action learning sets, 360 degree feedback on their leadership behaviours and the opportunity to lead on a specific service or practice development project relevant to their role.

Results Evaluation demonstrated that participants developed their abilities in:

- self-awareness, self-management and personal development;
- developing and enhancing person-centred services and care;
- managing effective relationships with team members within the hospice;
- networking and partnership working.

In addition participants designed and led a quality improvement project specific to their own area of work which supported the implementation of the hospice strategy.

P-75 IMPROVED MANAGEMENT PRACTICE THROUGH A FOCUSED DEVELOPMENT PROGRAMME

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Background In 2016 we introduced a Management Development Programme for senior managers. Programme evaluation highlighted benefits: managers bonded, gained a sense of collective responsibility, felt more confident in their roles and improved their communication within teams. Consequently, the programme was repeated for next level of management.

Aims To evaluate this second programme using the Kirkpatrick Model (*Evaluating training programs*, 1994), focusing on impact of managers' behaviours in relation to implementation of policies and performance management.

Method After modules attendees completed an evaluation/feedback questionnaire that measured reaction (level 1 evaluation) and learning (level 2 evaluation). Changes in behaviour (level 3 evaluation) were undertaken through individual interviews and group reflection session.

Results Initial reactions of attendees (Level 1):

- 99.5% agreed course was relevant to them;
- 96.5% agreed quality of training was high;
- 95.5% agreed session(s) would be useful in their work.

Learning (level 2) was evaluated through the question 'How do you hope to change your practice as a result of this training?' This question was answered 57% of the time and answers included: improvement in communication, confidence, management style. Some 18% of those who answered said they needed to reflect.

Examples given of subsequent changes in management behaviour (level 3 evaluation) included: increased confidence and assertiveness in performance management and management styles, more proactive sickness absence management, improved job descriptions and interview questions resulting in recruitment of higher calibre employees.

Quantitative longer-term results (level 4 evaluation) have yet to be established. Financial savings have been made through the proper management of long-term sickness absence.

Conclusion Evaluation of results (level 4) of this programme is ongoing through sickness absence, exit questionnaire, staff survey, performance management and appraisal monitoring. We plan to extend the programme in 2020/21.

P-76 DEVELOPING AND IMPLEMENTING A LEADERSHIP PROGRAMME FOR HOSPICE COMMUNITY NURSES

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Background and aims The aim of this project was to introduce an innovative leadership programme aimed at hospice nurses within the community palliative care team to help enhance their leadership skills and build resilience to reduce the risk of burnout. The programme aimed to develop nursing leadership skills, to enhance patient care and to improve practitioner self-management. To ensure the programme reflects the needs of the individuals and the group as a whole, a range of teaching and learning methods were employed. The programme included Myers Briggs Type Indicator (MBTI), FIERCE training, training on self-management techniques and change, group coaching and a workbook which supported the programme with self-reflection exercises. The programme was underpinned by the Clinical Leadership Competency Framework (NHS Leadership Academy, 2011) to ensure optimisation of leadership potential.

Method Focus groups were used to gather information from the participants regarding their understanding of leadership and how they felt about themselves as leaders.

Results Prior to the programme participants felt that the traits of a leader and the relationship between leader and follower were of paramount importance. There was also an acknowledgement from the participants that they did not self-identify as leaders in their role. Following the leadership programme further focus groups were used to evaluate the programme. Participants felt they had increased their confidence around their leadership skills and the programme had helped them to understand themselves and others more which they felt led to better team working which consequently increased resilience. Questionnaires were also used to demonstrate change in individuals with most showing an improvement in their confidence, self-management and team working.

Conclusion Overall, the evaluation of the leadership programme was extremely positive with the only suggested improvement to shorten the one-year programme to intensify the experience.

P-77 RESTORATIVE PRACTICE: EMOTIONAL INTELLIGENCE IN THE WORKPLACE

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Background/context In recent years evidence suggests that a happier workforce improves productivity and the quality of care being delivered to its service users. Restorative practice is an alternative, yet effective response to improving performance and avoiding unnecessary grievances. This approach saves time and the anxiety that can occur when there is conflict and unhappiness in the workplace. Restorative practice helps people to find their own solutions to problems and focuses more on the person rather than procedure.

Aim In 2016, the clinical department at Princess Alice Hospice began to adopt a less procedural approach to managing staff, and saw as a result the number of grievances fall with a happier workforce that played to the strengths of individuals. In

2017, the hospice trained six of its staff as restorative facilitators. Those chosen were skilled up to an accredited level to help individuals or teams find their way out of conflict without following a formal grievance procedure.

What do our restorative facilitators do? Our restorative facilitators act as:

- an advisor – support individuals and help them to work out their options;
- a coach – help individuals practise how to frame their argument;
- a facilitator – help to facilitate a conversation where there is tension and conflict.

Outcomes The hospice's restorative facilitators work across the organisation, and this has led to a more positive, supportive culture. There have been no formal grievances undertaken since 2016 and feedback suggests that restorative practice has played a significant part in achieving this. Time has been saved and the hospice now has empowered managers and a happier more productive workforce whereby issues are discussed as and when they arise and staff are enabled to have direct, honest conversations with each other without fear of retribution.

Conclusions Restorative practice supports emotionally intelligent leadership, reduces formal grievances between staff and ultimately supports a positive organisational culture which has the potential to increase productivity and happiness at work.

P-78 FEASIBILITY OF AN ONLINE TOOLKIT TO GUIDE IMPLEMENTATION OF THE CARER SUPPORT NEEDS ASSESSMENT TOOL

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Background The Carer Support Needs Assessment Tool (CSNAT) intervention identifies and addresses the support needs of family carers. This carer-centred approach involves a change in practice from a practitioner to carer-led process of assessment and support. Training is needed to help practitioners transition to this new way of working, and implementation support is required at an organisational level (Austin, Ewing & Grande, 2017; Diffin, Ewing, Harvey & Grande, 2018; Diffin, Ewing, Harvey & Grande, 2018). An online training and implementation toolkit was therefore developed to provide accessible and structured guidance on how to implement and embed the CSNAT intervention.

Aim To explore the feasibility and acceptability of delivering implementation training through an online format.

Methods The online toolkit has two learning components: (1) Individual: knowledge for practitioners to use the intervention, (2) Organisational: to assist a project team to plan, pilot and sustain implementation. Five UK palliative care services participated; 2–4 practitioners from each completed the toolkit. Online survey administered upon completion of each learning component for feedback on content, followed by telephone interview.

Results Fifteen practitioners completed 'Learning component 1' survey, 14 completed 'Learning component 2' survey, and 13 were interviewed. Feedback on content was positive. The most enjoyable aspects were the practical examples and the key steps to implementation being clearly detailed. The suitability

of online learning was influenced by resource availability, the nature/size of the team, and individual learning styles. Variation in location of completion (work/home or both) was partly explained by availability of IT equipment, space, and time within the organisation. Whilst the majority of participants saw the value of online learning, some preferred face-to-face delivery, and so blended learning to include group discussions was deemed appropriate.

Conclusions Whilst online learning is welcomed by practitioners, organisations need to give it the same priority as attendance at face-to-face workshops and ensure sufficient resources are available to enable completion. Blended learning may help accommodate different learning preferences.

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P-79 LESSONS FOR COMPREHENSIVE, PERSON-CENTRED CARER ASSESSMENT AND SUPPORT FROM THE CSNAT INTERVENTION

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Background The Carer Support Needs Assessment Tool (CSNAT) intervention comprises an evidence-based comprehensive tool incorporated into a person-centred process of assessment and support for carers of people with life-limiting conditions. It was developed from a programme of research, subsequently implemented across practice settings (community, hospital, hospice). The CSNAT's impact nationally and internationally is substantial: 87 UK services are licensed to use the intervention, the tool has been translated into 13 languages, and is used in 27 countries.

Aim To draw on the CSNAT intervention programme of research to illustrate why carer assessment needs to be comprehensive and person-centred, how this represents a change in practice, what difference it makes, and how this change in practice can be implemented.

Methods/results We will draw on three aspects of the research programme:

1. An overview of development, validation and initial implementation of the CSNAT: a qualitative study with 75 bereaved carers (01/2008–12/2008) identified the 14 support need domains that constitute the CSNAT; a survey of 225 current carers (04/2009–06/2010) established CSNAT's content and criterion validity; implementation studies with 29 practitioners in two hospices (08/2010–12/2010; 01/2011–04/2012) identified use of the CSNAT as a significant change in practice and the importance of adopting a person-centred approach.
2. Two cluster randomised control trials of the CSNAT intervention (UK: n=681 carers; 05/2012–11/2014); (Australia: n=322 carers; 03/2012–02/2014) showed a reduction in caregiver strain in current carers, and lower early grief and better physical/mental health in bereavement.
3. A national implementation study in 36 organisations (11/2013–09/2014) and a hospice case study (11/2015–12/2016) provided key insights into practitioners' training needs and vital organisational structures/processes needed to embed the intervention in practice, to underpin a CSNAT intervention Training and Implementation Toolkit.