Aim Our aim was to develop a range of bereavement support options for people to access in a hope to reach out to more people. Our aim was to increase the number of people receiving support from our service by 30% over a two-year period.

Method Over a two-year period we have developed a broader range of bereavement support services that has scope to encompass individual ways of grieving. These include the traditional one-to-one and telephone support as well as innovative support systems such as a bereavement online support group, monthly bereavement café, Make, Do and Mend, bereavement craft groups as well as offering advice and support sessions at the local library on a weekly basis.

Results We have now established a broader range of bereavement support services and are delighted to be supporting substantially more people. In May 2017 our service caseload for people accessing the service was 96 and by May 2019 this rose to 250 which confirms a 160% increase in support being provided.

P-249 ENTERING A PERSON'S WORLD RATHER THAN EXPECTING THEM TO ENTER OURS WHEN ADDRESSING PALLIATIVE CARE

Liz Mathews. *Ashgate Hospicecare, Chesterfield, UK*

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Background National and local research studies highlight the negative impact of social isolation, especially in remote areas of high economic and social deprivation (Marmot, 2010). Vulnerable groups e.g. the terminally ill, carers and the bereaved cannot always access mainstream support networks (Steptoe *et al.*, 2013) and can benefit more from accessible, culturally appropriate and varied support supplied within resourceful bereavement hubs in their local community (Social isolation: annual report of the Director Of Public Health For Wirral, 2012–2013).

Aims To develop multi-disciplinary bereavement hubs within isolated communities that provide tailor-made palliative care for pre/post bereavement. This support will embrace cultural diversity, encouraging self-sustaining provision, empowerment and resilience for terminally ill patients and their carers, friends and family, particularly focussing on the more vulnerable in society e.g. young carers. The project aims to lessen social isolation, increase social capital, and address the public health Five Ways To Wellbeing module.

Methods Review literature. Research local/national need. Feedback analysis. Internal consultation. Consultation with relevant local organisations. Funding applications. Secure premises. Recruit and train specialist hub volunteers to provide practical, spiritual and social support. Liaise with other agencies to collaborate. Assessment and personal goal planning. Continuous service review and evaluation, SystmOne reports of service, Core outcomes and individual evaluation questionnaires.

Results Increased coping skills, wellbeing and mental health measured by Core 34 psychological assessment. Greater social activity and increased peer support verified by group activity registers and regular evaluation. Increased referrals and access to service for isolated young carers. Improved multi-agency working. 36 volunteers trained to offer model of support. Increased education regarding self-care achieved by personal goal planning.

Conclusion Evaluation of the pilot hub showed substantial increase in social activity, peer support, resilience and access to local provision aided by increased multi-agency working. It is beneficial for service users and cost-effective for hospice provision. Also, we saw additional coping strategies and autonomy within families, resulting in an improvement in wellbeing.

P-250 DEVELOPING A SUCCESSFUL BEREAVEMENT DROP-IN GROUP

Tracey Addy, Helen Brown. *Kirkwood Hospice, Huddersfield, UK*

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Kirkwood's Bereavement Drop-in has evolved in recent years to its current successful model. Held every two weeks, on average 45 people attend. The Drop-in has been effective, in part due to its informal and relaxed feel. It is arranged in a 'café'-like style which gives us the ability to split people into smaller groups to help people feel more at ease and less intimidated. Although the Drop-in may feel informal, each session is structured and is set around 'themes'. An example might be 'adjustment and change', 'Making sense of my grief' etc.

Themes are discussed with a volunteer support worker or core staff member available to 'steer' the conversation. Peer support is very evident where members feel able to share personal stories – which are obviously encouraged. Halfway through the session, the group is split in order to offer a larger 'structured therapy group'. This group is facilitated by a core team counsellor and a volunteer counsellor.

In an attempt to manage numbers and to encourage people who are newly bereaved we set up a 'new to service' group. This is specifically for people who are newly bereaved or have had a more recent bereavement. It was evident that these people are clearly at a different 'stage' of grieving and they felt intimidated by the large group – who were clearly 'further on' in their grieving process. We offer five sessions in this group as a 'holding' and 'normalising' support.

Feedback for the drop-in session has been positive, and has been an excellent way of engaging the local bereaved community. There is future scope to expand the drop-in event to address isolation and loneliness. Currently, the possibility of an outreach service is being scoped, in order to reach further areas in Kirklees which could possibly involve other members of the hospice multidisciplinary team such as social workers.

Workplace Business and Culture

P-251 SOCIAL VALUE – WHY IS MEASURING IMPACT IMPORTANT TO HOSPICES?

Declan Carroll. *Peace Hospice Care, Watford, UK*

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Background Commissioners of public services should already take account of evidence impact where appropriate as part of their evaluation when commissioning services. We believe that we should evidence our impact and value for money and be in a stronger position to deliver more to our community i.e.