**Stakeholders in the Palliative and End of Life Care Service Ecosystem: A Study of the Hospice Sector**

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**Introduction**

This chapter seeks to provide a more nuanced understanding of the role of the not-for-profit sector in the current palliative and end of life care landscape. It has a particular focus upon exploring the role of different stakeholders in this landscape. It does this by reviewing a research driven collaboration with Oakhaven Hospice, a not-for-profit provider serving a particular geographical footprint, the New Forest, Waterside and Totton areas of the UK. The aim of this collaboration was to deploy a stakeholder engagement and service ecosystem lens to better understand the needs of current and future service users. Oakhaven provides palliative and end of life care both onsite (in-patient and day patient facilities) and through a community nursing service that includes hospice at home services. It is one of over 200 not-for-profit hospices in the UK, supporting around 200,000 palliative care patients annually and receiving an average of 32% of their funding from the government, with the rest coming from fundraising (Hospice UK 2017). Hospices deliver multiple services through Inpatient Units, Outpatient and Day Care Centres, programmes (e.g. Living Well), and clinics (e.g. Breathlessness Clinic and Lymphoedema Clinic). The combination is specific to the unit in question.

The demand for hospice care is rising. Advances in medical care have prompted a transition in the nature of deaths today. Non-communicable diseases, cancer and coronary heart disease for instance, now account for over two-thirds of all global deaths and are set to rise (WHO, 2012). Enhanced treatment regimes have extended the lifespan of patients, increasing numbers now living with the long-term consequences of treatment and chronic conditions. Indeed globally, life expectancy has increased by almost 20 years over the last five decades (UN, 2015). Overall morbidity rates have not changed (Davies, 2015). With the post war baby boom, and consequential ageing population the number of deaths in England and Wales is projected to increase by 27.0% in the next 2 decades (Bone et al., 2017). These trends become all the more important when set against a backdrop of changing society structures. Greater employment opportunities, alongside smaller and more fragmented families, is placing increasing demand upon palliative care services (Hospice UK, 2013).

The healthcare sector response to terminal illness involves a journey, a move into a liminal state of healthcare delivery. In this state, conversations shift beyond curative and treatable healthcare dialogues into palliative care where holistic care, psychosocial and spiritual support for patients and their families is prioritised (Cloyes et al 2014; WHO 2015). It is a transitional stage haunted by many misperceptions, a key one being associations with imminent death (Giovanni 2012, NHPCO 2015). This is not always the case, every disease trajectory unique. ‘Dying well’ is championed within policy rhetoric in the UK and all mechanisms for managing pain, symptoms and medicines are keenly sought (Department of Health 2008; National Palliative and EOLC Partnership, 2015; The Choice in End of Life Care Programme Board, 2015; Department of Health, 2016).

By adopting a stakeholder engagement and service ecosystems lens, this chapter adds to our understanding of the relationship between hospices and non-profit marketing. First, the theoretical arguments apparent in the stakeholder engagement literature are reviewed, followed by a brief review of the service ecosystems literature.

The chapter then progresses to explain the research with Oakhaven Hospice, the provider at the heart of this case study. Methods of data collection are then outlined followed by a discussion of the primary data collected from multiple stakeholder groups: General Practitioners (n=5); District nurses (n=5); Hospital staff (n=7); Care Home Managers (n=5); Hospice service users (n=31); and non-service users (n=100). Implications for practice are then presented.

**Stakeholder Engagement**

Stakeholder theory advocates that the main purpose of an organisation is to create maximum value for its stakeholders (see e.g. Voyer et al., 2017). Within this theory, idea, metaphors and expressions are brought together to achieve a ‘common purpose’ (Strand and Freeman, 2015). In his seminal work on stakeholders, Freeman (1984) discusses how there are two main types of stakeholder groups. These are primary and secondary stakeholders. Primary stakeholders could be employees, suppliers, the local community, shareholders, customers and secondary stakeholders could include government, competitors, consumer advocates and activists, media and social networks.

One of the central dilemmas of stakeholder theory is knowing who to prioritise and how as there are usually a plethora of stakeholder groups involved. In the context of not-for-profit organisations, identifying to whom these stakeholder groups are responsible and their remit (i.e. how far their power and influence extends) is key (O’Riordan and Fairbrass, 2014). For example, hospices serve multiple stakeholders. Externally, these might be patients, governing health bodies e.g. the National Health Service (NHS), community groups, specialist community groups (e.g. Marie Curie), quality assurance bodies such as the Care Quality Commission (CQC), Clinical Commissioning Groups overseeing GP networks, other hospitals in a particular geographical patch and many more. Internally, key stakeholders might include the board of trustees, clinicians, nurses and volunteers. Crucially, while a holistic understanding of who ‘exactly qualifies as a stakeholder’ is somewhat fragmented in the literature, the identification of what counts as a stakeholder claim is significant (Mitchell et al., 1997).

Emanating from stakeholder theory, stakeholder priorities and choices can come down to what is known as stakeholder prioritisation (Hill and Jones, 2007). Here, decisions are made about how to engage with a range of stakeholders. This leads onto a discussion of ‘stakeholder engagement’, which is broadly defined as the organisational practices undertaken to engage stakeholders in a positive vein with organisational activities (Greenwood, 2007). Process wise, this involves obtaining, developing and building up stakeholder relations via stakeholder identification, consultation, communication, dialogue and exchange (Burchell and Cook, 2006). Stakeholder engagement can take years, if not decades in some cases and it rests on the fundamental belief that interaction with fellow stakeholders is a logical pre-requisite for organisations. By engaging with stakeholders, engagement is viewed as the key driver in achieving organisational objectives and priorities including (but not limited to) aspects of consent, control, co-operation, accountability and involvement, mechanisms of fairness and trust. For example, consider how hospices proceed in terms of referral criteria and who gets access to one and how. The answer here cuts across multiple stakeholders and might entail evaluating aspects like the patient’s place of residence in proximity to the hospice, hospice capacity, prioritisation based on the type of illness. The key point here is that stakeholder engagement needs to be as mutually beneficial as possible for all parties. The ultimate goal of stakeholder engagement is to promote virtue and morally responsible decisions and organisational behaviour (Greenwood, 2007). Noland and Phillips (2010) for instance, take an ethical strategist view to stakeholder engagement and propose that for it to work in practice, the honest, open and respectful engagement of stakeholders as part of an overall organisation’s strategy is paramount. Noland and Phillips view here would seem to echo that of ‘business’s role in society and the pursuit for a better life. There are obvious parallel’s here with hospices striving to improve quality of life for patients, their families and the bereaved.

In a recent paper by Mitchell and Clark (2019), the authors reconceptualise the Product Life Cycle theory (PLC-developed over 50 years ago) and anchor their theorisations based on stakeholder engagement for not-for-profit organisations. In its most basic form, the original PLC model advocates four main stages that a ‘product’ takes over its lifecycle. These are introduction, growth, maturity and decline. Mitchell and Clark re-imagine the PLC through the lens of market orientation and discuss how stakeholder engagement forces a revised and fresh perspective to the original PLC. In this regard, they developed an ‘engagement life cycle’ (see figure below 1).

Figure 1: Engagement Life Cycle



(Source: Mitchell and Clark, 2019)

At the incubation stage, it is argued that stakeholder engagement is minimal and the not-for-profit organisation operates without external influence. This might be because the organisation is new or because it does not require external engagement to exist. Consider for example, a new hospice launch. The hospice is new so will embryonically grow. It might lack the necessary resources in the inauguration phase to establish a presence such as a dedicated marketing team for instance. At the interaction stage, this is where social exchanges start to proliferate. Think about a new hospice trying to accrue multiple donations via trustees, private groups, the NHS and the establishment of a volunteer network. Here, customers are key resources to getting the hospice off the ground. At the involvement stage, an active affinity develops between key stakeholder groups and the organisation. Value is assessed in the form of e.g. outcomes of funding or volunteering time for example. Stakeholders will be interested in how the organisation is furthering its ambition. This might also involve reach and significance and what progress the ‘new hospice’ has made on a particular geographical patch.

Unlike at the incubation and involvement phase, stakeholder engagement is usually steady at the interactive phase, meaning that they may not be as aggressively involved and rather, intermittently scan relevant communications such as news, emails and they will be invited to e.g. Hospice strategy away days (which for most hospices take place once or twice a year). At the fourth stage (immersion), it involves the key stakeholders being committed to the organisation for the long-haul. For example, a hospice might encourage stakeholders to support their mission and vision online via actively engaging with social media, the wider community, other charities e.g. Marie Curie or Macmillan, hospitals in close proximity to the hospice and so on. The key emphasis at this stage is on intensifying stakeholder commitment and encouraging feedback from key stakeholders in decision-making and the future trajectory of said hospice. The final stage (incapacitation), is where the engagement between stakeholders and the organisation is said to become obsolete. In this worst case scenario, a hospice for example might seek to merge with another hospice on a similar geographical patch or cease to exist (though this is very rare).

Overall, the stages of Mitchell and Clark’s (2019) engagement life cycle are fluid with no expectation that each stage must be fulfilled sequentially and some stages may be skipped with the exception of the incubation stage.

**Service ecosystems**

Service ecosystems are broadly defined as a “relatively self-contained, self-adjusting system of resource-integrating actors connected by shared institutional arrangements and mutual value creation through service exchange” (Vargo and Lusch, 2016, p.10). In simple terms, it involves the institutional arrangement of actors at multiple levels (Finsterwalder and Kuppelwieser, 2020). These levels are more commonly known as macro, meso and micro. Let us contextualise these levels via an example of a hospice. At the macro level, these ‘actors’ or stakeholders might be the government, NHS, CQC and so on. At the meso level, this might include the hospice itself, neighbouring hospices on a similar geographical patch, GP surgeries, nearby hospitals etc. At the micro level, this entail patients, families, and communities.

The main strand that links service ecosystems and stakeholder engagement together is the ‘engagement side’. Both concepts find common accord in engaging with service exchanges, co-creation processes and/or solution development. The common thread here being that within a service ecosystem, value must be added amongst key stakeholders (Loureiro et al., 2020). The co-creation of value is predicated on the interaction between stakeholders and organisations who are said to create value via collaborative exchanges that take place (see e.g. Prahalad and Ramaswamy, 2004). What this collaborative exchange means in a stakeholder context is that the key stakeholders join forces to co-construct an experience via active dialogue and mutual learning. In the hospice context for example, consider the service experience that one provides, the types of facilities on offer, clinical comfort and support, shared spaces, little extras and so on. More recently, theorisations on co-creation have advanced to include customers (Letaifa and Reynoso, 2015), or in the context of healthcare and hospices- patients, their families and the bereaved in the co-design and co-production of the service being offered (Brodie et al., 2021). Thus, a service ecosystem approach supports the mapping of direct and indirect stakeholders and influencers of a not-for-profit organisation.

The importance of sharing goals and priorities amongst stakeholders gives rise to interpersonal relationships, which in turn, contributes co-creation opportunities within the service ecosystem. As Loureiro et al. (2020) contend, certain factors can impact stakeholder engagement. For example, company size, smaller not-for-profit organisations might prefer closer interpersonal relationships. Strong personal relationships, high quality information exchange, affinity and transparency in sharing information can all contribute to reinforcing improved stakeholder engagement and input into the co-creation process. Referring back to the previous example on hospice admissions criteria for example, the aforementioned factors play a key role in the advancement of co-creation and the management of the service ecosystem within which the not-for-profit organisation operates.

The research team collaborated with Oakhaven hospice (Hampshire, UK), and looked at scoping the current ecosystem in and around Oakhaven’s geographical patch. The key headline findings are detailed via a case study, presented next.

**Case study-Oakhaven Hospice**

*Background:* Oakhaven Hospice provides palliative and end of life care both onsite (in-patient and day patient facilities) and through a hospice at home service. It began as a charitable trust in the 1980s and today covers a geographical patch (see Figure 1) which includes 15 primary care practices that are grouped into 10 Public Health England Profiles. This area has a total population of 114,000 registered patients. The services offered at Oakhaven are free to patients and their families. Fundraising is a pivotal means of raising the monies needed to support these services.

*Research questions:* In 2016, recognising the end of life care future projections, the Hospice Management embarked upon a project to plan for future service needs. They commissioned a research project with two research questions: what is happening in the Oakhaven geographical patch? And what explains these trends? A mixed-methods approach was adopted. Scoping out the end of life care landscape (research question 1) utilised desk-based research. The second part of the study (research question 2), drilling into understand factors contributing to the end of life care landscape, utilised semi-structured interviews to collect data.

*Research methods:* Routinely collected data was utilised for research question 1. Two sets of data were valuable here: mortality statistics; and Oakhaven daily statistics. This information was valuable in profiling patients who were referred to the hospice. Profiling was possible by five variables: diagnosis; who referred the patient; services accessed; the patient’s own GP practice; and place of death. Once the emergent trends were identified, primary data was collected with multiple stakeholders in order to explain these trends (research question 2). In-depth interviews, some lasting an hour were utilised for this purpose. Fifty-three stakeholders were interviewed. These included: General Practitioners (n=5); Community Nurses (n=5); Hospital staff (n=7); Care Home Managers (n=5); and Hospice service users (Day patient; inpatient; family; friends; carer; bereaved) (n=31), and a questionnaire with 100 non-users at Lymington Hospital (Hampshire).

Each stakeholder was asked to identify and explain the key issues facing end of life care provision and what could be done to improve care provision in the area. Each interview was audio recorded with permission, transcribed verbatim and then subjected to rigorous in-depth thematic analysis in order to identify common themes. Full ethical approval was granted by the University Ethics Committee prior to data collection.

**Figure 2: Oakhaven’s Geographical Patch**

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**Findings:**

**Table 1: Emergent Themes**

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| --- | --- | --- | --- | --- | --- |
| **Common Themes** | **General Practitioner (GP)** | **Community Nurses (CNS)** | **Lymington New Forest Hospital (LNFH)** | **Care Home Managers (CHM)** | **Service Users (SU)** |
| 1. Lack of communication and integration in EOLC provision
 |  |  |  |  |  |
| 1. Referral criteria issues
 |  |  |  |  |  |
| 1. Community role for Oakhaven
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| 1. Training
 |  |  |  |  |  |
| 1. Lack of resources in Community and Social Services
 |  |  |  |  |  |

*Communication and Integration*

A dominant theme within most stakeholder interviews was the lack of integration and communication between the different stakeholders providing end of life care in the area. One GP commented: “…*we are really poor at (…) sharing experience”,* going on to explain the ‘we’ in end of life care to be: “*…about what the primary care team do, what Oakhaven do, what Social Services do”.* For this GP, realising the opportunities integrated thinking offered was the key to moving forward, Oakhaven pivotal in this relationship: *“…so there are a lot of things that goes on, sharing best practice is something we don’t do as a health environment. I think we could learn from each other and it could be facilitated by Oakhaven.* (GP)

Poor communication and integration between different services were identified as a key issue for community nurses who spoke of arriving at a patients’ home unaware if the patient had an advanced care plan: *“… what does the patient know about it, it isn’t for us, we might have a little bit of information about their diagnosis and prognosis, but it isn’t for us to share that with them if it hasn’t been shared with them already. So it can be very tricky and you have to really fish around to get the information”.* (CNS)

Uniting all feedback was the need for increased integration and improved communication between different services:

*“If we could have someone who could liaise or coordinate within the hospital. The only times I feel less comfortable is not when we are palliating here, but when we are sending people home for palliation (…) what makes me anxious is I’m not so sure of what will be going on with the people we are sending out for care or palliation.* (LNFH)

Again, in common with GPs and CNS feedback, it was also suggested that Oakhaven could play a pivotal role in bringing end of life care services together:

*“I think that it is to get, whether it is run out of Oakhaven or whatever is to get some kind of broader palliative team, because the team that run out of Oakhaven is really their patients first isn’t it. We can go to them, and I think that our health needs probably contribute towards them”*. (LNFH)

An appetite was also voiced for Oakhaven to establish an end of life care team or an end of life care ward within LNFH itself, although the resource issues were readily recognised too:

*“What we have is we have a ward that is abandoned that isn’t used because they ran out of funding for it, so basically Oakhaven each year have put forward Southern Health to have an inpatient Hospice, which would be amazing, and I know a lot of our nurses here would really enjoy that opportunity and it would give us just all that we would need, it would give us the training, and the rooms for relatives to stay in. That would be amazing, so when we win the lottery!”* (LNFH)

*Referral criteria*

A significant issue identified by stakeholders such as GPs, LNFH nurses and service users in particular were problems with defining end of life care and confusion over referral criteria. This was particularly problematic given the population characteristics on the patch. For example, one GP remarked:

*“Our population has double the amount of over 85’s, 5.2% of our population is over 85 (…), as you age you are going to get disease everyone will have a bit of cancer somewhere when you reach 95, it is astounding if you don’t”*. (GP)

The consequences of this ambiguity were felt particularly in relation to decisions linked to referral criteria. GPs expressed concern over the timing of referrals:

*“…there is no clear defined way of when you refer to palliative care, and my opinion is that, and I think it’s true in all areas, some GP’s have the default and will refer everybody whereas I only refer at the point at which I can think of something that they can provide that I can’t”*. (GP)

And indeed what to refer patients for:

*“Referral criteria was quite tight at the beginning it was really only cancers, now it is motor neurone disease, coronary respiratory disease, some of the other stuff so it is a broader category. I think there is some confusion amongst GP’s”*. (GP)

There was a clear link between this confusion over referral criteria and the increased propensity for GPs to refer cancer patients to Oakhaven. For example, one GP explained he was more likely to refer cancer patients than those suffering with dementia and heart failure:

*“…the cancer patients are always easy to do because they do usually require a palliative care input the more difficult ones (…) conditions like dementia and heart failure are always tricky (…). Oakhaven are happy to take them but I guess I am reluctant to refer them”*. (GP)

*Community role*

In helping the wider community to appreciate the value of Oakhaven’s work and select them as their preferred charity to support, several stakeholders identified the importance of the community role on the New Forest patch. For example, one service user noted:

*“To be honest I think it would help with their fundraising as well, it sounds awful but, we used to take stuff into the charity shop, but if one understood how much they offer the community one may have been a bit more enthusiastic about that, you know. We used to spread ourselves amongst several charity shops but now it is going all to Oakhaven because we think this is a great local facility you know”.* (Family Carer)

Overall, it was suggested Oakhaven was well placed to play a pivotal role encouraging shared practice in the area. This role was considered particularly necessary given the changing relationships between community care and GPs, and the ambiguity which could arise:

“*I think sometimes it is a bit ad-hoc and sometimes it feels like, we will ring the patient or we will text them, it feels like we are working on two parallel tracks rather than as a team*”. (GP)

Key stakeholders such GPs, district nurses, staff at Lymington New Forest Hospital and service users collectively suggested the need for one organisation to act as a facilitator, an enabler, even a point of contact in end of life care in the area. Oakhaven was considered well placed to play a pivotal role as a central point of contact for local end of life care services. Clearly there are resources implications attached to this. Nevertheless, support in the community is high for Oakhaven.

*Training*

Training was another key theme that emerged from the findings. In particular, GPs spoke of a lack of specific training in end of life care and an appetite for more training programmes in this area. District Nurses, care home managers and hospital staff requested further training (e.g. through observation) to perform end of life care, especially in the areas of having difficult conversations, symptom management and medicine management. For example, one nurse remarked how many patients were reluctant to talk about death. Some were reluctant to go to Oakhaven:

*“Yes, but as a country we still don’t like to talk about death, we don’t at all, but yet we should and getting people to think about advanced care planning, but they are difficult conversations to have which is why the workforce has to have training so they can develop the skills”.* (LNFH)

The need for training to help them cope with these conversations was also cited by district nurses as a central theme. For instance, one told:

*“…it is sometimes hard to know who will be having those conversations with them (…) about where they want to die and those kinds of conversations would fall to, other than us, which we can do but it is not always appropriate as we are not experts”.* (CNS)

This was particularly important for those in the early years of their career development:

*“I knew in this community a large part of the service we provide is end of life care but I was not prepared for it in my training, nothing (…) it is hard, being newly qualified having those conversations, but I would feel so much more prepared if I knew what they knew and that conversations they had had”.* (CNS)

A common theme within interviews was the opportunity for Oakhaven to play a central role in wider training for those involved in palliative and end of life care. Multiple suggestions were offered, including the need for different levels of training:

*“Yes and I think the practical things of symptom management, I think it is hard to be taught that and it comes with experience. The training courses that Oakhaven provide, whilst they are good I think that they miss the mark for people at our level, we need a bit more than that.* (CNS)

*Resources Shortfall*

Under the theme of resource shortfall, two key headline findings emerge. First, a lack of resources in the community and social services and second, for Oakhaven to sustain a pivotal role in the community, greater resources are required. GPs for example, believed that Oakhaven would benefit from being better resourced, which in turn would support the wider palliative and end of life care community:

*“… I suppose more beds at Oakhaven, more Hospice at Home Staff (…) and an enhanced educational role. It would be nice for us to have education as GP’s on a regular basis, to discuss case scenarios, I think that is always helpful. So I think increased beds, increased services, just more of them”.* (GP)

The importance of Oakhaven’s work led to a question over funding and whether more statutory funding should be made available:

*“I think just better resources for palliative care services, I think they rely a lot on charitable donations and perhaps that should be centrally funded I think there is a very strong argument for that, especially with an aging population and more people dying at home”.* (GP)

Nurses also welcome more resources to help cope with demand. For instance, one nurse remarked:

*“I do find 80%, 90% of the time it’s the nurses that are actually looking after the patients that are the ones that recognise the signs. I think what would be good in a lovely, ideal world is that we’ve said about- I've spoken to our management team about having, whether or not it’s one CNS or having some more trained staff within the hospital, because Oakhaven are limited and obviously they can only provide a certain amount of support to us. It would be great if we had some resources here actually within the hospital”* (LNFH)

In summary, the findings regarding resource shortfall point in the direction of Oakhaven considering the implications for the wider end of life care community network on their own geographical patch. Yet from a stakeholder engagement perspective, how should Oakhaven proceed? Is it their sole responsibility? The answers to these complex questions are multifaceted. To gain a better idea of potential solutions, the conclusion/recommendation sections that follow, draw together the main implications for theory and practice.

**Conclusion**

This chapter set out to provide a more nuanced understanding of the role of the not-for-profit sector in the current palliative and end of life care landscape. It was particularly interested in listening to the voices of different stakeholders operating in this landscape and utilised a research driven collaboration with Oakhaven Hospice, a not-for-profit provider serving a particular geographical footprint in the UK to achieve this. In this conclusion we reflect back upon the learnings from this work, particularly in relation to stakeholder engagement as seen through a service ecosystem lens.

In relation to theory and as documented in this chapter, one of the central dilemmas of stakeholder theory is knowing exactly who to prioritise and how, especially when there are multiple stakeholders involved with potentially competing interests. Who has responsiblity and how far does this responsibility and influence extend (O’Riordan and Fairbass, 2015) within a service ecosystem can be a grey area (Vargo and Lusch, 2016). In this case study for instance, questions regarding should training for example be led by Oakhaven, should it be led by other stakeholders like Lymington hospital, by the GPs, illustrate well the complexity of the wider ecosystem There is no textbook answer here because it relies on key stakeholders consistently communicating and liaising with each other in an attempt to co-create value (Prahalad and Ramaswamy, 2004).

Often within stakeholder engagement, stakeholder prioritisation (Hill and Jones, 2007) is key. Sometimes, this means, as in the case of Oakhaven, that priorities have to be made in terms of designated patient need, yet other stakeholders such as GPs welcome greater clarity on aspects such as referral criteria. Thus, it is only through obtaining, developing and building up stakeholder relations via stakeholder identification, consultation, communication, dialogue and exchange (Burchell and Cook, 2006) that such issues can be remedied. Similarly, stakeholder engagement needs to be as mutually beneficial as possible for all parties. As Noland and Phillips (2010) suggest, for it to work in practice, it relies on the honest, open and respectful engagement of stakeholders. For a hospice like Oakhaven, it is likely to operate at the ‘immersion’ stage of Mitchell and Clarks Engagement Life Cycle. This is because it has developed a positive reputation over a long period and is influential on other stakeholders within the service ecosystem including hospitals, GPs, care homes and indeed the wider community. Given Oakhaven’s potent stakeholder power, it has the ability to implement key changes related to the key themes from this research. Namely; communication and integration in end of life care provision, referral criteria issues, energise the community role, support further training initiatives and work with other key stakeholders on their geographical patch to improve resources in the community. Each of these themes will likely resonate with other not-for-profit providers similarly embedded in a complex service ecosystem. Future research would benefit from exploring this in other service contexts.

**Questions**

1) How have Oakhaven hospice deployed stakeholder engagement in their organisation?

2) What key recommendations might you suggest for Oakhaven moving forward?

3) Prepare a short proposal for a not-for-profit organisation of your choice and consider the following questions. What key considerations need to be made for stakeholder engagement and why? What is their geographical patch? Where does your chosen organisation sit on Mitchell and Clark’s (2019) Engagement Life Cycle?

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