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P-94 ADDRESSING INEQUALITY OF ACCESS TO HOSPICE IN THE HOME (HITH) CARE IN THE UK'S MOST DEPRIVED NEIGHBOURHOOD BY ADOPTING A HYBRID MODEL OF WORKING

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Background Patients living in Jaywick, Essex, live in the most deprived neighbourhood in the UK. Jaywick has a high elderly population and high rates of poverty, deprivation and low socioeconomic status (SES) (Ministry of Housing, Communities & Local Government, 2019). It is proven that those in low SES settings are more likely to have emergency hospital admissions in last months of life and are less likely to die at home (Hospice UK, 2021). The COVID-19 pandemic has strained hospice services across the country with increase in demand (Kates, Gerolamo & Pogorzelska-Maziarz, 2021, Public Health Nurs. 38: 459) and changes to workforce delivery to protect the most vulnerable patients (Tseng, Wu, Ku et al., 2020. J Gerontol A Biol Sci Med Sci. 75: e128), the pandemic has added difficulty in reaching and providing HitH care to patients in Jaywick.
Aim(s) St Helena Hospice aimed to increase the number of patients living in Jaywick to access hospice in the home specialist palliative care support and to also increase the amount of clinical contacts with each patient by introducing a hybrid model of working, which would include telephone and virtual assessments and reducing number of face-to-face home visits.
Methods We obtained statistics from our health database of HitH patients living in the CO15 2 postcode and created a table of the number of patients accessing hospice in home support and the number of clinical contacts those patients received and categorised these per annum over a period of 3 years.
Results Each year over the last 3 years, we supported 10 more patients in the CO15 2 post code, and there were 100 more clinical contacts with each year. The clinical contacts included face to face, telephone and virtual assessments made by the HitH team.
Conclusions The study shows the value of hybrid working as a means for hospice clinicians to reach to wider populations, included those living in deprivation. The results also demonstrated that hybrid working is not just a model used during the COVID-19 pandemic but can be adopted into hospice policy across the nation (Open Access Government, 2021).

Patient care

P-95 DESIGNER-IN-RESIDENCE; A NEW MODEL FOR DESIGN-DRIVEN INNOVATION IN FUTURE HOSPICE CARE

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Background Hospice care is in a period of change, with shifts towards redefining access, diversified demand and advancements in technology transforming current models of care. Beyond a problem-solving activity resulting in product/service improvement and innovation, Design could help reimagine alternative scenarios and lead to system-level transitions, hence acting as a strategic agent of change in future hospice care.
Aim We aim to co-define and co-imagine current and future hospice care as an ecosystem of people, objects, environments, technologies, interactions and narratives of care. Objectives include; a) co-creating a systems map of the current hospice care; b) co-defining key values, requirements and challenges in the current system; and c) co-imagining new value propositions in future hospice care systems.
Methodology and methods We propose an advanced design approach to future hospice care informed by System-shifting design, Speculative design, Human centred design and Design framing principles. We adopt a Designer-in-Residence model as a new innovative method for interdisciplinary collaboration and investigation.

An innovative collaboration between a hospice and an academic design research centre allows for a team of design researchers to undertake a 12-month residency in a hospice to gain first-hand contextual understanding and to conduct 1) Semi-structured interviews with staff, visitors and patients (N=15); 2) Observations of patients and staff (N=10); 3) Co-define and co-design workshops with all stakeholders (N=2).
Finding First, a systems map of existing hospice care will help clarify and communicate how the system works, capture narratives, experiences and tensions and underline strategic areas for future system-level transitions. Second, a system-shifting design map will help identify new value propositions for future hospice care.
Conclusion This design-driven study incorporates advanced design principles and for the first time, introduces the innovative Designer-in-Residence model in the context of hospice care. We expect the outcomes to stimulate interdisciplinary discourse and collaboration and inform research and practice.

P-96 LESSONS FROM A HOSPICE ADAPTION OF A SCANDINAVIAN PERSON-CENTRED CARE MODEL

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Background The relocation of a hospice to a new purpose-built facility provides the focus for this research study. Aspirations for the architectural design are embedded in a person-centred philosophy, adapting the Scandinavian Sengetun model of care (Jensø & Haugen, 2005; Hansen & Jensø, 2009) to suit the needs of the hospice in-patient unit. This design features two small groups of 6 and 10 single bedrooms clustered around a social space supported by decentralised clinical facilities and other shared spaces.
Aims The intent has been to discover and document the performance of the design layout in respect of enhanced opportunities for social engagement, privacy, control and choice, inclusion and adaptability, interaction with nature, and indoor air quality.
Methods The design of a mixed-methods case study employed a post-occupancy evaluation person-centred toolkit and was undertaken after the first year of occupancy. Patients, their families and friends, staff and volunteers participated in semi-structured interviews and surveys. A thematic analysis of interview transcripts produced key themes from qualitative data while survey responses provided quantitative and statistical