, 2009).

Hospices have responded to the increased demand for their services (in stay and hospice at home visits, and broader holistic care) by developing and consolidating a range of income to maintain service capacity and meet regulatory demands. However, hospice income is uncertain and often volatile arising as it does from shops, legacies, lotteries, fundraising and financial market holding gains. Hospices trustees, following appropriate governance within this sector, operate with significant balance sheet reserves not only as a hedge against uncertain income but also leveraging additional financial return on invested assets. Reserves are subject to “mark to market” accounting in compliance with Accounting and Reporting by Charities (Statement of Recommended Practice, SORP). The global credit crunch has negatively affected hospices in terms of sustaining donations, predicting the value of legacies and extracting “mark to market” holding gains that, in recent years, all served to inflate reserves held for revenue contingency and longer term capital projects.

Voluntary charitable hospices make a significant contribution to end of life care and increase choice for patients either as in stay patients or through the hospice at home network and this is recognised in the Government’s End of Life care Strategy.

In July 2008, following consultation over two years, the Department 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

[http://www.nao.org.uk/publications/0708/end\\_of\\_life\\_care.aspx](http://www.nao.org.uk/publications/0708/end_of_life_care.aspx)

This paper considers whether the policy intersection between Primary Care Trust (PCT) commissioning and contribution of voluntary Hospices as outlined in the Government's 'End of Life Care Strategy' is founded upon a robust or fragile business model.

## **2. Hospices delivering and extending palliative care provision**

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 (Denice and Walter 1996, Milicevic 2002, 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 (Clark, 1998, Saunders 2000, Seymour et al. 2005, Twycross 2006). 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 of and cost of the service provided by hospices (Finlay, 2001, WHO, 2002).

Patients with motor neuron disease (MND) often require long-term provision of palliative care services instead of just terminal care (Hicks and Corcoran, 1993, Oliver and Webb, 2000). 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. 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 required palliative care services. 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, Foley and Flannery 1995, Stephenson et al. 2000).

Likewise palliative care provision to children differs from care provided to adults both in the nature of needs and the time-period that care is required (Goldman 1994). The aim of a children's hospice is not just to provide terminal care. Relief care to the patient and practical support to parents must be provided after diagnosis and continue even after the child's death

in the form of bereavement care for the family (Dominica 1987, Worswick 1995). In contrast to adult 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 nature of support and care provided requires the services of multidisciplinary care teams, able to anticipate both the practical care provided to the child as well as the psychosocial implications and the financial hardship for family members (Emond and Eaton 2004, Goldman 1994, Thomas 1994, Trapp 1994).

Apart from issues related to the widening patient base in need of palliative care services, demographic factors are imposing additional challenges on the voluntary hospice sector. The population of the UK is ageing such that over the last 25 years the percentage of the population aged 65 and over increased from 15 per cent in 1983 to 16 per cent in 2008, an increase of 1.5 million people in this age group <sup>2</sup>. Given that cancer is a disease of the elderly<sup>3</sup> changes in population demographics will add to the pressure for palliative care.

Although Government funding is one-third of their income hospices integrate into the complex structure of the National Health Service (NHS) and are subject to government policy and regulatory initiatives. Hospices contribute to the provision of patient choice and capacity for palliative care provision and help to ease pressure on acute hospitals.

In 2006-07, hospices provided inpatient services to over 38,000 people and supported over 112,000 people in the community, yet current contractual arrangements with PCTs limit their ability to plan and develop services

[http://www.nao.org.uk/publications/0708/end\\_of\\_life\\_care.aspx](http://www.nao.org.uk/publications/0708/end_of_life_care.aspx)

Analysis of the 2005/06 Hospital Episodes Statistics (HES) indicate that 5% of patients account for 49% of all inpatient bed days. This burden is expected to increase substantially in the future. There will be 18 million people in England by 2020 who will have at least one long-term condition

[http://www.nao.org.uk/publications/0708/end\\_of\\_life\\_care.aspx](http://www.nao.org.uk/publications/0708/end_of_life_care.aspx)

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<sup>2</sup> <http://www.statistics.gov.uk/cci/nugget.asp?ID=949>

<sup>3</sup>

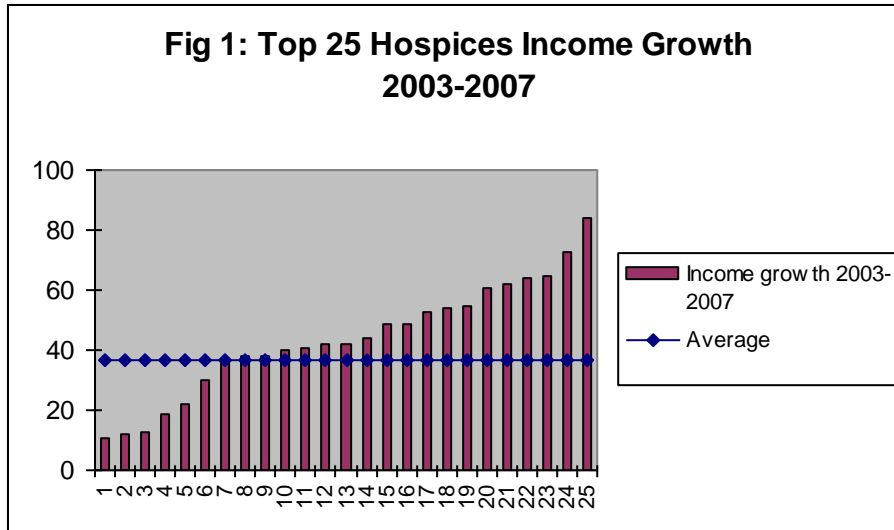
<http://www.statistics.gov.uk/CCI/nugget.asp?ID=1332andPos=1andColRank=1andRank=310>

Our concern, in this paper, is that the hospice “business model” may not be able to sustain its contribution towards widening patient choice, increasing palliative care capacity and reducing the burden on acute hospitals going forward thus testing the policy intersection between the state and voluntary sector partnership. To explore this tension we construct a hospice business model where we extract financials from hospice accounts disclosed according to the Statement of Recommended Practice (SORP) and use this information to describe the income, expenditure and balance sheet condition of hospices in England.

### **3. Hospices: a financial business model**

In this section, we argue that although hospices are charities they share many characteristics of the corporate profit-generating sector in terms of their need to report annual financials and governance. Help the Hospices report the total income of this sector in the UK to be £626 million in 2007 (Help the Hospices, 2009). Our analysis focuses on the top 25 hospices ranked by their total income and we estimate that this group accounts for roughly one-half of all hospice income in England. At the top of the list, we have St Christopher’s hospice receiving £14 million of income in 2007, and at the bottom of our group, we have the Marlet’s hospice with an income of £4.5 million. This means that the majority of hospices have incomes less than £4 million out of which they are providing palliative in-care facilities and home visits within their locality in addition to other forms of support to families. The group of 25 hospices reviewed in this paper are therefore not physically representative of the hospice voluntary sector where there are many small regionally embedded hospices. However, they are a financially significant sample. Aggregating the financials for this group, we are able to describe the underlying characteristics of the hospice business model in terms of trajectory and composition of income and expenditure.

In 2007, our group of hospices raised income totalling £182 million a figure that had increased by 37 percent since 2003 and representing an annual compound rate of growth of roughly 6 percent. This average conceals a wide distribution with five hospices reporting income growth of less than twenty percent and six reporting growth rates above sixty percent (see fig.1).



Source: Charity Commission for Hospice annual report and accounts, various years

Hospices are required under SORP to disclose financial information according to the recommended “Statement of financial activity” and an abbreviated version of this reproduced in table 1. Running down the table charities are asked to report: incoming resources, expenditure, transfers and other gains and losses and running across categorise income, expenses, gains and losses into unrestricted, restricted or endowments. Significantly, hospice annual financial statements disclose incoming resources by type: donations, legacies, shop or trading income.

Table 1: 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 / loss on investments			
<b>Fund balance brought forward</b>			

Summary of SORP 2005 updated 2008: table 3, page 15

<http://www.oscr.org.uk/SORPCommittee.stm>

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 recognising that such information

is likely to be less relevant to the users of small charity accounts. (SORP, 2005 revised paragraph 93)

<http://www.oscr.org.uk/SORPCommittee.stm>

In table 2 we summarise the income, by source, for the group of twenty-five hospices and this shows that in aggregate they are a deceptively stable share of total hospice income (see table 2).

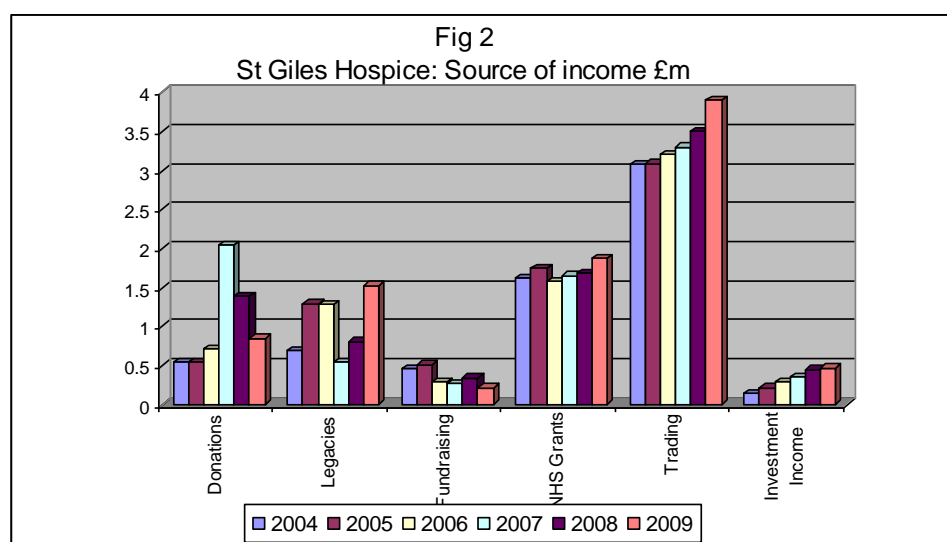
Table 2: Income profile of an average hospice (percent of total income)

	Donations	Legacies	Fund-raising	Trading income	Investment income plus other	Govt. Grants R'd	Total Income
	%	%	%	%	%	%	%
2007	18	21	10	21	5	25	100
2006	16	22	10	20	4	26	100
2005	17	20	9	21	5	27	100
2004	18	22	10	20	4	26	100
2003	19	21	10	20	5	25	100

Source: Charity Commission and Hospices annual reports and accounts, various years

Note: Financial analysis relates to top 25 hospices in England ranked by their income

This aggregate picture conceals significant variability in both the share and stability of different types of income between hospices surveyed. In figure 2, we show the pattern of income received in one hospice (St Giles) to illustrate just how volatile donations and legacies and fundraising income can be.



Source: hospice report and accounts

<http://www.charity-commission.gov.uk>

In this specific case, income from legacies oscillates between £0.5 million and £1.5 million and donations jump from £0.5 million in 2006 to £2 million in 2007 then fall back to £0.8 million in 2009. Legacies are particularly volatile because they represent “lumpy” contributions year on year and under SORP, charities must recognise the value of the legacy, when received not when promised or agreed.

Where a charity receives a payment on account of its interest in an estate or a letter advising that such a payment will be made, the payment, or intended payment, on account should be treated as receivable. (SORP, 2005 revised paragraph 126)

<http://www.oscr.org.uk/SORPCommittee.stm>

The pattern of legacy income is also volatile because real estate and financial assets are also subject to the vagaries of financial markets.

The reliance on donations and particularly legacies means that hospices face uncertainty in their income year on year. As the value of legacies is often dependent on either the property or stock market, there is even more uncertainty about such amounts in coming years.

<http://www.helpthehospices.org.uk/our-services/publications/publications-catalogue/>

The strategy of hospices trustees and managers has been to grow the number of charity shops operated to increase trading revenues and dampen income volatility. For example, one hospice St Peters, an adult only hospice in Bristol, opened its 48<sup>th</sup> shop in November 2009.

The new shop is the 48<sup>th</sup> in our ever-expanding chain and it will add to the £1.5million income that our shops already contribute towards patient care each year.

<http://www.stpetershospice.org.uk/about-us/news.html>

The addition of extra shops secured additional income for hospices and this is generally less volatile than legacies but the acquisition of property exposes charities to “fair value” or “mark to market” gains and losses where the property is an investment.



Any gains and losses on investment assets (including property investments) should be included under the gains and losses on the revaluation and disposal of investment assets. Realised and unrealised gains and losses may be included in a single row on the Statement of Financial Activities. In particular, this approach will be necessary where a charity adopts a “marking to market” or continuous revaluation approach in relation to its investment portfolio. (SORP, 2005 revised paragraph 219)

<http://www.oscr.org.uk/SORPCommittee.stm>

There are wide variations in hospice 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. Expenditure will at times run ahead of income and so hospice trustees do operate a reserves policy as part of good governance and risk management. Paragraph 55(a) of SORP 2005 requires trustees to include in their Annual Report information about their charity's reserves policy and the level of reserves held. In particular, trustees should: describe their charity's reserves policy;

The Running Costs Reserve has been set up because the Trustees recognise the need for adequate readily realisable resources to meet future charitable expenses. In recent years, the reserve was set at the level of budgeted expenses for the ensuing financial year. The overall level of reserves has been depleted over the last few years and the Trustees have determined that it is no longer possible at the current time to continue with this level of running costs reserve. Therefore, for this year the Running Costs Reserves has been set at 8 months budgeted expenditure for the ensuing financial year.

[http://www.pah.org.uk/hospiceinformation/AnnualReport/PAH\\_Trustees%20Report%202009\\_FINAL\\_Web.pdf](http://www.pah.org.uk/hospiceinformation/AnnualReport/PAH_Trustees%20Report%202009_FINAL_Web.pdf)

The Board has reviewed its reserves policy and has agreed that unrestricted reserves, which include the balance on the Income & Expenditure Account together with the designated Future Services Fund, should be a minimum of 6 months' future net charitable expenditure as budgeted for the ensuing financial year.

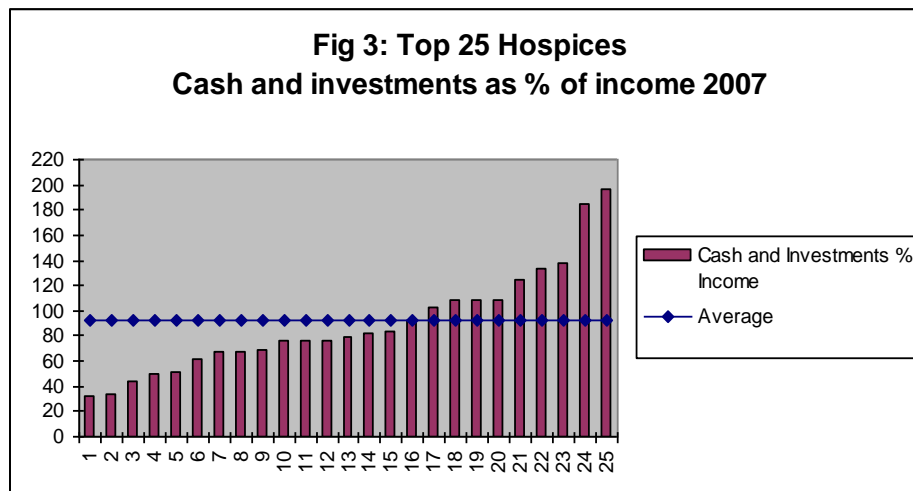
<http://www.stpetershospice.org.uk/files/file/About%20us/report+accounts%202009.pdf>

The Trustees' target is to accumulate reserves totalling £2.0m. Total reserves at the beginning of the year were 56% of the target, which the Trustees consider prudent for the security of the Hospice. By the end of the year this had reduced to 50% of the target of £2,000,000.

[http://www.stclare-hospice.co.uk/pdf/Annual\\_Report\\_2008.pdf](http://www.stclare-hospice.co.uk/pdf/Annual_Report_2008.pdf)

The above extracts reveal a variety of reserve policies set by trustees some are expressed in terms of a number of months of funds available against the anticipated budget whilst others set a financial target. Trustees are required to also report on the financial condition of these reserves in some cases noting that the hospice is above (or below) its target or has revised the number of months it is holding reserves.

Our analysis covering the period 2003-2007 reveals that the value of total reserves in our group of twenty-five hospices increased from 77% of annual income to 93 % of annual income although one-quarter of this group of hospices are running with less than six months of total income held in reserves.



Charity Commission and Hospice annual report and accounts, various years

In the group of hospices surveyed the value of total reserves increased from roughly £100 million to £170 million with the majority of the increase in reserves allocated into “investments” shifting the ratio of invested to cash reserves from 1:1 to roughly 2:1 over the period (see table 3).

Table 3: Top 25 group of hospices investments and cash deposits 2003-2007

Balance Sheet		
Year	Investments £ 000's	Cash and Deposits £ 000's
2007	106,955	62,745
2006	93,491	62,422
2005	75,051	60,147
2004	63,241	58,759
2003	51,505	51,730

Source: Hospice report and accounts, various years

Note: Financial analysis relates to top 25 hospices in England ranked by their income

Invested reserves are managed by investment banks nominated by hospice trustees where the investment portfolio is split between liquid assets (cash and deposits) set to meet income and expense contingency and a less liquid investment portfolio where returns on investment (income and capital gain) are allocated into general or restricted funds / endowments (see table 1)

The Trustees agreed the Hospice's investment policy in 2006. This split the Hospice's total investments into two portfolios: a Liquid Portfolio held in deposits to cover approximately six months running costs and an Investment Portfolio for investment's which are not required for working capital

[www.pah.org.uk/hospiceinformation/AnnualReport/PAH\\_Trustees%20Report%2009\\_FINAL\\_Web.pdf](http://www.pah.org.uk/hospiceinformation/AnnualReport/PAH_Trustees%20Report%2009_FINAL_Web.pdf)

Appointed investment managers are used to manage a general fund and an endowment fund. The funds comprise equities, fixed income stocks and cash. The Investment Committee has given the investment managers the discretion to manage the funds within an agreed risk profile.

[http://www.stpetershospice.org.uk/files/file/About%20us/report+accounts%202009.p  
df](http://www.stpetershospice.org.uk/files/file/About%20us/report+accounts%202009.pdf)

Hospices trustees do tend to allocate a proportion of their financial reserves into equities and alternative (property) funds where risk is higher than simply holding cash in a deposit account. Holding gains from trading investment portfolios provide additional financial income and boost reserves that are accumulating to replace or update facilities. However, holding gains can turn into holding losses when capital markets turn down.

Table 4: An illustrative hospice investment portfolio

	Market Value	% of total value
Equities	2,929.5	46.8
Fixed interest	2,254.3	35.8
Alternative Investment funds	1,029.5	16.3
Cash Accounts	65.7	1.1
Total portfolio value	6,299.0	100.0

<http://www.pilgrimshospice.org/filesystem/Documents/About%20us/Reports/PH%20in%20EK%20acs%20%20ye%2031%20March%202009.pdf>

Note: This table summarises data disclosed on page 6 of report and accounts

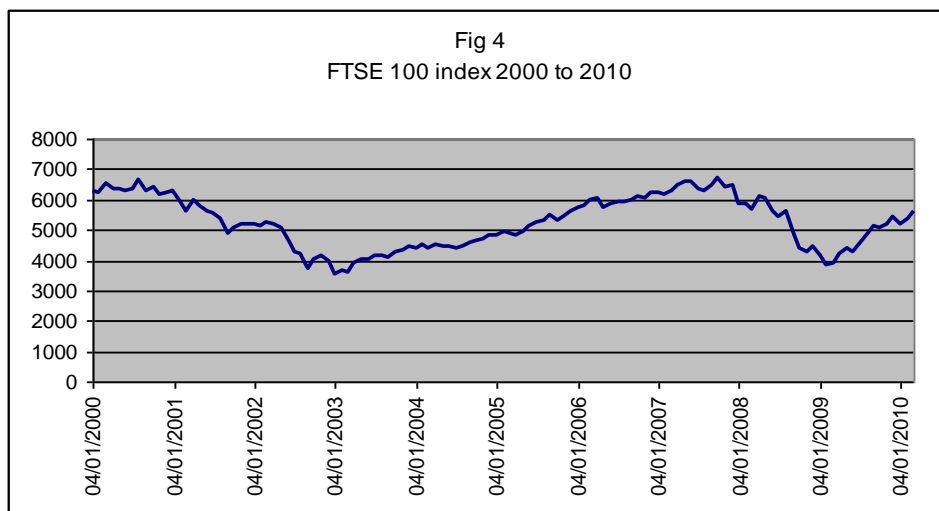
During the year £420k was invested in the funds managed by our investment manager. The total return for the year from investments held by our investment managers was minus 16.5% compared with the APCIMS balanced Index which showed minus 17.6%. We have holdings in the Charities Property Fund (CPF) which fell by £200k

<http://www.stpetershospice.org.uk/files/file/About%20us/report+accounts%202009.pdf>

The market value of our Investment Portfolio dropped by £1,231,000 during the year (2007/8: drop of £461,000). This represented a fall of 16.4% over the year, compared with a drop in the FTSE100 index of 31.1% over that same period

[http://www.pah.org.uk/hospiceinformation/AnnualReport/PAH\\_Trustees%20Report%2009\\_FINAL\\_Web.pdf](http://www.pah.org.uk/hospiceinformation/AnnualReport/PAH_Trustees%20Report%2009_FINAL_Web.pdf)

An accumulated fund of £100 million as at the mid of the year 2008 invested in a diversified FTSE100 portfolio would not have fared well in recent years as the value of funds held would have dropped 15 – 20 % (see fig.4) representing both unrealised (or realised) losses to hospices.



Source: Yahoo finance UK.

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. Often this forces expenditure ahead of income and thus reserves are required to cover not just a shortage of income but to help accrue holding gains to underwrite capital projects: new buildings and replacement facilities. Hospice trustees do allocate a substantial share of these reserves into investment funds but this can recycle risk and uncertainty.

Hospices also receive government funding directly from the Department of Health or from PCT contracts and this traditionally accounts for one quarter to one third of hospice income but it too is not stable long-term funding. 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. The National Audit Office report “End of Life Care” observes that:

In 2006-07, hospices provided inpatient services to over 38,000 people and supported over 112,000 people in the community, yet current contractual arrangements with PCTs limit their ability to plan and develop services...Seventy per cent of hospices have only one year contracts with PCTs.

[http://www.endoflifecare.nhs.uk/eolc/files/NAO-EoLC\\_Full\\_Report\\_Nov2008.pdf](http://www.endoflifecare.nhs.uk/eolc/files/NAO-EoLC_Full_Report_Nov2008.pdf)

A poll of member hospices has found most PCTs in their areas are unable to identify additional funding for end of life care for this year provided by the Department of Health.

<http://www.communitycare.co.uk/Articles/2009/07/13/112079/Help-the-Hospices-issues-warning-over-end-of-life-care.htm>

A letter from the DoH (25<sup>th</sup> February 2010) requested PCT’s to formally report on how £286 million of (un)ring-fenced funding for End of Life Care (EoLC) had been deployed by PCT’s.

[http://www.dh.gov.uk/dr\\_consum\\_dh/groups/dh\\_digitalassets/documents/digitalasset/dh\\_113338.pdf](http://www.dh.gov.uk/dr_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_113338.pdf)

Since 2004, Children's Hospices have been in receipt discretionary Department of Health (Section 64) funding but there is considerable uncertainty about this funding continuing after 2011.

Section 64 funding (for children's hospices) will stop and Primary Care Trusts (PCTs) will find the extra money instead. Unfortunately, as things stand, PCTs look very unlikely to provide the extra £10 million-plus needed

<http://www.helpthehospices.org.uk/media-centre/press-releases/vision-for-more-home-care/>

In the March 2010 budget, the Chancellor announced a funding shortfall in Government finances of £163 billion and the objective is to reduce this by £78 billion by 2013-14 through efficiency savings. The Departmental budgets for Health and Children, Schools and Families are to be ringfenced in 2011 but uncertainty remains. It is not clear how other departmental budgets can deliver the burden the \$11billion of savings recently announced in the 2010 Budget. The Financial Times reporting the findings of the Institute for Fiscal Studies (IFS) observed that:

“By 2014-15, if a Labour government protected schools, health, police and overseas aid from cuts, the unprotected parts of government would face cuts of 19-25 per cent over four years, far deeper and more sustained than any spending cuts in the past 30 years”

<http://www.ft.com/cms/s/0/9737d9d4-3850-11df-8420-00144feabdc0.html>.

## **Summary**

This Government's end of life care strategy draws upon the capacity and additional choice provided by charitable hospices in England. The purpose of this article is to consider the extent to which the policy intersection outlined in the Governments End of Life Care Strategy between Primary Care Trust (PCT) commissioning and the contribution of voluntary hospices is robust or fragile going forward.

In order to investigate this issue we have extracted financial data from the top twenty-five hospices that report their financials following SORP. Our analysis reveals that although hospice income has grown by an average rate of 6 percent in recent years this conceals variability and volatility. Hospices report their income by type: donations, legacies, trading, investment and government / PCT and a number of these components are volatile, for

example legacies and donations. Hospice managers and trustees are motivated to increase their investment in palliative care services but this also requires additional expenditure in activities that drive funding and trading activity. Frequently expenses run ahead of uncertain and volatile income streams and good governance requires trustees to maintain adequate balance sheet reserves. The general policy is to split hospice reserves into cash held in deposits and funds managed by investment banks where portfolios include equity shares and property. In the 'good years' hospices have extracted holding gains to boost income or finance capital projects but the current financial crisis exposes hospices to capital market risk as investments are marked to market and holding losses incurred.

The state-voluntary sector policy intersection outlined in the Government's end of life care strategy depends on the stability of the hospice business model going forward. Our argument is that the hospice business model is fragile and this could easily put palliative care at risk. If the Government is to secure a strong partnership with voluntary hospices it will need to consider how it can contribute to stabilising the underlying financial business model.

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