Fundraising MIG Conference – 25 September 2019

Unanswered SLIDO Questions

Stephen's session and Gemma's session

1. Have you found that clinicians ask donors to give to funds that explicitly benefit them?
   Ben: Generally, we would not expect clinicians to be in the position to ask patients for contributions. When clinicians do get involved in the process of asking for support it is with their partners from the charity. Donors may or may not be their patients, but the projects are explicitly in their area of expertise.

   Stephen: It would be unethical, a breach of NHS policy, and probably unlawful for clinicians to solicit gifts that benefit them personally. However, if you mean benefitting clinicians' departments or programmes, this does happen, but we would encourage the clinician to refer the patient to the charity under most circumstances.
   Gemma: The process of convincing (or enlightening!) clinicians to collaborate with the charity and refer patients appropriately works better when we are partnering to raise funds for a specific project that benefits their department. We have tested raising "designated" funds for the department rather than restricted, but clinicians see this as not worth their while, so we address this through increased visibility. Our model is to 'recruit' patients who would like to give to the department they care about and then migrate them to designated, and ultimately general, giving once they have been nicely stewarded and understand how the charity works.

2. Have you had any difficulty of clinicians starting the giving conversation with patients, potentially pressuring them into donating?
   Ben: Sometimes clinicians do get very excited about the opportunity to have patients involved in supporting their work. Typically, they do not pressure patients, but instead the challenge is they forget to involve the charity at the outset of the conversation. When this happens, the discussions may progress further than they should given the clinicians limited knowledge of philanthropic giving.

   Stephen: Best answered by Ben and Gemma.

   Gemma: I agree – sometimes they get carried away, but I have never seen any pressuring. I think that they would see this as unethical given the patient/clinician relationship.

3. How did you evidence ROI and get Trust buy in for investment?
   Ben: Best answered by Gemma or Stephen. The pivot to a focus on major donors will require the development of a referral pipeline from clinician partners. The return comes from the major gift opportunities through grateful patient/family referrals. It will take years to build the pipeline, not an overnight endeavour. Proof is in the success of similar programmes in the US and Canada. There is limited proof available in the UK as of now.

Stephen: By quantifying the proportion of our current income that came from patients and by quantifying the gulf between the number of people who made individual gifts and the number of people who use the hospital and those close to them. We found that the former was about 1% of the latter and argued that shifting this to a modest target like, say, 3% would still have a big impact on voluntary income.

Gemma: We also shared examples of where donors had tried to give by asking hospital staff and failed because staff didn't know what to say. The donors became disheartened and gave to other charities. Whenever I share good news with the hospital that we have funded something – I always point out that it wouldn't have been possible without a patient(s) who wanted to do something extraordinary to say thank you.

4. The data on how many new donors have joined is impressive. How does that compare to your rate of acquisition before you started the grateful patients programme?
   Ben & Stephen: Best answered by Gemma.

   Gemma: A very good question and one I would love to answer confidently but I can't due to our very old and lacklustre database. I've had to baseline metrics in Year 1 to establish trends going forward.

5. Do Ben and Stephen have insights on the differences in using Grateful Patient Programmes in non-acute settings - mental health or community care?
   Ben: In non-acute settings the focus remains on clinician partnerships, but may not always focus on a grateful patient. Instead in these environments (particularly mental health/addiction), the family or community may be the grateful party, similar to children's medicine. Given that the patient is not always the right individual and gratitude is not always the emotion, AR prefers to call the programme a referral-based medical philanthropy system instead of "Grateful Patient Programme".

   Stephen & Gemma: Nothing further to add.

<u>Andrew and Amy's session</u>

1. How important is getting the right Chair for a Campaign?
   The role of Campaign Chair is extremely important and selecting the right person should always be a priority during the planning of your campaign. Identifying a potential Campaign Chair is an integral part of the Feasibility Study and, if you have a couple of possible candidates in mind, they should be interviewed to establish their willingness to take on the role once they are in possession of the facts.
   It should always be remembered that the most effective Campaign Chairs are active and influential people. You need them to be capable of engaging with HNW prospects that they have personally identified and who have been identified by others. They should also be prepared to demonstrate their own commitment to the campaign by making a leadership gift (this does not have to be largest gift but it should be large enough to give them

credibility in the role) and by using their interpersonal skills to encourage others to do the same.
Overall getting the right Chair is very important and every effort should be made to recruit someone who understands the nature of the role and is fully committed to be the campaign's leading volunteer advocate.

2. Do we need to update our privacy policy to legitimately prospect research?
   You need to protect yourself from any potential wrong-doing and so it is imperative to have a privacy policy which covers everything that you might do as you plan your fundraising campaign. We recommend that you examine the privacy policies of one or two household name charities.

3. How would you engage corporate prospects in a capital project?
   Most listed companies have well-defined CSR policies and, generally, these are less geared towards capital projects unless the purpose of the capital build matches their CSR objectives. Cold approaches to local businesses will rarely be effective and the reality is that corporate prospects should be approached through a direct connection at a senior level. It is worth bearing in mind that some corporates may only be prepared to offer good or services in kind rather than cash. For capital builds therefore these are most likely to be building materials, equipment or furnishings. If these are in your project plan, it is worth exploring local businesses who might be able to supply them at no or low cost.

4. Is our role to facilitate peer to peer asking or to make that ask ourselves?
   The role of the Development professional managing a campaign should ideally be to facilitate peer to peer asking rather to make the ask personally. This is because asking is most successful when there is a degree of commercial or wealth equality between the asker and the prospect. However, the reality is that the professionals will often have to complete the ask, either when accompanying a volunteer or as a result of peer to peer cultivation. Try to stick to the principle of peer to peer (therefore facilitation) but be prepared to step in to complete an ask if necessary.

<u>Mandy's session</u>

1. How do you keep your team of fundraisers motivated when faced with such challenges?
   By being open and honest and keeping them informed of each change of circumstance even where we don't yet have the answers and by asking the team to be part of the solution. Also providing a statement of messaging to be used through any periods of uncertainty for both the fundraisers, comms and our service colleagues has been vital to ensure we remain on brand and on message and portray business as usual through uncertainty.

2. Do you work to a fundraising target based on Estates estimates, or after you have tender responses to contractors (but then with less time to fundraise)?
   We have done both but generally it has been on estates estimates to allow sufficient time for appeal fundraising.

3. How do you find your feasibility studies? ***(I think this should be 'fund' rather than 'find'!)*** ***We answered this at the MIG however answered it as 'find'.*** Funding has been through the General Fund or using in house resource and back filling positions.

4. What does your appeal materials say to safeguard you against the risk of the Trust pulling/changing a capital build?
   There is a caveat on all fundraising materials setting out that should we not be able to raise sufficient monies or if circumstances change we will use the monies raised for the purposes of x department. Obviously this wouldn't guard against having to hand back specific grants but does cover us for the community donations.

5. How do you decide if it will be an appeal or come from existing fund endowments?
   We haven't had sufficient resources in any designated funds previously for capital projects to be anything other than an appeal. We don't have any assets other than those in the designated or general funds so no endowments etc to draw from.