demonstrate our impact in monetary terms, how much value we bring for the money we receive.

Aim Establish and deliver implementation of an impact-reporting framework -identifying outcomes, their measurement and value. This project involved a predictive social value analysis that undertook a representative example of hospice activity upon which to base later monitoring.

Methods Independent company, Kingston Smith, commissioned to carry out relevant research. Mapped out plan for staff, volunteer, patient, relative and stakeholder engagement events, focus groups, surveys and telephone interviews. March 2019, report produced including end of year financial spend to calculate investment, determine impact, set up calculation model to track social value created by the hospice going forward.

Results Total value of impact captured within the scope of the study. Total value that is attributable to the hospice discarding value that is created by influences outside their activity. Return on investment identified – representing social value. Final report to the Board in July 2019 highlights the detailed calculations, but importantly identifies the range of outcomes experienced by stakeholder groups. The report details the context in which outcomes are created and how impact wholly attributable to the hospice is derived including how outcomes have been valued. A sensitivity analysis will test any remaining assumptions and include a range of ratios according to the variables.

Conclusions The full extent of this work will be realised over the coming year as we embed messaging about the impact of our work and its monetary value and see the response from beneficiaries, funders and the public.

P-252 MOVEMENT WIDE CHANGE AND ORGANISATIONAL INSTITUTIONALISM

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Hospices are being challenged by changing demographics. Originating from a response to cancer, hospices have struggled to significantly shift their narrative. This abstract relates to doctoral research exploring hospices' response to dementia from an organisational theoretical lens. The research highlighted a model of institutional change (Greenwood, Suddaby & Hinings, 2002) which can be applied, beyond dementia, to the challenges hospices currently face.

The model identifies stages of institutional change that potentially take an institutionalised organisational field (e.g. hospices) from their existing narrative through 'de-institutionalisation' to being 're-institutionalised' with a new, compelling narrative. The stages in-between are critical in creating the confidence for organisations to introduce significant change. The research highlights that in response to dementia (and other non-malignant diseases) key stages of institutional change have not taken place – in particular 'technical viability' (Greenwood, Suddaby & Hinings, 2002; Hodges & Read, 2018).

Technical viability is what moves thinking from an idea to a fully formed argument that gains moral and practical legitimacy. A case study on institutional change by Greenwood, Suddaby & Hinings (2002) highlighted a key ingredient being organisational failure. Hospices have not, up until now, failed.

The imperative for change has never been greater not only are the changing demographics challenging hospices so are the economic conditions.

Whatever the future holds for hospices, the theoretical lens of organisational institutionalism adds useful concepts that would help practically. The research in relation to dementia concludes:

- There needs to be a national conversation on the future of hospice care and Hospice UK are doing this;
- There needs to be a review, using institutional change models as to why other 'external jolts' haven't created a significant movement wide shift and;
- There needs to be training on institutional change including understanding the social context in which each hospice operates, being part of a movement, and also the essential need for the technical viability of any proposed models.

P-253 DRIVING IMPROVEMENT WITHIN THE HOSPICE. IMPACT OF THE PATIENT LED ASSESSMENT OF THE CARE ENVIRONMENT (PLACE)

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Background PLACE is an NHS Improvement Initiative which was introduced in 2013. It assesses the quality of an organisation's environment, putting patients' views at the forefront to assess how the environment supports the provision of care. PLACE assesses privacy and dignity, food and hydration, cleanliness and building maintenance. It looks at the extent to which the environment can support the provision of care for those with dementia or those with a disability.

Aim The aim of undertaking PLACE is to provide a snap-shot of how Saint Francis Hospice (SFH) is performing in relation to a variety of non-clinical activities which impact on the person's experience of their care.

Method A Steering Group was established in 2015 to provide leadership and oversee annual implementation of PLACE. Patient assessors are recruited in consultation with clinical teams. NHS Digital (2018) stipulates that 'the number of staff should not exceed the number of patient assessors'. Training for the assessors is provided. PLACE is undertaken using specified criteria. Scorecards are completed and agreed by the assessors. Data collected is inputted into a central NHS Digital database. On receipt of results the Steering Group agree and own an action plan. The outcome of the PLACE assessment is communicated to the organisation. Progress of the action plan is monitored by the Steering Group and reported accordingly.

Results By making relevant changes results have improved year on year.

2018:

Cleanliness: 100%

Food: 95.98%

Organisation food: 93.29%

Ward food: 98.59%

Privacy dignity and wellbeing: 100%

Condition appearance and maintenance: 99.68%

Dementia: 98.24%

Disability: 97.12%

NHS Digital publish all results to demonstrate how hospices are performing in relation to each other.