people did not know if cultural/religious/spiritual needs were met during EoLC. 58% believed that end of life care for older people should have equal priority for the NHS. 43% of respondents did not know where to get the support if someone close to him/her were to die. Only 41% believed that people could take part in decision-making around EoLC though 85% of respondents felt confident to get involved in EoLC decision-making. 82% thought that their preference should take priority over wishes of others, 61% considered that involving others in the EoLC decision making of using life-supporting technology would place extra burden on them whereas 27% considered that this would limit their privacy.

Conclusions Understanding public attitudes is essential to understanding changing contexts of care. Developing a need-based EoLC model will be innovative and enhances an effective service delivery.

Conclusions The TV series is the most significant opening up of the hospice sector in recent years.

Poster presentations
Bereavement, loss and grief

P-1 BEREAVEMENT CAFÉ: MORE WITH LESS IN BEREAVEMENT SUPPORT

Steve Nolan. Princess Alice Hospice, Esher, Surrey
10.1136/bmjspcare-2018-hospiceabs.26

Background Bereavement support is well-established within palliative care. The need for good quality bereavement support is exponential but the ability of hospices to address this need is limited. The Commission into the Future of Hospice Care identified the need to develop collaborative partnerships in order to extend hospice care (Calanzani, Higginson & Gomes, 2013). Partnering with volunteer community/faith groups suggests an opportunity to extend bereavement support beyond what a hospice might hope to achieve alone. It also furthers the goal of building compassionate communities (Kelklehear, 2005).

Aim To extend the hospice’s bereavement support to more people across its care area by building a network of collaborative partnerships between the hospice and community/faith groups.

Methods Three community/faith groups expressed interest in providing bereavement support by setting up a Bereavement Café. Each group provided a venue, volunteers to staff the Bereavement Café and modest refreshments. The hospice provided a two-day training course, publicity materials, guidance on setting up and running the Café and ongoing support and mentoring through the first year.

Results Initial meetings were held in March 2016 and a two-day training course delivered in June. The first two Cafés opened on a once-monthly basis in October 2016. The Cafés open at different times on different days of the week for up to 90 min. They welcome any bereaved person (regardless of previous hospice involvement). Average attendance is 4–8 people per session. The hospice provides regular supervision for Café volunteers through a debrief when the Café has closed. The partnerships require no financial commitment from the community/faith groups.

Conclusions Currently, five Cafés are operating, with five more planned in 2018. The model has proved replicable and sustainable and is achieving the hospice’s ambition of expanding its bereavement support to more people across its area of care.