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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10.1136/bmjspcare-2019-HUKNC.275

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.
Conclusion All people using a service should be cared for with dignity and respect in a safe and clean environment. Striving to maintain and improve our standards via PLACE will continue to enhance the quality of our service being provided.

P-254 TRANSFORMING A HOSPICE GARDEN: FROM ‘SEA OF GREEN’ TO NORDIC WALKING

Helen Parkinson. Wirral Hospice St John’s, Wirral, UK

Background In 2015 the staff at Wirral Hospice St John’s had identified that the hospice garden was an uninspiring ‘sea of green’ that patients and families gained little from. Whilst patients enjoyed garden views from their beds, there was a lack of interaction with the outside world and very few areas for quiet reflection.

Aim The hospice undertook a three-year project to transform the garden into an inviting and reflective sanctuary for patients, families and staff. The garden will enable enhanced interaction and increased rehabilitation potential through the range of new activities provided.

Method Over four open days, staff, volunteers and patients transformed the garden into a beautiful landscape of flowers, trees and modern art. This also required the engagement of the wider public in the form of individuals, community groups and corporate teams. There was much positive media attention surrounding this work and the garden will be opened by Dame Patricia Routledge in June 2019 over the course of a two day open garden weekend.

Expected results The feedback from those patients who volunteered to help in the transformation has been overwhelmingly positive, providing them with feelings of empowerment and ownership. This has been recognised by BBC North West Today who awarded the hospice the Dianne Oxberry Sunshine Garden prize from Tatton Park Flower Show 2019.

Conclusion The hospice now has a wonderful space that all can enjoy.

Innovation/or interest As a result of this transformation, patients can partake in a range of activities including Nordic walking, golf and working in the communal vegetable patch.

P-255 SUPPORTING HOSPICE TRUSTEES TO CARRY OUT THEIR ROLE

Mary Northrop. St Helena, Colchester, UK

Background The role of a trustee for a hospice can be daunting and carries a high level of responsibility. Following discussions with other trustees at the hospice and at the Hospice UK Trustee Conference, a survey was devised to ask hospice trustees about their experiences. A literature review found only two examples of surveys for charity trustees - Hospice UK (2018), who canvassed trustees as to how they could support them and Vincent, Harrow and Palmer (1998) who looked at trustee decision making in small UK charities.

Aim The aim of the survey was to discover how trustees can be supported to carry out their role in relation to the three legal duties set out by The Charity Commission:

- Act in your charity’s best interest;
- Manage your charity’s resources responsibly;
- Act with reasonable care and skill (Charity Commission May 2018).

Method A survey using Survey Monkey was sent out to hospice trustees via the CEO of St Helena to other CEOs and via the Hospice UK Chairs Forum.

Results The survey is currently still (at time of writing) open for responses. Initial responses (n=13) suggest that reasons for becoming a trustee included; family member being cared for by the hospice, being asked due to background and wanting to contribute to society. Two thirds of respondents had inductions and further training. A number of trustees contribute to the hospice in additional roles to that of trustee. Trustees commented on the need to keep up to date and have some understanding of the NHS and healthcare provision to carry out the role.

Conclusions Early conclusions suggest the need for training in relation to roles and responsibilities. Good practice includes new trustees having a ‘buddy’, a good administrator, regular updates regarding new documents, national policies and opportunities to interact with other trustees.

P-256 ESTABLISHING AN ETHICS ADVISORY COMMITTEE IN A HOSPICE SETTING

Paul Marriott. St Cuthbert’s Hospice, Durham, UK

There is little research into the extent to which Hospice Ethics Committees exist or how they operate (Ballentine & Dalinis, 2014). In the wider health system clinical and research Ethics Committees are more commonplace. In some countries other than the UK, Hospice Ethics Committees are more common. The role of an advisory ethics committee is one that has emerged, particularly in the USA. However, other than in relation to research, there is little evidence of the emergence of Ethics Committees in the UK.

The aim of the project was to establish an Ethics Advisory Committee and identify if it could add value to staff, patients and family members.

An Ethics Advisory Committee was established through open recruitment. Terms of reference and an induction programme were developed. Committee members have considered ethical issues relating to clinical service, fundraising, purchasing and the use of volunteers. In order to raise awareness of its existence, the Committee initiated an online survey with hospice staff who were asked to identify the ethical issues they faced. In order to ‘launch’ the Committee, a seminar was held on ‘The Ethics of Hospice Admissions’ attended by staff members, external partners (referrers) and patient/carer representatives.

The online survey was completed by 11 members of the clinical team. This confirmed that clinical staff (across the hospice: in-patient care, day care, and community work) are facing ethical dilemmas at least once a month. The evaluation of the ethics seminar showed that staff and external stakeholders valued the access to an Ethics Committee created by the hospice.

The project suggests that hospices should consider establishing an Ethics Advisory Committee to support the resilience of staff and add value to key stakeholders.