

Introduction and Background

The Cruse-ExtraCare Bereavement Supporter Project was funded by The National Lottery Community Fund, and ran from 2017 to 2021.

Cruse Bereavement Support is the UK's leading bereavement charity for people in England, Wales and Northern Ireland. They help people through one of the most painful times in life – with bereavement support, information and campaigning. The ExtraCare Charitable Trust's vision is to provide better lives for older people by providing sustainable communities of homes older people want, lifestyles they can enjoy, and care if it is needed.

Together, Cruse and ExtraCare developed the Bereavement Supporter Project after identifying a need to better support bereaved older people. It was hoped the project would open up conversations about bereavement, death and dying and that it would recognise the vulnerabilities that exist alongside the opportunities for social engagement, support, and care afforded by 21 ExtraCare retirement villages and schemes.

Special thanks go to The National Lottery Community Fund for their support and guidance, without which the Project would not have been possible.



The Evaluation Final Report

The Evaluation was designed to determine whether the Project met its objectives, which were to:

- Provide information and increase awareness about how grief may be experienced, and support services that are available.
- Recruit, train, and deploy ExtraCare residents to be Bereavement Supporters who will act as first contact listening support to bereaved people in their communities.
- Improve signposting and access to specialist bereavement and mental health support services.

In this Final Report of the Evaluation, we will use data gathered from stakeholders within ExtraCare and Cruse to report our findings.



The full report is available on the project page:
www.cruse.org.uk/about/our-work/bereavement-supporter-project/

Setting

The Bereavement Supporter Project sits within ExtraCare's commitment to the Gold Standards Framework for End-of-Life Care, which seeks to provide better support for people as they approach death, to ensure they live well until they die. Part of this is about fostering open dialogue about death.

The Project was designed around a tiered model of bereavement support in accordance with the public health and compassionate communities approaches to end of life care and bereavement as advocated by, for example the National Bereavement Alliance (Penny and Relf, 2017); and the Irish Hospice Foundation (2020). This ensures that support meets the needs of the 4330 individuals living in ExtraCare and that it is offered in an appropriate way, which for a majority will mean simply having access to reliable information and advice and peer support.

This model is dependent on the commitment of volunteers to provide peer support to other residents. Volunteering is a central aspect of ExtraCare village life.

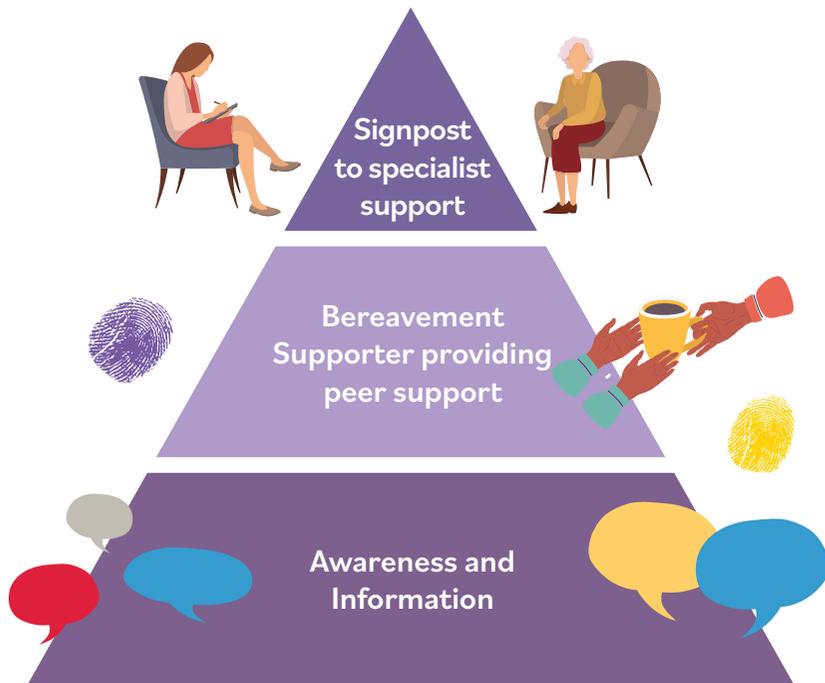


Figure 1. The three-tiered approach to improving bereavement support within ExtraCare villages.

The Bereavement Supporter Project

The Bereavement Supporter Project is made up of constituent parts:

- Cruse Loss and Bereavement Awareness Training
- Informal Loss and Bereavement Information Sessions
- Resident Bereavement Supporter Volunteers (henceforth, RBSVs)

RBSVs were required to attend the Cruse Loss and Bereavement Awareness training. Staff were also encouraged to attend. Informal information sessions, for staff and residents, were held to bring death conversations into the open.

The data we report on came from four ExtraCare villages:

- Hagley Road Village • Longbridge Village
- New Oscott Village • Pannel Croft Village



The Evaluation

The Evaluation was embedded within the wider project. Aston University won the tender to carry out the work, and began working alongside the Cruse and ExtraCare Project Leads. The remit of the Evaluation was to examine:

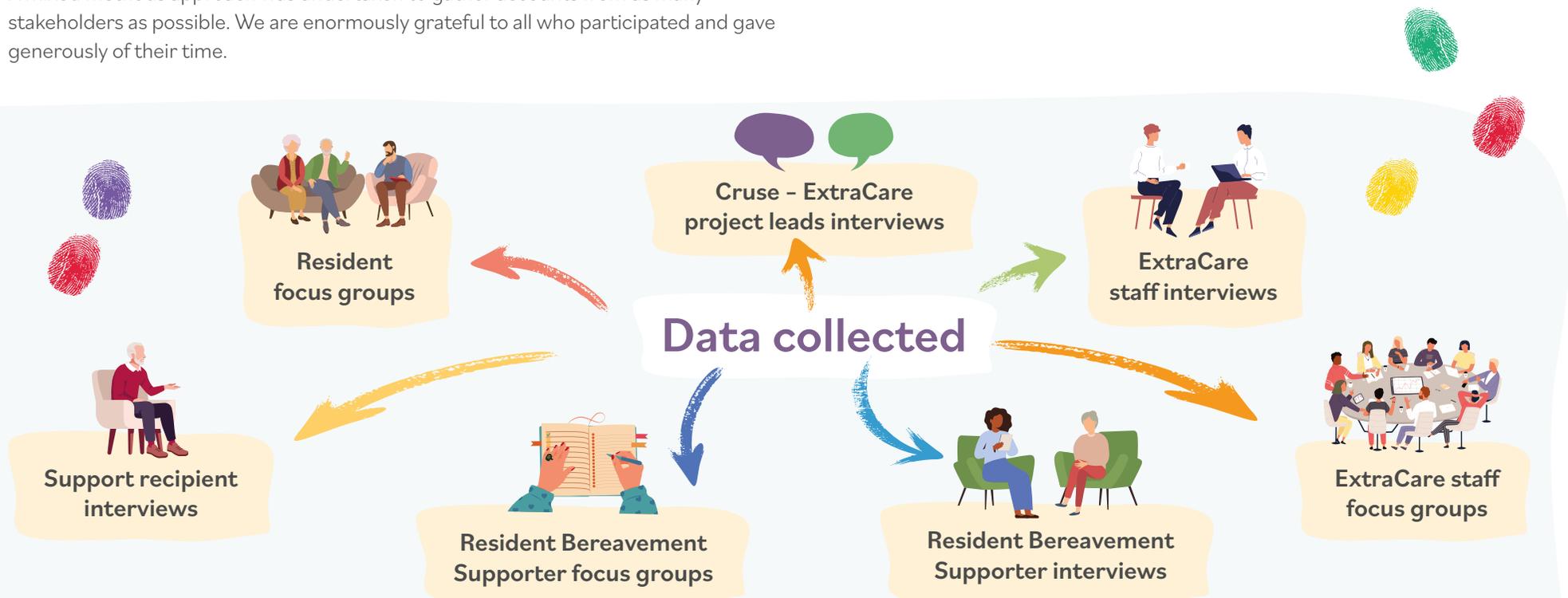
- How the service was organised and delivered.
- The quality of the training and information delivered.
- Outcomes for individuals (e.g. resident Bereavement Supporter Volunteers, staff, and residents who have received support).
- Wider impacts.

A mixed methods approach was undertaken to gather accounts from as many stakeholders as possible. We are enormously grateful to all who participated and gave generously of their time.

Summary of Findings from the Interim Report

The interim report focused on the experiences of the Loss and Bereavement Awareness Training, as well as the motivations of RBSVs for taking on the role. Volunteers also told us about their experiences of offering support, and we received several accounts from those in receipt of support.

Training was very well received. RBSVs were highly motivated and some were also highly skilled. Support offered varied, and on occasions it was more informal than originally planned by the Project. Capturing accounts from support recipients was challenged by the lack of formal referrals taking place. The variation in support offered, also meant a need for further clarification of roles and remit was required.



Data were gathered in 2 phases across the four sites.

Figure 2: Methods of data collection completed in the Evaluation of the Bereavement Supporter Project

Engagement with the Project (2017- 2021)

From available data collected, to date participation has included:



- **49 Bereavement Supporter volunteers** trained and **18 residents** trained as part of the new 'Community Model' approach



- **Over 390 staff** received Cruse Loss and Bereavement Awareness training; and over **210 staff** attended a Loss and Bereavement Information Session



- **Over 1290 individuals** accessed bereavement support (residents, family members and friends of the village)

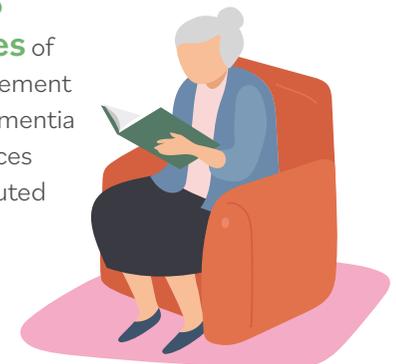
- **Over 1500 residents and members of the wider village community** engaged with Loss and Bereavement Information Sessions, information stands or attended talks



- **Over 400 residents** took part in #IRemember week 2020



- **3975 copies** of bereavement and dementia resources distributed



Final Evaluation Results

1. How the service was organised and delivered

The Project developed its bereavement support in quasi-professional terms with referrals, formal records and peer review. It quickly became obvious that that process-model gave way to a more informal and ad hoc provision of support, sometimes simply a one-off conversation – being a good neighbour, if you will.

“.....People in here that knew me put people forward to me “that she could do with a bit of counselling” or sometimes it was just that I met someone in the hall who had lost their partner and they needed support and felt that they were isolated so I just asked them their apartment number and asked if they didn’t mind me coming to visit them, and then I did.”
(Cathleen, RBSV)

As these changes were observed, the Project Management Group agreed to adopt a new Community Model involving a 2.5 hour training session offered to all residents to enable them to talk more confidently about death and dying. This new model potentially addresses some of the organisational factors that have hindered the Project’s initial objectives being fully realised.



The challenges included:

Project champion

There were several iterations of support structure, which led to inconsistency in the championing of the Project. Due to the changes in responsibilities between different roles, it was difficult for us to identify which role was best placed to champion the Project. Nevertheless, it was clear that a consistent Project champion within ExtraCare was required to develop the vital triangle of trust between staff, volunteers and residents.



Trust in the Project and volunteers

The Project has worked best in villages where there is a high degree of trust between residents and where residents feel empowered to drive their own initiatives. In other locations where the RBSVs were less well known and not such a well trusted figure, it was difficult to make successful referrals. Residents’ concerns about accessing support from an RBSV in their own village were sometimes reinforced by ExtraCare staff, which prevented the bereavement support from embedding in the community as it had elsewhere.



Vagaries of buy-in to the Project across villages

There was great variability in how the Project was implemented across the villages. Lack of visibility of the RBSVs and in some cases lack of endorsement of them and the role by ExtraCare staff posed challenges. Some staff suggested that RBSVs required more training. They were not always cognisant of the professional lives, qualifications, and status of some of the RBSVs, and it's possible staff felt their own professional standing was being threatened. To ensure the success of peer-led bereavement support, it is essential for staff and RBSVs to spend some time together to enable them to recognise each other's skills and experience and to develop appropriate boundaries between their roles.

“I think what you said about staff not referring, I probably should hold my hand up because I haven't done as many referrals as maybe I should...but it's like what you said, if somebody is coming in to see me and I've managed to engage with them and they've managed to start talking about something, why would I then say “would you like to” you kind of stop them to send them somewhere else I just allow them, and if they want to come back and see me then they can come back and see me because obviously you've started something so I... because I see it as part of my role anyway so I wouldn't sort of say “off you go” that's part of what I do, if I can support them then I would.”

(A Wellbeing Advisor)

This Wellbeing Advisor identified a major hurdle in the implementation of this peer-led bereavement support; boundaries between professional and volunteer were confused and RBSVs were perceived as not adequately trained, despite staff not knowing the full detail of the training received. This meant staff didn't always buy-in to the Project. It also meant RBSVs didn't receive referrals and didn't always have appropriate spaces in which to meet with residents.



2. The quality of the training and information delivered

The Loss and Bereavement Information Sessions and the formal Cruse Loss and Bereavement Training were valued highly by both ExtraCare staff and residents who participated in them. Feedback was very positive. Attendees reported that the training had enabled them to understand the impact of grief on emotions, body and mind, and that they would be able to support someone who had been bereaved.

“I speak more confidently more about bereavement I’ve listened more (quietly) instead of trying to fix. Reassured resident that bereavement is normal and different for everyone.”

“I think that I have encouraged people to talk a bit more even when they seem to be ok. I feel much more confident about discussing bereavement with Residents. I have felt more confident to offer my support and empathy to anyone either in the village or around me suffering a bereavement.”
(Staff members who have attended training)

Training fosters a broader understanding of residents’ losses

The training encouraged staff and volunteers to consider other kinds of losses, e.g. loss of the family home or pre-death experiences of loss through dementia, or indeed the losses endured during the Covid-19 pandemic. In short, it enabled attendees to perceive bereavement and people experiencing bereavement in a holistic way.



Training complements existing skills of RSBVs

The Cruse training was adopted by attendees into their own pre-existing worldviews and other roles. Some RSBVs had been involved in support or community activities previously and saw the RBSV role as an extension of those.

“I’ve got a group, I run a book club and an art club, as an art teacher and there’s quite a lot of us there where we share, we’re doing some art and we’re talking together so that helps as well as part of the bereavement and it’s very funny as well because I’ve found that when we’re talking to people who are in bereavement but are a bit closed sometimes a long-time bereavement but it’s still there so they’re able to talk while we’re doing something and I don’t think they even notice that they’re talking about the bereavement in that way while they’re doing something or other so in that way yes, it’s been good.”
(Nancy RBSV mixed site FG, T2)

Mixed attitudes of staff towards volunteer training

The majority of Volunteer Organisers and Enablers had attended the training, but uptake among other staff was lower in some sites. In one location, some staff were highly sceptical of the volunteer training. Because they hadn’t received the training themselves, they didn’t know its content, which meant they understood less about the purpose of the bereavement support and the ethos of the Project. Others, though integrated the training into their daily practice, even in roles where it may have felt less relevant.

“Just the way I approach relatives who have lost a loved one. Some want to deal with things straightaway whereas others prefer to wait before dealing with formalities. I deal with end of tenancies so have adopted a slightly different approach when dealing with the bereaved relatives – understanding that they all react in different ways.”
(Staff, Sales team).

In sum, the training and information sessions have been widely taken up by staff and volunteers across ExtraCare. The feedback is testament to their quality.

3. Outcomes for individuals

Individual volunteers, bereaved residents and residents with dementia were at the centre of the Project and of primary interest to the funder, The National Lottery Community Fund.

Volunteers

There was a variety of motivations for taking up the role of RBSV. Some were motivated by their own experience of grief and loss and wanted to give something back. While there were no formal qualifications to become a volunteer, there is a formal role description, a requirement to attend the training, and an assessment of suitability for the role. Nevertheless, the level of expertise among volunteers was striking. A number had held professional support roles in their careers (e.g. clergy, palliative care nurse, bereavement counsellor, physiotherapist, drug and alcohol support). It was clear that the RBSV provided a role for residents with these pre-existing skills. It also demonstrated that some of the support provided by RBSVs was challenging and required this expertise.

Some RBSVs went to extraordinary lengths to support people, including those people who may not be well liked in the community. However, there was a great amount of variability in the way RBSVs interpreted their role. The formal referral process initially implemented soon gave way to more informal conversations, thus moving from 'support' to being 'neighbourly'.

“...With the majority of people I speak to is informal, what I would call informal and that is really the majority and as I've mentioned on many occasions I find it difficult to know what is supporting or just being neighbourly [...] I find it very much a woolly area between formal referrals and informal because sometimes you can't separate the two [...] you don't know whether you're supporting as a Bereavement Supporter or whether you're being, whether your character is that you would help anyway, or support anyway...”
(Richard RBSV T2 FG)



For some, the blurred boundaries between formal support and this Community Model of being neighbourly was not a problem. For others, though, the role was perceived as quasi-professional and the lack of referrals for formal support posed a real barrier to them being able to fulfil their role.

Inconsistent support for RBSVs

There was a lack of consistency in how supported the volunteers felt.

“I think volunteer person should get support for themselves as well, coz you keep giving, giving all the time you should be able to receive sometimes. I've never had any support [...] it would be nice, it would be nice for all the volunteers to come together and somebody minister us, not just teaching about it, but talk to us about our experience.”
(Marilyn, RBSV)



Lack of visibility of the Project

Possibly, due to the inconsistencies in structural support for the Project, some RBSVs in some villages felt invisible. The lack of visibility and referrals also meant RBSVs experienced difficulties in finding appropriate space to carry out their support sessions when they were booked in.

“4th June 2020 - During our private session, indicted by a sign 'Meeting in Progress' on the door, we were interrupted by a Care Worker who prioritised putting her cup in the sink over our privacy. Asked by lady if she was a Carer, then told off. Flippant response 'get my wrists slapped'...She may put in a complaint?”
(L2P1 - RBSV and Diarist)

The Cruse Loss and Bereavement training emphasises respect and confidentiality, but it is difficult to sustain these values without the appropriate infrastructure.

Communication between staff and RBSVs

A further challenge related to the lack of information from staff about the wellbeing of the residents they support. The bureaucratic processes and a general sense of nervousness about revealing resident details had impeded communication, which in turn meant RBSVs were unable to provide proactive support.

At worst, RBSVs felt patronised by staff because they were not trusted with confidential information about residents they were supporting. This could be related to the extra care setting, which is ambiguous by nature. However, we have seen examples of very good practice in some locations, building towards a co-production approach between staff and volunteers, which creates a mutually productive environment for staff and volunteers.

The Bereavement Supporter role during the Covid-19 pandemic: evidence from the diaries project

The pandemic provided challenges for the Project, but it also provided an opportunity for new means of data collection which produced rich descriptions and insights from RBSVs and staff. The lockdown and social distancing requirements meant RBSVs offered their support in new ways (e.g. telephone support) and while some residents struggled to deal with their losses alone, others appreciated the space afforded by the lockdown and were able to process their grief at their own pace.

More information on the diaries project can be found here:
www.cruse.org.uk/about/our-work/bereavement-supporter-project/

Residents

Accurately capturing how many residents received support was challenging and became more so as the Project adopted more of a Community Model. Much bereavement support was provided on an ad hoc and informal basis which means it was not well documented. Plans to reach more residents who had received support, as part of the evaluation, were challenged by the pandemic.



Support for residents through Covid-19

The diaries gave additional insight into the support provided to residents during the pandemic.

“My friend Eunice, I told you her grandson was very ill [with the virus]. Well, he died. I did go round and see her. I didn’t break the rules. She was in the bedroom and I was in the passage just talking to her. I spent quite a few hours with her, because she was absolutely down, absolutely, absolutely devastated.”
(RBSV, diaries project)

RBSVs have provided a vital source of support to residents. They adapted to telephone or video call support, they created chains of calls around the villages to reduce isolation, they arranged socially distanced meetings for residents in doorways, and one diarist even cooked meals for another resident.

The benefits of being in the ExtraCare environment

Being part of a larger community was experienced as a benefit when there was a bereavement, even during the pandemic.

Men and bereavement

ExtraCare staff and a male volunteer have commented that fewer men are engaging with the Project than women. There are assumptions about how men seek support but it may be worthwhile doing some more work to fully understand the kind of support men feel they need. The uptake of bereavement support by men in the community is similarly low.

Residents with dementia

A number of resources have been developed by Cruse and ExtraCare to improve bereavement support and provide specialist information for residents living with dementia, carers, and staff. These include a staff guidance factsheet about responding to distress responses; a guide for carers written by carers about losses they’ve experienced; and a report exploring losses experienced by people living with dementia.

4. Wider impacts

Recognising a shared culture of loss

Culture change takes time, but what is striking in this Evaluation is the change in the way staff and RBSVs perceive loss. They have adopted a holistic approach to grief and loss and extended their understanding of bereavement beyond simple death-related loss. Since the introduction of the peer-led bereavement support, there have been more opportunities to talk about loss and grief and thus begin to build grief literacy within the community. The shared vulnerabilities experienced by residents, RBSVs, and staff alike, have been recognised, and amplified during the pandemic, which has enhanced understanding and empathy.

Communicating death and talking about death

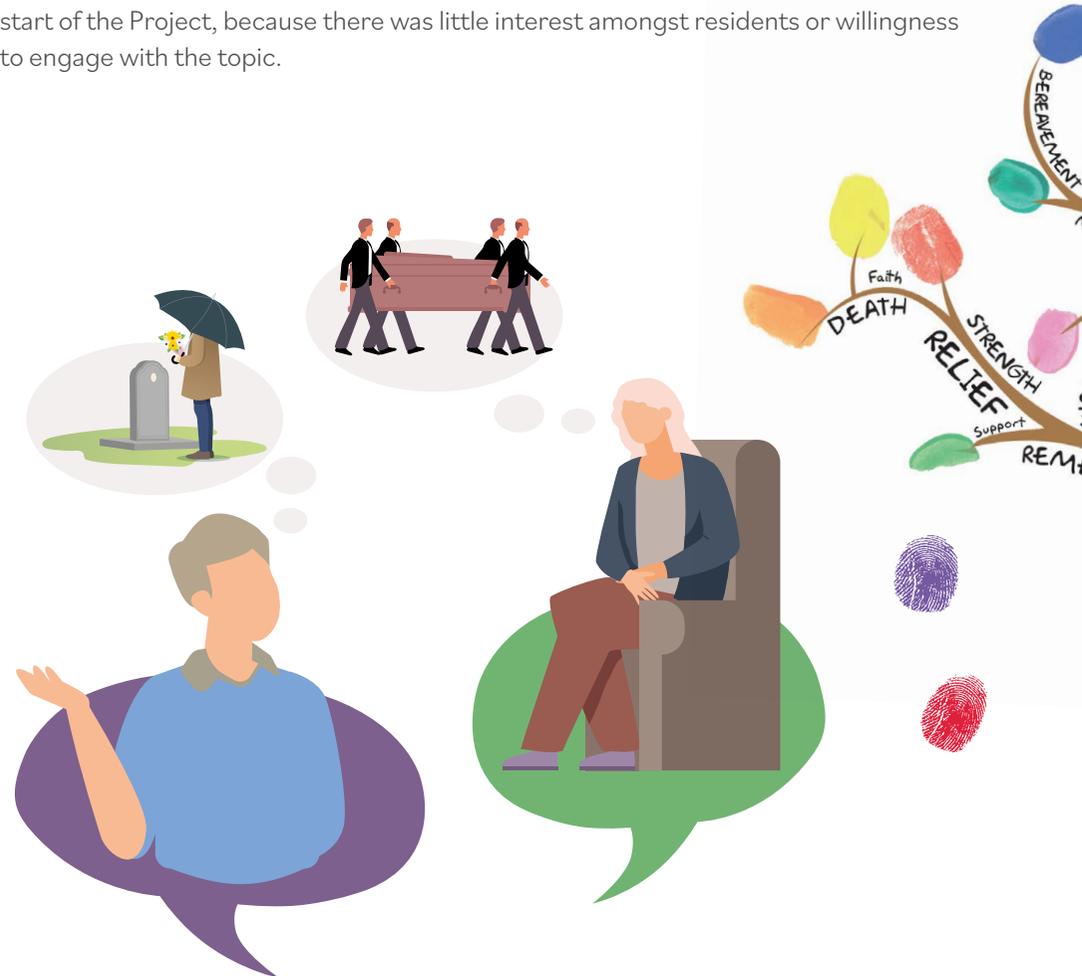
The Cruse Loss and Bereavement training has helped staff and RBSVs to overcome anxieties about talking to residents about death, dying and bereavement. A simple but significant change for staff has been the recognition that bereavement support doesn't always require action.

“Normally with care, you know, you've got somebody you have to action it, whereas if somebody is just talking, it doesn't necessarily need an action.”
(Phase 1 focus group with ExtraCare staff)

There remains some reluctance to open communication about the death of residents among some staff. This means death becomes an uncomfortable truth that some may try to cover up through platitudes as a way of avoiding the hard truths. Death becomes 'passing away', which does nothing to help foster an accepting environment for peer-supporting residents who are grieving. This is of course a wider cultural phenomenon, but arguably one an extra care community is well positioned to lead change. In its adoption of the Gold Standards Framework for end of life care, ExtraCare has made a commitment to opening up dialogue about death, dying and bereavement.

Collectively grieving

As a postscript to the data collection, ExtraCare (supported by Cruse) provided locations with resources and guidance to actively participate in the Dying Matters initiative #IRemember week held between 26th October and 1st November 2020. Over 400 residents took part giving them the time and space to collectively grieve for or reflect on a recent or historic loss, a chance to say goodbye in lieu of funeral attendance and a tangible and practical way to remember. Both the Cruse and ExtraCare project leads felt this participation would not have been possible at the start of the Project, because there was little interest amongst residents or willingness to engage with the topic.



Concluding Thoughts and Recommendations

The success of the Bereavement Supporter Project lies in the impact of the training on residents and staff at all levels of the organisation, which, in turn, has spurred the development of grief literacy across the organisation. What we have also learned through the diaries project is that RBSVs have been pivotal in supporting residents through death-related bereavement as well as through other significant emotional challenges associated with other kinds of loss. In many ways, the Covid-19 pandemic has proven the need for the Project and demonstrated the additional value of the RBSVs.

On reflection, we have observed challenges in implementation of bereavement support due to the perceived contradictions between traditional approaches to patient confidentiality and the public health approach of the Gold Standards Framework (GSF) for end of life care and the approach embedded within the notion of compassionate communities. ExtraCare staff's reticence to communicate residents' health and wellbeing status resulted in a need for residents to formally present with need or to self-refer to bereavement support. In practice, we didn't see those formal referrals. Instead, especially during the pandemic, we saw more of the proactive peer-to-peer support endorsed by the GSF and compassionate communities.

During the Evaluation period, the design of the Bereavement Supporter Project has undergone a number of iterations in response to the evaluation work. Among the changes is the move toward a more informal neighbourly supporter role, with a 2.5 hour training session open to all, instead of the 1 day training conferring eligibility to take on the role as RBSV. We have not been able to fully evaluate the implementation of the Community Model, although we have been able to glean some insights from residents' responses to scenarios of bereavement following the training. These would indicate that the Community Model is consistent with the compassionate communities model, fostering an environment in which all residents can each speak self-assuredly about death, dying and bereavement and be compassionate neighbours, and aligns well with the requirements of the GSF. What is also evident from these insights from residents in villages with no experience of the original and more formal RBSV model is that an infrastructure of support from appropriate staff would still be required to embed and legitimate the model. Both the more formal RBSV model and the Community Model require an organisational culture in which staff, for their part, feel able to share the news of resident deaths; and volunteers, for their part, feel that they have the backing and confidence of staff when it comes to offering support to other residents.

On balance and despite the introduction of the less formal Community Model, we do recommend the retention of the RBSV role for two key reasons:

1. It is evident that many resident RBSVs have professional experience and skills conducive to the RBSV role and it would be a shame not to utilise these for the good of the villages;
2. The RBSVs have provided a kind of support that goes beyond good neighbourliness; they have been able to support residents who are not well integrated or perhaps not well liked in villages and they have been able to overthrow some of the paternalistic organisational practices around death, dying and bereavement.

To retain the RBSV role successfully, work is required to clarify its remit.

Perhaps two roles could be taken forward:

- (i) a quasi-professional RBSV role with clear entry and training requirements and
- (ii) a compassionate neighbour role.



Limitations

There were limitations to our Evaluation of the Bereavement Supporter Project. We were unable to gather as much data as intended from support recipients and staff during phase 2.

Our data are therefore skewed toward the position of RBSVs. Nevertheless, the opportunity we took to gather diary data during the Covid-19 lockdown of spring-summer 2020 elicited rich, personal accounts that have added depth to our analysis. The four sites we accessed does not provide a representative sample, but what is lacking in breadth is more than compensated for in depth.

4. Clear protocols on data sharing between staff and Bereavement Supporter Volunteers

Any role requires boundaries within which to function, but it appears that boundaries between staff and RBSVs have been too rigidly interpreted by some members of staff when it comes to sharing even basic information about residents that could aid them in their role. A clear protocol needs to be established across the villages about what can be shared with RBSVs about residents' health, wellbeing and whereabouts.

5. A supportive forum for RBSVs

We noted that some RBSVs have suggested that they would like the kind of clinical supervision that is normally given in professional counselling roles. We also understand that this is probably not practical or necessary within the remit of the Project. Nonetheless, we recommend that some sort of supportive forum is established in which RBSVs can discuss the support they're providing, any problems experienced with support recipients, and any issues they have found difficult to deal with. The emotional cost of bereavement support needs to be recognised and ExtraCare needs to fulfil its duty of care to its residents in providing them with appropriate and on-going support. We understand that the initial service model placed onus on the Volunteer Organiser to have monthly peer meetings in their village with RBSs but this does not seem to be consistently applied. This needs to be revisited.

It is likely that ExtraCare staff would also benefit from the provision of such a forum; they are certainly not immune to the emotional labour inherent in grief work. It may be beneficial to further pursue the relationship between ExtraCare and Cruse in the provision of said supervision.



6. Open death dialogue fostering grief literacy

The Gold Standards Framework (GSF) for End-of-Life Care promotes open dialogue about death and advance care planning. As an organisation, ExtraCare has signed up to the GSF and offers expert End-of-Life Care. As part of that endeavour, and to develop grief literacy among staff and residents, there is a need to bring death conversations into everyday living in ExtraCare villages. We have seen some very positive signs that the Loss and Bereavement Awareness Training, and Information Sessions, have started to develop the grief literacy of both staff and residents. We have also seen how the RBSVs have challenged and modified entrenched practices around communication about ill health, death, dying and bereavement and organised collective memorial events and so on. These practices need to be strengthened and generalised across the villages to fully embed the ethos of the Bereavement Supporter project and to foster compassionate villages.

We also found euphemisms for death in common usage; language may seem unimportant, but the way we talk about (or don't talk about) death can significantly impact on the way people think about it and behave around it. The covid-19 pandemic has brought death and grief into the open somewhat. This offers an opportunity to capitalise on the shared experiences of grief residents and staff have had during the various stages of lockdown in 2020-21 by continuing conversations about loss, death, and dying.



7. Telephone support

Despite expectations of the former, RBSVs' experiences of providing telephone support were largely positive and they were well received by support recipients. Telephone support fosters anonymity, which can encourage some to seek support who would otherwise avoid it, perhaps men in particular. It also encourages wider uptake of bereavement support across villages; volunteers would not be restricted to supporting those living in their own village. It may be that telephone support is supplemented by use of other technologies (e.g. video call software) if desired by residents.



8. Appropriate spaces for bereavement support

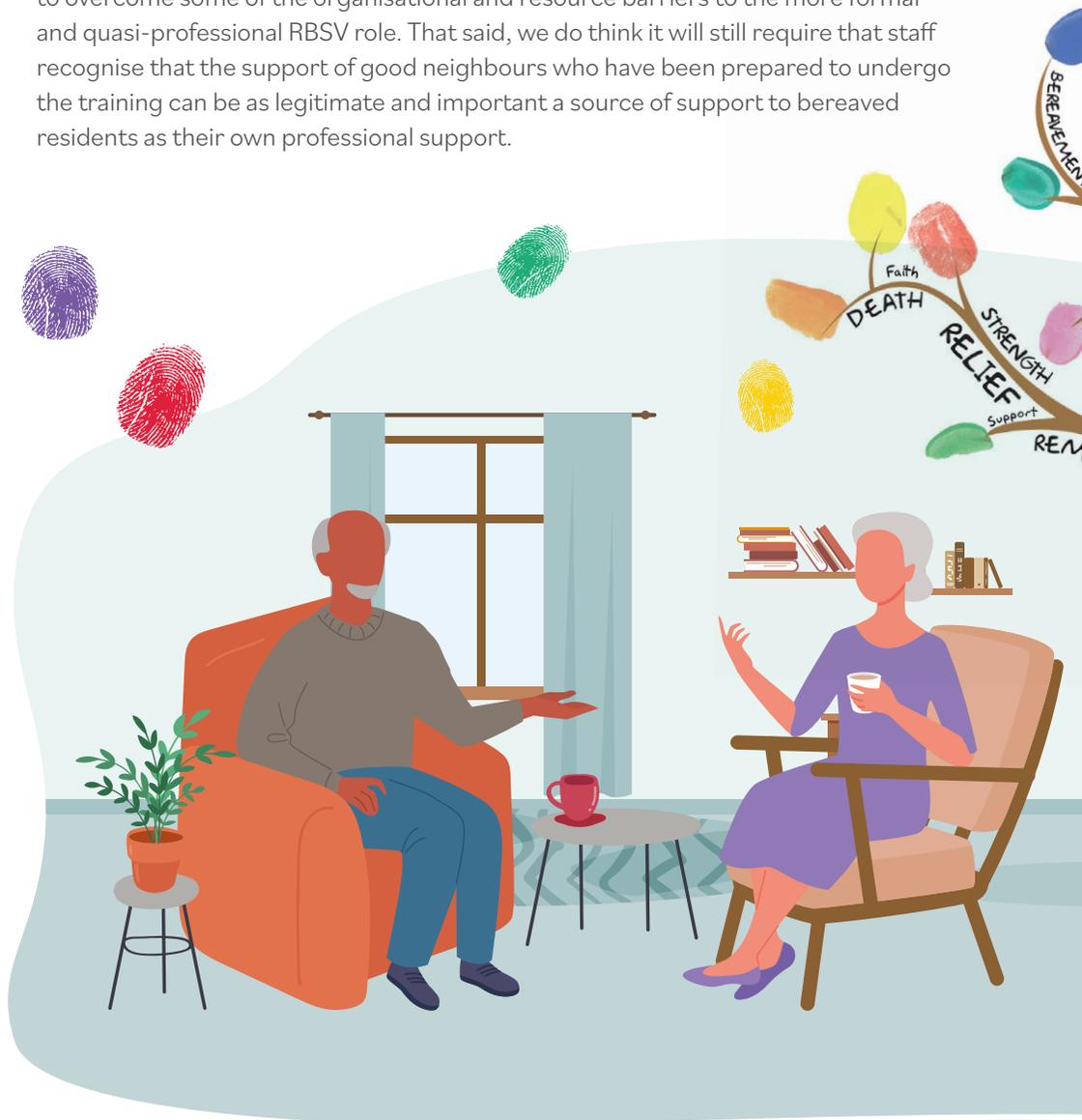
On several occasions the lack of space was identified as a problem for RBSVs. Existing spaces had been commandeered by volunteers which worked well, but they were not always available. Some support sessions were interrupted by residents who were unaware they were being used as a private space. Space needs to be culturally appropriate to recognise the different ways in which people grieve and make sense of death.

9. Compassionate communities training

The Cruse Loss and Bereavement Awareness training is arguably one of the most successful elements of the Project, so we see no reason to alter that. That said there seems to be little in the training about how to apply that knowledge of bereavement to the development of compassionate communities. We have seen some very good practice from the RBSVs in terms of working supportively with bereaved residents to reconnect them back with the wider community with which their bereavement has temporarily caused them to lose touch. However, we have also seen how there is perhaps also a tendency to see the role as becoming a special and exclusive friend to the bereaved. There is a fine line to be trodden here and some of the ideas from the compassionate communities model may help to supplement the training in terms of a better understanding of the end goal of peer bereavement support.

10. Further exploration of the Community Model

Although we have not carried out any formal evaluation of the new Community Model currently being trialled in some of the villages, we think there is merit in exploring this further. First, it is very much in line with the public health and compassionate communities approach that asserts that in most cases of bereavement nothing more is required than a neighbourly, sympathetic ear. Second, it has the potential to overcome some of the organisational and resource barriers to the more formal and quasi-professional RBSV role. That said, we do think it will still require that staff recognise that the support of good neighbours who have been prepared to undergo the training can be as legitimate and important a source of support to bereaved residents as their own professional support.



Cruse

Bereavement
Support

Cruse Bereavement Support is the leading national charity for bereaved people in England, Wales and Northern Ireland.

We help people through one of the most painful times in life – with bereavement support, information and campaigning.

For more information:

www.cruse.org.uk

Freephone National helpline number:

0808 808 1677



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The ExtraCare

Charitable Trust

ExtraCare is a registered charity established in 1988.

Our vision is better lives for older people.

The ExtraCare Charitable Trust is the UK's leading not-for-profit developer of housing for over 55s. Since 1988, we've operated retirement villages and smaller housing developments around our Midlands base and further south. Today, we support older people in 16 retirement villages and 5 housing schemes.

For more information:

www.extracare.org.uk



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